Santa Barbara County Department of Behavioral Wellness

Semi-Annual Data Report FY 2018/19

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

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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 the first half of fiscal year 18/19, the Department served over nine thousand unique clients; a 7% decrease in total clients from the first half of last fiscal year. The Mental Health (MH) System served more than twice as many unique clients as the Alcohol and Drug Program (ADP; about 6,481 in MH and 2,987 in ADP).

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.

By Age Group

Comparing the first half of FY 18/19 to the first half of FY 17/18, ADP and MH both saw overall reductions of about 7%. While this change was solely accounted for by fewer adults served by ADP, in MH, youth increased by 4% while adults decreased by 12%. Both MH and ADP served more adults, but MH served a greater proportion of youth (35% in MH and 7% in ADP).

	ADP			MH			
Q1 & Q2	**Child**	**Adult**	**Total Unique***	**Child**	**Adult**	**Total Unique***	**TOTAL****
FY 17 / 18	219	2,973	**3,193**	2,179	4,782	**6,970**	**10,163**
FY 18 / 19	219	2,766	**2,987**	2,265	4,212	**6,481**	**9,468**
% Change	**0.0%**	**-7.0%**	**-6.5%**	**3.9%**	**-11.9%**	**-7.0%**	**-6.8%**

**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.*

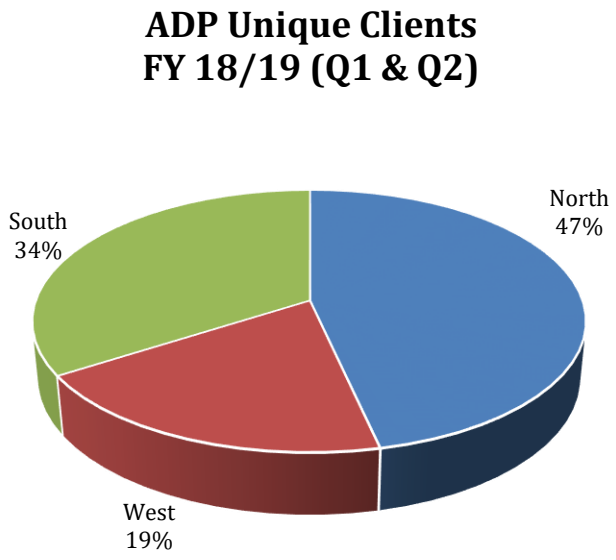
By Region

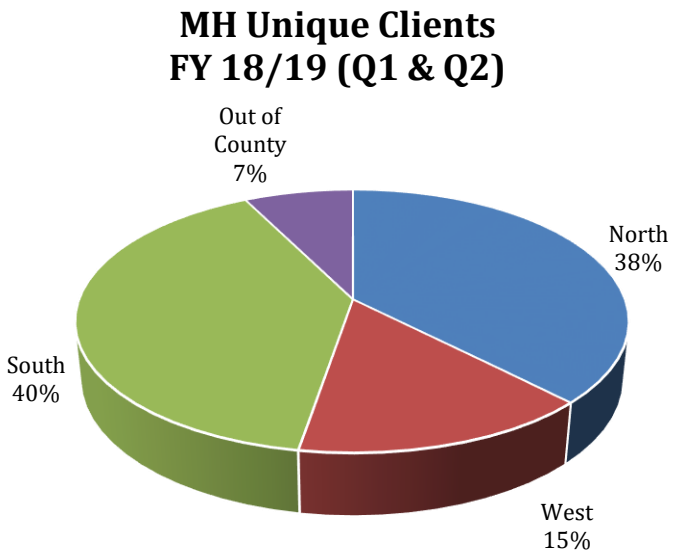
The table below displays the number of unduplicated clients that each region served via at least one program admission in the first half of the fiscal year. A client may be counted in multiple regions. For example, if a client is seen by mobile crisis in North County and then admitted to the PHF in South County, they are admitted to both programs and consequently counted in both regions. Fewer clients were served across all regions and both systems of care. By far the greatest difference was in out of county mental health clients, which had a 24% 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, which did not re-open until mid-October, 2018. During this time, the County's contract with Vista del Mar also ended for adults. Youth are still seen at Vista del Mar. South County Mental Health also saw a 13% reduction in clients from the first half of last fiscal year; this difference was mainly attributable to a reduction in the number of unique outpatient clients (300 fewer clients were open if adding county-provided and contracted outpatient services: 2,138 this year compared to 2,438 last year).

Unique Clients by Region 2018/19 Q1 & Q2

Q1 & Q2	ADP			MH			
	South	West	North	South	West	North	O of C
FY 17 / 18	1,185	558	1,531	3,112	1,283	2,860	896
FY 18 / 19	1,125	540	1,399	2,697	1,230	2,762	683
% Change	**-5.1%**	**-3.2%**	**-8.6%**	**-13.3%**	**-4.1%**	**-3.4%**	**-23.8%**

Similar proportions of mental health clients were served in North (38%) and South (40%) County, while in ADP, North County served the largest proportion of clients (47%). Seven percent of MH clients were served out of county.





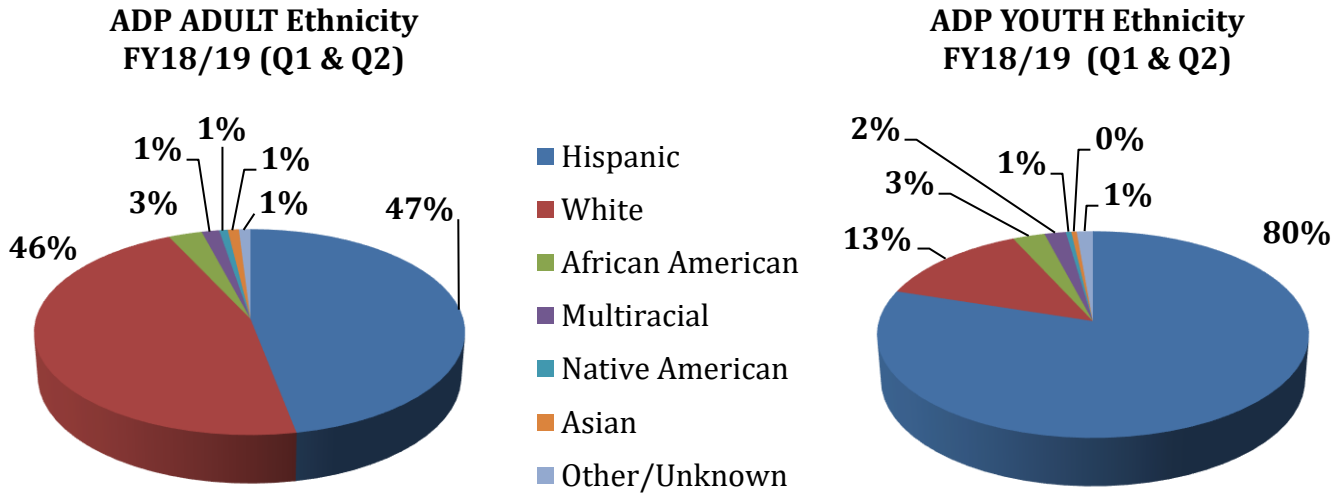
Alcohol & Drug Programs (ADP)

In the first half of FY 2018/19, **2,987 unique clients** were open to ADP: 93% adults and 7% youth. Among both adults and youth, about two–thirds of ADP clients were male. The ratios of age group and client gender are similar to FY 17/18.

	ALL Adult & Youth		Adult		Youth		Missing DOB
ADP - Unique Clients	**N**	**%**	**N**	**%**	**N**	**%**	**N**
Male	1,898	**64%**	1,753	**63%**	145	**66%**	*
Female	1,083	**36%**	1,010	**37%**	73	**33%**	*
Missing/Other	6	**0%**	3	**0%**	1	**0%**	*
Total	*2,987*		*2,766*	*93%*	*219*	*7%*	*2*
Race/Ethnicity							
Hispanic	1,475	**49%**	1,300	**47%**	175	**80%**	*
White	1,302	**44%**	1,273	**46%**	29	**13%**	*
African American	85	**3%**	79	**3%**	6	**3%**	*
Multiracial	45	**2%**	41	**1%**	4	**2%**	*
Native American	21	**1%**	20	**1%**	1	**0%**	*
Asian**	27	**1%**	26	**1%**	1	**0%**	*
Other/Unknown**	32	**1%**	27	**1%**	3	**1%**	*
Total	*2,987*		*2,766*		*219*		2

**Number not included due to small sample size*
***Note. Combined small sample sizes into a larger ethnic group for protection of client privacy*

Half (49%) of all APD clients served were Hispanic and 44% were White. Whereas among adult ADP clients ethnicity was more equally divided between Whites (46%) and Hispanics (47%), this was not the case among ADP youth: 80% were Hispanic and 13% were White. The adult and youth ADP system of care served proportionally dissimilar ethnic populations, and this trend is consistent with last fiscal year's data.



