ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 2 (7/1/2020 - 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES
AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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) 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 improve access to treatment and address 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 Home-Visiting (MCH) programs to provide mental health services to clients. ADAPT provides therapeutic treatment, peer support, and linkage to community resources and support for the entire family in an in-home setting. With the onset of the COVID-19 pandemic, the ADAPT program has had to substantially reduce the practice of providing in-home assessments and clinical sessions and had transitioned to providing these services primarily via telehealth video sessions. This allowed the ADAPT team to maintain continuity of care with minimal disruption to services; however, the number of referrals received from NFP and MCH has decreased substantially as public health nurses were redirected to other COVID-19-related priorities. To help address the lower-than-expected number of referrals from public health, the ADAPT program established additional referral partners.

Primary Findings for Fiscal Year (FY) 2020-21

1. The ADAPT program achieved substantial reductions in depression and anxiety symptoms and improved well-being among ADAPT participants. Additionally, the participants expressed high levels of satisfaction with ADAPT services.
2. Relative to both in-person and telephone-based services, the ADAPT team substantially increased the amount of ADAPT services delivered via telehealth with video during FY 2020-21, likely due to the ongoing COVID-19 pandemic.

3. Total ADAPT enrollment was less than the initial goal (i.e., 65 unduplicated persons compared to a target of 300). The ongoing COVID-19 pandemic continued to substantially reduce referrals from the NFP and MCH public health nursing programs. During FY 2020-21 new referral partnerships were established with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS (Sudden Infant Death Syndrome) Program. The addition of new referral partners coupled with the potential for public health nurses (PHNs) to have more time for non-COVID-19-related priorities is expected to increase referrals during FY 2021-22.
4. Good communication and coordination between ADAPT and PHNs remained critical to effective operations. PHNs expressed 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. In contrast, PHN eligibility exceeds these eligibility requirements, leading to PHNs reporting a gap in behavioral health services for their clients who may not meet these criteria.
5. The ADAPT program was designed with long-term sustainability in mind and has continued to make progress satisfying the requirements needed to allow for Medi-Cal insurance reimbursement billing. ADAPT anticipates beginning to submit Medi-Cal claims by the end of the first quarter of calendar year 2022.
6. ADAPT partnered with USCD researchers to develop and obtain approval from BHS for assessing the feasibility, acceptability, and effectiveness of using the innovative brief (two-week), fast-acting, non-pharmacological, in-home Sleep and Light Intervention (SALI) to treat perinatal depression. SALI has demonstrated the capacity to reduce depressive symptoms quickly and safely when administered by research clinicians to reset circadian rhythms by having participants engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session. During FY 2021-22, SALI will be implemented within ADAPT to examine whether the intervention can be successfully utilized by community providers to obtain reductions in perinatal depression.

Conclusion

During FY 2020-21, the ADAPT program was able to successfully navigate ever-changing public health recommendations to provide services safely and effectively throughout the ongoing COVID-19 pandemic. ADAPT staff continued to process referrals, screen clients, establish care, and provide continuing services via telehealth, as well as through socially distanced, outdoor, in-person sessions. The ADAPT program responded to the shifting priorities for PHNs by including multiple referral sources during FY 2020-21. While overall enrollment was less than anticipated, those receiving services demonstrated substantial reductions in symptoms of distress as well as improvements in domains such as illness management, functioning, and quality of life. High levels of satisfaction were reported by participants and echoed by public health nurses, who reported substantial benefits for their ADAPT-enrolled clients. The ADAPT program increased the role of the peer support partner throughout FY 2020-21 and will focus on additional ways to enhance the peer support aspect of ADAPT in FY 2021-22.

Primary Recommendations for FY 2021-22

1. Increase support and collaboration with PHNs by offering additional case consultations and roundtable discussion opportunities.

2. Identify practices to increase utilization of the ADAPT peer partners, potentially expanding their roles during screening and assessment so that ADAPT participants can interact with peer partners early in their engagement with the ADAPT program.
3. Identify additional referral sources to increase the number of persons enrolling into the ADAPT program.
4. Identify additional allowable communication methods with clients with regard to scheduling.
5. Identify barriers to engagement after admission into ADAPT.

Program Description

The County of San Diego BHS ADAPT program is funded through the INN component of the MHSA, with services provided by clinicians and staff from Vista Hill, a community-based nonprofit organization. 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, and linkage to community resources and support for the entire family, as well as other therapeutic interventions including skill building education, 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. Given the reduced number of referrals from PHNs during the COVID-19 pandemic, new referral partners were added during FY 2020-21.

The ADAPT program was designed to provide two tiers of services. Level-1 participants included those who met 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 being at risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors, and also demonstrated some impairments in functioning. 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. Persons in Level-2 could also include family members of Level-1 participants. ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce the symptoms of both maternal and paternal mental health disorders.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members, resulted in a substantial reliance upon remote work and remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they serve continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

For the ADAPT program, a major effect on services was the greatly reduced capability to provide in-home assessments and clinical sessions for much of FY 2020-21. These services initially transitioned to being provided via telephone, but then throughout FY 2020-21 most service contacts were shifted again to be completed via telehealth with video capability so that ADAPT participants and service providers could see each other. As conditions allowed, ADAPT reinstated efforts to meet in person with ADAPT participants (if desired by the ADAPT participant), with these visits typically occurring in outdoor settings conveniently accessible to the ADAPT participant. The number of referrals received from PHNs remained lower than originally planned due to the ongoing COVID-19 pandemic, which prompted the ADAPT team, in collaboration with BHS to establish additional partners who were able to refer clients to ADAPT as long as those clients also were concurrently referred to PHN services as well. These disruptions to referral flows contributed to the lower-than-expected FY 2020-21 enrollment totals (i.e., 65 unique persons newly enrolled compared to a target of 300 persons). 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 65 unique persons enrolled in the ADAPT program during FY 2020-21 (46 initial enrollments into Level-1 and 19 initial enrollments into Level-2). In addition to the 19 persons who enrolled directly into Level-2, four persons transitioned from Level-1 to Level-2 during FY

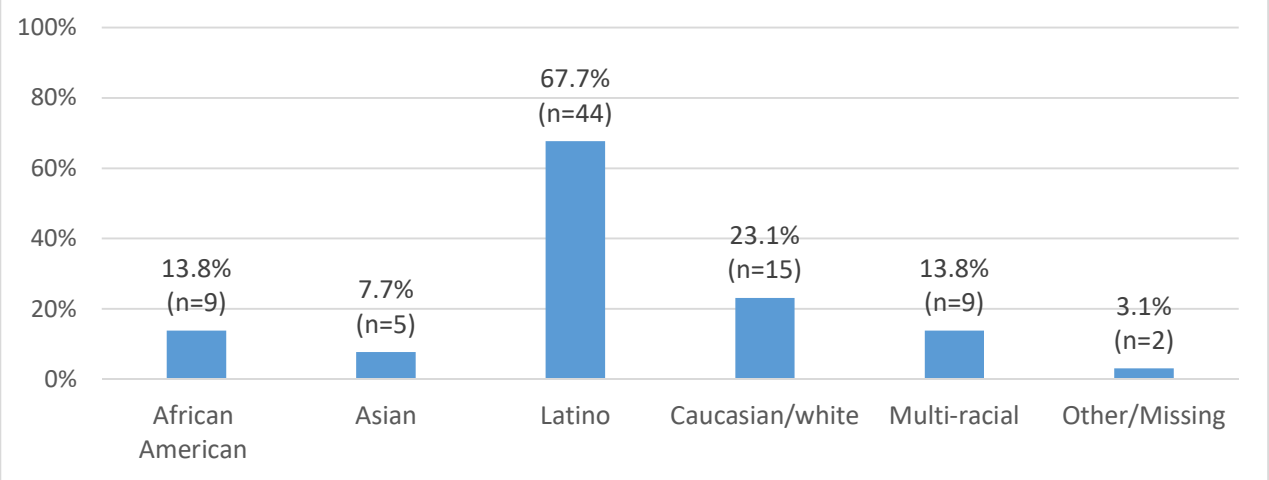
2020-21 when they no longer had a need for ongoing clinical therapy services but still wanted the education and support services provided by ADAPT. Similarly, four people transitioned from Level-2 to Level-1 once it was determined that more intensive services were appropriate. These 65 people enrolled into ADAPT during FY 2020-21 represent 64 different families with a total of 104 children in the households (including those not yet born at the time of ADAPT program enrollment).

Table 1. ADAPT Program Enrollment for FY 2020-21 (N=65 unique persons)

	FY 2020-21
Enrollment By ADAPT Service Level	**N**
Level-1 services (i.e., ongoing therapy services)	46
Level-2 services (i.e., education and support services)	19
Total unique ADAPT enrollees	**65**

Across both service levels, 96.9% of participants identified as female (n=63). While the majority of participants indicated English as their primary language (70.8%; n=46), almost one quarter (24.6%; n=16) indicated Spanish as their primary language and were served by Spanish-speaking ADAPT staff. More than 90% of participants (90.8%; n=59) identified as heterosexual or straight. Participants were overwhelmingly between the ages of 16-35 (n=58; 89.2%), with only 10.8% (n=7) over the age of 36. 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 (67.7%).

Figure 1. Race/Ethnicity of ADAPT Participants (N=65)



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 seeks to quantify a person's exposure to specific types of childhood trauma at home. A higher score is associated with numerous negative social and health outcomes. The mean ACE score (scored 0 to 10) among ADAPT participants was 4.5 while the median was 6.0. The majority of ADAPT

participants (56.9%) had an ACE score of 4.0 or greater, which is associated with a greater risk of developing health and mental health problems in adulthood.

Utilization of Program Services

Level-1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 indicates 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 2020-21. The information indicates that during each 30 days enrolled in ADAPT, participants typically received approximately 5.0 ADAPT services (comprised primarily of an average of 0.8 assessment visits, 1.7 therapy visits, and 1.0 case management visits per each 30 days enrolled in ADAPT). ADAPT offers family services for participants; however, the majority of participants in Year 1 did not utilize family therapy. ADAPT services were also expected to benefit the 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 three occasions during FY 2020-21. 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 2020-21 (N=68)

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	66	97.1%	1,214	5.0
Assessment/Tx. plan development	57	83.8%	191	0.8
Individual/Family therapy (i.e., by licensed clinician)	52	76.5%	419	1.7
Individual/Family rehab. (i.e., by peer support or other professional)	38	55.9%	174	0.7
Crisis	<5	<7.6%	3	<0.1
Case management	47	69.1%	241	1.0
Other services (e.g., Collateral)	55	80.9%	186	0.8

The average time in the ADAPT program was 190.3 days, with a median time of 177 days for the 41 persons who had been discharged from Level-1 services during FY 2020-21; however, a quarter of ADAPT participants were in the program for at least 259 days (with maximum program duration of over one year). These findings indicate that while the typical ADAPT program duration was approximately six months, there was a substantial number of participants who required a longer period of time. Often the request for extended time stemmed from a desire for additional support due to the pandemic.

As shown in Table 3, the method used to deliver ADAPT services fundamentally changed between FY 2019-20 and FY 2020-21 due to the onset of the COVID-19 pandemic. Prior to the pandemic, ADAPT services were almost exclusively provided face-to-face, which then shifted to primarily telephone-based service delivery during the initial months of the pandemic at the end of FY 2019-20. At that time, only a small number of services were conducted as telehealth visits that included a video component since the ADAPT program had never offered telehealth previously and many staff did not have equipment for this type of service delivery. Throughout FY 2020-21, Vista Hill was able to update policies allowing for telehealth and made efforts to ensure staff were comfortable and equipped with the necessary technological tools to provide telehealth services. These changes contributed to a substantial shift in how ADAPT services were delivered with 59.3% conducted via telehealth with video, reflecting an increased capacity for and comfort of both staff and participants in engaging in telehealth.

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21	
Contact Type	**N**	**%**	**N**	**%**
Telehealth with video	150	9.4%	720	59.3%
Telephone	426	26.7%	368	30.3%
Face to face	1011	63.5%	112	9.2%
Other	6	0.4%	14	1.2%
Total Services	**1,593**	**100%**	**1,214**	**100%**

Telephone continued to be utilized for a substantial number of visits (i.e., when telehealth visits were not feasible) with only a limited number of face-to-face visits (9.2%). It is expected that face-to-face visits will increase when COVID-19 safety concerns diminish.

Level-2 Services

A total of 24 persons enrolled directly into Level-2 services, including four persons who "stepped down" in care from Level-1 as they no longer needed the more intensive therapy services. Four additional persons enrolled from the prior FY were still active during FY 2020-21, for a total of 28 participants in Level-2 services. These 28 persons received a total of 300 different Level-2 ADAPT service contacts during FY 2020-21, representing a substantial increase in the provision of Level-2 services compared with FY 2019-20 (i.e., 14 persons with 73 services). Level-2 participants received an average of 10.7 ADAPT services (median = 9 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, housing assistance, 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 employment services, navigating public benefit or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2020-21 ADAPT Level-2 Service Encounters

	ADAPT Level-2 Service Encounters			
	Total persons (N=28)		Total services (N=300)	
	Number of Persons with service	Percent of persons with service	Number of services	Percent of total services*
Mental Health Education	14	50.0	39	13.0%
Goal Setting Skills	14	50.0	41	13.7%
Basic Needs	12	42.9	29	9.7%
Mindfulness Skills	12	42.9	45	15.0%
Self-Regulation Skills	11	39.3	38	12.7%
Organization Skills	10	35.7	18	6.0%
Housing	6	21.4	23	7.7%
Parenting Skills	5	17.9	10	3.3%

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

For the 16 persons who discharged from Level-2 ADAPT services during FY 2020-21, the average time in the ADAPT program was 104.0 days (median of 92 days). These findings suggest that 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.

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2020-21 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 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).

As shown in Table 5, during FY 2020-21 the average EPDS score at intake was 12.7, which reduced to 8.9 at the last EPDS follow-up assessment. This represents 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 75.8% 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 2019-20 (i.e., from 13.5 at intake to 9.7 at follow-up). Additional analyses that compared the FY 2020-21 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 10.1. This finding suggests that, on average, approximately half of the improvement in EPDS scores occurred within the first 30 days, with continued treatment leading to further improvements.

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

	FY 2020-21			FY 2019-20		
		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	62	0.7	0.4**	70	0.7	0.6
I have looked forward with enjoyment to things	62	1.0	0.6**	70	0.9	0.6^
I have blamed myself unnecessarily when things went wrong	62	1.9	1.5**	70	2.0	1.4**
I have been anxious or worried for no good reason	62	2.0	1.5**	70	2.1	1.5**
I have felt scared or panicky for no very good reason	62	1.4	0.8**	70	1.7	1.1**
Things have been getting on top of me	62	1.7	1.3*	70	1.7	1.4*
I have been so unhappy that I have had difficulty sleeping	62	1.3	1.0*	70	1.4	1.0*
I have felt sad or miserable	62	1.4	1.0**	70	1.5	1.2^
I have been so unhappy that I have been crying	62	1.2	0.7**	70	1.2	0.8**
The thought of harming myself has occurred to me	62	0.2	0.1	70	0.3	0.1*
EPDS Total Score	**62**	**12.7**	**8.9****	**70**	**13.5**	**9.7****
Likely Depression (i.e., score >=10)	**-**	**45 (72.6%)**	**27 (43.5%)**	**-**	**54 (78.3%)**	**34 (48.6%)**

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

An examination of the individual EPDS items indicates that improvements were generally evident across all dimensions. The items from FY 2020-21 with the largest changes from intake consist of reductions in self-blame, anxiousness, panic, and unhappiness (i.e., average EPDS differences of at least 0.5). While not statistically significant, thoughts of harming oneself were rare at intake and even less prevalent at follow-up. The pattern of reductions across the individual items matches closely to the changes observed in FY

2019-20. 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 nine 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 2020-21, average ratings for many items were between 2-3 (generally indicative of moderate impairment) with symptom distress being the lowest rated item at 1.9, which was indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, medication management and substance abuse were rated as areas of less concern (i.e., intake ratings between 4 and 5). The pattern of FY 2020-21 intake IMR-R scores was similar to that observed during FY 2019-20 with an overall IMR-R score of 3.1 during both FY 2020-21 and FY 2019-20.

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

	FY 2020-21			FY 2019-20		
(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	39	2.4	3.5**	44	2.7	3.6**
Knowledge about symptoms, treatment, coping strategies, and medication	39	2.6	3.6**	48	2.8	3.5**
Involvement of family and friends in his/her mental health treatment	39	3.2	3.4	48	3.2	3.7**
Symptom distress	39	1.9	2.9**	48	1.7	2.7**
Impairment of functioning	39	2.3	3.2**	48	2.2	3.1**
Coping with mental or emotional illness from day to day	39	2.6	3.7**	48	2.6	3.5**
Effective use of psychotropic medication	7	3.4	4.3	8	4.1	4.2
Impairment of functioning through alcohol use	39	4.9	4.9	45	5.0	4.9
Impairment of functioning through drug use	39	4.9	5.0	45	5.0	5.0
Overall	**39**	**3.1**	**3.8****	**48**	**3.1**	**3.7****

***statistical significance at p < 0.01*

During FY 2020-21 the overall IMR-R score increased from 3.1 to 3.8, 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 high intake levels (i.e. high functioning/less impairment), and many of other items approached or achieved a gain of 1.0. Particularly notable are the ratings of symptom distress, improving from 1.9 to 2.9, indicating clients went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. The IMR-R results indicate 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 2020-21, self-reported improvements occurred across multiple dimensions with statistically significant changes occurring for ratings of mental health/mood, hopefulness for the future, and feeling spiritually connected (see Table 7). The findings from FY 2020-21 were generally similar to those identified during FY 2019-20. Staff feedback regarding the findings in both FYs of increased self-rated spirituality at follow-up was interpreted to reflect ADAPT staff efforts to encourage ADAPT participants to utilize their personal resources and beliefs to develop their own strengths and sense of well-being. These areas of self-reported improvement were consistent with the primary areas of emphasis within the ADAPT program. Of note, in both FYs, participants reported an increase in emotional/behavioral problems from intake to follow-up. ADAPT staff attributed these ratings to two explanations: 1) Participants may be better able to recognize emotional/behavioral problems in their children after receiving psychoeducation that is part of ADAPT and 2) Participants have more capacity to notice challenging family dynamics as their personal mental health improves.

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

	FY 2020-21			FY 2019-20		
		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:	39	3.3	3.3	47	3.1	3.4*
In general, how would you rate your physical health?	40	2.9	3.0	48	2.8	2.9
In general, how would you rate your mental health, including your mood and your ability to think?	40	2.5	3.0**	48	2.4	2.7**
In general, how would you rate your satisfaction with your social activities and relationships?	40	2.8	3.0	48	2.5	2.9*
In general, please rate how well you carry out your usual social activities and roles.	40	3.1	3.2	48	2.9	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?	40	3.8	4.0	48	3.9	4.4**
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	40	2.6	2.9	48	2.3	2.7*
My child(ren) had emotional and/or behavioral problems.	35	4.7	4.2*	36	4.6	4.3
I felt hopeful about the future.	40	3.5	4.2**	38	3.3	3.9**
I felt spiritually connected.	40	3.1	3.6*	38	3.0	3.5^
I lived in a home that made me feel safe.	40	4.5	4.7	38	4.3	4.6
I used substances (alcohol, illegal drugs, etc.) too much.	40	4.9	5.0	38	4.8	4.9
How would you rate your fatigue on average?	40	2.9	3.1	48	3.1	3.2

*^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 2020-21, 95% of participants indicated they knew where to get help and 86% 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. For FY 2020-21, over 90% of participants indicated that services were available at convenient times, 95.3% reported they were able to receive all needed services, 100% reported that staff were sensitive to cultural background, and 95.3% were satisfied with ADAPT services. A similar pattern of participant responses was identified during FY 2019-20. 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 20-21 (N=43)	FY 19-20 (N=52)
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.	97.7%	94.2%
I am more comfortable seeking help.	97.7%	90.4%
I am better able to handle things.	86.0%	84.6%
Experiences with ADAPT services:	**%**	**%**
Services were available at times that were good for me.	100%	94.2%
I was able to get all the services I thought I needed.	95.3%	92.3%
Staff were sensitive to my cultural background (race, religion, language, etc.).	100%	100%
Overall, I am satisfied with the services I received here.	95.3%	96.2%

Participants were also asked what they thought were the most important benefits or services received through their participation in ADAPT. A review of the responses indicated the following themes:

Learning about mental health issues and the techniques to better manage/prevent symptoms.

1. "Most important benefit was learning how to cope and it's okay to feel my feelings"
2. "I learned not to be so hard on myself. It's ok to ask for help. Use resources that are there."

Learning and utilizing exercises that promoted self-care and compassion.

1. “Learned how I can manage my issues and about self-care and positive self-talk."
2. “Learning compassion exercises, how to be caring about myself and fight for my self-worth."

Receiving general emotional support/encouragement from therapists/peer support partners and always feeling “heard."

1. "My therapist was always there to listen and never judged me for whatever I had going on.”

Having positive social interactions and a sense of community/belonging.

1. "I feel like I have a place, an identity since I've been in ADAPT. It's been very helpful. It helped me feel like I belonged."
2. "The checking up on me in the beginning. I felt like I could pick up the phone at any time and someone will be there. It was so important! The feeling of not being alone."

Assistance with obtaining tangible community resources (e.g., food stamps).

1. "It was great being given support with mental health and housing resources."
2. "I liked everything about ADAPT. You listen to me, you helped me a lot, referred me to get clothes/diapers."
3. "Just trying to get myself back on track physically. Its good to have someone to help me through going and getting my job and going through this in a pandemic."
4. "All the local places that you guys direct me to."

When asked for recommendations to improve ADAPT program services, many indicated that they did not have recommendations since they were generally happy with the services received. The most common feedback was the request to continue receiving ADAPT services for a longer period. Another request was to allow for additional forms of communication with the ADAPT team, such as texting and emailing. After the onset of the COVID-19 pandemic, some participants indicated that they wished they were able to have in-person meetings in addition to the remote contact options of telephone and video calls. As a whole, the feedback generally reflected an interest for extended and/or enhanced communication and interaction with ADAPT program team members.

Referral Partner Feedback Survey

A brief online survey was conducted with PHNs and other Referral Partners to obtain feedback regarding their experiences with the ADAPT program. The questions were largely open-ended and served to explore referral partners' understanding of the ADAPT program and elicit recommendations for program improvement. Several themes emerged from the referral partners' feedback.

Eligibility

Given the overall success of clients who engage with ADAPT services, many referral partners expressed a desire to have wider eligibility requirements for the program. Often referral partners see clients who would benefit from ADAPT-style services from other community partners. One referral partner remarked:

> "Many clients were just referred back to their provider not qualifying for clinician visits. These clients are really needing a clinician in the home. When a mom is depressed, it is very difficult to get her out of the home with a newborn."

While ADAPT services are limited to individuals enrolled in Medi-Cal, Medi-Cal-eligible, or underinsured, the program's focus on perinatal mood disorders could potentially be replicated by other programs who serve a wider client base.

> "It would be wonderful if ADAPT clinicians could also see clients that do not fit the current criteria. There are times when a client has seen a mental health clinician within their insurance group in the past but stopped going to appointments (they didn't like the clinician; too overwhelmed to make an appointment; lack reliable transportation...). One of the wonderful qualities of the ADAPT program is being able to meet the client where they are at or in their home."

Bilingual Clinicians

Referral partners also highlighted the importance of Spanish-speaking clinicians. One referral partner indicated that when ADAPT staff turnover inhibited access to a bilingual clinician for their region for a period of time, they did not refer as many clients.

Electronic Communication

Referral partners felt ADAPT could benefit from additional communication methods with clients. Currently ADAPT clinicians do not have the ability to text with clients or email referral partners regarding client treatment. Referral partners felt the ADAPT team would benefit from "having the ability to text clients regarding their upcoming appointments or if they need to reschedule." Additional recommendations included the creation of a signed client consent that would allow for electronic communication to address ADAPT's liability.

Program Benefits

Overwhelmingly, referral partners reported positive outcomes for clients who engage in ADAPT services. One referral partner reported:

> "The ADAPT program has been a tremendous help to each of my clients that I have referred. The ADAPT services have allowed my clients to have focused, in-home mental health services that they truly need. Each of my clients that have completed the program have nothing but positive things to say about their experiences."

PHNs also reported significant assistance from ADAPT staff, given the PHN focus on COVID-19 pandemic responses:

> "I have not had a lot of available time during COVID-19 to be available for my clients. ADAPT has really helped by caring for their mental health needs when I'm not consistently able to take a phone call."

The peer support program was also specifically highlighted as a program benefit:

> "When my clients are eligible for services they enjoy having the peer support person and the clinician visit them in person. The staff have been amazing."

Additional Program Activities

Community Resources and Engagement

Partnership Presentations

ADAPT welcomed the following external presenters in staff meetings to increase knowledge of community resources and enhance partnerships with other community organizations: Adoption Center of San Diego, San Diego Breastfeeding Coalition, Steven A. Cohen Military Family Clinic, Safe Families for Children, and La Maestra Community Services. These efforts to enhance community partnerships directly support the ADAPT scope of work.

Connection to Community Resources

ADAPT was able to offer and deliver holiday gifts to clients in need who wished to participate in December 2020. ADAPT also collaborated with Gently Hugged, a resource that makes personalized and homemade baby blankets for families to request and deliver these blankets to families who are interested. This resource is offered to all clients who give birth. Additionally, ADAPT finalized a partnership with Yasukochi Farms to deliver fresh produce to families in need, who are enrolled in ADAPT for the duration of three months. A total of 18 deliveries were made to families from September to November 2020 with educational resources to link to similar services as well as nutrition and its impact on overall development and mental health.

Education and Outreach

Early Childhood Mental Health Virtual Conference

ADAPT staff attended the Early Childhood Mental Health Virtual Conference which included participation in breakout sessions and instruction on trauma-informed practices which contribute to their roles. Additionally, ADAPT was featured in a breakout session titled, “Hope from the Beginning: Supporting Peripartum Mental Health Within the Community." The presentation included a review and education of Perinatal Mood and Anxiety Disorders. The ADAPT Clinical Supervisor presented a review of the ADAPT program and highlighted the intention of ADAPT services in instilling “hope from the beginning” through service delivery and program model. The presentation highlighted ADAPT’s partnership with public health and included a presentation from a partnering nurse from a Maternal Child Health unit based in San Diego's North Central Region. Additionally, an ADAPT clinician from the Central Region and a Peer Support Partner from the North Central and Central Regions presented on their unique roles and responsibilities regarding the services they deliver.

