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I am pleased to present the Fiscal Year 2019-2020 Annual Report for the Santa Barbara County Department of Behavioral Wellness. With the COVID-19 virus entering our county a few months into the year, the department has encountered challenges, but also has experienced many learnings and made many system improvements.

I would like to begin by acknowledging the important work our staff do every day, diligence in consistently maximizing opportunities to expand housing, crisis services and the ongoing aim to provide the highest quality in service delivery practices despite the challenges of COVID-19 on both staffing and how we do our business. In addition, the department continues to be present to provide support during times of community crisis.

Important accomplishments included maintaining all services through telehealth due to the impact of COVID-19; Medication Assisted Treatment expansion; strengthening collaborative relationships with the schools to enhance school based mental health services; and expanding many housing resources throughout the community.

In addition, much movement was made toward the opening of a first time ever Mental Health Rehabilitation Center (MHRC) in Santa Barbara County, located at the Champion Center in Lompoc; the process was begun to develop an electronic health record at the Psychiatric Health Facility (PHF); and movement was made toward the launching of a Genoa pharmacy on campus through grant funding.

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 updated Strategic Plan which can be accessed on the Behavioral Wellness website.

We are proud of the many contributions staff have made to the health and well-being of Santa Barbara County both during daily service delivery, continuing this service delivery during a pandemic and during community disasters and traumatic events.

We appreciate your interest in the Department of Behavioral Wellness, and hope you enjoy our Annual Report.

Sincerely,

Alice Gleghorn, Ph.D.
Director
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.
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 2019-20 the Department of Behavioral Wellness served 7,803 mental health clients and 3,350 Alcohol and Drug Program clients.

As of June of 2020, Behavioral Wellness employed 429 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.

Behavioral Wellness is presently focusing on the Santa Barbara County Renew 2022 (Renew '22) transformation initiative which aims to address financial and organizational challenges and make decisions that will transform the County for success well into the future. In January 2018, the Board of Supervisors approved more than 100 initiatives generated by employee subcommittees focused on these five components of Renew ’22:

- Re-Vision Our Organization
- Re-Design How We Work, Re-Balance Our Resources
- Respond To Residents and Customers
- Retain High Performing Employees
- Prepare the Next Generation of Leaders.

RENEW ’22 has allowed Behavioral Wellness to establish and meet many system goals:

- Rebalance resources to create a paperless system
- Increasing access to substance abuse treatment
- Co-Response by law enforcement and mobile crisis mental health
- Non-emergency medical transportation support
- Collaboration with hospitals on system of care improvements
- Updating of the departmental Information Technology infrastructure and operations

This annual report is organized around the core areas of Clinical, Business and Fiscal Operations of the Department and key accomplishments within each.
Key Accomplishments

Transition Age Youth

At the end of the fiscal year, the Department established a true Transition Age Youth (TAY, ages 16-24) clinic, a goal first set forth in the MHSA 2017-2020 Three Year Plan. Previously TAY services had been provided through the existing Assertive Community Treatment (ACT) programs, the regional Childrens Programs, or through the Resiliency Interventions for Sexual Exploitation (RISE) program. RISE, a 2016 MHSA Innovations funded program, offered low/no barrier services for youth at risk for sexual exploitation, such as youth who previously survived sexual exploitation or sexual trauma, and were in foster care, resided in group homes, were experiencing homelessness, were unaccompanied minors, had unstable housing, and/or had been detained in Juvenile Hall. The sunsetting of the Innovations funding for the RISE program in 2020 and the community feedback from TAY clients asking for Full Service Partnership programming specific to their age group provided the ideal opportunity to launch the new TAY clinic.

At the same time, the Department wanted to ensure that the well-regarded RISE services remained available to the community. To provide for this continuity of programming, the Department has integrated Commercial Sexual Exploitation of Children (CSEC) services across all regions, offering training to all staff, especially targeting staff in the regional TAY programs where CSEC clients typically receive services. After working to identify staff and clients that would be most appropriate for the new program, the Santa Maria TAY clinic opened in the building that previously housed RISE. Office space was re-arranged, staff workstations were set up and TAY clients are now being seen in the new clinic. The Department is excited to offer the North County TAY population a clinic that will be comfortable for them, is designed in an age appropriate way and enhances the ability to serve this unique population. Finally, a RISE Toolkit, which sets forth the lessons learned while building and operating the RISE program over the five-year period, will be finalized in January 2021, providing all Department staff with resources and information to guide quality CSEC services throughout the County.

Co-Response Teams

Grant funding allowed an increase in the Co-Response program with the Sheriff’s Department, and the addition of vital services to the South County Crisis HUB. The Sheriff’s office submitted a grant proposal through the Edward Byrne Memorial Justice Assistance Grant (Byrne-JAG grant) that was awarded and provided funding for two Behavioral Wellness Clinicians for Co-Response. In addition, the county was awarded a PROP-47 grant that provided funding for one Co-Response clinician.
The two grants allowed expansion of the Co-Response program in the South County, and added a team in North County for the first time. Prop-47 also provided funding for a Stabilization Center located in the Crisis Hub on the campus in South County. The expanded Co-Response teams and Stabilization Center has added to the jail and Emergency Department diversion efforts and increased access points into Substance Use Disorder and Mental Health treatment programs.

COVID-19 Impact

FY 19-20 also saw the beginning of the world-wide COVID-19 pandemic. As cases grew in Santa Barbara County and it became evident that staffing would need to be reduced in programs, and face-to-face contact with clients limited, all Clinical Operations teams worked diligently to develop a robust telehealth program to continue uninterrupted services. While never closing any clinics/programs, an initial sharp decline in the number of clients showing up for in person appointments was seen. Clinical Operations worked closely with the IT division to ensure staff had adequate access to mobile and laptop devices with cameras so staff could engage clients via telehealth. After an initial downturn in client contact, staff began to see direct client contact numbers increase with the youth population due to their typically having smartphones capable of telehealth. Though more difficult to stay in contact with the adult population, staff were creative with field visits, outdoor sessions, assisting clients with accessing technology and “Zoom rooms” where clients could be alone in an office set up with a computer capable of doing a Zoom session with staff in a separate office, in the same building. This setup was also used for some of the Forensic population to attend court appointments via Zoom.

Current and Future Goals

• Continue to increase client access to telehealth by ensuring all staff have access to telehealth capable computers and clients have smartphone access.

• Develop and implement a universal Release of Information form for foster youth to improve collaboration with Social Services and increase timely access to services.

• Continue to expand Co-Response teams county-wide. Resume Co-Response program with Santa Barbara Police Department (pandemic placed on hold). Partner with Santa Maria Police Department on Co-Response pilot.

Key Initiatives

• Use of new data reports via the Tableau web-based data platform to improve tracking of direct client services and increase in billing and Medi-Cal revenue.

• Integration of Mobile Crisis and Access Line staff to an integrated unit to improve efficiency of both programs and reduce reliance on ProtoCall for after-hours Access line coverage.