Mental Health System

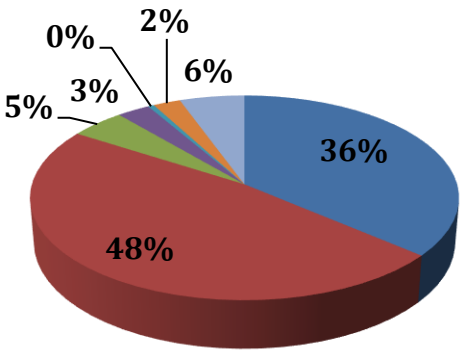
In the first half of FY 2018/19**, 6,481 unique clients** were open to the Mental Health System: Two-thirds were adults (4,212; 65%) and one-third were youth (2,265; 34%). Half (50%) of all Mental Health clients were female. The ratios of age group and client gender are similar to FY 17/18.

	ALL Adult & Youth		Adult		Youth		Missing DOB
Mental Health - Unique Clients	**N**	**%**	**N**	**%**	**N**	**%**	**N**
Male	3,156	**49%**	2,032	**48%**	1,122	**50%**	*
Female	3,272	**50%**	2,145	**51%**	1,125	**50%**	*
Missing/Other	53	**1%**	35	**1%**	18	**1%**	*
Total	6,481		*4,212*	*65%*	*2,265*	*35%*	4
Race/Ethnicity							
Hispanic	3,037	**47%**	1,526	**36%**	1,511	**67%**	*
White	2,469	**38%**	2,014	**48%**	453	**20%**	*
African American	243	**4%**	198	**5%**	45	**2%**	*
Multiracial	165	**3%**	119	**3%**	46	**2%**	*
Native American	26	**0%**	22	**1%**	4	**0%**	*
Asian**	110	**2%**	99	**2%**	11	**0%**	*
Other/Unknown**	431	**7%**	234	**6%**	195	**9%**	*
Total	*6,481*		*4,212*		*2265*		4

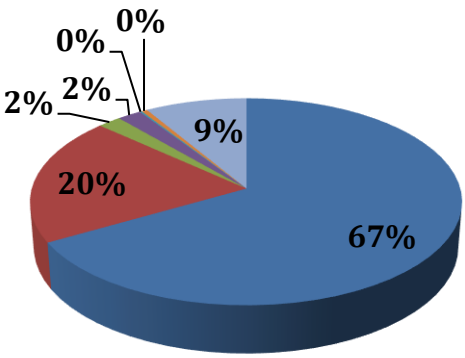
**Number not included due to small sample size*
***Note. Combined small sample sizes into a larger ethnic group for protection of client privacy*

The ethnicity of MH clients differed by age group: 48% of adults were White and 36% were Hispanic; 20% 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 Ethnicity FY18/19 (Q1 & Q2)



MH YOUTH Ethnicity FY18/19 (Q1 & Q2)



Client Service Settings

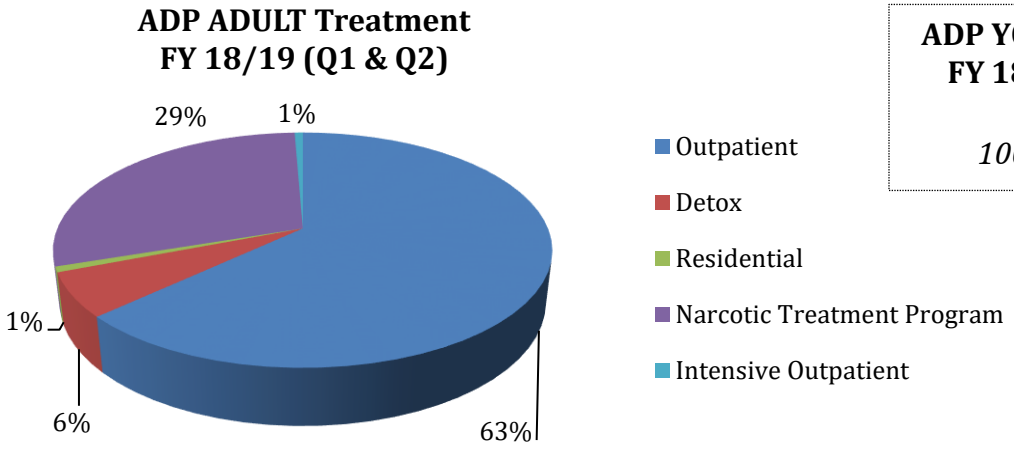
Behavioral Wellness and its partner agencies provide a variety of services in both inpatient and outpatient settings. Though most clients receive services in Santa Barbara County, due to limited in-County capacity (in number or kind), some clients are served at inpatient and residential facilities outside 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 also receive additional services from a crisis team or a partner organization in the community.

Alcohol & Drug Programs (ADP)

In 2015, the California Department of Health Care Services (DHCS) initiated an innovative pilot program called the Drug Medi-Cal Organized Delivery System (DMC-ODS). The program reorganized specialty substance use disorder (SUD) treatment in the state using the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment. The ASAM is a multidimensional assessment of a client's needs and strengths and the results inform treatment placement and planning. The DMC-ODS pilot also adds and expands DMC coverage of residential treatment services, case management, and recovery support services, enables selective provider contracting, supports coordination with managed care health plans, facilitates quality improvement, utilization management, evidence based practices, and promotes use of a licensed workforce.[1]

DMC-ODS was implemented on a staggered phase basis by county, and Santa Barbara County went "live" on December 1, 2018. The Access line experienced a significant increase in callers requesting SUD services; in particular, clients seeking newly covered services. As a result, we expect that in future reports, services provided under ADP will increase. However, as ODS went "live" with only a month left in this reporting period, we do not expect a significant increase in the overall ADP numbers for this report.

Behavioral Wellness contracts with community based organizations to deliver alcohol and other drug prevention and treatment services. Nearly all adult substance abuse treatment services were provided in outpatient settings, and almost a third (29%) of which were outpatient Narcotic Treatment Program (methadone) services. Six percent (6%) were social model detoxification services, 1% were intensive outpatient services, and 1% were residential treatment services. For youth, all substance abuse treatment services were provided in outpatient settings.



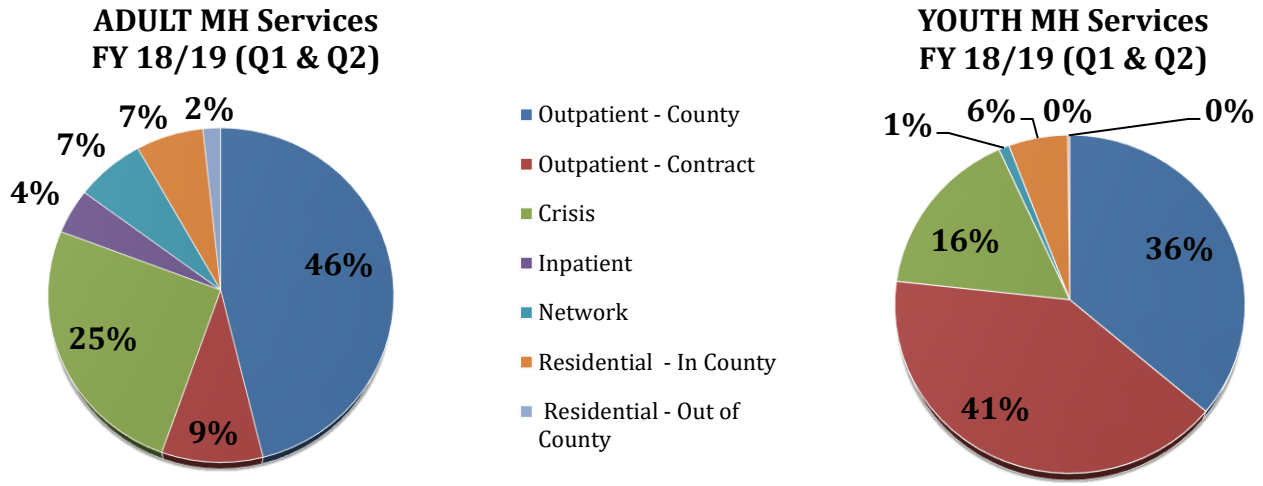
ADP YOUTH Treatment FY 18/19 (Q1 & Q2)

100% Outpatient

[1] Source: Urada, D., Teruya, C., Antonini, V. P., Joshi, V., Padwa, H., Huang, D., Lee, A.B., Castro-Moino, K., & Tran, E. (2018). California Drug Medi-Cal Organized Delivery System, 2018 Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs.

