Department of State Health Services
Community Mental Health
& Substance Abuse Services

FY 2006
Crisis Services Review Report

February 2006

DSHS MH & SA Quality Management Unit

FY 2006 Crisis Services Review Report

Executive Summary

The Department of State Health Services (DSHS) Community Mental Health and Substance Abuse Services Quality Management completed a review of crisis services on December 30, 2005. The purpose of the review was to identify opportunities for improvement in the crisis services response system and to provide information to the DSHS Crisis Services Redesign Committee which has been charged with developing an evidence-based model for effective crisis resolution services. This redesign is the next step of Resiliency and Disease Management, the department's major transformation of the community mental health service system.

Thirty two Local Mental Health Authorities (LMHAs) and ValueOptions, a behavioral health organization (BHO), were evaluated on the accessibility of their crisis services, the competency of their crisis service providers, availability of local community alternatives to hospitalization, and the crisis screening and assessment tools used.

The Crisis Services Review included surveys mailed to sheriff departments, police departments, and licensed hospitals throughout Texas to obtain information about their experience with coordination and delivery of crisis services by the LMHA/BHO; a desk review of LMHA/BHO crisis services documents including staff/provider training records; analysis of crisis services performance indicators; and onsite reviews of the LMHAs/BHO with the highest potential risk of poor performance.

Key Opportunities for Improvement:
Based on the findings of this review, the key opportunities for improvement are related to the following areas:

- Timeliness of crisis service provider response;
- Availability of community resources and crisis alternatives to hospitalization or incarceration;
- Training and competency determination for crisis service providers;
- Provision of ongoing intervention until the crisis is resolved or individuals are placed in a clinically appropriate environment;
- Appropriate 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.

Conclusion:
The outcomes for Texans in behavioral health crises are dependent on competent, well-trained staff, effective community collaboration and viable community based resources for crisis prevention and intervention. The current crisis services delivery system in Texas varies widely in how well it performs in all of these areas, sometimes resulting in negative outcomes for individuals, families and communities.

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Overview

The Department of State Health Services (DSHS) Community Mental Health and Substance Abuse Services Quality Management completed a review of crisis services for 32 Local Mental Health Authorities (LMHA) and ValueOptions, a behavioral health organization (BHO), on December 30, 2005. The purpose of the review was to identify opportunities for improvement in the crisis services response system. The department evaluated the quality and performance of crisis services response systems using the Texas Health and Safety Code Title 7, Section 534.060 and the FY 2006 Performance Contract Section 19.01, page GP -23. Each LMHA and BHO must have a crisis screening and response system in operation 24 hours a day, 365 days a year, that is available to consumers throughout the service delivery area.

The goal of this review is to provide information to the DSHS Crisis Services Redesign Committee that will develop an evidence-based statewide model for effective and efficient crisis resolution services. This redesign is in step with Resiliency and Disease Management, a legislatively mandated transformation of the mental health system. The key areas identified for review included accessibility of crisis services, competency of crisis service providers, available local community alternatives to hospitalization, and crisis screening and assessment tools that support clear and consistent documentation.

Seven LMHAs that were experiencing a significant impact to their mental health and substance abuse service delivery systems by Hurricane Katrina and/or Rita in the fall of 2005 were not required to submit desk review materials and were excluded from the onsite reviews portions of the Crisis Review. The exempted LMHAs were evaluated through the hospital and law enforcement surveys and performance indicator analysis.

Methodology and Data Collection

The Crisis Services Review included surveys of sheriff departments, police departments, and licensed hospitals; desk review of LMHA and BHO documents; analysis of crisis services performance indicators; and onsite reviews of LMHAs with the highest potential risk.

Community Survey Community surveys were sent to two distinct groups, law enforcement officials and hospital administrators. A total of sixteen hundred surveys were mailed to each Sheriff, Chief of Police, and licensed hospital across the state. Names and addresses for each department/facility were obtained from the Department of Public Safety and the DSHS Hospital Licensing Division. The surveys asked the respondent to evaluate the coordination and delivery of emergency psychiatric crisis services by the LMHA/BHO. Responses were entered into a database that was used to identify indicators for the crisis services performance assessment. A total of 258 out 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 survey respondents rated items such as their ability to reach the crisis hotline, the wait time for a mental health crisis evaluation, the LMHA staff's competency to resolve the crisis, and how the LMHA staff evaluate a person who appears intoxicated or under the influence of substances. Each survey also included a comment section for suggestions to improve the mental health crisis system in their community.

