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

Mental Health Services Act Innovation Projects (Cycle 3)

Annual Report: Year 1

FY 2015-16

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

UC San Diego

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CAREGIVER WELLNESS PROGRAM (INNOVATIONS-11)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Caregiver Wellness Program (CWP) is funded through the Innovations (INN) component of the Mental Health Services Act. CWP is designed to provide screening, needs assessments, linkage to services and resources, as well as therapeutic, educational, and support groups for parents and caregivers of children receiving services through KidSTART, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. CWP is intended to complement KidSTART services by directly addressing caregiver needs while their child is in treatment. Both CWP and KidSTART services are provided through Rady Children's Hospital Chadwick Center for Children and Families.

A primary innovation of CWP is the addition of Parent Care Coordinators (PCC) to the treatment team. After completing a detailed family needs assessments, the PCCs provides emotional support and worked to link caregivers with appropriate services and resources including their own behavioral health care. Additionally, therapeutic, educational, and support groups are offered directly through CWP in multiple San Diego County locations. CWP services are expected to improve the wellbeing of caregivers so that they could better care for themselves and their child/children.

EXECUTIVE SUMMARY

The Caregiver Wellness Program (CWP; INN-11) is designed to support parents/caregivers of children receiving treatment services through the County of San Diego KidSTART program by assessing caregivers and then linking 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.

- During Fiscal Year 2015-16, 82 caregivers were screened and 24 entered the CWP. Caregivers received a total of 99 case management visits and 91 psychoeducation support group sessions as of 6/30/2016.
- The primary language for 29.2% of caregivers was Spanish, with 58.3% indicating being of Hispanic origin. Half of the caregivers (50.0%) had a high school education or less.
- In general, caregivers who entered into CWP expressed favorable attitudes about the benefits of and their needs for receiving behavioral health services.
- The in-home needs assessments highlighted a wide range of caregiver needs. About half of respondents indicated a need for more knowledge parenting their children (61.9%), more emotional support (57.1%) and meeting with a professional to discuss problems (47.6%). Other common need areas were related to housing (38.1%), financial resources (33.3%), education (33.3%) and legal matters (28.6%).
- Over half of the caregivers (52.4%) were concerned that other demands on time (e.g., participating in services for their child) would make it difficult to participate in CWP.
- Based on the limited follow-up data (n=7) available as of 6/30/2016, all caregivers were satisfied with the services received through CWP and indicated receiving a range of emotional, educational, and tangible supports from PCCs.
- Caregiver participation rates in the CWP psychoeducation support groups were similar (about 50%) regardless of whether caregivers were accessing other non-CWP behavioral health services.
- CWP staff identified key factors that helped achieve CWP program goals: 1) providing one-on-one, in-home needs assessments, 2) offering psychoeducation groups within CWP, 3) having a structured curriculum for these groups, 4) making PCCs region-specific for building local resource expertise, 5) collaboration and communication between CWP leadership, PCCs, and therapists, and 6) CWP staff "buy-in" into the importance of caregiver well-being to child care.

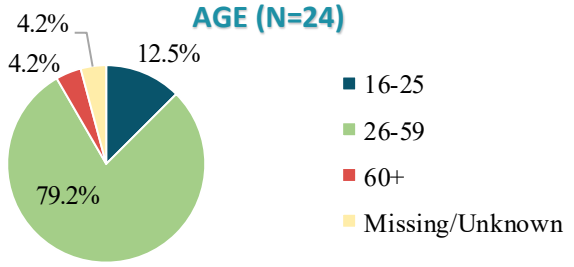
RECOMMENDATIONS

Primary recommendations include: 1) simplify and shorten the screening/assessment process, 2) accelerate timeframe for development of caregiver wellness plan and provision of PCC coordination and support services after in-home assessment, 3) explore providing individual therapy as part of CWP, 4) enhance the program's capacity to address barriers to CWP participation, 5) identify more bilingual therapists in the community that CWP can refer to, 6) provide additional PCC trainings, and 7) facilitate regular communication and coordination between PCCs and therapists.

CAREGIVER WELLNESS PROGRAM PARTICIPANT DEMOGRAPHICS

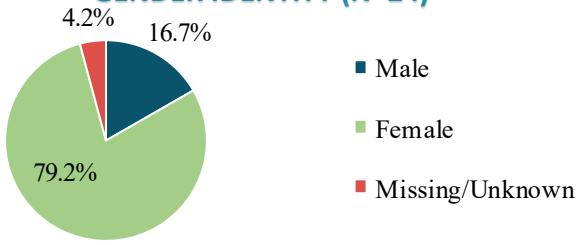
The following demographic data were collected from a participant self-report survey administered at the start of the CWP program.

AGE (N=24)



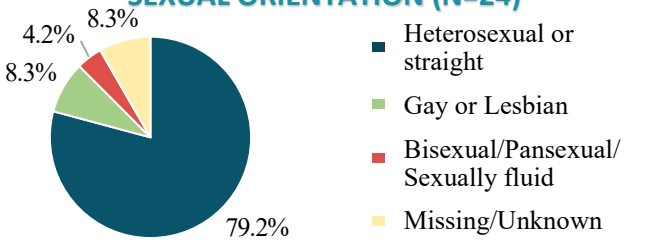
The majority of participants (79%) were between the ages of 26 and 59.

GENDER IDENTITY (N=24)



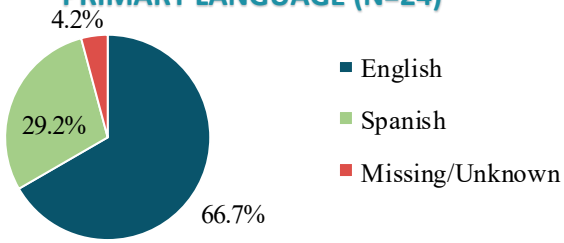
About three-quarters of participants were female (79%), and 17% of participants were male.

SEXUAL ORIENTATION (N=24)



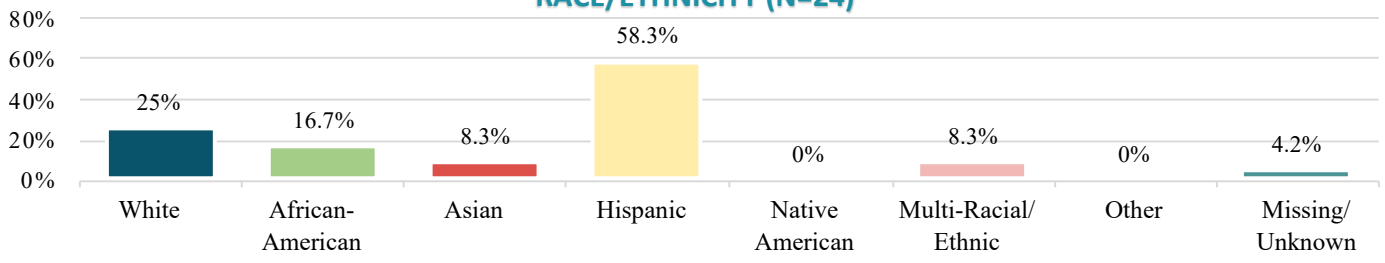
Most (79%) participants were heterosexual or straight, and about 8% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=24)



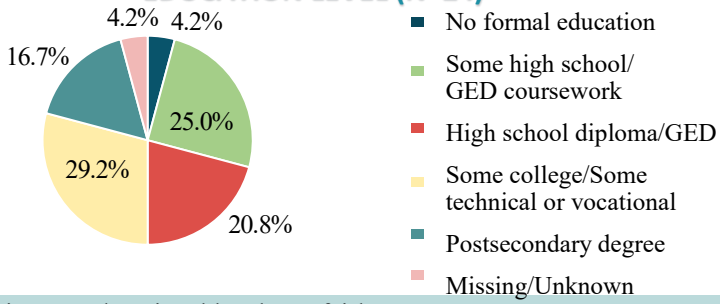
English was the primary language for two-thirds of participants (67%), with Spanish being the primary language for 29% of participants.

RACE/ETHNICITY (N=24)



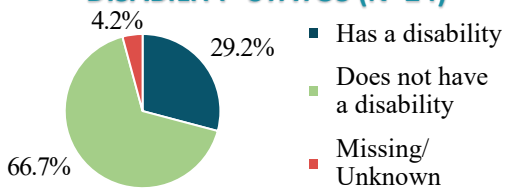
Fifty-eight percent of participants identified themselves as Hispanic, and 41.7% specifically indicated being of Mexican origin. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EDUCATION LEVEL (N=24)



Participants' educational level was fairly split between several categories, the largest being some high school/

DISABILITY[1] STATUS (N=24)



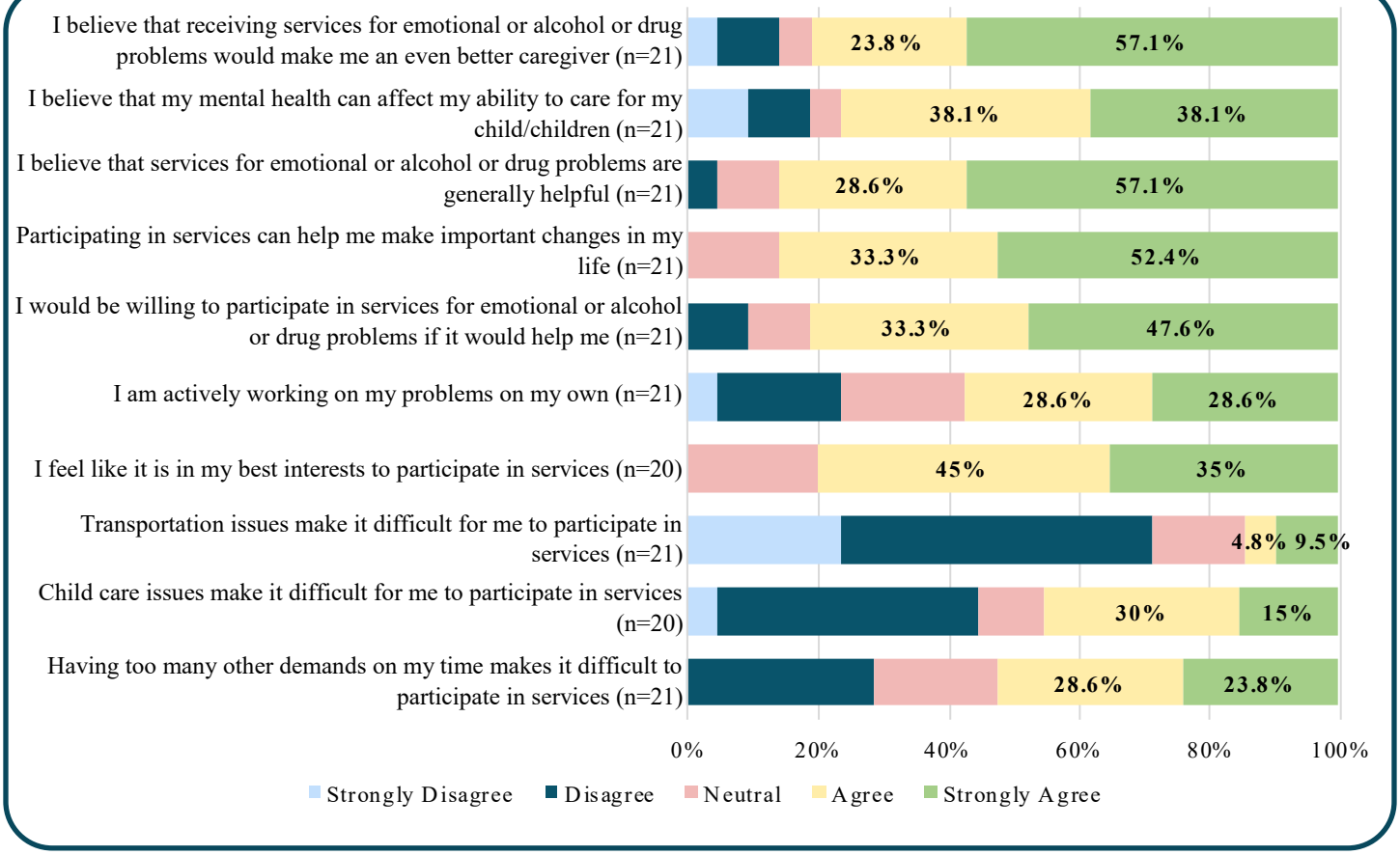
Twenty-nine percent of participants reported having some form of non-SMI disability.

The majority (92%) of participants had never served in the military.

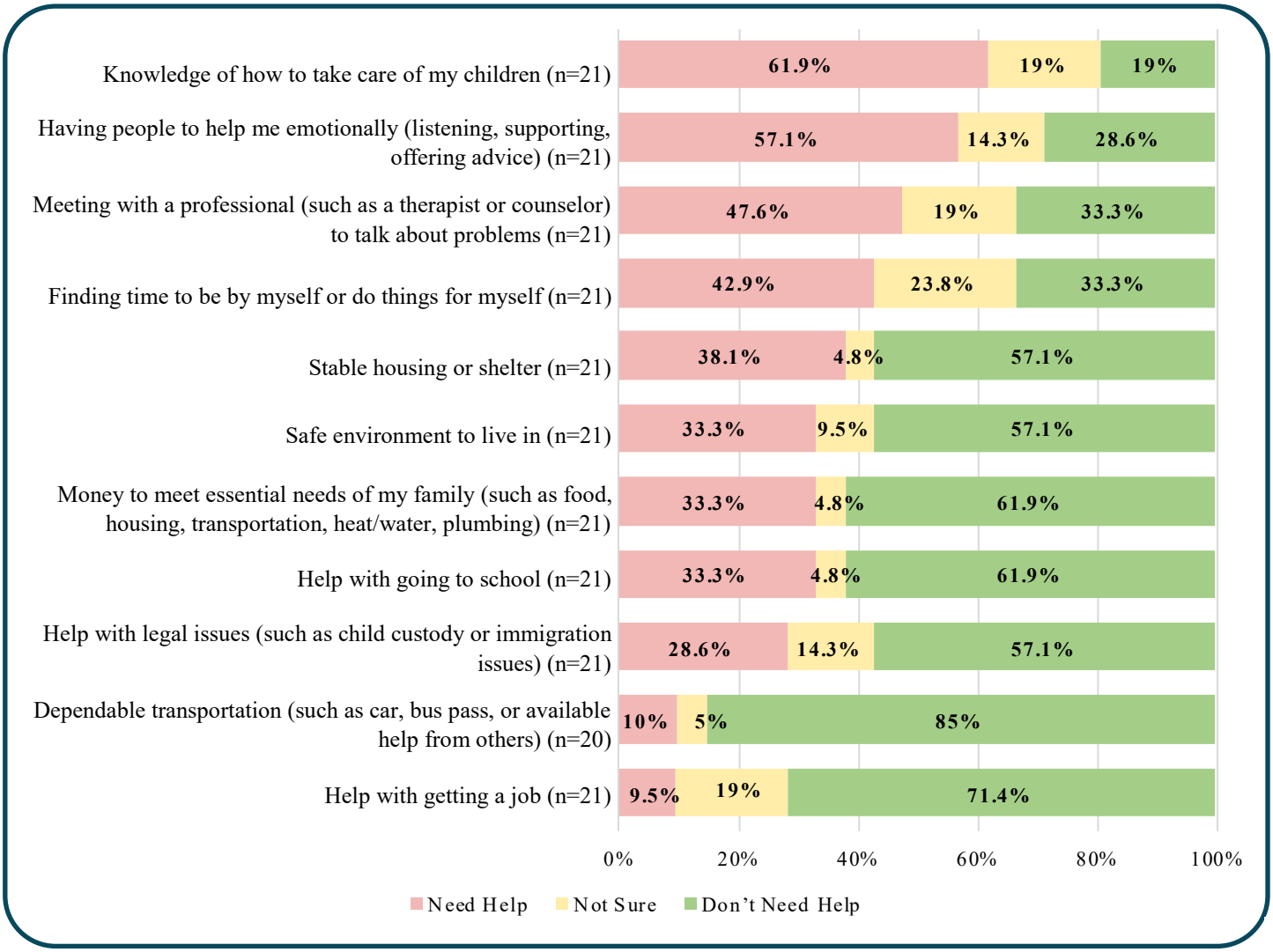
[1] A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness (SMI).

KEY EVALUATION FINDINGS: BASELINE

Upon entering CWP, caregivers typically expressed favorable attitudes about the value of and need for receiving additional support services (see chart below). For example, over 80% agreed or strongly agreed that "receiving services…would make [them] an even better caregiver" (80.9%), that such services were "generally helpful" (85.7%), that they would be "willing to participate in services" (80.9%), and that it is in their "best interest to participate in services" (80.0%). Relatively few (14.3%) 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 (45.0% and 52.4%, respectively).

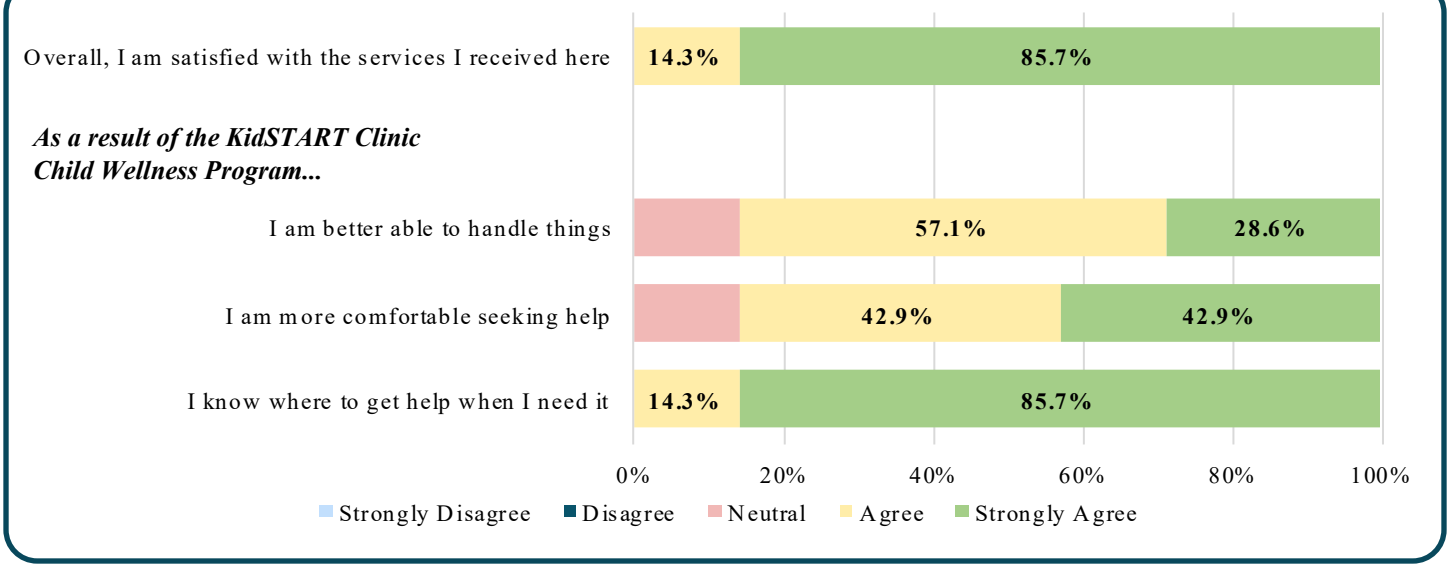


Select items from the comprehensive baseline family needs assessment are listed in the chart on the next page. Consistent with the caregiver's openness and interest in receiving mental health and/or alcohol and drug services discussed previously, almost half of caregivers indicated on a baseline family needs assessment that they needed help "meeting with a professional…to talk about problems" (47.6%), and over half (57.1%) indicated needing assistance with finding "people to help [them] emotionally." Additionally, the majority (61.9%) wanted help increasing their "knowledge of how to take care of [their] children." Needing help with other issues such as housing, finances, education, and legal matters were each expressed by about one-third of all caregivers entering CWP.

