

**California Health Facilities Financing
Authority (CHFFA) Grant (SB 82)**

Outcome and Process Evaluation Report

South County Crisis Residential
Lompoc Mobile Crisis
South County Crisis Stabilization Unit

April Howard, PhD

Erin Dowdy, PhD

Kathryn Moffa, B.A



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

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Executive Summary

The purpose of the California Health Facilities Financing Authority (CHFFA) grant is to improve responses and care to individuals in crisis with severe mental illness and substance use throughout Santa Barbara County. The grant includes three separate programs dedicated to improving the speed and quality of treatment to individuals in mental health crises: the Mobile Crisis Support Team for the City of Lompoc, the Crisis Residential Treatment Program in Santa Barbara, and the Crisis Stabilization Unit in Santa Barbara.

The Mobile Crisis Support Team in the City of Lompoc provides rapid response in mental health emergencies. Objectives for staffing and wait time for Mobile Crisis response were met.

The Crisis Residential Unit in Santa Barbara was opened in July 2015. The Crisis Residential Treatment Program allows clients in crisis with serious mental illness to receive treatment from mental health practitioners, caseworkers, peer recovery assistants, and psychiatrists while participating in various recovery programs. Clients have the option to stay at the facility for up to 30 days at a time and are allowed designated visitation hours. A second Crisis Residential Unit was opened in Santa Maria, CA, where the same programs were implemented. As this facility is not operated with funds from the CHFFA grant, results are not included in this report.

Progress was made toward grant-supported objectives, including client satisfaction with the program and staff members' professional quality of life. Overall, clients strongly agreed that they were satisfied with the Crisis Residential Treatment Program. In Quarter 1 of FY2015/2016, staff members reported feeling compassion satisfaction often, and burnout and secondary traumatic stress rarely. In Quarter 2 of FY2015/2016, staff members reported feeling compassion satisfaction often, burnout rarely, and secondary traumatic stress never.

In Quarter 2 of FY2015/2016, the Crisis Residential Treatment Program was evaluated based on post grant award objectives, including improvement in active behavioral health symptoms, improvement in housing situation, number of clients receiving outpatient referrals, and level of program participation. Clients reported significant improvement in psychological distress, although average client-rated psychological distress at intake and discharge were both low. Clinicians did not report significant improvement in clients' affective, behavioral, or cognitive impairment. It is important to note that average levels of impairment in all domains at intake were low or minimal, while average levels of impairment at discharge were minimal. Clinicians also rated clients' level of risk at intake and discharge; improvement was not statistically significant but clinicians rated all clients at a low level of risk at discharge.

Progress was made toward improving clients' housing situations, with 80% of clients reporting stable or permanent housing at discharge. More than 75% of clients were also connected with outpatient care. Less than 75% of clients showed full engagement in program participation, although 80% of clients engaged with group and individual programs to some extent.

The Crisis Stabilization Unit (CSU) provides a safe, nurturing, short-term emergency treatment alternative to hospitalization for individuals experiencing a mental health emergency. The CSU started admitting clients in January of 2016, and thus outcomes are not included in this report.

Methods

Data Collection

Department of Behavioral Wellness & Emergency Room Service Utilization

Data from the Cottage Emergency Department were collected to evaluate the amount of time that clients wait in the Emergency Department before transferring to inpatient or outpatient care and the number of residents with mental health and/or substance abuse issues awaiting placement at the Emergency Department. The number of psychiatric hospitalization admissions and readmission to the hospital rates were collected from Dept. of Behavioral Wellness.

Mobile Crisis Support Team

The mobile crisis support team was evaluated on wait time for response to a mental health emergency and number of staff hired prior to implementation.

Law Enforcement Satisfaction

Initially, significant coordination was required to create and implement data collection procedures for all law enforcement agencies involved. Beginning in Fall 2015, data were collected to evaluate the satisfaction of Santa Barbara County law enforcement with the response of the Dept. of Behavioral Wellness's CARES team to mental health crises. Data were collected after each mental health incident that required a response from law enforcement. Incidents in which law enforcement called on the CARES team to respond were evaluated.

Crisis Residential Treatment Program

To evaluate the crisis residential treatment program, measures were administered to clients upon intake and discharge from the facilities. Data were collected on clients' housing at intake and discharge, level of risk at intake and discharge, level of care needed at discharge, program participation, outpatient referrals, clinician- and client-reported behavioral health symptoms, and client satisfaction with the program. In addition to evaluation of the program's effectiveness on clients, staff members' professional quality of life was evaluated. The Crisis Residential program in Santa Barbara was also evaluated on the number of residential beds upon implementation.

Crisis Stabilization Unit

The Crisis Stabilization Unit opened in January 2016 and just recently begun to provide service to clients. Thus, the number of daily available 24-hour beds is not included in this report, but will be included in future reports.

Evaluation Measures

Law Enforcement Satisfaction Survey.

This 5-item survey is completed by Santa Barbara County law enforcement officers following each Dept. of Behavioral Wellness CARES response. Items ask law enforcement to rate the degree to which they were satisfied with the Dept. of Behavioral Wellness CARES crisis team's timeliness, helpfulness, collaboration, and ability to allow sheriffs/officers to focus on their role as law enforcement (Appendix A).

Consumer Satisfaction Survey.

This 18-item survey measures consumers' satisfaction with the Crisis Residential and Stabilization Units. Consumers are asked about their inclusion in treatment plans, services provided, conditions of the facilities, and respect shown by staff (Appendix B).

Professional Quality of Life Survey.

This is a 30-item measure is used to assess staff members' professional quality of life at the Crisis Residential and Stabilization Units. The survey measures three domains: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Appendix C).

Symptom Checklist.

This is a brief version of the Symptom Checklist-90 (SCL-90), which measures general psychological distress in heterogeneous clinical populations (Rosen et al., 2000). The 10-item scale, administered in the Crisis Residential Units and Crisis Stabilization Unit, pulls items from each of the nine subscales used in the SCL-90: Depression, Psychoticism, Interpersonal Sensitivity, Anxiety, Obsessive-Compulsive, Somatic, Phobic, Hostility, and Paranoia (Appendix D).

Triage Severity Scale.

This is a 7-item measure to assess consumers' level of functioning at intake and discharge to the Crisis Residential and Crisis Stabilization Units (Appendix E).

Clinical Risk Assessment/ Risk Assessment Version 2.

Clinicians reported clients' level of risk at intake and discharge using the Clinical Risk Assessment (07/01/15-11/30/15) and the Risk Screening Version 2 (12/1/15-12/30/15). Following initial data collection using the Clinical Risk Assessment, it became apparent that a transition to an assessment with more objective criteria would be helpful. While the Clinical Risk Assessment asked clinicians to make informed, but subjective, decisions on level of risk, the Risk Screening Version 2 now uses a mathematical formula based on yes/no questions to determine risk. On both forms, clients' levels of risk are rated as 1 = *Low*, 2 = *Medium*, and 3 = *High* (Appendix F).

Adult Intake Assessment.

Anka Behavioral Health, Inc.'s Adult Intake Assessment is given upon intake at the Crisis Residential Treatment Program. The form provides a comprehensive assessment of impairment in life and community functioning, including: risk assessment of current and past harm; mental status exam of mood, anxiety, and somatic symptoms; medical history; substance use history; psychiatric history; current housing and employment situation; and family/caregiver history (Appendix G).

Discharge Summary.

A discharge summary is to be completed by the clinician at client's discharge from the Crisis Residential Treatment Program. On this summary, clinician's note: services provided, level of achievement toward treatment plan goals, plans for outpatient care, level of program participation at the Crisis Residential Facility, areas of functioning, discharge medications, and mental status at discharge (Appendix H).

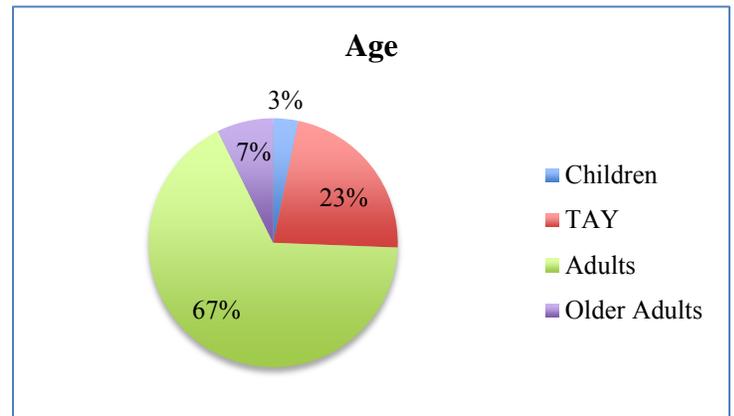
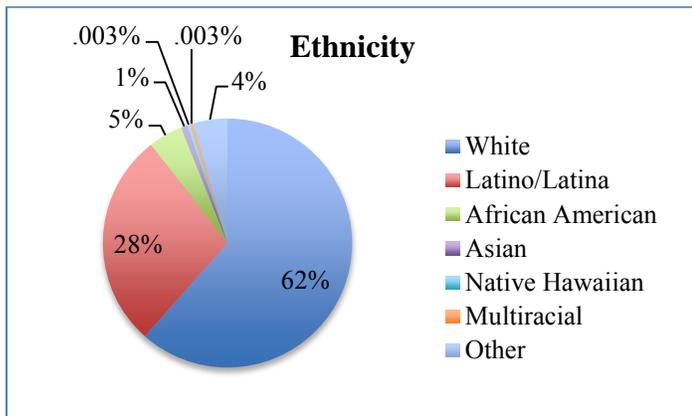
Participants

The target population for the CHFFA programs includes the county's highest risk – low-income individuals with serious mental illness, often presenting with co-occurring substance abuse conditions. In general, Crisis staff

