

# RAP Foundation’s Mental Health Initiative

## Collective Impact

Chris Morin, MS; Jenna LeComte-Hinely, PhD



### INTRODUCTION

**About RAP Foundation**  
Regional Access Project Foundation (RAP) is a 501(c)3 public benefit corporation located in Palm Desert that serves the community in Eastern Riverside County. RAP strives to enhance the quality of life for the residents of Eastern Riverside County by investing in nonprofits and empowering them to effectively serve unmet needs.

**About HARC**  
HARC, Inc. is a 501(c)(3) nonprofit organization that specializes in research and evaluation services. Located in the Coachella Valley region of Riverside County, HARC is one of only a handful of evaluators in based in the Inland Empire.

**The Mental Health Initiative**  
In 2014, RAP instituted a Mental Health Initiative (MHI) with the goal of enhancing the mental health quality of life in Eastern Riverside County through grantmaking to support innovative and collaborative efforts. Specifically, RAP issued several requests for proposals (RFPs) that offered the opportunity for community organizations to propose programs that would address specific aspects of mental health in the region.

**About Collective Impact**  
Collective impact involves the collaboration among multiple sectors committed to and making efforts to achieve a common goal for complex social problems such as mental health. There are five core aspects to the collective impact model: 1) a common agenda, 2) a shared measurement system, 3) mutually reinforcing activities, 4) continuous communication, and 5) a backbone function.

**About the Evaluation**  
At the start of the MHI, RAP did not implement shared measurement tools among the grantees. For that reason, RAP partnered with HARC to carry out a collective impact evaluation of the MHI. HARC designed a collective impact tool (shared measurement) for grantees to use in their evaluation efforts going forward. The information provided here summarizes outputs/outcomes as well as the collective impact of eight organizations working to address mental health in the Coachella Valley region.

### METHODS

RAP and HARC collaboratively identified areas of the MHI that should reflect progress (or setbacks) among the region. The four areas include mental health quality of life, access to mental healthcare, stigma in obtaining mental healthcare, and impact of services on support network. Once these areas were identified, HARC created a ten-item questionnaire that covered four domains.

#### Measures

**Mental Health Quality of Life**  
Mental health quality of life was measured through the WHO-5, a well-being index developed by the World Health Organization. The index includes five items of well-being that are rated on a scale ranging from “all of the time” to “at no time”.

The sum of all responses is converted to a percentage score that ranges from 0% (worst possible quality of life) to 100% (best possible quality of life). Altogether, a higher percentage indicates better well-being. A total score of 52% indicates poor well-being and is an indication for testing for depression under ICD-10. For the sake of clarity, the percent signs are removed from the narrative, and as such are reported simply as a scale from 0 to 100.

**Access to Mental Healthcare**  
Access to mental healthcare was adapted from HARC’s, population survey, “Coachella Valley Community Health Survey” and assesses whether participants need mental healthcare and cannot access it. Additionally, participants had the opportunity to describe why they cannot access mental healthcare.

**Stigma in Obtaining Mental Healthcare**  
Stigma related to obtaining mental health care was designed by HARC and assesses participants’ propensity to seek services, under the assumption that services are free. Following that question, participants could explain why they wouldn’t seek treatment if they needed and were able to.

**Impact of Services on Support Network**  
The impact of services on participants’ support network was designed by HARC and assesses how (positively/negatively) services influenced participants’ relationships with their friends, family, and/or other networks.

### METHODS Continued

The questions asked are provided below and numbered 1 to 10. Please indicate for each of the five statements which is closest to how you have been feeling over the last month. Notice that higher numbers mean better well-being.

**Procedure**  
Upon finalizing the collective impact measures, RAP and HARC met with the grantees and provided details on the concept of collective impact evaluation and how that relates to RAP’s MHI. Further, HARC provided the measure and explained how the grantees are to incorporate it into their evaluation efforts. An instruction sheet was also provided, and grantees were encouraged to contact HARC with any questions during implementation.

HARC also designed simpler versions of the collective impact measure, as some organizations were serving children. While the questions are slightly different, the theme of each domain was preserved to enable an aggregation across organizations and populations. Both of the adult and child versions were provided in both English and Spanish.

