URBAN BEATS INNOVATIONS-16

Final Report
(7/1/2015 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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 Urban Beats program was designed to provide wellness education and mental health support to transitional age youth (TAY) age 16-25 who were: 1) clients of the County of San Diego Behavioral Health Services (BHS) system, 2) experiencing mental health distress, or 3) at risk of mental health challenges. Core services were provided via a structured multi-week curriculum and individualized development of desired forms of artistic expression. The arts-based focus was intended to function as a mechanism to promote youth engagement as well as help reduce mental health-related stigma in both the TAY and the community through public performances.

For Urban Beats, the onset of the COVID-19 pandemic substantially affected program services. Since all in-person interactions were suspended, this halted the delivery of the standard cohort-based classes and workshops. In addition, the social distancing restrictions required that all community performances be cancelled and studio time with youth was not feasible. Staff continued to reach out and connect with youth via phone and video calls to maintain established relationships and offer encouragement and support during challenging times.

Primary Findings

1. The arts-based approach with a strong peer support/peer empowerment component appeared to be a successful strategy for connecting with and engaging youth in a mental health wellness and stigma reduction program as demonstrated by their ability to enroll over 770 unduplicated TAY into Urban Beats. Additionally, Urban Beats participants reflected substantial diversity in race/ethnicity, primary language, sexual orientation, and gender identity.
2. For those with matched pre- and post-Urban Beats participation assessment data, youth demonstrated improved attitudes regarding mental health services as participants indicated they felt more comfortable talking to mental health professionals and were more likely to think that professional mental health services were effective.
3. It is estimated that over 5,000 persons attended the more than 130 Urban Beats community performances/events. Of the almost 4,000 completed surveys, the vast majority (84.7%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. Most importantly, the public performance orientation was

essential to achieving overall Urban Beats programs objectives as it provided focal activities to motivate skill-building, relationship development, growth in self-esteem and leadership capabilities, as well as further reductions in personal and community stigma related to mental health and participation in mental health services when needed.

4. While generally uncommon among Urban Beats participants, especially as more recent cohorts included primarily "at-risk" youth rather than those already with a history of receiving mental health services, analyses indicated a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g., inpatient psychiatric hospitalizations, crisis residential treatment, and emergency/crisis-oriented psychiatric visits).
5. Approximately 85% of participants reported being satisfied with the Urban Beats program while approximately two-thirds reported key outcomes such as symptom reduction, improved management of problems, and reduced stigma for seeking help.
6. A total of 70 Urban Beats youth participated in one-on-one sessions with the "in-house" clinician after this role was added to the team during FY 2018-19. The majority of youth received Trauma Informed Therapy, suggesting a high need for such services.

Conclusion/Future Directions

Overall, the arts-based strategy appeared to be successful for engaging youth in services. Feedback from both youth and Urban Beats staff identified how the focus on artistic expression with an expectation of public presentation/performance contributed to improvements in self-confidence and mental well-being and reductions in mental health related stigma. Additionally, preparation for community performances promoted the development of strong relationships and peer support among Urban Beats participants, while the performances themselves created opportunities for sharing positive messages with other TAY and community members.

Given the unusual circumstances surrounding the emergence of COVID-19 during the latter part of FY 2019-20 that significantly altered Urban Beat's service delivery strategies, BHS provided a short-term, one-year extension using funds unrelated to the Mental Health Services Act (MHSA) Innovations portfolio. During FY 2020-21, BHS will make the determination about investing in the long-term provision of Urban Beats services and/or consider ways to strategically incorporate the valuable lessons learned from the program about youth outreach, engagement, and support into existing and future programs.

Program Description

The County of San Diego Health and Human Services Agency's BHS Urban Beats program was funded through the Innovations (INN) component of the MHSA. Urban Beats was developed to provide TAY (age 16-25) with increased access to and knowledge of behavioral health treatment and wellness services, as well as reduce mental illness stigma for TAY and the community. The primary innovation of this program was the utilization of artistic expression to communicate a recovery-focused message to TAY and develop artistic skills and self-esteem. The program added a therapist in its third year who provided counseling and emotional support directly to Urban Beats TAY as needed. An in-house therapist was expected to

increase access to and utilization of behavioral health care by Urban Beats TAY since these services could now be accessed within the network of trusted Urban Beats relationships, rather than requiring a referral to an external provider. For TAY with significant needs, the Urban Beats therapist worked to identify and link TAY to appropriate ongoing care. Another change included the expansion into new communities such that Urban Beats grew from the initial pilot programs to operating four programs throughout the Central and North Central Regions of San Diego County.

A core activity of the Urban Beats program was a structured 20-hour curriculum that focused on improving TAY health and mental health awareness and increasing overall well-being by addressing topics such as healthy relationships, wellness and trauma, identity, goal setting, and leadership. Following the structured multi-week classes, Urban Beats staff provide individualized attention to each TAY to help develop their desired form of artistic expression and create something for public presentation/performance (e.g., drawing, poetry, song, and videography). Throughout the program, TAY presented their creations in public performances designed to build greater self-esteem among participants, educate the community about mental health issues, and reduce stigma for both the Urban Beats participants and community members.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

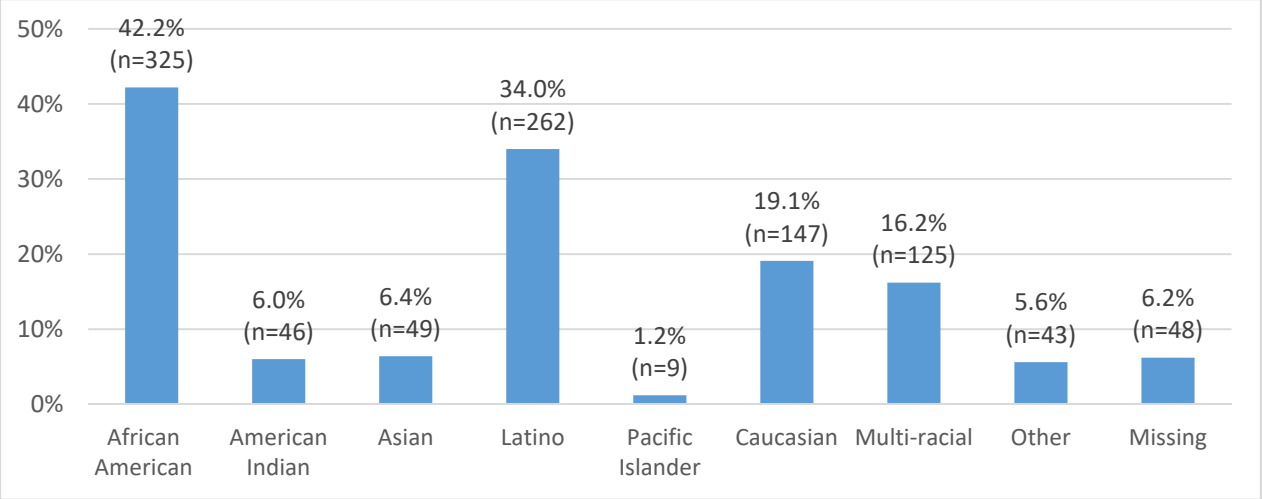
For Urban Beats, the onset of the COVID-19 pandemic substantially affected program services. Since all in-person interactions were suspended, this halted the delivery of the standard cohort-based classes and workshops. In addition, the social distancing restrictions required that all community performances be cancelled and made studio time not feasible, at least through the end of FY 2019-20. Staff continued to reach out and connect with youth via phone and video to maintain established relationships and offer encouragement and support during challenging times. The Urban Beats staff also worked to develop versions of the 20-session cohorts and workshops that would be viable for conducting remotely via video. It is expected that such services will be offered during FY 2020-21. Where relevant, findings and recommendations in this report indicate the unique challenges that COVID-19 poses within the local community and healthcare environment.

Participant Characteristics

A brief overview of the Urban Beats participant characteristics is presented here, with a more complete listing in the appendix. Urban Beats program eligibility criteria required that participants were TAY between the ages of 16 and 25. Of the 770 participants involved with Urban Beats between FY 2015-16 and FY 2019-20, the majority were male (53.4%), spoke English (71.8%), and identified as heterosexual (69.1%). When asked to indicate a disability that was not the result of a Serious Mental Illness (SMI), 24.6% indicated having a disability, with 10.9% reporting a learning disability specifically. As shown in Figure 1,

Urban Beats participants were racially and ethnically diverse with no single population group representing more than 50% of the population.

Figure 1. Race/Ethnicity of Youth Enrolled in Urban Beats between FY 2015-16 and FY 2019-20 (N=770).



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

Primary Program Outcomes

Urban Beats Participant Beliefs

Urban Beats participants were asked to complete a Wellness Survey, which includes select items from the Recovery Markers Questionnaire (RMQ) at the start of classes, 6 weeks later, and at the end of the 20-week program. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in Table 1. The table presents the average rating at baseline and the most recent follow-up for everyone involved in the program with both baseline and follow-up data (n=122). Additionally, to investigate the potential that participants have differing perspectives based on their self-reported mental health status at baseline, findings are presented separately for those who indicated low mental health (i.e., poor or fair; n=38) and high mental health (i.e., good, very good, or excellent; n=84).

Overall, at baseline, the most commonly endorsed statements (i.e., those with the highest means) focused on participants' beliefs about their self-efficacy (#12) and pursuit of goal achievement (#6). Participants appeared to be less enthusiastic about their stress management capabilities (#11) and having sufficient income (#4). These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

Table 1. Urban Beats Participant Beliefs – Baseline and Follow-up Comparisons (N=122)

		Overall (n=122)		Baseline Mental Health: Low (n=38)		Baseline Mental Health: High (n=84)	
#	Item	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean
1	In general, how would you rate your satisfaction with your social activities and relationships	3.3	3.4	2.3	2.7^	3.7	3.7
2	I have at least one close mutual relationship	4.0	4.1	3.7	3.8	4.1	4.2
3	I am involved in meaningful, productive activities	3.8	4.0	3.4	3.9**	4.0	4.0
4	I have enough income to meet my needs	2.9	3.2*	2.4	2.8*	3.1	3.3
5	I am using my personal strengths, skills, or talents	3.9	4.0	3.4	3.6	4.0	4.1
6	I have goals I'm working to achieve	4.2	4.3	3.8	4.1	4.4	4.3
7	I contribute to my community	3.6	3.8^	3.4	3.6	3.7	3.9
8	I have a sense of belonging	3.7	3.8	2.9	3.2	4.0	4.0
9	I feel hopeful about my future	4.0	4.1	3.6	3.9^	4.2	4.2
10	I treat myself with respect	3.8	4.0*	2.9	3.4*	4.2	4.3
11	I am able to deal with stress	3.4	3.6*	2.7	3.2*	3.7	3.8
12	I believe I can make positive changes in my life	4.1	4.4**	3.7	4.2**	4.3	4.4
13	Mental health services can effectively improve mental health	3.6	4.0**	3.5	4.1**	3.7	4.0*
14	I would feel comfortable talking to a mental health professional	3.5	4.0**	3.6	4.1*	3.5	3.9**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01; Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.*

Participants who reported having lower mental health at baseline typically also indicated lower baseline values across other Wellness Survey items. At follow-up, ratings across all items stayed the same or increased for both groups of participants, with the persons who indicated lower baseline mental health generally demonstrating larger improvements. Statistically significant changes unique to this group were evident in their participation in meaningful activities (#3), having sufficient income (#4), ability to manage stress (#11), and beliefs about personal positive self-efficacy (#12).

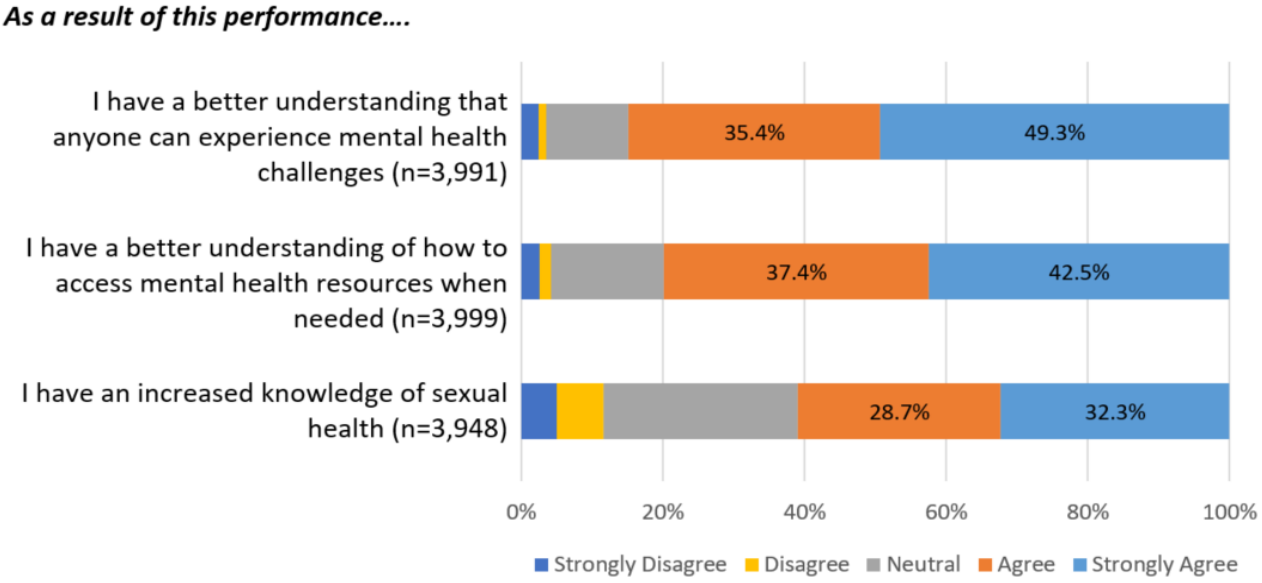
These findings suggest that participants who felt more negative about their mental health upon entry into Urban Beats were typically able to experience significant improvements in multiple domains central to

the goals of the program. Persons who entered Urban Beats with more favorable perceptions about their own mental health were able to maintain or slightly improve their already more positive outlook on these domains. For both groups, their attitudes regarding mental health services significantly improved, with initial scores of around 3.5 (i.e., neutral/agree) and follow-up scores around 4.0 (i.e., agree) in their sense that mental health services can improve mental health (#13) and feeling comfortable talking to a mental health professional (#14). These findings reflect success at improving perceptions about mental health services among both types of Urban Beats program participants.

Community Performance Outcomes

Over the life of the program (FY 2015-16 to FY 2019-20) Urban Beats hosted or co-hosted over 130 different community performances/events. It is estimated that over 5,000 persons attended these performances/events and 3,999 completed an outcome survey (note: surveys were not able to be distributed at all events). Transitional age youth (ages 16-25) comprised 70.3% (n=2,844) and persons younger than 16 comprised another 10.2% (n=412) of the audience. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 2, a majority of all respondents (84.7%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. A similar percent (79.9%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (61%).

Figure 2. Assessment of Community Performance Attendee Learning (N=3,999)



The response patterns between TAY and persons older than TAY who attended the performances were fairly similar for the three outcome questions. For persons younger than 16, the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" was also similar (i.e., approximately 74.6%); however, in comparison to TAY, they indicated slightly lower rates of "better understanding how to access mental health resources" (70.6% compared

to 82.2%) and substantially lower rate of “increased knowledge of sexual health” (46.9% compared to 65.5%) as a result of the performance.

Utilization of BHS Services by Urban Beats Participants

To assess the extent to which participation in Urban Beats may be associated with changes in BHS service utilization patterns, BHS service use by Urban Beats participants was examined 180 days before and 180 days after starting the Urban Beats program. To ensure that everyone included in the analyses had the entire 180 days to be observed for any behavioral health service utilization after starting Urban Beats, the analyses only included participants (n=659) who started the Urban Beats program at least 180 days prior to the end of the 6/30/2020 reporting period.

As shown in Table 2, 16.8% of the 659 Urban Beats ‘life-of-program’ participants included in the 180-day analyses attended at least one behavioral health outpatient visit within the 180 days prior to starting the Urban Beats program and slightly less than 10% (8.6%) participated in Assertive Community Treatment (ACT). There was little change in participation rates for outpatient visits while the participation rate and number of total visits for ACT had a modest increase (9.1%; 2,304 vs 2,523 visits).

While less frequent overall, the findings in Table 2 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) contacts, emergency psychiatric hospital visits, inpatient psychiatric hospitalizations, and justice-related mental health services (e.g., services received while in jail or participating in behavioral health court proceedings), were utilized less often after participants had started the Urban Beats program. For example, while 5.8% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 3.2% had a hospitalization after starting Urban Beats (a 45% reduction in the hospitalization rate; total admissions reduced from 73 to 37). There was also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (3.6% vs 1.1%; 30 vs 7 admissions).

Given the relatively low utilization rates of most acute/crisis care-oriented services, these findings should be interpreted with caution; however, the overall pattern suggests that participation in Urban Beats was associated with lower utilization of public mental health acute/crisis-oriented services.

Table 2. County BHS Utilization before and after Starting Urban Beats (N=659)

	180 Days Before Start Urban Beats			180 Days After Start Urban Beats		
	Persons with at least one session	% of Urban Beats population	Sum of visits	Persons with at least one session	% of Urban Beats population	Sum of visits
Outpatient Visits	111	16.8%	1,248	106	16.1%	1,216
Assertive Community Treatment (ACT)	57	8.6%	2,304	60	9.1%	2,523
Urgent Outpatient	34	5.2%	55	28	4.2%	39
Crisis Stabilization	20	3.0%	27	9	1.4%	15
Psychiatric Emergency Response Team (PERT)	23	3.5%	29	14	2.1%	19
Justice-Related Mental Health Visit	16	2.4%	57	11	1.7%	38
	Persons with at least one admission	**% of Urban Beats population**	**Sum of admissions**	**Persons with at least one admission**	**% of Urban Beats population**	**Sum of admissions**
Inpatient Psychiatric Hospital Admit	38	5.8%	73	21	3.2%	37
Crisis Residential Treatment	24	3.6%	30	7	1.1%	7

Participant Assessment of the Urban Beats Program

As shown in Table 3, the vast majority (83.7%) of Urban Beats participants with follow-up Wellness Survey data indicated that they were satisfied with the Urban Beats program (#1; 35.6% agreed and 48.1% strongly agreed) and a similar percentage (84.4%) felt appropriately supported by the Urban Beats staff (#2; 35.9% agreed and 48.5% strongly agreed). Participants who indicated that they had lower mental health upon program entry tended to be slightly more favorable about their experiences with Urban Beats, particularly in regard to feeling appropriately supported by staff (96.3% agreed/strongly agreed as compared to 84.4%, respectively). This suggests that while Urban Beats staff effectively engaged with

most participants, they were especially skilled at connecting with and supporting participants who were experiencing mental health-related difficulties when they entered the Urban Beats program.

Table 3. Urban Beats Participant Assessment of the Urban Beats Program (N=104)

		Overall			Baseline Mental Health: Low (n=27)			Baseline Mental Health: High (n=76)		
#	Item	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean
1	Overall, I am satisfied with the services I received	83.7%	35.6% (48.1%)	4.3	88.8%	44.4% (44.4%)	4.3	81.6%	32.9% (48.7%)	4.2
2	I felt appropriately supported by staff when I encountered challenges	84.4%	35.9% (48.5%)	4.3	96.3%	40.7% (55.6%)	4.5	80.0%	33.3% (46.7%)	4.2
As a result of the program…		**Agreed Total**	**Agree (Strongly Agree)**	**Mean**	**Agreed Total**	**Agree (Strongly Agree)**	**Mean**	**Agreed Total**	**Agree (Strongly Agree)**	**Mean**
3	I know where to get help when I need it	82.7%	46.2% (36.5%)	4.2	74.1%	51.9% (22.2%)	4.0	85.5%	43.4% (42.1%)	4.2
4	I am more comfortable seeking help	69.9%	38.8% (31.1%)	3.9	66.6%	48.1% (18.5%)	3.8	70.7%	34.7% (36.0%)	3.9
5	I deal more effectively with daily problems	64.1%	47.6% (16.5%)	3.7	59.3%	51.9% (7.4%)	3.6	65.3%	45.3% (20.0%)	3.8
6	My symptoms are bothering me less	62.5%	36.5% (26.0%)	3.8	55.5%	40.7% (14.8%)	3.6	64.5%	34.2% (30.3%)	3.8

The majority of participants indicated that as a result of the Urban Beats program, they knew where to get help (#3; 82.7%), felt more comfortable seeking help (#4; 69.9%), dealt more effectively with daily problems (#5; 64.1%), and were less bothered by symptoms (#6; 62.5%). The results were fairly similar between the two self-reported mental health groups of Urban Beats participants, however, a slightly larger proportion of the participants who entered the program with more favorable perceptions of their mental health indicated they agreed or strongly agreed with experiencing these outcomes. These findings suggest that while most youth experienced a range of positive benefits from participating in the Urban

Beats program, there continues to be a need for improvements, particularly among youth who enter the program with more significant mental health difficulties.

Findings from focus groups conducted with Urban Beats youth provided additional information regarding youth perceptions of the program. Overall, the language that youth used to describe their experiences with Urban Beats indicated that the staff had successfully adopted a strengths-based approach that highlighted the resilience and capabilities of the youth rather than focusing on deficiencies and "problems." Youth indicated that they were very satisfied with the program and that they understood and supported the goals of Urban Beats. Consistent with the quantitative survey data, youth spoke very positively about their interactions with Urban Beats staff and indicated that the support and recognition they received from staff was highly valued.

As a change from the original, linear form of anticipated Urban Beats program participation (i.e., youth enter and proceed through a class cohort and then leave the program upon successful completion), Urban Beats participants from prior cohorts often returned to participate in and help out with subsequent courses and performances. For this reason, the group of youths involved with Urban Beats often had various levels of prior interactions and experience with the program. Youth indicated that the ability to stay connected to Urban Beats beyond their initial cohort helped to support ongoing growth and learning.

Youth focus group participants frequently identified experiencing positive outcomes in the following domains:

1. Improved mental well-being/better stress management.
2. Enhanced skills in their preferred form of creative expression.
3. Better ability to communicate with others (particularly regarding mental health).
4. Greater sense of self-confidence and self-empowerment that helped them try new things.
5. Increased social support from other TAY, from Urban Beats staff, and from connections Urban Beats facilitated at other community organizations.
6. Increased capacity for leadership, goal setting, and goal attainment.

Youth also indicated that these skills and experiences laid the groundwork for accomplishing larger ambitions, such as identifying what careers they might want to pursue and giving them the skills and confidence to achieve their goals. Some youth, especially those who had participated in multiple rounds of Urban Beats cohorts, reported that either they themselves or others from their cohort had found jobs in entertainment/the arts or in mental health fields working as peers.

The following quotes from some of Urban Beats participants capture the transformative power of the opportunities, education, and support provided by and through Urban Beats participation:

"The first time I read one of the first poems I ever wrote was at an open mic that Urban Beats would take us to. I was so nervous I almost didn't read it, but with the support of Urban Beats I read it and the crowd's reaction to my poem was priceless. I never in my life felt support like that till that day. From that day on my life has never been the same. I felt for the first time in my life, I actually felt comfortable being me."

"They quite literally saved my life and helped me make healthier choices."

Utilization of Therapeutic Services Provided by the Urban Beats Clinician

Based on experiences during the early years of the Urban Beats program, particularly the ongoing challenges of connecting youth to formal behavioral health services when needed, the Urban Beats program added an "in-house" behavioral health clinician (pre-licensed) who could meet directly with Urban Beats participants. A total of 70 Urban Beats youth participated in one-on-one sessions with the clinician since this service was added during FY 2018-19. It is estimated that approximately 20% of Urban Beats youth active during this time frame participated in at least one session with the clinician. The 42 youth with detailed clinician service contact data received a total of 336 sessions (median number of sessions = 5). As shown in Table 4, a wide variety of services were provided during sessions and more than one service type could be provided in a single session. Cognitive Behavioral Therapy was the most common service provided (39.6%), followed closely by Trauma Informed Therapy (37.5%). Approximately 5.0% of all sessions were directly related to providing crisis intervention services (4.8%). Of these 42 Urban Beats youth participating in sessions with the clinician, 71.4% (n=30) had at least one session of Trauma Informed Therapy. This indicates a high need for trauma informed care among Urban Beats youth.

Table 4. Primary Types of Clinician Delivered Services (N=336 sessions)

	Total Sessions	
Type of Service	**N**	**%**
Cognitive Behavioral Therapy	133	39.6%
Trauma Informed Therapy	126	37.5%
Discharge planning	20	6.0%
Crisis Intervention	16	4.8%
Case Management	13	3.9%
Safety Assessment/ Planning	12	3.6%
Solution Focus Therapy	10	3.0%

Community Partner Feedback

The Urban Beats program interacted with a wide range of community organizations including schools, social services agencies, mental health providers, and other arts and culture organizations. A brief online survey was conducted with representatives of these community organizations to better understand their perceptions of the Urban Beats program. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes. Representatives from 13 of the 26 invited community agencies completed the survey for a 50% response rate. All respondents (n=13) indicated that Urban Beats provided important services to youth with 84.6% (n=11) saying that the collaborations with Urban Beats helped their organization achieve desired goals/objectives. Respondents also indicated that collaborations often included Urban Beats conducting trainings and workshop events with their youth on leadership, relationships, communication, arts, self-care, and mental health awareness. In addition to these workshops and trainings, Urban Beats collaborated with schools to offer mental health support services as well as after school enrichment activities.

When asked about the effect of the Urban Beats program, community partners reported a positive impact of the program in reducing the stigma of mental health while also providing mental health services. Community partners largely reported that the success of Urban Beats was due to the program staffs' ability to effectively engage and communicate with TAY, which led to a safe space for TAY to grow and develop confidence, skills, knowledge, and peer relationships. Overall, community partners reported being grateful for Urban Beats and the support, resources, and opportunities that were provided since they saw improved mental health, self-esteem, creativity and self-expression within their organization/clientele.

Additional Program Activities

Social Media Presence

The Urban Beats program developed a website (https://www.sdurbanbeats.org/) to help raise awareness of available program services, share information about other community resources, and promote upcoming performances. As of 6/30/2020, the website had recorded 116,140 visits. Additionally, Urban Beats had 1,056 Instagram followers, 726 Facebook "likes," 137 Twitter followers, and 1,725 SoundCloud plays.

TAY Engagement Trainings for Community Partners

In addition to their work directly with TAY, Urban Beats staff also conducted trainings with the staff of other community organizations to share their knowledge about how to increase TAY engagement in services. During FY 2019-20, a total of 10 such trainings were provided to 171 persons representing a wide range of community organizations (e.g., YMCA, SDSU, Mesa College, and Father Joe's).

Primary Implementation Findings

Findings reported in this section were derived from three primary data sources: 1) stakeholder meetings, 2) the Annual Urban Beats Staff Survey, and 3) focus groups conducted with Urban Beats staff. The stakeholder meetings were held throughout the year with representatives from BHS, Urban Beats, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual Urban Beats Staff Survey was conducted yearly throughout the MHSA Innovations Urban Beats program to generate feedback about staff experiences with, perceptions about, and recommendations for program implementation and operation. Staff focus groups were held periodically throughout the program to get more detailed feedback on program operations, challenges, and perceived opportunities.

Arts-Based Service Strategy

An arts-based curriculum was perceived to be an effective approach to engage TAY in a behavioral health-oriented outreach and support program, and, in particular, an important approach for racial/ethnic and sexual orientation minorities who may be uncomfortable and underserved in more traditional mental health service settings. There were five key benefits associated with utilizing an arts-based approach to provide services to TAY:

1. The arts-based approach facilitated outreach and recruitment as it had more intrinsic appeal compared to recruiting for something such as a "wellness class."
2. The arts-based approach facilitated relationship building via organic one-on-one mentorship with Urban Beats staff as well as providing opportunities for positive social relationships with peers while collaboratively practicing/preparing their art forms.
3. The ability to engage in artistic expression was viewed as a benefit in its own right as the subject matter of the art frequently related to the youth's experiences with loss, joy, struggle, or healing that helped youth think about and process their own emotions in a manner that promoted positive well-being.
4. The arts-based approach allowed the youth to have an end product, whether in the form of music, poetry, visual arts, etc., that could be used to engage with the broader community. Since their art was often intended to prompt discussion about well-being, acceptance, and the normalization of mental health challenges, the act of sharing their art provided important, destigmatizing messages to other TAY and community members.
5. The arts-based approach coupled with an expectation of public engagement (rather than solely for private, personal enrichment) created opportunities for personal growth, such as increased self-confidence by sharing their art with others, as well as additional skill and leadership building opportunities since youth were often involved with planning for and organizing the public performance activities.

Overall, the arts-based approach helped to facilitate the core objectives of engaging youth and providing them meaningful opportunities to increase their well-being and knowledge in a safe and socially supportive context.

Staff Characteristics

Staff indicated that techniques such as active listening worked well with youth and that they were able to relate to youth due to their own personal experiences. Staff also had education and/or work experience in mental health or social work which helped to address youth needs for emotional support and mental health well-being. Staff continued to be sensitive and adaptive, leveraging their diverse life experiences and prior engagement in mental health services to build rapport with youth and made sure to check in regularly. The personal "lived experience" of Urban Beats' staff having received mental health services in their own past facilitated connections with TAY and discussions about accessing needed services. The unique and wide set of staff skills and passions also helped to facilitate youth engagement, empowerment, and the development of their artistic talents.