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Desk Review of Crisis Services LMHAs and the BHO were required to submit documentation for the desk review that included crisis service providers' training and competency records, description of emergency care services, examples of screening and crisis assessment tools, and a list of local community alternatives to hospitalization.

Training and competency standards require LMHAs/BHO to have a process to ensure that staff performing specialized services be competent prior to provision of services and periodically thereafter. Key training/competency areas that were scored as part of the desk review include performing screening and crisis interventions; understanding the nature of severe and persistent mental illness and serious emotional disturbance; cultural competency; use of telecommunication devices for the deaf and hard of hearing (TTD/TTY); use of the Uniform Assessment/Texas Recommended Assessment Guidelines (UA/TRAG); Texas Implementation of Medication Algorithms-Quick Inventory of Depressive Symptoms (TIMA-QIDS); and provision of services to individuals with Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD).

Examples of each LMHA's and BHO's screening and crisis assessment instruments were scored based on whether required documentation elements were included on the forms. It is important for assessment instruments to prompt clinicians for important information necessary to evaluate persons who may be at risk of harming themselves or others. Each LMHA/BHO's description of local community alternatives to hospitalization were tabulated to provide a statewide perspective of crisis resources.

Crisis Performance Assessment Key performance indicators reflecting potential risk were identified from the community survey database, client assignment and registration (CARE), and encounter data reports. The crisis performance assessment and explanation of the indicators can be found at the end of this report. Thirty-nine LMHAs were ranked based on their performance. Although the BHO's performance data was analyzed, it is not included in this performance assessment due to incompatible encounter data.

Onsite Focused Review of Crisis Services LMHAs/BHO with the highest potential risk based on the crisis services performance indicators and desk review results were selected for an onsite review of crisis services. Eight LMHA onsite reviews (25%) were completed from December 6th through 29th, 2005. Information was collected from interviews with the Director of Crisis Services, testing of hotline services after hours, follow-up of desk review findings, and medical record reviews of crisis contacts. At least 10% of the sample included review of any suicides that had been reported to DSHS for FY 2005.

Analysis and Trends

The following analysis and reporting of trends is provided to facilitate a better understanding of the current system structure and barriers that are encountered in the provision of crisis services.

Crisis Response and Intervention

Timely response by the LMHA crisis service providers was identified by hospital and law enforcement survey respondents and through the onsite reviews as a major problem.

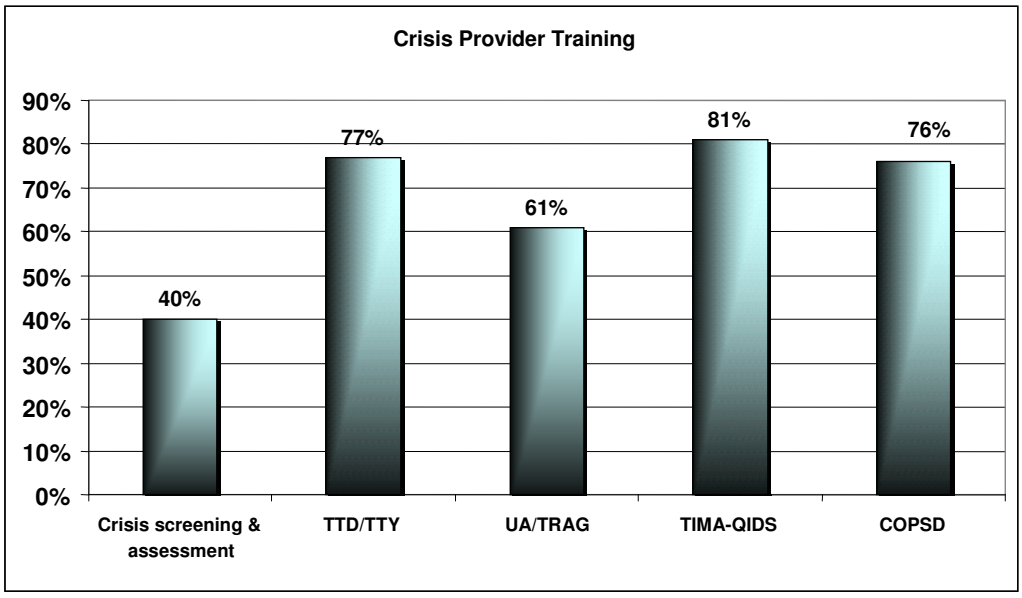
- The review of medical records of individuals who died by suicide did not evidence that there was a lack of crisis intervention services when the individual presented to the LMHA with suicidal ideation;

