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

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (1/1/16 - 12/31/18)

UC San Diego

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

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

EXECUTIVE SUMMARY

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

- A total of 488 persons participated in 25 Faith Based Academies.
- Most (73.2%) participants were between the ages of 26-59 and the majority were female (76.8%). Slightly over half (53.9%) identified as Hispanic/Latino, with 38.1% indicating Spanish as their primary preferred language.
- Faith leaders and behavioral health providers indicated they learned important information and gained confidence by participating in the academy. While enthusiastic overall, behavioral health providers tended to rate aspects of the training slightly less positive than the faith leaders.
- Primary Academy outcomes as reported by participants included: 1) increased knowledge, 2) stronger relationships, and 3) inspiration for initiating actions that reflected and/or furthered faith and behavioral health integration.
- Key factors identified by staff that helped the program achieve its goals included: 1) interactive nature of Academy sessions, 2) well written curriculum, 3) content contributors and presenters with diverse expertise, 4) passionate and organized staff, 5) high quality presentations, and 6) faith leader/behavioral health provider networking opportunities.

FUTURE DIRECTIONS

As a result of the positive pilot study findings for the INN-13 Faith Based Academy, BHS decided to continue financial support for these trainings using ongoing behavioral health funding sources. Future Academies will utilize the curriculum developed during this pilot study and build upon the lessons learned regarding successful delivery of Academy training sessions to foster increased behavioral health provider and faith leader knowledge, awareness, and integration. The Faith Based Academy program will be merged with the INN-13 Community Education program (another INN pilot program) to better coordinate the identification of champions and incorporate them into community education and outreach opportunities.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To develop a Faith Based Academy that integrates faith based leaders and clergy with behavioral health providers to support the development of collaborations and partnerships and to support capacity building.*

This objective comprises two distinct program activities: 1) development of the Faith Based Academy (i.e., content and structure), and 2) conducting Faith Based Academies in the community. For the first objective, the selected organizations started with a core set of topics to be covered (as specified by BHS) and then successfully worked with behavioral health professionals and faith leaders to design a detailed curriculum for use in the Academies. The process of developing the curriculum required a significant investment of time on the part of program staff to pull together relevant expertise, create the presentation content, and then refine and synthesize into a cohesive multi-session Academy. A significant challenge was consolidating all required and desired information into a 12-15 hour training Academy. In addition to the curriculum, the programs developed a comprehensive resource list of relevant community organizations.

For the second activity, a total of 488 persons participated in 25 Academies throughout the duration of the MHSA funded INN-13 pilot project phase. Based on available survey responses (n=443), this included 257 persons who primarily identified as faith leaders (FLs) and 186 who primarily identified as behavioral health providers (BHPs). Several different Academy formats were attempted (e.g., separate Academies for faith leaders and behavioral health professionals, 1-2 hours per week for a series of weeks versus a full day sessions over several days, etc.). While modifications and refinement were ongoing, the model that appeared to be most successful was to host Academies with both the target groups attending together over two full day sessions (sometimes with a shorter "kick-off" session the night before the first all-day session). Programs acknowledged challenges with trying to cover the substantial course content while also allowing sufficient time for discussion and engagement to promote shared learning and initial relationship building between faith leaders and behavioral health providers.

Overall, survey results indicated that Academy participants, particularly the faith leaders, learned new substantive information and how to better engage with each other (e.g., make referrals). Based on interviews with faith leaders and behavioral health providers, the primary impacts of Academy participation were: 1) increased knowledge, 2) stronger relationships between faith leaders and behavioral health providers, and 3) the confidence/tools to take further actions after the Academy related to integrating faith and behavioral health. There was much interest in the "alumni" events that brought people together after the initial Academies as well as requests for next steps for ongoing educational and training opportunities.

2. To identify faith based and behavioral health champions to provide ongoing community facilitator trainings.

Champions were identified and some transitioned on to the related MHSA funded INN-13 Community Education program. However, this aspect of the program was more challenging than initially expected due to logistical coordination and communication difficulties between the two separate programs. Additionally, while many persons were eager to share what they learned, they did not have the time or desire to become official champions and work as part of this other organization. Feedback from participants and program staff suggested the development of another version of the champions who would essentially become ambassadors to bring back the information they learned to their own places of worship, work, or other community agencies they interacted with. Based on the experiences of the pilot phase, it was determined to combine the functions of the Faith Based Academy and the Community Education programs into one organization for better coordination.

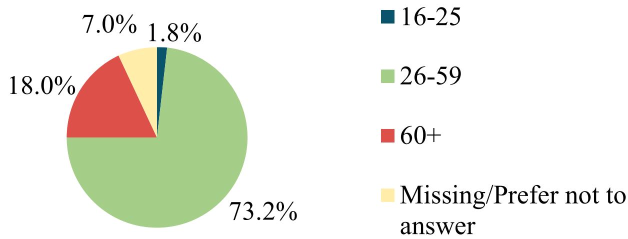
3. To introduce small community based organizations, particularly faith based organizations, to County contracting.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

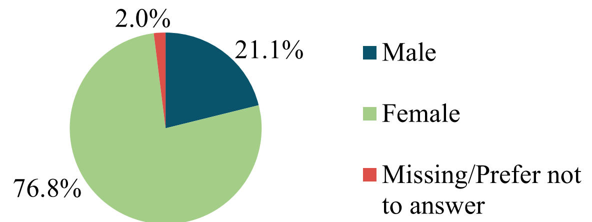
The following self-reported characteristic data were collected from Faith Based Academy participants.[1]

AGE (N=488)



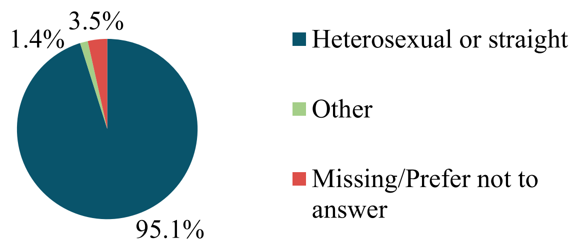
The majority of participants (73.2%) were between the ages of 26 and 59.

GENDER IDENTITY (N=488)



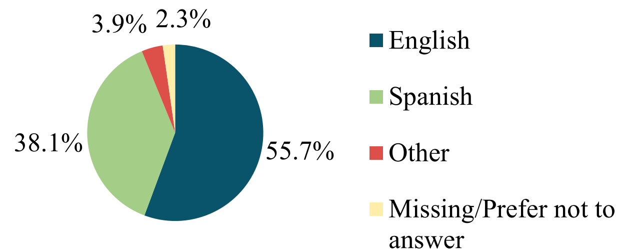
About three-quarters of participants were female (76.8%) and 21.1% of participants were male.

SEXUAL ORIENTATION (N=488)



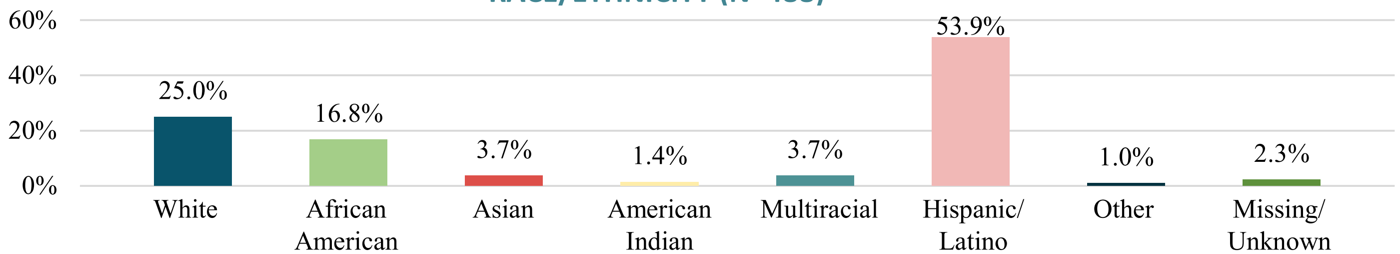
Most (95.1%) participants were heterosexual or straight and 3.5% of participants did not provide a response.

PRIMARY LANGUAGE (N=488)



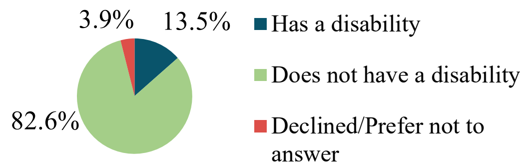
English was the primary language of most participants (55.7%) followed by Spanish (38.1%).

RACE/ETHNICITY (N=488)



Over half of the participants identified themselves as Hispanic (53.9%) with 25% identifying as White. Totals may exceed 100% as participants were able to indicate more than one race/ethnicity.

DISABILITY STATUS[2] (N=488)



13.5% of participants reported having some form of non-SMI related disability.

A little over 5% (6.2%) indicated they had served in the military.

TYPE OF DISABILITY (N=488)

Type	n	%
Communication	23	4.7
Mental (e.g., learning)	15	3.1
Physical	16	3.3
Chronic Health	17	3.5
Other	11	2.3

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

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

POST-TRAINING SURVEY RESULTS

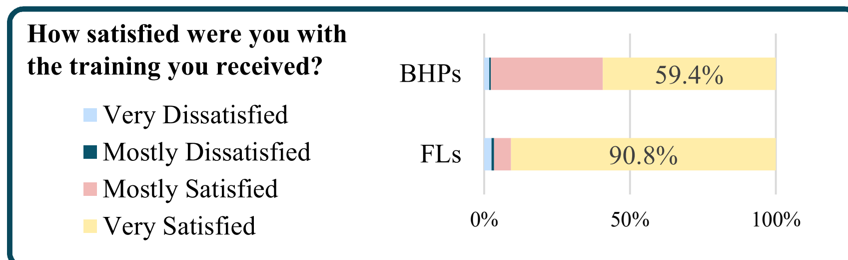
A total of 443 persons completed a Faith Based Academy training and a post-training survey (257 faith leaders and 186 behavioral health providers). As shown in Table 1, while the ratings regarding the content and impact of the trainings were generally favorable, the mean score differences between the two groups indicated that behavioral health providers may not have felt as informed about how to access or work with faith community resources as faith leaders felt informed about behavioral health issues and resources.

TABLE 1. POST-TRAINING SURVEY

Faith Leaders (FL) (n=257): "As a result of this training…"	*FL* *Means*	*BHPs* *Means*	Behavioral Health Providers (BHPs) (n=186): "As a result of this training…"
I know where to get help regarding mental health conditions and wellness for children/adolescents	4.6	4.2	I know where to access faith community resources for mental health conditions and wellness for chld./adols.
I know where to get help regarding substance abuse conditions and resources for chld./adols.	4.6	4.1	I know where to access faith community resources for substance abuse conditions for chld./adols.
I know where to get help regarding mental health conditions and wellness for adults/older adults	4.6	4.3	I know where to access faith community resources for mental health conditions and wellness for adults/older adults
I know where to get help regarding substance abuse conditions and resources for adults/older adults	4.6	4.1	I know where to access faith community resources regarding substance abuse conditions for adults/older adults
I know better when to refer/recommend someone to receive formal behavioral health services	4.7	4.3	I know better when to refer/recommend someone to faith based behavioral health resources
I am more comfortable discussing mental health and substance abuse issues	4.7	4.3	I am more comfortable talking with faith representatives about integrating spiritual needs and behavioral health care
I know better how to educate members of my faith community about behavioral health services	4.7	4.3	I know better how to educate other behavioral health providers about faith based behavioral health resources
I know better how to reduce the stigma of behavioral health within my faith community	4.7	4.3	I know better how to reduce the stigma of behavioral health within faith communities
I am more confident that rehabilitation and recovery are possible	4.7	4.4	I am more confident that faith communities can help support rehabilitation and recovery
I am more likely to refer/recommend someone to receive formal behavioral health services	4.8	4.5	I am more likely to refer/recommend someone to participate in faith community behavioral health resources

Scale responses: Strongly disagree (1), Disagree (2), Neither agree/disagree (3), Agree (4), Strongly agree (5)

FIGURE 1. OVERALL TRAINING SATISFACTION



In Figure 1, the majority (90.8%) of Faith Leaders reported being "very satisfied" with the training they received compared to about 60% (59.4%) of Behavioral Health Providers. This is consistent with the slight differences in mean score ratings presented in Table 1.

FAITH LEADER AND BEHAVIORAL HEALTH PROVIDER INTERVIEWS

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

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

1. **Increased Knowledge**

a. New information about topics of faith, behavioral health, and their integration.

i. BHPs reported increased understanding of:

1. The terminology used by the faith community.
2. The need for integration of faith and behavioral health.
3. Their own personal beliefs about faith.
4. How to handle faith oriented discussions with clients.

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

ii. FLs reported learning:

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

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

b. Awareness of community resources.

i. All individuals reported increased awareness of the resources available in their communities.

ii. The resource binders were considered particularly useful in identifying community resources.

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

a. Addressing misconceptions.

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

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

b. Increased comfort interacting with each other.

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

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

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

c. Creating opportunities to make connections.

   i. Interviewees reported exchanging information with each other so they had a specific, trusted person to reach out to for future referrals and questions.

   ii. Maintaining and promoting connections after the training was challenging, but crucial.

      1. Events such as BHP and FL breakfasts and luncheons were helpful.

      2. Significant interest in exploring other mechanisms such as regular "alumni" events, communication and dissemination of information via email, blog, etc.

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

a. Behavior changes.

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

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

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

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

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

   iii. BHPs indicated changes in practice related to:

      1. Assessment procedures (i.e., more attention to faith factors).

      2. More dialogue and actions with clients about faith matters when clients express interest in these areas.

      3. Organizational climate (e.g. more discussion of faith in clinical settings and between clinicians).

      4. Organizational structure (e.g. training graduates, becoming a "go-to" person about faith issues with clients).

b. Dissemination of information (i.e., "The Ripple Effect").

   i. BHPs and FLs are working together to bring mental health education into the churches.

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

   ii. FLs reported including behavioral health information from the training in their church newsletters, social media, and even bringing it to their (non-church) place of employment.

   iii. BHPs indicated sharing information with colleagues and developing written materials that examine the integration of faith and behavioral health.

   iv. Interviewees reported that they frequently encourage others to take the Academy training.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

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

1. The major program goals identified by staff:

a. Facilitate connections between mental health service providers and community clergy.
b. Educate faith leaders and faith communities about mental illness.
c. Reduce stigma surrounding mental illness and seeking mental health services.
d. Provide resources.
e. De-stigmatize religion in clinical practice.
f. Educate mental health professionals about faith based communities.
g. Increase the ability of faith leaders to support their community.

2. Factors that helped the program achieve goals:

a. Interactive nature of the Academy encouraging participant engagement.
b. Well written curriculum with plenty of mental health information.
c. Contributors bringing diverse expertise and experiences to the program and presentations.
d. Staff being passionate, committed, and organized.
e. Quality of the presentations and the information provided.
f. Networking opportunities that the trainings provide.
g. Bilingual workshops, presenters, and staff.

3. Factors that inhibited the program from achieving goals:

a. Time challenges/difficulties in fitting necessary material into available time for presentations.
b. Focusing only on Christianity.
c. Lack of buy-in about spirituality and mental health services.
d. Ineffective outreach efforts.
e. Complexity of merging different content styles.
f. Challenges in recruiting participants who would benefit the most.

4. Recommendations to help the program better achieve goals:

a. More preparation time for locating personnel and developing the curriculum.
b. Increase outreach efforts made to non-Christian places of worship/agencies.
c. Offer workshops to the public for wider access and broader distribution of the information.
d. Increase outreach efforts made to engage faith based leaders and mental health providers.
e. Add additional years to the program.
f. Provide more time for each training.
g. Survey participants about their availability to increase attendance.
h. Offer continuing education opportunities.
i. Get more information from faith-based providers on perceived community needs.

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

a. More funding for resources and more equipment for producing curriculum materials.
b. Increased communication between related faith-based “Innovation” programs for continuity and relationship building.
c. County provided trainings.
d. Volunteer assistance.
e. Training faith leaders to encourage referrals to the behavioral health system.
f. Yearly meetings to make improvements and revise goals.

6. Key "innovations" making this program unique:

a. The goal is education and not clinical or case management.
b. The need the program helped fill in the community.
c. The facilitators and panelists who can share their personal experiences.
d. The resource guide.
e. Participant engagement in exercises (i.e., the interactive nature of the training).
f. The quality of the presentations.
g. Different types of individuals are welcomed and community team building is encouraged.

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

a. Using a wide variety of workshop times during the week and workshop venues.
b. Using people who took the training to "advertise" their experience.
c. Visiting churches in the local area.
d. Advertising in church bulletins.
e. Having groups meet at the end of the year to share challenges/successes.
f. Personal referrals.
g. Stipends.

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

a. Providing information about the value and purpose of the Academy training.
b. Most behavioral health providers are easy to recruit because they are interested in this type of training.
c. Stipend.
d. Certifications from the County to validate the training of the agencies involved.
e. Flexible scheduling.
f. Offering free Continuing Education Units (CEUs).
g. Promoting through local colleges.

9. Recommendations for another agency starting a faith academy:

a. Find people who have the same passion and commitment.
b. Have group activities that engage participants.
c. Sustain/maintain the training process.
d. Simplify the curriculum.
e. Have lots of resources.
f. Use presenters with lived experience.
g. Train presenters to be able to effectively link congregations to community resources.

10. Strategies used to increase interactions between faith leaders and behavioral health providers:

a. Providing social events or opportunities for the cohort to network with each other.
b. Interactive activities.
c. Giving participants the opportunity to share their stories/testimonials.
d. Incentives.
e. Meals (e.g., breakfasts, luncheons).
f. Conferences with mental health professionals.
g. Community panels.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Faith Based Academy program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources, including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar integrated faith based behavioral health training programs. The key learnings are organized into general thematic categories.

1. Impact on Academy Participants

a. Based on feedback from Academy attendees, the effects of Academy participation were evident across three primary domains: 1) increased knowledge, 2) stronger relationships, 3) continued actions to promote faith and behavioral health integration.
b. Important to help Academy participants think through and identify a wide range of potential post-Academy actions that they could do to help further promote faith and behavioral health integration (e.g., within their place of employment, where they worship, among their family and friends).
c. Post-Academy opportunities to continue engagement and interaction (e.g., luncheons and other "alumni" events), were viewed as very important to continuing the faith and behavioral health integration started during the Academies.

2. Curriculum Development

a. Developing the curriculum and associated resource guide required substantial time commitments to acquire, consolidate, and polish the information for use in the Faith Based Academy.
b. Existing community partners/networks helped facilitate and provide credibility to the curriculum development process.

3. Academy Preparation/Logistics

a. Faith leaders and behavioral health providers should be included in the same Academy training sessions to promote interaction, integration, and co-learning (in contrast to offering separate academies for each type of participant).
b. Academies appear to work best when provided training via several in-depth sessions (e.g., 2-4) over two weekends rather than as a weekly session over many weeks.
c. Important to keep class size small enough to allow for active discussion/participation (target = 20 participants).
d. Scheduling is often limited by availability of targeted faith leaders (typically Saturdays) and behavioral health providers (typically weekdays).
e. Finding available and qualified presenters can be challenging, but particularly useful during full-day trainings to have multiple presenters so they can focus on their specific areas of expertise and provide variation in presentation styles for attendees.

4. Academy Presentations

a. It is challenging to fit the required and desired content into a reasonable length for Academy (e.g., 12-15 hours of training).
b. Need to balance presentation with enough content to educate attendees on each topic while also allowing sufficient time for attendees to engage with each other and discuss the material.
c. Presenters acting as facilitators rather than lecturers/teachers allowed participants to demonstrate their own expertise.
d. Team building exercises helped in getting faith leaders and behavioral health providers to work together and get to know one another.
e. While post-Academy ratings of satisfaction and learnings were generally high, behavioral health providers typically reported slightly lower ratings than faith leaders. This suggests a need to ensure that the material presented is sufficiently engaging and educational for behavioral health providers.
f. Although the Faith Based Academies were open to persons from all faiths, content language was more oriented towards the Christian perspective given the initial target populations (i.e., Latinos and African Americans). Explicit acknowledgement of this orientation and expressed openness to other faiths may facilitate comfort with core material by non-Christians.

5. Participant Outreach

a. Important to identify and recruit key faith leaders (e.g., clergy), to personally participate in the Faith Based Academy since "once the pulpit embraces an idea, it will disseminate more broadly" throughout congregation/faith community.

6. Relationship to Community Education Program

a. Good coordination and communication is needed with the programs providing Community Education component of the Faith Based Initiative to facilitate identification and recruitment of appropriate Faith Champions.

PROGRAM CHANGES FROM INITIAL DESIGN

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

FUTURE DIRECTIONS

Based on the positive pilot study findings for the INN-13 Faith Based Academy, BHS decided to continue financial support for these trainings using ongoing behavioral health funding sources. Future Academies will utilize the curriculum developed in this pilot study as well as the lessons learned regarding successful delivery of Academy training sessions to foster increased behavioral health provider and faith leader knowledge, awareness, and integration. The Faith Based Academy program will be merged with the INN-13 Community Education program (another INN pilot program) to better coordinate the identification of champions and incorporate them into community education and outreach opportunities.

For additional information about the INN–13 Faith-Based Initiative #1, Faith Based Academy, and/or this report, send your inquiry to: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #2 COMMUNITY EDUCATION

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/16 - 6/30/19)

UC San Diego

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

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

EXECUTIVE SUMMARY

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

- A total of 1,823 persons (1,175 from Central; 648 from North Inland region) provided personal characteristic information at 104 different Community Education presentations (program targets = 1,320 attendees and 120 presentations).
- Central Region presentation attendees were primarily female (53.5%) and included youth (8.9%), adults (54.1%), and older adults (28.2%). Most identified as African-American (55.5%).
- In the North Inland region, the majority (59.4%) of attendees indicated Spanish as their primary language (as compared 10.0% in the Central Region).
- Based on post-training survey responses, most attendees (90.8%) agreed or strongly agreed that the training increased their knowledge about relevant behavioral health issues and available resources. Of particular interest, the majority (87.6%) agreed or strongly agreed that they were committed to increasing awareness in their community.
- Attendees highlighted the importance of seeking help for behavioral health issues and learning how to obtain such assistance as key lessons of the presentations.
- The programs trained 80 champions (program target = 91).
- Key factors identified by staff that helped the program achieve its goals included: 1) skilled and passionate workshop facilitators and program staff, 2) maintaining accurate knowledge of available community resources to facilitate referrals, 3) ability to provide informative presentations on a wide range of topics, and 4) good community relationships/credibility.

FUTURE DIRECTIONS

Based on the experiences and findings from the INN-13 Faith Based Community Education Program pilot study, BHS continued the provision of these services using behavioral health funding sources. To better coordinate faith based education and training initiatives within San Diego County, the Community Education services were combined with the INN-13 Faith Based Academy services (another INN pilot program) to create one integrated program. The ongoing funding allowed the structure and operations of the Community Education services to continue as initially designed while building upon the partnerships and experiences developed during the pilot project phase.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To facilitate community education presentations to faith and behavioral health communities focusing on faith and spiritual values, mental health conditions, substance abuse, wellness and community health.

The INN-13 Faith Based Community Education programs were able to host 104 presentations in the community that covered a wide range of behavioral health related topics (e.g., managing stress and anxiety, identifying risk factors for suicide, substance abuse treatment approaches, caring for persons with serious mental illness, etc.). A total of 1,823 persons attended these presentations and provided personal characteristic information. Attendees indicated learning more about the specific topics, how to access help, and being encouraged to help promote positive changes in their community (e.g., reducing stigma). Overall, the Community Education program had initially projected to host 120 presentations for 1,320 attendees, so although the total number of presentations was slightly less than anticipated, the total number of attendees exceeded expectations.

The presentation topics were discussed by presenters who integrated behavioral health and faith perspectives. The presentations were typically held at religious (e.g., churches or synagogues) or other community organizations. Identifying locations to host presentations, particularly during the initial implementation of the program required a significant investment of time into outreach activities and into developing relationships with faith and community leaders. This was necessary in order to develop sufficient trust that the potentially sensitive material would be presented in a manner that reflected both the faith and behavioral health understandings generally consistent with the beliefs of the host organizations. The use of financial incentives to provide compensation to presenters and, where appropriate, provide presentation locations (i.e., paying facility rental fees or providing donations), was determined to be an important factor for increasing the availability of suitable presenters and locations to host the presentations.

2. To utilize champions from the MHSA funded INN-13 Faith Based Academy to train additional presenters and/or provide community education presentations.

The INN-13 Faith Based Community Education program was able to obtain champions who had previously completed the INN-13 Faith Based Academy training program. These persons were utilized within the Community Education program as presenters for the community presentations and as trainers to help support training of other presenters. A lesson learned through the implementation of these programs was that effective identification and utilization of potential champions was made more challenging and complicated due to the fact that the Faith Based Academy and Community Education programs were separate organizational entities. More clarity and guidance were needed regarding how the two programs were to work together in order to sequentially identify and then train champions, particularly during initial program implementation. Based on the experiences of the pilot study, it was determined to combine these two different programs into one program as a way of better coordinating the relevant training activities.

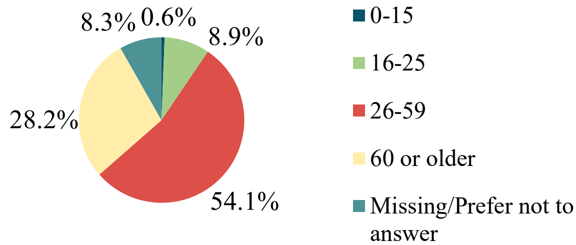
3. To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard “Request for Proposal” process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS – CENTRAL REGION PRESENTATIONS

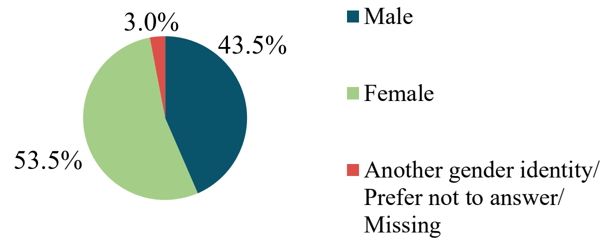
The following characteristic data were collected from an audience self-report survey administered at the community presentations.[1]

AGE (N=1,175)



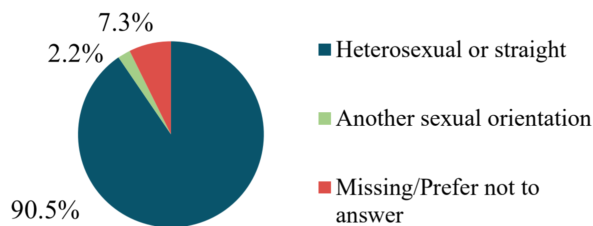
The majority (54.1%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=1,175)



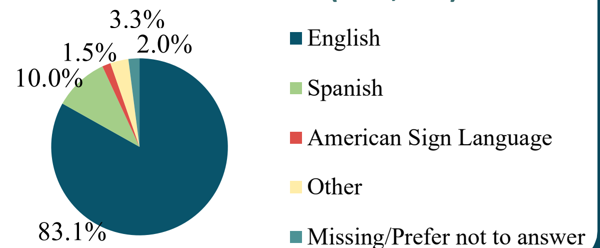
Over half of participants were female (53.5%) and 43.5% were male.

SEXUAL ORIENTATION (N=1,175)



Most (90.5%) participants identified as heterosexual or straight*.

PRIMARY LANGUAGE (N=1,175)



English was the primary language of most participants (83.1%) followed by Spanish (10.0%).

RACE/ETHNICITY (N=1,175)

	n	%
African-American	652	55.5
American Indian	28	2.4
Asian	30	2.6
Hispanic/Latino	241	20.5
Pacific Islander	5	0.4
White	161	13.7
Multi-Racial/Ethnic	39	3.3
Other	14	1.2
Missing/ Prefer not to answer	84	7.1

Totals may exceed 100% since attendees were able to indicate more than one race/ethnicity.

TYPE OF DISABILITY[2] (N=1,175)

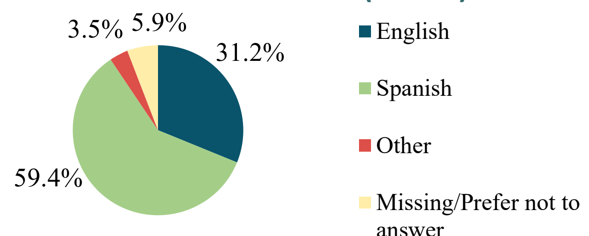
	n	%
Communication (e.g., seeing, hearing)	76	6.5
Mental (e.g., learning, developmental)	52	4.4
Physical	75	6.4
Chronic health condition	72	6.1
Other	46	3.9

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

PARTICIPANT CHARACTERISTICS – NORTH INLAND REGION PRESENTATIONS

Primary language was the only demographic information collected from attendees of North Inland region presentations. Implementation delays contributed to the lower number of attendees in North Inland.

PRIMARY LANGUAGE (N=648)



The majority of participants (59.4%) spoke Spanish as their primary language.

[1] Percentages may not total to 100% due to rounding. [2] A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a Serious Mental Illness (SMI).
**Another sexual orientation includes Queer, Questioning/unsure of sexual orientation, and Another sexual orientation.*

POST-PRESENTATION SURVEY RESULTS

The programs provided a total of 104 different behavioral health related Community Education presentations. As shown in Figure 1, the vast majority of community attendees (approximately 85% or more) at educational presentations agreed or strongly agreed that as a result of the training they were more knowledgeable, knew where to obtain appropriate assistance, and were more capable and committed advocates to help others in their community. Of particular interest for achieving the goals and objectives of the overall Faith Based Initiative and this specific Community Education strategy, the majority (87.6%) agreed or strongly agreed that they were committed to increasing awareness within their community. This suggests that the desired "ripple effect" of education and ultimately community transformation is potentially underway in that persons trained through the Faith Based Academy (Faith Based Initiative #1) are now providing community educational workshops and/or training facilitators to do so as part of the Community Education program (Faith Based Initiative #2). This is then leading attendees of those presentations to indicate that they are motivated to further expand the reach of this material by helping to increase awareness of these behavioral health topics among the people they know. Additionally, almost all presentation attendees indicated they were satisfied with the information they received (25.9% were mostly satisfied and 70.6% were very satisfied). The patterns were similar between North Inland and Central regions.

FIGURE 1. COMMUNITY EDUCATION POST-PRESENTATION OUTCOMES AND SATISFACTION

Item	Agree	Strongly agree
I have a better understanding of the topic presented today. (n=1,862)	43.2%	47.6%
I have a better understanding of how faith/spiritual principles can positively support the topic presented today. (n=1,855)	37.6%	51.6%
I know where to get help for Adults/Older Adults regarding the topic presented today. (n=1,819)	41.1%	47.0%
I know where to get help for Children/Adolescents regarding the topic presented today. (n=1,800)	41.3%	43.2%
I am more confident that rehabilitation and recovery are possible. (n=1,834)	37.9%	52.6%
I am committed to help increase awareness in my community on the topic presented today. (n=1,797)	38.7%	48.9%

0% 20% 40% 60% 80% 100%

Strongly disagree Disagree Neither agree/disagree Agree Strongly agree

Item	Mostly satisfied	Very satisfied
Overall, how satisfied were you with the information you received today? (n=1758)	25.9%	70.6%

0% 20% 40% 60% 80% 100%

Very dissatisfied Mostly dissatisfied Mostly satisfied Very satisfied

POST-PRESENTATION QUALITATIVE SURVEY RESULTS

FIGURE 2. COMMUNITY EDUCATION POST-PRESENTATION LEARNINGS

At the end of each community presentation, attendees were asked an open-ended question on what they thought were the most important things they had learned. Figure 2 is a visual representation of the approximately 1,200 responses of what attendees indicated learning, with more frequently utilized words appearing with greater prominence.

One of the most frequently indicated word was "help." In addition to learning where to get help for mental illnesses, people also indicated learning there was nothing wrong with asking for and receiving help. Another frequently cited word was "stress." Specifically, attendees said they learned about the variety of ways stress impacts mental and physical health as well as effective ways in which to deal with stress to maximize mental wellness.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

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

1. *The major program goals identified by staff:*
   a. Provide the community with resources.
   b. Raise awareness of mental health matters in Latino and African American communities.
   c. Educate the community about mental health issues and the role of faith in mental health recovery.
   d. Decrease stigma surrounding the topic of mental health.
   e. Bridge the gap between faith and mental health issues.
   f. Encourage people to use resources without fear.
   g. Identify community resources.
   h. Increase rapport between faith leaders and behavioral health providers.
   i. Increase understanding of professional help.
   j. Provide free mental health education.
   k. Train facilitators on giving community presentations.
2. *Factors that helped the program achieve goals:*
   a. Quality facilitators (e.g., interactive, knowledgeable about topics and accessing resources).
   b. Resources (e.g., list of counseling services, an app that has resource recommendations).
   c. Varied presentation topics providing good information.
   d. Good staff characteristics (e.g., preparedness, flexibility, adaptability, patience).
   e. Relationships within the community.
   f. Meeting the community in their local area.
   g. San Diego County helping to extend educational resources.
   h. Open communication and collaboration of all involved.
   i. The marketing and promotion.
3. *Factors that inhibited the program from achieving goals:*
   a. Stigma about mental health illness and accessing mental health services.
   b. Not collaborating with the other related faith based “Innovation” funded programs.
   c. Not having enough presenters for the Spanish-speaking community.
   d. Lack of communication with the faith community.
   e. Slow/inefficient marketing that was not highly visible.
   f. Limited church hours made coordinating presentations difficult.
   g. Not enough time to build relationships in the community.
4. *Recommendations to help the program better achieve goals*:
   a. Increase marketing and outreach efforts.
   b. Increase interagency communication.
   c. Have more Spanish-speaking staff & facilitators.
   d. Target the information more directly at the immediate needs of recipients.
   e. Do not limit facilitators to only Task Order 1 graduates.
   f. Target younger audiences.
   g. Make mental health appointments and doctor referrals on site.
   h. Bring in licensed clinicians to further discussions and dialogue.
5. *Key strengths of the program:*
   a. Strong facilitators and staff.
   b. Involvement of the Faith community.
   c. The support it provides to the community.
   d. The community relationships it produces.
   e. The ability to work with an underserved minority population.

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

a. Resource information for emergency assistance.
b. Increased marketing support.
c. Expansion to more areas in the community.
d. Increased participation in the Faith breakfast.
e. Public speaking training.
f. Certificates from the County to validate teaching credentials.
g. More communication and planning at the beginning of the program.

7. Key "innovations" making the program unique:

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

8. Strategies utilized to identify potential organizations or locations for community outreach:

a. Personal networking (e.g., word of mouth, talking to friends).
b. Reaching out to organizations in the area.
c. Using graduates from the target communities.
d. Talking to the Faith community.
e. Speaking directly with Faith Leaders (e.g., pastor, priest, etc.).
f. Networking through similar events.
g. Encouraging referrals.
h. Using social media.
i. Sending community newsletters.

9. Factors needed for successful community education presentations:

a. Marketing to ensure the community knows about the presentation.
b. Knowledgeable presenters.
c. The location of the presentation.
d. Networking.
e. Faith communities being open to mental health topics.
f. Connecting with the head of a Faith community.
g. Business cards.
h. An adequate number of presenters.
i. Likeable presenters.
j. Timeliness of presentations.

10. Primary impacts/outcomes of your activities within the community:

a. Faith entities have more knowledge about mental illness.
b. Mental illness stigma reduction.
c. Increased community openness to address mental health.
d. More awareness of the importance to connect faith and mental health.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Community Education program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar faith based Community Education programs. The key learnings are organized into general thematic categories.

1. ***Outreach and Relationships Crucial for Creating Presentations Opportunities***
   a. Need to develop trusting relationships with faith leaders in order to gain access to congregations.
   b. Existing credibility and relationships in the community are crucial for program success.
   c. Establishing, maintaining, and nurturing relationships with church leaders are crucial but time consuming activities which are needed to create opportunities for presentations in faith communities.
   d. Working with local community centers increased the number of presentation opportunities.
   e. Community centers can facilitate access to priority populations such as males and Latinos.
   f. As program became more established, additional opportunities for presentations facilitated by persons who attended previous workshops.
   g. Ongoing relationships with certain faith leaders and community centers allowed for "repeat" presentation opportunities with either the same subject matter with different populations or different content areas over time.
2. ***Program Logistics/Structure to Support Successful Presentations***
   a. Program relies on dedicated and passionate staff committed to achieve program objectives.
   b. Use of financial incentives to support presenters and where appropriate, presentation venues, was very important to ensure availability of persons to present the material and locations to host the presentations.
   c. Managing program logistics requires substantial time (e.g., finding venues, facilitating marketing/outreach, facility preparation).
   d. Presenters need to be knowledgeable and good communicators.
   e. When possible, beneficial to match experienced and new presenters together to support ongoing presenter training.
   f. Important to ensure a sufficient number of people are working at each presentation to facilitate a smooth process from set-up through clean-up, and promote a positive experience for both attendees and presentation staff.
   g. Role plays are effective tools for teaching about commonly diagnosed mental illnesses.
   h. Importance of meeting community members in the community (e.g., go to where they already are).
   i. Potentially sensitive or uncomfortable topics requires respectful and supportive communication.
   j. Need to be aware of, and ensure security of presenters and audience in varied community settings (e.g., include security guard as part of presentation team as needed).
3. ***Challenges and Strategies for Facilitating Connections to Community Resources***
   a. Often difficult to find appropriate, local resources for community member referrals, especially for primarily Spanish speaking attendees.
   b. For presentations at community centers, can often refer and/or link attendees back to their own community center to meet needs for further education and other resources prompted by the presentation.
   c. After presentations, it is common that a certain amount of 'case management' occurs during which staff answer attendee questions and seek to direct attendees to relevant community resources for further information and assistance.
4. ***Key Audience Group to Try to Reach***
   a. Persons who are not seeking out this information represent an important target audience (e.g., need to have opportunities to present to congregations, schools, and other locations where audience didn't purposefully choose to attend an educational presentation in order to reach persons who may not otherwise recognize the need for such information/services).

