EMQ FamiliesFirst

FY15 Santa Clara County Continuum of Crisis Services

2015

Annual Report

Contents

I. Continuum of Crisis Service

Mission Statement

EMQFF's Continuum of Crisis Services is structured to provide a variety of services to children and families experiencing a mental health crisis. The goal of these programs is to support children/adolescents in the least restrictive and most normative environment appropriate to their needs. All the crisis services attempt to divert from hospitalization as situations warrant. Interventions maximize the natural supports that exist in the family and community. When more restrictive treatment is needed, transition to a more secure setting is facilitated with appropriate attention to child safety and needs. The Crisis Continuum Program provides community based and onsite, rapid-response crisis assessment and intervention to children and families who are depressed, suicidal, a potential danger to themselves, others or are in some other form of acute psychological crisis. The Continuum of Crisis Services utilizes a family-centered, strengths-based approach. Children and families are viewed as living within many interrelated systems, including extended families, schools and communities, as well as professional external resources. Opportunities to involve and draw support from these systems are incorporated throughout the services provided by each component of the program.

Program Description

The Crisis Continuum of Service is made of three mental health service components: The Child Adolescent Crisis Program (CACP) aka Mobile Crisis, The Crisis Stabilization Unit (CSU) and the Community Transition Services (CTS).

CACP's services are twofold. First, clinicians provide assessment and stabilization in the current crisis episode, drawing as much as possible upon the strengths and resources of children, families and other natural supports and utilizing the least intrusive and restrictive means. Second, clinicians facilitate with children and families to find tools that promote ongoing health and growth and help maintain children in their homes and communities. This can include a direct referral to the Community Transition Service team. These tools consist of both practical strategies to stabilize current and future crises, improve communication and facilitate positive outcomes, and case-specific referrals and access information for ongoing treatment and other supports. The CACP staff is diverse, multi-lingual, and multi-disciplinary. All CACP clinicians are authorized 5150 evaluators, and can place youth on 72-hour holds for emergency hospitalization when needed.

The Crisis Stabilization Unit (CSU) is a short term secured unit to support youth who are experiencing a mental health crisis. This model has been developed to support youth 0-17 who are at risk for psychiatric hospitalization because of grave disability suicidal potential or homicidal intent. The services are family inclusive, and the Unit works closely with family/caregivers to support a safe transition. Children who are admitted to the CSU will be on a 5150/5585 psychiatric holds as established by the Lanterman-Petris-Short Act. All regulations outlined by the LPS Act will be followed by the CSU. The goals of this model are threefold:

1. Provide diversion from psychiatric hospital;
2. To provide a safe and nurturing environment for children who have been placed on a 5150/5585 psychiatric hold, and are awaiting admission into a psychiatric unit;
3. Proactive/ reactive safety planning as youth transfer to the community
4. Referral to the appropriate on going mental health services

The Community Transition Services (CTS) team is focused on longer term community based crisis stabilization lasting up to 90 days. Currently, CTS support youth 0-17 who are at risk of suicide or homicidal hospitalization. The program works collaboratively with CACP and CSU to help children in Santa Clara County who are going through a traumatic experience in their lives with a warm, safe, and caring service. Our team incorporates the family into assessment, treatment, safety planning, and discharge planning processes. Care is taken to ensure that services encompass the family's preferences, including language, cultural fit and accessibility for any needed follow up services.

Services

Child Adolescent Crisis Program (Mobile Crisis)

CACP provides mobile crisis assessment in Santa Clara County 24/7. A team of 1 to 4 clinicians respond to crisis, with the highest number of clinicians available during peak times (vary by day and month). Crisis response includes: Diagnostic interview, assessment of mental and emotional status, strengths-based family evaluation, risk assessment, consultation with other professionals, safety planning, facilitation of emergency hospitalizations, crisis counseling, therapeutic supports, case-specific referrals for follow-up or access to services. The CACP clinicians also provide phone crisis consultation to community partners. Additionally, CACP clinicians provide trainings in Crisis Intervention, Safety Planning and related topics for community partners.

Crisis Stabilization Unit

The Crisis Stabilization Unit is available for children on a psychiatric hold who will receive short term emergency assessment and stabilization instead of going to the hospital. Services include crisis assessment, youth and caregiver safety planning, referral and aftercare planning and referral to Community Transition Services for ongoing mental health services. Length of service is up to 23 hours and 59 minutes.

Community Transition Services

The Community Transition Services team is able to provide community based mental health services as soon the same day or following day for families who receive services either through the CACP or CSU programs. The mental health services include: psychosocial assessment, proactive reactive safety planning, individual therapy, family therapy and behavioral support services in the home and or community. The CTS team also provides psychiatric assessment and medication management. Case management is a key service of the CTS program. The team is able to provide referrals to appropriate level of ongoing services and linkage to community service providers.

Eligibility and Referral Process

Child Adolescent Crisis Program (Mobile Crisis)

Typical referral sources include parents, other family members, other caregivers, friends, school staff, police officers, firefighters, hospital staff, other health professionals and community service

providers. Requests for services are made via CACP's 24-hour crisis line: (408) 379-9085. When a mobile response is deemed appropriate in a brief phone screen, clinicians are dispatched and arrive at the scene of the crisis within one hour. This results in a thorough, less stressful and more strength-based assessment, intervention and stabilization process, with the addition of practical tools to promote ongoing stability and growth. When a mobile response is not appropriate, specific referrals are provided.

Crisis Stabilization Unit

Services are available in Santa Clara County to youth who are under the age of 18 and are unable to care for themselves due to a severe mental illness or who are in immediate danger of either harming themselves or others.

The referral assessment is conducted by a designated clinician, law enforcement or medical professional. This includes an interview of the youth and family, if possible, as well as gathering collateral information. Once it is determined that the client is appropriate for the level of care requested, a 5150 psychiatric hold will be written. The youth is transported to the Crisis Stabilization Unit. The nurse will conduct a medical assessment to determine if the youth needs further medical attention. If the youth is medically cleared, he or she will then be admitted to the Crisis Stabilization Unit.

Community Transition Services

This very critical service is the only piece of the Continuum that is limited to Santa Clara County children with full-scope Medi-Cal. The referrals mainly come directly from the CACP program and the CSU. The CTS team also accepts referrals from local acute hospitals, and Emergency Psychiatric Services.

Capacity:

Child Adolescent Crisis Program (Mobile Crisis): 50 episodes per month average, and team responds beyond capacity as available. Capacity is limited only by the availability of clinicians at any given time. When clinicians are not immediately available, efforts to make alternative arrangements are made wherever possible.

Crisis Stabilization Unit: 7 Youth

Community Transition Services: 30 Static

For additional information, please contact:

Child Adolescent Crisis Program: Clinical Program Manager Carlos Aguila at 408-364-4069

Crisis Stabilization Unit : Nurse Manager Melissa Nolan 408-628-5574

Community Transition Service: Clinical Program Manager Joyce Kearney 408-364-4007

Continuum of Crisis Services Clinical Director Karen A Meagher at 408- 364-4002

Executive Summary

This annual report provides an overall summary of population served, outcomes, staffing data, and a success story FY15. The descriptive data includes totals, referral source and demographics. The outcomes section includes improvements in functioning from intake to discharge, including in home, in school, and out of trouble measurements; treatment outcomes; and satisfaction ratings by consumers. The staff section includes demographic and language data, as well as training information. The success story section includes a vignette from the year (no personal information disclosed).

Summary of SCC Crisis Continuum Logic Model Outcomes

	Goal/Outcomes	Source	FY15
Combined	Hospital diversion and community transition will occur for at least 75% of youth receiving CTS services plus Mobile and/or CSU services.	Program tracking	86% of youth receiving CTS plus Mobile and/or CSU services were discharged to the community (n = 108).
Mobile	Hospital Diversion will occur for at least 70% of youth, and youth will instead be discharged to a community setting.	TIER – Crisis Disposition and program tracking	70% of youth had safety plan in place before discharged to a community setting. (n= 374)
CSU	Hospital Diversion will occur for at least 60% of youth, and youth will instead be discharged to a community setting.	TIER – Crisis Disposition	48% of youth had safety plan in place before discharged to a community setting. (n= 451)
	80% of youth will be discharged from Crisis Stabilization Unit services in under 23 hours and 59 minutes.	Program Tracking	76% of youth were discharged under 23 hours and 59 minutes. (n=759)
	80% of youth and families will be satisfied with Crisis Stabilization Unit services.	Youth Satisfaction Surveys (YSS, YSS-F, AS)	4.52 is the total average score for caregivers (n=4) 3.81 is the total average score for youth YSS (n=7)
CTS	80% of youth discharged in community with goals met	TIER – Discharge	82% of youth discharged in community with goals met (N=100)
	80% of youth and families will be satisfied with Community Transition Services.	YSS, YSS-F, AS (% Satisfied = Mean score of 4 or higher on Satisfaction domains and total.)	4.44 is the total average score for caregivers (n=3) 4.22 is the total average score for youth YSS (n=2)

Notes: (1) Outcomes from program logic model. (2) In GREEN: per desired target goal, and in BLUE: per program baseline or KPI standard. (3) N=number of youth who met the outcome/goal; different N's reflect variation on how many clients are addressing the specific outcome, as well as available data.

