

**Transformation State Incentive Grant
System-Level Evaluation
Results from Time 1 Interviews and Surveys
(Through December 2006)**

Kraig Knudsen, Ph.D.
Mental Health Transformation Evaluator
Office of Program Evaluation & Research
November, 2007

EXECUTIVE SUMMARY

The state of Ohio is in the third year of a five-year MHT-SIG grant to transform the infrastructure of Ohio's system of services to persons living with mental illness. The grant was awarded by SAMHSA to the Governor's office; it is being administered by ODMH. With the funds from the grant, Ohio is working to develop several approaches to improve the state's public mental health system; integrate currently fragmented programs across multiple service sectors; emphasize person-centered planning, peer support and cultural competence; and develop the infrastructure to ensure effective, sustainable collaboration and communication among all stakeholders in the mental health system.

For the past year and a half, the Office of Program Evaluation and Research of the Ohio Department of Mental Health has been actively evaluating the ongoing transformation efforts statewide. This evaluation assesses both the process and outcomes related to the TSIG project goals and objectives over time. In-depth interviews and surveys were conducted with 170 stakeholders in Ohio. This report represents the first round of these efforts, covering the time period from the beginning of the grant to December, 2006.

SUMMARY OF FINDINGS

It is important to note that the findings below were developed in the Time 1 TSIG System-Level Evaluation study, and cover the time period from the beginning of the grant to December, 2006.

Innovative programming is the foundation of Ohio's Transformation efforts. All of Ohio's transformation efforts have at their core a commitment to providing the best services available and improving the quality of life of persons living with mental illness. To do this, the Working Groups are advancing existing evidence-based practices, or are promoting emerging best practices that have been developed in Ohio, to address the unique mental health needs of adults, children, elderly individuals, trauma victims, individuals who are incarcerated, homeless, and those with physical health problems. The TSIG grant has made the expansion of many of these programs possible by providing a venue for state, county, and local agencies to dialogue and collaborate on issues of critical importance to Ohio's citizens who have mental illnesses.

There is motivation to participate and work for change.

In both the interviews and the surveys, respondents were quick to point out their eagerness to participate in the work of systems change. When looking at the surveys, respondents reported above-average levels of motivation to participate in TSIG. The most frequently endorsed motivators included: feeling that they made a contribution, not feeling nervous about participating, and having the freedom to choose to participate (i.e., voluntary involvement). In terms of agency motivation, respondents also reported above-average levels of agency motivation to participate in TSIG activities. The types of motivation most frequently mentioned by agencies were: 1) whether the activities of the workgroups would improve the efficiency of service provision; and 2) if the agency was eager to participate in the transformation project. Additionally, a theme in the interviews was the need to keep people involved over the long haul. Many participants indicated they felt "out of the loop". As one respondent suggested "It takes commitment and perseverance. That's the key to keeping people involved. Otherwise, in projects like this, I think the process of making improvements can lose steam over time in terms of systems cooperating, communicating and collaborating." Even now, 3 years into the TSIG project, leadership still needs to explore various ways of keeping people interested and invested in the project.

The grant's productivity is affected by the climate of the workgroups, the quality of the meetings, and project leadership.

Overall at Time 1, respondents felt that the climate of the TSIG workgroups was positive. The three most frequently mentioned workgroup descriptors were that the workgroups are actively seeking to understand the needs of persons with mental illness; their work is important; and they are striving to achieve success. Productivity was highly correlated with workgroup climate, the quality of the workgroup and project leadership. These results suggest that efforts put toward improving how people perceive their workgroups and leadership can yield positive results in terms of increased productivity. In the interviews, many indicated that participation would increase if meetings were action driven and not dominated by discussion, or process.

Agencies communicate with other organizations about mental health services based on existing relationships, not on what is needed for change.

As a measure of cross-system networking, respondents were asked to rate their frequency of communication with other agencies. The highest level of communication was with the Department of Mental Health. Eighty-three percent (83%) of the respondents indicated they communicated with the Department on mental health related matters. The next highest communication networks were found with the county mental health boards (65% of respondents), consumer advocacy organizations (56% of respondents), and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) (55% of respondents). These figures suggest that communication around transformation activities is occurring with agencies that either provide or advocate for services to persons with mental illness. Communication that occurs outside of the mental health system is topic-specific and based on strong individual relationships. For instance, the Justice Working Group communicates with the Ohio Supreme Court and the Ohio Department of Rehabilitation and Corrections. These relationships have been in existence for a number of years, long before the introduction of the TSIG Grant. There appear to be weak communication ties with some larger state agencies, which may be critical to systems change, e.g., the Ohio Department of Education. This department currently has only a few people dedicated to TSIG projects, yet school-aged children represent a large percentage of the transformation projects (32% of all first-draft CMHP projects).

Agencies have strict rules and rigid organizational cultures, hindering effective cross-system collaboration.

A significant finding of the interviews was that silos exist between and within departments on issues related to mental health. For instance, three individuals from the same organization were interviewed about supported employment. One staff member knew about the legislation being introduced about supported employment, another knew about the programmatic side of supported employment, while yet another staff member knew only about the financing of supported employment. When probed, they knew very little about what the others were doing even within their own department. These “knowledge inefficiencies” were found repeatedly in the interviews. While standardized roles and routines are common in large bureaucracies, they may also hamper system change. As one respondent stated “the main thing is to get people on the same page...our system is siloed, and for any of this to work that’s going to be a major barrier to break down—the silos in our state systems, and actually, the county systems.”

People’s capacity to work together is the most formidable challenge to achieving cross-system transformation in Ohio.

When asked about challenges to transformation in Ohio, fifty-four percent (54%) of the responses suggested that people’s capacity to work together was the biggest challenge to achieving cross-system transformation in Ohio (see Table 5). Participants named several areas that could deter systems from working together, including: not having key stakeholders participate who are in positions that can influence system change, restrictive rules and regulations that prevent cross-system collaboration, the need to maintain momentum over the long period of the grant, fragmented communication between different state and local agencies, the need for active support from the new governor and department directors, poor understanding of the TSIG grant itself, and finally, the inability of working groups to make decisions that would influence system change.

A repeated theme in the Time 1 interviews was Ohio’s home-rule status. Many believed that this could stand in the way of state-wide transformation: “I think you’re going to have a lot of battles at the local level, trying to get people to change their minds...and that’s why I am most skeptical about TSIG, because we’ve got this home rule thing going on here, where you can’t tell locals what to do...we’ve encountered it time and time again--getting change implemented locally is the biggest challenge.” As demonstrated by these comments, participants continually mentioned the need in Ohio to think about transformation as state-wide, and to focus on implementation efforts locally.

Mental Health Transformation System Incentive Grant System-Level Evaluation Study: *Time 1* Data Collection Results

BACKGROUND

On April, 29, 2002, the President created the New Freedom Commission on Mental Health. The Commission, chaired by then Ohio Department of Mental Health's (ODMH) Director, Michael Hogan, Ph.D., was tasked with studying the United States' mental health service delivery system and asked to establish a number of goals that would improve the quality of life of adults with serious mental illness and children with serious emotional disturbance (Hogan, 2003). Upon its completion the Commission recommended six goals to transform the system of services for persons living with mental illness; they are:

- Goal 1: Americans understand that mental health is essential to overall health.
- Goal 2: Mental health care is consumer and family driven.
- Goal 3: Disparities in mental health services are eliminated.
- Goal 4: Early mental health screening, assessment, and referral to services are common practice.
- Goal 5: Excellent mental health care is delivered, and research is accelerated.
- Goal 6: Technology is used to access mental health care and information.

While the Commission's recommendations were well received, there was an understanding that transforming services for persons with mental illness could only occur through the successful collaboration of all systems that serve people with mental illness (e.g., criminal justice, child welfare, courts, and education), not only the state's designated mental health authority. This understanding led the federal government, under the lead of the Substance Abuse and Mental Health Services Administration (SAMHSA), to establish state-level grants incentivizing infrastructure change at the state level, also known as MH-TSIG grants (SAMHSA, 2005).

The state of Ohio, under the direction of the director of the ODMH, applied for, and was awarded, a 5-year grant to transform the infrastructure of Ohio's system of services to persons living with mental illness. With the funds from the MH-TSIG grant, Ohio is working to develop several new approaches to mental health care; integrate currently fragmented programs across multiple service sectors; emphasize person-centered planning, peer support and cultural competence; and develop the infrastructure to ensure effective, sustainable collaboration and communication among all stakeholders in the mental health system.

To accomplish these goals, a number of Content Workgroups have been established with a mission to be agents of change by 1) assessing areas of needed improvement in specific content areas; 2) making recommendations to improve services in their areas; and 3) monitoring progress of changes made. Some of these content areas include: child and adult trauma, individuals with mental illness in the court system, offender re-entry in the community, housing, employment, and cultural competence.

PURPOSE

The purpose of the system-level evaluation study is to assess the overall effectiveness of the state's efforts to transform Ohio's system of services to persons with mental illness. This evaluation will assess the process and outcomes related to the TSIG project goals and objectives over time. Information from the evaluation will be provided to the Content Working Groups and be used to improve their ability to meet the goals specified in the Comprehensive Mental Health Plan (CMHP). To this end, the specific aims of the study are:

Specific Aim 1(A1): To determine what system-level infrastructure changes occur in each content area during the five year period of the grant.

Specific Aim 2 (A2): To identify what group, organizational, and contextual factors affect system-level infrastructure change in each content area.

Specific Aim 3 (A3): To explore how group, organizational, and contextual factors are likely to influence system-level infrastructure change in each content area.

METHODS AND PARTICIPANTS

In this first phase (T1) (October 2005-December 2006) of the TSIG system-level evaluation, a total of 170 participants were recruited through the various content working groups, advisory councils, and other state and local agencies involved in pursuing cross-system improvements in Ohio’s public mental health system through Ohio’s Transformation State Incentive grant. Of those recruited, a total of 90 (53%) agreed to participate in the evaluation of Ohio’s TSIG initiative.

Respondents included administrators from state-level Departments, consumer stakeholders, and community-based treatment providers, administrators, and support staff. The two most common roles of participants were mental health service administrators and advocates, and the highest level of education was a master’s degree (60%). In terms of organizations represented in the study, twenty-three (23) participants represented persons working in state or local mental health systems, 27 were working for other state agencies (e.g., Ohio Department of Rehabilitation and Corrections) and their local systems, and 20 respondents were from other agencies that were made up of trade or advocacy organizations or entities that work within the mental health arena, but are not part of the state system. Most participants had been employed at their organization approximately 9 years. Participants were asked to take part in an hour-long semi-structured interview and fill out a companion survey (See Table 1).

