ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT) INNOVATIONS-18

Annual Report (7/1/2022 - 6/30/2023)

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

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The ADAPT program was designed to address unmet needs, improve access to treatment and reduce the negative health outcomes of perinatal mood and anxiety disorders with a focus on women and families from underserved communities. A key component of the ADAPT program is the partnership with HHSA's Nurse Family Partnership (NFP) and Maternal Child Health (MCH) Home Visiting programs, with the goal of providing mental health services to Public Health Nursing (PHN) participants. ADAPT provides therapeutic treatment, peer support and advocacy, resource linkage and navigation to community resources and support for the entire family. Due to the COVID-19 pandemic, in fiscal year (FY) 2020-21 the ADAPT program transitioned from primarily in-home, in-person services to providing the majority of services via telehealth or telephone. The program has since re-introduced in-person services and is continuing to provide telehealth with reduced reliance on telephone-based services. ADAPT substantially expanded their referral partners during FY 2021-22 to accept eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

Primary Findings for FY 2022-23

Consistent ADAPT Program Enrollment Serving Racially/Ethnically Diverse Participants

1. A total of 110 people enrolled in the ADAPT program during FY 2022-23 (103 initial enrollments into Level 1 and 7 initial enrollments into Level 2). For Level 1, this was a slight increase from FY 2021-22 (6.2%).
2. The ADAPT program served a racially and ethnically diverse population with the majority (62.7%) identifying as Hispanic/Latino and 17.3% indicating that Spanish was their primary language.

Participants Experienced Improvements and Viewed ADAPT Program Favorably

3. As reported through both clinician and participant assessments (described in more detail below), ADAPT participants experienced substantial reductions in depression and anxiety symptoms. Clinicians reported improved perceptions of participant recovery and illness management, particularly with regard to symptom distress, impairment in functioning, progress toward goals, and knowledge of and coping with their mental health. Participants reported improved mood and ability to think, satisfaction with relationships, and ability to carry out day-to-day activities. Fatigue and distress from emotional struggles decreased while participants reported increased hope as well as skills and resources to manage stress.

4. All ADAPT participants (100%) expressed satisfaction with the services received and that they now know where to get help when they need it. More than 95% of clients report that as a result of participating in ADAPT, they are now comfortable seeking help. Participants rated highly the availability and range of services as well as the cultural sensitivity of staff. One participant stated, "I have had the best experience here. My therapist really cares and always advocates for me."

ADAPT Program Continued to Evolve to Support Effective and Sustainable Service Delivery

5. During FY 2022-23, the ADAPT team continued to increase the amount of ADAPT treatment and support services delivered via telehealth while also providing more in-person services than was possible during the earlier years of the pandemic. Feedback indicated that most participants preferred a hybrid service delivery model with both telehealth services and the option for in-person connections as needed. However, some participants still expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of the ADAPT program's flexibility and ability to personalize how services are provided to specific participants.

ADAPT Program Continued to Foster Partnerships

6. In a survey of ADAPT's many community referral partners, respondents reported that ADAPT has helped to ensure that their patients are connected to appropriate mental health services. Referral partners positively highlighted the ease of the referral process, care coordination, and communication with ADAPT providers. Many expressed a desire for expanded eligibility for the program, particularly related to health insurance restrictions (i.e., needing to have or be eligible for Medi-Cal).

7. In FY 2022-23, the ADAPT program manager and staff continued outreach efforts to increase referrals. Meetings with groups such as the regional PHN programs, San Diego Workforce Partnership, Family Support Connection, SAY San Diego and many others occurred to facilitate referral connections. ADAPT was represented at local conferences such as the 2022 Live Well Advance & School Summit, as well as the International Marcé Conference for Perinatal Mental Health.

8. Ongoing communication remains critical to effective coordination between ADAPT and PHN nurses. The ADAPT team facilitated six Mental Health Roundtable training opportunities for PHN programs. Presentation topics included: the peer support role at ADAPT; a training entirely in Spanish to facilitate a dialogue regarding culture, language, and mental health; training on Perinatal Mood and Anxiety Disorders (PMADs); case consultation opportunities; a review of peripartum treatment programs

including substance use disorders (SUD) during the peripartum period; and a training in Art Therapy which included the power of art, experiential practice, and reflection.

9. As described in more detail below, the ADAPT team continued to collaborate with UCSD to pilot test the integration of an evidence-based Sleep and Light Intervention (SALI) into ADAPT services, with preliminary results suggesting that: 1) SALI contributed to a reduction in depression symptoms among peripartum women and 2) SALI was feasible to implement within a community-based program such as ADAPT.

Conclusion

During FY 2022-23, enrollment into ADAPT continued to increase with over 100 (n=103) participants enrolling into ADAPT Level 1 services. The number of PHN referrals, which significantly decreased during the pandemic, are now on a rising trajectory. Additionally, ongoing outreach efforts to increase awareness of ADAPT throughout the County of San Diego have strengthened the referral network and led to more community connections.

Both clinician and participant assessments indicated that ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Other improvements included better relationships and ability to handle daily activities, as well as better sleep and less fatigue. High levels of satisfaction were reported by participants and echoed by PHNs, who reported substantial benefits for their ADAPT-enrolled clients as related to improvements in their mental health and ability to manage life challenges. ADAPT services also attend to the well-being of participating families by directly providing or facilitating connections to additional resources that allow them to better care for their children and address basic needs related to food, clothing, shelter, and employment. Both participants and PHNs highlighted the importance of having ADAPT, a program that specializes in the unique needs of pregnant and postpartum women experiencing depression, in the community.

Primary Recommendations for FY 2023-24

1. Extend the expected duration of peripartum services beyond six months, as peripartum depression typically occurs during pregnancy and for up to at least a year post-pregnancy.

2. Update privacy practices to better match participant preferences for communication and improve accessibility by allowing engagement through text, alert systems and/or mobile applications.

3. Increase funding to support staff retention and minimize staffing turnover, which disrupts continuity of care and relationship-building. Specifically, resources are needed to reduce staff travel burden and increase training opportunities.
4. Continue community outreach to support communication and collaboration with existing and new referral partners to promote awareness of ADAPT and identification of appropriate referrals.

5. Develop a triage, case management/care coordination program specially designed to support individuals getting connected to the best-fit services and align with “no wrong door” policy, particularly for those referred to, but not eligible for, ADAPT services.

6. Reduce administrative burden and non-billable activities by updating policies to allow for strategic utilization of technologies, such as DocuSign, to improve efficiency and accessibility.

7. Continue emphasis on participant "choice and voice" in how services are provided and continue refinement of hybrid service provision models that integrate in-person and remote (e.g., telehealth) interactions.

Program Description

The County of San Diego HHSA BHS ADAPT program is funded through the INN component of the MHSA, with services provided by behavioral health clinicians and peer support staff from Vista Hill Foundation, a community-based nonprofit organization. MHSA INN funding for ADAPT services was extended and is now expected to continue through 12/31/2023. Based on the positive results achieved by the ADAPT program during the INN-funded pilot project phase, also BHS determined that ADAPT services should be integrated into the overall BHS system of care with the specialized peripartum services to continue past the end of the INN-funded services on 12/31/2023.

ADAPT provides mental health services to clients of HHSA's public health NFP and MCH home visiting programs who have, or are at risk of, perinatal mood or anxiety disorders. The NFP is a free, voluntary program that provides in-home nurse visitation services to qualifying first-time mothers, many of whom are low-income, prior to their 28th week of pregnancy and through the child's second birthday. Through NFP, PHNs provide support, education and counseling on health, behavioral, and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides in-home nurse visitation to at-risk, pregnant, and postpartum women and their children from birth to five years old. Similar to NFP, PHNs in the MCH program provide support, health and parenting education, address bonding issues, medical, and mental risks.

The ADAPT program was developed in response to concerns about the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs, and the desire to prevent the negative consequences often related to perinatal mood disorders including challenges to the family unit, difficult infant temperament, emotional and cognitive delays in children, and suicidal ideation. ADAPT provides therapeutic treatment, peer support and advocacy, linkages and navigation to community resources, family support, and other therapeutic interventions such as skill-building education, group skill-building, and case management. Services are evidence-informed and include care coordination and case consultation. While ADAPT was designed to primarily provide in-home services, the COVID-19 pandemic demanded flexibility, which turned out to be a valuable component of ADAPT that remains today. Services are now provided in a variety of ways: in-home, via telehealth and even telephone when necessary.

A key innovative component of the ADAPT program is the partnership between ADAPT mental health clinicians, PHNs, and the certified peer support partners. During FY 2021-22, ADAPT began accepting eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

The ADAPT program was designed to provide two tiers of services:

- **Level 1** participants meet criteria for Title IX specialty mental health services and peripartum criteria, evidenced by significant functional impairments including but not limited to clinically significant depression and/or anxiety. The persons in Level 1 received ongoing therapy as well as other supportive services.

- **Level 2** participants did not meet full criteria for specialty mental health services and presented with less acute symptoms. However, they demonstrated impairments in functioning as well as risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors.
    - Level 2 also includes participants who would meet BHS eligibility for Level 1 services but are receiving services from another mental health provider or are not interested in receiving mental health services at the time of initial assessment.
    - Since ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce symptoms of maternal and paternal mental health disorders, Level 2 could also include family members of Level 1 participants.

COVID-19 Impact

In FY 2020-21, COVID-19 severely impacted the ability of the ADAPT program to provide in-home assessments and clinical sessions. Initially, services transitioned to telephone. As comfort level and capability with technology increased, the emphasis shifted to telehealth as the video component enabled the participants and service providers to see one another during sessions. As federal- and state-guided COVID-19 precautions became less stringent, ADAPT reinstated efforts to meet in person with participants. Initially, in-person visits typically occurred in outdoor settings accessible to the participant. Once COVID-19 safety guidelines permitted, providers were able to meet with clients in their homes or other preferred settings. Reflecting these broad changes in service delivery, during FY 2022-23 most services were still provided via telehealth while only about 15% were provided face-to-face (see Table 3).

Participant Characteristics

A brief overview of ADAPT participant characteristics is presented here, with a more complete listing in the appendix. As shown in Table 1, a total of 110 unique persons enrolled in the ADAPT program during FY 2022-23 (103 initial enrollments into Level 1 and 7 initial enrollments into Level 2). The 110 people enrolled into ADAPT during FY 2022-23 represented 109 different families with a total of 201 children in the households (including those not yet born at the time of ADAPT program enrollment). The 103 persons enrolled into Level 1 services during FY 2022-23 represented a slight increase (6.2%) from the 97 enrolled during FY 2021-22. A significant number of ineligible referrals (e.g., individuals with private insurance) was a barrier to enrollment.

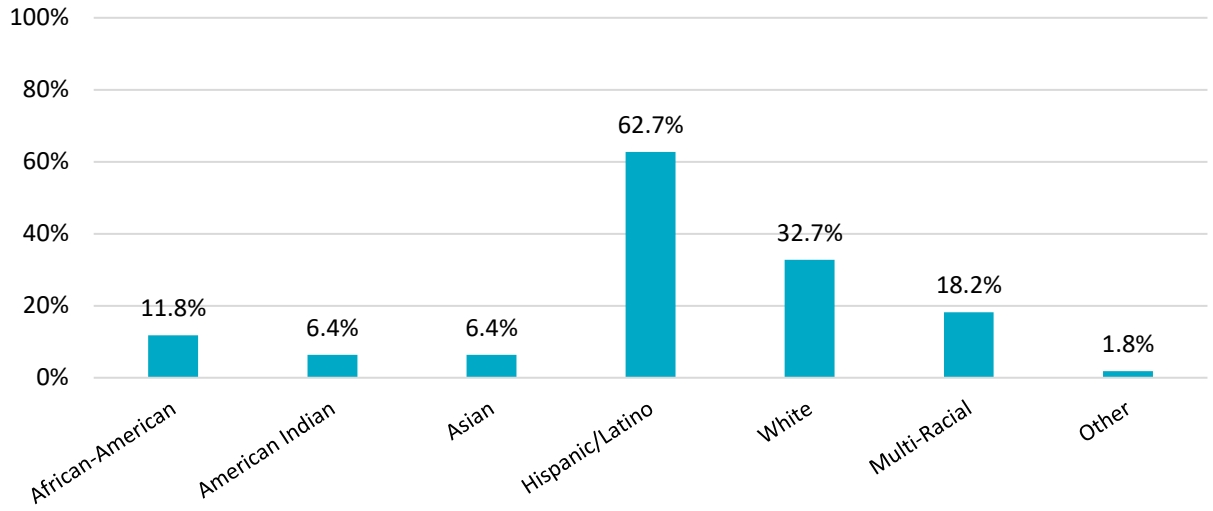
Table 1. ADAPT Program Enrollment for FY 2022-23 (N=110 unique persons)

	FY 2022-23
Enrollment by ADAPT Service Level	**n**
Level 1 services (i.e., ongoing therapy services)	103
Level 2 services (i.e., education and support services)	7
Total unique ADAPT enrollees	**110**

Across both service levels, 99.1% of participants identified as female (n=109). The majority indicated English was their primary language (79.1%; n=87), with 17.3% (n=19) selecting Spanish as their primary

language (served by Spanish-speaking ADAPT staff). Nearly 90% of participants (88.2%; n=97) identified as heterosexual or straight. While the majority of ADAPT participants were aged 26 or older (57.3%; n=63), almost half (42.7%; n=47) were Transitional Age Youth (TAY) aged 18-25. As shown in Figure 1, the ADAPT program served a racially and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (62.7%; n=69).

Figure 1. Race/Ethnicity of ADAPT Participants (N=110)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

ADAPT participants completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE seeks to quantify a person's exposure to specific types of childhood trauma at home. Scores range from 0 to 10, with higher values signifying more traumatic experiences. A score of 4 or more is considered to be a risk factor for experiencing health and mental health problems as an adult. The average ACE score among ADAPT participants was 4.4, with close to half (42.7%) having an ACE score of 4.0 or greater, indicating that many of the persons served by ADAPT have experienced substantial levels of childhood trauma that may be affecting their current well-being.

Utilization of Program Services

Level 1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 describes the number and type of services provided during an average 30-day period by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level 1 during FY 2022-23.

On average, during a 30-day period in ADAPT, participants typically received approximately 4.0 services. Most often, service contacts were therapy (an average of 2.4 services in 30 days) with other supportive services provided as needed (e.g., assessment, case management, and rehabilitation). Therapy visits included both individual, group, and family therapy. Although family therapy was rarely utilized as a specific treatment modality, ADAPT services benefit the overall family unit directly and indirectly through case management and resource support. Of note, ADAPT team members were available to respond to crisis events, but did so on less than five occasions during FY 2022-23. The rarity of such events suggests

that the ADAPT team was generally available to provide support and services that prevented the need for crisis care for almost all participants, highlighting the importance of having a program like ADAPT connected with these persons to address potentially serious situations.

Table 2. ADAPT Level 1 Services during FY 2022-23 (N=139)

ADAPT Service Type	Persons with at least one service		Total ADAPT services provided	Average number of services per person, per 30-day period
	n	%		
Any ADAPT service	132	95.0%	1,753	4.0
Assessment/Tx. plan development	108	77.7%	226	0.5
Therapy (i.e., by licensed clinician)	109	78.4%	1,062	2.4
Rehabilitation (i.e., by peer support or other professional)	32	23.0%	111	0.3
Peer/self-help services	14	10.1%	36	0.1
Crisis	<5[1]	<3.6%	<5[1]	<0.1
Case management	67	48.2%	185	0.4
Other services (e.g., collateral)	61	43.9%	133	0.3

[1]*Exact number masked due to the small number of persons experiencing this event.*

The average time in the ADAPT program was 139.1 days, with a median time of 145 days for the 97 persons who discharged from Level 1 services during FY 2022-23. There was quite a bit of variation in length of engagement, with about 25% participating for less than 50 days and 25% participating for more than 180 days. Overall, the typical length of time receiving ADAPT services was 5-6 months, which was similar to program durations during FY 2021-22.

As shown in Table 3, the method used to deliver ADAPT services fundamentally shifted over the years due to the onset of the COVID-19 pandemic.

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21		FY 2021-22		FY 2022-23	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth	150	9.4%	720	59.3%	1,175	64.7%	1,238	70.6%
Telephone	426	26.7%	368	30.3%	275	15.1%	218	12.4%
Face-to-face	1,011	63.5%	112	9.2%	357	19.7%	292	16.7%
Other	6	0.4%	14	1.2%	9	0.5%	5	0.3%
Total Services	**1,593**	**100%**	**1,214**	**100%**	**1,816**	**100%**	**1,753**	**100%**

Prior to the pandemic, the majority of ADAPT services were provided face-to-face. During the initial months of the pandemic (i.e., the end of FY 2019-20), services shifted to primarily telephone based. As COVID-19 safety concerns decreased from FY 2020-21 to FY 2022-23, the percentage of face-to-face visits

increased (from 9.2% to 16.7%). Telephone visits also decreased during the same timeframe (from 30.3% to 12.4%) due to the increased emphasis on telehealth. Utilization of telehealth has steadily increased over time (9.4% in FY 2019-20 to 70.6% in FY 2022-23) reflecting an increased capacity for and comfort of both staff and participants engaging in this treatment modality.

Level 2 Services

A total of 19 people participated in Level 2 services during FY 2022-23, receiving a total of 256 unique service contacts. This is a decrease in the total number of people receiving Level 2 services and total services provided as compared to the prior year (30 people and 296 services, respectively).

Table 4 highlights the most common types of services provided during Level 2 service contacts, which typically focused on educational/skill-building opportunities or assistance with basic needs. Both staff and participants noted the importance of being able to help address basic needs (e.g., food insecurity) as this can alleviate a major source of family distress. Additional types of supports provided to some Level 2 participants addressed a wide range of other issues including housing assistance, employment services, navigating public benefits or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2022-23 ADAPT Level 2 Service Encounters

	ADAPT Level 2 Service Encounters			
	Total persons (N=19)		Total services (N=256)	
	Number of persons with service	% of persons with service	Number of services	% of total services*
Goalsetting skills	14	73.7%	39	15.2%
Self-Regulation Skills	14	73.7%	75	29.3%
Mental Health Education	14	73.7%	26	10.2%
Mindfulness Skills	11	57.9%	48	18.8%
Basic Needs	11	57.9%	32	12.5%
Physical Health Assistance	9	47.4%	13	5.1%
Parenting Skills	7	36.8%	20	7.8%
Nutrition Education	5	26.3%	7	2.7%

** Total may exceed 100% as multiple services could be provided during an encounter.*

For the 17 persons who discharged from Level 2 ADAPT services during FY 2022-23, the average time in the ADAPT program was 143.6 days (median of 142.0 days). The length of time of Level 2 participation was generally similar to that of persons receiving Level 1 services, with some requiring services beyond the standard 6-month program duration.

Primary Program Outcomes

Due to the small number of Level 2 participants enrolled during FY 2022-23 and their differing service needs, participant outcomes referenced in this section only include Level 1 participants.

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report scale developed to identify individuals who may have postpartum depression in outpatient, home-visit settings, or at the 6-8 week postpartum examination in a physician's office. Individuals indicate which response comes closest to how they have felt over the previous seven days. Each item is scored from 0 to 3, with higher scores reflecting worse conditions/more distress. The maximum score is 30, and scores over 10 are considered to indicate likely depression. The EPDS was administered upon entry into ADAPT and then regularly thereafter as part of clinical/safety assessment and treatment planning (i.e., re-administration of the EPDS was done more frequently than other evaluation measures discussed below due to its direct use as part of treatment and risk assessment/mitigation).

As shown in Table 5, during FY 2022-23 the average EPDS score at intake was 12.4, which reduced to 8.7 at the last EPDS follow-up assessment. This statistically significant change in the total EPDS score reflects an overall reduction in symptoms as reported by ADAPT program participants. A total of 70.4% of all participants demonstrated at least some reduction in depression symptoms at follow-up. A statistically significant reduction of similar magnitude was also identified during the prior year, FY 2021-22 (i.e., from 12.2 at intake to 8.6 at follow-up). Additional analyses that compared the FY 2022-23 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 11.2. This finding suggests that, on average, a reduction in depressive symptoms begins within the first 30 days of ADAPT participation, and continued improvement occurs with further treatment beyond that point.

While the EPDS total score is generally utilized as an indicator of the extent to which a person is experiencing depressive symptoms, an examination of the individual EPDS items can help identify the specific types of changes experienced. For people served by ADAPT, changes were evident across all dimensions. In FY 2022-23, the items with the largest changes from intake consisted of reductions in self-blame, anxiousness, and unhappiness (i.e., average EPDS differences of at least 0.5). While not commonly endorsed at intake, it is important to also note that a critical risk item ("thoughts of self-harm") decreased significantly at follow-up (See Table 5). The pattern of reductions across the individual items paralleled the changes observed in FY 2021-22. Overall, ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

Table 5. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment by FY

	FY 2022-23			FY 2021-22		
		Initial EPDS	Last available EPDS		Initial EPDS	Last available EPDS
EPDS Item	**N**	**Mean** *Scale of 0 to 3 where higher value = worse condition*	**Mean**	**N**	**Mean** *Scale of 0 to 3 where higher value = worse condition*	**Mean**
I have been able to laugh and see the funny side of things	108	0.6	0.5	98	0.5	0.4*
I have looked forward with enjoyment to things	108	0.9	0.5**	98	0.7	0.4**
I have blamed myself unnecessarily when things went wrong	108	1.7	1.4*	98	1.8	1.3**
I have been anxious or worried for no good reason	108	1.9	1.4**	98	1.9	1.4**
I have felt scared or panicky for no very good reason	108	1.4	0.8**	98	1.3	0.9**
Things have been getting on top of me	108	1.8	1.3**	98	1.8	1.4**
I have been so unhappy that I have had difficulty sleeping	108	1.2	0.9*	98	1.3	1.0*
I have felt sad or miserable	108	1.4	1.0**	98	1.4	1.0**
I have been so unhappy that I have been crying	108	1.3	0.8**	98	1.2	0.7**
The thought of harming myself has occurred to me	108	0.2	0.1*	98	0.2	0.1*
EPDS Total Score	**108**	**12.4**	**8.7****	**98**	**12.2**	**8.6****
Likely Depression (i.e., score >=10)	-	**78 (72.2%)**	**41 (38.0%)**	-	**68 (69.4%)**	**41 (41.8%)**

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

Illness Management and Recovery Scale-Reduced

To measure clinician perceptions of client recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. Representatives from ADAPT, BHS and the UCSD evaluation team reviewed and chose 9 of the 15 items from the full IMR that were most relevant to the ADAPT program services and the focal service population (see Table 6). Each item on the scale has a 5-point behaviorally defined response option tailored to that specific domain, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the

amount of potential initial impairment and the extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians.

As shown in Table 6, the initial IMR-R ratings varied substantially across the individual items. For FY 2022-23, average ratings for many items were between 2 and 3, which is generally indicative of moderate impairment. Symptom distress was the lowest rated item at 2.1, indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, medication management and substance abuse were rated as areas that were not a concern (i.e., intake ratings of 4.9 or higher). This pattern of FY 2022-23 intake IMR-R scores was similar to that observed during FY 2021-22.

Table 6. Change in IMR-R Scores from Initial Assessment to Last Follow-up Assessment

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
IMR-R Item	**N**	**Mean** *Scale of 1 to 5 where higher value = better functioning*	**Mean**	**N**	**Mean** *Scale of 1 to 5 where higher value = better functioning*	**Mean**
Progress towards personal goals	69	2.6	3.7**	62	3.0	3.5**
Knowledge about symptoms, treatment, coping strategies, and medication	72	3.0	3.8**	64	3.0	3.7**
Involvement of family and friends in MH treatment	73	2.8	3.2*	64	2.8	3.3**
Symptom distress	73	2.1	3.3**	64	2.2	3.2**
Impairment of functioning	73	2.6	3.6**	63	2.6	3.4**
Coping with mental or emotional illness from day to day	73	2.8	3.7**	64	2.8	3.7**
Effective use of psychotropic medication	7[1]	4.9	4.4	4	5.0	5.0
Impairment of functioning through alcohol use	71	5.0	5.0	62	5.0	5.0
Impairment of functioning through drug use	71	5.0	5.0	62	5.0	5.0
Overall	**73**	**3.2**	**3.9****	**64**	**3.3**	**3.9****

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

[1] This item was only completed for participants who were taking psychotropic medications at the time of the initial and last IMR-R assessment.

During FY 2022-23, the overall IMR-R score increased from 3.2 to 3.9, indicating a statistically significant change and clinically meaningful improvements within the participant population. Among the individual items, medication management and substance use maintained their positive intake levels (i.e., high functioning/less impairment), and many of the other items achieved a gain of 0.5 to 1.0. Particularly notable were the ratings of symptom distress improving from 2.1 to 3.2, indicating clients went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. Consistent with prior year results, FY 2022-23 IMR-R results indicated the achievement of important improvements in minimizing symptom distress and impairment while also increasing knowledge, coping skills, and progress towards personal goals, which help to maintain benefits and minimize risk of future symptom recurrence.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool administered to participants upon enrollment into ADAPT and then every 90 days thereafter. Survey items were rated on a scale from 1 to 5, with higher values representing better reported wellness.