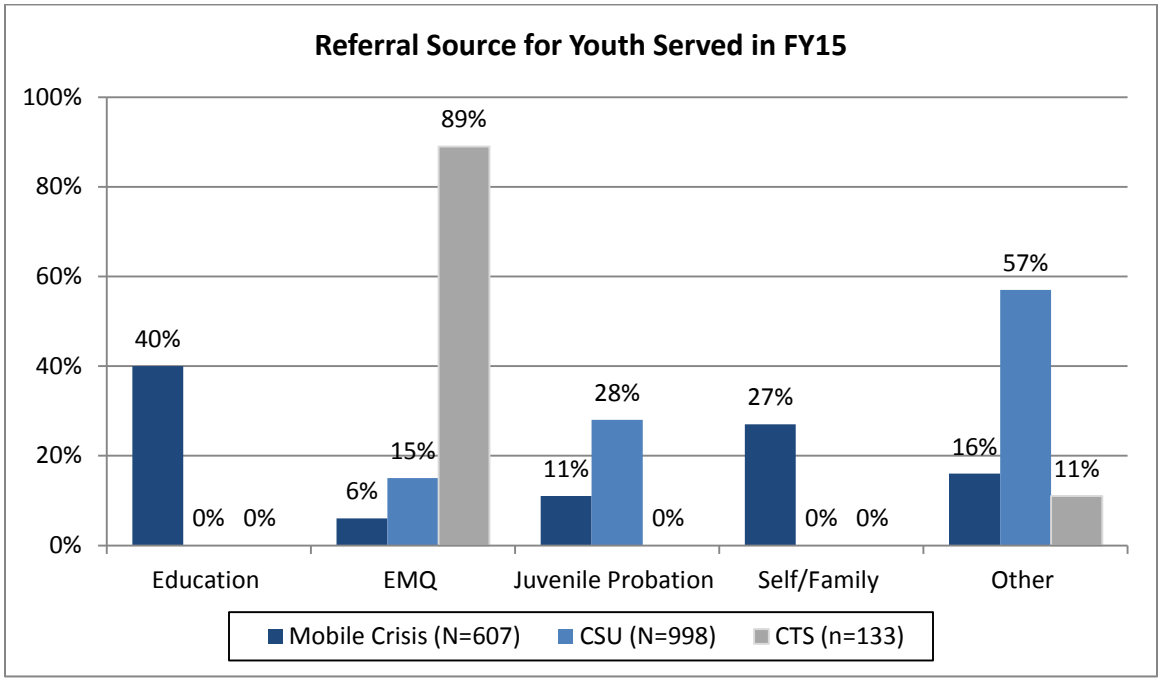
SECTION I: DESCRIPTIVE DATA

Number of Youth Served in FY15

Number of Youth Served	Mobile Crisis	CSU	CTS
Active Youth as of 06/30/15	0	1	21
Youth Admitted in FY15	607	1000	125
Youth Discharged in FY15	607	999	112
Total Youth Served Unduplicated	522	733	131
Total Youth Served	607	1000	133

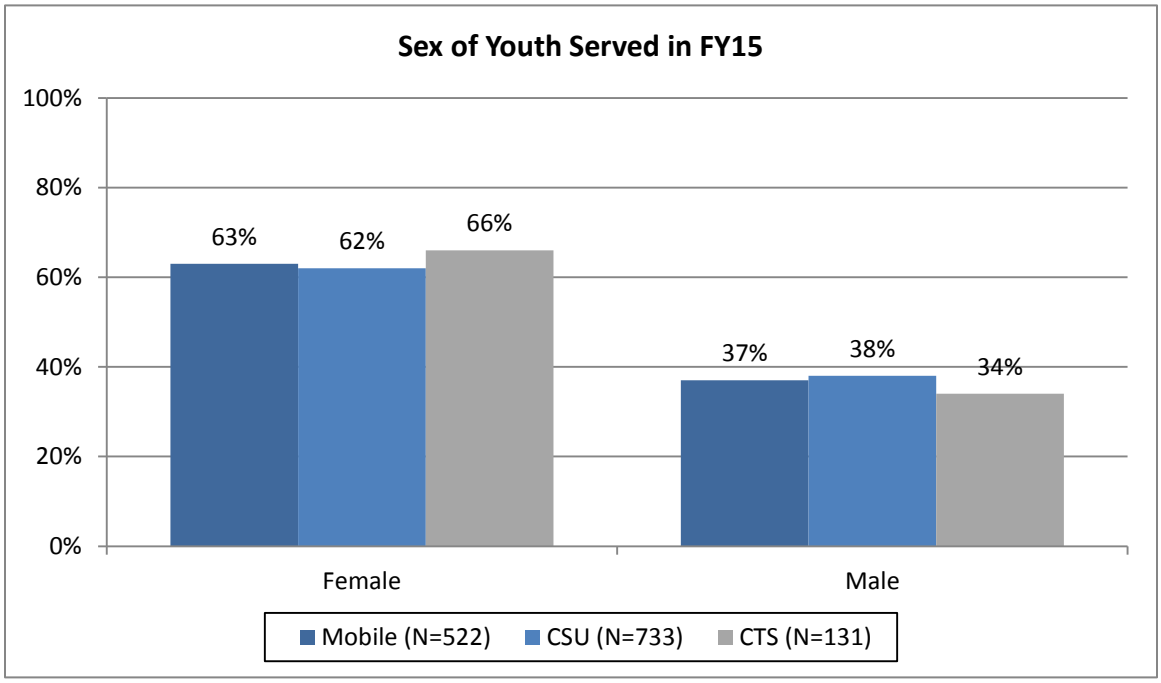
Source: Demographics and Basic Outcomes Report 08/03/2015.

Referral Source



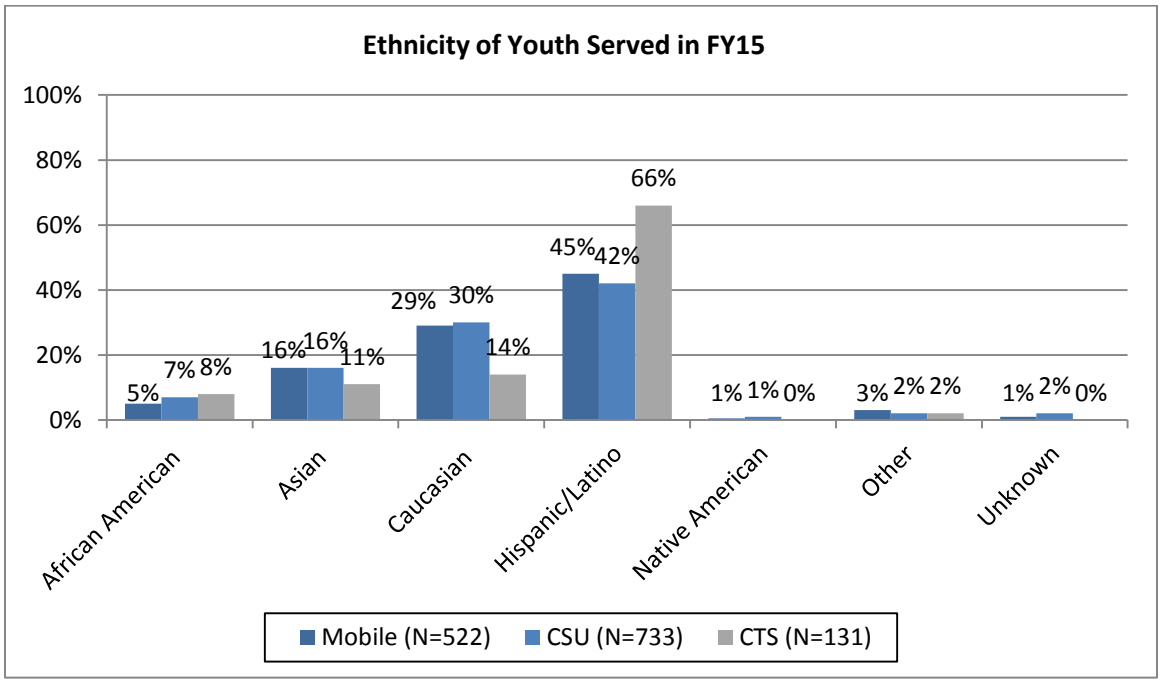
Source: Demographics and Basic Outcomes Report 08/03/2015.; Note(s): (1) Other category includes County Mental Health, Dept. of Social Services, and Medical Facility.

Sex



Source: Demographics and Basic Outcomes Report 08/03/2015. Note (1): N's are unduplicated.

Ethnicity

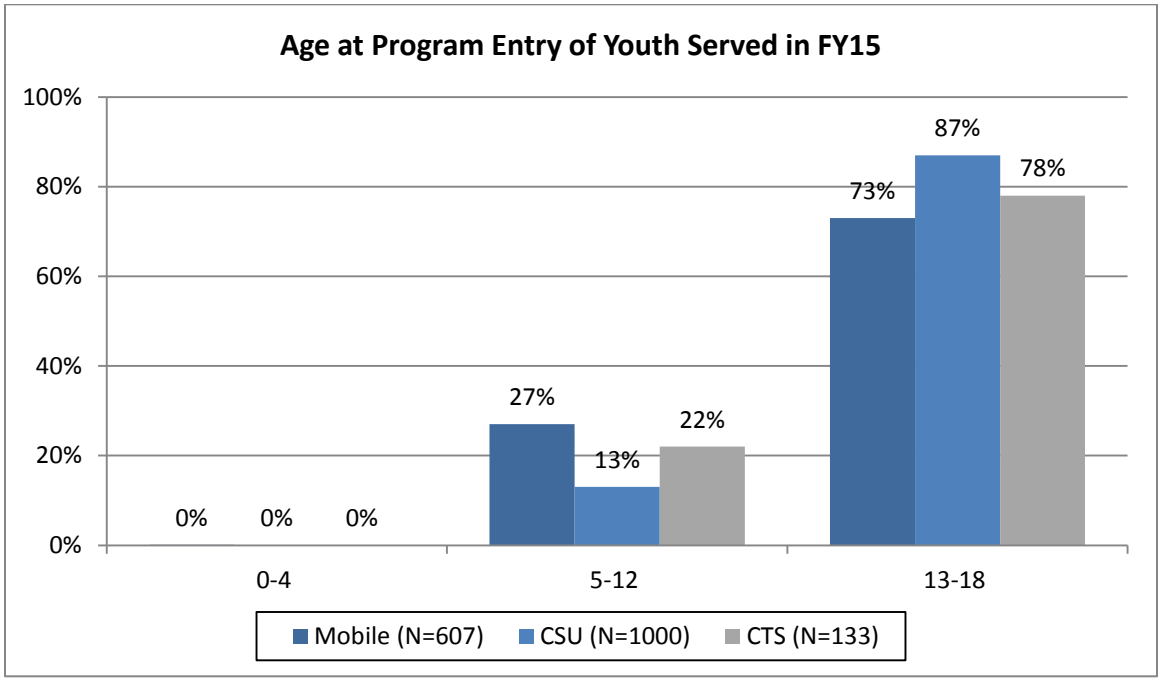


Source: Demographics and Basic Outcomes Report 08/03/2015. Note (1): N's are unduplicated.