Mental Health System

As seen in the pie charts below, 46% of mental health services for adults and 36% for youth are delivered by the county, in outpatient settings. There are few (9%) contracted outpatient services for adults, while 41% of all youth services are provided by contracted outpatient providers.



The next largest service "setting" for both adults and youth are crisis services, which are most frequently delivered by mobile crisis teams in hospitals, office, or over the phone. Adults had a greater proportion of crisis care (25%) than youth (16%), though it should be noted that these numbers have decreased in volume and proportion of total services from the first half of last fiscal year (29% to 25%). Residential treatment programs and inpatient care are less frequent treatment settings utilized by clients who need higher levels of care (comprising 11% of all adult services and 1% of all youth services). For youth, no residential services were provided in county, and less than 10 clients received residential services out of county.

In prior years, Santa Barbara County had separate triage and mobile crisis teams. At the beginning of the 18/19 fiscal year, North and South County programs were restructured to form regional County Crisis Services teams, while West County continued to keep its teams separate. The table below displays West County crisis teams separate as well as combined, in order to compare across regions. The common locations of services varied by region, reflecting the unique needs of the geographically diverse areas. In West County when combining triage and mobile crisis teams, almost two thirds of crisis services were delivered by phone or in the office. Consistent with previous reports, a larger ratio of triage services occurred in office/phone, while a larger portion of mobile crisis services were delivered in the hospital. While office/phone was still the most common crisis location in other regions, it was only 39% of services in North County and 46% in South County. In North County, 39% of crisis services were also delivered in a hospital, while this was half as common in West County (19%), and less common in South County (27%). Each region had similar proportions of crisis services delivered in the community.

Location of Crisis Services, FY 18/19 (Q1 & Q2)

	North	South	West		
			Triage	Mobile Crisis	Combined
Hospital	39%	27%	1%	21%	19%
Office/Phone	39%	46%	82%	59%	62%
Community	21%	17%	17%	19%	18%
Other	1%	10%	1%	1%	1%

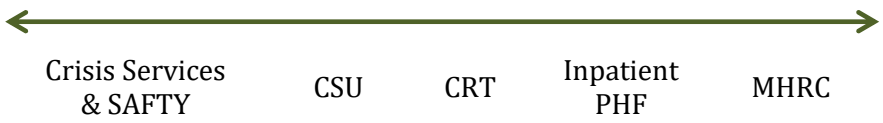
Crisis Services

For the last several years, the Department of Behavioral Wellness has been working to enhance outpatient crisis services and to expand the continuum of care by instituting more treatment options to appropriately serve client's needs, with the ultimate goal of decreasing in-patient hospitalization. In 2014, a grant (SB82) was received that enabled the department to address critical gaps in the crisis system.

The grant supported the implementation of:

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

Crisis Services Continuum



PHF = *Psychiatric Health Facility*
MHRC =*Mental Health Rehab Center*

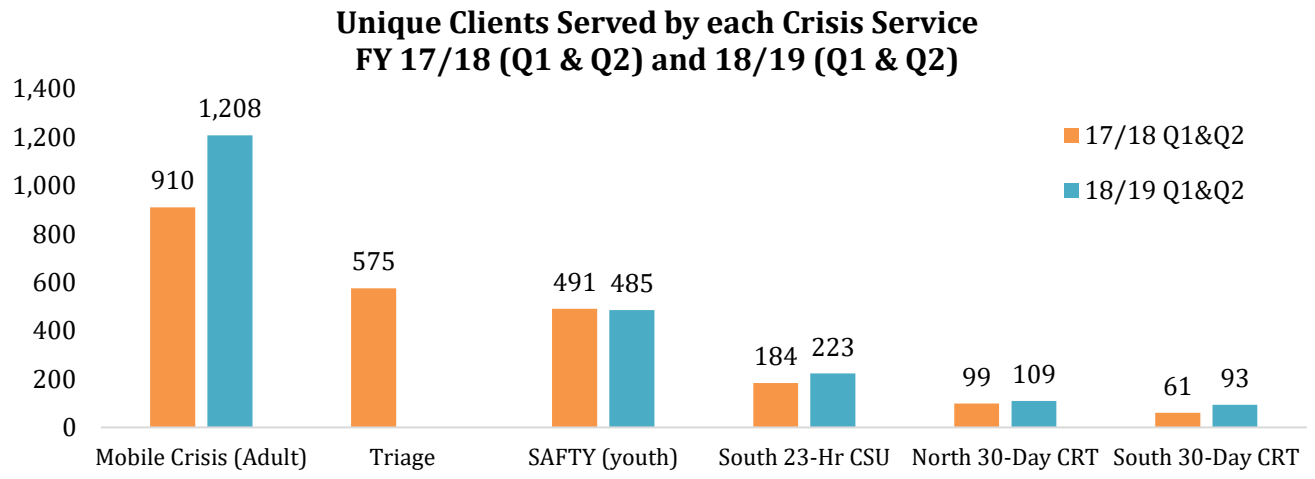
There were several crisis system interventions and changes during this time period. In July 2018, the Crisis Triage program integrated with mobile crisis in North and South County, and the SAFTY program (the youth equivalent to mobile crisis) changed its hours from 24 hours/day to 8am-8pm. Therefore, Mobile Crisis began taking youth crisis calls from 8pm to 8am, and is no longer a program solely serving adults.

Also, in South County in September 2018, a Behavioral Wellness/Sheriff's Department Co-Response Team Pilot program launched. Up to forty hours per week, a Behavioral Wellness clinician accompanies law enforcement on mental health crisis calls, with the goal of addressing mental health challenges and de-escalating situations in order to avoid law enforcement intervention and incarceration. So far, Behavioral Wellness typically responds to 5-7 calls per day. Data is continuing to be collected on the success of this program.

At the end of the year, in December 2018, the Crisis Action Team at Behavioral Wellness started a Hospital 5150 Pilot program to train Emergency Department Psychiatrists to write and rescind 5150 and 5585 holds. Cottage Hospital psychiatrists were trained at the end of the year and Marian Regional Medical Center doctors were trained at the beginning of 2019. This pilot should not impact data for this semi-annual report, but impacts will be examined in future reports.

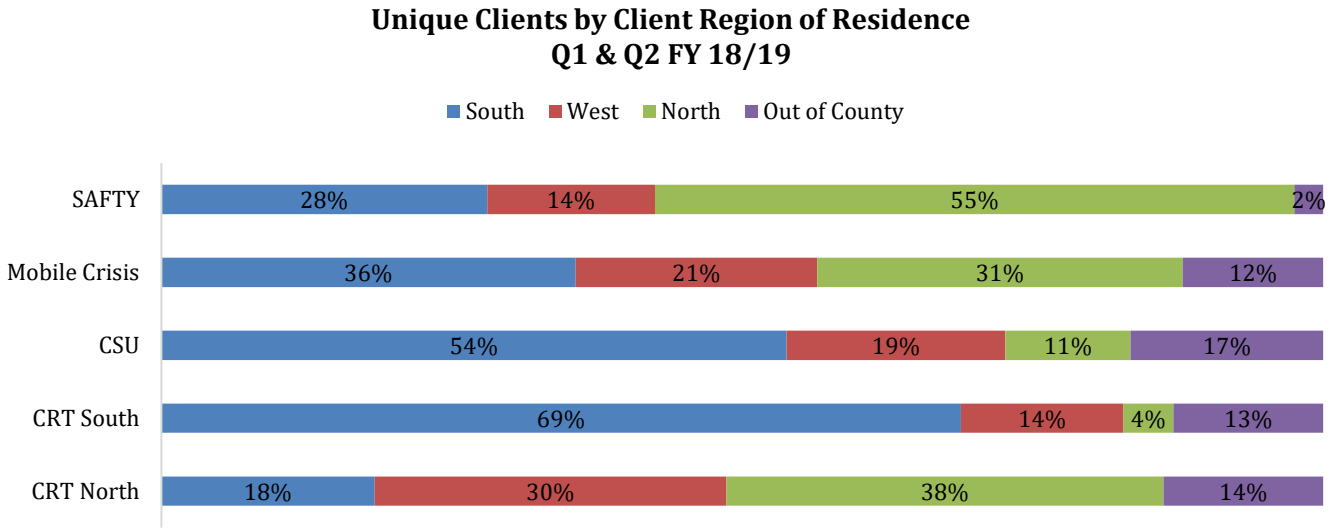
Clients Served by Crisis Service

As seen in the chart below, in the first half of FY 18/19, similar numbers of unique clients required a crisis service compared to last year (1,716 unique clients were served in the first half of this fiscal year; 1,688 in the first half of last fiscal year). It should be noted that these numbers reflect the services provided to unique individuals, and therefore include out of county residents who accessed crisis services. Because triage integrated with mobile crisis in North and South County, many of the clients who may have been duplicated under mobile crisis and triage last year are now only counted under mobile crisis this year. So, while the chart below appears to serve fewer clients than last year, the overall unique count is a more accurate picture of the clients served. The number of unique clients served by the CSU and CRTs all increased slightly, suggesting that there is increased awareness and utilization of our newest levels of care within the crisis services continuum.



