ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 3 (7/1/2021 - 6/30/2022)

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

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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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 to provide mental health services to public health nursing participants. ADAPT provides therapeutic treatment, peer support, linkage to community resources and support for the entire family. With the onset of 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/video calls. The program has since re-introduced in-person services in the community 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 2021-22

Increased Overall ADAPT Program Enrollment Serving Racially/Ethnically Diverse Participants

1. A total of 117 persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). Of note, the 97 persons enrolled into Level-1 services during FY 2021-22 represented a 110.9% increase from FY 2020-21 in which 46 persons enrolled into Level-1 services.

2. The increased FY 2021-22 enrollment was the result of: 1) more referrals from the MCH and NFP public health nursing (PHN) programs (n=181) as the COVID-19-related burdens on those programs lessened, and 2) increased referrals (n=80) originating from other community and hospital partners. Total ADAPT enrollment remained less than the initial program goal (i.e., 117 unduplicated persons compared to a target of 300). The effects of the ongoing COVID-19 pandemic, while not as severe as experienced during FY 2020-21, continued to result in lower than initially expected referrals from public health nursing programs.
3. The ADAPT program served a racially and ethnically diverse population with the majority (67.5%) identifying as Hispanic/Latino and approximately 20% indicating that Spanish was their primary language.

Participants Experienced Improvements and Viewed ADAPT Program Favorably

4. As reported through both clinician and participant assessments, ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Additionally, improved sleep and less fatigue were commonly reported along with improvements in other key life domains such as better social relationships and ability to handle daily activities.
5. Participants expressed high levels of satisfaction with ADAPT services and indicated they would recommend ADAPT to family or friends experiencing peripartum depression and anxiety. As one participant stated, "Every mom should have this kind of support - you guys really care and go out of your way to support us."

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

6. The ADAPT team continued to increase the amount of ADAPT services delivered via telehealth with video during FY 2021-22 while also providing more in-person services as conditions of the COVID-19 pandemic allowed (with telephone-based services decreasing). Feedback indicated that many participants preferred a hybrid service delivery model that allowed for the greater convenience and frequency of telehealth services while still having the option for in-person connections as needed. However, some clients expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.
7. To support the potential for long-term sustainability, during FY 2021-22 the ADAPT program completed the process to allow for Medi-Cal insurance reimbursement billing.

ADAPT Program Continued to Foster Community Partnerships

8. Ongoing communication remained critical to effective coordination between ADAPT and PHNs. PHNs continued to express recognition of the value of ADAPT services to their clients and indicated they wish the ADAPT program was available to more of their clients beyond the target population of Medi-Cal recipients, Medi-Cal eligible individuals, and those who are low income and uninsured.

9. The ADAPT program partnered with University of California researchers to pilot test the feasibility and effectiveness of community-based administration of an innovative Sleep and Light Intervention (SALI) to treat peripartum depression. ADAPT clients who voluntarily choose to participate in SALI engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session at a specific time of the day depending upon whether pregnant or postpartum. The study is ongoing with initial results suggesting high levels of feasibility to administer and complete SALI from the perspective of clinicians and participants. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors.

Conclusion

During FY 2021-22, the ADAPT program navigated the ongoing impact of the COVID-19 pandemic. While overall enrollment remained below initial goals (due in large part to the impact of the pandemic on PHN referrals), enrollment has increased substantially from FY 2020-21 (from 65 to 117). Continued expansion of referral sources is expected to increase enrollment in future years. 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 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 public health nurses, who reported substantial benefits for their ADAPT-enrolled clients.

Primary Recommendations for FY 2022-23

1. Continued emphasis on community outreach to raise awareness of ADAPT program services and increase the number of appropriate referrals.
2. Continued communication and collaboration with PHNs through case consultations, roundtable discussion, and other methods of engagement.
3. Explore opportunities for expanded Medi-Cal reimbursable services to be provided as appropriate to Level-2 participants.
4. Increased efforts to support staffing and workforce needs.
5. Explore potential for developing strategic partnerships to meet client psychiatric/medication management service needs.
6. Review incoming referral process to identify strategies to support efficient and effective workflow.

Program Description

The County of San Diego 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. 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. NFP is a free, voluntary program that provides at-home nurse visitation services to qualifying first-time mothers prior to their 28th week of pregnancy and continuing through the child's second

birthday, many of whom are low-income. 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 at-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, and emotional and cognitive delays in children of mothers with perinatal mood disorders. ADAPT provides therapeutic treatment, peer support, linkages to community resources, and support for the entire family, as well as other therapeutic interventions including skill building education, group skill building, case management, and facilitating collateral supports. Services are evidence-informed and include care coordination and case consultation. To facilitate better access to care services, the program was designed primarily to provide in-home visiting. As discussed in more detail below, the COVID-19 pandemic required ADAPT to shift their treatment approach from in-person visits to telehealth sessions. A key innovative component of the ADAPT program is the partnership between PHNs, the ADAPT mental health clinicians, and the peer support partners. During the COVID-19 pandemic, new referral partners have been added, and 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 in 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 but demonstrated impairments in functioning as well as risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors. These participants may have presented with less acute symptoms but were able to demonstrate risk and need for intervention to prevent development of functional impairments and maintain current functioning. Additionally, Level-2 included participants who would meet BHS eligibility for Level-1 services yet were receiving services from another mental health provider or reported not being 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 with video as this enabled the participants and service providers to see one another during sessions. As federal- and state-guided COVID-19 precautions became less stringent, ADAPT has 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 if the participant so desired. Reflecting these broad changes in how services were delivered, during FY 2021-22 in-person services increased but the majority of services were still provided via telehealth with video (see Table 3). A more detailed discussion of ADAPT experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

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 117 unique persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). The 117 people enrolled into ADAPT during FY 2021-22 represented 114 different families with a total of 197 children in the households (including those not yet born at the time of ADAPT program enrollment). Of note, the 97 persons enrolled into Level-1 services during FY 2021-22 represented a 110.9% increase from FY 2020-21 in which 46 persons enrolled into Level-1 services.

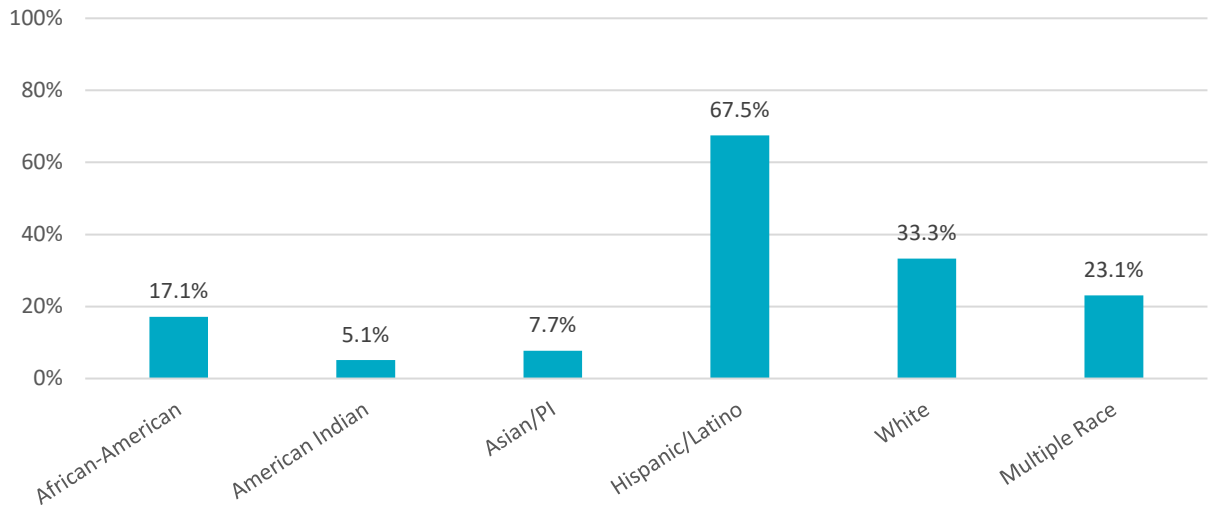
Table 1. ADAPT Program Enrollment for FY 2021-22 (N=117 unique persons)

	FY 2021-22
Enrollment By ADAPT Service Level	**n**
Level-1 services (i.e., ongoing therapy services)	97
Level-2 services (i.e., education and support services)	20
Total unique ADAPT enrollees	**117**

The increased FY 2021-22 enrollment was primarily the result of: 1) more referrals from PHN programs as the COVID-19-related burdens on those programs lessened (i.e., 181 referrals comprised of 124 from MCH and 97 from NFP), and 2) increased referrals originating from other community and hospital partners (i.e., 80 referrals comprised of 64 from Sharp Mary Birch, 9 from Sudden Infant Death Syndrome (SIDS) program, and 7 from other community organizations. Total ADAPT enrollment remained less than the initial program goal (i.e., 117 unduplicated persons compared to a target of 300). The effects of the ongoing COVID-19 pandemic, while not as severe as experienced during FY 2020-21, continued to impact referrals from PHN programs.

Across both service levels, 96.6% of participants identified as female (n=113). The majority indicated English was their primary language (77.8%; n=91), with 19.7% (n=23) selecting Spanish as their primary language (served by Spanish-speaking ADAPT staff). Nearly 90% of participants (88.0%; n=103) identified as heterosexual or straight. Slightly more than 1/3 of ADAPT participants (35.9%) were Transitional Age Youth aged 18-25 and the majority (50.4%) between the ages of 26 and 35. 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 (67.5%; n=79).

Figure 1. Race/Ethnicity of ADAPT Participants (N=117)



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

ADAPT participants also completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE is scored from 0 to 10 with higher values signifying more trauma experiences. The ACE seeks to quantify a person's exposure to specific types of childhood trauma at home, with a score of 4 or more considered to be a risk factor for experiencing health and mental health problems as an adult. The mean ACE score among ADAPT participants was 4.3 with approximately half of ADAPT participants (46.7%) having an ACE score of 4.0 or greater. These findings indicate 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 by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level-1 during FY 2021-22. The information indicates that on average *during each 30 days enrolled in ADAPT*, participants typically received approximately 4.3 ADAPT services (comprised primarily of an average of 0.6 assessment visits, 2.2 therapy visits, and 0.6 rehabilitation visits per each 30 days enrolled in ADAPT). Therapy visits included both individual and family therapy. While family therapy was rarely utilized as a specific treatment modality, ADAPT services were still anticipated to provide benefits to 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 and did so on less than five occasions during FY 2021-22. This highlights the importance of having a program like ADAPT connected with these persons to address potentially serious situations, while the rarity of such events also suggests that the ADAPT team was generally able to provide support and services that prevented the need for crisis care for almost all ADAPT participants.

Table 2. ADAPT Level-1 Services during FY 2021-22 (N=122)

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	118	96.7	1,816	4.3
Assessment/Tx. plan development	97	79.5	270	0.6
Therapy (i.e., by licensed clinician)	93	76.2	947	2.2
Rehabilitation (i.e., by peer support or other professional)	48	39.3	237	0.6
Crisis	<5[1]	4.2	<5[1]	<0.1
Case management	59	48.4	172	0.4
Other services (e.g., collateral)	75	61.5	189	0.5

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

The average time in the ADAPT program was 130.6 days, with a median time of 155 days for the 79 persons who discharged from Level-1 services during FY 2021-22. Approximately 25% of these persons had a relatively short engagement with ADAPT (less than 50 days) and 25% participated in ADAPT for more than 180 days (with maximum program duration of 274 days). Overall, the typical length of time receiving ADAPT services was 5-6 months.

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. 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. At that time, since ADAPT had never before offered telehealth with video, only a small number of services were conducted that way. Throughout FY 2020-21, Vista Hill updated policies allowing for telehealth and made efforts to ensure staff were comfortable and equipped with the necessary technological tools. Utilization of telehealth with video has steadily increased from FY 2019-20 to FY 2021-22, (9.4% to 64.7%) reflecting an increased capacity for and comfort of both staff and participants in engaging in this treatment modality (as opposed to conducting remote visits via telephone).

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21		FY 2021-22	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth with video	150	9.4	720	59.3	1,175	64.7
Telephone	426	26.7	368	30.3	275	15.1
Face to face	1,011	63.5	112	9.2	357	19.7
Other	6	0.4	14	1.2	9	0.5
Total Services	**1,593**	**100**	**1,214**	**100**	**1,816**	**100**

As COVID-19 safety concerns decreased from FY 2020-21 to FY 2021-22, the percentage of face-to-face visits increased (from 9.2% to 19.7%) while telephone visits decreased during the same timeframe (from 30.3% to 15.1%).

Level-2 Services

A total of 30 persons participated in Level-2 services, including 20 enrolled directly into Level-2 and 10 who were enrolled from the prior FY but still active in FY 2021-22. These 30 persons received a total of 296 unique Level-2 ADAPT service contacts during FY 2021-22, which is nearly identical to the 300 Level-2 services provided in FY 2020-21. Level-2 participants received an average of 10.6 ADAPT services (median = 8 services), provided by Peer Support Partners on the ADAPT team. 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, etc.) as this can alleviate a major source of family distress. Additional types of supports provided to some Level-2 ADAPT participants addressed a wide range of other issues including housing assistance, employment services, navigating public benefit or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2021-22 ADAPT Level-2 Service Encounters

	ADAPT Level-2 Service Encounters			
	Total persons (N=30)		Total services (N=296)	
	Number of Persons with service	Percent of persons with service	Number of services	Percent of total services*
Goal Setting Skills	21	70.0	66	22.3
Self-Regulation Skills	18	60.0	111	37.5
Mindfulness Skills	16	53.3	78	26.4
Mental Health Education	15	50.0	31	10.5
Basic Needs	15	50.0	26	8.8
Parenting Skills	9	30.0	18	6.1
Organization Skills	9	30.0	23	7.8
Social Health	9	30.0	21	7.1

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

For the 26 persons who discharged from Level-2 ADAPT services during FY 2021-22, the average time in the ADAPT program was 117.2 days (median of 103.5 days). Level-2 participation was typically shorter than that for persons receiving Level-1 services with very few requiring services beyond the standard 6-

month program duration. These findings potentially suggest that participation in Level-2 services prevented or reduced the need for engaging in a higher level of care.

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2021-22 and their differing service needs, participant outcomes referenced in this section only include the 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-visiting 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 on a 0 to 3 scale, with higher scores reflecting worse condition/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 2021-22 the average EPDS score at intake was 12.2, which reduced to 8.6 at the last EPDS follow-up assessment. This is a statistically significant change in the total EPDS score and reflects an overall reduction in symptoms as reported by ADAPT program participants. A total of 73.5% 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 FY 2020-21 (i.e., from 12.7 at intake to 8.9 at follow-up).

Additional analyses that compared the FY 2021-22 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 10.9. This finding suggests that, on average, a reduction in depressive symptoms begins within the first 30 days, followed by continued improvement with further treatment.

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

	FY 2021-22			FY 2020-21		
		Initial EPDS	Last available EPDS		Initial EPDS	Last available EPDS
EPDS Item *(Note: higher value = worse condition)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
I have been able to laugh and see the funny side of things	98	0.5	0.4*	62	0.7	0.4**
I have looked forward with enjoyment to things	98	0.7	0.4**	62	1.0	0.6**
I have blamed myself unnecessarily when things went wrong	98	1.8	1.3**	62	1.9	1.5**
I have been anxious or worried for no good reason	98	1.9	1.4**	62	2.0	1.5**
I have felt scared or panicky for no very good reason	98	1.3	0.9**	62	1.4	0.8**
Things have been getting on top of me	98	1.8	1.4**	62	1.7	1.3*
I have been so unhappy that I have had difficulty sleeping	98	1.3	1.0*	62	1.3	1.0*
I have felt sad or miserable	98	1.4	1.0**	62	1.4	1.0**
I have been so unhappy that I have been crying	98	1.2	0.7**	62	1.2	0.7**
The thought of harming myself has occurred to me	98	0.2	0.1*	62	0.2	0.1
EPDS Total Score	**98**	**12.2**	**8.6****	**62**	**12.7**	**8.9****
Likely Depression (i.e., score >=10)	**-**	**68 (69.4%)**	**41 (41.8%)**	**-**	**45 (72.6%)**	**27 (43.5%)**

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

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 persons served by ADAPT, changes were evident across all dimensions. The items from FY 2021-22 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 the critical risk item related to thoughts of self-harm decreased significantly at follow-up. The pattern of reductions across the individual items paralleled the changes observed in FY 2020-21. Overall, the findings demonstrated that ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

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. The IMR-R included 9 of the 15 items from the full IMR that were determined to be most relevant to the ADAPT program services and the focal service population (via review and consensus between representatives from ADAPT, BHS, and the evaluation team). Each item on the scale has a 5-point behaviorally defined response option tailored to that specific domain. Items are rated from 1 to 5, 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 2021-22, 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 2.2, indicative of fairly high levels of mental health-related distress upon entry to ADAPT. Conversely, medication management and substance abuse were rated as areas of less concern (i.e., intake ratings of 5). This pattern of FY 2021-22 intake IMR-R scores was similar to that observed during FY 2020-21.

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

	FY 2021-22			FY 2020-21		
(Note: higher value = better condition)		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
IMR Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
Progress towards personal goals	62	3.0	3.5**	39	2.4	3.5**
Knowledge about symptoms, treatment, coping strategies, and medication	64	3.0	3.7**	39	2.6	3.6**
Involvement of family and friends in his/her mental health treatment	64	2.8	3.3**	39	3.2	3.4
Symptom distress	64	2.2	3.2**	39	1.9	2.9**
Impairment of functioning	63	2.6	3.4**	39	2.3	3.2**
Coping with mental or emotional illness from day to day	64	2.8	3.7**	39	2.6	3.7**
Effective use of psychotropic medication	4	5.0	5.0	7	3.4	4.3
Impairment of functioning through alcohol use	62	5.0	5.0	39	4.9	4.9
Impairment of functioning through drug use	62	5.0	5.0	39	4.9	5.0
Overall	**64**	**3.3**	**3.9****	**39**	**3.1**	**3.8****

***statistical significance at p < 0.01*

During FY 2021-22 the overall IMR-R score increased from 3.3 to 3.9, indicating a statistically significant change and evidence of 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 other items achieved a gain of 0.5 to 1.0. Particularly notable were the ratings of symptom distress, improving from 2.2 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, the FY 2021-22 IMR-R result indicated the achievement of important improvements to minimize symptom distress and impairment, while also increasing knowledge, coping skills, and progress towards personal goals to help maintain benefits and minimize risks of future recurrence of symptoms.

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 the better or more desirable response.

During FY 2021-22, 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 and fatigue (see Table 7). Notably, ratings of hopefulness about the future also improved. The findings from FY 2021-22 were generally similar to those identified during FY 2020-21.

New questions were added in FY 2021-22, and many revealed statistically significant improvements in wellness. Clients reported improvements in sleep, sense of rest, and pain. Additionally, they reported significant improvement in skills and resources in managing conflict with their partner or supportive other.

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

	FY 2021-22			FY 2020-21		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items *(Note: higher value = better condition; Scale of 1 to 5)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
In general, would you say your quality of life is:	65	3.2	3.5**	39	3.3	3.3
In general, how would you rate your physical health?	65	2.9	3.2*	40	2.9	3.0
In general, how would you rate your mental health, including your mood and your ability to think?	65	2.3	3.1**	40	2.5	3.0**
In general, how would you rate your satisfaction with your social activities and relationships?	65	2.5	3.1**	40	2.8	3.0
In general, please rate how well you carry out your usual social activities and roles.	65	3.0	3.4**	40	3.1	3.2
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	65	3.8	4.2*	40	3.8	4.0

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

Select Wellness Survey Items *(Note: higher value = better condition; Scale of 1 to 5)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	65	2.3	3.2**	40	2.6	2.9
My child(ren) had emotional and/or behavioral problems.	48	3.9	4.0	35	4.7	4.2*
I felt hopeful about the future.	65	3.7	4.0^	40	3.5	4.2**
I felt spiritually connected.	65	3.6	3.8	40	3.1	3.6*
I lived in a home that made me feel safe.	65	4.6	4.7	40	4.5	4.7
I used substances (alcohol, illegal drugs, etc.) too much.	65	4.9	4.9	40	4.9	5.0
How would you rate your fatigue on average?	65	2.8	3.3**	40	2.9	3.1
I get the emotional help and support I need from supportive others.	54	3.6	3.8	N/A		
When I am in distress, I can identify supportive others and may use my supportive others.	54	3.9	4.1	N/A		
Conflict with my partner or supportive others interferes with my ability to respond to everyday life challenges.	54	3.5	3.8	N/A		
I have the skills and resources needed to manage stress stemming from conflict with my partner or supportive other.	54	3.6	4.1**	N/A		
(Note: These items are rated on a scale of 1-10 with higher ratings = worse condition)	**N**	**Mean**	**Mean**			
How would you rate your sleep?	54	5.8	2.6**	N/A		
How would you rate your sense of rest?	54	6.0	2.6**	N/A		
How would you rate your alertness?	54	4.1	2.5	N/A		
How would you rate your pain on average?	65	3.5	2.9**	N/A		

*^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 2021-22, 93.8% of participants indicated they knew where to get help and 92.3% indicated they were better able to handle things because of participating in ADAPT (see Table 8). Further, ADAPT participants were extremely positive about their experiences. Nearly 100% (98.4%) of participants indicated that services were available at convenient times, they were able to receive all needed services, that staff were sensitive to cultural background, and they were satisfied with ADAPT services. A similar pattern of participant responses was identified during FY 2020-21. 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 2021-22 (N=65)	FY 2020-21 (N=43)
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.	93.8	97.7
I am more comfortable seeking help.	92.3	97.7
I am better able to handle things.	92.3	86.0
Experiences with ADAPT services:	**%**	**%**
Services were available at times that were good for me.	98.4	100
I was able to get all the services I thought I needed.	98.4	95.3
Staff were sensitive to my cultural background (race, religion, language, etc.).	98.4	100
Overall, I am satisfied with the services I received here.	98.4	95.3

To elicit additional feedback on the program, ADAPT staff asked program participants to engage in a short qualitative survey in June 2022. Participants were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with ADAPT leadership and BHS input. Participants were given a short script explaining the purpose of the survey, and informed that feedback was voluntary, confidential and would not affect services. A total of 18 program participants provided feedback. Given that this information was collected from a sample of persons receiving services at one particular time during the FY, the findings may not reflect the perceptions of all ADAPT participants; however, many of the findings are 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. Additionally, it should be noted that the interviews were conducted by ADAPT program staff and therefore could be positively biased.