Age at Program Entry

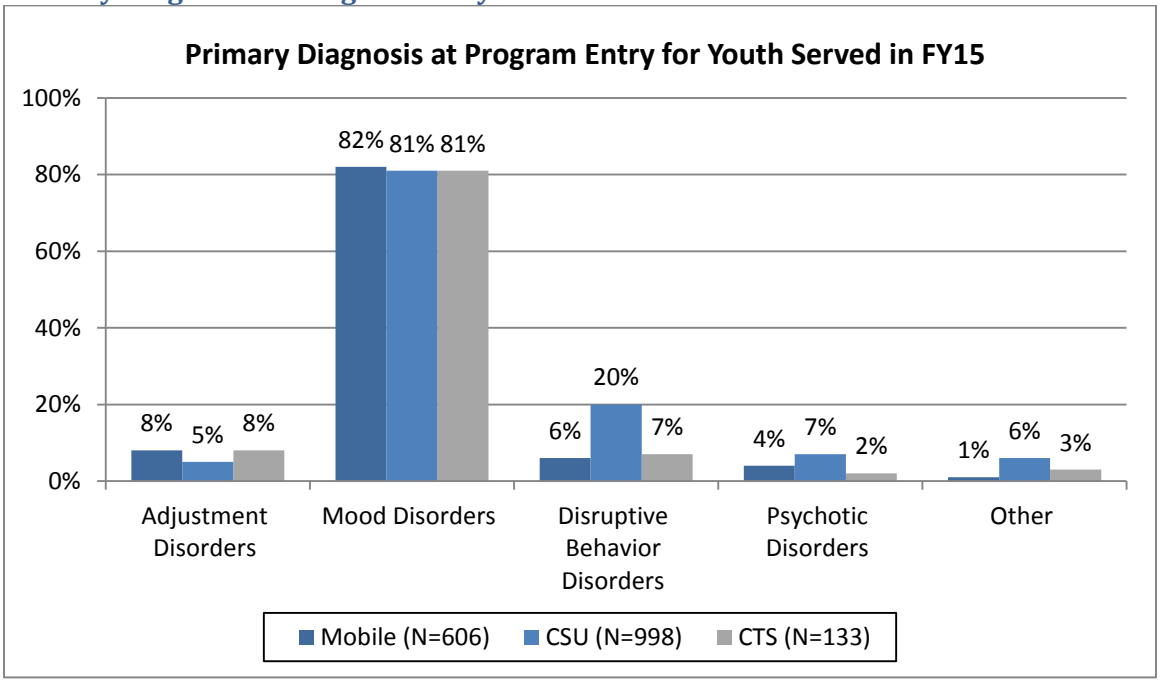
	Mobile (N=607)	**CSU** (N=1000)	**CTS** (N=133)
Mean	14.33	15.13	14.66
Median	14.73	15.41	14.99
Range	5.77-17.95	.56-18.01	6.36-17.92

Source: TIER Masterclient 07/24/15.; Note(s): (1) Age is reported in years.



Source: Demographics and Basic Outcomes Report 08/03/2015.; Note(s): (1) Age is reported in years.

Primary Diagnosis at Program Entry

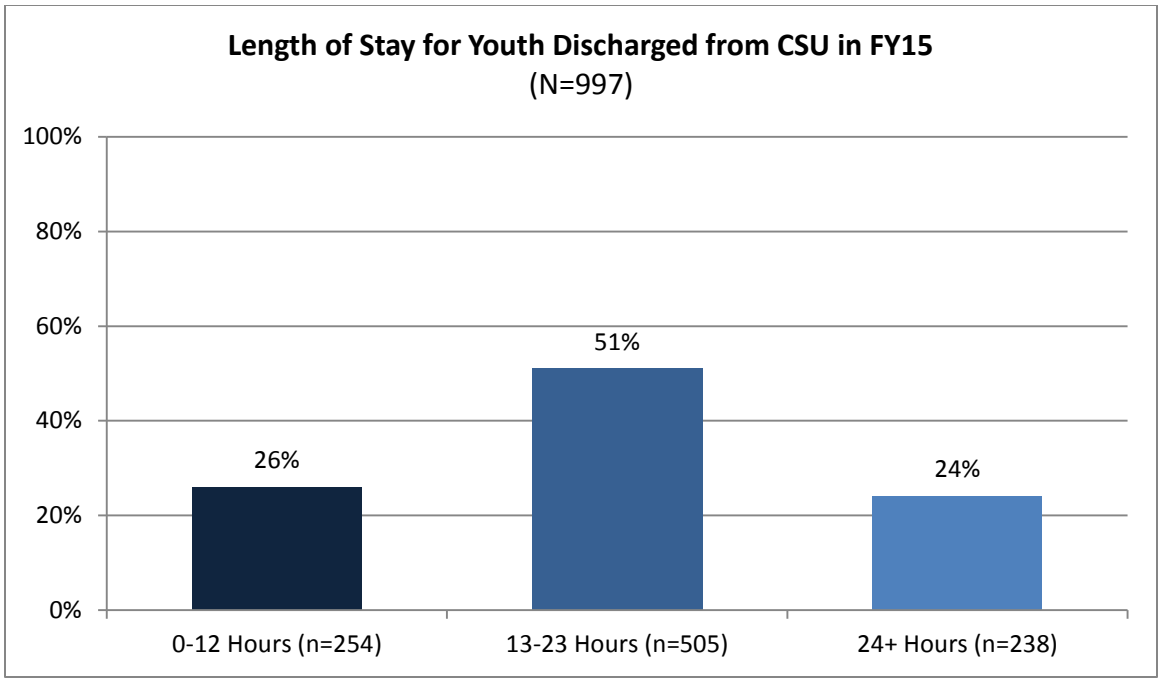


Source: TIER Masterclient 07/24/15.; Mobile Note(s): (1) One youth was excluded due to missing data. (2) Other category includes Abuse Neglect (1 youth), and Impulse-Control (3 youth). CSU Note(s): (1) Two youth were excluded due to missing data. (2) Other category includes Substance (3 youth), RAD (1 youth), PDD (6 youth), Impulse-Control (49 youth), and No Dx (2 youth) . CTS Note(s): (1) Other categories include Eating (1 youth) and Impulse-Control (3 youth).

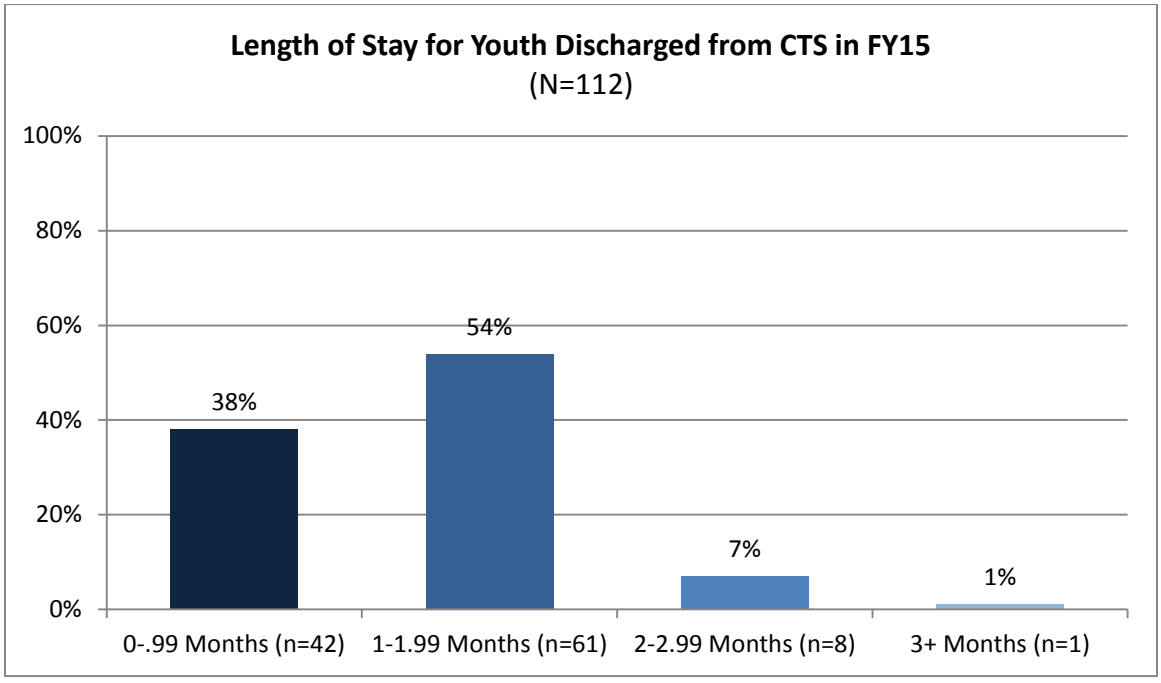
Length of Stay for Youth Discharged in FY15

	Mobile (N=607)	**CSU** (N=1000)	**CTS** (N=112)
Mean	1	21.68	1.27
Median	1	18.83	1.18
Range	1	1.00-193.77	.07-3.81

Source for CTS: TIER Masterclient 07/24/2015.; Note(s): (1) Length of Stay for CTS is reported in months. (2) The length of stay for all mobile youth discharged in FY15 is one day. (3)Source For CSU: CSU Program Tracking 07/22/2015.; (4) CSU Length of Stay is reported in hours

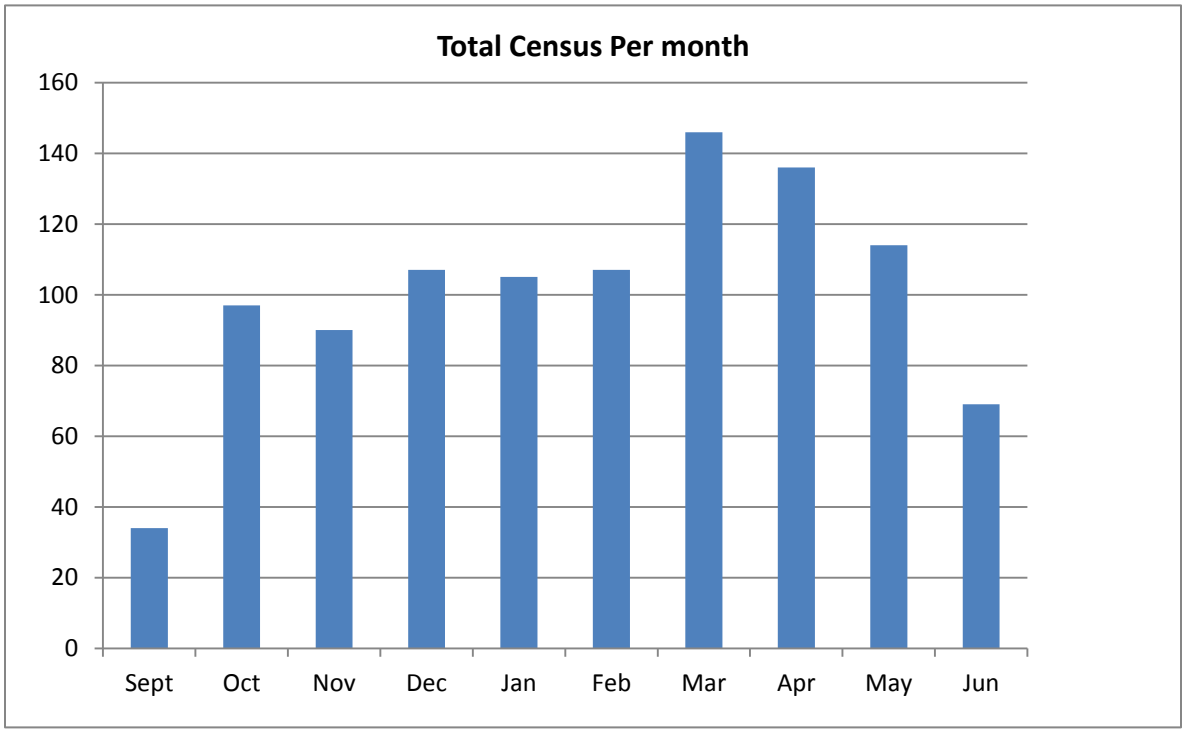


Source: CSU Program Tracking 07/22/2015.; Note(s): (1) Three youth were excluded due to missing data in the Program Tracking.