Marcé of North America Annual Conference

ADAPT, in partnership with the UC San Diego evaluation team, had an abstract, “Access to Perinatal Depression and Anxiety Treatment: Addressing Social Inequities through the ADAPT Program,” accepted for a presentation at the Marcé of North America (MONA) annual conference. MONA is the North American branch of the International Marcé Society for Perinatal Mental Health (https://marcesociety.com/). The presentation occurred in October 2021.

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

During FY 2020-21, the ADAPT program, with review and approval by County BHS, agreed to participate in a research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry to test the feasibility, acceptability, and effectiveness of community providers delivering the Sleep and Light Intervention (SALI) previously developed and tested by Dr. Parry in academic settings. 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 to reset circadian rhythms and reduce perinatal depressive symptoms. This research has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression when

administered by research personnel. The partnership with ADAPT will provide an opportunity to transition SALI from an academic setting to a community-based care program to assess the capacity of community providers to successfully provide SALI to community participants. The study was developed and approved during FY 2020-21 and will be implemented during FY 2021-22. 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.

Preparing for Medi-Cal Billing to Promote Program Sustainability

The ADAPT program was designed with sustainability in mind, and thus, from the onset, has made concerted efforts to develop a pathway to Medi-Cal billing. During FY 2020-21, the ADAPT program initiated a fire clearance, which is scheduled to be completed in FY 2021-22. All other items required for Medi-Cal billing application have been completed, including obtaining a National Provider Identifier (NPI). ADAPT continued to actively review updates to required policies and procedures in order to be Medi-Cal compliant. While ADAPT has made considerable progress toward the goal of Medi-Cal billing, some barriers remain. Level-2 services are provided to participants who identify as "at risk of perinatal mood and anxiety" as outlined in the scope of work. Thus, these individuals may not meet criteria for specialty mental health services (Title IX), which would not be Medi-Cal billable. ADAPT anticipates beginning to submit Medi-Cal claims by the end of the first quarter of calendar year 2022.

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 2020-21. ADAPT program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 12 respondents from the 14 ADAPT staff invited to participate in the survey, a response rate of 85.7%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths and Challenges

ADAPT staff reported having strong leadership, accessible services for clients, and a program that offers flexibility for individual client needs. The reported quality of communication between ADAPT staff and clients has improved since FY 2019-20, as well as perceptions of client's willingness to schedule sessions, client engagement during sessions, and rates of no-shows. ADAPT staff reported confidence in their ability to provide services via telehealth. When reflecting on program strengths, one staff member remarked, "The communication, perseverance, diligence, passion, intelligence, desire to serve others, dedication [of ADAPT staff] to the support of mental health as a whole and serving an underrepresented population in San Diego County." In addition to the frontline and support staff, the ADAPT team recognized the importance of having a dedicated and involved leader: "Our supervisor is very supportive and transparent, and I think this is super helpful" noted one staff member.

ADAPT staff reported the following issues becoming more challenging since FY 2019-20: the PHN referral process, documentation burden, issues with staff turnover, and client engagement in ongoing ADAPT services. A staff member suggested, "Reducing the number of assessment tools and using some of them when needed would be helpful because this would reduce time spent on intake process and it would be spent on building rapport with clients." Despite the challenges of the referral process and communication with PHNs, ADAPT staff continue to focus on "improving communication with programs, as well as regional Public Health Nursing office managers and nurses." Finally, as with many behavioral health programs during the pandemic, staff turnover has also been a challenge.

Accessibility of Services

ADAPT staff recognized the unique way in which the program is tailored to meet individual client needs. In reflecting on what sets ADAPT apart from other services, one staff member wrote, "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met." ADAPT staff also recognized individual efforts to meet the needs of clients. In discussing different approaches to meeting client needs, a staff member responded, "Being flexible with client requests about meeting in person or face to face, offering various times to schedule appointments, letting clients know about expectations for example how long appointments will be and the length of treatment. Also being able to offer services in Spanish."

ADAPT staff found unique ways to meet with clients while also ensuring safety during the ongoing COVID-19 pandemic. Appointments were set up via telehealth, outdoors with social distancing, or via the phone. ADAPT staff arranged times to drop off tangible items such as diapers, formula, and other necessities without face-to-face contact. The culture of going above and beyond for clients is something ADAPT staff recognized and appreciated.

PHN and ADAPT Program Coordination

The responsibilities of PHNs continued to focus on COVID-19 pandemic-related tasks during FY 2020-21. It is expected this pandemic focus will continue for PHNs for the foreseeable future. Some PHNs continue to reach out to ADAPT, even when clients do not qualify for ADAPT services. In these cases, ADAPT staff have tried to provide linkages to other, more appropriate, programs. While PHNs can identify referrals to ADAPT, they continue to express the need for additional programs like ADAPT, so that more PHN clients can receive ADAPT-style services. Other, non-Medi-Cal insurance providers and community behavioral health programs may benefit from developing services specifically addressing perinatal mood disorders for their clients. ADAPT staff have utilized multiple methods of communication to engage with PHNs. During one Program Advisory Group, PHNs provided feedback on the ADAPT program. From this feedback, ADAPT developed a program flier, which can be distributed to potential clients by PHNs.

ADAPT Participant Engagement and Retention

Efforts by ADAPT staff to keep clients and referral partners engaged in the ADAPT program are substantial. Staff reported frequent and consistent communication as necessary not just with clients, but with family members and referral partners as well. One staff member remarked on timing: "Not leaving a large gap of time between services and being over with calling clients more often to remind them of their sessions."

Staff have developed effective methods to engage with clients, including frequent phone calls to remind them of session, limiting the time between sessions, and providing tangible resources such as diapers and food. Regarding family engagement, ADAPT staff reflected that often family members are a source of conflict for clients, and that would need to be addressed individually before a family member is brought into client sessions. Additionally, staff reported that specific accommodations for family members may increase family engagement, such as having male therapists, resume support, and job connections. Finally, staff reported that continued communication with PHNs was necessary to coordinate services.

ADAPT staff have increased engagement during FY 2020-21 through concerted efforts to educate clients and referral sources about the benefits of peer support and the various ways peers can help. ADAPT has also provided additional training and education on best practices for utilizing peer support, when needed. Finally, peer partners were included in the Level-1 intakes, which gave clients the opportunity to understand the role of the peer partner.

Experiences with Telehealth Services

ADAPT staff saw increasing success with telehealth during FY 2020-21. Staff reported having a higher quality of communication between staff and clients than during FY 2019-20. ADAPT also saw an increase in client engagement in services with telehealth (as compared to in person sessions), a reduction in no-show rates, and an increase in client willingness to schedule services. ADAPT staff are overwhelmingly confident in their ability to provide services via telehealth, and generally felt their agency has done a good job supporting the shift to increased telehealth services. ADAPT staff agreed that providing telehealth services should continue to be a high priority, even after in-person services become safe and available.

Impact of COVID-19 on ADAPT Staff

The flexibility afforded by telehealth has proven beneficial but has also created challenges for ADAPT staff. As compared to FY 2019-20, staff reported a decreasing sense that their work tasks and personal life had changed due to the pandemic. One ADAPT staff member stated, “I enjoy working remotely and have found that quite satisfying.” While staff appreciated the ability to be more open and flexible with scheduling, they also reported difficulties with working from home. Loss of co-worker support and organizational challenges were cited as difficulties of working remotely. One staff member reflected, “I don't have enough space at home, and it can be challenging to keep documents like assessment tools organized at home.”

ADAPT staff are conscientious of their need for self-care and reported several methods of ensuring they were attending to their own mental health needs during the pandemic. When asked how they are reducing pandemic related stress in their personal life, one ADAPT staff reflected, “Finding things that make me joyful. Still making time to be out of the house, with friend, family, and safely adventuring.”

According to ADAPT staff, fewer clients are expressing a non-telehealth preference (less than 5%), as compared to FY 2019-20, but more clients experience some difficulties utilizing telehealth services (approximately 10%).

Recommendations and Additional Feedback

ADAPT staff would like more opportunities for county-funded training—particularly in topics that are evidence-based in their population of focus. Specifically mentioned were “adverse childhood effects specific with postpartum depression. All around suicide information including ideation, intent, plans, and how to do an effective safety plan.” Another staff member requested “more training in motivational interviewing, CBT, couples, and family therapies to support the clients' layered needs.” This focus on evidence-based training highlights the dedication ADAPT staff have to meeting their clients’ unique and specific needs.

Staff felt that expanded referral sources would help the program, as well as reach more at-risk individuals in San Diego County. “For example, I think referrals can come from programs like First 5 First Steps, from schools, directly from OBGYN doctors and staff, from different facilities like Sharp HealthCare, from Family Health Centers and not just the Nurses." Another suggestion was to allow clients to self-refer into the program. Staff felt that self-referral may decrease program attrition.

Finally, as mentioned above, staff felt the ability to text clients to remind them of their appointments would help facilitate attendance and engagement in the program. “It would be extremely beneficial to be able to text clients to schedule appointments at least. Extremely helpful.”

Changes from Initial Program Design

Establishing New Referral Partners

During FY 2020-21, the ADAPT Program Manager worked on improving programmatic referral process to reduce challenges reported by both ADAPT staff and PHNs. The Program Manager collaborated with IT to create a referral email and communicated relevant changes with Nurse Managers in all regions. The intention of changing referral procedures in this way will assist PHNs with more efficient access to sending referrals and streamline the way ADAPT receives referrals, allowing for more timely contact and screening. Additionally, ADAPT established new referral partnerships with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS Program to increase the number of referrals for ADAPT services.

COVID-19-Related Changes

The ADAPT program has utilized the greater flexibility associated with telehealth capabilities to support clients throughout all County of San Diego regions rather than having region specific clinicians and staff. Additionally, even when offered in-person services, many clients refused as they were uncomfortable with receiving in-person services due to COVID-19-related safety concerns. Where feasible and appropriate, efforts were made to identify safe alternatives, such as meeting outdoor at a location convenient for the ADAPT participant when an ADAPT clinician thinks that an in-person visit would be beneficial.

Program Recommendations

1. Increase support and collaboration with PHNs by offering additional case consultations and roundtable discussion opportunities.

2. Identify practices to increase utilization of the ADAPT peer partners, potentially expanding their roles during screening and assessment so that ADAPT participants interact with peer partners early in their engagement with the ADAPT program.
3. Identify additional referral sources to increase the number of persons enrolling into the ADAPT program.
4. Identify additional allowable communication methods with clients.
5. Identify barriers to engagement after admission into ADAPT.

Conclusion

During FY 2020-21, the ADAPT program achieved substantial reductions in depression and anxiety symptoms and improved well-being among ADAPT participants. The results were similar to the previous year (i.e., FY 2019-20), which indicates that the program has adjusted to the service delivery changes brought about by the COVID-19 pandemic (i.e., minimizing/eliminating in-person service contacts) and was still able to meet core program objectives. While some challenges remain with consistently being able to utilize video-based telehealth sessions with all participants (e.g., not all participants had sufficient internet connectivity), the ADAPT program has substantially increased their telehealth capabilities such that most services during FY 2020-21 were delivered via telehealth, with telephone used primarily as a "back-up" when telehealth visits were not feasible.

The ADAPT program has expanded the use of Level-2 services during FY 2020-21 and has increased the role of the peer support partners to engage with and provide additional assistance to ADAPT participant. Feedback from ADAPT participants about their experiences with the ADAPT program indicated that they felt well supported by the ADAPT team members, learned new skills for managing their mental health, and were very satisfied with services overall.

The ongoing COVID-19 pandemic continued to substantially reduce referrals from the NFP and MCH public health nursing programs. To help increase referrals into the ADAPT program, new partnerships were established with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS Program. The addition of new referral partners coupled with the potential for PHNs to have more time for non-COVID-19-related priorities is expected to increase referrals during FY 2021-22.

ADAPT partnered with USCD researchers to develop and obtain approval from BHS for assessing the feasibility, acceptability, and effectiveness of using the innovative brief (two-week), fast-acting, non-pharmacological, in-home Sleep and Light Intervention (SALI) to treat perinatal depression. SALI has demonstrated the capacity to reduce depressive symptoms quickly and safely when administered by research clinicians to reset circadian rhythms by having participants engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session. During FY 2021-22, SALI will be implemented within ADAPT to examine whether the intervention can be successfully utilized by community providers to obtain reductions in perinatal depression.

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 2020-21

	FY 2020-21		FY 2019-20	
Characteristic	Total Participants (N=65)		Total Participants (N=91)	
Gender	N	%	N	%
Female	63	96.9%	89	97.8%
Another Gender Identity/ Missing/Prefer not to answer	2	3.1%	2	2.2%
Total	65	100%	91	100%
Age Group	N	%	N	%
16-25	22	33.8%	34	37.4%
26-35	36	55.4%	46	50.5%
>=36	7	10.8%	11	12.1%
Total	65	100%	91	100%
Primary Language	N	%	N	%
English	46	70.8%	63	69.2%
Spanish	16	24.6%	22	24.2%
Other/Missing/Prefer not to answer	3	4.6%	6	6.6%
Total	91	100%	91	100%
Race/Ethnicity	N	%	N	%
African American	9	13.8%	16	17.6%
Asian	5	7.7%	-	-
Latino	44	67.7%	57	62.6%
Caucasian/white	15	23.1%	27	29.7%
Multi-racial	9	13.8%	17	18.7%
Other/Missing/Prefer not to answer	2	3.1%	9	9.9%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	59	90.8%	81	89.0%
Bisexual/Pansexual/Sexually fluid	3	4.6%	6	6.6%
Missing/Prefer not to answer	3	4.6%	4	4.4%
Total	65	100%	91	100%
Military Status	N	%	N	%
Never served in the military	64	98.5%	88	96.7%

	FY 2020-21		FY 2019-20	
Characteristic	**Total Participants (N=65)**		**Total Participants (N=91)**	
Other/Missing/Prefer not to answer	1	1.5%	3	3.3%
Total	65	100%	91	100%
Disability	**N**	**%**	**N**	**%**
Yes, Has a disability	20	30.8%	15	16.5%
No disability/Declined/Prefer not to answer	45	69.2%	76	83.5%
Total	65	100%	91	100%
Type of Disability	**N**	**%**	**N**	**%**
Learning Disability	5	7.7%	-	-
Physical Disability/Chronic Health	12	18.5%	9	9.9%
Other	9	13.8%	8	8.8%
Total[2]	-	-	-	-

[1] Total may exceed 100% since more than one race/ethnicity could be selected.

[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.

BHCONNECT INNOVATIONS-19

Annual Report
Year 2 (7/1/2020- 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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 exclusively 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. Maintaining engagement with clients is an important component of BHConnect activities. Initially, Welcome Home Health (WHH) was subcontracted to provide 24 hours a day/7 days a week telehealth technical support, treatment scheduling reminders, and to direct any crisis requests to appropriate services. During fiscal year (FY) 2020-21, BHConnect transitioned to providing such services and support directly via BHConnect staff. Since the initial design of BHConnect already relied exclusively on the provision of mental health treatment services via telehealth technologies, BHConnect has experienced minimal disruptions to treatment services due to the COVID-19 pandemic.

Primary Findings for FY 2020-21

1. A total of 89 persons enrolled in BHConnect during FY 2020-21 (i.e., 71 persons enrolled in the Children, Youth, and Family (CYF) BHS system and 18 persons enrolled in the Adult and Older Adult (AOA) BHS system). An additional 24 persons who had enrolled in the prior year continued services into FY 2020-21.
2. To address concerns with lower-than-expected enrollment, BHConnect continued to seek out and develop referral partners throughout FY 2020-21. These efforts contributed to the substantial increase in persons served (i.e., 113 during FY 2020-21 compared to 54 persons served during the initial FY 2019-20 start-up year), with expectations for continued growth during FY 2021-22.

3. BHConnect received a total of 169 referrals (131 CYF and 37 AOA) during FY 2020-21. Rady Children's Hospital Urgent Care was the primary referral source with 113 referrals. Overall, approximately 55% of CYF and AOA referrals enrolled in BHConnect with 20% declining services and 25% lost to contact.
4. Of those who participated in therapy services, the average number of sessions received was 12.0 and 15.1, respectively, for youth and adults (a substantial increase in the average number of treatment sessions from the prior year). Almost 65% of the enrolled youth and 45% of adults participated in at least 3 therapy sessions during FY 2020-21.
5. Persons enrolled in BHConnect as of 6/30/2021 had median service durations of 143.0 days and 208.0 days, respectively, for youth and adults. This indicates that a substantial portion of the active BHConnect caseload had been receiving BHConnect services for 5-7 months or more. These findings indicate that BHConnect is frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.
6. Preliminary findings suggest that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services.
7. For clients with assessment data at both an intake and a follow-up, improvements in well-being and symptom management were generally identified. This was true for both clinician and self-reported assessments among both youth and adult client populations.
8. BHConnect decided to phase out the subcontract with WHH and shift those outreach, engagement, and scheduling responsibilities directly to BHConnect staff, particularly the Field Health Navigators. This decision was made to facilitate better communication and continuity of care between clients and all members of the BHConnect team. It also served to minimize confusion on the part of clients by eliminating a second entity (WHH) involved in their care services. This required BHConnect staff to develop and implement new practices to replace the 24/7 access previously provided by WHH, as well as establish strategies to initiate and maintain engagement in BHConnect services. As the transition away from WHH occurred near the end of FY 2020-21, the implications for service delivery will be examined throughout FY 2021-22.

Conclusion

During FY 2020-21, BHConnect increased enrollment to 89 persons (71 youth and 18 adults), a substantial increase from the prior year, particularly among youth (i.e., 54 persons, 37 youth and 17 adults). The number of therapy services provided also substantially increased with youth receiving an average of 16 services (as compared to an average 9.6 services in FY 2019-20) and adults receiving an average of 15.3 services (as compared to an average 11.8 services in FY 2019-20). The increase in enrollees and provided services is a program success likely due in part to the program entering their second full year of operations and overcoming startup challenges. However, even though the program has grown, FY 2020-21 enrollment was still below initial expectations. In light of this, staff have reported continued interest in generating referrals from additional referral partners.

Services provided by BHConnect include psychosocial assessments, treatment plans, therapy, rehabilitation, and case management. Out of all the enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians. Once enrolled in the program and receiving services, youth and adults will stay engaged with the program anywhere from a few weeks to six months or more. Of those who were still involved with BHConnect services as of 06/30/2021, youth had a median enrollment duration of 143 days and adults had a median enrollment duration of 208 days.

BHConnect provided essential behavioral health services for both youth and adults as indicated by their respective assessments. A comparison between baseline and follow-up Child and Adolescent Needs and Strengths (CANS) assessment, and the Pediatric Symptoms Checklist (PSC) for youth, shows significant reductions (i.e., improvements) in behavioral and emotional needs, life functioning, risk behaviors, and clinical concern. Of the children and youth served by BHConnect, 60-65% experienced at least one reduction in a need item identified during the initial assessment. Alternatively, some youth showed an increase in impairment between their baseline PSC and follow-up. This same increase is also seen in the overall CYF BHS system and is indicative of the substantial variability of behavioral health needs and changes within this population. Similarly to the youth, a comparison of the Recovery Markers Questionnaire (RMQ) and Illness Management and Recovery (IMR) assessments for adults showed improvements in the desired direction, but unlike the youth, the changes were not statistically significant.

Overall, BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2020-21; however, a primary challenge for BHConnect was the difficulty generating the desired number of client referrals from other crisis-oriented mental health service provider organizations. BHConnect decided to phase out the subcontract to WHH in order to increase communication and continuity of care with the BHConnect team. This required BHConnect staff to develop and implement new practices to replace the 24/7 access previously provided by WHH as well as establish strategies to initiate and maintain engagement in BHConnect services. The transition away from WHH occurred near the end of FY 2020-21 and changes will be examined throughout FY 2021-22.

Primary Recommendations for FY 2021-22

1. Continue to diversify referral sources to increase referrals for youth, adult, and geriatric patients. In particular, expand referral sources to include adult crisis centers throughout all regions of San Diego, and add PERT and CPS as approved referral partners.
2. Maintain ongoing and close relations with hospitals to potentially provide more integrated care, with on-site onboarding/warm hand-offs, and inevitably, more continuity of care and engagement with BHConnect services.
3. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care.
4. Continue collaborating with psychiatry providers and primary care providers to provide coordinated, integrated care, and to assist clients in navigating the healthcare system.
5. Consider adding in-house psychiatry services or identifying a community partner to help meet the medication management needs for adults.
6. Increase San Diego Change Agents Developing Recovery Excellence (CADRE) and co-occurring capability through incorporating this integrated approach in program literature (website and brochure), clinical approach, and to always consider modifications to the clinical staff annual training plan to include trainings such as “Harm Reduction.”
7. Continue to provide clinical support and training to all staff so that they can feel effective and productive in their role.
8. Refine screening process and explore best practices to increase client engagement from the moment referral is received.
9. Provide in-home services when clinically indicated to further engage clients in treatment.

Program Description

BHConnect is funded through the Innovations (INN) component of the Mental Health Services Act. 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. Services are provided through Vista Hill.

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 elemental 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 entirely 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 provides clients with the technology necessary to maintain contact with telehealth professionals, such as tablet or phone equipped with built-in internet access. 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. Initially, Welcome Home Health (WHH) was subcontracted to provide 24 hours a day/7 days a week telehealth technical support, treatment scheduling reminders, and to direct any crisis requests to appropriate services. During FY 2020-21, BHConnect transitioned to providing such services and support directly via BHConnect staff.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members resulted in a substantial reliance upon remote work and remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19 related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

The initial design of BHConnect, which already relied exclusively on the provision of mental health treatment services via telehealth technologies, allowed BHConnect to adjust to the new practice realities with essentially no disruption to ongoing treatment services. The main changes for BHConnect due to the pandemic were staff and client safety-related practices such as social distancing, use of personal protective equipment, and implementing new cleaning protocols for the initial recruitment interactions and/or when providing the telehealth device to the client (which often now occurs at the client's home).

However, the COVID-19 pandemic changed initial client recruitment and engagement practices as BHConnect staff were no longer physically co-located at crisis sites to meet with potential clients at the time when they were at the crisis facility. This inhibited the ability to have "warm-handoffs" where BHConnect staff would be able to meet in-person with the clients and that staff they were receiving care from at the crisis facility prior to transitioning care solely to BHConnect. A more detailed discussion of BHConnect 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 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 2020-21, a total of 71 persons enrolled in CYF services and 18 enrolled in AOA services. This represents a near doubling of CYF clients entering BHConnect as compared to the prior year (i.e., FY 2019-20 CYF enrollment was 37 persons), however, enrollment remained below initial expectations and efforts were ongoing throughout FY 2020-21 to increase program awareness and expand the number of referral partners. During FY 2020-21, CYF clients ranged in age from 7-17 with the majority (60.6%; n=43) younger than 15. AOA clients ranged in age from 21-72, with 22.2% (n=4) as Transitional Age Youth (TAY) between the ages of 18-25. Approximately two-thirds (64.8%; n=46) of the CYF clients and almost 80% (77.8%; n=14) of AOA clients were female.

Referrals for BHConnect Services

BHConnect received a total of 169 referrals from community referral partners during FY 2020-21. The primary referral source for CYF was Rady Children's Hospital Urgent Care with 113 referrals. Of these referrals, 65 youth (57.5%) enrolled in BHConnect. All other community providers only referred a total of 18 youth to BHConnect. For AOA clients, the BHS-funded In Home Outreach Team (IHOT) and the San Diego County Psychiatric Hospital (SDCPH) were the primary BHConnect referrals sources with 20 and 11 referrals, respectively. The enrollment rate was 60.0% for IHOT referrals and 45.5% for SDCPH referrals. Other community organizations provided a total of seven additional referrals for AOA clients. For both CYF and AOA clients, approximately 55% of all referrals ended up enrolling in BHConnect. Of the 169 total referrals to BHConnect, 20.1% (n=34) declined services and 26.0% (n=44) were lost to contact.

Utilization of Program Services

BHConnect Services – Type and Amount

Often, there was a brief period of time (typically 2-4 days), between enrolling into BHConnect (following an acute care treatment episode) and receiving initial BHConnect services. During this time, the WHH team and/or BHConnect staff attempt to maintain daily contact with the newly enrolled BHConnect clients until their first therapy session. Despite these outreach and engagement activities, a portion of BHConnect enrollees (14.8% of youth and 20.0% of adults) did not participate in any BHConnect services during FY 2020-21. BHConnect stakeholders and evaluators will continue to examine this group of enrollees in the future to identify any potential characteristics or needs this group has that may inform enhanced

engagement strategies. Table 1 shows the overall service utilization patterns for persons who enrolled in BHConnect services during FY 2020-21. On average, youth and adults enrolled and receiving BHConnect services had more than 15 total services (16 and 15.3, respectively) as of 6/30/2021. Of those that participated in at least one BHConnect therapy session, the mean number of therapy sessions received by youth and adults was 12.0 and 15.1, respectively. Out of all BHConnect enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians.

Table 1. BHConnect Service Utilization during FY 2020-21

	Youth (N=88)			Adult (N=25)		
	Persons with at least one svc.		Mean number of services (of persons with svc.)	Persons with at least one svc.		Mean number of services (of persons with svc.)
Type of Service	n	%		n	%	
Any BHConnect service	75	85.2%	16.0	20	80.0%	15.3
Psychosocial assessment provided	66	75.0%	1.3	16	64.0%	1.5
Treatment plan session	68	77.3%	1.3	15	60.0%	1.1
Therapy sessions provided	71	80.7%	12.0	16	64.0%	15.1
Case management sessions provided	15	17.0%	2.1	7	28.0%	1.3
Other services provided (e.g., collateral contacts)	49	55.7%	3.0	8	32.0%	1.9
Received at least three therapy sessions	57	64.8%	-	11	44.0%	-

BHConnect Services – Duration and Discharge Status

As shown in Table 2, of the 88 youth and 25 adults who were enrolled in BHConnect services during FY 2020-21, there were 31 youth and 8 adults still active in the program as of 6/30/2021. These persons were typically enrolled for approximately 5-7 more months (i.e., median duration of 143.0 days and 208.0 days, respectively) than those who had already discharged. Of the persons who discharged from BHConnect prior to 6/30/2021, the duration times were typically shorter, particularly for adults, which reflects the fact that a portion of the BHConnect enrollees were only in the program for a brief period of time. The program duration patterns suggest some initial "sorting out" of client preferences and interest levels during the early weeks of BHConnect involvement; some closed out of services within a month or less, but many others connected with and maintained treatment for 6 months or more. These duration patterns will continue to be monitored in future years to better understand factors that promote engagement with BHConnect services.

