CAREGIVER WELLNESS PROGRAM (INNOVATIONS-11)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT (7/1/15 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Caregiver Wellness Program (CWP) was funded through the Innovations (INN) component of the Mental Health Services Act. CWP was designed to provide screening, needs assessments, linkage to services and resources, as well as therapeutic, educational, and support groups for caregivers of children receiving services through KidSTART clinic, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. While Medi-Cal funding allows for attending to caregiver needs as they relate to the child's diagnosis, attending to the specific well-being of the caregiver is outside the scope of billable services. CWP services were expected to improve the well-being of caregivers so that they could better care for themselves and their child/children. CWP and KidSTART clinic services were provided through Rady Children's Hospital Chadwick Center for Children and Families.

A primary innovation of CWP was the addition of Parent Care Coordinators (PCCs) to the KidSTART clinic treatment team. After completing detailed family needs assessments, the PCCs provided emotional support and worked to link caregivers with appropriate services and resources including their own behavioral health care. Additionally, therapeutic, educational, and support groups were developed and offered directly through CWP in multiple San Diego County locations.

EXECUTIVE SUMMARY

The Caregiver Wellness Program (CWP; INN-11) was designed to support parents/caregivers of children receiving treatment services through the BHS KidSTART clinic by assessing caregivers and then providing linkages to needed mental health, alcohol and drug, or other services, as well as directly providing therapeutic, educational, and support groups. A Parent Care Coordinator (PCC) role was created to provide caregivers with individualized case management following the completion of a detailed in-home family needs assessment.

- A total of 142 caregivers participated in the CWP program.
- The CWP program employed two PCC FTEs.
- Caregiver participation in CWP was associated with positive child outcomes (e.g., improved child behaviors).
- Most caregivers identified as female (75.4%). The primary language for 20.0% of the caregivers entering CWP was Spanish with 41.1% indicating an Hispanic origin.
- The in-home needs assessments highlighted many caregiver needs. About half of respondents indicated a need for more parenting knowledge (51.2%), more emotional support (49.4%), and to meet with a professional to discuss problems (47.6%). Other needs included financial (35.7%), housing (32.1%), or legal matters (30.1%).
- A total of 73.2% of participants received at least one CWP case management visit and 38.7% attended at least one structured psycho-education support group session provided by CWP. The average number of group sessions attended was 10.2, which suggests a high level of caregiver interest.
- CWP was successful at engaging commonly underserved populations (e.g., males and Spanish-language speakers).
- Consistent with program goals, at follow-up, caregivers were significantly more likely to indicate being actively involved in addressing their own problems.
- Through the work of the PCCs, most caregivers (71.1%) had at least one linkage to other behavioral health services (e.g., individual or family therapy, NAMI support groups).
- Additionally, 64.1% of the caregivers had at least one non-behavioral health linkage (e.g., financial, food, shelter).
- Caregivers indicated high levels of satisfaction with CWP and that most received a range of emotional, educational, and tangible supports from their PCCs.
- CWP staff were able to successfully develop, implement, and refine the core CWP practices of caregiver assessment, individualized care coordination, linkage to external resources, and provision of structured psycho-educational support groups during this three-year pilot project. Given ongoing challenges with linking to external treatment services, future versions of a CWP-type program may want to consider including an individual therapy component.

FUTURE DIRECTIONS

Based on the positive findings from the INN-11 Caregiver Wellness Program pilot study, BHS sustained the CWP programming by dedicating available Substance Abuse and Mental Health Service Administration (SAMHSA) resources. This funding allowed the structure and operations of the CWP program to continue uninterrupted. In addition, the program was able to allocate funds to begin supporting the provision of a limited amount of individual therapy within the program, a recommendation originating from the pilot study.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish and implement a novel approach for increasing access to mental health services for the caregivers of children in treatment for complex emotional, behavioral, and developmental issues.

Using the MHSA Innovations funding, the Caregiver Wellness Program (CWP) was successfully developed, implemented, and refined to provide services to caregivers of children receiving services through KidSTART clinic, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. The primary components of CWP consisted of: 1) a comprehensive needs assessment, which was often conducted "in-home," 2) provision of emotional support and individualized linkages to behavioral health and other community services by a Parent Care Coordinator (PCC), and 3) a range of structured multi-week therapeutic, educational, and support groups developed specifically for CWP caregivers. Of the 142 caregivers enrolled in CWP, 41.1% identified as Hispanic, a frequently underserved population. Staff identified the implementation of CWP as introducing a cultural shift throughout the entire KidSTART clinic in that raising awareness of and attending to caregiver needs became integral to their overall treatment approach. Primary CWP services were provided by two PCC FTE's with 0.5 therapist FTE for the groups.

2. To provide education about the impact of caregiver stress on personal and family well-being.

In addition to providing emotional support and facilitating linkages to needed services, over 80% of caregivers indicated that the PCC helped them understand the importance of getting services for emotional or drug or alcohol problems. All of the structured, multi-week group CWP classes had a primary emphasis on educating caregivers on how to better care for themselves and/or their children. Approximately 40% of CWP participants attended at least one of the classes. Of those who attended any classes, the average number of sessions attended was 10.2, suggesting a high degree of interest in and engagement with the classes developed by and offered through CWP.

3. To engage caregivers in their own mental health treatment and improve access to needed care.

There was a statistically significant increase in the extent to which caregivers indicated they were "actively working on my problems on my own" between when they entered CWP and the follow-up assessment. In addition to engaging in the services provided directly by the CWP, 71.1% of the caregivers had at least one behavioral health linkage facilitated by the PCC for services such as individual or family therapy, support groups, co-occurring mental health and substance abuse treatment, or connections to domestic violence support services. To further support engagement in mental health treatment, a recommendation that emerged from the experience with CWP was to add direct individual therapy for caregivers as a new service component, which builds upon existing trust developed with caregivers and increases access to treatment.

4. To improve caregiver well-being.

Approximately 90% of caregivers indicated that as a result of participating in CWP, they were "better able to handle things," were "more comfortable seeking help," or knew "where to get help when I need it." Caregivers also reported receiving a wide range of emotional and tangible supports from their PCC that were intended to improve caregiver well-being. As evidenced by the results of the comprehensive needs survey, many caregivers also had substantial needs not directly related to behavioral health services. Through the work of the PCCs, the majority of caregivers (64.1%) had a least one non-behavioral health linkage completed by the PCC to help meet basic needs (e.g., financial, food, shelter, clothing), or to help with other supports such as legal assistance. Working to address caregivers non-behavioral health needs was identified by staff as an important step for building trust and facilitating discussions related to potential linkages for caregiver behavioral health needs.

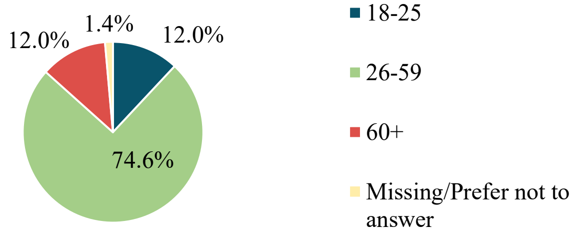
5. To improve outcomes for children whose caregivers improved their own well-being/became engaged in their own care.

CWP services were highly individualized to identify and address the specific, unique needs of a wide range of caregivers (e.g., biological, kin foster, non-kin foster, and adoptive parents). Most caregivers (90.6%) reported that the PCC helped them "feel better able to help my child/children." Qualitative feedback from caregivers identified three primary ways in which CWP services helped them improve the care of their children: 1) increased parenting skills and knowledge, 2) recognition of impact of their own mental health on their ability to care for their children, and 3) becoming more emotionally resilient and confident parents to help address the complex needs of their children. Quantitative analyses indicated that children whose caregivers participated in CWP were more likely to have successful KidSTART clinic discharges (i.e., completed treatment) and to experience greater behavioral improvements compared to children whose caregivers did not participate in CWP.

CAREGIVER WELLNESS PROGRAM PARTICIPANT DEMOGRAPHICS

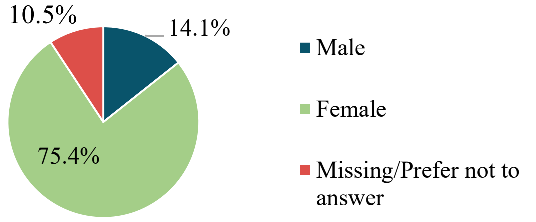
The following demographic data were collected from a participant self-report survey administered at the start of the CWP program.[1]

AGE (N=142)



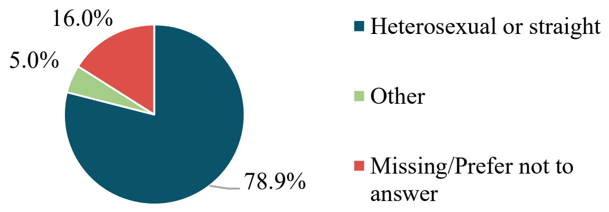
The majority of participants (74.6%) were between the ages of 26 and 59.

GENDER IDENTITY (N=142)



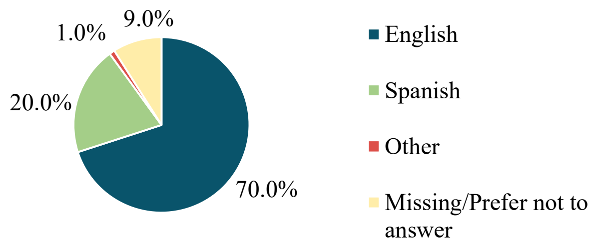
About three-quarters of participants were female (75.4%) and 14.1% of participants were male.

SEXUAL ORIENTATION(N=142)



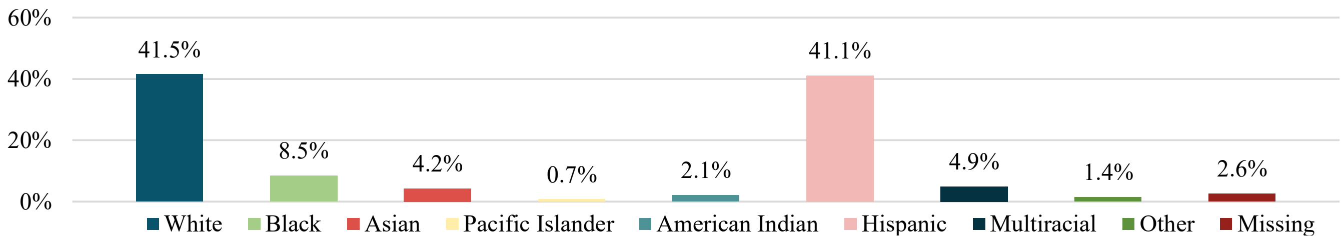
Most (78.9%) participants were heterosexual or straight and 16.0% of participants did not provide a response.

PRIMARY LANGUAGE (N=142)



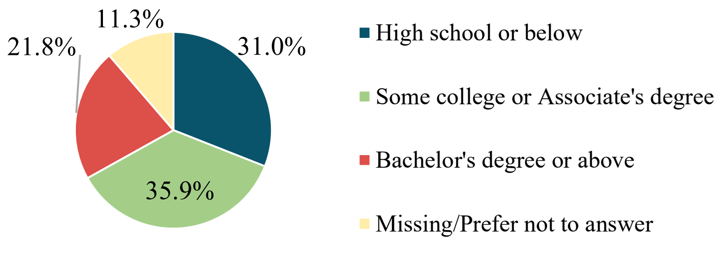
English was the primary language of most participants (70.0%) followed by Spanish (20.0%).

RACE/ETHNICITY (N=142)



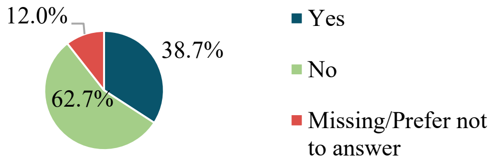
Forty-two percent of participants identified themselves as White, followed by 41.1% who identified as Hispanic. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EDUCATION LEVEL (N=142)



Participants' educational level were split between broad categories, the largest being some college or Associate's degree (35.9%).

DISABILITY STATUS[2] (N=142)



Thirty-nine percent of participants reported having some form of non-SMI related disability.

Approximately 5% (4.9%) indicated they had served in the military.

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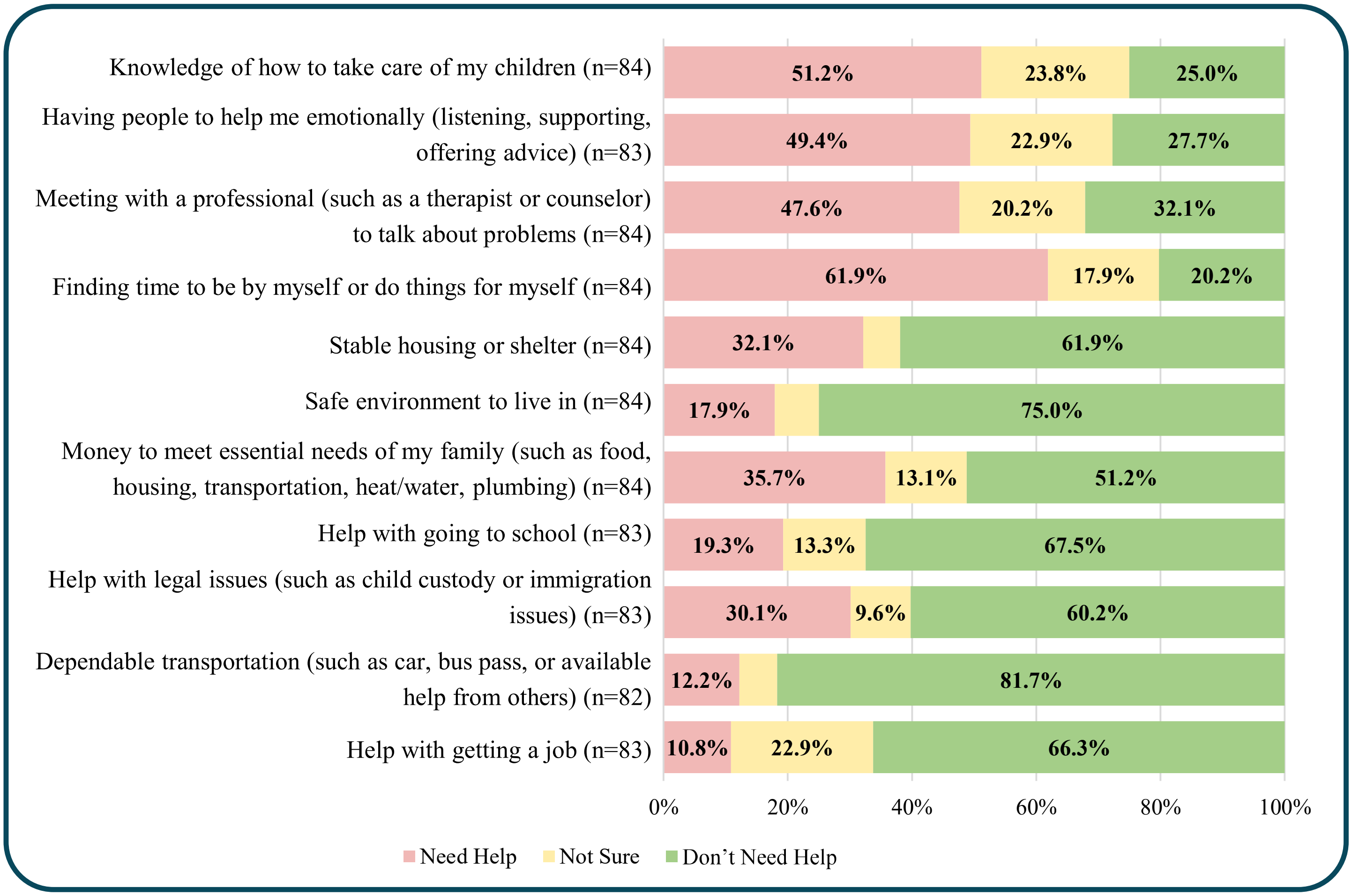
[1] Percentages may not total to 100% due to rounding. [2]A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).

CAREGIVER NEEDS

As shown in Figure 1, select items from the comprehensive baseline family needs assessment indicated a wide range of potential family needs. Consistent with the caregiver's openness to and interest in receiving mental health and/or alcohol and drug services noted below, nearly half (49.4%) indicated needing assistance with finding "people to help [them] emotionally," and nearly half (47.6%), indicated that they needed help "meeting with a professional…to talk about problems." Additionally, over half (51.2%) wanted help increasing their "knowledge of how to take care of [their] children." Needing help with other issues such as housing, finances, and legal matters were each expressed by about one-third of all caregivers entering CWP.

FIGURE 1. FAMILY NEEDS ASSESSMENT AT ENTRY INTO THE CAREGIVER WELLNESS PROGRAM

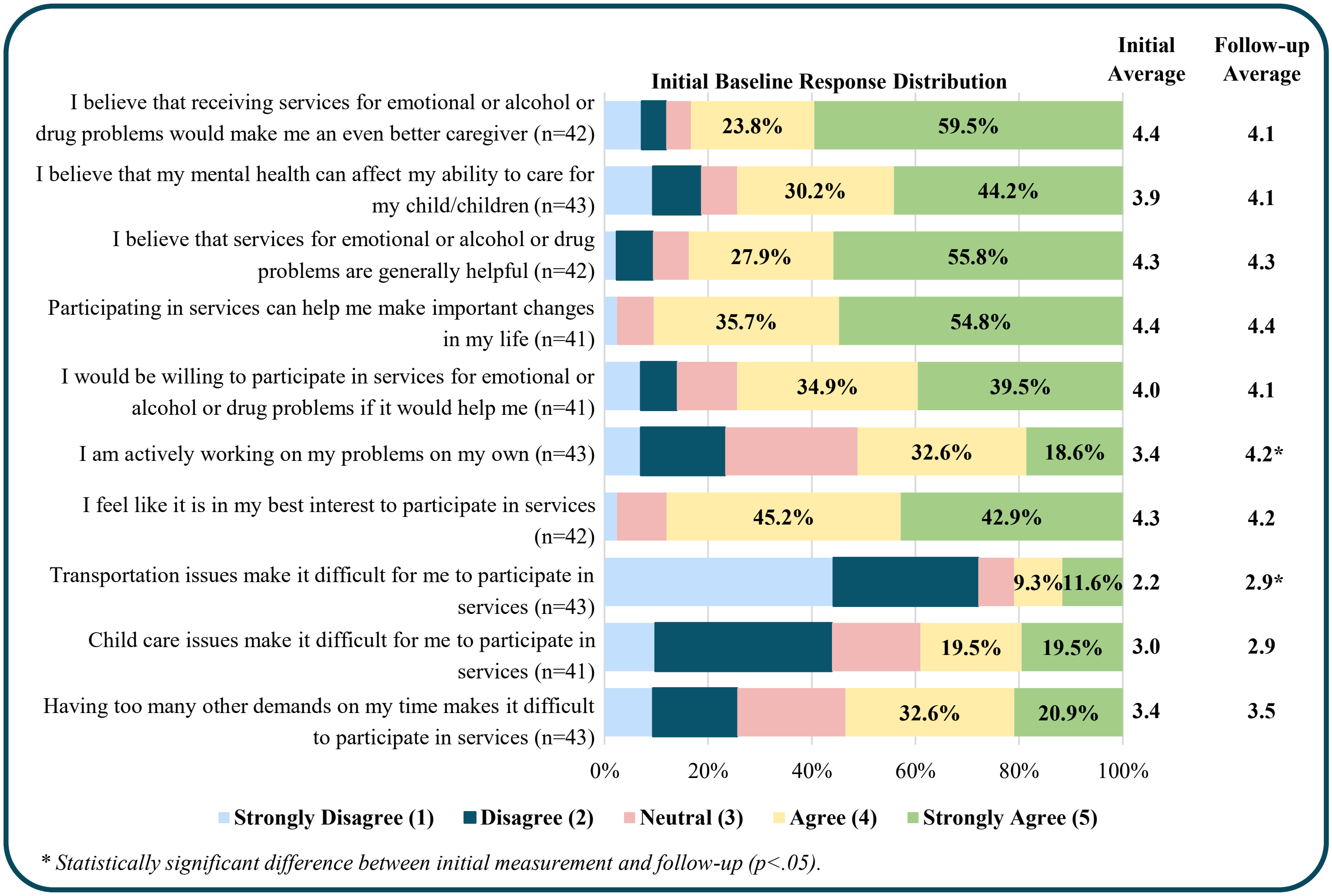


CAREGIVER ATTITUDES

Except where noted in Figure 2, average responses across CWP participants did not change much between initial assessment and follow-up measurements (every 90 days after entering CWP). Upon entering CWP, caregivers typically expressed favorable attitudes about the value of and need for receiving additional support services for emotional health and/or alcohol and drug problems. For example, at initial entry into CWP over 80% agreed or strongly agreed that "receiving services…would make [them] an even better caregiver" (83.3%), that such services were "generally helpful" (83.7%), that "participating in services can help [them] make important changes" (90.5%), and that it is in their "best interest to participate in services" (88.1%). Relatively few (20.9%) thought that transportation issues would make it difficult to participate in services, but concerns about childcare or other demands on their time were more prevalent (39.0% and 53.5%, respectively).

One area of significant change was the extent to which persons indicated they were "actively working on [their] problems." The average score across CWP participants increased from 3.4 to 4.2 on a 5-point scale ranging from Strongly Disagree (1) to Strongly Agree (5). This type of increase is consistent with a primary goal of CWP to get more persons engaged in efforts to address their own emotional health and/or alcohol and drug challenges. Another area of change related to whether transportation issues were expected to inhibit participation in services. Whereas relatively few thought transportation issues would be a problem initially (average score of 2.2), this was perceived to be more of a problem when measured at follow-up (average score of 2.9). One potential interpretation is that CWP participants increased their awareness of the various types of services that were available and/or were needed during their involvement with CWP staff and then indicated they had underlying transportation barriers that inhibited participation in those desired services.

FIGURE 2. INITIAL AND FOLLOW-UP CAREGIVER ATTITUDES



** Statistically significant difference between initial measurement and follow-up (p<.05).*

PARTICIPATION IN CWP CASE MANAGEMENT AND WELLNESS GROUP CLASSES

Through 6/30/2018, the CWP staff provided a total of 933 case management sessions to the 142 persons enrolled in the CWP program and these caregivers participated in a cumulative 562 psychoeducational support group sessions. As shown in Table 1, 73.2% (n=104) of all caregivers participating in the CWP had received at least one case management visit (average of 9.0 case management visits among those with any visits), and 38.7% (n=55) had participated in at least one psycho-educational support group session (average of 10.2 group sessions among those who attended any group sessions).

TABLE 1. CAREGIVER WELLNESS PROGRAM SERVICE UTILIZATION PATTERNS

	Received CWP Case Management Services		Attended Any CWP Group Sessions	
	%	n	%	n
Overall Total (n=142)	73.2	104	38.7	55
Gender				
Male (n=20)	75.0	15	50.0	10
Female (n=107)	72.9	78	40.2	43
Primary Language				
English (n=99)	68.7	68	36.4	36
Spanish (n=29)	86.2	25	55.2	16
Education				
HS or less (n=44)	81.8	36	52.3	23
Some College (n=51)	68.6	35	35.3	18
Bachelors Degree or above (n=31)	64.5	20	38.7	12
Work/Student Status				
Working or student (n=63)	65.1	41	34.9	22
Not working (n=63)	81.0	51	47.6	30
Receiving Behavioral Health Services at Start of CWP				
Yes (n=42)	83.3	35	40.5	17
No (n=89)	68.5	61	37.1	33
Elevated Need (PTSD/ Substance Abuse)				
Yes (n=35)	88.6	31	40.0	14
No (n=96)	67.7	65	37.5	36

Table 1 demonstrates that even though there were fewer male than female participants overall (n=20 vs. n=107), males participated in CWP services (i.e., case management and group psychoeducational support sessions) at similar to slightly higher rates than females.

Additionally, the participation rates of those who indicated Spanish as their primary language was substantially higher than primary English language speakers for both case management (86.2% vs. 68.7%) and group sessions (55.2% vs. 36.4%). Persons with lower levels of education and those not working were also more likely to participate in the case management and group sessions.

Persons receiving behavioral health treatment and/or medication at the time they enrolled in the program were more likely to engage in CWP case management sessions than those who were not receiving any behavioral health treatment (83.3% vs. 68.5%), but participation rates in group sessions were relatively similar (40.5% vs. 37.1%).

Overall, these findings suggest that CWP successfully connected with persons from population groups who might traditionally be less likely to engage in behavioral health related services (e.g., males, Spanish language speaking individuals, persons who have never received behavioral health related services). In particular, the high rates of engagement among persons whose primary language is Spanish highlights the importance of the Spanish language capabilities and cultural sensitivities of the CWP team members.

TYPES OF CAREGIVER WELLNESS GROUPS

CWP staff developed and provided structured, multi-week, group classes that covered a range of topics relevant to helping caregivers with their own well-being and/or that of their child. All of the classes integrated both educational and emotional support components. The types of classes included:

- Psychoeducation Group
- Therapeutic Play Group
- Empowerment: Therapeutic Group for Caregivers
- Success Group (e.g., education and support for foster and kinship/relative caregivers)
- Early School Readiness Group
- Executive Function Group
- Social Emotional Children's Group (provided to children while caregivers were in one of the adult wellness groups).

ASSESSMENT OF CHILD OUTCOMES AND CAREGIVER WELLNESS PROGRAM PARTICIPATION

To assess whether there were beneficial child-level outcomes associated with caregiver participation in CWP, three different data elements were examined: 1) KidSTART clinic discharge reasons, 2) Eyberg Child Behavior Inventory (ECBI) scores, and 3) Children's Functional Assessment Rating Scale (CFARS) scores. A total of 248 children with 257 treatment episodes were included after being enrolled and discharged from the KidSTART clinic within the INN-11 implementation timeframe (7/1/2015-6/30/2018).

REASON FOR DISCHARGE OF CHILD FROM KIDSTART CLINIC PROGRAM

Based on an analysis of children who were enrolled in KidSTART clinic for at least 60 days (i.e., a more conservative comparison of discharge reason with more equivalent groups; n = 113 in CWP and n = 118 not in CWP), the KidSTART clinic discharge reason was significantly associated with CWP participation. For instance, failure to return for treatment was more prevalent among children whose caregivers were not enrolled in CWP compared to children whose caregivers did participate (30.5% vs. 11.5%). Moreover, a greater proportion of children with caregivers in CWP attained a satisfactory status at discharge (71.7% vs. 52.5%). The proportion of cases discharged for other reasons, such as moving out of area, was similar in both groups of children.

CHANGE IN CHILD BEHAVIOR SYMPTOMS REPORTED BY CAREGIVERS

Disruptive behaviors in the children were assessed using the 36-item ECBI (Eyberg & Pincus, 1999), where parents/caregivers rated perceived behavioral issues (e.g., noncompliance and aggressiveness) on Intensity and Problem scales.

TABLE 2. ECBI ASSESSMENT OF CHILDREN IN KIDSTART CLINIC

	Caregiver not in CWP n = 59		Caregiver in CWP n = 82		
	Mean at intake	Mean at discharge	Mean at intake	Mean at discharge	Sig. diff.
ECBI Intensity Scale	134.3	118.3	143.9	112.9	*
ECBI Problem Scale	11.7	9.0	16.5	8.8	*

*$p < .05$

Mean score changes on the ECBI were investigated from intake to discharge using repeated measures analysis of variance (ANOVA). As shown in Table 2, all children on average demonstrated a significant decrease from intake to discharge on both the Intensity and Problem Scales. However, children with a caregiver enrolled in CWP experienced a greater reduction in the number of problematic behaviors and the frequency of behavioral issues compared to children without a caregiver in CWP.

CHANGE IN CHILD BEHAVIOR SYMPTOMS REPORTED BY CLINICIANS

Children were also assessed by clinicians using the CFARS tool (Ward, 1999). Sixteen domains, grouped into 4 index scores (relationships, safety, emotionality & disability), were rated on a scale of 1 to 9 ("no problem" to "extreme problem"). Changes on the CFARS were assessed using repeated measures ANOVA. The results were similar across all 4 index scores, with more detailed findings presented below from the relationships and emotionality domains. Children typically experienced improvements from intake to discharge, but children with a caregiver enrolled in CWP showed greater improvements.

TABLE 3. CFARS ASSESSMENT OF CHILDREN IN KIDSTART CLINIC

	Caregiver not in CWP n = 125		Caregiver in CWP n = 112		
	Mean at intake	Mean at discharge	Mean at intake	Mean at discharge	Sig. diff.
CFARS Domain - Relationships	3.0	2.4	3.2	2.3	*
Hyperactivity	3.9	3.1	3.9	3.1	
Work or School	2.1	1.9	2.4	1.8	
Interpersonal Relations	3.2	2.5	3.4	2.1	*
Cognitive Performance	2.3	2.0	2.7	2.2	
Behavior at Home	4.4	3.3	4.4	2.7	*
Danger to Others	2.0	1.7	2.6	1.7	*
CFARS Domain – Emotionality	3.1	2.3	3.2	2.2	*
Anxiety	3.2	2.3	3.5	2.5	
Traumatic Stress	3.5	2.6	3.7	2.4	*
Depression	2.5	2.0	2.4	1.7	

*$p < .05$; Note: CFARS values of 2 = "Less than Slight Problem", 3 = "Slight Problem", and 4 = "Slight to Moderate Problem"

Many individual domains also had significantly larger improvements in severity scores among children with caregivers in CWP. For example, children with enrolled caregivers saw a greater improvement in interpersonal relations than children without caregivers in CWP (mean improvement of 1.3 points vs. 0.7 points).

In summary, children whose caregivers participated in CWP were more likely to have a successful discharge and to experience greater behavioral improvements compared to children whose caregivers did not participate. This is consistent with initial CWP design expectations that the additional tools and resources provided to caregivers would lead to improved outcomes for their children.

These positive findings should be viewed with a note of caution. A "self-selection" bias may be influencing results in that caregivers open to and ultimately enrolled in CWP services may have already been more engaged and fluent in the treatment needs of their children, which potentially contributed to better treatment outcome independent of CWP participation.

ASSESSMENT OF CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION

UTILIZATION OF BEHAVIORAL HEALTH SERVICES PRIOR TO CWP

As shown in Table 4, at the time of enrollment into CWP, 14.5% of caregivers indicated that they had ever been hospitalized or in a residential treatment for mental health or substance abuse issues. Approximately half (52.3%) reported that they had ever participated in some form of therapy/counseling for emotional problems. At the time of enrollment into CWP, slightly less than one-quarter (22.3%), indicated that they were participating in therapy/counseling and 20% indicated they were taking some form of prescription medication for emotional health needs. Prior and current participation in treatment for alcohol or drug problems was much less common (5.3% and 2.3%, respectively).

TABLE 4. CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION PRIOR TO THE CAREGIVER WELLNESS PROGRAM

	% Yes	n
Ever admitted for an overnight stay in a hospital or other facility to receive help for problems with emotions, nerves, mental health, or use of alcohol or drugs. (n=131)	14.5	19
Ever had one or more sessions of psychological counseling or therapy for emotional problems with any type of professional. (n=130)	52.3	68
Currently receiving or on a waitlist for psychological counseling or therapy for emotional problems with any type of professional. (n=130)	22.3	29
Ever used a prescription medicine for emotions, nerves or mental health from any type of professional. (n=131)	35.1	46
Currently using a prescription medicine for emotions, nerves or mental health from any type of professional. (n=131)	19.8	26
Ever visited a clinic or doctor about an alcohol or drug problem. (n=131)	5.3	7
Currently going to or on a waitlist for a clinic or doctor for an alcohol or drug problem. (n=129)	2.3	3

Based on a review of available data, it was determined that very few CWP participants had any contact with the publicly funded County of San Diego BHS system. For example, only 5.6% of CWP participants had attended at least one BHS outpatient visit within the 90 days ***prior*** to starting CWP. Additionally, there were no identified interactions with the BHS acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) visits, crisis stabilization visits, or inpatient hospitalizations.

CAREGIVER BEHAVIORAL HEALTH AND OTHER SERVICE LINKAGES FACILITATED BY CWP

LINKAGES TO COMMUNITY BEHAVIORAL HEALTH RELATED SERVICES

A primary objective of the CWP program was to connect caregivers with appropriate behavioral health related services. While very few CWP participants were identified as having needs that would make them eligible for services within the formal BHS system (i.e., BHS primarily serves persons with serious mental illness who are on Medi-Cal/have no insurance), the majority of CWP participants, 71.1% (n=101), had at least one behavioral health linkage facilitated by the CWP team as of 6/30/2018. Types of behavioral health related linkages included:

- individual behavioral health therapy through community based agencies, health care agencies, and private providers
- family counseling services
- NAMI (National Alliance on Mental Illness) support groups
- services for co-occurring mental health and substance use concerns
- domestic violence support services

LINKAGES TO OTHER COMMUNITY SERVICES

Many CWP participants had other, non-behavioral health related needs identified through the comprehensive needs assessment and/or the ongoing care management interactions with the PCC. The PCCs worked to meet as many of these other needs as possible as a way of improving the overall well-being of the caregiver and family circumstances and building supportive relationships with the caregiver. The majority of CWP participants, 64.1% (n=91) had a least one form of non-behavioral health linkage completed by the CWP to address caregiver/household needs. Types of non-behavioral health related linkages included:

- food resources (such as food banks)
- clothing resources
- legal assistance
- financial aid/assistance
- educational resources (for caregiver)
- housing related services

ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

As shown in Figure 3, almost all caregivers who completed a satisfaction survey (n=57), indicated they were satisfied with the CWP services received (89.5% agreed or strongly agreed with this item). Most respondents indicated that as a result of their participation in CWP they "know where to get help" (89.5%), are "more comfortable seeking help" (84.2%), and are "better able to handle things" (91.2%).

FIGURE 3. CAREGIVER ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

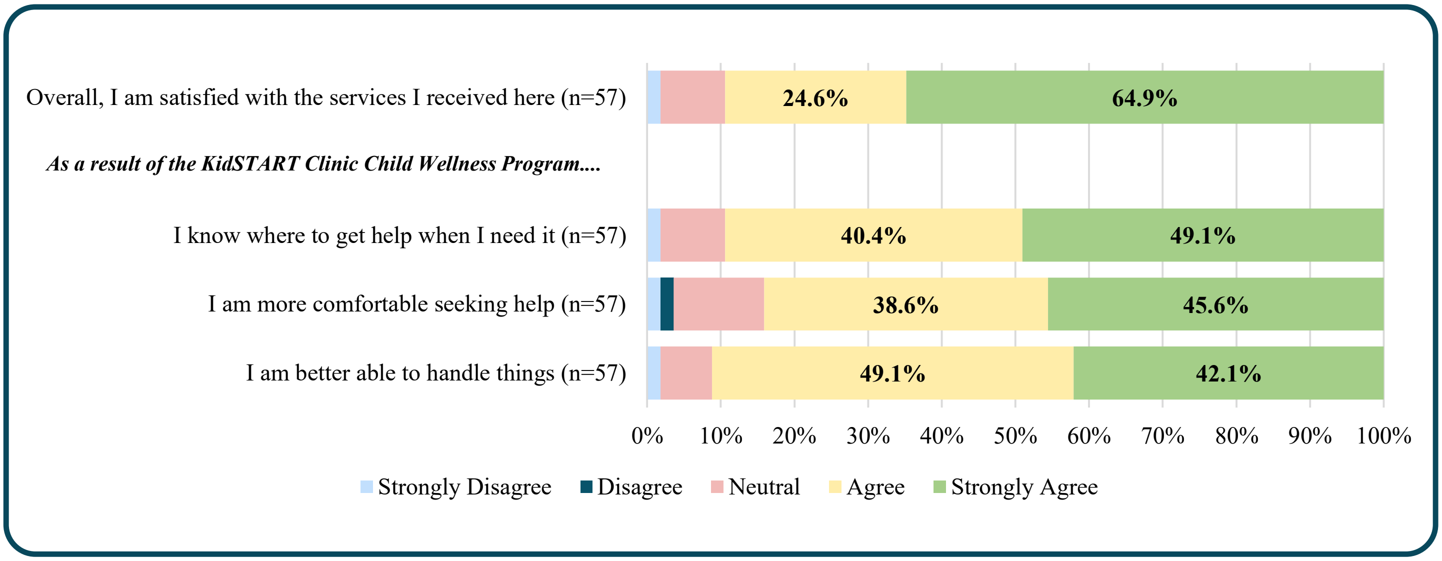
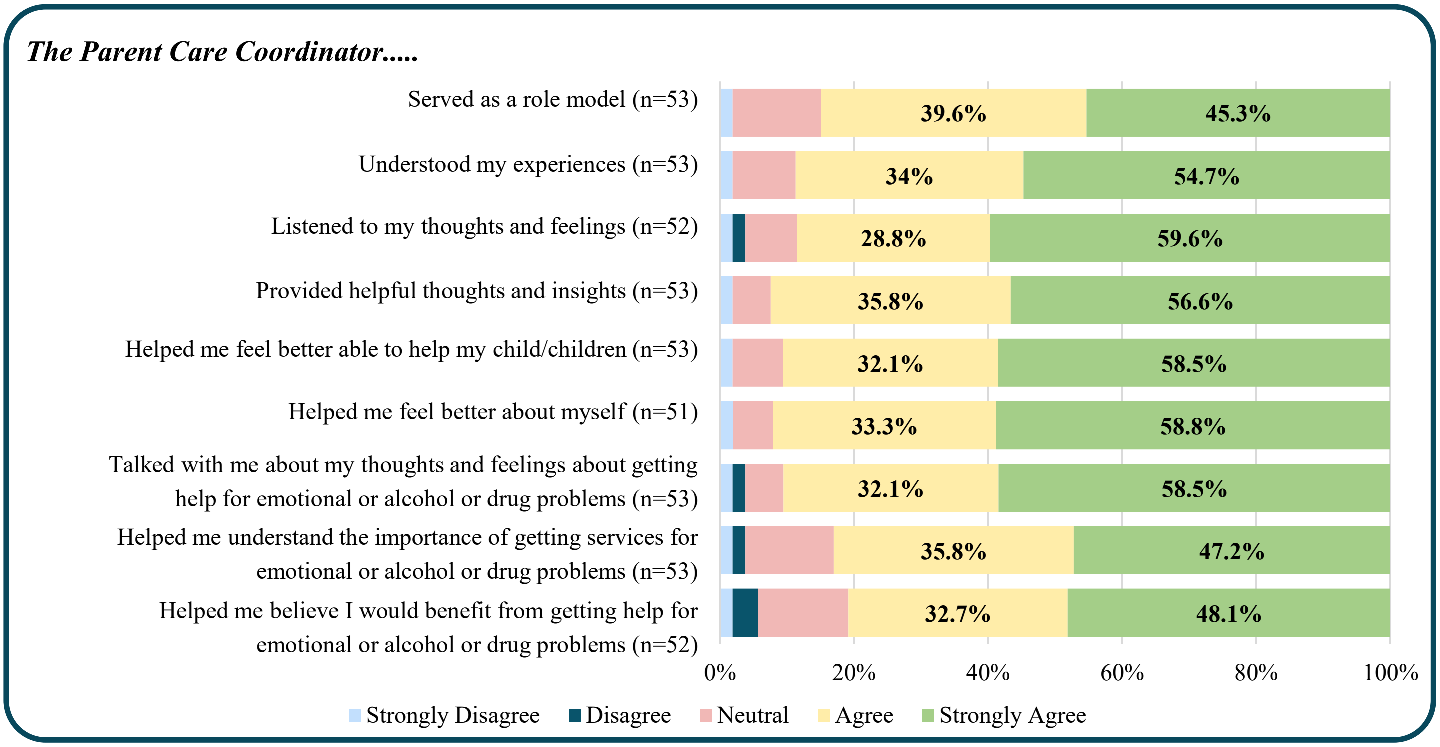


Figure 4 shows that at follow-up, caregivers nearly universally "agreed" or "strongly agreed" that their PCC provided a range of emotional and educational supports, including "listening to [their] thoughts and feelings," helping them "understand the importance of getting services for emotional or alcohol or drug problems," and helping them "feel better able to help [their] child/children."