- 77% of law enforcement and 71% of hospital surveys indicate waits for LMHA/BHO crisis provider face to face assessment that exceed the one hour timeframe as required;
- 87.5% of the LMHAs reviewed onsite did not meet the requirement of conducting face-to-face assessments immediately, but no later than one hour;
- 74% of law enforcement and 62% of hospital surveys indicate the ability to reach the hotline 24 hours a day/7 days per week;
- 75% of the LMHAs reviewed onsite that were contracting with telephone answering services (non-credentialed employees) did not meet the requirement for immediate telephone contact with a qualified professional within 15 minutes;
- 50% of the LMHAs reviewed onsite provided ongoing intervention until the crisis was resolved or the person was placed in a clinically appropriate environment; and
- 37.5% of the onsite reviews indicated that arrangement for a physician's assessment within twenty four hours of the emergency care determination did not occur.

Staff Training and Competency

Law enforcement and hospital survey respondents rated LMHA/BHO crisis providers' competency to resolve crises. The law enforcement surveys indicated that 21% of the crisis providers were competent to resolve the crisis, while 50% rated the providers as sometimes competent to resolve the crisis and 24% rated the providers as not competent to resolve the crisis. Hospital surveys indicated that 20% of the crisis providers competently resolved crises, with 38% rating the providers as sometimes competent to resolve the crisis and 20% rating the providers as not competent to resolve crises.

The desk review found deficiencies in training and competency documentation for crisis service providers. The following graph demonstrates the number of crisis service providers that did not consistently evidence of training prior to contact with consumers.



- 40 % of the provider records did not evidence training in performing screening and crisis interventions;
- 77% of the provider records did not demonstrate training in use of telecommunication devices for the deaf and hard of hearing (TTD/TTY);
- 61% of the provider records did not evidence training in use of the Uniform Assessment/Texas Recommended Assessment Guidelines (UA/TRAG);
- 81% of the provider records did not evidence training in use of Texas Implementation of Medication Algorithms-Quick Inventory of Depressive Symptoms (TIMA-QIDS); and
- 76% of the provider records reviewed did not evidence training in provision of services to individuals with Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD).

Law enforcement and hospital respondents consistently reported that the use of "no harm" contracts with individuals in crisis is ineffective. Desk review material indicates 45% of LMHAs use "no harm" contracts to manage crises.

Co-occurring Psychiatric and Substance Use Disorders

Survey results and desk review materials indicate that LMHA crisis providers do not treat individuals in crisis who are intoxicated or under the influence of drugs or alcohol the same as individuals in crisis who are not intoxicated or under the influence of drugs or alcohol. Law enforcement and hospital respondents report that LMHA crisis assessments are delayed; in some areas of the state people are required to have a blood alcohol level of less than .08, or be medically cleared prior to an LMHA crisis assessment. Desk review materials also indicate varying local requirements before a crisis assessment will be completed for people experiencing a psychiatric crisis and with substance use issues.

Community Collaboration and Partnership

Law enforcement survey responses identified the need for increased communication and coordination efforts for improved problem resolution, and the need for more training and written procedures/agreements between LMHAs/BHO and law enforcement. Development of local community crisis diversion alternatives to reduce the long distance travel time and expense for law enforcement to transport individuals for hospital commitments were also recommended.

There is a wide disparity in the types and quantity of community resources identified by LMHAs as alternatives to hospitalization. In many cases the LMHAs did not fully describe or define the services that they submitted in their desk review materials.

The following graph is a representation of the types of community resources that are available throughout the state as reported by the LMHAs.

