Santa Barbara County Department of Behavioral Wellness

The Santa Barbara County Department of Behavioral Wellness strives to continuously improve programs, practices and policies. The Department recognizes that improvement cannot happen without measurement; therefore, thoughtful data collection and analysis are important. As a part of a larger system change effort, Behavioral Wellness is working towards a more data-driven culture, which will lead to better decision-making, as well as improved program effectiveness. These efforts reflect the department's commitment to responsible stewardship of public resources, continuous evaluation and improvement, and delivering on the mission, vision and values. This semi-annual report provides data on clients served; location in the system; data on crisis and inpatient services; the timeliness of services provided; child and adult services outcomes; and staff accountability. For consistency and ease of comparison over time, this report shows data from the first two quarters of the two most recent fiscal years, FY15/16 and FY16/17. Because the Mental Health service data can be updated up to 12 months post-service date, metrics reported less than one year after delivery may change once the dataset is finalized.

Client Demographics

Alcohol & Drug Programs (ADP)

All Alcohol & Drug Program services are provided by Community-Based Organizations (CBOs). In FY206/17 (Q1-2), there were **3,261 unduplicated clients** open to the ADP system, 3,017 (93%) adults and 244 (7%) youth. Approximately two-thirds (66%) of all clients were male; half (49%) were Hispanic and 44% were White. Nearly three-quarters (69%) of ADP clients were primarily English-speaking. Among both adults and youth, two-thirds of ADP clients were male. Ethnicity was relatively equally divided between Whites and Hispanics, but among ADP youth, 76% were Hispanic and only 20% were White. Although ADP serves more Hispanic youth than White youth, it is important to note that the largest provider of youth ADP services is in North County, which also has a higher Hispanic population.

Table 1: Clients Open in Alcohol & Drug Programs (unduplicated count)

	FY15/16 Q1 & Q2				**FY16/17 Q1 & Q2**			
	Total Open to ADP: 3,277				**Total Open to ADP: 3,261**			
	New Clients Opened to ADP: 1,091				**New Clients Opened to ADP: 1,129**			
	Adult		**Youth**		**Adult**		**Youth**	
Gender	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Male	1,971	**66%**	197	**68%**	1,979	**63%**	162	**66%**
Female	1,012	34%	91	32%	1,034	37%	82	34%
Missing/Other	6	0.2%	0	0%	4	0.1%	0	0%
Total	***2,989***		***288***		***3,017***		***244***	
Race/Ethnicity								
White	1,347	**45%**	51	**18%**	**1,382**	**46%**	**48**	**20%**
Hispanic	1,418	**47%**	222	**77%**	**1,416**	**47%**	**186**	**76%**
African American	78	3%	*	2%	89	3%	*	2%
Multiracial	58	2%	*	2%	44	1%	*	1%
Native American	29	1%	*	0.4%	24	1%	0	0%
Asian	31	1%	0	0%	36	1%	0	0%
Other/Unknown	28	1%	*	1%	26*	1%	*	1%
Total	***2,989***		***288***		***3,017***		***244***	

**Omitted small sample sizes for protection of client privacy*

Mental Health System

In FY2016/17 (Q1-2), **6,162 unduplicated clients** were served in the Mental Health System. Of those clients, 4,425 (72%) were adults and 1,737 (28%) were youth. A little more than half (51%) of all Mental Health clients were male; 45% are Hispanic and 41% are White. Three-fourths (78%) of the clients indicated that English was their primary language. The ethnicity of MH clients was interestingly different by age group: adults were 51% White and 34% Hispanic, compared to youth MH clients who were 17% White, and 71% Hispanic. As with the ADP system, the MH system serves a much larger population of Hispanic youth compared to White. It is important to note that the largest Behavioral Wellness children's outpatient clinic is located in North County, which also has a higher Hispanic population.

Table 2: Clients Served in Mental Health Programs (unduplicated count)

	FY15/16 Q1 & Q2					**FY16/17 Q1 & Q2**			
	Total Clients Served: 6,450					**Total Clients Served: 6,162**			
	New Clients Opened:1,985					**New Clients Opened: 2,007**			
	Adult		**Youth**			**Adult**		**Youth**	
Gender	**N**	**%**	**N**	**%**		**N**	**%**	**N**	**%**
Male	2,182	48%	972	52%		2,148	49%	950	**55%**
Female	2,357	**51%**	895	**48%**		2,261	**51%**	772	44%
Missing/Other	34	1%	10	0.5%		16	0.02%	15	1%
Total	***4,573***		***1,877***			***4,425***		***1,737***	
Race/Ethnicity									
White	2,301	**50%**	333	**18%**		**2,236**	**51%**	**297**	**17%**
Hispanic	1,563	**34%**	1,339	**71%**		**1,518**	**34%**	**1,232**	**71%**
African American	224	5%	48	2%		212	5%	37	2%
Multiracial	125	3%	45	2%		122	3%	38	2%
Native American	39	1%	9	0.4%		31	1%	3	0.2%
Asian	92	2%	17	0.5%		108	2%	12	1%
Other/Unknown	229	5%	86	5%		198	4%	118	7%
Total	***4,573***		***1,877***			***4,425***		***1,737***	