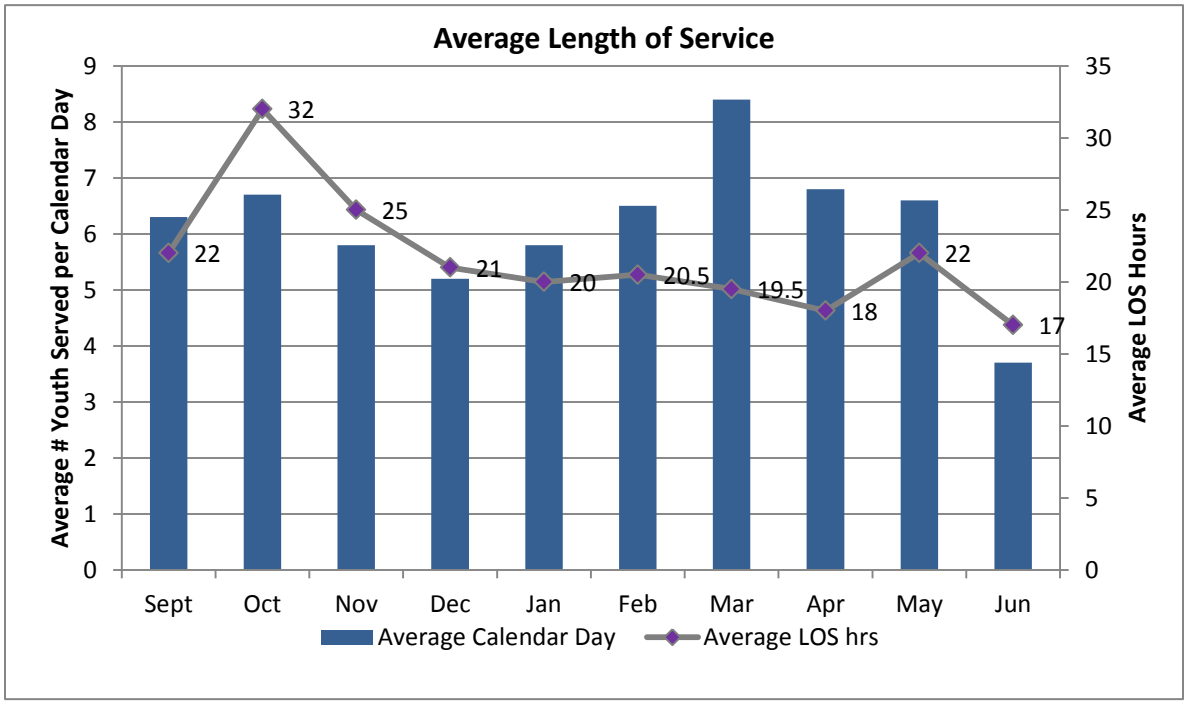


Source: TIER Masterclient 07/24/2015.

Crisis Stabilization Unit Utilization



Source: CSU Program Tracking 07/22/2015

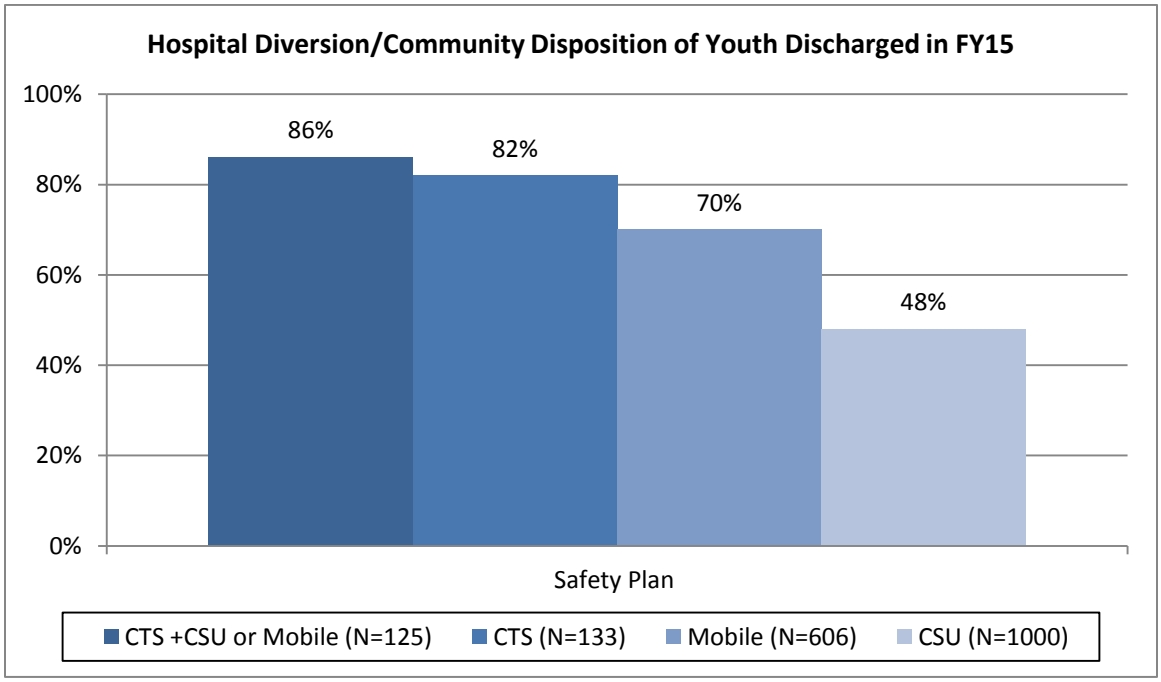


Source: CSU Program Tracking 07/22/2015. The average youth seen per calendar day was near the CSU 7 capacity most months, with some days far exceeding with intakes/discharges within the day. Average length of stay (hours) reflects higher due to the overstay outliers, when hospital beds were not available and youth exceeded 23hrs59min.

SECTION II: OUTCOMES

A. Continuum of Crisis Hospital Diversion/Community Disposition

The graph below reflects individual Continuum service outcomes (each program's diversion rate) as well as a combined Continuum outcome (multiple services utilized). Of note is the significant increase in hospital diversion and community disposition when a youth that receives Mobile Crisis and/or CSU services, as well as the community-based transitional CTS services. This 86% rate reflects no additional hospitalizations by the time of discharge. CTS services are currently utilized by Santa Clara County Medi-Cal recipients, and not available to commercial/private insurances.

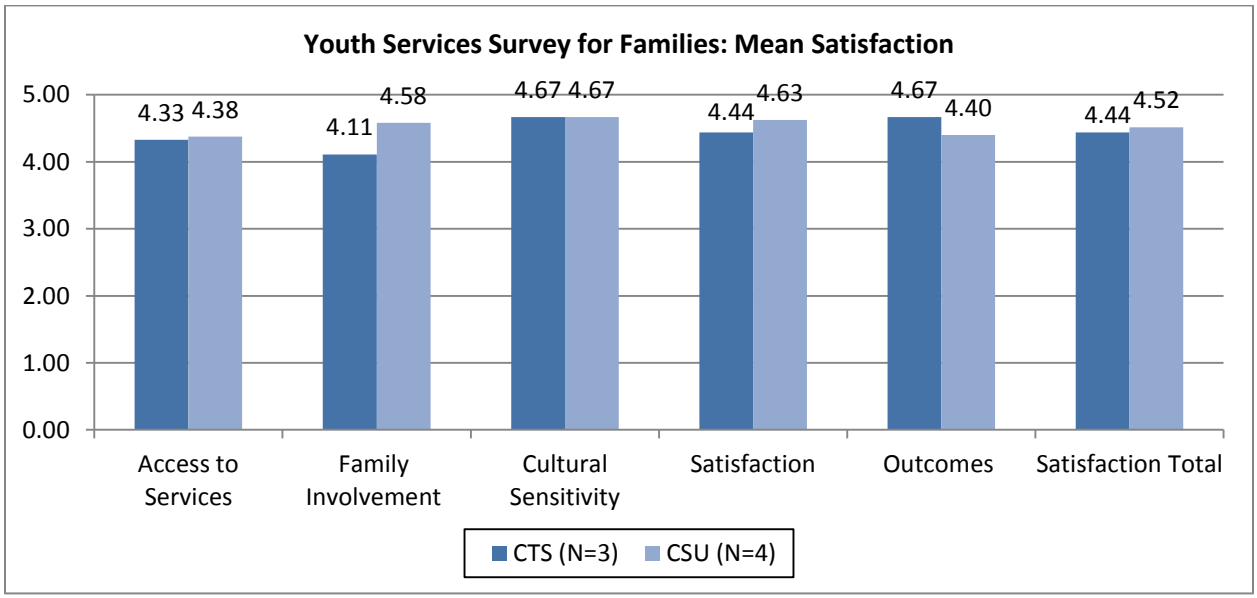


Source for mobile: TIER Masterclient 07/24/2015. Note(s): (1) Mobile Desired goal is 70%. (2) One youth was excluded from mobile due to missing data. (3)Source for CSU: CSU Program Tracking 07/22/2015. (4) CSU Desired goal is 60%.