Community Performance Component

During the second year of Urban Beats operations (FY 2016-17), Urban Beats managers and staff decided to increase the number of performances throughout the program. Using a flexible approach, many smaller performances were offered such as monthly open-mic nights. Staff indicated that despite initial concerns about the burden of more performances, youth rose to the challenge and thrived with the new schedule and the increased opportunities to refine their art, network with other artists, and build their confidence. Staff also indicated that increasing the number of performances led to more co-hosted events and more

connections with other community organizations. The shift to have more community performance opportunities instead of only a few high-profile events also lessened administrative planning burdens by establishing regularly scheduled community performances (e.g., open-mic nights every 3rd Friday of the month) and helped with outreach/advertising since times and locations were known well in advance. Having a community performance component of the program was identified as essential for achieving the program goals of the Urban Beats program. In particular, Urban Beats staff identified specific benefits of having a community performance component. The performances:

1. Provided a specific event to focus Urban Beats educational and mentorship activities around.
2. Encouraged TAY to express themselves publicly and build self-confidence.
3. Functioned as "platform" for communicating a mental health stigma reduction message to the community.
4. Increased awareness of the Urban Beats program to facilitate TAY recruitment and other organizational partnerships.
5. Required youth to develop other skills needed to create, plan, and execute the event, in addition to showcasing their artistic talents.

Mental Health Related Stigma Reduction

A core objective of the Urban Beats program was to reduce stigma related to mental health needs and service utilization. As reported in other sections of this report, it appears that Urban Beats was successful in reducing such stigma among both Urban Beats participants and the broader community via the performance activities. The following are the specific mechanisms identified by the Urban Beats staff that contributed to these stigma reduction achievements:

1. Staffing Urban Beats with compassionate persons who had "lived experience" both needing and utilizing mental health services.
2. Providing a safe and non-judgmental environment for TAY to hear and discuss life experiences with other TAY.
3. Offering psychoeducation in a relatable context.
4. Improving comfort levels with discussing mental health issues and services.
5. Facilitating youth-to-youth peer supports over an extended period of time through program participation.
6. Allowing TAY to communicate their stories to the community in creative and empowering manners.
7. Starting the conversation among the community regarding mental health stigma through public performances.
8. Using social media presence to provide education and reduce stigma for other TAY.

Recruitment Strategies

Urban Beats staff identified the following as effective approaches to identify and connect with potential Urban Beats participants:

1. Use Urban Beats community performances to educate other youth about Urban Beats.
2. Encourage youth "word-of-mouth" by current and former Urban Beats participants.
3. Develop partnerships with other youth serving community organizations.
4. Actively recruit youth receiving services in other mental health programs.
5. Develop and utilize social media presence to increase awareness of the Urban Beats program.
6. Conduct presentations/outreach in schools.
7. Targeted recruitment at homeless shelters for TAY.

Experiences with Telehealth Services

With COVID-19, the Urban Beats program shifted from providing primarily in-person services to only interacting with clients virtually via telephone or video telehealth calls. When asked to compare experiences between in-person and telehealth services, staff indicated that their relationships with participants suffered and that many TAY were unwilling to schedule virtual services or follow through with scheduled appointments. Overall, staff noted that TAY engagement with the program declined when the program shifted from in-person to virtual services. However, Urban Beats staff were very confident in their ability to provide services via telehealth and agreed that telehealth should remain a priority for the program even after in-person services become safe and available again.

According to Urban Beats staff, 11-25% of TAY were unable to consistently utilize telehealth with video due to problems with internet connectivity or other technical challenges managing video calls. Recommendations for overcoming barriers to working with TAY virtually and for facilitating telehealth video sessions included providing options for internet access and/or devices enabled for telehealth. Although telehealth services can provide greater flexibility in scheduling, Urban Beats staff noted that TAY were reluctant to schedule virtual services and that even when video calls were possible, staff estimated that approximately 10% of clients preferred telephone only sessions.

The challenges with engaging youth in telehealth services, particularly video, have been particularly evident for the clinician. While the clinician continued to offer one-on-one support and therapy services via telehealth, it has been difficult to keep Urban Beats participants engaged and interested in receiving consistent therapy without the rest of the overall Urban Beats service experience. A few clients have requested phone sessions since the start of the program operating remotely, but they frequently cancel. Although offered, there has been no interest in or requests for face-to-face sessions via video telehealth options.

Impact of COVID-19 on Urban Beats Staff

Urban Beats staff overwhelmingly indicated that COVID-19 had changed their work settings due to the transition away from in-person services to the use of virtual services. The lack of contact and connection with people was reported as having the biggest impact on their work tasks. Staff also reported substantial changes in their lives unrelated to work and most indicated experiencing additional stress and anxiety. Staff reported using self-care, personal interests and hobbies, and social connections to help manage or reduce COVID-19 related stress or anxiety.

Program Changes from Initial Design

The Urban Beats program was initially designed to include two primary service components: 1) a 20-week course that integrated education on mental health wellness and mentorship on a preferred form of artistic expression and 2) performances that showcased the art forms developed by TAY and disseminated positive messages intended to increase understandings of mental health wellness and reduce mental health-related stigma. Prior to COVID-19, the following key changes from original plans were implemented in response to identified needs and opportunities:

1. Expanding the Urban Beats program to serve additional communities in the Central and North Central regions of San Diego.
2. Allowing youth to stay involved in Urban Beats activities after completing the wellness course in order to facilitate ongoing learning and create opportunities for youth-to-youth mentorship. Graduates from earlier cohorts could support youth who were going through the course for the first time and assist with organizing Urban Beats activities.
3. Increasing the frequency and types of community performances to include more options ranging from large formal events (e.g., concerts and community festivals) to smaller, more informal, activities (e.g., open-mic events).
4. Redesigning the wellness course to offer both the original 20-week course structure as well as new "20-hour" courses that could be provided in a more condensed format with youth meeting together for longer periods of time over a fewer number of weeks. Allowing for both options enabled the programs to better tailor their offerings to the availability of youth and their interests.
5. Creating one-time "workshops" during which select topics from the main course would be provided to youth without requiring youth to commit to a multi-week course.
6. Developing "studio-time" and drop-in opportunities that allowed youth to come to the Urban Beats facilities to work on their artistic expression using available Urban Beats equipment and materials while receiving mentorship from Urban Beats staff.
7. Adding an Urban Beats van partway through the program was viewed as an invaluable resource that substantially reduced transportation barriers. The van supported program objectives by transporting youth to Urban Beats classes and other activities, transporting equipment and youth to community performances, and helping youth get to appointments with other service providers.
8. Adding a pre-licensed clinician was generally viewed favorably by helping meet the need for therapeutic services among youth who were not interested in referrals to external services. However, the clinician was not as consistently busy with providing therapy services to Urban Beats youth as expected. In this manner, the role of a clinician within the Urban Beats program may need to be reevaluated to better align the availability of the service with the extent to which youth will realistically utilize the "in-house" counseling option.

As described in other report sections, the onset of COVID-19 dramatically altered Urban Beats program activities by suspending all in-person activities and community performances for the final quarter of FY 2019-20. During this time period, Urban Beats staff maintained connections to participants via phone and video interactions. Staff also worked on retooling other service components such as the wellness course

and workshop materials to be more amenable to delivery via video formats. These efforts are expected to result in the provision of new methods of recruiting and interacting with Urban Beats youth during FY 2020-21. Additionally, building from existing relationships with local schools, Urban Beats was exploring opportunities to partner with schools in order to support their efforts to connect with students and help address mental health needs during this time of remote learning for the school systems.

Conclusion

Throughout the Urban Beats program (i.e., FY 2015-16 to FY 2019-20), a total of 770 unduplicated TAY enrolled in the Urban Beats program who reflected substantial diversity in race/ethnicity, language, sexual orientation, and gender identity. Program services changed throughout the project in response to identified needs. Whereas initial services only included a structured 20-week curriculum that focused on wellness topics and individualized artistic mentorship that concluded in a final performance, by the end of the project there were more flexible 20-hour configurations of the full curriculum that could be offered over a fewer number of weeks, the provision of one-session topical workshops, an "in-house" clinician who could provide one-on-one therapy without requiring a referral to external services, studio and drop-in times to use equipment and meet with Urban Beats staff, and a much more expanded array of large and small performance opportunities.

Of the participants with pre- and post-Urban Beats data, it generally appeared that the program was able to achieve key goals of improving youth well-being and reducing stigma associated with mental health needs and participation in mental health services. Feedback from youth indicated high levels of satisfaction with the program services and staff, and focus group participants articulated outcomes that were consistent with program objectives. Both youth and staff highlighted the importance of the public presentation/performance component of the program. Among other benefits, the engagement with the public gave the artistic development activities a specific focus, provided opportunities for personal growth and social connectedness, and helped reduce stigma among TAY and community members by sharing and discussing mental health challenges.

While the analysis of BHS service utilization did not provide evidence of many new linkages to outpatient or ACT services, the results suggested a reduced need for crisis/acute services after starting Urban Beats (although there were generally low levels of use during both time periods). It is likely that some of the need for mental health services was met via participating in counseling sessions with the Urban Beats clinician. It is estimated that approximately 20% of the Urban Beats participants active in the program after the clinician was added to the team received at least one counseling session. This indicates a substantial need for such services, however, the role may benefit from additional review to determine the most effective integration within Urban Beats as there were some concerns that the clinician services were not utilized as extensively as anticipated.

Overall, the Urban Beats program was successfully able to establish multiple locations utilizing an art-based approach for engaging youth and providing education and support related to mental health challenges. Urban Beats has developed an extensive network of community partners including schools, social service and mental health providers, and other arts and cultural organizations to help recruit youth and host events in the community. The onset of the COVID-19 pandemic substantially disrupted the flow of normal operations when all in-person interactions were suspended during the final months of FY 2019-20. As of 6/30/2020, Urban Beats staff were continuing to maintain communication with participants via

telephone and video and were in the process of adapting other Urban Beat services, such as the structured curriculum, to be more amendable to delivery via remote learning platforms.

Future Directions

Given the unusual circumstances surrounding the emergence of COVID-19 during the latter part of FY 2019-20 that significantly altered service delivery strategies, BHS provided a short-term, one-year extension of the Urban Beats program using funds unrelated to the MHSA Innovations portfolio. In this regard, the Innovations phase for Urban Beats ended on 6/30/2020. During FY 2020-21, BHS will make the determination about investing in the long-term provision of Urban Beats services and/or consider ways to strategically incorporate the valuable lessons learned from the program about youth outreach, engagement, and support into existing and future programs.

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

Participant Characteristics

Characteristic	Total Participants (N=770)	
Gender	N	%
Male	411	53.4%
Female	282	36.6%
Transgender	6	0.8%
Genderqueer/Gender non-conforming	15	1.9%
Questioning/Unsure/Another gender identity	6	0.8%
Missing/Prefer not to answer	50	6.5%
Total	770	100%
Age Group	N	%
14-17	152	19.7%
18-21	340	44.2%
22-29	234	30.4%
Missing/Prefer not to answer	44	5.7%
Total	770	100%
Primary Language	N	%
American Sign Language	6	0.8%
Arabic	6	0.8%
English	553	71.8%
Spanish	61	7.9%
Somali	21	2.7%
Swahili	50	6.5%
Other	40	5.2%
Missing/Prefer not to answer	33	4.3%
Total	770	100%
Race/Ethnicity	N	%
African American	325	42.2%
American Indian	46	6.0%
Asian	49	6.4%
Latino	262	34.0%
Pacific Islander	9	1.2%
Caucasian/white	147	19.1%
Multi-racial	125	16.2%
Other	43	5.6%
Missing	48	6.2%
Total[1]	-	-

Characteristic	Total Participants (N=770)	
Sexual Orientation	N	%
Heterosexual or straight	532	69.1%
Gay or lesbian	26	3.4%
Bisexual/Pansexual/Sexually fluid	80	10.4%
Queer	10	1.3%
Questioning/Unsure of sexual orientation	10	1.3%
Another sexual orientation	7	0.9%
Missing/Prefer not to answer	105	13.6%
Total	770	100%
Military Status	**N**	**%**
Never served in the military	690	89.6%
Previously served in the military	7	0.9%
Other/Missing/Prefer not to answer	73	9.5%
Total	770	100%
Disability	**N**	**%**
Yes, Has a disability	189	24.6%
No, Does not have a disability	477	61.9%
Declined/Preferred not to answer	104	13.5%
Total	770	100%
Type of Disability	**N**	**%**
Seeing	67	8.7%
Hearing	17	2.2%
Other Communication	6	0.8%
Learning	84	10.9%
Developmental	8	1.0%
Other Mental	16	2.1%
Physical	9	1.2%
Chronic Health	14	1.8%
Other	23	3.0%
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.*

COGNITIVE REHABILITATION AND EXPOSURE/SORTING TREATMENT (CREST)

INNOVATIONS-17

Final Report
(7/1/2015 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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 Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program was developed to reduce hoarding behaviors among adults age 60 and older through a unique treatment approach that integrated cognitive training and exposure therapy with care management, peer support, linkages to community services, and periodic assessments and evaluations to track progress. Throughout the duration of the 26-session CREST program, services were provided in the participant's home (at least until the COVID-19 pandemic during the latter part of Fiscal Year [FY] 2019-20, which required a shift to phone and video interactions). CREST services were provided by a multi-disciplinary team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Primary Findings

1. Assessment results across multiple tools demonstrated clinically significant and meaningful improvement among participants in each of the following domains: clutter severity, functional impairment, mobility impairments, risk for homelessness, eviction avoidance, fall/injury risk, and depression and anxiety.
2. CREST team members prevented 25 evictions from occurring by collaboratively developing and implementing plans with participants, property managers/owners, and where relevant, public agencies such as code enforcement to mitigate issues prior to eviction.
3. While demonstrating substantial improvements among CREST program completers, some participants still met criteria for hoarding disorder and required additional treatment and/or some form of aftercare (e.g., support groups) to minimize the risk of post-treatment relapse.

Additional Program Highlights

1. Between FY 2015-16 and FY 2019-20, a total of 173 participants enrolled into the CREST program. The average age of enrollees was 69.2 years. The majority of participants were female (68.8%; n=119), spoke English as their primary language (91.9%; n=159), and identified as heterosexual (77.5%; n=134). Approximately 10% (9.8%; n=17) reported previously serving in the military.

2. CREST participants frequently experienced other significant challenges such as comorbid mental health conditions, other physical and brain-related disabilities, chronic health concerns, social isolation, and limited economic resources available to obtain needed services
3. The Peer Support Specialist role (i.e., someone who had prior experience with successfully responding to hoarding disorder treatment), was particularly important for developing trust with participants and providing additional emotional support and encouragement along with opportunities to practice skills learned in the therapy sessions.

Conclusion/Future Directions

Although achieving clinically significant positive outcomes with many CREST participants, unanticipated budgetary limitations coinciding with the onset of the COVID-19 pandemic resulted in a decision to not continue funding the CREST program after the conclusion of the MHSA Innovations funding on 6/30/2020. Efforts by the CREST Program Director and other team members to secure additional funding to support the provision of CREST services for persons with hoarding disorder were ongoing at the time of preparing this report.

Program Description

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) CREST program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). CREST was designed to reduce hoarding behaviors among adults age 60 and older through a unique treatment approach that integrated cognitive training and exposure therapy combined with care management, peer support, linkages to community services, and periodic in-depth assessments and evaluations to track progress. To facilitate engagement in and completion of the 26-session treatment program, services were provided in the participant's home. CREST services were provided by a team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Key innovations of the CREST program included the use of a structured in-home evidence-based cognitive training and exposure treatment. Another important innovation of CREST was the addition of a peer specialist with successful prior hoarding disorder treatment experience to provide additional support to CREST participants. CREST clinicians used a whole person approach, informing the treatment through a combination of both psychotherapy and care management. Through the combined effect of the treatment sessions, peer specialist support, and comprehensive care management, CREST participants were expected to reduce their hoarding behaviors, resulting in improved mental health, well-being, housing stability, and safety.

Service Changes Due to COVID-19

The COVID pandemic first affected the San Diego area in a substantial manner during March 2020. San Diego County issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period San Diego County BHS programs had to quickly adapt to the new service

delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telemental health services.

With the onset of the COVID-19 pandemic, CREST suspended in-person visits with participants and transitioned to primarily phone and, where possible, video visits. This allowed the program to maintain contact with participants and continue with ongoing treatment activities, even if not as preferable as conducting in-home, in-person visits. Where relevant, findings and recommendations in this report indicate issues potentially related to the unique challenges that COVID-19 poses within the local community and healthcare environment.

Program Screening, Eligibility, and Enrollment

Throughout the CREST program (i.e., FY 2015-16 to FY 2019-20), a total of 504 persons were screened for eligibility. Of these, 446 (88.5%) were determined to meet criteria for hoarding disorder. Persons typically also needed to have Medi-Cal insurance (including those dually enrolled in both Medi-Cal and Medicare), or be uninsured and eligible for Medi-Cal insurance to enroll into the CREST program. While some case-by-case exceptions were allowed, this requirement was intended to keep the focus of CREST services primarily on the low income populations served by County-funded "safety net" behavioral health services.

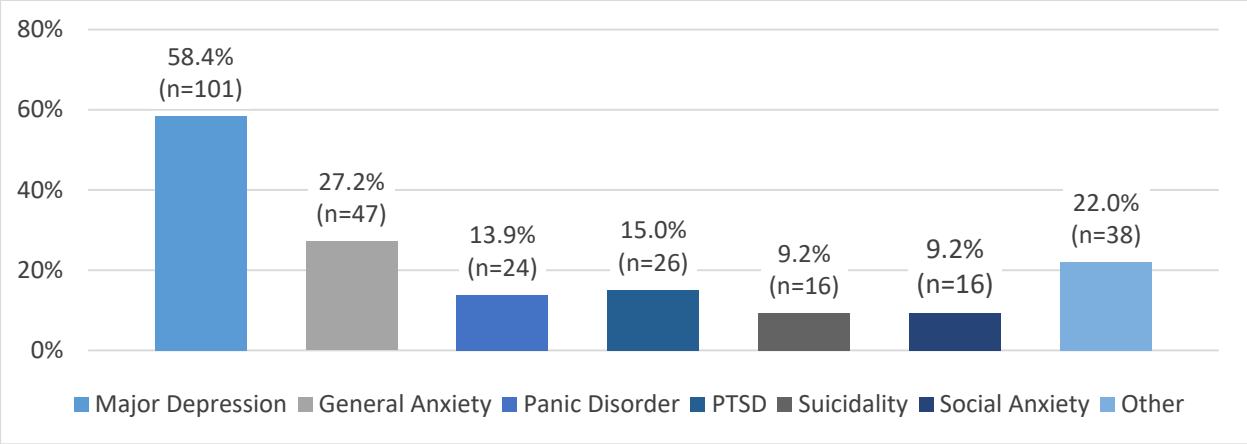
In addition, CREST initially began as a pilot program with specific geographic boundaries that restricted eligibility to select zip codes. However, the high number of persons identified by CREST as having hoarding disorder in other areas of San Diego County and preliminary success of the program prompted a countywide expansion during FY 2018-19. Overall, a total of 173 unique persons met all eligibility criteria and enrolled into the CREST program (i.e., 38.8% of the 446 determined to exhibit signs of hoarding disorder). Having income that exceeded Medi-Cal thresholds was the primary reason that persons identified with hoarding disorder were unable to enroll into CREST.

Participant Characteristics

A brief overview of the CREST participant characteristics is presented here with a more complete listing in the appendix. A total of 173 participants enrolled into the CREST program between FY 2015-16 and FY 2019-20. The average age of enrollees was 69.2 years. The majority of participants were female (68.8%; n=119), spoke English as their primary language (91.9%; n=159), and identified as heterosexual (77.5%; n=134). Approximately 10% (9.8%; n=17) reported they had previously served in the military. Over half of the participants identified as White (75.7%; n=131). Overall, 76.9% (n=133) of participants received some form of post-high school education. Asked to indicate a disability that was not the result of a serious mental illness (SMI), 72.2% (n=125) of participants indicated having a disability, with 37.6% (n=65) reporting a physical disability and 27.7% (n=48) reporting a chronic health disability.

As shown in Figure 1, CREST participants were also frequently diagnosed with other mental health conditions in addition to their hoarding diagnosis. The most common diagnoses were major depression (58.4%; n=101) and general anxiety (27.7%; n=47). Overall, almost 80% (79.8%; n=138) had at least one other mental health diagnosis.

Figure 1. Prevalence of Comorbid Mental Health Diagnoses (N=173)



Note: Total may exceed 100% since more than one mental health diagnosis could be selected.

Participant baseline responses to the Hoarding Rating Scale (HRS) questions indicated substantial negative effects on the lives of many CREST participants due to clutter in their home. Of the 143 who completed the HRS, 59.4% reported severe to extreme difficulty using rooms in their house, 60.1% reported severe to extreme clutter-related emotional distress, and 68.5% reported severe to extreme impairment in their life. These findings indicate that the majority of the persons who enrolled into CREST had very significant and serious negative implications on their well-being due to their hoarding related behaviors.

As shown in Table 1, baseline responses to the Homelessness Risk Screener (n=135), indicated that many CREST participants had risk factors for homelessness in addition to any hoarding-related home condition concerns.

Table 1. Homelessness Risk Factors of CREST Participants (N=135)

%	Homelessness Risk
35.6%	Ever homeless/not have a home of own
35.6%	Have poor credit history
56.3%	Without somewhere to stay/without plan for housing if lost current housing
65.2%	Have at least one barrier to getting or keeping their home, including: lack of employment (19.3%), lack of transportation (27.4%), and lack of financial assistance (40.0%).

Primary Program Outcomes

Reductions in Hoarding Behaviors and Impairment

Upon entering the CREST program and upon the time of program completion (n=104) participants would complete the Hoarding Rating Scale (HRS). This 5-item scale asks participants to rate the extent to which they experience each hoarding related behavior or impairment on a 9-point scale ranging from 0 (not at all) to 8 (extremely). As shown in Table 2, the reduction for each hoarding related item was statistically significant and substantially less of a problem following the completion of the CREST program. The overall

average rating was significantly reduced from 5.0 (moderate/severe) at baseline to 2.9 (mild/moderate) at the end of the program.

Table 2. Participant Hoarding Rating Scale (HRS) at Baseline and Post CREST Completion (N=104)

Hoarding Behavior Effects ***(Note: each item rated from 0 to 8 with higher values indicative of more serious hoarding behaviors)***	**Baseline**	**Post CREST**
1. Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?	4.9	3.0*
2. To what extent do you have difficulty discarding ordinary things that other people would get rid of?	5.1	3.0*
3. To what extent do you currently have a problem with collecting or buying more things than you can use or can afford?	4.2	2.0*
4. To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?	5.2	3.3*
5. To what extent do you experience impairment in your life because of clutter, difficulty discarding, or problems with buying or acquiring things?	5.4	3.2*
Average HRS Score	**5.0**	**2.9***
Total HRS Score (mean / median)	**24.8 / 25**	**14.4* / 14**

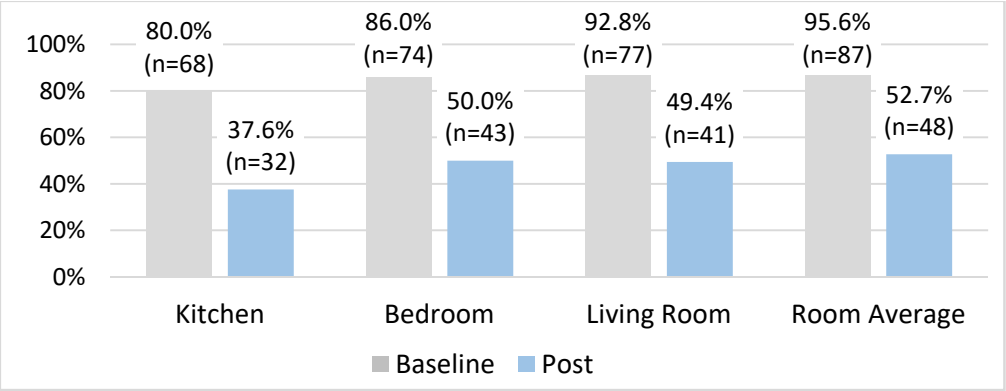
**statistical significance at p < 0.001*

An HRS total score of more than 14 is considered to indicate a person with clinically significant hoarding. As expected, CREST program participants exhibited significant problems with hoarding when entering the program showing an average baseline HRS total score of 24.8. Whereas upon completing the CREST program the average HRS total scores dropped to 14.4, with a median of 14. This indicates that many persons had reductions in their hoarding behaviors and 50% of the participants no longer exhibited clinically significant hoarding after completing the CREST program.

Reductions in Clutter

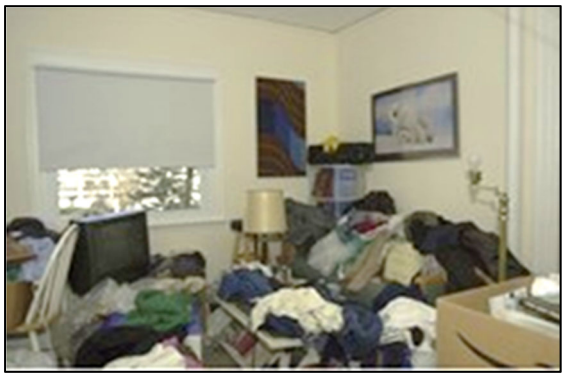
The Clutter Image Rating (CIR) scale is a tool used to rate clutter levels on a scale from 1 to 9 (most cluttered = 9) by selecting the image that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom; see example CIR images below). Figure 2 presents the percentage of participants who had a CIR value **greater than 2** before or after treatment (mean CIR values listed below the chart). Of participants with CIR ratings at both time points (n = 94), substantially fewer had CIR values greater than 2 after receiving CREST treatment services. Mean CIR scores significantly decreased as well for each room individually and the overall room average decreased from 4.5 to 2.7. These findings of decreased clutter were consistent with improved symptom management due to CREST program participation.

Figure 2. Percent of Participants with Clutter Image Ratings Greater than Two (N=94)

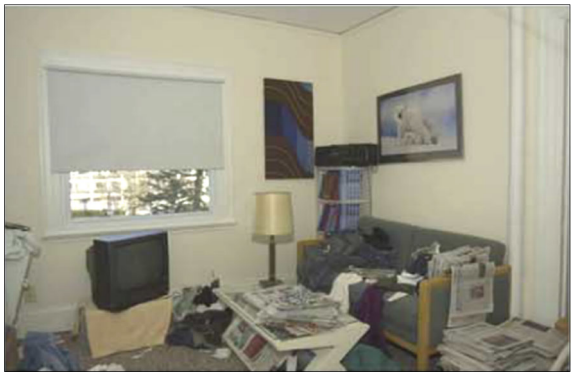


	Kitchen		Bedroom		Living Room		Room Average	
Mean Clutter Image Rating	4.0	2.4*	4.7	3.1*	4.9	3.0*	4.5	2.7*

**statistical significance at p < 0.001*



CIR Living Room Rating #5



CIR Living Room Rating #2

Reductions in Homelessness Risks

Upon entering the CREST program, participants completed the Homelessness Risk Screener designed to assess their personal risk for homelessness. Questions included such items as asking participants about their current and past living situations, the types of environments they have lived in, if they rely on family for financial support, and what types of barriers they face when it comes to housing stability. This same questionnaire was then completed again when participants completed the program.

Overall, there were fewer participants who were at risk for homelessness after completing the CREST program. In particular, 22.1% (n=21) of the 95 participants who completed the Current Homelessness Risk Screener were either homeless, living in temporary housing, or facing eviction/legal issues related to housing upon entering CREST, whereas only 11.6% (n=11) indicated these conditions after completing the CREST program. Likewise, at baseline 18.9% (n=18) reported receiving complaints from landlords and/or being contacted by public officials (i.e., code enforcement) about the condition of their home in the past 30 days. After completing CREST only 6.3% (n=6) indicated they had experienced those situations. CREST

also reduced future risk of homelessness by helping participant plan for alternative arrangements if for some reason they did need to move. Almost two-thirds (64.2%; n=61) indicated at baseline that they had no plans or place to go if they lost current housing, but that reduced to 41.1% (n=39) after completing CREST.

Additionally, CREST team members prevented 25 evictions from occurring to CREST participants. This frequently involved extensive coordination between participants, property owners/managers, and/or code enforcement to quickly develop and implement an effective remediation plan that would allow the participants to retain their housing. Where appropriate, CREST also helped participants identify and move into new housing that was more appropriate and sustainable.

The participant self-reported findings coupled with the actions of the CREST program indicate that actual homelessness and risks for homelessness were successfully eliminated or reduced for many CREST participants.

Reductions in Fall Risk

Participant responses to the Activities of Daily Living in Hoarding (ADL-H) scale at baseline and after completion of the CREST program provide evidence of reduced fall risks. In particular, average ratings (n=100) for the item "Move around inside the house" decreased significantly from 2.8 (little/moderate difficulty) at baseline to 1.8 (easily/little difficulty) following CREST program completion.

Reductions in Depression and Anxiety

Depression and anxiety are common among persons with a hoarding diagnosis (as reported above by the high prevalence of comorbid major depression (58.4%) and anxiety (27.2%) among CREST participants). To assess the extent to which CREST was successful at mitigating these additional behavioral health concerns, participants completed the 15-item Geriatric Depression Scale (GDS) and 30-item Geriatric Anxiety Scale (GAS).