ADDITIONAL PROGRAM ACTIVITIES

Overall, the programs trained a total of 80 champions (35 from the North Inland region and 45 from the Central region) to assist with community presentations, whereas the projected number of champions anticipated to be trained throughout this study was 91. There were difficulties in the coordination and communication between the INN-13 Faith Based Academy programs that were expected to identify potential champions and the INN-13 Community Education programs that were expected to provide training to those persons. These difficulties contributed to the decision to combine the Faith Based Academy and the Community Education into one program for ongoing services in the future.

PROGRAM CHANGES FROM INITIAL DESIGN

While there were learning and operational adaptations throughout the implementation of the INN-13 Faith Based Community Education pilot study, there were no changes that differed substantially from the initial program design.

FUTURE DIRECTIONS

Based on the experiences and findings from the INN-13 Faith Based Community Education Program pilot study, BHS continued the provision of these services using ongoing behavioral health funding sources. To better coordinate faith based education and training initiatives within San Diego County, the Community Education services were combined with the INN-13 Faith Based Academy services (another INN pilot program) to create one integrated program. The ongoing funding allowed the structure and operations of the Community Education services to continue as initially designed while building upon the partnerships and experiences developed during the pilot project phase.

For additional information about the INN–13 Faith Based Initiative #2, Community Education and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #3 CRISIS RESPONSE TEAM

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES FINAL REPORT: (7/1/16 - 6/30/19)

The Crisis Response Team (CRT) was one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprised the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The goals of the Faith Based Initiative included improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts were intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the CRT included the provision of faith based support services to individuals and families experiencing crisis situations (e.g., attempted or completed suicides, homicides, domestic violence), to improve their behavioral health and wellbeing. CRT services were ancillary to, and not replacement of, first responders.

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

EXECUTIVE SUMMARY

The CRT was designed to support individuals and families during and after experiencing crisis events (up to 90 days). The team had faith leaders and behavioral health professionals who responded quickly to crisis situations whenever needed (24 hours a day). The initial contacts were expected to help de-escalate challenging situations, and the follow-up services were designed to promote longer-term recovery and wellbeing.

- CRT served a total of 432 persons from 165 crisis events.
- Reflecting the family centric approach, almost one-quarter (22.9%) of persons served were under age 16.
- More than half (56.3%) of the persons served were female. The majority (50.7%) indicated Spanish as their primary language and most participants identified as Hispanic/Latino (60.2%) or African American (33.8%).
- Almost everyone (98.9%) with follow-up data (n=284) reported being satisfied with their overall CRT program experience. More specifically, the majority indicated satisfaction with the initial crisis services provided, the professionalism of the staff, the resources provided by team, and the quality of follow-up services.
- Primary services/resources participants reported receiving included: counseling (80.4%), food assistance (54.7%), religious support (52.4%), suicide prevention info (44.9%); domestic violence resources (32.9%) and connections to mental health services (32.9%).

services as an important CRT program benefit.

- Key program challenges included: 1) difficulty initiating direct referrals from first responders (e.g., police and fire), such that this strategy was eventually dropped, 2) difficulty maintaining CRT availability 24 hours/7 days a week, 3) unable to identify a provider for CRT services throughout North Inland region, eventually reduced area to only Escondido to make it more manageable, and 4) substantial time required to build trust and appropriate community connections for CRT awareness and utilization.

FUTURE DIRECTIONS

While CRT services were generally perceived to be beneficial to those who received them, given the operational challenges and the resources required to effectively provide such services, it was decided that the faith based CRT program would not be extended beyond the conclusion of the MHSA INN funded pilot study. The programs were able to provide integrated behavioral health and faith based support to persons in crisis during the pilot program and there were many lessons learned regarding how to implement and operate this type of an innovative program. However, given the overall demands and priorities of the County of San Diego BHS service system and the availability of other related services, it was decided to not continue the CRT program as part of ongoing BHS services.

2019-12-20

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish a community based, faith based team that pairs licensed/master's level behavioral health clinicians and faith based clergy to respond to individual/family crisis situations (e.g., incidents of suicide, homicide, domestic violence), as needed 24 hours/seven days a week and provide crisis intervention, counseling, and support services.

The CRTs were staffed with faith leaders and behavioral health professionals who could respond to crisis events 24 hours/day seven days a week. The teams responded to 165 crisis events and provided services to 432 persons (total target number of persons served = 560). Delays in identifying an organizational partner and then implementing a CRT program in North County (eventually had to reduce scope of service from the initially intended North Inland Region to only Escondido) resulted in fewer persons served given the much shorter duration of the program.

The CRTs responded to many different crisis events, including homicides, the primary crisis events included domestic violence calls and suicide (attempts and completed). While initial expectations were that crisis calls might come directly from first responders (i.e., police and fire personnel), calls primarily originated from clergy who were made aware of a crisis situation and who had prior knowledge of the crisis team and initiated contact. Developing appropriate referral connections into the CRT program was a challenge that required substantial investments of time.

Based on the survey results, recipients of the crises service noted high levels of satisfaction with the CRT and many indicated that having in-home services available at all hours was very helpful. The integrated faith and behavioral health approach was also viewed favorably by service recipients. Staff indicated that this approach appeared to help with de-escalating tensions and stress in the midst of difficult situations.

2. To provide follow-up support and services to individuals and families for up to 90 days after the crisis event.

The CRTs followed-up with persons after the crisis event to see if additional support and services were needed (for a period of time up to 90 days). Survey responses indicated that participants with follow-up services who were willing to complete a follow-up survey (n=284) rated the follow-up services very highly and frequently reported receiving both additional emotional support as well as material supports from the CRTs. Primary services/resources participants reported receiving included: counseling (80.4%), food assistance (54.7%), religious support (52.4%), suicide prevention info (44.9%); domestic violence resources (32.9%) and connections to mental health services (32.9%).

3. To link individuals and families to behavioral health services and other community supports as needed.

As reported in the participant survey, recipients of CRT services were connected to mental health services (32.9%) and a wide variety of other community resources (e.g., legal assistance, housing, domestic violence care, employment).

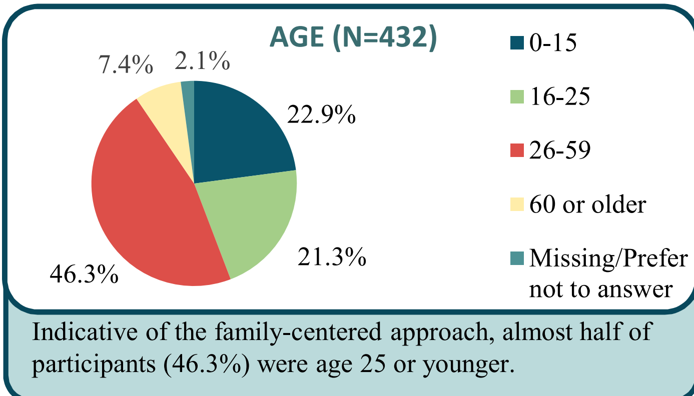
4. To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

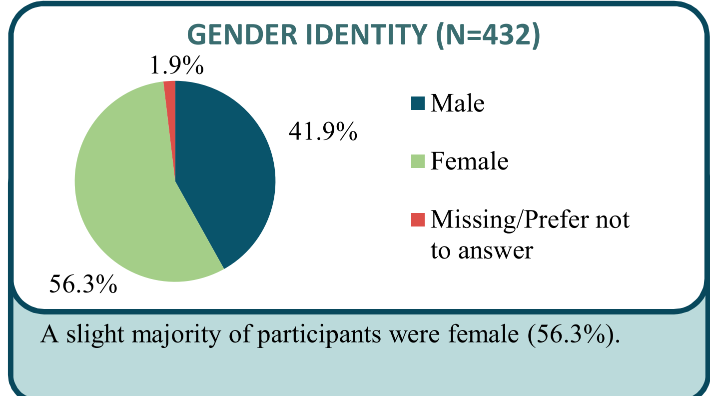
The following self-reported characteristic data were collected from the 402 Central Region and 30 Escondido CRT participants.[1]

AGE (N=432)



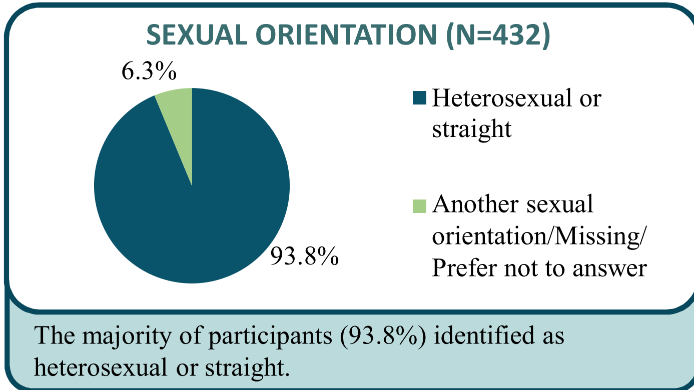
Indicative of the family-centered approach, almost half of participants (46.3%) were age 25 or younger.

GENDER IDENTITY (N=432)



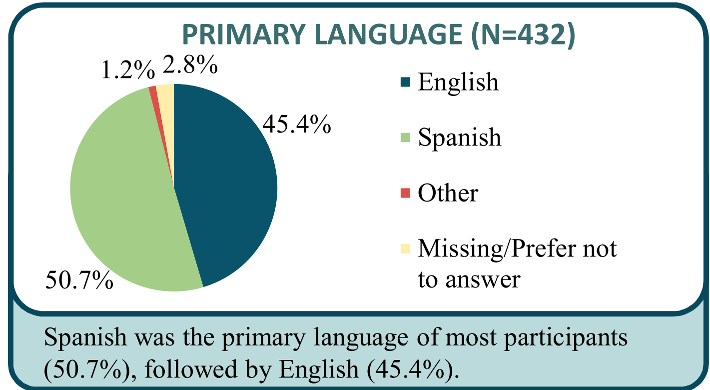
A slight majority of participants were female (56.3%).

SEXUAL ORIENTATION (N=432)



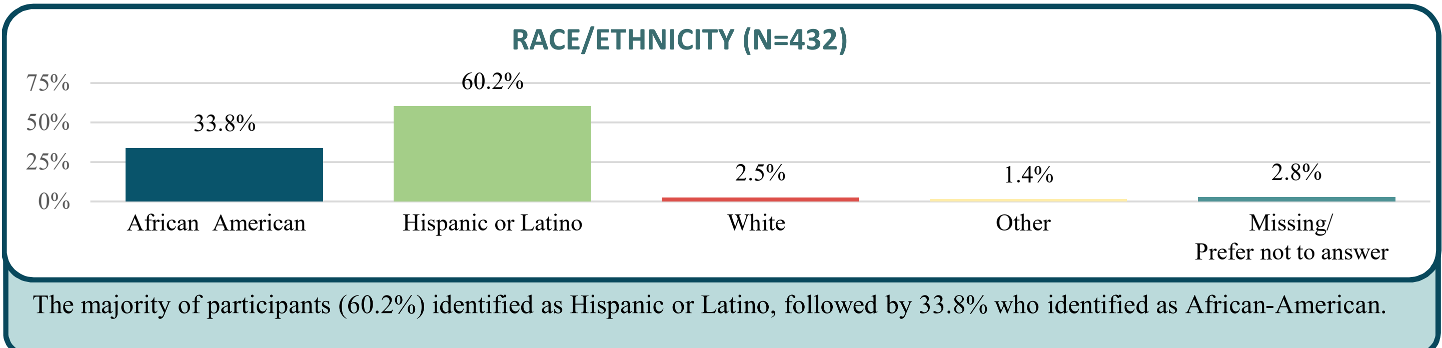
The majority of participants (93.8%) identified as heterosexual or straight.

PRIMARY LANGUAGE (N=432)



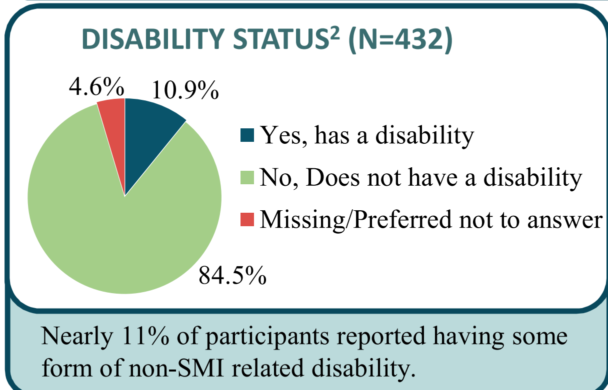
Spanish was the primary language of most participants (50.7%), followed by English (45.4%).

RACE/ETHNICITY (N=432)



The majority of participants (60.2%) identified as Hispanic or Latino, followed by 33.8% who identified as African-American.

DISABILITY STATUS[2] (N=432)



Nearly 11% of participants reported having some form of non-SMI related disability.

Prior military service was reported by 5.8% of participants.

TYPE OF DISABILITY (N=432)

Type	n	%
Visual	8	1.9
Hearing	< 5	< 1.2%
Learning	13	3.0
Dementia	< 5	< 1.2%
Chronic Health	14	3.2
Other	6	1.4

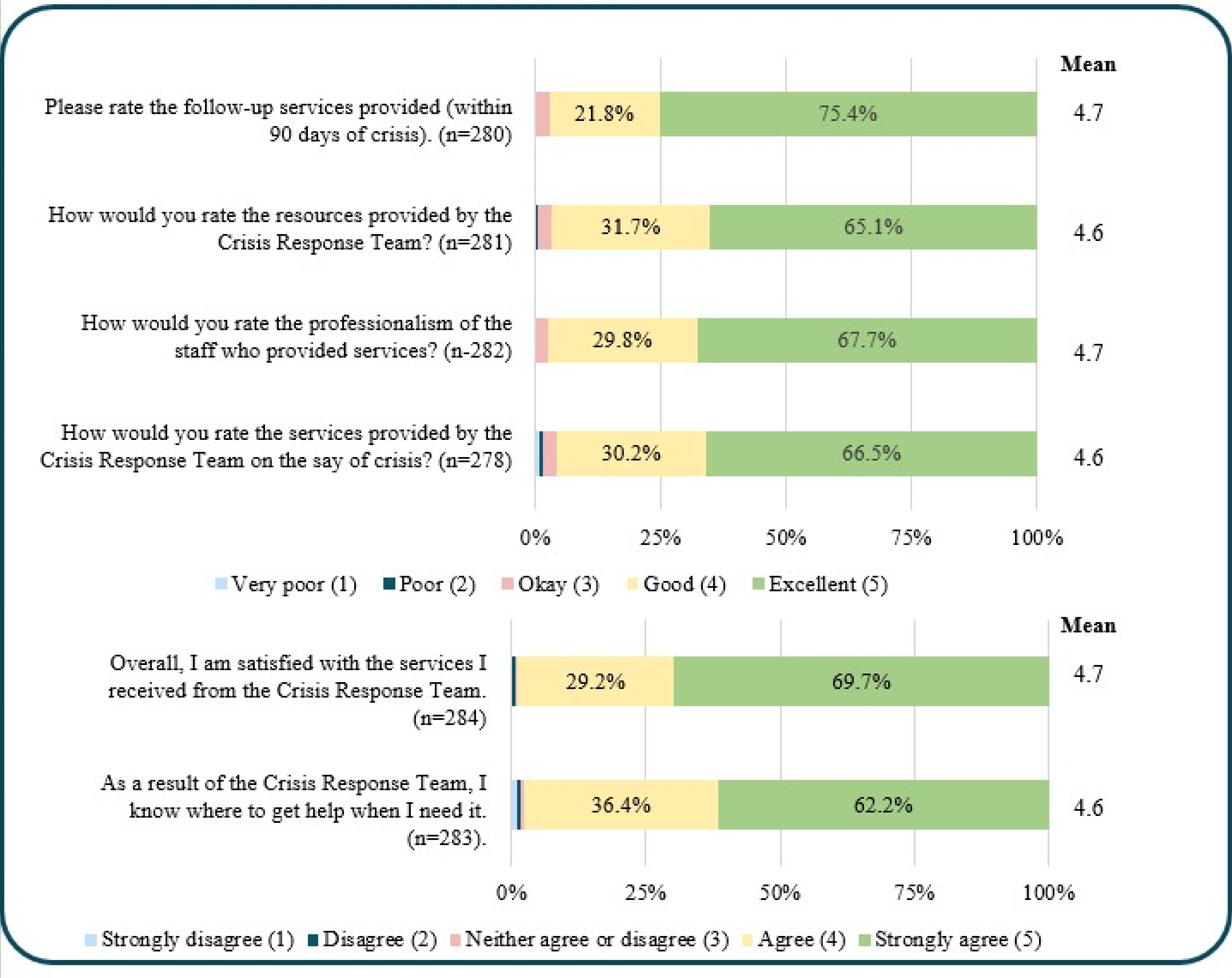
This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

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

CRISIS RESPONSE TEAM SERVICES FEEDBACK SURVEY

Persons from the 165 crisis events who had received services from the Crisis Response Team were asked to provide feedback about their interactions with the team at the end of the follow-up service period (within 90 days of the initial crisis event). The results from the completed surveys are presented in Figure 1 (note: more than one person may have completed a survey for each crisis event). In general, participants indicated high assessments of their experiences with the team and the services they provided (e.g., approximately 65-75% provided the highest rating of "excellent" for each question domain). Nearly all respondents agreed (29.2%) or strongly agreed (69.7%) with the statement indicating satisfaction with services received. The general response patterns were similar between those receiving CRT services in the Central Region and those receiving services in Escondido.

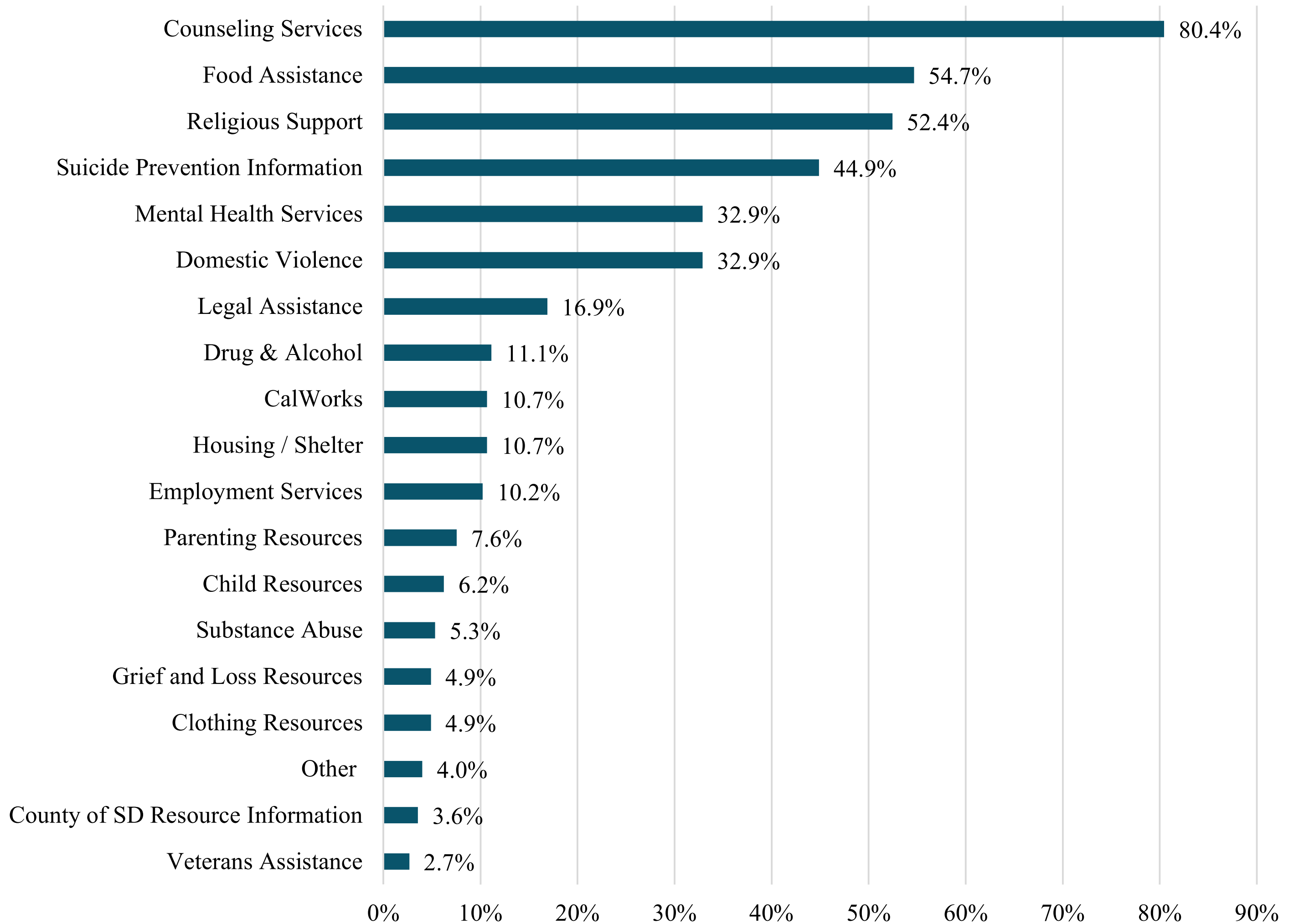
FIGURE 1. CRISIS RESPONSE TEAM SERVICE FEEDBACK SURVEY



RESOURCE UTILIZATION

The following figure indicates the types of services provided by the CRT as indicated by persons from the 165 crisis events who completed a follow-up survey. Consistent with the qualitative responses regarding resource benefits (see page 6), tangible resources such as food services were utilized with a majority of participants. Counseling and Mental Health services were also frequently provided for participants. Religious information was specifically indicated in more than half (52.4%) of the participants' responses. (Note: Participants could indicate more than one resource utilized so cumulative percentages will exceed 100%).

FIGURE 2. RESOURCES UTILIZED BY CRISIS RESPONSE TEAM (N=225)



QUALITIATIVE SURVEY RESPONSES REGARDING MOST BENEFICIAL ASPECTS OF CRT

Persons who had received services from the CRT were asked to provide feedback about their interactions with the team. The results of the open-ended, qualitative portion of the survey are summarized below. In general, participants reflected an appreciation for the resources offered by the CRT, as well as the presence of mental health professionals working in collaboration with faith leaders. Additionally, participants reported the team's service approach (i.e., fast responding time, family centered services, and in-home visits) as a beneficial aspect of the CRT.

1. **Participants reported resources as a beneficial aspect of the CRT.**

   A. *Tangible resources such as housing, food, and clothing helped participants:*

      - "I was able to find a place to stay for me and my boys."
      - "They helped me with food and clothes."
      - "Helping my dad find a job."

   B. *Participants reported that the knowledge and education offered by the CRT was beneficial:*

      - "They gave us a lot of information and where to go if we need something."
      - "The resources and information I received was very helpful."
      - "They were so helpful with the information they gave us."
      - "Information on suicide, developmental disabilities, and the food pantry."

2. **Participants reported emotional and spiritual support provided by counselors and clergy as helpful.**

   - "Counseling was extremely helpful."
   - "I felt peace and my counselor gave me information I didn't know."
   - "They didn't judge me."
   - "I can call when I need you! The Police can't do prayer & counseling like this."
   - "La concejeria y las oraciones por mi y mi familia." [The concern and prayers for me and my family.]
   - "They listen to me and prayed for me."

3. **Participants reported the service approach as a valuable facet of the CRT.**

   A. *The CRT's ability to respond quickly to situations, and remain available throughout the program, was appreciated by participants:*

      - "That they came fast to talk to me."
      - "Availability of staff, both clergy and mental health professionals."
      - "Has the time to come and talk to us."
      - "Personal attention and availability."

   B. *In-home services were reported as helpful to participants:*

      - "I like that you guys came to my house!"
      - "I got to be with my family, in my own home."
      - "Just having the team here in my home for support."

   C. *Family centered care was noted by participants as an important component of the program.*

      - "That they were able to include the whole family for a resolution."
      - "They gave me resources that helped me and my baby."
      - "Thank you for helping my son. He needs this extra support."

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

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

1. The major program goals identified by staff:

a. To provide services that de-escalate crisis situations (e.g., attempted suicides, domestic violence).
b. To provide resources and support to minority communities.
c. To restore peace back into people's homes.
d. To provide care and support from a faith-based perspective.
e. To encourage counseling services.
f. To provide follow-up services after crisis.
g. To provide hope and emotional support.

2. Factors that helped the program achieve goals:

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

3. Factors that inhibited the program from achieving goals:

a. Limited interagency coordination and communication (e.g., police, fire).
b. Individuals declining assistance.
c. Not enough resources to meet service needs.
d. Lack of promotion to the community.
e. Families not having good experiences with services in the past.

4. Recommendations to help the program better achieve goals:

a. Better interagency coordination (e.g., police, fire).
b. Increased funding.
c. Expand service areas to other regions.
d. Police and fire departments agreeing to send referrals.
e. Capacity to provide long-term follow-up care with clients.
f. Consolidation of resource information and ongoing updates of resource availability.
g. Ability to receive calls from multiple sources (e.g., pastors, community leaders).

5. Key program strengths:

a. Strength of the team and support provided to each other.
b. Needed resources and help being provided to the community.
c. Quality of the crisis intervention program.
d. Offering integrated faith based mental health services.
e. Using a team approach to provide services.
f. Community relationships.
g. Empowering clients and promoting self-representation.

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

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

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

a. Additional mental health and crisis training.
b. Facilitate communication and training between law enforcement and crisis team.
c. Additional faith training (e.g., incorporating faith material into crisis situations).
d. County updates on available resources within the community.

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

a. Allows those who receive the service to incorporate their faith into the process.
b. Facilitates cultural connections within African-American and Latino communities.
c. Supplies hope and provides relief.
d. Promotes trust and openness to suggestions and information.
e. Encourages de-escalation by relying on one's faith/beliefs.

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

a. Have presentations or meetings to educate police and fire departments about the program.
b. Create a memorandum of understanding with police and fire departments.
c. Distribute materials periodically to remind police and fire departments about the program.
d. Encourage service personnel to work in collaboration with the Crisis Response Team.

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

a. Social media marketing.
b. Share information with other service providers/agencies.
c. Present information at community events/presentations (e.g., Task Order 2 presentations, schools).
d. Share information in churches and other faith-based organizations.
e. Distribute newsletters within behavioral health service organizations.
f. Develop marketing materials (e.g., a brochure, a community flier).
g. Conduct prevention trainings (e.g., substance use, domestic violence).
h. Advertise in the newspaper.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Crisis Response Team (CRT) outcomes and operations throughout the three-year CRT MHSA Innovations-funded study. These findings were derived from multiple sources including, participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar faith based CRT programs. The key learnings are organized into general thematic categories.

1. ***Value of the Integrated Behavioral Health and Faith Based CRT Approach***
   a. Faith based approach promotes participant trust and openness.
   b. Faith based approach facilitates crisis de-escalation by utilizing existing beliefs and support mechanisms.
   c. Faith based counseling and emotional support identified by participants as a primary CRT benefit.
2. ***CRT Community Awareness and Outreach***
   a. Establishing direct referrals from police did not materialize as anticipated due to a variety of complications (e.g., liability concerns, jurisdiction/geographic boundaries).
   b. Educating and engaging with pastors is essential as they can be a "first line of defense" and recommend that persons call the Crisis Response Team.
   c. Encouraging people to spread information via "word of mouth" is an effective way to establish trust in the community.
   d. Due to need to balance high demand for services with program capacity to provide services, CRT program had to be strategic regarding outreach and awareness activities so that they were not overwhelmed with calls.
3. ***CRT Program Structure***
   a. Must be able to provide quick response time at all hours to meet participants' needs in time of crisis.
   b. Ability to provide in-home services (as opposed to requiring participants to go elsewhere) was important.
   c. Follow-up support services after the crisis event were utilized by many participants.
   d. Team-based approach relies on collaborative, passionate, and skilled team members.
   e. Team-based approach required good coordination, communication and overall leadership.
4. ***Linkages to Community Resources***
   a. CRT programs learned to provide full information resource packet to all participants since they may not articulate all needs during initial contact.
   b. Referrals or "warm hand-offs" to other resources such as counselors or psychiatrists can be challenging since the person has already established trust and shared sensitive information with the Crisis Response Team member.
   c. There often are more community resources available for women with children than there are for men with children.
5. ***CRT as "Preventative Care" for Future Crisis Avoidance***
   a. After initial interaction, some participants contact program directly if same/similar crisis emerges as a form of "pre-911" call.
   b. After trust has been established in the community, some participants may prefer to contact the Crisis Response Team instead of the police.
6. ***Community Relationships***
   a. High quality faith based and behavioral health reputation in community promotes credibility.
   b. Interagency coordination and communication is essential for effective program operations (e.g., crisis teams, BHS, Police Department, Fire Department).
7. ***CRT Implementation and Operational Challenges***
   a. Difficult to establish referrals from official first responders (i.e., police and fire), so eventually drop efforts to establish such referrals and focus instead on relationships with clergy and others who could initiate CRT referrals.
   b. Maintaining CRT availability and readiness to respond 24 hours a day difficult within available resources.
   c. Difficult to identify a program willing to implement CRT in North Inland region, resulted in substantial delays.
   d. Substantial time required to identify and establish relationships with appropriate community partners for referrals.

PROGRAM CHANGES FROM INITIAL DESIGN

While there were certainly program learnings and adaptations throughout the course of the three-year CRT MHSA program, there were no fundamental shifts or changes from the initial design of using integrated clergy and behavioral health clinician teams to provide faith based emotional and tangible supports to persons in crisis situations and within the 90-day period following the event. However, one change from initial expectations was that instead of getting referrals directly from first responders (i.e., police and fire personnel), most referrals ended up coming through other clergy who had prior knowledge of the CRT or "word-of-mouth" as the program became more widely known. Additionally, the intention was to have two CRT programs (one in the Central Region and one in the North Inland Region), throughout the entire three-year MHSA INN-funded initiative, but it was difficult to identify a partner program interested in providing North Inland Region CRT services. BHS had to conduct multiple rounds of solicitation seeking such a provider before eventually reducing the target area to only Escondido. This change allowed for a program to agree to provide CRT services, but the delays associated with identifying the program and then working through initial implementation challenges resulted in the CRT program in Escondido only being operational for approximately one year. These experiences contributed to the large difference in persons served between the Central Region (n=402) and in Escondido (n=30).

FUTURE DIRECTIONS

While CRT services were generally perceived to be beneficial to those who received them, given the operational challenges and the resources required to effectively provide such services, it was decided that the faith based CRT program would not be extended beyond the conclusion of the MHSA INN funded pilot study. The programs were able to provide integrated behavioral health and faith based support to persons in crisis during the pilot program and there were many lessons learned regarding how to implement and operate this type of an innovative program. However, given the overall demands and priorities of the County of San Diego BHS service system and the availability of other related services, it was decided to not continue the CRT program as part of ongoing BHS services.

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

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

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/16 - 6/30/19)

UC San Diego

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

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

EXECUTIVE SUMMARY

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

- A total of 442 persons participated in WMHIM.
- Of those who reported any personal characteristics (n=320), approximately 20% (19.7%) of the participants were female and 15.0% were Transitional Age Youth (i.e., age 18-25).
- The program served a diverse population, with 38.8% identifying as White, 24.4% as African-American, and 19.4% as Hispanic or Latino.
- Analysis of San Diego County jail data indicated a substantial reduction in re-bookings (i.e., interactions with police that resulted in transportation to jail and the assignment of a booking number) into jail after participants became involved with the WMHIM program. This decrease was evident across both short-term (i.e., 30-day) and intermediate term (i.e., 90-day and 180-day) recidivism analyses. For example, 30-day recidivism dropped from 34.3% before WMHIM to 13.3% and 180-day recidivism dropped from 76.9% to 46.2% before and after enrolling in WMHIM, respectively.
- Similarly, total bookings decreased sharply after involvement with the WMHIM program. Total bookings dropped from 160 before to 59 after WMHIM in the 30-day analyses, and from 617 before to 311 after WMHIM in the 180-day analyses. In both analyses, total bookings dropped by approximately 50% or more.
- Key factors identified by staff that helped the program achieve its goals included: 1) repeated interactions with inmates pre-release, 2) the ability to identify and offer linkages to needed services post-release, 3) prayer and a respectful faith based team, 4) teamwork between religious and non-religious groups, and 5) coordination within the team and with external partners to maintain contact with participants post-release.

FUTURE DIRECTIONS

The BHS system decided to consolidate multiple programs that focused on transitioning persons with SMI from jail settings back into the community. As such, this specific WMHIM pilot study program was not continued following the conclusion of the MHSA Innovations funding stage. However, the lessons learned about effective faith based engagement and support of persons returning to the community from jail were integrated into the ongoing faith based program with the expectation of continued reductions in recidivism.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To develop a Wellness and Health Ministry that focuses on supporting community re-entry for adults diagnosed with an SMI while in jail by providing spiritual and behavioral health support.*

The WMHIM program assembled a team of faith leaders and behavioral health providers, many with relevant lived experience related to the criminal justice system and/or mental health treatment system. Jail personnel identified potentially eligible persons and notified the WMHIM team of the persons estimated release date. The WMHIM team then attempted to make multiple visits to the individual while they were in jail to provide spiritual support and develop a trusting relationship. Building on these personal connections, WMHIM team members would also work with the individual to develop their post-release plans, particularly related to housing and establishing linkages to ongoing behavioral health treatment. When the actual release date was known in advance (release dates were subject to frequent changes due to many different circumstances), the WMHIM team member would meet the person at the jail to provide transportation wherever they wanted to go. The WMHIM team members identified this ride from jail as crucial for maintaining contact during the pre-release to post-release transition. Once released, the WMHIM team worked to connect them to any available services for which the person qualified. Lack of available/affordable housing, program wait lists, and./or complicated enrollment/eligibility determination criteria created challenges for getting persons directly into needed care.

Overall, the WHIM team was passionate and committed to the task of trying to facilitate community re-entry from jail and create connections to community treatment and supports. While not able to prove causality, an indicator that suggests the WMHIM team was successful at their overall objective for many persons they worked with was the decline in bookings into jail and total booking after participation in the WMHIM program (as compared to their prior experiences). This was evident for both short-term (i.e., 30- and 90-day) and longer-term (i.e., 180-days) recidivism rates as well as total bookings during these time periods. Reductions of 30-50% or more were evident across these metrics.

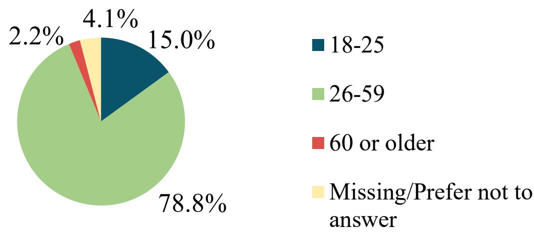
2. *To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.*

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

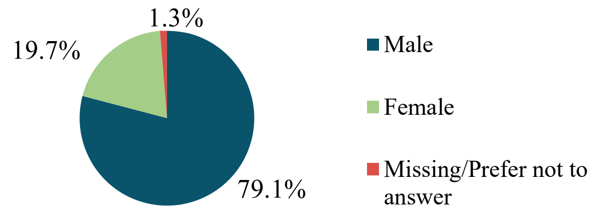
Of the 442 persons who participated in WMHIM, 320 persons completed a self-report characteristic form during their enrollment.[1]

AGE (N=320)



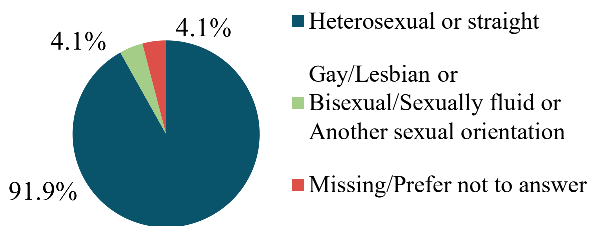
The majority of participants (78.8%) were between the ages of 26 and 59.

GENDER IDENTITY (N=320)



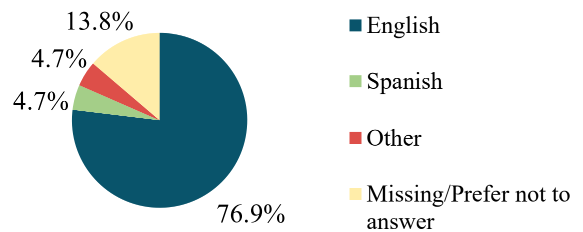
A little over three-quarters of participants were male (79.1%) and 19.7% of participants were female.

SEXUAL ORIENTATION (N=320)



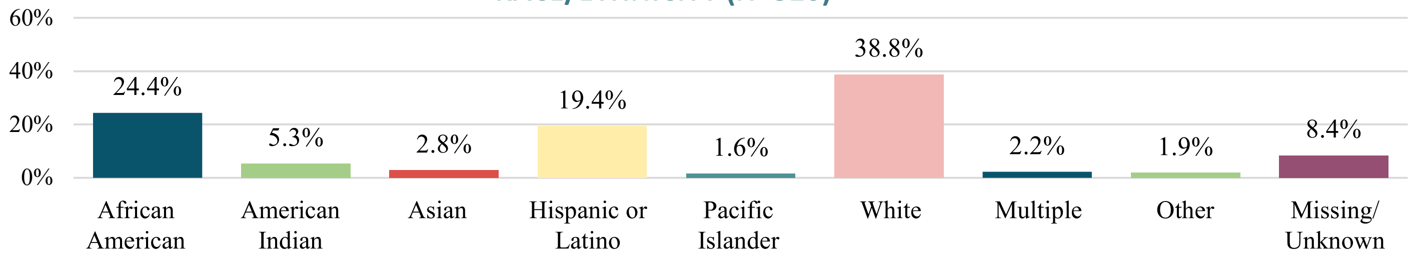
Most (91.9%) participants identified as heterosexual or straight.

PRIMARY LANGUAGE (N=320)



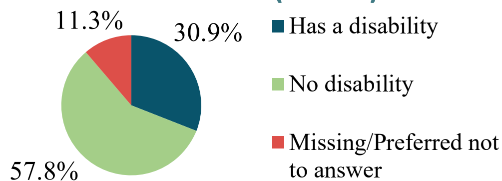
English was the primary language of most participants (76.9%).

