Helen Farabee Regional MHMR Crisis Services Plan

Fiscal Years
2008-2009

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Crisis Services Plan
Helen Farabee MHMR

Purpose

The Department of State Health Services (DSHS) has assessed the state of crisis services in Texas through surveys culminating in the Crises Services Redesign Report in September 2006. This report indicated some areas of need expressed by state stakeholders comprised of individual citizens and various community groups (e.g. law enforcement and hospital personnel). Subsequently, the 80th Texas Legislature appropriated $82 million for the Fiscal Year 08-09 biennium to be used by local centers to make progress toward improving the response to mental health and substance abuse crises.

The funds were divided among local authorities and Helen Farabee Regional MHMR received $331,281 over the next biennium to redesign and enhance its crisis response system in key areas identified by the state. The center is required by the FY08 Performance Contract to submit the following Crisis Services Plan to DSHS in order to provide a plan for how our local community will use the new crisis funds.

Community Stakeholders

Community stakeholders from the local service area have been actively involved in workgroups to plan, develop, and approve the Crisis Services Plan as well as to prepare for future improvements to the behavioral health crisis response system. Local center managers contacted sheriffs and general hospital representatives in their areas to inform them of proposed changes and elicit feedback.

The community stakeholders have met with center staff to consider the development of an enhanced Crisis Services Plan. Information describing our existing Crisis Service provision model was reviewed with and discussed by the Jail Diversion and Planning Network Advisory Committee (PNAC) groups on September 12, 2007 and October 15, 2007 while the Focus Group members reviewed the information on October 12, 2007. In addition to these meetings, summaries of the resulting proposed crisis enhancements were emailed to local county judges and the legislative delegation for comments. Comments and feedback have been collected from these sources and were considered in the current planning and proposed implementation of the crisis initiatives described in this plan. The feedback will also be used to shape future planning and implementation as available funding allows. See *Attachment A: Documentation of Stakeholder Solicitation* to review the list of stakeholders as well as our attempts at eliciting feedback from them as well as from other key individuals.

Current Service Gaps/Community Needs

There is currently a need to enhance the continuity of care dimension for those individuals who are transitioning to the community from an inpatient psychiatric facility or from the local voluntary Crisis Respite Unit (CRU). These individuals are sometimes served in Adult Service Package 5 (Crisis Follow-Up) which is a service

- Provided to individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid reoccurrence of the crisis event.
- The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events.
- This service includes ongoing assessment to determine crisis status and needs, provides time-limited (up to 30 days) brief, solution-focused interventions to individuals and families and focuses 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.

The following additions to the Crisis Follow-Up service package are recommended to meet the current service gaps and identified community needs:

- Adding Crisis Follow-Up and Relapse Prevention Staff.
- Adding additional clinicians to the after hours on call schedule in order to reduce the burden on routine service providers who have also served on call after hours.
- Increasing the number of dedicated day time crisis staff to improve availability to local agencies during business hours.

The local planning group also expressed an interest in investigating two additional areas of need:

- The cost of Registered Nurses and LPC coverage at our local Crisis Residential Unit and ways to fulfill the requisite time for Psychosocial Rehabilitation at the unit.
- The addition of Child and Adolescent respite services.

Existing vs. Enhanced Crisis Services

Current Service Types and Quantity

Our look at improving local crisis response began with a study of the types of services we provide and where they are provided, whether at the local center, emergency rooms, client homes, etc. The current crisis response system provides a number of services at the center and in the community 24 hours a day as a result of hotline calls or crisis walk-ins. The types of services currently provided range from phone screenings to face to face response 24 hours a day, 7 days a week in

the community. Service locations are generally dictated by the location of the crisis with responses typically occurring at the local center, psychiatric hospital, or the local emergency room. *Attachment B* provides a list of service types and the amount of service provision during Fiscal Years 2006 and 2007.

Current Crisis Response Process

Clinicians respond 24 hours a day by mobile crisis intervention through on-call clinicians or by assessment at the local center or community agency by day staff during regular business hours. Mobile calls after business hours are screened through the crisis hotline and on-call clinicians are paged to respond within 1 hour to the agency making the call or to the Crisis Respite Unit (CRU). The clinician determines what referrals need to be made (e.g. CRU, State Hospital, private psychiatric facility, home, outpatient or inpatient substance abuse treatment, counseling in the community, etc.). For crisis intakes during business hours, the day clinician completes an assessment and makes the appropriate referrals noted above. Crisis personnel answer these phone calls during business hours except during the lunch hour when the hotline is activated.

Current Crisis Staff

The current staffing model consists of dedicated day time crisis personnel who respond to calls in the community or see clients on a walk-in basis from 8am to 5pm, Monday through Friday. These crisis clinicians also serve as after-hours backup responders in the event of simultaneous calls for response or are available for clinical consultation by phone if indicated. The Director of Crisis Services and the Director of Nursing Services serve as Administrative Supervisors to the crisis staff 24 hours a day.

After hours on call personnel consist of 38 clinicians who are also employed as routine service providers during the day (case managers, social workers, LPC's, etc). These responders are divided among five regions of crisis coverage. They are distributed according to population density per region so that one region may have as few as 4 clinicians on rotation, while another region requires 15 clinicians to be on rotation.

How New Crisis Funds Will Be Used

In order to meet the new Department of State Health Services standards surrounding Crisis Hotline and Mobile Crisis Outreach Team (MCOT) services, our hotline and crisis team structure/duties need to be modified. These modifications consist of adding crisis staff, consultation services, transportation services, creating new positions/job descriptions—in sum, adding another dimension to crisis response and follow up activities. The major impact of the new MCOT services should be seen at the follow-up and tracking level. Services provided to individuals who have been in crisis but do not

meet the full definition of our contracted Target Population have been limited by our ability to engage and track these individuals for a meaningful length of time after crisis resolution. While previous crisis dollars and resources only allowed for nominal tracking of some cases that may eventually return to crisis, new dollars will improve the quality of crisis response and the intensity of post-crisis monitoring. The following side-by-side comparison shows our current structure and response to crises along with the proposed changes introduced with new Crisis Redesign Funding in FY 2008. (See *Attachment C* for a corresponding crisis response comparison flow chart).

Existing Services	**Enhanced Services** * *** These services are *in addition* to services in left column**
Staffing • Crisis Director (24hr Administrative Supervision and serves as on call backup) • 2 Full Time Equivalent (FTE) Crisis Day Clinicians (serves as on call backup) • 1 FTE Adult Continuity of Care (COC) [also serves as on call backup] • 1 Partial FTE Child/Adolescent COC • 1 FTE Support Staff • 38 Daytime caseworkers also serve on an on-call rotation after hours, divided by region • 1 FTE Director of Nursing (24hr Administrative Supervision only) • 1 Psychiatrist is available to the RN by phone if indicated	**Staffing** • Add 2 FTE Crisis Follow-up and Relapse Prevention staff to Wichita/Archer/Clay service area • Add 1 FTE Crisis Follow-up and Relapse Prevention staff to Wise/Montague/Jack/Young region • Add 1 FTE Crisis Follow-up and Relapse Prevention staff to Haskell service area • Crisis Follow-up and Relapse Prevention personnel are also added to the on call rotation after hours increasing the rotation from 38 to 42 staff center wide • Add 5 LPHA staff for after hour consultation 24/7 • Add 4 RN staff for after hour consultation 24/7 (includes DON who also serves as 24hr Administrative Supervision)
Hotline (Prior to September 1, 2007) • Hotlines answered locally 24/7 by Wood Group contracted staff • These non-credentialed hotline personnel activate QHMP to respond face to face to each call	**Hotline (As of September 1, 2007)** • Hotlines answered by Avail Solutions (AAS Accredited) 24/7 • Hotline personnel are QMHP level and screen each call to determine whether face to face QMHP assessment should be activated
Crisis Response • On call QMHP activated by hotline and recommends disposition • Backup available for response to multiple calls at once. • Walk in crisis services available at Crisis Center 8a-5p, M-F	**Crisis Response** • LPHA consultation by phone 24/7 to confirm disposition • RN Consultation by LPHA by phone 24/7 for medical screening if indicated

Continuity of Care • COC contacts made during hospitalization and at discharge • Non-Target clients are not tracked until presenting in crisis again	**Crisis Follow-up and Relapse Prevention (formerly COC)** • Non-Target clients are assigned to Relapse Prevention staff caseloads under Service Package 5 • Staff coordinate crisis referrals and ensure client has access to referral sources by using transportation and home contacts • Clients are tracked for at least 30 days to prevent relapse
Training • 8 hours New Employee Training for all crisis responders • Annual refresher training required	**Training** • Training for all existing staff regarding new crisis response process/resources
Transportation • Limited provision by Crisis Day Clinicians • Crisis Respite Unit staff contracted to transport clients one day a week	**Transportation** • Relapse Prevention staff are each assigned vehicles dedicated to serving clients throughout the service regions and to ensure clients can access crisis referrals • Crisis Respite Unit staff contracted to transport clients five days a week
Crisis Expenses, FY07 • On call pay for 38 crisis staff and backups = $173,000 • Salary for Crisis Director, Crisis Day Staff = $227,482 • Wood Group Annual Hotline Contract = $12,000 • Wood Group CRU Contract = $338,125 • TOTAL = $750,607	**Additional Dollars Budgeted Through Crisis Redesign for FY 08** • Adding 4 FTE Relapse Prevention staff = $162,016 • Adding LPHA On Call Stipend = $36,000 • Adding RN On Call Stipend = $28,800 • Added Vehicle Cost = $9,600 • New Avail Solutions Annual Contract = $64,000 • TOTAL = *$300,416*

Use of Funds in Other Areas

Although DSHS has required a plan for meeting the new standards related to Crisis Hotline and the Mobile Crisis Outreach Team by the end of October, 2007, there are other standards that are expected to be considered with the remainder of the FY08-09 allocation.