Table 2. BHConnect Program Participation Duration and Discharge

	Youth (N=88)		Adult (N=25)	
	Still in program	Discharged	Still in program	Discharged
N (persons)	31	57	8	17
Mean (days)	205.3	141.7	243.8	95.0
Median (days)	143.0	113.0	208.0	52.0

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 6/30/2021 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, these 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=98)				Adult (N=31)			
	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	14	14.3%	5	5.1%	15	48.4%	<5	<16.2%
Crisis Residential	0	-	0	-	<5	<16.2%	<5	<16.2%
Crisis Stabilization	14	14.3%	9	9.2%	13	41.9%	<5	<16.2%
Urgent Outpatient	0	-	<5	<5.1%	13	41.9%	7	22.6%
PERT*	8	8.2%	3	3.1%	<5	<16.2%	<5	<16.2%

*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 adult clients: clients with at least one inpatient psychiatric hospitalization decreased from almost 50% (48.4%) before BHConnect to approximately 10% (12.9%) during the 90 days after enrolling in BHConnect. These results should be considered preliminary given the relatively small

sample sizes, especially for the adult population, and the limitation that the analyses only included BHS services; however, initial indications 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 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 BHConnect, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 54 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2020-21 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. These findings show statistically significant reductions for all three CANS domains.

Table 4. CANS Average Change from Initial Assessment (N=54)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	1.80	1.24**
Life Functioning	1.59	1.41
Risk Behaviors	0.63	0.39*

**statistical significance at $p < 0.05$; **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 5, for each CANS domain, 60-65% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment.

The percent of persons with an improvement across these three domains was slightly lower than what was reported in the FY 2019-20 Systemwide Annual Report for the overall County of San Diego Children, Youth, and Families BHS for discharged clients (i.e., at least one improvement was evident in approximately 70-75% 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.

Table 5. Persons with CANS Improvement at Follow-up (N=54)

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	51	32	62.7%
Life Functioning	35	21	60.0%
Risk Behaviors	25	16	64.0%

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 2020-21, 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 24 caregivers and 30 youth in FY 2020-21 completed both a baseline and follow-up assessment. Table 6 shows that the majority of both parents and youth reported PSC scores (58.3% of parents and 63.3% 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 to approximately one-third of parents and youth (37.5% of parents and 36.7% of youth). Likewise, an examination of mean score changes show 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.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=24)					Child/Youth Report (N=30)				
		% Above clinical cutoff[1]		Mean			% Above clinical cutoff[1]		Mean	
Composites:	N	Baseline %	Post %	Baseline	Post	N	Baseline %	Post %	Baseline	Post
PSC Score	24	58.3%	37.5%	31.1	24.9**	30	63.3%	36.7%	30.4	22.3**
Attention Subscale	24	33.3%	29.2%	5.2	4.9	30	33.3%	23.3%	5.6	4.6*
Internalizing Subscale	24	70.8%	37.5%	6.4	4.3**	30	80.0%	43.3%	6.6	4.0**
Externalizing Subscale	24	25.0%	12.5%	4.2	3.5	30	13.3%	3.3%	3.4	2.5^

*[1]PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7; ^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

To better understand the distribution of PSC change scores 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 2019-20 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 a large improvement (9+ point reduction).

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

	Parent/Caregiver Report (N=24)		Child/Youth Report (N=30)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	6	25.0%	6	20.0%
No improvement (i.e., 0-1 point reduction)	2	8.3%	3	10.0%
Small improvement (i.e., 2-4 point reduction)	5	20.8%	4	13.3%
Medium improvement (i.e., 5-8 point reduction)	0	0.0%	2	6.7%
Large improvement (i.e., 9+ point reduction)	11	45.8%	15	50.0%

As shown in Table 7, approximately half of the parents/caregivers (45.8%) and children/youth (50.0%) in BHConnect reported a large improvement from their initial PSC assessment. Alternatively, 25.0% caregivers and 20.0% 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 similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2019-20 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements and about 20-25% reported increased impairment from initial PSC assessment.

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 persons to answer questions as it is "true for you now."

The total mean RMQ score for the seven adult participants who completed it at intake and at a follow-up assessment during FY 2020-21 was 3.0 at baseline and 3.3 a follow-up. While in the desired direction, the magnitude of the change was not statistically significant. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and TAY residential programs) was 3.3 with a follow-up RMQ of 3.6. 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. Seven participants completed an intake and a follow-up assessment in FY 2020-21 (see Table 8). The mean overall IMR score at intake was 2.3 and increased to 3.4 at last available follow-up. Primary areas of improvement included reductions in psychiatric hospitalization as well as improved ratings for recovery and management of symptoms.

As reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.3 at most recent follow-up. While definitive conclusions are not possible with the small number of BHConnect participants, clinicians assessed BHConnect participants to have slightly more impairment and/or worse recovery/management skills at program intake compared to participants in other BHS programs.

Table 8. IMR Assessments for BHConnect Adult Clients (N=7)

		Intake	Follow-up
IMR Assessment Item/Subscale	**N**	**Mean**	**Mean**
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?	7	2.6	3.4
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?	7	1.6	2.1
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	7	1.6	3.4*
Using medication effectively: How often does s/he take his/her medication as prescribed?	7	3.6	4.4
Recovery subscale	7	2.2	3.3*
Management subscale	7	1.3	3.0*
Substance abuse subscale	7	4.8	4.8
Overall IMR	**7**	**2.3**	**3.4***

**statistical significance at $p < 0.05$*

Additional Program Activities

Establishing Referral Sources

Per the initial design of the BHConnect program, potential clients are identified at crisis-oriented mental health service programs such as the Emergency Stabilization Unit (ESU), Child and Adolescent Psychiatry Services (CAPS), and the San Diego County Psychiatric Hospital (SDPH). Establishing a network of referral sites throughout FY 2020-21 required ongoing BHConnect outreach efforts that involved 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.

BHConnect also formed partnerships with other County BHS service programs such as the IHOT where BHConnect could provide the treatment services to the population of treatment unconnected persons that the IHOT teams worked to engage in services. Weekly meetings with another County BHS "Innovation" program, the Center for Child and Youth Psychiatry (CCYP), were established to discuss shared cases and mutual support approaches between the two programs, particularly with CCYP providing psychiatric support for CYF BHConnect 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 2020-21. 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=7). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths

Staff engagement with BHConnect is an overwhelming strength of the BHConnect program, according to annual survey feedback. BHConnect staff report working together to collaborate on client treatment plans, work on communication strategies, and supporting each other.

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

> "We have provided training for clinicians on how to assess for the need of case management or rehabilitation services to support the clients in achieving their mental health goals. We hold a weekly meeting with therapist and FHN's to collaborate on cases and discuss how FHN's can support clients more. We have started discussing with clinicians on how to increase service delivery when clinically indicated, such as twice a week individual session for clients that are first referred and also family therapy

> engagement when working with children clients. In addition, we have discussed strategies to increase engagement such as reminder calls, calling clients right away after a missed appointment, rescheduling missed sessions within the same week, utilizing motivational interviewing strategies to increase motivation for participation in treatment."

BHConnect staff also reported increased referrals from Rady Behavioral Health Urgent Care, IHOT, and Center for Child and Youth Psychiatry as program strengths during FY 2020-21. BHConnect is also seeing increased referrals from SDPH as well.

Program Challenges

BHConnect staff identified staff turnover as one of the biggest challenges to reaching program goals during FY 2020-21, as well as the lack of referrals from identified partners. During FY 2020-21, the BHConnect program began to make plans to move away from the WHH platform and transfer the outreach and engagement responsibilities to the Field Health Navigators. A detailed assessment of the strategies used by BHConnect staff to support this service structure change will be an ongoing evaluation activity during FY 2021-22.

Client engagement and attrition were additional difficulties faced by staff. One staff member remarked, "Clinicians have expressed frustration with this being a disengaged population. Many clients no show, don't reschedule during the week for missed appointments, and will be hard to reach and connect with to provide services." Other comments from staff highlighted the ways in which client disengagement reduces morale and enthusiasm among staff.

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, ambivalence or resistance to treatment among some clients was anticipated. BHConnect staff recommended structured roles for staff in the client treatment process, from a standardized screening process to the incorporation of case management, and finally a whole-team approach to maintaining client engagement. BHConnect staff were also cognizant of the need to have a client-centered approach to communication, understanding that each client may require a different frequency of communication and outreach.

BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Efforts to support participants include additional trainings, completing the Compass-EZ assessment, and inviting SUD programs and strengths-based case management programs to present to BHConnect staff. Staff also recommended including a screening tool for assessing client needs prior to admission to BHConnect.

The accessibility of BHConnect staff and services was seen as a positive feature of the program.

Experiences with Telehealth Services

Technical difficulties with both the telehealth platform and devices were reported as the most common difficulties when attempting to provide telehealth with video services. BHConnect staff recommended incorporating the development of an alternative contact method during the screening process, so that

providers and clients would have a back-up method of communication should disruption occur during a session.

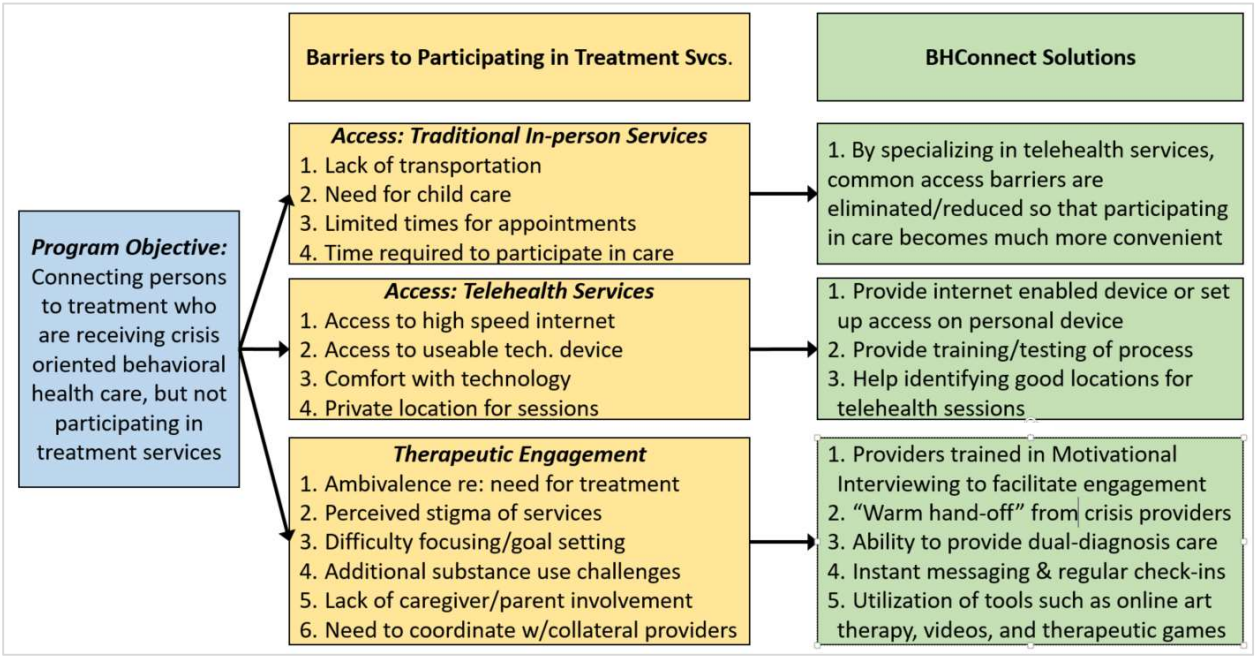
Impact of COVID-19 on BHConnect Staff

Staff reported productivity and communication as the primary issues impacted by COVID-19. BHConnect staff report utilizing routine schedules, exercise, and opportunities to be outdoors as ways to manage or reduce COVID-19-related stress or anxiety.

BHConnect Strategies to Connect Persons to Telehealth Care

Based on feedback from BHConnect staff and participants, the following model (as shown in Figure 1) was developed to summarize and illustrate both the common barriers experienced when attempting to connect people to needed behavioral health treatment services and the strategies that BHConnect has successfully implemented to facilitate connection to ongoing care.

Figure 1. Summary of BHConnect Strategies to Connect Persons to Ongoing Telehealth Care



The barriers for connecting to care are conceptually split into two domains pertaining to factors that affect 1) treatment "access" and 2) treatment "engagement" as they represent related, but distinct aspects of maintaining participation in treatment services. Access was separated between in-person services and telehealth services to identify the unique challenges relevant to each type of treatment modality. Key barriers for participating in traditional in-person services include transportation, need for child care, difficulty finding a time to match availability of service provider, and the overall time commitment needed to attend an in-person treatment session on a regular basis. Given the telehealth orientation of BHConnect, all these barriers are either eliminated or substantially reduced.

Participating in telehealth services has its own unique access barriers such as the need for sufficient quality internet capable of video-based communication, having a device that can access telehealth services, being comfortable navigating the device and initiating telehealth sessions, as well as needing to

find an appropriate space that allows for private, focused conversations. BHConnect has had success addressing these telehealth access barriers by providing clients with internet enabled devices and offering clients the option of setting up the connection to BHConnect telehealth services on clients' own personal device (i.e., personal smartphone). Additionally, BHConnect has identified the importance of providing training and support to clients so they can practice using their device to access services and prepare for how to have successful sessions such as finding appropriate locations that are quiet and private (e.g., an empty bedroom, their car, or an outside location).

Mostly independent of the access barriers, the extent to which clients engage in the therapeutic process also affects ongoing connection to services and the potential to receive the benefits of participating in services. Common engagement barriers to telehealth services seen in BHConnect clients include ambivalence to participating in services, resistance to services due to perceived stigma of engaging in behavioral health care, difficulty focusing on treatment objectives, particularly if mental health is substantially impaired or if there are other substance use issues present. For youth clients, the extent to which caregiver/parents are invested in supporting the process is critical, as is the ability to coordinate and communicate with other collateral providers (e.g., primary care doctors, social service providers). BHConnect team members focus on quickly building a positive rapport with clients and are trained in Motivational Interviewing techniques, an evidence-based practice to encourage treatment engagement. The telehealth-based orientation of the BHConnect program supports flexibility so that clinicians and other team members can engage with clients at convenient times when they are more open to receiving care. The online, telehealth approach also facilitates regular communication such as "messaging" to maintain brief interactions with clients and send reminders for upcoming treatment sessions. To promote engagement and retention in services, the BHConnect team also incorporates other tools to connect with participants such as online art therapy, watching and sharing appropriate informational and discussion videos, and engaging in therapeutic online games.

Overall, the experiences with the BHConnect program demonstrated that it was possible to eliminate or greatly reduce barriers for accessing behavioral health treatment by providing services in a convenient, telehealth-based approach, as long as specific attention is devoted to addressing access barriers unique to this form of treatment modality. Additionally, BHConnect has developed and continues to refine strategies to promote ongoing engagement in treatment services once the initial access barriers have been addressed. However, there will be some persons for whom a telehealth-based approach may not be the appropriate strategy given ongoing difficulty utilizing the device (e.g., frequently forgetting to charge device and not having regular capability to do so) or challenges maintaining focus and developing relationship via the device. BHConnect will continue to innovate and adapt in their effort to meet the needs of as many persons as possible and then facilitate connection to other forms of treatment services if it is determined that telehealth is not the optimal modality for providing care.

BHConnect Participant Feedback

During June of 2021, BHConnect providers asked participants to engage in a short qualitative survey to elicit feedback on the program. Clients were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with BHConnect leadership and BHS input. Providers were given a short script explaining the qualitative data collection process, and explained the feedback was completely voluntary and would not impact participation in the program. Of the 38 clients invited to participate, 21

agreed and 17 declined for a response rate of 55%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of BHConnect participant population. From the collected data, the following themes emerged:

Referrals from familiar sources helped clients to feel comfortable engaging in BHConnect services

1. "With the Rady's Children Hospital connection I was more confident in the program."
2. "I was just coming out of a mental hospital and they gave me your contact info for support with outpatient programs."

Clients appreciated the ease of referral and availability of appointments

1. "We were desperate to enroll him in therapy and it seemed that you guys could get him in quickly."
2. "Never had a therapist that genuinely cares about her clients and it is easier to get a hold of the therapist when you are in need."

BHConnect clients appreciated BHConnect staff

1. "More comfortable because the therapist is approachable and openness in services and topics and resisted therapy but has grown from therapy."
2. "There [sic] super friendly and welcome you with open arms."
3. "I needed someone to talk other than family, I needed a professional."

Clients enjoyed being able to access BHConnect services at home

1. "The convenience and comfort of being in our home."
2. "She likes that she doesn't have to leave the house and I like that I don't have to travel."
3. "Having access to a person from my home."

Changes from Initial Program Design

During FY 2020-21 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. During FY 2020-21, 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.

A substantial programmatic change that occurred during FY 2020-21 was the decision to phase out the subcontract with WHH and shift those outreach, engagement, and scheduling responsibilities directly to BHConnect staff, particularly the Field Health Navigator. This decision was made to facilitate communication and coordination between all members of the BHConnect team and the clients and to minimize confusion on the part of clients by having a separate entity (i.e., WHH) also involved in their care services. To promote engagement and maintain the 24/7 availability previously provided by WHH, the BHConnect program established an Access Line that was pre-programmed into the client's phone and monitored 24/7. After-hours calls were answered by specially trained medical answering service personnel who can either triage for immediate crisis care or deliver messages to the BHConnect team for less urgent matters. Clients who were issued a BHConnect device (rather than using personal phone) could confidentially message their therapist and Field Health Navigator during business hours. Additionally, the

Field Health Navigator and therapists offered services on evenings and weekends to better match the availability of clients and reduce overall burdens for engaging in BHConnect services. The transition away from WHH occurred near the end of FY 2020-21, so the implications for service delivery will be examined throughout FY 2021-22.

Program Recommendations

1. Continue to diversify referral sources to increase referrals for youth, adult, and geriatric patients. In particular, expand referral sources to include adult crisis centers throughout all regions of San Diego, and add PERT and CPS as approved referral partners.
2. Maintain ongoing and close relations with hospitals to potentially provide more integrated care, with on-site onboardings/warm hand-offs, and inevitably, more continuity of care and engagement with BHConnect services.
3. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care.
4. Continue collaborating with psychiatry providers and primary care providers to provide coordinated, integrated care, and to assist clients in navigating the healthcare system for improved mental health outcomes.
5. Consider adding in-house psychiatry services or identifying a community partner to help meet the medication management needs for adults.
6. Increase San Diego Change Agents Developing Recovery Excellence (CADRE) and co-occurring capability through incorporating this integrated approach in program literature (website and brochure), clinical approach, and to always consider modifications to the clinical staff annual training plan to include trainings such as “Harm Reduction.”
7. Continue to provide clinical support and training to all staff so that they can feel effective and productive in their role.
8. Refine screening process and explore best practices to increase client engagement from the moment referral is received.
9. Provide in-home services when clinically indicated to further engage clients in treatment.

Conclusion

During FY 2020-21, BHConnect enrolled 89 persons (71 youth and 18 adults), successfully increasing the number of people engaged in the program as compared to the 54 persons (37 youth and 17 adults) enrolled during FY 2019-20. The number of services provided also substantially increased with youth receiving an average of 16 services (as compared to an average 9.6 services in FY 2019-20) and adults receiving an average of 15.3 services (as compared to an average 11.8 services in FY 2019-20). The increase in enrollees and provided services is a program success likely due in part to the program entering their second full year of operations and overcoming startup challenges.

Challenges still remain for providing BHConnect services because even though the program has grown, enrollment remained below initial expectations. Staff reported a lack of referrals as one of the main barriers to achieving enrollment goals. BHConnect received a total of 169 referrals (131 CYF clients and 37 AOA clients) during FY 2020-21. Rady Children’s Hospital Urgent Care was the primary referral source

with 113 referrals. Overall, approximately 55% of CYF and AOA referrals enrolled in BHConnect with 20% declining services and 25% lost to contact.

Services provided by BHConnect include psychosocial assessments, treatment plans, therapy, case management and mental health rehabilitation. Out of all the enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians. 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 06/30/2021, youth had a median enrollment duration of 143 days and adults had a median enrollment duration of 208 days. Preliminary findings suggest that participation in BHConnect services was associated with a reduction in the need for crises and acute care services.

BHConnect provided essential behavioral health services for both youth and adults as indicated by the CANS, PSC, RMQ, and IMR assessments. A comparison between baseline and follow-up CANS and PSC assessments for youth shows significant reductions (i.e., improvements) in behavioral and emotional needs, life functioning, risk behaviors, and clinical concern. Of the children and youth served by BHConnect, 60-65% experienced at least one reduction in a need item identified during the initial assessment. Alternatively, some youth showed an increase in impairment between their baseline PSC and follow-up. This same increase is also seen in the overall CYF BHS system and is indicative of the substantial variability of behavioral health needs and changes within this population. Similarly to the youth, a comparison of the RMQ and IMR assessments for adults showed improvements in the desired direction, but unlike the youth, the changes were not statistically significant.

Overall, BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2020-21; however, a primary challenge for BHConnect was the difficulty generating the desired number of client referrals from other crisis-oriented mental health service provider organizations. The decision to move away from the WHH platform has implications for changing the roles and responsibilities of BHConnect team members, particularly the Field Health Navigators. This change is expected to create improved communication and coordination with BHConnect clients and additional opportunities for BHConnect staff to encourage and support ongoing engagement with treatment services.

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 2020-21

Characteristic	Child/Youth (N=71)		Adult (N=18)	
Gender	N	%	N	%
Male	20	28.2%	4	22.2%
Female	46	64.8%	14	77.8%
Another gender identity	5	7.0%	-	-
Total	71	100%	18	100%
Primary Language	N	%	N	%
English	67	94.4%	18	100%
Other	4	5.6%	-	-
Total	71	100%	18	100%
Race/Ethnicity	N	%	N	%
African American	9	12.7%	-	-
Hispanic/Latino	28	39.4%	2	11.1%
Caucasian/White	35	49.3%	6	33.3%
Multi-racial	14	19.7%	-	-
Asian	7	9.9%	-	-
Other	5	4.9%	2	11.1%
Missing/Unknown	5	4.9%	10	50.0%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	48	67.6%	9	50.0%
Another sexual orientation	6	8.5%	-	-
Prefer Not to Answer/Missing	17	23.9%	9	50.0%
Total	71	100%	18	100%
Disability[2]				
Has a disability	14	19.7%	-	-
Does not have a disability	52	73.2%	-	-
Declined/Preferred not to answer	5	7.0%	-	-
Total	71	100%	-	-

Characteristic	Child/Youth (N=71)		Characteristic	Adult (N=18)	
Age Group	N	%	Age Group	N	%
5 to 14	43	60.6%	18 to 25	4	22.2%
15 to 18	28	39.4%	26 to 65 (or older)	14	77.8%
Total	71	100%	Total	18	100%

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*

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

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Annual Report
Year 3 (7/1/2020 - 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES
AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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 Roaming Outpatient Access Mobile (ROAM) program was designed to increase access to and utilization of culturally competent mental health services in rural American Indian populations to decrease the effects of untreated mental health and co-occurring 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 typically 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 throughout fiscal year (FY) 2020-21 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 for FY 2020-21

1. During FY 2020-21 more persons participated in ROAM services (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY 2019-20) and total services provided increased substantially (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20).
2. Of those persons for whom initial and follow-up data were available, PHQ-9 and MORS scores improved at follow-up assessment indicating a reduction in depression symptoms and improved recovery and management of symptoms.
3. Participants 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.
4. COVID-19 initially prevented use of the mobile health units, but during FY 2020-21 both ROAM programs used their mobile health units to distribute COVID-19 vaccines, help with promoting awareness of the ROAM program and behavioral health more generally, and SIHC restarted regular provision of ROAM services on the mobile health unit.

5. 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.
6. Tribal, organizational, and program efforts were important for increasing the capacity to provide telehealth with video behavioral health services in Native communities.
7. 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.
8. Challenges remain for providing telehealth services throughout remote regions; however, additional infrastructure investments are expected to continue during FY 2021-22 that should expand opportunities to provide telehealth services, especially in areas served by IHC ROAM.
9. ROAM services were utilized to help address COVID-19 by providing education, testing, and vaccinations, particularly to those living in remote areas with limited access to those resources.

Conclusion

Collectively, IHC and SIHC ROAM programs substantially increased the number of people enrolled in the program (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY 2019-20) and the amount of ROAM services provided (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20). The ROAM services were particularly important as persons eligible for ROAM typically have barriers that inhibit participating in standard clinic-based outpatient behavioral health treatment.

ROAM provided essential behavioral health services as indicated by baseline PHQ-9 and MORS scores showing many persons in the service population experienced mild/moderate depression or were not coping well with their mental health symptoms. When measured again at follow-up, there was a reduction in depression symptoms and improved recovery and management of symptoms. In addition to providing needed behavioral health services, ROAM was able to help address COVID-19 through education, testing, and vaccinations. While challenges remain for providing telehealth services throughout remote regions, the importance of tribal, organizational, and program efforts to reach Native communities and provide services has become even more apparent during FY 2020-21.

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. Unfortunately, due to the pandemic and safety concerns, the mobile health unit was not able to deliver services consistently and contributed to the low utilization of in-person visits during FY 2020-21. However, the program's efforts at location and modality flexibility were substantial with approximately two-thirds of ROAM services provided to participants who were in their home (i.e., via phone or telehealth), with 62.1% of services at IHC provided via telephone and 57% of services at SIHC provided via telehealth.

A key factor allowing SIHC ROAM to provide more telehealth services was the additional infrastructure and organizational technical support to increase access to the internet that could support video telehealth interactions. Additional infrastructure investments are expected during FY 2021-22 that will increase the capabilities of the ROAM programs, particularly IHC, to offer telehealth services to persons in certain areas where that is not currently feasible.

Overall, the ROAM programs successfully served as a link between the clinical setting and their local communities to facilitate access to services and improve the cultural competence of service delivery for

persons who likely would not have received needed care. Both programs are continuing to plan for how best to utilize the mobile health units and improve their capabilities to provide telehealth services during FY 2021-22.