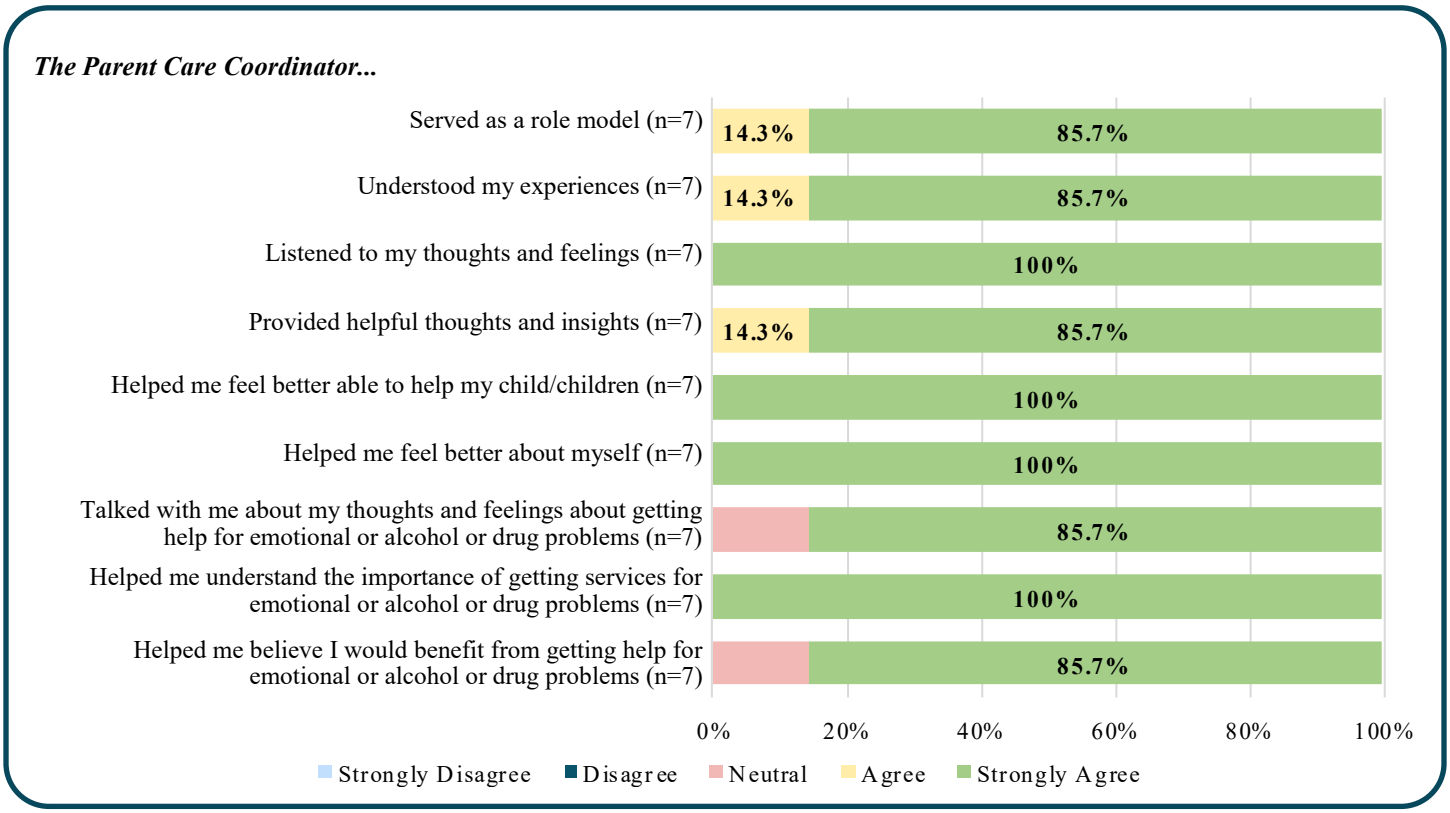


KEY EVALUATION FINDINGS: FOLLOW-UP

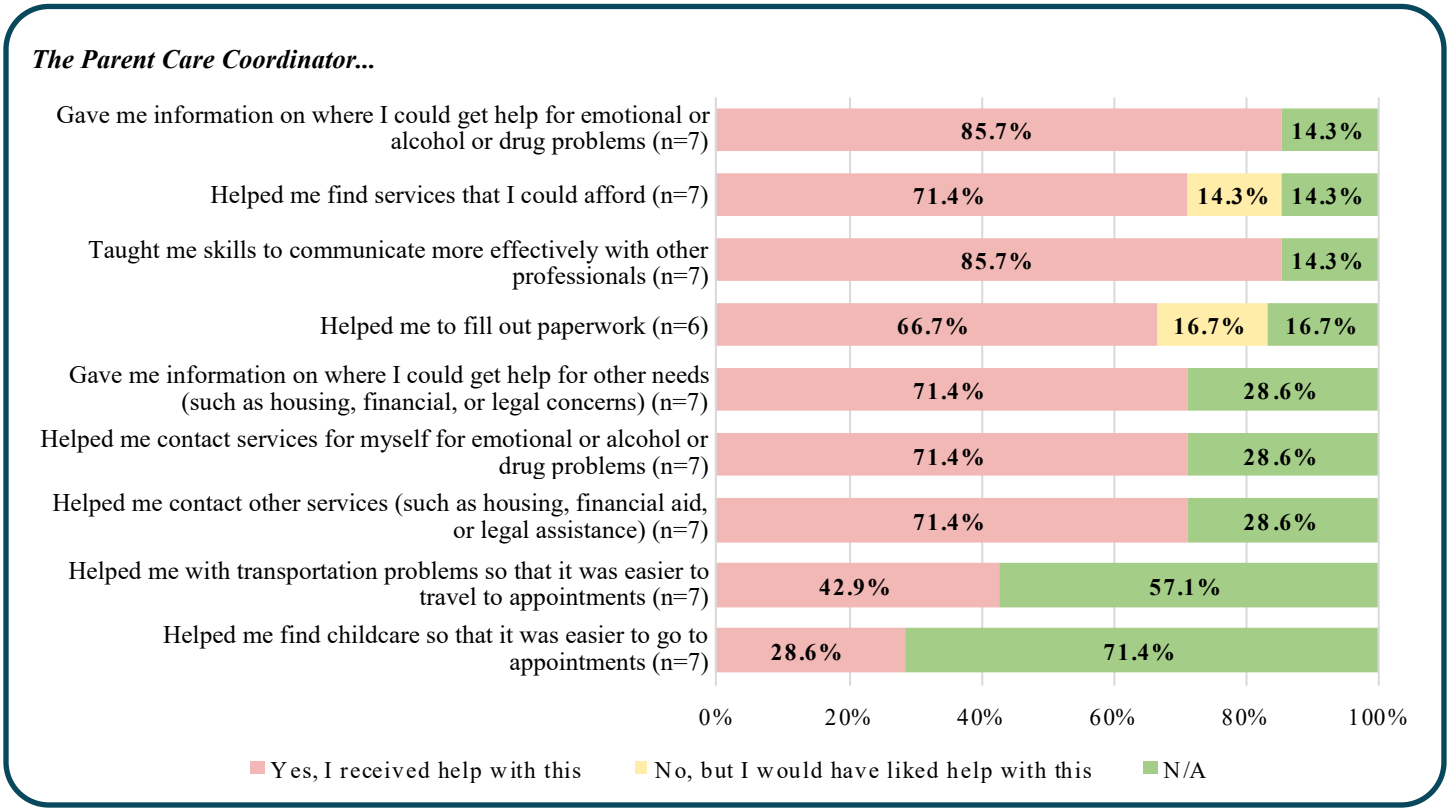
As seen in the chart below, all caregivers with follow-up data (n=7) indicated they were satisfied with the CWP services received (85.7% strongly agreed that they were satisfied with services). While respondents almost universally agreed or strongly agreed with being "better able handle things", "more comfortable seeking help" and "know[ing] where to get help" as a result of their participation in CWP, it appeared that knowledge of where to get help when needed was a primary outcome for caregivers (85.7% strongly agreed with this item).



The chart below shows that caregivers with follow-up data nearly universally "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".



Additionally, Parent Care Coordinators 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 (see chart below). Most caregivers with follow-up data indicated that they did not need assistance with finding transportation or childcare to attend appointments (57.1% and 71.4%, respectively). For those who did need these types of more tangible assistance, caregivers indicated that they did receive help from Parent Care Coordinators in these areas.



UTILIZATION OF SERVICES AT START OF THE CAREGIVER WELLNESS PROGRAM

As shown in Table 1, approximately one-quarter (23.8%) of caregivers indicated they had some type of hospitalization or residential treatment for mental health or substance abuse issues in the 90 days prior to entering CWP. At the start of CWP, 57.1% of caregivers were receiving or waitlisted for psychological counseling, and one person (4.8% of caregivers) was attending or waitlisted for alcohol or drug services. One-third (33.3%) of caregivers were using prescription medication for their emotional or mental health needs. Data from the County of San Diego Behavioral Health Services indicated that in the 90 days prior to starting CWP, three (3; 12.5%) of these caregivers had received outpatient treatment services through a County-funded program.

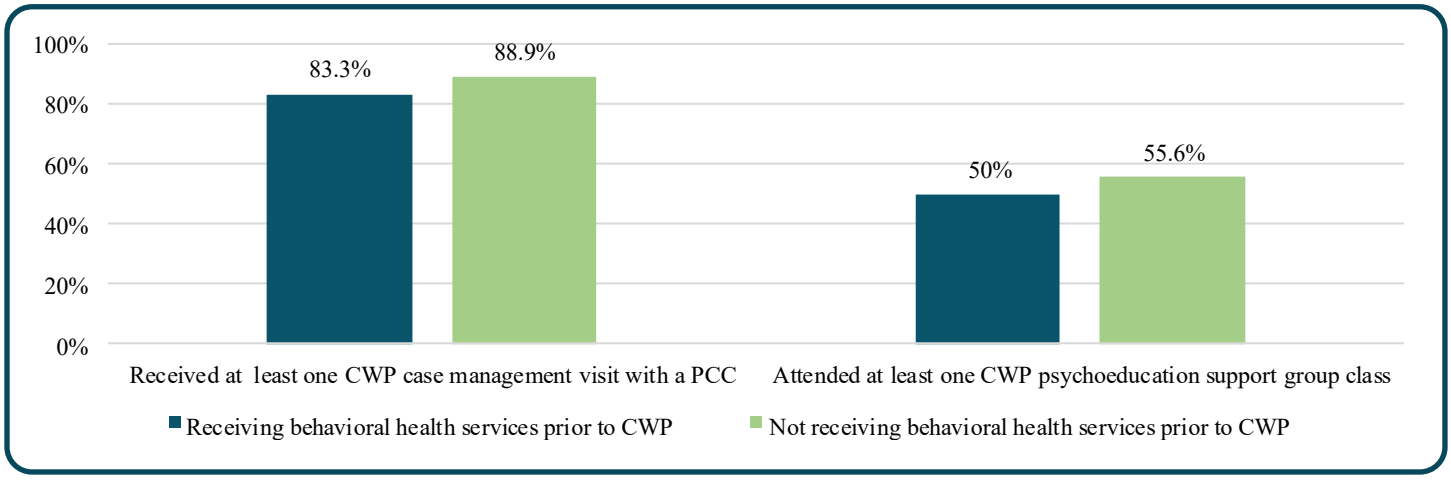
TABLE 1. CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION AT START OF CAREGIVER WELLNESS PROGRAM

	n	Yes	No
In the past 90 days have you been admitted for an overnight stay in a hospital or other facility to receive help for problems with your emotions, nerves, mental health, or your use of alcohol or drugs?	21	5 (23.8)%	16 (76.2%)
Are you currently receiving or are you on a waitlist for psychological counseling or therapy for emotional problems with any type of professional?	21	12 (57.1%)	9 (42.9%)
Are you currently going to or are you on a waitlist for a clinic or doctor for an alcohol or drug problem?	21	1 (4.8%)	20 (95.2%)
Are you currently using a prescription medicine for your emotions, nerves or mental health from any type of professional?	21	7 (33.3%)	14 (66.7%)

UTILIZATION OF CAREGIVER WELLNESS PROGRAM SERVICES

Through 6/30/2016, the CWP staff had provided 99 case management sessions and 91 psychoeducational support group sessions to the 24 persons participating in CWP. Of these 24 caregivers, 75% had received at least one case management visit (average of 5.5 visits) and 45.8% had participated in at least one psychoeducational support group session (average of 8.3 group sessions).

The chart below presents a comparison of the CWP service utilization of patterns based on whether a caregiver reported they were receiving some form of mental health or substance abuse counseling or assistance at the time they started CWP. The findings indicated that there were essentially no differences between the types of CWP services accessed by caregivers that were involved in other services and by caregivers that were not. About 85% of both groups of caregivers received at least one case management visit, and about 50% of both groups participated in the psychoeducational support groups.



These findings suggest that CWP had expanded access to and successfully engaged both caregivers who were not previously receiving behavioral health services, as well as supplementing the services for those who were already receiving some other forms of mental health or substance abuse treatment.

An examination of County of San Diego Behavioral Health Services data for the subset of caregivers who had started CWP at least 90 days before 6/30/2016 (the end of Year 1), indicated that there were no new caregivers linked up to County-funded outpatient treatment services. However, the persons receiving behavioral health services before starting CWP continued to do so after starting CWP. No SDCBHS psychiatric hospitalizations, emergency psychiatric unit visits or psychiatric emergency response team visits occurred in the 90 days before or after caregivers started CWP. These service utilization patterns will continue to be monitored in future reporting periods as more caregivers receive CWP services.

CAREGIVER WELLNESS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN Caregiver Wellness Program, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Caregiver Wellness 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 responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Factors that helped achieve CWP program goals:*
   a. Providing one-on-one, in-home comprehensive needs assessments
   b. CWP staff "buy-in" to importance of caregiver wellbeing for improving child behaviors
   c. Structured curriculum for psycho-education support groups
   d. Collaboration and communication between program leadership, PCCs and therapists
   e. Offering therapeutic, education, and support groups to caregivers not interested in individual mental health treatment
   f. Region specific PCCs developed expertise in available resources in that area
2. *Factors that inhibited achieving CWP program goals*:
   a. Lengthy/complicated assessment process can delay or prevent getting a caregiver connected with a PCC
   b. Not able to identify the caregivers that are in more need of services through the screening tool
   c. Not able to provide individual psychotherapy directly through CWP to caregivers
   d. Caregivers beliefs that it is more important to obtain services for their child than for themselves
   e. Time, transportation, and other tangible barriers to caregiver participation in services
3. *Factors that facilitated caregiver participation in CWP services:*
   a. Timely engagement with PCCs following needs assessment
   b. Regular, consistent contact with PCCs
   c. Flexibility to offer groups at wide range of times and days
   d. Clear communication to caregivers about how CWP services will help them and their child
   e. Effectively connecting caregivers with other needed resources or services
   f. Providing caregivers with information and tools that they perceive as important
   g. Being client-centered, respectful, and responsive, to build caregiver rapport and trust
4. *Caregiver responses to recommendation to participate in CWP:*
   a. Some very open and interested, others ambivalent or hesitant
   b. Often more interested in CWP and behavioral health services after the in-home needs assessment
   c. Knew and agreed with recommendation for behavioral health care, but prioritized their child's needs over their own needs
   d. Concern about how to care for themselves given other time commitments, particularly to their child
5. *Primary caregiver benefits of psychoeducation support group participation:*
   a. Increased understanding of the importance of caregivers wellness to their child
   b. Empowered caregivers with additional knowledge through psychoeducation
   c. Provided emotional support and comfort in a "safe space"
   d. Created opportunities for "light bulb" moments where caregivers have important realizations about caring for themselves and/or their child
   e. Facilitated the development of peer-support social relationships with others in similar situations
   f. Helped to normalize situation and reduce anxiety by seeing other caregivers with similar challenges
6. *Primary strategies for linking caregivers to external non-CWP services:*
   a. Acknowledging and empathizing with caregiver ambivalence/hesitancy to receive other services
   b. Normalizing the need for services
   c. Building trusting and supportive relationships with caregivers
   d. Making referrals directly for caregivers and following up with caregiver and agency
   e. Finding a good match between caregiver needs and available external services/resources
   f. Prioritizing caregiver goals
   g. Conducting a thorough needs assessment
   h. The existence of the PCC as a dedicated position for facilitating linkages for caregivers

KEY YEAR 1 CAREGIVER WELLNESS PROGRAM "LEARNINGS"

1. 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 CWP.
2. 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.
3. The PCC role facilitated both emotional support and education of caregivers, as well as identifying and connecting with needed external resources and services.
4. Offering therapeutic, educational and support groups directly within the CWP was an effective strategy for providing needed and desired caregiver-focused behavioral health services.
5. 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.
6. Need to ensure identification of all caregivers who may benefit from CWP services without creating too lengthy or cumbersome screening and assessment process.
7. Spanish-speaking PCCs and therapists were vital to delivering CWP services. Need additional Spanish-speaking therapists in the community who can receive adult behavioral health treatment referrals from CWP.
8. 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 there own wellbeing.
9. 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.
10. CWP participation enhanced KidSTART therapists' knowledge of caregiver strengths and needs, which facilitated caregiver engagement in child-caregiver dyadic treatment services and informed child treatment strategies.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-11 Caregiver Wellness Program during the first year of service provision (7/1/2015 to 6/30/2016) that differed substantially from the initial design of the program. As is typical during program start-ups, some basic practices and procedures were adjusted over the course of the first year to better fit the emerging service delivery context. These modifications included minor changes to the caregiver screening/assessment process, refinement of psychoeducation support group curriculum, PCC roles and responsibilities, and communication between CWP staff. However, no fundamental program changes were made.

Review of program services was integrated into the on-going operations of CWP, and during the latter part of Year 1, leadership began an assessment of practices and procedures through review of program data and informal feedback as well as input obtained during "debriefing meetings" with staff. Elimination of the screening process, better integration of the caregiver assessment into the case flow, assignment of a PCC concurrent with assignment of the child's therapist, and enhanced training for PCCs were keys areas that were identified for program changes in Year 2.

YEAR 1 PROGRAM RECOMMENDATIONS

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

1. Simplify and shorten screening/assessment process.
2. Following the completion of the in-home assessment by the PCC, accelerate timeframe for development of caregiver wellness plan and provision of PCC coordination and support services.
3. Explore potential for providing individual therapy as part of CWP.
4. Address barriers to CWP participation (e.g., improve caregiver outreach and engagement strategies, incentivize attendance at group sessions, offer classes at convenient times and locations, provide additional transportation and child care, etc.).
5. Identify more bilingual and/or Spanish language therapists in the community who can receive adult behavioral health treatment s referrals from CWP.
6. Provide additional training and education opportunities for PCCs (e.g., engagement strategies, trauma-informed care, etc.).
7. Create additional opportunities for communication and coordination between PCCs and therapists.

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

Participant Demographics: INN 11 Caregiver Wellness Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	3	*12.5%*
26-59 (adult)	19	*79.2%*
60+ (older adults)	1	*4.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Race	N	%
Black/African American	4	*16.7%*
Asian	2	*8.3%*
White	6	*25.0%*
Native American	0	*0%*
More than one race	1	*4.2%*
Other	0	*0%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	10	*41.7%*
TOTAL	**24**	***100%***

Ethnicity	**N**	**%**	**N**	**%***
Hispanic or Latino	13	*54.1%*		
Mexican			10	*41.7%*
Puerto Rican			1	*4.2%*
Other			1	*4.2%*
Missing/did not answer			1	*4.2%*
Non-Hispanic or Non-Latino	9	*37.5%*		
Filipino			1	*4.2%*
Japanese			1	*4.2%*
Other			0	*0%*
Missing/did not answer			7	*29.2%*
More than one ethnicity	1	*4.2%*	1	*4.2%*
Unknown/preferred not to answer	1	*4.2%*	1	*4.2%*
Missing/did not answer	0	*0%*	0	*0%*
TOTAL	**24**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
English	16	*66.7%*
Spanish	7	*29.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Sexual Orientation	N	%
Gay or Lesbian	2	8.3%
Heterosexual or Straight	19	79.2%
Bisexual	1	4.2%
Unknown/preferred not to answer	2	8.3%
Missing/did not answer	0	0%
TOTAL	**24**	**100%**

Disability	N	%	N	%*	N	%*
Yes disability	7	*29.1%*				
Communication disability			4	*16.7%*		
Difficulty seeing					4	*16.7%*
Mental disability			3	*12.5%*		
Learning disability					3	*12.5%*
Physical/mobility disability			0	*0%*	0	*0%*
Chronic health condition			2	*8.3%*	2	*8.3%*
Other disability			0	*0%*	0	*0%*
No disability	16	*66.7%*	16	*66.7%*	16	*66.7%*
Unknown/preferred not to answer	1	*4.2%*	1	*4.2%*	1	*4.2%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**24**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	2	*8.3%*
No	21	*87.5%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

Gender: Assigned Sex at Birth	N	%
Male	4	*16.7%*
Female	19	*79.2%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	1	*4.2%*
TOTAL	**24**	***100%***

Gender: Current Gender Identity	N	%
Male	4	*16.7%*
Female	19	*79.2%*
Unknown/preferred not to answer	1	*4.2%*
Missing/did not answer	0	*0%*
TOTAL	**24**	***100%***

FAMILY THERAPY PARTICIPATION ENGAGEMENT (INNOVATIONS-12)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Family Therapy Participation Engagement (FTPE) program is funded through the Innovations (INN) component of the Mental Health Services Act. FTPE is 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 are required to have prior experience caring for children receiving behavioral health services to facilitate their role as peer-supports for caregivers in similar situations. Parent Partners are 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 are intended 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 are 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 is designed to increase caregiver participation in Family Therapy visits by using peer-support Parent Partners to enhance caregivers' understanding of the importance of active participation in their child's treatment and to encourage participation in Family Therapy sessions.

- During Fiscal Year 2015-16, a total of 2,595 Parent Partner visits were provided to caregivers of 592 children receiving behavioral health treatment services at six agencies throughout San Diego County.
- Based on available caregiver demographics, most FTPE caregiver participants were female, and the majority spoke Spanish as their primary language. Over half of caregivers had a high school or lower level of education, and at least 15% were unemployed and looking for work.
- After implementing FTPE, regular participation in Family Therapy (i.e., at least 1 session per month) increased to 42.0% of children starting treatment services—up from 26.8% before FTPE's implementation (a 57% increase).
- Caregiver visits with Parent Partners appeared to increase the likelihood of regular participation in Family Therapy. About one-third (35.9%) of caregivers with no Parent Partner visits regularly participated in Family Therapy sessions (i.e., at least 1 session per month), compared to 53.2% of those with at least 1 Parent Partner visit. This 48% higher participation rate was accomplished despite Parent Partners appropriately focusing their efforts on caregivers less likely to participate in Family Therapy.
- Caregivers reported very high overall levels of satisfaction with Parent Partner services (97.5% satisfaction). 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.
- Key factors contributing to increased Family Therapy participation identified by FTPE administrative and service provider staff included: 1) support, encouragement, education, and tangible resources provided to caregivers by Parent Partners; 2) MI training and other trainings received by Parent Partners; 3) Parent Partners' "lived experience" with the CYF Behavioral Health System; and 4) an increased team care approach that facilitated Parent Partner and therapist communication/collaboration.

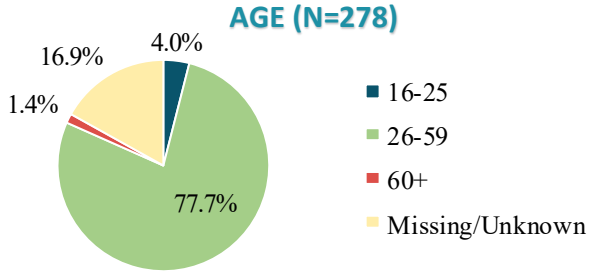
RECOMMENDATIONS

Primary recommendations include: 1) provide additional Motivational Interviewing and other trainings for Parent Partners, 2) increase availability of Parent Partner services (e.g., more FTE), 3) provide more opportunities for group meetings with caregivers and Parent Partners, 4) provide additional resources to address "tangible" barriers to Family Therapy visits (e.g., transportation and child care.), and 5) identify ways to encourage and support Parent Partners to minimize staff turnover and facilitate hiring.

FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS[1]

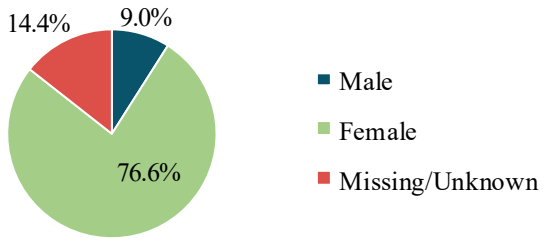
The following demographic data were collected from a caregiver self-report survey administered at the start of the FTPE program.

AGE (N=278)



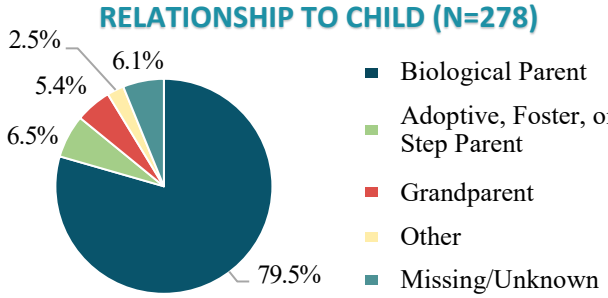
The majority of caregivers (78%) were between the ages of 26 and 59.

GENDER IDENTITY (N=278)



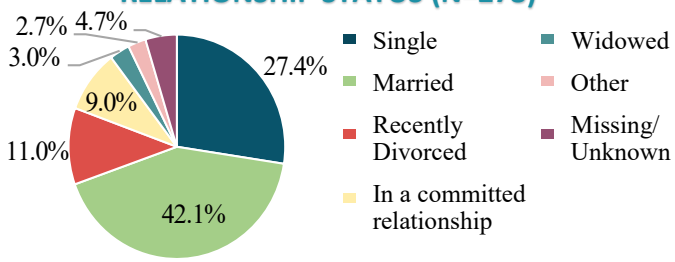
About three-quarters of caregivers were female (77%), and 14% of caregivers were male.

RELATIONSHIP TO CHILD (N=278)



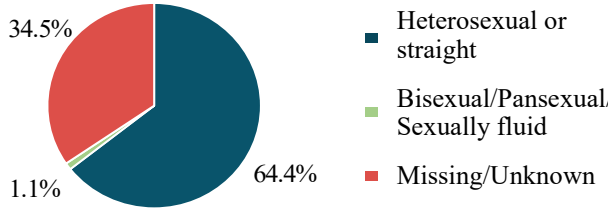
Most caregivers were a biological parent of the child receiving services (80%).

RELATIONSHIP STATUS (N=278)



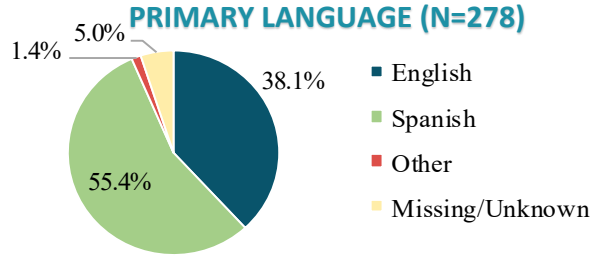
About one-quarter (27%) of caregivers were single, 42% were married, 11% were recently divorced, and 9% were in a committed relationship.

SEXUAL ORIENTATION (N=278)



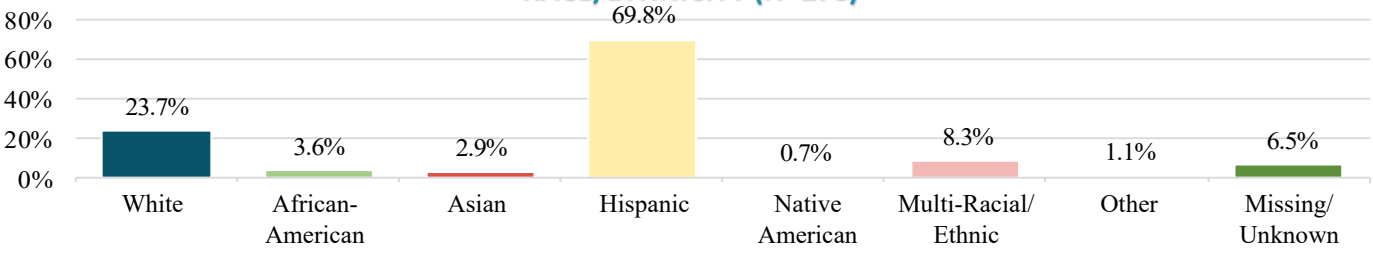
More than half (64%) of caregivers indicated they were heterosexual or straight, and about 1% indicated being bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=278)



Spanish was the primary language for the majority of caregivers (55%), with English as the primary language for 38% of caregivers.

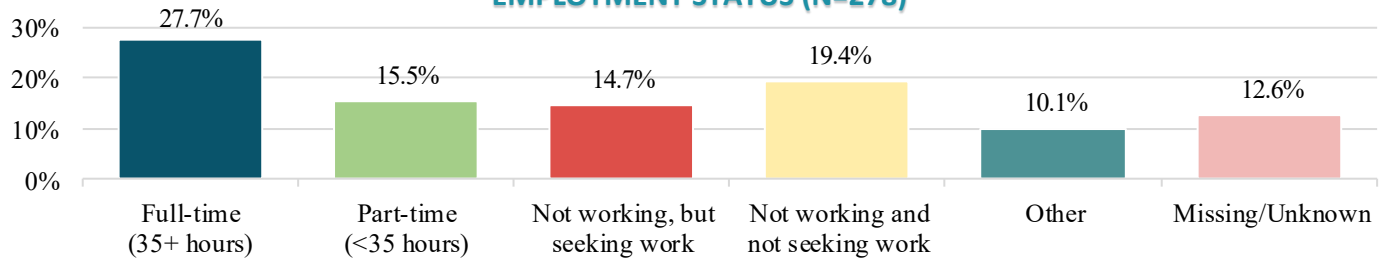
RACE/ETHNICITY (N=278)



Seventy percent of caregivers identified themselves as Hispanic. Of those caregivers, 39.6% specifically indicated being of Mexican origin. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

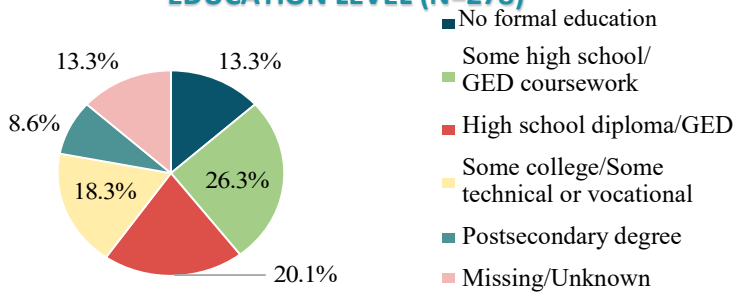
[1] *Caregiver demographic information was not required to be collected by participating FTPE programs prior to 1/1/2016. The charts include all available demographic information, which is expected to be generally representative of caregivers receiving FTPE services.*

EMPLOYMENT STATUS (N=278)



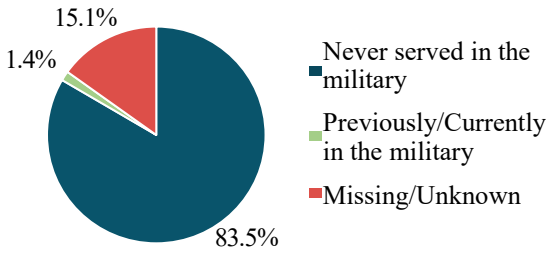
About one-quarter (28%) of caregivers worked full-time, 16% worked part-time, 15% were not working but seeking work, and 20% were not working and not seeking work.

EDUCATION LEVEL (N=278)



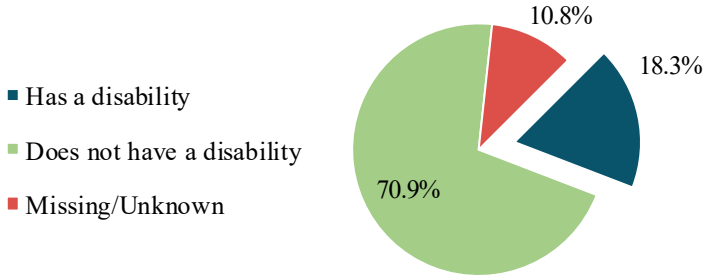
Caregivers' educational level was fairly split between several categories, the largest being some high school/GED coursework (26%).

MILITARY STATUS (N=278)



The majority (84%) of caregivers had never served in the military.

DISABILITY[1] STATUS (N=278)



Eighteen percent of caregivers had some type of non-SMI related disability.

TYPE OF DISABILITY (N=278)

Type	n	%
Communication	12	4.3
Mental (e.g., learning,)	12	4.3
Physical	17	6.1
Chronic Health	19	6.8
Other	11	4.0

This table describes the type of disability indicated by caregivers that had a as a percentage of total population. Caregivers may have indicated more than one disability.

[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 severe mental illness (SMI).*

KEY EVALUATION FINDINGS

OVERALL PROGRAM SERVICE PROVISION PRIOR TO AND AFTER INN FTPE IMPLEMENTATION

During Fiscal Year 2015-16, a total of 2,595 Parent Partner visits were provided to caregivers of 592 children receiving behavioral health treatment services at six Child, Youth and Family (CYF) programs throughout San Diego County. To help identify the overall impact of the FTPE program on Family Therapy participation, service utilization patterns at the Child, Youth, and Family (CYF) programs providing the new Parent Partner services through the FTPE program were examined before and after full FTPE program implementation. Two six-month blocks of time (1/1/2015 to 6/30/2015 and 1/1/2016 to 6/30/2016) were selected for this comparison.

TABLE 1. OVERALL SERVICE DISTRIBUTION PATTERNS BEFORE AND AFTER INN FTPE PROGRAM IMPLEMENTATION

	Before INN FTPE (1/1/2015 to 6/30/2015)	After INN FTPE (1/1/2016 to 6/30/2016)
Total Individual Therapy Sessions	8,989	8,467
Total Family Therapy Sessions	3,300	5,324
Total Parent Partner Visits	-	1,809
Ratio of Individual Therapy Sessions per each Family Therapy Session	2.7	1.6

As shown in the table above, the distribution of services provided by these CYF programs changed substantially before and after FTPE program implementation. The number of Family Therapy sessions increased greatly (3,300 to 5,324 = 61.3% increase) and the number of individual therapy sessions decreased slightly (8,989 to 8,467 = 5.8% decrease) between the six month reporting periods before and after the implementation of the FTPE program. This dropped the overall ratio of Individual Therapy sessions to Family Therapy sessions from 2.7 per family session to 1.6 per family session. These findings indicate a substantial shift in the overall number of Family Therapy sessions provided and in the distribution between Individual and Family Therapy sessions provided at these agencies. Feedback from program staff at the participating CYF agencies indicated that they were not aware of any other systemic changes that might have contributed to this shift in service utilization besides the implementation of the FTPE program.

SERVICE UTILIZATION OF FAMILIES ENTERING INN-12 CYF PROGRAMS PRIOR TO AND AFTER FTPE IMPLEMENTATION

The service utilization patterns of the families who began receiving services at these CYF programs (defined as no Family Therapy, Individual Therapy, or Parent Partner visits in the prior 6 months) during these two time periods were also examined. As shown in Table 2 on the next page, the service utilization patterns indicated that more caregivers participated in a least some Family Therapy sessions after the implementation of the FTPE program (70.9% vs. 58.5%). More importantly, the percentage of caregivers who more regularly participated in Family Therapy increased substantially after FTPE implementation (42.0% vs 26.8% averaged at least 1 session per month and 18.8% vs. 10.8% averaged at least 2 sessions per month). This means that after the implementation of the FTPE program, the number of families averaging at least 1 Family Therapy session per month increased by 57%, and number of families reaching the target threshold of 2 Family Therapy session per month increased by 74%. While additional work is needed to continue to bolster the number of families regularly participating in Family Therapy, the increase in the amount of participation following the implementation of FTPE was dramatic.

TABLE 2. SERVICE UTILIZATION PATTERNS BEFORE AND AFTER INN FTPE PROGRAM IMPLEMENTATION

	Before INN FTPE (1/1/2015 to 6/30/2015) (N=704)		After INN FTPE (1/1/2016 to 6/30/2016) (N=728)	
Individual Therapy	**%**	**n**	**%**	**n**
Had at least 1 session in the first 90 days of treatment	93.9%	661	89.4%	651
Averaged at least 1 session per month	81.0%	570	74.5%	543
Averaged at least 2 sessions per month	53.8%	379	43.3%	315
Family Therapy				
Had at least 1 session in the first 90 days of treatment	58.5%	412	70.9%	516
Averaged at least 1 session per month	26.8%	189	42.0%	306
Averaged at least 2 sessions per month	10.8%	76	18.8%	137
Parent Partner Visits				
Had at least 1 session in the first 90 days of treatment	-	-	36.1%	263
Averaged at least 1 session per month	-	-	18.7%	136
Averaged at least 2 sessions per month	-	-	6.6%	48

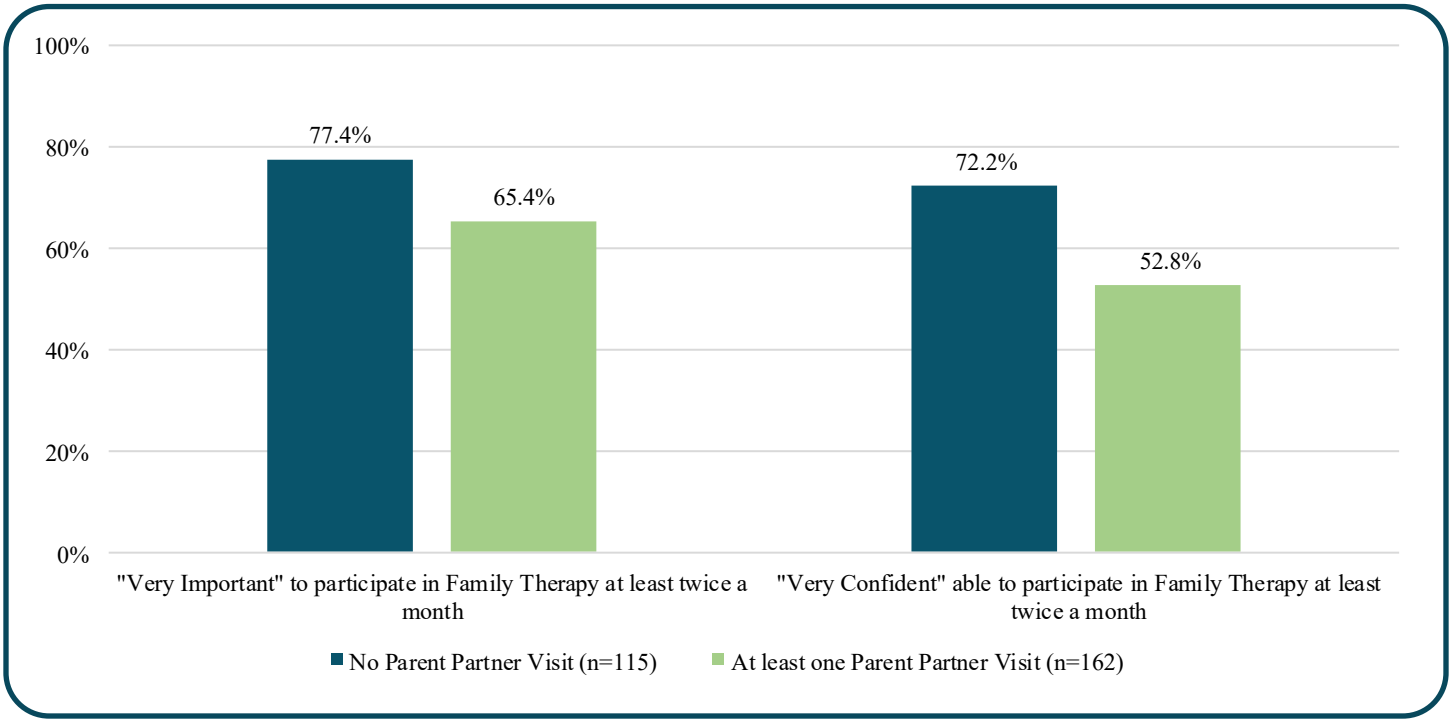
FAMILY THERAPY UTILIZATION AFTER INN FTPE PROGRAM IMPLEMENTATION

Out of the 728 children who entered into CYF programs after implementation of the FTPE program, 263 (36.1%) had caregivers that received at least 1 Parent Partner visit within 90 days of starting services, and 465 (63.9%) had caregivers that did not have a Parent Partner visit within 90 days of starting services. As shown in the Table 3 below, caregivers who received at least 1 Parent Partner visit were more likely to have participated in at least 1 Family Therapy session than those who did not have a Parent Partner visit (77.9% vs. 66.0%).

TABLE 3. RELATIONSHIP BETWEEN PARENT PARTNER VISITS AND FAMILY THERAPY PARTICIPATION

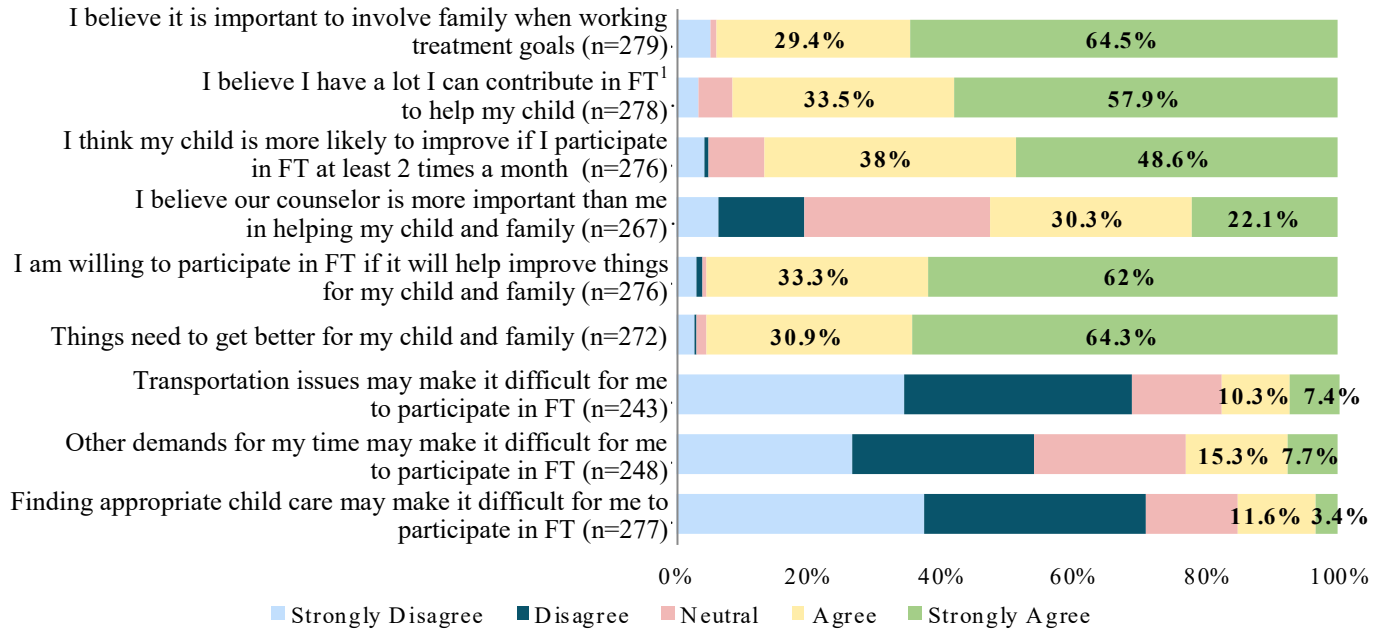
	No Parent Partner visits (1/1/2016 to 6/30/2016) (N=465)		Had at least 1 Parent Partner visit (1/1/2016 to 6/30/2016) (N=263)	
Family Therapy	**%**	**n**	**%**	**n**
Had at least 1 session in the first 90 days of treatment	66.0%	307	77.9%	205
Averaged at least 1 session per month	35.9%	167	53.2%	140
Averaged at least 2 sessions per month	15.1%	70	25.5%	67

The positive relationship between having a Parent Partner visit and increased participation in Family Therapy was especially evident when focusing on the percentage of children who reached the target threshold of averaging at least 2 Family Therapy sessions per month (25.5% vs. 15.1%). This difference is particularly significant given the fact that CYF programs reported seeking to direct their limited Parent Partner resources to caregivers who were considered most likely to not participate in Family Therapy. Based on data from the Caregiver Information survey administered to families when they first entered the CYF programs (see the chart below), the families who ended up receiving Parent Partner services were less likely to indicate that it was "Very Important" to participate in Family Therapy (65.4% vs. 77.4%) and less likely to indicate they were "Very Confident" that they would be able to participate in Family Therapy (52.8% vs. 72.2%). These findings suggest that the families receiving Parent Partner services were caregivers who were potentially less likely to participate in Family Therapy without some form of additional support. Thus, by providing Parent Partner visits, the FTPE program was able to obtain a higher proportion of caregivers meeting the target Family Therapy treatment threshold, especially among caregivers who were anticipated to be less likely to participate in Family Therapy.



