Project UNITE

Project Manual

Introduction

Individuals with developmental disabilities are more vulnerable to stress and may experience daily stressors more frequently compared to people without disabilities. Oftentimes, negative coping experiences, limited environmental supports, and lack of control over interpersonal interactions may activate their stress responses.[1] Significant life events can also trigger an emotional or behavioral crisis and result in depression, anxiety, or challenging behaviors.[2] These life changes are especially prominent during the period of late adolescence when youth transition to adulthood and make important decisions in areas such as education, vocation, housing, relationships, and health care.

Interventions that promote awareness and prevention of mental health disorders before they manifest offer the best opportunities to protect youth against emotional or behavioral crises. With Mental Health and Services Act (MHSA) funding from the Department of Developmental Services for fiscal years 2014-2017, Westside Regional Center (WRC) developed and administered Project UNITE to provide new and enhanced specialized services and supports for transition age youth (TAY), specifically youth between the ages 14-26, with developmental disabilities and, or at risk for, mental health conditions (dual diagnosis). Project UNITE is a collaborative and united effort that aims to address the needs of TAY with developmental disabilities and their family members by focusing on early intervention and provision of mental health supports. Beginning in 2014, WRC designed and implemented a multi-tiered program with the goal of providing support for youth and young adults with or at risk for dual diagnosis.

- Project UNITE includes the following components/tiers:
- Mental health screenings
- Transition Age Youth (TAY) Collaborative
- Youth wellness drop-in center program
- Parent Mentor Program

Project UNITE addressed mental health promotion and early intervention/prevention services by inviting youth and young adults, ages 14-26, receiving services from WRC to participate in mental health screenings to help determine and identify warning signs of common mental health conditions like anxiety and/or depression. The prevention and early intervention efforts were monitored by the TAY Collaborative, a cross system, multidisciplinary collaborative that consisted of representatives from mental health and developmental disabilities systems of care. Special interventions were also developed to empower youth and their family members via a wellness drop-in center program available in the community for TAY with or at risk of dual diagnosis (identified through the mental health screenings) and a Parent Mentor Program, which provided parent-to-parent support, resources and advocacy for clients and families in need of mental health supports.

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[1] Fletcher RJ, Baker D, St Croix JS, Cheplic M. Mental health approaches to intellectual/developmental disability: a resource for trainers. NADD 2015.

[2] Lunsky, Y. 2008. The impact of stress and social support on the mental health of individuals with intellectual disabilities. Available at: http://www.scielosp.org/pdf/spm/v50s2/a07v50s2.pdf. Accessed October 24, 2016.

Program Development & Implementation

The development of Project UNITE included the following steps:

1. Establish project's leading team and select subcontractors for each tier
2. Implement mental health screenings
3. Launch TAY Collaborative
4. Support development of wellness drop-in center program
5. Support development of Parent Mentor Program

Please see Attachment 1 for project's detailed timeline.

Step 1: Establish Project's Leading Team

WRC selected a project team to plan, develop and execute the components of Project UNITE. The project team was comprised of staff and vendors from WRC (e.g. department directors from Clinical Services, Community Services, and Client Services, physicians, psychologists, social workers, education and autism specialists, therapists, and other allied health professionals) as well as parent representatives from the Westside Family Resource and Empowerment Center (WFREC).

The team developed the following positions to coordinate various tiers of Project UNITE:

- Project Coordinator responsible for coordination of all tiers of the project,
- Parent Mentor Program Coordinator responsible for coordination of parent-to-parent training, monthly supervision of mentors, and all other aspects of Parent Mentor Program,
- Contractor to offer drop-in psycho-social support services for young adults with or at risk for dual diagnosis at a wellness drop-in center program,
- Contractor to adapt a parent-to-parent training curriculum and train parent mentors to offer parent-to-parent support and resources for families with young adults with or at risk for dual diagnosis,
- Screeners (e.g. service coordinators, contractors, social work interns) to perform mental health screenings,
- Parent mentors to provide social and emotional support to other parents,
- TAY Collaborative members from mental health and developmental disabilities systems of care to participate in multidisciplinary case management and facilitation of referrals for youth and young adults with or at risk for mental health conditions.

