Local Service Area Plan
Appendix A

Crisis Services Redesign
Implementation Plan

Updated
31 AUGUST 2010

“Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a health system that treats their illness with the same urgency as a physical illness.”

(Former President of the United States - George Walker Bush, 2002)
### Table of Contents

1. Cover Page
2. Executive Summary Update  
   a. 31 December 2007  
   b. 29 February 2008
3. Community Champion Letter
4. Table of Contents
5. List of Acronyms
6. Introduction
7. Background
8. Overview of Crisis Redesign Committee Report
9. Findings of Crisis Redesign Committee Report  
   a. Recommended Crisis Services
      i. Improved Crisis Services  
         1. Crisis Hotline Services  
         2. Mobile Crisis Outreach Teams
      ii. Enhanced Local Crisis Services  
         1. Crisis Outpatient Services  
         2. Children’s Outpatient Crisis Services  
         3. Emergency Psychiatric Services with Extended Observation  
         4. Crisis Stabilization Units (CSU)  
         5. Crisis Residential Services for AMH & CMH  
         6. Crisis Respite Services for AMH and CMH  
         7. Crisis Intervention Teams/MH Deputy Program  
         8. Transportation Services  
         9. Purchase of Local Inpatient Hospital Bed Days
         10. Purchase of Detox Bed Days
      iii. Community Investment Incentive Programs  
         1. Psychiatric Emergency Services Center (PESC)  
         2. Jail Diversion or Alternatives to State Hospitalization Projects  
         3. Outpatient Competency Restoration Services
   10. Rider 65, 81st Legislative Session  
      a. Engagement, Transition and Intensive On-Going Services  
         i. Transitional Services  
            1. AMH Population A
            2. AMH Population B  
            3. CMH Transitional Services
   11. Contractual Service Requirements  
      a. Local Planning  
         i. Crisis Service Plan Requirements
         ii. Community Champion for Crisis Redesign
         iii. Stakeholder Participation
         iv. Crisis Service Gaps/Community Needs  
            1. Adult Mental Health Services (AMH)
            2. Children’s Mental Health Services (CMH)
         v. Existing Crisis Services in Denton County
vi. Enhanced Crisis Services ............................................................... 21
   b. Maintenance of Current Crisis Funds ............................................. 22
12. Crisis Services Redesign Funding Allocations ........................................ 22
   a. Equity Allocations ........................................................................ 23
   b. Proportional Allocations ................................................................. 23
   c. Community Investment Incentive Allocations ............................... 24
       i. Selection of Psychiatric Emergency Service Centers ............... 24
       ii. Selection of Jail Diversion or Alternatives
            to State Hospitalization Projects .............................................. 24
   d. Outpatient Competency Restoration Sites ..................................... 25
       i. Selection of Outpatient Competency Restoration Sites ......... 25
   e. State Expenditures ........................................................................ 25
13. Implementation of Crisis Services Redesign ......................................... 26
   a. Accountability ................................................................................. 26
   b. Crisis Redesign Training ................................................................. 26
   c. Hotline Training ............................................................................. 27
   d. Measure of Success ........................................................................ 27
       i. Performance Contract Measures .............................................. 27
       ii. Legislative Budget Board Measures .................................... 28
   e. Fiscal Reporting for Crisis Services Redesign ................................. 29
   f. UM Guidelines for Crisis Services Redesign ................................. 30
       i. Crisis Services, SP-0 .................................................................. 30
       ii. Crisis Follow Up Services, SP-5 ............................................. 31
   g. Oversight of Crisis Services Redesign ............................................. 31
       i. Independent Evaluation ............................................................. 31
       ii. Refining Crisis Services Redesign .......................................... 31
       iii. Implementation Milestones ...................................................... 32
   h. Appendices .................................................................................... 35
       i. Appendix A, Community Stakeholders Listing 
       ii. Appendix B-1, Side by Side Comparison Crisis Services 
       iii. Appendix B-2, Side by Side Comparison Crisis Services Training 
       iv. Appendix B-3, Side by Side Comparison Crisis Services Contacts 
       v. Appendix B-4, Side by Side Comparison Crisis Services Budgets (29 Feb 08) 
       vi. Appendix B-4a, Crisis Services Budget Summary FY 2008 (29 Feb 08) 
       vii. Appendix B-4b, Crisis Services Budget Narrative FY 2008 (29 Feb 08) 
       viii. Appendix C, Crisis Services Flow Chart (29 Feb 08) 
       ix. Appendix D, Proposal for Contract Amendment for Funding of Psychiatric
            Emergency Service Centers and Projects for Jail Diversion or Alternatives to
            State Hospitalization RFI # PCA 0257.1, issued 13 Dec 07, due 29 Feb 08 
   i. References .................................................................................. 36
List of Acronyms

AAS - Association of American Suicidology
CSU - Crisis Stabilization Unit
DSHS - Texas Department of State Health Services
LAR - Legislative Appropriations Request
LBB - Legislative Budget Board
LMHA - Local Mental Health Authority
MCOT - Mobile Crisis Outreach Team
MH GR - Mental Health General Revenue
NIMH - National Institute of Mental Health
PESC - Psychiatric Emergency Service Center
RDM - Resiliency and Disease Management
TDMHMR - Texas Department of Mental Health and Mental Retardation
TCOOMMI - Texas Correctional Office on Offenders with Medical and Mental Impairments
Introduction

Whether the information source is statistics, expert conclusions, or the personal stories of individuals and their families affected by mental illness - It is evident today there are more people who need mental health services than there is access to existing services. This is true worldwide, nationally, in Texas and certainly in Denton County. These individuals in crisis cannot wait for attention. As President Bush stated in his speech announcing the formation of the New Freedom Commission on Mental Health in Albuquerque, New Mexico, on 29 April 2002, our country must make a commitment to the people of America. We must make that same commitment to the people of Texas and Denton County - a commitment of excellent care that treats individuals in crisis with the same urgency as any other person needing emergency medical care.

In the wide array of activities that are called mental health services the most essential element is immediate availability of crisis services. These mental health services are provided to individuals who are experiencing a mental health emergency. Those individuals, if left untreated, could hurt themselves, or others, could be hurt by others, or could end up in jail or homeless due to worsening symptoms of or chronic mental illness.

Crisis services are also frequently the gateway to ongoing mental health services, and a person’s experience with crisis service delivery often determines whether that person will continue with mental health services and their attitude whether toward the overall mental health system.

Background

The United States Surgeon General in their 1999 report on Mental Health cited data developed by the massive Global Burden of Disease Study. This study was jointly conducted by the World Health Organization, the World Bank, and Harvard University. It determined that mental illness, including suicide, ranks second in the burden of diseases for established market economies, such as that found in the United States. Here in the United States, the annual economic, indirect cost of mental illness is estimated to be $79 billion. Most of that amount, approximately $63 billion, reflects the loss of productivity as a result of illnesses. In 1997, the latest year of available comparable data, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illness.

Mental health expenditures are also predominantly publicly funded at 57%, compared to 46% of overall health care expenditures. According to the President’s New Freedom Commission on Mental Health (2003) - despite this disparity in public funding - between 1987 and 1997, mental health spending did not keep pace with general health care because of declines in private healthcare spending under managed care and hospital expenditure cutbacks.

In Denton County there has also been a great disparity in the per capita funding and availability of public mental health services, than in other parts of Texas, as the State’s allocation of funds has primarily been driven by each local authority’s ability to negotiate for available funding. These inequities have existed since the origin of community mental health centers in the 1960’s and on through the early 1980’s. In 1982, through the legacy State agency – the Texas Department of Mental Health
and Mental Retardation (TDMHMR), the Texas Department of State Health Services (DSHS) took the
first step to address previous funding inequities by allocating new dollars mainly on the basis of
population, but since the allocation of new dollars to the State for mental health services was also tied to
the availability of new funding which has been relatively stable over the years, achievement of equity
has been limited.

Despite those 1982 refinements in allocation methodology, substantial inequities remain with
Denton County Mental Health & Mental Retardation Center (the Center) continuing to remain the
lowest funded local mental health authority (LMHA) in the state. With a base rate of only $8.24 per
capita, this is $4.79 below the state average of $13.03 (63% of the State average). This is also $18.83
behind the highest funded center per capita of $27.07 (or 30% of the highest per capita funding
allocation in the State).

In their 2004 report, *In Harm’s Way: Suicide in America*, the National Institute of Mental Health
(NIMH) reported that individuals at risk for suicide often present with symptoms of mental illness or
untreated substance abuse. It has also been noted that suicide deaths outnumber homicide deaths by
five to three. Other estimates are that there may be from 8 to 25 attempted suicides for every suicide
death. NIMH also identified risk factors for attempted suicide in adults to include depression, alcohol
abuse, cocaine use, and separation or divorce. Risk factors for attempted suicide in youth include
depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior.

The failure to provide adequate crisis services can also lead to unnecessary incarceration or
hospitalization of the individual, the disruption and separation of families, and the costly involvement of
other community services, including law enforcement and the courts. According to a report released by
the United States General Accounting Office, in the year 2001, over 12,700 children with
mental health needs were voluntarily placed in child welfare and juvenile justice systems solely for the
purpose of accessing treatment.

Our local communities are also facing growing demands for crisis care at the same time they
are experiencing reductions in qualified medical personnel, outpatient programs, inpatient beds, and
public funding. National and State data tell the same story. According to the New Freedom
Commission on Mental Health Report of 2004, inpatient psychiatric beds per capita have significantly
deprecated. Nationally between 1990 and 2000, the number of State and County psychiatric beds declined
44%. The number of private beds declined 43% in freestanding hospitals and 32% in general
hospital psychiatric units.