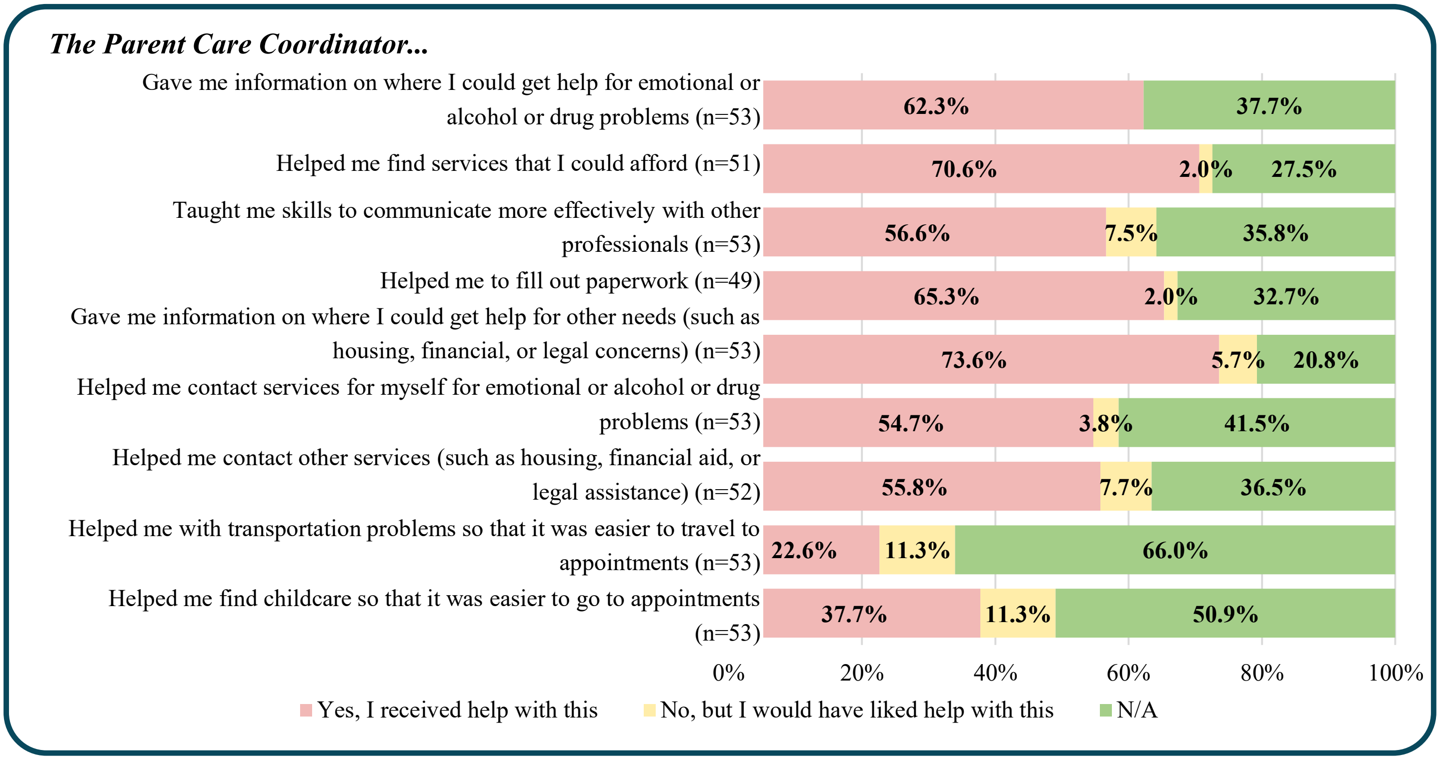
FIGURE 4. CAREGIVER PERCEPTIONS OF PARENT CARE COORDINATOR SUPPORTS



ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES (CONTINUED)

Additionally, as shown in Figure 5, PCCs provided a range of specific services to those who needed them, such as giving caregivers information about where to get help, teaching about effective communication, assisting with paperwork, and empowering caregivers to contact other needed support services. Few caregivers indicated having a specific need but not receiving help for that need from their Parent Care Coordinators. This indicates that the program is generally effective at identifying needs and providing relevant services to help address those needs.

FIGURE 5. TYPES OF SERVICES PROVIDED TO THE CAREGIVERS BY THE PARENT CARE COORDINATOR



CAREGIVER QUALITATIVE SURVEY RESPONSES REGARDING PERCEIVED IMPACT ON CHILD

Caregivers reported that the Caregiver Wellness Program helped develop their parenting skills and knowledge.

- "I have learned how to be a better parent and utilize the tools I have learned with my child."
- "…lots of coping skills in our tool box now and knowledge of conditions and diagnoses."
- "It's helped me develop my skills as a parent when it comes to communicating with my child and validating her feelings."
- "As a young mother that has no parenting skills it has been very helpful to have the therapists and Parent Care Coordinator hold my hand and guide me to be the mother my son needs."
- "The classes offered at KidSTART clinic help me realize how my child needs me to be present for him."

Caregivers reported that participation also encouraged them to improve their own mental health to better help their child.

- "Having attended the groups has taught me first that I have to be well in order to help my child. I realized that I needed professional help for my mental health in order to process my own trauma and help my child with his own."
- "The parent coordinator was very helpful and she encouraged me to sign up for school, and encouraged me to get help with my anxiety."

The Caregiver Wellness program helped caregivers to be better emotionally resilient and confident parents.

- "I never felt judged nor received negative feedback from the Therapist or Parent Care Coordinators that I was a bad parent due to my child's mental and emotional needs. On the contrary, I was embraced, empowered and educated on how to be emotionally present as parent for my child."
- "They emotionally were able to help me as a mother and my child. I was ready to give up and consider myself a horrible parent and now I feel confident."
- "I felt validated and understood by the KidStart Parent Care Coordinator. Knowing that there was someone else that had struggled with their own child and overcame their child's challenging and defiant behavior made me feel that I can do it too."

Participants in CWP come from a variety of backgrounds and family situations. Through CWP, caregivers receive support in understanding and meeting the needs of both their children and themselves. Caregivers have received assistance in pursuing and maintaining services for their own needs, have gained the knowledge and skills to advocate for their children, and have found meaningful social support through psycho-educational support groups and visits with their PCCs. The following brief case reports present examples of the types of situations and outcomes commonly experienced by CWP participants.

Case Report 1—Improved Caregiver Mental Health

A PCC assisted a caregiver with bipolar disorder by assessing needs and supporting goal achievement. These included changing mental health providers and improving interactions with their family. The PCC accompanied the caregiver to an appointment and witnessed the disrespect by the caregiver's psychiatrist. Together they found a different doctor and the PCC attended the first session with the nervous caregiver. The PCC encouraged the caregiver to try this provider for at least five sessions. After five sessions, the caregiver told the PCC that they felt better and were confident in the doctor's understanding of their disorder. The caregiver learned about triggers and warning signs and learned to trust others. The caregiver's symptoms are more manageable now and they now see asking for help when needed as the right thing to do. The caregiver continued to have sessions with the new doctor and attended support groups to interact with others. The caregiver appeared much better emotionally and physically and indicated that the "journey" is easier with the new support system.

Case Report 2—Improved Child Outcomes

A family approached KidSTART clinic regarding their child who engaged in destructive and impulsive behaviors. The parents learned about triggers and ways to help their child communicate. Their child began to verbalize feelings, but reports of harmful behaviors for unidentifiable reasons continued. During this time, parents had a greater understanding of the importance of their own mental health for their child's well-being. They joined CWP, which helped to improve their outlook on their situation and their understanding of themselves. They were able to understand their child's need for certain types of activities and supports (e.g., therapy and medication) to reduce impulsivity and angry responses. The parents were able to see their child's empathy, kindness and helpfulness and used these strengths to build the child's self-esteem and reduce the effect of triggers. The parents began advocating at school and among family members and their child is now known as a happy, empathic, energetic, and charismatic child. The parents feel empowered and proud of the changes they have seen in their child.

Case Report 3—Family Reunification

One caregiver was a single parent who was previously incarcerated and whose children were in foster care. The PCC worked to help the parent understand their emotional needs and hopes for the future. The parent expressed feeling no hope of making the positive life changes that would allow for reuniting with the children, particularly the difficulty in finding employment. The PCC suggested career training to network and obtain a license in the desired field as well as mentoring others in similar situations. The parent became emotional and stated that they had never thought about how their experiences could actually be used to help themselves and others. The parent was encouraged to seek individual therapy to help deal with personal traumas and fortunately, they completed all therapy sessions, gained career skills, and demonstrated the desire to be a good parent. Because of this, the courts looked favorably on the situation and reunited the family. The parent was very happy and expressed heartfelt gratitude for all the support and caring received from the PCC and the entire CWP team.

Case Report 4—Service Linkage Challenges

One caregiver in CWP had experienced domestic violence. During CWP services, the PCC discussed the benefits of self-care and how meeting one's own needs can benefit their children. The caregiver expressed the desire to pursue behavioral health services at a specific agency; however, they had not returned the caregiver's phone calls. The caregiver and PCC then left multiple voicemails. The PCC was contacted by someone at the agency and informed that the caregiver could be assessed that week. Unfortunately, when the caregiver attempted to schedule an assessment, they were told that there was no availability and no new clients would be accepted for months. The caregiver and PCC had spent much time trying to link to a needed service at a time when the caregiver was ready and motivated for services. This is an example of how waitlists and miscommunication across systems pose significant barriers to accessing needed services and can result in failed connections to treatment.

SUMMARY OF STAFF PERSPECTIVES – FOCUS GROUP THEMES

At the end of the second year of providing Caregiver Wellness Program (CWP) services, therapists, PCCs, and supervisors (n=8), participated in a focus group to discuss their experiences with, perceptions about, and recommendations for CWP.

1. *Caregivers in CWP have varying levels of mental health needs:*
   - Some caregivers may express that they experience symptoms related to mental health, but their current priority is the child (e.g., caregivers reported or exhibited PTSD, schizophrenia, bipolar disorder, depression, anxiety).
   - Caregivers who do not have a mental health diagnosis are still often in stressful situations and can benefit from stress reduction through self-care strategies and support groups.
2. *Different types of services and assistance provided to caregivers:*
   - Help with pursuit of education or career training, such as locating financial assistance or completing applications.
   - Childcare has been identified as a barrier to caregivers receiving treatment themselves. PCCs assist with locating childcare and preschool options.
   - Staff assist with distributing donations of food, clothing, and toys.
   - Legal and financial assistance: government documentation such as social security and taxes.
3. *Staff utilize a variety of strategies in enabling caregivers to seek and receive mental health services:*
   - "Mental health" as a phrase might not be received well. Instead, staff may tailor their discussions with caregivers to focus on symptoms (e.g., anxiety, troubled sleep, stress) and self-care techniques.
   - Normalize receiving behavioral health services by discussing with caregivers that people take care of their physical health by seeing a doctor or their appearance by getting a haircut. Therefore, seeking support for behavioral health is one way to take care of the mind.
   - Providers emphasize that the child is more likely to improve if the caregiver's well-being is also addressed. **"We value you as much as the child."**
   - Some caregivers had previously been encouraged to obtain services, but did not. Providers speculate that maybe the "warm handoff" was missing. In other words, the caregivers were told to go, or were informed of various resource, but did not get support, or have the motivation to go. Providers state importance of following-up with caregivers.
   - One provider noted that the first visit is the hardest and often needs support. **"Instead of saying 'you need to go,' I say, 'We will go together and I will help you.'"**
   - Prior negative experiences may need to be addressed since some caregivers have already been in treatment, and it was either not successful or they did not like it.
4. *Caregivers may want to continue with the program even if their children have improved and/or completed the program:*
   - There are situations where the child completes treatment, but the parent is not ready to let go. They have had access to a team that listens and understands them. After establishing a relationship with the team, and experiencing positive outcomes in CWP, it can feel like a difficult loss for the caregiver.
   - PCCs are informed that a child's treatment will be ending and to try and address any remaining needs of the caregiver and family before then.
   - PCCs try to assist families with contacting or transitioning to external services so that when the PCC is no longer available to the family, they already have some relationship with another service provider or organization.
   - Another strategy used by therapists and PCCs to ease the transition towards caregiver program completion is by spacing remaining visits further apart.
   - Providers have expressed concerns about how the adult mental health system will differ from the caregiver's experiences with the children's system.
   - One provider expressed concern about the time gap until an appointment is available: **"They get the initial linkage, but I'm worried about them not getting continued care."**
5. *The caregiver program has led to positive experiences among providers, caregivers and children:*
   - Improved demeanor and communication between caregiver and child. **"The mother talks differently with the child because her outlook on life has improved."**
   - Providers agreed that if parents are struggling with their mental health, the child will not do well in their treatment and daily life. One PCC shared this sentiment from a caregiver: **"Without the wellness program, she said she would not have been able to provide a stable home for her child."**
   - Increased interactions between providers (therapists and PCCs) and families (caregivers and children) builds rapport and encourages engagement in the treatment process.
   - Support groups lead to social relationships that provide informal support that may extend beyond time in CWP.
   - Support groups can help normalize and contextualize some childhood behaviors as well as demonstrate that other caregivers may have similar feelings and experiences.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for CWP. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the three annual surveys.

1. *Primary factors that helped achieve CWP goals:*

    - Good collaboration and communication between program leadership, Parent Care Coordinators (PCCs) and therapists
    - Ability to provide comprehensive in-home assessments
    - PCCs' ability to form supportive and trusting relationships with caregivers
    - Region specific PCCs with detailed expertise in locally available resources
    - Structured curricula for psycho-education support groups designed to improve caregiver functioning and well-being
    - Overall staff "buy-in" to importance of caregiver well-being for improving child behaviors
    - Efficient and effective program operations (e.g., offer services to all caregivers, streamlined assessments, familiarity with community resources)
    - Provision of childcare while caregivers participate in CWP services
    - Having Spanish language staff available to provide CWP services

2. *Primary factors that inhibited achieving CWP goals:*

    - Not being able to provide individual psychotherapy directly through CWP to caregivers
    - Caregivers who are not ready to work on their own needs (e.g., low interest/motivation and/or low insight due to SMI/active substance abuse)
    - Caregivers who may be interested, but have many other competing demands or other tangible CWP participation barriers (e.g., transportation and timing)
    - Ongoing challenges linking caregivers to appropriate community resources and treatment services
    - Ineligibility for public mental health services and lack of insurance or financial means to pay for care

3. *Primary factors needed to engage and maintain caregiver participation in CWP:*

    - Providing caregivers with individualized and beneficial resources, linkages, and information
    - Offering psycho-education support groups that are of interest to caregivers
    - Frequent, positive interactions with PCCs and the rest of the team
    - Prompt engagement with PCCs and delivery of services after initial enrollment
    - Educating caregivers about connections between their own behavioral health and their child's well-being
    - Coordinating communication between caregiver, child's therapist, and PCC
    - Providing CWP services at times and locations that are convenient for caregiver participation

4. *Primary perceived caregiver benefits of psycho-education support group participation:*

    - Increased understanding of the importance of caregivers' wellness to their child
    - Empowered caregivers with additional knowledge through psycho-education
    - Provided emotional support and comfort in a "safe space"
    - Created opportunities for "light bulb" moments/important realizations about caring for themselves and/or their child
    - Facilitated the development of peer-support social relationships with others in similar situations
    - Helped to normalize situation and reduce anxiety by seeing other caregivers with similar challenges

5. *Primary strategies used to link caregivers with recommended behavioral health services:*

    - PCCs collaborative approach to service linkages (e.g., calling places together, attending initial appointments)
    - PCCs offering support and encouragement from their "lived experience"
    - Educating caregivers about how their behavioral health affects their child
    - Having PCCs with knowledge of available programs (e.g., locations, service types, eligibility and cost requirements)
    - Providing ongoing support and education until caregiver is ready to change

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to CWP outcomes and operations throughout the three year CWP MHSA Innovations-funded study. These findings can help inform any potential future initiatives to implement a CWP program in other communities.

1. *CWP participant recruitment and engagement:*

   - Need to ensure identification of all caregivers who may benefit from CWP services without creating too lengthy or cumbersome screening and assessment processes.
   - Prompt development of the caregiver wellness plan and provision of PCC coordination and support services after completing the needs assessment was important for retaining and promoting caregiver CWP participation.
   - The many other child-related meetings and treatment sessions caregivers had to attend as well as other commitments of daily life substantially limited the time that caregivers were available to participant in services directed toward their own well-being.
   - Once caregivers decided they were interested in receiving CWP services, retention was typically high, with many not wanting to discontinue CWP services following the discharge of their child from KidSTART clinic.

2. *Role of the comprehensive needs assessment and the Parent Care Coordinator (PCC):*

   - Providing a comprehensive in-home needs assessment was crucial for obtaining a thorough understanding of the range of potential caregiver needs and often facilitated rapport building and caregiver "buy-in" to the CWP.
   - It was useful to start behavioral health related conversations early in relationship building process (e.g., while addressing non-behavioral health needs), to help normalize those discussions and facilitate participation in CWP services and external linkages.
   - The PCC role facilitated both emotional support and education of caregivers, as well as identifying and connecting with needed external resources and services.
   - The life situations for biological, adoptive, kin-based foster, and non-kin-based foster parents may differ significantly, which requires a detailed and individualized understanding of the family unit needs and resources in order to tailor CWP services appropriately.
   - Need for specialized care supports, preferably within the CWP team, to focus on unique and complex challenges such as substance abuse and domestic violence (e.g., someone with knowledge of legal system/relevant laws).

3. *Benefits of offering therapeutic, educational and support groups:*

   - Offering therapeutic, educational and support groups directly within the CWP was an effective strategy for providing needed and desired caregiver-focused behavioral health services.
   - Group sessions and PCC support increased caregiver awareness of the importance of receiving their own services to promote their wellness and the well-being of their children.
   - Caregiver participation rates in the groups provided within CWP were similar (about 50%) regardless of whether caregivers were also receiving other behavioral health services. This indicated that the groups were capable of both expanding access to needed information for those without any other behavioral health supports as well as supplementing any existing behavioral health care.
   - Caregivers form social connections with other caregivers in similar circumstances during the CWP group sessions that can provide social supports that last beyond their participation in CWP.

4. *Challenges linking to external behavioral health services:*

   - Prior negative experiences with mental health treatment are common and need to be discussed prior to new linkages.
   - The first visit to a behavioral health related service can be hardest for a caregiver. Important to match caregiver needs with appropriate level of PCC supports (e.g., from providing a phone number to attending the visit with caregiver).
   - Challenging to find behavior health related services that are 1) substantively appropriate, 2) feasible to participate in, and 3) of interest to the caregivers. All three conditions must be met for successful external linkages to occur.
   - CWP behavioral health related linkages were typically not to BHS outpatient treatment services, but to other community programs, private counselors, or other resources.
   - Need additional Spanish-speaking therapists in the community for behavioral health treatment referrals from the CWP.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS" (CONTINUED)

5. *Caregiver experiences within CWP:*
    - Spanish-speaking PCCs and therapists were vital to delivering CWP services.
    - CWP was successful at getting persons from commonly underserved populations (e.g., males, Spanish-language speakers) to participate in the CWP case management and psycho-education support group sessions.
    - Caregivers often want to continue receiving CWP services even after child is no longer in KidSTART clinic program. Need to plan for transition with caregiver to help promote ongoing and relevant linkages for caregiver.
6. *Impact on KidSTART clinic culture/treatment approaches:*
    - Offering CWP services to all caregivers with children in KidSTART clinic improved CWP operations (e.g., staff buy-in, consistency/coordination, recruitment), as a fully integrated program rather than a separate sub-program only for some caregivers.
    - CWP program has allowed for a "culture shift" within KidSTART clinic program by providing resources (e.g., PCC services, group sessions), that allow therapists to work much more effectively at the "family level" to promote long-term child well-being.
    - CWP participation enhanced KidSTART clinic therapists' knowledge of caregiver strengths and needs, which facilitated caregiver engagement in child-caregiver dyadic treatment services and informed child treatment strategies.

PROGRAM CHANGES FROM INITIAL DESIGN

The overall design of CWP did not fundamentally change over the course of the MHSA Innovations funding period (7/1/2015-6/30/2018). Throughout the duration of CWP, primary services included: 1) a comprehensive needs assessment (often conducted "in-home"), 2) provision of emotional support and individualized linkages to external resources by a Parent Care Coordinator (PCC), and 3) a range of therapeutic, educational, and support groups developed specifically for CWP caregivers.

However, there were some strategic adaptations in response to initial and ongoing program operations. CWP was originally intended to serve the subset of KidSTART clinic program caregivers who were identified via clinical assessments to have elevated psychiatric distress/needs. This initial round of screening and assessment was found to add substantial time to the intake process and delayed efforts to engage with caregivers. It was also found that while stress, anxiety, and depression were evident within the KidSTART clinic caregiver population, clinically identified psychiatric needs related to serious mental illness were not common.

Based on these findings, it was determined that instead of focusing only on a subset of caregivers who met select clinical threshold criteria, CWP services would be offered to all KidSTART clinic caregivers. This decision had two positive effects, 1) it lessened time between enrollment in KidSTART clinic and engagement with CWP services, and 2) it changed the culture throughout the KidSTART clinic program such that CWP services, and caregiver wellness concerns more generally, were more explicitly incorporated into the treatment approach of KidSTART clinic therapists. This encouraged greater coordination and communication between the CWP staff and KidSTART clinic treatment teams.

One change that was considered, but not implemented during the CWP program was the provision of individual therapy to caregivers enrolled in CWP. Given the many logistical and stigma-related challenges of linking caregivers to external behavioral health services, it was recommended that individual therapy be provided within the CWP program. This was expected to further improve access to behavioral health care given that the program could build upon the trusting relationships that had been developed and the fact that caregivers were often already "on-site" while their children were participating in treatment. This design change was implemented into the version of CWP that continued on after the MHSA Innovations funded project ended.

FUTURE DIRECTIONS

Based on the positive findings from the INN-11 Caregiver Wellness Program pilot study, BHS dedicated ongoing Substance Abuse and Mental Health Service Administration (SAMHSA) funding to sustain the CWP programming. This funding allowed the structure and operations of the CWP program to continue uninterrupted. In addition, the program was able to allocate some of the funds to begin supporting the provision of a limited amount of individual therapy within the program (as opposed to always needing to make a linkage to an external agency). This adaptation was based on a recommendation that emerged during the INN-11 CWP Innovations pilot project.

For additional information about the INN–11 Caregiver Wellness Program and/or this report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAMILY THERAPY PARTICIPATION ENGAGEMENT (INNOVATIONS-12)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT (7/1/15 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Family Therapy Participation Engagement (FTPE) programs were funded through the Innovations (INN) component of the Mental Health Services Act. FTPE was designed to increase parent and caregiver engagement in the treatment of their child through the innovative use of Parent Partners to encourage participation in family therapy. Note, we use the term "caregiver" in the remainder of this report to signify either the parent or other caregivers of the child receiving treatment.

Parent Partners were required to have prior lived experience caring for children receiving behavioral health services to facilitate their role as peer supports for caregivers in similar situations. Parent Partners were expected to enhance caregivers' understanding of the importance of active involvement in their child's treatment and to encourage caregiver participation in family therapy sessions. Parent Partners were expected to offer short-term supports (i.e., typically 2-4 visits, but more if needed), with Motivational Interviewing (MI) techniques providing the guiding framework for how Parent Partners engage with caregivers. Parent Partner staff were integrated into six existing Child, Youth, and Family (CYF) programs operating throughout the County of San Diego.

EXECUTIVE SUMMARY

The Family Therapy Participation Engagement (FTPE; INN-12) program was designed to increase caregiver participation in Family Therapy visits. This was accomplished by using peer-support Parent Partners who were trained in MI techniques to enhance caregivers' understanding of the importance of active participation in their child's treatment and to encourage participation in Family Therapy sessions. These Parent Partner services were provided at six behavioral health treatment programs throughout San Diego County.

- Overall, the utilization of family therapy increased and individual therapy decreased following implementation of the six FTPE programs.
- During "peak" FTPE implementation (FY 2016-17), the average number of family therapy sessions per child receiving treatment increased to 4.3 as compared to 3.6 pre-FTPE (a 19.4% increase). During this same time period the ratio between the number of family therapy sessions provided for each individual therapy session provided increased from 0.36 to 0.53 (a 47% increase).
- During "peak" FTPE implementation (FY 2016-17), at least 1 family therapy session occurred in half (51.1%) of all months that a child received any form of therapy and at least 2 family therapy sessions occurred in 17.3% of the months. Both of these indicators reflected substantial increases compared to pre-FTPE (a relative increase of 27.1% and 43.0%, respectively).
- Based on available caregiver demographics (n=1,081), most FTPE caregivers were female (81.2%), the majority spoke Spanish as their primary language (51.0%), and 71.0% identified as Hispanic. Over half of caregivers had a high school education or less and 12.1% were unemployed but seeking work.
- Caregivers reported very high overall levels of satisfaction with the Parent Partner services (96.5%). Over 90% agreed or strongly agreed that Parent Partners "understood [their] experiences," "helped [them] understand the importance of Family Therapy," and made them "feel [they] could help [their] child," in addition to providing other forms of support.
- Specific challenges to further increasing family therapy participation identified by FTPE staff included: 1) low caregiver motivation/ambivalence regarding importance of participation in therapy, 2) lack of caregiver resources (e.g., time, transportation, etc.), 3) caregiver personal challenges (e.g., substance abuse), 4) FTPE program limitations (e.g., not enough Parent Partner hours, staff turnover, etc.), and 5) general stigma associated with mental illness and participating in therapy.

FUTURE DIRECTIONS

Based on the promising outcomes from the MHSA funded INN-12 FTPE program, BHS has continued to support the structure and operations of FTPE (i.e., the Parent Partner model) at the initial six agencies by using MHSA Community Services and Support (CSS)/Full-Service Partnerships (FSP) funding.

V2019-06-21

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish and implement a novel approach that utilized Parent Partners (i.e., persons with direct "lived-experience" of being the caregiver of a child who received public sector emotional, behavioral health, or developmental services) to increase caregiver participation in family therapy.

Using MHSA Innovations funding, the Family Therapy Participation Engagement (FTPE) program was successfully implemented to provide Parent Partner services to caregivers of children receiving services at six existing Child, Youth, and Family (CYF) programs operating throughout the County of San Diego. The primary component of this program included the use of Parent Partners who provided education, encouragement, and other tangible supports where possible to promote caregiver participation in family therapy. While there were no substantial changes in program design over the three year project, program staff indicated there were some challenges defining the specific roles of the Parent Partner and keeping them distinct from those of a traditional case manager. However, FTPE program administrators indicated that the Parent Partners became integral parts of the overall treatment team and often coordinated their efforts to engage caregivers in family therapy with the therapists.

During the "peak" FTPE implementation year (FY 2016-17), approximately 50% (46.5%) of all children receiving any therapy (i.e., 1,015 out of 2,183 unduplicated children) had a caregiver who received at least one Parent Partner visit. Of those with any Parent Partner visits during FY 2016-17, the average number of visits was 4.6. Program staff indicated that they needed to "ration" the Parent Partners since there were not enough Parent Partner FTE's to see all caregivers who might have benefited from their services.

Caregivers reported being very pleased with the Parent Partner services (96.5% satisfied) and over 90% indicated receiving a range of positive benefits from their Parent Partner including emotional support, education about benefits of family therapy, and connection to other resources that facilitated participation in family therapy.

One aspect of the FTPE program that was a challenge to consistently implement across the six agencies and throughout the three-year project was the utilization of MI techniques by the Parent Partners. While assessment of MI fidelity was beyond the scope of this evaluation, program staff acknowledged difficulty providing Motivational Interviewing training and supervision, especially as new Parent Partners were hired over the three year project. Additional attention to and support of MI training, ongoing supervision, and MI fidelity assessment might contribute to further achievement of program objectives.

2. To increase overall participation in family therapy.

Based on a multi-year assessment of the provision of therapy services at the six programs with FTPE Parent Partner services, it appears that FTPE substantially increased overall family therapy participation. The total number of family therapy sessions increased from 5,294 pre-FTPE (FY 2014-15) to 7,159 at peak FTPE implementation (FY 2016-17), an increase of 35.2%. The average number of family therapy sessions per child in treatment also rose from 3.6 to 4.3 (a 19.4% increase). In contrast, while still the primary treatment modality during the same time period, individual therapy sessions dropped from 14,792 to 13,552 (a decrease of 8.4%). The reversal of the trend in FY 2017-18 toward greater family therapy and less individual therapy coincided with a reduction in Parent Partner FTE and service hours. This pattern actually provides additional evidence to the likely efficacy of the Parent Partner model in that some of the gains toward greater family therapy participation were diminished when the Parent Partner support was not as prevalent during the end of the FY 2017-18 period.

3. To increase the extent to which caregivers participate in family therapy at least twice per month.

To assess whether caregivers participated in at least two family therapy sessions per month, the overall number of treatment months for each fiscal year was calculated (i.e., the sum of the calendar months, per child, during which any individual or family therapy was received), and then the number of months that included at least two family therapy sessions was identified. The results of these analyses indicated that the percentage of treatment months with at least two family therapy sessions increased from 12.1% pre-FTPE in FY 2014-15 to 17.3% during peak FTPE implementation (FY 2016-17; a relative increase of 43.0%). For the four years included in the analyses, it appears that at least two therapy sessions of any type were received in approximately two-thirds (i.e., 66.6%) of all treatment months. These findings indicate that there were opportunities to increase the extent to which caregivers participated in family therapy at least twice per month, but that the FTPE program substantially increased the achievement of this treatment goal.

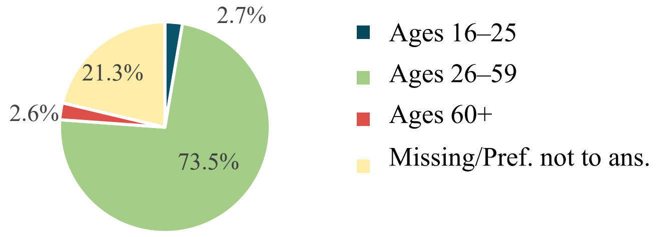
4. To engage underserved populations such as Latinos and African Americans.

The program successfully engaged the traditionally underserved Latino population by utilizing Spanish speaking Parent Partners. Based on the available demographic information, over half (51.0%) of the persons who received any Parent Partner services indicated that Spanish was their primary language and 71.0% indicated they were Hispanic. The success of engaging African American caregivers using the Parent Partner model was less clear, with about 4% of the persons who received any Parent Partner services indicating they were African American.

FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS

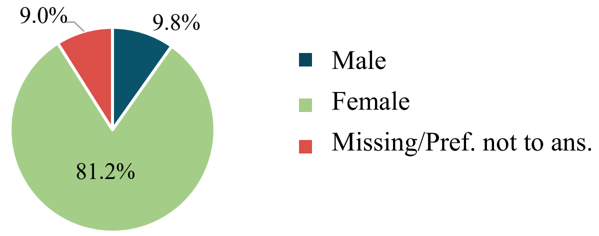
The following demographic data were collected from a caregiver self-report survey administered at the start of the FTPE program.[1]

AGE (N=1,081)



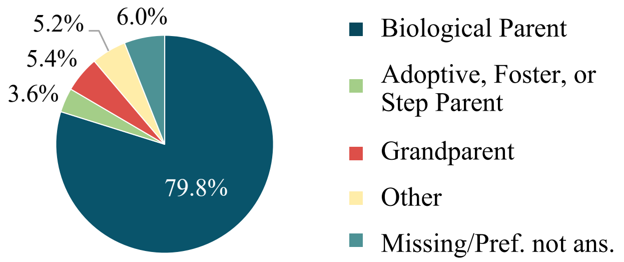
The majority of caregivers (73.5%) were between the ages of 26 and 59.

GENDER IDENTITY (N=1,081)



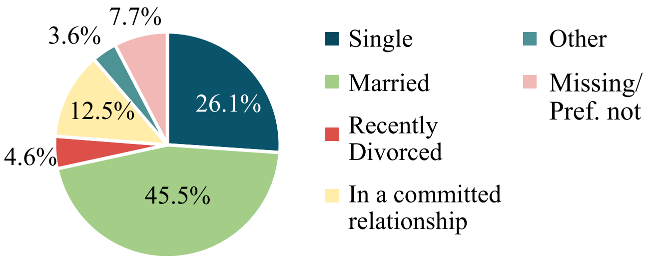
Most caregivers were female (81.2%).

RELATIONSHIP TO CHILD (N=1,081)



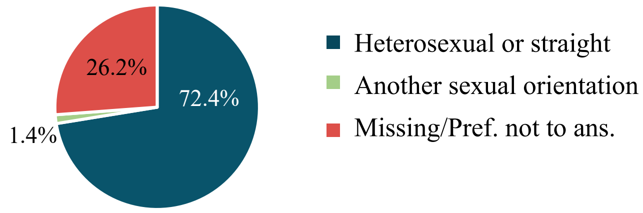
Most caregivers were a biological parent of the child receiving services (79.8%).

RELATIONSHIP STATUS (N=1,081)



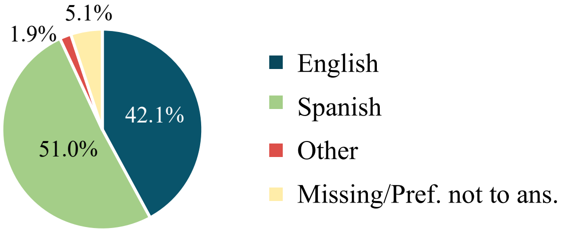
Almost half of the caregivers were married (45.5%), and about one-quarter (26.1%) were single.

SEXUAL ORIENTATION (N=1,081)



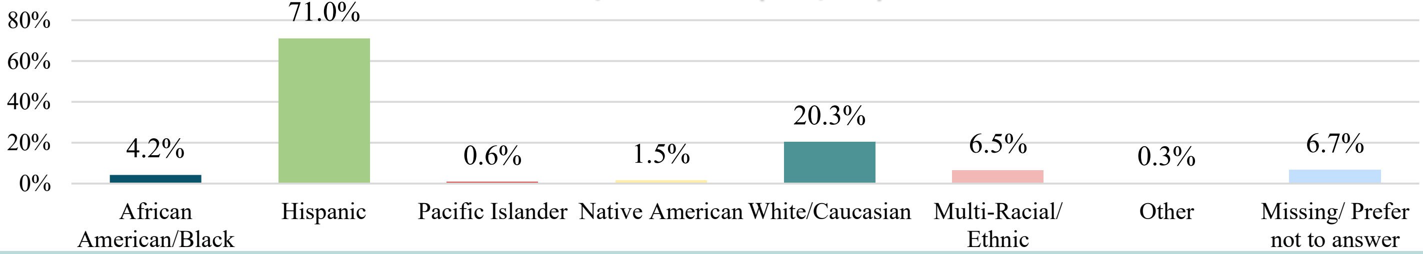
Most caregivers (72.4%) indicated they were heterosexual or straight.

PRIMARY LANGUAGE (N=1,081)



Spanish was the primary language for about half of the caregivers (51.0%).

RACE/ETHNICITY (N=1,081)



The majority of caregivers identified themselves as Hispanic (71.0%), and 20.3% identified as White. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

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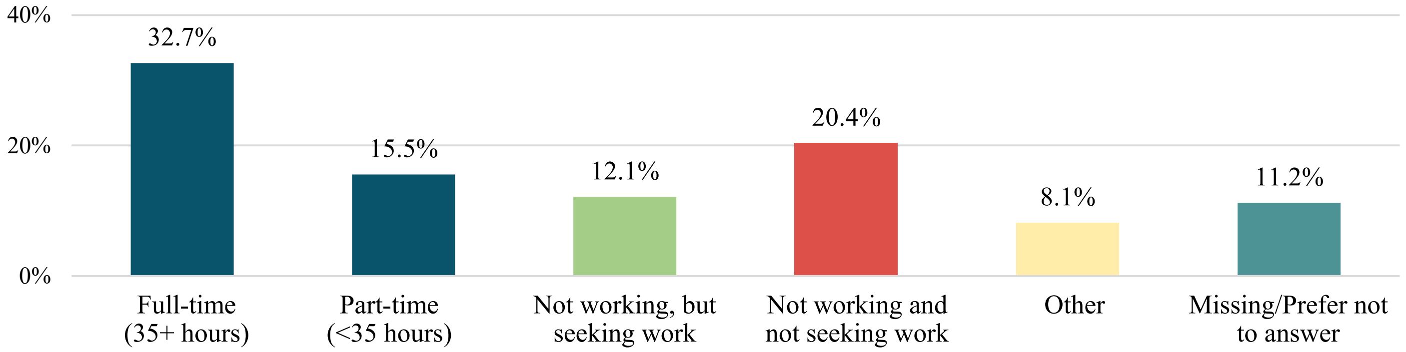
[1] *Percentages may not total to 100% due to rounding.*

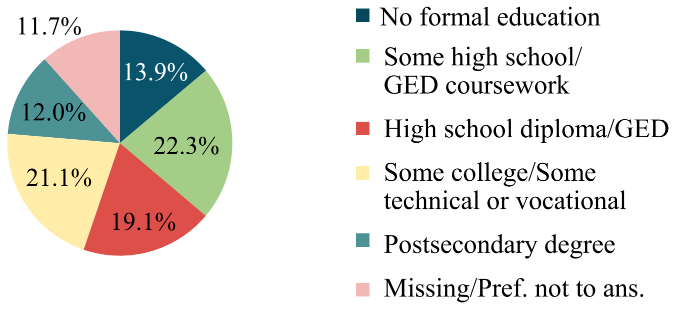
FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS (CONTINUED)

EMPLOYMENT STATUS (N=1,081)



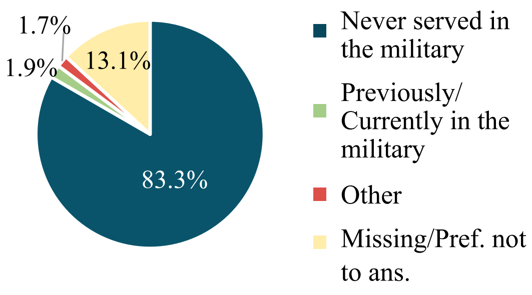
Approximately one-half of the caregivers indicated that they were employed (32.7% full-time and 15.5% part-time), and another 12.1% were not working, but seeking work (a higher unemployment rate than the 4-5% for San Diego County).

EDUCATION LEVEL (N=1,081)



Over half (55.3%), of the caregivers had a high school diploma/GED or a lower level of education.

MILITARY STATUS (N=1,081)



Very few caregivers (1.9%), indicated they had served in the military.

DISABILITY[2] STATUS (N=1,081)

Nearly 14% of caregivers had some type of non-SMI related disability.

TYPE OF DISABILITY (N=147)

Type	n	%
Communication	25	17.0
Mental (e.g., learning)	43	29.2
Physical	69	46.9
Chronic Health	51	34.7
Other	24	16.3

This table lists the type of disability indicated by caregivers. Totals may exceed 100% as caregivers could indicate more than one type of disability.

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[2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

OVERALL SERVICE UTILIZATION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

Table 1 presents aggregated service utilization data from the six INN-12 FTPE programs during the four years that highlight service provision before FTPE implementation, during initial FTPE implementation, and after full FTPE implementation. The three types of services included in Table 1, individual therapy, family therapy, and Parent Partner sessions, are the most relevant to assessing FTPE program goals and operations. Overall, there was a slight increase in the total number of therapy sessions provided and children served across these years. The average number of therapy sessions each child received was fairly constant (approximately 9.5). There was initially a small decrease in the number of individual therapy sessions provided following the implementation of the FTPE program, but by FY 2017-18 individual sessions had increased slightly. The average number of individual therapy sessions received remained slightly lower in FY 2017-18 than in FY 2014-15 (i.e., 7.2 compared to 7.6 sessions per child).

TABLE 1. SERVICE UTILIZATION PATTERNS BEFORE, DURING, AND AFTER FTPE PROGRAM IMPLEMENTATION

	FY 2014-15* (7/1/14 - 6/30/15)	FY 2015-16** (7/1/15 - 6/30/16)	FY 2016-17 (7/1/16 - 6/30/17)	FY 2017-18 (7/1/17 - 6/30/18)
Any Therapy (Individual or Family) **Total Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**20,086** **2,099** **9.7**	**20,110** **2,144** **9.4**	**20,711** **2,183** **9.5**	**21,770** **2,313** **9.4**
Individual Therapy **Total Individual Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**14,792** **1,944** **7.6**	**13,502** **1,931** **7.0**	**13,552** **1,975** **6.9**	**15,155** **2,100** **7.2**
Family Therapy **Total Family Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**5,294** **1,480** **3.6**	**6,608** **1,598** **4.1**	**7,159** **1,656** **4.3**	**6,615** **1,689** **3.9**
Parent Partner Sessions **Total Parent Partner Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**-**	**2,604** **596** **4.4**	**4,681** **1,015** **4.6**	**4,172** **890** **4.7**
Ratio of Family Therapy Sessions per each Individual Therapy Sessions	**0.36**	**0.49**	**0.53**	**0.44**
Total Parent Partner FTE / Parent Partner Billable Service Hours	**0 / 0**	**10.0 / 2,730**	**11.7 / 5,032**	**11.0 / 4,630**

* *Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

The service utilization changes related to family therapy sessions were initially more pronounced. The number of family therapy sessions provided increased from 5,294 to 7,159 (an increase of 1,865 sessions [35.2%]), between FY 2014-15 and FY 2016-17, but then reduced to 6,615 in FY 2017-18. The number of children whose caregivers participated in at least one family therapy session increased throughout the entire four years from 1,480 to 1,689. The average number of family therapy sessions per child who received any family therapy sessions increased from 3.6 to 4.3 sessions (a 19.4% increase), before reducing again in FY 2017-18. These service utilization pattern changes resulted in the ratio between family and individual services delivered increasing from 0.36 family sessions per individual session delivered during FY 2014-15 to 0.53 during FY 2016-17 (a 47.2% increase). These overall shifts in utilization of individual and family therapy were consistent with the timing of FTPE program implementation. As the FTPE program was implemented during FY 2015-16 and Parent Partners began to encourage and support participation in family therapy, provision of family therapy services increased and individual therapy decreased. The decrease in family therapy during FY 2017-18 corresponded to a slight decrease in Parent Partner FTE and service hours.