Helen Farabee center was allotted a total of $331,281 for Fiscal Years 08-09, all of which is marked for use with our Hotline services and the expansion of our mobile crisis outreach system described above. While additional standards (Crisis

Walk-In Services, Crisis Stabilization Unit, and Emergency Crisis Psychiatric Services to name a few) are valuable services, addressing them at this time is currently beyond our FY08 allocation. Additional improvements to the crisis response system would require additional funding through the legislature.

Integrating Mental Health and Substance Abuse Crisis Services

In addition to having our Outreach Screening Assessment and Referral (OSAR) Representative present at local planning sessions, collaboration occurred between the Helen Farabee MHMR Director of Substance Abuse and our local Substance Abuse treatment providers regarding the proposed changes to the local crisis response system as they relate to assessing and treating individuals presenting with substance abuse issues. These changes have been included in updates to memoranda of understanding between the center and local providers such as Red River Psychiatric Facility, Serenity House, local emergency rooms, etc. (*see Attachment D for a list of updated MOU's*).

Despite receiving funding sufficient to enhance our hotline response and create a Mobile Crisis Outreach Team, the local response to substance abuse issues still face some barriers. Specifically, there are still no inpatient detox facilities as those require a license and physicians trained in monitoring the process. While other centers in Texas have contracted with private psychiatric facilities to provide detox services, local funds are currently not available to meet this need. Local Substance Abuse personnel are available for assessment, referral to OSAR to secure residential treatment elsewhere, referral to local outpatient treatment if indicated, or provide escorts to the local emergency room for detox.

Timeline

<u>Hotline Services</u>

Our contract with Avail Solutions (accredited by the American Association of Suicidology as of 10/4/07) is current and fulfills the Performance Contract Standards for hotline response. See *Attachment D* for the Avail Solutions contract summary.

Mobile Crisis Outreach Team

The center has projected target dates associated with the major goals associated with creating and implementing an expanded Mobile Crisis Outreach Team (MCOT):

- Posting Relapse Prevention Specialist positions: Completed as of 11/15/07
- Hiring the new positions by 12/1/07
- Purchasing 4 vehicles for the new positions by 12/1/07
- New Employee Crisis Training on 12/5/07
- Crisis Refresher Training for existing personnel by 12/7/07
- Target start date for LPC/RN consultation is 12/12/07

Attachment A: Documentation of Stakeholder Solicitation

Membership Lists

Jail Diversion Task Force Members

Roddy Atkins, Executive Director, Helen Farabee MHMR

Doug Baker, Wichita Falls City Attorney

Lauren Parsons MD, Medical Director, Helen Farabee MHMR/North Texas State Hospital

Captain Bertie Foster, Wichita County Jail Administrator

Woody Gossom, County Judge

Gianna Harris, Director of Essential Services and Clinical Accountability, Helen Farabee MHMR

Bill Jennings, Director of Social Services, United Regional Health Care Systems

Mayor Lyne of Wichita Falls

Charles Martin, Director of Crisis Services, Helen Farabee MHMR

Steve Beggs and Donald Cole, Training Officers, Wichita Falls Police Department

Carmen Simpson, Parole Officer, Texas Department of Criminal Justice

Steven Sullwold, Director of Clinical Operations, North Texas State Hospital

Planning Network and Advisory Committee (PNAC) Members

Sherry Coombs, Contract Manager, Sheppard Air Force Base

Rebecca Dickson, Montague County Juvenile Probation Officer

Charlcie Flinn, Early Child Intervention Director, North Texas Rehab Center (also a family member)

Michaelle Kitchen, PhD, Education Professor, Midwestern State University

Susan Sportsman, PhD, Dean of Health Services, Midwestern State University

Brent Walker, LCSW/Professor, Midwestern State University and Sheppard Air Force Base

Two Consumers (one MH and one MR)

Four family members (two MH and two MR)

Community Focus Group Representatives

Charles Martin, Director, Helen Farabee MHMR Crisis Services

Shari Offutt Griffiths, North Texas Neurology Association

Tom Wisdom and Margie Smith, Star Council

John Welter, Faith Mission (serving homeless individuals)

Herbert Brown, American Red Cross

Cathy Brown, Midwestern State University Counseling Center

Karla Rose, Abilene Regional Council on Alcohol and Drug Abuse (Outreach Screening Assessment and Referral [OSAR] Representative)

Misty Ross, Helen Farabee Substance Abuse Staff

Becky Schreiber and Crystal Daniel, Serenity House (Inpatient and Outpatient Substance Abuse Facilities)

Lauren Parsons, MD, Medical Director, North Texas State Hospital/Helen Farabee MHMR

Steve Stout, Family Hearing Center

Mark Johnson, Sheppard Air Force Base Family Advocacy

Lynn Hartje, Behavioral Health Director, Helen Farabee MHMR

Beveryly Diekhoff, Alzheimer's Association

Nora Zarate Hodges, Nortex Regional Planning Commission

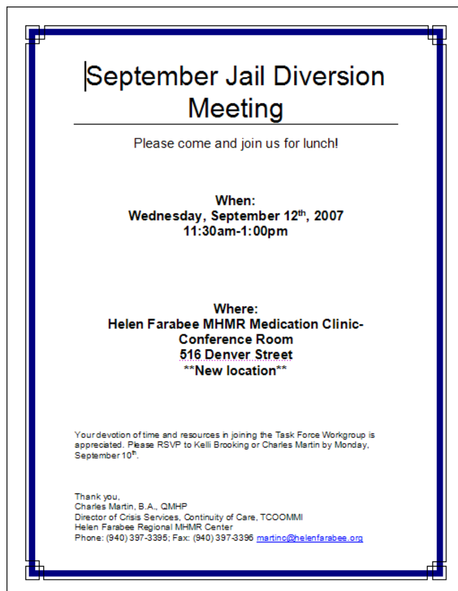
Dustin Phillips, Midwestern Health Care Center

Meeting Invitations

From: Lawrence, Patty
Sent: Wednesday, August 29, 2007 1:52 PM
To: 'PNAC - Brent Walker (brent.walker@sheppard.af.mil)'; 'PNAC - Charlcie Flinn'; 'PNAC - Debbie Lawson (debbiealawson@sbcglobal.net)'; 'PNAC - Jean Puckett (jpuckett1027@sbcglobal.net)'; 'PNAC - Michaelle Kitchen'; 'PNAC - Rebecca Dickson (moncojuv@wf.quik.com)'; 'PNAC - Sheila Hutchins'; 'PNAC - Stephanie Sokolosky'; 'PNAC - Susan Sportsman'; 'sherryz@quik.com'
Cc: Atkins, Roddy; Brennan, Rodney; Harris, Gianna; Hartje, Lynn; Johnston, Connie; Martin, Charles L.; Wilson, Rose; Beck, Kim
Subject: PLANNING AND NETWORK ADVISORY COMMITTEE MEETING
Importance: High

Just a note to let you know the Planning & Network Advisory Committee along with the Jail Diversion Task Force will meet on Wednesday, September 12, 2007, at 11:30 am; 516 Denver Street Conference Room. Lunch will be served. I am attaching copies of the handouts from the meeting on 08.15.07 for you to again review and send what comments you may have before the meeting. If you have any questions or I can be of any help, please let me know. Also, if you could, let me know if you are going to be able to attend this meeting. It is most important as we are working on a short time limit to get the Crisis Redesign Plan completed. Thank you for making time in your busy schedules for this important meeting.

Patty Lawrence
Community & Consumer Support
lawrencep@helenfarabee.org
500 Broad Street
Wichita Falls, Texas
940) 397-3363
1-888-700-1441


September Jail Diversion Meeting

Please come and join us for lunch!

When:
Wednesday, September 12th, 2007
11:30am-1:00pm

Where:
Helen Farabee MHMR Medication Clinic-
Conference Room
516 Denver Street
****New location****

Your devotion of time and resources in joining the Task Force Workgroup is appreciated. Please RSVP to Kelli Brooking or Charles Martin by Monday, September 10th.