• Utilization of Mobile Crisis staff to cover the Access line afterhours/weekends/holidays to reduce reliance on ProtoCall.
Alcohol and Drug System of Care

The County Alcohol and Drug Program (ADP) has continued to expand, enhance and integrate effective treatment strategies throughout each region. The Drug Medi-Cal Organized Delivery system (DMC-ODS) now boasts intensive, complex capable residential treatment and medically monitored withdrawal management or detoxification services. At any given time, there are approximately seventy-five (75) clients in residential treatment and or withdrawal management services, receiving levels of care that are more sophisticated and culturally sensitive than ever before. A host of wraparound services, including case management, recovery and peer support services has led to a treatment success rate of over 65%, well above all national or state averages. Harm reduction and medication assisted treatment models have been expanded to engage hard-to-reach clients.

The Sobering Center, now called the Stabilization Center, is in operation and has provided substance use disorder (SUD) intervention, diversion and referral resources to dozens of clients. As a result, County ADP is integrated with the South County Crisis System (SCCS) of care. A Medication Assisted Treatment (MAT) Access Point, called the SUD Wellness and Recovery Access Point, has been established to provide buprenorphine induction services to clients with opioid use disorder (OUD) coming from the jail or anywhere in the SCCS. As part of a positive external quality review (EQRO) report, County ADP is now integrating screening, referral and placement services between Behavioral Wellness children’s clinics and our contracted SUD providers.

ADP Services have remained robust and effective during COVID-19. Treatment programs have made the transition from face to face to telehealth services with minimum service disruption. The units of service provided post COVID-19 are roughly the same as during pre COVID-19. There are fewer unique clients this year than last for several reasons: Fewer clients are being mandated by the criminal justice system into treatment, there are more non-Medi-Cal treatment options available, the legalization of recreational marijuana and the pandemic have all served to disrupt client care. Nonetheless, County ADP not only continued to provide services to over 3,300 unique clients during the year, but those services were more inclusive, intensive and whole person centered than ever before. County ADP has now begun to establish care coordination services by hiring dedicated care coordination staff and developing protocols and processes to ensure that clients, and especially high need and high-risk clients do not fall through treatment and service gaps.

ADP Prevention Services continue to provide environmental services in addressing and combatting the four priorities of the current County Strategic Prevention Plan: Underage Drinking, Binge Drinking, Underage Cannabis Use; and Opioid Misuse. The Strengthening Families Program provides a state-of-the-art family intervention
model to strengthen relationship and communication skills and, in the process, reduce high risk factors such as alcohol and other drug (AOD) use. Coalitions have been established in all three regions to assess community needs and develop prevention interventions. Media campaigns have been created to highlight the dangers of underage AOD use and abuse.

Finally, the County Overdose, Prevention and Reversal program has resulted in widespread education regarding the opioid epidemic and the distribution of naloxone or Narcan that has reversed close to 400 overdoses this FY.

Through it all, our entire ADP treatment continuum of care strives to be more attractive and effective in engaging clients. As the percentage of mandated clients declines from over 80% in 2008 to less than 60% today, SUD providers are hard at work to point out the benefits of SUD treatment. Integrated services, harm reduction, MAT and primary prevention strategies combine to offer help, hope and worthwhile alternatives to clients with addiction and co-occurring mental health and SUD.

Cultural Competency and Diversity

Recent Accomplishments

- Translation Review Committee was established to review accuracy, readability and field testing of Spanish translated documents.
- New translation contracts were established for American Sign Language and Mixteco.
- The Cultural Competence and Diversity Action Team membership increased from 8 to 29 individuals with greater accessibility afforded through Zoom.
- Mental Health Services Act Community Planning sessions held countywide in Spanish and Mixteco and provided in unserved, underserved and marginalized communities.
- The Cultural Competency and Diversity Manager played a key leadership role for the Mental Health Working Group of the Immigrant Taskforce in Response to COVID-19 producing culturally and linguistically relevant outreach materials promoting mental wellness during the challenges of the pandemic.

Current and Future Focus

- New cultural competency trainings focused on engaging the Native American Indian, African American and Asian community.
- Standardized staff guide - developed on how to access interpretation services.
- The Cultural Competency and Development Action Team is collaborating with the Workforce Training Manager on recruitment and retention strategies for maximum support for a diverse and culturally attuned workforce.
Peer Support Program

Recent Accomplishments

• Peer support staff trained in the practice of Peer Support Services through an OSHP grant. Twenty-five Peers participated in the Peer Personnel Program and received a certification of accomplishment.

• Peer support staff received a 5-day Wellness Recovery Action Plan (WRAP) training certifying them to lead WRAP groups. WRAP helps clients with serious mental illness develop plans towards their wellness and recovery, and make these plans a part of their therapeutic process.

• Peer staff participation in the quarterly Peer Employee Forum which serves as a specialist training platform for Peers and a Peer employee stakeholder forum.

• The MHSA Innovations Project--Help@Hand Digital Peer Ambassadors were active:
  ✓ During Mental Health awareness month, the Help@Hand team hosted over 100 peer-run support groups via the ZOOM platform
  ✓ Hosted digital literacy Appy Hour sessions throughout the community via the ZOOM platform.
  ✓ Created outreach and engagement materials in English and Spanish including the following:
    ▪ Department bookmark with ACCESS Line information
    ▪ Wellness App Brochure based on the Eight (8) Dimensions of Wellness
    ▪ Mindfulness Minute easy step to mindfulness guide
    ▪ Guide to Social Connectedness During COVID-19

Current and Future Focus

• Improved standardized practice for onboarding of Peers
• Establishment of a Peer Internship Program
• Establishment of a pipeline for hiring Peers utilizing the Southern California Regional Partnership Grant
• Increase in Peer support groups within Behavioral Wellness and within the community
System Training

Recent Accomplishments

- Training Sub-Committee established to oversee the training activities of the department. Three-year training plan proposed which will provide guidance on training in evidence-based practices.
- Credentials established or renewed to enable Behavioral Wellness to certify continuing education credit for licensed and certified staff.
- Clinical supervision strengthened through training.
- Clinical training agreements initiated with local graduate school programs to create more clinical training opportunities within the department.
- Grant application submitted to support workforce development activities such as loan assumption, graduate student stipends, pipeline programs, and staff training and retention programs.
- Grant application to support the enhancement of an Early Psychosis Intervention program (including training in the evidence-based Coordination Specialty Care structure).
- Cultural Competency training has been expanded to include a variety of specialty topics. Some of the offerings this year have been:
  - Bridges out of Poverty (working with individuals living in generational poverty)
  - Mixtec Culture and Mental Health
  - Human Sexualities
  - Sexual Orientation/Gender Identity

Current and Future Focus

- Build internship opportunities throughout the department
- Select staff to participate in a train the trainer program on the Commercial Sexual Exploitation of Children (CSEC). This will enable the department to sustain training on this population.
- Ongoing evidence-based practices training.
- Enhance competency and staffing resources for clinical supervision.
- Assist in implementing Workforce Education and Training plan funding through the new Southern Counties Regional Partnership grant
Information Technology

Information Technology continues to prioritize objectives that align with Renew ‘22 focus areas, specifically Re-Designing, Re-Balancing, and Responding to Residents and Customers. A number of new technologies have been implemented and embraced by our community and workforce. In addition, accelerated deployment of solutions to meet the impact of COVID-19 has enabled a more digital workforce and created alternative service delivery options to serve our community. Implementation of new technology tools has led to innovative solutions that have increased process efficiency and enhanced collaboration across the Department, the County, and our partners.