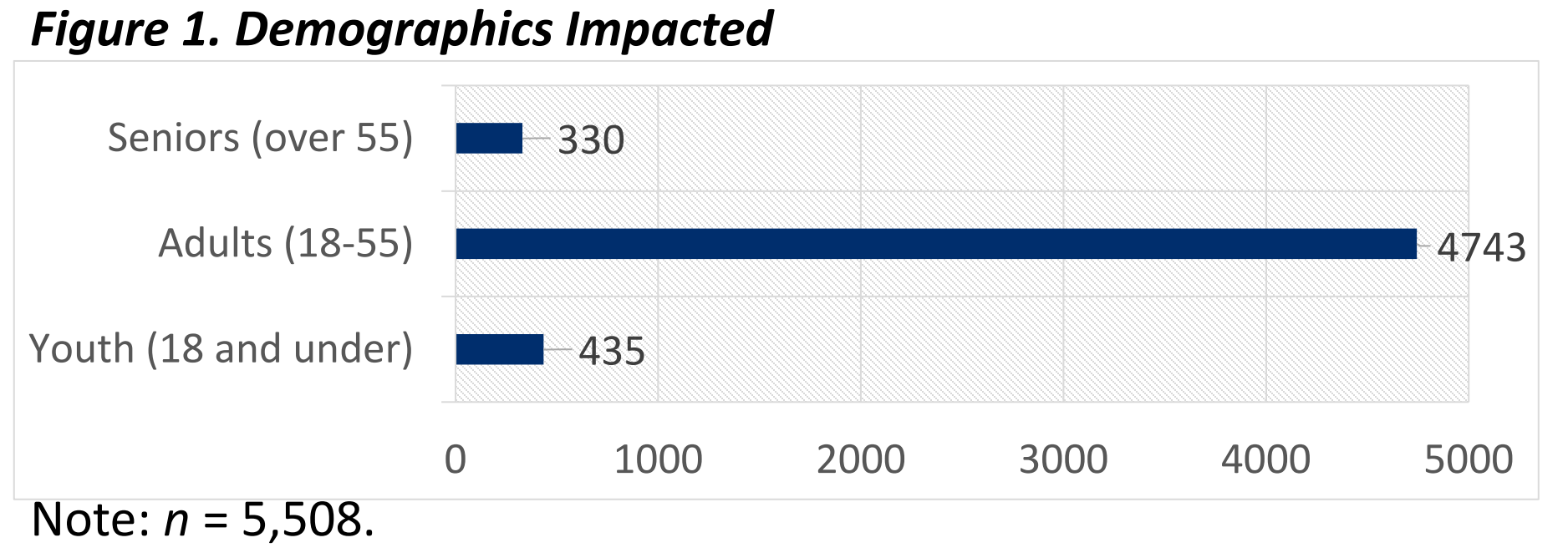
The collective impact measure was designed to be implemented in a pretest/posttest method, apart from the impact of services on support network. This pretest/posttest method allowed for a comparison of how participants improved or declined among the four domains over time. However, not all grantees administered the collective impact measure in a pretest/posttest method.

It is worth noting here that in some cases grantees did not gather the collective impact data as instructed. While support was provided to grantees throughout, some grantees did not collect data due to staffing/leadership changes, not having official “exit from program” times, and in other cases, simply chose not too collect any data.