Semi-Structured Interview: For the T1 data administration, questions in the interview focused on assessing the level of institutional change in several key areas, namely: training, organizational changes, the involvement of consumers, new programs and services, funding mechanisms, and information systems. Interviews were digitally recorded, transcribed, and coded for themes relevant to workgroup activities and transformation processes. For the purposes of this report, T1 interview content related to the challenges and barriers to transformation are detailed.

Table 1: Participant demographics

| Variable | N (%) |
|---|----------|
| CWG | |
| ABC | 9 (12) |
| Trauma | 13 (17) |
| Justice | 16 (22) |
| Housing | 4 (5) |
| Employment | 8 (12) |
| Older Ohioans | 12 (18) |
| Prevention | 10 (14) |
| Work Setting | |
| State and Local Mental Health System | 23 (33) |
| Other State Departments (Non-Mental Health) | 27 (39) |
| Other Organizations | 20 (28) |
| Region | |
| Central Ohio | 46 (65) |
| North East Ohio | 11 (16) |
| South West Ohio | 4 (6) |
| North West Ohio | 7 (10) |
| South East Ohio | 2 (2) |
| Out of State | 1 (1) |
| Present Position | |
| State Administration | 24 (33) |
| Agency Administration | 24 (33) |
| Direct Practice | 12 (16) |
| Other | 13 (18) |
| Years Worked at Agency | Mean=9.5 |
| People at Your Agency in your CWG | Mean=1 |
| People at your Agency in another CWG | Mean=0 |
| Level of Education | |
| Associates | 1 (2) |
| Bachelor’s | 14 (19) |
| Master’s | 43 (60) |
| Doctorate | 14 (19) |

Measures: Confidential surveys were mailed to 170 members of the Mental Health Transformation Content Working Groups between November-December, 2006. Eighty (80) surveys were returned completed, for a response rate of 48%. The survey portion of the study includes quantitative measures for the analysis of mediating/moderating factors related to workgroup and organizational process measures. The T1 survey instruments consisted of the scales described below.

The Intrinsic Motivation Inventory (IMI) measures factors that contribute to a person's motivation to participate in TSIG workgroup activities based on a 34-item, Likert scale (1=Strongly disagree; 5=Strongly agree). Exploratory factor analyses of this measure revealed four constructs: perceived enjoyability, performance anxiety, participation pressure, and individual contribution. The items had good internal consistency ($\alpha=.89$).

The Interaction Collaboration Scale (ICS). Workgroup transformation activities are measured using the Interaction Collaboration Scale (Greenbaum & Dedrick, 2006). The ICS is a measure developed to assess the extent of collaboration in a number of cross-system activities. The scale consists of 30 items to which a respondent answers via a 5-point Likert scale, where 1=To No Extent and 5=To a Great Extent. Examples of cross-system activities targeted in the scale include training, interagency committees, sharing viewpoints, shared information systems, new policies and agency agreements.

The Communication Activity Scale (CAS). The intensity of participants' professional social networks is measured using the CAS (Morrissey, Hall & Lindsey 1982). The CAS is a measure developed to assess the amount of communication between a respondent and their closest network ties. The scale asks respondents to list the top 10 agencies with which they have contact and rate their frequency of contact, where 1=No Contact, 2=A few times a year, 3=About once a month, 4=About once a week, and 5=Once a day.

The Agency Connections Questionnaire (ACQ). The level of collaboration between agencies was assessed using the ACQ (Gadja, 2004). The scale asks respondents to list the top 10 agencies with which they have contact and rate their level of collaboration on a 5-point Likert scale: 0=Absence of Connection, 1=Networking, 2=Cooperating, 3=Partnering, 4=Merging, and 5=Unifying. The version of the instrument used for this study was designed by the Ohio State University Center for Family Research for the FAST\$ evaluation. The instrument is based on the Strategic Alliance Formative Assessment Rubric in Gadja (2004).

The Internal Collaborative Functioning Scale (ICF). The workgroup's internal functioning was assessed using the ICF (Taylor-Powell, Rossing, & Geran 1998). The ICF measures how well workgroups function to meet their desired goals and objectives. The scale measures a number of constructs, including: trust, productivity, leadership, and decision-making. The scale asks respondents to rate how strongly they agree with a statement about their workgroup. For example, "Members communicate well with each other." Respondents are asked to rate their level of agreement on a 5-point Likert scale where 1=Strongly Disagree and 5=Strongly Agree. The instrument has been used previously to examine the effectiveness of collaborative teams.

FINDINGS

The findings will be outlined in accordance with the Cross-System Evaluation Logic Model (see appendix 1). Task status in the Logic Model is differentiated by bolded boxes or italicized lettering, as of the T1 data collection. Italicized lettering represents an ongoing task, a bolded box a completed task.

Outputs: Workgroup Activities

The specific goals and objectives for the first year of Ohio's TSIG grant were to develop a needs assessment and resource inventory, to then develop a state wide comprehensive plan, and continue and expand transformation activities already underway. Each workgroup's first year activities, i.e., Outputs, as well as their plans for subsequent years are outlined below.

Ohio Family and Children First/ABC Initiative: The ABC's Working Group's priorities are to more effectively address children's behavioral health across all of the child-serving systems. Their goal is to provide the most effective, accessible and timely behavioral health prevention, early intervention and treatment for all children, adolescents and families in their own homes, schools and communities. During the first year of the grant period, the ABC CWG identified a number of transformation activities the group will be pursuing during the grant, including: enhancing parent advocacy and early childhood parenting programs, school-based services, wraparound and transition-age services, and maternal and early childhood depression screening.

Multiethnic Advocates for Cultural Competence (MACC): The Cultural Competence Content Working Group conducted their own needs assessment, separate from the TSIG assessment, to evaluate the capacity of Ohio's behavioral health system to deliver culturally competent services. As a result of this assessment, the Cultural Competence CWG has focused their transformation activities in the following areas: conceptualizing a definition and purview of cultural competence services, implementing mandatory cultural competence training for behavioral health professionals, and advocating for cultural competence-related content in accreditation and licensing reviews.

Older Ohioans Behavioral Health Network: The Older Ohioans Behavioral Health Network did an assessment of the behavioral health needs of Older Ohioans. As a result of this assessment, the group held an Older Ohioans Policy Institute in 2005. Consequently, a number of transformation activities were identified, including: developing a statewide resource inventory; developing an "XYZ" biennial budget strategy in collaboration with Departments to fund behavioral health services for Older Ohioans; based on the success of the first policy institute, planning an additional Older Ohioans Policy Institute II for April 2007; awarding mini-grants to twelve Area Agencies on Aging (AAA) for cross-system training and coalition building; and disseminating 36,100 "Healthy Aging, Preventing Medication Misuse" brochures to physicians' offices, Boards, Area Agencies on Aging and others.

Childhood Trauma: The Childhood Trauma Task Force, in partnership with the Ohio Family and Children First Cabinet Council, hosted five regional educational forums on childhood trauma in November and December, 2006. Over 800 individuals participated in Akron, Athens, Cincinnati, Columbus and Toledo. Additionally, the Task Force created Ohio's Childhood Trauma Strategic Plan, which made detailed recommendations to address childhood traumatic stress throughout Ohio's Behavioral Healthcare System. Activities in the Plan include developing a public awareness/education campaign; identifying trauma-focused screening and assessment tools; providing training on the use of these tools to all child-serving systems; partnering with consumer/survivors to identify and/or developing best practices in childhood trauma; and developing and implementing a strategy to collect and analyze data to enhance the ability of child-serving systems to adequately identify traumatized children.

Diversion/Re-Entry: The mission of the Diversion and Reentry Content Working Group is to reduce the number of persons with mental illness in the criminal justice systems through diversion, treatment and reentry strategies. To accomplish this, the Working Group has convened a large diverse group of stakeholders around a number of transformative activities, including: implementing the sequential intercept model through cross-systems collaborations in local communities throughout Ohio; continuing to train police officers in Crisis Intervention Training (CIT); advocating for and/or locating funding for more mental health diversion projects throughout Ohio; creating a manual for the implementation of mental health courts, with the goal of increasing the number of such dockets in Ohio; working with the National GAINS Center to explore training trainers on doing system mapping; supporting research efforts that will promote best practices for diversion and reentry initiatives; working with the Ohio Department of Job and Family Services (ODJFS) to develop an expedited Medicaid application process for persons leaving jails, hospitals and youth facilities; working with communities to apply for federal grants geared toward reentry and diversion programs; and finally, promoting technical assistance to communities on promising and best practice models.

Prevention: This CWG is an Interagency Prevention Partnership (IPP) and is based on SAMHSA's Strategic Prevention Framework. For the first year, the group developed a shared prevention framework across state agencies, and created the Ohio Suicide Prevention Foundation at The Ohio State University. Additionally during the first year, the Prevention Content Working Group agreed to work on the following transformation activities for the remainder of the TSIG grant: implement the shared prevention framework, increase cross-systems training on mental health prevention; identify policies and standards around mental health prevention; advocate for funding for suicide prevention programming; and examine other systems' successful approaches to funding prevention activities.

Employment: The Employment Content Working Group's mission is to develop local systems plans for increasing employment for persons with mental illness by incorporating the Supported Employment CCOE (Coordinating Center of Excellence), the Medicaid Infrastructure Grant, and other emerging employment initiatives. During the first year, this Content Working Group convened and decided to pursue a number of infrastructure changes during the tenure of the TSIG grant in Ohio, including: increasing the training provided for Supported Employment; increasing the focus on employment in Ohio's Mental Health Code; increasing Supported Employment Programs in Ohio through the use of the Supported Employment CCOE, continuing to advocate for changes to Medicaid billing to allow for Supported Employment to be billed as a mental health service; and finally, training mental health agency staff on how to bill Medicaid for Supported Employment services.

Homelessness: The Homelessness and Housing CWG's vision is to eliminate homelessness, especially chronic homelessness, in Ohio. During the first year, this CWG completed the needs assessment/resource inventory and planned activities to be accomplished during the remainder of the grant period. The identified transformation activities included: training local Social Security offices to implement the Federal SOAR initiative (SOAR stands for: SSI/SSDI Outreach, Access and Recovery); conducting a comprehensive study of mental illness and homelessness in Ohio; disseminating a white paper to vested stakeholders on trying to unify the process around SSI and Medicaid applications; implementing the Homeless Management Information System in more counties; and securing funds for more supported housing units for persons with mental illness throughout the state of Ohio.

TSIG Process Indicators: Cross-System Motivation, Collaboration and Communication

The T1 data collection period captured the first year and a half of the TSIG grant (October, 2005-December, 2006). The first year of the grant was intended as a planning year; hence most TSIG activity was centered on setting the foundation on which all subsequent years of the grant would be based. As it is still early to evaluate intermediate or final outcomes of the TSIG process, the main focus of this section of the report will be on the outputs and process indicators of the TSIG Grant. As outlined in the system-level logic-model, there are two main immediate system-level outcomes of the TSIG process: enhancing cross-system understanding and awareness of mental illness, and improving collaboration and communication within and across participating systems.