In Texas, the average daily census in state hospital bed day use decreased 25% from 1994 to
2004 as reported by DSHS in 2006, with similar decreases in the private sector. For Denton County the
most significant impact to the availability of inpatient psychiatric beds was the closure of Flow Hospital
in 1992 eliminating the availability of this type of service until the opening of University Behavioral
Hospital and Mayhill Hospital in 2006. The decline in available beds has corresponded with an overall
reduced length of hospital stay which is in part driven by federal and state financing strategies that
include disincentives and penalties related to inpatient bed use.

Just as emergency medical services (EMS) responds to medical crises for all individuals in a
community, all Texans also rely on EMS, hospital emergency rooms or the local mental health authority
to respond to a mental health crisis. This system for responding to mental health crises in Texas are
uniformly inadequate to meet these community needs as alternative sources of help to people in crisis. Systems such as law enforcement, jails, emergency rooms of general hospitals, and social services, are not appropriate, cost effective, or able to provide the level and expertise of services that people in mental health crises need in order to recover. The lack of a swiftly responsive crisis system with an appropriate range of crisis services has also contributed to the increased incarceration of mentally ill individuals in jails.

From this background it was determined that model programs and best practices for mental health crises needed to be identified, integrated into our system of care, and replicated statewide in Texas. Determining how best to do this is the subject of the Crisis Services Redesign Committee report.

Overview of Crisis Redesign Committee Report

In December 2005, the Texas Department of State Health Services (DSHS) Commissioner, Eduardo Sanchez, established the Crisis Services Redesign Committee to assess crisis services and develop recommendations for improvements in mental health and substance abuse crisis services that are delivered through the local mental health authorities in the State of Texas. The committee formed included representation invited from Advocacy Groups such as NAMI, community services, consumer organizations, DSHS, emergency medical care, law enforcement, local mental health authorities, mental health professionals, mental health support and prevention groups, physicians, psychiatrists, representatives from the courts and judiciary, state and private hospitals. Dr. Joseph Burkett represented the Center on this committee through his position as our Medical Director Consultant.

The committee’s purpose was to develop recommendations for a comprehensive array of specific services that would best meet the needs of Texans who are having a mental health or substance abuse crisis. The vision of the committee was to develop a consistent state of the art system of crisis services across Texas with improved accessibility; standards of care; community involvement; consumer choice; less restrictive treatment environments and lessening the burden on local hospitals, jails and law enforcement. In order to accomplish this, the committee gathered to analyze information from mental health literature, medical experts, members of the public, and staff.

In developing the content of the report, the Committee used three primary sources of information: 1) A study of current biomedical and social services literature; 2) The results of a DSHS quality management review of crisis services completed in December 2005; and 3) Input gathered through a series of statewide hearings conducted in February 2006.

Stakeholder concerns and recommendations were central to the committee’s process for assessing services and formulating recommendations. The committee traveled across the state in February 2006 to hear public testimony in locations representing the border region (Harlingen), rural areas (Big Spring and West Texas), and urban areas (San Antonio). A hearing concerning statewide issues was also held in Austin.

In order to help the committee with its work, the Center participated in an evaluation of existing crisis services in Texas completed by the DSHS Community Mental Health and Substance Abuse Services Quality Management division in February 2006. The Center’s survey response along with 31
other local mental health authorities and Value Options, a behavioral health organization, provided an evaluation of the accessibility of our crisis services, the competency of our crisis service providers, the availability of local community alternatives to hospitalization, and the crisis screening and assessment tools use.

Another key component of the DSHS quality management review was a survey mailed to sheriff departments, police departments, and licensed hospitals throughout Texas to obtain information about their experience with coordination and delivery of crisis services provided by local mental health authorities. A total of 258 of 570 surveys sent to hospitals were returned for a response rate of 45%. A total of 442 out of 1030 surveys sent to law enforcement were returned for a response rate of 43%.

The overall responses from the community stakeholders were generally critical of current crisis services with emphasis on the following areas:

- Timeliness of crisis service provider response;
- Training and competency determination for 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 LMHAs, law enforcement and hospitals and other community resources; and
- Oversight systems to monitor the effectiveness (outcome) of crisis services.

Subcommittees were also created in order to –

- Define essential crisis services and recommend appropriate service standards;
- Identify considerations affecting the state’s rural areas;
- Define necessary collaborations and linkages for an efficient, effective crisis system; and
- Estimate the costs of recommendations for the system redesign.

Communication with stakeholders has been vital and ongoing throughout the crisis services redesign process. In February 2007, DSHS staff presented a report at the local mental health authorities Behavioral Health Consortium and brought back stakeholder input to the agency’s crisis redesign workgroup. A similar forum was addressed at a conference held by the Texas Council of Community Mental Health Mental Retardation Centers in June 2007.

Throughout the spring of 2007, DSHS staff worked with representatives from the Texas Council of Mental Health Mental Retardation Centers through meetings, teleconferences, and electronic communication. Input was also gathered from individual local mental health authorities through the use of written surveys and requests for information on specific topics. DSHS staff also visited the crisis service delivery systems in San Antonio, Harris County, Tarrant County, and Beaumont, gathering more valuable information from the local mental health authorities, law enforcement personnel, healthcare providers, and other stakeholders.
In July 2007, additional stakeholder input was obtained through meetings with representatives and committees of the Texas Council of Mental Health Mental Retardation Centers and the DSHS Mental Health Planning Advisory Committee.

**Findings of Crisis Redesign Committee Report**

The resulting September 2006, Crises Services Redesign Report identified an array of crisis services that are community based, rapidly deployed and focused on diversion from more restrictive or inappropriate care settings. The recommended redesign identifies the necessary elements of crisis services to include substance abuse, rural issues, clinical competencies, financial cost, and important collaborations and partnerships. The Crisis Services Redesign Committee concurred that the following core services should be the centerpiece of the mental health system of care for individuals in crisis:

- Crisis hotline services
- Psychiatric emergency services with extended observation services (23 to 48 hours)
- Crisis outpatient services
- Community crisis residential services
- Mobile outreach services
- Crisis intervention team (CIT)/mental health deputy/peace officer program.

A recurring statewide concern identified was the lack of medical transportation for individuals requiring mental health services, which often results in local law enforcement providing transportation for individuals to state hospitals. The committee also noted that the lack of medical transportation results in needless treatment delays for citizens experiencing mental health crises; unnecessary incarceration; inconvenience and expense for an already burdened local law enforcement system. The lack of readily available, medically appropriate transportation for people experiencing mental health crises also contributes to poor consumer outcomes, stigma, and inefficient use of limited public funds. The committee agreed that addressing these transportation issues is critical to meaningful transformation of crisis services in Texas.

Denton County, in 1989, recognized these transportation needs and addressed them through the development of our local Mental Health Deputy Program with additional county funding provided to support transportation needs. Using unmarked cars and non uniformed officers this program displaces those needless delays, incarceration and the stigma associated with other law enforcement transportation methods.

**Recommended Crisis Services**

Crisis redesign funds have been used in Denton County to support an array of services recommended by the Crisis Redesign Committee as noted below. In addition, these funds may also be used to help defray transportation costs incurred by local law enforcement agencies related to behavioral health crises. This overall effort is oriented towards first improving existing services in Denton County and then enhancing the mental health crisis response system by linking the many community organizations that play a role in mental health care and the state’s larger public health care system.

Crisis Redesign Funds will be available for the following type of services:
• **Improved Crisis Services** - Our first two priorities for crisis services redesign funding were to 1) ensure the continuation of our crisis hotline service and 2) the expansion of our mobile outreach services as a minimum level of critical crisis response. This will continue to provide Denton County with basic crisis response capabilities, including identification, screening and stabilization of patients who can be safely treated in the community.

  o **Crisis Hotline Services** - The crisis hotline is the critical gateway to behavioral health services. The Center currently contracts with Tarrant County to offer a continuously available, toll-free telephone service 24 hours per day, 7 days per week, for 365 days per year to any caller. Our contracted crisis hotline staff members are trained by Tarrant County and are credentialed as Qualified Mental Health Providers – Community Services (QMHP-CS). These QMHP-CS staff members provide information, screening, assessment, intervention, support, and referral services to our callers by telephone. As part of crisis redesign, the Center has further improved our Crisis Hotline Service in the course of having internal staff members become accredited by the American Association of Suicidology (AAS) through training and train the trainer sessions scheduled by the Texas Department of State Health Services (DSHS) and ensuring that Tarrant County has done so as well. In addition to individual hotline answers being certified, the Tarrant County MHMR hotline has become accredited as a Crisis Center as well.

  o **Mobile Crisis Outreach Teams (MCOT)** – Our current mobile crisis outreach staff members are operating in conjunction with our contracted crisis hotline service. These QMHP-CS and LPHA/RN qualified staff members provide emergency care, urgent care, crisis follow-up and relapse prevention as is safely appropriate and feasible in the child, adolescent, or adult caller’s natural environment. As part of crisis services redesign the Center is a designated urban Local Mental Health Authority (LMHA). We currently employ 8 -2 person MCOT teams. Each individual team is comprised of a QMHP-CS and a Registered Nurse (RN) or LPHA to provide mobile crisis outreach services for a minimum of 84 hours a week during our historically defined peak hours of crisis service requests. For after hours, holidays and weekends we have 2-2 person MCOTs on call. The Center plans to add a third on call team in FY 11. This will allow the Center to maintain our immediate access standards requirement for assessment and crisis resolution, regardless of the time and place of the precipitating event or the individual’s available transportation resources and will serve to shorten our overall response time. Each MCOT also provides temporary follow up and relapse-prevention services in the community to individuals who often have urgent needs or need psychiatric treatment, but do not meet the criteria for involuntary detention or can not use traditional systems to access available care. In addition to, follow up and relapse prevention, the LPHA member of the MCOT provides Cognitive Behavior Therapy (CBT). We employ 3 crisis case managers who work intensively with our crisis clients in service package 5, to link them with resources in the community to continue treatment upon the conclusion of crisis services. Our 2 LCDC staff provide individual and group substance abuse counseling as well as referrals for higher levels of care as needed. Clients also have quicker access to our outpatient psychiatric medical services. Our MCOTs continue to work closely with our Mental Health Deputy Program and other local law enforcement officers and emergency responders. As part of crisis redesign, Denton County MHMR Center has
also had many of the MCOT staff participate in AAS training to become Certified Crisis Workers. The Center plans to continue this training with the remaining MCOT staff.