By Region

There were some regional differences in clients' region of residence served by each crisis service. Between 2-17% of clients served by each crisis service were out of county residents (often transient individuals or students), with the largest portion being served by the CSU. 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. While the largest portion of clients seen by mobile crisis (36%) were residents of South County, residents of North County still accounted for 31% of mobile crisis clients. While two-thirds of CRT South clients were from South County, two-thirds of CRT North's clients were from either West or North County.



Stabilization Rates

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

- ✓ **99%** of clients served by the **Crisis Stabilization Unit** were stabilized (did not need hospitalization) within 24 hours of CSU service.
- ✓ **94%** of clients discharged from the **Crisis Stabilization Unit** remained stabilized (did not need hospitalization) within 30 days of discharge.
- ✓ **92%** of clients served by the **Crisis Residential Treatment** (CRT) Programs were stabilized (did not need hospitalization) within 30 days of discharge.

Inpatient Utilization

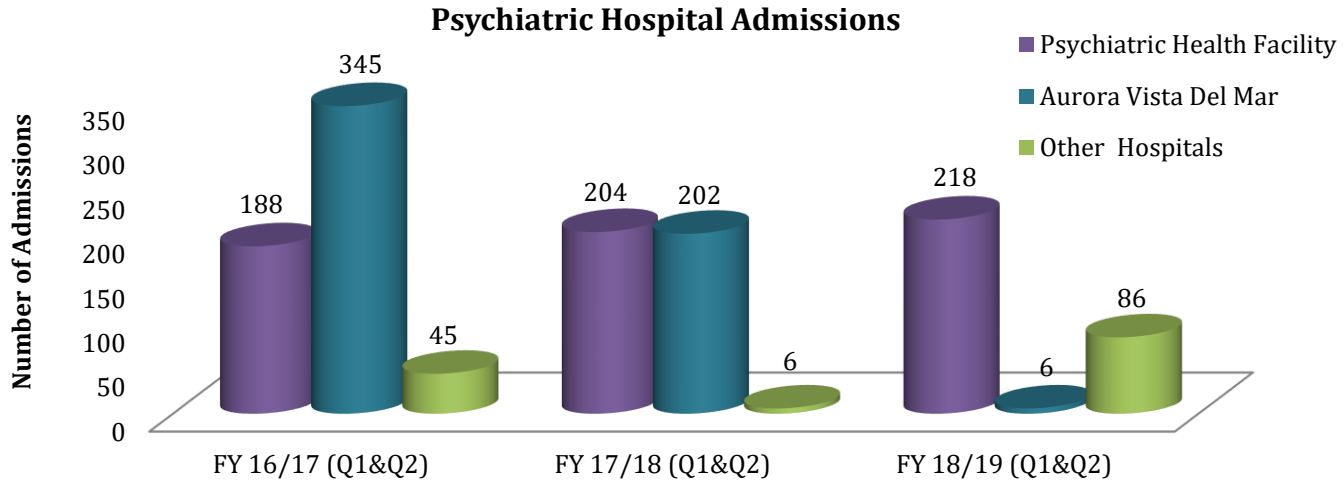
Behavioral Wellness monitors inpatient services closely in order to assess and address utilization, client care and fiscal impact. The department routinely tracks: the number of inpatient psychiatric hospital admissions by age group, ethnicity and region of the county. Hospital admission data are available for the County's Psychiatric Health Facility (PHF) and all other out-of-county hospitals that report admissions to the department. Through fiscal year 16/17, acute inpatient hospital admissions were steadily increasing and this was attributed to increased court-mandated defendants who were declared "incompetent to stand trial".

Admissions

Following three years of consistently having 1,100-1,200 psychiatric hospital admissions, in FY 17/18, there were 701 psychiatric hospital admissions (412 of which occurred in the first half of FY 17/18; a reduction of 29% when compared to the same timeframe of FY 16/17). This declining trend continued in the first half of FY 18/19; there were 310 total psychiatric hospital admissions. This is a 25% fewer psychiatric hospitalizations from the first half of FY 17/18. There have been several factors that may contribute to this reduction.

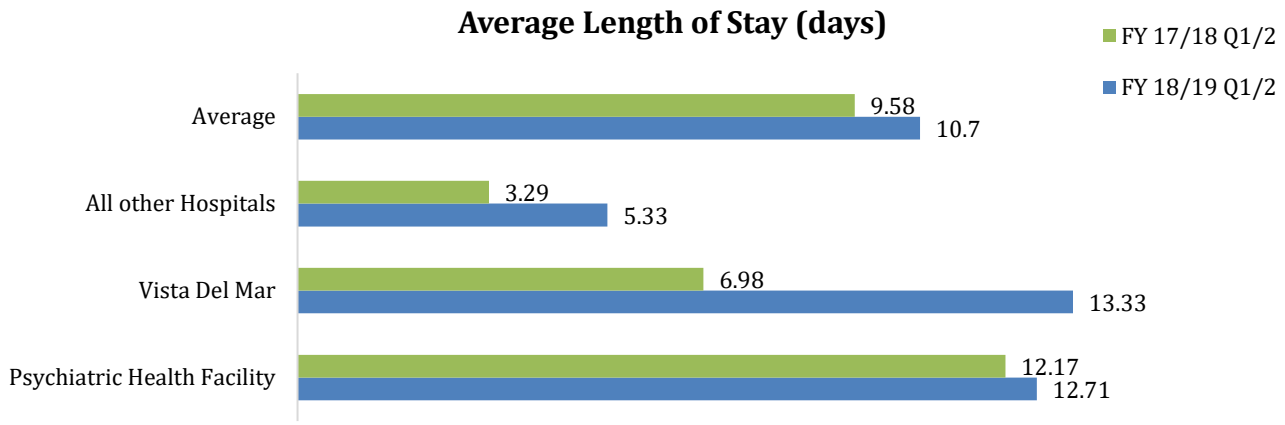
In May 2017, there was a change in staffing patterns through Traditions Behavioral Health (TBH), which shifted the PHF psychiatrists to 16 hours shifts. This shift change may be a factor in the decline in hospital admissions because it allowed for patients to be seen by a psychiatrist more quickly, and enabled more responsive patient care. In concert with the TBH changes, since last year's semi-annual report, the PHF has improved in program sophistication, safety planning, and care coordination with patients who have conservatorship or are found Incompetent to Stand Trial (IST).

Also, in December 2017, Vista Del Mar lost two buildings in the Thomas Fire. From December 2017 until its re-opening in October 2018, 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. Following the re-opening of Vista Del Mar in mid-October 2018, six Santa Barbara clients (all youth) were served at Vista Del Mar through December 2017, while the contract for adults ended.



