



## Year One Evaluation Findings for the Crisis Services Redesign Initiative

Report to the Texas Department  
of State Health Services

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# Table of Contents

■ Report Summary.....	i
■ Acknowledgements.....	ii
■ Executive Summary.....	iv
■ Introduction.....	1
■ Methodology.....	3
■ Finding 1.....	9
■ Finding 2.....	15
■ Finding 3.....	19
■ Finding 4.....	29
■ Finding 5.....	45
■ Finding 6.....	49
■ Conclusions and Recommendations.....	55
■ Endnotes.....	58



# Appendices

- Appendix A: Methodological Notes
- Appendix B: Description of Survey Respondents
- Appendix C: 2008 Crisis Hotline Caller Survey
- Appendix D: Characteristics of Individuals Included vs.  
Excluded from Crisis Hotline and Crisis Service User Surveys
- Appendix E: 2008 Crisis Service User Survey



## REPORT SUMMARY

The first year of the Crisis Services Redesign Evaluation is completed. The purpose of this report is to summarize the findings of this interim evaluation. At this time, the evaluation results suggest the following six findings:

**Finding 1: CSR funds are being used as intended to improve local crisis infrastructure.**

**Finding 2: Increased funding for crisis services alone is not sufficient. Parallel investment in ongoing routine services is also needed to prevent a crisis-driven mental health system.**

**Finding 3: CSR consumers are generally satisfied with services received.**

**Finding 4: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

**Finding 5: Communities with channels of routine communication between agencies seem to be implementing CSR more effectively.**

**Finding 6: Community partners must commit to resolve issues impacting the success of CSR.**

This interim evaluation points to the following early recommendations:

**Recommendation 1.** The types of changes being implemented under Crisis Services Redesign appear appropriate to the goals of the funding and merit continued support as their full impacts are assessed during the second year of the evaluation.

**Recommendation 2.** There is a need for LMHAs to employ creative strategies to engage a broader range of stakeholders in the CSR process. It is clear that many stakeholders are disengaged from CSR and that these disengaged stakeholders are also the least satisfied. Improved communication and collaboration between community stakeholders appears to be an important strategy for maximizing satisfaction among community partners, and for addressing many of the challenges facing CSR.

**Recommendation 3.** Efforts are needed to better balance funding available for crisis services and supports for ongoing mental health crisis services. LMHA reports suggest that CSR has been associated with increased costs to the mental health system, including increases in waits for non-crisis services, costs of increasing caseloads RDM services, and staff costs.

**Recommendation 4.** Enhancements to supportive services provided by community partners would help reinforce the success of CSR. In particular, additional funding for substance abuse detox and treatment, and for law enforcement officers with specialty mental health training, would assist many individuals in crisis.

**Recommendation 5.** To address shortages of qualified personnel, the state should consider policies to support the training of new professionals who can staff crisis services and provide incentives for those professionals to work in underserved areas.

*A full report of the entire CSR evaluation will be presented to the Department of State Health Services in January 2010.*



## ACKNOWLEDGEMENTS

There are many organizations and individuals who have contributed to this first year evaluation of Crisis Services Redesign (CSR) and to the development of this report. These professionals deserve our recognition and gratitude for the important assistance they have provided.

Local Mental Health Authorities. Each of the 38 Local Mental Health Authorities serving people with mental illness throughout Texas has cheerfully cooperated with the research team's every request. They have directly assisted the evaluation by assembling contact information for key community partners to be represented in the study, collecting satisfaction data from crisis service users, and participating in the community stakeholder satisfaction survey describing their mental health centers' experience with CSR. Despite major disruptions at some LMHAs due to Hurricane Ike, staff worked with the research team to make sure the evaluation stayed on track.

Site Visit Participants. Six LMHAs in particular deserve recognition for hosting the research team during site visits. These include:

- Burke Center
- Center for Health Care Services
- Denton MHMR
- Permian Basin Community Center
- Texas Panhandle
- Tropical Texas Behavioral Health
- Lufkin
- San Antonio
- Denton County
- Midland/Odessa
- Amarillo
- Edinburg

Staff at each of these centers welcomed the research team warmly and gave their time generously to help evaluators gain a thorough understanding of mental health crisis services in their community.

Crisis Hotline Service Providers. Special recognition also goes to the administrators and staff of the eight crisis hotline providers who assisted the evaluation by collecting satisfaction data from eligible callers. Their efforts were reflected in the high quality of the data collected. They include:

- Austin-Travis County Mental Health Mental Retardation Center
- Avail Solutions, Inc.
- Center for Health Care Services
- El Paso Mental Health Mental Retardation
- Mental Health Mental Retardation Authority of Harris County
- Mental Health Mental Retardation Center of Nueces County
- Mental Health Mental Retardation of Tarrant County
- North Texas Behavioral Health Authority

Community Stakeholders. Over the course of this evaluation, more than 70 local law enforcement officers, emergency room personnel, and judges set aside time to speak directly with members of the research team about mental health crisis services in their communities. An additional 1,021 other stakeholders voluntarily completed an online survey regarding their experiences with and perspectives on crisis service delivery. These included respondents in these same categories as well as planning committee members, consumer advocates, psychiatrists, and other concerned individuals. The participation of these knowledgeable and dedicated professionals and advocates has been essential to developing a well-rounded understanding of CSR and its impacts.

Texas Council of Community MHMR Centers. The Texas Council has readily offered their community provider network as a resource to the evaluation team. At the request of evaluators, the Council has provided access to knowledgeable individuals to review and comment upon research products such as survey instruments and reports. In addition, the Council provided a forum at their annual conference for researchers to meet with interested LMHAs and plan major collaborative data collection efforts such as the crisis hotline survey and crisis service user survey. Their organization has provided valuable assistance facilitating exchange of information and expertise.

Graduate Research Assistants. The evaluation was fortunate to benefit from the data collection support provided by three graduate students. During the summer of 2008, three doctoral students, Molly Gasbarrini, Leticia Osterberg, and Carly Peterson, attended site visits and conducted extensive telephone interviews with law enforcement, emergency room, and judicial stakeholders. Their detailed qualitative notes provided a solid information base for developing the statewide data collection effort. They are to be commended for their superior research capabilities as well as for their commitment to the project.

Report Production Assistants. Two individuals in particular must be recognized for their help in the preparation of the final report document. Megan McIntire of the Public Policy Research Institute assisted in the development of a number of graphics and tables and Jenna Kujawski of College of Education provided assistance with graphic design and formatting. Many of the display features of the document through which the major findings are communicated are attributable to their efforts.

## EXECUTIVE SUMMARY

In 2007, the 80th Texas Legislature appropriated \$82 million to the Department of State Health Services (DSHS) to address problems in the state's mental health and substance abuse crisis service delivery system. Texas A&M University was selected to serve as an independent, external evaluation team to examine the impact of Crisis Service Redesign (CSR). This report contains the initial evaluation findings regarding the first year of CSR.

Utilizing a combination of visits to selected Local Mental Health Authorities (LMHAs), interviews with law enforcement officers, judges, and emergency room staff, statewide online surveys of key stakeholder groups, and satisfaction surveys of users of CSR-funded services, the evaluation team has generated 6 findings regarding the impact of CSR.

### **Finding 1: CSR funds are being used as intended to improve local crisis infrastructure.**

- Crisis hotlines certified by the American Association of Suicidology (AAS) are now available statewide
- Mobile Crisis Outreach Teams (MCOTs) of clinicians who can provide a crisis response and treatment interventions in community settings are now available at all LMHAs.
- Some communities have increased alternatives to emergency rooms for psychiatric and medical screenings.
- Communities around the state have increased availability of community-based treatment as an alternative to state hospitalization.

### **Finding 2: Increased funding for crisis services alone is not sufficient. Parallel investment in ongoing routine services is also needed to prevent a crisis-driven mental health system.**

- Members of all stakeholder groups express concern that new funding to people in crisis should be balanced by comparable investment in DSHS' ongoing Resiliency and Disease Management (RDM) services.
  - After crisis events are resolved, many crisis consumers are enrolling for long-term mental health care. Caseloads and costs have increased for ongoing RDM services while funding has remained unchanged.
  - As crisis consumers gain priority access to maintenance RDM care, individuals already in line for non-crisis services experience greater delays, raising the likelihood that waitlist members will themselves decompensate.
  - CSR has unintentionally increased LMHA's personnel costs by requiring higher salaries to attract credentialed staff. Equity adjustments for similarly credentialed non-crisis staff were not covered by CSR funds.

### **Finding 3: CSR consumers are generally satisfied with services received.**

- 85 percent of crisis hotline callers are satisfied with the service received. Respondents are most satisfied if:
  - the call results in immediate action (i.e., activation of LMHA on-call staff or an emergency room referral),
  - the caller perceives immediate risk of harm at the time of the call,
  - the call is on behalf of a minor, or
  - the caller is from a rural area.

- 86 percent of mental health crisis service users are satisfied with the service received. Respondents are most satisfied if:
  - they receive crisis respite or residential services in their own community,
  - the crisis service user is at immediate risk of harm when the service is received, or
  - the consumer is male.
- Both crisis hotline and crisis service users are less satisfied if they receive a non-specific “other” response.
- 80 percent of consumers who had other crisis responders such as law enforcement, emergency rooms, the courts or schools involved in the episode said these entities were somewhat or very helpful.

**Finding 4: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

- Community partners feel LMHA crisis services have improved over the past year, although satisfaction ratings are still low in every respondent group except LMHAs.
- Community partners believe more funding is needed for CSR to have a significant impact.
- Emergency room personnel, law enforcement officers, judges and psychiatrists are much less satisfied with the goals and progress being made on local crisis service plans than are LMHA staff, planning committee members, and advocates.
- Awareness of and satisfaction with specific CSR services (i.e., hotlines, MCOTs and local treatment) also vary across stakeholder groups, with satisfaction being lowest among emergency room staff, law enforcement officers, and judges, and among individuals who were not involved in the CSR process.
- Some evidence points to specific positive impacts of CSR on law enforcement:
  - Law enforcement officers who have been involved in CSR report reduced transportation burden, although officers who are not CSR-involved are more likely to report unchanged or increased transportation burden.
  - Reductions in law enforcement wait times at emergency rooms are reported in some communities, but offsetting increases are also reported in others.
- The evidence suggests that, to date, CSR has done little to reduce demands on emergency rooms during mental health crises:
  - Emergency rooms remain the primary venue for medical screenings and are heavily used for psychiatric screenings.
  - Most emergency rooms do not report a change in the number of psychiatric screenings occurring at the emergency room. There are mixed reports about whether LMHAs are arriving more quickly to conduct screenings.
  - The role of emergency room staff in locating state hospital beds and in providing transportation to state mental health hospitals has increased in the past year.

**Finding 5: Communities with channels of routine communication between agencies seem to be implementing CSR more effectively.**

- Community forums promote shared responsibility and investment of resources.
- Community partners who are informed and engaged in CSR are more satisfied.
- Though LMHAs believe they have effectively recruited input from emergency rooms, law enforcement agencies, judges, and psychiatrists, these stakeholders are least likely to be aware of CSR funding and strategies. Because more involved constituencies are more likely to be satisfied with CSR, it is important to better understand why these key constituencies are not being successfully engaged.

- Although inter-agency collaboration to assist people in mental health crisis remains relatively low, community stakeholders report their ability to work together has improved since CSR.

### **Finding 6: Community partners must commit to resolve issues impacting the success of CSR.**

Several challenges to the success of CSR exist that cannot be resolved by the LMHAs alone, including:

- Lack of consensus about who is responsible for transporting people in mental health crisis.
- Reluctance of some law enforcement agencies to exercise their authority to detain an individual in crisis without first obtaining a warrant from a judge. This places a significant burden on families, LMHAs, and ER personnel required to obtain a warrant before police will act, and on judges.
- Reluctance of some law enforcement officers to deliver mentally ill offenders to treatment.
- Need for more law enforcement officers with specialty mental health training.
- Difficulty in some communities accessing a justice of the peace when an emergency mental health detention warrant is needed, particularly after hours or on weekends.
- Need to remove restrictions placed by some hospitals on LMHA screenings conducted in emergency rooms. When emergency rooms are unwilling to allow LMHAs to enter the emergency room, they face significant obstacles arranging the face-to-face screening needed to make an appropriate treatment determination.

### **Conclusions and Recommendations**

Although the second year of evaluation is needed before final conclusions can be drawn about the impact of CSR, this baseline evaluation points to several early recommendations:

- **Recommendation 1.** The types of changes being implemented under Crisis Services Redesign appear appropriate to the goals of the funding and merit continued support as their full impacts are assessed during the second year of the evaluation.
- **Recommendation 2.** There is a need for LMHAs to employ creative strategies to engage a broader range of stakeholders in the CSR process. It is clear that many stakeholders are disengaged from CSR and that these disengaged stakeholders are also the least satisfied. Improved communication and collaboration between community stakeholders appears to be an important strategy for maximizing satisfaction among community partners, and for addressing many of the challenges facing CSR.
- **Recommendation 3.** Efforts are needed to better balance funding available for crisis services and supports for ongoing mental health crisis services.
- **Recommendation 4.** Enhancements to supportive services provided by community partners would help reinforce the success of CSR. In particular, additional funding for substance abuse detox and treatment, and for law enforcement officers with specialty mental health training, would assist many individuals in crisis.
- **Recommendation 5.** To address shortages of qualified personnel, the state should consider policies to support the training of new professionals who can staff crisis services and provide incentives for those professionals to work in underserved areas.



**Introduction and Methodology**



## INTRODUCTION

In 2007, the 80<sup>th</sup> Texas Legislature appropriated \$82 million to the Department of State Health Services (DSHS) to address problems in the state's mental health and substance abuse crisis service delivery system. Input was gathered from stakeholders through public hearings, evaluations of community mental health providers, and surveys of local partners representing law enforcement and hospitals. The evidence showed low overall satisfaction with the crisis service infrastructure. A September 2006 DSHS<sup>1</sup> report summarized some of the main concerns including:

- Timeliness of crisis service provider response;
- Training and competency of crisis service providers;
- Availability of community resources and crisis alternatives to hospitalization or incarceration;
- Provision of ongoing intervention until the crisis is resolved or individuals are placed in a clinically appropriate environment;
- Inappropriate use of "no harm" contracts;
- Crisis response for individuals who are intoxicated or under the influence of substances;
- Communication, problem-solving, and coordination of efforts between Local Mental Health Authorities (LMHAs), law enforcement and hospitals and other community resources; and
- Oversight systems to monitor the effectiveness (outcome) of crisis services.

A Crisis Service Redesign (CSR) Committee representing knowledgeable experts, practitioners, policymakers, and advocates was assembled to help plan how the new funding might be used to address these challenges. The group recommended that the following core components be integrated into local crisis response systems:

- Crisis hotline services certified by the American Association of Suicidology (AAS);
- Mobile Crisis Outreach Teams (MCOT) to enable mental health professionals to provide a crisis response and treatment interventions in community settings;
- Increased availability of community-based treatment as an alternative to state hospitalization; and
- Capacity-building for law enforcement by supporting Crisis Intervention Teams (CIT) or mental health deputy/peace officer programs.

Funding to restructure basic crisis services was distributed to LMHAs through a formula-based allocation. In addition, centers had the option to apply for competitive Community Investment Incentive funding for psychiatric emergency service centers, jail diversion, and community-based competency restoration services.<sup>2</sup> Formula funding first became available in December of 2007, and Competitive Community Investment Incentive awards were announced in May of 2008.

Given the scope and significance of CSR, the legislature required that the impacts of the initiative be documented through "an analysis of the implementation of crisis services and the impact of crisis services, including on clients, local communities, mental health and health care providers, and law enforcement."<sup>3</sup> In December of 2007, Texas A&M University was selected through a competitive process to conduct the necessary research. The team was asked to evaluate the state's progress toward meeting four goals:

Goal 1: *Stakeholders will be satisfied with improvements made to the community mental health crisis system.*

Goal 2: *Texans who are experiencing a mental health crisis will be served in appropriate settings in a timely manner.*

Goal 3: *Communities have more local alternatives that are less restrictive for resolving mental health crises.*

Goal 4: *Community mental health services will be cost effective.*

This interim report documents the progress toward achieving these goals after one year of implementation. Crisis Services Redesign is inevitably an incremental process involving a basic restructuring of the way mental health crisis services are delivered by both community mental health providers and their local partners. Start-up time for all CSR projects has varied depending on the extent and type of services being developed. While services are now largely in place, adjustments are still being made in many communities. It is important to consider these findings as preliminary evidence. A fuller picture of the impacts of CSR will develop as LMHAs continue to refine their crisis programs in the second year of the evaluation.

The following paragraphs describe the research methods used. Evidence is then presented to support six main findings. The final chapter highlights the overall conclusions and offers recommendations based on the lessons learned to date.

## METHODOLOGY

In a state as large and varied as Texas, the research team felt that the evaluation of Crisis Services Redesign could not effectively be limited to a sub-sample of LMHAs. In order to develop a cohesive set of research themes within which to frame analyses across diverse local contexts, the study was designed around a series of concentric or expanding methodologies.

The overall research approach is illustrated Figure 1. Each stage of analysis expands upon information gained in the preceding stages. The design allows for hypotheses to be developed based on an in-depth understanding of CSR in a small subset of purposively selected communities. These hypotheses are then tested statewide through other methods including stakeholder surveys and archival data analysis.

The same methods used to define and document the issues central to CSR during the first year of the study will be replicated in the second year to assess further changes that have occurred as CSR has had more time to impact communities. The final evaluation report including all conclusions and recommendations will be completed in December of 2009. Specific research methods are described in detail below.

### **1. LMHA Self-Report Survey** (*April-May, 2008*)

The first major data collection effort was an online survey completed by one representative of each LMHA statewide. The survey had two purposes. First, it gathered information that was not available from other sources to help evaluators determine which centers to visit. Second, the survey provided a means for centers to identify individuals and organizations with whom they routinely collaborated. Because most LMHAs tried to target limited crisis funds where they would have the greatest impact, the research team needed to identify law enforcement agencies and hospitals that should be expected to be aware of the impacts of CSR in later stakeholder surveys. A total of 411 law enforcement officers, 214 hospital staff, and 119 judges were identified as agencies actively engaged as LMHA partners. Similarly, contact information was acquired for 901 local planning committee members so they could be contacted for input during the stakeholder survey described below.

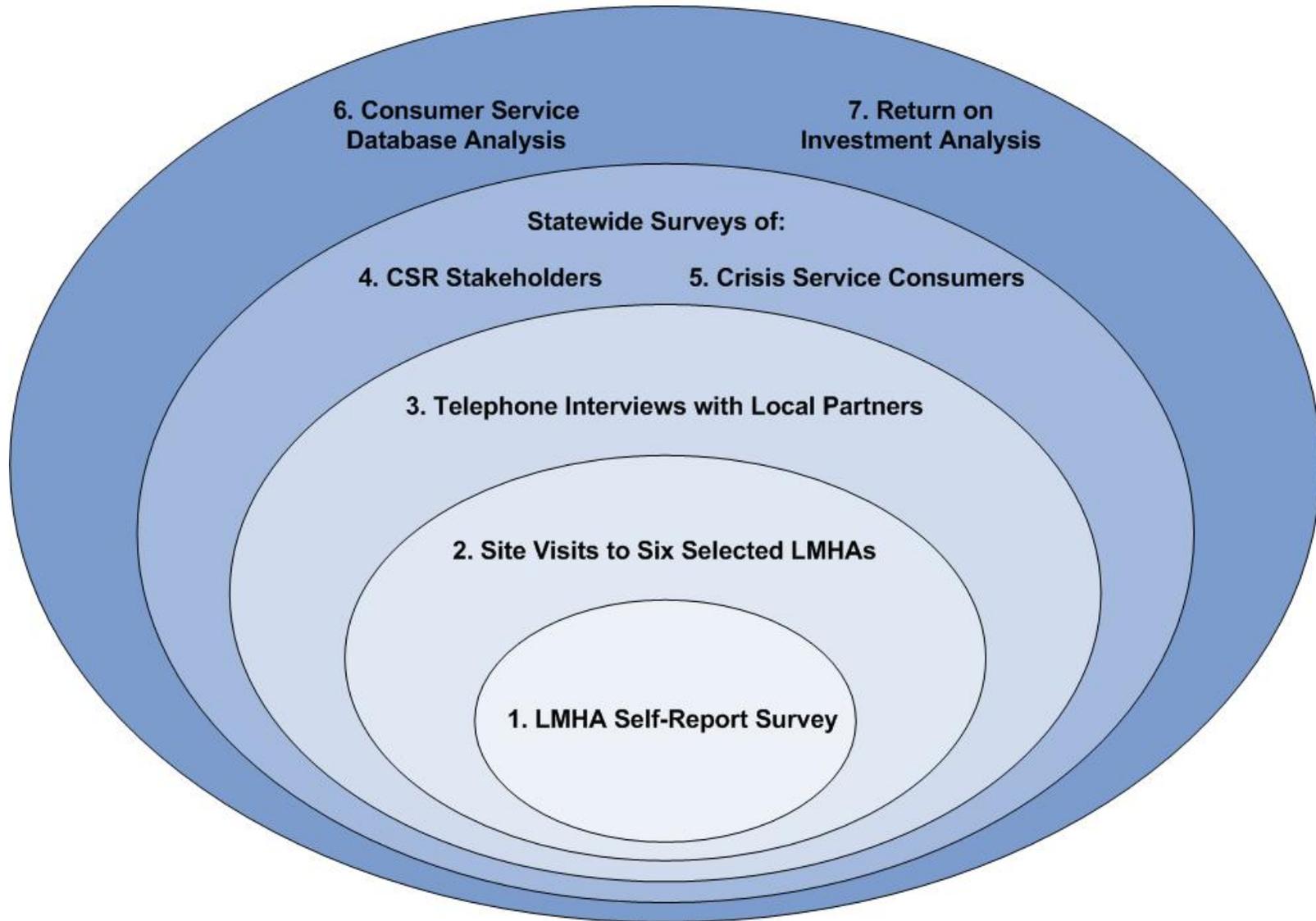
### **2. Site Visits to Six Selected LMHAs** (*May-June, 2008 and 2009*)

In order to gain an in-depth understanding of crisis redesign, six mental health centers were selected for site visits. LMHAs were chosen to provide a diverse representation of the many contexts in which crisis redesign is being implemented in Texas. A two-stage selection process was used. First, several quantifiable characteristics were examined using cluster analysis that grouped “similar” sites together.<sup>4</sup> The research team then chose sites from different clusters to ensure they would each contribute unique information. When selecting sites within clusters, an effort was also made to choose LMHAs that represented the state geographically. At the conclusion of this process, the following centers were selected:

- Burke Center (Lufkin)
- Center for Health Care Services (San Antonio)
- Denton MHMR (Denton County)
- Permian Basin Community Center (Midland/Odessa)
- Texas Panhandle (Amarillo)
- Tropical Texas Behavioral Health (Edinburg)

## Figure 1: Overview of Research Methods

*Baseline: 2008, Follow-up: 2009*



While on site, at least one full day, and typically two days were spent conducting interviews with administrators, supervisors, and crisis line staff including MCOT staff. At several sites, supplemental interviews were conducted with law enforcement or hospital personnel to gain additional context. Interview themes included:

- Description of crisis services before crisis redesign;
- Description of the local planning process to determine how CSR funds would be used;
- Partnerships with law enforcement, emergency rooms, and judges;
- Resources available in the community and how they are being used to support CSR objectives;
- Impacts of CSR that have already occurred and those that are anticipated; and
- Remaining goals and challenges.

A return visit will be made to these same centers one year after the initial visit to document how crisis services and relationships with local implementation partners have developed over time.

### **3. Telephone Interviews with Local Partners** (*July-August, 2008 and 2009*)

While it was helpful for evaluators to learn about CSR in each of the selected six communities through the lens of the community mental health provider, it was equally important to hear independent perspectives on the local crisis service system from community partners who also have a role in resolving mental health crises. Telephone interviews offered an affordable means to collect qualitative interview data from a broad cross-section of community partners. Interview participants were asked to describe:

- Experiences involving people with mental illness,
- Factors enhancing efficiency or creating obstacles in case processing,
- Relationships with other agencies including the LMHA, and
- Overall satisfaction with the process.

Thirty-two members of law enforcement were interviewed including urban and rural sheriffs with overarching county-wide responsibility, large and small police departments, and agencies with and without strong mental health expertise on staff. The twenty judges interviewed included both Justices of the Peace who issue emergency detention warrants, as well as County Court at Law Judges and Probate Judges responsible for court ordering mental health crisis treatment. Nineteen emergency room respondents represented isolated rural clinics as well as larger urban hospitals, some with in-house mental health expertise. Together, these interviews provided the research team with good insight into the unique perspectives of many different types of local LMHA partners. Follow-up calls will be made to the same set of respondents one year after the initial calls to collect updated information about stakeholder experiences and attitudes after CSR has become more fully established.

### **4. Statewide Surveys of Stakeholders** (*August-October, 2008 and 2009*)

Based on the detailed understanding of CSR gained during site visits, the research team developed questions for a larger statewide sample of stakeholders. An email survey was released on September 11, 2008 to individuals in each of the following respondent categories:

- State Planning Committee Members identified from the formal participant list;
- Local CSR Planning Committee Members identified by LMHAs during the self-report survey described above;

- LMHA Staff including at least the Executive Director with other staff knowledgeable about crisis services invited to respond;<sup>5</sup>
- Law Enforcement Agencies identified from the master list available from the Texas Department of Public Safety;
- Hospital Emergency Room nurses identified from the Emergency Room Nurses' Association membership list;
- Judges identified from the master list available from the Texas Office of Court Administration;
- Mental Health Advocacy Organizations including the National Alliance on Mental Illness (NAMI), the Depression and Bipolar Support Alliance (DBSA), Texas Mental Health Consumers (TMHC), Mental Health America (MHA) and the Federation of Families;
- Psychiatric physicians identified from the Texas Society of Psychiatric Physicians (TSPP) membership list.

A total of 1,020 individuals completed the survey. A detailed description of respondent characteristics is provided in Appendix B. Responses from specific law enforcement and emergency room contacts identified by LMHAs in the Self Report Survey (described above) were marked in the database. Satisfaction ratings and other input from these engaged and knowledgeable LMHA collaborators were considered separately in the analyses of survey findings reported below. Both the stakeholder and consumer (see Method 5, below) data collection efforts were interrupted by Hurricane Ike, which made landfall on the Texas coast September 12, 2008. The research team worked to accommodate communities impacted by this natural disaster, delaying some data collection for a month or longer for some centers. Deadlines were extended, and all survey administration was finally complete by November 4, 2008. It is important to be aware that findings have likely been impacted by the interruption caused by the hurricane, though it is not possible to precisely assess its impacts. The survey will be replicated beginning in August of 2009 to measure changes in stakeholder satisfaction as CSR has been more fully implemented and refined.