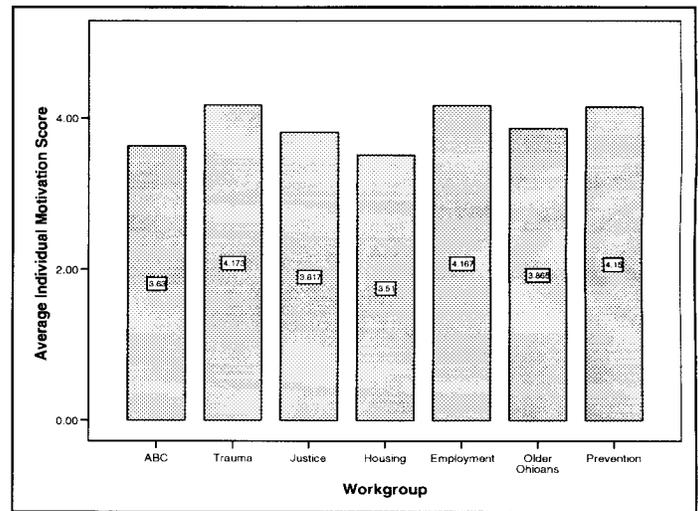
Motivation to Participate in TSIG

Individual Motivation. As evidenced in Graphs 1 and 2, respondents reported above-average levels of motivation to participate in TSIG activities ($M=3.94$; $SD=.49$; range: 1-5). The items with the most frequent endorsement included feelings of individual contribution ($m=4.30$), not feeling nervous about participating ($m=4.28$), and having the freedom to choose whether to participate ($m=4.27$). Marginal differences were found between the Working Groups, with scores ranging from 3.51 to 4.17 (see Graph 1). When examining respondent characteristics, there were no differences in individual motivation based on years of experience, work setting, position at agency, or level of education.

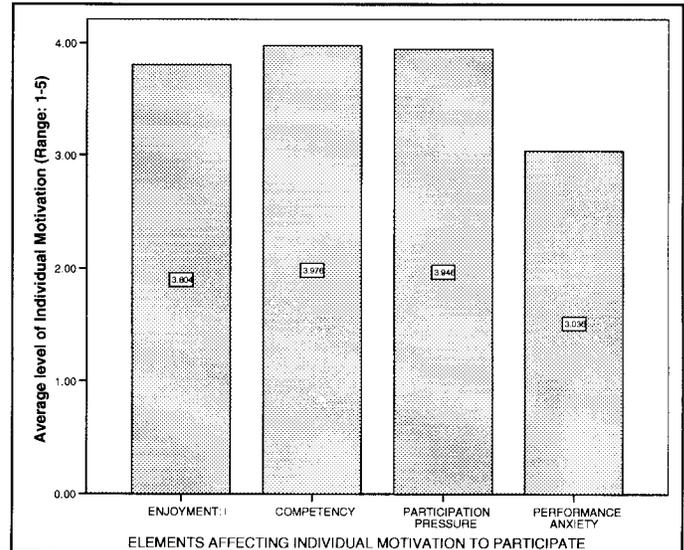
Agency Motivation. Respondents reported above-average levels of agency motivation to participate in TSIG activities ($m=3.91$; $SD=.57$; range: 1-5). The motivation characteristics most frequently endorsed by agencies were: 1) whether the activities of the workgroups would improve the efficiency of service provision ($m=4.25$); and 2) if the agency was eager to participate in the transformation project ($m=4.12$). While not statistically significant, participants working in mental health direct practice and living in northeast Ohio showed the most agency motivation to participate in transformation activities.

The scale also assessed two reasons for agencies to participate, the first being to improve the mental health system, and the second to enhance an agency's image and standing. According to respondents, enhancing image was the main motivation for agencies to participate in TSIG activities. In fact, agencies in the mental health system were significantly more likely than other state departments to participate in transformation activities based on enhancing agency image ($p>.05$). Additionally, state-level

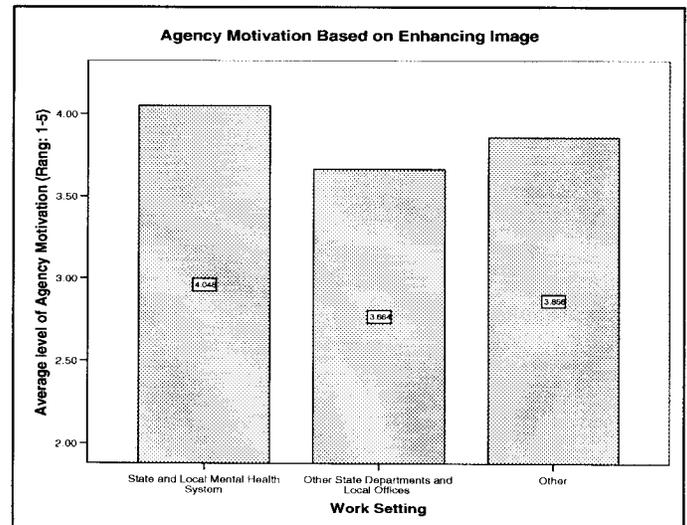
Graph 1: Individual Motivation X Workgroup



Graph 2: Elements of Individual Motivation to Participate



Graph 3: Agency Motivation x Enhanced Image



administrators endorsed agency image as the main motivator for participating in the activities of the TSIG grant ($f=3.29, p>.05$) (See Graph 3).

TSIG Workgroup Processes

Workgroup Climate. Overall, respondents felt that the climate of the TSIG workgroups was positive ($m=3.34, SD=.78$, range: 1-5). As illustrated in Table 2, the three most frequently endorsed workgroup descriptors were that the workgroups were seeking to understand the needs of persons with mental illness ($m=4.19$); their work was important ($m=4.14$); and they were striving to achieve success (3.97). The least endorsed workgroup characteristics included not having a procedure for changing members ($m=.99$), conflict being a problem (i.e., there is little conflict among members) ($m=1.31$), and having enough resources to do the work ($m=2.67$).

The subscales identified through exploratory factor analysis included: productivity ($\alpha=.93$, range: .56-.78), shared understanding ($\alpha=.90$, range: .45-.78), group cohesiveness ($\alpha=.84$, range: .56-.79), capacity to make changes ($\alpha=.69$, range: .54-.71), quality improvement ($\alpha=.59$, range: .54-.78), and communication ($\alpha=.59$, range: .44-.81). These subscales were analyzed for differences based on Working Group, Work setting, and position at agency. Significant differences in perception of workgroup climate were found between different Working Groups and Work Settings. The results follow.

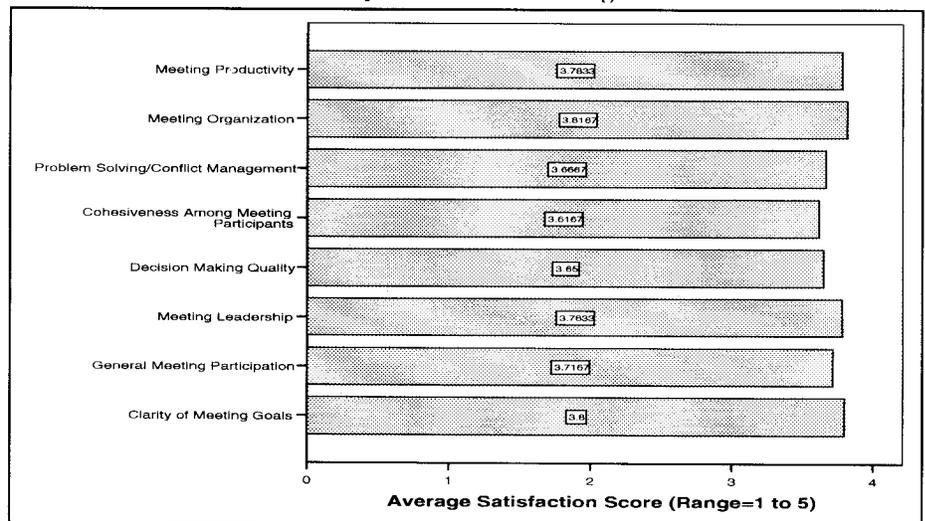
Working Groups: Significant differences existed between the Working Groups in a number of domains, namely: perception of productivity ($F=3.05, p>.01$), group cohesion ($F=2.41, p>.03$), shared understanding ($F=2.29, p>.04$), and communication ($F=2.76, p>.01$). While the system-level study does not assess causation, these findings may indicate differences in the development of these groups. Some groups, such as ABC, were established long before the TSIG grant, while others, such as the Employment Working Group were set up exclusively for TSIG, and hence are at an earlier stage of development.

Work Settings: When examining differences between work settings, no between-group differences were found. However, significant pair-wise comparisons were found between employees in different service systems (e.g., mental health vs. criminal justice). As opposed to those employed in other systems or agencies, participants employed in the mental health system perceived the Working

Table 2: Top Ten Endorsed Workgroup Descriptors

| Rank | Item Description | Mean |
|------|--|------|
| 1 | We seek to understand the needs of persons with mental illness | 4.19 |
| 2 | We feel our work is important | 4.14 |
| 3 | We strive to achieve success in our workgroup | 3.97 |
| 4 | Members communicate well with each other | 3.76 |
| 5 | We have a plan which guides our activities | 3.71 |
| 6 | We participate in the decisions of our workgroup | 3.69 |
| 7 | Our workgroup is productive | 3.69 |
| 8 | We take pride in our work | 3.68 |
| 9 | The workgroup has an adequate and representative cross-section of members (e.g., expertise, agency representation, demographic characteristics, and authority) | 3.64 |
| 10 | Members understand and agree on goals and objectives | 3.57 |

Graph 4: Overall Meeting Satisfaction



Groups as being more productive ($p > .05$), focused more on improving the quality of the mental health system ($p > .01$), and as having better communication between members ($p > .01$). While only speculative, these results may be linked to how involved the mental health system employees are in issues related to mental health as compared to those in other systems.