- ENHANCED LOCAL CRISIS SERVICES – Following the maintenance and certification of our contracted crisis hotline service and the expansion and improvement of our MCOT service, our 3rd priority was the improvement and enhancement of our available walk in outpatient crisis service delivery system.
  
  o Crisis Outpatient Services – The Center currently offers referral and walk-in office-based outpatient services for adults, children and adolescents that provide immediate screening and assessment and brief intensive interventions focused on resolving a crisis and preventing admission to a more restrictive level of care. These types of services meet two purposes: 1) ready access to psychiatric assessment and treatment for new patients with urgent needs, and access to same day psychiatric assessment and treatment for existing clients. 2) In addition, these services will provide treatment for individuals who are not currently likely to hurt themselves or others but who might develop an emergency if they do not receive same-day services. Clinicians are available during business hours to treat patients with fairly severe needs if a brief moderately intensive intervention might reduce the need for a more intensive level of care. Available services may include brief therapy, pharmacotherapy, and case management services. Currently, anyone walking in with acute psychiatric needs is seen immediately for an emergency face to face assessment to determine least restrictive treatment environment.

  o Children’s Outpatient Crisis Services – The Center currently provides children’s outpatient crisis services as noted above. Enhancement is proposed in the form of flexible, multi-faceted, and immediately accessible services when children and adolescents are at high risk for hospitalization or out-of-home placement through the MCOT. These types of services are designed to be family-focused, intensive, and time-limited.

  o Emergency Psychiatric Services with Extended Observation Service - Extended observation is an essential component of the crisis service array that can reduce unnecessary incarceration and inpatient psychiatric interventions. It includes provision of comprehensive psychiatric emergency services with the goal of comprehensive assessment, rapid stabilization, and appropriate aftercare planning, and can include up to 23-48 hours of observation and treatment. These services provide immediate access to emergency care at all times and have the ability to safely and appropriately manage the most severely ill psychiatric clients. Services would be delivered in a secure and protected environment that is generally co-located with a DSHS-licensed hospital or crisis stabilization unit. The Center currently contracts with Millwood Hospital, Wise Regional Behavioral Health, and University Behavioral Health to provide these types of inpatient stays and extended observation services through direct contract purchase with funding provided through local county dollars. Expansion or enhancement of these types of services will be explored with these and other local interested stakeholders through our local crisis services redesign planning process.
- **Crisis Stabilization Units (CSU)** - CSUs provide short-term residential treatment designed to reduce acute symptoms of mental illness. Services are provided in a secure and protected environment that is 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 (relating to Standards of Care and Treatment in Crisis Stabilization Units). CSUs are clinically staffed and psychiatrically supervised, and provide immediate access to emergency care. As above the Center will explore the enhancement of this type of service to our crisis service array through our planning process with interested local stakeholders.

- **Crisis Residential Services for Adults and Children** – Provide short-term community based residential crisis treatment to persons with some risk of harm who may have fairly severe functional impairment. These types of facilities provide a safe environment with clinical staff on site at all times; however, they are not designed to prevent elopement and individuals must have a least a minimal level of engagement to be served in this setting. The recommended length of stay is from 1 to 14 days based on LMHA assessed medical necessity. The Center is not considering this service as an enhancement to our crisis service array based on our local planning process with interested local stakeholders and risk management evaluation.

- **Crisis Respite Services for Adults and Children** – Provides short-term, community based residential crisis treatment to individuals 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. This type of service is appropriate for individuals with stressful and/or unsupportive recovery environments and those who have had limited response to prior treatment. Crisis respite services may also serve individuals with housing challenges or assist caretakers who need short term housing for the persons for whom they care to avoid a mental health crisis. They are not, however, equipped to handle individuals with severe or acute medical conditions. The expected duration of stay in this service is generally less than one week as determined by the LMHA’s assessed medical necessity. The Center is not considering this service as an enhancement to our crisis service array based on our local planning process with interested local stakeholders and risk management evaluation.

- **Crisis Intervention Teams/MH Deputy Program** – As addressed above, Denton County will continue to rely upon our existing program with the Denton County Mental Health Deputy program.

- **Transportation** – As addressed above.

- **Purchase of Local Inpatient Hospital Bed Days** – The Center has allocated a portion of our enhancement funds for the purchase of additional inpatient hospital bed days to provide additional hospitalization and jail diversion opportunities.

- **Purchase of Detox Bed Days/Residential Substance Abuse Treatment** - The Center is using a portion of our enhanced funds to purchase detox beds to serve our substance abuse population. Many of the individuals we see in crisis services are dual diagnosed.
Many of the individuals qualify for crisis services because portion of the TRAG directly related to substance use and abuse. These services will be provided to begin addressing the substance abuse needs of individuals in crisis in a safe, medical environment. Once the detox process is complete, these individuals may then continue treatment in an inpatient residential treatment program for 30-45 days or continue on an outpatient basis through our crisis services or local community referrals.

- COMMUNITY INVESTMENT INCENTIVE PROGRAM

  - **Psychiatric Emergency Service Center (PESC)** - A PESC would provide immediate access to assessment and a continuum of intensive stabilizing treatment for persons who present with a behavioral crisis. This PESC site will be co-located with a licensed hospital/CSU and be equipped to treat the most severely ill children, adolescents and adults at all times, including emergency medical care. It will provide referral and walk-in emergency psychiatric services with extended observation and, for individuals who cannot be stabilized within 23-48 hours, treatment in an inpatient hospital unit or CSU for up to 14 days. The Center is not considering this service as an enhancement to our crisis service array based on our local planning process with interested local stakeholders and risk management evaluation.

  - **JAIL DIVERSION OR ALTERNATIVES TO STATE HOSPITALIZATION PROJECTS** - The Center has and will continue to explore the enhancement for other community based projects that focus on diverting individuals from incarceration or providing alternatives to state hospitalization through our planning process with interested local stakeholders and other local mental health authorities. These projects include Crisis Stabilization Units, crisis respite, purchasing of local hospital beds and associated services that provide residential alternatives to incarceration or state hospitalization. Jail diversions projects will serve to minimize officer wait time and divert individuals prior to booking.

  - **OUTPATIENT COMPETENCY RESTORATION SERVICES** - The Texas Department of State Health Services (DSHS) proposes to extend its ability to provide competency restoration services beyond the existing State Mental Health Hospital based programs through the development and enhancement of the mental health crisis system. The Center will explore the enhancement of this type of service to our crisis service array through our planning process with interested local stakeholders and other local mental health authorities. The Center through its local planning process with interested stakeholders has decide to not seek additional Community Investment Incentive funds to support one of four proposed outpatient competency restoration service sites.

    It is anticipated that DSHS and the Center will partner in jail diversion and outpatient competency restoration programs with the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) as available in the State. It is expected that a successful outpatient competency restoration program would enhance the ability of local communities to provide effective treatments to individuals with mental illness involved in the legal system while reducing unnecessary burdens on jails and state psychiatric hospitals. Competency restoration
services would provide psychiatric stabilization in conjunction with any needed training in courtroom skills and behavior presentation.

Outpatient competency restoration programs established under this initiative will have available for use, as needed and appropriate, a curriculum adapted from the inpatient competency restoration curriculum used at North Texas State Hospital-Vernon Campus and the current DSHS community mental health Resiliency and Disease Management (RDM) system.

This model will require strong collaborative efforts among local judges, jail officials, community mental health systems, as well as community-based organizations providing support services. Additionally, DSHS is working with providers of outpatient competency restoration programs in other states to incorporate effective and successful strategies into the Texas model. Implementation will include judicial outreach and education as needed to support the initiative.

Rider 65, 81st Legislative Session

Engagement, Transition and Intensive ongoing services

From Senate Bill 1, this rider appropriated $55,000,000 to DSHS to fund transitional and intensive ongoing services in the community. Funds for both transitional and intensive ongoing services will be distributed both equitably and proportionally as previous Crisis Services Redesign funds have been. Successful implementation of these important statewide initiatives must include collaborative stakeholder input to reach the established viable and accountable contractual requirements to support these services as noted in the current DSHS Performance Contract Notebook.

- Transitional Services – are services provided to individuals in either AMH population A or B or CMH Transitional Services as described below –

  - AMH Population A Transitional Services is defined as those AMH individuals who have been stabilized in SP-0 or psychiatric hospitalization, but are otherwise not eligible for AMH SP 1-4
    - The major focus for population A is on maintaining stability, preventing further crisis, and assisting the individual in obtaining appropriate community based services.
      - This SP includes, but is not limited to ongoing assessment to determine crisis status and needs, and is time limited case management of up to 90 days and pharmacological services.

  - AMH Population B Transitional Services is defined as those AMH individuals who have stabilized in SP-0 or psychiatric hospitalization, or who may be homeless, in need of substance abuse treatment, primary healthcare, involved in the criminal justice system, and who are eligible for AMH SP 1-4, but either there is not current capacity to provide the recommended LOC, or the AMH individual is difficult to engage into the appropriate LOC.
    - The major focus for population B is on maintaining eligibility, and engaging the AMH individual into the appropriate AMH LOC. This AMH SP includes
ongoing assessment to determine crisis status and needs; time limited AMH case management of up to 90 days, engagement and pharmacological services.