A little over half of respondents (55%; n=10) 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 other clients, 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. All the respondents (100%) 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 client stated, "Every mom should have this kind of support - you guys really care and go out of your way to support us."

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:

> "For the first time I felt safe and understood by my therapist. I have seen lots of counselors and therapists starting from when I was [younger]. I think my therapist has made the biggest difference because she always listens to me and helps me think of new ways to get better."
>
> "ADAPT has more quality treatment and I feel more comfortable with ADAPT providers."
>
> "[ADAPT is] more intensive and tailored to my needs."

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:

- 6 respondents (33%) stated they prefer only/primarily remote services
- 8 respondents (44%) indicated they prefer having both remote and in-person services
- 4 participants (22%) stated they prefer only/primarily in-person services

Reasons for preferring remote services included social anxiety or considering themselves an "introvert." Others preferred telehealth due to the flexibility and/or other having other obligations ("I have 4 kids and it would be almost impossible for me to do it in person"). Clients who appreciated the choice between in-person and remote services shared, "In-person would be nice to go to but remotely allows me flexibility as a mom" and "I like in-person because it's easier, but also like the online because sometimes I'm really busy." The four participants who preferred in-person services commented on technological difficulties and the quality of the interaction over video. In this regard, improved capacity to engage successfully in telehealth sessions would likely increase the number of persons who would prefer telehealth as an option to receive ADAPT services.

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

100% of survey respondents (n=18) 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 don't feel as crazy as I used to because now I have learned about [my disorder] and ways to deal with it. It helped me understand how my childhood impacted me so I can be a better mom than I had. Being part of the program, I was able to apply and enroll to college, find transitional housing for my baby and I, plus I know lots more resources."
>
> "ADAPT helped me to improve and lessen anxiety and have been yelling less at others."
>
> "I truly am so thankful for your support, it is so helpful and has made a big difference. I have been able to work through a lot of anger…"

Other clients mentioned a new awareness of community resources and a sense of feeling heard and supported based on their experiences in ADAPT.

Participant Recommendations

The majority (72.2%; n=13) of the survey respondents offered no recommendations to improve the program and were happy with it as is. Approximately 25% (n=5) suggested that to improve ADAPT, the length of program should be extended. Of note, this recommendation to have services available for more than the standard six months was consistent with feedback provided to the ADAPT program via the Participant Advisory Group (PAG) meetings. Other suggestions were about increasing options for electronic communication, specifically the desire to be able to text their therapist.

Referral Partner Feedback Survey

In June 2022, 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 94 referral partners (e.g., PHNs and other providers) were invited and 15 completed the online survey (response rate of 16.0%). While the low response rate prompts some caution when interpreting the results, the core themes (presented below), are 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 almost all (93%; n=14) indicating they had referred at least three clients to ADAPT during FY 2021-22, with 53% (n=8) having referred 6 or more clients. Responding referral partners represented public health programs (47%; n=7), local hospitals and clinics (40%; n=6), and other community agencies (13%; n=2). 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

In open-ended responses, 14 out of 15 referral partners mentioned that the ADAPT program has helped to ensure that their patients are connected to appropriate mental health services. Respondents described how "ADAPT has made it easy to refer clients who are in need of peripartum mental health services" and "without this program there isn't much concrete I can do to get them help." ADAPT has improved access to care particularly for depressed individuals, remote clients, and those with public health insurance:

> "When someone is in a state of despair sometimes it's hard for them to follow up on their own to reach out and make the first step."
>
> "Many of our clients have a hard time leaving their homes for many reasons and this offers therapy to them even if they cannot make it to the clinic."
>
> "Moms with Medi-Cal can now get some much-needed counseling and support around PMADs and that was not available before."

Importance of Bilingual Clinicians

Referral partners also highlighted their appreciation of Spanish-speaking clinicians. One survey respondent stated, "ADAPT has been able to assist with my Spanish speaking clients by having bilingual therapists. This is so important and I am so happy to finally have this needed support in my region. Speaking the language is so crucial when you need mental health services."

Desire for Expanded Eligibility

Given the overall success of clients who engage with ADAPT services, in the prior fiscal year (2020-21) many referral partners expressed a desire to have wider eligibility requirements for the program. This theme emerged again in the FY 2021-22 survey, with 33.3% of referral partners mentioning private insurance as a barrier to services. One referral partner remarked, "having only Medi-Cal patients qualify for services is limiting. There are underinsured and insured patients that would benefit from this program."

Ease of Referrals

Well over half of the survey respondents (60%) described how referring clients to ADAPT is an easy and efficient process. One response read:

> "BHS ADAPT has been extremely fast to follow up with a referral, which is something that is really lacking in the mental health field. I also like the fact that they will come to the facility and meet with the [patient], instead of waiting for the [patient] to come to them."

Program Benefits

Referral partners shared that their clients have had positive feedback about ADAPT:

> "The ADAPT program has been a wonderful addition to our program! My clients have all had positive things to say about the services provided."

> "Every single client who has participated in the program has reported to me how helpful the program has been to them. I have had clients with suicidal ideation who have become more stable using coping skills provided by the ADAPT clinician, and will hopefully use the resources provided at closing of the program to continue mental health services."

Additionally, many noted how the presence of the ADAPT program helps them do their job better:

> "It has been great to have a mental health professional focus on the mental health needs of our patients so I can continue with other medical needs for them."

> "It allows us to fulfill our program goal of getting clients linked with ongoing mental health treatment."

> "It helps me so much to be able to provide a mental health option that is available rather than to meet multiple dead ends and long waits for services through other organizations."

All in all, the presence of the ADAPT program in the community has been overwhelmingly positive for the referral partners who participated in this survey.

> "Whereas many outpatient programs in the community have a waitlist ranging from 3 months to 18 months, [ADAPT] has done such a great job of meeting the needs of client and families and not having a waitlist. [ADAPT] has been able to successfully link with clients referred to them and we are so grateful to have a program like this in the community."

Additional Program Activities

Approval for Medi-Cal Billing to Promote Program Sustainability

During FY 2021-22, the ADAPT program completed the extensive process required to allow for Medi-Cal insurance reimbursement billing. The capacity to provide Medi-Cal reimbursable Level-1 treatment services will support the potential for long-term program sustainability. Level-2 services provided to participants who identified as "at risk of perinatal mood and anxiety" were not reimbursable as those individuals did not meet criteria for specialty mental health services (Title IX) although Medi-Cal changes through the Cal-AIM initiative may create opportunities for additional supportive and preventative services to be billable in the future. The potential for Level-2 service to become reimbursable will be explored during FY 2022-23.

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

Beginning in FY 2021-22, the ADAPT participants could voluntarily enroll in a pilot study of the SALI for treating peripartum depression. This study was approved by County BHS and administered by ADAPT clinician. SALI is a brief (two-week), non-pharmacological, in-home intervention that utilizes a one-night adjustment in the timing and duration of sleep coupled with two weeks of a 30-minute per day lightbox session at a specific time based upon whether pregnant or postpartum 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. The study is ongoing with initial results indicating it was relatively easy for participants to complete and for ADAPT clinicians to administer the required steps of the SALI intervention. This suggests that SALI is a feasible treatment approach for addressing peripartum depression that can be utilized in community settings. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors. The information learned from this study is expected to inform future wide-spread 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 conducted at the end of FY 2021-22. ADAPT program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Of the 12 ADAPT staff invited to participate, all 12 participated for a response rate of 100%. 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 “highly committed, passionate and empathetic" and highlighted the “collaboration, coordination, compassion, and camaraderie among the team members.” The “commitment and clinical integrity of program leadership and direct service providers” as well as “team environment where we all support each other and work well together” was credited for the success of ADAPT as a program.

Flexibility

The flexibility of the ADAPT program was also noted as a strength. As one staff member described, “we are very reasonable with our intake sessions as far as time frame goes, and we are willing to work around client schedules.” Others mentioned the uniqueness of ADAPT in this respect; the flexibility offered is not typically characteristic of mental health service agencies. For staff, the flexibility to have hybrid work arrangements was viewed favorably. As one staff member stated, “For me personally, work life balance is more achievable by having the flexibility to work remote.”

Accessibility

Since the start of the COVID-19 pandemic, staff have found unique ways to meet with clients 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 credit 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 clients. One survey respondent remarked that COVID-19 "provided an opportunity to be flexible in how services are delivered and to be able to meet clients where they are at."

Offering bilingual services, both from clinicians and peer partners, was highlighted as another key component of successful client recruitment and retention. Another respondent mentioned the importance of expanding the eligibility criteria for referral into ADAPT. Changes during FY 2021-22 allowed for anyone who met eligibility criteria throughout San Diego County (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) to be referred to ADAPT, whereas previously referrals had to come from a select set of approved referral partners.

Program Challenges

Managing Incoming Referrals for ADAPT Services

In the staff survey, participants highlighted the significant time commitment needed to effectively respond to incoming referrals for ADAPT services. These referrals frequently required follow-up communication in order to obtain the information needed for determining ADAPT eligibility. Additionally, for persons not eligible for ADAPT services, the ADAPT team worked to identify and then facilitate connections to other potentially appropriate community resources and services.

In this regard, ADAPT staff endeavored to provide assistance to persons for each referral received, regardless of whether ultimately enrolled into ADAPT. When receiving a substantial number of referrals, staff indicated that they struggled with feeling pulled in multiple directions by needing to serve the existing client caseload while also trying to connect persons ineligible for ADAPT services to other community resources.

Efforts were underway to increase awareness of and relationships with other potential community partners to make it easier to facilitate connections to other resources. Additionally, the ADAPT team will be exploring how best to manage the incoming referral workflow process to allow for the individualized communication, care, and community linkages needed for each referral, even if not ultimately enrolled into ADAPT, while ensuring appropriate allocation of staff resources and time.

Resource Awareness

To assist with the processing of ineligible referrals, staff members noted the need for increased knowledge of community programs.

> "We need more resources and more up to date resources and programs happening in San Diego. I feel like there has to be hundreds of more programs or resources for Clients regarding Childcare and Housing, but it feels like we can't connect to them or find them."

Engagement

As was the case in prior years, efforts by ADAPT staff to keep clients 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 benefits 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 client must approve of included family members, one staff member pointed out that motivational interviewing may be useful in helping the client to identify which family members would be most helpful to engage. Another staff member highlighted the need for explaining "the importance of having family support to our clients when we talk to them about their client plan." In terms of engaging the identified family members, one survey respondent suggested offering family or couples' therapy to provide support and increase motivation to participate.

PHN and ADAPT Program Coordination

The responsibilities of PHNs focused on pandemic-related tasks in FY 2020-21 and has continued that focus into FY 2021-22. ADAPT staff describe challenges in communicating with PHNs. ADAPT staff highlighted communication with PHNs as a challenge and an inhibiting factor in accomplishing the goal of effective referral streams. Several survey respondents mentioned the usefulness of roundtables and meetings with PHNs and how engagement in those activities has the potential to improve working relationships.

Several staff highlighted potential PHN engagement strategies including increased e-mail communication, regularly scheduled meetings, team-building activities. Other suggestions centered around the need for increased education about ADAPT to promote engagement with PHNs and PHN leadership. Staff members suggested the potential benefits of additional messaging to PHNs from PHN leadership about the ADAPT program and the important resource it can be to PHN clients.

Telehealth

While telehealth was mostly appreciated as a benefit to the ADAPT program, the option does come with some challenges. An unstable internet connection can make telehealth sessions difficult and not all clients have ready access to a device. ADAPT staff can facilitate efforts to successfully engage in telehealth services such as helping to find locations with sufficient connectivity and/or "hotspots" if maintain an internet connection is difficult and/or helping clients navigate technological steps for accessing telehealth visits. Where telehealth is not feasible or desirable, ADAPT provided in person services.

ADAPT Staff Recommendations and Additional Feedback

ADAPT staff would like more opportunities for training. Desired types of training included the following:

- EMDR
- Documentation
- Interpersonal Therapy
- Peer Support
- Suicide Prevention
- Peripartum Mental Health
- Medi-Cal Terminology
- Co-occurring Disorders

Several survey respondents shared a desire for more support materials and books, as well as materials to use with clients such as workbooks or other therapeutic aids/tools. Other staff suggested increased administrative support to assist with documentation requirements, and a resource specialist to improve team awareness of other community programs and facilitate processing of ineligible referrals.

A few staff mentioned lack of connections with coworkers/other ADAPT team members as a result of COVID-19 safety practices. One participant mentioned "feeling less supported and missing the full team environment of weekly time all in the office." Despite this challenge, the ADAPT staff overwhelmingly endorsed a positive team climate and "support from program manager and supervisors, support from other staff members, good staff morale."

Changes from Initial Program Design

Allowing Eligible Referrals from Throughout San Diego County

Initially, only PHN programs could send referrals to ADAPT. During FY 2020-21, additional referral partners were added including Sharp Mary Birch, Best Start Birth Center, and the Sudden Infant Death Syndrome (SIDS) program. In FY 2021-22, the options were expanded further to allow referrals from throughout San Diego County. Anyone can refer persons directly to ADAPT, and self-referrals are also accepted. This brought two issues to light: 1) the need for additional community outreach to increase awareness about ADAPT, and 2) the need for effectively communicating who ADAPT can serve (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) in order to encourage appropriate referrals.

Program Recommendations

1. Continued emphasis on community outreach to raise awareness of ADAPT program services and increase the number of appropriate referrals.
2. Continued communication and collaboration with PHNs through case consultations, roundtable discussion, and other methods of engagement.
3. Explore opportunities for expanded Medi-Cal reimbursable services to be provided as appropriate to Level-2 participants.
4. Increased efforts to support staffing and workforce needs.
5. Explore potential for developing strategic partnerships to meet client psychiatric/medication management service needs.
6. Review incoming referral process to identify strategies to support efficient and effective workflow.

Conclusion

A total of 117 persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). This Level-1 enrollment represents a 110.9% increase from FY 2020-21, where 46 persons enrolled in Level-1 services. Despite the increased enrollment in FY 2021-22, ADAPT enrollment remained less than the initial program goal of 300 person which was due, at least in part to the continued impact of COVID-19 on public health nursing programs and the resulting lower expected referrals to ADAPT. To support the potential for long-term program sustainability, during FY

2021-22, the ADAPT program completed the process to allow for Medi-Cal insurance reimbursement billing.

The ADAPT program served a racially and ethnically diverse population with the majority identifying as Hispanic/Latino (i.e., 67.5% Hispanic/Latino) and approximately 20% indicating that Spanish was their primary language. As reported through both clinician and participant assessments, ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Additionally, improved sleep and less fatigue were commonly reported along with improvements in other key life domains such better social relationships and ability to handle daily activities.

Participants also expressed high levels of satisfaction with ADAPT services and that they would recommend ADAPT to family or friends experiencing peripartum depression and anxiety. As one participant stated, "Every mom should have this kind of support - you guys really care and go out of your way to support us."

The ADAPT team continued to increase the amount of ADAPT services delivered via telehealth with video during FY 2021-22 while also providing more in-person services as conditions of the COVID-19 pandemic allowed (with telephone-based services decreasing). Feedback indicated that many participants preferred a hybrid service delivery model that allowed for the greater convenience and frequency of telehealth services while still having the option for in-person connections as needed. However, some clients expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.

Ongoing communication remained critical to effective coordination between ADAPT and PHNs. PHNs continued to express recognition of the value of ADAPT services to their clients and indicated they wish the ADAPT program was available to more of their clients beyond the target population of Medi-Cal recipients, Medi-Cal-eligible individuals, and those who are low income and uninsured.

The ADAPT program partnered with UCSD researchers to pilot test the feasibility and effectiveness of community-based administration of the innovative SALI to treat peripartum depression. ADAPT clients who voluntarily choose to participate in SALI engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session at a specific time of the day depending upon whether pregnant or postpartum. The study is ongoing with initial results suggesting high levels of feasibility from the perspective of both participants and clinicians. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors.

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 2021-22

Characteristic	Total Participants (N=117)	
Gender	**n**	**%**
Female	113	96.6
Another Gender Identity/Missing/Prefer not to answer	4	3.4
Total	**117**	**100**
Age Group	**n**	**%**
18-25	42	35.9
26-35	59	50.4
>35		
Total		
Primary Language	**n**	**%**
English	91	77.8
Spanish	23	19.7
Other/Missing/Prefer not to answer	3	2.5
Total	**117**	**100**
Race/Ethnicity	**n**	**%**
African American	20	17.1
Asian/Pacific Islander	9	7.7
Latino	79	67.5
Caucasian/white	39	33.3
American Indian	6	5.1
Multi-racial	27	23.1
Total[1]	-	-
Sexual Orientation	**n**	**%**
Heterosexual or straight	103	88.0
Bisexual/Pansexual/Sexually fluid	10	8.5
Another sexual orientation/Missing/Prefer not to answer	4	3.5
Total	**117**	**100**

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

Appendix (continued).

Military Status	n	%
Never served in the military	115	98.3
Other/Missing/Prefer not to answer	2	1.7
Total	**117**	**100**
Disability	**n**	**%**
Yes, has a disability	19	16.2
No, no disability	97	82.9
Prefer not to answer	1	0.9
Total	**117**	**100**
Type of Disability	**n**	**%**
Learning Disability	6	5.1
Physical Disability/Chronic Health	7	6.0
Other Physical Disability	13	11.1
Other Mental Disability	<5[3]	<4.3
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
Year 3 (7/1/2021 - 6/30/2022)

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

v.12.22.2022

COUNTY OF SAN DIEGO HHSA 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 persons 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 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. BHConnect provides services to persons of all ages, which are grouped into children, youth and families (CYF) services and adult and older adult (AOA) services for BHS reporting purposes.

Primary Findings for Fiscal Year 2021-22

BHConnect Enrollment, Referrals, and Referral Partners

1. During fiscal year (FY) 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an increase of approximately 30% in total new enrollments from FY 2020-21. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 76 AOA clients) were served by BHConnect in FY 2021-22. BHConnect enrollment increased from the prior year; however, it remained below initial program targets of 250 persons served each year. Efforts will continue during FY 2022-23 to further increase the number of referrals to and enrollees into BHConnect.

2. BHConnect received a total of 256 referrals from community referral partners during FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to receiving substantially more AOA referrals. AOA referrals increased from 38 in FY 2020-21 to 139 in FY 2021-22 (a 265.8% increase), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease).
3. A total of 20 different organizations referred clients to BHConnect. Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations achieving this threshold in FY 2020-21.
4. BHConnect prioritized a quick response to client referrals, with the majority of persons (56.0%) enrolled in BHConnect within one day of the initial referral and approximately 75% (74.4%) within three days.
5. As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by the growing number of referral partners throughout San Diego County. Key benefits of the BHConnect program identified by referral partners included that BHConnect filled a gap in needed services for persons who may not be interested in traditional outpatient programs by relying primarily on a telehealth model to reduce barriers to accessing services and offering prompt enrollment into services to make connections before participant interest and engagement fades.

BHConnect Program Engagement and Service Delivery Patterns

6. The primary reason for not enrolling in BHConnect was being unable to locate/contact the person (38.8% and 22.2% of AOA and CYF referrals, respectively). For both AOA and CYF referrals, only about 10% of all referrals declined to participate (7.2% and 12.0%, respectively), which suggests 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 anticipates re-establishing an onsite presence at select referral partners. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated after the onset of the COVID-19 pandemic.
7. Persons enrolled in BHConnect as of 6/30/2022 had median service durations of 142.0 days and 155.5 days, respectively, for youth and adults. These findings indicate that BHConnect is frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.
8. CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 total monthly CYF and AOA BHConnect services provided during the prior year. This increase in average monthly service contacts was due primarily to the greater provision of case management and other support services by the Health Navigators in FY 2021-22.

BHConnect Program Outcomes and Participant Perceptions

9. Service utilization patterns 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 and other related services for youth and adults after enrolling in BHConnect.
10. For clients with assessment data at both an intake and a follow-up, many youth and adult clients had improvements in well-being and symptom management identified via clinician and self-reported assessments. However, the target population served by BHConnect (i.e., those with treatment needs

but not engaged in treatment) remained a challenging population to serve with many CYF and AOA clients demonstrating needs for further behavioral health improvements.

11. Based on feedback from BHConnect CYF and AOA clients as well as the caregivers of CYF clients, the BHConnect program was perceived as accomplishing 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.

BHConnect Participant Telehealth Preferences and Experiences

12. When provided the option, approximately 40% of CYF clients and 50% of AOA clients chose to have an app installed on an existing personal device to participate in BHConnect telehealth services instead of receiving a separate device from BHConnect dedicated to participating in telehealth services.
13. While some technology-based difficulties remained with connectivity and/or device management, among those who provided feedback after their first BHConnect session, less than 10% of CYF and AOA clients and clinicians indicated any issues with audio or video quality and/or the ability to engage in a conversation during the telehealth session.

Conclusion

During FY 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. This increase reflected the efforts by BHConnect to expand the number of community referral partners, particularly for AOA clients, which resulted in a 51.5% increase from the previous year (169 referrals to 256 referrals). While BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year. BHConnect continues to build upon and expand their referral partner network as they seek to serve more people FY 2022-23.

A total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations reaching this threshold in FY 2020-21. As indicated in the referral partner feedback survey BHConnect was perceived to be an important resource by the growing number of referral partners throughout San Diego County.

Once enrolled in BHConnect and receiving services, CYF and AOA clients frequently engaged with BHConnect for 5-6 months or more with median durations of 142.0 and 155.5 days, respectively for youth and adults still in services as of 6/30/22. 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, as evidenced by fewer inpatient psychiatric hospitalizations and other related services for youth and adults after enrollment. 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 also demonstrating a need for further behavioral health improvements.

Overall, BHConnect program experienced significant expansion during FY 2021-22 and is expected to continue on a growth trajectory during FY 2022-23. Assessment data, administrative data regarding utilization of crisis and acute care services as well as and client and caregiver feedback indicated that BHConnect program was accomplishing the primary goal of connecting with and assisting a population of

persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. A potential challenge for the BHConnect program; however, is to continue to demonstrate its uniqueness and specific population niche within the overall behavioral health system of care given that telehealth is now more widely available in other treatment programs due to the changes in service provision strategies brought about in response to the COVID-19 pandemic.