During FY 2022-23, self-reported improvements occurred across multiple dimensions with statistically significant changes occurring for ratings of quality of life, physical health, mental health/mood, satisfaction with social activities/relationships, ability to carry out everyday activities, emotional problems, sleep, and fatigue (see Table 7). Notably, ratings of hopefulness about the future also improved substantially as well as belief that they have the skills and resources needed to manage stress related to interpersonal conflicts. Findings from FY 2022-23 were similar to those identified during FY 2021-22.

Table 7. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items	**N**	**Mean** *Scale of 1 to 5 where higher value = better condition*	**Mean**	**N**	**Mean** *Scale of 1 to 5 where higher value = better condition*	**Mean**
In general, would you say your quality of life is:	72	3.1	3.3*	65	3.2	3.5**
In general, how would you rate your physical health?	71	2.8	2.9	65	2.9	3.2*
In general, how would you rate your mental health, including your mood and your ability to think?	71	2.2	3.0**	65	2.3	3.1**
In general, how would you rate your satisfaction with your social activities and relationships?	70	2.6	3.1**	65	2.5	3.1**
In general, please rate how well you carry out your usual social activities and roles.	72	3.0	3.4**	65	3.0	3.4**
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	72	4.0	4.5**	65	3.8	4.2*
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	72	2.4	3.2**	65	2.3	3.2**
My child(ren) had emotional and/or behavioral problems.	51	4.1	4.0	48	3.9	4.0
I felt hopeful about the future.	72	3.6	4.1**	65	3.7	4.0^
I felt spiritually connected.	72	3.4	3.7*	65	3.6	3.8
I lived in a home that made me feel safe.	72	4.6	4.7	65	4.6	4.7
I used substances (alcohol, illegal drugs, etc.) too much.	72	4.8	4.8	65	4.9	4.9

Table 7. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (continued).

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items	**N**	**Mean** *Scale of 1 to 5 where higher value = better condition*	**Mean**	**N**	**Mean** *Scale of 1 to 5 where higher value = better condition*	**Mean**
How would you rate your fatigue on average?	72	3.0	3.4**	65	2.8	3.3**
I get the emotional help and support I need from supportive others.	72	3.5	3.8	54	3.6	3.8
When I am in distress, I can identify supportive others and may use my supportive others.	72	3.6	3.8	54	3.9	4.1
Conflict with my partner or supportive others interferes with my ability to respond to everyday life challenges.	72	3.7	3.9	54	3.5	3.8
I have the skills and resources needed to manage stress stemming from conflict with my partner or supportive other.	72	3.3	4.0**	54	3.6	4.1**
	N	**Mean** *Scale of 1 to 10 where higher value = worse condition*	**Mean**	**N**	**Mean** *Scale of 1 to 10 where higher value = worse condition*	**Mean**
How would you rate your sleep?	72	5.5	4.7*	54	5.8	2.6**
How would you rate your sense of rest?	72	6.0	5.0*	54	6.0	2.6**
How would you rate your alertness?	72	3.8	3.3	54	4.1	2.5
How would you rate your pain on average?	72	2.9	2.3	65	3.5	2.9**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

ADAPT Participant Feedback Survey

Every 90 days and at discharge, ADAPT participants were asked to rate the extent to which they were achieving specific ADAPT objectives. For FY 2022-23, 100% of participants indicated they knew where to get help and 92.9% indicated they were better able to handle things because of participating in ADAPT (see Table 8). Further, participants were extremely positive about their experiences. At least 95% indicated that services were available at convenient times, they were able to receive all services needed, that staff were sensitive to cultural background, and they were satisfied with services. These findings, particularly as related to service availability and cultural support, indicate that the ADAPT program has accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 8. ADAPT Participant Feedback Survey

	FY 2022-23 (N=70)	FY 2021-22 (N=65)
ADAPT Participant Feedback Survey Item	**Agree/Strongly Agree**	**Agree/Strongly Agree**
As a result of participating in ADAPT:	**%**	**%**
I know where to get help when I need it.	100%	93.8%
I am more comfortable seeking help.	95.8%	92.3%
I am better able to access services in the community.	89.9%	90.8%
I am better able to handle things.	92.9%	92.3%
Experiences with ADAPT services:	**%**	**%**
Services were available at times that were good for me.	95.7%	98.4%
I was able to get all the services I thought I needed.	97.2%	98.4%
Staff were sensitive to my cultural background (race, religion, language, etc.).	98.5%	98.4%
Overall, I am satisfied with the services I received here.	100%	98.4%

In June 2023, the UCSD evaluation team and ADAPT leadership developed a series of questions with BHS input to elicit additional feedback about the program from participants. A total of 20 program participants provided feedback. Given that this information was collected from a sample of people receiving services at one particular time during the FY, the findings may not reflect the perceptions of all ADAPT participants. Additionally, it should be noted that the interviews were conducted by ADAPT program staff and therefore could be positively biased. However, many of the findings were consistent with data collected in prior years and via other feedback mechanisms such as the ADAPT Participant Feedback Survey administered throughout the year, which increases confidence in their generalizability to the overall ADAPT program.

Many respondents (65.0%; n=13) indicated that they had not received services and/or medication to help with mental health or substance use related concerns in the five years prior to ADAPT participation. For some clients, the peripartum depression and anxiety symptoms experienced may be their first mental health challenges that rose to the level of needing intervention. For others, they may have had difficulty with or discomfort seeking services for symptoms in the past. Regardless of past need or level of usage, participants noted that ADAPT offers timely support and mental health resources. Nearly all respondents (90%; n=18) said they would refer a friend or family member to ADAPT. They described how the program helped them, so it could help others as well. One participant stated, “I have had the best experience here. My therapist really cares and always advocates for me.”

The following sections present key themes that emerged from the qualitative participant responses.

The ADAPT Program was Different from Prior Treatment Experiences

Clients shared feedback about ADAPT as compared to services they had received previously. A selection of comments are as follows:

> "I have a peer support partner which is less formal and is comfortable for me. She also comes to my home which is different."
>
> "The consistency of meeting with someone weekly was super helpful. Also, I would not have been able to afford care like this on my own. I am so grateful to have gotten this counseling at no cost!"
>
> "ADAPT staff cares. My therapist went above and beyond. The support felt different."
>
> "The postpartum specialization is different, and I've never had the option for the peer support aspect. I also like the ability to call my therapist if I needed to."

Client Preferences for In-Person and Telehealth Services Vary

When ADAPT began in FY 2019-20, services were primarily provided in person. Due to the onset of COVID-19, there was a rapid shift to remote services (i.e., telephone or telehealth with video). As safety demands of COVID-19 have decreased, clients have had more opportunities for in-person visits when desired. When asked about their preference between the available options (i.e., in-person vs. remote), respondents answered as follows:

- 10 respondents (50.0%) stated they prefer only/primarily remote services
- 6 respondents (30.0%) indicated they prefer having both remote and in-person services
- 3 participants (15.0%) stated they prefer only/primarily in-person services

The primary reason for preferring remote services was convenience. Others preferred telehealth due to the flexibility and/or other obligations, for example, "The convenience of having my baby near in case she needs me while being able to pay full attention to the session." Clients who appreciated the choice between in-person and remote services shared, "Because sometimes it's more flexible to meet via zoom" and "Video calls are convenient when I'm busy. It's also nice seeing my peer support partner in person." For the remaining clients, they found in-person services to be more attentive and personable. As one client who preferred in-person services shared, "I find meeting with someone in person more personable and it's also easier for me not to get distracted."

This feedback highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.

Positive Impact of ADAPT on Clients

All 20 of survey respondents (100%) stated that ADAPT has had a positive effect on their life. Impacts included improved communication skills, emotion management, relationships, and better understanding of themselves and/or others. Responses included the following:

> “I have learned so many helpful tools to manage the extreme emotions from postpartum. This has helped my marriage immensely and given my husband and I the tools to work through our stress and be better partners and parents.”
>
> “Being part of the program helped me understand myself better which has improved my relationships. I learned about my attachment style, how to show myself self-compassion, and I feel like I have better skills as a mom with multiple children.”
>
> “I have overcome my trauma and learned how to respond to stress and challenges in a healthier way. I have a better relationship with my [family].”

Other clients mentioned a new awareness of community resources. Furthermore, they felt heard and supported based on their experiences in ADAPT.

Participant Recommendations

More than half (55.0%; n=11) of the survey respondents offered no recommendations to improve the program and were happy with it as is. Approximately 15.0% (n=3) suggested that to improve ADAPT, the length of program should be extended. Other suggestions were about increasing options for electronic communication, specifically the desire to be able to text their therapist or for there to be an app to keep track of appointments (as well as cancel or reschedule appointments). As one participant shared, "I've tried mental health services that had their own app and that could be helpful to have everything contained in one place. I could message my therapist, log in to my sessions and have even more security, even though that is not something I worry much about." Another participant suggested that ADAPT should be “accessible to all new moms…having it as an option after childbirth and getting new moms enrolled right away.”

Referral Partner Feedback Survey

In June 2023, PHNs and other referral partners were asked to complete a brief online survey to obtain feedback regarding their experiences with the ADAPT program. Survey questions were largely open-ended and served to explore referral partners’ understanding of the ADAPT program and elicit recommendations for program improvement. A total of 108 referral partners (e.g., PHNs and representatives from seven other service providers) were invited and 42 completed the online survey for an overall response rate of 38.9%. At the organizational level, 87.5% of organizations had at least one respondent complete the survey. While the response rate for individuals may warrant some caution when interpreting the results, the core themes (presented below), were consistent with feedback received in prior years and from other feedback mechanisms such as through the PHN consultations and roundtables. Those who did participate generally had an ongoing relationship with the ADAPT program with the majority (71.4%; n=30) indicating they had referred at least three clients and 47.6% (n=20) having referred 6 or more clients to ADAPT in FY 2022-23. Responding referral partners represented public health programs (71.4%; n=30), local hospitals and clinics (14.3%; n=6), and other community agencies (14.3%; n=6). While the sample sizes were too small for detailed comparisons and conclusions, in general, the feedback was similar between the types of referral partners. Several themes emerged from the referral partners’ feedback.

Increased Access to Care

Almost all respondents (97.6%, n=41) mentioned that the ADAPT program has helped to ensure that their patients are connected to appropriate mental health services and significantly increased overall support for patients (92.9%; n=39). Specifically, referral partners most commonly selected "opportunities/availability for case consultation," (83.3%; n=35) and "increased mental health competency for nurses through education, consultation, and/or collaboration" (57.1%; n=24) as the key ways in which a partnership with ADAPT has enhanced their ability to serve clients. In addition, referral partners noted the ease of the ADAPT program's referral process.

Desire for Expanded Eligibility

Given the overall success of clients who engage with ADAPT services, in the prior fiscal year (2021-22) many referral partners expressed a desire to have wider eligibility requirements for the program. This theme emerged again in the FY 2022-23 survey, with 33.3% (n=14) of referral partners mentioning private insurance as a barrier to services. One referral partner remarked that ADAPT "only accepts Medi-Cal and we receive many referrals for individuals with private or dual insurance."

Program Benefits

The majority of referral partners highlighted "care coordination" (71.4%; n=30) followed by "communication with ADAPT providers," (52.4%; n=22) and "the referral pathway" (52.3%; n=22) as aspects of the ADAPT program that were working particularly well. Referral partners shared that their clients have had positive feedback about ADAPT:

> "My clients who stick with the program find it very helpful with managing symptoms of anxiety and depression."

Referral partners also shared what they perceived as potential negative impacts of not having a program like ADAPT available:

> "Negative impact on clients, some may be able to get care through their medical provider, but the ability to offer a resource specific to their needs in relation to maternal-child health and interactions is a comfort on its own. If their provider isn't able to assist, having ADAPT is an additional safety net for them and gives them some comfort just knowing its available to them."

> "If ADAPT services were no longer available, it would be very difficult to find an accessible resource for our clients. It is challenging to find and contact other local resources in a timely manner regarding service availability and eligibility, the partnership that ADAPT has with our programs has been such a big help."

PHN survey respondents, in particular, highlighted the benefits of participating in ADAPT with 86.2% (n=25) indicating that the ADAPT program helped with reducing the mental health symptoms of their clients.

Program Challenges

Lack of participant buy-in (i.e., openness to services, willingness to participate, motivation) was the most prominent challenge among referral partners (47.6%, n=20), followed by barriers to engagement (i.e.,

transportation, childcare, accessibility issues) (35.7%, n=15), and clients not knowing or understanding requirements (28.6%, n=12). Referral partners acknowledged the importance (and challenges) of coordinating communication and follow through after they submit a referral to ADAPT. They also requested expanded eligibility and an extension of the program service time. In terms of service, referral partners recommended that more in-person visits be allowed and that clinicians can receive and return texts from clients.

Additional Program Activities

Community Resources and Engagement

Support of Public Health Nurses

ADAPT continued to provide support to the PHNs by providing 219 case consultations in FY 2022-23. During these case consultations, ADAPT clinicians and Peer Support may provide PHNs with care coordination regarding participants goals, progress, gains, and identified needs; education and collaboration on ways in which providers can work together to meet participant goals; psychoeducation on participants behavioral health symptoms, impairments, and state change; and plan of care updates and collaboration. In addition, consultations may include programmatic eligibility and treatment recommendations. ADAPT also facilitated six Mental Health Roundtable training opportunities for PHNs. Presentation topics included the following: the Peer Support role at ADAPT, including the importance of this role, collaborative role characteristics, education, and examples of case conceptualizations; a training entirely in Spanish, facilitating a dialogue regarding culture, language, and mental health; a case consultation opportunity, review of PMADs, and review ADAPT services; a case consultation opportunity, review of Peripartum Treatment Programs and Services, SUD and the Peripartum Period, and ADAPT referral process; Training on PMADs and Sleep and Light intervention; and a training on Art Therapy, the power of art, experiential practice, and reflection.

Community Outreach to Increase Awareness of ADAPT

In addition to regular communication with PHNs and periodic "roundtables" to allow for greater education about ADAPT and provide opportunities for asking questions of ADAPT team members, ADAPT representatives attended community meetings and presented information about ADAPT to other potential referrals sources including: the Postpartum Health Alliance, Perinatal Care Network at 2-1-1 San Diego, San Diego Workforce Partnership, YMCA, Neighborhood House Association, Black Infant Health, American Academy of Pediatrics, First Five First Steps, Sharp Mary Birch, and Best Start among others. These efforts to enhance community partnerships directly support the ADAPT scope of work and resulted in a total of 274 referrals to ADAPT during FY 2022-23 (193 from PHNs and 81 from other community organizations).

Connection to Community Resources

ADAPT helps participants connect to and navigate community resources that both increase their immediate quality of life as well as work toward future goals. For example, ADAPT helped participants to obtain necessary baby care items, including baby formula, laundry detergent, diapers, pacifiers, baby wipes, swaddles, and baby soothers from donation funding through Vista Hill. A recipient shared, "I've been so stressed about financial stuff and working full time is still hard to make ends meet. I just feel so

thankful and it's such a relief to have these things for my son." One participant was provided with a multi-motion baby swing and others were given gift cards to address basic needs like groceries. ADAPT helped participants connect with clothing resources for older children and professional clothing for job interviews, emergency food supplies and hygiene items. Another participant successfully accessed childcare resources with ADAPT support and is working towards gaining employment.

Housing resource connections were another area of assistance. For example, a new Level 1 participant shared significant distress surrounding housing insecurity at admission. The participant was immediately provided with multiple resources to access housing and support their goals in this area. Within a week, the participant was able to contact, apply, and access housing services with Home Start. Other participants received assistance with applying for housing vouchers and/or rental assistance such as that offered by San Diego Housing Commission.

Another notable community connection was made with the Chula Vista Ladies Quilt Guild who provided ADAPT with handmade quilts for participants. Additionally, the ADAPT team worked to assemble holiday gift donations for participants as well as participant's children. The staff supported many families with limited economic resources through providing access to meaningful gifts and by delivering the gifts to the participants. ADAPT staff reported experiencing great joy while supporting participants during the holiday season.

ADAPT Participation in UCSD Research to Improve Perinatal Depression Treatment: The Sleep and Light Intervention (SALI) Study

The SALI community-academic research partnership continued throughout FY 2022-23. SALI is a brief (two-week), non-pharmacological, in-home intervention that utilizes a one-night adjustment in the timing and duration of sleep. The adjusted sleep night is coupled with two weeks of a 30-minute per day light therapy box session at a specified time to reset circadian rhythms and reduce perinatal depressive symptoms. This protocol has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression in research settings.

As part of an effort to move SALI into community settings, the pilot research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry is designed to test the feasibility, acceptability, and effectiveness of training community providers to deliver SALI. ADAPT participants are informed of the opportunity to participate in SALI as an additional strategy to address their depressive symptoms and are given the choice as to whether they would like to enroll in the pilot study of the SALI for treating peripartum depression. This study was approved by County BHS and the UCSD Institutional Review Board (IRB) and administered by ADAPT clinicians. The study is ongoing with initial results indicating meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors. Additionally, feedback from staff indicated that it is feasible to integrate SALI into usual care practices and that participants were able to successfully complete the steps of SALI. The first night of adjusted sleep was challenging for some, so the UCSD and ADAPT team collaborated to develop a "Mom's Night In" resource document intended to help women develop a plan for engaging in pleasant self-care activities during the one night of adjusted sleep. The findings to-date suggest that SALI is a feasible and effective treatment approach for addressing peripartum depression within community care settings. The information learned from this study is expected to inform future widespread dissemination of SALI to other community care providers and programs that treat perinatal depression.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was a brief online questionnaire conducted at the end of FY 2022-23 inquiring about experiences with, perceptions about, and recommendations for the program. Of the 13 ADAPT staff invited to participate, 12 completed a survey for a response rate of 92.3%. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes.

Program Strengths

Team and Leadership

When asked about strengths of the ADAPT program, nearly every staff member mentioned the quality of the team and leadership. Staff described the team as "dedicated" and highlighted the team's willingness to "adapt to the individual and nuanced needs of our participants." Another staff member shared that "The ADAPT program has great supervision provided to the clinicians and the team is very supportive of personal growth and learning. The team also supports clients and ensures continuity of care."

Flexibility

The flexibility of the ADAPT program was also noted as a strength. As one staff member described, "The flexibility of being able to work remotely/hybrid has been really helpful in being able to reach and provide services to more individuals." Others mentioned the uniqueness of ADAPT in this respect; the flexibility offered is not typically characteristic of mental health service agencies. As one staff member stated, "clinicians can use Telehealth which gives them more flexibility for scheduling client sessions."

Accessibility

Since the start of the COVID-19 pandemic, staff have found unique ways to meet with participants while ensuring safety. Appointments are set up via telehealth, outdoors with social distancing, or via the phone. ADAPT staff arrange times to drop off tangible items such as diapers, formula, and other necessities without face-to-face contact.

Staff credited this accessibility as a key component of program success and contributing factor their ability to reach more participants. Offering both telehealth and in-person services has been beneficial to both staff and participants. Offering bilingual services, both from clinicians and peer partners, was highlighted as another key component of successful recruitment and retention. As one survey respondent remarked, "Flexibility and availability to meet participant needs including but not limited to hybrid remote positions, efforts to hire and recruit Spanish-speaking clinicians, and advocating for both internal forms and partnerships to include Spanish-speaking participants."

PHN and ADAPT Program Coordination

Compared to FY 2021-22, ADAPT staff during FY 2022-23 describe the positive collaboration between themselves and PHN. One staff member noted the benefits of PHNs gaining more "knowledge of ADAPT

services and scope of practice." Another staff member shared the advantages of PHNs engaging and communicating with clients "if clients are not engaging" in ADAPT services.

Program Challenges

Staff reported waitlists for services, documentation requirements, and ineligible referrals among key challenges for the program. Other challenges mentioned by staff included resource awareness of community programs, client engagement, and telehealth access issues.

Resource Awareness

Although one staff member stated that the team "all pulled from one another's knowledge regarding resources in San Diego to support our clients," to assist with the processing of ineligible referrals, other staff members noted the need for increased knowledge of community programs. For instance, one staff member stated that "connection with housing, childcare, and employment/school resources," was a major challenge in providing and continuing services. Another staff member shared the following:

> "San Diego County programs are impacted heavily so it is very difficult for people to get the resources that they need. Housing is impacted. Childcare is impacted or costs too much and financial assistance is very difficult to maneuver and obtain. Low-income housing is still too expensive for mothers who don't have jobs and don't have anyone to watch their children to get jobs."

Engagement

As was the case in prior years, efforts by ADAPT staff to keep participants and referral partners engaged in the program have been substantial. Staff reported frequent and consistent communication and scheduling flexibility as two key components in retention. Several staff mentioned the potential benefit of expanding allowable communication methods to include texting and e-mailing clients.

One unique aspect of ADAPT is the inclusion of family members in the treatment process. As the participant must approve of included family members, one staff member pointed out the importance of engaging "family members in a variety of case management and counseling avenues." Other staff added that it is good practice to invite key support people for a session with the client and explain to them the many facets of pregnancy and motherhood physically and emotionally. However, not all clients have familial support, as one staff member noted, "Many of our clients don't have support from their family members or their family members are a source of conflict and trauma. I've also had clients who are supported by their family but are not interested including them in their treatment goals." Another survey respondent suggested "offering psychoeducation handouts or worksheets that the participant can use with their family members. psychoeducation for clients on how to discuss mental health and treatment with family members."

Telehealth

Based on FY 2022-23 survey responses, the majority of staff liked providing telehealth services. While the telehealth option does come with some challenges, staff reported that internet interruptions disrupted services less than 10% of the time. ADAPT staff facilitated efforts to successfully keep clients connected to telehealth services which included searching for a location with sufficient connectivity and/or "hotspots" if maintaining an internet connection is difficult and/or helping clients navigate technological

steps for accessing telehealth services. Where telehealth was not feasible or desirable, ADAPT provided in-person services. Despite these challenges, staff perceived numerous benefits of providing telehealth service options to clients; for instance, one staff member shared that delivering "services via telehealth has allowed the clients to meet more consistently with their therapist for sessions."

ADAPT Staff Recommendations and Additional Feedback

Several survey respondents shared a desire for more support and educational materials. ADAPT staff would like more opportunities for training, including perinatal and peripartum mental health, Eye Movement Desensitization and Reprocessing (EMDR), and Dialectical Behavior Therapy (DBT). The staff also suggested the need to increase administrative support to assist with the documentation requirements. As one staff member stated there are "…changes to documentation and various role's responsibilities. Clarity around these changes and requirements that is actually consistent would allow us to carry out our duties more smoothly." To reduce turnover, staff recommended wage increases, hiring additional peer support, extending the length of the program, and updating program policy to allow texting and e-mailing clients.

Changes from Initial Program Design

There were no significant changes to the overall design or strategy of how ADAPT services were provided during FY 2022-23. The ADAPT program continued to engage in community outreach activities to expand the number of potential community referral partners and increase the network of organizations that can provide additional supplemental resources for ADAPT clients.

Program Recommendations

1. Extend the expected duration of services beyond six months, as peripartum depression typically occurs during pregnancy and for up to at least a year post-pregnancy.
2. Update privacy practices to better match participant preferences for communication and improve accessibility by allowing engagement through text, alert systems and/or mobile applications.
3. Increase funding to support staff retention and minimize staffing turnover which disrupts continuity of care and relationship-building. Specifically, resources are needed to reduce staff travel burden and increase training opportunities.
4. Continue community outreach to support communication and collaboration with existing and new referral partners to promote awareness of ADAPT and identification of appropriate referrals.
5. Develop a triage, case management/care coordination program specially designed to support individuals getting connected to the best fit services and align with "no wrong door" policy, particularly for those referred to, but not eligible for, ADAPT services.
6. Reduce administrative burden and non-billable activities by updating policies to allow for strategic utilization of technologies such as DocuSign to improve efficiency and accessibility.
7. Continue emphasis on participant "choice and voice" in how services are provided and continue refinement of hybrid service provision models that integrate in-person and remote (e.g., telehealth) interactions.

Conclusion

During FY 2022-23, enrollment into ADAPT continued to increase with over 100 (n=103) participants enrolling into ADAPT Level 1 services. The number of PHN referrals, drastically lessened during the pandemic, are now on a rising trajectory. Additionally, ongoing outreach efforts to increase awareness of ADAPT throughout the County of San Diego have strengthened the referral network and led to more client connections.