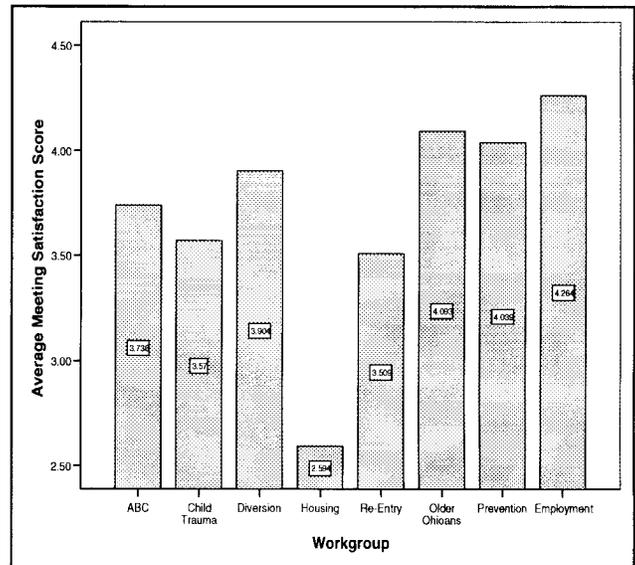
Workgroup Meetings. As evidenced in Graph 4, survey respondents who participated were generally satisfied with their Working Group meetings, with an average score for all Content Working Groups of 3.74. Differences were found in overall satisfaction with meetings between the different Working Groups, with scores ranging from 2.59 to 4.26 (see Graph 5). In terms of individual meeting characteristics, Content Working Group members were most satisfied with highly organized and productive meetings (average scores were 3.81 and 3.78 respectively). When looking at respondent characteristics, those that had worked at their jobs longer were more satisfied with the decisions made in the meetings, ($p < .03$).

Predictors of Meeting Satisfaction. To better understand how to create more enjoyable Working Group meetings, we also examined predictors of meeting satisfaction. The greatest predictors of meeting satisfaction for all the Content Working Groups were the organization of the meetings, and the Working Groups' ability to solve problems and manage conflict between members. Graph 6 illustrates this trend--meeting satisfaction increases as problem solving capacity (blue or dotted line) and meeting organization (green or solid line) also increase.

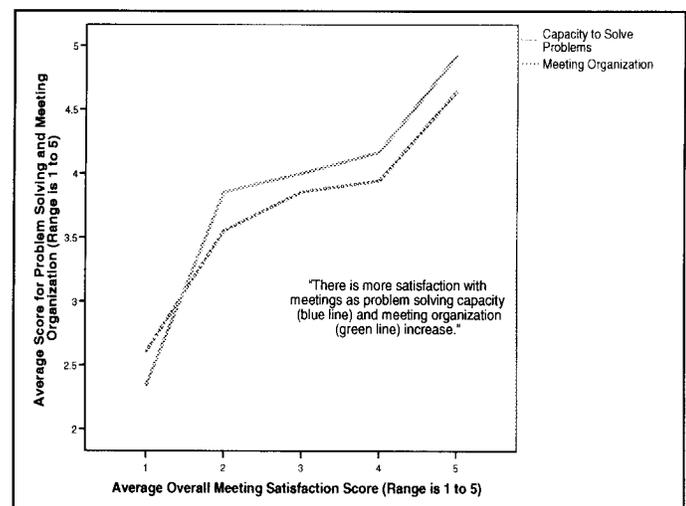
Agency-Level Transformation Processes

Agency Communication. As a measure of cross-system networking, respondents were asked to rate their frequency of communication with other agencies. As illustrated in Figure 1, the highest level of communication was with the Department of Mental Health. Eighty-three percent (83%) of the respondents indicated they communicated with the Department on mental health related matters. The next highest communication networks were found with the county mental health boards (65% of respondents), consumer advocacy organizations (56% of respondents), and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) (55% of respondents).

Graph 5: Meeting Satisfaction by Working Group



Graph 6: Predictors of Meeting Satisfaction



Workgroup Communication. In additional analyses (see Figures 2-7), the individual workgroups' communication networks were found to vary greatly.¹ These differences are likely due to natural alliances based on topic area. For instance, the Justice CWG (Figure 2) has strong communication ties with the Supreme Court, with 75% of respondents indicating ongoing communication regarding mental health issues. Yet, when examining the Supreme Court's communication ties within other CWGs (see Figure 2-7), the level falls drastically. Other members of CWGs rarely communicated with the Supreme Court regarding mental health: 16% for the Older Ohioans CWG communicated with the Supreme Court, 25% of the Trauma CWG members communicated with the Supreme Court, 30% for the ABC group communicated with the Supreme Court, and finally, 25% of the Employment group communicated with the Supreme Court. This is even more pronounced with the Ohio Department of Development, where 75% of the Housing CWG members communicated with this Department. Yet, overall only 8% of the total respondents maintained communication with the Department regarding mental health issues—and four of the Working Groups had no communication ties with this Department. This may be due to the Department of Development's strong emphasis on housing and homelessness in Ohio. If communication ties are considered a factor in policy development, then these ties may indicate policy trends in various topical areas. For instance, the Housing CWG's closest communication ties are with the Ohio Department of Youth Services (ODYS) and the Department of Rehabilitation and Corrections (ODRC) (Figure 3). From these communication networks, one could surmise that the Housing CWG's emphasis is on the need to house ex-offenders coming out of correctional facilities within Ohio—a theme also prevalent throughout the system-level interviews. This also suggests cross-pollination with another CWG--the Justice CWG. As this report only represents Time 1 data points, we may see communication ties change over time due to shifts in priorities and resources.

Figure 1: Overall Communication Networks

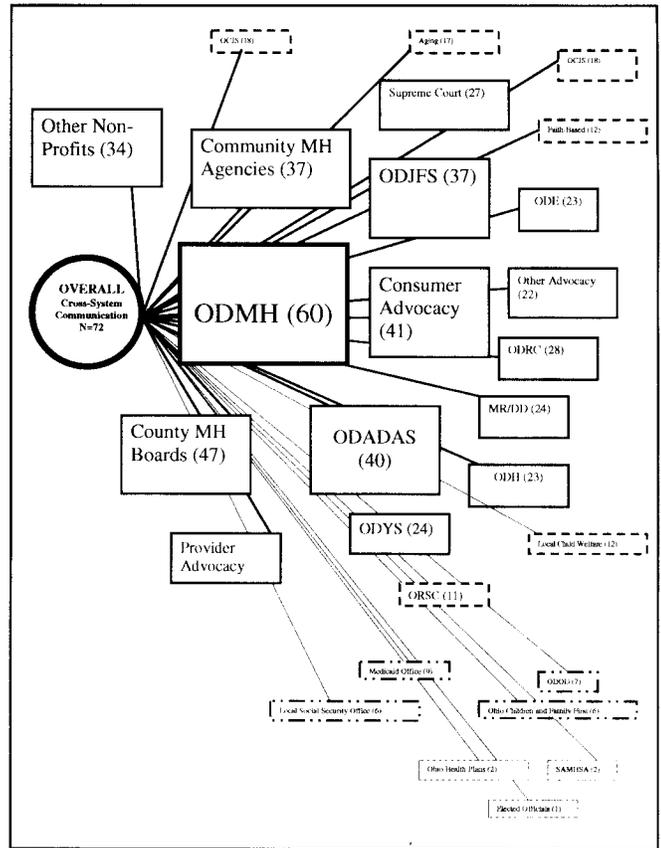
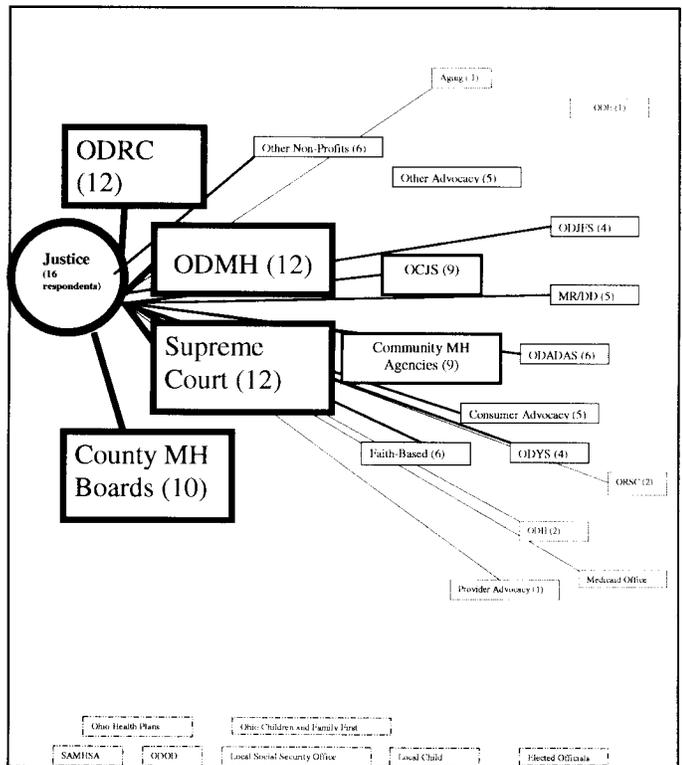


Figure 2: Justice CWG Communication Network



¹ Communication network intensity is depicted by the proximity of agencies to the workgroup in the circle, the size and outline of the boxes, and line density. Darker circles and lines represent the closest ties, while boxes that are dashed represent less connectivity. Boxes with no lines to them represent an absence of communication with the workgroups.