### RESULTS

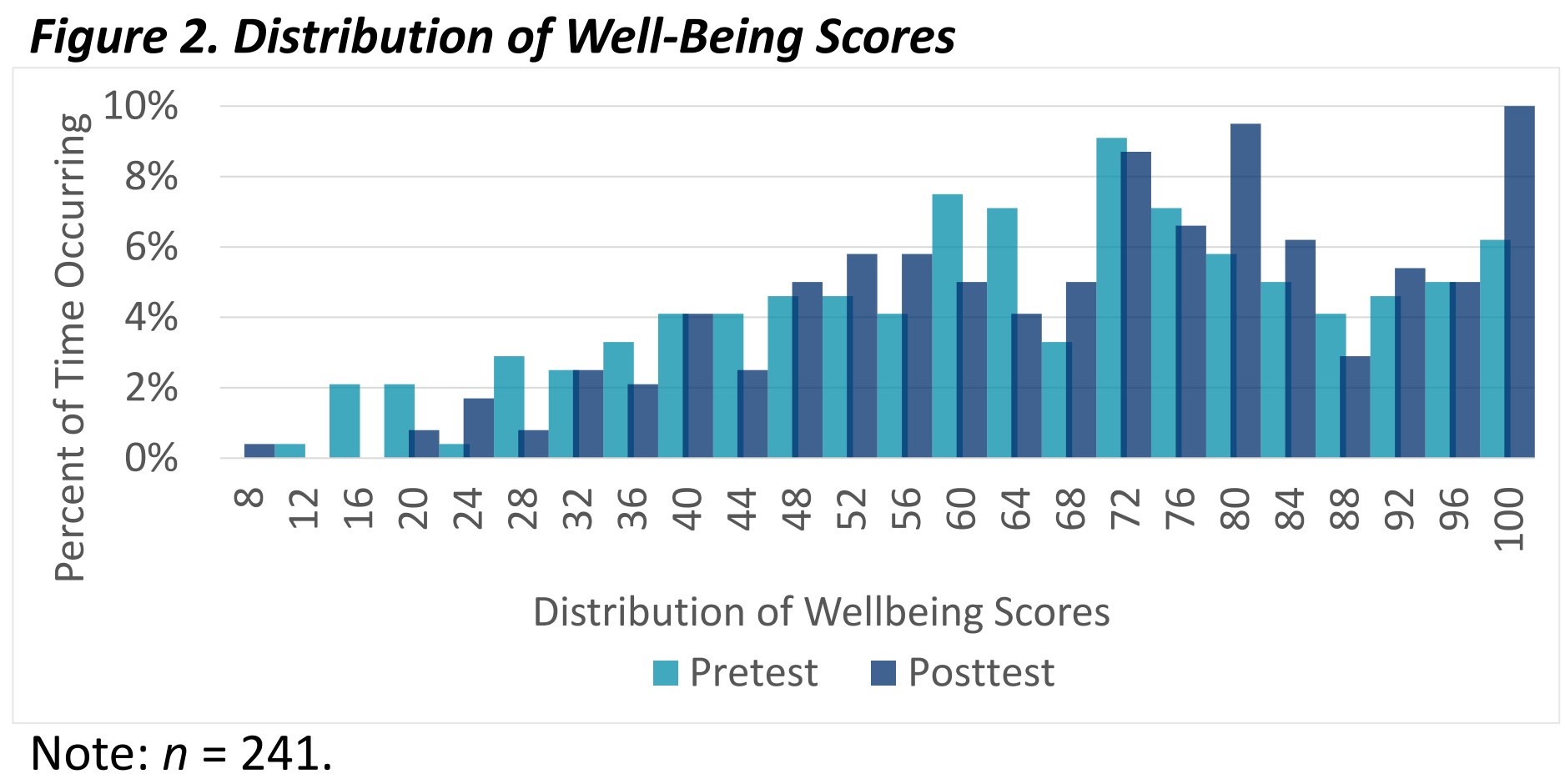
Our results first include the number of those directly and indirectly impacted, as reported in the grantee reports. Then, an analysis of the collective impact measure (quality of life, access to mental healthcare, stigma in obtaining mental healthcare, and impact of services on support network) is detailed.

All participants were asked to specify the number of youths, adults, and seniors impacted. Grantees were also asked to further specify the number of those being served that were living in poverty and to estimate how many people were indirectly served.



**Mental Health Quality of Life**  
There were 2,216 participants who completed a survey. However, because we are interested in how people improve, only those who completed both the pretest and posttest surveys (241 people) were analyzed. These participants were asked a series of questions related to their well-being. The sum of all responses was converted to a percentage score that ranges from 0% (worst possible quality of life) to 100% (best possible quality of life).