- Also, this AMH SP provides access to an array of flexible services designed to assist the AMH individual in obtaining appropriate community-based services, and to engage the AMH individual into the appropriate AMH LOC.

  - CMH Transitional Services targets those individuals who have stabilized in SP-0 or psychiatric hospitalization; who may be homeless, in need of substance abuse treatment, primary healthcare, involved in the juvenile justice system, and are eligible for CMH SP 1-4, but either there is no current capacity to provide the recommended LOC, or the AMH individual is difficult to engage into the appropriate LOC.
    - The major focus for this population is on maintaining stability, preventing further crisis and engaging the CMH individual into the appropriate CMH LOC or assisting the individual in obtaining appropriate community based services. This CMH SP includes, but is not limited to, ongoing assessment to determine crisis status and needs; time limited CMH case management of up to 90 days, and pharmacological services.
    - Also, this CMH SP provides access to an array of flexible services designed to assist the CMH individual in obtaining appropriate community-based services, and to engage the CMH individual into the appropriate CMH LOC.

Suicide Prevention Officer

Also new to the current FY 2010 DSHS Performance Contract Notebook is the designation by the Center of a staff member to act as the Suicide Prevention Coordinator. The purpose of the Suicide Prevention Coordinator is to work collaboratively with other local staff and the DSHS Suicide Prevention Coordinator to be recognized as a partner in suicide prevention, and as an authority on mental health in the local community.

Contractual Service Requirements

There are four main expectations from our proposed Performance Contract Amendments with DSHS on Crisis Services Redesign.

- First, is the implementation of a local planning process focused on crisis services redesign
- Second, is the maintenance of current general revenue allocations for crisis funding
- Third, is an oversight process for the Centers implementation process
- Forth, is the submission of an initial Crisis Service Plan and an updated Crisis services Plan for FY 2011 as part of a comprehensive Local Service Area Plan in FY 2010 as outlined the current DSHS Performance Contract Notebook.
Local Planning

Our local crisis planning process is specifically designed to address the needs of children, adolescents and adults. It will demonstrate a strong coordination with local law enforcement, healthcare, and protective services. As part of our local planning process, the Center has developed, updated, and will maintain a local crisis services redesign plan that is based on the needs and priorities of the community in conjunction with those interested local stakeholders. This plan is designed to meet the following objectives: 1) To ensure a rapid crisis services response system; 2) To provide local stabilization whenever possible; 3) To ensure diversion from jail incarceration; 4) Reduce the burden on local law enforcement agencies and 5) To decrease utilization of other emergency healthcare resources in the community.

At a minimum, our local plan will ensure the expenditure of available allocations to ensure a basic infrastructure of crisis services that includes an American Association of Suicidology accredited hotline with two or more crisis counselors on duty twenty-four hours a day, seven days a week, each day of the year and the deployment of a Mobile Crisis Outreach Team whose services are available with sufficient capacity to provide on-site response in the community from two or more credentialed staff persons, one being a Qualified Mental Health Professionals – Community Services (QMHP-CS) the other a Licensed Practitioner of Healing Arts (LPHA) or RN.

This and subsequent plan updates will address any remaining new crisis funding allocations. Funds will be used to enhance, bring into compliance with new standards or implement any or all of the following types of services: Crisis Outpatient Services; Crisis Residential Services; Crisis Intervention Teams (CIT)/Mental Health Deputy Program; Crisis Stabilization Unit; Psychiatric Emergency Service Center; Extended Observation; Crisis Transportation and local inpatient hospital bed days. Any of these additional services to be provided will be determined based on local needs and priorities, existing infrastructure, available funds, risk, and current collaborative activities with the community through our local crisis planning process.

Our local plan will also describe the strategies developed and implemented to maximize those dollars available to provide crisis services. This will include collaborations with local and regional stakeholders and other LMHAs. The Center will also examine all available opportunities to minimize overhead and administrative costs through cost sharing and joint service delivery in this process.

Crisis Service Plan Requirements

The Center’s Initial Crisis Service Plan was submitted to the Texas Department of State Health Services (DSHS) on 31 October 2007 for their review. DSHS approved this plan of implementation on 21 Nov 2007.

The Center expects to make revisions and updates to our Crisis Service Plan through our local planning process during the current biennium. Those updates will be submitted to DSHS for approval within 20 business days of the effective change.
Our plan shall contain the following information:

1. The identification of a community champion for the crisis services redesign planning and implementation process charged to assist the Center in bringing together stakeholders who have the organizational authority to make decisions regarding resources, collaboration, and coordination (see Appendix A, Community Stakeholders Listing).

2. A listing of all community stakeholders from the local service area invited by the Center to be involved in local crisis service planning (see Appendix A, Community Stakeholders Listing).

3. A listing of all community stakeholders from the local service area actively involved in the local crisis service planning (see Appendix A, Community Stakeholders Listing).

4. A description of the collaborative process and efforts used to develop and implement the Center’s Crisis Service Plan with community stakeholders from the local service area.

5. Documentation of the Center’s ongoing efforts to engage and involve those community stakeholders invited to participate but who have not actively participated in crisis service planning (see Appendix A, Community Stakeholders Listing).

6. A description of the current service gaps or community needs related to the delivery of crisis services for adults, adolescents and children, as well as gaps related to the delivery of crisis services to individuals with co-occurring psychiatric and substance use disorders. (see page 19 for listings)

7. A description of how the new crisis funding allocations were used to first improve our Crisis Hotline and Mobile Crisis Outreach Team infrastructure, training, and crisis response processes to achieve American Association of Suicidology accreditation and compliance with DSHS promulgated standards found in the current DSHS Performance Contract Notebook.

8. A description of how any remaining new crisis funding allocations will be used to enhance, or implement any or all the following services in compliance with the standards outlined in the current DSHS Performance Contract Notebook:
   a. Crisis outpatient services (AMH & CMH);
   b. Extended observation;
   c. Crisis Stabilization Unit;
   d. Crisis residential services (AMH & CMH);
   e. Crisis respite services (AMH & CMH);
   f. Psychiatric Emergency Service Center;
   g. Crisis Intervention Team (CIT)/Mental Health Deputy Program;
   h. Crisis transportation; and
   i. Purchase of Local Inpatient Hospital Bed Days

9. A description of and a formatted side-by-side comparison of the existing crisis services currently provided and the improved or enhanced services proposed to be provided with the new crisis funding allocations (see Appendix B-1, Side by Side Comparison Crisis Services). This descriptive comparison will include -
   a. A description of the Center’s former crisis response system for the FY 2006 – 2007 Biennium, that includes the types and quantity of crisis services provided in Denton County; a flowchart (see appendix C, Crisis Services Flow Chart) that describes the crisis response system from the first call or contact with the Center through crisis resolution and follow-up; our crisis response system staff make-up, training requirements, and line item budget(s).
b. A description of the Center’s improved crisis response system for the FY 2009 – 2010 Biennium, that includes the projected types and quantity of crisis services to be provided within Denton County from the allocation of new crisis funding (see Appendix B-2, Side by Side Comparison Crisis Contact Numbers), a flow chart that describes the improved crisis response system from the first call or contact with the Center through crisis resolution and follow up (see appendix C, Crisis Services Flowchart); our projected improved crisis response system staff make up, training requirements (see Appendix B-2, Side by Side Comparison Crisis Services Training), and line item budget(s) (see Appendix B-4, Side by Side Comparison Crisis Services Budget; B-4a, Crisis Services Budget Summary FY 2008; and B-4b, Crisis Services Budget Narrative FY 2008).

10. A description of how the Center’s crisis response system will integrate mental health and substance abuse crisis services.

11. A description of how the Center will coordinate with other local crisis response systems to improve or develop the local crisis response system’s ability to divert individuals from incarceration, or find alternatives to psychiatric hospitalization including any written agreements between crisis response entities and any marketing/public relations documentation used to inform the community about the changes in the crisis response system.

12. A description of strategies that will maximize the funding available to provide crisis services, including any collaboration with local or regional stakeholders, and collaboration with other local mental health authorities or Texas Department of State Health Services - funded substance abuse providers.

13. A timeline specific to the implementation activities described above.

14. A description of the Center’s oversight of implementation, with input from community stakeholders to ensure community needs and benchmarks are being met during the crisis redesign process.

Community Champion for Crisis Redesign

The Center has identified Denton County Judge Mary Horn to fill the role of the Community Champion for the Crisis Services Redesign planning and implementation. Judge Horn has accepted this key position to assist Denton County MHMR Center in bringing together the other essential community stakeholders who have the organizational authority to make decisions regarding resources, collaboration, and coordination around Crisis Services Redesign for Denton County.

Stakeholder Participation

Stakeholder participation is a key feature of this planning process. The Center has invited and engaged communication on Crisis Services Redesign Planning with representatives from the people we serve, their family members, child and adult advocates, mental health service providers, emergency healthcare providers, representatives from the local public health department, our Community Indigent Healthcare Center, the Tarrant County Outreach, Screening, and Referral (OSAR) provider serving Denton county; other substance abuse providers, and representatives from law enforcement, probation and parole departments, the judiciary, City Mayor, schools, colleges and universities.

We have met directly with the Tarrant County Outreach, Screening and Referral (OSAR) staff from Tarrant County to review our Crisis Services Redesign plan and DSHS requirements. Through this
process we have established a working relationship for service referrals through their Denton County representative.