RACE/ETHNICITY (N=320)



Close to forty percent (38.8%) of participants identified themselves as White, followed by 24.4% who identified as African American. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

DISABILITY STATUS[2] (N=320)



Nearly thirty-one percent of participants reported having some form of non-SMI related disability.

9.0% of participants indicated they had served or were currently serving in the military.

TYPE OF DISABILITY (N=320)

Type	n	%
Communication	16	5.0
Mental (e.g., learning)	14	4.4
Physical	12	3.8
Chronic Health	5	1.6
Other	67	20.9

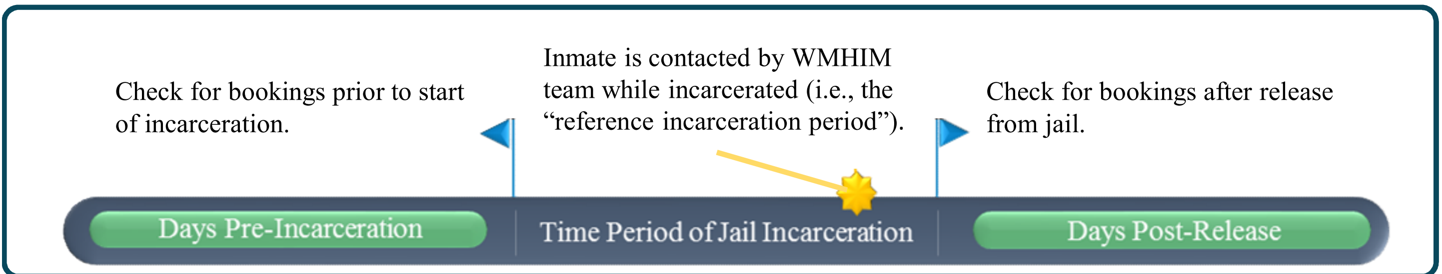
This table indicates the types of non-SMI disabilities reported as a percentage of all participants. Totals may exceed 100% as attendees could indicate more than one type of disability.

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

COUNTY OF SAN DIEGO CRIMINAL JUSTICE SYSTEM RECIDIVISM

A primary objective of WMHIM is to reduce future interactions with the County of San Diego criminal justice system after participants are released from jail. To assess the extent to which program participation may be associated with such a decline, the pattern of County jail bookings was examined before and after involvement with the WMHIM team. The instance of incarceration when first enrolled into the WMHIM program acts as the "reference" incarceration period from which to look forward and backward in time to determine the relevant recidivism information. As illustrated in Figure 1, jail data were reviewed to identify the number of times, if any, inmates had been booked during a 30-, 90-, and 180-day interval before the start of the reference incarceration period (i.e., when first enrolled in WMHIM). We then conducted a similar assessment of the data to identify any bookings that occurred during the 30-, 90-, and 180-day period after being released from jail. To ensure equal observation periods both before and after the reference incarceration period for all analyses, only inmates released at least 180 days before the end of FY 2018-19 (6/30/2019), were included in the recidivism analyses (n=338).

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



As shown in Table 1, at each time interval examined (30-, 90-, and 180-day), the recidivism rate and total number of bookings immediately prior to the reference incarceration (i.e., when the inmate first connected with the WMHIM program) was substantially higher than after initiating involvement with the WMHIM program. For example, of the 338 WMHIM participants included in these analyses, 34.3% (n=116) had at least one booking within the 30 days ***before*** their reference incarceration, but only 13.3% (n=45) had at least one booking within the 30 days ***after*** release from their reference incarceration. When examining a 180-day period before and after the reference incarceration, the corresponding recidivism rates were 76.9% (n=260) to 46.2% (n=156), respectively, and total bookings declined from 617 to 311 (a reduction of almost 50% in total bookings). The very high recidivism rates and total bookings prior to WMHIM program involvement indicate that the population served by this program was a high need, complex population with frequent justice system contacts. While these analyses do not allow for a specific test of causation, the findings suggest that participation in WMHIM contributed to a reduction in overall and repeat bookings into the County of San Diego jail. While substantial recidivism rate and total booking reductions were evident over both short- and intermediate-term time frames, the level of bookings occurring after WMHIM involvement indicate that opportunities for further improvements in supporting the transition from jail to back into the community remain.

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

	Before Start of Reference Incarceration (Total persons = 338)	After Release from Reference Incarceration (Total persons = 338)
At least one bookings within: 30 days	34.3% (n=116)	13.3% (n=45)
Total bookings within: 30 days	160	59
At least one bookings within: 90 days	62.1% (n=210)	32.8% (n=111)
Total bookings within: 90 days	370	162
At least one bookings within: 180 days	76.9% (n=260)	46.2% (n=156)
Total bookings within: 180 days	617	311

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

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

1. The major program goals identified by staff:

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

2. Factors that helped the program achieve goals:

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

3. Factors that inhibited the program from achieving goals:

a. Not enough contact with inmates.
b. Lack of available/appropriate housing for participants.
c. Lack of coordinated release efforts (e.g., with the participant, the parole officer, the program where the participant is going).
d. Lack of participant buy-in (e.g., won't meet or show up at scheduled times, drops out of the program).
e. Strict eligibility requirements in post-release programs.
f. Lack of funding.
g. Mental health treatment programs with required wait times (e.g., 30 days) before qualification.

4. Recommendations to help the program better achieve goals:

a. Identify ways to increase funding.
b. Increase the amount of housing available for participants being released.
c. Increase the ability to work with inmates prior to their release date (e.g., increase the number of visits).
d. Test for drugs and alcohol.
e. Expand program referrals and enrollments.
f. Improve internal communication and coordination.
g. Increase the amount of information received from the jail (e.g., mental health and incarceration histories).
h. Create a position for a program coordinator.

5. Key strengths of the program:

a. The combination of spirituality and mental health.

b. The quality of contact with inmates (e.g., one on one, personalized, empowering).

c. Having a unified passionate team.

d. The training employees receive.

e. The ability to achieve positive changes (e.g., lessening recidivism).

f. Resource knowledge (e.g., community programs, eligibility requirements).

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

a. Accurate resource information (e.g., community programs, eligibility requirements).

b. More information on current programs and services for inmates with a mental illness.

c. A "dispatch" like position to track/communicate current and accurate program participant information.

d. Increased ability to work with inmates over multiple visits prior to their release date.

e. Yearly trainings to keep knowledge and skills up to date.

f. A shortened version of reporting/documentation requirements.

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

a. Visiting with inmates frequently.

b. Having staff/volunteers with prior incarceration experiences.

c. Listening without judgment and empowering participants with support and encouragement.

d. Sharing faith (e.g., personal stories, journeys towards faith, prayer).

e. Offering the potential of safe housing post-release.

f. Combining behavioral health and faith based approaches.

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

a. Providing or acquiring relevant phone numbers.

b. Developing relationships with family members.

c. Encouraging participants to maintain contact (e.g., regular “check-ins”).

d. Making in-person contacts (e.g., homes, treatment programs, shelters).

e. Keeping track of where the participant is currently living.

f. Sponsoring participants who are in recovery.

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

a. Limited time to work with inmates and coordinate program referrals prior to release.

b. Not enough services for participants with serious mental illness.

c. Restrictions in program eligibility.

d. Lack of participant buy-in/motivation.

e. Not enough housing/treatment beds.

f. Lack of funding.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Faith Based Academy program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources including, participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar integrated faith based behavioral health training programs. The key learnings are organized into general thematic categories.

1. Service approach/ethos

a. Integrating behavioral health knowledge and a faith/spirituality perspective facilitates development of supportive and empowering relationships with inmates with SMI.

b. The personal "lived experience" of program staff and volunteers with the criminal justice and behavioral health system increases credibility with inmates.

c. Supportive relationships combined with availability of community resources and services appear to be important factors contributing to positive life changes.

d. Need a flexible team that can be available on short-notice and during non-traditional work hours to respond to unpredictable jail release timing and challenges that may arise at any time after release.

2. Pre-release relationship building and transition planning

a. Multiple pre-release contacts are important relationship building opportunities that facilitate maintaining post-release connections with participants.

b. Important to know when persons are releasing so that the team can mobilize to meet them in-person and continue their work on connecting them to post-release services.

3. Post release engagement strategies and resource needs

a. Providing post-release transport facilitates maintaining post-release connections with participants.

b. Access to safe post-release housing is often limited, which then becomes a primary post-release focus for participants.

c. Linking to relevant outpatient and residential treatment services can be challenging (e.g., limited availability within desired geographic areas, strict eligibility requirements, program waitlists, participant focusing on other needs).

d. Establishing a post-release assistance/services plan (e.g., housing, treatment, employment, family reunification) prior to their actual release helps keep inmates engaged and motivated to work with WMHIM after they are released.

4. Participant characteristics

a. Participants often need a range of behavioral health and non-behavioral health related services after release.

b. While most participants were males, about 20% were females who may experience other types of needs (e.g., child care) and challenges (e.g., domestic violence) that need to be addressed.

5. Administrative needs of small community organizations

a. Additional education, supports, and openness to simplifications where feasible can help small "grassroots" organizations navigate and respond to bureaucratic requirements associated with County of San Diego contracts.

PROGRAM CHANGES FROM INITIAL DESIGN

There were no changes to the INN-13 Faith Based Initiative #4, WMHIM that fundamentally differed from the initial program design. Throughout this initiative, WMHIM staff attempted to make contact with eligible inmates while they were still incarcerated in order to develop a relationship that could then be relied upon to help the person transition back into the community.

FUTURE DIRECTIONS

The County BHS system decided to consolidate multiple programs that focused on transitioning persons with SMI from jail settings back into the community. As such, this specific WMHIM pilot study program was not continued following the conclusion of the MHSA Innovations funding stage. However, the lessons learned about effective faith based engagement and support of persons returning to the community from jail were integrated into the ongoing faith based program with the expectation of continued reductions in recidivism.

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

NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES FINAL REPORT: (7/1/15 - 12/31/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Noble Works program was funded through the Innovations (INN) component of the Mental Health Services Act. Noble Works was designed to increase employment of persons with Serious Mental Illness (SMI) with a particular emphasis on expanding employment opportunities beyond traditional low-wage, low-skill positions. Through improvements in their employment situation, Noble Works was expected to also boost participants' sense of empowerment, social connectedness, and overall quality of life. The Union of Pan Asian Communities (UPAC) was 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 utilized a multi-faceted approach based on Supported Employment principles that targeted both prospective employers and persons with SMI. Core components of the program included utilization of Employment Specialists, who helped participants prepare for and find competitive employment positions of interest, and peer-support Job Coaches, who provided individualized support for maintaining employment. UPAC and NAMI SD conducted community presentations to help reduce stigma and educate potential employers about hiring persons with SMI. Other innovative Noble Works components included 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 employment resources.

EXECUTIVE SUMMARY

The Noble Works program (INN-14) was 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 included outreach to and education of potential employers to decrease stigma and expand awareness of employment opportunities.

- A total of 295 persons enrolled into Noble Works.
- The majority of enrollees were male (58.7%) and one-third (33.9%) were TAY (i.e., age 18-25). More than half (54.5%) reported some college education or more.
- Overall, 26.8% participants (n=79) obtained at least one job (similar rates were evident for TAY and non-TAY).
- Of the 113 total jobs acquired, the median wage was $11.50/hour with an average of 26.2 work hours per week. Participants employed at the end of the program or at the time they exited Noble Works (n=53) had been continuously employed for an median of 186 days.
- Approximately 20% of the jobs acquired were classified as occupations that required at least a "medium" amount of preparation (i.e., skills, education, experiences) to obtain.
- Compared to participants who obtained jobs, participants who did not were rated as having greater functional impairment and lower coping capabilities at their follow-up assessment. This suggests one potential factor contributing to difficulties obtaining jobs was related to participants' deteriorating mental health and/or well-being.
- Primary factors inhibiting achievement of program goals appeared to include: 1) challenges maintaining participant engagement/interest in program, 2) difficulties with job development/outreach efforts, and 3) high staff turnover.

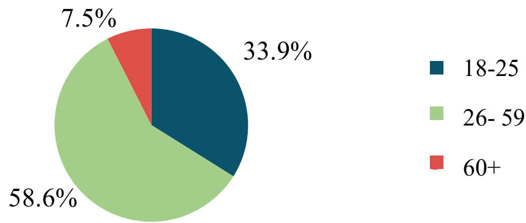
FUTURE DIRECTIONS

Based on the results of the MHSA funded INN pilot project and other BHS system priorities, it was determined to not continue the Noble Works program. While the overall program ended, two components, Apprenticeships and Consumer Owned Businesses were added to one existing BHS program that already provided Supported Employment/Individual Placement and support services to consumers with SMI. These unique approaches are expected to create additional opportunities to tailor employment and business start-up related services to the interests and skills of participants.

PARTICIPANT CHARACTERISTICS

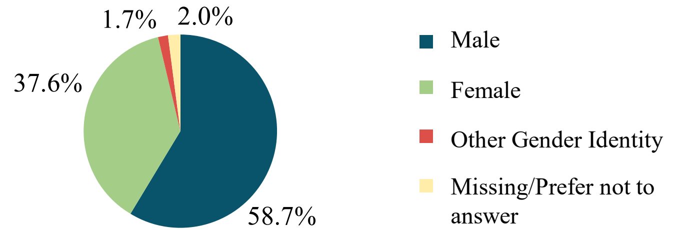
The following characteristic data were collected from a participant self-report survey at the start of Noble Works.[1]

AGE (N=295)



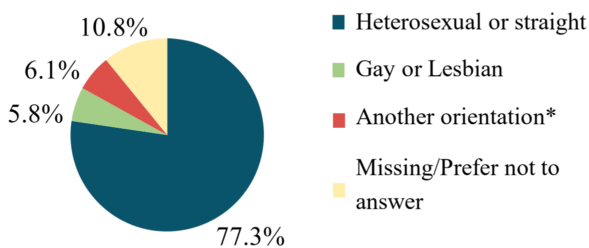
Over half (58.6%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=295)



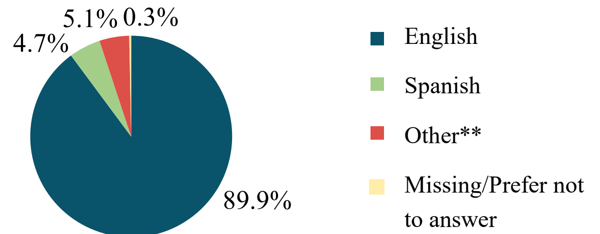
Nearly 60% (58.7%) of participants were male and 37.6% were female.

SEXUAL ORIENTATION (N=295)



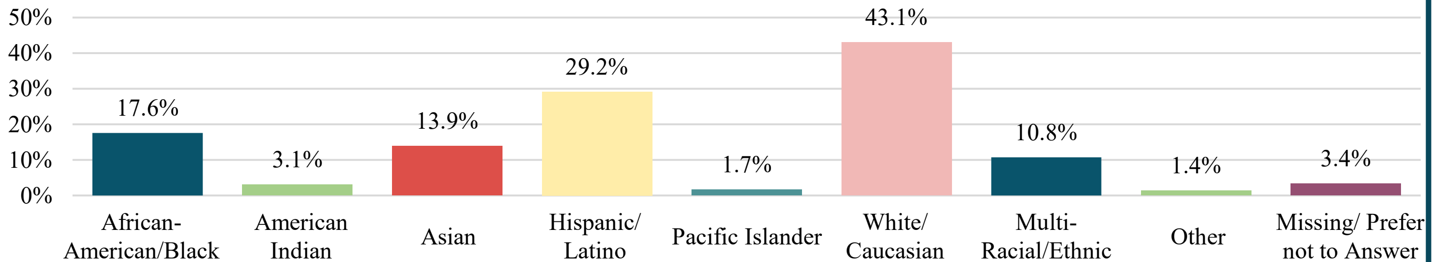
The majority (77.3%) of participants were heterosexual or straight, and 5.8% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=295)



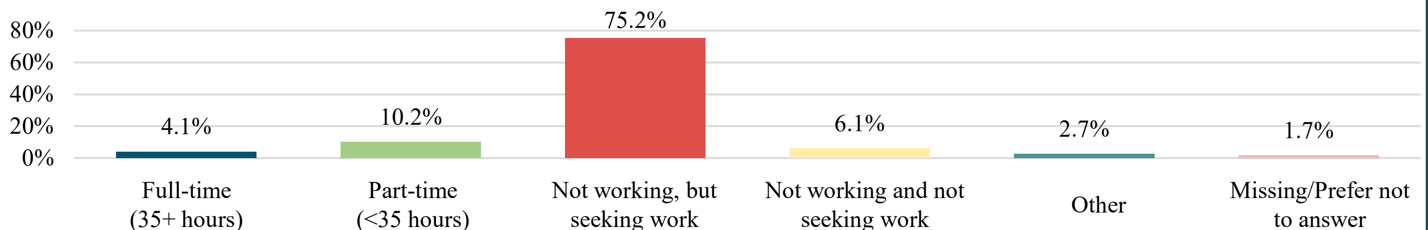
English was the primary preferred language for almost all of the participants (89.8%).

RACE/ETHNICITY (N=295)



Similar proportions of participants identified themselves as White (43.1%) and Hispanic/Latino (29.2%). Totals may exceed 100% as participants could indicate more than one race/ethnicity.

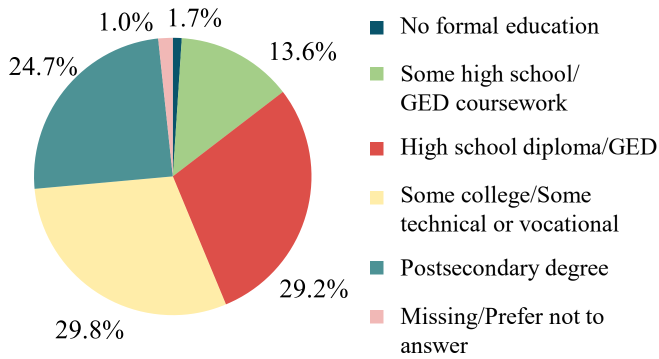
EMPLOYMENT STATUS (N=295)



As expected for this type of program, most participants were either not working, but seeking work (75.2%), or in part-time positions (10.2%), when they started Noble Works.

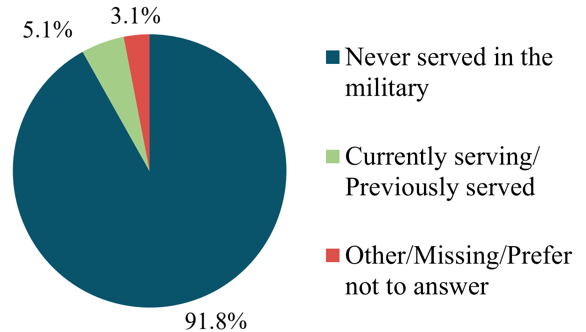
*[1]Percentages may not total to 100% due to rounding. *Another orientation includes Bisexual/Pansexual/Sexually fluid. **Other includes Farsi, Lao, Mandarin, Russian, Tagalog, and Vietnamese.*

EDUCATION LEVEL (N=295)



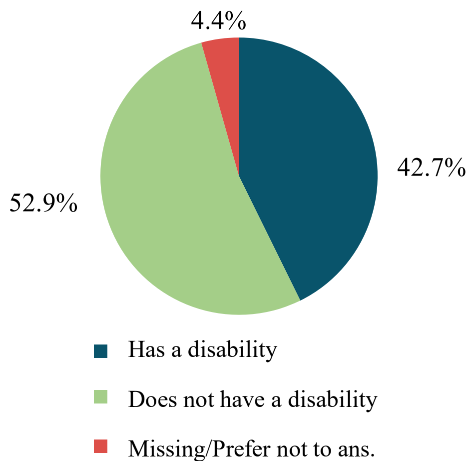
Approximately half of the participants (54.5%) had at least some postsecondary education.

MILITARY STATUS (N=295)



The majority (91.9%), of participants had never served in the military.

DISABILITY[2] STATUS (N=295)



A minority (42.7%) of the participants indicated having some form of non-SMI related disability.

TYPE OF DISABILITY (N=295)

Type	n	%
Communication	36	12.2
Mental (e.g., learning)	53	18.0
Physical	28	9.5
Chronic health condition	22	7.5
Other	26	8.8

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

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

JOBS ACQUIRED THROUGH NOBLE WORKS

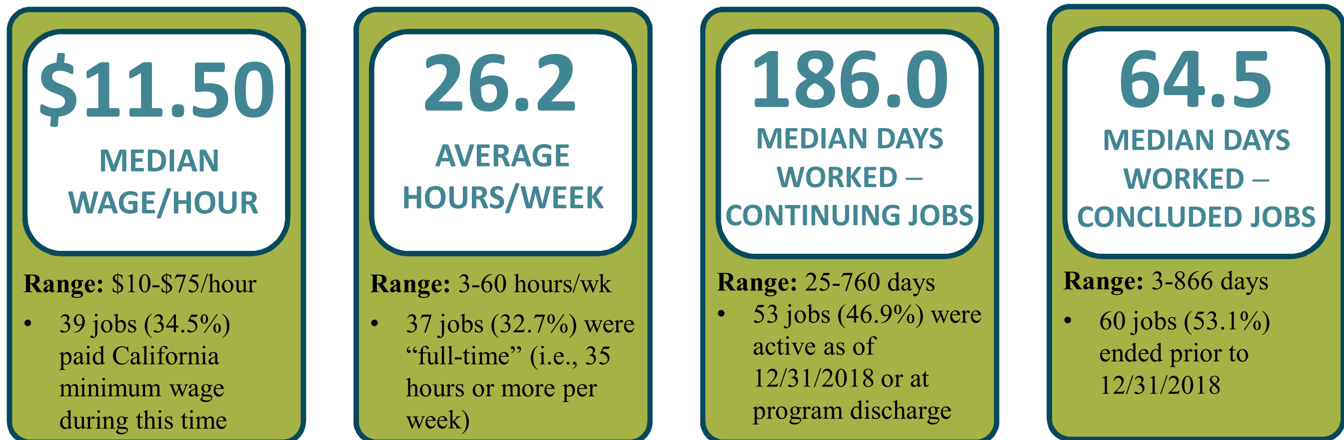
A total of 113 jobs were acquired by 79 people through the Noble Works program during its implementation from 07/1/2015-12/31/2018. As shown in Table 1, the jobs acquired covered a wide assortment of occupations, with the most common positions in the domains of office/administrative support (24.8%), food preparation and serving (20.4%), and sales (17.7%).

TABLE 1. JOB DOMAINS FOR JOBS ACQUIRED THROUGH NOBLE WORKS

	n	%
Building and Grounds Cleaning and Maintenance Occupations	8	7.1
Business and Financial Operations Occupations	2	1.8
Community and Social Services Occupations	6	5.3
Construction and Extraction Occupations	2	1.8
Food Preparation and Serving Related Occupations	23	20.4
Healthcare Support Occupations	6	5.3
Installation, Maintenance, and Repair Occupations	2	1.8
Office and Administrative Support Occupations	28	24.8
Personal Care and Service Occupations	3	2.7
Production Occupations	7	6.2
Protective Service Occupations	3	2.7
Sales and Related Occupations	20	17.7
Transportation and Material Moving Occupations	3	2.7

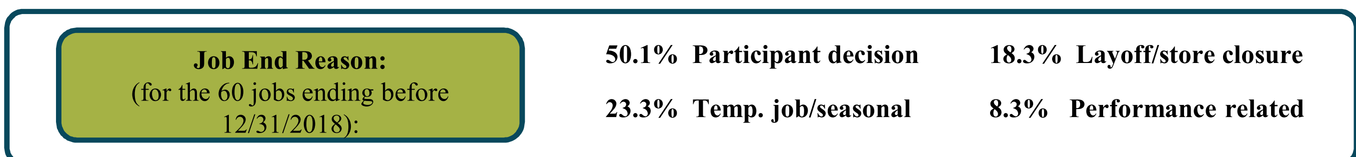
The median wage for these positions was $11.50 per hour. Of the 113 jobs obtained, 32.7% were full-time. The average number of hours worked per week was 26.2. Of the 53 jobs that were either still active as of 12/31/2018 or active at the time of program discharge, the median duration was 186.0 days. Meanwhile, the median duration of days worked for jobs that ended prior to 12/31/2018 was 64.5 days.

FIGURE 1. CHARACTERISTICS OF JOBS ACQUIRED THROUGH NOBLE WORKS DURING PROGRAM IMPLEMENTATION 07/1/2015-12/31/2018



As shown in Figure 2, for the majority of jobs that ending before 12/31/2018, the primary reason was due to the participant deciding to leave the position. There were less than 9% reported instances of jobs ending primarily due to performance-related issues.

FIGURE 2. PRIMARY REASONS WHY JOBS ENDED DURING PROGRAM IMPLEMENTATION 07/1/2015-12/31/2018



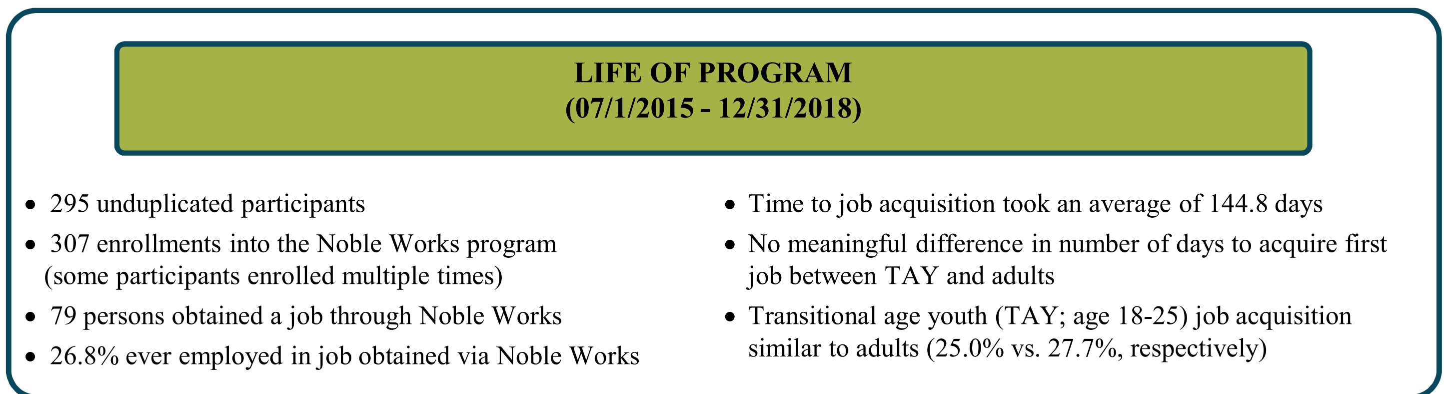
Based on the U.S. Department of Labor Occupational Information Network (O*NET) Standard Occupational Classifications (SOC), most of the jobs obtained through the Noble Works program required either little/no preparation (30.1%) or some preparation (48.7%), as shown in Table 2. This is generally consistent with the finding that 34.5% of the jobs started at minimum wage. During its final year of operations Noble Works was able to expand job placement opportunities to include a position in Category 5 (i.e., occupations that need extensive preparation). Approximately 20% of the jobs obtained were Category 3 or above.

TABLE 2. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	34	30.1
2 - Occupations that need some preparation	55	48.7
3 - Occupations that need medium preparation	14	12.4
4 - Occupations that need considerable preparation	9	8.0
5 - Occupations that need extensive preparation	1	0.9

As shown in Figure 3, 26.8% (n=79) of the participants who ever enrolled in Noble Works obtained a job by the end of program implementation (12/31/2018). Transitional age youth (TAY; age 18-25) were as likely and as timely as adults in finding jobs through the Noble Works program. However, TAY are more likely than adults to leave the program before getting a job. While many of the jobs were found within three months of entering Noble Works, some participants may take six or more months to find their first job.

FIGURE 3. NOBLE WORKS OVERALL JOB ACQUISITION DATA



NOBLE WORKS BUSINESS START-UP ACTIVITIES

Noble Works provided financial support and technical assistance to help five participants start businesses that reflected their unique interests and skills (e.g., jewelry making, catering consultant, grant writing company).

NOBLE WORKS SOCIAL ENTERPRISE ACTIVITIES

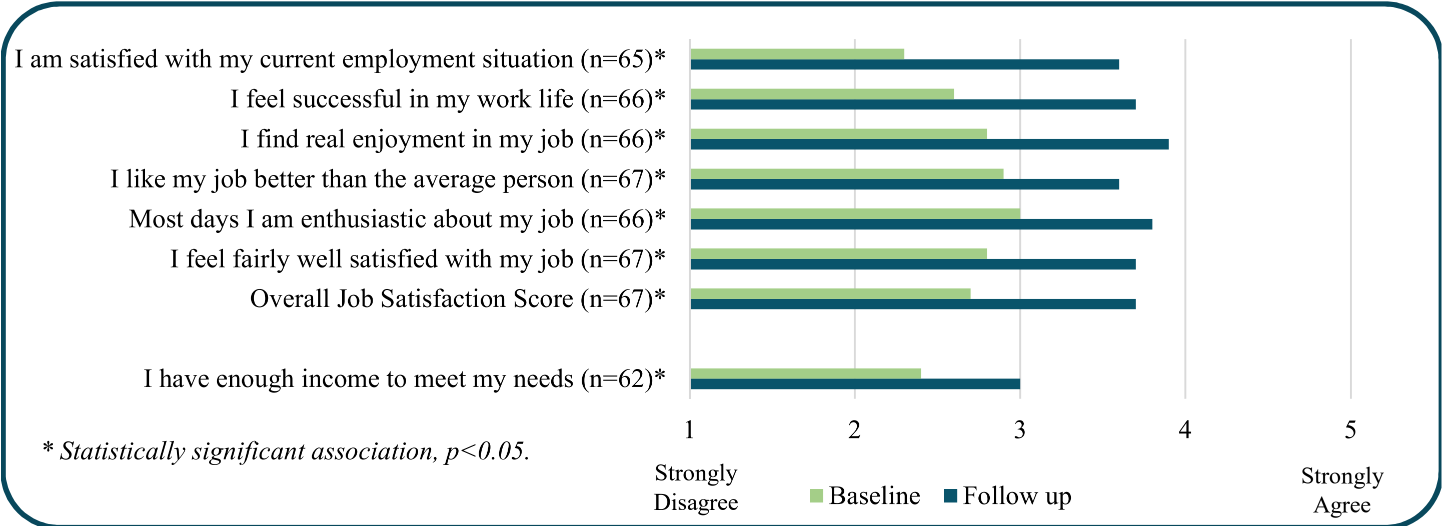
Noble Works assisted in the development of the Neighborhood Enterprise Center and participants received culinary arts training/employment in "Kitchen Creation," a rentable commercial kitchen used by local entrepreneurs to prepare food (e.g., caterers) as well as space to provide culinary arts related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

EXITS FROM NOBLE WORKS PRIOR TO JOB ACQUISITION

Of the 295 participants who entered the Noble Works program 59.3% (n=175) left the program prior to obtaining a job due to indicating they were no longer interested in receiving Noble Works services or dropping out due to loss of contact.

As shown in Figure 4, for persons who ever obtained a job through the Noble Works program, each measure of job satisfaction increased substantially from program entry (baseline) to post-job follow-up. Starred items had a statistically significant change in mean score from baseline to follow-up ($p<0.05$). The overall job satisfaction score (i.e., the average of all six satisfaction items), increased from 2.7 at baseline to 3.7 post-job (on a scale from 1-5 with higher values corresponding to greater job satisfaction). The statistically significant increases indicated that obtaining a job through Noble Works dramatically improved perceptions of their employment circumstances. While increasing post-job, the sense of having enough income only rose to about a 3 (on a scale of 1-5), suggesting opportunities for further improvements in this area.

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



The Illness Management and Recovery (IMR) scale is an assessment utilized by the Noble Works staff to measure perceptions of a participants recovery, with higher values indicating better outcomes. Overall, no improvements were seen in IMR scores between participants first and last IMR assessment, and looking at participants final IMR score, no significant differences were seen in IMR score changes between participants with lower job satisfaction and those with higher job satisfaction. However, significant differences were seen in IMR inventory scores between participants who acquired a job and those who did not (Figure 5). Participants who acquired a job had significantly improved IMR score ratings in the areas of contact with people outside family, time in structured roles, impairment of functioning, and coping. Whereas, participants who did not acquire job had similar or worsened IMR ratings in those same areas.

TABLE 3. IMR MEAN SCORES FOR PERSONS WHO DID AND DID NOT ACQUIRE A JOB THROUGH NOBLE WORKS

	Without job acquisition (n=156)			With job acquisition (n=72)			
	Baseline	Follow-up	Paired t-test, p-value	Baseline	Follow-up	Paired t-test, p-value	Significant difference at last follow-up, between groups
IMR4 'Contact with people outside my family'	3.4	3.4	0.699	3.5	4.0	0.002	*
IMR5 'Time in structured roles'	2.5	2.4	0.186	2.4	3.3	< 0.001	*
IMR7 'Impairment of functioning'	3.3	2.8	< 0.001	3.0	3.6	0.001	*
IMR11 'Coping'	3.6	3.0	< 0.001	3.6	3.8	0.465	*

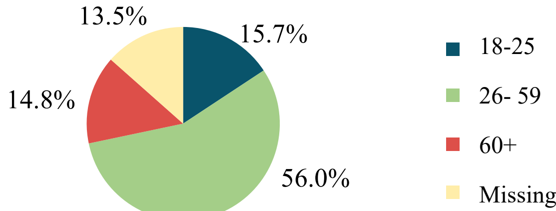
** Statistically significant association, $p<0.05$.*

Another assessment used by Noble Works is the recovery markers questionnaire (RMQ), a self-report measure of a participants own perception of their recovery. Improvements in participants overall RMQ composite scores between their initial and final assessments were not seen, however, improvements were seen in individual RMQ domains such as having enough income, contributing to the community, being less bothered by symptoms, and dealing more effectively with daily problems. Exploratory analysis using regression modeling suggested that final RMQ composite scores were associated with baseline RMQ scores before a job was acquired and with a participant’s level of job satisfaction. The magnitude of this effect was small, but it does lend support to the idea that people who liked their jobs showed greater self-reported improvements.

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

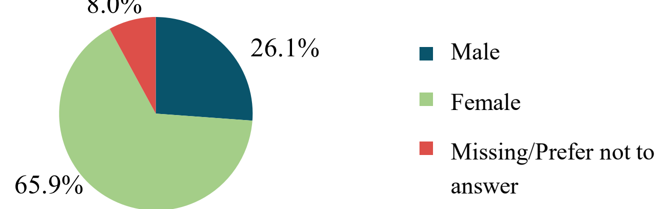
Throughout the life of the Noble Works program (7/1/15-12/31/18), NAMI SD, a program partner, conducted 97 "In Our Own Voice" (IOOV) community outreach and education presentations regarding mental illness and recovery. Either in conjunction with NAMI SD, or independently, Noble Works representatives also conducted 64 "Trainings to Businesses" presentations that provided mental health related education to potential employers. The charts below provide an overview of select presentation attendee demographics and outcomes, with 'respondent type' only pertaining to the "Trainings to Businesses" presentations.

AGE (N=1,262)



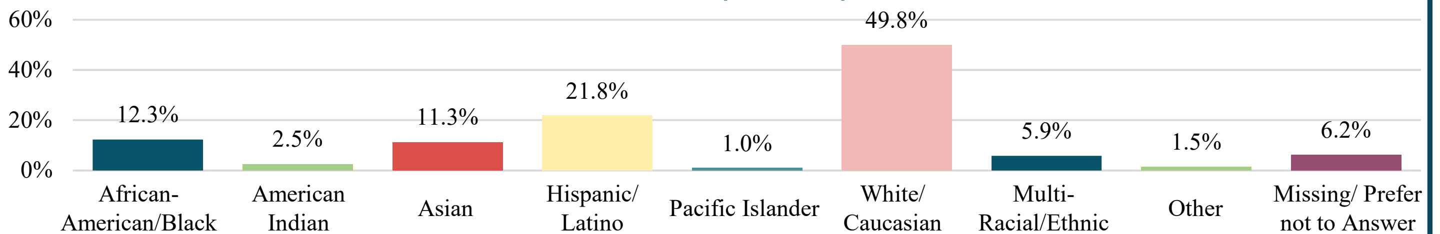
Over half (56.0%) of attendees were between the ages of 26 and 59.

GENDER IDENTITY (N=1,262)



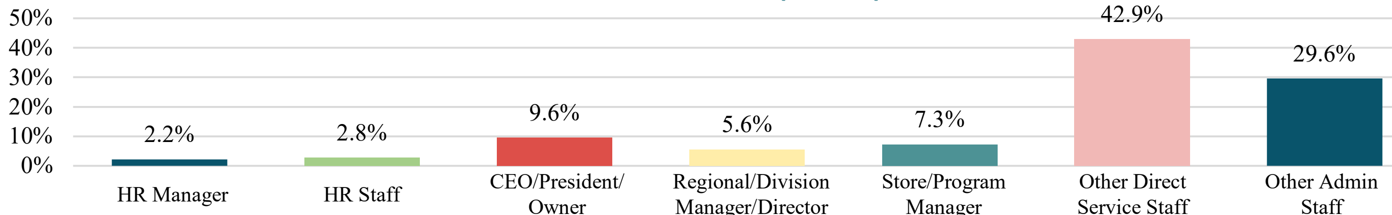
The majority of attendees were female (65.9%).