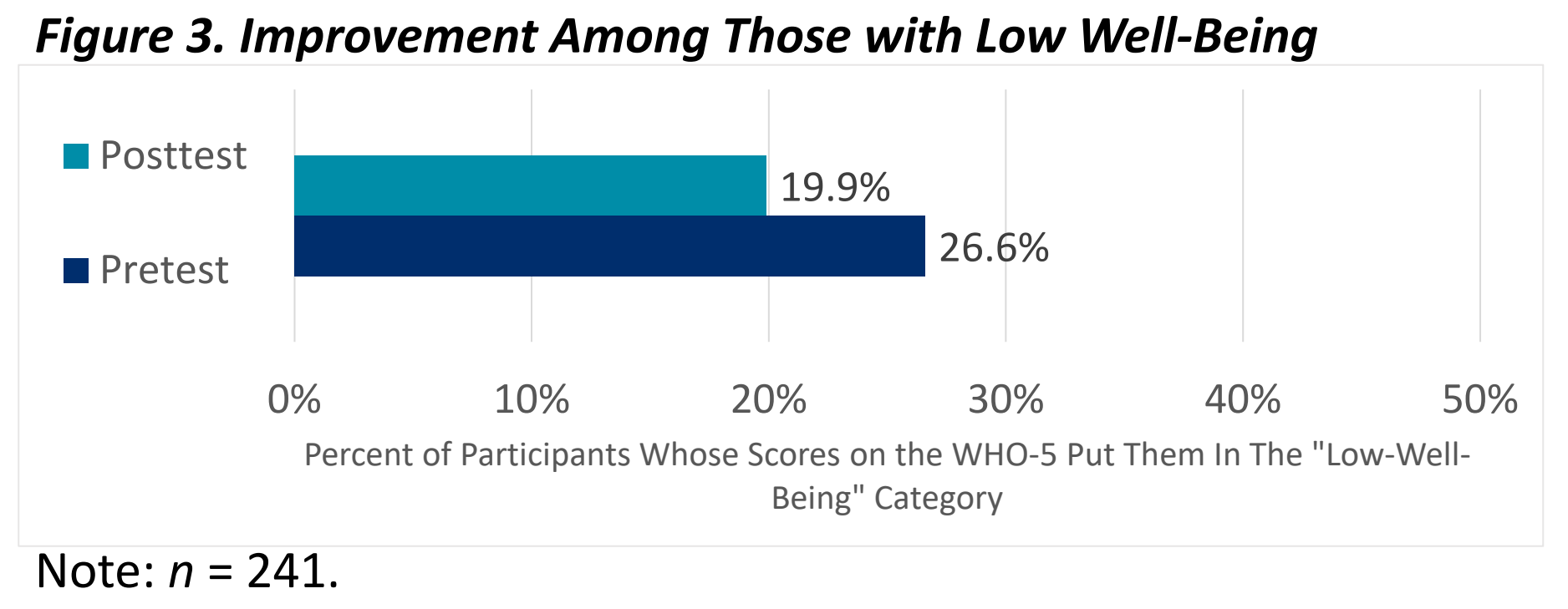
The average well-being score was 64.95 at pretest and increased to 69.26 at the time of posttest, reflecting a 4.31 increase in well-being. That 4.31 increase in well-being represents a statistically significant increase,  $t(240) = -2.70, p < .01$ . The difference between the means of the pretest/posttest scores has a magnitude of  $d = .174$ , representing a “small-sized” effect in statistical terms. This effect is illustrated in Figure 2 below.



### RESULTS Continued

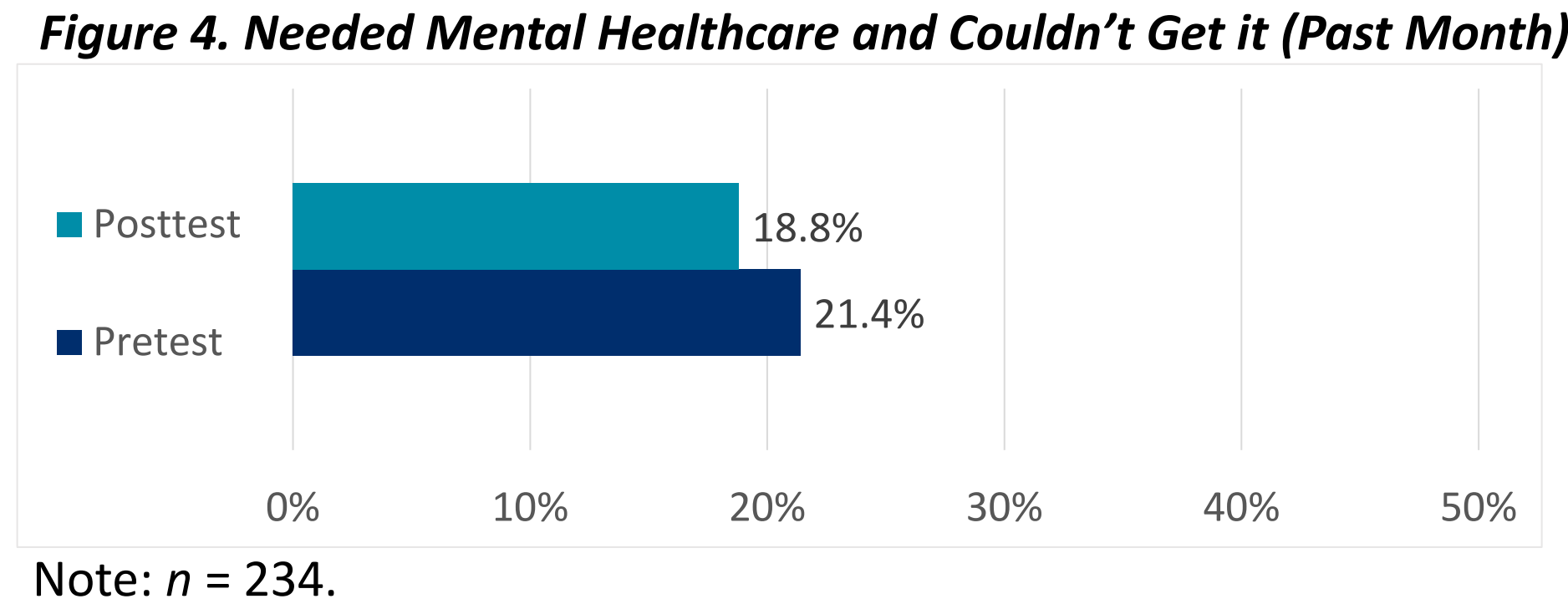
The well-being scale defines individuals who score less than 52 on the scale as having “poor well-being” and are at risk for depression. Because of that cut-off, HARC split the well-being scores by those who scored at/below 52 (low well-being) and those who scored above 52.