CAREGIVER ATTITUDES ABOUT FAMILY THERAPY

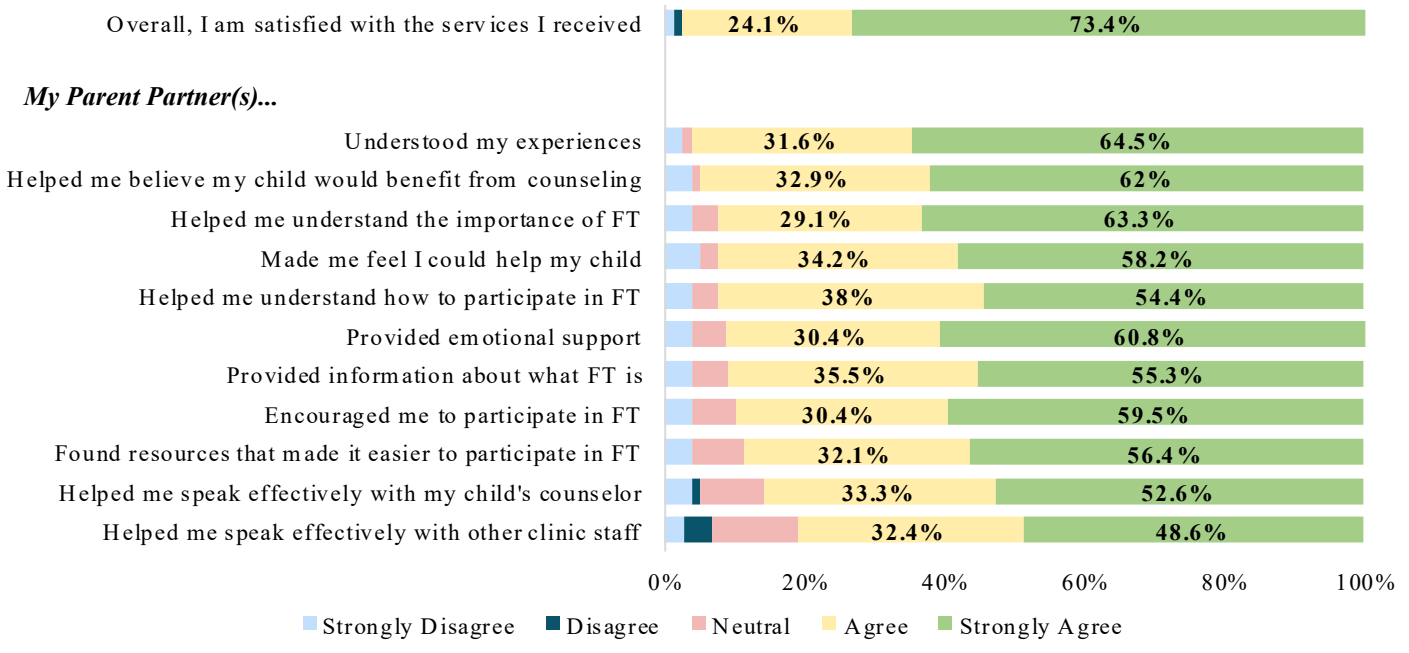
Overall, caregivers with children who first began to receive counseling services at the participating CYF programs prior to any Parent Partner visits expressed favorable attitudes about the importance of Family Therapy and their willingness to participate in Family Therapy, as shown in the chart below. Over 90% agreed or strongly agreed that it was important to involve family when working on child treatment goals and that they believed they had a lot to contribute in Family Therapy to help their child. However, there was more variability when asked about whether their counselor was more important than they were in helping their child and family (52.4% agreed or strongly agreed that the counselor was more important). Around 15-20% of caregivers agreed or strongly agreed that "tangible" barriers, such as transportation, child care, or other demands for their time would make it difficult for them to participate in Family Therapy.



[1] *FT stands for "Family Therapy."*

CAREGIVER FEEDBACK ON PARENT PARTNER SERVICES

At the conclusion of receiving short-term Parent Partner support services, caregivers were asked about their experiences with the Parent Partners (see chart on the following page). 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 below, caregivers were typically very satisfied with the Parent Partner services they received (97.5% indicated agreement or strong agreement with the satisfaction statements). The peer-support aspect of the Parent Partners likely contributed to the fact that almost all caregivers indicated (96.1% agreed or strongly agreed) that the Parent Partners "understood their experiences." Overall, the vast majority of caregivers agreed or strongly agreed that they received each type of support from their Parent Partners. The least common forms of support provided by Parent Partners were related to receiving assistance with how to communicate with the child's counselor and with other clinic staff.



Note: Not all caregivers who received Parent Partner visits completed the feedback survey. The results presented in this chart are based on the 79 follow-up surveys completed before 6/30/2016. Therefore, these results may not be representative of all caregivers receiving Parent Partner services.

FAMILY THERAPY PARTICIPATION ENGAGEMENT ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing FTPE services, program staff and others affiliated with the programs were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the FTPE program. We received 37 responses from 44 persons invited to participate in the survey, for a response rate of 84.1% (with a range of 67% to 100% across the individual programs). For the open-ended survey questions, at least two evaluators reviewed and coded the responses. Any discrepancies were discussed to arrive at a consensus on the key 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. Providing case management/support services
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. Parent Partners' lived experience
   d. The collaborative nature of the team approach to care (which included Parent Partners)
3. *Strategies most important for the success of the FTPE program:*
   a. Connecting with the caregiver consistently and early on in the program
   b. Using the MI approach (e.g., specific techniques to address ambivalence to Family Therapy, maintain the caregiver's autonomy, and assess the caregiver's needs and readiness to change),
   c. Providing education about topics like the benefits of Family Therapy and what to expect in treatment.
   d. Sharing the Parent Partner's own lived experience
   e. Providing emotional support to the caregivers
   f. Helping to reduce barriers
4. *Specific challenges to reaching the program goals described by respondents:*
   a. Low family attendance at services
   b. Caregiver ambivalence about services (both the Parent Partner service visits and treatment)
   c. Lack of resources like transportation and housing
   d. Caregivers' personal challenges (e.g., low literacy)
   e. Program barriers like high Parent Partner turnover

KEY YEAR 1 FAMILY THERAPY PARTICIPATION ENGAGEMENT PROGRAM "LEARNINGS"

1. Adding Parent Partners to the treatment team at CYF agencies substantially increased caregiver participation in Family Therapy sessions.
2. Caregivers typically reported having very positive experiences with their Parent Partners.
3. The "lived experience" or peer support model in which Parent Partners were required to have personal experience interacting with the children's behavioral health system was perceived to be an important component leading to successful engagement with caregivers.
4. The "lived experience" requirement, unique skill sets needed, and salary limitations made it challenging to identify and hire Parent Partners.
5. Motivational Interviewing and other trainings were crucial for equipping Parent Partners with the skills and tools they needed to connect with and support caregivers.
6. It was challenging and expensive to provide ongoing opportunities for Motivational Interviewing and other trainings for newly hired Parent Partners following staff turnover.
7. 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.
8. 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.
9. Besides potential language barriers, the caregivers served by Parent Partners often faced many other challenges to participating in Family Therapy, such as needs for child care, transportation, food assistance, and other supportive services. Caregivers frequently had low levels of formal education and were often unemployed.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-12 FTPE program that differed substantially from the initial design of the program during the first year of service provision (7/1/2015 to 6/30/2016). As is typical during program start-ups, some basic practices and procedures related to Parent Partner training, supervision, and service provision (e.g., when to first meet with caregivers) were adjusted over the course of the first year to better fit the context of the specific CYF agency. However, no fundamental or program-wide changes were made.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the FTPE program and further increase caregiver participation in Family Therapy during Year 2 include the following:

1. Identify ways to provide additional opportunities for Motivational Interviewing and other trainings (e.g., parenting skills), particularly for newly hired Parent Partners.
2. Increase availability of Parent Partner services (e.g., provide additional Parent Partner FTE), so that more caregivers can have Parent Partners to support and encourage their participation in Family Therapy.
3. Increase use of group meetings between caregivers and Parent Partners to encourage greater caregiver social supports.
4. Identify and/or directly provide additional resources to address the "tangible" barriers to Family Therapy participation, such as transportation and child care.
5. Seek out ways to encourage and support the Parent Partners (e.g., employee recognition, opportunities for peer-support between Parent Partners at different CYF agencies, increased pay or other benefits) to communicate importance of this position and potentially reduce turnover.

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

Participant Demographics: INN 12 Family Therapy Participation Engagement Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	11	*4.0%*
26-59 (adult)	216	*77.7%*
60+ (older adults)	4	*1.4%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	47	*16.9%*
TOTAL	**278**	***100%***

Race	N	%
Black/African American	10	*3.6%*
Asian	6	*2.2%*
White	62	*22.3%*
Native American	2	*0.7%*
More than one race	4	*1.4%*
Other	1	*0.4%*
Unknown/preferred not to answer	6	*2.2%*
Missing/did not answer	187	*67.2%*
TOTAL	**278**	***100%***

Ethnicity	**N**	**%**	**N**	**%***
Hispanic or Latino	175	*62.9%*		
Central American			1	*0.4%*
Mexican			104	*37.4%*
Other			11	*3.9%*
Missing/did not answer			60	*21.6%*
Non-Hispanic or Non-Latino	66	*23.7%*		
European			2	*0.7%*
Iraqi			1	*0.4%*
Japanese			1	*0.4%*
Other			10	*3.6%*
Missing/did not answer			52	*18.7%*
More than one ethnicity	19	*6.8%*	9	*3.2%*
Unknown/preferred not to answer	6	*2.2%*	6	*2.2%*
Missing/did not answer	12	*4.3%*	12	*6.5%*
TOTAL	**278**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
Arabic	1	*0.4%*
Armenian	1	*0.4%*
English	106	*38.1%*
Spanish	154	*55.4%*
Other	2	*0.7%*
Unknown/preferred not to answer	5	*1.8%*
Missing/did not answer	9	*3.2%*
TOTAL	**278**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	179	*64.4%*
Bisexual	3	*1.1%*
Unknown/preferred not to answer	52	*18.7%*
Missing/did not answer	44	*15.8%*
TOTAL	**278**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	51	*18.3%*				
Communication disability			12	*4.3%*		
Difficulty seeing					8	*2.9%*
Difficulty hearing/speaking					7	*2.5%*
Mental disability			12	*4.3%*		
Learning disability					6	*2.2%*
Other mental disability					7	*2.5%*
Physical/mobility disability			17	*6.1%*	17	*6.1%*
Chronic health condition			19	*6.8%*	19	*6.8%*
Other disability			11	*4.0%*	11	*4.0%*
No disability	197	*70.9%*	197	*70.9%*	197	*70.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*	0	*0%*
Missing/did not answer	30	*10.8%*	30	*10.8%*	30	*10.8%*
TOTAL	**278**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	8	*2.9%*
No	230	*82.7*
Unknown/preferred not to answer	24	*8.6%*
Missing/did not answer	16	*5.8%*
TOTAL	**278**	***100%***

Gender: Assigned Sex at Birth	N	%
Male	23	*8.3%*
Female	231	*83.1%*
Unknown/preferred not to answer	11	*3.9%*
Missing/did not answer	13	*4.7%*
TOTAL	**278**	***100%***

Gender: Current Gender Identity	N	%
Male	25	*9.0%*
Female	213	*76.6%*
Unknown/preferred not to answer	19	*6.8%*
Missing/did not answer	21	*7.6%*
TOTAL	**278**	***100%***

FAITH-BASED INITIATIVE PROGRAMS (INNOVATIONS-13)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

STATUS AS OF 6/30/16

The Faith-Based Initiative (FBI) is funded through the Innovations (INN) component of the Mental Health Services Act. Primary goals of the FBI are to: 1) develop meaningful collaborations and partnerships between Behavioral Health Services (BHS) and faith-based leaders; 2) increase BHS outreach and engagement within faith-based communities; 3) increase education and training about BHS; and 4) provide faith-based leaders and community members with information about where and how to access mental health services, alcohol and drug services, and other resources for children, adults, and older adults. FBI programs are focused primarily on African-American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. FBI services are designed to promote cross-education among both BHS and the faith-based community, as well as reduce the effects of untreated mental illness for community members. To achieve these overall goals, the FBI is divided into four Task Orders that target specific needs identified within the faith-based community.

Faith Based Academy (FBA) FBI Task Order #1 (TO1). The primary objective of TO1 is to recruit faith-based leaders and behavioral health providers to collaborate in developing an educational curriculum—one that specifically addresses faith/spirituality principles and values, wellness, mental health conditions, and resource information tailored for African-American and Latino communities. Through these Faith-Based Academies, faith-based and behavioral health "champions" will be identified, who will then train Facilitator Trainers (FT) to conduct education and outreach presentations throughout the community.

Community Education (CE) FBI Task Order #2 (TO2). TO2 is designed to have the faith-based and behavioral health "champions" identified in TO1 train program staff called Facilitator Trainers (FT) to provide educational presentations in the community using the approved FBA curriculum educational toolkit designed in TO1. Community education will be jointly provided by faith-based and Behavioral Health FTs.

Crisis Response (CR) FBI Task Order #3 (TO3). Through TO3, a supportive, trauma-informed, and strength-based crisis intervention protocol will be developed. The faith-based Crisis Response team will be on-call 24/7 to respond rapidly to individual or family crisis situations (e.g., suicides, homicides, domestic violence). The faith-based Crisis Response team will also provide follow-up support services and facilitate linkages to BHS and other community resources as needed.

Jail In-reach Health and Wellness Ministry (JIHWM) FBI Task Order #4 (TO4). A primary objective of TO4 is to develop a faith-based team that will outreach to adults in jail who are diagnosed with an SMI prior to their release, providing spiritual support consistent with the individual's faith and information regarding mental health and physical health wellness. The team will also provide support services and linkages to community-based resources to facilitate individuals' re-integration back into the community.

EXECUTIVE SUMMARY

Curriculum development work for the Faith-Based Academy (Task Order 1) began prior to 6/30/2016 but was still in progress at that time. Task Orders 2, 3, and 4 had not started service provision activities prior to 6/30/16.

Evaluation results for each FBI Task Order will be included in the next INN Annual Report cycle.

For additional information about the INN–13 Faith-Based Initiative programs please contact:
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NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The 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 severe 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 transitional 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 acquisition of desired 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.

- The Noble Works contract was awarded 8/1/2015, and services started 12/1/2015. During Fiscal Year 2015-16, a total of 77 persons with SMI entered the Noble Works program.
- Upon entry into Noble Works, almost half of the participants (44.2%) had a high school level education or less, about two-thirds (64.9%) reported they had a non-SMI related disability, and 71.4% indicated they were not working but seeking work.
- Approximately 70-80% of participants agreed/strongly agreed that they were engaged in activities relevant to successful job search and acquisition at the start of the program (e.g., learning new things, working towards goals, using personal strengths, etc.). Only about 25% thought they had sufficient income.
- Positive employment-relevant changes occurred at follow-up, indicated by participants reporting improved job satisfaction, dealing more effectively with problems, experiencing reduced symptoms, having more income, and working on goals.
- At follow-up, job satisfaction was positively associated with other indicators of participant well-being (e.g., self-fulfillment, quality of life), which indicated that as job satisfaction increased, other life domains improved as well.
- As of 6/30/2016, participants acquired a total of 11 jobs through Noble Works, with an average wage of $11.48/hour (range: $11-$19/hour) and 29.3 hours per week (5 jobs were full-time). Participants still employed as of 6/30/2016 had worked for an average of 60.7 days total.
- Noble Works staff identified the following key factors that helped achieve program goals: 1) program structure/flexibility to work with both participants and employers, 2) staff skills and passion, 3) NAMI SD partnership for community outreach and stigma reduction, 4) Pathways partnership to recruit and serve TAY, 5) motivated participants, and 5) access to tools and resources to support participants (e.g. class curriculum, etc.).
- Primary factors inhibiting achievement of program goals included high staff turnover, challenges with program "start-up", maintaining participant engagement, and finding desired and relevant employment opportunities for participants.

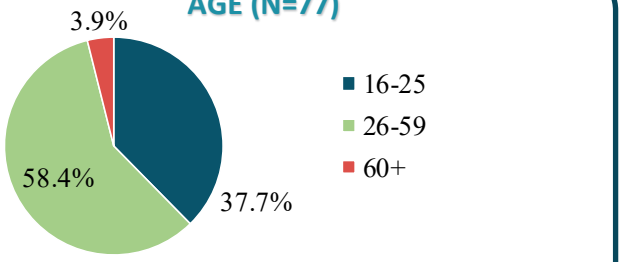
RECOMMENDATIONS

Primary recommendations include: 1) maintain full staffing levels and minimize turnover, 2) increase awareness of Noble Works, 3) identify strategies to support participant engagement in Noble Works (e.g., incentives, frequent "check-ins", etc.), 4) improve coordination and communication between staff roles and agency partners, 5) Maximize amount of time spent working directly with each participant, and 6) periodic review/fidelity checks between Noble Works practices and Supported Employment principles.

NOBLE WORKS PROGRAM PARTICIPANT DEMOGRAPHICS

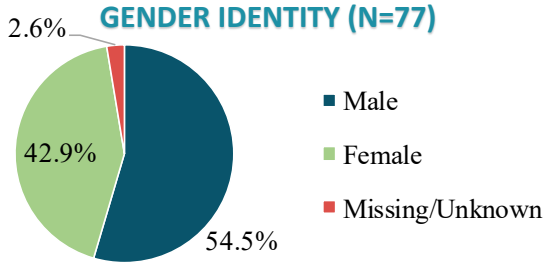
The following demographic data were collected from a participant self-report survey administered at the start of Noble Works.

AGE (N=77)



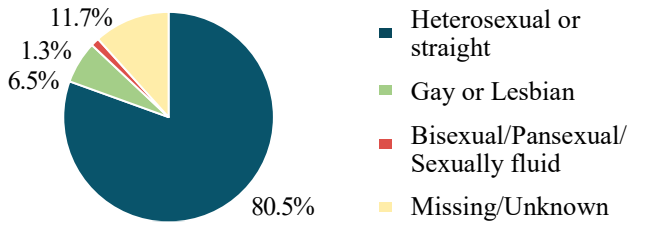
Over half (58%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=77)



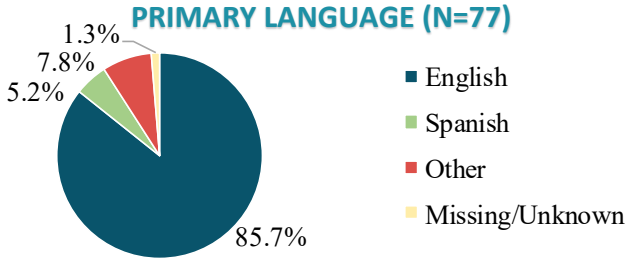
Over half (55%) of participants were male, and 43% were female.

SEXUAL ORIENTATION (N=77)



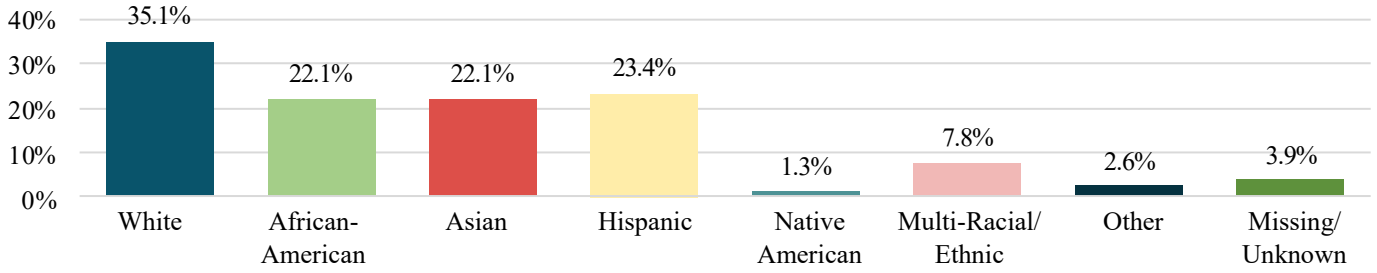
The majority (81%) of participants were heterosexual or straight, and 7% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=77)



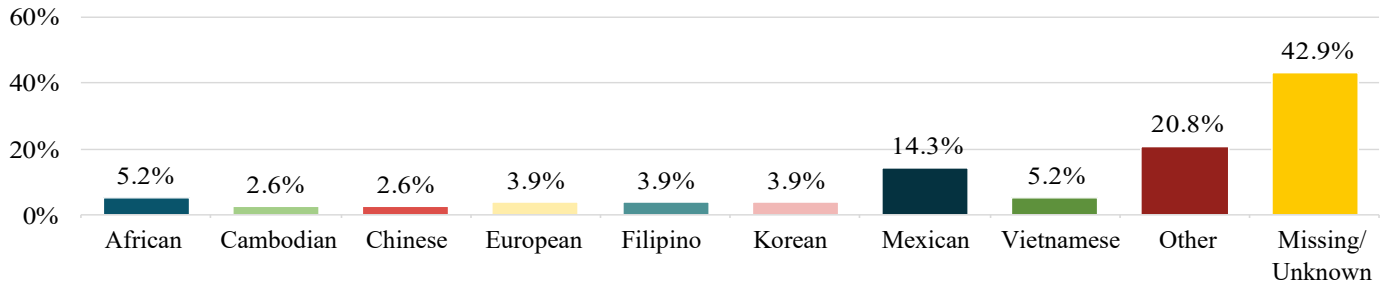
English was the primary language for the majority (86%) of participants, with Spanish being the primary language for 5% of participants.