The team advertised these various positions via WRC's website and various list serves (e.g. Los Angeles County Department of Public Health, Los Angeles County Department of Mental Health Service Area 5, Family Resource Center Network of Los Angeles County, and local universities).

Step 2: Implement Mental Health Screenings

Goal: implement comprehensive mental health screenings for youth and young adults ages 14-26 to increase early detection and assessment of mental health conditions

Project UNITE team members met on a weekly basis to adapt mental health screening tools, develop screening protocols, and identify, train, and supervise mental health screeners. The team investigated existing evidence-based mental health screening tools and selected the following: the BECK Youth Inventories for children and adolescents 2nd Edition (BYI-II), the Vineland –II Maladaptive Behavior Subscale, as well as an adapted and abbreviated version of the National Core Indicators (NCI) Adult Consumer Survey.

The BYI-II is an assessment tool with a set of norm-referenced diagnostic scales designed to assess typical children and youth between the ages of 7 and 18 in depression, anxiety, anger, disruptive behavior, and self-concept.[3] The second grade reading level of this self-completed form/interview makes it more suitable than other tools for assessing adolescents with special needs.[4] Administration and scoring can be completed by paraprofessionals under the supervision of a professional trained in clinical assessment procedures and interpretation.[3] Validity and test-retest reliability have been shown in multiple studies.[5] This clinical psychology assessment tool is available to Project UNITE through the Clinical Services Department at WRC. Full description of BYI-II is available at:
http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byiii.html

The Vineland Adaptive Behavior Scales-Second Edition is an assessment tool designed to measure adaptive behaviors of individuals from 0 to 90 years old in five main domains.[6] These domains include communication, daily living skills, socialization, motor skills, and maladaptive behavior. The individuals referred to project UNITE will have a previously developmental disability diagnosis, and therefore, we will not need to complete the entire form and repeat unnecessary diagnostic testing. We will only apply the maladaptive behavior subscale, which provides a composite of Internalizing, Externalizing, and other types of undesirable behaviors that may interfere with an individual's adaptive functioning.[7] This parent/caregiver rated form has been normed and standardized using individuals with special health care needs.[7] The Vineland-II manual recommends administration and scoring be completed by an individual with graduate training in test administration and interpretation.[6] Validity and test-retest reliability have been shown in multiple studies.[7] This clinical psychology assessment tool is available to WRC through the Clinical Services Department. Full Description of Vineland – II is available at:

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[3] Beck, JS, Beck, AT, Jolly, JB, and Steer, RA (2005). Beck Youth Inventories-Second Edition for Children and Adolescents manual. San Antonio, TX: PsychCorp.

[4] Pearson Clinical Psychology (2014). Beck Youth Inventory-II http://www.pearsonclinical.com/psychology/products/100000153/beck-youth-inventories-second-edition-byi-ii.html#tab-details. Accessed December 16, 2014.

[5] Community-University Partnership for Study of Children, Youth, and Families (2011). Review of the Beck Youth Inventories – For Children and Adolescents 2nd Edition (BYI-II). Edmonton, Alberta, Canada.

[6] Sparrow, SS, Cicchetti, DV, and Balla DA (2005). Vineland-II Adaptive Behavior Scales: Survey Forms Manual. Circle Pines, MN: AGS Publishing.

[7] Community-University Partnership for the Study of Children, Youth, and Families (2011). Review of the Vineland Adaptive Behavior Scales-Second Edition (Vineland-II). Edmonton, Alberta, Canada.

http://www.pearsonclinical.com/psychology/products/100000668/vineland-adaptive-behavior-scales-second-edition-vineland-ii-vinelandii.html#tab-details

The NCI Adult Consumer Survey is widely used by public developmental disabilities agencies to provide system-based information around the lives of, and services provided for, the people they serve.[8] Participating states have access to this survey, and although it is typically used to measure the performance of an agency, others have used and adapted it to examine quality of life.[9],[10] This tool was adapted to interview and assess current quality of life, need for support, and personal goals and desires. We received permission to use and adapt this survey to meet the needs of Project UNITE from the Human Services Research Institute (HRSI) and the California Department of Developmental Services. The adapted survey is referred to as "The Quality of Life (QOL) Questionnaire" (Please contact Project UNITE staff for a copy of the questionnaire).