As illustrated in Figure 3, 26.6% of participants had low levels of well-being at pretest. By the posttest, this dropped to 19.9%, representing a 6.7-point decrease in the percentage of people with poor-well-being. That decrease in the proportion of people with low well-being was statistically significant,  $\chi^2 (1, n = 241), Cochran's Q = 4.267, p < .05$ .



**Access to Mental Healthcare**  
Part of the RAP MHI includes increasing access to mental healthcare for people who are not able to get it. To determine access, participants were asked, “Was there a time in the past month when you needed mental healthcare (such as counseling, medication, etc.) and could not get it?”

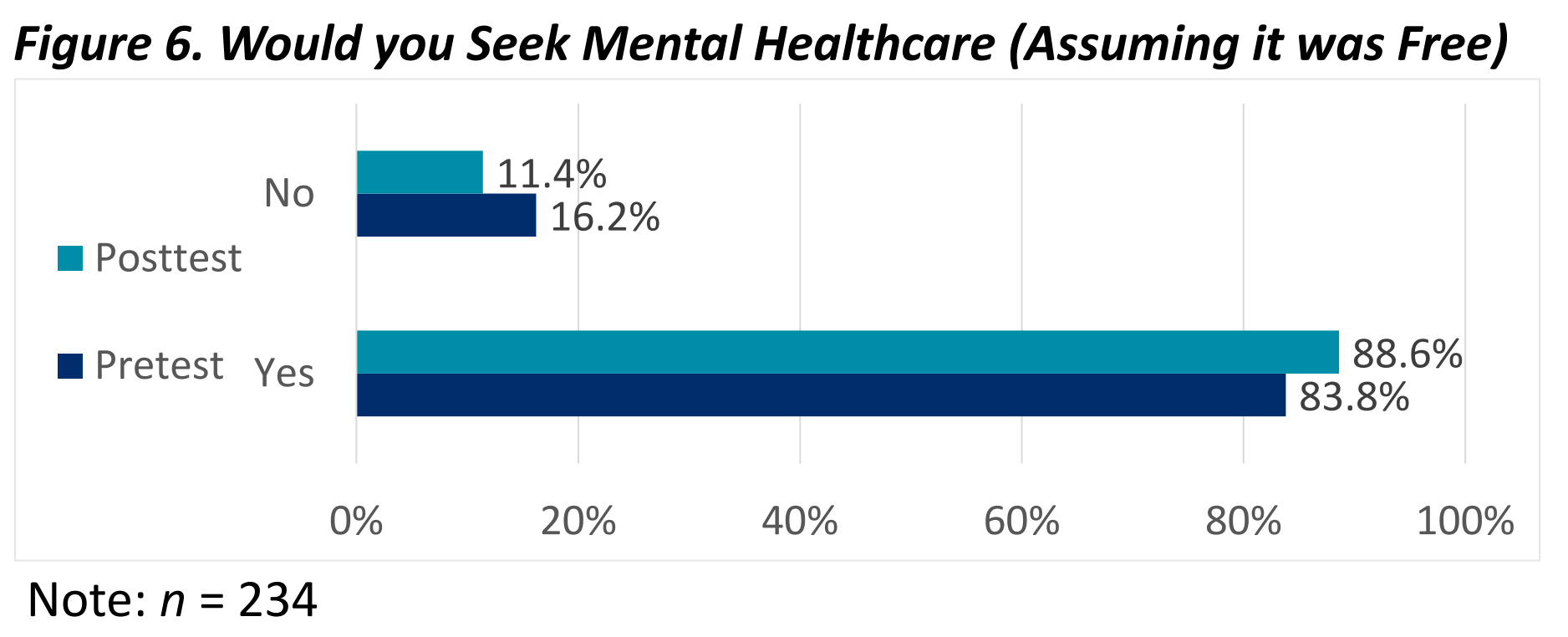
As illustrated in Figure 4 below, at pretest 21.4% of participants, reported “yes”, they did not have access to mental healthcare within the past month when they needed it. At posttest, this number dropped to 18.8%, which is encouraging. However, that decrease was not enough to be considered statistically significant,  $\chi^2 (1, n = 234), Cochran's Q = .621, p > .05$ .