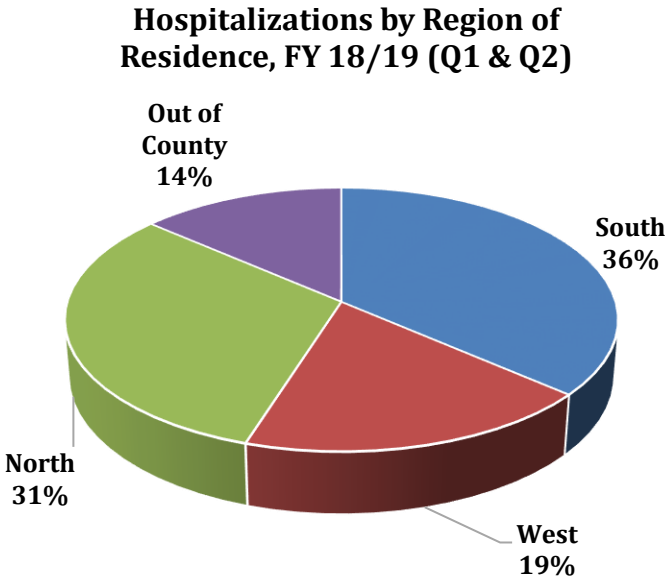
Length of Stay

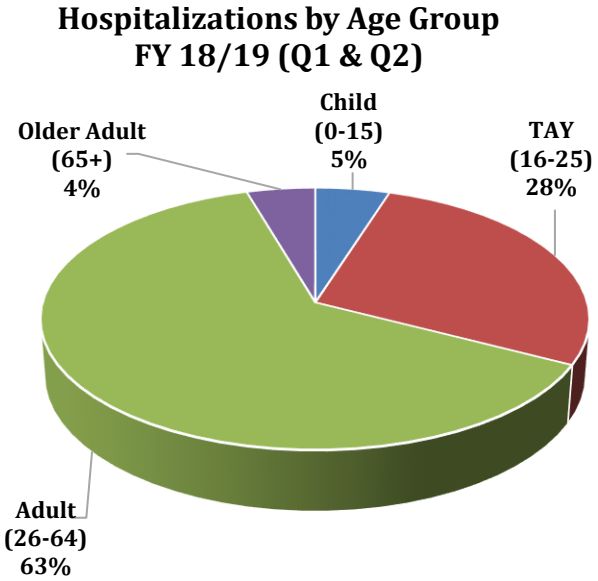
Across all hospitals, clients had an average length of stay of 10.7 days. Vista Del Mar, who served youth only, had the longest average length of stay (n = 6; LOS = 13.3 days), while all other hospitals were the shortest (n = 86; LOS = 5.3 days). The PHF length of stay includes both short-term psychiatric clients as well as clients who are conserved or IST, who typically experience longer stays (n = 218; LOS = 12.7 days). As seen in the chart below, compared to last year, stays in all hospitals increased in length.



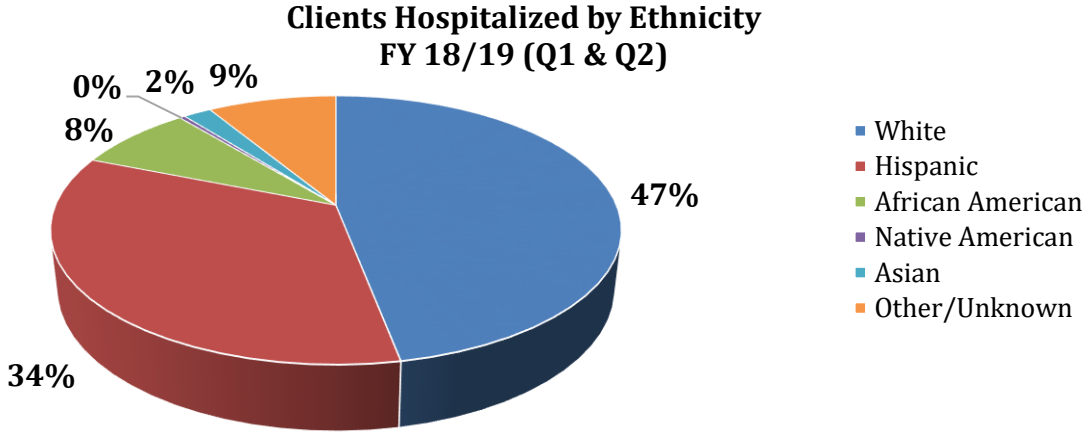
Demographics

The largest percentage (36%) of clients hospitalized lived in South County. Most (63%) were adults aged 26-64, followed by 28% that were Transitional Age Youth (TAY; 16-25); only 5% were 15 or younger and 4% over 65 years of age.





Just under half (47%) of hospitalized clients were White and a third (34%) were Hispanic. These demographics are similar to last year.



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.

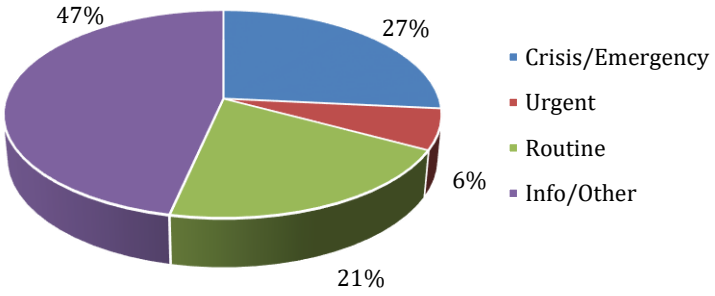
Access Call Type

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 redesigned and improved, and in October of 2016, Access staffing was centralized within Quality Care Management (QCM). Access calls/entries are categorized as follows:

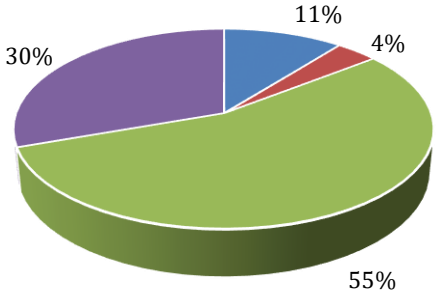
- **Crisis** calls/clients: Those who are at immediate risk of hospitalization (because they pose a danger to themselves or another).
- **Urgent** calls/clients: Those who, without assistance, would likely need inpatient hospitalization within 24 hours.
- **Routine** calls/clients: Those who are neither 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 the first half of FY 18/19, there were 4,805 total calls/entries, an average of 801 calls per month. Last fiscal year, there were an average of 743 calls per month, so this represents a 7.8% increase in calls per month. Half of all calls (49%) were to request information or "other". About one-fifth of all calls were classified as crisis/emergencies (22%), while urgent calls comprised 6%. Routine calls were about one-quarter of all calls (24%). These are similar proportions to last fiscal year, with the largest change in routine calls, from 22% in FY 17/18 to 24% in Q1 and Q2 of FY 18/19. Displayed below are the calls by age group[2].

Adult MH Access Calls by Type
FY 18/19 (Q1 & Q2) (n = 1,667)



Youth MH Access Calls by Type
FY 18/19 (Q1 & Q2) (n = 356)



While almost half of adult calls were to request information, over half of youth calls were "routine." A quarter of adult calls were considered crises, and a tenth of youth calls were considered crises.

[2] Date of birth was missing for 158 callers so they were not included in the charts above. Ninety-five percent of callers who were missing date of birth called to request information.

Timeliness

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.

It is expected that the accuracy of these indicators will continue to improve as the Department further refines data collection tools and processes. This year, the metrics were examined by adults and children in order to more fully understand the differences between groups. It should be noted that there were few urgent calls for youth, so the data represent a small number of individuals.

Access Timeliness		**FY 18/19**			
		Q1		**Q2**	
		Adult	**Youth**	**Adult**	**Youth**
Routine	offered an appointment within 10 business days	99%	90%	96%	90%
Urgent	offered an appointment within same/next day	94%	38%*	99%	50%*
Crisis	offered an appointment within same/next day	100%	96%	98%	97%

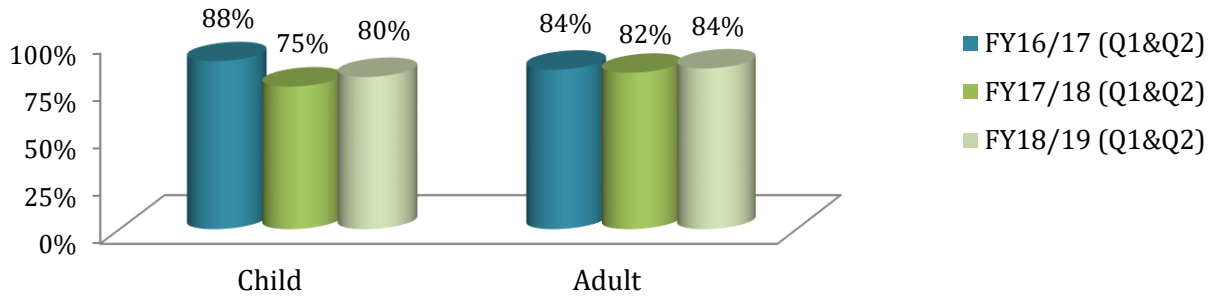
*Q1 n = 21; Q2 n = 8.

