

Outcome and Process Evaluation Report:

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

Fiscal Years 2015-2018

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Executive Summary

PROGRAM OVERVIEW

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: (1) Mobile Crisis Support Team in Lompoc, (2) Crisis Residential Treatment Program in Santa Barbara, and (3) Crisis Stabilization Unit in Santa Barbara.

1. The Mobile Crisis Support Team in the City of Lompoc provides rapid response in mental health emergencies.
2. The Crisis Residential Treatment (CRT) program in Santa Barbara was opened in July 2015. The CRT 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. Anka Behavioral Health, Inc. is contracted to operate an additional CRT in Santa Maria, CA. As this facility is not operated with funds from the CHFFA grant, results are not included in this report.
3. 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.

EXECUTIVE SUMMARY - EVALUATION

The CHFFA (SB 82) grant was evaluated by experts from the University of California, Santa Barbara, and the Dept. of Behavioral Wellness.

1) Psychiatric Hospital Utilization

Major Findings: Wait time for inpatient and outpatient care, number of hospital admissions, average length of stay in a psychiatric hospital setting, and readmission to a psychiatric hospital setting within 30 days of hospital discharge were somewhat stable across fiscal years. Readmissions to a psychiatric hospital within 31 to 365 days of discharge decreased by more than 50% from baseline to fiscal year 2015/2016 (Year 1), 2016/2017 (Year 2), and 2017/2018 (Year 3).

Recommendations: Dept. of Behavioral Wellness has redesigned and consolidated their crisis and triage services, now called Crisis Services. The goal of Crisis Services is to better integrate all aspects of the crisis system, with the hope of also decreasing Emergency Department utilization, boarding time, and hospitalizations, and increasing connections to inpatient and outpatient care following hospitalization for individuals experiencing serious mental illness and/or substance use issues.

2) Mobile Crisis Support Team

Major Findings: Objectives for staffing the Lompoc Mobile Crisis Team were met. Additionally, law enforcement personnel reported that they were satisfied with the Crisis and Recovery Emergency Services (CARES) response to crises, including timeliness, collaboration, and helpfulness across quarters.

Recommendations: Considering the positive impact of the Mobile Crisis Support Team, Dept. of Behavioral Wellness should continue to staff the Lompoc Mobile Crisis Team to be included in the West County Crisis Services.

3) Crisis Residential Treatment Program

Major Findings: Across fiscal years, clients who participated in the CRT program reported a decrease in psychological distress and active behavioral health symptoms from intake to discharge. On average, clients indicated satisfaction with the efficiency, effectiveness, level of client involvement, and staff treatment of the program. Additionally, staff members across years reported high professional quality of life. Objectives for decreasing clients' level of risk from intake to discharge were met in fiscal year 2015/2016 and 2017/2018. Objectives were not met in fiscal year 2016/2017, but this is likely due to changes made to the data collection procedures. Specifically, clients were only administered risk assessments multiple times if they showed evidence of declining behavioral health. Therefore, average level of risk at discharge appeared higher than at intake. Objectives for connecting individuals to stable housing were nearly met, and each year demonstrated a significant increase in the percent of clients connected to housing at discharge compared to intake.

Recommendations: In Quarter 4 of fiscal year 2017/2018, consultation between Dept. of Behavioral Wellness, Anka Behavioral Health, Inc., and evaluators led to collaborative solutions to address issues with data collection and evaluation procedures. Recommendations included adjustment to risk assessment procedures at intake and discharge to more accurately reflect client improvement at discharge; options for clinicians to note when clients were unable to complete interview and self-report measures about symptoms; include clients' progress on their specific goals as part of the evaluation procedures; and collect clients' reasons for discharge to better inform sources of missing data. Going forward, these solutions should continue to be implemented and adjusted to better demonstrate the CRT's positive impact on clients in the community.

4) Crisis Stabilization Unit

Major Findings: The CSU opened to clients in January 2016 with eight beds and has served 1,052 unique clients from January 2016 through June 2018. According to clinician report, 100% of clients were connected to outpatient care in every fiscal year. Due to the short-term nature of the CSU (i.e., 23 hours and 59 minutes), change in level of impairment in these areas was not assessed at discharge.

Recommendations: To continue to monitor the impact of the CSU, staff may consider developing data collection strategies to evaluate improvements in clients' behavioral health at the CSU and following outpatient care.

Methods

Data Collection

Dept. 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. Data were also collected on 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 the 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 Santa Barbara County law enforcement's satisfaction 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 (CRT) 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. Additionally, staff members' professional quality of life was evaluated. The CRT program in Santa Barbara was also evaluated on the number of residential beds upon implementation.

Crisis Stabilization Unit

The Crisis Stabilization Unit (CSU) opened in January 2016 to welcome clients for up to a 24-hour period. Data were collected on clients' behavioral health symptoms upon entering the CSU program, staff treatment, and conditions of the facility.

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 CARES crisis team's timeliness, helpfulness, collaboration, and ability to allow sheriffs/officers to focus on their role as law enforcement ([Appendices](#)).

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 ([Appendices](#)).

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 ([Appendices](#)).

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 ([Appendices](#)).

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 ([Appendices](#)).

Clinical Risk Assessment/ Risk Screening 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* ([Appendices](#)).

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 ([Appendices](#)).

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 ([Appendices](#)).

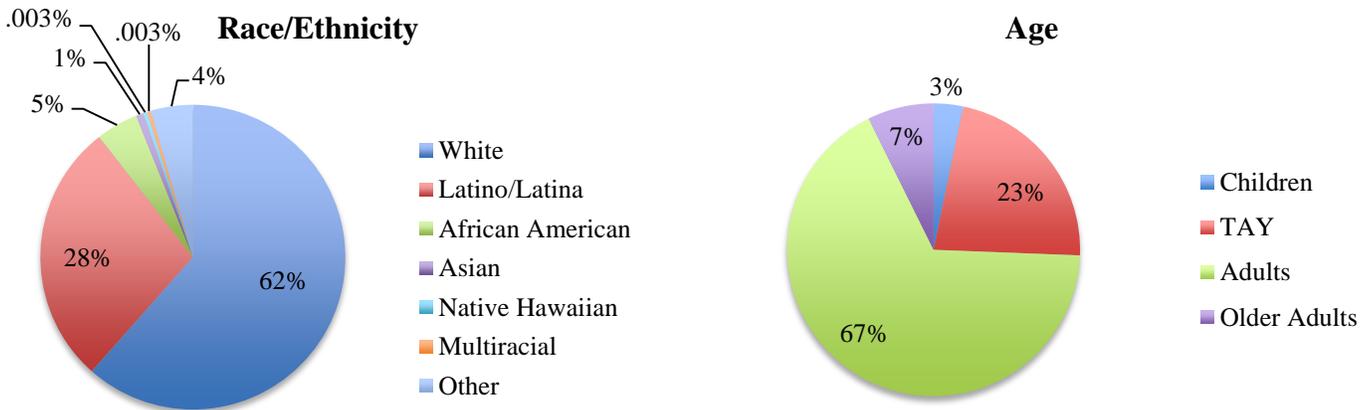
Population Served

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. Crisis staff report that individuals admitted often present with primary concerns of substance use and difficulties securing stable housing, with secondary concerns regarding mental health.