Primary Recommendations for FY 2022-23

1. Continue to develop and expand referral partners in order to identify under-served or vulnerable youth, transitional age youth, adult, and older adult residents of San Diego County who could benefit from the treatment services offered by BHConnect. New partners to include but not limited to: Cal State San Marcos, Adult Protective Services, and Perinatal Care Network.
2. Maintain ongoing and close relations with hospitals to provide on-site warm hand-offs and intakes, and ultimately, increased client engagement with BHConnect. Continue to explore best practices to increase client engagement from the moment referral is received.
3. Finalize internal policies and procedures to implement short-term psychiatric care for AOA clients in order to fill the gap as they are linked to long-term psychiatry. Include therapists and Health Navigators in virtual psychiatric evaluations for added, personalized support to clients.
4. Continue embracing a hybrid-treatment model that caters to the individual needs of BHConnect clients, offering in-home services and increased sessions when clinically indicated, and leveraging engagement strategies such as care packages, Motivational Interviewing, Harm Reduction and trauma-informed, compassion-based approaches.
5. To facilitate program effectiveness and sustainability, continue developing and refining opportunities for Health Navigators to provide creative and engaging case management and rehabilitation services that would be reimbursable through Medi-Cal/Cal-AIM.
6. Continue to provide clinical support and training to all staff on topics that support their effectiveness in working with serious mental illness in telehealth topics/trainings such as: screening, brief intervention and referral to treatment (SBIRT), best practices in suicidality assessment and treatment, psychopharmacology for serious mental illness, trauma grief counseling, virtual-compatible trauma therapies such as Eye Movement and Desensitization Reprocessing (EMDR), crisis management strategies, and creative interventions to maintain engagement with youth in virtual therapy.
7. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care. Continue annual staff training on parenting skills and modalities such as Parent-Child interaction therapy.
8. Refine the screening process by consulting with community stakeholders and internal leadership, refine BHConnect eligibility criteria as needed, educate referral partners on the risks and benefits of telehealth and what would constitute an appropriate referral to BHConnect.
9. Increase ability to address client preferences by including iPads as a device option available for participating in telehealth services.
10. Explore implementation of The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to provide homeless clients with increased linkages to housing resources.

Program Description

The County of San Diego BHS BHConnect program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). MHSA INN funding for BHConnect services was extended and is now expected to continue through 10/31/2023. 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.

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.

Offering services primarily through a telehealth platform, after an initial onsite evaluation by a case manager, is a key innovative component of the BHConnect program. To facilitate better access to care services, BHConnect either provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access or puts an app on an existing personal device that can be used for participating in the telehealth services if that is preferred by the client instead. Clients receive a full tutorial of how to use the technology, as well as assistance with in-home set up prior to being connected with a behavioral health professional. 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.

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 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. The increase among AOA clients was particularly stark as that increased over 300% from FY 2020-21 when only 18 AOA clients enrolled in BHConnect. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 67 AOA clients) were served by BHConnect. During FY 2021-22, there were similar percentages of CYF clients aged 5-14 (46.4%, n=26) and 15-18 years old (53.6%, n=30). Among AOA clients, Transitional Age Youth (TAY) between the ages of 18-25 comprised 28.3% (n=17) of this group. The majority of both CYF and AOA clients were female (60.7%, n=34 and 56.7%, n=34, respectively).

Referrals for BHConnect Services

BHConnect received a total of 256 referrals from community referral partners during FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to receiving substantially more AOA referrals. AOA referrals increased from 38 in FY 2020-21 to 139 in FY 2021-22 (a 265.8% increase), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease). A total of 10 organizations referred AOA clients to BHConnect with over 40% (42.4%; n=59) originating from Sharp Mesa Vista. Additional primary referrals sources included South East Mental Health Center (n=17), BHS funded In-Home Outreach Team (n=13), Sharp Grossmont (n=13), and San Diego County Psychiatric Hospital (n=9). Overall, approximately 50% (50.3%) of AOA referrals resulted in the person enrolling in BHConnect. The primary reason for not enrolling was being unable to contact the person (38.8% of all referrals).

A total of 10 different organizations referred CYF clients to BHConnect. Consistent with prior years, Rady Children's Hospital was the primary referral source with 70 referrals coming from either the emergency room or behavioral health urgent care. Other prominent CYF referrals sources that emerged during FY 2021-22 included the Crisis Action Connection and SmartCare with 24 and 10 referrals, respectively. The majority of CYF referrals enrolled into BHConnect (58.9%). As with AOA clients, the primary reason for not enrolling into BHConnect was being unable to contact the person (22.2% of all referrals).

Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 as compared to only four organizations achieving this threshold in FY 2020-21.

For both AOA and CYF referrals, only about 10% of all referrals declined to participate (7.2% and 12.0%, respectively), which suggests 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 anticipates re-establishing an onsite presence at select referral partners. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated after 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 56.0% of persons enrolled within a day of receiving the referral and over 85% (86.4%) of persons enrolled within five days of the original referral to BHConnect.

As shown in Table 1, of the 81 youth and 67 adults who were enrolled in BHConnect services during FY 2021-22, there were 34 youth and 29 adults still active in the program as of 6/30/2022. These persons were typically enrolled for approximately 5-6 months (i.e., median duration of 155.5 days and 142.0 days, respectively). Of the persons who discharged from BHConnect prior to 6/30/2022, the amount of time enrolled in BHConnect was typically shorter, particularly for youth (median of 121.0 and 83.5 days for youth and adults, respectively), but the duration data suggests that the majority of both youth and adults stay connected with the program for at least several months.

Table 1. BHConnect Program Participation Duration and Discharge

	Youth (N=81)		Adult (N=67)	
	Still in program	Discharged	Still in program	Discharged
n (persons)	34	47	29	38
Mean (days)	237.6	182.9	143.4	126.1
Median (days)	155.5	121.0	142.0	83.5

BHConnect Services – Type and Amount

As reported in Table 2, CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 in total monthly CYF and AOA BHConnect services provided during the prior year. For both CYF and AOA BHConnect clients, therapeutic sessions were the primary type of service contact, which represented approximately 55% of all monthly service contacts (57.1% and 58.1%, respectively). 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. The main difference contributing to the increased total monthly services provided during FY 2021-22 was an increase in these non-therapy, supplemental support service contacts. This is consistent with expectations given that the BHConnect team increased the role of the Health Navigators to provide additional forms of support to CYF and AOA clients during FY 2021-22. A potential growth area for future years would be an increased capacity to provide rehabilitation services by non-licensed clinicians as these were infrequently utilized during FY 2021-22.

Table 2. Average Number of BHConnect Services Provided Per Month during FY 2021-22

	Youth (N=81)	Adults (N=67)
Type of BHConnect Service	Average Number of Services per 30 Days	
Any BHConnect service	3.5	4.3
Psychosocial assessment	0.5	0.7
Therapy	2.0	2.5
Rehabilitation	<0.1	0.1
Case management	0.4	0.8
Other services (e.g., collateral)	0.6	0.3

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 6/30/2022 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=64)				Adult (N=55)			
	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	13	20.3	<5[1]	<7.8	22	40.0	<5[1]	<9.1
Crisis Residential	0	-	0	-	<5	<9.1	0	-
Crisis Stabilization	16	25.0	<5[1]	<7.8	<5	<9.1	<5[1]	<9.1
Urgent Outpatient	0	-	0	-	5	9.1	5	9.1
PERT[2]	<5[1]	7.8	<5[1]	<7.8	5	9.1	<5[1]	<9.1

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

Overall, the service utilization pattern for both youth and adult BHConnect participants suggested 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. A total of 40% had at least one inpatient psychiatric hospitalization in the 90 days prior to enrolling in BHConnect, as compared to less than 9.1% during the 90 days after enrolling 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 Baseline 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 47 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2021-22 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 0-3, 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 minimal overall changes from initial assessment.

Table 4. CANS Average Change from Initial Assessment (N=47)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	2.5	2.3
Life Functioning	2.7	3.0
Risk Behaviors	0.7	1.0

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 50-60% 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=47)

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	35	19	51.4
Risk Behaviors	24	13	54.2

The percent of persons with an improvement across these three domains was lower than what was reported in the FY 2020-21 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients (i.e., at least one improvement was evident in approximately 75% of discharged clients across each domain). 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. In this regard, the fact that the majority of the BHConnect population exhibited progress on the CANS suggests that the BHConnect team was successfully able to connect with these children, youth, and their families via telehealth and facilitate 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 Table 6.

In FY 2021-22, 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 33 caregivers and 32 youth in FY 2021-22 completed both a baseline and follow-up assessment. Table 6 shows that approximately two-thirds of both parents and youth reported PSC total scores (63.6% of parents and 68.8% of youth) 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 50.0% of parents and 40.6% of youth indicating PSC total scores that exceeded the threshold for ongoing clinical concerns. 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.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=33)					Child/Youth Report (N=32)				
Subscales	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Post**
Attention	33	18.2	17.6	4.8	4.7	32	50.0	31.2	6.2	5.3*
Internalizing	33	72.7	41.2	6.1[1]	4.8*	32	78.1	56.2	6.5[1]	4.8**
Externalizing	33	27.3	32.4	4.7	4.5	32	12.5	6.2	3.2	2.5
Total Score	**33**	**63.6**	**50.0**	**32.6[1]**	**28.6[1]***	**32**	**68.8**	**40.6**	**32.2[1]**	**25.4***

**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 2020-21 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=33)		Child/Youth Report (N=32)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	9	27.3	7	21.9
No improvement (i.e., 0-1 point reduction)	3	9.1	3	9.4
Small improvement (i.e., 2-4 point reduction)	6	18.2	4	12.5
Medium improvement (i.e., 5-8 point reduction)	3	9.1	8	25.0
Large improvement (i.e., 9+ point reduction)	12	36.4	10	31.3

As shown in Table 7, approximately one-third of the parents/caregivers (36.4%) and children/youth (31.3%) in BHConnect reported a large improvement from their initial PSC assessment. Alternatively, 27.3% caregivers and 21.9% of children reported a higher PSC score at follow-up, indicating some increased impairment. These findings suggest substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. Substantial variability and generally similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2020-21 Systemwide Annual Report. Approximately 45% of caregivers and children/youth reported large improvements and about 20% reported increased impairment from initial PSC assessment. Compared to overall BHS system, BHConnect youth were less likely to report large improvements (i.e., 31.3% compared to 44%); however, the unique composition of the BHConnect population likely contributed to this difference.

Adult Baseline 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 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 16 adult participants who completed the RMQ at intake and at a follow-up assessment during FY 2021-22 was 3.6 at baseline and 3.8 at follow-up. This change was in the desired direction and statistically significant. An important individual item from the RMQ with a statistically significant and clinically meaningful increase was "I deal more effectively with daily problems," which increased from a 3.1 to 4.4. 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 2020-21 (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. 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. 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 21 participants completed an intake and a follow-up assessment in FY 2021-22 (see Table 8). The mean overall IMR score at intake was 2.7 which increased to 3.5 at last available follow-up. Primary domains where improvements were observed included reductions in substance abuse, effective medication adherence, as well as improved ratings for family involvement.

Table 8. IMR Assessments for BHConnect Adult Clients (N=20)

		Intake	Follow-Up
Individual Assessment Items	**n**	**Mean[1]**	**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?	20	3.1	3.1
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?	21	2.0	3.3*
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	21	2.6	3.8*
Using medication effectively: How often does s/he take his/her medication as prescribed?	15	4.3	3.8
IMR Subscales	**n**	**Mean[1]**	**Mean[1]**
Recovery	21	2.5	3.5*
Management	21	1.9	2.9*
Substance Abuse	20	4.2	4.3
Overall IMR	21	2.7	3.5*

**statistically significant at $p < 0.05$*

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

As reported in the mHOMS Annual Outcomes Report for FY 2020-21 (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 and July of 2022, 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. Participants were given a short script explaining the purpose of the survey, and that feedback was voluntary, confidential, and would not affect services. Of the 25 program participants asked to participate in the survey, four declined and 21 began the survey (nine adult/older adult clients, six youth clients, and six parents/caregivers). One participant discontinued after the first question. Most respondents had been in the program either 3-6 months (35%) or 7-12 months (35%) while smaller groups had been in the program 1-3 months (15%) or more than 12 months (15%).

Given the participation rate relative to the number of clients served by BHConnect during FY 2021-22, 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

1. "This has been so much better for me because I don't have to figure out how to get there(sessions). I don't have to figure out who is going to take care of the kids."
2. "I work full time, and I did not have to take off work for [my child] to do his sessions."
3. "I like that I can go minutes before the session and don't have to ask mom to give me a ride or go on the bus to make it to session."

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

1. "Convenience, especially with the price of gas right now."
2. "I like remote services. I don't have to wait a lot. I don't have to work around my schedule that much. This also makes me have more time to schedule my other appointments, since I have physical therapy twice a week, and constant doctor's appointments."
3. "I can stay in familiar surroundings, and comfortable. I'm not around a lot of strange individuals or others. I can be more open with my therapist on the phone."

The BHConnect experience has differed from prior providers

1. "The fact that it's remote, more consistent, more of a team with BHConnect."
2. "The communication the therapist has with me and my son. If I have an issue with [my child] I can call [the therapist] and he will help me with the situation. I would say the constant communication."
3. "I feel like I am getting better care than I have from past providers."

Telehealth may be challenging for young clients

1. "Sometimes I feel that the children don't have that privacy at home. I also feel that some children get distracted in their room, and they are not fully focused on the appointment."
2. "It's been a struggle because my kid is not a phone person."

3. “Telehealth services have a lack of privacy in my home because I have younger kids that might distract my son's therapy appointment.”

Despite potential difficulties of conducting telehealth visits with young clients, 80% of survey respondents reported that BHConnect participation has had a positive effect on their life. Participants mentioned improved relationships and communication, better emotion management, behavior improvements (e.g., following rules at school), and reduced symptoms (e.g., panic attacks). Overall, 100% of survey respondents stated they would recommend BHConnect to a friend or family member.

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.

Telehealth Service Preferences and Experiences

During FY 2021-22, BHConnect clients were allowed to choose between receiving a device from the BHConnect program that would be used exclusively for participating in telehealth services or downloading an app onto a personal device of their choosing that would be utilized for the BHConnect telehealth sessions (previously all clients received a device from BHConnect). Approximately 40% of CYF clients (41.5%) and 50% of AOA clients (49.2%) requested to have an app put on an existing personal device rather than receiving a new device dedicated to only engaging in telehealth services from BHConnect. For those who requested the app to be installed on an existing personal device, the two primary reasons among both CYF and AOA clients for making that choice were: 1) inconvenience of having another duplicative device (i.e., to manage/keep track of), and 2) preferred the familiarity of their own personal device. Among those who opted for a device from BHConnect, the primary reasons for both CYF and AOA clients were: 1) preference of having a separate device dedicated to telehealth services, and 2) financial considerations due to barriers of having adequate personal phone service for telehealth.

At the end of select sessions, BHConnect CYF and AOA clients as well as their clinicians were asked to rate the telehealth session experience on several domains related to the quality of the visit from a technological perspective. Respondents were asked to indicate the extent to which they agreed with each statement on a 5-point scale ranging from strongly disagree to strongly agree. In Table 9, telehealth service feedback from the first BHConnect session is presented.

Table 9. Feedback Regarding the First BHConnect Telehealth Session

	CYF Client Response		CYF Clinician Response		AOA Client Response		AOA Clinician Response	
Amount of Change	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**
I was able to see clearly	34	5.8	33	9.1	31	3.2	31	3.2
I was able to hear clearly	34	5.9	34	8.8	31	0.0	31	0.
The back-and-forth timing of the conversation was good	34	2.9	34	8.8	31	3.2	31	3.2
There was enough technical assistance	33	0.0	-	-	25	0.0	-	-
I felt comfortable with the equipment used	34	2.9	-	-	31	6.4	-	-

Overall, the results indicated that from the perspective of both clients and clinicians, relatively few (i.e., less than 10%) of the first BHConnect sessions had any issues with the video or audio quality and/or technological disruptions to the conversation between client and clinician. Very few CYF and AOA clients (2.9% and 6.4%, respectively) reported that they were not comfortable using the equipment to conduct their initial telehealth service. These positive perceptions with the telehealth experience were likely particularly important as they helped established "first impressions" regarding engagement in BHConnect services. Analyses of feedback from later sessions indicated that experiences with the technology remained positive and even improved over time.

BHConnect Referral Partner Feedback

During July of 2022, BHConnect providers asked referral partners to engage in a short qualitative survey to elicit feedback on the 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 given a short script explaining the qualitative data collection process, and explained the feedback was voluntary and would be used only to inform recommendations for program improvements. Of the 31 referral partners invited to participate, 19 completed the survey for a response rate of 61%. 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.

1. "BHConnect team is responsive and they connect with patients quickly after the referral is made."
2. "The expediency in getting clients serviced has been of great value."
3. "The referral process is easy and the wait time is reasonable in comparison to other programs where they have a 3-6 month waiting list."

BHConnect reduces barriers to therapy.

1. "BHConnect is the only Medi-Cal based therapy that is available that offers telehealth/phone-based therapy for individuals with severe mental illness. Without the BHConnect program this population would have no other option for therapy besides attempting to return to the clinic model."
2. "Many clients have a difficult time maintaining services at a traditional mental health clinic due to various barriers such as lack of transportation, agoraphobia, and/or significant depression which impacts motivation to leave their house. BHConnect offers a unique way to reduce barriers and provide therapy supports to clients that would be otherwise difficult to connect."
3. "It makes for safer [hospital] discharges with greater chance of patients continuing treatment post discharge."

BHConnect fills a gap in services in the community.

1. "Families tend to sit on other agency wait lists for months and for patients with higher acuity safety concerns, they cannot wait several months before meeting with a therapist."
2. "Many in the community can only see patients on a monthly basis for individual therapy. That is not sufficient for most stepping down from the hospital."
3. "For patients with [serious mental illness], psychotic disorder, it would be extremely difficult to find other referral options."

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

1. "Not sure how many of the referrals follow through or were seen."
2. "Identify a point of contact between programs (BH Connect liaison/Strength Based Case Management Liaison) to ensure coordination of care and successful linkage between the programs. This will make it easier to address concerns, communicate urgent concerns, and better support client needs."

Additional Program Activities

Establishing Additional Referral Partners

As discussed above, the number of referrals, particularly for AOA clients, increased substantially during FY 2021-22. 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.

Developing A Partnership to Provide Child and Youth Psychiatric Services

To address any medication management needs of children and youth receiving BHConnect services, a partnership was established with another County BHS "Innovation" program, the Center for Child and Youth Psychiatry (CCYP). By collaborating with CCYP for the provision of psychiatric services (which also relies primarily on a telehealth approach for service delivery), BHConnect was able to better meet the needs of clients.

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 2021-22. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. All BHConnect staff invited to participate in the survey did so, for a 100% response rate (N=10). 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:

> "The key strength is the flexibility that [BHConnect] offers clients to receive services despite their living situation, living location, and schedules. It offers them the option to receive services remotely anywhere and anytime for the most part and provides the device that they might not otherwise have to participate in other remote services. BHConnect is a program that meets them where they are at, during a time of significant crisis and an option to get the support they might not otherwise receive in traditional programs and traditional settings. We will drive out anywhere in the county to provide a device, train them on the device, and engage them quickly after experiencing a mental health crisis!"

Staff identified the uniqueness of BHConnect in this respect: "How unique the program is. I might sound repetitive, yet the ability to accommodate clients in our schedule, our flexibility, and that we don't have a set limit of sessions." Another staff member stated, "We are one of the only programs that helps and assists 7-year olds to 70-year olds, and that's very unique for a therapeutic program."

Program Challenges

During the prior FY (2020-21), BHConnect staff identified staff turnover and shortages as one of the biggest challenges to reaching program goals. This theme continued into FY 2021-22. Multiple respondents highlighted the "learning curve" and increased need for training with new staff.

> "The transition from Welcome Home Health [WHH] to FHNs providing support to clients has been a difficult transition. The FHNs required a great deal more training than clinicians on service delivery and how to capture, bill and document the services being delivered under their role. In addition, we had to train the clinicians to consider more case management and rehab."

Staff also mentioned clinician burnout from working with a client population who can be difficult to engage in services.

> "Morale is always a work in progress at BHConnect because our population is chronically unconnected and difficult to engage. Our clients tend to no-show frequently, and this can contribute to clinician burnout or feeling like they are not doing a good job."

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.

Staff noted the need for frequent check-ins and contact with clients to maintain participation. One therapist stated, "When clients are affected by stressors such as pandemic, inflation, and life stressors we notice the change in their engagement with services." Health navigator visits, reminder calls and care packages were mentioned as helpful methods to maintain contact between appointments.

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

> "In my experience connecting with the clients in a more 'person to person' approach helped me a lot. Also meeting them where they are. Being flexible, and understanding of their situation is also a key. The program's structure also helped a lot in keeping them connected as we provide them with a lot of opportunities to miss, reschedule or meet more frequently if desired."

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. An on-site Alcohol and Other Drug (AOD) counselor was an additional suggestion.

Facilitating Client Referrals

The establishment and maintenance of referral sources has been a necessary goal of BHConnect since its inception. FY 2021-22 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. New connections with Rady Children's Hospital Emergency Department, Sharp Mesa Vista and Paradise Valley Hospital are expected to be strong referral partnerships. Respondents mentioned the need for additional adult referral sources, in an effort to fill midday appointments which are historically underutilized. Additionally, continued outreach is recommended to underserved communities "such as Native Americans, Asians, Latino, and African Americans [as well as] at risk-mothers [and] geriatric clients."

Health Navigator Role

During FY 2021-22, the role of Health Navigator was added to the BHConnect service provider team. Prior to FY 2021-22, a separate organization (WHH) provided some health navigation support services to BHConnect clients including device management, crisis intervention/safety planning, appointment scheduling, and reminders/follow-up. This change allowed for greater coordination and integration of health navigation/service engagement activities with the rest of the BHConnect care team.

When asked which key roles/activities should be the focus of Health Navigators as part of their recently enhanced role in BHConnect, most staff mentioned that it would be useful for Health Navigators to focus on case management and rehab activities (e.g., rehab groups). Additionally, staff mentioned that the Health Navigator role should include client engagement activities (e.g., welcome kits/care packages, frequent in-person visits).