Comparisons between the initial FTPE implementation year (FY 2015-16) and the first full year after FTPE implementation (FY 2016-17) highlight several key findings. First, Parent Partners dramatically increased the number of families they served during the first full year after FTPE implementation (from 596 families to 1,015 families; a 70.3% increase), but the average number of sessions received was fairly similar during both years (approximately 4.5 sessions). Secondly, while more family therapy sessions were provided during FY 2016-17 than in the prior year, the increase was less pronounced in absolute and relative terms (an increase of 551 sessions, [8.3% increase]) than demonstrated in the preceding year-over-year comparison (an increase of 1,314 sessions, [24.8% increase]). This substantial reduction in the rate of increase during the year in which FTPE was fully implemented and the slight decrease during FY 2017-18 as there was a drop in FTE indicates that FY 2016-17 data represented the maximum impact of FTPE on the distribution of family and individual therapy. Achieving further increases in family therapy participation would likely require additional enhancements to the current strategy and resource level of the FTPE program.

MONTHLY SERVICE UTILIZATION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

The assessment of the extent to which family therapy was provided at the six FTPE programs at the desired goal of at least two sessions per month required several steps. First, for each child receiving therapy services at one of the six FTPE programs, the number of calendar months during which the child received any therapy (individual or family) was summed to determine the total number of "treatment months" in a given fiscal year. For example, a child that received any type of therapy service (individual or family) in 5 different calendar months during a fiscal year would contribute the value of "5" to the number of "total treatment months" for that fiscal year. The "total treatment months" equals the total number of calendar months that children received any therapy services in a fiscal year. From the total treatment months, we can then assess the number (and percent) of the months during which the desired threshold of at least two sessions per month was achieved for any therapy and then separately for individual and family therapy. Table 2 presents the results of those analyses for the four years that span immediately before, during, and after full FTPE implementation. For comparison purposes, analyses related to a 1 session per month threshold are also included.

TABLE 2. MONTHLY SERVICE THRESHOLDS (I.E., TOTAL MONTHS OF TREATMENT REACHING EACH THRESHOLD)

	FY 2014-15* (Total Tx. Months=9,313)		**FY 2015-16** (Total Tx. Months=9,096)**		**FY 2016-17 (Total Tx. Months=9,494)**		**FY 2017-18 (Total Tx. Months=10,197)**	
Any Therapy (includes Individual or Family)	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
At least 1 session/month	100.0	9,313	100.0	9,096	100.0	9,494	100.0	10,197
At least 2 session/month	67.8	6,318	68.4	6,223	68.0	6,453	65.9	6,718
Individual Therapy								
At least 1 session/month	82.8	7,710	78.6	7,147	76.8	7,295	78.2	7,975
At least 2 session/month	48.4	4,507	44.8	4,073	43.2	4,099	45.1	4,596
Family Therapy								
At least 1 session/month	40.2	3,744	49.5	4,503	51.1	4,850	45.0	4,591
At least 2 session/month	12.1	1,126	16.7	1,520	17.3	1,640	14.6	1,485

* *Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

The findings from Table 2 reveal that across the four years examined, at least two therapy sessions were received in approximately two-thirds of the months during which any therapy sessions were received. Given that a treatment episode might start or end part-way through a calendar month and that some months might be affected by disruptions to intended treatment plans, it is not realistic to expect that 100% of treatment months would attain the desired threshold of two therapy session per month. Therefore, based on the results presented in Table 2, it appears that receiving at least two therapy sessions in about 66.6% of all treatment months represents a "real world" level of service intensity for these programs.

For individual therapy, close to half (48.4%) of the treatment months met the threshold of at least two sessions per month. There was initially a slight downward trend across the years that reversed itself in FY 2017-18. In contrast, family therapy demonstrated an upward trend in the number and percent of months that achieved two sessions per month during the early years of the FTPE program, which then turned slightly downward during FY 2017-18. The percentage of treatment months with at least two family therapy sessions increased from 12.1% to 17.3% (a relative increase of 43.0%). Similarly, while 40.2% of treatment months included at least 1 family therapy session during FY 2014-15, slightly more than half (51.1%), met this threshold by FY 2016-17 (a relative increase of 27.1%).

Most of the year-over-year changes occurred between FY 2014-15 (i.e., before FTPE implementation) and FY 2015-16 (i.e., during initial FTPE implementation). Slight changes continued during FY 2016-17, before changing direction during FY 2017-18. This change of direction during FY 2017-18 coincided with a slight reduction in Parent Partner FTE and service hours. The changes shown in Table 2 for individual and family therapy are consistent with the direction of the expected service utilization shifts following the implementation of the FTPE program and the corresponding increase in the provision of Parent Partner visits.

SERVICE UTILIZATION DISTRIBUTION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

Table 3 presents the distribution of total family therapy and Parent Partner sessions received during child treatment episodes that completed during each of four years of interest. A treatment episode was defined as a course of treatment for a child that contained at least one individual or family treatment session. Consistent with prior analyses, the results indicated a shift towards greater utilization of family therapy following the implementation of the FTPE programs. This is most evident when comparing pre-FTPE (FY 2014-15) to "peak" FTPE implementation (FY 2016-17). Between these two time periods the percentage of episodes with no family therapy visits decreased from 26.7% to 20.7% (a relative decrease of 22.5%) and the percentage of episodes with at least six family therapy visits increased from 15.6% to 27.1% (a relative increase of 73.7%). The pattern reversed to some extent in FY 2017-18 as there was a slight reduction of Parent Partner FTE and service hours. Approximately half of all treatment episodes included at least one visit with a Parent Partner following full FTPE implementation in FY 2016-17 and about 25-30% had at least three Parent Partner visits.

TABLE 3. TOTAL SERVICE UTILIZATION THRESHOLDS FOR COMPLETED TREATMENT EPISODES

	FY 2014-15* (Total Completed Treatment Episodes=1,563)		FY 2015-16** (Total Completed Treatment Episodes=1,983)		FY 2016-17 (Total Completed Treatment Episodes=1,660)		FY 2017-18 (Total Completed Treatment Episodes=1,993)	
Family Therapy Sessions	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
None	26.7%	417	25.3%	501	20.7%	344	23.2%	463
1 to 5	57.7%	902	56.8%	1,126	52.2%	866	54.2%	1080
6 to 11	13.2%	206	14.8%	294	20.7%	343	16.2%	322
12+	2.4%	38	3.1%	62	6.4%	107	6.4%	128
Parent Partner Sessions								
None	100%	1,563	85.4%	1,694	51.6%	857	50.9%	1014
1 to 2	-	-	6.9%	136	22.7%	376	19.1%	381
3 to 5	-	-	4.0%	79	12.0%	200	12.8%	256
6+	-	-	3.7%	74	13.7%	227	17.2%	342

** Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

SERVICE AREAS OF PROGRAMS PARTICIPATING IN FTPE

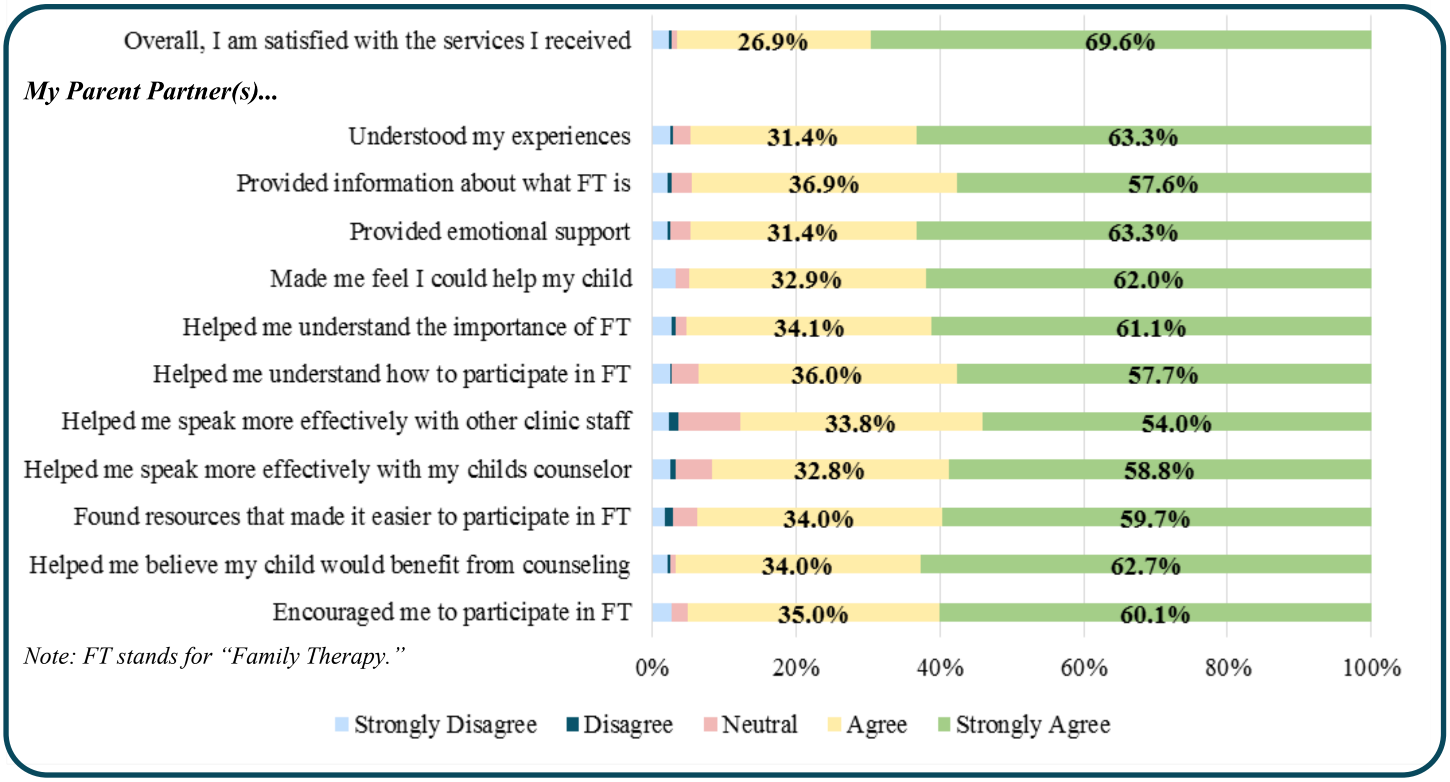
Program	*Service Area*
Vista Hill Foundation	**Escondido and North Inland; Escondido, Borrego Springs, Julian, Ramona, Spencer, & Warner School Districts**
North County Lifeline, Inc	**North County; Oceanside & Vista Unified School Districts**
Family Health Centers	**Central & East Region; La Mesa-Spring Valley School Districts**
Community Research Foundation: Crossroads	**Alpine, Jamul-Dulzura, & Mountain Empire School Districts**
Community Research Foundation: Nueva Vista	**South Region; Chula Vista Elementary, National, and Sweetwater Union School Districts**
Community Research Foundation: MAST	**San Diego County Office of Education, Juvenile Court and Community Schools**

CAREGIVER ASSESSMENT OF PARENT PARTNER SERVICES

CAREGIVER SATISFACTION AND FEEDBACK REGARDING PARENT PARTNER SERVICES

At the conclusion of receiving short-term Parent Partner support services, caregivers were asked about their experiences with the Parent Partners. In particular, caregivers were asked about their satisfaction with the Parent Partner services and their perceptions of the Parent Partner(s). Based on the results presented in Figure 1 (n=370), caregivers were typically very satisfied with the Parent Partner services they received (96.5% indicated agreement or strong agreement with the satisfaction statement). Overall, the vast majority of caregivers agreed or strongly agreed that they received each type of support listed in Figure 1 from their Parent Partners. The peer-support aspect of the Parent Partners likely contributed to the fact that almost all caregivers indicated (94.7% agreed or strongly agreed) that the Parent Partners "understood their experiences."

FIGURE 1. CAREGIVER ASSESSMENT OF PARENT PARTNER SERVICES



Note: FT stands for "Family Therapy."

QUALITATIVE CAREGIVER FEEDBACK REGARDING PARENT PARTNER SERVICES

An analyses of the open-ended qualitative responses that caregivers provided about their experiences with Parent Partners highlighted that emotional support was perceived as one of the most important services provided by the Parent Partners. Caregivers also emphasized the parenting support and education they received from Parent Partners as well as the resources and referrals specifically related to their unique caregiver needs (e.g., job assistance). Additionally, when asked how the Parent Partners could have served them better, a common caregiver response was to have had more time and interaction with the Parent Partners.

Overall, caregivers reported high levels of satisfaction with their Parent Partners and that they typically received a wide range of emotional, educational, and tangible resources from the Parent Partners to facilitate family therapy participation. These findings suggest a high level of caregiver acceptability of and interest in the Parent Partner role within the CYF treatment teams.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for FTPE. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the three annual surveys. response themes.

1. *Major program goals identified by respondents:*
    a. Increasing caregiver participation in family therapy and in treatment more generally
    b. Improving child and family outcomes
    c. Providing education and advocacy for families
    d. Increase case management/support services utilization by decreasing barriers
    e. Increase caregiver participation in Parent Partner services
    f. Developing rapport and increasing engagement with parents and family
    g. Providing education to increase engagement in family therapy
2. *Factors that helped the FTPE program achieve these goals:*
    a. The services that the Parent Partners provided (e.g., support, education, resources, working on obstacles)
    b. The training Parent Partners received on Motivational Interviewing and other important topics
    c. Sharing the Parent Partners' lived experience
    d. Availability of flexible scheduling, mobile or home-based options, and bilingual Parent Partners
    e. The collaborative nature of the team approach to care (which included Parent Partners)
    f. The use of both Parent Partners and other program supports/services
4. *Specific challenges to reaching the program goals:*
    a. Low caregiver motivation/caregiver ambivalence about the importance of therapy
    b. Lack of resources (e.g., transportation, housing, time, availability)
    c. Caregivers' personal challenges (e.g., low literacy, substance abuse, mental illness, family dynamic/relationships, etc.)
    d. Program barriers and Parent Partner factors (e.g., staff turnover, insufficient hours, paperwork demands, Cerner, program availability, county demands, trainings, turnover, etc.)
    e. The general stigma of communicating about mental illness and being in therapy
5. *Parent Partner roles/activities:*
    a. Providing emotional support to the caregivers
    b. Teaching caregivers about the importance of being involved in their child's treatment
    c. Working to reduce family barriers by helping provide resources
    d. Building rapport with caregivers
    e. Identifying caregiver needs and promoting participation in needed services
    f. Sharing personal experiences
    g. Engaging in community outreach
6. *Primary recommendations for how to successfully develop and implement a Parent Partner type program:*
    a. Hire a sufficient number of Parent Partners who fit in with population, are bilingual and diverse, and culturally competent.
    b. Connect with the caregiver consistently and early on in the program and facilitate Parent Partner connection with clients from the beginning and emphasize their value to staff
    c. Develop rapport between caregiver, Parent Partner, and therapist/treatment team
    d. Offer training opportunities for staff & parent partners
    e. Provide education to caregivers about topics like the benefits of family therapy and what to expect in treatment.
    f. Consider individual caregiver factors in engaging families, not everyone will engage
    g. Additional programmatic support (e.g., recruit more Parent Partners and case managers, increased community outreach)

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

1. Primary Roles of the Parent Partner

- Key Parent Partners roles included providing: emotional support, education about value of family therapy, encouragement/ motivation to participate in family therapy, and resources to remove/reduce barriers to participation in family therapy.
- While Parent Partner roles may overlap that of a case manager, the Parent Partner was intended to focus specifically on issues that had a direct influence on participation in family therapy.

2. Utilization of Parent Partners

- Some programs tried to include at least one Parent Partner visit at the start of treatment to introduce the Parent Partners in-person to the caregivers and to assess for motivational and/or tangible barriers to family therapy participation.
- For some caregivers not initially engaging in family therapy, multiple Parent Partner visits may be needed to build trust and start to remove motivational and/or tangible barriers to family therapy participation.
- Not enough Parent Partners were available to cover all families, so programs regularly evaluated family situations and tried to end Parent Partner services when no longer determined to be needed to free up Parent Partners to serve other families.
- With agency support and encouragement (e.g., allowing time for provider planning meetings), Parent Partners played an important role in a team-based, collaborative care model in which therapists, case managers, and Parent Partners communicated with each other about how best to provide treatment, encouragement, and other support services to children and their caregivers.

3. Importance of having Parent Partners who can establish a connection with caregivers

- Having Parent Partners who spoke Spanish was essential to meeting the service needs of the large population of San Diego County residents who primarily speak Spanish.
- The "lived experience" or peer support model in which Parent Partners were required to have personal experience with the children's behavioral health system was perceived to be an important component leading to successful caregiver engagement.
- Where possible, helpful to have multiple Parent Partners with different backgrounds and characteristics to help connect with and support a diverse caregiver population (e.g., sometimes the therapist is substantially younger than the caregiver, so Parent Partners who are similar in age can help bridge any perceived gap in understanding).
- Motivational Interviewing and other trainings were crucial for equipping Parent Partners with the skills and tools they needed to connect with and support caregivers.

4. Program/staffing challenges

- The "lived experience" requirement, unique skill sets needed, and salary limitations made it challenging to identify and hire Parent Partners.
- It was challenging and expensive to provide ongoing opportunities for Motivational Interviewing and other trainings for newly hired Parent Partners following staff turnover.
- The ability to provide childcare (onsite or with an offsite-partner) was identified by FTPE staff as one of the most important resources that needed to be added to the Parent Partner model to further increase participation in family therapy.

5. Caregiver challenges

- Even with Parent Partner supports, it was often still challenging for caregivers to participate in family therapy. Caregivers served by Parent Partners often faced many challenges to participating in family therapy, such as needs for child care, transportation, food assistance, employment, and other supportive services.

FUTURE DIRECTIONS

Based on the promising outcomes from the MHSA funded INN-12 FTPE program, BHS has continued to support the structure and operations of FTPE (i.e., the Parent Partner model) at the initial six programs by using MHSA Community Services and Support (CSS)/Full-Service Partnerships (FSP) funding.

For additional information about the INN–12 Family Therapy Participation Engagement program and/or this report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #1 FAITH BASED ACADEMY

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Faith Based Academy is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprises the County of San Diego Health and Human Services Agency's Behavioral Health Service (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative include improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the Faith Based Academy include the mutual education of behavioral health providers and faith leaders in order to promote greater understanding of each other as well as the range of resources available to effectively address behavioral health needs.

Two community organizations were selected to provide Faith Based Academy services (Interfaith Community Services and Neighborhood House Association). Each agency was responsible for: 1) developing and refining a structured training curriculum that addressed a range of relevant behavioral health topics (e.g., recognizing mental health conditions, suicide prevention, stigma reduction, the role of faith in recovery, etc.), and 2) hosting multiple Faith Based Academies for faith leaders and behavioral health providers. In addition to representing a unique outreach, engagement, and training mechanism, a primary innovation of the Faith Based Academy is the explicit emphasis on "cross education" of both faith leaders and behavioral health providers such that each group of participants is expected to develop a better understanding of the strengths and resources of the other. This two-way education is intended to improve relationships and reduce uncertainty and stigma between faith communities and behavioral health providers. Participants interested in sharing the information they learned are connected with another Faith Based Initiative organization that utilizes these "Faith Champions" to provide behavioral health related community education presentations.

EXECUTIVE SUMMARY

The Faith Based Academy was designed to educate faith leaders about behavioral health issues and make behavioral health providers more aware of faith community needs and resources while highlighting the role of faith within treatment and recovery. These objectives were accomplished through the development of a structured, multi-session curriculum that covered a range of behavioral health topics. Faith leaders and behavioral health providers were then recruited to attend and complete the academy.

- During FY 2017-18, a total of 170 persons participated in a Faith Based Academy.
- Most (74.1%) participants were between the ages of 26-59 and the majority were female (80%). Slightly over half (51.2%) identified as Hispanic, with 33.5% indicating Spanish as their primary preferred language.
- Faith leaders and behavioral health providers both reported favorably about the information learned and confidence gained by participating in the academy. While enthusiastic overall, behavioral health providers tended to rate aspects of the training slightly less positive than the faith leaders.
- Primary Academy outcomes as reported by participants included: 1) increased knowledge, 2) stronger relationships, and 3) inspiration for initiating actions that reflected and/or furthered faith and behavioral health integration.
- Key factors identified by staff that helped the program achieve its goals included: 1) interactive nature of Academy sessions, 2) well written curriculum, 3) content contributors and presenters with diverse expertise, 4) passionate and organized staff, 5) high quality presentations, and 6) faith leader/behavioral health provider networking opportunities.

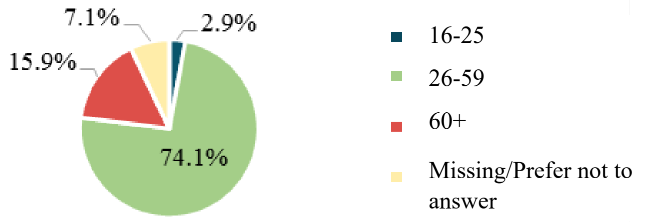
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) develop more opportunities for faith leaders and behavioral health providers to interact during and after Academy participation, 2) identify additional mechanisms for spreading awareness about and recruitment for the Academies among both faith leaders and behavioral health providers, 3) attempt to increase male participation in the Academies, 4) continued need for communication and coordination with other Faith Based Initiative partners (e.g., Community Education providers).

PARTICIPANT DEMOGRAPHICS

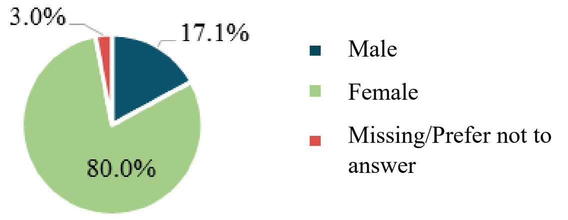
The following self-report demographic data were collected from Academy participants.[1]

AGE (N=170)



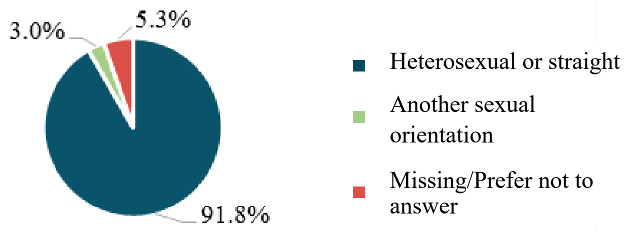
The majority (74.1%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=170)



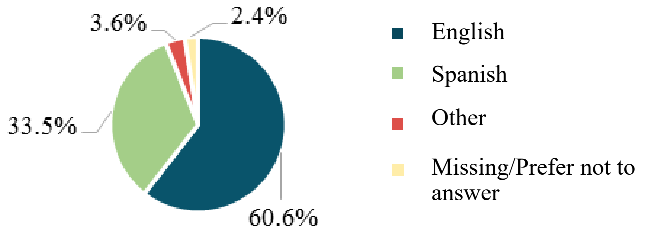
Over three-quarters (80%) of participants were female.

SEXUAL ORIENTATION (N=170)



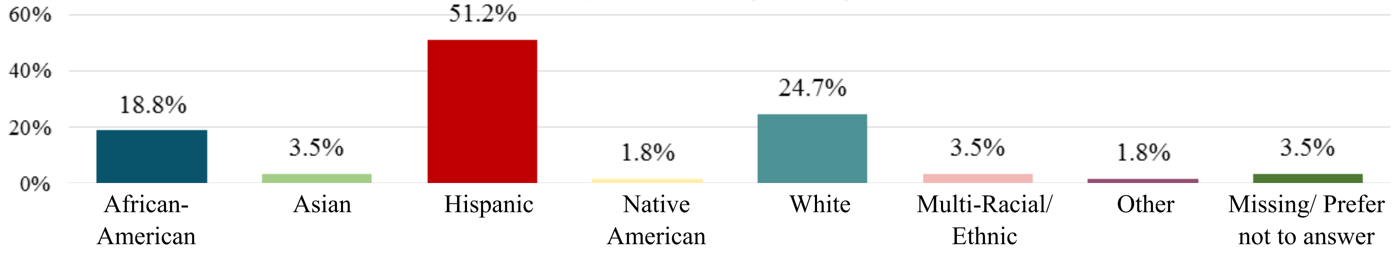
Almost all participants (91.8%) indicated a heterosexual or straight sexual orientation.

PRIMARY LANGUAGE (N=170)



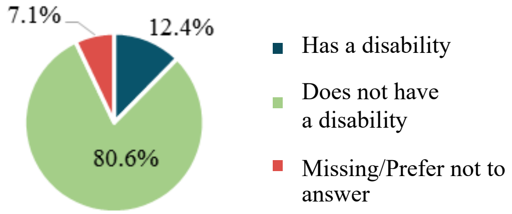
About one-third (33.5%) of participants spoke Spanish as their primary preferred language.

RACE/ETHNICITY (N=170)



About half (51.2%) of participants identified as Hispanic and 24.7% of participants identified as White. Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=170)



Around twelve percent of participants reported having some type of non-SMI related disability.

The majority (94.7%) of participants had never served in the military.

TYPE OF DISABILITY (N=21)

Type	n	%
Communication	3	14.3
Mental (e.g., learning, developmental)	8	38.1
Physical	4	19.0
Chronic Health	5	23.8
Other	5	23.8

The table above describes the types of disabilities participants reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

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[1] *Percentages may not total to 100% due to rounding.* [2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

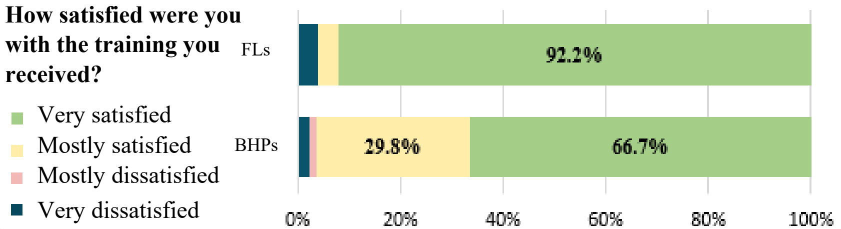
POST-TRAINING SURVEY RESULTS

A total of 171 persons completed a Faith Based Academy training and a post-training survey (82 faith leaders and 89 behavioral health providers). As shown in Table 1, while the ratings regarding the content and impact of the trainings were generally favorable, the mean score differences between the two groups indicated that behavioral health providers may not have felt as informed about how to access or work with faith community resources as faith leaders felt informed about behavioral health issues and resources.

TABLE 1. POST-TRAINING SURVEY

Faith Leaders (n=82): **"As a result of this training…"**	*Faith Leaders*	*Behavioral Health Providers*	**Behavioral Health Providers (n=89):** **"As a result of this training…"**
	Means	*Means*	
I know where to get help regarding mental health conditions and wellness for children/adolescents	**4.5**	**4.3**	**I know where to access faith community resources for mental health conditions and wellness for chld./adols.**
I know where to get help regarding substance abuse conditions and resources for chld./adols.	**4.5**	**4.1**	**I know where to access faith community resources for substance abuse conditions for chld./adols.**
I know where to get help regarding mental health conditions and wellness for adults/older adults	**4.5**	**4.3**	**I know where to access faith community resources for mental health conditions and wellness for adults/older adults**
I know where to get help regarding substance abuse conditions and resources for adults/older adults	**4.5**	**4.1**	**I know where to access faith community resources regarding substance abuse conditions for adults/older adults**
I know better when to refer/recommend someone to receive formal behavioral health services	**4.6**	**4.3**	**I know better when to refer/recommend someone to faith based behavioral health resources**
I am more comfortable discussing mental health and substance abuse issues	**4.6**	**4.4**	**I am more comfortable talking with faith representatives about integrating spiritual needs and behavioral health care**
I know better how to educate members of my faith community about behavioral health services	**4.6**	**4.2**	**I know better how to educate other behavioral health providers about faith based behavioral health resources**
I know better how to reduce the stigma of behavioral health within my faith community	**4.6**	**4.3**	**I know better how to reduce the stigma of behavioral health within faith communities**
I am more confident that rehabilitation and recovery are possible	**4.6**	**4.4**	**I am more confident that faith communities can help support rehabilitation and recovery**
I am more likely to refer/recommend someone to receive formal behavioral health services	**4.7**	**4.5**	**I am more likely to refer/recommend someone to participate in faith community behavioral health resources**
Scale responses: Strongly Disagree (1), Disagree (2), Neither agree/disagree (3), Agree (4), Strongly agree (5)			

FIGURE 1. OVERALL TRAINING SATISFACTION



In Figure 1, the majority (92.2%) of Faith Leaders reporting being "very satisfied" with the training they received compared to about two-thirds (66.7%) of behavioral health providers. This is consistent with the slight differences in mean score ratings presented in Table 1.

FAITH LEADER AND BEHAVIORAL HEALTH PROVIDER INTERVIEWS

The following findings were generated from a series of interviews and focus groups conducted with Faith Leaders (n=13) and Behavioral Health Providers (n=11) who previously completed one of the BHS-funded Academies. Where relevant, we indicate if a specific idea or impact was primarily associated with either Behavioral Health Providers (BHPs) or Faith Leaders (FLs).

In addition to widespread acknowledgement of the importance of bringing together FLs and BHPs, three primary areas emerged regarding how the Academy impacted participants:

1. **Increased Knowledge**
    a. New information about topics of faith, behavioral health, and their integration
        i. BHPs reported increased understanding of:
            1. The terminology used by the faith community
            2. The need for integration of faith and behavioral health
            3. Their own personal beliefs about faith
            4. How to handle faith oriented discussions with clients

            "When I first started I didn't have a clue how to discuss [faith] … But as I went on, I saw how important it was to talk about those things when they brought those up, and how it was very healing for them to talk about those things."

        ii. FLs reported learning:
            1. New concepts related to psychology and mental illness
            2. Increased knowledge of "warning signs" or when someone may need professional help

            "God can use modern medicine to heal this person. You're limiting God by just praying."

    b. Awareness of community resources
        i. All individuals reported increased awareness of the resources available in their communities
        ii. The resource binders were considered particularly useful in identifying community resources

2. **Stronger Relationships (i.e., "Bridging the Gap")**
    a. Addressing misconceptions

        "I didn't realize how many mental health providers have a very active faith."

        "*We're at a point now where trust is starting, and so we are able to stand together to work for the common good of our communities that we both want to serve."*

    b. Increased comfort interacting with each other
        i. Discussions may have been initially uncomfortable, however each person interviewed felt that the resulting understanding of the other group was worth their time

            "In the grand scheme of things, I believe that it's a good process for the two groups to be together in the same room, be trained together and hear each other's language. There's a lot of differences in the words that we use and how we refer to certain concepts."

            "[The faith leaders] were asking a lot of questions. They were fully engaged and especially when you start talking about the different diagnoses they were very interested in it. I think, who better to be trained than these people who are actually in the church and can spot maybe if somebody is going through a mental health problem?"

c. Creating opportunities to make connections
    i. Interviewees reported exchanging information with each other so they had a specific, trusted person to reach out to for future referrals and questions
    ii. Maintaining and promoting connections after the training was challenging, but crucial
        1. Events such as BHP and FL breakfasts and luncheons are helpful
        2. Significant interest in exploring other mechanisms such as regular "alumni" events, communication/dissemination of information via email, blog, etc.

3. Engaging in Actions that Reflect and Encourage Faith and Behavioral Health Integration

a. Behavior changes
    i. Overall, greater empowerment and movement toward action among both FLs and BHPs

"I think it has informed my approach with faith-based and other behavioral health-based individuals… helped me have these conversations and partner with other faith-based and behavioral health colleagues."

    ii. FLs reported increased confidence and likelihood of referring a help seeker to a BHP

"I recommended a few families to see [a psychologist] and get the help they need. And they are really happy."

"Now I can, with confidence, refer parents to take their kids to a professional."

    iii. BHPs indicated changes in practice related to:
        1. Assessment procedures (i.e., more attention to faith factors)
        2. More dialogue and actions with clients about faith matters when clients express interest in these areas
        3. Organizational climate (e.g. more discussion of faith in clinical settings and between clinicians)
        4. Organizational structure (e.g. training graduates, becoming a "go-to" person about faith issues with clients)

b. Dissemination of information (i.e., "The Ripple Effect")
    i. BHPs and FLs are working together to bring mental health education into the churches

"It helped me to understand more and with my knowledge now I'm trying to help other people understand by offering a new class."

    ii. FLs reported including behavioral health information from the training in their church newsletters, social media, and even bringing it to their (non-church) place of employment
    iii. BHPs indicated sharing information with colleagues and developing written materials that examine the integration of faith and behavioral health
    iv. Interviewees reported that they frequently encourage others to take the Academy training

ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 11 respondents from the 17 persons invited to participate in the survey, a response rate of 65%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. For each item, the survey responses are listed in order of declining prevalence (i.e., most frequently provided responses are listed first).

1. *The major program goals identified by staff:*
    a. Facilitate connections between mental health service providers and community clergy
    b. Educate faith leaders in the community about mental illness
    c. Reduce stigma surrounding mental illness and seeking mental health services
    d. To provide resources
    e. Destigmatize religion in clinical practice
    f. Educate mental health professionals about faith based communities
    g. Educate faith community about mental health and substance abuse

2. Factors that helped the program achieve goals:
    a. The interactive nature and participant engagement in the trainings
    b. Well written curriculum with plenty of mental health information
    c. Contributors bringing diverse expertise and experiences to the program and presentations
    d. The frequency of meetings
    e. Excellent program staff
    f. The quality of the presentations and the information provided
    g. The networking opportunities that the trainings provide

3. *Factors that inhibited the program from achieving goals:*
    a. Time challenges/difficulties fitting necessary material into available time for presentations
    b. Focusing only on Christianity
    c. Lack of buy-in about spirituality and mental health services
    d. Challenges in understanding the importance of learning about each other

4. Recommendations to help the program better achieve goals:
    a. More preparation time for locating personnel & developing the curriculum
    b. Increase outreach efforts made to non-Christian places of worship/agencies
    c. Offer workshops to the public for wider access
    d. Increase outreach efforts made to engage faith based leaders and mental health providers
    e. Presenters should have the opportunity to change their topics year to year
    f. Add additional years to the program
    g. Provide more time for each training
    h. Survey participants about their availability to increase attendance
    i. Offer continuing education opportunities

5. Desired supports, tools, and/or trainings for the program:
    a. More funding for resources and more equipment for producing curriculum materials
    b. Increased communication between related faith based "Innovation" funded programs for continuity and relationship building
    c. County provided trainings
    d. Volunteer assistance
    e. Training Faith leaders to encourage referrals to the behavioral health system

6. Key strengths of this program:

a. Experienced contributors/presenters
b. Successful efforts to reduce the divide between faith based and mental health based worldviews
c. Sharing resources
d. Enthusiasm of the participants
e. The need the program helped fill in the community

7. Key "innovations" making this program unique:

a. The facilitators and panelists
b. That the goal is education and not clinical or case management
c. Presenters sharing their personal experiences
d. The Resource Guide
e. Participant engagement in exercises
f. The quality of the presentations
g. The commitment level of participants
h. Different types of individuals are welcomed and community team building is encouraged

8. Successful strategies to identify and recruit faith community members:

a. Trying out new workshop times during the week to improve attendance
b. Using people who took the training to "advertise" their experience
c. One day of training that includes both faith based and behavioral health providers
d. Having groups meet at the end of the year to share challenges/successes
e. Personal referrals
f. Stipends

9. Successful strategies to identify and recruit behavioral health providers:

a. Behavioral health providers are easy to recruit because they are interested in this type of training
b. Stipend
c. Information about the value and purpose of the certification
d. Flexible scheduling

10. Recommendations for another agency starting a faith academy:

a. Find people who have the same passion and commitment
b. Have group activities that engage participants
c. Recruitment can be hard but do not give up
d. Simplify the curriculum
e. Have lots of resources
f. Use presenters with lived experience

11. Strategies used the past year to increase interactions between faith leaders and behavioral health providers:

a. Providing opportunities for the cohort to network with each other
b. Interactive activities
c. Incentives
d. Meals (e.g., breakfasts, luncheons)
e. Conferences with a mental health professional

12. Additional strategies to increase interactions between faith leaders and behavioral health providers:

a. More social events
b. More opportunities for participants to share their stories/testimonials
c. Additional training opportunities
d. More community panels or conferences
e. Pair together the passionate participants

KEY YEAR 1 PROGRAM “LEARNINGS”

1. Developing the curriculum and associated resource guide required substantial time commitments to acquire, consolidate, and “polish” the information for use in the Faith Based Academy.
2. Existing community partners/networks helped facilitate and provided credibility to the curriculum development process.
3. It is challenging to fit the required and desired content into a reasonable length for Academy (e.g., 12-15 hours of training).
4. Need to balance presentation of enough content to educate attendees on each topic while also allowing sufficient time for attendees to engage with each other and discuss the material.
5. Scheduling is often limited by availability of targeted faith leaders (typically Saturdays) and behavioral health providers (typically weekdays).
6. Finding available and qualified presenters can be challenging, but particularly useful during full-day trainings to have multiple presenters so they can focus on their specific areas of expertise and provide variation in presentation styles for attendees.
7. Important to identify and recruit key faith leaders (e.g., clergy), to personally participate in the Faith Based Academy since “once the pulpit embraces an idea, it will disseminate more broadly” throughout congregation/faith community.
8. Although the Faith Based Academies were open to persons from all faiths, content language was more oriented towards the Christian perspective given the initial target populations (i.e., Latinos and African Americans). Explicit acknowledgement of this orientation and expressed openness to other faiths may facilitate comfort with core material by non-Christians.
9. Important to keep class size small enough to allow for active discussion/participation (target = 20 participants).
10. Good coordination and communication is needed with the programs providing Community Education component of the Faith Based Initiative to facilitate identification and recruitment of appropriate “Faith Champions”.
11. While post-Academy ratings of satisfaction and learnings were generally high, behavioral health providers typically reported slightly lower ratings than faith leaders. This suggests a need to ensure that the material presented is sufficiently engaging and educational for behavioral health providers.

KEY YEAR 2 PROGRAM “LEARNINGS”

1. Faith leaders and behavioral health providers should be included in the same Academy training sessions to promote interaction, integration, and co-learning (in contrast to offering separate academies for each type of participant).
2. Academies appear to work best when provided training via several in-depth sessions (e.g., 2-4) over two weekends rather than as a weekly session over many weeks.
3. Based on feedback from Academy attendees, the effects of Academy participation were evident across three primary domains, 1) increased knowledge, 2) stronger relationships, 3) continued actions to promote faith and behavioral health integration.
4. Post-Academy opportunities to continue engagement and interaction (e.g., luncheons and other “alumni” events), were viewed as very important to continuing the faith and behavioral health integration started during the Academies.
5. Presenters acting as facilitators rather than lecturers/teachers allowed participants to demonstrate their own expertise.
6. Team building exercises helped in getting faith leaders and behavioral health providers to work together and get to know one another.
7. Important to help Academy participants think through and identify a wide range of potential post-Academy actions that they could do to help further promote faith and behavioral health integration (e.g., within their place of employment, where they worship, among their family and friends, etc).