These persons have been invited and others will be invited as identified to join or continue to participate in this on going process to plan, develop, and implement this Crisis Service Plan and prepare for the future improvements to the behavioral health crisis response system in Denton County. An initial survey was also included with those invitations to provide stakeholders with an alternate interaction avenue by responding directly to those surveys either beforehand or in lieu of attending any scheduled planning or public forum sessions. Results from of those survey responses and public forums are included in this Crisis Services Redesign Implementation Plan Update in the Gaps and Needs Section found below.

Additional follow up invitations and individual contacts with those persons and agencies listed that have not responded or did not previously participate have will also be made in an ongoing effort to engage them in the Crisis Services Redesign planning and implementation process for Denton County.

A series of public forums has begun in conjunction with our Public & Network Advisory Committee (PNAC) to directly involve other people we serve, their families and the general public.

**Crisis Service Gaps/Community Needs**

The following two tables identify the on going crisis services related gaps that have been previously identified in Denton County through our Local Service Area Planning process. These reflect the identified current service gaps or community needs related to the delivery of crisis services for adults, adolescents and children, as well as gaps related to the delivery of crisis services to individuals with co-occurring psychiatric and substance use disorders. Additional responses and input from the crisis redesign planning and survey invitations sent to local area stakeholders and from other planning meetings and public forums have also been included as received.

<table>
<thead>
<tr>
<th>#</th>
<th>Title</th>
<th>Description/Purpose</th>
<th>Identified Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Respite Care</td>
<td>To provide a break from the constant administration of care supervision by the family</td>
<td>Limited resources</td>
</tr>
<tr>
<td>2</td>
<td>Half Way House</td>
<td>Transitional living from or avoidance of hospitalization</td>
<td>No available resources</td>
</tr>
<tr>
<td>3</td>
<td>Transportation services</td>
<td>To social and non-medical events</td>
<td>Limited resources available and are continually reduced by economic factors</td>
</tr>
<tr>
<td>4</td>
<td>Substance Abuse Treatment</td>
<td>Treatment for dual diagnosis and single diagnosed persons who may or may not be intoxicated at the point of their presentation</td>
<td>Limited resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient group therapy program for medication compliance/relapse</td>
<td>Limited resources</td>
</tr>
<tr>
<td></td>
<td>Title</td>
<td>Description/Purpose</td>
<td>Identified Barrier</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5</td>
<td>Homeless outreach</td>
<td>Provide outreach to persons who are homeless and have a mental illness</td>
<td>Limited resources</td>
</tr>
<tr>
<td>6</td>
<td>Criminal Justice and Diversion Programs</td>
<td>Provide intervention and collateral treatment of people with mental illness</td>
<td>Lack of resources</td>
</tr>
<tr>
<td>7</td>
<td>No local inpatient hospital care</td>
<td>Local treatment for persons with mental illness</td>
<td>Limited resources</td>
</tr>
<tr>
<td>7</td>
<td>No local inpatient hospital care</td>
<td>Longer inpatient LOS through partial hospital stay services</td>
<td>Limited resources</td>
</tr>
<tr>
<td>8</td>
<td>No Psychiatric ER/walk-in services</td>
<td>Local treatment for persons with mental illness</td>
<td>Limited resources</td>
</tr>
</tbody>
</table>

### Gaps in Crisis Services – Children & Adolescents

<table>
<thead>
<tr>
<th>#</th>
<th>Title</th>
<th>Description/Purpose</th>
<th>Identified Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Respite Care</td>
<td>Break from the constant administration of care supervision by the family</td>
<td>Limited resources</td>
</tr>
<tr>
<td>2</td>
<td>Juvenile Delinquency and Conduct Disorders</td>
<td>Provide intervention and collateral treatment of people with mental illness</td>
<td>Lack of resources</td>
</tr>
<tr>
<td>3</td>
<td>Substance Abuse Treatment</td>
<td>Treatment for dual diagnosis and single diagnosed persons who may or may not be intoxicated at the point of their presentation.</td>
<td>Lack of resources diminished by economic down turn and agency funding reductions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient group therapy program for medication compliance/relapse</td>
<td>Limited resources</td>
</tr>
<tr>
<td>4</td>
<td>No local in patient hospital services</td>
<td>Local treatment for persons with mental illness</td>
<td>No local resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Longer inpatient LOS through partial hospital stay services</td>
<td>Limited resources</td>
</tr>
<tr>
<td>5</td>
<td>No psychiatric ER/walk-in services</td>
<td>Local treatment for persons with mental illness</td>
<td>Limited resources</td>
</tr>
</tbody>
</table>

### Existing Crisis Services in Denton County

The Center’s existing crisis response system consisted of a live 24 hour, seven days a week, 365 days a year manned Crisis Hotline and Mobile Crisis Outreach Teams. The Center is now contracting with Tarrant County MHMR Center’s Crisis Hotline Service to cover all crisis calls. There were 1873 emergency screenings performed during the FY 2006 - 2007 biennium by the Center. Of those 1094 occurred in the community (mobile outreach) and 779 occurred in one of our outpatient service locations. From those screenings 1094 resulted in an inpatient referral with 621 of those being a SMHF admission. The type and quantity of crisis services provided during the FY 2006 – 2007 biennium are also reflected in appendix B-2, Side by Side Comparison Crisis Contact Numbers with projections for...
service requests for FY 2008-2009. During the FY 2008-2009 biennium the MCOT teams performed 2,662 emergency assessments. Of those, 1,899 were performed in the community and 773 took place in one of our outpatient clinics. Inpatient was the recommendation in 1,273 of the screenings completed with 573 resulting in SMHF admission.

The Center’s previous mobile outreach crisis response system was comprised of a single staff person who met with the person in crisis at a hospital or other secure location in the community. A flow chart of how the previous crisis response system for Denton County moves from the first call or contact with the Center through resolution and follow-up is shown in Appendix C, Crisis Services Flow Chart.

The Center has assembled an Access & Crisis Training Package for all staff who maybe involved in the provision of a crisis service. This includes QMHP-CS crisis staff, LPHA/RN crisis staff, case managers, med clinic staff, continuity of care, hospital liaison and intake and therapy staff positions. Training provided to staff as reflected in Appendix B-2, Side by Side Comparison Crisis Services Training, includes information based on AAS crisis worker certification training, additional training topics for treatment, clinicians and documentation. Additional training elements include screening and management of crisis, assessing needs and basic communication skills. Information on risk factors for suicide is covered as well along with basics in telephone crisis screening, communication, and the mental status assessment process.

Further training is provided on the options of least restrictive environments and crisis risk factors, department rule requirements and center procedures. Along with information on mental health court application processes, court fees and obtaining a certificate of medical examination is also provided to these staff.

Our previous FY 2008 operating budget for existing crisis services was $741,951. Funding of these services was principally covered through Mental Health General Revenue (MH GR) funding. Local county funding accounted for $228,000 of this total which was used to purchase inpatient crisis beds at Millwood Hospital in Arlington, Texas, and University Behavioral Health in Denton, Texas, by contract purchase of inpatient hospital beds. This method was used to divert from the use of State Funded Inpatient Psychiatric bed days at North Texas State Hospital. County funding also includes related transportation activities by our local Mental Health Deputy Program (see Appendix B-4, Side by Side Comparison Crisis Services Budget for details).

Enhanced Crisis Services

Our plan describes how our existing crisis services were enhanced to provide an integrated crisis system built around the recommended best practices from the Crisis Redesign Committee. This included a description of how new crisis funding was first used to improve Crisis Hotline Services and enhance our Mobile Crisis Outreach Team(s) infrastructure through additional training, and improved crisis response processes to achieve American Association of Suicidology accreditation and compliance with DSHS promulgated standards.

More specifically the Center is currently contracting with Tarrant County MHMR Center to provide 100% of our Crisis Hotline coverage to ensure continuity in crisis call services. Initial planning by the Center resulted in the establishment of three MCOT teams consisting of a QMHP and an LPHA
or RN that were located in two areas of the county to provide immediate crisis response as needed. Over
the last 2 years, the Center has increased MCOTs to 8 Teams, which are spread out in two areas of the
county. These MCOTs consist of degreed QMHP-CS and an RN or LPHA staff member who are
supervised by an LPHA level Crisis Services Director position with direct access to Center psychiatrists. Additional crisis support staff positions have been identified for front desk/reception, clinical assistance, human resources contract, medical records and consumer benefits eligibility support services. The Center also has 2 MCOT teams on call for after hours, weekends and holidays. The center will be adding a 3rd on call MCOT team in FY 11.

**Maintenance of Current Crisis Funds**

In FY07 the Center invested significant dollars in our crisis system - $741,951. While these investments are significant, they had been insufficient to support truly effective crisis service delivery. Our intended use for new crisis service redesign funding is as an investment in additional crisis service resources to improve our response times and service delivery effectiveness. These additional funds will not be used to replace Mental Health General Revenue (MH GR) funds currently spent on existing crisis services.

The Center will use the Texas Department of State Health Services (DSHS) performance outcome measures related to crisis services redesign, monitoring of established Legislative Budget Board (LBB) measures prepared by DSHS, DSHS MH Report III fiscal information and an active local planning process to maintain current MH GR spending levels on our existing crisis services to protect those MH GR allocations. The Center also supports DSHS’ desire to generate legislative support for continued funding of improved and enhanced crisis and follow-up crisis services. Secondly, the Center supports increased State level funding for on going support services for existing and to new persons to be served.

**Crisis Services Redesign Funding Allocations**

In 2007, the 80th Texas Legislature appropriated $82 million for Crisis Services Redesign during the FY 08-09 biennium via Rider 69 - Community Mental Health Crisis Services. This was a major and unprecedented appropriation specifically designated for improvements in the crisis service delivery system.