Figure 3: Housing CWG Communication Network

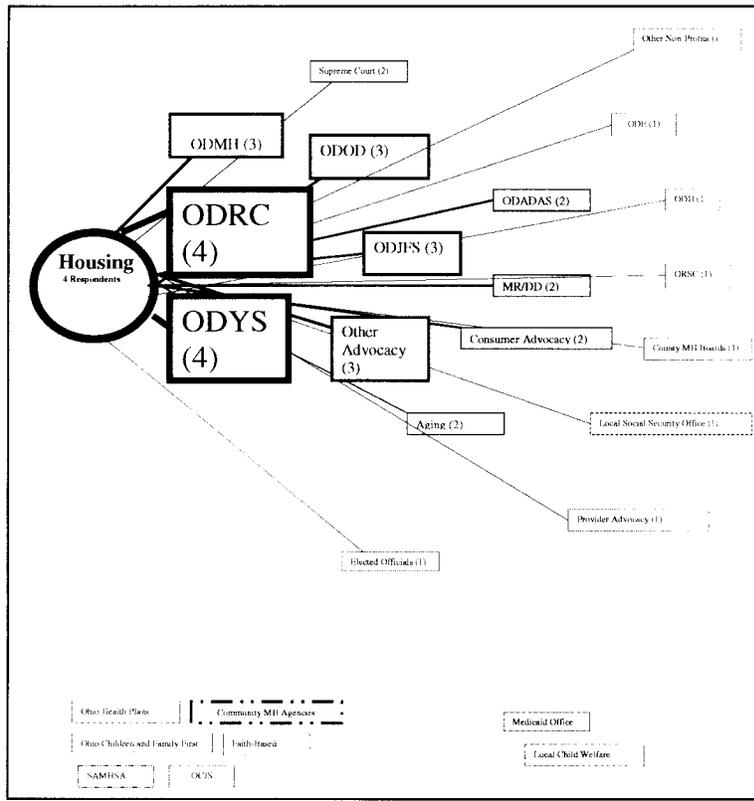


Figure 4: Employment CWG Communication Network

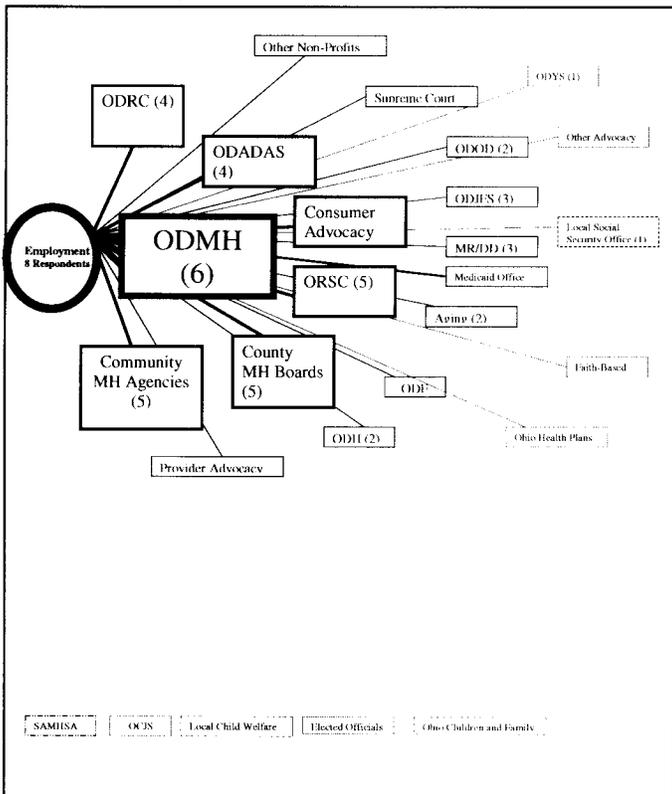


Figure 5: Older Ohioans Communication Network

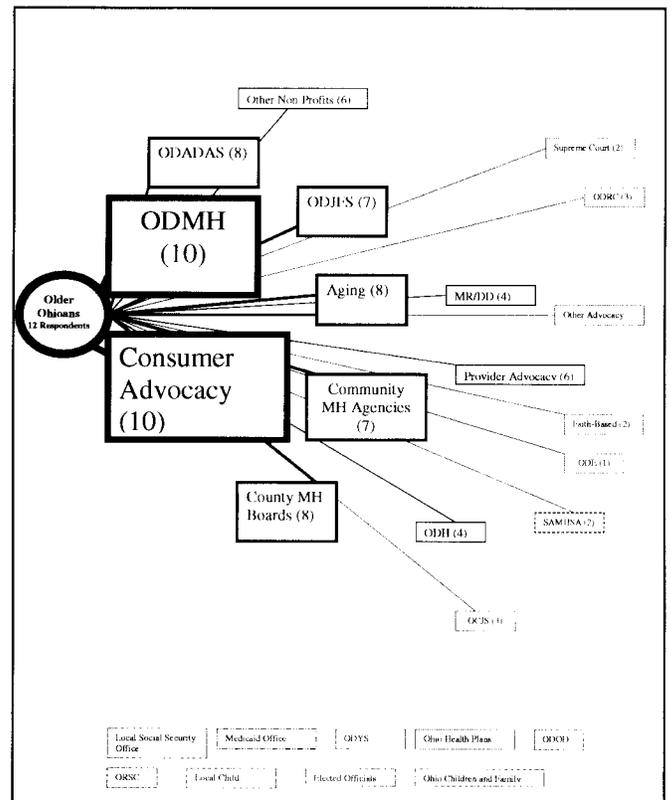


Figure 6: Trauma CWG Communication Network

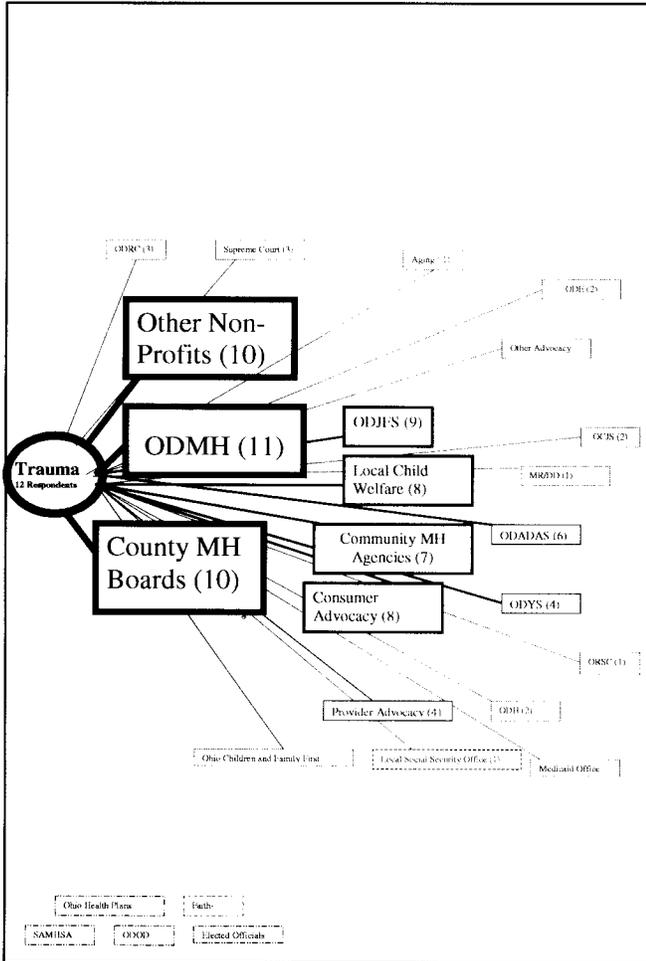
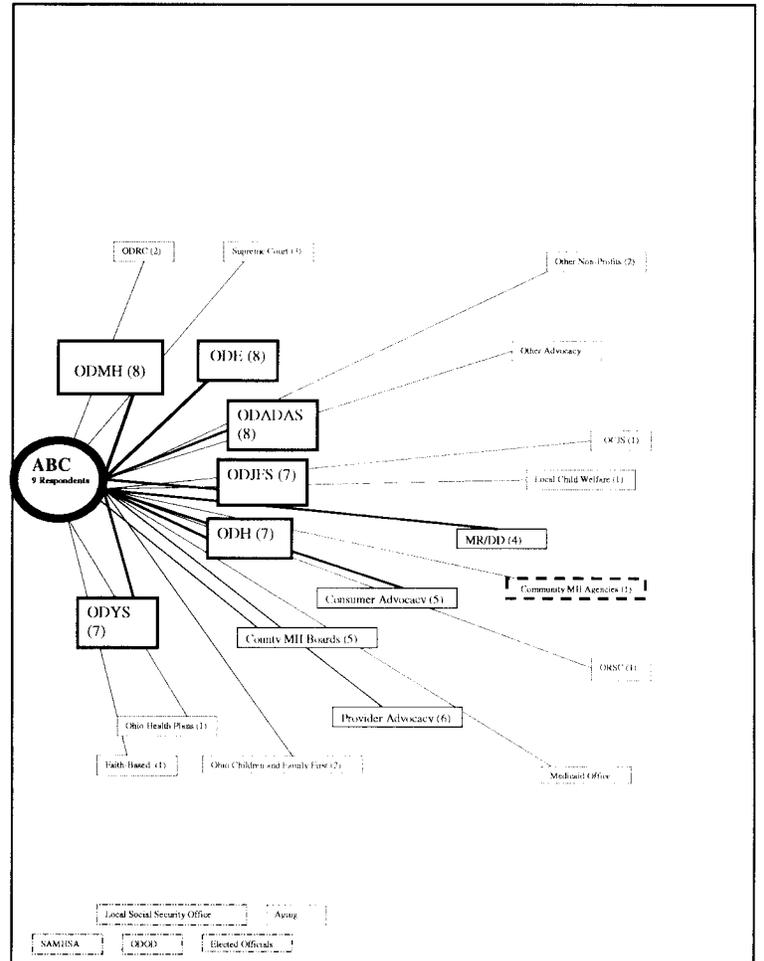


Figure 7: ABC Communication Network

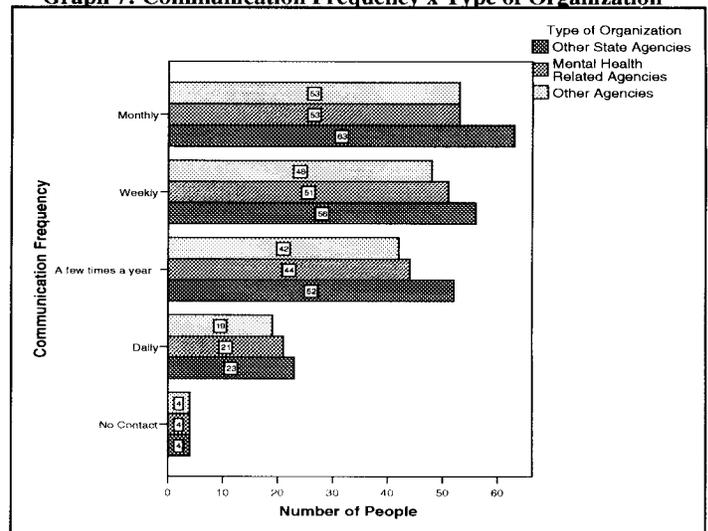


Communication Frequency. According to respondents, state agencies that were not related to mental health participated in cross-system communication about the mental health system more frequently than did mental health related agencies or other agencies (e.g., non-profits). As evidenced in Graph 7, mental health related agencies, other state agencies, and other agencies (e.g., non-profits) communicated the most on a monthly basis (56 mentions), followed by weekly (51 mentions), a few times a year (46), and daily (21 mentions).

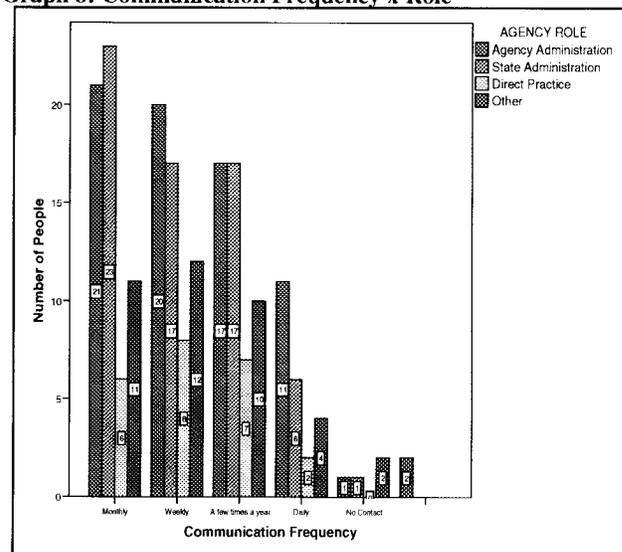
When examining the role of the respondent at the agency, agency administrators outside of state government (e.g., non-profits, advocacy agencies) had more cross-system communication than did state-level administrators or persons in direct practice with mental health consumers. The most frequent endorsement was monthly (60 mentions), followed by weekly (57 mentions), a few times a year (51 mentions), daily (23 mentions), and finally, no contact (7 mentions) (see graph 8).