The screening tools were administered individually to each referred client by trained screeners including interns from local universities working towards their Master's degrees in social work and/or licensure in clinical psychology. The screeners were trained and supervised by a licensed clinical psychologist and a licensed clinical social worker working at WRC.

The project team established a general protocol for implementation of the mental health screenings. The steps were as follows:

1. Project staff made recruitment flyers available to service coordinators and clients/families visiting WRC offices (e.g. reception areas of WRC and WFREC). Flyers available on the project's website http://reachacrossla.org/programs/project-unite/).
2. Service coordinators referred clients/families to the project coordinator, verifying age and eligibility the screenings and any need for.
3. The project coordinator clarified the mental health screening process with the service coordinator to confirm appropriateness and coordinated the screening with the individuals conducting the screenings (screeners).
4. The screeners communicated and scheduled a screening with the client/family/support staff using the Recruitment Screening Script as a guide (Please contact Project UNITE staff for a copy of the script).
5. The screeners completed the pre-interview section of QOL Questionnaire the screening.
6. The screeners completed the mental health screening using the three selected tools with the clients and their family members and/or support staff.
7. The screeners scored the mental health screening materials and summarized the findings in a

[8] National Core Indicators. Copyright © 2014 Human Services Research Institute (HSRI) and The National Association of State Directors of Developmental Disabilities Services (NASDDDS). http://www.nationalcoreindicators.org/ Accessed December 16, 2014.

[9] Quality Assessment Project. Copyright © 1969-2007 by Areaboard 10. http://www.areaboard10.org/projects_blank.asp?submode=lqa_project Accessed December 16, 2014.

[10] Sheppard-Jones, K. Quality of life dimensions for adults with developmental disabilities (2003). University of Kentucky Doctoral Dissertations. Paper 335. http://uknowledge.uky.edu/gradschool_diss/335. Accessed November 1, 2016.

written report.

8. The screeners presented the findings during cross-system, multi-disciplinary TAY Collaborative meetings.
9. TAY Collaborative members discussed the findings and gave appropriate recommendations based on each client's specific needs.

The recommendations were included in a final written report. The report and all findings were shared with the client and/or their caregiver(s).

Recruitment began after piloting the mental health screening tools and other protocols. Service coordinators shared recruitment flyers with the clients and families they support (via email). They also contacted many TAY clients and their families (by phone) and referred those they felt were at risk of mental health challenges, such as anxiety or depression. When demand for mental health screenings surpassed availability of screeners, referred individuals were informed they would be placed on a waiting list, as appropriate. The wait varied from two to four weeks. The project coordinator would periodically contact individuals on the waiting list and prioritize scheduling based on urgency of concerns.

Once scheduled, meeting with the client and/or caregiver and administration of the screening tools took about 1.5 hours. In a private room at WRC, the screener and client discussed and completed questions on the QOL Questionnaire and the BYI-II while the caregiver separately completed the Vineland –II Maladaptive Behavior Subscale. The clients were offered a choice to complete parts of the questionnaire by themselves or with the screener's assistance (who, if requested, would read the questions and response choices out loud so the client could mark the choice or let the screener know what choice to mark). The caregiver (e.g. parent or support staff) was asked to complete their portion independently.

Step 3: Launch TAY Collaborative

Goal: continue implementing cross system, multidisciplinary case management to facilitate linkages with treatment and support of youth at risk for mental health disorders

The TAY Collaborative, an interagency and multidisciplinary collaborative, was established during our previous MHSA funding to address multifaceted needs of young adults and their caregivers. This collaborative served as a template for the Project UNITE multidisciplinary case management meetings. Bi-monthly TAY Collaborative meetings were planned and designed to target early detection of mental health conditions and help facilitate linkages with treatment and integrate supports for TAY that participated in mental health screenings. The Project UNITE team recruited multidisciplinary TAY Collaborative members, including:

- Project UNITE coordinator
- Psychologist
- Licensed Social Workers
- Director of Clinical Services
- Director and/or Assistant Director of Client Services

- Autism Specialist
- Education Advocacy Specialist
- Mental and Behavioral Health Therapists/Professionals
- Psychiatrist
- Nurse
- Los Angeles County Department of Mental Health Service Area 5 Liaison
- MENTOR Family Behavioral Services Therapist
- Parent Mentor Program Coordinator
- Service coordinators, private mental health providers, and any other professionals that work closely with the client were also invited to the meetings on an as needed basis.