The GDS includes 15 "Yes/No" type questions such as "Do you often feel helpless?" and "Do you feel happy most of the time?" The GDS scores can range from 0 to 15 with a score greater than 5 suggestive of depression. Between FY 2015-16 and FY 2019-20, the 101 individuals who completed the GDS at baseline and after finishing CREST demonstrated a statistically significant mean score reduction from 7.1 to 4.7 and a median score reduction from 7 to 4. These GDS scores indicate that CREST participants typically exhibited evidence of depression when starting CREST, but not after completing the program. Of particular importance, at baseline only 40.8% of CREST participants indicated they were "basically satisfied with your life," whereas at the conclusion of CREST that percent rose to 66.3%.

Likewise, results from the GAS, showed reductions in anxiety among CREST participants. The GAS consists of 25 common symptoms of anxiety that are rated based on how frequently each symptom was experienced during the past week (i.e., a four-point scale ranging from "Not at all," "Sometimes," "Most of the time," to "All the time"). Total GAS scores can range from 0 to 75 with values higher than 16 indicative of clinical anxiety. The mean GAS total score reduced significantly from 24.1 at baseline to 16.5 at the completion of CREST (and median GAS reduced from 23 to 14) for the 98 participants with baseline and post-CREST GAS assessments. These changes suggest that anxiety was reduced for CREST participants, but challenges still remained for many even after completing CREST (e.g., a total of 72.4% demonstrated

GAS scores consistent with clinical anxiety at baseline compared to 42.9% at the end of the CREST program).

Examples of Clutter Reduction among CREST Participants

The CREST program was often able to make fundamental changes in the living environments of participants by partnering with them to collaboratively remove substantial amounts of clutter both within and outside of the home. These changes improved household safety and allowed for better access to and utilization of the space available to the participants. The photos below demonstrate the types of dramatic positive changes that CREST was able to accomplish.

Before Participating in CREST | **After Participating in CREST**

Additional Program Activities

In addition to the treatment and case management services provided directly to CREST program participants, the CREST team demonstrated a sustained commitment to educating the community about hoarding, its symptoms, and how to care for persons with hoarding disorder. The CREST team conducted more than 380 hoarding related community education presentations that were attended by more than 4,000 people. The CREST program also developed a directory with more than 70 local services particularly relevant to meeting the needs of persons with hoarding disorder symptoms (e.g., code enforcement, meal services, home care supports).

The CREST program created training opportunities within their team to allow undergraduate and graduate students to learn more about providing hoarding disorder treatment services. The CREST team also provided specialized trainings to psychiatrists who served geriatric populations to improve their capacity to identify and treat persons with a hoarding disorder (e.g., hoarding disorder specific education about diagnostic indicators, symptom assessment, and home visit procedures/safety considerations).

As the CREST program expanded over time, the CREST team noted an increased need for language services, particularly among Spanish-speaking clients. Identifying an opportunity to increase access to available services and enhance patient-provider communication, the CREST treatment manual and all assessment materials were translated into Spanish and eight clients received services provided by Spanish-speaking therapists.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual CREST Program Staff Survey. The stakeholder meetings were held periodically throughout the CREST program initiative with representatives from BHS, CREST, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CREST Staff Survey was conducted yearly throughout the CREST program initiative to generate feedback about staff experiences with, perceptions about, and recommendations for program implementation and operations.

Key Characteristics of Typical CREST Participants

1. Persons who needed services for treating hoarding disorder were identified throughout all regions of the County.
2. Hoarding behaviors among clients were frequently evident for long periods of time (i.e., more than several decades).
3. Individuals with hoarding disorder were often socially isolated from family and friends and were generally not connected to other existing community resources.
4. Clients typically had multiple additional challenges beyond their hoarding diagnosis that needed to be addressed or accommodated during the treatment process including co-occurring physical, mental health (especially depression and anxiety), or substance abuse conditions, limited financial resources, lack of transportation, and social conflicts.
5. Clients often had relatively high levels of education (i.e., 76.9% had at least some college).
6. Many potential CREST participants with hoarding disorder were just above the income level for Medi-Cal, but still too impoverished to access the services they needed.

Participant Recruitment, Retention, and Engagement

1. Outreach to property managers and other community groups can help identify potential referrals.
2. Participants typically recognized that their hoarding behaviors had negative effects on their lives, which helped with initial motivation to enroll in CREST.

3. External pressures such as threats of evictions or failed health inspections provided additional motivation for clients to address hoarding behaviors, but can create challenges for the treatment team to respond to the urgency of such deadlines.
4. Prioritization of safety improvements and increased functionality of participants' homes provided tangible goals that helped with client engagement in services. Being able to see specific improvements/progress towards goals encouraged continued program participation.
5. Without proactive attention, common tendencies among participants can inhibit active engagement in treatment (e.g., reluctance to allow staff into home, not completing homework, full voicemails or lost phones, avoidance, lack of motivation or desire for change).

CREST Treatment Service Approach

1. Usage of manualized, evidence-based CREST program practices provided important overall structure for intervention delivery, however, flexibility in the application of the CREST treatment manual was needed to accommodate specific needs (e.g., language services) and circumstances of individual participants.
2. Given the difficulties of sustaining participant engagement throughout the 26-treatment sessions, Motivational Interviewing and the associated techniques to promote "buy-in" were identified as good supplements to CREST treatment services.
3. Where possible, family members and loved ones can be invaluable resources (e.g., referrals for treatment, emotional support, and help with maintenance of positive behaviors). It was also important to prepare and support family members through education and family groups.
4. In addition to family and friends, outreach to and education of other relevant service providers, such as landlords/property managers, code enforcers, and community members helped to implement collaborative, long-term solutions.
5. Providing "in-home" services was essential for program success by allowing the team to fully understand the extent of hoarding and any potential safety concerns. With the onset of COVID-19, services were still provided "in-home" via video calls where possible, and telephone when needed for existing clients.
6. Important to have access to supplemental funds in order to hire services that can address clients' physical and financial limitations (e.g., move large objects or pay for removal services/dumpsters), particularly when under the threat of eviction.
7. Reducing hoarding behaviors was often not easy or comfortable for participants.
8. Reduction of symptoms and impairments can be difficult for participants to maintain after treatment completion and may benefit from continued support in the form of booster sessions, aftercare groups, and referrals to community resources.
9. Some participants may need more than the current 26 sessions of the CREST program to achieve desired results. While typically demonstrating improvements, many persons completing CREST still met diagnostic criteria for hoarding disorder and would benefit from some additional long-term supports.

Multi-Disciplinary Team Approach

1. Comprehensive, "whole person" services were needed to address the multiple factors contributing to hoarding behaviors and the other challenging circumstances that many clients were experiencing. Providing such services required a team of persons with different skill sets and roles including clinicians, peer specialists, interns, and other support staff.
2. Team-based care required substantial attention to coordination and communication via regular supervision, team meetings, and consultations to promote seamless continuity of care.
3. Team members also needed to demonstrate a genuinely caring and empathetic orientation to those receiving CREST program services to promote trust and relationship building with participants.

Benefits of Including a Peer Support Specialist on CREST Treatment Teams

Peer Support Specialists (i.e., persons who had experienced similar issues with hoarding and had success addressing them), provided important emotional and practical supports to participants in their efforts to change hoarding behaviors. Key contributions of the Peer Specialist included:

1. Establishing a relationship with someone who can understand barriers/struggles better than anyone else.
2. Normalizing treatment program participation and potential feelings of shame and apprehension.
3. Providing emotional support.
4. Providing an example of success and hope for recovery.
5. Providing additional opportunities for client to practice skills (i.e., being present while client sorts and discards items).
6. Helping the process move forward through regular, more informal, check-ins.

Conclusion

A total of 173 persons enrolled into the 26-session specialized CREST treatment program for hoarding disorder between FY 2015-16 and FY 2019-20. The program started as a pilot program in a limited geographic area, but was expanded countywide during FY 2018-19 due to increased awareness of the high levels of need for hoarding treatment services throughout San Diego County. The multi-disciplinary team approach that consisted of therapists, care managers, and peer supports appeared to match well with the multi-faceted needs commonly evident among persons with hoarding disorder. Comorbid mental health conditions, other physical and brain disabilities, and chronic health concerns were frequently coupled with social isolation and limited economic resources available to obtain needed services.

Within these challenging contexts, the CREST care team was often able to develop the relationships and trust necessary to keep persons engaged in a comprehensive 26-session treatment program. The Peer Support Specialist, who was required to have had prior experience with successfully responding to hoarding disorder treatment, played an important role in providing additional emotional support and encouragement to the participants as well as more informal opportunities to practice skills learned in the therapy sessions.

As of 6/30/2020, a total of 104 persons had completed the entire program and the post-program assessments. The outcome data from the measurement tools indicated that the CREST program frequently achieved program objectives with participants demonstrating clinically significant reductions in: clutter, functional impairment, mobility impairments, homelessness risks, depression, and anxiety after completing the CREST program. In addition to these areas of improvement, the CREST program was also able to actively intervene and prevent 25 evictions from occurring within this vulnerable population by collaboratively developing and implementing plans with participants, property managers/owners, and where relevant, public entities such as code enforcement to mitigate issues prior to eviction.

While frequently demonstrating substantial improvements among persons who completed the CREST program, treating hoarding disorder remained a complicated endeavor that often required an extended period of time to enact desired changes. This was evidenced by the fact that, even if improved, some participants still met criteria for hoarding disorder and required additional treatment beyond the standard 26 sessions and/or would benefit from some form of aftercare (i.e., support groups), to minimize the risk of post-treatment relapse.

Future Directions

Although achieving clinically significant positive outcomes with many CREST participants, unanticipated budgetary limitations coinciding with the onset of COVID-19 pandemic resulted in a decision to not continue funding for the CREST program after the conclusion of the MHSA Innovations funding cycle on 6/30/2020. In an attempt to allow for these specialized treatment services for persons with hoarding disorder to continue in some capacity either locally in San Diego or other communities, the CREST Program Director and other affiliated team members have explored alternative funding sources. The efforts to secure additional resources to maintain provision of CREST services were ongoing at the time of preparing this report.

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

Participant Characteristics

Characteristic	Total Participants (N=173)	
Gender	N	%
Male	50	28.9%
Female	119	68.8%
Prefer not to answer/Missing	4	2.3%
Total	173	100%
Age Group	N	%
55-59	9	5.2%
>60	164	94.8%
Total	173	100%
Primary Language	N	%
English	159	91.9%
Spanish	8	4.6%
Other	6	3.5%
Total	173	100%
Race/Ethnicity	N	%
African American	7	4.0%
American Indian	10	5.8%
Asian	9	5.2%
Latino	14	8.1%
Caucasian/white	131	75.7%
Multi-racial	9	5.2%
Other/Missing	12	7.0%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	134	77.5%
Gay or lesbian	6	3.4%
Bisexual/Pansexual/Sexually fluid	5	2.9%
Another sexual orientation/Missing/Prefer not to answer	28	16.2%
Total	173	100%

Characteristic	Total Participants (N=173)	
Education	**N**	**%**
GED Coursework	11	6.4%
High school diploma/GED	27	15.6%
Some College/Some Technical or Vocational	56	32.4%
Associates Degree	25	14.5%
Bachelor's Degree	40	23.1%
Master's Degree and Above	12	6.9%
Missing	2	1.1%
Total	173	100%
Military Status	**N**	**%**
Never served in the military	143	82.7%
Previously served in the military	17	9.8%
Missing/Prefer not to answer	13	7.5%
Total	173	100%
Disability	**N**	**%**
Yes, Has a disability	125	72.2%
No, Does not have a disability	6	3.5%
Declined/Preferred not to answer	42	24.3%
Total	173	100%
Type of Disability	**N**	**%**
Seeing	24	13.9%
Hearing	21	12.1%
Learning	20	11.6%
Dementia	9	5.2%
Other Mental	12	6.9%
Physical	65	37.6%
Chronic Health	48	27.7%
Other	49	28.3%
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.

ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 1 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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. 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 exclusive 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 suspended the practice of providing in-home assessments and clinical sessions and transitioned to providing these services via telephone or video where available. 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 decreased substantially as public health nurses were redirected to other COVID-19 related priorities.

Primary Findings for Fiscal Year (FY) 2019-20

1. The ADAPT program achieved substantial reductions in depression and/or anxiety symptoms and improved well-being among a significant number of participants.
2. Total ADAPT enrollment during Year 1 was less than the initial goal (i.e., 91 unduplicated persons compared to a target of 300). Key factors that contributed to lower than expected enrollment included: 1) initial program implementation challenges related to getting program and referral processes fully operational, 2) the onset of COVID-19 that dramatically reduced referrals from the NFP and MCH programs, and 3) fewer than expected partners and other family members enrolling in services. Additionally, the target of 300 served may need to be reevaluated in future years as a sizable portion of the client population persisted in the program for longer than the expected six months.

3. Good communication and coordination between ADAPT and public health nurses (PHNs) were critical to effective operations. Improved referral tracking processes and "roundtables" between ADAPT and PHNs helped to align expectations and practices.

Additional Program Highlights

1. Participant Characteristics
    a. A total of 91 participants enrolled in ADAPT during FY 2019-20.
    b. 98% of participants were female.
    c. 62.6% of participants identify as Hispanic/Latino.
    d. Approximately 40% of participants were between the ages of 16-25.
2. ADAPT Services
    a. Participants received, on average, 4.5 ADAPT services during each 30 days enrolled in ADAPT.
    b. 75.6% of ADAPT participants had at least one therapy session and 69.5% had at least one case management support visit.
3. Participant Outcomes
    a. Statistically significant improvements were seen across:
        i. Edinburgh Postnatal Depression Scale (EPDS)
        ii. Illness Management and Recovery-Reduced (IMR-R) scale
        iii. ADAPT Wellness Survey
4. ADAPT Participant Feedback
    a. 100% of participants indicated ADAPT staff were sensitive to their cultural backgrounds.
    b. 96.2% of participants indicated that they were satisfied with ADAPT services.
5. Partnership with Public Health Nurses
    a. Of the PHNs surveyed, 92.3% felt the ADAPT program provided important services to public health nursing clients.
    b. ADAPT staff provided a total of 589 PHN consultations to discuss the mental health needs of PHN clients.
    c. ADAPT staff conducted six training "roundtables" attended by a cumulative total of 72 PHNs.
6. Switch to Telehealth
    a. ADAPT staff indicated a high level of confidence in their ability to provide services via telehealth and recommended that telehealth services continue to be a priority even after resuming face-to-face visits.
    b. ADAPT staff estimated that less than 10% of clients were unable to consistently utilize telehealth with video due to problems with internet connectivity.

Conclusion

During FY 2019-20, the first year of ADAPT service provision, the program was able to successfully

establish Level-1 services (provided by licensed/license-eligible clinicians) and Level-2 services (provided by case managers) and demonstrate substantial reductions in participants' symptoms of distress as well as improvements in domains such as illness management, functioning, and quality of life. The onset of the COVID-19 pandemic required a shift away from in-person, in-home visits and substantially reduced referrals into the program, however, those receiving services indicated very high levels of satisfaction with ADAPT and the therapy, education, emotional support, and respect they received. As discussed above, overall enrollment was less than anticipated during FY 2019-20, so an emphasis in FY 2020-21 will be to better understand the reasons contributing to underutilization and to seek out opportunities to increase participation in ADAPT services.

Primary Recommendations for FY 2020-21

1. Identify additional sources of potential referrals, particularly while referrals from PHNs are reduced due to COVID-19.
2. Increase communication, coordination, and collaboration with PHNs.
3. Conduct record reviews to determine the extent to which ADAPT clients would qualify for Medi-Cal reimbursable services.
4. Examine Level-2 enrollment patterns to better understand why services were not utilized as much as anticipated.

ADAPT Program Description

The County of San Diego BHS ADAPT program is funded through the INN component of the Mental Health Services Act, 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 low-income, first-time mothers prior to their 28th week of pregnancy and continuing through the child's second birthday. Through NFP, PHNs provide support, education and counseling on health, behavioral and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides at-home nurse visitation to at-risk, low-income, 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 supports for the entire family. 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 and the ADAPT mental health clinicians and peer supports. Additionally, 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.

The ADAPT program was designed to provide two tiers of services. Level-1 participants included those who met criteria for 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, reported not being interested in receiving mental health services at the time of initial assessment, or were able to receive mental health services from a private insurance provider. Persons in Level-2 could also include family members of Level-1 participants.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, including ADAPT, these changes involved a switch to, or greater utilization of, telehealth services.

The ADAPT program suspended the practice of providing in-home assessments and clinical sessions and transitioned to providing these services via telephone or video where available. In this way, the ADAPT team maintained continuity of care and experienced minimal disruption to services. In support of the PHN partners who experienced an increased demand for their services to directly address the COVID-19 pandemic in San Diego, the ADAPT team conducted additional wellness check-ins with PHN clients who were not ADAPT participants, but who might be experiencing additional stress during the challenging times. The number of referrals received from PHNs reduced substantially from an average of 22.1 per month pre-COVID-19 to 3.8 per month due to the additional COVID-19 related responsibilities that limited PHN availability. This contributed to the lower than expected FY 2019-20 enrollment totals (i.e., 91 unique persons 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

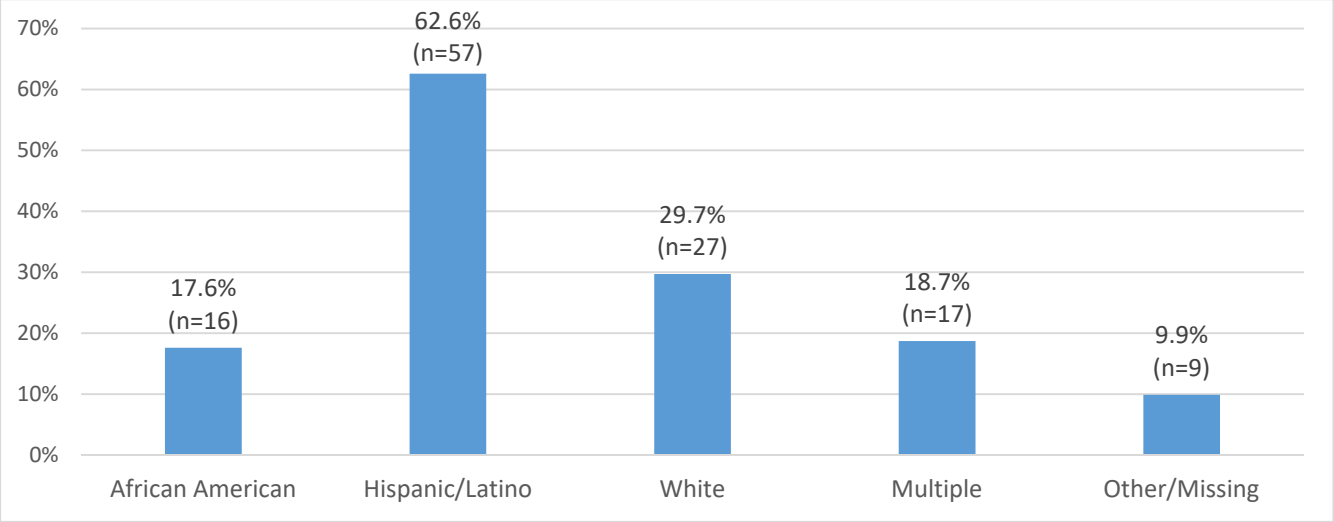
A brief overview of the ADAPT participant characteristics is presented here with a more complete listing in the appendix. As shown in Table 1, a total of 91 unique persons enrolled in the ADAPT program during FY 2019-20 (82 initial enrollments into Level-1 and 9 initial enrollments into Level-2). In addition to the nine persons who enrolled directly into Level-2, five persons transitioned from Level-1 to Level-2 during FY 2019-20 when they no longer had a need for ongoing clinical therapy services but still wanted the education and support services provided by ADAPT. These 91 persons enrolled into ADAPT during FY 2019-20 represent 89 different families with a total of 172 children in the households (including those not yet born at the time of ADAPT program enrollment).

Table 1. ADAPT Program Enrollment for FY 2019-20 (N=91)

	N
Level-1 services (i.e., ongoing therapy services)	82
Level-2 services (i.e., education and support services)	9
Total ADAPT enrollees	91

Across both service levels, 97.8% of participants identified as female (n=89). While the majority of participants indicated English as their primary language (69.2%; n=63), almost one quarter (24.2%; n=22) indicated Spanish as their primary language and were served by Spanish speaking ADAPT staff. Eighty-nine percent (n=81) of participants identified as heterosexual or straight. Participants were overwhelmingly between the ages of 16-35 (n=80; 87.9%), with only 12.1% (n=11) over the age of 36. As shown in Figure 1, the ADAPT program served a racial and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (62.6%).

Figure 1. Race/Ethnicity of ADAPT Participants (N=91)



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

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 2019-20. The information indicates that during each 30 days enrolled in ADAPT, participants typically received approximately 4.5 ADAPT services (comprised primarily of an average of 1.9 assessment visits and 1.4 therapy 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 directly and indirectly benefit the family unit through case management and resource support.

Table 2. ADAPT Level-1 Services during FY 2019-20 (N=82)

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	82	100.0%	1,593	4.5
Assessment/Tx. plan development	81	98.8%	468	1.9
Individual/Family therapy (i.e., by licensed clinician)	62	75.6%	655	1.4
Individual/Family rehab. (i.e., by peer support or other professional)	35	42.7%	85	0.2
Case management	57	69.5%	233	0.6
Other services (e.g., Collateral, Crisis intervention)	57	69.5%	152	0.4

The average time in the ADAPT program was 107.2 days (median of 87 days) for the 64 persons who had been discharged from Level-1 services prior to 6/30/2020; however, there was substantial variability among the participants. A quarter of these participants were in the program for less than one month (i.e., 28 days). These participants were classified by ADAPT staff as “discharged due to lost contact”, which includes the 20 participants who received an assessment but did not engage in individual or family therapy. A more detailed understanding of the reasons why some persons leave the program before fully engaging in services is needed to determine if ADAPT program practices can be adjusted to improve retention. On the other end of the continuum, a quarter of ADAPT participants were in the program for at least 176 days (maximum program duration of about one year). These findings indicate that while the typical ADAPT program duration was approximately three months, there was a substantial number of participants who required longer term services of six months or more, which required a program exception and approval from County of San Diego BHS.

Level-2 Services

A total of nine persons enrolled directly into Level-2 services, which were provided by case managers/peer support partners on the ADAPT team. An additional five persons transitioned from Level-1 to Level-2 services as a form of "step-down" in care since they no longer needed the more intensive therapy services provided in Level-1. These 14 persons received a total of 73 different Level-2 ADAPT service contacts during FY 2019-20. The Level-2 service contacts frequently focused on providing educational and/or skill-building opportunities. Self-regulation was the most common educational topic and occurred in almost half of the contacts (46.6%; n=34), followed by parenting skills (23.3%; n=17) and goal-setting (23.3%; n=17). Other services provided during these contacts included assistance with connecting to needed community resources (e.g., basic needs, physical health, housing, transportation, etc.).

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2019-20 and their differing service needs, participant outcomes referenced in this section of the report only include the 82 Level-1 participants.

Edinburgh Postnatal Depression Scale (EPDS)

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 3, the average EPDS score at intake was 13.5, which reduced to 9.7 at the last EPDS follow-up assessment. This represents a statistically significant change in the total EPDS scores and reflects an overall reduction in symptoms as reported by ADAPT program participants. Additional analyses that compared the EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 11.9. 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 3. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment (N=70)

		Initial EPDS	Last available EPDS
EPDS Item (Note: higher value = worse condition)	**N**	**Mean**	**Mean**
I have been able to laugh and see the funny side of things	70	0.7	0.6
I have looked forward with enjoyment to things	70	0.9	0.6^
I have blamed myself unnecessarily when things went wrong	70	2.0	1.4**
I have been anxious or worried for no good reason	70	2.1	1.5**
I have felt scared or panicky for no very good reason	70	1.7	1.1**
Things have been getting on top of me	70	1.7	1.4*
I have been so unhappy that I have had difficulty sleeping	70	1.4	1.0*
I have felt sad or miserable	70	1.5	1.2^
I have been so unhappy that I have been crying	70	1.2	0.8**
The thought of harming myself has occurred to me	70	0.3	0.1*
EPDS Total Score	70	13.5	9.7**
Likely Depression (i.e., score >=10)	-	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 with the largest changes from intake consist of reductions in self-blame, anxiousness, and panic (i.e., absolute EPDS differences of 0.6). It is important to note that while thoughts of self-harm had a relatively low prevalence at intake (i.e., EPDS score of 0.3), this was an even more rare occurrence at follow-up as evidenced by a statistically significant reduction to 0.1. 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 (IMR-R)

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 extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians. As shown in Table 4, the initial IMR-R ratings varied substantially

across the individual items. While average ratings for many items were between 2-3 (generally indicative of moderate impairment), symptom distress was the lowest rated item at 1.7, which was indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, domains that did not appear to be areas of concern at intake as determined by ADAPT providers included medication management or substance abuse (i.e., intake ratings ranged between 4 and 5). The overall IMR-R score at intake was 3.1.

Table 4. Change in IMR Scores from Initial Assessment to Last Follow-up Assessment (N=48)

		Initial Asmt.	Last Asmt.
IMR Item (Note: higher value = better condition)	**N**	**Mean**	**Mean**
Progress towards personal goals	44	2.7	3.6**
Knowledge about symptoms, treatment, coping strategies, and medication	48	2.8	3.5**
Involvement of family and friends in his/her mental health treatment	48	3.2	3.7**
Symptom distress	48	1.7	2.7**
Impairment of functioning	48	2.2	3.1**
Coping with mental or emotional illness from day to day	48	2.6	3.5**
Effective use of psychotropic medication	8	4.1	4.2
Impairment of functioning through alcohol use	45	5.0	4.9
Impairment of functioning through drug use	45	5.0	5.0
Overall	48	3.1	3.7**

***statistical significance at p < 0.01*

The overall IMR-R score increased from 3.1 to 3.7 at follow-up, which represented 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 values evident at intake (i.e., remaining as not areas of concern), while many of the gains for the other items approached or achieved a change score of 1.0. Of note, ratings of symptom distress improved from 1.7 to 2.7 at follow-up, which generally corresponds to a change from symptoms, on average, bothering clients "quite a bit" at intake to "somewhat" at follow-up. The results from the reduced IMR-R indicated the achievement of important improvements with minimizing symptom distress and impairment, while also increasing knowledge, coping skills, and involvement of family to help maintain benefits and minimize risks of future recurrence of symptoms.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool completed by the ADAPT participant. This tool was administered upon enrollment into ADAPT and then every 90 days thereafter. Unless otherwise noted, all survey items were rated on a scale from 1 to 5, with higher values representing the better or more desirable response. As shown in Table 5, self-reported improvements occurred across multiple dimensions including quality of life, mental health, social relationships, and hopefulness for the future.

These areas of improvement were consistent with the primary areas of emphasis within the ADAPT program.

Table 5. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (N=48)

		Initial Asmt.	Last Asmt.
Wellness Survey Item (Note: higher value = better condition; Scale of 1 to 5)	**N**	**Mean**	**Mean**
In general, would you say your health is:	48	2.9	3.1
In general, would you say your quality of life is:	47	3.1	3.4*
In general, how would you rate your physical health?	48	2.8	2.9
In general, how would you rate your mental health, including your mood and your ability to think?	48	2.4	2.7**
In general, how would you rate your satisfaction with your social activities and relationships?	48	2.5	2.9*
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).	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?	48	3.9	4.4**
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	48	2.3	2.7*
My child(ren) had emotional and/or behavioral problems.	36	4.6	4.3
I believed people were following or trying to harm me or my family.	38	4.9	5.0
I heard voices that no one else could hear.	38	4.9	4.8
I felt hopeful about the future.	38	3.3	3.9**
I felt spiritually connected.	38	3.0	3.5^
I lived in a home that made me feel safe.	38	4.3	4.6
I used substances (alcohol, illegal drugs, etc.) too much.	38	4.8	4.9
How would you rate your fatigue on average?	48	3.1	3.2
Scale of 0 to 10; Higher value = worse condition	**N**	**Mean**	**Mean**
How would you rate your pain on average?	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 program participants were asked to complete a survey regarding their perceptions of the ADAPT program and the extent to which they thought participation in ADAPT resulted in achieving general objectives of knowing where to get help, increased comfort in seeking help (i.e., stigma reductions), and overall ability to handle things. As shown in Table 6, over 90% of participants indicated that they knew where to get help and were more comfortable seeking help as a result of receiving ADAPT services and approximately 85% (84.6%) indicated that they were better able to handle things. Overall, participants in ADAPT services were extremely positive about their experiences. Over 90% indicated that ADAPT services were available at convenient times (94.2%), that they were able to obtain all needed services (92.3%), that staff were sensitive to cultural background (100%), and that they were satisfied with ADAPT services (96.2%). 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 6. ADAPT Program Feedback Survey (N=52)

ADAPT Program Feedback Survey Item	Agree/ Strongly Agree	
As a result of participating in ADAPT:	**N**	**%**
I know where to get help when I need it.	49	94.2%
I am more comfortable seeking help.	47	90.4%
I am better able to handle things.	44	84.6%
Experiences with ADAPT services:	N	**%**
Services were available at times that were good for me.	49	94.2%
I was able to get all the services I thought I needed.	48	92.3%
Staff were sensitive to my cultural background (race, religion, language, etc.).	52	100.0%
Overall, I am satisfied with the services I received here.	50	96.2%

Participants were also asked what they thought were the most important benefits or services received through their participation in ADAPT. The following quotes from the open-ended responses reflect typical content and tone of the comments:

"Helped me get out of dark deep hole I felt at start of postpartum. Thanks to this program I am no longer there."