RACE/ETHNICITY (N=77)



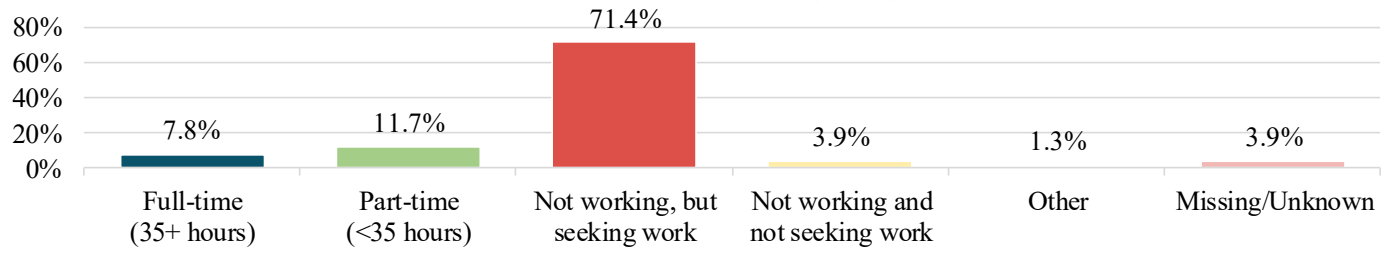
Thirty-five percent of participants identified themselves as White. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

ETHNIC BACKGROUND (N=77)



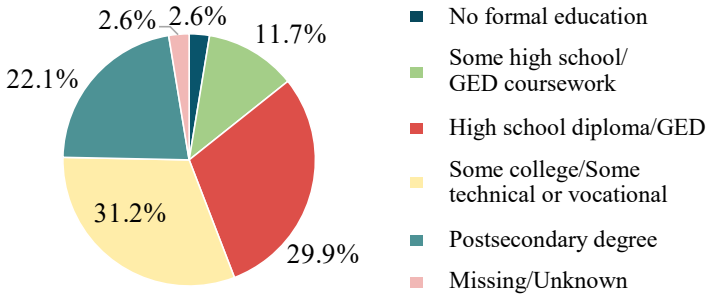
Fourteen percent of participants indicated being of Mexican origin. Totals may exceed 100% as participants could indicate more than ethnic background.

EMPLOYMENT STATUS (N=77)



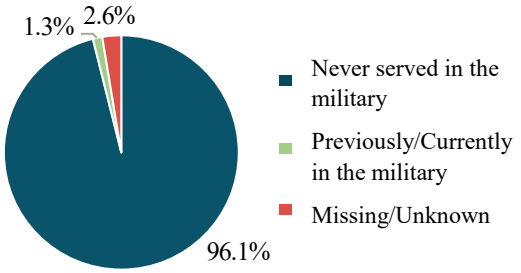
Almost three-quarters (71%) of participants were not working but seeking work. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=77)



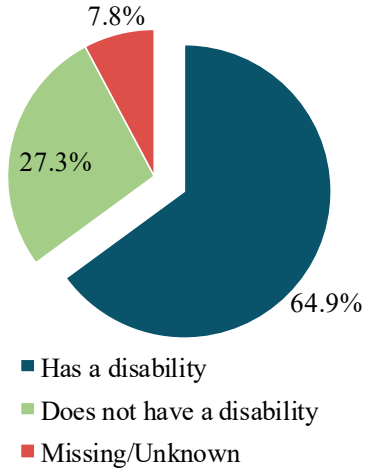
Thirty percent of participants had achieved a high school diploma or GED, and 31% had taken some college or technical/vocational courses.

MILITARY STATUS (N=77)



The majority (96%) of participants had never served in the military.

DISABILITY[1] STATUS (N=77)



Sixty-five percent of participants indicated having some form of non-SMI disability.

TYPE OF DISABILITY (N=77)

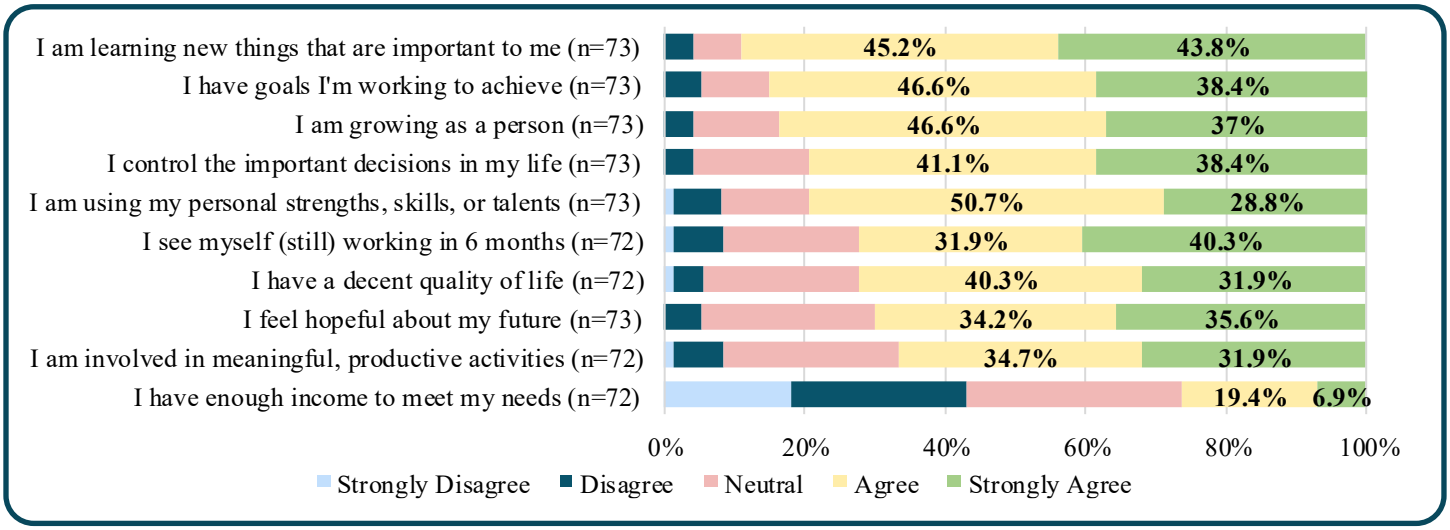
Type	n	%
Communication	13	16.9
Mental (e.g. learning, developmental)	25	32.5
Physical	4	5.2
Chronic Health	7	9.1
Other	20	26.0

This table describes the type of disability indicated by participants that had a disability, as a percentage of the total population. Totals may exceed 100% as participants could indicate more than one type of disability.

[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 severe mental illness (SMI).*

KEY EVALUATION FINDINGS: BASELINE

Upon entering Noble Works, participants completed a baseline survey, which included the Recovery Markers Questionnaire (RMQ) and items from the Brief Index of Affective Job Satisfaction (BIAJS). Results from this survey are shown in the following charts. Select items from the RMQ deemed relevant to the employment-focused outcomes of the program are presented in the chart below in order of highest to lowest percentage of agreement (i.e., indicated Agree or Strongly Agree). The majority of respondents indicated that they agreed or strongly agreed with many of the RMQ items, with the most commonly endorsed items being: "I am learning new things that are important to me", "I have goals I'm working to achieve", and "I am growing as a person" (89.0%, 85.0%, and 83.6%, respectively). The least commonly endorsed item was: "I have enough income to meet my needs" (26.3% agreed or strongly agreed). Participants' responses to these RMQ items suggest that many Noble Works participants felt positively about their overall life satisfaction and their prospects of accomplishing future goals even from the outset of the program, but lack of sufficient income was still a major presenting need for many of these participants.



KEY EVALUATION FINDINGS: FOLLOW-UP

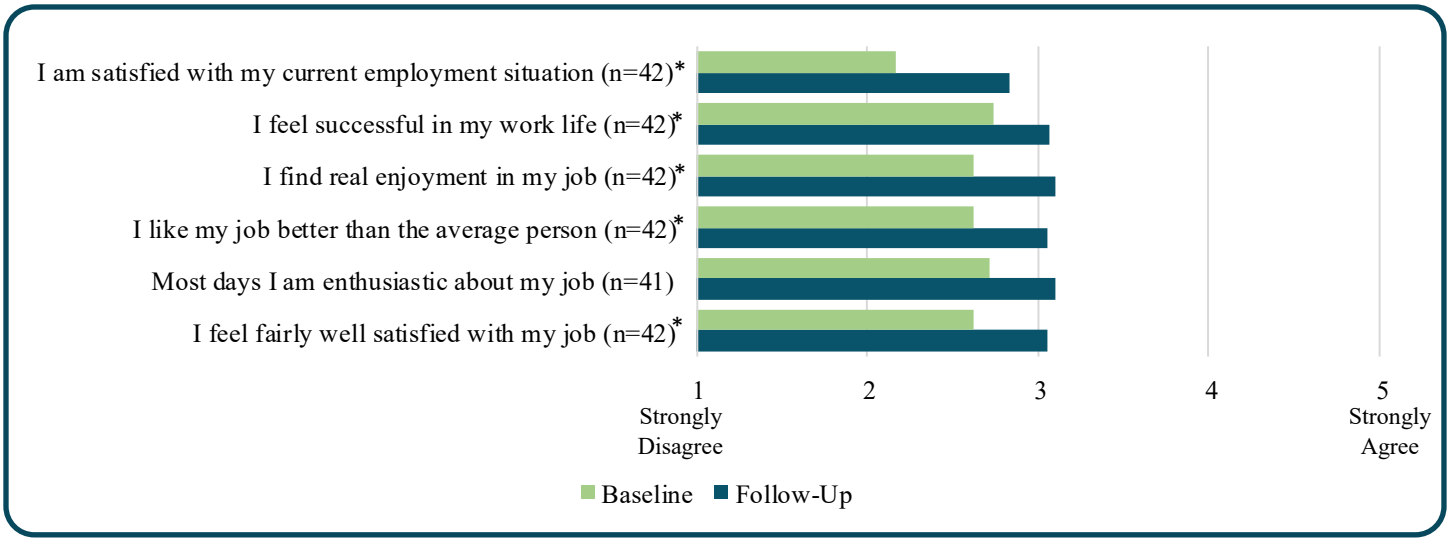
Approximately 90 days after entering Noble Works, participants were asked to fill out a follow-up survey, which also included the RMQ and items from the BIAJS. While samples sizes were relatively small, several items from the RMQ suggested areas of change compared to baseline. Starred items in Table 1 had a statistically significant change in mean score from baseline to follow-up; the other items listed showed potential for significant change if the patterns persist with a larger sample size. Indicators related to primary target outcomes of Noble Works, such as increased income, working on goals, coping with symptoms, and dealing effectively with problems all improved at follow-up. However, participants indicated lower ratings of learning new things and feeling hopeful about the future at follow-up. It is unclear at this time why these ratings changed in a negative way; it is possible that initial participant expectations may not have been met. These change patterns will continue to be assessed in future reporting periods with larger sample sizes.

TABLE 1. QUANTITATIVE ASSESSMENT OF CHANGES IN PERCEPTIONS OF NOBLE WORKS PARTICIPANTS

	Change in Mean Score
I have enough income to meet my needs (n=42)	Improved at follow-up
I have goals I'm working to achieve (n=43)	Improved at follow-up
My symptoms are bothering me less since starting services here (n=43)	Improved at follow-up
I deal more effectively with daily problems since starting services here (n=43)	Improved at follow-up*
I am learning new things that are important to me (n=43)	Worsened at follow-up*
I feel hopeful about my future (n=43)	Worsened at follow-up*

* Statistically significant change.

The 90-day follow-up survey also included job-related items from the RMQ and BIAJS, and the results from baseline and follow-up are depicted in the chart below. Starred items had a statistically significant change in mean score from baseline to follow-up. While not all of these participants were employed, the responses to items such as "I am satisfied with my current employment situation" and "I feel successful in my work life" provided a more generalized assessment of participants' work life perceptions. The average score across all six items increased from 2.6 at baseline to 3.0 at follow-up on a scale from 1 (strongly disagree) to 5 (strongly agree). The statistically significant increases suggest that participation in Noble Works was associated with a more positive outlook on their employment circumstances; however, there was still substantial opportunity for further improvements.



As shown in Table 2, at follow-up, a number of items from the RMQ correlated with overall job satisfaction. These correlations indicated positive associations between how the participant felt about their employment situation and a range of other life domains related to their self-fulfillment, social connectedness, symptom reduction, and quality of life. While a causal relationship cannot be determined through these analyses, there seemed to be strong relationships between job satisfaction and many of the other life domains that Noble Works intended to improve through increased employment opportunities. These results support the initial design of the Noble Works program and merit further examination as more data becomes available. It is also interesting to note that having enough income was *not* related to job satisfaction at follow-up.

TABLE 2. CORRELATIONS BETWEEN RMQ ITEMS AND OVERALL JOB SATISFACTION AT FOLLOW-UP

	Overall Job Satisfaction at Follow-Up
RMQ Responses at Follow-Up	**Correlation**
I am using my personal strengths, skills, or talents	.544**
I am learning new things that are important to me	.496**
I have a sense of belonging	.469**
I have a decent quality of life	.463**
I have reasons to get out of bed in the morning	.436**
I am growing as a person	.409**
My symptoms are bothering me less since starting services here	.407**
I am involved in meaningful, productive activities	.406**
I have enough income to meet my needs	.112

** Statistically significant change, p<.01.

JOBS ACQUIRED THROUGH NOBLE WORKS

A total of 11 jobs were acquired through the Noble Works program as of 6/30/2016. As shown in Table 3, the most common job domains for these positions were in sales and office/administrative support (36.4% and 27.3%, respectively).

TABLE 3. JOB DOMAIN

	n	%
Building and Grounds Cleaning and Maintenance Occupations	1	9.1
Food Preparation and Serving Related Occupations	1	9.1
Healthcare Support Occupations	1	9.1
Office and Administrative Support Occupations	3	27.3
Protective Service Occupations	1	9.1
Sales and Related Occupations	4	36.4

The average wage for these positions was $11.48 per hour. Almost half of the jobs (45.5%) were full-time, with 29.3 hours worked per week on average. Of the seven ongoing jobs as of 6/30/2016, the average duration was 60.7 days. Of the four jobs that ended prior to 6/30/2016, two were due to factors outside of the control of the Noble Works participant (i.e., store closing/job ending).

$11.48
AVERAGE WAGE

Range: $10-19/hour

- 6 jobs (54.5%) paid $10 per hour (California minimum wage during this time)

29.3
HOURS/WEEK

Range: 12-40 hours/wk

- 5 jobs (45.5%) were "full-time" (i.e., 35 hours or more per week)

60.7
DAYS WORKED

Range: 11-122 days

- 7 jobs (63.6%) were ongoing as of 6/30/2016

50.3
DAYS WORKED

Range: 10-93 days

- 4 jobs (36.3%) ended prior to 6/30/2016

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 (36.6%) or some preparation (45.5%). These preparation levels were consistent with the finding that the majority of positions (54.5%) started at minimum wage. As the Noble Works program expands their network of employers and provides more sophisticated training (e.g., CompTIA), it is expected that the job zone classifications and average wage will increase.

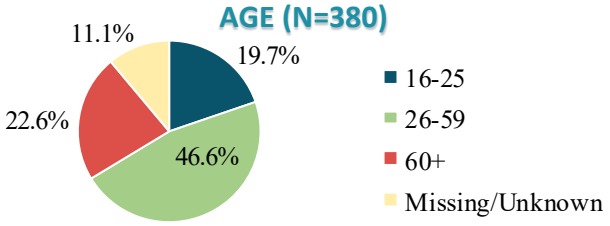
TABLE 4. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	4	36.3
2 - Occupations that need some preparation	5	45.5
3 - Occupations that need medium preparation	2	18.2

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

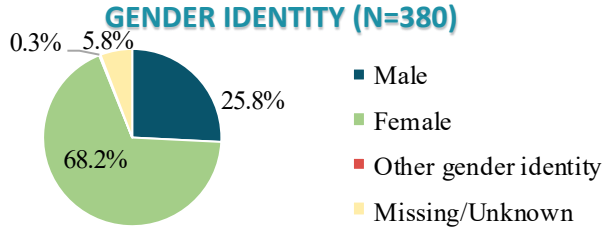
NAMI SD, as a Noble Works program partner, conducted 39 community outreach, education, and "In Our Own Voice" (IOOV) presentations regarding mental illness and recovery in their ongoing efforts to reduce mental health stigma in the community. Based on feedback data, less than half of the attendees (47.6%) were aware of NAMI prior to the presentation they attended. This suggests that NAMI SD was reaching many community members who were not well-informed about mental health issues, services, and recovery. For certain outreach events with potential employer organizations, Noble Works representatives also provided "Employer Wellness" presentations. The charts below provide an overview of select presentation attendee demographics and outcomes.

AGE (N=380)



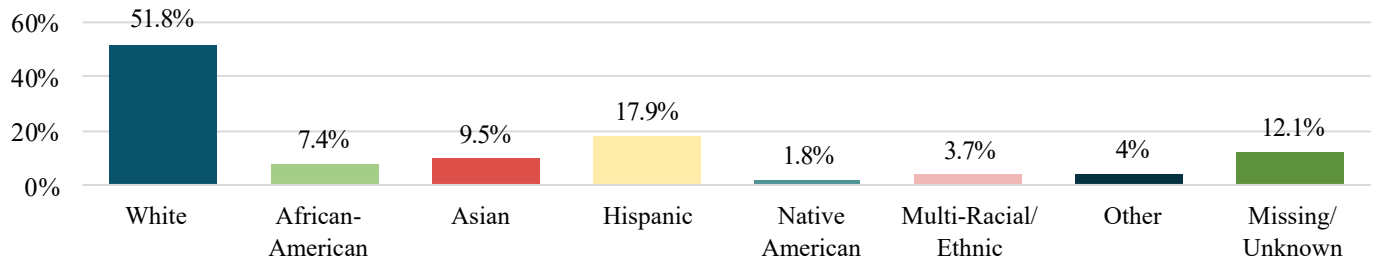
About half (47%) of attendees were between 26 and 59.

GENDER IDENTITY (N=380)



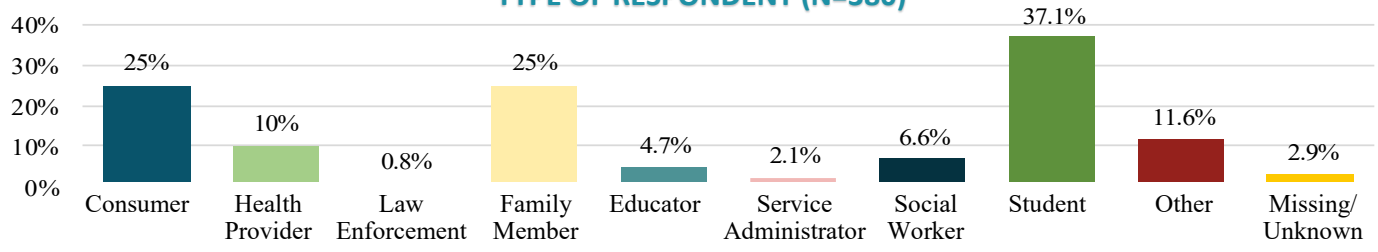
Attendees were 65% female and 25% male.

RACE/ETHNICITY (N=380)



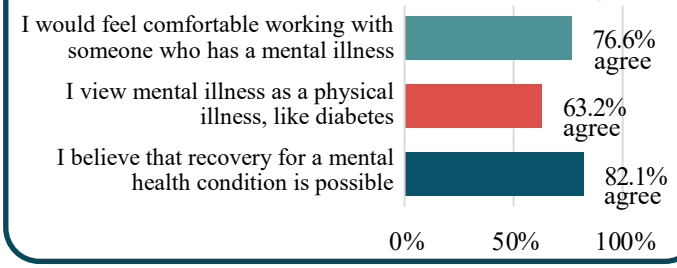
More than half (52%) of attendees identified themselves as White, and one-fifth (20%) identified as Hispanic. Totals may exceed 100% as attendees could indicate more than one race/ethnicity.

TYPE OF RESPONDENT (N=380)

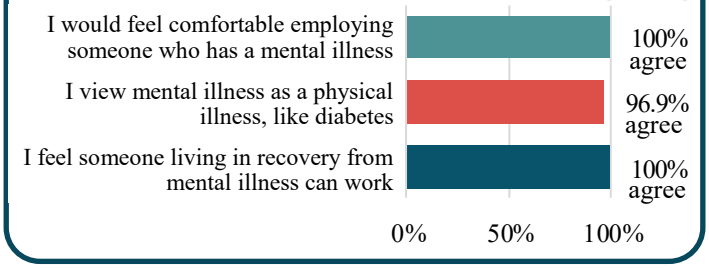


Thirty-seven percent of attendees identified themselves as students, one-quarter (25%) identified as consumers, and one-quarter (25%) identified as family members. Totals may exceed 100% as attendees could indicate more than category.

NAMI SD IOOV PRESENTATION OUTCOMES (N=380)



NOBLE WORKS PRESENTATION OUTCOMES (N=22)

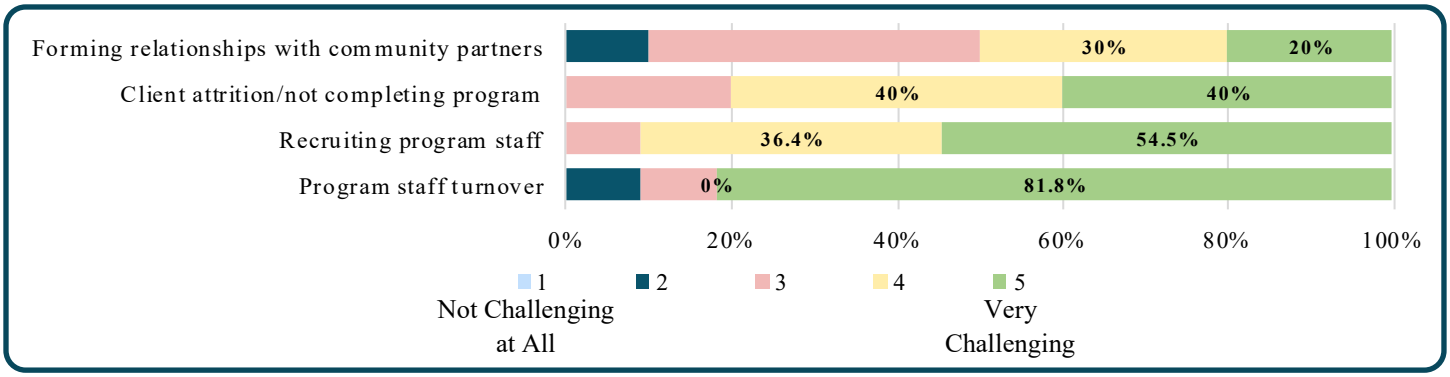


The majority of respondents indicated positive attitudinal changes as a result of NAMI SD's IOOV presentation. While the number of Noble Works "Employer Wellness" presentation attendees was smaller, nearly all indicated positive attitudinal changes.