Participants who stated that they were unable to get the mental healthcare they needed in the past month were then asked to specify what prevented them from getting mental healthcare. Responses were qualitatively coded in which similar themes among the data were grouped together and counted. Participants typically wanted to handle it by themselves or didn’t want to talk to others about their problems.



**Stigma and Mental Healthcare**  
Another goal of the initiative was to decrease stigma associated with seeking mental healthcare. This was assessed by asking participants, “If you had mental health issues that concerned you, would you seek mental health treatment (assuming it was free)?” As illustrated in Figure 6, 16.2% of participants reported, “No”, they would not seek mental healthcare (assuming it was free) if they had mental health concerns at pretest. This dropped to 11.4% at posttest, representing a 4.8 decrease in the proportion of people who won’t seek mental healthcare when they have mental health concerns. Although there was a decrease, it was not enough to be considered statistically significant,  $\chi^2 (1, n = 229), Cochran's Q = 2.28, p > .05$ .

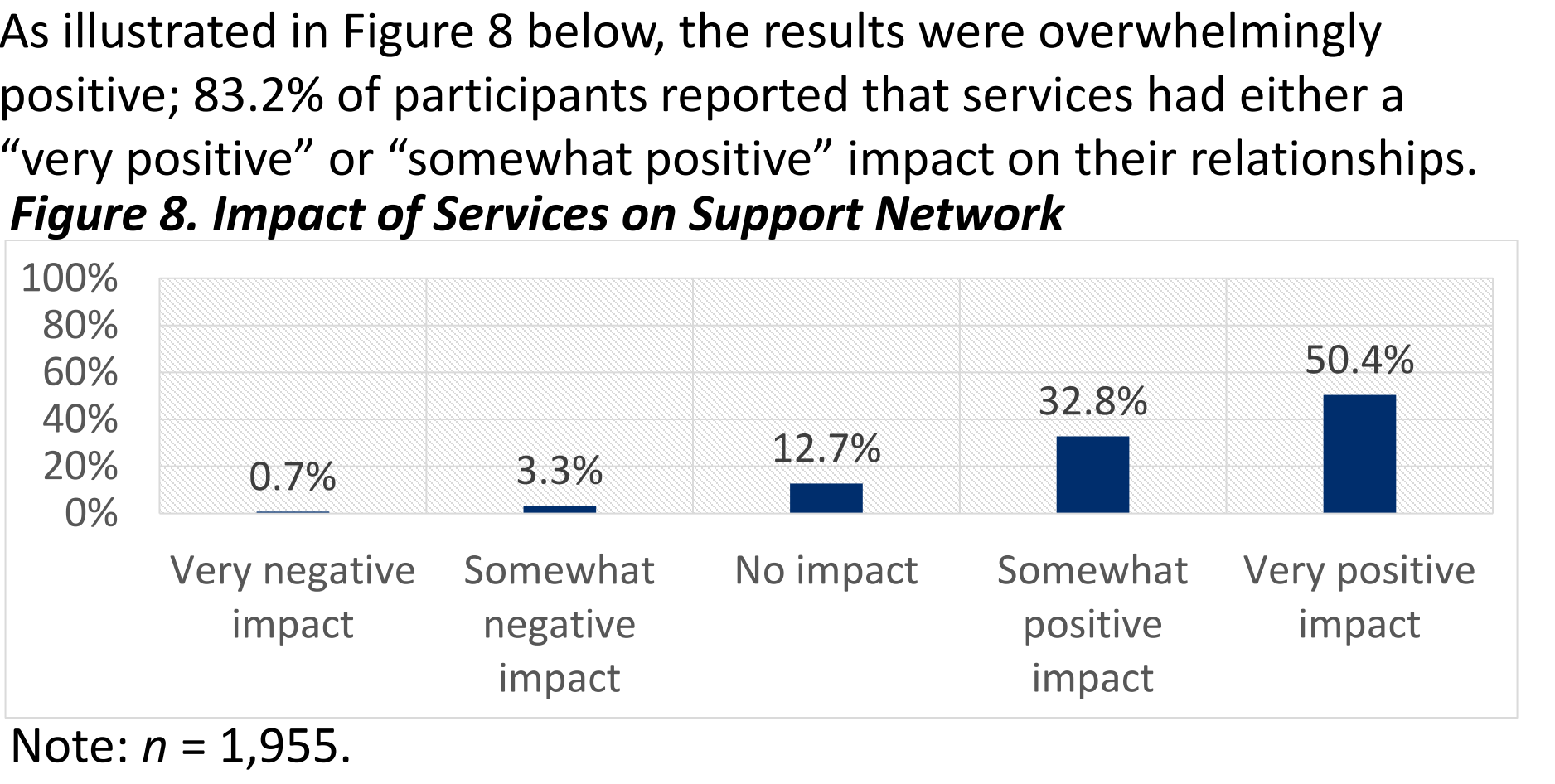


### RESULTS Continued

Participants who reported they wouldn’t seek mental healthcare were asked why. Responses were qualitatively coded with similar themes grouped together. Participants typically cited reasons such as feeling uncomfortable, ashamed, or embarrassed to open up to a stranger



**Impact on Support Network**  
RAP was interested in the impact that grantee’s services may have had on participants’ relationships with others. For example, participants were asked, “How have the services you’ve receive here at [organization]” influenced your relationships with friends, family, and/or other support networks?” This question was asked during the posttest portion of the surveys.



### CONCLUSION

**Progress in the MHI**  
The RAP Foundation sought to improve various aspects of mental health in the Coachella Valley region, by funding organizations focused on a variety of projects. The approach to evaluating this effort included the method of collective impact evaluation.

