Name of Program: Pacific Clinics – HOPE Program

What is the Program/Contract Goals? The goals include providing efficient, timely, and accessible medically necessary outpatient specialty mental health services for children, youth, and their parents who meet necessity, as well as court-specific services to children and families involved in Fresno County's Child Welfare Services (CWS) System.

Program Type: Contract-Operated

Type of Program: Outpatient

Other: Click here to enter text.

CLINICAL INFORMATION:

Does the Program Utilize Any of the Following? *(May select more than one)*

Evidence Informed Practice Best Practice Evidence Based Practice

Other: Click here to enter text.

Please Describe: **Click here to enter text.**

The program utilizes several different evidence-based practice modalities to treat individuals. These range from Trauma-Focused Cognitive-Behavioral Therapy to Dialectical Behavioral Therapy. The program applies best practice as they collaborate with multiple teams and agencies to provide quality care and reduce barriers to care.

Managing and Adapting Practice (MAP)

The MAP system is designed to coordinate and supplement the use of evidence-based programs for children's mental health. The system is not a single treatment program. Rather, it involves several decision and practice support tools to assist in the selection, review, adaptation, or construction of empirically derived common treatment elements to match particular child characteristics. There are three main tools within the MAP system:

1) The PracticeWise Evidence Based Services Database (PWEBS) - A database that includes hundreds of randomized clinical trials of treatments for children's mental health problems (e.g., anxiety, depression, trauma, etc). Using this online searchable database, providers can access summaries of the best and most current scientific research, and results can be customized to match an individual child's characteristics.

2) The Clinical Dashboard - A tool that presents a visual summary of individual persons served progress along with the history of clinical practices delivered

3) The Practitioner Guide - A set of treatment materials that summarize the most common elements of evidence-based treatments for youth.

MAP is a flexible, second generation evidence-based practice (EBP) that Pacific Clinics has chosen to become our core therapeutic practice. Like other EBP's, MAP offers the best possible outcomes, but it has some distinct advantages:

1) It is not limited to a particular diagnosis or demographic group;
2) It is sustainable;
3) It visually tracks progress;
4) It is flexible enough for staff to exercise their clinical judgment; and
5) It is consistent with our strength-based, family-centered philosophy.

Source: Core Elements – Day 1 – Anxiety Handout: Retrieved from http://emq-app7/Administration/Training/Learning%20and%20Development/Forms/AllItems.aspx?RootFolder=%2fAdministration%2fTraining%2fLearning%20and%20Development%2fCore%20Elements%2fCore%20Elements%20%2d%20Handouts&FolderCTID=0x01200037F3A508746F52409A1AC11C068624DD&View=%7bCB2A1339%2dB858%2d4BD0%2dA4D9%2d52C68BA96DCD%7d

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is an evidence-based psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children (0-5 [early childhood] and 6-12 [childhood]), adolescents [13-17 years] and their caregivers. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement.

The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. In general, the treatment addresses distorted beliefs and attributions related to the abuse and provide a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.

The acronym PRACTICE reflects the components of the treatment model: Psycho-education and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format.

Source: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Retrieved from **Error! Hyperlink reference not valid.**

Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning.

The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions. For example, with infants, the child is present, but treatment focuses on helping the parent to understand how the child's and parent's experience may affect the child's functioning and development. With older children, including toddlers, the child is a more active participant in treatment, and treatment often includes play as a vehicle for facilitating communication between the child and parent.

When the parent has a history of trauma that interferes with his or her response to the child, the therapist (a master's- or doctoral-level psychologist, a master's-level social worker or counselor, or a supervised trainee) helps the parent understand how this history can affect perceptions of and interactions with the child and helps the parent interact with the child in new, developmentally appropriate ways. In studies reviewed for this summary, mother-child dyads participated in weekly sessions for approximately 1 year with therapists who principally used a CPP treatment manual (Don't Hit My Mommy!).

Source: Child-Parent Psychotherapy (CPP). Retrieved from: http://legacy.nreppadmin.net/ViewIntervention.aspx?id=194

Motivational Interviewing (MI)

Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people with the following:

- Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs)
- Express in their own words their desire for change (i.e., "change-talk")
- Examine their ambivalence about the change
- Plan for and begin the process of change

- Elicit and strengthen change-talk
- Enhance their confidence in taking action and noticing that even small, incremental changes are important
- Strengthen their commitment to change

Source: https://www.centerforebp.case.edu/practices/mi

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) and it is now recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders. As such, DBT is a transdiagnostic, modular treatment.

The term “dialectical” means a synthesis or integration of opposites. The primary dialectic within DBT is between the seemingly opposite strategies of acceptance and change. For example, DBT therapists accept persons served as they are while also acknowledging that they need to change to reach their goals. In addition, the skills and strategies taught in DBT are balanced in terms of acceptance and change. The four skills modules include two sets of acceptance-oriented skills (mindfulness and distress tolerance) and two sets of change-oriented skills (emotion regulation and interpersonal effectiveness).

