Accessing Behavioral Health Services in Santa Barbara County:

System Strengths & Needs Analysis

Report to the Steering Committee

Presented by
April Howard, PhD
Access Survey Team

July 24, 2014

Executive Summary

The Access Survey Team, chartered by the System Change Steering Committee, conducted 25 semi-structured interviews with clinicians, clients, family members are partners in the Santa Barbara County behavioral health system. The purpose of the project was to provide in-depth understanding of access barriers and opportunities for improvement from the perspective of individuals providing and receiving services in the system.

Interviewees identified 8 broad categories of barriers to initial and ongoing access to services. The barriers ranged from client-specific such as language issues or documentation status to larger system barriers such as inadequate staffing, clinic hours of operation and lack of trust between programs. The report details findings related to the following barriers:

1. Communication, Relationship and Trust	2. Staffing, Caseloads, Clinic Caps and Bi-Lingual & Bi-Cultural Capacity
3. Psychiatry Capacity and Wait Times for Appointments	4. Transfers, Referrals and Warm Hand-Offs
5. Lack of Mental Health and Substance Abuse Treatment Options	6. Navigating Access & Services and Holman Group/Echo
7. Unclear Population Definition and Admission Criteria	8. ACT, Supported Housing & CARES Residential Under-Utilization

The stakeholders interviewed identified many ideas for how to improve the access to services. As with the barriers, the ideas generated were wide-ranging system changes while others were targeted at improving staff and client experience.

1. Communication & Coordination	2. Clinical Staffing/Caseloads/Support Staffing
3. Psychiatry Capacity	4. Offering More/Broader Range of Services
5. Transfers/Referrals/Warm Hand-Offs/Trust	6. Training and Equipment for Staff
7. Mental Health and Substance Abuse Resources	8. Access Line Improvement
9. High Level of Care Programs	

There is a wealth of information in this report that can be used to enhance client experience and access to the system as a whole. The Access Survey Team and Executive Team developed the following recommendations and next steps for the Steering Committee.

- The Executive and Clinical Operations Teams will evaluate the ideas for improvement to determine if action has already begun. For example, vacant psychiatric positions are being filled and the FY2014-15 budget expansion will enable the Department to hire additional clinical staff positions.
- The Department will identify improvement ideas that could be assigned to Action Teams and those that are best addressed by internal ADMHS processes. An example might be that the recommendations related to peer integration in the clinics could be assigned to the Peer Action Team.
- Further analysis of the ideas for improvement will be performed to highlight overarching theme and specific activities that the Steering Committee might consider championing, such as building partnerships and fostering communication between all stakeholders.

Accessing Behavioral Health Services in Santa Barbara County

In October 2013, the Steering Committee commissioned the Access Survey Team (AST) with the charter of providing more detailed information to the Committee about Access, which was a significant area needing improvement in the TriWest report. The AST was comprised of April Howard, Andy Keller, Michael Craft, JT Turner, Jonathon Eymann, Cathleen Ouimet and Larisa Traga. An interview protocol was developed that focused on understanding how people become engaged and connected to what they need, identifying the barriers to accessing services and gathering ideas for improvement. For purposes of this project, Access was defined as the ease with which individuals and families (including parents and caregivers of children served and families of adults involved in care) enter outpatient services through ADMHS clinics and CARES programs, community-based organizations (CBO), and other service settings.

Semi-structured interviews began in December 2013 and were finalized in June 2014, for a total of 25 interviews. The AST interviewed the three ADMHS children's and three adult clinic teams, CARES South and North (two interviews), CARES North Mobile Crisis, and Santa Barbara ACT. Interviews were conducted with the Client & Family Member Advisory Committee, Latino Advisory Committee and family members of NAMI. CBOs were represented by the Mental Wellness Center, CALM, CADA (Daniel Bryant, PC1000 & Project Recovery), Transitions Mental Health (Supervisors, ACT, Supported Housing & Growing Grounds) and Telecare (ACT & CARES Residential).

Data were gathered during each interview, synthesized and reported back to each interview group to ensure accuracy before inclusion in this report. A thematic analysis was performed on the data to understand, order and summarize the patterns across the 25 interviews. The barriers to access and ideas for improvement were categorized and rank ordered based on the number of times the barrier or idea was mentioned. The top 10 barriers and ideas for improvement were collapsed into 8 barriers and 9 idea areas, as presented in the report below.

Summary of Top Ranked Barriers

Communication, Relationships & Trust

The number one barrier to access identified by all groups interviewed was broken relationships, lack of communication and distrust between all partners. ADMHS staff, community partners, clients & family members indicated the following barriers make it difficult for the community to access services and pose significant challenges to staff in providing the care needed:

- Poor or lack of communication between ADMHS & community partners such as Primary Health Care, PHD, Jail/Corizon, CBOs and other partners
- Communication and trust between ADMHS & CBO programs is not robust
- ADMHS is isolated and not fully connected to community
- Clinics and CBOs operate largely in silo with turf issues
- Stress and burnout impact teamwork on ADMHS teams
- Misunderstandings, misinformation & miscommunication between ADMHS & CBOs about services offered, admission criteria, expectations and transfers
- Community resource and service waitlist information is unclear and out-of-date

Staffing, Caseloads, Clinic Caps and Bi-Lingual & Bi-Cultural Capacity
The second highest ranked barrier to accessing services was diminished staffing levels, rising caseloads, and program capacity (i.e., caps on the number of clients admitted to programs). A prominent thread running through the interviews was also the lack of adequate levels of bi-lingual and bi-cultural staff in the crisis system and long-term programs. Specifically, stakeholders identified the following:

- Caseloads are too high to adequately serve clients; which results in staff stress and burnout
- Lack of staff in all positions and shifts
- Inequity of caseload caps between specialty programs and clinics/CARES
- CARES Residential is under-utilized
- Not enough bi-lingual and bi-cultural staff, and translating negatively impacts client experience
- Intake protocol and assessments are not culturally responsive
- Staff are not trained to do culturally responsive assessments/treatment

Psychiatry Capacity and Wait Times for Appointments
In conjunction with the general staffing level concerns, the lack of psychiatrists, including bi-lingual and bi-cultural capacity, in the crisis system, long-term care, inpatient care and at CBO sites was ranked as a significant barrier to access. The shortage of psychiatrists has led to long wait times for appointments, concern for client care, and frustration on the part of staff and clients.

Transfers, Referrals and Warm Hand-Offs
The issue of how clients move between levels of care in the system was ranked as the third highest barrier to access and correlates to communication & relationship barriers. All stakeholder groups cited a lack of enough referral sources in the community. Clients and family members experience frustration, worry and fear when they are not transferred to the appropriate care or the transfer process takes months. Staff and CBO partners expressed a great deal of resentment and frustration with the unclear and non-consistent application of transfer policies and procedures, incomplete paperwork with transfers, lack of bi-directional access between programs and referrals of unstable clients to long-term care. The distrust and lack of communication that has developed over the years has fostered an environment of isolation and unwillingness to cooperate between internal and external programs. This feeling of distrust extends to concerns that programs do not work hard enough at client engagement upon transfer, which often results in clients returning to the original program and not receiving the care needed.

Lack of Mental Health and Alcohol & Drug Treatment Options
Santa Barbara County's diminished capacity to provide access to mental health and substance use care along the entire continuum of care was also ranked number three. The availability of substance use services, including residential; the unavailability of medical detox care for our client population; and shortage of prevention efforts were identified an important barriers to care. All stakeholders noted that not having enough treatment beds and residential care settings creates significant gaps in care for clients in the community. Critical gaps include mental health and substance treatment beds that are gender-specific and for adolescents; mental health step-down treatment beds along the continuum of care; and resources in the community that will accept clients with co-occurring and complex needs.

Navigating Access & Services and Holman Group/Echo
Accessing services via the Access line and understanding how to navigate through the system were barriers ranked number four. Several problems with Echo and Holman Group were outlined by staff and clients, including lack of Spanish-speaking operators, call routing mistakes, referral lists, and lack of knowledge about ADMHS. Too often, client calls are dropped or get lost in the phone system and some simply give up and hang up because there are too many steps before they reach a clinician for help. Clients and family members also feel overwhelmed by the system and have difficulty understanding how to get the care they need.

Unclear Population Definition and Admission Criteria
ADMHS and CBO/partner staff indicated that they do not have a clear definition of who ADMHS serves or what the admission criteria are for services. The lack of clarity causes confusion and stress for staff, which may be felt by clients. The community is also unclear about the mission, population and admission criteria, which leads to unrealistic expectations of ADMHS and disappointment.

ACT, Supported Housing & CARES Residential Under-Utilization
Barriers to accessing some of the highest levels of care in the system were ranked fifth. Both ADMHS and CBO staff outlined the challenges with ACT, Supported Housing and CARES Residential programs, and the points of breakdown when working to discuss or transfer clients. The barriers are detailed below:

- ADMHS staff unclear about mission, services provided & admission criteria for programs
- Lack of communication and distrust between programs and clinics
- ACT & Supported Housing:
  - Clinics frustrated with the caps placed on Axis II clients
  - "ACT for Life" model doesn't work well in our system
  - Not enough levels of care within ACT (i.e., step-down options)
  - Clients arrive at ACT/SHS with too high expectations about what program offers
  - Transfers between clinic & ACT/SHS are difficult; clinic doesn't accept clients back
  - Both the clinics and ACT/SHS feel like clients are dumped on them
- CARES Residential:
  - No psychiatric or nursing staff
  - Admission paperwork is restrictive
  - Few treatment/discharge plans
  - CARES Residential staff call CARES staff "for everything" (disruptive)
  - Restrictions about accepting medication orders from physicians and psychiatrists
  - Weekend admissions are difficult, if not impossible due to psychiatrist signature issues
  - CARES staff cannot provide case management at CARES Residential and bill for it

Root Causes of the Barriers
The Access Survey Team conducted a root cause analysis on the barriers to further understand the nature of and potential solutions to the identified barriers. Common root causes included:

- Long-term trend of not enough money & resources to meet the service demand
- Executive/Administration (i.e., personalities, style, decisions & turnover)
  - Policies and practices that demonstrated a lack of care and respect for employees and partners
  - Oppressive culture and lack of imagination & will
  - Poor messaging and communication
- System and staff stress, burden and overload (including high caseloads)

- Human Resource Issues
  - HR hiring practices, methods of recruitment, and procedures
  - Santa Barbara County cost of living is high and the salary structure for clinical and psychiatric positions may not be competitive
  - Shortage of bi-lingual & bi-cultural clinical & psychiatric staff in field
- Cultural Competency Plan not implemented in the system

<table>
<tr><th colspan="2">Ideas for Improvement</th></tr>
<tr><td>Communication/Coordination
Network Provider & CBO waitlist updates; community resource directory
Hold more in-services (ADMHS & CBOs together): bring everyone together to communicate about resources, service options, relationships, admission criteria, etc.
Improve communication with CBOs and partners about services
Work with partners to better serve clients (e.g., safe vehicle parking zones for homeless in cars, humane society agreement to shelter pets for clients in hospital/CARES Res; food & housing vouchers)
Improve communication with family members about mission, services and expectations
Define our service population and admission criteria
Communicate the message to internal & external staff
Conduct community education about CARES services
Improve outreach to specific cultural groups in community</td><td>Offer More Services/Broader Range of Services
Provide specific DBT programs for Axis II clients
Offer more services to clients in between assessment and psychiatric appointments to keep clients stable
Offer more short-term, life skills therapy at CARES
Extend therapeutic service hours beyond 5pm
Establish a crisis stabilization in Lompoc
Develop community-based opportunities for clients to get engaged & participate in life beyond their mental health services
Establish clinics/adequate services in Carpinteria & New Cuyama
Establish field-based and mobile clinic teams
Provide more services for children ages 0-5 years
Work with community partners to build housing options for mentally ill</td></tr>
<tr><td>Clinical Staffing/Caseloads/Support Staffing
Hire more clinical staff in all positions from mental health workers to psychologist positions; bi-lingual & bi-cultural
Reduce caseloads to improve client care and staff morale/stress levels
Hire more staff for mobile crisis teams
Hire more AOP, Patient Representatives & medical records clerks
Designate staff for specific functions such as access, mobile work, transfers, nights/weekend
Staff need adequate office space to provide services to clients
CARES should only handle crises and carry caseloads of 1-2 months before transfer/discharge
Greater inclusion of Peer Recovery Specialists to engage with clients</td><td>Psychiatry Capacity
ADMHS clinics need access to psychiatry time, including bi-lingual and bi-cultural capacity
CBOs need psychiatry access
Staff need access to psychiatrists after hours and/or urgently to avoid inpatient care
Staff want to feel like psychiatrists are part of the team
Establish Public Health psychiatric management for non-SMI
Consider using trained psychiatric nurse practitioners and physician assistants</td></tr>
</table>

<table>
<tr><th colspan="2">Ideas for Improvement</th></tr>
<tr><td>Transfers/Referrals/Warm Hand-Offs/Trust
Provide clients with realistic expectations about programs
Have warm handoff when transferring, in person case conference
Define diagnostic criteria & clear admission criteria and process for admitting clients
Referral packets need to be complete
Include more information in referral packets, more history, referral note
Build trust between programs & clinics to help facilitate flow of clients up & down continuum of care
Implement a request for change of clinician process from ACT/SHS back to clinic with clinical discussion between clinic and ACT/SHS</td><td rowspan="2">Training and Equipment for Staff
Implement an Access protocol/script for how to handle an access call, especially Spanish-speaking calls
Offer consistent and ongoing training on SC & CG, documentation, progress notes and general policies & procedures
Reinstate the new employee orientation
Offer more training on clinical/treatment topics such as trauma, cultural issues, DBT, elderly
ADMHS teams should attend teambuilding courses
Train staff to conduct culturally responsive assessments and treatment
Offer clinical supervisor training for clinicians that certify licensure hours for interns

Wireless access in CARES and Bluetooth for phones for mobile crisis teams
CBO ACT/SHS need more access in SC & CG to client records
Implement an electronic medication tracking system (RxNT)
Access to SC & Gateway, Scheduler, ShareCare should be incorporated into one easy accessible system CG remotely with laptops/tablets
Increase the number of computers and phone lines, particularly at CARES

ADMHS & CBO teams need more vehicles and safer vehicles so that staff don't personal cars and clients are safe, comfortable and not traumatized by police-looking vehicles</td></tr>
<tr><td>Mental Health & ADP Resources
Provide AOD services in all CBO and ADMHS programs with staff dedicated to providing AOD services
Establish medical detox programs
Expand AOD peri-natal programs
Provide residential & detox services for youth
Expand ability to work with parents of youth with ADO issues; and parents with AOD issues of their own
Establish more psychiatric inpatient beds in county
Establish more housing and bed options along the continuum of care, as well as gender-specific options</td></tr>
<tr><td>Access Line Improvement
Echo needs training to better screen and route calls
Centralize Access and staff with ADMHS clinicians (children's teams would like to do own access at clinics)
Have staff & peers designated to help clients & family members understand how to access services, educate & orient to system</td><td>High Level of Care Programs
Reconsider the "ACT for Life" model; select model that fits needs better
Create a tiered model in ACT such that clients can get varying levels of care
CARES Residential should hire medical & nursing staff
CARES Residential should hire licensed clinical staff
Offer more parent education/support and provide realistic expectations
Hire more staff to treat AOD issues in ACT & Supported Housing
Hire more bi-lingual staff in ACT & Supported Housing</td></tr>
</table>