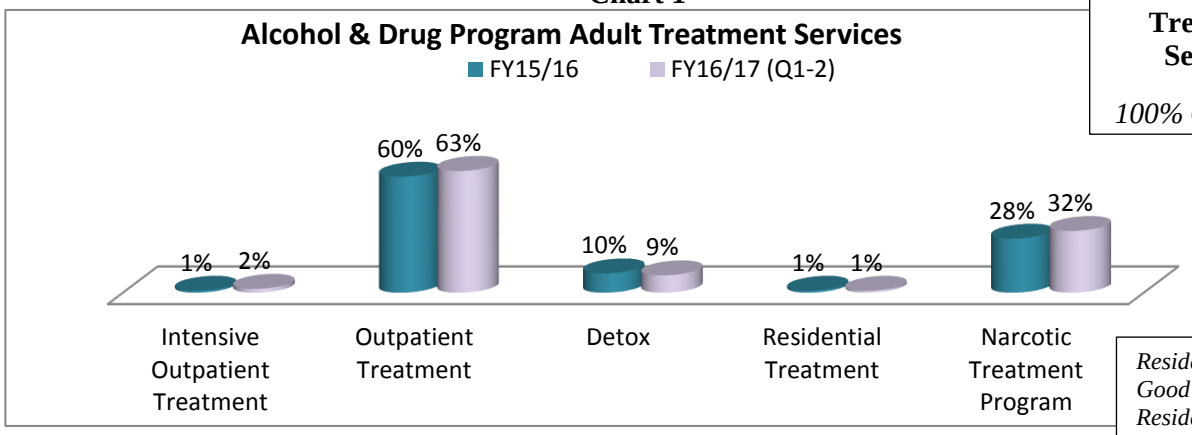
Client Service Settings

Behavioral Wellness and its partner agencies provide a variety of services in both inpatient and outpatient settings. Though most clients receive services in Santa Barbara County, due to in-county capacity limitations some clients are served in inpatient and residential facilities outside of the County. Clients may receive more than one service type during the fiscal year. For example, depending on individual treatment needs, a client may receive services in a Behavioral Wellness outpatient clinic but might also receive additional services from a crisis team or a partner organization in the community. Therefore, some clients may be counted in more than one service category below.

Alcohol & Drug Programs (ADP)

Behavioral Wellness contracts with community based organizations to deliver alcohol and other drug prevention and treatment services. Service locations remain relatively constant over time. In FY16/17 (Q1-2), the majority of adult substance abuse treatment services were provided in outpatient settings (63%) and in outpatient Narcotic Treatment Programs (32%) (NTP- methadone). All youth substance abuse treatment services were provided in outpatient settings.

Chart 1



ADP YOUTH Treatment Services

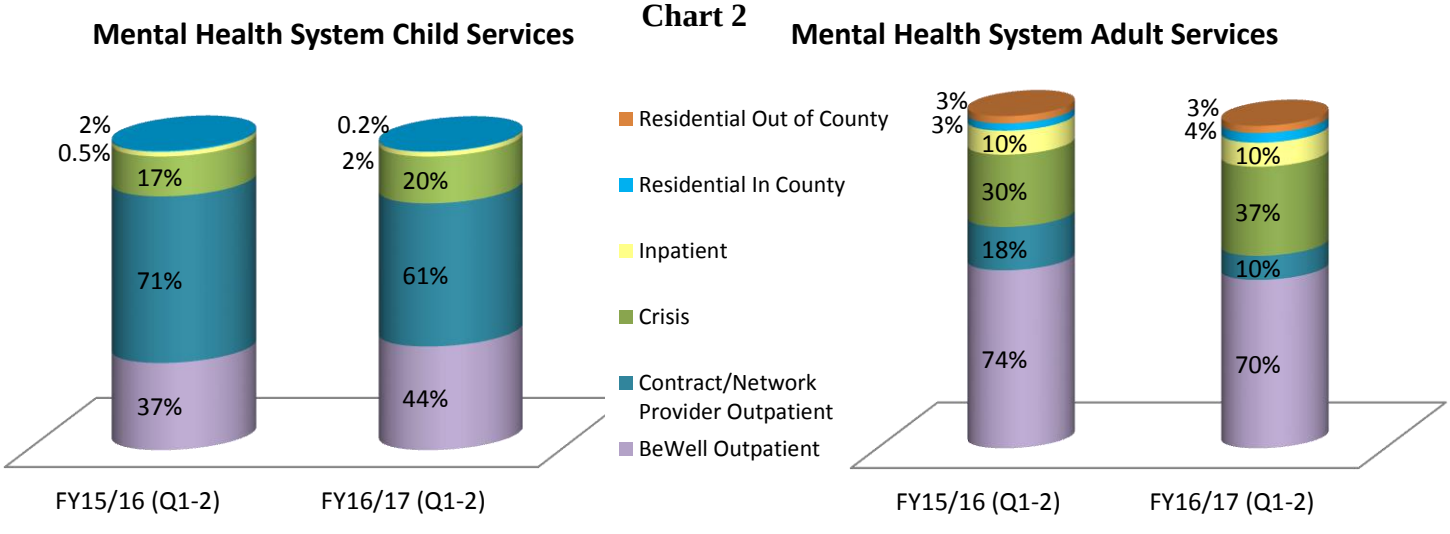
100% Outpatient

Residential Treatment:
Good Samaritan
Residential Detox
CADA Residential Detox
Casa Serena Residential

Mental Health System

As can be seen in Chart 2 below, the majority of mental health services were provided on an outpatient basis. Many clients, particularly children/youth, receive services from Behavioral Wellness outpatient clinics as well as contracted community-based providers because they offer specialized services such as Intensive In-Home or School-based Counseling for children/youth, and Assertive Community Treatment or Community Supportive Services for adults. The next largest service "setting" for adults and youth was crisis services, most frequently delivered in hospital emergency rooms and phone/office. High levels of care such as residential treatment programs and inpatient care were provided less frequently.

Chart 2



Crisis Services

For the last several years, Behavioral Wellness has been working to expand the continuum of care by enhancing our outpatient crisis services and instituting more treatment options/levels of care to appropriately serve client's needs, with the ultimate goal of decreasing inpatient hospitalization[1]. In 2014, Behavioral Wellness received a grant (SB82) that has enabled the department to address critical gaps in the crisis system. Existing Mobile (adult) and SAFTY (child) crisis response, North County Crisis Residential, and inpatient Psychiatric Health Facility (PHF) services were augmented with grant funds which supported the implementation of the following programs:

- **Crisis Triage Teams** in Santa Barbara, Santa Maria and Lompoc, by December 2014
- 30-day **Crisis Residential Treatment (CRT)** Facility in Santa Barbara, July 2015
- 23-hour **Crisis Stabilization Unit (CSU)** in Santa Barbara, January 2016
- **Mobile Crisis** Team in Lompoc serving West/Central County, December 2014

In-County Crisis Services Continuum

Triage Mobile/SAFTY CSU CRT Inpatient PHF

PHF = *Psychiatric Health Facility*
CRT = Crisis Residential Treatment
CSU = Crisis Stabilization Unit