YEAR 2 PROGRAM CHANGES

There were no fundamental changes to the INN-13 Faith Based Initiative #1, Faith Based Academy, during Year 2 that differed substantially from the initial program design. However after trying multiple formats, it was found that it generally worked best to offer Academies that included both faith leaders and behavioral health providers simultaneously over the course of two weekends via several in-depth sessions (e.g., 2-4). Total Academy length was approximately 12-15 hours.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Create more opportunities for faith leaders and behavioral health providers to interact with each other.
    a. *Programs have created a range of post-Academy events (e.g., breakfast/luncheons with speakers and other "alumni" gatherings) to promote continued interaction and engagement between faith leaders and behavioral health providers.*
2. Adapt content/presentation material to improve fit with non-Christian faith communities.
    a. *Presentation content with a less explicit Christian basis has been developed and successfully utilized.*
    b. *When content with a more explicit Christion orientation is utilized, acknowledgement of this basis and efforts to generalize core meanings to other faith contexts are provided.*
3. Increase outreach activities to key faith leaders (e.g., clergy, pastors, rabbis, imams).
    a. *Networking through personal relationships of Academy staff, utilization of Academy alumni as recruitment "ambassadors", participation in ongoing community/faith meetings, and distribution of physical and electronic fliers related to upcoming Academies are all used to expand awareness of the Academies among faith leaders and other potential participants.*
4. Improve communication and coordination with other Faith Based Initiative partners (e.g., Community Education provider).
    a. *Meetings between the Faith Based Initiative program partners has increased communication and coordination, and representatives from the Community Education program often attend the Academy to help identify potential "champions" who may want to engage in further community outreach activities.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Develop more opportunities for faith leaders and behavioral health providers to interact during and after Academy participation (e.g., incorporate "partnership shadowing", organize get-togethers outside of class, creatively utilize emails/blogs to facilitate ongoing dialogue about key issues, encourage behavioral health providers to visit a place of worship or attend a service with one of the faith leaders, etc.) .
2. Identify additional mechanisms for spreading awareness about and recruitment for the Academies among both faith leaders and behavioral health providers.
3. Work on increasing male participation in the Academies.
4. Continued need for communication and coordination with other Faith Based Initiative partners (e.g., Community Education provider).

For additional information about the INN–13 Faith Based Initiative #1, Faith Based Academy
and/or this annual report, please contact:
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FAITH BASED INITIATIVE (INNOVATIONS-13): #2 COMMUNITY EDUCATION

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

Community Education is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprise the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the Community Education program include extending behavioral health related education (e.g., recognizing mental health conditions, suicide prevention, stigma reduction, etc.) into congregations and communities that may not otherwise have access to this information.

Two community organizations, Stepping Higher and NAMI San Diego (National Alliance on Mental Illness), provided Community Education services. Within their target region in the county, each agency was responsible for 1) using "Faith Champions" to train behavioral health facilitators for community outreach and educational presentations, and 2) identifying agencies to partner with to host behavioral health related presentations. An important feature of the Community Education program is utilization of graduates of the Faith Based Academy as trained community facilitators to present the behavioral health related information. One of the other Faith Based Initiatives, the Faith Based Academy, supports the work of the Community Education program by identifying potential Faith Champions from Academy participants and then linking such persons to the Community Education program. The Community Education programs are expected to reduce stigma frequently associated with behavioral health needs and improve knowledge about available treatment and support resources.

EXECUTIVE SUMMARY

The Community Education program was designed to utilize Faith Champions identified in the Faith Based Academy to conduct behavioral health related workshops in the community and/or train additional facilitators to do so. The Community Education program also helps develop relationships with community faith leaders to expand opportunities and locations for delivering the educational workshops. These activities are intended to reduce behavioral health stigma in faith communities and increase knowledge about available resources.

- During FY 2017-18, a total of 866 persons attended 42 different Community Education behavioral health related workshops, a substantial increase from the prior year (n=295).
- Compared to the prior year, Central Region presentations substantially increased attendance by males (24.1% to 42.3%), Hispanics (13.6% to 25.4%), and older adults (16.6% to 34.1%)
- Across both regions, over 40% of attendees (41.9%) indicated Spanish as their primary language.
- These changes in attendee demographic profiles were facilitated, in part, by greater utilization of community centers as locations to hold community presentations.
- Based on post-training survey responses, most attendees (91%) agreed or strongly agreed that the training increased their knowledge about relevant behavioral health issues and available resources. Of particular interest, the majority (86.2%) agreed or strongly agreed that they were committed to increasing awareness in their community.
- Key factors identified by staff that helped the program achieve its goals included: 1) skilled and passionate workshop facilitators and program staff, 2) maintaining accurate knowledge of available community resources to facilitate referrals, 3) ability to provide informative presentations on a wide range of topics, and 4) good community relationships/credibility.

RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify new locations for community presentations based on recommendations/connections of the Faith Academy participants, 2) establish more relationships with other community organizations (e.g., Suicide Prevention Council) and behavioral health systems, and 3) include an American Sign Language signer for presentations where possible.

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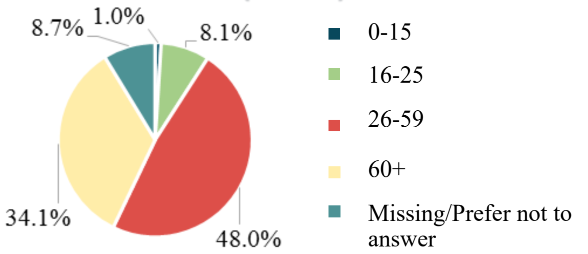
PARTICIPANT DEMOGRAPHICS - CENTRAL REGION PRESENTATIONS

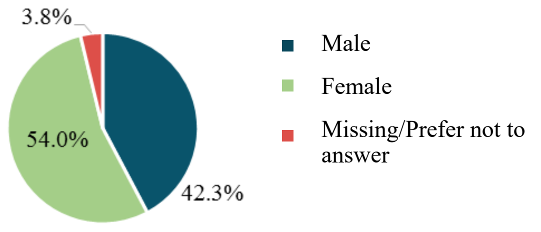
The following demographic data were collected from an audience self-report survey administered at the community presentations.[1]

AGE (N=504)



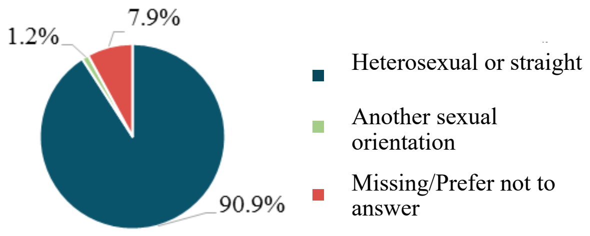
34.1% of participants were age 60 or above., as compared to the prior year in which only 16.6% were age 60 or above.

GENDER IDENTITY (N=504)



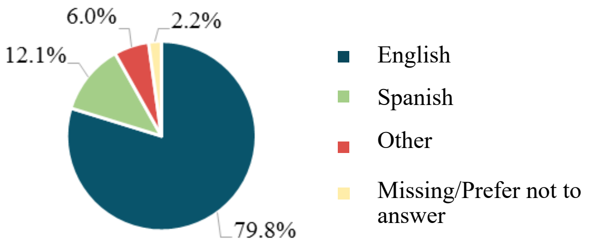
Fifty-four percent of participants identified as female.

SEXUAL ORIENTATION (N=504)



Almost all participants (90.9%) indicated they were heterosexual or straight.

PRIMARY LANGUAGE (N=504)



Most participants (79.8%) spoke English as their primary preferred language.

RACE/ETHNICITY (N=504)

	n	%
African-American	287	56.9
Hispanic	128	25.4
White	49	9.7
Multi-Racial/ Ethnic	22	4.4
Other	38	7.5
Missing/ Prefer not to answer	25	5.4

Over half of participants (56.9%) identified as African-American. Totals may exceed 100% since attendees were able to indicate more than one race/ethnicity.

TYPE OF DISABILITY[2] (N=103)

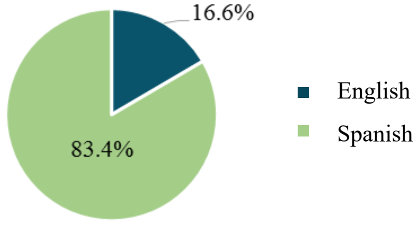
	n	%
Communication	38	36.9
Mental (e.g., learning, developmental)	18	17.5
Physical	31	30.1
Chronic Health	36	34.9
Other	31	30.1

Twenty percent of the attendees (n=103) indicated having a non-SMI related disability. The sum of the disability types may exceed 100% since attendees could indicate more than one.

PARTICIPANT DEMOGRAPHICS - NORTH INLAND REGION PRESENTATIONS

Primary language was the only demographic information collected from attendees of North Inland region presentations during FY 2017-18.

PRIMARY LANGUAGE (N=362)



Most participants (83.4%) spoke Spanish as their primary preferred language.

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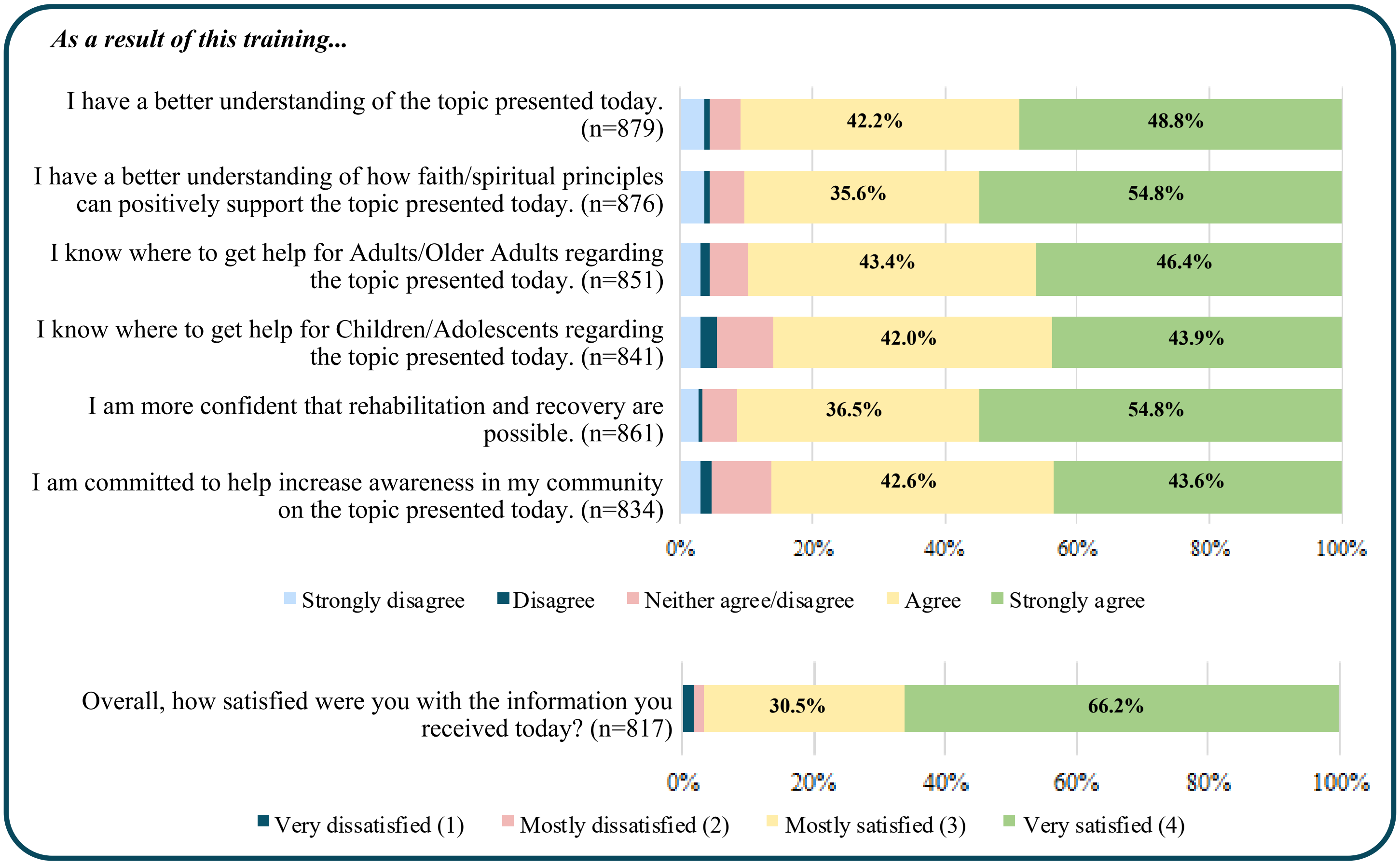
[1] *Percentages may not total to 100% due to rounding.* [2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

POST-TRAINING SURVEY RESULTS

During FY 2017-18, the programs provided a total of 42 different behavioral health related Community Education presentations. As shown in Figure 1, the vast majority of community attendees (85% or more) at educational presentations agreed or strongly agreed that as the result of the training they were more knowledgeable, knew where to obtain appropriate assistance, and were more capable and committed advocates to help others in their community. Of particular interest for achieving the goals and objectives of the overall Faith Based Initiative and this specific Community Education strategy, the majority (86.2%) agreed or strongly agreed that they were committed to increasing awareness within their community. This provides some evidence to suggest that the desired “ripple effect” of education and ultimately community transformation is potentially underway, in that persons trained through the Faith Based Academy (Faith Based Initiative #1), are now providing community educational workshops and/or training facilitators to do so as part of the Community Education program (Faith Based Initiative #2), which is then leading to attendees of those presentations indicating that they are motivated to further expand the reach of this material by helping to increase awareness of these behavioral health topics among the people they know. Additionally, almost all presentation attendees indicated they were satisfied with the information they received (30.5% were mostly satisfied and 66.2% were very satisfied).

FIGURE 1. COMMUNITY EDUCATION POST-PRESENTATION OUTCOMES AND SATISFACTION



ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were nine respondents from the 16 persons invited to participate in the survey (56% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. For each item, the survey responses are listed in order of declining prevalence (i.e., most frequently provided responses are listed first).

1. *The major program goals identified by staff:*
   a. Provide the community with resources
   b. Raise awareness on mental health matters in Latino and African American communities
   c. Emphasize the role of faith in mental health recovery
   d. Educate the community about mental health issues
   e. Increase the awareness of mental health while decreasing stigma
   f. Bridge the gap between faith and mental health issues
   g. Encourage people to use resources without fear
   h. Ensure equality of education between Latino and African American communities
   i. Identify community resources
   j. Increase rapport between faith leaders and behavioral health providers
   k. Increase understanding of professional help
   l. Provide free mental health education
2. *Factors that helped the program achieve goals:*
   a. Facilitator aspects (e.g., interactive, knowledgeable about topics and accessing resources)
   b. Resources (e.g., list of counseling services, an app that has resource recommendations)
   c. Presentation aspects (e.g., varied topics, good information)
   d. Staff aspects (e.g., preparedness, flexibility, adaptability, patience)
   e. The relationships within the community
   f. The lived experience of presenters
   g. Meeting the community in their local area
   h. San Diego County helping to extend educational resources
   i. The quality of the collaboration of all involved
   j. The positive reputation of NAMI
   k. The marketing and promotion efforts
3. *Factors that inhibited the program from achieving goals:*
   a. Time constraints (time of presentations, time allowed for project, time for paperwork)
   b. Stigma about mental health illness and accessing mental health services
   c. Not making plans or collaborating with the other related faith based "Innovation" funded programs
   d. Not having enough presenters for the Spanish-speaking community
   e. Lack of communication with the faith community
   f. Slow/inefficient marketing that was not highly visible
   g. Limited church hours (i.e., it made coordination difficult)
   h. Lack of trust by the faith communities
4. *Recommendations to help the program better achieve goals*:
   a. Increase marketing and hire a professional marketing service
   b. Increase interagency communication (e.g., between COR, NAMI, and SD County, and also between Task Order's)
   c. Increase funding (for staff hours, printing, office supplies, etc.)
   d. Simplify paperwork
   e. Have more Spanish-speaking staff & facilitators
   f. Target the information more directly at the immediate needs of recipients
   g. Do not limit facilitators to only Task Order 1 graduates
   h. Target younger audiences

5. Desired supports, tools, and/or trainings for the program:
  a. Resource information for emergency assistance
  b. More funding
  c. Expand to more areas of the local community
  d. Increased participation in the Faith breakfast
  e. Public speaking training

6. Key strengths of the program:
  a. Strong facilitators and staff
  b. Involvement of the Faith community
  c. The support to the community it provides
  d. The community relationships it produces

7. Key "innovations" making the program unique:
  a. The Faith based component of the mental health training
  b. Connecting with the community "at ground zero"
  c. Creating a bridge between behavioral health and Faith professionals
  d. Staff availability to assist others
  e. Presenters having a combination of expertise & lived experience
  f. Targeting Latino populations through their Faith community

8. Strategies utilized to identify potential organizations or locations for community outreach:
  a. Personal networking (e.g., word of mouth, talking to friends)
  b. Reaching out to organizations in the area
  c. Using graduates from the target communities
  d. Talking to the Faith community
  e. Speaking directly with Faith Leaders (e.g., pastor, priest, etc.)
  f. Reviewing organizational listings
  g. Encouraging referrals

9. Factors needed for successful community education presentations:
  a. Marketing to ensure the community knows about the presentation
  b. Knowledgeable presenters
  c. The location of the presentation
  d. Networking
  e. Faith communities being open to mental health topics
  f. Connecting with the head of a Faith community
  g. Business cards
  h. An adequate number of presenters
  i. Relatability of presenters
  j. Timeliness of presentations
  k. Time after presentations for attendees to mingle

10. Primary impacts/outcomes of your activities within the community:
  a. Mental illness stigma reduction
  b. Increased mental health awareness & education
  c. Increased hope about mental health recovery
  d. Faith entities having more knowledge about mental health
  e. Increased community openness to address mental health
  f. Awareness of the importance in connecting Faith and mental health
  g. Rapport between Faith leaders and mental health providers
  h. Participants utilizing resources provided

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Need to develop trusting relationships with faith leaders in order to gain access to congregations.
2. Managing program logistics requires substantial time (e.g., finding venues, facilitating marketing/outreach, facility preparation).
3. Existing credibility and relationships in the community are crucial for program success.
4. Presenters need to be knowledgeable and good communicators.
5. Program relies on dedicated and passionate staff committed to achieve program objectives.
6. Role plays are effective tools for teaching about commonly diagnosed mental illnesses.
7. Importance of meeting community members in the community (e.g., go to where they already are).
8. Potentially sensitive or uncomfortable topics requires respectful and supportive communication.
9. Often difficult to find appropriate, local resources for community member referrals.
10. Persons who are not seeking out this information represent an important target audience (e.g., need to have opportunities to present to congregations, schools, and other locations where audience didn't purposefully choose to attend an educational presentation in order to reach persons who may not otherwise recognize the need for such information/services).

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Working with local community centers increased the number of presentation opportunities.
2. Community centers can facilitate access to priority populations such as males and Latinos.
3. For presentations at community centers, can often refer and/or link attendees back to their own community center to meet needs for further education and other resources prompted by the presentation.
4. When possible, beneficial to match experienced and new presenters together to support ongoing presenter training.
5. Important to ensure a sufficient number of people are working at each presentation to facilitate a smooth process from set-up through clean-up, and promote a positive experience for both attendees and presentation staff.
6. Need to be aware of, and ensure security of presenters and audience in varied community settings (e.g., include security guard as part of presentation team as needed).
7. Establishing, maintaining, and nurturing relationships with church leaders are crucial but time consuming activities which are needed to create opportunities for presentations in faith communities.
8. After presentations, it is common that a certain amount of 'case management' occurs during which staff answer attendee questions and seek to direct attendees to relevant community resources for further information and assistance.
9. Ongoing relationships with certain faith leaders and community centers allowed for "repeat" presentation opportunities with either the same subject matter with different populations or different content areas over time.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #2, Community Education, during Year 2 that differed substantially from the initial program design.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Explore potential for adding a post-presentation "follow-up" component in which someone can contact audience members who request additional information/help with connecting to resources.
   a. *While a structured "follow-up" component was determined to be beyond the scope of this initiative, presentation staff continued to provide attendees with relevant referral information as needed (e.g., programs distributed resource packets at the presentations that contain information about other relevant community programs).*
2. Identify more Spanish speaking staff/facilitators.
   a. *Additional Spanish speaking program staff were added, which contributed to numerous Spanish language presentations (as evidenced by over 40% of all attendees during FY 2017-18 who indicated Spanish as their primary language).*
3. Expand marketing/outreach for community presentations (e.g., churches, schools, military bases).
   a. *Marketing/outreach activities expanded during FY 2017-18 to include community centers. Interest has been expressed from schools for presentations, but that has not yet been utilized as source for presentation locations.*
4. Continue to find additional venues for presentations.
   a. *Networking and personal connections were used to find additional venues for presentations.*
   b. *Connections with community centers increased the number of venues for presentations.*
5. Increase the number of males attending community presentations.
   a. *More presentations were given at community centers with a greater male presence.*
   b. *More presentations were offered at a wider range of times and days.*
   c. *This contributed to the percentage of Central Region attendees who identified as male to increase from 24.1% last year to 42.3% this year.*
6. Increase the number of Latinos attending community presentations.
   a. *More presentations were given at community centers that were oriented towards Latinos.*
   b. *More presentations were offered at a wider range of times and days.*
   c. *This contributed to the percentage of Central Region attendees who identifies as Latinos to increase from 13.6% last year to 25.4% this year.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Try to identify new locations for community presentations based on recommendations/connections of the Faith Academy participants.
2. Establish more relationships with other community organizations (e.g., Suicide Prevention Council) and behavioral health systems.
3. Include an American Sign Language signer for presentations where possible.

For additional information about the INN–13 Faith Based Initiative #2, Community Education
and/or this annual report, please contact:
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FAITH BASED INITIATIVE (INNOVATIONS-13): #3 CRISIS RESPONSE TEAM

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Crisis Response Team is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprise the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The goals of the Faith Based Initiative include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the Crisis Response Team include the provision of faith based support services to individuals and families experiencing crisis situations (e.g., attempted or completed suicides, homicides, domestic violence, etc.), to improve their behavioral health and wellbeing.

Two community organizations, Stepping Higher and Interfaith Community Services, provided Crisis Response Team services during this time period. Within two target areas, Central Region and Escondido, these programs were responsible for: 1) providing trained staff who could respond 24 hours a day to crisis situations as they occurred, and 2) offering short-term follow-up visits (up to 90 days), to support the individuals and families who experienced the crisis event and attempt to link them to appropriate behavioral health and non-behavioral health services. An innovative feature of this program is the provision of additional supports in the midst of and following a crisis event that incorporate shared understandings of faith and community to de-escalate situations and promote peace and healing within challenging circumstances. The emotional supports and additional linkages to community resources are expected to improve the behavioral health and wellbeing of those receiving Crisis Response Team services.

EXECUTIVE SUMMARY

The Crisis Response Team was designed to support individuals and families during and after experiencing crisis events (up to 90 days). The team has faith leaders and behavioral health professionals who can respond quickly to crisis situations whenever needed. The initial contacts are expected to help de-escalate challenging situations and the follow-up services are designed to promote longer-term recovery and well-being.

- During FY 2017-18, 149 people received crisis team services.
- Fifty percent of the persons served by the Crisis Response Teams were female and 48% were between the ages of 26 and 59. Participants identified primarily as Hispanic/Latino (68%).
- Over 95% reported being satisfied with their overall experience with the Crisis Response Team. More specifically, the majority indicated satisfaction with the initial crisis services provided, the professionalism of the staff, the resources provided by team, and the quality of follow-up services.
- Nearly two-thirds (61.7%) reported that they know where to get help when needed due to crises team services.
- Key factors identified by staff that helped the program achieve its goals included: 1) resource information, 2) having a team of experienced and knowledgeable clergy and behavioral health professionals, 3) existing relationships within the community, 4) quick crisis response time whenever needed, 5) timely follow-up after initial crisis contact, and 6) team commitment to support others and make a difference in the community.

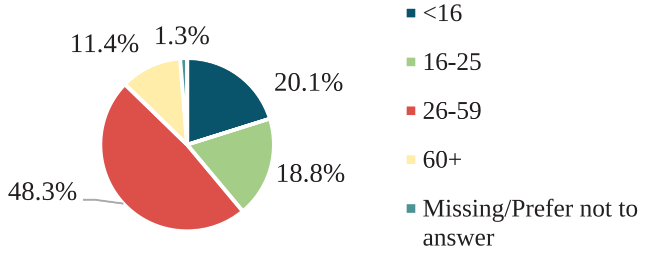
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) increase outreach efforts to community-based organizations in the Escondido area to expand opportunities for referrals to the Crisis Response Team program, 2) identify and utilize staff with additional language capabilities beyond English and Spanish (e.g., French to better serve needs of immigrants from some African nations), 3) identify and utilize community resources that can support persons who do not speak English or Spanish (e.g., French to better serve needs of immigrants from some African nations).

PARTICIPANT DEMOGRAPHICS

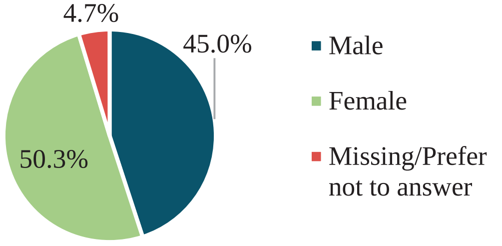
The following self-report demographic data were collected from participants during the initial or follow-up visit.[1]

AGE (N=149)



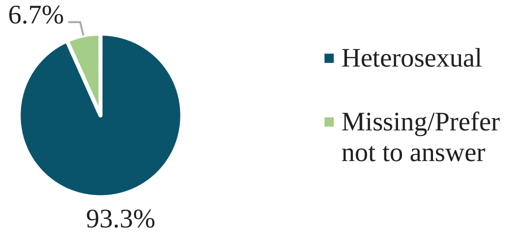
Most participants (48.3%) were between the ages of 26 and 59, and 18.8% were between ages 16 and 25.

GENDER IDENTITY (N=149)



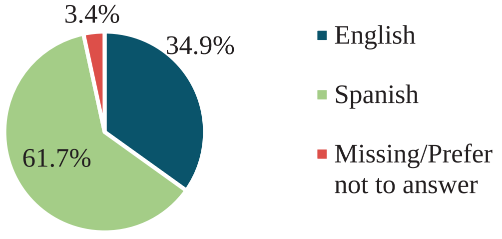
About half (50.3%) of participants were female and 45.0% of participants were male.

SEXUAL ORIENTATION (N=149)



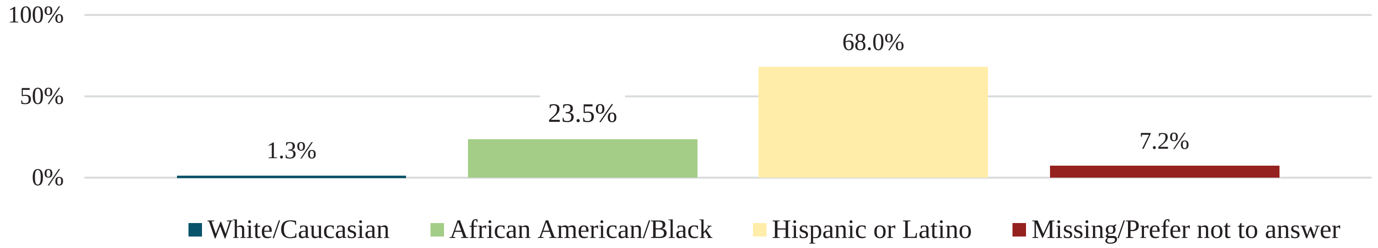
The majority (93.3%) of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=149)



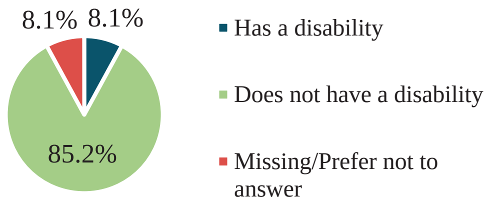
The majority (61.7%) of participants spoke Spanish as their primary language.

RACE/ETHNICITY (N=149)



Most participants identified either as Hispanic (68.0%) or African-American (23.5%) Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=149)



Eight percent of attendees reported having some type of non-SMI disability.

The majority (91.0%) of attendees had never served in the military.

TYPE OF DISABILITY (N=12)

Type	n	%
Visual	3	25.0
Hearing	1	8.3
Learning	2	16.7
Dementia	1	8.3
Chronic Health	3	25.0
Other	2	16.7

The table above describes the types of disabilities these participants reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

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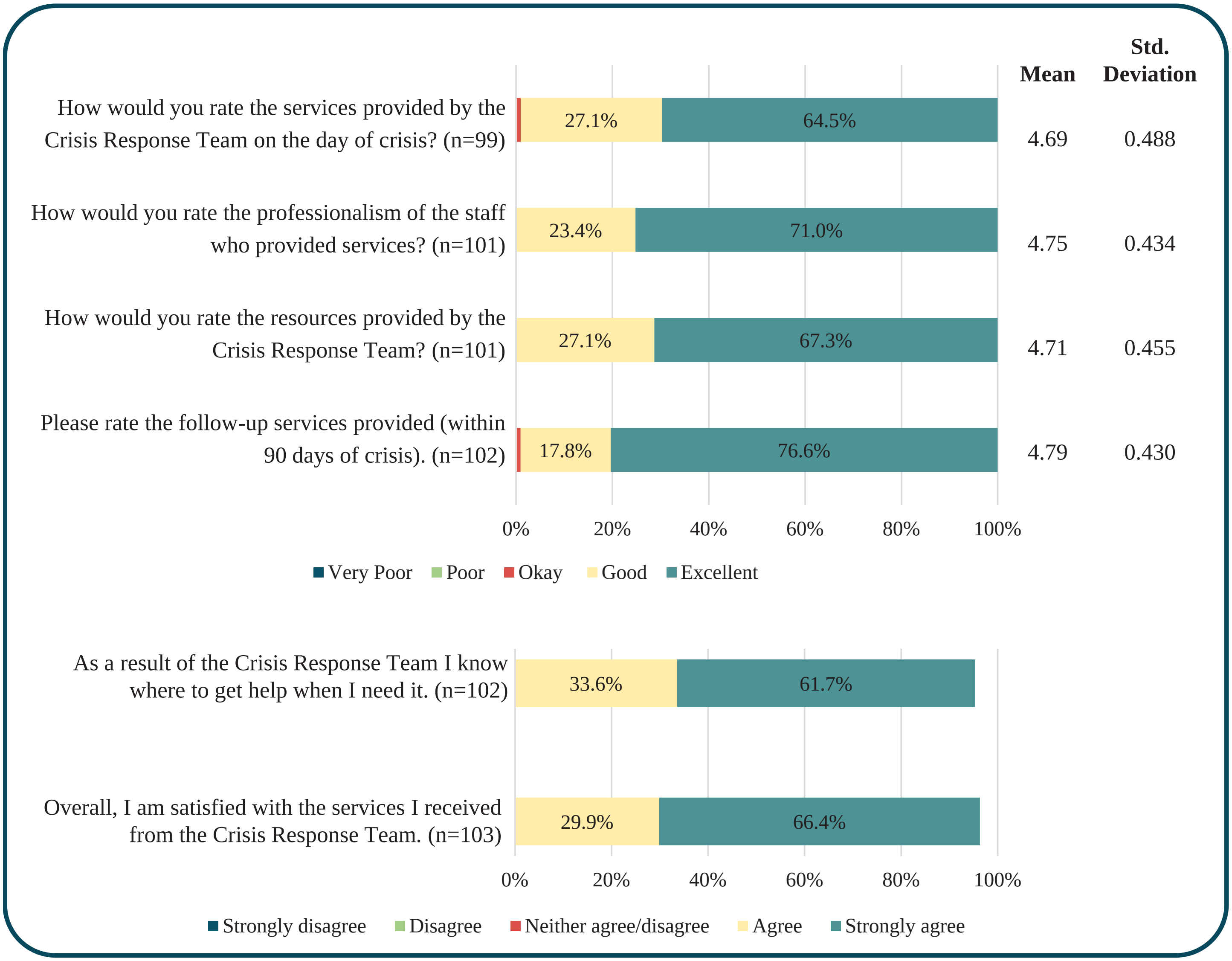
[1] Percentages may not total to 100% due to rounding. [2] A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).

CRISIS RESPONSE TEAM SERVICES FEEDBACK SURVEY

Persons who had received services from the Crisis Response Team were asked to provide feedback about their interactions with the team at the end of the follow-up service period (within 90 days of the initial crisis event). The results from the completed surveys are presented in Figure 1. In general, participants indicated high assessments of their experiences with the team and the services they provided (e.g., approximately 65-75% provided the highest rating of "excellent" for each question domain). Nearly all respondents agreed (29.9%) or strongly agreed (66.4%) with the statement indicating satisfaction with services received.

Figure 1. Crisis Response Team Service Feedback Survey



PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 11 respondents from the 17 persons invited to participate in the survey, a response rate of 65%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *The major program goals identified by staff:*
    a. To provide services that de-escalate crisis situations (e.g., attempted suicides, domestic violence, etc.)
    b. To provide resources
    c. To restore peace back into people's homes and provide emotional support
    d. To provide care and support from a faith-based perspective
    e. To encourage counseling services
    f. To provide follow-up services after crisis
    g. To provide hope

2. *Factors that helped the program achieve goals:*
    a. Resource information (e.g., a resource binder)
    b. Availability of behavioral health staff and clergy as needed
    c. Experienced/knowledgeable clergy and behavioral health professionals
    d. Team member skills (e.g., active listening skills, ability to normalize feelings, etc.)
    e. Existing relationships within the community
    f. Responding quickly to hotline calls
    g. Team commitment to support others/make difference in the community
    h. Timely follow-up (e.g., within days) after crisis contact
    i. The team originating from the community in need
    j. Marketing
    k. Multidisciplinary team
    l. Communication with law enforcement
    m. In-home visits or meeting the clients where they are

3. *Factors that inhibited the program from achieving goals:*
    a. Limited interagency coordination and communication (e.g., police, fire, etc.)
    b. Identified individuals declining assistance
    c. Not enough resources to meet service needs
    d. Lack of promotion to the community
    e. Families not having good experiences with services in the past

4. *Recommendations to help the program better achieve goals*:
    a. Better interagency coordination (e.g., police, fire, etc.)
    b. Increased funding
    c. Giving the program time to grow
    d. Police and fire departments agreeing to send referrals
    e. Capacity to provide long-term follow-up care with clients
    f. Consolidation of resource information
    g. Ability to receive calls from multiple sources (e.g., pastors, community leaders)

5. *Key program strengths:*
    a. Strength of the team & support provided to each other
    b. Needed resources and help being provided to the community
    c. Quality of the crisis intervention program
    d. Offering integrated faith based mental health services
    e. Using a team approach to providing services
    f. Community relationships

6. Key program 'innovations" making the program unique:

a. Faith based aspect of services
b. Service is available 24/7
c. Collaboration with law enforcement
d. Minority groups being served by professionals
e. High-risk populations being helped
f. Bilingual staff
g. Staff training/background is multidisciplinary
h. Connections within the community
i. Recipients of the service feel that staff really care

7. Desired supports, tools, and/or trainings for the program:

a. Additional mental health/crisis training
b. Facilitate communication and training between law enforcement and crisis team
c. Additional faith training (e.g., incorporating faith material into crisis situations)

8. Impact of the faith based aspect of the program on services provided:

a. Allows those who receive the service to incorporate their faith into the process
b. Supplies hope & relief
c. Provides a necessary component to connect with the community
d. Faith based services can increase trust & acceptance
e. Not all providers are open to faith based aspects

9. Factors that contribute to successful follow-ups after a crisis:

a. Phone contact
b. Provider skill set (e.g., demonstrating caring)
c. Learning and remembering names
d. Timeliness of follow-up
e. Resources specific to client's needs
f. Fulfill any promises made

10. Recommendations on how to educate other service personnel (e.g. police, fire) about Crisis Response Team services:

a. Have presentations/meetings/make phone calls to market to, and educate, police departments and fire departments about the program
b. Distribute materials periodically to remind police departments and fire departments about program
c. Encourage service personnel to work as a team with the faith based Crisis Response Team

11. Ideas on how to educate the general community about Crisis Response Team services:

a. Work as a team
b. Share information with other service providers/agencies
c. Present information at INN Community Education presentations (i.e., Task Order 2)
d. Share information in churches and other faith-based organizations
e. Educate the community about the benefits
f. Develop marketing materials (e.g., a brochure)
g. Conduct prevention trainings (e.g., substance use, domestic violence)
h. Highlight the need for services

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Good faith based and behavioral health reputation in community promotes credibility.
2. Good intra- and inter-agency coordination and communication is essential for effective program operations (e.g., crisis teams, BHS, PD, FD).
3. Team-based approach relies on collaborative, passionate, and skilled team members.
4. Faith-based approach promotes participant trust and openness.
5. Faith-based approach facilitates crisis de-escalation by utilizing existing beliefs and support mechanisms.
6. Must be able to provide quick response time at all hours to meet participants' needs in time of crisis.
7. Provide full information resource packet to all participants since they may not articulate all needs during initial contact.
8. Referrals or "warm hand-offs" to other resources such as counselors or psychiatrists can be challenging since the person has already established trust and shared sensitive information with the crisis response team member.
9. After initial interaction, some participants contact program directly if same/similar crisis emerges as a form of "pre-911" call.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Encouraging people to spread information via 'word of mouth' is an effective way to establish trust in the community.
2. Educating and engaging with pastors is essential as they can be a 'first line of defense' and recommend that persons call the Crisis Response Team.
3. There often are more community resources available for women with children than there are for men with children.
4. After trust has been established in the community, some participants may prefer to contact the Crisis Response Team instead of the police.
5. If police were not contacted prior to involvement by the Crisis Response Teams, knowing the appropriate time to call the police during a crises situation can be difficult and requires ongoing training and discussion.

YEAR 2 PROGRAM CHANGES

During FY 2017-18, the INN-13 Faith Based Initiative Task Order 3 Crisis Response Team program added a new community-based organization, Interfaith Community Services, to provide services to the Escondido community.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Improve interagency coordination and communication (e.g., crisis teams, BHS, PD, FD).
   Status: A business card was created and distributed to community partners that can be carried in a wallet or a pocket that contains relevant Crisis Response Team information.

2. Create direct referral mechanism from police and fire departments.
   Status: Establishing direct referrals from police and fire departments was still a work in progress but may not be an ongoing priority if sufficient number of referrals are being generated from faith leaders and direct calls from community members.

3. Identify additional community resources for participants.
   Status: The Crisis Response Teams reported continual updating of their knowledge of local community resources in order to be able to provide accurate and relevant referrals to those who access the Crisis Response Team services.

4. Explore provision of longer-term follow-up care with participants (e.g., additional care and case management services).
   Status: At this time, the programs continue to focus their efforts on short-term support services for up to 90 days after the crisis event and work to connect participants to other community resources for longer-term needs.

5. Explore expansion into other regions/communities.
   Status: Interfaith Community Services was selected to provide Crisis Response Team services to the Escondido community.

6. Develop and implement method for assessing utilization of formal crisis services (e.g., police contacts) after initial visit with crisis response team.
   Status: At this time is beyond the scope of the evaluation to collect police contact information after the initial visit with staff from the Crisis Response Teams.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Increase outreach efforts to community-based organizations in the Escondido area to expand opportunities for referrals to the Crisis Response Team program.
2. Identify and utilize staff with additional language capabilities beyond English and Spanish (e.g., French to better serve needs of immigrants from some African nations).
3. Identify and utilize community resources that can support persons who do not speak English or Spanish (e.g., French to better serve needs of immigrants from some African nations).

For additional information about the INN–13 Faith Based Initiative #3, Crisis Response Team and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #4
WELLNESS & MENTAL HEALTH IN-REACH MINISTRY

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Wellness and Mental Health In-Reach Ministry (WMHIM) is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprises the County of San Diego Heath and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objective of the WMHIM is to engage with inmates who have a serious mental illness (SMI), such as schizophrenia, while they are still in jail and develop a trusting relationship to support the transition back into the community and facilitate linkages to needed behavioral health and non-behavioral health services.

One community organization, Training Center, was selected to provide the WMHIM program. Within target regions in the county, the program was responsible for: 1) attempting to meet regularly with inmates who have a SMI while they are still in jail but are nearing their release date, and 2) offering short-term, post-release follow-up services (up to 90 days) to help individuals successfully transition back into the community by providing emotional support, empowerment, and linkages to appropriate services. An innovative feature of this program is the provision of behavioral health supports and linkages to community resources combined with a faith/spirituality perspective to help promote trusting relationships and personal growth. The emotional support and connections to community resources provided through WMHIM are expected to improve the behavioral health and well-being of those receiving services, which should contribute to lower rates of recidivism.

EXECUTIVE SUMMARY

The Wellness and Mental Health In-Reach Ministry (WMHIM) was designed to engage inmates with SMI while they are still in jail in order to build supportive relationships with them and help them access needed services upon release that will allow them to successfully transition back into the community and reduce future recidivism.