Thank you,
Charles Martin, B.A., QMHP
Director of Crisis Services, Continuity of Care, TCOOMMI
Helen Farabee Regional MHMR Center
Phone: (940) 397-3395; Fax: (940) 397-3396 martinc@helenfarabee.org

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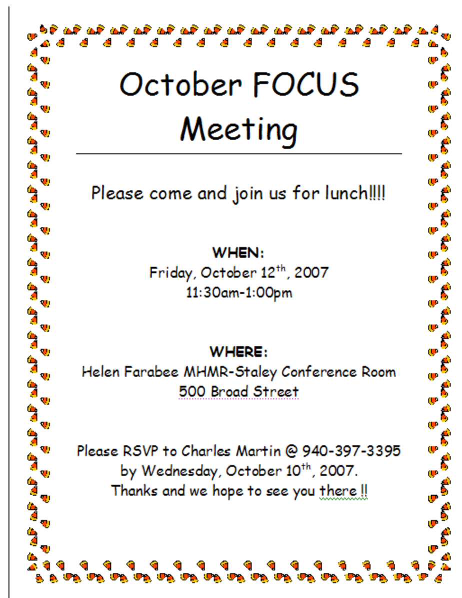
From: Brooking, Kelli R.
Sent: Wednesday, September 26, 2007 6:19 PM
To: Atkins, Roddy; Benedict, Stacy; Boitnott, Danny; Brown, Hobert; Cardwell, Susan; Collier, Andrew R.; Collins, Sheila; Diekhoff, Beverly; Dresbach, Lisa; Gass, Angie; Griffiths, W. Scott; Hamilton, Karen; Harris, Gianna; Hartje, Lynn; Hilbers, Melissa; Janes, Sherry L.; Johnson, Valerie; Johnston, Connie; Kelley, David; Knouf, Debbie; Kuehler-Holler, Ronda; Large, Sara; Luman, Jacquelyn R.; Martin, Andrew; Martin, Charles L.; Matherly, Judy; McIlvain, Scott; Murray, Mindy; New Horizons; O'Brien, Maureen; Phillips, Jayna; Piper, Donna; Popp, James W. "Jim"; Previe, Karen; Rose, James M. II; Rose, Karla; Ross, Misty D.; Schreiber, Becky; Smith, Capt. R.W.; Smith, Margie; Staats, Paula Maloney; Stiles, Dr. Beverly; Thomas, Marcia A.; Thompson, Kevin L.; Thompson, Susan K.; Van Winkle, Tracy; Womack, Lindsey B.
Subject: October FOCUS Meeting

Attachments: Focus Oct 12 Invite.doc
Thanks!

Kelli Brooking
Administrative Assistant
Crisis Intervention Services
Helen Farabee Regional MHMR Centers
phone: 940-397-3395


October FOCUS Meeting

Please come and join us for lunch!!!!

WHEN:
Friday, October 12th, 2007
11:30am-1:00pm

WHERE:
Helen Farabee MHMR-Staley Conference Room
500 Broad Street

Please RSVP to Charles Martin @ 940-397-3395
by Wednesday, October 10th, 2007.
Thanks and we hope to see you there !!

From: Lawrence, Patty
Sent: Thursday, October 11, 2007 2:11 PM
To: 'JDTF - Bill Jennings (mrbillsw@clearwire.net)'; 'JDTF - Capt. Bertie Foster (bertie.foster@co.wichita.tx.us)'; 'JDTF - Doug Baker (doug.baker@co.wichita.tx.us)'; 'JDTF - Judge Woody Gossom (woody.gossom@co.wichita.tx.us)'; 'JDTF - Mayor Lanham Lyne (lanham.lyne@cwftx.net)'; 'JDTF - Officer Donald Cole (Donald.Cole@wfpd.net)'; 'JDTF - Officer Steve Beggs (Steve.Beggs@wfpd.net)'; 'JDTF - Steven Sullwold (steven.sullwold@dshs.state.tx.us)'; 'PNAC - Brent Walker (brent.walker@sheppard.af.mil)'; 'PNAC - Charlcie Flinn'; 'PNAC - Debbie Lawson (debbiealawson@sbcglobal.net)'; 'PNAC - Jean Puckett (jpuckett1027@sbcglobal.net)'; 'PNAC - Michaelle Kitchen'; 'PNAC - Rebecca Dickson (moncojuv@wf.quik.com)'; 'PNAC - Sheila Hutchins'; 'PNAC - Stephanie Sokolosky'; 'PNAC - Susan Sportsman'; 'sherryz@quik.com'
Subject: Crisis Redesign Meeting 10-15-07

This is just a reminder of the Crisis Redesign meeting that is scheduled for Monday, October 15, 2007 at 11:30 in the Conference Room at 516 Denver Street. I am attaching a copy of the Crisis Service Redesign Standards that we will be using to establish our Crisis Services. We want to thank you in advance for making time for this most important meeting. If you have any questions or if I can be of any help please contact me. We look forward to seeing you on Monday. There will be hard copies of the attachment at the meeting. Lunch will be served.

Patty Lawrence
Community & Consumer Support
lawrencep@helenfarabee.org
500 Broad Street

Wichita Falls, Texas
940) 397-3363
Feedback Requests

From: Atkins, Roddy
Sent: Wednesday, October 24, 2007 1:01 PM
To: Bill McElhaney (cojudge@co.wise.tx.us); Bobby McGough (stoco.judge@srcaccess.net); Charlie Bell (cbell0140@hotmail.com); David C. Davis (cojudge@co.haskell.tx.us); Duane Daniel (kcjudge@caprock-spur.com); Gary Beesinger (gary.beesinger@co.archer.tx.us); Greg Tyra (abrown@co.wilbarger.tx.us); Jay Maden (childresscojudge@childresstexas.net); Kenneth Liggett (ccjudge@claycountytx.com); lanham.lyne@cwftx.net; Lesa Arnold (thejudge@caprock-spur.com); Linda Rogers (baylorcj@srcaccess.net); Mitchell Davenport (countyjudge@jackcounty.org); montagueihc@wavelinx.net; Ronald Ingram (hardemanjudge@speednet.com); Stan Peavy (s.peavy@youngcounty.org); Ted Winn (thwinn@hotmail.com); Travis Floyd (tfloyd@srcaccess.net); Trey Carrington (cojudgethrock@tgncable.com); Trey Carrington (jp224@tgncable.com); Woodrow W. "Woody" Gossom Jr. (county.judge@co.wichita.tx.us)
Subject: Mental Health Crisis Re-design Planning

Dear Judge,

As you are aware, the Department of State Health Services (DSHS) received $82 million in funding from the legislature to improve Mental Health Crisis Services at the community level for FY 2008 and FY 2009. The annual share or allocation for Helen Farabee Regional MHMR Centers is $321,281 annually. In terms of spending these funds, DSHS is requiring the Center to submit a plan on how we will use these funds to improve our Mental Health Crisis Services. The first two areas we have to address are to assure that our Crisis Hotline and Mobile Crisis Intervention Services meet newly developed standards and expectations. After that, we can then flexibly address things like Crisis Walk-in, Crisis Residential, and Crisis Observation services. $321,000 sounds like a lot of money on the surface, but it does not go that far. So far in our planning process we have involved stakeholders from hospital emergency rooms, law enforcement, the judiciary, other state agencies, other mental health/substance abuse providers, and patients/family members with regard to planning. Basically, given the money we will receive, we will be able to assure our Crisis Hotline meets new standards with regard to the telephone always being answered by Qualified Mental Health Professional (24/7) and being accredited by the American Association of Suicidology (A.A.S.). Additionally, we will be able to strategically add additional staff to our Mobile Crisis Intervention Response and Follow-up services in order to respond quicker to face-to-face assessment needs; increase our capacity to follow up with persons in crisis quicker, and for a longer period of time, so that they ultimately get the services they need; and increase our ability to provide appropriate clinical assessment/determinations by increasing our ability to have Licensed Masters Level Clinicians and Registered Nurses available for consultation and assessment when needed. In addressing these areas we have spent right at $300,000. With %10 for administrative costs added, we will have spent the allocation. As part of the planning process, I would like to seek feedback from you regarding the basics of the plan.

I have attached a very brief document for your review which describes our existing Mental Health Crisis Services and the shows what specific enhancements are being proposed with the Mental Health Crisis Re-design Funds. Please look this over and feel free to e-mail me or call me with any comments or suggestions you might have. Your support, and your feedback is always appreciated.

