SPECIFIC AIMS

Behavioral health concerns are prevalent across the lifespan, first emerging in childhood and accelerating through adolescence and into early adulthood. Approximately 54% of youth will experience a clinically significant behavioral health problem (e.g., ADHD, depression, anxiety, substance use disorder) before age 18. Left untreated, behavioral health problems levy tremendous costs ranging from academic and occupational underperformance to medical comorbidities to death. Careful assessment and evidence-based intervention can prevent negative outcomes, yet fewer than 2 in 5 youth who need treatment ever receive it. A major barrier to vulnerable youth receiving services is the severe lack of behavioral health specialists in many communities. This workforce shortage is especially prominent in rural communities. Nearly all families have access to local primary care clinics, however, and families often seek treatment for their children’s behavioral health problems in primary care settings. Primary care providers (PCPs) are rarely equipped with the training or resources to meet the full range of their patients’ behavioral health care needs, yet psychotropic medications (stimulants, SSRIs, etc.) are commonly prescribed in primary care. The current service model, with poor access to specialists, therefore yields both under- and over-treatment of pediatric behavioral health problems.

Efforts to expand the behavioral health workforce, in its traditional form, have proved costly and difficult to scale and sustain. One approach under evaluation within IU Health is to embed behavioral health specialists in primary care clinics; this model requires nearby availability of specialists and may favor high volume urban and suburban practices. Another approach is to broaden the reach of the existing behavioral health specialists to primary care practices in underserved communities via telemedicine (telephone, videoconference, etc.). One such model, Child Psychiatry Access Programs (CPAPs) has been launched in 28 states. No such program exists in Indiana, leaving Hoosier families without uniform access to high quality pediatric behavioral health care. Existing evidence supports the feasibility and value of CPAPs in improving access to care, but important questions about their implementation remain – such as what components of CPAPs are most effective, how to measure CPAP implementation fidelity, what strategies for disseminating CPAPs result in maximal uptake and impact, and which CPAP elements could be automated or enhanced via online and mobile tools (e.g., web-based treatment modules, telehealth delivery of brief psychotherapies, app-based decision-support tools) – and, ultimately, how CPAPs compare to in-person integrated behavioral health support.

We propose the development, launch, and preliminary implementation feasibility evaluation of the Indiana Behavioral Health Access Program for Youth (IN-BeHAPY) to begin to close the major gaps in access to quality behavioral health care for Indiana youth and families. Following a rigorous mixed method, user-guided design and development phase, the program will be piloted in two IU Health primary care practices and evaluated with regard to implementation feasibility. Results from this project will directly inform design of subsequent externally funded trials to establish methods and test program efficacy and effectiveness.

The long-term goal of this research program is to reduce the burden of behavioral health problems among Indiana families by optimizing a practical, effective, and sustainable technology-enhanced system for delivering best-practice services. The development of IN-BeHAPY and joining the national network of CPAPs will position the investigative team to conduct future large-scale, multi-site pediatric behavioral health studies. A necessary first step before launching these studies is to develop the program and conduct a methodologically rigorous open pilot test of feasibility. The current mixed methods project has two aims:

**Aim 1: Develop & launch the IN-BeHAPY program in selected IU Health primary care clinics (mos. 1-12)**

**Objective 1a.** Collect qualitative and quantitative formative data from patients and providers to inform development and refinement of program offerings and structure.

**Objective 1b.** Develop IN-BeHAPY operating procedures with input from users and an expert consultant.

**Objective 1c.** Launch IN-BeHAPY in two initial IU Health pediatric primary care sites (rural and urban) and conduct 1 month surveillance and refinement procedures ahead of the open pilot feasibility trial.

**Aim 2: Pilot the feasibility of methods for subsequent R21, R34, and R01 studies (mo. 13-24)**

**Objective 2a.** Collect quantitative data at baseline, 3, 9, and 12-mo post-baseline on utilization, implementation factors, and fidelity assessment requirements to characterize IN-BeHAPY.

**Objective 2b.** Collect, code, and analyze qualitative process data from audio-recorded consultation interactions between PCPs & IN-BeHAPY staff to identify key consultation themes and user experiences.

**Objective 2c.** Collect summative quantitative (survey) and qualitative (focus group/interview) data from IN-BeHAPY users to understand their reactions to the program and identify barriers and facilitators of use.

This study will provide critical foundational data for planning subsequent extramurally funded service and research projects, including (a) a statewide/multi-site randomized efficacy trial of IN-BeHAPY in primary care, (b) clinical studies (e.g., psychotropic deprescribing studies) and (c) evaluation of online and mobile technologies to optimize nationwide pediatric behavioral health care access and effectiveness.