Supports, Tools, & 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 & process skills (i.e., treatment session development, note writing).
3. Further training on County protocols.

Additionally, respondents highlighted the desire for reliable technological equipment and support.

Experiences with Telehealth Services

Technical difficulties with both the telehealth platform and devices were reported as the most common challenges when attempting to provide telehealth with video services. Most BHConnect staff recommended utilizing an alternative contact method (e.g., telephone) in case of issues. Additionally, one staff member suggested the following protocol to navigate technology problems:

> "Remind clients to ensure they have good service before logging into their session, and have a plan for if they get disconnected, such as a phone session as an alternative to a video session. I also recommend [to] check for seeing and hearing at the beginning of the session, and throughout as needed, and informing client that they can log off and log back in, or turn their phone off and back on to try to get a better connection."

Impact of COVID-19 on BHConnect Staff

As a result of COVID-19, staff reported that many team members transitioned to working from home and there has been a resulting lack of coworker connection. One staff mentioned they "can go days without seeing staff [in person]" and that "most communication with staff is via e-mail." A therapist stated,

> "I feel that in general something's changed, for example, stress levels, and being more careful/understanding about people's beliefs in the pandemic. More mental health issues on the rise so the frequency and intensity of the job has somewhat changed."

BHConnect staff report utilizing personal protection measures and mental/physical health self-care to manage pandemic-related demands. One staff member noted the need to be "mindful of how hybrid remote work impacts work relationships, team bonding, and communication [as well as] how hybrid remote work can have negative and positive effects on work performance."

Changes from Initial Program Design

During FY 2021-22, BHConnect expanded the options that clients could utilize to connect with BHConnect services. Originally, all clients were issued an electronic device that they would utilize solely for communicating with the BHConnect and WHH team members. BHConnect began to allow clients the option to choose whether they would like to utilize their personal smartphone to receive BHConnect service (and get the relevant programs installed on their phone) or if they would rather receive a device from BHConnect to use for interacting with the care team. When provided the option, approximately 40% of CYF clients and 50% of AOA clients chose to have an app installed on an existing personal device to participate in BHConnect telehealth services instead of receiving a separate device from BHConnect dedicated to participating in telehealth services.

Throughout FY 2021-22 the BHConnect team was refining the relatively new role of the Health Navigator, which was previously outsourced to a separate organization. Primary responsibilities of the Health Navigator include an emphasis on case management and rehab activities (e.g., rehab groups) as well as supporting client engagement activities such as preparing and delivering welcome kits/care packages and connecting with clients on a regular basis.

Program Recommendations

1. Continue to develop and expand referral partners in order to identify under-served or vulnerable youth, transitional age youth, adult, and older adult residents of San Diego County who could benefit from the treatment services offered by BHConnect. New partners to include but not limited to: Cal State San Marcos, Adult Protective Services, and Perinatal Care Network.
2. Maintain ongoing and close relations with hospitals to provide on-site warm hand-offs and intakes, and ultimately, increased client engagement with BHConnect. Continue to explore best practices to increase client engagement from the moment referral is received.
3. Finalize internal policies and procedures to implement short-term psychiatric care for AOA clients in order to fill the gap as they are linked to long-term psychiatry. Include therapists and Health Navigators in virtual psychiatric evaluations for added, personalized support to clients.
4. Continue embracing a hybrid-treatment model that caters to the individual needs of BHConnect clients, offering in-home services and increased sessions when clinically indicated, and leveraging engagement strategies such as care packages, Motivational Interviewing, Harm Reduction and trauma-informed, compassion-based approaches.
5. To facilitate program effectiveness and sustainability, continue providing Health Navigator check-ins and delivery of care packages and resources as clients are discharging from emergency/crisis services, continue incorporating individual and family rehab to augment teletherapy at BHConnect, maintain therapist and Health Navigator close-collaboration through regular virtual warm hand-offs, and offer rehabilitation groups (both virtually and in-person) on topics such as substance use recovery and

money management. Continue developing additional opportunities for Health Navigators to provide support services that are reimbursable through Medi-Cal/Cal-AIM.

6. Continue to provide clinical support and training to all staff on topics that support their effectiveness in working with serious mental illness in telehealth topics/trainings such as: screening, brief intervention and referral to treatment (SBIRT), best practices in suicidality assessment and treatment, psychopharmacology for serious mental illness, trauma grief counseling, virtual-compatible trauma therapies such as Eye Movement and Desensitization Reprocessing (EMDR), crisis management strategies, and creative interventions to maintain engagement with youth in virtual therapy.
7. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care. Continue annual staff training on parenting skills and modalities such as Parent-Child interaction therapy.
8. Refine the screening process by consulting with community stakeholders and internal leadership, refine BHConnect eligibility criteria as needed, educate referral partners on the risks and benefits of telehealth and what would constitute an appropriate referral to BHConnect.
9. Increase ability to address client preferences by including iPads as a device option available for participating in telehealth services.
10. Explore implementation of the VI-SPDAT to provide homeless clients with increased linkages to housing resources.

Conclusion

During FY 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 67 AOA clients) were served by BHConnect in FY 2021-22. While BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year.

As a result of the efforts of the BHConnect program to expand the number of community referral partners, a total of 20 different organizations referred 256 clients to BHConnect in FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to a 265.8% increase in AOA referrals between FY 2020-21 (n=38) and FY 2021-22 (n=139), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease). A total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations reaching this threshold in FY 2020-21.

As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by the increasing number of referral partners throughout San Diego County. Referral partners identified the key benefits of BHConnect as filling a gap in needed services for persons who may not be interested in traditional outpatient programs by offering prompt enrollment into services (i.e., before interest or engagement fades) and relying primarily on a telehealth model which reduces barriers to accessing services.

BHConnect prioritized a quick response to client referrals, with the majority of persons (56.0%) enrolled in BHConnect within one day of the initial referral and 74.4% within three days. Once enrolled in the program and receiving services, youth and adults will stay engaged with the program anywhere from a

few weeks to 6 months or more. Of those who were still involved with BHConnect services as of 06/30/2022, the median enrollment duration for youth and adults was 142.0 and 155.5 days, respectively.

CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 total monthly CYF and AOA BHConnect services provided during the prior year. This increase in average monthly service contacts was due primarily to the greater provision of case management and other support services by the Health Navigators in FY 2021-22.

Service utilization patterns 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 and other related services for youth and adults after enrolling in BHConnect. 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 the need for further behavioral health improvements.

Based on feedback from BHConnect youth and adult clients and the caregivers of youth, the BHConnect program was perceived as accomplishing 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. A potential challenge for the BHConnect program; however, is to continue to demonstrate its uniqueness and specific population niche within the overall behavioral health system of care given that telehealth is now more widely available in other treatment programs due to the changes in service provision strategies brought about in response to the COVID-19 pandemic.

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 2021-22

Characteristic	Child/Youth (N=56)		Adult (N=60)	
Gender	**n**	**%**	**n**	**%**
Male	18	32.1	25	41.7
Female	34	60.7	34	56.7
Another gender identity/Prefer not to answer	4	7.2	1	1.6
Total	**56**	**100**	**60**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	51	91.1	56	93.3
Other	5	8.9	4	6.7
Total	**56**	**100**	**60**	**100**
Race/Ethnicity[1]	**n**	**%**	**n**	**%**
African American	8	14.3	16	26.7
Asian	-	-	6	10.0
Hispanic/Latino	34	60.7	22	36.7
White	18	32.1	23	38.3
Multiple	10	17.9	8	13.3
Other	7	12.6	1	1.7
Missing/Unknown	-	-	1	1.7
Total[1]	**-**	**-**	**-**	**-**
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	24	42.9	36	60.0
Gay or Lesbian	<5[2]	<8.9	<5[2]	<8.3
Bisexual/Pansexual/Sexually Fluid	9	16.1	8	13.3
Questioning/Unsure	<5[2]	<8.9	<5[2]	<8.3
Missing/Prefer not to answer	19	33.9	9	15.0
Total	**56**	**100**	**60**	**100**
Disability	**n**	**%**	**n**	**%**
Has a disability	13	23.2	24	40.0
Does not have a disability	38	67.9	29	48.3
Declined/Prefer not to answer	5	8.9	7	11.7
Total	**56**	**100**	**60**	**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=56)		Adult (N=60)	
Type of Disability[2]	n	%	n	%
Communication (i.e., seeing, hearing)	<5[2]	<8.9	<5[2]	<8.3
Learning Disability	<5[2]	<8.9	11	18.3
Physical Disability	<5[2]	<8.9	9	15.0
Chronic Health	<5[2]	<8.9	8	13.3
Other	<5[2]	<8.9	<5[2]	<8.3
Total	-	-	-	-

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

	Child/Youth (N=56)			Adult (N=60)	
Age Group	n	%	Age Group	n	%
5 to 14	26	46.4	**18 to 25**	17	28.3
15 to 18	30	53.6	**26 to 69**	43	71.7
Total	**56**	**100**	**Total**	**60**	**100**

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Final Report

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

v.12.22.2022

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

UC San Diego

Table of Contents

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Roaming Outpatient Access Mobile (ROAM) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). ROAM was designed to increase access to and utilization of culturally competent mental health services in rural American Indian communities in San Diego County to decrease the effects of untreated mental health and co-occurring substance abuse conditions. Two organizations, the Indian Health Council (IHC) and Southern Indian Health Council (SIHC), were selected to provide ROAM services. To facilitate access to care and to help treat the typically underserved American Indian population, the ROAM program adopted the use of mobile health units (MHU) to provide effective health services in areas that may be hard to reach as well as offering telehealth and telepsychiatry services to lessen the need for in-person clinic visits. For both the IHC and SIHC ROAM programs, the ongoing effect of the COVID-19 pandemic and the required safety precautions led to periodic suspension of in-person behavioral health service provision, except for crisis situations. This also prevented the consistent use of mobile health units for delivering behavioral health care services.

Primary Findings and Conclusions

ROAM Programs Expanded Access to Behavioral Health Services through Responsiveness to Unique Community Needs and Priorities

1. While both IHC and SIHC operated a ROAM program with the same fundamental mission (i.e., to increase participation in needed behavioral health care by reducing barriers to accessing services) and the same core tools (i.e., MHU, telehealth, and a team of service providers), variations in the areas of expertise of those comprising each ROAM team and the range of unique opportunities and challenges within the communities they served resulted in the development of two similar, but different ROAM programs. An essential component of each ROAM program, particularly when required to strategically adjust to the new realities brought about by the COVID-19 pandemic, was the capacity to flexibly and creatively utilize the tools and resources within the ROAM program to address identified and emerging needs of those they served.

2. Both the IHC and SIHC ROAM programs provided an extensive amount of behavioral health services. IHC provided 2,626 services to 146 persons (average of 18.1 services per person) and SIHC provided 3,404 services to 403 persons (average of 8.4 services per person).

3. Primary services for both programs included the provision of therapeutic care as well as a range of other assessment, psychoeducation, and case management services. While both programs offered psychiatric care to support medication management, over half the participants (51.6%) at SIHC had at least one medication management visit, whereas less than a quarter (22.6%) of participants were served at IHC. With the inclusion of a licensed Alcohol and Other Drug (AOD) counselor on the IHC ROAM team, more than half of IHC participants (56.2%) engaged in at least one substance abuse counseling session, whereas this was not commonly provided by SIHC (only 2% of SIHC clients received the service).

ROAM Programs Provided Important, Accessible Services that Improved Recovery

4. Participant feedback reported that they highly valued ROAM services and noted they likely would not be in services if not for the accessible, trusted, and private ROAM services. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services in a flexible and private manner, stating that without the program they likely would not be in therapy.

5. While limited outcome data with baseline and follow-up assessments were available, of those persons with such data, reductions in depression symptoms and improved recovery and management of symptoms were identified for many.

Where Feasible, Telehealth Video-Based Sessions were a Promising Approach to Increase Accessibility of Behavioral Health Services

6. Feedback from ROAM staff and participants indicated that where technologically feasible, telehealth with video was an acceptable, and in many instances desirable mode for delivering behavioral health care services for Native community members due to convenience and privacy.

7. Challenges remained for providing telehealth services throughout remote and particularly mountainous regions. Based on the experiences of the ROAM programs, a multi-level model was created (as shown in Figure 1 below), to illustrate and summarize the foundational community-, organizational-, provider- and patient-level factors necessary to support widespread utilization of telehealth services.

Under Challenging Circumstances, Both ROAM Programs Creatively Utilized the MHUs to Provide Services and Increase Awareness of ROAM and Behavioral Health Needs

8. Mechanical and logistical issues delayed and disrupted utilization of the MHUs at times and the COVID-19 pandemic also prevented their use, at least initially, due to safety concerns regarding confined and shared spaces. Even with those challenges, both ROAM programs made creative use of their MHUs to provide behavioral health services throughout the community. When feasible, they also promoted awareness of the ROAM program and provided general behavioral health information via the MHUs through participation in community events. The MHUs were also utilized to address

emerging needs related to the pandemic by assisting with COVID-19 testing and administering vaccines at locations throughout the communities.

9. ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible, both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and understanding about mental health and substance use issues more generally. These outreach efforts contributed to the recognition of ROAM as an important community resource.

Future Directions

Between fiscal year (FY) 2018-19 and FY 2021-22, the IHC and SIHC ROAM programs were funded by BHS as part of an MHSA Innovations program to develop and pilot test new services. Based on the experiences, accomplishments, and operational learnings of the IHC and SIHC ROAM programs during this timeframe, both IHC and SIHC decided to continue the ROAM programs indefinitely using non-BHS funding sources such as other federal grants. Feedback from ROAM program staff indicated how ROAM was now perceived as an essential part of the community and a key resource that has been integrated within their existing behavioral health services. Ongoing ROAM program services were expected to closely resemble the types of services provided during the BHS-funded Innovations phase to reflect the unique needs and strengths of each program (i.e., strong emphasis on AOD at IHC and on medication management at SIHC in addition to extensive provision of mental health therapy at both). Additionally, each ROAM program will continue to make flexible use of the MHU and telehealth technologies where feasible to reduce barriers to accessing needed behavioral health services.

Program Description

The HHSA BHS ROAM program was funded through the INN component of the MHSA to develop and pilot-test new services. ROAM was developed to provide fully mobile mental health clinics to American Indians of all ages in the North Inland and East County regions of San Diego. Two organizations, the IHC and SIHC were selected to provide ROAM services. Program planning along with mobile health units design and acquisition began during FY 2018-19 with BHS-funded behavioral health services provided by each of the ROAM clinics from FY 2019-20 through FY 2021-22.

The ROAM teams at both IHC and SIHC included licensed therapists and psychiatrists. The IHC ROAM team also included a licensed AOD counselor; whereas the SIHC ROAM team incorporated a licensed nurse into their care team to help identify and address frequently identified physical health needs. The majority of ROAM staff at both IHC and SIHC identified as American Indian. This representative staffing was part of an effort to provide culturally competent services that were sensitive to the needs of American Indians.

ROAM services were intended to improve access to and utilization of mental health services for American Indian children, transitional age youth (TAY), adults, and older adults residing on tribal reservations and in rural communities in San Diego County. A key eligibility criterion for ROAM services was whether

barriers were identified that would inhibit participation in standard clinic-based outpatient behavioral health care services. ROAM services aimed to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. Each ROAM team was staffed with culturally competent licensed and unlicensed professionals who could provide a variety of care services. In addition, the ROAM program used telehealth to decrease burdens for accessing needed services, and as a response to the pandemic, when in-person services were either not possible or not preferred due to concerns about patient and staff safety.

To reduce the stigma often associated with behavioral health concerns and increase awareness of ROAM services in their respective communities, staff from each ROAM program participated in community events and meetings to provide education about behavioral health issues.

Participant Characteristics

A brief overview of the ROAM participant characteristics is presented here with a more complete listing in the report appendix. IHC served a total of 146 persons and SIHC served 403 between 7/1/2019-6/30/2022. In general, the characteristics of the enrollees in both ROAM programs were similar with females comprising a slightly higher percentage of those served at SIHC compared to IHC (57.3% to 50.7%). Of the populations served, 91.1% of IHC and 80.9% of SIHC ROAM clients identified as American Indian, with the majority from both programs indicating they spoke English (93.8% and 98.0%, respectively). , and did not have a disability (37.7% and 73.7%, respectively As shown in Table 1, children (i.e. less than age 16) and transitional age youth (i.e., age 16 to 25) comprised a larger proportion of the population served at SIHC than at IHC.

Table 1. Participant Age

	IHC (N=146)		SIHC (N=403)	
Age	**n**	**%**	**n**	**%**
0 - 15	5	3.4	56	13.9
16-25	15	10.3	79	19.6
26-45	66	45.2	152	37.7
46-65	39	26.7	87	21.6
>65	21	14.4	29	7.2
Total	**146**	**100**	**403**	**100**

Utilization of Program Services

ROAM Behavioral Health Service Provision

A total of 146 persons received 2,626 behavioral health services through IHC ROAM and 403 persons received a total of 3,404 services through SIHC ROAM. While IHC ROAM served fewer persons than SIHC ROAM, those served typically had more service contacts per person than those served at SIHC ROAM (average of 18.1 and 8.6 service contacts, respectively).

As shown in Table 2, one key area of difference between the two programs was the provision of substance abuse counseling, with over half (56.2%) of IHC participants receiving at least one such service compared to the 2.0% of SIHC participants. This difference reflects the composition of the respective ROAM teams and the inclusion of a SUD counselor at IHC. Another key area of difference was that medication management services were received by about twice as many participants at SIHC (51.6%) as compared to IHC (22.6%). Both programs included access to psychiatric care, but expanded access to this type of service was particularly emphasized at SIHC.

Psychoeducation was more commonly reported among IHC participants (38.4% and 8.4%, respectively). Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (36.3% and 36.5%, respectively). Of note, at both IHC and SIHC, substantial proportion of the clients (19.9% and 30.0%) were specifically reported as receiving trauma-informed therapy. This suggests that prior and/or current traumatic experiences were negatively impacting the lives of many persons served by IHC and SIHC. While there were some differences between the programs, most notably being the emphasis on substance abuse counseling evident at IHC and medication management at SIHC, the overall findings highlight the wide range of service activities that were provided to persons who may have had difficulty accessing needed behavioral health care through traditional outpatient clinic settings.

Table 2. Number and Type of ROAM Service Contact by Program

	IHC				SIHC			
	Total persons (N=146)		Total services (N=2,626)		Total persons (N=403)		Total services (N=3,404)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of persons with service	Percent of persons with service	Number of services	Percent of total services
Assessment	93	63.7	137	5.2	292	72.5	385	11.3
Psychoeducation: Individual	56	38.4	378	14.4	34	8.4	193	5.7
Psychoeducation: Group	<5[1]	<3.4	<5	<0.2	29	7.2	29	0.9
Therapy: Trauma Informed: Individual	29	19.9	364	13.9	121	30.0	538	15.8
Therapy: Cognitive Behavioral: Individual	53	36.3	819	31.2	147	36.5	1,450	42.6
Substance Abuse Counseling	82	56.2	1,015	38.7	8	2.0	21	0.6
Therapy: Cognitive Behavioral: Group	20	13.7	86	3.3	<5[1]	<1.2	5	0.1

[1]*Due to the small number of people receiving this service, (i.e., less than 5), the exact number is masked.*

Table 2. Number and Type of ROAM Service Contact by Program (continued).

	IHC				SIHC			
	Total persons (N=146)		Total services (N=2,626)		Total persons (N=403)		Total services (N=3,404)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of persons with service	Percent of persons with service	Number of services	Percent of total services
Referral to Substance Abuse Counseling	7	4.8	12	0.5	14	3.5	17	0.5
Therapy-Family Involved	<5[1]	<3.4	<5	<0.2	51	12.7	152	4.5
Case Management	9	6.2	18	0.7	74	18.4	208	6.1
Medication Management	33	22.6	220	8.5	208	51.6	1086	31.9
MAT-SUD	-	0	-	0	19	4.7	117	3.4
Other	46	31.5	206	8.1	13	3.2	14	0.4

[1]*Due to the small number of people receiving this service, (i.e., less than 5), the exact number is masked.*

The variety of service activities provided by both ROAM programs were delivered either in-person, over the phone, or via telehealth with video. As shown in Table 3, approximately half of the ROAM services at IHC were provided in-person (50.6%) as compared to 25.5% at SIHC. At IHC 44.3% of the service contacts were provided via telephone with only 5.0% via telehealth with video, whereas at SIHC, telephone-based services represented 26.1% of services contact and telehealth with video comprised almost half of all SIHC services provided (47.8%).

Table 3. Method of Contact

	IHC		SIHC	
Contact Type	**n**	**%**	**n**	**%**
In-Person	1,313	50.6	868	25.5
Telehealth w/video	130	5.0	1,628	47.8
Telephone	1,151	44.3	887	26.1
Other	3	0.1	31	0.9

Based upon feedback from the ROAM programs, the differences in how services were provided by IHC and SIHC were largely the result of two primary factors: 1) conditions of the COVID-19 pandemic, which pushed many services remotely for extended periods of time, and 2) variabilities in technological capabilities across the rural and mountainous communities.

With COVID-19 inhibiting the use of in-person services for long periods of time, SIHC moved rather easily into telehealth during this period due to their high prevalence of psychiatry services. In contrast, the move into telehealth created additional challenges for IHC due to the emphasis on providing substance abuse counseling, which were harder to effectively accomplish remotely, so in-person sessions were utilized whenever feasible.

Another factor in telehealth service utilization were variations in technological capabilities. Technological and internet connectivity difficulties were experienced more acutely across IHC communities which contributed to why only 5% of services were provided via telehealth with video compared to 47.8% at SIHC. Many IHC participants did not have internet connectivity that could support a video-based telehealth session. Where internet services were available, communication disruptions (i.e., dropped calls) and distortions interfered with the health providers ability to consistently engage in the therapeutic discussions with their participants. This prompted a greater reliance on delivering services via phone. Additional difficulties emerged for IHC with integrating information technology systems and the virtual platforms needed to securely conduct telehealth sessions.