Primary Recommendations for FY 2021-22

1. Continue to identify and address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
2. Develop and refine plans for how best to provide "hybrid" behavioral health care services that integrate in-person and remote service provision to keep participants engaged and benefiting from services.
3. Increase ROAM's participation in large-scale community outreach events to educate the community about behavioral health and physical health challenges as well as promote ROAM services as an option for those tribal and community members who cannot easily access services at the clinic.
4. Increase the number of psychoeducation events at local community centers with both community members and community center staff.
5. Increase group-oriented services within SIHC ROAM to facilitate community building and increase ROAM's impact.

Program Description

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) ROAM program is funded through the Innovations (INN) component of the Mental Health Services Act. ROAM was developed to provide fully mobile mental health clinics to American Indians of all ages in the North Inland and East County regions of San Diego. The ROAM teams at both IHC and SIHC included licensed therapists and psychiatrists, and the IHC ROAM team also included a licensed substance use disorder (SUD) counselor. The majority of ROAM staff at both IHC and SIHC identified as American Indians. This representative staffing is part of an effort to provide culturally competent services that are sensitive to the needs of American Indians.

Efforts by ROAM are 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 is whether barriers are identified that would inhibit participation in standard clinic-based outpatient behavioral health care services. ROAM services aim to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. Each ROAM team is staffed with culturally competent licensed and unlicensed professionals who can provide a variety of care services. In addition, the ROAM program will use telehealth for addressing ongoing mental health needs to decrease burdens for accessing needed services. The usage of telehealth in conjunction with, rather than in lieu of, face-to-face services was expected to be a key factor in minimizing barriers to treatment and furthering mental health engagement. To facilitate better access to care services, the program will provide at least some night and/or weekend services to better match availability of participants.

The ROAM program staff are also expected to participate in community events and meetings to provide education about behavioral health issues, reduce stigma often associated with behavioral health concerns, and make the community aware of ROAM services.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members resulted in a substantial reliance upon remote work and remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to and greater utilization of telehealth service delivery approaches.

For the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the initial suspension of all in-person service provision, except for crisis situations. During FY 2020-21, both ROAM programs resumed offering in-person services when community conditions, such as the relative prevalence of COVID-19 cases, allowed. Where feasible and appropriate, in-person visits were conducted in a manner to promote safety of ROAM staff and participants such as by conducting the visit outdoors and/or maintaining other safety protocols such as wearing masks and distancing. The ongoing effects of the COVID-19 pandemic throughout FY 2020-21 and associated concerns for safety inhibited the consistent use of the MHU for the delivery of mental health services. However, as described in more detail below, the MHUs were utilized to extend efforts to address COVID-19 by providing testing and vaccinations (when they became available in the fall of 2020) to persons living in remote areas. Both IHC and SIHC relied extensively on providing ROAM behavioral health services remotely using telephone and telehealth (i.e., video) technologies.

While the initial design of the ROAM program anticipated and encouraged providing services remotely as a way of increasing service accessibility, the impact of COVID-19 throughout FY 2020-21 also likely contributed to the low utilization of in-person visits. 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 methods of communication (e.g., in-person, phone, or telehealth with video) to meet the engagement preferences of ROAM participants. A more detailed discussion of the experience with telehealth services is provided below.

The COVID-19 pandemic also limited the ability of the ROAM programs to be involved in more large-scale outreach events during FY 2020-21 as almost all annual in-person tribal gatherings were canceled due to safety concerns. Among the events which ROAM program staff would typically participate in would be

Pow Wows, tribal gatherings, health fairs, wellness events and Native youth conferences. ROAM anticipates a return to more in-person community outreach events during FY 2021-22 to allow for more community education regarding mental health awareness and the opportunity to engage in services provided by ROAM.

Where relevant, findings and recommendations in this report indicate aspects potentially related to the unique challenges that COVID-19 posed within the local community and health care environment throughout FY 2020-21.

Participant Characteristics

A brief overview of the ROAM participant characteristics is presented here with a more complete listing found in the report appendix. In general, the characteristics of the enrollees in the respective ROAM programs were similar. A total of 323 persons received at least one ROAM service during FY 2020-21 (80 from IHC and 243 from SIHC). Of the 198 participants who entered the ROAM program during FY 2020-21 (40 from IHC and 158 from SIHC), the majority (53.0%) identified as female, spoke English (98.0%) and indicated their race/ethnicity to be American Indian (78.3%). Approximately one-quarter (22.7%) of ROAM participants indicated having a disability that was not the result of a serious mental illness (SMI) with 18.2% indicating their disability was a chronic health condition. One area in which the two programs differed in the composition of their new ROAM enrollees was that males comprised the majority of IHC enrollees (70.0%), but only 40.5% of enrollees at SIHC. Additionally, a larger proportion of new enrollees at SIHC were children or youth (26.0% at SIHC as compared with 10.0% at IHC).

Utilization of Program Services

ROAM Behavioral Health Service Provision

During FY 2020-21 there were 80 persons active in IHC ROAM who received a total of 1,070 services (average of 13.4 services per person) and 243 persons active in SIHC ROAM who received a total of 1,782 services (average of 7.3 services per person). As shown in Table 1, one key area of difference between the two programs was the provision of substance abuse counseling, with over half (66.3%) of IHC participants receiving at least one such service compared to the 2.5% of SIHC participants. This difference reflects the composition of the respective ROAM teams at IHC and SIHC 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 (52.7%) as compared to IHC (22.5%) due to the direct involvement of a psychiatrist on the SIHC ROAM team.

Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (43.8% and 44.9%, respectively), however psychoeducation was more prevalent among IHC participants (26.3% and 13.2%, respectively). While there were some differences between the IHC and SIHC programs, most notably 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 1. Number and Type of ROAM Service Contact by Program

	IHC				SIHC			
	Total persons (N=80)		Total services (N=1,070)		Total persons (N=243)		Total services (N=1,782)	
	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	27	33.8%	32	3.0%	142	58.4%	179	10.0%
Psychoeducation: Individual	21	26.3%	123	11.5%	32	13.2%	182	10.2%
Psychoeducation: Group	<5	<6.2%	<5	<0.5%	0	-	0	-
Therapy-Cognitive Behavioral: Individual	35	43.8%	376	35.1%	109	44.9%	942	52.9%
Therapy-Cognitive Behavioral: Group	0	-	0	-	<5	<2.1%	<5	<0.4%
Therapy-Trauma Informed: Individual	18	22.5%	135	12.6%	39	16.0%	182	10.2%
Therapy-Family Involved	0	-	0	-	29	11.9%	97	5.4%
Substance Abuse Counseling	53	66.3%	471	44.0%	6	2.5%	19	1.1%
Referral to Substance Abuse Counseling	<5	<6.2%	<5	<0.5%	<5	<2.1%	<5	<0.4%
Case Management	<5	<6.2%	<5	<0.5%	56	23.0%	121	6.8%
Medication Management	18	22.5%	73	6.8%	128	52.7%	545	30.6%
Traditional Healing-BH related	<5	<6.2%	<5	<0.5%	0	-	0	-
MAT	0	-	0	-	24	9.9%	113	6.3%

The wide range of service activities provided by both ROAM programs were delivered either in person, over the phone, or via telehealth. As shown in Table 2, the majority of services were provided remotely. At IHC 62.1% of the service contacts were provided via telephone whereas most services provided by SIHC were via telehealth (57.0%). While both programs provided at least some in-person services during FY 2020-21, demand for in-person service delivery was likely diminished due to the ongoing effects of the COVID-19 pandemic.

Table 2. Method of Contact

	IHC		SIHC	
Contact Type	**N**	**%**	**N**	**%**
In Person	345	32.2%	260	14.6%
Telehealth	59	5.5%	1,016	57.0%
Telephone	664	62.1%	508	28.5%
Other	2	0.2%	3	0.2%

The difference between IHC and SIHC utilization of telehealth services (5.5% and 57.0% of ROAM services, respectively), reflected the challenges that IHC experienced during FY 2020-21 with attempting to offer such services. A primary factor that limited the use of telehealth services at IHC was that many persons 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 video/audio distortions interfered with the ability to consistently engage in the therapeutic discussions needed by the ROAM participants. This prompted a greater reliance on delivering services via phone. Additional difficulties emerged during portions of FY 2020-21 with integrating IHC information technology systems and the virtual platforms needed to securely conduct telehealth sessions. The information technology systems issues were resolved at IHC and new community-wide infrastructure investments that will enhance the capability to provide telehealth services are expected during FY 2021-22. These factors should contribute to greater utilization of telehealth services at IHC in future years.

Since many services were provided remotely, this allowed participants more flexibility regarding where they were located when receiving ROAM services. While approximately two-thirds of ROAM services were provided while the participant was at home (i.e., via phone or telehealth), other common locations for participants included: 1) the home of friend/family member, 2) in a car, 3) at work, or 4) while located 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 during FY 2020-21. However, 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 well-validated, brief tool for identifying depression. The two-item PHQ-2 is often used as a depression screener while the PHQ-9 is used for a more complete assessment of depression symptoms. As shown in Table 3, a total of 32 persons at IHC and 41 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM and at least one FY 2020-21 follow-up assessment. The average intake PHQ-9 scores were 10.4 and 11.9 for IHC and SIHC participants, respectively, indicating moderate depression at initial assessment. However, there was substantial variability in the initial PHQ-9 scores with approximately 45% of participants from both programs who completed initial and follow-up PHQ-9 assessments demonstrating symptoms of a likely depressive disorder.

Both ROAM programs showed a decrease in depression symptoms between their participants' initial and last PHQ-9 assessment, with SIHC showing statistically significant decreases. Likewise, the percentage of persons exhibiting signs of likely depressive disorder reduced substantially for both programs. At IHC, 14 people (43.8%) qualified at their initial assessment as likely having a depressive disorder, whereas at their last follow-up assessment that number decreased to 10 people (31.2%). Similarly, for SIHC, 20 people (48.8%) qualified for a depressive disorder at their initial assessments, which decreased to 9 people (22.0%), at their last available follow-up assessment.

Table 3. Change in PHQ-9 Scores from Initial Assessment to Last Follow-up Assessment

	IHC (N=32)			SIHC (N=41)		
(Note: higher value = worse condition; scale of 0 to 3 that corresponds to "not at all" to "nearly every day" over the past few weeks)		**Initial PHQ-9**	**Last available PHQ-9**		**Initial PHQ-9**	**Last available PHQ-9**
PHQ-9 Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
1. Little interest or pleasure in doing things	32	1.2	1.1	41	1.6	0.8**
2. Feeling down, depressed, or hopeless	32	1.5	1.1	39	1.5	0.8**
3. Trouble falling or staying asleep, or sleeping too much	32	1.6	1.2	41	1.8	1.3*
4. Feeling tired or having little energy	32	1.4	1.4	41	1.8	1.4*
5. Poor appetite, weight loss, or overeating	32	1.2	0.8	41	1.1	0.6*
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	32	1.2	0.8	41	1.4	1.0*
7. Trouble concentrating on things, such as reading the newspaper or watching television	32	1.3	0.8	41	1.6	1.1*
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	32	0.8	0.5	41	0.7	0.3*
9. Thoughts that you would be better off dead, or of hurting yourself in some way	32	0.2	0.2	41	0.4	0.1*
PHQ-9 Total Score	**32**	**10.4**	**7.9**	**41**	**11.9**	**7.5****
Likely Depressive Disorder (i.e., at least 4 items scoring 2 or 3)	**-**	**14 (43.8%)**	**10 (31.2%)**	**-**	**20 (48.8%)**	**9 (22.0%)**

**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 4, there were 36 persons at IHC and 39 persons at SIHC who had a follow-up MORS completed during FY 2020-21 and an initial intake MORS from which to conduct a change assessment comparison. The average MORS score upon intake was nearly identical for IHC and SIHC (i.e., 5.3 and 5.2, 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 4. Change in MORS Scores from Initial Assessment to Last Follow-up Assessment

		IHC (N=36)				SIHC (N=39)			
		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	3	8.3%	2	5.6%	9	28.2%	3	7.7%
5	Not coping, engaged	19	52.8%	7	19.4%	12	30.8%	4	10.3%
6	Coping/rehabilitating	11	30.6%	19	52.8%	8	20.5%	16	41.0%
7-8	Early recovery; Advanced recovery	3	8.3%	8	22.2%	8	20.5%	16	41.0%
	Mean MORS	**5.3**		**6.0****		**5.2**		**6.2****	

***statistical significance at p < 0.01*

As of the last available follow-up assessment completed during FY 2020-21, the average MORS score increased for both IHC and SIHC participants. Scores were 6.0 and 6.2, 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

During June of 2021, 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

1. "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."
2. "I wouldn't be meeting with anyone. I have tried and it has not been good."
3. "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

1. "I heard from someone I know that you guys were doing telehealth."
2. "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."
3. "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

1. "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."
2. "I would add (additional medical) services and be more consistent… there are lots of ways to help the community out here."
3. "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

1. "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."
2. "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."
3. "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

1. "The fact that it is Native American culture, and plus you are on the reservation."
2. "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."
3. "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."

Additional Program Activities

Supporting Community Efforts to Address the COVID-19 Pandemic

In addition to providing mental health services, ROAM program resources, particularly at SIHC, were utilized to address the COVID-19 pandemic during FY 2020-21. SIHC utilized the ROAM program to assist with the goal of expanding COVID-19 testing and vaccination efforts to the local Native community. The ROAM RN provided COVID-related services at SIHC clinics, at large-scale community events, as well as by utilizing the ROAM MHU to extend outreach, education, and COVID-19 testing and vaccination services to those living in remote areas. A total of 1,523 COVID-19 vaccination doses were administered through SIHC ROAM during FY 2020-21. Additionally, the ROAM mobile unit at IHC was used to administer 1,148 COVID-19 vaccination doses throughout the community.

Reducing Opioid Overdose Risks in the Community

During FY 2020-21, SIHC ROAM led efforts to educate the community about Narcan use and distributed Narcan as an emergency treatment option in an effort to reduce the risk of opioid overdose deaths. To do this, ROAM used their network of tribal contacts to set up meetings with tribal leaders and hosted SIHC's Medication Assisted Treatment (MAT) nurse on the ROAM bus on select days throughout the month. Additionally, ROAM set up Narcan education courses for leaders at the community centers on the reservation and collaborated with the SIHC MAT nurse to provide education and distribute the Narcan. Narcan distribution and education efforts were conducted in response to concern from local law enforcement and health care organizations regarding the opioid crisis and overdose deaths on tribal lands.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ROAM Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ROAM, and the 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 FY 2020-21. 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. There were 14 respondents from the 14 IHC and SIHC ROAM staff invited to participate in the survey (i.e., a response rate of 100%). 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.

Community, Organizational, and Program Efforts to Support Telehealth

While telehealth was included as part of the original design of the ROAM programs, the emergence of the COVID-19 pandemic and the tribal, organizational, and ROAM program response to it substantially increased the capabilities and feasibility to provide a high level of these services. For example, during FY 2020-21, the majority of SIHC ROAM program services were provided using telehealth that allowed for video interaction between provider and participant (more than 1,000 telehealth service sessions). The

following were identified by the SIHC ROAM team as instrumental to support the widespread utilization of telehealth ROAM services:

1. **Community Efforts:**
    a. Where possible, local tribes provided cell phones, tablets, and upgrades on connectivity for tribal members.
2. **Organizational Efforts:**
    a. SIHC set up Wi-Fi zones at each clinic and in locations throughout the region such as at community centers.
    b. SIHC hired a part-time driver who drove hotspots and tablets to community members' homes on request.
    c. SIHC Information Technology (IT) department focused on thoroughly training SIHC staff to navigate OTTO Health (the virtual platform used by SIHC to deliver telehealth services), using collective learning sessions, supervisor learning sessions, helpful handouts, and consistent follow up conversations to troubleshoot challenges that emerged.
3. **ROAM Efforts:**
    a. ROAM clinicians educated clients at the start of each session about potential connectivity issues and established backup plans such as changing location, restarting the OTTO Health session, or if necessary, moving to phone if the telehealth session was disrupted.
    b. ROAM clinicians were flexible about appointment times and locations. When connectivity was disrupted, ROAM providers tried changing their location whenever possible such as moving from the bus to the clinic, or from the community center to SIHC's substance use center.

Favorable Staff Perspectives Regarding the Value of Remote Sessions

During FY 2020-21, 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, we found that most 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.

Staff Experiences with COVID and Telehealth Services

The COVID-19 pandemic had a substantial impact on the Native American communities served by ROAM. Community buildings were empty for much of the year, making outreach challenging. Contactless events made developing connections and relationships with community members and leaders even more challenging. In an attempt to address community needs due to the COVID-19 pandemic, many ROAM staff were reassigned to pandemic-related jobs, which decreased consistency and halted the process of building relationships with the community.

The flexibility afforded by telehealth has proven beneficial for ROAM staff but has also created challenges. Staff reported logistical challenges such as inadequate PPE, plastic barriers on the MHU, and difficulty finding privacy with clients as the greatest impacts of COVID-19 on their work. Other impacts include decreased in-person interaction, and a greater emphasis on telehealth and program flexibility. ROAM staff are conscientious of their need for self-care and reported several methods of ensuring they were attending to their own mental health needs during the pandemic, including an intentional self-care practice and dedicated time with friends and family. Compared to FY 2019-20, staff reported a decreasing sense that their work tasks and personal life were changed due to the pandemic. This is likely due, in part, to the "normalization" of new work activities and routines during the ongoing COVID-19 pandemic.

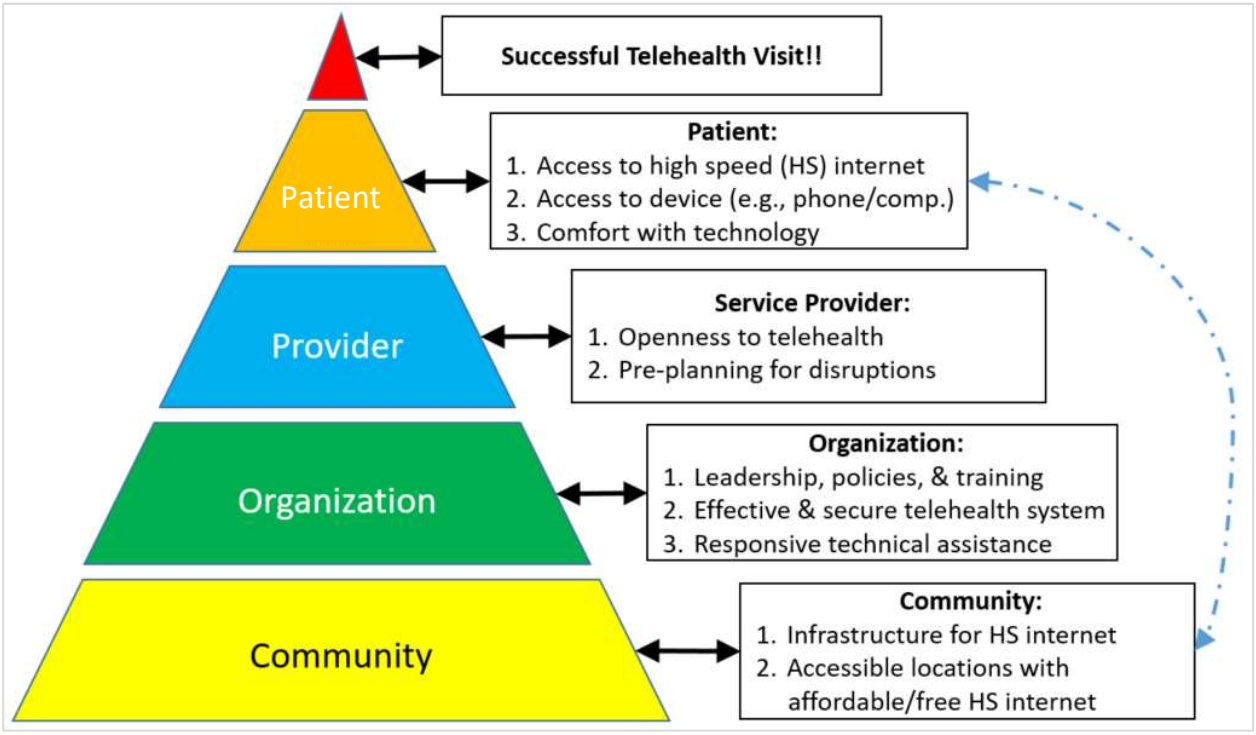
According to ROAM staff, as compared to FY 2019-20, more clients are expressing a preference for non-telehealth services as in-person services become more viable. While clients reported appreciating the flexibility of ROAM services, technological issues such as functional devices and appropriate internet services continue to be a barrier to telehealth for some clients living on reservations.

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 information technology infrastructure that can support telehealth services was not unique to the County of San Diego. ROAM program staff were 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 the 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 initially considered not part of standard practices; 2) the adoption of a telehealth platform that integrated well with clinic workflows and data systems; 3) and the importance of a responsive technical assistance team who can help with guiding providers through the telehealth platform and quickly ("real-time" is preferred) addressing questions and problems that arise when delivering telehealth care.

At the provider level, essential factors were 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 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 resources 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.

Outreach and Recruitment of ROAM Participants

ROAM staff indicated the following primary goals in the Annual Survey: increasing access to mental health care for historically underserved Native American populations, increasing engagement with local Native American communities, and addressing drug and alcohol use. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment, and more potential ROAM clients could be recruited using community/cultural events. Additionally, the flexibility and increased accessibility of the ROAM program were seen to be facilitating factors in reaching program goals. The following themes emerged from the qualitative data collection effort:

Staff are committed to the goals and mission of the ROAM program

1. "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."
2. "Our supervisor is very supportive and transparent, and I think this is super helpful."

Services flexibility

1. "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met."
2. "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."

Connection to the community and culture are a key component of ROAM services

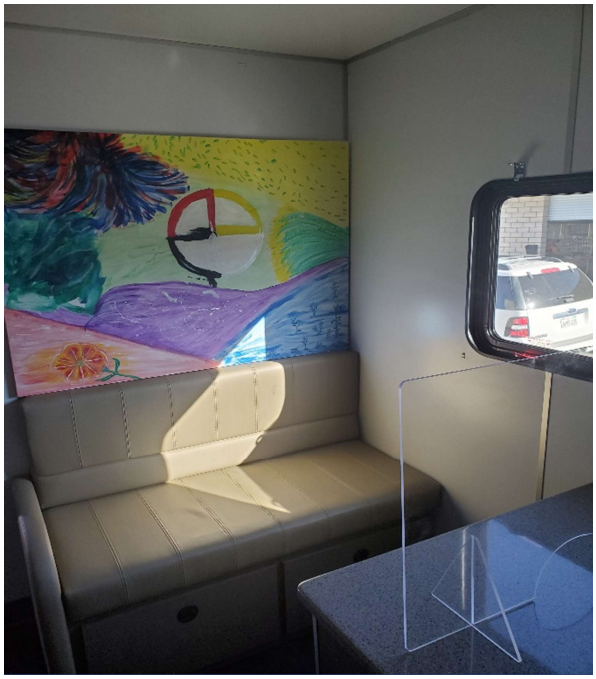
1. "The program spent the first year building relationships with community organizations on the reservation. This created an increased sense of trust with ROAM which led to more referrals and a greater confidence to seek treatment."
2. "[One factor that helped the ROAM program achieve its goals was] open conversation with the Tribal Councils about the availability of the services provided."

Role of Mobile Health Unit 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. A total of 65 persons (26.7% of

SIHC ROAM clients) received 299 SIHC ROAM services (16.8% of all SIHC ROAM services) via the ROAM mobile health unit. This allowed 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.

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

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.

MHU Flexibility is a strength of the ROAM program

1. "This program is excellent for the rural clients/patients without transportation. It aides in providing services in getting the much needed help for them."
2. "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."

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 has 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."

Program Recommendations

1. Continue to identify and address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
2. Develop and refine plans for how best to provide "hybrid" behavioral health care services that integrate in-person and remote service provision to keep participants engaged and benefiting from services.
3. Increase ROAM's participation in large-scale outreach events to educate the community about behavioral health and physical health challenges as well as promote ROAM services as an option for those tribal members who cannot easily access services at the clinic.
4. Increase the number of psychoeducation events at local community centers with both community members and community center staff.
5. Increase group-oriented services within SIHC ROAM to facilitate community building and increase ROAM's impact.

Conclusion

Both IHC and SIHC ROAM programs successfully implemented all their service approaches and substantially increased the number of people enrolled in the program (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY2019-20) and the quantity of services provided (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20). Enrollees were eligible to receive ROAM services because they had barriers that inhibited them from participating in standard clinic-based outpatient behavioral health treatment.

Behavioral health services provided by ROAM were necessary, as evidenced by baseline PHQ-9 and MORS scores showing many persons in the service population were experiencing mild/moderate depression or were not coping well with their mental health symptoms. When measured again at follow-up, there was a reduction in depression symptoms and improved recovery and management of symptoms. In addition to providing needed behavioral health services, ROAM was able to help address COVID-19 through education, testing, and vaccinations. While challenges remain for providing telehealth services throughout remote areas, the importance of tribal, organizational, and program efforts to reach Native communities and provide services has become even more apparent during FY 2020-21. Feedback from ROAM staff and participants indicated that when technologically feasible (e.g., having sufficient internet connectivity and a convenient device), telehealth with video was viewed positively as a method to provide behavioral health services due to convenience and privacy.

ROAM was designed to provide expanded access to care through two primary mechanisms: 1) a mobile health unit that would bring behavioral health care teams to remote areas of San Diego County with limited availability of behavioral health care services, and 2) expanded use of telehealth and telepsychiatry to connect behavioral health professionals with persons who need services via telephone and video sessions. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services, stating that without the program they likely would not be

in therapy. Unfortunately, due to the pandemic and safety concerns, the MHU was not able to deliver services consistently and contributed to the low utilization of in-person visits. However, the program's efforts at location and modality flexibility were not lost; approximately two-thirds of ROAM services were provided while the participant was at home (i.e., via phone or telehealth), with 62.1% of services at IHC provided via telephone and 57% of services at SIHC provided via telehealth. A key factor for allowing SIHC ROAM to provide more telehealth services was the additional infrastructure and organizational technical support to increase access to the internet that could support video telehealth interactions. Additional infrastructure investments are expected during FY 2021-22 that will increase the capabilities of the ROAM programs, particularly IHC, to offer telehealth services to persons in areas where that is not currently feasible.

