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

Mental Health Services Act Innovation Projects (Cycle 3)

Annual Report: FY 2016-17

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

UC San Diego

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CAREGIVER WELLNESS PROGRAM (INNOVATIONS-11)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 2 (7/1/16 - 6/30/17)

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

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

EXECUTIVE SUMMARY

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

- During 2016-17, 73 new caregivers entered CWP.
- The primary language for 23.3% of the caregivers entering CWP was Spanish, with 41.1% indicating Hispanic origin.
- In general, caregivers who entered into CWP expressed favorable attitudes regarding the benefits of and their needs for receiving behavioral health services.
- The in-home needs assessments highlighted many caregiver needs. About half of respondents indicated a need for more knowledge parenting their children (51.3%), more emotional support (53.8%), and meeting with a professional to discuss problems (48.7%). Other common need areas were related to housing (38.5%), financial resources (41.0%), and legal matters (33.3%).
- Approximately 70% of participants received at least one CWP case management visit and 40% attended at least one psycho-education support group session provided by CWP.
- At follow-up, caregivers were more likely to indicate active involvement in addressing their own problems.
- CWP successfully engaged participants from commonly underserved population groups (e.g., males and Spanish-language speakers), in CWP services.
- Very few participants received services from the County BHS system prior to or after CWP; however, most (72.2%) were linked by CWP to other behavioral health supports.
- Caregivers indicated high levels of satisfaction with CWP and that most received a range of emotional, educational, and tangible supports from PCCs.
- CWP staff identified key factors that helped achieve CWP program goals: 1) collaboration and communication between CWP leadership, PCCs, and therapists, 2) PCCs relationships with caregivers, 3) having structured curriculum for psycho-educational support groups, 4) CWP staff "buy-in" into the importance of caregiver well-being, and 5) efficient and effective program operations/coordination.

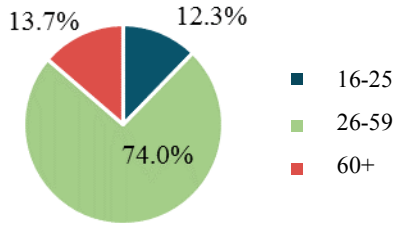
RECOMMENDATIONS

Primary recommendations include: 1) Explore options for providing individual therapy as part of CWP, 2) Examine potential for CWP "alumni" to continue participation in CWP services after child is no longer in KidSTART, 3) Obtain additional resources to expand frequency and diversity of times that psycho-educational support groups are offered.

CAREGIVER WELLNESS PROGRAM PARTICIPANT DEMOGRAPHICS

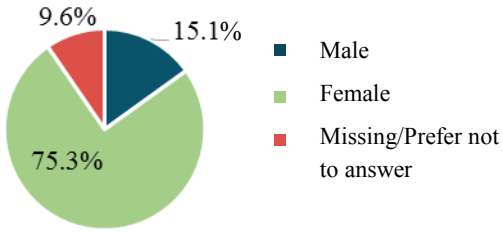
The following demographic data were collected from a participant self-report survey administered at the start of the CWP program.

AGE (N=73)



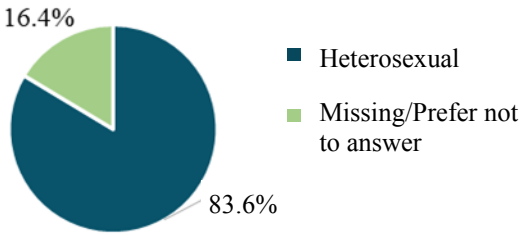
The majority of participants (74.0%) were between the ages of 26 and 59.

GENDER IDENTITY (N=73)



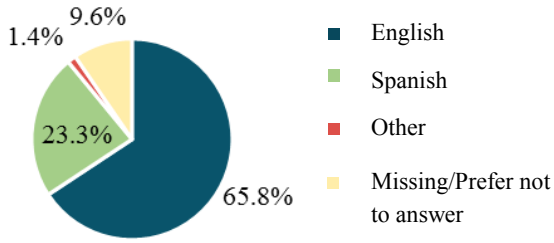
About three-quarters of participants were female (75.3%), and 15.1% of participants were male.

SEXUAL ORIENTATION (N=73)



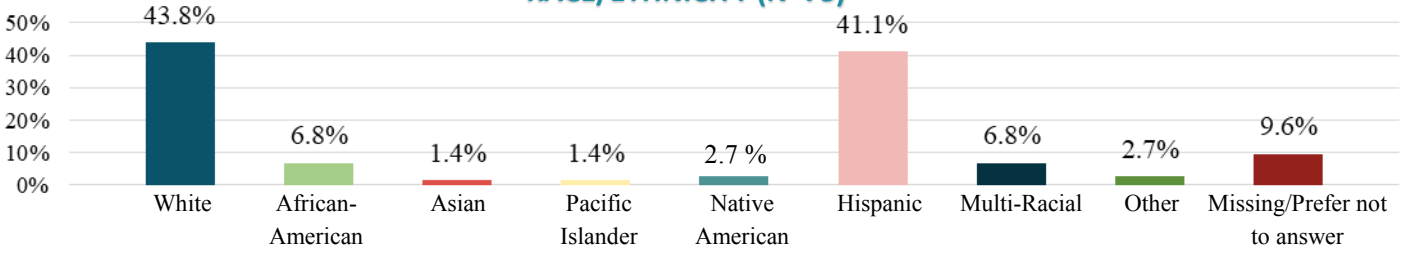
Most (83.6%) participants were heterosexual or straight. Around 16.4% of participants did not provide a response.

PRIMARY LANGUAGE (N=73)



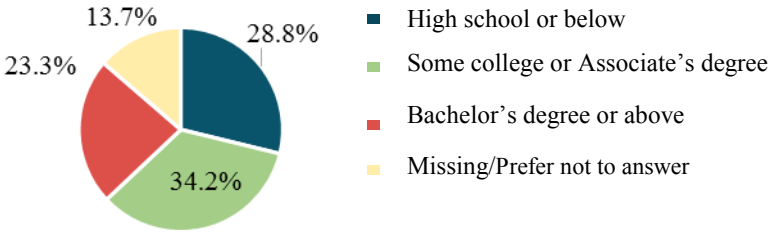
English was the primary language of most participants (65.8%), followed by Spanish (23.3%).

RACE/ETHNICITY (N=73)



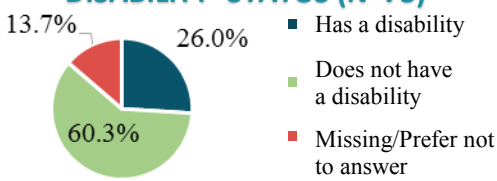
Forty-three percent of participants identified themselves as White, followed by 41.1% who identified as Hispanic. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EDUCATION LEVEL (N=73)



Participants' educational level were split between broad categories, the largest being some college or Associate's degree (34.2%).

DISABILITY[1] STATUS (N=73)



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

The majority (80.8%) of participants had never served in the military.

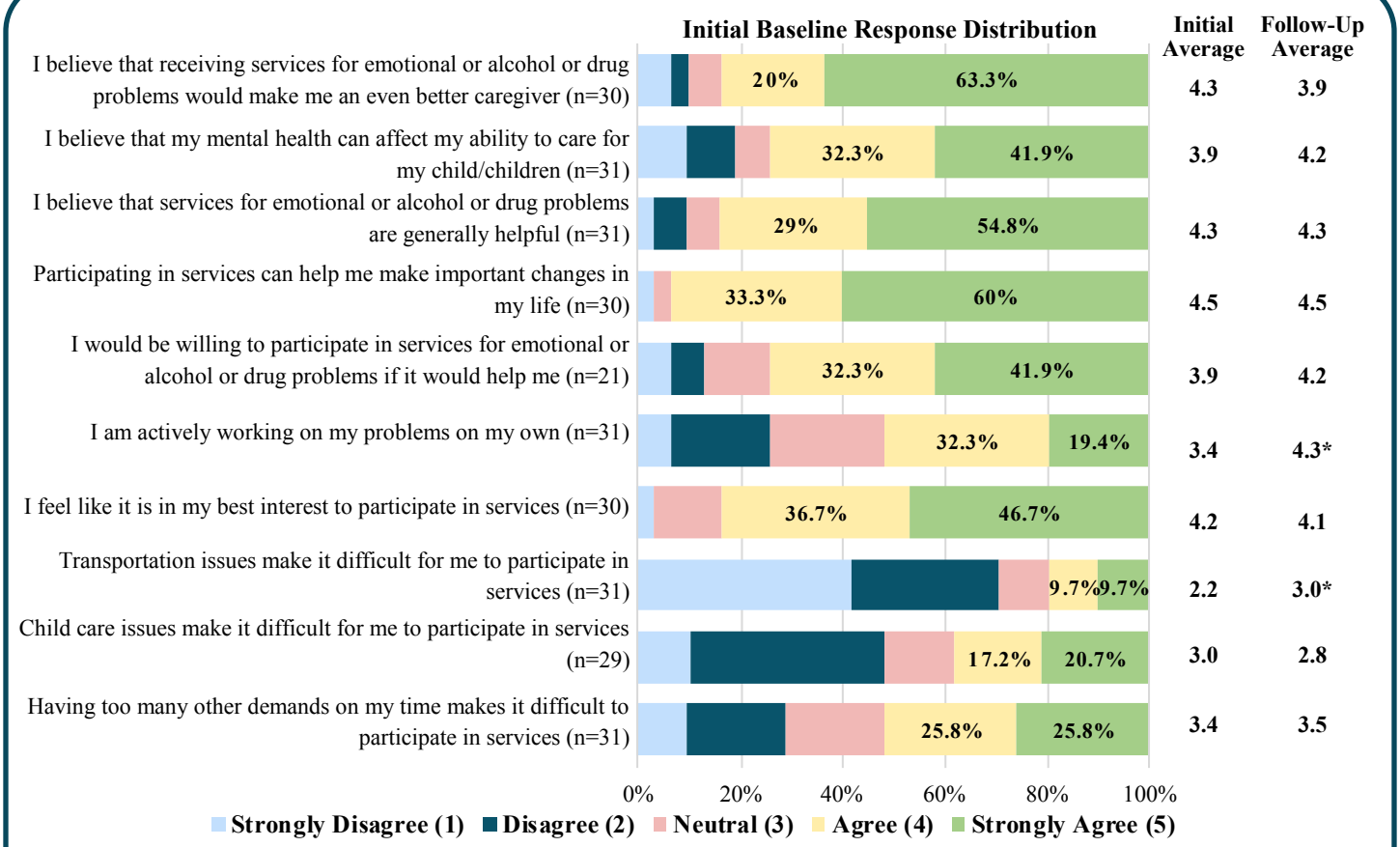
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

ASSESSMENT OF CAREGIVER ATTITUDES AND NEEDS

Except where noted in Figure 1, average responses across CWP participants did not change much between initial assessment and follow-up measurement (every 90 days after entering CWP). Upon entering CWP, caregivers typically expressed favorable attitudes about the value of and need for receiving additional support services for emotional health and/or alcohol and drug problems. For example, at initial entry into CWP over 80% agreed or strongly agreed that "receiving services…would make [them] an even better caregiver" (83.3%), that such services were "generally helpful" (83.8%), that "participating in services can help [them] make important changes" (93.3%), and that it is in their "best interest to participate in services" (83.4%). Relatively few (19.4%) thought that transportation issues would make it difficult to participate in services, but concerns about childcare or other demands on their time were more prevalent (37.9% and 51.6%, respectively).

One area of significant change was the extent to which persons indicated they were "actively working on [their] problems." The average score across CWP participants increased from 3.4 to 4.3 on a 5-point scale ranging from Strongly Disagree (1) to Strongly Agree (5). This type of increase is consistent with a primary goal of CWP to get more persons engaged in efforts to address their own emotional health and/or alcohol and drug challenges. The other area of change related to whether transportation issues were expected to inhibit participation in services. Whereas relatively few thought transportation issues would be a problem initially (average score of 2.2), this was perceived to be more of a problem when measured at follow-up (average score of 3.0). One potential interpretation is that CWP participants had a greater understanding of the various types of services that were available and/or were needed at follow-up than when they first enrolled and for some this highlighted underlying transportation barriers that inhibited participation in desired services.

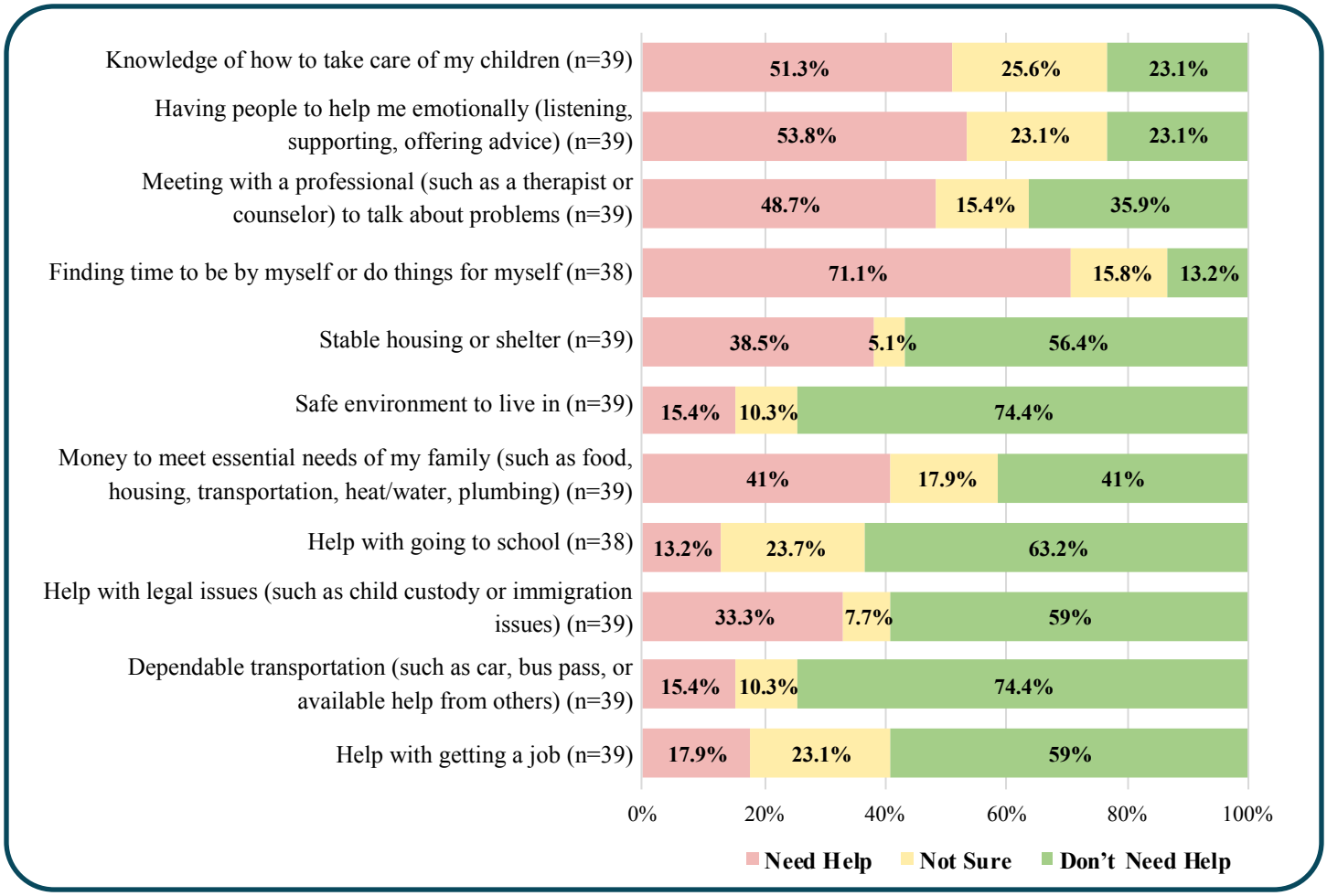
FIGURE 1. INITIAL AND FOLLOW-UP CAREGIVER ATTITUDES



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

As shown in Figure 2 on the next page, select items from the comprehensive baseline family needs assessment indicated a wide range of potential family needs. Consistent with the caregiver's openness to and interest in receiving mental health and/or alcohol and drug services noted above, over half (53.8%), indicated needing assistance with finding "people to help [them] emotionally," and almost half (48.7%), indicated that they needed help "meeting with a professional…to talk about problems." Additionally, the majority (51.3%) wanted help increasing their "knowledge of how to take care of [their] children." Needing help with other issues such as housing, finances, and legal matters were each expressed by about one-third of all caregivers entering CWP.

FIGURE 2. FAMILY NEEDS ASSESSMENT AT ENTRY INTO THE CAREGIVER WELLNESS PROGRAM



ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

As shown in Figure 3, nearly all caregivers with follow-up data (n=38) indicated they were satisfied with the CWP services received (94.7% agreed or strongly agreed with this item). Most respondents indicated that as a result of their participation in CWP they "know where to get help" (86.8%), are "more comfortable seeking help" (78.9%), and are "better able to handle things" (89.5%).

FIGURE 3. CAREGIVER ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

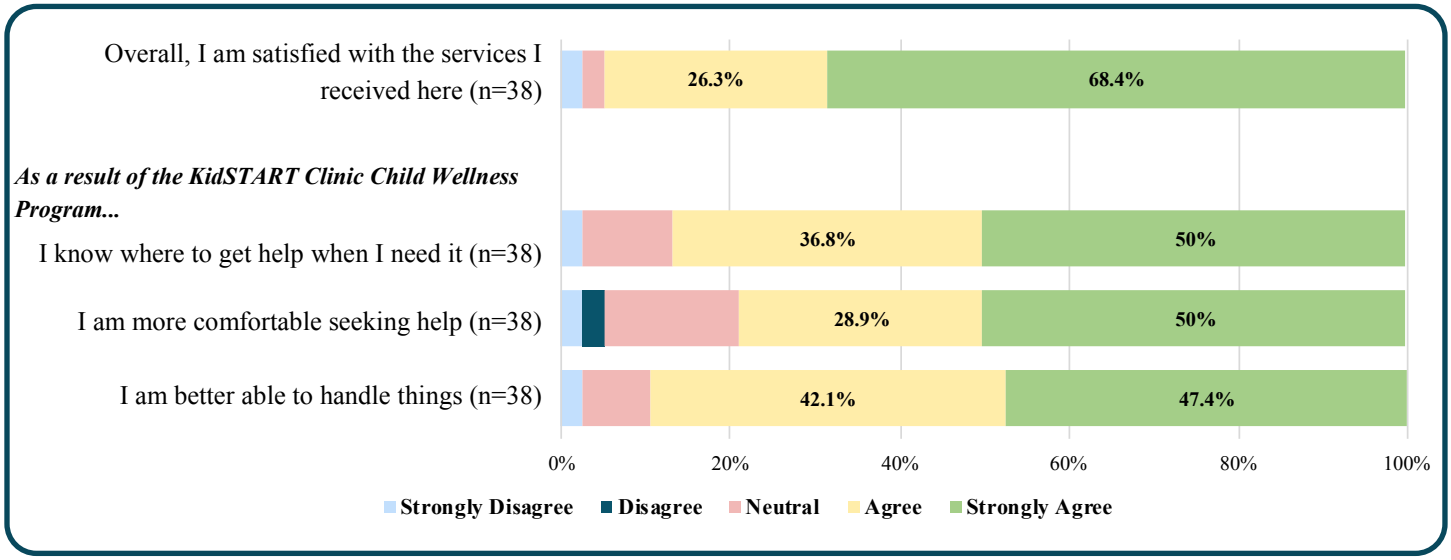
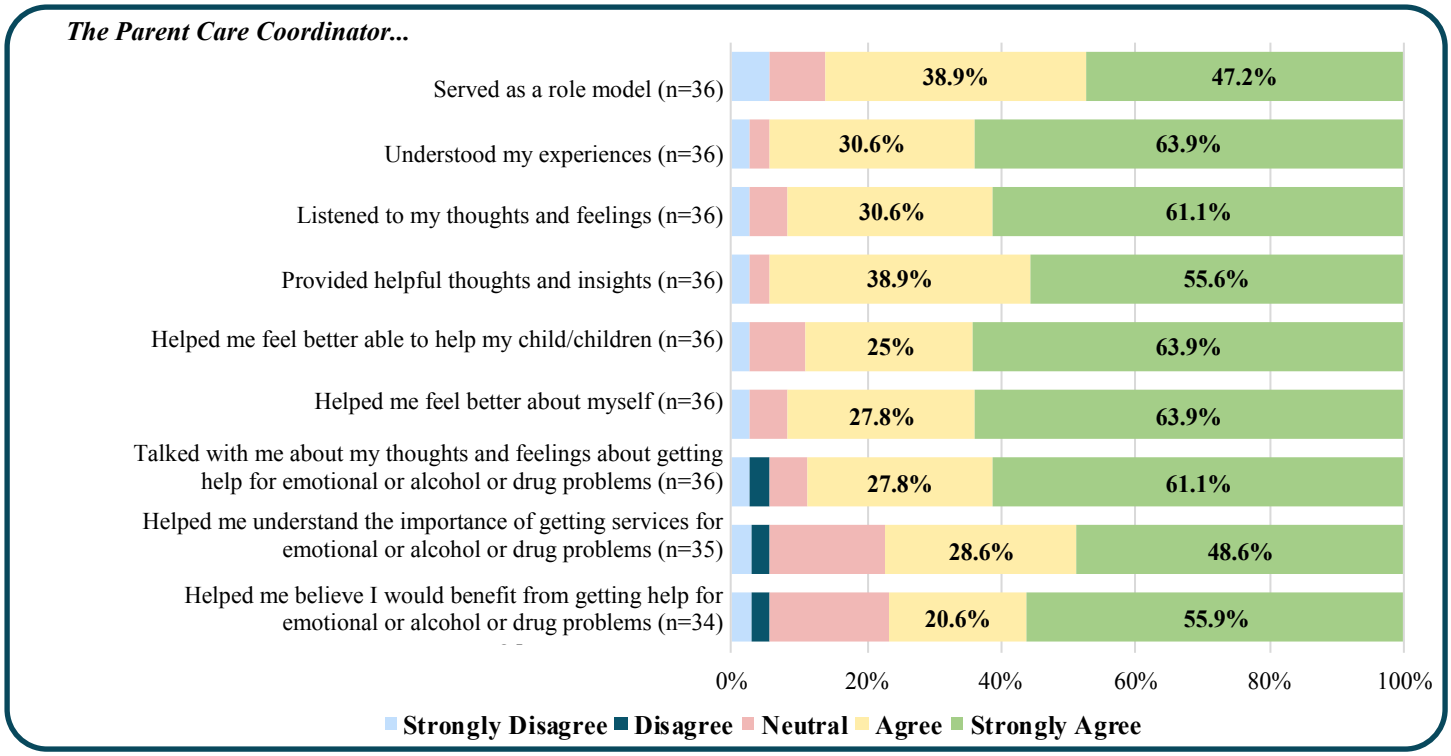


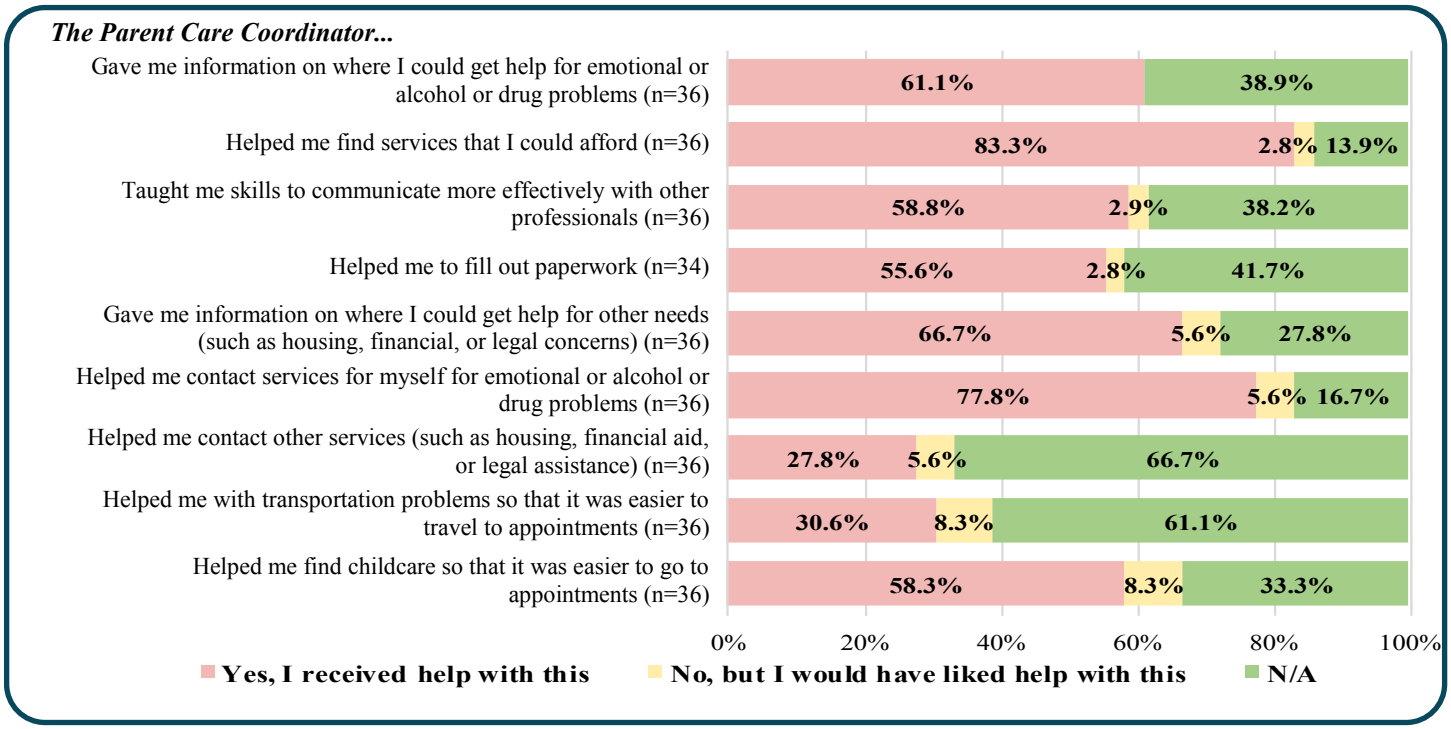
Figure 4 shows that at follow-up caregivers nearly universally "agreed" or "strongly agreed" that their PCC provided a range of emotional and educational supports, including "listening to [their] thoughts and feelings," helping them "understand the importance of getting services for emotional or alcohol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

FIGURE 4. CAREGIVER PERCEPTIONS OF PARENT CARE COORDINATOR SUPPORTS



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

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



ASSESSMENT OF CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION AND LINKAGES

UTILIZATION OF BEHAVIORAL HEALTH SERVICES PRIOR TO THE CAREGIVER WELLNESS PROGRAM

As shown in Table 1, 14.8% of caregivers indicated being hospitalized or in a residential treatment for mental health or substance abuse issues. Approximately half (49.4%), had ever participated in therapy and about one-quarter (28.7%), indicated that they were participating in therapy at the time they entered CWP. Overall and current participation in treatment for alcohol or drug problems was much less common (6.8% and 2.3%, respectively).

TABLE 1. CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION PRIOR TO THE CAREGIVER WELLNESS PROGRAM

	% Yes	n
Ever admitted for an overnight stay in a hospital/r other facility to receive help for problems with emotions, nerves, mental health, or use of alcohol or drugs. (n=88)	14.8%	13
Ever had one or more sessions of psychological counseling or therapy for emotional problems with any type of professional. (n=87)	49.4%	43
Currently receiving or on a waitlist for psychological counseling or therapy for emotional problems with any type of professional. (n=87)	28.7%	25
Currently going to or on a waitlist for a clinic or doctor for an alcohol or drug problem. (n=88)	6.8%	6
Ever visited a clinic or doctor about an alcohol or drug problem. (n=87)	2.3%	2
Ever used a prescription medicine for emotions, nerves or mental health from any type of professional. (n=88)	35.2%	31
Currently using a prescription medicine for emotions, nerves or mental health from any type of professional. (n=88)	21.6%	19

UTILIZATION OF COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SYSTEM SERVICES

County of San Diego BHS data were examined to identify the service utilization patterns of persons enrolled in CWP. Overall, very few CWP participants had involvement with the public sector BHS before or after their participation in CWP. For example, 6.7% of the 75 CWP participants who started the program at least 90 days before the end of the reporting period (6/30/2017), had attended at least one County of San Diego BHS outpatient visit within the 90 days prior to starting CWP. There was no substantial change in the BHS outpatient services participation rate 90 days after starting the Caregiver Wellness program (8.0%). Acute/crisis care oriented services such as psychiatric emergency response team (PERT) visits, crisis stabilization visits, and inpatient hospitalizations were extremely rare or non-existent (i.e., 2.0% or fewer of CWP participants), before or after starting CWP. A nearly identical pattern was found when examining County of San Diego BHS utilization 180 days before and after starting CWP.

UTILIZATION OF CAREGIVER WELLNESS PROGRAM SERVICES

Through 6/30/2017, the CWP staff had provided a total of 468 case management sessions to the 97 persons enrolled in the CWP program and these persons had participated in a cumulative 324 psychoeducational support group sessions. As shown in Table 2, 69.1% (n=67), of all caregivers participating in CWP had received at least one case management visit (average of 7.0 case management visits among those with any visits), and 41.2% (n=40) had participated in at least one psychoeducational support group session (average of 8.1 group sessions among those who attended any group sessions).

TABLE 2. CAREGIVER WELLNESS PROGRAM SERVICE UTILIZATION PATTERNS

	Received CWP Case Management Services		Attended Any CWP Group Sessions	
	%	n	%	n
Overall Total (n=97)	69.1%	67	41.2%	40
Gender				
Male (n=15)	73.3%	11	53.3%	8
Female (n=74)	68.9%	51	40.5%	30
Primary Language				
English (n=64)	64.1%	41	35.9%	23
Spanish (n=24)	83.3%	20	58.3%	14
Education				
HS or less (n=33)	75.8%	25	57.6%	19
Some College (n=33)	66.7%	22	36.4%	12
Bachelors Degree or above (n=20)	60.0%	12	35.0%	7
Work/Student Status				
Working or student (n=39)	61.5%	24	35.9%	14
Not working (n=43)	76.7%	33	46.5%	20
Receiving Behavioral Health Services at Start of CWP				
Yes (n=31)	77.4%	24	45.2%	14
No (n=57)	63.2%	36	38.6%	22
Elevated Need (PTSD/ Substance Abuse)				
Yes (n=26)	84.6%	22	42.3%	11
No (n=71)	63.4%	45	40.8%	29

Table 2 demonstrates that even though there were fewer male than female CWP participants overall (15 compared to 74), males participated CWP services (i.e., case management and group psychoeducational support sessions) at similar to slightly higher rates than females. Additionally, the participation rates of those who indicated Spanish as their primary language was substantially higher than primary English language speakers for both case management and group sessions. Persons with lower levels of education and those not working were also more likely to participate in the case management and group sessions. Persons receiving behavioral health treatment and/or medication at the time they enrolled in the program were slightly more likely to engage in CWP case management and group sessions.