The following protocol was established to help individuals that received mental health screenings to access services that the multidisciplinary team felt would benefit their particular mental health needs:

- Completed mental health screening
- Findings presented at the multidisciplinary TAY Collaborative meeting
- Discussed identified concerns and services recommended
- Final remarks, recommendations and referrals documented in a written report
- Screener shared the screening findings, team recommendations, and the final written report with clients/families and their service coordinators
- Project UNITE coordinator followed up with service coordinators on access to and appropriateness of recommended services

Examples of tangible results for the clients and their family members from the multidisciplinary meetings included connecting TAY and/or family members with:

- Community social skills programs
- Mental health counseling services
- Job training
- Support groups
- Project UNITE's wellness/drop-in program
- Higher education resources
- Parent Mentor Program
- Achievable Health Center
- NAMI Family-to-Family Education Program

Step 4: Support Development of Wellness Drop-In Center

Goal: implement youth wellness drop-in center program within the community for youth with or at risk for dual diagnosis

A request for applications (RFA) for the wellness drop-in center was posted on WRC's website.

The project's leading team derived a relevant scoring system using the point systems described in the RFA and created a selection committee of six WRC staff members representing different departments. The committee members also conducted site-visits and informal interview of applicants. Committee members scored applications independently. Scores were then aggregated and a sub-contractor was selected during a selection committee meeting. Project UNITE's staff contacted the selected program and sent a formal award notification.

Project SIDEKIX was awarded the funds to develop the wellness drop in program in Westchester, CA focusing on therapeutic lifestyle changes. Goals for this drop in program include fostering social and individual well-being and preserving and optimizing cognitive function through the use of exercise/recreation, including dance, yoga, nutrition education and relationship development (visit project's website at http://reachacrossla.org/programs/project-unite/ for additional program description and theoretical base). Other activities included relaxation and meditation exercises to decrease stress, discussions about nature and how it affects lives, contributions to others, and lastly, spirituality, to learn the different ways varying cultures view the meaning of life and how understanding of this can affect health.

Unfortunately the drop-in center program lost its original site and had to relocate. Securing a new location and an affordable lease was a challenge for the staff of SIDEKIX. As a result, this program was transitioned to another contractor and was subsequently named Full Circle Wellness (contact Project UNITE staff for full program description). This program operates on Sundays in Culver City, CA. It is managed by a licensed clinical psychologist and it provides structured therapeutic activities aiming to enhance the participants' sense of physical and psychological well-being. Referrals to the program came from the TAY Collaborative meetings or from families and service coordinators contacting Project UNITE staff.

Young adults participate in activities focusing on social and life skill development, community connectedness through interactions with local public agencies, and physical activities such as yoga, hiking, and progressive meditation at Full Circle Wellness. Other health promoting activities include anxiety management, one-on-one mentorship, and other exercises. The program is conveniently located next to bus stops, local parks, restaurants, and stores that are easily accessible for participants.

Full Circle Wellness' session activities are typically organized into three periods. The first period, usually lasting 30-60 minutes, allows time for participants to take part in unstructured activities (i.e., games, arts, crafts) while social interaction is supported by program staff. The second period is composed of 1-2 hours of physical activity that takes place inside a martial arts studio or a local park. Examples of physical activities include gymnastics, yoga, games, sports, agility/obstacle courses, self-defense, and nature walks. After a 15 minute snack break, the final period centers around a mindfulness based activity such as relaxation training, meditation exercises, or gardening.

Step 5: Support Development of Parent Mentor Program

Goal: implement parent mentoring program to provide support, resources and advocacy for WRC clients and families in need of mental health supports

Project staff established partnerships with the University of Southern California Center for

Excellence in Developmental Disabilities (UCEDD) at Children's Hospital Los Angeles, Westside Family Resource and Empowerment Center, and Family Resource Center Network of Los Angeles County in order to develop the Parent Mentor Program. These partnering agencies are experienced in developing and implementing parent-led initiatives, programs, training series, and support groups.