Consistent with the proposed use of funds described in the Legislative Appropriation Request (LAR) from above, the current allocation process to be used by the Texas Department of State Health services (DSHS) divides the new crisis redesign funding allocations into five specific portions with two distinct distribution processes to the local mental health authorities (LMHAs) in Texas. Four of those allocation portions were to address crisis services - first to improve and then to enhance - with the fifth allocation portion reserved for state wide training, monitoring and oversight functions performed by DSHS.

In the first distribution process, which occurred within the first quarter of FY 2008, a majority of the funds 68% ($56 million) were divided among each of the State’s LMHAs through amendments to our existing contracts with DSHS. The two funding portions under this first distribution process were
the Equity Contribution Allocations at 32% ($26 million) and Proportional Allocations of 36% ($30 million). These two allocations were designed to improve or enhance the crisis services already available in our community. For Denton County this amounted to $4.1 million dollars in total, with $1.5 million being allocated for FY 2008 and $2.6 million in FY 2009.

This first phase of implementation focused on ensuring statewide access to competent rapid response services, avoidance of hospitalization and reduction in the need for transportation. As stipulated by the Legislature and in response to Rider 69, these funds allowed Denton County to make significant progress toward improving our response to mental health and substance abuse crisis. A significant portion of the new funding coming to Denton County is found within this allocation.

### Equity Allocations

As required by the state legislature and under DSHS’s long term plan to improve equity among Centers, this proposed methodology allocated approximately 32% ($27 million) of available funds over the course of the biennium to bring under-funded Centers, such as Denton County, up to the current state average of per capita funding.

The 32% measure was arrived at after balancing many factors, including the effort to bring as many centers as possible up to the current state average per capita funding while trying to keep as close as possible to the roughly 1/3 allocation for equity as outlined in the exceptional item request. Under this approach, all but two of the LMHAs will reach the current per capita average for the State. If these funds were not used to address equity, greater disparity among LMHAs allocations would result from the allocation of the other crisis services funds.

### Proportional Allocations

The second portion approximately 36% ($30 million) of the available funding was divided proportionally among LMHAs based on the population of each local service area. This includes a basic allocation to ensure sufficient funding for each LMHA to implement the initial crisis service requirements. Under a simple per capita distribution of funds, many Centers would not receive sufficient dollars to allow full implementation of the required initial crisis services. Therefore, DSHS adopted a hybrid proportional allocation methodology.

Under proportional allocations all Centers were given an amount sufficient to implement the initial crisis services (hotline and mobile crisis outreach team). This amount was determined using cost models that account for differences between heavily populated urban areas and less populated rural areas. The remaining funds designated for proportional allocation were distributed according to a straight per capita formula. This per capita distribution will be limited to LMHAs whose allocation for initial crisis services is less than the amount they would have received if all of the dollars designated for proportional allocation was distributed using the simple per capita formula. This necessary distribution is why more than one third of the total crisis funds are allocated in this category.

Even with these adjustments for equity in the distribution process these funding allocations at the end of FY 2008 left Denton County with a funding per capita amount of only $10.91. This is only 78%
of the State’s proposed average per capita funding level of $13.94 and leaves Denton County in last place across the State for per capita funding. At the end of FY 2009 the Center saw our funding increase to $12.94 per capita. This amount is 89% of the per capita average funding allocation level proposed across the state of $14.52. This moved Denton County one place ahead of Harris County from our previous position as the lowest funded Center per capita in the State of Texas.

**Community Investment Incentive Allocations**

To leverage the state’s investment in crisis redesign services, around 30% of the funds (approximately $24 million) were offered to communities or regions that were willing to invest a significant level of local resources in the development of emergency psychiatric service centers, projects focusing on diverting individuals from incarceration or alternatives to State hospitalization (26%) and Outpatient Competency Restoration programs (4%). These are highly specialized and resource-intensive services that serve severely ill psychiatric clients. Because it would not be cost-effective to establish these services in communities across the state, award criteria were designed to ensure efficient utilization of these funds. Funding of all projects was competitive and based on resource availability. These funds required a minimum 25% local match and were awarded to LMHA’s offering the best value to the State of Texas. Communities willing to invest in these local resources to support crisis services were eligible for these funds through a competitive process that required communities to provide ongoing local funding to these sites once selected.

**Selection of Psychiatric Emergency Service Centers**

To ensure the development of strategically located sites that serve the needs of a geographic area of one or more counties or local service areas and population bases the Texas Department of State Health Services (DSHS) has revised the proposed competitive bid process for the Psychiatric Emergency Service Center sites to be open to any and all 39 LMHA’s separately or in collaboration with LMHA’s. The Center entered into discussions with Betty Hardwick, Dallas Metro Care, Helen Farabee, LifePath Systems, Pecan Valley, Texoma, and Tarrant County on collaborative regional efforts in order to become more eligible and compete for this funding opportunity. The Center has decided not to pursue this endeavor at this time. The criteria to be used by DSHS to evaluate any submitted a proposal included:

- The extent of local and regional collaboration;
- Level of coordination with local and regional healthcare and law enforcement;
- Program design, including integration with other local and regional crisis services;
- Size of geographic area to be served;
- Size of population to be served; and
- Demonstrated need for 23-48 hour observation services, including utilization of existing capacity in the region.

**Selection of Jail Diversion or Alternatives to State Hospitalization Projects**
The purpose of this type of funding is to focus on improving existing diversion processes from jail incarceration prior to booking or state hospitalization placement through defined crisis residential or respite services, CSUs, 23-48 hour hold, purchase of local hospital beds and associated services. As above the Center was in discussions with other local mental health authorities and local private providers for these type of service collaborations and was awaiting publication of the Texas Department of State Mental Health Services (DSHS) Standards for Jail diversion to determine if it would include this type of service in its crisis planning process, discussion and collaboration with other regionally located local mental health authorities, local law enforcement, judicial systems and probation and parole departments. Denton County MHMR will not pursue additional funding in this area.

The criteria used by DSHS to evaluate these types of proposals included:

- The Minimization of officer wait time;
- Local collaboration and support, or coordination with judiciary system and law enforcement;
- Timeliness of implementation; and
- Clinically appropriate program design.

### Outpatient Competency Restoration Sites

Competency Restoration Allocations of $3 million over the FY 08-09 Biennium are designed to provide outpatient competency restoration services to persons who are incompetent to stand trial but are eligible to receive mental health outpatient treatment and will not require any local matching resources. In FY 2008, $1 million dollars are available for four sites and $2 million dollars available in FY 2009.

### Selection of Outpatient Competency Restoration Sites

As above the Center participated with other local stakeholders and in collaboration with other local law enforcement, judicial systems and probation and parole departments to determine if Denton County would compete for one of four available sites planned by the Texas Department of State Health Service for the limited rollout of an Outpatient Competency Restoration program to meet both state and local goals. Denton County did not develop a competitive bid in this area. DSHS anticipates that an outpatient competency restoration program would be active by the 3rd Quarter of FY 2008. Funding for these four sites by DSHS was based on:

- Demonstrated need;
- Integration with existing services;
- Level of coordination with judiciary system and law enforcement; and
- Innovation and alignment with evidence-based practices including the integration of mental health, substance use treatment and physical health.

### State Expenditures

The Texas Department of State Health Services (DSHS) will reserve approximately 1.5% ($1.2 million) of the allocated funds to support state expenditures for crisis redesign implementation and oversight over the biennium. Expenses include:
• Hotline training necessary for LMHAs to attain American Association of Suicidology (AAS) accreditation ($456,321 or .56%);
• Four DSHS staff positions to provide support, training, and oversight for crisis redesign ($435,569 or .53%); and
• An independent evaluation of the crisis redesign project ($350,000 or .43%).

Within the overall funding allocation framework provided by DSHS, local decision-making will play a significant role in determining the final distribution of dollars among the identified service categories. This may result in some variance between the allocation of dollars presented in DSHS’s initial legislative appropriations request and actual expenditures at the local level.

As currently proposed total allocation opportunities available to Denton County in FY 2008-2009 was $26,347,634.

Implementation of Crisis Services Redesign

Accountability

The Center will initially follow the measures put into place by the Texas Department of State Health Services (DSHS) to ensure that allocated crisis funds are used effectively and efficiently. Components of DSHS’ plan for accountability include ongoing training and technical assistance for the Center and other local mental health authorities, requirements related to adherence to Legislative Budget Board (LBB) performance measures as well as current and proposed performance contract measures required by DSHS through contract with the Center, and quality management oversight.

Crisis Redesign Training

The Center reviewed the Texas Department of State Health Services (DSHS) provided information, attended sponsored training, and sought technical assistance to support implementation of the crisis redesign initiatives. In this initial phase of implementation, the Center attended regional workshops sponsored by DSHS for local mental health authorities (LMHAs) regarding the implementation of crisis redesign. These workshops included informational sessions for other stakeholders as needed. Topics covered included: crisis redesign overview; minimum crisis services infrastructure requirements; hotline accreditation process; minimum standards for crisis services delivery; performance measures; reporting requirements; opportunities for regional service systems; and age appropriate crisis assessment and intervention strategies.

The Center has also participated in regular teleconference calls with DSHS to obtain additional information and technical assistance from DSHS as scheduled. The Center will also monitor DSHS developed web pages that will enable LMHAs and stakeholders to access information, materials, resources related to crisis redesign, and progress regarding implementation. The Center will continue to participate in any DSHS sponsored training and conference calls as scheduled by DSHS staff.
Hotline Training

After examining other options, the Texas Department of State Health Services (DSHS) selected a training plan utilizing the American Association of Suicidology (AAS) resources as the best available strategy. AAS has an established curriculum that provided for the immediate access to quality hotline training for our workers and a hotline trainer certification program that enabled the Center to develop a sustainable training infrastructure.