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

LINKAGES TO COMMUNITY BEHAVIORAL HEALTH RELATED SERVICES FACILITATED BY CAREGIVER WELLNESS PROGRAM

A primary objective of the CWP program was to connect caregivers with appropriate behavioral health related services. While very few CWP participants had any contact with the formal County of San Diego BHS system, 72.2% (70 out of 97) had at least one behavioral health linkage facilitated by the CWP team as of 6/30/2017. Types of behavioral health related linkages facilitated by the CWP team included:

- Individual therapy/counseling
- NAMI support groups
- Hoarding assistance
- Domestic violence support services

CAREGIVER WELLNESS PROGRAM—CASE REPORTS

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

Case Report 1—Improved Caregiver Mental Health

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

Case Report 2—Improved Child Outcomes

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

Case Report 3—Family Reunification

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

Case Report 4—Service Linkage Challenges

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

CAREGIVER WELLNESS PROGRAM—FOCUS GROUP THEMES

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

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

CAREGIVER WELLNESS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the second year of providing INN Caregiver Wellness Program (CWP) services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for CWP. There were 12 respondents from the 15 persons invited to participate in the survey, a response rate of 80.0%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Primary factors that helped achieve CWP program goals:*
    a. Good collaboration and communication between program leadership, Parent Care Coordinators (PCCs) and therapists
    b. PCCs' ability to form supportive and trusting relationships with caregivers
    c. Structured curricula for psycho-education support groups that are designed to improve caregiver functioning and well-being
    d. CWP staff "buy-in" to importance of caregiver wellbeing for improving child behaviors
    e. Efficient and effective program operations (e.g., offer services to all caregivers, streamlined assessments, greater familiarity with community resources)
2. *Primary factors that inhibited achieving CWP program goals*:
    a. Not being able to provide individual psychotherapy directly through CWP to caregivers
    b. Caregivers who are not ready to work on their own needs (i.e., low interest/motivation and/or low insight due to SMI/ active substance abuse)
    c. Caregivers who may be interested, but have competing demands or other tangible CWP participation barriers (e.g., transportation and timing)
3. *Primary factors needed to engage and maintain caregiver participation in CWP:*
    a. Providing caregivers with beneficial and relevant resources, linkages, and information
    b. Offering psycho-education support groups that are of interest to caregivers
    c. Frequent, positive interactions with PCCs and the rest of the team
    d. Prompt engagement with PCCs and delivery of services after initial enrollment
    e. Educating caregivers about connections between their own behavioral health and their child's development and well-being
    f. Coordinating communication between caregiver, therapist, and PCC
4. *Primary barriers to linking caregivers with recommended behavioral health services:*
    a. Limited availability of appropriate services to link caregivers to
    b. Caregiver time management/logistical challenges (e.g., work, child treatment appointments, transportation difficulties)
    c. Lack of insurance or financial means to pay for needed behavioral health services
    d. Caregivers who may not recognize or understand need for additional services
5. *Primary strategies used to link caregivers with recommended behavioral health services:*
    a. PCCs collaborative approach to service linkages (e.g., calling places together, attending initial appointments)
    b. PCCs offering support and encouragement from their "lived experience"
    c. Educating caregivers about how their behavioral health affects their child
    d. Having PCCs with knowledge of available programs (e.g., locations, service types, eligibility and cost requirements)
    e. Providing ongoing support and education until caregiver is ready to change
6. *Primary strategies used to link caregivers with other resources (e.g., food assistance, child care):*
    a. PCCs collaborative approach to service linkages (e.g., calling places together, attending initial appointments)
    b. Having PCCs with knowledge of available programs (e.g., locations, service types, eligibility and cost requirements)
    c. Assessing and prioritizing caregiver needs and goals
    d. Educating caregivers on how to access services on their own

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Providing a comprehensive in-home needs assessment was crucial for obtaining a thorough understanding of the range of potential caregiver needs and often facilitated rapport building and caregiver "buy-in" to CWP.
2. Prompt development of the caregiver wellness plan and provision of PCC coordination and support services after completing the needs assessment was important for retaining and promoting caregiver CWP participation.
3. The PCC role facilitated both emotional support and education of caregivers, as well as identifying and connecting with needed external resources and services.
4. Offering therapeutic, educational and support groups directly within the CWP was an effective strategy for providing needed and desired caregiver-focused behavioral health services.
5. Caregiver participation rates in the groups provided within CWP were similar (about 50%) regardless of whether caregivers were also receiving other behavioral health services. This indicated that the groups were capable of both expanding access to needed information for those without any other behavioral health supports as well as supplementing any existing behavioral health care.
6. Need to ensure identification of all caregivers who may benefit from CWP services without creating too lengthy or cumbersome screening and assessment process.
7. Spanish-speaking PCCs and therapists were vital to delivering CWP services. Need additional Spanish-speaking therapists in the community who can receive adult behavioral health treatment referrals from CWP.
8. The many other child-related meetings and treatment sessions caregivers had to attend as well as other commitments of daily life substantially limited the time that caregivers were available to participant in services directed toward there own wellbeing.
9. Group sessions and PCC support increased caregiver awareness of the importance of receiving their own services to promote their wellness and the well-being of their children.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Offering CWP services to all caregivers with children in KidSTART improved CWP operations (e.g., staff buy-in, consistency/ coordination, recruitment), as a fully integrated program rather than a separate sub-program only for some caregivers.
2. It is useful to start behavioral health related conversations early in relationship building process (e.g., while addressing non-behavioral health needs), to help normalize those discussions and facilitate participation in CWP services and external linkages.
3. Prior negative experiences with mental health treatment are common and need to be discussed to allow for new linkages.
4. The first visit to a behavioral health related service can be hardest for a caregiver. Important to match caregiver needs with appropriate level of PCC supports (e.g., from providing a phone number to attending the visit with caregiver).
5. Challenging to find behavior health related services that are 1) substantively appropriate, 2) feasible to participate in, and 3) of interest to the caregivers. All three conditions must be met for successful external linkages to occur.
6. CWP behavioral health related linkages were typically not to County of San Diego BHS outpatient treatment services, but to other community programs, private counselors, or other resources.
7. CWP was successful at getting persons from commonly underserved populations (e.g., males, Spanish-language speakers) to participate in the CWP case management and psycho-education support group sessions.
8. Caregivers often want to continue receiving CWP services even after child is no longer in KidSTART program. Need to plan for transition with caregiver to help promote ongoing and relevant linkages for caregiver.
9. Caregivers form social connections with other caregivers in similar circumstances during the CWP group sessions that can provide social supports that last beyond their participation in CWP.
10. CWP program has allowed for a "culture shift" within KidSTART program by providing resources (e.g., PCC services, group sessions), that allow therapists to work much more effectively at the "family level" to promote long-term child well-being.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-11 Caregiver Wellness Program during Year 2 (7/1/2016 to 6/30/2017), that differed substantially from the initial design of the program. Program refinements included reduced initial assessments and expansion of eligibility to include all caregivers with a child in KidSTART. Additional PCC/therapist meetings were instituted to improve coordination and other programmatic changes have helped to streamline the initial intake, planning, and service delivery process. New psycho-educational support group curricula were developed and implemented based on expressed caregiver needs and interests.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Simplify and shorten screening/assessment process.

   Status: A thorough review of caregiver and staff feedback led to adjustments in the screening/assessment process that decreased paperwork and increased quicker access to CWP services.

2. Following the completion of the in-home assessment by the PCC, accelerate timeframe for development of caregiver wellness plan and provision of PCC coordination and support services.

   Status: Specific timelines were established to set clear expectations for the timing of service delivery components. Additional changes facilitated timely scheduling of Caregiver Support Team meetings and prompt delivery of linkage services (e.g., housing, food) for those with imminent needs.

3. Explore potential for providing individual therapy as part of CWP.

   Status: While the provision of individual therapy within CWP represents an area of ongoing interest, the program emphasized increased outreach and engagement activities in order to help build bridges for behavioral health and other services accessed by caregivers. This was accomplished by collaborating with community providers to learn about the needs of caregivers and young children in San Diego's System of Care and determine if the caregivers and children who needed KidSTART Clinic services had access to these services.

4. Address barriers to CWP participation (e.g., improve caregiver outreach and engagement strategies, incentivize attendance at group sessions, offer classes at convenient times and locations, provide additional transportation and child care). Explore potential for providing individual therapy as part of CWP.

   Status: CWP successfully hosted 3 Program Advisory Groups (PAGs) to obtain community feedback and enhance program quality. This feedback contributed to the development of two new 12-week group classes that were of interest to CWP caregivers (one regarding Executive Functioning and the other pertaining to Mood Disorders). These classes were offered multiple times throughout 2016-17.

5. Identify more bilingual and/or Spanish language therapists in the community who can receive adult behavioral health treatment referrals from CWP.

   Status: As part of their community outreach efforts, CWP was able to identify additional bilingual and/or Spanish language therapists to provide treatment services to caregivers.

6. Provide additional training and education opportunities for PCCs (e.g., engagement strategies, trauma-informed care).

   Status: In addition to ongoing individual and group supervision/coaching, the KidSTART Clinic's Family Partner/Parent Care Coordinator team participated in trainings on a variety of topics (e.g., establishing family partnerships, conducting PAG meetings, using Motivational Interviewing techniques, addressing domestic violence) from external agencies such as NAMI, County of San Diego BHS, and others.

7. Create additional opportunities for communication and coordination between PCCs and therapists.

   Status: Two PCC and therapist case consultation meetings have been added to ensure collaboration.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Caregiver Wellness program and support the achievement of program objectives include the following:

1. Explore potential options for providing individual therapy as part of CWP due to challenges of finding County of San Diego BHS and other community behavioral health related services that are 1) substantively appropriate, 2) feasible to participate in, and 3) of interest to the caregiver.
2. Examine potential for allowing CWP "alumni" (i.e., caregivers whose children are no longer in KidSTART) to still participate in some/all CWP services.
3. Obtain additional resources to expand the frequency and diversity of times that psycho-education support group classes are offered.

For additional information about the INN–11 Caregiver Wellness Program and/or annual report, send your inquiry to:

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

FAMILY THERAPY PARTICIPATION ENGAGEMENT (INNOVATIONS-12)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 2 (7/1/16 - 6/30/17)

The Family Therapy Participation Engagement (FTPE) program is funded through the Innovations (INN) component of the Mental Health Services Act. FTPE is designed to increase parent and caregiver engagement in the treatment of their child through the innovative use of Parent Partners to encourage participation in family therapy. Note, we use the term "caregiver" in the remainder of this report to signify either the parent or other caregivers of the child receiving treatment.

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

EXECUTIVE SUMMARY

The Family Therapy Participation Engagement (FTPE; INN-12) program is designed to increase caregiver participation in Family Therapy visits by using peer-support Parent Partners to enhance caregivers' understanding of the importance of active participation in their child's treatment and to encourage participation in Family Therapy sessions.

- During 2016-17, a total of 4,681 Parent Partner visits were provided to caregivers of 1,015 children receiving behavioral health treatment services at six agencies throughout San Diego County.
- Based on available caregiver demographics (n=433), most FTPE caregiver participants were female and the majority spoke Spanish as their primary language. Over half of caregivers had a high school or lower level of education and 12.5%were unemployed and looking for work.
- During 2016-17, the number of family therapy sessions increased from the prior year (7,159 compared to 6,608).
- During 2016-17, at least 1 family therapy session occurred in half (51.1%), of all months that a child received any form of therapy and least 2 family therapy sessions occurred in 17.3% of the months. Both of these indicators reflect slight increases from the preceding year.
- While continuing to increase, the absolute and relative year-over-year change in family therapy sessions was substantially smaller in 2016-17 than in 2015-16.
- Caregivers reported very high overall levels of satisfaction with Parent Partner services (97.0% satisfaction). Over 90% agreed or strongly agreed that Parent Partners "understood [their] experiences", "helped [them] understand the importance of Family Therapy", and made them "feel [they] could help [their] child", in addition to providing other forms of support.
- Specific challenges to increasing family therapy participation identified by FTPE administrative and service provider staff included: 1) low caregiver motivation/ambivalence regarding importance of participation in therapy, 2) lack of caregiver resources (e.g., time, transportation, etc.), 3) caregiver personal challenges (e.g., substance abuse), 4) FTPE program limitations (e.g., not enough Parent Partner hours, staff turnover, etc.), and 5) general stigma associated with mental illness and participating in therapy.

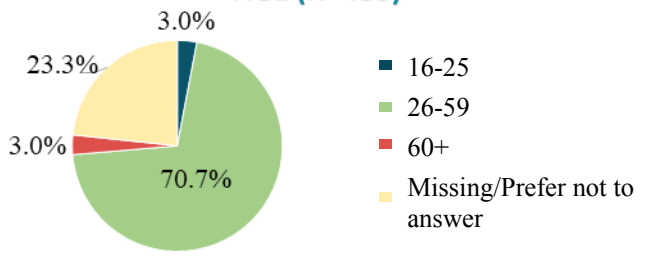
RECOMMENDATIONS

Primary recommendations include: 1) additional resources to address client factors affecting participation in family therapy, and 2) additional Motivational Interviewing training that includes ongoing supervision and feedback.

FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS

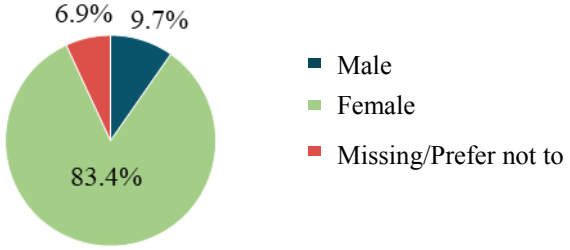
The following demographic data were collected from a caregiver self-report survey administered at the start of the FTPE program.

AGE (N=433)



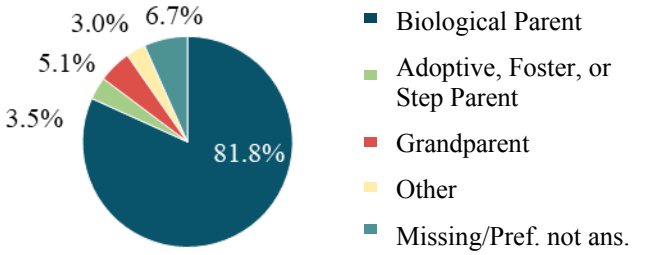
The majority of caregivers (70.7%) were between the ages of 26 and 59.

GENDER IDENTITY (N=433)



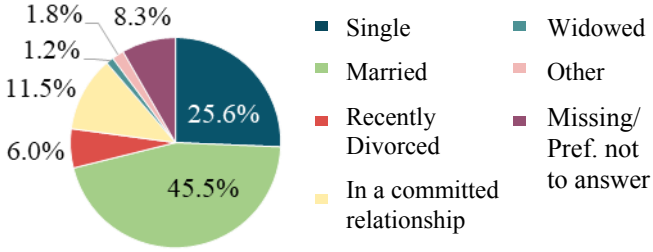
Most caregivers were female (83.4%).

RELATIONSHIP TO CHILD (N=433)



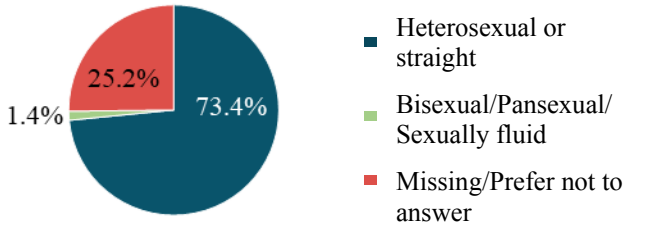
Most caregivers were a biological parent of the child receiving services (81.8%).

RELATIONSHIP STATUS (N=433)



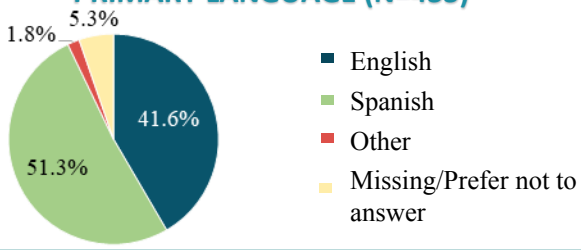
Almost half of the caregivers were married (45.5%), and about one-quarter (25.6%), were single.

SEXUAL ORIENTATION (N=433)



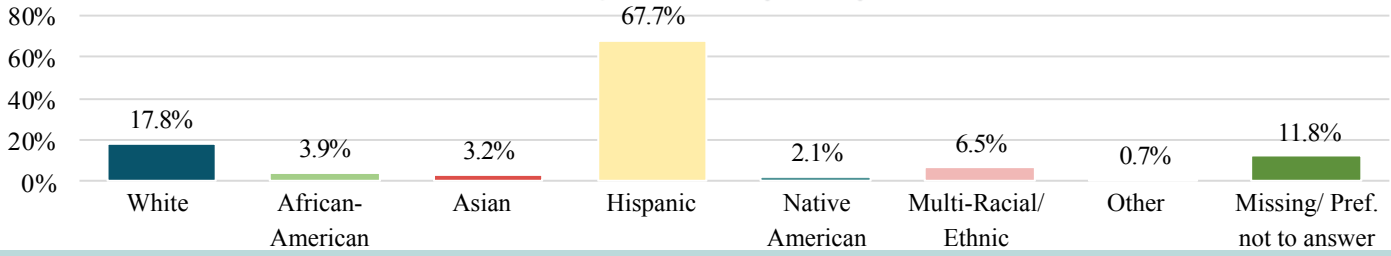
Most caregivers (73.4%) indicated they were heterosexual or straight.

PRIMARY LANGUAGE (N=433)



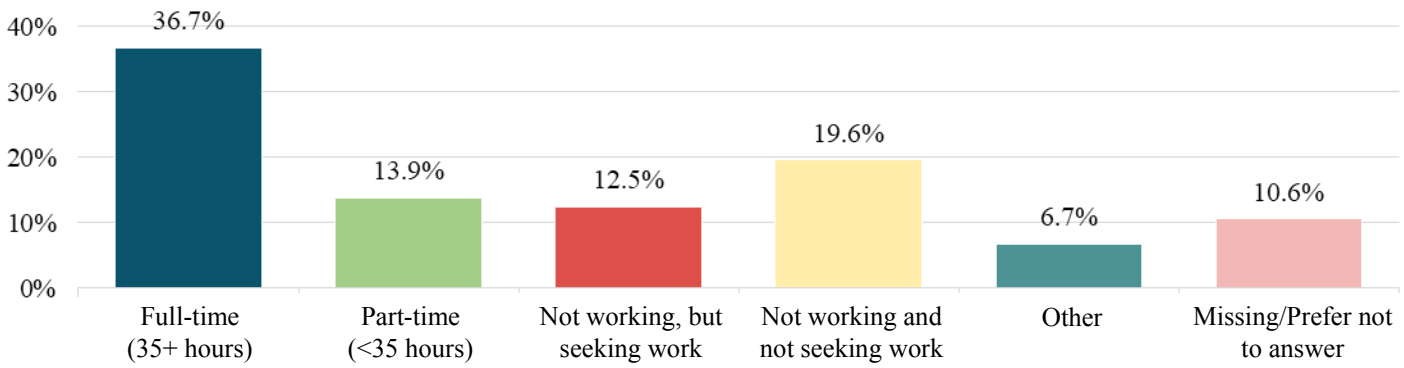
Spanish was the primary language for about half of the caregivers (51.3%).

RACE/ETHNICITY (N=433)



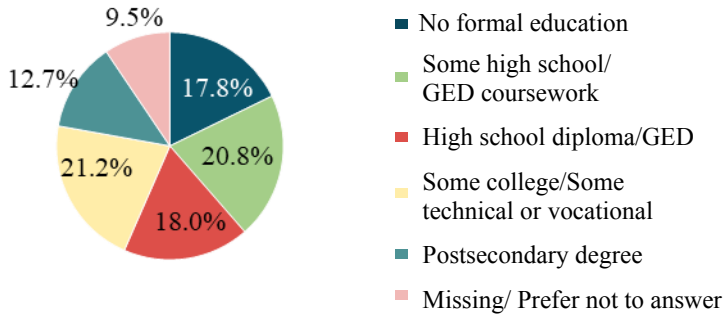
The majority of caregivers identified themselves as Hispanic (67.7%), and 17.8% identified as White. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EMPLOYMENT STATUS (N=433)



Approximately one-half of the caregivers indicated that they were employed (36.7% full-time and 13.9% part-time), and another 12.5% were not working, but seeking work (a much higher unemployment rate than the 4-5% for San Diego County).

EDUCATION LEVEL (N=433)

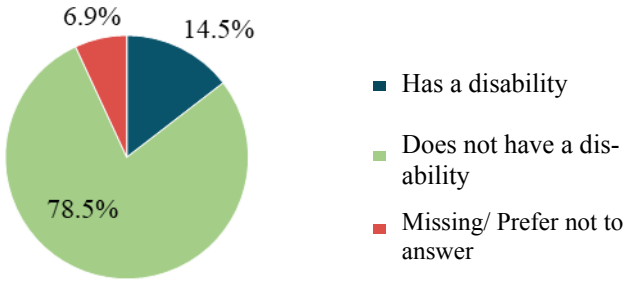


Over half (56.6%), of the caregivers had a high school diploma/GED or a lower level of education.

MILITARY STATUS (N=433)

Very few caregivers (i.e., less than 2%), indicated they had served in the military.

DISABILITY[1] STATUS (N=433)



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

TYPE OF DISABILITY (N=433)

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

This table lists the type of disability indicated by caregivers and provides the percentage out of the total population. Caregivers may have indicated more than one disability.

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

KEY EVALUATION FINDINGS

SERVICE UTILIZATION PATTERNS BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

Table 1 presents aggregated service utilization data from the six INN-12 FTPE programs during three years that highlight service provision before FTPE implementation, during initial FTPE implementation, and after full FTPE implementation. The three types of services included in Table 1 (i.e., individual therapy, family therapy, and Parent Partner sessions) are the most relevant to assessing FTPE program goals and operations. Overall, there was little change in the total number of therapy sessions provided and children served across these years. The average number of therapy sessions each child received was also fairly constant (approximately 9.5). There was a small decrease in the number of individual therapy sessions provided (a reduction of 1,240 sessions [8.3%] from 14,792 to 13,552), but essentially no change in the total number of children receiving any individual therapy (an increase of 31 children [1.6%] from 1,944 to 1,975). The net effect of these changes was a reduction in the average number of individual therapy sessions received per child from 7.6 to 6.9 across these three years.

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

	FY 2014-15 (7/1/14 - 6/30/15)	FY 2015-16* (7/1/15 - 6/30/16)	FY 2016-17 (7/1/16 - 6/30/17)
Total Therapy Sessions ***(Number of Unduplicated Children)*** **Average Sessions per Child**	**20,086** ***(2,099)*** **9.7**	**20,110** ***(2,144)*** **9.4**	**20,711** ***(2,183)*** **9.5**
Total Individual Therapy Sessions ***(Number of Unduplicated Children)*** **Average Sessions per Child**	**14,792** ***(1,944)*** **7.6**	**13,502** ***(1,931)*** **7.0**	**13,552** ***(1,975)*** **6.9**
Total Family Therapy Sessions ***(Number of Unduplicated Children)*** **Average Sessions per Child**	**5,294** ***(1,480)*** **3.6**	**6,608** ***(1,598)*** **4.1**	**7,159** ***(1,656)*** **4.3**
Total Parent Partner Sessions ***(Number of Unduplicated Children)*** **Average Sessions per Child**	**-**	**2,604** ***(596)*** **4.4**	**4,681** ***(1,015)*** **4.6**
Ratio of Individual Therapy Sessions per each Family Therapy Session	**2.8**	**2.0**	**1.9**

* INN-12 FTPE program implemented during FY 2015-16.

The service utilization changes related to family therapy sessions were more pronounced. The number of family therapy sessions provided increased from 5,294 to 7,159 (an increase of 1,865 sessions [35.2%]), during this time period. The number of children whose caregivers participated in at least one family therapy session increased as well, but to a lesser extent (an increase of 176 children [11.9%] from 1,480 to 1,656). The average number of family therapy sessions increased from 3.6 to 4.3 sessions per child who received any family therapy sessions (a 19.4% increase). These service utilization pattern changes resulted in the ratio between individual and family therapy services delivered decreasing from 2.8 individual therapy sessions per family session delivered during FY 2014-15 to 1.9 during FY 2016-17. While not a causal analysis, the preliminary data patterns are consistent with the expectation that the Parent Partners would help more people to participate in family therapy that those participating in family therapy would receive more sessions than was typical prior the introduction of the FTPE program.

Comparisons between the initial FTPE implementation year (FY 2015-16) and the first full year after FTPE implementation (FY 2016-17) highlight several key findings. First, Parent Partners dramatically increased the number of families they served during the first full year after FTPE implementation (a 70.3% increase). The average number of sessions received was fairly similar during both years (approximately 4.5 sessions). Secondly, while more family therapy sessions were provided during FY 2016-17 than in the prior year, the increase was less pronounced in absolute and relative terms (increase of 551 sessions, [8.3%]) than demonstrated in the preceding year-over-year comparison (increase of 1,314 sessions, [24.8%]). This substantial reduction in the rate of increase during the year in which FTPE was fully implemented suggests that the FY 2016-17 data may be approaching the "best possible" outcomes achievable with the current strategy and resource level of the FTPE program. These service utilization patterns will be examined in future reporting periods to determine if participation in family therapy sessions continues to increase further or plateaus at this new, higher level of service provision than before the implementation of the FTPE program.

MONTHLY SERVICE UTILIZATION THRESHOLDS BEFORE, DURING, AND AFTER FTPE PROGRAM IMPLEMENTATION

We also examined the extent to which the delivery of each type of therapy (i.e., individual or family) achieved specific monthly frequency targets/thresholds. This was accomplished by identifying and then summing together (for all children), the total number of months they received any therapy sessions and then determining the number of those "treatment months" during which the target thresholds were met for each type of therapy. Table 2 presents the results of those analyses for the three years that span immediately before, during, and after FTPE implementation.

TABLE 2. MONTHLY SERVICE THRESHOLDS BEFORE, DURING, AND AFTER FTPE PROGRAM IMPLEMENTATION

	FY 2014-15 (7/1/14 - 6/30/15)		FY 2015-16* (7/1/15- 6/30/16)		FY 2016-17 (7/1/16 - 6/30/17)	
	Total Number of Child "Treatment Months" n= 9,313		Total Number of Child "Treatment Months" n= 9,096		Total Number of Child "Treatment Months" n= 9,494	
	% of Treatment Months Achieving Threshold	Number of Treatment Months Achieving Threshold	% of Treatment Months Achieving Threshold	Number of Treatment Months Achieving Threshold	% of Treatment Months Achieving Threshold	Number of Treatment Months Achieving Threshold
Individual Therapy	%	n	%	n	%	n
At least 1 session per month	82.8	7,710	78.6	7,147	76.8	7,295
At least 2 sessions per month	48.4	4,507	44.8	4,073	43.2	4,099
Family Therapy						
At least 1 session per month	40.2	3,744	49.5	4,503	51.1	4,850
At least 2 sessions per month	12.1	1,126	16.7	1,520	17.3	1,640
Parent Partner Visits						
At least 1 session per month			12.0	1,088	22.7	2,157
At least 2 sessions per month			6.4	583	10.6	1,009

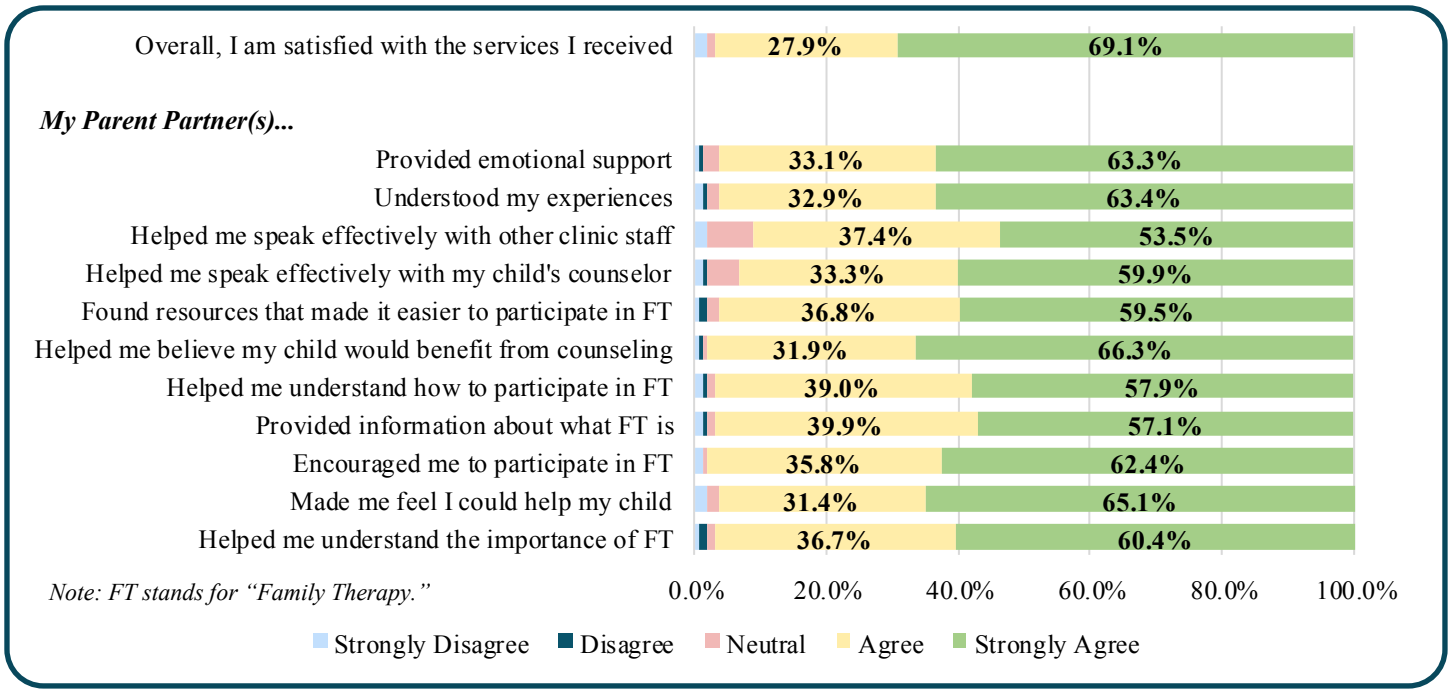
* INN-12 FTPE program implemented during FY 2015-16.

For individual therapy, there was a slight downward trend across the three years, but most treatment months met the threshold of at least 1 individual therapy session per month and close to half of the treatment months met the threshold at least 2 sessions per month. In contrast, the trend for family therapy demonstrated an upward trend. While only 40.2% of treatment months included at least 1 family therapy session during FY 2014-15, slightly more than half (51.1%), met this threshold by FY 2016-17 (a relative increase of 27.1%). Similarly, the percentage of treatment months with at least 2 family therapy sessions increased from 12.1% to 17.2% (a relative increase of 43.0%). These changes (i.e., a decrease in treatment months meeting individual therapy thresholds and an increase in treatment months meeting family therapy thresholds) are consistent with the direction of the expected service utilization shifts following the implementation of the FTPE program. Most of the year-over-year changes occurred between FY 2014-15 (i.e., before FTPE implementation) and FY 2015-16 (i.e., during FTPE implementation). The desired trends continued in FY 2016-17, but with only minor changes from the preceding year.

CAREGIVER FEEDBACK REGARDING PARENT PARTNER SERVICES

At the conclusion of receiving short-term Parent Partner support services, caregivers were asked about their experiences with the Parent Partners. In particular, caregivers were asked about their satisfaction with the Parent Partner services and their perceptions of the Parent Partner(s). Based on the results presented in Figure 1 (n=169), caregivers were typically very satisfied with the Parent Partner services they received (97.0% indicated agreement or strong agreement with the satisfaction statement). Overall, the vast majority of caregivers agreed or strongly agreed that they received each type of support from their Parent Partners. The peer-support aspect of the Parent Partners likely contributed to the fact that almost all caregivers indicated (96.3% agreed or strongly agreed) that the Parent Partners "understood their experiences."