Both clinician and participant assessments indicate that after participating in ADAPT, individuals experience substantial reductions in depression and anxiety symptoms and improve their ability to manage their emotional well-being. ADAPT services also attend to the well-being of participating families by directly providing or facilitating connections to additional resources that allow families to better care for their children and address basic needs related to food, clothing, shelter, and employment. Other reported improvements include better social relationships and ability to handle daily activities, as well as better sleep and less fatigue. High levels of satisfaction were reported by participants and echoed by PHNs, who report substantial benefits for their ADAPT-enrolled clients as related to improvements in their mental health and enhanced ability to manage life challenges. Both participants and PHNs highlighted the importance of having ADAPT, a program that specializes in the unique needs of pregnant and postpartum women experiencing depression, in the community.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants Who Enrolled During FY 2022-23

Characteristic	Total Participants (N=110)	
Gender	**n**	**%**
Female	109	99.1
Male	1	0.9
Total	**110**	**100**
Age Group	**n**	**%**
18-25	47	42.7
26-35	46	41.8
>35	17	15.5
Total	**110**	**100**
Primary Language	**n**	**%**
English	87	79.1
Spanish	19	17.3
Other/Missing/Prefer not to answer	4	3.6
Total	**110**	**100**
Race/Ethnicity	**n**	**%**
African American	13	11.8
American Indian	7	6.4
Asian	7	6.4
Hispanic/Latino	69	62.7
White	36	32.7
Multiple	20	18.2
Other	2	1.8
Total[1]	-	-
Sexual Orientation	**n**	**%**
Heterosexual or Straight	97	88.2
Bisexual/Pansexual/Sexually fluid	10	9.1
Another sexual orientation/Missing/Prefer not to answer	3	2.7
Total	**110**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

Appendix (continued).

Characteristic	Total Participants (N=110)	
Military Status	**n**	**%**
Never served in the military	107	97.3
Other/Missing/Prefer not to answer	3	2.7
Total	**110**	**100**
Disability	**n**	**%**
Yes, has a disability	18	16.4
No, no disability	90	81.8
Prefer not to answer	2	1.8
Total	**110**	**100**
Type of Disability	**n**	**%**
Learning Disability	6	5.5
Physical Disability/Chronic Health	8	7.3
Other Physical Disability	10	9.1
Other Mental Disability	<5[3]	<4.5
Total[2]	-	-

[2] *Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.*
[3] *Values were suppressed due to small n size.*

BHCONNECT INNOVATIONS-19

Annual Report (7/1/2022 - 6/30/2023)

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

v.12.22.2023

COUNTY OF SAN DIEGO Health and Human Services Agency | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) focuses on persons who have received crisis-oriented psychiatric care services, but are otherwise unconnected to behavioral health treatment services and identified as likely having barriers to accessing traditional outpatient services. The goal is to reduce the recurrence rate for psychiatric crisis services among these individuals by offering an alternative method of care that relies primarily on telehealth treatment. BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. The BHConnect service provider team is comprised of: 1) licensed and associate clinicians who provide therapeutic care services, and 2) Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. BHConnect provides services to children, youth and families (CYF) and adults/older adults (AOA).

During fiscal year (FY) 2022-23, a determination was made by BHS that the BHConnect program would not continue past the Mental Health Service Act (MHSA) Innovations-funded phase of the pilot program. While recognizing the benefits of the treatment services provided to BHConnect clients, primary reasons for not continuing BHConnect included less than expected enrollment and the greater availability of telehealth services throughout the overall network of BHS-funded treatment service providers. BHConnect stopped enrolling new clients at the end of FY 2022-23 and will focus on completing treatment and/or transitioning care to other service providers during the first part of FY 2023-24.

Primary Findings for Fiscal Year 2022-23

BHConnect Enrollment, Referrals, and Referral Partners

1. During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). This represented an increase of approximately 25% in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served by BHConnect in FY 2022-23. While

BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year.

2. From FY 2021-22 to 2022-23, BHConnect referrals from community partners increased 40.2% (256 to 359). Referrals for CYF clients increased 36.8% (117 to 160) and AOA client referrals increased 43.2% (139 to 199).

3. Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 17 different organizations (7 CYF and 10 AOA) referred at least five clients to BHConnect compared to 12 organizations in FY 2021-22. Many of these referrals (34.7% of CYF and 45% of AOA referrals) enrolled into BHConnect. If enrollment was unsuccessful, the primary reason was that BHConnect was unable to contact the person.

4. BHConnect prioritized a quick response to client referrals, with 31.7% of persons enrolled within one day and over half (51.1%) of persons enrolled within five days of referral.

BHConnect as an Important Community Resource

5. As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by their referral partners throughout San Diego County. Respondents to the Referral Partner Survey highlighted the ease of the referral process, the immediacy of available services, and the minimal (if any) waitlist, which is key in a community where waitlists, transportation, and insurance coverage are significant barriers to those who need services. As one partner noted, "there are other referral options, but they come with longer waitlists and other barriers" and another stated "BHConnect fills a gap in services and overcomes barriers that already exist in which services delivery is compromised."

6. Similarly, respondents in the Participant Survey noted the high quality of services offered by BHConnect. Participants particularly valued the capability of receiving help remotely. Clients highlighted the convenience of telehealth, as childcare and/or transportation barriers are alleviated. Clients stated that they would delay or not seek out treatment if they did not have access to BHConnect services.

BHConnect Program Engagement and Service Delivery Patterns

7. When BHConnect enrollment was unsuccessful, the primary reason was that the program was unable to locate/contact the person (25.6% of CYF and 42.7% of AOA referrals). For both CYF and AOA referrals, only about 16% declined to participate (21.9% and 11.1%, respectively), suggesting a high degree of interest in participating in BHConnect once contact has been initiated. In an effort to increase the number of clients that BHConnect is able to directly engage as part of the referral and recruitment process, during FY 2022-23 BHConnect established an on-site presence at Sharp Mesa Vista to facilitate "warm handoff" from crisis care to outpatient treatment. This practice of co-locating with potential referral sources was originally part of the design of BHConnect, but was terminated at the onset of the COVID-19 pandemic.

8. Individuals, both youth and adult, who enrolled in BHConnect typically participated for about four months. These findings indicate that BHConnect was frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.

9. CYF clients and AOA clients were provided an average of 4.2 and 4.5 BHConnect services per month (i.e., every 30 days enrolled in BHConnect), respectively. This represented a 20% increase for CYF clients and a 5% increase for AOA clients from the prior year.

BHConnect Program Outcomes and Participant Perceptions

10. Service utilization patterns (described in more detail below) indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services as evidenced by fewer inpatient psychiatric hospitalizations, particularly among AOA clients (e.g., 37.5% of AOA clients had psychiatric hospitalizations in the 90 days prior to enrolling in BHConnect compared to less than 6.3% with psychiatric hospitalizations in the 90 days after enrolling in BHConnect). Additionally, decreased crisis stabilization and Psychiatric Emergency Response Team (PERT)/Mobile Crisis Response Team (MCRT) contacts were evident among CYF clients after enrolling in BHConnect.

11. For clients with assessment data at both intake and follow-up, many youth and adult clients had improvements in well-being and symptom management identified via clinician and self-reported assessments. Nearly half of parents and caregivers reported medium or large improvements in impairment after participation in BHConnect, and another 21.4% reported at least a small improvement. Similarly, adult clients reported significant improvements in illness management and recovery, with lessened need for psychiatric hospitalizations and increased ability to participate in structured roles (i.e., work, student, parent).

12. The target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remained a challenge to serve. However, based on feedback from BHConnect CYF and AOA clients, the BHConnect program accomplished the primary goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services.

Conclusion

During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). To facilitate referrals, BHConnect engaged in outreach efforts including meeting with representatives of potential partner organizations to educate them about available services and develop processes for identifying and screening potential clients. Additionally, they continued to build upon and expand their referral partner network by giving presentations at multiple community service provider meetings to increase awareness of BHConnect services. These efforts were reflected in a 25% increase in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served in FY 2022-23; however, this remained below initial program targets of 250 persons served each year.

Once enrolled in BHConnect and receiving services, both CYF and AOA clients remained in care and typically engaged with BHConnect for approximately four months. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. Additionally, an examination of the data from the electronic health record system that documents participation in county-funded BHS programs indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services. Both youth and

adults experienced fewer inpatient psychiatric hospitalizations after enrolling in BHConnect, and youth also had fewer crisis stabilization visits and PERT/MCRT contacts after engagement with BHConnect.

However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many demonstrating a need for further behavioral health improvements. Homelessness, symptom complexity, attrition and difficulties with electronic devices were identified as barriers in maintaining consistent contact with clients and maintaining engagement in services.

Overall, the BHConnect program continued to experience significant growth during FY 2022-23, but did not reach the intended goal of providing services to at least 250 unduplicated clients. While acknowledging the accomplishments of BHConnect to engage and provide treatment to a population of persons who were previously unconnected to care, BHS determined during FY 2022-23 that the BHConnect program would not continue past the conclusion of the Innovations-funded phase of the pilot program. Primary reasons for not continuing BHConnect included less than expected enrollment into the program and the greater availability of telehealth services at other outpatient treatment programs throughout the BHS system than when BHConnect started.

Program Description

The County of San Diego BHS BHConnect program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). Services are provided through the Vista Hill community-based organization. BHConnect was developed to increase access and connection to follow-up behavioral health services after a psychiatric emergency in which a San Diego resident utilized a psychiatric hospital, emergency screening, and/or crisis response services. MHSA INN funding for the BHConnect program ended on 10/31/2023 with the remaining client caseload transitioning to other service providers.

BHConnect services focus on persons who have received crisis-oriented psychiatric care services, but who are otherwise unconnected to behavioral health treatment services. The goal is to reduce recidivism rates for psychiatric crisis services among these persons by providing specialized supports through telehealth treatment services that reduce barriers to accessing ongoing care. San Diego County residents of all ages are eligible for BHConnect services. Services are culturally and developmentally appropriate and aim to overcome current barriers when clients attempt to connect to care following a psychiatric crisis.

The BHConnect service provider team is comprised of licensed and associate clinicians who provide therapeutic care services as well as Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. Services are offered on a telehealth platform, after an initial onsite evaluation by a case manager. To facilitate better access to care services, BHConnect provides clients with the technology necessary to maintain contact with telehealth professional. Clients may install a communication app on an existing personal device, or the program will provide a phone/tablet to use while receiving BHConnect services that is equipped with built-in internet access and the communication app. Clients receive a full tutorial on how to use the technology, as well as assistance with in-home setup prior to being connected with a behavioral health professional.

Participant Characteristics

A brief overview of the BHConnect participant characteristics is presented here with a more complete listing in the report appendix. The BHConnect program provided mental health outpatient treatment services to clients of all ages through both the CYF and AOA BHS service systems. During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). This represented an approximate 25% increase in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served by BHConnect (a 40% increase from FY 2021-22).

Referrals for BHConnect Services

BHConnect received a total of 359 referrals from community referral partners during FY 2022-23, which represented a 40.2% increase from the prior year (n=256). The growth in referrals was due to receiving substantially more CYF and AOA referrals. From FY 2021-22 to 2022-23, CYF referrals increased 36.8% (117 to 160) and AOA referrals increased 43.2% (139 to 199).

A total of 13 different organizations referred CYF clients to BHConnect. Consistent with prior years, Rady Children's Hospital was the primary referral source with 77 referrals coming from either the emergency room or behavioral health urgent care. Other prominent CYF referrals sources that emerged during FY 2022-23 included the SmartCare and Child and Adolescent Psychiatry Services with 27 and 18 referrals, respectively. Many of these referrals enrolled into BHConnect (45%).

A total of 20 organizations referred AOA clients to BHConnect with over 35% (37.2%; n=74) originating from Sharp Mesa Vista. Additional primary referrals sources included Adult Protective Services (n=24), SmartCare (n=15), Paradise Valley Hospital/Bayview (n=14), and Strength Based Case Management-Central/North (n=13). Overall, approximately 35% (34.7%) of these referrals enrolled in BHConnect.

Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 17 different organizations (seven CYF and ten AOA) referred at least five clients to BHConnect during FY 2022-23 as compared to 12 organizations achieving this threshold in FY 2021-22.

For both CYF and AOA referrals, if enrollment was unsuccessful the primary reason was that BHConnect staff were not able to locate or contact the person based on the referral information (25.6% and 42.7% of all referrals, respectively). Only about 15.9% of all referrals declined to participate (21.9% CYF and 11.1% AOA), suggesting a high degree of interest in participating in BHConnect once contact has been initiated. During FY 2022-23 BHConnect re-established an onsite presence at Sharp Mesa Vista to facilitate rapid "warm handoffs" from the crisis care services into BHConnect for outpatient treatment. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated at the onset of the COVID-19 pandemic.

Utilization of Program Services

BHConnect Services – Duration and Discharge Status

The BHConnect program was very responsive to referrals with 31.7% of persons enrolled within one day and over half (51.1%) enrolled within five days of the referral to BHConnect.

As shown in Table 1, of the 105 youth and 101 adults who were enrolled in BHConnect services during FY 2022-23, there were 50 youth and 47 adults still active in the program as of 6/30/2023. These persons were typically enrolled for approximately 4 months (i.e., median duration of 117.0 days and 130.0 days, respectively). Of the persons who discharged from BHConnect prior to 6/30/2023, the amount of time enrolled in BHConnect was similar (median of 126.0 and 106.0 for youth and adults, respectively), which suggests that the majority of both youth and adults stay connected with the program for at least 3 months.

Table 1. BHConnect Program Participation Duration and Discharge

	Youth (N=105)		Adult (N=101)	
	Still in program	**Discharged**	**Still in program**	**Discharged**
n (persons)	50	55	47	54
Mean (days)	173.2	236.7	187.7	154.7
Median (days)	117.0	126.0	130.0	106.0

BHConnect Services – Type and Amount

CYF clients and AOA clients were provided, respectively, an average of 4.2 and 4.5 BHConnect services per month (i.e., 30 days) (see Table 2). This represented a slight increase from the 3.5 and 4.3 average monthly services provided during FY 2021-22. For both CYF and AOA BHConnect clients, therapeutic sessions were the primary type of service contact. These sessions represented approximately 60% of all monthly service contacts (56.3% and 59.8%, respectively) with an average of 2.4 and 2.7 psychotherapy contacts provided to each CYF and AOA client each month. Conducting assessments and providing case management services as well as other forms of support such as working with collateral contacts were the other primary forms of interactions.

Table 2. Average Number of BHConnect Services Provided Per Month during FY 2022-23

	Youth (N=105)	Adults (N=101)
Type of BHConnect Service	**Average Number of Services per 30 Days**	
Any BHConnect service	4.2	4.5
Psychosocial assessment	0.5	0.5
Therapy	2.4	2.7
Rehabilitation	<0.1	0.3
Case management	0.7	0.8
Other services (e.g., collateral)	0.5	0.2

Primary Program Outcomes

Utilization of BHS Crisis and Acute Oriented Services

An examination of the BHS crisis and acute care service utilization patterns before and after enrolling in BHConnect can help identify the extent to which participation in BHConnect was associated with a reduced need for such services. The following analyses were accomplished by reviewing the electronic health record that documents participation in county-funded BHS crisis and acute care-oriented services during the 90 days before and after enrolling in BHConnect. To ensure equal 90-day observation periods for all persons, only clients enrolled at least 90 days prior to 6/30/2023 were included in the analysis. Of note, a limitation of these analyses is that they only include BHS-funded services, so any crisis services received outside the BHS system are not reflected. As such, the results presented in Table 3 should be interpreted cautiously as they do not reflect all services received, particularly for the youth population given that many received behavioral health-related care at Rady Children's Hospital Urgent Care.

Table 3. Utilization of BHS Crisis and Acute Oriented Services Before and After Enrolling in BHConnect

	Youth (N=84)				Adult (N=80)			
	90 days before enrolling in BHConnect		90 days after enrolling in BHConnect		90 days before enrolling in BHConnect		90 days after enrolling in BHConnect	
	n	%	n	%	n	%	n	%
Inpatient Psychiatric Hospitalization	15	17.9%	<5[1]	<6.0%	30	37.5%	<5[1]	<6.3%
Crisis Residential	0	-	0	-	<5[1]	<6.3%	<5[1]	<6.3%
Crisis Stabilization	26	31.0%	7	8.3%	<5[1]	<6.3%	<5[1]	<6.3%
Urgent Outpatient	0	-	<5[1]	<6.0%	<5[1]	<6.3%	<5[1]	<6.3%
PERT/MCRT[2]	12	14.3%	6	7.1%	<5[1]	<6.3%	6	7.5%

[1] *Due to the small number of persons experiencing this service the exact number is masked.*
[2] *PERT = Psychiatric Emergency Response Teams; MCRT = Mobile Crisis Response Team*

Overall, the service utilization pattern for both youth and adult BHConnect participants demonstrated a reduced need for crisis and acute care services after enrolling in BHConnect. This improvement was particularly evident among inpatient psychiatric hospitalizations for adult clients, as 37.5% had at least one inpatient psychiatric hospitalization in the 90 days prior to enrolling in BHConnect while less than 6.3% utilized these services during the 90 days afterward. Reductions in hospitalizations, crisis stabilization visits, and PERT/MCRT contacts were also evident for youth participating in BHConnect. While these analyses only include BHS services and may therefore not reflect all crisis services received, the results suggest that participation in BHConnect helped to reduce the need for crisis and acute care services.

Child/Youth Assessments

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS) assessment is a structured tool used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In BHConnect, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 50 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2022-23 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a "2" or "3" indicating a specific area that could potentially be addressed in the particular service or treatment plan. Table 4 shows the mean number of needs at initial assessment and last available assessment for the domains of child behavioral and emotional needs, life functioning, and risk behaviors. Overall, the findings indicated statistically significant reductions for all three CANS domains.

Table 4. CANS Average Change from Initial Assessment (N=50)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	2.6	2.0*
Life Functioning	2.9	2.3*
Risk Behaviors	0.8	0.6^

*^ statistical significance at $p < 0.10$; *statistical significance at $p < 0.05$*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a "2" or "3" at initial assessment to a "0" or "1" on the same item at the discharge assessment). As shown in Table 5, for each CANS domain, approximately 55-65% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment.

Table 5. Persons with CANS Improvement at Follow-up (N=50)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Behavioral/Emotional	46	27	58.7%
Life Functioning	40	26	65.0%
Risk Behaviors	26	14	53.8%

The percent of persons with an improvement across these three domains was lower than what was reported in the FY 2021-22 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients, as approximately 75% of discharged clients had at least one improvement area. This

difference is likely due, in part, to the nature of the population served by BHConnect, which is comprised of youth who have had difficulty engaging in traditional outpatient treatment programs. Overall, client improvements on the CANS suggests that the BHConnect team was generally successful at engaging children, youth, and their families who had barriers to participating in treatment via telehealth, and achieving improvements in well-being at rates almost as high as those observed across the broader CYF service system.

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below in Table 6.

In FY 2022-23, the PSC-35 was administered at initial entry into BHConnect, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 28 caregivers and 29 youth in FY 2022-23 completed both a baseline and follow-up assessment. Table 6 shows that the majority of both parents and youth (60.7% of parents and 79.3% of youth) reported PSC total scores at entry into BHConnect that met or exceeded the PSC total score cut point for clinical concerns[1]. At follow-up, this had reduced substantially, particularly among youth, with 42.9% of parents and 37.9% of youth indicating PSC total scores that exceeded the clinical threshold. Likewise, an examination of mean score changes showed statistically significant reductions (i.e., improvement) in total PSC scores for both parents and youth. Among the PSC subscales, there were indications of improvements from initial Internalizing scores for both caregivers and youth. With the reduced sample sizes for completed self-report PSC assessments, the findings should be interpreted cautiously as they may not reflect the broader experiences of the full BHConnect youth population; however, the results are generally consistent with prior years, which supports greater confidence in the overall pattern of findings to reflect improvements among children and youth who remain in BHConnect long enough and are willing to complete a follow-up assessment.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=28)					Child/Youth Report (N=29)				
Subscales	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	28	28.6%	17.9%	5.0	4.2^	29	41.4%	17.2%	5.6	4.8*
Internalizing	28	67.9%	46.4%	6.0[1]	4.7*	29	75.9%	55.2%	6.2[1]	4.5**
Externalizing	28	25.0%	28.6%	4.6	4.7	29	20.7%	13.8%	3.1	2.3
Total Score	**28**	**60.7%**	**42.9%**	**30.6[1]**	**25.5[1]***	**29**	**79.3%**	**37.9%**	**31.4[1]**	**22.7****

*^ statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

[1] Score above clinical cutoff. Note: PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

To better understand the extent to which PSC scores changed within the BHConnect client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2021-22 Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 7. Distribution of FY 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=28)		Child/Youth Report (N=29)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	7	25.0%	4	13.8%
No improvement (i.e., 0-1 point reduction)	2	7.1%	2	6.9%
Small improvement (i.e., 2-4 point reduction)	6	21.4%	3	10.3%
Medium improvement (i.e., 5-8 point reduction)	5	17.9%	5	17.3%
Large improvement (i.e., 9+ point reduction)	8	28.6%	15	51.7%

There was substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. As shown in Table 7, while a quarter of parents/caregivers (28.6%) and half of children/youth (51.7%) in BHConnect reported large improvements from their initial PSC assessment, 25.0% of caregivers and 13.8% of children reported increased impairment. Similar variability and distribution patterns in PSC change score analyses were also evident in the overall CYF BHS system as reported in the FY 2021-22 Systemwide Annual Report where 45% of caregivers and children/youth reported improvements while 20% reported increased impairment from initial PSC assessment. When comparing BHConnect clients to the overall BHS system, BHConnect youth were more likely to report large improvements (i.e., 51.7% compared to 45%); however, caregivers were less likely to report large improvements (i.e., 28.6% compared to 41%).

Adult Assessments

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The RMQ is administered at initial entry into BHConnect, at 6-month reassessment, and at discharge. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks respondents to answer questions as it is "true for you now."

The total mean score for the 33 adult participants who completed the RMQ at intake and at a follow-up assessment during FY 2021-22 was 3.4 at baseline and 3.7 at follow-up. This change was in the desired direction and is statistically significant. An important individual item from the RMQ with a statistically

significant and clinically meaningful increase was "My symptoms are bothering me less since starting services here" which increased from a 3.2 to 4.2. This difference corresponds to an initial "neutral" response to an "agree/strongly agree" response at follow-up. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, Assertive Community Treatment (ACT), case management, and TAY residential programs) was 3.3 with a follow-up RMQ of 3.7. It appears that BHConnect participants self-report generally similar assessments of their recovery status and outlook on life as do clients in other BHS programs.

Illness Management and Recovery

To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by BHConnect staff at initial program entry, at 6-month reassessment, and at discharge. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement.

Table 8. IMR Assessments for BHConnect Adult Clients (N=39)

		Intake	Follow-Up
Individual Assessment Items	**n**	**Mean**[1] *Scale of 1 to 5 where higher value = better functioning*	**Mean**[1]
Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriends or girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his or her health treatment?	39	3.1	2.9
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	38	2.7	3.3**
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	39	3.3	4.3**
Using medication effectively: How often does s/he take his/her medication as prescribed?	29	4.4	4.4
IMR Subscales	**n**	**Mean**[1]	**Mean**[1]
Recovery	39	3.0	3.6***
Management	39	2.3	3.0**
Substance Abuse	33	4.1	4.4
Overall IMR	39	3.0	3.6***

***statistically significant at p < 0.01; ***statistically significant at p < 0.001;*

[1] *IMR scores range from 1 to 5, where 5 = highest level of recovery*

Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery. A total of 39 participants completed an intake and a follow-up assessment in FY 2022-23 (see Table 8). The mean overall IMR score at intake was 3.0, which increased to 3.6 at last available follow-up, a statistically significant improvement. Primary domains where improvements were observed included greater recovery (i.e., reduced impairment due to symptoms) and better management of their illness.

As reported in the mHOMS Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.4 at most recent follow-up. This pattern indicates that BHConnect adult clients have similar levels of impairment and recovery/management skills at program intake as other BHS programs and can achieve similar or greater improvements at follow-up.

BHConnect Participant Feedback

During June of 2023, BHConnect staff asked program participants to engage in a short qualitative survey to elicit feedback on the program. Participants were asked a series of questions which had been developed by the University of California San Diego (UCSD) evaluation team in collaboration with BHConnect leadership and BHS input. A total of 19 participants provided feedback regarding their experiences with and perceptions of BHConnect.

Given the participation rate relative to the number of clients served by BHConnect during FY 2022-23, a limitation of the findings presented is that they may not reflect the perceptions of the entire BHConnect program participant population. Additionally, it should be noted that the interviews were conducted by BHConnect program staff and therefore could be positively biased.

From the collected data, the following themes emerged:

The BHConnect program model improves service accessibility.

> "I know people genuinely care about me when receiving services."
>
> "Participating in [BHConnect] services has affected me in a positive way. I get the help I need from my therapist and case management when needed. I feel like it's a more personalized service, I always know if I reach out to my therapist she always gets back with me and makes time for me when in crisis."
>
> "Easier to access, via in person would be more of a challenge to make it to sessions."
>
> "In the past it has been difficult to get to in person sessions verses telephonic sessions. It's more flexible for me to be able to connect with my therapist when needed. I had to miss a few appointments with my therapist but luckily they were able to be flexible with my schedule so I could make up the missed sessions."

BHConnect clients prefer the hybrid model over traditional in-person services.

> "I like the fact that I can do therapy sessions over zoom and the phone with my clinician, whom I have grown to trust, without leaving home."