Since many services were provided remotely, this allowed participants more flexibility regarding where they were located when receiving ROAM services, with approximately two-thirds of ROAM services provided while the participant was at home (i.e., via phone or telehealth). This highlights the importance of programs such as ROAM that allow services to be accessible and eliminate transportation barriers for many visits. Other locations commonly used by ROAM participants included: 1) the home of friend/family member, 2) the car, 3) work, or 4) while in another inpatient or residential treatment program. The ongoing effects of the COVID-19 pandemic limited the programs' ability to consistently provide ROAM services using the MHU, however, when possible, offering services via the MHU represented another approach used to extend the reach of ROAM into the community and make services as accessible as possible.

Primary Program Outcomes

Patient Health Questionnaire

The Patient Health Questionnaire (PHQ) is a brief, self-report tool used for identifying depression, with higher scores indicating increased severity of depression symptoms. As shown in Table 4, a total of 40 persons at IHC and 65 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM and completed at least one follow-up assessment. The average intake scores were 9.7 for IHC and 11.2 for SIHC participants, which were generally indicative of moderate depression. However, there was substantial variability in the initial PHQ-9 scores with approximately 35-45% of participants from both programs demonstrating symptoms likely indicative of a depressive disorder.

Table 4. Change in PHQ-9 Scores from Initial Assessment to Last Follow-up Assessment

	IHC (N=40)			SIHC (N=65)		
PHQ-9 Item		**Initial PHQ-9**	**Last available PHQ-9**		**Initial PHQ-9**	**Last available PHQ-9**
Note: higher value = worse condition Scale: 0 ("not at all) to 3 ("nearly every day")	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
Little interest or pleasure	40	1.1	0.9	65	1.4	0.8**
Feeling down	40	1.3	1	62	1.4	1.1**
Trouble sleeping or excessive sleep	40	1.6	1.1	65	1.8	1.2**
Feeling tired	40	1.2	1.2	65	1.6	1.2**
Poor appetite or overeating	40	1.1	0.7	65	1.2	0.6**
Feeling bad about self	40	1.1	0.9	65	1.3	0.9**
Trouble concentrating	40	1.2	0.9	65	1.6	1.1**
Moving or speaking slowly, or being fidgety/restless	40	0.8	0.6	64	0.6	0.3**
Thoughts of being better off dead, or of hurting self	40	0.2	0.2	65	0.3	0.1*
PHQ-9 Total Score	40	**9.7**	**7.8^**	65	**11.2**	**7.4****
MEDIAN	40	**10**	**6.5**	65	**10**	**6**
Likely Depressive Disorder (i.e., at least 4 items scoring 2 or 3)	-	**16 (36.4%)**	**12 (27.3%)**	-	**29 (44.6%)**	**13** (20.0%)**

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

Milestones of Recovery Scale

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

As shown in Table 5, there were 44 persons at IHC and 57 persons at SIHC who had both an intake and follow-up MORS completed from which to conduct a change assessment comparison. The average MORS score upon intake was similar for IHC and SIHC (i.e., 5.3 and 5.0, respectively), which corresponds most closely to "not coping, engaged." The initial MORS score distribution differed to some extent between the two programs; SIHC participants exhibited a broader range of values relative to IHC, demonstrated by a higher proportion of their participants falling in both the lowest and highest MORS ratings categories.

Table 5. Change in MORS Scores from Initial Assessment to Last Follow-up Assessment

		IHC (N=44)				SIHC (N=57)			
		Intake		Follow-Up		Intake		Follow-Up	
Value	MORS Rating Category	n	%	n	%	n	%	n	%
1-4	Extreme risk; High risk, not engaged; High risk, engaged; Not coping, not engaged	4	9.1	4	9.1	23	40.4	4	7.0
5	Not coping, engaged	23	52.3	7	15.9	13	22.8	8	14.0
6	Coping/rehabilitating	14	31.8	21	47.7	12	21.1	24	42.1
7-8	Early recovery; Advanced recovery	3	6.8	12	27.3	9	15.8	21	36.8
	Mean MORS	**5.3**		**6.0****		**5.0**		**6.1****	

***statistical significance at p < 0.01*

As of the last available follow-up assessment completed, the average MORS score increased for both IHC and SIHC participants. Scores were 6.0 and 6.1, respectively, corresponding most closely to "coping/rehabilitating." For both programs, these changes reflected statistically significant and clinically meaningful improvements in recovering and management of symptoms.

ROAM Participant Feedback

ROAM providers asked participants to engage in a short qualitative survey to elicit feedback on the program. Providers were given a short script that explained the qualitative data collection process and that their feedback was completely voluntary and would not impact participation in the program. The 16 ROAM clients who participated were asked a series of questions which had been developed by the evaluation team in collaboration with ROAM leadership and BHS. The following themes emerged from the qualitative data collection effort:

Clients would not be in therapy without ROAM

- "I would feel like there is no help. I wouldn't go and be seen by anybody. I would feel at a loss that there would be no programs to deal with mental health issues."
- "I wouldn't be meeting with anyone. I have tried and it has not been good."
- "I would probably go to the clinic because I needed support. I wouldn't have liked that option though. This has been convenient and private."

Word of mouth and community presence are important for program success

- "I heard from someone I know that you guys were doing telehealth."
- "I was going through difficulties at the time. I saw the bus come out every week and one day I decided to come over. I have anxiety about meeting new people so it helped to have said hello to you (therapist) a few times."
- "Because I knew [the ROAM therapist], I felt comfortable with you and ROAM. Plus, I had no choice I needed some support at the time. Then when I met you I felt even more comfortable because I knew you were cool."

Combination of behavioral health and medical services is helpful

- "I like how ROAM is set up. I can be close to my home and get medical care and therapy. It's convenient and private."
- "I would add (additional medical) services and be more consistent… there are lots of ways to help the community out here."
- "Maybe do more medical services for the elders or people that don't make it to the clinic."

Clients value flexibility in appointment types and locations

- "I liked in-person with ROAM because I was given the option to meet outside. It's hard for me to sit in a room for an hour."
- "If we hadn't started talking on the phone and you hadn't been so nice I never would have started this. The phone helped me with my anxiety. There is no way I would have come and met with you face to face right away."
- "I met with a psychiatrist at another clinic but it was too hard to keep appointments. Transportations was the problem."

Clients appreciate ROAM culturally appropriate and private services

- "The fact that it is Native American culture, and plus you are on the reservation."
- "I don't trust counselors. I felt you were different. It seemed like you actually listened and cared. You weren't trying to be better than me."
- "There is no way I would be getting (behavioral health) services if ROAM didn't come out here. I don't feel comfortable at the clinic because everyone knows your business. This feels private."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings with ROAM program staff and 2) the Annual ROAM Staff Survey. The stakeholder meetings were held periodically with representatives from BHS, ROAM, and the University of California San Diego (UCSD) evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ROAM Staff Survey was conducted at the end of each FY. IHC and SIHC ROAM program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were

discussed to arrive at a consensus on the key response themes. Information included in the following sections is applicable to both the IHC and SIHC programs unless otherwise indicated.

Favorable Staff Perspectives Regarding the Value of Remote Sessions

Staff from both ROAM programs indicated developing a more favorable view on the role of remote visits (i.e., telephone and telehealth) to provide behavioral health services. Overall, ROAM clinicians thought they were able to accomplish much more in their therapeutic interactions via remote sessions than originally expected. The following observations were provided regarding the change in staff perspectives about utilizing telehealth with video services:

1. Many ROAM clinicians initially had doubts that the Native community would engage in telehealth services regularly. However, after utilizing telehealth they report a significant drop in no-show rates and that Native clients were engaged with services at similar levels to those observed for in-person sessions.
2. ROAM clinicians also had concerns that the lack of person-to-person contact may prevent significant rapport building. However, after extensively utilizing telehealth, clinicians shared that rapport building was effective in most, although not all, telehealth cases.
3. ROAM clinicians thought that technological problems due to remote locations on the reservation would prevent widespread utilization of telehealth services. However, many people living on the reservations were able to find a location where they could engage in a successful telehealth meeting without technical issues, especially after the tribal and organizational investments to expand connectivity options following the onset of the COVID-19 pandemic.

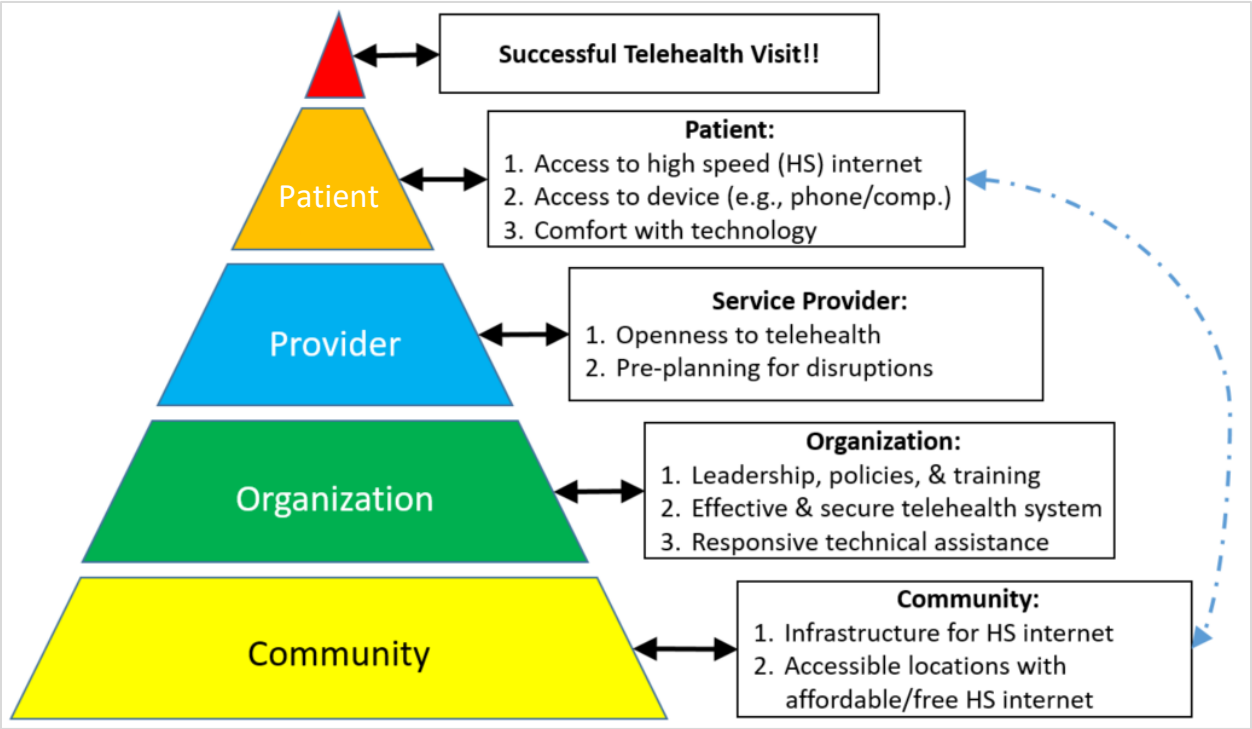
While ROAM staff were generally impressed with what could be accomplished via remote service provision, there was recognition that remote services were not ideal for some persons and that being able to offer at least some in-person services was still essential.

In addition, ROAM staff indicated that the difficulties experienced while trying to comprehensively provide behavioral health care via telehealth services throughout the community helped identify the geographic areas where such services were not feasible (i.e., areas where internet connectivity was nonexistent or not strong enough to support the upload speeds needed to seamlessly conduct video-based telehealth sessions). An increased awareness of the need for improved rural technology infrastructure that can support telehealth services is not unique to the County of San Diego, and ROAM program staff are aware of federal funding sources that will create opportunities for rural and Native communities to enhance the capacity to provide telehealth services. It is expected that these investments will increase the availability of telehealth services for the ROAM programs, particularly for IHC ROAM.

Establishing a Multi-Level Foundation for Successful Delivery of Telehealth Services

Based on the experiences of both ROAM programs and feedback from ROAM participants and staff, the following model was developed to summarize and illustrate the foundational factors needed to successfully deliver telehealth services in the communities served by ROAM. As shown in Figure 1, key foundational elements across multiple levels were identified as necessary to create the context for widespread delivery of telehealth visits.

Figure 1. Multi-Level Foundation for Successful Delivery of Telehealth Services



The overall foundation, upon which everything else is dependent, is community-level infrastructure needed to provide widespread high-speed internet capable of seamlessly and consistently handling video-based interactions between patients and providers. While the goal is for all community members to have their own personal high-speed internet access, or at least have a local friend or family member who does, there are areas where this is not feasible. In that case, locations such as community centers, clinics, etc. should offer secure and free Wi-Fi in private settings so that telehealth options are accessible close to a person's home.

At the organization level, three key factors are needed: 1) organizational support in terms of leadership, provision of staff training, and developing policies and protocols to guide telehealth practice are critical to encourage and champion use of telehealth, especially when it was not initially considered part of standard practices; 2) the adoption of a telehealth platform that integrates well with clinic workflows and data systems; and 3) the importance of a responsive technical assistance team who can help with guiding providers through the telehealth platform and quickly ("real-time" is preferred) address questions and problems that arise when delivering telehealth care.

At the provider level, essential factors are 1) a general openness to trying to provide telehealth care services (which can be greatly facilitated by the organizational-level factors discussed above), as well as 2) pre-emptively developing a plan for how to handle the eventuality that a telehealth visit will get disrupted due to technological issues and communicating that with the patient (e.g., attempting to reconnect via video or switch to a phone call).

At the patient level, two logistical access issues much be addressed: 1) accessibility of high-speed internet and 2) a device capable of accessing the telehealth platform.

As discussed above, community investment into the availability of affordable high-speed internet access is crucial. Additionally, where a patient does not have their own device (e.g., phone, tablet, or computer) or ability to easily access one via friends and family or at a local resource such as community center or clinic, health care organizations should consider providing such a device to patients. A final step, and often one of the easiest, is to ensure (and increase where needed) patient knowledge and comfort with using telehealth technologies (e.g., how to access the internet, start the telehealth session, etc.). Feedback from the ROAM team members indicated that many patients quickly learned how to utilize telehealth technologies, felt comfortable communicating with providers in this manner, and appreciated the flexibility and convenience that it allowed. In this regard, once the multi-level foundation was prepared, successful telehealth visits with patients were feasible and common.

Community Outreach, Education, and Engagement

ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment. This investment in new and existing relationships resulted in invitations to participate in community and cultural events. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and awareness about mental health and substance use issues more generally. These outreach efforts, coupled with dedicated staff and the inherent flexibility in how services could be offered provided increased accessibility of the ROAM program and acceptability of ROAM as an important community resource. Staff qualitative feedback provided the following related themes:

Connection to the community and culture were key components of ROAM services

- "The program spent the first year building relationships with community organizations on the reservation. This created an increased sense of trust with ROAM which led to more referrals and a greater confidence to seek treatment."
- "[One factor that helped the ROAM program achieve its goals was] open conversation with the Tribal Councils about the availability of the services provided."
- "The communication, perseverance, diligence, passion, intelligence, desire to serve others, dedication [of ROAM staff] to the support of mental health as a whole and serving an underrepresented population in San Diego County."

Services flexibility

- "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met."
- "Adaptability, flexibility, and organization. We are able to meet client needs and adjust to the new requirements and the ever-changing needs of our clientele."

Role of MHU to Support ROAM Operations and Outreach

While the ROAM programs initially stopped utilizing the mobile health units during March 2020 due to the onset of the COVID-19 pandemic and the associated health and safety concerns, SIHC ROAM was able to restart regular "ROAM Bus" mobile health services during FY 2020-21 with adaptations as needed to respond to safety protocols due to the ongoing pandemic. Likewise, IHC ROAM was able to utilize the MHU when conditions allowed. Having access to the MHUs enabled ROAM to expand their reach and provide services to persons who would otherwise have difficulty accessing services, particularly if there was a desire or need for in-person sessions.

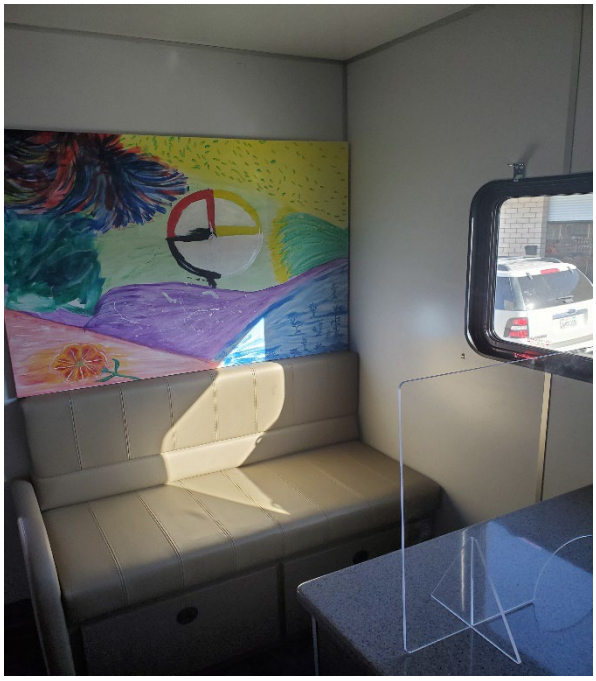
Even though the utilization of the mobile health units was affected by the COVID-19 pandemic the ROAM staff from both IHC and SIHC viewed the mobile health units as a particularly important part of the ROAM programs, as can be seen in some example feedback from the staff survey.

Overall, the ROAM programs endeavored to offer flexibility in location and communication modality to allow participants to engage in services however they preferred and felt safe doing. As such, during a typical day, ROAM clinicians provided services in a variety of physical locations (e.g., at community centers, remote clinics, or on the MHU) and used different methods of communication (e.g., in-person, phone, or telehealth with video) to meet the engagement preferences of ROAM participants.

MHU Flexibility is a strength of the ROAM program

- "This program is excellent for the rural clients/patients without transportation. It aides in providing services in getting the much needed help for them."
- "With the ROAM Bus [i.e., the MHU] acting as a central hub in the community ROAM could potentially expand to include more staff who go out into the community each day to meet needs of community members who cannot make a trip to the clinic."

Photo 1: Outside view of SIHC mobile health unit



Picture 2: Clinician's office

Picture 3: Substance counselor's office

Additionally, both SIHC and IHC reported using their mobile health units to promote awareness of their respective programs in the community via the logos and other information on the units themselves to encourage engagement. The ROAM mobile health units were invited to community events to provide education, behavioral health services, as well as contribute efforts to provide COVID-19 related testing and vaccination services.

Photo 4: Outside view of IHC mobile health unit

Changes from Initial Program Design

The primary changes from initial program design included the adaptations required in response to the ongoing COVID-19 pandemic. The pandemic limited the availability of in-person sessions and increased reliance on remote interactions for both ROAM programs. However, since the ROAM programs were specifically developed to provide a range of options for delivering behavioral health services, the COVID-19-related changes do not represent a completely new approach to service provision. Instead, the adaptations were a shift in emphasis such that remote services via telephone and telehealth have become more common and normalized than initially expected.

In addition, the initial ROAM program design anticipated the use of "cultural brokers" as part of the ROAM staff in order to facilitate connections to and engagement with the American Indian communities intended to be served by the ROAM programs. The decision to utilize organizations already established within these communities (i.e., IHC and SIHC) essentially eliminated the need for maintaining a specific "cultural broker" role on the ROAM teams given that many IHC and SIHC staff identified as American Indians and the organizations had a long history of working with and serving American Indians. In this regard, by embedding the ROAM program within IHC and SIHC, the original goal of promoting engagement with American Indians was achieved without the need for designating specific staff as "cultural brokers."

Conclusion

While both IHC and SIHC operated a ROAM program with the same fundamental mission (i.e., to increase participation in needed behavioral health care by reducing barriers to accessing services) and the same core tools (i.e., MHU, telehealth, and a team of service providers), variations in the areas of expertise of those comprising each ROAM team and the range of unique opportunities and challenges within the communities they served resulted in the development of two similar, but different ROAM programs. An essential component of each ROAM program, particularly when required to strategically adjust to the new realities brought about by the COVID-19 pandemic, was the capacity to flexibly and creatively utilize the tools and resources within the program to address identified and emerging needs of those they served.

Both the IHC and SIHC ROAM programs provided an extensive amount of behavioral health services. IHC provided 2,626 services to 146 persons (average of 18.1 services per person) and SIHC provided 3,404 services to 403 persons (average of 8.4 services per person). Primary services for both programs included the provision of therapeutic care as well as a range of other assessment, psychoeducation, and case management services. While both programs offered psychiatric care to support medication management, this was a primary area of emphasis for SIHC with over half of their participants (51.6%) having at least one medication management visit as compared to 22.6% of the those served by IHC. With the inclusion of a licensed AOD counselor on the IHC ROAM team, more than half of IHC participants (56.2%) engaged in at least once substance abuse counseling session whereas this was not commonly provided by SIHC (only 2% of SIHC clients received the service).

While limited outcome data with baseline and follow-up assessments were available, of those persons with such data, reductions in depression symptoms and improved recovery and management of symptoms were identified for many.

Participant feedback reported that they highly valued ROAM services and noted they likely would not be in services if not for the accessible, trusted, and private ROAM services. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services in a flexible and private manner, stating that without the program they likely would not be in therapy.

Feedback from ROAM staff and participants indicated that where technologically feasible, telehealth with video was an acceptable, and in many instances desirable, mode for delivering behavioral health care services for Native community members due to convenience and privacy.

Challenges remained for providing telehealth services throughout remote regions. Based on the experiences of the ROAM programs, a multi-level model was created to illustrate and summarize the foundational community-, organizational-, provider- and patient-level factors necessary to support widespread utilization of telehealth services.

Mechanical and logistical issues delayed and disrupted utilization of the MHUs at times and the COVID-19 pandemic also prevented their use, at least initially, due to safety concerns regarding confined and shared spaces. Even with those challenges, both ROAM programs made creative use of their MHUs to provide behavioral health services throughout the community. When feasible, they also promoted awareness of the ROAM program and provided general behavioral health information via the MHUs through participation in community events. The MHUs were also utilized to address emerging needs related to the pandemic by assisting with COVID-19 testing and administering vaccines at locations throughout the communities.

ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible, both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and understanding about mental health and substance use issues more generally. These outreach efforts contributed to the recognition of ROAM as an important community resource.