In terms of Working Group communication, cross-system communication was most frequently cited by the Justice CWG (31.50 mentions), followed by Trauma (31.15 mentions), ABC (30.62 mentions), Prevention (30.54 mentions), Older Ohioans (29.55 mentions), Employment (28.30 mentions), and Housing (22.56 mentions) Content Working Groups (see Graph 9). The Justice CWG endorsed cross-system communication the most—having discussions on a weekly basis. The other CWGs typically cited cross-system communications occurring either monthly (e.g., Trauma, Prevention, ABC), or a few times a year (e.g., Employment, Housing, Older Ohioans).

Graph 7: Communication Frequency x Type of Organization



Graph 8: Communication Frequency x Role



Graph 9: CWG x Communication Frequency

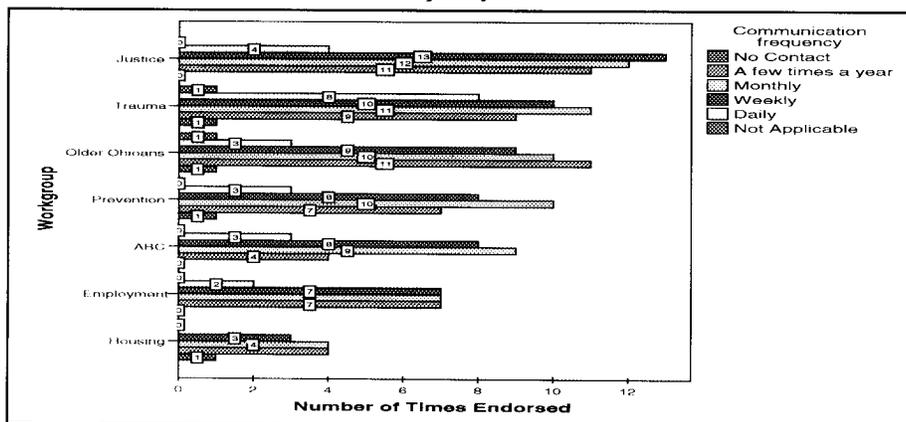


Table 3: Agencies with Highest Level of Connection

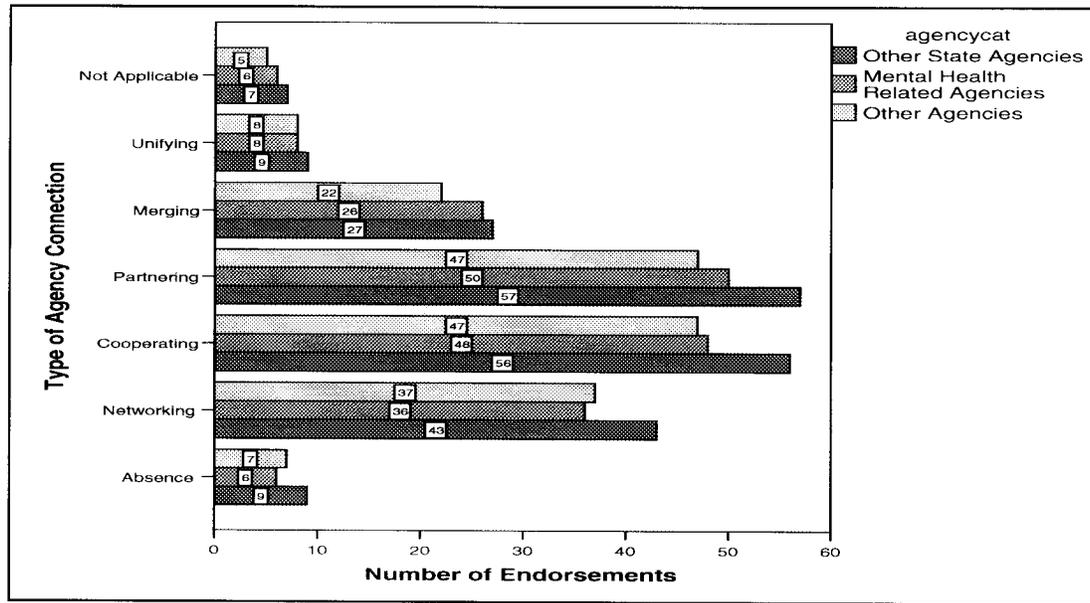
| Rank | Agency Connection Level (N/%)* | | | | |
|------|---|----------------------------------|-------------------------------|--|-------------------------------|
| | Absence (14/3) | Networking (113/21) | Cooperating (169/30) | Partnering (177/33) | Merging (66/12) |
| 1 | MR/DD (2/14.3) | Consumer Advocacy (11/9.7) | County MH Boards (16/9.5) | County MH Boards (20/11.3) | ODMH (16/24.2) |
| 2 | Supreme Court (2/14.3) | Other Non- Profit (8/7.1) | ODJFS (14/8.3) | ODJFS (15/8.5) | ODRC (7/10.6) |
| 3 | Local Social Security Office (2/14.3) | ODMH (8/7.1) | Consumer Advocacy (14/8.3) | ODADAS (14/7.9) | ODADAS (5/7.6) |
| 4 | Aging (1/7.1) | ODH (8/7.1) | ODMH (13/7.7) | Other Non- Profit (14/7.9) | County MH Boards (5/7.6) |
| 5 | Ohio Health Plans (1/7.1) | ODADAS (7/6.2) | ODADAS (10/5.9) | Community Mental Health Agencies (13/7.3) | Other Non- Profits (5/7.6) |

* N=number of endorsements; %=percentage of total endorsements

Agency Connections. To examine the impact of the TSIG grant on agency connections we asked participants to rate their agency's connection with other organizations. Respondents wrote in a list of agencies and then rated their organization's connection with each of those agencies. Participants had six options to choose from: an absence of a relationship, networking, cooperating, partnering, merging, and unifying--each option representing an increased connection. Table 3 shows the agencies that have the most frequent number of connections according to survey respondents. In terms of type of connection, the most frequent types of connections mentioned were partnering (33%), cooperating (30%), networking (21%), merging (12%), and no connection (3%). The agencies most frequently mentioned, included the County Mental Health Boards (8% of total mentions), ODMH (7% of total mentions), and ODADAS (6% of total mentions). Those with the least connections included SAMHSA (0.2% of total mentions), Ohio Children and Family First (0.7% of total mentions), and Ohio Health Plans (0.3% of total mentions). By examining Table 3, it appears that the vast majority of agency-level activity on mental health related issues occurs between agencies that directly serve consumers with mental illness. Far less present were connections with agencies that would be considered ancillary or policy related, e.g., Ohio Department of Development or the Department of Aging.

Work Settings. The vast majority of respondents suggested that their agencies were most frequently cooperating and partnering with other organizations on mental health related matters (see Graph 10). Participants also indicated that their organizations, irrespective of type, very rarely merged or unified operations with other organizations.

Graph 10: Agency Connection by Type of Organization



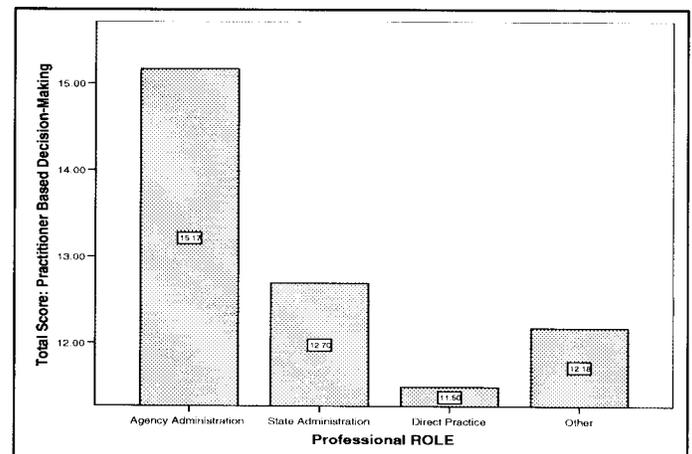
Agency Process of Change. Respondents were asked how change occurred at their workplace. As illustrated in Table 4, the most endorsed method of change was through collaborative action ($m=4.05$, $SD=1.02$, range: 1-5), followed by model practitioners or practices ($m=3.78$, $SD=.96$). The least endorsed process of change at participants' agencies was family involvement ($m=3.23$). The two subscales identified through exploratory factor analysis were Practitioner-based Decision-Making ($\alpha=.74$, range: .57-.78) and Administratively-driven Decision-Making ($\alpha=.61$, range: .47-.81). The two subscales were analyzed for differences based on Working Group, work setting, and position at agency. Significant differences in perception of decision making locus of control were found between different work settings and professional roles.

Table 4 : How Does your Organization Change?

| Rank | Item Description | Mean |
|------|----------------------------------|------|
| 1 | Collaborative Action | 4.05 |
| 2 | Model Practitioners or Practices | 3.78 |
| 3 | Practitioner/Employee Action | 3.73 |
| 4 | Administrative Action | 3.63 |
| 5 | Committee | 3.26 |
| 6 | Consumer Involvement | 3.26 |
| 7 | Family Involvement | 3.23 |

Work Settings: When examining differences between work settings, no between-group differences were found. However, significant pair-wise comparisons were found between employees in different service systems (e.g., state government vs. non-profit, private sector). Those employed outside of government were more likely to be encouraged to change their agencies through practitioner or employee action than those employed inside state government ($F=2.25$, $m_{A-B}=2.73$, $p>.05$).

Graph 11: Type of Change Process x Respondent Role



Professional Roles. Significant pair-wise comparisons were found between participants with different roles, particularly between those in direct practice and in agency administration. Interestingly, those in direct practice roles were less likely to perceive their agencies as driven by practitioner-based decision making, while agency administrators felt just the opposite, perceiving their agencies' decisions as highly practitioner and employee driven ($F=2.25$, $m_{A-B}=3.67$), $P>.03$) (see Graph 11).