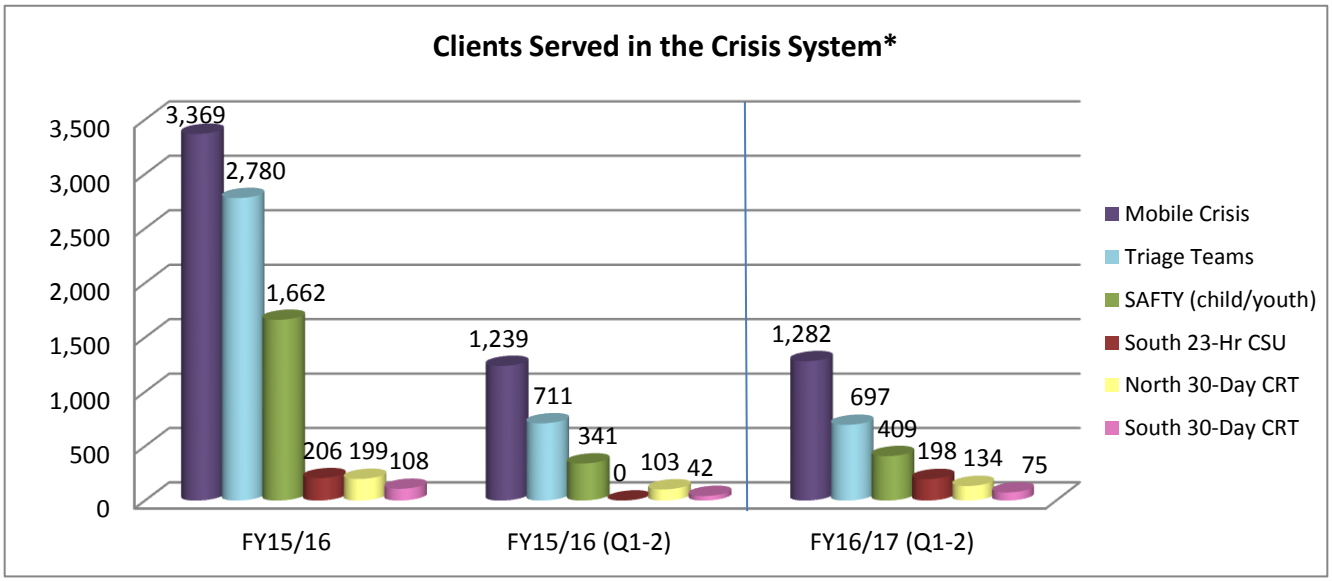
FY16/17 (Q1-2) Success - Stabilizing Clients:

✓ **97%** of clients served by the **Crisis Stabilization Unit** were stabilized without needing admission to an inpatient psychiatric facility within 24 hours of discharge from the CSU.

✓ **86%** of clients served by the **Crisis Residential Treatment** (CRT) programs were stabilized without needing hospitalization within 30 days of discharge. This represents a 3% increase in hospital diversion from FY15/16.

The chart (3) below includes annual totals for FY15/16, as well as data for the first 6 months of FY16/17. Crisis programs are on target to meet or exceed FY15/16 clients served, particularly Mobile Crisis, CRT and CSU. SAFTY generally sees fewer clients in Quarter 1 (July-Sept) as most youth are on summer break and stressors that cause crises are reduced. It is also important to note that the CSU was not open in Q1-2 of FY15/16; therefore, the clients served in that program will be much higher in FY16/17.

Chart 3

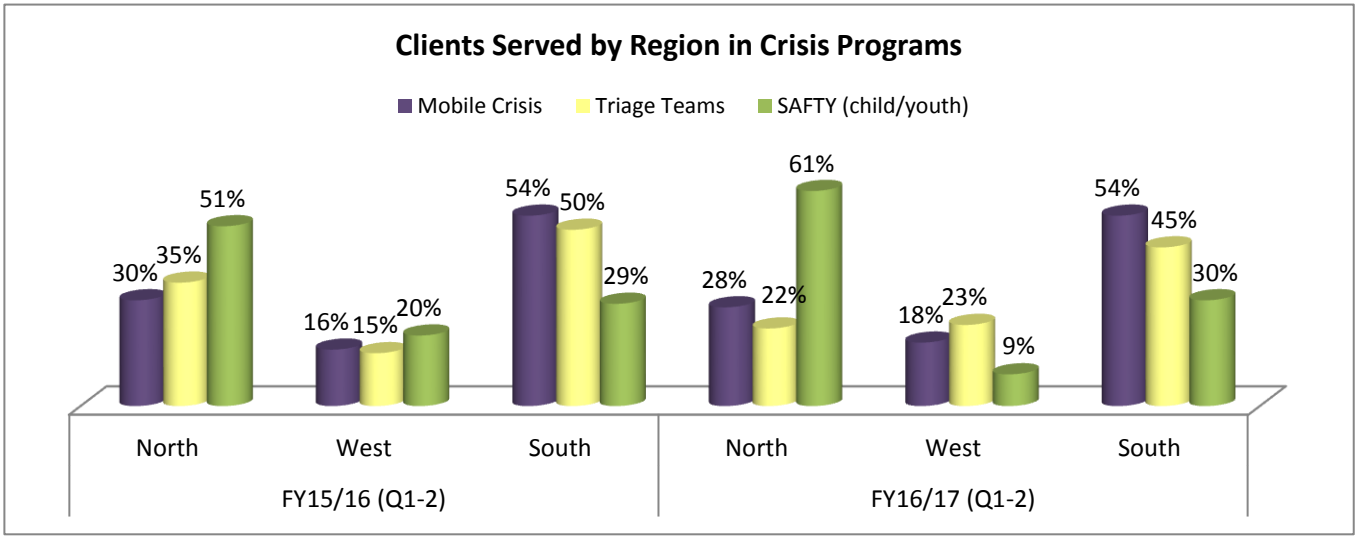


**Clients may have received a service from more than one type of crisis program.*

[1] Note that an evaluation of the crisis system is being conducted, including an analysis of the impact of new crisis services.