RACE/ETHNICITY (N=1,262)



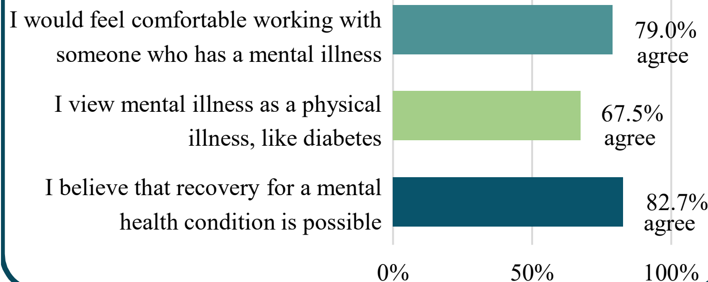
The majority of attendees identified as White/Caucasian (49.8%), with 21.8% indicating an Hispanic/Latino background. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

TYPE OF RESPONDENT (N=575)

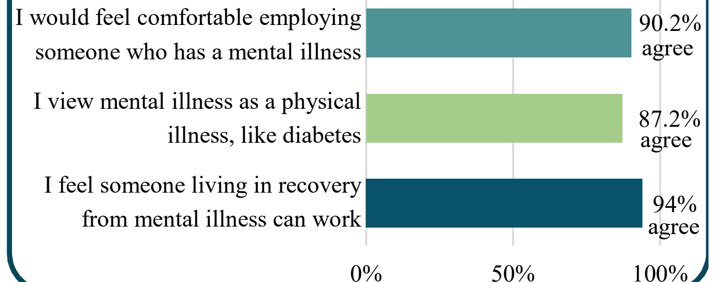


Almost half (43.0%) of the attendees identified themselves as direct service staff, with close to one-third (29.6%) identifying as administrative staff.

NAMI IOOV PRESENTATION OUTCOMES (N=1,096)



NOBLE WORKS PRESENTATION OUTCOMES (N=430)



The majority of respondents indicated positive attitudinal changes as a result of NAMI SD's IOOV and Noble Works "Training to Businesses" presentation. These findings reflect ongoing efforts to normalize attitudes about mental health in the workforce. However, more improvements are possible since only 67.5% from IOOV indicated viewing mental illness similar to a physical illness.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

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

1. *Primary factors that helped achieve Noble Works goals:*
    a. Skilled and passionate staff who worked to support participants and increase participant employment opportunities.
    b. Participants being provided one on one support through working with an employment specialist or job coach.
    c. Community presentations that worked to increase knowledge of mental health, reduce stigma, and emphasize the vital role that employment plays in mental health recovery.
    d. Tools and resources such as classes, employment leads, and connections within the community provided by the program that were available to help support and educate participants.
    e. Partnerships and collaborations within the Noble Works program as well as with programs and organizations in the community.
    f. Participants who were engaged in program activities and were motivated to learn and enhance their skills.

2. *Primary factors that inhibited achieving Noble Works goals:*
    a. High levels of staff turnover created challenges affecting program operations.
    b. Staff uncertainty about job roles/tasks (e.g., communication methods with participants and employers).
    c. Challenges maintaining participant effort and interest.
    d. Intake process inhibits quick engagement with participants and connections to potential employers.
    e. Outreach efforts not reaching the right types of businesses, employers, or the community.

3. *Primary challenges obtaining and maintaining employment for participants:*
    a. Employers with a lack of awareness about mental illness who are resistant to learning about the program or getting to know participants.
    b. Participants who want a 'dream job' but do not want to take classes, trainings, or certifications to qualify.
    c. Participants not properly managing their symptoms.
    d. Unrefined work skills (e.g., communication skills, professional behavior, social interactions, conflict resolution).
    e. Participant with low motivation.
    f. Lack of relevant and suitable job openings.

4. *Primary factors that facilitated ongoing participant engagement in Noble Works:*
    a. Staff efforts to build relationships with participants and maintain regular contact with supportive communication.
    b. Resources and incentives offered to participants for participating in program activities and classes.
    c. Unique opportunities that are available to participants through the Noble Works program, such as Kitchen Creations, and the Tech Café.
    d. Passionate staff that are committed to empowering participants.
    e. A welcoming and inclusive environment where participants can see the progress they are making within the program.
    f. Time spent with participants to build trust and rapport and to meet clients “where they are at” within their recovery and to work with them regarding their employment interests.

5. *Primary impacts of trainings and business development opportunities:*
    a. Increases the chances that a participant will be hired.
    b. Contributes to the quality/marketability of the program as a whole.
    c. Capitalizes on the strengths/interests of participants.
    d. Enhances learning opportunities.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Noble Works outcomes and operations throughout the three and one half year MHSA Innovations-funded study. These findings were derived from multiple sources including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform implementation and operational activities of any similar job placement and support programs. The key learnings are organized into general thematic categories.

1. ***Noble Works program implementation and operations***
    a. Program start-up issues (i.e., hiring, training, establishing facilities, collaborating with partners, developing trainings) required substantial time commitments.
    b. Noble Works staff were passionate and committed to achieving program objectives.
    c. Staff trainings, such as in Supported Employment evidence-based practices, supported the achievement of program objectives.
    d. High staff turnover was an ongoing substantial challenge to Noble Works' implementation and operations.
2. ***Creating/identifying training/mentorship opportunities***
    a. Training and certification programs need to be reviewed cautiously to promote greater likelihood that the time required of program staff and participants will lead to specific employment opportunities.
    b. The development of personal job mentors as part of the Noble Works program was difficult to establish, with few people interested in acting as a job mentor for Noble Works participants.
    c. The development of the multi-faceted Neighborhood Enterprise Center, near the end of the pilot study timeframe, created new job-specific training and certifications opportunities for the Noble Works SMI population.
3. ***Creating/identifying employment opportunities***
    a. Program was successful at identifying a diverse set of jobs for participants.
    b. In general, approximately 20% of jobs acquired through Noble Works were classified as needing at least a "medium" amount of preparation, skills, and/or experience (i.e., SOC Job Zone of Category 3 or higher).
    c. The Noble Works program demonstrated the capability for business "start-ups" among the SMI population, but findings suggest that such services were only relevant for a small portion of those served by Noble Works.
    d. Identifying and educating potential employers was difficult, but this objective was perceived as crucial for increasing the pool of known employment opportunities.
    e. Community presentations with employers appeared to have helped with overall mental health awareness and stigma reduction, but did not often contribute to the identification of new employers with employment opportunities for Noble Works participants.
4. ***Job placement rates and associated outcomes***
    a. Participant satisfaction with their employment situation increased after participating in the Noble Works program.
    b. 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).
    c. Job placement timing varied substantially (i.e., average of 145 days; range from less than 30 days to more than 200).
    d. It was challenging to identify jobs that were of interest to as well as a good skills match for Noble Works participants.
    e. Difficult to maintain participant motivation throughout process.
    f. Poor symptom management perceived as a barrier to job acquisition.
    g. Noble Works overall job placement rate (26.8%), was lower than typically achieved by structured Supported Employment/Individual Placement and Support programs (i.e., 50-65%).
    h. TAY (i.e., participants age 18-25) had similar rates of job acquisition as adults/older adults.

PROGRAM CHANGES FROM INITIAL DESIGN

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

FUTURE DIRECTIONS

Based on the results of the MHSA funded INN pilot project and other BHS system priorities, it was determined to not continue the Noble Works program. While the overall program ended, two components, Apprenticeships and Consumer Owned Businesses were added to one existing BHS program that already provided Supported Employment/Individual Placement and support services to consumers with SMI. These unique approaches are expected to create additional opportunities within the existing program to further tailor employment and business start-up related services to the interests and skills of participants.

For additional information about the INN–14 Noble Works program and/or this report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

PEERLINKS (PEER ASSISTED TRANSITIONS) (INNOVATIONS-15)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES FINAL REPORT (7/1/16 - 6/30/19)

UC San Diego

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

EXECUTIVE SUMMARY

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

- During Fiscal Years 2016-18 to 2018-2019 a total of 659 unique participants were newly enrolled in the program.

Participant Demographics

- The majority of participants were between the ages of 26 and 59 (80.4%), there were slightly more male (49.9%) than female participants (45.8%), 76.2% were heterosexual, English was the primary language for the large majority (95.1%), and 55.1% were White/Caucasian. A small minority were veterans (5.5%).
- All participants had SMI. Of those, a little more than half (51.7%) reported having an additional non-SMI related disability.

Participant Rated Outcomes and Program Satisfaction

- The large majority of participants were satisfied with the services they received (96.9%), and as a result of the program, 92.2% knew where to get help when needed, 89.4% were more comfortable seeking help, and 85.4% were better able to handle things.

Participant Outcomes: Participants improved on a range of assessments.

- **Milestones of Recovery Scale (MORS):** Overall, participants increased in their MORS score from an average of 2.2 (experiencing high risk/not engaged) to 4.8 (not coping successfully/engaged). This increase was statistically significant. A total of 86.0% improved on the MORS, 10.3% remained stable, and 3.7% of participants decreased.
- **Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS):** Pre-post data on the CHAMPSSS showed that participants had statistically significant increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and had more people actively support them in recovery. In addition, participants demonstrated statistically significant improvements on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales.

Health and Substance Use

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

Housing and Employment

- A total of 41.9% of participants moved into less restrictive and more independent housing. The average housing level improved from 3.2 at baseline to 4.2 at the most recent assessment, which was statistically significant.
- Pre-post data on housing outcomes indicated that the total number of participants and the total number of days being homeless decreased.
- Pre-post data on employment outcomes showed that the percentage of participants who were competitively employed increased from 8.9% to 16.7%. The number of participants who identified as unemployed decreased from 83.7% to 68.0%. The majority were unemployed due to mental health symptoms or disability. The average increase in employment level was statistically significant.

Linkages to Services

- Overall, 3,490 successful connections to services or resources were made. Participants could be connected to multiple services. For mental health services, 592 successful connections were made for 237 participants. For substance abuse services, 225 successful connections were made for 94 participants.
- Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection.
- Mental Health service data based on Linkage and Referral Tracker entries for participants who had been in the program for *at least 30 days* showed that, of those 412 participants who had been in the program for at least 30 days, 336 had either a referral or linkage across the mental dimension and 213 were successfully connected.

Critical Events

- Overall, the number of participant reported emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to the most recent follow-up assessment. The number of participants and the number of encounters participants had with non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up.

Service Utilization

- Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

FUTURE DIRECTIONS

Based on the positive findings from the INN-15 PeerLINKS innovations program, County of San Diego Behavioral Health Services dedicated ongoing Community Services and Supports Program (CSS) funding to continue the PeerLINKS program. This funding allowed the structure and operations of the program to continue uninterrupted. Under the new contract, Peer Assisted Supportive Services, began services on 8/1/2019. The new contract increased the number of unique participants served per year and expanded to a third crisis residential program. Participants are able to remain in the program up to 6 months.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To provide peer support services to adults with Serious Mental Illness (SMI) who present at Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as at the Community Research Foundation's (CRF) Vista Balboa and New Vistas Crisis Residential facilities.* Using MHSA's Innovation (INN) funding, the PeerLINKS program was successfully developed, implemented, and refined to provide peer support services to adults with SMI. PeerLINKS enrolled a total of 659 individuals; 46.5% of participants were referred from psychiatric inpatient unit settings and 51.3% from crisis homes; a small percentage of participants (2.2%) were referred from emergency departments.

2. *To engage with persons in the inpatient or crisis residence setting; maintenance of engagement with person following discharge from inpatient/residential setting, and support with navigation of behavioral health system of care and other support resources.* The team of nine Peer/Family Support Specialists typically met with participants while still in the inpatient crisis residence setting or ED and continued to work with them in the community. Whenever possible, the Peer/Family Support Specialist who was assigned to work with them continued to work with the same participant during their entire time in the program, thus reducing the need for multiple warm handoffs. Once in the community, their assigned Peer/Family Support Specialist met with them in areas convenient to the participant. Throughout the program, their assigned Peer/Family Support Specialist partnered with the same participants to identify each participant's needs, goals, and preferences and supported them in being connected with services and resources of their choosing. Participants were empowered and encouraged by their Peer/Family Support Specialist to have an active role in their recovery and in reaching their goals. Therefore, in addition to being connected to resources, they learned and practiced being connected to a variety of resources and services. As a result, many participants (92.2%) agreed or strongly agreed that they felt comfortable navigating resources and accessing services as a result of the program.

3. *To enroll a minimum of 200 unduplicated adult participants into the program annually.* The PeerLINKS program started operation on July 1, 2016 with participants enrolled in the program from November 2016 onward. A total of 659 unduplicated adult participants were enrolled into PeerLINKS. In the first year of operation (FY 2016-17), 189 participants enrolled; during the second year of operation (FY 2017-18), 272 participants enrolled; and 201 participants were enrolled during the third year (FY 2018-19), of which a small number of individuals had previously been enrolled in PeerLINKS.

4. *To decrease psychiatric hospitalization re-admissions and crisis residential facility re-admissions.* Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES (CONTINUED)

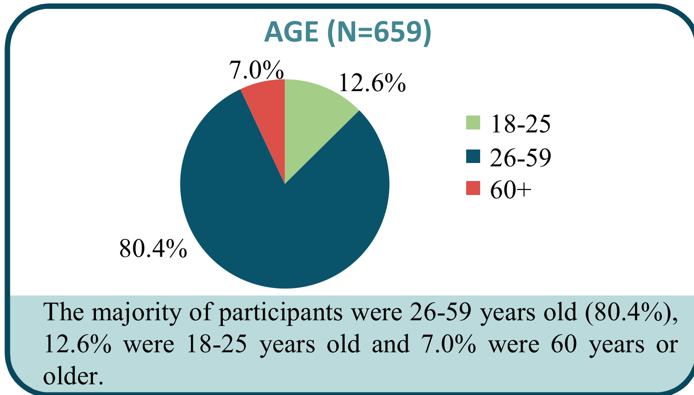
5. *To increase linkages with formal support services and identify personal goals for recovery and wellness.* An important aspect of the program was linking participants with formal support services. The Linkage and Referral Tracker was used to track discussions, referrals, linkages, and successful connections that Peer/Family Support Specialists made to other services. It reports on ten Dimensions of Wellness which include physical health, social health, mental health, substance abuse, housing, occupation/education, financial assistance/benefits and legal, transportation, identification, and basic needs. A total of 3,490 successful connections with formal support services were made for 455 unique participants since program operation started. In addition, 4,444 referrals and 1,512 linkages were made (for 518 unique participants and 351 unique participants, respectively). For the mental health dimension, 592 successful connections were made for 237 unique participants. For participants enrolled in the program for at least 30 days (N=412), 336 unique participants were referred or linked to mental health related services, while 213 unique participants were successfully connected (63.4% successfully connected). For the substance abuse dimension, 225 successful connections for 94 unique participants were made. Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection. The Linkage and Referral Tracker was also used as a shared decision-making tool with participants and to help set their personal goals for recovery and wellness.

6. *To increase participant's active social support recovery network.* Compared to baseline, participants reported increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and having more people actively support them in recovery at follow-up, as measured by the CHAMPSSS. These increases were statistically significant. The program reported that several participants reconnected with family and their children, others found new individuals that joined their lives and supported their well-being and recovery.

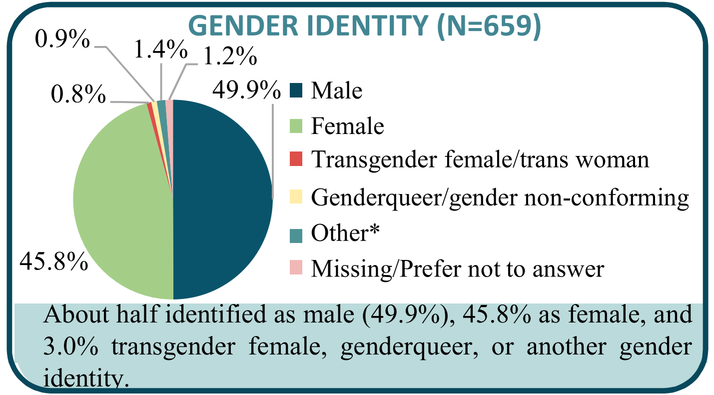
7. *To demonstrate improved level of recovery.* On average, participants showed statistically significant improvement in all of the CHAMPSSS subscales (i.e., Global Health, Resilience, Depression, Anger, Anxiety, Substance use, Memory/Cognition, Suicidality, and Impact of Symptoms Scales) with the exception of Substance Use Frequency Scale which stayed the same. In addition, MORS scores have been increasing from an average of 2.2 to 4.8, which was statistically significant. A total of 86.0% of participants improved on the MORS and 10.3% remained stable (no change in score). Only 3.7% decreased. In addition, the large majority of participants agreed or strongly agreed that as a result of the PeerLINKS program, they know where to get help when needed (92.2%), are more comfortable seeking help (89.4%), and are better able to handle things (85.4%).

PARTICIPANT CHARACTERISTICS

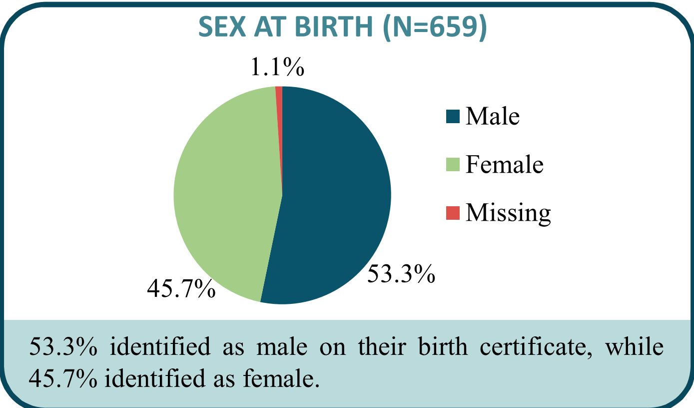
The following characteristic data were collected from the intake assessment administered at the start of the program.[1]



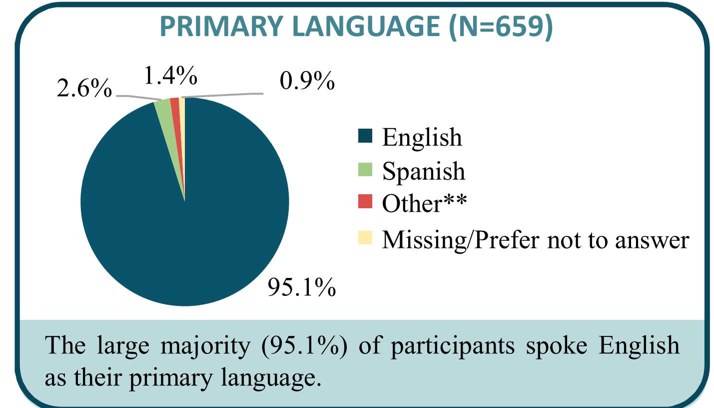
The majority of participants were 26-59 years old (80.4%), 12.6% were 18-25 years old and 7.0% were 60 years or older.



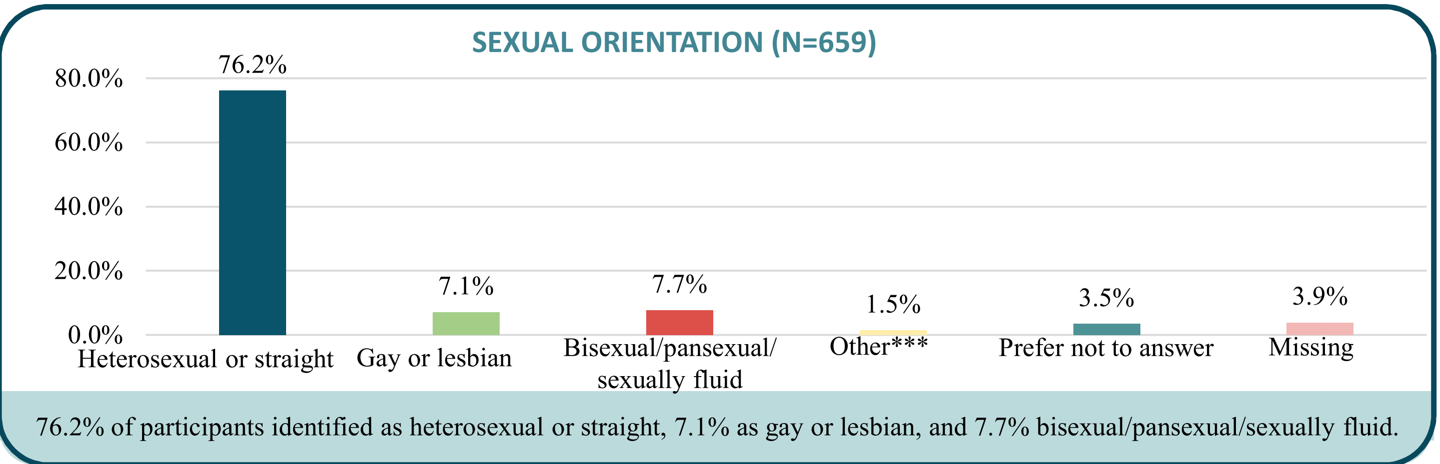
About half identified as male (49.9%), 45.8% as female, and 3.0% transgender female, genderqueer, or another gender identity.



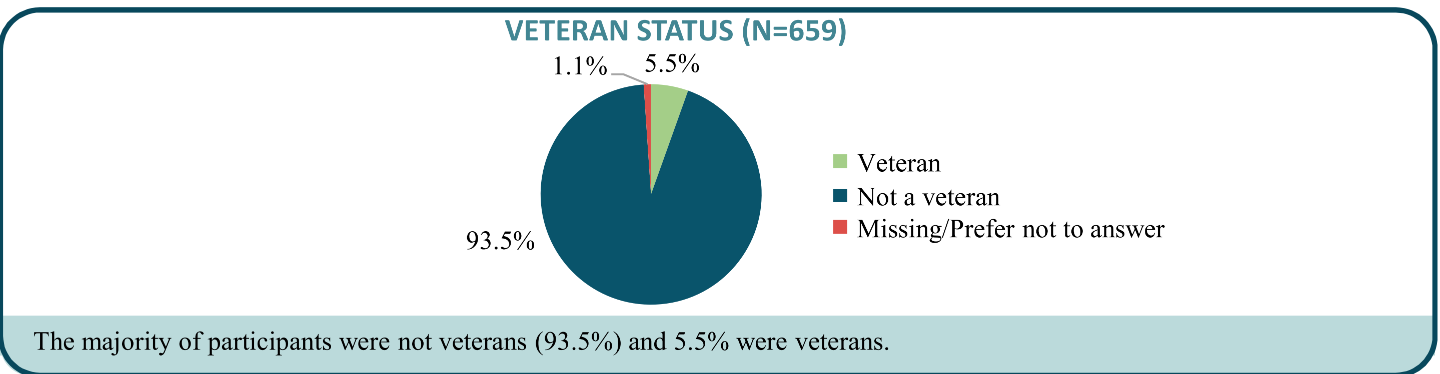
53.3% identified as male on their birth certificate, while 45.7% identified as female.



The large majority (95.1%) of participants spoke English as their primary language.



76.2% of participants identified as heterosexual or straight, 7.1% as gay or lesbian, and 7.7% bisexual/pansexual/sexually fluid.

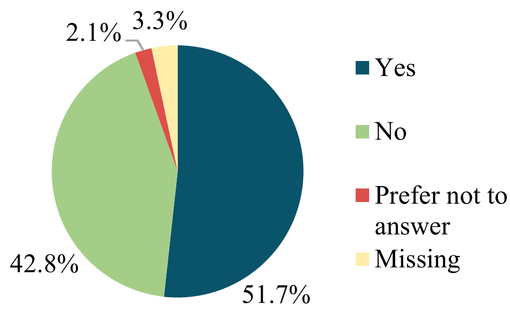


The majority of participants were not veterans (93.5%) and 5.5% were veterans.

[1] Percentages may not total to 100% due to rounding. *Other includes Transgender male/trans man, Questioning/unsure of gender identity, and Another gender identity. **Other includes American Sign Language, Arabic, Cambodian, Japanese, Vietnamese, and Other. ***Other includes Queer, Questioning/unsure of sexual orientation, and Another sexual orientation.

PEERLINKS PROGRAM PARTICIPANT DEMOGRAPHICS (CONTINUED)

DISABILITY STATUS (N=659)[2]



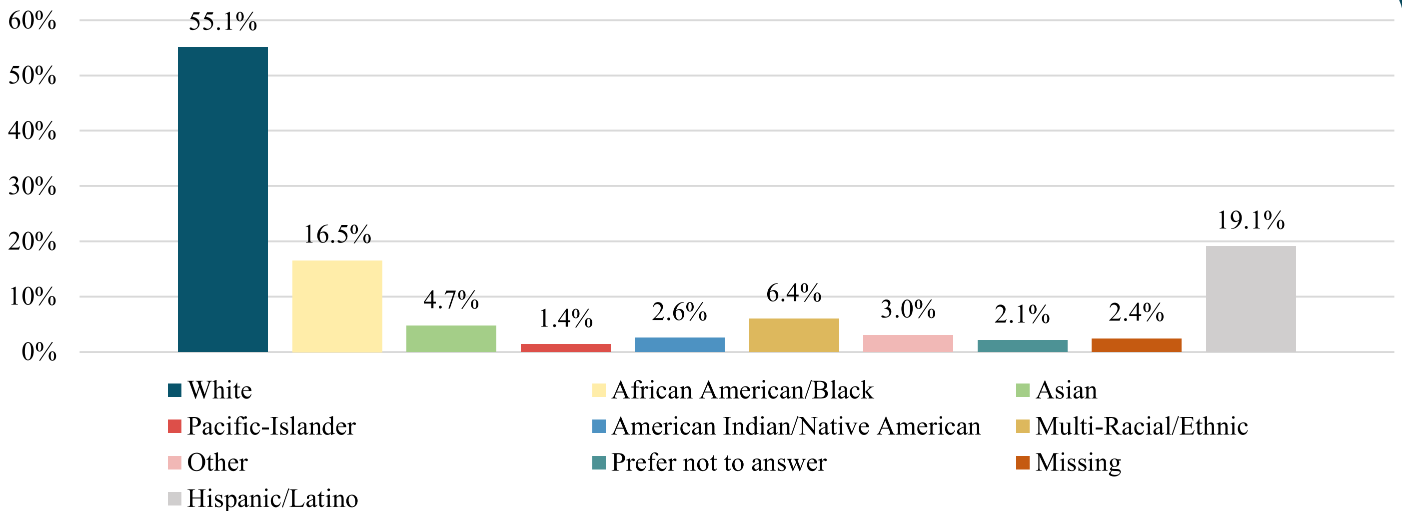
All participants had SMI. In addition, a total of 51.7% reported having some type of non-SMI related disability.

TYPE OF DISABILITY (N=659)

Type	N	%
Communication disability	92	14.0
Mental disability (e.g., learning)	85	12.9
Physical disability	76	11.5
Chronic Health Condition	114	17.3
Other	129	19.6

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

RACE/ETHNICITY (N=659)



The majority of participants were White/Caucasian (55.1%), 16.5% were African American/Black, and 19.1% identified as Hispanic/Latino ethnicity. Totals exceed 100% as participants were able to indicate more than one race/ethnicity.

[2] A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a Serious Mental Illness (SMI). Data includes communication disability, mental disability, physical/mobility disability, and other. Communication disabilities include difficulty seeing, difficulty hearing or having speech understood, and other communication disability. Mental disabilities not related to mental illness include learning disability, developmental disability, dementia, and other mental disability not related to mental illness. Physical/mobility disabilities include chronic health condition/chronic pain.

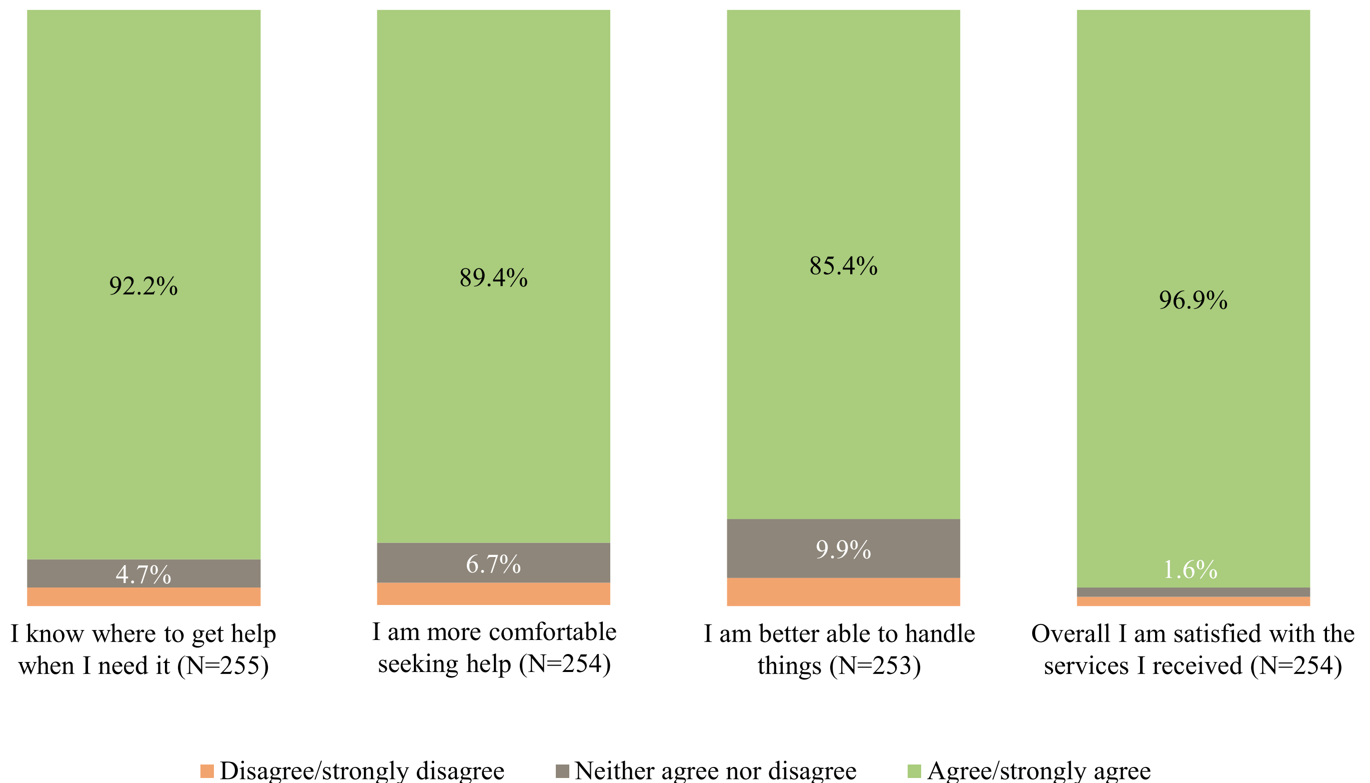
The key evaluation findings are based on a comprehensive set of assessment tools used by PeerLINKS. The assessments are administered by Peer/Family Support Specialists and other trained mental health professionals. They include participant demographics, key outcome domains (housing, employment, and critical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

PARTICIPANT SATISFACTION AND PARTICIPANT-RATED OUTCOMES

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

Overall, the large majority of participants agreed or strongly agreed that as a result of the PeerLINKS program, they know where to get help when needed (92.2%), are more comfortable seeking help (89.4%), and are better able to handle things (85.4%). The large majority of participants agreed or strongly agreed that they were satisfied with the services they received at PeerLINKS (96.9%).

Figure 1: Participant Satisfaction and Participant Rated Outcomes



MILESTONES OF RECOVERY SCALE (MORS)

The Milestones of Recovery Scale (MORS) captures recovery as assessed by trained staff using a single-item recovery indicator. Participants are being placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the past month. Although MORS ratings do not comprise a linear scale, higher ratings are associated with greater recovery. The MORS is completed at baseline and at regular follow-up assessments (the most recent follow-up assessment can be at 1, 2, 3, 6, 9, 12 months, or discharge, whichever comes sooner).

Changes in MORS Ratings Over Time

A total of 271 participants had valid MORS assessments at two (or more) points in time. The data matching process selected the most recent complete MORS follow-up assessment during the reporting timeframe (i.e., FY 2016-17 to FY 2018-19) and matched this to the baseline assessment. The average duration between the baseline and most recent MORS assessment was approximately 4.4 months (134 days).[3]

Overall, MORS scores from these 271 participants have been increasing from an average of 2.2 to 4.8 (summarized in Figure 2). This increase was statistically significant. Specifically, as shown in Figure 3, 86.0% of participants improved on the MORS and 10.3% remained stable (no change in score). Only 3.7% decreased.

Figure 2: Change in Average MORS Scores (Pre-post, N=271)

Figure 3: Change in MORS Scores (Pre-post, N=271)

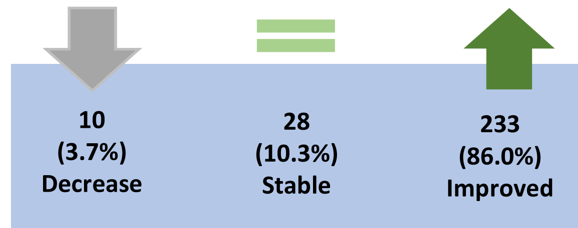


Table 1 compares the distribution of MORS scores at baseline and the most recent follow-up assessment.[4] At baseline, 90.0% of participants had MORS scores within the extreme risk and high risk categories (scores 1-3) and only 7.3% had scores at or above 5. In contrast, at follow-up 21.4% had scores in the extreme/high risk categories, and 72.3% scored 5 or above.

Table 1: MORS Ratings (Pre-post; N=271)

		Baseline		Most recent	
1	Extreme Risk	41.3%		2.2%	
2	High Risk/Not Engaged with mental health providers	17.7%	90.0%	3.7%	21.4%
3	High Risk/Engaged with mental health providers	31.0%		15.5%	
4	Poorly Coping/Not Engaged with mental health providers	2.6%	2.6%	6.3%	6.3%
5	Poorly Coping/Engaged with mental health providers	6.6%		46.1%	
6	Coping/Rehabilitating	0.7%	7.3%	21.4%	72.3%
7	Early Recovery	0.0%		3.3%	
8	Advanced Recovery	0.0%		1.5%	

[3] The average duration was calculated for participants with a valid baseline and most recent follow-up MORS who had only been enrolled in the program once (N=240). The average baseline and most recent follow-up MORS score (2.2 and 4.8) was the same for the N=240 participants and the slightly larger sample of N=271 participants. [4] Percentages may not total to 100% due to rounding.

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

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

Changes in Participants' Active Social Support and Recovery Network

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

Table 2: Mean CHAMPSSS Active Social Support and Recovery Network Items at Baseline and Follow-up (Pre-post)

CHAMPSSS Item	N	Baseline		Follow-up	
		M	SD	M	SD
In general, how would you rate your satisfaction with your social activities and relationships? (Item 5)	266	2.0	1.1	2.5	1.1
I had contact with people that care about me. (Item 10)	261	3.2	1.2	3.7	1.0
Outside of health care professionals, how many individuals actively support you in your recovery? (Item 32)	239	3.2	4.6	4.9	8.0

[5] Item 30 "How would you rate your pain on average" ranges from 0-10 but was recoded to a 5-point scale. Participants can enter any value for Item 32 "Outside of health care professionals, how many people actively support you in your recovery?".

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

Changes in CHAMPSSS Subscales

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

Table 3: Mean CHAMPSSS Subscale Scores at Baseline and Follow-up (Pre-post)

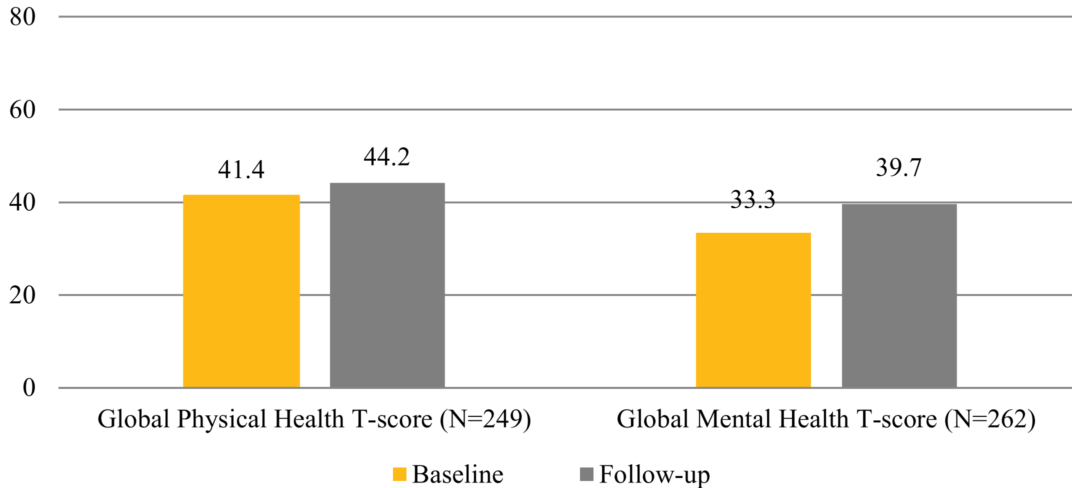
CHAMPSSS Subscale	N	Baseline		Follow-up	
		M	SD	M	SD
Global Health Scale (average of items 1-7, 25, 29, and 30)[6]	269	2.6	0.6	2.9	0.8
Resilience Scale (average of items 8, 9, 10, 11, and 12)	268	3.2	0.8	3.5	0.8
Depression Scale (average of items 13, 14, and 15)	267	2.3	0.9	3.1	0.9
Anger Scale (item 16)	264	3.0	1.1	3.5	1.0
Anxiety Scale (average of items 17, 18, and 19)	266	2.4	0.9	3.1	1.0
Substance Use Scale (average of items 20 and 21)	265	3.7	1.3	4.3	1.0
Memory/Cognition Scale (average of items 22 and 23)	265	2.9	1.1	3.4	1.1
Suicidality Scale (item 24)	265	3.3	1.3	4.2	1.0
Impact of Symptoms Scale (item 26)	260	2.6	1.0	3.1	0.8
Substance Use Frequency Scale (average of items 27 and 28)[5]	264	4.6	0.7	4.6	0.8

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

PROMIS GLOBAL HEALTH

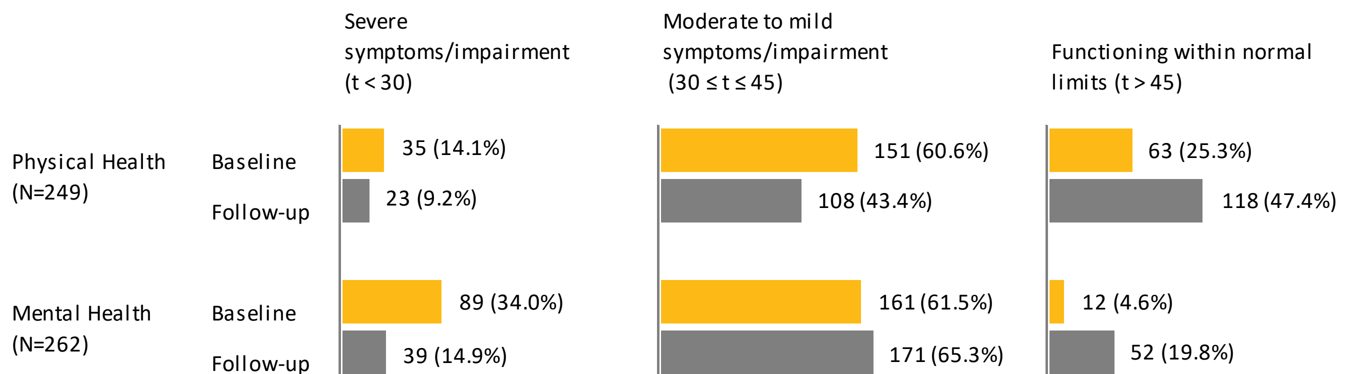
The PROMIS Global Health Scale is a 10-item patient-reported assessment of symptomatology, functioning, and health-related quality of life including physical health, mental health, and social health. PROMIS Global Health scores have been converted into T-score values. T-scores are standardized such that a score of 50 represents the average for the general population, and the standard deviation around the mean is 10 points. As a rule of thumb, half a standard deviation (5 points on the T-score metric) can be viewed as an estimate of a meaningful change.[7]

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



On average, PeerLINKS participants demonstrated improvement in both Global Physical Health and Global Mental Health scores (Figure 4). The improvement on the Global Mental Health Scale suggested a meaningful change. Average T-scores were in the moderate to mild range of functioning/impairment, with participants' average level of physical health being higher (better) compared to their mental health. Figure 5 provides additional breakdowns of participant groups by levels of symptoms/functioning. Figure 5 provides additional breakdowns of participant groups by levels of symptoms/functioning.