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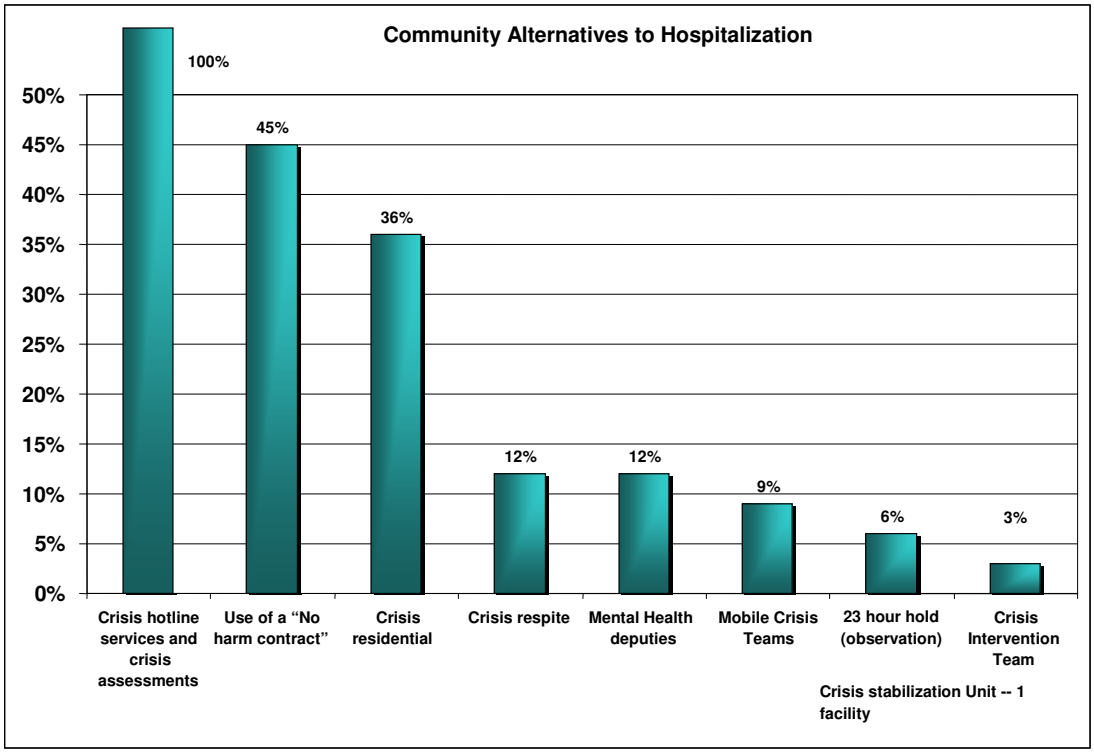
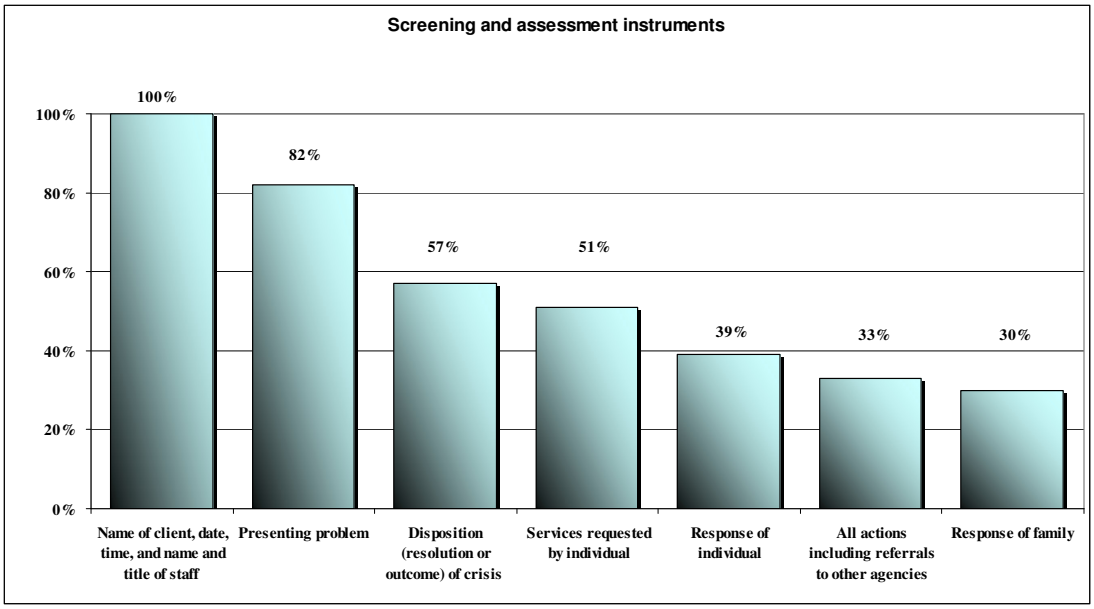


LMHA Oversight and Improvement

Onsite reviews found 6 of the 8 LMHAs do not have a formal oversight system to monitor emergency care service delivery by their providers and timeliness of crisis service provision.