Chart 4 below shows regional variations in crisis services delivered. South County accounts for the largest portion of Mobile and Triage services, and North County serves the largest volume of children's crisis services.

Chart 4



The table (3) below displays service locations for Mobile Crisis and Triage Teams. Hospitals include emergency rooms, inpatient medical units as well as inpatient psychiatric units. Community locations include, but are not limited to, home, field, homeless shelters and schools. Consistent with FY15/16, the majority of Triage services in FY16/17 (Q1-2) were provided in the office or via telephone, while Mobile Crisis services were primarily provided in hospitals and emergency rooms. However, during the first 6 months of FY16/17, the distribution of service location shifted in North and South County for Triage and Mobile Crisis. Both Triage and Mobile Crisis were relocated to a more central office in Santa Maria and in Santa Barbara. As a result, Triage staff began responding to more walk-in clients, in-office crises and urgent calls for service. Triage staff provided more office/phone-based services such as assessments and crisis intervention, while Mobile Crisis continued to respond in the community and hospitals.

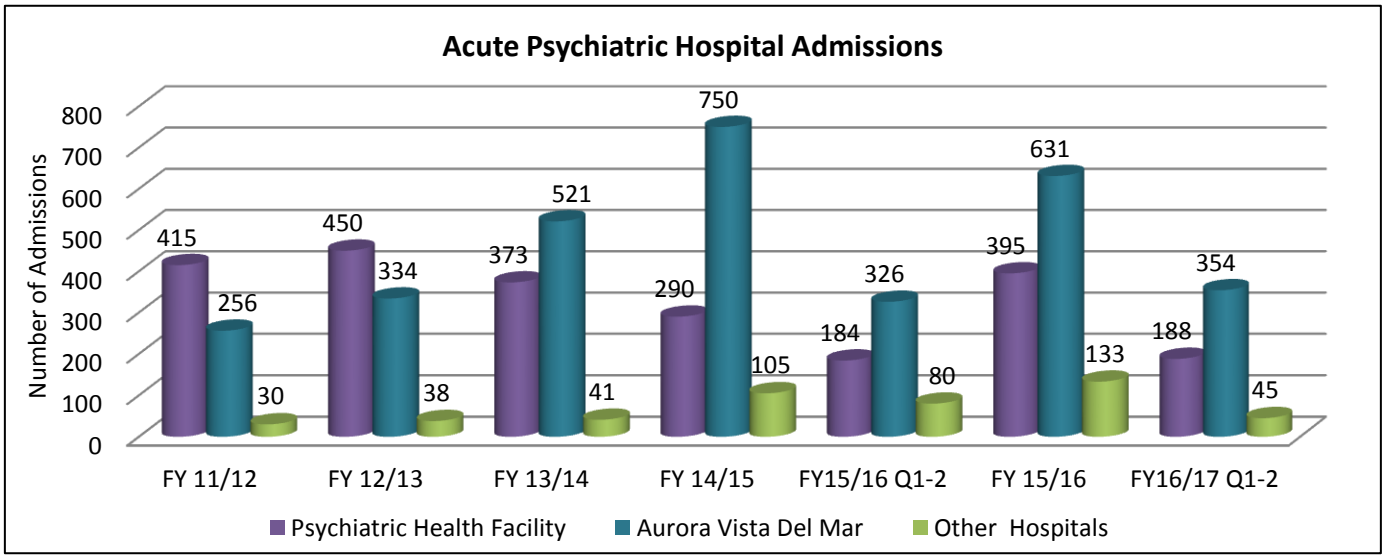
Table 3: Location of Services Provided by Triage and Mobile Crisis

	FY16/17 (Q1-2)					
	Triage			**Mobile Crisis**		
	West	**South**	**North**	**West**	**South**	**North**
Hospital	2%	24%	2%	**56%**	**67%**	**72%**
Phone/Office	**77%**	**58%**	**79%**	25%	9%	13%
Community	21%	18%	19%	19%	22%	15%
Other	0.05%	0%	0%	0.04%	2%	0.1%
	FY15/16 (Q1-2)					
	Triage			**Mobile Crisis**		
	West	**South**	**North**	**West**	**South**	**North**
Hospital	8%	36%	7%	**60%**	**51%**	**61%**
Phone/Office	**81%**	**42%**	**63%**	19%	15%	19%
Community	11%	20%	30%	20%	29%	20%
Other	1%	3%	0%	0%	4%	0%

Inpatient Utilization

Behavioral Wellness monitors inpatient services closely in order to assess and address utilization, client care and financial impacts. The Department routinely tracks the number of inpatient psychiatric hospital admissions[2] by age group, ethnicity and region of the county. Hospital admission data are available for the County's Psychiatric Health Facility (PHF) and all other out-of-county hospitals (that report admissions to the department). As is evident below, acute inpatient hospital admissions have been increasing over the last several years. One factor contributing to this increase is a change in the volume of court-mandated defendants who are declared, "Incompetent to Stand Trial" (IST). This increase has a large system impact in terms of service delivery and cost.

Chart 5



As shown below, the demographics of clients hospitalized are similar between FY15/16 (Q1-2) and FY16/17 (Q1-2). Thus far in FY16/17, the largest percentage (41%) of clients hospitalized were residents of South County, followed by North County (24%), West (14%), and non-residents (19%). Most (71%) were adults aged 26-64, followed by another 21% that were TAY (16-25 years of age); only 8% were under 15 or over 65 years of age. Nearly half (49%) of hospitalized clients were White and a third (33%) were Hispanic.