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



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

PROMIS-DERIVED SUBSTANCE USE

Table 4 shows participants' answers to substance use related questions at baseline and most recent follow-up assessment. Items are scored on a scale from almost always=1 to never=5, with higher scores indicating less substance use treatment need. Participants were reporting on the past 7 days. On average, participants showed improvement across the 10 substance use items. The improvement in responses to all items with the exception of "I used alcohol or substances throughout the day" were statistically significant. The average scores across all items was 4.2 at baseline and 4.6 at the most recent assessment and the improvement was statistically significant.

Table 4: PROMIS-Derived Substance Use

PROMIS Derived Substance Use Items	N	Baseline		Follow-up	
		M	SD	M	SD
I used alcohol or substances throughout the day.	192	4.5	1.1	4.7	0.9
I had an urge to continue drinking or using substances once I started.	192	4.2	1.3	4.5	1.0
I felt I needed help for my alcohol or substance use.	191	3.9	1.5	4.5	1.1
I took risks when I used alcohol or substances.	191	4.3	1.3	4.6	0.9
I felt guilty when I used alcohol or substances.	186	4.2	1.4	4.5	1.1
Others complained about my alcohol or substance use.	190	4.2	1.3	4.7	0.9
Alcohol or substance use created problems between me and others.	190	4.2	1.4	4.6	1.0
Others had trouble counting on me when I used alcohol or substances.	193	4.2	1.3	4.6	1.0
I felt dizzy after I used alcohol or substances.	192	4.3	1.2	4.7	0.9
Alcohol or substance use made my physical or mental health symptoms worse.	193	4.1	1.5	4.7	0.9
Mean PROMIS-Derived Substance Use (average of items 1-10)	193	4.2	1.1	4.6	0.8

HOUSING

A total of 41.9% of participants moved into less restrictive and more independent housing level and for 41.9% of participants, the housing level remained unchanged. Only 16.3% of participants moved to more restrictive/less independent housing (Figure 6).

Figure 6: Housing Levels Summary (Pre-post, N=203, Excluding Other or Unknown Housing Levels)

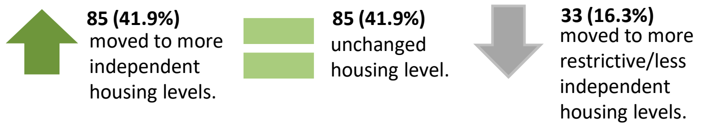


Figure 7 shows the percentage of participants in each housing level as reported for the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=203). The average housing level was 3.2 at baseline and 4.2 at the most recent assessment, indicating that, on average, the housing level improved. This increase was statistically significant.

Figure 7: Housing Levels (Pre-post, N=203, Excluding Other or Unknown Housing Levels)[8]

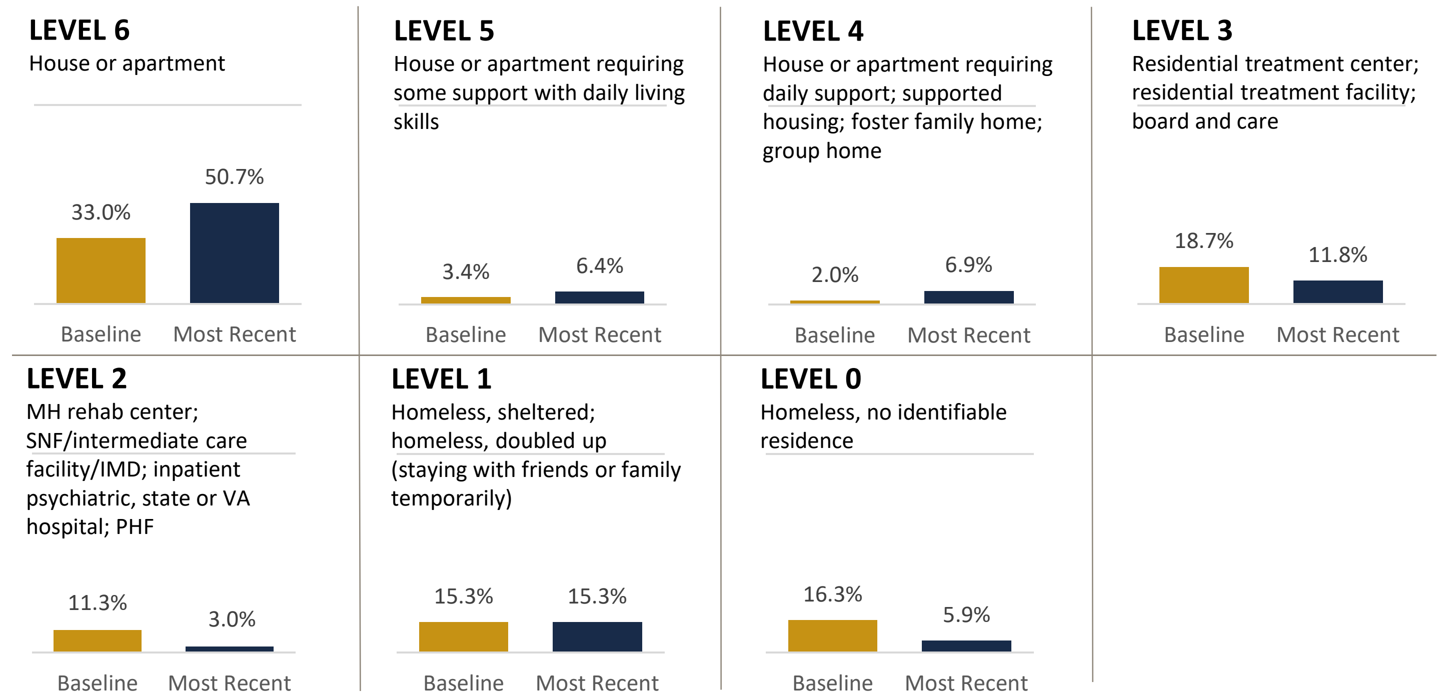


Table 5: Homeless Settings During Past 30 days (Pre-post, Excluding Other or Unknown Homeless Settings)

Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)	Baseline	Most Recent
# of participants unsheltered at least 1 day	69	24
# of Days	1203	509
Total participant responses	184	184

Sheltered (staying in emergency shelters or transitional housing)	Baseline	Most Recent
# of participants sheltered at least 1 day	49	36
# of Days	833	807
Total participant responses	185	185

Doubled-up (temporarily staying with friends or family)	Baseline	Most Recent
# of participants doubled-up at least 1 day	39	26
# of Days	733	640
Total participant responses	172	172

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

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

[8] Values <5 for Level -1 Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.) are de-identified and not shown to protect the confidentiality of the individuals summarized in the data.

EMPLOYMENT

Table 6 shows the percentage of participants in each employment level as reported in the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=203). The average employment level (for participants with Levels 0-4 at baseline and most recent assessment) increased from 0.5 to 0.9. This increase was statistically significant. The percentage of participants who selected not employed decreased from 83.7% to 68.0%. The percentage of participants who were competitively employed increased from 8.9% to 16.7%.

Table 6: Employment Levels (Pre-post, N=203)

Employment Level	Baseline		Follow-up	
	N	Percent	N	Percent
Level 0: Not employed	170	83.7%	138	68.0%
Level 1: Volunteer/job training/other gainful/employment activity	5	2.5%	5	2.5%
Level 2: Paid in-house work	2	1.0%	1	0.5%
Level 3: Transitional employment/enclave/supported employment	1	0.5%	6	3.0%
Level 4: Competitive employment	18	8.9%	34	16.7%
No employment level: student, retired, homemaker	12	5.9%	24	11.8%
Total responses	208	102.5%	208	102.5%
Total number of participants	203	100.0%	203	100.0%

Note: Percentages exceed 100% due to multiple responses. Statistical significance was calculated on a matched sample of n=180 participants with a Level 0-4 at baseline and most recent follow-up.

Table 7 shows the reasons for unemployment for participants who had been unemployed at both time points where the reason was available (N=78). The majority were unemployed due to mental health symptoms or disability.

Table 7: Reasons for Unemployment (Pre-post, N=78)

Reasons for Unemployment	Baseline		Follow-up	
	N	Percent	N	Percent
Disabled	24	30.8%	18	23.1%
Mental Health Symptoms	58	74.4%	55	70.5%
Other	11	14.1%	10	12.8%
Total responses	93	119.2%	83	106.4%
Total number of participants	78	100.0%	78	100.0%

Note: Percentages exceed 100% due to multiple responses.

LINKAGES TO SERVICES

PeerLINKS uses the Linkage and Referral Tracker, which is a tool that helps Peer/Family Support Specialists and other healthcare professionals track the discussions, referrals, linkages, and successful connections they make to other services, and whether these linkages were successful.[9] The Linkage and Referral Tracker was specifically designed for programs that focus mainly on connecting people with needed services, rather than providing treatment themselves. It can also be used as a shared decision-making tool with participants and to help set their personal goals for recovery and wellness.

Table 8 quantifies the discussions, referrals, linkages, and the extent of the successful connections. A total of 3,490 successful connections were made during the reporting period. Specifically, for the mental health dimension, 592 successful connections were made for 237 unique participants. For the substance abuse dimension, 225 successful connections were made for 94 unique participants.

Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection (not shown in table).

Table 8: Linkage and Referral Tracker Summary (N=651)

Dimension of Wellness	Linkage and Referral Tracker Actions			
	Discussed (Unique Participants)	Referred (Unique Participants)	Linked (Unique Participants)	Successfully Connected (Unique Participants)
Physical Health	1776 (n=603)	260 (n=161)	102 (n=66)	282 (N=127)
Social Health	1697 (n=508)	352 (n=166)	91 (n=58)	324 (N=129)
Mental Health	4203 (n=616)	1037 (n=369)	307 (n=159)	592 (N=237)
Substance Abuse	2208 (n=558)	373 (n=172)	100 (n=62)	225 (N=94)
Housing	3287 (n=614)	859 (n=291)	282 (n=145)	360 (N=177)
Occupation/Education	1738 (n=524)	302 (n=140)	108 (n=63)	166 (N=80)
Financial Assistance/Benefits and Legal	2688 (n=595)	588 (n=240)	201 (n=111)	267 (N=136)
Transportation	1313 (n=588)	189 (n=138)	91 (n=66)	349 (N=188)
Identification	1296 (n=554)	125 (n=79)	64 (n=40)	110 (N=72)
Basic Needs	2283 (n=573)	359 (n=168)	166 (n=86)	815 (N=329)
Total	22489 (n=649)	4444 (n=518)	1512 (n=351)	3490 (N=455)

[9] Definition of actions: Discussed – talked about a specific tool and/or service with participant (e.g., discussed prospect of the participant renting an apartment); Referred – provided a participant with information (e.g., a phone number or address) about a specific tool and/or service to enable the participant to obtain that tool and/or service on his/her own; Linked – made an appointment for a participant to obtain a specific tool and/or service (e.g., made an appointment for the participant to meet with a leasing agent to complete a rental application); Successfully Connected – confirmed that the participant actually obtained a specific tool and/or service (e.g., if the participant submitted a rental application and obtained an apartment)

Tables 9 shows Mental Health service data based on Linkage and Referral Tracker entries for participants who had been in the program for at least 30 days. Of those 412 participants who had been in the program for at least 30 days (not shown in table), 336 had either a referral or linkage across the mental dimension and 213 were successfully connected, i.e., a successful connection rate of 63.4% (Table 9).

The following caveats need to be noted. Participants who had been successfully connected and left the program within less than 30 days will have been excluded from this analysis. The column "Unique Participants Referred or Linked" shows the count of the unique number of participants who have either been referred, linked, or had a successful connection without a preceding referral or linkage (i.e., a referral or linkage was implied). A successful connection may not necessarily mean that the program initiated a preceding referral/linkage; the program could have provided services to support the participant to attend ongoing services.

Table 9: Mental Health Service Successful Connection Rate for Participants in the Program for at Least 30 Days (N=336 participants referred or linked; N=412 participants had been in the program for at least 30 days)

Type of Mental Health Service	Unique Participants Referred or Linked	Unique Participants Successfully Connected	% Successfully Connected
Independent psychiatrist	41	23	56.1%
Private counselor/therapist	65	26	40.0%
Specialty mental health clinic	193	99	51.3%
Primary care provider	17	6	35.3%
Behavioral health within primary care clinic	50	23	46.0%
Intensive outpatient/day treatment	61	26	42.6%
Inpatient treatment	44	33	75.0%
Crisis house	55	26	47.3%
Self-help groups e.g., WRAP, Road to Recovery	94	34	36.2%
Clubhouse	129	44	34.1%
Other	127	58	45.7%
Total	336	213	63.4%

CRITICAL EVENTS (BASED ON mHOMS DATA)

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

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

Physical health related	Baseline	Most Recent
# of participants with at least 1 service	38	10
# of services	52	14
Total participant responses	179	179

Mental health/substance use related	Baseline	Most Recent
# of participants with at least 1 service	137	21
# of services	217	42
Total participant responses	190	190

Physical AND mental health/substance use related	Baseline	Most Recent
# of participants with at least 1 service	29	DID*
# of services	51	6
Total participant responses	172	172

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

Non-psychiatric hospitalization	Baseline	Most Recent
# of participants with at least 1 encounter	18	DID*
# of encounters	28	8
Total participant responses	175	175

Jail/prison	Baseline	Most Recent
# of participants with at least 1 encounter	9	DID*
# of encounters	11	DID*
Total participant responses	186	186

Note. *Values <5 are de-identified (DID) and not shown to protect the confidentiality of the individuals summarized in the data.

The number of participants and the number of encounters participants had with non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up (Table 11). It should be noted that some participants who are experiencing critical events at baseline and at follow-up may have a higher level of need and may require additional support.

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

The utilization of Behavioral Health Services by PeerLINKS participants was examined 30 days before and after starting the PeerLINKS program in order to assess recurrence rates (see Table 12). Participants who were enrolled in PeerLINKS prior to 07-01-2019 and had an index event (i.e. the psychiatric hospitalization or crisis residential treatment episode that occurred around the time of enrollment) identified in CCBH data were included in this analysis. The pre-30-day recurrence rate is determined by whether a prior admission ended within 30 days before the start of the index event. The post-30-day recurrence rate is determined by whether a subsequent admission started within 30 days after the end of the index event.

Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

Table 12: 30-Day Recurrence Rates for PeerLINKS Participants (N=480)[10]

	Number of participants included in each cohort	Participants with at least one recurrence event within 30 days prior to PeerLINKS enrollment[11]	30-day recurrence rate prior to PeerLINKS enrollment[11]	Participants with at least one recurrence event within 30 days after PeerLINKS enrollment[12]	30-day recurrence rate after PeerLINKS enrollment[12]
Hospital Cohort	197	42	21.3%	31	15.7%
Crisis Residential Cohort	283	33	11.7%	36	12.7%

Note: [10] Includes participants enrolled in PeerLINKS from 07-01-2016 to 06-30-2019 with an index event (i.e., hospitalization or crisis residential treatment episode) identified in Cerner. [11] 30-day recurrence rate prior to PeerLINKS enrollment determined by whether a prior admission ended within 30 days before the start of the index event. [12] 30-day recurrence rate after PeerLINKS enrollment determined by whether a subsequent admission occurred within 30 days after the end of the index event.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year of providing the program services, administrative and Peer/Family Support Specialist staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. For the open-ended survey questions, at least two evaluators reviewed and coded the responses independently. Any discrepancies were discussed to arrive at a consensus on the key response themes. The following represent key findings identified via qualitative analyses of the open-ended staff survey response across three annual surveys.

1. *Key program "innovations" or factors that make this program unique:*
   - Program services rendered come from peers with lived experience.
   - Participant-centered support provided by peers.
   - Staff ability to link participants to community resources and external connections.

2. *Major program goals identified by respondents:*
   - Providing peer support to participants.
   - Linking participants to resources in the community.
   - Reducing participant readmissions to hospitals and crisis homes.
   - Enrolling participants in PeerLINKS.

3. *Factors that helped the program achieve these goals:*
   - Staff access to community services and resources for participants.
   - Knowledgeable team with a variety of skills for staff to rely on for support.
   - Compassion for participants, rapport with participants.
   - Collaboration between PeerLINKS staff, other service providers, behavioral health team, etc.
   - Peer support that staff provide to participants.

4. *Specific challenges to reaching the program goals described by respondents:*
   - Participant related factors (e.g., losing contact with participants, lack of participant engagement).
   - Lack of available housing in San Diego County.
   - Administrative and documentation processes (e.g., challenges to make referrals to services that participants would like to be connected to, long wait times for external services).
   - Lack of resources and/or staffing.

5. *Tools and supports needed to do job well as defined by respondents:*
   - Support from leadership.
   - A well-equipped work environment (e.g., adequate workspace, computer technology/electronic health record).
   - Continued staff training (e.g., peer support training, self-care training, mental health training).
   - Clear roles and expectations including program processes.
   - Team support/team building.
   - Staff development/reward.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

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

1. Participant referral and engagement

- **Engaging regularly with referral sites:** The program served adults living with a Severe Mental Illness, who had multiple acute care visits and were not effectively connected to resources/services or lacked a strong support network. Referrals were received from each referral site on a regular schedule. Visiting sites regularly, particularly during the early stages of the program, allowed PeerLINKS staff to build trust with the sites' staff and to provide and clarify information about the program or referral.
- **Connecting participants to case management and the "right level of care":** To increase the team's awareness and understanding of the various case management programs, the program co-organized a Case Management Panel where representatives from several case management teams and programs from San Diego County were represented. Discussing participants' need and eligibility for case management became an additional part of the individual weekly supervision of the Behavioral Health Clinician with each Peer/Family Support Specialist. All participants who were appropriate for case management services and were open to being connected to this service were referred to case management. While many of the participants were connected to the appropriate level of care based on the participants meeting eligibility and criteria, the program found that for some participants, "the right level of care" was the one in which the participant was willing and able to engage with.
- **Rebuilding participants' family ties:** The PeerLINKS team found that far less family members of participants were involved in the lives of participants than what had originally been anticipated by the program. The program supported participants with rebuilding ties to family, and supported family members as needed.
- **Providing flexibility in facilitating Program Advisory Groups:** Given that PeerLINKS meets participants in the community and there is no common place where participants visit the program regularly, quarterly program advisory groups tended to have low participant attendance. Despite the attendees providing valuable insights and ideas, the program felt that it would be beneficial to be allowed to hold several individual interviews instead. This would likely yield higher participation and would cause less of a burden for each participant (i.e., no need to travel to participate). This would also allow participants who are uncomfortable in groups to be able to participate.
- **Checking-in with participants post closure:** A post-closure follow-up phone call was implemented in early 2019 in order to check-in with participants approximately three months and six months after they had graduated or left the program. The program found that many participants had changed phone numbers and, thus, staff were unable to reach them; this was especially true when participants were called six months after their closure.

2. Connecting participants to external resources

- **Challenges connecting participants to housing resources:** A large proportion of participants lack housing and any form of income. PeerLINKS did not have dedicated funds for housing, or housing vouchers available. A key learning for future programs that wish to provide similar services to a high proportion of individuals who are experiencing homelessness or at risk for homelessness, is to have access to sufficient housing funds, dedicated beds and vouchers. During the second year of the program, PeerLINKS was able to access information and enter participants into the Homeless Management Information System/Coordinated Entry System (HMIS/CES) and refer participants to a Housing Navigator within CES. Additionally, the program continued to refer participants to housing programs and navigators if the participant was interested in receiving such services.
- **Flexibility in using additional funds:** During the second and third year of the program, NAMI San Diego obtained a donation to provide items important for participants' recovery and well-being which augmented the program's limited budget for these items. For example, the PeerLINKS program used donor funds to buy home/kitchen/cleaning items for participants who obtained their own apartment/home following lengthy periods of homeless or transitional housing. Additionally, PeerLINKS received generous donations from several locally-based businesses and individuals, specifically: nearly 150 items (toiletries, towels and sleeping bags) from employees of a commercial real estate company, gift-certificates for free haircuts from the owner of a local hair salon, and free pet food from a small pet store/veterinary's office.

3. Peer/Family Support Specialists

- **Recruiting diverse workforce of Peer/Family Support Specialists:** Peer/Family Support Specialists were recruited from a variety of sources including, e.g., posting on RI International's listserv for graduates of Peer Employment Training (PET), NAMI Sand Diego's listserv for graduates of Peer/Family Support Specialist training, and Peer/Family Support Specialist Job Clubs. Over the course of the program, PeerLINKS had a diverse team including individuals from various backgrounds (including varied ethnic backgrounds, ages, gender, and members of the LGBTQ community). Nonetheless, applicants to the Peer/Family Support Specialist position tended to be predominantly female, thus, it was a challenge for the program to maintain a representation of other genders on the team at all times.
- **Establishing career progression for Peer/Family Support Specialists:** The program included two Peer/Family Support Specialist leadership positions, specifically Team Leads. Over the course of the program, PeerLINKS realized that the team needed additional career progression opportunities. These opportunities are being implemented going forward.
- **Clarifying the role of the program and Peer/Family Support Specialist:** Peer/Family Support Specialists reported to experience certain barriers in accessing services for participants, which was partly attributed to a perceived lack of awareness of their role. PeerLINKS took various approaches to clearly communicate the role, purpose, and limits of the work of the Peer/Family Support Specialist as well as the program to participants, referring agencies, and external programs. PeerLINKS created a Partnership Agreement Form which was reviewed with all potential participants before they enrolled in the program. An abbreviated form was also created and shared with referral sites. A program brochure that provided an overview of the program was created for outreach purposes.
- **Multiple Peer/Family Support Specialists supporting a participant:** Whenever possible, the Peer/Family Support Specialist who was assigned to work with a participant provided support throughout the program participation. However, this was not always feasible. At times, it had been logistically necessary to have the initial or intake visit completed by one team member and for another to be assigned as the Peer/Family Support Specialist. This had an unforeseen benefit, especially when the participant's assigned Peer/Family Support Specialist was not available (e.g., on vacation), as there was another individual on the team that the participant had met and was comfortable to work with.

PROGRAM CHANGES FROM INITIAL DESIGN

There were no changes to the INN-15 PeerLINKS program that differed substantially from the initial design over the course of the service provision (7/1/2016 to 6/30/2019). Some basic practices and procedures were adjusted across the three year period, as described in a number of enhancements to the program under "Key Program Implementation and Operational Learnings." However, no fundamental or program-wide changes were made.

FUTURE DIRECTIONS

Based on the positive findings from the INN-15 PeerLINKS innovations program, County of San Diego Behavioral Health Services dedicated ongoing Community Services and Supports Program (CSS) funding to continue the PeerLINKS program. This funding allowed the structure and operations of the program to continue uninterrupted. Under the new contract, Peer Assisted Supportive Services, began services on 8/1/2019. The new contract increased the number of unique participants served per year and expanded to a third crisis residential program. Participants are able to remain in the program up to 6 months.

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

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URBAN BEATS
(INNOVATIONS-16)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 4 (7/1/18 - 6/30/19)

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

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

EXECUTIVE SUMMARY

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

- During FY 2018-19, a total of 200 new, unduplicated TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial diversity in race/ethnicity, language, sexual orientation, and gender identity. However, females comprised a much smaller proportion than males (28.5% and 64.5%, respectively).
- Analyses indicate a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g., inpatient psychiatric hospitalizations, crisis residential treatment, emergency/crisis-oriented psychiatric visits).
- Urban Beats appears to improve attitudes regarding mental health services as participants indicated they felt more comfortable talking to mental health professionals and were more likely to think that professional mental health services were effective for improving mental health.
- Over 80% of participants reported being satisfied with Urban Beats, with the majority indicating that, as a result of the program, they knew better where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms.
- Of participants who had at least one session with the "in-house" clinician (n=40), the majority (75%) received trauma informed therapy services. Approximately 5% of all clinical sessions included a focus on crisis interventions.
- The Urban Beats program increased the number of community performances to 42 (from 28 in FY 2017-18), with attendees completing 958 outcomes surveys.
- Urban Beats staff identified the following key factors that helped achieve program goals: 1) collaborations and partnerships in the community, 2) intensive outreach and engagement, 3) offering art as a focus, and 4) program design (e.g., unique resources, individual mentoring).

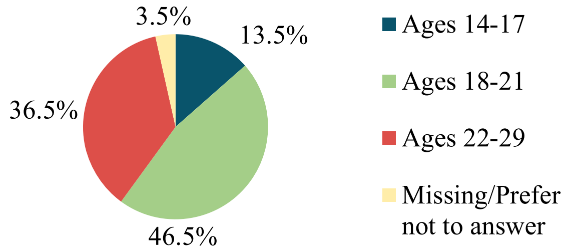
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) implement a process for following up with TAY after program completion, 2) explore mandatory clinical services, 3) attend/participate in quarterly health fairs, 4) incorporate specialized services for TAY not interested in the program or other "in-house" services, 5) create/implement curriculums for unique TAY populations, and 6) consider omitting Twitter and Sound Cloud from data tracking.

PARTICIPANT CHARACTERISTICS[1]

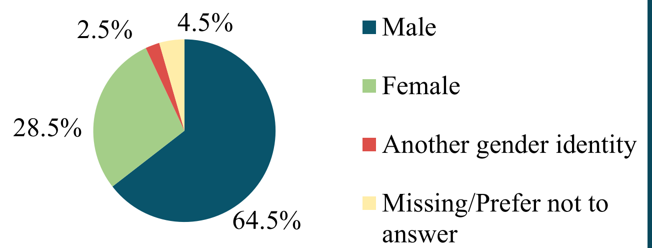
The following self-reported characteristic data were collected from participants during the initial or follow-up visit.[1]

AGE (N=200)



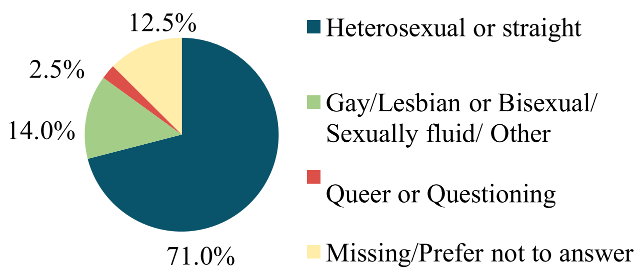
Most participants (46.5%) were between the ages of 18 and 21, with 36.5% between the ages of 22 and 29.

GENDER IDENTITY (N=200)



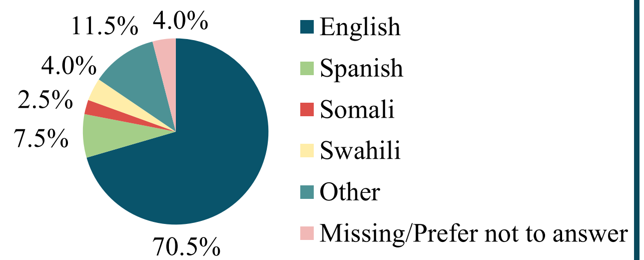
About two-thirds (64.5%) of participants were male and 28.5% of participants were female.

SEXUAL ORIENTATION (N=200)



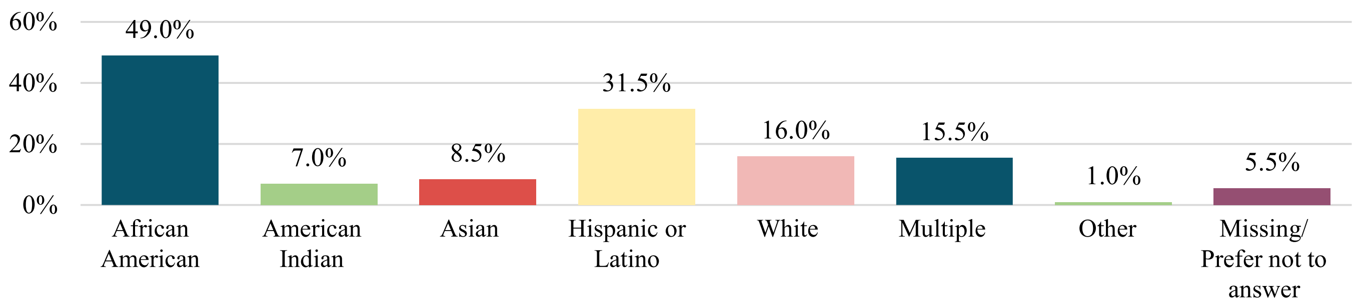
The majority (71.0%) of participants identified as heterosexual or straight.

PRIMARY LANGUAGE (N=200)



The majority (70.5%) of participants spoke English as their primary language.

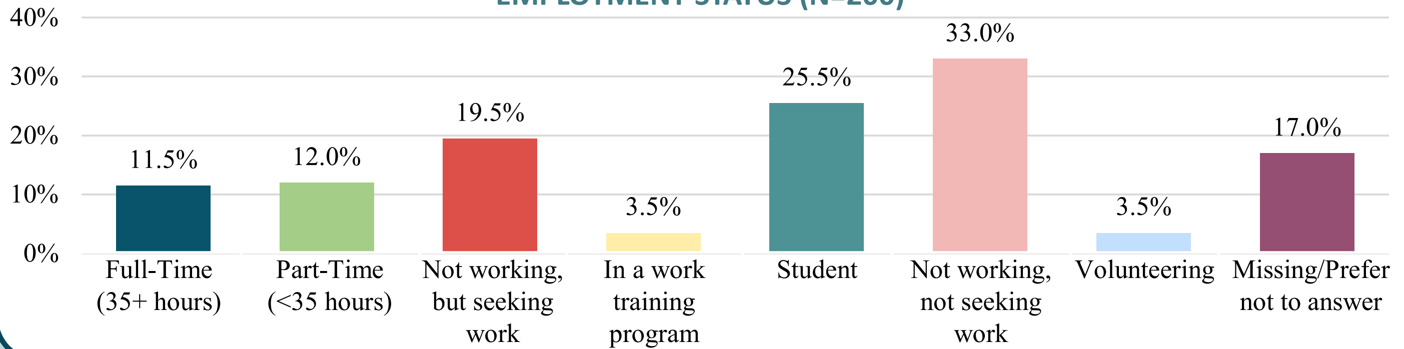
RACE/ETHNICITY (N=200)



Most participants identified either as African American (49.0%) or Hispanic or Latino (31.5%). Totals may exceed 100% since participants could indicate more than one race/ethnicity.

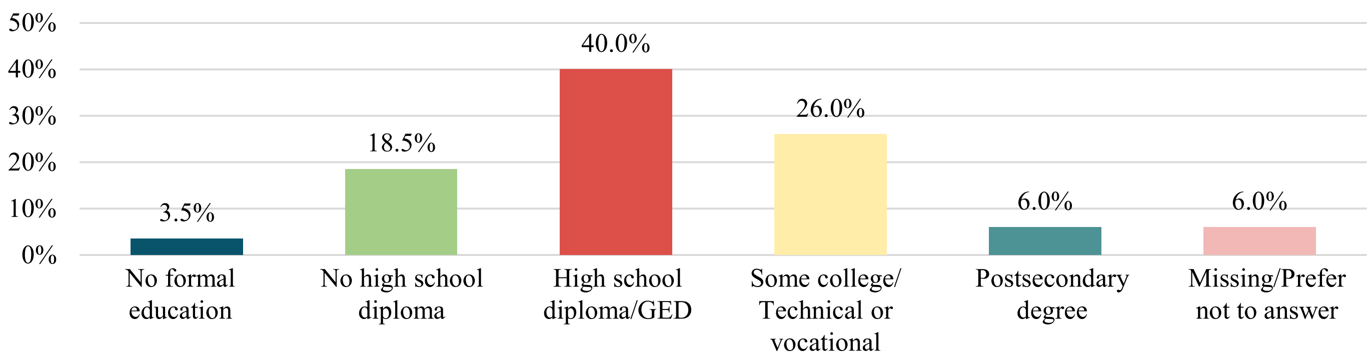
[1] *Percentages may not total to 100% due to rounding.*

EMPLOYMENT STATUS (N=200)



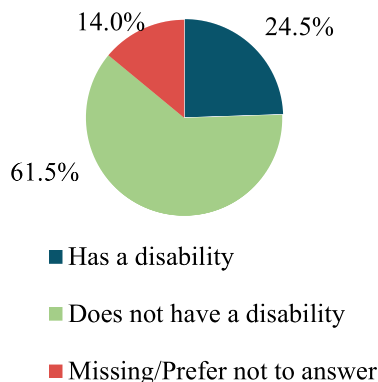
About 25% of participants indicated that they were working (11.5% full-time and 12.0% part-time) and 19.5% were not working, but seeking work. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=200)



Close to two-thirds (62.0%) of participants indicated they had a high school diploma/GED or lower level of education. 26.0% indicated they had some college/technical or vocational education.

DISABILITY[2] STATUS (N=200)



Approximately one-quarter (24.5%) of participant reported having some type of non-SMI disability.

The majority (90%) of participants had never served in the military.

TYPE OF DISABILITY (N=200)

Type	n	%
Seeing	18	9.0
Hearing	< 5	< 2.5
Other Communication	< 5	< 2.5
Learning	23	11.5
Developmental	< 5	< 2.5
Other Mental	< 5	< 2.5
Physical	< 5	< 2.5
Chronic Health	5	2.5
Other	5	2.5

This table indicates the non-SMI disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

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

KEY EVALUATION FINDINGS

BHS BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of behavioral health services by Urban Beats participants was examined 180 days before and 180 days after starting the Urban Beats program. To ensure that everyone included in the analyses had the entire 180 days to be observed for any behavioral health service utilization after starting Urban Beats, the analyses only included participants (n=438) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2019).

As shown in Table 1, nearly one-quarter (23.3%) of the 438 Urban Beats 'life-of-program' participants included in the 180-day analyses had attended at least one behavioral health outpatient visit within the 180 days prior to starting the Urban Beats program. Approximately thirteen percent (12.8%) participated in Assertive Community Treatment (ACT) in the 180 days before entering Urban Beats. There was little change in participation rates for these services in the 180 days after starting the Urban Beats program. There was a small decrease in participation rate for outpatient visits (22.1%), while the participation rate and number of total visits for ACT had a modest increase (13.2%; 2,251 vs 2,451 visits).

While less frequent overall, the findings in Table 1 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) contacts, emergency psychiatric hospital visits, inpatient psychiatric hospitalizations, and justice-related mental health services (e.g., services received while in jail or participating in behavioral health court proceedings), were utilized less often after participants had started the Urban Beats program. For example, while 8.0% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 4.8% (a 40% reduction in the hospitalization rate) had a hospitalization after starting Urban Beats (total admissions reduced from 35 to 21). There is also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (4.8% vs 1.1%; 21 vs 5 admissions).

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

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

	180 Days Before Start Urban Beats (n=438)			180 Days After Start Urban Beats (n=438)		
	Persons with at least one session	% of Urban Beats population	Sum of visits	Persons with at least one session	% of Urban Beats population	Sum of visits
Outpatient Visits	102	23.3	1,168	97	22.1	1,149
Assertive Community Treatment (ACT)	56	12.8	2,251	58	13.2	2,451
Case Management	0	-	0	0	-	0
Urgent Outpatient	29	6.6	47	21	4.8	29
Crisis Stabilization	19	4.3	25	8	1.8	14
Psychiatric Emergency Response Team (PERT)	22	5.0	28	12	2.7	17
Justice-Related Mental Health Visit	15	3.4	55	8	1.8	28
	Persons with at least one admission	% of Urban Beats population	Sum of admissions	Persons with at least one admission	% of Urban Beats population	Sum of admissions
Inpatient Psychiatric Hospital Admit	35	8.0	69	21	4.8	37
Crisis Residential Treatment	21	4.8	26	5	1.1	5

URBAN BEATS PARTICIPANT BELIEFS

Urban Beats participants were asked to complete a Wellness Survey, which includes select items from the Recovery Markers Questionnaire (RMQ), at the start of class, 6 weeks later, and at the end of the 20-week program. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in Table 2. The table presents the average rating at baseline and most recent follow-up for everyone involved in the program with both baseline and follow-up data (n=117). Additionally, to examine the potential for differing participant perspectives based upon their self-reported mental health status at baseline, findings are presented separately for those who indicated low mental heath (i.e., poor or fair; n=36) and high mental health (i.e., good, very good, or excellent; n=81).