Mobile Crisis Support Team Program

Fiscal Year 2014/2015

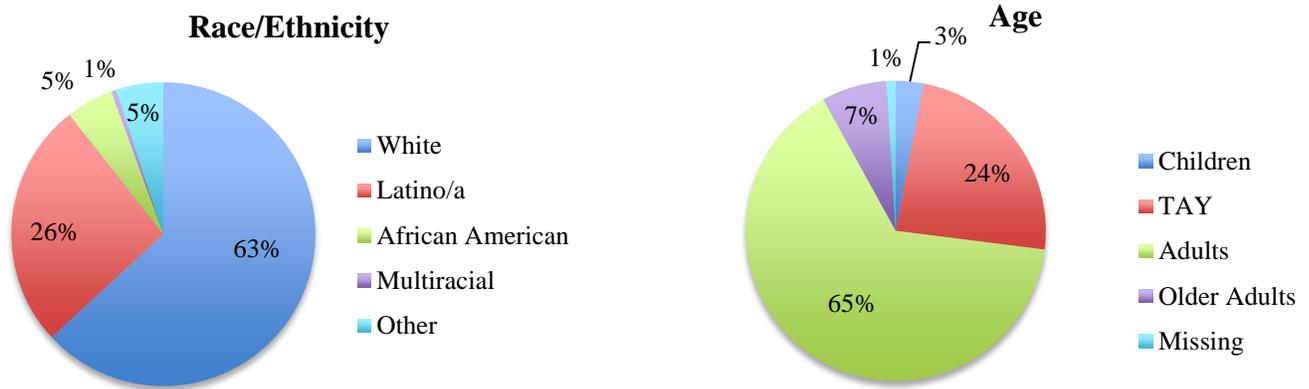
In the 2014/2015 fiscal year, the Lompoc Mobile Crisis Support Team served 247 residents. Of the 247 clients served, 161 were new to the system and/or had not received a service from Dept. of Behavioral Wellness within one year of Mobile Crisis service. The Mobile Crisis Support Team served 8 children 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 American/Pacific Islander, 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.



Fiscal Year 2015/2016

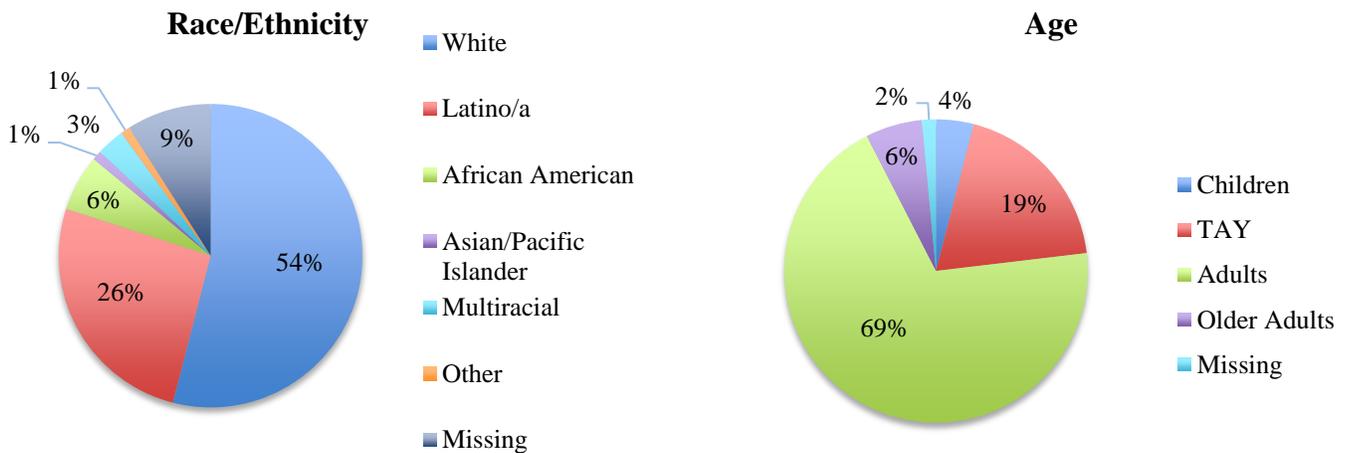
During the 2015/2016 fiscal year, the Lompoc Mobile Crisis Support Team served 403 residents. Of the 403 clients served, 286 were new to the system and/or had not received a service from Dept. of Behavioral Wellness within one year of Mobile Crisis response. Throughout the fiscal year, the Mobile Crisis Team served 12 children, 96 TAY, 261 adults, 30 older adults, and 4 with a missing date of birth. A total of 253 individuals identified as White, 107 as Latino/a, 20 as African American, 3 as Multiracial, and 20 as Other. Of these

individuals, 211 identified as female, 185 as male, and 7 did not have this information reported.



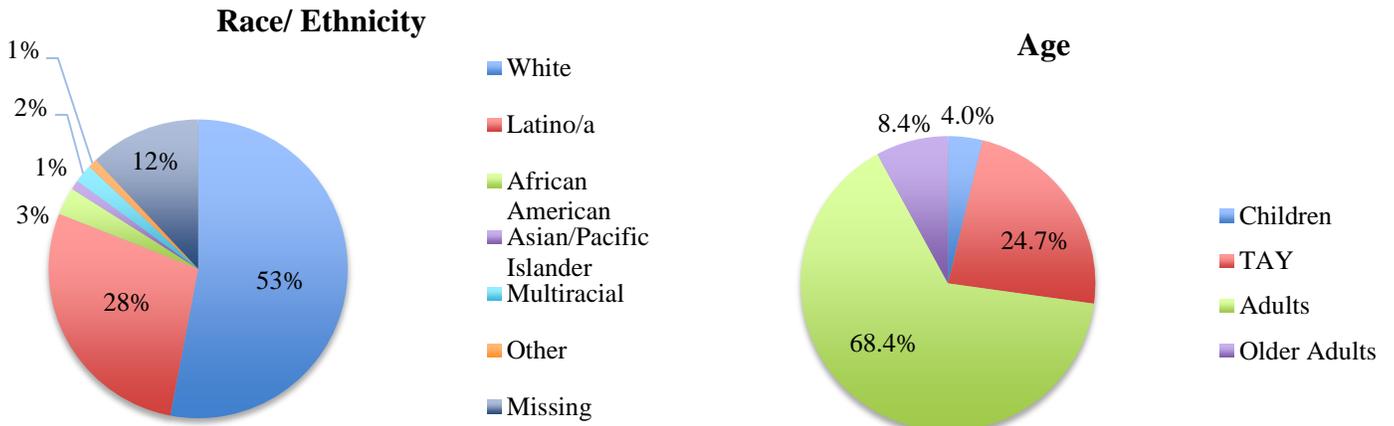
Fiscal Year 2016/2017

In fiscal year 2016/2017, the Lompoc Mobile Crisis served 474 individuals. Twenty (20) children were served, 92 TAY, 326 adults, 30 older adults, and 7 with a missing date of birth. A total of 258 individuals identified as White, 123 as Hispanic or Latinx, 30 as Black or African American, 2 as American Indian, 4 as Asian or Pacific Islander, 13 as Multiracial, 1 as other, and 43 with missing information for race. Of these individuals served, 245 identified as female, 216 as male, and 13 did not have this information reported.