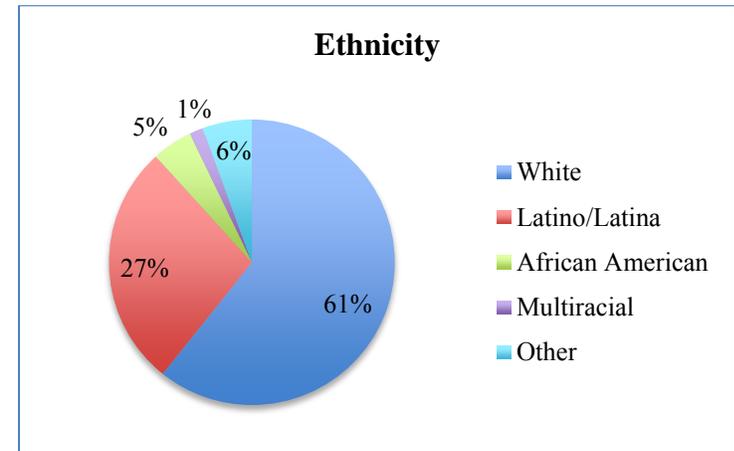
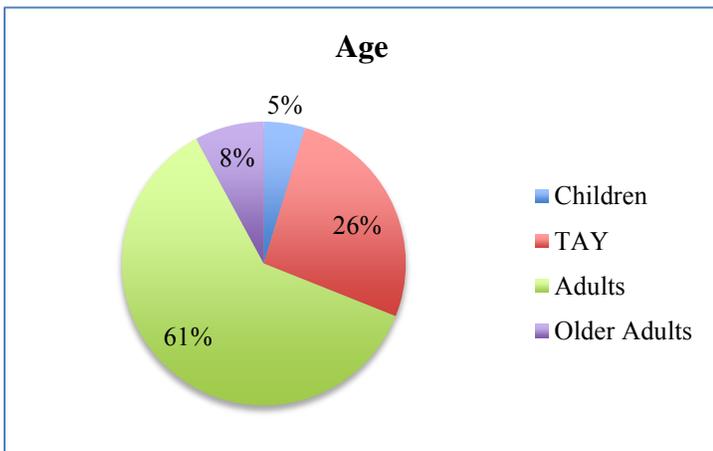
serve individuals with mental illness who are 1) brought to emergency departments in crisis, 2) have frequent contact with law enforcement or time in jail, 3) are discharged from psychiatric inpatient treatment, and/or 4) persons or family members who call the access line asking for crisis intervention that do not meet 5150 criteria.

Mobile Crisis Support Team Program

In the 2014/2015 fiscal year, the Lompoc Mobile Crisis Support Team served 247 residents. Of the 247 clients served, 161 were new to the system and/or had not received a service from Dept. of Behavioral Wellness within one year of Mobile Crisis service. The Mobile Crisis Support Team served 8 children between the ages of 8 and 15, 55 transition age youth (TAY) between the ages of 16 and 25, 165 adults between the ages of 26 and 64, and 18 older adults 64 years of age and older. Of these individuals, 152 identified as White, 69 as Latino/a, 11 as African American, 2 as Asian, 1 as Native Hawaiian, 1 as Multiracial, and 11 as Other. A total of 153 individuals identified as female, 91 as male, and 3 had missing gender information.

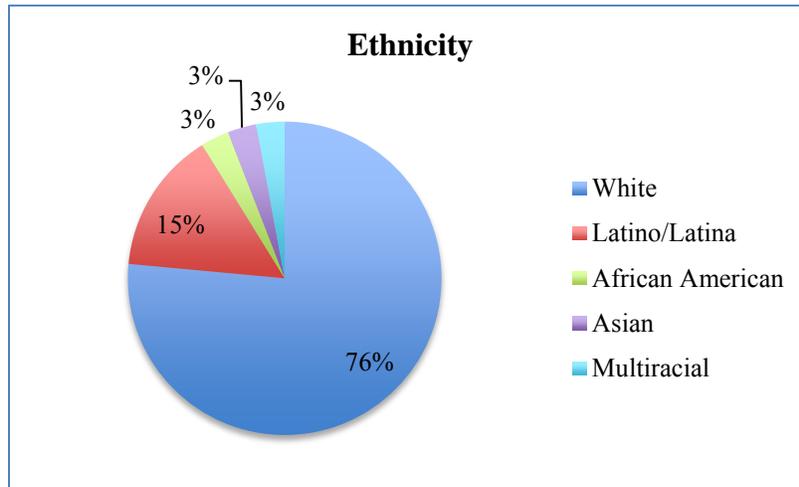


In the first six months of the 2015/2016 fiscal year, the Lompoc Mobile Crisis Support Team served 191 residents. Of the 191 clients served, 124 were new to the system and/or had not received a service from Dept. of Behavioral Wellness within one year of Mobile Crisis response. From July 2015 to January 2016, the Mobile Crisis Team served 9 children, 50 TAY, 116 adults, 15 older adults, and 1 with a missing date of birth. A total of 119 individuals identified as White, 54 as Latino/a, 9 as African American, 3 as Multiracial, and 11 as Other. Of these individuals, 97 identified as female, 92 as male, and 2 did not have this information reported.



Crisis Residential Treatment Program

Since opening on July 15, 2015, 36 clients have been served in the program. Only 5 (14%) of the 36 clients served were admitted to a psychiatric hospital within 30 days of discharge from the Crisis Residential Unit. The Crisis Residential Unit has served 34 Adults and 1 TAY. A total of 26 clients identified as White, 5 as Latino/, 1 as African American, 1 as Asian, 1 Multiracial, and 1 unknown. The program served 20 females and 15 males.

**Analyses***Dept. of Behavioral Wellness Service Utilization*

Client demographic, psychiatric hospital utilization and service data were drawn from the Department's electronic health record for analysis. Counts and percentages were calculated.

Mobile Crisis Support Team

Response time of the mobile crisis support team to mental health emergencies in the City of Lompoc was collected for each mobile response. A mean response time was generated.

Law Enforcement Satisfaction

Frequencies of item responses for each item on the Law Enforcement Satisfaction Survey were collected.

Crisis Residential Treatment Program

Evaluation of the crisis residential facilities involved examining the number of clients served by each facility and descriptive statistics from each evaluation measure. Improvement scores were examined for active behavioral health symptoms, level of risk, and required level of care. Mean scores were generated for individual items on the Triage Severity Scale, Symptom Checklist, Consumer Satisfaction Survey, and Professional Quality of Life Survey. Paired samples t-tests were conducted to evaluate statistically significant changes in housing situation, symptoms, and level of risk at intake and discharge.

Results on Grant Supported Objectives

Objective 1: Reduce the time that medically stable clients wait in the Cottage Emergency Department before transferring to an inpatient setting or outpatient care, including crisis stabilization and respite care. The average wait time for transfers to inpatient care will be reduced by 50%, from 22 hours to 11 hours by the end of the first grant year. Wait time for transfers to outpatient care will be reduced by 50%, from 15 to 7.5, by the end of Year 1.

Inpatient and outpatient transfer wait time data are only available from the South County Hospital. Currently, only the North County Hospital has the technology to collect inpatient transfer wait time data; however, the hospital is in the process of upgrading computer systems, which may make the data available in Year 2 of the grant cycle.

Fiscal Year 2014/2015

Inpatient care includes the Psychiatric Health Facility (PHF) and out-of-county contract hospital providers. At the South Santa Barbara County Hospital, the average transfer wait time for inpatient care was 25 hours. The average transfer wait time for inpatient care at the North Santa Barbara County Hospital was 29 hours. Outpatient care includes services provided by Alcohol, Drugs, and Mental Health Services (Dept. of Behavioral Wellness), including CARES and Mobile Crisis Triage. The average transfer wait time for outpatient care was 31 hours.

Fiscal Year 2015/2016 (July – December)

At the South Santa Barbara County Hospital, average transfer wait time for inpatient care was 27 hours and outpatient care was 25 hours. At the North Santa Barbara County Hospital, average transfer wait time for inpatient care was 31 hours.

Objective 2: Decrease psychiatric hospitalization admissions by 20% in Year 1, 35% by Year 2, and 50% by Year 3.

Fiscal Year 2014/2015

A total of 842 clients were admitted for psychiatric hospitalization. There were a total of 1,145 admissions and the average length of stay was 10.42 days.

Fiscal Year 2015/2016 (July – December)

Of the 582 hospital admissions, 460 clients were admitted for psychiatric hospitalization. Psychiatric hospitalizations decreased by 45% from FY2014/2015. The average length of stay was 10.80 days. Although the system is on course to exceed the number of clients admitted to hospitals and the total number of admissions in FY2015/16, Dept. of Behavioral Wellness may see these numbers decline in the second half of the fiscal year due to the opening of the Crisis Stabilization Unit and full implementation of the Crisis Residential Treatment Program.

Objective 3: Decrease the number of hospital readmissions within 30 days by 50%, from 88 to 44; and between 31 days and one year by 50%, from 94 to 47, by the end of Year 1.

Fiscal Year 2014/2015

Thirteen percent (13%; $n = 152$) of clients were readmitted to the hospital within 30 days of hospital discharge, 7% ($n = 85$) were readmitted between 31 and 90 days of discharge, and 6% ($n = 65$) were readmitted between 91 and 365 days of discharge.

Fiscal Year 2015/2016 (July – December)

Twelve percent (12%; $n = 72$) of clients were readmitted to the hospital within 30 days of hospital discharge, 7% ($n = 39$) were readmitted between 31 and 90 days of discharge, and 2% ($n = 10$) were readmitted between 91 and 365 days of discharge. As stated above, Dept. of Behavioral Wellness anticipates a reduction in the second half of FY2015/16 due to full implementation of programs.

Objective 4: Decrease the number of residents with mental health and/or substance abuse issues awaiting placement at the Emergency Department (for care beyond medical clearance) in South County by 50%, from approximately 900 to 450, in the first year. The decrease will be 75% in Year 2 and 90% by the end of Year 3.

A mechanism for collecting these data from the hospital Emergency Departments has not been established. Therefore, the data are not available for reporting at this time.