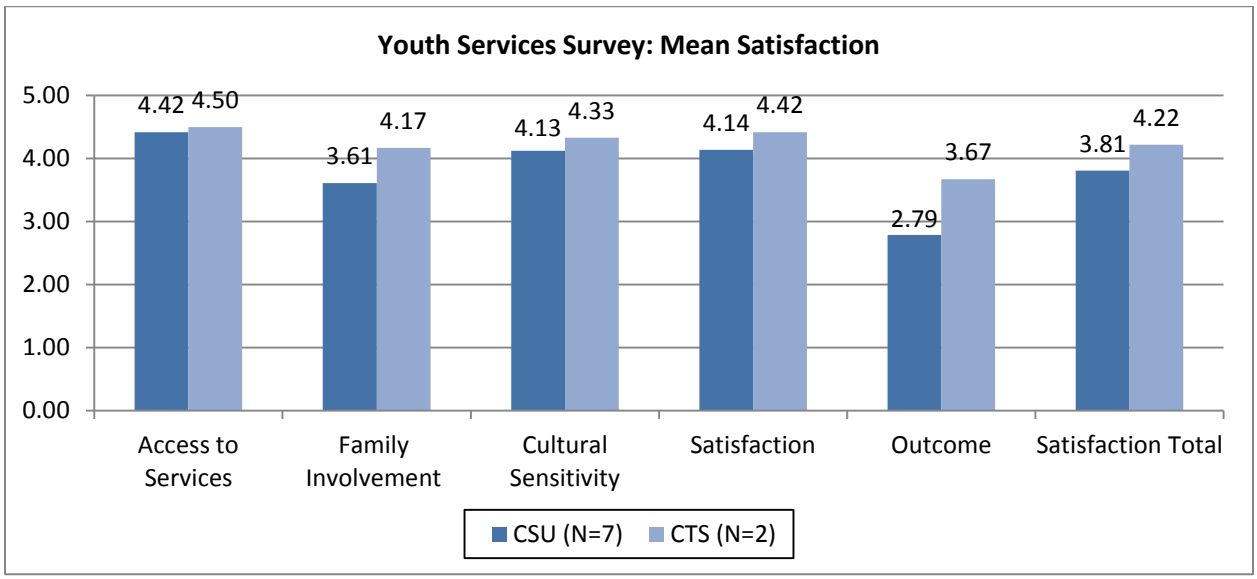
B. Satisfaction Outcomes

Youth Services Survey

To measure youth and caregiver satisfaction EMQ FF utilizes the Youth Services Survey for Families (YSS-F), the Youth Services Survey (YSS), and Adult Survey (AS). Satisfaction is collected two times per fiscal year, during the POQI State-Wide administration period. The YSS surveys ask caregivers and youth to rate to what extent they disagree or agree with statements on a 5-point Likert-type scale, ranging from "Strongly Disagree" (1) to "Strongly Agree" (5), with a score of 5 indicating the highest level of satisfaction. Our agency goal for satisfaction is defined as an average rating of 4.0 and above.



Source: YSS-F 07/22/2015. Note(s): (1) Satisfaction is defined as an average rating of 4.0 or above. (2) For CSU: Cultural sensitivity and Satisfaction total are missing one case. (3) No information available for Mobile.

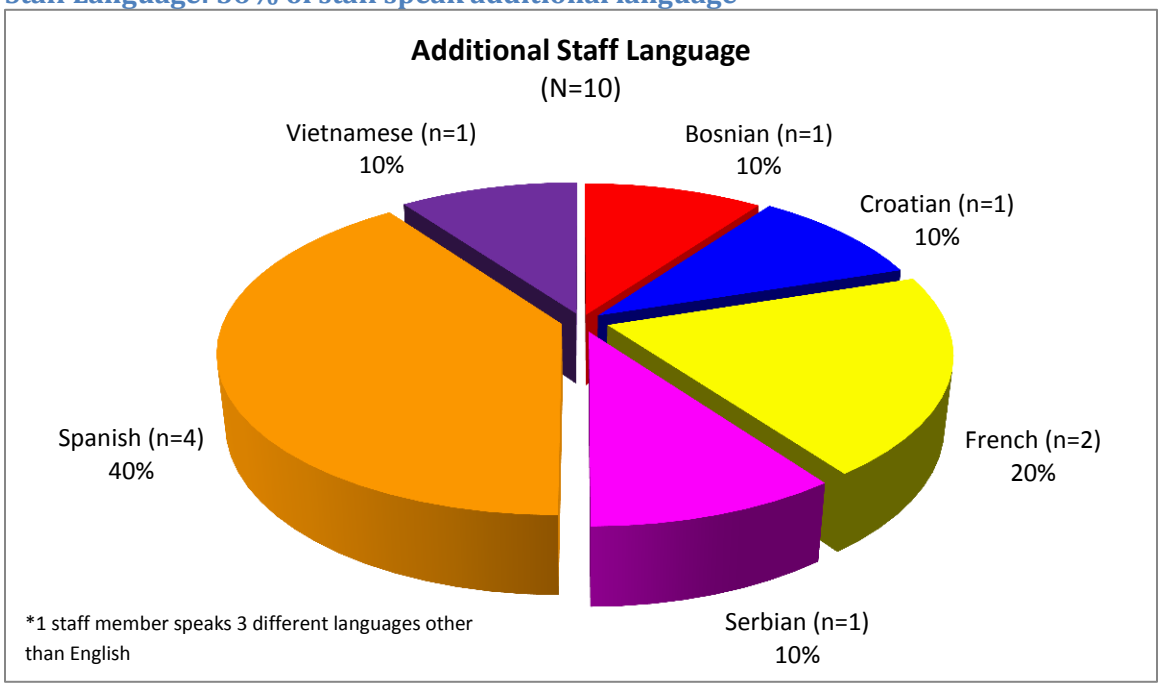


Source: YSS 07/22/2015. Note(s): (1) Satisfaction is defined as an average rating of 4.0 or above. (2) For CSU: Access to services is missing one case; family involvement is missing one case; cultural sensitivity is missing 3 cases; outcome is missing one case; satisfaction total is missing 3 cases. (3) No information available for Mobile.

SECTION III: STAFF INFORMATION

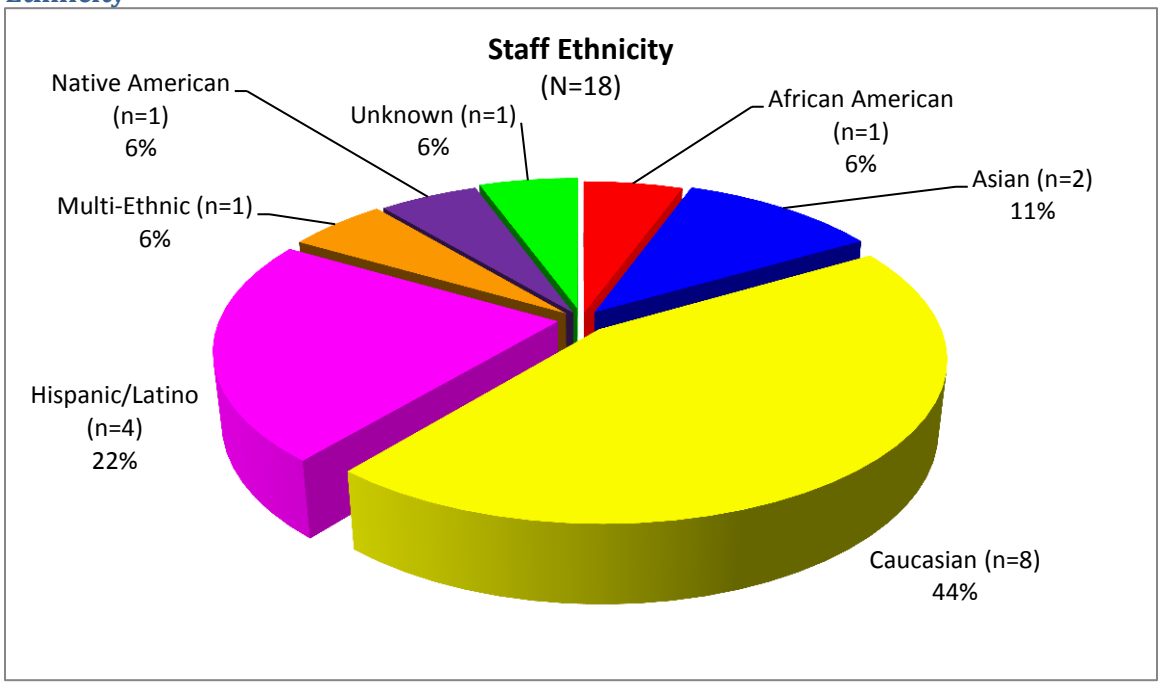
A. Mobile

Staff Language: 56% of staff speak additional language



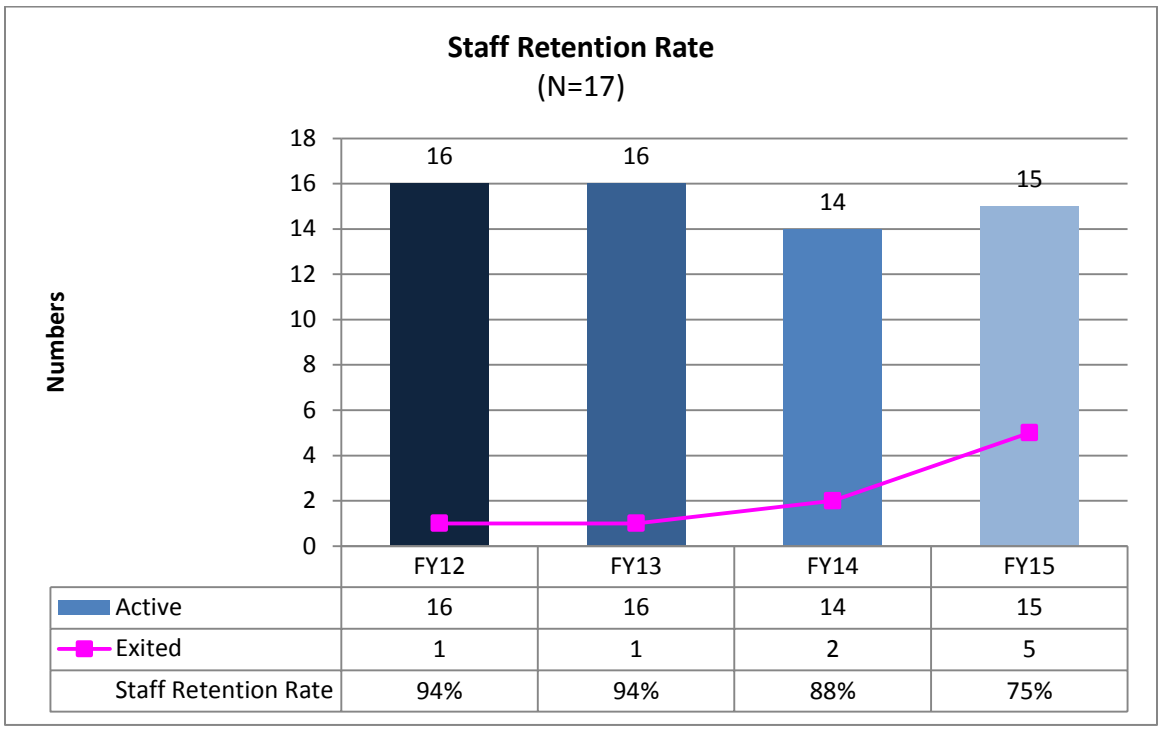
Source: Employee Language Details 07/28/2015. Note(s): (1).