- During FY 2017-18, a total of 234 inmates enrolled into WMHIM, a more than 100% increase from the prior year (n=103).
- Less than 15% of the persons served were female and about 15% were Transition Age Youth (i.e., age 16-25).
- The program served a diverse population, with 36.8% identifying as White, 19.2% as African-American, and 18.4% as Hispanic.
- Analysis of San Diego County jail data indicated a substantial reduction in re-bookings into jail after participants became involved with the WMHIM program. This decrease was evident across both short-term (i.e., 30-day) and intermediate term (i.e., 90-day and 180-day) recidivism analyses. For example, 30-day recidivism dropped from 33.0% before WMHIM to 13.1% and 180-day recidivism dropped from 78.3% to 44.8% before and after enrolling in WMHIM, respectively.
- Similarly, total bookings decreased sharply after involvement with the WMHIM program. Total bookings dropped from 105 before to 36 after WMHIM in the 30-day analyses, and from 400 before to 188 after WMHIM in the 180-day analyses. In both analyses, total bookings dropped by more than 50%.
- Key factors identified by staff that helped the program achieve its goals included: 1) repeated interactions with inmates pre-release, 2) the ability to identify and offer linkages to needed services post-release, 3) prayer and a respectful faith based team, and 4) teamwork between religious and non-religious groups 5) coordination within the team and with external partners to maintain contact with participants post-release.

RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify additional resources for providing and/or linking to safe, affordable housing, and 2) explore options for increasing number of pre-release visits.

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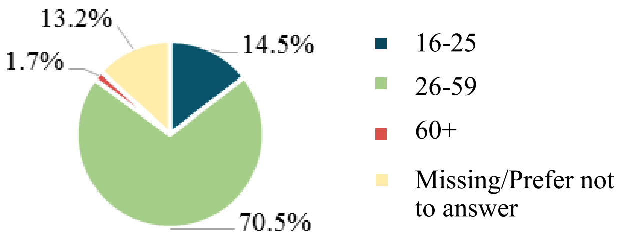
PARTICIPANT DEMOGRAPHICS

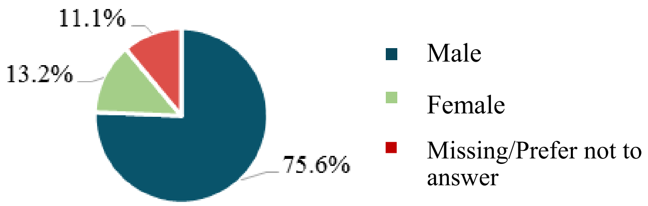
The following demographic data were collected from participants during an initial intake visit.[1]

AGE (N=234)



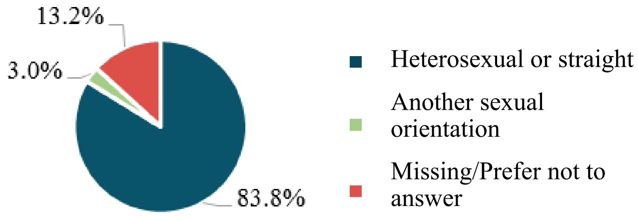
The majority of participants (70.5%) were between the ages of 26 to 59 with 14.5% between ages 16 and 25.

GENDER IDENTITY (N=234)



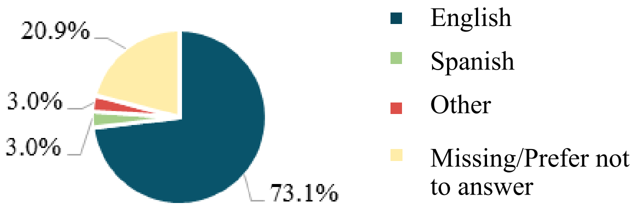
Most participants (75.6%) were male, with females comprising less than one-fifth of those served.

SEXUAL ORIENTATION (N=234)



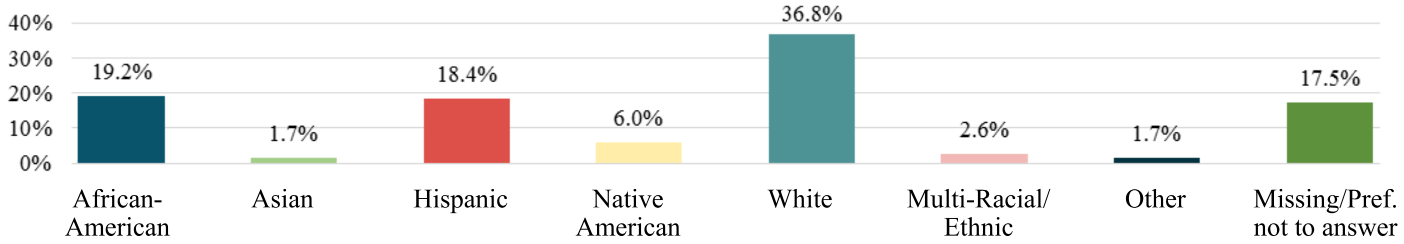
The majority of participants (83.8%) identified as heterosexual or straight.

PRIMARY LANGUAGE (N=234)



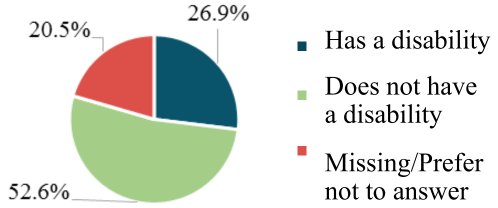
The majority of participants (73.1%) preferred English as their primary language.

RACE/ETHNICITY (N=234)



More than one-third of participants identified as White (36.8%). Similar proportions identified as African-American (19.2%) and Hispanic (18.4%). Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=234)



Close to a quarter (26.9%) of the participants indicated some type of non-SMI related disability.

The majority (73.9%) of participants had never served in the military.

TYPE OF DISABILITY (N=63)

Type	n	%
Communication	15	23.8
Mental (e.g., learning, developmental)	12	19.0
Physical	6	9.5
Chronic Health	3	4.8
Other	30	47.6

The table above describes the types of disabilities participants reported. Totals may exceed 100% as participants could indicate more than one type of disability.

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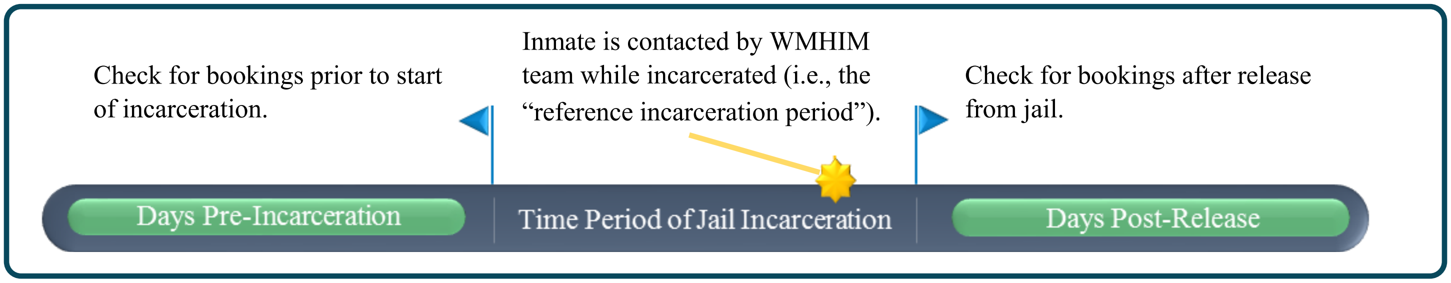
[1] Percentages may not total to 100% due to rounding. [2] A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).

COUNTY OF SAN DIEGO CRIMINAL JUSTICE SYSTEM RECIDIVISM

A primary objective of WMHIM is to reduce future interactions with the County of San Diego criminal justice system after participants are released from jail. To assess the extent to which program participation may be associated with such a decline, the pattern of County jail "bookings" (i.e., interactions with police that resulted in transportation to jail and the assignment of a booking number) was examined before and after involvement with the WMHIM team. The instance of incarceration when first enrolled into the WMHIM program acts as the "reference" incarceration period from which to look forward and backward in time to determine the relevant recidivism information. As illustrated in Figure 1, jail data were reviewed to identify the number of times, if any, inmates had been booked during a 30-, 90-, and 180-day interval before the start of the reference incarceration period (i.e., when first enrolled in WMHIM). We then conducted a similar assessment of the data to identify any bookings that occurred during the 30-, 90-, and 180-day period after being released from jail. To ensure equal observation periods both before and after the reference incarceration period for all analyses, only inmates released at least 180 days before the end of FY 2017-18 (6/30/2018), were included in the recidivism analyses (n=221).

FIGURE 1. ILLUSTRATION OF PROCESS TO COMPARE PRE- AND POST-INCARCERATION BOOKING RATES



As shown in Table 1, at each time interval examined (30-, 90-, and 180-day), the recidivism rate and total number of bookings immediately prior to the reference incarceration (i.e., when the inmate first connected with the WMHIM program) was substantially higher than after initiating involvement with the WMHIM program. For example, of the 221 WMHIM participants included in these analyses, 33.0% (n=73) had at least one booking within the 30 days ***before*** their reference incarceration, but only 13.1% (n=29) had at least one booking within the 30 days ***after*** release from their reference incarceration. When examining a 180-day period before and after the reference incarceration, the corresponding recidivism rates were 78.3% (n=173) to 44.8% (n=99), respectively, and total bookings declined from 400 to 188. The very high recidivism rates and total bookings prior to WMHIM program involvement indicate that the population served by this program was a high need, complex population with frequent justice system contacts. While these analyses do not allow for a specific test of causation, the findings suggest that participation in WMHIM contributed to a reduction in overall and repeat bookings into the County of San Diego jail. While substantial recidivism rate and total booking reductions were evident over both short– and intermediate-term time frames, the level of bookings even after WMHIM involvement indicate that opportunities for further improvements in supporting the transition from jail to back into the community remain.

TABLE 1. COUNTY OF SAN DIEGO BOOKINGS INTO JAIL BEFORE AND AFTER REFERENCE INCARCERATION PERIOD

	Before Start of Reference Incarceration **(Total persons = 221)**	**After Release from Reference Incarceration** **(Total persons = 221)**
At least one bookings within: 30 days	**33.0%** **(n=73)**	**13.1%** **(n=29)**
Total bookings within: 30 days	**105**	**36**
At least one bookings within: 90 days	**63.3%** **(n=140)**	**31.7%** **(n=70)**
Total bookings within: 90 days	**244**	**97**
At least one bookings within: 180 days	**78.3%** **(n=173)**	**44.8%** **(n=99)**
Total bookings within: 180 days	**400**	**188**

ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were nine respondents from the 13 persons invited to participate in the survey, a response rate of 69%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. The major program goals identified by staff:

- a. To build positive relationships with inmates pre-release (e.g., encouragement, mental health counseling, pastoral ministering)
- b. To incorporate a faith based perspective into program services
- c. To encourage and empower releasing inmates
- d. To provide resources and facilitate referrals
- e. To maintain connections with participants post-release
- f. To prevent re-incarceration of releasing inmates with serious mental illness
- g. To help releasing inmates find housing
- h. To help releasing inmates get into mental health programs

2. Factors that helped the program achieve goals:

- a. Accessing and working with inmates over repeated visits prior to their release date
- b. Identifying appropriate service providers and programs
- c. Having complete/accurate information to provide to participants regarding services in the community
- d. Lots of prayer/reliance upon one's faith
- e. Using teamwork between non-religious and religious groups to help releasing participants
- f. Facilitating access to needed post-release services
- g. Having coordinated release efforts to maintain participant contact
- h. Staff skills

3. Factors that inhibited the program from achieving goals:

- a. Not enough contact with inmates
- b. Lack of available/appropriate housing for participants
- c. Lack of coordinated release efforts (e.g., with the participant, the parole officer, the program where the participant is going)
- d. Lack of participant buy-in (e.g., won't meet or show up at scheduled times, drops out of the program)
- e. Difficulty meeting eligibility requirements for participation in post-release programs
- f. Lack of funding

4. Recommendations to help the program better achieve goals:

- a. Identify ways to increase funding for the program
- b. Increase the amount of housing available for participants being released from programs/facilities
- c. Increase the ability to work with inmates prior to their release date (e.g., increase the number of visits)
- d. Expand program referrals and enrollments
- e. Improve internal communication and coordination
- f. Increase the amount of information received from the jail (e.g., mental health and incarceration histories)
- g. Increase the amount of accurate resource information available to provide to participants

5. Affect of the faith based aspect of the program on services:

- a. Develops rapport and understanding of the personal needs of the inmates (e.g., preference for faith based facility)
- b. Provides hope and purpose with shared faith, prayer, and encouragement through scripture

6. Key "innovations" making the program unique:

- a. Combination of behavioral health expertise and spiritual, faith based support
- b. Comprehensive support (e.g., transportation, finance, self-improvement, weekend hours)

ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

7. Key strengths of the program:

- a. The combination of spirituality and mental health
- b. The quality of contact with inmates (e.g., one on one, personalized, empowering)
- c. Having a unified passionate team
- d. The training employees receive
- e. The ability to achieve positive changes (e.g., lessening recidivism)
- f. Resource knowledge (e.g., community programs, eligibility requirements)

8. Desired supports, tools, and/or trainings for the program:

- a. Accurate resource information (e.g., community programs, eligibility requirements)
- b. More information on current programs and services for inmates and individuals with a mental illness
- c. A "dispatch" like position to track/communicate current and accurate program participant information
- d. Increased ability to work with inmates over multiple visits prior to their release date

9. Primary strategies for connecting/developing relationships with inmates prior to release from jail:

- a. Visiting with inmates frequently
- b. Listening without judgment and empowering participants with support and encouragement
- c. Sharing faith (e.g., personal stories, journeys towards faith, prayer)
- d. Offering the potential of safe housing post-release
- e. Combining of behavioral health and faith based approaches

10. Primary strategies for maintaining contact with participants after they were released from jail:

- a. Providing or acquiring relevant phone numbers
- b. Encouraging and proving logistical support to maintain contact (e.g., regular “check-ins”)
- c. Making in-person contacts (e.g., homes, treatment programs, shelters)
- d. Keeping track of where the participant is currently living
- e. Administrative factors (e.g., internal procedures/defined roles about who will maintain contact)

11. Factors that prevented/inhibited linking participants to services and supports:

- a. Limited time to work with inmates and coordinate program referrals prior to release
- b. Not enough services for participants with serious mental illness
- c. Restrictions in program eligibility
- d. Lack of participant buy-in/motivation
- e. Not enough housing/treatment beds
- f. Lack of funding

12. Affect of inmate substance abuse (history or current) on linkages/supports:

- a. Detox/drug dependency may prevent released inmate from moving forward
- b. Easier to obtain services with substance abuse history than with history of mental illness
- c. Lack of beds in treatment facilities
- d. Substance abuse may affect coherence and willingness to receive help
- e. Substance abuse issues requires staff to know more about available treatment and housing resources

13. Recommendations to improve the program:

- a. Increase coordination and communication with community programs to ease the process of inmate acceptance/intake
- b. Increase housing facilities with appropriate services
- c. Hire more staff to provide support and develop rapport
- d. Identify more services that address recidivism for persons with serious mental illness

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Multiple pre-release contacts are important relationship building opportunities that facilitate maintaining post-release connections with participants.
2. Providing post-release transport facilitates maintaining post-release connections with participants.
3. Need a flexible team that can be available on short-notice and during non-traditional work hours to respond to unpredictable jail release timing and challenges that may arise at anytime after release.
4. Access to safe post-release housing is often limited, which then becomes a primary post-release focus for participants.
5. Participants often need a range of behavioral health and non-behavioral health related services after release.
6. Linking to relevant outpatient and residential treatment services can be challenging (e.g., limited availability within desired geographic areas, strict eligibility requirements, program waitlists, participant focusing on other needs).
7. Integrating behavioral health knowledge and a faith/spirituality perspective facilitates development of supportive and empowering relationships with inmates with SMI.
8. The personal "lived experience" of program staff and volunteers with the criminal justice and behavioral health system increases credibility with inmates.
9. While most participants were males, about 20% were females who may experience other types of needs (e.g., child care) and challenges (e.g., domestic violence) that need to be addressed.
10. Initial analyses indicate lower rates of short-term recidivism (i.e., 90-day booking rates) after program participation.
11. Supportive relationships combined with availability of community resources and services appear to be important factors contributing to positive life changes.
12. Additional education, supports, and openness to simplifications where feasible can help small "grassroots" organizations navigate and respond to bureaucratic requirements associated with County of San Diego contracts.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Participation in the WMHIM program appears to be associated with substantial a decrease in short-and intermediate-term recidivism rates and total bookings (as demonstrated in 30-,90-, and 180-day recidivism analyses.
2. Important to know when persons are releasing so that the team can mobilize to meet them in-person and continue their work on connecting them to post-release services.
3. Establishing a post-release assistance/services plan (e.g., housing, treatment, employment, family reunification, etc.) prior to their actual release helps keep inmates engaged and motivated to work with WHIM after they are released.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #4, Wellness and Mental Health In-Reach Ministry, that differed substantially from the initial service delivery model.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Identify additional resources for providing and/or linking to safe, affordable housing.
2. Explore options for increasing number of pre-release visits (e.g., establish regular/specific hours to connect with inmates, etc.).

For additional information about the INN–13 Faith Based Initiative #4, Wellness and Mental Health In-Reach Ministry and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 3 (7/1/17 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Noble Works program is funded through the Innovations (INN) component of the Mental Health Services Act. Noble Works is designed to increase employment of persons with serious mental illness (SMI) with a particular emphasis on expanding employment opportunities beyond traditional low-wage, low-skill positions. Through improvements in their employment situation, Noble Works is expected to also boost participants' sense of empowerment, social connectedness, and overall quality of life. The Union of Pan Asian Communities (UPAC) is the lead agency in the Noble Works collaboration, with Pathways Community Services providing employment services oriented towards transition age youth (TAY) and the National Alliance on Mental Illness San Diego (NAMI SD) providing community presentations and other training supports.

Noble Works utilizes a multi-faceted approach based on Supported Employment principles that target both prospective employers and persons with SMI. Core components of the program include utilization of Employment Specialists, who help participants prepare for and find competitive employment positions of interest, and peer-support Job Coaches, who provide individualized support for maintaining employment. UPAC and NAMI SD conduct community presentations to help reduce stigma and educate potential employers about hiring persons with SMI. Other innovative Noble Works components include: funding for apprenticeships to incentivize hiring persons with SMI, access to the NAMI SD Tech Café, technology-related training and certificate opportunities (e.g., CompTIA A+), entrepreneurial business development supports, and other resources to facilitate employment opportunities.

EXECUTIVE SUMMARY

The Noble Works program (INN-14) is designed to increase competitive employment among persons with SMI by providing extensive pre- and post-employment training and support via Noble Works Employment Specialists and Job Coaches. Noble Works program activities also include outreach to and education of potential employers to decrease stigma and expand awareness of employment opportunities for Noble Works participants.

- During FY 2017-18, there were 109 first-time program enrollees and 3 from a prior year who re-enrolled (112 total enrollees).
- The majority of new enrollees were male (65.1%) and over half (58.7%), were TAY (i.e., age 18-25). Some were employed (11.9%), but most (70.6%) indicated they were not currently working but seeking work.
- To date, approximately 25% of all Noble Works participants obtained at least one job as of 6/30/2018.
- During FY 2017-18, 31 participants acquired a total of 35 jobs through Noble Works, with an average wage of $14.34/hour and 24.1 hours per week (7 full-time jobs). Participants still employed as of 6/30/2018 or at the time they exited Noble Works had been employed in that job for an average of 149.3 days.
- For those who obtained jobs, job satisfaction was positively associated with other aspects of well-being (e.g., sense of belonging, hopefulness about future, etc.), such that persons with high job satisfaction were more likely to have positive perceptions of other life domains as well.
- Noble Works staff identified the following key factors that helped achieve program goals: 1) successful outreach efforts, 2) staff skills and passion, 3) one on one individualized support with staff, 4) access to tools and resources to support participants (e.g. class curriculum, etc.), 5) participant attitudes (e.g., motivation, engagement, etc., and 6) intra-and interagency collaborations.
- Primary factors inhibiting achievement of program goals included: 1) challenges maintaining participant engagement, 2) difficulties with job development/outreach efforts, and 3) high staff turnover.

RECOMMENDATIONS

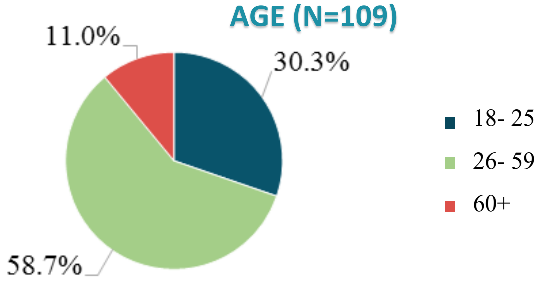
Primary recommendations include: 1) continue transition towards full implementation of the Supported Employment/ Individual Placement and Support service delivery model, 2) continue development and utilization of Neighborhood Enterprise Center employment, training, and business support opportunities, and 3) increased utilization of apprenticeships.

V2019-06-21

DEMOGRAPHICS: NEWLY ENROLLED NOBLE WORKS PROGRAM PARTICIPANTS

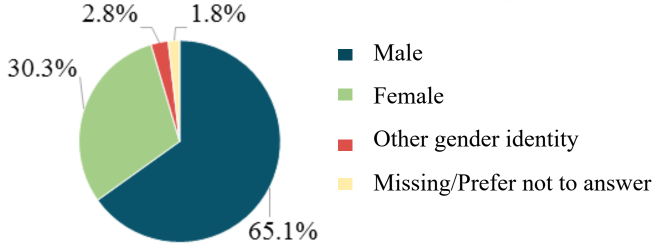
The following demographic data were collected from a participant self-report survey administered when they entered Noble Works.[1]

AGE (N=109)



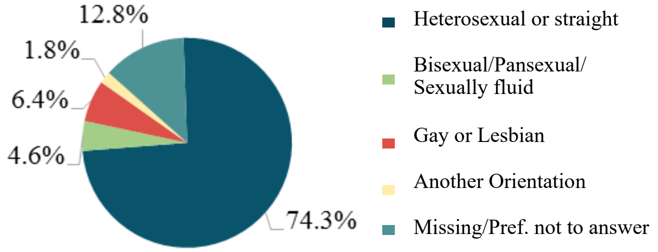
Over half (58.7%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=109)



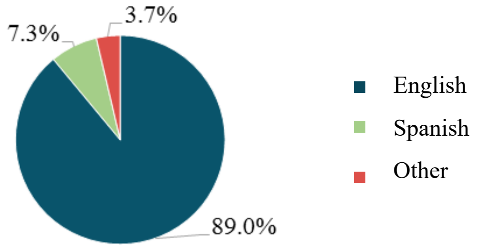
Nearly two-thirds (65.1%) of participants were male and 30.3% were female.

SEXUAL ORIENTATION (N=109)



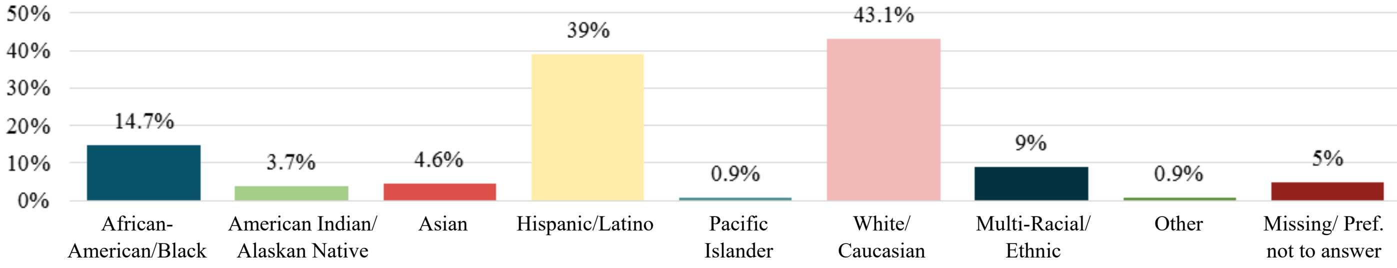
The majority (74.3%) of participants were heterosexual or straight, and 6.4% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=109)



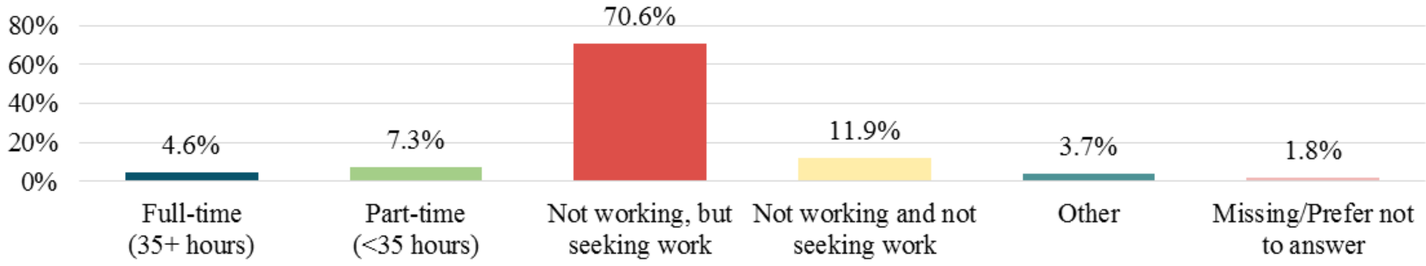
English was the primary preferred language for almost all of the participants (89%).

RACE/ETHNICITY (N=109)



Similar proportions of participants identified themselves as White (43.1%) and Hispanic/Latino (39%). Totals may exceed 100% as participants could indicate more than one race/ethnicity.

EMPLOYMENT STATUS (N=109)



As expected for this type of program, most participants were either not working, but seeking work (70.6%), or in part-time positions (7.3%), when they started Noble Works.

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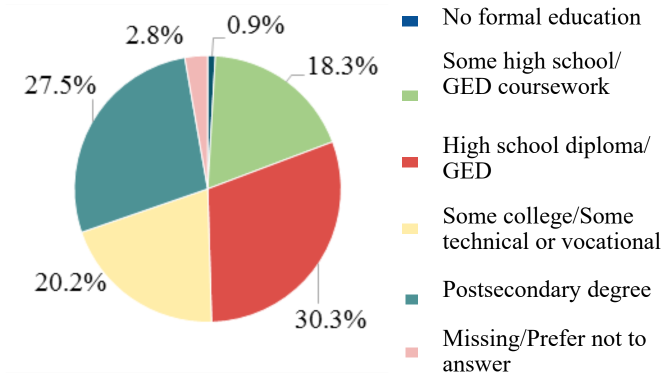
[1] *Percentages may not total to 100% due to rounding.*

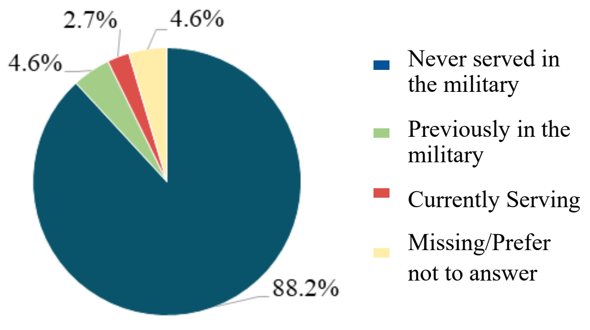
DEMOGRAPHICS: NEWLY ENROLLED NOBLE WORKS PROGRAM PARTICIPANTS (CONTINUED)

EDUCATION LEVEL (N=109)



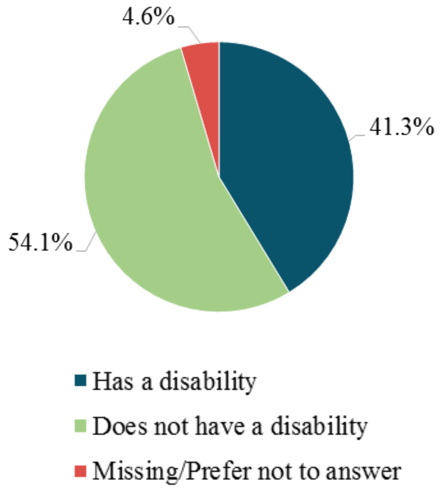
Approximately half of the participants (47.7%) had at least some postsecondary education.

MILITARY STATUS (N=109)



The majority (88.2%), of participants had never served in the military.

DISABILITY[2] STATUS (N=109)



A substantial minority (41.3%) of the participants indicated having some form of non-SMI related disability.

TYPE OF DISABILITY (N=45)

Type	n	%
Physical/Mobility Disability	14	31.1
Learning Disability	11	24.4
Difficulty Seeing	8	17.8
Difficulty hearing/speaking	8	17.8
Chronic Health	8	17.8
Developmental Disability	6	13.3
Other	5	11.1

The table above lists the types of disability participants reported. Totals may exceed 100% as participants could indicate more than one type of disability.

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[2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

JOBS ACQUIRED THROUGH NOBLE WORKS

A total of 35 jobs were acquired by 31 people through the Noble Works program during Fiscal Year 2017-2018. As shown in Table 1, the jobs acquired covered a wide assortment of occupations, with the most common positions in the job domains of food preparation and serving (25.7%), office/administrative support (20%), and sales (20%).

TABLE 1. JOB DOMAINS FOR JOBS AQUIRED THROUGH NOBLE WORKS

	n	%
Building and Grounds Cleaning and Maintenance Occupations	**5**	**14.3**
Business and Financial Operations Occupations	**1**	**2.9**
Community and Social Services Occupations	**2**	**5.7**
Food Preparation and Serving Related Occupations	**9**	**25.7**
Healthcare Support Occupations	**2**	**5.7**
Office and Administrative Support Occupations	**7**	**20.0**
Production Occupations	**2**	**5.7**
Sales and Related Occupations	**7**	**20.0**

The average wage for these positions was $14.34 per hour. Of the 35 jobs obtained, 20% were full-time. The average number of hours worked per week was 24.1. Of the 23 jobs that were either still active as of 6/30/2018 or active at the time of program discharge, the average duration was 149.3 days.

FIGURE 1. CHARACTERISTICS OF JOBS ACQUIRED THROUGH NOBLE WORKS DURING FISCAL YEAR 2017-2018

$14.34

AVERAGE WAGE

Range: $10.5-75/hour

- 9 jobs (25.7%) paid California minimum wage during this time

24.1

HOURS/WEEK

Range: 4-40 hours/wk

- 7 jobs (20%) were "full-time" (i.e., 35 hours or more per week)

149.3

DAYS WORKED

Range: 11-278 days

- 23 jobs (65.7%) were active as of 6/30/2018 or at program discharge

69.7

DAYS WORKED

Range: 21-213 days

- 12 jobs (34.3%) ended prior to 6/30/2018

As shown in Figure 2, for the majority of jobs that ending during FY 2017-18, the primary reason was due to the participant deciding to leave the position. Of note, there were no reported instances of jobs ending primarily due to performance-related issues.

FIGURE 2. PRIMARY REASONS FOR WHY JOBS ENDED DURING FISCAL YEAR 2017-2018

Job End Reason:
(for the 22 jobs ending between 7/1/2017 and 6/30/2018):

54.5%	**Participant decision**
27.3%	**Temp. job/seasonal**
18.2%	**Layoff/store closure**

JOBS ACQUIRED THROUGH NOBLE WORKS

Based on the U.S. Department of Labor Occupational Information Network (O*NET) Standard Occupational Classifications (SOC), most of the jobs obtained through the Noble Works program required either little/no preparation (28.6%) or some preparation (51.4%) as shown in Table 2. This is generally consistent with the finding that 25.7% of the jobs started at minimum wage. During this past year Noble Works was able to expand job placement opportunities to include a position in Category 5 (i.e., occupations that need extensive preparation). Approximately 20% of the jobs obtained were Category 3 or above, which was similar to the percentage of Category 3 or higher job obtained in the prior year.

TABLE 2. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	**10**	**28.6**
2 - Occupations that need some preparation	**18**	**51.4**
3 - Occupations that need medium preparation	**4**	**11.4**
4 - Occupations that need considerable preparation	**2**	**5.7**
5 - Occupations that need extensive preparation	**1**	**2.9**

As shown in Figure 3, 10.1% of the participants who enrolled in Noble Works during FY17-18 obtained a job by the end of the year (6/30/2018). Since it typically requires some time to find a job, it is not surprising that the prior year cohort had a higher placement rate (32.0%) given they have been with the program longer. Overall, 24.4% of the 283 unduplicated Noble Works participants had obtained at least one job by 6/30/2018. Notably, TAY appear to be as likely and timely as adults in finding jobs through the Noble Works program. However, TAY are more likely than adults to leave the program before getting a job. While many of the jobs were found within 3 months of entering Noble Works, some participants may take six or more months to find their first job.

FIGURE 3. NOBLE WORKS OVERALL AND COHORT SPECIFIC JOB ACQUISITION DATA

CURRENT YEAR COHORT
(7/1/2017 - 6/30/2018)

- 109 new participants
- ***10.1% ever employed*** (as of 6/30/2018); this rate will increase as some get jobs in the next year
- Days to first job was quite varied, but generally it took nearly 3 months, similar to year 2 cohort (average = 83.1 days; SD = 88.1)
- TAY as likely as adults to get jobs (9.1% v 10.5%)

PRIOR YEAR COHORT
(7/1/2016 - 6/30/2017)

- 97 new participants
- ***32.0% ever employed*** (as of 6/30/2018)
- Days to first job was quite varied, but generally it took nearly 3 months (average = 82.3 days; SD = 72.1)
- TAY as likely as adults to get jobs (31.6% vs. 32.2%)

LIFE OF PROGRAM
(12/1/2015 - 6/30/2018)

- 283 unduplicated participants
- ***24.4% ever employed*** (as of 6/30/2018)
- Time to jobs acquisition in recent years generally occurred more quickly than those who enrolled in Year 1 (average = 155.2 days)
- Difference between TAY and adult job acquisition rates evident in Year 1 has been eliminated

NOBLE WORKS BUSINESS START-UP ACTIVITIES

During Year 3, Noble Works provided financial support and technical assistance to help two participants start businesses.

NOBLE WORKS SOCIAL ENTERPRISE ACTIVITIES

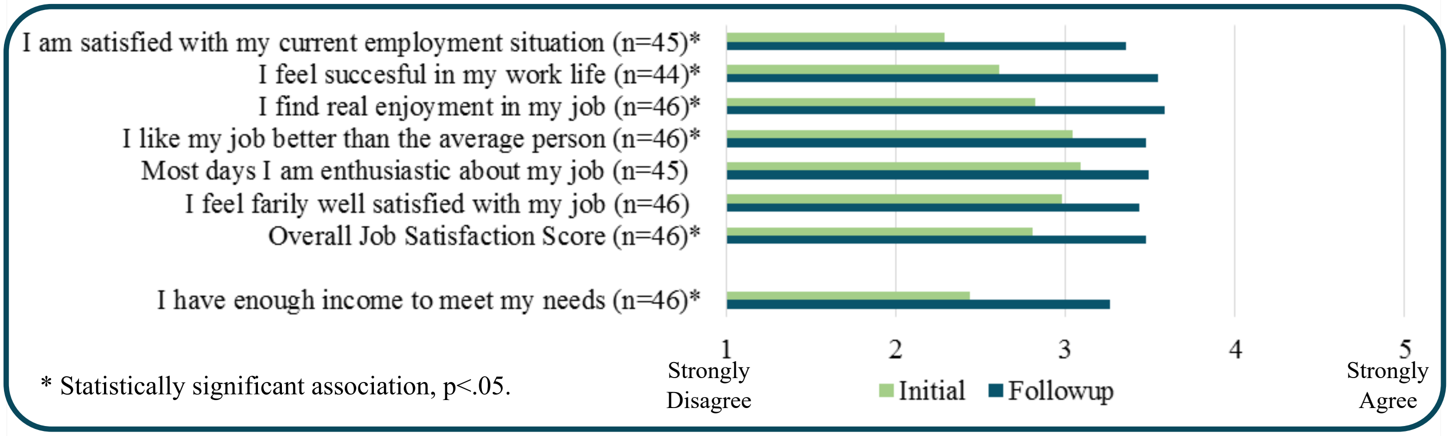
During Year 3, Noble Works assisted in the development of the Neighborhood Enterprise Center and participants received culinary arts training/employment in "Kitchen Creation," a rentable commercial kitchen used by local entrepreneurs to prepare food (e.g., caterers) as well as space to provide culinary arts related trainings/certifications.

EXITS FROM NOBLE WORKS PRIOR TO JOB ACQUISITION

- Of the 198 participants who entered or were still in Noble Works during the current year, 43.4% had left the program prior to obtaining a job as of 6/30/2018.
- TAY were more likely than adults to leave the Noble Works program prior to getting a job (59.0% to 34.4%).
- Primary reasons for leaving prior to job acquisition were, 1) no longer interested in Noble Works and, 2) loss of contact between Noble Works and the participant.

As shown in Figure 4, for persons who ever obtained a job through the Noble Works program, each measure of job satisfaction increased substantially from program entry (baseline) to post-job assessment. Starred items had a statistically significant change in mean score from baseline to follow-up (p<.05). The overall job satisfaction score (i.e., the average of all six satisfaction items), increased from 2.8 at baseline to 3.5 post-job (on a scale from 1-5 with higher values corresponding to greater job satisfaction). The statistically significant increases indicated that obtaining a job through Noble Works dramatically improved perceptions of their employment circumstances. While increasing post-job, the sense of having enough income only rose to about a 3 (on a scale of 1-5), suggesting opportunities for further improvements in this area.

FIGURE 4. EMPLOYMENT RELATED SATISFACTION - COMPARISION OF INITIAL AND FOLLLOW-UP RATINGS



* Statistically significant association, p<.05.

Table 3 presents key associations between overall job satisfaction and items from last completed Recovery Markers Questionnaire (RMQ). These correlations indicated positive associations between how participants felt about their employment situation and a range of other life domains related to their sense of belonging, personal growth, future aspirations, and symptom reduction. While a causal relationship cannot be determined through these analyses, the results suggest a strong correlation between job satisfaction and many of the other life domains that Noble Works is designed to improve through increased and better employment opportunities. These results support the initial premise of the Noble Works program and are consistent with research highlighting the importance of work and job satisfaction on many quality of life aspects for persons with SMI. It is interesting to note that job satisfaction at follow-up was *not* related to participants' beliefs about whether they would be working in 6 months.

TABLE 3. CORRELATIONS BETWEEN RMQ ITEMS AND OVERALL JOB SATISFACTION AT FOLLOW-UP FOR PERSONS WHO AQUIRED A JOB THROUGH NOBLE WORKS

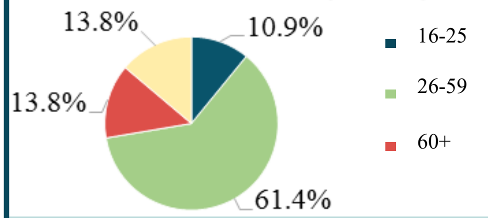
	Overall Job Satisfaction Score
RMQ Responses at Follow-Up	**Correlation**
My symptoms are bothering me less since starting services here (n=46)	**.623***
I have more good days than bad (n=46)	**.623***
I have enough income to meet my needs (n=46)	**.582***
I have a sense of belonging (n=46)	**.541***
I feel hopeful about my future (n=46)	**.479***
I have goals I'm working to achieve (n=46)	**.418***
I am growing as a person (n=45)	**.334***
I am learning new things that are important to me (n=46)	**.328***
I see myself (still) working in 6 months (n=46)	**.264**

* Statistically significant association, p<.05.

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

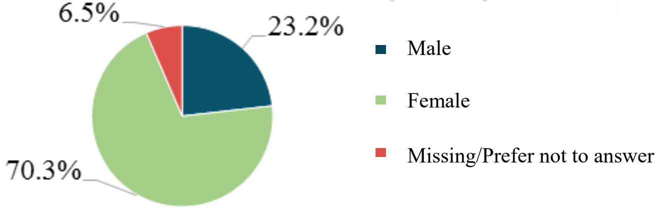
During Year 3 NAMI SD, a Noble Works program partner, conducted 22 "In Our Own Voice" (IOOV) community outreach and education presentations regarding mental illness and recovery in their ongoing efforts to reduce mental health stigma in the community. Either in conjunction with NAMI SD, or independently, Noble Works representatives also conducted 33 "Trainings to Businesses" presentations that provided mental health related education to potential employers. The charts below provide an overview of select presentation attendee demographics and outcomes.[3]

AGE (N=448)



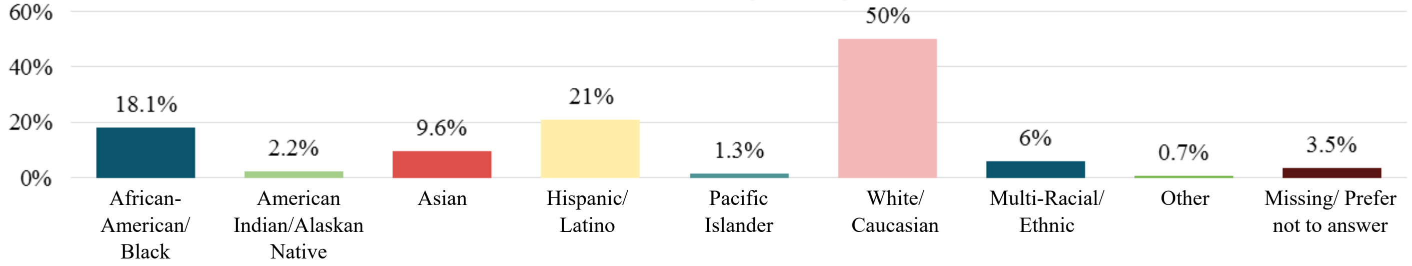
About two-thirds (61.4%) of attendees were age 26-59.