"I like the screen share ability so we do our practices together."

"It's more convenient. No need to find child care."

The BHConnect experience has differed from prior providers.

"Since starting services, my trust level with mental health workers has improved."

"More experienced people working there."

"It's a more personal connection."

"I like that my privacy is kept private with [BHConnect], I didn't really feel the same way with my previous program."

"I find it easier to open up to my therapist in telephonic sessions."

These findings, combined with the themes found in the open-ended survey responses, indicate that the BHConnect program has accomplished the goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. Special considerations should be made in the future to accommodate youth clients who may struggle with the logistics of telehealth services.

Clients also reported concerns related to the need to transition to a new service provider once BHConnect closes. One client stated, "I'm stressed now to find another good therapist and hate having to go through that process again, and again." Clients emphasized the importance of treatment consistency and the difficulties related to establishing relationships with therapists, particularly while in the midst of experiencing the symptoms of their mental illness. Other clients reported that they would delay or not seek out treatment if they did not have access to BHConnect services.

Additional Program Activities

In FY 2022-23, BHConnect engaged in activities to further develop provider knowledge and skills in treating individuals with serious mental illness (SMI). This process included participation in a range of ongoing trainings and educational conferences. Additionally, weekly team meetings included an agenda item to share virtual interventions, applications, and websites the team discovered to help engage with or teach mental health-related interventions. Examples of mental health apps included the following:

- ACT coach
- CBT-I Coach (for insomnia)
- Mindfulness Coach
- PTSD Coach

More general wellness applications explored and incorporated into client devices included:

- OscarER
- OscarER Jr. (for community resources)
- Insight Timer (for stress management)
- Sleep Cycle (for insomnia)
- Lose It (for weight management)
- MyFitnessPal and Strides (to track exercise)
- Clarity (to log moods and symptoms)

The team also worked to develop a library of books on virtual interventions for youth, families and adults including art-based websites (e.g., drawing, coloring), websites that have games (e.g., creating a doll

house together, two-player games, creating an avatar that expresses feeling states and moods). Books reviewed as a team included "Teletherapy Toolkit" by Dr. Roseann Capanna-Hodge, "Telemental Health with Kids Toolbox" by Amy Marschall, and "Therapy Games for Teens" by Kevin Gruzewski.

Additionally, as discussed above, the number of persons enrolling in BHConnect increased during FY 2022-23. This increase was the result of the ongoing outreach and engagement efforts on the part of BHConnect leadership to increase awareness of BHConnect services throughout the County of San Diego and expand the number of referral partner organizations. Essential to the outreach activities was participation in various service provider related meetings and presentations regarding BHConnect services.

BHConnect Referral Partner Feedback

During June of 2023, BHConnect referral partners were asked to engage in a short survey to elicit feedback about their experiences with and perceptions of the BHConnect program. Referral partners were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with BHConnect leadership and BHS input. Referral partners were emailed a link to complete the online survey. Of the 93 referral partners invited to participate (representing 14 different organizations), 35 completed the survey (representing 11 organizations) for an individual response rate of 37.6% and an organizational response rate of 78.6%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of the BHConnect referral partner population. From the collected data, the following themes emerged from the qualitative data feedback:

BHConnect offers immediate services to clients in need.

> "I love how responsive the team has been when referrals are summitted. The partnership we have with BHConnect is phenomenal."
>
> "The referral process is simple and straightforward. BHConnect staff are responsive and engaging."
>
> "That there is minimal waitlist, they are responsive, and they are a good lifeline for patients that are coming out of a crisis."
>
> "My experience with BHConnect was a seamless process. I found it very easy to get in contact with Vista Hill and found that responses to emails and telephone calls were prompt, friendly and extremely helpful. Even after just one interaction it was made very clear to me that BHConnect is maintaining a culture of excellent service toward members, cooperation with other providers and a true passion for helping members get connected to these valuable therapeutic services."

BHConnect reduces barriers to therapy.

> "There are other referral options, but they come with longer waitlists and other barriers (transportation, not set up to treat severe concerns)."
>
> "Client that are interested in receiving therapy but are impacted by different barriers that make it difficult for them to receive traditional therapy. I often refer clients that self-isolate or are agoraphobic, due to their difficulty in public settings."

> "Limited access to care both through Medi-Cal coverage but also areas in County without many resources. Those whose parents have limited transportation and time to travel."

BHConnect fills a gap in services in the community.

> "[BHConnect] fills a gap in services and overcomes barriers that already exist in which services delivery is compromised. For all the reasons listed in previous answers... transportation, waiting lists..."

> "We always have them in mind and have also recommended them to clients cold-calling for resource support."

> "We believe that it has improved the quality of care for patients transitioning from the hospital and are hoping that it would prevent patients needing to return to the hospital."

Referral partners would like more collaboration and follow-up after the referral has been made.

> "Provide a follow up email to the referring party to confirm receipt of referral, what services (if any) the client has been offered, and the client's response. It can be very helpful to us because if we have a relationship with the client we can remind and support them in getting connected."

> "Improve communication with organizations about services available and appropriate referral process."

> "Collaborate with the referring provider, at least to the extent that we know our clients are being served."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual BHConnect Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect Staff Survey was conducted at the end of FY 2022-23. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Of the 13 BHConnect staff invited to participate in the survey, 12 did so, for a response rate of 92.3%. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify the following emergent themes.

Program Strengths

According to annual survey feedback, the flexibility offered by BHConnect is an overwhelming strength of the program. BHConnect staff described their ability to accommodate clients in terms of therapy modality (i.e., offering telehealth when in-person sessions are not possible), scheduling, and location.

One staff member captured the lengths to which the BHConnect team goes to meet the needs of clients:

> "Therapists and health navigators are flexible in scheduling and providing clients with session times that work for them. Therapists make several attempts to engage and re-engage clients who have disconnected from therapy. Therapists use interventions to build rapport with clients."

Staff identified the unparalleled approach of the BHConnect team in this respect:

> "This program is outstanding and unique. We serve a very unique population. The clients in the program would most likely NOT make the effort to receive services in another setting due to the efforts that they would most likely choose not to make. Without our program, most of my clients would most likely not receive treatment and would consequently decline mentally."

Program Challenges

During FY 2022-23, BHConnect staff identified forming relationships with referral partners, waitlists for services, level of client complexity/acuity of treatment, client attrition, and staff turnover and shortages as the biggest challenges to reaching program goals.

Staff also mentioned the difficulties experienced by participants, as well as supporting participants:

> "Some are homeless and lose contact due to moving around or they lose or damage their devices. Also, with the high-needs population, many have severe mental health issues or they are addicts and have difficulty with follow through and consistency in meeting with their provider. Some lose track of the day of the week, or the time that their appointment was scheduled for."

However, some of these concerns have been addressed, according to one staff member:

> "We have provided extra training and supervision support in order to addressed the high-risk nature of this population. We have provided additional trainings on risk assessment, suicide, and vicarious trauma to meet the needs of clinical staff. In addition, staff need more self-care support in order to address burnout."

BHConnect Participant Engagement and Retention

As a program designed to work with clients who have experienced a mental health-related crisis but were otherwise unconnected to outpatient services, issues with client engagement were anticipated and have been a focus since the beginning. As one staff member stated,

> "We can provide services to them, but they too have to participate in services. Some are not ready to work on their mental health, and some have to hit rock bottom before they are ready and willing. We can continue to reach out and continue to the best of our ability to assist them, but ultimately it is up to them to participate and engage in services."

Staff also highlighted the importance of program flexibility in maintaining client engagement. The hybrid treatment model offers options for treatment location and modality, as well as scheduling flexibility:

> "I think it is important to be flexible in scheduling by adapting to the clients' needs. It is helpful to have more than one session per week when these clients are struggling and considering emergency services, and space out appointments when stable. For unconnected clients, any participation in treatment (and not emergency services) is a plus for them. Work with them in short segments to recognize the benefit."

BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Staff mentioned the need for partnerships with substance use treatment programs, to receive further training in assisting this population and/or to refer the clients to those programs when BHConnect cannot effectively serve them.

Facilitating Client Referrals

The establishment and maintenance of referral sources has been a necessary goal of BHConnect since its inception. In FY 2022-23, ongoing BHConnect outreach efforts included meeting with representatives of potential partner organizations to educate them about BHConnect services and develop processes for identifying and screening potential clients. Additionally, BHConnect gave presentations at multiple community service provider meetings to increase awareness of BHConnect services.

Multiple staff noted the program manager's commendable efforts at outreach and connection with potential referral sources and the resulting increase in referrals. Respondents mentioned the need for additional adult referral sources, in an effort to fill midday appointments which are historically underutilized.

Supports, Tools, and Trainings

In the survey, staff were asked to identify supports, tools, and trainings that they would like more of to do their job well. The responses fell into three categories:

1. Additional training to build upon therapeutic skills (i.e., cognitive behavioral therapy, dialectical behavior therapy, training on working with high-risk clients and co-occurring disorders, parenting skills training, and generalized education on evidence-based practices)
2. Organizational and process skills (i.e., billing and paperwork processing)
3. Telehealth technical support

Experiences with Telehealth Services

The most commonly reported challenges when attempting to provide telehealth services was technical difficulties both with the telehealth platform and devices. However, several staff members also reported the relative ease and convenience of providing telehealth services.

As one staff member shared regarding their views on the many benefits of telehealth services:

> "Telehealth/Virtual Sessions have been an instrumental opportunity for use in assisting the population we serve, which has various challenges in obtaining services. The populations that we serve include, but are not limited to those with physical health challenges whom are unable to leave the home, those with multiple children whom are unable to attend in person appointments due to lack of childcare resources, and those with agoraphobia, and have extreme fear of leaving the home."

Other potential benefits of telehealth services through BHConnect, include less reliance on transportation and fewer no-shows. In addition, clients can access services from wherever they are and can potentially attend a virtual appointment even if they are sick with a virus, such as a cold or COVID-19.

Changes from Initial Program Design

During FY 2022-23, BHConnect continued to expand the network of community partners sending referrals to the program, particularly among adult/older adult clients. However, no changes were implemented that substantially differed from prior year program operations.

Conclusion

A total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients) during FY 2022-23, which reflected a 25% increase in total enrollment as compared to FY 2021-22. BHConnect's efforts to expand their referral partner network contributed to the increased enrollment, with 17 different organizations referring at least five clients to BHConnect (compared to 12 reaching this threshold in FY 2021-22) and a 40% increase in the total number of referrals received by BHConnect during FY 2022-23. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served in FY 2022-23. Despite the increase from prior years, this number remained below initial program targets of 250 persons served each year.

Once enrolled in BHConnect and receiving services, both CYF and AOA clients typically engaged with BHConnect for approximately four months. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many demonstrating a need for further behavioral health improvements. Common challenges included homelessness, symptom complexity, and co-morbid substance use. An examination of BHS service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services. Both youth and adults experienced fewer inpatient psychiatric hospitalizations after 90 days in BHConnect, and youth also had fewer crisis stabilization visits and PERT/MCRT contacts after engagement with BHConnect.

During FY 2022-23, the BHConnect program continued to experience significant growth but did not reach the original goal of providing services to at least 250 unduplicated clients. The lower-than-expected enrollment and increased availability of telehealth services throughout the BHS System of Care contributed to a determination by BHS to not continue the BHConnect program after the end of the Innovations-funded phase of the pilot program. The BHConnect program stopped enrolling new clients at the end of FY 2022-23 and will either complete treatment or identify and transition care to service providers who appear to best meet any needs for ongoing treatment services during the first quarter of FY 2023-24. While the BHConnect program will not be incorporated into the BHS System of Care as an ongoing service, it is expected that the lessons learned during the Innovations-funded phase of the pilot project will help inform other BHS efforts to ensure continuity of care and the provision of appropriate and accessible treatment options for persons receiving crisis/acute care services but not connected to treatment services. This information will be a primary focus of the Final Report for the BHConnect program.

For more information about this Innovations program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled during FY 2022-23

Characteristic	Child/Youth (N=73)		Adult (N=73)	
Gender	**n**	**%**	**n**	**%**
Male	25	34.2	24	32.9
Female	38	52.1	46	63.0
Another gender identity/Prefer not to answer	10	13.7	3	4.1
Total	**73**	**100**	**73**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	63	86.3	66	90.3
Other	10	13.7	7	9.7
Total	**73**	**100**	**73**	**100**
Race/Ethnicity[1]	**n**	**%**	**n**	**%**
African American	19	26.0	19	26.0
American Indian	<5[2]	<6.8	<5[2]	<6.8
Asian	6	8.2	6	8.2
Hispanic/Latino	34	46.6	26	35.6
White	29	39.7	27	37.0
Multiple	19	26.0	9	12.3
Other	2	1.7	1	1.4
Missing/Unknown	2	2.7	2	2.7
Total[1]	**-**	**-**	**-**	**-**
Sexual Orientation	**n**	**%**	**N**	**%**
Heterosexual or straight	45	61.6	51	69.9
Gay or Lesbian	<5[2]	<6.8	<5[2]	<6.8
Bisexual/Pansexual/Sexually Fluid	7	9.6	10	13.7
Queer	<5[2]	<6.8	<5[2]	<6.8
Questioning/Unsure	<5[2]	<6.8	-	-
Missing/Prefer not to answer	16	21.9	7	9.6
Total	**73**	**100**	**73**	**100**
Disability	**n**	**%**	**N**	**%**
Has a disability	22	30.2	26	35.6
Does not have a disability	46	63.0	44	60.3
Declined/Prefer not to answer	5	6.8	3	4.1
Total	**73**	**100**	**73**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

[2] *Values were suppressed due to small n size.*

Appendix (continued).

Characteristic	Child/Youth (N=73)		Adult (N=73)	
Type of Disability[2]	**n**	**%**	**n**	**%**
Communication (i.e., seeing, hearing)	7	9.6	7	9.6
Learning Disability	11	15.1	6	8.2
Physical Disability/Chronic Health	<5[2]	<6.8	14	19.2
Other Mental Disability	8	11.0	<5[2]	<6.8
Other	6	8.2	<5[2]	<6.8

[2] *Values were suppressed due to small n size.*

Characteristic	Child/Youth (N=73)		Characteristic	Adult (N=73)	
Age Group	**n**	**%**	**Age Group**	**n**	**%**
5 to 14	35	47.9	18 to 25	21	28.8
15 to 18	38	52.1	26+	52	71.2
Total	**73**	**100**	**Total**	73	**100**

JUST BE U INNOVATIONS-21

Final Report
(7/1/2018 - 6/30/2023)

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

v.12.22.2023

COUNTY OF SAN DIEGO Health and Human Services Agency | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Just Be U (JBU) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) from 7/1/2018 to 6/30/2023. JBU was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY; age 18-25; referred to as "youth" throughout this report) with serious mental illness (SMI) who are homeless or otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services but are otherwise unconnected to services. JBU, operated by the Urban Street Angels nonprofit organization, provides short-term housing for youth in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions coupled with occupational therapy (OT) to teach skills needed to accomplish personal goals. JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on youth-centric, whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging youth.

Overall, the findings from the Innovations-funded portion of the JBU program indicated that key objectives were successfully achieved. The program was able to consistently contact and engage with their priority youth population, create linkages to appropriate mental health and substance use treatment, and improve the general well-being of the youth who participated in JBU services. However, many of the youth have one or more factors that inhibit greater short- and long-term gains including co-occurring substance use disorder (SUD), complex physical health needs, and difficulty transitioning to external treatment providers, among others. Based on the successful results obtained by the JBU program during the Innovations-funded phase, BHS decided to continue to fund the JBU program as part of the ongoing and overall behavioral health service system.

Program Description

Using BHS Electronic Health Record (EHR) data, BHS personnel identified youth who met core criteria: age 18-25, multiple acute/crisis-related BHS service contacts, SMI diagnosis, unconnected to behavioral health services, and homeless or at risk of homelessness. After JBU received the list of eligible names from BHS, intensive outreach efforts were made by JBU staff to locate and contact each youth using available contact information provided by County databases, street searches, and coordination with other County and support agencies. Due to difficulties with physically locating many of the identified youth, during Fiscal Year (FY) 2020-21, a BHS-approved change was made to allow for "open" referrals, as well, so that JBU was allowed to enroll youth who were referred from other organizations such as community social service agencies and mental health service providers if they met the core criteria as listed above.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing (typically around 120 days) while providing holistic youth-centric recuperative services. Eligible youth are contacted, given an explanation about the program's offerings, and asked to enroll in the program. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services with the goal of improving mental health and quality of life. The dormitory-style housing facilitates easy access to many resources in one location. A centralized kitchen is available with cooking and nutritional classes. Youth can access integrative medicine, holistic healthcare and other wellness services including acupuncture, yoga, massage therapy, chiropractic care, meditation and mindfulness education. Further, other support services available include case management, peer support, group outings, and various in-house community-building training and events.

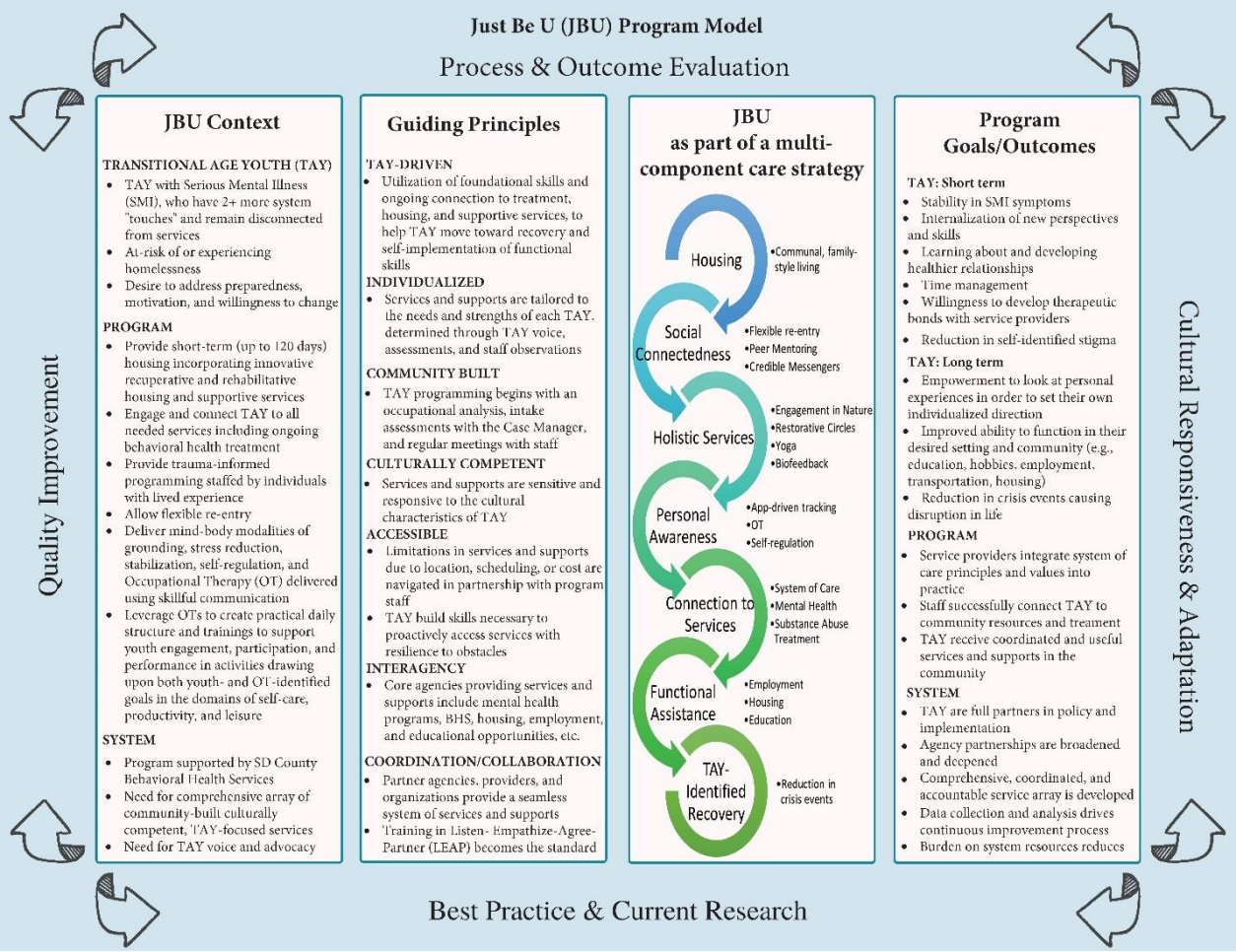
The program's emphasis on community-building, de-stigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation and engagement with holistic and integrative therapies helps to attract and retain this historically difficult-to-reach cohort of the homeless population. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless and/or helpless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize disruptive and financially burdensome levels of emergency and mental health services. Further, the program's emphasis on community and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

Program Model

JBU leadership, the UCSD evaluation team, and BHS representatives met regularly during the Innovations-funded phase of the program to review evaluation practices, share updates on the program operations, and better understand the experiences of JBU as an innovative and evolving program. To define JBU's multi-faceted service approach more clearly within a broader strategy of youth care, the team endeavored to develop a JBU Program Model. The model outlines the complicated context in which JBU operates, which is critical to understanding how improvements may be made and where successes are truly occurring. The model also includes guiding principles, various parts of the multi-component care strategy of JBU, and goals/outcomes as defined across multiple levels (i.e., individual, program, and system-based levels).

Programmatically, JBU relies on individual youth to engage in services and outside providers to have accessible treatment options reliably available for youth. Within the JBU program, there remains a commitment to using current research, engaging in culturally-informed responses, and improving quality of care. The JBU Program Model is presented in Figure 1. A full-size rendering of the Program Model is available to review in the appendix.

Figure 1. JBU Program Model



Assessment of Primary Project Objectives

The main goals of the JBU Innovation-funded project included the following:

1. ***Use a habilitation model to demonstrate the ability to identify, engage, and retain TAY who are unconnected to treatment and have repeatedly utilized acute care, STARTs, EDs, PERT, EPU and jail mental health services.***

   In the beginning stages of the Innovations-funded phase of JBU, BHS provided a list of youth appearing to meet eligibility criteria (i.e., the BHS CO-19 report). It was difficult to physically locate challenging many of the youth, which prompted the change to allow for "open" referrals from other organizations for youth who also met the core eligibility criteria. Despite difficulties locating youth, once contact was made and JBU was explained to youth by the JBU outreach workers, most youth (typically 75% or

more) agreed to enroll in the program. Youth identified the provision of housing as a key factor for initially agreeing to enter JBU. A total of 204 youth enrolled into JBU during the Innovations-funded phase. JBU successfully created an inclusive environment with much gender, race/ethnicity, and sexual orientation diversity reflected among the enrolled youth.

The JBU program also demonstrated the capacity to retain youth in services, despite working with a population of youth with potentially significant impairments (i.e., 65% of youth had a diagnosis of schizophrenia or other psychosis and 58.3% had a co-occurring SUD). JBU was designed to operate as a short-term linkage and support program, initially 90 days and then extended to allow for 120-day stays if needed. In reality, youth typically remained in residential care and support services from JBU for approximately 75 days; however, 43.1% (n=88) were in JBU for at least 90 days and about one-quarter (25.5%; n=52) required services lasting more than 120 days.

2. ***Decrease TAY's inappropriate utilization of acute care services and/or returning to jail.***

   While enrolled in JBU, participants demonstrated approximately 50% reduced need for crisis and acute care BHS services (i.e., inpatient psychiatric hospitalizations, crisis stabilization visits, and crisis residential admissions). This is likely due to the increased participation in treatment services (i.e., outpatient, Assertive Community Treatment (ACT), and urgent outpatient care) as well as the care and support provided directly by JBU. The decreased engagement with crisis/acute care services persisted in the 180 days following discharge, markedly lower than the 180 days prior to enrollment. Across the service types of inpatient psychiatric hospitalizations, crisis stabilization visits, crisis residential admissions and psychiatric emergency response (PERT)/mobile crisis response team (MCRT), the prevalence across the youth (i.e., the percentage of persons experiencing at least one service contact) dropped approximately 30-40%.

3. ***Increase TAY's ability to manage their symptoms and improve their level of functioning and ability to live independently.***

   For the 103 TAY with completed baseline and follow-up assessments on the Milestones of Recovery Scale (MORS), statistically significant and clinically meaningful improvements were evident in their symptom management and recovery orientation. The MORS is scored on a scale of 1 to 8, with lower numbers meaning higher risk. Upon entrance into JBU, the majority of youth scored 3 (i.e., "experiencing high risk/engaged with mental health provider") or worse. At the end of services, the majority scored 6 (i.e., "coping/rehabilitating") or better. The average MORS rating increased from 3.4 at baseline to 5.7 at follow-up.

   OT services were comprehensively incorporated into JBU practices via both individual and group interactions. Structured OT assessments helped youth to identify, develop and take steps to achieve goals commonly related to education, employment, and/or personal growth/skill building. Outcome data indicated TAY were able to achieve desired objectives and increased their satisfaction from completing identified tasks.