NOBLE WORKS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN Noble Works program, 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. We had 12 respondents from the 14 persons invited to participate in the survey, for a response rate of 85.7%. 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.

The chart below highlights key Year 1 programmatic difficulties identified by Noble Works staff. Many staff regarded forming community partnerships and client attrition as challenges for the Noble Works program. Concerns about staffing were even more salient, with 54.5% indicating that it was very challenging to recruit staff and 81.8% indicating that staff turnover was a very challenging issue for the program.



1. *Primary goals of the Noble Works program as identified by survey respondents:*
   a. Increase employment opportunities by identifying and educating potential employers
   b. Increase employment opportunities through education and skill-building of participants
   c. Reduce mental health stigma in community and workplace
2. *Factors that facilitated the achievement of program goals:*
   a. Program structure/flexibility allowed for supporting and educating both participants and employers
   b. Staff skills and passion to support participants and work towards overall program goals
   c. Partnership with NAMI SD to utilize the "In Our Own Voice" presentation for community outreach and stigma reduction
   d. Partnership with Pathways to recruit and provide Noble Work service to transitional age youth
   e. Participants who were motivated and engaged in program activities
   f. Program tools/resources available to educate and support participants (e.g., class curriculum, NAMI SD Tech Café, etc.)
3. *Factors that inhibited the achievement of program goals:*
   a. High staff turnover
   b. Time and energy needed for program start-up activities and learning staff roles and responsibilities
   c. Coordination and communication challenges between program staff/partners
   d. Not enough time available to work directly with participants
   e. Challenges maintaining participant motivation and engagement
   f. Participants with episodes of unmanaged symptoms
4. *Challenges obtaining and maintaining participant employment:*
   a. Participant motivation levels
   b. The level of skill, experience, and/or education of participants
   c. Few relevant job openings
   d. Employer stigma or lack of awareness about SMI
   e. Participant symptom management
   f. Difficulties with coworker/supervisor social interactions and/or conflict resolution for some participants
5. *Strategies for maintaining participant engagement in Noble Works:*
   a. Offer incentives for participating in program activities/classes
   b. Maintain regular contact/communication with participants
   c. Invest time in building trust and rapport with participants
   d. Meet clients "where they are at" regarding recovery and employment interests
   e. Support staff commitment and passion for empowering participants
   f. Foster a welcoming and inclusive environment among participants
   g. Highlight the unique opportunities available through Noble Works

GROUP TRAININGS AND SUPPORTS PROVIDED THROUGH NOBLE WORKS

The Noble Works program skill-enhancing and social support classes provided during the Year 1 included:

1. Employment Preparation Classes: 12-week series to help participants with employment preparation
2. Business Development Workshops: 6-week series to help participants with business development
3. Comp TIA A+ Training: Intensive training providing skills and knowledge to help participants prepare for Comp TIA A+ certification (covers technical skills such as installing and configuring computer operating systems, PC hardware and peripherals, mobile device hardware, networking and troubleshooting hardware and network connectivity issues)
4. NAMI SD Tech Café Classes: 7-week series to help participants learn and improve computer usage skills
5. Support Group: 4-week series of support groups to provide participants with a platform to share and discuss challenges as well as success in their employment journey with Noble Works

SUPPORTED EMPLOYMENT PRINCIPLES AND YEAR 1 NOBLE WORKS PRACTICES

Supported Employment is an evidence-based practice recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Supported Employment has been shown to successfully increase competitive work attainment among persons with SMI, with research indicating that more than half of participants in Supported Employment programs typically obtain competitive employment, compared to about one-quarter of participants in conventional vocational rehabilitation programs.

The Noble Works service delivery approach was intended to incorporate many Supported Employment principles. Table 5 indicates which of the eight key Supported Employment principles were also Noble Works objectives during Year 1, as well as the relevant Noble Works program activities as of 6/30/2016 (based upon program administration review and feedback). In general, Noble Works attempted to operate in a manner consistent with many Supported Employment principles. A primary area of divergence was the separation of vocational and mental health/rehabilitation services. This separation of services was part of the initial Noble Works program design and contract award from the County of San Diego Behavioral Health Services. Additionally, Noble Works staff reviewed referrals to the Noble Works program to determine whether participants appeared to be capable of benefiting from program services, whereas Supported Employment programs only require participant desire to work as the eligibility criteria. This variation was also related to the fact that mental health treatment services were not available directly through the Noble Works program, which increased the perceived need to focus on those determined to be more "ready" to engage in Noble Works program activities.

TABLE 5. SUPPORTED EMPLOYMENT PRINCIPLES AND YEAR 1 NOBLE WORKS PRACTICES

Supported Employment Principles	Year 1 Noble Works Objective	Year 1 Noble Works Activities
1. Focus on competitive employment	Yes	All Noble Work activities were directed towards competitive employment opportunities
2. Program eligibility based on client choice	Partial	Client choice plus referrals were screened for eligibility
3. Integration of mental health and rehabilitation services	No	By contract, Noble Works was designed as a "standalone" vocational program for persons with SMI
4. Attention to participant job preferences	Yes	Participant preferences influenced job search and support activities
5. Personalized governmental benefits counseling	Yes	Public benefits were reviewed with participants
6. Rapid job search	Yes	First contact with employer was reported to typically occur 1-6 months after entering program
7. Systematic job development	Yes	Noble Works initiated outreach to potential employers through community presentations
8. Time-unlimited and individualized support	Yes	Supports were ongoing and tailored to participants

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 (i.e., hiring, training, establishing facilities, collaborating with partners, developing trainings, etc.) 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.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-14 Noble Works program that differed substantially from the initial design of the program during the first year of the program (7/1/2015 to 6/30/2016). As is typical during program start-ups, some basic practices and procedures related to recruitment of participants, training and supervision of staff, presentation development and delivery, and coordination with Noble Works partners were adjusted over the course of the first year to better fit the emerging service delivery context of the Noble Works program. However, no changes were made to the fundamental program structure or design. While no major changes were instituted, not all facets of the Noble Works program were implemented during Year 1. Noble Works program components that were not implemented included social enterprise, subsidized apprenticeships with employers, and entrepreneurial business start-ups.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Noble Works program during Year 2 and further increase opportunities for employment for persons with SMI include the following:

1. Maintain full staffing levels and minimize turnover.
2. Increase awareness of Noble Works program to help recruit participants and potential employers (e.g., increase number of community events and/or use of social media).
3. Identify opportunities for maintaining and increasing participant engagement in Noble Works' services (e.g., incentives, frequent "check-ins", etc.).
4. Improve coordination and communication between staff roles and agency partners within Noble Works to present more of a "seamless" program to participants and employers.
5. Assess program operations and streamline activities to maximize the amount of time that staff can work directly with each participant.
6. Implement periodic review/fidelity checks between Noble Works practices and Supported Employment principles.

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

Presentation Attendee Demographics: INN 14 Noble Works Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	75	*19.7%*
26-59 (adult)	177	*46.6%*
60+ (older adults)	86	*22.6%*
Unknown/preferred not to answer	1	*0.3%*
Missing/did not answer	41	*10.8*
TOTAL	**380**	***100%***

Race	N	%
Black/African American	25	*6.6%*
Asian	30	*7.9%*
White	191	*50.3%*
Native American	4	*1.0%*
More than one race	11	*2.9%*
Other	23	*6.0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	96	*25.3%*
TOTAL	**380**	***100%***

Ethnicity*	**N**	**%**
Hispanic or Latino	63	*16.6%*
Non-Hispanic or Non-Latino	266	*70.0%*
More than one ethnicity	5	*1.3%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	46	*12.1%*
TOTAL	**380**	***100%***

* Presentation attendees completed a demographic form that did not include detailed ethnicities.

Primary Language	**N**	**%**
Unknown/preferred not to answer	0	*0%*
Missing/did not answer[1]	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Sexual Orientation	N	%
Unknown/preferred not to answer	0	*0%*
Missing/did not answer[1]	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Disability	N	%
Yes disability	0	*0%*
No disability	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Veteran Status	N	%
Yes	0	*0%*
No	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Gender: Assigned Sex at Birth	N	*%*
Male	0	*0%*
Female	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	380	*100%*
TOTAL	**380**	***100%***

Presentation attendees completed a demographic form that did not include this item.

Gender: Current Gender Identity	N	%
Male	93	*24.5%*
Female	244	*64.2%*
Another gender identity	2	*0.5%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	41	*10.8%*
TOTAL	**380**	***100%***

Participant Demographics: INN 14 Noble Works Program

Supplemental Summary

Age	**N**	**%**
0-15 (children/youth)	0	*0%*
16-25 (transition age youth)	29	*37.7*
26-59 (adult)	45	*58.4*
60+ (older adults)	3	*3.9*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Race	N	%
Black/African American	14	*18.2%*
Asian	16	*20.8%*
White	23	*29.9%*
Native American	0	*0%*
More than one race	4	*5.2%*
Other	2	*2.6%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	18	*23.4%*
TOTAL	**77**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	15	*19.5%*		
Central American			1	1.3%
Mexican			10	13.0%
Puerto Rican			1	1.3%
Missing/did not answer			4	5.2%
Non-Hispanic or Non-Latino	56	*72.7%*		
African			4	5.2%
Cambodian			2	2.6%
Chinese			2	2.6%
Filipino			3	3.9%
Japanese			1	1.3%
Korean			3	3.9%
Laotian			1	1.3%
Vietnamese			4	5.2%
Eastern European			1	1.3%
European			3	3.9%
Middle Eastern			1	1.3%
Other			9	11.7%
Missing/did not answer			25	32.5%
More than one ethnicity	3	*3.9%*	3	*3.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	3	*3.9%*	3	*3.9%*
TOTAL	**77**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
English	66	*85.7%*
Lao	1	*1.3%*
Spanish	4	*5.2%*
Vietnamese	2	*2.6%*
Other	3	*3.9%*
Unknown/preferred not to answer	1	*1.3%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	62	*80.5%*
Gay or Lesbian	5	*6.5%*
Bisexual	1	*1.3%*
Unknown/preferred not to answer	9	*11.7%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	50	*64.9%*				
Communication disability			10	*13.0%*		
Difficulty seeing					6	*7.8%*
Difficulty hearing/speaking					5	*6.5%*
Other communication disability					2	*2.6%*
Mental disability			22	*28.6%*		
Learning disability					14	*18.2%*
Developmental disability					3	*3.9%*
Other mental disability					8	*10.4%*
Physical/mobility disability			4	*5.2%*	4	*5.2%*
Chronic health condition			7	*9.1%*	7	*9.1%*
Other disability			18	*23.4%*	18	*23.4%*
No disability	21	*27.3%*	21	*27.3%*	21	*27.3%*
Unknown/preferred not to answer	6	*7.8%*	6	*7.8%*	6	*7.8%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**77**	**100%**				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	2	*2.6%*
No	73	*94.8%*
Unknown/preferred not to answer	2	*2.6%*
Missing/did not answer	0	*0%*
TOTAL	**77**	**100%**

Gender: Assigned Sex at Birth	N	*%*
Male	42	*54.5%*
Female	35	*45.5%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

Gender: Current Gender Identity	N	%
Male	42	*54.5%*
Female	33	*42.9%*
Unknown/preferred not to answer	2	*2.6%*
Missing/did not answer	0	*0%*
TOTAL	**77**	***100%***

PEER ASSISTED TRANSITIONS PROGRAM (INNOVATIONS-15)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

STATUS AS OF 6/30/16

The Peer Assisted Transitions (PAT; INN-15) program is funded through the Innovations (INN) component of the Mental Health Services Act. PAT assists individuals receiving services in acute care settings (e.g., psychiatric hospital or crisis residential) with their transition to the community in a manner that supports long-term health and well-being.

A key component of this program is the use of peer support partners with "lived experience" receiving Behavioral Health Services (BHS). Peer support partners will deliver a 'Welcome Home Basket' of sundries (e.g., toiletries, plants, healthy food, resource information) to the participant to welcome them back to their home. Peer support partners will also help participants bridge the gap between use of acute crisis resources and community-based resources by encouraging regular social outings, thereby reducing isolation and building social relationships. To promote long-term health and wellness, PAT services will be provided for up to 12 months post-discharge from the acute care setting. The extended period of time that PAT services will be available to participants is expected to allow for participants to stabilize in the community, establish additional social relationships, and acquire needed community resources.

EXECUTIVE SUMMARY

The Peer Assisted Transitions (PAT; INN-15) contract began after 6/30/2016, so there were no service provision activities during this current reporting period.

Evaluation results for PAT will be included in the next INN Annual Report cycle.

For additional information about the INN–15 Peer Assisted Transitions program please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

URBAN BEATS (INNOVATIONS-16)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/15 - 6/30/16)

The Urban Beats program is funded through the Innovations (INN) component of the Mental Health Services Act and was developed to provide Transitional Age Youth (TAY) with increased access to and knowledge of behavioral health treatment and other wellness services while, as well as reduce mental illness stigma for TAY and for other community members. The primary innovation of this program is the utilization of artistic expression to communicate a recovery-focused message to TAY and develop their artistic skills and self-esteem.

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. During the second half of the class, 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.). At the end of the class, the TAY present their creation in a public performance designed to help educate the community about mental health issues and reduce the stigma associated with mental illness.

EXECUTIVE SUMMARY

The Urban Beats program (INN-16) was designed to provide wellness education and social support to transitional age youth (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 fiscal year 2015-16, a total of 94 TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial racial/ethnic diversity and diversity of sexual orientation. The majority indicated they were seeking employment.
- Urban Beats participants had fairly optimistic views of their future and their ability to make positive life changes, but many had concerns about their ability to handle stress, having enough income to meet needs, and the quality of their social relationships and health.
- While the small number of participants with follow-up data (n=25) limited definitive conclusions, preliminary findings suggested positive improvements in key outcome areas targeted by the Urban Beats program, including the increased ability of TAY to manage stress, have sufficient income, be involved in meaningful activities, and have higher satisfaction with their social relationships.
- Almost 80% reported being satisfied with the Urban Beats program, 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.
- Preliminary analyses indicated a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g. inpatient psychiatric admissions, emergency psychiatric visits).
- Key qualitative focus group findings showed that: 1) youth indicated satisfaction and positive outcomes from Urban Beats activities, classes, and performances, underscoring its value as a strengths-based program, 2) outreach and recruitment activities evolved as staff worked to expand the program, moving away from traditional mental health venues and into schools and other settings, and 3) each successive Urban Beats cohort had less prior exposure to mental health and wellness issues.

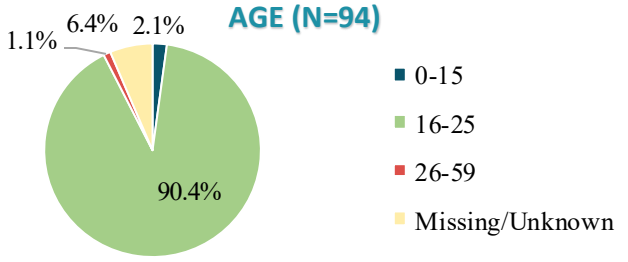
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify additional community partners, particularly schools, to facilitate TAY recruitment, 2) provide more training and team building opportunities for staff, 3) develop strategies to increase the number of community performances and performance attendance, 4) use Urban Beats "graduates" to help recruit new TAY and mentor future Urban Beats classes, 5) employ social media strategies to advance program goals (e.g., TAY recruitment, retention, and community outreach), 6) continue to assess and update Urban Beats curriculum to promote ongoing good fit with target TAY participants, 7) reexamine evaluation approach to identify optimal balance between data collection needs and burden on participants and staff.

URBAN BEATS PARTICIPANT DEMOGRAPHICS

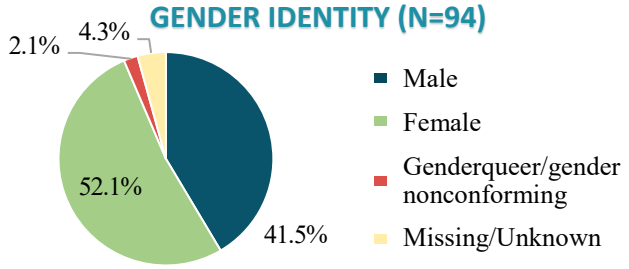
The following demographic data were collected from a participant self-report survey administered at the start of Urban Beats.

AGE (N=94)



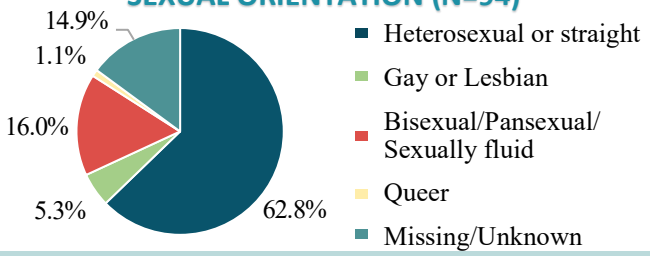
The majority (90%) of participants were between the ages of 16 and 25.

GENDER IDENTITY (N=94)



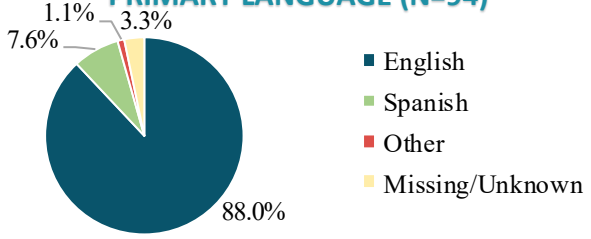
Forty-two percent of participants were male, and 52% of participants were female.

SEXUAL ORIENTATION (N=94)



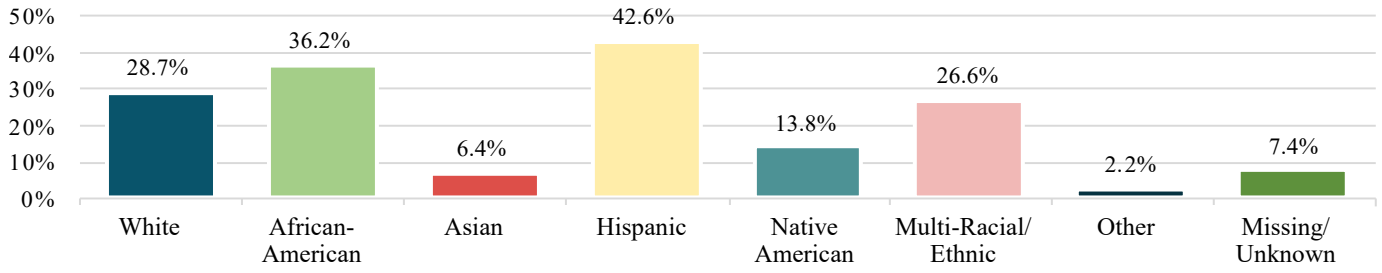
Over half (63%) of participants were heterosexual or straight, and 16% identified as bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=94)



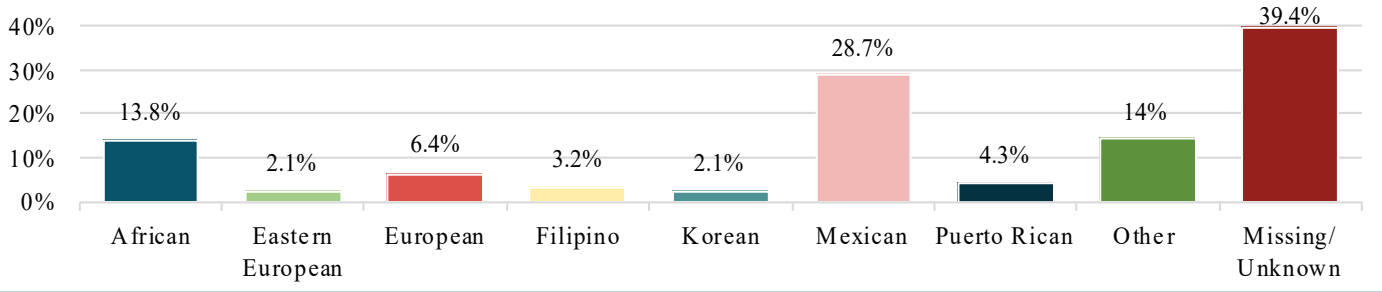
The majority (88%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=94)



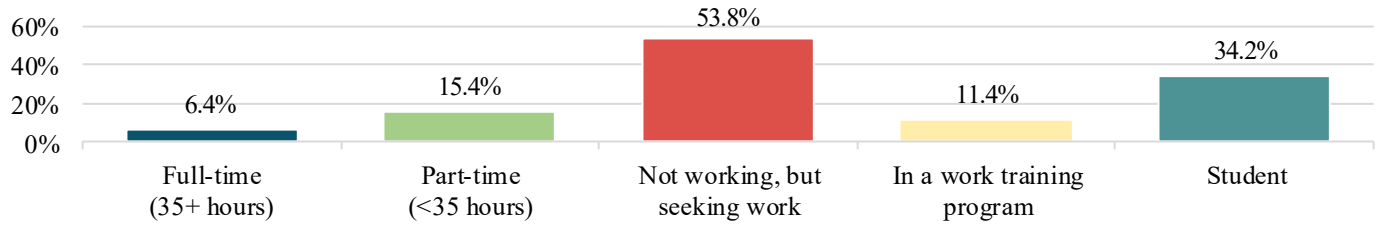
Forty-three percent of participants identified as Hispanic, 36% were African-American, 29% were White, and 27% were multi-racial/ethnic. Totals may exceed 100% as participants were able to indicate more than one race/ethnicity.

ETHNIC BACKGROUND (N=94)



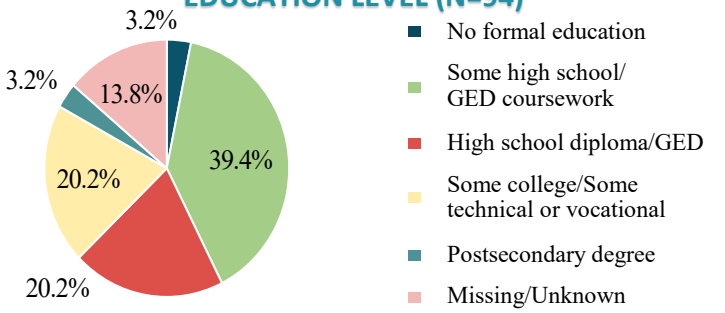
Twenty-nine percent of participants identified as being of Mexican origin, and 14% identified as being of African origin. Total may exceed 100% as participants were able to indicate more than one ethnic background.