Source: https://depts.washington.edu/uwbrtc/about-us/dialectical-behavior-therapy/

Eye Movement Desensitization Reprocessing (EMDR)

EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories (Shapiro, 1989a, 1989b). During EMDR therapy the persons served attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used (Shapiro, 1991). Shapiro (1995, 2001) hypothesizes that EMDR therapy facilitates the accessing of the traumatic memory network, so that information processing is enhanced, with new associations forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in complete information processing, new learning, elimination of emotional distress, and development of cognitive insights. EMDR therapy uses a three pronged protocol: (1) the past events that have laid the groundwork for dysfunction are processed, forging new associative links with adaptive information; (2) the current circumstances that elicit distress are targeted, and internal and external triggers are desensitized; (3) imaginal templates of future events are incorporated, to assist the persons served in acquiring the skills needed for adaptive functioning.

https://www.emdr.com/what-is-emdr/

OUTCOMES

What Outcome Measures Are Being Used?

The outcome measures that are being used include the following:

Efficiency/Timeliness of Service

- Percentage of timely access to services from referral to first contact
- Percentage of persons served who have received timely access to services from assessment to ongoing treatment
- Percentage of persons served who have received timely access to services from referral to medication evaluation
- Percentage of assessments for persons served that were completed within the appropriate timeframes
- Number of services provided per person served
- Percentage of services that were provided in the community
- Percentage of discharges that were due to successful completion of treatment

Access/Engagement

- Percentage of no-shows
- Percentage of discharges due to "no show"
- Rate of Intensive Home-Based Services billing
- Rate of Intensive Care Coordination billing
- Rate of community-based services

Effectiveness – Improved Child Functioning

- Percentage of persons served who maintained or improved academic performance
- Percentage of persons served who improved school attendance
- Percentage of persons served who decreased suspensions or school disciplinary actions
- Percentage of persons served who maintained or increased healthy friendships/participation in age-appropriate activities
- Percentage of persons served who maintained or improved their ability to function within their current living situation
- Percentage of persons served who maintained or improved healthy and stable relationships at home/school
- Percentage of persons served who improved their emotional and behavioral status
- Percentage of persons served who reduced risk behaviors
- Percentage of persons served who improved clinical condition and quality of life
- Percentage of persons served who made progress or met treatment goals
- Percentage of persons served who improved psychosocial impairment functioning or maintained no impairment

Effectiveness – Improved Family Functioning

- Percentage of caregivers who are knowledgeable about a child's needs and monitor and manage a child's behavior
- Percentage of caregivers who refrained from behavior that puts the child at risk

- Percentage of caregivers that are protective of the child from others that pose a risk to a child
- Percentage of caregivers who maintained safe and stable housing

Effectiveness – Improved Parent Functioning

- Percentage of caregivers who increased social supports and safety networks
- Percentage of caregivers who maintained a job or means of livelihood
- Percentage of caregivers who maintained sage and stable housing
- Percentage of caregivers who maintained or improved their participation in drug testing and were able to refrain from substance abuse
- Percentage of caregivers who participated in mental health treatment
- Percentage of caregivers who maintained or improved their physical health
- Percentage of caregivers who made progress towards their treatment goals

Satisfaction

- Percentage of persons served and families who were satisfied with program services

- Child and Adolescent Needs and Strengths (Comprehensive CANS Core 50); Core Evaluation and Data Elements (CEDE)(internal agency measurement tool); Consumer Perception Survey (formerly Performance Outcome & Quality Improvement –POQI; YSS, YSS-F, AS); PSC-35

What Outcome Measures/Functional Variables Could Be Added to Better Explain the Program's Effectiveness?

The outcome measures and functional variables that the program currently uses to measure effectiveness are sufficient.

Describe the Program's analysis (i.e. have the program/contract goals been met? Number served, waiting list, wait times, budget to volume, etc.):

Most of the contract goals have been met by the program. The program has provided timely access to services, increased IHBS services, and maintained high service satisfaction. The program has shown effectiveness of services through usage of the CANS data. The data shows that persons served were able to improve their school attendance and maintain or improve their suspensions/expulsions. The program has met their target goals for caregivers being knowledgeable about the child's needs and managing the child's needs. Data collected also shows caregivers served by Pacific Clinics were also able to stay away of substance abuse and maintain or secure stable housing.

Based on the outcomes of the persons served discharged to date, persons served are able to maintain or improve (90%) their school attendance while staying out of trouble, by maintaining or improving their suspensions/expulsions (98%) at zero, and maintain or improve school grades and academic performance (81%). In addition, Fresno Hope persons served are increasingly capable of caring for their children by being knowledgeable about the child's needs and managing the child's needs (84%) and developing a support network to help promote a safe environment for their children (98%). Persons served (YSSF: 95%; YSS: 89%; Adults: 90%) are satisfied with services received from Fresno Hope program. These results indicate that the Fresno Hope program has been highly effective in helping persons served and families to achieve their goals.