Future Directions

Between FY 2018-19 and FY 2021-22, the IHC and SIHC ROAM programs were funded by BHS as part of an MHSA Innovations initiative to develop and pilot test new services. Based on the experiences, accomplishments, and operational learnings of the IHC and SIHC ROAM programs during this timeframe, both IHC and SIHC decided to continue the ROAM programs indefinitely using their own non-BHS funding sources. Feedback from ROAM program staff indicated how ROAM was now perceived as an essential part of the community and a key resource that has been integrated within their existing behavioral health services. Ongoing ROAM program services were expected to closely resemble the types of services provided during the BHS-funded Innovations phase to reflect the unique needs and strengths of each program (i.e., strong emphasis on AOD at IHC and on medication management at SIHC in addition to extensive provision of mental health therapy at both). Additionally, each ROAM program will continue to make flexible use of the MHU and telehealth technologies where feasible to reduce barriers to accessing needed behavioral health services.

Appendix

Characteristics of Participants who Enrolled into ROAM

Characteristic	IHC Participants (N=146)		SIHC Participants (N=403)	
Gender	**n**	**%**	**n**	**%**
Male	70	47.9	170	42.2
Female	74	50.7	231	57.3
Other/Missing/Prefer not to answer	2	1.4	2	0.5
Total	**146**	**100**	**403**	**100**
Age Group	**n**	**%**	**n**	**%**
<16	5	3.4	56	13.9
16-25	15	10.3	79	19.6
26-45	66	45.2	152	37.7
46-65	39	26.7	87	21.6
>65	21	14.4	29	7.2
Total	**146**	**100**	**403**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	137	93.8	395	98.0
Other/Missing/Prefer not to answer	9	6.2	8	2.0
Total	**146**	**100**	**403**	**100**
Race/Ethnicity	**n**	**%**	**n**	**%**
American Indian	133	91.1	326	80.9
Latino	5	3.4	28	6.9
Caucasian	4	2.7	51	12.7
Multi-racial	6	4.1	19	4.7
Other	2	1.2	9	2.2
Missing/Prefer not to answer	8	5.5	8	2.0
Total[1]	-	-	-	-
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	112	76.7	154	38.2
Gay/Lesbian/Bisexual/Pansexual	5	3.4	19	4.8
Prefer not to answer	22	15.1	144	35.7
Missing	7	4.8	86	21.3
Total	**146**	**100**	**403**	**100**

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

Appendix (continued).

Characteristic	IHC Participants (N=146)		SIHC Participants (N=403)	
Military Status	**n**	**%**	**n**	**%**
Previously served in the military	4	2.7	6	1.5
Never served in the military	98	67.1	301	74.7
NA/less than age 18	6	4.1	81	20.1
Other/Missing/Prefer not to answer	38	26.1	15	3.7
Total	**146**	**100**	**403**	**100**
Disability	**n**	**%**	**n**	**%**
Yes, has a disability	44	30.1	86	21.3
No, does not have a disability	55	37.7	297	73.7
Declined/Prefer not to answer	47	32.2	20	5.0
Total	**146**	**100**	**403**	**100**
Type of Disability	**n**	**%**	**n**	**%**
Communication (e.g., seeing, hearing)	<5	<3.4	7	1.7
Learning/Developmental	<5	<3.4	11	2.7
Dementia/Other Mental	<5	<3.4	5	1.2
Physical	10	6.8	6	6.1
Chronic Health	13	8.9	66	16.4
Other Disability	21	14.4	2	0.5
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.*

JUST BE U INNOVATIONS-21

Annual Report
Year 4 (7/1/2021-6/30/2022)

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

v.12.22.2022

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

UC San Diego

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Executive Summary

Program Overview

The Just Be U (JBU) program 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 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) supports to help teach skills needed to accomplish personal goals. Throughout these interactions with youth, 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.

Primary Findings for FY 2021-22

JBU Enrollment and Key Participant Characteristics

1. During FY 2021-22, JBU staff were able to successfully locate and enroll 52 youth who were homeless/at risk of homelessness and receiving crisis services for untreated serious mental illness.
2. The youth served by JBU were a racially/ethnically diverse population with 51.9% of youth identifying as Caucasian, 36.5% as Hispanic/Latino, 21.2% as African American and 13.4% as another race (note: youth could indicate more than one race/ethnicity, so totals exceed 100%).

Improvements in JBU Youth Functioning and Goal Achievement

3. TAY with completed baseline and follow-up assessments on the Milestones of Recovery Scale (MORS) demonstrated statistically significant and meaningful improvements in their symptom management and recovery orientation. Upon entrance into JBU the majority of youth were considered to be "high risk, not engaged" or worse (i.e., MORS score of 2 or less out of 8 recovery levels), whereas at the end

of JBU services, the majority of youth were "coping/rehabilitating" or better (i.e., MORS score of 6 or higher out of 8 recovery levels).

4. 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 achieve desired objectives and increased their satisfaction from completing identified tasks.

Participation in Behavioral Health Treatment Services Increased

5. After participating in JBU, TAY typically increased their utilization of BHS outpatient and Assertive Community Team (ACT) program services as evidenced by 40% of youth engaging in outpatient mental health treatment services while enrolled in JBU and 25% connected with ACT services following discharge from the residential phase of JBU.

Participation in Acute/Crisis Behavioral Health Services Diminished While in JBU

6. Participation in JBU was also associated with reduced need for crisis and acute care BHS services while enrolled in JBU (i.e., inpatient psychiatric hospitalizations, crisis stabilization visits, crisis residential admissions, and Psychiatric Emergency Response Team (PERT) interactions).
7. Following discharge from the residential phase of the JBU program, there were signals of some reduction in the number of youths receiving crisis and acute care behavioral health services as compared the period of time before enrolling in JBU. Notably, utilization patterns were higher than while in JBU, which suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants.

JBU Helped Connect Youth to Needed Housing

8. During FY 2021-22 JBU increased their capacity to 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 approximately 85% demonstrating the highest level of need and prioritized for permanent supportive housing. JBU was able to connect 18 youth with housing-related assistance and this is expected to increase during FY 2022-23.

Conclusion

Overall, the findings from FY 2021-22 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 JBU services. However, substantial challenges remain to enable even more youth to experience greater short- and long-term recovery given that many youth have multiple factors inhibiting such gains include co-occurring substance use disorder (SUD), complex physical health needs, and difficulty transitioning to external treatment providers among others.

Primary Recommendations for FY 2022-23

1. To minimize post-JBU relapse of symptoms and utilization of crisis/acute care services, explore potential for longer-term support services by JBU after completing the residential phase and/or developing partnership with long-term care management services tailored to TAY-specific populations.
2. Develop specific partnerships with other provider organizations to allow JBU to have dedicated access to SUD and mental health services via quick referrals and easy onboarding pathways (e.g., like a "fast pass" referral lane) and/or incorporate those services directly into JBU.
3. Explore viability of extending duration of residential phase of JBU to allow a longer period of time for JBU to help youth achieve desired fundamental life changes related to their mental health, housing, and life skills/personal growth.
4. Explore potential for someone with medical expertise on staff in close partnership with JBU to assist with medication management, complex healthcare needs, and navigating insurance challenges.

Program Description

Using County of San Diego BHS Electronic Health Record (EHR) data, BHS personnel identify youth who meet 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 receives the list of eligible names from BHS, intensive outreach efforts are 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. During 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 if they met the core criteria as listed above.

Once eligible youth have been contacted, given an explanation about the program's offerings, and agreed to enroll in the program, JBU provides short-term housing that incorporates support services, integrative medicine, and holistic health care in location. With dormitory-style housing, JBU youth can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same housing unit. During their time in the program youth will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, chiropractic care, and meditation, as well as mindfulness education, nutritional counseling, individual case management, peer support, group outings, and various in-house community-building trainings and events.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing (typically around 120 days) while providing holistic youth-centric recuperative services. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services, thereby improving their mental health and quality of life in the community. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless 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.

The program's emphasis on community-building, destigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation, self-regulation training, and engagement

with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

It is particularly salient that the program aims to intervene early in the cycle of homelessness, before youth self-identify as homeless and/or helpless, and before the personal and societal costs escalate and become more intractable. Further, the program's emphasis on destigmatization, 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.

Service Changes Due to COVID-19

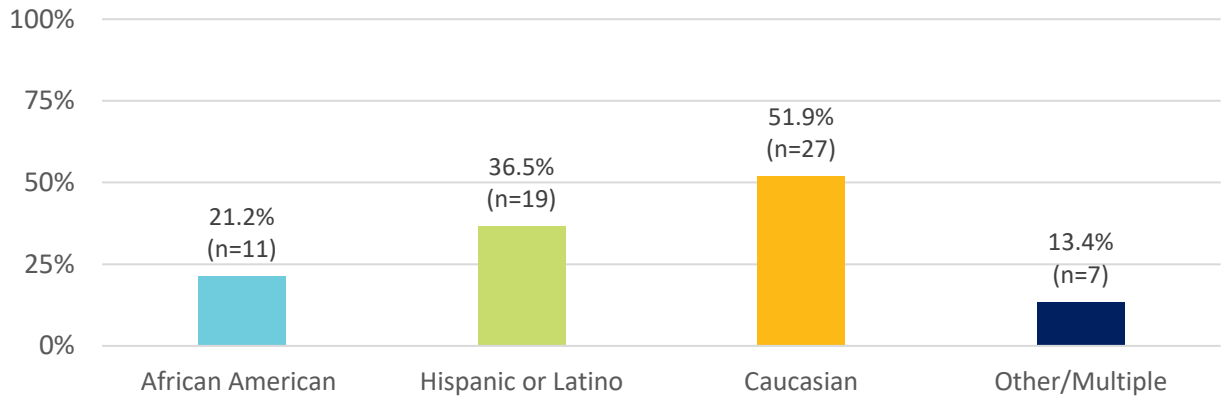
As a residential program serving homeless youth, a population at considerable risk for exposure to disease, JBU implemented several policies and procedures that allowed staff to continue providing in-person services while complying with CDC and San Diego County public health guidelines. These policies and procedures included: 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 measure. While the basic residential component continued without interruption, JBU has 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 FY 2021-22 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 isolate from JBU youth periodically throughout FY 2021-22, which did create additional burdens and challenges for staff to cover JBU operations amidst staffing disruptions.

Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 52 youth who enrolled during FY 2021-22, 19 originated from the BHS CO-19 report and 33 were from other referral sources. JBU program eligibility criteria requires that participants are youth between the ages of 18 and 25. Of the 52 youth who enrolled in JBU during FY 2021-22, slightly more than half (n=28; 53.8%) identified as male. All JBU youth (n=52, 100%) spoke English as their primary language. Two-thirds of youth enrolled in JBU had a diagnosis of schizophrenia/psychotic disorders (n=34; 65.4%). Other common diagnoses included bipolar disorders (n=9; 17.3%) and depressive disorders (n=8; 15.4%).

As shown in Figure 1, JBU youth were racially and ethnically diverse. Approximately half (n=27; 51.9%) identified as Caucasian with 36.5% (n=19) identifying as Hispanic/Latino followed by 21.2% identifying as African American.

Figure 1. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2021-22 (N=52)



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 FY 2021-22 there were six OT interns at JBU. 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. Collectively, they provided over 1,400 hours of service to the JBU program over the course of FY 2021-22. The interns worked under the supervision of Dr. Bianca Doherty, who transitioned from Director of Occupational Therapy to JBU Program Director during FY 2021-22. Christina Lavery, who was, notably, the first OT intern at JBU in 2020, was hired at the end of the fiscal year to support continued OT intern supervision at JBU.

The OT team developed intervention plans with the JBU youth which included individualized long-term and short-term goals related to enhancing participation in activities of: 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). This OT intervention plan was based on an initial interview with the 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).

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 1-3 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.

OTs would conduct observations and activity analyses during a client's transition into the program and their participation in services. These observations served to identify barriers to occupational 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 client with additional needs including cognitive challenges, neurological or sensory differences, physical disabilities, and/or significant mental health challenges. Additionally, the OT team supported 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 in picture on page 6).

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

Engagement in JBU Activities

Holistic Services

In FY 2021-22, the primary holistic services provided were: yoga, massage, acupuncture, chiropractic and cryotherapy (i.e., exposure to extreme cold for several minutes in an effort to improve health). Massage therapy was typically the most well-attended service. Approximately 2-6 youth attended each weekly holistic service offering.

Group Outings

JBU youth participated in both major and relatively more minor group outings during FY 2021-22. The major outings included two overnight trips to Harrison Serenity Ranch (HSR) on Mount Palomar. HSR is a working ranch located 55 miles from 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,

trampoline park, elderly dog rescue "Frosted Faces," the Japanese Friendship Garden at Balboa Park, rollerblading, bowling, the beach, a San Diego Padres baseball game, and hikes. Additionally, some activities focused on engagement were provided in-house such as gardening, embroidery, and mask making.

JBU Services – Duration and Discharge Status

As shown in Table 1, of the 62 youth who received JBU services during FY 2021-22, 54 had discharged and eight were still active in JBU as 6/30/2022. Youth typically received JBU residential care and support services for approximately 75 days, with about one-third (31.5%) needing services for 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 1. JBU Program Participation Duration and Discharge (N=62)

	JBU Youth (N=62)	
	Still in program	**Discharged**
n (persons)	8	54
Mean (days)	73.9	74.1
Median (days)	60.0	63.0

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 were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

As shown in Table 2, the results indicated substantial changes in recovery status at follow-up. At intake, only 5% of youth were considered as coping or in recovery, whereas 60% were doing so at follow-up. The number of youth in the "high risk" categories dropped from 12 to 4 (60% to 20%) from intake to follow-up. Overall, the average MORS score increased from 2.9 at intake (corresponds to "high risk, not engaged") to 5.2 at follow-up (corresponds to "not coping, engaged"). This trend was similar to that of FY 2020-21 where overall MORS scores increased from 3.4 to 5.3 from intake to follow-up.

Table 2. MORS Results for JBU Youth with Follow-up during FY 2021-22 (N=20)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**n**	**%**	**n**	**%**
1	Extreme risk	1	5.0	0	0.0
2	High risk, not engaged	11	55.0	1	5.0
3	High risk, engaged	1	5.0	3	15.0
4	Not coping, not engaged	6	30.0	0	0.0
5	Not coping, engaged	0	0.0	4	20.0
6	Coping/rehabilitating	0	0.0	10	50.0
7	Early recovery	1	5.0	2	10.0
8	Advanced recovery	0	0.0	0	0.0
	Mean MORS	**2.9**		**5.2****	

***statistical significance at p < 0.01*

As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2020-21 (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). 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.

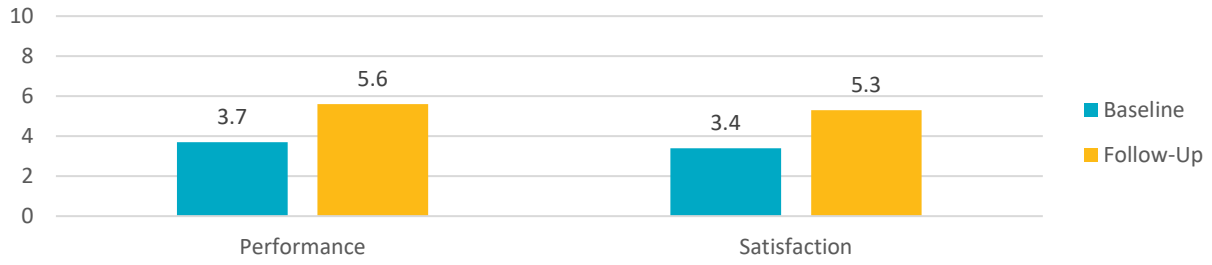
Canadian Occupational Performance Measure

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.

A total of 16 JBU youth had baseline and follow-up COPM assessments completed during FY 2021-22. Figure 2 shows that that average performance assessment increased from 3.7 to 5.6 at follow-up and the satisfaction score increased from 3.4 to 5.3. Both the performance and satisfaction domains had average change scores of approximately two, indicating clinically important improvements for youth. Of the 16 youth with both baseline and follow-up scores, the majority 56.3% (n=9) had score changes indicating

clinically important changes on performance and 43.8% (n=7) had clinically meaningful improvements regarding task satisfaction. The COPM results indicate that the JBU OT team is 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 2. COPM Mean Scores for JBU Youth with Follow-up during FY 2021-22 (N=16)



OT Facilitated JBU Youth Accomplishments

The JBU OT team regularly met with JBU youth both one-on-one and in groups throughout FY 2021-22. The following information presents an overview of the accomplishments of the OT team generated via a review of notes from the 23 one-on-one sessions conducted with nine participating JBU youth during June 2022 (i.e., the last month of FY 2021-22). As shown in Table 3, work and education were the most common areas that OT staff and JBU youth focused on during their one-on-one sessions (39.1% of sessions for each). Building skills, developing good habits for spending leisure time, and increasing capabilities for handling activities of daily life (e.g., hygiene, financial management, etc.) were each discussed in 34.8% of the sessions. These findings indicate that the OT team helps to address a wide range of individualized needs and goals for the JBU youth, with education and work emerging as primary domains of emphasis.

Table 3. Primary Topic Areas Addressed During June 2022 OT Sessions (N=23)

	Total OT Sessions (N=23)
Primary Area of Emphasis	**% of Sessions Discussed**
Education	39.1
Work	39.1
Skill Building	34.8
Leisure Time	34.8
Activities of Daily Life/Functioning	34.8
Health Management	21.7
Life Transitions	17.4
Social Participation	13.0

A summary of the June 2022 one-on-one OT sessions reviewed the following key areas of impact: education/employment, medical care, and life-skills development.

OT sessions were helpful in preparing youth for next steps in employment. OTs assisted youth in school enrollment and helped spark their interest and investment in finding a future career. This career development was the most frequent focus of the OT sessions. Another focus of OT sessions was medical consistency and self-advocacy. Medical consistency mostly refers to being open to seeking and accepting treatment or medical services, while self-advocacy refers to the ability to speak up for oneself and declare whether they believe something is beneficial to them. Youth also noted improvements in financial competency, comfort level in social skills, self-care through exercise, and ability to identify goals for the future. It appears that OT was especially helpful in guiding youth toward finding leisure activities that provide an outlook for positive coping skills. Lastly, youth were offered assistance in adjusting to bereavement to help deal with loss. Youth frequently cited looking forward to being able to implement these skills upon their completion of the OT session.

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 Enjoy 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 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, and helped with my social anxiety... 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 is 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

To support efforts to connect JBU to housing, during FY 2021-22 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. In the County of San Diego, organizations who are 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. 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.

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

Baseline Score (N=32)	n	% of youth at intake
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

While the short-term nature of the JBU program presented challenges in matching youth with housing prior to program discharge, during FY 2021-22 youth were connected to local housing resources directly as a result of the VI-SPDAT scores. This total is expected to increase in future years now that VI-SPDAT assessment has been incorporated into standard intake procedures for the JBU program. 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 JBU participants who enrolled after 7/1/2020 if they had been discharged at least 180 days before the end of FY 2021-22 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 5, the 66 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 1.1 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as 40.9% of the youth linked to outpatient care and the 180-day average number of outpatient sessions increased to 7.4. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 1.6 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. A quarter of JBU (25.8%) youth had ACT visits post-JBU, with the average of 8.1 sessions compared to less than 0.1 pre-JBU and 1.5 during JBU.

Table 5. BHS Service Utilization Patterns Before, During, and After JBU Participation (N=66)

	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	12.1	75	1.1	40.9	185	7.4	28.8	107	1.6
ACT	<7.6[2]	<5[2]	<0.1[2]	15.2	38	1.5	25.8	532	8.1
Urgent Outpatient	39.4	51	0.8	42.4	37	1.5	40.9	50	0.8
PERT	28.8	27	0.4	9.1	8	0.3	21.2	25	0.4
Crisis Stabilization	37.9	48	0.7	9.1	11	0.4	25.8	37	0.6
Inpatient Psychiatric Hospitalization	47.0	45	0.7	7.6	5	0.2	34.8	44	0.7
Crisis Residential	36.4	32	0.5	<7.6[2]	6[2]	0.2[2]	22.7	20	0.3

[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 (mean = 68.4 days). Only the average is comparable across all time periods.

[2]Due to the small number of youths experiencing this service, (i.e., less than 5), the exact number is masked.

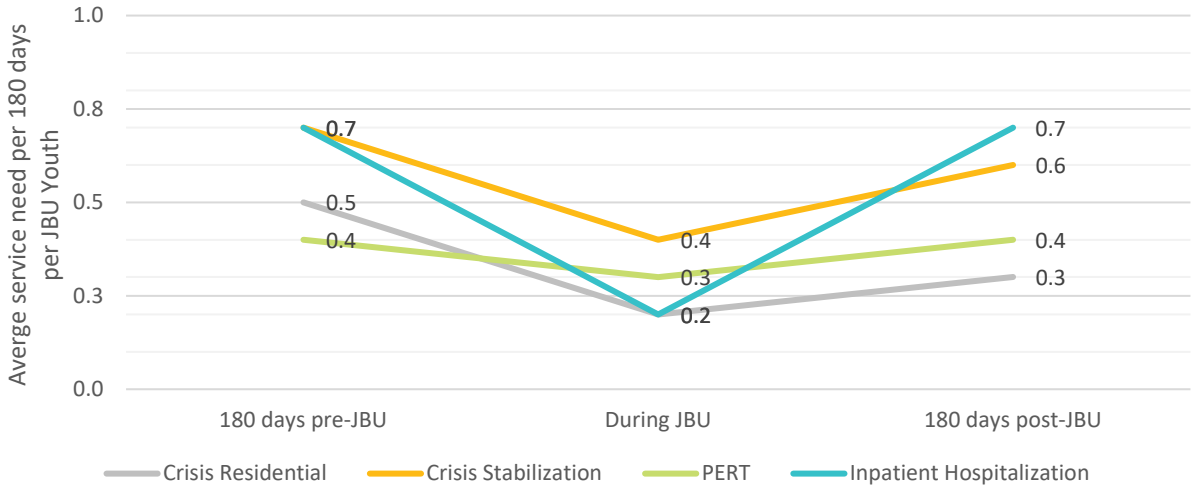
The patterns evident among acute/crisis-oriented type BHS services were more nuanced. Interestingly, the average number of urgent outpatient visits was similar before and after JBU (0.8), but was higher during JBU (1.5). This can likely be explained by the fact that JBU staff facilitated access to needed 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 (the percentage of youth needing crisis stabilization dropped from 37.9% to 9.1%, and inpatient hospitalization dropped from 47.0% to 7.6%).