The Parent Mentor Program was based on a pilot parent-to-parent program developed by the Family Resource Center Network of Los Angeles County called Mentors Assisting Parents with Supports (MAPS), a program for parents of young children with developmental disabilities and mental health challenges. Based on feedback from the community, we contacted the partnering agencies to discuss adapting MAPS to the needs of families whose older children may be at risk for mental health issues while dealing with changes in significant life events. Plans included development of a network of parents of TAY who would be interested in providing parent-to-parent emotional and informational support.

Project staff and a trainer from UCEDD held two focus groups in order to obtain feedback from parents regarding the program and parent mentor training curriculum. Focus group participants felt that the most important training learning objectives were:

1. How to provide parent support
2. Learn about person first language
3. Discuss systems of care
    a. Regional Centers
    b. Department of Mental Health
4. Provide system navigation principles and how to find quality informational resources
5. Discuss common mental health condition
6. Obtain skills on basic parent to parent coaching and communication
7. Identify cultural issues
8. Identifying when a parent needs more support
9. Managing stress
10. Discussions regarding "what do I do if…?"

Focus group participants also indicated a possible need for additional monthly workshops. During the continuing education workshop, parent mentors could cover additional topics and share their experiences. Focus group participants indicated the following topics for possible upcoming continuing education workshops:

1. Systems of care and how to manage multiple systems such as
    - Behavioral health services
    - Special education
    - Department of Rehabilitation
    - Social Security

2. Human development
    - With specific focus on adolescence
3. Mental Health Stigma
4. What to expect from mental health providers
5. Helpful tools for organizing and record keeping

Based on the information from the focus groups, the trainer created an interactive 3-day training curriculum with materials. In addition, partnering agencies, the contracted parent mentor program coordinator, and project staff created training recruitment flyers as well as program policies, protocols, brochures, handbook, and intake and contact forms (program materials available on the project's website at http://reachacrossla.org/programs/project-unite/).

Project staff attended community meetings, fairs and conferences to inform the community about the program and to recruit potential parent mentors. Individuals interested in participating were informed about:

- The Parent Mentor Program (a training and support program for family caregivers who want to mentor parents caring for youth and young adults with developmental disabilities and mental health conditions like anxiety and depression)
- Criteria to become a Parent Mentor:
  Parent of a child/adult between the ages 14-26 with dual diagnosis and experience accessing developmental and mental health services
- Individual willing, available, and flexible to provide support to other parents
- Desired commitment:
    - Availability for trainings on three consecutive Saturdays
    - Ability to volunteer for up to 9 months
    - Interest in attending monthly supervision/continuing education meetings

The first cohort of parent mentors was trained in June 2015. Included in the 3 day training agenda were common mental health conditions, a discussion on cultural issues, finding quality resources, providing parent support, system navigation principles, coaching practice, rights and responsibilities for mental health, ways to manage stress, identifying when a parent needs more help, what to do if certain situations arise and an overview of program logistics. Plenty of time was also available for questions and discussion of homework assignments. Mentors who attended this training provided support to sixteen families in the nine months following the training. As the first cohort was finishing their commitment to the program, project staff held trainings for the second cohort of parent mentors in July 2016. All mentors received a stipend ($50 gift card per day) for participating in the training and signed a contract and confidentiality agreement.

Referrals for support from the Parent Mentor Program came from individual service coordinators, TAY Collaborative recommendations, and the Westside Family Resource and Empowerment

Center. The Parent Mentor Program Coordinator matched the referred parent with a mentor with similar backgrounds or experiences and provided background information to both parties. The mentor called the parent within 24 hours of receiving each referral. Most mentoring interactions were done over the phone with phone calls usually lasting between 10-30 minutes and occurring 2-4 times per month. Mentors kept phone logs to document interactions and turned them in to project staff monthly (available on the project's website at http://reachacrossla.org/programs/project-unite/).

Parent-to-parent mentoring included the following support: The Individualized Education Program (IEP) and appeal process, out of state educational services, psychiatric re-evaluation referrals, grief management, single parenting struggles, blended families issues, facilitation of behavioral support attendance/meetings, situational stressors (i.e. temporary housing, separation anxiety, job loss etc.), insurance navigation, sibling relationship boundaries and daily living skills assistance (i.e. time management, structure of daily needs etc.) and other resources as needed.