Roddy Atkins, M.Ed., Executive Director
Helen Farabee Regional MHMR Centers
e-mail: AtkinsR@helenfarabee.org
phone#: (940)397-3101
fax#: (940)397-3150
From: Atkins, Roddy
Sent: Wednesday, October 24, 2007 1:08 PM
To: Craig Estes (craig.estes@senate.state.tx.us); david.farabee@house.state.tx.us; Rick Hardcastle
Cc: Lewis Simmons; Thure Cannon; Missy Warren
Subject: Mental Health Crisis Re-design Planning

Dear Sen. Estes and Reps. Farabee and Hardcastle,

As you are aware, the Department of State Health Services (DSHS) received $82 million in funding from the legislature (you guys!!) to improve Mental Health Crisis Services at the community level for FY 2008 and FY 2009. The annual share or allocation for Helen Farabee Regional MHMR Centers is $321,281 annually. In terms of spending these funds, DSHS is requiring the Center to submit a plan on how we will use these funds to improve our Mental Health Crisis Services. The first two areas we have to address are to assure that our Crisis Hotline and Mobile Crisis Intervention Services meet newly developed standards and expectations. After that, we can then flexibly address things like Crisis Walk-in, Crisis Residential, and Crisis Observation services. $321,000 sounds like a lot of money on the surface, but it does not go that far. So far in our planning process we have involved stakeholders from hospital emergency rooms, law enforcement, the judiciary, other state agencies, other mental health/substance abuse providers, and patients/family members with regard to planning. Basically, given the money we will receive, we will be able to assure our Crisis Hotline meets new standards with regard to the telephone always being answered by Qualified Mental Health Professional (24/7) and being accredited by the American Association of Suicidology (A.A.S.). Additionally, we will be able to strategically add additional staff to our Mobile Crisis Intervention Response and Follow-up services in order to respond quicker to face-to-face assessment needs; increase our capacity to follow up with persons in crisis quicker, and for a longer period of time, so that they ultimately get the services they need; and increase our ability to provide appropriate clinical assessment/determinations by increasing our ability to have Licensed Masters Level Clinicians and Registered Nurses available for consultation and assessment when needed. In addressing these areas we have spent right at $300,000. With %10 for administrative costs added, we will have spent the allocation. As part of the planning process, I would like to seek feedback from you regarding the basics of the plan. I have attached a very brief document for your review which describes our existing

Mental Health Crisis Services and the shows what specific enhancements are being proposed with the Mental Health Crisis Re-design Funds. Please look this over and feel free to e-mail me or call me with any comments or suggestions you might have. Your support, and your feedback is always appreciated.

Roddy Atkins, M.Ed., Executive Director
Helen Farabee Regional MHMR Centers
e-mail: AtkinsR@helenfarabee.org
phone#: (940)397-3101
fax#: (940)397-3150

From: Gardner, Terry L.
Sent: Thursday, October 25, 2007 4:33 PM
To: 'stacybenedict@hotmail.com'; 'dboitnott@starcouncil.com'; 'sjcardwell@msn.com'; 'marketing.wichita@merrillgardens.com'; 'lisacas@nts-online.net'; 'andie.gass@cwftx.net'; 'karen.hamilton@co.wichita.tx.us'; 'teenshlt@nts-online.net'; 'david.kelley@thewoodgroup.us'; 'debbie.knouf@co.wichita.tx.us'; 'ronda.kuehler-holler@dshs.state.tx.us'; 'sara@wfha.com'; 'scottemc@earthlink.net'; 'mindy.murray@arcadatx.org'; 'nhwfcpa@newhorizonc.com'; 'jayna.phillips@cwftx.net'; 'donnap@wfha.com'; 'karen.previe.ctr@sheppard.af.mil'; 'beverly.stiles@mwsu.edu'; 'tracy.vanwinkle@co.wichita.tx.us'; 'doug.baker@co.wichita.tx.us'; 'lanham.lyne@cwftx.net'; 'steve.beggs@wfpd.net'; 'donald.cole@wfpd.net'; 'steven.sullwold@dshs.state.tx.us'
Cc: Martin, Charles L.; Martin, Andrew
Subject: Crisis Redesign

Please view the attached document.

During the months of September and October, 2007, stakeholder groups (Jail Diversion, PNAC, and Focus Group) attended meetings and reviewed the proposed enhancements to our Crisis System to be funded through Crisis Re-Design dollars appropriated through the 80th Texas Legislature.

We would like to give you an opportunity to comment on the changes proposed for Fiscal Years 2008-2009 as our records indicate you were unable to attend one of the above meetings. Please review the following comparison between our existing crisis services and the proposed enhancements for FY 08-09.

We would appreciate any comments you might have and we would like them by 10/31/07. Please comment by replying to this email and all comments will be forwarded to the appropriate person.

Thank you for your time.

Charles Martin
Director, Crisis Service HFRMHMRC

Thank you,
Terry Gardner
Crisis Secretary

Meeting Minutes

Jail Diversion Workgroup

Date: 9/12/07

Start Time: 12:06pm

Meeting called by: Roddy Atkins

Attendees: Roddy Atkins, Rod Brennan, Capt. Bertie Foster, Judge Woody Gossom, Gianna Harris, Lynn Hartje, Connie Johnston, Patty Lawrence, Charlie Martin, Carmen Simpson, PNAC Members

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RA: The State has not totally figured out what is wants as far as crisis redesign funding. We have some drafts standards that we are working with. We still don't know what the total dollar amount is, but they are expecting a plan from us by October 31st. Some of the things we decide might have to be tweaked depening on if they change the standards. To summarize where this is going, we are talking about the money we will be receiving this time around has a focus on new crisis hotline standards…we discussed that last time. Secondly, how we address crisis intervention services to make sure our center is meeting those standards. Any other needs will be addressed after that. I can tell you that roughly, we will probably receive somewhere between $250,00 and $300,000. Charlie had an excellent suggestion and came up with a one page overview of our system and some recommended areas. With the way our crisis hotline is set up, we should be in compliance with any requirement that DSHS will have. Our hotline is going through their American Association of Suicidology accredidation in October. Out of that money, our cost to run the hotline is $75,000 a year, $12,000 is old money, $63,000 will come from the crisis redesign. The next area we want to address is mobile crisis intervention. Charlie, can you briefly give an overview?

CM: Very briefly, either a proposed patient or community stakeholder will call our crisis hotline that is answered by qualified mental health professionals. They will then triage that phone call to see if they need to do either phone counseling or do they need to

immediately dispatch a clinician to do a face-to-face assessment. We have one hour to respond with our recommendation.

RA: Those recommendation, not to interrupt Charlie, but basically what we are required to do when they do a face-to-face, the major thing is to assess whether or not someone is a danger to themselves or someone else because of their mental illness. After that, a couple of things can happen…someone could be hospitalized based on our recommendation with law enforcement with the EDO. If they don't meet that criteria then we will recommend other intervention services.

CM: If the recommendation based on having our patients in the least restrictive environment going from highest to lowest is the EDO to the State Hospital, under that may be an admission to Red River Hospital, under that may be an admission to our crisis respite unit. The very least would be for them to send them home to come back during hours for an intake appointment.

PNAC Member: Question really quick, you didn't say voluntary to the State Hospital…is that no longer done?

RA: Not through us.

PNAC Member: What if they don't have any money? How would they get into Red River?

CM: We are not going to make a recommendation for them to go to Red River without a funding source.

PNAC Member: Well if they need inpatient but don't have the money to go to Red River what happens then?

RA: Then they will go to the hospital.

PNAC Member: Then it will be on an EDO not voluntary.

RA: That's right. We don't approve voluntary to NTSH.

CM: If the funding should be different, adult medicaid instead of medicare, then we will see what we can do to get them the care needed with the funding they have. There are some hospitals in Denton, one in Sherman…

BF: If they want to go somewhere can they go to CRU and then y'all decide where they will go.

CM: Yes. Even if you have resolved their crisis and there is a good care package wrapped around the person, they go to CRU, then their symptoms exacerbate then we can reasses them to change that level of care.

RA: Occasionaly we can even do an involuntary to a private hospital as long as they have the funding source. The moblile crisis intervention is the assessment teams and then a traffic cop…now we can go and assess them and that doesn't mean that law enforcement can do something despite our recommendation. Once someone is at the hospital, it becomes the physicians recommendation at that point. Charlie, can you lay out the difference between what happens during the day and during the evening since they are a little different?

CM: During the day, we still get calls from our hotline since they work 24-7. The calls are forwarded to me and my staff to go out and perform the assessment. We still get the EDO's to NTSH, however, during the day, we are a lot better equipped on sending folks to the least restrictive environment since we have more places open to do the utilization management for us. It is me and three staff members that will respond to crisis is Wichita, Archer, and Clay counties. The outer counties will receive the calls at their center and will respond the same way.

RA: We have a dedicated team because Wichita Falls is so much bigger.

PNAC Member: And they have a one hour response?

RA: The one hour response is still in place throughout the whole region…even out to Dickens or Guthrie. Can we say we meet that in every location across our 19 county area? No, but we get really close. What else during the day?

PNAC Member: Where can you find the crisis hotline number?

RA: It is publicized in every phone book, it is on our website, we give it to law enforcement, it is on all of our cards…

CM: Every hospital has it, every law enforcement has it…

RA: Every Health Fair, Senior Focus, Kid's Fest…it is on all our stuff. There is a requirement by the state that we have it published in every phone book in our catchment area.

CM: When we get a call, and one of our staff goes to do an assessment, we may or may not have law enforcement. We might have to go and file the emergency detention ourselves.

RA: Evening?

CM: Evening…we have it divided into five different regions with one dedicated person for each region. We now know when we get the call we need to start tying our shoes and go do the assessment. We do have a lot of law enforcement in the evening. We do things

the same way as the day, but we don't have access to a County Court of Law so we rely on law enforcement for that.

RA: How many folks are on call in the evening, after hours?

CM: Five primary for each of the regions and one back up member from our crisis services. They are able to go out and help these clinicians if needed, but are always available for phone support. We have one psychiatrist we can access if we need to.