GENDER IDENTITY (N=448)



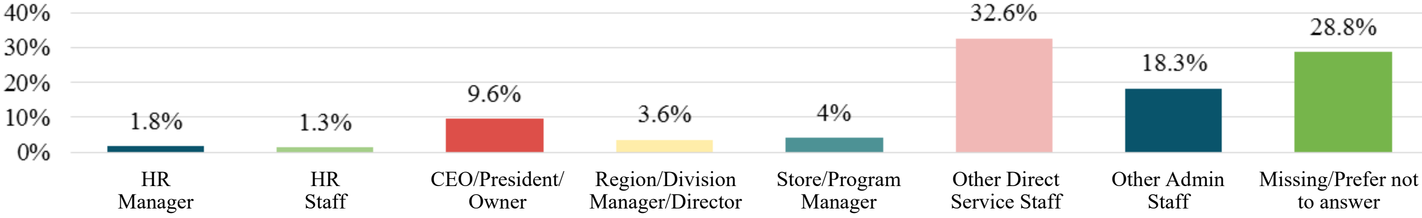
The majority of attendees were female (70.3%).

RACE/ETHNICITY (N=448)



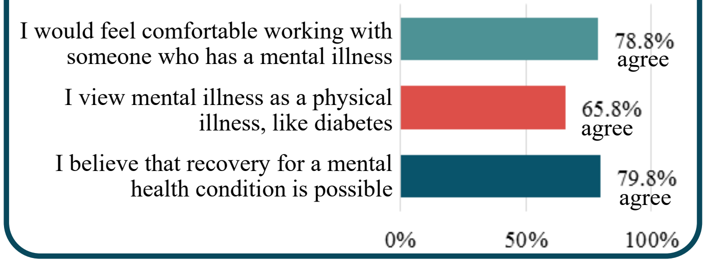
The majority of attendees were White/Caucasian (50%), with 21% indicating an Hispanic/Latino background. Totals may exceed 100% as attendees could indicate more than category.

TYPE OF RESPONDENT (N=448)

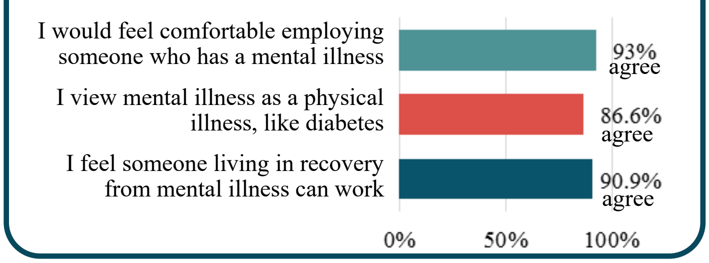


About one-third (32.6%) of the attendees identified themselves as direct service staff, with close to twenty percent (18.3%) identifying as administrative staff.

NAMI SD IOOV PRESENTATION OUTCOMES (N=292)



NOBLE WORKS PRESENTATION OUTCOMES (N=187)



The majority of respondents indicated positive attitudinal changes as a result of NAMI SD's IOOV and Noble Works "Training to Businesses" presentation. These findings reflect ongoing efforts to normalize attitudes about mental health in the workforce. However, more improvements are possible since only 65.8% from IOOV indicated viewing mental illness similar to a physical illness.

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[3] *Percentages may not total to 100% due to rounding.*

ANNUAL NOBLE WORKS STAFF FEEDBACK SURVEY

At the end of the third year of providing Noble Works program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Noble Works program. There were eight respondents from the 16 persons invited to participate in the survey, for a response rate of 50%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Concerns about staff turnover continued to be identified as a substantial issue affecting program operations. The majority of respondents (62.5%; n=8) rated staff turnover as a “very challenging” issue for the program (on a 5-point scale ranging from “not challenging at all” to “very challenging”).

1. *Primary factors that facilitated the achievement of program goals:*
    a. Outreach efforts (e.g., personalized outreach to small businesses, community presentations)
    b. Staff skills and passion to support participants and work towards program goals
    c. Participants being able to work one on one with either an employment specialist or a job coach
    d. Program tools/resources available to educate and support participants (e.g., employment leads, classes, community backing)
    e. Participant attitudes (e.g., motivation, engagement)
    f. Intra- and interagency collaboration
2. *Factors that inhibited the achievement of program goals*:
    a. Staff uncertainty about job roles/tasks (e.g., communication methods with participants and employers)
    b. Challenges maintaining participant motivation and engagement
    c. Outreach efforts not reaching the right types of businesses, employers, or the community
    d. High staff turnover
    e. Intake process inhibits quick engagement with participants and connections to potential employers
3. *Impact of trainings and business development opportunities:*
    a. Increases the chances that a participant will be hired
    b. Contributes to the quality/marketability of the program as a whole
    c. Capitalizes on the strengths/interests of participants
    d. Enhances the learning opportunities
4. *Outcomes of employer-oriented community presentations:*
    a. Increased awareness and understanding about SMI
    b. Effectiveness would increase if employers were targeted based on participant needs
    c. Increased credibility of the program
    d. Facilitated community partnerships
5. *Challenges obtaining and maintaining participant employment:*
    a. Participant motivation levels
    b. Participants not properly managing their symptoms
    c. A lack of suitable jobs
    d. Participants who want a 'dream job' but do not want to take classes, trainings, or certifications to qualify
    e. Unrefined work skills (e.g., communication skills, appropriate behavior, how to leave a job with grace)
6. *Challenges developing job opportunities with employers:*
    a. Breaking stigma associated with mental health
    b. Resistant employers that are not interested in learning about Noble Works or getting to know clients
7. *Factors that facilitated ongoing consumer engagement:*
    a. Staff efforts to build relationships and maintain supportive contact with participants
    b. The unique program opportunities (e.g., Kitchen Creations, Tech Café)
    c. Resources and incentives for participants
    d. Participants seeing the progress they have made

KEY YEAR 1 NOBLE WORKS PROGRAM “LEARNINGS”

1. High staff turnover was a major challenge to Noble Works’ implementation and operations.
2. Program “start-up” issues (e.g., hiring, training, establishing facilities, collaborating with partners, developing trainings) required substantial time commitments during Year 1.
3. Participant satisfaction with their employment situation increased after participating in the Noble Works program.
4. Participant satisfaction with their employment situation was positively associated with a range of other self-reported indicators of their well-being (e.g., self-fulfillment, social connectedness).
5. It was challenging to identify jobs that were of interest to as well as a good skills match for Noble Works participants.
6. Identifying and educating potential employers was difficult, but this objective was perceived as crucial for increasing the pool of known employment opportunities.
7. Noble Works staff were passionate and committed to achieving program objectives.
8. Staff trainings, such as in Supported Employment evidence-based practices, supported the achievement of program objectives.

KEY YEAR 2 NOBLE WORKS PROGRAM “LEARNINGS”

1. Staff perceived both benefits (e.g., role expertise/specialization) and challenges (e.g., potential client confusion and relationship disruption with staff) associated with separating the roles of Employment Specialist and Job Coach.
2. Program was successful at identifying a diverse set of jobs for participants.
3. Difficult to maintain participant motivation throughout process.
4. Poor symptom management perceived as a barrier to job acquisition.
5. Job placement timing varied substantially (25% of first jobs found in less than a month in program; another 25% of first jobs found after 6 months in program).
6. Job placement rates improved from Year 1, but were lower than traditional Supported Employment programs.
7. TAY had lower rates of job acquisition then adults/older adults.

KEY YEAR 3 NOBLE WORKS PROGRAM “LEARNINGS”

1. The development of the multi-faceted Neighborhood Enterprise Center has created new opportunities for the Noble Works SMI population for employment and job-specific training and certifications.
2. Training and certification programs need to be reviewed cautiously to promote greater likelihood that the time required of program staff and participants will lead to specific employment opportunities.
3. The development of job mentors as part of the Noble Works program was difficult to establish, with few people interested in acting as a job mentor for Noble Works participants.
4. The Noble Works program has demonstrated the capability for business “start-ups” among the SMI population, but typically only relevant for a small portion of those served by Noble Works.
5. In general, approximately 20% of jobs acquired through Noble Works were classified as needing at least a “medium” amount of preparation, skills, and/or experience (i.e., SOC Job Zone of Category 3 or higher).
6. Community presentations with employers appear to have helped with overall mental health awareness and stigma reduction but did not often contribute to the identification of new employers with employment opportunities for Noble Works participants.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Explore opportunities for enhanced coordination/communication with participant's behavioral health treatment providers.

   Status: No new processes related to coordination/communication with behavioral health providers, but this has generally improved as providers are becoming more familiar with Noble Works staff and primary objectives of the program.

2. Consider consolidating Employment Specialist and Job Coach into one role where staff conduct all phases of job search, placement, and support processes.

   Status: The Employment Specialist and Job Coach roles were combined as part of the transition to the Supported Employment/Individual Placement and Support model of service delivery. In this model, each staff person works on all facets of the job identification, placement, and support process.

3. Increase group caseload supervision to occur weekly.

   Status: The program decided not to implement weekly caseload supervision given the other existing opportunities for supervision (caseload review twice a month, individual supervision twice a month, and monthly full team meeting with external partners).

4. Implement system for tracking date of first face-to-face contact with employers.

   Status: Tracking date of first face-to-face contact was implemented during FY17-18.

5. Review closure process to ensure that services and supports are provided as long as desired by participants.

   Status: Program closure process allows for ongoing interaction with participants as desired (no predetermined time period of program participation). If after multiple attempts a participant no longer engages with the program a letter will be mailed to last known address letting them know their case/account will be closed unless they initiate contact with the program.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Noble Works program and increase opportunities for employment for persons with SMI include the following:

1. Continue the transition towards full implementation of the Supported Employment/Individual Placement and Support service delivery model.
2. Continue the development and utilization of Neighborhood Enterprise Center employment, training, and business support opportunities.
3. Increased utilization of funded apprenticeships.

YEAR 3 PROGRAM CHANGES

During the end of FY17-18, the INN-14 Noble Works program began a transition to more closely reflect the standard practices and procedures of the structured Supported Employment/Individual Placement and Support model of service delivery. This primarily entailed ending some of the job classes and combining the Job Coach and Employment Specialist roles into one position so that all staff work on all stages of the job identification, placement, and post-employment support process.

For additional information about the INN–14 Noble Works program and/or this annual report, please contact:

David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

PEERLINKS/PEER ASSISTED TRANSITIONS (INNOVATIONS-15)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Peer Assisted Transitions (INN-15 PAT) program, was funded through the Innovations (INN) component of the Mental Health Services Act. This program was subsequently renamed to "PeerLINKS" to better reflect the services it provides and is henceforth referred to by this name. The primary innovation component of PeerLINKS is to increase the depth and breadth of services for persons diagnosed with serious mental illness (SMI) who use acute crisis-oriented mental health services but are not effectively connected with community resources and/or lack active support networks through the provision of peer specialists. During Fiscal Year 2017-18, the program received referrals from Scripps Mercy's inpatient unit and emergency department, UC San Diego's inpatient unit, Vista Balboa Crisis Center, and New Vistas Crisis Center.

EXECUTIVE SUMMARY

PeerLINKS was designed to provide a culturally-competent, recovery-focused program for adults with SMI who receive care at two psychiatric hospitals and crisis residential facilities. The program started operation on July 1, 2016 with participants enrolled in the program from November 2016 onwards.

- During Fiscal Year 2017-18 a total of 272 participants were newly enrolled in the program.

Participant Demographics

- The majority of participants were between the ages of 26 and 59 (79%), equal percentages of male and female (47%), 76% were heterosexual, English was the primary language for the large majority (96%), and 54% were White/Caucasian. A small number of participants were veterans.
- Half of the participants reported having a non-SMI related disability. The majority reported other non-SMI related disabilities (18%) and/or chronic health conditions (16%).

Participant Rated Outcomes and Program Satisfaction

- The large majority of participants were satisfied with the services they received (97.3%), and as a result of the program, 92.5% knew where to get help when needed, 90.5% were more comfortable seeking help, and 82.2% were better able to handle things.

Participant Outcomes: Participants improved on a range of assessments.

- **Milestones of Recovery Scale (MORS):** Overall, participants increased in their MORS score from an average of 2.2 (experiencing high risk/not engaged) to 4.9 (not coping successfully/engaged). Eighty-six percent improved on the MORS, 10% remained stable, and 4% of participants decreased.
- **Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS):** Pre-post data on the CHAMPSSS showed that participants had increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and had more people actively support them in recovery. In addition, participants demonstrated statistically significant increases on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales.

Health and Substance Use

- Pre-post data on the Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health demonstrated improvement in both Global Physical Health and Global Mental Health scores. The improvement on the Global Mental Health Scale suggested a meaningful change. Average scores were in the moderate to mild symptoms range, with participants showing a higher level of physical health compared to their mental health.
- On average, participants showed improvement in all substance use related questions (PROMIS-Derived Substance Use) at baseline and most recent follow-up assessment, indicating less substance use treatment need.

Housing and Employment

- A total of 43.8% of participants moved into less restrictive and more independent housing. The average housing level improved from 3.3 at baseline to 4.3 at the most recent assessment. Pre-post data on housing outcomes indicate that the total number of participants and the total number of days being homeless decreased.
- Pre-post data on employment outcomes showed that the percentage of participants who were competitively employed increased from 5.8% to 18.1%. The number of participants who identified as unemployed decreased from 87.0% to 64.5%. The majority were unemployed due to mental health symptoms or disability.

Linkages to Services

- Overall, 1,585 successful connections to services or resources were made. Participants could be connected to multiple services. For mental health services, 259 successful connections were made for 119 participants. For substance abuse services, 100 successful connections were made for 52 participants.

Service Utilization

- The number of emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to follow-up assessment based on participant self-report. Participants experiencing a range of critical events in non-psychiatric hospitalization and jail/prison settings also decreased.
- Overall, participant service utilization based on Cerner Community Behavioral Health system data indicate a decrease in psychiatric hospitalization re-admissions. Among the psychiatric hospital cohort (participants with a hospitalization index event), the recurrence rate decreased by 30.0% after starting the program (25.6% vs 17.9% with any recurrence event).

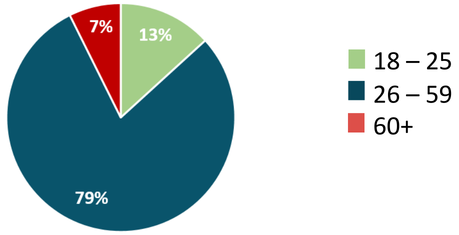
RECOMMENDATIONS

1. To continue to focus on linkages to mental health and substance abuse treatment programs and to improve the tracking of this information, as well as to connect program participants who utilize acute care repeatedly and to connect them to the San Diego County behavioral health system.
2. To systematically capture participants' level of motivation for engaging in the program and working towards their recovery-related goals by adding relevant items to the baseline and follow-up assessments. This information would help the program to explore ways to increase motivation, or support these participants in succeeding despite not being interested in working towards goals.
3. To conduct a "check-in" with discharged participants at approximately three months past discharge and six months, if possible. The check-in will also focus on any changes to the participants' housing situation, employment, and use of emergency services.

PARTICIPANT DEMOGRAPHICS

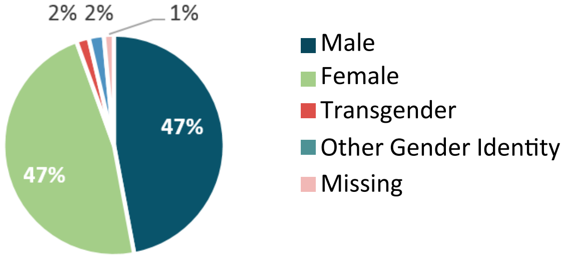
The following demographic data were collected from the intake assessment administered at the start of the program.[1]

AGE (N=272)



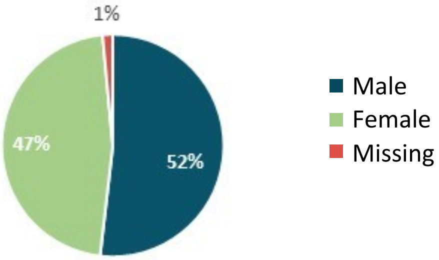
The majority of participants were 26-59 years old (79%), 13% were 18-25 years old and 7% were 60 years or older.

GENDER IDENTITY (N=272)



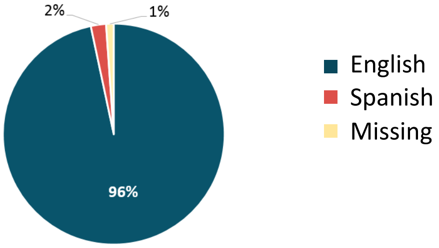
Equal percentages (47%) identified as male and female, and 4% identified as transgender or other gender identity.

SEX AT BIRTH (N=272)



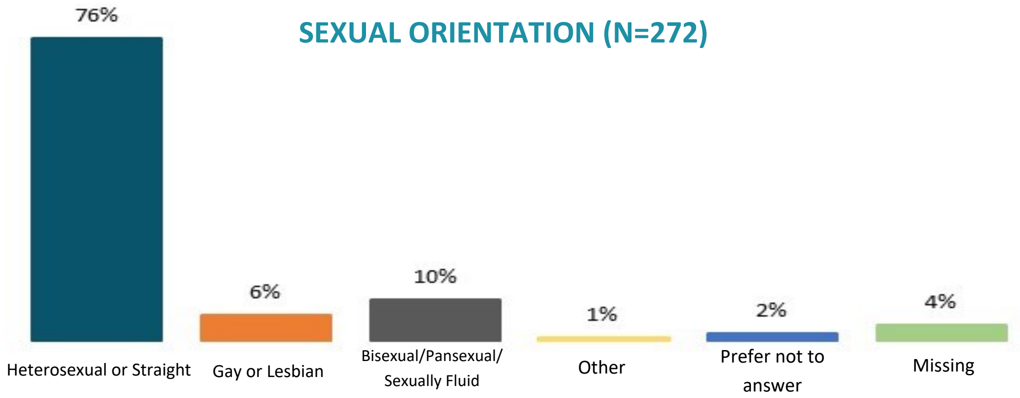
Fifty-two percent were identified as male on their birth certificate and 47% were identified as female.

PRIMARY LANGUAGE (N=272)



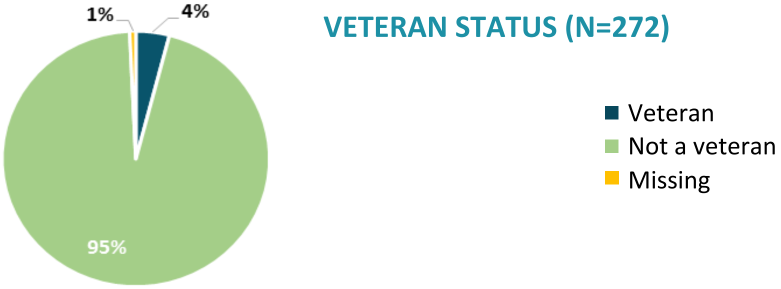
The large majority (96%) of participants spoke English as their primary language.

SEXUAL ORIENTATION (N=272)



Seventy-six percent of participants identified as heterosexual or straight, 6% as gay or lesbian, and 10% as bisexual/pansexual/ sexually fluid.

VETERAN STATUS (N=272)



The majority of participants were not veterans (95%) and 4% were veterans.

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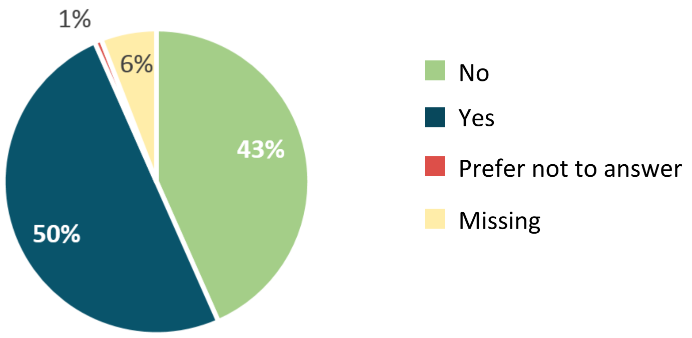
[1] *Percentages may not total to 100% due to rounding.*

PARTICIPANT DEMOGRAPHICS (CONTINUED)

DISABILITY STATUS (N=272)[2]



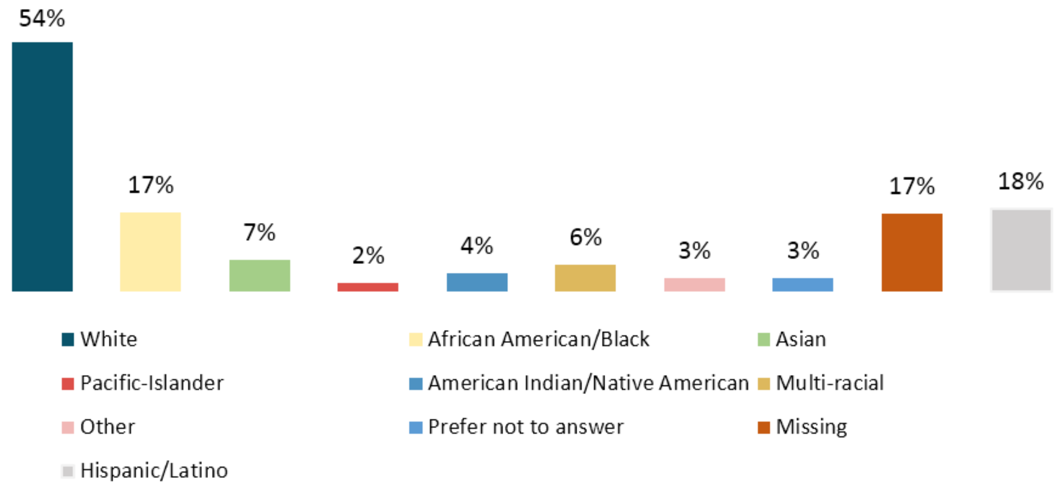
A total of 50% reported having some type of non-SMI related disability.

TYPE OF DISABILITY (N=136)

Type	N	%
Communication	42	30.9
Mental (e.g., learning)	32	23.5
Physical	31	22.8
Chronic Health Condition	44	32.3
Other	50	36.8

This table describes the type of disability indicated by participants. Totals may exceed 100% as participants could indicate more than one type of disability.

RACE/ETHNICITY (N=272)



The majority of participants were White/Caucasian (54%), 17% were African American/Black, and 18% identified as Hispanic/Latino ethnicity. Totals exceed 100% as participants were able to indicate more than one race/ethnicity.

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[2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

KEY EVALUATION FINDINGS

The key evaluation findings are based on a comprehensive set of assessment tools used by PeerLINKS. The assessments are administered by Peer/Family Support Specialists and other trained mental health professionals. They include participant demographics, key outcome domains (housing, employment, and critical events), the Milestones of Recovery Scale (MORS), the Linkage & Referral Tracker, and the Encounter Form. Participants complete an integrated self-assessment, the Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS), which includes the PROMIS Global Health scales (mental health and physical health) as well as items measuring substance use, suicidality, satisfaction, and impact of symptoms on daily activities. In addition, the CHAMPSSS form includes four items measuring satisfaction and participant outcomes, which have been used extensively across a wide range of programs in San Diego County.

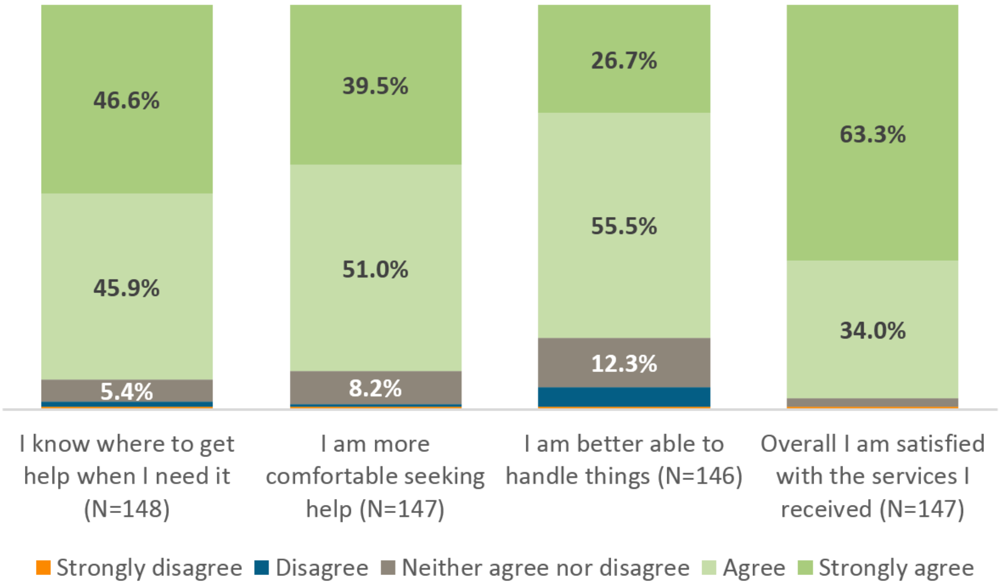
The data are entered into the Mental Health Outcome Management System (mHOMS), an electronic health record system.

PARTICIPANT SATISFACTION AND PARTICIPANT-RATED OUTCOMES

Program participants responded to the post outcome survey, which is completed at follow-up and discharge assessments. The survey captures items regarding knowledge about where to get help, comfort in seeking help, coping, and overall satisfaction with program services. Figure 1 provides data for participants' most recent assessment during FY 2017-18.

Overall, the large majority of participants agreed or strongly agreed that, as a result of the PeerLINKS program, they know where to get help when needed (92.5%), are more comfortable seeking help (90.5%), and are better able to handle things (82.2%). The large majority of participants agreed or strongly agreed that they were satisfied with the services they received at PeerLINKS (97.3%).

Figure 1: Participant Satisfaction and Participant Rated Outcomes



MILESTONES OF RECOVERY SCALE (MORS)

The Milestones of Recovery Scale (MORS) captures recovery as assessed by trained staff using a single-item recovery indicator. Participants are being placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the past month. Although MORS ratings do not comprise a linear scale, higher ratings are associated with greater recovery.

Changes in MORS Ratings Over Time

A total of 150 participants had valid MORS assessments at two (or more) points in time. The data matching process selected the most recent complete MORS follow-up assessment during the reporting timeframe (i.e., FY 2017/18) and matched this to the baseline assessment.

Overall, MORS scores from these 150 participants have been increasing from an average of 2.2 to 4.9 (summarized in Figure 2). This increase was statistically significant. Specifically, as shown in Figure 3, 86.0% of participants improved on the MORS and 10.0% remained stable (no change in score). Only 4.0% decreased.

Figure 2: Change in Average MORS Scores (Pre-post, N=150)

Figure 3: Change in MORS Scores (Pre-post, N=150)

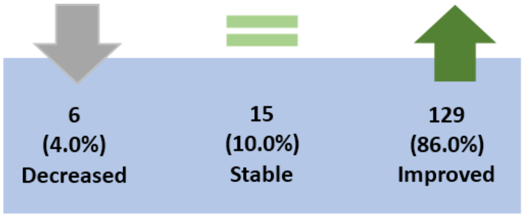


Table 1 compares the distribution of MORS scores at baseline and the most recent follow-up assessment. It is noteworthy that at baseline 87.3% of participants had MORS scores within the extreme risk and high risk categories (scores 1-3) and only 10.0% had scores at or above 5. In contrast, at follow-up, these values were nearly reversed, where only 16.0% had scores in the extreme/high risk categories and 77.3% scored 5 or above.

Table 1: MORS Ratings (Pre-post; N=150)

		Baseline		Most Recent	
1	Extreme risk	41.3%	**87.3%**	3.3%	16.0%
2	Experiencing high risk/not engaged with mental health providers	19.3%		2.0%	
3	Experiencing high risk/engaged with mental health providers	26.7%		10.7%	
4	Not coping successfully/not engaged with mental health providers	2.7%	2.7%	6.7%	6.7%
5	Not coping successfully/engaged with mental health providers	8.7%	10.0%	47.3%	**77.3%**
6	Coping successfully/rehabilitating	1.3%		24.0%	
7	Early recovery	0.0%		4.0%	
8	Advanced recovery	0.0%		2.0%	

COMBINED HEALTH ASSESSMENT: MENTAL, PHYSICAL, SOCIAL, SUBSTANCE, STRENGTHS (CHAMPSSS)

The CHAMPSSS assesses participants' perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded such that higher scores indicate more positive perceptions and experiences.[2]

Changes in Participants' Active Social Support and Recovery Network

Changes in participants' active social support and recovery network were measured based on three items included in the CHAMPSSS. Mean CHAMPSSS items that reflect active social support and recovery networks are displayed in Table 2 below. Compared to baseline, participants reported increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and having more people actively support them in recovery at follow-up. The improvement in responses to the items "In general, how would you rate your satisfaction with your social activities and relationships" and "I had contact with people that care about me" were statistically significant.

Table 2: Means (M) and Standard Deviations (SD) of CHAMPSSS Active Social Support and Recovery Network Items at Baseline and Follow-up (Pre-post)

CHAMPSSS Item	N	Baseline		Follow-up	
		M	SD	M	SD
In general, how would you rate your satisfaction with your social activities and relationships? (Item 5)	146	2.0	1.1	2.5	1.1
I had contact with people that care about me. (Item 10)	147	3.3	1.2	3.6	1.0
Outside of health care professionals, how many people actively support you in your recovery? (Item 32)	130	3.0	3.8	4.7	10.4

Changes in CHAMPSSS Subscales

Mean CHAMPSSS subscale scores are displayed in Table 3 below. On average, participants showed improvement in all of the CHAMPSSS subscales. The increases on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales were statistically significant.

Table 3: Means (M) and Standard Deviations (SD) of CHAMPSSS Subscale Scores at Baseline and Follow-up (Pre-post)

CHAMPSSS Subscale	N	Baseline		Follow-up	
		M	SD	M	SD
Global Health Scale (average of items 1-7, 25, 29, and 30)[2]	149	2.5	0.6	2.9	0.8
Resilience Scale (average of items 8, 9, 10, 11, and 12)	149	3.2	0.8	3.5	0.8
Depression Scale (average of items 13, 14, and 15)	149	2.4	0.8	3.1	1.0
Anger Scale (item 16)	149	3.0	1.1	3.4	1.0
Anxiety Scale (average of items 17, 18, and 19)	149	2.5	0.9	3.1	0.9
Substance Use Scale (average of items 20 and 21)	148	3.7	1.3	4.4	0.9
Memory/Cognition Scale (average of items 22 and 23)	148	3.0	1.1	3.4	1.2
Suicidality Scale (item 24)	148	3.3	1.3	4.2	1.0
Substance Use Frequency Scale (average of items 27 and 28)[3]	146	4.6	0.8	4.7	0.7

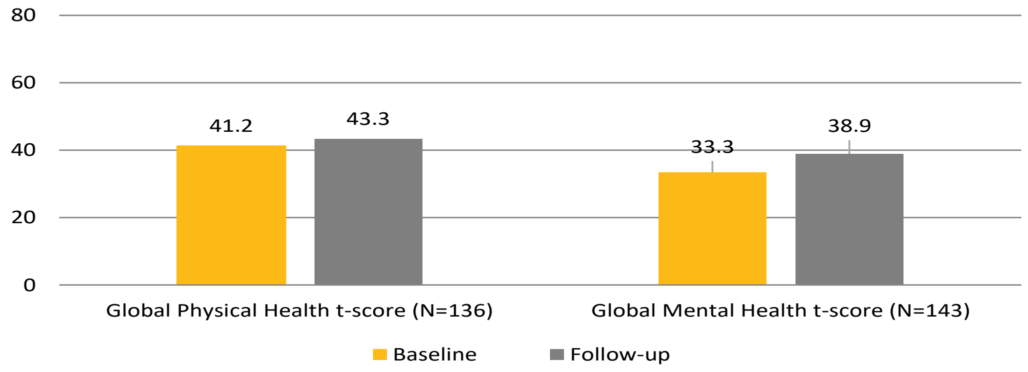
[2] Item 30 "How would you rate your pain on average" ranges from 0-10 but was recoded to a 5-point scale. Participants can enter any value for Item 32 "Outside of health care professionals, how many people actively support you in your recovery?". [3] The intake assessment is usually undertaken while participants are in Behavioral Health Units or Crisis Residential facilities. This might account for the low levels of substance use frequency (i.e., a high average score on the Substance Use Frequency Scale) reported by participants at baseline as access to substances would be prohibited in these facilities. The data indicates that levels were also low at follow-up.

PARTICIPANT RECOVERY (CONTINUED)

PROMIS GLOBAL HEALTH

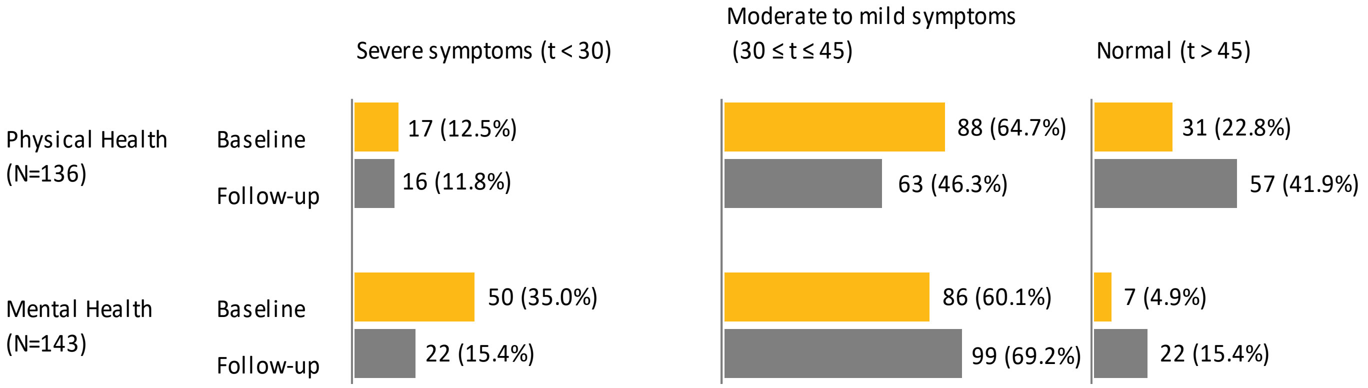
The PROMIS Global Health Scale is a 10-item patient-reported assessment of symptomatology, functioning, and health-related quality of life including physical health, mental health, and social health. PROMIS Global Health scores have been converted into T-score values. T-scores are standardized such that a score of 50 represents the average for the general population, and the standard deviation around the mean is 10 points. As a rule of thumb, half a standard deviation (5 points on the T-score metric) can be viewed as an estimate of a meaningful change.[4]

Figure 4: PROMIS Global Physical and Mental Health Mean T-scores at Baseline and Follow-up



On average, PeerLINKS participants demonstrated improvement in both Global Physical Health and Global Mental Health scores (Figure 4). The improvement on the Global Mental Health Scale suggested a meaningful change. The average T-scores were in the moderate to mild symptoms range, with participants showing a higher level of physical health compared to their mental health. Figure 5 provides additional breakdowns of participant groups by severity of symptoms.

Figure 5: Percentage of Participants by Severity of Symptoms for PROMIS Global Physical Health and Mental Health at Baseline and Follow-up (Pre-post)



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[4] http://www.healthmeasures.net/score-and-interpret/interpret-scores/meaningful-change

PROMIS-DERIVED SUBSTANCE USE

Table 4 shows participants' answers to substance use related questions at baseline and most recent follow-up assessment. Items are scored on a scale from almost always=1 to never=5, with higher scores indicating less substance use treatment need. Participants were reporting on the past 7 days. On average, participants showed improvement across the 10 substance use items. The improvement in responses to all items with the exception of "I used alcohol or substances throughout the day" were statistically significant. The average scores across all items was 4.2 at baseline and 4.7 at the most recent assessment and the improvement was statistically significant.

Table 4: Means (M) and Standard Deviations (SD) of PROMIS-Derived Substance Use

PROMIS Derived Substance Use Items	N	Baseline		Follow-up	
		M	SD	M	SD
I used alcohol or substances throughout the day.	95	4.6	1.1	4.8	0.7
I had an urge to continue drinking or using substances once I started.	95	4.2	1.4	4.6	0.9
I felt I needed help for my alcohol or substance use.	95	3.9	1.6	4.6	1.0
I took risks when I used alcohol or substances.	95	4.4	1.2	4.8	0.6
I felt guilty when I used alcohol or substances.	92	4.3	1.4	4.7	0.8
Others complained about my alcohol or substance use.	95	4.2	1.3	4.9	0.4
Alcohol or substance use created problems between me and others.	93	4.2	1.4	4.8	0.6
Others had trouble counting on me when I used alcohol or substances.	95	4.2	1.4	4.8	0.7
I felt dizzy after I used alcohol or substances.	94	4.3	1.3	4.8	0.8
Alcohol or substance use made my physical or mental health symptoms worse.	95	4.2	1.5	4.8	0.8
Mean PROMIS-Derived Substance Use (average of items 1-10)	95	4.2	1.1	4.7	0.5

HOUSING

A total of 43.8% of participants moved into less restrictive and more independent housing levels and, for 40.1% of participants, the housing level remained stable. Only 16.1% of participants moved to lower housing levels (summarized in Figure 6).

Figure 6: Housing Levels Summary (Pre-post, N=137, Excluding Other or Unknown Housing Levels)

⬆ **60 (43.8%)** moved to more independent housing levels.

= **55 (40.1%)** unchanged housing level.

⬇ **22 (16.1%)** moved to more restrictive/less independent housing levels.

Figure 7 shows the percentage of participants in each housing level as reported for the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=137). The average housing level was 3.3 at baseline and 4.3 at the most recent assessment, indicating that, on average, the housing level improved. This increase was statistically significant.

Figure 7: Housing Levels (Pre-post, N=137, Excluding Other or Unknown Housing Levels)

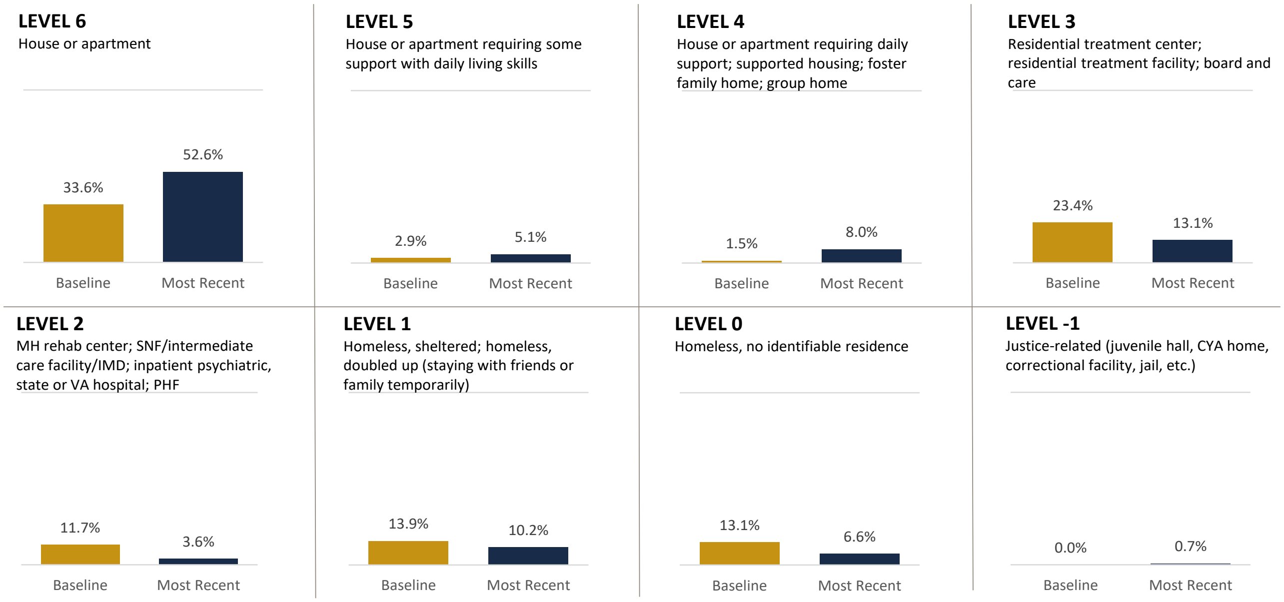

Table 5: Homeless Settings During Past 30 days (Pre-post, Excluding Other or Unknown Homeless Settings)

Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)	**Baseline**	**Most Recent**
# of participants unsheltered at least 1 day	47	15
# of Days	820	356
Total participant responses	124	124
Sheltered (staying in emergency shelters or transitional housing)	**Baseline**	**Most Recent**
# of participants sheltered at least 1 day	42	28
# of Days	737	673
Total participant responses	127	127
Doubled-up (temporarily staying with friends or family)	**Baseline**	**Most Recent**
# of participants doubled-up at least 1 day	22	14
# of Days	445	356
Total participant responses	114	114

Table 5 shows a decrease in the number of participants (and number of days) being homeless unsheltered, sheltered, and doubled-up.