   Additionally, JBU helped connect youth to available housing resources by getting approved and trained to administer the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. All JBU youth who completed the VI-SPDAT were identified as needing housing supports, with the majority demonstrating the highest level of need and

prioritized for permanent supportive housing. JBU has increased their capacity to successfully connect youth with housing-related assistance throughout the Innovations-funded phase of the program.

4. ***Increase connection with an ongoing outpatient mental health program.***

   The JBU program demonstrated substantial success in facilitating connections to needed outpatient treatment services. Compared to 180 days prior to JBU enrollment, more youth had at least one outpatient visit (i.e., 18% to 62.2%) and the average number of visits across all youth increased from 1.4 to 12.8. While engagement in outpatient treatment reduced post-JBU, this was likely because engagement with ACT increased. While only 2.3% had ACT engagement prior to JBU, nearly one-third (29.7%) were connected to an ACT program upon discharge. Overall, the majority of JBU were connected to either outpatient treatment programs and/or ACT through their involvement with the JBU program.

Future Directions

After the Innovations-funded phase of the JBU program concluded on 6/30/23, JBU was incorporated into the overall BHS system of care as an ongoing service using MHSA Prevention and Early Intervention funds. Following the conclusion of an open Request for Proposal review process in which other organizations could propose to provide JBU services, the JBU program will continue to be operated by the Urban Street Angels organization. Reflecting the successful experiences during the Innovations-funded phase, the priority population for JBU services will continue to be TAY (ages 18-25) who have or are at risk for SMI, may have a co-occurring SUD, are homeless or at risk of homelessness, are unconnected to services, and are repeat utilizers of acute/emergency mental health services. Likewise, the specific type of services provided through JBU and the overall orientation for how to approach service delivery will be very consistent with how JBU was operated during the Innovations-funded phase. As such, the core service delivery strategies will continue to be providing 24 hour/7 days-per-week residential care and support services that have a restorative and habilitative emphasis specifically tailored to meet all life domains for eligible youth. Primary objectives will continue to be facilitating connections to all needed behavioral health treatment services and providing opportunities for social connectedness and personal wellness and growth. JBU will also help youth better meet some of their basic living needs by providing job training and assistance with finding post-JBU housing.

JBU Enrollment

A total of 204 unduplicated youth enrolled into the JBU program throughout the MHSA Innovations-funded phase of the program that ended on 6/30/2023. Of the 204 enrollees, 104 (51.0%) originated from the BHS CO-19 report of homeless youth with recent emergency BHS service contacts and 100 (49.0%) were identified from other referral sources (see Table 1).

Since allowing “open” referrals into JBU for youth with similar histories to those included on the BHS CO-19 report starting in FY 2020-21, the open referrals have comprised the majority of the newly enrolled youth. The final year of the Innovations-funded phase of the pilot project (FY 2022-23), open referrals represented 84.8% of the newly enrolled youth.

Table 1. JBU Program Enrollment (N=204)

Type of JBU Enrollee	n	%
Identified via BHS CO-19 report	104	51.0%
Open referrals from other service provider organizations	100	49.0%
Total JBU enrollees	**204**	**100%**

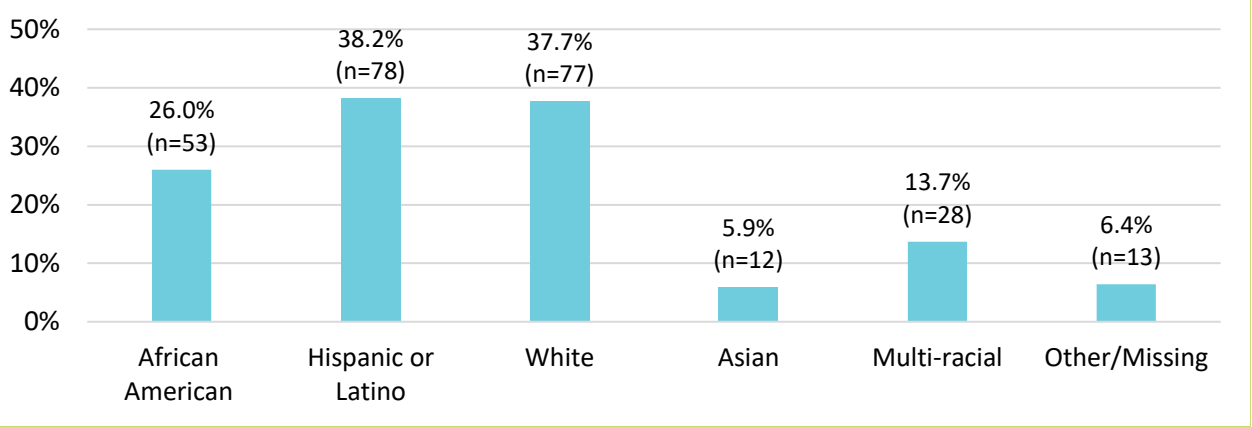
Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 204 unique youth who enrolled in JBU during the Innovations-funded phase of the JBU program, the majority (n=121; 59.3%) identified as male. Almost all JBU youth (n=198, 97.1%) spoke English as their primary language. Approximately two-thirds of youth enrolled in JBU had a diagnosis of schizophrenia/psychotic disorders (n=133; 65.2%). Other common diagnoses included bipolar (n=41; 20.1%) and depressive disorders (n=19; 9.3%). More than half of all youth also have a co-occurring SUD (n=119; 58.3%).

JBU provided services to a substantial number of sexual minorities with at least 8.3% (n=17) identifying as Bisexual/Pansexual/Sexually Fluid, 2.5% (n=5) identifying as gay or lesbian and 3.9% (n=8) identifying as another sexual orientation. Since approximately 30% (29.9%; n=61) of the youth did not answer the question, it is likely that the actual number of sexual minorities served by JBU is even higher than reported.

As shown in Figure 2, JBU youth were also racially and ethnically diverse. Nearly identical numbers of youth identified as Hispanic/Latino and Caucasian (n=78; 38.2% and n=77; 37.7%, respectively) followed by 26.0% (n=53) identifying as African American and 5.9% (n=12) as Asian.

Figure 2. Race/Ethnicity of Youth Who Enrolled in JBU (N=204)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Many JBU youth had additional challenges as well as those related to their mental health, including cognitive and sensory differences affecting their ability to process information and engage with certain environments. Many also presented with other complex physical health issues and/or intellectual and developmental disabilities that required support from additional agencies such as the San Diego Regional Center and specialized healthcare providers.

Utilization of Program Services

OT at JBU

Throughout the final three years of the JBU program, there were up to eight OT interns providing services to JBU youth, who collectively provided over 5,000 hours of volunteer support services to the JBU program. Interns were graduate students enrolled in either Masters or Doctorate programs in OT at one of several university partners, including the University of St. Augustine for Health Sciences and San Jose State University who were supervised by licensed OT specialists on JBU staff.

The OT team conducted an initial interview with each youth to develop an occupational profile (e.g., client history, strengths, interests, goals, and barriers) as well as standardized and non-standardized assessments to measure client factors impacting performance skills and patterns (e.g., time-use, cognitive, sensory, and goal-focused assessments). Together with the youth, they developed intervention plans which included individualized short- and long-term goals related to 1) self-care (e.g., grooming and hygiene, community mobility, sleep hygiene, health management), 2) productivity (e.g., work, financial management, school, volunteering), and 3) leisure (e.g., social activities, activities for fun).

In collaboration with the JBU team, OTs would determine a uniquely tailored service delivery method and outcome measurement approach. The OTs conducted individual client intervention sessions every one to three weeks to address identified client needs and goals, as well as running as-needed weekly group interventions addressing topics such as: leisure exploration, social participation, time management and organization, employment seeking and maintenance, pursuing volunteer opportunities, managing finances, home maintenance, meal preparation, community exploration and engagement, medication management, and self-care. OT group session typically lasted about one hour with an average attendance of 6.6 youth.

OTs conducted observations and activity analyses during a client's transition into the program and their participation in services. These observations served to identify barriers to participation (i.e., being able to do the activities or tasks they want and/or need to do). Youth would review their personal intervention plan with OTs every month and modify as needed. OT services at JBU also provided consultation to the JBU team regarding supporting clients with additional needs including cognitive challenges, neurological or sensory differences, physical disabilities, and/or significant mental health challenges. Additionally, the OT team supported the participation of JBU youth in program and organization-wide activities, such as the completion of a mural in the downtown Urban Street Angels location (as shown below).

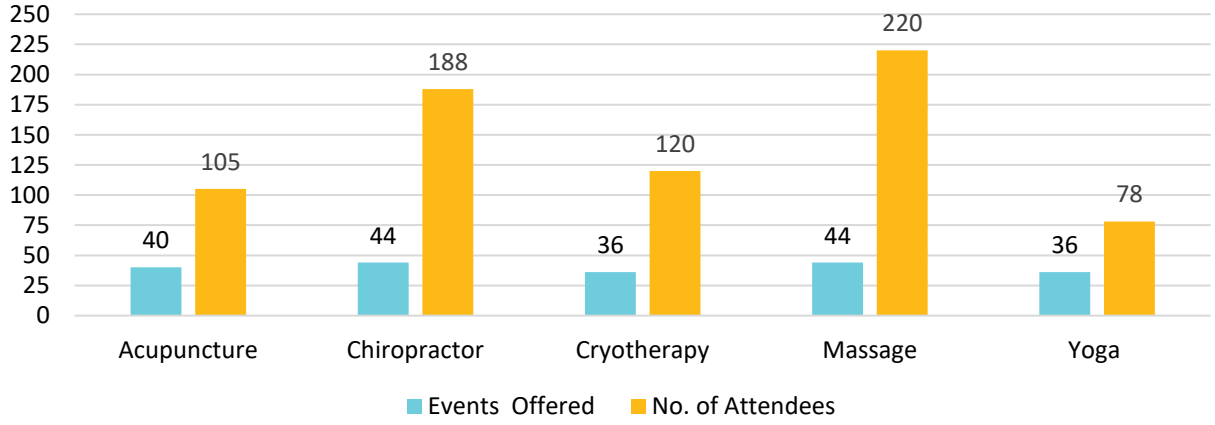
Urban Street Angels mural that JBU youth helped to paint with OT support.

Engagement in JBU Activities

Holistic Wellness Services

In addition to the ongoing support and encouragement of the youth through daily personal interactions with JBU staff and peer supports, JBU offered a wide range of wellness-oriented group and individual structured activities that covered a range of holistic services and general living/educational events such as yoga, reiki, meditation, cooking classes, acupuncture, and others. In addition to promoting relationships and skill-building, participation in these activities seeks to promote improvements in personal well-being such as greater self-esteem and a more hopeful outlook for the future. Many of these activities were impacted by the onset of the pandemic as they were frequently led by external professionals. Some services were able to be completed remotely (e.g., following an instructor via a video call), others transitioned to being led by onsite staff, and others were discontinued. Based on these experiences and an assessment of youth attendance and interest levels, JBU holistic wellness services regularly offered during the final year of the Innovations-funded phase (i.e., FY 2022-23) included: acupuncture, chiropractor, cryotherapy, massage, and yoga. Figure 3 indicates number of sessions and total youth participation across these activities during FY 2022-23.

Figure 3. JBU Sponsored Wellness Activities



Group Outings

JBU youth participated in both major and relatively more minor group outings. The major outings included overnight trips to Harrison Serenity Ranch (HSR) on Mount Palomar. HSR is a working ranch located over 50 miles from downtown San Diego. The facility offers recreation, relaxation and wildlife encounter opportunities. These outings were facilitated by the full JBU staff team, while more minor group outings were facilitated primarily by Peer Support with assistance from OT interns and other staff as needed. Examples of these minor outings include trips to the movie theater, makeovers at a salon, Living Coast and Birch Aquarium, trampoline park, elderly dog rescue "Frosted Faces," San Diego Pride Parade, the Japanese Friendship Garden at Balboa Park, rollerblading, bowling, the beach, a San Diego Padres baseball game, hikes and various other outings. Additionally, some activities focused on engagement were provided in-house such as gardening, embroidery, mask making, and game nights.

JBU Services – Duration and Discharge Status

As shown in Table 2, of the 204 youth who received JBU services, 189 had discharged as of the end of the Innovations-funded phase of the project on 6/30/2023 and 15 were still active. The average and median length of time receiving residential care and support services from JBU was approximately 75 days; however, 43.1% (n=88) were in JBU for at least 90 days and about one-quarter (25.5%; n=52) required services lasting more than 120 days. These data indicated that JBU was generally adhering to the initial goal of operating as a short-term linkage and support program while also allowing somewhat extended (but not long-term) care for youth who needed additional time in the program.

Table 2. JBU Program Participation Duration and Discharge (N=204)

	JBU Youth (N=204)	
	Still in program 6/30/2023	**Discharged as of 6/30/2023**
n (persons)	15	189
Mean (days)	76.5	75.6
Median (days)	74.0	71.0

Key Evaluation Findings

Milestones of Recovery Scale

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

As shown in Table 3, the results indicated substantial changes in recovery status at follow-up. At intake, only 8.7% (n=9) of youth were considered as coping or in recovery, whereas 60.2% (n=62) were doing so at follow-up. The number of youth in the "extreme/high risk" categories dropped from 52 to 7 (50.5% to 6.8%) from intake to follow-up. Overall, 84.5% (n=87) improved at least one level at follow-up and the average MORS score increased from 3.4 at intake (corresponds most closely to "high risk, engaged") to 5.7 at follow-up (corresponds most closely to "coping/rehabilitating").

As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.5 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average MORS score (i.e., more impaired/less engaged in treatment), but had a higher-than-average MORS score at follow-up (i.e., less impaired/more engaged in treatment).

Table 3. MORS Results for JBU Youth with Follow-up (N=103)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**n**	**%**	**n**	**%**
1/2	Extreme risk / High risk, not engaged	37	35.9%	<5[1]	<4.9%
3	High risk, engaged	15	14.6%	<5[1]	<4.9%
4	Not coping, not engaged	37	35.8%	12	11.6%
5	Not coping, engaged	5	4.9%	22	21.4%
6	Coping/rehabilitating	5	4.9%	42	40.8%
7	Early recovery	<5[1]	<4.9%	7	6.8%
8	Advanced recovery	<5[1]	<4.9%	13	12.6%
	Mean MORS	**3.4**		**5.7***	

[1]*Exact number masked due to the small number of persons in this category. *Statistical significance at p < 0.01*

The lower-than-average MORS score at intake was consistent with the JBU focal population (i.e., youth with serious mental illness who were not currently in or seeking treatment), with the substantial positive change in MORS score suggesting a high capability of the JBU team to support and connect with youth and get them linked to appropriate levels of treatment. Of note, since follow-up MORS scores were not available for all JBU participants, these results may not generalize to the entire JBU population and potentially overstate the typical level of improvement experienced by JBU youth; however, the results clearly indicate substantial portions of the JBU client population improve in their illness management and recovery orientation by the time they discharge from the program.

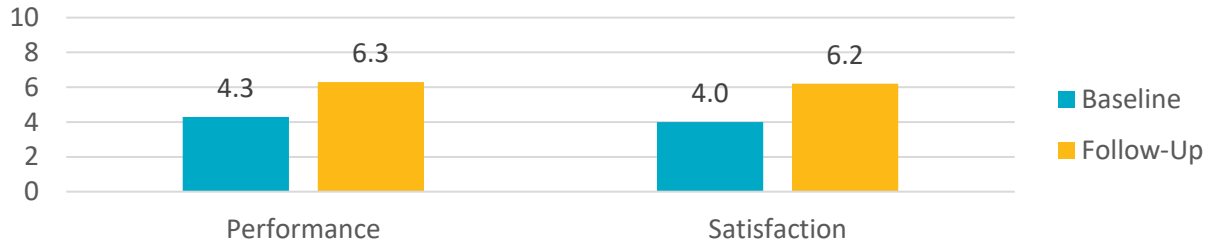
Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a widely used (e.g., translated into more than 35 languages), individualized, client-centered, evidence-based outcome measure designed to document a client's self-perception of performance in everyday living at multiple time points. The COPM is a standardized instrument, in that there are specific instructions and methods for administering and scoring the test. It is designed as an outcome measure, with a semi-structured interview format and structured scoring method. The COPM asks individuals to identify everyday activities that they want or need to do but are currently unable to do or are dissatisfied in the way they are doing them, across all areas of life, including self-care, leisure, and productivity. The assessment then asks clients to rate these activities on a 1-10 scale for importance, performance, and satisfaction with performance with "1" representing not important/not able to do it/not satisfied at all. Typically, differences of two points or more between the pre- and post-OT intervention scores are considered clinically important.

Over the final two years of the Innovation-funded phase of JBU, 63 JBU youth developed 289 unique goals in collaboration with the OT specialists. Primary goal domain areas included: personal hygiene/self-care, getting/maintaining employment, social interactions, obtaining needed resources, developing positive hobbies, and furthering education. A total of 28 JBU youth had baseline and follow-up COPM assessments completed by 6/30/2023. Figure 4 shows that average performance assessment increased from 4.3 to 6.3 at follow-up and the satisfaction score increased from 4.0 to 6.2. Both the performance and satisfaction

domains had average change scores of approximately two, indicating clinically important improvements for youth overall. Of the 28 youth with both baseline and follow-up scores, the majority 53.6% (n=15) had score changes indicating clinically important changes on performance and 57.1% (n=16) had clinically meaningful improvements regarding task satisfaction. The COPM results indicate that the JBU OT team was able to increase the capabilities of many JBU youth to function successfully in their daily lives; however; the COPM data also reveal that JBU youth have relatively low initial abilities to accomplish their goals and that substantial numbers of youth continue to experience challenges even after working with JBU staff. These findings highlight both the promise of what JBU and the participating youth can accomplish together to improve their lives while also reflecting the difficulties of consistently achieving such objectives.

Figure 4. COPM Mean Scores for JBU Youth with Follow-up (N=28)



Youth Feedback Regarding OT Experiences

JBU youth were asked about their experiences with OT as part of JBU. Responses fell into the following categories:

Participants Enjoyed Working with OT Providers

> "The OT interns were enjoyable to be around, easy to talk to. They didn't make you feel bad for coming to them…They wouldn't pressure you to have a conversation. They listened. They'll do activities with you if you need it and it will help you. They don't expect you to do things if you're not comfortable. They would ask me to do things, and if I didn't want to, they might ask me just to try, and then check in after if it helped me and I would realize after that it did. But they were not pressuring me or to continuously do things if it didn't work for me."

> "It helped me get through the program by having some extra support… People from occupational therapy positively impacted my life. They gave me hope that I can succeed and do better and improve my habits. The interns were super nice and a positive influence and encouraging. They would help you out whenever you felt down, they were uplifting."

> "I was satisfied on how OTs made everyone engaged in group activity and made everyone have a good time. I liked how the OTS planned engaging group activities (i.e., pill bottles for medication management). We also got to play basketball together in one of our sessions."

OT Offered New Experiences for Participants

> "Helped me spend time with people I wouldn't normally... It helped me meet and make more friends."

"It gets you out of your comfort zone and makes you feel comfortable with being uncomfortable. OT is my favorite group because it makes you get up and get out to do stuff you don't necessarily want to do, which creates a sense of structure."

OT Helped Participants with Goals and Skills

"[Helped with…] a lot of tasks that I was embarrassed to ever ask anyone for advice on."

"I like occupational therapy because it actually puts my goals into practice."

"Going on walks, encouraging me to do better activities instead of just smoking or hanging out all day on the couch e.g., reading manga, getting a job, getting up on time, going to groups/activities, eating (regularly)."

"It continued to help me after the program as I search for a new job."

OT was Fun

"Occupational therapy is a way of being in a fun environment and doing fun stuff but also being intimate and focusing on what you need."

"It is an outlet as well as just having fun and gets you involved with the people around you."

Overall, participant feedback was very positive. One participant summarized, "I hate therapy in general, but OT is different than regular therapy... It's like you're not just sitting there, you're building a connection…it actually helps you figure out what you can do to fix it, instead of just sitting there talking about it."

Increased Connections to Housing and Housing Assistance

Near the end of the Innovations-funded phase of the JBU program, to support efforts to connect JBU to housing, the JBU program began administering the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. The VI-SPDAT is a tool used to assess housing needs and risks in order to establish prioritization of housing-related assistance. Organizations trained to utilize the VI-SPDAT with their clients are then able to enter the resulting information into a centralized data system that assists with matching available housing resources with expressed needs. The VI-SPDAT helps to inform the type of housing intervention or support that may be most beneficial, as well as the order in which individuals should be served. Table 4 presents the VI-SPDAT scores for the 32 youth who had this assessment completed upon enrollment into JBU.

Table 4. VI-SPDAT Score at Time of Enrollment into JBU (N=32)

Baseline Score (N=32)	n	%
Score of 0 to 3: No Housing Intervention	0	0.0%
Score of 4 to 7: Assessment for Rapid Re-Housing	5	15.6%
Score of 8+: Assessment for Permanent Supportive Housing/Housing First	27	84.4%

The results indicate a high level of housing need among JBU, with almost 85% scoring in the highest priority category with a recommendation for permanent supportive housing. The average score for JBU was 10.1. The substantial need for housing among JBU youth indicated that the JBU program was successfully connecting with the intended focal population given the overall objectives to serve youth with an SMI who are currently homeless or at risk of homelessness.

While the short-term nature of the JBU program presented challenges in matching youth with housing prior to program discharge, youth were connected to local housing resources directly as a result of the VI-SPDAT scores. In addition, JBU staff were able to successfully connect 18 JBU youth to other housing supports such as assistance with maintaining current living situation, obtaining vouchers to access affordable housing options, and other forms of support to reduce vulnerability to homelessness.

Behavioral Health Service Utilization Patterns

San Diego County BHS Services Utilized Before, During, and After JBU

BHS utilization patterns before, during, and after leaving the residential portion of JBU can help identify the extent to which participation in JBU is associated with a fundamental shift in the mix of service utilization (i.e., increased engagement in treatment and reduced interaction with crisis/acute care). The following analyses were accomplished by reviewing the electronic health record that documents County-funded BHS services provided throughout San Diego County to identify other mental health services received by JBU participants. Given the variable length of time that a youth might be in the residential portion of the JBU program, a standardized metric was created to enable equivalent comparisons for the three time periods of interest. The standardized metric for the "during JBU" period reflects the average amount of services JBU youth would be expected to receive during a 180 day stay with JBU. This metric facilitates comparisons to the 180-day period immediately preceding JBU enrollment and the 180-day period after leaving the residential phase of the JBU program.

The standardized "during JBU" metric was computed by summing the total number of BHS services (by service type) that occurred while the youths were enrolled in JBU and dividing that by the total number of days that all youth were enrolled in JBU. The resulting values represents the average number of each specific BHS service that a JBU youth received per day, which is then multiplied by 180 to generate the estimate of BHS services that JBU youth would receive if they were enrolled in JBU for 180 days. For the 180 days prior to JBU, all BHS services (by service type) were summed and then divided by the total number of JBU clients to generate an estimate of the average number of BHS services received by JBU clients prior to enrolling in JBU. A similar calculation was made for the 180-day period after youth left the residential phase of the JBU program.

The analyses presented in Table 5 include all JBU participants who enrolled at least 180 days before the end of FY 2022-23 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 5, the 172 JBU youth included in these analyses had either no or limited involvement with BHS outpatient treatment services in the 180 days prior to entering JBU (average of 1.4 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as 62.2% of the youth linked to outpatient care and the 180-day average number of outpatient sessions increased to 12.8. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.8 sessions per youth. For some, this reduction in outpatient services

post-JBU can likely be explained by linkages to the ACT programs that the youth made while in the JBU program. Approximately 30% (29.7%) of all youth were linked to ACT post-JBU, with the average of 7.8 sessions compared to 0.3 pre-JBU and 2.6 during JBU.

Table 5. BHS Service Utilization Patterns Before, During, and After JBU Participation (N=172)

	180 Days Prior to JBU Enrollment			Standardized 180 Days During JBU Residential Phase			180 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth [1]	# of visits/ episodes[1]	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	18.0%	234	1.4	62.2%	938	12.8	47.7%	486	2.8
ACT	2.3%	49	0.3	19.8%	187	2.6	29.7%	1,340	7.8
Urgent Outpatient	40.7%	131	0.8	35.5%	76	1.0	29.7%	91	0.5
PERT/MCRT	30.8%	73	0.4	10.5%	28	0.4	21.5%	63	0.4
Crisis Stabilization	37.2%	128	0.7	8.1%	23	0.3	20.3%	71	0.4
Inpatient Psychiatric Hospitalization	46.5%	130	0.8	13.4%	30	0.4	27.9%	90	0.5
Crisis Residential	30.8%	71	0.4	7.0%	16	0.2	17.4%	40	0.2

[1]The number of persons and number of visits/episodes during JBU is not comparable to "prior" and "after" JBU since the average length of time in JBU was less than 180 days (i.e., mean = 77.0 days). Only the average is comparable across all time periods.