Digital Transformation

Information Technology activities focus on IT service management and delivery, securing our IT assets, and enabling digital transformation across people, process, and technology. Digital transformation centers around the promotion and adoption of digital technology to transform an organization through implementation of new technology and replacement of manual processes with automated processes.

Increasing Community Engagement.
The Department significantly increased the availability of telehealth services to the community and implemented a solution to more effectively manage the placement of clients in need of residential treatment.

- Expanded the availability of onsite drop in locations where clients have access to technology needed to participate in telehealth in a safe environment.
- Provided our workforce with the tools needed to engage clients in telehealth services – including the distribution of modern mobile devices and the use of Zoom (HIPAA compliant and secure).
- Improved management of residential treatment facility placement across providers through Smartsheet, a new process automation and collaboration tool, that allows for tracking of real time residential treatment availability.

Improving Workforce Effectiveness.
Several key technology implementations have led to a more data-driven culture. Providing our workforce and partners with value added tools has increased operational efficiency and effectiveness.

- Continued to cultivate a data culture by harnessing Tableau, a visual analytics platform, to build dashboards and reports with real-time data, accessible anywhere, anytime.
✓ Enhanced team collaboration, policy and procedure management, and project management across the Department and County leveraging Smartsheet solutions.

✓ Developed a Community Based Organization (CBO) portal within Smartsheet to centralize required data collection from partners and enhance reporting capabilities.

✓ Expanded ServiceNow, an enterprise workflow automation platform, to include management of contracts and additional IT service capabilities which further reduced manual paperwork and traditional email-based communications.

✓ Adopted DocuSign, a digital signature platform, to significantly reduce paper use and the manual effort of collecting wet signatures from across the County.

Focusing on the Future
Information Technology supports the organization and the community served, with a focus on listening, understanding, and improving the customer experience, both internal and external to the organization. When looking to the future, Information Technology will continue to prioritize the following objectives:

✓ Minimize the administrative burden of technology on our workforce enabling staff to focus on impactful activities for our community.

✓ Introduce digital technology solutions that create an agile and mobile workforce, able to work safely and securely from anywhere as needed.

✓ Enable a data-driven culture by providing staff with the training, tools, and ongoing support to become more digitally proficient.

✓ Increase our capability to rapidly digitize processes and pivot as needed to meet the needs of the community, regulatory changes, and data collection, analysis, and reporting requirements.

Compliance

Recent Accomplishments

First MHSA Audit a Success.
Following a series of successful audits and reviews, the Department had its first ever Mental Health Services Act (MHSA) audit by the Department of Health Care Services (DHCS) in May of 2020. Prior to the start of the audit, the Department’s MHSA audit review team had learned that other counties were experiencing challenging audits and facing significant corrective actions.
But true to form, and after thorough preparation, the Department received much positive feedback from the DHCS auditors on its MHSA program. Receiving particular positive attention was the Department’s Full Service Partnership programs, including ACT and Supported Housing, Cultural Competence awareness and efforts to outreach to diverse groups within Santa Barbara County, and the Department’s Innovation Program, RISE, which targeted outreach and mental health services to Commercially Sexually Exploited Children (CSEC). The corrective action plan received from DHCS was minimal. In the last five years, the Department has invested significant effort in broadening its community engagement in the MHSA plan development and updates. The Department is pleased that the DHCS auditors were able to recognize the dedication the MHSA team has to ensuring that the voices of the underserved and unserved are considered in the services provided to the community.

Health and Safety in the Mental Health Clinics.
As part of the annual Risk Assessment process and development of the Compliance Audit Plan, in July of 2019, the Compliance Committee focused on minimizing the spread of infectious diseases in all of the Department’s outpatient clinics. Outpatient clinics received supplies of masks and gloves, signs were posted asking clients to request a mask if they were not feeling well, and cleaning protocols were developed to ensure that clinics where ill clients were seen were sequestered for the rest of the day and rigorously cleaned in the evening. Thankfully, these protocols were put in place in late Summer early Fall of 2019, before COVID-19 descended on the planet. These efforts facilitated the transition to the COVID-19 guidelines that the County operates under today.

Warm Handoffs.
Another area of focus for the Compliance Committee was improving warm handoffs of clients throughout the behavioral health system. Through the Risk Assessment process, the Compliance Committee learned that clients sometimes fall through the cracks after receiving services at all levels of care, and at times did not successfully transition to new providers. To address these concerns, a Warm Handoff Policy and Procedure was developed and enacted; staff for mental health and substance use disorder services were hired or identified within the clinics to connect with clients to ensure warm handoffs to the next level of care; and greater attention was paid to providing warm handoffs after hospitalization, crisis services, and jail release or diversion.

100% Compliance with Mandatory Trainings.
The Compliance Program continues to report 100% compliance with all mandatory trainings: HIPAA; Code of Conduct; Cultural Competency; Peer Support; and recently added MHSA Overview training.

Hotline Complaints.
Over Fiscal Year 2019-2020, the Compliance Program responded to 29 Hotline Complaints from the phone and e-mail contact forms.
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

- Adoption of a balanced departmental budget for FY 2020-21 ($147M) with no service level reductions.

- Updated the department’s published charges to ensure full cost recovery for county operated clinics, as COVID-19 impacted services volume, and therefore cost per unit.

- Amended 12 Mental Health Medi-Cal provider board contracts to remove the County Maximum Allowable (CMA) rate from FY 19/20 provider agreements. This modification allowed providers to be paid at a full cost reimbursement rate in response to lower service volumes due to COVID 19 impacts.

- Moved all fiscal operations to telework arrangement where possible, while maintaining all fiscal operations. Review of all fiscal policies and updated six to align with current operational procedures.

- Continued regular rate reviews for Mental Health Medi-Cal and Drug Medi-Cal ODS contracted providers, with additional technical assistance provided as requested.

- Provide fiscal oversight, including executing payments, collecting revenues, and/or monitoring compliance with fiscal contract terms for approximately 280 contracts, leases, and/or other legal agreements.

- Performed fiscal monitoring and settled approximately 35 major subcontracts totaling $45M.

- Completed and submitted mandated cost and financial reports in accordance with State timelines, including Short Doyle Medi-Cal, Drug Medi-Cal, Medicare, and the MHSA Revenue and Expenditure Report.
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 2019-20 Medi-Cal revenues from clients covered by ACA Medi-Cal increased by 23.7% as compared with FY 2018-19. Medi-Cal revenues from clients covered by Traditional Medi-Cal increased by 6.7% in FY 2019-20 as compared with FY 2018-19. ACA Medi-Cal revenue made up $12.1M (37.7%) of the total FY 2019-20 Medi-Cal revenue $32.0M.