FIGURE 1. CAREGIVER ASSESSMENT OF PARENT PARTNER SERVICES



FAMILY THERAPY PARTICIPATION ENGAGEMENT ANNUAL STAFF FEEDBACK SURVEY

At the end of the first full year of providing FTPE services, program staff and others affiliated with the programs were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the FTPE program. We received 42 responses from 53 persons invited to participate in the survey, for a response rate of 79.4% (with a range of 62.5% to 100% across the individual programs). For the open-ended survey questions, at least two evaluators reviewed and coded the responses. Any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *Major program goals identified by respondents:*
   a. Increasing caregiver participation in family therapy and in treatment more generally
   b. Improving child and family outcomes
   c. Providing education and advocacy for families
   d. Increase case management/support services utilization by decreasing barriers
   e. Increase caregiver participation in Parent Partner services
2. *Factors that helped the FTPE program achieve these goals:*
   a. The services that the Parent Partners provided (e.g., support, education, resources, working on obstacles)
   b. The training Parent Partners received on Motivational Interviewing and other important topics
   c. Sharing the Parent Partners' lived experience
   d. Availability of flexible scheduling, mobile or home-based options, and bilingual Parent Partners
   e. The collaborative nature of the team approach to care (which included Parent Partners)
3. *Strategies most important for the success of the FTPE program:*
   a. Connecting with the caregiver consistently and early on in the program
   b. Providing education about topics like the benefits of Family Therapy and what to expect in treatment.
   c. Collaboration between Parent Partners and Therapists/Treatment Team
   d. Developing rapport between caregiver, Parent Partner, Therapist/Treatment Team
   e. Additional programmatic support (e.g., recruit more Parent Partners and case managers, increased community outreach)
4. *Specific challenges to reaching the program goals:*
   a. Low caregiver motivation/caregiver ambivalence about the importance of therapy
   b. Lack of resources (e.g., transportation, housing, time, availability)
   c. Caregivers' personal challenges (e.g., low literacy, substance abuse, mental illness, etc.)
   d. Program barriers and Parent Partner factors (e.g., staff turnover, insufficient hours, paperwork demands, etc.)
   e. The general stigma of communicating about mental illness and being in therapy
5. *Parent Partner roles/activities:*
   a. Providing support for the caregivers
   b. Teaching caregivers about the importance of being involved in their child's treatment
   c. Working to reduce family barriers by helping provide resources
   d. Building rapport with caregivers
   e. Identifying caregiver needs and promoting participation in needed services
   f. Sharing personal experiences
   g. Engaging in community outreach

Compared to staff feedback from the prior year, it appears that Parent Partners were thought to be better integrated within the rest of the treatment team and participated more fully within a collaborative care approach. This collaboration was viewed as an important factor for achieving program goals, particularly this year. Of note, there was more emphasis in the responses this year on the provision of case management services/support services as a primary goal of the program. This shift towards more of a case management perspective may be related to the greater focus on client factors (e.g., lack of resources, transportation, etc.), as primary barriers to participation in family therapy.

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Adding Parent Partners to the treatment team at CYF agencies substantially increased caregiver participation in Family Therapy sessions.
2. Caregivers typically reported having very positive experiences with their Parent Partners.
3. The "lived experience" or peer support model in which Parent Partners were required to have personal experience interacting with the children's behavioral health system was perceived to be an important component leading to successful engagement with caregivers.
4. The "lived experience" requirement, unique skill sets needed, and salary limitations made it challenging to identify and hire Parent Partners.
5. Motivational Interviewing and other trainings were crucial for equipping Parent Partners with the skills and tools they needed to connect with and support caregivers.
6. It was challenging and expensive to provide ongoing opportunities for Motivational Interviewing and other trainings for newly hired Parent Partners following staff turnover.
7. With agency support and encouragement (e.g., allowing time for provider planning meetings), Parent Partners played an important role in a team-based, collaborative care model in which therapists, case managers, and Parent Partners communicated with each other about how best to provide treatment, encouragement, and other support services to children and their caregivers.
8. Having Parent Partners who spoke Spanish was essential to meeting the service needs of the large population of San Diego County residents who primarily speak Spanish.
9. Besides potential language barriers, the caregivers served by Parent Partners often faced many other challenges to participating in Family Therapy, such as needs for child care, transportation, food assistance, and other supportive services. Caregivers frequently had low levels of formal education and were often unemployed.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Programs provided Parent Partner services to substantially more families during the first full year of FTPE implementation.
2. Not enough Parent Partners were available to cover all families, so programs regularly evaluated family situation and tried to end Parent Partner services when no longer determined to be needed (will re-engage if circumstances change) to free up Parent Partners to serve other families.
3. Even with Parent Partner supports, it was often still challenging for caregivers to participate in family therapy.
4. While family therapy participation still increased compared to the prior year, the size of increase was substantially smaller than during initial implementation year.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-12 FTPE program during the second year of service provision (7/1/2016 to 6/30/2017) that differed substantially from the initial design of the program.

PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Identify ways to provide additional opportunities for Motivational Interviewing and other trainings (e.g., parenting skills), particularly for newly hired Parent Partners.

   ***Status**: Agencies have provided a range of training opportunities including Positive Parenting and Trauma-Informed care; however, due to limited availability, cost, and timing challenges Motivational Interview training was difficult to obtain, particularly for new hires.*

2. Increase availability of Parent Partner services (e.g., provide additional Parent Partner FTE), so that more caregivers can have Parent Partners to support and encourage their participation in family therapy.

   ***Status**: While generally unable to increase the number of Parent Partners and/or their work hours, agencies reported trying to be more efficient with this limited resource. Try to participate in as many client intake meetings as possible and then the relationships between caregivers and Parent Partners are regularly evaluated to determine if continued services are needed (i.e., caregiver is regularly attending Family Therapy without additional supports or caregiver is not participating in family therapy, but ongoing Parent Partner efforts do not seem likely to change the situation). If no longer needed, the Parent Partners shift efforts to support others.*

3. Increase use of group meetings between caregivers and Parent Partners to encourage greater caregiver social supports.

   ***Status**: Agencies reported experimenting with the use of groups (e.g. Parent Advisory Groups) as another way to provide support and encouragement for participating in the treatment of their child. Some indicated they had hosted family oriented social/educational events. While there was general interest in better use of groups to support goals of program, there was also a recognition that caregivers have limited time, so programs were concerned about caregivers attending support groups instead of family therapy sessions.*

4. Identify and/or directly provide additional resources to address the "tangible" barriers to family therapy participation, such as transportation and child care.

   ***Status**: Transportation and child care remain significant barriers to family therapy participation. Agencies try to provide some "tangible" supports to caregivers particularly for transportation related issues (e.g., gas cards/bus passes). One agency indicated they applied for and received funds from an external organization specifically to help with these types of expenses. Providing Parent Partners with cell phones was viewed as an effective and useful approach for at least increasing communication and support (e.g., appointment reminders, general check-ins), with caregivers who may experience many other challenges.*

5. Seek out ways to encourage and support the Parent Partners (e.g., employee recognition, opportunities for peer-support between Parent Partners at different CYF agencies, increased pay or other benefits) to communicate importance of this position and potentially reduce turnover.

   ***Status**: Agencies reported various activities to better support Parent Partners from increasing pay and providing more opportunities for clinical supervision and integration within clinical team to ensuring that Parent Partners feel more connected to overall organization (e.g., participate in agency trainings, award nominations). One agency with multiple INN - 12 programs across several sites brings Parent Partners together for mutual encouragement and support.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Additional resources to address client factors affecting participation in family therapy.
2. Additional Motivational Interviewing training that includes ongoing supervision and feedback.

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

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

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/16 - 6/30/17)

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

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

EXECUTIVE SUMMARY

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

- During 2016-17, a total of 221 persons participated in a Faith Based Academy.
- Most (70.6%) participants were between the ages of 26-59 and the majority were female (72.4%). Slightly over half (52.0%) identified as Hispanic, with 40.2% indicating Spanish as their primary preferred language.
- Faith leaders and behavioral health providers both reported favorably about the information learned and confidence gained by participating in the academy. While enthusiastic overall, behavioral health providers tended to rate aspects of the training slightly less positive than the faith leaders.
- Key factors identified by staff that helped the program achieve its goals included: 1) content contributors and presenter with diverse expertise, 2) passionate and organized staff, 3) bilingual staff, 4) community-based trainings, 5) the capacity to educate behavioral health providers about value and influence of faith on mental recovery, and 6), well written curriculum with an abundance of important content.

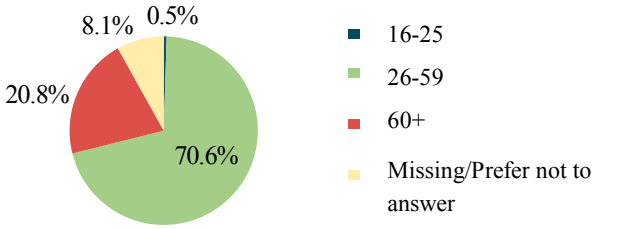
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) create more opportunities for faith leaders and behavioral health providers to interact with each other, 2) adapt content/presentation material to improve fit with non-Christian faith communities, 3) increase outreach activities to key faith leaders, and 4) improve communication and coordination with other Faith Based Initiative partners.

PARTICIPANT DEMOGRAPHICS

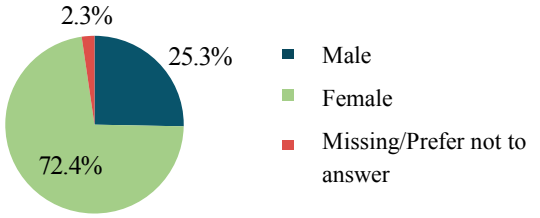
The following self-report demographic data were collected from Faith Based Academy participants.

AGE (N=221)



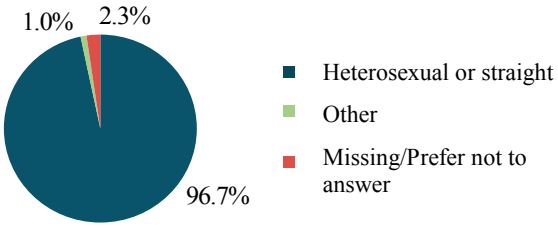
The majority (70.6%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=221)



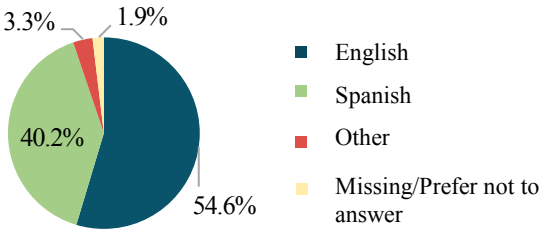
Almost three-quarters (72.4%) of participants were female.

SEXUAL ORIENTATION (N=221)



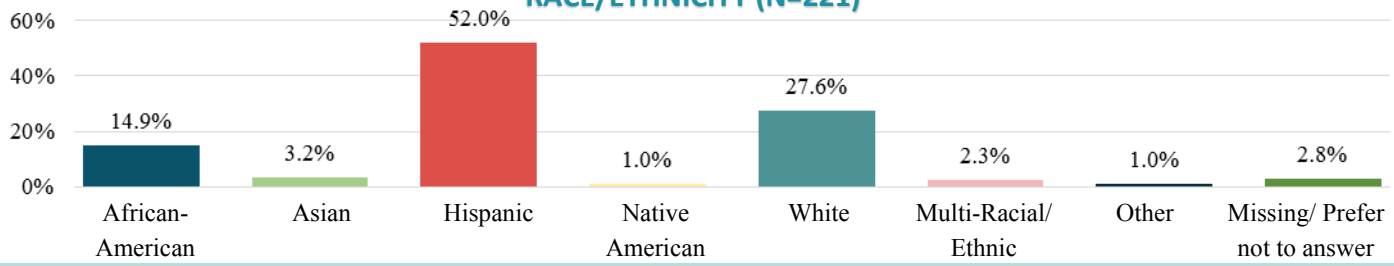
Almost all participants (96.7%) indicated a heterosexual or straight sexual orientation.

PRIMARY LANGUAGE (N=221)



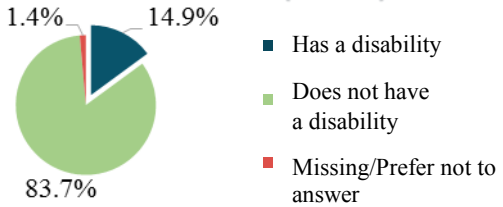
Close to half (40.2%) of participants spoke Spanish as their primary preferred language.

RACE/ETHNICITY (N=221)



About half (52.0%) of participants identified as Hispanic and 27.6% of participants identified as White. Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=221)



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

The majority (87.3%) of participants had never served in the military.

TYPE OF DISABILITY (N=221)

Type	n	%
Communication	11	3.7
Mental (e.g., learning, developmental)	14	4.7
Physical	17	5.8
Chronic Health	14	4.7
Other	16	5.4

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

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

POST-TRAINING SURVEY RESULTS

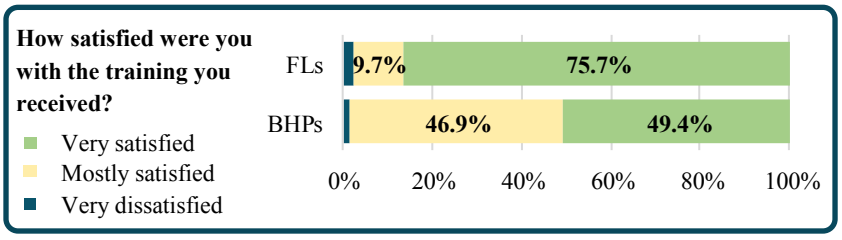
A total of 184 persons completed a Faith Based Academy training and a post-training survey (103 faith leaders and 81 behavioral health providers). As shown in Table 1, while the ratings regarding the content and impact of the trainings were generally favorable, the mean score differences between the two groups indicated that behavioral health providers may not have felt as informed about how to access or work with faith community resources as faith leaders felt informed about behavioral health issues and resources.

TABLE 1. POST-TRAINING SURVEY

Faith Leaders (n=103): "As a result of this training…"	*Faith Leaders* Means	*Behavioral Health Providers* Means	Behavioral Health Providers (n=81): "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	4.2	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	4.7	4.4	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	4.2	I know better how to educate other behavioral health providers about faith-based behavioral health resources
I know better how to reduce the stigma of behavioral health within my faith community	4.7	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	4.4	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, three-quarters (75.7%) of Faith Leaders reporting being "very satisfied" with the training they received compared to about half (49.4%) of Behavioral Health Providers. This is consistent with the slight differences in mean score ratings presented in Table 1.

PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2016-17 (6/30/2017), 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 6 respondents from the 18 persons invited to participate in the survey, a response rate of 33.3%. Most invited persons (16 of 18) were persons with very specific / targeted program roles (i.e., presenter, curriculum content contributor). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *The major program goals identified by staff:*
    a. Educate faith leaders in the community about mental illness
    b. Educate mental health professionals about faith-based communities
    c. Educate faith community leaders about drug addiction
    d. Reduce stigma surrounding mental illness and seeking mental health (MH) services
    e. Facilitate connections between MH service providers and community clergy
    f. Increase the ability of faith leaders to support their community
    g. Train and reach faith-based organizations

2. *Factors that helped the program achieve goals:*
    a. Diverse contributors bringing expertise and experiences to the program and presentations
    b. Staff being passionate, committed, and organized
    c. Workshops in the community
    d. Bilingual workshops, presenters, and staff
    e. Providers being educated on the value and influence of faith-based communities on MH recovery
    f. Well written curriculum with plenty of information

3. *Factors that inhibited the program from achieving goals:*
    a. Delays in program implementation
    b. The complexity of merging different content styles
    c. Too much content for presentations
    d. Participant reasons (e.g., dropped out, low attendance, unable to attend)
    e. Ineffective outreach efforts
    f. Workshops not being offered to the public (i.e., for wider distribution of the information)
    g. Challenges in recruiting participants in faith-based communities who can benefit the most

4. *Recommendations to help the program better achieve goals*:
    a. More inter/intra agency collaboration (e.g., between related faith-based "Innovation" funded programs and between MH providers and clergy)
    b. More preparation time for locating personnel & developing the curriculum
    c. Greater flexibility with budget line items during program development
    d. Increase outreach efforts made to non-Christian places of worship/agencies
    e. Increase the number of yearly workshops
    f. Increase the amount of staff that can reach out and educate the community about program goals
    g. Stronger commitment from attendees to complete training
    h. Offer workshops to the broader public for wider access
    i. Get more information from faith-based providers on perceived community needs
    j. Increase outreach efforts made to engage faith-based leaders and MH providers

5. *Existing supports, tools, and/or trainings that helped the program be successful:*
    a. Committed agency members in the faith-based community giving their time
    b. Workshops scheduled on the weekend
    c. Dialogue exchanges between faith entities and MH facilities
    d. Awareness of the need to understand and integrate faith-based and MH strategies
    e. Funding from the county to do the work and produce curriculum materials

PROGRAM ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

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

a. Better communication between related faith-based "Innovation" funded programs for continuity and relationship building
b. Yearly meetings to make improvements and revise goals
c. Attendee feedback on satisfaction with presenters
d. More funding for resources and more equipment for producing curriculum materials

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

a. Visiting churches in the local area
b. Sharing information at clergy associations
c. Holding workshops at a diverse number of religious and community venues
d. Requesting endorsement from Catholic Diocese as trainers for MH Missions
e. Advertising training academies in church bulletins
f. Trying multiple workshop times (during the week) to improve attendance
g. Asking clergy for "best times" that fit their schedule to secure them as presenters
h. Having more bible-based topics (i.e. scrupulosity, religious-based trauma)
i. Using people who took the training to "advertise" their positive experience

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

a. Having the County send out info via County and community events
b. The County approving training or the cultural competency of particular agencies involved
c. The North Inland Faith Council being a recruiting source
d. Offering more free Continuing Education Units (CEUs)
e. Promoting through local colleges
f. Conducting trainings at campus facilities
g. Having weekday trainings
h. Promoting research and values of faith-based involvement in MH recovery

9. Successful strategies to identify and recruit training academy presenters:

a. Recruiting from North Inland Faith Council
b. Recruiting from seminars and trainings attended by faith-based leaders
c. Incorporating BH providers on the faith-based presenters team
d. Monetary compensation
e. Communicating with local churches (e.g., emails, phone calls, direct mailings)
f. Recruiting presenters with passion to educate
g. Developing good long-term relationships with presenters
h. Community outreach (e.g., posting in local papers such as Good News)
i. Personal networking/"word-of-mouth"

10. Factors that led to successful training academies:

a. People with commitment to program goals
b. Curriculum being meaningful for participants
c. Participant feedback being implemented into the curriculum
d. Good training discussions

11. Lessons learned in regards to developing and/or delivering training academies:

a. Sustain/maintain the training process (i.e. keep ideas fresh, aids, and presenter turnover)
b. Train presenters to be more effective in linking congregation to community resources
c. Know the audience; speak to people who are interested
d. Be careful not to deliver too much info for people to comprehend

KEY YEAR 1 PROGRAM "LEARNINGS"

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

YEAR 1 PROGRAM RECOMMENDATIONS

1. Create more opportunities for faith leaders and behavioral health providers to interact with each other.
2. Adapt content/presentation material to improve fit with non-Christian faith communities.
3. Increase outreach activities to key faith leaders (e.g., clergy, pastors, rabbis, imams).
4. Improve communication and coordination with other Faith Based Initiative partners (e.g., Community Education provider).

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #1, Faith Based Academy, during Year 1 that differed substantially from the initial program design.

For additional information about the INN–13 Faith Based Initiative #1, Faith Based Academy and/or this annual report, please contact:

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

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

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/16 - 6/30/17)

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

Two community organizations were selected to provide Community Education services (Stepping Higher and National Alliance on Mental Illness [NAMI], San Diego). 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 the behavioral health related presentations. An important feature of the Community Education program is the recruitment of persons from the community to act as the Faith Champions and facilitators to present the behavioral health related information. One of the other Faith Based Initiatives, the Faith Based Academy, supports the work of the Community Education program by identifying potential Faith Champions from Academy participants and then linking such persons to the Community Education program. The Community Education programs are expected to reduce stigma frequently associated with behavioral health needs and improve knowledge about available treatment and support resources.

EXECUTIVE SUMMARY

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

- During 2016-17, 295 persons attended a Community Education behavioral health related workshop.
- The majority (63.3%) of attendees were between the age of 26 and 59 and were female (72.9%). Most identified as African American (79.3%) and 13.6% identified as Hispanic.
- Based on post-training survey responses, most attendees (85% or more) agreed or strongly agreed that the training increased their knowledge about relevant behavioral health issues and available resources. Of particular interest, over half (53.9%) strongly agreed that they were committed to increasing awareness within their community.
- Key factors identified by staff that helped the program achieve its goals included: 1) skilled and passionate program staff and workshop facilitators, 2) successful integration of faith and scientific evidence, 3) using role-plays as an educational tool, 4) presenting at community locations, and 5) community relationships/credibility.

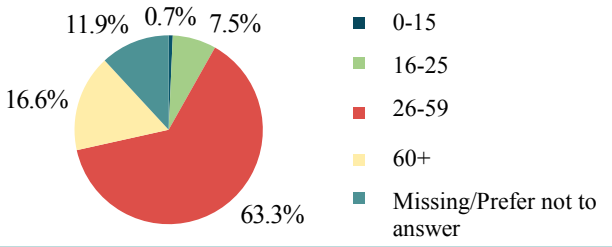
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) explore potential for adding a post-presentation "follow-up" component in which someone can contact audience members who request additional information/help with connecting to resources, 2) identify more Spanish speaking staff/facilitators, 3) expand marketing/outreach for community presentations, 4) continue to find additional venues for presentations, 5) increase the number of males attending community presentations, and 6) increase the number of Latinos attending community presentations.

PARTICIPANT DEMOGRAPHICS

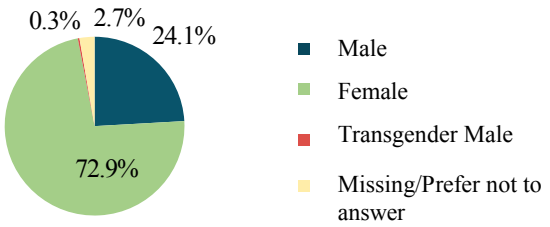
The following demographic data were collected from an audience self-report survey administered at the community presentations.

AGE (N=295)



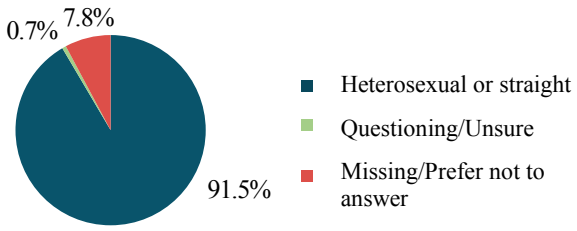
The majority (63.3%) of participants were between the ages of 26 and 59, and 16.3% were age 60 or above.

GENDER IDENTITY (N=295)



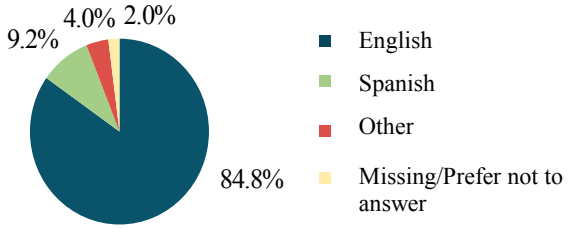
Seventy-three percent of participants identified as female.

SEXUAL ORIENTATION (N=295)



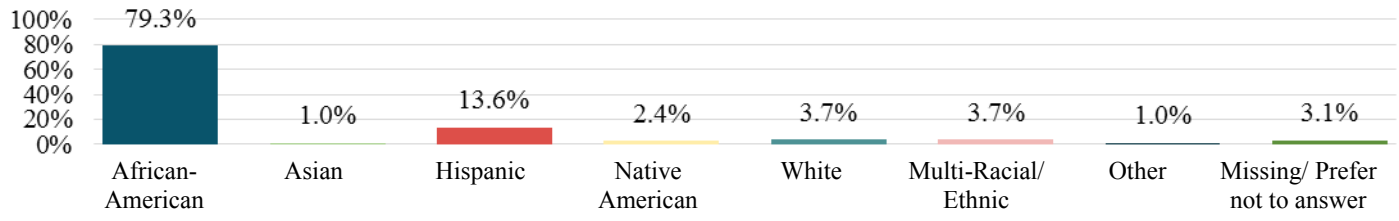
Almost all participants (91.5%), indicated they were hetero-sexual or straight.

PRIMARY LANGUAGE (N=295)



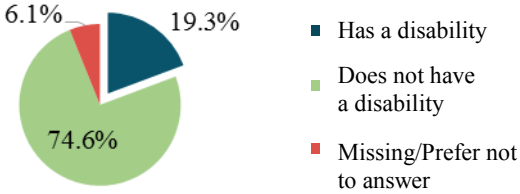
Most participants (84.8%), spoke English as their primary preferred language.

RACE/ETHNICITY (N=295)



Most participants (79.3%) identified as African-American. Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=295)



Nineteen percent of participants had some type of non-SMI disability.

The majority (84.1%) of participants had never served in the military.

TYPE OF DISABILITY (N=295)

Type	n	%
Communication	15	6.8
Mental (e.g., learning, developmental)	6	2.7
Physical	10	4.5
Chronic Health	10	4.5
Other	6	2.7

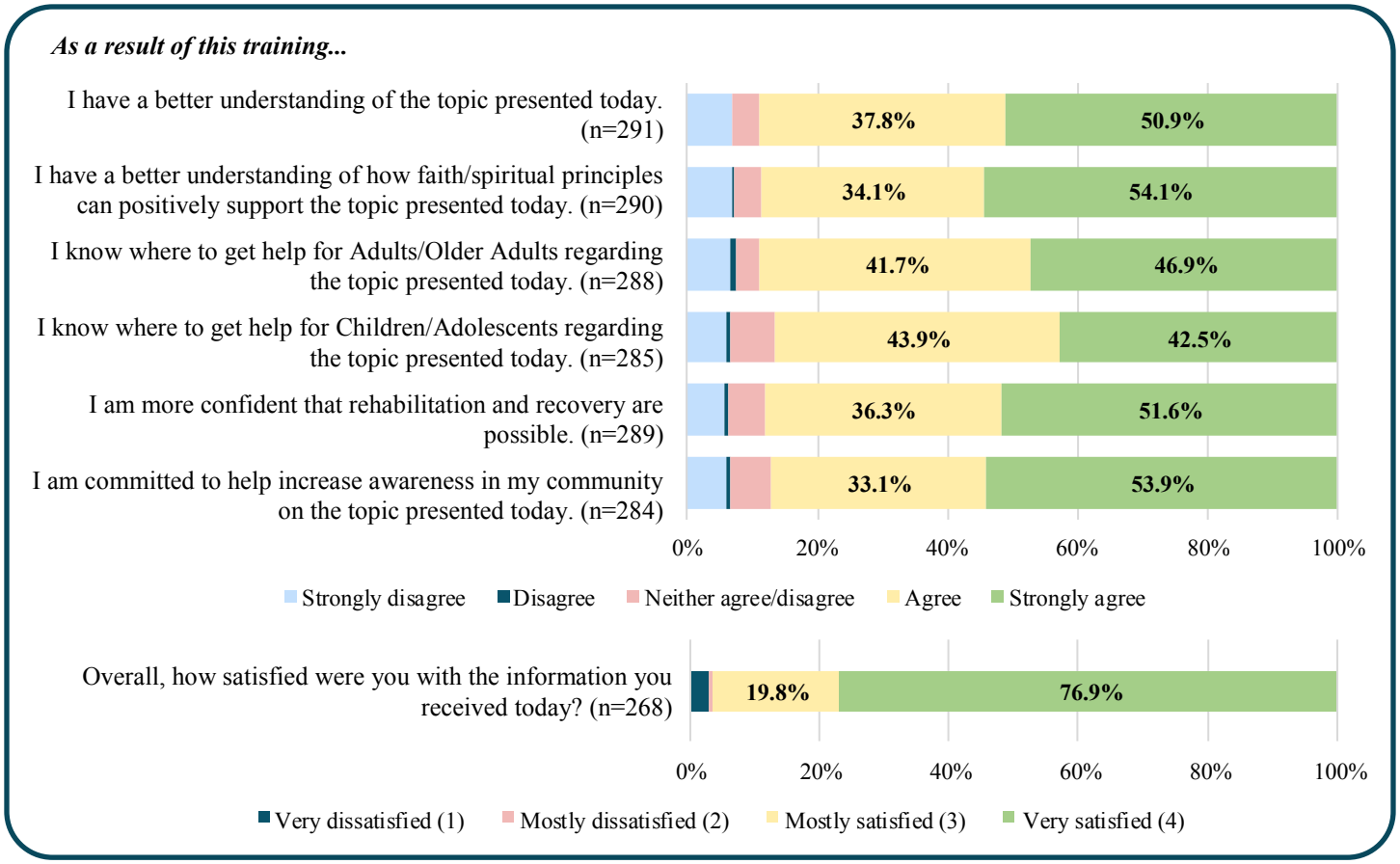
The table above describes the types of disabilities these participants reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

[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).*

POST-TRAINING SURVEY RESULTS

As shown in Figure 1, the vast majority of community attendees (85% or more) at educational presentations agreed or strongly agreed that as the result of the training they were more knowledgeable, knew where to obtain appropriate assistance, and were more capable and committed advocates to help others in their community. Of particular interest for achieving the goals and objectives of the overall Faith Based Initiative and this specific Community Education strategy, over half (53.9%), strongly agreed that they were committed to increasing awareness within their community. This provides some evidence to suggest that the desired "ripple effect" of education and ultimately community transformation is potentially underway, in that persons trained through the Faith Based Academy (Faith Based Initiative #1), are now providing community educational workshops and/or training facilitators to do so as part of the Community Education program (Faith Based Initiative #2), which is then leading to attendees of those presentations indicating that they are motivated to further expand the reach of this material by helping to increase awareness of these behavioral health topics among the people they know. Additionally, almost all presentation attendees indicated they were satisfied with the information they received (19.8% were mostly satisfied and 76.9% were very satisfied).

FIGURE 1. COMMUNITY EDUCATION POST-PRESENTATION OUTCOMES AND SATISFACTION



PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2016-17 (6/30/2017), 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 10 respondents from the 16 persons invited to participate in the survey (62.5% 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. The major program goals identified by staff:

a. Recruit champions who have completed training
b. Recruit mental health (MH) trainers interested in working in faith settings
c. Evaluate and work collaboratively with the other related faith-based "Innovation" funded programs
d. Teach faith leaders and trainers MH topics to educate within the community
e. Provide the community with resources
f. Raise awareness of MH realities within African American/Latino communities
g. Increase the awareness of MH while decreasing stigma
h. Train facilitators on giving community presentations
i. Identify community resources

2. Factors that helped the program achieve goals:

a. Staff aspects (e.g., preparedness, flexibility, adaptability, patience)
b. The combination of scientific evidence and spirituality, and their benefit to each other
c. Respectful presentations using simple language
d. Using role-plays as an educational tool for understanding commonly diagnosed mental illness
e. Sustained training in the Faith community
f. Meeting the community in their local area
g. Facilitator aspects (e.g., interactive, knowledgeable about topics and accessing resources)
h. County helping to extend educational resources
i. Open communication and sharing about MH in a respectful and recovery oriented way
j. Relationships within the community
k. Resources (e.g., list of counseling services, an app that had resource recommendations)

3. Factors that inhibited the program from achieving goals:

a. Irregular attendance
b. Not making plans or collaborating with the other related faith-based "Innovation" funded programs
c. Not having enough presenters for the Spanish-speaking community
d. Not enough local programs available to work make linkages with
e. Lack of communication with the faith community
f. Slow/inefficient marketing that was not highly visible
g. Limited outreach to schools, colleges, and military bases
h. Stigma about mental health illness and accessing mental health services
i. Limited church hours (i.e., it made coordination difficult)
j. Not enough time to build relationships within the community
k. Recruitment difficulties
l. Limited venues that are free for the presentations
m. County personnel staffing changes (i.e., it made work flow more difficult)

4. Key strengths of the program:

a. Involvement of the faith community
b. Free education
c. The ability to work with an underserved minority population
d. The support to the community it provides
e. Strong facilitators/staff

PROGRAM ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

5. Recommendations to help the program better achieve goals:

a. Increase interagency communication (e.g., with County and other related faith-based "Innovation" funded programs)
b. Make mental health appointments and doctor referrals on site
c. Have more Spanish speaking staff/facilitators (i.e., to truly connect with the community)
d. More marketing in local churches
e. Engage local community resources in the trainings
f. Increase referrals
g. Bring in licensed clinicians to further discussions and dialogue
h. Increase outreach (e.g., via schools, treatment homes, and the internet)
i. Use incentives (e.g., monetary compensation)
j. Have more flexibility with County contract/statement of work

6. Existing supports, tools, and/or trainings that helped the program be successful:

a. Resources that allow for coordinating presentations
b. NAMI (e.g., their classes, programs, and groups)
c. Agency factors (e.g., training, guidance, providing support for trainers)
d. Marketing (e.g., neighborhood canvassing)
e. Trainings for how to give presentations
f. County Partnership
g. Knowledgeable facilitators
h. Interacting and having better coordination with other related faith-based "Innovation" funded programs

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

a. More discussions at the beginning of the program/more planning of communications
b. Spanish presentations
c. Region expansion to the South Bay area
d. More promotion in the Latino community
e. A variety of classes (e.g., for families, parents, teachers)
f. A counseling program that could offer in-house MH services
g. Certificates from the County to validate teaching credentials
h. Increased marketing support to reach the appropriate demographic

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

a. Using graduates from the target communities
b. Encouraging graduates to continually train others
c. Continually making phone calls
d. Personal networking (e.g., word of mouth, talking to friends)
e. Talking to the Faith community
f. Scouting locations for sites that work with underserved/minorities
g. Networking through similar events
h. Reaching out via events at communal locations (e.g., libraries, schools, YMCA)
i. Using social media
j. Using email blasts
k. Encouraging congregations to reach out to their members (e.g., mailings/emails)
l. Sending community news letters

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

a. Faith entities having 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 YEAR 1 PROGRAM "LEARNINGS"

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

YEAR 1 PROGRAM RECOMMENDATIONS

1. Explore potential for adding a post-presentation "follow-up" component in which someone can contact audience members who request additional information/help with connecting to resources.
2. Identify more Spanish speaking staff/facilitators.
3. Expand marketing/outreach for community presentations (e.g., churches, schools, military bases).
4. Continue to find additional venues for presentations.
5. Increase the number of males attending community presentations.
6. Increase the number of Latinos attending community presentations.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #2, Community Education, during Year 1 that differed substantially from the initial program design.