When comparing pre-JBU to post-JBU service utilization, the percentage of youth accessing crisis-oriented BHS services was lower during than after participating in JBU. This was most evident for crisis stabilization services which reduced from 37.9% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to 25.8% in the 180 days after leaving JBU. However, the average number of crisis stabilization visits only reduced slightly before and after JBU (0.7 to 0.6, respectively) since the total number of crisis stabilization visits did not decrease as much (48 to 37, respectively). This pattern was evident among other crisis/acute care services as well (i.e., a reduction in the number of youth who required such services, but minimal reduction in total crisis/acute care services required as those who did access the care did so on multiple occasions).

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 3, 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 3. 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.

Additional Program Activities

Moving JBU to a New Location with New Congregate Living Approach

During FY 2021-22, the JBU program moved to a new location within San Diego. This relocation substantially changed the context in which JBU services were provided. Prior to the move in May 2022, JBU residential and support services were provided in a duplex home located in a residential community. The JBU program moved to a new facility in a mixed-use, urban community with the JBU residential and support services provided within a converted motel. While renovations to the new location were ongoing at the end of FY 2021-22, the new living arrangements allowed for 1-2 youth to share an apartment-like studio room with shared programming and dining facilities located in other rooms. Additional onsite recreational space is planned for development in FY 2022-23. Nearby trolley and bus stops substantially increase opportunities for mobility compared to the prior location. Overall, the move was a significant event for the JBU program during FY 2021-22 that resulted in a very different environment for providing JBU services. The goal with this new location is to demonstrate the sustainability of the residential model as well as more closely replicating the type of living situations that JBU youth with be encountering after discharging from the program.

Establishing New Community Partnerships

As a program with a strong emphasis promoting the well-being of youth across many life domains, JBU continued to seek out new community partners to meet the unique needs of JBU youth. With the move to a new location, identifying and establishing new partnerships was particularly salient during FY 2021-22. Examples of community partnerships included the following:

- Oasis Clubhouse – TAY-specific clubhouse with free meals, haircuts, employment support, and social activities.
- Helen Woodward Animal Center – provided Pet Encounter Therapy once per month until move when they could no longer serve us as moved to another city (Chula Vista).
- Mobile Crisis Response Team – utilized when clients experience mental health crisis but were not expressing active thoughts of harming themselves or others (in which case PERT would have been called).
- David's Harp – nonprofit dedicated to engaging homeless youth through music and media production.

Designed and Implemented "Forever Follow Ups" with Former JBU Participants

In collaboration with the University of California San Diego (UCSD) evaluation team, JBU program staff developed and tested an assessment tool to conduct "Forever Follow-ups" with youth who previously participated in the JBU program. While designed to minimize completion burden, the assessment tool gathers information on multiple domains of interest related to the youth's post-JBU experience including: housing, employment, mental health needs/service utilization, and perceptions of JBU among others. The "Forever Follow Ups" were initiated end of FY 2021-22 with data collection efforts expected to continue during FY 2022-23. The results of these follow-ups will be included in future reports and are anticipated to provide greater understanding of the longer-term impact of the JBU program.

App Development

Additional work continued during the early part of FY 2021-22, to create an app that would enable JBU youth to: 1) actively monitor their health and wellness in real-time, 2) access health and wellness educational information, 3) develop and track personal goals, and 4) interact and engage with JBU program staff through either an iOS or Android platform, both while enrolled in the JBU program and potentially afterward during a specified follow-up period of care. However, given the challenges experienced while trying to develop the app and a more complete understanding of the needs, interests, and capabilities of the youth that JBU serves, a decision was made later in FY 2021-22 that the app would not be incorporated into existing JBU services. With the decision to not implement the app within JBU, as of the end of FY 2021-22, BHS was considering whether the app would be beneficial for other programs and therefore warrant additional efforts to make the app fully operational.

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. The 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 FY 2021-22. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. 100% of JBU staff participated in the survey (N=15). Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes.

The main goals identified by JBU staff in FY 2021-22 were the same as FY 2020-21: 1) providing secure housing and 2) supporting youth to stabilize mental health. Staff were asked to identify program strengths and areas for improvement, as well as facilitating and inhibiting factors in goal achievement. The following themes emerged:

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."

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 for 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" as well as "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.”

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 in FY 2021-22. When asked to identify the most effective engagement strategies, staff members described:

- “Maintaining a tight knit community between staff. Supporting each other and having each other's backs. Being compassionate and transparent with each other.”
- “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.”

Other staff identified client rapport as crucial in maintaining engagement, naming many similar strategies including “creating positive and empathetic relationships”, "making them feel comfortable and supported”, and “building honest, trusting relationships”. One team member described:

- “Successfully connecting/building rapport with youth and meeting them where they are at to build trust allows them to open up about their difficulties/struggles and learn more about what hasn't worked in the past.”

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

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, most JBU staff mentioned how it helps clients work toward self-sufficiency:

- “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.”
- “A lot of the goals that youth have are in relation to self-care/creating a morning routine, finding and obtaining employment, enrolling in school/participation in school, leisure exploration, medication management, financial management, and more. These are all areas that occupational therapy can address during their time at JBU. We also address the development of skills in the areas of time management, planning, safety, judgement, decision making, and problem-solving, which will aid the youth in becoming more independent in preparation for independent living.”

Program Challenges

Relocation to New Community within San Diego

As discussed above, the JBU program moved to a new location during FY 2021-22. The JBU staff identified the move 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 few staff named effects of this relocation as inhibiting the program's goals in FY 2021-22:

- "Difficulties with site transitions /change in environment (moving from a facility in one city to another)"
- "The move: JBU had to find a new acupuncturist, massage therapist, therapy provider, and psychiatry providers"
- "Staff shortage, temporary transitional periods, uncertain program location"

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.

- "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."
- "One of the few challenges that JBU staff face when attempting to help a youth and offer them services, is when the youth isn't open to recovery and refuses the help. In those cases, which are rare, the youth is only in this program for the housing."

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.

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 2021-22. Staff describe that "rehab centers are consistently full" and state 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.

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:

- "4 months is not long enough for the youth to be stable in their mental health, get housing services, and stable on their medications."
- "I think a big factor that could improve the program is allowing clients to have more than the current allotted time at JBU. This can allow staff members to have more time to create and develop healthy habits and routines with the clients, as well as more time for them to find adequate housing for after the program is completed."
- "There is so much to tackle since homelessness and the experiences that residents are recovering from is so complex that in 3 months, it's difficult to fully support residents."

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.

- "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."

Changes from Initial Program Design

During FY 2021-22 there were ongoing adaptations to JBU service delivery and community referral partners, particularly following the move to a new location; however, there were no fundamental changes to the types of JBU services provided or to JBU program objectives from the initial program design.

Primary Recommendations for FY 2022-23

1. To minimize post-JBU relapse of symptoms and utilization of crisis/acute care services, explore potential for longer-term support services by JBU after completing the residential phase and/or developing partnership with long-term care management services tailored to TAY-specific populations.
2. Develop specific partnerships with other provider organizations to allow JBU to have dedicated access to SUD and mental health services via quick referrals and easy onboarding pathways (e.g., like a "fast pass" referral lane) and/or incorporate those services directly into JBU.

3. Explore viability of extending duration of residential phase of JBU to allow a longer period of time for JBU to help youth achieve desired fundamental life changes related to their mental health, housing, and life skills/personal growth.
4. Explore potential for someone with medical expertise on staff in close partnership with JBU to assist with medication management, complex healthcare needs, and navigating insurance challenges.

Conclusion

During FY 2021-22, JBU was able to successfully contact and enroll 52 youth who met all eligibility requirements (a level of enrollment similar to prior years). Coupled with having SMI, many of the youth also had substance use and abuse issues or other complex physical health or cognitive development challenges. The youth served by JBU were a racially/ethnically diverse population with 51.9% of youth identifying as Caucasian, 36.5% as Hispanic/Latino, 21.2% as African American and 13.4% as another race (note: youth could indicate more than one race/ethnicity so totals exceed 100%).

JBU staff provided daily encouragement and support throughout the residential phase of the program (commonly about 75-100 days), primarily through extensive OT support services as well as offering group and individual sessions for various holistic services and educational/enrichment activities. While access to external holistic providers was more limited related to the ongoing impact of the COVID-19 pandemic and disruptions due to moving to a new location within San Diego County, JBU staff continued to provide residential care services and facilitated telehealth and in-person connection to outpatient treatment providers. OT sessions while in JBU were perceived favorably by the youth with many demonstrating improvements in the capability to achieve collaboratively identified and individualized goals related to employment, education, life-skills/personal development, constructive use of leisure time and among other life domains.

JBU increased their capacity to 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 approximately 85% demonstrating the highest level of need and prioritized for permanent supportive housing. JBU was able to connect 18 youth with housing related assistance and this is expected to increase during FY 2022-23.

In addition to the emphasis on increasing awareness and practices of wellness among JBU youth, the program was successful at creating linkages to other BHS treatment programs with approximately 40% of youth participating in outpatient care while enrolled in JBU and 25% transitioning to ACT programs after completing the residential phase of JBU. Following discharge from the residential phase of the JBU program, there was a reduction in the number of youths receiving crisis and acute care behavioral health services through the BHS system as compared to the period of time before enrolling in JBU, but utilization patterns were higher than while in JBU. This suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants.

Youth with baseline and follow-up outcome assessment data demonstrated statistically significant and meaningful improvements in their symptom management and recovery orientation. Upon entrance into JBU the majority of youth were considered to be “high risk, not engaged” or worse (i.e., MORS score of 2

or less out of 8 recovery levels), whereas at the end of JBU services, the majority of youth were "coping/rehabilitating" or better (i.e., MORS score of 6 or higher out of 8 recovery levels).

Staff feedback indicated that for youth who were not successfully engaged in JBU services, substance abuse was a primary factor that impeded their efforts. These experiences prompted the JBU program to create additional community connections and develop internal resources to better address substance abuse issues among youth enrolled in the JBU program.

Overall, the findings from FY 2021-22 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 JBU services. 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 include co-occurring SUD, complex physical health needs, 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 during FY 2021-22

Characteristic	Total Participants (N=52)	
Gender	**n**	**%**
Male	28	53.8
Female	22	42.4
Another Gender Identity/Missing	2	3.8
Total	**52**	**100**
Age Group	**n**	**%**
18-21	19	36.5
22-25	26	63.5
Total	**52**	**100**
Primary Language	**n**	**%**
English	52	100
Total	**52**	**100**
Race/Ethnicity	**n**	**%**
African American	11	21.2
Hispanic or Latino	19	36.5
Caucasian	27	51.9
Other/Multiple	7	13.4
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
Depressive Disorder	8	15.4
Schizophrenia or other psychotic disorder	34	65.4
Bipolar Disorder	9	17.3
Other/Missing	1	1.9
Total	**52**	**100**

[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.

Appendix (continued).

Characteristic	Total Participants (N=52)	
Sexual Orientation	**n**	**%**
Heterosexual or straight	5	9.6
Another orientation	4	7.7
Missing/Prefer not to answer	43	82.7
Total	**52**	**100**
Disability	**n**	%
Yes, has a disability	3	5.8
No, does not have a disability	5	9.6
Declined/Prefer not to answer	44	84.6
Total	**52**	**100**
Type of Disability	**n**	%
Learning/Developmental	4	7.7
Physical/Chronic/Other	1	1.9
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.*

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

Annual Report
Year 4 (7/1/2021-6/30/2022)

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

v.12.22.2022

COUNTY OF SAN DIEGO HHSA 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) Center for Child and Youth Psychiatry (CCYP) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, the BHS has 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. The CCYP program was designed to provide psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring that is not viable with their primary care physician (PCP). Additionally, CCYP provides psychiatric care when other County-funded programs experience 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) ensures continuity of care and has become part of standard CCYP operations. During fiscal year (FY) 2021-22 an additional subset of youth enrolled in BHS-funded Short-Term Residential Therapeutic Programs (STRTP) were incorporated into CCYP to obtain medication management services.

CCYP staff include assessment coordinators, a health care coordinator, a nurse, and contracted psychiatrists who provide services both at centrally located clinics and remotely via telepsychiatry. Additionally, the role of transition planner was added during FY 2021-22 primarily to assist families connect with any ongoing medication management (e.g., primary care physicians) or other care services following discharge from CCYP. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. 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.

Primary Findings for FY 2021-22

CCYP Enrollment and Key Participant Characteristics

1. During FY 2021-22, a total of 588 children and youth were served by the CCYP program, including 235 new intake clients and 353 who had enrolled in a prior year (i.e., substantially exceeding the program goal of 500 unique clients served per year). This represented almost 100 more youth served in FY 2021-22 than the 499 served during FY 2020-21.
2. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (59.1%).

CCYP Contributions to Meet Medication Management Needs Throughout BHS System of Care

3. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services, which ultimately ensures continuity of care for youth. However, this occurred less frequently by the end of FY 2021-22 and overall these ancillary clients represented a much smaller share of new CCYP enrollees in FY 2021-22 (6.4%) than in the prior year (26.4%).
4. A new referral partnership was developed during FY 2021-22 with small BHS-funded STRTPs (i.e., those with 12 beds or less), in which CCYP provided any needed medication management services. A total 35 youth from STRTPs (14.9% of CCYP enrollees) received CCYP services.

Enhanced CCYP Services to Support the Transition of Medication Management to Other Community Providers

5. To ensure that CCYP did not reach full capacity and could continue to enroll new clients, additional attention was focused on identifying long-term stable CCYP clients who appeared to have medication management needs that could now be successfully handled by other services providers such as primary care physicians. During FY 2021-22, this led to the creation of a new role on the CCYP service delivery team, the Transition Planner. The Transition Planner engaged with families to identify and support transitions to appropriate service providers in the community.
6. The Transition Planner aided in nearly doubling the transitions out of CCYP when compared to the prior FY (135 to 278).

Youth Rarely Received Crisis/Acute Care Behavioral Health Services While Enrolled in CCYP

7. BHS crisis/acute care services were rarely accessed during the 180 days prior to enrolling in CCYP or while enrolled in CCYP. This pattern, combined with the lengthy average enrollment, indicates that CCYP was achieving the primary objective of maintaining stability for clients with complex medication management needs.

Improved Well-Being for Many CCYP Youth Even Without a Therapeutic Treatment Component

8. Although therapeutic services are 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.
9. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.

Similar Patterns of CCYP Service Utilization and Duration Across CCYP Enrollment Groups

10. Maintenance and ancillary/STRTP clients were estimated to receive 1 - 2 CCYP services per each 30 days of enrollment (1.30 and 1.49, respectively). Approximately half of the service contacts were medication management, for both groups. In the prior FY (2020-21) ancillary clients required almost twice as many psychosocial assessment and collateral service contacts as maintenance clients. This year (2021-22), the numbers were generally equivalent, indicating the workload requirements for Assessment Coordinators are now more similar.
11. CCYP youth typically received services for an extended period of time as evidenced by median durations of 352.0 days and 378.0 days for maintenance and ancillary/STRTP youth who were receiving CCYP services as of 6/30/2022.

Telehealth Services Perceived Favorably by CCYP Psychiatrists and Staff

12. CCYP psychiatrists and other staff indicated favorable views of telehealth services with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.

Conclusion

During FY 2021-22, CCYP served a total of 588 children and youth (466 maintenance, 85 ancillary clients, and 35 from the new partnership with STRTP. Of these, 235 enrolled in CCYP during FY 2021-22). As in prior years, CCYP continued to serve a racially and ethnically diverse client population with the majority of newly enrolled clients identifying as Hispanic/Latino (59.1%).

In contrast to prior years, in FY 2021-22 CCYP discharged more persons (n=278) than were enrolled (n=235). This number is more than double that of FY 2020-21 (n=135), the result of a strategic decision by the CCYP program to identify and discharge clients who appeared to have medication management needs that could be successfully handled by other service providers (e.g., primary care physicians) to ensure that CCYP continued to have capacity for new clients who needed CCYP services. To facilitate these changes, CCYP created the role of the Transition Planner to engage with families and support discharge to appropriate service providers in the community.

Overall, the pattern of lengthy CCYP program participation 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. In addition, CCYP fulfilled additional objectives by providing continuity of care for youth who otherwise faced disruptions in access psychiatric medication management at the location where they participated in ongoing therapy. During FY 2021-22, CCYP also became an ongoing partner with STRTPs to meet any medication management needs for youth participating in these programs. CCYP services provided to these ancillary and STRTP youth helped to strengthen the local BHS system of care and minimize potential service delivery gaps.

Primary Recommendations for Future Changes

1. Assess feasibility and potential benefits of incorporating some capacity to deliver short-term therapeutic support services within CCYP.
2. Increase outreach and education to physicians who may be serving medically fragile youth that also have mental health/behavioral medication management needs that could be supported by CCYP.
3. Identify and implement additional strategies for remotely obtaining completed required assessments and other paperwork, particularly for items that traditionally have required a "wet signature."
4. Incorporate additional technical support resources into CCYP services to assist youth and family members with any device and/or connectivity issues that may negatively impact ability to consistently engage in telehealth services.

Program Description

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 are essential for their wellness and stability but not easily managed by their PCP. Services are provided through a variety of means, including a centrally located psychiatric clinic and telepsychiatry at satellite clinics and clients' homes. CCYP provides linkages and facilitates 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. CCYP 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 including: 1) establishing a team of psychiatrists, assessment coordinators, a nurse, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families.

CCYP is an important county-wide resource that can fulfill the need for temporary access to psychiatric services when other county-funded programs experience a gap in 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 support the overall Children, Youth, and Families (CYF) BHS system of care. 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 is responsible for providing medication management services youth enrolled in BHS-funded STRTP 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 have not been viable so an emphasis on the medically fragile has not been implemented as part of CCYP operations.

MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, BHS has 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.

Service Changes Due to COVID-19

The initial design of CCYP, which included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county, allowed CCYP to adjust to the new practice realities without substantial disruption to ongoing services. Due to the ongoing COVID-19 pandemic, CCYP clients continued to be seen remotely throughout FY 2021-22. If in-person services were needed, individualized arrangements were made as appropriate. One challenge with conducting services exclusively or almost exclusively via telehealth is greater difficulty obtaining completed youth and parent/caregiver assessment tools given the limited amount of in-person interaction.

Participant Characteristics

A total of 235 persons enrolled into the CCYP program during FY 2021-22 (as compared to 258 in FY 2020-21) (see Table 1). Of the 235 enrollees, 185 (78.7%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), 15 (6.4%) were considered ancillary enrollees, and 35 (14.9%) 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. A larger proportion of clients who enrolled in CCYP during FY 2021-22 were maintenance enrollees as compared to FY 2020-21 (i.e., 78.7% and 73.6%, respectively).

Table 1. CCYP Program Enrollment for FY 2021-22 (N=235)

Type of CCYP Enrollee	n	%
Maintenance enrollees (i.e., not receiving therapy elsewhere)	185	78.7
Ancillary enrollees (i.e., receiving therapy elsewhere)	15	6.4
STRTP enrollees (i.e., receiving therapy services via STRTPs)	35	14.9
Total CCYP enrollees	**235**	**100**

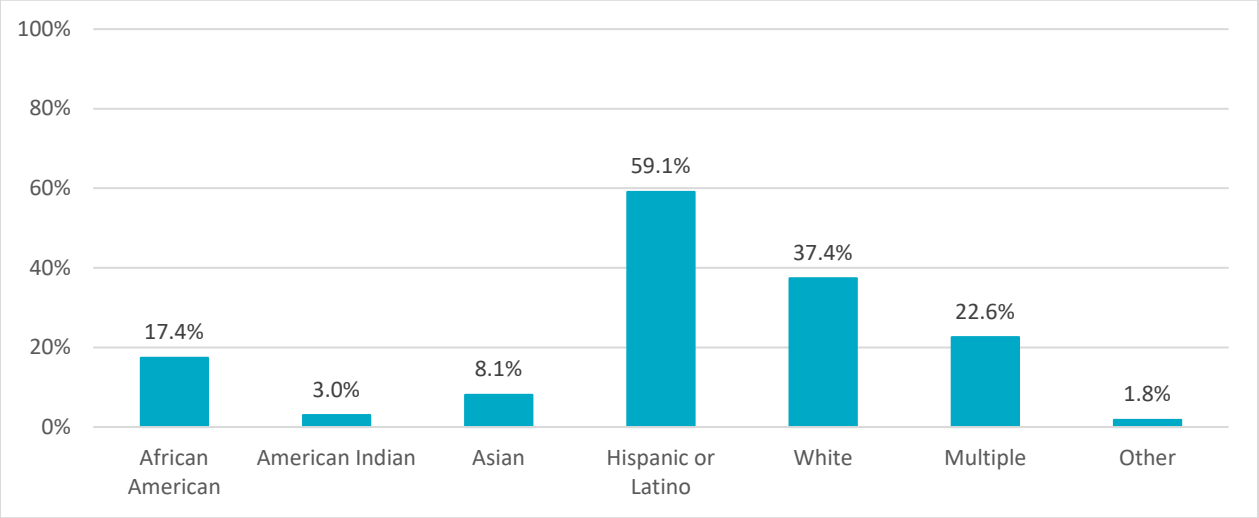
Key characteristics of the 235 persons who enrolled in CCYP during FY 2021-22 (i.e., includes both maintenance and ancillary referrals) are discussed below. A more complete listing of participant characteristics and response options can be found in the appendix. Additional analyses not reported here found similar demographic characteristics between maintenance and ancillary clients.

During FY 2021-22, the majority (77.4%; n=182) of clients enrolled in CCYP were at least 12 years old, with approximately one-fourth of clients age 5 to 11 (22.6%; n=53). More females enrolled than males (49.8%; n=117 and 37.4%; n=88, respectively). Almost half of clients identified as heterosexual (47.2%; n=111),

with 20.4% (n=48) indicating being bisexual, pansexual, or sexually fluid and 20.9% (n=49) declining to select an orientation.

While most clients reported English as their primary language (88.9%; n=209), more than 10% indicated Spanish (10.6%; n=25). As shown in Figure 1, CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (59.1%; n=139), followed by White (37.4%; n=88), multiple racial/ethnic backgrounds (22.6%; n=53), African American (17.4%; n=41), and Asian (8.1%; n=19).