Overall, the ROAM programs successfully served as a link between the clinical setting and their local communities to facilitate access to services and improve the cultural competence of service delivery for persons who likely would not have received needed care. Both programs are continuing to plan for how best to utilize the mobile health units and improve their capabilities to provide telehealth services during FY 2021-22.

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 2020-21

Characteristic	Total Participants (N=198)	
Gender	N	%
Male	92	46.5%
Female	105	53.0%
Missing/Prefer not to answer	1	0.5%
Total	198	100%
Age Group	N	%
<16	14	7.1%
16-25	31	15.7%
26-45	87	43.9%
46-65	51	25.8%
>65	15	7.6%
Total	198	100%
Primary Language	N	%
English	194	98.0%
Missing/Prefer not to answer	4	2.0%
Total	198	100%
Race/Ethnicity	N	%
American Indian	155	78.3%
Latino	13	6.6%
Caucasian	30	15.2%
Multi-racial	9	4.5%
Other	5	2.5%
Missing/Prefer not to answer	4	2.0%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	88	52.5%
Gay/Lesbian/Bisexual/Pansexual	6	3.0%
Missing/Prefer not to answer	104	44.5%
Total	198	100%
Military Status	N	%
Never served in the military	189	95.5%
Other/Missing/Prefer not to answer	9	4.5%
Total	198	100%

Characteristic	Total Participants (N=198)	
Disability	**N**	**%**
Yes, Has a disability	45	22.7%
No, Does not have a disability	146	73.7%
Declined/Preferred not to answer	7	3.6%
Total	198	100%
Type of Disability	**N**	**%**
Learning/Developmental/Other Mental	7	3.5%
Physical	8	4.0%
Chronic Health	36	18.2%
Total[2]	-	-

[1] Total may exceed 100% since more than one race/ethnicity could be selected.
[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 3 (7/01/2020-6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES
AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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 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.

As a residential program serving a population at considerable risk for exposure to disease (i.e., homeless youth), JBU staff maintained in-person operations throughout the COVID-19 pandemic by implementing CDC and San Diego County public health guidelines. While JBU's residential component continued without interruption, the availability of holistic services was more limited during fiscal year (FY) 2020-21 except those that could be socially distanced or completed via remote technologies, and community-based educational and enrichment events shifted to primarily outdoor, nature-based activities (e.g., hiking, trips to beach, etc.).

Primary Findings for FY 2020-21

1. To help expand enrollment, Behavioral Health Services (BHS) approved JBU to accept referrals from other service provider organizations for youth who met the core eligibility criteria. Previously, only youth identified by BHS as potentially eligible based upon their service utilization patterns of receiving in-crisis services while not connected to treatment could enroll in JBU.
2. During FY 2020-21, JBU staff were able to successfully locate and contact 50.4% (n=113) of the 224 potentially eligible TAY and enrolled approximately 80% (n=45) of the youth determined to still be eligible for JBU services (i.e., not housed).
3. TAY with completed baseline and follow-up assessments demonstrated improvements across many domains including symptom management, recovery orientation, sense of well-being, and impairment due to substance use.
4. Occupational therapy (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 their goals. Initial outcome data indicate improvements in TAY capabilities to perform and derive satisfaction from completing desired tasks.
5. After participating in JBU, TAY typically increased their utilization of BHS outpatient and Assertive Community Team (ACT) program services as evidenced by approximately 70% of JBU youth connecting with outpatient mental health treatment services while enrolled in JBU and almost 30% receiving ACT services following discharge from the residential phase of JBU.
6. Participation in JBU was also associated with reduced need for crisis and acute care BHS services (i.e., crisis stabilization, urgent outpatient visits, and PERT interactions). Fewer youth accessed such services during the 180 days after JBU discharge as compared to the 180 days prior to enrolling in JBU.
7. The Photovoice Project generated youth feedback regarding their perceptions of the JBU program. Key emergent themes included the following: 1) Housing was the most important part of JBU, 2) JBU provided a sense of stability, 3) Community can be uncomfortable for JBU youth, but they recognize its importance, 4) A sense of control was important while youth work towards independence, and 5) Participation in JBU gets youth to independence faster than if they tried on their own.

Conclusion

Although the COVID-19 pandemic continued to disrupt normal operations during FY 2020-21, the JBU program provided residential care and support services to enrolled youth throughout the year while abiding by relevant safety protocols. In fact, no COVID-19 cases were identified among JBU youth. JBU expanded their services in FY 2020-21 to include comprehensive assessment and individualized goal planning with occupational therapists. These OT services provided another mechanism to engage with youth and help support efforts to improve wellbeing and facilitate connections to needed behavioral health care services.

JBU continued to demonstrate high levels of success creating linkages to other BHS treatment programs with approximately 70% of youth participating in outpatient care while enrolled in JBU and almost 30% transitioning into ACT programs after completing the residential phase of JBU. JBU has also established relationships with organizations that provide substance use disorder (SUD) treatment services as SUD remained a primary barrier to successfully achieving program objectives with JBU youth.

Primary Recommendations for FY 2021-22

1. Develop additional connections to outside providers for TAY-appropriate mental health care in the San Diego region.
2. Incorporate more intensive case management for JBU youth.
3. Evaluate opportunities for an increased transportation budget to mitigate the need for additional transportation assistance associated with moving the JBU program from downtown San Diego to a residential neighborhood.
4. Increase attention to post-discharge follow-ups.

Program Description

Using County of San Diego BHS Electronic Health Record (EHR) data, BHS personnel identify youth (age 18-25) who appear eligible for JBU services (i.e., multiple acute/crisis-related BHS service contacts, SMI diagnosis, and unconnected to behavioral health services) and who are 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 (i.e., multiple acute/crisis related BHS service contacts, SMI diagnosis, and unconnected to behavioral health services, all while experiencing homelessness or being at-risk of homelessness).

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, smart device-based apps and biometric technology, integrative medicine, and holistic health care in one central, urban 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 in central San Diego. 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 inappropriate 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

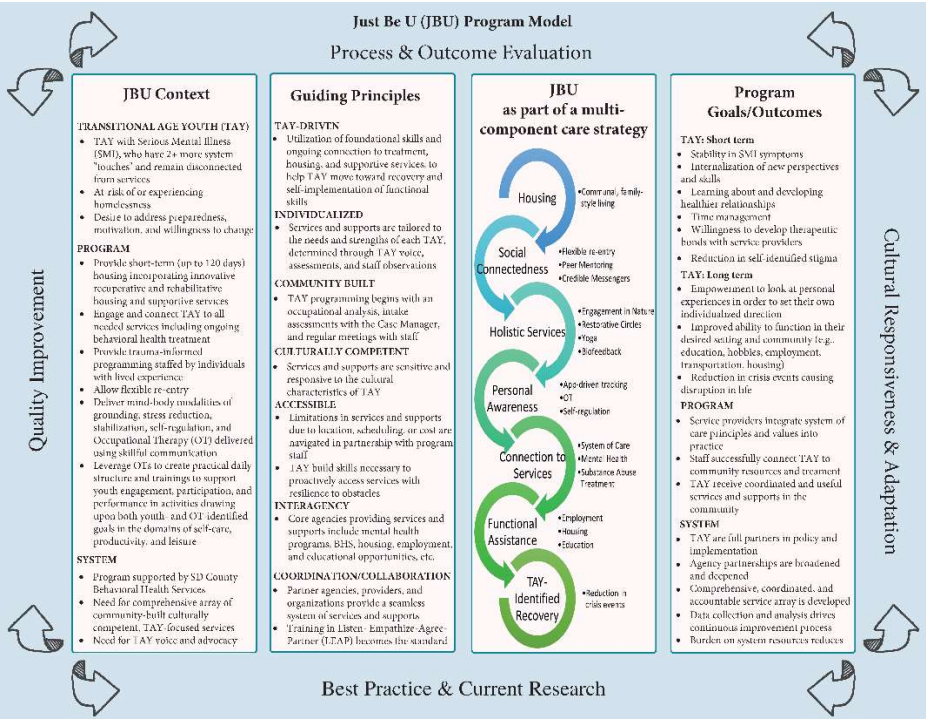
with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

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.

Program Model

Throughout FY 2020-21, the UCSD evaluation team, JBU leadership, and BHS County representatives met monthly to review JBU evaluation practices, get updates on the program, and better understand the general practice experiences of JBU as an innovative and evolving program. To define JBU's multi-faceted service approach more clearly within a broader strategy of care for these youth, the team endeavored to develop a JBU Program Model. Through these discussions a model was created in which JBU's context, guiding principles, role as a single component in a multi-component care strategy, and goals/outcomes were defined across multiple levels (individual, program, and system-based levels).

Figure 1. JBU Program Model



Understanding the complex context in which a program such as JBU operates is critical to understanding how improvements may be made and where successes are truly occurring.

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

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members, resulted in a substantial reliance upon remote work and remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

As a residential program serving homeless youth, a population at considerable risk for exposure to disease, JBU implemented a number of 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 the "stay-at-home" order to prevent opportunities for exposure. Of note, JBU's safety practices contributed to an environment in which there have been no identified COVID-19 cases. While the basic residential component continued without interruption, JBU suspended all 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 were more limited during FY 2020-21 due to COVID-19. Sessions with behavioral health providers (e.g., from Areta Crowell Center) continued, but were transitioned to telehealth platforms. JBU staff facilitated sessions by setting up a computer for private video sessions with therapists and other external service providers.

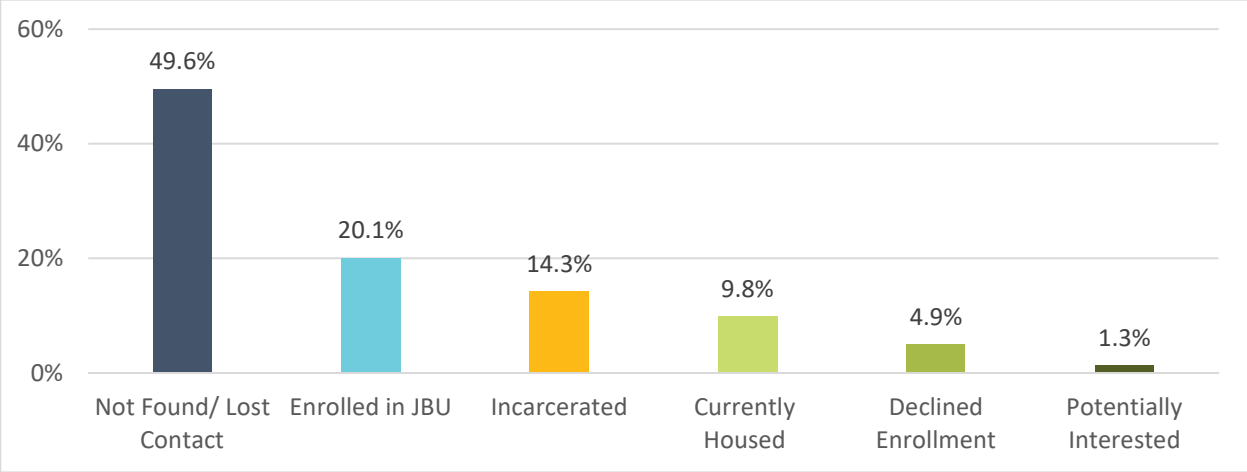
Where relevant, findings and recommendations in this report underscore issues potentially related to the unique challenges that COVID-19 poses within the local community and healthcare environment.

Program Outreach and Enrollment

Based on the BHS CO-19 report (i.e., a BHS listing of youth appearing to meet eligibility criteria) and the open referral sources, a roster of 224 individuals potentially eligible for JBU services was generated throughout FY 2020-21. Extensive efforts were made by JBU's Outreach Coordinator to locate and contact youth identified as eligible for JBU services. JBU works closely with a variety of individuals and organizations (e.g., PERT, parole officers, District Attorney's office, family members, etc.) to locate eligible JBU youth. However, despite these active outreach efforts, many youths identified by the CO-19 report cannot be located by the time JBU receives their names. Alerts may be listed in the BHS EHR for youth to indicate eligibility for JBU services while they access acute care services; however, these alerts are only visible if the staff at the hospital or other crisis facility access the BHS EHR, which may not occur prior to

the discharge of the youth. As shown in Figure 2, JBU outreach staff were unable to contact nearly half (49.6%; n= 111) of youth identified as eligible for JBU services. Another approximately 25% were ineligible for JBU due to either being incarcerated (14.3%; n=32) or having housing with family/friends/programs (9.8%; n=22) throughout FY 2020-21. Only 11 people (4.9%) indicated that they were not interested in JBU services while 45 youth (20.1%) agreed to enroll. This distribution of JBU outreach outcomes highlights: 1) the challenges of locating potentially eligible youth who frequently have transient living situations and limited options for establishing communication, 2) a relatively high proportion of potentially eligible youth who were unable to participate due to extended periods of incarceration (i.e., not just a few days or weeks), and 3) the high levels of interest in JBU participation (i.e., among youth who were contacted and determined to be eligible, only 18.6% declined JBU services).

Figure 2. Status of Potential JBU Youth According to Outreach Efforts during FY 2020-21 (N=224)

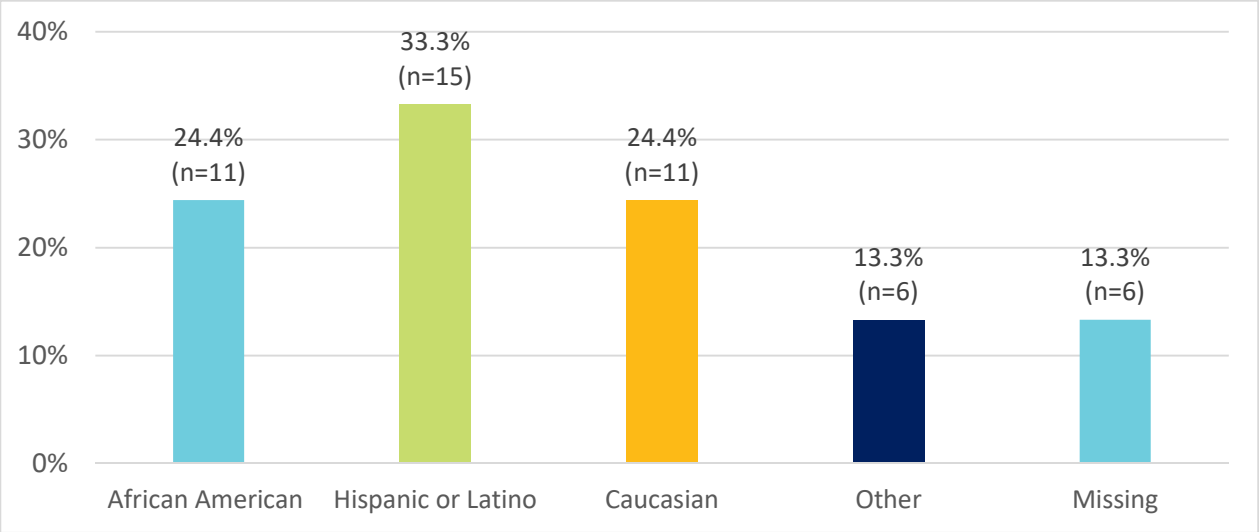


Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 45 youth enrolled during FY 2020-21, 15 originated from the BHS CO-19 report and 30 were from other referral sources. The demographic profiles were similar for both types of referrals. JBU program eligibility criteria required that participants are youth between the ages of 18 and 25. Of the 45 youth who enrolled in JBU during FY 2020-21, the majority (n=30; 66.7%) identified as male. Almost all JBU youth, 91.1% (n=41), spoke English as their primary language, and 64.4% (n=29) identified as heterosexual or straight, with 11.1% (n=5) identifying as bisexual, pansexual, or sexually fluid. None of the JBU youth indicated they had served in the military. The most common diagnoses for JBU youth included depressive disorders (n=16; 35.6%), schizophrenia/psychotic disorders (n=12; 26.7%) and bipolar disorders (n=10; 22.2%).

As shown in Figure 3, JBU youth were racially and ethnically diverse with no single population group representing more than 50% of the population. Approximately one-third identified as Hispanic or Latino (33.3%; n=15), followed equally by African American (24.4%; n=11) and Caucasian (24.4%; n=11).

Figure 3. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2020-21 (N=45)



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

Utilization of Program Services

Engagement in JBU Activities

Holistic Services

Throughout FY 2020-21, yoga and fitness classes were reduced to 1x per week and social distancing was applied. Attendance averages were 3-6 youth per class. Holistic services (e.g., chiropractic, acupuncture, massage) were suspended March 2020 through the beginning of FY 2021-21. Chiropractic and acupuncture services restarted September 2020. Massage services did not occur during FY 2020-21. Biofeedback was suspended indefinitely due limited availability of the practitioner and variable levels of participation by youth in this service activity.

Group Outings

JBU youth participated in one overnight trip to Harrison Serenity Ranch on Mount Palomar 10/21/20. Due to statewide shutdowns and stay at home orders, many indoor activities were no longer an option throughout much of FY 2020-21. As a result, JBU staff initiated more outdoor activities with youth such as group hikes at local trails, walks by the bay, and trips to local beaches.

Occupational Therapy at JBU

Throughout FY 2020-21 there were seven occupational therapy (OT) "interns" at JBU who were graduate students enrolled in both the master's and Doctorate programs in OT at the University of St. Augustine for Health Sciences, California campus. Collectively, they provided over 2,500 hours of service to the JBU program. The interns worked under the supervision of Dr. Bianca Doherty, the Director of Occupational Therapy, who was onsite at JBU a minimum of one day per week.

OTs developed an intervention plan to include 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.

Throughout a youth's time at JBU, 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, OT interns supported participation of JBU youth in program and organization-wide activities including Mental Health Awareness Month art activities, trips to Oasis Clubhouse for socialization, haircuts, etc., and a "mural project" in collaboration with Urban Beats at the downtown Urban Street Angels site location. This involved driving approximately six interested youth to the downtown site weekly for 5-6 weeks and supporting their participation in the mural project from design to implementation.

Key Evaluation Findings – BHS Outcome Measures

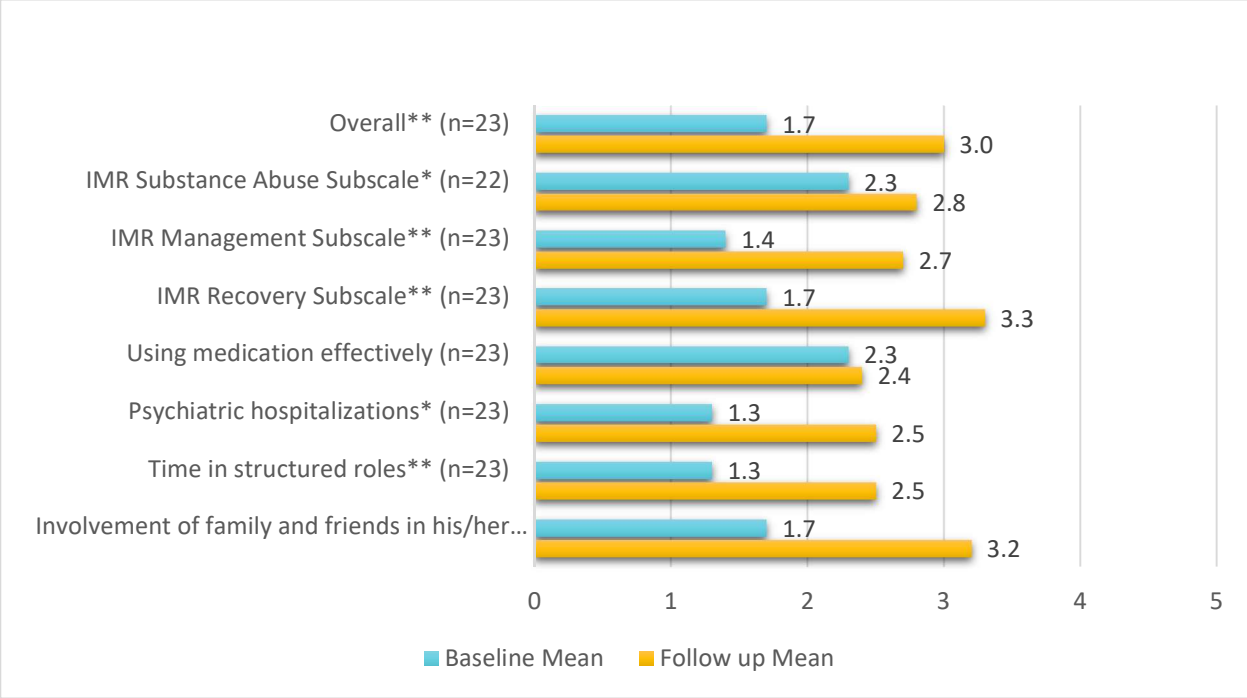
The following sections highlight outcomes for youth gleaned via assessment tools completed upon intake into the JBU program and at least one follow-up time point (e.g., the monthly assessments administered during the residential phase of JBU). In situations where a youth may have multiple completed follow-up assessments, the most recently completed assessment prior to end of FY on 6/30/2021 was used in the analysis. The requirement to have at least two data points allows for examinations of change that might occur while enrolled in JBU, however, this also reduces the sample size included in the analyses as not all participants completed follow-up assessments. There were two primary reasons for incomplete follow-ups: 1) youth may decline to complete self-assessment tools and 2) youth may leave the program prior to the follow-up assessment. Further, in some cases there may also be insufficient information for staff to complete the staff-reported measures. These data collection challenges are not unique to JBU as evidenced by the Mental Health Outcomes Management System's (mHOMS) Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), which indicates that less than one-third of clients in BHS programs throughout San Diego County have completed both the standard client self-reported and staff-reported outcome measures. The primary implication of this circumstance is that the findings presented below may not generalize to the subset of JBU participants for whom follow-up data

is unavailable. Investigations into the generalizability of the findings to all JBU participants will be examined in future reports as the cumulative number of JBU participants increases and allows for more definitive conclusions.

Illness Management and Recovery Scale

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

Figure 4. IMR Results for JBU Youth with Follow-up during FY 2020-21 (N=23)



**Statistically significant change with a p-value less than 0.05; **Statistically significant change with a p-value less than 0.01*

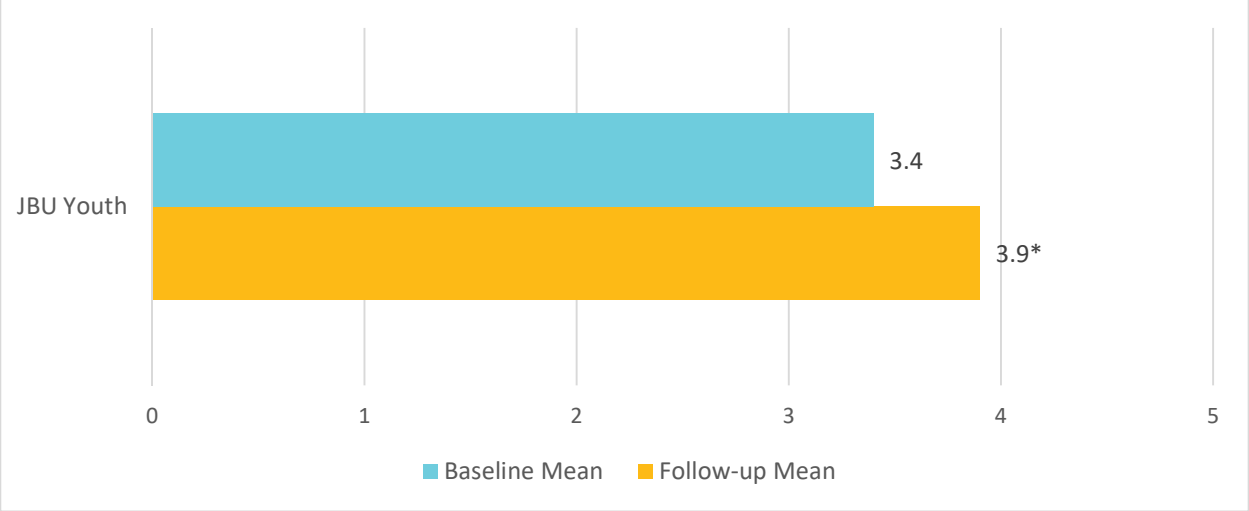
Scores of participants entering JBU reflected more overall impairment (1.7) than participants entering other BHS programs (2.8) as reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison). These differences were evident across each of the IMR subscales. The average Management subscale scores for JBU youth were lower (1.4 at intake and 2.7 at follow-up) than other BHS programs (2.0 at intake and 2.9 at follow-up), as were the average intake Recovery subscale scores (1.7) as compared to other BHS programs (2.3). Notably, however, the average Recovery subscale follow-up score for JBU participants was higher (3.3) than other BHS programs (2.9), suggesting that JBU was able to obtain substantial improvements among participants who were generally less recovery-oriented at intake when compared to participants in other BHS programs.

The greatest area of difference between JBU and other BHS program participants was found within the IMR Substance Abuse subscale at intake (2.3 and 4.6, respectively). This demonstrates the high prevalence of and substantial levels of impairment due to substance abuse among JBU participants, which is consistent with ongoing staff reports. Improvements in substance abuse was evident at follow-up (2.8), but remains well below the system-wide average of 4.8. The overall pattern of JBU IMR results indicated that positive changes were typically achieved – across multiple illness management and recovery domains – while receiving JBU services.

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements relevant to mental health recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure of personal recovery. The results listed below are scaled from 1-5 with higher values corresponding to higher levels of well-being. The RMQ asks youth to answer questions from the perspective of what is "true for you now."

Figure 5. RMQ Results for JBU Youth with Follow-up during FY 2020-21 (N=13)



**Statistically significant change at a p-value less than 0.05*

As shown in Figure 5, average RMQ scores improved from baseline to follow-up (3.4 to 3.9). According to the mHOMS Annual Outcomes Report for FY 2019-20, the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and youth residential programs) was 3.3 and increased to 3.6 at follow-up, suggesting that, at intake, JBU participants self-report similar assessments of their recovery status and outlook on life as do clients in other BHS programs. However, the average follow-up RMQ score for JBU participants (3.9) was higher than the average follow-up RMQ scores reported by other BHS programs (3.6).