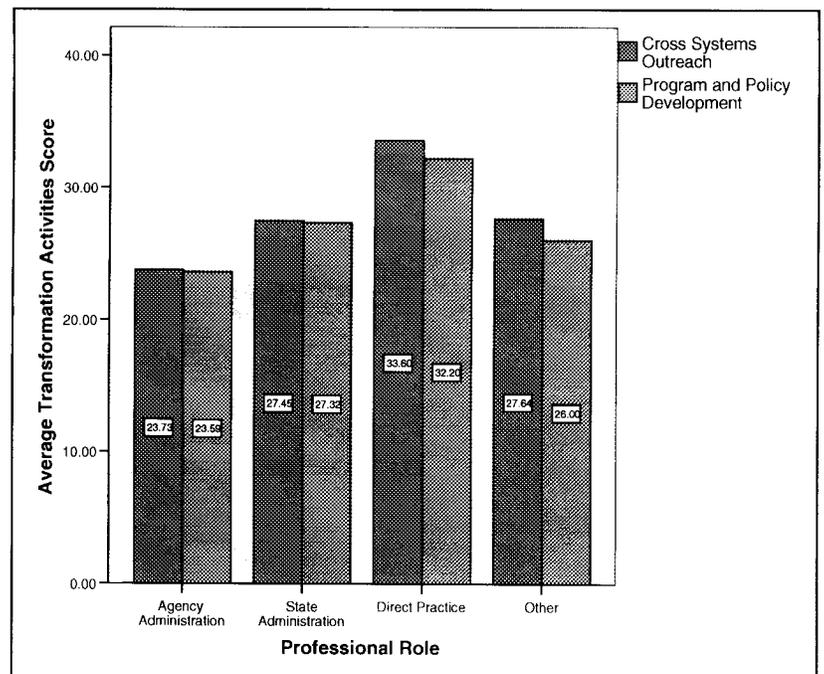
Cross-System Collaborative Activities. Respondents indicated that the most frequent cross-system activity their agencies engaged in was to participate in standing committees ($m=4.35$), followed by sharing and disseminating information ($m=4.16$), and sharing different points of view ($m=4.14$) (See Table 5). The least-engaged-in activity was to develop and implement formal written interagency agreements ($m=3.60$) (not in list of top 10). These data suggest that agencies readily cooperate when sharing information during meetings and on committees, but are much less likely to coordinate and integrate service systems around sharing data, funding, or embarking on contractual relationships.

Table 5 : Most Frequent Collaborative Activities

| Rank | Item Description | Mean (SD) |
|------|---|-----------|
| 1 | Participate in committees | 4.35 |
| 2 | Share/Disseminate Information | 4.16 |
| 3 | Share differing points of view | 4.14 |
| 4 | Implement voluntary contractual relationships | 4.06 |
| 5 | Fund Projects | 4.03 |
| 6 | Implement new policies | 4.00 |
| 7 | Develop programs and services | 3.89 |
| 8 | Evaluate Programs | 3.89 |
| 9 | Inform the public | 3.84 |
| 10 | Purchase Services | 3.80 |

The two subscales identified through exploratory factor analysis of the Interaction Collaboration Scale include Program and Policy Development Activities and Cross-System Outreach. When comparing these two subscales across respondent characteristics, significant differences were found between respondents' professional roles and their endorsement of cross-system activities. As illustrated in Graph 12, direct practitioners more frequently engaged in cross-systems outreach ($f=3.74$, $p>.01$) as well as program and policy development ($f=4.36$, $p>.05$) than did their administrative counterparts.

Graph 12: Professional Role x Cross System Activity



Qualitative Findings: Challenges Influencing Cross-System Transformation

In this section, results from the qualitative portion of the system-level study will be discussed. While a number of questions were asked for the system-level study, this report will only review one question asked of participants: the opinions of Content Working Group members with regard to the challenges that exist in transforming Ohio’s public mental health system. Participant comments centered on four cross-cutting concerns related to mental health system transformation: the capacity to work together, establishing and executing a plan to address ongoing system finance issues, investing in workforce development, and finally, addressing attitudinal issues about mental illness and change within and outside the mental health system.

Capacity to Work Together

Fifty-four percent (54%) of the responses to this question suggested that people’s capacity to work together was the biggest challenge to achieving cross-system transformation in Ohio. Participants named several areas that could deter systems from working together, including: not having key stakeholders participate who are in positions that can influence system change, restrictive rules and regulations that prevent cross-system collaboration, the need to maintain momentum over the long period of the grant, fragmented communication between different state and local agencies, the need for active support from the new governor and department directors, poor understanding of the TSIG grant itself, and finally, the inability of working groups to make decisions that would influence system change (see Table 5). Respondents suggested that working together to solve common problems is severely compromised by these issues.

Within this group of comments, respondents most frequently mentioned the need to have the right people at the table as the largest barrier to working together. “I mean, you have to have that whole group there and you have to make those agreements to stay and debate those hard issues. And as soon as one of them walks away from the table and decides to use another process to achieve their means, usually the political process, the whole thing falls apart”. Other comments included “We have [people] who could do a better job of reading the information, as well as being accountable to attend meetings to hear what’s going on,” and “we need to learn how to really create effective consumer-survivor-professional partnerships.” As these observations illustrate, participants in the Content Working Groups have encountered a number of times when meetings

Table 5

Comments of the 87 respondents about potential challenges to Transformation

| Theme and comment | N | % |
|--|----|----|
| <i>Capacity to Work Together (97 quotes)</i> | | |
| Have right people at the table | 21 | 24 |
| Various systems’ rules, regulations, and culture restrict cross-system collaboration | 20 | 23 |
| Maintaining momentum over the entire grant--long period of time | 16 | 18 |
| Inability to communicate between systems openly and frequently | 10 | 11 |
| Need support from new governor and new department directors | 11 | 13 |
| Understanding the TSIG grant and its processes | 11 | 13 |
| The inability to, or lacking the power to make decisions about system changes | 8 | 9 |

were not well attended, or not all stakeholders were well represented. Having sufficient advance notice of meetings was frequently suggested as a way to increase attendance.

Participants also reported the rules and regulations of various systems as being a barrier to working together. Participants continually mentioned how “siloes” systems and restrictions on the sharing of resources could hinder cross-system transformation. “I think there are still siloes resources and sometimes rules, and administrative rules can get in the way of true collaboration, or trying new things. People are aware and are figuring out solutions, but I think you still run into challenges in appropriately using resources across systems,” and “the main thing is trying to get everybody on the same page...our system is siloes, and for any of this to work that’s going to be a major barrier to break down—the siloes in our state system, and, actually, the county system.”

Many mentioned the bureaucracy of state and local government as being a challenge: “I’d say dotting our i’s and crossing our t’s. The thing that I’ve learned after being in state and county governments as long as I have is that things take time, and especially [at the] state, there’s a lot of red tape you have to go through to get anything accomplished.” Finally, several respondents suggested Ohio’s reputation as a home-rule state stood in the way of state-wide transformation: “I think you’re going to have a lot of battles at the local level, trying to get people to change their minds...and that’s why I am most skeptical about TSIG, because we’ve got this home rule thing going on here, where

you can’t tell locals what to do...we’ve encountered it time and time again-- getting change implemented locally is the biggest challenge.” As demonstrated by these comments, participants continually mentioned the need in Ohio to think about transformation as state-wide, and to focus on implementation efforts locally.

Funding

The second most common challenge brought up by the respondents was funding (see Table 6). Approximately 20% of responses mentioned system

financing as a significant challenge. Major themes in this category included the need for new revenue streams or being creative with existing ones, too many restrictions on the use of Medicaid funds, Medicaid eligibility issues, and the increasing dependency on Medicaid for system financing.

The need for new revenue or the creative use of existing revenue streams to fund mental health services was the most frequently mentioned challenge. When describing this challenge, one respondent suggested we needed a whole new view of looking for funds: “there are pots of funding, pools of funding, and streams of funding. And the pots taste good, go quick. The pools, like a pool of water you jump in, feels good but it goes away. And the streams, which continue to come—most of us are only able to get funded in the pot and the pool categories. And that seems to be what’s offered these days. And we are all chasing the pots and the pools, and we can’t find the streams. So, it’s a short way of saying we are struggling to find ongoing funding opportunities.”

| Theme and comment | N | % |
|--|----|----|
| <i>Funding (35 quotes)</i> | | |
| New or creative use of revenue streams are needed for the mental health system | 14 | 16 |
| Too many restrictions on use of Medicaid Funds | 11 | 13 |
| Many people are not covered by Medicaid | 7 | 8 |
| The mental health system is too dependent on Medicaid | 3 | 3 |

Many commented on the restrictions placed on the use of Medicaid funds as a barrier to transformation, especially when funding evidence-based practices or innovative programming. “In terms of funding, that’s a really big barrier. And programs would like to extend supportive employment, but there’s an increasing wariness about using Medicaid funds to do that,” and “On the Medicaid side...training people to look very narrowly at medical necessity—that it requires us to frankly have to gerrymander and put [things] together with paperclips and chewing gum...string together services, that way they can be reimbursable.” These comments show the frustration that respondents have experienced due to the lack of funding for mental health services and the restrictions placed on providers when billing for these services.

Attitude

Sixteen percent (16%) of the comments indicated that long-standing stigmatizing beliefs and attitudes about mental illness are an obstacle to change (see Table 7). These comments reflected the challenge of changing the beliefs of the existing workforce and general public about persons with mental illness.

Many respondents indicated that the general public and the mental health workforce still hold long-standing beliefs that people with mental illness are not capable of caring for themselves. Examples of such comments include, “people [the professional workforce] perceive people with mental illness as a problem and a ‘pain in the butt’... even in the community, society as a whole’s perception of mental illness is ‘psycho’; they don’t see the normal people with mental illness day-to-day taking jobs. They see people wandering the streets or the homeless people,” and “I don’t think by and large that the world thinks recovery is a real thing. And until they do, then there’s going to be conscious and unconscious roadblocks....there’s a lot of well-meaning people that work in this field [mental health], but I think there is still resistance to recognizing that people have the right and, with support, even the ability to make a decision for themselves.” Repeatedly, respondents suggested that addressing the stigma associated with mental illness needs to be one of the top priorities in cross-system transformation.

| <i>Table 7</i> | | |
|---|----|----|
| Comments of the 87 respondents about potential challenges to Transformation | | |
| Theme and comment | N | % |
| Attitude (29 quotes) | | |
| Lack of knowledge and understanding of mental illness | 18 | 21 |
| Resistant to change | 11 | 13 |

Workforce

The fourth and final challenge identified in the interviews was related to issues of workforce development. Nine percent (9%) of the responses suggested workforce issues to be a significant challenge to transforming the mental health system. In this category respondents suggested that all systems, and in particular the mental health system, need to better train and recruit staff to work with persons who have mental illness.

| <i>Table 8</i> | | |
|---|----|----|
| Comments of the 87 respondents about potential challenges to Transformation | | |
| Theme and comment | N | % |
| Workforce (17 quotes) | | |
| Better training of direct care staff | 14 | 16 |
| Better recruiting and retaining of qualified staff | 3 | 3 |

Respondents were particularly concerned about the lack of training available to the mental health workforce and those in other systems. “We’re coming up with some, and reinforcing some, best practices. But we really are challenged across the state to have the workforce trained and available to do these things,” and “we need to include universities, because we are not being trained; students are coming out without the training. They come to the mental health system since we employ quite a few, and we’re then required to train them or they get training on the job as they work with people, and that doesn’t always work—it takes a long time to do that” and finally, “I think that workforce development issues are huge. We don’t know how to train staff. We don’t know how to recruit or retain staff. We don’t have any kind of staff development plan once we even have people. And I’m thinking even at the simple levels. I’m talking about basic clinical skills and basic resource knowledge. So, I think workforce development is actually a huge issue that pervades all of this TSIG stuff.” These themes suggest that issues of workforce development, particularly around competency and recruitment, should be a central component to the transformation of mental health care in Ohio.