RA: Weekend and holidays are taken the same as evenings. I mentioned one of the things we run into...here in our region they rotate on-call every night, but our outer regions might carry their on-call for up to a week.

CM: They do, but they usually can juggle it so it isn't quite a week. In those areas, you can do three or four nights on call because you might not even have a call some of those nights. Here, you earn your money so you couldn't do it for more than a night.

RA: Outside of Charlie's folks, these people are still doing other jobs during the day. They are doing skills training, case management…they have a case load to carry. Charlie's crew during the day is only for crisis and continuity of care. One of the things the State is proposing that we are arguing…initially they wanted dedicated teams with a minimum of two to go out. There has been a lot of discussion that that isn't realistic. You couldn't afford to cover 19 counties and pay for 10 or so people to go out on mulitple calls…

PNAC Member: Can a police officer be one of the two?

RA: They were wanting that in addition to the team. That is probably not going to happen. I think minimally we will be meeting the requirements when they come out. That doesn't mean that we can enhance things. Part of the reason is that it is safer if you go out with law enforcement. There is an issue with folks being on call and then doing things during the day…does that wear on them? One of the things we will be talking about if this groups wants to consider enhancing…we could consider having more dedicated crisis workers? You aren't going to be able to solve the problem of people working on call and then during they day. From a dollar standpoint…Haskell, TX. Those people are working the on call, but they may only get called out one time in their five days. It doesn't make sense to have two people working that.

PNAC Member: What if someone wants to take vacation or a personal day?

GH: We don't dictate their schedules. Each region makes their own schedules to accommodate for vacation time, etc. If someone gets sick and is scheduled…they work together to get it covered.

RA: One of the things that Charlie and Gianna…is increasing the number of dedicated crisis staff in these heavily populated areas like the Wichita area where they stay busy. We can potentially look at adding some crisis resources.

PNAC Member: Resource-wise…what is really out there?

RA: What is out there is to relieve the amount of time that someone is pulling an all-nighter and having to come back and deliver services the next day. One of the other recommendation is to look at some dedication for crisis follow-ups.

GH: Those that are discharged from our crisis services…to catch the people that might not revolve back through. These people could help make sure that these people are making it to their doctors and caseworker appointments.

RA: When you look at the stats…we are running anywhere between 350-450 crisis calls per month. About 50% of those result in a face-to-face assessment. The hotline tracks all of those things and we can track all the data. When you look at those number and you figure that most of that is concentrated from our three biggest counties…the continuity piece of making sure these people are following up…those are the two areas…when we talk about restructuring the regions. One of the areas is Wise and Montague County. That is a big region. They get a lot of overflow from Tarrant and Denton Counties. Sometimes it is difficult for someone in Wise to get to where they need to be within that hour. We have talked about maybe restructuring these regions…probably 98% of the time we respond within the hour. One of the issues we see is there are difficulties and those crisis situation come up more often so we can make sure we can get to 100% of the time. Here in Wichita we will really look at adding some more dedicated staff. If they come back and say we have to have a two person dedicated team…I don't think that will happen. If it does then it will blow everything out of the water and we will have to start all over. We haven't put a cost to it, but it is probably going to cost a couple hundred thousand dollars. What are some of y'alls thoughts?

PNAC Member: How many people are we talking about?

RA: Well, roughly with salary and benefits…I think depending on how we structure things…

PNAC Member: Well, if you say three or four…how many would stay in Wichita County?

RA: Well, I think the continuity of care person would definitely stay here even though they would be working across the regions.

PNAC Member: How much trouble will it be to find a qualified person…

RA: It is not easy. Well, I am not going to tell you we will be able to find these people in certain areas. Thanks to Midwestern we don't really have those problems here in Wichita.

PNAC Member: I am just concerned about the burn out. You can't tell me doing what you all are talking about you won't have burn out, then there will be a turn over and we are back to square one again. True or false? The people that work during the day…do they get any extra compensation for being on call at night?

RA: Yes.

CM: We pay an on call rate of $60 for a weeknight and $90 for a weekend or holiday. My staff and myself get a fixed monthly rate. We may be up all night on the phone, but we don't have to go out that much. We are faced with challenges from time to time because we will have people from out catchment area that are wondering around and get sick in say Austin, and be committed there. In order to get them back into our area and services, we need that extra continuity of care person to help get that person back home.

RA: The problem with them flexing their time is that they all have minimum service requirements that they have to meet. So if they flex their time off, then they are away from where they can get that time. Wichita Falls can get really busy.

CM: However, with the addition of Avail Solutions our number of face-to-face assessments have gone down.

RA: I mean, with those outer areas you might have one crisis call the whole year where as Wichita Falls….the demographics are that the population is increasing. I don't see that changing. I know that our case load populations out west have dropped. You have an older population where we are seeing a younger population in our other counties.

PNAC Member: How are you dealing with the bi-lingual population?

RA: Well, our hotline is definitely capable of handling that. We do the best that we can to recruit bi-lingual individuals. We actually pay additional for it, but there just aren't enough. We will get interpreters when we can. Here, we just do what we can.

PNAC Member: Isn't there a thing through AT& T you can call?

RA: We have used it, and we have also used the one for deaf individuals.

GH: Well, at night, we aren't going to someone's home alone. Most the time the sheriff or hospital will have that staff on hand for us to utilize at that point. During they day we have some staff that we will utilize if we know a head of time if we are presented with it.

RA: I have a child and adolescent phyciatrist coming in December or January. I am looking at adult. Part of what I see primarily is not for on call access, but more for crisis

walk-on and our ability to see the people who come in through the CRU process. That is where we need the additional psychiatrists.

PNAC Member: (inaudible)

RA: Well, we are talking about people having access to atleast a diagnostic interview and getting started on meds as quickly as possible. Right now, when you talk about what do we do with our CRU…when someone is admitted we actually have a scheduled time everyday for them to go and see the doctor. It actually takes up a lot of time…between the crisis and walk-ins. There are probably about three or four a day lately.

CM: Yeah about three or four a day.

RA: That is just from CRU. That doesn't count when we have to work someone in from like Wise County who may be in crisis. Part of it is looking at that additional medical resource. If there were some dollars left over after this.

PNAC Member: Do you do any sort of telecommunication?

RA: Yes. Dr. Smith does the bulk of it and Dr. Vachhani does some. We have done some emergency stuff that way, but mostly to cover some of the outer areas. There is still something uncomfortable about doing an initial assessment that way. We do all of our intakes that way except for in Wichita Falls.

PNAC Member: So what do we need to do today?

RA: Well, what I would like is maybe some, in terms of the whole crisis intervention piece…I think we feel very strong about the continuity of care piece, and where we can maybe beef up the after hours response. Does that sound reasonable or unreasonable? The reason I am focused on that is because that is the first two things, and some of this may be subject to change. Based on what you have heard, would you like to see something different.

PNAC Member: I would like to see four instead of three. If you can afford it.

RB: Well when you look at the whole package, four people and the hotline takes up about all of it.

RA: If we can look at four, then we will make sure then there is an actual need for that. We may could split Wise and Montague and make them their own regions. Now, what kind of impact is the hotline…I think we have seen a good response from the them. They are handling a lot more stuff in a triage fashion. That is a positive thing. I think it has also kept people from showing up…I think we have seen more people over the last months…I would hope we could see a reduction in any inappropriate admissions to the hospital. We have had good feedback from some of the stakeholders'…emergency room, peace officers. Hopefully, what we are doing based on numbers, we are keeping people

from going into more restrictive services and our people aren't having to go out repeatedly like they were before. We are now doing very solid crisis assessments in that people are getting into appropriate care. The continuity of care piece is what I am thinking will really be able to follow the people that we have dealt with in a crisis situation that weren't appropriate for higher placement.

CM: It will provide them with at least some problem solving case management if nothing else.

RA: It will give us more capacity to do that, but it that runs us $250,000-$350,00, then we aren't going to be able to do much more at all. Now there are some other things that I think what we can do is an analysis of what we need to if there is some additional money then we can pull you guys back in. We already know that $63,000 is going to additional costs of the crisis hotline. That will leave us with a couple hundred thousand for the mobile crisis intervention piece. If there are some dollars left over…we can bring y'all back together. The money is supposed to be allocated the second quarter. That is why they want this submitted by the 31st of October. They are still changing everything so we still don't know the dollars, and I have to come with y'all with a bunch of what if's. I am fairly confident, I know our hotline will meet the standards, and I think out mobile crisis with the enhancements will be great. If they come back and say something totally different then we will have to some back to the table. I just didn't want to rush in last minute and push this out there at a thousand miles per hour. The Board is aware that PNAC and jail diversion have been helping out with this. They also know that we get a contract every year from the State that they have to approve, usually after it is submitted and they just change it. We are paying attention to the standards and requirements. I think we are talking about bringing you back together in October anyway so y'all can look at the plan. Thank y'all.