EMPLOYMENT STATUS (N=94)



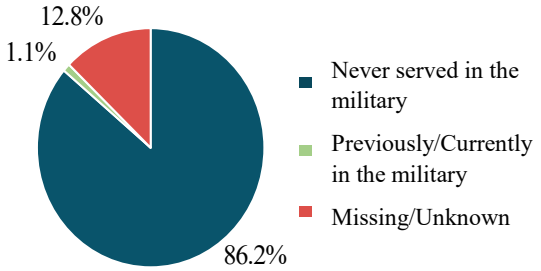
The majority (53.8%) of participants indicated they were not working but seeking work, and approximately 20% were working either full-time (6.4%) or part-time (15.4%). Almost half were in an educational program (34.2% in school and 11.4 in a work training program). Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=94)



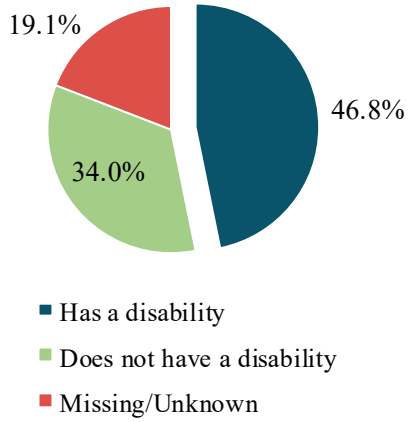
Thirty-nine percent had some high school/GED coursework, 20% had a high school diploma or GED, and 20% had completed some college.

MILITARY STATUS (N=94)



The majority (86%) of participants had never served in the military.

DISABILITY[1] STATUS (N=94)



Forty-seven percent of participants indicated having some type of non-SMI disability.

TYPE OF DISABILITY (N=94)

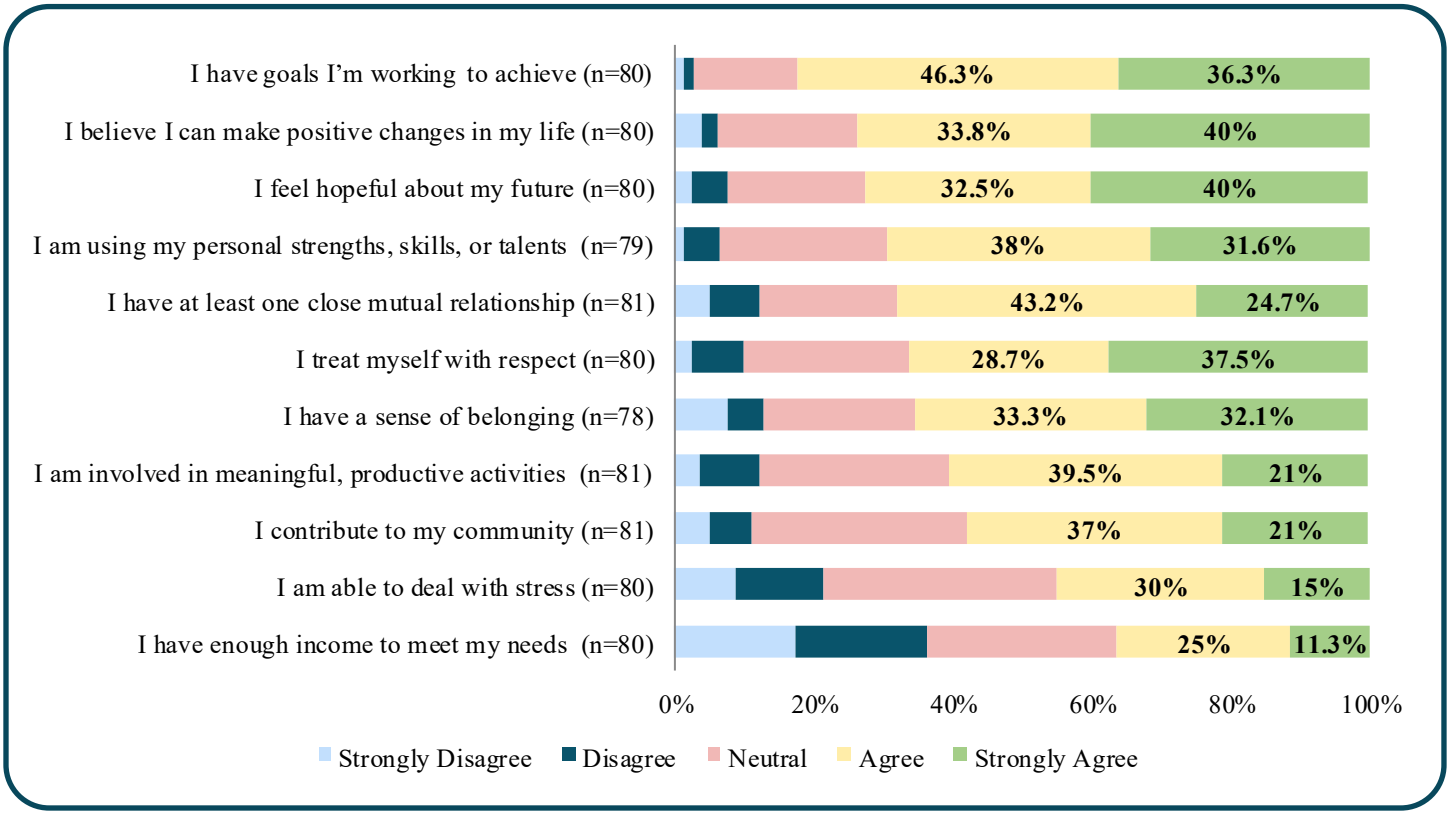
Type	n	%
Difficulty Seeing	17	18.1
Communication	4	4.3
Learning	21	22.3
Other Mental/Developmental	10	10.6
Physical	3	3.2
Other	10	10.7

This table describes the type of disability indicated by participants that had a disability, as a percentage of the total population. The high percentage of participants indicating difficulty seeing appears to be related to participants who needed some form of vision correction, such as glasses or contacts. Totals may exceed 100% as participants could indicate more than one type of disability.

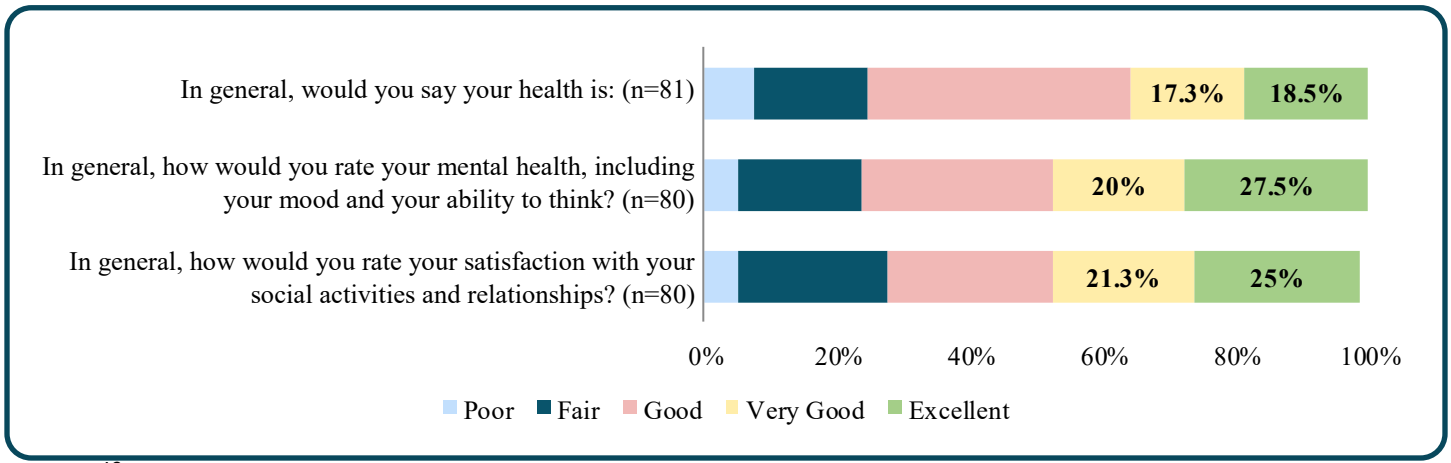
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness (SMI).*

URBAN BEATS PARTICIPANT BELIEFS

Over the course of fiscal year 2015-16, Urban Beats had two cohorts of participants that completed the Urban Beats curriculum. At the start of each Urban Beats round, participants were asked to complete a baseline Wellness Survey, the results of which are shown in the following charts. Part of the Wellness Survey included select items from the Recovery Markers Questionnaire (RMQ), and participant responses are listed in the chart below in order of highest to lowest percentage of agreement (i.e., indicated Agree or Strongly Agree). The most commonly endorsed statements (i.e., at least 70% agreed or strongly agreed) focused on participants' beliefs about their self-efficacy and optimism regarding their future. Participants appeared to be less enthusiastic about their stress management capabilities and having sufficient income. Only 15.0% strongly agreed that they were "able to deal with stress", and 11.3% strongly agreed that they had "enough income to meet [their] needs." These findings suggest that the Urban Beats program is enrolling TAY who are generally goal oriented and optimistic about what they can accomplish, but who are also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

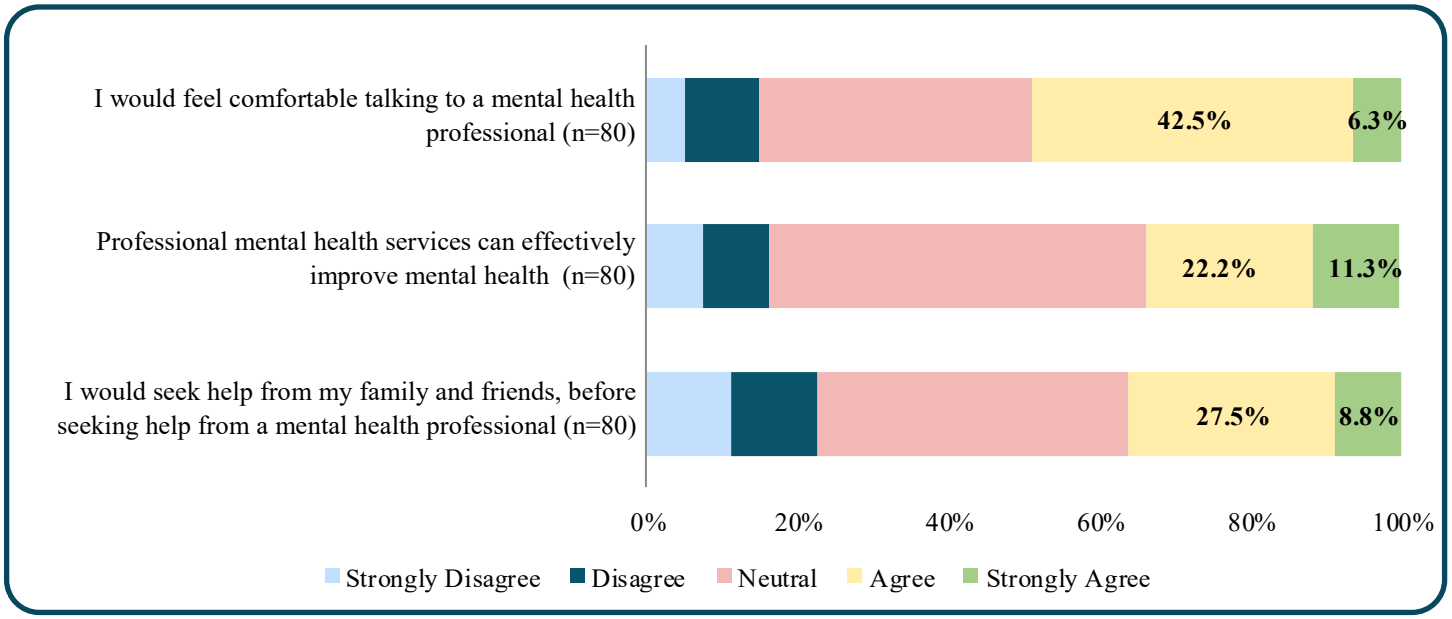


The baseline Wellness Survey also inquired about the quality of health, mental health, and satisfaction with social activities and relationships. As shown in the chart below, a substantial number of the Urban Beat participants had health and mental health concerns—only 18.5% thought their overall health was excellent, and 27.5% thought their mental health was excellent. Almost 30% (28.8%) also rated their satisfaction with their social activities and relationships as fair or poor. These findings highlight the importance of focusing on physical and mental health and social relationships within the Urban Beats program.



URBAN BEATS PARTICIPANT ATTITUDES ABOUT MENTAL HEALTH SERVICES

Lastly, the baseline Wellness Survey asked Urban Beats participants about their attitudes about mental health services. Almost half (48.8%) of the Urban Beats participants agreed or strongly agreed that they would "feel comfortable talking to a mental health professional" (although only 6.3% strongly agreed). However, only 33.5% agreed or strongly agreed that "professional mental health services can effectively improve mental health." These findings indicate that many Urban Beats participants have negative or ambivalent perceptions of professional mental health services and may not feel comfortable 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.



KEY EVALUATION FINDINGS: FOLLOW-UP

CHANGES IN URBAN BEATS PARTICIPANT BELIEFS

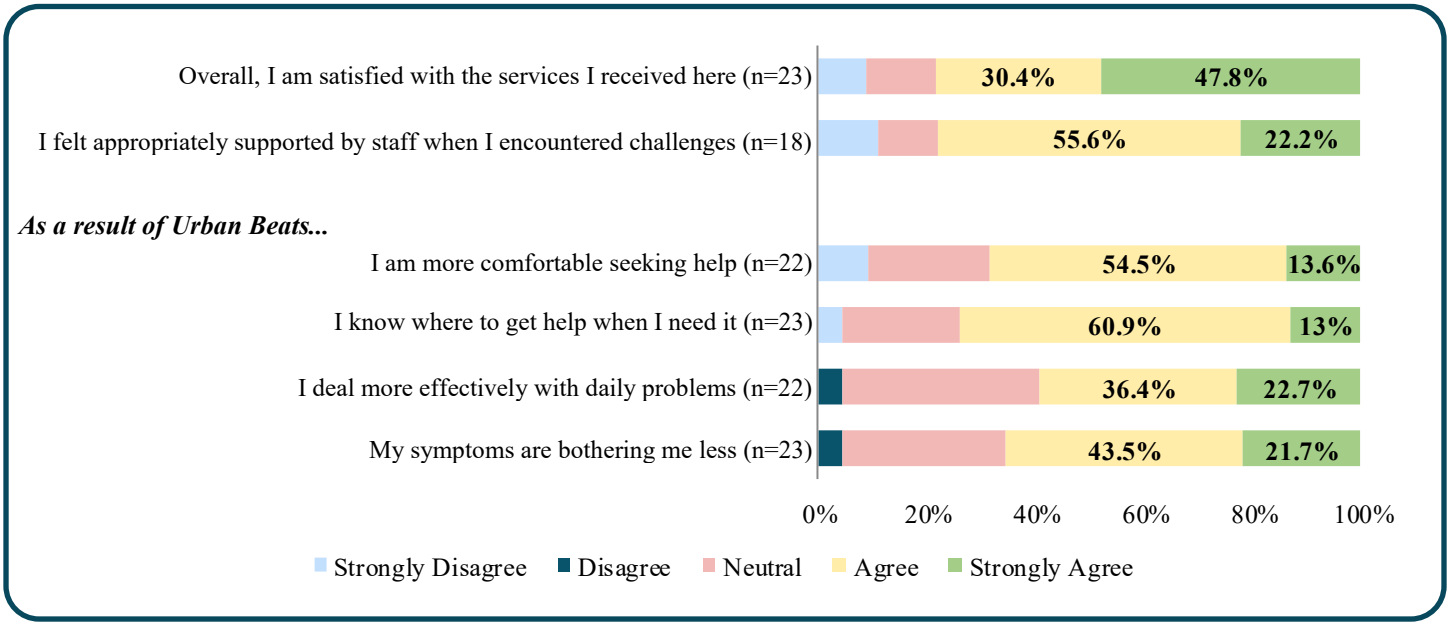
A 6-month follow-up Wellness Survey was administered to Urban Beats program participants; however, there were no statistically significant differences between baseline and the 6-week follow-up responses. A contributing factor was the small number of participants who responded to both baseline and follow-up surveys (n=25). However, several items exhibited potentially meaningful changes that will continue to be monitored in future reporting periods as the number of Urban Beats participants with completed follow-up surveys increases. As shown in Table 1 below, indicators related to satisfaction with social relationships, sense of involvement in meaningful activities, having sufficient income, and dealing with stress all improved at follow-up. Each of these represents different issues that the Urban Beats programs specifically sought to address. Of note, participants indicated slightly lower ratings of their mental health at follow-up. One potential explanation is that by the 6-week follow-up, Urban Beats participants might have felt more open, honest, and aware of their mental health.

TABLE 1. QUANTITATIVE ASSESSMENT OF URBAN BEATS PARTICIPANT CHANGES

	Change in Mean Score
In general, how would you rate your mental health, including your mood and your ability to think?	Worsened at follow-up
In general, how would you rate your satisfaction with your social activities and relationships?	Improved at follow-up
I am involved in meaningful, productive activities.	Improved at follow-up
I have enough income to meet my needs.	Improved at follow-up
I am able to deal with stress.	Improved at follow-up

URBAN BEATS OUTCOMES

As shown in the charts below, over three-quarters (78.2%) of Urban Beats participants with follow-up Wellness Survey data indicated they were satisfied with the Urban Beats program (47.8% strongly agreed). A similar percentage (77.8%) 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 felt "more comfortable seeking help" (68.0%), knew "where to get help" (73.9%), dealt "more effectively with daily problems (59.1%), and were less bothered by symptoms (65.2%).



BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of San Diego County Behavioral Health Services by Urban Beats participants was examined at several time points, both before and after starting participation in the Urban Beats program. As shown in Table 2, a little over one-quarter of the 94 Urban Beats participants had at least one SDCBHS outpatient or Assertive Community Treatment (ACT) visit within the 90 days prior to starting Urban Beats (27.7% and 24.5%, respectively). The participation rates for these services were essentially the same at 90 days after starting the Urban Beats program. A similar pattern of no substantial change in outpatient and ACT participation rates was found when examining utilization 180 days both before and after starting Urban Beats. These analyses only include the subset of participants (n=55) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2016).

While acute/crisis care services of Psychiatric Emergency Response Teams (PERT), Emergency Psychiatric Units (EPU), and inpatient hospitalizations were lower frequency events overall, there was some evidence of reduced utilization of these services after starting the Urban Beats program. This trend appeared to be particularly evident when examining the subset of participants observed for 180 days before and after starting Urban Beats. Given the relatively small sample size (n=55) and the low frequencies of the acute care services, these findings should be interpreted with caution. Service utilization patterns will continue to be examined in future reporting periods to determine if these trends persist with larger sample sizes.

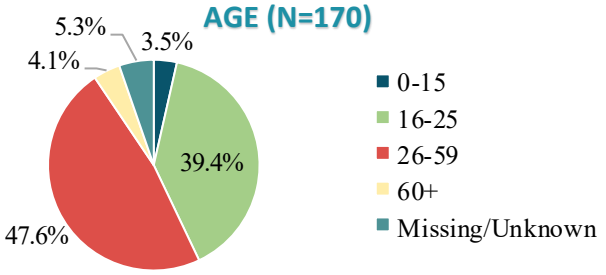
TABLE 2. COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICE UTILIZATION BEFORE/AFTER URBAN BEATS PARTICIPATION

At least one...	90 Days Before Start Urban Beats (n=94)	90 Days After Start Urban Beats (n=94)	180 Days Before Start Urban Beats (n=55)	180 Days After Start Urban Beats (n=55)
Outpatient Visit	27.7%	24.5%	38.2%	36.4%
ACT Visit	28.7%	28.7%	34.5%	32.7%
PERT	1.1%	3.2%	5.5%	1.8%
EPU	6.4%	0%	10.9%	3.6%
Inpatient Admit	4.3%	3.2%	16.4%	3.6%

COMMUNITY PERFORMANCE ATTENDEE DEMOGRAPHICS

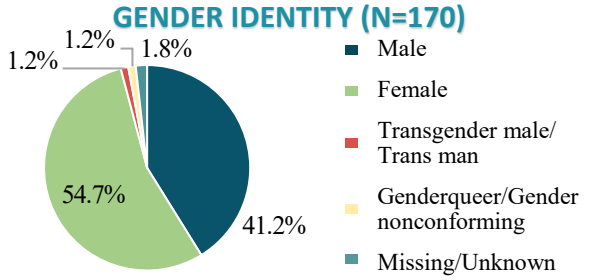
The following demographic data were collected from an audience self-report survey administered at the community performances.

AGE (N=170)



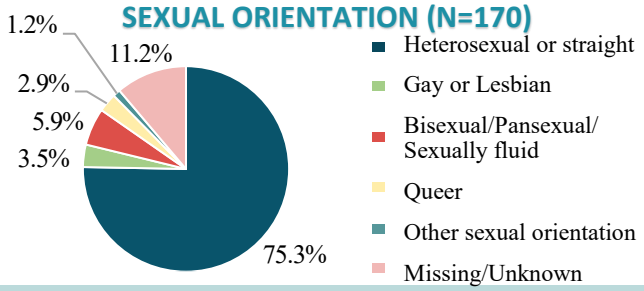
Thirty-nine percent of attendees were between the ages of 16 and 25, and 48% were between 26 and 59.