Table 2: MH Medi-Cal Services Revenue
Within Drug Medi-Cal (DMC) funded programs for Alcohol and Drug treatment, revenue for clients enrolled due to ACA has increased significantly each year, while revenue from clients covered by Traditional Medi-Cal has grown at a much slower pace. Overall, compared with FY 2018-19, DMC revenue increased by $1.4M (43.3%) in FY 2019-20. ACA Medi-Cal revenue made up $5.1M, or 67.1% of the almost $7.7M revenue collected for FY 2019-20 services. This is an increase of $1.8M (52.5%), over FY 2018-19. The Organized Delivery System (ODS) became effective December 2018, and is the primary factor driving the overall increase in FY 2019-20 Drug Medi-Cal revenue.

Table 3: Drug Medi-Cal Services FFP Revenue

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>ACA-Medi-Cal</th>
<th>Traditional</th>
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</thead>
<tbody>
<tr>
<td>FY 2015/16</td>
<td>$2,218,817</td>
<td>$1,608,988</td>
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<tr>
<td>FY 2016/17</td>
<td>$2,629,982</td>
<td>$2,047,704</td>
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<tr>
<td>FY 2017/18</td>
<td>$2,902,980</td>
<td>$2,527,249</td>
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<tr>
<td>FY 2018/19</td>
<td>$3,374,381</td>
<td>$3,514,301</td>
</tr>
<tr>
<td>FY 2019/20</td>
<td>$5,144,302</td>
<td>$4,199,784</td>
</tr>
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</table>
Current and Future Efforts

- Work with the State to address backlog of cost report settlements and audits. Closure of prior year settlements and audits will likely bring unanticipated revenue to the Department.

- Implement SmartSheet for CBO’s to upload required financial data.

- Implement ServiceNow HR module to increase transparency in the departmental position control and position budgeting process.

- Long Term Institute for Mental Disease (IMD), including state Hospital costs continue to be an area of significant concern. Expenditures have increased by over 500% in the last five years and continue to rise, outpacing revenue growth.

- The Department’s new contract with Crestwood Behavioral Health to operate the Champions Healing Center as the first in-county IMD is anticipated to have a significantly positive impact on client care and IMD expenditures in the long term.
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, analyze and report data. As a part of our larger system change efforts, we are working to change our culture to be more data-driven to improve decisions (e.g., 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, vision, and values.

In February 2016, the Board of Supervisors approved the Semi-Annual Metrics Report, which includes specific, thoughtfully selected measures. This annual report for fiscal year 19/20 includes these key performance measures, as well as some additional analyses. This report provides data on: who was served and where; crisis and inpatient services; access to and timeliness of services; youth and adult outcomes including client satisfaction and system performance; and comparisons to the previous annual report. Many of these outcomes are also required and reported to the California Department of Health Care Services.

Client Demographics

In FY 19/20, the Department served over eleven thousand unique clients; an 11% decrease in total clients from FY 18/19. The Mental Health (MH) System served more than twice as many unique clients as the Alcohol and Drug Program (ADP) (about 7,803 in MH and 3,350 in ADP), similar to prior years.

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

Clients and services may be counted in multiple 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; the client has three program admissions.
  - Ex: A client is in outpatient services, discharges, and then later returns to outpatient services in the same fiscal year; the client has two program admissions.

By Age Group

Similar to previous years, compared with youth clients, MH and ADP served more adult clients. There was a decrease in clients served by ADP and MH resulting in an overall decrease (11%) in total unique clients served (compared with a 7% decrease in the last annual report).

There are several possible explanations for the decrease in unique clients served. In the last year, the Department made considerable efforts to identify duplicate client data, and to close open, unserved clients.
impact of COVID-19, recent legislative and practice changes have meant fewer youth and adults are mandated and referred to participate in substance use disorder (SUD) treatment. There are also more treatment options, particularly with regard to MAT, available for SUD clients outside of the Department’s continuum of care.

**Unique Clients by System of Care FY 19/20**

<table>
<thead>
<tr>
<th></th>
<th>ADP</th>
<th></th>
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<th>MH</th>
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<td></td>
<td>Youth</td>
<td>Adult</td>
<td>Total*</td>
<td>Youth</td>
<td>Adult</td>
<td>Total*</td>
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<td>FY 18 / 19</td>
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<td>3,085</td>
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<td>8,649</td>
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<td>FY 19 / 20</td>
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<td>3,350</td>
<td>2,904</td>
<td>4,889</td>
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<td>% Change</td>
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<td>-13.4%</td>
<td>-14.1%</td>
<td>-5.9%</td>
<td>-11.9%</td>
<td>-9.9%</td>
</tr>
</tbody>
</table>

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

**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 served in each region with at least one or more program admissions during 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 Psychiatric Health Facility (PHF) in South County, they are admitted to both programs and counted in both regions. Compared with FY 18/19, in FY 19/20, fewer ADP and MH clients were served across South, West, and North County.

**Unique Clients by Region of Service FY 19/20**

<table>
<thead>
<tr>
<th></th>
<th>ADP</th>
<th></th>
<th></th>
<th>MH</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>South</td>
<td>West</td>
<td>North</td>
<td>O of C</td>
<td>South</td>
<td>West</td>
</tr>
<tr>
<td>FY 18 / 19</td>
<td>1,488</td>
<td>729</td>
<td>1,855</td>
<td>8</td>
<td>3,719</td>
<td>1,646</td>
</tr>
<tr>
<td>FY 19 / 20</td>
<td>1,337</td>
<td>557</td>
<td>1,634</td>
<td>2</td>
<td>3,422</td>
<td>1,686</td>
</tr>
<tr>
<td>% Change</td>
<td>-10.1%</td>
<td>-23.6%</td>
<td>-11.9%</td>
<td>-75%</td>
<td>-8%</td>
<td>-2.4%</td>
</tr>
</tbody>
</table>

More ADP clients were served in North County (46%) than South County (38%). Similar proportions of MH clients were served in North (39%) and South (38%) County. West County rates of service were similar for ADP (16%) and MH (18%).

---

**ADP Region of Service FY 19/20**

- North: 38%
- West: 16%
- South: 46%
- Out of County: 0%

**MH Region of Service FY 19/20**

- North: 38%
- West: 18%
- South: 39%
- Out of County: 5%
Alcohol & Drug Programs (ADP)

In FY 19/20, 3,350 unique clients were open to ADP: 93% adults and 7% youth. Among adults and youth, 63% of ADP clients were male. Age and gender demographics were similar to FY 18/19.