Each mentor was fully supported by the Parent Mentor Program Coordinator. Mentors met with the program coordinator monthly to discuss any presenting issues and to seek support as needed. Topics of continuing education meetings included behavior support, diagnosis of autism, conservatorship, reporting suspected abuse, dealing with resistance, helping children cope with trauma, and communication pitfalls.

Outcomes

Project UNITE has proven to be a successful endeavor in reaching and supporting transition age youth and their families. We have assisted close to 100 youth and young adults and have reached almost 70 parents through various training, intervention, and outreach programs. An immense amount of positive feedback has resulted from all aspects of the project. We are confident that this program has increased access to community resources, expanded collaborative case-management efforts across multiple systems of care and has positively influenced our TAY clients. Continuation of Project UNITE would allow further support for these TAY clients through their life changing transitions and mitigate risks for mental health conditions.

Mental Health Screenings Outcomes

Referral to and completion of the Project UNITE mental health screenings has provided much needed support for many TAY. Of the 60 individuals screened, it was discovered that 50% had elevated scores (any score above 65) indicating some anxiety, depression, anger, disruptive behavior and/or low self-esteem and were in need of additional mental health follow-up and supports. Although the scores were not shown to be clinically significant, their elevated levels (i.e. average of 59 for anxiety, 60 for depression, 61 for anger, and 52 for disruptive behavior) prompted follow-up care from the team. The Vineland Maladaptive Scale, completed by parents or caregivers, also provided a view on the individual's behaviors from another person's perspective. Most of the scores reported by the parents were not in the clinical significance range (a score between 21 and 24) except for internalizing behaviors (i.e., 21). The remaining scores for externalizing behaviors (19) and maladaptive behaviors (20) were considered elevated but in in the clinical range. Overall, majority of screened respondents also indicated feeling hopeful about their

lives (5%), having friends to they liked to talk to or do things with (60%), and having employment and education goals for the future (60%). About 10 individuals expressed suicidal ideations and were referred to mental health treatment services.

Service coordinators have expressed appreciation for the mental health screenings. One client's service coordinator informed us that after completing the mental health screening, the client was in "a much better place since seeking the recommended individual therapy and has begun to look in to group social activities."

We have also developed a comprehensive database that includes data from the Quality of Life questionnaire that we hope to use for future research studies to examine trends in this population and to collect follow-up data on utilization of recommendations by clients, family members, and service coordinators.

Parent Mentor Program Outcomes

Some TAY and their family members who participated in the screening have also received support from our Parent Mentor Program. The Project's Parent Mentor Program coordinator shared that "one family, with help from the TAY Collaborative recommendations and supporting documents, has been actively pursuing a psychological evaluation in order to reapply for regional center services. They are doing great and taking the steps they need to get the help they want." Another mentor assisted a parent in obtaining behavioral services in their home by attending the required orientation with the parent receiving support. In addition, one mentor referred a parent to a support group as a resource to help this parent process challenging behaviors of her child; this parent did not think a support group was right for her and was surprised to discover how helpful the group actually was. One mentor has also stated that she "learned very good means of providing peer to peer support that can be useful in all walks of life". Other success stories that parent mentors shared include:

- "It was great knowing that I had information to share from my personal experiences."
- "The experience was so rewarding! Over time I was able to talk with parents and thein their voice lessened."
- "One parent felt they had failed as a parent. She told of all the things she had done on her son's behalf and the mentor said 'that sounds like a good parent to me' and she began to cry."

TAY Collaborative Outcomes

The mental health screenings and the referral process and has shown to be beneficial in supporting WRC families and clients. One of the TAY Collaborative members shared with us this feedback:

"…I attended the TAY collaborative staffing today and was very impressed. Take it from someone who attends lots of meeting. This was substantive, well-run and produced tangible results for several clients who are at a very pivotal time in their young lives. My hat is off to the folks that make this happen."

Project UNITE helped connect TAY with community social skills programs, mental health

counseling services, job training, support groups, wellness/drop-in program, higher education resources, and programs aimed at helping clients transition towards more independent lives. Clinical recommendations shared with the clients and their family members included establishing medication routines at home to assist with medication compliance, connecting individuals with the National Alliance on Mental Illness Family-to-Family Education Program, referring clients to the Edelman Westside Mental Health Center for their Field Capable Clinical Services and the Center for Assessment and Prevention of Prodromal States (targets young adults at risks for psychosis), and exploring *Actors for Autism* and Exceptional Minds programs.