Overall, at baseline, the most commonly endorsed statements (i.e., those with the highest means) focused on participants' beliefs about their self-efficacy (#11) and pursuit of goal achievement (#5). Participants appeared to be less enthusiastic about their stress management capabilities (#10) and having sufficient income (#3). These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

TABLE 2. URBAN BEATS PARTICIPANT BELIEFS—BASELINE AND FOLLOW-UP COMPARISONS

		Overall (n=117)		Baseline Mental Health: Low (n=36)		Baseline Mental Health: High (n=81)	
#	Item	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean
1	I have at least one close mutual relationship	4.0	4.1	3.7	3.9	4.1	4.2
2	I am involved in meaningful, productive activities	3.8	4.0	3.4	3.9*	4.0	4.0
3	I have enough income to meet my needs	2.9	3.1	2.4	2.8*	3.1	3.3
4	I am using my personal strengths, skills, or talents	3.8	3.9	3.4	3.6	4.0	4.1
5	I have goals I'm working to achieve	4.2	4.3	3.8	4.1	4.4	4.4
6	I contribute to my community	3.6	3.8	3.4	3.6	3.7	3.9
7	I have a sense of belonging	3.7	3.8	2.9	3.2	4.0	4.1
8	I feel hopeful about my future	4.0	4.1	3.6	3.9	4.2	4.2
9	I treat myself with respect	3.8	4.0*	3.0	3.4	4.2	4.2
10	I am able to deal with stress	3.3	3.6*	2.7	3.2*	3.6	3.8
11	I believe I can make positive changes in my life	4.1	4.3*	3.7	4.2*	4.3	4.4
12	Mental health services can effectively improve mental health	3.6	4.0*	3.6	4.0*	3.7	4.0*
13	I would feel comfortable talking to a mental health professional	3.5	3.9*	3.6	4.0*	3.5	3.9*

** Statistically significant change in mean rating scores, p<.05.; Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.*

Participants who self-reported having lower mental health at baseline typically also indicated lower baseline values across other Wellness Survey items. At follow-up, ratings across all items stayed the same or increased for both groups of participants, with the persons who indicated lower baseline mental health generally demonstrating larger improvements. Statistically significant changes unique to this group were evident in their participation in meaningful activities (#2), having sufficient income (#3), ability to manage stress (#10), and beliefs about personal positive self-efficacy (#11). These findings suggest that participants who felt more negative about their mental health upon entry into Urban Beats were typically able to experience significant improvements in multiple domains central to the goals of the program and persons who entered Urban Beats with more favorable beliefs about their mental health were able to maintain or slightly improve their already more positive outlook on these domains. For both groups, their attitudes regarding mental health services significantly improved, with initial scores of around 3.5 (i.e., neutral/agree) and follow-up scores around 4.0 (i.e., agree) in their sense that mental health services can improve mental health (#12) and feeling comfortable talking to a mental health professional (#13). These findings reflect success at improving perceptions about mental health services.

PARTICIPANT ASSESSMENT OF THE URBAN BEATS PROGRAM

As shown in Table 3 below, the vast majority (84.0%) of Urban Beats participants with follow-up Wellness Survey data indicated that they were satisfied with the Urban Beats program (#1; 38.0% agreed and 46.0% strongly agreed) and a similar percentage (82.9%) felt appropriately supported by the Urban Beats staff (#2; 36.4% agreed and 46.5% strongly agreed). Participants who indicated that they had lower mental health upon program entry tended to be slightly more favorable about their experiences with Urban Beats, particularly in regards to feeling appropriately supported by staff (96.3% agreed/strongly agreed as compared to 77.8%). This suggests that while Urban Beats staff effectively engaged with most participants, they were especially skilled at connecting with and supporting participants who were experiencing mental health related difficulties when they entered the Urban Beats program.

The majority indicated that as a result of participating in the Urban Beats program, they knew where to get help (#3; 82.0%), felt more comfortable seeking help (#4; 69.7%), dealt more effectively with daily problems (#5; 62.0%), and were less bothered by symptoms (#6; 61.0%). The results were fairly similar between the two group of Urban Beats participants, however, a slightly larger proportion of the participants who entered the program with more favorable perceptions of their mental health indicated they agreed or strongly agreed with experiencing these outcomes. These findings suggest that while most youth experienced a range of positive benefits from participating in the Urban Beats program, there continues to be a need for improvements, particularly among youth who enter the program with more significant mental health difficulties.

TABLE 3. URBAN BEATS PARTICIPANT ASSESSMENT OF URBAN BEATS PROGRAM

		Overall (n=100)			Baseline Mental Health: Low (n=27)			Baseline Mental Health: High (n=73)		
#	Item	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean
1	Overall, I am satisfied with the services I received	84.0%	38.0% (46.0%)	4.3	92.5%	44.4% (48.1%)	4.4	80.8%	35.6% (45.2%)	4.2
2	I felt appropriately supported by staff when I encountered challenges	82.9%	36.4% (46.5%)	4.2	96.3%	40.7% (55.6%)	4.5	77.8%	34.7% (43.1%)	4.1
As a result of the program…										
3	I know where to get help when I need it	82.0%	46.0% (36.0%)	4.1	74.1%	51.9% (22.2%)	4.0	84.9%	43.8% (41.1%)	4.2
4	I am more comfortable seeking help	69.7%	40.4% (29.3%)	3.9	66.7%	51.9% (14.8%)	3.8	70.8%	36.1% (34.7%)	3.9
5	I deal more effectively with daily problems	62.0%	46.0% (16.0%)	3.7	59.3%	51.9% (7.4%)	3.6	63.0%	43.8% (19.2%)	3.8
6	My symptoms are bothering me less	61.0%	35.0% (26.0%)	3.7	55.5%	40.7% (14.8%)	3.6	63.0%	32.9% (30.1%)	3.8

Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.

UTILIZATION OF TECHNOLOGY TO EXPAND REACH OF URBAN BEATS PROGRAM

URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

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

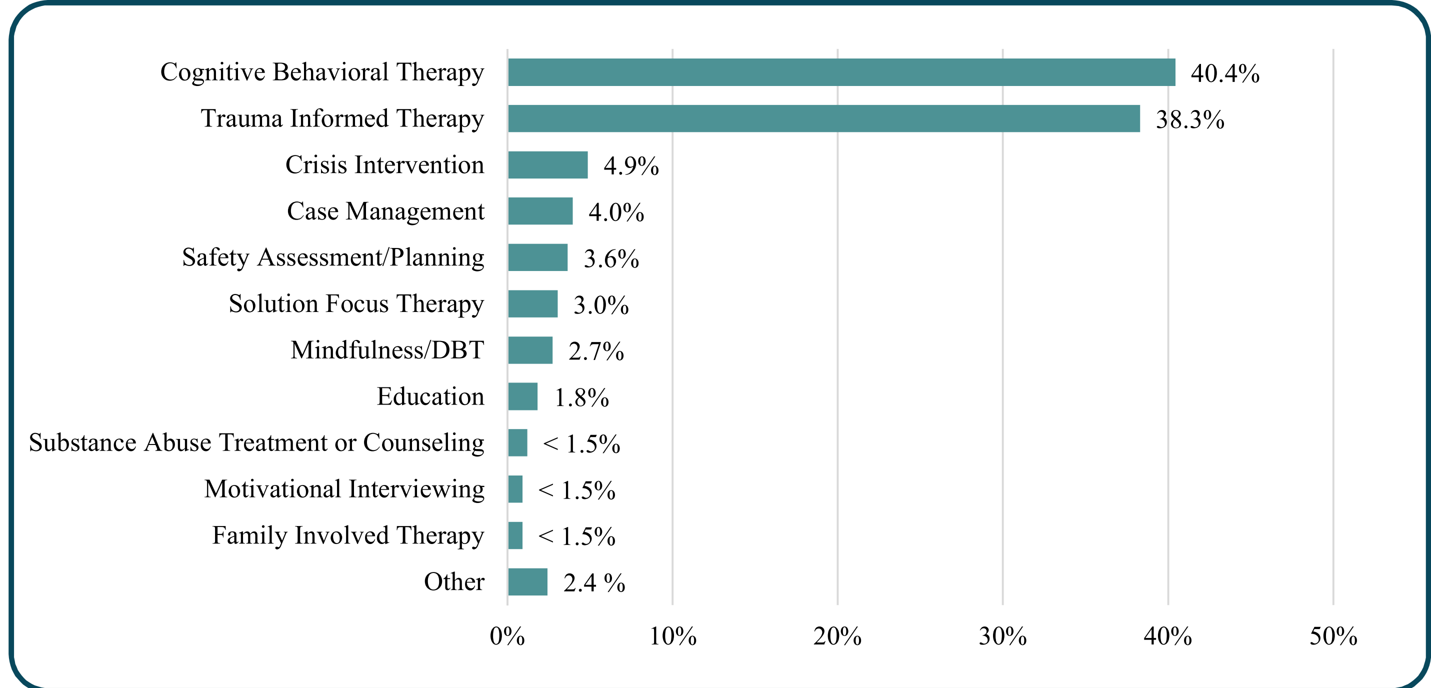
TABLE 4. URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

Type	Fiscal Year 2018-19	Type	Fiscal Year 2018-19
New Instagram Followers	254 (1,005 Total)	Facebook	
New Twitter Followers	9 (145 Total)	• Page Likes	91
Website Visits	3,297	• Post Likes	1,042
SoundCloud Plays/Likes	304	• Reach (unique views)	4,777

UTILIZATION OF THERAPUETIC SERVICES PROVIDED BY THE URBAN BEATS CLINICIAN

Based on experiences during the early years of the Urban Beats program, particularly the ongoing challenges of connecting youth to formal behavioral health services when needed, the Urban Beats program added an "in-house" behavioral health clinician (pre-licensed) who could meet directly with Urban Beats participants. A total of 40 Urban Beats youth participated in 329 sessions with the clinician (median number of sessions = 5). As shown in Figure 1, a wide variety of services were provided during sessions and more than one service type could be provided in a single session. Cognitive Behavioral Therapy was the most common service provided (40.4%), followed closely by Trauma Informed Therapy (38.3%). Approximately 5.0% of all sessions were directly related to providing crisis intervention services (4.9%). Of the 40 Urban Beats youth participating in sessions with the clinician, 75.0% (n=30) had at least one session of Trauma Informed Therapy. This indicates a high need for trauma informed care among Urban Beats youth.

FIGURE 1. TYPES OF CLINICIAN DELIVERED SERVICES PROVIDED TO URBAN BEAT PARTICIPANTS (N=329 sessions)



Note: percentages total up to more than 100% since multiple services could be provided during a single session with the clinician.

Based on an examination of San Diego County BHS service utilization data, only about 25% of the youth who had sessions with the Urban Beats clinician also participated in other San Diego County outpatient clinical services. This indicates that for the majority of youth, it is likely that their interactions with the Urban Beats clinician were the only form of therapeutic support they were receiving.

UTILIZATION OF URBAN BEATS VAN FOR TRANSPORTATION ASSISTANCE

The Urban Beats van was utilized for a total of 172 trips during FY 2018-19, for a total of 3,753 miles driven. Primary destinations included:

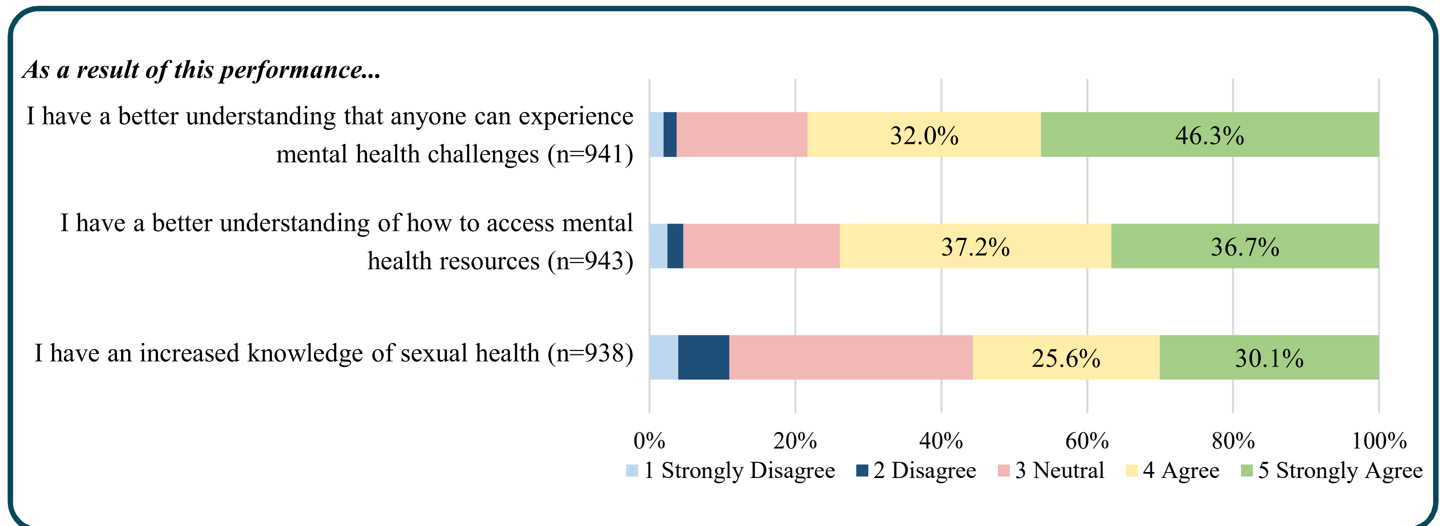
- Urban Beats and community partner youth performances
- Transportation to/from Urban Beats locations for program activities
- Transportation to/from other community partners and/or for other needed services
- Outreach events in the community
- Picking up supplies for activities/events
- TAY Academy

Urban Beats staff reported the van had an important logistical impact on the program, allowing them to transport people and equipment to events throughout the community. They also indicated the van made it possible for participants to attend more activities than was possible in previous years, without the van.

COMMUNITY PERFORMANCE OUTCOMES

During Year 4, the Urban Beats program hosted or co-hosted 42 community performance, up from 28 performances during FY 2017-18. It is estimated that over 2,000 persons attended these performances, and 958 audience members completed an outcome survey (note: surveys were not able to be distributed at all events). Transitional age youth (ages 16-25) comprised 72.7% (n=696) and persons younger than 16 comprised another 10.6% (n=102) of the audience. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 2, a majority of all respondents (78.3%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. A similar percent (73.9%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (55.7%).

FIGURE 2. ASSESSMENT OF COMMUNITY PERFOMANCE ATTENDEE LEARNING



The response patterns between TAY (i.e., aged 16-25) and persons older than TAY who attended the performances were fairly similar for the three outcome questions. For the persons younger than 16, the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" was also similar (i.e., approximately 75%), however in comparison to TAY they indicated slightly lower rates of "better understanding how to access mental health resources" (64.7% compared to 75.7%), and substantially lower rates of "increased knowledge of sexual health" (38.2% compared to 58.0%) as a result of the performance.

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2018-19, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 7 respondents from the 11 persons invited to participate in the survey, a response rate of 64%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Major program goals identified by staff:*
    a. Stigma reduction and mental health education.
    b. Artistic expression.
    c. Engagement with transitional age youth.
    d. Increase service access.
    e. Improve coping skills.
2. *Factors that helped the program achieve goals:*
    a. Art as a focus.
    b. Performances/ showcases/ workshops.
    c. Staff skills.
    d. Engaging curriculum.
    e. Resources for participants.
    f. Collaboration outside of program (i.e. partnerships).
3. *Factors that inhibited the program from achieving goals:*
    a. Leadership issues.
    b. Staff turnover.
    c. Unprepared staff.
    d. Lack of materials/supplies.
    e. Low staff pay.
    f. Low staff morale.
4. *Recommendations to help the program better achieve goals*:
    a. More staff training.
    b. More staff/resources/supplies.
    c. Leadership improvement (i.e., advocate for staff, connections with other programs, goal setting).
    d. Better communication.
    e. Better program foundation/implementation.
    f. Change outreach strategies (i.e., more outreach, review current outreach, target TAY-specific activities).
    g. Higher pay for staff.
5. *Types of needed supports, tools, and/or trainings:*
    a. More training (i.e., motivational interviewing, peer support training, mental health first aid).
    b. Tools and materials for data collection.
    c. More staff.
    d. Connections to community organizations/artists.
    e. Supplies (i.e., furniture, white boards, filing cabinets, stencil cutting machine).
    f. Funding.
6. *Types of desired supports, tools, and/or trainings:*
    a. Additional training (i.e. new art mediums, attending art therapy events, DBT, resource awareness).
    b. More staff.
    c. Music studio, more music therapy options.
    d. Supplies (i.e., furniture, white boards, filing cabinets, stencil cutting machine).
    e. Counseling opportunities for staff.
    f. Higher pay.

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY (CONT.)

7. *Key strengths of the program:*
    a. Use of creative/ artistic expression.
    b. Connections with the community.
    c. Engaging, passionate staff.
    d. Youth engagement.
    e. The approach of the program (i.e., strengths-based, client focused, trauma-informed).
    f. Creativity in interventions.
    g. Making mental health a fun/approachable topic.
    h. Program flexibility.
    i. The music studio.
8. *Effective ways to identify and recruit potential TAY participants:*
    a. Community outreach/performances.
    b. Connect with other organizations that serve TAY.
    c. Social media outreach.
    d. In-person recruitment.
    e. Recruit youth involved in other services.
    f. Expand to new areas (i.e. North Central, Ocean Beach).
9. *Types of engagement strategies and resources used to facilitate participation:*
    a. Focus on building trust, rapport building.
    b. Offer resource information.
    c. Offer food.
    d. Go to their location (i.e. pop-up workshop).
10. *Benefits of changing cohort schedules from 20-hours over 20-weeks to 20-hours over a few weeks:*
    a. Higher attendance/retention/completion rates.
    b. Progress is based on individual commitment to the program.
    c. Incentives are awarded faster.
    d. Easier to engage quickly.
    e. Deadlines are realistic.
11. *Barriers to linking Urban Beats TAY with needed mental health services:*
    a. Participant is not ready or interested, or doesn't follow through.
    b. Previous negative experiences or lack of trust with treatment.
    c. Housing issues.
    d. Process is overwhelming to participant.
    e. Stigma.
    f. Wait lists.
    g. Lack of fitting program service requirements.
    h. Lack of culturally competent services.
    i. Lack of information/consolidated information about resources.
12. *Additional recommendations:*
    a. Additional support/staff (i.e., volunteers or interns).
    b. More space (i.e., for brainstorming).
    c. Flexibility in implementation.
    d. Ongoing curriculum development (i.e., trying more innovative approaches).
    e. Leadership advocacy for staff.
    f. More funding.
    g. Incentives.

CURRENT YEAR KEY PROGRAM "LEARNINGS"

1. Approximately 20% of Urban Beats participants had at least one session with the "in-house" clinician.
2. The majority of participants who had sessions with the Urban Beats clinician were not participating other San Diego County outpatient or ACT therapeutic care services.
3. Many participants who had sessions with the clinician received some form of trauma informed therapy.

YEAR 4 PROGRAM CHANGES

During FY 2018-19 the Urban Beats program continued to evolve to meet the needs of TAY and has expanded the ways that youth can participate in the program. In addition to the cohorts that involve a 20-hour structured curriculum and mentorship related to their chosen form of artistic expression, select Urban Beats locations offered shortened one-day workshops which included the structured curriculum, studio time, and other activities that allow youth to interact with Urban Beats staff and other youth actively participating in the program.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Change cohorts from 20 weeks to a curriculum with a total of 20 hours spread across fewer weeks to facilitate TAY retention and allow for more community collaborations through the ability to customize program schedules.

   Status: The Urban Beats program has successfully developed and utilized a 20-hour version of the curriculum that covers the same content as the original 20-week cohort format, but in fewer sessions. The shorter number of weeks facilitates participation and allows for more frequent cohorts. Programs now have the option of running either version of the curriculum for their cohorts.

2. Establish a location for the North Central office in order to better serve the target population (e.g., ability to host classes).

   Status: During FY 2018-19 the Urban Beats program was successfully able to open a new location.

CURRENT YEAR PROGRAM RECOMMENDATIONS

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

1. Implement a structured process for follow up with enrolled TAY to encourage on-going participation and engagement of services after program completion.
2. Work with the Urban Beats clinician to explore mandatory clinical services.
3. Attend or participate in at least one health fair in San Diego per quarter.
4. Incorporate specialized services for TAY that are not interested in cohorts or other "in-house" services (e.g., homeless TAY whose immediate needs are housing, food, and medical needs).
5. Create/implement a modified cohort curriculum to reach unique TAY populations (e.g., a curriculum that is sensitive to cultural/religious beliefs or specific socioeconomic backgrounds).
6. Consider the option of omitting Twitter and Sound Cloud from data tracking.

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

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

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ANNUAL REPORT YEAR 3 (1/1/18 – 12/31/18)

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

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

EXECUTIVE SUMMARY

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

- Due to expanding countywide, admissions into the CREST program increased from 12 persons in 2017 to 45 persons in 2018. Of the 107 persons screened during 2018 almost all met criteria for hoarding disorder (98.1%), but only 30.8% met all eligibility requirements (i.e., Medi-Cal/uninsured). A total of 13 persons successfully completed CREST during 2018.
- Of the 45 new enrollees, the average age was 68 (range = 59 to 81) and nearly three-quarters (71.1%) were female. The majority identified as white (73.3%), nearly all reported English as their primary language (91.1%), and over half (51.1%) had a post-secondary degree.
- Over 75% reported having at least one disability unrelated to mental health (e.g., physical disability or pain) and the majority had at least one comorbid psychiatric diagnosis in addition to hoarding disorder (e.g., major depression).
- During 2018 a total of eight evictions were prevented.
- Following CREST program completion participants demonstrated reductions in clutter, functional impairment, mobility impairments, and risk for homelessness.
- While demonstrating improvements, 61.5% of the persons who completed the 26-sessions during 2018 still met criteria for hoarding disorder and required additional treatment.
- Key factors identified by CREST staff that helped achieve program goals: 1) using an evidence-based treatment protocol, 2) skill/training of therapists, 3) having supportive and collaborative community partners, 4) expanding service provision countywide, and 5) having coordinated, full-service care provided by a multi-disciplinary team.

RECOMMENDATIONS

Primary recommendations include: 1) expand insurance eligibility requirements to accept low income Medicare clients, 2) lower the age requirement (e.g., to over age 50 or 55), 3) establish city/county process to refer to treatment prior to punitive measures by code enforcement/Section 8/HUD, 4) provide training opportunities for volunteers and clinicians, and 5) expand family support and education groups.

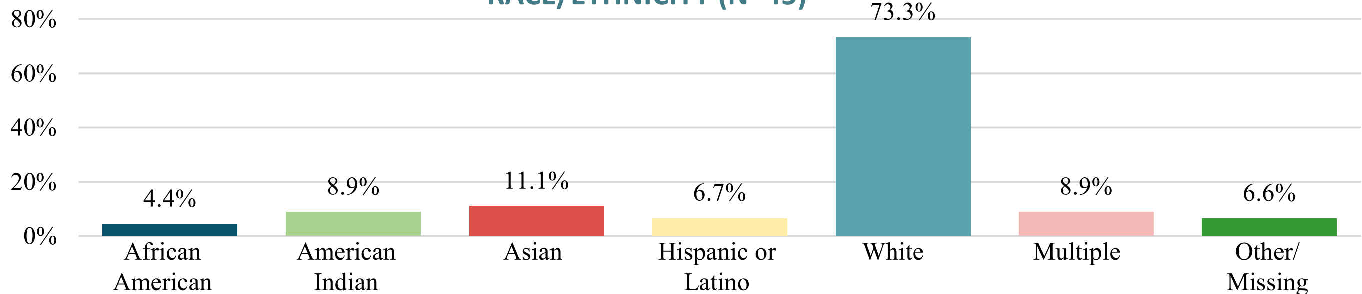
PARTICIPANT CHARACTERISTICS

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

- During 2018, 107 new persons were screened for CREST program eligibility. 105 (98.1%) met criteria for hoarding disorder and 33 (30.8%) met all eligibility requirements.
- The 45 new enrollees during 2018 included 12 individuals who were screened in previous years and had become eligible following the countywide expansion of services or they were allowed as Medicare exceptions.
- During 2018 a total of 60 clients actively participated in the CREST program (i.e., 12 had enrolled in 2017).

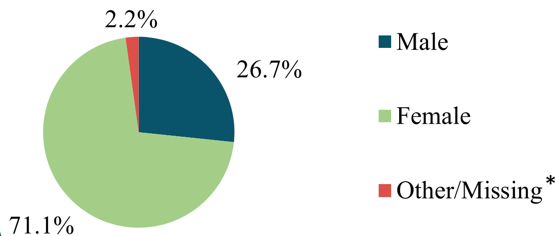
- Participants ranged in age from 59 to 81, with an average age of 68.
- Most participants (91.1%) reported English as their primary language with 8.9% reporting another primary language.
- Most participants (82.2%) reported never having served in the military, 13.3% reported having previously served, and 4.4% reported either other/missing.

RACE/ETHNICITY (N=45)



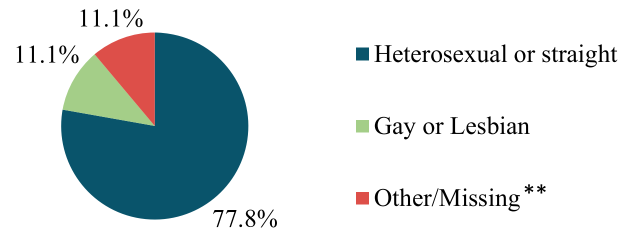
The majority of participants identified as White (73.3%) with 11.1% identifying as Asian. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

GENDER IDENTITY (N=45)



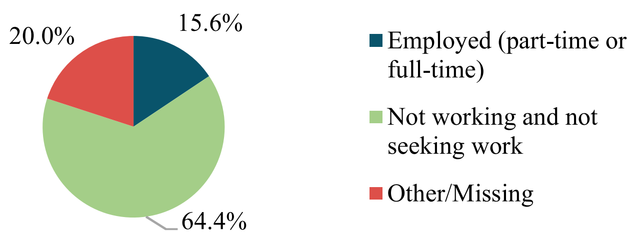
Nearly three-quarters of participants identified as female (71.1%) and 26.7% identified as male.

SEXUAL ORIENTATION (N=45)



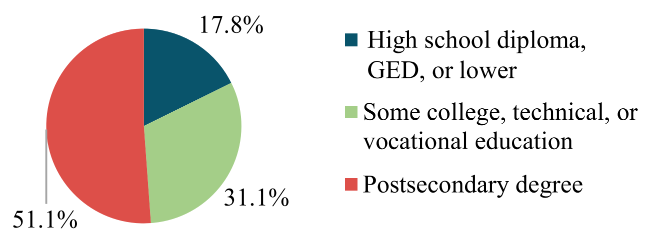
Over three-quarters (77.8%) of participants reported their sexual orientation as heterosexual and 11.1% reported as gay or lesbian.

EMPLOYMENT (N=45)



Approximately two-thirds (64.4%) of participants were not employed and were not seeking employment.

EDUCATION (N=45)

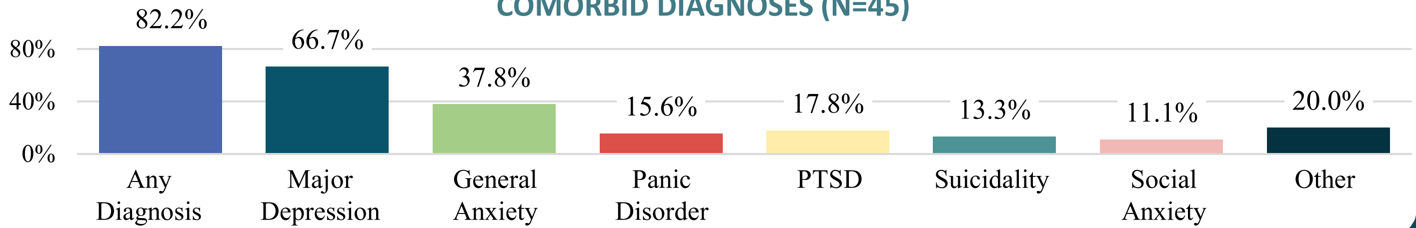


Over half (51.1%) of participants had completed a postsecondary degree.

* *Other may include bisexual, pansexual, sexually fluid, unsure of sexuality, or questioning. ** Other may include seeking work or other situations.*

CREST PROGRAM PARTICIPANT CHARACTERISTICS (CONTINUED)

COMORBID DIAGNOSES (N=45)



Most participants (82.2%; n=37) had at least one comorbid mental health related diagnosis with over half (66.7%) of the participants having comorbid major depression.

DISABILITY[1] STATUS (N =45)

Type	n	%
Seeing	5	11.1%
Hearing	6	13.3%
Mental (e.g., learning)	9	20.0%
Physical	16	35.6%
Chronic Health Issues	12	26.7%
Other	20	44.4%

The distribution of disabilities is listed above. Totals may exceed 100% as participants could indicate more than one.

HOMELESSNESS RISK FACTORS (N=45)

40.0%	Have poor credit history
35.6%	Ever homeless/not have a home of own
64.4%	Without somewhere to stay/without plan for housing if lost current housing
51.1%	Have at least one barrier to getting or keeping their home, including: lack of employment (11.1%), lack of transportation (24.4%), and lack of financial assistance (35.6%).

Homelessness risk factors were prevalent with approximately one-third indicating they had previously been homeless.

FIGURE 1. PARTICIPANT HOARDING RATING SCALE RESPONSES AT BASELINE

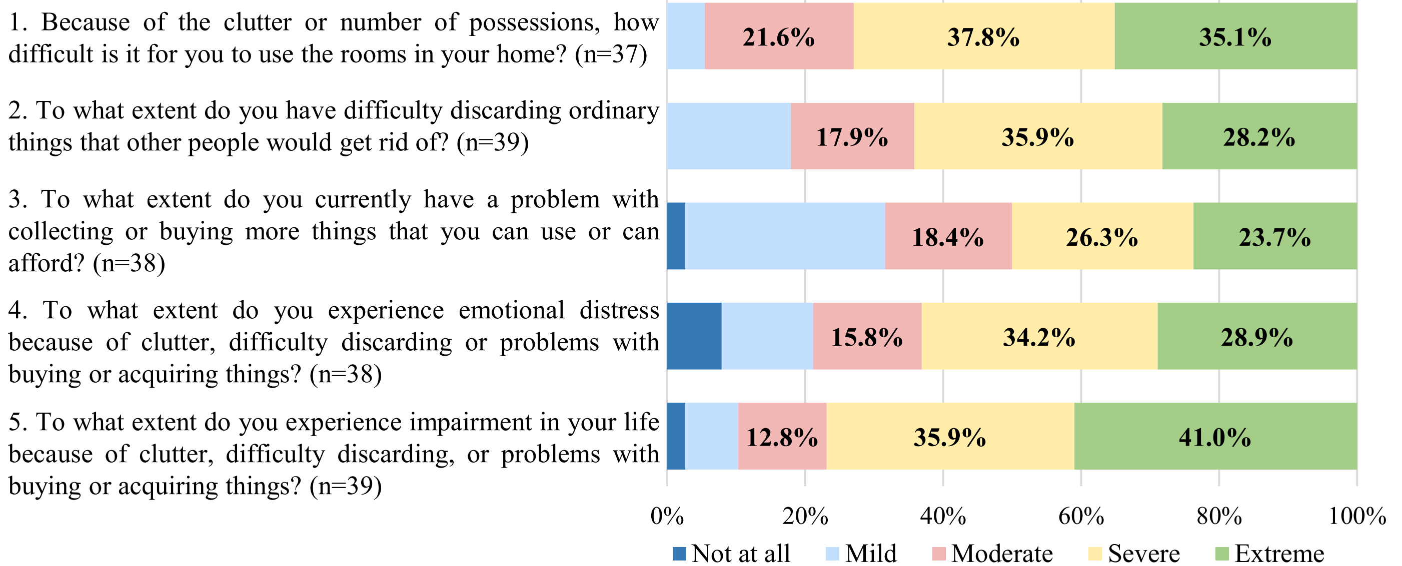


Figure 1 presents baseline responses to the Hoarding Rating Scale (HRS) questions for participants enrolled during 2018. Overall, results indicated substantial negative effects on the lives of CREST participants due to clutter in their home, with 94.5% reporting moderate to extreme difficulty using rooms in their house, 78.9% reporting moderate to extreme emotional distress, and 89.7% reporting moderate to extreme impairment in their life.

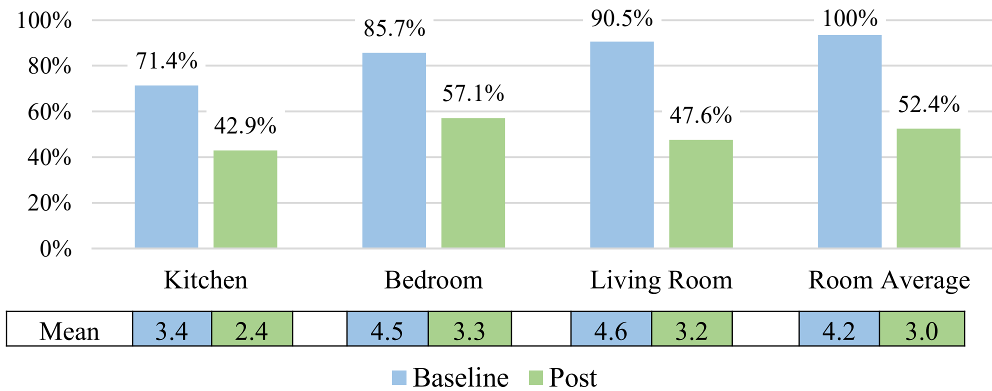
Participants also completed the Activities of Daily Living in Hoarding (ADL-H) scale. The ADL-H is a 9-item measure used to rate the ease with which a set of common activities (e.g., prepare food, use bath/shower, etc.) can be completed. The response options of the 5-point scale range from 1 (Can do it easily) to 5 (Unable to do). The average baseline ADL-H score was 2.5 (little difficulty/moderate difficulty) with a key mobility item, "move around inside the house" rated 3.1.

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

REDUCTIONS IN CLUTTER

The Clutter Image Rating (CIR) scale is a tool used to rate clutter levels on a scale from 1 to 9 (most cluttered = 9), by selecting the image that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom; see example CIR images below). Figure 2 presents the percentage of participants who had a CIR value **greater than 2** before or after treatment (mean CIR values listed below the chart). Of participants with CIR ratings at both time points (n = 21), substantially fewer had CIR values greater than 2 after receiving CREST treatment services. Mean CIR scores decreased as well for each room individually and the overall room average decreased from 4.2 to 3.0. These findings of decreased clutter are consistent with improved symptom management due to CREST program participation.

FIGURE 2. PARTICIPANT CLUTTER IMAGE RATINGS AT BASELINE AND POST



CIR Living Room Rating #2

CIR Living Room Rating #4

REDUCTIONS IN HOMELESSNESS RISKS

Upon entering the CREST program, participants completed the Homelessness Risk Screener designed to assess their personal risk for homelessness. Questions include such items as asking participants about their current and past living situations, the types of environments they have lived in, if they rely on family for financial support, and what types of barriers they face when it comes to housing stability. This same questionnaire is then completed again when participants discharge from the program.

While the sample sizes were too small for definitive conclusions, in general, there were fewer participants who were at risk for homelessness after completing the CREST program. In particular, 35.7% of the 14 participants who completed the Current Homelessness Risk Screener were either homeless, living in temporary housing, or facing eviction upon entering CREST, whereas none (0.0%) indicated these conditions after completing the CREST program. At both time points, the majority of participants indicated not having a place to stay and/or plan for housing if they lost their current housing. This suggests that while immediate risks for homelessness have been reduced, many of those served by the CREST program remain vulnerable to future housing disruptions.

KEY EVALUATION OUTCOMES (CONTINUED)

Reductions in Hoarding Behaviors and Impairment

Participants also completed the Hoarding Rating Scale (HRS) upon entering the CREST program and at the time of program completion (n=22). This 5-item scale asks participants to rate the extent to which they experience each hoarding related behavior or impairment on a 9-point scale ranging from 0 (not at all) to 8 (extremely). As shown in Table 1, each hoarding related item was perceived to be significantly less of a problem following the completion of the CREST program. The overall average rating was reduced from 4.9 (moderate/severe) at baseline to 2.8 (mild/moderate) at the end of the program.

TABLE 1. PARTICIPANT HOARDING RATING SCALE AT BASELINE AND POST CREST PARTICIPATION

Hoarding Behavior Effects	Baseline	Post CREST
1. Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?	4.7	2.5
2. To what extent do you have difficulty discarding ordinary things that other people would get rid of?	5.1	3.3
3. To what extent do you currently have a problem with collecting or buying more things that you can use or can afford?	4.6	2.0
4. To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?	4.9	3.3
5. To what extent do you experience impairment in your life because of clutter, difficulty discarding, or problems with buying or acquiring things?	5.3	2.7
Average HRS Score	**4.9**	**2.8**

Reductions in Fall Risk

Participant responses to the Activities of Daily Living in Hoarding scale at baseline and after completion of the CREST program provide evidence of reduced fall risks. In particular, average ratings (n=21) for the "Move around inside the house" item decreased significantly from 2.6 (little/moderate difficulty) at baseline to 1.7 (easily/little difficulty) following CREST program completion.

ADDITIONAL PROGRAM OUTCOMES

- In 2018, the CREST program helped eight participants avoid evictions.
- While many participants experienced functional and behavioral improvements, eight participants who completed the CREST program during 2018 (61.5% of the 13 CREST program completers in 2018) still met criteria for hoarding disorder at the end of the 26-session program.

ADDITIONAL CREST PROGRAM ACTIVITIES

- In 2018, the CREST program held 108 outreach and engagement presentations and educated 903 individuals about the CREST program and issues related to hoarding behaviors.
- The team continued to revise a County-wide resource guide specifically for clients with hoarding disorder symptoms. As of 12/31/2018 there were over 2,800 community resources listed.
- Drafted a referral process in partnership with the San Diego Hoarding Collaborative.
- The CREST Program Director, Dr. Catherine Ayers, continued to lead the San Diego Hoarding Collaborative.
- Trained undergraduate volunteers to assist with advanced exposures to discarding.
- Trained geriatric psychiatrists to consult on Hoarding Disorder cases.