Alcohol and Drug Unique Client Demographics FY 19/20

<table>
<thead>
<tr>
<th></th>
<th>ALL Adult &amp; Youth</th>
<th>Adult</th>
<th>Youth</th>
<th>Missing DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>2,097</td>
<td>63%</td>
<td>1,954</td>
<td>63%</td>
</tr>
<tr>
<td>Female</td>
<td>1,244</td>
<td>37%</td>
<td>1,155</td>
<td>37%</td>
</tr>
<tr>
<td>Missing/Other</td>
<td>9</td>
<td>0%</td>
<td>6</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>3,350</td>
<td>100%</td>
<td>3,115</td>
<td>93%</td>
</tr>
</tbody>
</table>

Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>Hispanic</th>
<th>50%</th>
<th>1,671</th>
<th>48%</th>
<th>1,480</th>
<th>45%</th>
<th>1,391</th>
<th>12%</th>
<th>27</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>42%</td>
<td>1,418</td>
<td>3%</td>
<td>80</td>
<td>2%</td>
<td>69</td>
<td>2%</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>3%</td>
<td>85</td>
<td>1%</td>
<td>80</td>
<td>2%</td>
<td>69</td>
<td>2%</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Multiracial</td>
<td>2%</td>
<td>72</td>
<td>1%</td>
<td>69</td>
<td>2%</td>
<td>69</td>
<td>2%</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Native American**</td>
<td>1%</td>
<td>29</td>
<td>1%</td>
<td>29</td>
<td>1%</td>
<td>29</td>
<td>1%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Asian**</td>
<td>1%</td>
<td>26</td>
<td>1%</td>
<td>26</td>
<td>1%</td>
<td>26</td>
<td>1%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Other/Unknown**</td>
<td>1%</td>
<td>49</td>
<td>1%</td>
<td>40</td>
<td>1%</td>
<td>40</td>
<td>1%</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>3,350</td>
<td></td>
<td>3,115</td>
<td></td>
<td>234</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

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

Half (50%) of all ADP clients served were Hispanic and 42% were White. As shown in the below, among adult ADP clients, ethnicity was nearly evenly divided between Hispanic (48%) and White (45%). However, among ADP youth: 82% were Hispanic and 12% were White. The adult and youth ADP system of care served proportionally dissimilar ethnic populations, consistent with FY 18/19.
Mental Health System
In FY 19/20, 7,803 unique clients were open to MH. Two-thirds were adults (4,889; 63%) and one-third were youth (2,904; 37%). Half (50%) of all MH clients were male. Age and gender demographics were similar to FY 18/19.

MH Unique Client Demographics FY 19/20

<table>
<thead>
<tr>
<th></th>
<th>ALL Adult &amp; Youth</th>
<th>Adult</th>
<th>Youth</th>
<th>Missing DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Male</td>
<td>3,878</td>
<td>50%</td>
<td>2,486</td>
<td>51%</td>
</tr>
<tr>
<td>Female</td>
<td>3,819</td>
<td>49%</td>
<td>2,355</td>
<td>48%</td>
</tr>
<tr>
<td>Missing/Other</td>
<td>106</td>
<td>1%</td>
<td>48</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>7,803</td>
<td></td>
<td>4,889</td>
<td>63%</td>
</tr>
</tbody>
</table>

Race/Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>3,632</td>
<td>47%</td>
<td>1,754</td>
<td>36%</td>
<td>1,878</td>
<td>65%</td>
<td>0</td>
</tr>
<tr>
<td>White</td>
<td>2,923</td>
<td>38%</td>
<td>2,364</td>
<td>48%</td>
<td>559</td>
<td>19%</td>
<td>0</td>
</tr>
<tr>
<td>African American</td>
<td>258</td>
<td>4%</td>
<td>200</td>
<td>4%</td>
<td>58</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Multiracial</td>
<td>235</td>
<td>3%</td>
<td>170</td>
<td>3%</td>
<td>65</td>
<td>2%</td>
<td>0</td>
</tr>
<tr>
<td>Native American**</td>
<td>41</td>
<td>1%</td>
<td>29</td>
<td>1%</td>
<td>12</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Asian**</td>
<td>120</td>
<td>2%</td>
<td>102</td>
<td>2%</td>
<td>17</td>
<td>1%</td>
<td>1</td>
</tr>
<tr>
<td>Other/Unknown**</td>
<td>594</td>
<td>7%</td>
<td>270</td>
<td>6%</td>
<td>315</td>
<td>11%</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>7,803</td>
<td></td>
<td>4,152</td>
<td></td>
<td>2,374</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

*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% were White and 36% of MH adults were Hispanic; 65% of MH youth were Hispanic and 19% were White. Consistent with the population served by ADP, the adult and youth MH systems of care served proportionally dissimilar ethnic groups.
Behavioral Wellness and its partner agencies provide a variety of services in inpatient and outpatient settings. Although 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 the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program. The DMC-ODS pilot adds and expands DMC coverage of residential treatment services, case management, MAT 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 Santa Barbara County went “live” with the DMC-ODS on December 1, 2018. FY 19/20 was the first full fiscal year of ODS.

Behavioral Wellness contracts with community-based organizations to deliver alcohol and other drug prevention and treatment services. Over a third (36%) of adult substance abuse treatment services were provided in outpatient settings (Level 1.0). Nearly one fourth of services were provided in outpatient Narcotic Treatment Program (NTP) (methadone) settings. Residential treatment services (Level 3.1) accounted for 11% of services, 9% were intensive outpatient services (Level 2.1), and 8% were withdrawal management services (Level 3.2). All youth substance abuse treatment services were provided in outpatient settings.

**ADP Adult Treatment**

**FY 19/20**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>36%</td>
</tr>
<tr>
<td>Residential</td>
<td>9%</td>
</tr>
<tr>
<td>Narcotic Treatment Program</td>
<td>22%</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Mental Health System**

Forty percent of mental health services, for adults and youth, were delivered by the county in outpatient settings. Thirteen percent of adult and 36% of youth services were provided by contracted outpatient providers. The next largest service “setting” for adults and youth are crisis services, which are most frequently delivered by Mobile Crisis teams in hospitals, in an office, over the phone, or in the community.

Adults had a greater proportion of crisis care (34%) than youth (21%), these numbers are similar to the previous fiscal year. Residential treatment programs and inpatient care are less frequent treatment settings (utilized by clients who need higher levels of care) and were utilized by 11% of adult clients and 2% of youth clients. Fewer than 2% of adult clients received residential services out of county.

In prior years, Santa Barbara County had separate Triage and Mobile Crisis teams. At the beginning of fiscal year 18/19, North and South County programs were restructured to form regional Crisis Services teams. The location of service delivery varies by region, reflecting the unique needs of the geographically diverse areas.

<table>
<thead>
<tr>
<th>Location of Crisis Services, FY 19/20</th>
<th>West</th>
<th>South</th>
<th>North</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>45%</td>
<td>18%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Phone/Office</strong></td>
<td>18%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>36%</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>1%</td>
<td>12%</td>
<td>2%</td>
</tr>
</tbody>
</table>

The most common method of crisis service provision was in the hospital for West and North County, with 45% of services in West County and 42% of services in North County being delivered in a hospital. This was less common in South County (18%). In South County, the most common method of crisis service provision was tied between phone/office (35%) and community (35%).

**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 creating more treatment options to appropriately serve client’s needs with the ultimate goal of decreasing in-patient hospitalization.
There have been several recent enhancements to the crisis system of care. 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. Mobile Crisis began taking youth crisis calls from 8pm to 8am and is no longer a program solely serving adults.