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 BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/16 - 6/30/17)

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

One community organization, Stepping Higher, was selected to provide Crisis Response Team services during this time period. Within their target region in the county, Central, the program was responsible for: 1) providing trained staff who could respond 24 hours a day to crisis situations as they occurred, and 2) offering short-term follow-up visits (up to 90 days), to support the individuals and families who experienced the crisis event and attempt to link them to appropriate behavioral health and non-behavioral health services. An innovative feature of this program is the provision of additional supports in the midst of and following a crisis event that incorporate shared understandings of faith and community to deescalate situations and promote peace and healing within challenging circumstances. The emotional supports and additional linkages to community resources provided by Crisis Response Teams members are expected to improve the behavioral health and wellbeing of those receiving Crisis Response Team services.

EXECUTIVE SUMMARY

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

- During 2016-17, 142 people received crisis team services.
- Approximately 55% of the persons served were female and nearly 40% were between the ages of 26 and 59. Participants identified primarily as African-American (54.2%) or Hispanic (45.8%).
- Over 90% reported being satisfied with their overall experience with the Crisis Response Team. More specifically, the majority indicated satisfaction with the initial crisis services provided, the professionalism of the staff, the resources provided by team, and the quality of follow-up services.
- Nearly three-quarters (72.6%) reported that they know where to get help when needed due to crises team services.
- Key factors identified by staff that helped the program achieve its goals included: 1) existing relationships within the community, 2) having a team of experienced/ knowledgeable clergy and behavioral health professionals, 3) quick crisis response time whenever needed, 4) culturally connecting with clients by having a team representative of the community being served, 5) timely follow-up after initial crisis contact, and 6) collaborative approach to services (i.e., clients and staff working together).

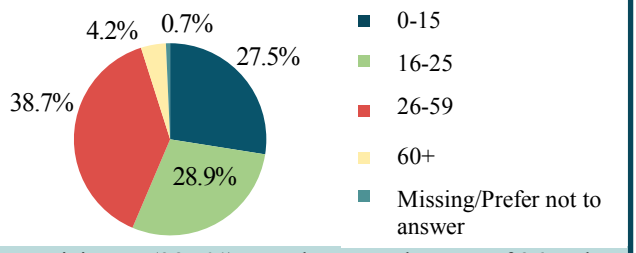
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) improve interagency coordination and communication, 2) create direct referral mechanism from police and fire departments, 3) identify additional community resources for participants, 4) explore provision of longer-term follow-up care with participants, 5) explore expansion into other regions/ communities, and 6) develop and implement method for assessing utilization of formal crisis services after initial visit with crisis response team.

PARTICIPANT DEMOGRAPHICS

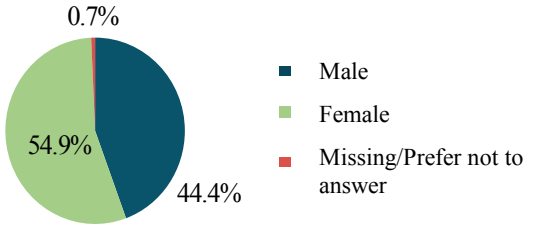
The following self-report demographic data were collected from participants during the initial or follow-up visit.

AGE (N=142)



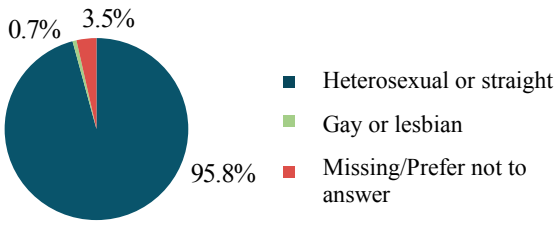
Most participants (38.7%) were between the ages of 26 and 59, and 29% were between ages 16 and 25.

GENDER IDENTITY (N=142)



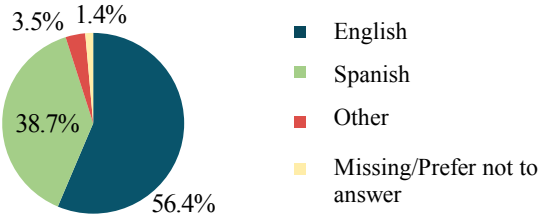
Slightly more females over half (54.9%) of participants were female and 44.4% of participants were male.

SEXUAL ORIENTATION (N=142)



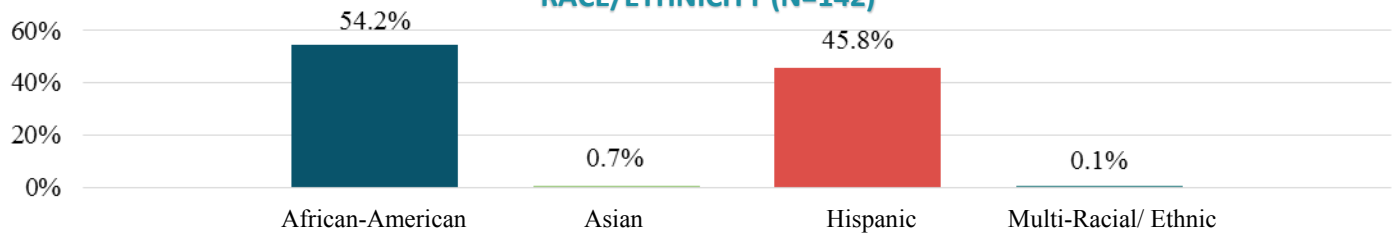
The majority (95.8%) of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=142)



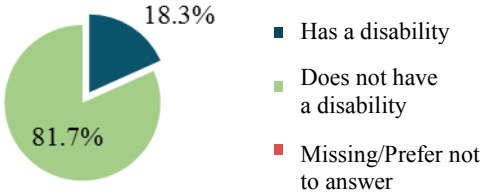
The majority (56.4%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=142)



Most participants identified either as African-American (54.2%) or Hispanic (45.8%). Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=142)



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

The majority (90.8%) of attendees had never served in the military.

TYPE OF DISABILITY (N=142)

Type	n	%
Communication	5	3.5
Mental (e.g., learning, developmental)	15	10.6
Physical	3	2.1
Chronic Health	6	4.2
Other	3	2.1

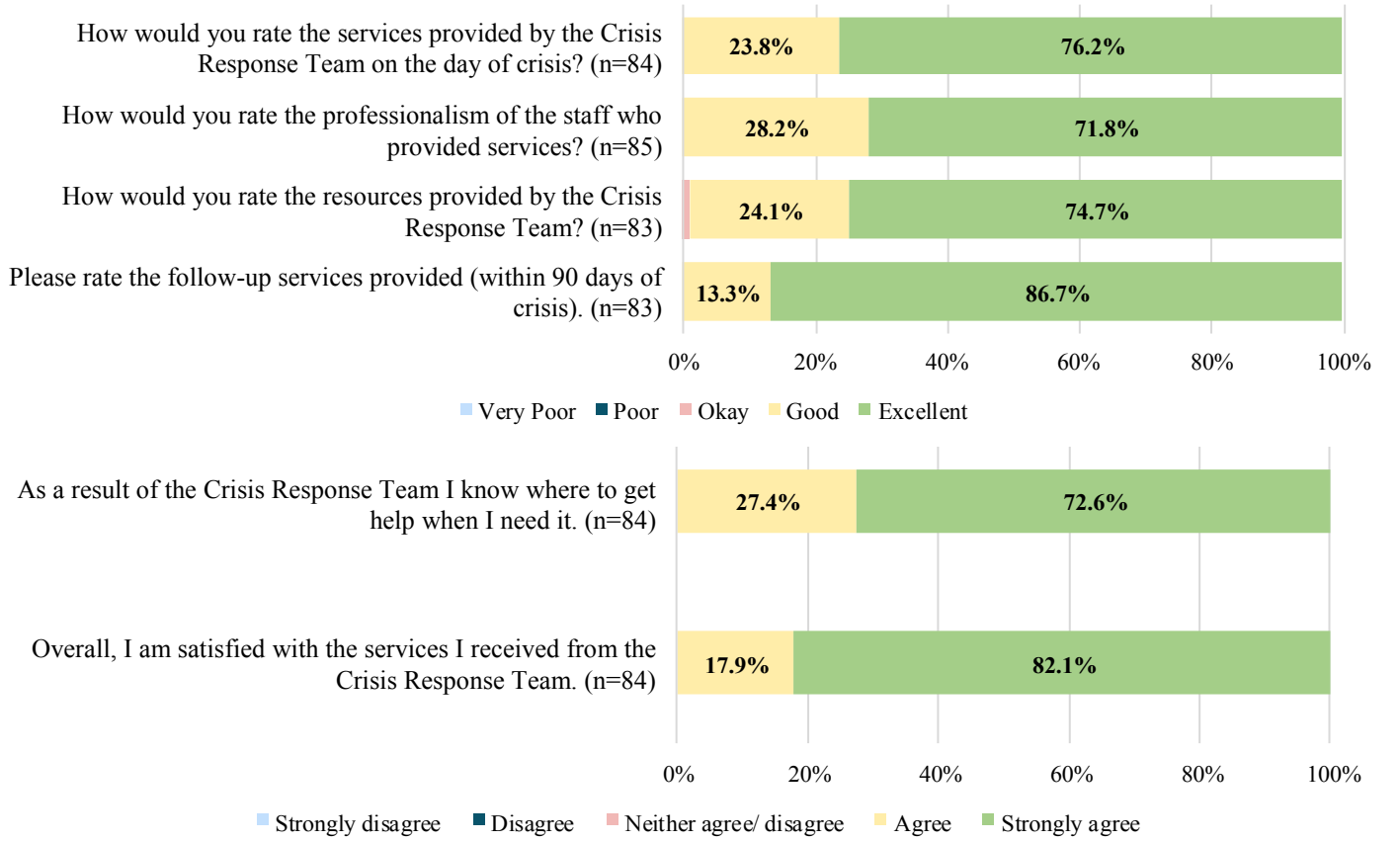
The table above describes the types of disabilities these participants reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

[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).*

CRISIS RESPONSE TEAM SERVICES FEEDBACK SURVEY

Persons who had received services from the Crisis Response Team were asked to provide feedback about their interactions with the team at the end of the follow-up service period (within 90 days of the initial crisis event). The results from the completed surveys are presented in Figure 1. In general, participants indicated have very assessments of their experiences with the team and the services they provided (e.g., 70-80% provided the highest rating of "excellent" for each question domain). All respondents agreed (17.9%) or strongly agreed (82.1%) with the statement indicating satisfaction with services received.

FIGURE 1. CRISIS RESPONSE TEAM SERVICE FEEDBACK SURVEY



PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2016-17 (6/30/2017), 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 3 respondents from the 5 persons invited to participate in the survey (a 60% 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. The major program goals identified by staff:

a. To provide services that de-escalate crisis situations (e.g. attempted suicides, domestic violence, etc.)
b. To support to minority, primarily African-American/Latino communities
c. To provide support from a faith-based perspective
d. To restore peace back into people's homes
e. To provide follow-up services after crisis

2. Factors that helped the program achieve goals:

a. Existing relationships within the community
b. Good reputation as faith-based, behavioral health (BH) professionals
c. Availability of BH staff and clergy as needed
d. Responding quickly to hotline calls
e. Team commitment to support others/make difference in community
f. Ability to connect with clients by having a team comprised of similar racial/cultural backgrounds
g. Timely follow-up (i.e., within days) after crisis contact
h. Experienced/knowledgeable clergy and BH professionals
i. Collaborative approach to services (i.e., clients and staff working together)

3. Factors that inhibited the program from achieving goals:

a. Limited interagency coordination/communication (e.g., police, fire, etc.)
b. Not enough resources to meet service needs
c. Difficult situations with clients
d. County personnel staffing changes (i.e., it made work flow more difficult)

4. Recommendations to help the program better achieve goals:

a. Better interagency coordination (e.g., police, fire, etc.)
b. Police Department (PD) and Fire Department (FD) agreeing to send referrals
c. Expand service area to other regions
d. Ongoing updates of resources available for target communities
e. Capacity to provide long-term follow-up care with client
f. Increased funding
g. Continued openness to and support of clients

5. Existing supports, tools, and/or trainings that helped the program be successful:

a. Staff trainings on crisis intervention/management
b. Staff background/education in mental health
c. Community resources for supporting clients
d. Team effort/collaboration across staff roles
e. Staff that support and assist clients

PROGRAM ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

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

a. Funds to cover transportation to crises sites (e.g., gas)
b. County updates on available resources for the community

7. Key strengths of the program:

a. Offering integrated faith-based mental health services
b. Using a team approach to providing services
c. Providing needed resources and help to the community
d. Empowering clients/promoting self-representation

8. Noted differences between Peace Team services and other non-faith crisis response programs:

a. Facilitates cultural connections within African-American/Latino communities
b. Promotes trust and client openness to suggestions/information
c. Consistent with how clients already respond to crisis
d. Encourages de-escalation by relying on one's faith/beliefs

9. Reactions of persons/families needing Peace Team services:

a. Clients were grateful for support and services
b. Thought program was a "fantastic idea"
c. Clients felt supported from both a faith and mental health perspective

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

a. Get help from the County to establish relationship with PD, FD, etc.
b. Create a memorandum of understanding with PD and FD
c. Distribute materials periodically to remind PD and FD about program
d. Have meetings/make phone calls to market to, and educate, PD and FD about the program

11. Strategy ideas about how to educate the general community about Peace Team services:

a. Social media marketing
b. Newsletters within behavior health services
c. Community events/presentations (e.g., public forums, schools, etc.)
d. Local newspapers
e. Community networking/collaboration
f. Community fliers (e.g. YMCA, library, teen centers, etc.)

KEY YEAR 1 PROGRAM "LEARNINGS"

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

YEAR 1 PROGRAM RECOMMENDATIONS

1. Improve interagency coordination and communication (e.g., crisis teams, BHS, PD, FD).
2. Create direct referral mechanism from police and fire departments.
3. Identify additional community resources for participants.
4. Explore provision of longer-term follow-up care with participants (e.g., additional care and case management services).
5. Explore expansion into other regions/communities.
6. Develop and implement method for assessing utilization of formal crisis services (e.g., police contacts) after initial visit with crisis response team.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #3, Crisis Response Team, that differed substantially from the initial service delivery model.

For additional information about the INN–13 Faith Based Initiative #3 , Crisis Response Team program 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 BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/16 - 6/30/17)

The Wellness and Mental Health In-Reach Ministry (WMHIM) is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprises the County of San Diego Behavioral Health Services' (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objective of the WMHIM is to engage with inmates who have a serious mental illness (SMI; e.g., 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 an SMI while they are still in jail, but are nearing their release date, and 2) offering short-term, post-release follow-up services (up to 90 days), to help individuals successfully transition back into the community by providing emotional support, empowerment, and linkages to appropriate services. An innovative feature of this program is the provision of behavioral health supports and linkages to community resources combined with a faith/spirituality perspective to help promote trusting relationships and personal growth. The emotional support and connections to community resources provided through WMHIM are expected to improve the behavioral health and well-being of those receiving services, which should contribute to lower rates of recidivism back into jail.

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 back into jail.

- During 2016-17, a total of 103 inmates received services through WMHIM.
- Approximately 20% of the persons served were female and about 10% were Transition Age Youth (i.e., age 16-25).
- The program served a diverse population, with 35.9% identifying as African-American, 34.0% as White and 13.6% as Hispanic.
- Preliminary analyses of short-term recidivism (i.e., bookings into jail within 90 days of release), indicated a sharp reduction after involvement with the program. Almost two-thirds (64.7%), had a previous jail booking within 90 days of their current incarceration, whereas only 28.4% had a subsequent booking in the 90 days post-release after involvement with WMHIM.
- 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 (particularly housing when possible), 3) a patient and respectful faith based team, and 4) coordination within the team and with external partners to maintain post-release contact.

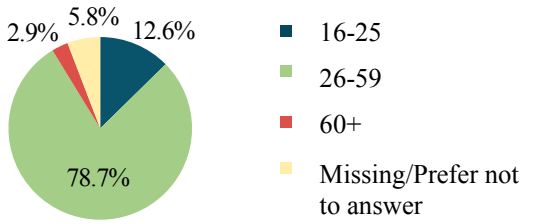
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify additional housing resources, 2) explore options for increasing number of pre-release visits, 3) increase amount of information provided to the program from the jail about inmates, 4) improve program data tracking/documentation capabilities, 5) enhance tools/procedures for maintaining accurate information about community resources and services, 6) improve communication/coordination with jails/probation, and 7) adapt regional service requirements to better fit distribution of referrals.

PARTICIPANT DEMOGRAPHICS

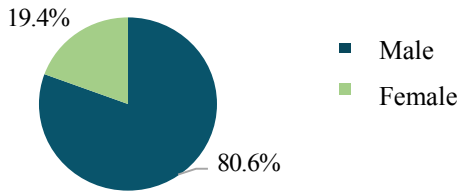
The following demographic data were collected from participants during an initial intake visit.

AGE (N=103)



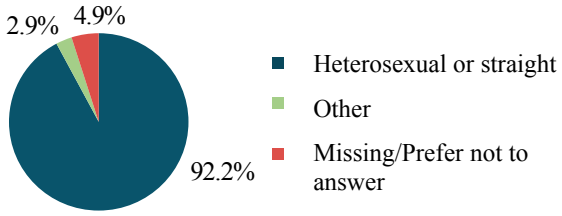
The majority of participants (78.7%), were between the ages of 26 to 59 with 13% between ages 16 and 25.

GENDER IDENTITY (N=103)



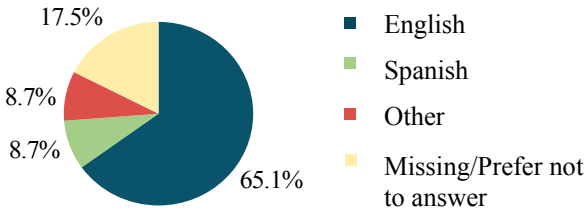
Most participants (80.6%), were male, with females comprising about one-fifth of those served.

SEXUAL ORIENTATION (N=103)



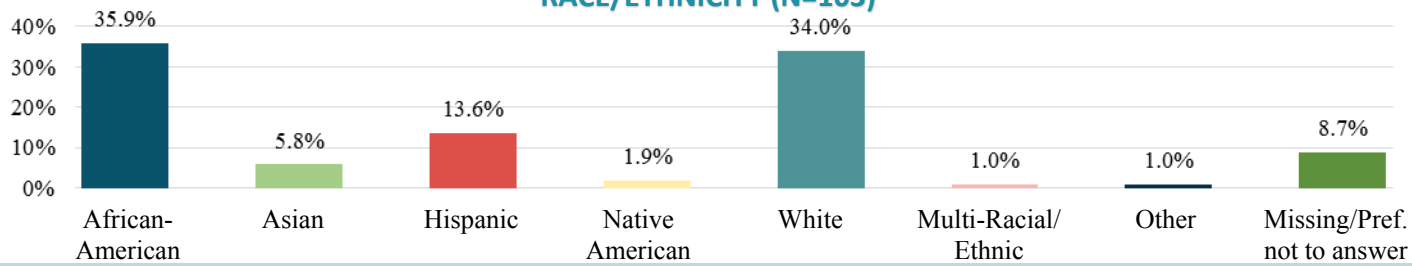
Almost all participants (92.2%), identified as heterosexual or straight.

PRIMARY LANGUAGE (N=103)



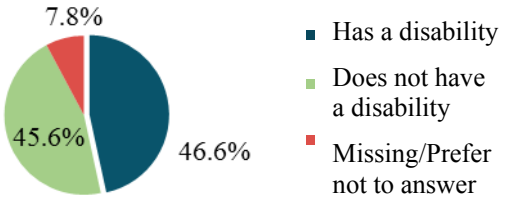
The majority of participants (65.1%), preferred English as their primary language.

RACE/ETHNICITY (N=103)



Similar proportions (approximately one-third), of participants identified as African-American and White. Another 13.6% identified as Hispanic. Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[1] STATUS (N=103)



Almost half (46.6%), of the participants indicated some type of non-SMI related disability.

The majority (82%), of participants had never served in the military.

TYPE OF DISABILITY (N=103)

Type	n	%
Communication	7	6.8
Mental (e.g., learning,	4	3.9
Physical	4	3.9
Chronic Health	4	3.9
Other	34	33.0

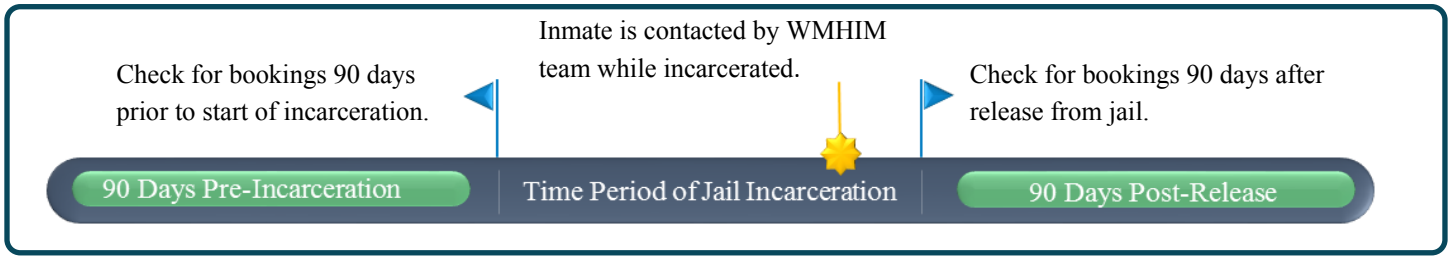
The table above describes the types of disabilities participants reported. Totals may exceed 100% as participants could indicate more than one type of disability.

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

COUNTY OF SAN DIEGO CRIMINAL JUSTICE SYSTEM RECIDIVISM

A primary objective of WMHIM is to reduce future interactions with the County of San Diego criminal justice system after participants are released from jail. To assess the extent to which program participation may be associated with such a decline, the pattern of County jail "bookings" (i.e., interactions with police that resulted in transportation to jail and the assignment of a booking number), was examined before and after involvement with the WMHIM team. As illustrated in Figure 1, jail data were reviewed to identify the number of times, if any, inmates had been booked during the 90 days before the start of the incarceration period during which the WMHIM team first contact the inmates (i.e.,, the "reference incarceration period"), and then compare that to the number of bookings during the 90-day period after being released from jail. To ensure equal 90-day observation periods both before and after the reference incarceration period, only inmates released at least 90 days before the end of FY 2016-17 (6/30/2017), were included in the recidivism analyses (n=74) discussed below.

FIGURE 1. ILLUSTRATION OF PROCESS TO COMPARE 90-DAY PRE- AND POST-INCARCERATION BOOKING RATES



As shown in Table 1, almost two-thirds (64.7%), of the participants had at least one booking during the 90 days before the start of the reference incarceration period. In contrast, only 28.4% of these participants experienced a booking during the 90 days after release from jail during the incarceration period in which they first met the WMHIM team. While these analyses do not allow for a specific test of causation, the findings strongly suggest that participation in WMHIM contributed to a reduction in repeat bookings into the County of San Diego jail. In future reporting periods these analyses will be extended to examine longer-term recidivism patterns.

TABLE 1. COUNTY OF SAN DIEGO JAIL BOOKINGS 90 DAYS BEFORE AND AFTER REFERENCE INCARCERATION PERIOD

	Booking within 90 Days Before Start of Reference Incarceration Period (n=74)	Booking within 90 Days After Release from Reference Incarceration Period (n=74)
Any Bookings	64.7%	28.4%
Total Bookings (persons can have more than one)	78	35

ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2016-17 (6/30/2017), 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 6 respondents from the 9 persons invited to participate in the survey, a response rate of 66.6%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. The major program goals identified by staff:

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

2. Factors that helped the program achieve goals:

a. Having complete/accurate information to provide to participants regarding community services
b. Having repeated, positive interactions (e.g., befriending inmates, encouraging them, weekly visits)
c. Evaluating mental health and skills early on
d. Identifying appropriate service providers and programs
e. Facilitating access to needed post-release services
f. Lots of prayer/reliance upon one's faith
g. Funding from the state
h. Having clearance to enter jails/prisons
i. Using teamwork between non-religious and religious groups to help releasing participants
j. Having coordinated release efforts to maintain participant contact
k. Training sessions at the Training Center
l. Having patient and respectful team members

3. Factors that inhibited the program from achieving goals:

a. Not enough contact with inmates
b. Lack of coordinated release efforts (e.g., with the participant, the parole officer, the program where the participant is going)
c. Poor internal communication/coordination
d. Not having medications released with participant
e. Lack of housing for participants
f. Poor communication/coordination between program and jail/probation
g. Mental health treatment programs with required wait times (e.g., 30 days) before qualification
h. SMI documentation/determination requirements too strict
i. Lack of participant buy in (e.g., won't meet or show up at scheduled times, drops out of the program)

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

a. Acquiring relevant phone numbers
b. Developing relationships with family members
c. Sponsoring participants who are in recovery
d. Continued encouragement to maintain contact (i.e., regular "check-ins")
e. Linking them to appropriate residential or community services/programs
f. Making in-person contacts wherever living (e.g., homes, treatment programs, shelters)
g. Transporting them from jail when they are released
h. Keeping track of where the participant is currently living
i. Finding housing for the recently released participant

ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

5. Recommendations to help the program better achieve goals:

a. Write more grants to acquire increased state funding
b. Increase the amount of housing available for participants being released from programs/facilities
c. Test for drugs and alcohol
d. Enroll more participants
e. Improve internal communication/coordination
f. Increase the amount of information received from the jail (e.g., SMI and incarceration histories)
g. Decrease the amount of "red tape" around linking participants with SMI to services
h. Create a position for a program coordinator
i. Work more closely with SDPD to help participants being released
j. Ongoing support for program

6. Existing supports, tools, and/or trainings that helped the program be successful:

a. Having information to track release and court dates
b. Having good training (e.g., by County and program)
c. Consistently communicating and visiting participants
d. Lessening the amount of paperwork needing to be completed every month

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

a. A "dispatch" like position to track/communicate current and accurate program participant information
b. More information on current programs and services for inmates and individuals with SMI
c. Yearly trainings to keep knowledge and skills up to date
d. Specific hours to connect with participants pre-release
e. A shortened version of reporting/documentation requirements

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

a. Having staff/volunteers with prior incarceration experiences
b. Sharing faith (e.g., personal stories, journeys towards faith, prayer)
c. Visiting with inmates frequently
d. Offering potential of safe housing post-release
e. Empowering participants with support/encouragement to make positive life change

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

a. Lack of participant buy-in/motivation
b. Not enough housing/treatment beds
c. Challenges of working with participants with SMI
d. Not enough services for participants with SMI

10. Reported inmate comparisons between this program and other community re-entry programs inmates may have participated in:

a. Good staff "follow-through" on what they said they would do for participants
b. If problems arose, probation officers more likely to send participants back to program (instead of jail)
c. More frequent pre-/post-release visits
d. The spiritual component of the program provided substantial emotional support/increased motivation
e. Perceived as a "new" approach compared to other re-entry programs
f. Focus on trusting and encouraging participants more, even in midst of setbacks
g. After completing this program, it appears that recidivism decreases

KEY YEAR 1 PROGRAM "LEARNINGS"

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

YEAR 1 PROGRAM RECOMMENDATIONS

1. Identify additional resources for providing and/or linking to safe, affordable housing.
2. Explore options for increasing number of pre-release visits (i.e., establish regular/specific hours to connect with inmates, etc.).
3. Increase amount of information available to program regarding treatment and incarceration histories.
4. Improve program service tracking/documentation capabilities.
5. Develop tools/procedures for maintaining accurate information regarding availability of community services and resources.
6. Improve communication and coordination between program and jail/probation systems.
7. Adapt regional service requirements to better fit distribution of referrals from jails.

YEAR 1 PROGRAM CHANGES

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

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 BEHAVIORAL HEALTH SERVICES ANNUAL REPORT: YEAR 2 (7/1/16 - 6/30/17)

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

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

EXECUTIVE SUMMARY

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

- During 2016-17, there were 97 first-time program enrollees and 8 from prior year who re-enrolled (105 total enrollees).
- The majority of new enrollees (56.7%), were male and approximately one-third (36.1%), were TAY (i.e., age 18-25). Some were employed (12.4%), but most (83.5%), indicated they were not currently working but seeking work.
- Participants had acquired a total of 63 jobs through Noble Works, with an average wage of $12.04/hour and 27.5 hours per week (24 full-time jobs). Participants still employed as of 6/30/2017 or at the time they exited Noble Works had been employed in that job for an average of 156.7 days.
- 33.7% of the year one Noble Works cohort obtained at least one job as of 6/30/2017.
- For those who obtained jobs, their job satisfaction was positively associated with other aspects of well-being (e.g., sense of belonging, hopefulness about future, etc.), such that persons with high job satisfaction were more likely to have positive perceptions of other life domains as well.
- Noble Works staff identified the following key factors that helped achieve program goals: 1) staff skills and passion, 2) one on one individualized support with staff, 3) NAMI SD partnership for community outreach and stigma reduction, 4) access to tools and resources to support participants (e.g. class curriculum, etc.), and 5) intra-and interagency collaborations.
- Primary factors inhibiting achievement of program goals included high staff turnover, difficulty finding employers, and challenges maintaining participant engagement.

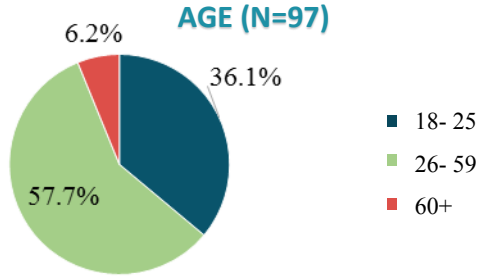
RECOMMENDATIONS

Primary recommendations include: 1) explore opportunities for more coordination with participants' mental health providers, 2) consider consolidating Employment Specialist and Job Coach into one role, 3) increase group caseload supervision to weekly, 4) implement system to track date of first face to face contact with employers, and 5) review closure process to ensure that services are provided as long as desired by participants.

DEMOGRAPHICS: NEWLY ENROLLED NOBLE WORKS PROGRAM PARTICIPANTS

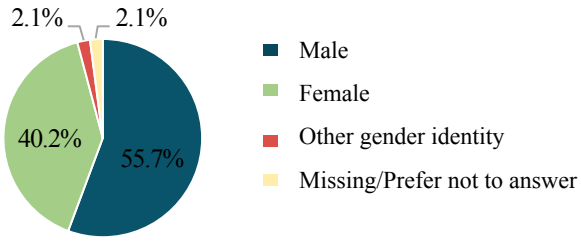
The following demographic data were collected from a participant self-report survey administered when they entered Noble Works.