Figure 6. IMR and RMQ Results for JBU Youth with Follow-up during FY 2020-21

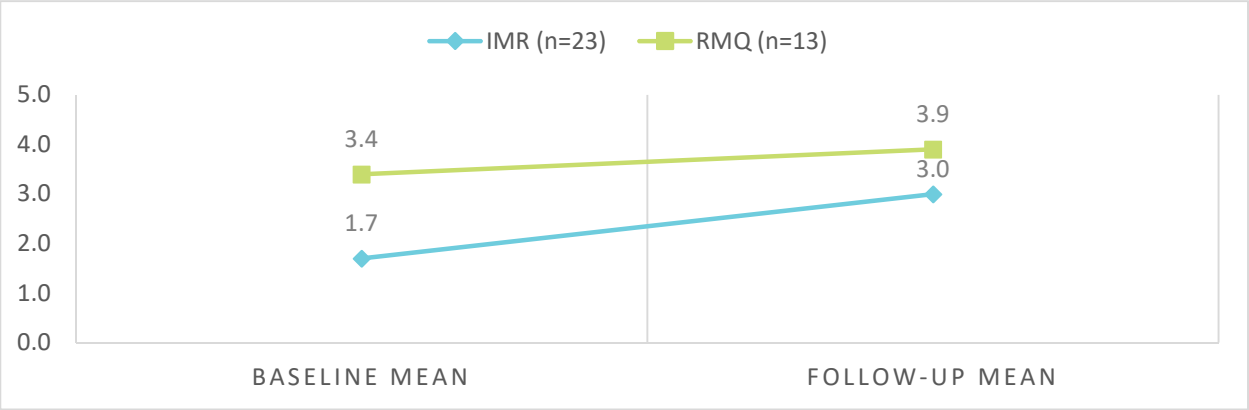


Figure 6 highlights a similar trend line in recovery reporting from both youth and staff reported measures, an indication of the reliability and validity of the data.

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.

Table 1. MORS Results for JBU Youth with Follow-up during FY 2020-21 (N=23)

		Baseline		Last Follow-Up	
Value	MORS Category	N	%	N	%
1	Extreme risk	0	-	0	-
2	High risk, not engaged	≤5	≤21.7%	0	-
3	High risk, engaged	≤5	≤21.7%	0	-
4	Not coping, not engaged	12	52.2%	≤5	≤21.7%
5	Not coping, engaged	0	-	≤5	≤21.7%
6	Coping/rehabilitating	≤5	≤21.7%	13	56.5%
7	Early recovery	0	-	0	-
8	Advanced recovery	0	-	0	-
	Mean MORS	**3.4**		**5.3****	

***statistical significance at p < 0.01*

The results indicate substantial changes in recovery status at follow-up. At intake, less than 22% of youth were considered as coping or in recovery, whereas more than 50% were doing so at follow-up and none of the youth were in one of the "high risk" categories. Overall, the average MORS score increased from 3.4 at intake (corresponds to "high risk, engaged") to 5.3 at follow-up (corresponds to "not coping,

engaged"). The change in average MORS score for JBU youth was similar to prior JBU results (i.e., MORS score increased from 3.4 at intake to 5.5 at follow-up during FY 2019-20).

As reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.4 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.

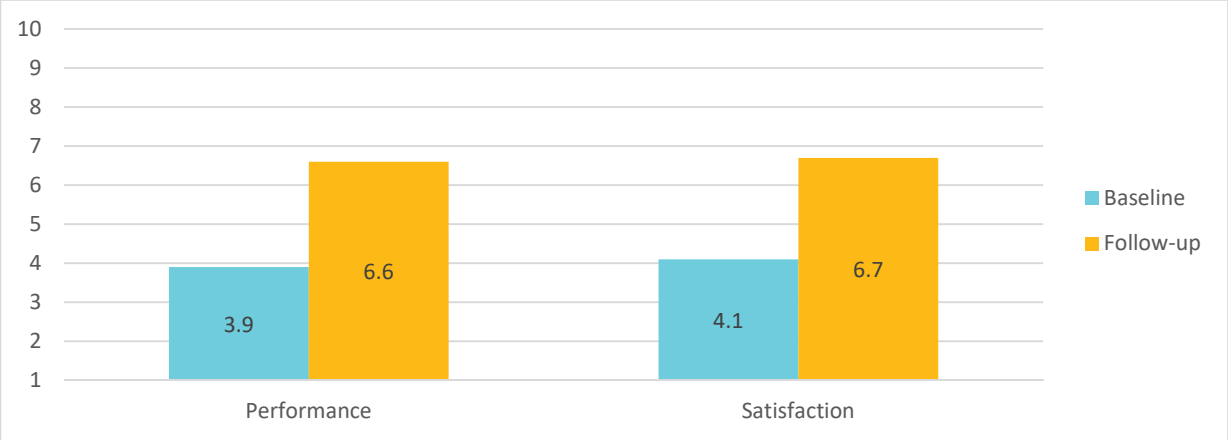
Key Evaluation Findings – Additional Outcome Measures

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 8 JBU youth had baseline and follow-up COPM assessments completed during FY 2020-21. Figure 7 shows that that average performance assessment increased from 3.9 to 6.6 at follow-up and the satisfaction score increased from 4.1 to 6.7. Both the performance and satisfaction domains had average change scores higher than 2.5 (2.7 and 2.6, respectively) indicating clinically important changes for youth.

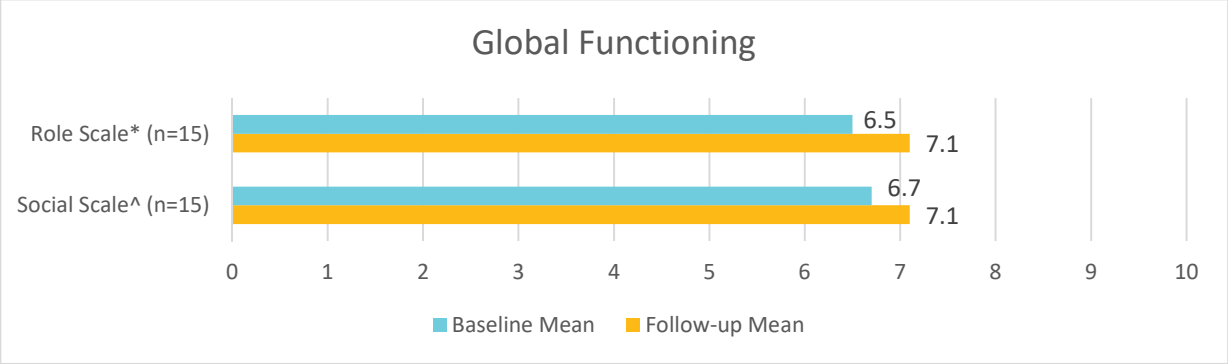
Figure 7. COPM Mean Scores for JBU Youth with Follow-up during FY 2020-21 (N=8)



Global Functioning

Following a semi-structured interview, the provider rated the Role and Social Functioning of JBU youth on a 10-point scale (1 = Extreme Dysfunction; 5 = Serious Impairment; 10 = Superior Functioning).

Figure 8. Global Functioning Results for JBU Youth with Follow-up during FY 2020-21



*^Statistically significant change at a p-value less than 0.1; *Statistically significant change at a p-value less than 0.05*

For both scales, baseline mean values were typically around 6.5 range (indicative of moderate impairment). Follow-up mean values increased to over 7.0, which is indicative of moderate/mild impairment). The improvements were statistically significant for JBU youth.

Perceptions of Mental Health Challenges and Mental Health Services

The Mental Health Perceptions survey was introduced during FY 2020-21 as a shorter tool with items that focused more directly on mental health perceptions likely to be affected by participation in JBU. The 10-item questionnaire asks participants to rate various aspects of mental health wellness and challenges on a 5-point scale with 1 representing strongly disagree and 5 representing strongly agree. As shown in Table 2, results were mixed across the individual items, but generally a trend towards more favorable perceptions, particularly regarding the efficacy of mental health services and feeling more comfortable talking with mental health professionals.

Table 2. Youth Perceptions of Mental Health Challenges and Mental Health Services (N=11)

#	*Note: questions 2,7,9 were reverse scored so that higher values equal better condition/lower level of stigma.*	N	Baseline Mean	Follow-up Mean
1	I can have a good, fulfilling life, despite my mental health challenges.	11	3.9	4.4
2	I rarely share my mental health challenges with others.	11	3.4	3.2
3	Acceptance of my mental health challenges can help me better manage them.	11	3.7	4.3^
4	It is possible to manage and/or recover from mental health challenges.	11	3.8	4.3
5	I would feel comfortable talking with a mental health professional.	11	3.6	4.3^
6	I have not had any trouble from people because of my mental health challenges.	11	3.0	2.9
7	I feel ashamed or embarrassed about having had mental health challenges.	11	2.8	2.6
8	Participating in mental health services can effectively improve my mental well-being.	11	3.5	4.4*
9	I feel the need to hide my mental health challenges from others.	11	3.1	2.8
10	Like any life challenge, mental health challenges can improve with understanding, skill development, and/or help from others.	11	3.8	4.5^

*^Statistically significant change at a p-value less than 0.1; *Statistically significant change at a p-value less than 0.05*

BHS 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 3 include JBU participants who enrolled after 7/1/2020 if they had been discharged at least 180 days before the end of FY 2020-21 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 3, the 49 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 0.9 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as almost 70% of the youth (69.4%) linked to outpatient care and the 180 day average number of outpatient sessions increased to 16.4. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.3 sessions per youth. This apparent reduction in outpatient services 180 days post-JBU is likely partially explained by the linkages to ACT programs that many JBU youth made while in the program. Fully 28.6% (i.e., 14 out of 53) of JBU youth had ACT visits post-JBU, with the average of 7.1 sessions compared to 0.1 pre-JBU and 0.9 during JBU.

Table 3. BHS Service Utilizations Patterns Before, During, and After JBU Participation (N=49)

	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	10.2%	43	0.9	69.4%	264	16.4	40.8%	114	2.3
ACT	2.0%	7	0.1	14.3%	15	0.9	28.6%	350	7.1
Urgent Outpatient	28.6%	26	0.5	49.0%	26	1.6	26.5%	17	0.4
PERT	22.4%	16	0.3	6.1%	3	0.2	18.4%	17	0.4
Crisis Stabilization	24.5%	24	0.5	4.1%	2	0.1	12.2%	18	0.4
Inpatient	34.7%	26	0.5	10.2%	7	0.4	26.5%	30	0.6
Crisis Residential	26.5%	22	0.5	8.2%	5	0.3	18.4%	16	0.3

[1]*The number of persons and number of visits/episodes is not directly comparable to the other time periods since the average length of time in JBU was less than 180 days (mean = 59.3 days). Only the average is directly comparable across all three time periods.*

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 (0.5 and 0.4, respectively), but was substantially higher during JBU (1.6). This can be explained by the fact that JBU staff facilitate access to needed urgent outpatient care, in an effort to avoid situations escalating into the need for a

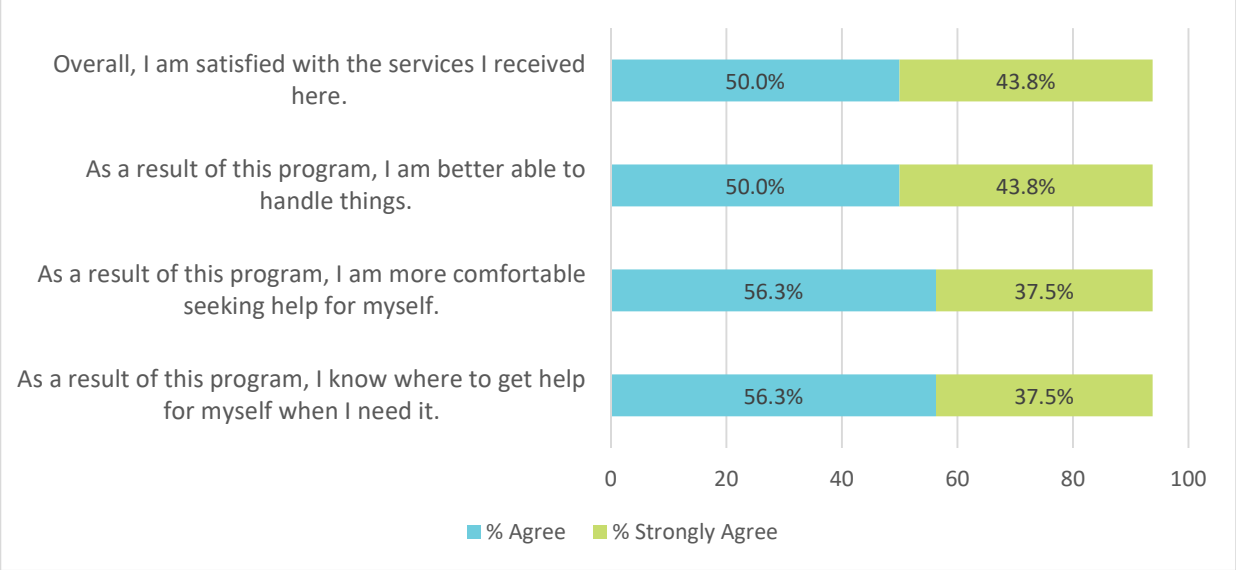
crisis stabilization visit or inpatient hospitalization (both of which occurred less frequently during JBU than pre-JBU).

Overall, the percentage of youth accessing crisis-oriented BHS services was lower during the 180 days post-JBU than during the 180 days pre-JBU. This was most evident for crisis stabilization services which reduced from 24.5% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to only 12.2% in the 180 days after leaving JBU. However, the average number of crisis stabilization visits only reduced slightly before and after JBU (0.5 to 0.4, respectively) since the total number of crisis stabilization visits did not decrease as much (24 to 18, respectively). With the relatively small sample sizes caution is warranted when interpreting findings, however it is evident that JBU substantially increased engagement with outpatient treatment services and facilitated connections to ACT programs (a preferred discharge destination for many JBU youth).

Youth Perspectives on JBU Services

A total of 16 youth completed feedback surveys at one of the follow-up time periods during FY 2020-21. As shown in Figure 9, over 90% of youth agreed/strongly agreed that because of participating in JBU they knew where to get help when needed (93.8%), were more comfortable seeking help (93.8%), were better able to handle things (93.8%) and were satisfied with the services they received from JBU (93.8%). Overall, these findings suggest that among youth who completed a follow-up assessment, there was widespread acknowledgement of achieving key JBU program outcomes of increasing youth knowledge of how to access services, reduced stigma associated with accessing services, and an increased sense of being better able to manage themselves.

Figure 9. JBU Services Feedback Questions for FY 2020-21 (N=16)



Photovoice Project

Photovoice is a visual research method employed with the intention of addressing social issues and fostering change. It is defined as a process where "people can identify, represent, and enhance their

community through a specific photographic technique." Photovoice provides the opportunity for community members to creatively document their concerns and simultaneously act as "catalysts for change."

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

Youth were invited to participate during a house meeting in May 2021. In collaboration with 11 JBU youth, the evaluation question was identified: "How does participation in JBU affect my life?"

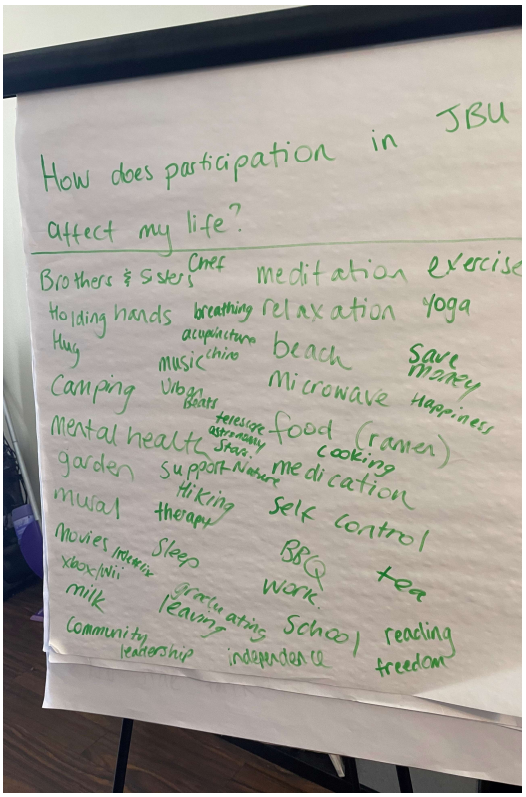


Photo 1: Notes during JBU brainstorming session

Photos (n=48) were taken by nine unique JBU youth during the month of June 2021. In four separate analysis sessions, seven of the photos were analyzed by ten JBU youth. These analysis sessions were recorded and reviewed by the evaluation team. The following themes emerged:

JBU provides housing, so youth can someday have a home

JBU youth overwhelmingly identified housing as the most important component of the JBU program. In addition to housing, however, JBU youth routinely expressed a desire to have a "home" and not just

housing. Youth mentioned ideas such as painting the rooms assorted colors or having themed rooms to create a place that reflects the people inhabiting JBU. Other youth remarked on the personal connection to staff and youth that the vegetable garden has and discussed how their goal was to have something like that in their own home someday. Youth understood that participation in JBU required them to learn skills such as chores, responsibility to the community, and stabilizing their mental health so that they can eventually sustain independent living. One thread that was apparent in all the analysis sessions was the idea of independence. JBU youth recognized the importance of being pushed outside their comfort zones, particularly when it comes to group or community activities. However, youth frequently expressed a desire to have more control over their immediate surroundings, as well as the activities in which they participate.

Youth Quotes

"I am here to have a place to live and that's it. I just don't want a lot of extra activities to be mandatory because I'm here to have a roof over my head and not anything else."

"I have never been interested in watering plants, but when I am here [in this] living situation, I want to better myself."

Photo 2: Garden boxes being watered by a JBU Youth

Photo 3: Dining table at JBU

JBU gives youth a chance to become comfortable with being uncomfortable

JBU youth reported enjoying JBU activities, even when the activities pushed them to expand beyond their comfort zone. They often used skills from holistic activities like yoga to "make it" through the week, using breathing techniques to calm down and center themselves in stressful situations. Youth felt that activities

built a sense of community at JBU—a sense that was often missing in their lives prior to JBU. Gardening, camping trips, movie nights, and nature walks were all examples of group activities that youth enjoyed, even when they were initially apprehensive about participating.

JBU youth also analyzed the difficulty of learning to live with other people, while also maintaining a home. Group outings, chores, and JBU activities give youth a chance to practice living with other people while also completing undesirable tasks. Youth remarked that while they were not always comfortable being in a shared space with other people, they understood how important it was to practice being around others without getting annoyed, irritated, or frustrated. Youth also shared insight on how to handle those inevitable negative emotions, citing yoga practice as one way to help them choose healthy responses to feelings of dismay or agitation.

Youth Quotes

"[W]hen you allow yourself to go out of your comfort zone… I mean, I haven't been camping since I was eight years old."

"This gives you a chance to go out and be comfortable with being uncomfortable… have the opportunity to get out of your room, out of your house… build relationships that maybe some of us haven't had before."

"It's like a break for the whole house… I mean, I can give myself a break, but this is an opportunity to go out with the other people here. Yeah, I live here, but I am not always at the house, so I am not always seeing people here. It's different when we aren't doing chores."

Photo 4: Poster for upcoming camping trip for JBU youth

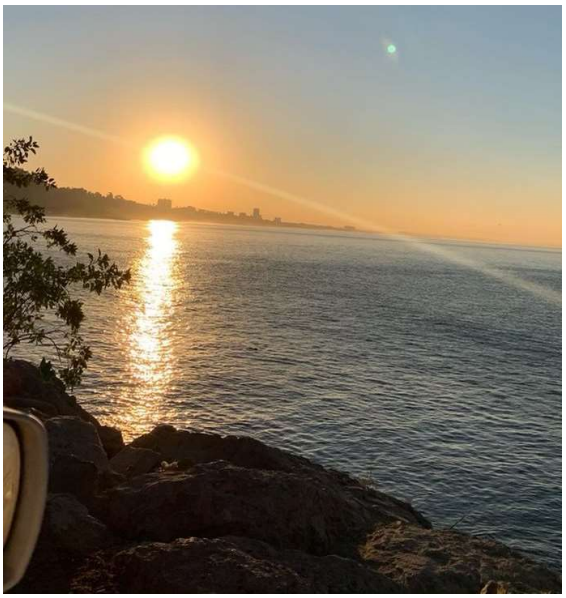


Photo 5: Sunset, taken during a JBU outing

JBU provides security

Social/Emotional Security: Youth reflected on the ability to make mistakes and know that they can return to the JBU program. During analysis sessions, youth discussed how a main component of the safety they felt at JBU was knowing they could return even after. Watching other youth leave and return was also impactful, as youth felt they contributed to that sense of safety for others as well.

Physical Security: In addition to the re-entry policy, a sense of security came from the actual physical neighborhood. While they did note that the downtown location provided more job opportunities, the house setting provided a sense of stability and structure that was not present downtown. Having a physical space to leave their items was important for the youth. They discussed the simple behavior of going for a walk and leaving their belongings on their beds, knowing they could return and nothing would be disturbed.

Personal Security: Finally, youth analyzed the efforts at JBU to ensure personal, holistic security. Youth identified weekly yoga practices as a source of personal security. Youth discussed the safety they felt with the instructor, who has a history of his own lived experiences with homelessness, as well as the mindfulness and grounding that came along with a routine practice of yoga.

Photo 6: Yoga mat during JBU practice

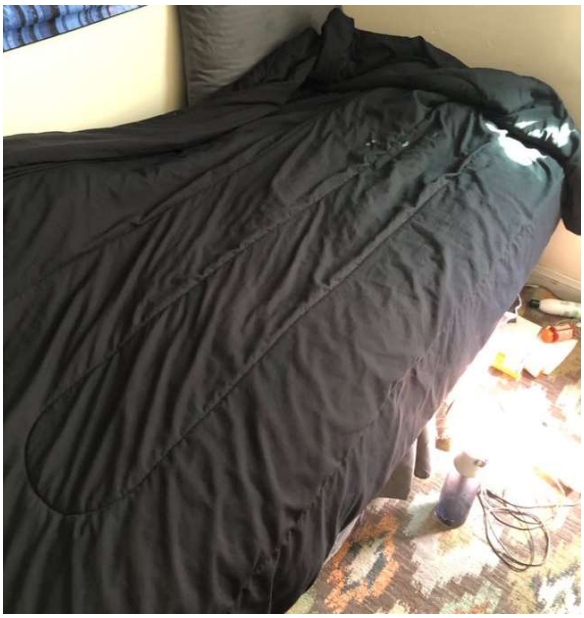


Photo 7: Bed at JBU

Photo 8: Neighborhood during dusk

Youth Quotes

"I do have family, but my mental issues are really not their first priority. So having a place to put my head at every day or every night is really nice to look forward to, and not have to worry about. We make sure there is a place where homeless youth have a place to return to."

"I haven't always had a safe place to eat my food, so that table is something I don't take for granted. I was here before and got kicked out, and out there it isn't always safe… just knowing that I won't be starving."

"Thinking back to how bad my mental health issues were, before I didn't even want to go outside."

Overall Key Takeaways

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

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

Composite of JBU Youth Experiences

JBU youth have a variety of experiences and needs when they arrive at the program. The following is a composite infographic, derived from multiple youth accounts. While all examples are from JBU youth, it is important to recognize youth entering and exiting the program will have a variety of experiences.

A JOURNEY THROUGH JBU

The following example is a composite of multiple JBU youth, who have successfully engaged with JBU programming.

COMING TO JBU

Often, when youth come to JBU, they have been in and out of many programs and failed to stick with any. Many youth come from other programs where they have struggled with issues such as personal hygiene, sobriety, or mental health conditions. Youth are often unconnected to their community and family of origin.

GOALS AT JBU

Once settled at JBU, youth work with the JBU team to determine goals. These goals are highly specific to the individual, and may include obtaining legal custody of children, establishing sobriety, maintaining employment, obtain a driver's license, and securing housing.

ENGAGEMENT AT JBU

Youth who successfully complete the JBU program are often engaged in JBU programming. However, JBU staff understand this is not a linear process. Occasionally, youth need to exit JBU and receive outside services before returning to successfully complete the program.

INDICATION OF JBU SUCCESS

JBU staff see successful youth as committed to their goals, such as taking the bus independently, or seeking out leadership roles with their peers. Other indications of success may include a sense of "grit"-- where youth are determined to accomplish their goals despite setbacks such as SUD relapse, legal issues, or interpersonal conflict.

BEYOND JBU

Successful JBU youth are currently housed and continue to pursue the goals they set in the program. Often these youth have reunified with their children, are gainfully employed, purchased personal vehicles, or have completed rehab programs. Youth typically remain in contact with JBU through the peer support program.

While the journey for JBU is **unique** and **personalized** to each individual youth, it is not uncommon for youth to transition from *living on the streets* or other *unstable housing arrangements* to *engaging in treatment* and *making progress* on personal goals regarding employment, housing, and relationships.

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 2020-21. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 11 respondents from the 14 JBU staff invited to participate in the survey (i.e., a 79% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies found were discussed to arrive at a consensus on the key response themes.

JBU staff identified two main goals for FY 2020-21: 1) providing secure housing and 2) supporting youth to stabilize mental health. Connections with San Diego County BHS providers and programs as well as JBU staff and peer support were identified as having helped JBU achieve their goals. Conversely, JBU youth resistance to change and lack of follow-through were identified as inhibiting factors.

Connections to Treatment

Finding available and appropriate treatment options for JBU youth continues to be cited as a challenge for JBU staff. One JBU staff reported, “We lack resources/availability for inpatient or outpatient services all over the county. No emergency services for youth interested in SUD support.” Maintaining a positive relationship with outside providers is seen as an effective strategy to successfully connect youth with needed services. Staff also reported significant effort on their end to support and encourage youth to remain engaged in treatment.

> “We must be aggressive and proactive. It's not easy. Too few SUD inpatient beds. Too little skill or time or flexibility in mental health providers. We need complete and consistent access in a rapid timeframe. And we need providers who follow up. If we don't drive it as staff, it doesn't happen.”

This support comes in tangible ways such as transportation and assistance with scheduling, and less tangible ways, such as partnering with youth in a strengths-based perspective.

> “Mental Health partners (or on-site professionals) to flexibly and aggressively make appointments with TAY for SMI and SUD counseling [are needed supports]. They need special training, e.g., LEAP, to connect well with the TAY, not in a hurry or dismissive or seen to "push" medications without explanation or deep engagement. They need time and savvy. Same for SUD challenges.”

JBU staff also recognized the need to collaborate with each other, so that staff members are all aware of a youth’s status toward goals and treatment and any concerns regarding behavioral health or substance use. The most cited recommendation for program success was faster, more secure community referrals to housing and treatment.