In September 2018, a Behavioral Wellness/Sheriff’s Department Co-Response Team Pilot program was launched in South County. A Behavioral Wellness clinician accompanies law enforcement on mental health crisis calls up to forty hours per week with the goal of addressing mental health challenges and de-escalating situations to avoid law enforcement intervention and incarceration. This collaboration with the Sheriff’s Department expanded in February 2020 through grant funding from Prop 47 and Byrne JAG grants; it expanded to three full time co-response teams (two in South County and one split between North and West County).

Additionally, in February 2020 through Prop 47 funding, the CREDO47 Center opened. With its opening, another service was added to the menu available at the Crisis “Hub.” Initially the CREDO47 Center was established as a sobering center and important second point of field diversion from law enforcement: rather than sober up in jail, they could be monitored safely and be connected with mental health and substance use services. However, in response to the early jail release program due to COVID-19, the CREDO47 Center adapted its services to also include jail transition services. In addition to sobering, the CREDO47 Center is now a place where individuals can also have a short-term, soft landing while they wait for a bed to open up in a residential program, housing, or other transitions to treatment. From opening (February 2020) to the end of FY 1920 (June 2020), 131 unique individuals were served. There were 157 total encounters and 94 of the 131 individuals (71.7%) reported not having a permanent residence; 75.5% were referred to a shelter or housing resource.

The new SUD Wellness & Recovery Access Point opened in July 2020. The purpose of the Access Point is to improve engagement and enhance the effective delivery of MAT services and to improve client outcomes in long-term recovery. The Access point provides MAT, AOD information, as well as referrals to treatment.

**Clients Served**

In FY 19/20, a slightly smaller number of unique clients received a crisis service, as compared to FY 18/19 (1,903 in FY 19/20 compared to 2,036 in FY 18/19). There have been some administrative changes that have impacted these numbers. Triage integrated with Mobile Crisis (now called North, South, and West County Crisis Services); therefore, many of the clients who may have been duplicated under Mobile Crisis/County Crisis Services and Triage in the past are now only counted under one program. Furthermore, because the organization that operated both CRT’s went out of business in May 2019 and new providers were brought in to operate the sites, total numbers served was impacted.
Note. North 30-Day CRT reflects the addition of a new CRT for FY 19/20.

Co-Response
The collaboration between the Sheriff’s Department and Behavioral Wellness has expanded to include three full time Mobile Crisis staff spending 40 hours a week with a field Sheriff Deputy riding along and responding to community need. When not responding to crisis calls, the co-response teams are able to provide outreach and engagement services. During the FY 19/20, there were a total of 674 encounters, composed of 369 crisis calls and 305 proactive engagement calls.

By Region
Of those served by crisis services, differences in clients’ region of residence were observed. Approximately 1% of clients served by each crisis service were out of county residents (often transient individuals or students). About half (51%) of SAFTY’s services were provided to North County residents, which is consistent with the larger proportion of youth clients in North County. Crisis services served slightly more clients from South County compared to North County.

Unique Clients by Client Region of Residence
FY 19/20

<table>
<thead>
<tr>
<th>SAFTY</th>
<th>Crisis Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>27%</td>
</tr>
<tr>
<td>West</td>
<td>19%</td>
</tr>
<tr>
<td>North</td>
<td>51%</td>
</tr>
<tr>
<td>Out of County</td>
<td>0%</td>
</tr>
<tr>
<td>South</td>
<td>36%</td>
</tr>
<tr>
<td>West</td>
<td>21%</td>
</tr>
<tr>
<td>North</td>
<td>31%</td>
</tr>
<tr>
<td>Out of County</td>
<td>1%</td>
</tr>
</tbody>
</table>
Stabilization Rates

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

97% of clients served by the **Crisis Stabilization Unit** were stabilized (did not need hospitalization) within 24 hours of CSU discharge.

92% of clients discharged from the **Crisis Stabilization Unit** remained stabilized (did not need hospitalization) within 30 days of discharge.

87% 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 to assess and address utilization, client care, and fiscal impact. Hospital admission data are available for the County’s PHF and all other out-of-county hospitals that report admissions to the department. Through FY 16/17, acute inpatient hospital admissions were steadily increasing, which was attributed to increased court-mandated defendants who were declared “incompetent to stand trial”.

Admissions

In FY 19/20, there were 706 psychiatric hospital admissions; this was lower than the 802 psychiatric hospital admissions in FY 18/19. While youth continue to access inpatient services at Aurora Vista del Mar, the county has begun referring adults to Aurora Las Encinas hospital instead of Aurora Vista del Mar, accounting for the increase in “other hospitals.”

**Psychiatric Hospital Admissions**

<table>
<thead>
<tr>
<th>Year</th>
<th>Psychiatric Health Facility</th>
<th>Aurora Vista Del Mar</th>
<th>Other Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 17/18</td>
<td>436</td>
<td>419</td>
<td>467</td>
</tr>
<tr>
<td>FY 18/19</td>
<td>220</td>
<td>41</td>
<td>342</td>
</tr>
<tr>
<td>FY 19/20</td>
<td>45</td>
<td>46</td>
<td>193</td>
</tr>
</tbody>
</table>

Length of Stay

Across all hospitals, clients had an average length of stay of 7.7 days, which is three days shorter than FY 18/19’s average length of stay (10.7 days). The PHF had the longest average length of
stay (n = 365; LOS = 11.3 days), which includes both short-term psychiatric clients and longer term conserved or IST clients, while Vista Del Mar had the shortest length of stay (n = 45; LOS = 4.7 days).

### Average Length of Stay, Days

<table>
<thead>
<tr>
<th></th>
<th>FY 18/19</th>
<th>FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>10.7</td>
<td>7.7</td>
</tr>
<tr>
<td>All other Hospitals</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Vista Del Mar</td>
<td>6.2</td>
<td>4.7</td>
</tr>
<tr>
<td>Psychiatric Health Facility</td>
<td>13.2</td>
<td>11.3</td>
</tr>
</tbody>
</table>

### Demographics

The largest percentage (36%) of hospitalized clients lived in South County. Most hospitalized clients (65%) were adults aged 26-64 and 25% were Transitional Age Youth (TAY; 16-25); few were under 15 (6%) or older than 65 (4%).

### Clients Hospitalized by Region of Residence

**FY 19/20**

- South (36%)
- North (33%)
- West (18%)
- Out of County (13%)

### Clients Hospitalized by Age Group

**FY 19/20**

- Adult (26-64) (65%)
- Child (0-15) (6%)
- Older Adult (65+) (4%)
- TAY (16-25) (25%)

A similar proportion of hospitalized clients were White (46%) and Hispanic (39%) during FY 19/20 as compared to FY 18/19 (White: 46% and Hispanic: 36%).
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 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 stabilize clients and help avoid hospitalization.

Access Timeliness

In FY 15/16, 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).

Timeliness from contact with the 24-hour Access Line to services are a critical set of metrics for the Department. Access calls(entries) are categorized as follows for MH:

- **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 receive 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.