Across all three homeless settings, the total number of participants living unsheltered, sheltered, or doubled-up, decreased from the baseline assessment to the most recent follow-up assessment, indicating that the program has been successful in decreasing the number of homeless participants. It should be noted that the intake assessment is usually undertaken while participants are in Behavioral Health Units or Crisis Residential facilities. Some participants would not necessarily consider themselves homeless while in these settings and the number of homeless participants or days homeless at baseline may be underreported.

EMPLOYMENT

Table 6 shows the percentage of participants in each employment level as reported in the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=138). The percentage of participants who selected not employed decreased from 87.0% to 64.5%. The percentage of participants who were competitively employed increased from 5.8% to 18.1%.

Table 6: Employment Levels (Pre-post, N=138)

Employment Level	Baseline		Follow-up	
	N	Percent	N	Percent
Level 0: Not employed	120	87.0%	89	64.5%
Level 1: Volunteer/job training/other gainful/ employment activity	3	2.2%	4	2.9%
Level 2: Paid in-house work	1	0.7%	1	0.7%
Level 3: Transitional employment/enclave/ supported employment	1	0.7%	4	2.9%
Level 4: Competitive employment	8	5.8%	25	18.1%
No employment level: student	2	1.4%	4	2.9%
No employment level: retired	6	4.3%	13	9.4%
No employment level: homemaker	1	0.7%	1	0.7%
Total responses	142	102.9%	141	102.2%
Total number of participants	138	100.0%	138	100.0%

Note: Percentages for total responses exceed 100% due to multiple responses.

Table 7 shows the reasons for unemployment for participants who had been unemployed at both time points where the reason was available (N=53). The majority were unemployed due to mental health symptoms or disability.

Table 7: Reasons for Unemployment (Pre-post, N=53)

Reasons for Unemployment	Baseline		Follow-up	
	N	Percent	N	Percent
Disabled	18	34.0%	18	34.0%
Mental Health Symptoms	37	69.8%	36	67.9%
Other	8	15.1%	3	5.7%
Total responses	63	118.9%	57	107.5%
Total number of participants	53	100.0%	53	100.0%

Note: Percentages for total responses exceed 100% due to multiple responses. Based on pre-post data with missing, unknown/not reported, and item not assessed excluded.

LINKAGES TO SERVICES

PeerLINKS uses the "Linkage and Referral Tracker," a tool that helps Peer/Family Support Specialists and other healthcare professionals track the discussions, referrals, linkages, and successful connections they make to other services, and whether these linkages were successful.[5] The Linkage and Referral Tracker was specifically designed for programs that focus mainly on connecting people with needed services, rather than providing treatment. It can also be used as a shared decision-making tool with participants and to help set their personal goals for recovery and wellness.

Table 8 quantifies the extent of the successful connections. A total of 1,585 successful connections were made during the reporting period. Specifically, for the mental health dimension, 259 successful connections were made for 119 unique participants. For the substance abuse dimension, 100 successful connections were made for 52 unique participants.

Table 9 shows Mental Health service data based on Linkage and Referral Tracker entries (during 7/1/2017-6/30/2018) for participants who had been in the program for at least 30 days. Overall, 61.8% of participants were referred or linked and were successfully connected to one or multiple mental health services (percentage not shown in table).

Table 8: Successful Connections[5]

Dimension of Wellness	Successfully Connected (Unique Participants)
Physical Health	133 (N=66)
Social Health	178 (N=66)
Mental Health	259 (N=119)
Substance Abuse	100 (N=52)
Housing	175 (N=85)
Occupation/Education	90 (N=47)
Financial Assistance Benefits	127 (N=66)
Transportation	151 (N=84)
Identification	71 (N=46)
Basic Needs	301 (N=155)
Total	1585 (N=247)

Table 9: Mental Health Service Successful Connections for Participants in the Program at Least 30 Days[5]

Type of Mental Health Service	Unique Participants Referred or Linked	Unique Participants Successfully Connected	% Successfully Connected
Independent psychiatrist	15	8	53.3%
Private counselor/therapist	24	7	29.2%
Specialty mental health clinic	90	43	47.8%
Primary care provider	3	1	33.3%
Behavioral health within primary care clinic	26	16	61.5%
Intensive outpatient	19	8	42.1%
Self-help groups (e.g., WRAP, Roadmap to Recovery)	42	10	23.8%
Clubhouse	58	20	34.5%
Inpatient treatment	15	14	93.3%
Crisis house	30	18	60.0%
Other	56	29	51.8%

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[5] Definition of successful connection: Provider was able to confirm that the participant actually obtained a specific tool and/or service

CRITICAL EVENTS (BASED ON mHOMS DATA)

Table 10 shows the number of different types of emergency interventions participants received during the past 30 days. The data is based on participant self-report during regular assessments by PeerLINKS staff. The data is entered into mHOMS. The number of emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to the most recent follow-up assessment.

Table 10: Number of Emergency Interventions Participants Received During Past 30 Days (Pre-post)

Physical health related	Baseline	Most Recent
# of participants with at least 1 service	29	11
# of services	37	21
Total participant responses	120	120
Mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	95	11
# of services	155	30
Total participant responses	131	131
Physical AND mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	24	3
# of services	38	5
Total participant responses	116	116

Table 11: Number of Critical Events During Past 30 days (Pre-post)

Non-psychiatric hospitalization	Baseline	Most Recent
# of participants with at least 1 time	13	3
# of times	21	6
Total participant responses (times)	117	117
# of participants with at least 1 day	5	3
# of days	23	49
Total participant responses (days)	69	69
Jail/prison	**Baseline**	**Most Recent**
# of participants with at least 1 time	8	1
# of times	10	1
Total participant responses (times)	126	126
# of participants with at least 1 day	5	2
# of days	42	44
Total participant responses (days)	67	67

The number of participants in non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up (Table 11). The number of times participants experienced critical events also decreased. However, it should be noted that some participants who are experiencing critical events at baseline and at follow-up may have a higher level of need and may require additional support.

PEERLINKS PARTICIPANT SERVICE UTILIZATION ANALYSES USING CERNER COMMUNITY BEHAVIORAL HEALTH (CCBH) DATA

The utilization of behavioral health services by PeerLINKS participants was examined 30 days before and after starting the program in order to assess recurrence rates (see Table 12). Participants enrolled in PeerLINKS during calendar year 2017 and had an index event (i.e. the psychiatric hospitalization or crisis residential treatment episode that occurred around the time of enrollment) identified in CCBH data were included in this analysis. The pre-30-day recurrence rate is determined by whether a prior admission ended within 30 days before the start of the index event. The post-30-day recurrence rate is determined by whether a subsequent admission started within 30 days after the end of the index event.

Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=117), the recurrence rate decreased by 30.0% after starting the program (25.6% vs 17.9% with any recurrence event). Among the crisis residential cohort (participants with a crisis residential treatment index event; N=129), the recurrence rate remained the same (10.9% vs 10.9% with any recurrence event).

Table 12: 30-Day Recurrence Rates for PeerLINKS Participants (N=246)[6]

	Number of participants included in each cohort	Participants with at least one recurrence event within 30 days prior to PeerLINKS enrollment[7]	30-day recurrence rate prior to PeerLINKS enrollment[7]	Participants with at least one recurrence event within 30 days after PeerLINKS enrollment	30-day recurrence rate after PeerLINKS enrollment[8]
Hospital Cohort	117	30	25.6%	21	17.9%
Crisis Residential Cohort	129	14	10.9%	14	10.9%

Note: [6] Includes participants enrolled in PeerLINKS during calendar year 2017 with an index event (i.e., hospitalization or crisis residential treatment episode) identified in Cerner. [7] 30-day recurrence rate prior to PeerLINKS enrollment determined by whether a prior admission ended within 30 days before the start of the index event. [8] 30-day recurrence rate after PeerLINKS enrollment determined by whether a subsequent admission occurred within 30 days after the end of the index event.

PEERLINKS ANNUAL STAFF FEEDBACK SURVEY

At the end of the second year of providing the program, administrative and Peer/Family Support Specialist staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Thirteen staff participated (87% response rate). For the open-ended survey questions, three evaluators reviewed and coded the responses independently. Any discrepancies were discussed to arrive at a consensus on the key response themes.

STAFF SURVEY FINDINGS

Staff highlighted the main innovative factors and program goals, the factors that helped achieve these goals as well as specific challenges they had experienced during the second year of operation.

Key program "innovations" or factors that make this program unique:

a. Support that is participant-centered
b. Services for participants that come from peers with lived experience
c. Linking participants to community resources and external connections

Major program goals identified by respondents:

a. Linking participants to community resources
b. Providing support to participants
c. Reducing readmission of participants to psychiatric hospitals and crisis homes

Factors that helped the program achieve these goals:

a. PeerLINKS staff being able to rely on a knowledgeable and supportive team
b. Providing peer support to participants
c. Being able to access community services and resources for participants

Specific challenges to reaching the program goals described by respondents:

a. Participant-related characteristics and factors such as losing contact with participants or the participants being disengaged, unwilling (e.g., declining suggestion for referral), or unable to actively participate in their recovery (e.g., due to language barriers)
b. Lack of resources for participants (e.g., emergency services and available housing)
c. Time-related factors such as long wait times for external services
d. Some respondents noted that there were no factors preventing them from achieving program goals

Almost half of the respondents identified that the waitlists for services that participants were referred to (46%) were an issue that was challenging or very challenging for the program during the past year. Additionally, about a third of the respondents found that participants not completing referrals for other services (38%) and participant attrition/not completing the program (31%) to be challenging or very challenging.

In addition, staff were asked to provide their feedback on what they believe were the key characteristics of participants who were successful in the program.

Key characteristics of participants that have been successful:

a. Participant is ready and interested to receive help and services
b. Participant maintained communication/engagement with Peer Support Specialist
c. Participant has gained a support system(s)
d. Participant has housing, employment, and/or income

KEY YEAR 2 PEERLINKS PROGRAM "LEARNINGS"

1. **Pool Employee:** The program added a Pool Employee who can cover while other team members are on medical leave or vacation. Depending on budget, the program hopes to continue this arrangement during Year 3.
2. **Connecting to housing services:** The program has now the ability to access information and enter participants into the Homeless Management Information System/Coordinated Entry System (HMIS, CES); this includes the ability to complete the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) and refer participants to a Housing Navigator within CES. Additionally, the program continues to refer participants to housing programs and navigators if the participant is interested in receiving such services.
3. **Homeless Court Program (HCP):** In May of 2018, the PeerLINKS program became a referring agency for The Homeless Court Program, which is "*a special Superior Court session convened in a homeless shelter where homeless participants can voluntarily resolve outstanding misdemeanor offenses and warrants,*" as well as have fines reduced or removed. HCP utilizes alternative sentencing, where the court essentially "credits" participant's engagement and accomplishments in the PeerLINKS program as "time served." Therefore, to be referred to HCP by the program, participants must make substantial progress towards their goals, be engaged with the program for at least two months, and exhibit changes in the behavior or situation that led to their offense. In addition to reducing stress and improving participants' well-being, resolving offenses, and removing warrants help reduce barriers to housing; furthermore, having fines removed or reduced allows participants to use their income towards housing and other essential needs.
4. **Donor funds:** The program obtained a donation to provide items important for participants' recovery and well -being but which cannot be purchased with San Diego County funds; that is, items/activities that do not meet the definition of Flex Funds (Flex Funds are monies of last resort used to assist participants whose recovery would be jeopardized by unmet needs). Examples of ways the program has used these donor funds include: buying home/ kitchen/cleaning items for participants who obtained their own apartment/home following lengthy periods of homeless or transitional housing. Other examples include registration fee for a recovery-related conference, and fun activities such as tickets to attend movies and art shows.
5. **Connecting participants to appropriate level of care**. While many of the participants are connected to the appropriate level of care, the program has found that some of the participants are not interested in receiving services at the appropriate level of care. This is due to various reasons, including: having an appointment made with a federally qualified health center by staff at the inpatient unit prior to discharge; a preference for a clinic that is closer to where participants live; ability to receive physical and mental healthcare at the same location; participants had previous experience with various clinics and developed a preference for specific ones. Additionally, some participants lost interest in being connected with an Assertive Community Treatment (ACT) program or may feel that their mental illness may not be severe enough to be in that program.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. ***Continue outreach and strengthening of connections with external services and sites across San Diego County and specifically, services related to housing, particularly for participants who may be more difficult to connect.*** The PeerLINKS team built and strengthened connections and conducted outreach with a variety of organizations and programs that provide services related to mental health, substance use disorders/co-occurring disorders, vocational training/education, and supportive employment. The team connected with agencies that serve individuals experiencing homelessness, including shelters, housing providers and navigators, and agencies that provide food and/or clothing; and agencies that serve justice-involved populations. Specifically, the program team conducted outreach activities with over 40 organizations; presented to over 200 individuals at various council and committee meetings, panels and symposiums; and attended several special events, open houses, trainings, and meetings, where the team took the opportunity to provide information about PeerLINKS and build/strengthen relationships with various programs and providers.
2. ***Refine program materials to provide a clearer description of the program, role, purpose and limits of the program; ensure these materials are provided to and reviewed with all potential participants and staff from the crisis homes/hospitals which the program serves.*** The program created a Partnership Agreement Form which is reviewed with all potential participants before they enroll in PeerLINKS. The form includes the purpose and limits of the program, as well as the role of the Peer/Family Support Specialist. An abbreviated version of the form was reviewed with staff from the crisis homes/hospitals served by the program. A program brochure which provides an overview of the program was also created.
3. ***Promote the role of Peer/Family Support Specialists among participants, service providers, and other stakeholders, to increase ease of access to services.*** The program team took various approaches to address this, including: describing the role of the Peer/Family Support Specialist in detail in the Partnership Agreement Form and the abbreviated version of the form; the team promoted and clarified the role of the Peer/Family Support Specialists during outreach activities and presentations; moreover, the team has continued to clarify the role when communicating and coordinating care with service providers.
4. ***Refine PeerLINKS' enrollment/eligibility to ensure enrollment of participants who are most likely to benefit from the program, given budget limitations.*** The program continued to serve adults living with a Serious Mental Illness, who had multiple acute care visits in the previous year and are not effectively connected to resources/ services or lack a strong support network. Participants receive Medi-Cal or are Medi-Cal eligible and are being referred by one of four sites: Scripps Mercy's inpatient unit and emergency department, UC San Diego's inpatient unit, Vista Balboa Crisis Center, and New Vistas Crisis Center.
5. ***When possible, connect participants with case management services soon after they join the program.*** To increase the team's awareness and understanding of the various case management programs, the program co-organized a Case Management Panel where representatives from several case management teams and programs from San Diego County were represented. Discussing participants' need and eligibility for case management became an additional part of the individual, weekly supervision of the Behavioral Health Clinician with each Peer/Family Support Specialist. All participants who were appropriate for case management services and were open to being connected to this service were referred to case management.
6. ***Develop strategies to increase the number of closure packets completed by participants who are leaving or graduating from the program. Offering an incentive (e.g., meal, gift card) may be explored.*** The program held various team meetings, where the team identified barriers to collecting assessments, proposed solutions for reducing these barriers whenever possible, and shared their strategies and best practices. The program also explored the option of offering incentives to participants who complete the closure paperwork, however, this is not common practice and the additional expenses were not approved by the County.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS CONTINUED

7. ***Continue the collection of regular participant assessments, and in particular, increase the number of participants who provide feedback on items related to participant satisfaction and participant rated outcomes. In addition, transition towards using electronic documentation rather than hardcopies whenever possible.*** Team members now receive weekly reports that identify their active participants, provide assessment windows for current or upcoming assessment periods, and indicate whether the documentation has been completed. The program implemented quality assurance practices; specifically, the program's Behavioral Health Clinician reviews all paperwork prior to data entry to identify missing items, as well as to identify need for training or coaching for the entire team or specific members. Additionally, the program held various team meetings, where the team identified barriers to collecting assessments, proposed solutions for reducing these barriers whenever possible, and shared their strategies and best practices. A brief incentive strategy was created for the team, which increased the number of assessments being collected; the process also allowed the team to further identify barriers, as well as learn how these had been successfully overcome by the team.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-15 PeerLINKS program that differed substantially from the initial design of the program during the second year of service provision (7/1/2017 to 6/30/2018). Some basic practices and procedures were adjusted over the course of the second year, as described in a number of enhancements to the program under "Key Year 2 PeerLINKS Program Learnings" or "Status of Prior Year Program Recommendations." However, no fundamental or program-wide changes were made.

YEAR 3 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the program and further increase participant services and engagement during Year 3 include the following:

1. To continue to focus on linkages to mental health and substance abuse treatment programs and to improve the tracking of this information. To continue to connect program participants who utilize acute care repeatedly and to connect them to the San Diego County behavioral health system.
2. To systematically capture participants' level of motivation for engaging in the program and working towards their recovery-related goals by adding relevant items to the baseline and follow-up assessments. This information would help the program to explore ways to increase motivation, or support these participants in succeeding despite not being interested in working towards goals.
3. To conduct a "check-in" with discharged participants at approximately three months past discharge and six months, if possible. The check-in will also focus on any changes to the participants' housing situation, employment, and use of emergency services.

For additional information about the INN–15 PeerLINKS program and/or this annual report,

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URBAN BEATS
(INNOVATIONS-16)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 3 (7/1/17 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Urban Beats program is funded through the Innovations (INN) component of the Mental Health Services Act and was developed to provide Transition Age Youth (TAY; age 16-25) with increased access to and knowledge of behavioral health treatment and wellness services, as well as reduce mental illness stigma for TAY and the community. The primary innovation of this program is the utilization of artistic expression to communicate a recovery-focused message to TAY and develop artistic skills and self-esteem. The program now includes a therapist who provides counselling and emotional support directly to Urban Beats TAY as needed. This is expected to increase access to and utilization of behavioral health care by Urban Beats TAY since these services can be accessed within the network of trusted Urban Beats relationships rather than requiring a referral to an external provider agency for services. For TAY with significant needs the Urban Beats therapist works to identify and link the TAY to appropriate ongoing care. The Urban Beats program expanded and now operates in multiple communities throughout the Central and North Central Regions of San Diego County.

The Urban Beats program consists of a 20-week curriculum that focuses on improving TAY wellness and developing each TAYs desired form of artistic expression. Following the structured multi-week classes, Urban Beats staff provide individualized attention to each TAY to help create a performance piece in their preferred form of artistic expression (such as drawing, poetry, song, videography, etc.). Throughout the program, the TAY present their creations in public performances designed to create greater self-esteem among Urban Beats participants, educate the community about mental health issues, and reduce stigma.

EXECUTIVE SUMMARY

The Urban Beats program (INN-16) was designed to provide wellness education and social support to TAY with mental health needs through individualized development of TAY artistic expression skills and interests. Artistic expression is expected to reduce stigma in both TAY and the general community through public performances.

- During FY 2017-18, a total of 177 new, unduplicated TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial diversity in race/ethnicity, sexual orientation, and gender identity. The proportion of females increased from last year (18.2% vs 41.2%), but still lower than males (50.8%).
- Based on follow-up data from this year (n=45), the findings suggested that Urban Beats participants felt more able to make positive changes in their lives and comfortable talking to mental health professionals; they were also more likely to think that professional mental health services were effective for improving mental health.
- Over 80% of participants reported being satisfied with Urban Beats, with the majority indicating that, as a result of the program, they knew better where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms.
- Analyses indicate a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g., inpatient psychiatric hospitalizations, crisis residential treatment, emergency/ crisis-oriented psychiatric visits).
- The Urban Beats program held a similar number of community performances (n=28) compared to the prior year, with 950 persons in attendance. By contrast, the first program year had only four performances with approximately 250 attendees.
- Urban Beats staff identified the following key factors that helped achieve program goals: 1) collaborations and partnerships in the community, 2) intensive outreach and engagement, 3) offering art as a focus, and 4) program design (e.g., unique resources, individual mentoring).

RECOMMENDATIONS

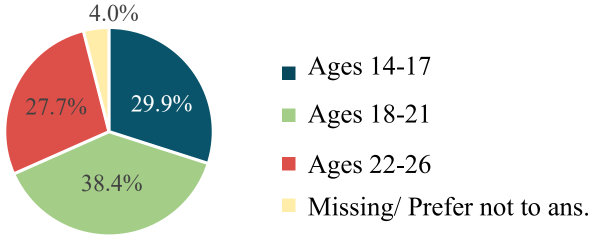
Primary recommendations for service provision improvements include: 1) develop a shorter version of the Urban Beats program (i.e., still 20 hours, but during less than 20 weeks), and 2) establish a location for the North Central office in order to better serve the target population.

V2019-06-21

URBAN BEATS PARTICIPANT DEMOGRAPHICS

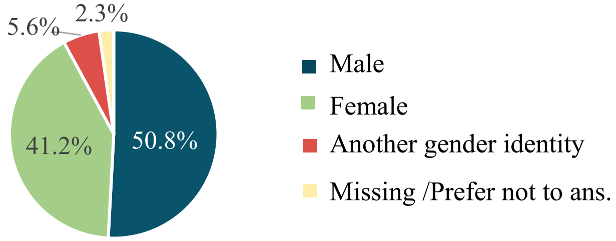
The following demographic data were collected from a participant self-report survey administered when enrolling in the Urban Beats program.[1]

AGE(N=177)



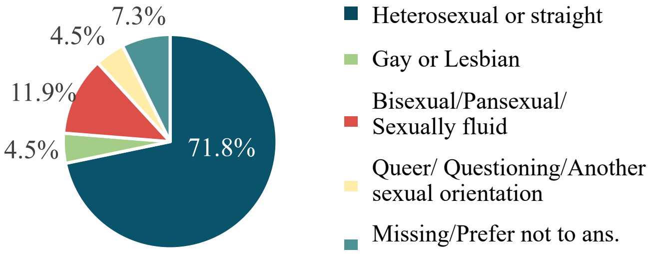
The age distribution was relatively consistent across youth age categories (roughly 30% in each age group).

GENDER IDENTITY (N=177)



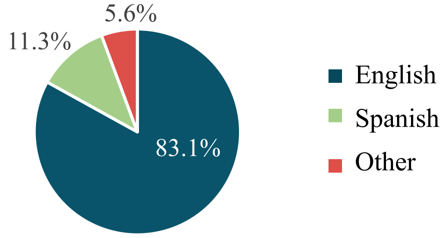
Forty-one percent of participants identified as female, as compared to the prior year in which 18.2% identified as female.

SEXUAL ORIENTATION (N=177)



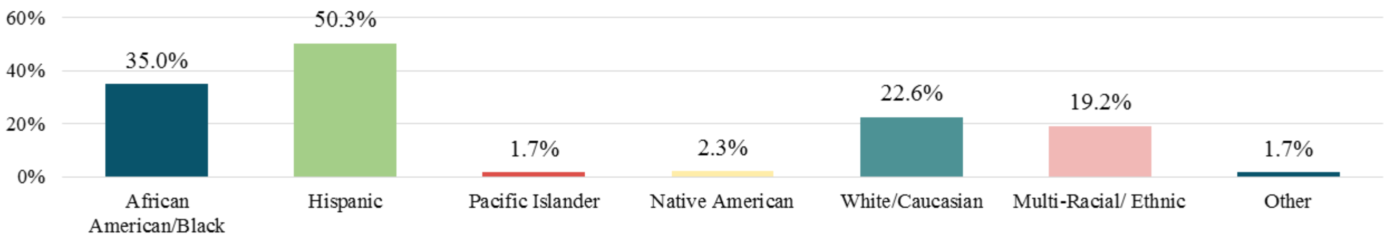
Over half (72%) of participants were heterosexual or straight, and 12% identified as bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=177)



The majority (83%) of participants preferred English as their primary language.

RACE/ETHNICITY (N=177)



About half (50.3%) of the participants identified as Hispanic, 35.0% as African-American, and 22.6% as White. Another 19.2% identified with multiple racial/ethnic backgrounds. Totals may exceed 100% as participants were able to indicate more than one race.

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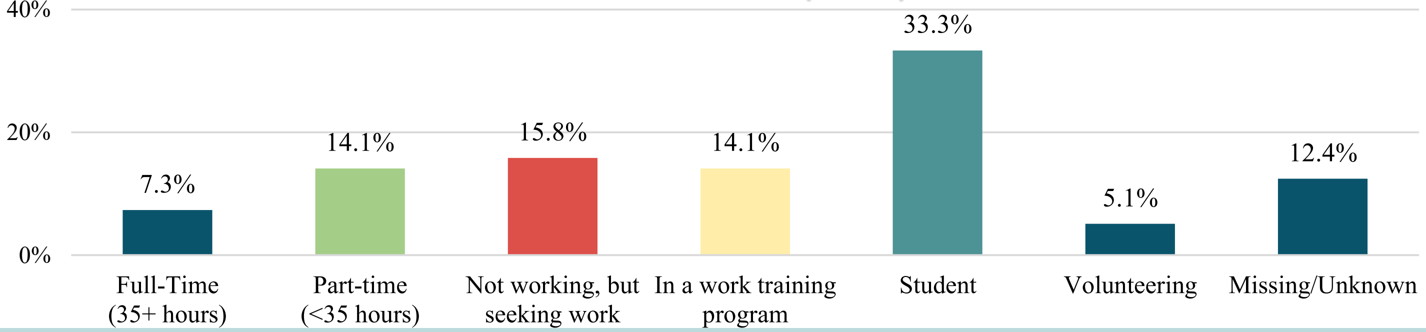
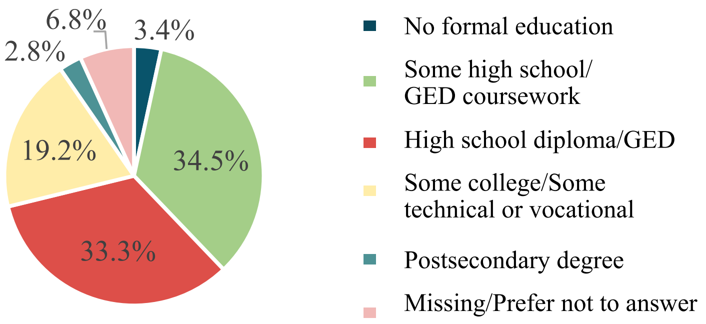
[1] *Percentages may not total to 100% due to rounding.*

EMPLOYMENT STATUS (N=177)



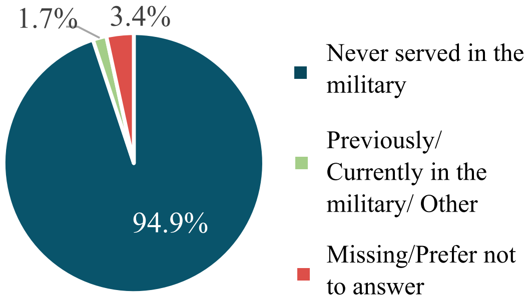
About 20% of participants indicated that they were working (7.3% full-time and 14.1% part-time), 14% were in some form of work training program, and 16% were not working, but seeking work. Approximately 33% indicated they were in school. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=177)



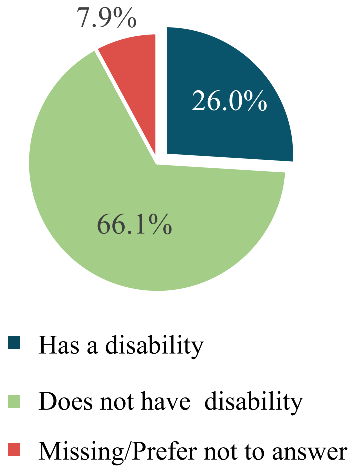
Approximately two-thirds (71.2%) of participants indicated that they had a high school diploma/GED or lower level of education.

MILITARY STATUS (N=177)



Very few participants (1.7%) indicated having served in the military.

DISABILITY[2] STATUS (N=177)



Over a quarter (26%) of participants, indicated having some type of non-SMI related disability.

TYPE OF DISABILITY (N=46)

Type	n	%
Difficulty Seeing	14	30.4
Difficulty Hearing	6	13.0
Learning Disability	19	41.3
Physical	3	6.5
Chronic Health	5	10.9
Other	8	17.4

This table lists the type of non-SMI related disability indicated by participants. Totals may exceed 100% as participants could indicate more than one type of disability. The high percentage of participants indicating difficulty seeing appeared to be related to participants who needed some form of vision correction, such as glasses or contacts.

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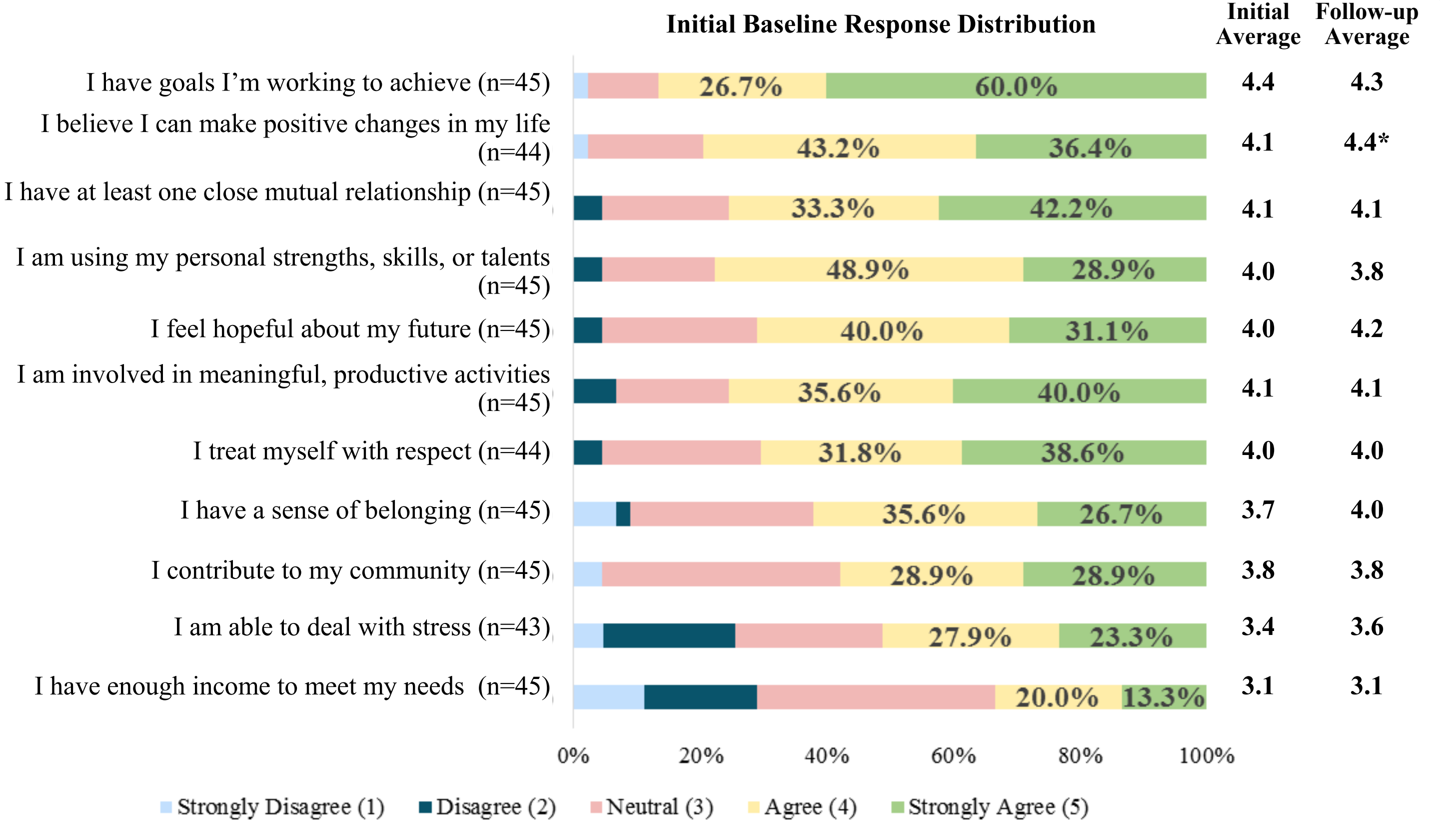
[2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

URBAN BEATS PARTICIPANT BELIEFS

At the start of each Urban Beats round of classes, participants were asked to complete a Wellness Survey. They were asked again after 6 weeks, and at the end of the 20-week program participants completed a follow-up Wellness Survey. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in the following chart. The chart presents the distribution of responses at initial baseline, the average rating at initial baseline, and the average rating at the most recent follow-up. Part of the Wellness Survey included select items from the Recovery Markers Questionnaire (RMQ). Participants included in this chart had a follow-up survey completed during FY 2017-18 (n=45).

At baseline, the most commonly endorsed statements (i.e., at least 75% agreed or strongly agreed) focused on participants' beliefs about their self-efficacy and pursuit of goal achievement. Participants appeared to be less enthusiastic about their stress management capabilities and having sufficient income. These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program. The average ratings for all items increased or stayed the same at follow-up, with one item demonstrating a statistically significant difference ("I believe I can make positive changes in my life"). This aspect of well-being is a priority of the Urban Beats program. While we do not see the same increase as last year in ratings for ability to deal with stress and involvement in meaningful and productive activities, the baseline scores for these two items were substantially higher compared to last year's Urban Beats enrollees (e.g., "meaningful and productive activity" was 3.6 at baseline last year as compared to 4.1 at baseline this year). This suggests that this year's participants were potentially at a somewhat higher wellness level on these dimensions than last year's.

FIGURE 1. URBAN BEATS PARTICIPANT BELIEFS—BASELINE AND FOLLOW-UP COMPARISONS



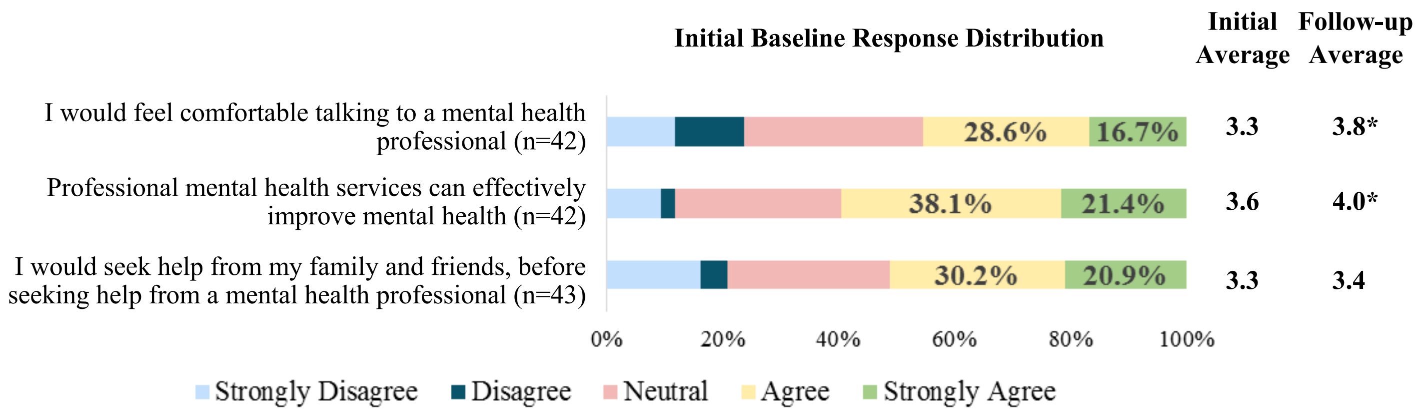
* Statistically significant change in mean rating scores, p<.05.

The Wellness Survey also inquired about the quality of health, mental health, and satisfaction with social activities/relationships. Many Urban Beats participants indicated they had health and mental health concerns, with 17.7% and 24.4%, respectively rating their overall health and mental health, as "Poor" or "Fair." These findings highlight the importance of focusing on physical and mental health within the Urban Beats program. The average ratings for these items did not change significantly at follow-up.

URBAN BEATS PARTICIPANT ATTITUDES ABOUT MENTAL HEALTH SERVICES

The Wellness Survey also included questions about participant attitudes towards mental health services. At baseline, 45.3% of the Urban Beats participants agreed or strongly agreed that they would “feel comfortable talking to a mental health professional.” A majority (59.5%) agreed or strongly agreed that “professional mental health services can effectively improve mental health.” These findings indicate that many Urban Beats participants had positive perceptions of professional mental health services in improving mental health, but at the same time may not feel entirely comfortable interacting with mental health professionals. The Urban Beats program sought to address these concerns through psychoeducation and promoting engagement with professional mental health services when needed. Likely as a result of these efforts, the average rating for whether “I would feel comfortable talking to a mental health professional” increased significantly from an average rating of 3.3 at baseline to 3.8 at most recent follow-up. These values correspond to an average response close to “Neutral” at baseline and “Agree” at follow-up.

FIGURE 2. URBAN BEATS PARTICIPANT ATTITUDES-BASELINE AND FOLLOW-UP COMPARISONS

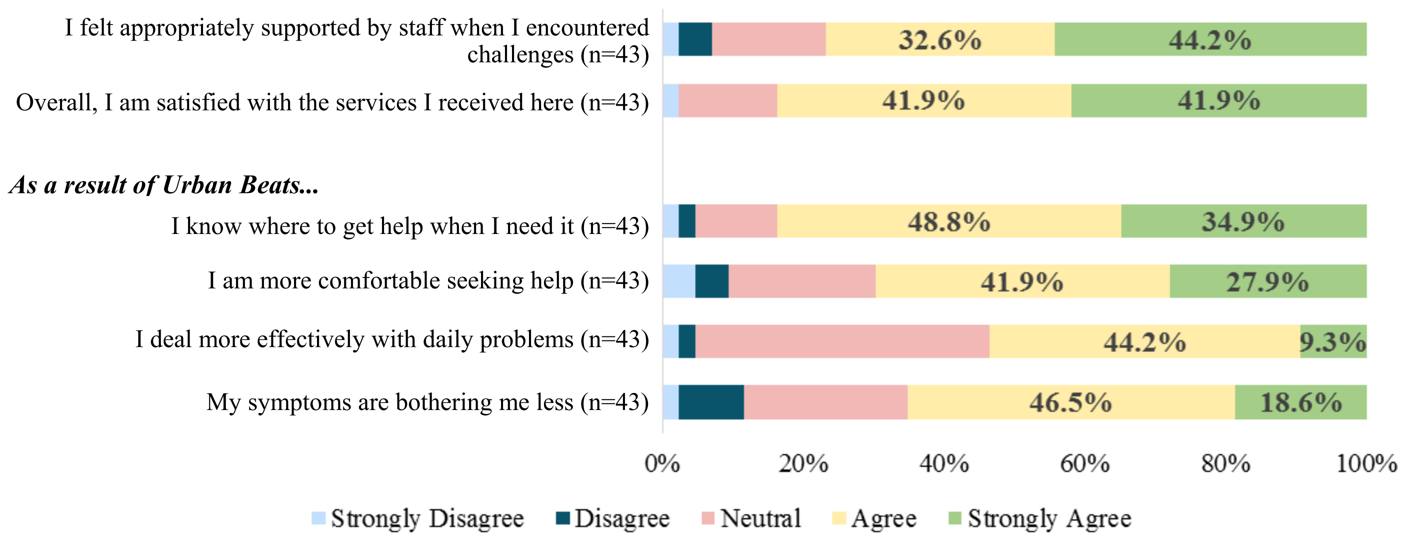


* Statistically significant change in mean rating scores, $p<.05$.

URBAN BEATS OUTCOMES

As shown in the chart below, the vast majority (83.8%) of Urban Beats participants with follow-up Wellness Survey data indicated they were satisfied with the Urban Beats program (41.9% strongly agreed). A similar percentage (76.8%) thought they were “appropriately supported by staff when [they] encountered challenges.” The majority indicated that as a result of participating in the Urban Beats program, they knew “where to get help” (83.7%), felt “more comfortable seeking help” (69.8%), dealt “more effectively with daily problems” (53.5%), and were less bothered by symptoms (65.1%).

FIGURE 3. URBAN BEATS PARTICIPANT ASSESSMENT OF URBAN BEATS PROGRAM



BHS BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of behavioral health services by Urban Beats participants was examined 180 days before and 180 days after starting the Urban Beats program. To ensure that everyone included in the analyses had the entire 180 days to be observed for any behavioral health service utilization after starting Urban Beats, the analyses only included participants (n=227) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2018).