Compared to last fiscal year in which only totals were examined, these metrics have improved substantially. Last year, *routine* calls were offered an appointment within 10 business days between 73-87%; this year, the range was 90-99%. For *urgent* calls, the range last year was between 72-91%; this year for adults it was 94-99%. For youth, examining the low percentages for *urgent* calls (38-50%) highlighted an area for timeliness improvement that was not identifiable when both age groups were examined together. While the percentages do represent a small numbers of calls considered *urgent*, this potential process issue has been addressed with Access and clinic staff. Finally, calls designated as *crisis* improved in timeliness from 86-98% within same/next day last fiscal year to 96-100% this fiscal year.

Outpatient Aftercare

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. In past years, we reported the percent of <u>all</u> clients who were hospitalized, rather than the percent of clients hospitalized who ever received subsequent SMHS from Behavioral Wellness. Many clients who are hospitalized may have a follow up appointment with a private insurance or other non-MediCal-funded provider, or may be transient and leave town following hospitalization, and we do not have access to their subsequent mental health services. Clients may also choose not to attend any scheduled follow up SMHS, even though scheduled upon discharge. Therefore, in previous reports, we underreported our success in seeing clients at Behavioral Wellness in a timely manner. We corrected this to specifically look at timeliness for clients ever subsequently served by Behavioral Wellness. Also, the timeliness goal changed from SMHS within 10 days of discharge to within 7 days of discharge.

Seen within 7 Days of Hospital Disharge



Because our denominator in the calculation and the number of days changed, the past two years' Q1 and Q2 numbers are different than were previously reported. The figure above uses data that were re-calculated for the past two years in order to make an accurate comparison. In the first half of FY 18/19, of those who were ever subsequently seen by Behavioral Wellness for a SMHS, 84% of adults and 80% of children were seen within 7 days of hospital discharge. This is a slight improvement as compared to follow up from the first half of FY 17/18: a 2% increase for adults and a 5% increase for children. Compared to two years ago, our timeliness in FY 16/17 was better for children (88%) the same for adults (84%).

In the first half of FY 18/19, the average time from PHF discharge to a SMHS appointment was **5.8 days**. In FY 17/18, the average was **3.6 days** from PHF discharge to a SMHS. Thus, the time to SMHS appointment increased by about two days from last year, though more clients were seen within 7 days of discharge.

Psychiatry

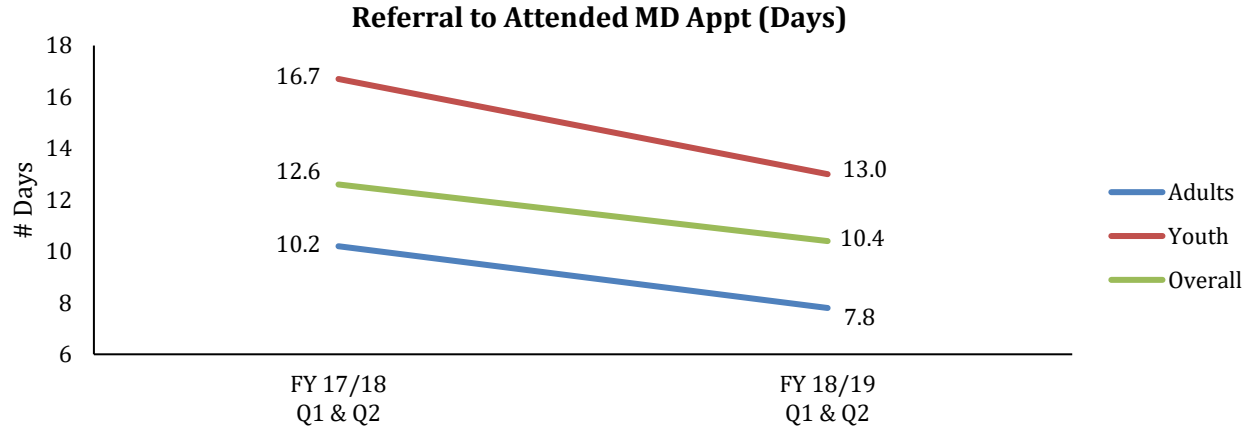
Due to limited resources, psychiatric appointments must be prioritized. For example, adults with urgent medication needs are seen more quickly than routine appointments. Similarly, youth with urgent needs are scheduled with a psychiatrist after an assessment, whereas others might have several therapeutic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

Psychiatry Timeliness FY 18/19 Q1 & Q2

	Unique Adults (n = 79)	Unique Youth (n = 86)	**Total Unique (n = 165)**
Referral to Offered			
Offered appt. within 15 calendar days*	85%	56%	**70%**
Average days to offered	7.8 days	13.0 days	**10.4 days**
Referral to Attended			
Attended appt. within 15 calendar days*	91%	73%	**81%**
Average days to attended	6.6 days	10.6 days	**8.7 days**

**Note.* Clients whose offered and attended dates were not recorded due to cancellation, no show, or not recording were counted as not within the 15-day window (n = 18 offered; n = 0 attended).

On average, over two-thirds of clients (70%) were **offered** a psychiatry/MD appointment within 15 calendar days of referral, and 81% of clients **attended** a psychiatric/MD appointment within that time frame. The lower percentage of offered is likely due to the offered appointment not being recorded, or being cancelled, while we were not missing this data for attended appointments. Adults had shorter wait times than youth, (6.6 days to attended appointment for adults; 10.6 days to attended appointment for youth). The longer wait time for youth is partially a provider availability issue; there are fewer child psychiatrists and thus longer wait times. These wait times reflect an improvement compared to the first half of last fiscal year (see below).



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.

On July 1, 2018, the CANS was updated to the CANS-50, which has slightly different scales and items within each scale. Because all clients received the new version, comparisons over time between the two scales are not comparable. For clients who received an initial CANS prior to 7/1/2018 and a follow up CANS after 7/1/2018, we are unable to compare their change over time using their initial CANS as baseline. For clients who entered treatment after 7/1/2018, they received a CANS-50 upon program entry, but would not have been eligible to receive a 6-month follow up CANS-50 prior to the end of 2018. Therefore, for this semi-annual report, we have no CANS outcome data to report. We look forward to reporting on client progress as reflected in the CANS-50 in the next annual report, when clients entering treatment after 7/1/2018 will have received a 6-month follow up CANS-50.

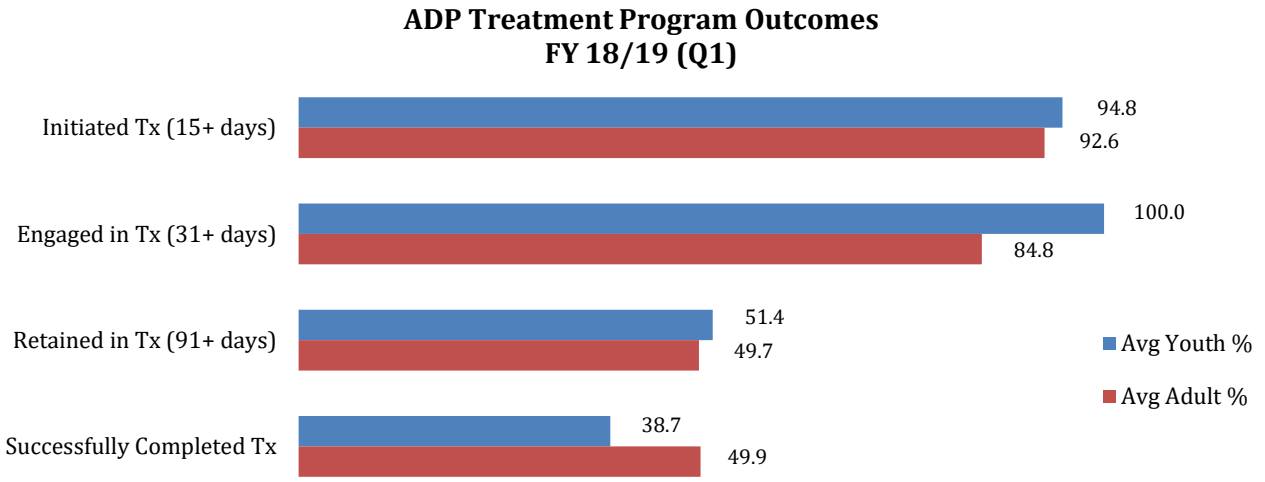
Adult Outcomes

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).

Because ODS went live in the middle of Q2, and clients administratively had to be exited and re-entered into the electronic health record, data was unavailable for Q2. Therefore, this report captures Q1 data only. Compared to last fiscal year, youth in the first quarter had higher rates of initiation and engagement in treatment, and lower rates of retention and successful completion. Adults had similar rates of initiation and engagement and lower rates of retention and successful completion.