'"Emotional support and guidance. Understanding life a little better. I love my therapist's passion and dedication to my individual needs."

"For me and my child, feel more secure with being a mom."

"The most important benefit was having [the therapist] come into our home to provide therapy to the whole family. It really helped us connect with each other."

"The resources, as there were so many and also the support & encouragement. So flexible and helpful to not leave [home]."

A review of the responses indicated the following four primary types of ADAPT service benefits:

1. Learning about mental health issues and the techniques to better manage/prevent symptoms.
2. Receiving general emotional support and encouragement from therapists/peer support partners.
3. Opportunity to have someone to talk to/with which to have positive social interactions.
4. Assistance with obtaining tangible community resources (e.g., food stamps).

Within these responses, participants also identified two key factors that facilitated their engagement in the ADAPT services:

1. Positive and trusting relationships with ADAPT therapists and peer support partners.
2. Convenience of participating in services via home visits (pre-COVID) or telephone/video calls.

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 specific recommendation was to request that they could continue receiving ADAPT services for a longer period. Another recommendation was to allow for additional forms of communication with the ADAPT team, such as texting. 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 telephone and video call options. As a whole, the recommendations generally reflected an interest on the part of ADAPT participants for extended and/or enhanced communication and interaction with ADAPT program team members.

Public Health Nurse Feedback Survey

As an important ADAPT program partner, a brief online survey was conducted with PHNs to obtain feedback regarding their experiences with the ADAPT program. PHNs were asked to indicate the extent to which they agreed with a series of statements on a 5-point rating scale ranging from "strongly disagree" to "strongly agree". For the qualitative open-ended survey questions seeking PHN feedback and recommendations, 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. A total of 26 PHNs completed the survey. As shown in Table 7, PHNs almost universally agreed (92.3%; n=24) that the ADAPT program provided important services to their clients. PHNs indicated they often observed client improvements such as increased confidence and hope, better decision-making and overall mental well-being, and additional connections to needed community resources. PHNs commented that they found the collaboration with ADAPT helpful and complementary to their services.

Table 7. PHN Reponses from ADAPT Program Feedback Survey (N=26)

ADAPT Program Feedback Survey PHN Responses	Agree/Strongly Agree	
Item	**N**	**%**
The ADAPT program provides important services to public health nursing clients.	24	92.3
I am confident that I can identify appropriate ADAPT program referrals.	20	76.9
It is easy to connect potential referrals to the ADAPT program.	16	61.5
Overall, I am satisfied with the partnership with the ADAPT program.	19	73.1

Approximately three-quarters (76.9%; n=20) indicated that they were confident identifying potential clients for ADAPT services and 61.5% indicated that it was easy to connect clients to the ADAPT program. Respondents indicated that mental health "roundtable" trainings conducted by ADAPT staff were helpful to the PHNs. Additional trainings related to mental health and mental health assessments were of interest to PHNs as this would allow them to further increase their capabilities and confidence in identifying persons who would likely benefit from ADAPT services.

Coordination and communication activities between ADAPT and the PHNs evolved throughout FY 2019-20, with a particular emphasis on improving the initial referral process. Initial referral efforts by PHNs were found to be challenging, and substantial effort was made by PHNs, ADAPT staff, and County of San Diego BHS to build a sustainable partnership. Recommendations from PHNs included additional options for submitting referrals, such as via secure email. Given the additional responsibilities for PHNs with the onset of the COVID-19 pandemic, PHNs acknowledged that there was less time to focus on the ADAPT partnership, which resulted in a reduced flow of referrals into ADAPT. Some PHNs expressed appreciation that ADAPT provided extra services during the pandemic to PHN clients who needed additional supports due to the challenging circumstances. Overall, 73.1% (n=19) indicated that they were satisfied with the partnership with ADAPT.

Additional Program Activities

Training and Consultation with PHNs

In addition to the direct services offered to Level-1 and Level-2 ADAPT participants, ADAPT staff provided a total of 589 PHN consultations to discuss the mental health needs of their clients. ADAPT staff also collaborated with PHNs to conduct 38 case conferences during which specific treatment and care strategies for assisting clients were reviewed. Case conferences are scheduled meetings of PHN program which ADAPT staff attend to support education and consultation regarding client cases.

To increase PHN awareness and understanding of mental health issues, ADAPT staff conducted six training "roundtables" that were attended by a cumulative total of 72 PHN (note: PHNs could have attended multiple trainings). Roundtable trainings are offered by ADAPT to PHNs and are typically facilitated by the ADAPT clinical supervisor and/or Program Manager. The focus of the roundtable varies based on requests from PHNs. Topics covered in FY 2019-20 included programmatic support, support for nurses struggling with staff changes, trauma-informed language to use with clients, what success can look like for PHN meetings, and self-care.

Feedback from these roundtables indicated that nurses appreciated this time to reflect on their experiences with and offer recommendations for the ADAPT partnership. Many of these roundtables have included assistance with understanding ADAPT services and eligibility requirements as PHNs reported some challenges with identifying appropriate referrals. Unfortunately, case conferences and ADAPT-led trainings of PHNs were suspended due to the onset of the COVID-19 pandemic and the additional demands that were placed on PHNs as part of the local frontline response. This likely reduced the total number of case conferences and trainings that otherwise would have been provided during FY 2019-20.

Outreach and Support to PHN Clients during COVID-19 Pandemic

With the onset of the COVID-19 pandemic, ADAPT offered to conduct outreach and support sessions to PHN clients who were not enrolled in ADAPT, but who might be experiencing additional stress related to COVID-19 and/or the community response to it (e.g., stay-at-home orders, difficulties obtaining needed supplies, disruptions to employment and schooling, etc.). As of 6/30/2020, ADAPT providers had conducted a total of 16 such sessions with 13 different PHN clients.

These sessions served to support PHN clients while PHNs were responding solely to COVID-19 specific public health needs and duties. Many of these services included case management and general well-being check-ins due to PHNs having less availability to attend to such needs.

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 2019-20. 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 10 respondents from the 13 ADAPT staff invited to participate in the survey for a 76.9% response rate. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

PHN and ADAPT Program Collaboration and Communication

As with many new initiatives, especially those with multiple organizational partners, mutual learning between the ADAPT program and the PHNs was required in order to develop, implement, and refine the coordination of information and services. Overall, ADAPT staff indicated that improving communication with PHNs would help achieve program goals. While not feasible after the pandemic, periodic face-to-face interactions with the PHNs was identified as an effective strategy to better coordinate PHN and ADAPT activities. Overall, PHNs had reduced availability to interact with the ADAPT program after the emergence of COVID-19. Two components of the relationship between PHNs and ADAPT that were of particular importance during FY 2019-20 included: 1) the identification of potential ADAPT referrals and 2) communication of referrals from PHNs to the ADAPT program.

PHN Identification of Potential ADAPT Participants

Potential ADAPT participants were not recruited directly by ADAPT, but were identified by PHNs and then referred to the ADAPT program for eligibility determination. As noted above, responses from the PHN feedback survey suggest that about 75% of PHNs felt confident at the end of FY 2019-20 that they could identify appropriate referrals for ADAPT. This has been an area of emphasis and progress throughout FY 2019-20. Trainings designed to increase PHN awareness and understanding of mental health issues coupled with ongoing review and feedback about PHN referrals helped to improve the fit between PHN referrals and ADAPT program eligibility criteria. Additionally, individuals screened may have had an interest in talking with someone to help them with difficult days but were unsure about enrolling into a formal mental health treatment program, even the more generalized Level-2 services. ADAPT staff recommended further education and communication with PHNs to support their efforts to identify ADAPT program referrals.

Referral Process from PHNs to ADAPT Program

A crucial aspect of PHN and ADAPT program coordination involved the process of submitting referrals of PHN clients identified as potential ADAPT candidates to the ADAPT program. Key steps in the referral process included the development of referral documents that met the needs of both sets of users and protocols to guide the process of submitting and tracking status of referrals. As a result of ongoing discussions, the referral documents and process were revised multiple times during FY 2019-20, which facilitated more efficient and effective communication. In January 2020, ADAPT implemented a shared referral tracker that provided the disposition of referrals to each public health region. This referral tracker was shared weekly via email and has improved communication between PHNs and ADAPT.

Of note, the number of referrals from PHNs to the ADAPT program reduced substantially following the onset of the COVID-19 pandemic and remained very low as of 6/30/2020 (i.e., reduced from an average of 22.1 to 3.8 per month pre- and post-pandemic, respectively).

ADAPT Participant Engagement and Retention

ADAPT staff reported that maintaining client active engagement in services and/or retaining clients in services was not a major challenge for the program. Staff cited the convenience of services (i.e., in-home services and flexible scheduling) as a factor that helped keep clients engaged as well as the positive relationships with ADAPT therapists and peer support partners. ADAPT staff recommended increasing communication options (i.e., text and e-mail) as an effective strategy for increasing communication with clients and further supporting their active engagement in services.

One aspect of the ADAPT program that did not develop as anticipated during FY 2019-20 was the involvement of substantial numbers of male partners and/or other family members in ADAPT services. While some clients indicated that there were indirect benefits for the broader family unit such as improved communication skills, direct participation in ADAPT services by persons other than the mothers was rare. ADAPT staff indicated that this situation could be due, in part, to perceived reluctance on part of male partners/other family members as well as to some potential hesitation on the part of the mothers to involve others as they valued the time to focus specifically on their personal experiences and needs.

Experiences with Telehealth Services

With COVID-19, the ADAPT program was required to shift from providing primarily in-person, in-home services to only interacting with clients "virtually" via telephone or video telehealth calls. When asked to compare experiences between in-person and telehealth services, ADAPT providers indicated both approaches were equally effective for maintaining client engagement and focus during sessions, enabling quality communication, and openness of clients to share personal information. Providers indicated that telehealth might actually be slightly better for maintaining relationships with clients. In general, ADAPT staff indicated a high level of confidence in their ability to provide services via telehealth, and thought that telehealth should remain a priority for the program even after in-person services become safe and available again. In this regard, a mixture of in-person and telehealth services was considered to be ideal.

A key benefit of the greater use of telehealth services was the substantial amount of time saved by not having staff travel throughout the entire County to provide the in-home services. Additionally, the switch to telehealth services facilitated a more efficient allocation of staffing resources to meet client needs throughout the County rather than maintaining primarily region-based service teams, particularly when needed to cover any staffing gaps due to turnover or leaves of absence.

According to ADAPT staff, less than 10% of clients were unable to consistently utilize telehealth with video due to problems with internet connectivity or other technical challenges managing video calls. Staff indicated that issues with providing telehealth video calls were generally diminishing by the end of FY 2019-20 as comfort and expertise on the part of both clients and providers increased. Staff highlighted the importance of setting clear expectations with how to conduct telehealth with video sessions and establishing a pre-arranged plan for if and when a connection was lost (i.e., telephone follow-up). Additional recommendations would be to provide options for internet access and/or devices to facilitate telehealth video sessions. Even when video calls were possible, staff estimated that approximately 10-20% of clients preferred telephone only sessions. While telephone may be perceived as more convenient by some clients, ADAPT staff encouraged video calls as much as possible.

Impact of COVID-19 on ADAPT Staff

ADAPT staff indicated that COVID-19 nearly universally changed their work settings with the transition away from in-person services provided at the homes of ADAPT clients to telehealth services provided primarily from the homes of ADAPT personnel. Staff also reported substantial changes in their lives unrelated to work due to COVID-19 and most indicated experiencing additional stress and anxiety. Staff used self-care and social connections to help manage or reduce COVID-19 related stress or anxiety.

Program Changes from Initial Design

Non-COVID Related Changes

While there were ongoing administrative and programmatic adjustments that occurred throughout FY 2019-20, there were no substantial changes from initial program design unrelated to the COVID-19 response (i.e., transition to telehealth). As noted above, however, one aspect of the program that did not materialize as anticipated was the inclusion of substantial numbers of male partners and/or other family members in ADAPT services. Such services will continue to be offered in future years.

Program Recommendations

1. Identify additional sources of potential referrals, particularly while referrals from PHNs are reduced due to COVID-19.
2. Increase communication, coordination, and collaboration with PHNs.
3. Increase allowable communication methods with clients (e.g., texting and email).
4. Improve administrative efficiencies (i.e., review of referral, intake, and evaluation practices).
5. Conduct record reviews to determine the extent to which ADAPT clients would qualify for Medi-Cal reimbursable services.
6. Examine Level-2 enrollment patterns to better understand why services were not utilized as much as anticipated.
7. Generate a more detailed understanding of the reasons why some persons leave the program before fully engaging in services.
8. Promote community education of peripartum behavioral health.
9. Explore development of a County designated "Peripartum Warm Line" that can be called when needed to provide support during challenging times that do not require a crisis/emergency response.

Conclusion

During FY 2019-20, the first year of ADAPT service provision, the program enrolled a total of 91 persons. Factors that contributed to lower enrollment than anticipated (i.e., the initial goal was 300 persons per year) included: 1) initial program start-up challenges related to establishing and implementing program operations and aligning PHN referrals with ADAPT eligibility criteria, 2) receiving very few referrals from PHNs following the onset of the COVID-19 pandemic, and 3) lower than expected enrollment of partners and other family members into ADAPT services. The ADAPT program will continue to explore options during FY 2020-21 to increase the number of enrollees.

The program was able to successfully establish the two tiers of ADAPT services with Level-1 for those who needed ongoing therapy and Level-2 for those who primarily needed psychoeducation and more generalized forms of supports. There were five persons who had a "step-down" in care needs and transitioned from Level-1 to Level-2. While service durations varied substantially among those discharged from Level-1 services, many were enrolled for approximately 3-4 months, but 25% of the client population remained in the program for at least 176 days.

As documented by both participant self-report and clinician-completed assessments, the ADAPT program demonstrated substantial reductions in symptom distress as well as improvements in multiple domains including illness management, functioning, and quality of life. Feedback from ADAPT participants about their experiences with the ADAPT program indicated high levels of appreciation for the services with the most common request for change being a recommendation to allow persons to stay in the program for a longer period of time. These findings indicate that the program has been able to achieve program outcomes and is well regarded by participants, even with the adjustment to telehealth services due to the

COVID-19 pandemic. Given the lasting impact of COVID-19 into at least FY 2020-21, an ongoing challenge for the ADAPT program will be to continue to adjust to service environment realities and seek out ways to enhance and support the relationship with PHNs while also exploring other opportunities to provide the much-needed treatment and/or education services to others throughout San Diego.

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 2019-20

Characteristic	Total Participants (N=91)	
Gender	N	%
Female	89	97.8%
Another Gender Identity/ Missing/Prefer not to answer	2	2.2%
Total	91	100%
Age Group	N	%
16-25	34	37.4%
26-35	46	50.5%
>=36	11	12.1%
Total	91	100%
Primary Language	N	%
English	63	69.2%
Spanish	22	24.2%
Other/Missing/Prefer not to answer	6	6.6%
Total	91	100%
Race/Ethnicity	N	%
African American	16	17.6%
Latino	57	62.6%
Caucasian/white	27	29.7%
Multi-racial	17	18.7%
Other/Missing/Prefer not to answer	9	9.9%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	81	89.0%
Bisexual/Pansexual/Sexually fluid	6	6.6%
Missing/Prefer not to answer	4	4.4%
Total	91	100%
Military Status	N	%
Never served in the military	88	96.7%
Other/Missing/Prefer not to answer	3	3.3%
Total	91	100%

Characteristic	Total Participants (N=91)	
Disability	**N**	**%**
Yes, Has a disability	15	16.5%
No disability/Declined/Prefer not to answer	76	83.5%
Total	91	100%
Type of Disability	**N**	**%**
Seeing/Hearing/ Other Communication	5	5.5%
Physical Disability/Chronic Health	7	7.7%
Other	9	9.9%
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 1 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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. The goal is to reduce recidivism rates 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. As part of BHConnect, Welcome Home Health (WHH) services are available 24 hours a day/7 days a week to provide telehealth technical support, treatment scheduling reminders, follow-up for missed appointments, and to direct any crisis requests to appropriate services. Since the initial design of BHConnect already relied exclusively on the provision of mental health treatment services via telehealth technologies, BHConnect had essentially no disruptions to ongoing treatment services following the onset of the COVID-19 pandemic.

Primary Findings for Fiscal Year (FY) 2019-20

1. Overall, substantially fewer referrals than expected originated from referral partner agencies, which resulted in relatively low BHConnect enrollment for FY 2019-20 (i.e., 37 persons enrolled in the Children, Youth, and Family (CYF) BHS system and 17 persons enrolled in the Adult and Older Adult (AOA) BHS system).
2. Utilization of BHConnect services varied substantially within the youth and adult service populations. Approximately 15% of youth and 35% of enrolled adults did not participate in any BHConnect services (e.g., assessment, therapy, or case management); however, of those with any therapy services, the average number of sessions received was 6.9 and 9.9 for youth and adults, respectively as of 6/30/2020. Almost 65% of the enrolled youth and 40% of adults had at least 3 therapy sessions.
3. The BHConnect staff reported that successful client recruitment of persons previously unconnected to services was facilitated by key program components such as offering clients a dedicated device for telehealth services, providing crisis coverage through telehealth services 24 hours a day/7 days a week

via the WHH partnership, and enabling clients to quickly start services (i.e., not being put on a program waitlist).

Additional Program Highlights

1. Through the Recovery Markers Questionnaire, adults self-reported similar assessments of their recovery status and outlook on life as did adults in other adult BHS programs.
2. At baseline, the Child and Adolescent Needs and Strengths assessment indicated multiple needs that BHConnect providers could address in their treatment plan with their child/youth.
3. BHConnect staff indicated the most common difficulties in providing telehealth services were poor/unstable internet connections, device malfunctions, and user error in accessing the telehealth services. Besides some of these issues, BHConnect staff did not indicate any major limitations to the provision of therapy via telehealth.
4. WHH was an important BH Connect service partner who facilitated ongoing engagement via the telehealth device to manage scheduling and provide wellness check-ins, primarily via video.

Conclusion

During FY 2019-20, the first full year of program operations, BHConnect demonstrated the viability of the initial program design (i.e., only having one in-person interaction before conducting everything else via telehealth). This model was ideal with the onset of the COVID-19 pandemic and the need for many different types of services to be provided remotely. BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services; however, generating substantial numbers of client referrals from other crisis-oriented mental health service provider organizations was an ongoing challenge. Additional approaches for increasing referrals will be pursued during FY 2020-21. Recognizing that a portion of these clients may only participate in services for a limited amount of time, BHConnect will develop short-term treatment priorities during FY 2020-21 in an effort to impart as many key educational and therapeutic benefits as possible to clients during the initial visits.

Primary Recommendations for FY 2020-21

1. Continue outreach efforts with community providers to increase referrals into BHConnect.
2. Coordinate with BHS to utilize BHS-generated reports to identify and engage additional potential BHConnect candidates.
3. Explore strategies to increase active engagement in telehealth treatment services.
4. Develop short-term treatment priorities to maximize educational and treatment benefits of initial visits.

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 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. As part of BHConnect, WHH services are available 24 hours a day/7 days a week to provide telehealth technical support, treatment scheduling reminders, follow-up for missed appointments, and to direct any crisis requests to appropriate services.

Welcome Home Health Activities

WHH is a key partner in the provision of BHConnect services. The primary role of WHH is to facilitate and manage initial and ongoing technological connections with BHConnect clients. Following agreement to participate in BHConnect services, a computer tablet or phone is provided to the client by BHConnect staff to use for their telehealth services (note: the functionality of the tablet is restricted to only allow access to WHH telehealth services so no other activities such as browsing the internet are possible). Once the device is provided to the client, a WHH representative will connect with the client via the device to introduce WHH and describe how to access telehealth services. WHH will also work with the BHConnect client to establish a plan for how best to participate in telehealth services (e.g., finding the best locations for good internet connectivity in the home, creating a plan for when any potential disruptions occur, etc.). A representative from WHH will also schedule the telehealth services, provide daily check-ins via the device until the first appointment, and then follow up with periodic check-ins and reminders throughout treatment. WHH services are available 24 hours a day/7 days a week to help with questions, provide check-ins, and to direct clients to crisis services if needed. In addition to the direct interactions with BHConnect clients, WHH and BHConnect staff regularly meet to review program operations and discuss specific cases. This communication and coordination ensures that staff from both partner organizations are aware of issues related to the well-being and ongoing treatment of BHConnect clients.

Table 1 provides an overview of the interactions between BHConnect clients and WHH for June 2020, the last month of FY 2019-20. While all WHH calls had the primary purpose of scheduling or confirming treatment appointments, approximately half (49.5%) had a wellness/treatment support component as well. A small but important subset of calls (3.4%) involved crisis/urgent issues that prompted referrals to the BHConnect treatment team. The majority of calls were conducted via video (83.6%). Reflecting the capability for two-way communication, 33.4% of the calls were initiated by BHConnect clients. For these calls, the average response time for WHH representative availability was less than three minutes. These findings highlight how multiple purposes can be accomplished through the communication between WHH

representatives and BHConnect clients to support engagement in telehealth treatment services. Additionally, the high percentage of video calls indicate that BHConnect clients typically had reliable internet connections, could successfully navigate the device, and were comfortable with the video interactions – all of which are important precursors for participating in video telehealth treatment services.

Table 1. WHH Calls with BHConnect Clients during June 2020 (N=293)

Type of Call	N	% of Total WHH Calls
Appointment scheduling/confirmation calls	293	100%
Wellness check-in/goal follow up calls	145	49.5%
Crisis/urgent calls referred to BHConnect team	10	3.4%
Additional Call Information		
Calls conducted via video	245	83.6%
Calls conducted via phone	48	16.4%
Calls initiated by BHConnect clients	98	33.4%
Average response time for calls initiated by client	2.9 min.	

Service Changes Due to COVID-19

The COVID-19 pandemic first substantially affected the San Diego area during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period county BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety, while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

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). 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 2019-20, a

total of 37 persons enrolled in CYF services and 17 enrolled in AOA services. CYF clients ranged in age from 5-18 with the majority (64.9%; n=24) between the ages of 15-18. AOA clients ranged in age from 18-65, with 35.3% (n=6) as Transitional Age Youth (TAY) between the ages of 18-25. Approximately two-thirds (64.9%; n=24) of the CYF clients were female, whereas the majority of AOA clients were male (58.8%; n=10). The majority of both CYF and AOA clients identified as Heterosexual or straight (78.4%; n=29 and 76.5%; n=13, respectively).

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 would attempt to maintain daily contact with the newly enrolled BHConnect clients until their first therapy session. Despite these WHH activities, a portion of BHConnect enrollees (16.2% of youth and 35.3% of adults) did not participate in any BHConnect services during FY 2019-20. 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 2 shows the overall service utilization patterns for persons who enrolled in BHConnect services during FY 2019-20. On average, youth and adults enrolled and receiving BHConnect services had approximately 10 total services (9.6 and 11.8, respectively) as of 6/30/2020. Of those that participated in at least one BHConnect therapy session, the mean number of therapy sessions received by youth and adults was 6.9 and 9.9, respectively. Out of all BHConnect enrollees, 64.9% of youth (n=24) and 41.2% of adults (n=7) received at least three therapy sessions from BHConnect clinicians.

Table 2. BHConnect Service Utilization

	Youth (N=37)			Adult (N=17)		
	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	31	83.8	9.6	11	64.7	11.8
Psychosocial assessment provided	27	73.0	1.4	9	52.9	1.2
Treatment plan session	23	62.1	1.0	8	47.0	1.0
Therapy sessions provided	29	78.4	6.9	10	58.8	9.9
Case management sessions provided	4	10.8	1.0	2	11.8	2.0
Other services provided (e.g., collateral contacts)	14	37.8	2.4	4	11.0	2.0
Received at least three therapy sessions	24	64.9	-	7	41.2	-

BHConnect Services – Duration and Discharge Status

As shown in Table 3, of the 37 youth and 17 adults who enrolled in BHConnect services during FY 2019-20, there were 19 youth and 7 adults active in the program as of 6/30/2020. These persons were typically enrolled for approximately three months (i.e., median duration of 91 days and 84 days, respectively), however there was a wide range for both youth and adults (i.e., duration of 7 to 220 days and 5 to 209 days, respectively). Of the persons who closed out of BHConnect prior to 6/30/2020, the duration times were generally much shorter (i.e., median durations of 44.5 and 37.0 days, respectively), which reflects the fact that a portion of the BHConnect enrollees were only in the program for a brief period of time. While the Year 1 sample sizes are too small to draw definitive conclusions, the program duration patterns suggest some initial "sorting out" of client preferences and interest levels during the initial few weeks of BHConnect involvement; some closed out of services within a month or less, but many others connected with and maintained treatment for 3 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 3. BHConnect Program Participation Duration and Discharge

	Youth (N=37)		Adult (N=17)	
	Still in program	**Discharged**	**Still in program**	**Discharged**
N (persons)	19	18	7	10
Mean (days)	103.7	46.7	87.3	62.1
Median (days)	91.0	44.5	84.0	37.0
Std. Dev. (days)	62.5	31.8	74.2	69.7
Minimum (days)	7	8	5	3
Maximum (days)	220	119	209	231

Primary Program Outcomes

Child/Youth Baseline Assessments

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (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 information from both the youth and family members to inform planning, support decisions, and monitor outcomes. The CANS is completed by providers at initial assessment, 6-month reassessment, and discharge.

The CANS assessment includes a variety of domains to identify the strengths and needs of youth. Each domain contains a certain number of questions that are rated 0-3, with a "2" or "3" indicating a specific domain that should be addressed in the service or treatment plan. Within a domain, the number of

questions rated at least a 2 or a 3 can be counted as a way to see which areas indicate a higher need for support. Table 4 shows the mean counts of the initial assessment needs for the domains of Child Behavioral/Emotional Needs, Life Functioning, and Risk Behaviors.

Of the 28 CANS assessments completed during the initial intake, on average, providers recorded approximately two needs in both the domains of Child Behavioral/Emotional Needs and Life Functioning and one need in the domain of Risk Behavior. These CANS ratings indicate that there are multiple needs for BHConnect providers to try to address in partnership with BHConnect clients. In future reporting periods, it is anticipated that there will be a sufficient sample size to assess for improvements between initial and follow-up/discharge CANS ratings.

Table 4. Child and Adolescent Needs and Strengths (CANS) at Baseline (N=28)

CANS Domain	Initial mean number of needs
Child behavioral/emotional needs	2.1
Life functioning	1.7
Risk behaviors	0.9

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist (PSC-35) is a screening tool designed to support the identification of emotional and behavioral problems. 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[1] indicating impairment for emotional and behavioral problems are seen through the total PSC score and through the three subscales contained within the PSC located below in Table 5. In FY 2019-20, the PSC-35 was administered at entry into BHConnect, at 6-month reassessment, and discharge. Table 5 shows about half of all youth were above the total PSC clinical cutoff score as reported by caregivers (50.0%) and youth (57.7%) at baseline. Mean scores across the total score and three subscales were generally consistent between caregivers and youth. The Internalizing subscale domain was most commonly rated above the clinical cut point (i.e., 66.7% of caregiver reports and 73.1% of youth self-reports).

[1] *PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7*

Table 5. Pediatric Symptoms Checklist (PSC) at Baseline

	Caregiver Report			Youth Report		
Higher scores indicate worse condition	N	% Above cutoff	Mean	N	% Above cutoff	Mean
PSC Total Score	24	50.0%	28.1	26	57.7%	29.1
Attention Subscale	24	25.0%	4.6	26	30.8%	5.6
Internalizing Subscale	24	66.7%	5.5	26	73.1%	6.0
Externalizing Subscale	24	12.5%	3.2	26	15.4%	3.2

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 8 adult participants who completed it at intake was 3.6. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2018-19 (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 3.4. It appears that BHConnect participants self-report 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. The mean overall IMR score (n=9) at intake was 2.5. As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8. With the small sample size no definitive conclusions are possible, however, it appears that clinicians assessed BHConnect participants to have fairly similar levels of impairment as seen among participants in other BHS programs. Of note, BHConnect participants reported fairly high levels of involvement of others in their mental health treatment, using medications effectively, and limited impairment due to substance use (i.e., all were rated 3.6 or higher on a 5-point scale); however, mental health management was rated low (i.e., 1.6 on a 5-

point scale). These findings and potential changes in IMR scores will be evaluated in future reporting periods as the sample sizes increase.

Table 6. IMR Assessments for BHConnect Adult Clients (N=9)

	Baseline	
IMR Assessment Item/Subscale	**N**	**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?	9	3.9
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	9	1.8
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	9	1.1
Using medication effectively: How often does s/he take his/her medication as prescribed?	9	3.6
Recovery subscale	9	2.6
Management subscale	9	1.6
Substance abuse subscale	9	3.8
Overall IMR	**9**	**2.5**

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 2019-20 required extensive 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. Overall, fewer referrals than expected were generated from potential partners, which prompted ongoing outreach and networking activities for much of FY 2019-20. To help facilitate referrals with some partners (e.g., ESU), BHConnect staff were stationed on location to assist with identifying and screening potential candidates. For locations without an onsite BHConnect presence, a referral process was designed and revised to allow for a brief screening call to determine eligibility of potential candidates interested in BHConnect services.