What Barriers Prevent the Program from Achieving Better Outcomes?

A barrier we continued to experience this past fiscal year was significant impact with regards to an ongoing high volume of no shows and reduced engagement due to the pandemic. After such a long time participating in remote services, persons served reported feeling burned out by telehealth as well as screen fatigue. One of the implications is that we provided more phone services which impacted our ability to meet the requirement for 70% of services being provided in the community. We started the fiscal year providing more in person services; however, due to the Omicron variant and increased Covid numbers and exposures in January, we had to pivot back to telehealth where clinically appropriate. In March, we were able to start moving back to in person services, but each time we have to pivot, we see an impact on engagement. Anytime a person served has any symptoms, we have to pivot to telehealth, but we find that often the persons served attempt to simply cancel the sessions. Staff are having to work much harder at engagement when either they or the persons served experience symptoms and many persons served do not want to engage in telehealth any longer. Additionally, we have received a lot of re-referrals and noticed that these persons served often are not engaged and not ready to return to services. Although staff work very hard to engage these persons served, (often adults) they are not always willing to engage and many times result in an unsuccessful discharge. We have given feedback about the screening process of re-referrals, but many of them are pushed through to our program despite the persons served not being ready or willing to participate in mental health services. Sometimes this is because they have competing priorities and are overwhelmed. This contributes to a higher volume of no shows and discharges due to no shows.

Another area that we found we did not meet the requirement for was 70% of persons served would be discharged due to successful completion of treatment. Through our analysis, our persons served who refused services more than doubled (from 42 persons in the prior fiscal year, to 95 persons served this past year.) We believe this was due to our team holding persons served accountable to be engaged in treatment and participate in the services provided. When a person served was offered multiple opportunities to engage in treatment and failed to do so, they were ultimately discharged and invited to return when they were able to and ready to participate.

For the outcome that persons served will maintain or increase in healthy friendships and participation in age-appropriate activities, we believe that we did not meet this outcome as many of our persons served were socially isolated during the pandemic and we are still seeing the repercussions of this. This has been something we have focused on for our youth in the program by offering social outings during the summer where they could safely engage with other youth in our programs to build their social skills. Even those youth that returned to school did not return back in a pre-pandemic fashion and are still trying to make up the lost social skills from more than a year and half of being isolated. Further, when they returned to school there were many safety practices in place that continued to disrupt normal social functioning. These things also impacted persons served's abilities to improve emotional and behavioral status but as we have been able to provide more in person and intensive services, we believe we will see an improvement over time in these areas.
As a result of the pandemic, we continue to experience much higher acuity persons served being referred. These persons served are experiencing more mental health symptoms, more frequent hospitalizations, and a higher need for intensive services. We have provided more IHBS services as a result.

Another barrier that is constantly being addressed and supported is the high level of secondary trauma which attributes to staff burnout and turnover. Pacific Clinics continues to make available full Reflective Practice groups for everyone involved in the program to provide support around this level of trauma, and it is also addressed in clinical and administrative supervision.

What Changes to the Program Would You Recommend to Improve the outcomes?

Pacific Clinics has provided a high quality of care for an increasingly complex population of youth and adults that is evidenced by the outstanding outcomes being realized by those served.

One recommendation to improve the outcomes is to add additional case managers to support the clinicians with case management tasks, rehabilitation services, and providing additional ICC and IHBS services to the population. This would address the need based on higher acuity persons served, as well as resolve some of the burnout that the clinicians are experiencing as a result of trying to manage a higher caseload with more intensive need persons served. We were able to add one case manager position this last fiscal year but reducing a clinician position and turning it into a case manager. We have seen the benefits of this change as it has allowed more persons served to have a team based approach and a higher level of support. We believe that this population would benefit from having a larger treatment team to meet the more intensive needs that we are seeing in our persons served. Specifically with our adult population, who do not qualify for Wrap or TBS, having case managers to support them has been highly beneficial.

There are also systemic barriers that have direct impact on our staff and the mutual families served such as turnover of Social Workers within the Department, a lack of training for Social workers, specifically with regard to secondary and vicarious trauma, and high Social worker caseloads. Although DSS is aware of these barriers and working diligently to mitigate them, they do impact our shared families as well as the staff, who often are asked to take on responsibilities outside the scope of their role.

Additionally, the Mental health providers in this contract offer ongoing training to the Department and social workers in order educate them about mental health services, attendance has been minimal and perhaps this is an area we could partner to improve upon.

Our clinical outcomes were excellent and despite the ongoing barriers, demonstrate that we have persisted and met the clinical expectations of the contract.

For Committee Use Only:

Recommendations: do include a conclusion and a to-do list with action items

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