Fiscal Year 2017/2018

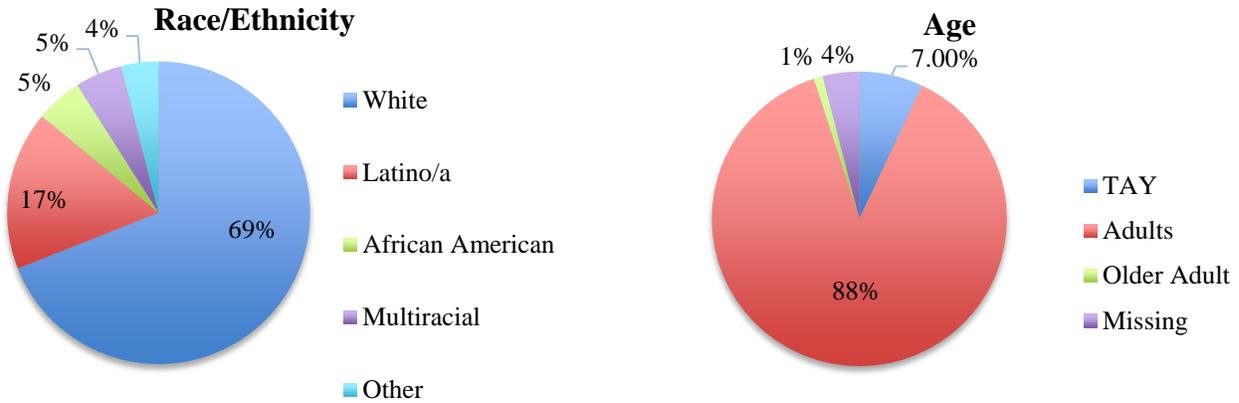
During fiscal year 2017/2018, 458 clients were served by Lompoc Mental Health Services/Mobile Crisis Team. The Lompoc Crisis Team served 18 children, 113 TAY, 293 adults, and 34 older adults. A total of 243 individuals identified as White, 127 as Hispanic or Latinx, 16 as Black or African American, 5 as Asian or Pacific Islander, 8 as Multiracial, 1 as Alaska Native, 1 as “Other,” and 57 with missing information for race. Of these individuals served, 238 identified as female, 208 as male, and 13 did not have this information reported.



Crisis Residential Treatment Program

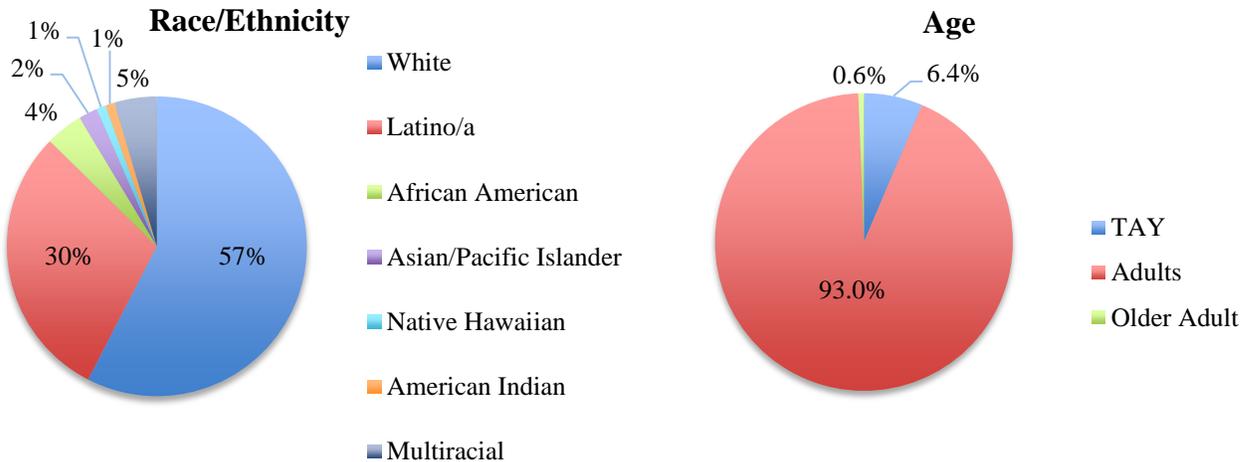
Fiscal Year 2015/2016

In the 2015/2016 fiscal year, 112 unique clients participated in the program in Santa Barbara. Of these clients served, there were 99 Adults, 8 TAY, 1 older adult, and 4 with a missing date of birth. A total of 75 clients identified as White, 18 as Latino/a, 5 as African American, 6 as Multiracial, and 4 as other. The program served 48 females and 60 males.



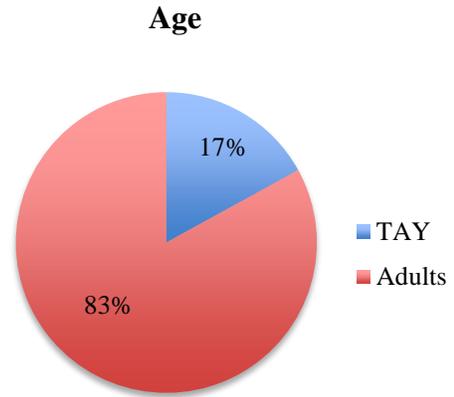
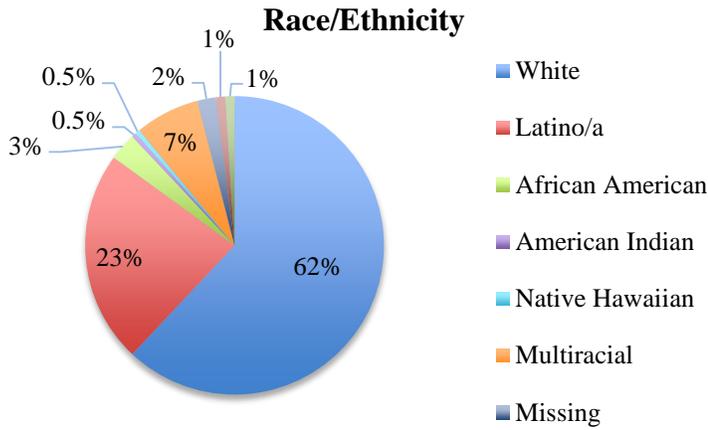
Fiscal Year 2016/2017

In 2016/2017 fiscal year, 156 clients participated in the program. Out of the 156 clients served, 10 were TAY, 143 were adults, and 1 was an older adult. Eighty-nine (89) individuals identified as White, 46 as Hispanic/Latinx, 6 as Black or African American, 3 as Asian American/Pacific Islander, 2 as Native Hawaiian, 1 as American Indian, and 7 as Multiracial. A total of 48 females and 106 males were served during this time.



Fiscal Year 2017/2018

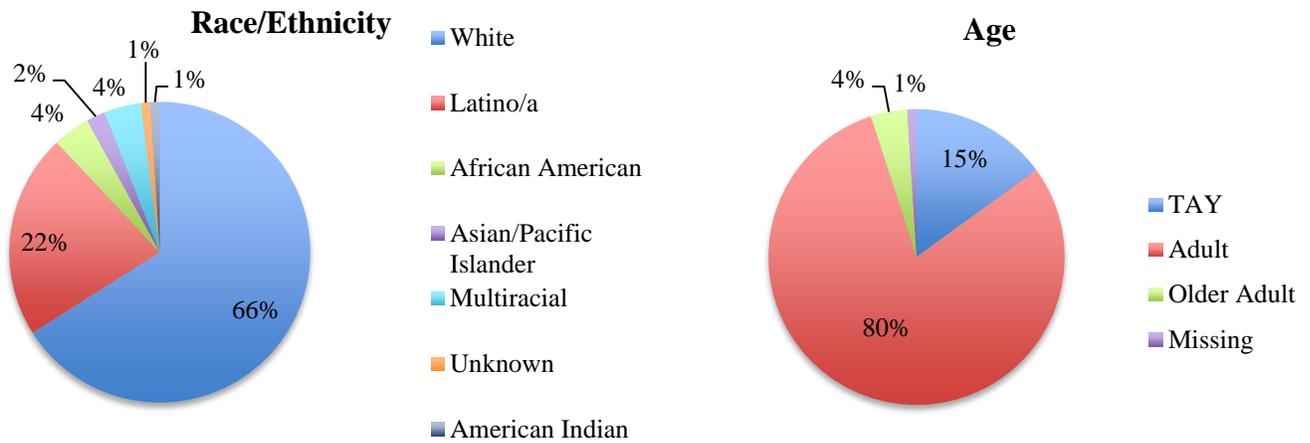
During fiscal year 2017/2018, 164 clients participated in the Santa Barbara CRT program. Twenty-eight (28) clients were TAY, and 136 clients were adults. Clients' self-reported race were as follows: 101 identified as White, 37 as Hispanic or Latinx, 5 as Black or African American, 3 as American Indian, 1 as Asian/Pacific Islander, 1 as American Indian, 1 as Native Hawaiian, 12 as multiracial, and 4 did not report this information. Sixty-two (62) clients served identified as female and 102 as male.



Crisis Stabilization Unit

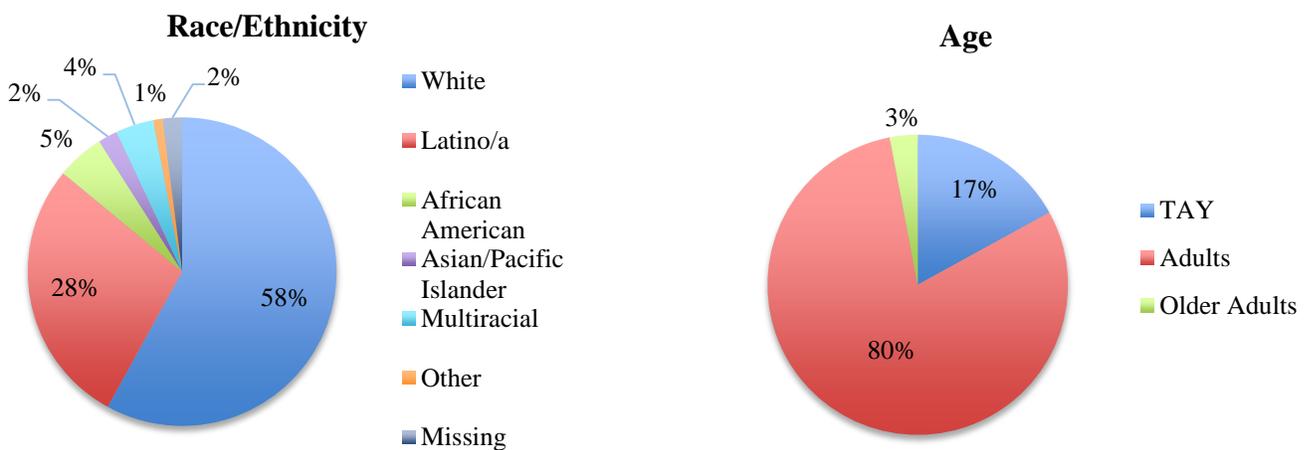
Fiscal Year 2015/2016 (January – June)

The CSU opened to clients in January of fiscal year 2015/2016. During Quarter 3 and 4 of fiscal year 2015/2016, the CSU served 216 unique clients. Thirty-three (33) of these individuals were TAY, 179 were adults, 9 were older adults, and 1 did not have a date of birth recorded. A total of 143 clients identified as white, 47 as Latino/a, 9 as African American, 5 as Asian/Pacific Islander, 9 as multiracial, 1 as American Indian, and 2 that did not have this information reported. The CSU served 85 females and 131 males during this time.



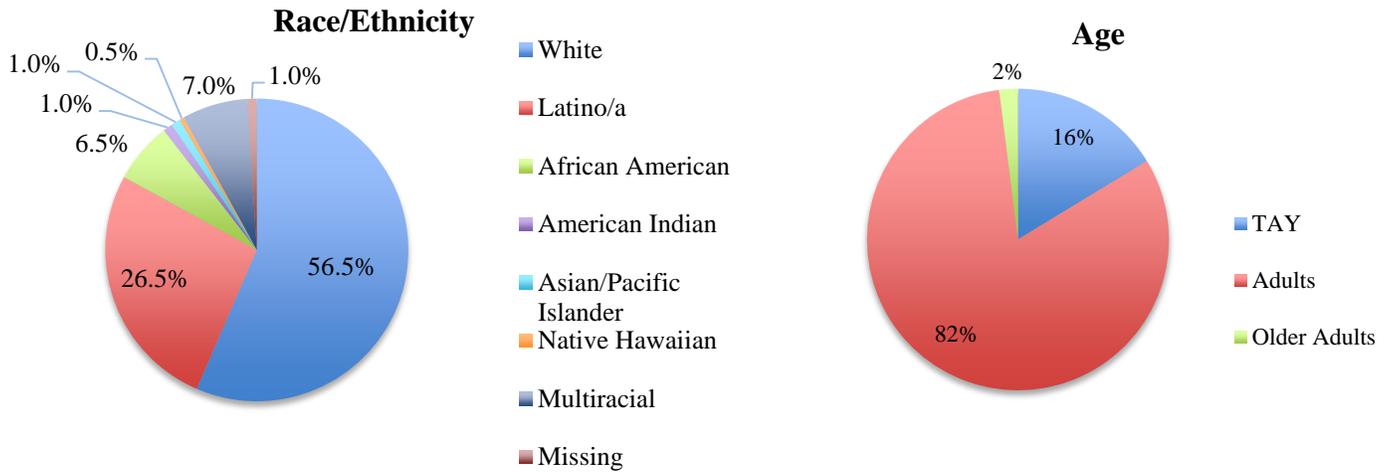
Fiscal Year 2016/2017

During fiscal year 2016/2017, there were 465 new clients served by the CSU. The CSU served 80 TAY, 370 adults, and 14 older adults. A total of 271 clients identified as White, 130 as Hispanic/Latinx, 23 as African American, 7 as Asian/Pacific Islander, 18 as multiracial, 6 as other, and 10 did not have this information reported. The CSU served 217 females, 245 males, and 3 did not report this information.



Fiscal Year 2017/2018

In fiscal year 2017/2018, there were 471 unique clients admitted to the CSU. Seventy-seven (77) TAY, 385 adults, and nine older adults were served by the CSU. The CSU served 265 clients who identified as White, 124 as Hispanic/Latinx, 30 as Black or African American, 5 as American Indian, 4 as Asian/Pacific Islander, 2 as Native Hawaiian, 34 as multiracial, and 7 who did not report this information. One hundred eighty-eight (188) clients identified as female and 283 as male.



Analyses

Dept. of Behavioral Wellness Service Utilization

Client demographic, psychiatric hospital utilization and service data were drawn from the Dept. of Behavioral Wellness'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 and mean scores 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: SB 82 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.