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 2019-20. 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.

Challenges Establishing Referral Network

As discussed above, BHConnect engaged in extensive outreach and education activities throughout FY 2019-20 in an effort to establish referral partnerships with crisis-oriented mental health service providers. Organizations typically expressed interest in having BHConnect as a new outpatient resource to offer clients following crisis episodes; however, the number of resulting referrals was substantially less than anticipated. While the specific reasons for this likely varied between organizations, the main barrier appeared to be difficulties with introducing change into well-established referral processes. In response, the BHConnect team streamlined the screening and referral process to reduce potential burdens or complexities that might inhibit identification of BHConnect candidates. Referrals increased near the end of FY 2019-20, which was due to both the ongoing efforts of the BHConnect team as well as the increased interest in telehealth-based mental health services brought on by the COVID-19 pandemic.

Recruitment of Potential BHConnect Participants

The BHConnect staff reported that successful client recruitment was facilitated by key program components such as offering clients a dedicated device for the telehealth services, providing crisis coverage for telehealth services 24 hours a day/7 days a week via the WHH partnership, and enabling clients to quickly start services (i.e., not get put on a program waitlist).

Engagement and Retention of BHConnect Participants

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. Consistent with expectations, BHConnect staff survey responses identified client engagement with treatment services and client attrition as substantial challenges during FY2019-20. In this regard, the capabilities of BHConnect to reduce treatment burdens via easy to access telehealth services and 24/7 availability were viewed by staff as instrumental to program success, but still subject to client motivation and interest to participate in services. In this regard, the telehealth approach of BHConnect may represent a necessary, but not entirely sufficient, condition to keep some persons in treatment. Further explorations into strategies to promote client engagement in telehealth services will be conducted during FY 2020-21.

Experiences with Telehealth Services

When BHConnect staff were asked about the most common difficulties they encountered when providing telehealth the primary answers were technology involved: internet connectivity issues (in both rural and urban settings), experiencing problems/challenges with devices, troubleshooting user error in accessing the telehealth services, etc. Staff indicated that between 11-25% of telehealth calls experienced some type of disruption due to connectivity or device issues. Staff indicated that most participants were comfortable with the video aspect of the telehealth sessions and there were few requests for telephone only telehealth sessions. When asked to compare their BHConnect telehealth experiences to prior in-person therapy experiences, staff indicated that the approaches were fairly equivalent in key therapeutic domains of establishing relationships with clients, having quality communication, and engaging clients in services. Overall, besides some issues with devices and maintaining internet connectivity, BHConnect staff did not indicate any major limitations to the provision of therapy via telehealth.

Impact of COVID-19 on BHConnect Staff

Overall, BHConnect staff members indicated there were aspects of their lives, both related and unrelated to work, which changed substantially due to the COVID-19 pandemic and contributed to some elevated levels of personal stress and anxiety.

Program Recommendations

1. Continue outreach efforts with community providers to increase referrals into BHConnect.
2. Coordinate with BHS to utilize BHS-generated reports to identify and engage additional potential BHConnect candidates.
3. Explore strategies to increase active engagement in telehealth treatment services.
4. Develop short-term treatment priorities to maximize educational and treatment benefits of initial visits.

Conclusion

During FY 2019-20, the first full year of program operations, BHConnect enrolled 54 persons (37 youth and 17 adults). BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2019-20; however, a primary challenge for BHConnect was the difficulty generating substantial numbers of client referrals from other crisis-oriented mental health service provider organizations. While referrals increased during the final months of FY 2019-20, continued efforts to prompt more referrals into BHConnect are expected during FY 2020-21.

Apart from the low number of referrals, the basic initial design of the program (i.e., only having one in-person interaction before conducting everything else via telehealth), proved viable and actually fortuitous with the onset of COVID-19 pandemic and the need for many different types of services to be provided remotely. The WHH partner was successfully able to support program operations via maintaining communication with BHConnect clients between treatment sessions. While the telehealth services made participation in treatment services more convenient, the focal client population (i.e., those unconnected to treatment), still exhibited some difficulties with treatment engagement and retention in services. An

assessment of program duration indicated that of those who had discharged from BHConnect services, 50% of both CYF and AOA clients did so within approximately the first 45 days. Examining strategies to enhance telehealth treatment engagement and retention in services will be an objective for FY 2020-21. Additionally, recognizing that a portion of these clients may only participate in services for a limited amount of time, BHConnect will develop short-term treatment priorities during FY 2020-21 in an effort to impart as many key educational and therapeutic benefits as possible to clients during the initial visits.

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 2019-20

Characteristic	Child/Youth (N=37)		Adult (N=17)	
Gender	N	%	N	%
Male	13	35.1%	10	58.8%
Female	24	64.9%	7	41.2%
Total	37	100%	17	100%
Primary Language	N	%	N	%
English	36	97.3%	16	94.1%
Other	1	2.7%	1	5.9%
Total	37	100%	17	100%
Race/Ethnicity	N	%	N	%
Hispanic/Latino	22	59.5%	-	-
Caucasian/White	11	29.7%	7	41.2%
Multi-racial/Other/Missing	8	21.6%	10	58.8%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	29	78.4%	13	76.5%
Another sexual orientation/Prefer Not to Answer/Missing	8	21.6%	4	23.5%
Total	37	100%	17	100%

Characteristic	Child/Youth (N=37)		Characteristic	Adult (N=17)	
Age Group	N	%	Age Group	N	%
5 to 14	13	35.1%	18 to 25	6	35.3%
15 to 18	24	64.9%	26 to 65	11	64.7%
Total	37	100%	Total	17	100%

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

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Annual Report
Year 2 (7/1/2019 - 6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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 clinics 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, in-clinic visits. For both the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the suspension of all in-person service provision, except for crisis situations. This also prevented the use of the mobile health units at each program.

Primary Findings for Fiscal Year (FY) 2019-20

1. During FY 2019-20, 242 participants enrolled into one of the ROAM programs (93 into IHC and 149 into SIHC).
2. The ROAM program provided nearly 1,900 behavioral health related services across both IHC and SIHC including services such as cognitive behavioral therapy, trauma informed therapy, substance abuse counseling, and medication management.
3. Depression assessments among the population enrolling into the ROAM programs demonstrated that across both programs many of the ROAM participants were showing signs of mild to moderate depression.
4. The Milestones of Recovery Scale (MORS) indicated that on a recovery scale of 1-8, with higher scores indicating greater recovery, on average, persons were enrolling into both IHC and SIHC with a score of approximately 5.0, which corresponds with a recovery level of “not coping, engaged.”
5. Due to COVID-19, the ROAM programs accelerated the planned adoption of telehealth and telepsychiatry services via phone and video sessions. While there were some difficulties with connectivity, overall both the IHC and SIHC ROAM teams reported generally favorable experiences using technology to engage with persons and provide behavioral health services. With the transition

to telehealth services, ROAM program staff reported seeing a decrease in "no-shows" for scheduled appointments and an increase in client willingness to participate in program services.

6. The COVID-19 related disruptions to the planned use of the mobile health units coupled with delays due to repairs during the early part of the year resulted in limited utilization of the mobile health units during FY 2019-20.

Conclusion

Overall, FY 2019-20 was a challenging, but ultimately successful year in terms of both the IHC and SIHC ROAM programs implementing all of their relevant service approaches (even with the limited time using the mobile health units), developing outreach activities, and fully incorporating telehealth and telepsychiatry services into their operations. The lessons learned from the experiences during FY 2019-20 will help inform continued refinement of ROAM practices in FY 2020-21 and contribute to anticipated growth in the number of persons able to benefit from ROAM services.

Primary Recommendations for FY 2020-21

1. Refine plans for strategic utilization of mobile health units (once safe to redeploy) and integration with telehealth services.
2. Address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
3. Enhance evaluation approaches to identify primary impacts of ROAM services on participants.

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. In order for the programs to provide culturally competent services that are sensitive to the needs of American Indians, the majority of ROAM staff at both IHC and SIHC identified as 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 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 on-going and continuing 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 services at night and/or on the weekends to better match availability of participants.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period County BHS programs had to quickly adapt to the new service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

For the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the suspension of all in-person service provision, except for crisis situations. This also prevented the use of the mobile health units at each program. Prior to the COVID-19 pandemic, both programs had started to explore the use of telehealth services to support their in-clinic and mobile health unit ROAM activities, but telehealth services, particularly using video technology, were not commonly utilized. After the emergence of COVID-19, both programs quickly established the capability to provide telehealth services via a mixture of telephone and video-supported interactions with clients. In this regard, there were limited disruptions to the delivery of services to current ROAM participants. A more detailed discussion of the experience with telehealth services is provided below. 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 the end of FY 2019-20.

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. Of the 242 participants enrolled in ROAM during FY 2019-20 (93 from IHC and 149 from SIHC), the majority (54.1%) identified as female, spoke English (99.2%) and indicated their race/ethnicity to be American Indian (88.0%). Asked if they had a disability that was not the result of a serious mental illness (SMI), 31.4% indicated having a disability and 15.7% indicated their disability was a chronic health condition. One area in which the two programs differed to some extent was in the age distribution of their ROAM participants. As shown in Table 1, close to half of SIHC participants were age 25 or younger (41.6%) as compared to less than 16.1% of those receiving ROAM services at IHC (exact numbers less than 5 are obscured). At the other end of the age continuum, almost 20% (18.3%) of IHC participants were over the age of 65, whereas this age group comprised only 8.7% of SIHC participants.

Table 1. Age Distribution of ROAM Participants by Program

	IHC		SIHC	
Age	**N**	**%**	**N**	**%**
<16	<5	<5.4%	29	19.5%
16-25	10	10.7%	33	22.1%
26-45	38	40.9%	45	30.2%
46-65	25	26.9%	25	16.8%
>65	17	18.3%	13	8.7%
Missing/Prefer not to answer	-	-	4	2.7%
Total	**93**	**100**	**149**	**100**

Utilization of Program Services

ROAM Behavioral Health Service Provision

The 93 persons enrolled in IHC ROAM received a total of 1,121 services (average of 12.1 services per person) and the 149 persons enrolled in SIHC ROAM received a total of 753 services (average of 5.1 services per person). As shown in Table 2, a key area of difference between the two programs was the provision of substance abuse counseling, with over half (52.7%) of IHC participants receiving at least one such service compared to less than 3.3% of SIHC participants (exact numbers less than 5 are obscured). This difference reflects the composition of the respective ROAM teams at IHC and SIHC and the inclusion of an SUD counselor at IHC.

Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (32.3% and 31.5%, respectively), however trauma informed therapy was more prevalent at SIHC (38.9% and 19.4%, respectively). For both programs, medication management was a relatively common service provided to ROAM participants, with 26.9% and 34.9%, respectively having at least one medication management session. While there were some differences between the IHC and SIHC programs, most notably the emphasis on substance abuse counseling evident at IHC, the overall findings highlight the wide range of service activities that were provided to persons who may have had difficulty accessing needed behavioral health care through traditional outpatient clinic settings.

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

	IHC				SIHC			
	Total persons (n=93)		Total services (n=1,121)		Total persons (n=149)		Total services (n=753)	
	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	62	66.7%	82	7.3%	89	59.7%	122	16.2%
Psychoeducation: Individual	36	38.7%	197	17.6%	<5	<3.3%	7	0.9%
Psychoeducation: Group	<5	<5.4%	<5	<0.5%	29	19.5%	29	3.9%
Therapy-Cognitive Behavioral: Individual	30	32.3%	232	20.7%	47	31.5%	296	39.3%
Therapy-Cognitive Behavioral: Group	20	21.5%	85	7.6%	<5	<3.3%	<5	<0.7%
Therapy-Trauma Informed: Individual	18	19.4%	119	10.6%	58	38.9%	162	21.5%
Therapy-Family Involved	<5	<5.4%	<5	<0.5%	21	14.1%	44	5.8%
Substance Abuse Counseling	49	52.7%	463	41.3%	<5	<3.3%	<5	<0.7%
Referral to Substance Abuse Counseling	<5	<5.4%	<5	<0.5%	11	7.4%	13	1.7%
Case Management	<5	<5.4%	12	1.1%	22	14.8%	51	6.8%
Medication Management	25	26.9%	123	11.0%	52	34.9%	203	27.0%
Traditional Healing-BH related	<5	5.4%	22	2.0%	0	0.0%	0	0.0%

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. A total of 44 persons at IHC and 62 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM. The average and median PHQ-9 scores were similar for both

programs and indicative of mild/moderate depression for many ROAM participants. However, as shown in Table 3, the top 25% of the PHQ-9 scores were significantly more affected by depression symptoms with IHC showing scores of 14.3 and above, and SIHC showing scores of 13.8 and above, both of which correspond to moderate/moderately severe depression. Some ROAM participants only completed the PHQ-2 screener (not included in Table 3) and did not exhibit evidence of depression. Overall, this pattern of findings suggests substantial variability in the extent to which ROAM participants experienced depression when entering the ROAM program. In future reporting periods, changes in PHQ scores will be assessed as the number of participants with completed baseline and follow-up PHQ-9's increases.

Table 3. Intake PHQ-9 Scores by Program

	IHC	SIHC
Persons with completed baseline PHQ-9	**n=44**	**n=62**
Average PHQ-9 score	9.8	9.9
Standard Deviation	7.1	6.6
Median PHQ-9 score	9.0	8.5
Highest 25% PHQ-9 score	14.3	13.8

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. For those with a completed MORS score upon entry into ROAM, the average score was approximately 5.0 for both IHC and SIHC (which corresponds with "not coping, engaged"). There was some difference in the distribution of MORS scores with SIHC serving a higher percentage of persons with a MORS score between 1-4 than IHC, (35.6% and 14.0% respectively). Since MORS scores were not available for the full cohort of ROAM participants, there is uncertainty regarding the extent to which the ROAM population served by SIHC may have a higher proportion of more seriously impaired persons. This will continue to be monitored in future reporting periods as well as an assessment of potential changes in MORS score when more participants have completed both an intake and follow-up MORS.

Table 4. Intake MORS Scores by Program

		IHC (n=50)		SIHC (n=45)	
MORS Value	**MORS Categories**	**N**	**%**	**N**	**%**
1-4	*Extreme risk; High risk, not engaged; High risk, engaged; Not coping, not engaged*	7	14.0%	16	35.6%
5	*Not coping, engaged*	28	56.0%	13	28.8%
6-8	*Coping/rehabilitating; Early recovery; Advanced recovery*	15	30.0%	16	35.6%
	Mean MORS score	**5.2**		**4.8**	

Additional Program Activities

One of the primary objectives of the ROAM program was to link Tribal communities with resources to help improve mental and physical well-being. To improve linkages and increase utilization of treatment/services, a variety of outreach efforts were made to engage with the community and raise awareness of the ROAM program. Outreach efforts from both programs included attending services fairs, passing out flyers, allowing community members to walk through the mobile units, attending tribal gatherings (e.g., Pow Wows, health fairs), posting on social media about ROAM events/activities, conducting psychoeducation talks at community events, and hosting breakfasts.

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 2019-20. 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 10 respondents from the 15 IHC and SIHC ROAM staff invited to participate in the survey (a response rate of 66.6%). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Information included in the following sections is applicable to both the IHC and SIHC programs unless otherwise indicated.

Outreach and Recruitment of ROAM Participants

Expanding services to rural areas, improving access to care, and reaching underserved populations were among the primary goals ROAM staff identified in the Annual Survey. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment, and more potential ROAM clients could be recruited through the use of community/cultural events.

Engagement and Retention of ROAM Participants

The ROAM program was designed to work with underserved populations in rural areas, and the ROAM staff reported that the best way of accomplishing that was through connecting with clients by listening, learning, and building strong relationships. Additionally, staff found providing consistent but flexible transportation options enhanced their ability to engage clients.

Both programs agreed that client engagement and retention would be strengthened by staff trainings in specific mental health topics such as Motivational Interviewing, Family/Group Therapy, and Eating Disorders. Specifically, the IHC program noted that additional trainings such as computer training, mobile unit function training, and driver training would help to better accomplish program goals.

Mobile Health Unit Experiences and Perspectives

For both IHC and SIHC, the mobile health units were only utilized for a brief period of time during FY 2019-20. Mechanical issues, repairs, and availability of trained drivers disrupted consistent use during the first part of the year and then the onset of the COVID-19 pandemic during March 2020 suspended use for the remainder of FY 2019-20. However, there was a period of time for each program when the mobile health units were operational and utilized to extend the reach of in-person services to more remote areas (i.e., approximately 10% of all FY 2019-20 service contacts for each ROAM program involved the mobile health units). During this time, the programs established fixed schedules for the units such that the behavioral health team would be available to provide in-person sessions at known locations throughout the more remote regions served by IHC and SIHC. Based on the experiences using the mobile health units to expand access to care and the unusual circumstances brought about by COVID-19, the IHC and SIHC teams indicated developing plans for re-introducing the mobile health units into their service delivery approach during FY 2020-21 after it becomes safe to do so. While there was general interest in and demand for these in-person mobile health unit services, ongoing outreach and engagement activities were recommended to increase community awareness and promote greater utilization of services by persons who might need them.

Experiences with Telehealth Services

When the ROAM staff were asked about the most common difficulties they encountered while providing telehealth services, the primary answer was technological issues such as frozen screens, ineffectual audio, software problems, and connectivity issues. In response to difficulties with internet connections, ROAM programs have been working with community partners to establish additional local Wi-Fi hotspot networks that persons can use when wanting to engage in telehealth services.

Staff also reported that approximately 20% of clients preferred to use the telephone and not telehealth with video. As compared to January-March 2020, the program reported an increase in client willingness to participate in services and over a 50% decrease in “no-shows” for appointments during April-June 2020. Other dimensions of client services, such as quality of communication, relationships, client focus, openness, and engagement in services, were perceived as not having been negatively impacted by providing telehealth services as compared to in-person services. Overall, the general response regarding the switch to primarily offering services via telehealth has been largely positive, potentially even more positive than program staff were anticipating.

Impact of COVID-19 on ROAM Staff

Administered during the summer of 2020, the staff survey had the opportunity to collect information on the COVID-19 pandemic and its impact on staff. Overall, staff members indicated there were aspects of their lives, both related to work and unrelated to work, that changed due to the COVID-19 pandemic.

Staff noted that the pandemic had, to a great extent, created additional stress and anxiety in their lives. To help manage or reduce stress and anxiety related to the pandemic, staff reporting using coping skills such as self-care (e.g., exercise, therapy, sleep, etc.), hobbies (e.g., games, spending time outside), and connecting with coworkers and other personal relationships. Overall, staff noted that the change in workspace and not being able to work from the office impacted their abilities to interact with clients. Specifically, SIHC reported that COVID-19 had a notable impact on client retention.

Program Changes from Initial Design

Besides the changes in service provision due to the COVID-19 pandemic (i.e., suspending use of the mobile unit and in-person counseling), there were not any major changes from the initial design and goals of the ROAM program.

Program Recommendations

1. Refine plans for strategic utilization of mobile health units (once safe to redeploy) and integration with telehealth services.
2. Address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
3. Enhance evaluation approaches to identify primary impacts of ROAM services on participants.

Conclusion

Between both the IHC and SIHC ROAM programs almost 1,900 behavioral health related services were provided to 242 persons during FY 2019-20. These persons were eligible to receive ROAM services because they had barriers that inhibited them from participating in standard clinic-based outpatient behavioral health treatment. In this manner, ROAM provided essential behavioral health services to persons, primarily American Indians, who would likely not have received needed care. The baseline PHQ-9 and MORS scores indicated that many in the overall ROAM service population experienced mild/moderate depression and/or were not coping well with their mental health symptoms, but were interested in engaging in treatment services. However, fluctuations in symptom management over time and variability in the severity of mental health needs within the population resulted in the ROAM care teams also responding to and treating serious mental health situations throughout FY 2019-20.

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. Unfortunately, various delays prevented the use of the mobile health units at both IHC and SIHC at various times during FY 2019-20 and then the onset of the COVID-19 required suspending use of the

mobile health units as of March 2020. During the limited amount of time that the mobile units were operational, both clinics established traveling location schedules and refined techniques for the outreach and communication needed to raise community awareness of available services. The programs are continuing to plan for how best to utilize the mobile health units once such operations are determined to be safe and feasible in FY 2020-21.

The second mechanism for increasing access to behavioral health care, expanded use of telehealth and telepsychiatry services, was more fully adopted following the emergence of COVID-19. In this manner, the external circumstances caused by the pandemic and the suspension of in-person visits required the ROAM staff and the entire IHC and SIHC organizations to quickly extend the offering of telehealth and telepsychiatry services. Based on feedback from both IHC and SIHC ROAM teams, the switch to greater utilization of telehealth approaches for providing behavioral health services was broadly embraced and viewed more favorably than originally anticipated. There were some challenges with internet connectivity for certain participants, but both programs indicated working to improve their capabilities to provide telehealth service and will continue to do so during FY 2020-21.

Overall, FY 2019-20, was a challenging, but ultimately successful year in terms of both the IHC and SIHC ROAM programs implementing all of their relevant service approaches (even if for a limited time with the mobile health units), developing outreach activities, and fully incorporating telehealth and telepsychiatry services into their operations. The lessons learned from the experiences during FY 2019-20 will help inform continued refinement of ROAM practices in FY 2020-21 and contribute to anticipated growth in the number of persons able to benefit from ROAM 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 2019-20

Characteristic	Total Participants (N=242)	
Gender	N	%
Male	107	44.2%
Female	131	54.1%
Missing/Prefer not to answer	4	1.7%
Total	242	100%
Age Group	N	%
<16	32	13.2%
16-25	43	17.8%
26-45	83	34.3%
46-65	50	20.7%
>65	30	12.4%
Missing/Prefer not to answer	4	1.6%
Total	242	100%
Primary Language	N	%
English	240	99.2%
Missing/Prefer not to answer	2	0.8%
Total	242	100%
Race/Ethnicity	N	%
American Indian	213	88.0%
Latino	11	4.5%
Caucasian/white	19	7.9%
Multi-racial	8	3.3%
Other/Missing/Prefer not to answer	7	2.9%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	154	63.6%
Gay/Lesbian/Bisexual/Pansexual	6	2.5%
Missing/Prefer not to answer	82	33.9%
Total	242	100%
Military Status	N	%
Never served in the military	200	82.6%
General service	5	2.1%
Served in another country's military	12	5.0%
Missing/Prefer not to answer	25	10.3%
Total	242	100%

Characteristic	Total Participants (N=242)	
Disability	**N**	**%**
Yes, Has a disability	76	31.4%
No, Does not have a disability	123	50.8%
Declined/Preferred not to answer	43	17.8%
Total	242	100%
Type of Disability	**N**	**%**
Learning/Developmental/Other Mental	11	4.5%
Physical	11	4.5%
Chronic Health	38	15.7%
Other	24	9.9%
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 2 (7/01/2019-6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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. 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 high 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, JBU suspended all in-person holistic services except those that could be socially distanced or completed via remote technologies and also stopped all community-based educational and enrichment events.

Primary Findings for Fiscal Year (FY) 2019-20

1. During FY 2019-20, JBU staff were able to successfully locate and contact 49.2% (n=123) of the 250 potentially eligible youth and enrolled 100% (n=42) of the youth determined to still be eligible for JBU services (i.e., not housed).

2. Youth with completed baseline and follow-up assessments demonstrated improvements across many domains including: improved symptom management, greater recovery orientation, increased sense of well-being, and reductions in impairment due to substance use.
3. After participating in JBU, youth typically increased their utilization of BHS outpatient and ACT program services and decreased their use of BHS crisis and acute care services (i.e., crisis stabilization, urgent outpatient visits, and PERT interactions).
4. While 33.3% (n=13) of the 39 discharged were able to achieve desired goals and successfully discharge from JBU (often directly to other behavioral health programs with a residential component), more than half (56.4%; n=22) were discharged from JBU prior to achieving objectives due to issues related to substance use disorders (SUD) that disrupted participation in services.

Additional Program Highlights

1. Enrolled youth were between the ages of 18-25 and racially diverse.
2. 100% of JBU enrollees had an SMI diagnosis (approximately 50% had a diagnosis of schizophrenia or bipolar disorder), and many had a history of co-occurring substance abuse.
3. JBU staff and external partners provided over 1,000 different group and individual holistic wellness services (e.g., meditation, biofeedback, yoga), or educational/enrichment activities (e.g., cooking classes, nature-based activities).
4. Participation in JBU holistic services was associated with improved sense of belonging, greater self-esteem and increased hopefulness for the future.
5. A total of 124 linkages to services were made across mental health, housing, and substance abuse domains, with multiple linkages per youth made to provide individualized treatment plans.

Conclusion

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 75% of youth participating in outpatient care while enrolled in JBU and approximately 25% of youth transitioning to ACT programs after completing the residential phase of JBU. The program also continued to evolve to address emerging issues to better meet ongoing needs of the youth they were serving, specifically that of mental health stabilization. Substance abuse was identified as a significant issue that disrupted youth engagement in JBU services and inhibited the achievement of program objectives. A more explicit focus on providing the education, supports, and treatment linkages needed to help address co-occurring substance use disorder (SUD) will be a priority for JBU during FY 2020-21.

Primary Recommendations for FY 2020-21

1. Focus program activities on improving youth comfort with and interest in participating in mental health treatment.
2. Proactively address factors that inhibit engagement in program services through holistic and other supportive services.
3. Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.

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

Program Description

Using County of San Diego Behavioral Health Services (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). Once JBU receives these names from BHS, intensive outreach efforts are made by JBU staff to locate and contact each youth using available information provided by BHS, street searches, and coordination with other County and support agencies.

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 (i.e., up to 120 days), 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 on one floor, JBU youth can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same building in downtown San Diego. During their time in the program youth will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, Reiki, chiropractic care, and meditation, as well as mindfulness education, biofeedback therapy, 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 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.

Service Changes Due to COVID-19

The COVID pandemic first affected the San Diego area in a substantial manner during March 2020. San Diego County issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, San Diego County BHS programs had to quickly adapt to the new service delivery environment to protect both client and staff safety while continuing to provide mental health services. For many programs, these changes included a switch to or greater utilization of telehealth services.

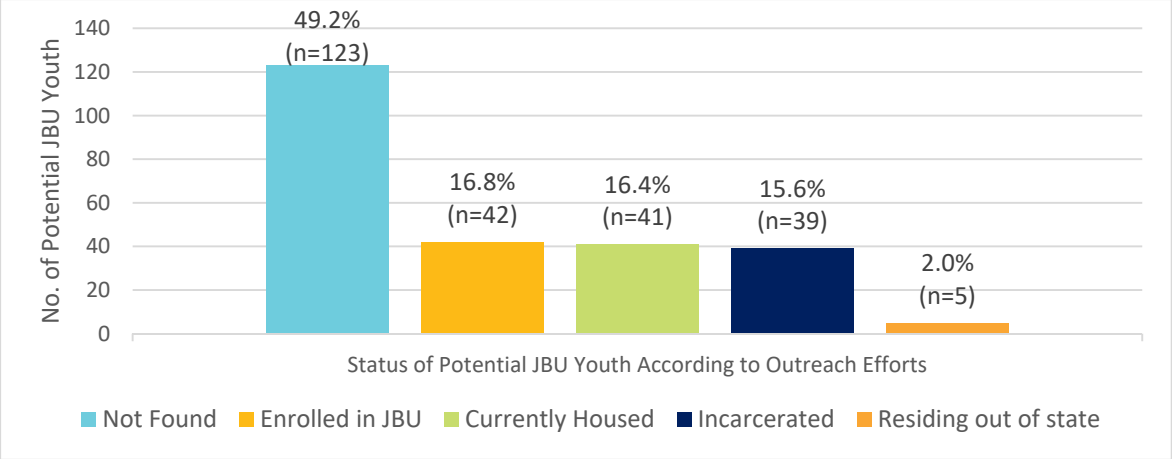
As a residential program serving a population at high risk for exposure to disease (i.e., homeless youth), JBU staff maintained in-person operations throughout the pandemic. JBU staff worked to ensure compliance with all CDC and San Diego County public health guidelines, such as holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, staff and youth mask requirements, rigorous sanitation procedures, and compliance with the "stay-at-home" order to prevent opportunities for exposure. 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 also halted through the end of FY 2019-20. Sessions with behavioral health providers (e.g., from Areta Crowell Center) continued, but were moved 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

After JBU was notified of youth who appeared to meet the specific JBU eligibility criteria set by BHS personnel, substantial efforts were made by the JBU team to locate eligible youth who might benefit from the program. Where made possible by the availability of sufficient contact information or leads, outreach efforts were directly made to each youth. In all cases of eligibility, 100% of youth were sought out for contact. In the event of there being insufficient contact information, the JBU team attempted to reach youth through other means, such as by direct street canvasing, utilizing the BHS EHR system to alert other programs that the youth was potentially eligible for JBU services, contacting other key service providers connected to the youth (e.g., parole officers, jails, psychiatric hospitals, inpatient rehabilitation centers), and reaching out to other programs in San Diego County.