Access calls(entries) are categorized as follows for ADP:

- **Crisis** calls/clients: Those who have a severity rating of 4 on ASAM Severity Rating Dimension 1-3.
- **Urgent** calls/clients: Clients who score a severity rating of 3 on ASAM Dimension 1 and/or a severity rating of 4 on the ASAM Dimensions 5 and/or 6. Special consideration for all pregnant persons and anyone with a combination of risk factors that would require admission to substance use disorder.
treatment within 48 hours to avoid serious damage to their physical or mental health due to their continued substance use.

- **Routine** calls/clients: Those who are neither crisis nor urgent, but rather are seeking services.
- **Information/Other** calls/clients: Those seeking information about services or referrals but not seeking an intake.

Crisis appointments are scheduled within 24 hours. Urgent appointments are scheduled within 48 hours and Routine appointments are scheduled within 10 business days.

**ADP Access Calls**
During FY 19/20 there were 5,859 SUD Access calls. About half (48%) of all adult and youth calls were routine calls; the remaining calls were primarily requests for information (few crisis or urgent). Although few of the calls were urgent and most were informational, the Access screeners have been trained to expand the definition of urgency to include residential treatment and to ask additional questions of those who want “information only” to identify possible treatment needs.

**ADP Access Calls by Type**

<table>
<thead>
<tr>
<th>Type</th>
<th>Adult</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis/Emergency</td>
<td>51%</td>
<td>48%</td>
</tr>
<tr>
<td>Urgent</td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>Routine</td>
<td>.2%</td>
<td>.7%</td>
</tr>
<tr>
<td>N/A Other Information</td>
<td>.7%</td>
<td>.2%</td>
</tr>
</tbody>
</table>

**ADP Timeliness**
There were 5,859 calls during FY 19/20; of those, a little over half (2,989) were for information/other and no appointment was requested nor offered. The average number of days from Access call to offered appointment is calculated based on the remaining 2,870 adult and youth calls, which includes routine, urgent, and crisis calls.

**ADP Access Timeliness, FY 19/20**

<table>
<thead>
<tr>
<th>Routine (Screening and Referral) Calls</th>
<th>Adult</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVG # Days: Call to Offered Appt</td>
<td>6.6 days</td>
<td>7.1 days</td>
</tr>
<tr>
<td>% w/in 10 Days: Call to Offered Appt</td>
<td>77%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Mental Health Access Calls**
In the FY 19/20, there were 9,491 MH calls/entries, an average of 791 calls per month. These numbers are higher than FY 18/19 (8,724).
Nearly half of all adult calls (48%) were to request information or “other”, whereas almost half of youth calls were routine. About one-quarter (23%) of adult calls were classified as crisis/emergencies while 10% of youth calls were for crisis/emergency. Eight percent of adults and 4% of youth calls were urgent calls. Routine calls were about one-fifth of all calls (21%) for adults and more than half (53%) of youth calls. These are similar proportions to last fiscal year. Calls are displayed below by age and type.

**Mental Health Access Timeliness**
During FY 19/20, of the routine calls, 88% were offered an appointment within 10 business days for adults (slightly down from 92% for FY 18/19) and 95% for youth (up from 91%). For urgent calls, 95% were offered an appointment within the same/next day, which is comparable to FY 18/19. Seventy two percent of urgent youth calls were offered an appointment within the same/next day; however, there were few urgent calls (small N). Additional Access screener training was provided; definitions and timeliness standards were reviewed. Finally, of the calls designated as crisis, 98% were offered an appointment within the same/next day for adults and 97% for youth (comparable to FY 18/19).

**Mental Health Access Timeliness FY 19/20 (Q1-Q4)**

<table>
<thead>
<tr>
<th></th>
<th>Adult</th>
<th>Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine</td>
<td>offered an appointment within 10 business days</td>
<td>88%</td>
</tr>
<tr>
<td>Urgent</td>
<td>offered an appointment within same/next day</td>
<td>95%</td>
</tr>
<tr>
<td>Crisis</td>
<td>offered an appointment within same/next day</td>
<td>98%</td>
</tr>
</tbody>
</table>

**Outpatient Aftercare**
Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. In the past we reported the percent of all 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-Medi-Cal funded provider, or may be transient and leave town following hospitalization, and we do not have knowledge of their subsequent mental health services. Clients may also choose not to attend a follow up SMHS, even though scheduled upon discharge. Therefore, in previous reports, we underreported our success in serving clients in a timely manner. We corrected this to specifically look at timeliness for clients ever subsequently served by Behavioral Wellness. There is a significant improvement (+10%) in
specialty mental health services within 7 days for youth during FY 19/20 compared to FY 18/19 but decrease for adults (-19%).

In FY 19/20, the average time from PHF discharge to a SMHS appointment was **7.4 days**. In FY 18/19, the average was **5.0** from PHF discharge to a SMHS. Though the time to SMHS appointment increased by a little over two days from last fiscal year, 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). The following data are from the point of referral to a psychiatry appointment:

**Psychiatry Timeliness FY 19/20**

<table>
<thead>
<tr>
<th></th>
<th>Unique Adults (n = 193)</th>
<th>Unique Youth (n = 150)</th>
<th>Total Unique (n = 343)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral to Offered</strong></td>
<td>Offered appt. within 15 calendar days*</td>
<td>81%</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Average days to offered</td>
<td>5.2 days</td>
<td>6.5 days</td>
</tr>
<tr>
<td><strong>Referral to Attended</strong></td>
<td>Attended appt. within 15 calendar days*</td>
<td>87%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>Average days to attended</td>
<td>4.8 days</td>
<td>5.2 days</td>
</tr>
</tbody>
</table>

*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.

On average, 82% of clients were **offered** a psychiatry/MD appointment within 15 calendar days of referral, (up from 71% from FY 18/19) and 90% of clients **attended** a psychiatric/MD appointment within that timeframe (up from 80% from FY 18/19).
In the last four years, we have improved timeliness to psychiatry. The current average reflects meaningful reduction: from 9.5 to 6.8 days to attended appointment for adults and from 11.0 to 6.1 days for youth.

**Referral to Attended MD Appt, Days**

<table>
<thead>
<tr>
<th># Days</th>
<th>FY 18/19</th>
<th>FY 19/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>11.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Youth</td>
<td>10.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Overall</td>
<td>9.54</td>
<td>6.5</td>
</tr>
</tbody>
</table>

**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.

Due to a State mandated change, Santa Barbara County had to begin using a different version of the CANS in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete; new reports have since been designed.

This chart represents data with admissions starting 7/1/18 and still open or closed in FY 19/20. This data compares the 1st CANS to the 2nd CANS, excluding CANS that occurred in the same month.

- 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.
- Cultural Factors remained similar, indicating that the difficulties that children might be experiencing as a result of their membership in any cultural group remain stable/unchanged.
Child Strengths such as optimism, relationship permanence, talents/interests, and involvement in treatment, improved over time. Caregiver Needs & Strengths such as child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status, improved over 6 months.
ADP
In FY 19/20, on average, 91% of client admissions were served; of those, on average, 97% initiated treatment. On average, 3% of admissions dropped (did not return for treatment). On average 90% engaged in treatment. The average successful completion of treatment was high, and exceeded goals at 68%, compared to 64% as reported in 2018/19.