SUMMARY OF FINDINGS

It is important to note that the findings above were developed in the Time 1 TSIG System-Level Evaluation study, and cover the time period from the beginning of the grant to December, 2006.

Innovative programming is the foundation of Ohio’s Transformation efforts.

All of Ohio’s transformation efforts have at their core a commitment to providing the best services available and improving the quality of life of persons living with mental illness. To do this, the Working Groups are advancing existing evidence-based practices, or are promoting emerging best practices that have been developed in Ohio, to address the unique mental health needs of adults, children, elderly individuals, trauma victims, individuals who are incarcerated, homeless, and those with physical health problems. The TSIG grant has made the expansion of many of these programs possible by providing a venue for state, county, and local agencies to dialogue and collaborate on issues of critical importance to Ohio’s citizens who have mental illnesses (see pages 4 & 5 for details).

There is motivation to participate and work for change.

In both the interviews and the surveys, respondents were quick to point out their eagerness to participate in the work of systems change. When looking at the surveys, respondents reported above-average levels of motivation to participate in TSIG activities ($M=3.94$; $SD=.49$; range: 1-5). The most frequently endorsed motivators included: feeling that they made a contribution, not feeling nervous about participating, and having the freedom to choose to participate (i.e., voluntary involvement). In terms of agency motivation, respondents also reported above-average levels of agency motivation to participate in TSIG activities ($m=3.91$; $SD=.57$; range: 1-5). The types of motivation most frequently mentioned by agencies were: 1) whether the activities of the workgroups would improve the efficiency of service provision; and 2) if the agency was eager to participate in the transformation project. Additionally, a theme in the interviews was the need to keep people involved over the long haul. Many participants indicated they felt “out of the loop”. As one respondent suggested “It takes commitment and perseverance. That’s the key to keeping people involved. Otherwise, in projects like this, I think the process of making improvements can lose steam over time in terms of systems cooperating, communicating and collaborating.” TSIG project leadership need to explore various ways of keeping people interested and invested in the project.

The grant's productivity is affected by the climate of the workgroups, the quality of the meetings, and project leadership.

Overall at Time 1, respondents felt that the climate of the TSIG workgroups was positive ($m=3.34$, $SD=.78$, range: 1-5). The three most frequently mentioned workgroup descriptors were that the workgroups are actively seeking to understand the needs of persons with mental illness ($m=4.19$); their work is important ($m=4.14$); and they are striving to achieve success (3.97). Productivity was highly correlated with workgroup climate ($r=.90$, $p>.001$), the quality of the workgroup meetings ($r=.42$, $p>.01$) and project leadership ($r=.30$, $p>.01$). These results suggest that efforts put toward improving how people perceive their workgroups and leadership can yield positive results in terms of increased productivity. In the interviews, many indicated that participation would increase if meetings were action-driven and not dominated by discussion, or process.

Agencies communicate with other organizations about mental health services based on existing relationships, not on what is needed for change.

As a measure of cross-system networking, respondents were asked to rate their frequency of communication with other agencies. The highest level of communication was with the Department of Mental Health. Eighty-three percent (83%) of the respondents indicated they communicated with the Department on mental health related matters. The next highest communication networks were found with the county mental health boards (65% of respondents), consumer advocacy organizations (56% of respondents), and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) (55% of respondents). These figures suggest that communication around transformation activities is occurring with agencies that either provide or advocate for services to persons with mental illness. Communication that occurs outside of the mental health system is topic-specific and based on strong individual relationships. For instance, the Justice Working Group communicates with the Ohio Supreme Court and the Ohio Department of Rehabilitation and Corrections. These relationships have been in existence for a number of years, long before the introduction of the TSIG Grant. There appear to be weak communication ties with some larger state agencies, which may be critical to systems change, e.g., the Ohio Department of Education. This department currently has only a few people dedicated to TSIG projects, yet school-aged children represent a large percentage of the transformation projects (32% of all first-draft CMHP projects).

Agencies have strict rules and rigid organizational cultures, hindering effective cross-system collaboration.

A significant finding of the interviews was that silos exist between and within departments on issues related to mental health. For instance, in one agency, three individuals were interviewed about supported employment. One staff member knew about the legislation being introduced about supported employment, another knew about the programmatic side of supported employment, while yet another staff member knew only about the financing of supported employment. When probed, they knew very little about what the others were doing even within their own department. These "knowledge inefficiencies" were found repeatedly in the interviews. While standardized roles and routines are common in large bureaucracies, they may also hamper system change. As one respondent stated "the main thing is to get people on the same page...our system is siloed, and for any of this to work that's going to be a major barrier to break down—the silos in our state systems, and actually, the county systems."

People's capacity to work together is the most formidable challenge to achieving cross-system transformation in Ohio.

When asked about challenges to transformation in Ohio, fifty-four percent (54%) of the responses suggested that people's capacity to work together was the biggest challenge to achieving cross-system transformation in Ohio (see Table 5). Participants named several areas that could deter systems from working together, including: not having key stakeholders participate who are in positions that can

influence system change, restrictive rules and regulations that prevent cross-system collaboration, the need to maintain momentum over the long period of the grant, fragmented communication between different state and local agencies, the need for active support from the new governor and department directors, poor understanding of the TSIG grant itself, and finally, the inability of working groups to make decisions that would influence system change.

A repeated theme in the Time 1 interviews was Ohio's home-rule status. Many believed that this could stand in the way of state-wide transformation: "I think you're going to have a lot of battles at the local level, trying to get people to change their minds...and that's why I am most skeptical about TSIG, because we've got this home rule thing going on here, where you can't tell locals what to do...we've encountered it time and time again--getting change implemented locally is the biggest challenge." As demonstrated by these comments, participants continually mentioned the need in Ohio to think about transformation as state-wide, but to focus on implementation efforts locally.

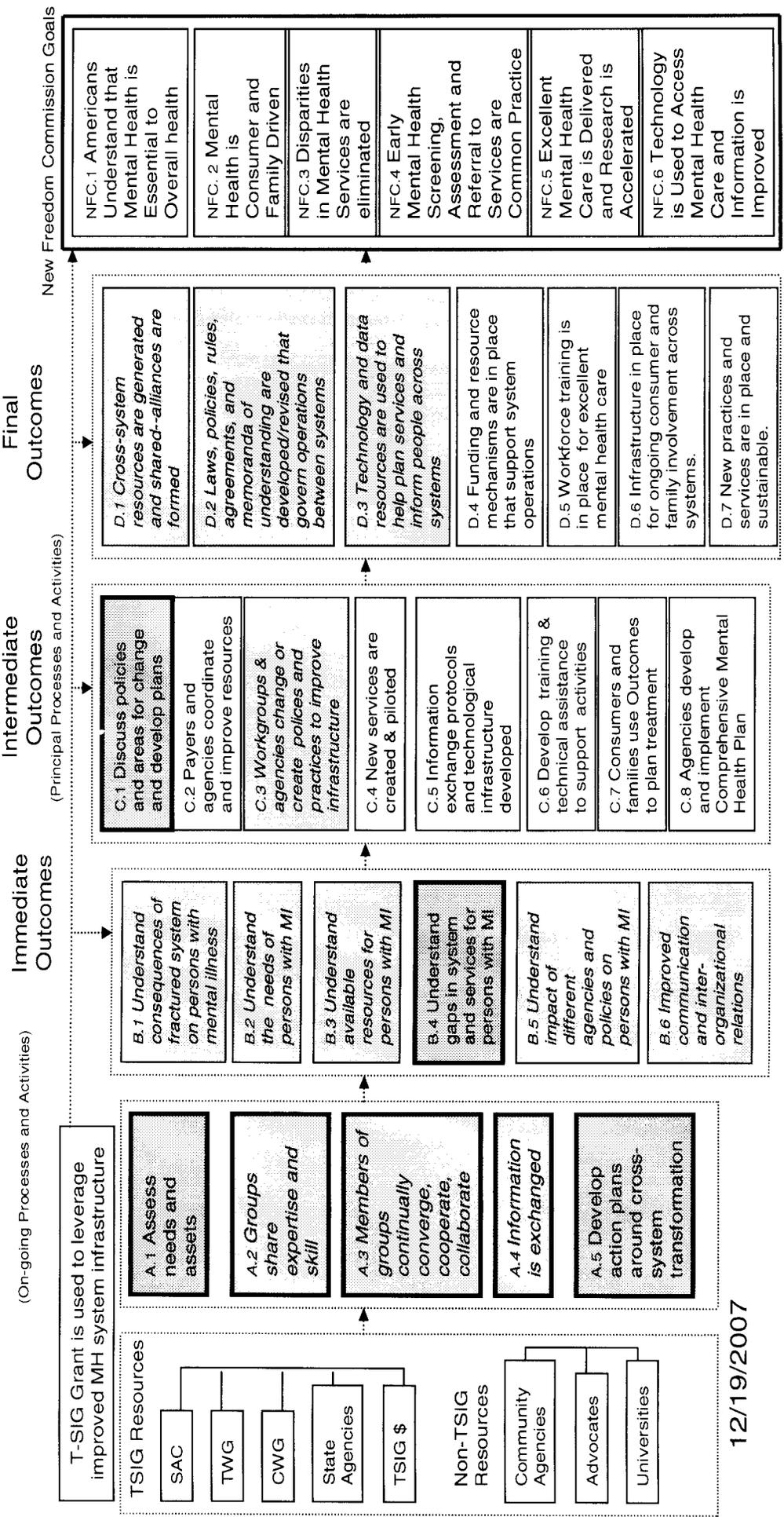
**APPENDIX 1-
CROSS-SYSTEM LOGIC MODEL**

Mental Health Transformation-System Infrastructure Grant (Cross-System Evaluation-Logic Model)

INPUTS OUTPUTS

SYSTEM OUTCOMES

IMPACT



12/19/2007