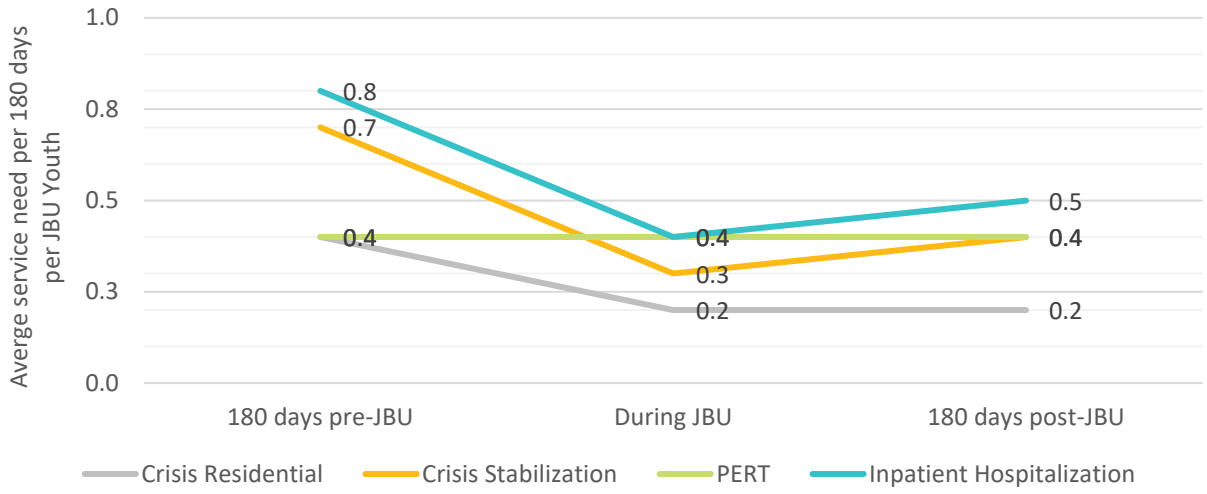
The patterns evident among acute/crisis-oriented type BHS services were more nuanced. Interestingly, the average number of urgent outpatient visits decreased from before JBU to after JBU (0.8 to 0.5, respectively) but was slightly higher during JBU (1.0). This can likely be explained by the fact that JBU staff facilitated access to needed urgent outpatient care in an effort to avoid situations escalating into the need for a crisis stabilization visit or inpatient hospitalization, both of which occurred much less frequently during JBU than pre-JBU (i.e., dropping from 0.7 and 0.8 pre-JBU to 0.3 and 0.4 during JBU, respectively).

When comparing pre-JBU to post-JBU service utilization, the percentage of youth accessing crisis-oriented BHS services was lower after participating in JBU. This was most evident for crisis stabilization services which reduced from 37.2% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to 20.3% in the 180 days after leaving JBU, with the average visits per 180 days dropping from 0.7 to 0.4 (a 42.9% reduction) and total visits reduced from 128 to 71, (a 44.5% reduction). A similar pattern was evident for inpatient hospitalizations (i.e., reducing from 0.8 pre-JBU to 0.5 post-JBU) with total hospitalizations reducing from 130 to 90 (a 30.8% reduction) in the 180 days before JBU compared to the 180 days after JBU.

With the small sample sizes, caution is warranted when interpreting findings, however it is evident that JBU increased engagement with outpatient treatment services and facilitated connections to ACT programs (a preferred discharge destination for many JBU youth). As shown in Figure 5, there was a small

reduction in crisis and acute care behavioral health service utilization from pre-JBU to post-JBU, however the utilization patterns were higher than while in the residential phase of the JBU program.

Figure 5. Visualization of Average Crisis and Acute Care Service Utilization Per JBU Youth Per 180 Days Before, During, and After JBU Residential Phase



This pattern suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants. This may require exploring the provision of additional services by JBU for a longer period of time and/or more extensive partnerships with other long-term services with a TAY-specific orientation such as case management that can seek to maintain and build upon the gains experienced while in the JBU program.

Photovoice Project

In May 2021, youth were invited to participate in a structured photovoice project. Photovoice is a visual research method employed with the intention of addressing social issues and fostering change. It is defined as a process where "people can identify, represent, and enhance their community through a specific photographic technique." Photovoice provides the opportunity for community members to creatively document their concerns and simultaneously act as "catalysts for change."

Additionally, it is designed to promote interest in important topics that are relevant within a community and allows a community to communicate through what they chose to include in their photographs. Photovoice breaks past language and traditional communication barriers that often prevent members of a group from expressing their concerns. Photovoice is a highly customizable community-based intervention and is an excellent tool to use when there is a need to create awareness around a certain issue or concern, particularly when the issue of concern is one that is traditionally difficult to address or discuss. As such, it was determined by JBU leadership and BHS that Photovoice would be an appropriate method of evaluation in partnership with JBU youth.

In collaboration with 11 JBU youth, the evaluation question was identified: "How does participation in JBU affect my life?" The full Photovoice results were included in the FY 2020-21 JBU Annual Report with the main findings reported as follows:

Overall Key Takeaways

1. Housing was the most important part of JBU.
2. JBU provided a sense of stability.
3. Community can be uncomfortable for JBU youth, but they recognized its importance.
4. A sense of control was important while youth worked towards independence.
5. Youth believed that participation in JBU gets them to independence faster than if they tried on their own.

> "We are all here to better our lives.
> We aren't where we want to be, so we don't leave because we are here trying to get our lives together. We aren't just going to throw that away. We've put the effort in to be here."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual JBU Staff Survey. Stakeholder meetings were held throughout the year with representatives from BHS, JBU, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual JBU Staff Survey was conducted at the end of each year. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes. The following themes emerged throughout the Innovations-funded phase of the JBU program:

Program Strengths

JBU Team

JBU staff identified their team as a primary strength of the program. Staff described coworkers as caring, compassionate, and communicative. One staff member highlighted "the skill set [and] life experiences that the staff can use to support each other and support the youth." Another team member recounted the collaboration of all team members where "through staff meetings each staff would dictate their roles for the week and update their progress," as well as "a solid teamwork ethic and bond" and "an organized plan" for operations. Team members are described as having "passion and drive to help their clients be successful."

Staff members shared the following:

> "I genuinely believe [staff] are there with an open heart and compassion to support residents to the best of their abilities."
>
> "We all get along very well and have all the same goals in mind for the success of the youth and the program."

> "The program provides the participants with housing, food, holistic resources, and a routine that would otherwise not be accessible. The team is made up of people who are empathetic, care deeply about the participants, and work diligently to support everyone's success. The staff serve as some of the first and only healthy attachments to the youth and model healthy behaviors as well."

> "The team - good relationships among staff and youth. Holistic view of the youth and the complex interaction between mental health, substance use, trauma, and all of the other negative past experiences they have had in their lives including racism, sexism, transphobia, homophobia, ableism, and just general stigmatization."

JBU strives to create a home-like environment for the clients, in an effort to "provide advocacy for daily functioning." Staff described their ability to work together as exceptional, as well as their ability to "understand one another to better move through program challenges." Such ability is in part due to "weekly team meetings, building good relationships and partnerships with housing programs, good team communication and delegation of tasks." Moreover:

> "The collaborative efforts of the interdisciplinary team, including the Case Manager (CM), Program Manager (PM), Peer Support Specialists (PSS), and Occupational Therapist (OT)/Occupational Therapy Interns, collectively work together to support the connection to these necessary services. Although this goal falls directly under the CM's role, the other members of the team have made great effort to support this goal and advocate for the client's needs."

According to survey responses, this effort is reflected in the overall feel of the program. JBU strives to create a home-like environment for the clients, in an effort to create a "sense of connection and belonging." Staff describe the climate of JBU as "tight-knit," "cohesive," "personable and homey" and "more of a family feeling than just staff and clients."

> "Staff is very open and caring toward the clients. They understand and sympathize with where they came from and what they have experienced. Staff provide the necessary resources for the clients to achieve their goals."

Connections to Outside Providers

Providing secure housing is a primary goal of JBU, as well as connecting clients with mental health services. To do this, JBU staff work hard to build linkages with outside organizations. Several staff describe case managers' hard work to identify and connect with housing and mental health services. "Regular communication" and "connection with our community mental health partner providers" is key to JBU's successful case management efforts. Staff also describe "outreach connections to public defender's office and psychiatric hospitals to receive youth" and "connections with therapy and psychiatry, as well as holistic care providers."

As one staff member put it:

> "Connecting [clients] with mental health care is instrumental towards having a solid foundation for themselves and helps prevent repeating the cycle of experiencing homelessness again."

According to staff, “connecting clients with mental health services,” is a primary goal of JBU. To do this, JBU staff work hard to build linkages with outside organizations. Several staff describe case managers’ hard work to identify and connect with housing and mental health services, as well as enrolling clients in the Community Queue Partnerships. Staff also describe “familiarity with the community partnerships (i.e., The Center, The County of San Diego BHS, UPAC, Timmy's, The Lucky Duck Foundation, Family Health Services, among others).”

Client Engagement

The above-described staff characteristics, combined with the ability to link clients with outside providers, helped the JBU program with client engagement and retention. When asked to identify the most effective engagement strategies, staff members described:

> “Collaborative efforts to support the clients and express empathy for where the clients are at in their journey of independence, recovery, and mental health. Understand the client’s needs and interests and connect the clients to activities that engage their interests in a safe space.”
>
> “Dedicated and persistent staff members at JBU who go the extra mile to ensure their clients are receiving or being connected to the resources they need to be successful.”

One team member described the team’s non-judgmental and engaged approach with clients:

> “Recognizing where they are at and not punishing them for lack of engagement. Harm reduction principles (as much as possible) re. substance use. Outings - a chance to connect socially where nothing is expected of them other than having fun. Supporting them with reminders about medication/appointments etc.”

Staff also identified communication about goals as an important component of success:

> “Occupational therapy and peer support staff help develop and assist in achieving youth goals for self-sufficiency (in areas of establishing employment/income, physical and mental health self-care skills and other personal development).”

Additionally, concrete elements for successful retention were also shared:

> “Incentivizing participation. Focusing on youth wants/needs and planning events/groups around these wants/needs”
>
> “Being honest with them about how the program works and why we have the expectations of them, such as what needs to happen for us to get funding and why we want them to engage with programs, rather than just telling them that's just the way it is. Also, treating them like peers and not like children or lesser than.”
>
> “The greatest challenge to connecting the services for use is the youth's level of readiness to connect to services and trust between the youth and the people in the organization. This can be surpassed with rapport-building, supporting the youth through challenges, and being consistent with the services provided.”

Staff also identified communication about goals as an important component of success:

> “Identifying meaningful goals and connecting those goals to the services provided.”

"Reminding them of their goals and helping them achieve them."

"Continuing to have conversations [about] what they are working towards."

Additionally, concrete elements for successful retention were named: food, gift cards, engaging outings and recreational activities, as well as individualized incentives/rewards for participation.

OT as a Core Component of JBU Services

The use of OT to assist youth in their goals and treatment plan was cited as a significant strength for the JBU program. OTs aid their clients with vocational and leisure pursuits, social engagements, financial management, medication management, community mobility, among other things. When asked about the potential benefits of OT, JBU staff had much to share:

> "Skill building with OT: advocacy skills, time management. Working on IADLs in OT to ensure youth can be independent in housing: home maintenance/management, meal preparation, housekeeping, safety"

> "OT services connects the gaps of the organization that are unable to be filled by the interdisciplinary team, including identifying occupational performance problems and sensory deficits, collaborating with clients to complete routine building/maintenance, and performing activity analysis and other skilled OT intervention."

The value of OT services led one staff member to suggest the following:

> "I recommend hiring an occupational therapist full-time to increase the frequency of OT services and support the client's ability to perform and participate in daily occupations…OT services provides residents an opportunity to understand and work towards their personal goals. The OT supports residents in gaining autonomy towards their goals by assessing their needs and creating a treatment plan that is specific to each resident."

Program Challenges

Program Relocated Multiple Times, then Returned to Original Downtown San Diego Location

The JBU program moved multiple times in order to try alternative types of housing arrangements. The program ultimately returned to the original downtown San Diego location after having brief periods of operations within a residential community in Clairmont as well as operating within a rehabilitated motel in Chula Vista. The JBU staff identified the moves as creating some challenges for meeting program objectives given the need to establish new relationships with a range of behavioral health and other service providers in their new community as well as the added time and efforts required to complete the actual move. A couple of staff members noted the disorganization they had to face when changing locations. However, one staff member shared the following benefit of relocating back to the original downtown San Diego location:

> "Having a safe environment or a program environment with additional security that help our youths feel safe and secured (as compared to our last placement in the facility at Chula Vista)."

Several staff members suggested ways to improve the location. For instance:

> “A "village" of houses with mental health/SUD/primary care/dental/LGBTQ-affirming services all in the one neighborhood.”
>
> “The facility must have a recreational/communal area for the clients to engage in leisure activities (i.e., playing board games/video games, watch digital media, use computers, be outdoors, a communal place to eat and possibly cook, and access to bathrooms. The facility must also have 24/7 surveillance and a security check upon entrance to increase the safety of the clients and staff on-site.”

Staff Support Concerns

Some of the staff mentioned staff concerns, particularly in terms of overwork and staff shortages.

> “Achieving this goal is a team effort and requires team support. At the time of my internship, there were several occasions in which staff shortages limited the team's ability to meet this goal due to a lack of support.”
>
> “Extreme burnout felt in work culture. Limited staff insights or staff with background on how to support youths struggling with substance use.”

Client Factors

Client factors are the primary challenges named by JBU staff. Client resistance is identified as a significant inhibiting factor in the success of JBU. Staff describe client resistance due to negative experiences with treatment and/or institutions in the past, or difficulty engaging with services due to the severity of their mental health symptoms. Other reasons for such client resistance listed by staff include, stigma, “youth reporting not wanting services due to fear of being labelled/fear of being ‘drugged out’ on medications,” not identifying with their mental health diagnosis, belief that they do not need medication, losing motivation for obtaining services due to waitlists or an inordinate number of steps (or paperwork burden) to access services, lack of staff follow through or support due to low staffing, providers cancelling appointments with youth or rescheduling appointments to dates beyond allotted JBU program time. One staff member also reported the ACT teams may be “denying clients they deem ‘not severe enough’,” while another staff member mentioned “youth struggling with the amount of tasks and expectations,” as reasons for client resistance or lack of follow through.

Substance use can pose an additional hurdle. In the past, JBU staff reported difficulties in connecting with SUD providers who had availability to admit new clients. This continued to be a theme in FY 2022-23. One staff member described the program “not having an adequate SUD approach.” Other staff shared that there is a need for in-house SUD counseling and/or more support from addiction specialists including group therapy and interventions targeting substance use and addiction.

Transportation was a challenge as well. Staff described how some clients struggle with utilizing public transportation and staff are not always available to provide private transit to/from appointments.

According to staff, medication resistance can create particularly serious difficulties in the engagement process: “resistance to medication... creates room for more youth to experience psychosis.” In this case, depending on the severity, duration, and willingness/ability of person to engage in relevant treatment, the client may need to receive crisis services or be hospitalized.

Finally, lack of long-term housing options was another common concern noted by staff:

> “If housing matches aren't yielding from time worked with case management near the end of the program (2 and a half to 3-month range), some youths have reported feeling they are "in survival mode" and no longer feeling secure, leading to a dramatic disengagement with staff and services or decline in quality of engagements from loss of hope for long-term stability.”

> “Youth’s interest and motivation in participating in provided services can be difficult due to their different mental illnesses. Follow-through and scheduling also pose as difficulties as many of them have challenges with organizing their schedules. Additionally, using public transportation to get to services is difficult for some youth.”

> “Youth who have described feeling so traumatized/hurt by the previous mental health/medical care they've received (Not being heard/acknowledged in their care, being forced to take medication they didn't understand, feeling violated or abused) that they are resistant to the idea of services.”

Program Duration

A few staff members shared a desire for clients to be able to stay in the program longer. Staff describe how the program duration is “not enough time to affect change.” Other relevant statements are as follows:

> “120-days is not a long enough time for client to receive all services and care necessary”

> “Not long enough of a duration for the clients in the program to be connected to services and gather missing documents as well as rehabilitate in understanding their SMI diagnosis.”

> “Four months is not long enough for the youth to be stable in their mental health, get housing services, and stable on their medications.”

One staff member also suggested that there needs to be a guaranteed “next level” transitional housing program for youth to go after completing and gaining stability in JBU, as well as the need for easier access to “youth psychiatric/behavioral health records (not all records of diagnostic information/history of service engagements are listed in CERNER which has been detrimental in getting people connected to services and permanent housing programs).”

In addition, staff reported the need for long term housing options for clients:

> “Improved coordination or tools to connect to longer-term housing options/programs for youths at the end of their program duration through County or stakeholders.”

> “Lack of viable housing options for our youth (Reportedly from multiple case managers from this program and other USA programs) despite utilization of VI-SPIDAT tools designed to provide housing matches.”

Other concerns around gaps in service were also noted by staff:

> “I recommend increasing or allocating funding towards hiring an additional PSS or PRN PSS to fulfill the needs of the team and prevent staffing shortages. Although there is no solution to end homelessness and create more housing opportunities, the CM and PM can collaborate to connect with housing organizations and create a ‘funnel’ program depending on the level of independence of the participants.”

> "Clients without insurance, clients in higher level of care unable to access mental health services, or little staffing from mental health clinics unable to serve our clients."

Telehealth

Telehealth can be a solution for clients who cannot attend appointments in person. However, a reliable internet connection and private space are necessary for successful utilization of telehealth services and these things are not always available. Besides having better WIFI connections, staff suggested setting up private spaces with a webcam for clients to use exclusively for telehealth services.

> "Some youth have felt they do not have a space with enough privacy in order to conduct their Telehealth calls (We have two office spaces with a joint den space, however one has to cross through the den space in order to access staff in the office)."

Additionally, one staff member described how some medical providers "require in-person visits as the youth may be less engaged or inconsistent during their telehealth appointments/attending telehealth appointments."

Composite of JBU Youth Experiences

JBU youth have a variety of experiences and needs when they arrive at the program. To reflect the types of experiences we developed the following composite infographic (see Figure 6), derived from multiple youth accounts. While all examples are from JBU youth, it is important to recognize youth entering and exiting the program will have a variety of experiences.

Please see the next page for the infographic characterizing youth experiences with the JBU program.

Figure 6. Infographic Characterizing Youth Experiences with the JBU Program

Changes from Initial Program Design

As a residential program serving homeless youth, a population at considerable risk for exposure to disease, the COVID-19 pandemic required JBU to implement many policies and procedures to comply with CDC and County public health guidelines. JBU successfully navigated these changes to manage risk to participants and maintained the ability to provide in-person services. Examples of policies and procedures are as follows: holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, implementing staff and youth mask requirements and rigorous sanitation procedures, and complying with County public health safety measures. While the basic residential component continued without interruption, JBU had to periodically suspend or alter the provision of in-person holistic services except those which could be socially distanced or completed via remote technologies (i.e., yoga, fitness, mindfulness, and biofeedback). Public outings to promote education, enrichment, and/or growth with peers continued, but were more limited during due to COVID-19. Where possible, activities and events were held outdoors to promote safety among staff and youth. Due to potential exposures to COVID-19 or infections, various JBU staff were required to periodically isolate from JBU youth, which did create additional burdens and challenges for staff to cover JBU operations amidst staffing disruptions. Additional strategic changes from the initial design included:

1. After reviewing outcome data and collecting experiences of JBU youth, JBU stakeholders recognized the difficulties of trying to address the multiple needs of youth within 90 days. While still maintaining the emphasis on short-term support, it was decided to extend the in-residence phase of the JBU program from 90 days to 120 days for those youth who needed additional time in JBU.

2. To increase the number of youth enrolled in JBU, referrals were expanded beyond those provided by BHS. Youth identified through JBU outreach efforts and/or referrals from other community partners could also be admitted into JBU as long as they exhibited similar characteristics and histories as youth referred by BHS (i.e., SMI diagnosis, homeless, utilization of BHS crisis/acute services, and not engaged in treatment). This change was fully implemented during FY 2020-21.
3. The availability of OT services was expanded, with OT services becoming an essential component of how JBU engages with and supports youth. Through interactions with the OT personnel, youth were encouraged to develop and then act on achieving personal goals.

Conclusion

Overall, the findings indicated that the JBU program was able to achieve key objectives of contacting and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in services. A key contributing factor to the success of JBU was the addition of OT services, which helped to further strengthen and focus efforts on developing and implementing individualized, goal-oriented self-improvement activities among the JBU youth. However, substantial challenges remain to enable even more youth to experience greater short- and long-term recovery given that many youths have multiple factors inhibiting such gains including co-occurring SUD, complex physical health needs, limited housing options, and difficulty transitioning to external treatment providers among others.

For more information about this Innovation program and/or the report please contact:
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Appendix

Characteristics of Participants who Enrolled in JBU

Characteristic	Total Participants (N=204)	
Gender	**n**	**%**
Male	121	59.3
Female	70	34.3
Another Gender Identity/Missing	13	6.4
Total	**204**	**100**
Age Group	**n**	**%**
18-21	93	45.6
22-25	111	54.4
Total	**204**	**100**
Primary Language	**n**	**%**
English	198	97.1
Other	6	2.9
Total	**204**	**100**
Race/Ethnicity	**n**	**%**
African American	53	26.0
Asian	12	5.9
Hispanic or Latino	78	38.2
White	77	37.7
Multi-Racial	28	13.7
Other/Missing	**13**	**6.3**
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
Schizophrenia or other psychotic disorder	133	65.2
Bipolar Disorder	41	20.1
Depressive Disorder	19	9.3
Other/Missing	11	5.4
Total	**204**	**100**

[1] Total may exceed 100% since participants could select more than one response.

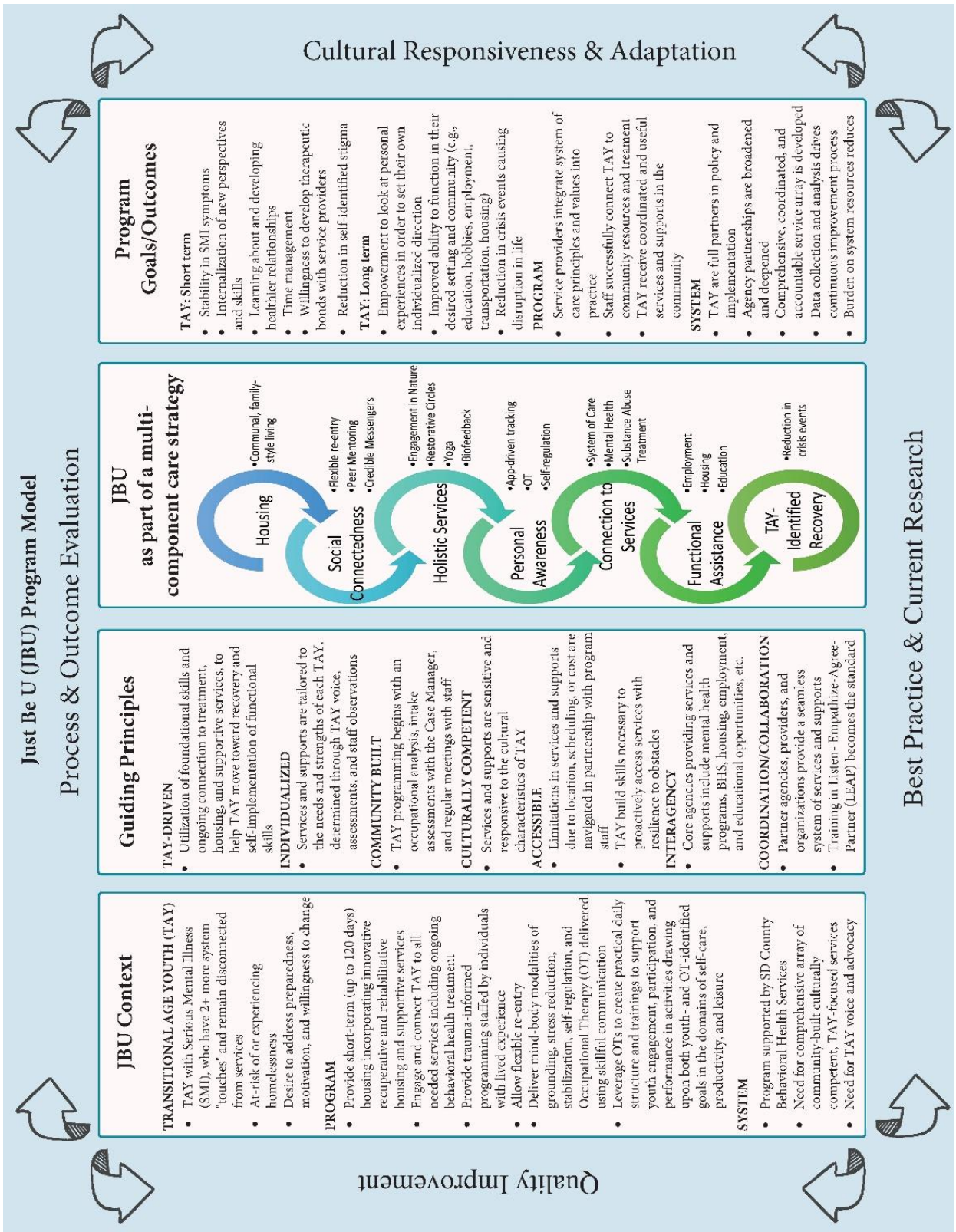
[2] Mental health and substance use diagnosis information is obtained from BHS Cerner data system.