Figure 1. Status of Potential JBU Youth According to Outreach Efforts during FY 2019-20 (N=250)



Of the 250 youth determined by BHS to be potentially eligible during FY 2019-20, 49.2% (n=123) were unable to be reached by JBU due to an unknown location or inability to contact via information provided. Outreach efforts made by JBU staff highlight the difficulty in contacting this population, who are by definition unconnected to County services. Thirty-nine youth (15.6%) were found upon contact to be unavailable due to ongoing involvement with the criminal justice system. Of the remaining 88 youth, 41 (16.4%) were ineligible due to having established housing and five (2.0%) had moved out of state. Forty-two (16.8%) youth enrolled in the JBU program.

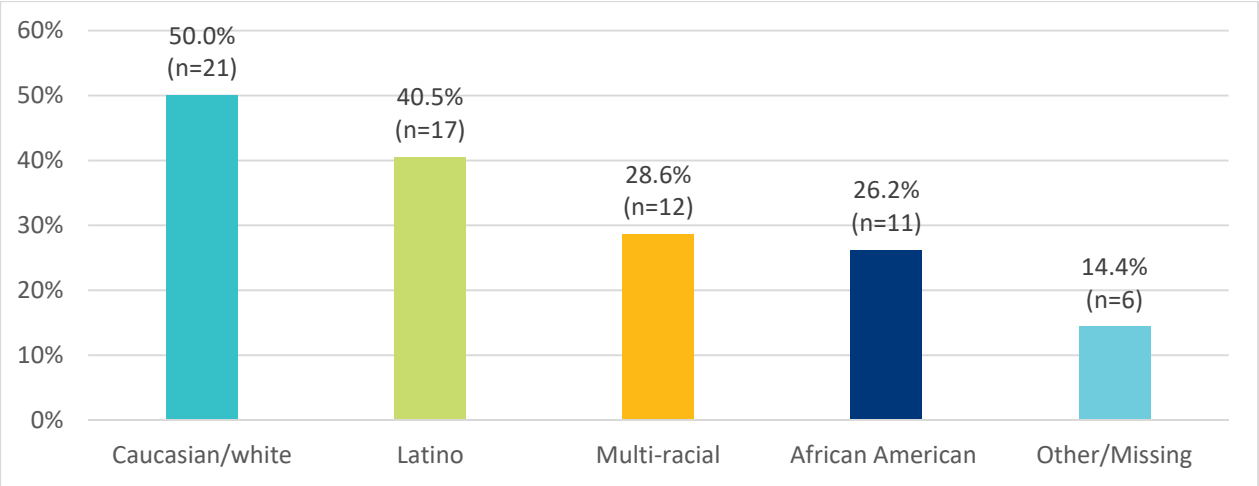
The distribution of JBU outreach and enrollment efforts highlight both challenges of locating potentially eligible youth (i.e., approximately 50% were not found) as well as the high level of interest in the services offered by JBU – fully 100% of the youth who were located and found to still be eligible enrolled into the JBU program. This suggests that that types of services offered by JBU and the manner in which JBU staff conduct their outreach communication has high levels of intrinsic appeal to youth. Of note, the 42 youth newly enrolled in JBU during FY 2019-20 represent a 90.1% increase in enrollment from the 22 enrolled during the prior "start-up" year.

Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. JBU program eligibility criteria required that participants were youth between the ages of 18 and 25. Of the 42 youth who enrolled in JBU during FY 2019-20, the majority (n=30; 71.4%) identified as male. Almost all JBU youth, 92.9% (n=39), spoke English as their primary language, and 88.1% (n=37) identified as heterosexual or straight. None of the JBU youth indicated they had served in the military.

As shown in Figure 2, JBU youth were racially and ethnically diverse with no single population group representing more than 50% of the population. Note: Numbers may exceed 100%, as youth may select more than one racial identity.

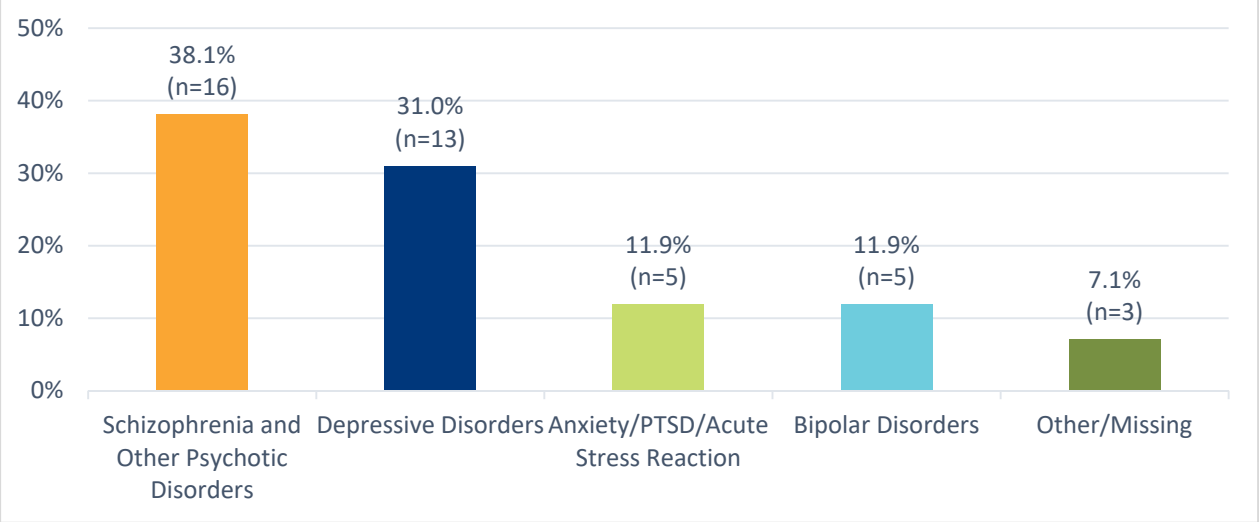
Figure 2. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2019-20 (N=42)



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

One of the eligibility requirements for JBU participation is the diagnosis of a serious mental illness (SMI). As shown in Figure 3, of the JBU youth enrolled during FY 2019-20, over 60% were diagnosed with Schizophrenia and Other Psychotic Disorders, or Bipolar Disorders. In addition (as discussed in other report sections below), there was a high prevalence of co-occurring substance abuse issues among JBU participants.

Figure 3. Primary Mental Health Diagnosis of Youth Who Enrolled in JBU during FY 2019-20 (N=42)



In response to the nearly 70% of youth with Depressive Disorders or Schizophrenia/Other Psychotic Disorders, JBU staff made substantial attempts to support the mental health needs of JBU youth and connect youth to appropriate community partners. More information on services linked to by JBU staff is available in this report.

Utilization of Program Services

Engagement in JBU Activities

In addition to the ongoing support and encouragement of the youth through daily personal interactions with JBU staff and peer supports during FY 2019-20, JBU offered 441 group and 594 individual structured activities that covered a range of holistic services and general living/educational events. Group outings had an average participation of four youth per session. Cooking classes and grocery shopping were also well attended group activities. Many of these activities were impacted by San Diego County Public Health orders in response to the COVID-19 pandemic. Social distancing mandates were in place, and outings to grocery stores and other public spaces were cancelled due to "stay-at-home" orders. These changes substantially reduced the number of activities that that would otherwise have been provided during FY 2019-20. Despite the limitations due to the pandemic, JBU programming demonstrated extensive opportunities to connect with, enrich, and promote well-being among youth. As discussed in more detail in Key Evaluation Findings—Additional Outcome Measures, in addition to promoting relationship and skill-building, participation in these activities also achieved changes in personal well-being including greater self-esteem and a more hopeful outlook for the future.

Figure 4a. JBU Sponsored Group Activities (N=441)

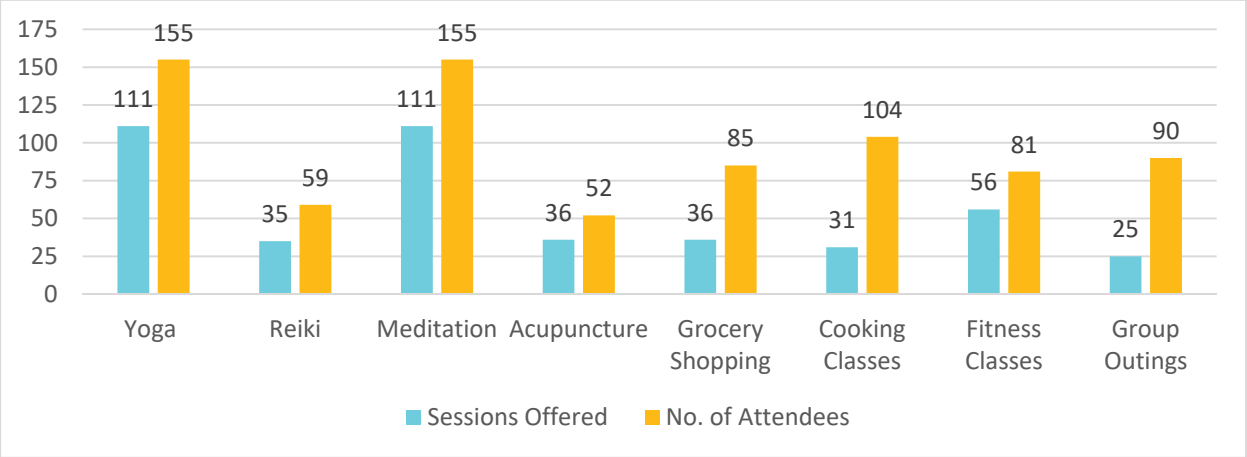
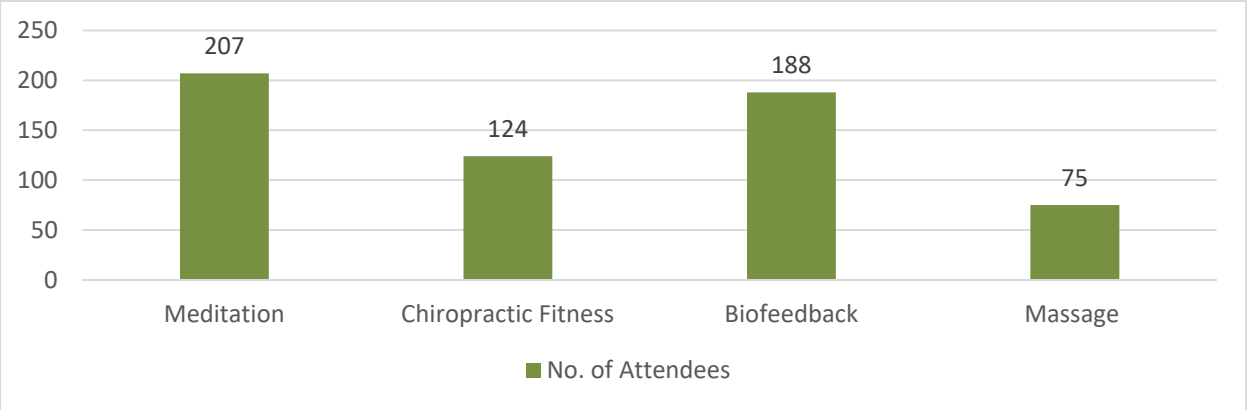


Figure 4b. Youth Attendance in JBU Sponsored Individual Activities (N=594)

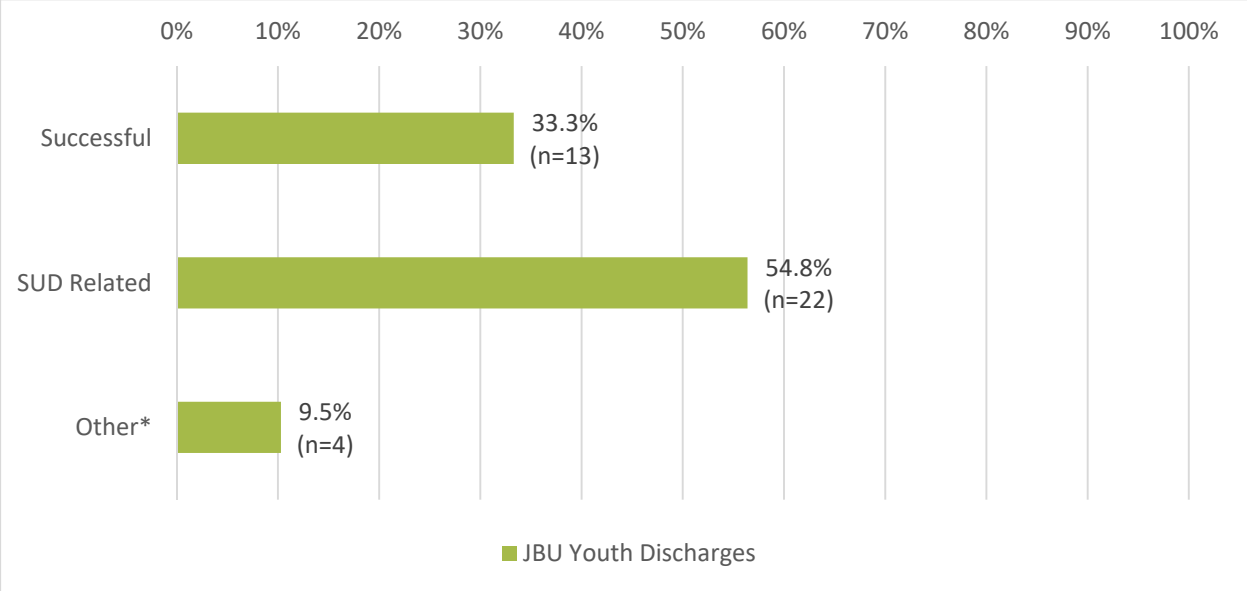


Retention

JBU enrolled a total of 42 individuals in services during FY 2019-20. Of these youth, 33 (78.6%) disengaged from services at least once during their time at JBU. Primary reasons for disengagement included declining need for services, SUD-related challenges that disrupted participation, or a exhibiting a need for more intensive inpatient/residential SUD or mental health treatment. In an attempt to maintain relationships and connections with youth and re-integrate them into services, JBU developed a flexible return-to-JBU policy tailored to the unique circumstances of the individual youth. This personalized approach allowed for 10 youth (30.3% of those who to disengaged) to return to the JBU program after they satisfied the conditions of their return. Most of the youth who disengaged and then returned to JBU had a gap in services of 7 days or less, but for some the gap was longer than 30 days. For a select few youth, disruption of services occurred multiple times. Individual follow-up discussions were offered to each youth who disengaged to identify specific re-entry criteria and encourage each youth to address any behavioral challenges related to the disengagement issue(s).

Of the 42 youth enrolled during FY 2019-20, a total of 39 had been discharged as of 6/30/2020. As shown in Figure 5, of those who were discharged, 33.3% (n=13) of the youth were discharged from the JBU program after successfully completing their goals and/or transitioning on to other treatment services. However, the majority were discharged prior to achieving desired objectives, with SUD-related issues as the primary factor for discharge (56.4%).

Figure 5. Primary Reasons for Discharge from JBU during FY 2019-20 (N=39)



**Other includes: declined services, SMI impairment, damaging facilities, etc.*

This discharge data highlights that while JBU was able to accomplish positive goals with many of the youth who entered the program, comorbid SUD-related challenges presented a formidable obstacle. The SUD-related challenges disrupted the potential of widespread engagement of these youth in the core objectives of promoting wellness and connecting youth to appropriate treatment. More explicit attention to addressing co-occurring SUD-related challenges of youth will be a priority during FY 2020-21.

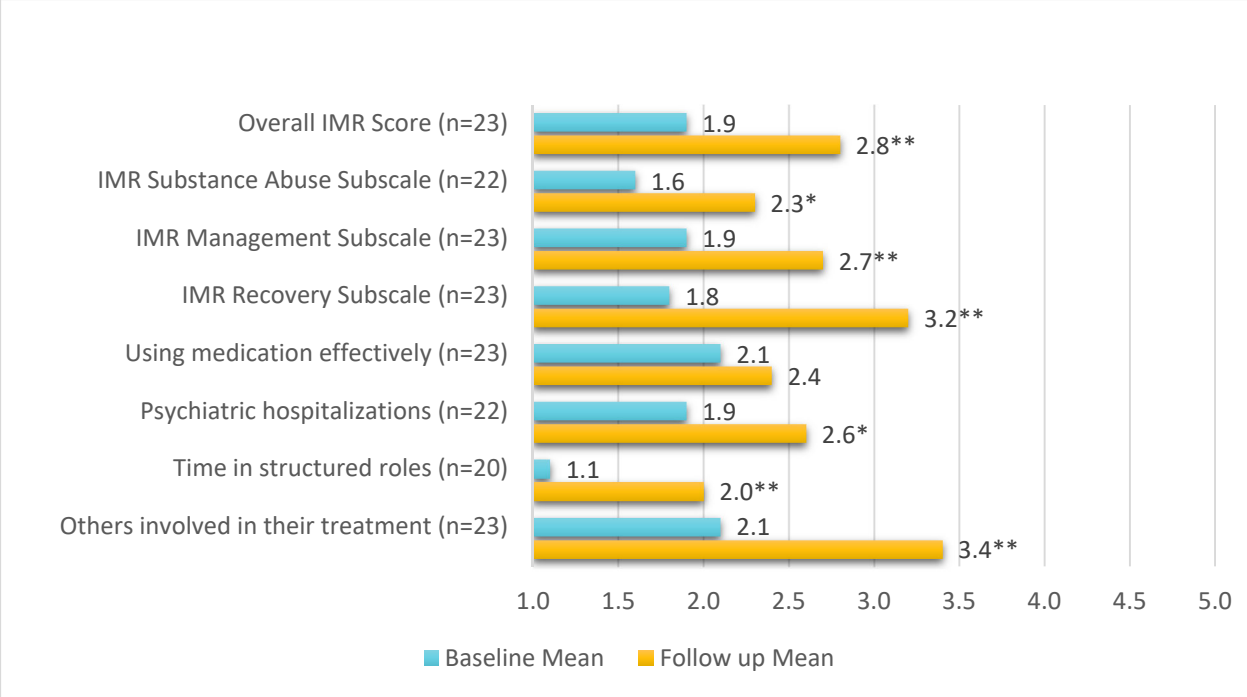
Key Evaluation Findings – BHS Outcome Measures

The following sections highlight outcomes for youth gleaned via assessment tools completed upon intake into the JBU program and at least during one follow-up time point (i.e., assessments are administered monthly 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 6/30/2020) was used in the analysis. The requirement to have at least two data points allows for examinations into changes that might occur while enrolled in JBU, however, this also reduces the sample size included in the analyses. Two primary reasons exist for not having completed follow-ups. First, for measures based on youth self-report, not all youth choose to complete the voluntary self-assessment tools at the follow-up time point(s). Second, youth may leave the program prior to a follow-up assessment, which precludes obtaining youth self-report measures. 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 (mHOMS) Annual Outcomes Report for FY 2018-19 (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 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 (IMR)

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 known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

Figure 6. IMR Results for JBU Youth with Follow-up during FY 2019-20 (N=23)



**Indicates statistically significant change with a p-value less than or equal to 0.05; **Indicates statistically significant change with a p-value less than or equal to 0.01*

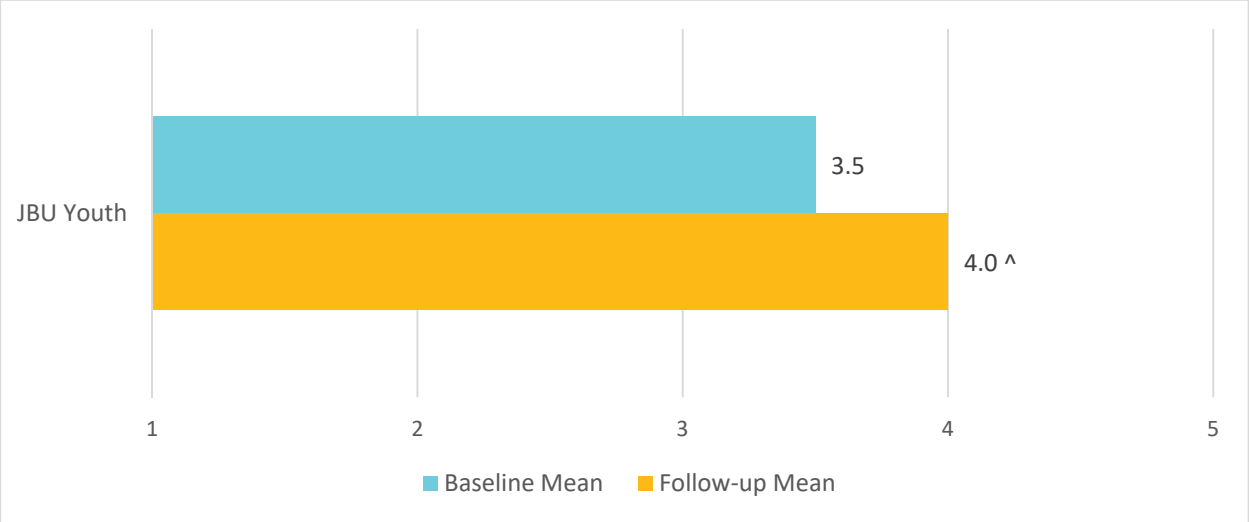
The overall IMR and subscale scores indicated relatively high levels of impairment across many dimensions with average intake IMR values typically 2 or less out of a 5-point scale. However, all items indicated improvements at follow-up (i.e., average scores across the items and scales ranging from 2.0 to 3.4 out of a 5-point scale).

As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average overall IMR score for other BHS programs was 2.8 at intake and 3.3 at follow-up. These values indicate higher levels of impairment for participants entering JBU than reflected in the systemwide BHS average (i.e., 1.9 compared to 2.8 at intake). While the Management Subscale for other BHS programs mirrored JBU values of 1.9 at baseline and 2.7 at follow-up, the Recovery Subscale among other BHS programs reported a higher average intake score (2.4) and lower average follow-up score (3.0) than found for JBU participants. This suggests that JBU was able to obtain substantial improvements among participants who were generally less recovery-oriented at intake. The greatest area of difference between JBU and other BHS program participants at intake was found within the IMR Substance Abuse (1.6 and 4.7, 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 were evident at follow-up (2.3) but remained well below 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 (RMQ)

The 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 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 youth to answer questions from the perspective of what is "true for you now."

Figure 7. RMQ Results for JBU Youth with Follow-up during FY 2019-20 (N=18)



^Indicates a statistically significant change at a p-value less than or equal to 0.10

As shown in Figure 7, overall RMQ mean scores improved from baseline to follow-up (3.5 to 4.0). As reported in the mHOMS Annual Outcomes Report for FY 2018-19, the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and youth residential programs) was 3.4. It appears that JBU participants self-report similar assessments of their recovery status and outlook on life as do clients in other BHS programs upon entry into JBU. However, the average follow-up RMQ score for JBU participants (i.e., 4.0) increased to a level higher than the average follow-up RMQ scores reported by other BHS programs (i.e., 3.7).

Figure 8. IMR and RMQ Results for JBU Youth with Follow-up during FY 2019-20

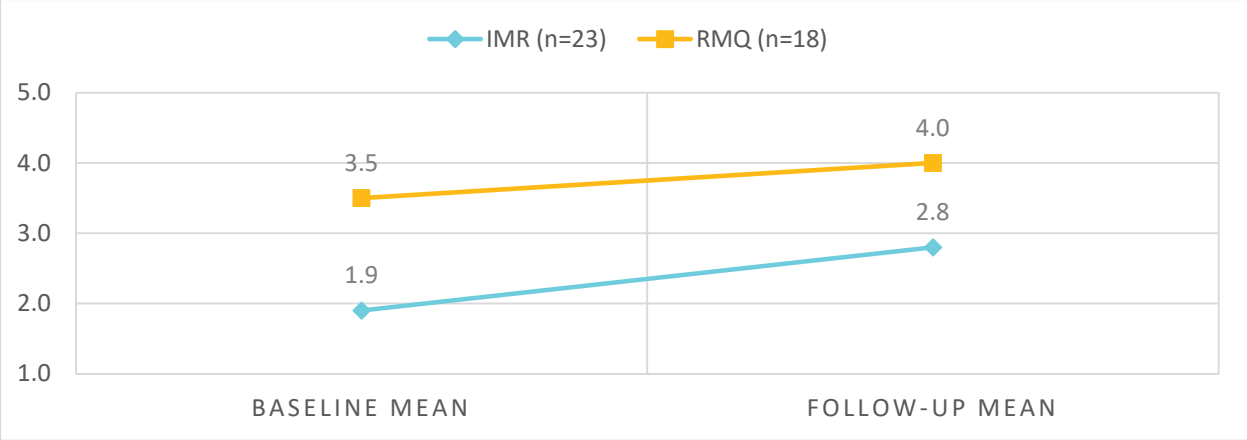


Figure 8 highlights a similar trend line in recovery reporting from both youth and staff reported measures, an indication of the reliability and validity of the data.

Milestones of Recovery Scale (MORS)

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 typical milestone of recovery that an individual displayed over the previous month, with higher MORS ratings indicate greater recovery.

Table 1. MORS Results for JBU Youth with Follow-up during FY 2019-20 (N=24)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**N**	**%**	**N**	**%**
1	*Extreme risk*	2	8.3%	0	0.0%
2	*High risk, not engaged*	5	20.8%	0	0.0%
3	*High risk, engaged*	2	8.3%	1	4.2%
4	*Not coping, not engaged*	12	50.0%	2	8.3%
5	*Not coping, engaged*	3	12.5%	9	37.5%
6	*Coping/rehabilitating*	0	0.0%	10	41.7%
7	*Early recovery*	0	0.0%	1	4.2%
8	*Advanced recovery*	0	0.0%	1	4.2%
	Unique N	24	/	24	/
	Mean MORS	**3.4**		**5.5****	
**Indicates statistically significant results at a p-value less than or equal to 0.01					

The results indicate substantial changes in recovery status at follow-up. At intake, no youth were considered as coping or in recovery, whereas fully 50% were doing so at follow-up, and an additional 37.5% were at least engaged in efforts to improve their mental health.

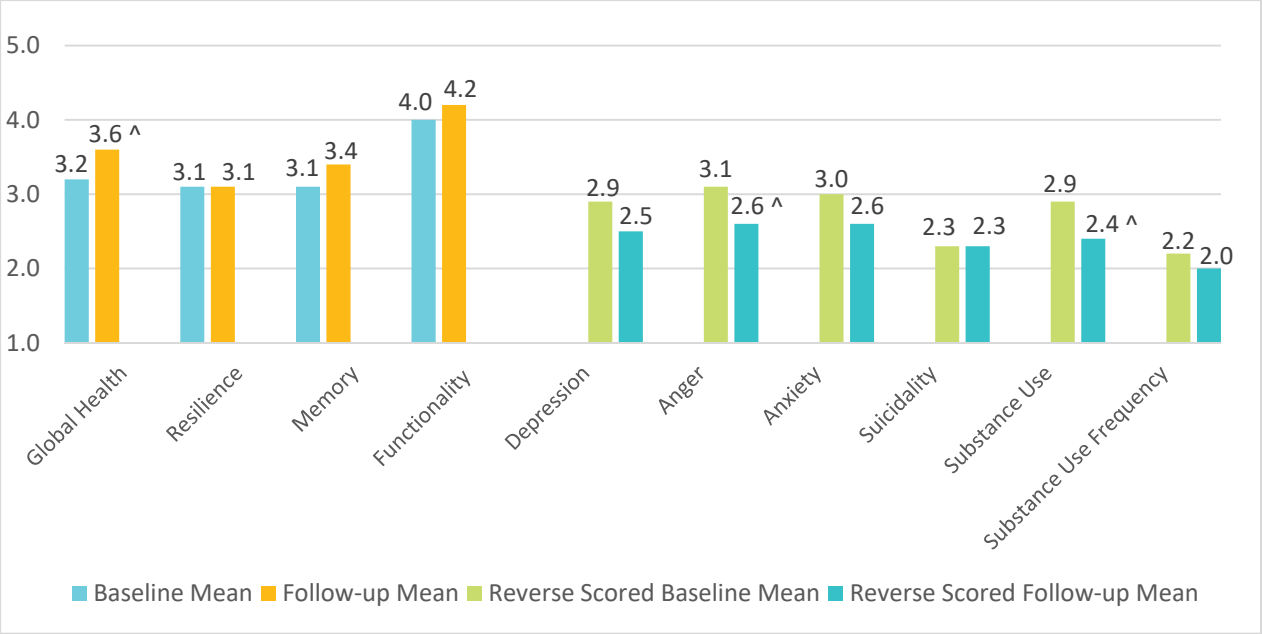
As reported in the mHOMS Annual Outcomes Report for FY 2018-19 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.4 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average 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

CHAMPSSS

The CHAMPSSS is completed by the youth and assesses youth perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded as follows: Global Health, Resilience, Memory, and Functionality subscales were coded so a higher score indicated a more desirable outcome (1=least desirable and 5=most desirable). The Depression, Anger, Anxiety, Suicidality, Substance Use, and Substance Use Frequency subscales were coded so a lower score indicated a more desirable outcome (1=most desirable and 5=least desirable). Scales were coded in this manner to facilitate a more intuitive interpretation of the results.