Chart 6

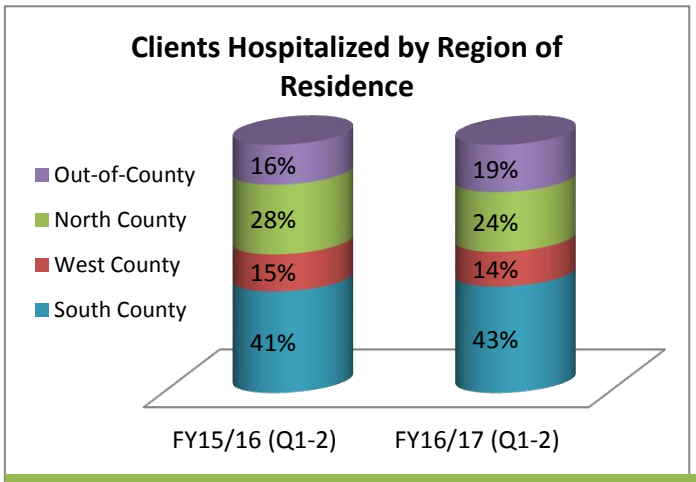
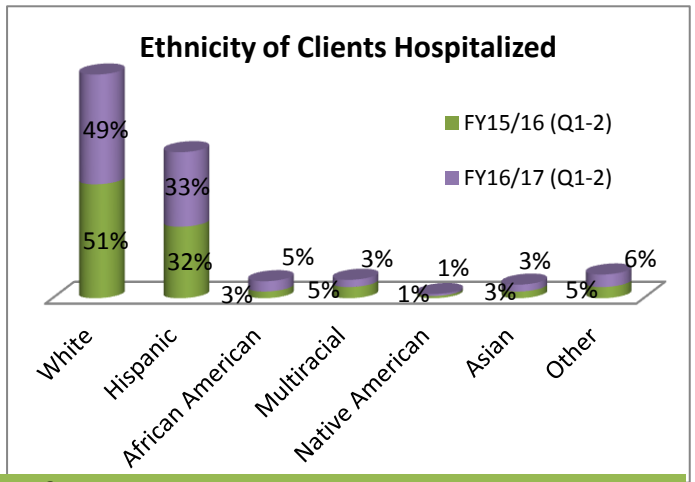


Chart 7



Timeliness of Care

[2] The Department monitors psychiatric hospital admissions for clients open to the department and Medi-Cal beneficiaries that become hospitalized prior to admission to Behavioral Wellness.

Behavioral Wellness monitors metrics related to timeliness of care, in adherence with regulatory requirements, and also to support to system improvement. Ensuring that clients discharged from hospitals, are connected to outpatient services, is an important component of continuity of care and reducing hospital readmissions. Likewise, responding in a timely manner to Access Line calls, particularly those designated as *urgent*, can help stabilize clients and avoid hospitalization. In FY15/16, the Department recognized improvements were needed to provide more detailed data to access timeliness to care. As a result, structural changes are being made in FY16/17 that will improve the staffing and practices of the Access Line services, including a focus on more comprehensive and refined data collection. In October 2016, the department centralized the Access Line screening process and implemented an improved call logging mechanism in the electronic health record. This will allow the department to monitor wait time to services with more detail. Beginning in FY17/18, time to care data will be reported using the new method.

Urgent Call Response Rate

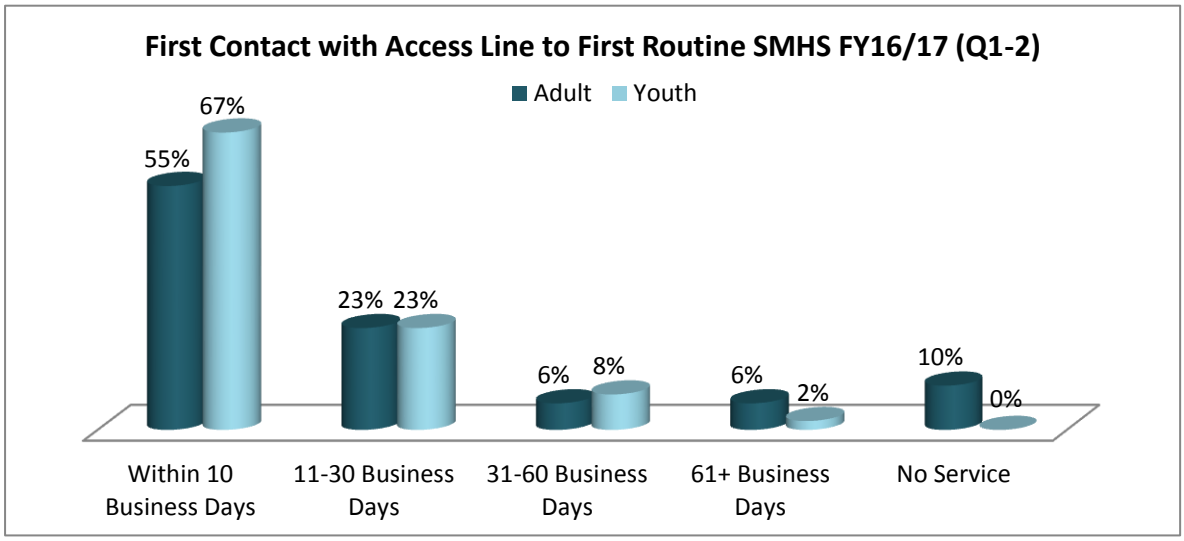
The Departments' goal is that 100% of urgent clients are scheduled for an appointment within an hour of their call, and that they are seen within 24 hours. "Urgent" calls/clients are defined as those who, without assistance, would likely need inpatient hospitalization within 24 hours. In FY16/17 (Q1-2), 88% of youth and 96% of adult (92% in FY15/16) urgent calls were seen face-to-face within 24 hours. The youth response rate decreased from 96% in FY15/16 due to SAFTY staffing shortages and turnover.

Contact with Access Line to First Service

The time from contact with the Behavioral Wellness 24-hour Access Line to first Specialty Mental Health Service (SMHS) is an important metric. The goal is to have 100% of clients seen within 10 business days. In previous fiscal years, the goal was 10 calendar days. In FY16/17, the Department of Health Care Services changed the metric to 10 business days; therefore, data in previous departmental reports are not comparable to these data.

In FY16/17 (Q1-2), the data indicate that more than half (55%) of children and two-thirds (67%) of adults were seen within 10 business days of their first call to the Access Line; 23% were seen between 11-30 days; and another 8% of children and 6% of adults were seen between 31-60 days after the first call to the Access Line. A small portion of adults did not receive a routine service following the Access line contact within Quarters 1 or 2. In FY16/17 (Q1-2), the average wait time for adults was 15 days and 11 days for children.