CRISIS REDESIGN MEETING
Joint Meeting - PNAC and Jail Diversion Committee
Wednesday, September 12, 2007
516 Denver, Wichita Falls, Texas

MEMBER	COMMITTEE	SIGNATURE
Bill Jennings	Jail Diversion	
Bill Sullivan	Jail Diversion	
Brent Walker	PNAC	
Bruce Patterson	PNAC	
Capt. Bertie Foster	Jail Diversion	
Carmen Simpson	Jail Diversion	
Charlcie Flinn	PNAC	
Debbie Lawson	PNAC	
Doug Baker	Jail Diversion	
Jean Puckett	PNAC	
Judge Janice Sons	Jail Diversion	
Judge Woody Gossom	Jail Diversion	
Mayor Lanham Lyne	Jail Diversion	
Michaelle Kitchen	PNAC	
Officer Donald Cole	Jail Diversion	
Officer Steven Beggs	Jail Diversion	
Patty Galloway	PNAC	
Rebecca Dickson	PNAC	
Sheila Miller-Hutchins	PNAC	
Sherry Coombs	PNAC	
Shirley Kissner	PNAC	
Steven Sullwold	Jail Diversion	
Susan Sportsman	PNAC	Unable to attend
Roddy Atkins	Executive Director	
Gianna Harris	Utilization Management	
Connie Johnston	Community & Consumer Support	
Rod Brennan	Chief Financial Officer	
Dr. Lauren Parsons	Medical Director	
Lynn Hartje	Mental Health Services	
Rose Wilson	Mental Retardation Services	
Charles Martin	Crisis Services	
Andy Martin	Utilization Management	
Patty Lawrence	Community & Consumer Support	
Kellie Brookings	Crisis Services	
Carmen Simpson	Parole	Carmen Simpson

FOCUS Meeting
October 12, 2007
Meeting was called to order by Roddy Atkins at approximately 12:00pm

Roddy: We are going to get started today. We normally do not ask for people to sign in but we are doing some thing different today. The reason we are having you sign in is because we will be seeking some feedback from you guys. We want to be able to say "here are the folks and agencies that have given us feedback about what we talked about today." At the last legislation there was a big push for around crisis services thing in the

state of Texas around the public mental heath system. Starting two years ago there were a series of public hearings held regionally across the state. They brought different stakeholders to the table to discuss the state of mental health crises in the state of Texas. The feedback generated planning and basically the basis of appropriations request by the department of state health services to fund crisis intervention services. Some of the concerns were around how the crisis hotline services operate and the strength of mobile crisis intervention services. What kinds of crisis programs and offerings were available other then the state hospitals for example. How do you deal with other behavioral health issues in a crisis like substance abuse? One of the things we typically see are folks with primary substance abuse problems that come crashing down and go into a crisis situation. How do we intervene and get them going in the right direction? There was a lot of discussion; lots of folks that gave input. We are talking about emergency room staff , physicians and law enforcement. Law enforcement gets involved in a multitude of behavioral health crisis interventions. Commitment to a state hospital is pretty much a civil process that, in most cases, gets executed on the end with a law enforcement officer. Transportation issues- there are a lot of concerns from law enforcement about the cost, time, effort and energy that it takes to get from Haskell to Wichita Falls NTSH. Plus issues that the state hospital system has become over burdened in terms of many, many days over the last several years the state hospital have been over their census, over their funding. We are even seeing scenarios where there might not be an open bed for one part of the state and have to transport for example from Corpus Christi to El Paso to get a state hospital bed. That was the basis of the discussions that were around Crisis Response Services. Efforts were made with the state legislature. I am happy to say that the three primary legislators that we deal with in our area are Representative Hardcastle, Representative Farabee and Senator Estes were all supportive of the efforts around the funding for crisis services. Part of the effort is now being called Crisis Redesign - to make sure there are consistent standards for different services across the state. To improve the intensity and the ability for public systems to respond to the to those crisis services, then to begin to measure the outcome. To begin to develop alternative services other than the state hospital. The initial estimate really making this work is two hundred million dollars per year. Dr Parsons was involved with a lot of the crisis redesign work on the state level. The legislature funded eighty two million over the biennium. Which is basically forty one million dollars a year. It is new money and is sounds like a lot of money but when you are talking about the size of the state of Texas it is not a lot of money.

What I am going to get now is how does this impact our center and what the plans that we are talking about doing. I mentioned the 82 million dollars. Our share of that is three hundred thirty one thousand and two hundred eighty one thousand dollars. We have two initial mandates from the department of state health services. One is dealing with new draft standards around crisis hotline. Two is new draft standards around mobile crisis intervention. Mobile Crisis intervention is where our staff will go out into the community and intervene. A handout of a brief summary of things concerning this was given to you.. We are soliciting your feedback from. We also have some other folks that are working on this. We need to meet the standards for crisis hotline and mobile crisis intervention.

To go over the hand out. Our crisis hotline has already done some re-engineering. The new standards according to DSHS is who ever answers your crisis hotline have to be a mental health professional. The hotline has to be accredited by the American Association of Suicidology. We began the upgrade in anticipation of this several months ago. We are in the processes of meeting the standards. We contracted Avail Solutions Inc. to manage the hotline. Avail answers it twenty four hours a day seven days a week. They are qualified mental health professionals or better. They do telephone assessment triage. If a face to face assessment is needed Avail will contact the mobile crisis unit. This will cost us roughly sixty seven thousand dollars out of the crisis redesign fund.

Community Member: I have the opportunity to contact the Crisis Hotline the other day. I have nothing to compare to but they seemed really professional and nice.

Roddy: The hotline is aware of who is on call and designated to go out and do face to face intervention. We keep them up to date on available resources. We exchange information daily. Everything they do is reported back to Charlie and his crew.

Community Member: I think this happened around two to three weeks ago. She called the crisis hotline and she was told that if the client were at the agency someone could come out but we could not go out to the client's house because it may put the clinician in danger.

Roddy: I think it may have been a little bit of miscommunication. We will, depending on the circumstances of who it is and where it is, we will go out individually. If we get a call to go out to someone's house and we do not know who it is we will ask Law Enforcement to go out with us.

(This was inaudible.)

Discussion was made about the difference between medical emergency and mental emergency. (Inaudible)

Roddy: We serve nineteen counties. We are required to provide a face to face assessment with in one hour of notification. We do it ninety nine percent of the time. We divide the on call into five regions. The on call clinician does an assessment and makes recommendations based on signs, symptoms and severity. The recommendation has to do with the least restrictive environment of care. The crisis respite unit here has been averaging 13-14 people per day for the last several months. We cannot have more then 16 people at one time. People are typically in for 3-7 days. During that time we provide them twenty four hour care, we work them in to see clinicians and physicians and provide other things as well. This is all voluntary; this is not a holding facility. We also have the availability to consult psychiatrists when needed in a crisis. We are proposing to you that we add three full time crisis follow-up and relapse prevention clinicians. One of the issue is what happens after clients leave the crisis center. How can we better follow up after a crisis situation? Many times we deal with in crisis are not necessarily eligible when the crisis is over for ongoing services. We have a targeted population for the clients we serve.

Schizophrenia, major depression and bipolar is the targeted area we serve. However everyone is eligible for 30 days of services for follow-up. How do we assure that people get to the right place and follow up? The concept for these positions would be if we assess and got them back home but still need intervention wither that be substance abuse services, working with OSAR, set up appointments. Basically making sure that they get where they need to go after a crisis. Some people show up again and again. These folks will also help enhance mobile crisis services as well.

Community member: When would police be called in? (other inaudible)

Roddy: The police are called if someone is a danger to themselves or someone else. That is out of protection. Periodically we will call Law Enforcement to do a wellness check on someone.

Community member: We had a situation with the boy that just died. They asked him, do you want to go to jail or to the state hospital. He said he wanted to go to jail. Is that the questions that you ask them?

Roddy: No, that was the police asking him. Not us.

(Inaudible)

Roddy: In terms of the mobile crisis intervention piece, the other thing we want to do is add additional consultation to clinicians on call in the form of licensed practitioners of the healing arts (LPHA's) – LPC's, RN's, and LCSW's. It will not eat up every bit of the remaining 300 thousand dollars. What that will do is let us have availability for consultation for clinicians on call, we have got that we just need to enhance it. Adding the follow-up piece will help improve the services we offer.
Does any one feel this is unreasonable, good idea or bad idea? Does anyone think we should do something different?

Community member: I think you got is covered

Community member: I think you got a pretty good idea.

(inaudible)
Meeting was adorned approximately 12:50 by Roddy Atkins.
Minutes prepared by Terry Gardner

Helen Farabee Regional MHMR Center
Community Focus Group
October 12, 2007
Topic: Crisis Redesign

NAME	AGENCY
W. Scott Griffiths	HFRMHMRC
Shari Offutt Griffiths	NTNA (Private Practice)
Tom Wisdom	STAR Council
Margie Smith	STAR Council
Becky Browning	Faith Mission
John Welter	
Hobert Brown	American Red Cross
Cathy G. Brown	MSU Counseling Center
Karla Rose	Abilene Regional Council on Alcohol & Drug Abuse
Misty Ross	Helen Farabee
Becky Schreiber	Serenity
Crystal Daniel	Serenity
Lauren Parsons, MD	NTSH / HFR
Steve Stout	Family Hearing Center
Mark Johnson	Sheppard AFB Family Advocacy
Lynn D. Hartje	HFRMHMRC

NAME	AGENCY
Beverly Diekhoff	Alzheimer's Association
Nora Zárate Hodges	Nortex RPC
Jason Forques	Family Advocacy Sheppard AFB
Dustin Phillips	Midwestern Healthcare Center

October 15, 2007

Jail Diversion Meeting

Meeting was called to order by Roddy Atkins at 12:05pm.