#### **5. Statewide Surveys of Crisis Service Consumers** (*August-October, 2008 and 2009*)

In addition to the broad-based stakeholder internet survey, satisfaction data was also collected from crisis service users and hotline callers statewide. During the week of September 8-14, 2008, LMHAs were asked to administer a satisfaction survey instrument to a one-week sample of consumers receiving any type of crisis service. Similarly, the state's eight hotline providers were asked to survey all callers with an urgent or emergent crisis, as well as any individuals requiring a mental health crisis service or follow-up. During the one-week data collection period, LMHAs and hotline providers had the choice of either actively surveying individuals receiving services during that week or contacting a retrospective sample of individuals who received services two weeks prior. These consumer surveys will be replicated beginning in August of 2009 to measure changes in consumer satisfaction as crisis services and hotlines have been more fully implemented and refined.

#### **6. DSHS Consumer Service Database Analysis** (*January-August, 2009*)

The methods described above assess community-level change in crisis infrastructure and resulting satisfaction among stakeholders. Beginning in January, 2009, an additional evaluation component will examine changes in crisis service utilization patterns. Evaluators will receive de-identified records from DSHS' consumer service databases<sup>6</sup> from a two-year period prior to the CSR start date (December 2007) through the most recent data available. Findings to be included in the 2009 final report will answer questions such as:

- Does the number of crisis consumers screened and/or served by MCOTs increase over time?
- Does the number of individuals receiving crisis treatment in their own community increase over time?

- How have crisis service enhancements impacted waitlists for non-crisis services?
- Has the average duration of a civil state hospitalization increased, indicating short-term crises are being handled locally?
- Does the number of community forensic commitments increase (and/or the number of state hospital forensic commitments decrease) in communities where competency restoration services are available?

In keeping with the nested or concentric research approach, client service outcomes will be linked analytically to stakeholder perspectives on changes in local crisis infrastructure measured through the preceding research methods. The research will seek to identify those service system features most closely linked with the attainment of positive crisis outcomes.

#### **7. Return on Investment Analysis** (*March-August, 2009*)

Beyond measuring changes in local mental health crisis systems and the resulting impact on clients, it is essential to quantify how these factors impact costs. In 2009, a “return on investment” analysis will be conducted to estimate the cost impacts of Crisis Services Redesign. Analyses will be based on DSHS’ internal data systems combined with self-report assessments collected in the statewide survey of stakeholders. Results will project system costs for mental health services as well as for law enforcement and hospital facilities involved in delivering crisis services with and without the changes in resource use achieved through the CSR initiative. The difference in system costs assuming the presence vs. the absence of CSR will quantify the direct benefits of the program in tangible monetary terms.

#### **Reports to be Produced**

As noted above, this is an interim report offering some insight into the early impacts of Crisis Services Redesign. The final evaluation report will be completed in December of 2009. The final report will incorporate an additional year of data analyses to further develop the preliminary findings reported herein. In general, the report will describe how community crisis services have changed as a result of the CSR initiative, including impacts on LMHAs as well as members of their community network such as law enforcement agencies and emergency rooms. Objective DSHS database measures will also be used to quantify the impact of CSR on consumer service utilization, state hospitalization rates, and system-wide costs. Overall, the report will identify factors that distinguish communities achieving the greatest and least success in improving crisis services for communities and individuals.

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## **Finding 1: CSR funds are being used as intended to improve local crisis infrastructure.**

“I think we’ve moved away from the idea of crisis as a conduit to the hospital, and I think the percentage of folks who actually end up in the hospital has gone down because of this new level of intermediate care.”

— *LMHA Staff Member*

“Our previous crisis staff thought, ‘I’m here to decide if you’ll go in the hospital or not,’ and it was very cut and dry. I think the MCOT teams think more, ‘Okay, let’s see what this client really needs to get through this period.’”

— *LMHA Staff Member*



## **Finding 1: CSR funds are being used as intended to improve local crisis infrastructure.**

The most fundamental priority for Crisis Service Redesign has been to improve local mental health authorities' capacity for a rapid and coordinated mobile crisis response. Primary strategies to strengthen community infrastructure include:

- AAS certified crisis hotlines available statewide 24-hours a day;
- Mobile Crisis Outreach Teams available in every mental health center;
- Increased alternatives to emergency rooms for psychiatric and medical screenings; and
- Increased access to crisis mental health treatment in the community as an alternative to state hospitalization.

As a basic first question, the evaluation team asked whether progress is being made in establishing these new service capabilities. The evidence suggests implementation is occurring according to plan.

### **Certified Crisis Hotlines**

Prior to Crisis Service Redesign, access to crisis hotlines was inconsistent around the state. Many mental health centers took hotline calls during business hours which sometimes interfered with regular clinic functioning. Some centers did not offer a 24-hour response, and after-hours calls could potentially be taken by untrained personnel such as an answering service, with intervention delayed until an on-call mental health professional could be contacted.

Trained Hotline Responders Are Available 24/7. With the infusion of resources through CSR, every LMHA now offers an AAS certified crisis hotline service. Front-line call takers are trained and supervised to provide information, screening, intervention, and referrals 24 hours a day. In many instances crises can be fully resolved through telephone intervention by skilled hotline personnel. However, hotline workers are also trained to recognize when outside expertise is needed and activate appropriate responders.

Hotlines Have An Expanded Role in Case Triage and Emergency Response. As part of crisis redesign, hotline workers also now have a significant coordinating role. With training to make judgments about consumer needs, hotline workers can immediately provide direct instruction to callers and organize supporting action among LMHAs and emergency responders. For this new hotline capability to be used effectively, law enforcement and emergency room staff must be aware of the service and educated to call the crisis hotline when they encounter an individual in mental health crisis.

### **Mobile Crisis Outreach Teams (MCOT)**

Prior to Crisis Service Redesign, few LMHAs had Mobile Crisis Outreach Teams (MCOTs). These dedicated response teams have the ability to make clinical determinations to address crisis events in community locations. Every mental health center statewide has used CSR funding to develop MCOTs, positioning LMHAs to achieve a faster and more therapeutically robust crisis response. Due to resource limitations, not every LMHA is able to provide this service throughout their entire coverage area, though most major population centers have access MCOT services.

More Staff Are Now Available for Crisis Response. CSR funding has increased the number of staff available when mental health crises occur. In the past, LMHA staff often combined crisis response with other duties. Now, MCOT personnel are dedicated entirely to crisis service delivery so other services are not compromised. Prior to CSR, with limited access to crisis responders, multiple crises were handled in sequence, often resulting in long delays. With more staff available, LMHAs can now

respond more quickly. Faster response times can help contain the crisis, reducing the degree and cost of emergency care required.

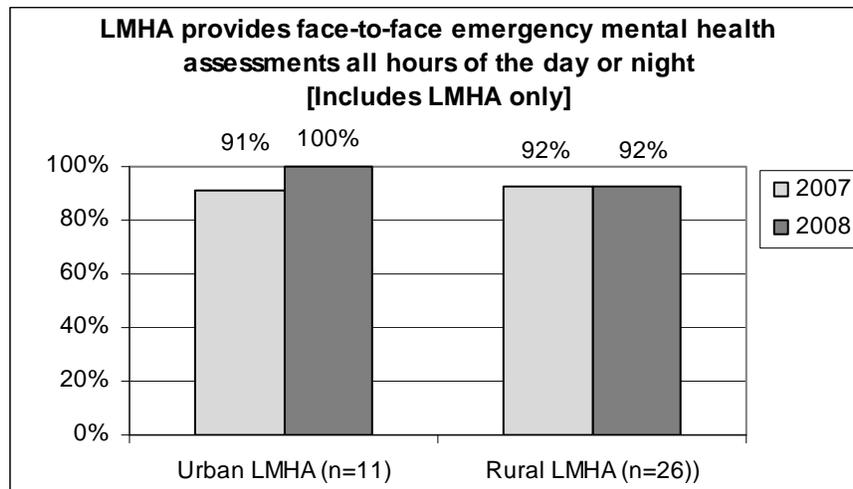
Better Qualified MCOT Staff Make More Clinically Appropriate Treatment Decisions. In the past, LMHA crisis responders primarily focused on screening individuals for state hospitalization. Now, more highly skilled MCOT staff are able to consider other intervention strategies tailored to the needs of the situation. Where registered nurses (RNs) are members of the team, MCOT staff, under the supervision of a psychiatrist, can make medication adjustments to stabilize the crisis at the scene. They can also evaluate the clinical appropriateness of treatment alternatives other than hospitalization, increasing the likelihood that crises can be resolved in the community.

MCOT staff time is spent:

- Conducting mental health screenings in community settings (44% of staff time)
- Locating placements for individuals in need of treatment (13% of staff time)
- Providing follow-up care for consumers recently released from treatment (13% of staff time)
- Providing preventive supports to individuals at risk of crisis (12% of staff time)
- Providing temporary supports to people in crisis who are not eligible for long-term public mental health care (12% of staff time)
- “Other” duties (6% of staff time )

MCOT Duties Include Direct Crisis Screening, Intervention and Prevention. MCOT personnel are engaged in a wide variety of activities. They spend the most time conducting screenings and, when appropriate, locating placements for individuals in need of treatment. The vast majority of LMHAs offer face-to-face emergency mental health assessments at all hours of the day or night (Figure 2).

**Figure 2**



In addition to providing assistance during crisis events, MCOTs have also assumed new responsibilities helping consumers prevent future crises. Nearly 40 percent of their time is spent providing support and care for people at risk for or immediately following a crisis. Key to their ability to engage in these activities is the creation of two new Service Packages created to complement CSR.<sup>7</sup>

- Service Package 0. Brief seven-day intervention delivered in the community for individuals who are not currently enrolled in LMHA services.

- Service Package 5. Thirty days of continued intervention for individuals with ongoing need who were initially stabilized through Service Package 0 or through hospitalization. Services are intended help maintain stability, prevent crisis relapse, and provide linkages to additional community supports.

These service options link consumers with appropriate community resources near the time of the crisis then provide follow-up supports if needed for up to a month.

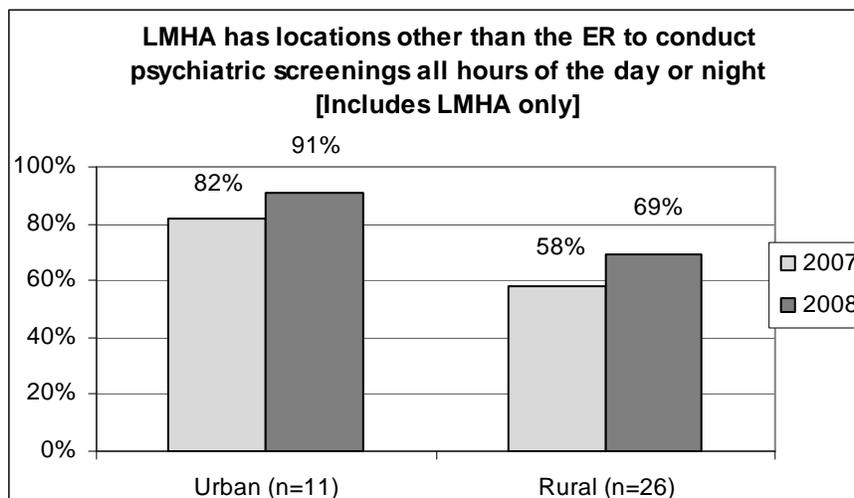
MCOTs Have the Capacity to Relieve Some Transportation Burden on Law Enforcement. MCOT staff at most LMHAs (63%) say they are helping transport consumers to emergency medical screenings. This service is provided by MCOTs in both urban and rural centers and respondents estimate they transport about five individuals per month on average. About 40 percent of LMHAs say their role in providing transportation has increased compared to the same period one year ago.

### Alternatives to Emergency Rooms for Medical and Psychiatric Screenings

With the exception of urban centers with advanced crisis service systems, most LMHAs are only beginning to develop facilities and procedures to reduce the volume of consumers seen in emergency rooms. Ideally, emergency rooms should be reserved for mental health consumers experiencing a true medical emergency, or for a small number referred to a state hospital because local treatment options are not appropriate.

Alternatives to the ER for Psychiatric Screenings Are Beginning to Develop. Historically, emergency rooms have been a central venue for psychiatric assessments. For years, the standard law enforcement protocol in most communities has been to deliver individuals in crisis directly to the emergency room for mental health and medical evaluations. Interview participants say prior to CSR, LMHA staff typically met these crisis consumers at the ER for screening, followed by direct admission to a state hospital. Individuals with no significant physical health concerns often spent hours or days in the care of emergency room staff while the hospital admission was being arranged. This is a pattern CSR aspires to change.

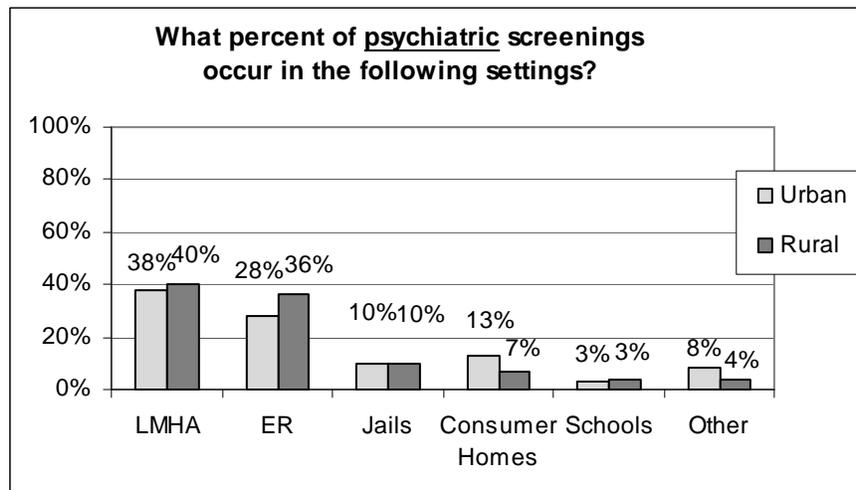
**Figure 3**



Some mostly rural communities still lack locations other than ERs where they can conduct after-hours mental health assessments (Figure 3). The majority of centers, however, do have access to alternative screening sites, with the proportion increasing slightly in the first year of CSR.

Nonetheless, about one-third of psychiatric screenings continue to be held in emergency rooms (Figure 4). Follow-up data collected a year from now will provide insight into whether this proportion will in fact decline as intended.

**Figure 4**



Alternatives to the ER For Medical Screenings Are Beginning to Develop. When people in mental health crisis require state hospitalization, emergency rooms remain the primary resource for pre-admission medical screenings. At present, an average 70 percent of medical evaluations for psychiatric hospitalizations are conducted in emergency rooms.

As local treatment alternatives become more widely available, and as MCOTs de-escalate crises without the need for hospitalization, fewer medical screenings should be required in the future. Some LMHAs are also working to move medical screenings to other locations. Communities adding new crisis treatment capacity often include medical screening in the services provided. At least one center is enhancing MCOT qualifications to support medical assessments. These strategies are all intended to reduce the volume of mental health consumers seen in emergency rooms. Additional long-term data is needed to assess progress toward this goal.

**Alternatives to State Hospitalization through Enhanced Local Treatment Services**

A cornerstone of CSR is to strengthen local service systems so mental health crises can be resolved near home, in the least restrictive setting possible. Local treatment is favorable to consumers in several ways:

- Treatment placement occurs more quickly when transport to a distant state hospital is not required.
- Some judges have reported fewer coerced state hospital commitments as individuals have the option to accept voluntary commitments in their own community.
- Clinical outcomes may be better for individuals hospitalized near friends and family who can lend support during recovery.

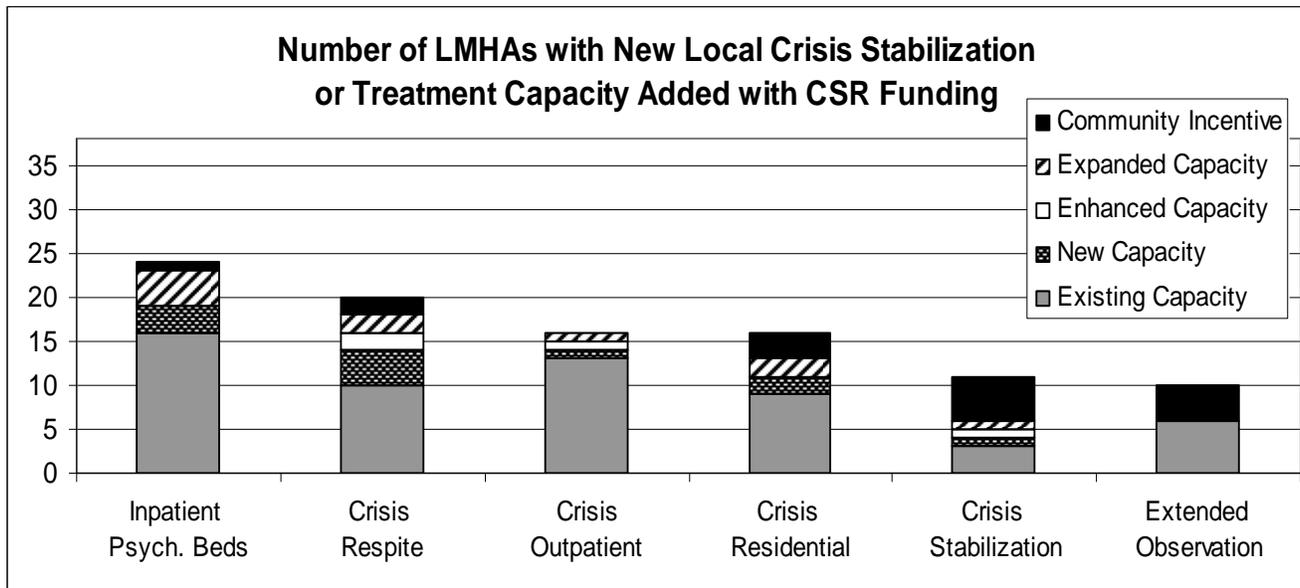
Local Treatment Services Are Increasing through Base CSR Funding. The first priority for CSR spending has been for mental health centers to establish accredited crisis hotlines and MCOTs. After achieving these objectives, remaining funds have been used to expand local crisis service

infrastructure (see Figure 5). Of the 38 LMHA centers, 16 (42%) were able to add some services to stabilize or treat crisis patients locally. Of those, 10 centers (26%) established at least one new type of crisis service that had not previously been available in the community. Decisions about specific improvements were made locally. Most centers adding or improving capacity invested in crisis respite (8 centers) or inpatient psychiatric beds (7 centers), though other types of services were also added.

Local Treatment Services Are Increasing through “Community Investment Incentive” Funding. LMHAs were also invited to apply for separate competitive funding to improve their ability to treat mental health crisis consumers in their own community. Thirteen centers received competitive awards to establish or enhance local psychiatric emergency facilities.

- Austin Travis County MHMR: Adult Rapid Crisis Stabilization Beds, Adult Respite
- Betty Hardwick: Adult & Adolescent Crisis Stabilization Beds
- Bluebonnet Trails: Adult Respite
- Burke Center: Adult Residential, Adult Extended Observation
- Central Plains Center: Adult Extended Observation and Respite
- El Paso Mental Health and Mental Retardation
- Heart of Texas MHMR: Community Triage & Respite Center
- Hill Country Community MHMR: Adult Crisis Stabilization Unit
- MHMR of Nueces County: Adult Extended Observation
- MHMR of Tarrant County: Adult Residential, Adult Respite, Adult Crisis Stabilization Unit
- Spindletop MHMR Services: Adult Extended Observation
- Tri-County MHMR: Adult Residential
- Tropical Texas Center: Adult, Child & Adolescent Rapid Crisis Stabilization Beds
- West Texas Centers: Adult & Adolescent Regional Psychiatric Emergency / Step-Down Beds

**Figure 5**



Five centers received additional competitive allocations to provide outpatient treatment to people who have been found incompetent to stand trial.

- Austin Travis County Mental Health Mental Retardation Center
- The Center for Health Care Services
- North Texas Behavioral Health Authority / ValueOptions
- Mental Health and Mental Retardation Authority of Harris County
- Mental Health Mental Retardation of Tarrant County

Other LMHA Strategies Are also Being Used to Enhance Local Treatment. In addition to developing new or enhanced crisis services, mental health providers have used other creative approaches to help individuals get better near home. Therapeutic foster care is available in at least one center as an alternative to hospitalization for children. In addition, a number of LMHAs have applied their crisis flexible funds to address non-clinical issues that may be contributing to the crisis such as short-term assistance with housing or transportation.

**Finding 2: Increased funding for crisis services alone is not sufficient. Parallel investment in ongoing routine services is also needed to prevent a crisis-driven mental health system.**

“Now it seems that we’ve got a Cadillac of crisis services but still are driving a Pinto in ongoing services.”

— *LMHA Executive Director*

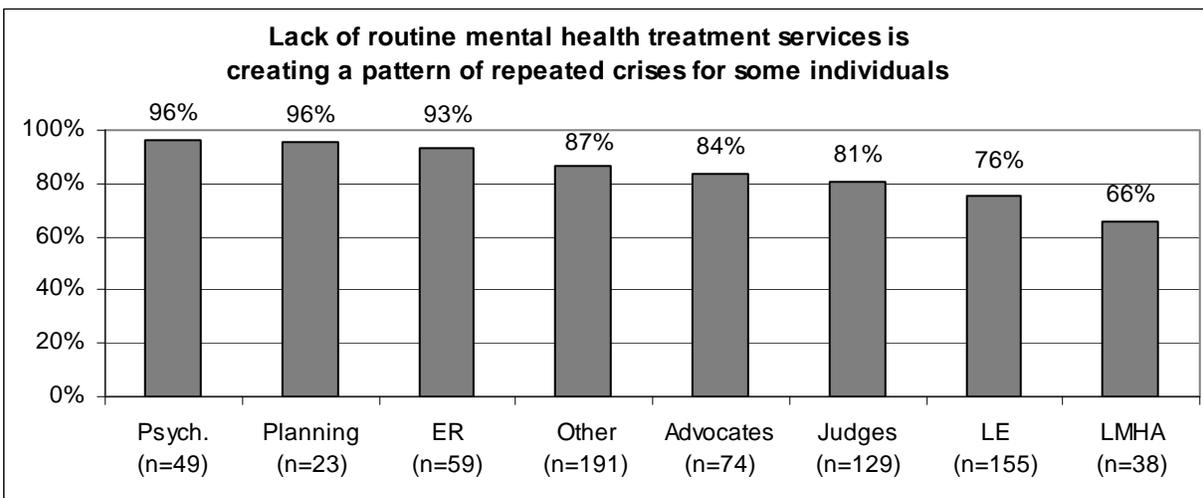


**Finding 2: Increased funding for crisis services alone is not sufficient. Parallel investment in ongoing routine services is also needed to prevent a crisis-driven mental health system.**

A broad cross-section of stakeholders have raised concerns that the significant growth in mental health crisis services, while needed, has not been adequately balanced by comparable investment in DSHS' ongoing Resiliency and Disease Management (RDM) services.

Community Stakeholders Want Investment in Maintenance Services to Prevent Repeat Crisis Contact. Members of every community stakeholder group voiced concern that failure to provide additional funding for RDM services will result in a pattern of repeated crises. These qualitative interview findings were confirmed in the statewide survey (Figure 6). At least three of every four LMHA partners agree that a lack of routine mental health treatment services is creating a pattern of repeated crises for some individuals, with agreement nearly unanimous among psychiatric physicians, planning committee members, and emergency room personnel.

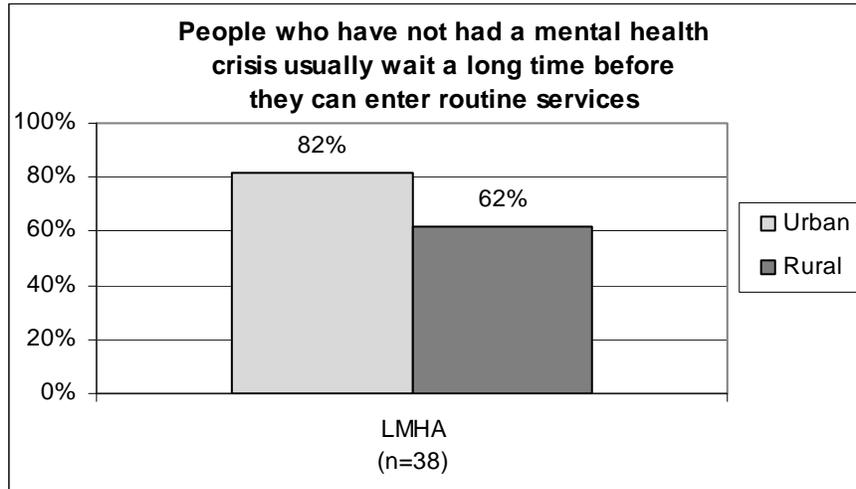
**Figure 6**



Many emergency responders say they could literally name the individuals in their community who cycle from one crisis to the next, and they believe these repeat encounters impose significant costs on law enforcement, emergency rooms and the courts. Though stakeholders appreciate efforts to improve systems that respond to mental health crises, they also want adequate investment in services needed to prevent the occurrence of crises in the first place.

Growing Waiting Lists Increase Risk of Crisis for Non-Crisis Consumers. Survey findings indicate that, since CSR, mental health centers statewide are concerned about their ability to provide prompt access to non-crisis services, particularly in urban areas. In interviews, LMHA staff stated that the influx of new crisis consumers, combined with no new funding for RDM services, is generating long lists of people waiting for non-crisis care. As more people in crisis get priority RDM placement, individuals already in line for services experience greater delays, raising the likelihood that waitlist members will themselves decompensate.

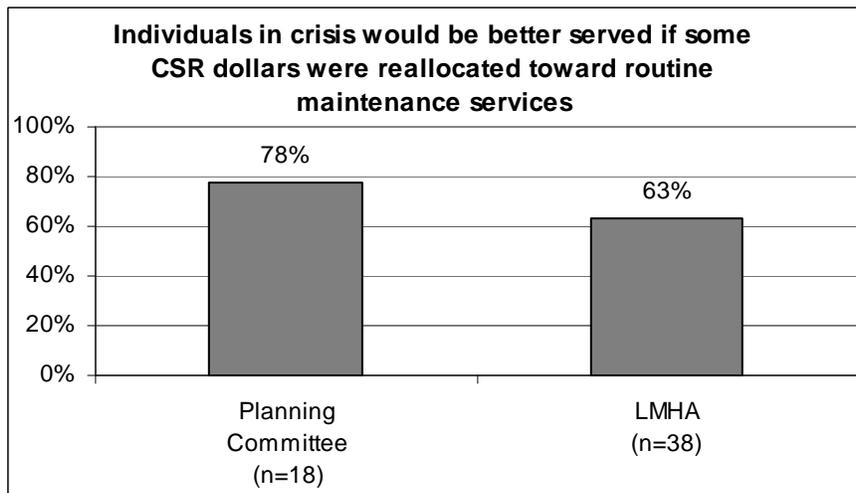
**Figure 7**



Both current consumers and those on waiting lists are experiencing what mental health professionals agree is a “long time” getting help when it is needed (Figure 7). Unless resources for RDM services are increased, the crisis system may become the primary avenue of access to public mental health treatment.