Looking at some of the specific areas of interest, the well-being scores of seven organizations’ clients significantly increased. Moreover, among the participants who had low levels of well-being, and were at risk of depression, there was an even larger increase in well-being. There were no significant changes in access to mental healthcare or stigma regarding seeking treatment. People who did not obtain mental healthcare invoked overarching themes of a fear of negative evaluation or they want care and can’t get it because of external barriers. These findings illustrate the utility of collective impact evaluation; across multiple organizations, common barriers to pursuing mental healthcare were identified and interventions can be based around these barriers to bring more mental healthcare to those who need it.

**Implications for Practicing Evaluators**  
While collective impact evaluation allows for a broader snapshot of nonprofit efforts to address community need, evaluators should note the additional impediments that accompany this methodology. Despite multiple trainings, data collection was impeded by factors such as changes in leadership and staffing, not having an official “exit” in the program, and simply choosing not to collect data at all.

To mitigate these factors surrounding data collection, HARC suggests having multiple people responsible for data collection within each organization. Thus, if one member leaves, others are still aware of required evaluation activities. In addition to that, having organizations send their pretest, or pre-survey data collection and while their program is still operating allows for potential modifications and improved data quality. Lastly, having data collection requirements specified in service agreements may help with compliance issues.

Typically, evaluations will focus on the siloed efforts of one organization. While an isolated evaluation is valid and useful, it also has limitations for the effectiveness of that work in cultivating lasting change at a community level. Funders should consider the adoption of collective impact evaluations as these will help to determine how well priorities within service regions are being met on a larger scale. Collective impact evaluations not only create a stronger infrastructure for greater community impact, but also ensure this important work is being measured and documented successfully.