Figure 9. CHAMPSSS Results for JBU Youth with Follow-up during FY 2019-20 (N=18)



^Indicates a statistically significant change at a p-value less than or equal to 0.10

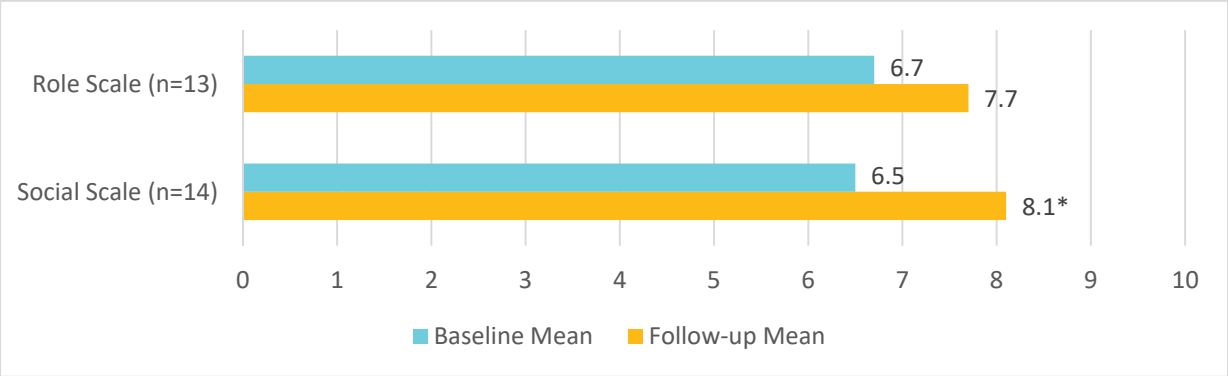
The CHAMPSSS findings demonstrated improvement in many different aspects of well-being from baseline, with statistically significant differences identified among the domains of Global Health, Anger,

and Substance Use subscales of the CHAMPSSS. Changes were not seen across the Resilience nor Suicidality subscales.

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 10. Global Functioning Results for JBU Youth with Follow-up during FY 2019-20



**Indicates a statistically significant change at a p-value less than or equal to 0.05*

For both scales, baseline mean values were typically in the 3-5 range (indicative of substantial impairment). Follow-up mean values increased to over 7.5, which is indicative of mild impairment/good functioning. Improvement in the Social Scale was statistically significant for JBU youth.

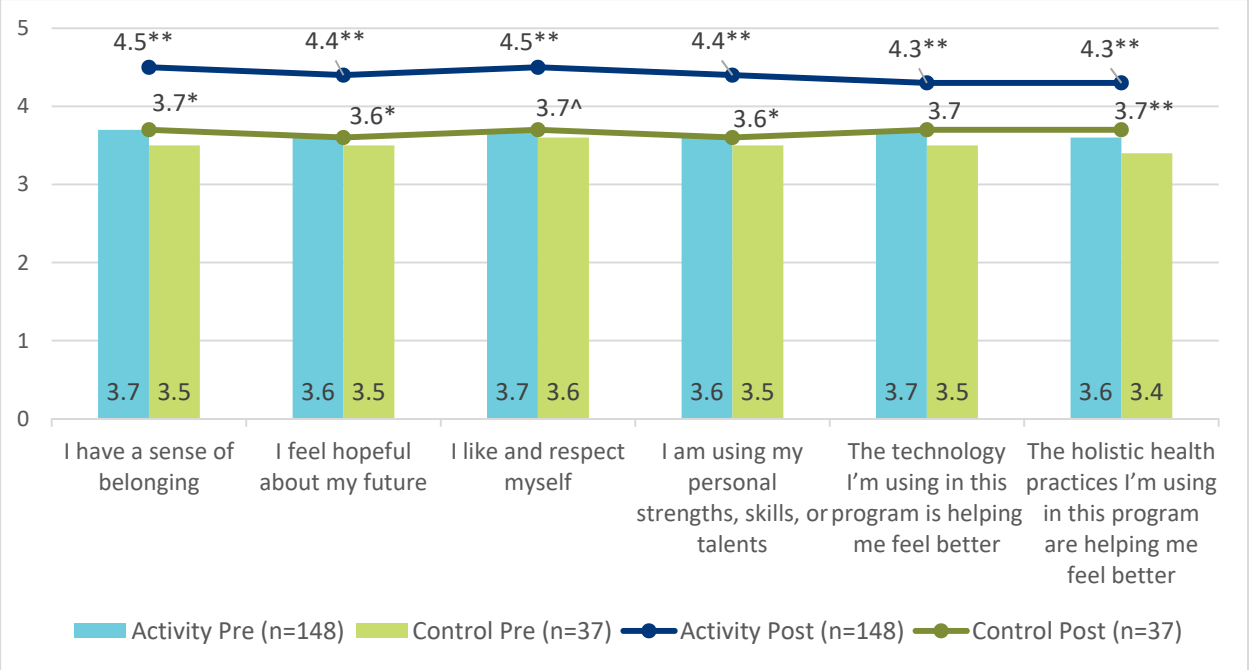
Pre/Post Holistic Practice Assessment

In addition to the goal of promoting engagement, the holistic activities supported by JBU programming are designed to achieve changes in skill-building, address social skills, and increase personal well-being including greater self-esteem and a more hopeful outlook for the future. While some of these outcomes are measured in the longer-term, JBU and the evaluation team identified mood and positive thinking as one component which could be measured immediately.

To help identify whether participation in the holistic activities was directly associated with at least short-term improvements in mood and positive thinking, youth answered the six questions listed in Figure 11 on multiple occasions – typically before and after participating in a JBU-provided holistic practices including: yoga (n=31), reiki (n=15), massage (n= 34), chiropractic care (n=24), biofeedback (n=32), and acupuncture (n=12).

Occasionally, they were asked the questions without having a corresponding activity occurring in between question administrations, to generate "control/no activity" data for comparison purposes. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree. Higher values correspond to higher levels of well-being and/or positive perceptions.

Figure 11. Pre-Post Holistic Practice Assessment for JBU Youth with Follow-up during FY 2019-20



*^Indicates a statistically significant change at a p-value less than or equal to 0.10; *Indicates a statistically significant change at a p-value less than or equal to 0.05; **Indicates a statistically significant change at a p-value less than or equal to 0.01*

Overall, there was a pattern of more favorable ratings after participating in a holistic practice with pre-tests averages of 3.6 or 3.7 on a 5-point scale and post-test averages ranging from 4.3 to 4.5, for a typical change of nearly a full point increase (~0.8) in well-being after participation.

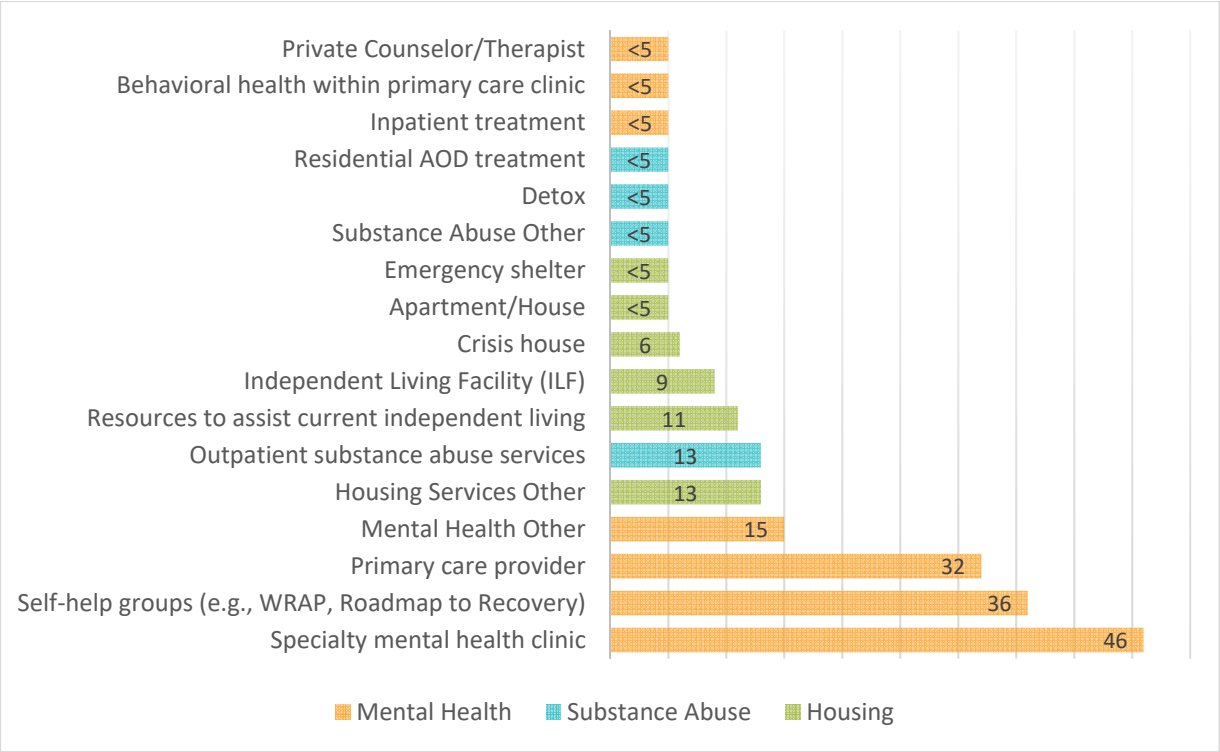
By contrast, changes were either not evident or minor when no activity occurred between question administrations (i.e., typically change of approximately 0.2). Additionally, the data suggest the potential for an anticipatory priming effect in that "pre" values were higher when participation in holistic activities was expected than during the no activity controls. These findings suggest that there are positive changes in youth attitudes about themselves and their future due to participating in the range of holistic services provided through JBU.

Linkages to Services

The following tables indicate the linkages to external community services made across several key domains: mental health, substance abuse, and housing. These linkages were facilitated by JBU staff according to the individual and unique needs of each youth. In total, 124 linkages were made, with 73 of the linkages (58.9%) connecting youth to mental health services. Of substance abuse linkages (n=19), 13 (68.4%) were to residential or outpatient substance abuse services.

These linkages are consistent with other evaluation data points indicating substance abuse as a substantial issue facing JBU youth. Totals may exceed 100% due to multiple linkages. Figure 12 reflects linkages across different domains.

Figure 12. Linkages to External Services during FY 2019-20 (N=124)



In stakeholder meetings throughout FY 2019-20, increased access to residential SUD and mental health treatment programs were most cited as factors that would benefit the program.

BHS Utilization Patterns

San Diego County BHS Services 90 Days Before, During, and 90 Days 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 changing 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 service JBU youth would be expected to receive during a 90 day stay with JBU. This metric facilitates comparisons to the 90-day period immediately preceding JBU enrollment and the 90-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 90 to generate the estimate of BHS services that JBU youth would receive during a typical 90 days in JBU. For the 90 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 90-day period after youth left the residential phase of the JBU program. The analyses include JBU participants who enrolled in both FY 2018-19 and FY 2019-20 as long as they had been discharged at least 90 days before the end of FY 2019-20 to ensure full and equivalent 90-day "post-JBU" observation periods for all persons.

As shown in Table 2, the 53 JBU youth included in these analyses had either no or very limited involvement with BHS outpatient services in the 90 days prior to entering JBU (average of 0.4 outpatient sessions across all youth). However, that changed substantially during their time in JBU as many more youth linked to outpatient care and the 90-day average number of outpatient sessions increased to 9.6. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.1 sessions per youth. This apparent reduction in outpatient services 90 days post-JBU is likely partially explained by the linkages to ACT programs that JBU was able to accomplish for many youth while in the JBU program. Fully 26.4% (i.e., 14 out of 53), of JBU youth had ACT visits post JBU, with the average number of sessions increasing to 4.3 from 2.0 during JBU and none pre-JBU.

Table 2. BHS Service Utilizations Patterns Before, During, and After JBU Participation[1] (N=53)

	90 Days Prior to JBU Enrollment			Standardized 90 Days During JBU Residential Phase			90 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth	# of visits/ episodes	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	11.3%	21	0.4	75.5%	422	9.6	49.1%	109	2.1
ACT	0.0%	0	0.0	24.5%	86	2.0	26.4%	229	4.3
Urgent Outpatient	39.6%	36	0.7	41.5%	25	0.6	22.6%	13	0.2
PERT	28.3%	19	0.4	13.2%	9	0.2	13.2%	11	0.2
Crisis Stabilization	26.4%	21	0.4	0.0%	0	0.0	9.4%	5	0.1
Inpatient	30.2%	27	0.5	18.9%	15	0.3	20.8%	21	0.4
Crisis Residential	20.8%	14	0.3	13.2%	7	0.2	11.3%	9	0.2

[1] *Note: the percent of youth and number of visits/episodes columns are not directly comparable across all three time periods since the average length of time during JBU was less than 90 days (i.e., mean = 75 days). Only the average column is directly comparable across all three time periods.*

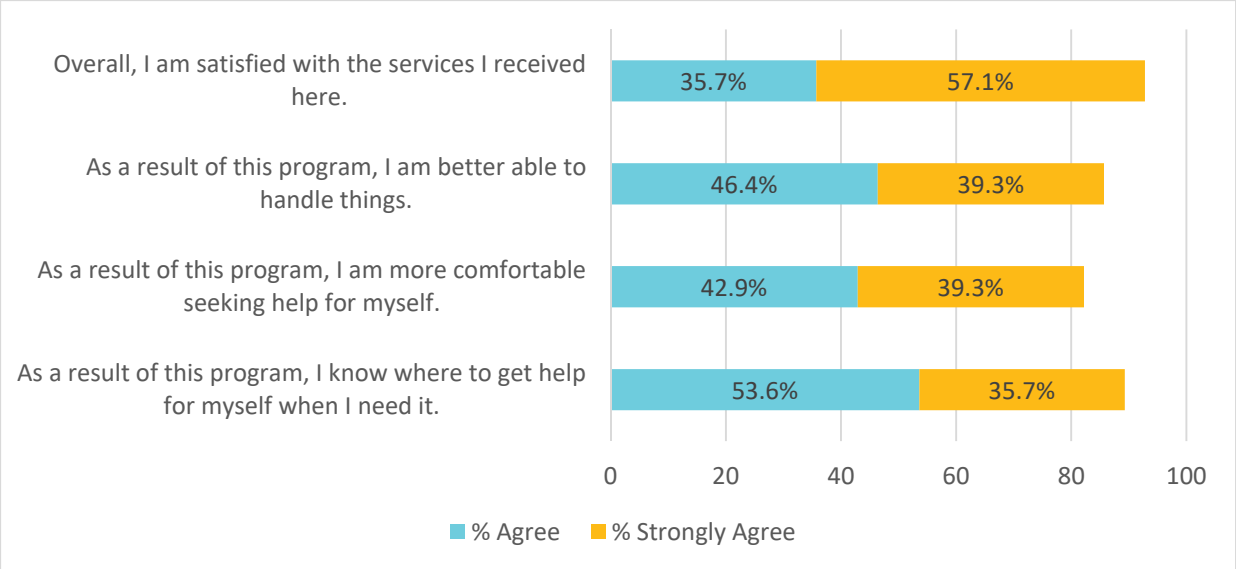
The patterns evident among acute/crisis-oriented type BHS services were more nuanced, but overall suggested a trend towards a reduction in need for such services. Interestingly, the average number of urgent outpatient visits was similar before and during JBU (0.7 and 0.6, respectively), but was substantially lower post-JBU (0.2). This is consistent with JBU staff facilitating access to needed urgent outpatient care among youth during JBU as part of treating their illness and avoiding more serious situations that might

require a crisis stabilization visit (none occurred during JBU) or an inpatient hospitalization (fewer occurred during JBU than pre-JBU). For all crisis/acute care services, the number of youths accessing these services post-JBU was less than the number pre-JBU. While caution is warranted when interpreting findings with relatively small sample sizes, reductions in the total number of youth and/or average service counts between pre-JBU and post-JBU were 40% or more for urgent outpatient, PERT, crisis stabilization and crisis residential. Overall, these findings provide evidence of increased connections to outpatient and ACT treatment services and a corresponding decrease in crisis and acute care service utilization resulting from JBU participation.

Youth Perspectives on JBU Services

A total of 28 youth completed feedback surveys at one of the follow-up time periods during FY 2019-20. As shown in Figure 13, approximately 80-90% of youth agreed/strongly agreed that as a result of participating in JBU they knew where to get help when needed (89.3%), were more comfortable seeking help (82.2%), and were better able to handle things (85.7%). Over 90% (92.8%) indicated that they were satisfied with the services they received from JBU with 57.1% indicating strong agreement. Overall, these finding 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 13. JBU Services Feedback Questions for FY 2019-20 (N=28)



Program 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 2019-20. 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 10 respondents from the 10 JBU staff invited to participate in the survey (a 100% 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.

Outreach and Recruitment of Potential JBU Participants

Reaching underserved youth was a primary goal of the JBU program, as identified by staff in the Annual Survey. Staff also indicated that locating youth identified for JBU participation proved difficult, but the program shifted outreach efforts to address that particular challenge. In collaboration with BHS, JBU developed an outreach plan to include youth who may have dropped off the county provided list of names but were still in need of housing services.

Environmental Influences

Based on feedback from JBU staff, the location of JBU in San Diego's downtown presented a substantial barrier to stabilization for JBU youth. Access to illicit drugs near JBU proved a challenge for youth attempting to remain sober. JBU staff indicated moving to a location where fewer environmental challenges existed that could potentially benefit youth.

Engagement and Retention of JBU Participants

Ultimately, JBU staff felt the program was designed to provide social and logistical support to youth to properly function in the "outside" world. One way in which the staff felt they were able to provide this support was through the personal relationships staff made with JBU youth. Overwhelmingly, JBU staff reflected on the important skill among their staff colleagues of engaging and retaining JBU youth. Additionally, staff reported that their connections to community partners helped JBU provide the services necessary for JBU youth to remain engaged in services.

In collaboration with BHS partners, the JBU in-residence service period was extended from the original 90-day period to a 120-day period to accommodate timeframes for key linkage implementation (e.g., housing, SUD training, SMI stabilization).

SUD and Participation in Mental Health Treatment

In response to program observations from FY 2018-19, JBU brought in SAY San Diego lecturers to speak to JBU youth during mandatory sessions regarding SUD. Additionally, JBU sought funding through Proposition 64 to provide a SUD training program, as well as training in the Restorative Talking Circles (RTC) format. JBU plans to integrate the RTC format into future sessions with JBU youth, providing opportunities for youth to develop marketable skills, as well as address issues with SUD. In order to proactively address co-occurring mental health and SUD-related issues, all youth were encouraged to connect with community partner therapists and psychiatrists to establish individualized treatment plans. Pill organizers, reminder contracts, and appointment compliance efforts were utilized with a majority of youth. JBU staff also suggested youth may want to consider discussing long-acting inhibitors (LAIs) with mental health professionals as a potential mechanism to support medication adherence where youth

reported unfilled prescriptions, inconvenience, or forgetfulness was a consistent reason for non-adherence.

Other Program Services

JBU has also combined Occupational Therapy (OT) sessions with SUD programming to best serve the needs of youth. Integration of OT interns, overseen by Dr. Bianca Doherty, resulted in group-facilitated and one-on-one sessions, focusing on skills such as socialization, emotional intelligence, and job-seeking/readiness skills.

JBU partnered with clinicians from The Jane Westin Center, who were on-site at least bi-weekly to provide youth psychiatric evaluations and prescriptions for medications as needed. This on-site service also scheduled youth for intake appointments at Areta Crowell Center if needed.

Nature outings and experiences were also included in JBU programing during FY 2019-20, including day hikes and overnight stay in Alpine mountain campgrounds. A garden project was initiated with youth input, for construction in courtyard of USA's main building. The concept of nature as a paradigm is reinforced in nutrition classes, cooking events, and kitchen work opportunities, and during weekly biofeedback/mind-body skills training. Youth were taken on a camping trip to Harrison Serenity Ranch at Palomar Mountain, an event which will continue on a semi-annual basis.

Additionally, JBU has partnered with a new app designer to better serve the needs of youth and the evaluation team. The holistic service of Reiki was discontinued.

Experiences with Telehealth Services

JBU staff who engaged with youth via telehealth reported approximately 15% of youth were consistently unable to utilize telehealth with video services. Approximately 20% of telehealth sessions experienced tech-based difficulties (i.e., dropped/poor connections, difficulties with devices, etc.). Staff providing services via telehealth reported JBU youth were willing to attend and schedule sessions via telehealth.

Individual providers reported different levels of youth responses to telehealth: some observed that certain youth struggled to engage and remain focused during the session, while others observed excellent engagement characterized by an increased sense of confidentiality during sessions and youth willingness to share personal information that was both unexpected and consistent. Utilization of telehealth technology may be modality- and/or provider-specific, such that some services and some providers are better able to leverage this form of service provision. Overall, staff indicated that utilization of telehealth services should continue to be a high priority for the program even after in-person services become safe and available again.

Additionally, the increased reliance upon telehealth services brought about by the COVID-19 pandemic has resulted in a wider range of community organizations and individual service providers now offering telehealth services. This expanded set of available telehealth services created opportunities for JBU youth to access services that would previously have been more difficult or impossible to obtain in-person.

Impact of COVID-19 on Program Staff

Overall, staff members indicated there were aspects of their lives, both related to work and unrelated to work, which changed due to the COVID-19 pandemic. JBU staff overwhelmingly 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. 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.

Program Changes from Initial Design

After reviewing outcome data and collecting experiences of JBU youth, JBU stakeholders recognized those finding success in the program were typically engaged in services for a longer period of time. In discussions with BHS, it was decided to extend the in-residence phase of the JBU program from 90 days to 120 days. Also, to increase the number of youth enrolled in JBU, it was determined that in addition to the list of potentially eligible youth provided to JBU by BHS, youth identified through JBU outreach efforts and/or referrals from other community partners could also be admitted into JBU as long as they exhibited similar characteristics and histories as youth on the BHS list (i.e., SMI diagnosis, homeless, utilization of BHS crisis/acute services, and not engaged in treatment). This change will be fully implemented during FY 2020-21.

Program Recommendations

During FY 2019-20, the issues of mental health stabilization and addressing SUD continued to be highlighted as priorities for program staff. Holistic/integrative services were considered to be insufficient alone to address severe mental illness, especially when exacerbated by non-adherence to prescription medications and co-occurring SUD. As such, JBU staff recommend addressing the following during FY 2020-21:

1. Focus program activities on improving youth awareness of their own mental health needs and increasing openness to engaging in mental health treatment.
2. Proactively address factors that inhibit engagement in program services through holistic and other supportive services.
3. Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.
4. Re-locate program to a neighborhood with fewer negative environmental opportunities for engaging in undesired behaviors (e.g., less access to drugs).

Conclusion

During FY 2019-20, the second year of program operations, JBU was able to conduct outreach to and successfully enroll 42 youth who met all eligibility requirements (a 90.1% increase in enrollment from the prior year). Coupled with having an 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 as well as offering 441 group and 594 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 75% of youth participating in outpatient care while enrolled in JBU and approximately 25% of youth 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. Overall, the findings from FY 2019-20 indicated that the JBU program was able to achieve key program objectives of outreaching to 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 ongoing needs of the youth they are serving, specifically that of mental health stabilization. Substance abuse was identified as a significant issue that often disrupted youth engagement in JBU services and inhibited the achievement of program objectives. As such, a more explicit focus on providing the education, supports, and treatment linkages needed to help address co-occurring SUD will be a priority for JBU during FY 2020-21.

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 2019-20

Characteristic	Total Participants (N=42)	
Gender	N	%
Male	30	71.4%
Female	10	23.8%
Another Gender Identity/Missing	2	4.8%
Total	42	100%
Age Group	N	%
18-21	20	47.6%
22-25	21	50.0%
Missing	1	2.4%
Total	42	100%
Primary Language	N	%
English	39	92.9%
Other/Missing	3	7.1%
Total	42	100%
Race/Ethnicity	N	%
African American	11	26.2%
Latino	17	40.5%
Caucasian/white	21	50.0%
Multi-racial	12	28.6%
Other/Missing	6	14.4%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	13	31.0%
Bipolar Disorders	5	11.9%
Anxiety/PTSD/Acute Stress Reaction	5	11.9%
Schizophrenia and Other Psychotic Disorders	16	38.1%
Other/Missing	3	7.1%
Total	42	100%

Characteristic	Total Participants (N=42)	
Sexual Orientation	N	%
Heterosexual or straight	37	88.1%
Another orientation/Missing	5	11.9%
Total	42	100%
Military Status	N	%
Never served in the military	40	95.2%
Missing	2	4.8%
Total	42	100%
Disability	N	%
Yes, Has a disability	5	11.9%
No, Does not have a disability	35	83.3%
Declined/Preferred not to answer	2	4.8%
Total	42	100%
Type of Disability	N	%
Learning Disability/Other	5	11.9%
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.*

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

Annual Report
Year 2 (7/01/2019-6/30/2020)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES (v.12.28.2020)

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 (HHSA)'s 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. 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 ability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). This role of providing services to "exception" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere), ensured continuity of care and became part of standard CCYP operations during fiscal year (FY) 2019-20.

CCYP staff include care coordinators, a health care coordinator, 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 substantial reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services.

Primary Findings for FY 2019-20

1. During FY 2019-20, a total of 397 youth were served by the CCYP program, including 211 new unduplicated clients and 186 prior year enrollees.
2. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services. During FY 2019-20 CCYP enrolled 32 youth from seven different agencies as exception referrals.
3. CCYP youth typically received services for an extended period of time as evidenced by a median duration of 354 days for the 248 persons who were receiving CCYP services as of 6/30/2020.

4. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.
5. 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 long average program durations indicate that CCYP was achieving the primary objective of maintaining stability for clients with complex medication management needs.

Additional Program Highlights

1. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (57.8%).
2. Program capacity issues contributed to staffing adjustments and the establishment of partnerships to help transfer more youth to primary care physicians for medication management.
3. Following the COVID-19 adjustments to service provision, CCYP psychiatrists and other staff indicated that they generally did not perceive a substantial difference between in-person and telehealth visits in regards to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.
4. CCYP psychiatrists and other staff estimated that between 11-25% of CCYP clients were unable to consistently participate in telehealth with video services due to issues such as not having access to a suitable device and/or reliable internet.

Conclusion

During FY 2019-20, the second year of program operations, CCYP enrolled 211 youth (179 authorized referrals and 32 exception referrals). Overall, the patterns of long CCYP program durations, relatively few program discharges, and similar frequency of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior to enrolling in CCYP, indicated that CCYP generally 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. To help address issues with capacity and ongoing enrollment of new participants, CCYP initiated relationships with community partners that will help transition youth who have less complex medication needs back to PCPs or Federally Qualified Health Centers (FQHC) who are comfortable with managing psychotropic medications.

Primary Recommendations for FY 2020-21

1. Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.
2. Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirement back to PCPs or FQHCs for medication management.
3. Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services, but have insufficient or non-existent access to psychiatric medication management services.
4. Examine strategies to enhance client active engagement in services.

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.

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, was contracted to provide CCYP services, which included: 1) establishing a team of psychiatrists, care coordinators, a nurse, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families.

During the first year of CCYP program operations (i.e., FY 2018-19), an unanticipated role for CCYP emerged. 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., exception referrals), typically differed from the traditional authorized 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. The County of San Diego issued a public health order effective 3/13/2020 to limit the size of public gatherings to less than 250 persons and to restrict access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs had to quickly adapt to the new

service delivery environment to protect both client and provider safety while continuing to provide mental health services. For many programs these changes included a switch to or greater utilization of telehealth services.

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. The main change involved suspending the home visits by a CCYP care coordinator or nurse to facilitate the telehealth visits with clients (as was the practice prior to COVID-19). As of 6/30/2020 almost all service contacts provided by CCYP occurred via telehealth (i.e., phone or video). A more detailed discussion of CCYP experiences with providing telehealth services and the impact on CCYP staff and contracted psychiatrists is included in other sections of the report.

Participant Characteristics

As shown in Table 1, a total of 211 persons enrolled into the CCYP program during FY 2019-20 (as compared to 241 in FY 2018-19). Of the 211 enrollees, 179 (84.8%) were considered authorized enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), and 32 (15.2%) were considered exception enrollees (a similar total number of exceptions and percentage of the CCYP population as in FY 2018-19, 34 and 14.1%, respectively). These exception 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 seven different organizations referred exception enrollees to CCYP during FY 2019-20.