As shown in Table 1, a little over one-quarter (26.4%) of the 227 Urban Beats 'life-of-program' participants included in the 180-day analyses had attended at least one behavioral health outpatient visit within the 180 days prior to starting the Urban Beats program. Approximately 18.5% participated in Assertive Community Treatment (ACT) in the 180 days before entering Urban Beats. There was little change in participation rates for these services in the 180 days after starting the Urban Beats program. There was a small decrease in participation rate for outpatient visits (21.6%), while the participation rate and number of total visits for ACT had a modest increase (19.8%; 1793 vs 1879 visits).

While less frequent overall, the findings in Table 1 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) contacts, emergency psychiatric hospital visits, inpatient psychiatric hospitalizations, and justice-related mental health services (e.g., services received while in jail or participating in behavioral health court proceedings), were utilized less often after participants had started the Urban Beats program. For example, while 11% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 4.4% (a 60% reduction in the hospitalization rate), had a hospitalization after starting Urban Beats (total admissions reduced from 52 to 18). There is also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (6.2% vs 1.3%; 19 vs 3 admissions).

Given the relatively low utilization rates of most acute/crisis care oriented services, these findings should be interpreted with caution; however, the overall pattern suggests that participation in Urban Beats is associated with lower utilization of public mental health acute/crisis care oriented services.

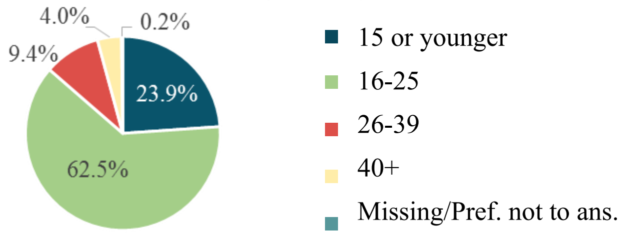
TABLE 1. BEHAVIORAL HEALTH SERVICE UTILIZATION BEFORE AND AFTER STARTING THE URBAN BEATS PROGRAM

	180 Days Before Start Urban Beats (n=227)			180 Days After Start Urban Beats (n=227)		
	Persons with at least one session	% of Urban Beats population	Sum of visits	Persons with at least one session	% of Urban Beats population	Sum of visits
Outpatient Visits	60	26.4%	721	49	21.6%	539
Assertive Community Treatment (ACT)	42	18.5%	1,793	45	19.8%	1,879
Case Management	1	0.4%	20	1	0.4%	4
Urgent Outpatient	22	9.7%	40	11	4.8%	17
Crisis Stabilization	13	5.7%	17	1	0.4%	6
Psychiatric Emergency Response Team (PERT)	15	6.6%	20	6	2.6%	8
Justice-Related Mental Health Visit	13	5.7%	47	6	2.6%	25
	Persons with at least one admission	% of Urban Beats population	Sum of admissions	Persons with at least one admission	% of Urban Beats population	Sum of admissions
Inpatient Psychiatric Hospital Admit	25	11%	52	10	4.4%	18
Crisis Residential Treatment	14	6.2%	19	3	1.3%	3

COMMUNITY PERFORMANCE ATTENDEE DEMOGRAPHICS

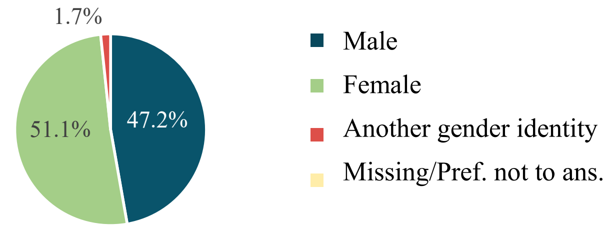
The following demographic data were collected from an audience self-report survey administered at the community performances.

AGE (N=180)



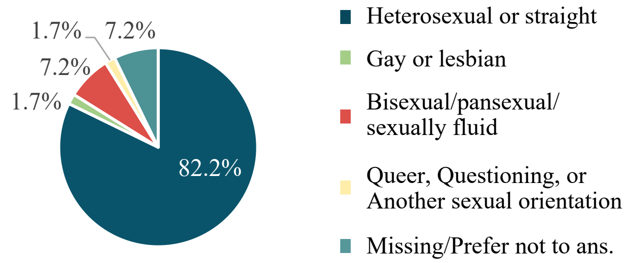
The majority (62.5%) of attendees were between the ages of 16 and 25, and about a quarter (23.9%) were under 15.

GENDER IDENTITY (N=180)



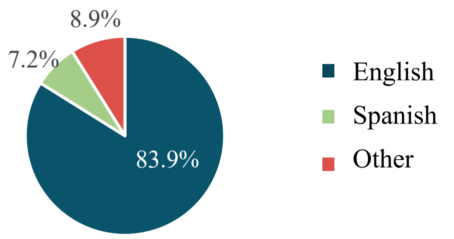
A slight majority (51.1%) of attendees were female.

SEXUAL ORIENTATION (N=180)



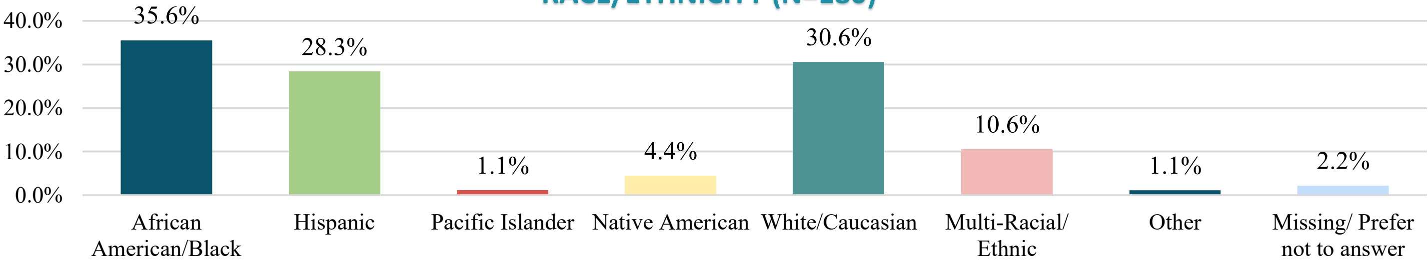
Eighty-two percent of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=180)



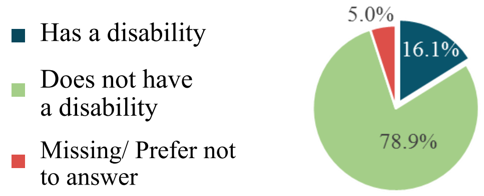
The vast majority (83.9%) of participants preferred English as their primary language.

RACE/ETHNICITY (N=180)



The performances reached a diverse audience. Approximately one-third (30.6%) identified as White, one-third (35.6%) as African American, and one-quarter as Hispanic (28.3%). Totals may exceed 100% as attendees could indicate more than one option.

DISABILITY[1] STATUS (N=180)



Sixteen percent of attendees had some type of non-SMI disability.

Most attendees (92.2%) indicated they had never served in the military.

TYPE OF DISABILITY (N=29)

Type	n	%
Communication	4	13.8
Mental (e.g., learning, developmental)	6	20.7
Physical	7	24.1
Other	13	44.9

The table above describes the types of disabilities these attendees reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

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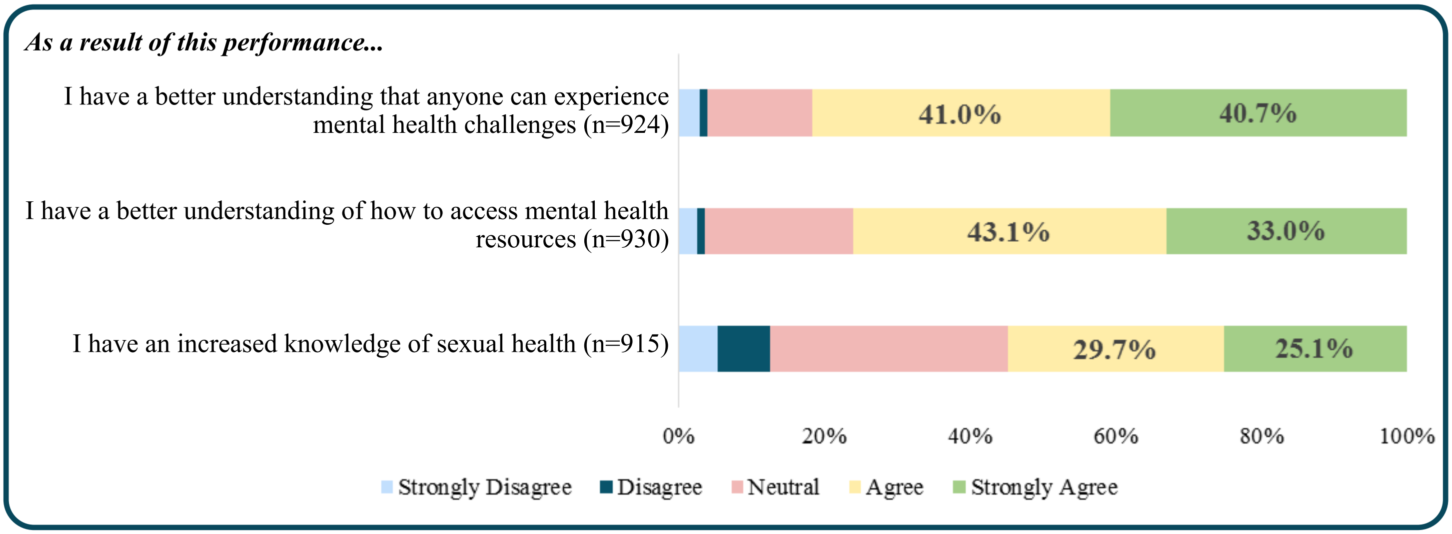
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

KEY EVALUATION FINDINGS: COMMUNITY PERFORMANCES

COMMUNITY PERFORMANCE OUTCOMES

During year 3, the Urban Beats program hosted or co-hosted 28 community performances and collected outcome surveys from 950 persons. By contrast, only four performances with 250 attendees occurred during the first year of the program. TAY audience members (ages 16-25) comprised 62.5% (n=180) of the demographics survey respondents. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 4, a majority of respondents (81.7%) agreed or strongly agreed that as a result of the performance, they had a better understanding that anyone can experience mental health challenges. A similar percent (76.1%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (54.8%).

FIGURE 4. ASSESSMENT OF COMMUNITY PERFOMANCE ATTENDEE LEARNING



The response patterns between TAY (n=594) and non-TAY (n=356) who attended the performances were fairly similar regarding the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" (83.2% compared to 79.1%) and "had a better understanding of how to access mental health resources" (77.4% compared to 73.8%). However, TAY audience had a much higher feedback that they "had increased knowledge of sexual health" (59.7% compared to 46.4%) as a result of the performance.

UTILIZATION OF TECHNOLOGY TO EXPAND REACH OF URBAN BEATS PROGRAM

URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTVITIES

The Urban Beats program focused on increasing their social media utilization as a means for dissemination information about Urban Beats events and for distributing media products developed by Urban Beats participant. Table 2 lists the website (https://www.sdurbanbeats.org/) and other social media activities for the program.

TABLE 2. URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

	Fiscal Year 2017-18		Fiscal Year 2017-18
New Instagram Followers	461 (751 Total)	**Facebook**	
New Twitter Followers	94 (134 Total)	• Page Likes	459
Website Visits	5,102	• Post Likes	3,358
SoundCloud Plays/Likes	359	• Reach (unique views)	21,032

URBAN BEATS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

Urban Beats program administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Urban Beats program. There were 12 respondents from the 15 persons invited to participate in the survey, a response rate of 80%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *The major program goals identified by Urban Beats staff:*
    a. Mental health education and stigma reduction
    b. Provide opportunities for artistic expression
    c. Engagement of transitional age youth (TAY) in a positive, wellness-oriented program
    d. Community education and outreach related to mental health and stigma reduction
    e. Increase TAY service access and utilization
2. *Factors that helped the Urban Beats achieve program goals:*
    a. Collaborations and partnerships with other community organizations
    b. Intensive outreach and engagement efforts
    c. Offering art as a focus
    d. The unique resources available to participants through Urban Beats
    e. The structure of the program (i.e., social cohorts with individual mentoring)
    f. Providing linkages to resources in the community
    g. Increased staffing levels
    h. Conducting performances throughout community
    i. Providing psychoeducation to TAY
    j. Staff skills/support of participants
3. *Key program "innovations" or factors that make this program unique from other programs with similar goals:*
    a. Using art and music to engage youth in mental health
    b. Providing a safe space to discuss mental health
    c. Youth-led events/youth control over their own project/process
    d. Diversity of the staff
4. *Most effective ways to identify and recruit potential TAY participants for the Urban Beats program:*
    a. Community outreach/performances
    b. Actively recruit youth involved in other services
    c. Encourage referrals from other community partners/service providers
    d. Outreach to schools
    e. Youth word-of-mouth
    f. Social media outreach
    g. Recruitment at homeless shelters
5. *Primary barriers to linking Urban Beats TAY with mental health services:*
    a. Lack of information about mental health resources
    b. Challenges with participant motivation/follow-through
    c. Ongoing stigmas related to receiving services
    d. Transportation barriers
    e. Participants not meeting treatment program requirements
    f. Previous negative experiences/lack of trust in treatment
6. *Role of Urban Beats to help TAY reduce mental illness stigma among themselves and in the community:*
    a. It improved comfort levels with discussing mental health
    b. It facilitated youth growth & education
    c. It offered opportunities for youth expression
    d. It created opportunities for youth-to-youth support
    e. It increased TAY connections/engagement in their communities
    f. It provided a "safe space"
    g. It used social media presence to provide education and reduce stigma
    h. It facilitated linkages to providers

KEY YEAR 1 URBAN BEATS PROGRAM “LEARNINGS”

1. An arts-based curriculum was an effective approach to engage TAY in a behavioral health-oriented outreach and support program, particularly for racial/ethnic and sexual orientation minorities who may be underserved in more traditional service settings.
2. Including a public performance component of the Urban Beats program was vital for achieving program objectives.
3. The personal “lived experience” of Urban Beats’ staff with receiving mental health services facilitated connections with TAY and discussions about accessing needed services.
4. The length of the Urban Beats program (i.e., 20 weeks), created some difficulties retaining participants throughout program, but the extended amount of time that the TAY worked with each other and Urban Beats staff also encouraged the development of mentor- and peer-support relationships.
5. It was important to adapt the Urban Beats curriculum to accommodate and recruit a broader population of youth (e.g., initially focus on trauma rather than stigma for youth with less direct exposure to mental health issues and services).
6. Short-term Urban Beats outcomes, such as increased communication, leadership, and self-discovery skills, may be “stepping stones” to bigger, longer-term outcomes related to education, employment, and mental health and wellness management.
7. It is essential to recruit and retain creative, talented, and passionate Urban Beats staff.
8. Urban Beats “graduates” who assisted with subsequent classes took on more responsibilities for outreach and performance planning and functioned as peer mentors for incoming cohorts.

KEY YEAR 2 URBAN BEATS PROGRAM “LEARNINGS”

1. Having more community performances facilitated greater engagement of TAY throughout the program and increased opportunities for community education/stigma reduction, particularly among TAY audience members.
2. Establishing regularly scheduled community performances (e.g., every 3rd Friday), reduced planning burdens and helped with outreach/advertising since times and locations were known well in advance.
3. Challenges/barriers still exist with linking more TAY to appropriate mental health services. For example, older TAY (i.e., 21-25), were not always comfortable receiving services in traditional “adult” oriented mental health programs and may benefit from additional mental health services more targeted to their needs/experiences.
4. Continuing to expand the community partner network is important to allow for reaching diverse, and often under-served TAY populations (e.g., partnerships in Year 2 allowed for greater recruitment/engagement of justice-involved and LGBTQI youth).
5. Evidence is emerging that utilization of acute/crises-oriented mental health care services diminishes after enrolling in the Urban Beats program.
6. Allowing youth to participate multiple times in Urban Beats is important for some youth since the positive, significant changes may not occur until 2nd or 3rd time through the program.

KEY YEAR 3 URBAN BEATS PROGRAM “LEARNINGS”

1. Access to a vehicle (i.e., Urban Beats van) facilitates TAY participation in performances and program events.
2. Substantial need and interest increased within other San Diego communities, prompting Urban Beats program expansion.

YEAR 3 PROGRAM CHANGES

During FY 2017-18 the INN-16 Urban Beats program implemented three substantial programmatic changes. First, they expanded into several communities in San Diego, including a partnership designed to increase engagement with TAY from East Africa. Second, the program added a clinical position to the Urban Beats team so that therapeutic care could be made available to TAY from someone within the Urban Beats program while still working to facilitate appropriate linkages to external treatment services as needed. Finally, the Urban Beats program acquired a van to facilitate transportation to Urban Beats classes and performances and other community services as needed.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Increased access to technical resources/facilities (e.g., computers, recording studios, editing equipment).

   Status: During FY 2017-18, Urban Beats was able to increase TAY access to other resources, such as DJ equipment and smartphones. The DJ equipment provided an opportunity for TAY to learn an art medium, which is also a lucrative employment skill. The smartphone provided opportunities for TAY to create social media posts and engage in the platform in real time. Urban Beats also created a second studio (for North Central), which enabled TAY to create more artistic content and learn music production.

2. More strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach).

   Status: Program staff created a Social Media Branding Guide, which was used to train all staff and TAY to create their own social media. This process led the program to rely less on a social media consultant. The social media component of the program included an increased use of social media marketing strategies (e.g., use of popular uniform hashtags, timed posts, intentional content geared towards the mental health community, and disclaimers for mental health resources). Based on these strategies, the program has seen a dramatic increase in online followings, mostly on Instagram and Twitter.

3. Explore potential for providing on-site or direct, dedicated access to mental health counseling for Urban Beats participants.

   Status: During FY 2017-18 the Urban Beats program added a clinician who can provide therapeutic services directly to Urban Beats participants prior to any linkages to external treatment services.

4. Improve data collection approach to facilitate completion of greater numbers of Urban Beats participant follow-up surveys.

   Status: Consistently collecting follow-up surveys from Urban Beats participants continues to be a challenge. One reason to develop a shorter version of Urban Beats (i.e., still 20 hours, but during less than 20 weeks) is to increase retention and therefore have increased opportunities to collect the follow-up survey data to assess impact of Urban Beats participation.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Urban Beats program and support the achievement of program objectives include the following:

1. Change cohorts from 20 weeks to a curriculum with a total of 20 hours spread across fewer weeks to facilitate TAY retention and allow for more community collaborations through the ability to customize program schedules.
2. Establish a location for the North Central office in order to better serve the target population (e.g., having the ability to host classes).

For additional information about the INN–16 Urban Beats program and/or annual report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

COGNITIVE REHABILITATION AND EXPOSURE/ SORTING TREATMENT (CREST) PROGRAM (INNOVATIONS-17)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 2 (1/1/17 - 12/31/17)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program is funded through the Innovations (INN) component of the Mental Health Services Act. CREST is designed to reduce hoarding behaviors among older adults age 60 and older through a unique treatment approach that integrates cognitive training and exposure therapy combined with care management, peer support, linkages to community services, and periodic in-depth assessments and evaluations to track progress. To facilitate engagement in and completion of the 26-session treatment program, services were provided in the participant's home. CREST services are provided by a team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Key innovations of the CREST program include the use of a structured, "in-home," evidence-based cognitive training and exposure therapy treatment approach. Another important innovation of CREST is the addition of a peer specialist with successful treatment experience to provide additional support to CREST participants. CREST clinicians use a whole person approach, informing the treatment through a combination of both psychotherapy and care management. Through the combined effect of the treatment sessions, peer specialist support, and comprehensive care management, it is expected that CREST participants will reduce their hoarding behaviors, resulting in improved mental health, well-being, housing stability, and safety.

EXECUTIVE SUMMARY

The Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST; INN-17) is a 26-session "in-home" program designed to reduce hoarding behaviors among older adults age 60 and older. The unique treatment approach integrates cognitive training and exposure therapy with care management, peer support, and periodic in-depth assessments to track participant progress. The services are provided by a team of psychologists, social workers, care managers, and peer support specialists.

- During 2017, 36 persons participated in CREST (12 were new enrollees in 2017). Of the 77 persons screened during 2017 almost all met criteria for hoarding disorder (94.8%), but the majority (71.4%) were unable to enroll due to insurance status (e.g., had Medicare) or zip code restrictions.
- Of the 12 new enrollees, the average age was 66 (range = 60 to 76) and nearly 60% were female. The majority identified as "white" (58.3%), all reported English as their primary language, and half (50.0%) had a post-secondary degree.
- Over 80% reported having at least one disability unrelated to mental health (e.g., physical disability or pain) and many had at least one comorbid psychiatric diagnosis in addition to hoarding disorder such as major depression (58.3%).
- During 2017, key outcomes included preventing evictions (n = 7), substantially reducing clutter (measured by the Clutter Image Rating scale), and substantially reducing functional impairment (measured by the Hoarding Rating Scale).
- While demonstrating improvements, 54.5% of the persons who completed the 26-sessions during 2017 still met criteria for hoarding disorder and required additional treatment.
- Key factors identified by CREST staff that helped achieve program goals: 1) using an evidence-based treatment protocol, 2) having a mobile team to provide in-home visits, 3) having coordinated, full-service care provided by a multi-disciplinary team, 4) focusing on factors affecting home safety, 5) having funds to purchase services (e.g., home repairs/dumpster rentals), and 6) having supportive and collaborative community partners.

RECOMMENDATIONS

Primary recommendations include: 1) expand services by modifying eligibility criteria (e.g., allowing Medicare enrollees), 2) improve media outreach/community engagement for recruitment and establishing community partnerships, 3) improve home repair and clutter removal processes, 4) incorporate family groups into treatment model, 5) increase flexibility regarding length of stay in the CREST program, and 6) add yearly income to screening tool to identify persons who may have incomes higher than Medi-Cal thresholds, but still have limited resources.

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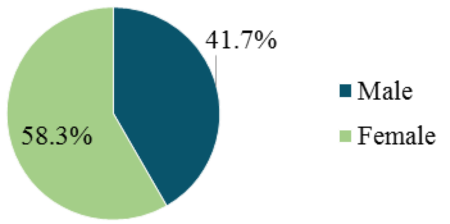
CREST PROGRAM PARTICIPANT CHARACTERISTICS

The following data elements were collected via a participant self-report survey administered at the start of the CREST program.

- During 2017, 77 new persons were screened for CREST program eligibility, 73 (94.8%) met criteria for hoarding disorder, 18 (23.4%) met all eligibility requirements (i.e., region and insurance status), and 12 (15.6%) decided to enroll into CREST.
- During 2017, a total of 36 clients participated in the CREST program (24 were enrolled during 2016).
- Many referrals earned more than Medi-Cal income thresholds, but were too impoverished to afford services.

- New participants ranged in age from 60 to 76, with an average age of 66.
- All new participants reported English as their primary language.
- All new participants identified as heterosexual.
- One (8.3%) new participant previously served in the military.
- Seven (58.3%) participants identified as White and five (41.2%) participants identified as another race/ethnicity.

GENDER IDENTITY (N=12)

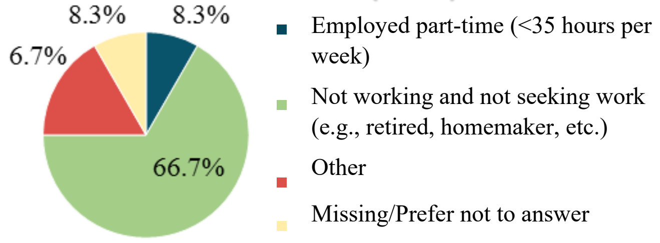


Over half (58.3%) of participants identified as female.

HOMELESSNESS RISK FACTORS (N=12)

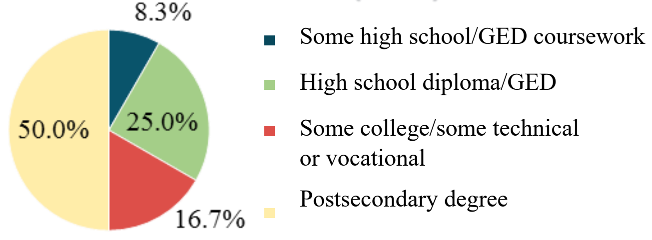
41.7%	Have a poor credit history
41.7%	Ever homeless/not have a home of own
41.7%	Without somewhere to stay/without plan for housing if lost current housing
66.7%	Have at least one barrier to getting or keeping their home, including: lack of employment (25%), lack of transportation (50%), and lack of financial assistance (50%).

EMPLOYMENT (N=12)



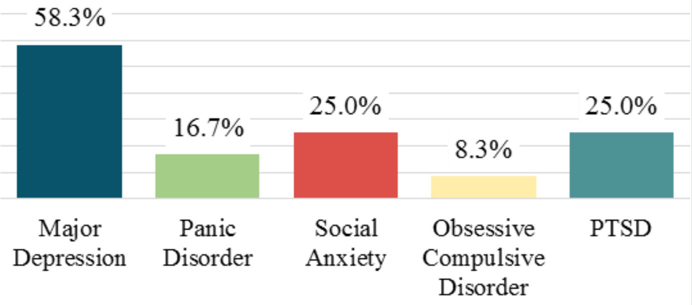
Two-thirds (66.7%) of participants were not employed and were not seeking employment.

EDUCATION (N=12)



Half (50.0%) of participants had completed a postsecondary degree.

COMORBID DIAGNOSES (N=12)



Over half (58.3%) of the participants were diagnosed with comorbid major depression.

DISABILITY STATUS[1] (N=12)

Type	n	%
Physical	6	50.0
Chronic health/pain	5	41.7
Learning disability	1	8.3
Communication (hearing/speaking)	3	25.0
Difficulty seeing	1	8.3
Dementia	1	8.3
Other	4	33.3
Missing/Prefer not to answer	2	16.7

Totals exceed 100% as participants could indicate more than one type of disability.

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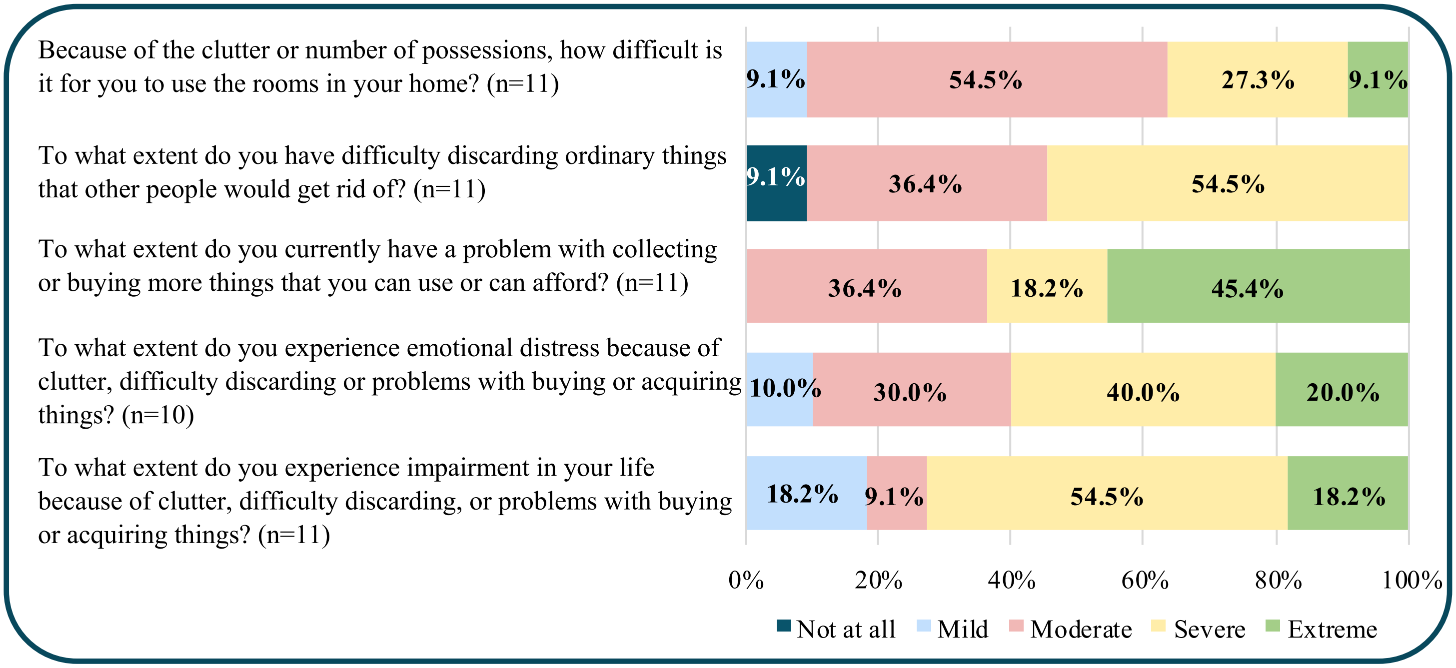
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*

KEY EVALUATION FINDINGS—BASELINE HOARDING RATING SCALE

The chart below presents baseline responses to Hoarding Rating Scale (HRS) questions for participants enrolled during 2017. Overall, results indicated substantial negative effects on the lives of CREST participants due to clutter in their home, with 91% reporting moderate to extreme difficulty using rooms in their house, 90% reporting moderate to extreme emotional distress, and 82% reporting moderate to extreme impairment in their life.

Figure 1. Participant Hoarding Rating Scale Responses at Baseline



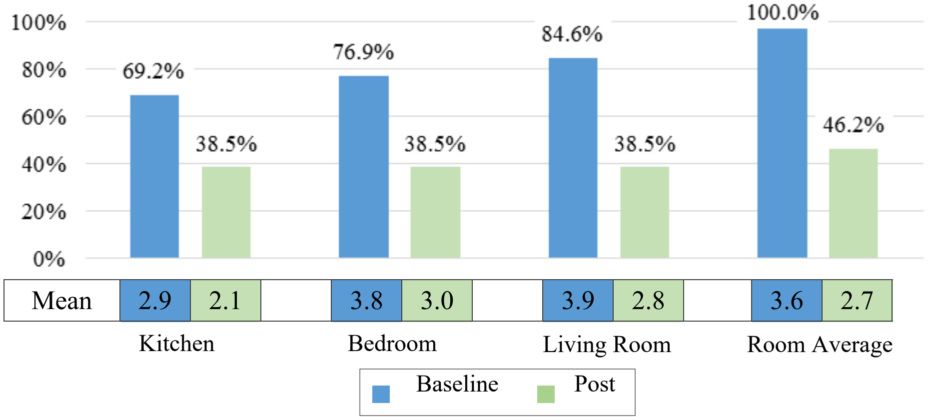
KEY EVALUATION FINDINGS—CLUTTER IMAGE RATING SCALE SCORES

CIR Living Room Rating #2

CIR Living Room Rating #4

The Clutter Image Rating (CIR) scale is a tool used to rate clutter levels on a scale from 1 to 9 (most cluttered = 9), by selecting the image that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom; see example CIR images to the left). Figure 2 presents the percentage of participants who had a CIR value greater than 2 before or after treatment (mean CIR values listed below the chart). Of participants with CIR ratings at both time points (n = 13), substantially fewer had CIR values greater than 2 after receiving CREST treatment services (mean CIR scores decreased as well). These findings of decreased clutter are consistent with improved symptom management due to CREST program participation.

Figure 2. Percent of Participants with a Clutter Inventory Rating Score Greater than 2



ADDITIONAL CREST PROGRAM OUTCOMES

- As measured by the Hoarding Rating Scale, participant's level of self-rated functional impairment due to clutter reduced from an average of 5.5 (moderate/severe) to 3.4 (mild/moderate) after CREST program treatment.
- While many participants experienced functional and behavioral improvements, 6 participants who completed the CREST program during 2017 (54.5% of the 11 CREST program completers in 2017) still met criteria for medical necessity at the end of the 26-session program.
- In 2017, the CREST program helped 7 participants avoid evictions.

COMMON CREST PROGRAM PARTICIPANT PROFILES

Profile 1: Clutter Reduction Takes Time—Importance of Participant Commitment/Re-Commitment to Goals

Untreated mental health needs (e.g., depression) for some CREST program participants can worsen with various emotional triggers (e.g., holidays, death anniversaries) and result in increased acquisition of items. CREST program therapists responded by providing motivational enhancement sessions and facilitating connections to relevant external supports (e.g., physicians and psychiatrists). Furthermore, additional exposure therapy sessions provided through the CREST program often led to positive outcomes such as increased independent sorting/discarding practices. By establishing trust and maintaining relationships throughout the duration of a longer-term treatment strategy, CREST program team members identified potential challenges and intervened to transform the situations into ones of reinvigorated sorting/discarding practices and greater commitment to achieving overall goals.

Profile 2: Eviction Prevention and Improved Housing and Financial Situations

Participants often entered the CREST program on the verge of being evicted from their home and many exhibited health issues related to the unsafe home environment. Their living spaces may be nearly uninhabitable due to pest infestations, hazardous materials, and clutter that prevents the use of rooms and walkways. In addition, clients frequently also had external storage units whose monthly payments represented significant financial burdens. The CREST team worked with property managers and participants to improve the safety of their current living situation and/or identified and facilitated moving to a new living situation that better fit the needs of the participant. The CREST program then helped participants establish routines to keep their housing safe and functional. Additionally, some CREST participants have improved their finances by eliminating/reducing the number of external storage units utilized.

EXAMPLE OF CLUTTER REDUCTION DUE TO CREST PROGRAM PARTICIPATION

Before CREST program participation

After CREST program participation

ADDITIONAL CREST PROGRAM ACTIVITIES

- In 2017, the CREST program held 105 outreach and engagement presentations and educated 405 individuals about the CREST program and issues related to hoarding behaviors.
- The CREST manual was extensively revised by the team based on clinician and participant feedback.
- The CREST manual was translated into Spanish for future use with clients.
- The team continued to revise a County-wide resource guide specifically for clients with hoarding disorder symptoms. As of 12/31/2017 there were over 2,800 community resources listed.
- The team organized Program Advisory Group (PAG) meetings with community stakeholders to inform program actions.
- Per the recommendation of the PAG, a library of shareable hoarding-related reading materials was established for use by CREST program participants.

CREST PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the second year of providing INN-17 Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the CREST Program. All potential survey participants (n=8) responded to the survey for a response rate of 100%.

1. ***Major program goals as identified by CREST program personnel***
    a. Reduce hoarding behaviors by providing comprehensive evidence-based treatment and care management.
    b. Improve home safety, prevent evictions and reduce risk of homelessness.
    c. Provide wraparound services and connect participants to needed resources and services.
    d. Increase outreach and education to communities to improve knowledge of hoarding.

2. ***Factors that helped the CREST program achieve these goals (Helping Factors)***
    a. Using evidence-based treatment practices for hoarding disorder.
    b. Flexibility of mobile treatment staff to provide services in patients' homes.
    c. Coordinated care provided by a multi-disciplinary team targets specific issues, increases awareness of community resources, and helps maintain long-term improvements (e.g., individual therapy, case management, aftercare group activities).
    d. Prioritization of safety improvements and increased functionality of participants’ homes helped to reduce evictions, fines and code enforcements, and negative impact on relationships.
    e. Having funds to hire services that can address clients’ physical and financial limitations (e.g., unable to move large objects or afford removal services/dumpsters).
    f. Support and collaboration from stakeholders, volunteers, and community partners to allow the CREST program to expand and improve its services.

3. ***Specific challenges to reaching program goals (Inhibiting Factors)***
    a. Limitations to serving potential participants due to eligibility and exclusion criteria (e.g., insurance status and region within county).
    b. Some clients with comorbid psychiatric conditions may have difficulty adhering to program objectives.
    c. Eviction notices require increased urgency in the treatment and case management timeline.

4. ***Factors for successful recruitment and retention of participants***
    a. Media outreach and development of community partners to identify and recruit program participants.
    b. Easing the restrictions caused by existing eligibility criteria (e.g., insurance status and location).
    c. Maintain progress using motivational interviewing throughout treatment and forming aftercare groups.
    d. Using the Program Advisory Group to identify effective ways to recruit participants.

KEY YEAR 1 CREST PROGRAM “LEARNINGS”

1. Providing “in-home” services is essential.
2. Peer Support Specialists appear to provide important emotional and practical supports to participants in their efforts to change hoarding behaviors.
3. Comprehensive, “whole person” services are needed to address multiple factors contributing to hoarding behaviors.
4. Good communication and coordination is required to facilitate work of multi-disciplinary treatment and support team.
5. Usage of manualized, evidence-based practices helps provide structure to intervention delivery and is expected to promote achievement of desired outcomes.
6. External pressures such as threats of evictions or failed health inspections can provide initial motivation for hoarding behavior change.
7. Participants typically recognize that their hoarding behaviors have negative effects on their lives.
8. Hoarding behaviors have often been evident for long periods of time (i.e., more than several decades).
9. Change of hoarding behaviors is often not easy or comfortable for participants.
10. Involvement of other non-CREST team personnel such as landlords/property managers and other community connections can help support desired behavioral changes.
11. Initial results suggest that participation in CREST services can lead directly to positive outcomes such as evictions avoided, increased social connectedness, and improved sense of well-being.

KEY YEAR 2 PROGRAM “LEARNINGS”

1. Results suggest that participants who completed the CREST program demonstrate measurable reductions in household clutter and functional impairment.
2. Individuals with hoarding disorder are often socially isolated and poorly connected to community resources, which highlights importance of the mobile/in-home outreach and case management approach of the CREST program.
3. Reduction of symptoms and impairments can be difficult for participants to maintain after treatment completion and require continued support in the form of booster sessions, aftercare group, and referrals to community resources.
4. Family members and loved ones can be invaluable resources (e.g., referrals for treatment, emotional support, and help with maintenance) and it is important to prepare and support them through education and family groups.
5. The Program Advisory Group is an important resource in learning about effective ways to recruit participants.
6. Results suggest improvement in functional impairment and psychiatric symptom severity among participants.
7. Some participants may need more than the current 26 sessions of the CREST program to achieve desired results.
8. The CREST treatment manual needs to be applied with flexibility to accommodate specific needs and circumstances of individual participants.
9. Outreach engagement revealed that many potential participants are just above the income level for Medi-Cal, but still too impoverished to access the services they need.
10. Persons who need services for treating hoarding disorder are found throughout the County.
11. Having ample funds available for assistance with removal of items is a key element, particularly for participants who are under the threat of eviction.
12. Motivational interviewing is a good supplement to treatment.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-17 CREST Program during the second year of service provision (1/1/2017 to 12/31/2017) that differed substantially from the initial design of the program. However, some modifications to practices and procedures occurred throughout the year to improve operations and the fit between CREST and the service delivery context. For example, Drs. Ayers and Twamley have continued to refine the CREST treatment manual based upon clinician and participant feedback. An aftercare group was implemented to support maintenance of results following program completion. Additionally, the treatment team adopted a more flexible approach to applying the manual. Approvals received for CREST program expansions (i.e., increased eligibility and countywide service provision) will be implemented during Year 3.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the CREST Program during Year 2 and further increase caregiver access to needed behavioral health and other support services and resources include the following:

1. Expand services by reducing/eliminating insurance status restrictions (i.e., not required to be uninsured) and providing services in additional zip codes.

   Status: The CREST program received approval during Year 2 to provide services to Medicare only patients if justified and approved (previously required to be uninsured or participating in Medicaid). Additionally, the CREST program expansion allows for treatment of participants throughout all of San Diego County. These changes will take effect during Year 3.

2. Add a bilingual (Spanish-speaking) therapist to the treatment team.

   Status: The CREST program will be adding a Spanish-speaking therapist during Year 3.

3. Improve communication options between participants and CREST team members.

   Status: Staff now have cell phones to use when they are in the community providing care. Participants are given staff members' cell phone numbers.

4. Explore opportunities for program sustainment.

   Status: In addition to the approved CREST program expansions discussed above, the CREST program was extended for an additional 18 months (total project time now = 4.5 years), which will provide additional time to establish program effectiveness and community partnerships. The program was also approved to start using the BHS electronic health record system and is exploring options for billing insurance for services provided.

YEAR 2 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the CREST program and further increase caregiver access to needed behavioral health and other support services and resources:

1. Modify eligibility and inclusion criteria to allow interested persons to participate, particularly those enrolled in Medicare.
2. Improve media outreach and community engagement to recruit more participants and strengthen relationships with mental health providers and local partners.
3. Address need for home repairs or removal services by allocating funding or partnering with local business or organizations.
4. Incorporate family groups into treatment model.
5. Increase flexibility regarding length of stay in the CREST program.
6. Add yearly income to the CREST program screening tool to identify potential clients with incomes over the Medi-Cal threshold who still may have limited resources and find it difficult to acquire needed treatment services.

For additional information about the INN–17 CREST Program and/or this annual report, please contact:
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