Mental Health System

Milestones of Recovery Scale (MORS)

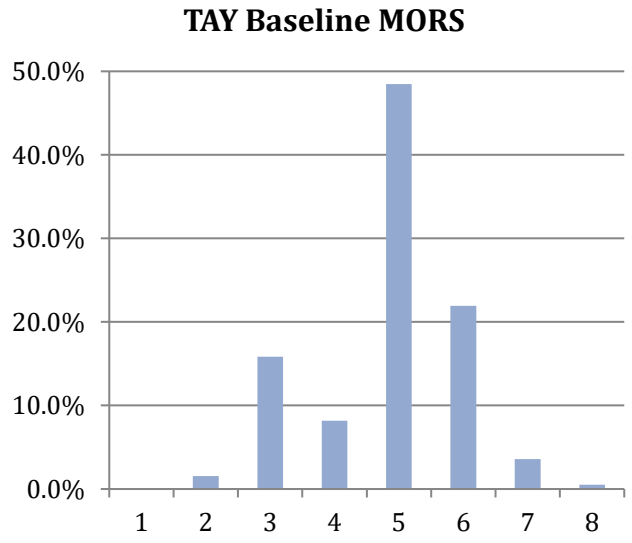
The MORS is an 8-item tool for identifying stage of recovery. The MORS can be used to assign clients to appropriate levels of care, based on a person-centered assessment of where they are in their recovery process, and can also be used to measure progress towards recovery. Scores of 1-3 indicate extreme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

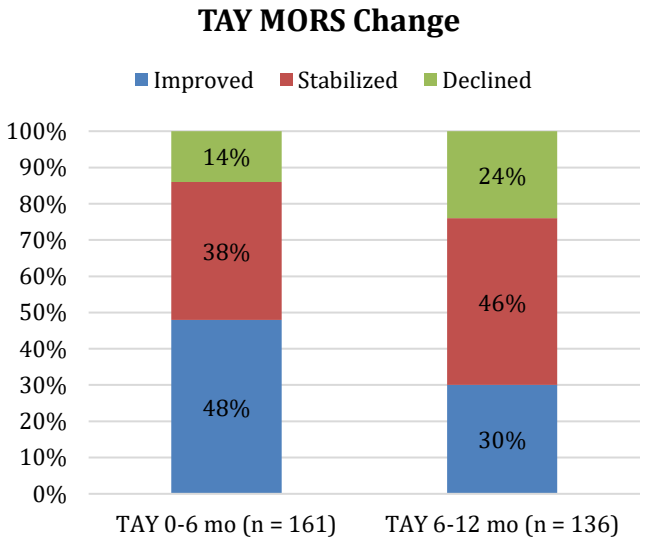
Risk/Need	MORS Scale	
Highest	1	Extreme Risk
	2	High Risk / Not Engaged
	3	High Risk / Engaged
Moderate	4	Poorly Coping / Not Engaged
	5	Poorly Coping / Engaged
Least	6	Coping / Rehabilitating
	7	Early Recovery
	8	Advanced Recovery

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 the first half of FY 2018/19, who had an intake/baseline MORS as well as MORS scores at 6- and 12-months.

Transitional Age Youth Programs

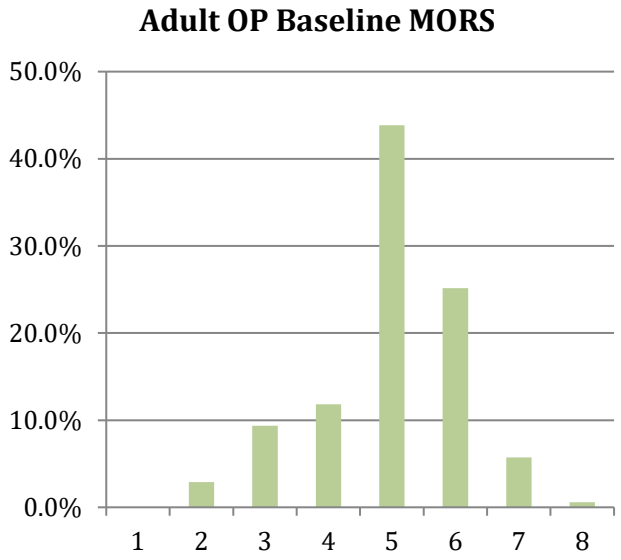
Of all open TAY (N=246), 80% had a baseline MORS score (N=196). Of those, over two–thirds (70%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 48% improved, 38% stabilized (no change in score), and 14% declined in functioning (N = 161). Between 6 and 12 months, 30% improved, 46% stabilized, and 24% of clients declined (N = 136). Thus, in the first six months of treatment, 86% of TAY improved or stabilized, and in the next six months of treatment, 76% improved or stabilized. These results are similar to FY 17/18.

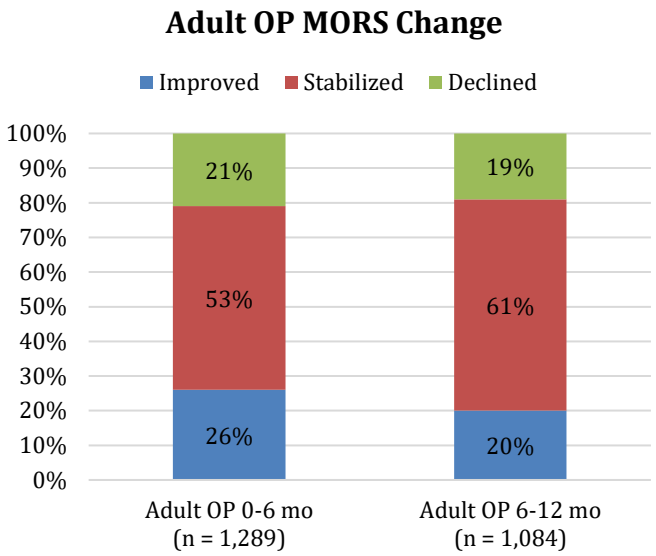




Adult Outpatient Programs

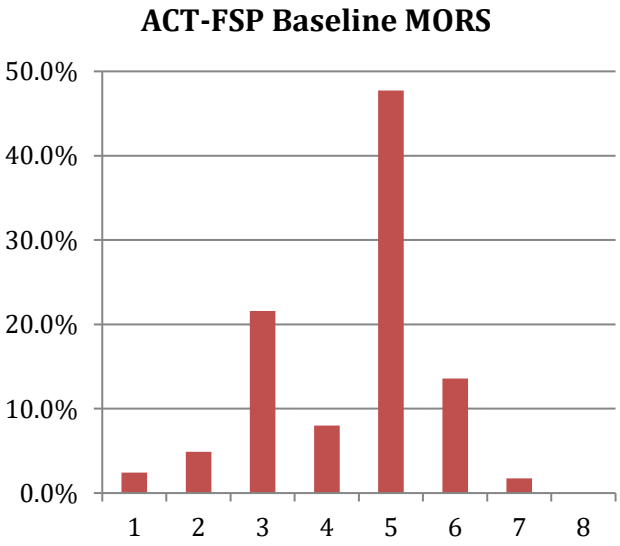
Of all open adult outpatient clients (N=1,924), 79% had a baseline MORS score (N=1,521). The percent of clients with a baseline MORS score increased 9% from FY 17/18. Of those, the majority (69%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 26% improved, 53% stabilized (no change in score), and 21% declined in functioning (N = 1,289). Between 6 and 12 months, 20% improved, 61% stabilized, and 19% of clients declined (N = 1,084). Thus, in the first six months of treatment, 79% of adult outpatient clients improved or stabilized, and in the next six months of treatment, 81% improved or stabilized. These results represent an increase from FY 17/18.