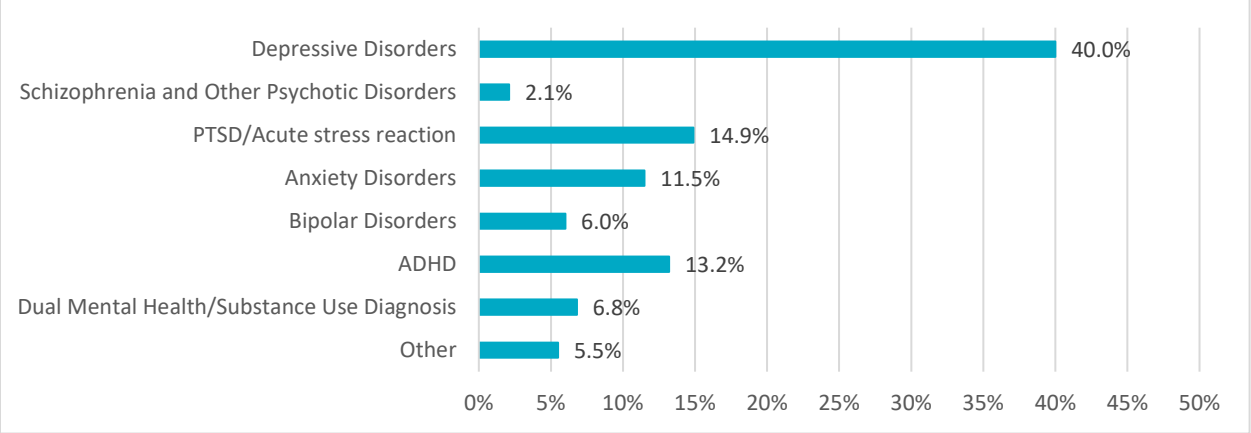
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2021-22 (N=235)



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

As shown in Figure 2, the youth served by CCYP had a wide range of mental health diagnoses. The most common diagnoses included depression (40.0%; n=94), Post-Traumatic Stress Disorder (PTSD)/Acute Stress Reaction (14.9%; n=35) and attention-deficit/hyperactivity disorder (ADHD) (13.2%; n=31).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2021-22 (N=235)



In addition, 5.5% (n=13) of the FY 2021-22 enrollees reported having a non-mental-health-related disability. The most common disability reported among CCYP participants was a learning disability (n=5).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2021-22, the CCYP program served a total of 588 youth (466 maintenance, 85 ancillary youth, and 35 STRTP youth). This total was comprised of the 235 FY 2021-22 enrollees, plus 353 prior year enrollees who were still active during FY 2021-22. The 588 youth served during FY 2021-22 exceeded the original service targets established prior to CCYP implementation (n=500) and represented an increase of almost 100 youth served compared to the previous year (n=499).

For each 30 days enrolled in CCYP, maintenance and ancillary/STRTP youth received between 1 and 2 CCYP services (see Table 2). As reported in Table 2, maintenance clients received an average of 1.30 CCYP services per month (i.e., every 30 days enrolled in CCYP) compared to 1.49 CCYP services for ancillary/STRTP youth. For both groups of CCYP clients, medication management services and nurse consultations represented approximately 50% and 25%, respectively, of 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. When looking more closely, maintenance clients received an average of 1.30 services while ancillary/STRTP clients received 1.49 services per 30 days of enrollment. This 0.19 difference in average, while small, represents a narrowing of the difference evident in the prior year (0.28 in FY 2020-21). Additionally, whereas in FY 2020-21, the difference in services was due primarily to ancillary clients having a higher average number of monthly psychosocial assessment and other services/collateral contacts, the remaining difference in FY 2021-22 was due to a slightly higher average number of medication management and nursing services per month for ancillary/STRTP clients. 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/STRTP clients.

Table 2. Average Number of CCYP Services Provided Per Month during FY 2021-22 (N=588)

Type of CCYP Service	Mean Number of Services per 30 Days	
	Maintenance (N=466)	Ancillary/STRTP (N=120)
Any CCYP service	1.30	1.49
Psychosocial assessment	0.19	0.18
Medication management	0.68	0.77
Nurse consult	0.31	0.39
Other services (e.g., collateral)	0.12	0.15

Program Duration

To generate a better understanding of typical CCYP participation patterns, the following analyses examine CCYP program duration and discharge status for all FY 2021-22 maintenance and ancillary CCYP clients. Table 3 shows that the average duration for all maintenance clients still participating in CCYP services as of 6/30/2022 was approximately 15 months at 469.5 days. The median duration, which represents the midpoint value (i.e., 50% are shorter and 50% are longer), indicates that half of all CCYP maintenance enrollees had been enrolled in CCYP for more than 352 days. In contrast, ancillary clients still participating

in CCYP services as of 6/30/2022 had shorter mean and median duration values of 392.4 and 378.0 days, respectively.

Table 3. CCYP Duration for Youth Receiving Services During FY 2021-22

	Maintenance (N=466)			Ancillary/STRTP (N=120)		
	n	Mean Number of Days	Median Number of Days	n	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2022	249	469.5	352.0	59	392.4	378.0
Discharged during FY 2021-22	217	490.8	399.0	61	247.7	219.0

Of note, the total number of persons discharged during FY 2021-22 (n=278) represented a more than doubling from the prior year (n=135). This increase in the number of CCYP discharges was purposeful and by design on the part of the CCYP program. As discussed below, the CCYP program added the role of Transition Planner to their service delivery team to help identify cases that may be appropriate for medication management provided by another community-based health provider such as a primary care physician. By adding the Transition Planner and facilitating additional discharges from the CCYP program, CCYP was able to focus more closely on those cases needing the unique psychiatric expertise provided by CCYP and continue to enroll substantial numbers of new clients without reaching program capacity limitations.

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 by 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 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 FY 2021-22 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 during FY 2021-22. 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 4. Comparison of BHS Service Utilization Prior to and During CCYP

	Maintenance Clients (N=466)		Ancillary/STRTP Clients (N=120)	
	Average number of BHS services per person, per 180 days			
	Prior to CCYP	In CCYP	Prior to CCYP	In CCYP
Inpatient hospitalization	0.04	0.02	0.13	0.08
Crisis stabilization visits	0.10	0.08	0.35	0.23
PERT/MCRT[1] visits	0.02	0.03	0.12	0.06
Therapeutic behavioral services	2.33	0.15	1.08	0.49
Outpatient sessions (not CCYP)	18.82	1.59	17.53	13.28

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

For the 466 maintenance youth served by CCYP during FY 2021-22 (see Table 4), prior to their CCYP enrollment they utilized crisis/acute care services such as inpatient hospitalizations and crisis stabilization visits relatively rarely (i.e., averaging much less than 1 instance per person in the 180 day period). Further, the average number of instances for these services remained nearly the same from the 180 days pre-enrollment to 180 days in CCYP. This is consistent with CCYP program design in that persons referred to CCYP have been determined to be relatively stable and not in need of ongoing therapy.

An additional component of 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 18.82 to 1.59 from the 180 days prior to 180 days during enrollment in the program. 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.

A comparison of the behavioral health service utilization patterns of ancillary and maintenance 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 are approximately twice as common in ancillary clients prior to CCYP enrollment and remains higher during CCYP enrollment when compared to maintenance clients. These findings are consistent with the expectation that maintenance clients are determined to be more stable and not in need of ongoing therapeutic services, whereas the ancillary clients are still in active treatment elsewhere and rely on CCYP to provide medication management services to address a temporary disruption in access to psychiatric care. 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 (13.28 and 1.59, respectively).

Overall, these findings highlight the difference in service needs between the maintenance and ancillary CCYP clients and provide evidence that CCYP was typically able to successfully maintain stable mental health among their participants, particularly among the maintenance client population.

Of note, the findings regarding BHS service utilization before and during CCYP were similar to those reported for FY 2020-21. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., often more than a year) indicates that CCYP is 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) and the Pediatric Symptoms Checklist (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 333 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2021-22 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 5 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. These findings show statistically significant reductions at the last available follow-up for the Child Behavioral and 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 5. CANS Average Change from Initial Assessment (N=333)

	FY 2021-22 (N=333)	
Key CANS Domains	**Initial Mean Number of Needs**	**Follow-up Mean Number of Needs**
Child Behavioral	1.71	1.35**
Life Functioning	1.10	1.13
Risk Behaviors	0.08	0.08

***statistical significance at p < 0.01*

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 6, for Behavioral and Emotional Needs and Life Functioning domains approximately 60% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment. This reduction in need is close, but slightly less than found in traditional outpatient programs (i.e., approximately 70-75% had 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 such that 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, almost all (94.1%) had a reduction in need in this area at follow-up.

Table 6. Persons with CANS Improvement at FY 2021-22 Follow-up (N=333)

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	264	156	59.1%
Life Functioning	193	115	59.6%
Risk Behaviors	17	16	94.1%

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 5.

In FY 2021-22, the PSC-35 was administered at entry into CCYP, 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 139 caregivers and 81 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 48.2% of parents and 37.0% of youth reported PSC scores that indicated clinical concern (see Table 7). At follow-up, slightly fewer (42.4%) parents reported clinically significant scores, however this limited amount of change is to be expected as there are no therapy services offered as part of the CCYP program. An examination of mean score changes in parent self-report show a small, but statistically significant reduction (i.e., improvement) for both the Attention subscale and the 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.

Table 7. PSC Average Change from Baseline

	Parent/Caregiver Report (N=139)					Child/Youth Report (N=81)				
Subscales	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	139	46.8	29.5	5.9	5.1*	81	30.9	27.2	5.0	4.7
Internalizing	139	36.0	38.1	4.0	3.7	81	35.8	46.9	3.6	4.0
Externalizing	139	26.6	26.6	4.4	4.6	81	7.4	4.9	2.8	2.2
Total Score	**139**	**48.2**	**42.4**	**27.3**	**25.7***	**81**	**37.0**	**34.6**	**23.2**	**21.9**

**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

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 8. Distribution of FY 2021-22 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=139)		Child/Youth Report (N=81)	
Amount of Change	**n**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	58	41.7	36	44.4
No improvement (i.e., 0-1 point reduction)	11	8.1	5	6.2
Small improvement (i.e., 2-4 point reduction)	15	10.8	11	13.6
Medium improvement (i.e., 5-8 point reduction)	24	17.3	9	11.1
Large improvement (i.e., 9+ point reduction)	31	22.3	20	24.7

As shown in Table 8, approximately one-third of parents/caregivers (39.6%) and children/youth (35.8%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 41.7% of caregivers and 44.4% 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 2020-21 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 CYF and CCYP 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 81 caregiver feedback surveys and 61 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2021-22. As shown in Table 9, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (93.8% and 86.9%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on client functioning and help-seeking. More caregivers reported that their child was able to function better in life (87.5%), compared to 81.4% of children/youth. Likewise, 88.8% of caregivers reported knowing where to get help and 88.5% felt comfortable seeking help, compared to 85.0% and 73.4%, respectively, among youth. Most caregivers reported feeling the needs of their family were met by the program (90.1%), while 75.5% of youth reported the same. The above findings should be interpreted with some caution as the number of caregivers and youth who completed a feedback survey is relatively low (i.e., less than 20.0% of all CCYP participants); however, the response patterns are similar to prior years.

Table 9. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=81)**	**Youth (N=61)**
As a result of this program, my child is/I am able to function better.	87.5	81.4
As a result of this program, my child/I know where to get help.	88.8	85.0
As a result of this program, my child is/I am more comfortable seeking help for myself.	88.5	73.4
My child's/my needs were met by this program.	90.1	75.5
Overall, I am satisfied with the services I received here.	93.8	86.9

For the open-ended caregiver and youth feedback survey questions (n=55 caregivers; n=34 youth with codable responses), 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. Across both

caregivers and youth, respondents reported that CCYP was succeeding at providing needed medication management by supportive and responsive staff. When asked about ideas for improving CCYP, most respondents said that CCYP services were helpful and did not have any specific recommendations. Some suggestions mentioned included providing more in-person appointment options and increasing the amount of contact between the program and clients/families.

Additionally, 23 caregivers and clients completed a survey regarding the transition planner position. In general, the survey responses indicated that the transition planner was helpful overall and specifically in providing referrals, information, and resources. The survey responses suggested that the transition planner could be more helpful by increasing their referrals to outside care.

Additional Program Activities

Developing Relationships to Support Transitions From CCYP

CCYP continued to develop partnerships with Children's Primary Care Medical Group (CPCMG) and other primary care physicians throughout San Diego County to facilitate transitions from CCYP service utilization to primary care services with providers able to continue medication management.

Community Outreach and Education

CCYP continued to develop and enhance mechanisms for providing psychoeducation and support to CCYP youth, parents/caregivers, and community members via a monthly newsletter and website (https://www.ccypsd.org/).

Primary Implementation Findings

Findings in this section were derived from two primary data sources: 1) CCYP stakeholder meetings; and 2) the Annual CCYP Staff/Psychiatrist Survey. 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 FY 2021-22. CCYP 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. There were 14 respondents (4 psychiatrists and 10 assessment coordinators/administrators/support staff) from the 15 CCYP staff or contractors invited to participate in the survey (i.e., a 93.3% response rate). 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. Secondary open-ended questions were summarized.

Program Strengths

CCYP Staff & Leadership

When asked which factors helped most toward achieving goals in FY 2021-22, staff highlighted the availability of licensed psychiatrists, strong management, and high performing staff. One staff member 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."

Additionally, CCYP added a new role in FY 2021-22. The transition planner meets with families to set the expectation that in many cases the client will eventually be discharged to a primary care physician. Staff highlighted the importance of the transition planner in helping discharges occur to allow new clients to be served.

> "The role of transition planner has been very helpful in initiating the process of discharging clients that no longer meet criteria for the program and therefore referring the client to appropriate level of care."

Outreach and Recruitment

Similar to previous years, outreach and recruitment were not perceived as substantial challenges for the CCYP program. The CCYP program continues to be well-known and accepts 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 in FY 2021-22, such as 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

In FY 2021-22, the CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for FY 2021-22 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 concern this year. 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 education clients and caregivers about medication management.

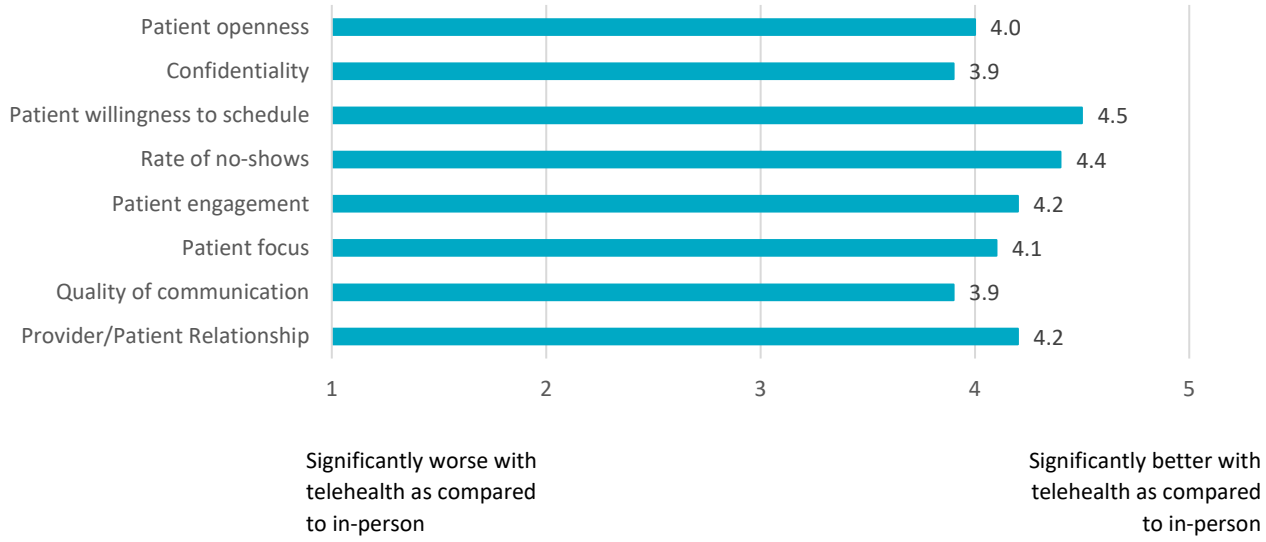
Telehealth

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 2021-22 survey, staff were asked to rate their client interactions: how does telehealth compare to in-person sessions?

On average, staff rated client interactions via telehealth as better than in-person services (see Figure 3). Highest rated items were patient willingness to schedule sessions and 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.

Figure 3. Ratings of Interactions with Clients via Telehealth



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).

> "Clients and parents are pleased that the services are provided via telehealth. This has been very helpful. Clients and families express how they are satisfied with the services."

Program Challenges

Factors that inhibited achieving program goals included high staff turnover and protocol changes that took time to adjust to.

Referrals

In the FY 2021-22 survey, staff scored various aspects of referrals as the most challenging aspects providing CCYP services. On occasion, a CCYP participant may need a referral out 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 10).

Table 10. 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 & client attrition more challenging than psychiatrists. Both groups found clients not engaging in services and clients not completing referrals similarly challenging.

Barriers to Telehealth with Video

While overall impressions of telehealth with video were favorable in the FY 2021-22 survey, staff reported that some caregivers 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. 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. 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.
2. CCYP began a partnership with the BHS-funded STRTP programs to provide medication management services for youth participating in STRTPs.

Program Recommendations

1. Assess feasibility and potential benefits of incorporating some capacity to deliver short-term therapeutic support services within CCYP.
2. Increase outreach and education to physicians who may be serving medically fragile youth that also have mental health/behavioral medication management needs that could be supported by CCYP.
3. Identify and implement additional strategies for remotely obtaining completed required assessments and other paperwork, particularly for items that traditionally have required a "wet signature."
4. Incorporate additional technical support resources into CCYP services to assist youth and family members with any device and/or connectivity issues that may negatively impact ability to consistently engage in telehealth services.

Conclusion

During FY 2021-22, CCYP served a total of 588 children and youth (466 maintenance, 85 ancillary clients, and 35 from the new partnership with small STRTPs to provide medication management services). Of these, 235 enrolled in CCYP during FY 2021-22). As in prior years, CCYP continued to serve a racially and ethnically diverse client population with the majority of newly enrolled clients identifying as Hispanic/Latino (59.1%).

In contrast to prior years, in FY 2021-22 CCYP discharged more persons (n=278) than were enrolled (n=235). This number is more than double that of FY 2020-21 (n=135), the result of a strategic decision by the CCYP program to identify and discharge clients who appeared to have medication management needs that could be successfully handled by other service providers (e.g., primary care physicians) to ensure that CCYP continued to have capacity for new clients who needed CCYP services. To facilitate these changes, CCYP created the role of the Transition Planner to engage with families and support discharge to appropriate service providers in the community.

Maintenance and ancillary/STRTP clients were estimated to receive 1 - 2 CCYP services per each 30 days of enrollment (1.30 and 1.49, respectively). Approximately half of the service contacts were medication management, for both groups. In the prior FY (2020-21) ancillary clients required almost twice as many psychosocial assessment and collateral service contacts as maintenance clients. This year (2021-22), the numbers were generally equivalent, indicating the workload requirements for Assessment Coordinators are now more similar. These findings highlight successful efforts on the part of CCYP to lessen the additional burden of ancillary clients on Assessment Coordinators.

CCYP clients often received services for a year or more with a median length of stay of 352.0 days for maintenance clients receiving CCYP services of 6/30/2022. While enrolled in CCYP, maintenance clients

utilized crisis or acute care BHS services at a rate similar to or lower than prior to CCYP enrollment. Although therapeutic services are 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. Approximately 90% of caregivers and youth indicated that they were satisfied with the services received from CCYP.

The program continued to serve clients during the ongoing COVID-19 pandemic throughout FY 2020-21 without substantial disruption to services due to the planned utilization of telehealth as the main modality for interacting with clients. Staff expressed favorable perspectives regarding the benefits of providing services via telehealth and telehealth services are expected to remain a primary approach for providing services even if in-person services become more available.

MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, BHS has 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.

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 2021-22

Characteristic	Total Participants (N=235)	
Age Group	**n**	**%**
5 to 11	53	22.6
12 to 15	84	35.7
16 to 17	79	33.6
18 to 20	19	8.1
Total	**235**	**100.0**
Gender	**n**	**%**
Male	88	37.4
Female	117	49.8
Transgender	10	4.2
Genderqueer/Gender non-conforming	5	2.1
Questioning/Unsure of gender identity	4	1.7
Another gender identity	8	3.4
Prefer not to answer	3	1.3
Total	**235**	**100.0**
Sex at Birth	**n**	**%**
Male	87	37.0
Female	144	61.3
Prefer not to answer	3	1.3
Total	**235**	**100.0**
Sexual Orientation	**n**	**%**
Heterosexual or straight	111	47.2
Gay or lesbian	11	4.7
Bisexual/Pansexual/Sexually fluid	48	20.4
Questioning/Unsure of sexual orientation	12	5.1
Other sexual orientation	4	1.7
Missing/Prefer Not to Answer	49	20.9
Total	**235**	**100.0**

Appendix (continued).

Characteristic	Total Participants (N=235)	
Language	**n**	**%**
English	209	88.9
Spanish	25	10.6
Other	1	0.4
Total	**235**	**100.0**
Race/Ethnicity	**n**	**%**
African American	41	17.4
American Indian	7	3.0
Asian	19	8.1
Hispanic/Latino	139	59.1
White	88	37.4
Multiple	53	22.6
Other	4	1.8
Missing/Prefer not to answer	1	0.4
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
ADHD	31	13.2
Depressive Disorder	94	40.0
Bipolar Disorder	14	6.0
Anxiety Disorder	27	11.5
PTSD/Acute stress reaction	35	14.9
Schizophrenia or other psychotic disorder	5	2.1
Dual Diagnosis: Mental Health and Substance Use Disorder	16	6.8
Other	13	5.5
Total	**235**	**100.0**
Disability	**n**	**%**
Yes, has a disability	13	5.5
No, does not have a disability	222	94.5
Total	**235**	**100.0**

[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.*

Appendix (continued).

Characteristic	Total Participants (N=235)	
Type of Disability	**n**	%
Hearing	<5[4]	<2.1
Learning	5	33.3
Developmental	<5[4]	<2.1
Physical	<5[4]	<2.1
Chronic/Health	<5[4]	<2.1
Other	<5[4]	<2.1
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.*
[4] *Values were suppressed due to small n size.*