### ADP Treatment Program Outcomes
**FY 19/20**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY 19/20 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Served</td>
<td>91%</td>
</tr>
<tr>
<td>Initiated Tx</td>
<td>97%</td>
</tr>
<tr>
<td>Engaged in Tx</td>
<td>90%</td>
</tr>
<tr>
<td>Retention</td>
<td>47%</td>
</tr>
<tr>
<td>Successfully Completed Tx</td>
<td>68%</td>
</tr>
</tbody>
</table>

Note: Served - of clients opened, those that received services; Initiate - of clients opened, those that initiated treatment within 14 days; Engaged - initiation + 2 services within 29 days after the first service; Success – CalOMS discharge status 1, 2 or 3 [Completed Treatment/Recovery Plan Goals – Referred (status 1), Not Referred (status 2), or Left Before Completion with Satisfactory Progress (status 3)].

The average lengths of stay (LOS) in days for FY 19/20 are as follows:

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>AVG LOS All (in days)</th>
<th>AVG LOS Discharged (in days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient (1.0)</td>
<td>110</td>
<td>105</td>
</tr>
<tr>
<td>Intensive Outpatient (2.1)</td>
<td>73</td>
<td>70</td>
</tr>
<tr>
<td>Residential (3.1)</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td>Withdrawal Management (3.2)</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

We expect that for any given episode of treatment, some clients will have several admissions, at different levels of care – this is both appropriate and positive. For example, a client might initially be admitted to withdrawal management, then to residential, and later to outpatient treatment. To that end, 42% of clients were readmitted within 14 days after discharge from any/all levels of care, suggesting substantial utilization (step up or down) along the continuum of SUD care.

**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.
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 Full-Service Partnership (FSP) ACT clients are administered monthly. These analyses include clients with open admissions in FY 19/20, 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 = 257), 151 had a baseline MORS score (59%), which is less than the number of TAY who had a baseline score in FY 18/19 (n = 238; 72%). On July 1, 2019 a policy change went into effect: the CANS age range was expanded from 18 to 20 years. Clients who are 18–20 should be completing the CANS and the MORS. Staff are in the process of adopting this change, which has resulted in a reduction in the percent of TAY who appropriately received a MORS (compared to a CANS). Staff will receive additional training in order to increase their understanding that they need to complete both the CANS and MORS for TAY.

Of the TAY that had a baseline score, over two–thirds (68%) scored a five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months (n = 101), 50% improved, 31% stabilized (no change in score), and 17% declined in functioning. Between 6 and 12 months (n = 86), 29% improved, 47% stabilized, and 23% of clients declined. Thus, in the first six months of treatment, 81% of TAY improved or stabilized (which is similar to the FY 18/19), and in the next six months of treatment, 76% improved or stabilized, also similar to the FY 18/19 (74%).

<table>
<thead>
<tr>
<th>Risk/Need</th>
<th>MORS Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest</td>
<td>1 Extreme Risk</td>
</tr>
<tr>
<td></td>
<td>2 High Risk / Not Engaged</td>
</tr>
<tr>
<td></td>
<td>3 High Risk / Engaged</td>
</tr>
<tr>
<td>Moderate</td>
<td>4 Poorly Coping / Not Engaged</td>
</tr>
<tr>
<td></td>
<td>5 Poorly Coping / Engaged</td>
</tr>
<tr>
<td>Least</td>
<td>6 Coping / Rehabilitating</td>
</tr>
<tr>
<td></td>
<td>7 Early Recovery</td>
</tr>
<tr>
<td></td>
<td>8 Advanced Recovery</td>
</tr>
</tbody>
</table>

### TAY MORS Change

<table>
<thead>
<tr>
<th></th>
<th>Improved</th>
<th>Stabilized</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAY 0-6 mo (n = 101)</td>
<td>50%</td>
<td>31%</td>
<td>17%</td>
</tr>
<tr>
<td>TAY 6-12 mo (n = 86)</td>
<td>47%</td>
<td>29%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Adult Outpatient Programs
Of all open adult outpatient clients (n=2,346), 70% (1,653) had a baseline MORS score. Of those, the majority (70%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months (n = 1,356), 27% improved, 51% stabilized (no change in score), and 20% declined in functioning. Between 6 and 12 months (n = 1,193), 22% improved, 56% stabilized, and 20% of clients declined. Thus, in the first six months of treatment, and in the subsequent 6 months of treatment, 78% of clients improved or stabilized.

Assertive Community Treatment Programs
All open Assertive Community Treatment (ACT) program clients (n =337) had a baseline MORS score. As we might expect, the vast majority (80%) had a baseline MORS score of three to five, lower than TAY and other adult outpatient clients. Between baseline and 6 months (n = 331), 25% improved, 44% stabilized (no change in score), and 29% declined in functioning. Between 6 and 12 months (n =319), 21% improved, 62% stabilized, and 16% of clients declined. Thus, in the first six months of treatment, 69% of ACT clients improved or stabilized, and in the next six months of treatment, 83% improved or stabilized. These results are similar to FY 18/19.
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 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”.

Data from FY 19-20 is not yet available. Average satisfaction ratings, by fiscal year, have been high and relatively stable (small <3% fluctuations) over time.
ADP - TPS Satisfaction
As part of the DMC-ODS evaluation, counties administer the client Treatment Perceptions Survey (TPS) on an annual basis. The TPS was administered for the first time in November 2019. Clients answered four questions related to satisfaction. About 90% or more agreed or strongly agreed they felt welcome, were satisfied with services, got the help they needed and would recommend their treatment provider.

Adult - TPS, Fall 2019, Domain: General Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Agree - Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt Welcomed</td>
<td>93.5%</td>
</tr>
<tr>
<td>Overall Satisfied with Services</td>
<td>91.3%</td>
</tr>
<tr>
<td>Got the Help I Needed</td>
<td>89.4%</td>
</tr>
<tr>
<td>Recommend Agency</td>
<td>90.8%</td>
</tr>
</tbody>
</table>
Staff Activity - MH
The Department designed a new report for managers and supervisors 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 50% (comparable to FY 18/19); for Crisis staff, it was 27% (comparable to FY 18/19). 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.

<table>
<thead>
<tr>
<th></th>
<th>% Meetings/Training</th>
<th>% Direct/Client Support</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Clinics</td>
<td>12%</td>
<td>38%</td>
<td>50%</td>
</tr>
<tr>
<td>Crisis/Triage Services</td>
<td>9%</td>
<td>18%</td>
<td>27%</td>
</tr>
</tbody>
</table>

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, Quality Care Management Coordinators perform randomly selected internal chart audits. In FY 19/20, 177 charts were reviewed and 168 of those (95%) had a current treatment plan.

Client Treatment Plan
FY 19/20

- Yes current plan
- No current plan

5% Yes current plan
95% No current plan