Appendix (continued).

Characteristic	Total Participants (N=204)	
Co-Occurring Substance Use Diagnosis[2]	n	%
Yes	119	58.3
No	85	41.7
Total	**204**	**100**
Sexual Orientation	n	%
Heterosexual or straight	113	55.4
Bisexual/Pansexual/Sexually Fluid	17	8.3
Gay or lesbian	5	2.5
Another orientation	8	3.9
Missing/Prefer not to answer	61	29.9
Total	**204**	**100**
Disability	n	%
Yes, has a disability	49	24.1
No, does not have a disability	97	47.5
Declined/Prefer not to answer	58	28.4
Total	**204**	**100**
Type of Disability	n	%
Learning/Developmental	47	22.7
Physical/Chronic/Other	20	9.6
Total[3]	-	-

[3] *Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.*

JBU Program Model



THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (CCYP) INNOVATIONS-22

Final Report (7/1/2018 - 12/31/2022)

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

v.12.22.2023

COUNTY OF SAN DIEGO Health and Human Services Agency | LIVE WELL SAN DIEGO | UC San Diego

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Executive Summary

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Center for Child and Youth Psychiatry (CCYP) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). CCYP was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that were essential for their wellness and stability, but not easily managed by their primary care provider (PCP). Psychiatric care services were designed to be delivered primarily via telehealth in order to reduce barriers to accessing care and service youth and families throughout the entire County of San Diego. MHSA INN funding for CCYP services ended on 12/31/2022; however, by successfully achieving the primary program objective and demonstrating the capacity to keep youth stable for extended periods of time through the provision of medication management services, CCYP has been incorporated into the existing BHS System of Care as an ongoing service funded through non-INN resources. In addition to providing psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring not viable with their PCP, CCYP supported the overall BHS Child, Youth and Family (CYF) System of Care (SOC) by providing psychiatric care services when other BHS-funded treatment programs experienced temporary gaps in their ability to offer timely psychiatric care (e.g., due to psychiatrist departures or leaves of absence). This role of providing services to "ancillary" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensured continuity of care and has become part of standard CCYP operations. During fiscal year (FY) 2021-22, CCYP expanded their support of the BHS CYF SOC by providing psychiatric care services to youth enrolled in BHS-funded Short-Term Residential Therapeutic Programs (STRTP) that were too small (i.e., 12 or fewer beds) to feasibly provide their own psychiatric services.

Program Description

The CCYP program was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that were essential for their wellness and stability which is not easily managed by their PCP. For children and youth with complex combinations of mental health problems or with complex mental disorders (e.g., PTSD, bipolar disorder, schizophrenia, autism with aggression, ADHD with mood

dysregulation), it can be difficult to find a primary care doctor prepared to manage the medication treatment aspect of their care. Services were provided through a variety of means, including a centrally located psychiatric clinic as well as strong emphasis on telepsychiatry to reduce barriers to accessing care and to extend the reach of CCYP services across San Diego County, a large geographic area covering over 4,250 square miles (an area larger than the combined size of the states of Rhode Island and Delaware). The CCYP program provided linkages and facilitated access to psychotropic medication, including the administration of long-acting injectable psychotropic medication when indicated and necessary for the child or youth's stability. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full-service clinics, schools, PCPs), and the communities they serve. The CCYP program also provided psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. A San Diego-based community organization, New Alternatives Incorporated (NAI), was contracted to provide CCYP services during the Innovations-funded phase of the pilot project.

The CCYP program also developed into an important county-wide BHS CYF SOC resource that can fulfill the need for psychiatric services when other county-funded programs experience a temporary gap in their capability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). Providing continuity of psychiatric care in these situations was determined to be an important ongoing benefit that CCYP could contribute to the CYF SOC. Youth who were admitted via this additional service strategy (i.e., ancillary referrals), differed from the traditional maintenance CCYP enrollees in that they continued to receive psychotherapeutic care services from the referring agency while CCYP provided needed medication management support. This required additional communication and coordination between CCYP and the organization providing the therapy services. During FY 2021-22, a new role was added such that CCYP was responsible for providing medication management services to youth enrolled in BHS-funded STRTPs with less than 12 beds.

The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships were eventually determined to not be feasible, so an emphasis on the medically fragile was not implemented as part of CCYP operations.

MHSA INN funding for CCYP services ended on 12/31/2022; however, with the successful achievement of program objectives, BHS decided that the CCYP program should be incorporated into the existing BHS System of Care as an ongoing service that will be funded through non-INN resources.

Assessment of Primary Project Objectives

The main goal of the CCYP Innovation-funded project was:

1. ***To determine if a Medication Clinic could serve as a specialty program for children and youth who have been clinically stabilized and require sophisticated psychiatric services sufficient to meet their ongoing complex prescribing needs (i.e., too complex for primary care physicians).***

   A total of 760 unique “maintenance” enrollees (i.e., those requiring medication management services, but not therapy services) enrolled into the CCYP program throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. The majority (70.1%; n=533) of clients enrolled in CCYP were at least 12 years old. More females enrolled than males (50.4%; n=383 and 44.3%; n=337,

respectively). CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (58.6%; n=445), followed by White (40.1%; n=305). While most clients reported English as their primary language (85.8%; n=652), more than 10% selected Spanish (11.3%; n=86).

As described in more detail in other report sections below, the pattern of lengthy CCYP program participation of maintenance clients (i.e., average and median CCYP duration 431.5 and 344.5 days, respectively for clients who discharged prior to 12/31/2022), coupled with similar or reduced frequency of BHS crisis and acute care services utilized while in CCYP, indicated that CCYP achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. Additionally, although therapeutic services were not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP. In quantitative and qualitative feedback, both caregivers and youth typically indicated high levels of satisfaction with CCYP services. These findings provide evidence that CCYP successfully accomplished the overall goal of providing psychiatric services to maintain the stability of a diverse population of children and youth living throughout San Diego County who had completed therapy but needed ongoing medication management support.

Additional objectives from the original design of the CCYP program included:

2. ***Provide coordinated and co-located access to care for children and youth who access primary care in Developmental Pediatricians' Offices due to having complex medical needs*.**

   The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships were ultimately determined not to be viable. Therefore, the specific partnership to support medically fragile clients was not implemented as part of CCYP operations during the Innovations-funded pilot phase of CCYP.

3. ***Expand access to care by developing telepsychiatry options in multiple locations throughout the County of San Diego for children and youth who do not have or have not accessed Specialty Psychiatric Care due to geographical distance, cultural reluctance, stigma, fear, or socioeconomic concerns.***

   The initial design of CCYP included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county. Telehealth visits with psychiatrists were initially available at select clinics or in the clients' home during home visits by a CCYP care coordinator or nurse to facilitate the telehealth visits. With the onset of the COVID-19 pandemic in March 2020, home visits and most clinic visits were suspended, and telehealth visits occurred directly with clients and/or their families using their own devices. Since 6/30/2020, almost all service contacts provided by CCYP occurred via telehealth (i.e., phone or video). At the beginning of the project, however, telehealth was a relatively novel service modality and there was some uncertainty about the capability of building client rapport when services were not face-to-face. The results of multiple staff surveys throughout the Innovations-funded phase of CCYP indicated that staff typically rated client interactions via telehealth as better than in-person services. The highest rated items were patient willingness to

schedule sessions and a lowered rate of no-shows. Patient openness, provider/patient relationships, patient/client engagement and focus during sessions were all rated as better with telehealth as compared to in-person sessions. Technological capabilities (i.e., access to high-speed internet) were noted as factors that inhibited delivery of telehealth services, but this was perceived as a diminishing barrier over time. Overall, CCYP demonstrated that telehealth modalities could be successfully utilized to provide medication management and other needed support services to clients throughout the County of San Diego.

4. ***Address workforce shortages by exploring telepsychiatry with psychiatry groups who may be outside of the County of San Diego.***

   During the Innovation-funded phase of CCYP program, the program was able to identify and utilize a team of psychiatrists based in the County of San Diego. In this regard, supplementing the local psychiatric workforce with persons residing in other areas was not needed; however, the success with utilizing telehealth modalities for providing medication management services suggests that utilizing non-local psychiatrists who maintain the necessary licenses would likely be a viable option to pursue in the future.

5. ***Provide evening programs to families on relevant topics and host resource fairs for families to obtain psychoeducation- and medication management-related information and resources via videos, books, pamphlets, websites, and other materials.***

   During the initial years of the Innovations-funded phase of CCYP, the program offered educational sessions at multiple locations throughout the County of San Diego that covered topics such as: 1) psychopharmacology, 2) medication administration & storage, and 3) trauma and how it affects the bodies, minds, and behaviors of kids. Likewise, resource fairs were developed and held at publicly accessible locations such as local libraries that brought together a range of community partners to provide education and support to CCYP clients and the general community. These in-person events had relatively low rates of attendance (typically about 10 persons or less), despite offering childcare. With the onset of the COVID-19 pandemic in 2020, in-person events were no longer feasible and the CCYP program shifted to providing opportunities for remote psychoeducation via video conferences/webinars and hosted sessions such as “Ask a Psychiatrist,” which allowed CCYP clients and the general public to have an opportunity to engage with psychiatrists in a more informal interaction. Additionally, CCYP developed and enhanced other mechanisms for providing psychoeducation and support to CCYP youth, parents/caregivers, and community members via a monthly newsletter and website (https://www.ccypsd.org/). Based on CCYP experiences, even without pandemic-related concerns, hosting in-person community psychoeducation events may not represent a good utilization of CCYP staff time and energy and should be considered cautiously rather than an ongoing expectation of CCYP operations.

6. ***Support the overall CYF SOC by providing psychiatric coverage for programs that have disruptions in access to psychiatric consultation services.***

   While not without some challenges, CCYP fulfilled the supplementary objective of supporting the overall CYF SOC by providing continuity of care for youth who would have otherwise faced disruption in accessing psychiatric medication management services at the location where they participated in ongoing therapy (e.g., due to unexpected leaves). Since FY 2021-22, CCYP also partnered with small

Short-Term Residential Therapeutic Programs (STRTPs; i.e., those with 12 or fewer beds) to meet any medication management needs for youth participating in these programs. A total of 180 youth received CCYP services through these arrangements. When CCYP initially began accepting ancillary referrals, there were some CCYP workforce challenges since providing services for these youth required additional communication and coordination with their treatment providers and these youth had higher levels of need than the maintenance clients who had successfully completed their treatment services prior to enrolling in CCYP. Over time, CCYP leadership adjusted assessment coordinator task requirements and expectations such that their workload requirements were similar regardless of whether providing services to maintenance or ancillary/STRTP clients. Overall, CCYP was able to successfully support the overall CYF SOC by strategically providing psychiatric services when other treatment programs experienced temporary disruptions in their ability to offer medication management services and partnering with select small organizations (e.g., STRTPs) without regular access to psychiatric services.

Future Directions

After the Innovations-funded phase of the CCYP program concluded on 12/31/22, CCYP was incorporated into the overall BHS CYF SOC as an ongoing service. Reflecting the evolution of the CCYP during the Innovations-funded phase, expectations for ongoing CCYP services continued the emphasis on three core populations including:

- Children and youth who have successfully completed their behavioral health treatment but have complex medication requirements that are difficult to manage by PCPs.
- Children and youth receiving behavioral health treatment services at providers who have temporarily experienced a disruption in the capability to provide psychiatric services.
- Youth enrolled in STRTPs with 12 or fewer beds.

Given the success of CCYP to serve as a centralized resource providing needed CYF-oriented psychiatric care, several additional populations will be emphasized in the ongoing CCYP services:

- Youth who are involved in the justice system.
- Youth with co-morbid substance use concerns who may benefit from medication assisted treatment (MAT) approaches.
- Youth who are dependents of the court and for whom consultation, review, and/or feedback is required regarding Juvenile Court JV-220 applications to start or change utilization of psychotropic medications.

Psychoeducation

Providing opportunities for psychoeducation, particularly related to psychotropic medication, will continue to be a priority for ongoing CCYP services. However, based on the experiences of the CCYP program during the Innovations-funded pilot phase, the emphasis will be on electronic forms of communicating information such as via website and newsletters rather than attempting to host in-person community education and training events.

Relationships with Community Providers

Consistent with an area of emphasis during the latter years of the Innovations-funded phase of CCYP, relationships will be fostered with local PCPs and medical groups such as the Children's Primary Care Medical Group (CPCMG), as well as other programs like Smart Care. During the Innovations-funded phase of CCYP, it was common for clients to receive services for more than a year. However, that limited the capacity of CCYP to enroll new children and youth into services. These relationships with outside providers will be essential to allow CCYP to achieve the newly established goal of transitioning most of their clients within a year. The approach currently adopted by CCYP will try to balance the need for stable access to psychiatric care (for up to a year), while also setting up expectations that CCYP will facilitate the needed support and education to ultimately transition medication management responsibilities to other service providers.

CCYP Enrollment

As shown in Table 1, a total of 935 unique persons were enrolled into the CCYP program throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. Of the 935 enrollees, 760 (81.3%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), 175 (18.7%) were considered ancillary enrollees including 44 (4.7%) youth enrolled in CCYP services as part of the new partnership with small STRTP programs (i.e., those with 12 beds or less), in which CCYP is responsible for medication management while other forms of treatment and support occur within the STRTP program.

Table 1. CCYP Program Enrollment (N=935)

Type of CCYP Enrollee	n	%
Maintenance enrollees (i.e., not receiving therapy elsewhere)	760	81.3%
Ancillary enrollees (i.e., receiving therapy elsewhere)	175	18.7%
Total CCYP enrollees	**935**	**100%**

Participant Characteristics

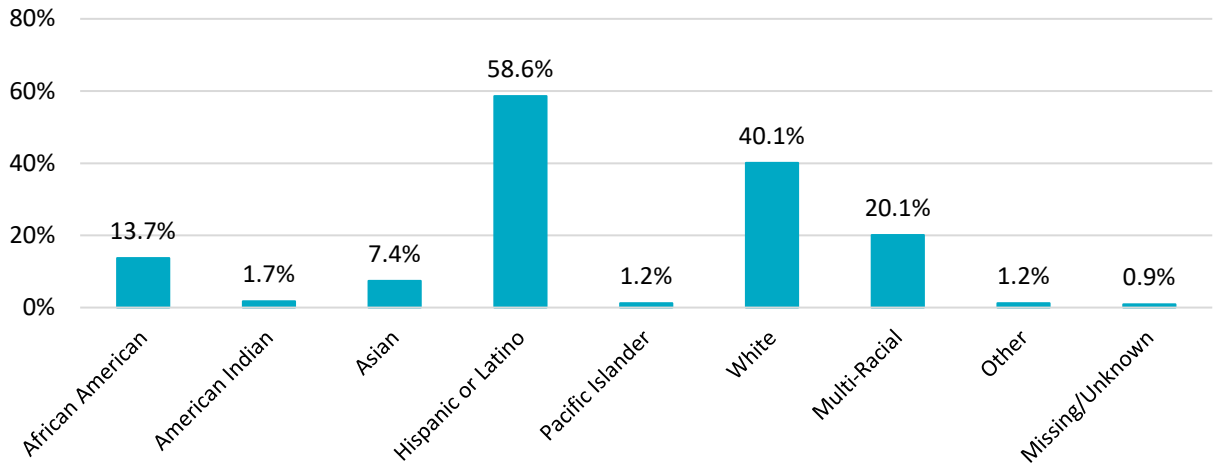
During the life of the program, 935 people enrolled in CCYP. Key characteristics of maintenance participants are discussed below. Additional analyses not reported here found similar demographic characteristics between maintenance and ancillary clients. More detailed information for both maintenance and ancillary participants can be found in the appendix.

The majority (70.1%; n=533) of maintenance clients enrolled in CCYP were at least 12 years old. More females enrolled than males (50.4%; n=383 and 44.3%; n=337, respectively). Over half of clients identified as heterosexual (55.8%; n=424), with 13.3% (n=101) indicating being bisexual, pansexual, or sexually fluid and 23.2% (n=176) declining to select an orientation.

As shown in Figure 1, CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (58.6%; n=445), followed by White (40.1%; n=305), multiple racial/ethnic backgrounds (20.1%; n=153), African American (13.7%; n=104), and Asian (7.4%; n=56).

While most clients reported English as their primary language (85.8%; n=652), more than 10% selected Spanish (11.3%; n=86).

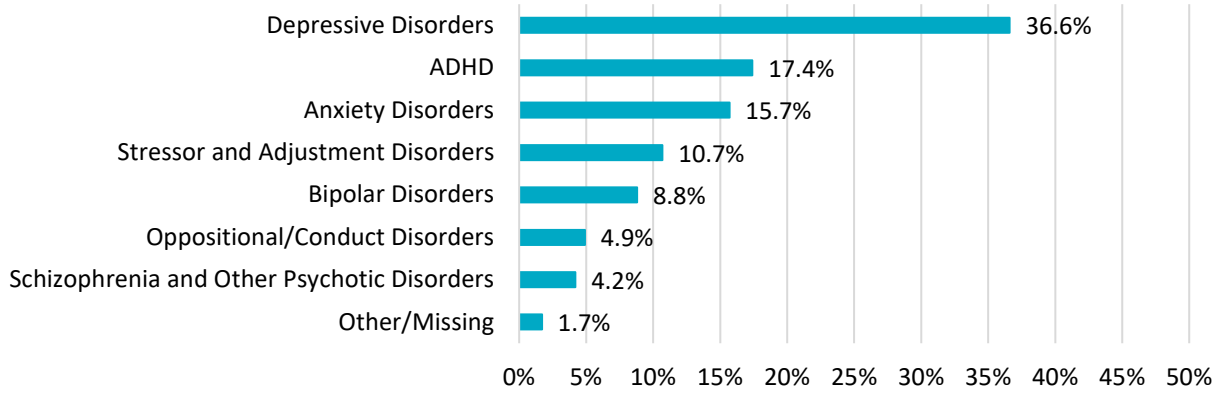
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP (N=760)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

The youth served by CCYP had a wide range of mental health diagnoses (see Figure 2). The most common diagnoses included depression (36.6%; n=279), attention-deficit/hyperactivity disorder (ADHD) (17.4%; n=132), and anxiety disorders (15.7%; n=119).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP (N=760)



The most common disability reported among CCYP participants was a learning disability (8.8%; n=67).

Utilization of Program Services

Program Service Contacts/Service Utilization

The CCYP program served a total of 935 unique youth (760 maintenance and 175 ancillary) throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. The number of youth served annually was substantial: 500 or more youth served per year during the final two years. This level of service was consistent with the original program goals of providing CCYP services to 500 unique youth

each year. Once enrolled, many youth participated in CCYP for more than a year (discussed in more detail below).

Table 2 presents the average number of services received for each 30 days (i.e., one month) of CCYP enrollment across primary service types. On average, maintenance and ancillary/STRTP youth received 1.50 and 1.69 CCYP services per 30 days, respectively. The 0.19 overall difference reflects a narrowing of the gap between maintenance and ancillary evident in earlier years (e.g., 0.28 in FY 2020-21), in which ancillary youth were creating some staffing burdens due to requiring more service contacts per 30 days of receiving CCYP services. This shift highlights successful efforts by CCYP leadership to adjust assessment coordinator task requirements and expectations such that their workload requirements were similar regardless of whether providing services to maintenance or ancillary clients.

Table 2. Average Number and Type of CCYP Services Received by Client Per Month (N=935)

Type of CCYP Service	Mean Number of Services per 30 Days	
	Maintenance (N=760)	Ancillary/STRTP (N=175)
Any CCYP service	1.50	1.69
Psychosocial assessment	0.21	0.26
Medication management	0.70	0.79
Nurse consult	0.37	0.41
Other services (e.g., collateral)	0.22	0.23

For both groups of CCYP clients, medication management services and nurse consultations represented approximately 50% and 25%, respectively, of the average total monthly CCYP services provided. The remaining 25% of contacts were related to psychosocial assessments to track client needs as well as other supportive services such as collateral contacts with other providers.

As shown in Table 3, the method used to deliver CCYP services fundamentally shifted over the years due to the onset of the COVID-19 pandemic. Prior to the pandemic, the majority of CCYP services were provided face-to-face (often with a CCYP team member in the home facilitating a telehealth visit with the psychiatrist). During the initial months of the pandemic (i.e., the end of FY 2019-20), many services shifted to telephone-based, with only a small portion of services provided as telehealth with video directly to clients. Throughout FY 2020-21, CCYP adapted their approach and increased utilization of telehealth such that by the end of the Innovations-funded CCYP project, slightly under 50% of services were provided via telehealth.

Table 3. Type of CCYP Service Contact

	FY 2018-19		FY 2019-20		FY 2020-21		FY 2021-22	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth with video	119	6.4%	419	11.1%	1,790	40.6%	2,029	48.3%
Telephone	403	21.7%	1,658	43.7%	2,544	57.7%	2,125	50.6%
Face to face	1,335	71.9%	1,713	45.2%	75	1.7%	46	1.1%
Total Services	**1,857**	**100%**	**3,790**	**100%**	**4,409**	**100%**	**4,200**	**100%**

Program Duration

Enrollment duration and discharge status were analyzed for all maintenance and ancillary CCYP clients to generate a better understanding of typical CCYP participation patterns. As shown in Table 4, for maintenance clients still participating in CCYP services as of 12/31/2022, the average duration of enrollment was 15 months (459.5 days) and the median duration (i.e., the midpoint value where 50% are shorter and 50% are longer) was 289.0 days. For ancillary clients, the average was 386.3 days, and the median was 360.5 days. This difference between mean and median in maintenance clients was largely driven by a group of long-term CCYP clients, who have been receiving services for multiple years and thereby increase the average duration value. A similar pattern was evident among maintenance youth who had discharged from CCYP prior to 12/31/2022 (i.e., mean and median of 431.5 and 344.5, respectively). The mean and median duration of ancillary clients who had discharged was substantially shorter (276.1 and 222.0, respectively), suggesting that more recent ancillary clients were continuing with CCYP program for longer periods of time.

Table 4. CCYP Duration for Youth Receiving Services (N=935)

	Maintenance (N=760)			Ancillary/STRTP (N=175)		
	n	Number of Days		n	Number of Days	
		Mean	Median		Mean	Median
Open in CCYP as of 12/31/2022	156	459.9	289.0	24	386.3	360.5
Discharged from CCYP prior to 12/31/2022	604	431.5	344.5	151	276.1	222.0

BHS Utilization Patterns

BHS Services Utilization Before and During CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without need for crisis or acute care services, BHS service utilization patterns before and during CCYP enrollment were compared. This was accomplished using the Cerner administrative database that documents the provision of BHS-funded services throughout San Diego County to identify mental health services received by CCYP clients from other BHS providers.

Since the amount of time enrolled in CCYP varies considerably between maintenance and ancillary clients, and can be quite lengthy (i.e., frequently more than a year for maintenance clients), a standardized metric was created to enable equivalent comparisons for BHS service utilization before and during CCYP. The standardized metric for the "during CCYP" period reflects the average amount of services youth would be expected to receive during a 180-day period with CCYP. This metric facilitates comparisons to the 180-day period immediately prior to entering CCYP, and between maintenance and ancillary clients. The standardized or average utilization of other BHS services during a 180-day period while enrolled in CCYP was calculated by adding all BHS services (by service type) that occurred while clients were enrolled in CCYP and dividing that by the total number of days that all clients were enrolled in CCYP. The resulting

value represents the average number of BHS services that CCYP clients received per day, which is then multiplied by 180 to generate the estimate of BHS services that CCYP clients would receive during any 180-day period in CCYP. This allows for an equivalent comparison to the average amount of BHS services utilized by youth during the 180 days prior to CCYP.

Table 5. Comparison of BHS Service Utilization Prior to and During CCYP (N=935)

	Maintenance Clients (N=760)		Ancillary/STRTP Clients (N=175)	
	Average number of BHS services per person, per 180 days			
	Prior to CCYP	In CCYP	Prior to CCYP	In CCYP
Inpatient hospitalization	0.05	0.03	0.17	0.08
Crisis stabilization visits	0.14	0.10	0.48	0.34
PERT/MCRT[1] visits	0.03	0.04	0.11	0.09
Therapeutic behavioral services	2.45	0.22	1.82	0.70
Outpatient sessions (not CCYP)	17.76	2.10	16.77	12.48

[1] *Psychiatric Emergency Response Team (PERT) /Mobile Crisis Response Team (MCRT)*

For the 760 maintenance youth served by CCYP, prior to their CCYP enrollment they utilized crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT/MCRT contacts relatively rarely (i.e., averaging much less than one instance per person in the 180-day period; see Table 5). Further, the average number of instances for these services was nearly the same from the 180 days pre-enrollment to 180 days in CCYP which is consistent with CCYP program design (i.e., that persons referred to CCYP have been determined to be relatively stable and not in need of ongoing therapy in order to maintain their health and well-being).