AAS provided two tracks of training relating to hotline services:

1) A three-day training for hotline workers that meets AAS Level IV training requirements, and
2) A five day training program that includes the above and two additional training days designed specifically to train trainers to deliver the AAS hotline worker curriculum to others.

The Center also maintains its option to adopt an alternative hotline training curriculum with request to and prior approval from DSHS.

The Center required its crisis hotline services contract provider to attain AAS training and accreditation by the end of FY 2008 Q4. Those staff persons selected as train the trainers will ensure other staff and our contractors have the intensive training and demonstrated competency to maintain AAS certification.

To ensure adequate access in this certification process the Center attended both tracks of the DSHS sponsored AAS hotline training sessions offered during the first quarter of FY 2008. These AAS hotline training events were scheduled in four locations: Dallas, Houston, San Antonio, and Austin. The Center scheduled to attend the first training sessions offered in Dallas during the week of 5 November 2007.

Each participant that passes the AAS trainer certification exam will be qualified to teach the AAS hotline worker curriculum to other hotline workers. AAS will continue to provide training materials and support (such as production of participant certificates) for local training events. The Center will collaborate with neighboring local mental health authorities to share training resources as appropriate to achieve greater efficiency.

The Center will also utilize the selected DSHS staff members from their Mental Health Substance Abuse Training and Technical Assistance Department who have completed the two training tracks noted above as needed for additional training and technical assistance.

Measures of Success

Performance Contract Measures
The Center will be held accountable by the Texas Department of State Health Services (DSHS) for effective and efficient use of crisis redesign funds through our current performance contract. The performance contract will contain a balanced package of crisis response system measures that describe the outcomes, outputs, and efficiencies expected from our crisis response system.

<table>
<thead>
<tr>
<th>#</th>
<th>Performance Contract Measure</th>
<th>Reported</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Psychiatric hospitalizations after community-based crisis services</td>
<td>Exclusions and limitations to contract performance measures will be noted within Information Item C of the DSHS FY 2008 Performance Contract</td>
<td>The % of persons with a front door or community MH crisis episode at LMHAs with a State or community psychiatric hospitalization within 30 days after the end of the crisis episode.</td>
</tr>
<tr>
<td>2</td>
<td>Linkage to community based services as appropriate</td>
<td>The % of persons with a front door MH crisis episode that is followed by a community MH LOC-A = 1, and or a service encounter at a DSHS funded SA treatment facility or at an OSAR provider within 14 days of their front door crisis episode.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Transition from the crisis assessment to crisis follow up services</td>
<td>The % of persons with a front door MH crisis episode who have a follow up community MH LOC-A = 5, who receive a crisis follow-up service encounter within 30 days of the crisis assessment.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Psychiatric hospitalizations with/without a crisis assessment within the community prior to admission</td>
<td>The % of persons who have a State or community psychiatric hospitalization and have a crisis assessment within 5 days prior to their hospitalization. This measure would exclude persons hospitalized who have a community MH LOC-A = 1 through 4.</td>
<td></td>
</tr>
</tbody>
</table>

In addition, a baseline measure of the number of DSHS funded staff with AAS hotline certification will be established and monitored.

**Legislative Budget Board Measures**

Other crisis response system measures include those from Rider 69(b) that allows DSHS to work with the LBB to develop statewide performance measures that will be reported on a quarterly basis. DSHS has proposed the following measures to the LBB in the first quarter of FY08:
<table>
<thead>
<tr>
<th>Type</th>
<th>#</th>
<th>LBB Measure</th>
<th>Reported</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPUTS</td>
<td>1</td>
<td>Average Monthly Number of Persons Served in Residential Crisis Services</td>
<td>Quarterly</td>
<td>The unduplicated average monthly number of persons who receive a residential crisis service (i.e., respite, crisis residential, crisis stabilization unit, or extended observation) from Community Mental Health Centers including NorthSTAR paid from GR or CRD awarded to DSHS.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Average Monthly Number of Persons Served in Outpatient Crisis Services</td>
<td>Quarterly</td>
<td>The unduplicated average monthly number of persons who receive an outpatient crisis service (i.e., mobile crisis outreach team, walk-in crisis, or crisis follow-up) from Community Mental Health Centers including NorthSTAR paid from GR or CRD awarded to DSHS.</td>
</tr>
<tr>
<td>OUTCOMES</td>
<td>1</td>
<td>Percent of Persons with Medicaid Receiving Crisis Services that is followed by an ER Visit within 30 days</td>
<td>Annual</td>
<td>The percent of persons with Medicaid receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by an ER visit within 30 days.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Percent of Persons Receiving Crisis Services that is followed by a Psychiatric Hospitalization within 30 Days</td>
<td>Annual</td>
<td>The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a State or Community psychiatric hospitalization within 30 days.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Percent of Persons Receiving Crisis Services that is followed by a Jail Booking within 7 Days</td>
<td>Annual</td>
<td>The percent of persons receiving crisis services at Community Mental Health Centers including NorthSTAR that is followed by a jail booking within 7 days.</td>
</tr>
</tbody>
</table>

**FISCAL Reporting for Crisis Services Redesign**

Our Texas Department of State Health Services (DSHS) CARE III Mental Health Budget report was also revised and submitted on 30 Nov 07 to include specific reporting of budget and costs related to our crisis response system. This allowed the Center and DSHS to accurately account for all crisis redesign funds and calculate the general costs to deliver crisis services. A new line item budget for crisis services was included to cover all new crisis funding used for crisis services by the Center.

In addition a new crisis strategy to report only new crisis dollar allocations for new crisis services provided are included. There are four sub strategies for each of these new strategies. Those are: 1) crisis residential/inpatient, 2) crisis outpatient; 3) crisis screening and eligibility; and 4) crisis other. These measures are in place to ensure the continuance of MH GR funding for existing crisis services as separate measures while also providing a measure of new crisis funds use during implementation and development of the Centers improved and enhanced crisis services redesign.
A new Report III Crosswalk is also in development for Center use to appropriately map encounter codes, procedure codes and authority functions to these Report III sub strategies and ensure accurate and timely billing of services. In this process the Center is also continuing to move towards the use of American Medical Association industry standard Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) codes at the request of DSHS. Implementation of the transition for this to occur has been negotiated by the Texas Department of State Health Services to occur in the 3rd Quarter of FY 2008 on 1 March 2008.

The transition from service grid codes to procedure codes will only allow for a group of existing services to be delivered in response to a crisis. The services available for delivery in response to a crisis will ultimately be reported by procedure code with an “ET” modifier. These services are: 1) psychiatric diagnostic interview examination; routine case management; psychosocial rehabilitative services (rehabilitative case management); pharmacological management; administration of an injection; medication training and supports; individual/family and group counseling, and respite services.

Other uniquely qualified existing services defined as services that are provided in response to a crisis that do not require the “ET” modifier are 1) crisis intervention services; 2) crisis stabilization unit services; and 3) crisis residential services.

New crisis services that have been added to the service array are 1) crisis transportation (staff time and funding provided); 2) crisis follow up and relapse prevention (one staff and second staff); 3) safety monitoring; and 4) crisis flexible benefits (staff time and funding provided).

**UM Guidelines for Crisis Services Redesign**

New Utilization Management guidelines for Crisis Services and Crisis Follow-up Services have been developed and are now available for both Adult Mental Health (AMH) and Children’s Mental Health (CMH) to define the purpose of each new service package and list the core crisis services available for authorization based on the local mental health authorities (LMHA’s) assessed medical necessity. The Center is anticipating the UM guideline updates reflecting the FY10 changes to be available soon.

**Crisis Services, SP-0**

The purpose of crisis services is to provide brief interventions in the community that will ameliorate the crisis situation and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of more intensive and restrictive interventions or relapse. These services do not require prior authorization but the Center UM department must authorize within 2 business days of presentation for crisis services based on medical necessity criteria. No diagnosis for crisis services is needed as long as the person meets the TRAG, LOC-R = 0 and the definition of a crisis is met.

By rule a Crisis is defined as a situation in which because of a mental health condition the individual presents an immediate danger to self or others; or the individuals mental or physical health is at risk of serious deterioration; or another individual believes that he or she presents an immediate danger to self or others or that their mental or physical health is at risk of serious deterioration.
Crisis Follow Up Services, SP-5

This service package is oriented towards individuals who have been discharged from crisis services or hospitalization and are not eligible for Service Package 1-4 or they have opted to seek service from an external provider, but continued follow up is indicated until the referral access is completed; or they are eligible for Service Package 1-4, but there is no current capacity to provide the assigned service package. Any mental health diagnosis may be used for Crisis Follow Up eligibility. Medicaid recipients cannot be underserved due to resource limitations. The focus is on ameliorating the situation that gave rise to the crisis event, ensuring stability, and preventing future crisis events and assisting an individual in obtaining the services they need. Services provided include an ongoing assessment to determine crisis status and needs and provision of time limited (up to 90 days) brief solution focused interventions to the person and their family if the person is a child or adolescent. The focus is on providing guidance and developing problem solving techniques to enable the individual to adapt and cope with the situation and stressors that prompted the crisis event.

Oversight of Crisis Services Redesign

Over the biennium, the Center along with DSHS oversaw the utilization of crisis funds through its quality management program and analysis of information in the data warehouse. The following are the kinds of tools that were employed to assure in the proper oversight of behavioral health programs:

- Data monitoring, including evaluation of both performance and outcome data to identify needs for further oversight or request of technical assistance
- Desk reviews, including monitoring crisis hotline services and reviewing submissions related to crisis redesign implementation
- Stakeholder satisfaction assessment, to include a follow-up survey of law enforcement and hospital stakeholders using databases from the DSHS Licensing and Regulatory and the Department of Public Safety
- Participation in DSHS on-site reviews, including both reviews to evaluate adherence to clinical design and reviews based upon information and analysis of data of providers implementing new crisis services.