Table 1. CCYP Program Enrollment for FY 2019-20 (N=211)

Type of CCYP Enrollee	N	% of Total
Authorized enrollees (i.e., not receiving therapy elsewhere)	179	84.8%
Exception enrollees (i.e., receiving therapy elsewhere)	32	15.2%
Total CCYP enrollees	211	100%

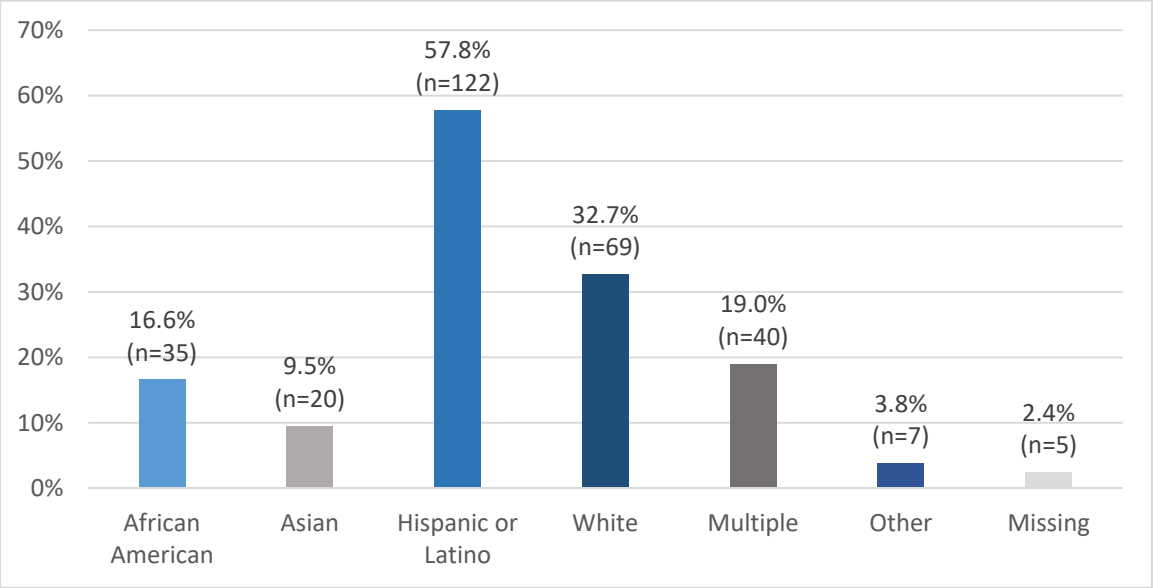
Key characteristics of the 211 persons who enrolled in CCYP during FY 2019-20 (i.e., includes both authorized and exception referrals) are discussed below. A more complete listing of participant characteristics and response options are listed in the appendix. Additional analyses not reported here found generally similar demographic characteristics between authorized and exception clients.

During FY 2019-20, the majority (67.3%; n=142) of clients enrolled in CCYP were at least 12 years old or older, with approximately one-third of clients age 5 to 11 (32.7%; n=69). Nearly equal numbers of males and females enrolled (49.8%; n=105 and 46.9%; n=99, respectively). Almost two-thirds of clients identified as heterosexual (63.5%; n=134), with 15.6% (n=33) indicating another orientation and 18.0% (n=38) declining to select an orientation.

While most clients reported English as their primary language (84.8%; n=179), over 10% indicated Spanish (11.4%; n=24) and 3.8% (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 (57.8%; n=122),

followed by White (32.7%; n=69), multiple racial/ethnic backgrounds (19.0%; n=40), African American (16.6%; n=35), and Asian (9.5%; n=20).

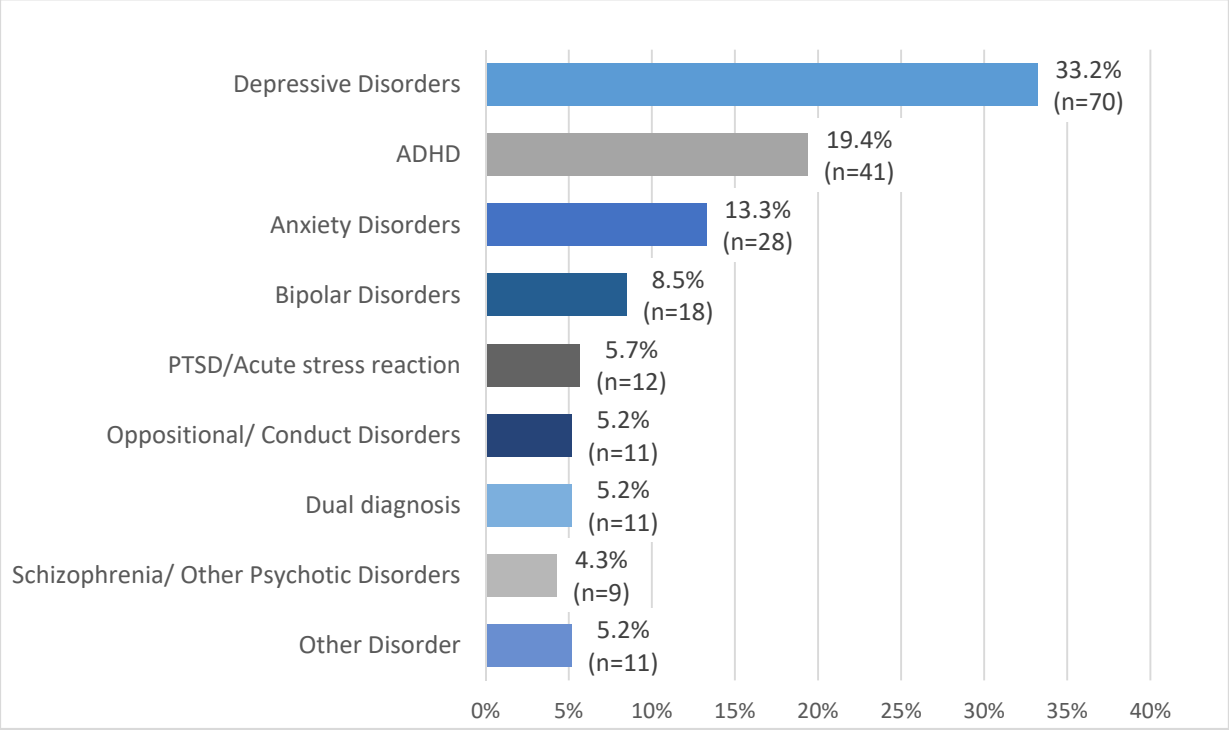
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2019-20 (N=211)



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

As shown in Figure 2, the youth served by CCYP has a wide range of mental health diagnoses. The most common diagnoses included depression (33.2%; n=70), ADHD (19.4%; n=41), and anxiety disorder (13.3%; n=28).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2019-20 (N=211)



In addition, nearly one-third of the FY 2019-20 enrollees reported having a non-mental health related disability (31.3%; n=66). The most common disabilities among CCYP participants included learning disability (10.4%; n=22) followed by developmental disability (7.6%; n=16).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2019-20, the CCYP program served a total of 397 youth (345 authorized and 52 exception youth). This total was comprised of the 211 FY 2019-20 enrollees, discussed above, plus 186 prior year enrollees (166 authorized and 20 exception youth), who were still active during FY 2019-20. The 397 youth served during FY 2019-20 represented approximately 80% of the original service targets established prior to CCYP implementation (n=500). As discussed in more detail below, the lengthy duration of CCYP program participation likely contributed to fewer persons served per year than initially expected; however, developing a better understanding of program capacity is an objective that will be explored in more detail during FY 2020-21.

The following, more detailed analyses of CCYP program services focuses only on the experiences of the authorized youth who were active in CCYP during FY 2019-20 (n=345). As reported in Table 2, approximately 70% (n=239) of CCYP participants received at least one psychosocial assessment during FY 2019-20 (mean of 2.5). Almost all participants had at least one medication management-oriented service (88.7%; n=306), with an average of 5.4 services (note: the remaining persons without any CCYP medication services were active in CCYP for only a short period of time during FY 2019-20). Interactions with the nurse were also common with 71.9% having at least one session and a mean of 5.1 sessions. Overall, the CCYP program provided a substantial amount of psychiatric care to persons needing these specialized services.

Table 2. Services Provided by CCYP to Authorized Enrollees during FY 2019-20 (N=345)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Total Number of Services
	N	%		
Any CCYP service	338	98.0%	12.4	4,203
Psychosocial assessment	239	69.3%	2.5	588
Medication management	306	88.7%	5.4	1,641
Nurse consult	248	71.9%	5.1	1,261
Other services (e.g., collateral)	249	72.2%	2.9	713

Program Duration and Discharge

To generate a better understanding of typical CCYP participation patterns, the following analyses examine CCYP program duration and discharge status for all authorized CCYP enrollees from both FY 2018-19 and FY 2019-20 (n=385). As of 6/30/2020, the majority (64.4%; n=248) were still enrolled in CCYP and only 35.6% (n=137) had discharged. Table 3 shows that the average duration for all persons still open in CCYP was 345.4 days. The median duration, which represents the midpoint value (i.e., 50% are shorter and 50% are longer), indicates that fully half of all CCYP authorized enrollees had been enrolled in CCYP for more

than 354 days). In contrast, those who had discharged by 6/30/2020 had shorter CCYP durations (i.e., mean and median of 204.4 and 172 days, respectively). These findings highlight that persons stay enrolled in CCYP for an extended period of time, with even those who had discharged typically participating in CCYP services for approximately six months. The lengthy CCYP program participation duration patterns likely contributed to the decrease in total new enrollment totals in FY 2019-20 (n=211) as compared to FY 2018-19 (n=241), since many of those persons enrolled in the prior year were still receiving CCYP services across years. 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 FQHCs for ongoing medication management.

Table 3. CCYP Duration for Total FY 2018-19 and FY 2019-20 Authorized Enrollees as of 6/30/2020 (N=385)

	N	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2020	248	345.4	354
Discharged as of 6/30/2020	137	204.4	172
Total enrollees	385	295.2	280

Table 4 presents the discharge reasons and CCYP durations for youth who had been discharged from the CCYP program as of 6/30/2020. Three reasons (noted in Table 4 in italics), accounted for 80.3% of all CCYP discharges: 1) required higher level of care (31.4%; n=43), 2) receiving services elsewhere (27.0%; n=37), and 3) lost contact (21.9%; n=30). Of note, since CCYP does not provide ongoing therapy, discharges due to needing "a higher level of care" typically involved situations where a determination was made that therapeutic care services were needed and then CCYP worked to facilitate continuity of care with a more traditional outpatient program. The median CCYP duration of 149 days for those who required a higher level of care indicated that these youth often received CCYP services for an extended period of time prior to exhibiting a need for further therapy services.

Table 4. CCYP Discharge Reason and Duration for Authorized Enrollees as of 6/30/2020 (N=385)

		% of All Discharges (n=137)	% of All Enrollees (n=385)	Duration in CCYP (days)	
Discharge Reason	**N**			**Mean**	**Median**
Required higher level of care	43	31.4%	11.2%	165.5	149.0
Receiving services elsewhere	37	27.0%	9.6%	200.8	161.0
Lost contact	30	21.9%	7.8%	250.0	223.0
No longer required services	9	6.6%	2.3%	268.8	230.0
Moved away from service area	8	5.8%	2.1%	146.1	156.0
Other	10	7.3%	2.6%	236.6	241.5
Total discharges as of 6/30/2020	**137**	**100.0%**	**35.6%**	**204.4**	**172.0**

In general, discharging any authorized CCYP enrollees was a relatively rare occurrence (i.e., only 35.6% of the 385 authorized children and youth enrolled during the past two years had been discharged as of 6/30/2020). Given that there were few discharges overall, a potentially more informative assessment of the prevalence of any specific discharge reason is the percentage of that reason out of all CCYP enrollees. From this perspective, the low prevalence of discharging persons to a higher level of care (i.e., 11.2% of the 385 CCYP authorized enrollees since FY 2018-19), combined with the high median CCYP duration of 149 days suggests a high degree of accuracy when making initial eligibility determinations regarding youth who are likely to be stable without needing ongoing psychotherapeutic treatment. Similarly, discharging a youth from CCYP specifically due to loss of contact was a relatively rare event (i.e., only 7.8% of all 385 enrollees), and often occurred after participating in CCYP services for more than 6 months (i.e., median duration of 223 days). This suggests that CCYP was generally successful at maintaining contact with their client population throughout the provision of medication management 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 one of 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, only clients that are part of the primary target population of "authorized" 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 205 clients were open at least six months and had a follow-up or discharge CANS completed during FY 2019-20 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 (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 5 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral and Emotional Needs, Life Functioning, and Risk Behaviors. These findings show statistically significant reductions at the last available follow-up for all three CANS domains. These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that had improved while participating in CCYP.

Table 5. CANS Average Change from Initial Assessment (N=205)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Child Behavioral	2.28	1.44**
Life Functioning	1.27	1.01**
Risk Behaviors	0.24	0.15*

**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 6, for each CANS domain approximately 55% 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 slightly lower than what was reported in the FY 2018-19 Systemwide Annual Report for the overall County of San Diego Children, Youth, and Families system of care for discharged clients (i.e., approximately 70% had at least one improvement for each domain). This difference is likely due, in part, to the nature of the population served by CCYP, which is comprised of youth who are determined to no longer have needs for ongoing therapy. In this regard, the fact that the majority of the CCYP population 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 well-being.

Table 6. Persons with CANS Improvement at Follow-up (N=205)

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	168	99	58.9%
Life Functioning	128	71	55.5%
Risk Behaviors	26	14	53.8%

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 in Table 7.

In FY 2019-20, the PSC-35 was administered at initial 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 92 caregivers and 75 youth completed a PSC follow-up/discharge in FY 2019-20 as well as an initial PSC assessment to compare against. Table 7 shows that 58.3% of parents and 42.7% of youth reported total PSC scores at entry into CCYP that met or exceeded the PSC total score cut point for clinical concerns. Given that there are no therapy services provided as part of the CCYP program, it is not surprising that there was little change in the percentage

meeting the clinical threshold at follow-up for parent report (56.2%); however, the percent among youth reduced to 32.0%. Likewise, an examination of mean score changes shows a small, but statistically significant reduction (i.e., improvement) in total PSC score among youth. Among the PSC subscales, there was some indication of small improvements from initial Internalizing scores for both caregivers and youth, but not large enough to be statistically significant. 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 CCYP population. Additional strategies are being implemented to increase the number of completed PSC assessments in future reporting periods. PSC scores will continue to be monitored in future years to see if significant differences in PSC change scores emerge.

Table 7. PSC Average Change from Baseline

	Parent/Caregiver Report (N=92)					Child/Youth Report (N=75)				
Higher score indicates worse condition		% Above clinical cutoff		Mean			% Above clinical cutoff		Mean	
Composites:	**N**	**Baseline %**	**Post %**	**Baseline**	**Post**	**N**	**Baseline %**	**Post %**	**Baseline**	**Post**
PSC Score	92	58.3%	56.2%	29.2	28.6^	75	42.7%	32.0%	24.1	22.1*
Attention Subscale	92	42.2%	33.3%	5.5	5.3	75	22.7%	17.3%	4.5	4.4
Internalizing Subscale	92	50.0%	38.2%	4.3	4.0^	75	40.0%	34.7%	3.8	3.3^
Externalizing Subscale	92	32.4%	34.0%	5.0	5.3	75	8.0%	10.7%	3.0	3.0

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

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 also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2018-19 Systemwide Annual Report, PSC change thresholds were operationally defined using the following five 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 8. Distribution of FY19-20 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=92)		Child/Youth Report (N=75)	
Amount of Change	**N**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	35	38.0%	20	26.7%
No improvement (i.e., 0-1 point reduction)	18	19.6%	21	28.0%
Small improvement (i.e., 2-4 point reduction)	9	9.8%	10	13.3%
Medium improvement (i.e., 5-8 point reduction)	16	17.4%	8	10.7%
Large improvement (i.e., 9+ point reduction)	14	15.2%	16	21.3%

As shown in Table 8, approximately one third of parents/caregivers (32.6%) and children/youth (32.0%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 38.0% of caregivers and 26.7% of children reported a higher PSC score at follow-up, indicating some increased impairment. These findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes. Substantial variability was also evident in PSC change score analyses within the overall CYF BHS system as reported in the FY 2018-19 Systemwide Annual Report. Approximately 55% of caregivers and children/youth reported medium or large improvements and about 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, which likely includes a higher proportion of persons who have successfully 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.

PROMIS Global Health

The Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health measure was administered at baseline, 6-month reassessment, and discharge to caregivers of youth ages 5 to 21 and youth (self-report; ages 8 to 21) to examine multiple health and quality-of-life-related domains. Items were rated on a five-point scale with higher scores indicating better health. To determine whether general health remained stable while enrolled in CCYP, PROMIS follow-up/discharge assessments were compared to initial PROMIS assessments completed upon intake into CCYP.

As shown in Table 9, during FY 2019-20, a total of 92 caregivers and 71 youth had assessments completed at baseline and at follow-up or discharge time points. In general, both caregivers and youth rated their quality of life and physical health higher at baseline than items related to their mental health. Stability across time points was seen for all items except, “how often does your child/do you feel really sad," which demonstrated a statistically significant change from initial assessment. This change, indicative of a reduction in feelings of sadness, was apparent in both the caregiver and youth responses. Additionally, both caregivers and youth indicated increased perception that caregivers listen to the ideas of the youth, suggesting some improvements in communication skills between youths and caregivers.

Table 9. Global Health Assessment Average Change from Baseline

	Parent/Caregiver Report (N=92)				Child/Youth Report (N=71)		
Global Health - Scale of 1 to 5 (higher numeric score indicates better outcome)	N	Baseline Mean	Follow-up Mean		N	Baseline Mean	Follow-up Mean
In general, would you say your child's health is:	92	3.7	3.6		71	3.6	3.6
In general, would you say your child's quality of life is:	92	3.7	3.6		71	3.6	3.7
In general, how would you rate your child's physical health:	92	3.7	3.6		71	3.5	3.6
In general, how would you rate your child's mental health, including mood and ability to think:	92	2.5	2.6		71	3.0	3.1
How often does your child feel really sad:	92	3.0	3.2*		71	3.2	3.5**
How often does your child have fun with friends:	92	3.1	3.3		71	3.7	3.7
How often does your child feel that you listen to his or her ideas:	92	3.3	3.6*		71	3.4	3.7*

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

Caregiver and Client Perspectives on CCYP Services

A total of 120 caregiver feedback surveys and 97 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2019-20. As shown in Table 10, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (94.2% and 86.6%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on client functioning and help-seeking. More caregivers reported that their child was able to function better in life (87.5%), compared to 79.4% of children/youth. Likewise, 92.5% of caregivers reported knowing where to get help and 86.7% felt comfortable seeking help, compared to 81.4% and 72.2%, respectively, of youth. The large majority of caregivers reported feeling the needs of their family were met by the program (90.1%), while 77.3% of youth reported the same.

Table 10. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=120)**	**Youth (N=97)**
As a result of this program, my child is/I am able to function better in daily life.	87.5%	79.4%
As a result of this program, my child/I know (s) where to get help for myself when I need it.	92.5%	81.4%
As a result of this program, my child is/I am more comfortable seeking help for myself.	86.7%	72.2%
My child's/my needs were met by this program.	90.1%	77.3%
Overall, I am satisfied with the services I received here.	94.2%	86.6%

For the open-ended caregiver and youth 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. In terms of what CCYP was doing well for its clients, both caregivers and youth overall reported in open-ended responses that they felt supported by the program and found the medication management services that are the program's focus to be helpful. Caregivers particularly appreciated the flexibility and variability of appointments (e.g., increased accessibility via telepsychiatry visits) and some caregivers and youth reported positive client/family outcomes as a result of the program. When asked for any recommendations for CCYP program improvements, very few ideas were mentioned. Some caregivers indicated an interest for providing more counseling services as part of CCYP as opposed to getting transferred to another outpatient program if needs for therapy emerged. A few youth suggested expanding the services provided by CCYP to include access to therapy and some expressed interest in having more contact from the program. Overall, both the qualitative and quantitative feedback from caregivers and youth who completed a survey indicated high levels of satisfaction with CCYP services.

Behavioral Health Service (BHS) Utilization Patterns

Non-CCYP BHS Services Utilization 180 Days before CCYP Compared to 180 Days during CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without needs 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 and can be quite lengthy (i.e., mean number of days is 295.2), a method of standardizing service utilization during CCYP was needed to allow for an equivalent comparison to the BHS services received during the 180 days immediately prior to entering CCYP.

The standardized or average utilization of other BHS services during a 180 day period of time while enrolled in CCYP was calculated by adding up all FY 2019-20 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 2019-20. 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 time 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.

As shown in Table 11, for the 338 authorized youth served by CCYP during FY 2019-20 (note: seven youth out of the 345 authorized youth served by CCYP in FY 2019-20 were excluded from this analysis since they had multiple CCYP enrollments), crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT contacts were relatively rare events (i.e., substantially less than 1 instance on average), 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 thought to no longer need 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. These findings provide evidence that CCYP was typically able to successfully maintain stable mental health among their participants. 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 14.39 in the 180 days immediately before CCYP to 2.85 for 180 days enrolled in CCYP. Based on feedback from CCYP staff, many of the non-CCYP outpatient visits that occurred while enrolled in CCYP were related to situations where emergent circumstances resulted in the recognition that the youth now needed ongoing therapy. This often led to a "warm-handoff" period during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program to facilitate a smooth transition.

Table 11. Comparison of BHS Service Utilization Prior to and During CCYP (N=338)

	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 hospitalizations	0.04	0.05
Crisis stabilization visits	0.14	0.18
PERT	0.04	0.05
Therapeutic behavioral services	2.43	0.31
Outpatient sessions (not CCYP)	14.39	2.85

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. 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 behavioral health related medication management needs, other supports from SmartCare psychiatrists (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 2019-20, 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 2020-21 as well as exploring opportunities to transition youth to local Federally Qualified Health Centers (FQHCs) for ongoing medication management needs.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) CCYP stakeholder meetings and 2) the Annual CCYP Staff/Psychiatrist Survey. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of FY 2019-20. 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 10 respondents (5 psychiatrists and 5 care coordinators/administrators/support staff) from the 13 CCYP staff or contractors invited to participate in the survey (a 76.9% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

Outreach/Recruitment

Overall, outreach and recruitment were not perceived as substantial challenges for the CCYP program during FY 2019-20. In its second year of operation, the CCYP program appeared to be well known throughout San Diego County and accepted referrals from 30 different organizations/providers (both authorized and exception referrals). In response to the 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.

Engagement/Retention

The CCYP program was generally considered to be successful at retaining clients in services as evidenced by long program durations and few program drop-outs, however, CCYP staff acknowledged that active engagement in services by caregivers and/or youth was more of a concern. The engagement issues were evident via appointment no-shows and lack of client responsiveness. One explanation for these findings may be the shift this FY in care coordinator responsibilities from providing ongoing regular contact with families to primarily conducting intake and discharge assessments only (to allow the care coordinators to serve more clients). Ideas for improving caregiver and youth engagement included educating clients more thoroughly about expectations for their participation in CCYP services and increased communication with

clients about appointment reminders and follow-ups. Enhancing client engagement strategies was identified as a goal for FY 2020-21.

Experiences with Telehealth Services

CCYP was providing a mixture of in-person and telepsychiatry services prior to shifting exclusively to offering telehealth and telepsychiatry services with the onset of the COVID-19 pandemic during March of 2020. Both CCYP psychiatrists and other staff indicated that they generally did not perceive a substantial difference between in-person and telehealth visits that include a video in regards to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information. Additionally, psychiatrists and other CCYP staff both indicated that they thought there was potentially greater engagement with clients via telehealth as well as a greater willingness to schedule sessions and a reduced number of "no-shows".

An examination of FY 2019-20 CCYP service utilization data from prior to the onset of COVID-19 pandemic (i.e., July 2019 – February 2020) confirmed this perception of CCYP staff, as face-to-face medication management sessions with the psychiatrist had a combined no-show/cancellation rate of approximately 15%, whereas the combined no-show/cancellation rate for telehealth sessions was approximately 5%. Of note, during the April-June 2020 time period, telehealth services maintained a combined no-show/cancellation rate of approximately 5%, but medication visits conducted via telephone (a very rare occurrence pre-pandemic), had a combined no-show/cancellation rate of approximately 10%.

CCYP psychiatrists and other staff estimated that between 11-25% of CCYP clients were unable to consistently participate in telehealth with video services due to issues such as not having access to a suitable device and/or reliable internet. CCYP psychiatrists highlighted the importance of having "back-up" plans (e.g., process for quickly restarting a session, switching to phone only), when video session disruptions occurred. 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. Developing additional options for technology-oriented education and support was identified as a potential approach for increasing use of video sessions. Overall, psychiatrists and other CCYP staff strongly agreed that telehealth services should continue to be high priority for CCYP even after in-person visits become safe and available again.

Impact of COVID-19 on Program Staff

Overall, CCYP psychiatrists and other staff members indicated there were aspects of their lives, both related and unrelated to work, which changed substantially due to the COVID-19 pandemic and contributed to additional stress and anxiety. Some CCYP personnel also indicated noticing increased stress and potential for destabilization among CCYP youth and their caregivers.

Workload Challenges

Factors identified by CCYP staff that inhibit achievement of CCYP objectives included the high caseload levels for the Care Coordinators (i.e., often 60 or more), that make it difficult to provide follow-up services

as frequently and as comprehensively as initially planned. As noted above, the Care Coordinator role was reconfigured during FY 2019-20 to primarily focus on client intake assessments and the facilitation of more psychiatry sessions. Some families have more extensive needs that may benefit from additional Care Coordinator services. In particular, the exception 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 Care Coordinators. Addressing such needs while still maintaining a large caseload represented a challenge for Care Coordinators. Efforts to further improve work efficiencies and effectiveness will continue in FY 2020-21.

Program Changes from Initial Design

In addition to changes brought about by the response to COVID-19 during the final few months of FY 2019-20 (i.e., transitioning exclusively to telehealth service provision), CCYP also adjusted the workflow for the Care Coordinators earlier in FY 2019-20. Due to high client caseloads for the Care Coordinators (typically 60 or more when fully staffed, higher when not), and the need to increase overall program capacity by facilitating additional psychiatry visits, the role of the Care Coordinators shifted such that monthly follow-up with clients were no longer feasible. Care Coordinators continued to provide additional support and resources as needed when informed of issues by psychiatrists and/or family. As discussed above, due to administrative and institutional barriers the anticipated partnerships that would have allowed CCYP to have an emphasis on serving medically fragile youth have not been viable so that part of the initial CCYP design has not been implemented.

Program Recommendations

1. Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.
2. Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirements back to PCPs or FQHCs for medication management.
3. Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services, but have insufficient or non-existent access to psychiatric medication management services.
4. Examine strategies to enhance client active engagement in services.
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.

Conclusion

During FY 2019-20, the second year of program operations, CCYP served a total of 397 children and youth. Of these, 211 enrolled in CCYP during FY 2019-20 (179 authorized referrals and 32 exception referrals), whereas the remainder had enrolled in the prior year. The slight decrease in enrollment from the prior year (n=241), was likely due to the extended duration of CCYP program participation (i.e., mean of 295.2 days), such that many of the persons enrolled in the prior year were still active in CCYP during FY 2019-20 and created capacity challenges for the CCYP program during FY 2019-20. Overall, the patterns of long

CCYP program durations, relatively few program discharges, and similar amounts of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior CCYP, indicated that CCYP generally 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. Findings from the outcome assessments (i.e., CANS and PSC), suggest that even without an explicit treatment focus, there were often improvements in behavior or functioning from the perspective of CCYP providers and/or caregivers and youth.

To help address issues with capacity and ongoing enrollment of new participants, CCYP, with the assistance of the evaluation team, initiated a partnership with CPCMG during FY 2019-20 to transition youth with less complex medication needs to PCPs or FQHCs who are comfortable with managing psychotropic medications. As needed, SmartCare services (an independent county-funded program that provides medication consultation services by psychiatrists) will be utilized to provide PCPs with additional supports. This partnership will continue to be developed during FY 2020-21. Now that the program has a more thorough understanding of the service needs of the focal population, CCYP will also conduct a detailed review of staffing roles, responsibilities, and workload during FY 2020-21 to refine program capacity estimates and optimal team structure.

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 2019-20

Characteristic	Total Participants (N=211)	
Age Group	**N**	**%**
5 to 11	69	32.7%
12 to 15	71	33.6%
16 to 17	55	26.1%
18 to 20	16	7.6%
Total	211	100%
Gender	**N**	**%**
Male	105	49.8%
Female	99	46.9%
Another gender identity	6	2.8%
Prefer not to answer	1	0.5%
Total	211	100%
Sexual Orientation	**N**	**%**
Heterosexual or straight	134	63.5%
Gay or lesbian	8	3.8%
Bisexual/Pansexual/Sexually fluid	20	9.5%
Other sexual orientation	5	2.4%
Prefer Not to Answer	38	18.0%
Missing	6	2.8%
Total	211	100%
Language	**N**	**%**
English	179	84.8%
Spanish	24	11.4%
Other	8	3.8%
Total	211	100%

Characteristic	Total Participants (N=211)	
Race/Ethnicity	N	%
African American	35	16.6%
Asian	20	9.5%
Hispanic or Latino	122	57.8%
White	69	32.7%
Multiple	40	19.0%
Other	8	3.8%
Missing	5	2.4%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	70	33.2%
ADHD	41	19.4%
Anxiety Disorders	28	13.3%
Bipolar Disorders	18	8.5%
PTSD/Acute stress reaction	12	5.7%
Oppositional/ Conduct Disorders	11	5.2%
Dual diagnosis	11	5.2%
Schizophrenia/ Other Psychotic Disorders	9	4.3%
Other Disorder	11	5.2%
Total	211	100%
Disability	N	%
Yes, has a disability	66	31.3%
No, does not have a disability	135	64.0%
Declined/Preferred not to answer	10	4.7%
Total	211	100%

Characteristic	Total Participants (N=211)	
Type of Disability	N	%
Seeing	13	6.2%
Hearing	7	3.3%
Other Communication	8	3.8%
Learning	22	10.4%
Develop	16	7.6%
Other Mental	5	2.4%
Physical	5	2.4%
Other	28	12.2%
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.