An additional component of the CCYP concept is that the program provides psychiatric care without requiring participation in therapy. Given this design, the average number of non-CCYP outpatient sessions understandably reduced substantially from 17.76 in the 180 days prior to CCYP to 2.10 during the 180 days enrolled in CCYP. Feedback from CCYP staff indicated the non-CCYP outpatient visits that did occur were frequently related to situations where emergent circumstances resulted in the need for a youth to reconnect with a program that offered ongoing therapy. To facilitate the transition, a "warm-handoff" occurred during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program.

Results highlighted differences in service needs between maintenance and ancillary clients. A comparison of the behavioral health service utilization patterns of maintenance and ancillary clients prior to CCYP and while enrolled in CCYP reveals some key differences. While still relatively rare events, inpatient hospitalizations, crisis stabilization visits, and Psychiatric Emergency Response Team (PERT) encounters were approximately 2-4x as common in ancillary clients prior to CCYP enrollment and then remained higher during CCYP enrollment when compared to maintenance clients. These findings were consistent with the expectation that maintenance clients had been previously evaluated and determined to be more stable and not in need of ongoing therapeutic services. Meanwhile, the ancillary clients were still in active treatment elsewhere and relied upon CCYP to provide need medication management services to address

a temporary disruption in access to psychiatric care or as a strategic partner for medication management services for select programs such as STRTPs. For the same reason, it is not surprising that ancillary clients exhibited a much higher utilization of non-CCYP outpatient treatment services while enrolled in CCYP compared to maintenance clients (12.48 and 2.10, respectively). This apparent difference in service utilization patterns between maintenance and ancillary clients provides evidence that overall, CCYP was able to successfully identify clients who had completed their treatment and were no longer in need of therapeutic services to maintain mental health stability.

For maintenance clients, additional examinations of BHS service utilization patterns were conducted to assess for differences based on age (i.e., 12 or younger compared to those older than 12), gender, race/ethnicity, language (English compared to Spanish-speaking) and duration in CCYP (i.e., 90 days or less in CCYP compared to those in CCYP for more than 90 days). Overall, the pattern of maintaining or reducing the amount of interaction with BHS crisis-oriented services while enrolled in CCYP coupled with substantially reduced outpatient visits (i.e., from approximately 18 sessions during the 180 days pre-CCYP to two during each 180 days in CCYP) did not vary based on age, gender, race/ethnicity, or language. These findings indicate that the benefits of long-term stability provided by CCYP were generally experienced similarly across clients with a wide range of demographic characteristics.

For the approximately 10% of clients who were in CCYP for 90 days or less, these persons exhibited higher levels of crisis interactions with BHS before and during their time in CCYP compared to those who were in CCYP for more than 90 days and had substantially higher incidence of needing outpatient therapy while enrolled in CCYP. These results suggest that approximately 10% of the persons who enrolled in CCYP likely still needed additional treatment and/or decompensated relatively quickly after enrolling into CCYP and needed to be transitioned back to other forms of treatment.

Overall, findings demonstrate that CCYP was typically able to successfully maintain stable mental health among their participants, particularly among the maintenance client population. Notably, the findings regarding BHS service utilization have been consistent during each annual report review. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., often more than a year) indicate that CCYP was consistently able to maintain the stability and well-being of youth by providing regular psychiatric consultation services.

Primary Program Outcomes

Three assessment-based outcome tools are reported in this section of the report: the Child and Adolescent Needs and Strengths (CANS), the Pediatric Symptoms Checklist (PSC), and Caregiver/Youth Feedback Surveys. The CANS and PSC are BHS-required tools to evaluate services provided across all levels and types of care. It is important to note that the primary goal of CCYP is maintaining stability through medication management only; thus, it is not necessarily expected that significant improvements would be seen between initial enrollment into CCYP and later follow-up assessments. Note that only maintenance clients, the primary target population, are included in these analyses (i.e., those who are only receiving CCYP medication management services and not receiving therapy services in other programs).

Child and Adolescent Needs and Strengths

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In CCYP, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 656 clients were enrolled for at least six months and had a follow-up or discharge CANS completed to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a "2" or "3" indicating a specific area that could be potentially addressed in the service or treatment plan (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 6 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral/Emotional Needs, Life Functioning, and Risk Behaviors. These findings show statistically significant reductions at the last available follow-up for the Child Behavioral/Emotional Needs domain. These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that improved while participating in CCYP.

Table 6. CANS Average Change from Initial Assessment (N=656)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Child Behavioral	2.0	1.5***
Life Functioning	1.2	1.2
Risk Behaviors	0.2	0.1

****statistical significance at p < 0.001*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). For Child Behavioral/Emotional Needs and Life Functioning domains, approximately 55-60% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment (see Table 7). This reduction in need is close, but slightly less than found in traditional outpatient programs (i.e., where 70-75% typically have at least one improvement for each domain). Given that CCYP does not provide therapeutic services to address specific treatment needs, the findings highlight the importance of consistent medication management and the associated care team: the majority of the CCYP population with needs at baseline experienced improvements in their overall well-being in these treatment-related domains while receiving CCYP services. For Risk Behaviors, only a small number of CCYP clients had such a need, but of those, most (66.7%) had a reduction in need in this area at follow-up.

Table 7. Persons with CANS Improvement at Follow-up (N=656)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Child Behavioral	537	292	54.4%
Life Functioning	402	237	59.0%
Risk Behaviors	57	38	66.7%

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 8.

The PSC-35 was administered at entry into CCYP, at 6-month reassessment, and at discharge. However, as a voluntary self-report tool, the completion rates at follow-up or discharge are lower than clinician-completed tools such as the CANS. A total of 323 caregivers and 231 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 47.7% of parents and 39.4% of youth reported PSC scores that indicated clinical concern (see Table 8). At follow-up, fewer parents and youth (37.5% and 30.3%, respectively) reported clinically significant scores. PSC scores indicate that even without a therapeutic component, providing access to ongoing medication management services can be associated with perceived improvements in behavioral outcomes for at least a portion of parents and youth.

Table 8. PSC Average Change from Baseline

	Parent/Caregiver Report (N=323)					Child/Youth Report (N=231)				
Subscales	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	323	37.2%	28.5%	5.4	4.9*	231	31.6%	24.2%	4.9	4.7
Internalizing	323	42.1%	39.6%	4.1	3.8*	231	42.0%	38.1%	4.0	3.7
Externalizing	323	27.9%	23.8%	4.5	4.3	231	8.2%	9.1%	2.8	2.5*
Total Score	**323**	**47.7%**	**37.5%**	**27.0**	**25.3***	**231**	**39.4%**	**30.3%**	**24.2**	**22.0***

**statistical significance at $p < 0.05$*

[1] PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

An examination of mean score changes in parent self-report shows a small, but statistically significant reduction (i.e., improvement) for both the Attention subscale and the total PSC score. Among youth

respondents, a small but statistically significant reduction (i.e., improvement) was found for the Externalizing subscale and total PSC score. With the reduced sample sizes for completed self-report PSC assessments (as compared to the clinician completed CANS), the findings should be interpreted cautiously as they may not reflect the broader experiences of the full CCYP population.

To better understand the distribution of PSC change scores within the CCYP client population and to facilitate comparisons with the overall CYF BHS system, analyses were conducted that examined the level of change from initial PSC assessment. Consistent with the Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 9. Distribution of Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=323)		Child/Youth Report (N=231)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	130	40.2%	81	35.1%
No improvement (i.e., 0-1 point reduction)	32	9.9%	36	15.6%
Small improvement (i.e., 2-4 point reduction)	42	13.0%	32	13.8%
Medium improvement (i.e., 5-8 point reduction)	51	15.8%	36	15.6%
Large improvement (i.e., 9+ point reduction)	68	21.1%	46	19.9%

As shown in Table 9, approximately one-third of parents/caregivers (36.9%) and children/youth (35.5%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 40.2% of caregivers and 35.1% of children reported a higher PSC score at follow-up, indicating perceptions of increased impairment. Given that the CCYP population was determined to be relatively stable and not needing ongoing therapy upon entrance into CCYP, this finding of increased impairment likely reflects, at least in part, a "ceiling effect" in that there was not much room for improvement for many youths so it is not surprising that a portion of parents and youth might identify a few additional concerns at a later time point. Overall, these findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes.

Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2021-22 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements while about 20-25% reported increased impairment from initial PSC assessment. While caution is warranted when making any direct comparisons between CCYP and CYF PSC change score analyses, it is not surprising that the CCYP population appears to exhibit lower levels of PSC improvement, given the specific nature of the CCYP population (i.e., demonstrating mental health stability without a perceived need for ongoing therapy), and the fact that the CYF analyses only include persons with completed discharge assessments (i.e., have concluded treatment goals). However, the variability of PSC change scores among CCYP clients is a reminder that there are CCYP clients who may benefit from additional therapeutic support and may require linkage to ongoing behavioral health care outside of CCYP.

Caregiver and Client Perspectives on CCYP Services

A total of 190 caregiver feedback surveys and 154 youth feedback surveys were completed at either the 6-month time point or discharge. As shown in Table 10, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (91.6% and 86.4%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on child functioning and help-seeking. More caregivers reported improvements in functioning (83.2%), compared to 74.0% of children/youth. Likewise, 90.0% of caregivers reported knowing where to get help and 82.6% felt comfortable seeking help, compared to 81.2% and 73.4%, respectively, among youth. Similarly, more caregivers than youth reported feeling that their needs were met by the program (85.8% and 74.7%, respectively). The above findings should be interpreted with some caution as the number of caregivers and youth who completed a feedback survey was relatively low (i.e., approximately 25% of all CCYP participants) and may not reflect the perspective of all participants.

Table 10. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=190)**	**Youth (N=154)**
As a result of this program, my child is/I am able to function better.	83.2%	74.0%
As a result of this program, my child/I know where to get help.	90.0%	81.2%
As a result of this program, my child is/I am more comfortable seeking help for myself.	82.6%	73.4%
My child's/my needs were met by this program.	85.8%	74.7%
Overall, I am satisfied with the services I received here.	91.6%	86.4%

For the open-ended caregiver and youth feedback survey questions, at least two evaluators reviewed and coded the individual question responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Overall, the open-ended feedback provided by clients and caregivers across the years of the Innovations-funded phase of CCYP indicated that they felt supported by the program and found the medication management services to be helpful. Caregivers particularly appreciated the flexibility and variability of appointments (e.g., increased accessibility via telepsychiatry visits) and some caregivers and youth reported positive client/family outcomes as a result of the program. In the last year of the program, caregivers and clients were asked about the new transition planner role. Overall perceptions were that the transition planner was helpful, specifically in providing referrals, information, and resources. Very few suggestions for improving CCYP services were indicated across the reports by a small number of caregiver and client respondents.

Primary Implementation Findings

Findings in this section were derived from three primary data sources: 1) CCYP stakeholder meetings, 2) the Annual CCYP Staff/Psychiatrist Survey and 3) semi-structured interviews with psychiatrists conducted during Spring 2021. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program

operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of each FY during which program staff and contracted psychiatrists were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Survey response rates were typically above 90%. For the primary open-ended staff survey questions, at least two evaluators reviewed and coded the individual responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths

CCYP Staff & Leadership

When asked which factors helped most toward achieving goals, staff and psychiatrists consistently highlighted the availability of licensed psychiatrists, strong management, and high performing staff. A typical response was offered by one staff member who described "a strong team of psychiatrists, program leadership, [and a] solid team of staff who are dedicated and loyal," while another highlighted "committed team members working to improve mental health outcomes for kids and families."

Outreach and Recruitment

Across the years, outreach and recruitment were not perceived as substantial challenges for the CCYP program. The CCYP program appeared to be well-known throughout the county and accepted referrals from many different organizations & providers (both maintenance and ancillary referrals). In response to the continued substantial demands for youth psychiatric services, additional partnership opportunities were developed each year including the formal relationship with BHS-funded STRTP operating throughout San Diego County, in which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

Client Engagement and Retention

The CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for the final years of the Innovations-funded phase of CCYP was to enhance client engagement strategies, and staff reported using several strategies such as a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips, follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary. Overall, these strategies appeared to have been successful, as CCYP staff overall did not indicate client engagement as a significant area of concern by the end of the Innovations-funded phase of CCYP. When asked about how they facilitated client and caregiver engagement in CCYP services, the most common responses were communication with clients/families including appointment reminders, follow-ups, and simply listening, as well as working to set appropriate expectations about the service and educating clients and caregivers about medication management.

This represents an improvement across the years as engagement in care was previously identified as a challenge in terms of no-shows and lack of client responsiveness during medication management services. A hypothesized reason for the lack of engagement was the shift away from care coordinators having ongoing contact with clients and families. Once the program began setting expectations for families in terms of their contact with care coordinators and psychiatrists, as well as using engagement strategies such as, a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips,

follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary, engagement ceased to be a common theme in open-ended feedback survey responses.

When psychiatrists were asked to comment specifically on factors affecting client medication adherence, providers mentioned: a lack of available resources for clients who need additional supports, difficulties in obtaining labs, a lack of understanding among clients regarding why medication is needed, and a lack of understanding among clients about medication side effects. Resources needed include increased psychoeducation materials, assistance with completing lab draw appointments, assessment coordinators to provide increased reminders and check-ins, and supports such as telephone alarms and pill boxes.

Telehealth

The initial design of CCYP, which already included a reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services. At the beginning of the project, however, telehealth was a relatively novel service modality and there was some uncertainty about the capability of building client rapport when services are not face-to-face. In the FY end surveys, staff were asked to rate their client interactions: how does telehealth compare to in-person sessions?

By the final few years of the Innovation-funded phase of CCYP, staff typically rated client interactions via telehealth as better than in-person services. The highest rated items were often patient willingness to schedule sessions and a reduction in the rate of no-shows. Patient openness, provider/patient relationships, patient/client engagement and focus during sessions were all rated as better with telehealth as compared to in-person sessions. Confidentiality and quality of patient communication were rated the lowest, although still well in favor of telehealth.

In the last year of the survey (FY 2021-22) on a scale of 1 to 5 where 1 = strongly disagree and 5 = strongly agree, staff indicated they like providing telehealth services (4.9) and they feel confident about their ability to provide services via telehealth (4.8). Staff strongly agreed that the agency has done a good job supporting the shift to telehealth services (4.5) and that providing telehealth services should continue to be a high priority (4.8).

Prior to the onset of the pandemic in March 2020, CCYP was providing a mixture of in-person and telepsychiatry services. Both CCYP psychiatrists and other staff indicated across the years that they generally did not perceive a substantial difference between in-person and telehealth visits with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information. Staff indicated that the telehealth mode of service delivery provides unique insight into life at home (e.g., family dynamics), that clients can be more open and comfortable at home, a decreased no-show rate, and increased flexibility of scheduling. Strategies to further facilitate telehealth included giving clients a choice between phone and video conferencing for appointments (to address personal preferences and/or technology challenges) and providing equipment to obtain essential vital signs as home.

Program Challenges

Referrals to other Community Services

In the final staff survey (i.e., FY 2021-22), staff scored various aspects of referrals to other services as the most challenging domain for providing CCYP services. On occasion, a CCYP participant may need a referral for additional therapeutic or social assistance services. The limited availability of other community services, wait lists for other services, and clients not completing their referrals were scored on average as 4.6, 4.5 and 4.0 on a scale of 1 to 5 where 1= not challenging at all and 5 = very challenging. There were some differences in how psychiatrists and non-psychiatrists rated items (see Table 11).

Table 11. Ratings of Service Delivery Challenges by Role

	Psychiatrist Mean Score (N=4)	Non-Psychiatrist Mean Score (N=9)
Limited availability of other community services	5.0	4.4
Waitlists for services clients were referred to	5.0	4.2
Difficulties getting required documentation completed (e.g., BHAs, updated vitals)	2.8	3.8
Forming relationships with community partners	3.8	3.1
Program staff turnover	3.0	3.8
Client attrition/not completing program	2.0	2.4
Clients not actively engaging with CCYP services (i.e., frequent no shows or rescheduling, limited "buy-in")	3.3	3.1
Clients not completing referrals for other services	4.0	4.0

On average, psychiatrists found the following more challenging than non-psychiatrist staff: limited availability of other community services, waitlists for services clients were referred to, and forming relationships with community partners. One survey respondent stated a need for "allowing CCYP to make referrals to programs county-wide in order to assist caregivers and clients that may be struggling to get connected." Non-psychiatrists found program staff turnover and client attrition more challenging than psychiatrists. Both groups rated client engagement and lack of client follow-through on referrals similarly challenging.

Barriers to Telehealth with Video

While overall impressions of telehealth with video were favorable, staff and psychiatrists reported that some caregivers and clients are unable to engage in services this way. Staff reported that 5-10% of clients are unable to consistently utilize telehealth with video (i.e., do not have a suitable device or reliable internet) and 5-10% of video sessions experience tech-based difficulties. However, the number of clients who prefer not to use telehealth with video was less than 5%. This discrepancy implies that there are clients willing to and may even prefer telehealth with video but are unable to successfully utilize it. While

familiarity and access to the technology to conduct telehealth visits have improved over recent years, one staff member shared:

> "There may be caregivers that are not familiar with how to connect to the video session. There may be some families where the internet connection may be poor making it difficult to connect to the video session."

Changes from Initial Program Design

1. The proposed partnership with UCSD to serve medically complex patients who have psychiatric medication needs did not come to fruition due to administrative and logistical reasons that did not allow for integrated services as originally envisioned. After substantial negotiations, BHS determined that this aspect of the initial design for CCYP would not be implemented.

2. The initial approach to providing psychiatry visits via telehealth was to have clients visit select clinics set up to facilitate telehealth visits with a remotely located psychiatrist or to have a CCYP team member (typically a nurse or care coordinator) travel to the home of the client with the device used to complete the telehealth visit with the psychiatrist. After the onset of the pandemic in March of 2020, telehealth visits were more typically accomplished by directly connecting with clients and utilizing their computer or smartphone to conduct the telehealth visit.

3. The Care Coordinator position that was part of the original program design morphed in several ways over the life of the program. When the program started, Care Coordinators were licensed clinicians who provided ongoing support to families from intake to discharge with CCYP. Given CCYP is designed for clients who have completed a course of psychotherapy, Care Coordinators were asked not to provide clinical services to their clients and yet this proved difficult with the original service structure design and position title. Over the course of the program, Care Coordinators (who remained licensed clinicians) transitioned to being named (and recruited) as "Assessment Coordinators," and their role was more clearly and narrowly defined as focused on the initial intake with some minimal check-ins and support during treatment, primarily focused on supporting psychiatrist recommendations.

4. During FY 2021-22, CCYP began a partnership with the BHS-funded STRTP programs to provide medication management services for youth participating in small STRTPs (i.e., 12 or fewer beds).

5. During FY 2021-22, a "Transition Planner" was added to the CCYP service delivery team to help with connecting youth and families to relevant post-CCYP services. This position was created after the team observed a "bottleneck" where clients were experiencing delays in discharge, sometimes after years in the program. These delays were preventing new clients from being served.

6. In addition to the Transition Planner position, CCYP worked for the second half of the Innovations-funded phase of the program to foster a pipeline to some larger pediatric and family medicine practices, including CPCMG. CCYP identified and worked with CPCMG lead physicians who had some experience and interest in serving clients with psychiatric needs to create a seamless referral process.

Conclusion

The CCYP program served a total of 935 unique youth (760 maintenance and 175 ancillary) throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. During the final two full

years of the project CCYP provides services to approximately 500 youth and their families each year. Once enrolled, many youth participated in CCYP for more than a year. CCYP successfully served a diverse client population (58.6% Hispanic) as evidenced by a pattern of lengthy CCYP program participation of maintenance clients (i.e., average and median CCYP duration 431.5 and 344.5 days, respectively for clients who discharged prior to 12/31/2022), coupled with similar or reduced frequency BHS crisis and acute care services utilized while in CCYP. These findings indicated that CCYP was able to achieve the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy.

Additionally, although therapeutic services were not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP. In quantitative and qualitative feedback, both caregivers and youth typically indicated high levels of satisfaction with CCYP services. Overall, these findings provide evidence that CCYP successfully accomplished the overall goal of providing psychiatric evaluation and treatment to a diverse population of children and youth living throughout San Diego County who had completed therapy services but needed ongoing and complex medication monitoring not viable with their PCP.

As a centralized resource with capacity to provide needed child and adolescent psychiatry services, CCYP supported the overall BHS SOC by providing psychiatric care services when other BHS-funded treatment programs experienced temporary gaps in their ability to offer timely psychiatric care as well as for select small programs who were determined to be unable to provide their own psychiatric services. This role of providing services to “ancillary” referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensured continuity of care and has become part of standard CCYP operations.

Based on the findings from the Innovations-funded CCYP pilot project, it was decided by the County of San Diego to incorporate the CCYP medication clinic services into the ongoing BHS SOC so this resource will be available to children, youth and families for the foreseeable future.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of CCYP Participants

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Age Group	**n**	**%**	**n**	**%**
5 to 11	227	29.9	36	20.5
12 to 15	265	34.9	61	34.9
16 to 17	210	27.6	67	38.3
18 to 20	58	7.6	11	6.3
Total	**760**	**100**	**175**	**100**
Gender	**n**	**%**	**n**	**%**
Male	337	44.3	75	42.9
Female	383	50.4	85	48.6
Transgender	8	1.1	<5[4]	<2.9
Genderqueer/Gender non-conforming	13	1.7	<5[4]	<2.9
Questioning/Unsure of gender identity	7	0.9	<5[4]	<2.9
Another gender identity	7	0.9	6	3.4
Prefer not to answer	5	0.7	0	0.0
Total	**760**	**100**	**175**	**100**
Sex at Birth	**n**	**%**	**n**	**%**
Male	324	42.6	71	40.6
Female	403	53.0	93	53.1
Missing/Prefer not to answer	33	4.4	11	6.3
Total	**760**	**100**	**175**	**100**
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	424	55.8	97	55.4
Gay or lesbian	17	2.2	7	4.0
Bisexual/Pansexual/Sexually fluid	101	13.3	25	14.3
Questioning/Unsure of sexual orientation	28	3.7	<5[4]	<2.9
Other sexual orientation	14	1.8	<5[4]	<2.9
Missing/Prefer Not to Answer	176	23.2	38	21.7
Total	**760**	**100**	**175**	**100**

Appendix (continued).

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Language	**n**	**%**	**n**	**%**
English	652	85.8	152	86.9
Spanish	86	11.3	19	10.9
Other/Prefer not to answer	22	2.9	4	2.2
Total	**760**	**100**	**175**	**100**
Race/Ethnicity	**n**	**%**	**n**	**%**
African American	104	13.7	40	22.9
American Indian	13	1.7	6	3.4
Asian	56	7.4	13	7.4
Hispanic/Latino	445	58.6	85	48.6
Pacific Islander	9	1.2	<5[4]	<2.9
White	305	40.1	74	42.3
Multiple	153	20.1	41	23.4
Other	9	1.2	<5[4]	<2.9
Missing/Prefer not to answer	7	0.9	40	22.9
Total[1]	-	-	-	-
Mental Health Diagnosis[2]	**n**	**%**	**n**	**%**
ADHD	132	17.4	16	9.1
Oppositional/Conduct Disorders	37	4.9	9	5.1
Depressive Disorders	279	36.6	68	38.8
Bipolar Disorders	67	8.8	12	6.9
Anxiety Disorders	119	15.7	14	8.0
Stressor and Adjustment Disorders	81	10.7	42	24.0
Schizophrenia and Other Psychotic Disorders	32	4.2	11	6.3
Other/Missing	13	1.7	3	1.8
Total	**760**	**100**	**175**	**100**

Appendix (continued).

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Substance Use Disorder (SUD) Diagnosis	**n**	**%**	**n**	**%**
Yes, has SUD Diagnosis	17	2.2	23	13.1
No, does not have SUD Diagnosis	743	97.8	152	86.9
Total	**760**	**100**	**175**	**100**
Disability	**n**	**%**	**n**	**%**
Yes, has a disability	166	21.9	19	10.9
No, does not have a disability	565	74.3	137	78.2
Declined/Preferred not to answer	29	3.8	19	10.9
Total	**760**	**100**	**175**	**100**
Type of Disability	**n**	**%**	**n**	**%**
Seeing	36	4.7	<5[4]	<2.9
Hearing	18	2.4	<5[4]	<2.9
Other Communication Disability	14	1.8	<5[4]	<2.9
Learning	67	8.8	9	5.1
Developmental	45	5.9	<5[4]	<2.9
Other Mental Disability	12	1.6	<5[4]	<2.9
Physical Disability	12	1.6	<5[4]	<2.9
Chronic Health	7	0.9	<5[4]	<2.9
Other	44	5.8	<5[4]	<2.9
Total[3]	-	-	-	-

[1] Total may exceed 100% since participants could select more than one response.
[2] Mental health diagnosis information is obtained from BHS Cerner data system.
[3] Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.
[4] Values were suppressed due to small n size.