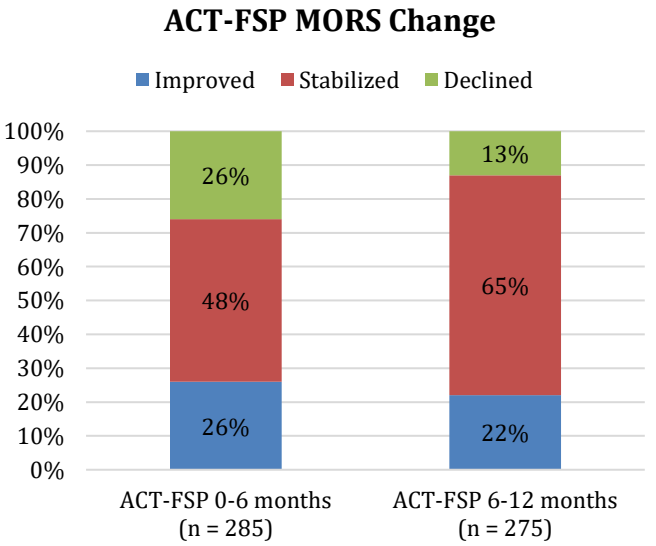




Assertive Community Treatment Programs

Of all open Assertive Community Treatment (ACT) program clients (N=287), 100% had a baseline MORS score (N=287). As we might expect, the vast majority (77%) had a baseline MORS score of three to five, lower than TAY and other adult outpatient clients. Between baseline and 6 months, 26% improved, 48% stabilized (no change in score), and 26% declined in functioning (N = 285). Between 6 and 12 months, 22% improved, 65% stabilized, and 13% of clients declined (N = 275). Thus, in the first six months of treatment, 74% of ACT clients improved or stabilized, and in the next six months of treatment, 87% improved or stabilized. These results represent an increase from FY 17/18.

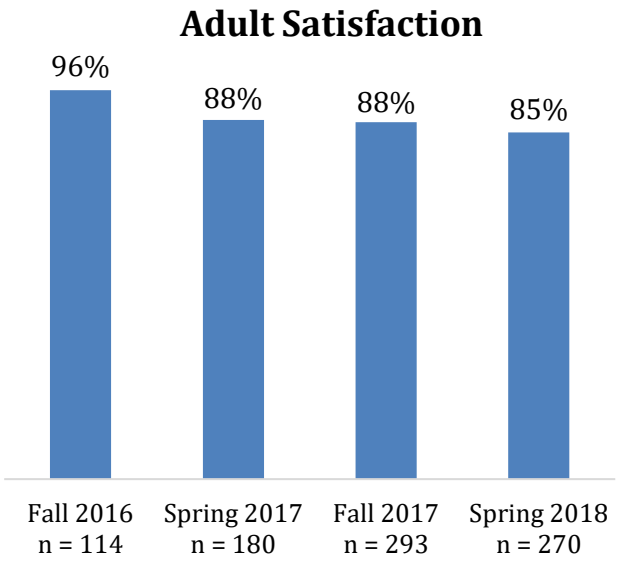


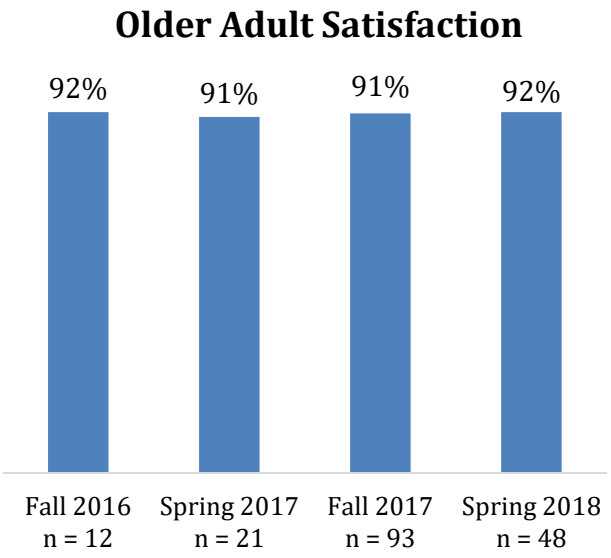


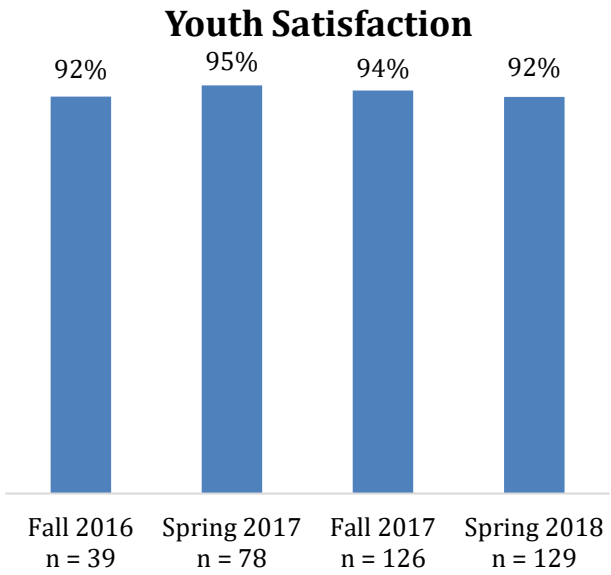
CPS – Client Satisfaction

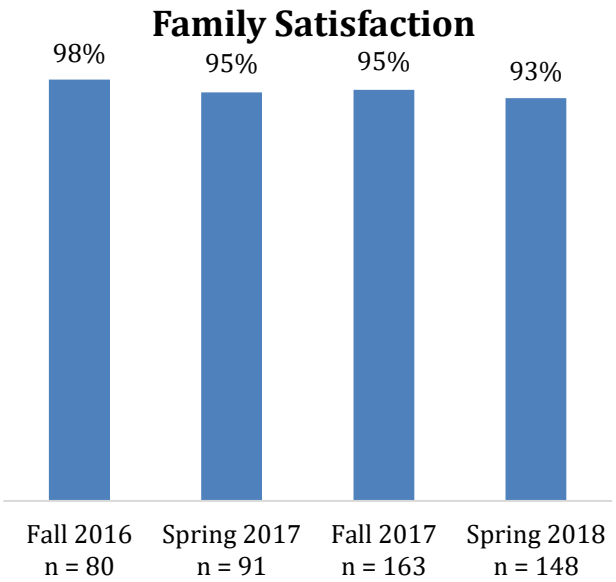
The Consumer Perception Survey is administered to a sample of outpatient mental health (not ADP) clients in May and November of every year, including clients served in County operated programs and those served by our community based partners. There are separate, but similar, surveys given to adults, 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".*

No new data for the CPS from fall 2018 is available. Therefore, the same data from the FY 17/18 annual report is reported again here. Satisfaction was quite high over the past two years as is seen below, and was highest with families, youth, and older adults (92-93%), while a little lower with adults (85%).









Staff Activity

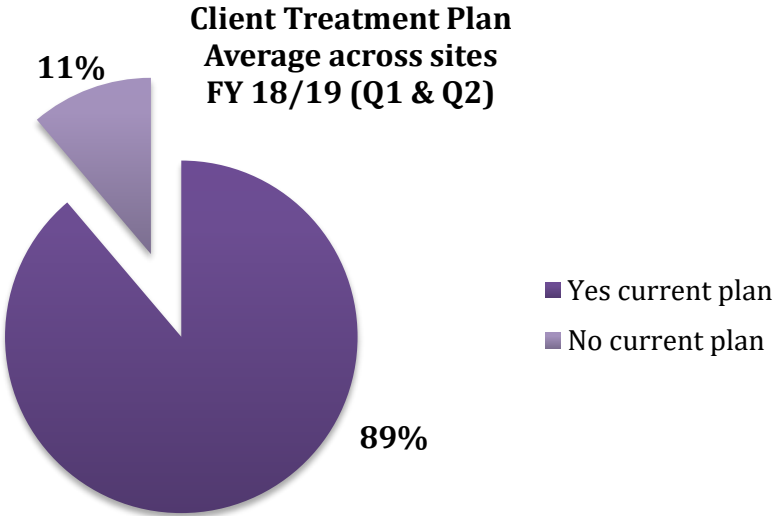
The Department designed a new report for managers and supervisors in order to help them monitor and support higher levels of client engagement. Data are drawn from employee's timesheets and the report provides both the number and percentage of time recorded on different types of activities, such as time spent in trainings, meetings and providing services. The total is the sum of direct and non-direct services, training and meeting hours. The Managed Care Final Rule has necessitated some changes in how staff code and complete timecards. As more training is provided for staff and timecards are more accurately completed, we expect that documented staff activities will increase.

The total average documented time for staff of outpatient clinics was 48%; for Crisis staff, it was 29%. 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. These numbers are similar compared to last fiscal year.

	% Meetings & Training	% Client Services	% Total
Outpatient Clinics	16	32	48
Crisis/Triage Services	11	18	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.



The average percent of current treatment plans on 1/1/2019 across all outpatient programs was 89%. This is slightly higher than the 86% current at the end of last fiscal year. It should be noted that this is a "snapshot" from 1/1/2019, and clients with "no current plan" includes both clients whose plans are expired and clients who just had an intake 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 11% of clients with no current plan does not mean that these clients necessarily have expired treatment plans.