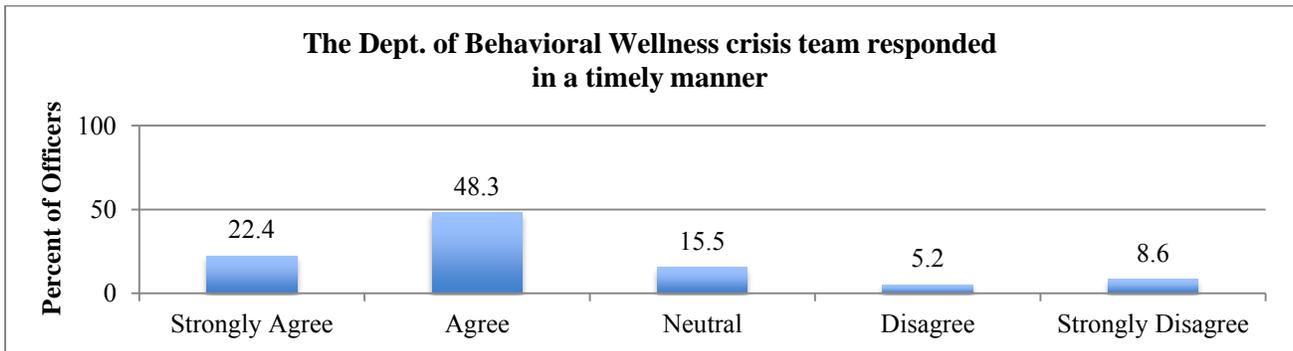
Objective 5: Decrease the time that law enforcement spends waiting in the Emergency Department with residents with mental illness and/or co-occurring substance abuse issues by 20% in Year 1, and 30% in Year 2.

After grant funding was received, discussions with the law enforcement entities in Santa Barbara County revealed that the standard practice for officers is to wait at the scene for medical/behavioral health personnel to arrive and resolve the situation. Officers do not routinely wait in Emergency Departments with patients; therefore, this outcome measure will not be reported.

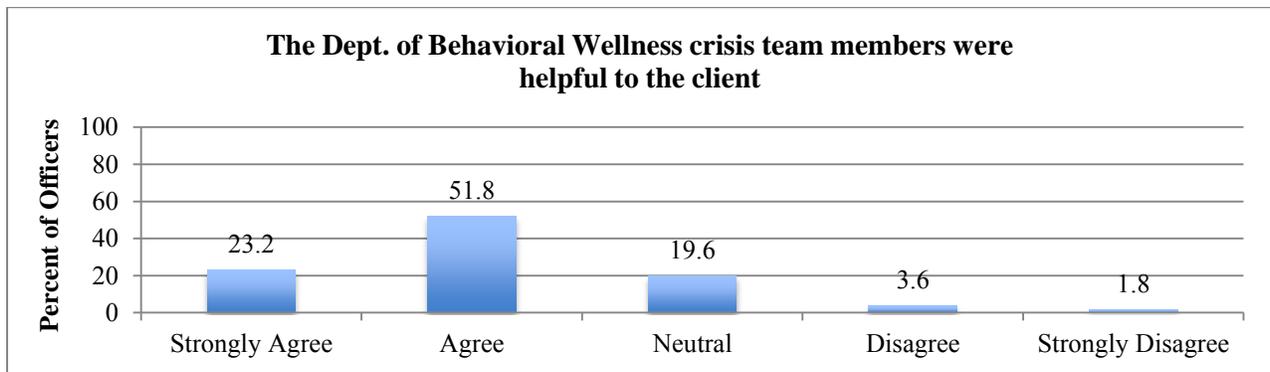
Objective 6: Increase law enforcement partner satisfaction with crisis response time, successful intervention and alternatives to restrictive care.

Data were not collected during FY 2014/2015 because the Crisis Stabilization Unit and Crisis Residential Program were not implemented. A satisfaction survey was implemented in October 2015. Santa Barbara Sheriff and local police officers were asked to rate the degree to which they agree with the following items about the response from the Dept. of Behavioral Wellness crisis team. Between October and December 2015, surveys were completed for 58 crisis incidents.

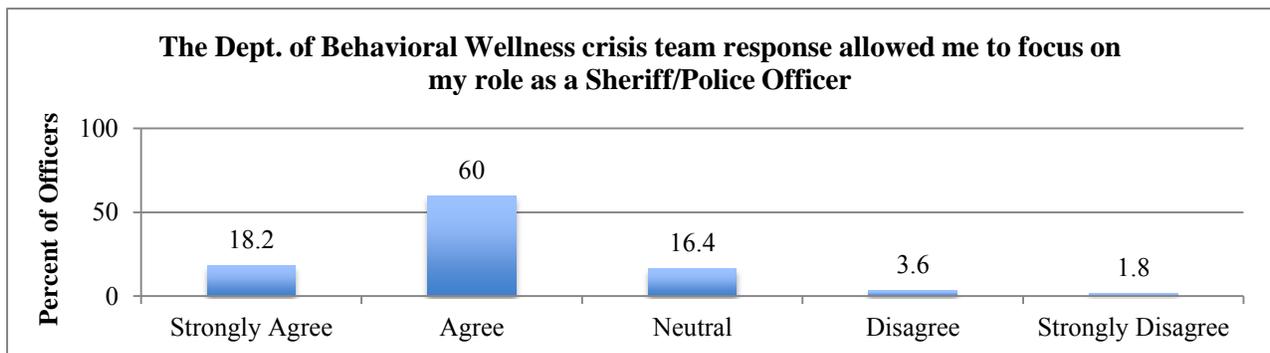
A total of 58 officers responded to the item, “The Dept. of Behavioral Wellness crisis team responded in a timely manner.” Of these, 22.4% ($n = 13$) reported that they strongly agreed, 48.3% ($n = 28$) agreed, 15.5% ($n = 9$) were neutral, 5.2% ($n = 3$) disagreed, and 8.6% ($n = 5$) strongly disagreed.



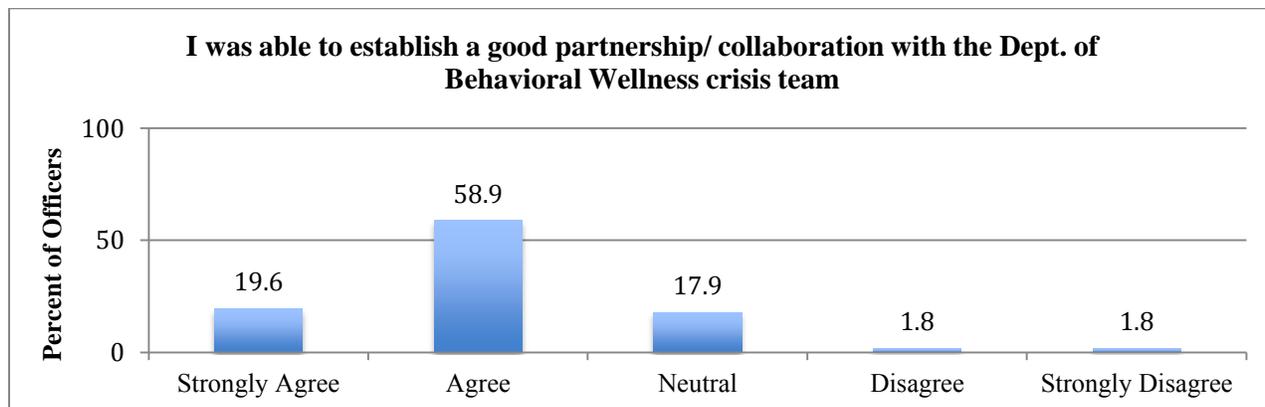
Fifty-six (56) officers responded to the item, “The Dept. of Behavioral Wellness crisis team members were helpful to the client.” Item responses indicate that 23.2% ($n = 13$) strongly agreed, 51.8% ($n = 29$) agreed, 19.6% ($n = 11$) were neutral, 3.6% ($n = 2$) disagreed, and 1.8% ($n = 1$) strongly disagreed. Two (2) officers did not respond.



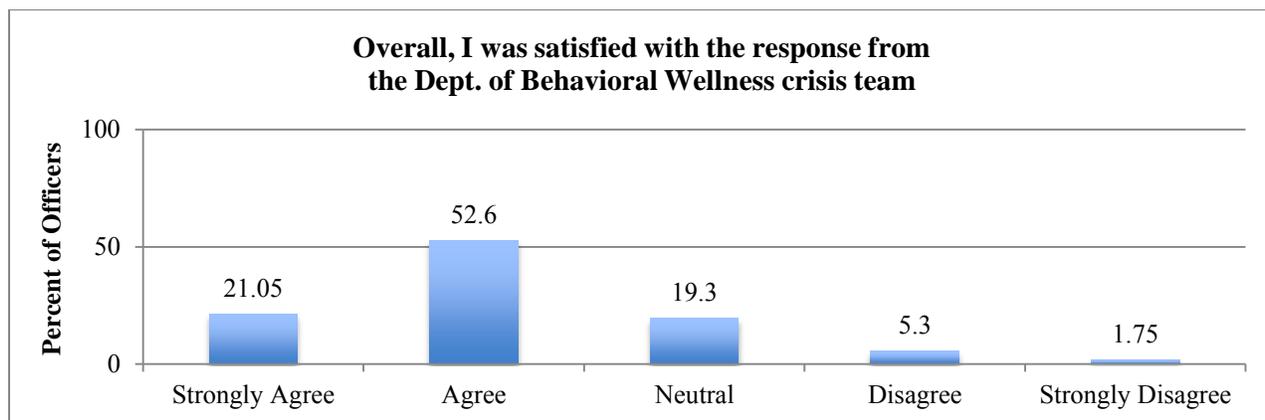
Fifty-five (55) members of law enforcement rated the degree to which they agreed with the statement, “The Dept. of Behavioral Wellness crisis team response allowed me to focus on my role as sheriff/police officer.” 18.2% ($n = 10$) of officers strongly agreed, 60% ($n = 33$) agreed, 16.4% ($n = 9$) were neutral, 3.6% ($n = 2$) disagreed, and 1.8% ($n = 1$) strongly disagreed. Three (3) officers did not respond to this item.



A total of 56 officers responded to the item, “I was able to establish a good partnership/ collaboration with the Dept. of Behavioral Wellness crisis team.” Item responses indicate that 19.6% ($n = 11$) strongly agreed, 58.9% ($n = 33$) agreed, 17.9% ($n = 10$) were neutral, 1.8% ($n = 1$) disagreed, and 1.8% ($n = 1$) strongly disagreed. Two (2) members of law enforcement did not respond to this item.



Finally, 57 officers rated the degree to which they agreed with the statement, “Overall, I was satisfied with the response from the Dept. of Behavioral Wellness crisis team.” Results indicate that 21.05% ($n = 12$) strongly agreed, 52.6% ($n = 30$) agreed, 19.3% ($n = 11$) were neutral, 5.3% ($n = 3$) disagreed, and 1.75% ($n = 1$) strongly disagreed.



Objective 7: Clients receiving crisis services will be engaged in peer support and ongoing outpatient mental health services, including case management and placement, upon discharge or transfer from the three CHFFA Programs.

Upon discharge from the Crisis Residential program, 75% of clients are engaged with and connected to ongoing outpatient services. The Crisis Stabilization Unit anticipates that 100% of clients will be connected to ongoing services at discharge.

Objective 8: Client and family member perspective, experience in the program, and satisfaction with services provided at Crisis Stabilization Unit and Crisis Residential Program by peer and non-peer staff will be high, and remain high throughout the grant cycle.

Client Satisfaction

Client satisfaction with services received at the Crisis Residential Treatment Program was evaluated using the Consumer Satisfaction Questionnaire (CSQ) at discharge. Items ask consumers to rate the degree to which they agree with each item using six choices: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5), and Not Applicable.

Fiscal Year 2015/2016 (July – December)

In July 2015, the Crisis Residential Unit opened with eight beds. Due to implementation of new data collection procedures in September 2015, data from the Consumer Satisfaction Questionnaire were incomplete and are not included in this report. However, a total of 11 clients completed the survey between October and December 2015. Mean scores in all domains indicate that clients strongly agreed that they were satisfied with services from the Crisis Residential Treatment Program.

Client Satisfaction with the Crisis Residential Treatment Program

Category	Description	Santa Barbara 2015, Q2; n = 11	
		Descriptor	Mean
EFFECTIVENESS	The program has helped me deal with my problems.	Strongly Agree	4.80
	The program helped me with my overall needs.	Strongly Agree	5.00
	Program staff worked with me to develop a written housing plan to follow upon discharge.	Strongly Agree	4.50
	The services I received have helped me to feel better about myself.	Strongly Agree	4.80
	I gained tools necessary for my recovery.	Strongly Agree	4.70
	I was offered assistance in obtaining employment or education.	Agree	3.75
	I was given assistance with obtaining benefits (Veterans, SSI/SSDI/Medicaid)	Agree	4.00
	EFFECTIVENESS	Strongly Agree	4.51
EFFICIENCY	I received the services as described to me at intake.	Strongly Agree	4.70
	The admission process was prompt and courteous.	Strongly Agree	4.90
	My questions were answered quickly.	Strongly Agree	4.70
	EFFICIENCY	Strongly Agree	4.77
CLIENT INVOLVEMENT	I was able to make choices in the services I received.	Strongly Agree	4.50
	I helped to develop my treatment plan.	Strongly Agree	4.60
	I am leaving the program with a clear discharge/follow up plan.	Strongly Agree	5.00
	I was able to participate in program activities such as chores and groups.	Strongly Agree	4.90
	CLIENT INVOLVEMENT	Strongly Agree	4.75
STAFF TREATMENT	Staff was sensitive to my cultural background (race, religion, language, etc.).	Strongly Agree	4.75
	I felt understood and respected by staff.	Strongly Agree	5.00
	STAFF TREATMENT	Strongly Agree	4.88
TELEMEDICINE EXPERIENCE	I saw the doctor using telemedicine and the experience was as good as seeing the doctor in person.	N/A	
	I felt comfortable talking to the doctor using telemedicine.	N/A	
	I would use telemedicine again.	N/A	
	TELEMEDICINE EXPERIENCE	N/A	
SATISFACTION	I was satisfied with the services I received.	Strongly Agree	3.81
ACCESSIBILITY	The facility was clean, comfortable, and inviting.	Strongly Agree	4.08
	OVERALL CONSUMER SATISFACTION	Strongly Agree	4.77

Family Member and Friend Satisfaction

Following the opening of the Crisis Residential Program and discussion with Anka Behavioral, Inc., it was determined that data collection of family member/friend satisfaction with the program may be difficult, as staff reported that family members/friends did not visit enough to respond to items on the Family Member and Friend Satisfaction Scale. Therefore, there are no data to report.

Staff Professional Quality of Life

Both peer and non-peer staff quality of life was evaluated using the Professional Quality of Life Scale (ProQOL). The ProQOL was administered to staff between 9/27/15 and 10/2/15 and again between 12/18/15 and 12/28/15. Items ask staff members to rate the frequency at which they experience each item using five

choices: Never (1), Rarely (2), Sometimes (3), Often (4), and Very Often (5). Five items in the Burnout domain are reverse scored (marked by *). In Quarter 1 (FY2015/16), nine staff members completed the survey.

Professional Quality of Life of Staff Members at the Crisis Residential Unit

Category	Description	Santa Barbara 2015, Q1; n = 9	
		Descriptor	Mean
COMPASSION SATISFACTION	I get satisfaction from being able to help people.	Very Often	4.67
	I feel invigorated after working with those I help.	Often	4.06
	I like my work as a helper.	Often	4.44
	I am pleased with how I am able to keep up with helping techniques and protocols.	Often	4.11
	My work makes me feel satisfied.	Often	4.17
	I have happy thoughts and feelings about those I help and how I could help them.	Often	4.00
	I believe I can make a difference through my work.	Often	4.44
	I am proud of what I can do to help.	Often	4.22
	I have thoughts that I am a “success” as a helper.	Often	4.06
	I am happy that I chose to do this work.	Often	4.17
	COMPASSION SATISFACTION	Often	4.24
BURNOUT	I am happy.	Often	2.11
	I feel connected to others.	Often	1.89
	I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	Rarely	1.72
	I feel trapped by my job as a helper.	Rarely	1.94
	I have beliefs that sustain me.	Often	1.57
	I am the person I always wanted to be.	Often	2.39
	I feel worn out because of my work as a helper.	Sometimes	2.61
	I feel overwhelmed because my case work load seems endless.	Rarely	1.89
	I feel “bogged down” by the system.	Sometimes	2.83
	I am a very caring person.	Very Often	1.44
	BURNOUT	Rarely	2.06
SECONDARY TRAUMATIC STRESS	I am preoccupied with more than one person I help.	Sometimes	3.22
	I jump or am startled by unexpected sounds.	Rarely	1.89
	I find it difficult to separate my personal life from my life as a helper.	Rarely	1.83
	I think that I might have been affected by the traumatic stress of those I help.	Rarely	1.89
	Because of my helping, I have felt “on edge” about various things.		
	I feel depressed because of the traumatic experiences of the people I help.	Rarely	1.94
	I feel as though I am experiencing the trauma of someone I have helped.	Rarely	1.78
	I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	Never	1.44
		Never	1.33
	As a result of my helping, I have intrusive, frightening thoughts.	Never	1.25
I can’t recall important parts of my work with trauma victims.	Rarely	1.75	
	SECONDARY TRAUMATIC STRESS	Rarely	1.85

Staff members were given the option to disclose their identities as peer or non-peer staff. Out of nine staff members, three identified as peer staff and five did not. One person chose not to answer. There was no

significant difference in compassion satisfaction, burnout, or secondary traumatic stress between peer staff and non-peer staff.

Staff members were also given the option of disclosing their work shift at the facility: AM, PM, or nocturnal. Four staff members marked the AM shift, three marked the PM shift, one marked that he/she works AM and PM, and one marked that he/she works PM and nocturnal. There were no significant differences in compassion satisfaction, burnout, or secondary traumatic stress among staff members working different shifts at the facility.

Although overall mean scores for each item indicate high professional quality of life for staff members at the Santa Barbara Crisis Residential Unit, there were a few items that received notable responses.

Number of Staff with Notable Item Responses

Item	Very Often	Often
I find it difficult to separate my personal life from my life as a helper.	0	1
I think that I might have been affected by the traumatic experiences of those I help.	0	1
I feel “bogged down” by the system.	0	2
I feel trapped by my job as a helper.	0	1

At the end of Quarter 2, eight staff members completed the Staff Professional Quality of Life survey.