Crisis screening and assessment instruments were evaluated to determine if DSHS' required documentation elements needed to collect critical clinical information to evaluate individuals who may be at risk of harming themselves or others were present on the forms. It is significant that 67% percent of LMHAs included an additional suicide assessment or risk of harm measures from the Uniform Assessment as part of their crisis screening and assessment tools to evaluate suicide risk.

The following graph illustrates the overall compliance by the LMHAs with DSHS' required documentation elements for crisis services.



- 100% of the crisis forms prompted documentation of the name of client, date, time, and name and title of staff;
- 82% of the crisis forms included the presenting problem;
- 57% of the crisis forms addressed the disposition (resolution or outcome) of crisis;
- 51% of the crisis forms included services requested by individual;
- 39 % of the crisis forms prompted inclusion of the response of individual;
- 33 % of the crisis forms addressed all actions including referrals to other agencies;
- 30% of the crisis forms included the response of family.

Based on the evaluation of the crisis documentation requirements, there is a need for LMHA oversight to ensure complete documentation. Twenty-five percent of the onsite reviews found inadequate documentation (resolution) of the crisis including all efforts to ensure the person's safety. Some Centers use the documentation element "presenting problem" to identify the mental disorder or program such as mental health, mental retardation, or early childhood intervention. Presenting problem should specify the current event or circumstances which brought the person in for a crisis assessment as presented by the client and/or collateral informant. Individual and family or significant other response should describe how the person and their family reacted and behaved as a result of the crisis intervention. The provider should document all actions used to address the problems and the dates and time of such actions.

Conclusions

There is a great deal of variation in the mental health crisis services delivery system across Texas and availability of crisis diversion alternatives. Limited community coordination and communication contribute to ineffective management of individuals in mental health crises and inefficient use of local community resources including emergency room, law enforcement and jail resources.

A comprehensive system of mental health crisis services will reduce the need for more restrictive and expensive levels of care, use of overtaxed emergency room facilities and unnecessary incarceration.

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The after business hours practice of using hospital emergency rooms to evaluate psychiatric emergency crises appears to be a practical and safe environment for many communities, but alternatives must be found when a hospital is not accessible or the crisis service needs are ongoing. This is particularly a problem in rural areas where a local clinic or hospital is several hours away.

Recommendations

- Revision by DSHS of the Mental Health Community Services Standards to strengthen timeframe requirements for emergency care services, requirements for crisis provider training and competency, and oversight of crisis resolution services and staff.
- Establish LMHA/BHO oversight mechanisms to monitor provider emergency care response times, monitor provider training and competency and outcomes of crisis service interventions.
- Identify best practices and develop technical assistance for communities to address the community's need for mental health and substance abuse training, coordination and communication among mental health crisis stakeholders (individuals, and families, law enforcement, hospitals, and judiciary).
- Standardize screening and crisis assessments.
- Provide clear guidelines for response and evaluation of individuals in crisis under the influence of alcohol and/or drugs and integrate and expand community resources for these individuals.
- Develop and implement guidelines for the use of "no harm" contracts.
- Define parameters when medical clearance is and is not required.
- Improve use of community resources; e.g., law enforcement detained for several hours waiting in the hospital emergency room or transporting individuals long distances for assessment or hospitalization.

Quality Improvement and Follow-up

DSHS has organized a Crisis Services Redesign Committee to develop a comprehensive array of specific services to best meet the needs of Texans who are having a mental health and/or substance abuse crisis. The committee will gather and analyze information from mental health literature, medical experts, and members of the public and staff. Four public hearings are being conducted around the state during February 2006 to gain an understanding of the best practices as well as problems associated with the current crisis services delivery system. The public hearings are being conducted in an urban location (San Antonio), rural location (Big Spring), and border (Harlingen) location. A statewide hearing is being conducted in Austin. The Crisis Services Redesign Committee will reconvene in Austin in March 2006 to present findings and conclusions from the public hearings and their research on evidence-based practices.

The Quality Management Unit of DSHS, Community Mental Health and Substance Abuse Services will continue to monitor plans of improvement from the eight focused onsite reviews. The findings from the focused desk reviews and the crisis services performance assessment will be shared with each LMHA/BHO to promote continuous quality improvement efforts at each organization. In addition, the LMHAs effected by the hurricanes, that had potential risk based on analysis of surveys and performance indicators, will be requested to submit to DSHS a plan to identify the causes of the variations and plans to improve their services.