Chart 8



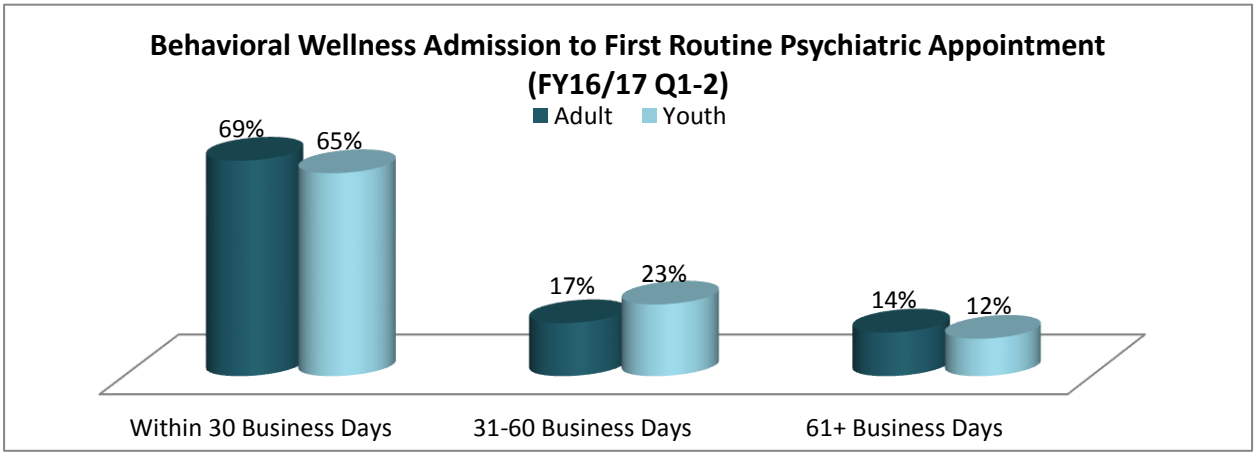
First Routine Psychiatric Appointment

Due to limited resources, psychiatric appointments must be prioritized according to need. For example, adults with urgent medication needs are seen more quickly than routine appointments. Similarly, children

with urgent needs are scheduled with a psychiatrist right after an assessment, whereas other children might have several therapeutic sessions before a referral to a psychiatrist is considered.

Prior to FY16/17, the electronic information system was not designed to capture the date a referral was made to a psychiatrist; wait times have therefore been measured from *date of admission* to the system, rather than date of referral (or determination of psychiatry need). In mid-FY16/17, the electronic information system was modified to include a psychiatric referral form for clinicians to use when a psychiatric consultation is needed for adults and children. It is anticipated that the new referral form will be fully implemented by July 2017. For FY16/17, however, the data will be reported from date admission to first routine psychiatric appointment. Beginning in FY16/17, the department changed the metric to be consistent with the statewide average wait time of 30 business days; therefore, data in previous departmental reports are not comparable to these data. During Q1-2 of FY16/17, Behavioral Wellness's average wait time to non-urgent psychiatry was 27 days for adults and 32 days for children (Chart 9).

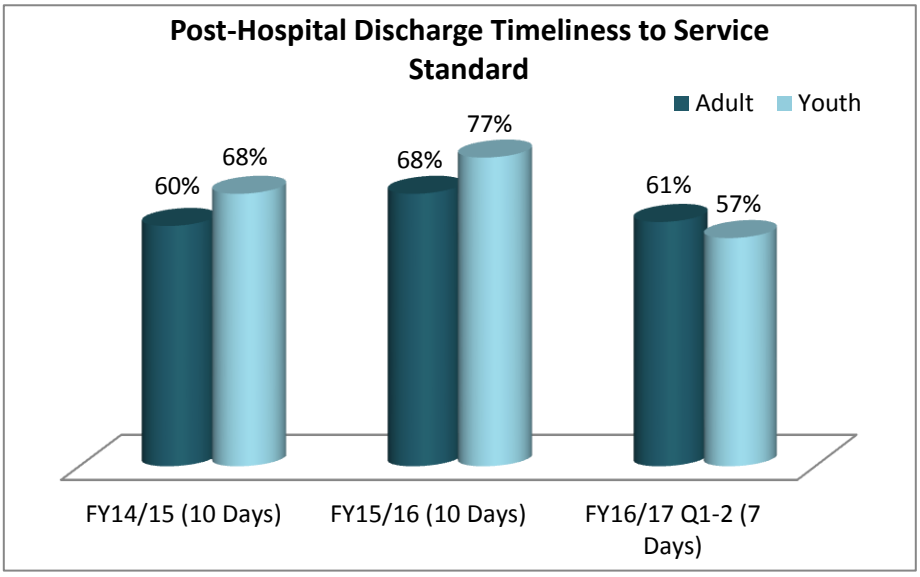
Chart 9



Hospital Discharge – Aftercare

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. In FY16/17, the Department of Health Care Services changed the standard from 10 calendar days to 7 calendar days. Beginning with this report, Behavioral Wellness will measure this wait time against the new standard of 7 days. The average wait time for a mental health service for adults in FY16/17 (Q1-2) was 7.2 days and 4.3 days for children.

Chart 10



Children's Mental Health Outcomes

Child and Adolescent Needs and Strengths (CANS)