Ethnicity



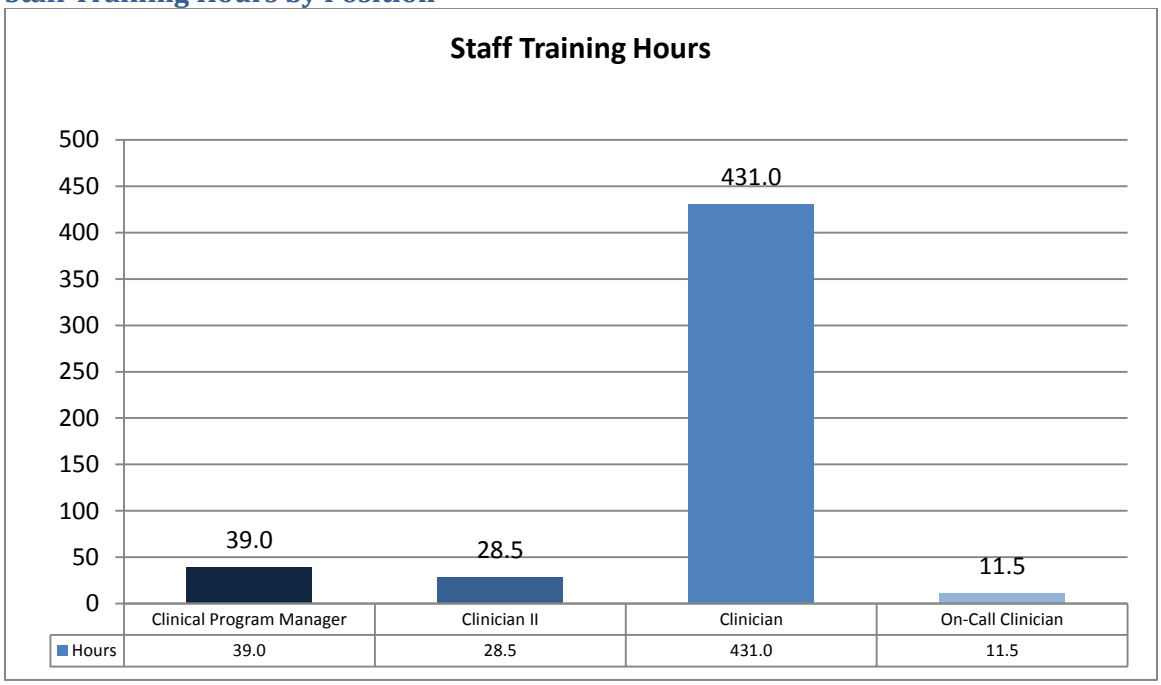
Source: Ethnicity Headcounts by Department 07/28/2015. Note(s): (1)

Staff Retention



Source: Turnover by Department 07/28/2015. Note(s): (1)

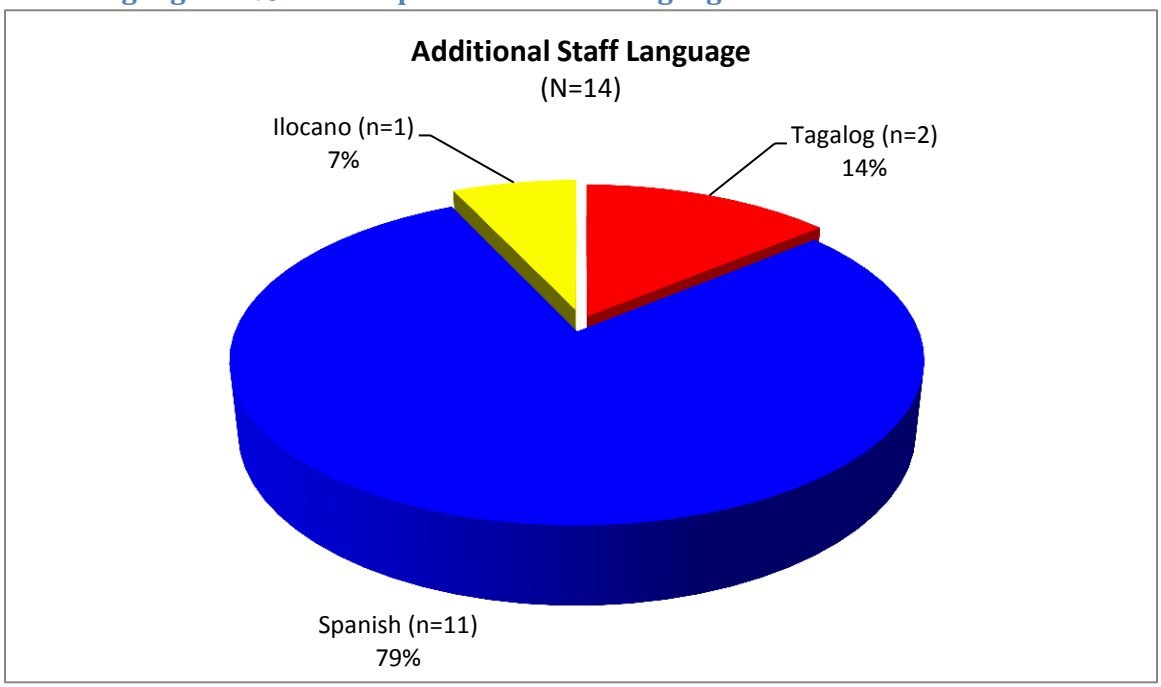
Staff Training Hours by Position



Source: Training Details and Summary 07/28/2015.