Engagement of JBU Participants

Youth engagement and willingness to participate in JBU programming also remains a challenge. One staff member cited “the inability to enforce or require connection to mental health services as part of the

agreement to continue with the program" as a consistent barrier to program success. JBU staff recognize the unique difficulties facing JBU youth, and work to train providers to also understand these difficulties. "Successful integration into society is complex and unique to each individual. This makes it challenging but is an inherent part of working with mental health clients." Many of the mental health conditions dealt with by JBU youth prevent youth from accepting or addressing their mental health. In explaining this, a staff member commented, "Youth not being receptive to certain types of services [is a challenge]. The frequency of services offered may be 'too much' or 'too overwhelming'." These barriers were often cited as factors that inhibited JBU from achieving program objectives.

Rapport with JBU Participants

JBU staff highlighted rapport with youth as one of the great strengths of the program. When reflecting on this strength, a staff member remarked:

> "Rapport and genuineness of staff who truly care and the TAY see and feel this. It's real. Also, our services are loving and supportive. We are flexible and show tough love, such that early exits for cause are followed up and TAY are welcomed back after doing something to remediate e.g., SUD or SMI issues that led to early exit"

While creating connections with youth can be challenging, JBU staff see their ability to make the youth feel at home, safe, and accountable as one of the main reasons JBU remains a successful program. Staff highlighted practices such as texting youth to encourage engagement in JBU activities, even though it might feel "silly" when they are in the same house. "This program is effective in diminishing the gap between "us and them" which makes the youth feel comfortable and more related to staff." Practices such as these, to "meet the youth where they are," help to cultivate a culture of partnership and empowerment for youth. Staff also reflected on the practice of offering incentives to youth to meet their personal goals, citing it as another effective way to maintain engagement.

Substance Use Disorder (SUD) Challenges

As is the case for many behavioral health programs, SUD continues to be a challenge for JBU youth. In addressing SUD, JBU staff reported needing LEAP-trained mental health providers in the community to appropriately address the unique mental health needs of JBU youth.

> "MH providers who are hip, savvy, can connect with TAY (or a specialist communicator who does this). They need the time to explain all Rx's and therapy approaches, address concerns, adjust regimens based on reports and observations of TAY... all much more like an informed partnership, not a hierarchy of over-worked providers in a hurry and dismissive or unable to communicate well. Best would on-site at JBU… We need immediate access to inpatient SMI and SUD programs, to stabilize TAY who need this, before the holistic services or follow-thru on linkages can have much effect. We must stabilize before we optimize."

Additionally, JBU staff reported difficulties in connecting with SUD providers who had availability to admit new clients. While the Access & Crisis Line (ACL), a service in San Diego County which screens for substance use needs, crisis intervention, and mental health referrals, is available for JBU to utilize, JBU staff felt that additional resources for TAY oriented SUD services could benefit youth.

Occupational Therapy

The use of Occupational Therapy (OT) to assist youth in their goals and treatment plan is seen as a great strength for the JBU program. OTs aid their clients with vocational pursuits, leisure pursuits, social engagements, financial management, medication management, community mobility, etc., and they bridge the gap between clinicians and peer support specialists. A staff member commented, "Inclusion of occupational therapy [is a key program strength and] has allowed for an increased focus on needed life skill development (e.g., self-care, meal prep, social participation, leisure exploration, daily routine-building, community mobility)."

OT benefits JBU youth in a variety of ways, including with their occupational engagements and with successful transitions into the community. According to one JBU youth:

> "Occupational therapy was very helpful during my time with the program. I worked with the occupational therapist once a week and could have benefited from more one-on-one sessions. I feel like the one-on-one sessions were more beneficial than the occupational therapy groups."

Impact of COVID-19 on JBU Staff

Overall, staff members indicated there were aspects of their lives, both related and unrelated to work, which changed due to the COVID-19 pandemic. In the work setting, the public health measures necessary to keep staff and youth safe were the most cited ways JBU needed to adapt in the era of COVID-19 during FY 2020-21. JBU staff indicated they experienced an increase in stress or anxiety due to COVID-19 and the response to the pandemic. Staff members reported coping with this increase in stress by using yoga, meditation, mindfulness, and healthy sleep practices as well as becoming vaccinated. Of note, these are many of the services JBU staff provide to youth as part of the holistic service delivery. Staff also reported other changes in their roles and work-related tasks due to COVID-19, however, not to the degree in which they reported change during FY 2019-20.

Additional Program Activities

App Development

To further support achieving JBU objectives (and with BHS approval), JBU partnered with a software development firm to create a unique TAY-oriented software application (i.e., 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.

The app development process has encountered difficulties and delays related to multiple developer changes and the complexities associated with the ambitious nature of the desired product. A prototype of the app was completed during the end of FY 2020-21, but further testing and refinement will be required during FY 2021-22 prior to any actual utilization by JBU youth.

Program Changes from Initial Design

Beginning in September 2020, JBU was approved to accept direct referrals from other service providers if they met all standard eligibility criteria and were approved by BHS. This allowed for the identification and enrollment of eligible youth who were not included on the BHS CO-19 lists provided to JBU.

The availability of OT services was expanded during FY 2020-21, with OT services becoming an essential component of how JBU engages with and supports youth. Through interactions with the OT personnel, youth are encouraged to develop and then act on achieving personal goals.

Status Update on Prior Year Program Recommendations

Recommendation 1: Focus program activities on improving youth awareness of their own mental health needs and increasing openness to engaging in mental health treatment.

FY 2020-21 Update: With addition of OT interns and onsite OT supervisor one day per week, youth have access to additional staff members with whom to build rapport and open up to in order to better understand the barriers to engaging in activities to support their mental health and wellbeing. The JBU program also conducted a "Listen & Learn" session in partnership with NAMI and UCSD researcher Dr. Annick Borquez. Originally this was intended to understand youth experiences about marijuana use, but ultimately raised discussion around previous negative experiences with mental health providers.

Recommendation 2: Proactively address factors that inhibit engagement in program services through holistic and other supportive services.

FY 2020-21 Update: Engagement proved to be particularly challenging during FY 2020-21 due to the ongoing issues associated with the COVID-19 pandemic. JBU expanded the delivery of individual and group OT services during FY 2020-21 with regular staffing by OT interns. These services were well-received by youth and the OT interactions provided additional support and information to JBU staff by developing a greater understanding of client factors potentially affecting engagement (e.g., cognition, sensory differences) and creating ideas for task or environment adaptation to support successful youth participation in JBU. Additionally, text messaging was found to be best method for maintaining contact with clients, so texting was utilized to send reminders before activities and meetings.

Recommendation 3: Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.

FY 2020-21 Update: Youth were connected to SUD counseling through a partnership with SAY San Diego and a new SUD service partnership with Vista Hill. Given the importance of this issue to the JBU population, JBU anticipated ongoing efforts to expand SUD service referral options further.

Recommendation 4: Relocate program to a neighborhood with fewer negative environmental opportunities for engaging in undesired behaviors (e.g., less access to drugs).

FY 2020-21 Update: This recommendation was achieved, and client feedback has generally been positive (see findings from Photovoice project discussed above), despite more difficulties with transportation.

New Program Recommendations

1. Develop additional connections to outside providers for TAY appropriate mental health care in the San Diego region.
2. Incorporate more intensive case management for JBU youth.
3. Evaluate opportunities for an increased transportation budget to mitigate the need for additional transportation assistance associated with moving JBU program from downtown San Diego to a residential neighborhood.
4. Increase attention to post-discharge follow-ups.

Conclusion

During FY 2020-21, JBU was able to successfully contact and enroll 45 youth who met all eligibility requirements (a level of enrollment similar prior years). Coupled with having SMI, many of the youth also had substance use and abuse issues. JBU staff provided daily encouragement and support throughout the residential phase of the program, primarily through the addition of extensive OT support services as well as offering group and individual sessions for various holistic services and educational/enrichment activities. 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 70% of youth participating in outpatient care while enrolled in JBU and almost 30% transitioning to ACT programs after completing the residential phase of JBU. While access to external holistic providers was more limited as a direct response to the COVID-19 pandemic, the JBU staff continued to provide residential care services and facilitated telehealth connections to outpatient treatment providers.

For youth with baseline and follow-up outcome assessment data, both the staff self-report and the youth self-report measures indicated positive changes related to numerous domains such as: improved symptom management, greater recovery orientation, increased sense of well-being, and reductions in impairment due to substance use. 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.

The Photovoice Project generated youth feedback regarding their perceptions of the JBU program. Key emergent themes included the following: 1) Housing was the most important part of JBU, 2) JBU provided a sense of stability, 3) Community can be uncomfortable for JBU youth, but they recognized its importance, 4) A sense of control was important while youth work towards independence, and 5) Youth believed that participation in JBU gets them to independence faster than if they tried on their own.

Overall, the findings from FY 2020-21 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. The program also continued to evolve to address emerging issues to better meet the behavioral health and wellness needs of the youth they are serving.

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

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Appendix

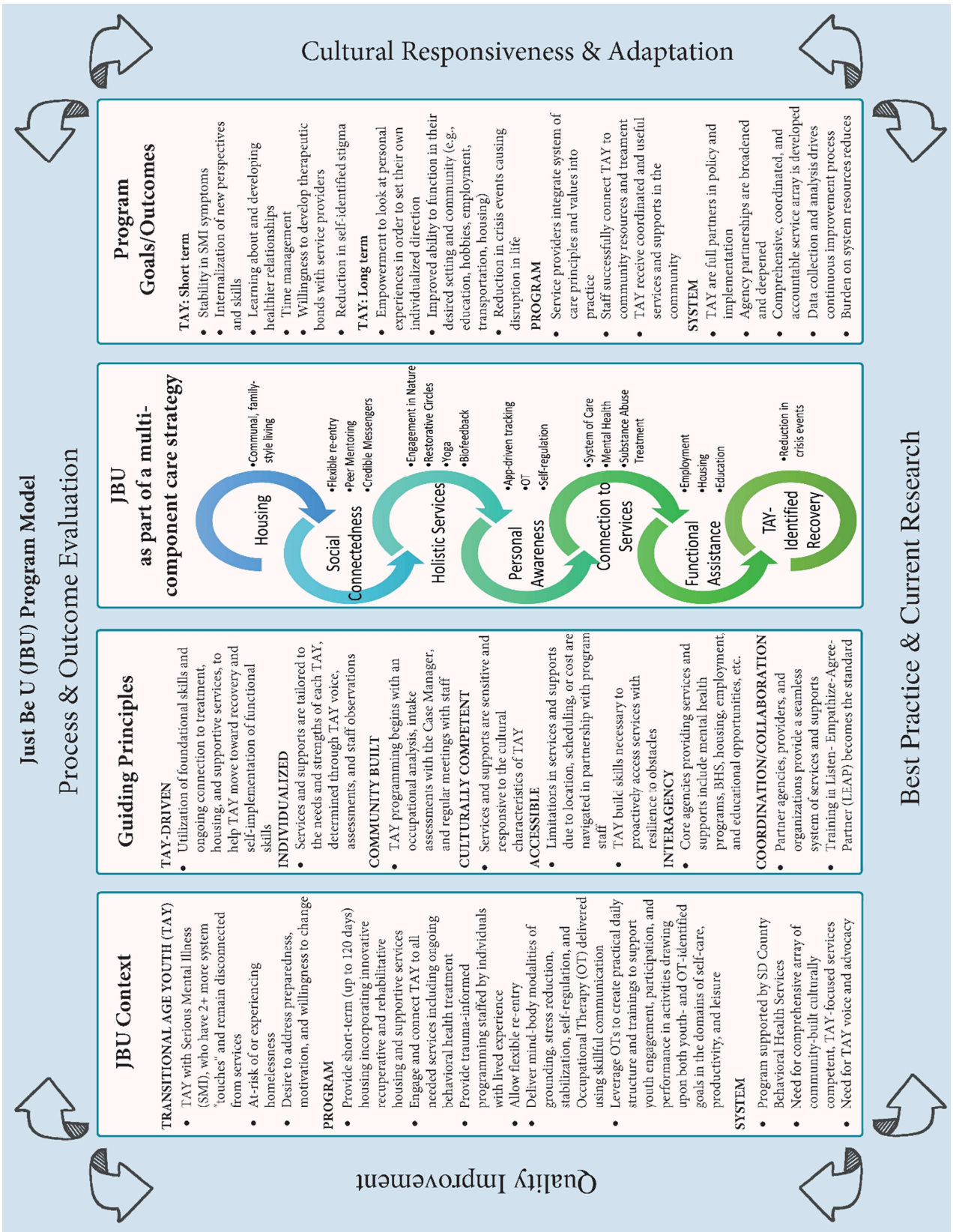
Characteristics of Participants who Enrolled during FY 2020-21

Characteristic	Total Participants (N=45)	
Gender	N	%
Male	30	66.7%
Female	13	28.9%
Another Gender Identity/Missing	2	4.4%
Total	45	100%
Age Group	N	%
18-21	26	57.8%
22-25	19	42.2%
Total	45	100%
Primary Language	N	%
English	41	91.1%
Other/Missing	4	8.9%
Total	45	100%
Race/Ethnicity	N	%
African American	11	24.4%
Hispanic or Latino	15	33.3%
Caucasian	11	24.4%
Other	6	13.3%
Missing	6	13.3%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	16	35.6%
Schizophrenia and Other Psychotic Disorders	12	26.7%
Bipolar Disorders	10	22.2%
Anxiety/PTSD/Acute Stress Reaction	2	4.4%
Other/Missing	5	11.1%
Total	45	100%

Characteristic	Total Participants (N=45)	
Sexual Orientation	N	%
Heterosexual or straight	29	64.4%
Bisexual/Pansexual/Sexually fluid	5	11.1%
Another orientation/Missing	6	13.4%
Prefer not to answer	5	11.1%
Total	45	100%
Military Status	N	%
Never served in the military	41	91.1%
Other/Missing	4	8.9%
Total		
Disability	N	%
Yes, Has a disability	9	20.0%
No, Does not have a disability	33	73.3%
Declined/Preferred not to answer	3	6.7%
Total	45	100%
Type of Disability	N	%
Learning/Developmental	7	77.7%
Physical/Chronic/Other	8	88.9%
Total[3]	-	-

[1] Total may exceed 100% since youth could select more than one response.
[2] Mental health diagnosis information is obtain form BHS Cerner data system.
[3] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.

JBU Program Model



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

Annual Report
Year 3 (7/01/2020-6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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). 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). An additional unanticipated role has emerged, however, in which 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) ensured continuity of care and has become part of standard CCYP operations.

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. 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 Fiscal Year (FY) 2020-21

1. During FY 2020-21, a total of 499 children and youth were served by the CCYP program, including 258 new intake clients and 241 who had enrolled in a prior year (program goal = 500 unique clients served per year). This represented more than 100 additional youth served than the 397 youth served during FY 2019-20.

2. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (55.8%).
3. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services. During FY 2020-21 CCYP enrolled 68 youth from eight different agencies as ancillary referrals. The ancillary population represented a growing proportion of new CCYP enrollees (26.4% during FY 2020-21 compared to 15.2% in FY 2019-20).
4. Per each 30 days of CCYP enrollment, ancillary clients were estimated to receive approximately twice as many psychosocial assessment and collateral service contacts as maintenance clients, which increased workload requirements for the Assessment Coordinators.
5. CCYP youth typically received services for an extended period of time as evidenced by a median duration of 319.5 days for the 296 persons who were receiving CCYP services as of 6/30/2021.
6. Less than 10% of the youth served by CCYP during FY 2020-21 had behavioral health concerns emerge that required a transition to a higher level of care (e.g., a return to ongoing therapy).
7. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.
8. 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.
9. With the ongoing COVID-19-related adjustments to service provision, CCYP psychiatrists and other staff indicated that they did not perceive a substantial difference between in-person and telehealth visits with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.
10. Feedback from CCYP caregivers indicated that many expected to continue to utilize CCYP services via telehealth with video even if in-person services become more readily available.

Conclusion

During FY 2020-21, the third year of program operations, CCYP served more youth than during the prior year (i.e., 499 in FY 2020-21 compared to 397 in FY 2019-20) and enrolled substantially more persons than discharged (258 to 135, respectively). This growth rate may challenge program capacity and potentially limit future availability for new enrollment without changes to staffing levels or discharge patterns.

Growth can be partially attributed to CCYP enrolling an increased number of ancillary youth (i.e., over 25% of new CCYP enrollees during FY 2020-21), who continued to receive therapy services at another organization while CCYP provided needed medication management and psychiatric care. Based on staff feedback and service utilization data, the ancillary youth appear to have higher acuity needs and/or require additional attention by CCYP to support coordination and communication with the external organization providing their ongoing therapy.

Overall, the patterns of lengthy CCYP program participation, the few program discharges, and the similar frequency of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior to enrolling, 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 a second objective by providing continuity of psychiatric medication management for youth who otherwise faced disruptions in their access to such services at the location

where they participated in ongoing therapy. The CCYP services provided to these ancillary youth helped to strengthen the local BHS system of care and minimize potential service delivery gaps.

Primary Recommendations for FY 2021-22

1. Continue to develop an educational and outreach oriented CCYP website (e.g., basic materials about disorders, resource library for caregivers, resource library for providers, past newsletters, commonly used handouts or worksheets).
2. Assess staffing requirements and/or staffing supports needed to best serve the unique service needs of the "maintenance" and "ancillary" CCYP populations.
3. Explore providing families with the equipment needed to obtain essential vital signs at home such as blood pressure monitoring tools.

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 the child or youth's 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 is also expected to provide 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, which included: 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.

Since the first year of the CCYP program (i.e., FY 2018-19), an unanticipated role for CCYP emerged and has been subsequently incorporated into CCYP operations. In addition to the intended focal population discussed above, CCYP was identified as an important county-wide resource that could fulfill the need for temporary access to psychiatric services when other county-funded programs experienced 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.

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.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members, resulted in a substantial reliance upon remote work and remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

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 2020-21. As discussed in more detail below, caregivers have become increasingly comfortable utilizing Zoom and other secure platforms to attend telepsychiatry or telehealth sessions with the psychiatrists and assessment coordinators, allowing CCYP to further streamline services and increase availability of services. CCYP administrative staff have been available to provide technical support as needed. Additionally, the CCYP program has worked to ensure that updated policies regarding receiving and providing documentation securely have been updated and all staff have been trained on the new procedures.

Participant Characteristics

As shown in Table 1, a total of 258 persons enrolled into the CCYP program during FY 2020-21 (as compared to 211 in FY 2019-20). Of the 258 enrollees, 190 (73.6%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), and 68 (26.4%) were considered ancillary enrollees, which represents an increase in the number of ancillary referrals and percentage of the CCYP population as compared to FY 2019-20 (32 and 15.2%, respectively). These ancillary enrollees were approved to receive CCYP services due to their inability to obtain needed psychiatric care at their primary (non-CCYP) service provider. A total of eight different organizations referred ancillary enrollees to CCYP during FY 2020-21.

Table 1. CCYP Program Enrollment for FY 2019-20 (N=258)

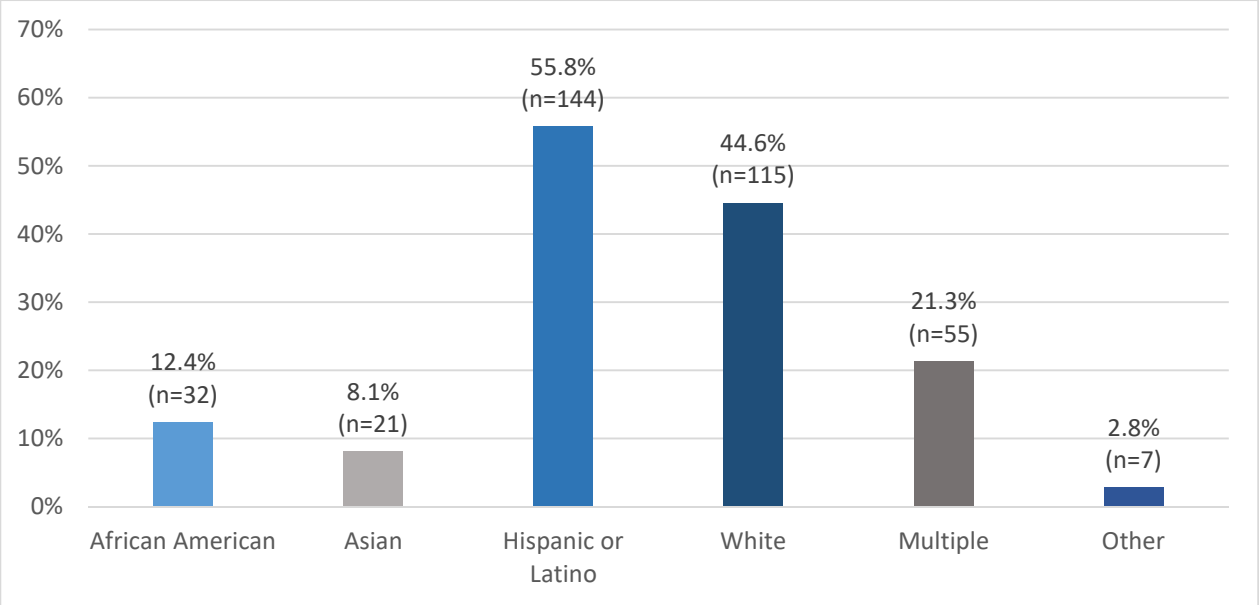
Type of CCYP Enrollee	N	% of Total
Maintenance enrollees (i.e., not receiving therapy elsewhere)	190	73.6%
Ancillary enrollees (i.e., receiving therapy elsewhere)	68	26.4%
Total CCYP enrollees	**258**	**100%**

Key characteristics of the 258 persons who enrolled in CCYP during FY 2020-21 (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 2020-21, the majority (69.4%; n=179) of clients enrolled in CCYP were at least 12 years old or older, with approximately one-third of clients age 5 to 11 (30.6%; n=79). Similar numbers of males and females enrolled (46.9%; n=121 and 52.3%; n=135, respectively). Almost two-thirds of clients identified as heterosexual (60.5%; n=156), with 12.4% (n=32) indicating being bisexual, pansexual, or sexually fluid and 19.0% (n=49) declining to select an orientation.

While most clients reported English as their primary language (88.8%; n=229), nearly 10% indicated Spanish (8.1%; n=21) and 3.1% (n=8) another primary language. As shown in Figure 1, CCYP served a racially and ethnically diverse population. Over half of participants identified as Hispanic or Latino (55.8%; n=144), followed by White (44.6%; n=115), multiple racial/ethnic backgrounds (21.3%; n=55), African American (12.4%; n=32), and Asian (8.1%; n=21).

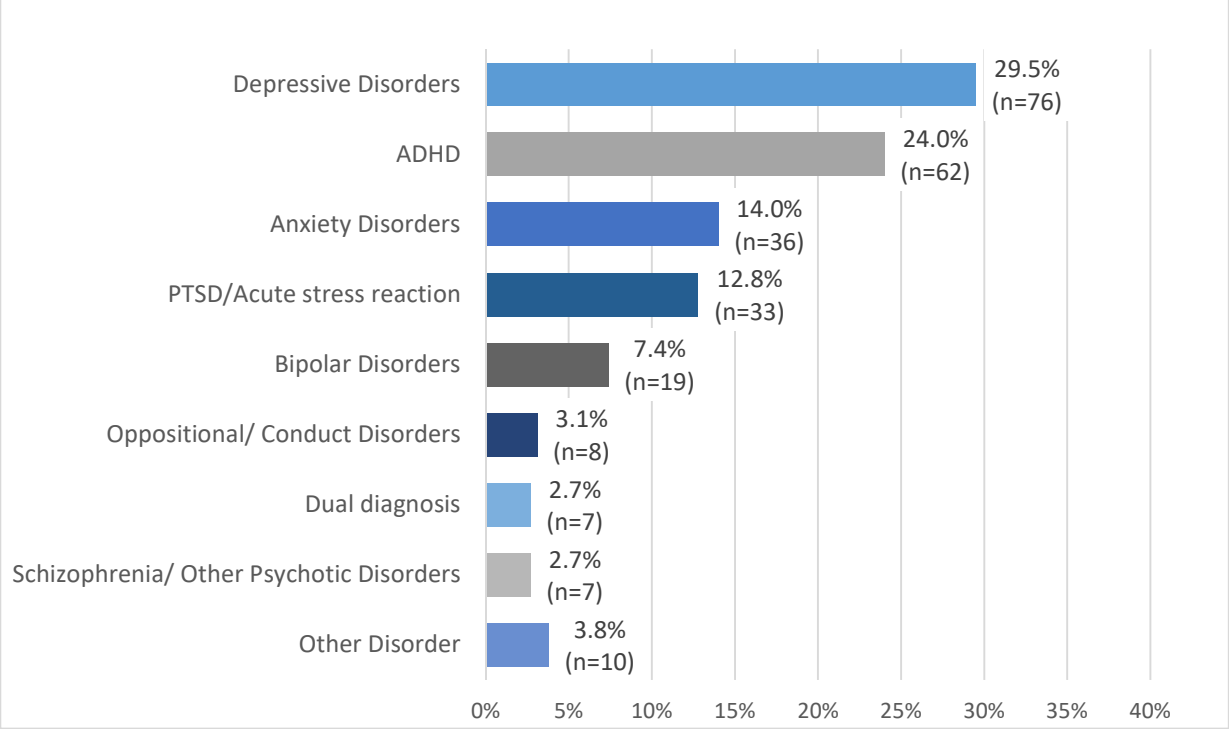
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2020-21 (N=258)



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 (29.5%; n=76), ADHD (24.0%; n=62), and anxiety disorder (14.0%; n=36).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2020-21 (N=258)



In addition, 12.0% (n=31) of the FY 2020-21 enrollees reported having a non-mental-health-related disability. The most common disability reported among CCYP participants was a learning disability (5.4%; n=14).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2020-21, the CCYP program served a total of 499 youth (419 maintenance and 80 ancillary youth). This total was comprised of the 258 FY 2020-21 enrollees, plus 241 prior year enrollees who were still active during FY 2020-21. The 499 youth served during FY 2020-21 represented approximately 100% of the original service targets established prior to CCYP implementation (n=500) and an increase of more than 100 youth served compared to the previous year (i.e., 397 youth were served during FY 2019-20).