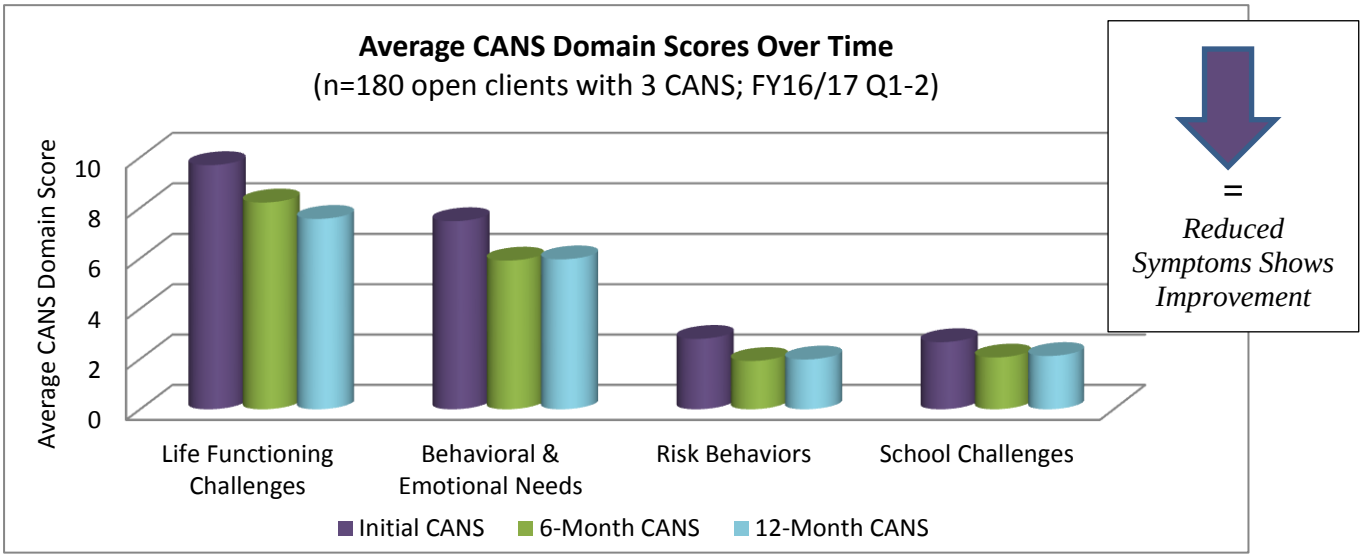
The CANS is a multi-purpose tool developed for children's service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. Staff began to administer CANS in FY2014/15 to all clients in Children's programs, including those already enrolled. Therefore, data reflecting changes over time do not represent the full scope of treatment impact. The CANS is scored from zero (no evidence of a problem/well developed strength) to three (immediate or intensive action needed/no strength identified). Therefore, improvement on the CANS is evidenced by a decrease in scores. The CANS is organized into six primary domains:

1. Life Functioning
2. School
3. Child Strengths
4. Risk Behaviors
5. Behavioral/Emotional Needs
6. Caregiver Needs & Strengths

During the first two quarters of FY16/17, there were 180 clients open to the system with three CANS. The chart (11) below displays the average CANS scores for clients with an initial, 6-month and 12-month CANS. A reduction in the average scores on the four domains indicates that children have made progress in treatment and reduced the severity of their needs, distress and challenges. The data indicate that children improve between both the initial CANS and 6-month CANS and the subsequent 12-month CANS.

- Behavioral/Emotional Needs were reduced, suggesting that clients had fewer symptoms of depression, anxiety, psychosis and other conditions.
- Children showed improvement in Life Functioning, which includes the ability to communicate/ interact with their families, having positive social relationships, and improved health status, with fewer challenges observed.
- There was a reduction in Child Risk Behaviors, indicating that children are stabilizing and displaying fewer behaviors such as self-injury, suicidal behavior, bullying, and running away.
- School behavior, attendance and grades also improved, with fewer challenges noted.

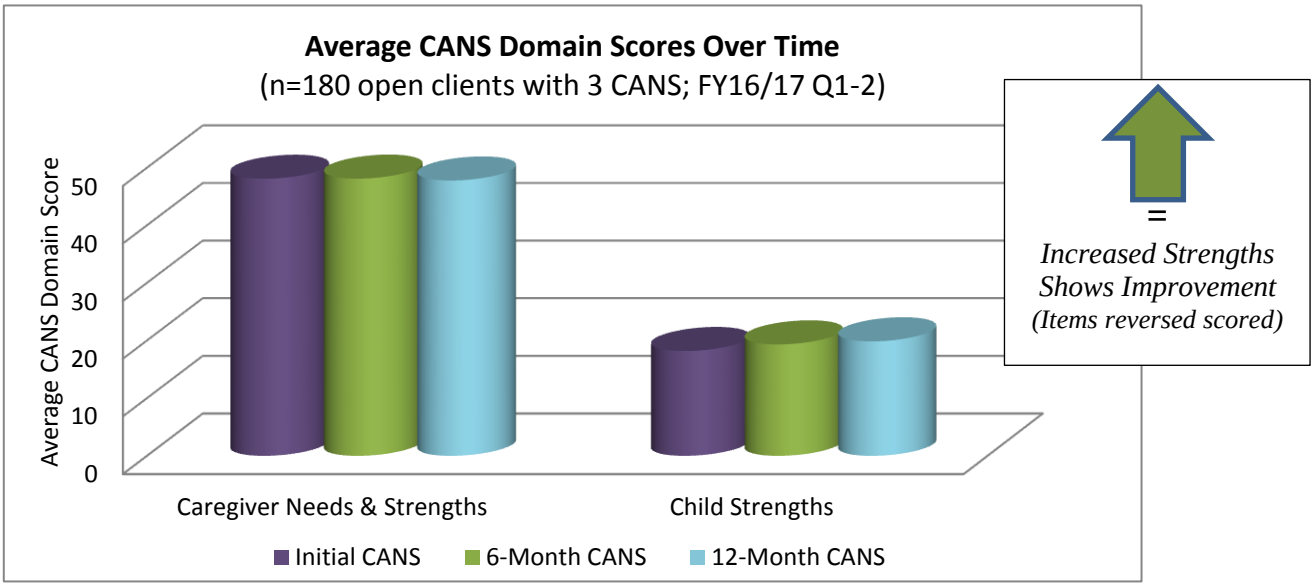
Chart 11



Responses to the items in the Child Strengths and Caregiver Strengths & Needs domains were reverse scored to demonstrate improvement over time. Chart 12 below displays that **Caregiver Needs &**

Strengths, such as child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status, showed no change. This is not surprising given that the child is the identified, primary client; however, it may suggest possibilities for future services directed at caregivers.

Chart 12



Child Strengths improved slightly, indicating that children were increasingly able to develop strengths such as optimism, relationship permanence, talents/interests, and involvement in treatment. Many of the items measured in this domain are internal qualities that take time to develop in children. Therefore, it is expected that change in this domain will be much slower than other domains.

Adult Mental Health Outcomes

Milestones of Recovery Scale (MORS)

The MORS is an 8-item tool for identifying stage of recovery and is used to evaluate effectiveness in helping adults achieve recovery. The MORS can also be utilized to assign clients to appropriate levels of care, based on a person-centered assessment of where they are in their recovery process. Scores of 1-3 indicate extreme risk to high risk/engaged in treatment; 4-5 indicate poor coping and somewhat engaged in treatment; 6-8 indicate coping/rehabilitating and early or advanced recovery.

Risk/Need	MORS Scale	
Highest	1	Extreme Risk
	2	High Risk *I* Not Engaged
	3	High Risk *I* Engaged
Moderate	4	Poorly Coping *I* Not Engaged
	5	Poorly Coping *I* Engaged
Least	6	Coping *I* Rehabilitating
	7	Early Recovery
	8	Advanced Recovery

Improvement on the MORS (higher number) indicates that clients increased their level of engagement, coping skills and stage of recovery. Lower scores indicate that clients have not improved, are less engaged and at increased risk.

The ACT programs began using the MORS in early FY2015/16. Adult Outpatient and TAY programs implemented MORS in early 2016.

The Department implemented the MORS in FY15/16 with existing clients, which means that analyses include scores that were obtained from clients already enrolled in treatment. Data in this report focus on comparison of these "initial" scores to subsequent MORS. It is anticipated that in FY17/18, there will be a higher number of new clients with a MORS administered prior to any treatment. This will allow for tracking of clients from admission through treatment for more robust analyses of program impact.

In order to evaluate if change over time is significant, average MORS scores at Initial, 6-month, 12-month and 18-month (ACT only) were compared. Adult Outpatient clients remained at Poorly Coping Engaged in Treatment (5) across a 1-year period. TAY clients demonstrated some improvement in mean MORS scores. At baseline, TAY's were on average 4.93 (Poorly Coping Not Engaged in Treatment), and at 12 months they scored on average 5.19, which is Poorly Coping Engaged in Treatment. Adult Outpatient clients remained in the Poorly Coping Engaged in Treatment level from baseline (5.09) to 12 months (5.22). ACT clients remained in the high Poorly Coping Not Engaged in Treatment level of the MORS, with an average baseline score of 4.90 and an 18-month average score of 4.86. Using repeated measures Analysis of Variance (ANOVA), it was determined that there was not a statistically significant effect of length of treatment on MORS scores for TAY clients ($F(2, 78) = 2.65$, $p = .077$), Adult Outpatient clients ($F(2, 264) = 1.59$, $p = .206$), or ACT ($F(3, 120) = .217$, $p = .884$) clients.

Although, the majority of clients remained stable with MORS scores over time, it is important to consider additional outcome variables, such as incarcerations, hospitalizations and crisis service utilization, in evaluating the effectiveness of services. Clients in all three groups successfully avoided hospitalizations at high rates, 88% and above. Approximately a quarter or less of the clients needed crisis interventions services, and fewer than 10% of the clients were incarcerated during the first 6 months of FY16/17.

Table 4: Client Outcomes

FY16/17 Q1 & Q2	Transitional Age Youth (n=80)	Adult Outpatient (n=266)	ACT (n=123)
Percent with Hospital Admissions	1%	12%	4%
Percent Utilizing Crisis Services	11%	26%	12%
Percent Incarcerated	9%	9%	6%

Staff Accountability

A critical element to providing effective treatment and maintaining organizational financial stability is documentation of all services provided. The metrics below are used for monitoring documentation of clinical services provided to clients.

Table 5: Documentation and Timeliness of Progress Notes by Behavioral Wellness Staff (Mobile Crisis and Triage Teams excluded)

	FY16/17 (Q1-2)	
	Physician	**Non-Physician**
Average number of progress notes written per month	1,389	8,919
Average time between service provision and finalization of progress note	6.6 days	13.8 days
	FY15/16 (Q1-2)	
	Physician	**Non-Physician**
Average number of progress notes written per month	1,386	8,401
Average time between service provision and finalization of progress note	3.9 days	15.5 days

Table 6: Progress Notes Written by Physicians and Non-Physician Clinicians

FY16/17 (Q1-2)							
Total Clients Served* 6,173							
Behavioral Wellness Programs (excludes Mobile and Triage Teams)		**Total Notes**	**# of Staff****	**Average Notes per Staff**	**Median**	**Range**	**Average Minutes Documented per Note*****
Physicians	**Q1-2 FY16/17**	**8,319**	**26**	**320.0**	**228**	**1-1,029**	**40.7**
	Q1-2 FY15/16	*8,316*	*28*	*297.0*	*246*	*3-1,162*	*43.0*
Clinicians	**Q1-2 FY16/17**	**53,193**	**205**	**259.5**	**201**	**1-1,911**	**40.2**
	Q1-2 FY15/16	*50,407*	*198*	*254.6*	*153*	*1-1,558*	*38.4*
Behavioral Wellness Crisis Teams Only							
Triage Teams	**Q1-2 FY16/17**	**4,890**	**70**	**69.9**	**8**	**1-431**	**46.6**
	Q1-2 FY15/16	*4,985*	*75*	*66*	*5*	*1-457*	*41.4*
Mobile Crisis	**Q1-2 FY16/17**	**2,698**	**86**	**31.4**	**5.5**	**1-214**	**92.5**
	Q1-2 FY15/16	*2,782*	*100*	*28*	*5*	*1-220*	*98.7*
Contract Providers							
Clinicians	**Q1-2 FY16/17**	**55,362**	**294**	**188.31**	**127.5**	**1-1,479**	**128.6**
	Q1-2 FY15/16	*64,788*	*298*	*217.4*	*175*	*1-1,335*	*102.0*

** The data represent an unduplicated count of Mental Health clients served in the system during the time period.*
***Represents the total number of staff that wrote progress notes during the time period. FTE is assumed for entire reporting period, and does not adjust for staff turnover. Therefore, averages are likely an underestimate of actual staff volume.*
****Average minutes per note data includes both service provision and documentation time.*
PHF, client no-show and cancellations notes were excluded from the analysis. Pending and finalized notes were included.

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