Professional Quality of Life of Staff Members at the Crisis Residential Unit

Category	Description	Santa Barbara 2015, Q2 <i>n</i> = 8	
		Descriptor	Mean
COMPASSION SATISFACTION	I get satisfaction from being able to help people.	Very Often	5.00
	I feel invigorated after working with those I help.	Sometimes	3.38
	I like my work as a helper.	Very Often	4.50
	I am pleased with how I am able to keep up with helping techniques and protocols.	Often	4.25
	My work makes me feel satisfied.	Often	4.00
	I have happy thoughts and feelings about those I help and how I could help them.	Often	4.25
	I believe I can make a difference through my work.	Often	3.88
	I am proud of what I can do to help.	Very Often	4.50
	I have thoughts that I am a “success” as a helper.	Often	4.38
	I am happy that I chose to do this work.	Very Often	4.63
	COMPASSION SATISFACTION	Often	4.28
BURNOUT	I am happy.	Often	1.88
	I feel connected to others.	Often	1.50
	I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	Never	1.00
	I feel trapped by my job as a helper.	Never	1.25
	I have beliefs that sustain me.	Often	1.88
	I am the person I always wanted to be.	Often	1.50
	I feel worn out because of my work as a helper.	Sometimes	3.00
	I feel overwhelmed because my case work load seems endless.	Rarely	2.13
	I feel “bogged down” by the system.	Rarely	1.63
	I am a very caring person.	Very Often	1.38
	BURNOUT	Rarely	1.71
SECONDARY TRAUMATIC STRESS	I am preoccupied with more than one person I help.	Sometimes	3.13
	I jump or am startled by unexpected sounds.	Rarely	1.88
	I find it difficult to separate my personal life from my life as a helper.	Never	1.25
	I think that I might have been affected by the traumatic stress of those I help.	Never	1.25
	Because of my helping, I have felt “on edge” about various things.	Never	1.00
	I feel depressed because of the traumatic experiences of the people I help.	Never	1.25
	I feel as though I am experiencing the trauma of someone I have helped.	Never	1.00
	I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	Never	1.25
	As a result of my helping, I have intrusive, frightening thoughts.	Never	1.25
I can't recall important parts of my work with trauma victims.	Never	1.00	
	SECONDARY TRAUMATIC STRESS	Never	1.43

Out of eight staff members, four identified as peer staff and four did not. There were no significant differences in compassion satisfaction, burnout, or secondary traumatic stress between peer staff and non-peer staff.

At the time of survey administration, four staff members reported working the AM shift and four reported the PM shift. There were no significant differences in compassion satisfaction, burnout, or secondary traumatic stress among staff members working different shifts at the facility.

Although overall mean scores for each item indicate high professional quality of life for staff members at the Santa Barbara Crisis Residential Unit, there were a few items that received notable responses.

Number of Staff Members with Notable Item Responses

Item	Very Often	Often
I feel worn out from my job as a helper	0	4
I feel overwhelmed because my casework load seems endless.	0	1
I feel “bogged down” by the system.	1	0
I am preoccupied with more than one person I help.	0	3

Objective 9: The Crisis Stabilization Unit in Santa Barbara will increase the number of daily available 24-hour beds from 0 to 10 upon implementation of the program in Year 1.

The Crisis Stabilization Unit opened in January 2016, and has begun to provide service to clients. The unit has eight beds and served 16 clients in the month of January.

Objective 10: The Lompoc Mobile Crisis Support Team will hire a minimum of two mental health specialists and one peer advocate in Year 1. The team will be supplied with two vehicles outfitted for rapid response to mental health emergencies.

The Lompoc Mobile Crisis Support Team has hired three mental health caseworkers, two practitioner interns, one recovery assistant with lived experience, and one psychiatric nurse. Two vehicles have been purchased to allow for rapid responses to mental health emergencies.

Objective 11: Reduce wait time for crisis response in Lompoc to 15 minutes upon implementation of the Lompoc Mobile Crisis Support Team.

The average wait time for crisis response from the Lompoc Mobile Crisis Support Team is currently 15 minutes. In Santa Ynez Valley, the wait time for crisis response from the Mobile Crisis Team is 30 minutes due to the distance between the Lompoc and cities such as Buellton and Solvang.

Objective 12: The Crisis Residential Respite Care in Santa Barbara will increase the number of residential beds from 0 to eight upon implementation of the program in Year 1.

In July 2015, the Crisis Residential Program was opened in Santa Barbara with eight beds.

Results on Post Grant Award Objectives

Following the award of the CHFFA grant, additional objectives were developed to evaluate the effectiveness of services provided by the Crisis Residential Treatment Program and the Crisis Stabilization Unit.

Objective 1: Reduce active behavioral health symptoms by 50%, as reported by client.

The Santa Barbara Crisis Residential Program was opened in July of 2015 to help improve the active behavioral health symptoms of individuals in crisis due to severe mental illness and substance use while connecting them to outpatient treatment and stable housing. Individuals' self-reported active behavioral health symptoms were measured by the Symptom Checklist (SCL) at intake and discharge. Since this measure was introduced to staff at the Crisis Residential Program in September 2015, data are reported for Quarter 2 of FY 2015/2016. A total of seven clients completed the Symptom Checklist at both intake and discharge.

The SCL asks clients to rate themselves on a four-point scale ranging from 0 = *Not at all*, 1 = *A little bit*, 2 = *Moderately*, 3 = *Quite a bit*, and 4 = *Extremely*. Clients are provided with two additional response options of *Not Applicable* and *Decline to State* (which do not contribute to an overall score). Clients' scores on each item were summed for an overall general psychological distress score ranging from 0-10 = *Low distress*, 10-20 = *Moderate distress*, 20-30 = *Quite a bit of distress*, and 30-40 = *Extremely distressed*.

At intake, clients reported, on average, Low ($M = 9.14$, $SD = 5.34$) levels of psychological distress. At discharge, clients reported, on average, Low ($M = 5.43$, $SD = 5.22$) levels of distress. This difference is statistically significant, $t(6) = 3.02$, $p = .02$, with individuals reporting lower levels of distress at discharge.

All 7 clients reported stable or improved psychological distress levels while at the Crisis Residential Program. Although any improvement is considered positive, it should be noted that some individuals experienced more improvement. This may be attributed to individuals' intake scores on the SCL, as a higher intake score allows for more improvement at discharge.

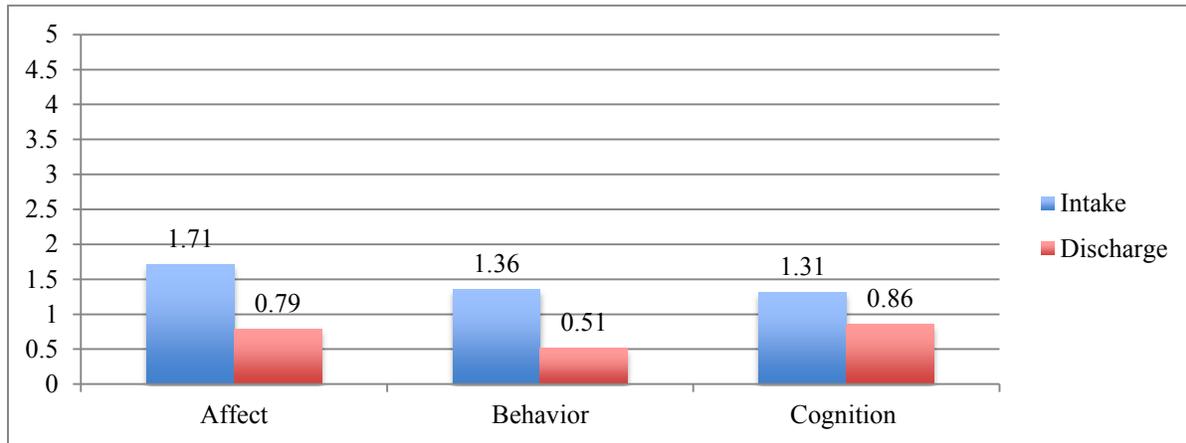
Frequency and Level of Improvement

Change from Intake to Discharge	Number of Clients
Symptoms Worsened	0
No Change	1
1-10	6

Objective 2: Reduce active behavioral health symptoms by 50%, as reported by clinician.

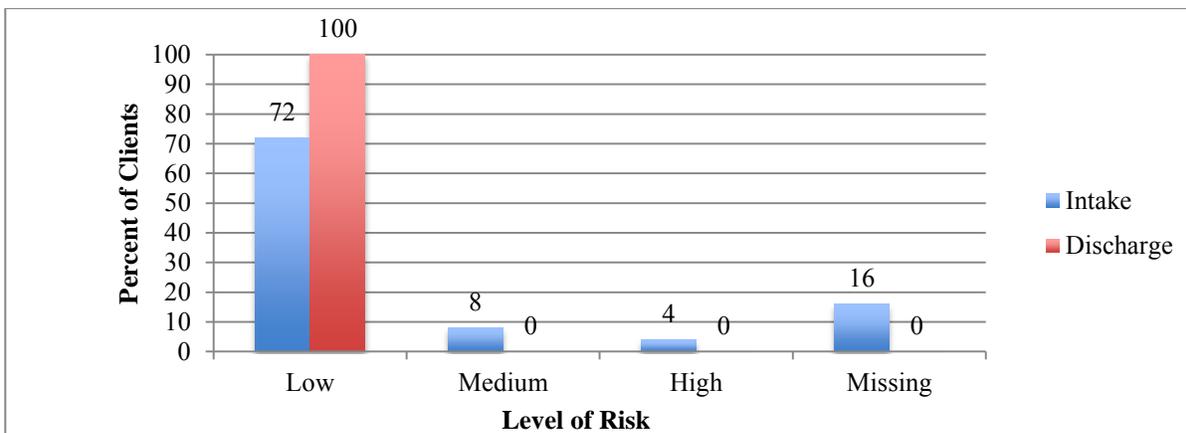
The Triage Severity Scale (TSS) was administered to clients at intake and discharge to assess the severity of clients' active behavioral health symptoms, as rated by a clinician. A total of seven clients were administered the TSS at both intake and discharge. Clinicians score consumers' level of impairment in affect, behavior, and cognition on a six-point scale where 0 = *No Impairment*, 1 = *Minimal Impairment*, 2 = *Low Impairment*, 3 = *Moderate Impairment*, 4 = *Marked Impairment*, and 5 = *Severe Impairment*.

At intake, clinicians rated clients as having, on average, low impairment ($M = 1.71, SD = .91$) in affect, minimal impairment ($M = 1.36, SD = .90$) in behavior, and minimal impairment ($M = 1.31, SD = 1.06$) in cognition. At discharge, on average, clinicians rated clients as having minimal impairment in affect ($M = .79, SD = 1.08$), behavior ($M = .51, SD = .93$), and cognition ($M = .86, SD = 1.00$). There were no statistically significant differences between intake and discharge in affect ($t(6) = 1.32, p = .23$), behavior ($t(6) = 1.33, p = .23$), or cognition ($t(6) = .76, p = .48$).



Objective 3: Reduce clients’ levels of risk, as reported by clinician.

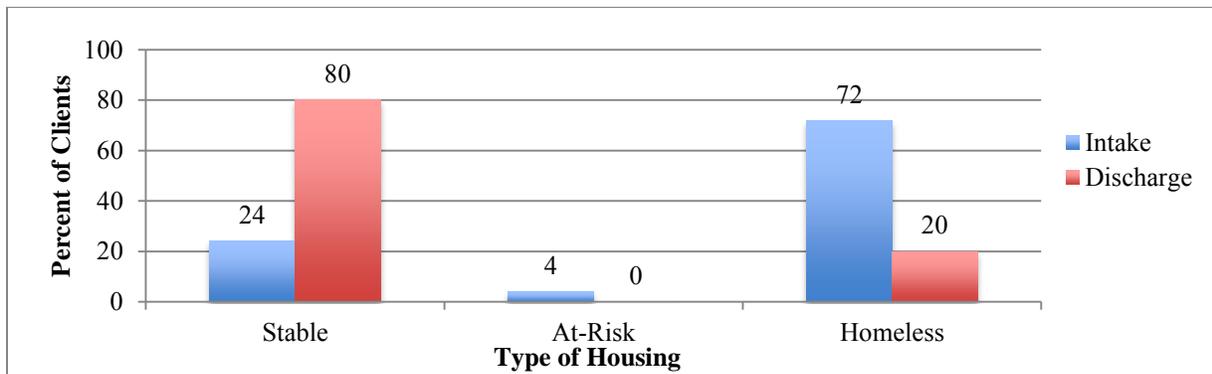
A total of 25 clients were assessed for level of risk at intake and discharge. At intake, 72% ($n = 18$) of clients were rated at a low level of risk, 8% ($n = 2$) at a medium level, and only 4% ($n = 1$) at a high level. Scores for level of risk at intake were not recorded for 16% ($n = 4$) of clients. At discharge, 100% ($n = 25$) of clients were reported to be at a low level of risk. The difference in mean level of risk at intake ($M = 1.29, SD = .64$) and mean level of risk at discharge ($M = 1.00, SD = 0.00$) was not statistically significant, $t(20) = 2.03, p = .06$.



Objective 4: 75% of clients will leave the Crisis Residential Unit with a plan for stable or permanent housing.

Clinicians reported clients’ housing at intake and discharge using the Adult Intake Assessment and Discharge Summary. Clinicians rate housing as 1 = Stable/Permanent, 2 = At-Risk, and 3 = Homeless. At intake, 24% ($n = 6$) of clients had stable or permanent housing, 72% ($n = 18$) of clients were homeless, and 4% ($n = 1$) of clients

were at-risk, as reported by clinicians on the Adult Intake Assessment. At discharge, 80% ($n = 20$) of clients left the program with stable or permanent housing and 20% ($n = 5$) of clients left without housing, as reported by clinicians on the Discharge Summary. The difference in mean housing at intake ($M = 2.46, SD = .88$) and mean housing at discharge ($M = 1.33, SD = .76$) was statistically significant, $t(23) = 5.56, p < .001$, with fewer clients experiencing homelessness at discharge.

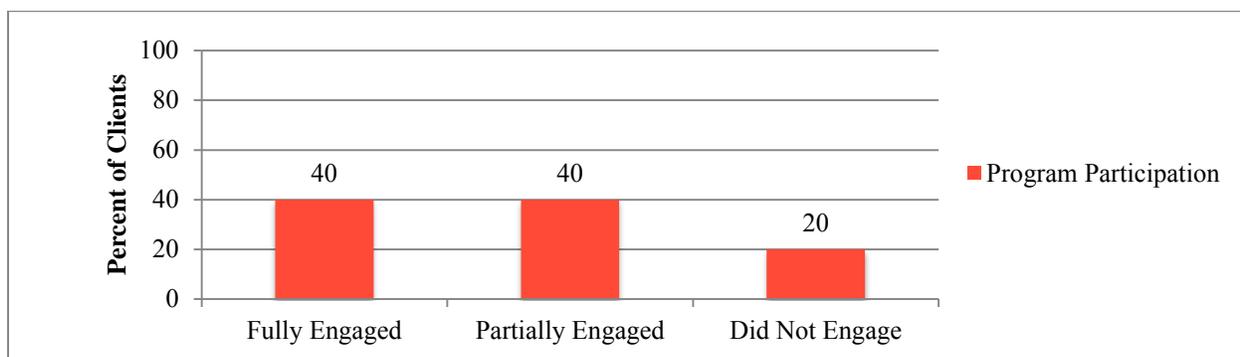


Objective 5: 75% of clients will be connected to long-term outpatient care after their stay at the Crisis Residential Program. This includes outpatient mental health services and case management services.

Of the 25 clients who went through discharge procedures between October 1, 2015 and December 30, 2015, 84% ($n = 21$) were offered outpatient referrals and 16% ($n = 4$) did not have referrals noted.

Objective 6: 75% of patients will show a high level of individual and group program participation at discharge.

Clinicians rated clients' program participation on the Discharge Summary form. Clinicians rated clients as 1 = *Did not engage*, 2 = *Partially engaged*, and 3 = *Fully engaged*. A total of 40% ($n = 10$) of clients were rated by clinicians as fully engaging in group programs, 40% ($n = 10$) were rated as partially engaging in group programs, and 20% ($n = 5$) did not engage in group programs.



Appendices

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Law Enforcement Survey

CHFFA (SB 82) Report

AGENCY OR STATION:

FY2014-2016

DATE		OFC/DEPUTY		I.D.#		CASE#			
DISPATCH TIME		ARRIVAL TIME		DISPO TIME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN			
LOCATION				CITY		RACE:			
						<input type="checkbox"/> UNK. RACE			
L/NAME		F/NAME		M/N		DOB:			
ADMHS UNIT RESPONSE (CARES/SAFTY/TRIAGE, ETC.) <input type="checkbox"/> YES <input type="checkbox"/> NO CLINICIAN: PHONE: TRANSPORT:						TC: TA:			
<input type="checkbox"/> CONTACTED IN EMERGENCY ROOM HOSPITAL:									
SERVED IN U.S. MILITARY? BRANCH: <input type="checkbox"/> CURRENT <input type="checkbox"/> PAST <input type="checkbox"/> NO <input type="checkbox"/> UNK.				PRIOR MENTAL HEALTH HOSPITALIZAION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.					
LIVING ARRANGEMENTS? (NOTE CONTACT) <input type="checkbox"/> FAMILY: <input type="checkbox"/> ROOMMATE: <input type="checkbox"/> MOTEL: <input type="checkbox"/> BOARD & CARE <input type="checkbox"/> HOMELESS <input type="checkbox"/> UNKNOWN		CURRENTLY TAKING MEDS FOR MENTAL ILLNESS? <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NO <input type="checkbox"/> SUPPOSED TO, BUT ISN'T <input type="checkbox"/> YES TYPE:		PRIOR MENTAL HEALTH TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.		CURRENT MENTAL HEALTH TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.			
		EMERGENCY CONTACT: NAME/RELATIONSHIP:		DID ANYTHING YOU LEARNED IN THE CIT PRORAM ASSIST YOU IN THIS CALL? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT CIT TRAINED		DISPOSITION OF SUBJECT: <input type="checkbox"/> CONTACT ONLY <input type="checkbox"/> VOLUNTARY TRANSPORT TO PSYCHIATRIC FACILITY <input type="checkbox"/> 5150 APPLICATION <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> JAIL CHARGES: <input type="checkbox"/> OTHER			
		PHONE#		WEAPONS INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CHECKED VIA CLETS FOR WEAPONS <input type="checkbox"/> PHYSICALLY CHECKED FOR WEAPONS ACCESS TO FIREARMS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.					
		<input type="checkbox"/> AUTISM SPECTRUM DISORDER <input type="checkbox"/> PTSD- POST TRAUMATIC STRESS DISORDER <input type="checkbox"/> TBI- TRAUMATIC BRAIN INJURY <input type="checkbox"/> OTHER(S):				PROBATION/PAROLE STATUS: <input type="checkbox"/> YES <input type="checkbox"/> NO		PHYSICAL FORCE USED? <input type="checkbox"/> YES <input type="checkbox"/> NO LE INJURED <input type="checkbox"/> YES <input type="checkbox"/> NO SUBJECT INJURED BY LE FORCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
BEHAVIORS <input type="checkbox"/> NOTHING UNUSUAL <input type="checkbox"/> ABSURD/ILLOGICAL THINKING OR SPEAKING <input type="checkbox"/> AGITATION/PACING <input type="checkbox"/> ANXIETY <input type="checkbox"/> BELIEFS WITH NO BASIS IN REALITY <input type="checkbox"/> BIZARRE BEHAVIOR <input type="checkbox"/> DISHEVELED <input type="checkbox"/> FLASHBACKS <input type="checkbox"/> HEARING VOICES <input type="checkbox"/> VISUAL HALLUCINATIONS <input type="checkbox"/> HOSTILITY <input type="checkbox"/> MEMORY PROBLEMS <input type="checkbox"/> OVERLY ELATED MOOD <input type="checkbox"/> PARANOIA OR SUSPICIOUSNESS <input type="checkbox"/> SEVERE DEPRESSED MOOD, CRYING <input type="checkbox"/> SIGNS OF INTOXICATION (ALCOHOL) <input type="checkbox"/> SIGNS OF DRUG USE <input type="checkbox"/> SIGNS OF BOTH ALCOHOL/DRUG USE <input type="checkbox"/> SUICIDAL TALK <input type="checkbox"/> SUICIDAL GESTURES/ACTIONS (E.G. OVERDOSE, CUTTING, ETC.) <input type="checkbox"/> TREMORS <input type="checkbox"/> WITHDRAWN <input type="checkbox"/> OTHER:									

OFFICER EQUIPMENT/TECHNIQUE ESCORT HANDCUFFS CONTROL HOLD HOBBLE SPIT MASK CHEMICAL BATON ECD DISPLAYED ECD USED CANINE LVNR OIS OTHER:
SUMMARY:
COMMENTS REGARDING RESPONSE BY ADMHS UNIT(S):
The ADMHS crisis team responded in a timely manner. (Please circle applicable answer) Strongly agree Agree Neutral Disagree Strongly Disagree
The ADMHS crisis team members were helpful to the client. Strongly agree Agree Neutral Disagree Strongly Disagree
The ADMHS crisis team response allowed me to focus on my role as a Sheriff/Police Officer. Strongly agree Agree Neutral Disagree Strongly Disagree
I was able to establish a good partnership/collaboration with the ADMHS crisis team. Strongly agree Agree Neutral Disagree Strongly Disagree
Overall, I was satisfied with the response from the ADMHS crisis team. Strongly agree Agree Neutral Disagree Strongly Disagree
THIS FORM IS FOR INTERNAL DEPARTMENT USE ONLY. PLEASE COMPLETE AND TURN IT IN TO THE CIT COORDINATOR. COORDINATOR REVIEWED



Consumer Satisfaction Survey

Your opinion counts! Please take a few moments to give us feedback so we can continue to provide our services. Thank you for your input.

Name of Program: _____

Date Survey Completed: _____

Please check the answer that best describes how much you Agree or Disagree with the following:

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Not Applicable
The program has helped me deal with my problems.	<input type="checkbox"/>					
I was able to make choices in the services I received.	<input type="checkbox"/>					
I received the services as described to me during intake.	<input type="checkbox"/>					
I was offered assistance in obtaining employment or education.	<input type="checkbox"/>					
I was satisfied with the services I received.	<input type="checkbox"/>					
The facility was clean, comfortable, and inviting.	<input type="checkbox"/>					
My questions were answered quickly.	<input type="checkbox"/>					
I helped to develop my treatment plan.	<input type="checkbox"/>					
I gained tools necessary for my recovery.	<input type="checkbox"/>					
The program helped me with my overall needs.	<input type="checkbox"/>					
The admission process was prompt and courteous.	<input type="checkbox"/>					
I felt understood and respected by staff.	<input type="checkbox"/>					
The services I received has helped me to feel better about myself.	<input type="checkbox"/>					
I was able to participate in program activities such as chores and groups.	<input type="checkbox"/>					
I am leaving the program with a clear discharge/follow up plan.	<input type="checkbox"/>					
Program staff worked with me to develop a written housing plan to follow upon discharge.	<input type="checkbox"/>					
I was given assistance with obtaining benefits (veterans, SSI/SSDI, Medicaid)	<input type="checkbox"/>					
Staff were sensitive to my cultural background (race, religion, language, etc.)	<input type="checkbox"/>					

Addition comments to help us improve the program:

Professional Quality of Life Scale (ProQOL)

I am an employee in: _____Santa Barbara _____Santa Maria

The following questions are optional:

1. What shift do you work? _____AM _____PM _____Nocturnal
2. Approximately, how long have you worked at this facility? _____Months
3. Do you identify as a peer staff member? _____Yes _____No

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. The following are questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Circle the choice that honestly reflects how frequently you experienced these things in the *last 30 days*.

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
1. I am happy.....	1	2	3	4	5
2. I am preoccupied with more than one person I help.....	1	2	3	4	5
3. I get satisfaction from being able to help people.....	1	2	3	4	5
4. I feel connected to others.....	1	2	3	4	5
5. I jump or am startled by unexpected sounds.....	1	2	3	4	5
6. I feel invigorated after working with those I help.....	1	2	3	4	5
7. I find it difficult to separate my personal life from my life as a helper.....	1	2	3	4	5
8. I am not as productive at work because I am losing sleep over traumatic experiences of the people I help.....	1	2	3	4	5
9. I think that I might have been affected by the traumatic stress of those I help..	1	2	3	4	5
10. I feel trapped by my job as a helper.....	1	2	3	4	5
11. Because of my helping, I have felt "on edge" about various things.....	1	2	3	4	5
12. I like my work as a helper.....	1	2	3	4	5
13. I feel depressed because of the traumatic experiences of the people I help.....	1	2	3	4	5
14. I feel as though I am experiencing the trauma of someone I have helped.....	1	2	3	4	5
15. I have beliefs that sustain me.....	1	2	3	4	5
16. I am pleased with how I am able to keep up with helping techniques and protocols.....	1	2	3	4	5
17. I am the person I always wanted to be.....	1	2	3	4	5
18. My work makes me feel satisfied.....	1	2	3	4	5
19. I feel worn out because of my work as a helper.....	1	2	3	4	5
20. I have happy thoughts and feelings about those I help and how I could help them.....	1	2	3	4	5
21. I feel overwhelmed because my case load seems endless.....	1	2	3	4	5
22. I believe I can make a difference through my work.....	1	2	3	4	5
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.....	1	2	3	4	5
24. I am proud of what I can do to help.....	1	2	3	4	5
25. As a result of my helping, I have intrusive, frightening thoughts.....	1	2	3	4	5
26. I feel "bogged down" by the system.....	1	2	3	4	5
27. I have thoughts that I am a "success" as a helper.....	1	2	3	4	5
28. I can't recall important parts of my work with trauma victims.....	1	2	3	4	5
29. I am a very caring person.....	1	2	3	4	5
30. I am happy that I chose to do this work.....	1	2	3	4	5

Symptom Checklist

During the **past week**, how much have you been distressed by:

	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4	Not Applicable 5	Decline to State 6
1. Feeling blue.							
2. Feeling afraid in open spaces or on the street.							
3. Temper outbursts that you could not control.							
4. Your feelings being easily hurt.							
5. Feeling that you are watched or talked about by others.							
6. Difficulty making decisions.							
7. Trouble getting your breath.							
8. Feeling hopeless about the future.							
9. Feeling tense or keyed up.							
10. The idea that something is wrong with your mind.							

Revise: take away values for NA and Decline to State

Triage Severity Scale

	Area of Functioning	0	1	2	3	4	5
		No Impairment	Minimal Impairment	Low Impairment	Moderate Impairment	Marked Impairment	Severe Impairment
Cognitive	Concentration	Intact	May drift to crisis event, but can refocus	Diminished control over thoughts of crisis	Frequently disturbed with little control of thoughts	Thoughts of crisis are intrusive	Only concentrates on crisis
	Problem Solving/ Decision Making	Normal	Minimally affected	Recurrent difficulties	Moderately affected by obsessiveness, self-doubt, confusion	Markedly affected by obsessiveness, self-doubt, confusion	Shut down
	Perception of Crisis	Matches with reality	Mostly matches with reality	Differs from reality in some ways	Differs noticeably from reality	Differs substantially	Client's welfare may be at risk
		0	1	2	3	4	5
		No Impairment	Minimal Impairment	Low Impairment	Moderate Impairment	Marked Impairment	Severe Impairment
Affective	Mood	Stable; Variation is appropriate for daily functioning	Appropriate; Negative mood slightly too intense for brief periods	Appropriate; Negative mood slightly too intense for longer periods of time	Inappropriate for situation; Extended periods of intensely negative emotions	Very inappropriate for situation; Pronounced mood swings may occur	Decompensation or depersonalization
	Control of Emotions	Under control	Mostly under control	Client perceives as under control	Effort required	Client cannot control negative emotions	No control of any emotions
		0	1	2	3	4	5
		No Impairment	Minimal Impairment	Low Impairment	Moderate Impairment	Marked Impairment	Severe Impairment
Behavior	Coping Behavior	Appropriate to crisis	Occasionally ineffective	Frequently ineffective	Ineffective and maladaptive	Behavior worsens crisis situation	Erratic, unpredictable
	Daily Functioning	Performs necessary tasks	Performs necessary tasks with noticeable effort	Neglects some necessary tasks	Noticeably compromised	Absent	Harmful to self and/or others

Anka Behavioral Health Outpatient Program Clinical Risk Assessment

Client (Person Served) Name: _____ Date: _____

Key: (H) High Risk

(M) Medium Risk

(L) Low Risk

Please see last page for details of the key.

Please advise Clinical Administrator, Program Administrator and staff when client scores "High" on any of the items listed below:

RISK OF SELF-INJURIOUS BEHAVIOR

PAST HISTORY OF SELF-INJURIOUS BEHAVIOR

___ Have you ever injured yourself in any way? (i.e. Cutting, Burning, etc.) Y or N

___ How many times have you injured yourself? _____

___ When was the last time you injured yourself and what method(s) did you use?

Date	Method

___ Is there a pattern you notice before you injure yourself (i.e. Isolating, Writing Poems, Cutting Hair, etc?)

Y or N If yes, please specify _____

___ Would you be willing to share your intentions with therapist or staff before you take action?

Y or N If yes, proceed to next question

CURRENT RISK OF SELF-INJURIOUS BEHAVIOR

_____ Do you ever tell someone before you injure yourself that you feel like harming yourself?

___ Do you currently have A/H telling you to injure yourself?

___ Do you currently feel like injuring yourself?

___ If yes, do you have the means to injure yourself?

___ If yes, what might help to manage these feelings? (List a specific plan)

SELF INJURIOUS BEHAVIOR RISK INTERVENTION PLAN

1. _____

2. _____

3. _____

___ Would you be willing to contract now? Y or N If yes, complete contract

SUICIDE RISK

PAST HISTORY OF SUICIDE

__ Have you ever attempted suicide? Y or N

When were the suicide attempts (mo/yr/s) and what methods used? (Starting with most recent first).

Date	Method

__ When you were feeling suicidal, did you ever give personal items away, or write suicide notes?

__ Were suicide attempts related to substance use?

__ Were suicide attempts related to A/H?

__ Do you have anyone in your family that has attempted or completed suicide?

CURRENT RISK

Do you currently have any thoughts about suicide? Y or N, if yes what are they? _____

If yes, do you currently have a plan? Y or N, if yes what is the plan? _____

If yes, do you currently have the means? Y or N, if yes what are the means? _____

Do you currently feel hopeless? Y or N

Do you have a lack of interest in activities that you used to enjoy? Y or N

Do you currently wish you were dead, even if it were by natural causes? Y or N

SUICIDE RISK INTERVENTION PLAN

1. _____

2. _____

3. _____

__ Would you be willing to contract now? Y or N, if yes, complete contract

VIOLENCE RISK

PAST HISTORY OF VIOLENCE

Have you ever been violent with anyone in the past? Y or N

If yes, number of outbreaks? _____

Date	Target Person

If yes, type of weapon(s) used? _____

If yes, were you ever arrested for hurting others? _____

Did you see violence in your home as a child? Y or N

Have you ever intentionally started a fire? Y or N Were

you ever physically or sexually abused? Y or N

CURRENT RISK OF VIOLENCE

Do you have a plan to hurt anyone? Y or N Do

you have the means to hurt anyone? Y or N **Is**

there a risk of?

Verbal Outbreaks

Destruction of property

Pushing, kicking, throwing, hitting

AGGRESSIVE PATTERNS/ASSAULT TARGETS

Staff

Random

Authority Figure

Family

Significant Other

Male

Consumer

Female

Other _____

ASSAULT TYPE

Psychotic

Affectively Driven

Sexual Predator

DESIRE FOR TREATMENT

Client has express no desire to be at this program

WEAPONS

Do you routinely carry a weapon? Y or N

If yes, what type of weapon do you routinely carry? _____

If yes, refer to program policy regarding weapons.

Precautions for Facility by History (L, M, H or N/A)

_____ **Weapon Precautions**

_____ **Suicide History Precaution**

_____ **AWOL History Precaution**

_____ **Violent History Precaution**

Risk Assessment Detail: (Please check one)

Level One: High Risk - The client feels suicidal, has urges to harm themselves or others

- **Staff will follow Protocol for Suicidal Clients Procedure.**

Level Two: Medium Risk – The client is not currently feeling suicidal and does not feel like hurting others, but has had recent thoughts of one of the above.

- **Client will be reassessed in 24 hours and given after hours resources (crisis line, Emergency Psychiatric Services).**

Level Three: Low Risk – The client is not currently feeling suicidal, does not feel like hurting others, and has no history of either.

- **All clients at this level prior to discharge.**

Commitment to Safety

I am giving my promise that while I am in treatment at

,

I will not attempt to:

_____Harm myself or end my life

_____Harm anyone else (verbally/physically/or end their life)

_____Damage Property

_____ Leave the facility without notifying staff

With the help of my treatment team, I am going to try to learn and use new coping skills to deal with my problems.

If I am having_____thoughts, I will use the following techniques:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

If these thoughts persist, or seem to be getting worse, I will talk to my therapist, or staff. If that is not possible, I will call the suicide/crisis hotline or call 911 to take me to the hospital.

Client Signature

Date

Witness Signature

Date

Anka Behavioral Health, Inc.
Risk Screening V2

DOB:05/04/1992 Gender:Male

No-Show Information

Exempt from Billing: _____
No Show: _____
Attempt To Contact: _____

Service Entry

Entered With: _____
Type: _____
Actual Date: _____
Duration (hh:mm): _____
Approved By: _____
Client Involved: _____
Location: _____

Risk Screening:

Self-Injurious Behavior

Have you ever intentionally injured yourself in any way? (i.e. Cutting, Burning, etc.)

Yes No

Have you intentionally injured yourself in the last 30 days?

Yes No

Can you promise you won't intentionally injure yourself while at this program?

Yes No

Risk of AWOL

Have you ever gone AWOL or run away when you were at a program in the past?

Yes No

Have you gone AWOL in the last 30 days at a program?

Yes No

Can you promise that you won't AWOL while in this program?

Yes No

Risk of Suicide

Have you ever attempted suicide?

Yes No

Have you experienced suicidal thoughts or behaviors (including attempts) in the last 30 days?

Yes No

Can you promise that you won't attempt suicide while in this program?

Yes No

Risk of Violence

Have you ever been in a physical altercation?

Anka Behavioral Health, Inc.
Risk Screening V2

DOB:05/04/1992 Gender:Male

Yes No

Have you been violent with anyone in the past 30 days?

Yes No

Can you promise you won't be violent with anyone while at this program?

Yes No

Objective (from referral packet, other sources):

Self-injurious behavior within last 30 days?

Yes No

AWOL within the last 30 days?

Yes No

Suicide attempt within last 30 days?

Yes No

Violence toward others within last 30 days?

Yes No

Domains:

Domain	Score	Score Type	Interpretation	Problem Identified	Strength Identified	Manual?	Remarks
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Staff Signature: _____

Service Related Encounter Information

Program Providing Service: _____

Facility Providing Service: _____

CONFIDENTIAL PATIENT INFORMATION See: Ca W & I Code, Section 5328

Anka Behavioral Health, Inc. ADULT INTAKE ASSESSMENT	NAME: _____ CID/MRN#: _____ DOB: _____ Dx: _____
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SERVICE PROVIDED: Date of Service: _____ Procedure Code: _____ Documenting Staff: _____ Total Time, Date of Service: _____	DAY OF SERVICE: _____ Time _____ Planning: _____ Travel: _____ Service to Client: _____ Documentation: _____
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Service Location: Office Home Field School Other EBP/SS: _____

Other Staff Present: _____ Proc Code: _____ Others / Family / Friends / Interpreter Present: _____
 Time: _____

Episode Opening / Axis I, II, III

Opening Date: _____ Trauma Yes No Substance Abuse Issue: Yes No Unknown
 Legal Status: _____ RU: _____ Referred From: _____

	Code: Primary DX	P/S Secondary DX	Change in dx since initial assessment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Axis I	_____	<input type="checkbox"/>	_____
	_____	<input type="checkbox"/>	_____
	_____	<input type="checkbox"/>	_____
Axis II	_____	<input type="checkbox"/>	_____
	_____	<input type="checkbox"/>	_____
	_____	<input type="checkbox"/>	_____
Axis III	<input type="checkbox"/> <input type="checkbox"/>		_____
	<input type="checkbox"/> <input type="checkbox"/>		_____
	<input type="checkbox"/> <input type="checkbox"/>		_____

Physician Name: _____ Physician ID: _____ Clinician Name: _____ Clinician ID: _____

Axis IV (Psychosocial & Environmental Problems)

	Goal Area	SPUDS		Goal Area	SPUDS
<input type="checkbox"/> Housing Problems	1	E	<input type="checkbox"/> Occupational problems	5	D
<input type="checkbox"/> Economic Problems	2	F	<input type="checkbox"/> Problems with the legal system / crime	6	H
<input type="checkbox"/> Problems with primary support group	3	A	<input type="checkbox"/> Problems with access to health care services	9	G
<input type="checkbox"/> Problems related to social environment	3	B	<input type="checkbox"/> Other psychosocial & environmental problems		I
<input type="checkbox"/> Educational Problems	5	C	<input type="checkbox"/> Language / cultural factors		I

Anka Discharge Summary

Client (Person Served) Name:		ID/MRN #	
Kaiser # (if applicable):		Admission Date:	
Discharge Type:		Discharge Date & Time:	

Presenting Problems:

Collateral Contacts: (Name, Date, Relationship)

Services Provided: (Therapy, Appointments, etc.) – select all boxes that apply:

SERVICES PROVIDED	
<input type="checkbox"/> Alcohol/drug abuse services (AA, NA, materials)	<input type="checkbox"/> Family/case management meeting
<input type="checkbox"/> Housing assistance or placement	<input type="checkbox"/> Medication consultation/stabilization
<input type="checkbox"/> Leisure time activities or community resources	<input type="checkbox"/> Legal assistance
<input type="checkbox"/> Group therapy	<input type="checkbox"/> Self-help assistance and materials
<input type="checkbox"/> Exercise and outdoor activities	<input type="checkbox"/> Financial assistance (SDI, SSI, EDD)
<input type="checkbox"/> Education or vocational assistance	<input type="checkbox"/> Meal assistance & skill building
<input type="checkbox"/> Individual therapy	
List Other: (specify groups if applicable)	

Goals Achieved (from Treatment Plan – indicate if goals were accomplished):

1. Goals:

1. Achieved Worked toward Not Achieved

2. Achieved Worked toward Not Achieved

3. **Medication compliance 7 days/week.** Achieved Worked toward Not Achieved

Comments/Additional:

Reason for Discharge:

Discharge Plan: (Referrals and follow-up plans; include contact info. if applicable)

Level of Participation in the program:

High Moderate Low

Functioning at Discharge:

Areas of Functioning	<i>Please include client's (person served) level of functioning and if any level of assistance is required in the following areas:</i>
Ability to take medication without assistance	
ADL's	
Social Functioning	

Discharge Mental Status Exam (Clinician Complete):

Orientation:	Speech:
Appearance:	Cognition:

Motor Activity:	Memory:
Mood:	Insight:
Affect:	Judgment:
Delusions:	Hallucinations:
Homicidal/Suicidal Ideation:	

SNAP Areas at Discharge:

Strengths: _____

Needs: _____

Abilities: _____

Preferences: _____

Medication Compliant:

YES NO - If the client was non-compliant with medication(s), please explain.

Discharge Medications:

See attached document "Client Discharge Medication List & Instructions."

Status at Discharge:

Legal Status	
*Living Situation	
Educational/Vocational Status	
AOD Status	
Other	

**If referred to a homeless shelter please refer to supplementary documents.*

Client Signature: _____

Date: _____

Family/Guardian Signature (if applicable): _____

Date: _____

Staff Signature: _____

Date: _____

Clinician Signature: _____

Date: _____