CSR Generates New Costs to LMHAs for Routine RDM Services. Once short-term crisis service recipients enroll for routine long-term care, by law treatment costs are no longer covered by CSR funds. LMHA resources are therefore strained by an increasing volume of people on maintenance caseloads, with no corresponding increase in funding. Some mental health administrators say it is sometimes difficult to provide non-crisis consumers with the minimum amount of services recommended under RDM. Furthermore, these underserved consumers may have an elevated risk of crisis.

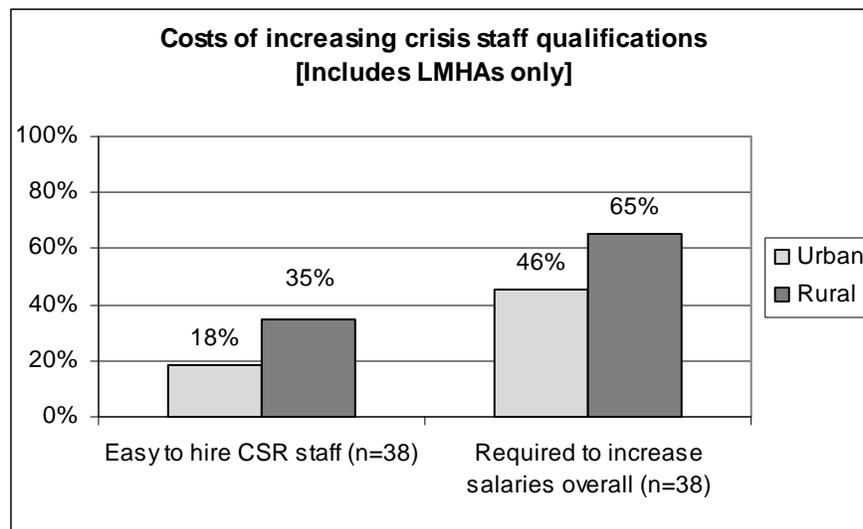
**Figure 8**



To address the problem, increased funding for ongoing mental health services is needed. Should new funding streams not be available, one possible solution might be to increase the flexibility with which CSR dollars can be used. Mental health center staff and members of their planning committees generally agree that individuals in crisis would ultimately be better served if some CSR dollars were reallocated to support routine maintenance services (Figure 8).

The expectation is that overall need for emergency services might decline if timely access to routine care is consistently available to both crisis and non-crisis consumers. This hypothesis can be tested empirically using actual DSHS service utilization data in the next phase of the evaluation. The final evaluation report will provide more objective evidence regarding the impacts of delayed access to routine RDM care for non-crisis consumers.

**Figure 9**



CSR Generates New Costs to LMHAs for Non-Crisis Clinicians. Only a very few mental health centers say it was easy to hire credentialed personnel to staff CSR crisis response teams (Figure 9). LMHAs in rural communities or in communities with a strong competing healthcare sector have had particular difficulty recruiting. To fill new positions funded by CSR, many LMHAs (especially those in rural areas) have had to increase salaries. Importantly, corresponding equity adjustments for similarly credentialed non-crisis staff were not covered by CSR funds.

These findings suggest that new support for CSR has unintentionally increased the cost of routine services by raising personnel costs and increasing the number of consumers enrolling for routine care (discussed above). If these new financial stresses on basic maintenance services continue accrue without relief, CSR may inadvertently evolve into a system in which access to non-crisis care is limited, and people predominantly get help after having an emergency.

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**Finding 3: CSR consumers are generally satisfied with services received.**

“A year ago, many [individuals in crisis] were being shipped out of the community. They were away from their families and away from their support groups. At least if they are local, families that want to support can support, and can come and see them.”

— *Emergency Room Staff Member*



### Finding 3: CSR consumers are generally satisfied with services received.

Consumers are among the most important constituencies expected to be positively affected by Crisis Services Redesign. Their attitudes toward the crisis service system were measured through surveys of all urgent or emergent hotline callers and all users of LMHA crisis services conducted during a one-week period during fall of 2008.<sup>1</sup> These same surveys will be repeated in fall of 2009 to determine if attitudes change after CSR is more fully implemented. It is not clear to what extent the consumer opinions reported here reflect a true baseline because CSR had been underway for about ten months at the time these data were collected.

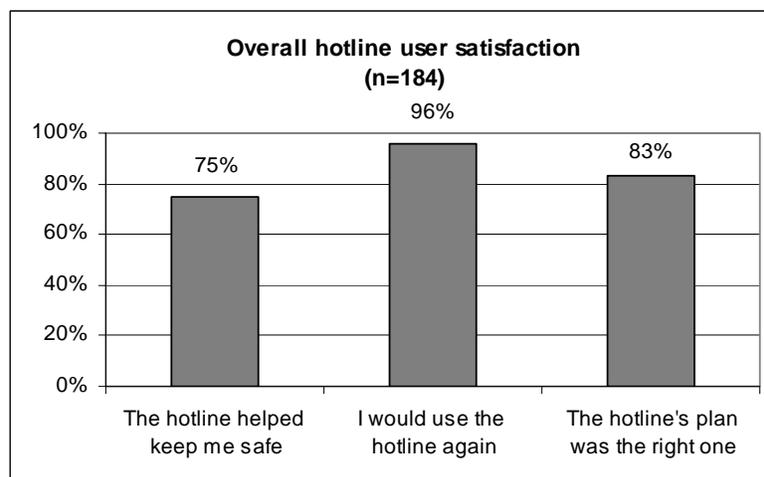
#### Crisis Hotline User Satisfaction

Crisis hotline survey instruments, presented in Appendix C, are comprised of two sections. The first section, completed by hotline staff, provides some basic information about the classification of the call, consumer information, and action taken. The second section asks consumers to indicate the extent to which they agree with four questions:<sup>2</sup>

- I called the hotline because I thought I or someone I am close to might hurt themselves or others.
- The hotline helped keep that person safe or helped prevent harm to others.
- If I or someone I am close to had a similar problem in the future, I would use this hotline again.
- The plan that the hotline worker came up with to keep me or others safe was the right one.

Of 338 completed surveys, only 184 (54%) had both the staff and consumer sections completed. The remaining 154 instruments, with the staff portion completed but no consumer data, were excluded from the analyses.<sup>3</sup> T-tests were used to determine if the individuals dropped from the sample differed from those who were included. Results presented in Appendix D show excluded individuals are identical to those for whom data is available, with the exception that those excluded are significantly more likely to have had their hotline call resolved in a non-specific way with “other” action taken ( $p < .01$ ). Administration methods (i.e., whether the survey was administered at the time of the hotline call vs. at follow-up and whether it was completed by a consumer vs. a friend or family member) were also tested and found not to impact participant ratings. It is therefore reasonable to assume the sample of respondents is representative of typical hotline callers.

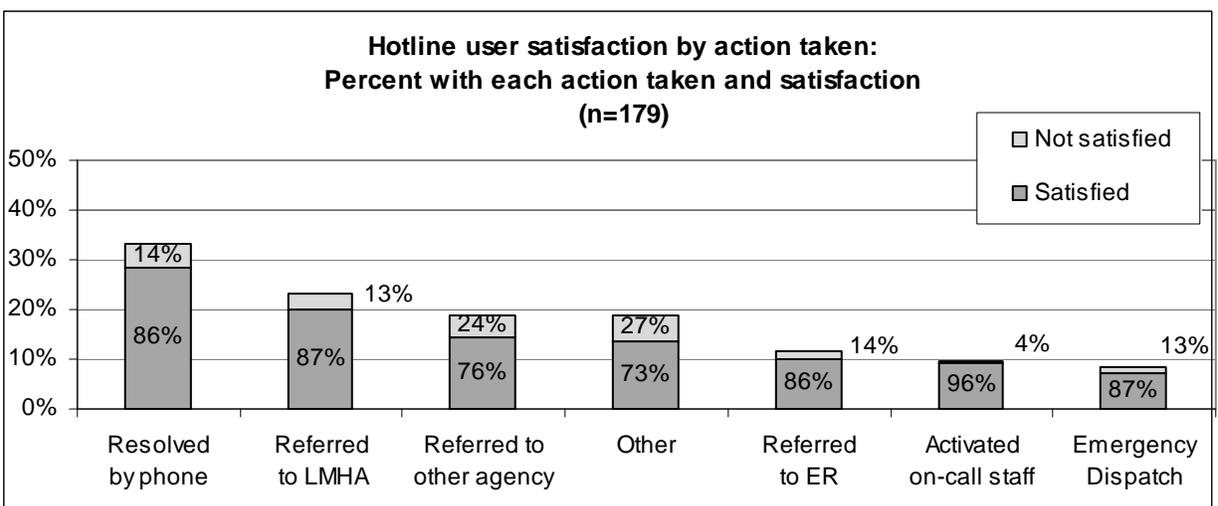
Figure 10



Crisis Hotline Users Are Satisfied Overall. Figure 10 illustrates that in general, crisis hotline users are highly satisfied with the service. Three out of four callers believe the hotline contributed to their safety, and more believe the hotline’s plan was a good idea. Nearly all respondents say they would use the hotline again.

Hotline Callers Receiving an Immediate Emergency Response Are More Satisfied. The most frequent action taken on behalf of urgent and emergent hotline callers is a phone resolution of the crisis (Figure 11), confirming that hotlines are giving many callers the help they need without activating other responders. The next most-used responses refer consumers to the LMHA or to another agency (e.g., private psychiatric facility or substance abuse services) during regular business hours. In these cases hotlines are helping to avoid the cost associated with activating after-hours emergency personnel.

**Figure 11**



Note: The total number of individuals represented in this figure is 222, indicating that 43 respondents had more than one action taken.

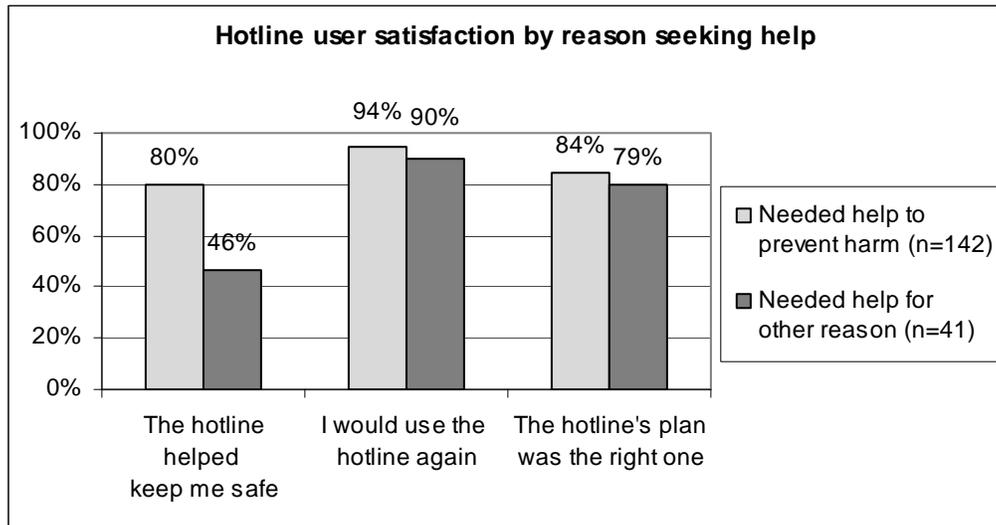
Satisfaction is clearly impacted by the hotline response, with consumers being happier when direct and immediate action occurs. Specifically, the following groups are significantly more satisfied than their peers:

- LMHA on-call staff are activated (96% satisfied) vs. Not activated (82% satisfied,  $p < .001$ )
- Consumer is referred to the emergency room (86% satisfied) vs. Not referred to the ER (83% satisfied,  $p < .05$ )

Conversely, callers that receive non-specific “other” resolutions (73% satisfied) are significantly less happy with the service than those who received a more specific response (86% satisfied,  $p < .01$ ).

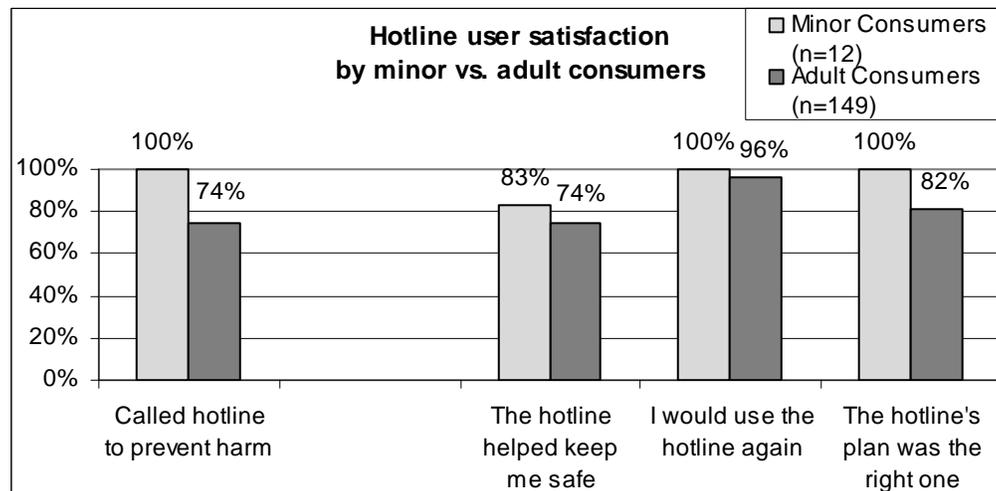
Individuals Who Called to Prevent Harm Were More Satisfied with Hotlines. People who used the hotline as a resource to prevent harm to themselves or others are significantly more satisfied than those who used the service for other reasons ( $p < .001$ ). Figure 12 shows that respondents who perceived imminent danger at the time of the call are much more likely to say the hotline kept them safe. They are also somewhat more likely to say the plan they received was appropriate and they will use the hotline again if needed.

**Figure 12**



Hotlines Are Especially Valued for Minors. Only twelve individuals under the age of eighteen are represented in the study sample. However, calls regarding younger individuals are considerably more likely to be about preventing harm to that individual or others (Figure 13).

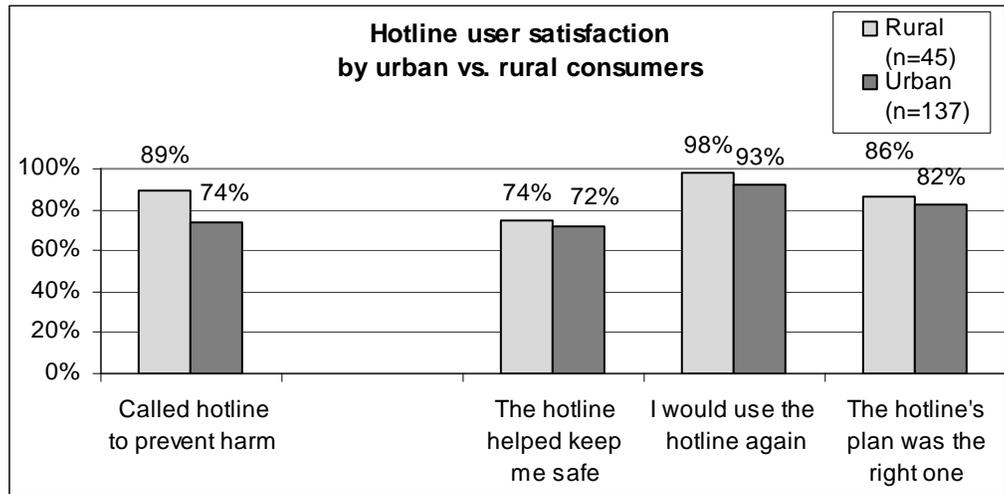
**Figure 13**



Perhaps in part due to the urgent need for help, people calling on behalf of children are significantly more satisfied with the hotline service ( $p < .05$ ). Callers representing minors are happier with every dimension of the hotlines, but are particularly more likely than adults to feel the hotline kept them safe, and the recommended plan to get help was the right one.

Urban Callers Are Less Satisfied with Crisis Hotlines. Three times as many hotline calls originate in urban centers ( $n=137$ ) as in rural communities ( $n=45$ ), but urban callers are significantly less likely to say they are pleased with their experience ( $p < .05$ ).

**Figure 14**



Notably, callers in rural locations are considerably more likely to think the consumer is at risk of immediate harm, and it has been shown above that greater perceived risk is associated with higher satisfaction ratings (Figure 14). Rural isolation could be a factor, causing individuals to wait until the need is more extreme before seeking help. Limited access to early intervention resources may also cause more callers to be in advanced stages of crisis. In any event, this finding suggests crisis hotlines may be a particularly valued resource for remote rural callers in urgent need of help.

Other Factors Were Not Associated with Hotline User Satisfaction. Two other measures were tested and found to have no impact on hotline callers' satisfaction with the service received. Hotline user ratings were statistically identical indicating no differences in satisfaction for the following categories of respondents:

- Current MHMR client vs. New crisis consumer
- Male vs. Female consumer

### **Crisis Service User Satisfaction**

As with hotline surveys, crisis service user surveys (see Appendix E) asked LMHA staff to report basic descriptive information about each consumer and the services he or she received. This was followed by two sets of questions. First, callers were asked the extent to which they agree with the following statements:<sup>4</sup>

- I or someone I am close to needed to receive this help because I/they might have hurt themselves or others.
- The crisis services helped keep me or that person safe or prevented harm to others.
- If I or someone I am close to had a similar problem in the future, I would use these services again.
- I or someone I am close to received the types of help I thought were needed.

Second consumers were asked if they encountered other service providers including law enforcement, emergency rooms, judges or courts, and schools during this crisis episode. If so, they were asked to indicate how helpful they were.

Surveys were returned for 1,584 respondents. Of those, 599 (38%) could not be used because consumer responses were missing (indicating that either the LMHA determined it was not appropriate to administer the survey or that the consumer declined to participate).<sup>5</sup> To determine whether the excluded sample differs from the usable sample, t-tests were conducted. Results presented in Appendix D show a number of potentially important ways in which the two samples differ. Compared to retained respondents, those excluded are significantly more likely to have the following attributes:

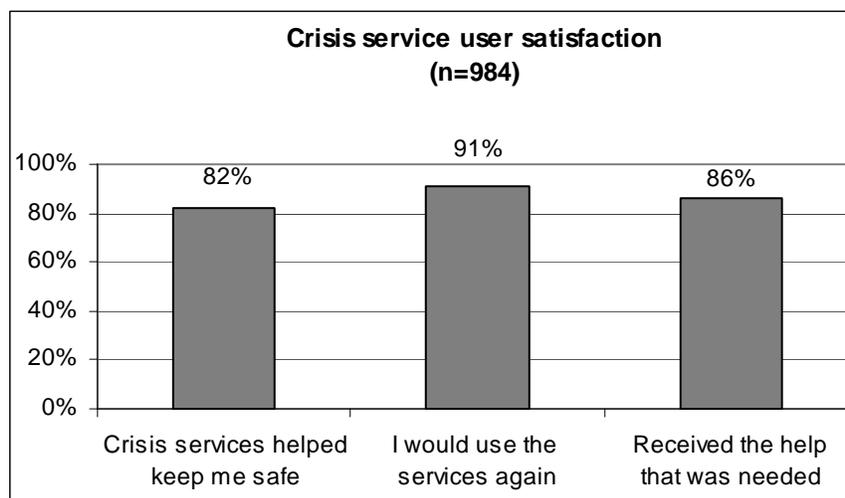
- Younger age ( $p < .0001$ )
- Anglo ( $p < .01$ )
- Urban ( $p < .01$ )
- Consumer completed the survey rather than friend or family ( $p < .01$ )
- Survey administered by someone with a clinical role in the case ( $p < .00001$ )
- Did not receive residential/respite treatment ( $p < .001$ )
- Treated in private hospital ( $p < .0001$ )
- Treated in state hospital ( $p < .0001$ )

These differences suggest the results presented here may not be completely representative of all crisis service users. Caution should be used in drawing conclusions from a dataset in which some important categories of respondents may be disproportionately under represented.

Systematic response differences were also measured depending on the survey administration methods used. People who took the survey from someone who played a clinical role in their crisis services were both less likely to complete the survey (see above), and, if they did take the survey, to report positive ratings of the services received (89% satisfied vs. 83% for those not surveyed by a clinician,  $p < .05$ ). People who had the survey read to them (85% satisfaction) were significantly less likely to be satisfied compared to people who took it in writing (88% satisfaction,  $p < .05$ ).

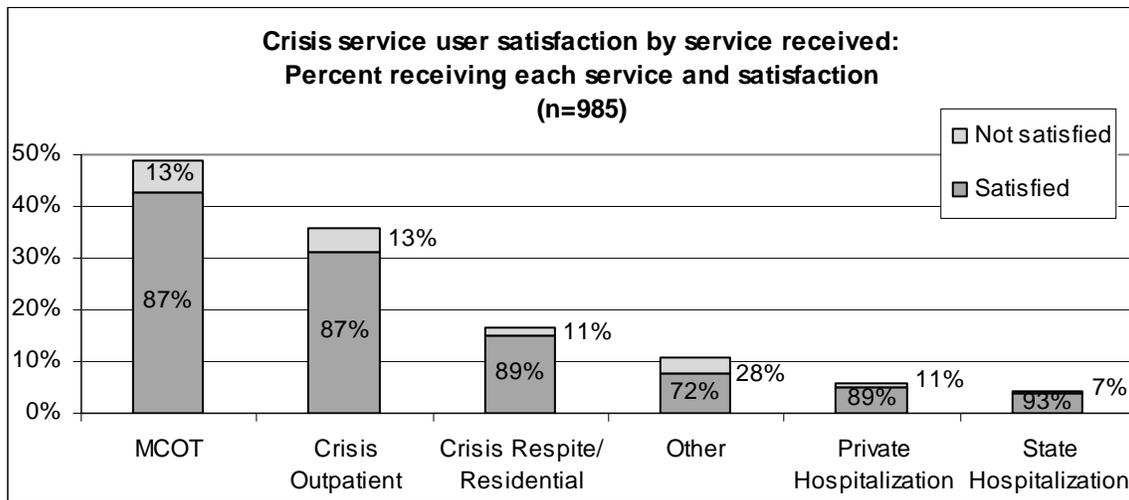
Crisis Service Users Are Satisfied Overall. As with crisis hotlines, users of other types of crisis services who participated in the survey are generally very satisfied with the help received (Figure 15). The majority of respondents agree that the hotline kept them safe, the help was needed, and they will use the service again if the need arises.

**Figure 15**



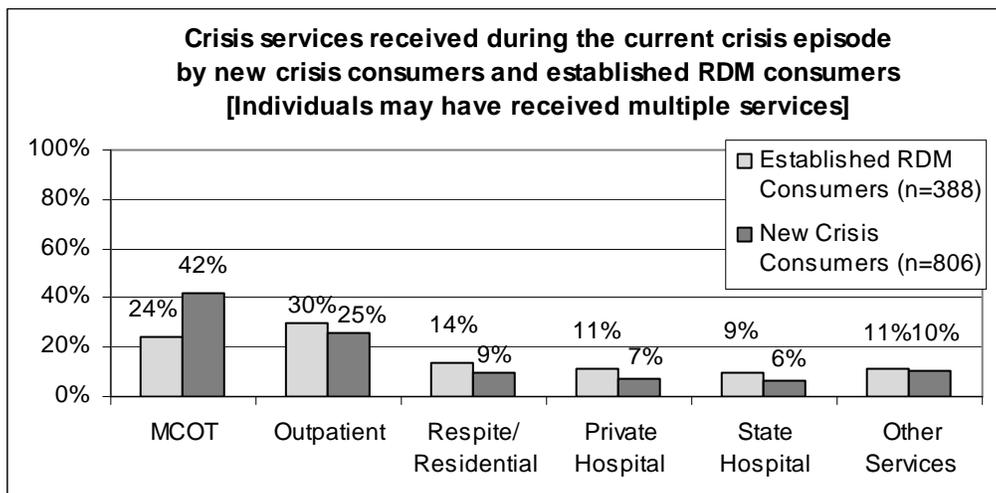
**Crisis Service Users Receiving Respite/Residential Services Are More Satisfied.** Not surprisingly, the most common types of crisis service provided are MCOT services and crisis outpatient treatment (Figure 16). At present, 6 percent of crisis service users are treated in state hospitals, and 53 percent get either crisis respite/residential or crisis outpatient treatment.

**Figure 16**



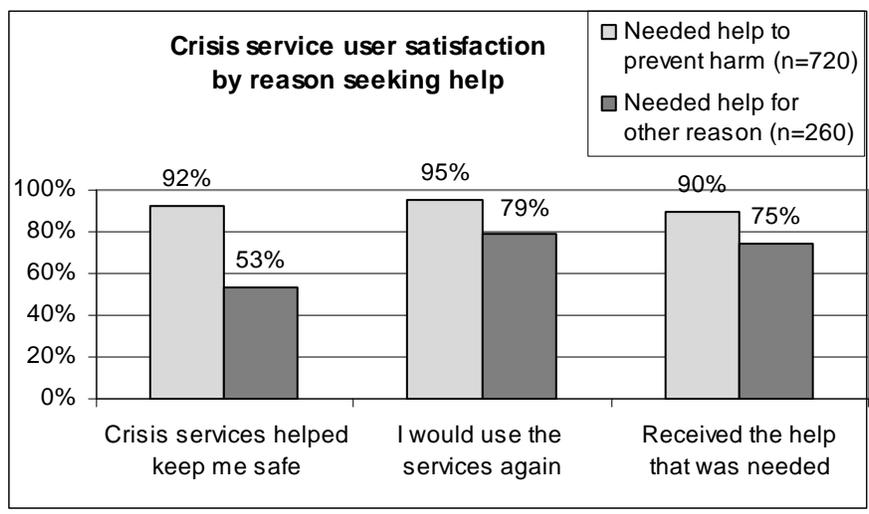
For the most part, crisis consumers are equally pleased regardless of the type of service received. Individuals getting crisis respite or residential services (89% satisfied) are slightly happier than those receiving other types of services (86% satisfied,  $p < .05$ ). On the other hand, consumers receiving non-specific “other” services are a great deal less satisfied (72%) than their peers getting more standard types of services (88% satisfied,  $p < .01$ ). As with the hotline callers, respondents prefer their problem be addressed through standard available solutions.

**Figure 17**



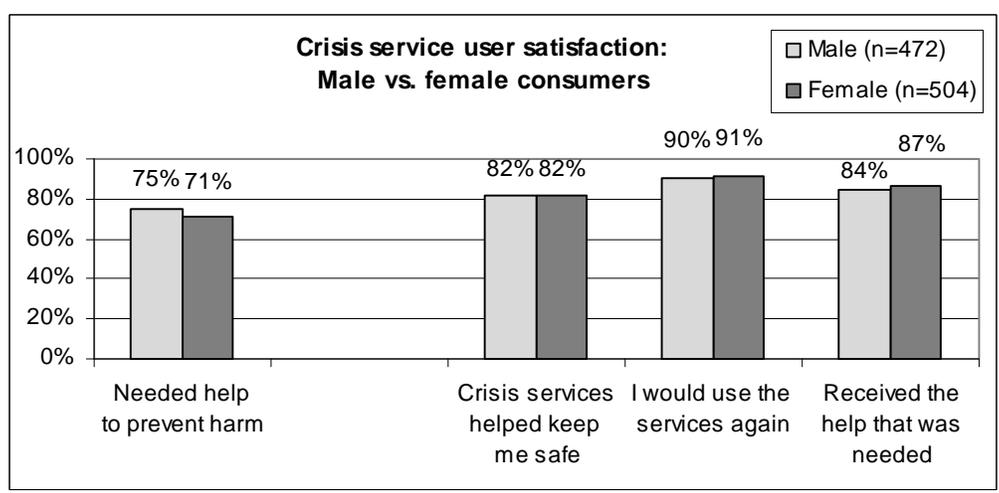
Most Crisis Services Are Delivered to New Rather Than Established Consumers. The largest consumers of crisis services are not already enrolled as ongoing LMHA clients. About 70 percent of services go to people who are new to the system (Figure 17). These consumers are most likely to get MCOT services, with treatment options delivered somewhat more frequently to registered clients. Despite some differences in the types of services received, however, analyses of satisfaction ratings did not find satisfaction differences between new and existing consumers.

**Figure 18**



Individuals Who Needed Help to Prevent Harm Are More Satisfied with Crisis Services. About three-fourths of respondents say they needed help to prevent harm to themselves or someone else (Figure 18). As with crisis hotline users, individuals using crisis services are significantly happier if they perceive the help is in response to an immediate threat ( $p < .001$ ). These individuals are nearly twice as likely to believe the crisis services helped keep them or their loved one safe. They are also much more likely to favorably evaluate the appropriateness of the help, and to report they will use the service again if needed.

**Figure 19**



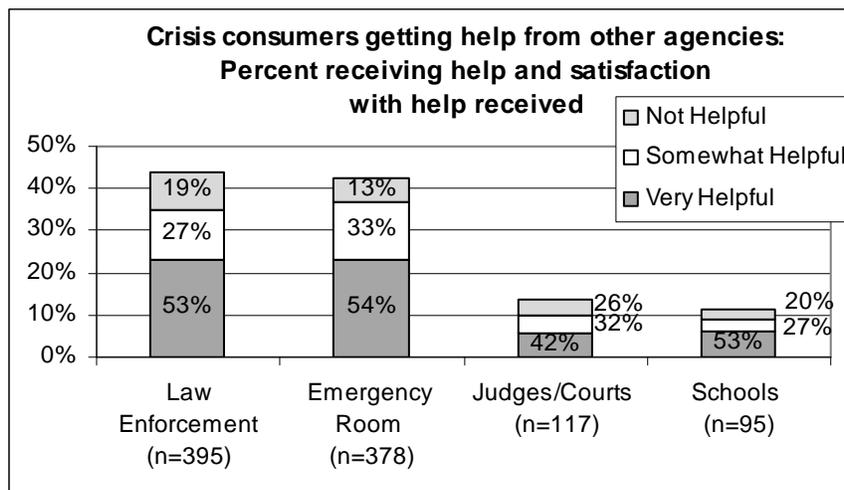
Males Are Less Satisfied with Crisis Services. Crisis services targeting males are somewhat more likely to be in response to a perceived threat of harm, but male respondents are significantly less pleased with services received ( $p < .05$ ). The magnitude of difference between males and females is relatively small suggesting it has little practical significance (Figure 19). Females are about equally inclined to believe the help was useful, and only slightly more likely to say they would use the service again.

Other Factors Were Not Associated with Crisis Service User Satisfaction. Several other measures were tested to see if they effectively differentiate happy vs. unhappy users of crisis services. Satisfaction ratings for the following categories of respondents were found to be statistically identical, although these findings should be interpreted with caution given that many of these variables are those that were not accurately represented among survey participants.

- Current MHMR client vs. New crisis consumers
- Adult vs. Minor consumers
- Anglo Consumers vs. Other race/ethnicity
- Urban vs. Rural consumers
- Survey administered at the time of service delivery vs. Survey administered at follow-up
- Survey response provided by consumer vs. Response provided by friend or family member
- Percent increase CSR funds provided to LMHA over baseline funding (indicating funding enrichment)
- Percent of target population served by LMHA (indicating service load)
- Percent of client base in high-need service packages (indicating average consumer level of need)

About Half of Crisis Service Users Are Satisfied with Services from Other Crisis Responders. A minority of crisis service users report having any contact with service providers other than the LMHA (Figure 20). Approximately equal numbers (43%) encountered both law enforcement and emergency rooms. Courts (14%) and schools (11%) are the least frequently used external agencies.

**Figure 20**



Most consumers who have worked with these partner agencies during mental health emergencies rate their assistance as somewhat or very helpful. Only about one in five respondents (20% on average) say these agencies were not helpful at all.

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**Finding 4: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

“[Crisis resolution has] become a bit more efficient for the hospitals and for law enforcement. It’s not tying up critical ER beds as long as it was; it’s not tying up local small town law enforcement agencies that are sorely needed on the streets. And so from us, please send a big thanks, and please continue to fund this effort.”

— *Emergency Room Staff Member*



**Finding 4: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

Many features of Crisis Services Redesign are designed to help LMHAs improve supports and relieve burden on community partners. Finding 1 shows that during the first year of CSR, new services and infrastructure have been put in place to address many of these stakeholders' most significant concerns. This section describes how this new infrastructure is being perceived by the community partners who work closely with LMHAs.

When interpreting satisfaction findings, bear in mind that at the time these data were collected, CSR had only been funded ten months. Expectations for change at this early point are conservative. System change of this complexity and magnitude takes time to achieve and even now, many aspects of local CSR services are still being adjusted and refined. Additional data collected in next year's survey will give a clearer picture of the impacts of crisis redesign on stakeholder attitudes.

**General Satisfaction with Crisis Redesign**

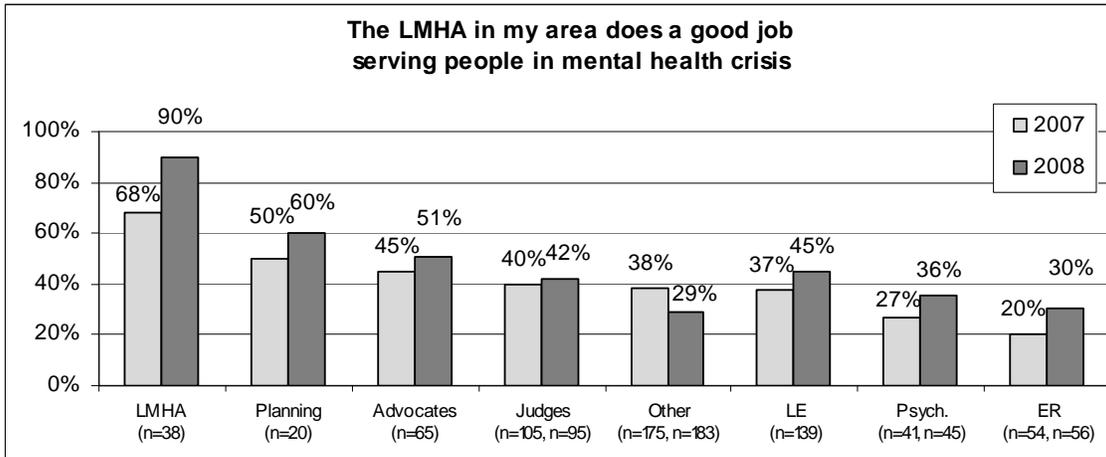
The survey results that follow show CSR is beginning to improve stakeholder attitudes. However, overall satisfaction remains relatively low among emergency room personnel, law enforcement, and judges – the very entities that mental health providers most rely on for support in resolving crisis cases.

Community Partners Feel LMHA Crisis Services Have Improved Since CSR. A series of questions asked local stakeholders to indicate whether they believe LMHAs are doing a better job serving people in crisis since the implementation of CSR. It was not possible to assess baseline satisfaction prior to the implementation of CSR services. Therefore, evaluators measured change over time by asking local stakeholders to compare their LMHA's performance "in the past 3 months" against their recollections from "the same 3-month period one year ago."

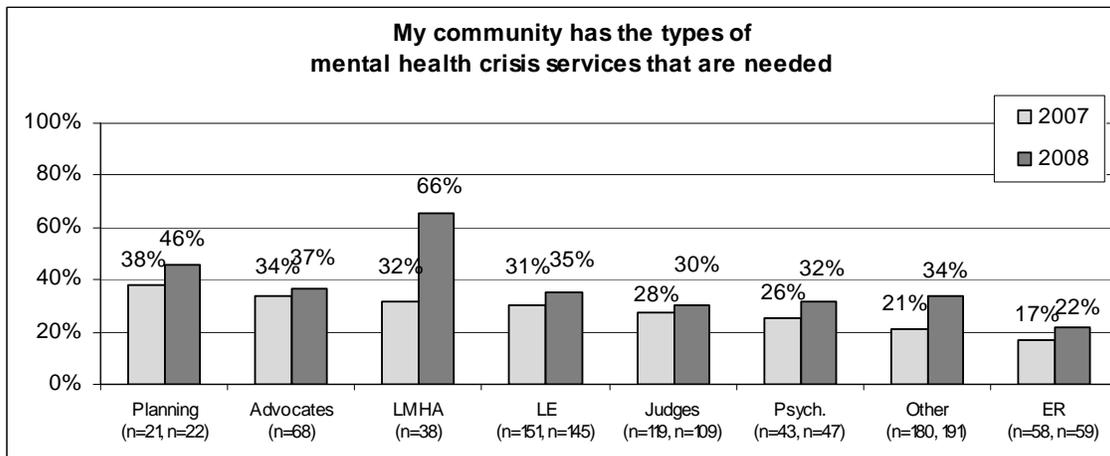
Virtually all types of stakeholders report some improvement in LMHA performance on every measure (Figures 21 through 24). Respondents say LMHAs are doing a better job:

- Serving people in mental health crisis (47% of stakeholders providing a positive overall rating, up 8 percentage points from 2007);
- Offering the types of services that are needed (35% positive overall rating, up 8 percentage points from 2007);
- Getting help to people in crisis quickly (34% positive overall rating, up 7 percentage points from 2007); and
- Offering high quality crisis services (43% positive overall rating, up 6 percentage points from 2007).

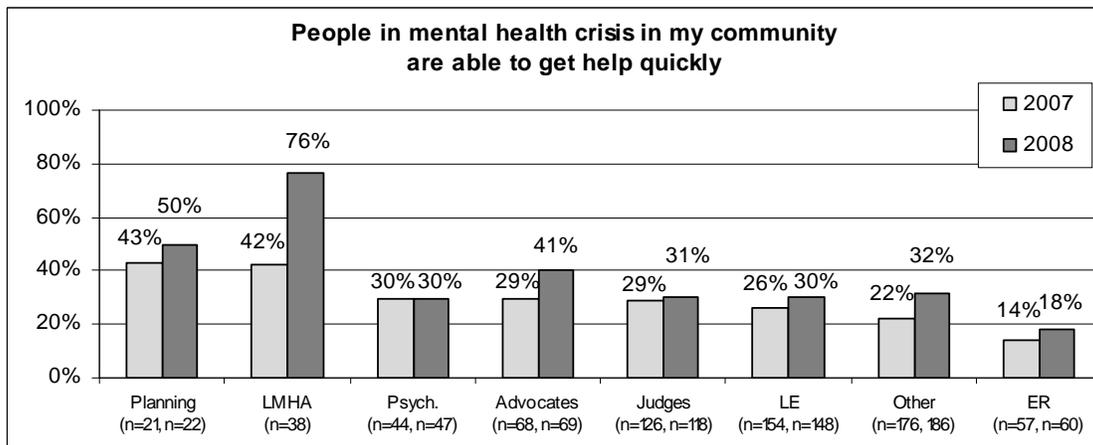
**Figure 21**



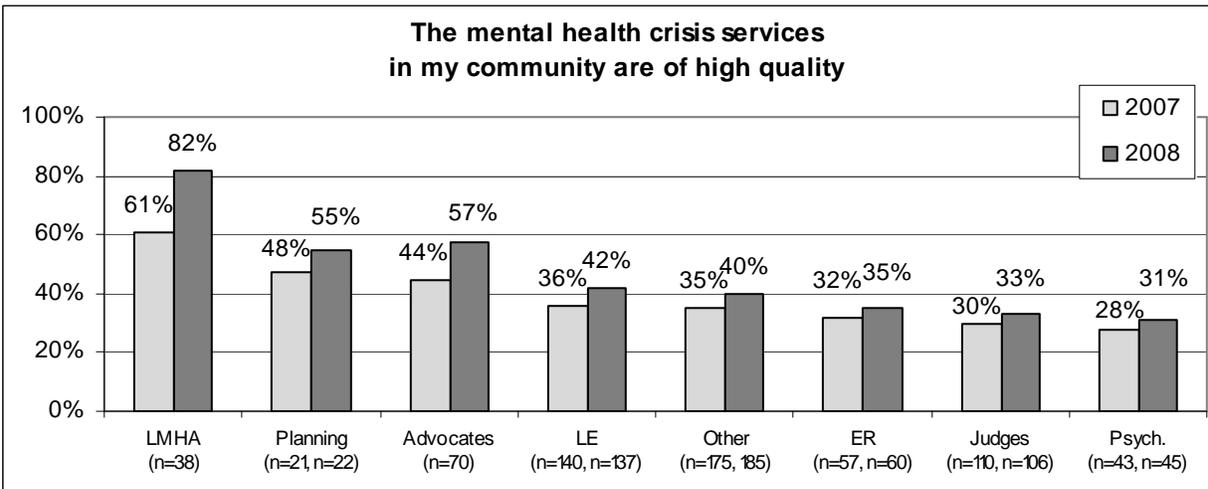
**Figure 22**



**Figure 23**



**Figure 24**

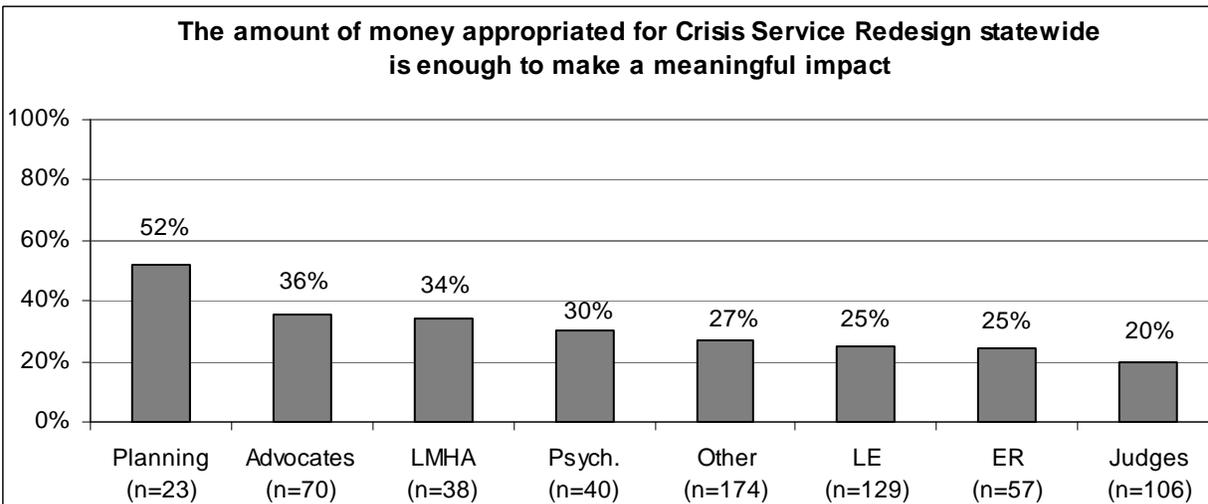


While there is a general perception that crisis response is improving, however, satisfaction ratings are still low in every respondent group except LMHAs. Emergency room personnel are the least satisfied of all stakeholders. They assigned the lowest ratings on three of the four measures.

**Community Partners Believe More Funding Is Needed for CSR to Have a Significant Impact.**

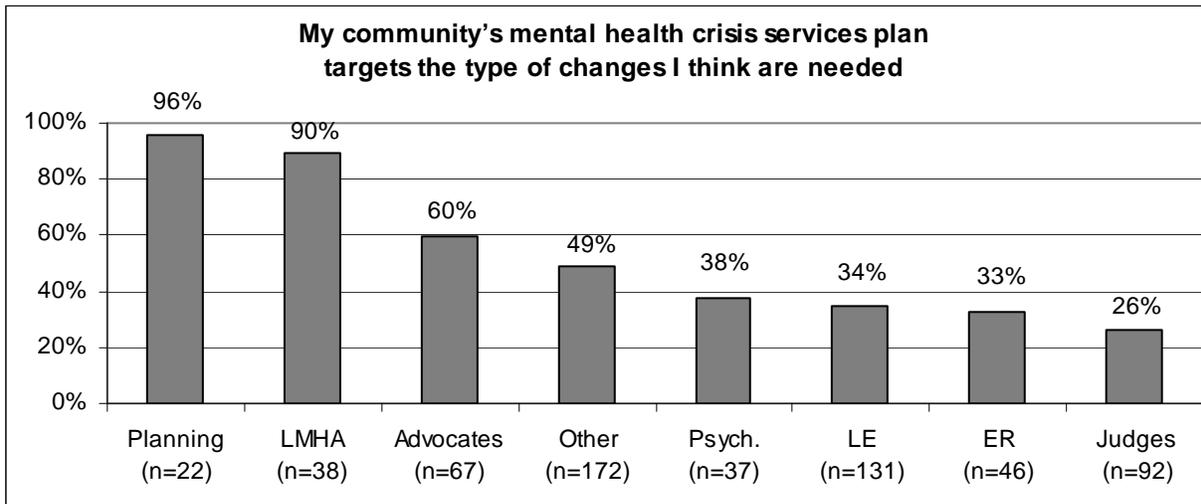
Respondents generally agree that greater investment is needed for Crisis Service Redesign to achieve a meaningful impact (Figure 25). Overall, less than one in three respondents (27%) believe enough funding has been committed to the effort.

**Figure 25**

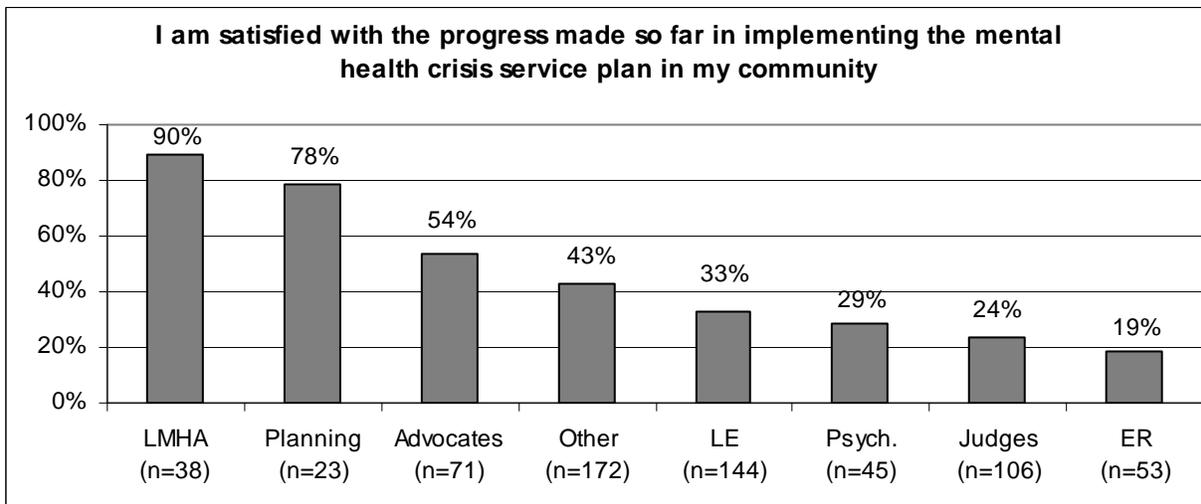


**Community Partners Report Different Levels of Satisfaction with Local Crisis Plans.** Stakeholders were asked to rate their satisfaction with two specific features of the crisis plan adopted in their community (Figures 26 and 27). Respondents were not highly satisfied with either the type of changes being implemented (43%) or the progress made so far (38%).

**Figure 26**



**Figure 27**



Interestingly, two very different points of view emerged. On the one hand, 75 percent of LMHA staff, planning committee members, and advocates strongly believe crisis service plans target the type of change that is needed in their community. Sixty-eight percent of these same individuals also think adequate progress is being made with plan implementation. By contrast, emergency room staff, judges, psychiatric physicians, and law enforcement officers are less than half as satisfied with the appropriateness of the crisis plans (32%) and the speed with which they are being met (27%).

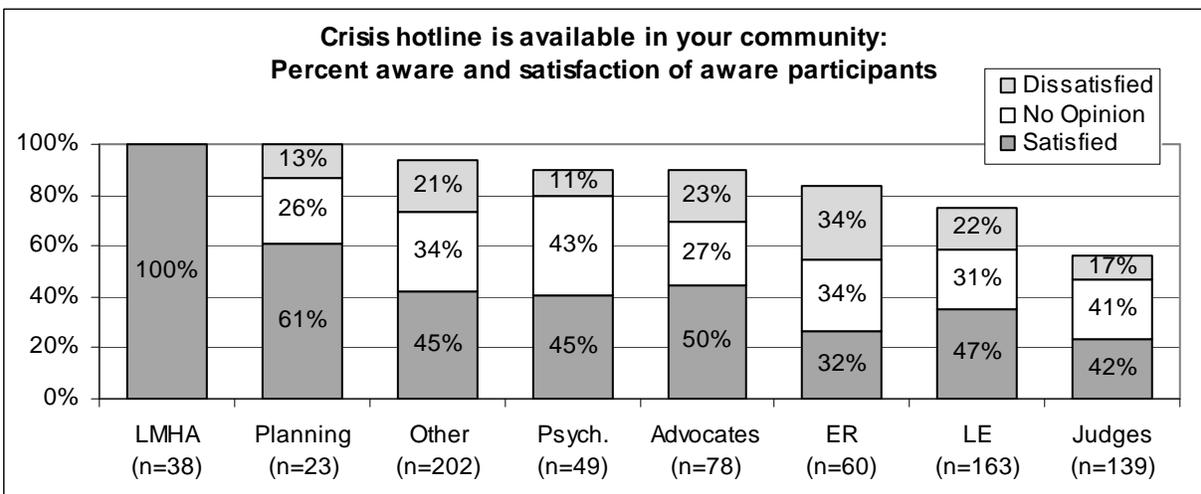
There appears to be a connection between satisfaction and involvement in the planning and implementation of CSR. Results presented in Finding 5 (below) indicate that the same groups who are least satisfied with Crisis Services Redesign are also the groups least likely to have been aware of the initiative or to have participated in planning.

## Awareness and Satisfaction with Specific CSR Crisis Service Components

In addition to providing global ratings, stakeholders were asked rate their awareness of and satisfaction with each of the three main CSR components. These include crisis hotlines, MCOTs, and local treatment capacity. In the charts that follow, these data are presented together such that the total bar indicates the percent of all respondents in a category that are aware of each service. The proportion of those who are satisfied, neutral, and dissatisfied is then labeled within each bar, and sums to 100 percent of all aware respondents. Thus, satisfaction was not assessed for individuals not familiar with the services being rated.

53 Percent of All Stakeholders Are Satisfied with Crisis Hotlines. Because hotlines have existed in most communities for a number of years, it is not surprising that the majority of community partners know about their availability (Figure 28). Awareness is somewhat lower among emergency room and law enforcement respondents who might be expected to benefit most from new hotline capabilities. Since CSR, trained hotline staff are now prepared to assess the level of consumer need and orchestrate action among emergency responders. However, information about this hotline function must be communicated and explained to crisis responders before it can be used to enhance service efficiency.

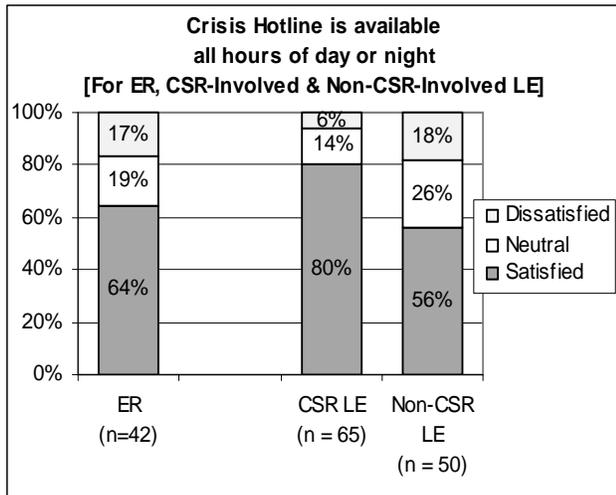
**Figure 28**



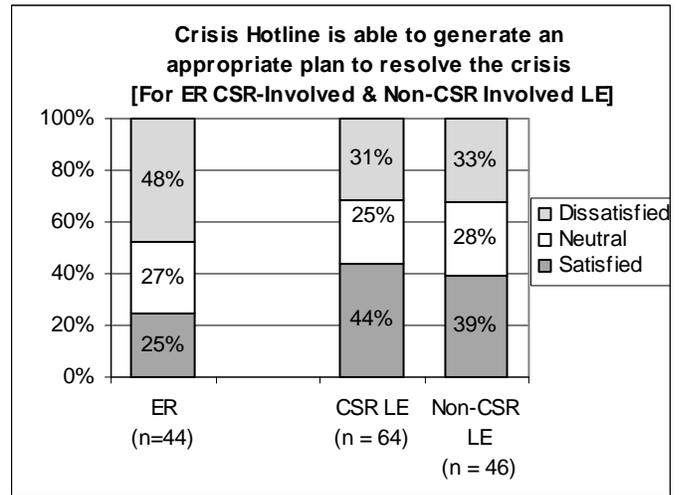
Hotlines are viewed positively by every LMHA with 100 percent reporting satisfaction. Among non-LMHA respondents who know about crisis hotlines, only 46 percent are pleased with the services. About one-third (34%) have no opinion, while the remainder (20%) are dissatisfied.

Because hotlines are largely intended to help LMHAs coordinate action with emergency room staff and law enforcement, these key local partners were asked about four specific features of the hotline service. Also, since LMHAs have worked more closely with some community agencies than others, results are reported separately for law enforcement agencies identified by the LMHAs as being actively involved in CSR. This division was not helpful in analyzing emergency room data because 85 percent of all ER respondents were identified as CSR-involved. Results show satisfaction is uniformly higher among law enforcement officers who are knowledgeable about and engaged in CSR in their community.

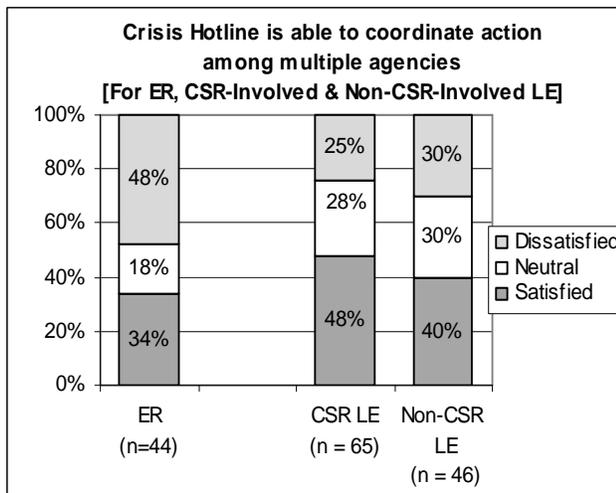
**Figure 29**



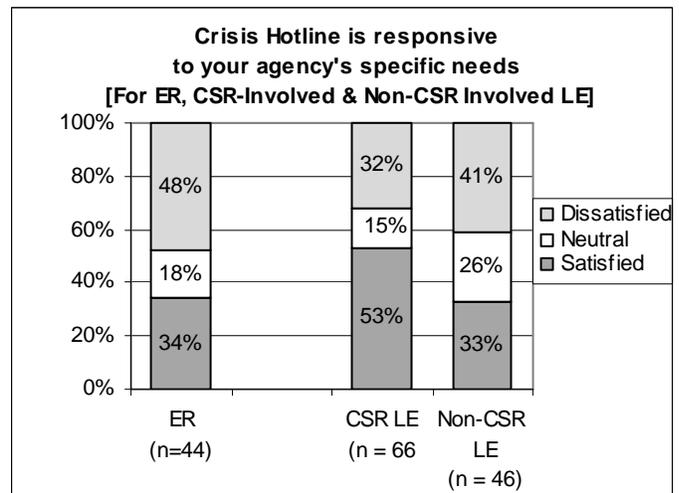
**Figure 30**



**Figure 31**



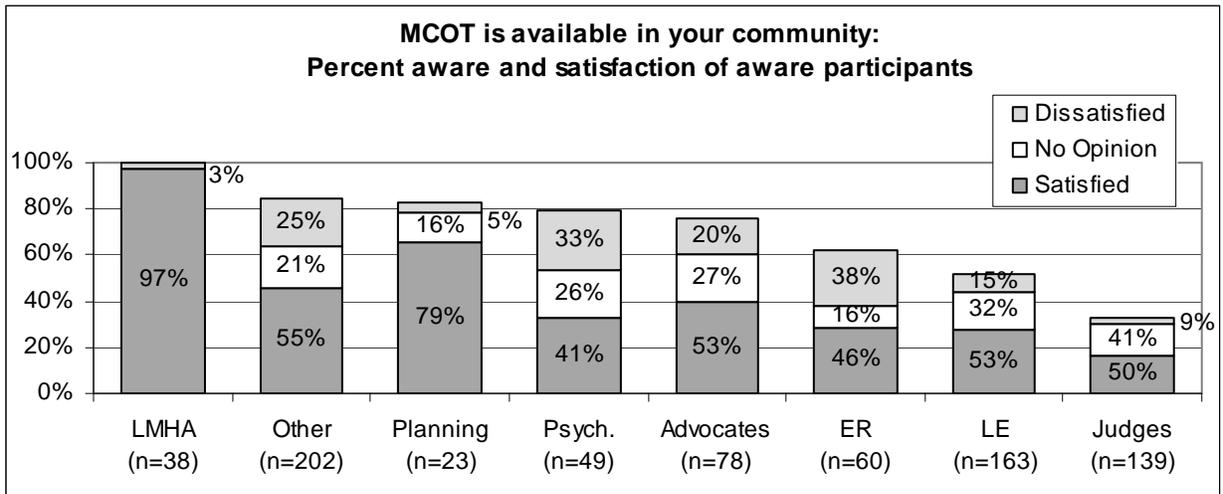
**Figure 32**



Law enforcement and emergency room representatives are most positive about the fact that crisis hotlines are available 24-hours a day (Figure 29). They are, however, less pleased with other hotline features. Fewer than half are happy with hotlines' ability to generate a plan to resolve the crisis (Figure 30), to coordinate action between responding agencies (Figure 31), or to address the needs of their specific agency (Figure 32). Law enforcement agencies identified as CSR-involved are notably more pleased with hotlines' responsiveness to their specific agency concerns.

**60 Percent of All Stakeholders Are Satisfied with MCOTs.** Since the implementation of CSR, Mobile Crisis Outreach Teams are now the front-line responders to mental health emergencies. As noted in Finding 1, MCOTs have strengthened LMHA's capacity for rapid response and improved their ability to support other responders such as law enforcement and emergency rooms. The results below offer insight into how these changes are perceived by community partners they are designed to help.

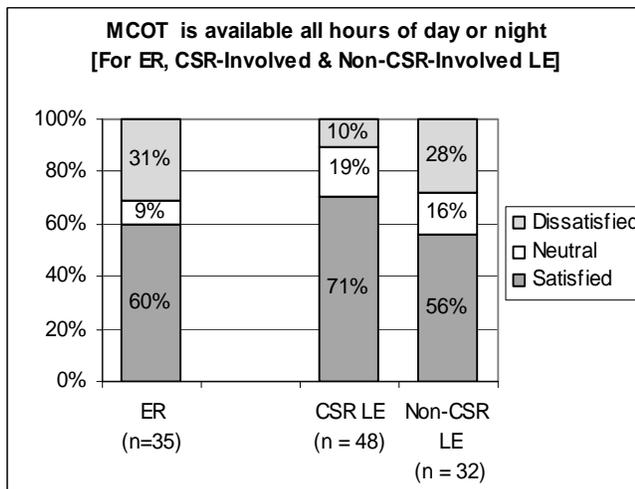
**Figure 33**



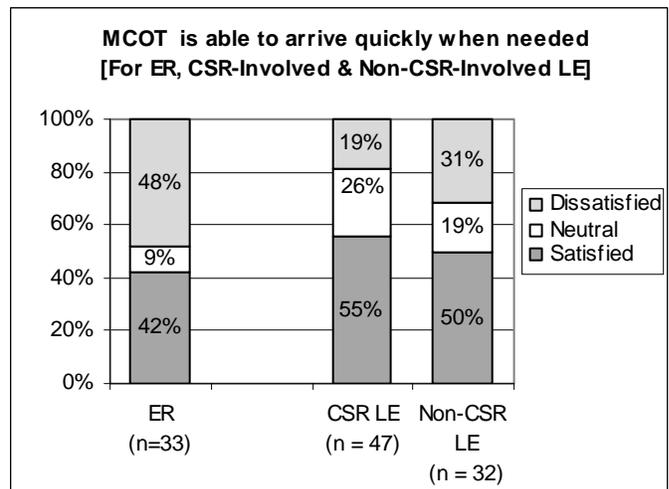
Overall, 65 percent of stakeholders surveyed are aware of MCOTs. However, as was the case with crisis hotlines, the respondent groups most likely to need their assistance day-to-day are the least likely to know about their existence. Emergency rooms, law enforcement, and judges are the least aware about MCOT services (Figure 33).

As with hotlines, LMHAs are much more satisfied with nearly all community mental health providers (97%) report rating the new crisis response teams positively. Among non-LMHA respondents who know about MCOTs, over half (54%) are pleased with the service, while about 25 percent have no opinion and 21 percent are dissatisfied.

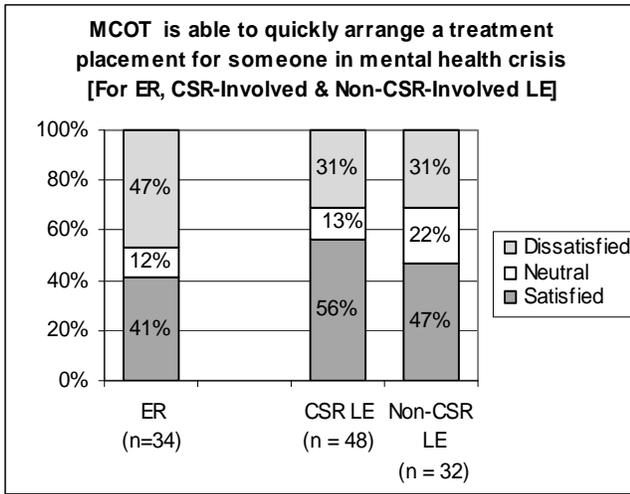
**Figure 34**



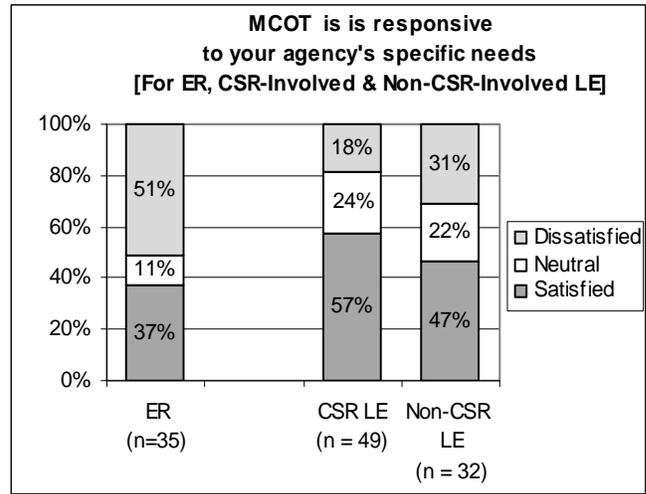
**Figure 35**



**Figure 36**



**Figure 37**



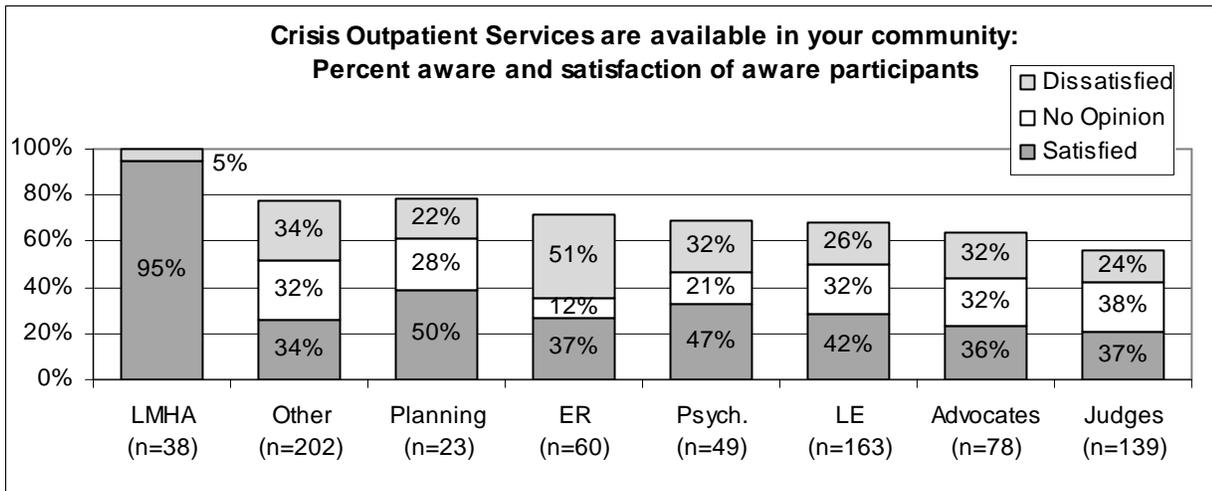
Law enforcement and emergency room respondents who are aware of MCOTs were asked to comment on four specific functions. On the whole, law enforcement officers are more satisfied than emergency room staff. Officers identified as being involved in CSR are also more satisfied than those not involved.

Respondents are most pleased with the MCOT's availability at all hours of the day or night (Figure 34). They are only moderately satisfied with the MCOTs' ability to arrive quickly when needed (Figure 35) or to arrange prompt treatment for people in crisis (Figure 36). A large proportion of emergency rooms in particular feel that MCOTs are not responsive to their specific needs (Figure 37). Law enforcement officers view them as being somewhat more responsive.

45 Percent of All Stakeholders Are Satisfied with Local Outpatient Treatment Options.<sup>6</sup> Finding 1 confirms that CSR has increased local alternatives to state hospitalization. Overall, 70 percent of stakeholders are aware that crisis outpatient treatment services are available in their communities. However, as with the other services, LMHAs' are much more satisfied with this treatment than are their community partners (Figure 38). Nearly all LMHAs (95%) reported being satisfied with their outpatient crisis services. Among non-LMHA respondents who are aware of these services, less than half (41%) are pleased with them, while about 28 percent have no opinion and 32 percent are dissatisfied.

It is only possible to speculate about reasons for these dramatically different levels of satisfaction with crisis services. The positive viewpoint of mental health center staff may result from their greater awareness of, and direct involvement in, recent service improvements, while those of other stakeholders may be based on past experience with the pre-CSR delivery system. It is also possible that stakeholder perceptions were negatively influenced by experiences during Hurricane Ike, as many LMHAs were not able to maintain their typical level of services during this time. In addition, the fact that many participants indicated they have no opinions about the services suggests that perhaps they are not yet familiar enough with the new services to evaluate their efficacy. If so, higher satisfaction ratings may be expected when follow-up data is collected next year.

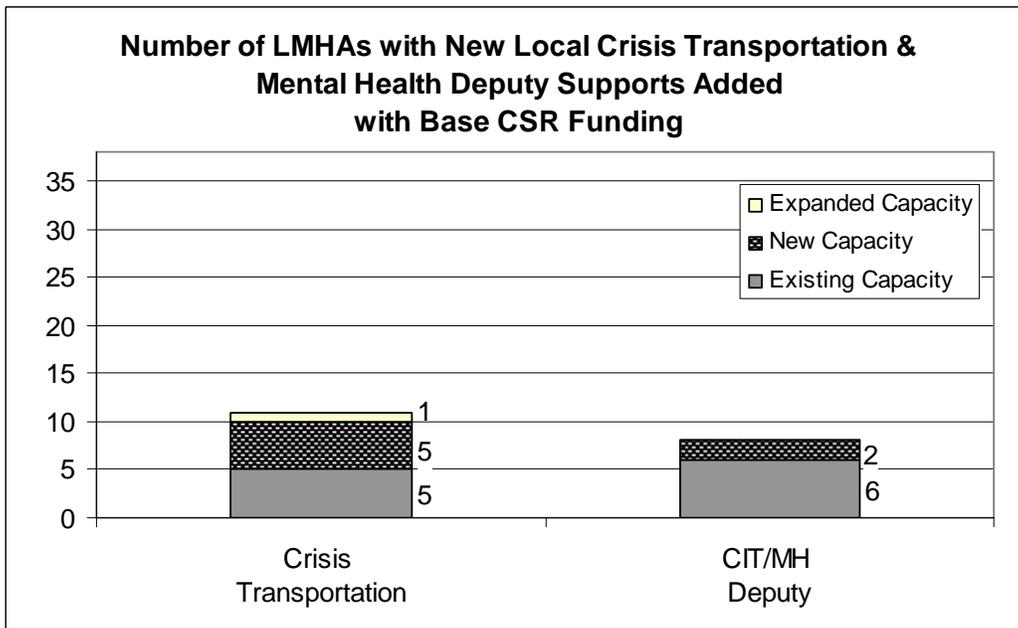
**Figure 38**



**Impacts of Crisis Redesign on Law Enforcement**

When an individual in mental health crisis poses a danger to others, law enforcement officers are necessarily involved in transportation for medical and mental screenings. Similarly, when an individual’s liberty is taken away for an involuntary mental health commitment, responsibility for transportation again falls on law enforcement. During site visit interviews, law enforcement respondents clearly articulated the extreme burden this responsibility places on the agency. Mental health centers were encouraged to consider ways to offset these costs in their local crisis redesign plans.

**Figure 39**



LMHA staff describe several strategies being used to reduce transportation burden on law enforcement.

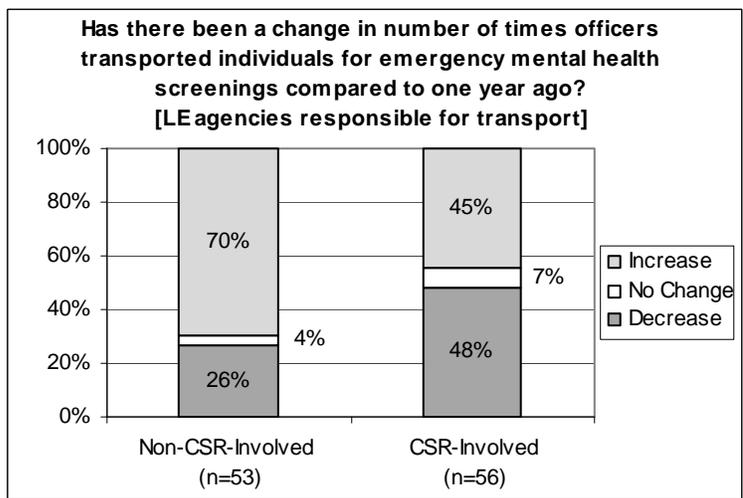
- If MCOT responders can de-escalate crises at the scene, then officers are relieved of significant responsibility to transport people to the ER, wait for medical clearance, then provide further transport to a mental health treatment facility.
- If de-escalation at the scene is not possible, MCOT staff can transport treatment participants for screening, local treatment, or state hospitalization, assuming the client is willing to be treated and does not pose a safety threat.
- Eleven LMHAs have formally dedicated CSR resources to offset law enforcement transportation costs, either through direct reimbursements to agencies, or by making LMHA staff available to provide transport in appropriate cases (See Figure 39).
- As more crisis treatment becomes available in the community, law enforcement should be called upon less often to make lengthy trips to distant state hospitals.

CSR-Involved Law Enforcement Agencies Report Reduced Transportation Burden. In order to assess whether these new supports are making a difference, law enforcement survey respondents were asked whether transportation responsibilities have increased, decreased, or remained the same compared to last year. Across the board, respondents from law enforcement agencies identified by LMHAs as being actively involved in CSR are the most likely to report reductions in burden.

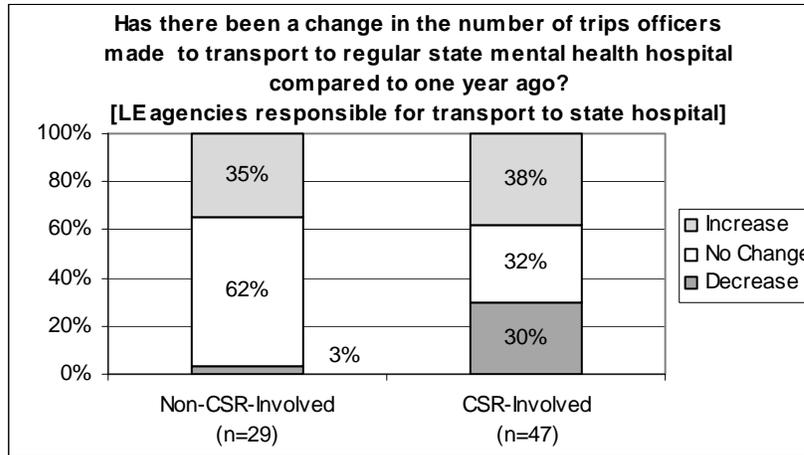
Nearly half of all CSR-involved respondents report making fewer trips for emergency mental health screenings (Figure 40). Still, challenges remain, as about the same percentage say trip counts have gone up. Similarly, one-third of these same officers say they are traveling less often to state mental health hospitals, offset by another one-third who report traveling more frequently (Figure 41). When they are called upon to transport consumers to state hospitals, most officers say they are driving about the same distances as last year (Figure 42). However, those who are reporting change say distances are longer because closer hospitals are more frequently on diversion.

Reported impacts of CSR are less positive for law enforcement agencies not working directly with their LMHAs. This group reports some declines in local transportation for mental health screening, but they are far more likely to say medical screening trips have increased. There are no significant improvements for this group in other transportation measures assessed.

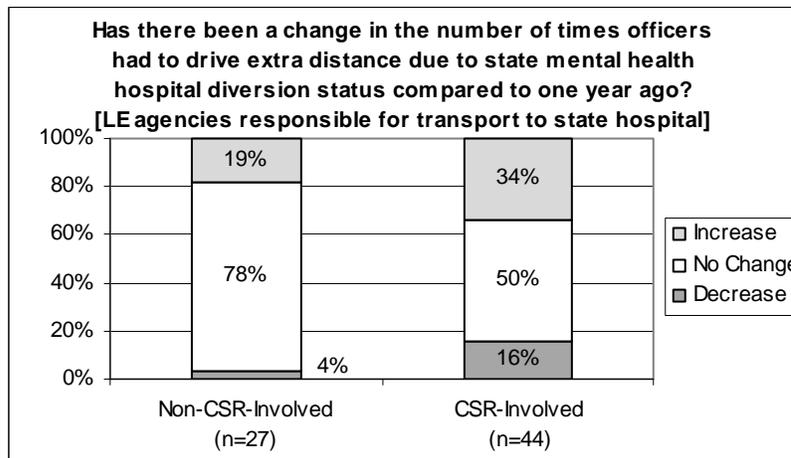
**Figure 40**



**Figure 41**



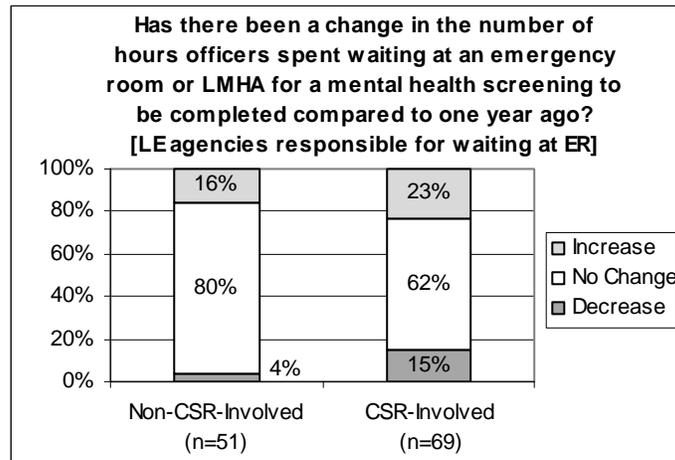
**Figure 42**



CSR-Involved Law Enforcement Agencies Report Small Reductions in ER Wait Times. Law enforcement officers are commonly asked to provide security to emergency rooms while potentially dangerous individuals are present. Officers are off the street at least 4 hours, sometimes up to 48 hours, providing security during mental health crisis episodes.

As MCOT response times improve and more local treatment options open, mental health screenings and treatment placements can be completed more quickly, relieving officers on duty. At present, however, there is no evidence that law enforcement wait times are being substantially reduced (Figure 43). CSR-involved agencies actively partnering with mental health centers are most likely to report reductions in time spent waiting. However, change has been modest, and offsetting increases in wait times are also reported.

**Figure 43**



**Impacts of Crisis Redesign on Emergency Rooms**

Individuals preparing for mental health treatment at a state hospital are required to have a medical clearance, and emergency rooms are the traditional provider of this screening service. However, if a treatment placement cannot be found quickly, these patients may remain in their care for hours or days, potentially impeding the treatment of others experiencing true medical emergencies.

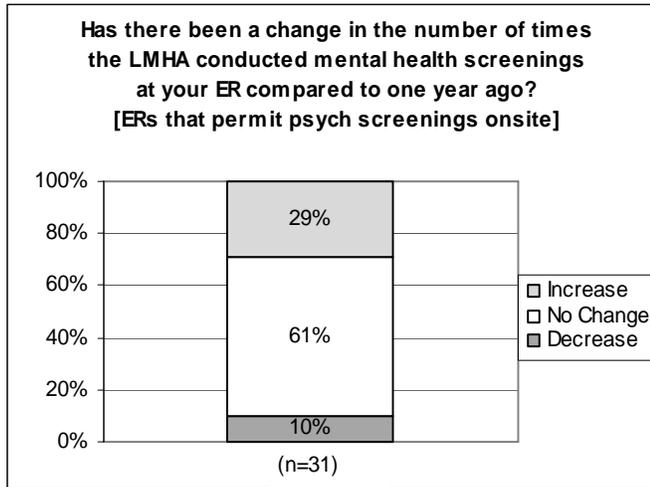
LMHAs are using varied approaches emergency room diversion suited to their own service system and community.

- Some new crisis emergency centers have qualified medical personnel on staff to perform their own medical clearances.
- Some LMHAs have enacted policies to encourage completion of a psychiatric screening in a community setting or mental health clinic before individuals are taken to the emergency room. As a result, only people who are going to be hospitalized for mental health services actually visit the ER.
- Some MCOTs are working to develop their own capabilities to do basic medical screenings.
- All LMHAs are developing alternatives to state hospitalization, which will reduce demand for medical clearances.

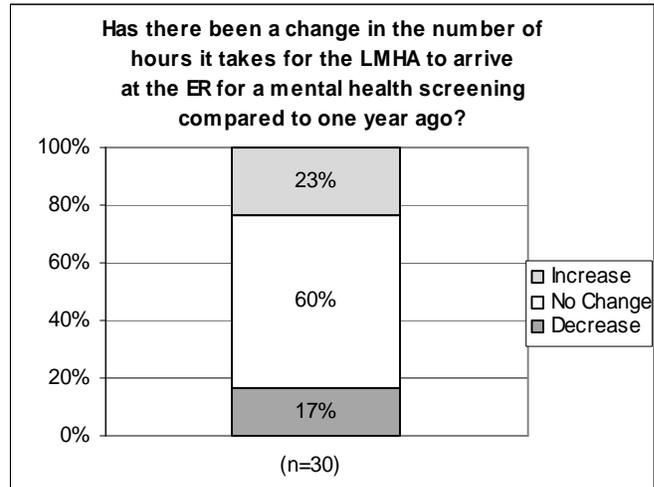
Emergency Rooms Remain the Primary Venue for Medical Screenings. In many communities, law enforcement officers still routinely deliver mental health crisis consumers directly to the ER. Although LMHAs are working to develop alternatives, an average 70 percent of medical evaluations and 36 percent of psychiatric screenings are conducted in emergency rooms.

Once consumers arrive at the ER, MCOT staff ordinarily provide a mental health screening at that location. Most ER respondents say there has been no change in the number of screenings conducted at the ER over the past year (Figure 44), but volume has increased in about one-third of hospitals. There are mixed reports whether LMHA response time has improved since CSR (Figure 45). About the same proportion of emergency room respondents report increases as decreases.

**Figure 44**



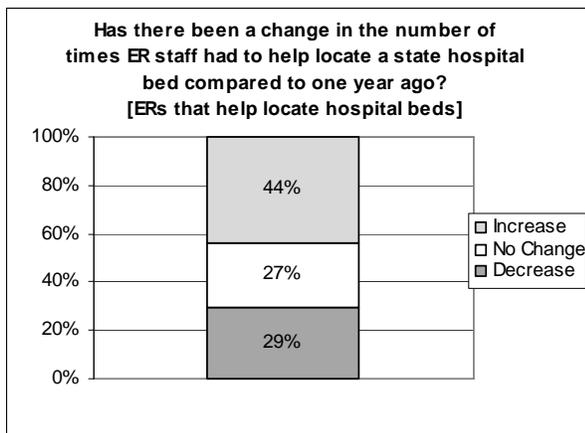
**Figure 45**



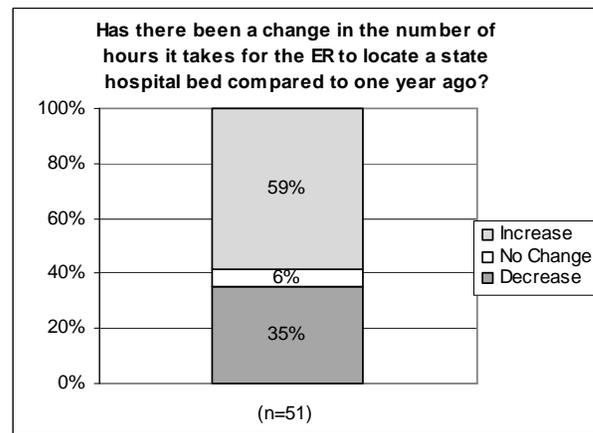
Limited Drug and Alcohol Detox Services Increases Burden on Emergency Rooms. Interview respondents told evaluators that once mental health crisis consumers enter the emergency room, they often remain for extended periods of time taking up scarce physical space and requiring the attention of staff with little available time. Individuals who have been using drugs or alcohol, in particular, must remain in a medically supervised environment until their system is completely clear of substances before a valid mental health assessment can be done. Without access to detox facilities, the burden falls almost exclusively on emergency rooms. Increased detox services may be beyond the scope of CSR. However, substance use among people in mental health crisis appears to be a factor impacting overall satisfaction with CSR among emergency room personnel.

Difficulties Locating Treatment and Transporting Consumers Continue to Place Burden on Emergency Rooms. Once mental health consumers are stable and medically cleared, ER interview participants say it is difficult to move them out of their care and into treatment placements. Staff spend hours per case trying to locate an available state hospital bed. Since last year, irrespective of whether LMHAs are allowed to conduct on-site screenings, most ERs surveyed report the number of occasions when they must help find a treatment bed has stayed the same or increased. Most also believe the amount of time required to resolve each case is increasing (Figures 46 and 47), although in about one-third of these communities this burden has decreased.

**Figure 46**

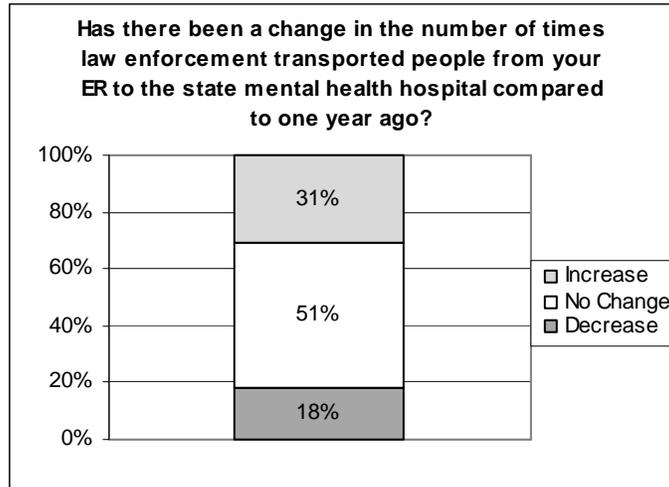


**Figure 47**

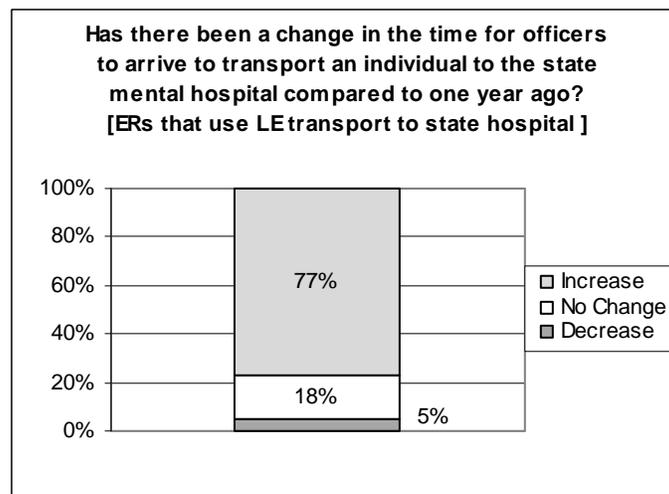


Once a treatment placement is found, emergency room staff say they face further challenges arranging transportation for consumers. Law enforcement assumes most of this responsibility. Most ER respondents agree law enforcement officers have transported as many or more of their patients to state hospitals this year as in the past (Figure 48). However, ERs are waiting longer for officers to arrive (Figure 49). As a result, a sizeable majority of emergency room respondents say that increasingly, hospitals are assuming the duty to deliver people to state mental health hospitals (Figure 50).

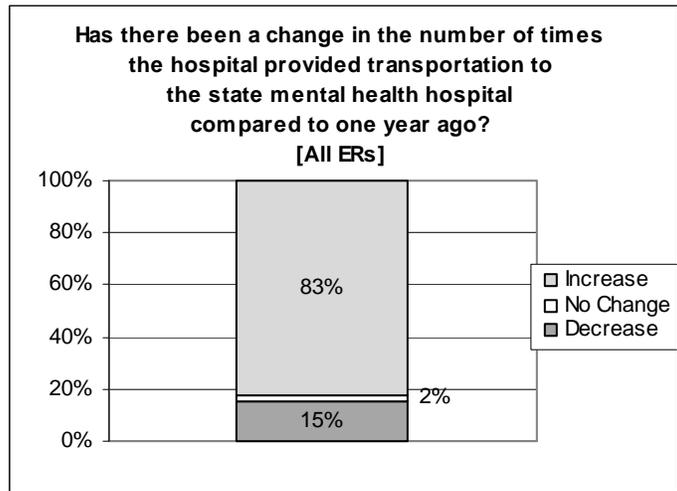
**Figure 48**



**Figure 49**



**Figure 50**



The evidence suggests that, thus far, CSR has done little to reduce demands on emergency rooms during mental health crises. In fact, there is considerable evidence their burden is increasing. This important finding likely explains emergency room respondents' low overall satisfaction with Crisis Services Redesign. As reported in Finding 4, ERs are the single least satisfied stakeholder group on a number of measures including available MH services, speed of MCOT response, and progress made so far implementing CSR.

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**Finding 5: Communities with channels of routine communication between agencies seem to be implementing CSR more effectively.**

“It’s just wonderful to sit at a table with a judge, lawyer, nurse, doctor, or counselor. There are so many different people willing to come together for one cause, and that’s pretty unique to be a part of that.”  
— *MCOT Supervisor*



**Finding 5: Communities with channels of routine communication between agencies seem to be implementing CSR more effectively.**

Wherever inter-organizational communication and collaboration is strong within a mental health region, interview results indicate that the objectives of crisis redesign are better understood and more fully implemented. Where communication is not well established and community partners are relatively unaware of the crisis redesign initiative, respondents feel more isolated from support and frustrated in seeking solutions.

Community Forums Promote Shared Responsibility and Investment of Resources. Some communities have established formal forums for ongoing collaboration between judges, hospital representatives, law enforcement, mental health workers, administrators, and others involved in the local crisis service system. By bringing diverse local actors together, these groups help foster the attitude that mental health crises are a shared responsibility. They help create a mutual understanding of the factors underlying the mental health crisis system so all members can see their role in improving outcomes for consumers and for the community service system as a whole. Community partners also appear to be more willing to contribute resources toward resolving issues they understand.

Two examples of effective local collaboratives observed during site visits include:

- Rural East Texas Health Network (RETHN). This regional planning group, supported through a federal grant written by Burk Center, is comprised of 11 Local Advisory Boards representing 13 counties in rural East Texas. Through this group, planning and activity is coordinated at both the county and regional level. The group established standardized crisis case processing procedures, designated a “Mental Health Services Legislative Day,” and is involved in planning and oversight of new mental health emergency treatment services being established through CSR.
- Community Medical Director’s Round Table. This Bexar County mental health planning group brings together community partners on a monthly basis. A number of highly innovative and cost-effective collaborations have emerged from these efforts, funded by a multitude of community partners, including the LMHA, the hospital district, the court system, and law enforcement agencies. These innovations include a multi-function crisis services complex providing offices for mental health deputies, emergency mental health screening, medical screening, respite, and detox; a social worker placed at the jail magistration center to assist with pre-booking jail diversion of people with mental illness; and members of law enforcement serving on the LMHA’s MCOT.

Community Partners Who Are Informed and Engaged in CSR are More Satisfied. To determine whether community partners who are actively engaged in planning and implementing CSR are in fact more satisfied, multivariate statistical tests controlling for LMHA, county, and stakeholder category were conducted. Results show individuals who are aware and informed are more content. Global satisfaction<sup>7</sup> is significantly higher for people who answer affirmatively to the following items:

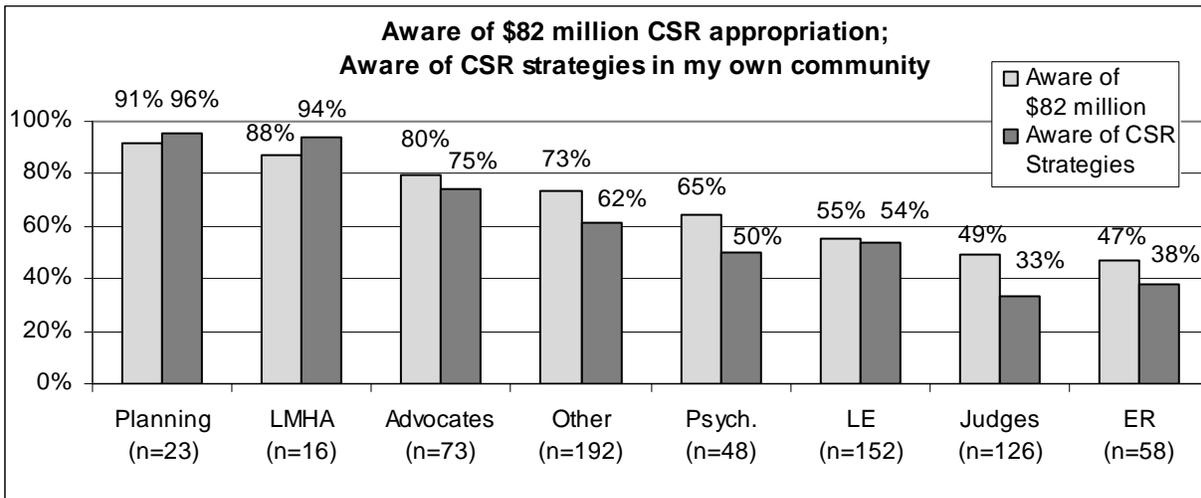
- Prior to this survey, I was aware that the Texas legislature appropriated \$82 million to redesign the community mental health crisis system ( $p < .001$ ).
- I am aware of the mental health Crisis Services Redesign strategies being implemented in my community ( $p < .001$ ).

- My Local Mental Health Authority keeps me informed about mental health crisis services (p<.001)
- I have participated in planning changes to local mental health crisis services in my community (p<.001).
- Agencies in my community work well together to assist people in mental health crisis (p<.001).

Respondents who were identified by LMHAs as being actively involved in CSR are also significantly more satisfied than others (p<.05). Taken together with the higher hotline and MCOT ratings provided by CSR-involved law enforcement agencies in Finding 4, these results suggest that keeping local partners informed and engaged can be key to the success of CSR.

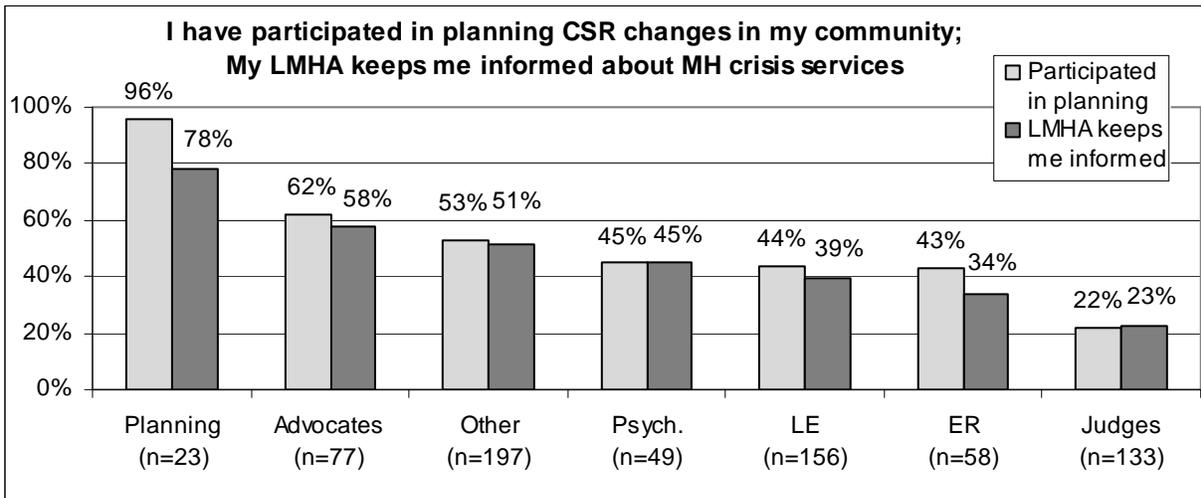
Judges, Emergency Rooms, Law Enforcement, Psychiatrists Are Least Likely to be Informed and Engaged. If involvement in CSR is a strong predictor of satisfaction, it is important to evaluate whether all stakeholder groups are successfully recruited into local planning and decision making. The evidence suggests they are not. Judges, emergency room personnel, law enforcement, and psychiatrists are the least likely to say they were even aware that CSR has been funded (Figure 51). Among those who were aware of the money, even fewer know about the plan for change in their own community.

**Figure 51**



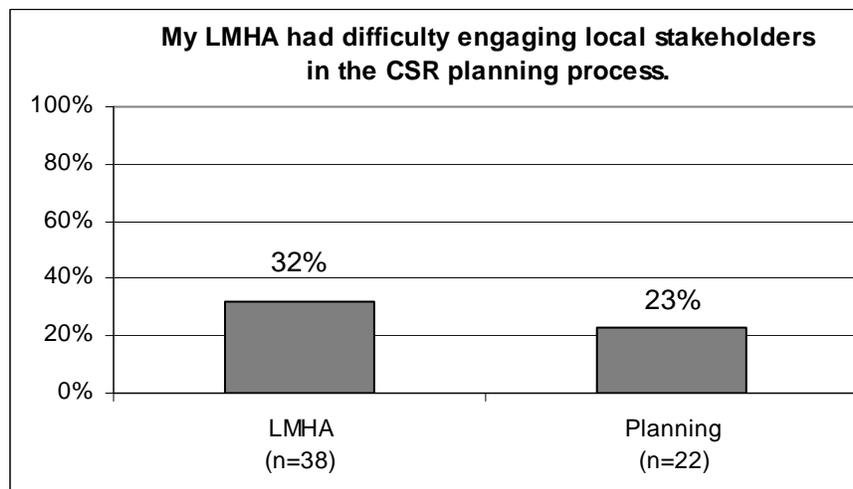
Not surprisingly, most of these same stakeholders have been disengaged from planning CSR-related changes (Figure 52). About two-thirds of law enforcement, ER, and judicial respondents say their LMHA does not keep them informed about MH crisis services (Figure 52). This sentiment of exclusion from the redesign effort is likely related to the relative overall dissatisfaction with crisis redesign expressed by these same constituencies in Finding 4.

**Figure 52**



Reasons for Disengagement of Key Partners Is Not Well Understood. It is not clear from the data currently available why these essential constituencies are consistently uninformed and dissatisfied with CSR. Despite a clear perception among most law enforcement, emergency rooms, and judges that they were not informed about crisis redesign, most LMHAs have the opposite point of view. Two-thirds believe they were successful in engaging local stakeholders in the CSR planning process (Figure 53). It is possible that the LMHA definition of inclusion is discrepant from that of their local partners. LMHAs may believe input from a few leading representatives of law enforcement, ERs or judges in their service area is sufficient to inform their thinking. At the same time, other agencies not included on planning committees or not receiving other forms of direct communication from LMHAs may feel excluded and uninformed.

**Figure 53**



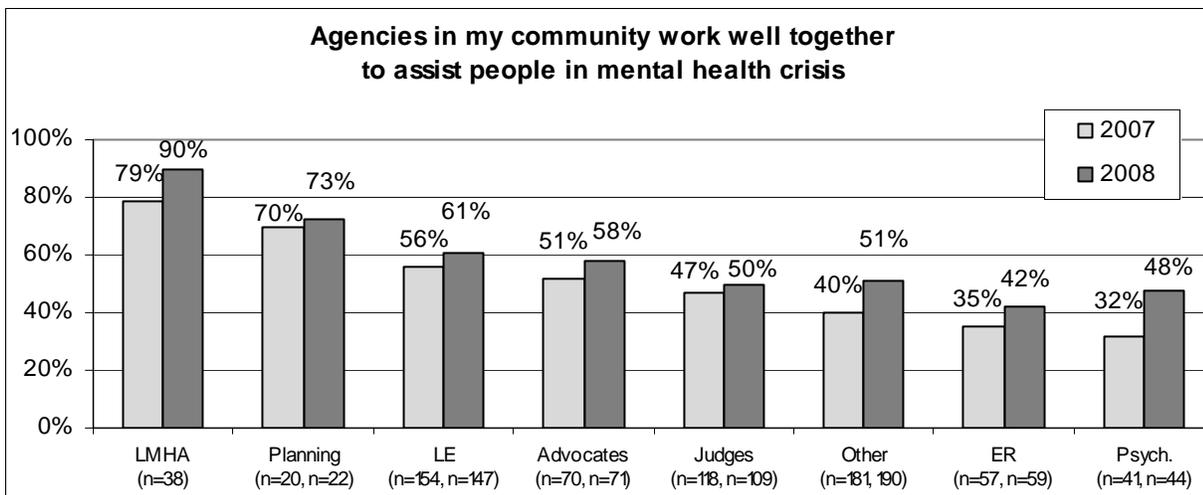
On the other hand, in their CSR applications to DSHS, most LMHAs described an open and inclusive planning process in which all agencies and organizations impacted by CSR were invited and encouraged to have input during planning. It is possible that many entities that now report being

marginalized simply chose not to participate. In interviews, both law enforcement and emergency room respondents clearly articulated the stresses of being understaffed and over extended. In small or rural communities in particular, it may be difficult to release staff for meetings which may involve travel and time away from duty.

Close communication and networking is emerging as an essential element to improve community satisfaction with crisis redesign. Formal forums of willing partners are certainly a model to aspire to in every LMHA. However, it may be necessary to explore new forms of outreach and education that fit the logistic and political context in each service region. Creative thinking may be required to convey the vision of CSR and to draw in participation from these organizations.

Community Partners Say Collaboration Is Improving. While there is still a great deal of room for improved collaboration in the delivery of mental health crisis services, survey respondents say community agencies are doing a better job working together now than last year (Figure 54). Mental health providers and planning committee members are the most satisfied with other community stakeholders' ability to coordinate their efforts. Other stakeholder groups are less pleased. Nonetheless, all respondents acknowledged change is occurring in a positive direction.

**Figure 54**



## **Finding 6: Community partners must commit to resolve issues impacting the success of CSR.**

“I’m not sure if the state can help with this, but if there is some way, some how to intervene with county and local justices of the peace to reinforce [issuing mental health warrants] as part of their role and community service. Whether they rotate night/weekend on call or do something creative, that is still a huge gap in the community. It is not a responsibility of MHMR, but it affects the whole process.”  
— *Emergency Room Staff Member*

“I don’t know what to tell you except that I wish we had drug treatment.”  
— *Emergency Room Staff Member*

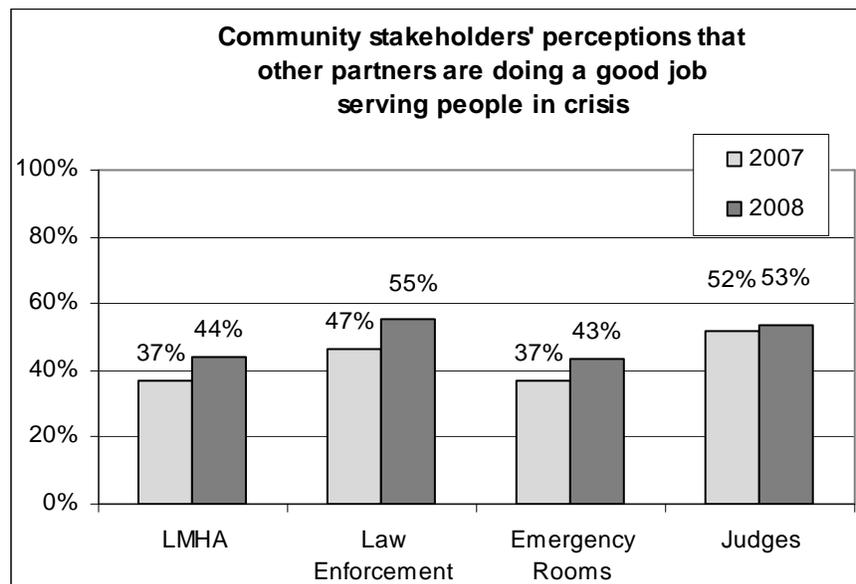
“The easy shot is the jail, but the correct one is the treatment.”  
— *Judge describing why some law enforcement officers take individuals in crisis to jail*



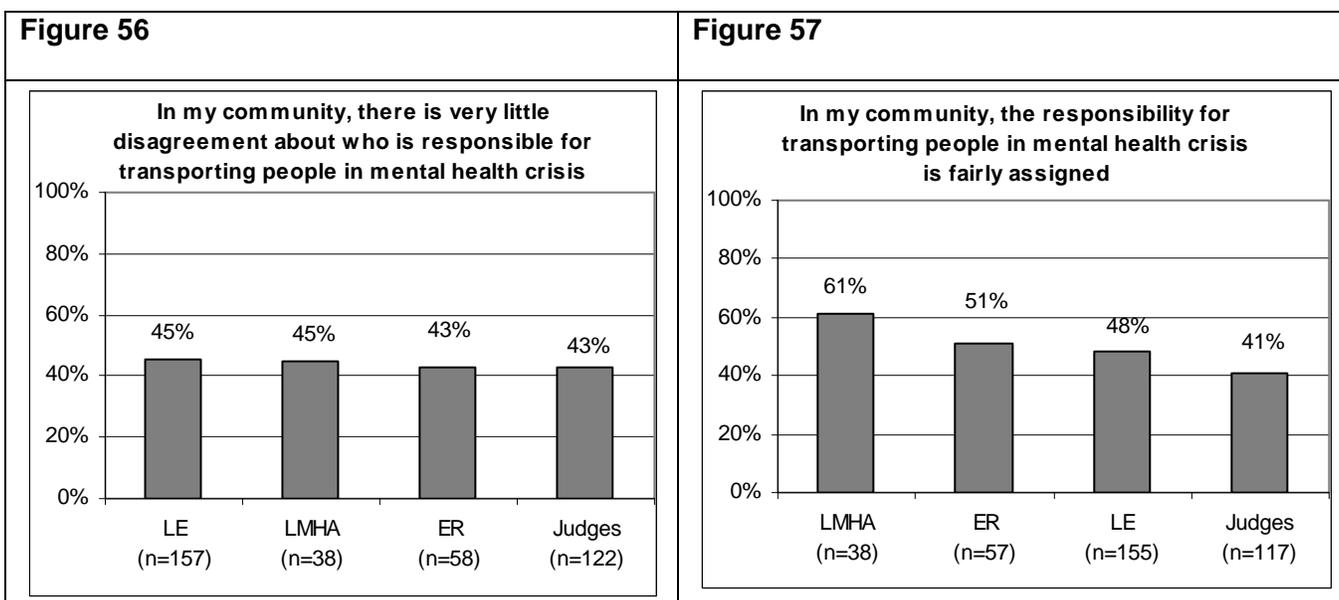
**Finding 6: Community partners must commit to resolve issues impacting the success of CSR.**

While the LMHAs provide leadership in mental health crisis services, other stakeholders must be willing to reasonably adapt their own attitudes and procedures to develop solutions that are best for the overall community and for mental health consumers. Each stakeholder group was asked to rate whether other community partners do a good job serving people in mental health crisis, excluding their own self-ratings. These evaluations suggest that, in the eyes of their peers, each of these groups has room to improve (Figure 55). Several issues have been identified that require the commitment of community partners to be resolved.

**Figure 55**

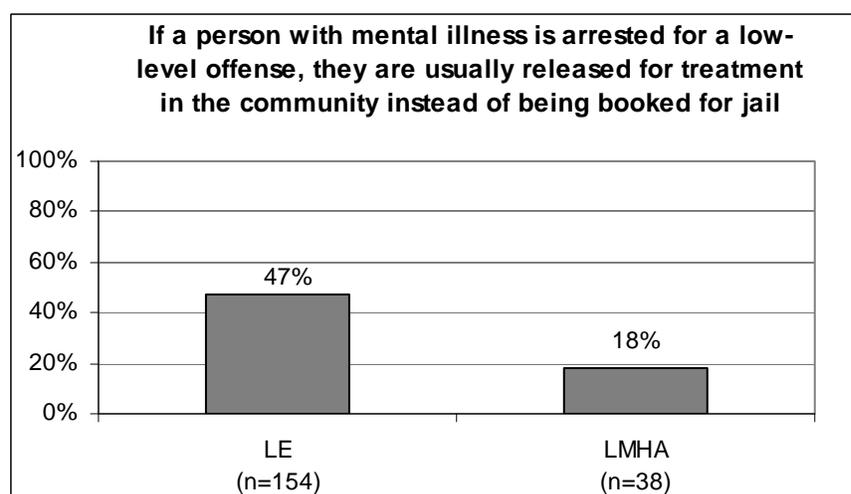


- Lack of Consensus about Who is Responsible for Transportation. In many communities, there is considerable disagreement about who is responsible for transporting people in mental health crisis (Figure 56). Responsibility is not clearly assigned between sheriffs' offices and police departments. Emergency rooms have a growing role, as well. There is a strong perception that some agencies assume an unfair share of the burden and cost (Figure 57). Where this is a source of conflict, community partners can improve crisis case flow by working toward a resolution.
- Reluctance of Some Enforcement Agencies to Use Warrantless Detention. Although law enforcement agencies are legally authorized to detain an individual in crisis without first obtaining a warrant from a judge, officers in some communities are unwilling to do so. Twenty-five percent of law enforcement survey respondents say it is their agency policy to require a warrant before detaining an individual in crisis. This policy places a significant burden on families, LMHAs, and ER personnel required to visit a judge before police will act, and on judges, who are called upon to issue more warrants, often outside of business hours. Greater law enforcement flexibility in these cases would help expedite mental health crisis case processing.



- Reluctance of Some Law Enforcement Officers to Deliver Mentally Ill Offenders to Treatment.** Rather than expend the time and costs associated with transportation and screenings for people in mental health crisis, interview respondents say some law enforcement officers still find it easier to deliver these individuals to jail (Figure 58). This perception is supported by law enforcement and LMHA survey respondents, a minority of who report active efforts in their community to divert low-level offenders to treatment. Diversion and treatment in appropriate cases are far more productive and cost-effective solutions.

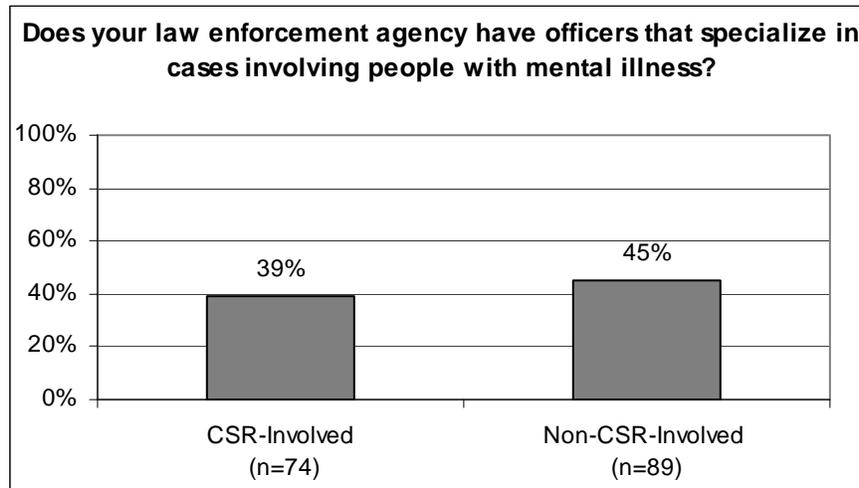
**Figure 58**



- Need for More Mental Health Deputies.** Most law enforcement agencies have met basic peace officer training requirements for mental health expertise. However, fewer than half of all law enforcement survey respondents (42%) say their agency has officers that specialize in cases involving people with mental illness (Figure 59). The proportion is slightly higher among those working closely with LMHAs. Only a few sheriffs' departments have committed to develop

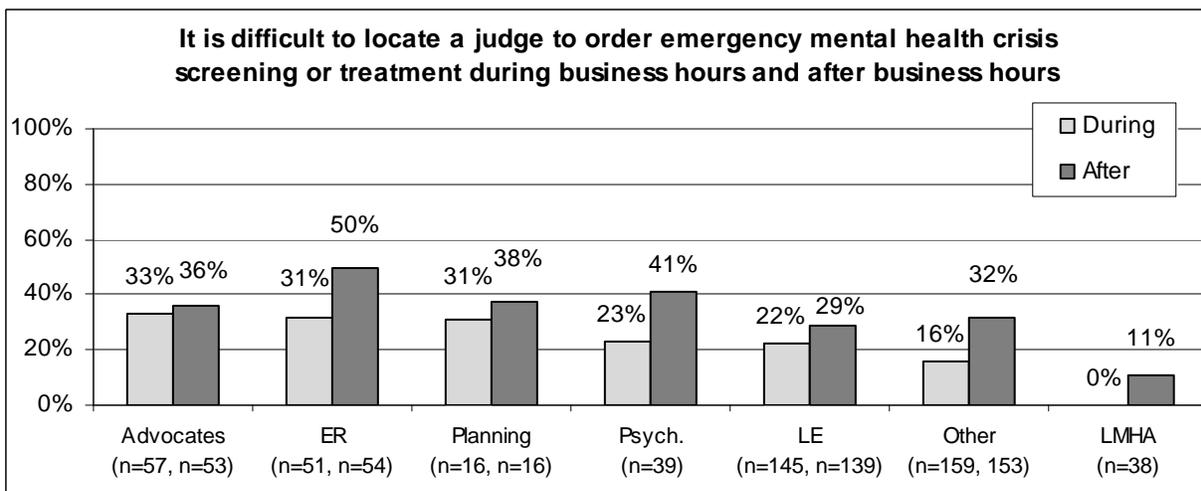
strong, specialized teams to coordinate the law enforcement crisis response for the entire county. Where mental health deputies are available, significant benefits accrue to police departments, emergency rooms, the courts, LMHAs, and mental health crisis consumers.

**Figure 59**



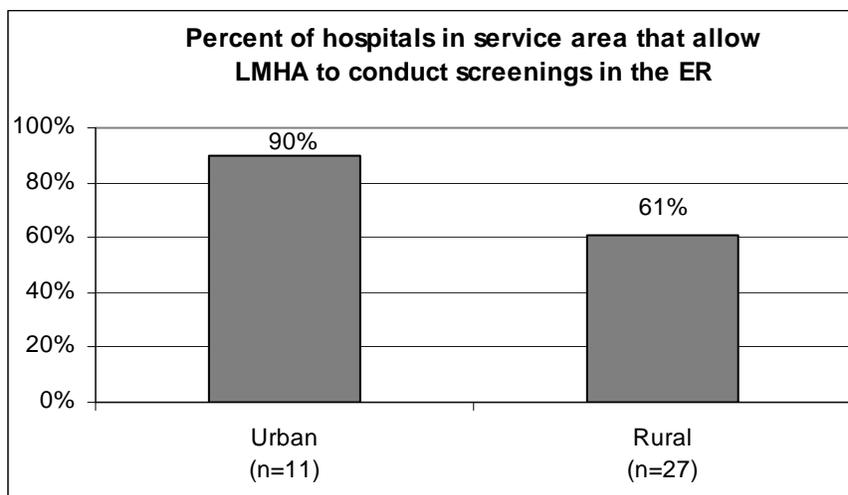
- Inability to Access a Justice of the Peace When Needed.** In some communities, justices of the peace are not always available to issue emergency detention warrants when needed, particularly after hours or on weekends (Figure 60). Inability to access a judge can present a significant obstacle to prompt assistance for people in crisis. On average, 21 percent of survey respondents say it is difficult to locate a judge during business hours. After hours, that proportion rises to 33 percent. Emergency room personnel and psychiatrists report the greatest difficulty obtaining emergency detention warrants, while LMHAs have the least difficulty.

**Figure 60**



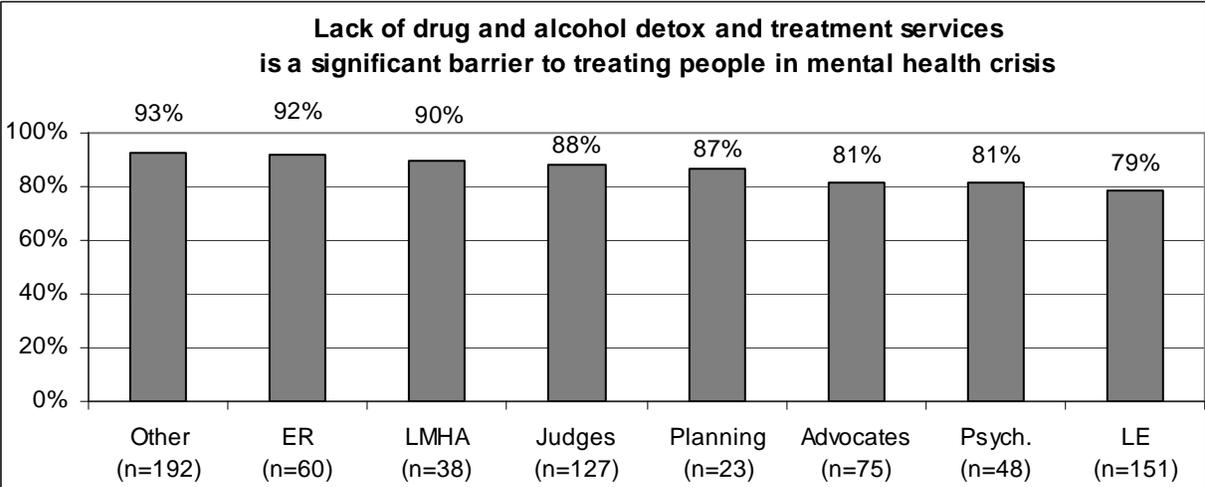
- Use of Private Hospital Security during Crisis Screenings. Emergency rooms routinely require law enforcement to provide security during mental health screenings. In a few hospitals, ERs have met this responsibility on their own using private security. Law enforcement agencies interviewed in these communities report this has a significant impact by allowing them to return their officers to other duties.
- Need to Remove Restrictions on LMHA Screenings Conducted in Emergency Rooms. Some emergency rooms, mostly in rural areas, have formal policies that prohibit LMHA staff from conducting mental health screenings on site (Figure 61). The LMHA must authorize a treatment placement, yet it is extremely difficult for the MCOT to determine the best course of action without a face-to-face screening. Eliminating restrictions on ER-based LMHA screenings would remove a significant obstacle and improve outcomes for everyone involved.

**Figure 61**



- Confusion and Disagreement over Legal Requirements. From county to county and across LMHA regions, interviews indicate that there is widespread confusion over legal requirements for crisis case processing. Clarification and agreement needs to be established regarding laws affecting medical clearances, transportation to state mental health hospitals, and procedures for detention and commitment of children. A lack of common understanding about the law can be a significant barrier to cooperation.
- Inadequate Access to Drug and Alcohol Detox and Treatment. The lack of drug and alcohol detoxification and treatment services is broadly viewed as a significant problem when resolving mental health crises (Figure 62). As noted in Finding 4, emergency room resources are strained by people requiring detox before mental health screening and treatment can occur. Furthermore, once people with co-occurring mental health and substance abuse disorders receive treatment for their mental health problem, there are few resources available to help with the drug or alcohol use. The vast majority of community stakeholders agree that mental health crises could be resolved more efficiently if adequate substance abuse services were available.

**Figure 62**



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**Conclusions and Recommendations**



## CONCLUSIONS AND RECOMMENDATIONS

This report presents the findings from the first step of a two-year evaluation of the Crisis Services Redesign initiative. Although the data presented here were collected ten months after CSR funding first became available to LMHAs, it serves as the best available representation of stakeholder baseline attitudes. There is reason to expect that the attitudes and opinions of community partners measured in year one will evolve further in the coming year as CSR continues to be implemented and refined.

The second year of the evaluation will not only measure longer-term change in stakeholders' and consumers' self-reported attitudes, but will also consider additional, more objective indicators of the impacts of CSR. DSHS service record analyses will be used to document actual changes in service utilization patterns, including state hospitalizations. DSHS databases will also be used to estimate the return on investment achieved by CSR funding across multiple community service systems.

As such, this report should be considered an interim evaluation, with additional impacts of Crisis Services Redesign continuing to unfold in the coming year. A final evaluation report summarizing the entire body of evidence regarding CSR will be available in January, 2010. This interim evaluation points to five early recommendations:

**Recommendation 1. The types of changes being implemented under Crisis Services Redesign appear appropriate to the goals of the funding and merit continued support as their full impacts are assessed during the second year of the evaluation.**

Although many communities are still early in the process of implementing changes to crisis services, initial evaluation findings suggest that CSR funds are being used as intended to improve local crisis infrastructure. Individuals experiencing a mental health crisis and their family members rate these new services positively. In addition, there is some evidence that CSR is beginning to have a small but positive impact on community agencies with whom the LMHAs partner in assisting people in a mental health emergency.

**Recommendation 2. There is a need for LMHAs to employ creative strategies to engage a broader range of stakeholders in the CSR process.**

Despite evidence that more crisis services are available, the evaluation also makes clear that many stakeholders, particularly law enforcement officers and emergency room staff, continue to perceive Texas' crisis mental health services as less than satisfactory. Satisfaction is greatest among respondents from agencies that are actively involved in local CSR planning and implementation. However, despite LMHA perceptions that they have successfully engaged a broad range of stakeholders in the CSR planning and implementation process, this evaluation suggests that many law enforcement officers, emergency room staff, and judges, are among the least informed about and least satisfied with the changes taking place in their communities.

While it is not clear if this lack of engagement is due to lack of outreach on the part of LMHAs or lack of willingness to collaborate on the part of stakeholders, the costs are evident. Without good strategies for ongoing communication in place, many communities will be unable to resolve many of the challenges preventing the full success of CSR. Issues such as conflicts over transportation or disagreements over how to interpret mental health laws can only be resolved through collaborative solutions.

It is recommended that LMHAs work toward generating creative strategies to foster information exchange and collaboration. Solutions can be inexpensive. The research team was surprised to learn during this evaluation that many LMHAs do not have a ready email distribution lists to facilitate information-sharing with local partners. As a basic first step, this type of communication infrastructure needs to be developed. In addition to email updates, dissemination tools such as DVDs, PowerPoint presentations, or printed newsletters could be used to explain new crisis services to stakeholders.

Other formats such as quarterly telephone conferences may be more conducive to common planning and discussion. Permanent community forums that meet regularly to problem solve have been successfully established both urban and rural communities. It may also be feasible to use increasingly available video teleconferencing to facilitate information exchange.

Whatever specific strategies are adopted, it is important that LMHAs find a way to reach community partners who do not feel engaged in CSR. Collaborations may emerge slowly as communication and trust often evolve over time. Still, taking measures to include and involve all partners appears to be essential for achieving stakeholder satisfaction. Furthermore, mutual problem solving is a practical tool for attracting investment from partners and finding solutions that work for the entire community.

**Recommendation 3. Efforts are needed to better balance funding available for crisis services and supports for ongoing mental health crisis services.**

As noted in Finding 2, a broad cross-section of stakeholders have raised concerns that the significant growth in mental health crisis services, while needed, has not been adequately balanced by comparable investment in DSHS' ongoing Resiliency and Disease Management (RDM) services. These stakeholders are concerned that, without available services to help maintain the stability of individuals after a crisis has been resolved, many of them will experience a cycle of repeated crises. LMHA reports suggest that CSR has been associated with increased costs to the mental health system, including increases in waits for non-crisis services, increasing RDM service caseloads, and personnel costs. While increased funding for RDM services is preferred, if this is not an option, some LMHAs have expressed interest in having the flexibility to apply some CSR resources toward RDM services. At this time, it is not clear that budgetary regulations would permit this type of resource reallocation.

**Recommendation 4. Enhancements to supportive services provided by community partners would help reinforce the success of CSR.**

Finding 6 identifies several challenges to the success of CSR that cannot be resolved by the LMHAs alone. While the increased collaboration suggested in Recommendation 2 would help address many of these challenges, as least two will likely require investment in supportive services outside the mental health system.

First, stakeholders around the state and in every respondent category agree that lack of drug and alcohol detox and treatment services is a significant barrier to treating people in mental health crisis (see Figure 62). Because individuals using substances often end up in emergency rooms, the absence of public detox services largely shifts responsibility for this service to emergency rooms. When people in mental health crisis have also been using substances, the burden on emergency rooms is increased. Furthermore, repeated contact with the crisis service system may be exacerbated by the lack of treatment available for drug- or alcohol-involved mental health consumers.

Second, while most law enforcement agencies have met basic peace officer training requirements for mental health expertise, fewer than half of law enforcement representatives surveyed say their agency has officers that specialize in cases involving people with mental illness. A model used in one site visit community calls for the sheriff to dedicate highly trained mental health staff able to support other law enforcement agencies in the county. It would also be beneficial to have at least one expert mental health officer in every agency. In interviews, many law enforcement agencies cited cost as a barrier to having these specialty officers on staff, yet enhanced law enforcement capacity directly complements the objectives of CSR.

**Recommendation 5. The state should consider policies to support the training of new professionals who can staff crisis services and incentives for these professionals to work in underserved areas.**

As mentioned in Finding 2, most LMHAs have had difficulty hiring qualified staff for the new CSR services. Many, particularly in rural areas, have had to increase salaries or adjust job requirements in order to attract these individuals. It is recommended that the state consider ways to encourage increased production of qualified mental health professionals by the state universities or other training institutions. In addition, the state should consider incentive programs, such as scholarships with post-graduation service requirements, to encourage these professionals to seek employment in underserved areas.

**Conclusion**

At the completion of the first year of Crisis Services Redesign, evaluations results suggest that, overall, there is reason for optimism. LMHAs, who understand CSR best, are uniformly pleased with the initiative and see it as a significant improvement over the preceding service structure. The earliest evidence suggests changes in satisfaction are beginning to occur among community partners, especially those that have been actively involved in planning and implementing CSR. Consumers themselves, as well as their families, assign strong positive ratings to crisis services. Certainly more time is needed for CSR-related services to mature and for their impacts to be more fully realized among community stakeholders. Nonetheless, these first evaluation results suggest the overall endeavor is on the right track, and that greater positive impacts can be expected in the future.

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## END NOTES

<sup>1</sup> Texas Department of State Health Services. (2006). *Texas Mental Health and Crisis Services Redesign Report*. Retrieved December 16, 2008, from the Texas Department of State Health Services Web site: <http://www.dshs.state.tx.us/mhsacsr/PDF/mhsacsr.pdf>

<sup>2</sup> Texas Department of State Health Services. (2007). *Crisis Services Redesign: Implementation Overview*. Retrieved December 16, 2008, from the Texas Department of State Health Services Web site: <http://www.dshs.state.tx.us/mhsacsr/default.shtm>

<sup>3</sup> Texas Health and Human Services Code, Article II, §1.69(c) (2007).

<sup>4</sup> LMHA characteristics considered in cluster analysis included (a) Urbanicity (urban, rural, or blended categories); (b) Burden (percent of target population served); (c) Number of new CSR service enhancements; (d) Consumer need (percent of all clients in Service Package 1); (e) Percent increase in CSR funds over baseline; (f) Access to funding streams other than DSHS; and (g) Availability of community assets such as drug and alcohol detox and law enforcement partners trained to handle mental health crises.

<sup>5</sup> Survey responses were accepted from multiple staff at each LMHA who were knowledgeable about crisis services. Responses were then aggregated to produce a single record for each mental health center. A description of methods used is included in Appendix A.

<sup>6</sup> Databases to be used in these analyses include the Client Assignment and Registration System (CARE), the Mental Health and Behavioral Health Outpatient Warehouse (MBOW), LMHA Accounting Leger Data, and the Wait-List for Authorized Services.

<sup>7</sup> “Service Packages” define the amount and intensity of DSHS-funded mental health care services to be provided. There are currently five service packages defining access to crisis services, pharmacological management, medication training and supports, routine case management, rehabilitation counseling and psychotherapy, supported employment, medical services, and assertive community treatment.

<sup>8</sup> See “Methodology” for additional detail on data collection methods and factors impacting the data collection effort.

<sup>9</sup> Satisfaction results are either reported by individual survey item, or as overall satisfaction. The “global hotline caller satisfaction” scale was created by averaging three satisfaction items. The items, scale reliability, and methodological notes are included in Appendix A.

<sup>10</sup> Of 154 surveys missing consumer data, the most common reasons were callers were unable to contact respondents using follow-up methodologies (47%); it was deemed clinically inappropriate to collect the data at the time of the call (8%); consumer refusals (6%); or the hotline worker needed to take another call (4%). The reason for the remaining missing data (34%) is unknown.

<sup>11</sup> Satisfaction results are either reported by individual survey item, or as overall satisfaction. The “global crisis service user satisfaction” scale was created by averaging three satisfaction items. The items, scale reliability, and methodological notes are included in Appendix A.

<sup>12</sup> Of 599 surveys missing consumer data, 14 percent were deemed clinically inappropriate to collect at the time of the service contact. The reason for the remaining missing data (86%) is unknown.

<sup>13</sup> Respondents were asked to indicate their awareness of and satisfaction with “Crisis Residential, Stabilization, or Respite Services.” There was considerable disagreement among respondents, including staff members within

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the same LMHA, regarding whether these services were available in each service area, precluding the team's ability to assess "awareness" of the services. It was also not clear that community partners could reliably distinguish these LMHA services from other community providers of similar services. Because responses could not be clearly interpreted, they are not being reported.

<sup>14</sup> Satisfaction results are either reported by individual survey item, or as overall satisfaction. The "global community stakeholder satisfaction" scale was created by combining six different measures of satisfaction. The items, scale reliability, and methodological notes are included in Appendix A.



**Appendix A: Methodological Notes**



## METHODOLOGICAL NOTES

### 1. Procedure used to aggregate responses from multiple LMHA survey participants into a single response for each LMHA.

- a. Rationale: All LMHA personnel who are knowledgeable about Crisis Services Redesign (CSR) were invited to complete a CSR Community Stakeholder Survey. Respondents were instructed to answer “don’t know” or to skip any questions for which they did not know the information being requested. The research team felt this approach would yield a more complete picture of how CSR is being implemented from multiple perspectives. On the other hand, these diverse responses within each LMHA needed to be aggregated for analysis purposes in order to provide a single response for each community mental health center.
- b. Approach: For most survey questions, LMHA survey participants were asked to indicate either the extent of agreement with a statement or the degree of satisfaction with a service using a 5-point scale. Individual responses were re-coded to 0 for individuals who disagreed or were dissatisfied (i.e., rating was between 1 and 3). Responses were recoded to 1 for individuals who agreed or were satisfied (i.e., rating was either 4 or 5). The 0 and 1 answers to each question were then averaged for all respondents within an LMHA. The resulting value between 0 and 1 was reported as the aggregate percent agreement or satisfaction.

Other questions asked LMHA respondents for estimations of percentages on a continuous scale (e.g., percent of psychiatric screenings occurring in an emergency room). In these instances a simple average was taken of answers provided by all respondents within an LMHA.

### 2. Computation of the “Global Hotline Caller Satisfaction” Scale

- a. Rationale: In addition to analyses describing hotline survey respondents’ answers to individual satisfaction questions, it was also of interest to report a measure of their “overall” or “global” satisfaction.
- b. Approach: Three questions were used to measure hotline callers’ satisfaction with the service received. These included:
  - The hotline helped keep that person safe or helped prevent harm to others.
  - If I or someone I am close to had a similar problem in the future, I would use this hotline again.
  - The plan that the hotline worker came up with to keep me or others safe was the right one.

Survey participants were asked to indicate the extent to which they agreed with each statement based on a 5-point scale.

To combine these three separate measures, a simple average was computed for each individual respondent to create a “global hotline satisfaction” score. Internal consistency reliability for these scaled items is .74.

### **3. Computation of the “Global Crisis Service User Satisfaction” Scale**

- a. Rationale: In addition to analyses describing crisis service user survey respondents’ answers to individual satisfaction questions, it was also of interest to report a measure of their “overall” or “global” satisfaction.
- b. Approach: Three questions were used to measure crisis service users’ satisfaction with the service received. These included:
  - The crisis services helped keep me or that person safe or prevented harm to others.
  - If I or someone I am close to had a similar problem in the future, I would use these services again.
  - I or someone I am close to received the types of help I thought were needed.

Survey participants were asked to indicate the extent to which they agreed with each statement based on a 5-point scale.

To combine these three separate measures, a simple average was computed for each individual respondent to create a “global crisis service user satisfaction” score. Internal consistency reliability for these scaled items is .69.

### **4. Computation of the “Global Community Stakeholder Satisfaction” Scale**

- a. Rationale: In addition to analyses describing community stakeholder survey respondents’ answers to individual satisfaction questions, it was also of interest to report a measure of their “overall” or “global” satisfaction.
- b. Approach: Six questions were used to measure crisis service users’ satisfaction with the service received. These included:
  - The LMHA in my community does a good job serving people in mental health crisis.
  - My community has the types of mental health crisis services that are needed.

- People in mental health crisis in my community are able to get help quickly.
- The mental health crisis services in my community are of high quality.
- My community's mental health crisis services plan targets the type of changes I think are needed.
- I am satisfied with the progress made so far in implementing the mental health crisis service plan in my community.

Survey participants were asked to indicate the extent to which they agreed with each statement based on a 5-point scale.

To combine these three separate measures, a simple average was computed for each individual respondent to create a "global community stakeholder satisfaction" score. Internal consistency reliability for these scaled items is .93.



**Appendix B: Description of Survey Respondents**



## Detailed Description of Crisis Hotline Survey Respondents

	CALL TYPE		TOTAL
	Emergent Crisis Callers	Urgent Crisis Callers	
<b>GENDER</b>			
Female	11	92	103
Male	10	65	75
<b>AGE</b>			
0 to 18 years	2	10	12
18 to 34 years	8	49	57
34 to 50 years	7	46	53
50 to 75 years	3	33	36
75+ years	1	21	22
<b>URBANICITY</b>			
Rural	6	39	45
Urban	15	119	134
<b>PERSON TAKING THE SURVEY</b>			
Consumer	14	95	109
Consumer Friend or Family Member	7	62	69
<b>CURRENT MHMR CLIENT?</b>			
No	15	105	120
Yes	6	47	53
Other	0	2	2
<b>ACTION TAKEN BY HOTLINE</b>			
Crisis Resolved by Phone	7	54	61
Referred to LMHA DBA	4	38	42
Activated LMHA staff on call	6	12	18
Referred to ER	4	17	21
Referred to Other Agency	2	32	34
Called Emergency Services Dispatcher	3	12	15
Other	1	33	34
<b>TOTAL</b>	<b>21</b>	<b>159</b>	<b>180</b>



## Detailed Description of Crisis Service User Survey Respondents

	TYPE OF CONSUMER		TOTAL
	Existing RDM Consumers	New Crisis Service Users	
<b>GENDER</b>			
Male	91	264	355
Female	129	269	398
<b>AGE</b>			
0 to 18 years	27	82	109
18 to 34 years	75	200	275
34 to 50 years	76	168	244
50 to 75 years	34	54	88
75+ years	0	3	3
<b>RACE/ETHNICITY</b>			
Black	40	82	122
Hispanic	49	170	219
White	121	249	370
Asian	1	3	4
Mixed/other	2	7	9
Unknown	6	5	11
<b>URBANICITY</b>			
Rural	115	247	362
Urban	99	286	385
<b>PERSON TAKING THE SURVEY</b>			
Consumer	164	415	579
Consumer family member	30	85	115
Consumer friend/associate	3	6	9
<b>ADMINISTERED BY PERSON WITH CLINICAL ROLE?</b>			
No	111	336	447
Yes	101	176	277
<b>SERVICE PROVIDED</b>			
MCOT	97	320	417
Outpatient	106	163	269
Respite/Residential	40	58	98
Private Hospital	19	36	55
State Hospital	19	21	40
Other	21	61	82
<b>TOTAL</b>	<b>220</b>	<b>533</b>	<b>753</b>



## Detailed Description of CSR Community Stakeholder Survey Respondents

	LMHA URBANICITY		CSR INVOLVEMENT		
	Rural	Urban	Not CSR-Involved	CSR-Involved	TOTAL
<b>GENDER</b>					
Female	260	258	300	235	535
Male	283	182	283	194	477
<b>RACE</b>					
African American	23	31	34	20	54
Hispanic	68	90	103	55	158
White	443	306	432	346	778
Asian	4	4	5	3	8
Indian	5	6	7	4	11
<b>CATEGORY</b>					
State/Local Planning Committee	12	10	0	23	23
Consumer Advocacy	33	44	32	46	78
Psychiatrist	9	40	40	9	49
ER/Hospital	18	35	9	51	60
Law Enforcement	112	48	74	89	163
Judge	103	32	125	14	139
LMHA	173	127	258	49	307
OTHER	86	110	51	151	202
<b>LMHA RESPONDENTS</b>					
Administrator	65	43	83	26	109
Clinician	51	35	80	10	90
Supervisor	43	32	62	17	79
Staff	28	29	54	3	57
<b>LAW ENFORCEMENT RESPONDENTS</b>					
Sheriff	42	13	13	42	55
Municipal	66	30	57	41	98
Other LE	3	0	0	3	3
Constable	2	1	0	3	3
<b>JUDICIAL RESPONDENTS**</b>					
Justice of the Peace	0	0	0	0	0
County	18	2	15	7	22
District	10	6	16	0	16
Probate	1	6	3	4	7
<b>CONSUMER ADVOCACY RESPONDENTS**</b>					
NAMI	17	33	28	23	51
DBSA	1	8	2	7	9
TMHC	4	2	2	4	6
MHA	1	7	2	6	8
FOF	3	3	3	3	6
CFC	1	2	2	1	3

\* 94 judges did not report the type of office held.

\*\* Some respondents indicated affiliations with multiple membership organizations within the "consumer advocacy" category.

Continued...

## Detailed Description of CSR Community Stakeholder Survey Respondents (contd.)

	LMHA URBANICITY		CSR INVOLVEMENT		TOTAL
	Rural	Urban	Not CSR-Involved	CSR-Involved	
<b>"OTHER" RESPONDENTS***</b>					
Mental Health Service Provider	16	41	19	40	59
Emergency Health Care Provider	6	11	3	18	21
Public Health Care Provider	7	17	4	21	25
Probation or Parole	12	9	4	17	21
Outreach, Screening, and Referral	4	6	2	8	10
Other Affiliations	57	54	26	90	116
<b>TOTAL</b>	546	446	589	432	<b>1,020</b>

\*\*\* Some respondents indicated affiliations with multiple membership organizations within the "Other" category.

**Appendix C: 2008 Crisis Hotline Caller Survey**



## **Hotline Satisfaction Survey Instructions to Hotline Providers**

The Department of State Health Services (DSHS) is currently sponsoring a statewide evaluation of the impacts of the Crisis Services Redesign (CSR) initiative on stakeholder satisfaction. Because it is particularly important to include consumer perspectives in this study, DSHS is asking hotline service providers to assist in a survey of crisis service recipients. The survey was developed and will be analyzed by the statewide CSR evaluation team at Texas A&M University. Data entry will be conducted at DSHS.

Instructions for collecting the survey data are provided below. Please try to follow these guidelines as closely as possible, though we understand some adaptation may be necessary to accommodate your local call procedures. Please note any significant variations in administrative procedures on the Cover Page found at the end of this document. This information will assist the CSR evaluation team in describing the data collection methods and interpreting the data obtained from this survey.

### **When is the survey to be conducted?**

Survey data should be collected during the one-week period from September 8 to September 14, 2008.

### **Which callers should be included in the survey?**

#### **DO administer the survey to:**

- Callers in the following three categories:
  - **Emergent**
  - **Urgent**
  - **Any other callers requiring a mental health crisis service or follow-up**
    - We are interested in surveying all people experiencing a mental health crisis, even if your hotline's definition of Emergent or Urgent does not apply to them
- Mental health consumers.
  - Include callers referred to LMHAs and those referred to mental health providers other than the LMHA (e.g., private providers).
- Individuals calling in the role of a friend or family member of a consumer.
  - If the consumer is not able to complete the survey, it may be completed by a friend or family member who has been involved in helping the consumer during the crisis.

#### **DO NOT administer the survey to:**

- Callers other than consumers or their friends/family.
  - Other hotline users such as emergency room staff or members of law enforcement will be surveyed separately by the evaluation team at Texas A&M.

- Callers who do not require a mental health crisis service response (e.g., those requesting information about available services, or those who are not having a mental health crisis).
- Hotline users who have already taken the survey before. Collect only ONE survey per hotline user.

### **Should the survey be given during the initial hotline call or during a follow-up call?**

Each hotline provider can determine the best time to administer the survey given your clinical and procedural protocols.

- **If the survey is administered during the initial call**, include all Emergent, Urgent, or Other callers who contact the hotline between September 8 and September 14, 2008.
  - If it is not appropriate to ask callers to complete the survey during the initial call, you may administer it during a follow-up call later in the data collection week, if one is to be made.
- **If the survey is administered during a follow-up call**, include all Emergent, Urgent, or Other callers receiving a follow-up contact between September 8 and September 14, 2008.

Indicate the method used on Item 6 of the survey.

### **Are there times when the survey should not be administered?**

Do NOT complete the survey if:

- You believe a respondent is not in an appropriate state of mind to answer survey questions; or
- Completing the survey would limit your ability to respond to another hotline caller.

### **How should the survey be administered?**

You may choose between administering the survey online or using hard copy instruments.

The online survey is available at <http://pprisurvey.tamu.edu/index.php?sid=23163&lang=en>

The hard copy “Hotline Satisfaction Survey” instrument is provided below:

- **Type the hotline provider name** into the appropriate blank on the original so that it is consistently entered on all instruments.
- **Make 2-SIDED COPIES** for the approximate number of eligible crisis callers you expect to encounter in a week. This will ensure the two pages of the survey do not get separated.

## How should I prepare to administer the survey?

At least two weeks before the September 8 beginning of the data collection period, notify the hotline staff about the surveys. It is critical that all key staff are informed about the survey and prepared to begin data collection on time. You might wish to:

Practice online submission: <http://pprisurvey.tamu.edu/index.php?sid=23163&lang=en>

- ***Unlimited practice surveys may be submitted through Friday, September 5.***
- ***Starting Monday, Sept. 8 only actual survey data should be entered.***
- Discuss the survey at a regular planning meetings or staffings.
- Designate one individual to supervise data collection during each shift.

Make sure all crisis staff have clear instructions on:

- Who is responsible for administering the survey.
  - Survey data may be collected by the original call-taker or you may choose to have all calls routed to a designated hotline staff person.
- Where to find the survey (i.e., either online or in hard copy).
- Who should be surveyed (i.e., emergent and urgent or other callers experiencing a mental health crisis).
- How data collection should be integrated with the overall hotline response.
  - Provide guidelines for your staff to determine which types of callers may be clinically inappropriate to survey.

## What do staff need to be aware of when administering the survey?

There are two parts to the survey

- Hotline staff enter descriptive information about the respondent and the call.
- The consumer or caller completes a four-item satisfaction survey.

When completing the hotline staff portion of the survey:

- Be sure to ask each consumer if they have already taken the survey. We only want one survey per consumer.
- Item 5c asks for "Birth Month/Year." Do not record day of birth because that could potentially be considered protected health information.

## What do we do with the surveys after they have been collected?

**No later than September 19, 2008:**

- 1) Complete the "Consumer Satisfaction Summary Page" describing your data collection procedures and return it directly by mail, fax, or email to:

Eric Booth  
314 H.C. Dulie Bell Bldg.  
Public Policy Research Institute  
Texas A&M University  
College Station, Tx. 77843-4476

Email: EBooth@ppri.tamu.edu  
Phone: 979.458.0620  
Fax: 979.845.0249

- 2) If you administer the survey on paper, seal the completed surveys in envelopes or boxes. Label each box "1 of   N  ", "2 of   N  ", etc., and mail them to the address below.

Eric Booth  
314 H.C. Dulie Bell Bldg.  
Public Policy Research Institute  
Texas A&M University  
College Station, Tx. 77843-4476

Email: EBooth@ppri.tamu.edu  
Phone: 979.458.0620  
Fax: 979.845.0249

It is strongly advised that you get a tracking number to help locate boxes if they get lost.

### **What will be done with the data?**

After the paper and online survey results are combined and analyzed,

- Results will be summarized in a report on CSR being prepared for the Texas Legislature. The report will be finalized in November, 2008.
- No individual LMHAs will be identified in this report.

This survey represents the "baseline" data collection period reflecting consumer satisfaction during the early months of CSR implementation.

- You will be asked to help with second survey during late summer of 2009 to see if consumer satisfaction levels increase as CSR services are more fully implemented and refined.

### **Who can I contact if I have questions?**

If you have questions or comments about any aspect of this project, please feel free to contact the principal investigators at Texas A&M University directly:

Amanda Jensen-Doss, Ph.D.  
Department of Educational Psychology  
Texas A&M University  
(979) 845-9250  
[ajensendoss@tamu.edu](mailto:ajensendoss@tamu.edu)

Dottie Carmichael, Ph.D.  
Public Policy Research Institute  
Texas A&M University  
(979) 845-9378  
[dottie@ppri.tamu.edu](mailto:dottie@ppri.tamu.edu)

**HOTLINE PROVIDER SUMMARY PAGE**  
**2008 Hotline Satisfaction Survey**

**INSTRUCTIONS**

The purpose of this form is to provide information about how the 2008 Hotline Satisfaction Survey was administered. This information will help the evaluation team describe the data collection procedures and may help interpret the representativeness of the findings

**No later than September 19, 2008, this form should be completed and forwarded by mail, fax, or email to:**

Eric Booth  
314 H.C. Dulie Bell Bldg.  
Public Policy Research Institute  
Texas A&M University  
College Station, Tx. 77843-4476

Email: EBooth@ppri.tamu.edu  
Phone: 979.458.0620  
Fax: 979.845.0249

**At the same time, if you administer the surveys on paper, mail the completed Hotline Satisfaction Surveys to DSHS at the following address:**

Liang Y. Liu, Ph.D.  
Decision Support Unit  
Mental Health & Substance Abuse Program Services  
Texas Department of State Health Services  
909 W. 45th Street, Mail Code 2018  
P.O. BOX 149347  
Austin, Texas 78714-9347

- 
1. Hotline Provider Organization Name: \_\_\_\_\_
  2. Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  3. Dates of active survey collection
    - a. Beginning Date: \_\_\_\_\_
    - b. Ending Date \_\_\_\_\_
  4. How many hotline calls meeting criteria for the survey during the dates of active survey collection were classified as emergent, urgent, or other?
    - a. Emergent Calls Received: \_\_\_\_\_
    - b. Urgent Calls Received: \_\_\_\_\_
    - c. Other Calls Received: \_\_\_\_\_
  5. Total number of Hotline Satisfaction Surveys administered on paper (if applicable): \_\_\_\_\_
  6. Date surveys were mailed (if applicable): \_\_\_\_\_



## HOTLINE SATISFACTION SURVEY

### ***THIS PAGE COMPLETED BY HOTLINE STAFF***

**[NOTE: Complete this page for all eligible respondents (see Instructions), even if the survey is not conducted].**

1. Hotline Provider Organization Name: \_\_\_\_\_

2. Hotline classification of call

- Emergent
- Urgent
- Other calls requiring a mental health crisis service response or follow-up

3. Action taken (please select all that apply)

- Crisis resolved by phone
- Referred consumer to LMHA during regular business hours
- Activated LMHA staff on call
- Referred to Emergency Room
- Referred to other agency (e.g., private psychiatric facility, substance abuse services)
- Called Emergency Service Dispatcher
- Other \_\_\_\_\_

4. Consumer Information

a. Current MHMR Client?	b. Sex	c. Date of Birth	d. County of Call Origin
Yes            1	Male            1	_____/_____ Month        Year	
No             2	Female        2		

5. If you chose NOT to administer the survey, please indicate why. Check all that apply:

- Clinically Inappropriate
- Hotline worker needed to take another call
- Other \_\_\_\_\_

[If attempt WAS made to complete the survey, continue]

6. When is this survey being administered?

- At the end of the initial hotline call
- During a follow-up call \_\_\_\_\_ days following the initial call

7. Is this survey being administered by the same hotline worker who took the original call?

- Yes
- No

8. Person participating in survey:

- Consumer
- Consumer friend or family member

# HOTLINE SATISFACTION SURVEY

INSTRUCTIONS: Bolded text should be read to caller

We are interested in learning about your experiences using the emergency hotline. We would like you to answer a few questions about your satisfaction with the hotline. Have you completed a survey like this in the past week or so?

[IF YES]:            Already participated previously            1            [STOP HERE: **OK. Thanks for your participation. I won't need you to complete it again.**]

[IF NO, Continue]:

Answering these questions will take no more than a few minutes. Your answers to these questions and some information about your call, but no information that can identify you, will be provided to the Texas Department of State Health Services and researchers at Texas A&M University. You are not required to answer these questions and you can skip any questions you are not comfortable answering. Would you mind answering four brief questions?

Yes, will answer questions            2  
No, will not answer questions            3 [STOP HERE]

Do you have any questions before we begin? *[Answer any questions]* Please tell me how much you agree with the following statements: *[Circle the number to indicate response.]*

1. I called the hotline because I thought I or someone I am close to might hurt themselves or others. Do you:

<b>Strongly Agree</b>	<b>Agree</b>	<b>Have No Opinion</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	Refused Response
5	4	3	2	1	0

2. The hotline helped keep that person safe or helped prevent harm to others. Do you:

<b>Strongly Agree</b>	<b>Agree</b>	<b>Have No Opinion</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	Refused Response
5	4	3	2	1	0

3. If I or someone I am close to had a similar problem in the future, I would use this hotline again. Do you:

<b>Strongly Agree</b>	<b>Agree</b>	<b>Have No Opinion</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	Refused Response
5	4	3	2	1	0

4. The plan that the hotline worker came up with to keep me or others safe was the right one. Do you:

<b>Strongly Agree</b>	<b>Agree</b>	<b>Have No Opinion</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	Refused Response
5	4	3	2	1	0

That's all the questions I have. Thank you for participating in this survey.

**Appendix D: Characteristics of Individuals Included vs.  
Excluded from Crisis Hotline and Crisis Service User Surveys**



**Tests for Significant Differences between Individuals  
Included vs. Excluded from the Crisis Hotline and Crisis Service User Surveys**

	Hotline Survey			Crisis User Survey		
	Respondents Included in Survey Sample	Respondents Excluded from Survey Sample	p-value	Respondents Included in Survey Sample	Respondents Excluded from Survey Sample	p-value
<b>Descriptor</b>			ns			
% Males			ns			
Average Age			ns	33	37	0.0001
% White	--	--	--	51%	58%	0.003
% Urban			ns	58%	48%	0.003
% Consumer took the survey (rather than family or friend)			ns	83%	92%	0.003
% Current MHMR Client			ns	--	--	--
% Survey was administered by someone with a clinical role in the case	--	--	--	39%	72%	0.00001
<b>Action Taken</b>			ns			
Crisis Resolved by Phone			ns	--	--	--
Referred to LMHA DBA			ns	--	--	--
Activated LMHA staff on call			ns	--	--	--
Referred to ER			ns	--	--	--
Referred to Other Agency			ns	--	--	--
Called Emergency Services Dispatcher			ns	--	--	--
% Other Action	18%	34%	0.008	--	--	--
<b>Service Provided</b>						
% MCOT	--	--	--			ns
% Outpatient	--	--	--			ns
% Respite/Residential	--	--	--	17%	11%	0.001
% Private Hospital	--	--	--	6%	12%	0.0001
% State Hospital	--	--	--	4%	11%	0.0001
Other	--	--	--			ns



**Appendix E: 2008 Crisis Service User Survey**



## CRISIS CONSUMER SATISFACTION SURVEY

### Instructions to LMHAs

The Department of State Health Services (DSHS) is currently sponsoring a statewide evaluation of the impacts of the Crisis Services Redesign (CSR) initiative on stakeholder satisfaction. Because it is particularly important to include consumer perspectives in this study, DSHS is asking Local Mental Health Authorities (LMHAs) to assist in a survey of crisis service recipients. The survey was developed and will be analyzed by the statewide CSR evaluation team at Texas A&M University. Data entry will be conducted at DSHS.

Instructions for collecting the survey data are provided below. Please try to follow these guidelines as closely as possible, though we understand some adaptation may be necessary to accommodate your local organizational structure and procedures. Please note any significant variations in administrative procedures on the LMHA Summary Page found at the end of this document. This information will assist the evaluation team in describing the data collection methods and interpreting the data obtained from this survey.

### When is the survey to be conducted?

Survey data should be collected during the one-week period from September 8 to September 14, 2008.

### Should the survey be given during a crisis service contact or during a follow-up contact?

Every consumer receiving any type of crisis service during a one-week period should be surveyed. Clinics can make the choice whether to administer the survey at the time of crisis service delivery, or to follow up on all crisis service recipients from a period two weeks prior.

- **If the survey is administered at the time of crisis service delivery**, include all consumers receiving any type of crisis service between September 8 and September 14, 2008.
- **If the survey is administered in a follow-up interview AFTER crisis service delivery**, respondents should include all consumers receiving any type of crisis service between August 25 and August 31, 2008.
  - The data collection should still occur during the one-week period from September 8 to September 14, 2008.

Indicate the method used in Item 8 of the Staff portion of the survey.

### Which consumers are to be included in the survey?

Include **all crisis service recipients** regardless of their authorized Service Package or type of crisis service received.

- In addition, **please identify all consumers enrolled in Service Package 5 on the first day of the week the sample is selected** (either September 8<sup>th</sup> or August 25<sup>th</sup>) and include these individuals in the survey. If necessary, the survey can be administered to these individuals by phone.

Collect only ONE survey per crisis service recipient.

## How should I prepare to administer the survey?

- 1) Identify the appropriate centers within your agency where crisis services might be delivered.
- 2) Determine who will be responsible for administering the survey.
  - To ensure survey responses are objective, you may wish to have a Quality Management or Client Rights staff person administer the instrument.
- 3) At least two weeks before the September 8 beginning of the data collection period, notify staff at each crisis service delivery location about the surveys. You might wish to:
  - Discuss the survey at a regular planning meetings or staffings.
  - Designate one individual to supervise data collection at each location.
  - Distribute survey so staff can practice and become familiar with the instrument.
- 4) Make sure all crisis staff have clear instructions on:
  - Who is responsible for administering the survey (i.e., clinical staff, clerical staff, other)
  - Who should be surveyed (i.e., all crisis service recipients)
  - How data collection should be integrated with crisis service delivery.
- 5) Distribute sufficient English and Spanish copies of the survey to each service delivery location a few days in advance of September 8. When reproducing forms:
  - **Type the LMHA name** into the appropriate blank on the original so that it is consistently entered on all instruments.
  - **Make 2-SIDED COPIES** for the approximate number of crisis consumers you expect to encounter in a week. This will ensure the two pages of the survey do not get separated.

## What do staff need to be aware of when administering the survey?

There are two parts to the survey:

- LMHA staff provide descriptive information about the consumer and the type of crisis services received.
- The consumer completes an eight-item satisfaction survey.

When completing the LMHA staff portion of the survey:

- Be sure to ask each consumer if they have already taken the survey before you administer it. We only want one survey per consumer.
- Complete items 1-10 for every eligible respondent, even if a survey is not successfully completed by the consumer.
- Item 3 asks for you to mark all crisis services received “since the beginning of the current crisis episode.” You should therefore record all services connected to the same crisis event, including those delivered before the date of survey administration.
- Item 6c asks for “Birth Month/Year.” Do not record day of birth because that could potentially be considered protected health information.

If the consumer is not able to complete the survey, it may be completed by a friend or family member who has been involved in helping the consumer during the crisis.

When consumers complete the satisfaction portion of the survey, please provide:

- A quiet, private place to complete the survey.
- Access to someone who can answer questions.
- A central location where they can hand in the completed survey to someone who is not their clinician (e.g., a receptionist).
- If this is not possible (e.g., the services are delivered in the community), please provide the consumer with an envelope to seal the completed survey for privacy. You may wish to provide all consumers with an envelope to seal completed surveys for privacy.

## **What do I do with the surveys after they have been collected?**

### **No later than September 19, 2008:**

- 1) Complete the "Crisis Consumer Satisfaction Summary Page" describing your data collection procedures and return it directly by mail, fax, or email to:

Eric Booth  
314 H.C. Dulie Bell Bldg.  
Public Policy Research Institute  
Texas A&M University  
College Station, Tx. 77843-4476

Email: EBooth@ppri.tamu.edu  
Phone: 979.458.0620  
Fax: 979.845.0249

- 2) Seal the completed surveys in boxes. Label each box "1 of   N  ," "2 of   N  ," etc., and mail them to the address below. It is strongly advised that you get a tracking number to help locate boxes if they get lost.

Liang Y. Liu, Ph.D.  
Decision Support Unit  
Mental Health & Substance Abuse Program Services  
Texas Department of State Health Services  
909 W. 45th Street, Mail Code 2018  
P.O. BOX 149347  
Austin, Texas 78714-9347

## **What will be done with the data?**

After the survey results have been entered by DSHS staff, the data file will be sent to the Texas A&M University evaluation team for analysis.

- Results will be summarized in a report on CSR being prepared for the Texas Legislature. The report will be finalized in November, 2008.
- No individual LMHAs will be identified in this report.

This survey represents the “baseline” data collection period reflecting consumer satisfaction during the early months of CSR implementation.

- You will be asked to help with second survey during late summer of 2009 to see if consumer satisfaction levels increase as CSR services are more fully implemented and refined.

### **Who can I contact if I have questions?**

Please feel free to contact the principal investigators at Texas A&M University directly:

Amanda Jensen-Doss, Ph.D.  
Department of Educational Psychology  
Texas A&M University  
(979) 845-9250  
[ajensendoss@tamu.edu](mailto:ajensendoss@tamu.edu)

Dottie Carmichael, Ph.D.  
Public Policy Research Institute  
Texas A&M University  
(979) 845-9378  
[dottie@ppri.tamu.edu](mailto:dottie@ppri.tamu.edu)

**LMHA SUMMARY PAGE**  
**2008 Crisis Consumer Satisfaction Survey**

**INSTRUCTIONS**

The purpose of this form is to provide information about how the 2008 Consumer Satisfaction Survey was administered in your LMHA. This information will help the evaluation team describe the data collection procedures and may help interpret the representativeness of the findings.

**No later than September 19, 2008, this form should be completed and forwarded by mail, fax, or email to:**

Eric Booth	Email: EBooth@ppri.tamu.edu
314 H.C. Dulie Bell Bldg.	Phone: 979.458.0620
Public Policy Research Institute	Fax: 979.845.0249
Texas A&M University	
College Station, Tx. 77843-4476	

**At the same time, mail the completed Consumer Satisfaction Surveys to DSHS at the following address:**

Liang Y. Liu, Ph.D.  
Decision Support Unit  
Mental Health & Substance Abuse Program Services  
Texas Department of State Health Services  
Mail Code 2018  
909 W. 45th Street  
Austin, Texas 78751-2803

- 
1. LMHA Name: \_\_\_\_\_
  2. Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  3. Dates of active survey collection
    - a. Beginning Date: \_\_\_\_\_
    - b. Ending Date: \_\_\_\_\_
  4. Number of consumers at your LMHA enrolled in SP0 and SP5 on the first day of the sampling period (i.e., either September 8, 2008 or August 25<sup>th</sup>, 2008):
    - a. Number in SP0: \_\_\_\_\_
    - b. Number in SP5: \_\_\_\_\_
  5. Number of separate crisis service delivery locations where data was collected: \_\_\_\_\_
  6. Total number of people receiving a crisis service during the data collection period: \_\_\_\_\_
  7. Total number of Consumer Satisfaction Surveys collected and mailed to DSHS: \_\_\_\_\_
  8. Date surveys were mailed: \_\_\_\_\_



**THIS PAGE COMPLETED BY LMHA STAFF**

**[NOTE: Before administering, confirm verbally that the consumer has not already completed the survey. Complete this page for all eligible respondents (see Instructions), even if the survey is not conducted]**

1. LMHA Name: \_\_\_\_\_
2. Crisis Services received by this consumer since the beginning of the current crisis episode (select all that apply):
- Mobile Crisis Outreach Team Services 1
  - Office-based Outpatient Crisis Services 2
  - Crisis Respite or Crisis Residential or Crisis Stabilization Unit 3
  - Inpatient Hospitalization- Private 4
  - Inpatient Hospitalization- State 5
  - Other: \_\_\_\_\_ 9

3. Consumer's current crisis service package
- |                           |   |                                |   |
|---------------------------|---|--------------------------------|---|
| Adult Service Package 0   | 1 | Children's Service Package 0   | 4 |
| Adult Service Package 1-4 | 2 | Children's Service Package 1-4 | 5 |
| Adult Service Package 5   | 3 | Children's Service Package 5   | 6 |

4. After this crisis is resolved, will this person be eligible to receive ongoing mental health services from your LMHA?
- Yes 1
  - No 2
  - Still to be determined 3

5. Consumer Demographic Information

a. Sex		b. Ethnicity		c. Birth Month/Year		d. County of Residence
Male	1	Black	1	_____/_____ Month Year	_____	_____
	Female	2	Hispanic			
White			3			
Asian			4			
Mixed/Other			5			
		Unknown	6			

6. If you chose not to administer the survey, please indicate why:
- Clinically inappropriate 1
  - Other: \_\_\_\_\_ 9

[If attempt WAS made to complete the survey, continue]

- |   |   |
|---|---|
| <p>7. Person completing the measure:</p> <ul style="list-style-type: none"> <li>Consumer 1</li> <li>Consumer family member 2</li> <li>Friend/Associate 3</li> <li>Other: _____ 9</li> </ul> | <p>8. When is this survey being administered?</p> <ul style="list-style-type: none"> <li>At the time of a crisis service contact 1</li> <li>During a follow-up contact _____ days following the initial crisis episode 2</li> </ul> |
| <p>9. Is this survey being administered by someone who has a clinical role in this case?</p> <ul style="list-style-type: none"> <li>Yes 1</li> <li>No 2</li> </ul>                          | <p>10. How is this survey being administered?</p> <ul style="list-style-type: none"> <li>Participant is completing it in writing 1</li> <li>Survey read to the participant either in person or over the phone 2</li> </ul>          |

## CRISIS CONSUMER SATISFACTION SURVEY

**DIRECTIONS:** You are being asked to fill out this questionnaire because we are interested in learning about your satisfaction with the services you or your friend or family member received during a recent mental health emergency. If you have any questions about which services we are asking you about or about anything else, please ask the person who gave you this survey.

If you have already taken this survey, please tell the person who gave it to you; do not complete it more than once.

It should only take a few minutes to fill out this survey. Your answers to these questions and some information about your personal characteristics (such as your age and gender) and service use (such as which clinic services you have used), but no information that can identify you, will be provided to the Texas Department of State Health Services and researchers at Texas A&M University. You are not required to answer these questions and you can skip any questions you are not comfortable answering.

**MENTAL HEALTH SERVICES:** The next four questions are about services received from the mental health system. Please circle a number to show how much you agree with the following:

1. I or someone I am close to needed to receive this help because I/they might have hurt themselves or others.

Strongly Agree	Agree	Have No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

2. The crisis services helped keep me or that person safe or prevented harm to others.

Strongly Agree	Agree	Have No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

3. If I or someone I am close to had a similar problem in the future, I would use these services again.

Strongly Agree	Agree	Have No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

4. I or someone I am close to received the types of help I thought were needed.

Strongly Agree	Agree	Have No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

**OTHER SERVICES:** We are interested in hearing about other people or agencies that might have helped you during this emergency. Please tell us how helpful each of the following were:

	Not Involved	Not Helpful at All	Somewhat Helpful	Very Helpful
5. Police/Sheriff	0	1	2	3
6. Emergency Room	0	1	2	3
7. Judges/Courts	0	1	2	3
8. Schools	0	1	2	3

[STOP HERE. Thank you for providing this useful information!]