One client who participated in the mental health screening was taking medication for attention deficit/hyperactivity disorder; however, after reviewing the comprehensive screening materials and information, the TAY Collaborative team members recommended he be reevaluated to rule out general anxiety and hypervigilance related to possible post-traumatic stress disorder. The clinical team stressed that it was imperative to gain understanding of his overall mental health status because his prescribed medication may have been contributing to his symptoms. This would not have been investigated if it were not for the Project UNITE screening.

Moreover, the TAY Collaborative allowed for continuing partnership between the two systems of care, LA County Department of Mental Health in Service Area 5 and WRC. Liaisons from both systems have access to shared case-management where they can discuss existing services and brainstorm additional support.

Wellness Drop-In Center Outcomes

Participant feedback regarding the wellness drop in program has been unanimously positive. Comments include:

- "I love coming here because it is fun and we do fun things."
- "This is really cool, I've never done activities like these (i.e., yoga, self-defense, gymnastics) before."
- After successfully completing a meditation exercise, one of the participants said to the program leader, "I did it! I did a good job!"
- One parent described her son as being "enthusiastic" about the program and always looking forward to attending every Sunday.
- A participant's one-on-one instructor stated, "she needs this, she needs the socializing and healthy activities and I hope she continues to participate."
- One parent stated that the family lives near the program and after attending a couple of sessions, her son wanted to independently walk to the program.

Project staff also worked with the wellness drop-in center subcontractor on developing a guide of how to start a California nonprofit titled "Everything You Wanted to Know About Starting a California Nonprofit but Were Afraid to Ask" (available on the project's website at http://reachacrossla.org/programs/project-unite/). This guide was developed based on our experiences with developing a wellness drop-in program, which could eventually become a

nonprofit charitable organization in our local community in order to sustain its operations past the current MHSA funding.

Lessons Learned

Mental Health Screenings

- Allow for enough screeners to conduct the screenings before promoting the screenings to the whole agency; thereby minimizing wait times and burnout.
- Each face-to-face screening with the client and parent/caregiver takes about 1.5 hours; however, the whole screening process including reviewing referrals, gathering background information, meeting with clients and parents/caregivers, administering the screenings, writing case summaries, presenting at the TAY Collaborative meetings, and communicating the findings and the recommendations with the client/parent/caregiver, takes about three to four hours; as a result, allot more time for screenings.
- If there are only limited number of screeners available (e.g. two to three people), promote screenings on a staggered basis (e.g. one unit at a time) to avoid wait-lists.
- Initiate contacts with local universities to provide internship opportunities for social work students to learn about regional center systems and to conduct the screenings; however, plan a back-up in case the universities are not able to provide qualified students.

TAY Collaborative

- Establish partnerships with local mental health agencies.
- Be flexible – the more representatives attending the TAY Collaborative, the more challenging the scheduling becomes. We had some representatives call in to the meetings, if they could not attend in person.

Wellness Drop-in Center Program

- Since the referrals to the wellness drop-in center program come from the TAY Collaborative and screenings' findings, start the wellness drop-in center program 3-6 months after initiating the screenings and TAY Collaborative meetings to delay referrals.
- Since the definition of a drop-in center is to drop-in and attend the sessions based on individual needs, expect the attendance to vary weekly/monthly.
- New programs face many challenges with staff and location, plan a backup when a vendor loses permanent location (e.g. connect the vendor with other local programs, etc.).

Parent Mentor Program

- Knowing that the referrals to the Parent Mentor Program come from the TAY

Collaborative and the findings from the screenings, train parent mentors 3-6 months after initiating the screenings and TAY Collaborative meetings to avoid delays in referrals.

- Since the parent mentors are volunteers, allow for more flexibility and expect a six month commitment to the program rather than nine.

For more information regarding Project UNITE or to request program materials, please contact Aga Spatzier, MPH, Wellness Manager, at agas@westsiderc.org or visit http://reachacrossla.org/programs/project-unite/

Attachment 1 - Timeline