KEYS TO CREST PROGRAM SUCCESS: RELATIONSHIP BUILDING

CREST Program Relationships:
Collaborating with Community Partnerships

Cases of hoarding disorder often require a broad and diverse group of organizations to address needs not always applicable to hoarding, but key in reducing hoarding impairments. In 2018 CREST collaborated significantly with service providers to address co-occurring mental health issues, substance use disorders, case management, housing programs, interpreting services, waste removal, home repairs, and physical health. In many of these cases addressing issues outside of CREST's scope directly led to increased engagement with hoarding treatment and associated decreases in impairments. The San Diego Hoarding Collaborative identified a network of providers integral to the diverse needs of hoarding sufferers, and is developing a handbook to coordinate collaboration on these cases.

CREST Participant Relationships:
Increasing Social Connectivity

CREST program participants often experience social isolation and lack of family support which leads to increased emotional distress and contributes to hoarding behaviors including excessive acquisition and difficulty parting with possessions. CREST clinicians work to involve family members in treatment whenever possible through educational family groups and family therapy sessions. This has led to increase support and improved outcomes including healing significant relationships through enjoying time together that is not associated with acquiring possessions and partnering to help with sorting, discarding, and organizing possessions.

EXAMPLE OF CREST PROGRAM CLUTTER REDUCTION

Before CREST program participation

After CREST program participation

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY

At the end of the third year of providing INN-17 Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the CREST Program. All potential survey participants (n=11) responded to the survey for a response rate of 100%.

1. *Major program goals as identified by CREST program personnel:*
    a. Provide comprehensive evidence-based treatment and care management services to reduce hoarding.
    b. Improve home safety, prevent evictions, and reduce risk of homelessness.
    c. Provide wraparound services and connect participants to needed resources and services.
    d. Increase community engagement to strengthen knowledge of hoarding and supports to persons with hoarding disorder.

2. *Factors that helped the CREST program achieve these goals (Helping Factors):*
    a. Existing evidence-based training (CREST) and protocol in place.
    b. Therapist skills and training (e.g., bilingual training).
    c. Outreach efforts and supportive stakeholders, contract representatives, and local community.
    d. Expansion of service area.
    e. Multidisciplinary care coordination.

3. *Specific challenges to reaching program goals (Inhibiting Factors):*
    a. Eligibility/exclusion criteria limited amount of participants.
    b. Lack of staff physical resources (e.g., office space, computers).
    c. Referral process – potential clients fall "through the cracks" because they have to be the one to ask for help.

4. *Key program innovations:*
    a. Evidence-based treatment and characteristics of that treatment.
    b. Using peer support as part of the program.
    c. Multi-disciplinary, wraparound care coordination.
    d. Mobility of treatment team.
    e. Meeting with the client in their home.
    f. Involve client family members (e.g., support groups).

5. *Benefits of using peer supports:*
    a. Establishes a relationship with someone who can understand barriers/struggles better than anyone else.
    b. Normalizes treatment program.
    c. Provides emotional support and hope/evidence of success.
    d. Provide additional opportunities for client to practice skills.
    e. Keeps progress moving forward.

6. *Participant characteristics or circumstances that make it challenging to effectively provide services:*
    a. Co-occurring health problems in addition to hoarding disorder including mental or physical conditions.
    b. Avoidance, lack of motivation or desire to change.
    c. Participants may not always have reliable transportation.

KEY YEAR 3 PROGRAM "LEARNINGS"

1. Removing ZIP code restrictions during 2018 substantially increased CREST program enrollment.
2. Approximately 10-15% of individuals seeking treatment were between the ages of 50 and 60. Lowering the age requirement for participation in the CREST program (e.g., to over age 50 or 55), would further increase enrollment and help address Hoarding Disorder earlier in the lifespan and prevent negative consequences for older adults.

KEY YEAR 3 PROGRAM CHANGES

During the third year of service provision (1/1/2018 – 12/31/2018), CREST implemented changes related to program expansion into all regions of San Diego County. The program also implemented the use of family support and education groups when appropriate as another tool to help individuals and their families address hoarding related concerns. During the third year of service provision, the CREST program added two Spanish-speaking clinicians in an effort to reach additional clientele in San Diego County. Two new offices were opened in San Marcos and south San Diego and four new clinicians were hired as part of this expansion. Additionally, CREST developed a community "on-the-spot" screening process to better engage individuals in the community.

STATUS OF PRIOR YEAR RECOMMENDATIONS

1. Modify eligibility and inclusion criteria to allow interested persons to participate, particularly those enrolled in Medicare.

   Status: Eligibility and inclusion criteria are unmodified due to contract stipulations, but the program consistently advocates for clients not on Medi-Cal but could not otherwise access services.

2. Improve media outreach and community engagement to recruit more participants and strengthen relationships with mental health providers and local partners.

   Status: Outreach and community engagement have been primarily focused on presenting in regions of county newly serviced by CREST program. San Diego Hoarding Collaborative continues to organize majority of primary community partnerships.

3. Address need for home repairs or removal services by allocating funding or partnering with local business or organizations.

   Status: Additional funds were allocated in the expansion contract to address junk removal needs. Home repair needs are primarily addressed via community partnerships and programs (i.e., SDG&E, JFS Fix-IT, ElderHelp).

4. Incorporate family groups into treatment model.

   Status: Family groups are now being facilitated as needed based on clients' family willingness to participate.

5. Increase flexibility regarding length of stay in the CREST program.

   Status: Implemented additional assessment and treatment sessions for individuals meeting medical necessity for ongoing treatment at the end of 26 sessions.

6. Add yearly income to the CREST program screening tool to identify potential clients with incomes over the Medi-Cal threshold who still may have limited resources and find it difficult to acquire needed treatment services.

   Status: Screening now includes estimated monthly income to identify individuals minimally over Medi-Cal eligibility.

YEAR 3 PROGRAM RECOMMENDATIONS

1. Expand insurance eligibility requirements to accept low income Medicare clients to enable CREST program enrollment for the many applicants (approximately 70%) who meet criteria for Hoarding Disorder, but not the insurance requirements.
2. Explore lowering age requirements (e.g., to over age 50 or 55) to address Hoarding Disorder earlier in life and better prevent such impairment among older adults.
3. Establish city/county process to refer to treatment prior to punitive measures by code enforcement/Section 8/HUD.
4. Provide training opportunities for undergraduate volunteers, psychologists, and geriatric psychiatrists.
5. Expand family support and education groups into North and South regions as the number of clients/graduates increase.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) (INNOVATIONS-20)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS)' Roaming Outpatient Access Mobile (ROAM) program is funded through the Innovations (INN) component of the Mental Health Services Act. ROAM was developed to provide fully mobile mental health clinics to Native American individuals of all ages in the North Inland and East County regions of San Diego. Services are provided through Southern Indian Health Council (SIHC) and the Indian Health Council (IHC).

Efforts by ROAM are intended to improve access to and utilization of mental health services for Native American children, Transitional Age Youth (TAY), adults, and older adults residing on tribal reservations and rural communities in San Diego County. Services aim to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. To facilitate better access to care services, the program will provide at least some services at night and/or on the weekends. Each mobile unit will be staffed with culturally competent licensed and unlicensed professionals who can provide a variety of care services. A key innovative component of the ROAM program is the use of telemental health for on-going and continuing mental health needs. The usage of telemental health in conjunction with, rather than in lieu of, face to face services is expected to be a key factor in minimizing barriers to treatment and is intended to allow for further mental health engagement.

YEAR ONE ACTIVITIES

During Year 1 of the ROAM program (FY 2018-19), the primary implementation related activities included the following:

1. Obtained approval for ROAM service activities from Tribal Councils.
2. Designed, procured, and tested the mobile health units.
3. Reviewed, selected, and obtained authorization for the specific telemental health platform (OTTO Health).
4. Hired and trained staff.
5. Conducted outreach to inform community leaders and members of the new service delivery options.
6. Established key points of contact throughout the community for coordination of services.
7. Established plans/schedule for mobile unit location rotation throughout the week.
8. Developed ROAM promotional materials (e.g., brochures and flyers).
9. Identified and set up administrative office space
10. Created policies and procedures to guide ROAM team activities (e.g., safety protocols, business operations, etc.).
11. Researched and identified outcome measurement tools.

All of these actions were intended to help prepare for the utilization of ROAM to expand the reach of behavioral health services, particularly psychiatry, to underserved rural communities.

FUTURE DIRECTIONS

In Year 2, each program will fully implement the ROAM mobile unit and telemental health technologies to provide expanded behavioral health care services to Native Americans living in the North Inland and East regions of San Diego County.

2019-12-20

JUST BE U
(INNOVATIONS-21)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Just Be U (JBU) program is funded through the Innovations (INN) component of the Mental Health Services Act. The goals of the program include improved mental health and quality of life outcomes for Transitional Age Youth (TAY; 18-25 years old), with Serious Mental Illness (SMI) who are homeless or otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services, but are otherwise unconnected to services.

The specific objectives of JBU include the provision of short-term housing (up to 90 days), in a supportive environment that seeks to reduce stigma and behavioral health challenges while instilling hope for recovery and independence. JBU whole-health services target healthy eating, exercise, sleep, and a range of holistic interventions to support rehabilitation and promote improved social connections with family, peers, and the community. The program also seeks to utilize technology in creative ways to promote engagement with TAY. Throughout these interactions with TAY, JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on TAY centric whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging TAY.

EXECUTIVE SUMMARY

The Just Be U (JBU) program was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY), with Serious Mental Illness (SMI) who are homeless of otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services, but are otherwise unconnected to services. JBU provides short-term housing for TAY in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions.

Outreach Efforts
- JBU staff attempted to contact 100% (n=120) of eligible TAY, according to strict county eligibly requirements.
- Staff successfully contacted 30.8% of eligible TAY (n=37).

Enrollment
- A total of 22 TAY were enrolled in the program.

TAY Characteristics
- Enrolled TAY are between the ages of 18-25 and racially diverse.
- 100% of enrollees have an SMI diagnosis, but the majority are non-compliant with prescribed medications.
- The majority of JBU TAY have a history of co-occurring Substance Use Disorders (SUD).
- Over a quarter of JBU TAY reported having a disability beyond SMI.

JBU Provision of Holistic Services
- JBU staff and external partners provided a wide range of services/trainings focused on self-regulation and wellness (e.g. meditation, biofeedback, yoga).
- Approximately 40-80% of JBU TAY attended holistic services each week.

Participant Outcomes
- Pre-Post holistic services data collection revealed positive trends regarding: (1) Sense of belonging, (2) Feeling hopeful for the future, and (3) Sense of program practices helping them feel better.

Linkages to Services
- A total of 107 linkages to services were made across mental health, housing, and substance abuse domains, with multiple linkages per youth to provide individualized treatment plans.

Staff survey
- Staff reported holistic service offerings and connections to the community as the factors which best supported JBU goals.
- Increased access to SUD and mental health treatment were most commonly cited as factors which would benefit the program.

Year 1 Data Trends

While the number of youth with completed baseline and follow-up data was relatively small during the JBU program start-up year, the findings from participant self-report and provider surveys suggested that desired changes were occurring in multiple areas of program emphasis (e.g., social connectedness, mental wellbeing, engagement in treatment). The trends in positive directions indicate the program appears to be achieving desired outcomes. The UCSD Innovations Evaluation team will monitor data trends as enrollment continues to increase.

PROGRAM DESCRIPTION

Using County of San Diego Behavioral Health Services Electronic Health Record (EHR) data, BHS personnel identify youth (age 18-25) who appear to be eligible for JBU services (i.e., multiple acute/crisis related BHS service contacts, 100% have diagnosis of SMI, and unconnected to behavioral health services). Once JBU receives these names, intensive outreach efforts are made by JBU staff to locate and make contact with each TAY using available contact information provided by County databases, street searches, and coordination with other county and support agencies.

Once eligible TAY have been contacted, given an explanation about the program's offerings, and enrolled in the program, JBU provides short-term (up to 90 days) housing that incorporates support services, smart device-based apps and biometric technology, integrative medicine, and holistic health care in one central, urban location. With dormitory-style housing on one floor, JBU TAY can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same building in downtown San Diego. During their 90 days in the program TAY will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, Reiki, chiropractic care, and meditation, as well as mindfulness education, biofeedback therapy, nutritional counseling, individual case management, peer support, group outings, and various in-house community-building trainings and events.

The overarching goal of JBU is to engage and stabilize TAY into short-term housing for up to 90 days while providing holistic, TAY-centered recuperative services, and then link these TAY to ongoing treatment, housing, and supportive services; thereby improving their mental health and quality of life in the community and breaking the cycle of homelessness early in the process by which TAY may otherwise harden in identity as homeless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize inappropriate and financially burdensome levels of emergency and mental health services.

The program's emphasis on community-building, de-stigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation, self-regulation training, and engagement with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

It is particularly salient that the program aims to intervene early on in the cycle of homelessness, before youth self-identify as homeless and/or helpless, and before the personal and societal costs escalate and become more intractable. Further, the program's emphasis on de-stigmatization, community, and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

EVALUATION PLAN

The key evaluation findings are based on a comprehensive set of assessment tools used by JBU. TAY at JBU complete an integrated self-assessment, the Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS), which includes the Patient-reported Outcomes Measurement Information System (PROMIS) Global Health scales (mental health and physical health) as well as items measuring substance use, suicidality, satisfaction, and impact of symptoms on daily activities. In addition, the CHAMPSSS form includes four items measuring satisfaction and participant outcomes, which have been used extensively across a wide range of programs in San Diego County. JBU TAY also complete the Recovery Markers Questionnaire (RMQ), and respond to questions both before and after engaging in holistic health practices.

Additional assessments are administered by staff and other trained health professionals. They include participant demographics, key outcome domains (housing, employment, and critical events), the Global Functioning Scale, the Illness Management and Recovery (IMR) Scale, the Milestones of Recovery Scale (MORS), the Linkage & Referral Tracker, and the Encounter Form. The data are entered into the Mental Health Outcome Management System (mHOMS), an electronic health record system, and then analyzed by the UCSD Innovations evaluation team.

Due to the small number of TAY enrolled in JBU during FY 2018-19, the UCSD Innovations evaluation team determined that reporting on statistical significance of outcomes would not be appropriate. For this reporting cycle, the UCSD Innovations evaluation team highlighted data trends and the direction of behavior changes. Future reports will discuss statistical significance when appropriate.

OUTREACH EFFORTS

After the program was notified of youth who appear to meet strict JBU eligibility criteria set by San Diego County BHS personnel, substantial efforts were made by the JBU team to locate eligible TAY who might benefit from the program. Where made possible by the availability of sufficient contact information or leads, outreach was directly made to each TAY. In all cases of eligibility, 100% of eligible TAY were sought out for contact. In the event of there being insufficient contact information, the JBU team attempted to reach TAY through other means, such as by direct street canvasing, utilizing the BHS EHR system to alert other programs that the youth was potentially eligible for JBU services, contacting other key service providers connected to the youth (e.g., parole officers, jails, psychological hospitals, in-patient rehabilitation centers), and reaching out to other programs in San Diego County.

Of the 120 TAY determined to be eligible during FY 2018-19, 42.5% (n=51) were unable to be reached by JBU due to an unknown location or inability to contact via county-provided information. Twenty-eight TAY (23.3%) were unavailable due to ongoing involvement with the criminal justice system. At the end of FY 2018-19 JBU was ultimately able to successfully contact 37 TAY (30.8%). Of those contacted, nine currently had housing, three were in communication with JBU, two came to tour JBU facilities, and 22 (18.3% of original 120) enrolled in the JBU program.

None of the TAY who were introduced to the program's structure and benefits via an outreach coordinator claimed to be not interested or refused participation, indicating high receptivity.

TABLE 1. OUTCOME OF OUTREACH ATTEMPTS

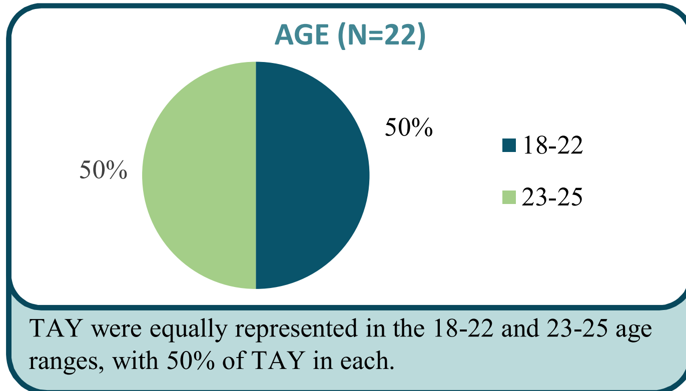
Final Outreach Disposition	n	Percentage of eligible TAY
No contact/location unknown	51	42.5
Located: Unavailable- criminal justice facility	28	23.3
Located: Unavailable- other restrictive program	4	3.3
Contacted: Has housing	9	7.5
Contacted: Not interested/refused JBU services	0	0.0
Contacted: Active Outreach- Established communication	3	2.5
Contacted: Active Outreach- Visited JBU	2	1.7
Contacted: Lost contact	1	0.8
Contacted: Enrolled in JBU	22	18.3
Total Outreach	120	100.0

The data regarding JBU outreach efforts indicate of TAY who still required housing at time of JBU contact, nearly all enrolled in the JBU program, or were in discussions regarding enrollment as of the end of FY 2018-19. This is noteworthy, as this cohort of TAY experiencing homelessness are historically among the most difficult to contact, recruit, or retain in a stable program.

PARTICIPANT CHARACTERISTICS

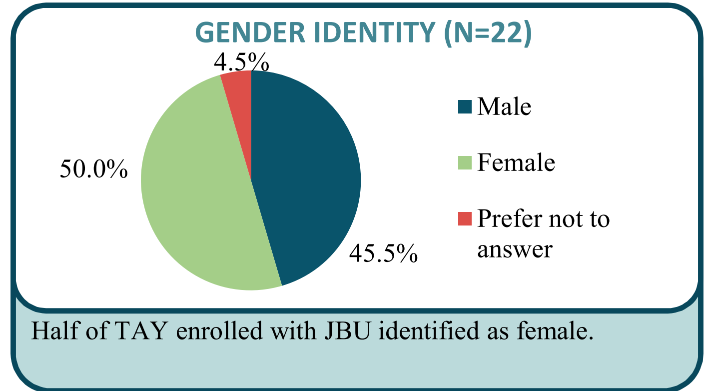
The following self-reported characteristic data were collected from TAY during the enrollment process.[1]

AGE (N=22)



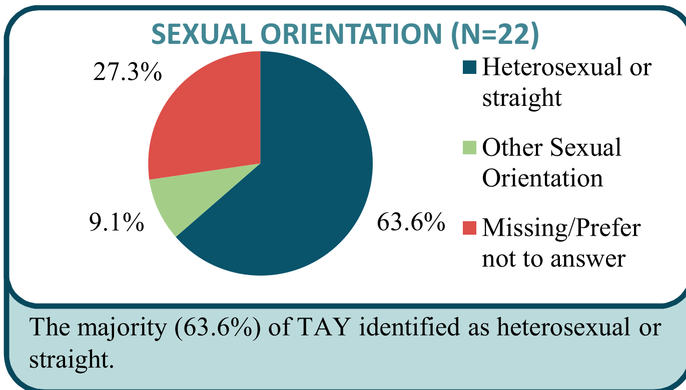
TAY were equally represented in the 18-22 and 23-25 age ranges, with 50% of TAY in each.

GENDER IDENTITY (N=22)



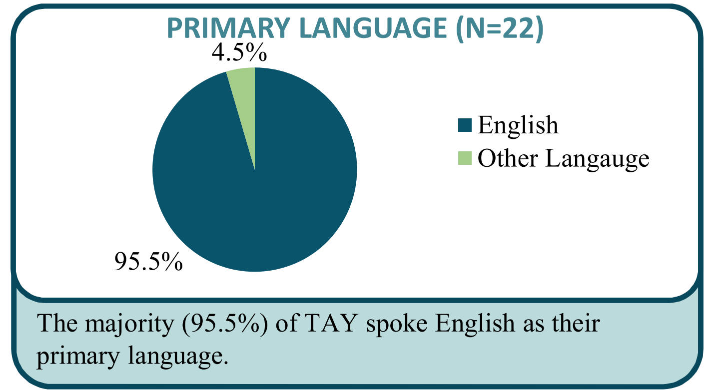
Half of TAY enrolled with JBU identified as female.

SEXUAL ORIENTATION (N=22)



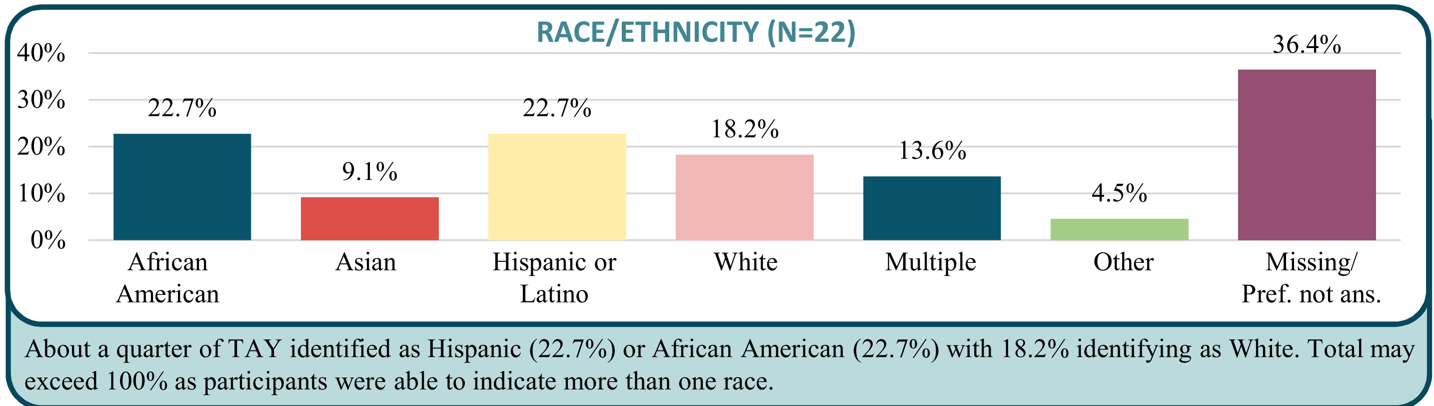
The majority (63.6%) of TAY identified as heterosexual or straight.

PRIMARY LANGUAGE (N=22)



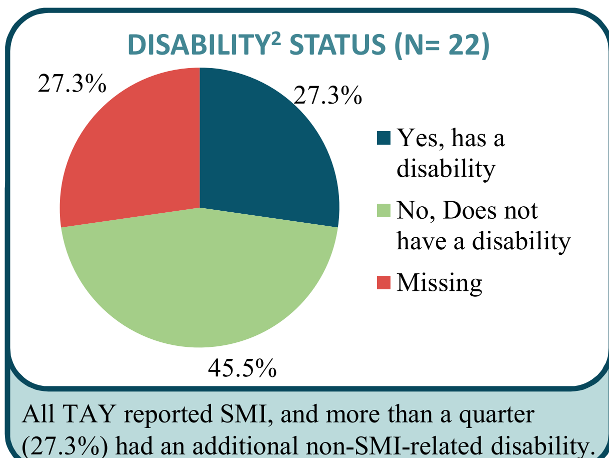
The majority (95.5%) of TAY spoke English as their primary language.

RACE/ETHNICITY (N=22)



About a quarter of TAY identified as Hispanic (22.7%) or African American (22.7%) with 18.2% identifying as White. Total may exceed 100% as participants were able to indicate more than one race.

DISABILITY[2] STATUS (N= 22)



All TAY reported SMI, and more than a quarter (27.3%) had an additional non-SMI-related disability.

TYPE OF DISABILITY (N=22)

Type	n	%
Hearing	< 5	< 22.7
Learning	< 5	< 22.7
Developmental	< 5	< 22.7

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

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

PROGRAM ATTENDANCE

During the last three months of FY 2018-19, an average of 50 group sessions and 71 individual sessions were offered per month. When analyzed according to enrollment reports, this represents a 40% rate of attendance by enrolled TAY (average of 2.4) in each group session. An average of four individual and/or group sessions were offered per day throughout the April-June reporting period.

Cooking classes had the highest mean attendance rate, at 80% of enrolled TAY (average of 4.8 TAY per session), with 12 sessions offered during the three month reporting period. Among the group sessions, Yoga and Meditation drew the most TAY throughout the April-June reporting period, with 66 attendees across the 38 offered group sessions. Meditation was offered in group and individual settings for a total of 75 sessions.

Among the individual sessions, Biofeedback was most highly attended, with an average of nearly one individual session provided every day of the three month period. Biofeedback sessions comprised psychoeducation, personalized holistic health planning, self-regulation and attention training, and physiological monitoring and training of stress-triggers, autonomic reactivity, and/or habitual stress reactions (e.g., shifts in and learned control of heart rate, breath dynamics, and muscle tension).

TABLE 2. HOLISTIC SERVICES ATTENDANCE RATES (APRIL-JUNE 2019)

April 2019-June 2019				
Services	**Group Sessions**	**Group Attendees**	**Group Mean Attendance**	**Individual Sessions**
Yoga	38	66	1.7	-
Reiki	13	30	2.3	-
Acupuncture	12	27	2.3	-
Grocery Shopping	14	44	3.1	-
Cooking Classes	12	57	4.8	-
Fitness Classes	12	35	2.9	-
Group Outings	11	33	3	-
Meditation	38	66	1.7	37
Massage	-	-	-	40
Biofeedback	-	-	-	83
Chiropractic Fitness	-	-	-	54
Totals	150	358	2.4	214

KEY EVALUATION FINDINGS

PARTICIPANT RATED OUTCOMES

Pre/Post Holistic Practice Assessment: TAY answered these six questions on multiple occasions – typically before and after participating in a JBU provided holistic practice (e.g., yoga, massage, biofeedback). Occasionally they were asked the questions without having a corresponding activity occurring in between question administrations to generate "control/no activity" data for comparison purposes. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree. Higher values correspond to higher levels of well-being and/or positive perceptions.

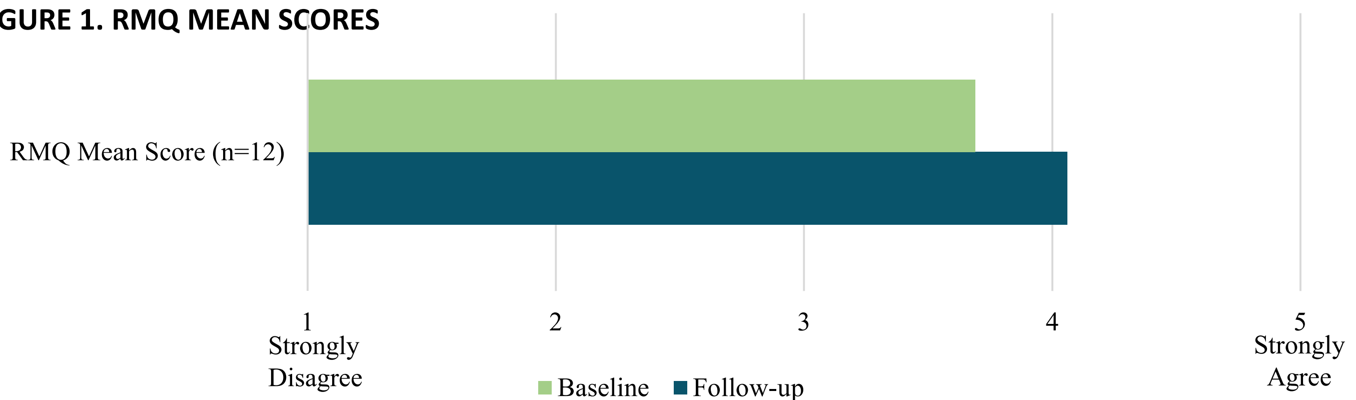
TABLE 3. PRE/POST HOLISTIC PRACTICE ASSESSMENT

Assessment Questions	Any Activity (n=74)		No Activity (n=21)	
	Mean		Mean	
	Pre	Post	Pre	Post
I have a sense of belonging	2.9	3.2	2.6	2.7
I feel hopeful about my future	3.0	3.2	2.6	2.6
I like and respect myself	2.9	3.2	2.5	2.6
I am using my personal strengths, skills, or talents	2.9	3.1	2.7	2.8
The technology I'm using in this program is helping me feel better	3.1	3.3	2.9	3.1
The holistic health practices I'm using in this program are helping me feel better	3.2	3.3	2.9	3.1

Overall, there was a pattern of more favorable ratings after participating in a holistic practice. In comparison, changes were either not evident or more muted when no activity occurred between question administrations. Additionally, the data suggest the potential for an anticipatory priming effect in that "Pre" values were higher when participation in holistic activities was expected than during the no activity controls. These findings suggest that there are positive changes in youth attitudes about themselves and their future due to participating in the range of holistic services provided through JBU.

Recovery Markers Questionnaire (RMQ): The RMQ is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks TAY to answer questions as it is "true for you now." As shown in the chart below, overall RMQ mean scores improved from baseline to follow-up.

FIGURE 1. RMQ MEAN SCORES



CHAMPSSS: The CHAMPSSS assesses TAY perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded such that higher scores indicate more positive perceptions and experiences. As such, an increase in scores regarding Suicidality reflect a more positive perception and experience for TAY.

TABLE 4. CHAMPSSS SUBSCALE

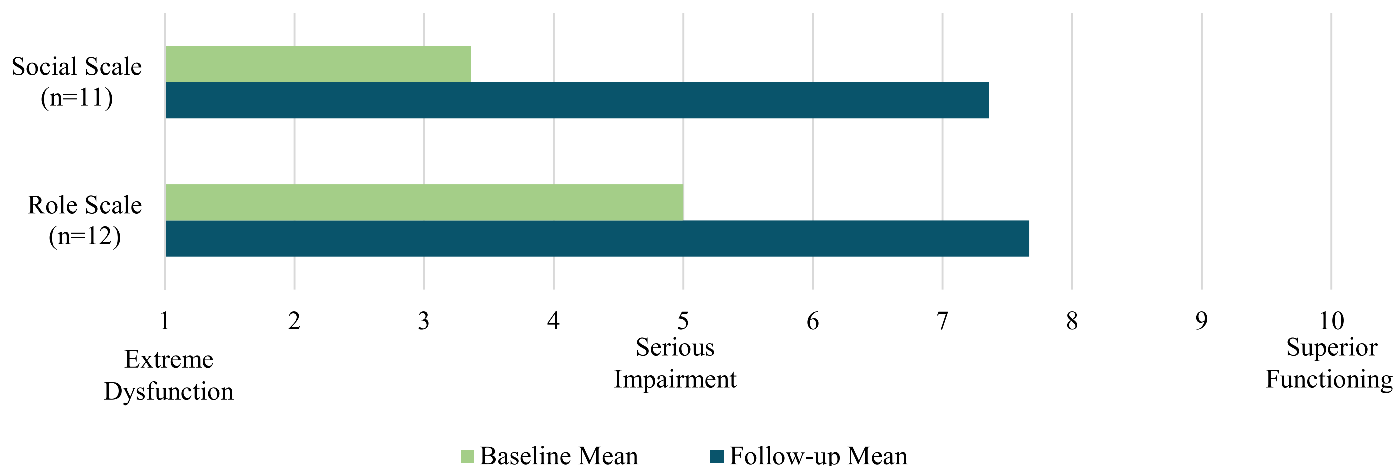
CHAMPSSS Subscale	n	Baseline		Follow-up	
		Mean	SD	Mean	SD
Global Health	12	3.0	0.6	3.4	0.4
Resilience	12	2.9	0.9	3.6	0.7
Depression	12	2.4	1.1	2.9	0.8
Anger	12	2.8	0.9	3.5	1.0
Anxiety	12	2.6	1.0	3.4	1.0
Suicidality	12	3.5	1.2	3.6	1.1
Substance Use	12	2.8	1.3	3.5	0.9
Substance Use Frequency	12	3.5	1.5	4.4	0.9
Memory	12	4.2	0.8	3.8	1.0
Functioning (4 point scale)	11	3.0	1.0	3.6	0.7

The CHAMPSSS findings demonstrated improvement in many different aspects of well-being from baseline. Factors related to substance abuse showed a slight positive trend. Of the nine TAY who were linked to voluntary substance abuse services, 44% (n=4) completed treatment/training, while 56% (n=5) declined.

PROVIDER RATED OUTCOMES

Global Functioning: Following a semi-structured interview, the provider rated the Role and Social Functioning of JBU TAY on a 10 point scale (1 = Extreme Dysfunction; 5 = Serious Impairment; 10 = Superior Functioning). For both scales, baseline mean values were typically in the 3-5 range (indicative of substantial impairment).

FIGURE 2. GLOBAL FUNCTIONING



Mean values increased to approximately 7.5, which is indicative of mild impairment/good functioning.

KEY EVALUATION FINDINGS CONTINUED

Illness Management and Recovery (IMR) Scale: To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by JBU staff. The IMR has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

TABLE 5. ILLNESS MANAGEMENT AND RECOVERY SCALE ITEMS AND SUBSCALES

IMR Item or Subscale	n	Baseline		Follow-up	
		Mean	SD	Mean	SD
Involvement of family and friends in his/her mental health treatment	12	2.0	1.2	3.0	1.4
Time in structured roles	11	1.7	1.0	3.5	1.4
Psychiatric hospitalizations	7	2.4	1.8	3.4	1.3
Using medication effectively	10	3.2	1.9	4.5	1.0
IMR Recovery Subscale	12	2.8	0.8	3.8	0.7
IMR Management Subscale	12	2.3	0.9	2.0	1.1
IMR Substance Abuse Subscale	7	2.9	1.6	2.9	1.4
Overall	12	2.6	0.4	2.9	0.7

The overall IMR scores indicated substantial improvements from baseline based on provider perceptions of the TAYs' recovery. The Recovery subscale demonstrated the largest area of improvement.

Milestones of Recovery Scale (MORS): The Milestones of Recovery Scale (MORS) captures recovery as assessed by staff using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

TABLE 6. MILESTONES OF RECOVERY SCALE (Pre-post; n=12)

		Baseline		Most recent	
1	Extreme Risk	8.3%	33.3%	0.0%	16.7%
2	High Risk/Not Engaged with mental health providers	16.7%		0.0%	
3	High Risk/Engaged with mental health providers	8.3%		16.7%	
4	Poorly Coping/Not Engaged with mental health providers	41.7%	41.7%	8.3%	8.3%
5	Poorly Coping/Engaged with mental health providers	0.0%	25.0%	8.3%	75.0%
6	Coping/Rehabilitating	8.3%		33.3%	
7	Early Recovery	16.7%		8.3%	
8	Advanced Recovery	0.0%		25.0%	

The findings indicate that upon entering JBU, the majority of TAY were in the lower categories (i.e., "higher risk"), whereas at follow-up there is a trend towards greater engagement and improved coping/rehabilitation.

LINKAGES TO SERVICES

The following tables indicate the linkages to external community services made across several key domains: mental health, substance abuse, and housing. These linkages were facilitated by JBU staff according to the individual and unique needs of JBU TAY. In total, 107 linkages were made, with 57 of the linkages (53.3%) connecting TAY to mental health services. Of substance abuse linkages, 18 (64.3%) were to residential or outpatient substance abuse services. These linkages reflect other evaluation data points indicating substance abuse as a substantial issue facing JBU TAY. Totals may exceed 100% due to multiple linkages.

MENTAL HEALTH	Unique TAY	Total Linkages
Linkage Type*	n=18	n=57
Independent psychiatrist	< 5	< 5
Private counselor/therapist	6	8
Specialty mental health clinic	9	13
Behavioral health within primary care clinic	< 5	< 5
Inpatient treatment	< 5	< 5
Crisis house	< 5	< 5
Self-help groups (e.g., WRAP, Roadmap to Recovery – these may be offered outside of clinics)	5	5
Clubhouse	< 5	< 5
Assertive Community Treatment	7	12
Psychiatric Evaluations	< 5	< 5
Medication Management	5	6

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

SUBSTANCE ABUSE	Unique TAY	Total Linkages
Linkage Type*	n=9	n=28
Outpatient substance abuse services	7	11
Substance abuse recovery self-help group (12 Step)	< 5	< 5
Residential AOD treatment	< 5	7
Sober living	< 5	< 5
Detox	< 5	< 5
Inpatient hospital treatment (includes medical detox)	< 5	< 5

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

HOUSING	Unique TAY	Total Linkages
Linkage Type*	n=14	n=22
Housing assistance voucher program (Section 8, Shelter Plus Care, CalWORKS, etc.)	5	5
Emergency Shelter	< 5	< 5
Apartment/House	< 5	5
Independent Living Facility (ILF)	< 5	< 5
Resources to assist obtaining a living environment (e.g., Housing Prioritization Assessment)	9	11

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

ANNUAL FEEDBACK SURVEY – JBU STAFF

At the end of FY 2018-19 (6/30/2019), staff for the Just Be U Program were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 5 respondents from the 9 staff members invited to participate in the survey, a response rate of 55.5%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Primary goals of this program during this past year:*
    a. Improve mental health of TAY.
    b. Decrease stigma around mental health issues.
    c. Utilize a holistic approach to mental health.
    d. Supporting housing.

2. *Factors that helped the program achieve goals:*
    a. Service offerings (i.e., massage, needling, biofeedback, classes, etc.).
    b. Connection/outreach with community (i.e., jails and hospitals).
    c. Holistic nature of services.
    d. Peer support.

3. *Factors that inhibited the program from achieving goals:*
    a. SUD behavior/lack of counseling available.
    b. Youth attendance/retention/engagement.
    c. Need for more/more frequent mental health services.

4. *Recommendations to better achieve program goals:*
    a. Increased access to SUD services.
    b. More/more frequent mental health services.
    c. Attendance/retention/engagement efforts.
    d. Change the eligibility requirements.
    e. Medication services.