AGE (N=97)



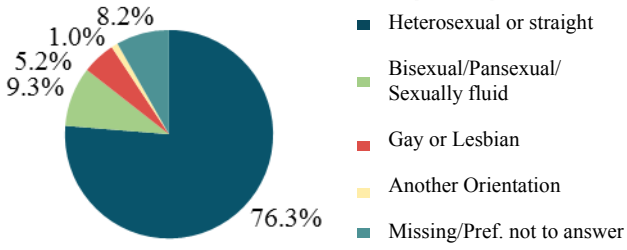
Over half (57.7%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=97)



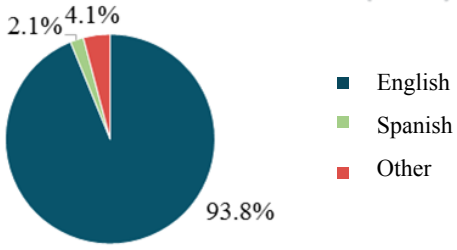
Over half (55.7%) of participants were male and 40.2% were female.

SEXUAL ORIENTATION (N=97)



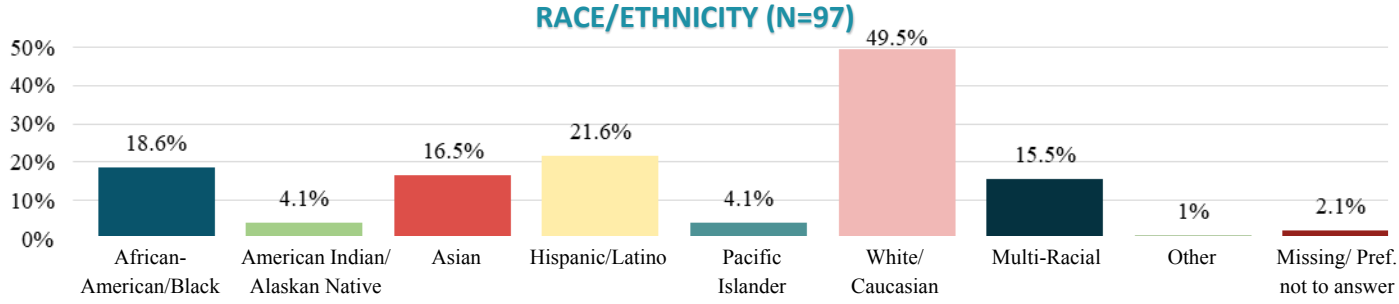
The majority (76.3%) of participants were heterosexual or straight, and 9.3% indicated being Bisexual/Pansexual/ Sexually fluid.

PRIMARY LANGUAGE (N=97)



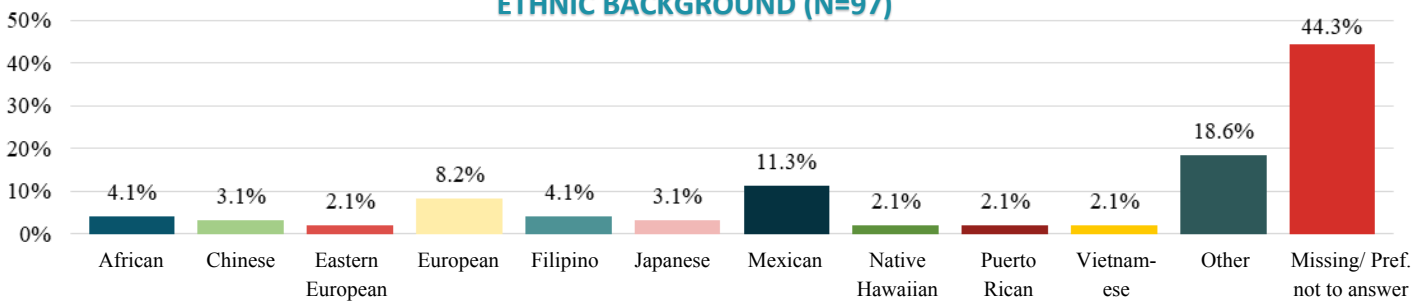
English was the primary preferred language for almost all of the participants (93.8%).

RACE/ETHNICITY (N=97)



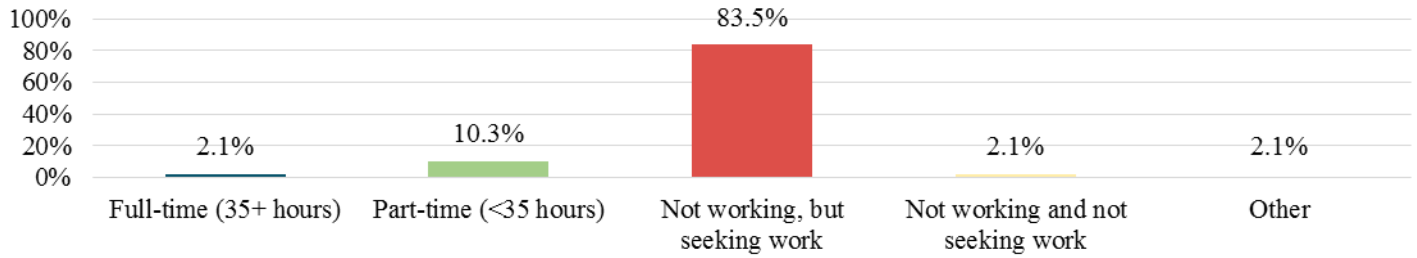
Nearly half (49.5%) of participants identified themselves as White. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

ETHNIC BACKGROUND (N=97)



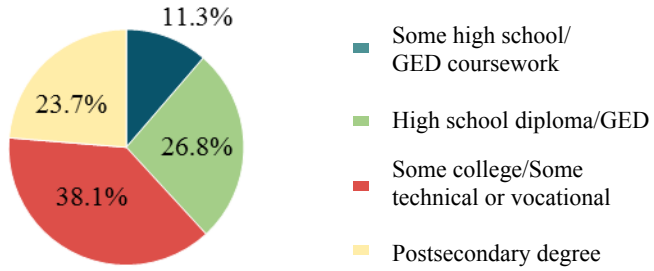
Participants in Noble Works represented a wide range of ethnic backgrounds with Mexican indicated most frequently (11.3%). Totals may exceed 100% as participants could indicate more than one ethnic background.

EMPLOYMENT STATUS (N=97)



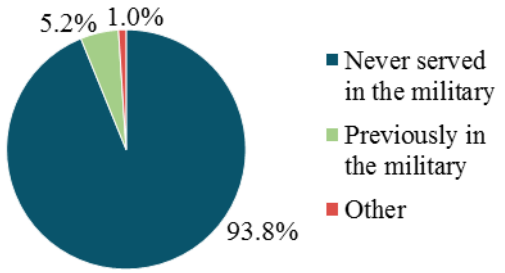
As expected for this type of program, almost all participants were either not working, but seeking work (83.5%), or in part-time positions (10.3%), when they started Noble Works.

EDUCATION LEVEL (N=97)



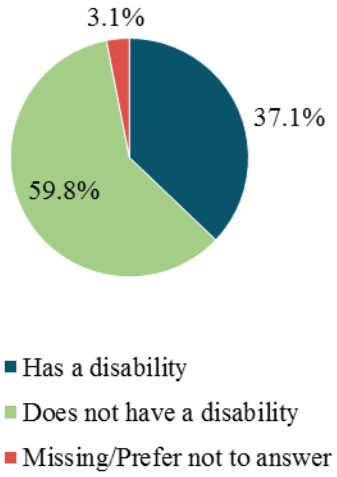
About one-quarter of participants (23.7%), had some form of college degree and over one-third (38.1%), had some college/technical/vocational classes.

MILITARY STATUS (N=97)



The majority (93.8%), of participants had never served in the military.

DISABILITY[1] STATUS (N=97)



Approximately one-third (37.1%), indicated having some form of non-SMI disability.

TYPE OF DISABILITY (N=97)

Type	n	%
Learning Disability	10	10.3
Difficulty Seeing	9	9.3
Physical/Mobility Disability	7	7.2
Chronic Health	6	6.2
Developmental Disability	2	2.1
Other	15	15.5

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

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

JOBS ACQUIRED THROUGH NOBLE WORKS

A total of 63 jobs were acquired by 45 people through the Noble Works program as of 6/30/2017. As shown in Table 1, the jobs acquired covered a wide assortment of occupations, with the most common positions in the job domains of office/administrative support and sales (25.4% and 20.6%, respectively). Four jobs were supported initially through subsidized apprenticeships.

TABLE 1. JOB DOMAINS FOR JOBS AQUIRED THROUGH NOBLE WORKS

	n	%
Building and Grounds Cleaning and Maintenance Occupations	3	4.8
Business and Financial Operations Occupations	1	1.6
Community and Social Services Occupations	4	6.3
Construction and Extraction Occupations	1	1.6
Food Preparation and Serving Related Occupations	7	11.1
Healthcare Support Occupations	4	6.3
Installation, Maintenance, and Repair Occupations	2	3.2
Office and Administrative Support Occupations	16	25.4
Personal Care and Service Occupations	3	4.8
Production Occupations	5	7.9
Protective Service Occupations	3	4.8
Sales and Related Occupations	13	20.6
Transportation and Material Moving Occupations	1	1.6

The average wage for these positions was $12.04 per hour. Of the 63 jobs obtained through Noble Works, 38% were full-time, with an average of 27.5 hours worked per week. Of the 30 jobs that were either still active as of 6/30/2017 or active at the time of program discharge, the average duration was 156.7 days. Of the 33 jobs that ended prior to 6/30/2017, 15 (45.5%) were due to factors outside of the control of the Noble Works participant (i.e., store closing, layoffs, job ending, etc.).

FIGURE 1. CHARACTERISTICS OF JOBS ACQUIRED THROUGH NOBLE WORKS

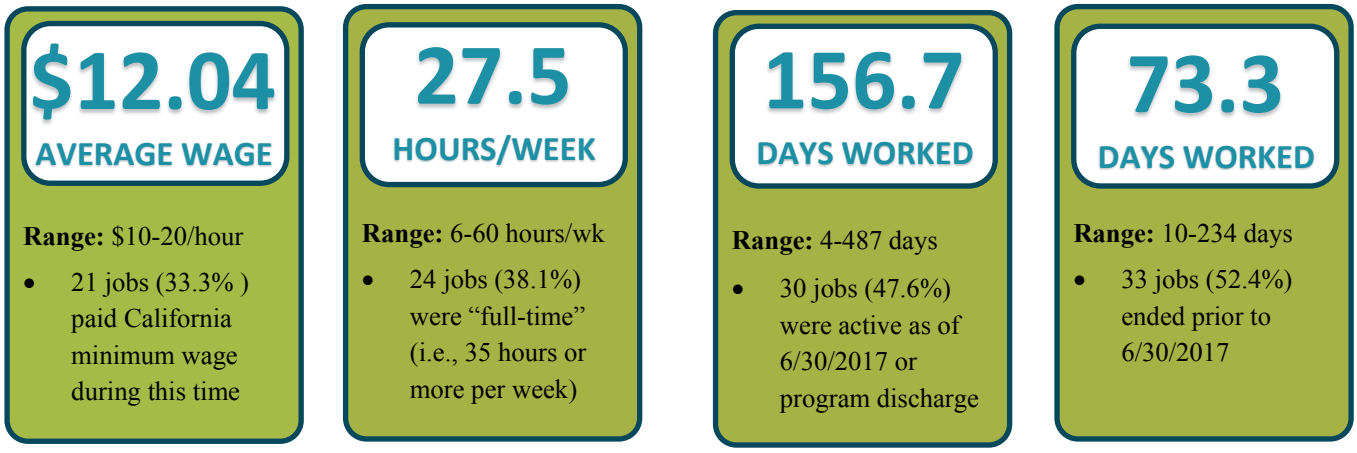
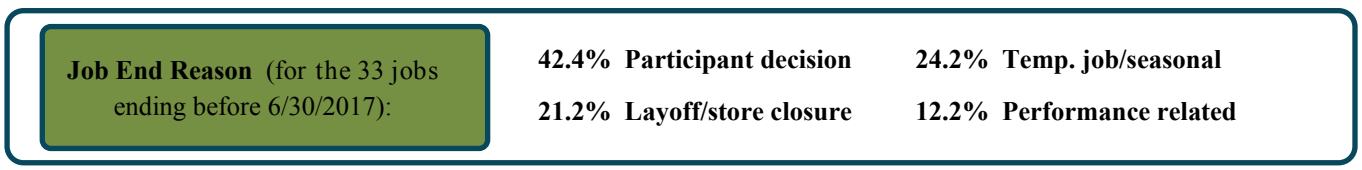


FIGURE 2. PRIMARY REASONS FOR WHY JOBS ENDED



JOBS ACQUIRED THROUGH NOBLE WORKS

Based on the U.S. Department of Labor Occupational Information Network (O*NET) Standard Occupational Classifications (SOC), most of the jobs obtained through the Noble Works program required either little/no preparation (28.6%) or some preparation (47.6%), as shown in Table 2. This is generally consistent with the finding that 33.3% (n=21) of the jobs started at minimum wage. During this past year Noble Works was able to expand job placement opportunities to include at least some positions in Category 4 (i.e., occupations that need considerable preparation). It is expected that as the program expands their network of employers and provides more sophisticated trainings (e.g., CompTIA), the job zone classifications and average wage will continue to increase.

TABLE 2. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	18	28.6
2 - Occupations that need some preparation	30	47.6
3 - Occupations that need medium preparation	8	12.7
4 - Occupations that need considerable preparation	7	11.1

As shown in Figure 3, 25.8% of all Noble Works participants had obtained at least one job by 6/30/2017. Since it typically requires some time to find a job, it is not surprising that the cohort from year one currently has a higher placement rate than the year two cohort (33.8% and 19.6%, respectively). It is anticipated that the job acquisition rate for the year two cohort will increase as more of those persons find jobs during year three of Noble Works program. Of note, TAY appear to have a harder time finding jobs through Noble Works, especially for the year one cohort. The timing of job acquisition varies considerably. While many of the jobs, particularly for the year two cohort were found within a 1-2 months of entering Noble Works, other participants may take 6 or more months to find their first job.

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

YEAR ONE COHORT (12/1/2015 - 6/30/2016)

- 77 new participants
- ***33.8% ever employed*** (as of 6/30/2017)
- Days to first job varied substantially, but generally took a long time (average = 197.6 days; SD = 137.4)
- TAY much less likely than adults to get jobs (20.7% vs. 41.7%)

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

- 97 new participants
- ***19.6% ever employed*** (as of 6/30/2017); this rate will increase as some get jobs during Year 3
- Variation in days to first job, but generally found more quickly (average = 55.4 days; SD = 59.8)
- TAY somewhat less likely than adults to get jobs (14.3% v 22.6%)

LIFE OF PROGRAM (12/1/2015 - 6/30/2017)

- 174 unduplicated participants
- ***25.8% ever employed*** (as of 6/30/2017); this rate will increase as some get jobs during Year 3
- Jobs for Year 2 enrollees were generally obtained more quickly than those who enrolled in Year 1
- TAY job acquisition rates were lower than adults, but much less of a difference during Year 2

NOBLE WORKS BUSINESS START-UP ACTIVITIES

- During Year 2, Noble Works provided financial support and technical assistance to help three participants start their own businesses.
- Reflecting the individualized service orientation of Noble Works, the businesses matched the diverse interests and talents of the participants:
  - Handcrafted jewelry maker
  - Dessert and pastry consulting business
  - Grant writing business

EXITS FROM NOBLE WORKS PRIOR TO JOB ACQUISITION

- Of the 174 total unduplicated participants who have ever participated in Noble Works, 42.5% had left the program prior to obtaining a job as of 6/30/2017.
- Females were more likely than males to leave the Noble Works program prior to getting a job (50.0% to 36.5%).
- Primary reasons for leaving prior to job acquisition were, 1) no longer interested in Noble Works and, 2) loss of contact between Noble Works and the participant.

As shown in Figure 4, for persons who ever obtained a job through the Noble Works program, each measure of job satisfaction increased substantially from program entry (baseline) to post-job assessment. Starred items had a statistically significant change in mean score from baseline to follow-up ($p<.05$). The overall job satisfaction score (i.e., the average of all six satisfaction items), increased from 2.7 at baseline to 3.9 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

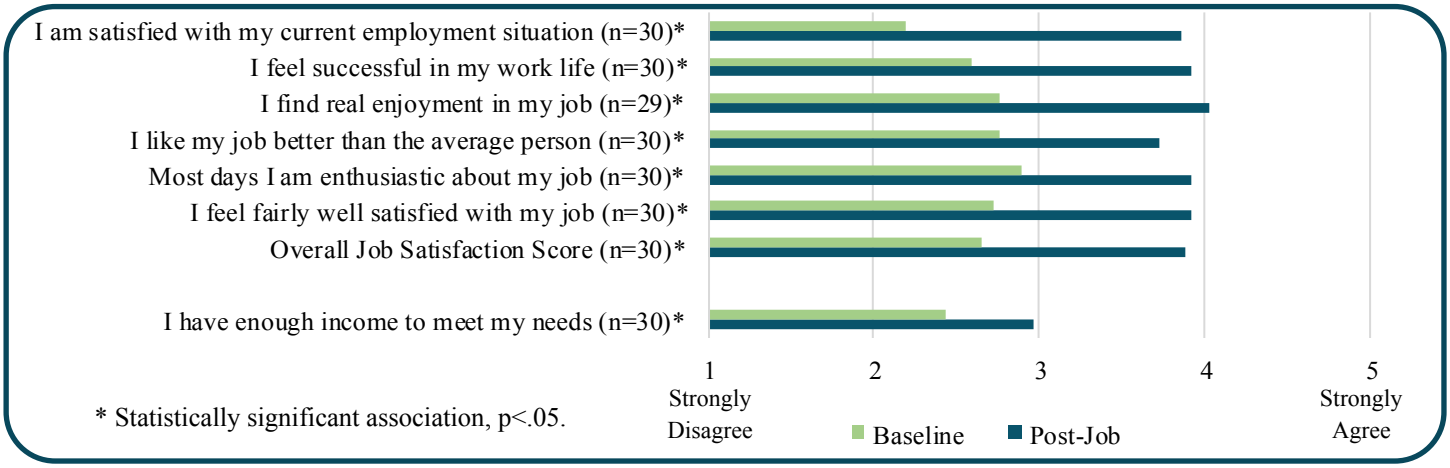


Table 3 presents key associations between overall job satisfaction and items from last completed Recovery Markers Questionnaire (RMQ). These correlations indicated positive associations between how participants felt about their employment situation and a range of other life domains related to their sense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

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

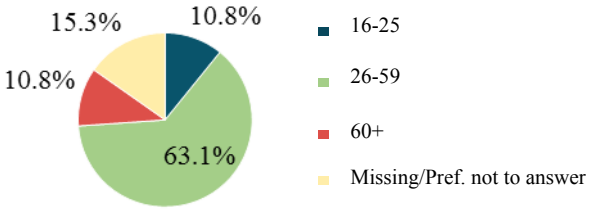
	Overall Job Satisfaction Score
RMQ Responses at Follow-Up	**Correlation**
I have a sense of belonging (n=26)	.647*
I am learning new things that are important to me (n=26)	.530*
I have more good days than bad (n=26)	.530*
I am growing as a person (n=26)	.519*
I feel hopeful about my future (n=26)	.509*
I have goals I'm working to achieve (n=26)	.506*
I see myself (still) working in 6 months (n=25)	.414*
My symptoms are bothering me less since starting services here (n=26)	.399*
I have enough income to meet my needs (n=25)	.192

* Statistically significant association, p<.05.

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

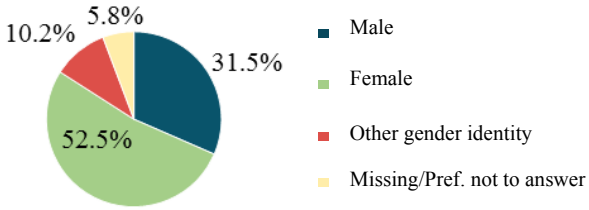
During Year 2 NAMI SD, a Noble Works program partner, conducted 26 "In Our Own Voice" (IOOV) community outreach and education presentations regarding mental illness and recovery in their ongoing efforts to reduce mental health stigma in the community. Either in conjunction with NAMI SD, or independently, Noble Works representatives also conducted 31 "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.

AGE (N=295)



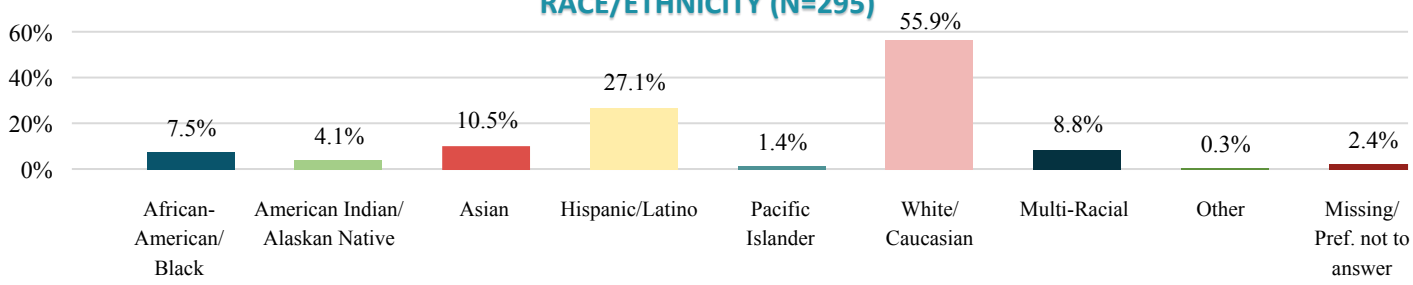
About two-thirds (63.1%) of attendees were age 26-59.

GENDER IDENTITY (N=295)



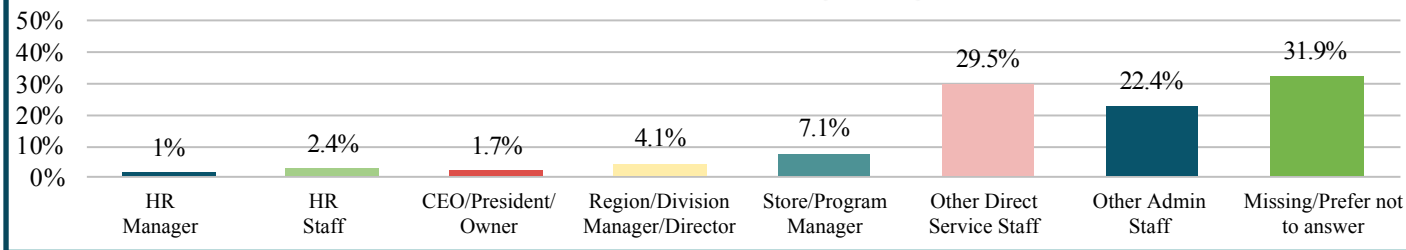
The majority of attendees were female (52.5%).

RACE/ETHNICITY (N=295)



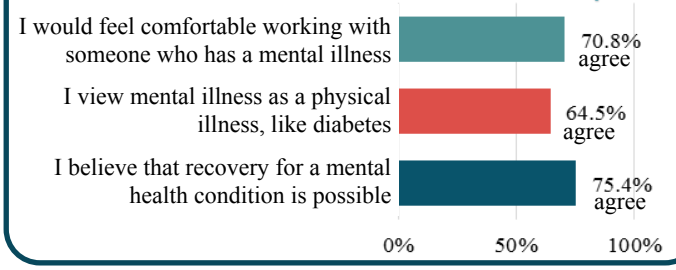
The majority of attendees were White/Caucasian (55.9%), with approximately one-quarter (27.1%) indicating an Hispanic/ Latino background. Totals may exceed 100% as attendees could indicate more than category.

TYPE OF RESPONDENT (N=295)

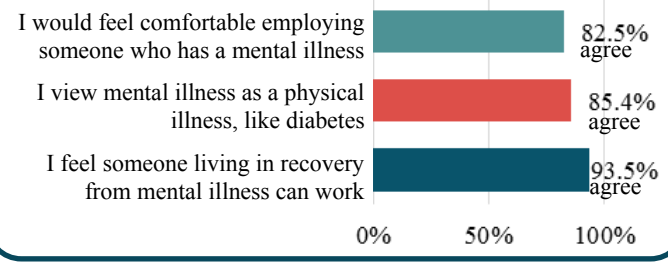


About one-third (29.5%), of the attendees identified themselves as direct service staff, and approximately one-quarter (22.4%), identifying as administrative staff.

NAMI SD IOOV PRESENTATION OUTCOMES (N=301)



NOBLE WORKS PRESENTATION OUTCOMES (N=171)



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.

SUPPORTED EMPLOYMENT PRINCIPLES AND YEAR 2 NOBLE WORKS PRACTICES

Supported Employment (SE) is an evidence-based practice recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Supported Employment has been shown to successfully increase competitive work attainment among persons with SMI (e.g., research indicates that more than half of SE participants typically obtain competitive employment, compared to about one-quarter of vocational rehabilitation participants). Noble Works was designed to incorporate many SE principles.

During Year 2, external consultants conducted a formal SE fidelity review of Noble Works practices and rated the program using the SAMHSA SE Fidelity Scale. A brief summary of the review finings is presented in Table 4. Noble Works achieved high fidelity ratings on many domains, particularly related to providing individualized job search activities and connecting participants to a diverse set of employment opportunities. Several contractual factors (i.e., outside the control of Noble Works), negatively impacted the fidelity ratings including the fact that Noble Works was established as an independent program rather than embedded within a mental health treatment team and that their service delivery contract indicates specific participant eligibility criteria. In addition to the recommendations listed in Table 4, the reviewers noted high staff turnover as an area of potential concern. The SE reviewers commended the program for their partnerships with NAMI to expand the reach of employer education and stigma reduction efforts.

TABLE 4. SUPPORTED EMPLOYMENT FIDELITY REVIEW OF NOBLE WORKS PRACTICES

SE Fidelity Criterion	Fidelity Rating	Notes/Recommendations
1. **Caseload** - Employment specialists management of case-loads up to 25 consumers	High	
2. **Vocational services staff** - Employment specialists provide only vocational services	High	
3. **Vocational generalists** - Employment specialists carry out all phases of vocational services	Medium	Have Employment Specialists and Job Coaches provide identical, "all phases" of services
4. **Integration of rehabilitation with mental health treat-ment** - Employment specialists are part of treatment teams	Low	By contract, Noble Works operates as a standalone, not integrated, vocational program
5. **Vocational unit** - Employment specialists function as a unit rather than a group of practitioners	Medium	Conduct group supervision weekly
6. **Zero-exclusion criteria** - No eligibility requirements	Medium	By contract, Noble Works is required to enroll participants who meet specific eligibility criteria
7. **On going work based assessment** - Vocational assessment is an ongoing process based on work experiences	High	
8. **Rapid search for competitive jobs** - The search for compet-itive jobs occurs rapidly after program entry	Medium	Standardize implementation and documentation of "30-days" to face to face employer contact
9. **Individualized job search** - Employer contacts are based on consumers' job preferences	High	
10. **Diversity of jobs developed** - Employment specialists provide job options that are in different settings	High	
11. **Permanence of jobs developed** - Employment specialists provide competitive job options that have permanent status	High	
12. **Jobs as transitions** - Jobs are viewed as positive experi-ences for vocational growth and development	High	
13. **Follow along supports** - Individualized, follow-along supports are provided on a time-unlimited basis	Medium	Review closure process to ensure that follow along supports are provided as long as needed
14. **Community based services** - Vocational services are provided in community settings	Medium	Increase staff time meeting clients and employers in the community
15. **Assertive engagement and outreach** - Assertive engage-ment and outreach are conducted as needed	High	

NOBLE WORKS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the second year of providing Noble Works program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Noble Works program. There were 12 respondents from the 19 persons invited to participate in the survey, for a response rate of 63.2%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Concerns about staff turnover were identified as a substantial issue effecting program implementation. Almost all respondents (83.3%; n=10), rated staff turnover as a "very challenging" issue for the program (on a 5-point scale ranging from "not challenging at all" to "very challenging").

1. *Primary factors that facilitated the achievement of program goals:*
   a. Staff skills and passion to support participants and work towards program goals
   b. Participants being able to work one on one with either an employment specialist or a job coach
   c. Community presentations teaching about mental health recovery and the vital role that employment plays
   d. Program tools/resources available to educate and support participants (e.g., employment leads, classes, community backing)
   e. Intra- and interagency collaboration promoting continuity of knowledge
2. *Factors that inhibited the achievement of program goals*:
   a. Challenges maintaining participant motivation and engagement
   b. Outreach efforts not reaching the right types of businesses, employers, or the community
   c. High staff turnover
   d. Slow process development before being able to work with participants (e.g., high volumes of paperwork)
   e. Staff uncertainty about job roles/tasks (e.g., communication methods with participants and employers)
3. *Challenges obtaining and maintaining participant employment:*
   a. Resistant employers that do not understand the program or get to know participants
   b. Participants who want a 'dream job' but do not want to take classes, trainings, or certifications to qualify
   c. Unrefined work skills (e.g., communication skills, appropriate behavior, how to leave a job with grace)
   d. Participants not properly managing their symptoms
   e. The difficulty of communicating with employers the overall skills and strengths of participants
   f. Participant motivation levels
4. *Strategies for maintaining participant engagement in Noble Works:*
   a. Building good relationships and keeping frequent contact
   b. Offering incentives for participating in activities/classes
   c. Highlighting unique opportunities available through Noble Works (e.g., CompTIA, Tech Café)
   d. Supporting staff commitment and passion for empowering participants
5. *Benefits of separating the roles of Employment Specialist and Job Coach:*
   a. Focused work allowing staff to have a well-defined role
   b. Effective use of time
   c. Better services for participants due to having two people thinking about how to best deliver services
   d. Similar distributions of work load amongst staff
6. *Challenges of separating the roles of Employment Specialist and Job Coach:*
   a. Disrupts relationship building with participants
   b. Participant confusion about the transition
   c. Unequal distributions of work load amongst staff
   d. Losing participants due to the transition (e.g., participants may not feel as comfortable with their job coach after having developed a relationship with their employment specialist)

KEY YEAR 1 NOBLE WORKS PROGRAM "LEARNINGS"

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

KEY YEAR 2 NOBLE WORKS PROGRAM "LEARNINGS"

No substantial changes to Year 1 learnings, all are relevant to Year 2 experiences. Additional learnings included:

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

YEAR 2 PROGRAM CHANGES

There were no fundamental Year 2 changes to the INN-14 Noble Works program that differed substantially from the initial design of the program. As noted within other sections of the report, some basic practices and procedures related content and length of employment related classes and more clarification and coordination of the Job Coach and Employment Specialist roles.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Maintain full staffing levels and minimize turnover.
    a. *Team building enhancements were integrated such as staff recognition during team meetings.*
    b. *Adjustments in the training schedule established a more efficient work flow.*
2. Increase awareness of Noble Works program to help recruit participants and potential employers (e.g., increase number of community events and/or use of social media).
    a. *Implemented expectation of at least five (5) hours of outreach each week by staff to identify potential employers.*
    b. *Increased the amount of cold calls to resources around the community and participation in community events suitable for finding and recruiting employers.*
3. Identify opportunities for maintaining and increasing participant engagement in Noble Works' services (e.g., incentives, frequent "check-ins").
    a. *Launched the Noble Works website and newsletter to help increase awareness.*
    b. *Implemented a scheduled "job search hour" to provide participants with structured time to search for jobs and for when they could obtain help from NW staff if needed.*
4. Improve coordination and communication between staff roles and agency partners within Noble Works to present more of a "seamless" program to participants and employers.
    a. *Increased frequency of group supervision meetings to twice a month to help staff increase communication and full Noble Work team meetings occur on a monthly basis.*
    b. *Increased communication with outside agencies through regularly scheduled meetings.*
5. Assess program operations and streamline activities to maximize the amount of time that staff can work directly with each participant.
    a. *A review of the employment preparation series led to remodeling the program into a 6 week design that included job search activities during the program.*
    b. *Increased separation between the roles of the employment specialist and the job coach allowed the employment specialist to work solely on getting to know the participant while job searching with them.*
6. Implement periodic review/fidelity checks between Noble Works practices and Supported Employment principles.
    a. *An external, formal Supported Employment fidelity review was completed.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

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

1. Explore opportunities for enhanced coordination/communication with participant's behavioral health treatment providers.
2. Consider consolidating Employment Specialist and Job Coach into one role where staff conduct all phases of job search, placement, and support processes.
3. Increase group caseload supervision to occur weekly.
4. Implement system for tracking date of first face to face contact with employers.
5. Review closure process to ensure that services and supports are provided as long as desired by participants.

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

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

PEERLINKS
(PEER ASSISTED TRANSITIONS INNOVATIONS-15)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (7/1/16 - 6/30/17)

The Peer Assisted Transitions (INN-15 PAT) program was funded through the Innovations (INN) component of the Mental Health Services Act. PAT was subsequently renamed to "PeerLINKS" to better reflect the services it provides and is henceforth referred to by this name. The primary innovation component of PeerLINKS is to increase the depth and breadth of services to persons diagnosed with Serious Mental Illness (SMI) who use acute crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialists. During FY 2016-17, the program received referrals from Scripps Mercy Hospital and University of California San Diego Behavioral Health Units, as well as the Community Research Foundation's Vista Balboa and New Vistas Crisis Residential facilities.

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 FY 2016-17 (since November 2016) a total of 189 participants were enrolled in the program.
- The majority of participants were between the ages of 26 and 59 (82.0%), English was the primary language for 94.2%, more than half identified as male (58.7%), 73.0% were heterosexual, and 60.3% were White/Caucasian. A small minority were veterans.
- Participants improved on a range of self-report and mental health staff assessments.
- Overall, 90.0% of participants remained stable or improved on their Milestones of Recovery Scale (MORS) score.
- Pre-post data on the Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS) showed statistically significant increases on the Global Health, Resilience, Depression, Anger, Anxiety, Memory, and Suicidality scales at follow-up.
- Pre-post data on housing outcomes indicate that the total number of participants being homeless decreased. However, there may be a small group of participants who may be more difficult to connect to stable housing resources.
- The number of participants who identified as unemployed decreased. In addition, the number of participants requiring emergency interventions as well as the number of participants experiencing a range of critical events decreased from baseline to follow-up.
- PeerLINKS made a combined total of 1,732 referrals, linkages, and successful connections.

RECOMMENDATIONS

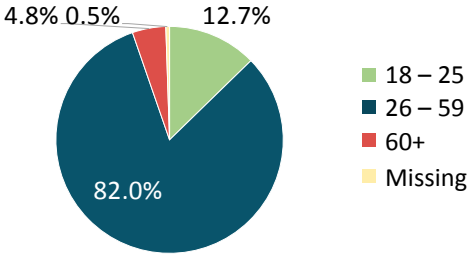
Recommendations for program improvements during Year 2 include the following:

- Continue outreach and strengthening of connections with external services and sites across San Diego County.
- Promote the role of Peer/Family Support Specialists and refine program materials, to provide a clearer description of the program, role, purpose, and limits of the program.
- Refine PeerLINKS' enrollment/eligibility to ensure enrollment of participants who are most likely to benefit from the program, given budget limitations.
- When possible, connect participants with case management services soon after they join the program.
- Continue the collection of regular participant assessments using electronic documentation where possible; in particular, increase number of participant satisfaction items and closure packets completed.
- Provide on-going refresher trainings to PeerLINKS staff.

PARTICIPANT DEMOGRAPHICS

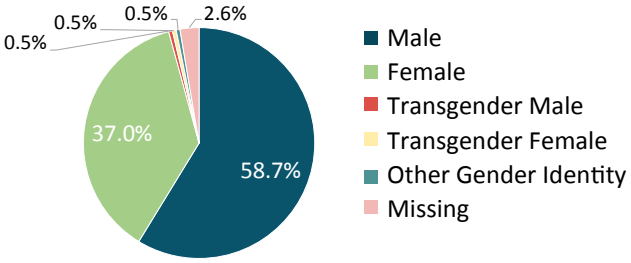
The following demographic data were collected from the intake assessment administered at the start of the program.

AGE (N=189)



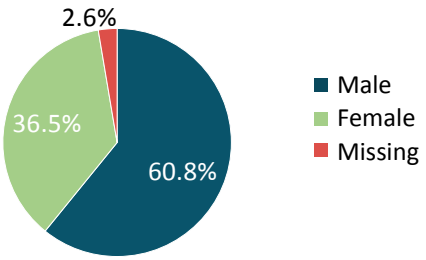
The majority of PeerLINKS participants were between the ages of 26 and 59 (82.0%), 12.7% were 18-25 years old and 4.8% were 60 years or older.

GENDER IDENTITY (N=189)



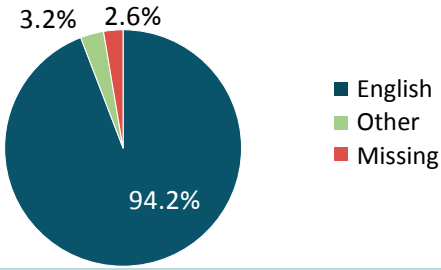
A total of 58.7% of participants identified as male and 37.0% identified as female.

SEX AT BIRTH (N=189)



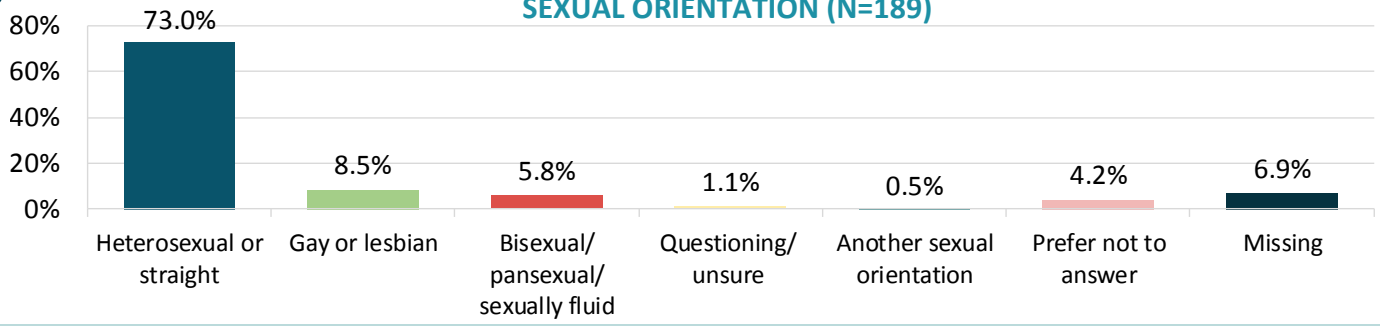
The majority of participants (60.8%) were identified as male on their birth certificate and 36.5% were identified as female.

PRIMARY LANGUAGE (N=189)



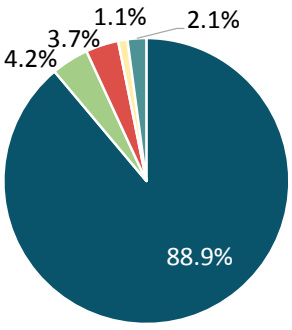
The large majority (94.2%) of participants spoke English as their primary language.

SEXUAL ORIENTATION (N=189)



Seventy-three percent of participants identified as heterosexual or straight, 8.5% as gay or lesbian, and 5.8% as bisexual/pansexual/ sexually fluid.

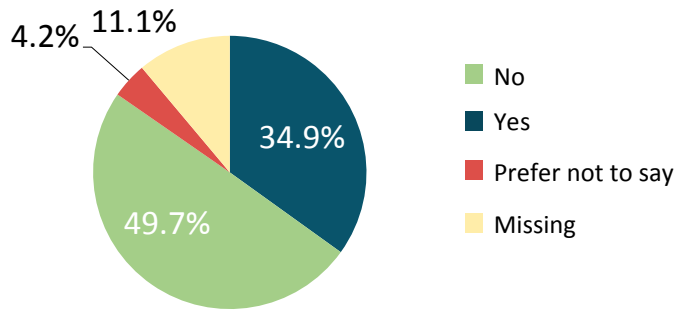
MILITARY STATUS (N=189)



- Never served in military
- Previously served (US): honorable or general
- Previously served (US): entry-level separation or other than honorable discharge
- Other
- Missing

The majority of participants had never served in the military (88.9%), 4.2% were veterans, and 3.7% had previously served but received entry level separation or other than honorable discharge.

DISABILITY STATUS (N=189)[1]



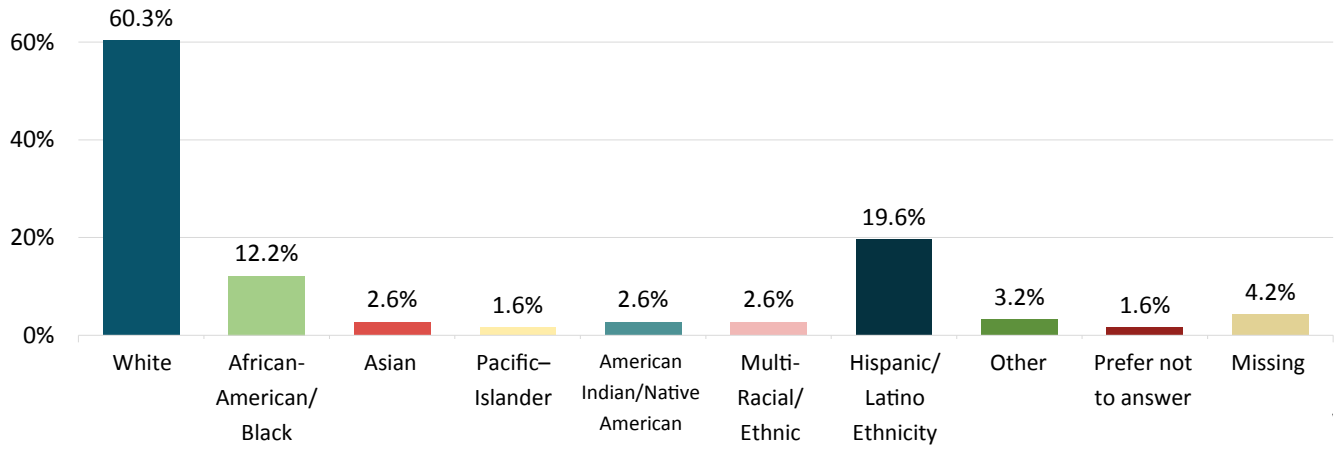
A total of 49.7% reported having some type of non-SMI related disability.

TYPE OF DISABILITY (N=189)

Type	N	%
Communication	29	15.3
Mental (e.g., learning)	25	13.2
Physical	22	11.6
Chronic Health	39	20.6
Other	24	12.7

This table describes the type of disability indicated by participants who had a disability as a percentage of the total population. Participants may have indicated more than one disability.

RACE/ETHNICITY (N=189)



The majority of participants were White/Caucasian (60.3%), 12.2% were African American/Black, and 19.6% identified as Hispanic/Latino ethnicity. Totals exceed 100% as participants were able to indicate more than one race/ethnicity.

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

KEY EVALUATION FINDINGS

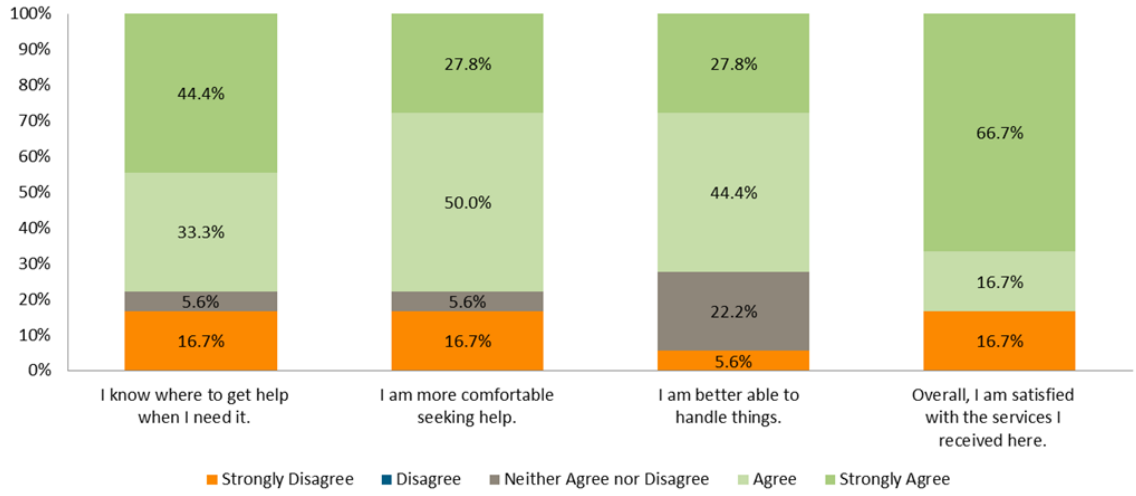
The key evaluation findings are based on a comprehensive set of assessment tools used by PeerLINKS. The assessments are administered by Peer/Family Support Specialists and other trained mental health professionals. They include participant demographics, key outcome domains (housing, employment, and critical events), the Milestones of Recovery Scale (MORS), the Linkage & Referral Tracker, and the Encounter Form. Participants complete an integrated self-assessment, the 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 Outcomes Management System (mHOMS), an electronic health record system.

PARTICIPANT SATISFACTION AND PARTICIPANT-RATED OUTCOMES

A total of 18 participants responded to the post outcome survey, which was completed at follow-up and discharge assessments (Figure 1). Overall, the majority of participants agreed or strongly agreed that as a result of the PeerLINKS program, they know where to get help when needed (77.7%), are more comfortable seeking help (77.8%), and are better able to handle things (72.2%). The large majority of participants agreed or strongly agreed that they were satisfied with the services they received at PeerLINKS (83.4%) but 16.7% strongly disagreed. Similarly, 16.7% of participants strongly disagreed on items regarding knowledge about where to get help and comfort in seeking help.

Figure 1: Participant Satisfaction and Participant Rated Outcomes (N=18)



MILESTONES OF RECOVERY SCALE (MORS)

The Milestones of Recovery Scale (MORS) captures recovery as assessed by trained mental health 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.

Baseline MORS Ratings

A total of 152 participants had received MORS assessments at intake (Table 1). The majority of participants were in the "high risk" stages of recovery, with 28.3% at extreme risk, 21.1% experiencing high risk/not engaged and 30.9% experiencing high risk/engaged. The average MORS score at baseline was 2.6 (SD=1.5).

Table 1: MORS Ratings at Baseline (N=152)

MORS Scores		Baseline
1	Extreme risk	28.3%
2	Experiencing high risk/ not engaged	21.1%
3	Experiencing high risk/ engaged	30.9%
4	Not coping successfully/ not engaged	3.9%
5	Not coping successfully/ engaged	11.8%
6	Coping successfully/ rehabilitating	3.3%
7	Early recovery	0.7%
8	Advanced recovery	0.0%

Changes in MORS Ratings Over Time

A total of 40 participants had valid MORS assessments at two (or more) points in time. The data matching process selected the MORS assessment at baseline and the most recent MORS follow-up assessment during the reporting timeframe (i.e., FY 2016-17). The average duration between the baseline and most recent MORS assessment was just under two months (58.4 days) and ranged from 23 to 212 days.

Overall, MORS scores from these 40 participants have been increasing from an average of 2.7 to 4.6 (summarized in Figure 2). This increase was statistically significant. A total of 90.0% of participants were stable or improved on the MORS (summarized in Figure 3).

Figure 2: Change in MORS Scores (Pre-post, N=40)

Figure 3: Stable and Improving MORS Scores (Pre-post, N=40)

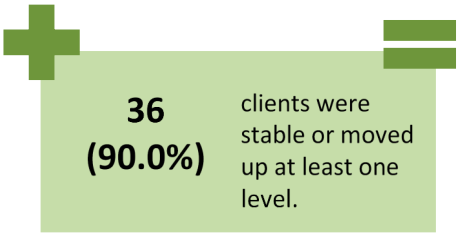


Table 2: MORS Ratings at Baseline and Most Recent Assessment (Pre-post, N=40)

Baseline \ Most Recent	1	2	3	4	5	6	7	8	Total
1	0.0%	2.5%	5.0%	2.5%	15.0%	0.0%	0.0%	0.0%	25.0%
2	2.5%	2.5%	5.0%	0.0%	0.0%	2.5%	0.0%	0.0%	12.5%
3	0.0%	0.0%	10.0%	0.0%	10.0%	20.0%	2.5%	0.0%	42.5%
4	0.0%	0.0%	2.5%	0.0%	5.0%	0.0%	0.0%	0.0%	7.5%
5	0.0%	0.0%	2.5%	2.5%	2.5%	2.5%	0.0%	2.5%	12.5%
6	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
8	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	2.5%	5.0%	25.0%	5.0%	32.5%	25.0%	2.5%	2.5%	100.0%

Table 2 demonstrates changes in MORS scores from baseline to the most recent follow-up assessments by the eight stages of recovery. Percentages in dark grey cells indicate a decrease (i.e., worsening) in MORS scores, light grey cells a stabilization of MORS scores, and green cells an increase (i.e., improvement) in MORS scores. For example, 5.0% of participants received a score of 2 at baseline but improved to a score of 3 at the most recent follow-up assessment. Overall, 75.0% of participants demonstrated an increase in their MORS ratings over time, as indicated by the green cells; 10.0% of participants demonstrated a decrease in their ratings, as indicated by the dark grey cells. Lastly, 15.0% of participants demonstrated no change in their MORS ratings over time, as indicated by the light grey diagonal cells.

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 ranged from 1 to 5, and items were coded such that higher scores indicated more positive perceptions and experiences.[2]

Changes in Participants' Active Social Support and Recovery Network

Changes in participants' active social support and recovery network were measured based on three items included in the CHAMPSSS. Mean CHAMPSSS items that reflect active social support and recovery networks are displayed in Table 3 below. Compared to baseline, participants reported increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and having more people actively support them in recovery at follow-up. The improvement in responses to the item "I had contact with people that care about me" was approaching statistical significance.

Table 3: 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)	40	1.9	1.0	2.3	1.2
I had contact with people that care about me. (Item 10)	37	3.0	1.2	3.4	1.0
Outside of health care professionals, how many people actively support you in your recovery? (Item 32)	27	2.8	2.2	4.0	3.4

Changes in CHAMPSSS Subscales

Mean CHAMPSSS subscale scores are displayed in Table 4 below. On average, participants showed improvement in all of the CHAMPSSS subscales, except the Substance Use Frequency Scale, although the change was minimal. The increases on the Global Health, Resilience, Depression, Anger, Anxiety, Memory, and Suicidality Scales were statistically significant.

Table 4: 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)	40	2.5	0.7	2.8	0.7
Resilience Scale (average of items 8, 9, 10, 11, and 12)	38	3.0	0.7	3.3	0.6
Depression Scale (average of items 13, 14, and 15)	36	2.3	0.8	3.1	0.8
Anger Scale (item 16)	36	2.8	1.0	3.4	1.1
Anxiety Scale (average of items 17, 18, and 19)	37	2.5	0.9	2.9	0.9
Substance Use Scale (average of items 20 and 21)	37	3.8	1.2	4.2	1.2
Memory Scale (average of items 22 and 23)	36	3.1	1.1	3.5	0.9
Suicidality Scale (item 24)	36	3.1	1.4	4.1	1.0
Substance Use Frequency Scale (average of items 27 and 28)[3]	37	4.6	0.7	4.5	0.8

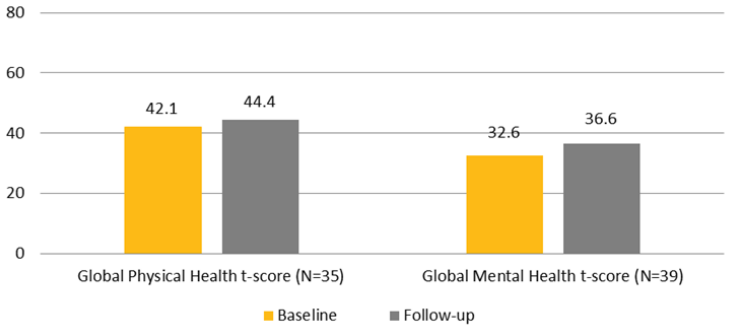
[2] Item 30 "How would you rate your pain on average" ranges from 0-10 but was recoded to a 5-point scale.

[3] The intake assessment is usually undertaken while participants are in Behavioral Health Units or Crisis Residential facilities. This might account for the low levels of substance use frequency (i.e., a high average score on the Substance Use Frequency Scale) reported by participants at baseline as access to substances would be prohibited in these facilities.

PROMIS GLOBAL HEALTH

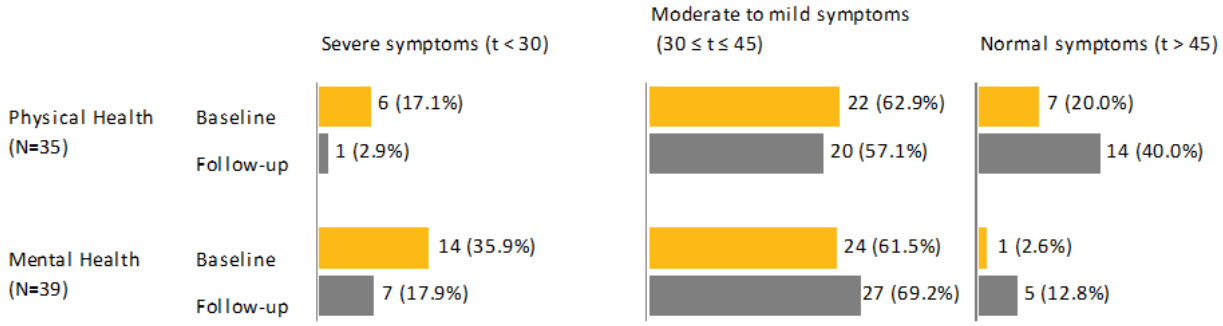
The PROMIS Global Health Scale is a 10-item patient-reported assessment of symptomatology, functioning, and health-related quality of life. On average, participants demonstrated improvement in both Global Physical Health and Global Mental Health scores (Figure 4). The average T-scores were in the moderate to mild symptoms range, with participants showing a higher level of physical health compared to their mental health. Figure 5 provides additional breakdowns of participant groups by severity of symptoms.

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



Note: PROMIS Global Health scores have been converted into T-score values. T-score distributions are standardized such that a score of 50 represents the average for the general population, and the standard deviation around the mean is 10 points. As a rule of thumb, half a standard deviation (5 points on the T-score metric) can be viewed as an estimate of a meaningful change.[4]

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



PROMIS DERIVED SUBSTANCE USE

Table 5 shows participants' answers to substance use related questions at intake. Items are scored on a scale from never = 5 to almost always = 1, with higher scores indicating less substance use treatment need. Participants were reporting on the past 7 days.

Table 5: PROMIS-Derived Substance Use

Item	In the past 7 days…	N	M	SD
1	I used alcohol or substances throughout the day.	125	4.4	1.1
2	I had an urge to continue drinking or using substances once I started.	126	4.1	1.4
3	I felt I needed help for my alcohol or substance use.	124	3.5	1.6
4	I took risks when I used alcohol or substances.	126	3.9	1.5
5	I felt guilty when I used alcohol or substances.	124	3.8	1.6
6	Others complained about my alcohol or substance use.	121	3.9	1.5
7	Alcohol or substance use created problems between me and others.	123	3.8	1.5
8	Others had trouble counting on me when I used alcohol or substances.	124	3.8	1.6
9	I felt dizzy after I used alcohol or substances.	123	4.1	1.4
10	Alcohol or substance use made my physical or mental health symptoms worse.	125	3.6	1.7
	Total	125	3.9	1.2

The average score across the 10 substance use items was 3.9. It should be noted that 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 (i.e., relatively high average score on the PROMIS-Derived Substance Use Scale) reported by participants at baseline as access to substances would be prohibited while in these facilities.

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

HOUSING

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=48). The average housing level was 4.1 in the current assessment, and 2.9 in the baseline assessment, indicating that, on average, the housing level improved. This increase was statistically significant. A total of 58.3% of participants moved into less restrictive and more independent housing levels and for 25.0% the housing level remained stable. Only 16.7% of participants moved to lower housing levels (summarized in Figure 6).

Figure 6: Housing Levels Summary (Pre-post, N=48, Excluding Other or Unknown Housing Levels)

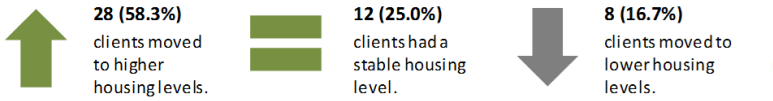


Figure 7: Housing Levels (Pre-post, N=48, Excluding Other or Unknown Housing Levels)

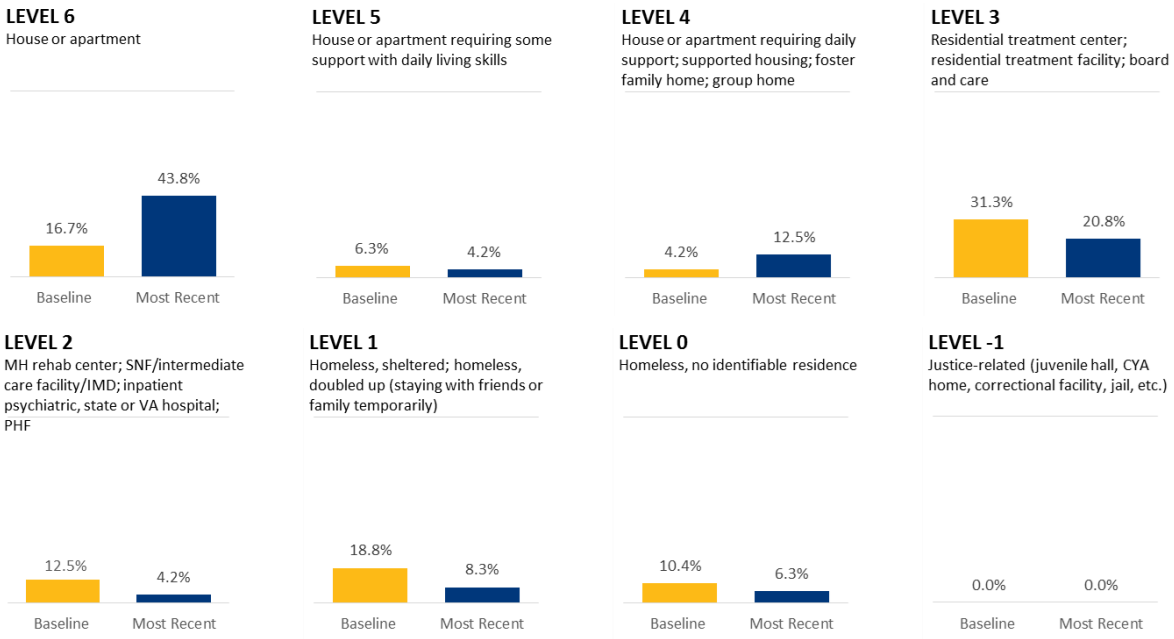


Table 6: Homeless Settings During Past 30 days (Pre-post, Excluding Other or Unknown Homeless Settings)

Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)	Baseline	Most Recent
# of participants unsheltered at least 1 day	20	9
# of days	316	234
Total participant responses	41	41
Sheltered (staying in emergency shelters or transitional housing)	**Baseline**	**Most Recent**
# of participants unsheltered at least 1 day	21	16
# of days	289	315
Total participant responses	45	45
Doubled-up (temporarily staying with friends or family)	**Baseline**	**Most Recent**
# of participants unsheltered at least 1 day	10	2
# of days	150	50
Total participant responses	38	38

Table 6 shows a decrease in the number of days and number of participants 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. 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.

However, there is still a relatively small number of participants who were homeless at baseline and follow-up (number not shown in Table 6) and who may be more difficult to connect to stable housing resources.

EMPLOYMENT

Table 7 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=50). The percentage of participants who selected not employed decreased from 88.0% to 70.0%.

Table 7: Employment Levels (Pre-post, N=50)

Employment Level	Baseline		Follow-up	
	N	Percent	N	Percent
Level 0: Not employed	44	88.0%	35	70.0%
Level 1: Volunteer/job training/other gainful/employment activity	1	2.0%	3	6.0%
Level 2: Paid in-house work	0	0.0%	1	2.0%
Level 3: Transitional employment/enclave/supported employment	0	0.0%	3	6.0%
Level 4: Competitive employment	4	8.0%	4	8.0%
No employment level: student	1	2.0%	4	8.0%
No employment level: retired	2	4.0%	3	6.0%
Total responses	52	N/A	53	N/A
Total number of clients	50	104.0%	50	106.0%

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

Table 8 shows the reasons for unemployment for participants who had been unemployed at baseline and most recent follow-up assessment (N=25). The majority were unemployed and not looking for employment due to mental health symptoms.

Table 8: Reasons for Unemployment (Pre-post, N=25)

Reasons - Not Seeking Employment	Baseline		Follow-up	
	N	Percent	N	Percent
Disabled	5	20.0%	8	32.0%
Mental health symptoms	20	80.0%	17	68.0%
Other	6	24.0%	4	16.0%
Total responses	31	N/A	29	N/A
Total number of clients	25	124.0%	25	116.0%

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

LINKAGES TO SERVICES

PeerLINKS uses the "Linkage and Referral Tracker", 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.[5] 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 9 quantifies the extent of the discussions with participants, as well as referrals, linkages, and successful connections. Overall, 5,665 actions (either discussed, referred, linked, or successfully connected) were recorded during the reporting period. A total of 1,732 referrals, linkages, or successful connections were made.

Table 9: Summary of Discussions, Referrals, Linkages, and Successful Connections[5]

Dimension of Wellness (Unique Participants)	Discussed	Referred	Linked	Successfully Connected (Unique Participants)
Physical Health (N=184)	395	72	12	47 (N=26)
Social Health (N=144)	284	96	20	38 (N=19)
Mental Health (N=184)	591	158	38	90 (N=50)
Substance Abuse (N=153)	368	83	22	26 (N=15)
Housing (N=180)	566	169	50	57 (N=38)
Occupation/Education (N=141)	259	65	11	21 (N=15)
Financial Assistance/Benefits (N=173)	544	167	49	42 (N=26)
Transportation (N=168)	244	34	14	68 (N=45)
Identification(N=146)	272	25	8	15 (N=12)
Basic Needs (N= 165)	410	61	23	151 (N=71)
Total (N=188)	3,933	930	247	555 (N=114)

Specifically, for the mental health dimension, 90 successful connections were made for 50 unique participants. For the substance abuse dimension, 26 successful connections were made for 15 unique participants. All participants (100%) who had been in the program for a minimum of 30 days (N=101) had discussed at least one personal goal for recovery and wellness across the ten dimensions of wellness. In addition, 23 participants who had been enrolled in the program for a minimum of 30 days were able to attend one or more groups or group activities, such as Alcoholics Anonymous meetings.

[5] Definition of Actions:
Discussed: provider talked about a specific tool and/or service with a participant
Referred: provider gave the participant information about a specific tool and/or service to enable the participant to obtain that tool and/or service on his/her own
Linked: provider made an appointment for a participant to obtain a specific tool and/or service
Successfully connected: Provider was able to confirm that the participant actually obtained a specific tool and/or service

CRITICAL EVENTS (BASED ON mHOMS DATA)

Table 10 shows the number of different types of emergency interventions that participants received during the past 30 days. The data is based on participant self-report during regular assessments by PeerLINKS staff. The data is entered into mHOMS. The number of participants requiring 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	14	5
# of services	26	6
Total participant responses	43	43
Mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	36	12
# of services	61	16
Total participant responses	47	47
Physical AND mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	11	2
# of services	21	2
Total participant responses	39	39

The number of participants in psychiatric hospitalization, crisis residential treatment, non-psychiatric hospitalization, and jail/ prison settings decreased (Table 11) from baseline to follow-up.

However, some participants who are experiencing critical events at baseline and at follow-up (number not shown in tables) may have a higher level of need and may require additional support.