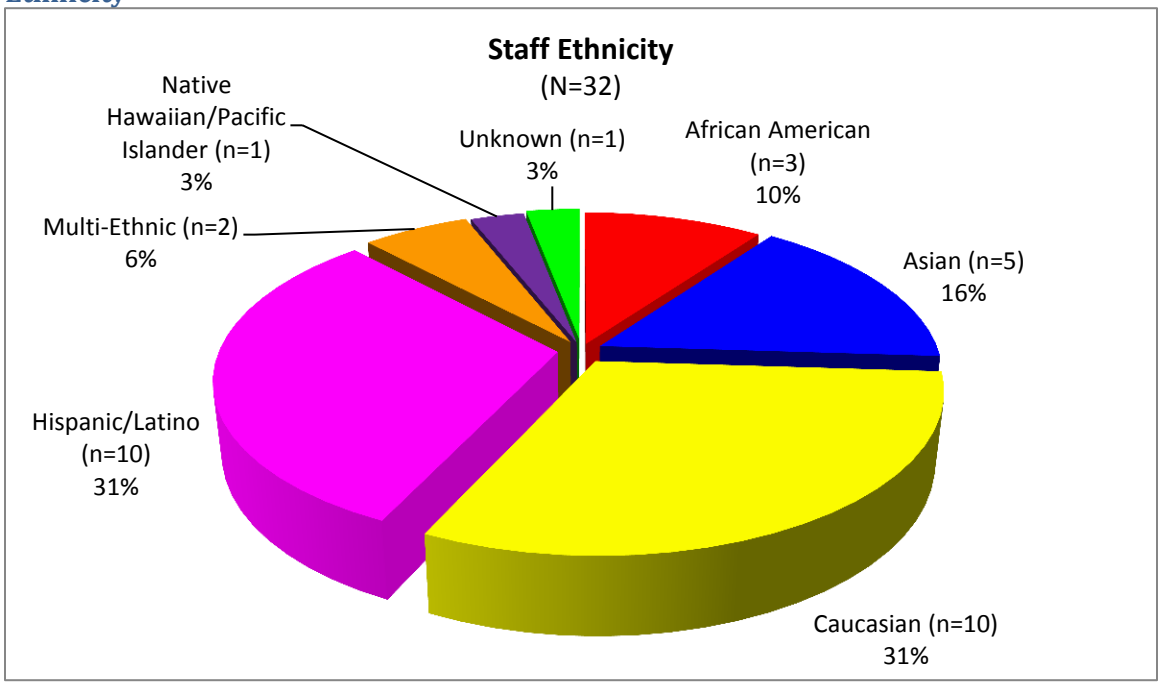
C. CSU

Staff Language: 44% of staff speak additional language



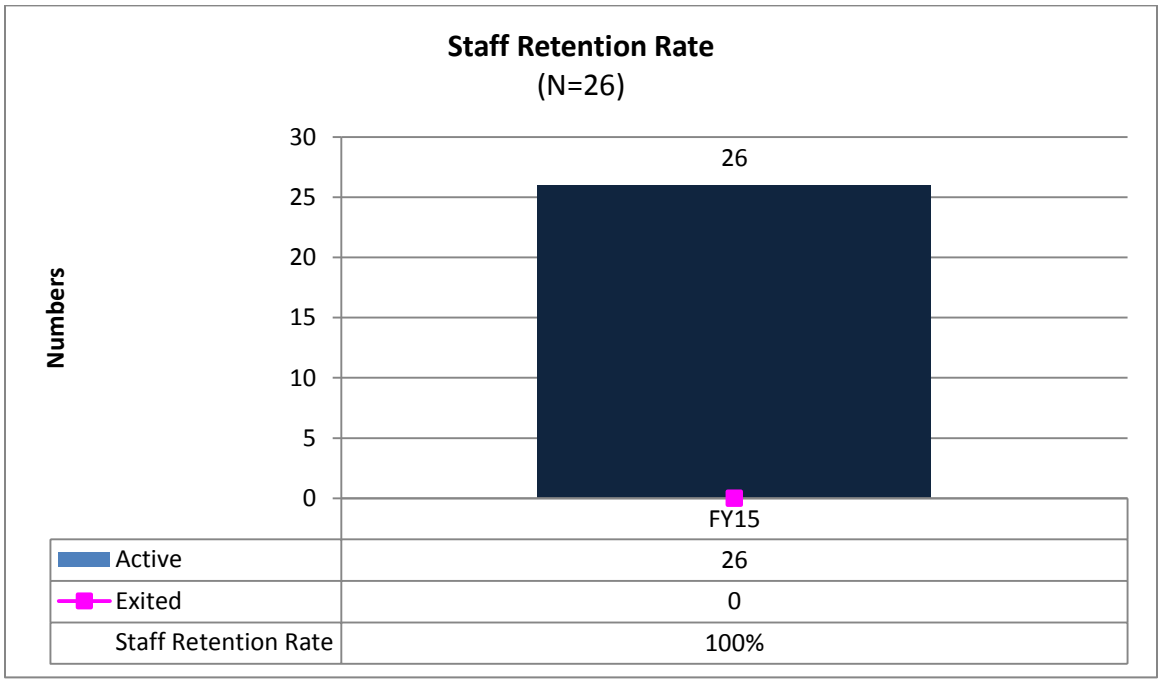
Source: HR Report 08/02/2015.

Ethnicity



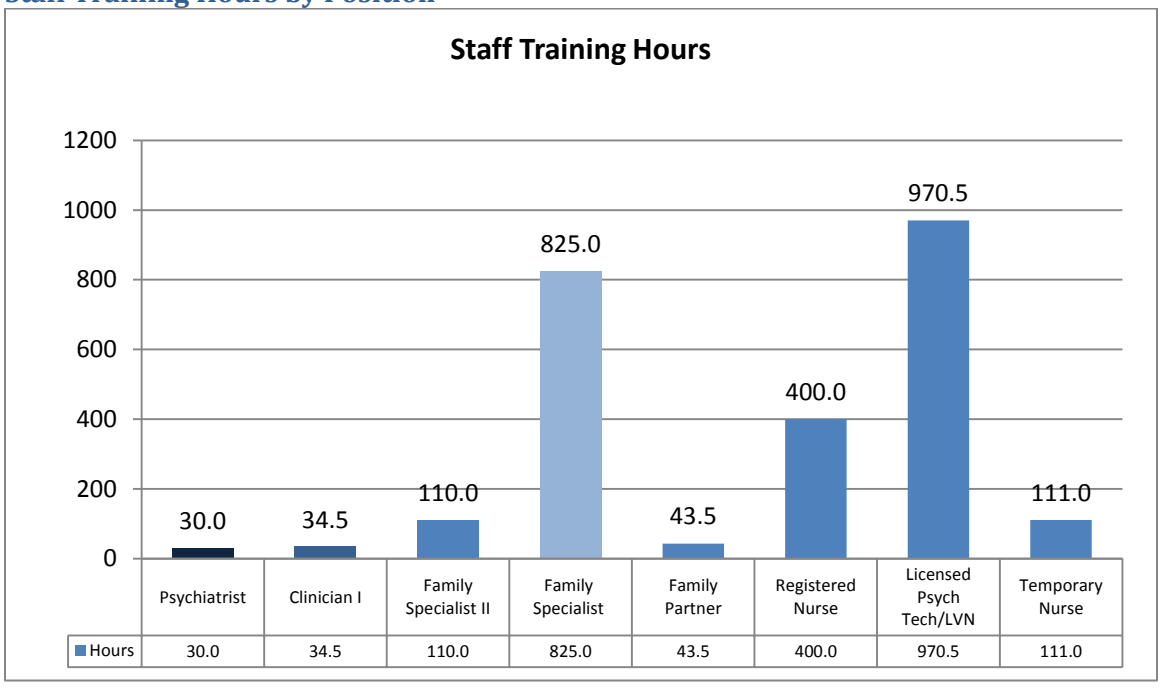
Source: Ethnicity Count 8/2/2015.

Staff Retention



Source: Turnover Report 8/2/15. Note(s): (1)

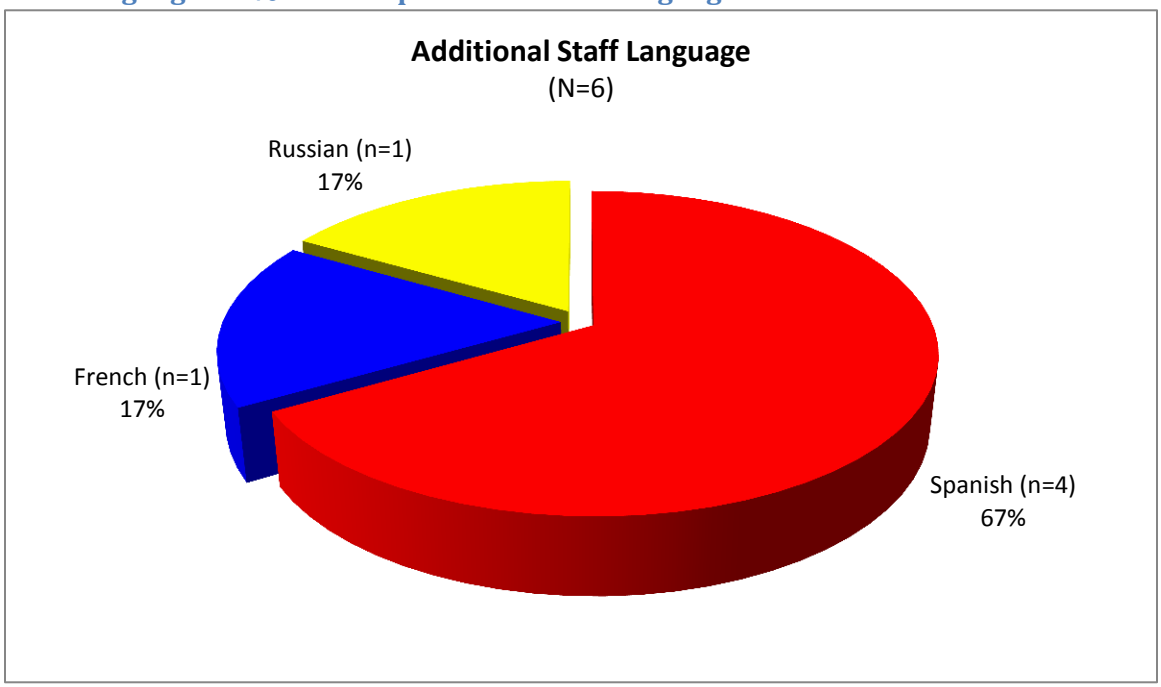
Staff Training Hours by Position



Source: Training Report 8/2/15.