5. *Supports, tools, and/or trainings needed to do job well:*
    a. SUD resources.
    b. More training (i.e., peer support, mental health, WRAP, WHAM, case management).
    c. Group therapy.
    d. Group communications for community building.
    e. On-site mental health services.

6. *Key strengths of this program:*
    a. Staff factors (i.e., dedication, relatability).
    b. Holistic approach of the program.
    c. The variety of offerings.
    d. Provision of basic needs (i.e., food, shelter).

7. *Primary barriers or challenges to achieving objectives with JBU participants:*
    a. SUD issues (use/abuse, or lack of services available).
    b. SMI issues.
    c. Medication/psychiatric service issues (i.e., med compliance, lack of psychiatric follow-up).
    d. Lack of mental health resources.

ANNUAL FEEDBACK SURVEY – EXTERNAL SERVICE PROVIDERS

At the end of FY 2018-19 (6/30/2019), external service providers (e.g., yoga instructors, chiropractors, etc.) for the Just Be U Program were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 6 respondents from the 7 providers invited to participate in the survey, a response rate of 85.7%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Primary goals of the JBU program:*
   a. Calm/relaxation.
   b. Youth personal development, self-discovery.
   c. Provide a safe space.
   d. Provide support.

2. *Factors that helped the program achieve goals:*
   a. Service offerings (i.e. massage, needling, biofeedback, classes, etc.).
   b. Staff factors (i.e. supportive, encourage participation, etc.).
   c. Space factors (i.e. comfortable, quiet, etc.).
   d. Leadership factors.

3. *Factors that inhibited the program from achieving goals:*
   a. Youth attendance/retention/engagement.
   b. Fear of needles.
   c. Scheduling issues.
   d. Provider issues (i.e. training, biases, etc.).

4. *Recommendations to better achieve program goals:*
   a. Attendance/retention/engagement efforts.
   b. Community collaboration.
   c. Scheduling changes (i.e. times that services are offered).
   d. Promotion efforts.

5. *Key strengths of this program:*
   a. Staff factors (i.e. dedication, relatability).
   b. Holistic approach of the program.
   c. The variety of offerings.
   d. Leadership factors.

6. *Supports, tools, and/or trainings would you want more of to work well with the JBU program:*
   a. Additional training (i.e. mental health, at-risk youth, etc.).
   b. Guidance and mentorship from leaders.

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Addressing substance use is a substantial challenge for most JBU enrollees.

2. Finding and making contact with potentially eligible youth is difficult due to limited or old contact information, and restrictive program eligibility criteria.

3. Program design is uniquely appealing to this difficult-to-reach populations as evidenced by a 100% receptivity rate, with nearly all youth contacted by JBU becoming either enrolled or awaiting enrollment by the end of the Year 1 reporting period.

4. The holistic practices appear to have an immediate positive effect on youth attitudes about themselves and outlook for future.

5. Non-compliance with prescribed medications for severe mental illness is common and presents challenges to TAY's behavioral and mental stability, and with staff's ability to improve engagement with services. The majority of TAY have or had prior prescriptions for psychiatric medications, 100% have severe mental illness, but very few are able or willing to comply with an oral drug regimen. TAY who were receptive to long-acting injections (e.g., once per month) experienced greater benefit from this ease-of-compliance, however the qualification process for this drug-delivery option is difficult, such that oral prescriptions remain the norm despite low compliance rates.

6. The primary inputs to homelessness in this population appear to be unaddressed severe mental illness and co-occurring substance abuse disorders, and not simply the unavailability of material resources or access to social services.

7. A high level of daily engagement and incentivizing by staff is required to link TAY to available outside services, despite the importance of such services to ongoing well-being, including healthcare, housing, education, and employment. This seems to reflect TAY's low expectations of success and low levels of sustained effort to recall or arrive at scheduled service appointments.

8. The characterization of being "independent living" capable among the TAY defined as eligible for this program should be more carefully considered and professionally assessed in each case, given the tenacity of the mental illness and substance use disorders observed in this cohort. A high-touch approach, with regular supervision and monitoring by staff has been required to link and sustain services and functioning for all the initial graduates of the program.

9. The human factors among staff, such as warmth, friendliness, compassion, advocacy, flexibility/forgiveness, and availability/willingness to respond to TAY's pressing needs account for the highest success rates in retaining and linking TAY to services. Following a breach of program rules, our TAY typically expect and quickly resign themselves to an expectation of immediate rejection from the program/community. They are usually surprised, however, by the flexibility and individual case considerations applied by staff. This non-rejection, and the trust born of well-established rapport, consistently arises as a central causative factor in beneficial outcomes.

10. The 90-day period of enrollment passes quickly from both the perspective of the staff and TAY, and both consider that a longer period would be more beneficial, especially given the importance of both establishing mental/sobriety stabilization and cultivating trust/rapport with staff to deliver the best outcomes.

YEAR 1 PROGRAM CHANGES

1. Enrollment criteria, which had been predominantly limited by the requirement of five prior crisis/acute care contacts per TAY, was, in the final two months of the year, relaxed to four such contacts, to incrementally expand the eligibility pool and counteract the insufficiency or out-datedness of the available contact information provided to outreach staff.

2. JBU maintains engagement with youth after leaving JBU facility for 60 days to facilitate and support the connections made to other community programs/resources.

3. JBU encourages program graduates to return and participate in services and to motivate current enrollees.

4. Streamlined visual and audio feedback to TAY during biofeedback sessions to improve focus and make more clear the moment, direction, and magnitude of shifts (e.g., muscle tension, heart rate). Reduced complexity of virtual reality-based feedback to render the visual and audio feedback more accessible and apparent via dedicated biofeedback software.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Explore options for additional substance abuse-related education and treatment supports, including on-site resources.

2. Increase rapid access to psychological/psychiatric evaluations for TAY demonstrating behaviors consistent with SMI and probable non-adherence to previously prescribed medication, undiagnosed SMI issues, and need for psychoeducation/destigmatization of psychiatric medication use/effects, as appropriate.

3. Discuss reducing current enrollment criteria to fewer prior crisis/acute care contacts to ensure maximal enrollment and provision of services to homeless TAY.

4. Expand capabilities of web-based Administrator Portal for management of biometric measurements data, services scheduling/reminders, community participation, push-notification of TAY self-assessment quizzes, tracking of incentive point system, and delivery and tracking of use-patterns of training tools within JBU App (e.g., guided meditations, paced breathing, psychoeducation modules, motivational messaging, resources directory); expansion of same to web- and Android-based platforms to improve adoption by TAY.

5. Improve participation and program compliance through greater individualization of holistic health plans, use of written behavior/program-expectations contracts, improved staff use of shared data on compliance (e.g., status of required data input, services attendance, key linkages attended, housing/employment/education track progress, personal goals, community participation, incentives earned), and use of creative incentivizing of TAY.

6. Increase group trainings/events to further deepen community connections among JBU and affiliated program's TAY.

7. Elevate awareness among TAY of nature as template and resource for maintaining balance, perspective, and sense of well-being through increased exposure to natural environments, natural cycles, nature-reverence, and engagement with professionally trained/certified facility animals and handlers.

8. Explore potential for extending JBU services beyond the initial 90-day period to further increase the rapport and trust between TAY and staff that strongly determined successes to date, as well as to accommodate timeframes for key linkage implementation (e.g., housing, SUD training, SMI stabilization).

For additional information about the INN–21 Just Be U program and/or this annual report,
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THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (INNOVATIONS-22)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

UC San Diego

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS)' Center for Child and Youth Psychiatry (CCYP) program is funded through the Innovations (INN) component of the Mental Health Services Act. CCYP was developed to provide medication support to children and youth who have completed behavioral health treatment yet require ongoing monitoring by a psychiatrist of psychotropic medications essential for the child and youth's sustainable wellness and stability.

Treatment and education efforts by CCYP are intended to increase access to and knowledge of appropriate behavioral health services for underserved persons who are not able to be monitored by their primary care physician. Services are to be provided through a variety of means, including a centrally located psychiatric clinic, remote telepsychiatry, and a specialty medical clinic for youth with complex medical problems. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full service clinics, schools, primary care physicians), and the communities they serve.

A San Diego-based community organization, New Alternatives, was contracted to provide CCYP services, which included: 1) recruiting psychiatrists, care coordinators, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families. An innovative feature of this program is the provision of remote telepsychiatry services to support clients throughout San Diego county.

EXECUTIVE SUMMARY

The Center for Child and Youth Psychiatry was designed to provide psychiatric evaluation and treatment to children and youth with complex medication needs who have completed behavioral health treatment yet require ongoing medication monitoring to support stability. Staff include psychiatrists and care coordinators who provide services both at clinics and remotely via telepsychiatry. Psychoeducation is also provided to family members of clients.

- During FY 2018-19, 241 clients were enrolled into the CCYP program (program target = 500). Of these, 70.1% were at least 12 years old. Approximately half (51.1%) of the clients served were female and 39.0% reported having a disability that was not mental health-related.
- CCYP served a diverse population: Hispanic or Latino (52.7%), White (35.3%), and African American (14.5%).
- While the CCYP enrollment population is expected to not need ongoing therapy, the baseline assessment results across multiple tools suggest that there still may be needs for behavioral and/or functional improvements for some.
- Consistent with expectations, BHS crisis/acute care services were rarely accessed prior to or after CCYP enrollment. This pattern suggests the program was achieving the primary objective of maintaining stability for clients with complex medication management needs.
- Telepsychiatry was utilized by 25.8% of the CCYP clients for at least some of their medication management visits with a psychiatrist.
- Key factors identified by staff that helped the program achieve its goals included: 1) strong organization, management, and communication, 2) a high performing multidisciplinary team, 3) professional communication with staff, and 4) an easy and prompt referral process.
- Challenges to utilizing telepsychiatry included its perceived impact on the doctor-patient relationship, technological issues, and the time taken by staff to facilitate the telepsychiatry sessions.

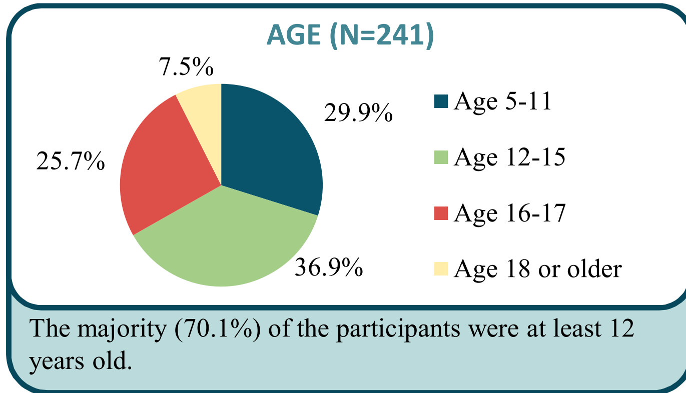
RECOMMENDATIONS

Program recommendations included: 1) continue to pursue options for providing CCYP services to medically complex populations, 2) enhance follow-up data collection to allow for detailed assessment of program outcomes, 3) explore CCYP client preferences for and experiences with telepsychiatry services via surveys and/or interviews and focus groups to determine if opportunities for greater utilization of telepsychiatry exist, 4) enhance internal and external communication regarding the program's ability to incorporate provision of short-term therapy services as needed, and 5) replace the Licensed Vocational Nurse position with a Certified Nursing Assistant to enhance the position's ability to support the care coordinators in facilitating telepsychiatry services.

PARTICIPANT CHARACTERISTICS

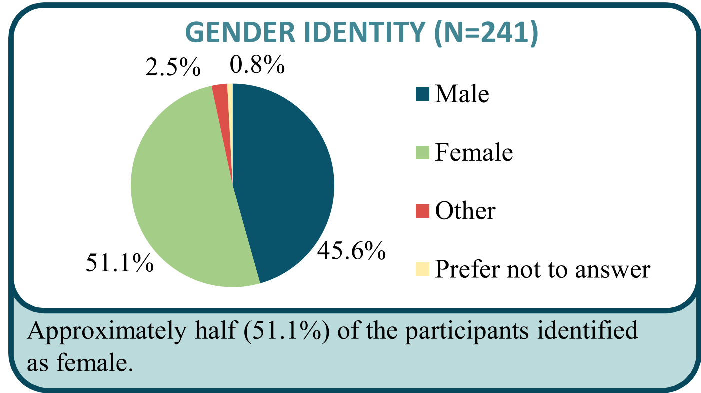
The following self-reported characteristic data were collected from participants during initial enrollment into CCYP.[1]

AGE (N=241)



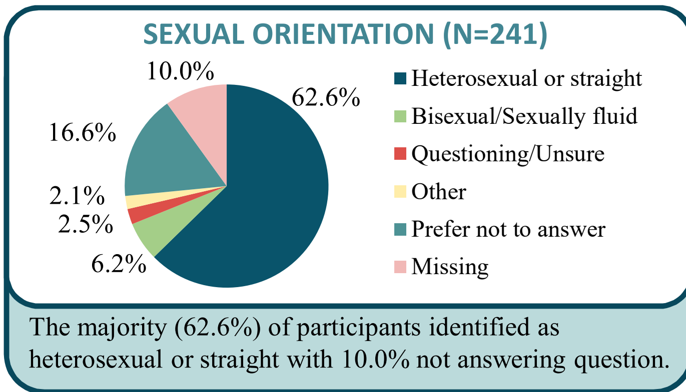
The majority (70.1%) of the participants were at least 12 years old.

GENDER IDENTITY (N=241)



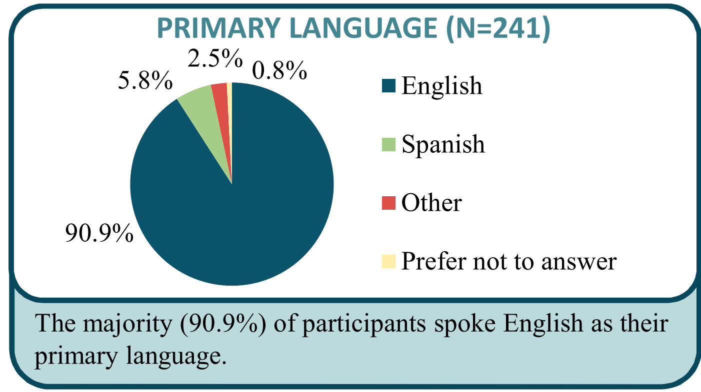
Approximately half (51.1%) of the participants identified as female.

SEXUAL ORIENTATION (N=241)



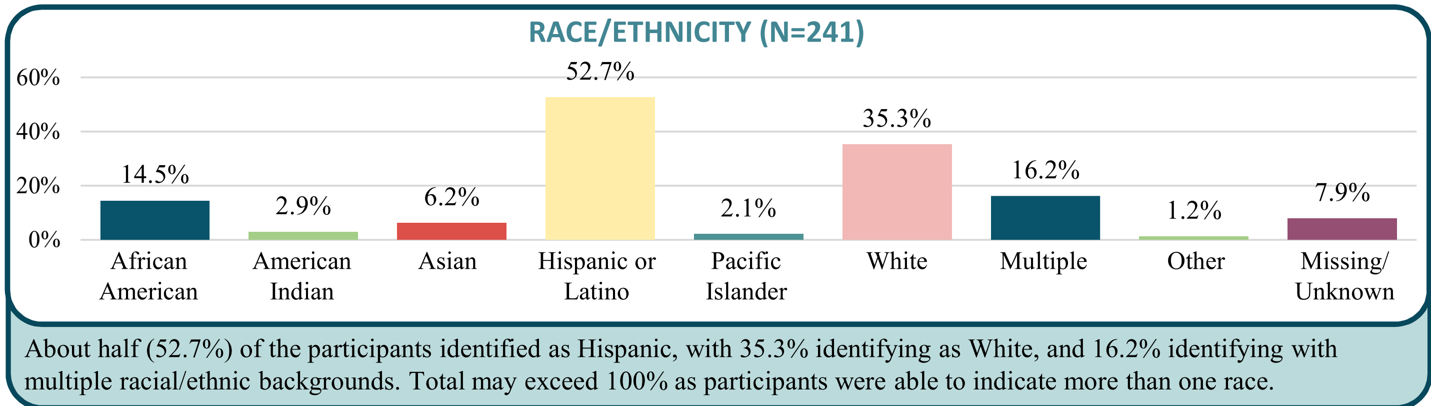
The majority (62.6%) of participants identified as heterosexual or straight with 10.0% not answering question.

PRIMARY LANGUAGE (N=241)



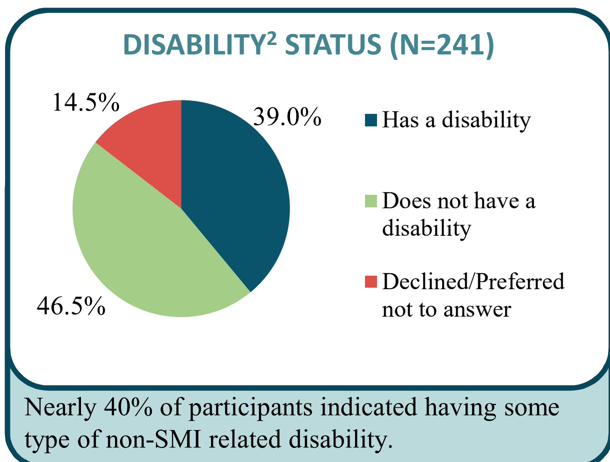
The majority (90.9%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=241)



About half (52.7%) of the participants identified as Hispanic, with 35.3% identifying as White, and 16.2% identifying with multiple racial/ethnic backgrounds. Total may exceed 100% as participants were able to indicate more than one race.

DISABILITY[2] STATUS (N=241)



Nearly 40% of participants indicated having some type of non-SMI related disability.

TYPE OF DISABILITY (N=94)

Type	n	%
Communication (e.g., seeing, hearing)	42	44.7
Mental (e.g., learning)	38	40.4
Developmental	25	26.6
Other Mental	11	11.7
Physical	7	7.4
Other	23	24.5

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

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

CCYP ENROLLMENT CATEGORIES

AUTHORIZED AND EXCEPTION CLIENTS

- A total of 241 persons were enrolled into the CCYP program during FY2018-19 (program target = 500). The time needed for initial program implementation was the primary factor inhibiting the achievement of the enrollment target of 500 clients during Year 1. Of the 241 enrollees, 207 (85.9%) were considered "authorized" enrollees who met the standard eligibility criteria (i.e., requiring medication management services but not therapy services), and 34 (14.1%) were considered "exception" enrollees who were approved to receive CCYP services even if they did not meet standard eligibility criteria.
- The primary reason for "exceptions" was to address short-term gaps in the availability of psychiatric care at outpatient clinics throughout San Diego county. These situations typically resulted due to unexpected absences or turnover among psychiatrists at these clinics.
- Providing continuity of psychiatric care in these situations was determined to be an unanticipated, but important role for CCYP to fulfill as a resource to support the overall San Diego County Child, Youth, and Family System of Care.
- Unless otherwise noted, data presented in this report refers to authorized referral cases only
- Data from exception referrals will be further explored and presented upon separately in future reports.

BASELINE CHARACTERISTIC OF CCYP PARTICIPANTS

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a structured assessment used for identifying actionable needs and useful strengths among youth. It provides a framework for developing and communicating a shared vision by using information from both the youth and family members to inform planning, support decisions, and monitor outcomes. The CANS is completed by providers at baseline, 6-month reassessment, and discharge. During FY2018-19, the CANS was completed at baseline by CCYP providers for 206 youth aged 6 to 21.

As can be seen in Table 1, the CANS assessment measures a variety of domains to identify the strengths and needs of youth. Each domain contains a certain number of questions that are rated 0-3, with twos and threes indicating a specific area that should be addressed in the service or treatment plan. Within a domain, the number of questions rated at least a 2 or a 3 can be counted as a way to see which areas indicate a higher need for support. Table 1 shows the mean, median, and max count of needs. For example, the domain of Behavioral/Emotional Needs contains 9 questions and shows that the average youth in the program had 2.5 questions rated at least a 2 or a 3.

Overall, providers reported the highest mean count of needs for the Strengths (i.e., lack thereof) and the Behavioral/Emotional Needs domains. Moreover, the high median count of needs in the strengths domain is striking compared to the median for the other domains. The lowest mean counts of needs are seen in cultural factors, caregiver resources, and risk behaviors. These ratings suggest that although the target CCYP enrollment population is expected to be not needing ongoing therapy, there were still some areas in their lives that could benefit from improvement.

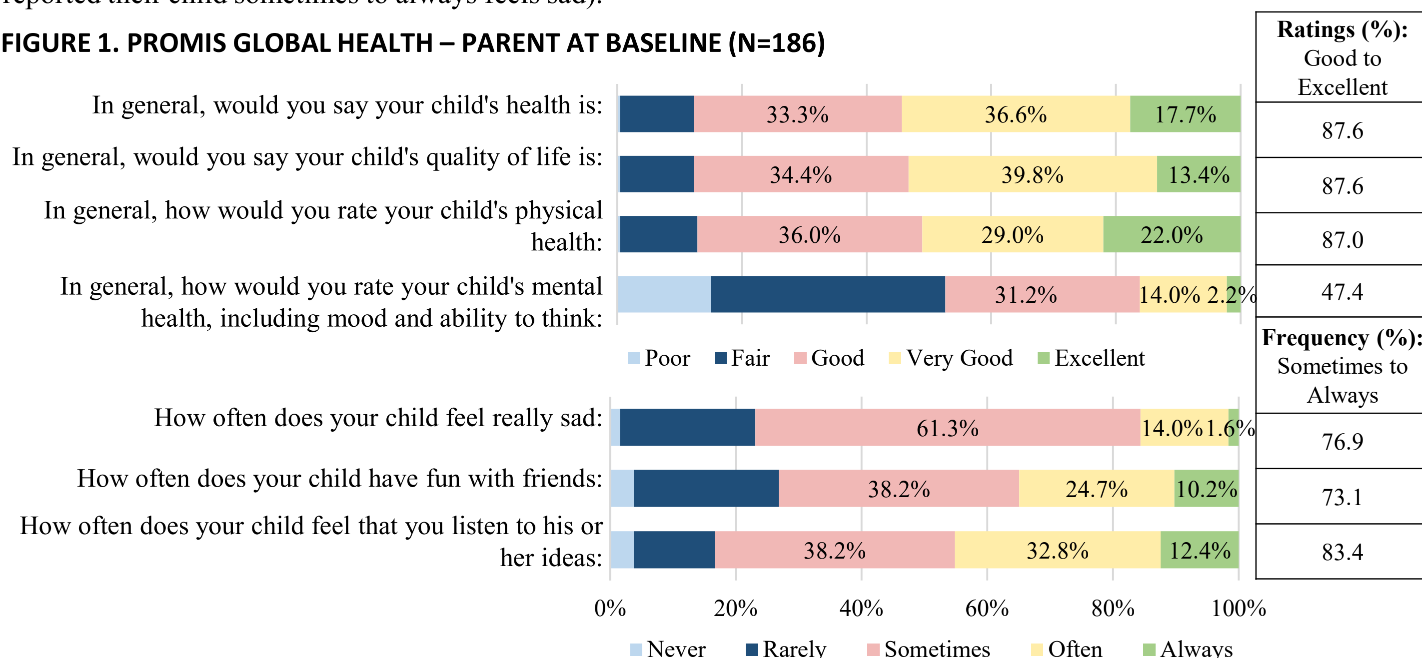
TABLE 1. CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) AT BASELINE (N=206)

	Baseline CANS			
# of questions in domain	Domain	Mean count of needs (i.e. ratings of 2,3)	Median count of needs	Max count of needs
9	Behavioral/Emotional Needs	2.5	2	8
10	Caregiver Resources	0.2	0	6
9	Strengths (i.e., lack thereof)	5.3	6	9
11	Life Functioning	1.4	1	8
3	Cultural Factors	0.1	0	3
8	Risk Behaviors	0.3	0	5
50	All items	9.7	10	22

PROMIS GLOBAL HEALTH

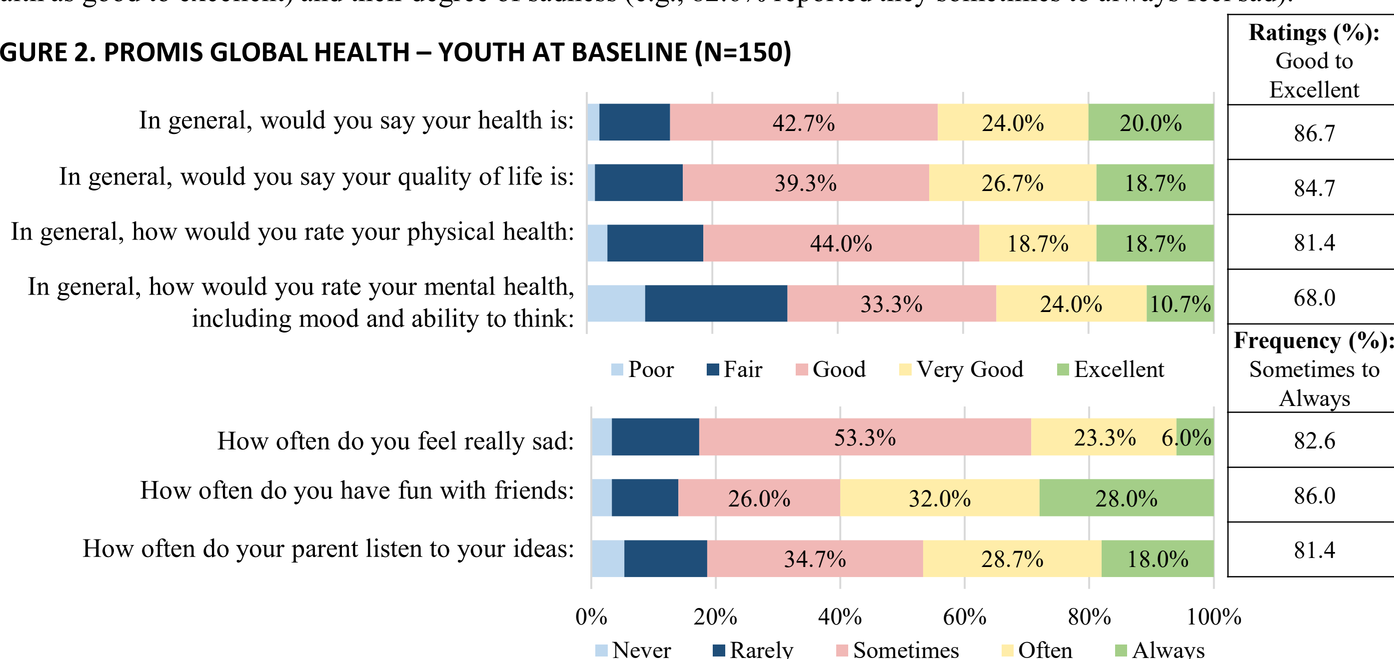
The Patient-reported Outcomes Measurement Information System (PROMIS) Global Health measure was administered at baseline, 6-month reassessment, and discharge. Items are rated on a five-point scale with higher scores indicating better health. During FY 2018-19, the PROMIS Global Health – Parent measure was completed at baseline by 186 caregivers of children and youth ages 5 to 21. On average, caregivers reported that the best areas of functioning were children's overall health, physical health, and quality of life, while the poorest areas of functioning were children's overall mental health (e.g., only 47.4% rated mental health as good to excellent) and their degree of sadness (e.g., 76.9% reported their child sometimes to always feels sad).

FIGURE 1. PROMIS GLOBAL HEALTH – PARENT AT BASELINE (N=186)



During FY 2018-19, the PROMIS Global Health – Youth measure was completed at baseline by 150 children and youth ages 8 to 21. Somewhat similar to their caregivers, children and youth reported on average that the best areas of functioning were their peer interactions, overall health, and quality of life. Similar to their caregivers, children and youth reported on average that the poorest areas of functioning were their overall mental health (e.g., only 68.0% rated mental health as good to excellent) and their degree of sadness (e.g., 82.6% reported they sometimes to always feel sad).

FIGURE 2. PROMIS GLOBAL HEALTH – YOUTH AT BASELINE (N=150)



PEDIATRIC SYMPTOMS CHECKLIST (PSC)

The Pediatric Symptoms Checklist (PSC-35) is a screening tool designed to support the identification of emotional and behavioral problems. Parents/caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 2.[1]

In FY2018-19, the PSC-35 was administered at baseline, 6-month reassessment, and discharge. The PSC-Parent was completed by 188 caregivers of children at baseline. The PSC-Youth was completed by 150 youth at baseline. Table 2 shows about half of all youth were above the total cutoff score on both the parent report (51.1%) and youth report (44.0%). Mean scores across the total score and three subscale scores were comparable for caregivers and youth, with the exception of the externalizing subscale (33.0% of caregiver reports were above the cutoff; 8.7% of youth reports were above the cutoff).

TABLE 2. PEDIATRIC SYMPTOMS CHECKLIST AT BASELINE

	PSC-Parent (n=188)				PSC-Youth (n=150)			
	Mean:	Median:	Above cutoff		Mean:	Median:	Above cutoff	
			n	%			n	%
PSC Score	28.6	28	96	51.1	24.5	26	66	44.0
Attention Subscale	5.2	5	64	34.0	4.6	4	35	23.3
Internalizing Subscale	4.5	4	92	48.9	3.8	4	57	38.0
Externalizing Subscale	5.0	5	62	33.0	3.1	3	13	8.7

[1] PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7

CCYP SERVICE UTILIZATION

Of the 155 clients who enrolled by April 1, 2019 (allows for at least 90 days of service provision prior to end of report period), the mean number of total services provided per client was 11.6 (Table 5). The mean number of medication management services provided per client was 3.4, with 2.5 nurse consults and 3.1 other CCYP support service contacts.

TABLE 3. CCYP SERVICE UTILIZATION (N=155)

	Total Services Provided	Mean Services per Client	Maximum Services per Client
Psychosocial assessments	279	1.8	3
Medication assessments	135	0.9	2
Medication management/consults	534	3.4	10
Nurse consults	380	2.5	10
Other CCYP support services	473	3.1	22
All CCYP services provided	1,801	11.6	34

As shown in Table 6, 25.8% of the clients receive some or all of their CCYP psychiatrist medication management visits via video telehealth/telemedicine interactions.

TABLE 4. UTILIZATION OF TELEPSYCHIATRY SERVICES (N=155)

	Number of unique clients	
Only video telehealth/telemedicine	9	5.8%
Only face-to-face only	115	74.2%
Combination or video telehealth/telemedicine and face-to-face	31	20.0%

BEHAVIORAL HEALTH SERVICE (BHS) UTILIZATION PATTERNS

SAN DIEGO COUNTY BHS SERVICES 90 DAYS BEFORE AND AFTER CCYP ENROLLMENT

The utilization of behavioral health services by CCYP participants was examined 90 days before and 90 days after starting the program. To ensure that everyone included in the analyses had 90 days to be observed for any behavioral health service utilization after starting CCYP, the analyses only included participants (n=155) who started the program at least 90 days prior to the end of the reporting period (6/30/2019).

Utilization of various BHS acute/crisis care services appeared to be very stable across the pre-CCYP and post-CCYP time periods (Table 7). This pattern was consistent with expectations that CCYP can maintain stability among persons with complex medication management needs.

TABLE 5. BHS UTILIZATION BEFORE AND AFTER CCYP SERVICES (N=155)

Service utilization, among those with enrollment before 4/1/2019	90 Days Pre-CCYP Enrollment		90 Days Post-CCYP Enrollment	
	n	%	n	%
Inpatient hospitalization	< 5*	< 3.2*	< 5*	< 3.2*
Crisis stabilization	< 5*	< 3.2*	5	3.2
Urgent outpatient	< 5*	< 3.2*	< 5*	< 3.2*
PERT[1]	< 5*	< 3.2*	< 5*	< 3.2*
Day treatment	< 5*	< 3.2*	< 5*	< 3.2*
Therapeutic behavioral services	8	5.2	< 5*	< 3.2*

* The exact number of persons was suppressed due to small numbers and the need to minimize risk of potentially identifying individual participants; [1] PERT = Psychiatric Emergency Response Team

OTHER SERVICE UTILIZATION

SELECT NON-MEDICATION SERVICES

Clients were surveyed on various services delivered within and outside of school settings. More than half of all clients reported having an IEP or a 504 plan (65.5% total) at baseline. Less than half (45.3%) reported receiving non-medication services outside of school settings.

TABLE 6. PARTICIPATION IN ADDITIONAL SUPPORT SERVICES AT CCYP ENROLLMENT (N=203)

Service	Yes	
	n	%
Current 504 plan	28	13.8
Current IEP	105	51.7
Non-medication related services outside school	92	45.3

- Examples of non-medication services received outside of school settings included: speech, occupational and physical therapies, special education, social skills, and respite care.

ADDITIONAL EDUCATION / COMMUNITY OUTREACH ACTIVITIES

Education Sessions:

- For FY2018-19, CCYP held 5 education sessions and different locations throughout San Diego.
- The topics included: 1) Psychopharmacology, 2) Medication administration & storage, and 3) Trauma and how it affects the bodies, minds, and behaviors of kids.
- Total attendees = 33

Resource Fair:

- For FY2018-19, CCYP held one resource fair (a four hour event) at a community library.
- Programs in attendance included: Mental Health Systems Families Forward, San Diego Regional Center, Transitional Housing Program, North County Crisis Intervention and Response Team, SmartCare (Vista Hill), Emergency Screening Unit.
- Additionally, brief education sessions were offered throughout the event that covered: 1) Trauma and its effects on behavior, 2) Nutrition, and 3) Medication administration and storage.
- Total attendees = 9

Challenges:

- Getting people in the door for all events.
- Organizing and staffing events with resulting low attendance.
- Because CCYP clients have already completed intensive therapy and medication services prior to coming to CCYP, they appear reluctant to engage in any additional activities outside of their normal psychiatry appointments.

Approaches to Address Challenges:

- CCYP has solicited inputs from families on what motivates them to come to education sessions.
- Childcare and food have been offered, along with topics of interest to parents.
- Locations have been changed to see if distance/accessibility affects attendance.
- Multiple forms of advertising have been used: hard mailings, calls, emails to other programs, and leveraging personal and professional networks, when possible.

ANNUAL PROGRAM STAFF AND PROVIDER FEEDBACK SURVEY

At the end of FY 2018-19, CCYP program staff and external referring providers were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 14 respondents from the 14 CCYP staff invited to participate in the survey (a 100% response rate), and 11 respondents from the 41 referring providers invited to participate in the survey (a 27% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Major program goals identified by respondents:*
   - Both staff and referring providers identified the major program goal as providing medication management, followed by providing education and linkages.

2. *Factors that helped CCYP achieve program goals:*
   - Staff identified the following factors:
     a. Strong organization, management, and communication.
     b. High performing multidisciplinary team.
     c. Psychiatrist availability and motivation to serve this population.
   - Referring providers identified the following factors:
     a. Professional communication with staff.
     b. Easy and prompt referral process.

3. *Factors that made it challenging for CCYP to achieve program goals:*
   - Staff identified the following factors:
     a. Inappropriate referrals.
     b. Internal program challenges regarding protocols and productivity expectations, in particular for care coordinators.
   - Referring providers did not comment on this topic.

4. *Benefits to telepsychiatry:*
   - Both staff and referring providers commented that telepsychiatry provides greater access to services.

5. *Challenges to telepsychiatry:*
   - Both staff and referring providers commented that telepsychiatry can:
     a. Affect the quality of the doctor-patient relationship.
     b. Affect the doctor's ability to assess nuances in client behavior and presentation.
     c. Be impacted by technological issues.
   - Staff also commented that the time taken by licensed care coordinators is not billable and takes time away from service provision.

6. *Recommendations to increase CCYP's ability to achieve program goals in Year 2:*
   - Staff identified several recommendations, including:
     a. Increase marketing to obtain more appropriate referrals.
     b. More support for a minimal psychotherapy component to facilitate maintenance of current level of functioning.
     c. Increase general staff support and resources (e.g., administrative support for scheduling and paperwork).
     d. Enhance care coordinator and psychiatrist ability to link clients to community resources.
     e. Increase continuing education and training opportunities for staff.
     f. Address productivity and staffing challenges for care coordinators.

KEY YEAR 1 PROGRAM "LEARNINGS"

1. CCYP is meeting an important need in the community with almost 250 clients served in the first year of the new program.
2. Findings suggest that CCYP is able to maintain stability among clients as evidenced by low utilization rates of acute/crisis care services both prior to and after enrollment in CCYP.
3. Telepsychiatry is a complex service provision modality and there is more to learn about how to optimize its use for this population. For example, a combination of telepsychiatry and face-to-face utilization was more common than telepsychiatry alone, suggesting that some in-person contact with providers is desired. In addition, only 25% of clients utilized telepsychiatry to receive at least some of their CCYP services, indicating that that families are making efforts to attend sessions in person even when telepsychiatry options are available.
4. CCYP's ability to provide short-term psychotherapy when indicated to maintain stability can be more widely communicated both internally and externally.

YEAR 1 PROGRAM CHANGES

One change to the program in Year 1 involved making exceptions for certain clients who were still in psychotherapy to receive medication management through CCYP. The reason for these exceptions typically was due to filling a need for medication management services when an outpatient clinic had psychiatrist leaves of absence or vacancies. Additionally, the CCYP program was not able to establish a co-located clinic for medically complex children during Year 1 due to a range of inter-organizational challenges and barriers. Providing services to this population will continue to be pursued during Year 2.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Continue to pursue options for providing CCYP services to medically complex populations.
2. Enhance follow-up data collection to allow for detailed assessment of program outcomes.
3. Explore CCYP client preferences for and experiences with telepsychiatry services via surveys and/or interviews and focus groups to determine if opportunities for greater utilization of telepsychiatry exist.
4. Enhance internal and external communication regarding the program's ability to incorporate provision of short-term therapy services as needed.
5. Replace the Licensed Vocational Nurse position with a Certified Nursing Assistant to better fit the position's ability to support the care coordinators in facilitating telepsychiatry services.

For additional information about the INN–22 Center for Child and Youth Psychiatry (CCYP) and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu