



## Evaluation Findings for the Crisis Services Redesign Initiative



Report to the Texas Department  
of State Health Services

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**Public Policy Research Institute**  
329 H.C. Dulie Bell Bldg.  
4476 TAMU  
College Station, TX 77843-4476  
(979) 845-8800



# Authors

**Dottie Carmichael, Ph.D.**  
***Research Scientist***  
Public Policy Research Institute  
Texas A&M University

**Amanda Jensen-Doss, Ph.D.**  
***Assistant Professor***  
Department of Psychology  
University of Miami

**Eric Booth, M.A.**  
***Research Associate***  
Public Policy Research Institute  
Texas A&M University

**Miner P. Marchbanks III, Ph.D.**  
***Assistant Research Scientist***  
Public Policy Research Institute  
Texas A&M University

**David Ellis, Ph.D.**  
***Research Scientist***  
Texas Transportation Institute  
Texas A&M University System



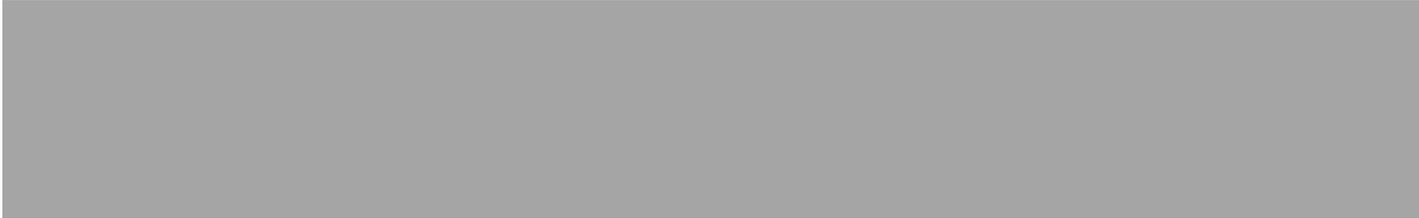
# Table of Contents

Report Summary .....	i
Recommendations .....	iii
Acknowledgements.....	v
Executive Summary.....	vii
Introduction .....	1
Methodology.....	3
Finding 1.....	9
Finding 2.....	21
Finding 3.....	29
Finding 4.....	37
Finding 5.....	45
Finding 6.....	59
Finding 7.....	65
Finding 8.....	79
Finding 9.....	91
Finding 10.....	99
Conclusions and Recommendations .....	109
Endnotes .....	117





## **Table of Appendices**



Appendix A: Methodological Notes for Stakeholder Survey and Care Data Analysis

Appendix B: Description of Local Treatment Alternatives

Appendix C: Crisis Hotline User Survey Materials

Appendix D: Crisis Service User Survey Materials

Appendix E: Description of Survey Respondents



## REPORT SUMMARY

The purpose of this report is to summarize the findings resulting from a two-year evaluation of Crisis Services Redesign (CSR). Evaluation results suggest the following ten findings:

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

**Finding 2:** Since CSR, more crisis consumers are being served than ever before, and they are more likely to receive treatment in a community setting.

**Finding 3:** Direct and measurable reductions in cost of services associated with crisis redesign more than cover the cost of the program, even while supporting a 24% increase in crisis episodes from 2007 to 2008.

**Finding 4:** 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 5:** Crisis hotline users remain generally pleased with the help received while users of other types of crisis services reported lower rates of satisfaction in 2009.

**Finding 6:** Changing characteristics of the crisis user population since CSR may require an adaptive response from LMHAs if the needs of new crisis consumers are to be met.

**Finding 7:** Community partners perceive some positive impacts of CSR, but further improvements are needed.

**Finding 8:** Increasing numbers of crises continue to place burdens on law enforcement agencies and emergency rooms.

**Finding 9:** Communities with engaged and informed stakeholders seem to be implementing CSR more effectively, although many communities continue to have difficulty collaborating.

**Finding 10:** Community partners must commit to resolve issues impacting the success of CSR.



## RECOMMENDATIONS

This report presents the findings of a two-year evaluation of the Crisis Services Redesign initiative. The study points to seven recommendations:

**Recommendation 1. The types of changes implemented under Crisis Services Redesign are appropriate to the goals of the funding and merit continued support.**

The evaluation shows CSR funds are being used as intended to improve local crisis infrastructure. Communities have developed new capacity to provide intensive intervention to consumers with urgent needs in their own community. This new capacity is effectively reducing the need for more intensive care in a higher cost setting. The percentage of crises involving hospitalization has fallen from 17% to 13%. More people than ever before are receiving crisis intervention locally and at a lower cost per crisis episode than before CSR.

**Recommendation 2. Further investigation is needed to better understand and address declining satisfaction among crisis service users.**

Although crisis hotline users are generally satisfied with the help they receive, users of other types of crisis services are reporting much lower satisfaction with every type of treatment service except private hospitalization and “other” services. The reasons for this decline are not well understood, but they appear to be related to the changing nature of the crisis service user population. Further study is needed to better understand this population and their service needs to determine if a policy response is needed.

**Recommendation 3. Steps must be taken to help community partners such as law enforcement, emergency rooms, and judges accommodate the growing number of crisis consumers.**

The number of crisis consumers served has increased from 52,000 in 2007 to a projected 98,000 in 2009. This level of increase over a two year period has placed stresses on all service systems involved. While the mental health system has invested in an entire new infrastructure to accommodate this rising demand, law enforcement agencies, emergency rooms, and courts continue to operate at previous resource levels. In the absence of further investment in measures to help LMHA partners deal with the growing number of crisis cases, there is a risk of burnout and alienation within community support networks statewide.

**Recommendation 4. LMHAs must increase their efforts to engage a broader range of stakeholders in the CSR process.**

Many community partners report declining satisfaction with crisis redesign. Importantly, satisfaction is greatest among respondents from agencies that are actively involved in local CSR planning and implementation. Although LMHAs perceive that they have successfully engaged a broad range of stakeholders in the CSR planning and implementation process, stakeholders report the opposite. It is recommended that LMHAs continue to work toward generating creative strategies to foster information exchange and collaboration, particularly strategies that can reach a larger number of stakeholders.

**Recommendation 5. The extraordinary growth in mental health crisis services has not been adequately balanced by comparable investment in DSHS’ ongoing Resiliency and Disease Management (RDM) services.**

Crisis redesign is a prominent factor creating rising demand for routine mental health services. Caseloads are projected to rise 21% in 2009 alone. While new state funding has expanded and improved services for people in mental health crisis, treatment costs are no longer covered by the new CSR-related funding streams once these same individuals enroll for routine long-term care. Without renewed investment in the original RDM system of maintenance care, CSR may inadvertently evolve into

a system in which access to non-crisis care is limited, and people predominantly get help only after decompensating into crisis.

**Recommendation 6. Enhancements to supportive services provided by community partners would help reinforce the success of CSR.** At least two important challenges to crisis service delivery 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. Second, the number of officers specializing in mental health should be increased among law enforcement agencies.

**Recommendation 7. Efforts should be made to provide better information to stakeholders clarifying the legal code regarding processing of crisis cases.** In interviews, it was apparent that stakeholders often held very different understandings of the laws surrounding the processing of mental health crisis cases. Clarification of the statutes might help improve collaboration between agencies by fostering a common understanding of these important issues.

## ACKNOWLEDGEMENTS

There are many organizations and individuals who have contributed to this evaluation of 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 during the first year of evaluation due to Hurricane Ike, staff at affected LMHAs 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. Staff at each of these centers helped evaluators gain a thorough understanding of mental health crisis services in their community. 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

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. These 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 140 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. Additionally, approximately 2000 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 conferences 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 graduate students: Molly Gasbarrini, Leticia Osterberg, Carly Peterson, and Jessica Hoskins. These doctoral students 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. Tiffany McCann and Megan McIntire of the Public Policy Research Institute assisted in the development of a number of graphics and tables and 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

### **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 are now available at all LMHAs.
  - MCOTs provide crisis assessment and treatment in the community for people in mental health crisis as well as close monitoring and preventive services to help avoid relapse.
  - MCOTs are designed to operate differently across communities depending on local service infrastructure and consumer needs.
- LMHAs are adding facilities and procedures to reduce the volume of consumers seen in emergency rooms. Nonetheless, staff report the proportion of crisis cases involving contact with emergency rooms has not declined.
  - Increasing access to alternative psychiatric and medical screening sites may not be able to fully offset the use of emergency rooms given that the number of consumers seeking crisis care has risen 88% since the 2007 pre-CSR baseline.
  - About 70% of medical evaluations in preparation for psychiatric hospitalizations are still conducted in emergency rooms.
  - It is possible that a certain fixed proportion of mental health crisis service users have a true medical need making it unavoidable that a constant percentage of individuals will require emergency room contact.
  - Further research is needed to better understand the factors impacting continued emergency room usage and to determine if feasible alternatives for reducing mental health burden on emergency rooms can be developed in the future.
- Communities around the state have significantly increased community-based mental health treatment as an alternative to state hospitalization.
  - More than half of all LMHAs have used crisis funds to add at least one new local treatment option.
  - Communities are adding capacity that is tailored to their local consumer and service environment.
  - Telepsychiatry is being used as a cost-effective way to expand crisis service delivery in some communities.

### **Finding 2: Since CSR, more crisis consumers are being served than ever before, and they are more likely to receive treatment in a community setting.**

- Since the introduction of crisis redesign, the total number of individuals experiencing crisis has risen 87%, and the total number of crisis services delivered has more than doubled.
  - A major reason for this increased demand is the introduction of two new treatment Service Packages targeting individuals who are not currently enrolled in LMHA services and who are not required to meet DSHS traditional priority population criteria for service eligibility.
- In order to serve this rising volume of crisis consumers, reliance on mental health hospital treatment is being replaced with an expanded and enhanced community-based service system.

- The percentage of crisis service users entering state hospitals has declined by about 23% since CSR. However, due to the larger number of people being served, the absolute number of admissions has fallen only 3 to 5%.
- As more services are being delivered in community settings, acute care treatment has emerged as the most fundamental treatment modality underlying crisis redesign.
  - While the count of individuals served has increased in every crisis treatment category, acute care is the only area showing a substantial rise in the percentage of people served. In 2008, 78% of crisis episodes had acute care as a component, up from 58% in 2007.
  - The significant proportional increase in the use of acute care reflects the key principal that crisis care systems able to provide brief, moderately intensive intervention in the community can effectively contain many crises and reduce the need for more intensive care in a higher cost setting.
  - The most prevalent non-acute crisis services are inpatient and community residential care.

**Finding 3: Direct and measurable reductions in cost of services with crisis redesign more than cover the cost of the program, even while supporting a 24% increase in crisis episodes from 2007 to 2008.**

- An \$81 million investment in CSR over a two-year period generated treatment cost benefits of at least \$12.7 million. As a result, more consumers could be served at a lower cost per crisis episode. Specifically, \$1.16 economic impact was returned on every dollar invested.
- Although crisis service encounters increased almost 24% from 2007 to 2008, the cost per encounter was reduced by almost the same amount. As a result, total program cost decreased by 5.4% despite the increased consumer load.
- Had crisis redesign not been implemented in 2008, program costs for the two fiscal years would have been \$51.8 million higher in 2008 dollars.

**Finding 4: 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.**

- Long-term Resiliency and Disease Management (RDM) caseloads are projected to increase by 21% in 2009 as many newly engaged crisis consumers qualify for long-term services.
- As RDM caseloads rise, those who are not in crisis are being pushed back to expedite the provision of long-term supports to those who are.
  - Crisis service users who qualify for RDM are likely to be enrolled immediately, while people who are not in crisis when they seek help are increasingly told they must wait to access mental health services.
  - The proportion of consumers who enter RDM at a lower than recommended level of care is also rising for both crisis and non-crisis consumers.
  - People who are placed on an RDM waitlist or are underserved spend an average of more than two months awaiting upgraded status.

- Although a growing number of consumers are receiving delayed or reduced services, the percentage of individuals entering crisis while waitlisted has remained relatively stable over the past three years.
  - LMHAs appear to be successfully identifying consumers with sufficient supports and resiliency to postpone care. MCOTs and other LMHA staff also closely monitor waitlisted individuals for signs of stress or instability that might indicate need for an immediate service response.
- While new state funding has expanded and improved services for people in mental health crisis, once these short-term crisis service recipients enroll for routine long-term care, treatment costs are no longer covered by the new CSR-related funding streams.
  - LMHA resources are strained by expanding caseloads and rising personnel costs.
  - With limited ability to fully support all mental health consumers in need of routine care, individuals with an ability to pay receive the best service response. Since CSR, the percentage of uninsured people waitlisted upon entering RDM has more than doubled, and the percentage underserved has tripled.
- Community stakeholders also stand to benefit from increased investment in mental health maintenance services. There is broad-based consensus in literally every community stakeholder group that the lack of adequate mental health treatment services is creating a pattern of repeated crisis for some individuals.

**Finding 5: Crisis hotline users remain generally pleased with the help received while users of other types of crisis services reported lower rates of satisfaction in 2009.**

- Crisis hotline users are highly satisfied with the services received in both 2008 and 2009.
  - People who called to prevent harm, people calling on behalf of minors, and urban callers gave the highest satisfaction ratings.
  - Most hotline calls are resolved by phone, indicating hotlines are able to give many callers the help they need without activating other responders.
  - The next most common response is a referral 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.
- People using other types of crisis treatment services are less satisfied in 2009 than they were in 2008. This finding holds for virtually every type of service.
  - The greatest declines occurred for consumers receiving residential treatment where satisfaction fell 20%. People receiving state hospitalization, outpatient treatment, and MCOT services are 12%, 11% and 8% less satisfied respectively.
  - Virtually all the decline in satisfaction from 2008 to 2009 can be attributed to the subgroup of crisis service users who were not seeking help for the purpose of preventing harm to themselves or others. Among people seeking treatment for some other reason, satisfaction with the services received is low and declining.
  - In contrast, individuals who felt they needed help to prevent harm reported consistently high satisfaction ratings (above 90%) both years on all dimensions rated.
- Further study is needed to more clearly define this sub-category of dissatisfied crisis service users and to attempt to learn why they believe their service needs are not being met.

**Finding 6: Changing characteristics of the crisis user population since CSR may require an adaptive response from LMHAs if the needs of new crisis consumers are to be met.**

- The number of people who do not qualify for ongoing RDM services after the completion of a crisis episode is growing rapidly. Because RDM ineligible service users do not conform to traditional mental health enrollment criteria, little is known about their needs.
- The crisis service user survey data reveals a parallel group of consumers who are seeking crisis services for some reason other than to prevent harm to themselves or others. Again, because their concerns differ from those in a traditional mental health emergency, the exact needs of these individuals are not well understood.
  - These survey respondents are more likely to say they did not receive the help they needed. Dissatisfaction is highest for people who also fail to qualify for long-term RDM services.
- While more information is needed to draw firm conclusions, there appears to exist a potentially important subgroup of crisis service users whose needs are not fully addressed by the current service system.
- Further study is recommended to better understand these people and their concerns, and to determine if a policy response is appropriate.

**Finding 7: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

- Community partners feel LMHA crisis services have improved since the start of CSR, although global satisfaction ratings are still low in every respondent group except LMHAs.
- All stakeholder groups believe more funding is needed for CSR to have a significant impact.
- All stakeholder groups report declining satisfaction with the goals and progress being made on local crisis service plans.
- The majority of stakeholders are satisfied with crisis hotlines and satisfaction is improving over time.
- The majority of stakeholders are satisfied with MCOTs, up slightly from 2008.

**Finding 8. Increasing numbers of crises continue to place burdens on law enforcement agencies and emergency rooms.**

- Although LMHAs have enacted many changes designed to decrease burden on law enforcement agencies and emergency rooms, these efforts have generally not led to reduced reliance on these community partners.
  - Continued demands placed on community partners may be expected given the increased volume of crisis cases since the implementation of CSR.
- Demands on law enforcement agencies to provide crisis transportation have not increased as much as might be expected given the increased volume of crisis consumers.
  - Law enforcement agencies who are more knowledgeable about and actively involved in CSR are reporting greater involvement in transporting people long distances to state hospitals than are agencies who do not work closely with the LMHA.

- 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.
  - Most ER respondents 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.
  - Emergency room staffs say they have had increasing responsibility for locating state hospital beds and providing transportation to state mental health hospitals since CSR.

**Finding 9: Communities with engaged and informed stakeholders seem to be implementing CSR more effectively, although many communities continue to have difficulty collaborating.**

- Community partners who are informed and engaged in CSR are more satisfied, but LMHA have had limited success keeping local stakeholders involved in crisis service planning.
  - 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 community partners are not being successfully engaged.
- Community forums promote shared responsibility and investment of resources, although few communities use these approaches.
  - All LMHAs say they have formal mechanisms for keeping stakeholders informed about crisis services. However very few community partners are aware of these mechanisms.
- During the first year of CSR, community stakeholders felt their ability to work together with local LMHAs was improving. However, most groups report these gains have been lost in 2009.

**Finding 10: Community partners must commit to resolve issues impacting the success of CSR.**

- Several challenges to the success of CSR exist cannot be resolved by the LMHAs alone. These include:
  - 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 who must issue the warrant.
  - Reluctance of some law enforcement officers to deliver mentally ill offenders to treatment.
  - Need for more law enforcement officers with specialty mental health training.

- Reluctance of some law enforcement officers to wait with unsafe or involuntary individuals during mental health or medical screenings.
- Difficulty in some communities accessing a justice of the peace when an emergency mental health detention warrant is needed.
- Need to remove restrictions placed by some hospitals, particularly in rural areas, 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.
- Confusion and disagreement over legal requirements for crisis case processing.



## **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 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. 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." In December of 2008, 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 final evaluation report documents the progress toward achieving these goals after two years of implementation. CSR 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 continue to be made in many communities.

The following paragraphs describe the research methodology. Evidence is then presented to support ten 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 in which each stage of analysis builds 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. Specific research methods are described in detail below.

### **1. LMHA Self-Report Survey** (*April-May 2008; July-August 2009*)

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 during the first year of the evaluation. 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.

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

Based on the LMHA Self-Report Survey findings, six mental health centers were selected for site visits in order to gain an in-depth understanding of crisis redesign. 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>i</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       |

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 CSR planning process;

- 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.

### **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.

During the six site visits, LMHAs were asked to identify knowledgeable agencies and organizations with whom they collaborate closely in the implementation of CSR. In each of the six communities, contact information was acquired for partners in law enforcement, hospitals or clinics, and courts.

Graduate research assistants contacted these local stakeholders for an in-depth telephone interview. . 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. Following the initial interviews conducted in 2008, follow-up calls were 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 sent 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;

- 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;
- A purchased list of medical professionals who had affiliations with an emergency room and/or who had a specialty potentially related to mental health;
- 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.

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.

#### **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. 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.

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

Crisis services and consumer outcomes were analyzed using records found in the DSHS CARE and encounter data systems. These databases offer a means to quantify the impact of CSR on service patterns at the individual, LMHA and statewide levels.

In addition to longstanding service records, new measures have recently been developed by DSHS to track new crisis-related outcomes. Using this data, the research team examined records on MCOT activity, crisis residential and outpatient utilization, long-term service engagement, and psychiatric hospitalizations.

#### **7. Return on Investment Analysis** *(January-December, 2009)*

The Return on Investment (ROI) analysis is a comprehensive assessment of the impact of CSR on service utilization and associated costs for these services. The analysis estimates total system costs for a population of individuals who experience a crisis with the new CSR program in place, and compares these costs to a projection of total system costs that would have been observed for the same population under the pre-existing system. The difference in system costs with and without CSR represents an estimate of the direct benefits of the program in tangible monetary terms. The ROI is formulated as benefit/cost ratios (i.e., present value of program benefits divided the present value of program costs) for 2007 and 2008, and estimates of the rate-of-return on investment. The primary data source for ROI analyses is the DSHS Cost Accounting and Encounter data systems.

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





## **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:

- American Association of Suicidology (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 (ERs) for psychiatric and medical screenings; and
- Increased access to crisis mental health treatment in the community as an alternative to state hospitalization.

The evaluation examined whether progress is being made in establishing these new service capabilities. The evidence suggests implementation is largely occurring according to plan.

### **Certified Crisis Hotlines Mobilize an Appropriate Response to Mental Health Crises**

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.

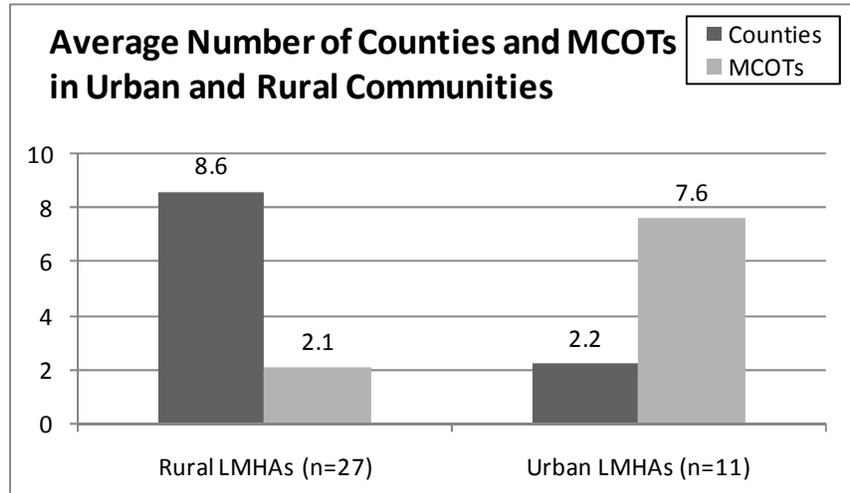
### **Mobile Crisis Outreach Teams (MCOTs) Are Strengthening Community Treatment Capacity**

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.

MCOT Coverage Differs by LMHA. MCOT services are designed and operate differently across communities. Rural LMHAs, on average, have two MCOTs to cover more than eight counties. Larger population centers have more than three times as many MCOTs to respond in two counties on

average (Figure 1.1). Nearly all LMHAs (92%) report that MCOTs provide coverage for their entire service region.

**Figure 1.1**

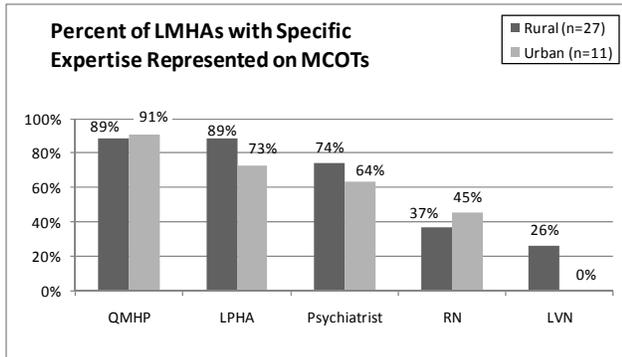


While MCOT services are available 24 hours/day in most LMHAs, they are usually only fully operational 8 to 16 hours/day on weekdays with reduced availability on weekends. Only one urban and two rural centers say their MCOT is fully mobilized 24 hours/day. The centers without 24-hour MCOT functionality (92% of LMHAs) rely on hotlines to determine when on-call staff should be activated for a face-to-face screening. In some centers, on-call personnel are members of the regular MCOT staff, but about half of LMHAs also utilize non-MCOT personnel for some after-hours assessments, particularly during off-peak hours or in remote locations.

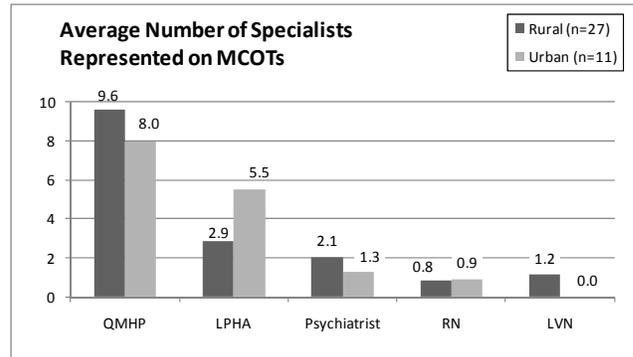
MCOTs Have Strengthened Mental Health Crisis Expertise. CSR funding has increased the number of staff available when mental health crises occur. In the past, LMHA staff often combined crisis response with other duties. With limited access to crisis responders, multiple crises were handled in sequence, often resulting in long delays. Now, MCOT personnel are dedicated entirely to crisis service delivery so the response is timely and other services are not compromised. Faster response times can help also contain the crisis, reducing the degree and cost of emergency care required.

Whereas LMHA crisis responders once focused primarily 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. This increases the likelihood that crises can be resolved in the community. Most MCOTs combine differing levels of expertise including Qualified Mental Health Professionals (QMHPs)<sup>2</sup>, Licensed Practitioners of the Healing Arts (LPHAs)<sup>3</sup>, psychiatrists, and nurses. While these are the most prevalent categories of specialization, 10 centers mentioned MCOT staff with other credentials. These include law enforcement (3 centers), psychiatric nurse practitioners or technicians (2 centers), LCDCs (1 center), or other generalists such as backup responders or support staff.

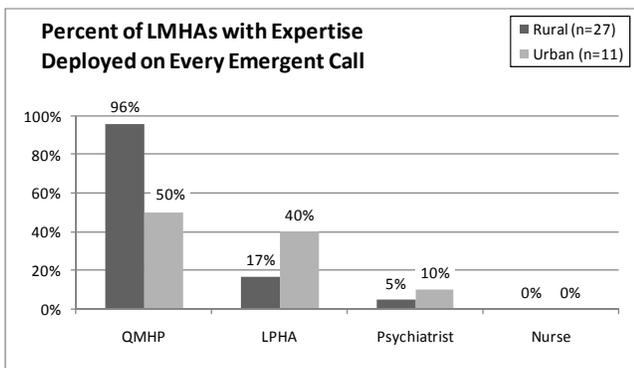
**Figure 1.2**



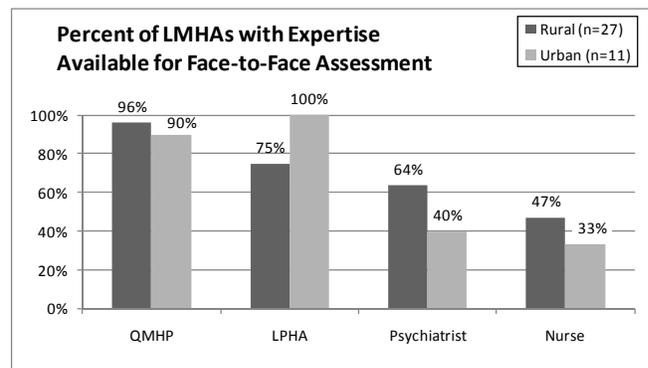
**Figure 1.3**



**Figure 1.4**



**Figure 1.5**



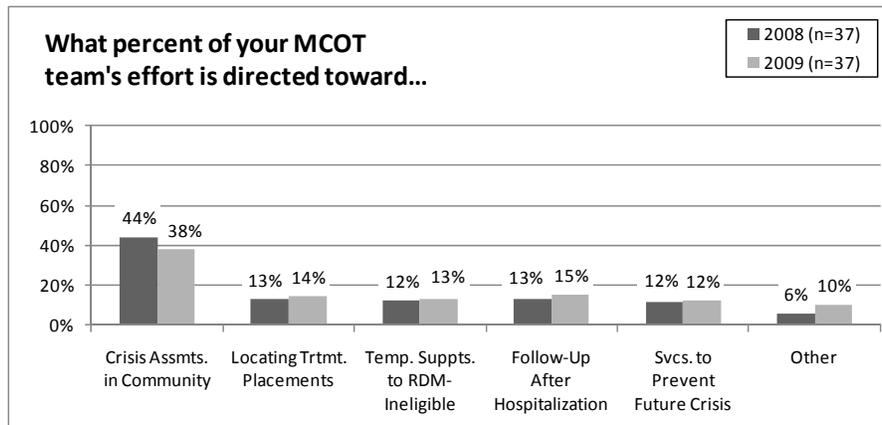
QMHPs are at the center of most day-to-day MCOT operations. They represent the largest category of MCOT personnel (Figures 1.2 and 1.3), and are the most likely to be routinely deployed on emergent calls (Figure 1.4), particularly in rural areas. In urban areas, responsibility for emergent calls is more likely to be shared between QMHPs and an LPHA or a psychiatrist. Psychiatrists are available for face-to-face crisis assessments in more than half of all centers (56%). However, given the shortage of these professionals statewide, LPHAs and QMHPs help meet this need for many mental health providers (Figure 1.5).

MCOT Activities Include Crisis Assessment, Treatment Placement, and Preventive Crisis Support Services. MCOT personnel deliver an array of services to identify and stabilize people in mental health crisis (Figure 1.6). About 40% of their effort is spent conducting crisis assessments in the community. MCOT staff are often involved in providing face-to-face emergency assessments, now available at all hours of the day or night in nearly every LMHA statewide.

In addition to helping resolve imminent crisis episodes, MCOTs also help recovering consumers regain stability and resiliency to avoid an immediate relapse. Nearly 40% of their time is spent:

- Providing temporary supports to people in crisis who are not eligible for long-term public mental health care,
- Providing support and care for vulnerable individuals in eminent danger of or immediately following a crisis, and
- Providing follow-up care for consumers recently released from a state hospitalization.

**Figure 1.6**



MCOT staff also perform other duties required for the job. These include

- Documenting and staffing cases with other team members,
- Evaluating individuals on the waiting list for RDM services for signs of deterioration,
- Educating members of the community about LMHA procedures and crisis service protocols, and
- Extensive travel to provide community-based care.

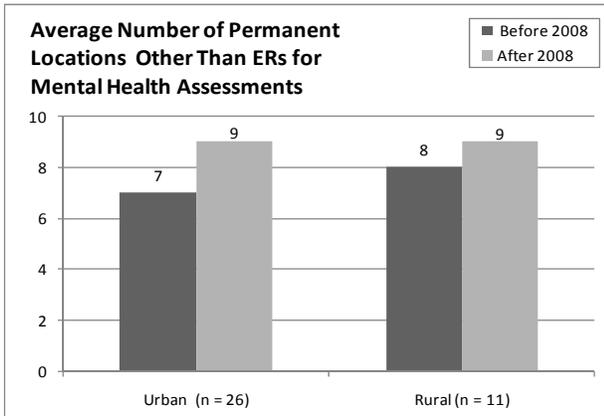
About half of MCOT team members surveyed (53%) say they also play a role in helping law enforcement officers transport consumers in the community. Overall, about one third of LMHAs provided more assistance with consumer transportation in 2009 than they did the previous year.

### **Alternatives to Emergency Rooms for Medical and Psychiatric Screenings Are Being Developed**

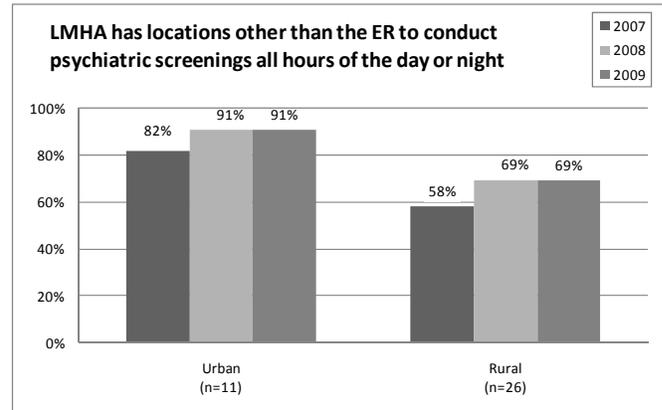
Historically, emergency rooms have been a central venue for psychiatric assessments. For years, the standard protocol in most communities has been for law enforcement officers to deliver individuals in crisis directly to emergency rooms regardless of their medical need. LMHA staff routinely met these crisis consumers at the emergency room for a mental health screening, followed by 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. CSR aspires to change this pattern.

Alternatives to Emergency Room Mental Health Screenings Are Developing. Most LMHAs are adding facilities and procedures to reduce the volume of consumers seen in ERs. Both urban and rural centers have about 9 permanent locations on average where mental health assessments can be conducted outside of emergency rooms (Figure 1.7). Although some, mostly rural, communities still lack locations other than ERs where they can conduct mental health assessments at all hours of the day or night, the majority of centers do have after-hours alternative screening sites (Figure 1.8). Half of LMHA executive directors surveyed also say they also now have at least one mental health treatment location where law enforcement can bring people in mental health crisis any time of the day or night instead of transporting them to the emergency room.

**Figure 1.7**



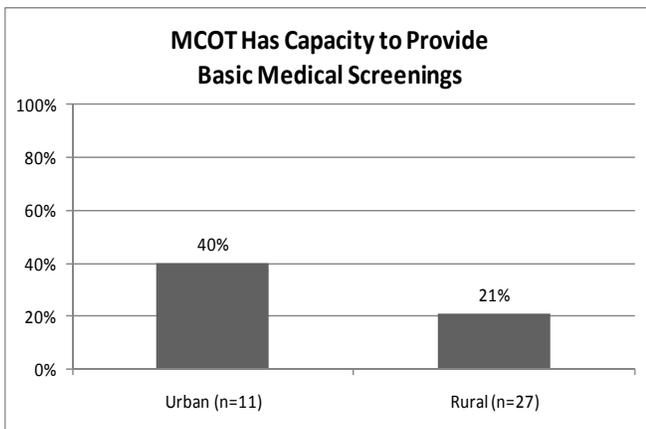
**Figure 1.8**



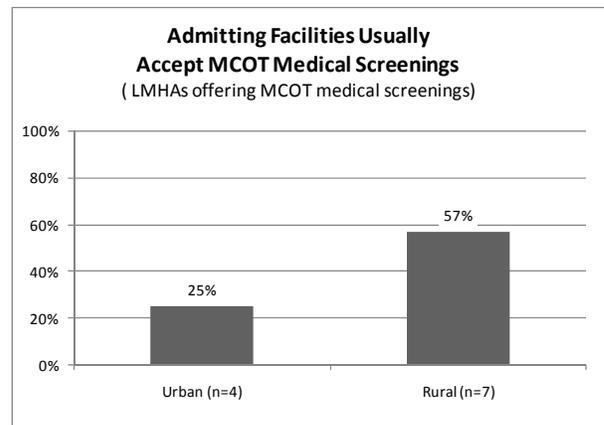
LMHAs Are Adding New Capacity for Medical Screenings Outside of Emergency Rooms. In addition to developing new sites for mental health screenings, LMHAs are also working to conduct medical screenings in other locations when appropriate. Communities adding new local treatment programs often include medical screening in the services provided, and/or request that contract treatment providers offer this service.

40% of urban MCOTS and about half as many in rural communities (21%) say they can perform basic medical screenings (Figure 1.9). However, where these screenings are available, fewer than half of all psychiatric facilities are willing to accept them (Figure 1.10). This data suggests that even when LMHAs expand their own capacity to perform medical functions, they may not be an acceptable alternative to the third-party medical screening typically performed in an emergency room.

**Figure 1.9**



**Figure 1.10**

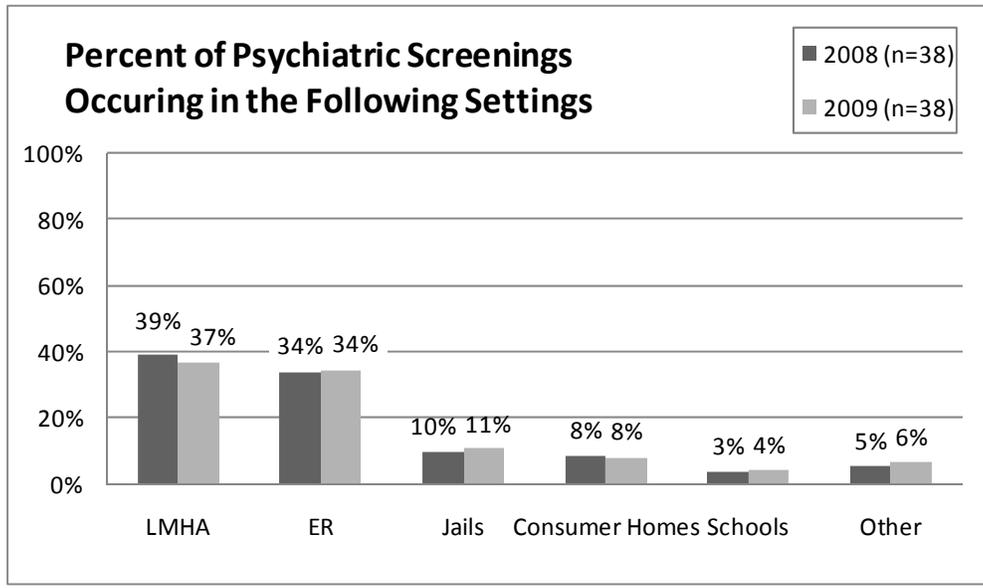


The Proportion of Cases Screened in Emergency Rooms Has Not Declined. Despite efforts to treat as many consumers as possible in other locations, LMHAs report that about one-third of psychiatric screenings continue to be held in emergency rooms (Figure 1.11). This figure has not changed in the first two years of crisis redesign. This unexpected finding may be explained by the fact that the number of individuals seeking help for a mental health crisis has risen 87% since the 2007 pre-CSR

baseline (Figure 2.1). It is no doubt challenging to reduce consumers' use of emergency rooms when confronting a large and growing demand for crisis assessments.

In addition, 70% of medical evaluations for psychiatric hospitalizations are currently conducted in emergency rooms, accounting for up to 8,000 ER visits in 2008 alone<sup>4</sup>. It is not clear whether it may be possible to reduce emergency-room based medical screening for hospitalized consumers. On the one hand, this highest need group of crisis service users may, in fact, be more prone to health concerns necessitating all medical caution before state hospitalization. On the other hand, if most screenings are precautionary rather than in response to acute need, it may be possible to use qualified LMHA staff (e.g., RNs) where they are available, contract with private providers, or conduct health screenings in conjunction with the state hospital admission process. Solutions such as these would shift costs for routine medical clearance away from emergency rooms and onto the mental health system.

**Figure 1.11**



It is also possible that about one-third of individuals in mental health crisis have a true medical need across the board. If true, it would be unavoidable that this approximate proportion of cases will require emergency room contact. This evaluation has not gathered information about the specific factors explaining emergency room usage patterns at the consumer level. Further study would potentially generate answers to this important question and increase the likelihood that feasible alternatives for reducing mental health burden on emergency rooms can be developed in the future.

**Expanded Local Treatment Services Offer Alternatives to State Hospitalization**

A cornerstone of crisis redesign 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 are more willing to accept voluntary commitments in their own community.

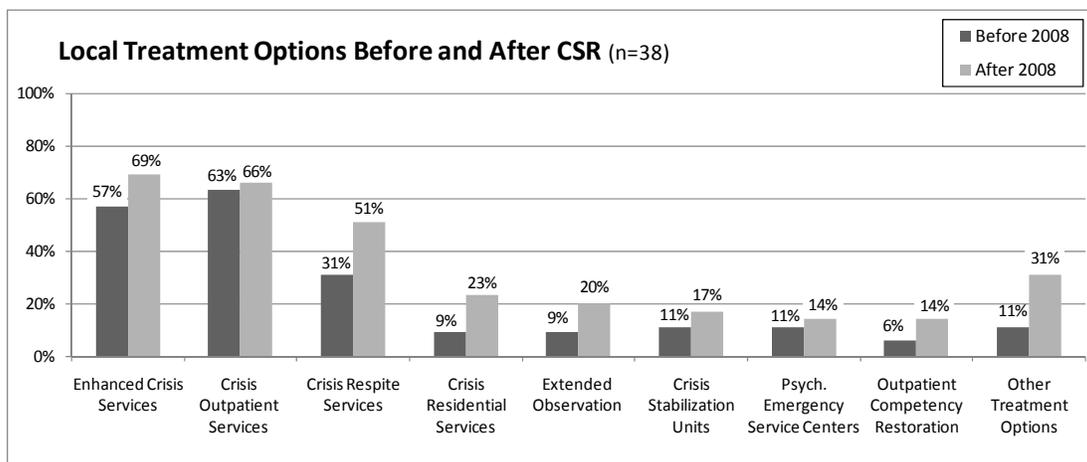
- Clinical outcomes may be better for individuals hospitalized near friends and family who can lend support during recovery.

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. In addition to expanding service capacity through their base allocations, LMHAs were also invited to apply for separate competitive crisis service funding. In 2008, thirteen centers received competitive awards to establish or enhance local psychiatric emergency facilities. Five centers received additional competitive allocations to provide outpatient treatment to people who have been found incompetent to stand trial. As a result of this investment, mental health providers have expanded and diversified infrastructure to treat mental health crisis consumers in their own community.

LMHAs Have Expanded the Breadth and Diversity of Local Treatment Options. More than half of all LMHAs used crisis funds to add at least one new local treatment choice. Seven urban communities introduced 3 new programs each, on average. Thirteen rural centers added 2 programs each on average.

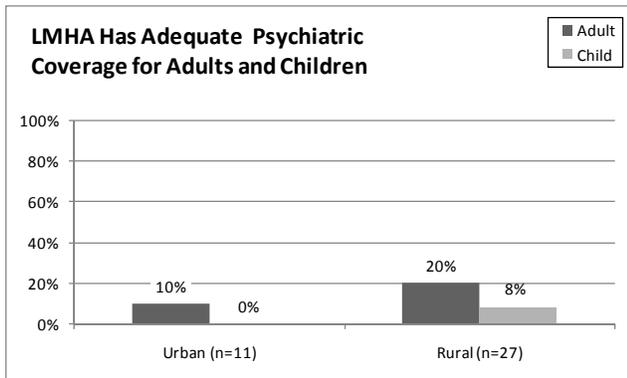
Rather than adopting a uniform approach to building local treatment capacity, communities are choosing solutions that are tailored to the unique local consumer and service environment. Figure 1.12<sup>5</sup> illustrates a pattern of small increases across a variety of treatment categories, suggesting LMHAs are making targeted selections. The largest number of centers (n=7) added new crisis respite capacity, with half of all LMHAs statewide now offering this option. Only a few centers have added office-based outpatient services, which were already prevalent before crisis redesign.

**Figure 1.12**

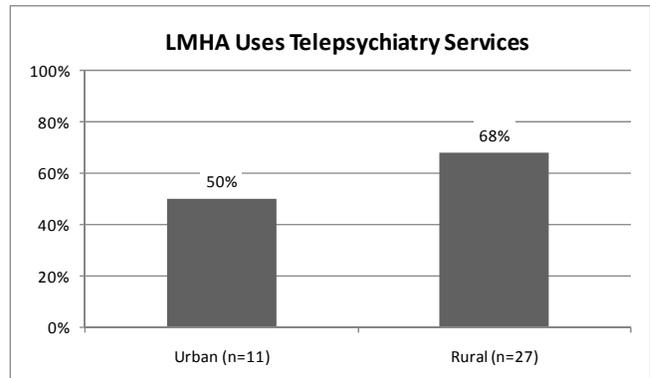


Local Treatment Options Are Being Enhanced Through Telepsychiatry. Another way in which LMHAs are expanding their ability to deliver both crisis and non-crisis services is through the use of telepsychiatry. Only 6 LMHAs (5 rural, 1 urban) report having adequate psychiatric coverage for adults and only 2 (both rural) say they have sufficient child psychiatric expertise (Figure 1.13). More than half of all community mental health centers therefore at least partially rely on telepsychiatric services to make up this shortfall (Figure 1.14), though the percentage of all psychiatric services provided through telemedicine is less than 25% (Figure 1.15).

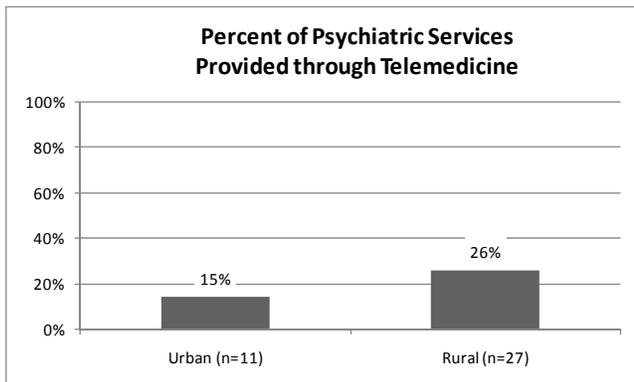
**Figure 1.13**



**Figure 1.14**



**Figure 1.15**



**Figure 1.16**

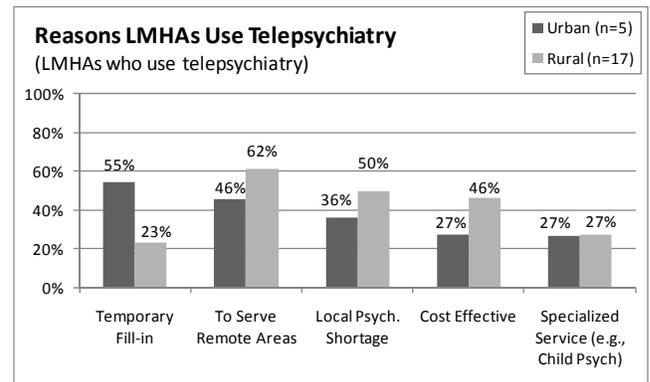


Figure 1.16 shows urban LMHAs that use telemedicine do so to provide coverage when on-staff psychiatrists are unavailable. Both urban and rural LMHAs use this service to reach parts of the service region that are otherwise difficult to access. Other reasons given for using telepsychiatry are to compensate for the local psychiatric shortage, cost effectiveness, or to access specialized psychiatric expertise. Five LMHAs added that telepsychiatry is used to provide services in jail while reducing the need to transport criminally-involved consumers.

**Summary**

Over 2008 and 2009, Crisis Services Redesign has been fully implemented throughout the State of Texas. The major service components include crisis hotlines, Mobile Crisis Outreach Teams, and expanded local treatment capacity. Crisis hotlines staffed by trained responders provide 24-hour support triaging consumer requests for assistance and coordinating emergency responders when needed. MCOTs comprise the primary workforce of crisis redesign. The combination of expertise and the operational features of each team are customized to accommodate unique local needs and resources in the communities they serve. Team members provide emergency crisis assessment, arrange appropriate treatment, and provide follow-up support services to restore resiliency and prevent repeat crisis.

CSR is also working to reshape some features of the local service environment. LMHAs are successfully developing alternatives to both mental health and medical screenings conducted in emergency rooms. Despite these efforts, LMHA staff say use of emergency rooms has not declined. The expansion of local treatment capacity is an area in which CSR has had a discernable positive impact. Communities have greatly broadened the array of local alternatives to state hospitalization. As with MCOTs, other treatment offerings are being tailored to complement existing service capacity and to suit the local community characteristics. Taken together, these findings demonstrate many ways in which CSR is strengthening communities' ability to respond and assist individuals in mental health crisis.

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**Finding 2: Since CSR, more crisis consumers are being served than ever before, and they are more likely to receive treatment in a community setting.**





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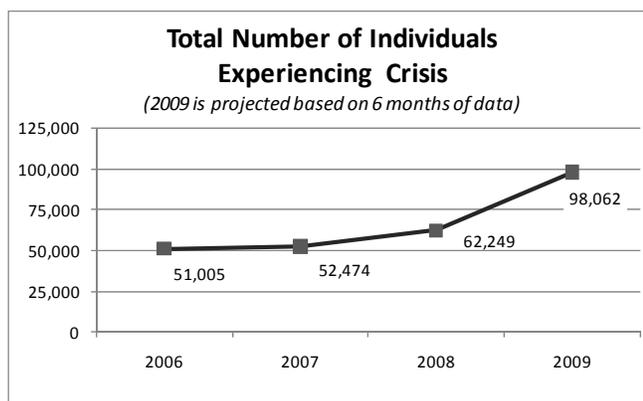
Finding 1 has shown the ways in which CSR has re-shaped the infrastructure of the crisis service system. This section documents the impacts of this transformation on consumers. Major changes have occurred in both the number of individuals being served and the amount and types of services being delivered.<sup>6</sup>

**More People Are Using the Crisis Service System than Ever Before**

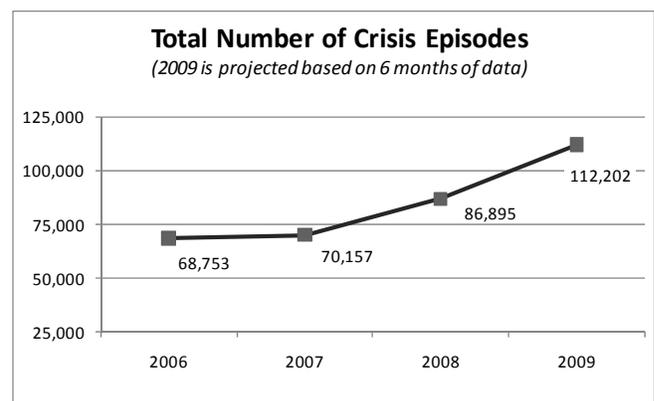
Several Factors are Contributing to an Increase in Crisis Consumers. Crisis mental health services have long been available to anyone in need of assistance. Since crisis redesign, however, the number of people taking advantage of this help has risen sharply. Redesigned crisis hotlines and MCOTs offer more visible and accessible assistance. Law enforcement officers, emergency room personnel, physicians, families, and people under mental stress now have a more direct and efficient means to seek help than in the past. In addition, factors such as returning war veterans, economic downturn, and general social pressures may have contributed to the growing overall demand for mental health crisis services.

As demand has increased, the introduction of two new Service Packages (SPs)<sup>7</sup> designed to complement CSR has offered a means for people to get help. Targeting individuals who are not currently enrolled in LMHA services, SP0 offers brief seven-day intervention delivered in the community. SP5 provides thirty days of continued intervention for individuals with ongoing need who were initially stabilized through Service Package 0 or through hospitalization. For the first time, consumers who are not otherwise eligible for long-term mental health treatment can qualify for up to 37 days of flexible crisis intervention and follow-up. In addition, they can potentially receive the same level of care in future crisis episodes should the need arise. The impact of this change has been to introduce a large new group into the crisis care system who were not previously represented among mental health consumers.

**Figure 2.1**



**Figure 2.2**



Record Numbers of Consumers are Receiving Crisis Services. Figures 2.1 and 2.2 show the impact of recent developments on crisis caseloads. The numbers represent everyone receiving crisis care either through long-term Resiliency and Disease Management (RDM) services or under short-term SP0 or SP5. Since the introduction of crisis redesign, community mental health systems have

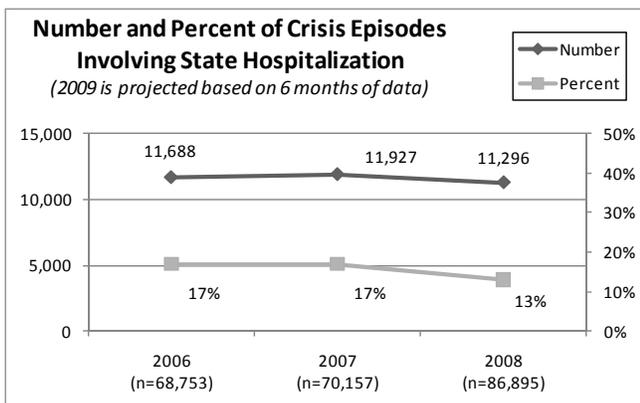
experienced an extraordinary 87% increase in the number of individuals experiencing crisis compared to the 2007 pre-CSR baseline. Nearly 100,000 people are projected to receive crisis assistance in 2009, up from about 52,000 in 2007.

Equally remarkable, the total number of crisis services delivered has more than doubled in just two years. Not only are significantly more people being served, but more services are being provided. While in 2007 people in crisis received 4.6 services on average, in 2009 the average increased to 6.1 services. More crisis consumers are receiving more services than ever before and the trajectory appears to be upward. Fortunately, corresponding new treatment protocols are helping make this level of support more feasible.

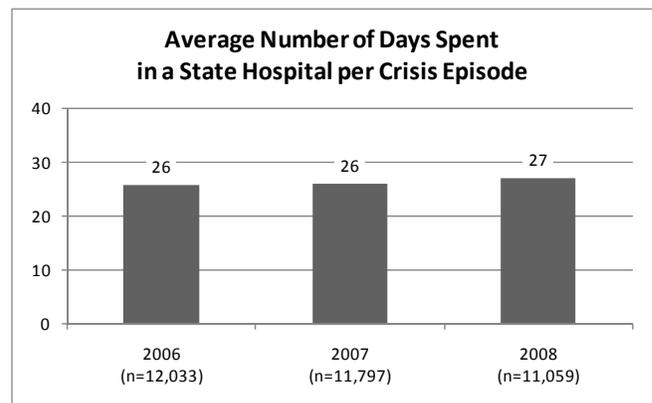
### Mental Health Hospitalization is Declining as a Crisis Response

Reducing the use of state mental health services is an essential component of the strategy to expand crisis services. Figure 2.3 examines the number of crisis episodes involving a mental health hospitalization. Prior to CSR, few options existed outside of the largest urban centers for community-based crisis care. Nearly 1 of every 6 crisis cases was resolved through a state hospitalization. In the post-CSR era, with access to more local treatment choices about 1 in 8 crisis episodes involve hospitalization.

**Figure 2.3**



**Figure 2.4**



While the percentage of crisis service users entering state hospitals has declined by about 23%, the raw number of admissions has fallen only 3 to 5% compared to prior years. This is not surprising in light of the large increase in the number of consumers entering crisis care in the post-CSR period. Among those that have been hospitalized, average length of stay has grown one day longer on average (Figure 2.4). This small increase could be related to new triage protocols that reserve hospitalization for more severe crisis cases.

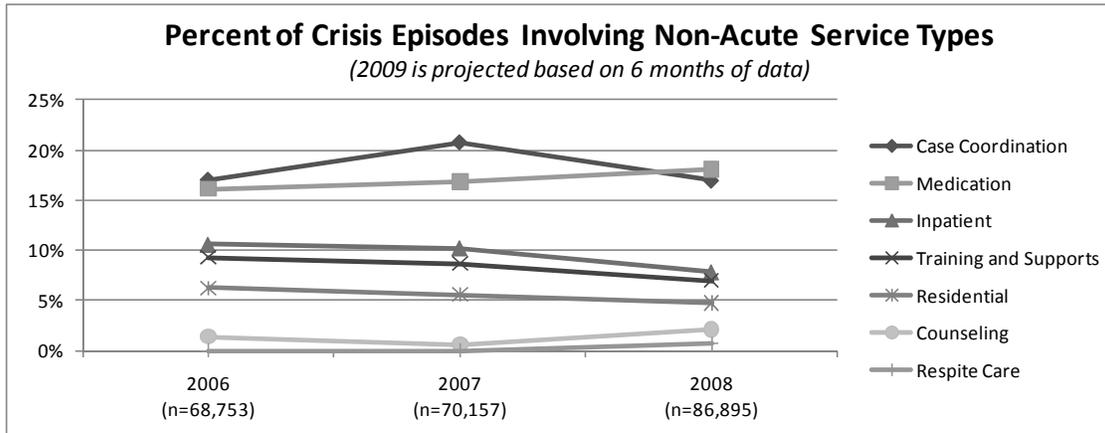
### Mental Health Crisis Care Is Increasingly Centered in the Community

As LMHAs rely less on mental health hospitalizations, more crisis services are being delivered in community settings. Using DSHS' service encounter databases, it is possible to directly observe the impact of these recent changes in service delivery.

Acute Care Is the Backbone of Community Crisis Treatment. As is noted throughout this report, the absolute number of crisis service users has increased sharply since redesign. The count of

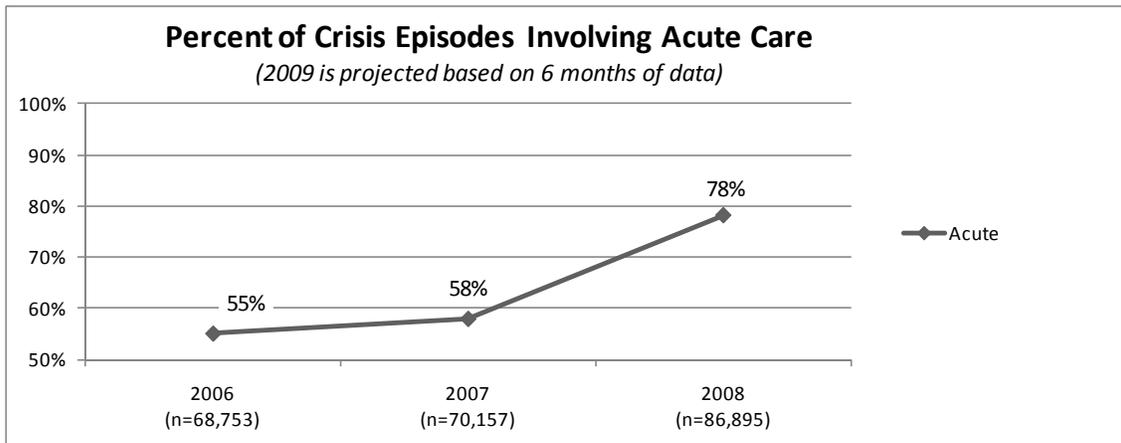
individuals served has risen in every crisis service category. Despite these numeric increases, however, the proportion of individuals being directed to nearly all types of community care modalities has remained relatively low and flat. Figure 2.5 lists seven types of community-based crisis services that, at least in proportional terms, have neither increased nor declined since the introduction of CSR. The maximum change within any of these categories is 4%.

**Figure 2.5**



Acute care stands as the single exception to this pattern (Figure 2.6). Acute treatment involves an outpatient contact of less than 24 hours in order to address emergent mental health needs. It has emerged as the most fundamental community treatment modality underlying crisis redesign. In 2008, fully 78% of crisis episodes have acute care as a component, up from just 58% in 2007.

**Figure 2.6**

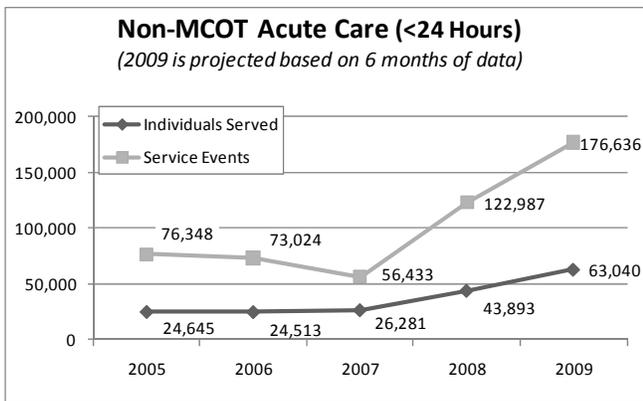


This significant proportional increase in the use of acute care reflects a strong underlying principal of crisis redesign: Crisis care systems able to provide brief, moderately intensive intervention to help consumers with urgent needs can effectively contain many crises and reduce the need for more intensive care in a higher cost setting. While most acute care is delivered in a clinical setting (Figure 2.7), mobile crisis teams play an important and growing role in providing this service (Figure 2.8). More than 95% of all MCOT services are acute, affirming that individuals are able to receive outpatient emergency care wherever and whenever it is needed.

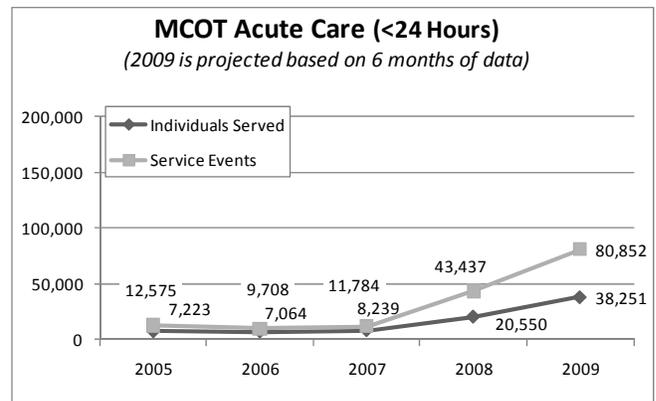
More Consumers Have Greater Access to All Types of Crisis Services. Figures 2.9 through 2.14 summarize changes over time in the number of individuals served and the number of service events for each of the eight treatment categories by which DSHS services are coded.

The most prevalent non-acute services are crisis inpatient and community residential care. Inpatient care is relatively short-term (about 4 days or less), while residential placements involve more intense intervention lasting several weeks. These types of environments offer an alternative to lengthy state hospital placements for consumers with a higher level of need. They also allow for local community resources to be integrated into the treatment process, helping consumers benefit from supports close to home over the long term. Both crisis inpatient and community residential services developed slowly in the first year of CSR. However, as the local infrastructure has grown and matured, substantial increases in the use of these services are projected for 2009.

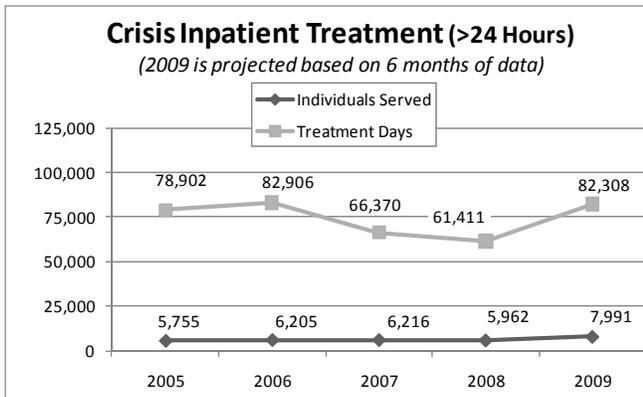
**Figure 2.7**



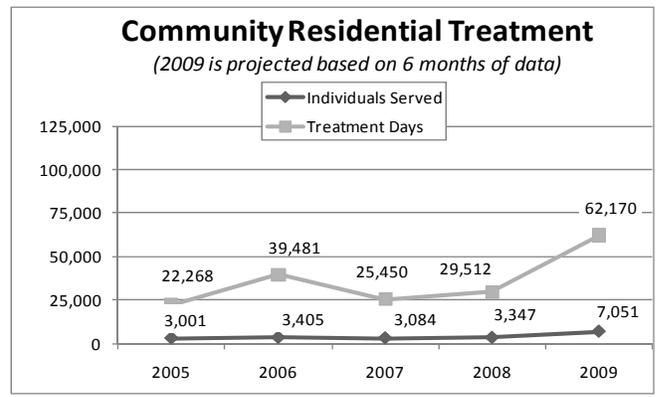
**Figure 2.8**



**Figure 2.9**

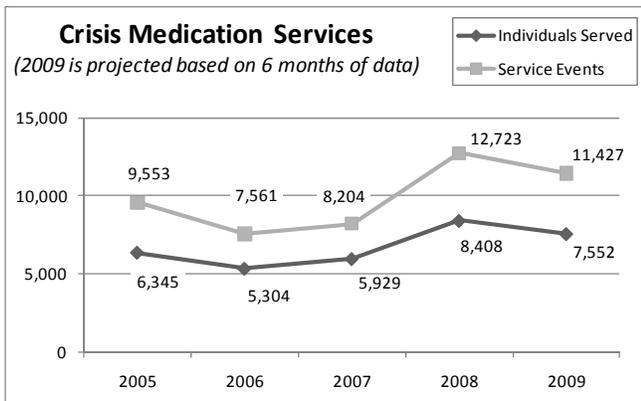


**Figure 2.10**

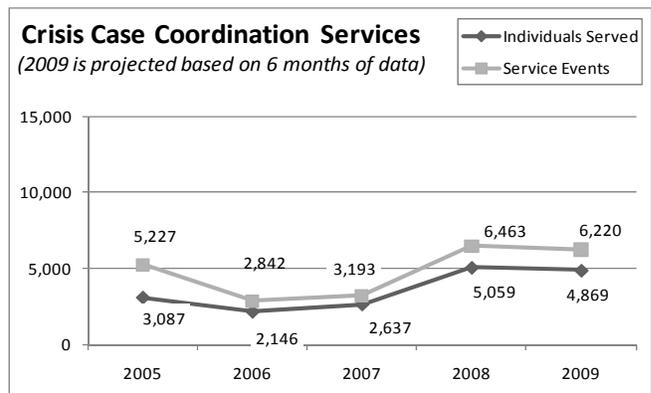


It is also interesting to note the increased utilization of crisis respite as a treatment option. Respite services provide a safe and calm environment for consumers who are capable of self-monitoring to stabilize and recover with limited supervision. While respite remains the least-used of all current treatment modalities, there appears to be developing interest in this highly cost-effective option. Although no centers formally documented delivering a crisis respite service in the years before CSR, more than 900 individuals are projected to use this treatment option in 2009. The data also suggest that this targeted group of people use respite frequently, receiving an average of 14 days of care per year over multiple respite episodes. It is possible that, with MCOT personnel to monitor individuals' wellbeing, LMHAs feel more confident allowing appropriate crisis users to recover in this semi-autonomous environment.

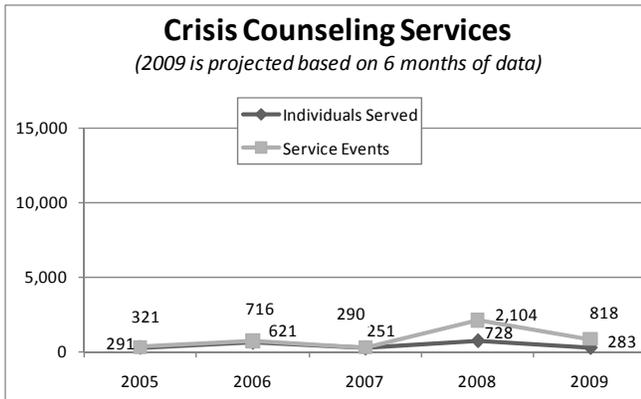
**Figure 2.11**



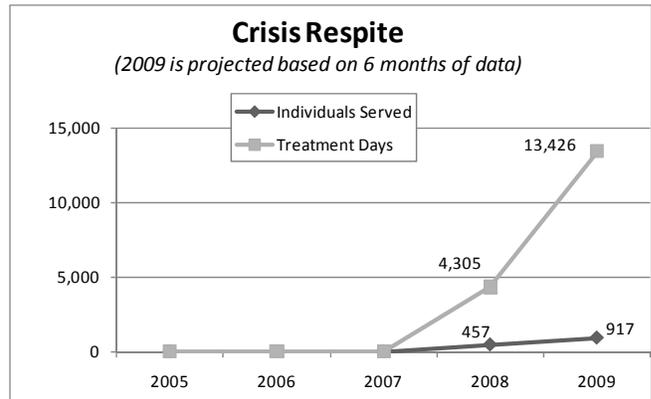
**Figure 2.12**



**Figure 2.13**



**Figure 2.14**



## **Summary**

Since CSR, Texas' community mental health centers are serving large numbers of new crisis consumers. The increase is largely attributable to two new Service Packages that provide up to 37 days of assistance to people who do not qualify for long-term mental health care. Since the introduction of these new service options in 2008, the number of individuals seeking crisis services has doubled.

In order to accommodate this growing volume of crisis consumers, new community-based treatment options are developing to replace state mental health hospitalization as the primary treatment modality. Since CSR, the number of crisis episodes involving state hospitalization has fallen from 17% to 13%. Community-based acute care delivers moderately intensive intervention to address urgent needs and contain the crisis promptly. As more people enter crisis care, though, the number of people participating in all categories of treatment has increased. By strengthening and enhancing community treatment options, CSR is successfully reducing the need for more intensive care in a higher cost setting.



**Finding 3: Direct and measurable reductions in cost of services associated with crisis redesign more than cover the cost of the program, even while supporting a 24% increase in crisis episodes from 2007 to 2008.**





**Finding 3: Direct and measurable reductions in cost of services associated with crisis redesign more than cover the cost of the program, even while supporting a 24% increase in crisis episodes from 2007 to 2008.**

Crisis redesign is intended not only to improve services to consumers, but also to reduce the overall costs for providing mental health crisis care. The “return on investment” component of the evaluation quantifies the extent to which cost reductions have been achieved through CSR funding to create new, more efficient service infrastructure.

Data Sources and Approach for the Return on Investment Analysis. To estimate the benefits resulting from investment in crisis redesign, it was first necessary to identify the treatment categories associated with CSR. These include:

- Hospital Costs
- Assessment/Screening Cost
- Counseling Costs
- Inpatient Costs
- Medication Costs
- Residential Costs
- Service/Case Coordination Costs
- Therapy Costs
- Training and Support Costs
- Respite Costs
- Acute Costs

The per unit cost of each of these treatment modalities was determined based on cost accounting data available in the CARE dataset. Information about the amount of treatment services provided was taken from client encounter records in the same dataset. State mental health hospital costs were calculated using the average inflation-adjusted (2008 dollars) bed-day cost of \$402.81 for FY2006-FY2008.<sup>8</sup>

For purposes of analysis, treatment service costs were aggregated by crisis episode. A crisis episode is a series of crisis treatment services delivered over a period of time during which there is not a break in services greater than 7 days. If a break exceeding 7 days occurs, the next crisis service marks the beginning of a new crisis episode. The resulting unit of analysis is average cost per episode.

Crisis episodes beginning in or before 2007 are defined as the “pre-CSR” period, while those beginning in 2008 are treated as “post-CSR.” Because data was only available for the first six months of 2009, all crisis episodes were truncated at 180 days (i.e., 6 months) in order to standardize the follow-up period in both the pre- and post-CSR period. Without limiting the crisis period, those crises that occur later in 2008 would have artificially low cost estimates because a decreasing number of months are available for analysis (see Appendix A for further methodological notes).

In the tables that follow, “cost per episode” in 2007 is based on a 3-year average cost per episode for the period 2005 to 2007. This approach provides a more stable baseline. “Numbers of crisis episodes” per year in 2007 and 2008 represent the actual values for each calendar year. All costs were converted to constant-value 2008 dollars. The cost inflation escalator used to make this adjustment shown in Table 3.1 below was developed from the U.S. Bureau of Labor Statistics Consumer Price Index Data Series for Health and Medical Services.

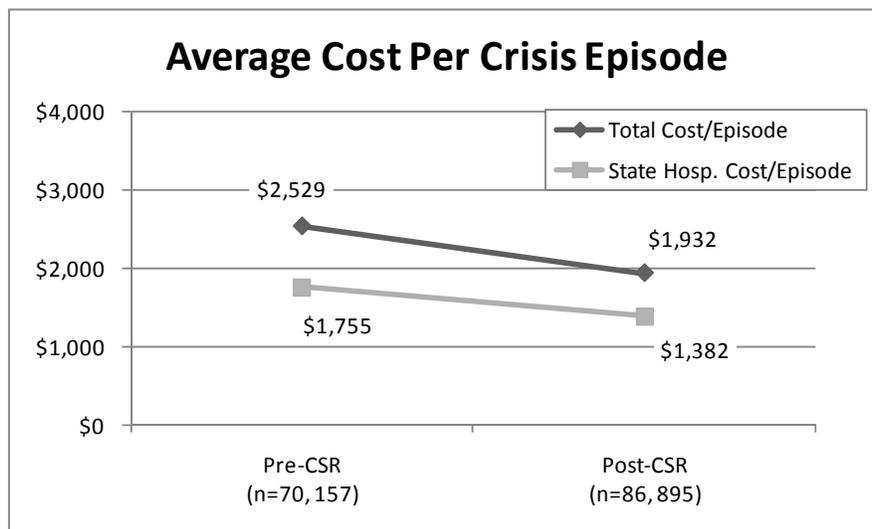
**Table 3.1: 2008 Cost Inflation Escalator**

Year	Inflation Escalator
2005	1.143
2006	1.098
2007	1.042
2008	1.000
2009	0.975

Reduced Use of State Hospitalizations Is A Primary Factor Reducing Crisis Treatment Costs. Prior to CSR, 17% of all mental health crisis episodes involved an average 26-day stay in a state mental health hospital at a cost of \$402.81 per day (see Figures 2.3 and 2.4). Through crisis redesign, new investment has been made in developing an alternative local crisis service infrastructure. With increased use of acute outpatient services, enhanced if needed by local short-term residential or inpatient treatment, more crisis care is available to consumers in their own community (see Finding 2).

Since the addition of this enhanced local treatment capacity, only 13% of crisis episodes now involve state hospitalization (Figure 2.3). As a result, the average state hospitalization cost per crisis episode, as well as the average overall cost of the episode, have both fallen more than 20% (Figure 3.1).

**Figure 3.1**



As cost per crisis has declined, the number of people receiving crisis services has risen. Compared to the pre-CSR baseline, 24% more consumers were served in 2008, with a projected 87% increase over baseline for 2009 (see Figures 2.1 and 2.2). By shifting the delivery of mental health services away from the high-cost hospital setting and toward investment in new crisis infrastructure at the community level, CSR has achieved impressive cost reductions overall. The following tables provide detailed analysis of the financial and consumer service impacts of CSR.

The Cost of Treating a Crisis Episode Has Declined Since Crisis Redesign. Table 3.2 shows total crisis episodes, the cost per episode in 2008 dollars, and the total program cost for years 2007 and 2008. As can be seen, the number of episodes increased almost 24% from 2007 to 2008 while the average cost per episode fell by almost the same amount. The result is a 5.4% total program cost decrease despite the increased volume of consumers served.

**Table 3.2: Actual Cost per Crisis Episode Before and After CSR**

Year	Number of Crisis Episodes	Cost per Episode	Total Cost
2007	70,157	\$2,529	\$177,402,498
2008	86,895	\$1,932	\$167,890,698
Increase/(Decrease)	16,738	(\$597)	(\$9,511,800)
Percent Change	23.9%	-23.6%	-5.4%

In interpreting Table 3.2, it is important to be aware that cost reductions would have been considerably greater than \$9.5 million had the number of individuals served not risen so dramatically. If the entire \$81 million CSR investment had been used only to improve efficiency and reduce cost per crisis in 2008 while serving the same number of individuals as in 2007 (70,157), the program would have more than paid for itself (Table 3.3). By reducing costs by \$41.9 million per year, an estimated benefit of \$83.7 million would have been achieved over the two-year biennium.

**Table 3.3: Unrealized Cost Savings in 2007**

(Savings that would have been realized had CSR been implemented in 2007)

Year	Number of Crisis Episodes	Cost per Episode	Total Cost
2007 w/ Pre-Costs	70,157	\$2,529	\$177,402,498
2007 w/ Post-CSR Costs	70,157	\$1,932	\$135,551,041
Increase/(Decrease)		(\$597)	(\$41,851,457)
Percent Change			-23.6%

Table 3.4 examines the same issue another way. If LMHAs had served the actual increased number of individuals in 2008 (86,895), but had done so without the benefit of the CSR investment, an additional \$51.8 million would have been required in one year alone to meet their treatment needs (\$103.7 million over the biennium).

**Table 3.4: Costs Avoided in 2008**

(Costs that did not accrue in 2008 due to CSR implementation)

Year	Number of Crisis Episodes	Cost per Episode	Total Cost
2008 w/ Pre-CSR Costs	86,895	\$2,529	\$219,727,042
2008 w/ Post-CSR Costs	86,895	\$1,932	\$167,881,140
Cost Avoided		\$597	\$51,845,902
Percent Change			30.9%

Table 3.5 shows the estimated effect of increased efficiency in crisis service delivery based on the actual number of consumers served during 2007 and 2008 combined (157,052). Had CSR not been implemented at all, total program costs for 2007 and 2008 would have been \$397.1 million. If it had been in place both years, program costs would have been \$303.4 million in constant-value 2008 dollars. As a result, we can conclude that if CSR had been in effect for the two full years, estimated cost benefits of \$93.7 million would have been achieved, returning more treatment benefits than the amount of the entire \$81 million investment.

**Table 3.5: Total Estimated Effect of CSR Cost Savings for 2007 and 2008**  
(Cost of treatment both years without CSR) - (Cost of treatment both years with CSR)

Year	Number of Crisis Episodes	Cost per Episode	Total Cost
2007 and 2008 w/ Pre-CSR Costs	157,052	\$2,529	\$397,129,540
2007 and 2008 w/ Post-CSR Costs	157,052	\$1,932	\$303,424,464
Increase/(Decrease)		(\$597)	(\$93,705,076)

Increased Treatment Service Efficiency Alone More Than Covers the Cost of Crisis Redesign. There are two primary ways in which LMHAs have utilized the \$81 million CSR allocation. First, many have hired additional service personnel or contracted with external providers for treatment services. These costs comprise the “costs per crisis episode” measured in the analyses above using CARE data. Additionally, part of the CSR allocation was used for other purposes besides the direct delivery of crisis services. These costs include, for example, costs to construct or renovate buildings for new psychiatric emergency facilities funded through CSR competitive allocations, purchase of computers or vehicles to support mobile crisis teams, travel costs, etc. Cost for these and other non-treatment service items cannot be adequately assessed using the CARE data and therefore are not included in the estimated cost savings derived from Tables 3.3-3.5. This means some of the costs of CSR (i.e., any costs other than direct services) have not been measured in these tables.

If we assume for a moment the worst case scenario, that the unknown and unmeasured non-treatment service costs described above equal the entire \$81 million CSR appropriation, then we can add them to the Post-CSR service costs represented above in Table 3.5. In this scenario, the total costs for 2007-2008 total \$384 million.<sup>9</sup> This value is obtained by adding the \$303 million in direct service costs (157,052 crisis episodes at \$1,932 each) to \$81 million in non-treatment costs (i.e. computers, vehicles or buildings).

**Table 3.6: Total Estimated Effect of Cost Savings for Both 2007 and 2008 Including the \$81 Million Investment in CSR as a 2008 Expense**

Year	Number of Crisis Episodes	Cost per Episode	Non-Treatment CSR Costs	Total Cost
2007-2008 w/ Pre-CSR Costs	157,052	\$2,529	-----	\$397,129,540
2007-2008 w/ Post-CSR Costs	157,052	\$1,932	\$81,000,000	\$384,424,464
Increase/(Decrease)		(\$597)	\$81,000,000	(\$12,697,359)
<b>Benefit/Cost Ratio</b>				<b>1.16</b>

Table 3.6 indicates estimated cost savings associated with direct services resulting from crisis redesign more than cover the cost of the program. This is true even if we assume that the entire \$81 million CSR allocation was spent on items other than direct services. The included benefit/cost ratio indicates that for every dollar that is spent on CSR, there is a benefit of \$1.16.

CSR May Also Contribute to Broader Economic Impacts. Analysis to this point has addressed the cost benefits of CSR associated with the direct delivery of treatment services. Table 3.6 estimates that a minimum of \$12.7 million additional dollars would have been available to serve more consumers had the program been in place for the full 2007-2008 period. Due to the cost reductions resulting from CSR, more patients in need of service can be reached with the same amount of investment. Furthermore, mental health crises often affect the ability of an individual to gain employment or to stay employed. To the extent that CSR reaches more of those in need, increases outpatient treatment and hastens recovery, there are fewer days of missed work than would be the case under the old system. While it is not possible with available data to precisely measure these secondary economic impacts, the reduction in lost wages clearly magnifies the positive economic impact resulting from crisis redesign.

Other Costs Have Not Been Considered In This Analysis. The above analysis focuses primarily on direct program costs and benefits associated with crisis redesign. Other factors, some representing additional benefits, others representing uncounted costs were not included in the analysis.

In terms of unmeasured benefits, CSR was expected to reduce time and other costs for law enforcement officers associated with providing safety during emergency room visits or accompaniment during transport to state hospitals. On average, the data indicate that transportation costs (law enforcement time, mileage, hotel, meals) spent moving patients to and from state hospitals average more than \$8 per crisis episode, or over \$720,000 in 2008. To the extent that CSR allows patients to be treated locally, some of this cost is avoided. Data presented in Finding 8 suggests that these costs are largely unchanged, but data is not available to make a clear determination.

Crisis redesign was also expected to reduce the number of people visiting emergency rooms for mental health or medical screenings. However, reliable data assessing actual emergency room encounters for crisis consumers was unavailable. Finding 8 documents a growing burden on emergency rooms. There is no evidence from the survey findings that ER usage has declined since CSR and staff time spent arranging transportation and mental health treatment placements has reportedly increased. Given that the total volume of crisis consumers has risen, it is reasonable to expect costs to emergency rooms have not decreased.

The implementation of CSR has also resulted in increased costs to the RDM service system. Finding 4 documents the ways in which the influx of new crisis consumers has had secondary impacts raising the number of people entering non-crisis maintenance care. Because these individuals legitimately meet criteria for help in the RDM system, their enrollment cannot be modeled as a "cost" of CSR. Nonetheless, there are very real new expenses associated with treating these individuals that would not have occurred in the absence of CSR. As is recommended in Finding 4, additional investment in the non-crisis mental health service system is needed to offset new costs of providing long-term care to new consumers qualifying through the crisis service system.

## **Summary**

Measurable cost reductions resulting from CSR are significant. From 2007 to 2008, total crisis treatment costs decreased 5.4% despite a 23.9% increase in the number of crisis episodes. The

service data indicate that had the program been in place in both 2007 and 2008, a gross benefit of \$93.7 million would have been realized, with a net benefit (after deducting the \$81 million program cost) of \$12.7 million. In other words, for every \$1.00 in additional investment, a \$1.16 in service was provided.



**Finding 4: 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.**





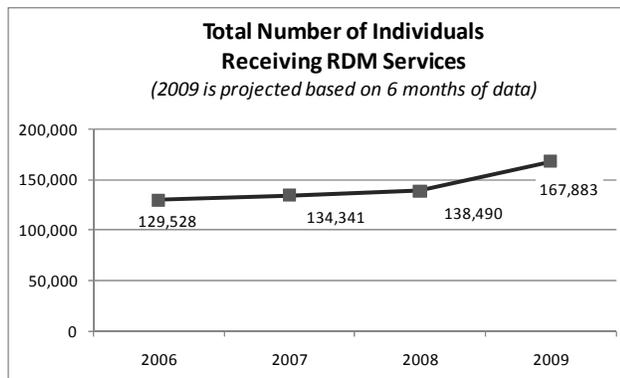
**Finding 4: Increased funding for crisis services alone is not sufficient. Parallel investment in ongoing routine services is also needed to prevent a crisis-driven mental health system.**

LMHA staff and other stakeholders have raised concerns that the extraordinary growth in mental health crisis services has not been adequately balanced by comparable investment in DSHS' ongoing Resiliency and Disease Management (RDM) services. As more RDM treatment openings are prioritized for people recovering from crisis, those in need of routine care are increasingly being placed on waiting lists or served at a level below that clinically recommended. New investment in RDM maintenance services is needed to avoid a system in which help is primarily dispensed to consumers who have declined to crisis status.

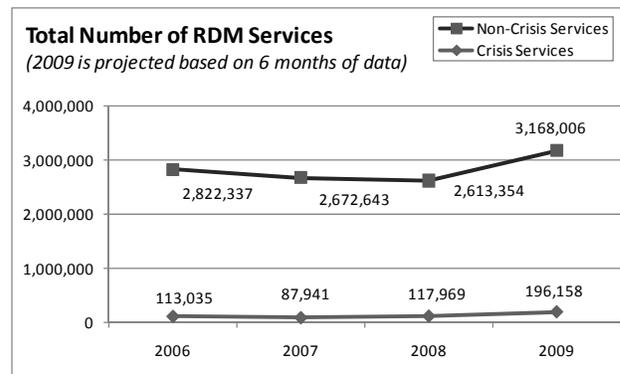
**New RDM-Eligible Crisis Service Users Are Taxing the Capacity of the Routine Mental Health Service System**

Routine Mental Health Care Is Increasingly Delayed for People Who Are Not In Crisis. Crisis redesign is a prominent factor creating rising demand for routine mental health services. As crisis services are expanded, many newly engaged crisis consumers qualify for long-term services. While annual average increases in RDM caseloads were about 3-4% through 2008, caseloads will rise a projected 21% in 2009 (Figure 4.1). A projected 30,000 new RDM consumers will enter long-term services that year compared to no more than 9,000 consumers added in recent preceding years (Figure 4.2).

**Figure 4.1**



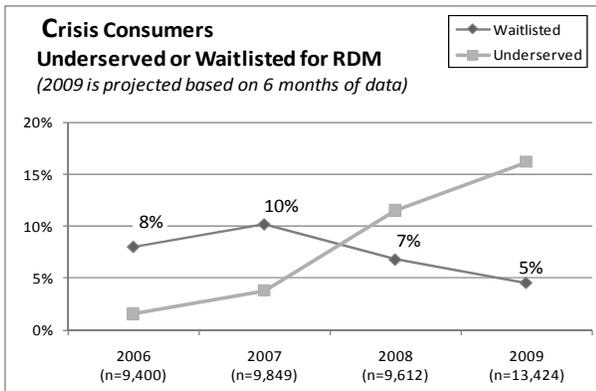
**Figure 4.2**



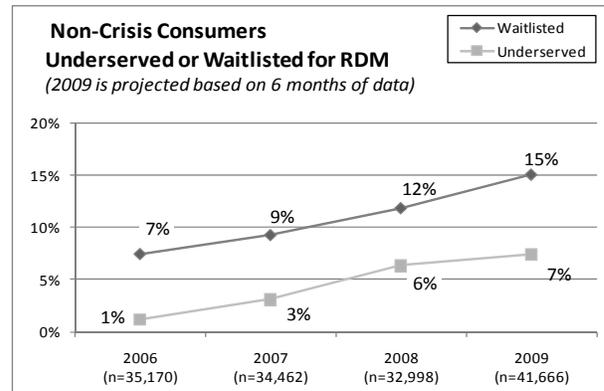
People who are not in crisis are being pushed back to expedite the provision of long-term supports to those who are. Figure 4.3 shows that crisis service users who qualify for RDM are likely to be enrolled immediately. Half as many people in crisis enter waitlists today (5%) than before CSR (10%). On the other hand, more are being served at a lower than recommended level with 4 times as many crisis consumers currently underserved (16%) compared to the year before crisis redesign (4%).

People who are not in crisis when they seek help increasingly must wait to access care (Figure 4.4). Waitlists for non-crisis consumers have been steadily increasing over the past four years, reaching 15% in 2009. The proportion of non-crisis RDM intakes being underserved is rising as well. Altogether, more than 1 in 5 non-crisis consumers entering RDM face limits on available treatment either through a waitlist placement or through a reduced service level and crisis redesign has exacerbated this trajectory by increasing overall caseloads.

**Figure 4.3**<sup>10</sup>

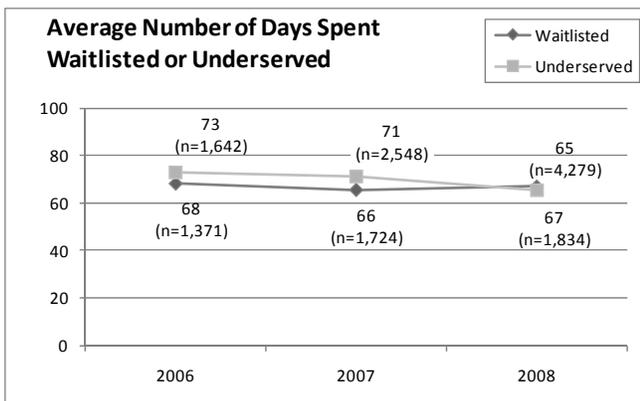


**Figure 4.4**

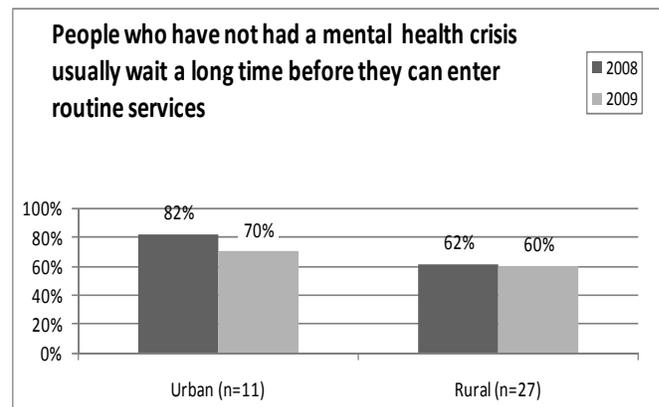


**People Underserved or Waitlisted Wait a Long Time for Services.** People who are placed on an RDM waitlist or who are underserved spend an average of more than two months awaiting upgraded status (Figure 4.5). Some people spend time as both waitlisted, then underserved. The average number of days people are waitlisted has remained constant since CSR, while the amount of time spent underserved has been shortened by 6 to 8 days. Still, the majority of LMHA stakeholders surveyed affirm that consumers who are not in crisis “usually wait a long time” to get help when it is needed (Figure 4.6). Respondents in urban areas are more likely to report long waits for service as a problem, though it also appears that wait times are improving in these same communities.

**Figure 4.5**<sup>11</sup>



**Figure 4.6**

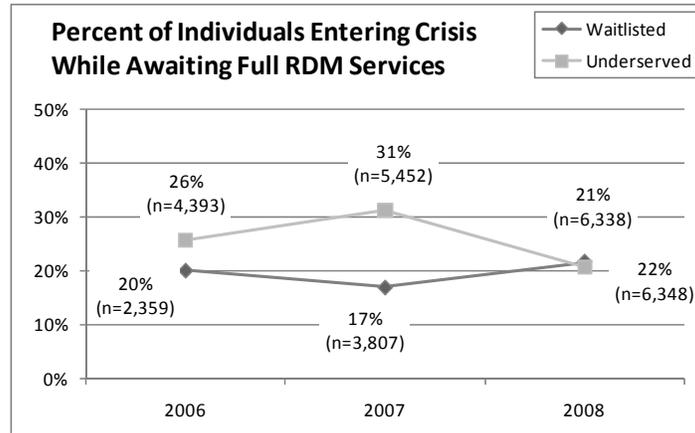


**LMHAs Do a Good Job Selecting and Supporting Waitlisted or Underserved Consumers.** As LMHAs have been overwhelmed with a rapidly-rising volume of consumers seeking both crisis care and ongoing services, they have increasingly had to make difficult decisions about which individuals are in most urgent need of help. Whenever service is deferred, there is a chance that some people might devolve into crisis while they wait.

Over the past three years about 20 to 30% of waitlisted consumers have experienced decompensation (Figure 4.7). However, the data show the percentage entering crisis while waitlisted has remained relatively stable over that period, and the percentage of crises among underserved consumers has actually declined. Because the overall mental health caseload is growing, even a

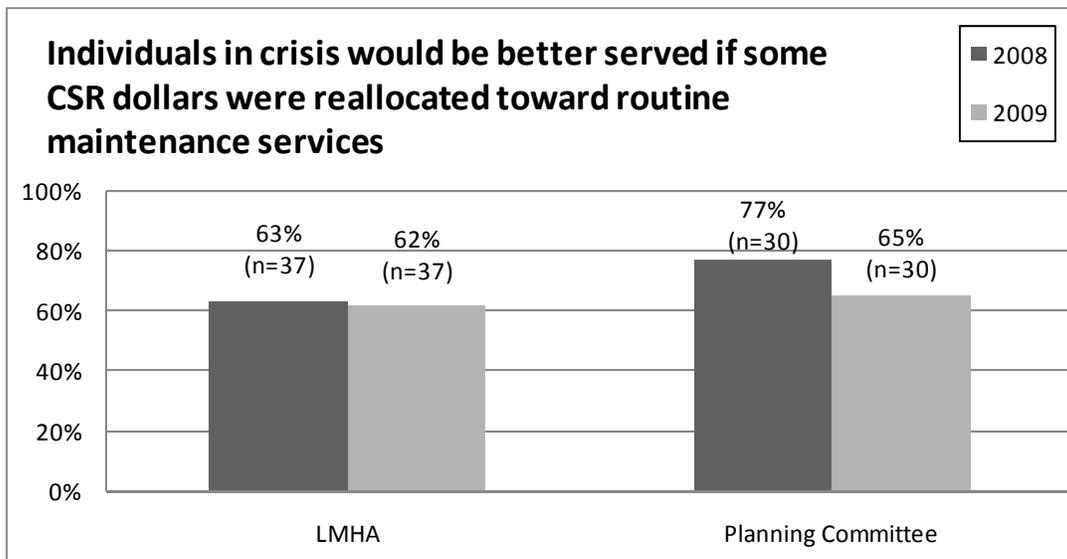
stable decompensation rate still impacts a larger number of individuals each year. Nonetheless, a stable rate is a remarkable accomplishment considering a concurrent 66% increase in waitlisted consumers from 2007 (n=3,807) to 2008 (n=6,348).

**Figure 4.7<sup>12</sup>**



Two factors account for LMHAs' ability to defer care when necessary while also containing crises. First, individuals being considered for waitlists are carefully triaged to ensure they are relatively stable and have access to external supports during the waiting interval. Second, in addition to regular assessments, mobile crisis teams monitor the people on waiting lists. Those who show signs of stress or instability receive immediate crisis services and priority access to RDM thereafter. This approach of focusing resources where they are most needed combined with vigilant watchfulness among those who must await full services appears to successfully prevent crises among most people awaiting a service opening.

**Figure 4.8**



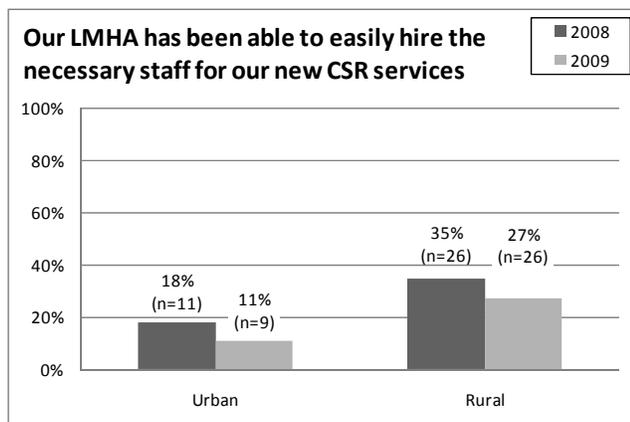
## The RDM System is Under-Resourced to Accommodate the Influx of New Crisis Consumers Seeking Long-Term Care

Current Funding Does Not Fully Cover Costs for Routine RDM Services. While new state funding has expanded and improved services for people in mental health crisis, treatment costs are no longer covered by the new CSR-related funding streams once these same individuals enroll for routine long-term care. As a result, LMHA resources are increasingly strained serving expanding caseloads of people in maintenance care without a corresponding increase in RDM funding. Demand for routine ongoing treatment is outstripping supply under current resource levels.

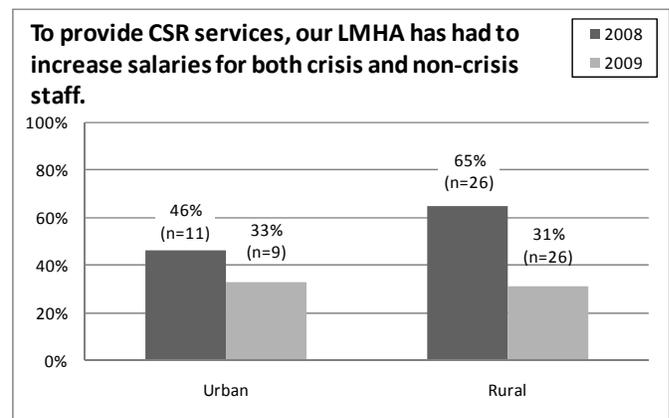
Adequate funding for both crisis and non-crisis systems is the strongly preferred solution. However, until that is achieved, mental health center staff and their planning committee members generally agree that individuals in crisis would be better served if some CSR dollars could be reallocated to support routine maintenance services (Figure 4.8).

Implementation of CSR Has Increased Overall Personnel Costs in Some LMHAs. Exacerbating the costs associated with increasing RDM caseloads, some LMHAs report that overall salaries have been increased in order to hire staff at a higher level of expertise required by crisis redesign. Only about 1 in 3 rural LMHAs say it has been “easy” to hire credentialed individuals (Figure 4.9). Even fewer urban centers (11%) have found hiring “easy,” possibly due to a stronger competing healthcare sector in larger communities. Despite a general economic downturn the healthcare industry has remained relatively robust, sustaining competition for qualified healthcare professionals.<sup>13</sup>

**Figure 4.9**



**Figure 4.10**

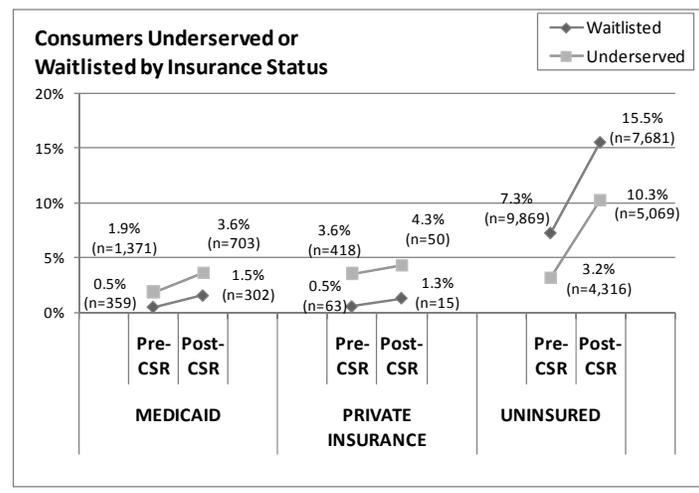


To fill new positions funded by CSR, about one-third of LMHAs have had to offer higher salaries to all types of staff (Figure 4.10). Importantly, while salaries for crisis staff are largely covered by CSR funds, corresponding equity adjustments for similarly credentialed non-crisis staff had to be taken from RDM service budgets. These findings suggest that an additional financial pressure resulting from crisis redesign is the increased cost of attracting qualified personnel including both crisis- and non-crisis clinicians.

Crisis Redesign Has Reduced Services to Consumers with No Ability to Pay. With limited ability to fully serve everyone who is eligible for routine care, there is evidence that consumers’ insurance status partially determines who can be treated. Figure 4.11 shows that individuals with an ability to

pay either through Medicaid or private insurance receive the best service response. Medicaid-eligible consumers are entitled to immediate treatment by law. Fewer than 5% of people with either public or private insurance have ever entered RDM on underserved status and almost none have been waitlisted.

**Figure 4.11**



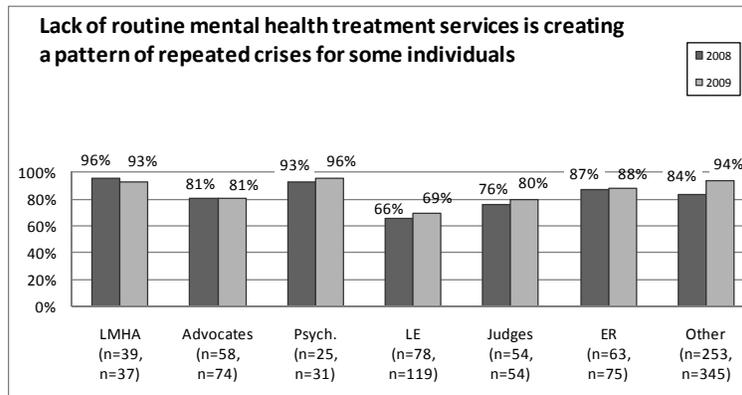
People without any form of insurance, in contrast, are the most directly impacted by LMHAs' recent CSR-related resource constraints. The uninsured, by far the largest category of consumers in the public mental health system, are the most likely to receive reduced or delayed treatment. They are the only group more likely to be denied services than to be underserved. Since the implementation of crisis redesign, the percentage of uninsured people waitlisted upon entering RDM has more than doubled, and the percentage underserved has tripled. In this under-resourced system, service cut-backs clearly impact those with the fewest resources to pay for their own care.

**Community Partners Also Stand to Benefit from Increased Investment in RDM Services**

Community Stakeholders Support More Mental Health Maintenance Services to Prevent Repeat Crisis Contact. There is broad-based consensus among every community stakeholder group that the lack of adequate mental health treatment services is creating a pattern of repeated crisis for some individuals (Figure 4.12). Interestingly, though only two-thirds of LMHA respondents held this view last year, after a year of experience with CSR, now 93% agree a shortage of routine RDM services is creating repeated crises.

Respondents in other categories (87%) share this perspective. Many emergency responders interviewed say they can 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 are also interested in seeing improvements in services needed to prevent the occurrence of crises in the first place.

Figure 4.12



**Summary**

Taken together, the evidence presented in this section highlights the ways in which crisis redesign has introduced new stresses on the original RDM system of maintenance care. More people are entering long-term mental health care since CSR, yet the RDM system has not expanded its service capacity at a comparable pace. Most new investment in the service system continues to target crisis service users, leaving RDM services significantly under-funded. If this pattern continues in the future, CSR may inadvertently evolve into a system in which access to non-crisis care is limited, and people predominantly get help only after decompensating into crisis.



**Finding 5: Crisis hotline users remain generally pleased with the help received while users of other types of crisis services reported lower rates of satisfaction in 2009.**





**Finding 5: Crisis hotline users remain generally pleased with the help received, while users of other types of crisis services reported lower rates of satisfaction in 2009.**

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 conducted during a one-week period during fall of 2008 and again at the same time in 2009.<sup>14</sup> The consumer opinions reported here do not reflect a true assessment of satisfaction before versus after crisis redesign because CSR had been underway for about ten months at the time the first satisfaction data were collected. Nonetheless, it provides important perspective on the extent to which users of the crisis system feel it meets their needs.

**Crisis Hotline User Satisfaction**

Crisis hotline survey instruments 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:

- 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.

**Table 5.1**

**Crisis Hotline User Survey Response Rates**

	<b>2008</b>	<b>2009</b>
a. Total surveys received	338	480
b. Surveys with staff responses only <i>(Excluded from analysis)</i>	154	228
c. Surveys with both staff and consumer responses <i>(Included in analysis)</i>	184	252
d. Response Rate (d/a)	54%	52%

Hotline providers were instructed to administer the survey to all callers during a one-week data collection period. Even if the caller was unable to complete the call, the staff portion of the survey was completed. Surveys with only a staff response could not be included in the consumer satisfaction analysis, but were helpful for the analysis of the non-response sample described below. 338 urgent or emergent calls were taken in 2008 and 480 calls were taken in 2009. Final resulting response rates based on complete surveys are 54% and 52% respectively (Table 5.1).

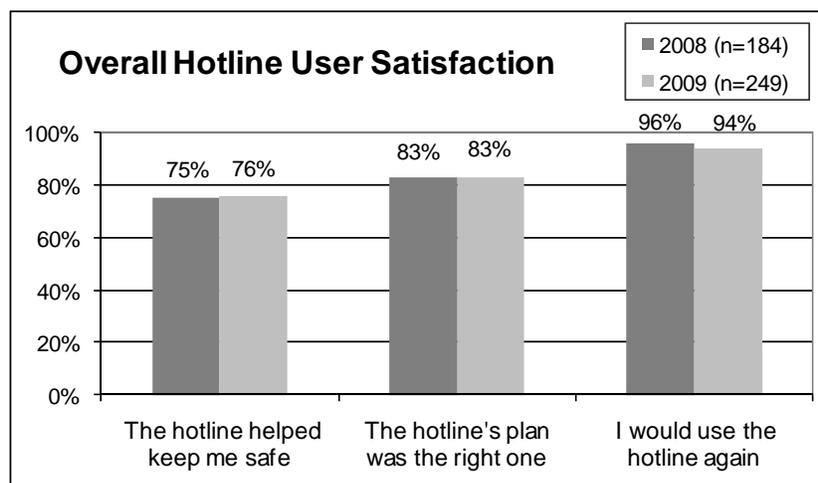
**Table 5.2**

**Significant Differences between Hotline Users Submitting Surveys and Non-Responders**

<b>Individuals who failed to provide satisfaction data are more likely to have the following attributes:</b>	<b>2008</b>	<b>2009</b>
Hotline call resolved with “other” action taken	(p<.01)	n.s.
Consumer not referred to LMHA	n.s.	(p<.05)
Urban	n.s.	(p<.01)
Call was placed by friend or family	(p<.05)	(p<.001)

Staff descriptions of respondents were used to determine if individuals who provided satisfaction data differ in any important ways from those who chose not to respond. Items for which significant differences were found are illustrated in Table 5.2. Due to non-response, the views of some types of consumer hotline users are not fully represented in the findings. While the data still provide useful information, results should be interpreted with this consideration in mind.

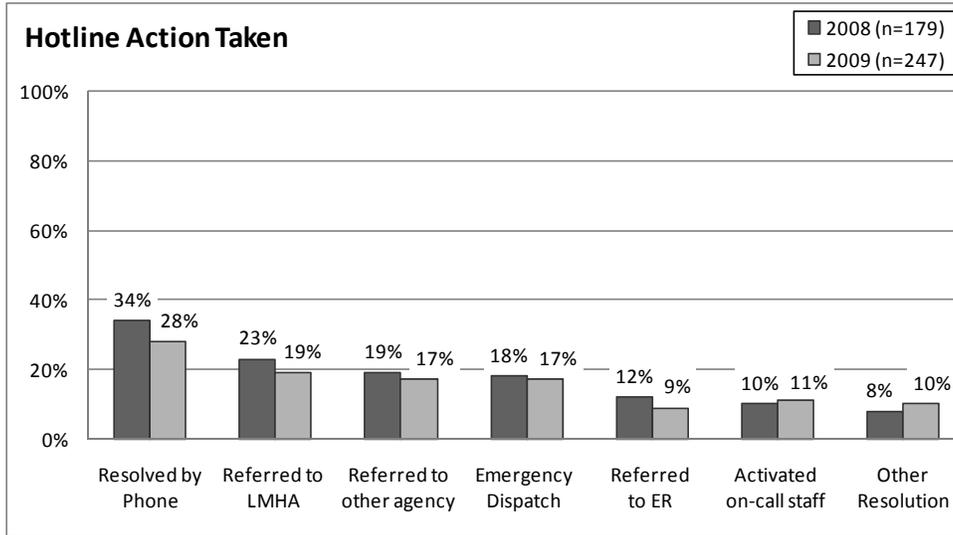
**Figure 5.1**



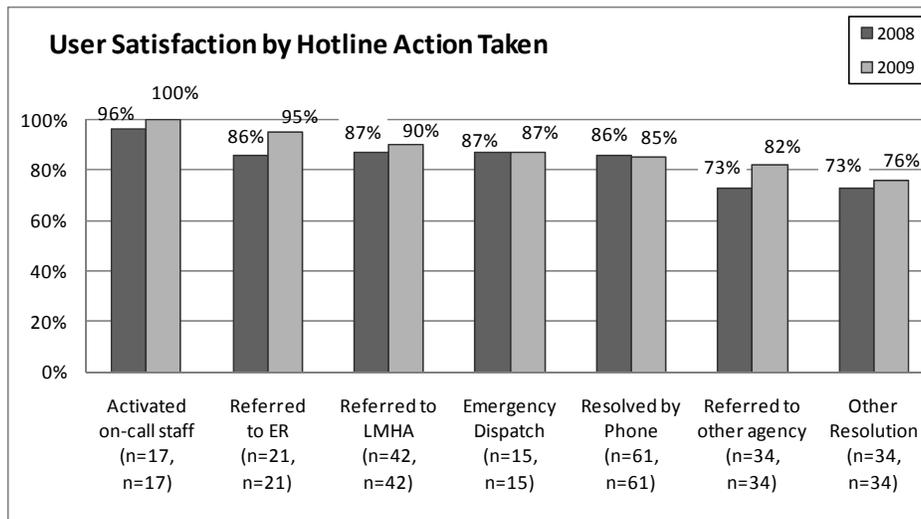
Crisis Hotline Users Are Satisfied Overall. Figure 5.1 illustrates that in general, crisis hotline users are highly satisfied with the service. Three out of four callers believe the hotline contributed to their safety, and more believe the hotline’s plan was a good idea. Nearly all respondents say they 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 who participated in the survey is a phone resolution of the crisis (Figure 5.2). Hotlines are able to give many callers the help they need without activating other responders. The next most common response reported for survey participants is a referral 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. If there is a concern for the caller’s or others’ safety, an emergency dispatch will be made. Emergency room referrals or activation of the LMHA’s on-call staff are the least frequently mentioned responses.

**Figure 5.2**

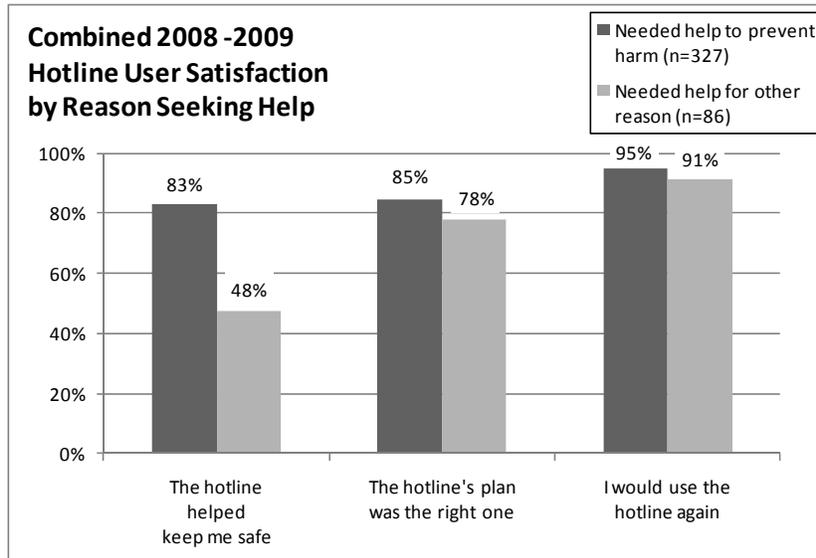


**Figure 5.2a**



Though all hotline responses please the majority of consumers, they are happiest when immediate action is taken like a referral to the emergency room or activation of the LMHA’s on-call staff (Figure 5.2a). Conversely, callers who receive non-specific “other” resolutions are much less happy with the service than those who received a more specific response. Satisfaction increased slightly over the past year for several types of call dispositions, most notably referrals to other agencies and referrals to the emergency room.

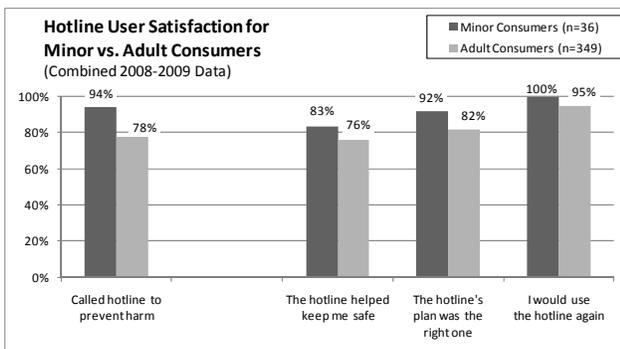
**Figure 5.3**



Individuals Who Called to Prevent Harm Were More Satisfied with Hotlines. Figure 5.3 shows that respondents who perceived imminent danger to themselves or others at the time the hotline was called believe the service kept them safe (83%). By contrast, safety was not an area of satisfaction for people who contacted the hotline for a different reason (48%). Those who were not concerned about harm were also somewhat less likely to believe the hotline's plan was the right one. Nonetheless, more than 90% of all respondents said they would use the hotline again. Responses on these items are virtually unchanged from 2008 to 2009.

Hotlines Are Especially Valued for Minors. Figure 5.4 compares reasons for using the hotline and resulting satisfaction among minors vs. adults. Minors are much more likely than adults to contact the hotline in an attempt to prevent harm (Figure 5.4). Perhaps because they perceive a great urgency to get help, people calling on behalf of children are also more satisfied virtually with every dimension of the hotline service. They are considerably more likely than adult callers to feel the hotline kept them safe, and that the recommended plan for help was the right one.

**Figure 5.4**



**Figure 5.5**

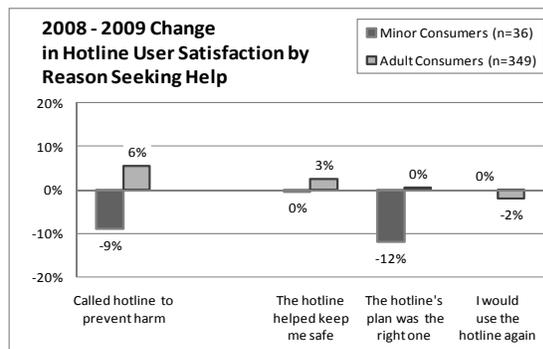
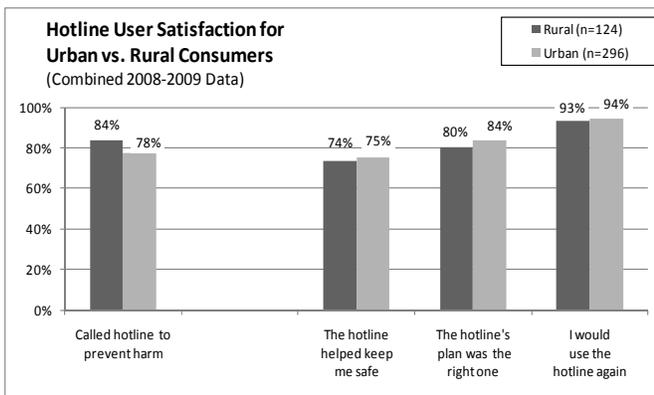


Figure 5.5 provides detail on the survey items that have changed from 2008 to 2009. The percentage of calls intended to prevent harm has declined by 9% among minors from 2008 to 2009 while increasing about 6% for adults in that same timeframe (Figure 5.5). The greatest change in satisfaction occurred for minors who are 12% less likely to believe that the hotline’s plan was the right one in 2009 compared to 2008.

**Rural Callers Are Less Satisfied with Crisis Hotlines.** In the two years consumer satisfaction data has been collected, more than twice as many hotline calls have originated in urban centers (n=296) as in rural communities (n=124). In 2008, urban callers were more satisfied than their rural peers, and over the past year urban callers have grown more satisfied over time. Rural callers, in contrast, have grown less satisfied (Figure 5.6).

**Figure 5.6**



**Figure 5.7**

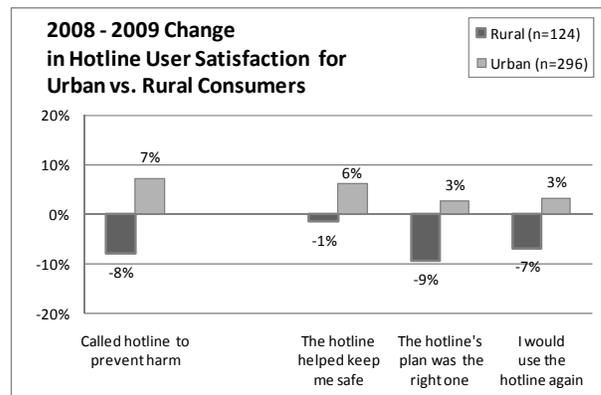


Figure 5.7 illustrates the survey items where the greatest increases or decreases in satisfaction have occurred. Rural callers have grown less satisfied with the hotline’s plan, and are less likely to use the service again. Urban callers felt the opposite with increases in satisfaction across all measures.

### Crisis Service User Satisfaction

As with hotline surveys, crisis service user surveys 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>15</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.

Crisis service clinicians were asked to collect data from all individuals receiving crisis care during a one-week period. If consumers were unable or unwilling to respond, staff still completed the clinical

portion of the instrument making it possible to examine differences between people who did and didn't complete the survey. According to information provided by crisis service providers, 1,594 crisis consumers were served in 2008 and 2,202 were served in 2009. Final resulting response rates based on complete surveys are 62% and 64% respectively.

**Table 5.3**  
**Crisis Service User Survey Response Rates**

	2008	2009
a. Total crisis consumers served during the data collection interval	1,594	2,202
b. Total surveys received	1,584	1,807
c. Surveys with staff responses only <i>(Excluded from analysis)</i>	599	736
d. Surveys with both staff and consumer responses <i>(Included in analysis)</i>	985	1,071
e. Response Rate (d/a)	62%	48%

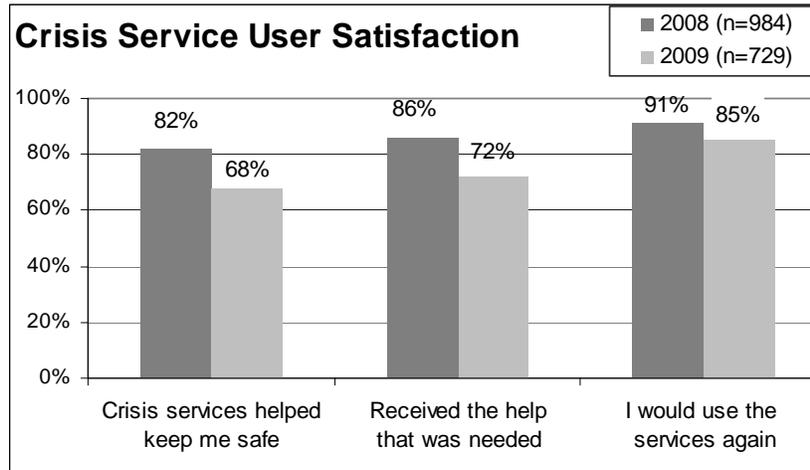
Analyses comparing the characteristics of people who responded to the survey versus those who did not are presented in Table 5.4. There are a number of potentially important ways in which the respondent and non-respondent samples differ. These dissimilarities should be considered when interpreting the consumer satisfaction data presented here.

**Table 5.4**  
**Significant Differences between Crisis Users Submitting Surveys and Non-Responders**

<b>Individuals who failed to provide satisfaction data are more likely to have the following attributes:</b>	<b>2008</b>	<b>2009</b>
Young	(p<.0001)	(p<.05)
Anglo	(p<.01)	n.s.
Rural	(p<.01)	n.s.
Survey administered by someone with a clinical role	(p<.00001)	(p<.00001)
Received residential treatment	(p<.001)	n.s.
Treated in a private hospital	(p<.0001)	(p<.001)
Treated in state hospital	(p<.0001)	(p<.001)
Treated in outpatient facility	n.s.	(p<.00001)
Male	n.s.	(p<.01)

Crisis Service User Satisfaction has Declined Overall. Over the past year, users of crisis redesign services have become less satisfied with the help they are receiving (Figure 5.8). The majority of respondents still agree that the services kept them safe, the help was needed, and they will use the service again if the need arises. However, noteworthy declines in satisfaction ratings exist in all of these areas.

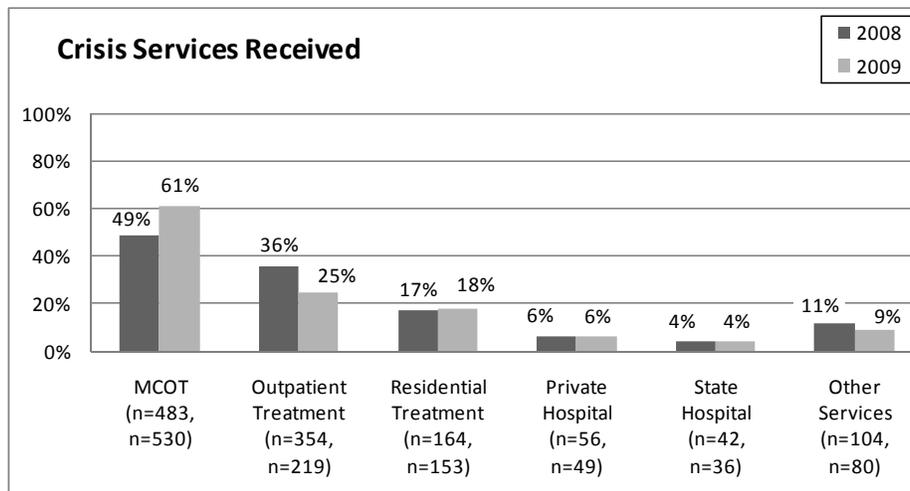
**Figure 5.8**



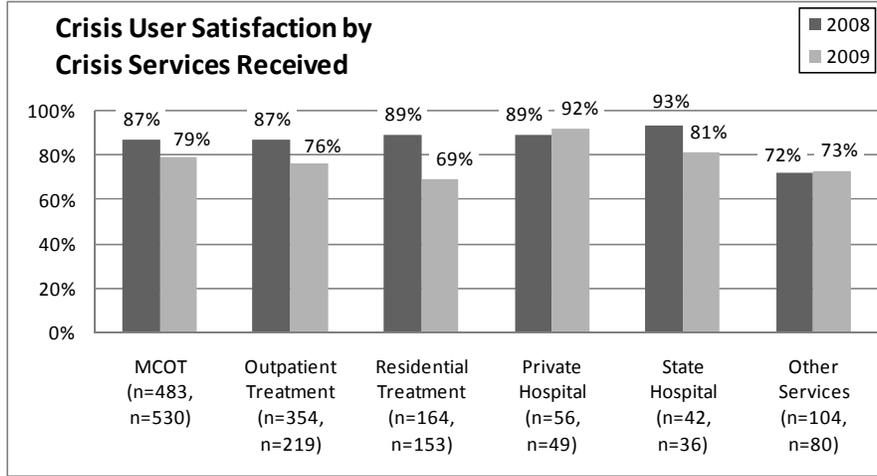
Respondents were not asked to name the reasons for their growing displeasure. Other aspects of the evaluation, however, suggest that current crisis consumers may be different from traditional mental health crisis consumers, and the crisis system may not directly address the increasingly divergent needs of these new service users (see Finding 6). This incompatibility, if it exists, might help explain declining satisfaction with the services received.

Crisis Service User Satisfaction Has Declined in Four of Six Service Areas. Figure 5.9 depicts the most common types of crisis services being provided to survey respondents. MCOT and crisis outpatient treatment are the most frequently represented services types. A smaller number of respondents received residential treatment, and even fewer were in private or state mental health hospitals.

**Figure 5.9**



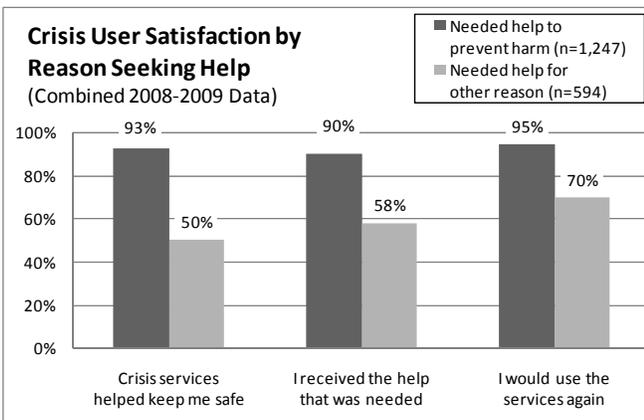
**Figure 5.10**



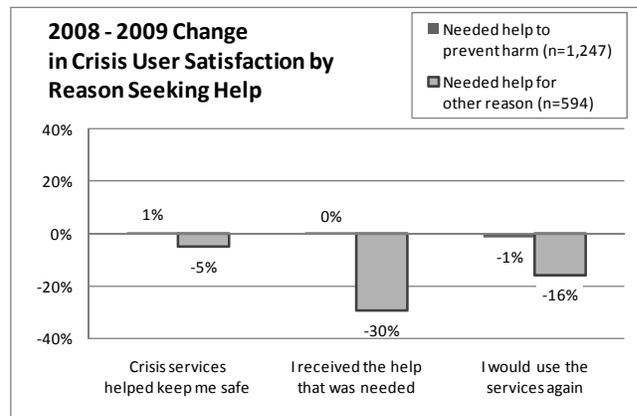
Compared to 2008, consumers say they are less satisfied with virtually every type of service except private hospitalization and “other” types of treatment. The greatest decline is associated with residential treatment where satisfaction fell 20%. However, people receiving state hospitalization, outpatient treatment, and MCOT services are 12%, 11% and 8% less satisfied respectively (Figure 5.10). The reasons for these declines are not well understood, but may relate to changes in the population of individuals being served. As CSR has expanded access to crisis treatment, service users have needs and characteristics unlike those of people served in the past, and crisis services tailored for people who are mentally ill may not directly meet their needs.

Individuals Seeking Help For A Reason Other than the Prevention of Harm Are Growing Less Satisfied with Crisis Services. About 68% of crisis service users surveyed believed they needed help to prevent harm (Figure 5.8). Satisfaction among this group of consumers is both very high and extremely stable over time. Ratings exceed 90% on all dimensions rated in both 2008 and 2009.

**Figure 5.11**



**Figure 5.12**



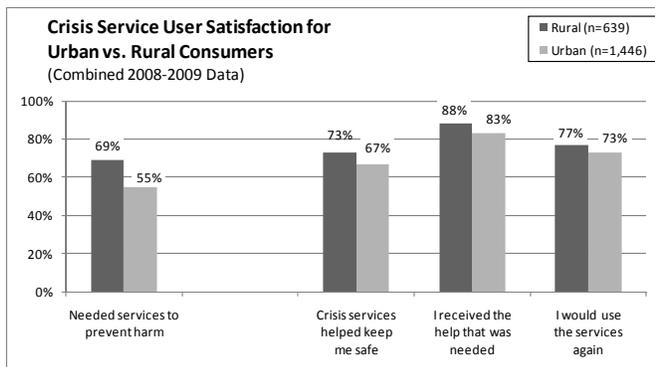
Against this backdrop, Figure 5.11 is extremely telling. It demonstrates that virtually all the decline in satisfaction from 2008 to 2009 can be attributed to the much smaller subgroup of crisis service users

who are not worried about hurting themselves or others. Among people who are seeking help for some other reason, satisfaction is low and declining. This finding raises intriguing but unanswered questions about who these dissatisfied individuals are, what type of help they are seeking, and why the mental health crisis system was unable to help with their problem. Finding 6 considers this potentially important question further.

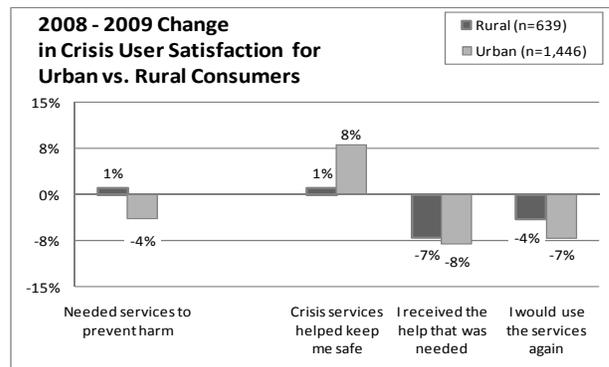
**Urban Crisis Service Users Are Less Satisfied with Crisis Services.** More than twice as many crisis service users surveyed have been from urban areas (n=1,446) than from rural communities (n=639). Figure 5.13 shows that rural service users are more satisfied than their urban peers, on every dimension.

Figure 5.14 describes the percent change in satisfaction from 2008 to 2009. Urban callers' satisfaction has fallen over time on two of the three measures. They are less likely now than a year ago to believe they received the help that was needed, or that they will use the service again. Interestingly, however, they were much more likely to think crisis services kept them safe this year compared to last.

**Figure 5.13**



**Figure 5.14**



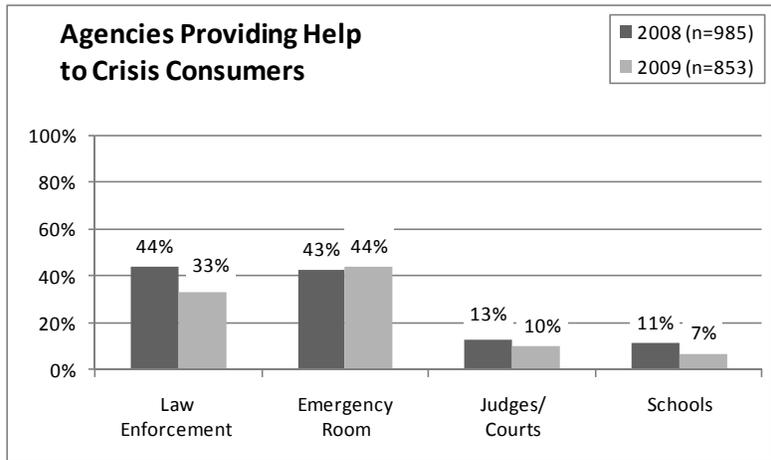
**Crisis Service Users Are Satisfied with the Help Received from Crisis Responders Other than LMHAs.** During a mental health crisis, people may encounter emergency responders other than the LMHA. The consumer survey provided an opportunity to learn more about the prevalence of such contact and people's satisfaction with the experience.

A minority of crisis service users report having any contact with service providers other than the LMHA (Figure 5.15). The most commonly encountered external agencies during a mental health crisis are law enforcement and emergency rooms. Courts and schools are encountered by far fewer individuals in crisis.

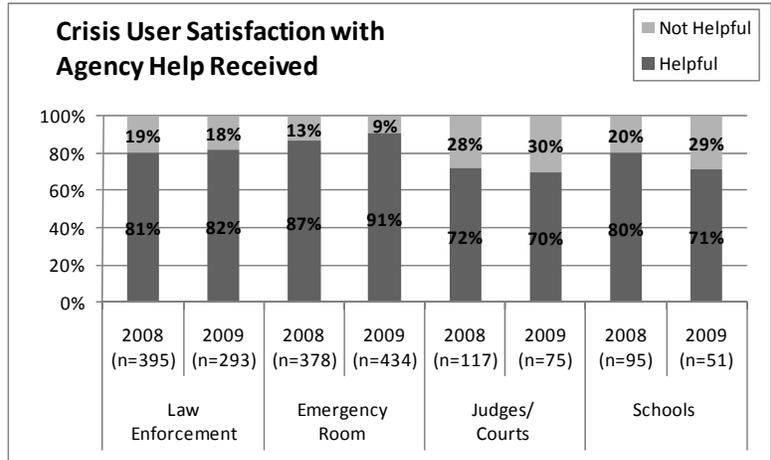
It is encouraging to note that the proportion of crisis service users who say they had contact with law enforcement has declined by fully 11%. To the extent that this finding can be broadly generalized, it suggests CSR may be reducing the proportion of consumers with law enforcement interaction. Still, evidence in Finding 8 suggests any reductions in law enforcement burden are being offset by the rising number of people being served.

Emergency room contact, by contrast, is just as commonly reported in 2009 as it was last year. Again, this is consistent with Finding 8 where the evidence shows ERs are not reducing their involvement in mental health crisis. Slight reductions are observed in contact with the courts and schools.

**Figure 5.15**



**Figure 5.16**



On the whole, survey respondents describe these encounters with agencies other than the LMHA as positive. They have been most pleased with the help received from emergency rooms, with satisfaction rates topping 90% in 2009 (Figure 5.16). However, respondents also favorably rated assistance from law enforcement (81%) and schools (about 75%). They were least enthusiastic about working with the courts (71%), possibly because they might be perceived as responsible for coerced treatment through a civil commitment process. Generally speaking, crisis service users see community partners as a valuable resource during their mental health emergency.

**Summary**

Satisfaction data was collected from crisis hotline users and users of crisis treatment services in 2008 (about ten months after the implementation of CSR), and again one year later. At least three out of four crisis hotline users were generally pleased with the services received both years. The largest percentage of hotline calls are resolved by telephone or referred to an agency to be handled during business hours. Hotline users were satisfied with all types of services received, and satisfaction improved from 2008 to 2009 in five of seven service categories.

Users of other crisis services, in contrast, showed substantial declines in satisfaction from 2008 to 2009. The largest percentage of individuals surveyed received MCOT services, followed by outpatient or community residential treatment, then hospitalization. 2009 survey respondents say their satisfaction has declined for four of the six crisis service types assessed. Most of this decrease occurs among individuals who sought crisis care for some reason other than to prevent harm to themselves or others. Respondents did, however, give favorable ratings to community partners other than the LMHA.

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**Finding 6: Changing characteristics of the crisis user population since CSR may require an adaptive response from LMHAs if the needs of new crisis consumers are to be met.**





**Finding 6: Changing characteristics of the crisis user population since CSR may require an adaptive response from LMHAs if the needs of new crisis consumers are to be met.**

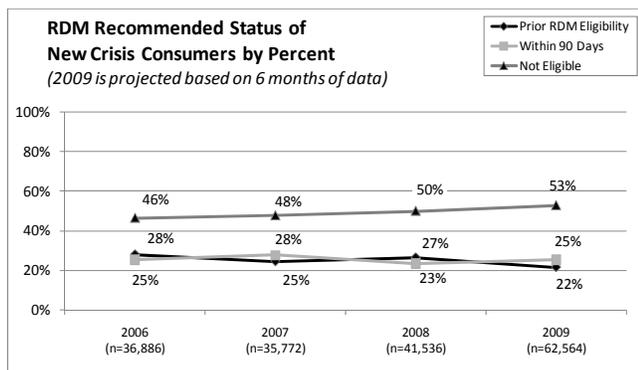
Since the introduction of CSR, Service Packages 0 and 5 now offer a comprehensive set of crisis services to individuals who are not currently enrolled in RDM, and who are not required to meet DSHS' traditional priority population criteria for service eligibility, which are based on diagnostic characteristics and level of impairment. As a result, the redesigned crisis service system is seeing substantial growth in the population of crisis consumers who do not qualify for long-term services under the Resiliency and Disease Management (RDM) System.

Relatively little is known about the characteristics of these service users, and the data presented here are tenuous. The discussion below examines available evidence about this potentially important group of new crisis consumers, and recommends future research to better understand their needs determine if an adaptive response might be required in the future.

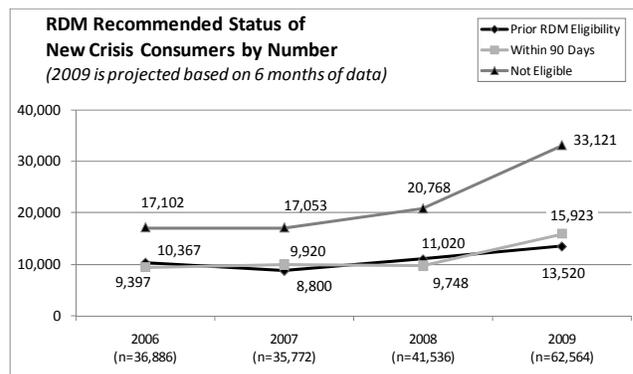
**A Growing Number of Crisis Consumers Are Ineligible for Long-Term RDM Care**

RDM Ineligible Crisis Consumers Are a Growing Group of Crisis Service Users. Figure 6.1 shows a rapidly expanding group of crisis service users who do not, and may never, meet eligibility criteria to enroll in RDM care. In 2009, for the first time, people who will not qualify to participate in mental health services over the long-term became the majority of crisis service users. Not only are they growing in percentage terms, but the absolute number of people in this category is projected to nearly double in 2009 compared to the 2007 pre-CSR baseline (Figure 6.2).

**Figure 6.1**



**Figure 6.2**



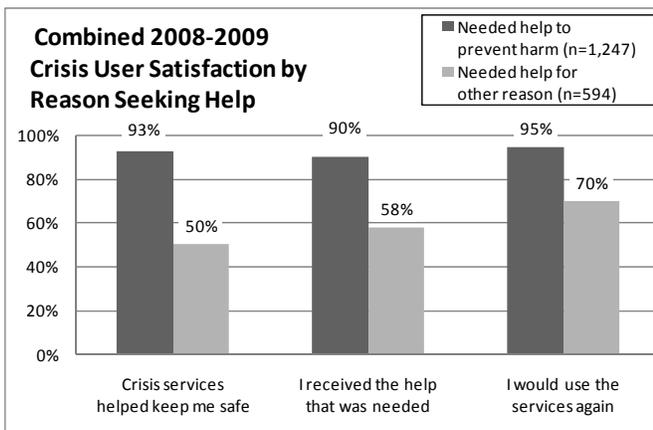
**Consumer Satisfaction Survey Data Provides Additional Information about Non-Traditional Crisis Service Users**

The data above establish that a large number of new crisis service users are not qualified for continued enrollment in RDM services. That alone implies that these individuals must have needs unlike those of the mental health priority population. At the same time, data from consumer satisfaction surveys reveal a parallel subgroup of crisis service users that say they are seeking help for some reason other than to prevent harm to themselves or others. This group, as well, has concerns other than those that define a traditional mental health emergency.

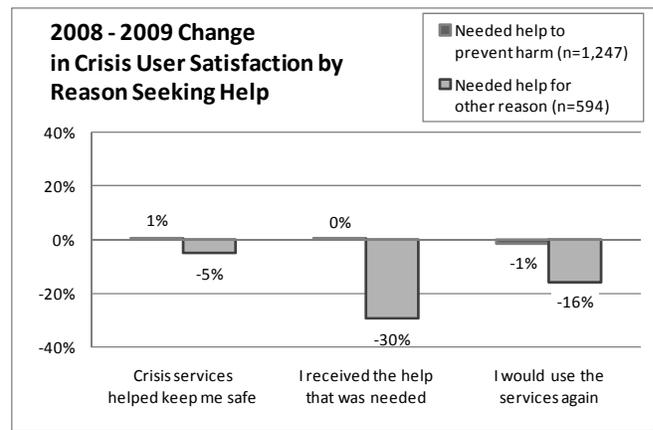
To the extent that these two consumer groups converge, data from the CARE system and the consumer survey together seem to indicate a potentially important sub-group of service users whose interests are different from those historically addressed in the mental health system. Little else is known about these individuals, but they do not feel the crisis services received met their needs, and they reported low satisfaction rates as a result.

**Crisis Service Users are Seeking Care for a Reason Other Than to Prevent Harm Are Much Less Satisfied with the Help Received.** The majority of crisis service users surveyed (68%, n=1,247) report they are seeking help from the mental health system in order to prevent harm to themselves or others. As shown in Figure 6.3, over 90% of these individuals are extremely pleased with the care received and expect to use the service again if needed.

**Figure 6.3**



**Figure 6.4**

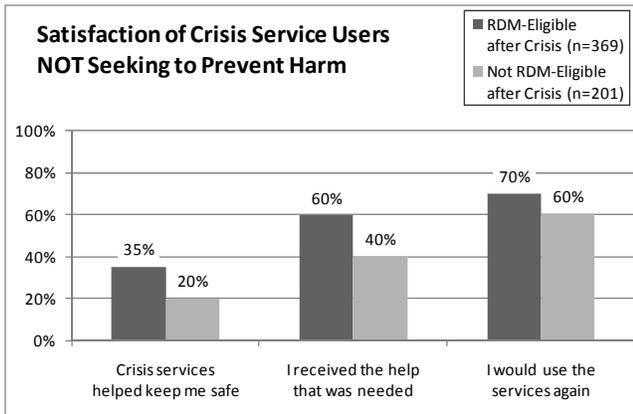


The remaining third of crisis service users (n=594), say they are seeking help for some reason other than to prevent harm to themselves or others. Their exact service needs are not well understood, but it is clear that they do not conform to the traditional criteria associated with a mental health emergency. Importantly, these individuals are highly dissatisfied with the services received. Compared to their peers seeking to prevent harm, they are 25 to 30% less happy overall.

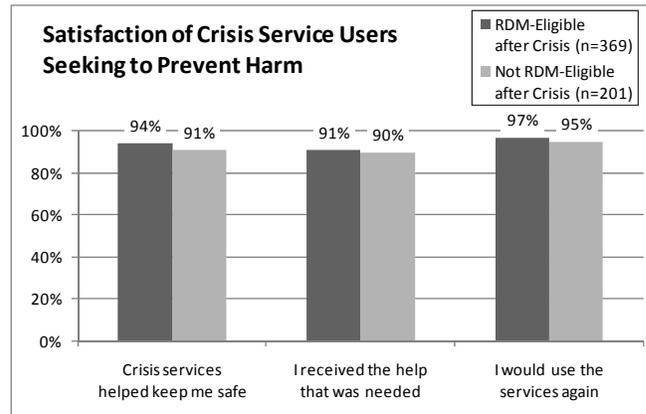
Not only are they currently less satisfied, but their satisfaction levels have declined sharply in just the past year. Figure 6.4 shows that the number of respondents who felt they received the help that was needed declined from 75% in 2008 to just 45% in 2009. The number who would use the service again fell from 79% to 60%.

**RDM Ineligible Crisis Consumers Are Significantly Less Satisfied.** RDM status is another factor contributing to the extreme dissatisfaction of some survey respondents. Figure 6.5 shows that among the subgroup of interest – people seeking crisis care for reasons other than to prevent harm – those who subsequently fail to qualify for RDM (33%) are significantly less satisfied than their peers who do qualify (66%). Stated differently, seeking help for an “other” reason plus failure to qualify for RDM results in the lowest satisfaction levels overall (Figure 6.5). Among those seeking to prevent harm, by contrast, satisfaction with the service received is high irrespective of long-term RDM eligibility (Figure 6.6).

**Figure 6.5**



**Figure 6.6**



These Findings Could Depict A Group of Crisis Service Users That are Not Well Suited to the Existing Service System. It is necessary to be cautious drawing firm conclusions on the basis of the tenuous data currently available. However, to the extent that these survey findings can be extrapolated to the RDM Ineligible group depicted in Figures 6.1 and 6.2, an interesting profile of new crisis consumers emerges. Taken together, these findings portray a new and growing group of crisis service users who:

- Do not meet criteria for RDM enrollment;
- Do not feel the current crisis system is meeting their needs; and
- Have very low satisfaction rates that are exacerbated by the lack of prospects for RDM enrollment.

It is possible that CSR could be attracting more consumers whose needs are not being fully addressed by the existing service system. This would explain the behaviors bulleted above. However, little else is understood about the characteristics of these individuals or the problems underlying their crisis encounters. It is possible that these are individuals who need mental health services, but who do not meet the inclusionary criteria for RDM, which are based on a small number of severe mental health diagnoses for adults and a high level of impairment for both adults and children.

Anecdotally, some may be primary substance abusers. Fully 93% of advocates, law enforcement, emergency room staff, judges, and other community partners participating in the stakeholder survey believe outcomes for mental health crisis consumers would be better if substance abuse services were more widely available. Because this is a known area of under-service in most communities, there are also clear incentives for individuals with drug or alcohol problems to seek help in the crisis service system.

Further study is needed to better understand this potentially important subgroup of consumers and to determine what policy options exist. It may be beneficial to refine crisis eligibility criteria to select those individuals who are best served by the services currently offered by LMHAs. Alternatively, the service system could be adapted so it is capable of truly addressing the needs of the present users. If this track is taken, and substance abusers are a significant component of the RDM ineligible service group, then further redesign efforts could result in a truly integrated mental health and substance abuse system. Conversely, without taking action to learn more about this issue, the mental health

system risks expending resources on a population whose needs cannot be fully met, and who incur even greater costs through repeat crises, while potentially undermining the ability of LMHAs to deliver high-quality services to the base constituency.

### **Summary**

The number of people who will not qualify for ongoing RDM services after the completion of a crisis episode has increased both in absolute terms and as a proportion of all crisis service users. Furthermore, some of these same consumers may belong to a subgroup of crisis survey respondents who say crisis service system is not well matched to their needs. They report they are using the service system for a reason other than to prevent harm. This makes them different from traditional mental health crisis service users. Finally, individuals in this group are highly dissatisfied with the services received. Further study is recommended to learn more about the needs of this population in order to determine if a policy response is appropriate.



**Finding 7: Community partners perceive some positive impacts of CSR, but further improvements are needed.**





## **Finding 7: Community partners perceive some positive impacts of CSR, but further improvements are needed.**

Many features of Crisis Services Redesign are intended to help LMHAs improve supports and relieve burden on community partners. Finding 1 shows that CSR has resulted in new services and infrastructure, addressing many of stakeholders' most significant concerns. This section describes how this new infrastructure is being perceived by the community partners who work closely with LMHAs.

The following sections report data obtained during the 2008 and 2009 stakeholder satisfaction surveys. The characteristics of the individuals who responded to the survey are presented in Appendix E. An important question to consider when interpreting this information is how well the responses represent the perspectives of an adequate number of stakeholders from a variety of LMHAs. Several patterns emerged to answer this question:

- Although nearly 1,000 participants responded to the survey each year, the number in some stakeholder groups, particularly consumer advocates, psychiatrists, and emergency room personnel, was somewhat low in both 2007 and 2008 (fewer than 80 per year).
- Stakeholders from all LMHAs were represented in the survey, and most groups of stakeholders consisted of participants from at least 20 different LMHAs.
  - The single exception to this was the psychiatrist participants, who came from only 15 different LMHAs in 2008 and 12 different LMHAs in 2009.
- Most groups of stakeholders had a good distribution of participants across LMHAs (defined as having no more than 20% of participants from a single LMHA within the stakeholder group), although there were two exceptions:
  - In 2008, 47% of psychiatrist participants were from one of only two LMHAs.
  - In 2008, 35% of emergency room participants were from a single LMHA

Thus, survey responses seem to represent a good cross-section of important stakeholder groups, with the exception of the psychiatrist participants, who were relatively small in number and who came from relatively few LMHAs. In addition, the 2008 emergency room data may have been dominated by participants from a single LMHA, although the data presented below shows similar responses obtained in 2009, when the emergency room data did not have this problem. Finally, the numbers of emergency room and consumer advocate participants were somewhat small, which should be taken into consideration when interpreting the information presented below.

### **General Satisfaction with Crisis Redesign**

The survey results that follow show that 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.

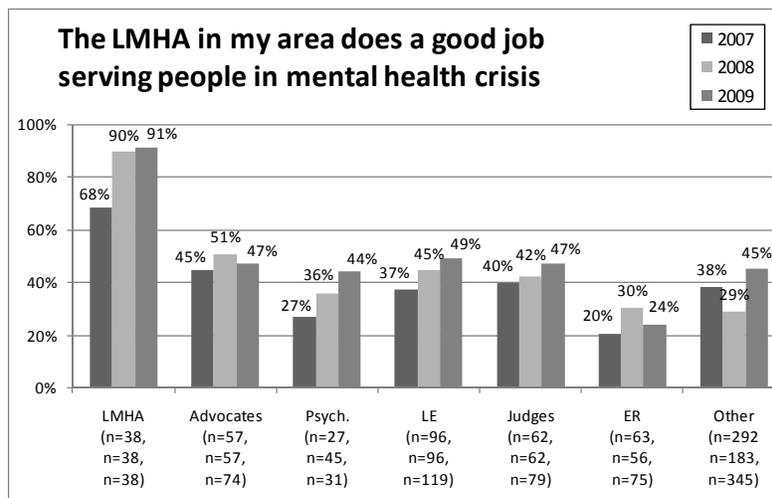
Community Partners Feel LMHA Crisis Services Have Improved Since CSR. Local stakeholders were asked to indicate whether they believe LMHAs are doing a better job serving people in crisis since the implementation of CSR. It was not possible to assess baseline satisfaction prior to the implementation of CSR services. Therefore, in 2008, 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.” In 2009, stakeholders were again asked to rate their satisfaction “in the past 3 months.”

Compared to the 2007 ratings, all types of stakeholders report some improvement in LMHA performance on nearly every measure (Figures 7.1 through 7.4). By 2009, respondents say LMHAs are doing a better job:

- Serving people in mental health crisis (a positive overall rating of 48% of stakeholders in 2009, up 9 percentage points from 2007);
- Offering the types of services that are needed (a positive overall rating of 34% in 2009, up 7 percentage points from 2007);
- Getting help to people in crisis quickly (a positive overall rating of 34% in 2008, up 6 percentage points from 2007); and
- Offering high quality crisis services (a positive overall rating of 41% in 2009, up 4 percentage points from 2007).

**Figure 7.1**



**Figure 7.2**

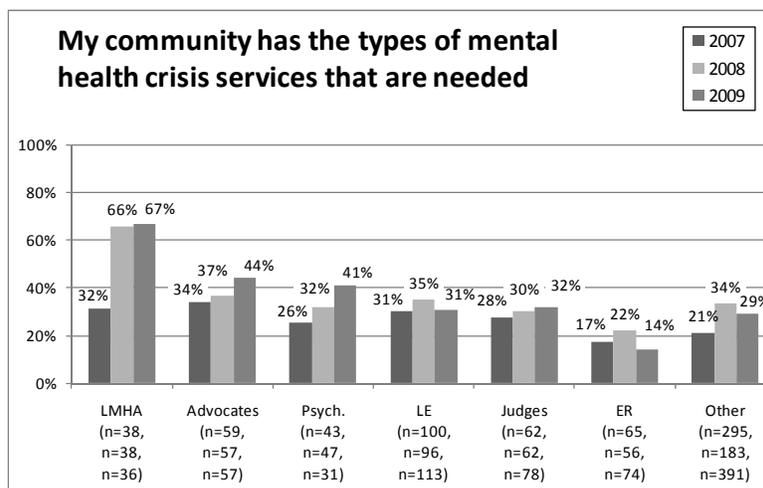


Figure 7.3

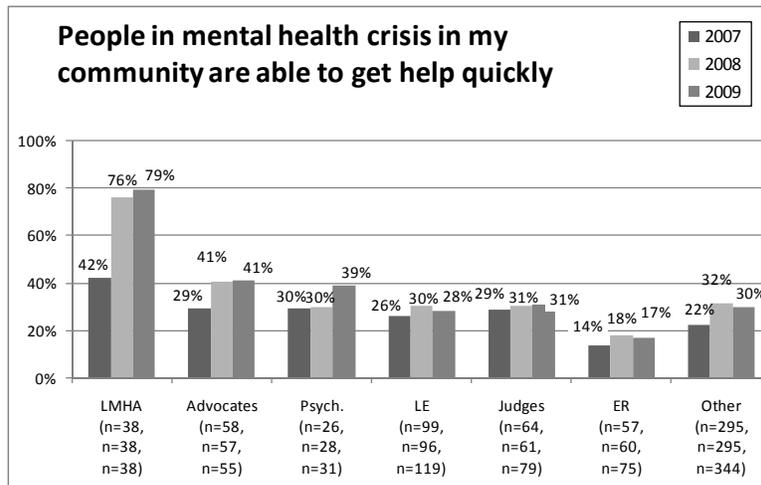
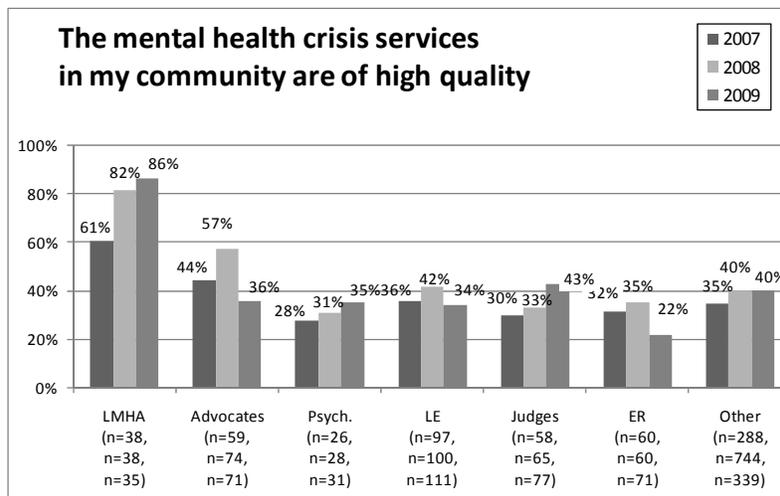


Figure 7.4

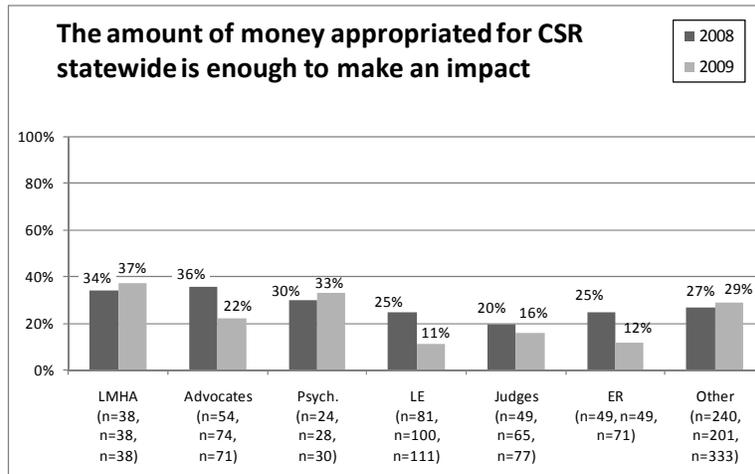


While there is a general perception that crisis response is improving, however, satisfaction ratings are still low in every respondent group except LMHAs. Emergency room personnel are the least satisfied of all stakeholders. They assigned the lowest ratings on all four measures. ERs, in particular, commonly reported lower satisfaction in 2009 compared to 2008 when crisis redesign was implemented.

In the site visits, LMHA staff expressed concern that some declines in satisfaction might be expected if CSR could not meet the initially high expectations of partner agencies, although only 37% of LMHA survey respondents indicated in their survey responses that this was a concern. It is also possible that burdens associated with the large increase in the number of mental health crisis service users that has followed CSR (see Finding 2) have overwhelmed any perception of benefits from the new services being provided.

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 7.5). Overall, only about one in four respondents (27% in 2008; 24% in 2009) believe enough funding has been committed to the effort.

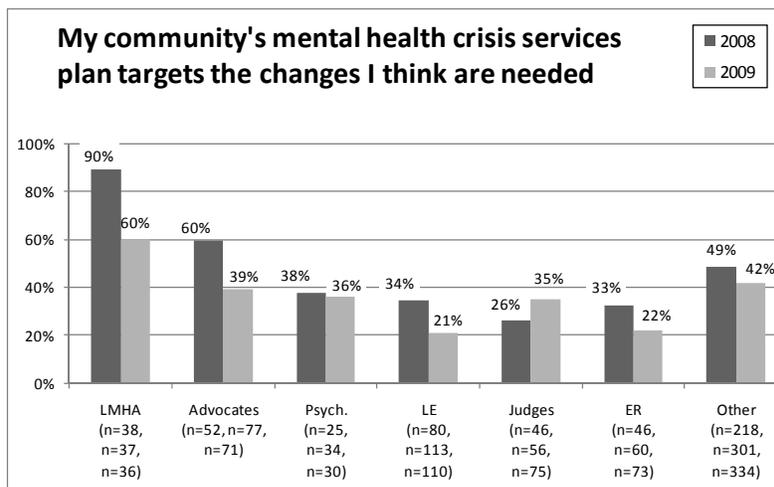
**Figure 7.5**



Advocates, law enforcement, ERs and judges have grown more discouraged that adequate resources are being invested in CSR. Satisfaction with the level of investment has been low but stable in other respondent categories.

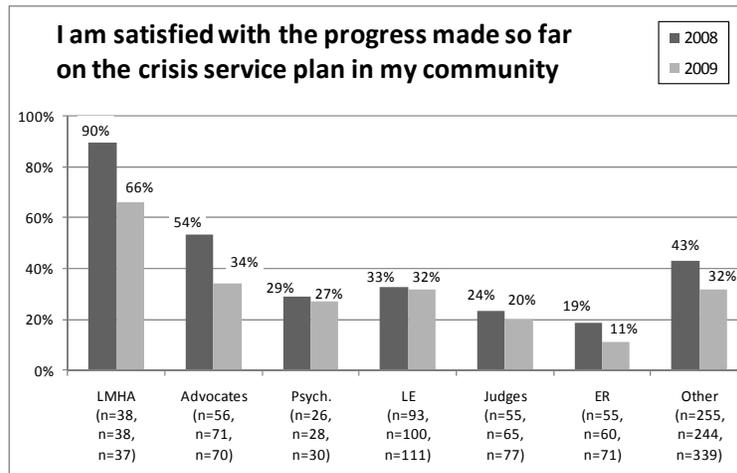
Community Partners Report Declining Levels of Satisfaction with Local Crisis Plans. Stakeholders were asked to rate their satisfaction with two specific features of the crisis plan adopted in their community (Figures 7.6 and 7.7). Respondents were not highly satisfied with either the type of changes being implemented (43% in 2008; 27% in 2009) or the progress made so far (38% in 2008; 32% in 2009).

**Figure 7.6**



As with the general satisfaction items above, satisfaction with the crisis plans and the progress made toward implementing those plans decreased for all groups between 2008 and 2009, with the largest declines reported by the LMHA respondents. Again, it is possible that the large influx of crisis consumers is overwhelming the system, hindering progress toward CSR goals and making LMHAs reconsider the approaches they are taking to CSR.

**Figure 7.7**

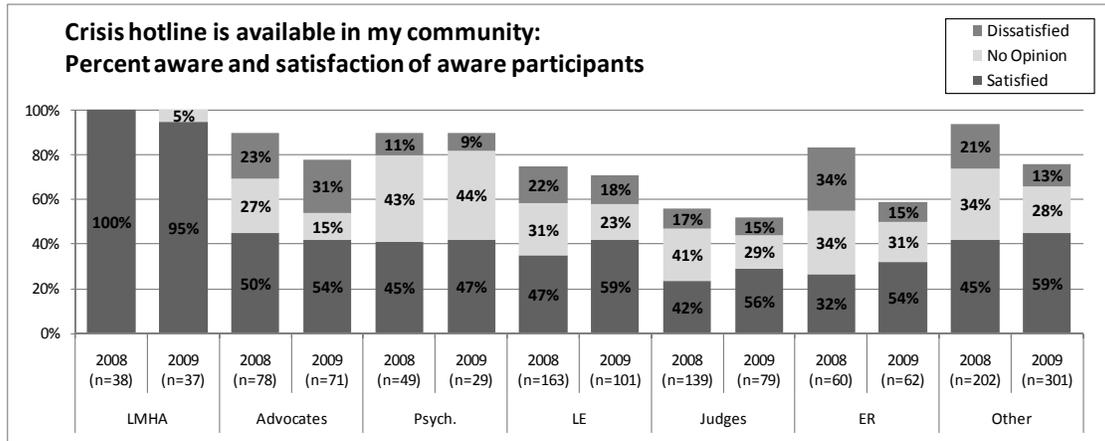


**Awareness and Satisfaction with Specific CSR Crisis Service Components**

In addition to providing global ratings, stakeholders were asked to rate their awareness of and satisfaction with each of the three main CSR service components. These include crisis hotlines, MCOTs, and crisis outpatient treatment. 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% of all aware respondents. Thus, satisfaction was not assessed for individuals who are unfamiliar with the services being rated.

Nearly Two Thirds 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 7.8), although the percent of survey respondents who were aware of the hotlines declined between 2008 (81%) and 2009 (73%). The largest drop in awareness was observed among ER respondents. This is concerning, as they might be expected to be among those who benefit most from new hotline capabilities given the role of the hotlines in orchestrating action among emergency responders. As all communities have maintained their hotlines during the past year, it is not clear what explains this drop in awareness. It is possible that issues such as turnover among ER staff could be contributing to a lack of knowledge about services. This decrease in awareness highlights the importance of LMHAs keeping regular lines of communication open with their community partners (see Finding 9, below).

**Figure 7.8**

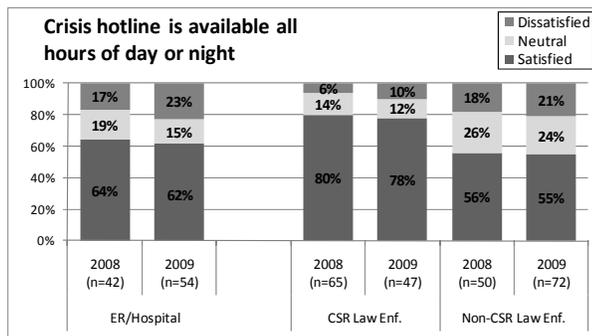


Although awareness declined somewhat from 2008 to 2009, satisfaction among aware participants significantly increased across the two years ( $p < .001$ ). Over half of respondents (60% in 2009, up from 48% in 2008) are satisfied with hotlines, and the percentage who are dissatisfied also significantly decreased between 2008 (20%) and 2009 (15%;  $p < .05$ ).

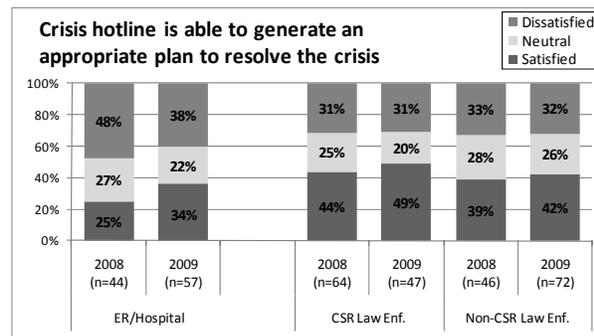
Hotlines are viewed positively by every LMHA with 100% reporting satisfaction in 2008 and 95% reporting satisfaction in 2009. Among non-LMHA respondents who know about crisis hotlines, 57% are pleased with the services in 2009 (up from 44% in 2008). Thus, it appears that, while general satisfaction with CSR may be decreasing, satisfaction with the specific hotline service seems to be increasing.

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 over 80% 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.

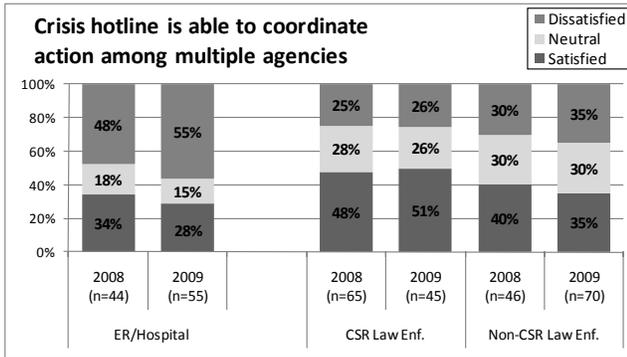
**Figure 7.9**



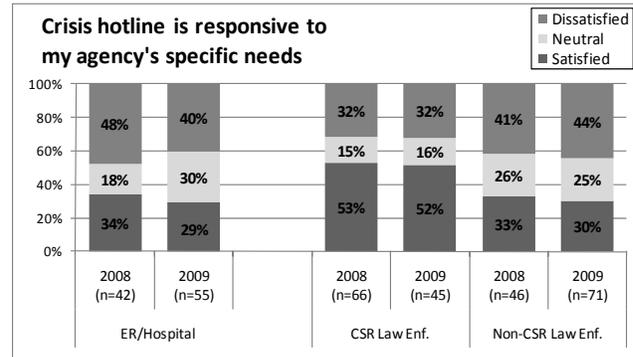
**Figure 7.10**



**Figure 7.11**



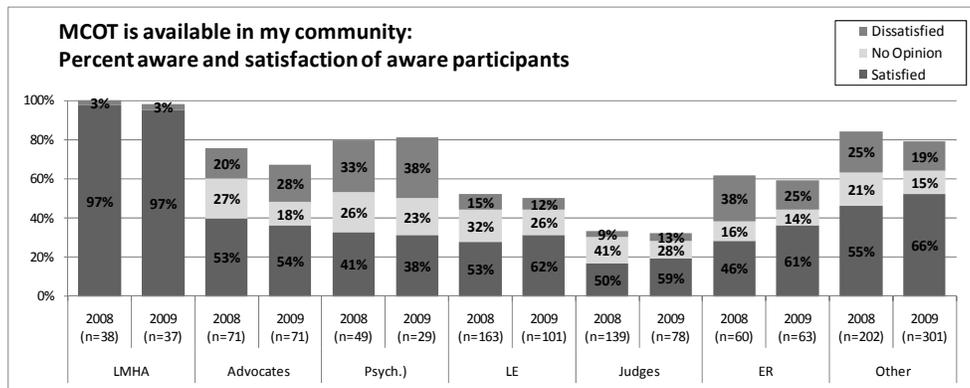
**Figure 7.12**



Emergency room and law enforcement representatives, particularly those who are CSR-involved, are most positive about the fact that crisis hotlines are available 24-hours a day (Figure 7.9). 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 7.10), to coordinate action between responding agencies (Figure 7.11), or to address the needs of their specific agency (Figure 7.12). Law enforcement agencies identified as CSR-involved are notably more pleased with hotlines' responsiveness to their specific agency concerns. Satisfaction with these specific aspects of hotline functioning has remained stable across 2008 and 2009.

Nearly Two Thirds 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 7.13**



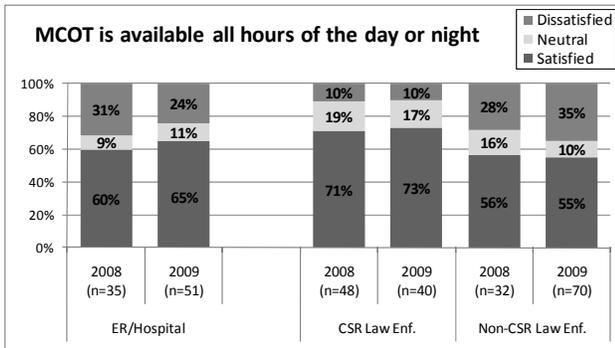
In 2009, awareness of MCOTs increased from 65% to 67% overall. However, as with crisis hotlines, the respondent groups most likely to need their assistance day-to-day are the least likely to know about their existence. Emergency rooms, law enforcement, and judges are the least aware about MCOT services (Figure 7.13).

Similar to hotlines, satisfaction across participant groups increased significantly ( $p < .05$ ) between 2008 (55%) and 2009 (64%), and the percent of dissatisfied participants decreased slightly (21% in

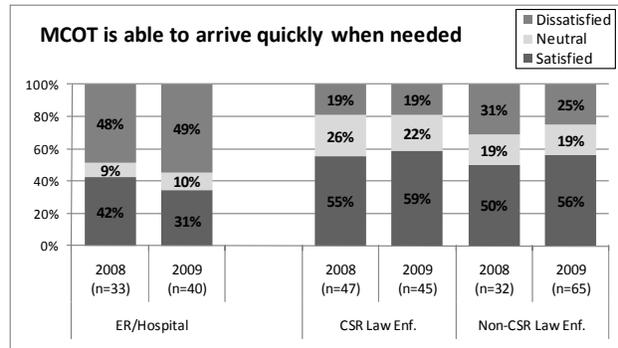
2008 and 19% in 2009). Nearly all community mental health providers are satisfied with the MCOTs (97% satisfied in 2008; 95% in 2009). Among non-LMHA respondents who know about MCOTs, 62% are pleased with this service in 2009 (up from 52% in 2008).

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.

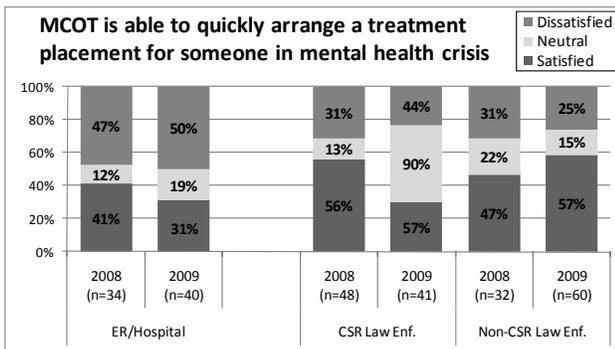
**Figure 7.14**



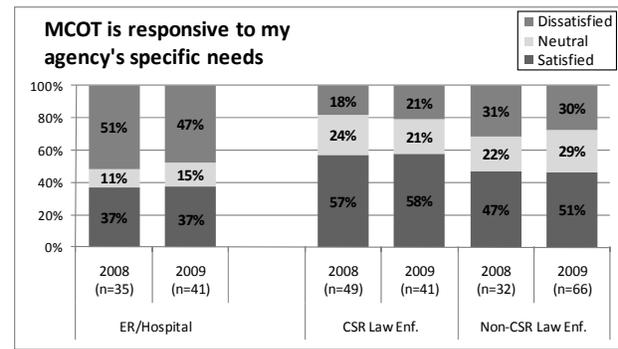
**Figure 7.15**



**Figure 7.16**



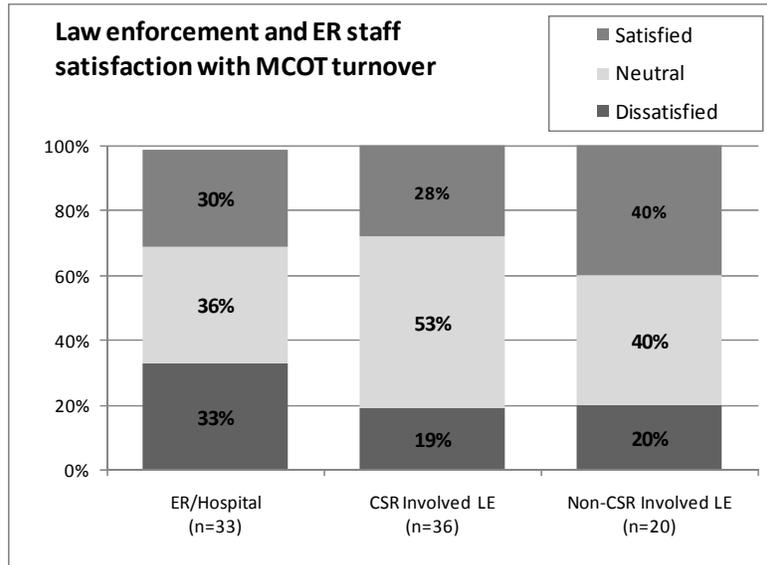
**Figure 7.17**



As with the hotlines, respondents are most pleased with the MCOTs' availability at all hours of the day or night (Figure 7.14). They are only moderately satisfied with the MCOTs' ability to arrive quickly when needed (Figure 7.15) or to arrange prompt treatment for people in crisis (Figure 7.16). A large proportion of emergency rooms in particular feel that MCOTs are not responsive to their specific needs (Figure 7.17). Law enforcement officers view them as being somewhat more responsive.

Satisfaction with these specific aspects of hotline functioning has generally remained stable across 2008 and 2009, although CSR-involved law enforcement representatives did report a large drop in their satisfaction with the LMHAs' ability to quickly arrange a treatment placement. It may be that the large increase in crisis consumers reported in Finding 2 is making it more difficult to secure treatment placements, despite the increased availability of treatment options in many communities.

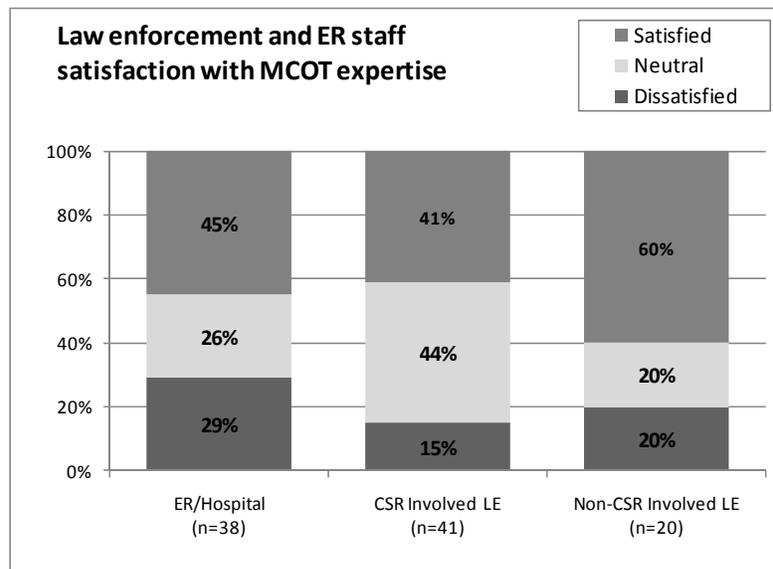
**Figure 7.18**



To assess some new questions that came up during the 2009 site visits, two additional items were added to assess satisfaction with MCOTs' turnover and expertise. Law enforcement officers and emergency room personnel, particularly, express some dissatisfaction with MCOT staff turnover (Figure 7.18), although only 23% of LMHAs indicated in the survey that they have had difficulty with turnover on the MCOTs.

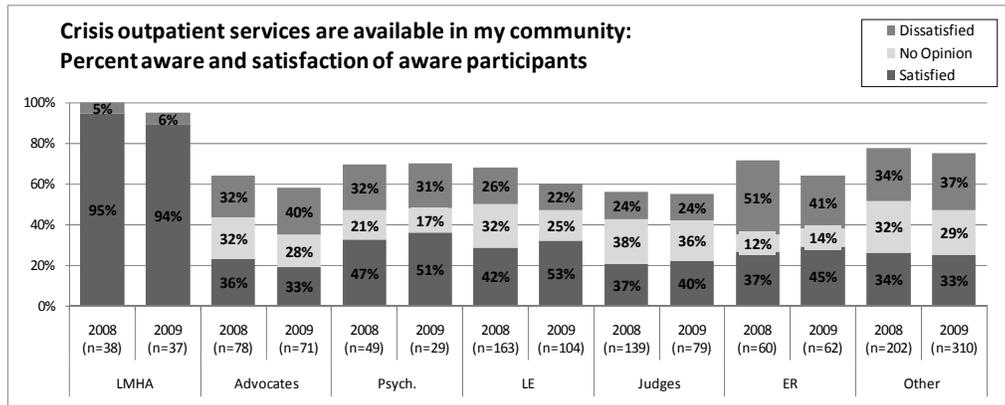
Many participants are satisfied with MCOT staff expertise. The Non-CSR Involved law enforcement officers were particularly pleased with their job knowledge, but nearly a third of emergency room participants are dissatisfied with this aspect of the MCOTs (Figure 7.19).

**Figure 7.19**



Nearly Half of All Stakeholders Are Satisfied with Local Outpatient Treatment Options.<sup>16</sup> Finding 1 confirms that CSR has increased local alternatives to state hospitalization. Still, in 2009 68% of stakeholders are aware that crisis outpatient treatment services are available locally. This figure is down slightly from 72% awareness of these facilities in 2008.

**Figure 7.20**



Satisfaction with crisis outpatient services was stable across participant groups between 2008 (42%) and 2009 (43%). The percent of dissatisfied participants (30% in 2008 and 32% in 2009) was also unchanged. However, as with the other services, LMHAs' are much more satisfied with this treatment than are their community partners (Figure 7.20). Nearly all LMHAs (95% in 2008; 89% in 2009) reported being satisfied with their outpatient crisis services. Among non-LMHA respondents who are aware of these services, the percent of respondents satisfied with these facilities was 39% in 2009 and 38% in 2008.

It is only possible to speculate about reasons why satisfaction is lower with the crisis outpatient services. Unlike crisis hotlines and MCOTs, crisis outpatient services do not involve direct interaction with other stakeholder groups. Rather these services are offered exclusively by the LMHA after the initial crisis evaluation has taken place and a treatment determination has been made. The positive viewpoint of mental health center staff may therefore result from their greater awareness of, and direct involvement in, recent service improvements, while those of other stakeholders may be based on limited contacts with the services or on past experience with the pre-CSR delivery system. It is also possible that, for the 2008 survey respondents, 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, although the similar 2009 numbers suggest this was not a driving force behind those ratings.

**Summary**

The stakeholder survey was used to evaluate satisfaction with crisis services overall, satisfaction with crisis plans and available resources, and progress made toward accomplishing CSR goals including satisfaction with three specific aspects of CSR: hotlines, MCOTs and crisis outpatient services.

Relative to ratings of 2007 services, general satisfaction with crisis services remains low, but has improved across all stakeholder groups. In 2009, ratings for emergency room respondents were even lower than their 2008 ratings. Several other groups also reported some decreases in satisfaction between 2008 and 2009. It is possible that these decreases are due to stakeholders' initially high expectations for CSR being disappointed, or because the rapid increase in the numbers of crisis

service users that has occurred during CSR has been overwhelming to stakeholders and has overshadowed any improvements that have been made.

All stakeholder groups say they believe insufficient funds have been allocated statewide to support CSR, and these perceptions have gotten stronger between 2008 and 2009. Nearly all groups also report less faith that their communities' crisis service plans are targeting the right types of changes and lower satisfaction with the progress being made toward implementing these plans. Notably, the largest decreases in these items are among LMHA respondents. Again, it may be that the large influx of crisis service users into the system is making it difficult to implement changes and may be making stakeholders reconsider the types of investments that may be needed to work with this population.

Finally, although general satisfaction with CSR seems to be declining somewhat, satisfaction with specific CSR services appears stable and, in some cases, quite good. In 2009, approximately two thirds of participants are satisfied with hotline and MCOT services. These two sets of numbers are encouraging, given that hotlines and MCOTs are the cornerstone of CSR and are being utilized statewide. Somewhat less encouraging are the satisfaction figures with crisis outpatient services, although nearly half of participants are also satisfied with those services. However, it is likely that these stakeholder groups have less involvement with these services, so their ability to evaluate them is unclear.

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**Finding 8: Increasing numbers of crises continue to place burdens on law enforcement agencies and emergency rooms.**





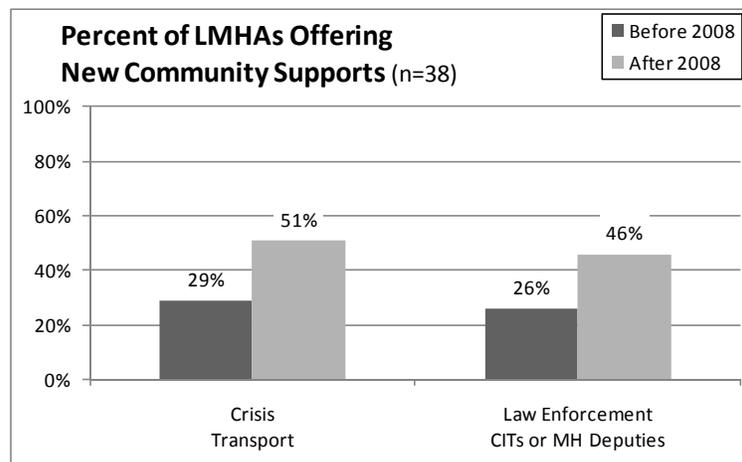
## Finding 8: Increasing Numbers of Crises Continue to Place Burden on Law Enforcement Agencies and Emergency Rooms.

Other than the LMHAs themselves, the two community stakeholder groups for which CSR holds the largest potential impact are law enforcement officers and emergency room personnel. Both groups often represent the first point of contact for individuals in crisis. This section presents data on the types of impacts CSR has had on these two groups.

### 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 8.1



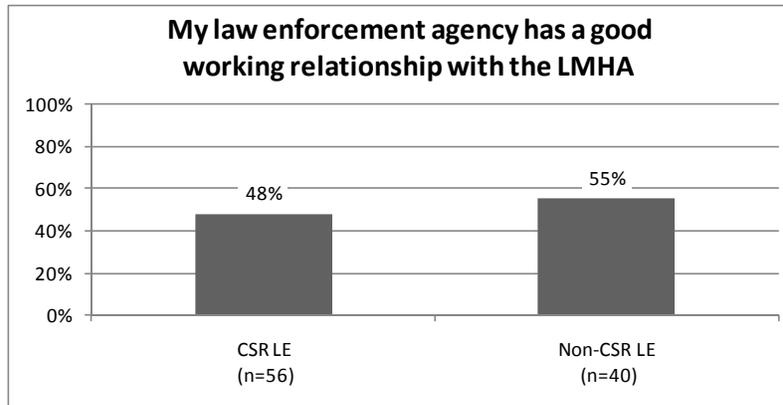
LMHA staff describe several strategies being used to reduce transportation burden on law enforcement.

- 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 locally for screening, treatment, or state hospitalization, assuming the client is willing to be treated and does not pose a safety threat.
- If MCOTs can do medical screenings, a service currently offered by 13 LMHAs, this potentially saves officers a separate trip to the emergency room or to another medical facility for this purpose.
- 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 8.1).

- 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.

Despite these efforts, however, law enforcement officers indicate that their working relationship with LMHAs has room to improve (Figure 8.2). Only half of law enforcement participants in 2009 said they have a good working relationship with their LMHA. Interestingly, ratings by CSR-Involved law enforcement officers were somewhat lower than those by non-CSR involved officers.

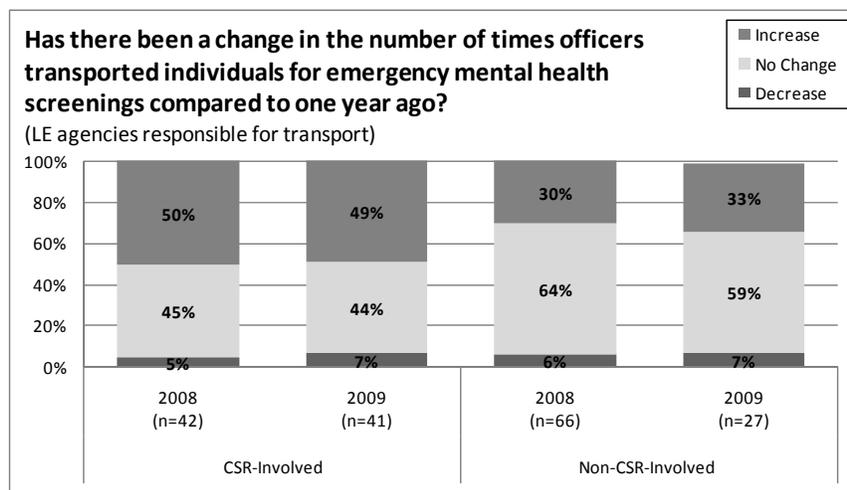
**Figure 8.2**



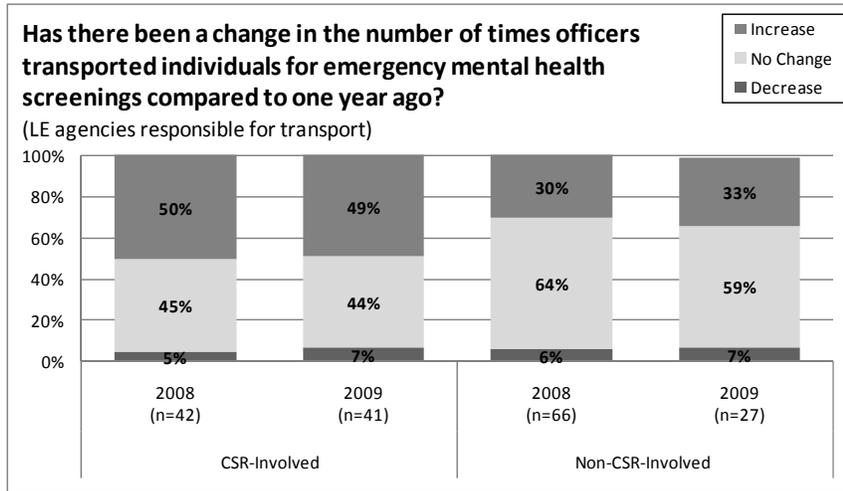
Law Enforcement Transportation Burden is Unchanged. In order to assess whether these new supports are making a difference, law enforcement survey respondents were to say whether they engage in a given activity. Those who indicated they do were then asked to indicate whether that activity has decreased, increased, or remained the same relative to the same period one year ago.

The percentages of law enforcement agencies that have some responsibility for local transportation to emergency mental health screenings have remained stable between 2008 and 2009 (approximately 80% of all respondents both years). Still they are making the same or fewer trips for community-based emergency mental health screenings. This finding holds for two-thirds of non-CSR-involved law enforcement agencies and half of all CSR-involved respondents (Figure 8.3).

**Figure 8.3**

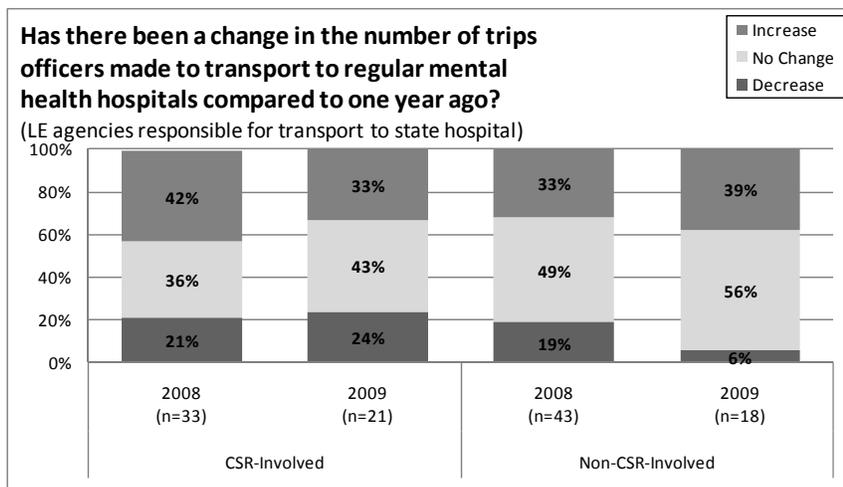


**Figure 8.4**



Although the percentage of all crisis consumers going to the state hospital has decreased, the total number of state hospitalizations has remained stable post-CSR (Finding 2). The burden of transporting individuals to the state hospital among CSR Involved agencies decreased somewhat between 2008 and 2009 while the percent of Non-CSR Involved agencies with this responsibility slightly increased. Approximately two thirds of both groups of law enforcement participants indicated that the numbers of trips they are taking to the state hospital are either decreasing or stable (Figure 8.5). Still it may be important that one third say that the number of trips is increasing (Figure 8.4).

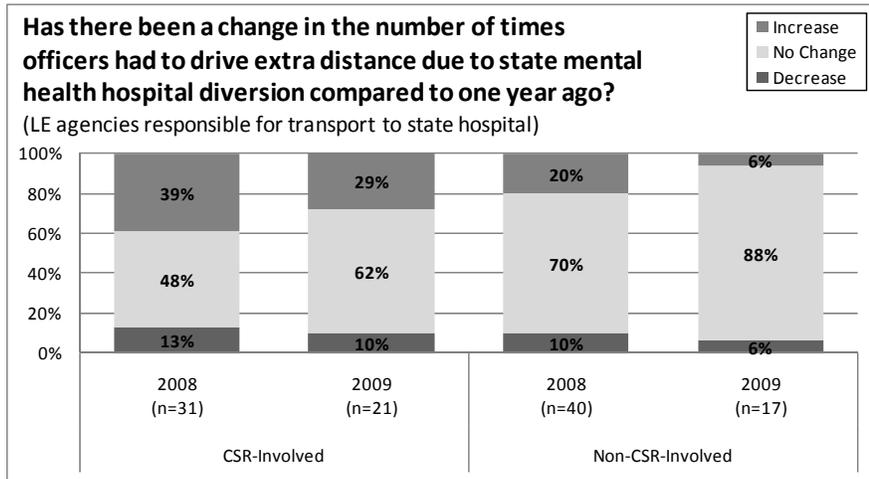
**Figure 8.5**



Finally, evaluators were interested in whether the burden of traveling extra distances when the state hospital is full (i.e., “on diversion”) has despite stable numbers of individuals being hospitalized post CSR. For Non-CSR Involved agencies, most (94%) report that this burden is either unchanged or decreasing (Figure 8.6). However, a different pattern emerges for the CSR-Involved agencies, about

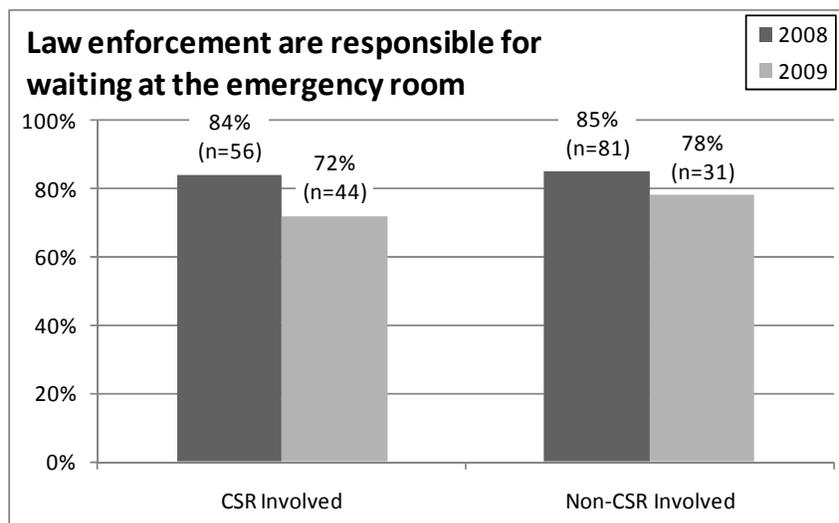
a third of whom (39% in 2008 and 29% in 2009) say that they must make more trips involving extra distances. During site visits, LMHA staff often described relying on sympathetic or cooperative law enforcement agencies to deal with their more difficult cases. It may well be that these agencies are experiencing increased transportation burden due to their willingness to cooperate with LMHAs when other agencies are not.

**Figure 8.6**



Law Enforcement Agencies' Emergency Room Wait Times Are Unchanged. Law enforcement officers are commonly asked to provide security to emergency rooms while potentially dangerous individuals are present. Until a treatment placement is found for the person in crisis, 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 rapidly, relieving officers of this duty more quickly. It is also possible that other solutions, such as use of emergency room security rather than police officers, might also decrease this burden.

**Figure 8.7**

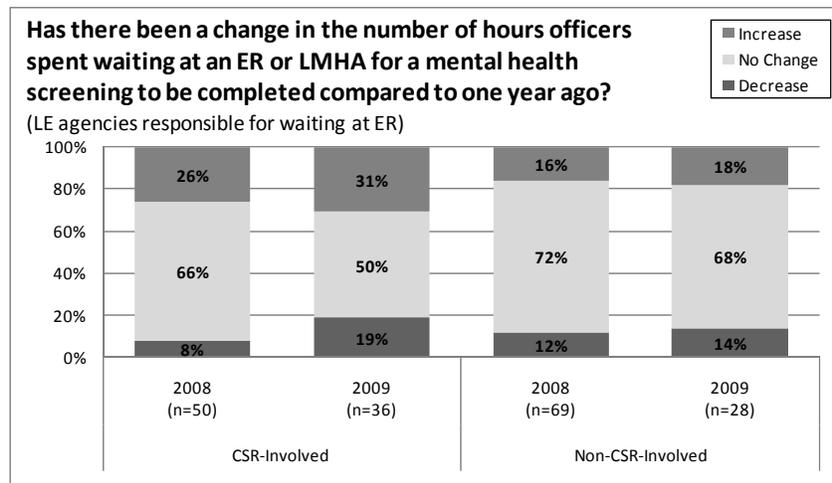


At present, however, there is no evidence that law enforcement wait times are being substantially reduced. While the number of law enforcement agencies being asked to wait in emergency rooms has declined slightly (Figure 8.7), once there, very few officers say their wait times are reduced (Figure 8.8). Indeed, CSR-involved agencies actively partnering with mental health centers are most likely to report increases in time spent waiting.

### 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.

**Figure 8.8**

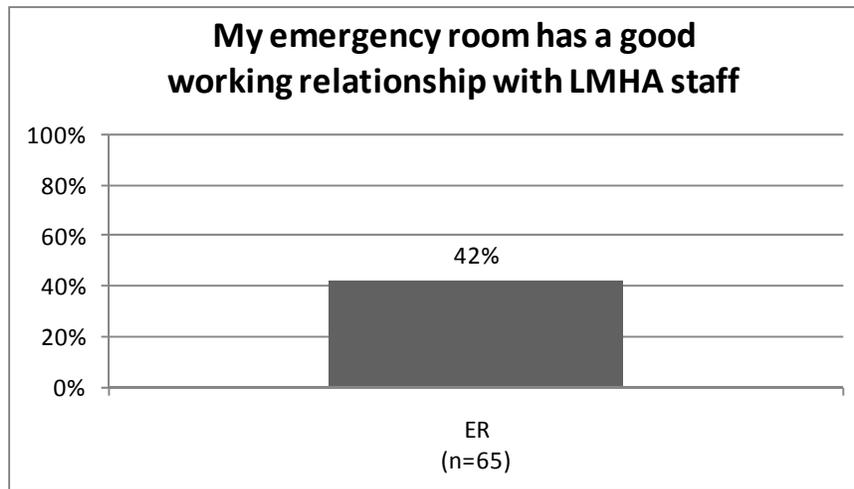


Some LMHAs have enacted policies to encourage completion of a psychiatric screening in a community setting or mental health clinic before individuals are taken to the emergency room. LMHAs are using varied approaches for emergency room diversion suited to their own service system and community (see Finding 1).

- Some new crisis emergency centers have qualified medical personnel on staff to perform their own medical clearances.
- As a result, only people who are going to be hospitalized for mental health services actually visit the ER.
- 13 LMHAs report that their MCOTs have the capability to do basic medical screenings.
- All LMHAs are developing alternatives to state hospitalization, which will reduce demand for medical clearances.

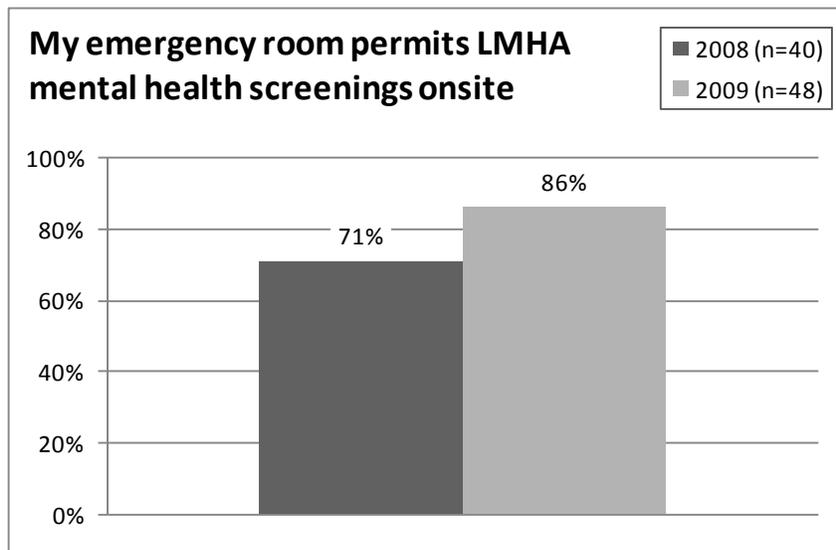
Despite these efforts, however, emergency room personnel, like law enforcement officers, indicate that their working relationships with LMHAs have room to improve (Figure 8.9).

Figure 8.9



Emergency Rooms Remain the Primary Venue for Medical Screenings. In many communities, law enforcement officers still routinely deliver people in mental health crisis directly to the emergency room. Although LMHAs are working to develop alternatives, an average 72% of medical evaluations and 40% of psychiatric screenings are conducted in emergency rooms in 2009.

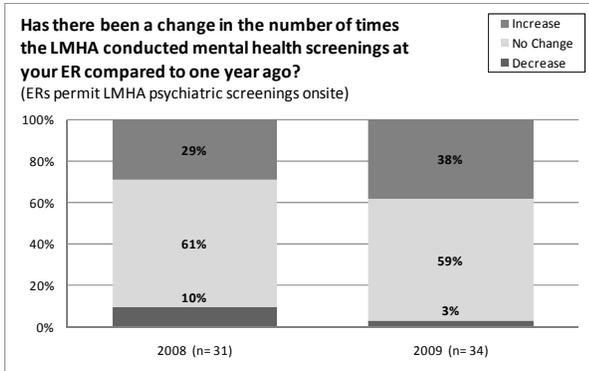
Figure 8.10



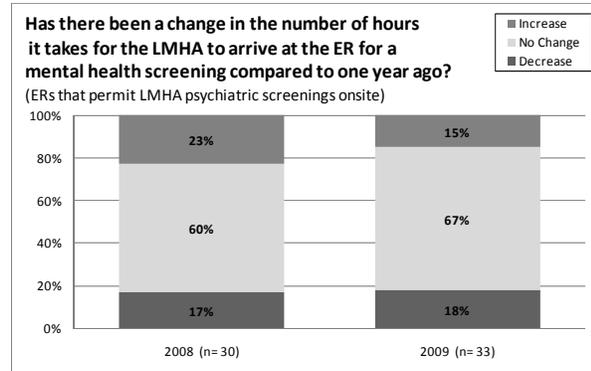
Once consumers arrive at the ER, MCOT staff ordinarily provide a mental health screening at that location. Emergency rooms seem to be increasingly open to allowing this to occur (Figure 8.10). With a larger number of people accessing crisis care post-CSR (Finding 2), one would expect that the number of screenings taking place in ERs would be increasing. However, nearly two thirds of ER respondents say there has been no change or there have been decreases in ER-based screenings over the past year (Figure 8.11). There are mixed reports whether LMHA response time has improved

since CSR (Figure 8.12). About the same proportion of emergency room respondents say they are occurring more or less quickly. Most report no changes.

**Figure 8.11**

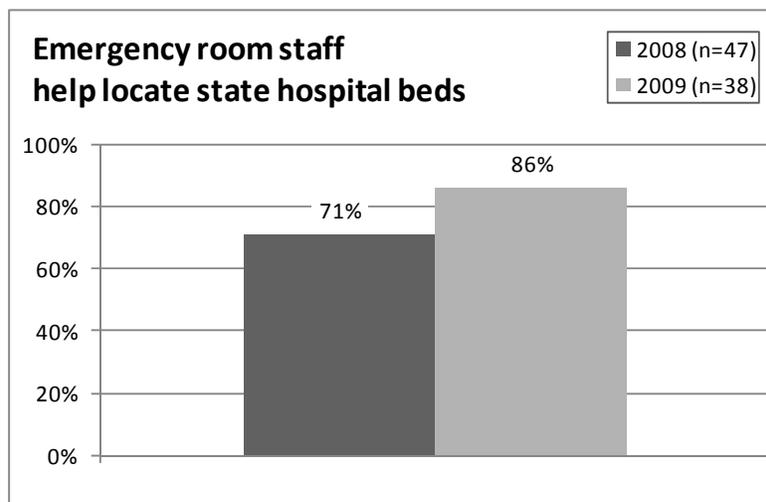


**Figure 8.12**



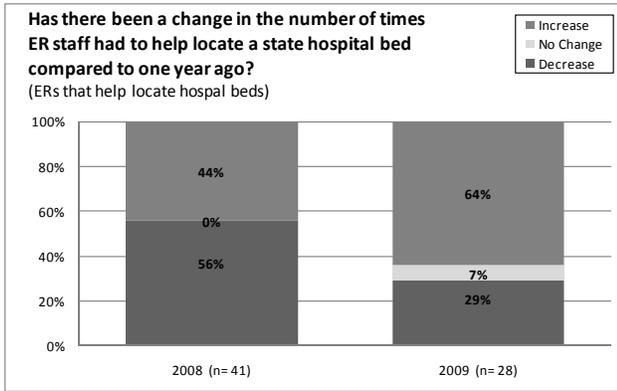
**Difficulties Locating Treatment and Transporting Consumers Continue to Place Burden on Emergency Rooms.** Once mental health consumers are stable and medically cleared, ER interview participants say it is difficult to move them out of their care and into treatment placements. Between 2008 and 2009, the percentage of emergency room respondents who say they have had to help locate a state hospital bed has increased (Figure 8.13). They are also doing so more frequently as nearly two thirds of ER staff in 2009 say that this burden is increasing (Figure 8.14). Many also believe the amount of time required to resolve each case is increasing (Figure 8.15).

**Figure 8.13**

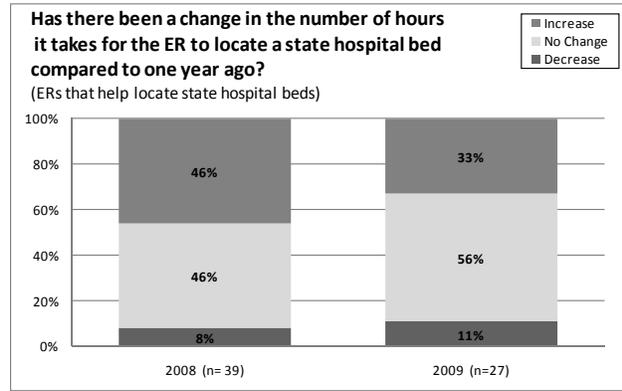


Emergency room participants reported difficulties locating hospital beds are supported by information provided by the LMHAs. Only 11% of LMHAs say CSR has made it easier to locate state hospital beds. More importantly for emergency rooms, nearly all LMHAs say it is particularly difficult to find a placement for individuals with co-occurring health conditions (Figure 8.16). These are the very consumers who may be most likely to require emergency room care during their crisis.

**Figure 8.14**

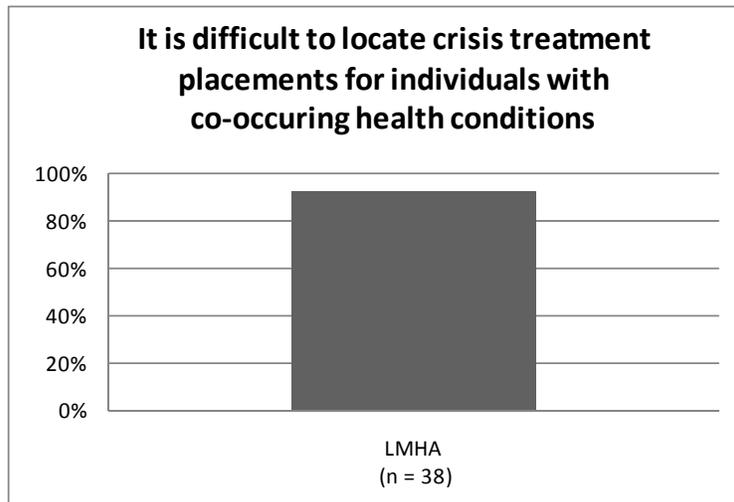


**Figure 8.15**



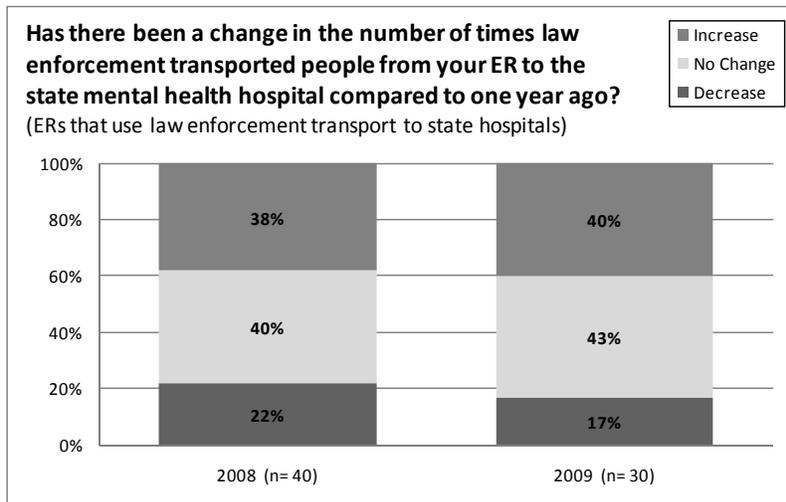
Once a treatment placement is found, emergency room staff face further challenges arranging transportation to the treatment location. Most ER respondents (80% in 2008 and 72% in 2009) say that law enforcement officers have transported their patients to state hospitals during the past year. Although the numbers of state hospitalizations have not increased, about 40% of participants say that the number of law enforcement transports is increasing (Figure 8.17).

**Figure 8.16**

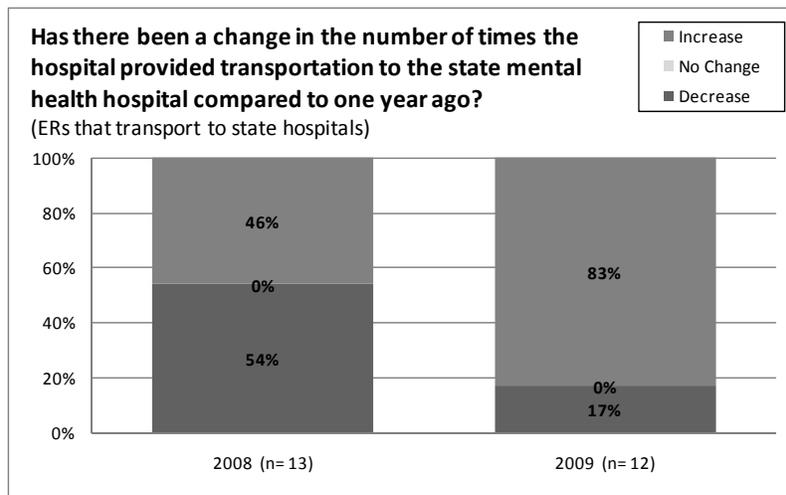


In addition to increased duties coordinating transportation with law enforcement, a sizeable majority of emergency room respondents (72% in 2008 and 69% in 2009) say that their hospital has had to assume the duty of delivering people to state mental health hospitals. The agencies also report this has occurred with increasing frequency over the past year (Figure 8.18).

**Figure 8.17**



**Figure 8.18**



**Summary**

The information provided in Finding 2 indicates that the numbers of individuals using crisis services has increased under CSR. As such, it is not surprising that, although LMHAs have enacted many changes designed to decrease burden on law enforcement agencies and emergency rooms, these efforts have not been entirely successful. For law enforcement agencies, the burden of crisis transportation has not increased as much as might be expected given this increased volume. The law enforcement agencies who are more actively collaborating with LMHA staff are reporting some increases in burden, particularly for transporting individuals long distances to state hospitals. Interview data suggests that LMHAs often learn to rely on “cooperative agencies” when dealing with difficult cases; these survey data suggest that this may be leading these agencies to become burned out and dissatisfied.

In contrast to the law enforcement data, there is evidence that emergency room burden is increasing, although the relatively small numbers of ER staff responding to these items, particularly in 2009, must be considered when interpreting these data. This increased burden for hosting mental health screenings and coordinating or providing transportation to crisis consumers likely explains emergency room respondents' low overall satisfaction with crisis redesign. As reported in Finding 4, ERs are the single least satisfied stakeholder group on a number of measures including available mental health services, speed of MCOT response, and progress made so far implementing CSR.



**Finding 9: Communities with engaged and informed stakeholders seem to be implementing CSR more effectively, although many communities continue to have difficulty collaborating.**



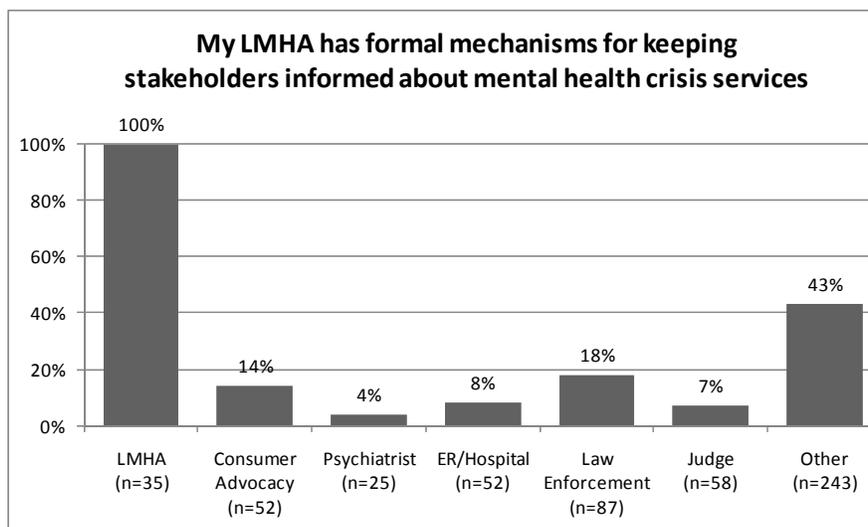


**Finding 9: Communities with engaged and informed stakeholders seem to be implementing CSR more effectively, although many communities continue to have difficulty collaborating.**

Interview results indicate that, wherever inter-organizational communication and collaboration is strong within a mental health region, 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 more 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.

**Figure 9.1**



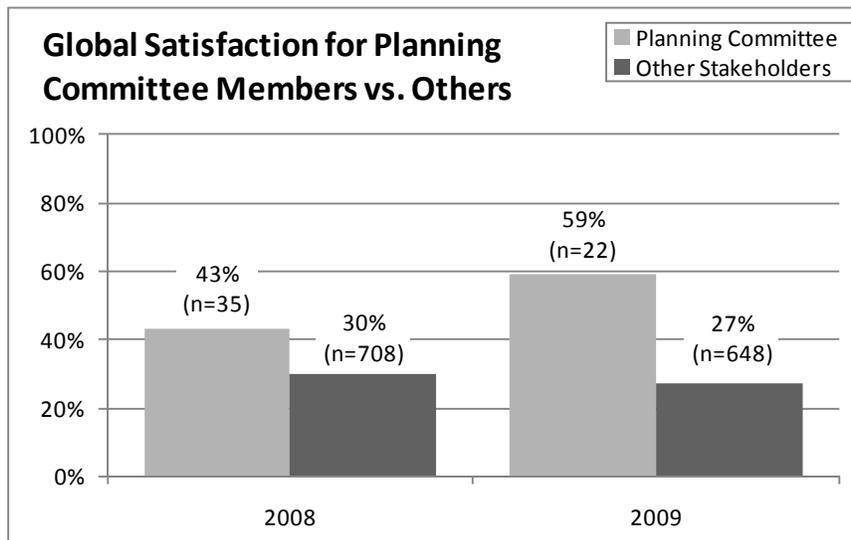
Two examples of effective local collaboratives observed during site visits include:

- 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.

Items were added to the 2009 stakeholder survey assessing the degree to which LMHAs have formal mechanisms for communicating about crisis services with their community stakeholders. All LMHAs indicate they have such mechanisms. More than one third (37%) have standing community planning meetings, 11% use newsletters, 18% use e-mail distribution lists, and 13% circulate data about CSR outcomes to their stakeholders. However, very few community stakeholders are aware of these efforts (Figure 9.1), making it clear that intended audiences are not being reached.

**Figure 9.2**



Community Partners Who Are Informed and Engaged in CSR are More Satisfied. Analyses were conducted to determine whether community partners who are actively engaged in planning and implementing CSR are in fact more satisfied. Results show individuals who are aware and informed are more content. Global satisfaction<sup>17</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 ( $p < .01$ ).
- I am aware of the mental health Crisis Services Redesign strategies being implemented in my community ( $p < .05$ ).
- My Local Mental Health Authority keeps me informed about mental health crisis services ( $p < .01$ )

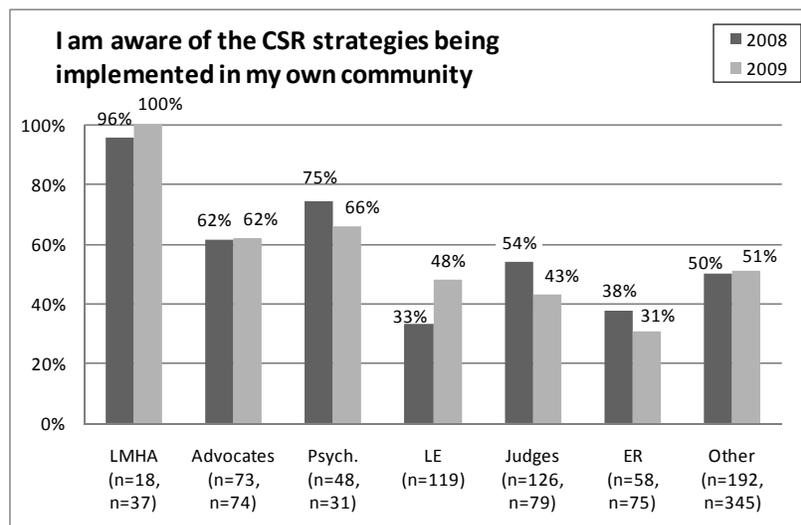
- Agencies in my community work well together to assist people in mental health crisis ( $p < .01$ ).

Significantly more positive satisfaction ratings were also attributed to:

- Respondents who were identified by LMHAs as being actively involved in CSR ( $p < .05$ ).
- Stakeholders who indicated they were part of their community's CSR planning committee ( $p < .01$ ) (Figure 9.2).

Combined with the higher hotline and MCOT ratings provided by CSR-involved law enforcement agencies in Finding 7, these results suggest that keeping local partners informed and engaged can be central to the success of CSR. At the same time, Finding 8 suggests LMHAs exercise caution about relying too heavily on close collaborators, risking burn out among those most willing to be proactive partners.

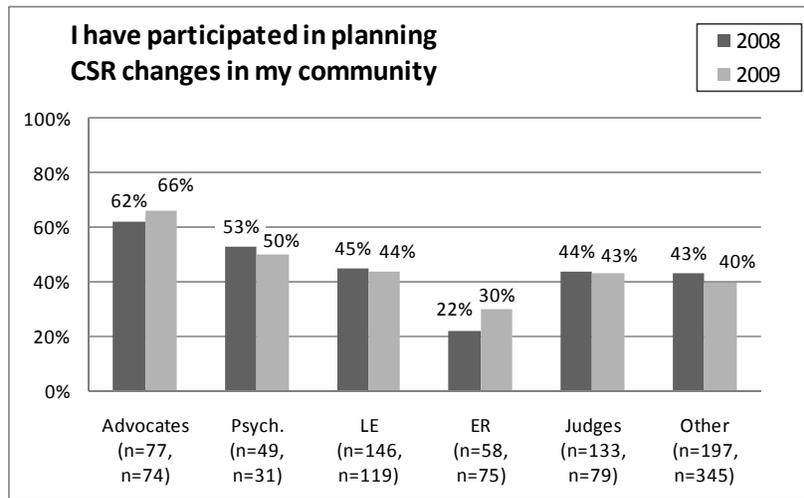
**Figure 9.3**



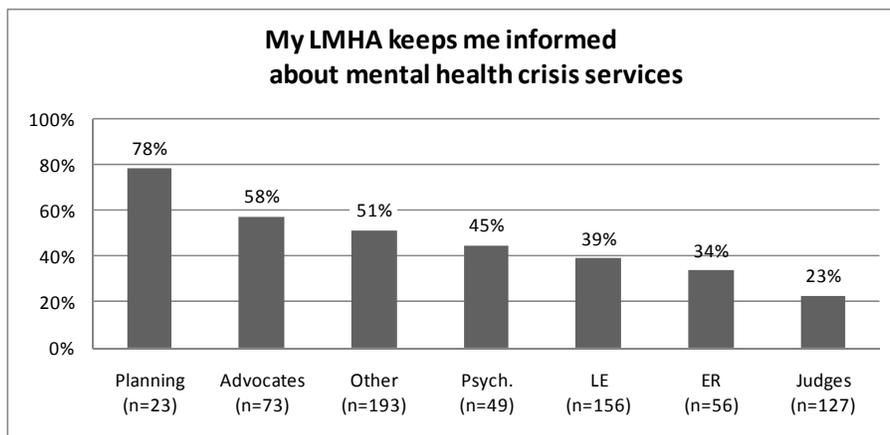
Judges, Emergency Rooms, Law Enforcement, and Psychiatrists Are Least Likely to Be Informed and Engaged. If involvement in CSR is a strong predictor of satisfaction, it is important to evaluate whether all stakeholder groups are successfully recruited into local planning and decision making. The evidence suggests they are not. In both 2008 and 2009, judges, emergency room personnel, law enforcement, and psychiatrists are the least likely to say they are aware of strategies for crisis redesign being used in their community (Figure 9.3). In 2009, law enforcement awareness did increase significantly from 33% to 48%, but overall consciousness of CSR in the community is still quite low.

Most of these same stakeholders have been disengaged from the process of planning CSR-related changes (Figure 9.4). About two-thirds of law enforcement, ER, and judicial respondents say their LMHA does not keep them informed about mental health crisis services (Figure 9.5). 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 7.

**Figure 9.4**



**Figure 9.5**

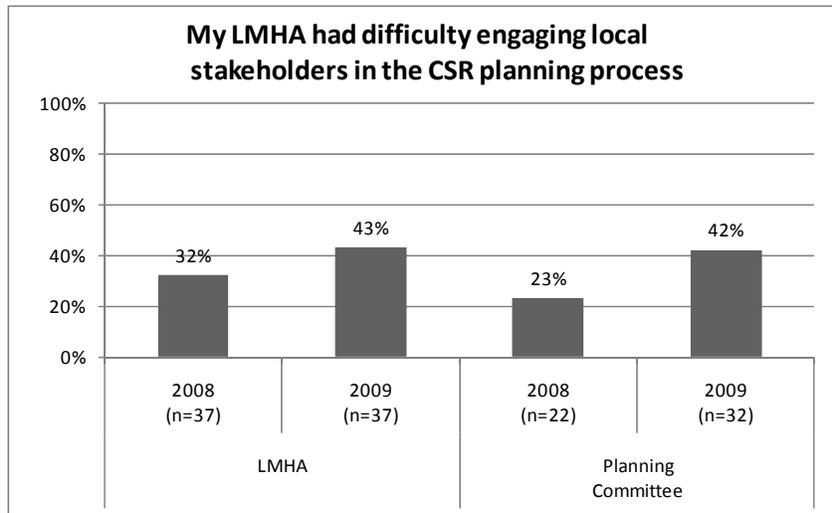


Reasons for Disengagement of Key Partners Is Not Well Understood. It is not clear from the data currently available why these essential constituencies are consistently uninformed and dissatisfied with CSR. Despite a clear perception among most law enforcement, emergency rooms, and judges that they were not informed about crisis redesign, most LMHAs and their planning committee members have the opposite point of view. In 2008, only one-third of LMHAs said they had difficulty engaging local stakeholders in CSR planning, increasing to 43% of LMHAs and 42% of their planning committee members in 2009 (Figure 9.6). Half of LMHAs also say it has been difficult to maintain stakeholder engagement as CSR has progressed.

Despite these difficulties, however, LMHAs also report sustaining or increasing their number of community partners in the past year. Since 2008, 23% of LMHAs have increased their number of community collaborators, and 40% have maintained past levels. Another 37% say their number of collaborators has declined. Those that have maintained partnership levels have an average of about 40 agencies with whom they work closely.

It would be useful to understand how LMHAs can think they are communicating with and engaging stakeholders effectively while the stakeholders themselves have such a different perspective. 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 9.6**

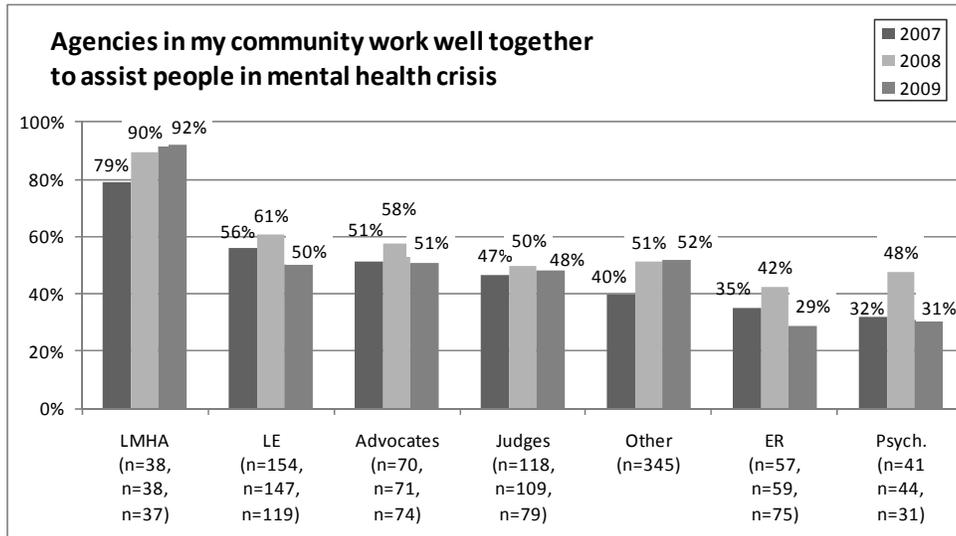


On the other hand, in their CSR applications to DSHS, most LMHAs described an open and inclusive planning process in which all agencies and organizations impacted by CSR were invited and encouraged to have input during planning. It is possible that many entities that now report being marginalized simply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

Initial Improvements in Collaboration are Not Being Maintained. In 2008, acknowledging that there was room for improvement, survey respondents said community agencies were doing a better job working together than in previous years (Figure 9.7). Mental health providers were highly satisfied with other community stakeholders' ability to coordinate efforts, but other stakeholder groups were less pleased. Nonetheless, all respondents acknowledged change was occurring in a positive direction. In 2009, a reversal occurred with virtually every stakeholder groups reporting worse collaboration than the previous year. In many cases ratings of collaboration levels were at or below the pre-CSR levels.

**Figure 9.7**



It is only possible to speculate why perceived collaboration is declining. It may be that, as initial enthusiasm about CSR has waned, it has been more difficult to maintain engagement in the collaborative process. In addition, the large increase of crisis consumers reported in Finding 2 may be stressing the system, making it more difficult for partners to work well together.

### Summary of Collaboration Data

When LMHAs are able to successfully engage stakeholders in the CSR process, those stakeholders are more satisfied with the changes taking place in their communities. Yet, despite LMHAs' formal efforts to keep their stakeholders informed about CSR, remarkably few of their community partners are aware of these efforts. Unfortunately, some of the most important stakeholder groups, including judges, law enforcement officers, and emergency room staff members, are the least engaged. These and other stakeholder groups also report that collaboration is declining over time. In order to improve community stakeholder satisfaction with crisis redesign, LMHA's must find creative ways to draw them into shared thinking, planning, and action about this issue.



**Finding 10: Community partners must commit to resolve issues impacting the success of CSR.**

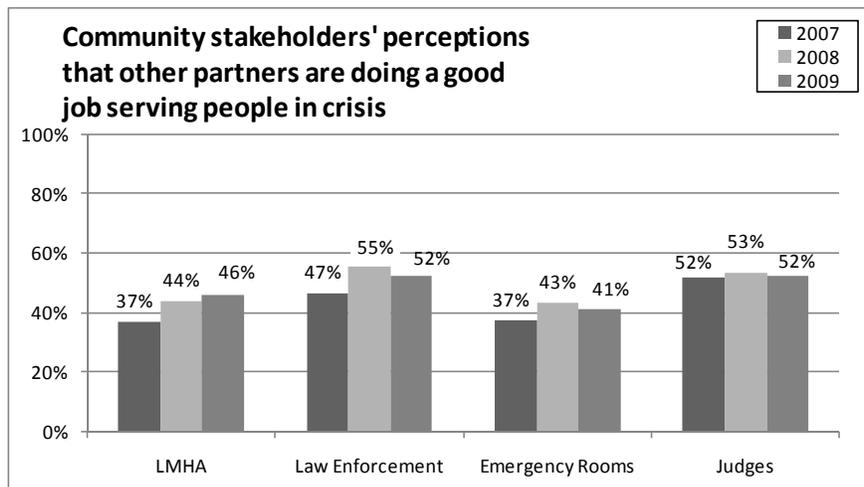




**Finding 10: Community partners must commit to resolve issues impacting the success of CSR.**

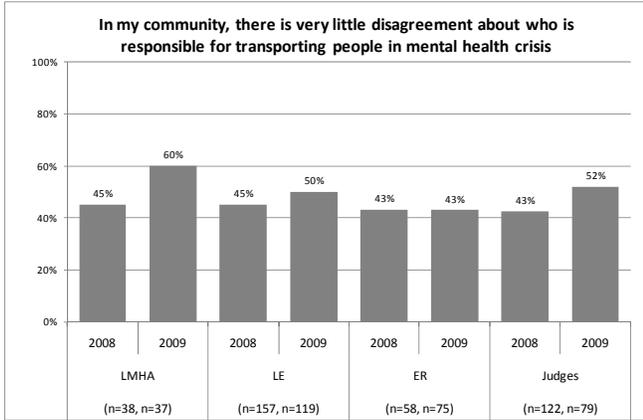
While the LMHAs provide leadership in mental health crisis services, other stakeholders must be willing to reasonably adapt their own attitudes and procedures to develop solutions that are best for the overall community and for mental health consumers. Each stakeholder group was asked to rate whether 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 10.1). Several issues have been identified that require the commitment of community partners to be resolved.

**Figure 10.1**

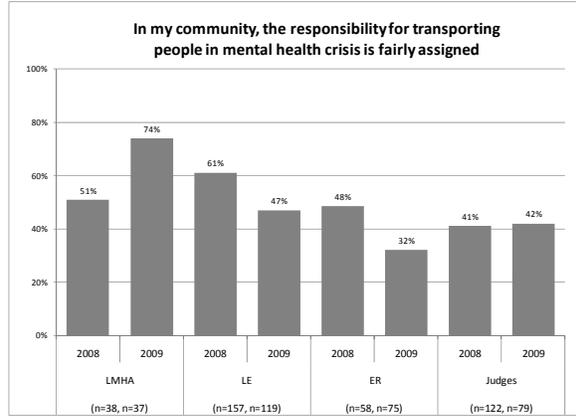


Lack of Consensus about Who is Responsible for Transportation. In many communities, there is considerable disagreement about who is responsible for transporting people in mental health crisis (Figure 10.2). Responsibility is not clearly assigned between sheriffs' offices and police departments. Emergency 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 10.3). Where this is a source of conflict, community partners can improve crisis case flow by working toward a resolution.

**Figure 10.2**

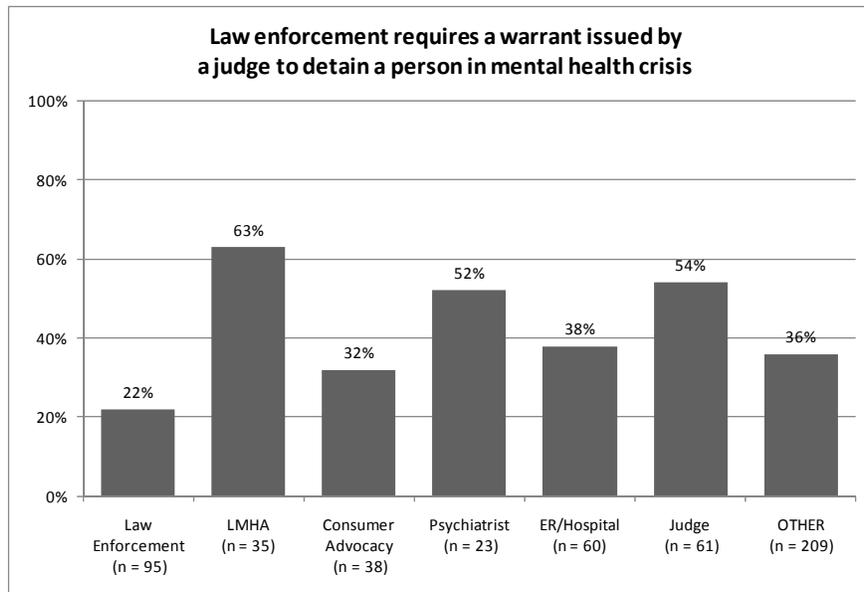


**Figure 10.3**



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, individual officers or agencies in some communities are unwilling to do so. Though only 22% of law enforcement survey respondents say it is their agency policy to require a warrant before detaining an individual in crisis, other stakeholder groups, particularly LMHAs, psychiatrists and judges, believe this practice is much more widespread (Figure 10.4). 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.

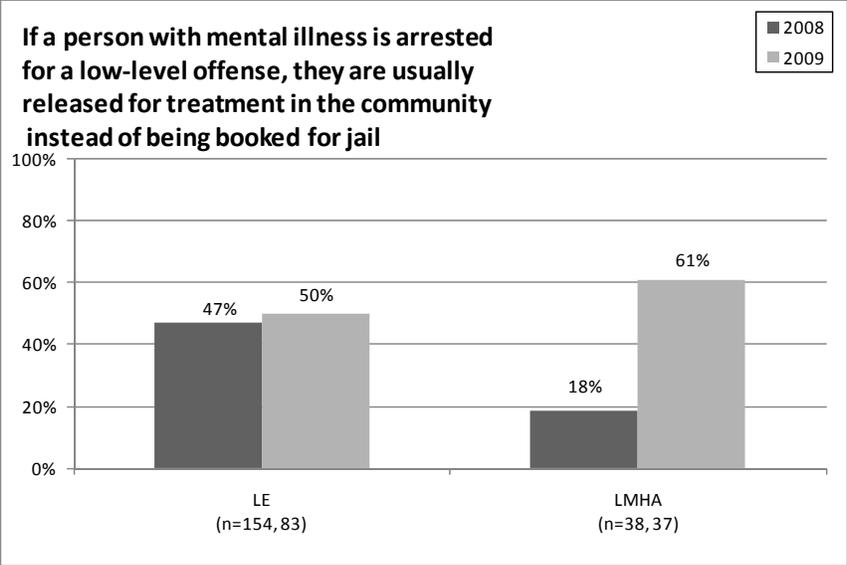
**Figure 10.4**



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

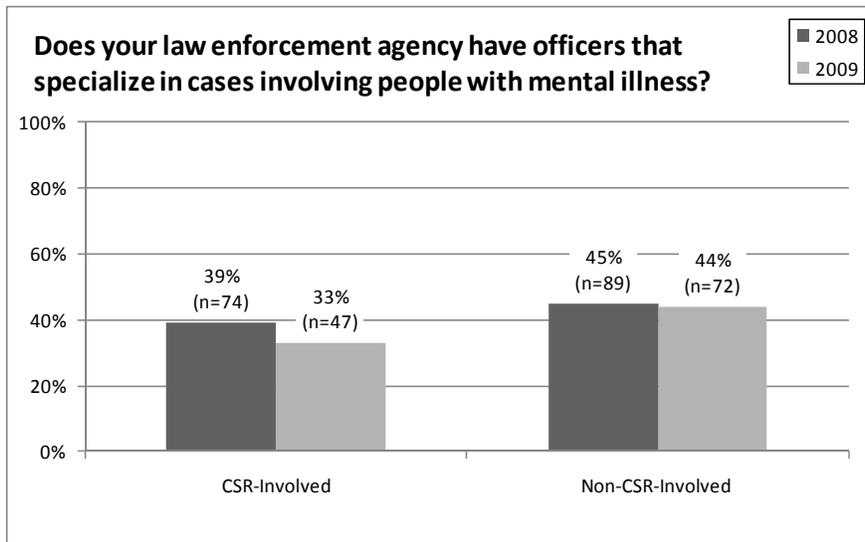
health crisis, interview respondents say some law enforcement officers still find it easier to deliver these individuals to jail. Only about half of law enforcement survey respondents report active efforts in their department to divert low-level offenders to treatment (Figure 10.5). Interestingly, LMHA survey respondents report significant improvements in this domain between 2008 and 2009 ( $p < .001$ ), although this appears to be due to their perceptions becoming more consistent with those of the law enforcement respondents. Given that diversion and treatment in appropriate cases can be far more productive and cost-effective than incarceration, this problem deserves additional attention in many communities.

**Figure 10.5**



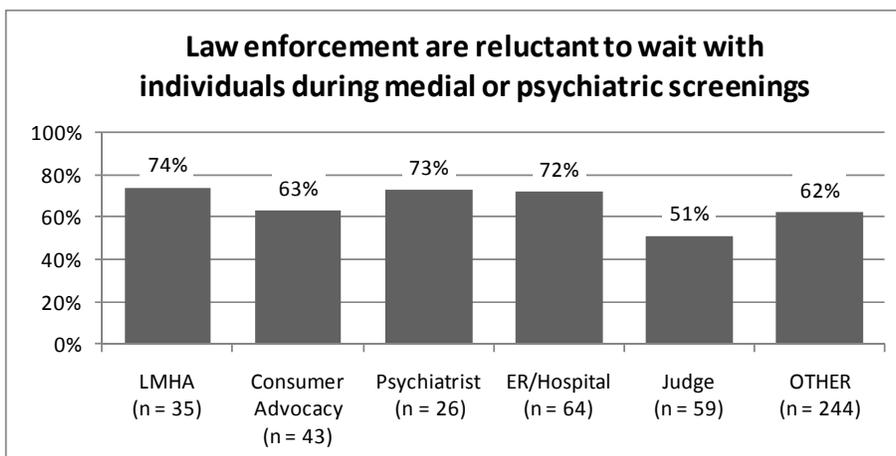
Need for More Mental Health Deputies. Most law enforcement agencies have met basic peace officer training requirements for mental health expertise. However, fewer than half of all law enforcement survey respondents say their agency has officers that specialize in cases involving people with mental illness (Figure 10.6). 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 10.6**



Reluctance of Some Law Enforcement Officers to Wait with Individuals During Screenings. When individuals are brought to a mental health screening involuntarily, or when they are disruptive or violent, emergency rooms and LMHAs often rely on law enforcement officers to provide security to keep the individual and agency staff safe. In interviews, many ER and LMHA staff expressed concerns about some law enforcement officers not being willing to provide this service. In some instances patients who are a risk to themselves or others have been known to leave without an assessment. This perception was supported by survey data, with the majority of stakeholder groups indicating that law enforcement officers are reluctant to wait during screenings (Figure 10.7).

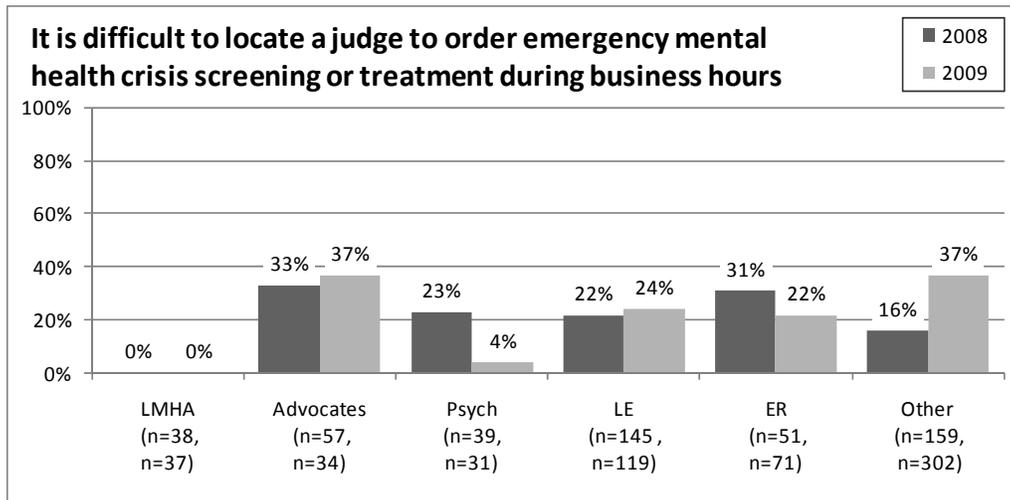
**Figure 10.7**



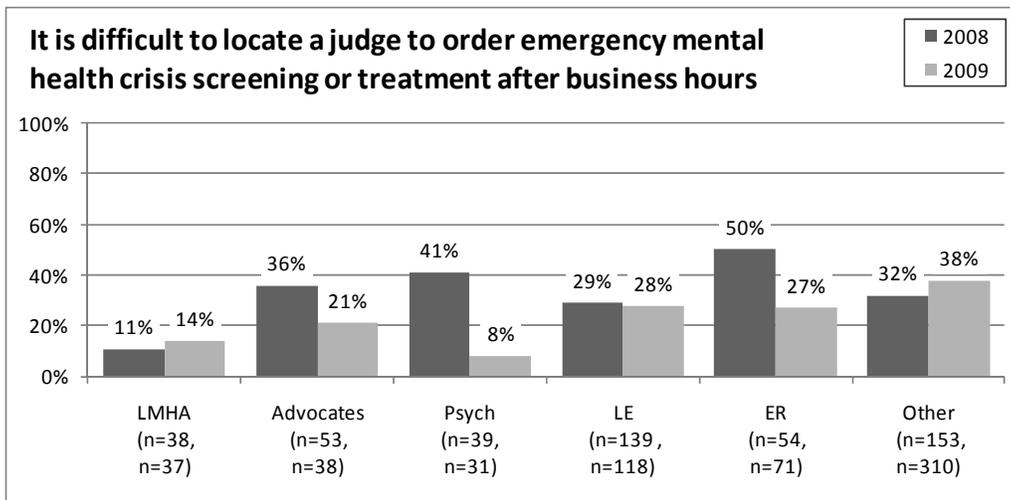
Difficulty Accessing a Justice of the Peace When Needed. In some communities, justices of the peace are not always available to issue emergency detention warrants when needed, particularly after hours or on weekends (Figures 10.8 and 10.9). Inability to access a judge can present a significant obstacle to prompt assistance for people in crisis. On average, 29% of survey respondents in 2009 say it is

difficult to locate a judge during business hours and problem has gotten worse since 2008. After hours, that proportion rises somewhat to 31% (down slightly from 33% in 2008). Emergency room personnel and psychiatrists report the greatest difficulty obtaining emergency detention warrants, although both groups reported improvements between 2008 and 2009. During site visits, some communities reported using strategies to address this difficulty, such as using “on call” schedules for judges or having one judge contracted to issue all warrants.

**Figure 10.8**



**Figure 10.9**

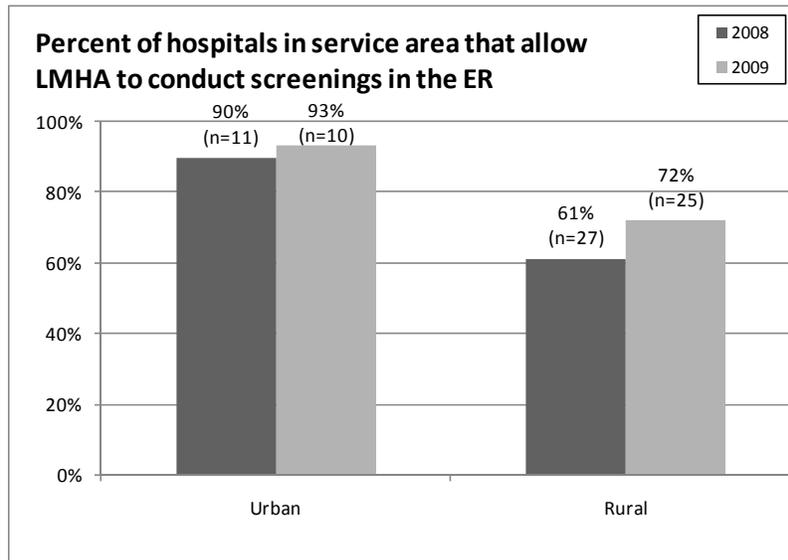


Use of Private Hospital Security during Crisis Screenings. Emergency rooms routinely require law enforcement to provide security during mental health screenings. In a few hospitals, ERs have met this responsibility on their own using private security. Law enforcement agencies interviewed in these communities 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 10.10). The LMHA must authorize a treatment placement,

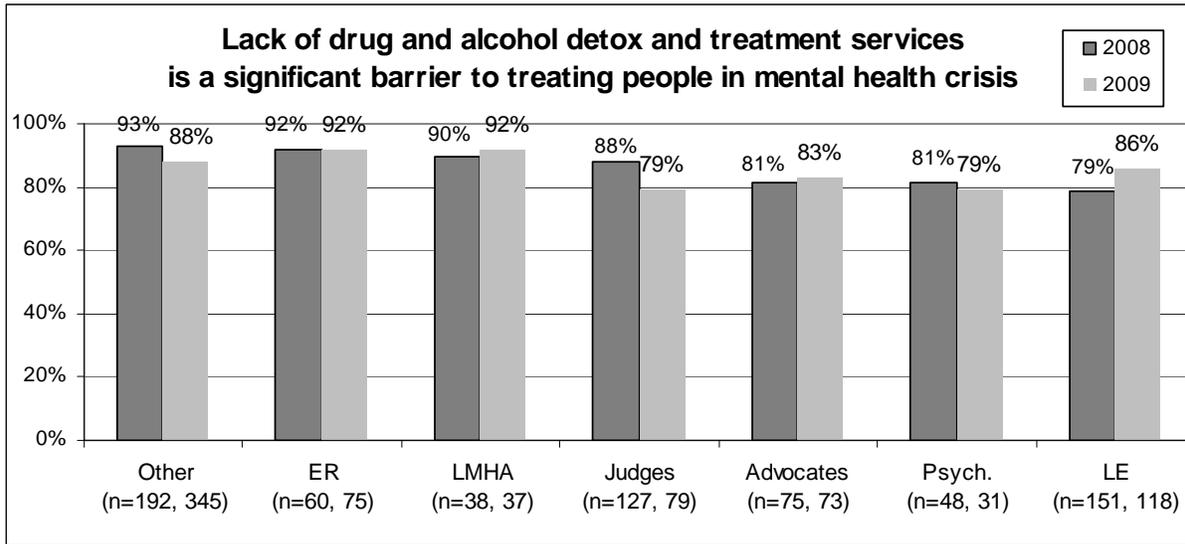
yet it is extremely difficult for the MCOT to determine the best course of action without a face-to-face screening. Eliminating restrictions on ER-based LMHA screenings would remove a significant obstacle and improve outcomes for everyone involved. Consistent with the emergency room reports presented in Finding 7, however, this situation appears to be improving between 2008 and 2009.

**Figure 10.10**



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. As one example, although some MCOTs are beginning to offer medical clearance capabilities, fewer than half (46%) say their screenings are acceptable to admitting hospitals (see Figure 1.10). Another source of confusion raised in some site visits is lack of agreement between LMHA staff and law enforcement agencies regarding whether a given individual qualifies for emergency detention. Among survey respondents, 26% of LMHA staff and 54% of law enforcement officers agreed that this is a problem. Transportation to state hospitals is another area of conflict and confusion in some communities. Clarification and agreement is needed regarding laws and policies 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.

Figure 10.11

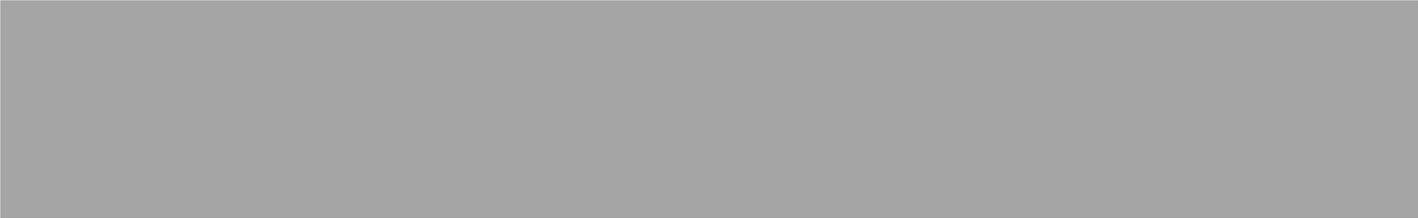


Inadequate Access to Drug and Alcohol Detox and Treatment. The lack of drug and alcohol detoxification and treatment services is broadly viewed as a significant problem when resolving mental health crises (Figure 10.11). Emergency room resources are often strained by people requiring detox before mental 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.

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**Conclusions and Recommendations**





## Conclusions and Recommendations

This report presents the findings of a two-year evaluation of the Crisis Services Redesign initiative. The study points to seven recommendations:

### **Recommendation 1. The types of changes implemented under Crisis Services Redesign are appropriate to the goals of the funding and merit continued support.**

The evaluation shows CSR funds are being used as intended to improve local crisis infrastructure. Communities have developed new capacity to provide intensive intervention to consumers with urgent needs in their own community. This new capacity is effectively reducing the need for more intensive care in a higher cost setting. The percentage of crises involving hospitalization has fallen from 17% to 13%. More people than ever before are receiving crisis intervention locally and at a lower cost per crisis episode than before CSR.

### **Recommendation 2. Further investigation is needed to better understand and address declining satisfaction among crisis service users.**

Although crisis hotline users are generally satisfied with the help they receive, users of other types of crisis services are reporting much lower satisfaction with every type of treatment service except private hospitalization and “other” services.

The reasons for this decline are not well understood, but they appear to be related to the changing nature of the crisis service user population. Service Packages 0 and 5 now offer a comprehensive set of crisis services to individuals who are not required to meet DSHS’ traditional priority population criteria for service eligibility. Furthermore, the majority of new crisis service users eventually fail to meet eligibility criteria for RDM. A growing number are also seeking help for some reason other than a psychiatric emergency. These individuals seeking help for a reason other than to prevent harm, particularly those that do not qualify for RDM after completion of the crisis episode, are the least satisfied overall.

These findings suggest there is a sizeable sub-population of users whose needs are not being met by the current crisis service system. Further study is needed to better understand this population and their service needs to determine if a policy response is needed. For example, it may be beneficial to refine crisis eligibility criteria to select those individuals who are best served by the services currently offered by LMHAs. Alternatively, the service system could be adapted so it is capable of truly addressing the needs of the present users.

If this track is taken, and substance abusers are a significant component of the RDM ineligible service group, then further redesign efforts could result in a truly integrated mental health and substance abuse system. Conversely, without taking action to learn more about this issue, the mental health system risks expending resources on a population whose needs cannot be fully met, and who incur even greater costs through repeat crises, while potentially undermining the ability of LMHAs to deliver high-quality services to the base constituency.

**Recommendation 3. Steps must be taken to help community partners such as law enforcement, emergency rooms, and judges accommodate the growing number of crisis consumers.**

The number of crisis consumers served has increased from 52,000 in 2007 to a projected 98,000 in 2009. This level of increase over a two year period has placed stresses on all service systems involved. While the mental health system has invested in an entire new infrastructure to accommodate this rising demand, law enforcement agencies, emergency rooms, and courts continue to operate at previous resource levels.

Certainly LMHAs are working hard to accommodate the needs of local partners, and many features of CSR were developed with the interests of local collaborators in mind. However, caseloads and costs for these ancillary systems are unchanged or worsening as they work to keep up with a rising tide of new crisis consumers entering the system since CSR. Several possible solutions may help alleviate these systemic stresses.

Law Enforcement Solutions. One option is increased funding for law enforcement specialists to assist in mental health crises. While virtually all law enforcement officers have basic peace officer training in mental health, few departments have individuals dedicated to the needs of this population. Officers specializing in mental health crisis cases will be more efficient, have greater knowledge about LMHA protocols, and will be better and more informed partners for planning local system improvements.

Investment in law enforcement specialists would also yield benefits for other community partners. Many of the problems faced by emergency rooms could be improved if skilled law enforcement officers were more aware of protocols to divert cases to other locations for a mental health screenings. In addition, a faster transportation response from law enforcement taking consumers to treatment would help emergency rooms. Likewise, judges would benefit from officers skilled in making judgments about the appropriate use of warrantless detention.

Emergency Room Solutions. Emergency room use by people in crisis has also not declined since CSR despite efforts among LMHAs to develop and use alternative screening sites. Problems locating treatment options and arranging transportation to get people out of their care have grown worse in the past year. Emergency room staff are consistently the least satisfied of all stakeholders when asked about crisis redesign. Again, a large part of the problem is the sheer volume of consumers being served.

At present, 70% of consumers entering a state hospital receive medical clearance in an emergency room. If most screenings are precautionary rather than in response to acute need, it may be possible to use qualified LMHA staff (e.g., RNs) where they are available, contract with private providers, or conduct health screenings in conjunction with the state hospital admission process. Solutions such as these would shift costs and responsibility for routine medical clearance away from emergency rooms and onto the mental health system.

At the same time, although nearly one-third of LMHAs say their MCOTs have the capacity to perform medical screenings, fewer than half these LMHAs say these assessments are usually accepted by admitting facilities. Better education of these psychiatric hospitals, criteria and standards establishing acceptable screening quality levels, and/or policy change are all potential approaches for overcoming this barrier. Emergency rooms are currently paying the price for inflexible policies on the part of psychiatric hospitals. As a long-term policy, expanding MCOTs resources and role in providing medical screenings could significantly impact emergency room use.

Finally, to the extent that emergency rooms are used as a safe location to conduct mental health screenings, community partners need to continue to think creatively about alternative locations. If there is no medical need to visit the ER, then it is far more cost effective to use a room in a non-medical facility. Law enforcement offices and jails are available 24-hours per day.

In addition to increased funding, these challenges require more problem-focused collaboration at the community level (see Recommendation 4). In the absence of further investment in measures to help LMHA partners deal with the growing number of crisis cases, there is a risk of burnout and alienation within community support networks statewide.

#### **Recommendation 4. LMHAs must increase their efforts to engage a broader range of stakeholders in the CSR process.**

Despite evidence that more crisis services are being delivered, many stakeholders, particularly law enforcement officers and emergency room staff, continue to perceive Texas' crisis mental health services as less than satisfactory. Furthermore, satisfaction has declined even further in the past year. Some stakeholder groups also report less awareness of CSR strategies than in the past, making it difficult for these constituencies to understand or appreciate the impacts CSR may be having in their communities.

Satisfaction is greatest among respondents from agencies that are actively involved in local CSR planning and implementation. In the 2008 report, "Year-One Evaluation Findings for the Crisis Services Redesign Initiative," a key recommendation was for LMHAs to work toward developing creative strategies to engage additional stakeholders. In 2009, LMHAs seem to be responding to this recommendation. All LMHAs indicate they have formal mechanisms for communicating with their stakeholders, including standing meetings (37%), newsletters (11%), e-mail distribution lists (18%), and circulating data about CSR outcomes to their stakeholders (13%). However, very few community stakeholders were aware of these efforts, with the majority believing that their LMHA does not have formal mechanisms for communicating about crisis services with them.

In addition, 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.

It is recommended that LMHAs continue to work toward generating creative strategies to foster information exchange and collaboration, particularly strategies that can reach a larger number of stakeholders. Of the strategies reported by the LMHAs, the most commonly used was standing meetings. The advantage of this approach is that it allows for in-depth discussion between stakeholders. Still, fewer than half of LMHAs currently meet regularly with their stakeholders to discuss crisis services. It is recommended that more LMHAs consider this strategy.

While meetings have their advantages, however, the number of participants that can be engaged in such a process is limited. LMHAs will need to develop parallel approaches likely have broader impact such as newsletters or e-mail distribution lists. Each of these is currently being used by fewer than 20% of LMHAs. 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 5. The extraordinary growth in mental health crisis services has not been adequately balanced by comparable investment in DSHS' ongoing Resiliency and Disease Management (RDM) services.**

Crisis redesign is a prominent factor creating rising demand for routine mental health services (Finding 4). As crisis services are expanded, many newly engaged crisis consumers qualify for long-term services. While annual average increases in RDM caseloads were about 3-4% through 2008, caseloads are projected to rise 21% in 2009 alone. People who are not in crisis are being pushed back to expedite the provision of long-term supports to those who are. Waitlists for non-crisis consumers have been steadily increasing over the past four years, reaching 15% in 2009. The proportion of non-crisis RDM intakes being underserved is rising as well.

While new state funding has expanded and improved services for people in mental health crisis, treatment costs are no longer covered by the new CSR-related funding streams once these same individuals enroll for routine long-term care. As a result, LMHA resources are increasingly strained serving expanding caseloads of people in maintenance care without a corresponding increase in RDM funding. Demand for routine ongoing treatment is outstripping supply under current resource levels. Some LMHAs also report that overall salaries have been increased in order to hire staff at a higher level of expertise required by crisis redesign, further stretching budgets for the delivery of routine care.

There is broad-based consensus in every community stakeholder group that the lack of adequate mental health treatment services is creating a pattern of repeated crisis for some individuals. Without renewed investment in the original RDM system of maintenance care, CSR may inadvertently evolve into a system in which access to non-crisis care is limited, and people predominantly get help only after decompensating into crisis.

**Recommendation 6. Enhancements to supportive services provided by community partners would help reinforce the success of CSR.**

Finding 10 identifies several challenges to the success of CSR that cannot be resolved by the LMHAs alone. While increased collaboration (Recommendation 4) would help address many of these challenges, at least two important changes 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. 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 7. Efforts should be made to provide better information to stakeholders clarifying the legal code regarding processing of crisis cases.**

In interviews, it was apparent that stakeholders often held very different understandings of the laws surrounding the processing of mental health crisis cases, including issues such as who is responsible for transportation, whether medical screenings are legally required before hospitalizations and who must administer them, and the criteria for holding someone for treatment against their will. Clarification of the statutes might help improve collaboration between agencies by fostering a common understanding of these important issues.

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**Endnotes**



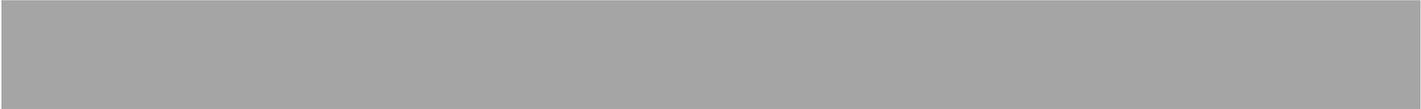


## Endnotes

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- <sup>1</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>2</sup> Qualified Mental Health Professionals (QMHPs) include professionals who either hold a bachelor's degree in a relevant field, are a Registered Nurse, or complete an alternative credentialing process specified by the Department of State Health Services.
- <sup>3</sup> Licensed Practitioners of the Healing Arts (LPHAs) include physicians, advanced practice nurses, and licensed clinical practitioners (i.e., psychologists, social workers, professional counselors, and marriage and family therapists).
- <sup>4</sup> This estimate is based on 70% of 11,296 state hospitalizations observed in the DSHS data for 2008, reported in Figure 7.
- <sup>5</sup> Service categories represented in Figure 1.12 are described in Appendix B.
- <sup>6</sup> Additional detail on the analysis methods used is provided in Appendix A.
- <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> *DSHS 2009 Statewide Performance Indicators: 4<sup>th</sup> Quarter FY 2008* (pg. 44). Austin, TX: DSHS. Available, as of February 2, 2010, at: <http://www.dshs.state.tx.us/mhreports/MhBook804.pdf>
- <sup>9</sup> This value is obtained by adding the \$303 million in direct service costs (157,052 crisis episodes at \$1,932 each) to \$81 million in non-treatment costs (i.e. computers, vehicles or buildings).
- <sup>10</sup> This analysis selects consumers' first RDM recommended level of care, then distinguishes individuals receiving waitlist status (LOC-8), underserved status (LOC-R<LOC-A), or full enrollment (LOC-1 through 4). The analysis then identifies crisis and non-crisis consumers by determining if the individual had a crisis service delivered in the preceding 90 days.
- <sup>11</sup> This analysis selects consumers' first RDM recommended level of care to identify individuals receiving waitlist status (LOC-8) and underserved status (LOC-R<LOC-A). The analysis then finds the date when full RDM enrollment was established and counts the number of days in the interim.
- <sup>12</sup> This analysis selects consumers' first RDM recommended level of care to identify individuals receiving waitlist status (LOC-8) and underserved status (LOC-R<LOC-A). The analysis then finds the date when full RDM enrollment was established and determines if the individual had a crisis service delivered in the interim.

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- <sup>13</sup> Bureau of Labor Statistics. (November 2009). *Spotlight on Statistics: Health Care*. Retrieved from [http://www.bls.gov/spotlight/2009/health\\_care/home.htm](http://www.bls.gov/spotlight/2009/health_care/home.htm)
- <sup>14</sup> See Appendix C for the hotline user survey instructions and instruments. See Appendix E for a description of hotline survey respondent characteristics.
- <sup>15</sup> See Appendix D for the crisis service user survey instructions and instruments. See Appendix E for a description of hotline survey respondent characteristics.
- <sup>16</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 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>17</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 for  
Stakeholder Survey and Care Data Analysis**





## METHODOLOGICAL NOTES FOR COMMUNITY STAKEHOLDER SURVEY ANALYSIS

### 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.



## **METHODOLOGICAL NOTES FOR CARE MENTAL HEALTH SERVICE DATABASE ANALYSIS**

The Client Assignment and Registration (CARE) maintained by the Department of State Health Services (DSHS) was the primary source of information used to quantify changes in the use of crisis treatment costs and services before and after Crisis Services Redesign (CSR). While CARE contains complete records of the number and type of services individuals enrolled in the mental health system receive, this complex set of data needed to be aggregated and summarized in a way that would produce standardized units of measurement appropriate to the research questions being answered. The following paragraphs describe these units of measurement including information about the rationale, methods, and limitations associated with each.

### **Service Event**

A service event is a single treatment encounter. A service event is measured as a full day for services ordinarily lasting at least 24 hours. These include hospitalization, residential, inpatient, or respite treatment. For other types of treatment delivered in increments less than 24 hours (e.g., acute care), a service event is counted as single encounter on each day in which the service was provided.

Although service events are characterized in the CARE dataset by a “Cost Accounting Methodology (CAM) Cost,” and a time (in hours), for analysis purposes, a treatment service administered on any given day was counted only once irrespective of the duration. Because multiple services may be provided in a single treatment encounter, (e.g., case coordination and medication) multiple service events commonly occur on the same day.

### **Crisis Episode**

A crisis episode is a series of crisis treatment services delivered over a period of time during which there is not a break in services greater than 7 days. If a break exceeding 7 days occurs, the next crisis service marks the beginning of a new crisis episode. While a crisis episode may span multiple years, for purposes of analysis all crisis episodes are attributed to the year in which the first crisis event occurred.

Because only 6 months of CARE data were available for 2009, the maximum follow-up period or a crisis ending the last day of 2008 (i.e., the first year of the post-CSR period) was 180 days. In order to standardize the measurement period for crises during the pre- and post-CSR period, all crisis episodes were truncated at 180 days (i.e., 6 months).

Data was available to follow crisis episodes beginning in 2007 (i.e., the last year of the pre-CSR period) for a longer period of time. However, limiting the duration of all crisis episodes ensured they were measured the same way in all analyses. Had the length of a crisis episode not been limited in this way, crisis episodes closer to the end of the period for which data was available would have had biased measurements due to the declining number of months during which events per episode could be counted. For this reason in analyses using crisis episode as the unit of measurement, results for 2009 could not be reported because episodes starting during that timeframe did not have a uniform 180 days to complete.

## Projected Data for 2009

Throughout the report there are instances where a notation advises “2009 is projected based on 6 months of data.” Because only 6 months of actual consumer records were available for the 2009 calendar year, for some analyses it was appropriate to use available data to estimate values for the full 12-month period.

In calculating projected data, services were assumed to occur evenly across the year. They could therefore be doubled without introducing bias into service projections. For analyses involving counts of individuals served, however, a simple “doubling” approach is problematic because any individuals receiving service in the first half of the year will continue to receive services in the following half. By simply “doubling,” these individuals would be counted twice—leading to an overestimation of the number of people who received services.

To account for this, estimates of individuals served were adjusted based on counts of the services provided in the preceding year. The formula used is illustrated below:

# INDIVIDUALS SERVED	# SERVICES PROVIDED	SERVICES/ INDIVIDUAL
A = # individuals served in 2008	B = # services provided in 2008	A/B
$(A/B)*C$ = Projected # individuals served in all 12 months of 2009	C = # Services provided in the first 6 months of 2009	

## Measurement of Waitlisted or Underserved Status

A person is considered to be waitlisted (i.e., qualified for RDM care, but awaiting an opening for services) if they are assigned an authorized Level of Care (LOC) of 8. A person is considered underserved if they are not assigned a Level of Care (LOC) of 8 and if they are authorized for one level of care but are recommended for a higher level of care. In addition, the reason for the discrepancy between the authorized and recommended LOC must be specified as “resource limitations” rather than other reasons, such as individual refusing the service.



**Appendix B: Description of  
Local Treatment Alternatives**

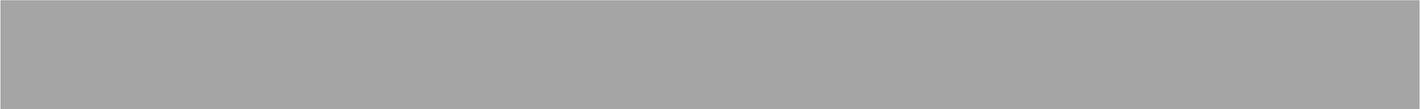




## Description of Local Treatment Alternatives

Enhanced Crisis Services	<ul style="list-style-type: none"> <li>• Office-based outpatient services</li> <li>• Immediate screening and assessment</li> <li>• Brief, intensive interventions focused on resolving a crisis and preventing admission to a more intensive level of care</li> </ul>
Crisis Outpatient Services	<ul style="list-style-type: none"> <li>• Office-based outpatient services</li> <li>• May include extended hours or time on weekends to deliver walk-in crisis services</li> </ul>
Extended Observation Services	<ul style="list-style-type: none"> <li>• Emergency and crisis stabilization services</li> <li>• Secure treatment and protected treatment environment</li> <li>• Clinically staffed (including medical and nursing professionals), psychiatrically supervised</li> <li>• Immediate access to urgent or emergent medical evaluation and treatment. Individuals who cannot be stabilized within 48 hours would be linked to the appropriate level of care (inpatient hospital unit or CSU).</li> </ul>
Crisis Stabilization Units	<ul style="list-style-type: none"> <li>• Short-term residential treatment designed to reduce acute symptoms of mental illness</li> <li>• Secure treatment and protected treatment environment</li> <li>• Clinically staffed (including medical and nursing professionals), psychiatrically supervised</li> <li>• Complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code.</li> </ul>
Crisis Residential	<ul style="list-style-type: none"> <li>• Short-term, community-based residential, crisis treatment</li> <li>• Serves persons with some risk of harm who may have fairly severe functional impairment.</li> <li>• Safe treatment environment with clinical staff on site at all times; not designed to prevent elopement and individuals must have at least a minimal level of engagement to be served in this environment.</li> <li>• Recommended length of stay is from 1-14 days.</li> </ul>
Crisis Respite	<ul style="list-style-type: none"> <li>• Short-term, community-based residential, crisis treatment</li> <li>• Serves persons with no risk of harm to self or others who may have some functional impairment and require direct supervision and care but do not require hospitalization</li> <li>• Generally serves individuals with housing challenges or assists caretakers who need short-term housing for the persons for whom they care to avoid a mental health crisis.</li> <li>• Service utilization is managed by the LMHA based on medical necessity.</li> <li>• The recommended length of stay is 1-7 days.</li> </ul>

<p>Psychiatric Emergency Service Centers</p>	<ul style="list-style-type: none"><li>• Provides immediate access to assessment and a continuum of stabilizing treatment for individuals presenting with behavioral crises.</li><li>• Available to individuals who walk in</li><li>• Co-located with licensed hospitals or Crisis Stabilization Units (CSUs)</li><li>• Able to manage the most severely ill individuals at all times, including immediate access to emergency medical care.</li><li>• Offer a combination of service types including Extended Observation and Inpatient Hospital Services or a CSU.</li></ul>
<p>Outpatient Competency Restoration</p>	<ul style="list-style-type: none"><li>• Community-based mental health treatment to help mentally ill criminal defendants regain competency in preparation to face the charges. Outpatient competency restoration is offered on an outpatient basis as an alternative to a forensic placement in a state hospital.</li></ul>



## **Appendix C: Crisis Hotline User Survey Materials**





## **2009 Hotline User 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.

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 **August 3 to August 9, 2009**.

### **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
    - Include callers referred to mental health providers other than the LMHA (e.g., private providers).
  
- Mental health consumers.
  
- 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 **August 3 to August 9, 2009**.
  - 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 **August 3 to August 9, 2009**.

Indicate the method used on Item 6 of each 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.

**To access the survey online**, go to:

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

**To access a hard copy of the instrument:**

- Open filename: "Hotline Satisfaction Survey\_2009"
- Type the hotline provider name into the appropriate blank on the original so that it is consistently entered.
- Make 2-SIDED COPIES for the approximate number of emergent and urgent hotline 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 August 3 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:

- Discuss the survey at a regular planning or staff meetings.
- 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 August 13, 2009:**

- 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: 979.845.6754  
Fax: 979.845.0249

- 2) If you administer the survey on paper, seal the completed surveys in 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

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?**

- Results will be summarized in a report on CSR being prepared for the Texas Legislature. The report will be finalized in December, 2009.
- No individual LMHAs or Hotline providers will be identified in this report.

### **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**  
**2009 Hotline Satisfaction Survey**

**INSTRUCTIONS**

The purpose of this form is to provide information about how the 2009 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 August 13, 2009, 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 Texas A&M University at the following address:**

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

- 
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): \_\_\_\_\_



**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	_____/____		
No	2	Female	2	Month	Year	

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>	<b>Refused Response</b>
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>	<b>Refused Response</b>
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>	<b>Refused Response</b>
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>	<b>Refused Response</b>
5	4	3	2	1	0

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



## **Appendix D: Crisis Service User Survey Materials**





## **2009 CRISIS SERVICES CONSUMER 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.

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 **August 3 to August 9, 2009**.

### **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 August 3 to August 9, 2009**.
- **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 during **any 7-day period falling between July 20 and August 3, 2009**.
  - The data collection should still occur during the one-week period from **August 3 to August 9, 2009**.

Indicate the method used in Item 6 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 survey all consumers enrolled in Service Package 5** on the first day of the week the sample is selected. 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 August 3 beginning of the data collection period, notify staff at each crisis service delivery location 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:
  - Discuss the survey at a regular planning or staff meetings.
  - Designate one individual to supervise data collection at each location.
- 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 the survey a few days in advance of August 3<sup>rd</sup>.
  - Open filename: "Consumer Satisfaction Survey\_2009"
  - **Type the LMHA name** into the appropriate blank on the original so that it is consistently entered.
  - **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.
- 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 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 1-6 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.

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.

Please DO NOT write the consumer's name on the survey or cover page.

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

**No later than August 13, 2009:**

- 1) Complete the "Consumer Satisfaction Cover Page" describing your data collection procedures and return this form along with all surveys 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](mailto:EBooth@ppri.tamu.edu)  
Phone: 979.845.6754  
Fax: 979.845.0249

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

- Results will be summarized in a report on CSR being prepared for the Texas Legislature. The report will be finalized in December, 2009.
- No individual LMHAs will be identified in this report.
- 

## **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**  
**2009 Consumer Satisfaction Survey**

**INSTRUCTIONS**

The purpose of this form is to provide information about how the 2009 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 August 13, 2009, this form and all consumer surveys 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: 979.845.6754  
Fax: 979.845.0249

- 
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
    - 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 Female         2	Black            1 Hispanic        2 White            3 Asian            4 Mixed/Other    5 Unknown        6	_____ / _____ Month            Year	_____

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]**

- |   |          |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
|---|----------|---|------------------------|---|------------------|---|--------------|---|-----|---|----|---|--|---|---|--|---|---|---|--|---|
| <ol style="list-style-type: none"> <li>7. Person completing the measure:               <table style="width: 100%; border: none;"> <tr> <td>Consumer</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Consumer family member</td> <td style="text-align: right;">2</td> </tr> <tr> <td>Friend/Associate</td> <td style="text-align: right;">3</td> </tr> <tr> <td>Other: _____</td> <td style="text-align: right;">9</td> </tr> </table> </li> <li>8. Is this survey being administered by someone who has a clinical role in this case?               <table style="width: 100%; border: none;"> <tr> <td>Yes</td> <td style="text-align: right;">1</td> </tr> <tr> <td>No</td> <td style="text-align: right;">2</td> </tr> </table> </li> </ol> | Consumer | 1 | Consumer family member | 2 | Friend/Associate | 3 | Other: _____ | 9 | Yes | 1 | No | 2 | <ol style="list-style-type: none"> <li>9. When is this survey being administered?               <table style="width: 100%; border: none;"> <tr> <td>At the time of a crisis service contact</td> <td style="text-align: right;">1</td> </tr> <tr> <td>During a follow-up contact _____ days following the initial crisis episode</td> <td style="text-align: right;">2</td> </tr> </table> </li> <li>10. How is this survey being administered?               <table style="width: 100%; border: none;"> <tr> <td>Participant is completing it in writing</td> <td style="text-align: right;">1</td> </tr> <tr> <td>Survey is being read to the participant either in person or over the phone</td> <td style="text-align: right;">2</td> </tr> </table> </li> </ol> | At the time of a crisis service contact | 1 | During a follow-up contact _____ days following the initial crisis episode | 2 | Participant is completing it in writing | 1 | Survey is being read to the participant either in person or over the phone | 2 |
| Consumer  | 1        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Consumer family member  | 2        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Friend/Associate  | 3        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Other: _____  | 9        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Yes   | 1        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| No  | 2        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| At the time of a crisis service contact   | 1        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| During a follow-up contact _____ days following the initial crisis episode  | 2        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Participant is completing it in writing   | 1        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |
| Survey is being read to the participant either in person or over the phone  | 2        |   |                        |   |                  |   |              |   |     |   |    |   |  |   |   |  |   |   |   |  |   |

## 2009 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!]

## ENCUESTA DE SATISFACCION DEL CONSUMIDOR

**INSTRUCCIONES:** Se le está pidiendo que llene este cuestionario porque estamos interesados en saber sobre su satisfacción con los servicios que usted o su amigo o pariente recibió durante una emergencia de salud mental reciente. Si usted tiene cualquier pregunta acerca de sobre que servicios le estamos preguntando, por favor pregúntele a la persona que le dio esta encuesta.

Si usted ya ha tomado esta encuesta, por favor dígame a la persona que se lo dio; no lo llene más de una vez.

Sus respuestas a estas preguntas y alguna información sobre sus características personal (como su edad y género) y uso de servicio (como cuales servicios clínicos a usado), pero ninguna información que lo(a) identifique será provista al Departamento Estatal de Servicios de la Salud de Texas e investigadores en la Universidad de Texas A & M. No le es requerido contestar a estas preguntas y puede saltar cualquier pregunta que le incomode contestar.

**SERVICIOS DE SALUD MENTAL:** Las siguientes cuatro preguntas son sobre servicios recibidos del sistema de salud mental. Por favor circule un número para indicar que tanto está de acuerdo con lo siguiente:

1. Yo o alguien cercano a mí necesitaba recibir esta ayuda porque yo/ellos podría(n) haberse hecho daño a si mismos o a otros.

Totalmente de acuerdo	De acuerdo	Sin opinión	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

2. Los servicios de crisis ayudaron a mantenerme a mí o a esa persona a salvo o previno daño a otros.

Totalmente de acuerdo	De acuerdo	Sin opinión	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

3. Si yo o alguien cercano a mí tuviera un problema similar en el futuro, usaría estos servicios de nuevo.

Totalmente de acuerdo	De acuerdo	Sin opinión	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

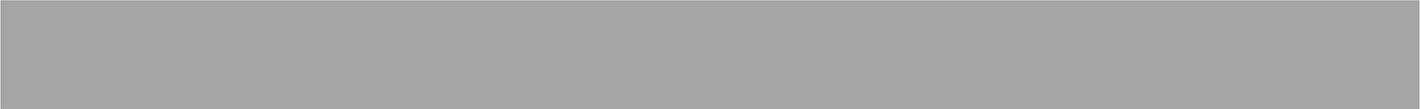
4. Yo o alguien cercano a mi recibieron los tipos de ayuda que yo pienso eran necesitados.

Totalmente de acuerdo	De acuerdo	Sin opinión	En desacuerdo	Totalmente en desacuerdo
5	4	3	2	1

**OTROS SERVICIOS:** Estamos interesados en oír sobre otra gente o agencias que pudieron ayudarlo(a) durante esta emergencia. Por favor díganos que tan útiles fueron las siguientes:

	No involucradas	No útiles para nada	Algo útiles	Muy útiles
5. Policía/Alguacil	0	1	2	3
6. Sala de emergencia	0	1	2	3
7. Jueces/Cortes	0	1	2	3
8. Escuelas	0	1	2	3

[DETENGASE AQUÍ. ¡Gracias por proveernos esta útil información!]



## **Appendix E: Description of Survey Respondents**





## Hotline Survey Respondents Overview

	2008			2009		
	Emergent	Urgent	Total	Emergent	Urgent	Total
<b>GENDER</b>						
Female	11%	89%	103	9%	91%	124
Male	13%	87%	75	9%	91%	124
<b>AGE RANGE</b>						
0 to 18 years	17%	83%	12	12%	88%	24
18 to 34 years	14%	86%	57	7%	93%	84
34 to 50 years	13%	87%	53	11%	89%	72
50 to 75 years	8%	92%	36	8%	92%	37
75+ years	5%	95%	22	6%	94%	32
<b>URBANICITY</b>						
Rural	14%	86%	43	11%	89%	79
Urban	11%	89%	136	8%	92%	158
<b>PERSON TAKING THE SURVEY</b>						
Consumer	13%	87%	109	9%	91%	129
Consumer Friend or Family Member	10%	90%	69	10%	90%	113
<b>CURRENT MHMR CLIENT</b>						
No	12%	88%	120	5%	95%	137
Other	0%	100%	2	8%	92%	12
Yes	11%	89%	53	14%	86%	99
<b>ACTION TAKEN BY HOTLINE</b>						
Crisis Resolved by Phone	9%	91%	35	4%	96%	51
Referred to LMHA DBA	9%	91%	33	2%	98%	46
Activated LMHA staff on call	35%	65%	17	27%	73%	26
Referred to ER	17%	83%	18	17%	83%	18
Referred to Other Agency	7%	93%	28	3%	97%	38
Called Emergency Services	20%	80%	15	29%	71%	24
Other	3%	97%	34	2%	98%	44
<b>Total</b>	<b>12%</b>	<b>88%</b>	<b>180</b>	<b>9%</b>	<b>91%</b>	<b>247</b>

## Consumer Survey Respondents Overview

	2008			2009		
	Existing RDM Consumers	New Crisis Service Users	Total	Existing RDM Consumers	New Crisis Service Users	Total
<b>GENDER</b>						
Male	27%	73%	368	23%	77%	400
Female	32%	68%	414	29%	71%	449
<b>RACE / ETHNICITY</b>						
Black	33%	67%	125	32%	68%	130
Hispanic	23%	77%	226	22%	78%	264
White	33%	67%	386	27%	73%	415
Asian	25%	75%	4	33%	67%	9
Mixed/other	22%	78%	9	50%	50%	8
Unknown	46%	54%	13	12%	88%	8
<b>AGE RANGE</b>						
0 to 18 years	25%	75%	111	22%	78%	136
18 to 34 years	26%	74%	279	27%	73%	349
34 to 50 years	33%	67%	259	29%	71%	261
50 to 75 years	39%	61%	95	31%	69%	105
75+ years	0%	100%	4	0%	100%	4
<b>URBANICITY</b>						
Rural	34%	66%	398	30%	70%	410
Urban	25%	75%	387	24%	76%	455
<b>PERSON COMPLETING THE SURVEY</b>						
consumer	28%	72%	600	27%	73%	698
consumer family member	28%	72%	120	22%	78%	107
friend/associate	33%	67%	9	50%	50%	2
<b>SERVICES PROVIDED</b>						
Other Services	30%	70%	91	19%	81%	89
Outpatient	30%	70%	211	38%	62%	171
Respite/Residential	41%	59%	83	55%	45%	95
State Hosp	48%	52%	40	32%	68%	25
Private Hosp	34%	66%	58	32%	68%	57
MCOT	22%	78%	295	17%	83%	417
<b>Total</b>	29%	71%	778	27%	73%	854

## Statewide Stakeholder Survey Overview

	2008			2009			2008			2009		
	Rural	Urban	Total	Non-CSR Involved	CSR Involved	Total	Rural	Urban	Total	Non-CSR Involved	CSR Involved	Total
<b>GENDER</b>												
Female	51%	49%	529	84%	16%	535	54%	46%	541	36%	64%	541
Male	62%	38%	477	81%	19%	477	60%	40%	367	40%	60%	369
<b>RACE / ETHNICITY</b>												
African American	42%	58%	53	91%	9%	53	30%	70%	37	24%	76%	37
Hispanic	43%	57%	153	85%	15%	153	46%	54%	94	40%	60%	95
Anglo American	60%	40%	767	81%	19%	773	60%	40%	753	38%	62%	754
Asian American	50%	50%	8	75%	25%	8	50%	50%	10	50%	50%	10
Indian American or Alaskan Native	45%	55%	11	91%	9%	11	12%	88%	8	25%	75%	8
<b>URBANICITY</b>												
Rural	92%	8%	333	82%	18%	333	87%	13%	274	35%	65%	275
Midsized or Semi-Urban	60%	40%	344	78%	22%	350	66%	34%	333	37%	63%	334
Urban	15%	85%	322	89%	11%	322	18%	82%	296	43%	57%	296
<b>LMHA RESPONDENTS</b>												
Admin	63%	37%	90	98%	2%	91	69%	31%	51	27%	73%	51
Clinician	58%	42%	62	100%	0%	64	78%	22%	50	24%	76%	50
Supervisor	58%	42%	73	96%	4%	75	72%	28%	40	22%	78%	40
Staff	49%	51%	57	100%	0%	57	68%	32%	31	19%	81%	31
<b>LAW ENFORCEMENT RESPONDENTS</b>												
Sheriff	77%	23%	52	46%	54%	52	68%	32%	31	45%	55%	31
Constable	100%	0%	1	0%	100%	1	50%	50%	2	0%	100%	2
Municipal	69%	31%	98	68%	32%	98	68%	32%	78	41%	59%	78
Other	100%	0%	3	0%	100%	3	50%	50%	2	50%	50%	2
<b>JUDICIAL RESPONDENTS</b>												
JOP	81%	19%	74	100%	0%	74	80%	20%	35	63%	37%	35
County	90%	10%	21	95%	5%	21	79%	21%	14	64%	36%	14
District	62%	38%	16	100%	0%	16	89%	11%	9	78%	22%	9
Probate	14%	86%	7	100%	0%	7	40%	60%	10	60%	40%	10
<b>CONSUMER ADVOCACY RESPONDENTS</b>												
NAMI	41%	59%	37	89%	11%	42	36%	64%	36	28%	72%	39
DBSA	0%	100%	3	100%	0%	3	0%	0%	0	0%	0%	0
TMHC	80%	20%	5	60%	40%	5	67%	33%	3	67%	33%	3
MHA	17%	83%	6	67%	33%	6	12%	88%	8	38%	62%	8
FOF	50%	50%	6	50%	50%	6	50%	50%	2	0%	100%	2
CFC	33%	67%	3	100%	0%	3	0%	100%	3	0%	100%	3
<b>CATEGORIES</b>												
State/Local Planning Committee	57%	43%	23	78%	22%	23	50%	50%	14	57%	43%	14
OTHER	45%	55%	201	69%	31%	202	45%	55%	344	43%	57%	345
Consumer Advocacy	44%	56%	78	82%	18%	78	41%	59%	74	26%	74%	74
Psychiatrist	18%	82%	49	96%	4%	49	32%	68%	31	32%	68%	31
ER/Hospital	42%	58%	60	67%	33%	60	61%	39%	74	28%	72%	75
Law Enforcement	71%	29%	163	60%	40%	163	65%	35%	119	39%	61%	119
Judge	77%	23%	139	99%	1%	139	75%	25%	79	63%	37%	79
LMHA	58%	42%	302	98%	2%	307	71%	29%	189	24%	76%	190
<b>Total</b>	<b>56%</b>	<b>44%</b>	<b>989</b>	<b>83%</b>	<b>17%</b>	<b>1021</b>	<b>56%</b>	<b>44%</b>	<b>951</b>	<b>38%</b>	<b>62%</b>	<b>965</b>