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

Psychiatric hospitalization	Baseline	Most Recent
# of participants with at least 1 time	35	9
# of times	47	19
Total participant responses (times)	49	49
# of participants with at least 1 day	31	5
# of days	208	43
Total participant responses (days)	43	43
Crisis residential	**Baseline**	**Most Recent**
# of participants with at least 1 time	37	13
# of times	87	44
Total participant responses (times)	52	52
# of participants with at least 1 day	24	5
# of days	239	52
Total participant responses (days)	39	39
Non-psychiatric hospitalization	**Baseline**	**Most Recent**
# of participants with at least 1 time	8	2
# of times	11	6
Total participant responses (times)	42	42
# of participants with at least 1 day	7	1
# of days	22	5
Total participant responses (days)	40	40
Jail/prison	**Baseline**	**Most Recent**
# of participants with at least 1 time	3	0
# of times	3	0
Total participant responses (times)	45	45
# of participants with at least 1 day	4	0
# of days	63	0
Total participant responses (days)	46	46

PEERLINKS ANNUAL STAFF FEEDBACK SURVEY

At the end of the first year of providing the program, administrative and Peer/Family Support Specialist staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. All staff employed for at least one week at the time of the survey administration participated (100% response rate). For the open-ended survey questions, two evaluators reviewed and coded the responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

STAFF SURVEY FINDINGS

Staff highlighted the main innovative factors and program goals, the factors that helped achieve these goals as well as specific challenges they had experienced during the first year of operation. In addition, some barriers that the title Peer/Family Support Specialist brings, compared to the title Case Manager, were identified.

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

a. Services for participants that come from peers with lived experience
b. Support that is participant-centered

Major program goals identified by respondents:

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

Factors that helped the program achieve these goals:

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

In addition, all PeerLINKS staff (100%) indicated that services such as consumer and/or family member education, referrals and linkage to other behavioral health services, and peer support services were important or very important to the overall success of this program.

Specific challenges to reaching the program goals described by respondents:

a. Participant-related factors such as losing contact with participants, participants experiencing crises, and lack of participant engagement
b. Lack of available housing resources for participants
c. Scarcity or lack of general and mental health specific resources for participants

About half (58%) identified that the waitlists for services that participants were referred to and participants not completing referrals for other services were issues that were challenging or very challenging for the program during the past year. In addition, two staff members suggested improving the referral and screening process to ensure that participants who enter the program have a desire as well as a need to receive services.

Specific challenges related to the title Peer/Family Support Specialist compared to the title Case Manager:

a. Lack of awareness of the title Peer/Family Support Specialist; the title Case Manager was described as being more valued and respected
b. Peer/Family Support Specialists' experience of some barriers in accessing facilities where Case Managers would have been granted access more easily

Some positive remarks regarding the title Peer/Family Support Specialist, such as it being less intimidating for participants and it (slowly) gaining in value, were also made.

KEY YEAR 1 PEERLINKS PROGRAM "LEARNINGS"

1. The initial program design envisioned two separate teams of Peer/Family Support Specialists, one specific team for the two psychiatric hospitals (Scripps Mercy Hospital and University of California San Diego Behavioral Health Units), and one for the two crisis homes (the Community Research Foundation's Vista Balboa and New Vistas Crisis Residential facilities). However, due to the timing of the start of the referral process from the sites (i.e., PeerLINKS started receiving referrals from the crisis homes in November 2016, followed by Scripps Mercy in January 2017 and UC San Diego in March 2017), as well as due to site specific training requirements, it was decided that PeerLINKS staff should be trained to serve all four sites. At the end of Year 1, each team now serves one hospital and one crisis home and teams are rotated on a monthly basis.
2. Having a single Peer/Family Support Specialist assigned to work with a participant throughout their participation in the program is not always feasible. At times, it has been logistically necessary to have the initial, intake visit completed by one team member, and have another person assigned to be their Peer/Family Support Specialist during the rest of their time in the program.
3. It is important to communicate with sites often to ensure that they understand the purpose and role of the PeerLINKS program, and to dissipate any misconceptions about the services the program provides.
4. Initially, participants were assessed at intake and at three month intervals, but it became clear that follow-up assessments would be missed for participants who stayed in the program for less than three months. The assessment schedule was enhanced to accommodate monthly assessments for the first three months and quarterly assessments thereafter.
5. The role of the PeerLINKS clinician evolved during year one, from an initial focus on quality assurance of documents and progress notes to playing a more active role in providing clinical oversight.
6. The program found that a large proportion of participants lack housing and any form of income; thus, the team of Peer/Family Support Specialists has performed far more case management-related activities than initially expected.
7. Participants can be in multiple programs, including PeerLINKS, without duplicating services. In these cases, the program provides services that are not already being provided by the other programs (usually peer support) and coordinates care with them.
8. The PeerLINKS program received a far greater number of referrals than originally anticipated. Due to staffing and budgeting constraints coupled with a vision to provide quality of care to its clients, PeerLINKS may need to develop strategies to ensure it only enrolls as many participants as it can serve.

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-15 PeerLINKS program that differed substantially from the initial design of the program during the first year of service provision (7/1/2016 to 6/30/2017). As is typical during program start-ups, some basic practices and procedures were adjusted over the course of the first year, as described in a number of enhancements to the program under Key Year 1 PeerLINKS Program "Learnings." However, no fundamental or program-wide changes were made.

YEAR 1 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the program and further increase participant services and engagement during Year 2 include the following:

1. Continue outreach and strengthening of connections with external services and sites across San Diego County and specifically, services related to housing, particularly for participants who may be more difficult to connect.
2. Promote the role of Peer/Family Support Specialists among participants, service providers, and other stakeholders, to increase ease of access to services.
3. Refine program materials to provide a clearer description of the program, role, purpose and limits of the program; ensure these materials are provided to and reviewed with all potential participants and staff from the crisis homes/hospitals which the program serves.
4. Refine PeerLINKS' enrollment/eligibility to ensure enrollment of participants who are most likely to benefit from the program, given budget limitations.
5. When possible, connect participants with case management services soon after they join the program.
6. Develop strategies to increase the number of closure packets completed by participants who are leaving or graduating from the program. Offering an incentive (e.g., meal, gift card) may be explored.
7. Continue the collection of regular participant assessments, and in particular, increase the number of participants who provide feedback on items related to participant satisfaction and participant rated outcomes. In addition, transition towards using electronic documentation rather than hardcopies whenever possible.
8. Provide on-going refresher trainings to PeerLINKS staff on all of the program's measures and check data regularly to see if there is an indication that particular items are getting routinely missed or miscoded.

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

please contact: Edith Wilson, Ph.D., at eewilson@ucsd.edu.

URBAN BEATS (INNOVATIONS-16)

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 2 (7/1/16 - 6/30/17)

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

EXECUTIVE SUMMARY

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

- During 2016-17, a total of 76 new, unduplicated TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial diversity in race/ethnicity, sexual orientation, and gender identity. Females comprised a much smaller proportion of the participants this year (18.2% vs 52.1%).
- Based on available follow-up data (n=51), the findings suggested that Urban Beats participants improved their ability to handle stress, felt more productive, 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.
- Preliminary 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, emergency/crisis-oriented psychiatric visits).
- The Urban Beats program substantially increased the number of community performances (n=29) with more than 1,100 persons in attendance compared to prior year (i.e., four performances with approximately 250 attendees).
- Primary qualitative focus group findings: 1) Urban Beats has diversified/expanded recruitment efforts, which has led to recent cohorts with less prior exposure to mental health services, 2) new format of having many different performances worked better to meet program/participant goals, 3) commonly reported outcomes included increased self-esteem, communication skills, and sense of direction, as well as greater awareness of mental health needs and openness to addressing mental health stigma.

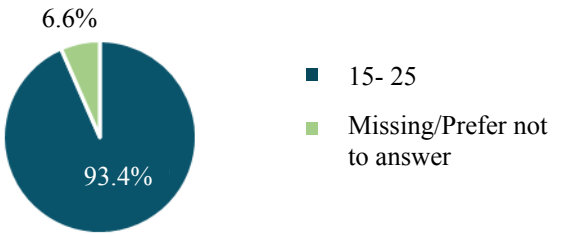
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) increase access to technical resources/facilities (e.g., computers, recording studios, editing equipment, etc.), 2) more strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach), 3) explore potential for providing on-site or direct, dedicated access to mental health counseling for Urban Beats participants, 4) improve data collection approach to facilitate completion of greater numbers of follow-up surveys.

URBAN BEATS PARTICIPANT DEMOGRAPHICS

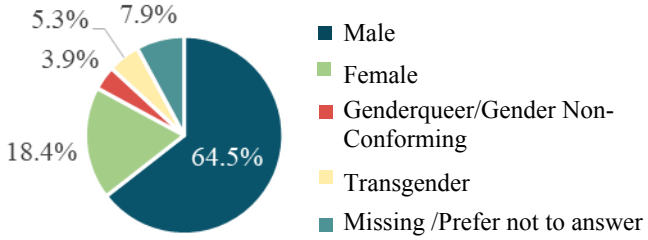
The following demographic data were collected from a participant self-report survey administered at the start of Urban Beats.

AGE (N=76)



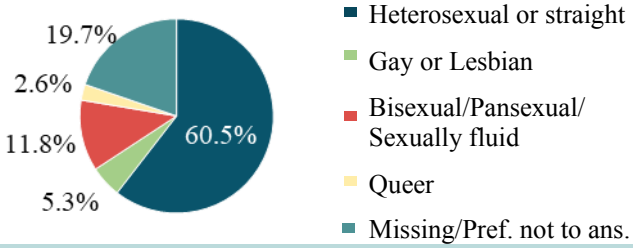
Almost all participants (93.4%) were between the ages of 15 and 25.

GENDER IDENTITY (N=76)



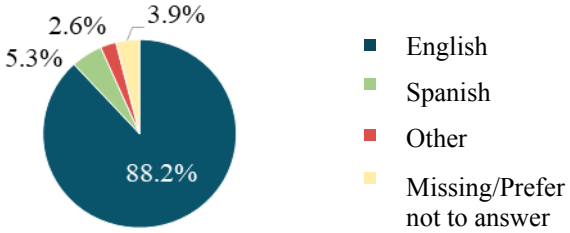
Sixty-five percent of participants were male, and 18% of participants were female.

SEXUAL ORIENTATION (N=76)



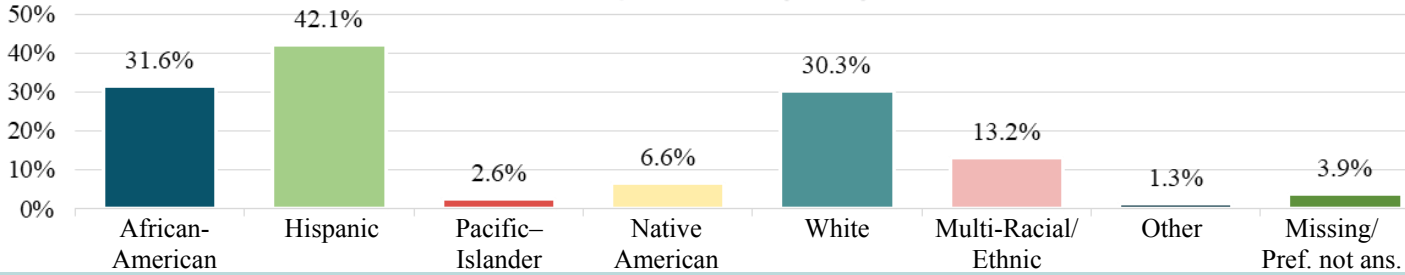
Over half (61%) of participants were heterosexual or straight, and 12% identified as bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=76)



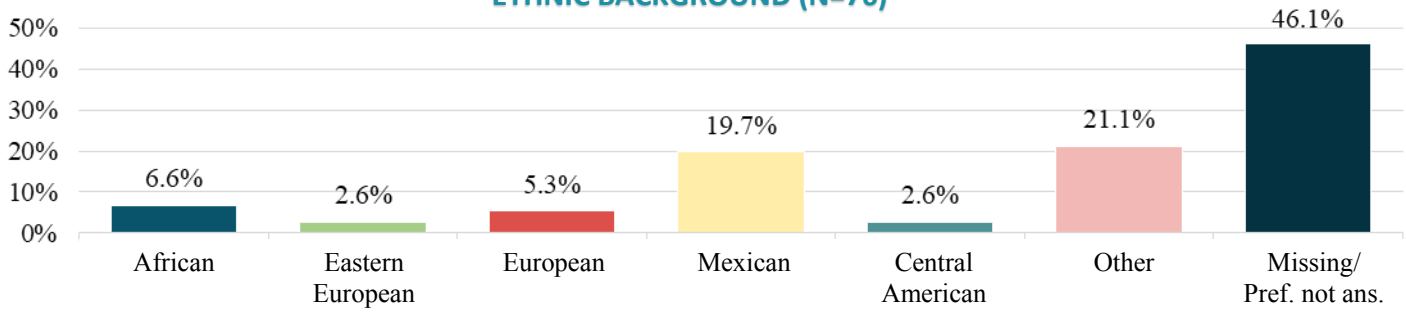
The majority (88%) of participants preferred English as their primary language.

RACE/ETHNICITY (N=76)



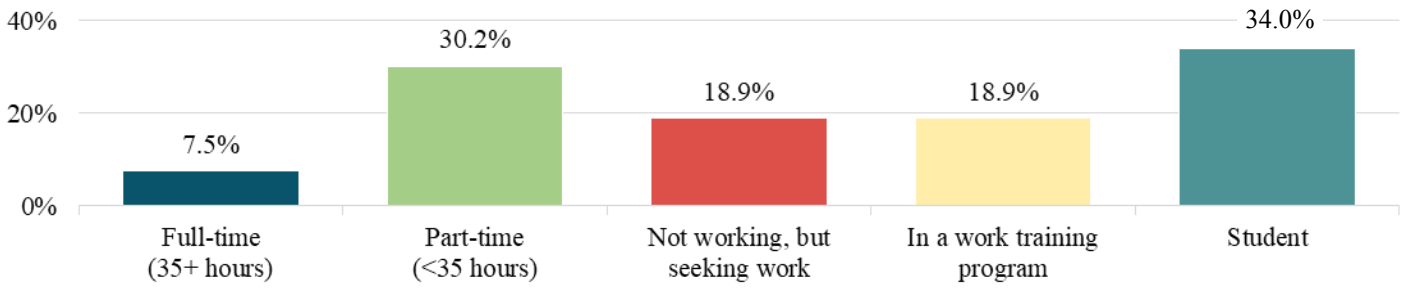
Close to half (42.1%) of the participants identified as Hispanic, 32% as African-American, and 30% as White. Another 13% identified with multiple racial/ethnic backgrounds. Totals may exceed 100% as participants were able to indicate more than one race.

ETHNIC BACKGROUND (N=76)



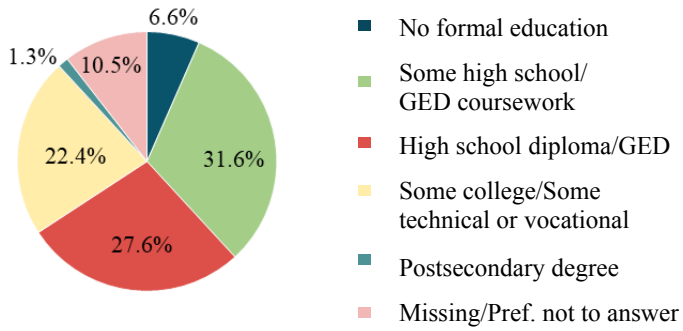
Approximately 20% of the participants indicated being of Mexican origin. Almost half (46%) of the respondents did not indicate a specific ethnic background. Totals may exceed 100% as participants were able to indicate more than one ethnic background.

EMPLOYMENT STATUS (N=76)



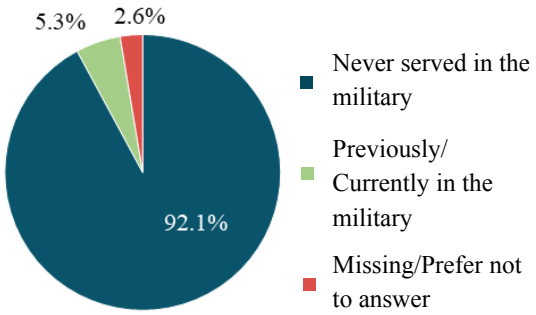
Almost 40% indicated that they were working (nearly 8% full-time and around 30% part-time), nearly 19% were in some form of work training program, and nearly 19% were not working, but seeking work. Approximately one-third (34.0%) indicated they were in school. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=76)



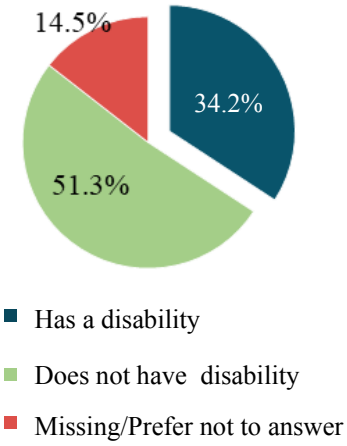
Approximately two-thirds (65.8%), of participants indicated that they had a high school diploma/GED or lower level of education.

MILITARY STATUS (N=76)



Very few participants (5.3%), indicated having served in the military.

DISABILITY[1] STATUS (N=76)



About one-third (34.2%), indicated having some type of non-SMI related disability.

TYPE OF DISABILITY (N=76)

Type	n	%
Difficulty Seeing	9	11.8
Difficulty Hearing	2	2.6
Learning Disability	11	14.5
Physical	1	1.3
Chronic Health	2	2.6
Other	6	7.9

This table lists the type of disability indicated by participants as a percentage of the total population. The high percentage of participants indicating difficulty seeing appeared to be related to participants who needed some form of vision correction, such as glasses or contacts. Participants could indicate more than one type of disability.

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

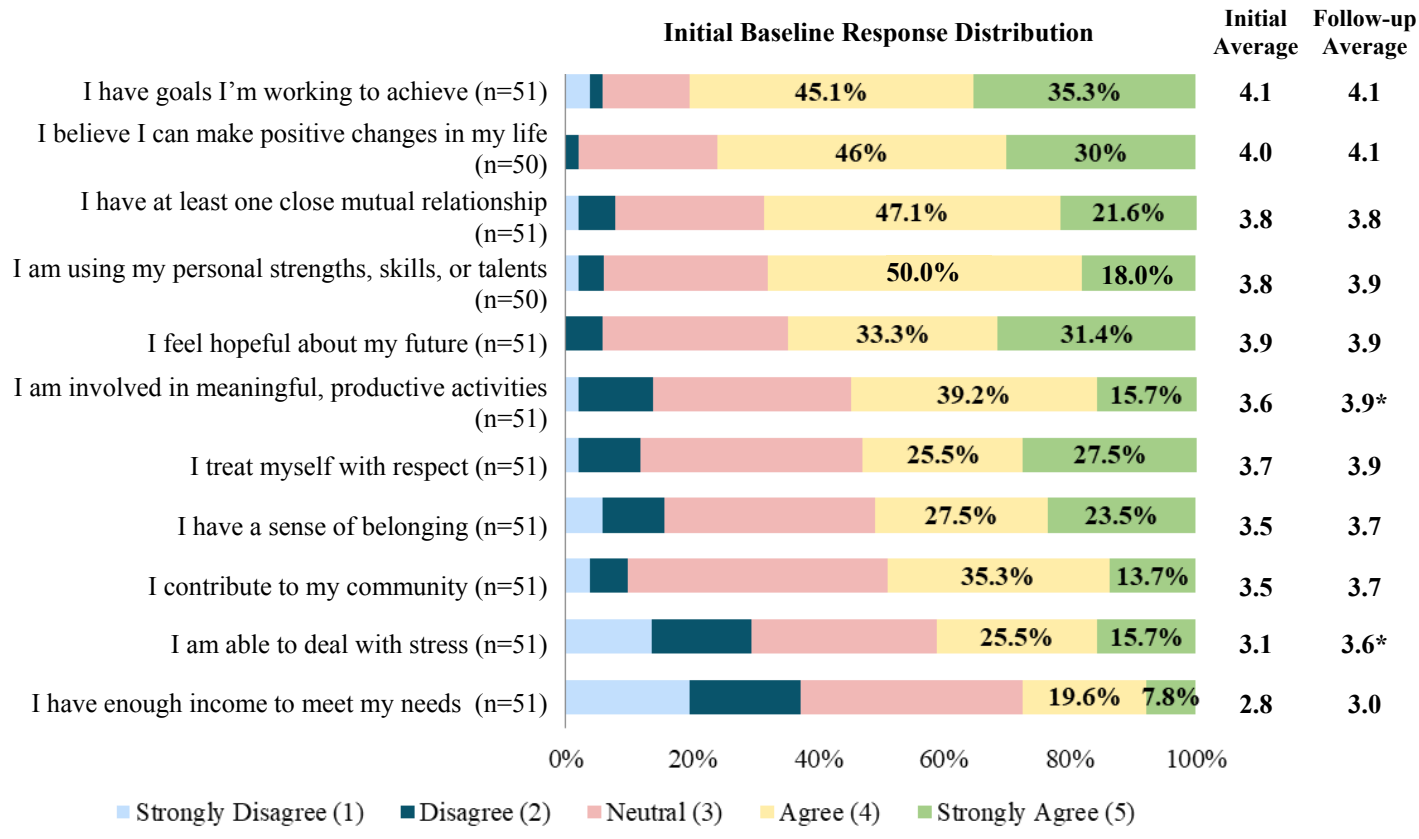
KEY EVALUATION FINDINGS

URBAN BEATS PARTICIPANT BELIEFS

At the start of each Urban Beats round of classes, participants were asked to complete a Wellness Survey. They were asked again after 6 weeks, and at the end of the 20-week program participants to complete a follow-up Wellness Survey. To identify areas of change, the responses from participants who completed both an and a follow-up survey are listed in the following charts. The charts present the distribution of responses at initial baseline, the average rating at initial baseline, and the average rating at most recent follow-up. Part of the Wellness Survey included select items from the Recovery Markers Questionnaire (RMQ). Items are listed in order of highest to lowest percentage of agreement (i.e., indicated Agree or Strongly Agree).

The most commonly endorsed statements (i.e., at least 75% agreed or strongly agreed) focused on participants' beliefs about their self-efficacy and pursuit of goal achievement. Participants appeared to be less enthusiastic about their stress management capabilities and having sufficient income. These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program. The average ratings for all items increased or stayed the same at follow-up, with two items demonstrating statistically significant increases between baseline and follow-up. These items were "I am involved in meaningful, productive activities" and "I am able to deal with stress." Both of these aspects of well-being are priorities of the Urban Beats program. Whereas the average baseline rating for dealing with stress corresponded to a response of "Neutral" (3.1), at follow-up the average rating was substantially closer to "Agree" (3.6). These findings suggest that Urban Beats program participation may contribute to improvements in perceptions of well-being.

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



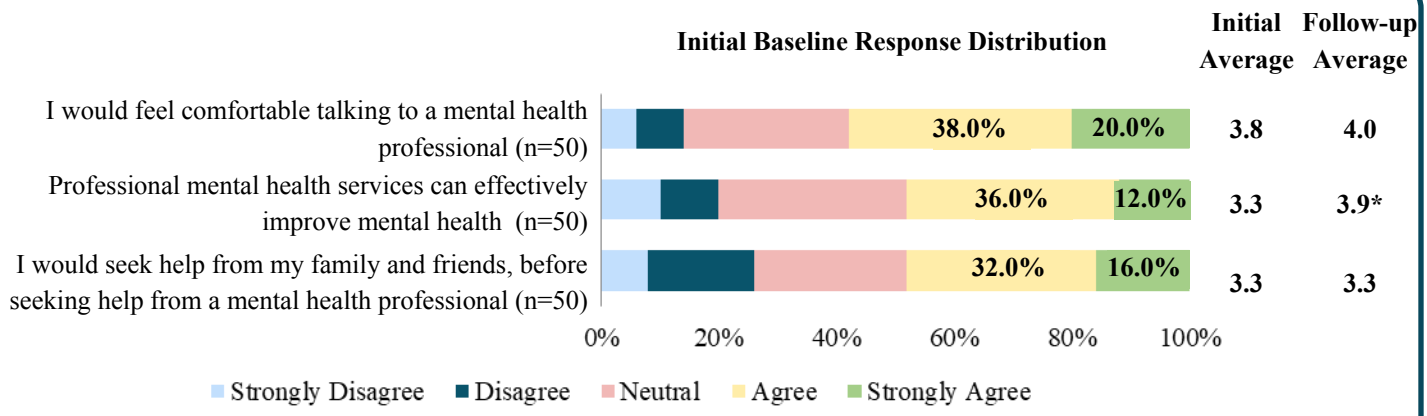
* Statistically significant change in mean rating scores, $p<.05$.

The Wellness Survey also inquired about the quality of health, mental health, and satisfaction with social activities/relationships. Many Urban Beats participants indicated they had health and mental health concerns, with 32.6% and 41.2%, respectively rating their overall health and mental health, as "Poor" or "Fair." These findings highlight the importance of focusing on physical and mental health within the Urban Beats program. The average ratings for these items did not change significantly at follow-up.

URBAN BEATS PARTICIPANT ATTITUDES ABOUT MENTAL HEALTH SERVICES

The Wellness Survey also included questions about their attitudes towards mental health services. At baseline, over half (58.0%) of the Urban Beats participants agreed or strongly agreed that they would "feel comfortable talking to a mental health professional." Approximately half (48.0%) agreed or strongly agreed that "professional mental health services can effectively improve mental health." These findings indicate that many Urban Beats participants had negative or ambivalent perceptions of professional mental health services and may not feel comfortable with mental health professionals. The Urban Beats program sought to address these concerns through psychoeducation and promoting engagement with professional mental health services when needed. Likely as a result of these efforts, the average rating for whether "Professional mental health services can effectively improve mental health" increased significantly from an average rating of 3.3 at baseline to 3.9 at most recent follow-up. These values correspond to an average response close to "Neutral" at baseline and "Agree" at follow-up.

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

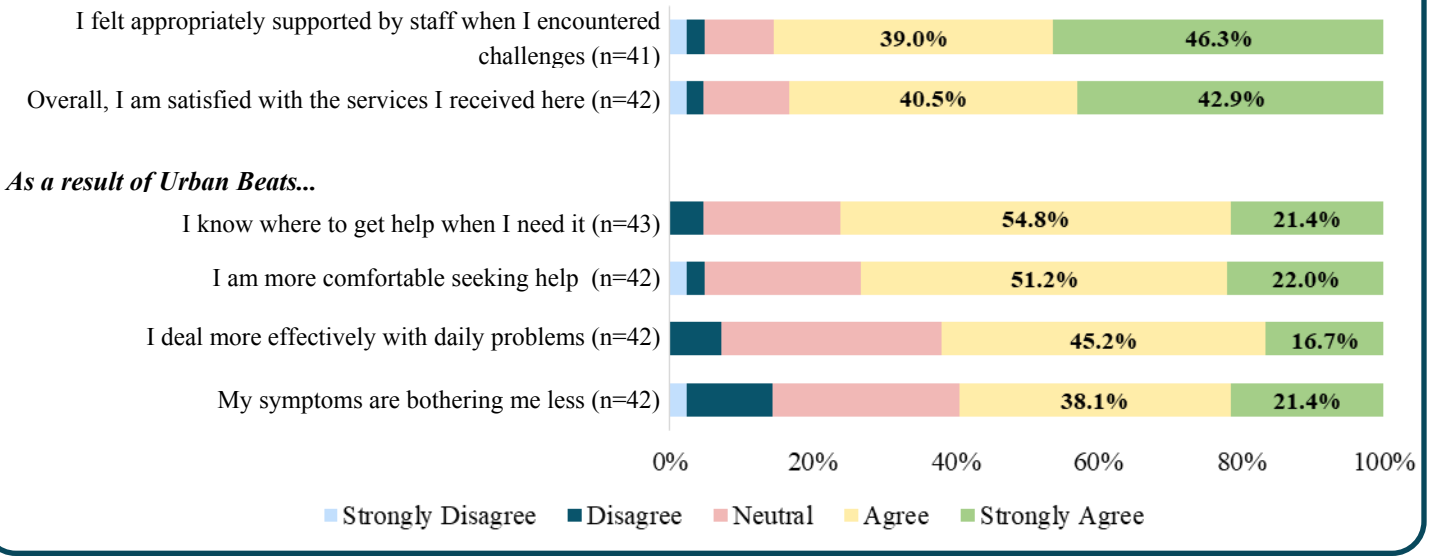


* Statistically significant change in mean rating scores, p<.05.

URBAN BEATS OUTCOMES

As shown in the chart below, the vast majority (83.4%) of Urban Beats participants with follow-up Wellness Survey data indicated they were satisfied with the Urban Beats program (42.9% strongly agreed). A similar percentage (85.3%) thought they were "appropriately supported by staff when [they] encountered challenges." The majority indicated that as a result of participating in the Urban Beats program, they knew "where to get help" (76.2%), felt "more comfortable seeking help" (73.2%), dealt "more effectively with daily problems" (61.9%), and were less bothered by symptoms (59.5%).

FIGURE 3. URBAN BEATS PARTICIPANT ASSESSMENT OF URBAN BEATS PROGRAM



BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of County of San Diego Behavioral Health Services (BHS) by Urban Beats participants was examined during several time periods, before and after starting the Urban Beats program. To ensure equal comparison times, the '90 days' analyses only included participants (n=153), who started the Urban Beats program at least 90 days prior to the end of the reporting period (6/30/2017). Likewise, the '180 days' analyses only included the subset of participants (n=124), who started the program at least 180 days before the end of the reporting period (6/30/2017). This ensured that everyone included in the analyses had the entire 90 or 180 days to be observed for any BHS utilization after starting Urban Beats.

As shown in Table 1, a little over one-quarter (27.5%) of the 153 Urban Beats participants included in the 90-day analyses had attended at least one BHS outpatient visit within the 90 days prior to starting the Urban Beats program. Approximately 20% participated in Assertive Community Treatment (ACT) in the 90 days before entering Urban Beats. There was almost no change in participation rates for these services in the 90 days after starting the Urban Beats program. Similarly, no substantial change in outpatient and ACT participation rates was found when examining 180 days before and after starting the Urban Beats program.

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

At least one...	90 Days Before Start Urban Beats (n=153)	90 Days After Start Urban Beats (n=153)	180 Days Before Start Urban Beats (n=124)	180 Days After Start Urban Beats (n=124)
Outpatient Visits	27.5%	28.8%	39.5%	42.7%
Assertive Community Treatment (ACT) Visit	18.9%	19.0%	27.4%	24.2%
Psychiatric Emergency Response Team (PERT)	3.3%	2.0%	6.5%	3.2%
Psychiatric Emergency/Crisis Hospital Visit	5.9%	2.0%	10.5%	2.4%
Inpatient Psychiatric Hospital Admit	5.2%	2.0%	15.3%	4.8%
Justice-Related Mental Health Visit	4.6%	1.3%	8.1%	4.8%

While less frequent overall, the findings in Table 1 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Teams (PERT), 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. This trend appeared to be particularly evident when examining 180 days before and after starting Urban Beats. For example, while 15.3% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 4.8% (a 68.6% reduction in hospitalizations), had a hospitalization after starting Urban Beats.

Given the relatively small sample sizes and 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.

URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTVITIES

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

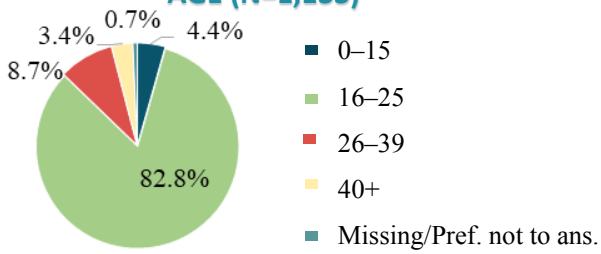
TABLE 2. URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

	Fiscal Year 2016-17		Fiscal Year 2016-17
New Instagram Followers	175 (289 Total)	**Facebook**	
New Twitter Followers	25 (60 Total)	• Page Likes	110
Website Visits	3,086	• Post Likes	470
SoundCloud Plays/Likes	547	• Reach (unique views)	55,629

COMMUNITY PERFORMANCE ATTENDEE DEMOGRAPHICS

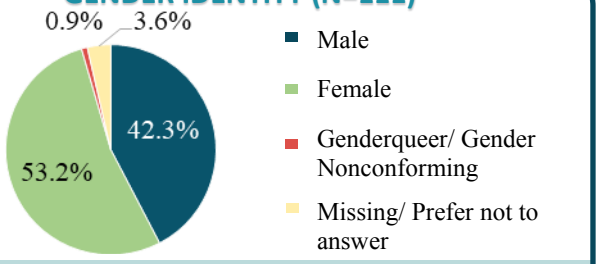
The following demographic data were collected from an audience self-report survey administered at the community performances.