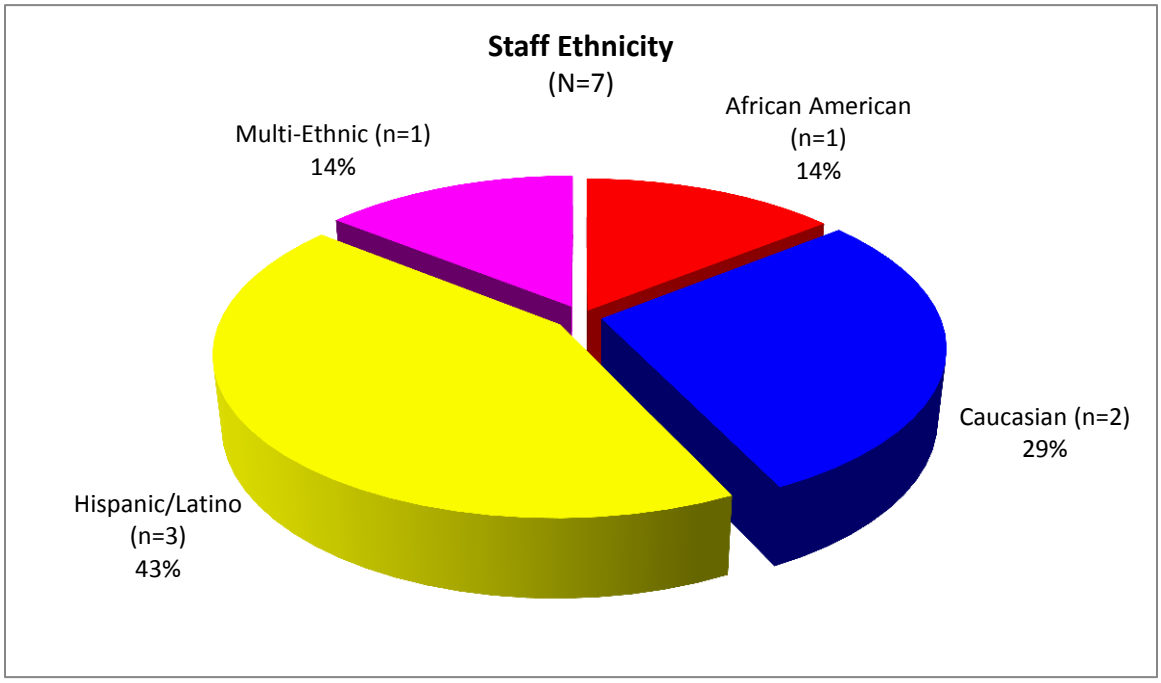
C. CTS

Staff Language: 86% of staff speak additional language



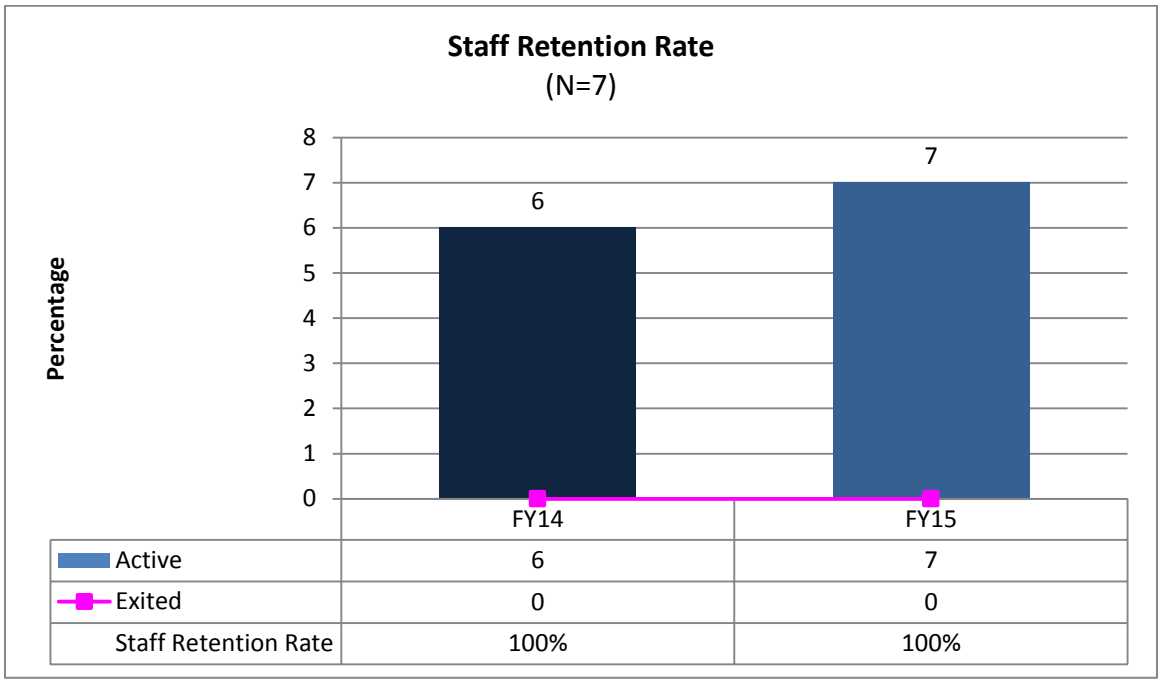
Source: Employee Language Details and Summary 07/28/2015.

Ethnicity



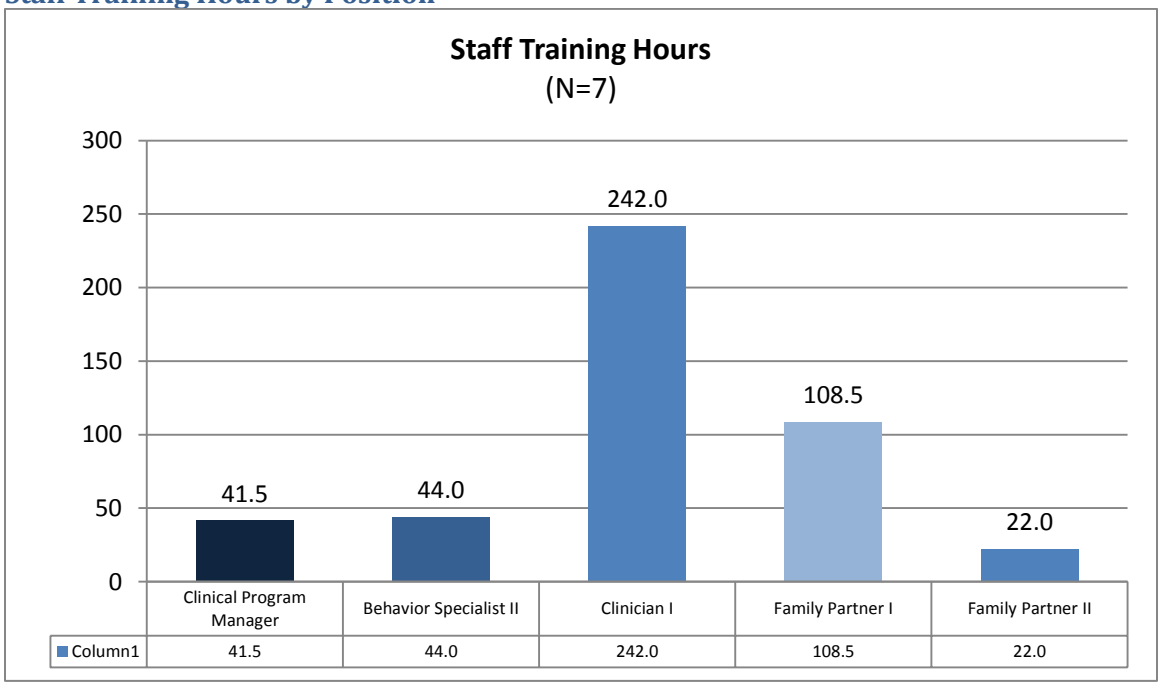
Source: Ethnicity Headcount 07/28/2015.

Staff Retention



Source: Turnover 07/28/2015.

Staff Training Hours by Position



Source: Training Details and Summary 07/28/2015.

SECTION IV: SUCCESS STORIES

Angela's Story

Angela came to the counselor at Moreland Middle School for help due to having thoughts of suicide. At 13 years old, she was feeling overwhelmed by her life and did not feel she had any support. When she was 6 years old, her mother left the family due to her substance use. Her father began to rely on her to help care for her two younger brothers, and as she got older, the weight of this role increased. At the time of this incident, her father had remarried and she felt she had lost the support of her father, she had no relationship with her mother, and she was also feeling stress from her peer relationships. All of this resulted in her feeling lost and without hope. The school counselor contacted the police and she was transported to the Crisis Stabilization Unit (CSU) on a 5150 hold.

While at CSU, she was able to participate in a youth group led by one of the Family Specialists. She was able to share her concerns about talking with her father about what led her to talk with the school counselor. While she wanted her father to be happy and was glad he had a new wife in his life, she missed time with her father and wanted to have family time without their step-mother. By the time her assessment was completed and she was cleared to return home, a family session was arranged and she was feeling prepared to talk with her father. He was open to all she had to say and was interested in having further services to help his children make the adjustment to having a step-mother. A safety plan was developed with Angela and her father, and a referral was made to the Community Transition Services (CTS) program.

CTS worked with the family on communication skills between all the family members. The Behavioral Specialist worked with Angela specifically on developing anger management skills and managing feelings of frustration. The strengths she had developed and used in caring for her younger brothers were identified as inner resources to help her grow and move forward. She was coached on learning how to let go of resentments and moving forward with the benefit of lessons learned from past experiences. Finally, she was able to identify that her personal goal was to be happy and what she needed to achieve this goal.

By Angela's own report, she stated she is now able to deal with her emotions, not lose sight of her goals, and to always have a sense of direction. She has come to realize that following her impulsive thoughts isn't always a good idea. She now has trust and confidence in herself and feels she is not subject to outside factors controlling her life. She has come to realize that her choices will affect her future, and she is now ready to move forward, knowing what she wants for herself.

A referral was made for Angela to receive long-term counseling from Gardner Family Care, and once services had started, the case was closed.

Ruby's Story

Ruby is a quiet, 13-year-old Hispanic high school student. Ruby's sister died of cancer about four years ago. Ruby has been grieving since that time, and keeping her feelings almost entirely to herself. The family had naturally felt deep shock at the time and had never really processed the experience. Ruby came to believe that her parents had told her that she should simply "move on." Although her parents appeared to be stoic, she also felt that she didn't want to burden them further with her own sadness. About a year ago, Ruby began having thoughts of finding her life unbearable and wishing it would end. Today, she came forward for the first time and told a school counselor about her feelings. She said the thoughts of wanting her life to be over had increased to the point that she had actually begun thinking about taking action. In fact, she had taken a few pills about a week ago with vague thoughts of wanting to get some sort of respite. She came forward because she was beginning to feel concerned about her ability to remain safe.

A CACP clinician spent about an hour and a half with Ruby and her father. Ruby had an opportunity to express her feelings freely, some for the first time, in a safe and supportive atmosphere. The experience of expressing herself provided her with some immediate relief. Perhaps more importantly, it gave her the sense that it is possible to share her feelings, feel supported and see things in a different light. Her father had the opportunity, with the assistance of the CACP clinician, to share his own feelings of grief with his daughter and to convey his deep love and concern for Ruby—something that he had been unable to do for four years. A real breakthrough in communication occurred, drawing on the natural resources of family love and relationship. Specific arrangements were made for Ruby to begin regular therapy, and for the family to share their feelings with the support of ongoing grief counseling.

The school counselor could have called 911. In this case, prior to the Crisis Stabilization Unit opening, Ruby would have been taken to Emergency Psychiatric Services at Valley Medical Hospital. There, due to the nature of EPS as an emergency room facility, she would have had a short assessment that would have focused on her immediate safety issues and with limited involvement from her father. She might have been transferred to a psychiatric hospital on a 72-hour hold. She would thus have been wrenched away from her family for the first time for several days and placed in an environment that is foreign and usually experienced as harsh by children, in spite of hospital staff's best efforts. Fortunately with the assessment and engagement with the mobile Crisis team, she was able to remain with dad with a strong safety plan that supported safety and identified some additional longer term resources to support the family moving forward.

Ramon's Story

Ramon's psychiatrist at the County Department of Mental Health called CACP. Ramon's mother and brother had come in to see her this morning. Both were in tears and seeking help both for themselves and for Ramon. Ramon, 16, had stopped taking his medications and had been experiencing delusions and hallucinations for about two weeks. These were increasing to the point that his mother and brother were concerned that Ramon might eventually become violent, as he had in a similar episode about a year earlier. They felt helpless because Ramon was becoming increasingly isolated and suspicious, and was refusing to see his psychiatrist or therapist. A CACP clinician met with Ramon and his brother at his aunt's home. Ramon's mother said that she was too distressed by the prospect of seeing Ramon hospitalized again face to face, but the clinician was able to speak with her at length by phone. The clinician was able to listen compassionately to Ramon's personal experience at length and without pressure. The result was that Ramon was able to recognize on his own that going to the hospital would provide a much-needed respite from the strain that he had been under. He was even able to remember that medications had provided him with relief in the past and to consider trying them again. The CACP clinician was able to support Ramon, his mother and other family members through the difficult process of an emergency hospitalization. Ramon did resume his medication treatment and was feeling much better within a few days.

The family's alternative would have been to wait until Ramon's symptoms escalated to the point at which a 911 call would have been required. At that time, the even more distressed and suspicious Ramon and his family would have had to endure a dramatic physical intervention, most likely involving police presence and Ramon being taken to the hospital in restraints or handcuffs. While the hospitalization was necessary and the ultimate resumption of medications would have been accomplished, the experience of both Ramon and his family and their view of mental health treatment in the future would have been substantially different.