Independent Evaluation

Denton County MHMR Center participated in the evaluation of community health crisis services as contracted by DSHS with an independent entity conducted in FY 09. This external evaluator submitted a comprehensive plan from the evaluation for the Center to review. This evaluation process is included data collection protocols and data analysis methodology prior to initiating the evaluation that will be used to track and monitor crisis services activities. The resulting report also included an analysis of the implementation and impact of services on clients, local communities, mental health and health care providers, and law enforcement. The evaluation included a review of structural and process changes to determine how the crisis response and service delivery system is affected by crisis redesign. The impact will be examined through an analysis of changes in service delivery patterns and outcomes.
before and after crisis redesign implementation, using data collected through the DSHS information systems and other available sources.

It is anticipated that the external evaluator will also periodically conduct on-site reviews and surveys of the Center and other Local Mental Health Authorities (LMHAs) to assess the procedures and processes LMHAs have in place for implementing crisis services. It will compile information on best practices observed during the reviews and provide recommendations to DSHS on improvements to the current system. Progress will be reported on a quarterly basis, with a summary submitted to DSHS at the end of FY 09. The Center did participate in an on-site review process during FY09 and anticipates further evaluation processes in the upcoming biennium.

Refining Crisis Services Redesign

The crisis redesign implementation plan developed by the Center will continue to be refined in collaboration with stakeholders in a variety of forums in the coming years. This will include meetings and teleconferences with members of the original Crisis Redesign Committee, the Texas Council of Community MHMR Centers’ crisis redesign committee, representatives of the Behavioral Health Consortium, QM consortium; UM consortium IS consortium, Medical Directors consortium, the LMAH Crisis Redesign Workgroup, consumer and family representatives, and consumer advocates. The Center will also attend DSHS sponsored informational sessions for local stakeholders in conjunction with its LMHA Crisis Redesign Workshops as scheduled. These events will allow the Center to provide and receive feedback from a variety of sources and make appropriate revisions to its implementation plan as needed.

The Center will also work with DSHS program staff members through an open line of communication between DSHS and stakeholders during the implementation phase of crisis redesign. As part of this strategy, the Center will participate in DSHS sponsored teleconference calls with other LMHAs as scheduled. The Center will also provide other stakeholders with updated information from organizations such as the DSHS MH Planning Advisory Committee and quarterly provider association meetings of the Association of Substance Abuse Programs (ASAP) as available through our web site and PNAC. The Center’s crisis redesign webpage will provide another avenue for information-sharing and stakeholder input.

Implementation Milestones

The following timeline includes key milestones identified by the Center and required by DSHS for crisis redesign implementation with the Center’s expected date for meeting compliance with the standards outlined in the FY 2008 and current DSHS Performance Contract Notebooks.

FY 2007, Q4

- Review local crisis plan requirements released by DSHS
- Monitor Crisis Redesign Committee activities
- Participate in implementation teleconference calls with DSHS (Dr Burkett)
FY 2008, Q1

- Identify local champion for Denton County
- Invite community stakeholders to participate in crisis service planning
- Review DSHS Crisis Implementation Overview (Draft - 2 Oct 2007)
- Participate in DSHS CSR teleconferences as scheduled
  - 03 October 2007 – Standards (Required Services)
  - 10 October 2007 – Standards (Enhanced Services)
  - 17 October 2007 – Standards (All)
  - 24 October 2007 – Local Planning (Crisis Service Plans)
  - 31 October 2007 – UM Guidelines, Authorizations SP 0 & 5
  - 07 November 2007 – Crisis Services Reporting
  - 14 November 2007 – Training Needs
  - 28 November 2007 – Competitive Funding
- 19 October 2007 – Participate in DSHS/AAS Hotline-Accreditation Process teleconference
- 22 October 2007 - Attend DSHS CSR Implementation Overview Session (Austin)
- Review Psychiatric Emergency Services Center requirements as released by DSHS
- 31 Oct 2007 - Submit Initial Local Crisis Redesign Plans to DSHS as requested
- 5-7 November 2007 - Attend scheduled Hotline worker training
- 8-9 November 2007 - Attend scheduled Hotline trainer training
- 09 November 2007 - meet with other regional LMHAs on Community Incentive Allocations
- 21 November 2007 – DSHS approved our initial implementation plan
- 29 November 2007 – Legislative Luncheon presentation on Crisis Services Redesign

FY 2008, Q2

- Review requirements for Community Investment Incentive Fund provided by DHS
- Review Outpatient Competency Restoration curriculum complete as released by DSHS
- Review Outpatient Competency Restoration requirements released (including eligible applicants)
- 01 December 2007 – Implement new Hotline and MCOT local crisis redesign services
- 05 December 2007 – Conduct Public Forum with PNAC
- 31 December 2007 - Submit Local Crisis Redesign Plan Update to DSHS as requested
- 07 January 2008 – Review Proposal to Evaluate the Community MH CSR Initiative by Texas A&M University
- 18 January 2008 – Submit Outpatient Competency Restoration proposals to SHS by this date as requested
- 29 February 2007 - Submit Psychiatric Emergency Services Center/Project proposals to DSHS as requested by this date

FY 2008, Q3

- Monitor Outpatient Competency Restoration sites selection and notification process by DSHS
- Monitor Psychiatric Emergency Services Center/Projects selection and notification process by DSHS
- 7 March 2008 - Review Updated Proposal to Evaluate the Community MH CSR Initiative by Texas A&M University
FY 2008, Q4
- Outpatient Competency Restoration sites begin operation
- Psychiatric Emergency Services Centers/Projects begin operation
- 31 August 2008 - Ensure Tarrant County Crisis Hotline service attains AAS accreditation

FY 2009
- Participate in External Monitor evaluation as selected by DSHS
- Review Crisis Redesign Evaluation Report submitted to 81st Legislature

FY 2010
- Participate in External Monitor evaluation as selected by DSHS
Appendices

Appendix A, Community Stakeholders Listings
Appendix B-1, Side by Side Comparison Crisis Services
Appendix B-2, Side by Side Comparison Crisis Services Training
Appendix B-3, Side by Side Comparison Crisis Services Contacts
Appendix B-4, Side by Side Comparison Crisis Services Budget
Appendix B-4a, Crisis Services Budget Summary FY 2008
Appendix B-4b, Crisis Services Budget Narrative FY 2008
Appendix C, Crisis Services Flow Chart
Appendix D, Proposal for Contract Amendment for Funding of Psychiatric Emergency Service Centers and Projects for Jail Diversion or Alternatives to State Hospitalization RFI # PCA 0257.1, issued 13 Dec 07, due 29 Feb 08
References

Child Welfare and Juvenile Justice; *Federal agencies should play a stronger role in helping states reduce the number of children placed solely to obtain mental health services*; United States General Accounting Office; GAO-03-8651; 2003.

National Institute of Mental Health; *In Harm’s Way: Suicide in America*; National Institute of Health Publication Number - 03-4594; Printed - January 2001; Revised - April 2004

New Freedom Commission on Mental Health; *Achieving the Promise: Transforming Mental Health Care in America: Final Report*; United States Department of Health & Human Services Publication Number - SMA-03-3832; Rockville, MD; 2004

New Freedom Commission on Mental Health; *Subcommittee on Acute Care: Background Paper*; United States Department of Health & Human Services; Publication Number - SMA-04-3876; Rockville, MD; 2004

Proposal to Evaluate the Community Mental Health Crisis Services Redesign Initiative – Detailed Evaluation Proposal; Texas A&M University, 7 March 2008

Presidential Speech; George W Bush - announcing the formation of the New Freedom Commission on Mental Health, Albuquerque, New Mexico, 29 April 2002

Public Testimony; *Hearing of the Crisis Services Redesign Committee*; Austin, Texas; February 15, 2006

Texas Department of State Health Services, 2006

Texas Department of State Health Services; *FY 2006 Crisis Services Review Report*; Community Mental Health & Substance Abuse Services – Department of State Health Services – Mental Health & Substance Abuse – Quality Management Unit; February, 2006

Texas Department of State Health Services; *Crisis Services Redesign*; Texas Mental Health and Substance Abuse; Austin, Texas; September 2006

Texas Department of State Health Services; *Crisis Services Redesign - Implementation Overview*; October 2, 2007

Texas Department of State Health Services; *Initial Crisis Service Plan Review*, E-mail from Daniel Thompson, Contract Manager – DSHS MH Contracts Management Unit

Texas Department of State Health Services Letter; *Crisis Redesign Competitive Funding*; 13 December 2007
Texas Department of State Health Services Information; Proposals for Contract Amendment for Funding of Outpatient Competency Restoration Programs RFI # PCA 256.1 Issued 13 December 2007 Due 31 January 2008

Texas Department of State Health Services Information; Proposals for Contract Amendment for Funding of Psychiatric Emergency Services Center and Projects for Jail Diversion or Alternatives to State Hospitalization RFI # PCA 257.1; Issued - 13 December 2007; Due - 31 January 2008

Texas Department of State Health Services Letter; COMNET Questions and Answers on Psychiatric Emergency Services Centers and Projects Focused on Jail Diversion or Alternatives to State Hospitalization; 1 February 2008

United States Department of Health and Human Services; Mental Health: A Report of the Surgeon General, Rockville, Maryland; United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health; National Institutes of Mental Health, 1999

Tammy Weppelman
Director of Crisis Services

Pam Gutierrez
Chief Operations Officer

Bill Drybread
Chief Executive Officer