AGE (N=1,133)



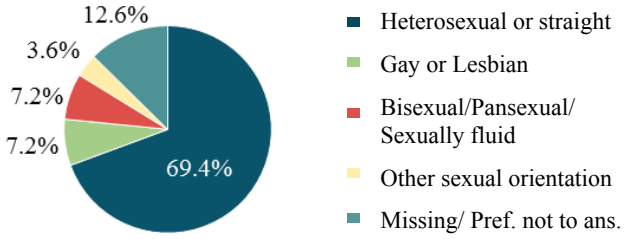
The majority (82.8%), of attendees were between the ages of 16 and 25, and 9% were between 26 and 39.

GENDER IDENTITY (N=111)



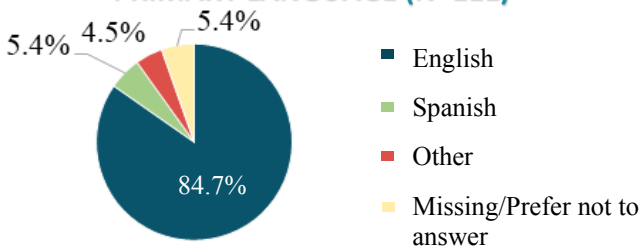
A slight majority (53.2%), of attendees were female.

SEXUAL ORIENTATION (N=111)



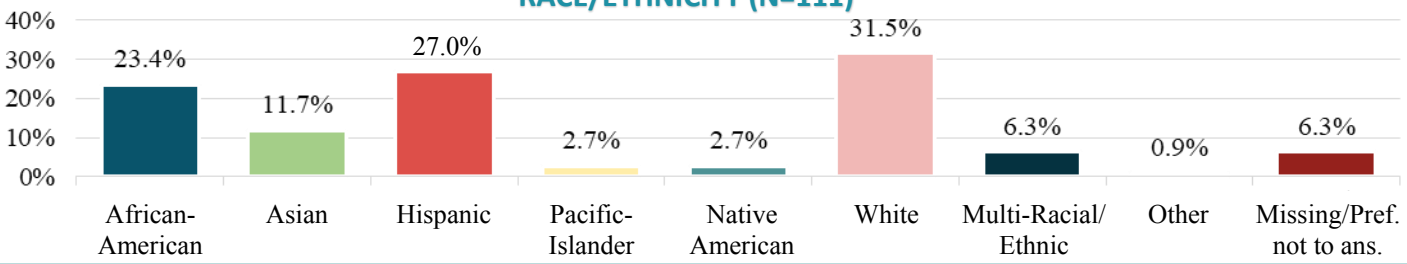
Sixty-nine percent of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=111)



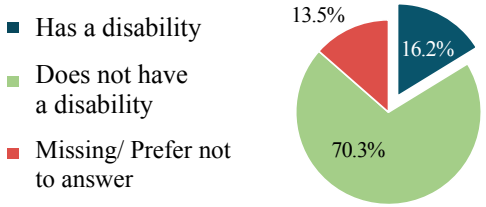
The vast majority (84.7%), of participants preferred English as their primary language.

RACE/ETHNICITY (N=111)



The performances reached a diverse audience. Approximately one-third (31.5%) identified as White, one-quarter (23.4%) as African American, and one-quarter as Hispanic (27.0%). Totals may exceed 100% as attendees could indicate more than one option.

DISABILITY[1] STATUS (N=111)



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

Most attendees (83.8%) indicated they had never served in the military.

TYPE OF DISABILITY (N=111)

Type	n	%
Communication	8	7.2
Mental (e.g., learning, developmental)	6	5.4
Physical	4	3.6
Other	2	1.8

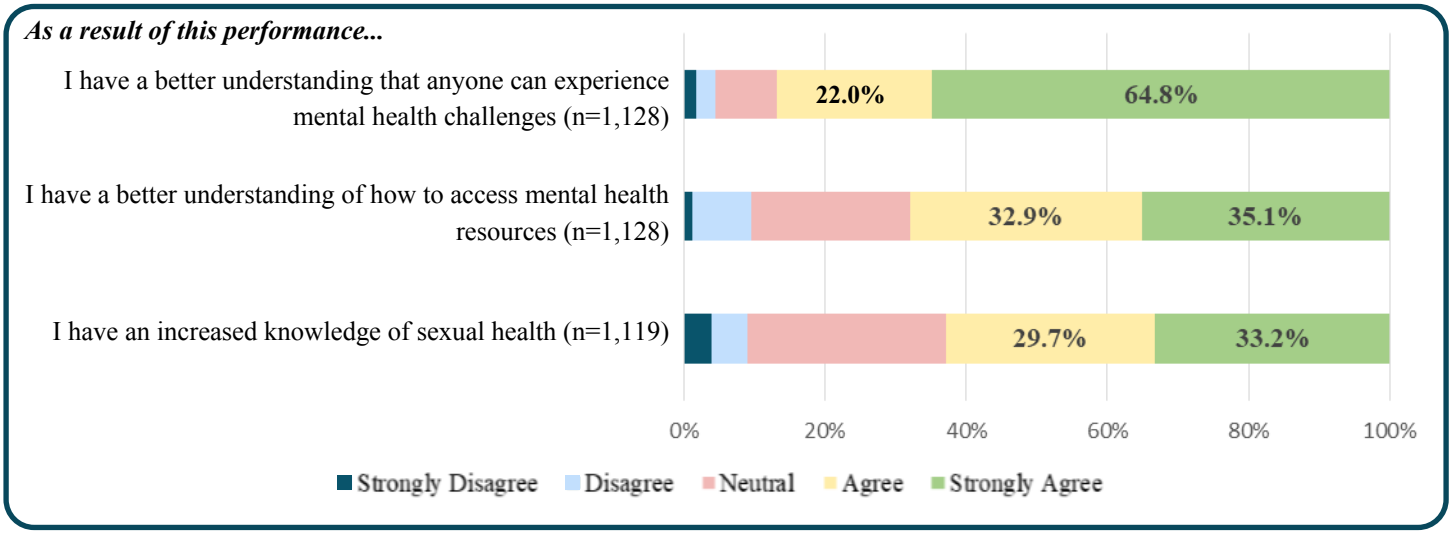
The table above describes the types of disabilities these attendees reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

[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).*

COMMUNITY PERFORMANCE OUTCOMES

The Urban Beats program hosted or co-hosted 29 community performances and collected outcomes surveys from 1,113 persons. TAY audience members (ages 16-25), comprised 82.8% (n=938), of the survey respondents. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 4, almost all (92.7%) respondents 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 (89.1%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (80.3%).

FIGURE 4. ASSESSMENT OF COMMUNITY PERFOMANCE ATTENDEE LEARNING



The response patterns between TAY (n=938) and non-TAY (n=195), who attended the performances were fairly similar regarding the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" (93.9% compared to 85.7%). However, TAY were substantially more likely to agree or strongly agree that they "had a better understanding of how to access mental health resources" (92.2% compared to 74.9%) and "had increased knowledge of sexual health" (85.1% compared to 57.4%) as a result of the performance.

URBAN BEATS YOUTH AND STAFF QUALITATIVE FOCUS GROUP FINDINGS

In 2017, four Urban Beats focus groups were held; two with current members (n=8), one with Youth Support Partner (YSP) staff (n=3), and one with "alumni" members (n=5), which included participants who began the program in 2015/16 and had been involved in multiple rounds of the program. This section provides a summary of findings from these focus groups.

DIVERSE RECRUITMENT VENUES

Urban Beats continued to expand recruitment efforts to new programs/populations of youth having less experience with mental health services, as compared to initial cohorts. Recruitment sites were programs targeting justice-involved and LGBTQI youth, which may help explain why the new cohorts included more men than women and a greater proportion of LGBTQI members. YSPs continued to be sensitive and adaptive to youth with diverse life experiences and varied prior engagement in mental health services by building rapport and checking in regularly. Current and alumni members participated in some outreach and recruitment events, and YSPs reported that these youth were very effective in recruiting new members.

MORE FREQUENT PERFORMANCE SCHEDULE

In 2017, Urban Beats managers and staff decided to increase the number of performances throughout the program. Using a flexible approach, many smaller performances were offered to the youth to participate in, such as monthly open-mic nights. YSPs indicated that despite initial concerns about the burden of more performances, youth rose to the challenge and thrived with the new schedule, and the increased opportunities to refine their art, network with other artists, and build their confidence. YSPs also discussed greater outreach in the community with the support of management, which led to more performances and subsequently more community connections.

COMMON OUTCOMES REPORTED BY YOUTH AND STAFF

Across the focus groups, *the majority* of youth and staff reported several common outcomes of Urban Beats, such as increased:

- Confidence/self-esteem
- Self-empowerment
- Social skills and support
- Networking
- Public speaking skills
- Sense of direction in terms of future goals

Some youth reported:

- Greater awareness or being more proactive about their own mental health
- Greater engagement in mental health or other social services
- Being linked to or supported in pursuing educational and employment opportunities
- Having an increased desire to discuss mental health publicly and reduce stigma

YSPs observed that some youth saw greater or more profound improvements in their second or third round of Urban Beats, which might be due to these youth having more time to internalize the messages they were receiving. Alumni of Urban Beats noted that the outcomes for youth with prior experiences in mental health services may be different than the youth who do not, and that the latter may be more likely to seek mental health services after entering the program.

POTENTIAL IMPROVEMENTS TO URBAN BEATS

Although overall satisfaction with the Urban Beats program was high, youth and staff were able to reflect on multiple ways that Urban Beats could be improved. Current youth members and alumni requested:

- More *facilities and technical resources*, such as recording booths, editing equipment, computers, and access to experts in their various art forms. YSPs indicated similar requests, especially computers and tablets, but noted that recently made connections with local arts organizations had expanded available facilities.
- More *employment opportunities*, particularly those without eligibility requirements (e.g., having a mental illness diagnosis).
- *Outreach and programming for non-TAY*, including those both above and below the age range; this would include recruitment into Urban Beats once they reached TAY status. Alumni members wanted Urban Beats programming for youth older than the TAY age range (16-25), and were concerned about the prospect of "aging out."
- *Greater involvement in social media*, but also indicated that no youth had agreed to take responsibility for Urban Beats social media accounts. YSPs suggested making an internship to potentially be more attractive to an Urban Beats member.
- *On-site counseling options for Urban Beats participants.* YSPs discussed how it would be helpful to have a staff person, contractor, or intern to serve as a trained clinician who could hold counseling on-site for Urban Beats participants.

URBAN BEATS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

Urban Beats program administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Urban Beats program. There were five respondents from the seven persons invited to participate in the survey, for a response rate of 71%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

1. *The major program goals identified by Urban Beats staff:*
   a. Engage TAY through artistic expression
   b. Reduce mental health stigma
   c. Facilitate general wellness education
   d. Utilize innovative techniques to provide the youth a voice
   e. Increase emotional expression and healthy coping techniques

2. *Factors that helped the Urban Beats achieve program goals:*
   a. Developing partnerships with other community organizations
   b. Increasing the number of community performances
   c. Promoting community awareness through interactive activities and art pieces
   d. Providing TAY a voice in decision-making and leadership
   e. Supporting TAY on an individual level through close collaboration between staff and participants
   f. Providing TAY with opportunities to express and utilize healthy coping strategies

3. *How Urban Beats helped TAY engage with needed mental health services:*
   a. Created a space for reducing the stigma of mental health
   b. Opened up non-judgmental communication between peers about accessing mental health services
   c. Provided direct linkages/referrals to outpatient and other services

4. *Primary barriers to linking Urban Beats TAY with mental health services:*
   a. Lack of TAY-oriented mental health and psychiatric services for youth over 21
   b. Limited access to quickly attainable, but not crisis-related, mental health services

5. *Relationship between public performances and achievement of overall program goals:*
   a. Provided a specific event to bring the community, youth, and providers together
   b. Platform for youth to express themselves and showcase their talent publicly
   c. Engages the community in conversations about mental illness and stigma reduction

6. *Role of Urban Beats to help TAY reduce mental illness stigma among themselves and in the community:*
   a. Provided a “Safe Space” for the youth to communicate their stories while also hearing from other TAY
   b. Facilitated development of peer supports over an extended period of time through program participation
   c. Started conversation among the community regarding mental health stigma through a public performances
   d. Created positive community reception to TAY communicating their stories in creative and empowering ways

KEY YEAR 1 URBAN BEATS PROGRAM "LEARNINGS"

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

KEY YEAR 2 URBAN BEATS PROGRAM "LEARNINGS"

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

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-16 Urban Beats program that differed substantially from the initial program design during the second year of service provision (7/1/2016 to 6/30/2017). However, as noted elsewhere, Urban Beats altered their approach to community performances during Year 2. Instead of primarily focusing on a few larger performances at the end of each Urban Beats cohort, performances included ongoing participation in multiple "open-mic" opportunities, as well as collaborative events hosted by community partners.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Identify additional community partners, particularly schools, to facilitate TAY recruitment.

   Status: Urban Beats successfully connected with additional community partners during Year 2, including two local high schools to increase recruiting opportunities.

2. Provide more training and team building opportunities for staff.

   Status: Urban Beats included more trainings to support the work of the staff. This helped staff become more independent and confident developing and implementing linkage and therapeutic support strategies for Urban Beats participants.

3. Develop strategies to increase number of community performances and performance attendance.

   Status: Urban Beats dedicated substantial efforts towards increasing performance opportunities and attendance during Year 2. As a result of an expanding network of partner schools, service provider organizations, and other community collaborators, Urban Beats successfully increased the number of performances from 5 in Year 1 to 29 in Year 2, with more than 1,100 completed attendee surveys.

4. Expand use of Urban Beats "graduates" to help recruit new TAY and act as mentors in future Urban Beats classes.

   Status: Urban Beats regularly has "graduates" from prior cohorts maintaining their involvement with the Urban Beats program as a way to support the current cohorts and continue their own personal growth. Current and past Urban Beats participants help identify many of the TAY who attend community events and enroll in the program.

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

   Status: Urban Beats utilized social media outlets in a more meaningful and impactful way during Year 2. The program highlighted certain social media campaigns by using polished and professional looking content to extend the reach of Urban Beats into the community.

6. Continue to purposefully assess, revise, and implement Urban Beats curriculum to promote ongoing fit with target participants.

   Status: Urban Beats staff continued to make minor modifications to the curriculum with each new cohort in order to improve content, teaching strategies, and general fit with the TAY participating in that round of classes.

7. Re-examine evaluation approach to identify optimal balance between data collection needs and burden on participants and staff.

   Status: Urban Beats program staff have successfully integrated survey data collection activities into their many performance opportunities. Getting demographic forms completed at community performances has been more difficult.

   The baseline and follow-up surveys have been shortened, but challenges remain, particularly with getting follow-up surveys completed.

CURRENT YEAR PROGRAM RECOMMENDATIONS

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

1. Increased access to technical resources/facilities (e.g., computers, recording studios, editing equipment).
2. More strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach).
3. Explore potential for providing on-site or direct, dedicated access to mental health counseling for Urban Beats participants.
4. Improve data collection approach to facilitate completion of greater numbers of Urban Beats participant follow-up surveys.

For additional information about the INN–16 Urban Beats program and/or annual report, send your inquiry to:

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

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

ANNUAL REPORT: YEAR 1 (1/1/16 - 12/31/16)

The 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 to the treatment and support team. The peer specialist is someone who previously demonstrated hoarding behaviors but successfully completed treatment to minimize or eliminate these detrimental activities. The peer support specialist meets regularly with CREST participants to help with their decluttering tasks, as well as providing essential emotional support, empathy, and encouragement. Through the combined effect of the treatment sessions, peer specialist support, and comprehensive care management/linkages, it is expected that hoarding behaviors among CREST participants will be reduced resulting in improved mental health, well-being, and safety of participants.

EXECUTIVE SUMMARY

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

- During Year 1 (2016), 25 persons aged 60 and older entered into the CREST program (average age = 70; range of 60-93).
- Approximately 75% of the participants were female. All reported English as their primary language and almost all identified as "white" (88.0%). Over half (56.0%) had a post-secondary degree and very few were employed (12.0%).
- Over two-thirds (68.0%), reported having at least one disability unrelated to mental health (e.g., physical disability or chronic pain).
- In addition to having a hoarding disorder diagnosis, almost half (48.0%), had a comorbid major depression diagnosis.
- Based on the Hoarding Rating Scale, 50-60% of participants reported "severe" or "extreme" emotional distress and impairment due to their hoarding behaviors.
- Preliminary outcomes reported by program staff included improvements such as avoided evictions, increased social connections, and improved sense of well-being.
- CREST staff identified key factors that helped achieve program goals: 1) using an evidence-based treatment protocol, 2) having a mobile team to provide in-home visits, 3) having coordinated, full-service care provided by a multi-disciplinary team, 4) engaging in outreach to and education of participants, providers, landlords, etc., to implement collaborative solutions, 5) conducting regular supervision of and consultation with CREST staff, and 6) having a well-managed team of dedicated and caring professionals.

RECOMMENDATIONS

Primary recommendations include: 1) expand services by reducing/eliminating insurance criteria and providing services in additional areas, 2) add a bilingual (Spanish-speaking) therapist, 3) improve communication options between participants and CREST team members, and 4) explore opportunities to promote program sustainment.

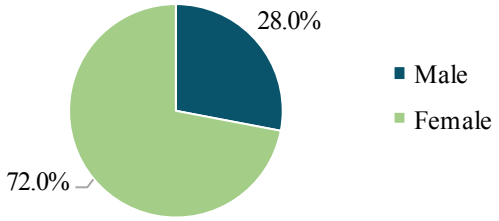
CREST PROGRAM PARTICIPANT DEMOGRAPHICS

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

As of 12/31/2016, 114 persons were screened for CREST program eligibility. 74 (65.0%) met criteria for hoarding disorder, however, only 25 (22.0%) met all eligibility requirements (i.e., Medi-Cal/uninsured & region in county).

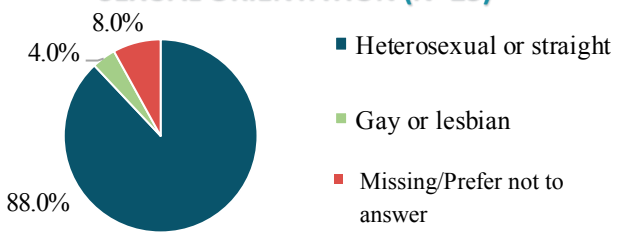
- Participants ranged in age from 60 to 93 (mean age: 70).
- All participants reported English as primary language.
- Two (8.0%) participants previously served in the military.

GENDER IDENTITY (N=25)



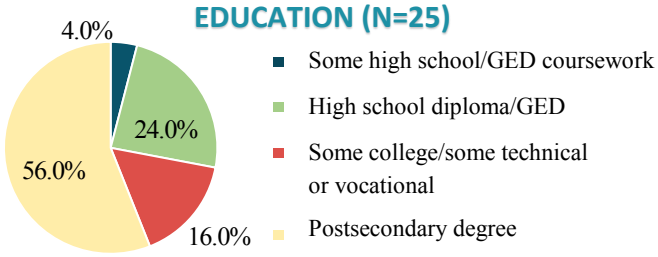
Nearly three-quarters (72%) of participants were female.

SEXUAL ORIENTATION (N=25)



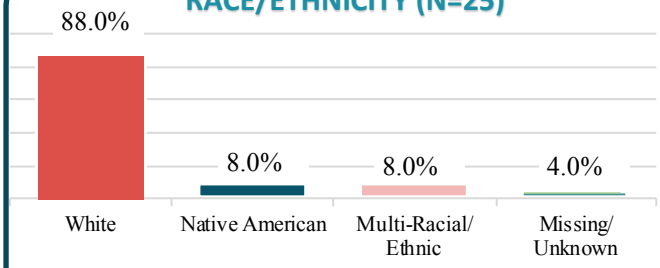
Most (88.0%) participants were heterosexual or straight, and about 4.0% indicated being gay or lesbian.

EDUCATION (N=25)



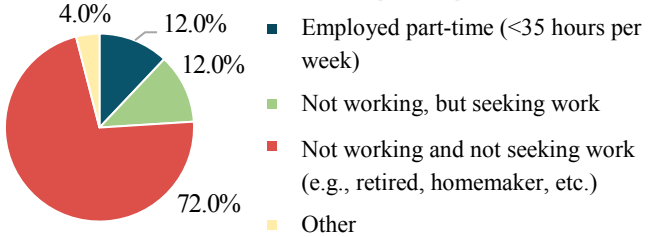
Over half (56.0%) of participants had completed a postsecondary degree.

RACE/ETHNICITY (N=25)



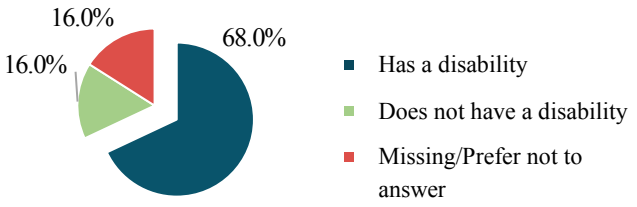
Most participants (88.0%) identified as White. Totals exceed 100% as participants could indicate more than one.

EMPLOYMENT (N=25)



Nearly three-quarters of participants (72.0%) were not employed and not seeking employment.

DISABILITY STATUS[1] (N=25)



Almost 70% of the participants reported having some form of disability unrelated to SMI.

TYPE OF DISABILITY (N=25)

Type	n	%
Physical	10	40.0
Chronic health/pain	8	32.0
Learning disability	6	24.0
Communication (hearing/speaking)	3	12.0
Difficulty seeing	2	8.0
Dementia	1	4.0
Other	3	12.0

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

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

KEY EVALUATION FINDINGS: BASELINE

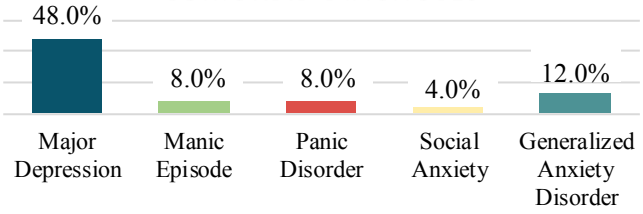
The following data elements were collected from participants at the start of the CREST program.

HOMELESSNESS RISK FACTORS

% "Yes"

64%	Experienced "clean-up" pressure from others (e.g., from property managers or city officials)
43%	Have a poor credit history
50%	Ever homeless/not have a home of own
43%	Without somewhere to stay/without plan for housing if lost current housing

COMORBID DIAGNOSES



Almost half (48.0%) of the participants were diagnosed with comorbid major depression.

The chart below presents the distribution of participant baseline responses to each question on the Hoarding Rating Scale. Overall, the results indicate widespread negative effects on the lives of the CREST participants due to clutter in their home, with fully 92% reporting moderate to extreme difficulty using rooms in their house, 80% reporting moderate to extreme emotional distress, and 96% reporting that they experienced moderate to extreme impairment in their life. For approximately 50-60% of participants, the level of negative impact was considered severe or extreme.

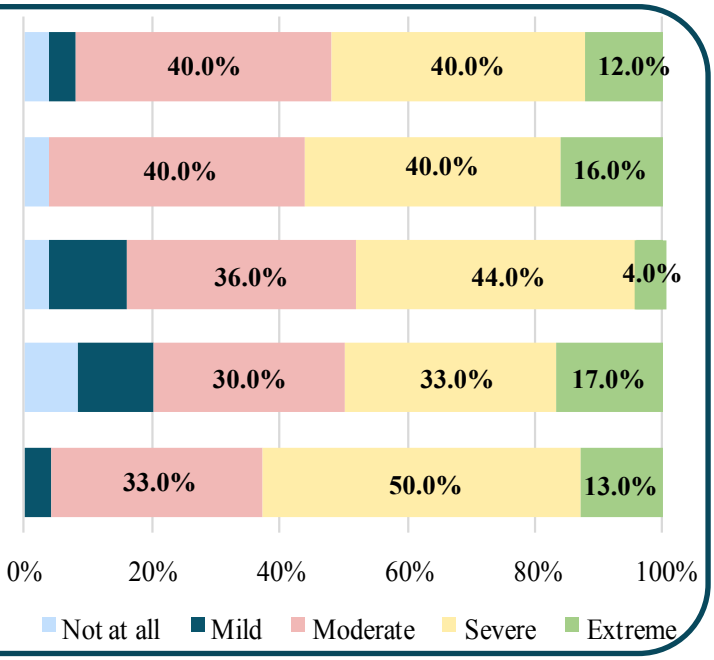
Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home? (n=23)

To what extent do you have difficulty discarding ordinary things that other people would get rid of? (n=23)

To what extent do you currently have a problem with collecting or buying more things that you can use or can afford? (n=23)

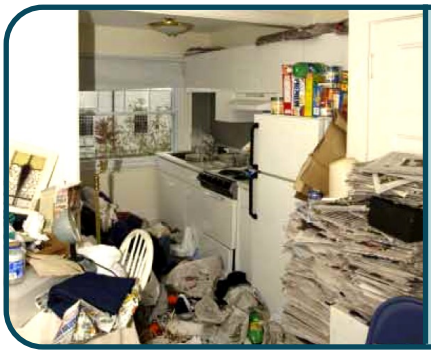
To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things? (n=23)

To what extent do you experience impairment in your life because of clutter, difficulty discarding, or problems with buying or acquiring things? (n=23)



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 images (from 9 standard images depicting increasingly more cluttered living spaces) that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom). The images below include kitchen CIR Image #1 (typically selected by persons with no hoarding disorder concerns) and kitchen CIR Image #5 (typically selected by persons entering CREST program).

Kitchen CIR #1: Reflects clutter level of persons with no hoarding concerns



Kitchen CIR #5: Reflects baseline clutter level typically selected by participants of CREST Program

PARTICIPANT PROFILES AND PROGRAM SUCCESSES

COMMON PARTICIPANT PROFILE

Each person and hoarding situation is unique; however, common factors often included:

- Facing potential evictions/failed health or safety inspections.
- Often having long histories (e.g., >30 years) of hoarding behaviors.
- Embarrassed to have people see their living environment.
- Experiencing stress, anxiety, depression related to the hoarding situation.

TYPES OF PROGRAM SUCCESSES

While the improvement process is often slow (and is ongoing for many CREST participants), the following types of successes have been observed:

- Evictions avoided.
- Health and safety inspections passed.
- Friends and/or family invited to visit.
- Allowed to move to more desirable locations.
- Holding ceremonies/celebrations to commemorate reductions in clutter.
- Improved sense of well-being related to living situation.

EXAMPLE OF CLUTTER REDUCTION DUE TO CREST PROGRAM PARTICIPATION

Before CREST program participation

After CREST program participation

ADDITIONAL COMMUNITY BENEFITS

RESOURCE DIRECTORY

Staff and volunteers at CREST collected information and developed a community resource directory:

- Over 700 resources and over 2000 faith based organizations are included in the directory.
- The directory has been shared with over 40 community agencies in San Diego.

EDUCATIONAL OPPORTUNITIES

The CREST program has developed educational opportunities for psychology undergraduates and clinicians in training:

- Undergraduates entered clinical data into the CREST database and were trained on various psychological assessments.
- The CREST program provided a 4-week rotation to geriatric fellowship trainees.
- A doctorate level clinical psychology intern performed neuropsychological assessments and psychotherapy.

ROLE OF PEER SUPPORT SPECIALISTS

Based upon a semi-structured interview with a CREST Program Peer Support Specialist (conducted 8/10/2016), and feedback from CREST program administrators, the following were identified as key roles of the Peer Support Specialist on the treatment and support team:

1. Providing emotional support to participants.
2. Conducting weekly check-ins with participant.
3. Helping participant sort items into different types of piles (e.g., keep, trash, and donate piles).
4. Facilitating improved problem-solving among participants (e.g., not telling participant in which pile an item should go, but helping them work through what they think should be the appropriate pile).
5. Monitoring and encouraging progress toward task completion (e.g., checking on homework assignments).
6. Reminding participants of desired long-term objectives.
7. Providing social motivation/incentive to complete weekly clean-up tasks due to regular home visits.
8. Acting as an example to demonstrate that improvements in hoarding behaviors are possible.

CREST PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the first 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. Seven out of nine participants (77.8%) responded to the survey.

1. *Major program goals as identified by CREST program personnel*
    a. Reduce hoarding by providing comprehensive evidence-based treatment and supportive wraparound services
    b. Prevent evictions and reduce risk of homelessness
    c. Conduct outreach to local agencies to inform them of CREST program
    d. Establish intervention as a well-known and effective program
2. *Factors that helped the CREST program achieve these goals*
    a. The usage of an evidence-based treatment program with an existing protocol
    b. Mobility of treatment team enables visits in patients' homes
    c. Coordinated, full-service care provided by a multi-disciplinary team of clinicians, peer specialists, interns, and other support staff
    d. Outreach to and education of clients, providers, landlords, and community members to implement collaborative solutions
    e. Regular supervision and consultation to guide intervention implementation
    f. Having a well-managed team of dedicated and caring professionals
3. *Specific challenges to reaching program goals*
    a. Limitations due to eligibility and exclusion criteria (e.g., insurance status and location)
    b. More staff needed to expand program and support additional languages
    c. Staff experience barriers to coordination and communication
        i. Lack of mobile communication technology for staff in-the-field
        ii. No administrative contact at main office to relay messages to mobile staff
        iii. Clients cannot leave messages for specific clinicians
    d. Client characteristics make it difficult to recruit and retain participants (e.g., reluctance to allow staff into home, not completing homework, full voicemails or lost phones)
4. *Key program "innovations" that make CREST different from other treatment options*
    a. Delivering an evidence-based treatment for hoarding behaviors
    b. Providing services in patients' homes
    c. Participants having multiple one-on-one meetings with the psychologists, care managers, and peer support specialists
    d. Utilizing a "whole-person" approach that incorporates additional assessments and care management services
    e. Providing the intervention through the use of a coordinated multi-disciplinary team
5. *Factors that facilitate successful recruitment and retention of CREST program participants*
    a. Outreach to property managers and other community groups to identify potential referrals
    b. Self-referrals identify which persons are ready for change (i.e., they acknowledge need for assistance)
    c. Persistent efforts to follow-up and engage with participants
    d. Having a trusted health care provider (or other trusted person) make the referral or recommendation for services
    e. Seeing improvements/progress towards goals encourages continued program participation
    f. Skillfully navigating participants' anxiety to promote trust and willingness to follow through with recommended changes
6. *Benefits of including a Peer Specialist on treatment teams*
    a. Helps normalize feelings such as shame and apprehension
    b. Offers emotional support and encouragement
    c. Provides example of and hope for recovery

KEY YEAR 1 CREST PROGRAM "LEARNINGS"

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

YEAR 1 PROGRAM CHANGES

There were no changes to the INN-17 CREST Program during the first year of service provision (1/1/2016 to 12/31/2016) that differed substantially from the initial design of the program. As is typical during program start-ups, basic practices and procedures were adjusted over the course of the first year to better fit the emerging service delivery context. For example, Dr. Ayers, the developer of the CREST program, has modified the treatment manual based upon clinician and participant feedback. Also, several assessments have been added to the protocol to further guide the work of the CREST team including: 1) a medication evaluation with a gero-psychiatry fellow, 2) a neuropsychological assessment, and 3) an assessment of housing concerns as they relate to hoarding behaviors.

YEAR 1 PROGRAM RECOMMENDATIONS

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

1. Expand services by:
   a. Reducing/eliminating insurance status restrictions (i.e., not required to be uninsured).
   b. Providing services in additional zip codes.
2. Add a bilingual (Spanish-speaking) therapist to the treatment team.
3. Improve communication options between participants and CREST team members.
4. Explore opportunities for program sustainment.

For additional information about the INN–17 CREST Program and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu