
FY 2017-2018

Annual Report



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

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(805) 681-5220 ♦ Alice Gleghorn, Ph.D., Director

Contents

Letter from the Director, [Page 4](#)

Mission, Vision, Guiding Principles, [Page 5](#)

About Behavioral Wellness, [Page 6](#)

Clinical Operations, [Pages 7 - 12](#)

Business Operations, [Pages 13 - 15](#)

Fiscal, [Pages 16 - 19](#)

Annual Data Report [Pages 20 - 38](#)

From the Director

I am pleased to present the third Annual Report of the Santa Barbara County Department of Behavioral Wellness. This past year, the Department has accomplished many achievements and faced many challenges. I would like to acknowledge the important work our staff do every day, and also honor the extraordinary efforts they have made during times of community crisis.

Important achievements this year included the decision of the System Change Steering Committee to retire further meetings in recognition of the significant progress the Department has made across all areas of change designated in the TriWest report. This initiative defined a broad scope of strategic activities that were pursued by department staff in continuous quality improvement efforts, and formed the basis of our Strategic Plan. Through dedicated work beginning in FY 2012-2013, the Department transformed Clinical, Fiscal, Compliance, System, Administration and Cultural Competence functions. Our annual reports provide ongoing updates and data on our continued progress. In a similar quality improvement effort, the County has launched the Renew '22 initiative. The Department is an active Renew '22 participant; key initiatives appear in the department's FY18-20 Strategic Plan which can be accessed on the Behavioral Wellness website. Our annual metrics summary (pages 20-38) documents important information on the scope and impact of our services.

Behavioral Wellness staff actively supported the community before, during and after the dual Thomas Fire/Debris Flow disasters. Performing services in a variety of roles (page 9), staff at all levels assisted Emergency Operations efforts, evacuation shelter needs, family and community assistance centers, trauma and grief counseling, school based interventions, and recovery actions including mental health First Aid. We are proud of the many contributions staff have made to the health and well-being of Santa Barbara County. We appreciate your interest in the Department of Behavioral Wellness, and hope you enjoy our Annual Report.

Sincerely,

Alice Gleghorn, Ph.D.
Director

Mission, Vision and Guiding Principles

Mission

The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

Values

- ♦ Quality services for persons of all ages with mental illness and/or substance abuse
- ♦ Integrity in individual and organizational actions
- ♦ Dignity, respect, and compassion for all persons
- ♦ Active involvement of clients and families in treatment, recovery, and policy development
- ♦ Diversity throughout our organization and cultural competency in service delivery
- ♦ A system of care and recovery that is clearly defined and promotes recovery and resiliency
- ♦ Emphasis on prevention and treatment
- ♦ Teamwork among department employees in an atmosphere that is respectful and creative
- ♦ Continuous quality improvement in service delivery and administration
- ♦ Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient
- ♦ Safety for everyone

Guiding Principles

Client- and family-driven system of care: Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.

Partnership Culture: We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.

Peer employment: Client and family employees are trained, valued, and budgeted- for in ever-increasing numbers as part of a well-trained workforce.

Integrated service experiences: Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies and organizations.

Cultural competence, diversity and inclusivity: Our culturally diverse workforce represents this community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes and policies that enable staff and providers to communicate with people of all ethnicities, genders, sexual orientations, religious beliefs, and abilities.

Focus on wellness, recovery and resilience: We believe that people with psychiatric and/or substance use disorders are able to recover, live, work, learn and participate fully in their communities.

Strengths-based perspective: Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.

Fiscal responsibility: We efficiently leverage finite resources to provide the highest quality care to our clients, including those who are indigent.

Transparency and accountability: There are no secrets. We do what we say we will do, or we explain why we can't.

Continuous quality improvement: We reliably collect and consistently use data on outcomes in our system of clients and other pertinent populations (such as incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

About Behavioral Wellness



Founded in 1962, the Santa Barbara County Department of Behavioral Wellness promotes the prevention of, and recovery from, addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

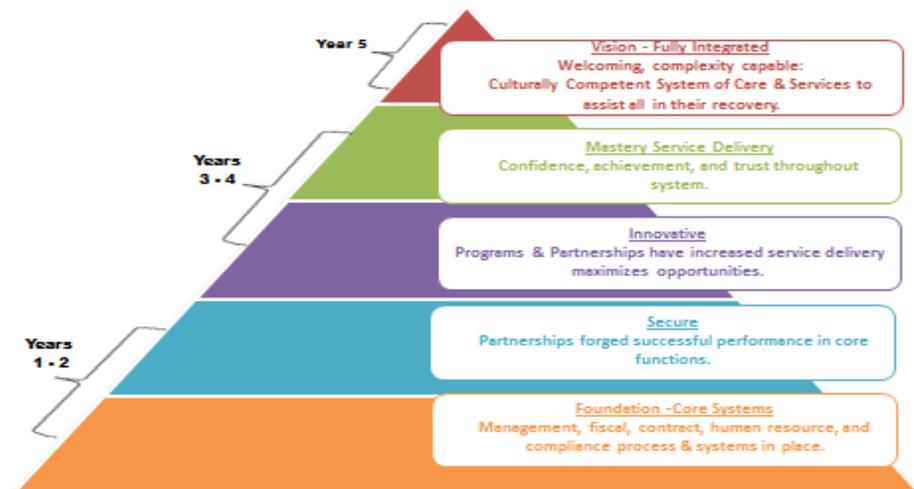
An array of services is provided countywide for adults, children and transition-age youth. Services are provided on an inpatient, outpatient and crisis basis. During FY 2017-18 the Department of Behavioral Wellness served 9,600 mental health clients and 4,453 Alcohol and Drug Program clients.

As of June of 2018, Behavioral Wellness employed 432 persons.

Behavioral Wellness also contracts with a number of community-based alcohol, drug and mental health providers, as well as with individual practitioners called "network providers" to offer additional services countywide including newly expanded substance use disorder residential services.

All goals established in the System Change process developed following the TriWest report of the department, have been met. The Behavioral Wellness Systems Change Steering Committee, formed to follow the established objectives has retired as result of goals being accomplished. Continuous Quality Improvement efforts will remain ongoing throughout the department.

Timeline of Systems Change



This report is organized around the core areas of Clinical, Business and Fiscal Operations of the Department. Each core area will be introduced by a brief definition, followed by key achievements and recent accomplishments.

Clinical operations focus on inpatient and outpatient service delivery systems, the crisis system of care and contracted community-based organization (CBO) services.

Client and Family Experiences

- ✓ The opening of South County Crisis services in a new location to allow for “a crisis walk-in clinic” in a centralized location. This newly created “Crisis Hub” provides a convenient drop-off location for law enforcement and other community providers as we have a full array of services (outpatient, voluntary CSU and involuntary PHF) within walking distance of each other. Practitioners are available to assess individuals in a mental health crisis, and there is improved coordination with the outpatient clinics to assist in timely linkage to Psychiatry and specialty mental health services.
- ✓ Addressed the consumer requests to improve transitions to care by the implementation of the adult program in Santa Maria to offer multi-disciplinary teams to be able to serve clients in one clinic by the same providers offering multi-levels of care. The complexity capable model moves teams toward a holistic model of service delivery where knowledge, skill and confidence is present to support clients with complex needs.
- ✓ Expansion of SUD services in the Santa Maria’s Children’s Clinic for TAY youth and their families through Strengthening Families groups. The Strengthening Families model is a research informed approach designed to increase family strengths, child development and reduce abuse and substance use through strengthening key protective factors.
- ✓ Redesign of team based care approaches to incorporate continuity of care practices that assist in individualized care of clients that are served in multiple agencies and require coordinated and integrated care. The continuity of care is important for clients that need support with health, SUD, housing, and other services.
- ✓ Behavioral Wellness Clinics have improved the collaboration and partnership with health facilities, law enforcement, courts, schools, SUD programs, housing entities, and CBOs to improve care coordination and to better integrate services for clients.

Change Agents and Action Teams

As result of our Department’s commitment to excellence, many systemic improvements and change process have continued through the leadership of Action Teams and the Change Agents over the past year. Although supervisors and regional managers support the PDSA (Plan-Do-Study-Act) process, there has been an increase in line staff participation with Change Agents this year with line staff suggesting the major process changes to be made within the clinics/programs. Highlights from our system Action Teams, including the Housing Action Team (H.E.A.R.T.), Forensic Action Team, Crisis Action Team, Cultural Competency and Diversity Action Team, Peer Action Team, and the Children’s System of Care Action Team are noted throughout this report. Action Teams continue to serve as important venues to encourage communication, planning and coordination throughout the system.

Cultural Competency and Diversity

- ✓ According to interpreter utilization data for 2017, Mixteco is the second-most prevalent language at Behavioral Wellness service sites. A Mixtec Culture and Mental Health training was created in response, to better engage our service providers with the Mixtec population.
- ✓ Through partnerships made available by the Reducing Racial and Ethnic Disparities (RED) grant awarded to the department from the California Board of State and Community Corrections, UCSB led research has identified areas for growth. As result, customized implicit bias training focused on clinical assessment, diagnosis, and treatment practices within the behavioral health setting have been offered.
- ✓ The 24/7 Access Line is key to ensuring all beneficiaries receive timely care and is staffed with both English and Spanish screeners. If a bilingual screener is not available or the caller speaks a language in which the screeners are not proficient, the department utilizes over-the-phone Language Line services, available 24/7 and in over 240+ languages.
- ✓ Many new policies and procedures have been developed to address system-wide cultural competency. Some of these new policies include Non-discrimination, Accessibility for Persons with Disabilities, Notice of Adverse Benefit Determination, Mandatory “Cultural Competence Training,” 24/7 provision of language capability through the Toll-free Access Line, and Network Adequacy Standards and Monitoring to ensure sufficient cultural competent service providers.
- ✓ New contracts have been developed to assure availability of in-person interpretation needs for county-operated service locations. FY17-18 data for in-person interpretation shows that Spanish interpretation accounted for 95% of services, Mixteco followed by 4.3% and .7% was made of languages of lesser diffusion.
- ✓ Behavioral Wellness has partnered with the American Indian Health and Services (AIHS) to address disparities in access to quality, culturally-appropriate mental health services to Native youth and families within Santa Barbara County.
- ✓ Members of the Department’s Cultural Competence and Diversity Action Team (CCDAT) guided the revision of several documentation templates, including the Comprehensive Assessment and Treatment Plan templates, to strengthen collection of culturally relevant information. A key focus this year was the integration of the American Psychiatric Association’s Cultural Formulation Interview (CFI) questions throughout the assessment. Posing these questions during an assessment enhance a mental health practitioner’s clinical understanding of the problem and functional impairments, potential sources of help, and expectations for services from the client’s cultural perspective.

Strengthening Community Outreach and Engagement

- ✓ Behavioral Wellness and the Behavioral Wellness Response Team continue to provide ongoing community crisis and trauma response. During the 2017-2018 year, the department has been contacted by schools countywide for support of student deaths or traumatic events; by first responder agencies for critical incident stress debriefings; and by other county departments for team support in the aftermath of critical incidents.
- ✓ Behavioral Wellness provided broad response efforts and community support following the Thomas Fire and 1/9 Debris Flow which had unprecedented impact on our community and resulting in the loss of 23 community members. Behavioral Wellness provided 24/7 response in a variety of ways including supporting the Community Information Emergency Call Center, supporting the community in connecting to family and hearing the devastating news of loss of family members, supporting the community at the Local Assistance Centers, supporting people returning to damaged or destroyed neighborhoods as they returned for the first time to see the impact on their homes, providing crisis counseling for those who were directly impacted or lost family members, and remaining connected to long term recovery efforts through leadership of the Community Wellness Team and Community Long Term Recovery group.
- ✓ When Vista Del Mar hospital burned as result of the Thomas Fire, Behavioral Wellness staff immediately drove to Ventura to connect with Santa Barbara County clients and aid in their return to a safe place. This created a direct impact on the Psychiatric Health Facility who immediately applied for a waiver to accommodate clients which would place the hospital over census.
- ✓ The Community Wellness Team was established in December of 2017 in response to the impact of the Thomas Fire in Santa Barbara County. The Community Wellness Team is led by the Department of Behavioral Wellness and is a collaboration of many local agencies working together to support the wellness of our community in response to the Thomas Fire and 1/9 Debris Flow in Santa Barbara County. This collaborative team comprises a coordinated continuum of services available to meet the needs of individuals impacted by the collective and individual trauma experienced in our county. The team is comprised of 13 local agencies working together. Services provided by the Community Wellness Team include immediate crisis response; short and long term grief, trauma and bereavement counseling for children and adults in an individual or group format; school support; spiritual care; critical incident stress debriefings and counseling for first responders or other impacted entities; and groups offered through the intensive outpatient program at Cottage Hospital designed for this response.
- ✓ Behavioral Wellness has hosted countless resources tables, offering resource and outreach information, at forums and events at schools and in the community. Behavioral Wellness has provided many trainings and presentations on services throughout the community as well.

Forensic Program Development

The Forensic Action Team met five times in 2018. Participants included staff and leadership from Probation, Sheriff's Department, Office of the Public Defender, District Attorney, Santa Barbara County Superior Court, the Public Guardian, NAMI (National Alliance for the Mentally Ill) and Families Act. John Lewis, Ph.D., Behavioral Wellness' Forensic Services Manager and Celeste Andersen, J.D., Behavioral Wellness' Compliance Chief, co-facilitated the meetings. The meeting served as a forum to discuss a wide range of community issues involving behavioral health and the criminal justice system, and in so doing it improved collaboration among stakeholders.

Among the topics addressed in 2018 were the following:

- ✓ Support for families of individuals in the criminal justice system. There were several wide ranging discussions of how families can learn about a loved one who is in jail or otherwise involved in the criminal justice system. NAMI reported on an informational brochure it created in collaboration with the Sheriff's Department titled, "What to Do if your Loved One is in Jail."
- ✓ Behavioral Wellness/Sheriff's collaboration. As an outcome of this meeting, a process was implemented to provide access to information on jail admissions and releases to select staff from Behavioral Wellness. This has improved Behavioral Wellness' ability to intervene and assist clients who become involved in the criminal justice system.
- ✓ AB 1810 Diversion bill. There were several discussions of this new "diversion" bill, which provides a mechanism for certain individuals with behavioral health problems to avoid a criminal conviction if they successfully complete a course of treatment. The County has also begun the process of applying for a grant funding to establish procedures for diverting individuals with mental health problems, who have contact with the criminal justice system, into treatment.
- ✓ A dedicated IST Court Hearing Calendar. Many stakeholders have advocated for an IST Calendar that would consolidate legal proceedings for individuals found to be incompetent to stand trial (i.e., "IST") to improve efficiency. The Superior Court managed to organize calendars in both Santa Maria and Santa Barbara and these began handling IST cases in November of 2018.

Improvements in Access to Care

The average wait time to see a Psychiatrist is 18 days. This represents a **36% improvement** from last year when the average wait time was 28 days

98% of crisis services are offered the same or next day

91% of urgent services are offered the same or next day

Alcohol and Drug System of Care

- ✓ The Drug Medi-Cal Organized Delivery System (DMC-ODS) began on December 1. With this, the transformation of the substance use disorder (SUD) system of care to a managed care model with expanded benefits has begun. In preparation, Requests for Proposals (RFPs) for new providers were developed and rate preparation occurred for new rates through ODS.
- ✓ Numerous Behavioral Wellness staff have been reassigned to address a high volume of calls to the Access line and to ensure our electronic health records and other protocols are operating as efficiently as possible.
- ✓ Clients are being screened and assessed more thoroughly and accurately than ever before. In-county expanded residential treatment capacity is available in addition to Tarzana Treatment Center (TTC). Suboxone is available through local opioid treatment programs.
- ✓ In less than a month of the ODS launch, the Access line had received over 750 calls for specialty mental health and substance abuse treatment services with at least a quarter of the calls being for residential services.
- ✓ Behavioral Wellness departments CBOs and partner agencies have never been more collaborative or integrated.

As with any new implementation, growth exists. Demand currently exceeds our resources and wait times with the Access Line are too long for some. Those in custody are having difficulty accessing out of custody services and more services are needed. But help and reform is on the way. In the end, even higher quality services will result.

- ✓ We are currently hiring more Access Screeners and trouble-shooting specific problems.
- ✓ Service gaps have been identified and are strategies are being developed to address these needs.
- ✓ County ADP is working closely with QCM, Crisis and IT departments to address problem areas.

Thanks to everyone who has contributed to this exciting change of substance use disorder (SUD) services.

Crisis System Improvements

- ✓ Crisis Triage staff joined together with Mobile Crisis staff and are now organized as one team working as “Crisis Services.” This team provides a spectrum of outreach/engagement, intensive follow-up with individuals experiencing a mental health crisis but not meeting criteria for involuntary psychiatric hospitalization, as well as those experiencing a psychiatric crisis.
- ✓ Behavioral Wellness Crisis Teams were very involved in the departmental response for the twin disasters of 2018. During the Thomas Fire, Crisis Staff provided 24/7 mental health support at the Red Cross evacuation shelters and supported the re-population in areas of Carpinteria where homes were destroyed. Immediately following the 1/9 Debris Flow, Crisis Services staff supported the Evacuation Center as well as the Local Assistance Center and continued in ongoing support.
- ✓ Crisis Services continues to partner with the Sheriff’s Department Behavioral Sciences Unit (BSU). Crisis Services staff attended the Crisis Intervention Team (CIT) training facilitated by the Sheriff’s Department. Behavioral Wellness team members John Winckler and Bonnie Zant aided in course facilitation.
- ✓ A co-response pilot program has begun in the Santa Barbara region. One day a week a Sheriff Behavioral Sciences Unit Deputy is paired up in a County vehicle with a senior Crisis Services staff. The co-response team responds to primary mental health calls that come into Sheriff Dispatch and also engage in outreach and engagement efforts. Sheriff data reflects a significant reduction for deputy call times on mental health calls. This is attributed to the quick relief by the co-response team allowing other deputies to return to their law enforcement patrols.
- ✓ 5150 Holds have decreased steadily over the past two years.
- ✓ Data reflects that clients who went to the Crisis Stabilization Unit (CSU) for care are getting stabilized and avoiding hospitalization.
 - **98%** of clients did not need hospitalization within 24 hours of their discharge from the CSU. **91.3%** did not need hospitalization within 30 days of discharge

Many Accomplishments

- ✓ Implementation of a new platform for tracking IT Help Desk requests called “Service Now” which has greatly increased system efficiency
- ✓ Improvements in the integration of physical health and behavioral health care and transitioning between care systems positively impacted by regular coordination meetings with CenCal Health

Employee Recognition and Appreciation

- ✓ The Behavioral Wellness Employee Engagement and Appreciation Committee has continued the employee recognition activity which is catching stars and strengthening morale. Each quarter, peers nominate several “stars” to be honored in the quarterly “Salute to a Star” recognition which includes items of reward as well as written biographies published in the quarterly newsletter. The Committee coordinated the yearly All Staff Employee event recognizing staff on their years of service and past year’s accomplishments.
- ✓ Shereen Khatapoush was recognized as employees of the month for the County of Santa Barbara.



Only some of the many Behavioral Wellness staff who received recognition during the FY17-18 through the employee nominations in the “Salute to a Star” program.

Key Initiatives at the Psychiatric Health Facility

Pharmacy Improvements

- ✓ New Pharmacist in charge and inpatient pharmacy opened
- ✓ Installation of a medication dispensing machine (Pyxis)
- ✓ In collaboration with PHF, development of a contract with AmerisourceBergen for the purchase of medications at wholesale prices

Administrative Improvements

- ✓ Revision and new development of 101 Policies and Procedures
- ✓ Implementation of a PHF patient satisfaction survey. The majority of the responses for each survey question were in the Agree or Strongly Agree rating category.
- ✓ Improvements made in the areas of environmental services, emergency preparations, and restraint/seclusion reduction.
- ✓ New model for medical coverage at the PHF, which includes 16 hour medical shifts to provide support to other crisis services

Emergency Preparedness Efforts

- ✓ Navigation of the Thomas Fire/Debris Flow Events of 2017 to ensure that the PHF was adequately staffed and remained operational.
- ✓ Entering into Memorandums of Understanding (MOUs) with both North and South bordering Counties for the provision of Emergency Mutual Aid for each county's Psychiatric Health Facility (PHF) or Acute Care Hospital Psychiatric Unit. PHF has MOUs with the County of San Luis Obispo Health Agency Behavioral Health and the County of Ventura Health Care Agency Behavioral Health.
- ✓ Development of a new Emergency Preparedness Plan including PHF staff participation in multiple emergency preparedness drills.



A Year of Training

This past year Behavioral Wellness held many new trainings for staff.

- Implicit Bias training was hosted this summer which taught the basics of implicit bias and how it may contribute to behavioral health disparities.
- In early fall Behavioral Wellness hosted a two day training on new Innovations in Youth Engagement through the Transition to Independence (TIP) Model. This training focused on the pervasive and profound impacts of trauma on children and transition-age youth; and taught our staff how to equip these populations with more effective ways to manage and overcome these challenges.
- In November and December our department hosted a series of Trauma-Informed Care Trainings. This series was designed to help staff develop a foundational understanding of trauma-informed care and trauma informed transformation.
- Department staff were trained on community trauma response and many additional team members joined the countywide Behavioral Wellness Response Team.
- Late in the FY 17-18 year, Behavioral Wellness co-hosted, with the Department of Public Health, a Law and Ethics Training for Health Care Providers.
- The Department continued to ensure 100% compliance with HIPAA, Code of Conduct and Cultural Diversity training.



Fiscal activities focus on capacity and performance in regard to budgeting, the revenue cycle, Medi-Cal cost recovery and broader financial resources management.

Recent Accomplishments

- ✓ Once again, adoption of a balanced departmental budget for FY 2018-19 (\$135M).
- ✓ Developed and adopted the FY 2017-20 Mental Health Services Act (MHSA) three- year budget plan.
- ✓ Implementation of fiscal controls has led to a 98% reduction in cost report audit liabilities; a high compliance; and of \$3.9M in FY 2004-05 to a low of \$66K in the most recent finalized audit for FY 2010-11. State audit findings for FY 2008-09 were also successfully challenged at the informal appeal stage resulting in the County recovering \$758K in funding.
- ✓ In order to provide additional transparency, the Mental Health Service Act Oversight and Accountability Commission has posted a State-wide tool to review Revenue and Expense Reports by county. <http://mhsoac.ca.gov/fiscal-reporting>

Staffing Levels

Table 1: Behavioral Wellness Staffing Fiscal Year 2017-18

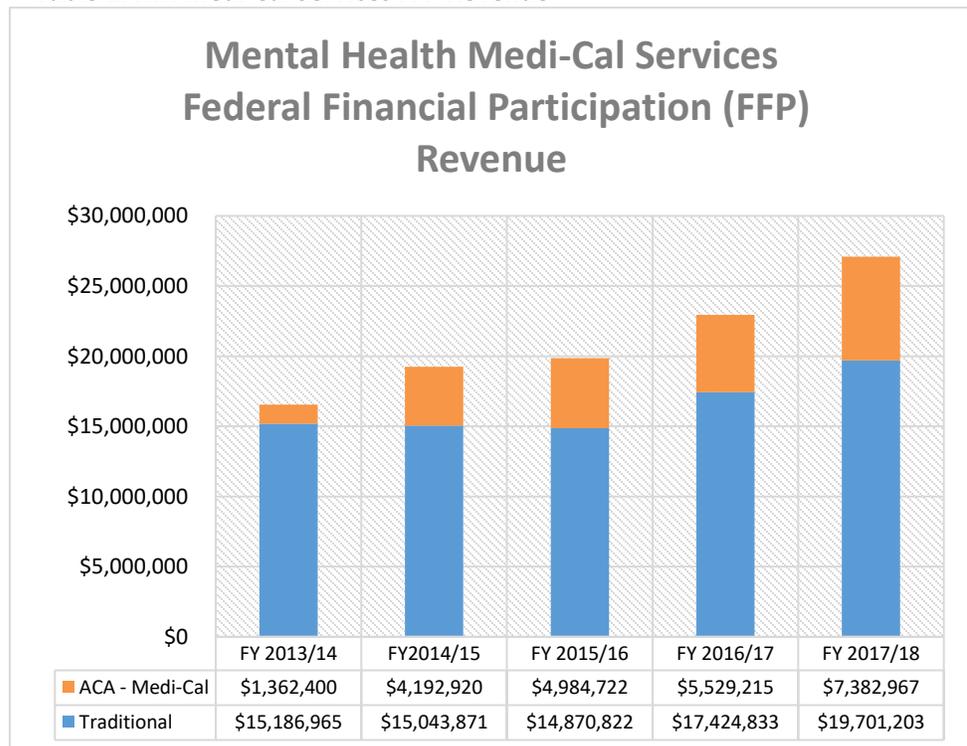
Staff Type	FTE Total	FTE Vacant	FTE Filled	Vacancy % Rate
Regular	370	45	325	12%
Extra Help	59	25	34	42%
Contract	2	1	1	42%
Total	432	71	361	16%



Left-to-Right: Dessi Mladenova, David Simon, Melissa Manzo, Anthony Villa, Rebecca Spears, Susan Goodman, Kimberley Matthews, Christine Foschaar, Keiko Monahan, Tor Hargens, Kathleen Mansell, Diana Johnson, Emma Gomez, Chris Ribeiro, Christie Boyer

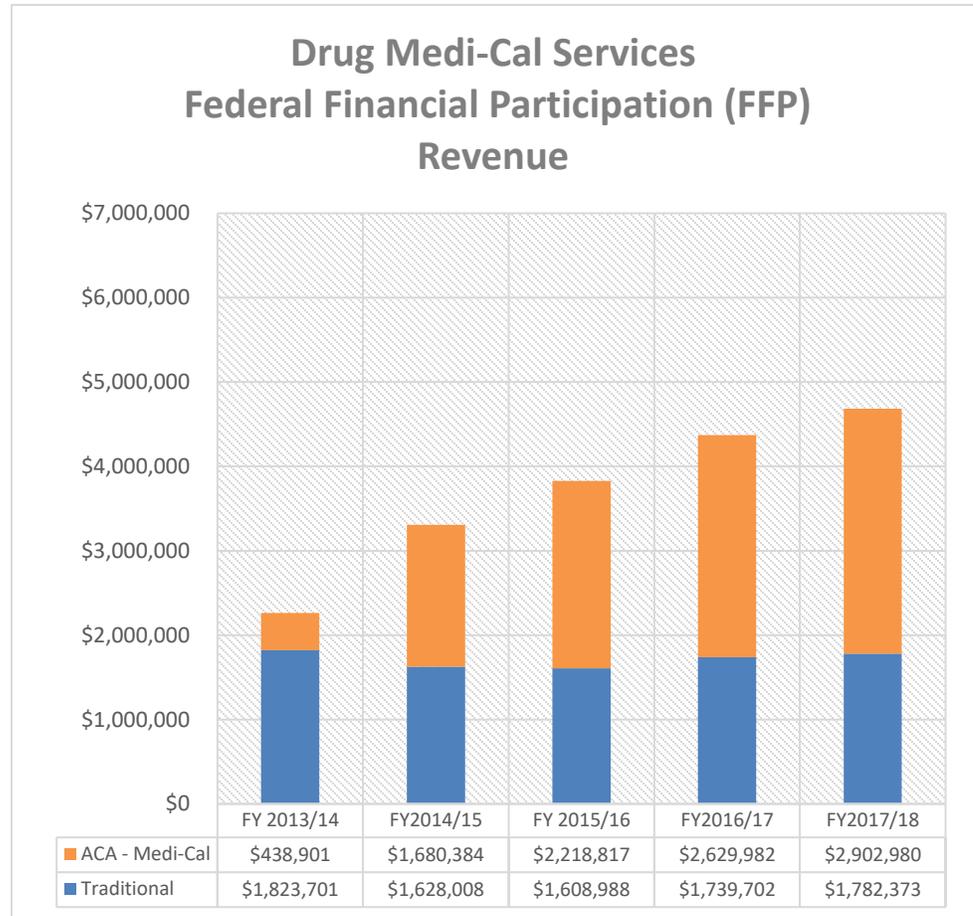
Within Mental Health Medi-Cal-funded programs, revenue from services provided to clients enrolled in the Affordable Care Act (ACA) Medicaid Expansion has increased significantly each year since the inception of this coverage on January 1, 2014. In FY 2017-18 Medi-Cal revenues from clients covered by ACA Medi-Cal increased by 33.5% as compared to FY 2016-17. Medi-Cal revenues from clients covered by Traditional Medi-Cal increased by 13.1% in FY 2017-18 as compared to FY 2016-17. ACA Medi-Cal revenue made up \$7.4M (27%) of the total FY 2017-18 Medi-Cal revenue \$27.1M.

Table 2: MH Medi-Cal Services FFP Revenue



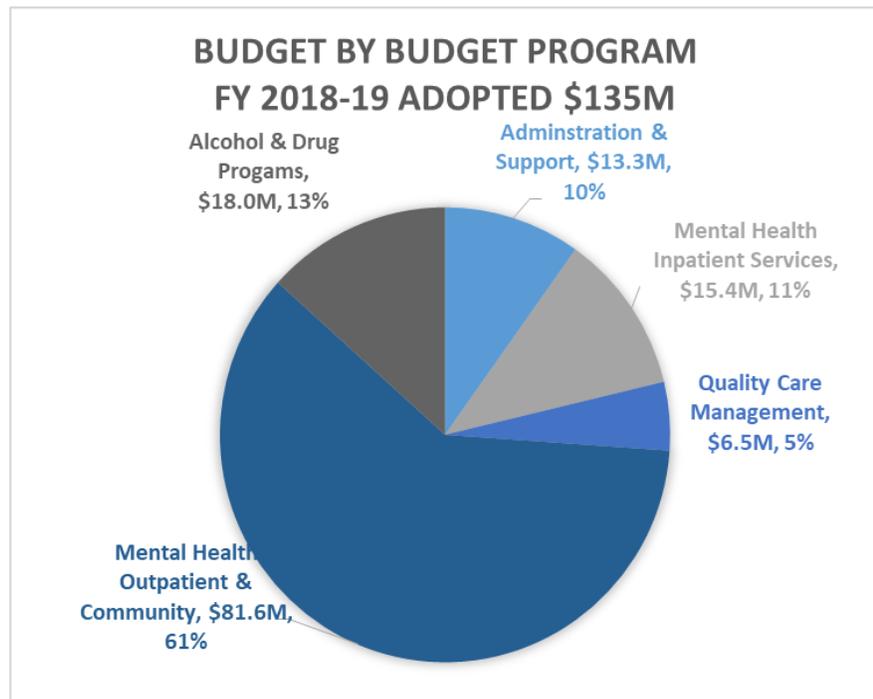
Within Drug Medi-Cal (DMC) funded programs for Alcohol and Drug treatment, revenue for clients newly enrolled due to ACA has increased significantly each year, while revenue from clients covered by Traditional Medi-Cal has remained flat. Overall DMC revenue increased by \$315k (7%) in FY 2017-18 as compared to FY 2016-17. ACA Medi-Cal revenue made up \$2.9M, or 62% of the almost \$4.7M FFP revenue collected in FY 2017-18. This is an increase of \$273k (10%), over FY 2016-17.

Table 3: Drug Medi-Cal Services FFP Revenue



Current and Future Efforts

- ✓ Implement a fiscal plan for the Organized Delivery System (ODS) that includes rates developed to provide for full cost recovery for all Drug Medi-Cal services.
- ✓ Crisis Triage Teams: Grant funding through June 2018; development of sustainable model underway, to be implemented with FY 2018-19 Budget.
- ✓ Long Term Institute for Mental Disease (IMD) Costs continue to be an area of significant concern. Expenditures have increased by over 500% in the last five years (thru FY 2016-17) and continue to rise. The Department continues to explore alternative service models to leverage additional funding and improve efficiencies to mitigate fiscal impact of continued rising IMD service demands.
- ✓ Forensic MHRC, \$2.6M (funded in CCP Budget) to provide secure MH treatment for justice involved clients. Potential sites are being reviewed for this program.
- ✓ Crisis Residential Treatment Program-Santa Maria, \$1.1M Grant funded renovation for a 10 bed step down facility for 30 days post crisis/hospital discharge. Projected start of FY 18-19.



Santa Barbara County Department of Behavioral Wellness

Annual Data Report FY 2017/18

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Shereen Khatapoush, PhD

Jelena Pavlov, MA



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

February 2019

Santa Barbara County Department of Behavioral Wellness

The Santa Barbara County Department of Behavioral Wellness aims to continuously improve programs, practices and policies. We recognize that we cannot improve what we do not measure; it is, therefore, important to thoughtfully collect and analyze data. As a part of our larger system change efforts, we are working to change our culture to be more data-driven, in order to make better decisions (such as adjusting practices or altering resource allocation) and to increase our impact and effectiveness. Efforts to become more data driven, including this report, reflect our commitment to accountable stewardship of public resources, to continuous evaluation and improvement and, most importantly, to delivering on our mission, our vision and values.

In February 2016, the Board of Supervisors approved the Semi-Annual Metrics Report, which includes specific, thoughtfully chosen measures. This annual report for fiscal year 2017/2018 includes all of those key performance measures, as well as a few other analyses and provides data on: Who was served and where; data on our crisis and inpatient services; access to and timeliness of services; child and adult outcomes, including client satisfaction and system performance, as well as comparisons to the previous fiscal year. Many of these variables are also required data elements that the Department reports to the California Department of Health Care Services.

Client Demographics

In fiscal year 17/18, the Department served over thirteen thousand unique clients; a 5% decrease in total clients from last fiscal year. The Mental Health (MH) System served twice as many unique clients as the

Understanding Key Terms: “Unique Clients” vs. “Program Admissions”

Clients and services may be counted in different ways.

- A **unique client** is a single, unduplicated person. They may be unique to the system, or unique to the program.
- A **program admission** is counted each time a client is opened to a new program or service.
 - Ex: A client is open in an outpatient clinic, has one mobile crisis encounter, and has one inpatient hospital stay. She has three program admissions.
 - Ex: A client is in outpatient services, discharges, and then later returns to outpatient services in the same fiscal year. He has two program admissions.

Alcohol and Drug Program (ADP; about 9,100 in MH and 4,300 in ADP).

By Age Group

While the number of clients served by ADP were similar to last year, MH saw a 6% increase in children and 10% decrease in adults served. Both MH and ADP served more adults, but MH served a greater proportion of youth (34% in MH and 9% in ADP).

	ADP			MH			TOTAL**
	Child	Adult	Total Unique*	Child	Adult	Total Unique*	
FY 16 / 17	376	4,075	4,453	2,953	6,628	9,600	14,053
FY 17 / 18	367	3,932	4,300	3,127	5,957	9,100	13,400
% Change	-2.4%	-3.5%	-3.4%	5.9%	-10.1%	-5.2%	-4.6%

*Note. Clients missing date of birth were included in total but not classified as adult or child.

**Note. If a client was open to both ADP and MH, they are duplicated (not all unique clients) in this total count.

By Region

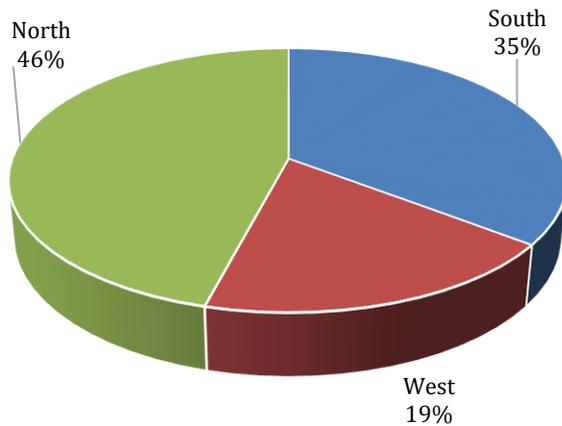
The table below displays the number of unduplicated clients that each region served via at least one program admission in the fiscal year. A client may be counted in multiple regions. For example, if a client is seen by mobile crisis in North County and then admitted to the PHF in South County, they are admitted to both programs and consequently counted in both counties. South, West, and Out of County (O of C) served fewer clients than last year, while North County served 7% more clients in MH and 6% more in ADP. By far the greatest difference was in out of county mental health clients, which had a 43% reduction in unique clients from last year. This is in large part due to the closing of the Vista del Mar psychiatric hospital from the Thomas Fire.

Unique Clients by Region 2017/18

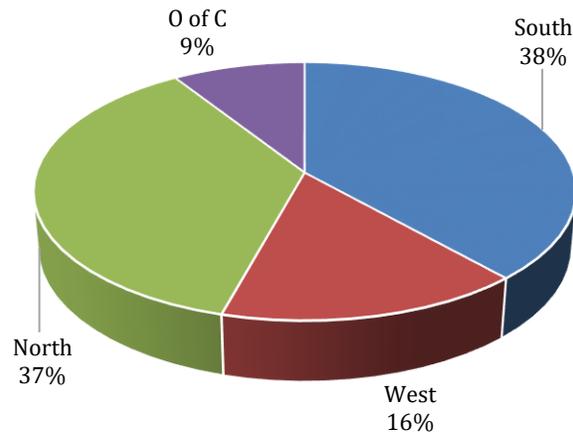
	ADP				MH			
	South	West	North	O of C	South	West	North	O of C
FY 16 / 17	1800	887	1932	0	4647	1762	3685	1727
FY 17 / 18	1576	835	2045	0	4132	1714	3943	980
% Change	-12.4%	-5.9%	5.8%	--	-11.1%	-2.7%	7.0%	-43.3%

While there were no ADP clients served out of county (O of C), nine percent of MH clients were served out of county (primarily inpatient services). Similar proportions of mental health clients were served in North (37%) and South (38%) County, while in ADP, North County served the largest proportion of clients (46%).

**ADP Unique Clients
FY 17/18**



**MH Unique Clients
FY 17/18**



Alcohol & Drug Programs (ADP)

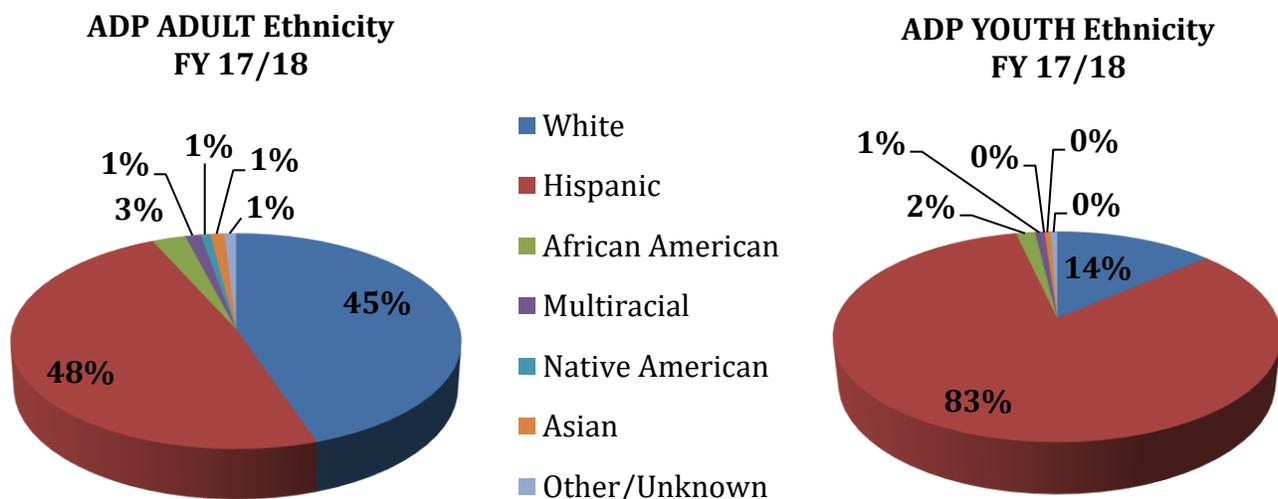
In FY 2017/18, **4,300 unique clients** were open to ADP: 91% adults and 9% youth. Among both adults and youth, just about two-thirds of ADP clients were male.

	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	N
ADP - Unique Clients							
Male	2,779	65%	2,533	64%	246	67%	*
Female	1,515	35%	1,394	35%	121	33%	*
Missing/Other	*	0%	*	0%	*	0%	*
Total	4,300		3,932	91.44%	367	8.53%	1
Race/Ethnicity							
White	1,811	42%	1,761	45%	50	14%	*
Hispanic	2,210	51%	1,906	48%	304	83%	*
African American	112	3%	106	3%	*	2%	*
Multiracial	51	1%	48	1%	*	1%	*
Native American	30	1%	30	1%	*	0%	*
Asian**	46	1%	44	1%	*	1%	*
Other/Unknown**	40	1%	37	1%	*	1%	*
Total	4,300		3932		367		1

*Number not included due to small sample size

**Note. Combined small sample sizes into a larger ethnic group for protection of client privacy

Over half (51%) of all APD clients served were Hispanic and 42% were White. Whereas among adult ADP clients ethnicity was more equally divided between Whites (45%) and Hispanics (48%), this was not the case among ADP youth: 83% were Hispanic and 14% were White. The adult and youth ADP system of care served proportionally dissimilar ethnic populations.



Mental Health System

In FY 2017/18, **9,100 unique clients** were open to the Mental Health System: Two-thirds were adults (5,957; 66%) and one-third were youth (3,127; 34%). Half (50%) of all Mental Health clients were male.

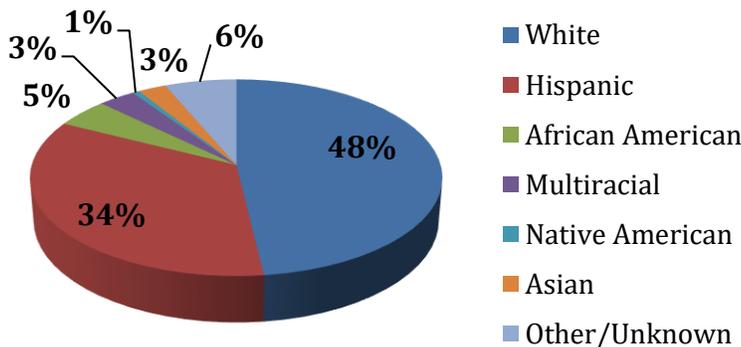
Mental Health - Unique Clients	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	N
Male	4,556	50%	2,960	50%	1,590	51%	*
Female	4,464	49%	2,950	50%	1,509	48%	*
Missing/Other	80	1%	47	1%	28	1%	*
<i>Total</i>	9,100		5,957		3,127		16
Race/Ethnicity							
White	3,465	38%	2,867	48%	594	19%	*
Hispanic	4,138	45%	2,045	34%	2,092	67%	*
African American	345	4%	283	5%	62	2%	*
Multiracial	262	3%	196	3%	66	2%	*
Native American	43	0%	37	1%	*	0%	*
Asian**	165	2%	149	3%	16	1%	*
Other/Unknown**	682	7%	380	6%	291	9%	11
<i>Total</i>	9,100		5,957		3,127		16

*Number not included due to small sample size

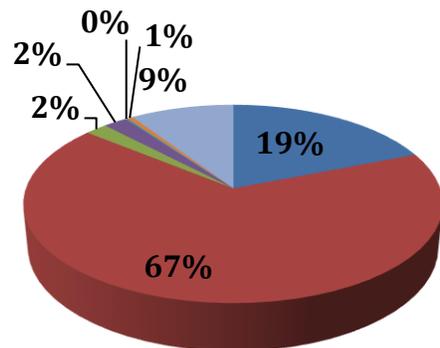
**Note. Combined small sample sizes into a larger ethnic group for protection of client privacy

The ethnicity of MH clients differed by age group: 48% of adults were White and 34% were Hispanic; 19% of youth MH clients were White and 67% were Hispanic. Consistent with the population served by ADP, the adult and youth MH systems of care served proportionally dissimilar ethnic populations.

**MH ADULT Client Ethnicity
FY 17/18**



**MH YOUTH Client Ethnicity
FY 17/18**

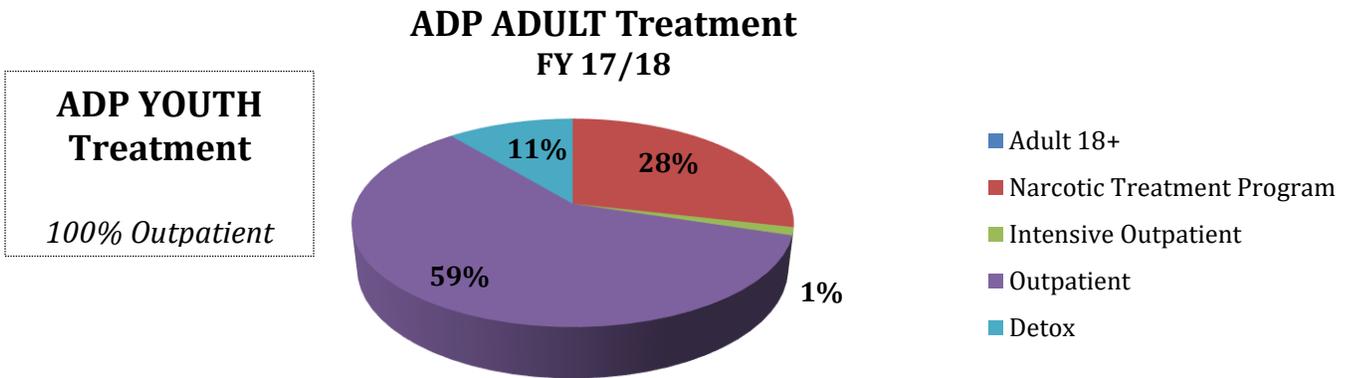


Client Service Settings

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 limited in-County capacity (in number or kind), some clients are served at 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 clinic and might receive additional services from a crisis team or a partner organization in the community.

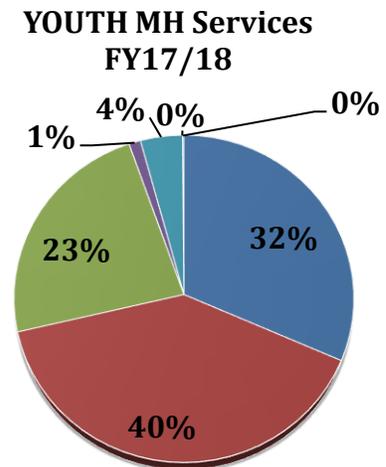
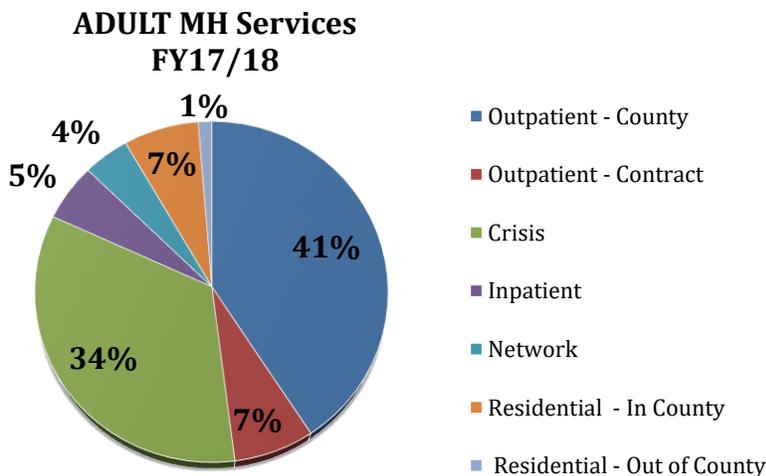
Alcohol & Drug Programs (ADP)

Behavioral Wellness contracts with community based organizations to deliver alcohol and other drug prevention and treatment services. Nearly all adult substance abuse treatment services are provided in outpatient settings, almost a third (28%) of which are outpatient Narcotic Treatment Program (methadone) services. Twelve percent (12%) are social model detoxification services. Finally, all youth substance abuse treatment services are provided in outpatient settings.

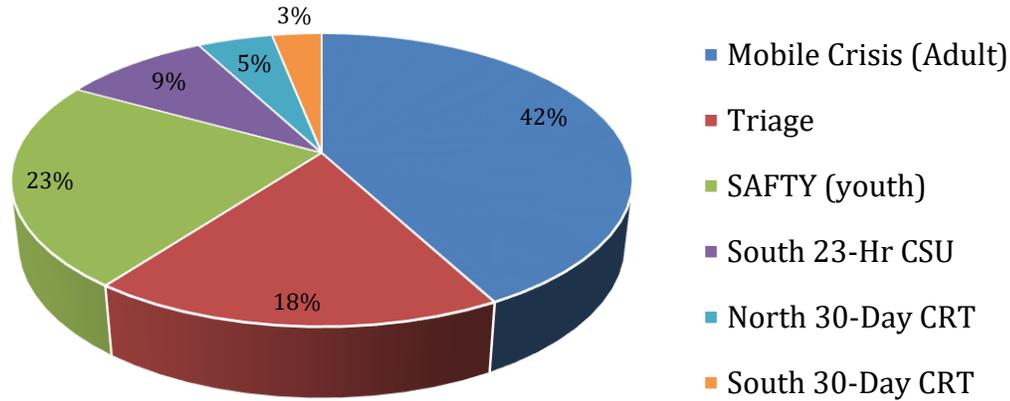


Mental Health System

As seen in the pie charts below, 41% of mental health services for adults and 32% for youth are delivered by the county, in outpatient settings. There are few (7%) contracted outpatient services for adults, while 40% of all youth services are provided by contracted outpatient providers. While the proportion of services adults received from the county and from contracted providers was similar in FY 16/17 and FY 17/18, youth experienced a change in proportion. In FY 16/17, 41% of child services were delivered by county and 31% by contract agencies. In FY 17/18 there was a 9% shift in outpatient services from county to contracted providers.



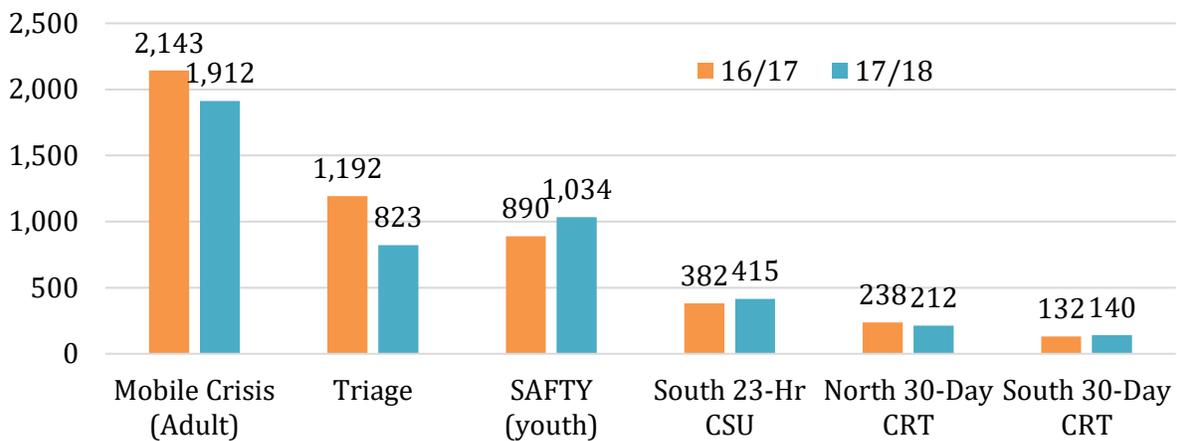
Clients Served, Crisis Services FY 17/18



Mobile crisis, which serves adults, served the greatest number of clients (42%). While it served fewer clients than last year, it remained the most frequently used crisis service; this is consistent with last year. SAFTY is the youth program equivalent to mobile crisis, and its use increased from last fiscal year (see below) despite other crisis services experiencing decreased use. Across crisis programs, clients were served in similar proportions as last year except in use of SAFTY and Triage: the proportion of total clients served by SAFTY increased, while clients served by Triage decreased (depicted below).

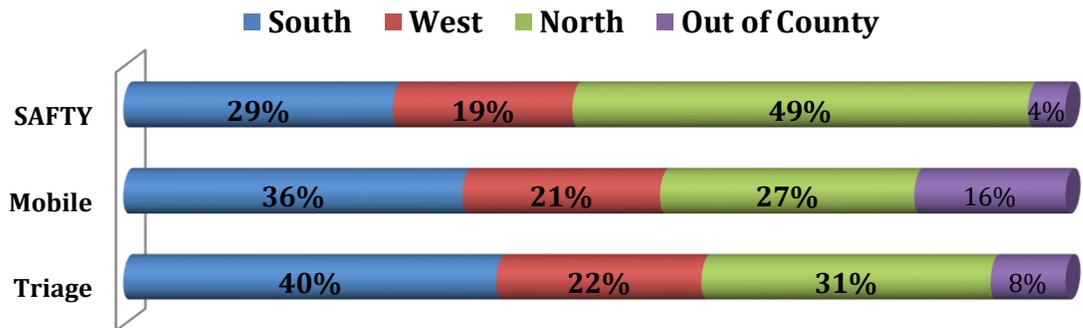
There are several factors that likely contributed to this decline for Triage, including a gradual scaling-down of services in anticipation of the ending of the program at the end of the fiscal year. Additionally, the Thomas fire and mudslides resulted in some clients leaving town, while others likely received more support when services were expanded in response to the disasters. In regards to the increase in SAFTY clients, there was an increase in deaths and traumatic response support within some school districts which contributed to an increase in SAFTY use. Schools also started universal screenings. Schools also started universal screenings. Collaboration with law enforcement has also resulted in reduced reliance on mobile crisis.

Clients Served by Crisis Services FY 16/17 and 17/18



There were some regional differences in clients served by each crisis service (see below). Between 4-16% of clients served by crisis services were out of county residents (often transient individuals or students), with the largest portion being served by mobile crisis. About half of SAFTY’s services were provided to North County residents, which is consistent with the larger proportion of child clients in North County. Conversely, the largest portion of clients seen by mobile crisis (36%) and triage (40%) were residents of South County.

Services by Client Region of Residence FY 17/18



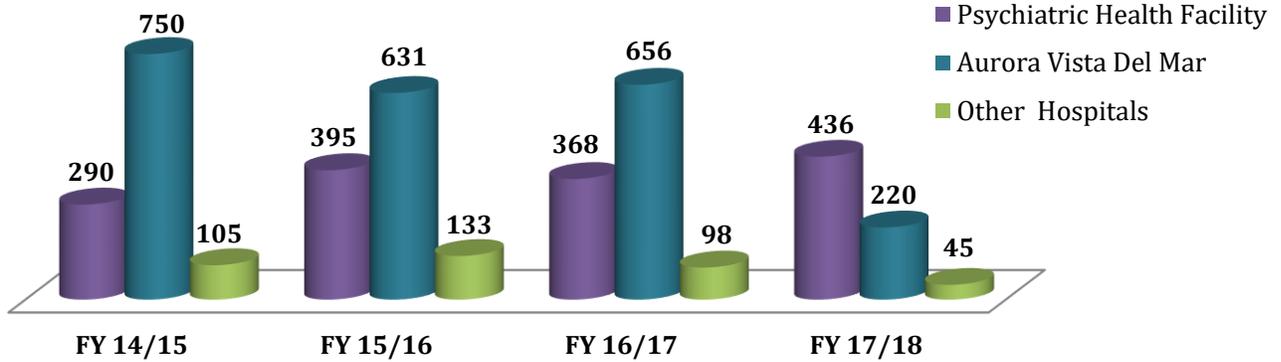
Crisis programs continued to be successful in stabilizing clients and preventing hospitalizations:

- ✓ **98%** of clients served by the **Crisis Stabilization Unit** were stabilized (did not need hospitalization) within 24 hours of CSU service.
- ✓ **92%** of clients discharged from the **Crisis Stabilization Unit** remained stabilized (did not need hospitalization) within 30 days of discharge. This is an increase of 6% from last year.
- ✓ **92%** of clients served by the **Crisis Residential Treatment (CRT)** Programs were stabilized (did not need hospitalization) within 30 days of discharge. This is an increase of 7% from last fiscal year.

Inpatient Utilization

Behavioral Wellness monitors inpatient services closely in order to assess and address utilization, client care and fiscal impact. The department routinely tracks: the number of inpatient psychiatric hospital admissions 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 were steadily increasing for several years, much of which was attributed to increased court-mandated defendants who were declared “incompetent to stand trial”.

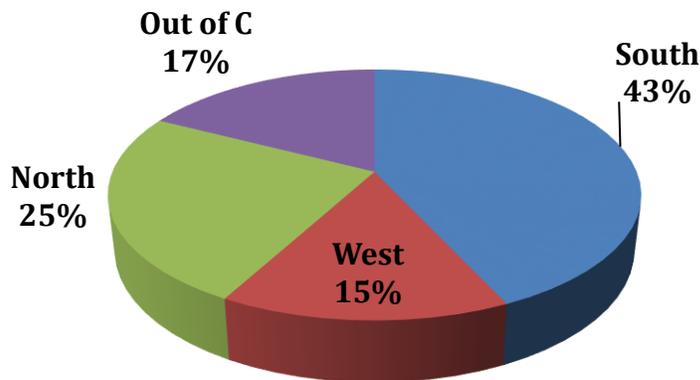
Psychiatric Hospital Admissions



Following three years of consistently having 1,100-1,200 psychiatric hospital admissions, in FY 17/18, there were 701 psychiatric hospital admissions, a reduction of 38%. This reduction is consistent with the reduction in crisis services. It should be noted that in December 2017, Vista Del Mar lost two buildings in the Thomas Fire. This meant that after December 2017, clients who would have gone to Vista Del Mar were either treated at the PHF or other psychiatric hospitals, or may have accessed a different level of care in lieu of hospitalization.

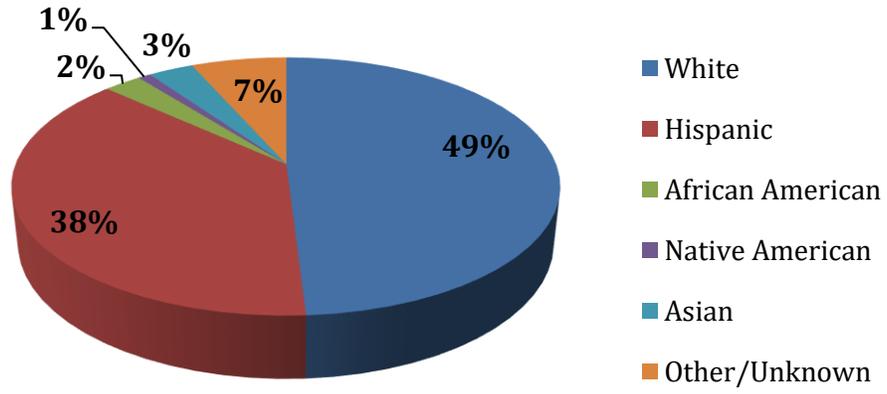
The largest percentage (43%) of clients hospitalized lived in South County. Most (69%) were adults aged 26-64, followed by another 24% that were TAY (16-25); only 5% were under 15 and 2% over 65 years of age.

Clients Hospitalized by Region of Residence FY 17/18



About half (49%) of hospitalized clients were White and just over a third (38%) were Hispanic. These demographics are similar to last year.

**Clients Hospitalized by Ethnicity
FY 17/18**



Timeliness of Care

In adherence with regulatory requirements, and to support system improvement efforts, Behavioral Wellness monitors numerous metrics related to timeliness of care. Ensuring that clients discharged from hospitals, for example, 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 *crisis* or *urgent*, can help stabilize clients, meet their mental health needs and aid in avoiding hospitalization.

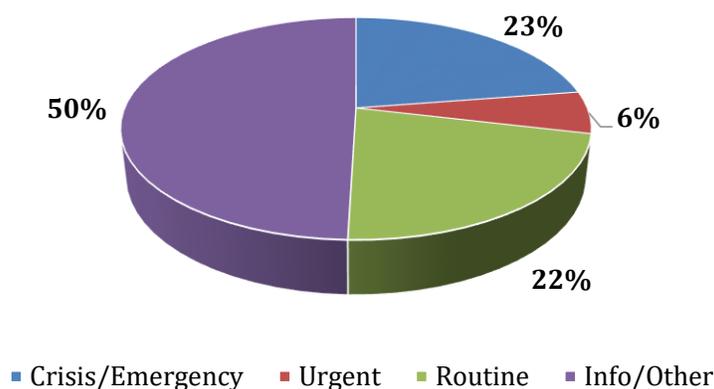
Access

In FY15/16, the Department recognized the opportunity to improve the functioning of the Access line and the specificity of data collection. The electronic data collection form was revamped and improved and in October of 2016, Access staffing was centralized within Quality Care Management (QCM). Access calls/entries are categorized as follows:

- **Crisis** calls/clients: Those who are at immediate risk of hospitalization (because they pose a danger to themselves or another).
- **Urgent** calls/clients: Those who, without assistance, would likely need inpatient hospitalization within 24 hours.
- **Routine** calls/clients: Those who are neither crisis nor urgent, but rather are seeking outpatient services. Callers typically received an assessment on the phone and are given an appointment with an appropriate clinic.
- **Information/Other** calls/clients: Those seeking information about services or referrals but not seeking an intake.

In FY 17/18, there were 8,910 total call/entries, an average of 743 calls per month. Last fiscal year, there were an average of 603 calls per month, so this represents a 23% increase in calls per month. Half of all calls were to request information or “other”. Nearly one-quarter of all calls were classified as crisis/emergencies, while urgent calls comprised 6% of the total calls. Finally, routine calls were 22%.

Access Calls by Type
FY 17/18 (n = 8,910)



Timeliness, from contact with the 24-hour Access Line to services, serves as a critical set of metrics for the Department. It is important to note that the Access Line structure, staffing and data collection tools changed in October 2016, and that the State changed reporting requirements and regulations. Therefore, this year's data is only comparable to data collected after October 2016.

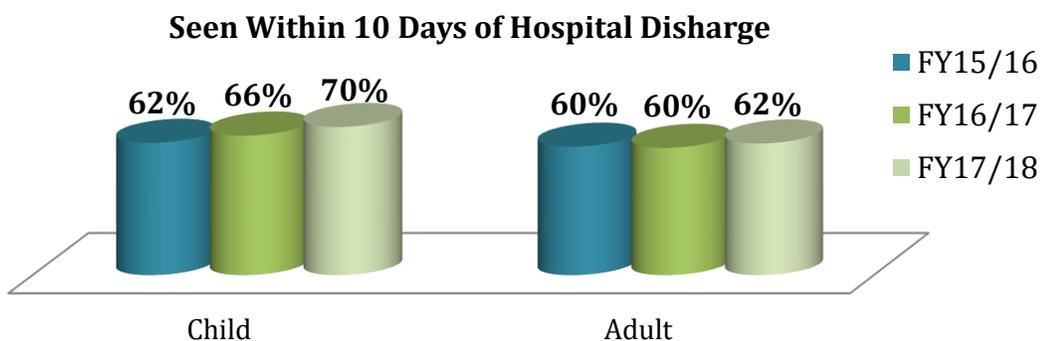
The Access data reflect the challenges of implementing system changes, and as we would expect, improved throughout the year, as is evident below. It is expected that these indicators will continue to improve as the Department further refines data collection tools and processes.

Access		Q1	Q2	Q3	Q4
Routine	offered an appointment within 14 days	87%	73%	79%	78%
Urgent	offered an appointment within 24 hours	72%	84%	91%	90%
Crisis	offered an appointment within 24 hours	86%	98%	98%	98%

Hospital Discharge - Aftercare

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. As can be seen below, the percentage of clients that have their first SMHS within 10 days, has remained relatively stable. Changes from year to year have been small (under 5%) for both children and adults

In FY 17/18, the average time from PHF discharge to an outpatient appointment was 3.6 days.



Psychiatry

Due to limited resources, psychiatric appointments must be prioritized. For example, adults with urgent medication needs are seen more quickly than routine appointments. Similarly, youth with urgent needs are scheduled with a psychiatrist after an assessment, whereas others might have several therapeutic sessions before they are referred to a psychiatrist (and some may never need to see a psychiatrist). From the point of referral to psychiatry:

- On average, **71%** of clients were **offered** an appointment with a **Psychiatrist/MD within 15 days**; 76% of adults, and 65% of youth. This is an increase of 6% from last year.
- On average, **76%** of clients **attended** their **psychiatric/MD appointment within 15 days**; 77% of adults, and 74% of youth. This is an increase of 6% from last year.
- The **average wait time to Psychiatry/MD is improving**: it was **18 days**, compared to an average wait time of 28 days in 16/17 and 38 days in 15/16. This represents a **35% reduction** from FY 16/17 and **53% reduction** since FY 15/16.

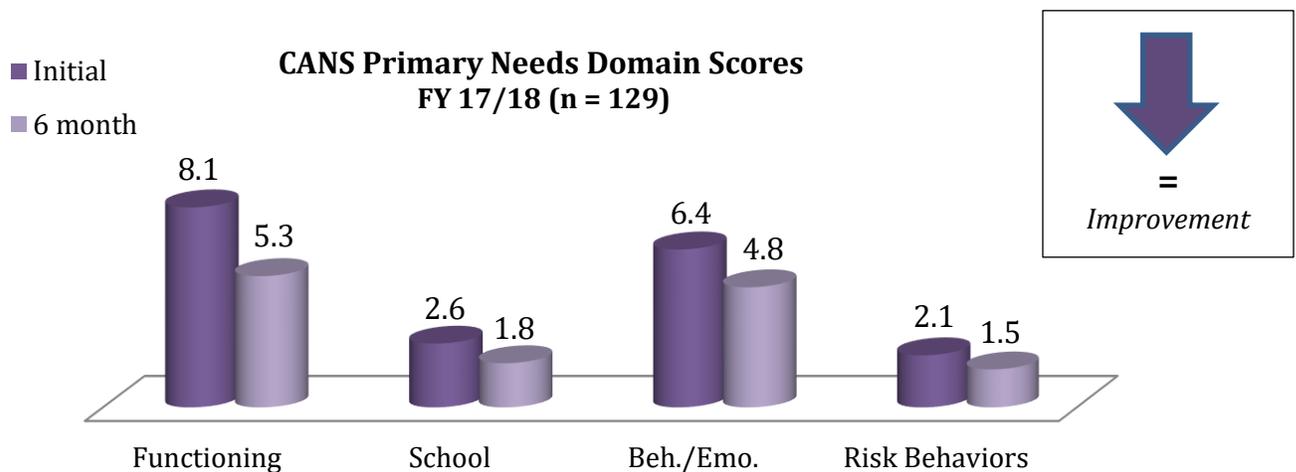
Child Outcomes

Child and Adolescent Needs and Strengths (CANS)

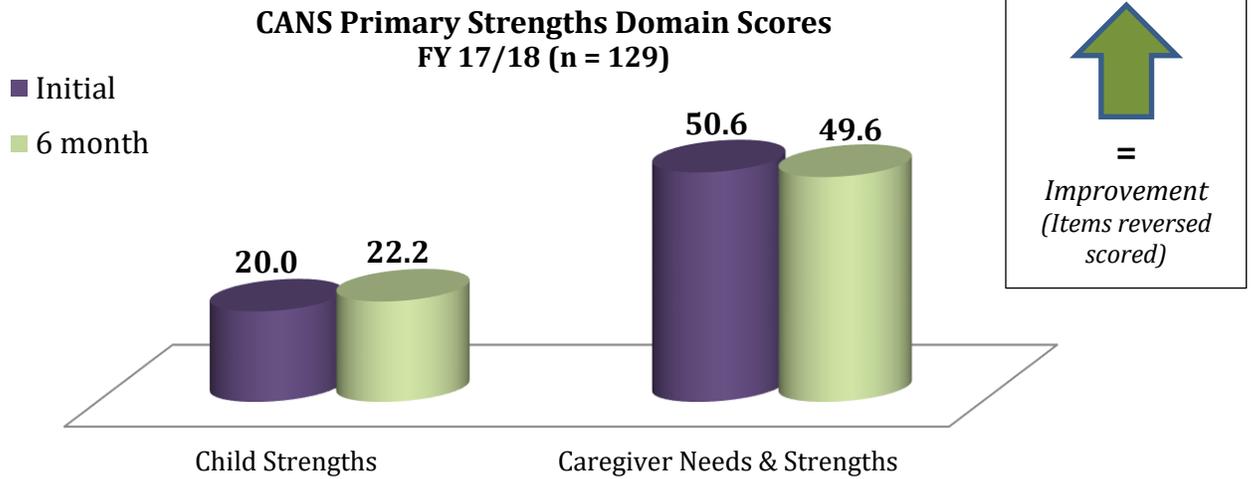
The CANS is a multi-purpose tool developed for children’s service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. The CANS is scored from zero (no evidence of a problem/well developed strength) to three (immediate or intensive action needed/no strength identified). Therefore, improvement on the CANS is indicated by a decrease in scores. The CANS is organized into six primary domains: 1) Life Functioning, 2) Risk Behaviors, 3) Child Strengths, 4) School, 5) Behavioral/Emotional Needs, and 6) Caregiver Needs & Strengths.

These analyses include clients who had their initial CANS in FY 17/18 (N=129) so that we could assess problems and functioning concerns prior to receiving treatment, and changes in these same areas after receiving services. The CANS is also administered at 6 and 12 months in treatment, but the number of clients who have all three data points is much lower. Therefore, only clients with at least two data points (initial and 6 months) are displayed. A reduction in the average scores on all four “primary needs” domains indicates that children have made progress in treatment and reduced the severity of their needs, distress and challenges.

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



Responses to the items in the Child Strengths and Caregiver Needs & Strengths domains were reverse scored to demonstrate improvement over time. **Child Strengths** such as optimism, relationship permanence, talents/interests, and involvement in treatment, **improved slightly** over time. **Caregiver Needs & Strengths** such as child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status, remained relatively stable over 6 months.

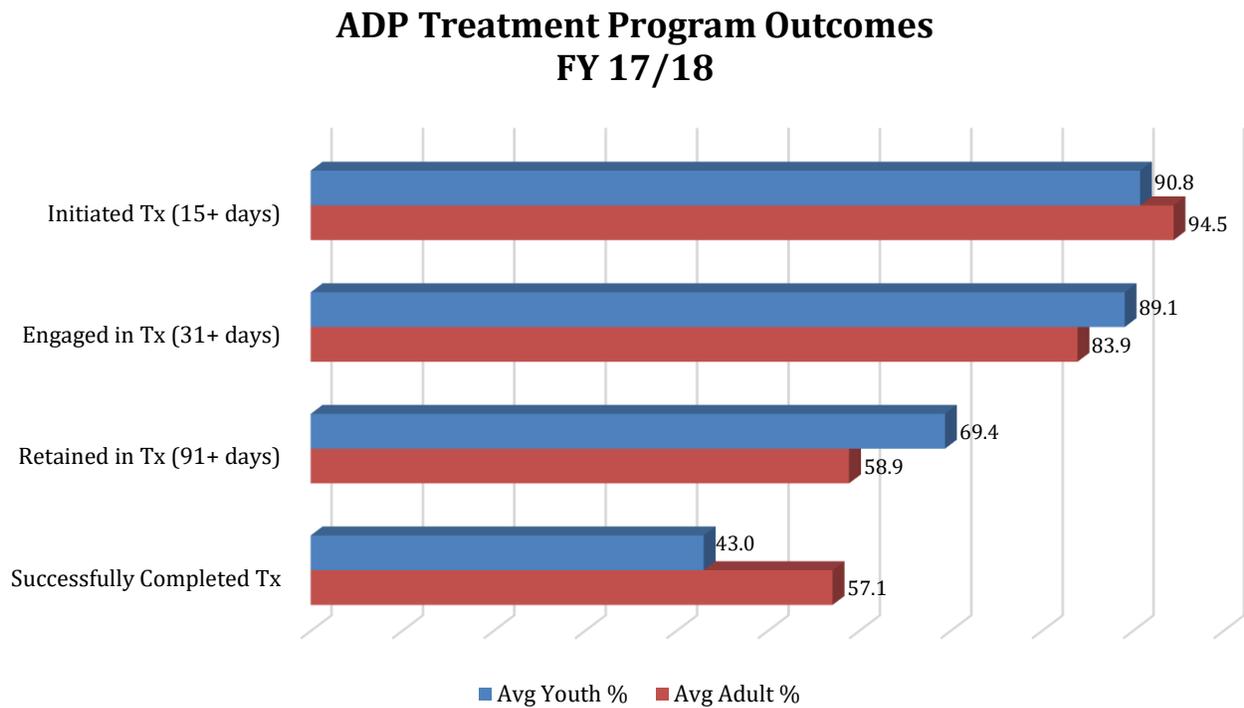


Adult Outcomes

ADP

Client Involvement

“Initiation” in treatment is defined as more than two weeks of treatment services; “Engagement” as more than one month and “Retained” as more than three months in treatment. “Successful Completion” of treatment includes completing treatment, with or without being referred to another program. Successful “completion” can include leaving before treatment completion, if satisfactory progress was being made. Note: all ADP services are delivered by community-based organizations (not civil service staff).



Mental Health System

Milestones of Recovery Scale (MORS)

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

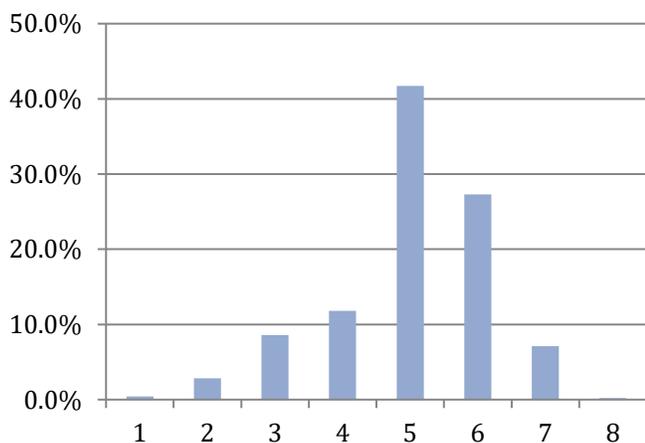
Risk/Need	MORS Scale
Highest	1 Extreme Risk
	2 High Risk / Not Engaged
	3 High Risk / Engaged
Moderate	4 Poorly Coping / Not Engaged
	5 Poorly Coping / Engaged
Least	6 Coping / Rehabilitating
	7 Early Recovery
	8 Advanced Recovery

Improvement on the MORS (higher number) indicates that clients have increased their level of engagement, coping skills and stage of recovery. Decreased scores indicate that clients have not improved and are less engaged (at increased risk). Results of MORS data analyses are reported here, separately, for Transitional Age Youth (TAY) programs, Adult Outpatient and Assertive Community Treatment (ACT). TAY and adult outpatient MORS are administered every 6 months, while adult FP/ACT clients are administered monthly. These analyses include clients with open admissions in FY 2017/18, who had an intake/baseline MORS as well as MORS scores at 6 and 12-months.

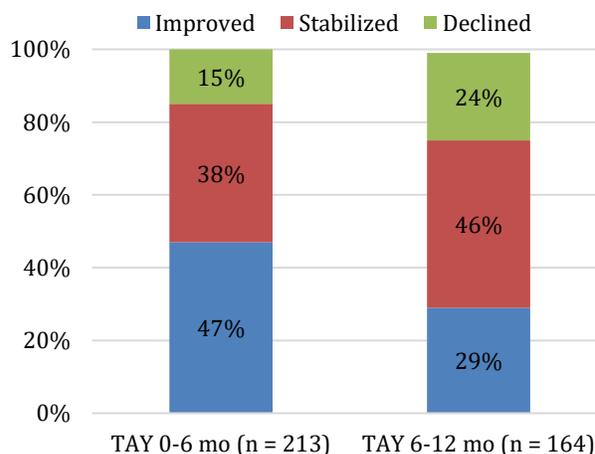
Transitional Age Youth Programs

Of all open TAY (N=317), 89% had a baseline MORS score (N=282). Of those, two-thirds (66%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 47% improved, 38% stabilized (no change in score), and 15% declined in functioning (N = 213). Between 6 and 12 months, 29% improved, 46% stabilized, and 24% of clients declined (N = 164). Thus, in the first six months of treatment, 85% of TAY improved or stabilized, and in the next six months of treatment, 75% improved or stabilized. These results are similar to FY 16/17.

TAY Baseline MORS



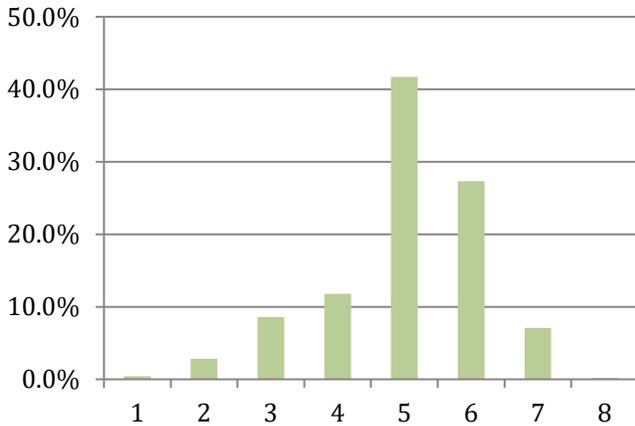
TAY MORS Change



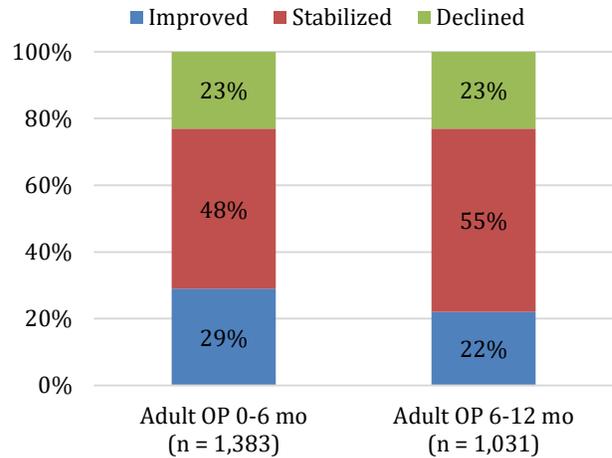
Adult Outpatient Programs

Of all open adult outpatient clients (N=2,593), 70% had a baseline MORS score (N=1,805). Of those, the majority (69%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 29% improved, 48% stabilized (no change in score), and 23% declined in functioning (N = 1,383). Between 6 and 12 months, 22% improved, 55% stabilized, and 23% of clients declined (N = 1,031). Thus, in the first six months of treatment, 77% of adult outpatient clients improved or stabilized, and in the next six months of treatment, 77% improved or stabilized. These results are similar to FY 16/17.

Adult OP Baseline MORS



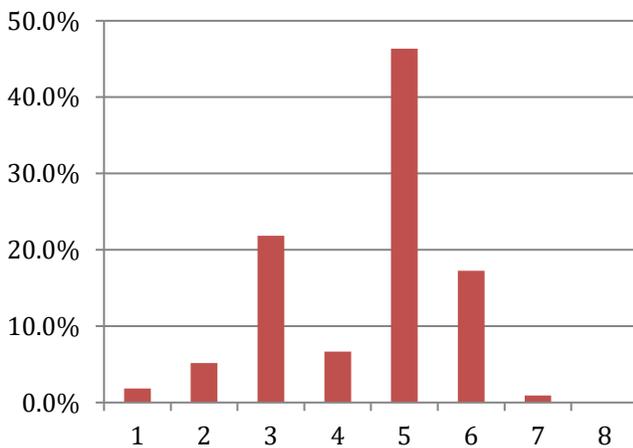
Adult OP MORS Change



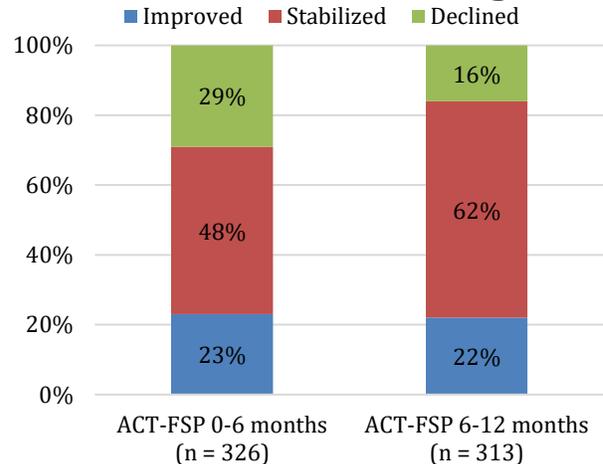
Assertive Community Treatment Programs

Of all open Assertive Community Treatment (ACT) program clients (N=337) 99% had a baseline MORS score (N=334). As we might expect, the vast majority (75%) had a baseline MORS score of three to five, lower than TAY and other adult outpatient clients. Between baseline and 6 months, 23% improved, 48% stabilized (no change in score), and 29% declined in functioning (N = 326). Between 6 and 12 months, 22% improved, 62% stabilized, and 16% of clients declined (N = 313). Thus, in the first six months of treatment, 71% of ACT clients improved or stabilized, and in the next six months of treatment, 84% improved or stabilized. These results are similar to FY 16/17.

ACT-FSP Baseline MORS



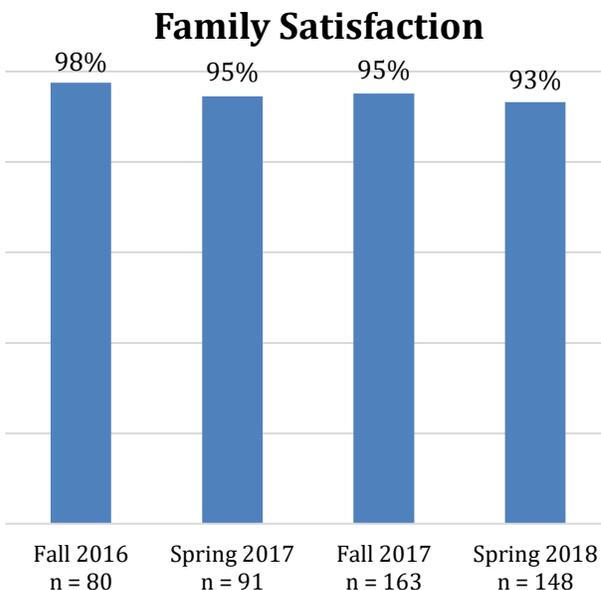
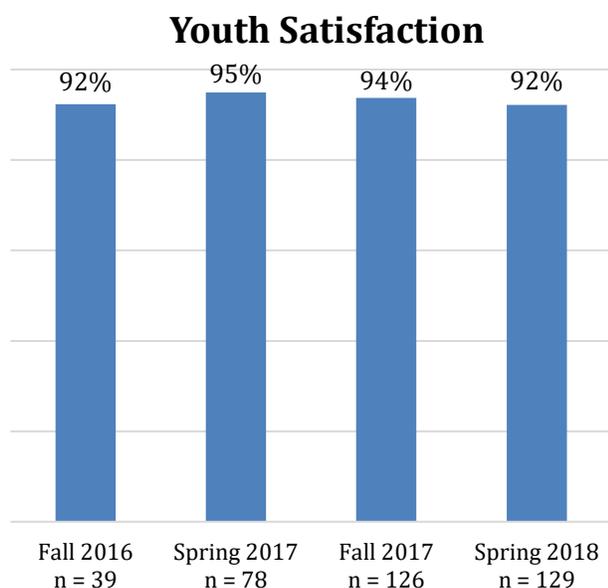
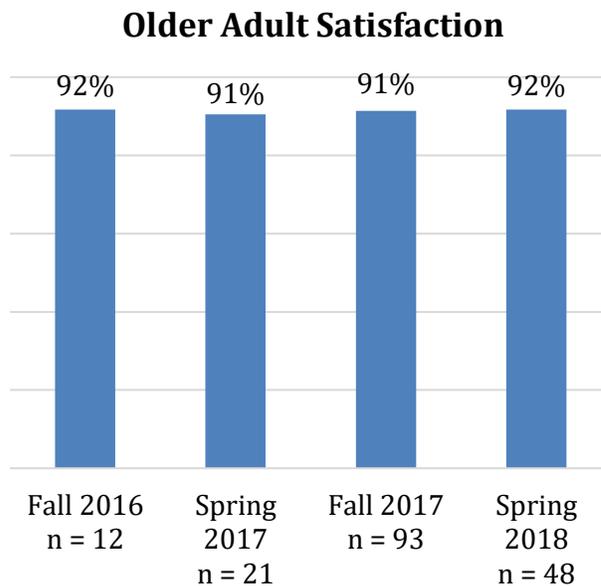
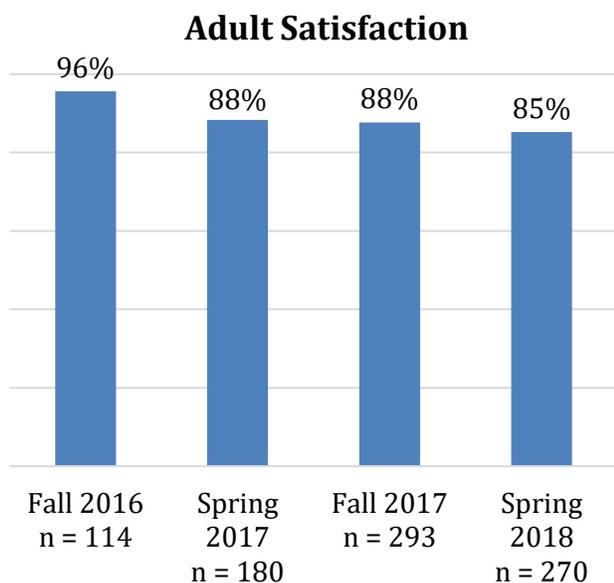
ACT-FSP MORS Change



CPS – Client Satisfaction

The Consumer Perception Survey is administered to a sample of outpatient mental health (not ADP) clients in May and November of every year, including clients served in County operated programs and those served by our community based partners. There are separate, but similar, surveys given to adults, older adults, youth, and parents/guardians. Clients report on their satisfaction with services. The graphs below indicate the percent of clients who **agree to strongly agree** that, “Overall, I am satisfied with the services I/my child received,” or “I like the services that I receive here”.

Satisfaction was quite high over the past two years, and the number of clients who complete the survey increased significantly in FY 17/18 from FY 16/17: two to four times as many clients completed surveys in FY 17/18 as did in FY 16/17.



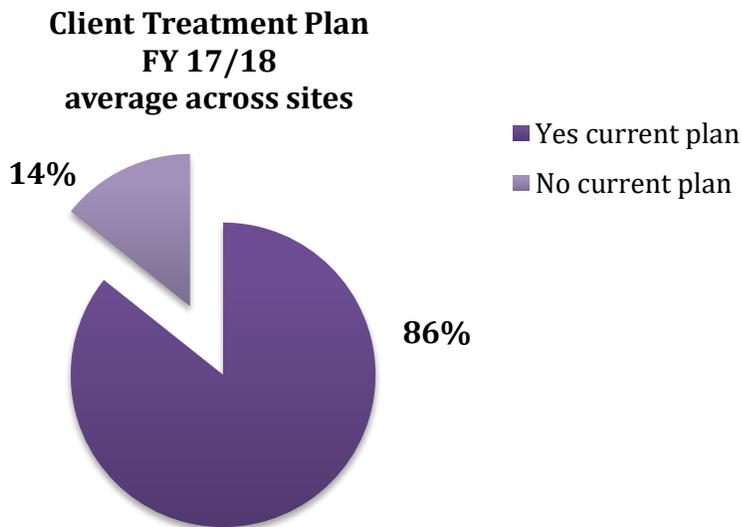
Client Engagement

The Department designed a new report for managers and supervisors in order to help them monitor and support higher levels of client engagement. Data are drawn from employee’s timesheets and the report provides both the number and percentage of hours recorded on different types of activities, such as time spent in trainings, meetings and providing services. The total is the sum of direct and non-direct services, training and meeting hours. The total average documented time for staff of outpatient clinics was 46%; for Crisis/Triage staff, it was 29%. These numbers are similar to last year. Crisis numbers are expected to be lower because their work is responsive to demand, not scheduled, as in outpatient settings. Only finalized notes are included; that is, pending and draft notes are not accounted for in direct services.

	% Meetings & Training	% Client Services	% Total
Outpatient Clinics	12%	34%	46%
Crisis/Triage Services	12%	17%	29%

Current Treatment Plans

An important indicator of our performance as a system is the extent to which we have current clinical treatment/care plans for clients. As part of Quality Improvement (QI) efforts, reports were developed to monitor this indicator, and staff have been using this data to update and complete treatment plans as required. Since implementing these reports and training staff in their use, completion rates have steadily improved.



At the end of the 2016/2017 fiscal year, treatment plans were current for 88% percent of clients. In 2017/18, across sites, 86% of clients had a current treatment plan. It should be noted that this is a “snapshot” from 6/30/2018, and clients with “no current plan” includes clients who may have just had an intake done and are still in the process of assessment. For clients who had their intake appointment less than 60 days ago, their treatment plan may still be in development (and is in compliance with standards of care), yet would be reflected in these numbers as “no current plan.” Therefore, the 14% of clients with no current plan does not mean that these clients necessarily have expired treatment plans.