GENDER IDENTITY (N=170)



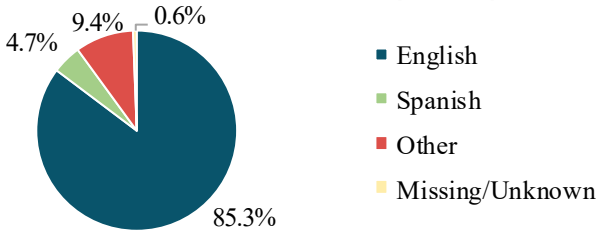
Forty-one percent of attendees were male, and 55% of attendees were female.

SEXUAL ORIENTATION (N=170)



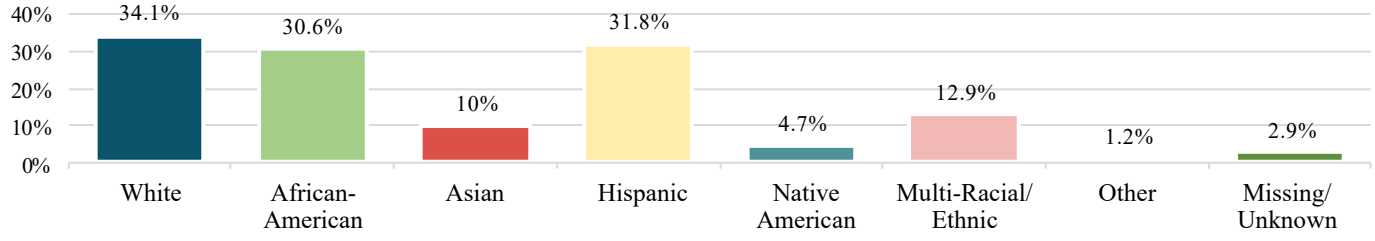
Three-quarters (75%) of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=170)



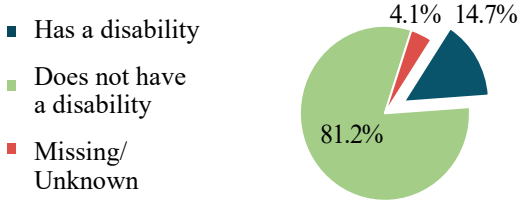
The majority (85%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=170)



About one-third (34%) of attendees identified as White, one-third (31%) as African-American, and one-third (32%) as Hispanic. Totals may exceed 100% as attendees could indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=170)



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

The majority (91%) of attendees had never served in the military.

TYPE OF DISABILITY (N=170)

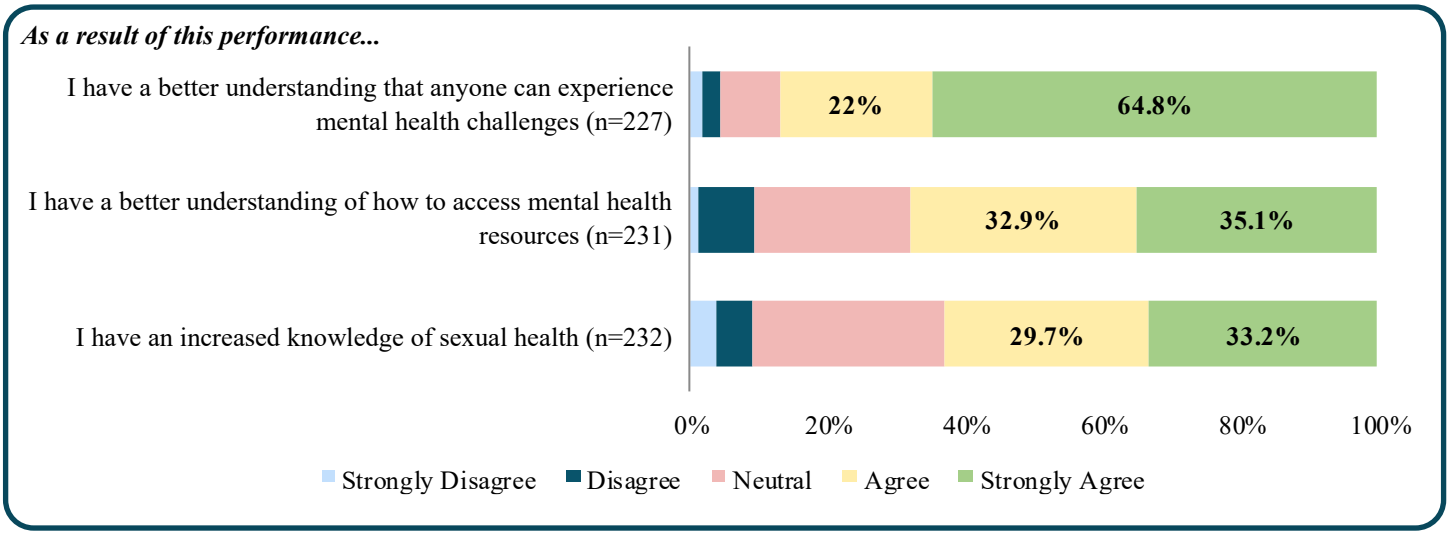
Type	n	%
Communication	11	6.5
Mental (e.g., learning, developmental)	12	7.1
Physical	1	0.6
Chronic Health	0	0.0
Other	4	2.4

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

[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 severe mental illness (SMI).*

COMMUNITY PERFORMANCE OUTCOMES

A total of 234 persons who attended the community performances completed a brief "outcomes" survey. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in the chart below, 64.8% of all respondents strongly agreed and 22.0% agreed that because of the performance, they had a better understanding that anyone can experience mental health challenges. This was the most prominent outcome from the post-performance survey data, although significant majorities also agreed or strongly agreed that they had a better understanding of how to access mental health resources (68.0%) and an increased knowledge of sexual health (62.9%).



The response patterns between TAY (n=100) and non-TAY (n=134) that attended the performance were nearly identical, except that a higher percentage of non-TAY respondents indicated they strongly agreed that they "had a better understanding that anyone can experience mental health challenges" (69.8% compared to 58.2%). This may suggest that while a substantial majority of both TAY and non-TAY respondents better understood mental health challenges as a result of the community performance, community performances may be particularly effective at communicating messages of empathy and stigma reduction related to mental health issues for non-TAY community members.

URBAN BEATS YOUTH AND STAFF QUALITATIVE FOCUS GROUP FINDINGS

Focus groups were held with Urban Beats youth and staff periodically throughout the year. Per the evaluation plan described in the original contract, the focus groups were designed to "*examine whether UB is perceived as adopting a **strengths-based approach** and document their perspectives on how programs like UB can **improve youth outreach to and engagement of underserved TAY populations**.*"

Six focus groups were held throughout the year, including two with Youth Service Partner (YSP) staff and four with Urban Beats youth:

December 2015, halfway through the first round of Urban Beats: two focus groups with youth and one focus group with staff, centering on the experience of Urban Beats so far.

March 2016, after the final performance of the first round of Urban Beats: one focus group with youth, centering on their final performance.

July/August 2016, after the final performance of the second round of Urban Beats: one focus group with youth and one focus group with staff, centering on their final performance. A few youth at the focus group were involved in both the first and second rounds of Urban Beats.

Youth focus groups typically included between four and eight Urban Beats members, while staff focus groups included between three and five YSPs. Question guides that covered relevant topic areas for each time point were developed for each focus group and asked similar questions of both youth and staff. The focus groups included discussions of the successes and challenges of developing Urban Beats' content and structure; outreach, recruitment, and retention in the program; youth satisfaction and perceived outcomes; using a strengths-based approach; and the final performances.

DIFFERENCES BETWEEN THE FIRST AND SECOND COHORTS OF URBAN BEATS

It is important to note that as Urban Beats grew and conducted more widespread outreach and recruitment over the year, the profile of each successive cohort changed. Most of the first cohort of Urban Beats youth were already engaged with the Oasis Clubhouse (Pathways) or TAY Academy (San Diego Youth Services, SDYS) before joining Urban Beats. These youth were already familiar with mental health issues, terminology, and stigma, and most had been diagnosed with a mental illness. Those who participated in the second round of Urban Beats included both youth who had also participated in the first round, as well as new youth, who had been less exposed to mental health programs and had less familiarity with terms, diagnoses, and stigma.

Consequently, YSPs described that messages about stigma resonated with the youth in the first round of Urban Beats, whereas messages about trauma resonated more with the youth in the second round. YSPs developed different activities and curricula for each round accordingly.

At both staff focus groups, YSPs expressed some concern at the rapid pace of Urban Beats' development and implementation. While they had spent time reflecting on their practices and adapting the program accordingly during the course of the program, the YSPs felt that a short break in the programming would help them reflect and reorient to improve the program.

YOUTH SATISFACTION, STRENGTHS-BASED APPROACH, AND PERCEIVED OUTCOMES

The way youth and staff described their experiences with Urban Beats reflected a strengths-based approach. In all youth focus groups, youth were very satisfied with the program, understood and supported the goals of Urban Beats, and were able to link Urban Beats activities to perceived personal benefits (i.e., outcomes).

Youth focus group participants felt they had improved in their creative skills, were better able to communicate with others (particularly regarding mental health stigma), were more confident and comfortable, and had also learned leadership and self-discovery skills. Youth also indicated that these skills were laying the groundwork for larger ambitions, such as identifying what careers they might want to pursue and giving them the skills and confidence to achieve their goals. This sentiment was echoed in the YSP focus groups. A few youth, especially those who had been in both rounds of Urban Beats, reported that either they themselves or others from their cohort had found jobs in entertainment/the arts or in mental health as peers.

Across the focus groups, youth spoke very positively about their interactions with YSPs, indicating that the support and recognition they received from staff was valued by them, made them feel more confident, and helped them try new things (e.g. different types of artistic expression, public speaking). Staff indicated that they felt their techniques, such as active listening, worked well with youth, and that they were able to relate well to youth given their own personal experiences. YSPs described having a role similar to being a peer mentor but also had education/work experience in the field of mental health or social work, which they believed helped them earn the respect of the Urban Beats youth.

PERFORMANCES

At the time of the focus groups, youth were either planning or had recently completed their final performance. The youth discussed attending other open-mic nights or similar events in the community where they could practice and become more comfortable performing for an audience, which they found enjoyable and helpful. Several youths indicated that they had started going to open-mic nights on their own. Some youth talked about feeling nervous and unprepared for the final performances but felt relieved and accomplished afterwards.

Urban Beats youth enjoyed having a substantial role in planning the second final performance, such as creating the stage decorations. Held in different local venues, the second performance was not as well attended as the first final performance; youth indicated that this may have been due to parking issues or less collaboration from other organizations to bring in more attendees. Youth suggested promoting the events at other similar performances in the community.

OUTREACH, RECRUITMENT, AND RETENTION IN URBAN BEATS

YSPs indicated that although efforts were made to shorten the evaluation survey and make it more youth-friendly, the evaluation survey's resemblance to a formal mental health treatment assessment still alienated some youth, affecting early program retention rates negatively. Youth stated that a good approach would be to have youth recruit other youth and conduct outreach through a variety of venues and platforms, such as social media, local performances, and schools. In the final focus group with youth, those who had been in both cohorts of Urban Beats mentioned that they were actively participating in outreach and recruitment events, such as the Four Corners of Life event held in the Southeast San Diego community. Staff were especially interested in conducting more comprehensive outreach with local community organizations, but felt that they had little time to do so while running overlapping rounds of Urban Beats. Staff also felt that they had little authority to make real connections or promises to community groups, as this needed to come from leadership.

URBAN BEATS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the INN 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 nine respondents from the 10 persons invited to participate in the survey, for a response rate of 90.0%. 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.

1. *The major program goals identified by Urban Beats staff:*
    a. Engage TAY through artistic expression
    b. Facilitate mental health and general wellness education
    c. Reduce mental health stigma
    d. Conduct community outreach and education
    e. Increase awareness of and connection to mental health services
2. *Factors that helped the Urban Beats program achieve goals:*
    a. The unique and wide set of Urban Beats staff's skills and passions related to artistic talents, youth engagement, and leadership
    b. Urban Beats staff having "lived experience" with mental health services
    c. Opportunities for community performances benefit both TAY and community members
    d. Close collaboration between Urban Beat staff and participants, resulting in individualized support
    e. Developing partnerships with other community organizations
    f. Creation of a positive, safe, and inclusive program climate
    g. Providing TAY with a voice in program decision-making
3. *Relationship between public performances and achievement of overall program goals:*
    a. Provided a specific event to center Urban Beats educational activities around
    b. Encouraged TAY to express themselves publicly and build self-confidence
    c. Functioned as "platform" for communicating a mental health stigma reduction message to the community
    d. Increased awareness of the Urban Beats program to facilitate TAY recruitment and other organizational partnerships
    e. Required youth to develop other skills needed to create, plan, and execute the event, in addition to their artistic talents
4. *How Urban Beats helped TAY engage with needed mental health services:*
    a. Created a "safe space" for open and non-judgmental communication about mental health services
    b. Provided direct linkages/referrals to outpatient and other services
5. *Role of Urban Beats to help TAY reduce mental illness stigma among themselves and in the community:*
    a. Allowing TAY to communicate their stories to the community in a creative and empowering way
    b. Starting the conversation among the community regarding mental health stigma through public performances
    c. Providing an opportunity for TAY hear stories from other TAY in a safe and non-judgmental environment
    d. Facilitating development of peer supports over an extended period of time through program participation

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.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-16 Urban Beats program that differed substantially from the initial program design during the first year of service provision (7/1/2015 to 6/30/2016). As is typical during program start-ups, basic practices and procedures were adjusted and refined over the course of the first year to better fit the service delivery context and the emerging set of community partnerships. These changes were related to curriculum development and delivery, TAY recruitment, and the community performance. However, no fundamental or program-wide changes were made.

YEAR 1 PROGRAM RECOMMENDATIONS

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

1. Identify additional community partners, particularly schools, to facilitate TAY recruitment.
2. Provide more training and team building opportunities for staff.
3. Develop strategies to increase number of community performances and performance attendance.
4. Expand use of Urban Beats "graduates" to help recruit new TAY and act as mentors in future Urban Beats classes.
5. Incorporate more strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach).
6. Continue to purposefully assess, revise, and implement Urban Beats curriculum to promote ongoing fit with target participants.
7. Re-examine evaluation approach to identify optimal balance between data collection needs and burden on participants and staff.

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

Performance Attendee Demographics: INN 16 Urban Beats Program

Supplemental Summary

Age	N	%
0-15 (children/youth)	6	*3.5%*
16-25 (transition age youth)	67	*39.4%*
26-59 (adult)	81	*47.6%*
60+ (older adults)	7	*4.1%*
Unknown/preferred not to answer	9	*5.3%*
Missing/did not answer	0	*0%*
TOTAL	**170**	***100%***

Race	N	%
Black/African American	42	*24.7%*
Asian	14	*8.2%*
White	45	*26.5%*
Native American	4	*2.4%*
Pacific Islander	14	*8.2%*
More than one race	1	*0.6%*
Other	1	*0.6%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	49	*28.8%*
TOTAL	**170**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	44	*25.9%*		
Mexican			26	*15.3%*
Puerto Rican			10	*5.9%*
Other			4	*2.4%*
South American			1	*0.6%*
Missing/did not answer			8	*4.7%*
Non-Hispanic or Non-Latino	111	*65.3%*		
African			13	*7.6%*
Chinese			4	*2.4%*
Filipino			7	*4.1%*
Vietnamese			3	*1.8%*
European			6	*3.5%*
Other			15	*9.5%*
Missing/did not answer			68	*40.0%*
More than one ethnicity	10	*5.9%*	10	*5.9%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	5	*2.9%*	5	*2.9%*
TOTAL	**170**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
American Sign Language	7	*4.1%*
Arabic	1	*0.6%*
Armenian	1	*0.6%*
English	145	*85.3%*
Portuguese	1	*0.6%*
Spanish	8	*4.7%*
Vietnamese	3	*1.8%*
Other	3	*1.8%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	1	*0.6%*
TOTAL	**170**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	128	*75.3%*
Gay or Lesbian	6	*3.5%*
Bisexual	10	*5.9%*
Queer	5	*2.9%*
Another sexual orientation	2	*1.2%*
Unknown/preferred not to answer	16	*9.4%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	25	*14.7%*				
Communication disability			11	*6.5%*		
Difficulty seeing					7	*4.1%*
Difficulty hearing/speaking					4	*2.4%*
Mental disability			12	*7.1%*		
Learning disability					8	*4.7%*
Developmental disability					1	*0.6%*
Other mental disability					3	*1.8%*
Physical/mobility disability			1	*0.6%*	1	*0.6%*
Chronic health condition			0	*0%*	0	*0%*
Other disability			4	*2.4%*	4	*2.4%*
No disability	138	*81.2%*	138	*81.2%*	138	*81.2%*
Unknown/preferred not to answer	7	*4.1%*	7	*4.1%*	7	*4.1%*
Missing/did not answer	0	*0%*	0	*0%*	0	*0%*
TOTAL	**170**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	13	*7.7%*
No	149	*87.6%*
Unknown/preferred not to answer	8	*2.9%*
Missing/did not answer	0	*0%*
TOTAL	**170**	***100%***

Gender: Assigned Sex at Birth	N	*%*
Male	68	*40.0%*
Female	97	*57.1%*
Unknown/preferred not to answer	2	*1.2%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Gender: Current Gender Identity	N	%
Male	70	*41.2%*
Female	93	*54.6%*
Transgender	2	*1.2%*
Genderqueer	2	*1.2%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	3	*1.8%*
TOTAL	**170**	***100%***

Participant Demographics: INN 16 Urban Beats Program

Supplemental Summary

Age	N	%
0-15 (children/youth)	2	*2.1%*
16-25 (transition age youth)	85	*90.4%*
26-59 (adult)	1	*1.1%*
60+ (older adults)	0	*0%*
Unknown/preferred not to answer	6	*6.4%*
Missing/did not answer	0	*0%*
TOTAL	**94**	***100%***

Race	N	%
Black/African American	24	*25.5%*
Asian	2	*2.1%*
White	17	*18.1%*
Native American	4	*4.3%*
More than one race	15	*16.0%*
Other	0	*0%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	32	*34.0%*
TOTAL	**94**	***100%***

Ethnicity	N	%	N	%*
Hispanic or Latino	25	*26.6%*		
Mexican			23	*24.5%*
Puerto Rican			2	*2.1%*
Other			3	*3.2%*
Missing/did not answer			6	*6.4%*
Non-Hispanic or Non-Latino	47	*50.0%*	47	*50.0%*
African			11	*11.7%*
Asian Indian/South Asian			1	*1.1%*
Filipino			2	*2.1%*
Korean			1	*1.1%*
European			4	*4.3%*
Other			7	*7.4%*
Missing/did not answer			24	*25.5%*
More than one ethnicity	15	*16.0%*	7	*7.4%*
Unknown/preferred not to answer	0	*0%*	0	*0%*
Missing/did not answer	7	*7.4%*	7	*7.4%*
TOTAL	**94**	***100%***		

* Totals may add to more than 100% since participants could indicate multiple subethnicities.

Primary Language	N	%
American Sign Language	1	*1.1%*
Armenian	1	*1.1%*
English	81	*86.2%*
Spanish	7	*7.4%*
Other	1	*1.1%*
Unknown/preferred not to answer	0	*0%*
Missing/did not answer	3	*3.2%*
TOTAL	**94**	***100%***

Sexual Orientation	N	%
Heterosexual or Straight	59	*62.8*
Gay or Lesbian	5	*5.3*
Bisexual	15	*16.0*
Queer	1	*1.1*
Unknown/preferred not to answer	11	*11.7*
Missing/did not answer	3	*3.2*
TOTAL	**94**	***100%***

Disability	N	%	N	%*	N	%*
Yes disability	44	*46.8%*				
Communication disability			20	*21.3%*		
Difficulty seeing					17	*18.1%*
Difficulty hearing/speaking					3	*3.2%*
Other communication disability					1	*1.1%*
Mental disability			25	*26.6%*		
Learning disability					21	*22.3%*
Developmental disability					2	*2.1%*
Other mental disability					1	*1.1%*
Physical/mobility disability			3	*3.2%*	3	*3.2%*
Chronic health condition			1	*1.1%*	1	*1.1%*
Other disability			9	*9.6%*	9	*9.6%*
No disability	32	*34.0%*	32	*34.0%*	32	*34.0%*
Unknown/preferred not to answer	14	*14.9%*	14	*14.9%*	14	*14.9%*
Missing/did not answer	4	*4.3%*	4	*4.3%*	4	*4.3%*
TOTAL	**94**	***100%***				

* Totals may add to more than 100% since participants could indicate multiple disabilities.

Veteran Status	N	%
Yes	1	*1.1%*
No	81	*86.1%*
Unknown/preferred not to answer	8	*8.5%*
Missing/did not answer	4	*4.3%*
TOTAL	**94**	***100%***

Gender: Assigned Sex at Birth	N	*%*
Male	40	*42.6*
Female	51	*54.3*
Unknown/preferred not to answer	1	*1.1*
Missing/did not answer	2	*2.1*
TOTAL	**94**	***100%***

Gender: Current Gender Identity	N	%
Male	39	*41.5%*
Female	49	*52.1%*
Genderqueer	2	*2.1%*
Unknown/preferred not to answer	3	*3.2%*
Missing/did not answer	1	*1.1%*
TOTAL	**94**	***100%***

INNOVATIVE MOBILE HOARDING INTERVENTION PROGRAM (INNOVATIONS-17)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

The Innovative Mobile Hoarding Intervention Program (IMHIP; INN-17) program is funded through the Innovations (INN) component of the Mental Health Services Act. The overall goal of IMHIP is to diminish long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior "lived experience" receiving treatment for hoarding behaviors to provide support and encouragement to IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participant's overall quality of life.

EXECUTIVE SUMMARY

The Innovative Mobile Hoarding Intervention Program (IMHIP; INN-17) began providing services in April 2016. Therefore, minimal data collection had occurred prior to 6/30/2016.

Evaluation results for IMHIP will be included in the next INN Annual Report cycle.

For additional information about the INN–17 Innovative Mobile Hoarding Intervention Program please contact:
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