The topic of this meeting was Crisis Services Redesign.

HFMHMR has contracted Avail Solutions Inc. to answer crisis calls. Discussions were made concerning the accreditation of Avail Solutions Inc. Avail Solutions received the American Association of Suicidology Accreditation. The Qualified Mental Health

Professionals that answer the calls are equipped with either the Bachelor's or Master's Level in education.

Discussion was made about the crisis response team which is divided into VI regions. Each region covers certain mapped areas. There is one clinician and one back up clinician on call twenty-four hours a day, seven days a week, three hundred sixty five days a year. As well as one of HFMHMR's psychiatrists are on call for medication consultation if contacted by the Director of Crisis Services or Director of Nursing. A face to face assessment is established with in one hour of clinician notification.

HFMHMR proposed to assemble a Crisis follow-up, relapse prevention team. This team would consist of two positions in the Wichita, Archer, Clay region and one position for the Montague, Wise, Jack and Young region. The required education level for these positions will be QMHP or higher. A motion was made by the PNAC group to not contract out Crisis services.

This meeting was adjourned by Roddy Atkins at 12:50pm.

CRISIS REDESIGN MEETING
Joint Meeting - PNAC and Jail Diversion Committee
Monday, October 15, 2007
516 Denver, Wichita Falls, Texas

MEMBER	COMMITTEE	SIGNATURE
Bill Jennings	Jail Diversion	
Bill Sullivan	Jail Diversion	
Brent Walker	PNAC	
Bruce Patterson	PNAC	
Capt. Bertie Foster	Jail Diversion	
Carmen Simpson	Jail Diversion	
Charlcie Flinn	PNAC	
Debbie Lawson	PNAC	
Doug Baker	Jail Diversion	
Jean Puckett	PNAC	
Judge Janice Sons	Jail Diversion	
Judge Woody Gossom	Jail Diversion	
Mayor Lanham Lyne	Jail Diversion	
Michaelle Kitchen	PNAC	
Officer Donald Cole	Jail Diversion	
Officer Steven Beggs	Jail Diversion	
Patty Galloway	PNAC	
Rebecca Dickson	PNAC	
Sheila Miller-Hutchins	PNAC	
Sherry Coombs	PNAC	
Shirley Kissner	PNAC	
Rick Hoban	Jail Diversion	
Susan Sportsman	PNAC	
Roddy Atkins	Executive Director	
Gianna Harris	Utilization Management	
Connie Johnston	Community & Consumer Support	
Rod Brennan	Chief Financial Officer	
Dr. Lauren Parsons	Medical Director	
Lynn Hartje	Mental Health Services	
Rose Wilson	Mental Retardation Services	
Charles Martin	Crisis Services	
Andy Martin	Utilization Management	
Patty Lawrence	Community & Consumer Support	
Terry Gardner	Crisis Services	
[illegible]	MIS Director	

Stakeholder Responses/Feedback

From: Martin, Charles L.
Sent: Wednesday, October 24, 2007 10:43 AM
To: Harris, Gianna
Subject: feedback
Importance: High

Montague County - Denise was the first with her response. She spoke with law enforcement and the medical community. Positive responses received from both entities regarding the hotline enhancement. Law enforcement reports LPHA and possible RN overlay would also be good but they were relatively non-committal about it. Medical community offered positive response to LPHA and possible RN overlay. Improvement question to both entities yielded positive response in the fashion that they were happy with services and response time.

Jack County - Spoke with law enforcement and medical community. Positive responses received from both entities regarding the hotline enhancement. Law enforcement reports LPHA and possible RN overlay would be positive with credentialed "back up." Medical community receptive to possible RN overlay. Got to talk to actual doctor (Dr. Jamal). He was also pleased with the LPHA overlay. Response to improvement question was typical. Everyone wants quicker response time and more state hospital availability.

From: Martin, Charles L.
Sent: Wednesday, October 24, 2007 12:56 PM
To: Harris, Gianna
Subject: feedback comment - Young Co.
Importance: High

Elizabeth reached BJ (administrator for the Young Co. jail). He remains one of the agency's biggest fans. He posed the question of the community utilizing the proposed overlay piece. He posed a scenario. If a person is being held by law enforcement, could they (law enforcement) glean information from the overlay regarding appropriateness of requesting a face to face assessment?

From: Martin, Charles L.
Sent: Wednesday, October 24, 2007 2:39 PM
To: Harris, Gianna
Subject: Crisis Redesign feedback - Childress
Importance: High

Edna was able to visit with law enforcement but not the medical community. Her contacts at the local hospital were out. Positive reports regarding all enhancements. Favorable impression of the crisis hotline. Positive feelings regarding the possible 2 versions of the overlays. Addressing the improvement portion - this is more of a resource issue. Law enforcement wants the provision of dedicated anger management therapy. With regard to crisis service delivery - favorable impressions with no mention of improvements.

From: Martin, Charles L.
Sent: Thursday, October 25, 2007 1:20 PM
To: Harris, Gianna; Martin, Andrew
Subject: Crisis Redesign Feedback - Wise
Importance: High

Center manager spoke with local law enforcement and primary emergency room (Wise Regional Hospital). Both were positive in their responses toward the enhancement for the crisis hotline. With regard to the possible LPHA and/or RN overlay - law enforcement replied "anything to add support to the call is good." The medical community replied that placement has been a difficult hurdle at times and if the overlay helps the responding clinician, then it's a positive move. In a more general query of other possible improvements, law enforcement indicated interest in a more local type of after hours treatment but were understanding of expenses involved. The medical community offered a desire of a shorter response time but did verbalize understanding of distances involved within rural areas.

Haskell County Sheriff and Police Department

- Transporting patients is a big problem for their department; they recommended hiring someone to do transports.
- Sometimes it takes too much time for the hotline to screen and they feel like they get hassled.

Haskell Memorial Hospital

- No recommendations for improvement.

Baylor County Police Department

- Good feedback on response time and assistance.
- Transport can sometimes become an issue due to lack of staff.

Baylor County Hospital

- Good feedback, but requested documentation for the record when someone assesses a patient in their facility.

Stonewall County Sheriff

- No complaints, good feedback.

Stonewall Memorial Hospital

- Did not provide any feedback, they rarely contact MH/MR for assistance because most of the patients are shipped out for more advanced medical assistance.

Throckmorton County

- Good feedback on Avail and the response time.
- Complained about transports being difficult due to lack of people to transport.

Throckmorton Hospital

- No recommendations for improvement
- Mentioned the issue of patient transport being difficult due to lack of officers.

Knox County Sheriff Department

- Would like a delegated person just to transport patients to the hospital, they find it difficult because they are short handed.

- Gave positive feedback on Avail and our response time.

Knox County Hospital

- Would like to see more inpatient treatment for people without insurance.

Dickens County

- No recommendations for improvement, they rarely request our services.

From: Judge Liggett [mailto:ccjudge@claycountytx.com]
Sent: Thursday, October 25, 2007 2:53 PM
To: Atkins, Roddy
Subject: Re: Mental Health Crisis Re-design Planning

Let it never be said that you could not find a use for additional dollars. The plan looks good to me. I am not sure if it is the best use of additional money, but I don't have a better suggestion at this time.

From: Simmons, Gloria
Sent: Friday, October 26, 2007 10:01 AM
To: Martin, Charles L.
Subject: RE: Crisis Redesign feedback

There were no specific comments to any of these items, just attentive listening on their part and acknowledgement that these are positive changes. They are grateful for the service we provide, and while response time is a concern, they understand that we cover a lot of territory and we do the best we can.
Thanks,
Gloria

The only request I have had came from the PD in Vernon, and that is to offer training to officer so that they better know how to handle the folks with mental health issues.

Thanks,
Gloria

From: Lewis Simmons [mailto:Lewis.Simmons@senate.state.tx.us]
Sent: Wednesday, October 24, 2007 2:11 PM
To: Atkins, Roddy
Subject: Re: Mental Health Crisis Re-design Planning

Understood.