As reported in Table 2a, maintenance clients received an average of 12.2 services during FY 2020-21 with approximately 70% (n=302) receiving at least one psychosocial assessment (mean of 2.0) and 81.6% receiving at least one medication management-oriented service (n=342; mean of 7.0). Interactions with the nurse were also common, with 64.4% having at least one session and a mean of 5.2 sessions. Overall, the CCYP program provided a substantial amount of psychiatric care to persons needing these specialized services. To generate a population-based, service contact estimate of workload for CCYP team members, the average number of services provided during each 30 days that a participant was enrolled in CCYP was

calculated. For each 30 days that a maintenance client was enrolled, an estimated 1.46 CCYP services were provided, with half of those being medication management visits (0.73) with the psychiatrists.

Table 2a. Services Provided by CCYP to Maintenance Clients during FY 2020-21* (N=419)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Mean Number of Services per 30 Days	Total Number of Services
	N	%			
Any CCYP service	391	93.3%	12.2	1.46	4,760
Psychosocial assessment	302	72.1%	2.0	0.19	602
Medication management	342	81.6%	7.0	0.73	2,387
Nurse consult	270	64.4%	5.2	0.43	1,409
Other services (e.g., collateral)	193	46.1%	1.9	0.11	362

**Note: Analyses include all maintenance clients enrolled in CCYP at any point during FY 2020-21, which means that for some, certain services may have occurred in the previous year or if they enrolled at the end of FY 2020-21 they may not have received all relevant services as of 6/30/2021.*

Table 2b presents the same CCYP service contact information for the 80 ancillary clients. Ancillary clients received an average of 8.1 services during FY 2020-21. Almost all (86.3%; n=69) received at least one psychosocial assessment (mean of 2.0) and 75.0% received at least one medication management-oriented service (n=60), with a mean of 4.5, which was substantially lower than the mean for maintenance clients (i.e., 7.0). Interactions with the nurse were also less common for ancillary clients with 46.3% having at least one session and a mean of 4.3 sessions (as compared to 64.4% for maintenance clients). The generally lower mean levels of services received by ancillary clients likely reflects their shorter durations of CCYP enrollment. However, when examined per 30 days of CCYP enrollment, ancillary clients received more overall services than maintenance clients (1.74 to 1.46 services, respectively). Of note, the per 30-day estimates for medication management and nurse consultation services were nearly identical between ancillary and maintenance clients, but ancillary clients had essentially twice as many psychosocial assessment and other/collateral service contacts per 30 days as did maintenance clients. From a CCYP workload perspective, this means that the increased enrollment of ancillary clients that occurred during FY 2020-21 disproportionately affected the Assessment Coordinators who provide these additional supportive services.

Table 2b. Services Provided by CCYP to Ancillary Clients during FY 2020-21 (N=80)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Mean Number of Services per 30 Days	Total Number of Services
	N	%			
Any CCYP service	78	97.5%	8.1	1.74	635
Psychosocial assessment	69	86.3%	2.0	0.38	137
Medication management	60	75.0%	4.5	0.74	270
Nurse consult	37	46.3%	4.3	0.44	159
Other services (e.g., collateral)	29	36.3%	2.4	0.19	69

**Note: Analyses include all maintenance clients enrolled in CCYP at any point during FY 2020-21, which means that for some, certain services may have occurred in the previous year or if they enrolled at the end of FY 2020-21 they may not have received all relevant services as of 6/30/2021.*

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 2020-21 maintenance and ancillary CCYP clients. Table 3 shows that the average duration for all maintenance clients still participating in CCYP services as of 6/30/2021 was more than a year at 407.8 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 319 days. In contrast, ancillary clients still participating in CCYP services as of 6/30/2021 had much shorter mean and median duration values of 156.5 and 74.0 days, respectively.

Table 3. CCYP Duration for Youth Receiving Services During FY 2020-21

	Maintenance (N=419)			Ancillary (N=80)		
	N	Mean Number of Days	Median Number of Days	N	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2021	296	407.8	319.5	68	156.5	74.0
Discharged during FY 2020-21	123	436.3	433.0	12	277.7	229.0

Maintenance clients who had discharged during FY 2020-21 had mean and median CCYP program participation durations of 436.3 and 433.0 days, respectively. In contrast, the mean and median CCYP program participation duration values for discharged ancillary clients were substantially shorter (277.7 and 229.0 days, respectively). These findings indicate that both maintenance and ancillary CCYP clients stay enrolled in CCYP for an extended period of time, with maintenance clients typically participating in CCYP services for more than a year. The duration differences between maintenance and ancillary CCYP clients highlight the comparatively shorter-term orientation of ancillary clients who are receiving CCYP services due to a temporary disruption in their ability to access psychiatric care in their primary service program where they are receiving ongoing therapy. These shorter CCYP durations result in a greater amount of "churn" among ancillary CCYP clients (i.e., onboarding into CCYP and then transitioning back to home programs and all associated coordination and communication required with clients, their families, and their primary service program).

As discussed in more detail below, efforts to increase program capacity contributed to the reorganization of some staffing responsibilities as well as provided additional motivation for developing partnerships to increase the number of youths who can be successfully discharged to PCPs or Federally Qualified Health Centers (FQHCs) for ongoing medication management. During FY 2020-21, a total of 13 maintenance youth CCYP discharges (approximately 10% of all 123 CCYP discharges) were coordinated specifically to transfer medication management responsibilities back to their PCP. Approximately 30% of all CCYP discharges for maintenance youth (n=37) were due to the emergence of behavioral health needs that required higher levels of care beyond the medication management services provided by CCYP. Given that over 400 maintenance youth received CCYP services during FY 2020-21, this indicates that less than 10% of youth were discharged for reasons of needing more intensive services such as a return to ongoing therapy.

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 2020-21 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 2020-21. 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=419)		Ancillary Clients (N=80)	
	Average number of BHS services per person during 180 days pre-CCYP	Average number of BHS services per person during standardized 180 days in CCYP	Average number of BHS services per person during 180 days pre-CCYP	Average number of BHS services per person during standardized 180 days in CCYP
Inpatient hospitalization	0.07	0.02	0.13	0.08
Crisis stabilization visits	0.16	0.09	0.35	0.67
PERT[1]	0.03	0.04	0.05	0.18
Therapeutic behavioral services	2.88	0.14	2.09	1.63
Outpatient sessions (not CCYP)	17.53	2.96	21.34	14.02

[1] *PERT = Psychiatric Emergency Response Team*

For the 419 maintenance youth served by CCYP during FY 2020-21 (see Table 4), crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT contacts were relatively rare events (i.e., much less than 1 instance per person) during the 180 days prior to CCYP enrollment. 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. In comparison, during an equivalent 180 days while enrolled in CCYP services, the average number of instances for each of these crisis/acute care services was essentially the same as during the 180 days prior to entering CCYP. Given that CCYP was designed to provide psychiatric care without requiring participation in outpatient therapy, the average number of non-CCYP outpatient sessions understandably reduced substantially from 17.53 in the 180 days immediately before CCYP to 2.96 for the 180 days enrolled in CCYP. Feedback from CCYP staff indicated that non-CCYP outpatient visits that occurred while enrolled in CCYP 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 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 outpatient treatment services while enrolled in CCYP compared to maintenance clients (14.02 and 2.96, respectively) given that ancillary clients are expected to be receiving treatment services elsewhere.

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 2019-20. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., typically 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 clients that are part of the primary target population of

"maintenance" enrollees 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 (CANS)

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 222 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2020-21 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 reductions at the last available follow-up for the three CANS domains, with Child Behavioral and Emotional Needs, and Life Functioning showing statistically significant reductions (i.e., change unlikely due to chance). 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=222)

	FY 2020-21 (N=222)	
Key CANS Domains	**Initial Mean Number of Needs**	**Follow-up Mean Number of Needs**
Child Behavioral	1.74	1.00**
Life Functioning	1.06	0.79**
Risk Behaviors	0.13	0.09

***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 each CANS domain approximately 70-80% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment. The percent of persons with an improvement across these three domains was similar to what was reported in the FY 2019-20 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients (i.e., approximately 70-75% had at least one improvement for each domain). The fact that most of the CCYP population with needs at baseline exhibited at least some progress on the CANS suggests that CCYP services provided by the psychiatrists and care team continue to help children, youth, and families make improvements in their overall well-being.

Table 6. Persons with CANS Improvement at FY 2020-21 Follow-up (N=222)

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	169	122	72.2%
Life Functioning	122	89	73.0%
Risk Behaviors	20	16	80.0%

Pediatric Symptoms Checklist (PSC)

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 7.

In FY 2020-21, 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 135 caregivers and 82 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 48.9% of parents and 39.0% of youth reported PSC scores that indicated clinical concern (see Table 7). At follow-up, 45.2% of parents still reported scores of clinical significance, however this lack of change is to be expected, as there are no therapy services offered as part of the CCYP program. Interestingly, youth self-reported scores improved with only 26.8% scoring beyond the clinical cutoff at follow-up. Likewise, an examination of mean score changes in youth self-report show a small, but statistically significant reduction (i.e., improvement) for both the Internalizing 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=135)					Child/Youth Report (N=82)				
		% Above clinical cutoff[1]		Mean			% Above clinical cutoff[1]		Mean	
Composites:	N	Baseline %	Post %	Baseline	Post	N	Baseline %	Post %	Baseline	Post
PSC Score	135	48.9%	45.2%	26.8	26.5	82	39.0%	26.8%	23	20.2*
Attention Subscale	135	37.0%	38.5%	5.4	5.5	82	25.6%	22.0%	4.5	4.5
Internalizing Subscale	135	37.0%	36.3%	3.7	3.6	82	41.5%	24.4%	3.7	3.1*
Externalizing Subscale	135	34.8%	35.6%	4.9	4.9	82	11.0%	14.6%	3.1	2.6

**statistical significance at $p < 0.05$; [1] PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7. Note: Higher scores indicate worse condition.*

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 FY 2019-20 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 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=135)		Child/Youth Report (N=82)	
Amount of Change	**N**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	62	45.9%	28	34.1%
No improvement (i.e., 0-1 point reduction)	13	9.6%	8	9.8%
Small improvement (i.e., 2-4 point reduction)	13	9.6%	13	15.9%
Medium improvement (i.e., 5-8 point reduction)	16	11.9%	12	14.6%
Large improvement (i.e., 9+ point reduction)	30	22.2%	21	25.6%

As shown in Table 8, approximately one-third of parents/caregivers (34.1%) and children/youth (40.2%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 45.9% of caregivers and 34.1% of children reported a higher PSC score at follow-up, indicating perceptions of increased impairment. Given that the CCYP population was determined to be relatively stable and not needing ongoing therapy upon entrance into CCYP, this finding of increased impairment likely reflects, at least in part, a "ceiling effect" in that there was not much room for improvement for many youths so it is not surprising that a portion of parents and youth might identify a few additional concerns at a later time point. Overall, these findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes.

Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2019-20 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 56 caregiver feedback surveys and 41 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2020-21. As shown in Table 9, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (89.3% and 82.9%, 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 (83.6%), compared to 75.6% of children/youth. Likewise, 94.4% of caregivers reported knowing where to get help and 83.7% felt comfortable seeking help, compared to 67.5% and 61.0%, respectively, among youth. Most caregivers reported feeling the needs of their family were met by the program (85.5%), while 68.3% 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% 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=56)**	**Youth (N=41)**
As a result of this program, my child is/I am able to function better.	83.6%	75.6%
As a result of this program, my child/I know where to get help.	94.4%	67.5%
As a result of this program, my child is/I am more comfortable seeking help for myself.	83.7%	61.0%
My child's/my needs were met by this program.	85.5%	68.3%
Overall, I am satisfied with the services I received here.	89.3%	82.9%

For the open-ended caregiver and youth feedback survey questions (n=55 caregivers; n=41 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. In addition, at the end of this fiscal year, three caregivers were interviewed via telephone, 24 caregivers and two youth completed a brief survey as part of interview recruitment, and 69 caregivers and youth completed telepsychiatry-specific surveys.

Across both caregivers and youth, respondents reported that CCYP is succeeding at providing needed medication management, providing supportive, responsive, helpful, attentive services, as well as flexible and convenient appointments. Families reported that if CCYP was not available they would not know where else to go for psychiatric medication management services given many PCPs are not comfortable prescribing the types and/or combinations of medications needed by their children.

Families were asked specifically about telepsychiatry, and about half indicated they would prefer telepsychiatry all the time while the other half would prefer a hybrid model. Many families cited convenience, safety due to the pandemic, and the visits being more comfortable than in-person as benefits to telepsychiatry, whereas some families were interested in some in-person interaction for rapport building as well as to allow the psychiatrist to view the client's symptoms more directly.

When asked about ideas for improving CCYP, most respondents said that overall services are helpful and did not have any specific recommendations. Some suggestions mentioned included increasing staff diversity to provide better racial/gender representation of clients/caregivers; improved communication between staff and clients, including more contact and attention and improved technical and interpersonal interactions with CCYP staff; and expanding services and referrals, in particular counseling services for those having difficulty transitioning away from counseling. Overall, both the qualitative and quantitative

feedback from caregivers and youth who completed a survey indicated high levels of satisfaction with CCYP services.

Other Program Activities

Establishing New Partnerships

CCYP has been pursuing a partnership with Children's Primary Care Medical Group (CPCMG) to develop a transition pipeline from CCYP service utilization to primary care services with providers able to continue medication management. This desired transition was motivated, in part, by a recognition that CCYP had many long-term stable clients who would likely be able to be cared for by either their current PCP with proper supports or another PCP with more experience managing psychotropic mediations. During FY 2020-21, a total of 13 youth were purposefully discharged from CCYP and transitioned back to medication management by their PCP. Increasing the number of youth who could successfully be cared for by PCPs would allow CCYP to admit additional new clients with more complex needs. In addition to the resources within CPCMG to assist PCPs with patients who have potentially complex medication management needs related to behavioral health, additional supports by psychiatrists from SmartCare (an independent organization designed to provide psychotropic medication consultations for PCPs) can be accessed. In this manner, coordination and communication between CCYP, CPCMG, and SmartCare is anticipated to allow for more successful discharges of CCYP clients to the care of PCPs. In FY 2020-21, contact was made with CPCMG leadership/representatives and plans were developed to identify youth who were candidates for transitioning medication management services to a CPCMG PCP. This partnership will be further developed during FY 2021-22 and opportunities to transition youth to local FQHCs for ongoing medication management needs will be explored.

Primary Implementation Findings

Findings in this section were derived from three primary data sources: 1) CCYP stakeholder meetings, 2) the Annual CCYP Staff/Psychiatrist Survey, and 3) semi-structured interviews with psychiatrists conducted during spring 2021. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of FY 2020-21. 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 13 respondents (6 psychiatrists and 7 assessment coordinators/administrators/support staff) from the 13 CCYP staff or contractors invited to participate in the survey (i.e., a 100.0% 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. For the psychiatrist interviews, the transcribed interviews were analyzed using elements of the Rapid Assessment Procedures framework (RAP; Beebe, 2001; Palinkas & Zatzick, 2019). The first step was to create a summary template from the main questions in the interview guide. Two independent coders reviewed each recording. Coders then independently completed summary templates for each interview. The templates were compared and any inconsistencies were discussed with a third member of the research team. Finalized summary templates were entered into a matrix and then distilled into themes.

Program Outreach and Recruitment

Similar to FY 2019-20, outreach and recruitment were not perceived as substantial challenges for the CCYP program. In its third year of operation, the CCYP program continues to be well known throughout San Diego County and accepted referrals from more than 20 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 which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

CCYP Participant Engagement and Retention

The CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for FY 2020-21 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 seem to have been successful, as CCYP staff overall did not indicate client engagement as a concern this year.

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

Experience with Telehealth Services

Staff identified several strengths of the telepsychiatry platform: including that the mode of service delivery provides unique insight into life at home (e.g., family dynamics), that clients can be more open and comfortable at home, a decreased no-show rate, and increased flexibility of scheduling. The main challenges identified by staff included technology challenges, client preferences to not use video capabilities during sessions (i.e., audio only), and difficulties obtaining needed vitals. Proposed solutions include having technology support available and giving clients a choice between phone and video conferencing for appointments. Additionally, providing families with the equipment to obtain essential vital signs at home, such as blood pressure monitoring tools, might improve remote service provision efforts. Overall, psychiatrists reported that telepsychiatry in CCYP worked similarly to other programs they worked for, with comments that CCYP was more organized and flexible about digital platform use.

Approximately 11-25% of clients were estimated to prefer telephone-only sessions even when they had the ability to participate in a video session. This is likely due to both client preferences as well as the additional technology proficiency/comfort issues required to conduct a video session.

Communication and Administrative Processes

Staff indicated a need for increased community and collaboration among various provider types within CCYP (psychiatrists, assessment coordinators, nurse), as well as more streamlined internal communication

protocols. Staff also suggested additional training on the administrative elements of the program such as managing the intake process, billing codes, and documentation standards, as well as increased efforts to streamline and simplify such protocols when possible.

Staff also requested clear indicators for discharge from CCYP. Some psychiatrists indicated that those clients appropriate for transfer might be those on no more than two medications, those prescribed basic medications such as stimulants, simple anti-depressants, alpha antagonists, anti-anxiety medications, and ADHD medications. To increase the comfort and capacity of PCPs to manage psychotropic medications, staff suggested developing a consultation/collaboration model between CCYP psychiatrists and PCPs, and implementing specific training and psychoeducation for PCPs through consultation programs such as SmartCare. However, one staff member noted that there could be billing issues with these types of collaborative activities.

Impact of COVID-19 on CCYP Staff

In terms of COVID-19 impact, CCYP psychiatrists and other staff members indicated there were aspects of their lives, both related and unrelated to work, that continued to be sources of stress and anxiety because of the pandemic. Additionally, they noted continued increased stress and potential for destabilization among CCYP youth and their caregivers. Some staff did indicate that the remote work setting allows for greater flexibility and reduced no-shows. Other staff indicated they felt that their productivity was lower because of the remote work setting as compared to prior office-based workflow.

Workload Challenges

Similar to the previous fiscal year, staff continued to indicate high caseload levels for the Assessment Coordinators, which may in part contribute to turnover for this position. Although the role was shifted from a Care Coordinator to an Assessment Coordinator over the last two years to primarily focus on client intake assessments and the facilitation of more psychiatry sessions, both psychiatrists and assessment coordinators reported that some families (particularly the ancillary families where the client is still receiving therapy) have more extensive needs that would benefit from additional Care Coordinator services. Further, ancillary referrals who are still receiving psychotherapeutic services elsewhere do not have the benefit of the natural within-agency lines of communication across psychiatry and psychotherapy, thus requiring additional support from CCYP that is not built into the current program structure. One solution moving forward might be to assign an Assessment Coordinator to maintenance CCYP clients, and a more traditional Care Coordinator to the ancillary clients.

Changes from Initial Program Design

1. In FY 2020-21, the Care Coordinator position at CCYP was rebranded to Assessment Coordinator to reflect the primary responsibilities of this position more accurately.

2. New partnerships were developed with new contractors (e.g., BHConnect), which have uniquely affected the types of services provided by CCYP. Some of these ancillary youth required an increased level of services from CCYP as they still need therapy, case management and linkages to community resources based on their mental health concerns, which are primarily provided by their treatment provider. To support this population, CCYP has developed new service strategies to expedite communication, collaboration, and coordination between the youth, their families, the CCYP

psychiatrists, and the providers at their ongoing treatment program in order to effectively meet the needs of these youth.

3. In addition, CCYP provide psychiatry services for eight County BHS contracted programs that experienced disruptions in their ability to provide psychiatric services. Deviating from the initial design of CCYP, these youth required continued therapy and have mental health needs not originally intended for CCYP. CCYP leadership continues to work closely with their COR to update policies related to the changing service population and challenges that occur as a result.

Status Update on Prior Year Program Recommendations

Recommendation 1: Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.

FY 2020-21 Update: CCYP program leadership has worked with existing CCYP staff to examine and review tasks, duties, and documentation requirements. Specific changes to the health care coordinator and assessment coordinator positions were reported.

During FY 2020-21, the health care coordinator position was given new responsibilities related to telehealth documentation, County QI timelines, and examining efficiencies and productivity of the psychiatrists and assessment coordinators. As a result, CCYP achieved an increase in the availability of psychiatry hours for clients.

In addition, the assessment coordinator position has been streamlined. Assessment coordinators are required not to see clients monthly, but every six months instead, unless otherwise determined by mental health needs. As a result, assessment coordinators can see more clients and increase efficiency in their day-to-day duties.

Recommendation 2: Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirements back to PCPs or FQHCs for medication management.

FY 2020-21 Update: CCYP has made referrals to Children's Primary Care Medical Group (CPCMG) when necessary. Although the partnership with CPCMG has been slow to ramp up, collaboration efforts have increased to date. Additionally, coordinators are aware of the SmartCare referral process and all staff will continue to be trained on SmartCare. As an ongoing effort, leadership will continue to identify and connect with additional alternatives (PCPs and FQHCs) for families who are appropriate for discharge from CCYP.

Recommendation 3: Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services but have insufficient or nonexistent access to psychiatric medication management services.

FY 2020-21 Update: Partnership development has shown expansion over the last year with more ancillary clients being served, a partnership with BHConnect, and increased numbers of County-contracted programs receiving CCYP services.

Recommendation 4: Examine strategies to enhance client active engagement in services.

FY 2020-21 Update: To enhance engagement, CCYP has developed a strategy to expand the information on their website. For example, CCYP developed and distributed a monthly newsletter starting in FY 2021-

22. The newsletter will highlight an article written by one of the psychiatrists and focus on a common diagnosis, its intervention strategies, and medication considerations. Additional information will include healthy recipes, no or low-cost community activities, and other community and educational resources. Special consideration will be given to the reader's attention span and capabilities so that the newsletter can effectively offer useful solutions, educate caregivers, and provide a knowledge base of community resources.

Recommendation 5: Revise evaluation approach to minimize staff and participant burden, while still generating information relevant to enhancing understanding of CCYP program outcomes and opportunities for improvement.

FY 2020-21 Update: The evaluation team and program leadership collaboratively decided to stop using an assessment tool that was determined to not generate useful information in order to reduce participant and staff burden. To generate information from which to better understand participant experiences and perceptions, particularly related to telehealth service provision, new brief survey tools were developed and distributed to CCYP participants.

New Program Recommendations

1. Continue to develop educational and outreach oriented CCYP website (e.g., basic materials about disorders, resource library for caregivers, resource library for providers, past newsletters, commonly used handouts or worksheets).
2. Assess staffing requirements and/or staffing supports needed to best serve the unique service needs of the “maintenance” and “ancillary” CCYP populations.
3. Explore opportunities to provide families with the equipment needed to obtain essential vital signs at home such as blood pressure monitoring tools.

Conclusion

During FY 2020-21, the third year of program operations, CCYP served a total of 499 children and youth (419 maintenance and 80 ancillary clients). Of these, 258 enrolled in CCYP during FY 2020-21 (190 maintenance referrals and 68 ancillary referrals). CCYP enrolled substantially more persons than discharged during FY 2020-21 (258 to 135). This rate of annual growth will contribute to program capacity challenges that will potentially limit future availability for new enrollment without changes to staffing levels or discharge patterns.

Growth can be partially attributed to CCYP enrolling an increased number of ancillary youth (i.e., over 25% of new CCYP enrollees during FY 2020-21), who continued to receive therapy services at another organization while CCYP provided needed medication management or psychiatric care. Based on staff feedback and CCYP service utilization data, the ancillary youth appear to have higher acuity needs and require additional attention by CCYP in order to support coordination and communication with the external organization providing ongoing therapy.

During FY 2020-21, CCYP maintenance youth typically received services for more than a year (i.e., median length of stay for those who discharged during FY 2020-21 was 433 days). Overall, CCYP maintenance enrollees utilized crisis or acute care BHS services at a rate similar to or lower than prior to CCYP enrollment.

Due to the inclusion of telehealth services in CCYP's initial design, the program continued to serve clients during the ongoing COVID-19 pandemic without substantial disruption to services. Staff and caregiver feedback provided in FY 2020-21 expressed favorable views of telehealth services. Telehealth services are expected to remain a primary modality for providing services even if in-person services become more available.

Although pragmatic needs remain, CCYP is developing the program's ability to address these issues. Community partnerships have expanded to meet the needs of the service population and opportunities for enhanced client engagement are being explored via digital spaces such as the CCYP website and mailing lists. Remaining challenges are specific to caregiver or client needs that could be supported by in-person solutions, specifically challenges related to technological barriers to telehealth and assistance obtaining lab draws and vitals.

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

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Appendix

Participant Characteristics of Persons Enrolled during FY 2020-21

Characteristic	Total Participants (N=258)	
Age Group	N	%
5 to 11	79	30.6%
12 to 15	95	36.8%
16 to 17	69	26.7%
18 to 20	15	5.8%
Total	258	100%
Gender	N	%
Male	121	46.9%
Female	135	52.3%
Prefer not to answer	2	0.8%
Total	258	100%
Sexual Orientation	N	%
Heterosexual or straight	156	60.5%
Gay or lesbian	5	1.9%
Bisexual/Pansexual/Sexually fluid	32	12.4%
Questioning/Unsure of sexual orientation	11	4.3%
Other sexual orientation	5	1.9%
Missing/Prefer Not to Answer	49	19.0%
Total	258	100%
Language	N	%
English	229	88.8%
Spanish	21	8.1%
Other	8	3.1%
Total	258	100%
Race/Ethnicity	N	%
African American	32	12.4%
Asian	21	8.1%
Hispanic or Latino	144	55.8%
White	115	44.6%
Multiple	55	21.3%

Characteristic	Total Participants (N=258)	
Other	7	2.8%
Total[1]	-	-
Mental Health Diagnosis[2]	**N**	**%**
Depressive Disorders	76	29.5%
ADHD	62	24.0%
Anxiety Disorders	36	14.0%
PTSD/Acute stress reaction	33	12.8%
Bipolar Disorders	19	7.4%
Oppositional/ Conduct Disorders	8	3.1%
Dual diagnosis	7	2.7%
Schizophrenia/ Other Psychotic Disorders	7	2.7%
Other Disorder	10	3.8%
Total	258	100%
Disability	**N**	**%**
Yes, has a disability	31	12.0%
No, does not have a disability	227	88.0%
Total	258	100%
Type of Disability	**N**	**%**
Seeing	7	2.7%
Other Communication	5	1.9%
Learning	14	5.4%
Developmental	6	2.3%
Physical/Chronic/Other	6	2.3%
Total[3]	-	-

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