Outpatient transfer wait time data are only available from the South County Hospital.

Fiscal Year 2014/2015 (Baseline)

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 24.7 hours. The average transfer wait time for inpatient care at the North Santa Barbara County Hospital was 31.1 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

At the South Santa Barbara County Hospital, average transfer wait time for inpatient care was 25.5 hours and for outpatient care it was 36 hours. At the North Santa Barbara County Hospital, average transfer wait time for inpatient care was 25.7 hours. Wait time for inpatient care from the South County Hospital increased by 3.4% and from the North County Hospital decreased by 17.4% from baseline. Emergency Department boarding time for outpatient care increased by 13.9%. This objective was not met for transfer time to inpatient or outpatient care.

Fiscal Year 2016/2017 (July – December)

The average transfer wait time for inpatient care decreased by 9.8% to 23 hours at the South Santa Barbara County Hospital, and increased by 3.7% to 26.7 hours at the North Santa Barbara County Hospital. Average transfer wait time to outpatient care from the South County Hospital was 23.7 hours, which was a decrease of 8.4%. The shortest transfer wait time was 1 hour and the longest was approximately 16 days. The objective not met.

Fiscal Year 2017/2018

Emergency boarding time data were not available for fiscal year 2017/2018 at the time of evaluation due to changes in the electronic data system.

Average Emergency Department Boarding Time Prior to Inpatient and Outpatient Transfer for FY 2015 – 2018

	2014-15	2015-15	2016-17
Cottage			
Inpatient	24.7 hours	25.5 hours	23.0 hours
Outpatient	31.0 hours	36.0 hours	23.7 hours
Marian			
Inpatient	31.1 hours	25.7 hours	26.7 hours

	2015/2016	2016/2017	2017/2018
Objective Met?	No	No	N/A

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

Fiscal Year 2014/2015 (Baseline)

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

Fiscal Year 2015/2016

A total of 836 clients were admitted for psychiatric hospitalization, with 1,160 hospital admissions during the 2015/2016 fiscal year. This was an 1.3% increase in hospitalizations from baseline, indicating that the objective was not met. The average length of stay was 10.70 days.

Fiscal Year 2016/2017

In fiscal year 2016/2017, there were 937 clients admitted for psychiatric hospitalization and 1,121 hospitalizations, which was a 3.4% decrease from the previous fiscal year. Therefore, the objective was not met. The average length of stay was 10.75 days, which was slightly longer than the previous fiscal year.

Fiscal Year 2017/2018

During fiscal year 2017/2018, 611 unique clients were admitted to inpatient psychiatric hospitalization, and there were 696 total hospitalizations. This was a decrease of 37.9% from the previous fiscal year. Although the objective was not met for Year 3, this was a substantial decrease in inpatient hospitalizations compared to other fiscal years. The average length of stay was 11.93 days across all hospitals, which was an increase from previous fiscal years. It should be noted that other than the Psychiatric Health Facility-Santa Barbara (PHF-SB), all other hospitals facilitated an average length of stay of 7.30 days. It is possible that the PHF-SB has experienced an increase in average length of stay due to a shortage of beds across the state and the halting of services at Vista Del Mar Psychiatric Hospital following damage from the Thomas Fire.

	2015/2016	2016/2017	2017/2018
Objective Met?	No	No	No

Objective 3: Decrease the number of hospital readmissions within 30 days by 50%, and between 31 days and one year by 50%, by the end of Year 1.

Fiscal Year 2014/2015 (Baseline)

Thirteen percent (13%; $n = 152$) of hospitalizations resulted in readmission to a psychiatric hospital within 30 days of hospital discharge and 13% ($n = 150$) within 31 days and one year.

Fiscal Year 2015/2016

Fourteen percent (14%; *n* = 166) of hospitalizations resulted in readmission within 30 days of hospital discharge, resulting in a 9.2% increase from baseline in number of hospital readmissions within 30 days. Approximately 14% (*n* = 157) of hospitalizations resulted in readmission within 31 days and one year of discharge, which was a 4.7% increase in hospital readmissions from the previous year. Therefore, the objective was not met for either timeline from discharge.

Fiscal Year 2016/2017

Within 30 days of hospital discharge, approximately 12% (*n* = 135) of hospitalizations resulted in psychiatric hospital readmission within 30 days of discharge, which was an 11.2% decrease in readmissions from the baseline year. Hospital readmissions within 31 days and one year of discharge reduced by 52.7% from baseline (*n* = 71). Although the objective was not met for readmissions within 30 days, the objective was met for readmissions within 31 days and one year.

Fiscal Year 2017/2018

During fiscal year 2017/2018, 11.6% (*n* = 81) of hospitalizations resulted in readmission within 30 days of discharge, which was reduction in readmissions of 46.7% from baseline. Approximately 10.6% (*n* = 74) of hospitalizations resulted in readmission within 31 days and one year of discharge, which was a reduction of 50.7% from baseline. The objective was almost met within 30 days of discharge and was met within 31 days and one year of discharge.

	2015/2016	2016/2017	2017/2018
Objective Met?			
<i>30 days</i>	No	No	No
<i>31 days to one year</i>	No	Yes	Yes

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 were not available for reporting across fiscal years.

Objective 5: Decrease the time that law enforcement spends waiting in the Emergency Department with patients 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 was not reported across fiscal years.

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 on a five-point scale: 1 = *Strongly disagree*, 2 = *Disagree*, 3 = *I am neutral*, 4 = *Agree*, and 5 = *Strongly agree* (see items below).

Fiscal Year 2015/2016

Between October 2015 and June 2016, law enforcement members completed 146 case incident forms that involved mental health issues. Item responses indicated that, on average, law enforcement agreed that they were satisfied with the crisis response from the Dept. of Behavioral Wellness CARES teams. Since there are no baseline data for this objective, an increase in satisfaction cannot be evaluated. However, law enforcement personnel reported satisfaction with the CARES response, so the objective was met.

“CARES response was extremely helpful.”
 “Great. Arrived quickly and evaluated subject.”
 “They were prompt and professional.”
 “Positive, helpful, attentive.”

Fiscal Year 2016/2017

During fiscal year 2016/2017, law enforcement members completed 170 case incident forms involving mental health issues and a response from the Dept. of Behavioral Wellness CARES teams. Overall, law enforcement members reported that they were satisfied with CARES’ crisis response, and the objective was met.

Fiscal Year 2017/2018 (July – December)

In Quarters 1 and 2 of fiscal year 2017/2018, law enforcement completed 43 case incident forms involving a response from the CARES teams. Evaluators were not able to collect data at the time of evaluation for Quarters 3 and 4 of fiscal year 2017/2018. Based on item responses to the Law Enforcement Satisfaction Survey, law enforcement members reported overall satisfaction with the CARES response, and the objective was met as it was intended to be interpreted.

Law Enforcement Satisfaction Survey, October 2015 – December 2017

Item	Descriptor	Mean	FY2015/2016		FY2016/2017		FY2017/2018	
			n = 146		n = 170		n = 43	
The crisis team responded in a timely manner.	Agree	3.90	Agree	3.88	Agree	3.72		
The Department of Behavioral Wellness crisis team members were helpful to the client.	Agree	4.05	Agree	3.94	Agree	3.88		
The Department of Behavioral Wellness crisis team allowed me to focus on my role as a Sheriff/Police Officer.	Agree	4.06	Agree	4.08	Agree	3.94		
I was able to establish a good partnership/collaboration with the Department of Behavioral Wellness crisis team.	Agree	4.22	Agree	4.08	Agree	3.84		
Overall, I was satisfied with the response from the Department of Behavioral Wellness crisis team.	Agree	4.06	Agree	4.00	Agree	3.74		

	2015/2016	2016/2017	2017/2018 (July – December)
Objective Met?	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>

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.

Crisis Residential Treatment Program

Fiscal Year 2015/2016

Upon discharge from the CRT program, 58% of clients were engaged with and connected to ongoing outpatient services. Through further consultation, Anka program staff reported that clients previously served by the Dept. of Behavioral Wellness were already connected to outpatient care, and therefore did not have new outpatient referrals recorded. It is probable that more clients were connected to long-term care, or were already accessing long-term care, than reported. Since there is no specified metric in this objective, and most clients were connected to ongoing outpatient care, the objective was met

Fiscal Year 2016/2017

At discharge from the CRT program, approximately 58% of individuals served were connected with long-term outpatient care, which did not change from the previous fiscal year. Thus, the objective was met.

Fiscal Year 2017/2018 (July – December)

During fiscal year 2017/2018, approximately 66% of clients served were connected to long-term outpatient care, which is an increase from the previous fiscal year. The objective was met.

Crisis Stabilization Unit

Fiscal Year 2015/2016 (January – June)

The CSU connected 100% (n = 216) of clients to outpatient care within six months of discharge from the facility, and the objective was met.

Fiscal Year 2016/2017

During fiscal year 2016/2017, 100% (n = 465) of clients were connected to outpatient services within six months of discharge. Therefore, the objective was met.

Fiscal Year 2017/2018

In fiscal year 2017/2018, 100% (n = 471) of individuals served by the CSU were connected to outpatient care within six months of discharge, and the objective was met.

	2015/2016	2016/2017	2017/2018
Objective Met?			
<i>CRT</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>
<i>CSU</i>	<i>Yes</i>	<i>Yes</i>	<i>Yes</i>

Objective 8: Client 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

In July 2015, the Crisis Residential Unit opened with eight beds. A total of 48 clients completed the Consumer Satisfaction Survey prior to discharge from the program. Mean scores in all domains indicate that clients agreed or strongly agreed that they were satisfied with services from the Crisis Residential Treatment Program.

“Staff was exceptionally helpful during this time of crisis.”

“The classes were comforting and the knowledge was so good.”

“Great facility and hope it stays that way for future clients.”

“It’s a wonderful place. I feel very safe, staff is very supportive.”

“I like it here, staff is friendly and helpful.”

Fiscal Year 2016/2017

Sixty-seven (67) clients completed the Consumer Satisfaction Survey prior to discharge from the CRT program in South Santa Barbara County during fiscal year 2016/2017. Overall, mean scores in each of the domains indicate that clients were satisfied with their experiences in the program.

Fiscal Year 2017/2018

During fiscal year 2017/2018, clients ($N = 68$) indicated that they were satisfied with their experiences at the CRT and treatment by staff members. In Quarter 2 and Quarter 3 of this fiscal year, only three clients completed the CSQ due to staff turnover and resulting difficulties keeping the data collection protocol consistent. Dept. of Behavioral Wellness and evaluators consulted with staff at the CRT to provide additional training on protocols. During Quarter 4 of this fiscal year, 47 clients completed the CSQ, indicating improvements in data collection procedures.

Client Satisfaction with the Crisis Residential Treatment Program for FY 2015 – 2018

Category	Client			Staff		Accessibility	Overall Satisfaction
	Effectiveness	Efficiency	Involvement	Treatment	Satisfaction		
FY2015/2016	Agree 4.29	Agree 4.42	Agree 4.49	Strongly Agree 4.52	Strongly Agree 4.52	Strongly Agree 4.81	Strongly Agree 4.51
FY2016/2017	Agree 4.21	Agree 4.31	Agree 4.34	Agree 4.39	Agree 4.28	Agree 4.41	Agree 4.32
FY2017/2018	Agree 4.21	Agree 4.29	Agree 4.29	Agree 4.25	Agree 4.27	Agree 4.49	Agree 4.21

	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	Yes	Yes

Objective 9: The Crisis Stabilization Unit in Santa Barbara will increase the number of daily available 24-hour beds from 0 to 8 upon implementation of the program in Year 1.

The CSU opened in January 2016 with eight beds. During fiscal year 2016/2017, 717 new clients were served by the program, and during fiscal year 2017/2018, 242 new clients were served by the CSU.

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 hired three mental health caseworkers, two practitioner interns, one recovery assistant with lived experience, and one psychiatric nurse. Two vehicles were purchased to allow for rapid responses to mental health emergencies. Therefore, the objective was met.

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

As of June 30, 2017, the average wait time for crisis response from the Lompoc Mobile Crisis Support Team was 15 minutes, and the objective was met. 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. Therefore, the objective was met.

Results: Post-SB 82 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 13: Staff members’ professional quality of life will be high, and remain high throughout the grant cycle.

Both peer and non-peer staff quality of life were evaluated using the Professional Quality of Life Scale (ProQOL). Staff members were asked 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.

Fiscal Year 2015/2016

Overall, staff members in South County indicated a high professional quality of life, reporting that they often feel satisfaction from their work and rarely experience burnout and secondary traumatic stress.

Fiscal Year 2016/2017

During fiscal year 2016/2017, staff members reported that they often feel compassion satisfaction and rarely feel burnout or secondary traumatic stress, indicating that staff members’ professional quality of life was high.

Fiscal Year 2017/2018

Consistent with previous years, staff members, on average, reported high professional quality of life in their positions at the CRT.

Professional Quality of Life for FY 2015 – 2018

Category	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
FY 2015/2016	Often 4.25	Rarely 1.81	Rarely 1.64
FY 2016/2017	Often 4.33	Rarely 1.83	Rarely 1.69
FY 2017/2018	Often 4.23	Rarely 1.90	Rarely 1.78

“The clients really do put a smile on my face. They’re the ones that make me love my job. Knowing that I help them and they help me in certain areas in my life as well. They’ve taught me patience and understanding. They help me grow every day.”

“Working with individuals in crisis we face many challenges on a day to day basis. The way that we get through it is by working together as a team so it’s not just one person making decisions it’s a team as a whole to come up with the best solution.”

	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	Yes	Yes

Objective 14: 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.

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*.

Fiscal Year 2015/2016

Data on client-reported active behavioral health symptoms were not collected during Quarter 1. During Quarters 2 through 4, clients consistently reported reductions in active behavioral health symptoms from intake to discharge. Clients reported reductions in symptoms by more than 50% in Quarters 3 and 4, thus meeting the objective.

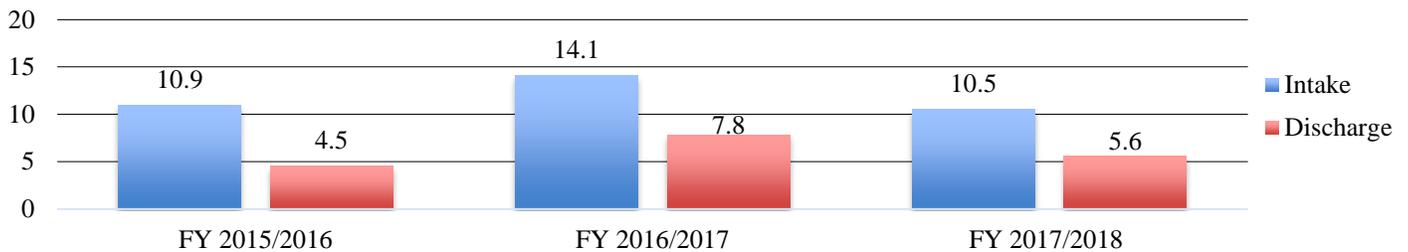
Fiscal Year 2016/2017

Clients reported an average reduction in psychological distress by 45%. Although the objective was not met for the year, this objective was met in Quarter 1 of fiscal year 2016/2017.

Fiscal Year 2017/2018

During fiscal year 2017/2018, clients reported an average reduction in active behavioral health symptoms of 46.7%. Therefore, the objective was almost met.

**Client-Reported Active Behavioral Health Symptoms
FY 2015-2018**



	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	No	No

Objective 15: Reduce active behavioral health symptoms by 50% at the CRT, as reported by **clinician**.

The Triage Severity Scale (TSS) was administered to clients at intake at the CSU and at intake and discharge at the CRT to assess the severity of clients’ active behavioral health symptoms, as rated by a clinician. Clinicians score consumers’ level of impairment in affect, behavior, and cognition on a six-point scale: 0 = *No*

Impairment, 1 = Minimal Impairment, 2 = Low Impairment, 3 = Moderate Impairment, 4 = Marked Impairment, and 5 = Severe Impairment.

Crisis Residential Treatment Program

Fiscal Year 2015/2016

During Quarter 1, data were not collected on clients’ clinician-reported active behavioral health symptoms. Overall, clinicians reported reductions in clients’ affective, behavioral, and cognitive impairment across Quarters 2, 3, and 4. Although the objective was met in Quarters 3 and 4, it may be noted that, on average, clinicians rated clients as entering the program with either low or minimal impairment in affect, behavior, and cognition.

Fiscal Year 2016/2017

Overall, clinicians reported small to moderate reductions in average client impairment in affect, behavior, and cognition from intake to discharge, indicating that the objective was not met. Evaluation of this objective was likely negatively impacted by missing data. Additionally, consultation with Anka Behavioral Health, Inc. staff indicated that some clients’ primary concerns may have been substance use or homelessness, with secondary or tertiary concerns of mental health. Consultation between the Dept. of Behavioral Wellness, CRT staff, and evaluators revealed that some clients did not have clinician-rated impairment reported because the mental health clinician was not on duty during discharge procedures, particularly when discharges were unplanned. Evaluators and staff members continue to problem solve.

Fiscal Year 2017/2018

In fiscal year 2017/2018, significant reductions in impairment in affect, behavior, and cognition were reported by clinicians at the CRT. Although impairment in cognition, on average, reduced by 48%, the objective was functionally met. Based on the findings that most clients, on average, entered the program with minimal impairment, Dept. of Behavioral Wellness, evaluators, and CRT staff have engaged in continuing consultation regarding clients being served and staff training on severity of client symptoms. Training on modified versions of the TSS, which include options for clinicians to indicate if assessment with the TSS was not possible or inappropriate due to clients’ symptoms, were offered to the staff for Quarters 3 and 4 of this fiscal year, and consultation with the supervisor and primary mental health clinician have been ongoing. Based on reductions in fiscal year 2017/2018, it is possible that these changes to the TSS are helping to show clients’ improvement.

Average Psychological Distress Score for FY 2015 – 2018

	Intake			Discharge			% change		
	FY15/16	FY16/17	FY17/18	FY15/16	FY16/17	FY17/18	FY15/16	FY16/17	FY17/18
<i>Affect</i>	Minimal 1.49	Minimal 1.15	Minimal 1.10	Minimal .50	Minimal .85	Minimal .52	66%	26%	53%
<i>Behavior</i>	Minimal 1.41	Minimal 1.01	Minimal 1.29	Minimal .35	Minimal .70	Minimal .57	75%	31%	56%
<i>Cognition</i>	Minimal 1.45	Minimal 1.15	Minimal 1.20	Minimal .62	Minimal 1.08	Minimal .62	57%	6%	48%

	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	No	Yes

Objective 16: Reduce clients' levels of risk, as reported by clinician.

Clinicians reported clients' levels 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 – 6/30/18). 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* for fiscal year 2015/2016.

For fiscal year 2016/2017, each area of risk was rated on a scale of 1 – 20: *Low* (0), *Medium* (1 – 4), and *High* (5 – 20). At discharge, clients were rated for their overall level of risk on the same 20-point scale.

Fiscal Year 2015/2016

During Quarters 1 and 2, the South County CRT did not evaluate clients' level of risk. In Quarters 3 and 4, clients were evaluated for risk of AWOL, self-injury, 5150 hold, suicide, and violence at intake only. During these quarters, clients experienced low and medium levels of risk for AWOL, self-injury, 5150 hold, suicide, and violence toward others at intake (see tables below). Overall, scores during Quarters 2, 3, and 4 indicated that clients entered with a medium level of overall risk and left the program at a low level of risk. Therefore, the objective was met.

Fiscal Year 2016/2017

Overall, clinicians reported that clients experienced low and medium levels of risk for AWOL, self-injury, 5150 hold, suicide, and violence at intake. When comparing mean overall risk scores from intake to discharge, clinicians rated clients at a higher level of risk at discharge than intake (see tables below). The objective was not met during this fiscal year.

In Quarters 1, 2, and 3, CRT staff reported that clients were only administered secondary risk assessments if they experienced an increase in distress, and these secondary scores were filed as discharge scores in the system. As a result, overall level of client risk appeared to increase from intake to discharge; however, this is likely simply an artifact of the timing in which risk scores were recorded. Staff reported to evaluators that clients are not discharged with a high level of risk, and a new protocol was implemented to improve administration of risk assessments to all clients at discharge.

Fiscal Year 2017/2018

In fiscal year 2017/2018, clients' average level of risk significantly improved from intake to discharge, although average scores at intake and discharge fell in the low range. After Quarter 2, evaluators, Anka, and CRT staff collaborated to revise risk assessment questions, as it was determined that individuals were reported at a medium level of risk if they experienced any increased risk in any categories at discharge. However, it is reasonable to expect that clients served may be experiencing some level of risk at discharge. Following these discussions, new risk assessment procedures at discharge have been put into place, and clients are assessed for their risk of AWOL, self-injury, suicide, and violence at discharge to make direct comparisons to intake.

Average Risk Assessment Scores at Intake for FY 2015-2018

Category	AWOL	Self-Injury	5150 Consultation	Suicide	Violence
FY 2015/2016	Low .37	Low .75	Low .11	Medium 1.73	Low .79
FY 2016/2017	Low .46	Medium .73	Low .03	Medium 1.85	Low 1.19
FY 2017/2018	Low .32	Low 1.08	Low .15	Medium 2.06	Low .83

Note. Average scores in FY2015/2016 are based on Quarters 3 and 4.

Overall Risk Assessment Scores for FY 2015 – 2018

Fiscal Year	Intake	Discharge	% Improvement
FY 2015/2016	Medium 2.79	Low .58	79%
FY 2016/2017	Low .85	Medium 2.07	-144%
FY 2017/2018	Low .87	Low .26	70%

	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	No	Yes

Objective 17: 75% of clients will leave the Crisis Residential Unit with a plan for stable or permanent housing.

Clinicians reported clients’ housing status 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*.

Fiscal Year 2015/2016

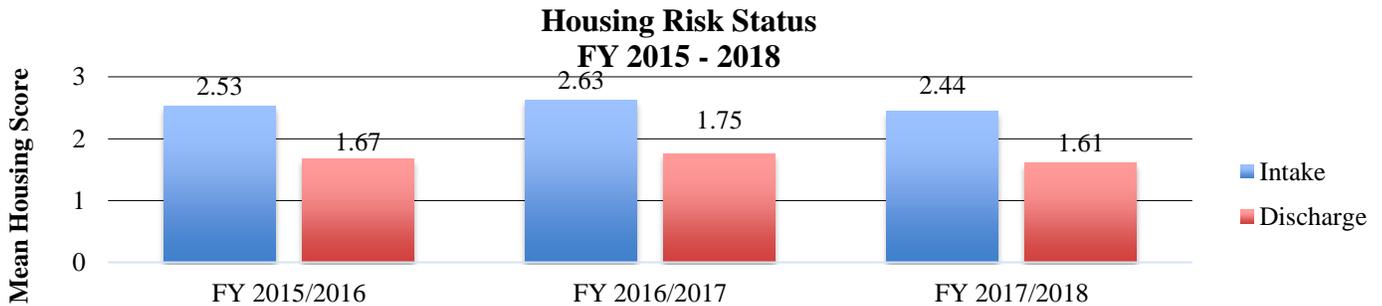
During Quarter 1, the South County facility was not evaluated for the number of clients connected to stable housing. Across Quarters 2, 3, and 4, clients consistently experienced significantly less homelessness at discharge than intake. Although fewer clients left the program with no plan for housing, objectives were not met for the percent of clients that left the program with stable housing, except for in Quarter 2. Overall, mean housing status significantly decreased from intake to discharge.

Fiscal Year 2016/2017

In fiscal year 2016/2017, more clients left with stable housing than at intake (ranging from 27% to 71% by quarter). Although the objective was not met for all quarters, consultation with CRT staff indicated that all clients who go through discharge procedures are, at minimum, placed on a waiting list for housing.

Fiscal Year 2017/2018

In fiscal year 2017/2018, approximately 55% of individuals served at the CRT left the program with stable housing in both quarters. Although the objective was not met, CRT staff reported that clients without stable housing were set up with housing plans and placed on waiting lists.



Objective 18: 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*. Clients that were rated as partially engaged (2) or fully engaged (3) were considered to be demonstrating high levels of program participation.

Fiscal Year 2015/2016

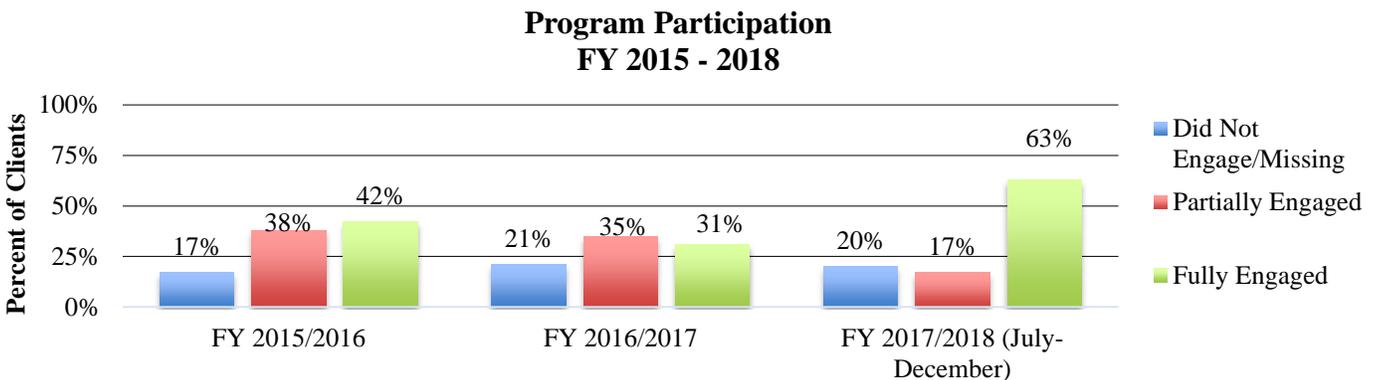
Overall, 80% of clients engaged in CRT group and individual programs to some extent, as rated by clinicians. Thus, the objective was met during this fiscal year.

Fiscal Year 2016/2017

During fiscal year 2016/2017, 66% of clients showed partial or full engagement with CRT programs, indicating that the objective was nearly met.

Fiscal Year 2017/2018

In fiscal year 2017/2018, 80% of clients engaged in program participation at the CRT. Therefore, this objective was met.



	2015/2016	2016/2017	2017/2018
Objective Met?	Yes	No	Yes

Summary

Overall, the CHFFA grant has led to improved outcomes for individuals in Santa Barbara County experiencing difficulties related to severe mental illness and/or substance use. The Lompoc Mobile Crisis Team was appropriately staffed and provided satisfactory responses to crises according to law enforcement personnel. Across grant years, staff members and clients at the CRT reported high satisfaction with their professional life at the CRT and services received, respectively. Additionally, clients and clinicians reported improvements in clients' active behavioral health symptoms across most quarters, with most clients connected to housing plans and outpatient care at discharge. The CSU has connected 100% of clients to outpatient care since its opening in January of 2016. Hospital utilization and transfer times to inpatient and outpatient care have varied across grant years, and improvements in these areas are detailed below.

Recommendations and Future Directions

Considering the increased access to crisis services and improvement in client outcomes in Santa Barbara County facilitated by the CHFFA grant, efforts should be made to maintain staffing and facility needs for the Mobile Crisis Support Team, CRT, and CSU. To improve utilization of the crisis system and address barriers to tracking clients through the system, the Dept. of Behavioral Wellness has incorporated crisis and triage services into one system of integrated services, called Crisis Services. This new crisis system aims to improve clients' transitions and overall experience through Crisis Services, including Emergency Department utilization and boarding time, hospitalizations, and connections to inpatient and outpatient care for individuals experiencing serious mental illness and/or substance use issues. In conjunction with the implementation of Crisis Services, the Dept. of Behavioral Wellness and evaluators should collaborate to revise objectives so that they are realistic and accurately reflect clients' improvement as a result of services.

Appendices

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Law Enforcement Survey

CIT EVENT SUMMARY AGENCY OR STATION:

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: EMERGENCY CONTACT: NAME/RELATIONSHIP: PHONE#		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.			
				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			
				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?

Facility Providing Service: _____

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

Anka Behavioral Health, Inc. ADULT INTAKE ASSESSMENT	NAME: <input style="width: 100%;" type="text"/> CID/MRN#: <input style="width: 100%;" type="text"/> DOB: <input style="width: 150px;" type="text"/> Dx: <input style="width: 100px;" type="text"/>
--	--

SERVICE PROVIDED: Date of Service: _____ Procedure Code: _____ Documenting Staff: _____ Total Time, Date of Service: _____	DAY OF SERVICE: _____ Time _____ Planning: _____ Travel: _____ Service to Client: _____ Documentation: _____
---	---

Service Location: Office Home Field School Other EBP/SS: _____

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

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: _____