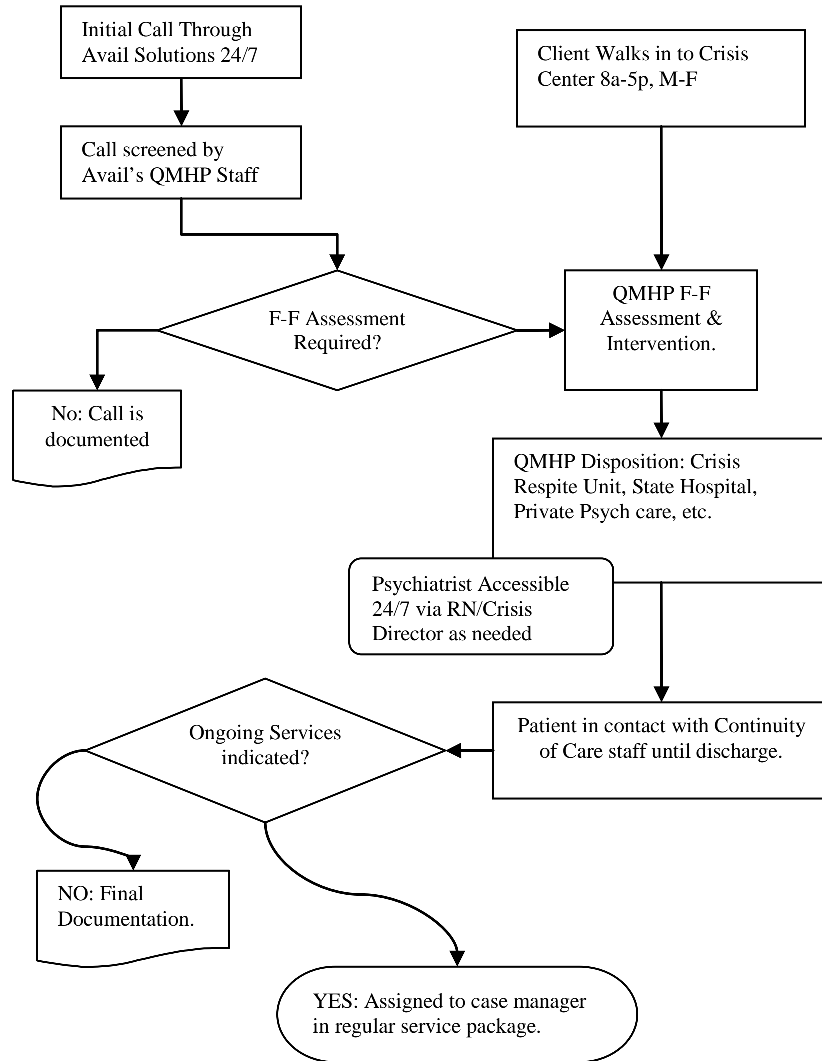
Attachment B: Crisis Service Types by Location, FY 2006-2007

Number of Events **FY2006**	Location	Percentage
1084	At the Center	19%
79	Client's Home	1.4%
492	Inpatient Hospital	8.6%
78	Nursing Home/ICF MR	1.4%
136	Outpatient Hospital (e.g. ER)	2.4%
6	Independent Lab	0.1%
415	Jail	7.3%
7	Boarding Home/Ext. Care	0.1%
753	Other	13.2%
9	School	0.2%
1642	Pre-Discharge Planning (starts when admitted to NTSH or CRU)	28.8%
1002	Discharge Planning (prior to actual discharge from NTSH or CRU)	17.6%

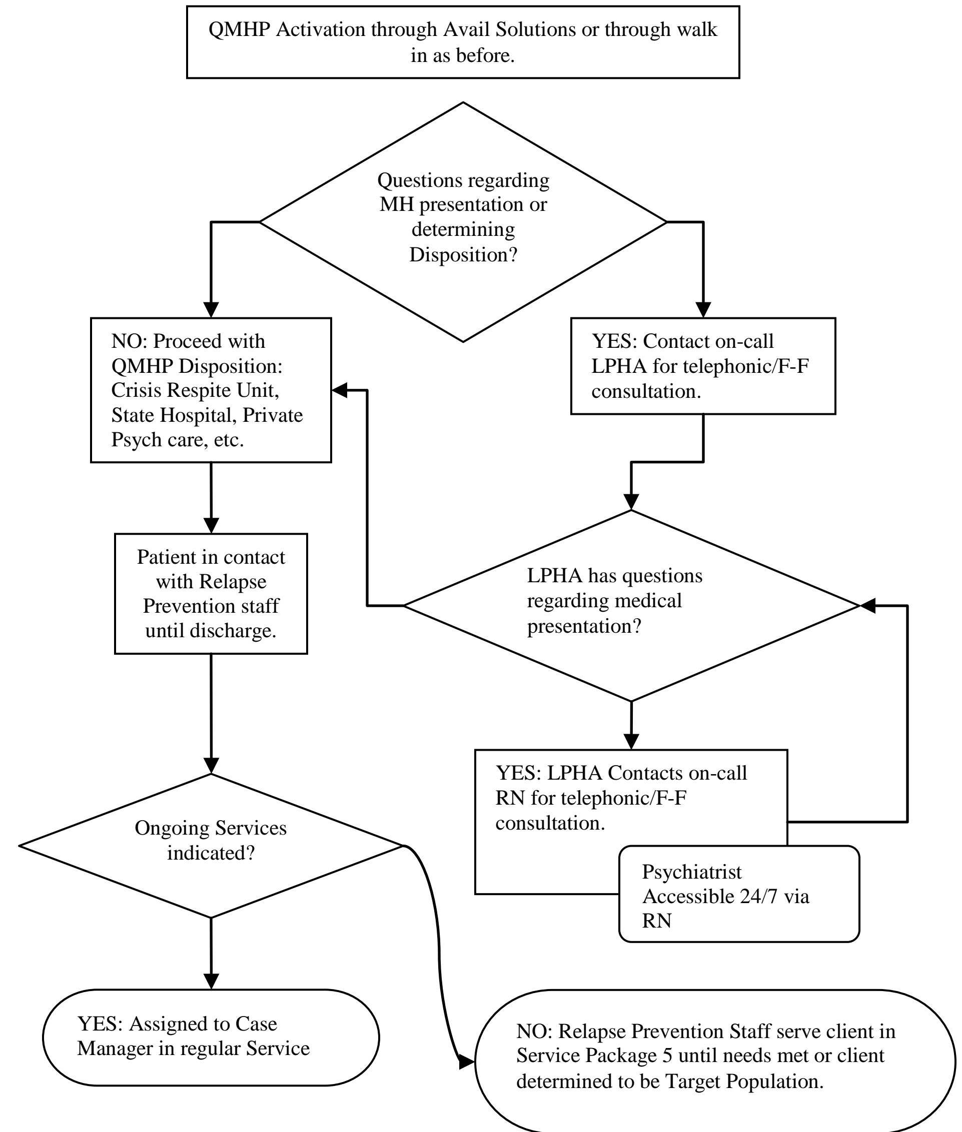
Number of Events **FY2007**	Location	Percentage
1068	At the Center	18.55%
84	Client's Home	1.46%
266	Inpatient Hospital	4.62%
70	Nursing Home/ICF MR	1.22%
83	Outpatient Hospital (e.g. ER)	1.44%
0	Independent Lab	0.00%
389	Jail	6.76%
0	Boarding Home/Ext. Care	0.00%
1182	Other	20.53%
4	School	0.07%
1493	Pre-Discharge Planning (starts when admitted to NTSH or CRU)	25.93%
1118	Discharge Planning (prior to actual discharge from NTSH or CRU)	19.42%

Attachment C: Existing vs. Enhanced Crisis Services Flow Chart

Existing Services



Enhanced Services



Attachment D: List of Updated Memoranda of Understanding (MOU) and Contracts

Memoranda of Understanding

Helen Farabee Regional MHMR currently has Memoranda of Understanding (MOU) between its Substance Abuse program and local entities regarding conditions of referral for SA treatment through the center and a brief description of the types of services typically offered. The following entities have signed current MOU’s:

- Wichita Falls Health Department
- Wichita Falls Independent School District
- Wichita County Court
- Judge Mike Little's Truancy Court
- Wichita County Courthouse and Jail Facilities
- Wichita Falls Division Office of Parole
- Wichita County Adult Probation
- Serenity Foundation Treatment Services
- Star Connection
- Star Council
- Red River Hospital
- Outreach, Screening, Assessment, and Referral Agency (OSAR) in Abilene, Texas
- United Regional Healthcare Systems
- TDPRS (Child Protective Services)
- S and A Lab Services

Relevant Contracts

Helen Farabee Regional MHMR contracts with the Wood Group to provide hotline coverage. In an effort to meet DSHS hotline standards, Avail Solutions is now providing the AAS accredited screenings under a sub-contract with the Wood Group. The sub-contract will remain in effect until the terms of the original Wood Group contract lapses allowing the center to directly contract with Avail Solutions. The following excerpt from the current contract describes the terms of hotline coverage:

> 1.2 Services: Contractor shall provide Crisis Hot Line services to Helen Farabee Regional MHMR Centers’ consumers via Authority provided toll free phone number 24 hours per day, 7 days per week by a Qualified Mental Health Professional. At least one bilingual, credentialed, and trained QMHP will be available to respond to crisis and information calls at all times. QMHP will be clinically supervised by a Licensed Practitioner of the Healing Arts (LPHA). Copies of current Staff licenses, degrees, training, and other necessary information to show proof of meeting current DSHS requirements to be designated as a QMHP or LPHA will be provided on an annual basis. Calls will be answered within 5 rings.