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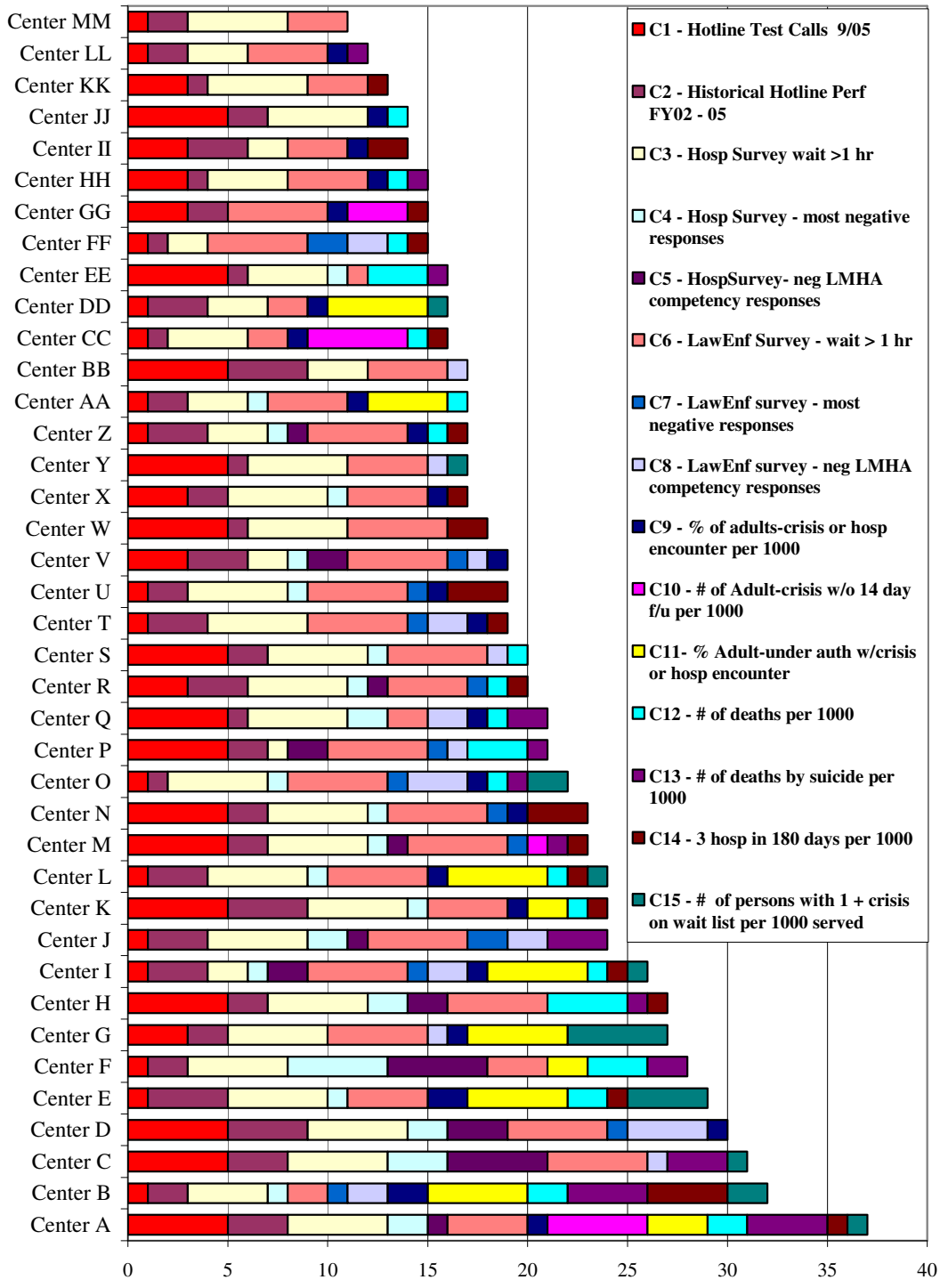
DSHS MH Crisis Services Performance Assessment



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Crisis Services Performance Assessment Indicators

C1 **Results of Hotline Test Calls for 9/2005**

Compliance ranking with 3 being high risk (non-compliant - no answer, answering machine, no 24/7 crisis response coverage, recorded message when all screeners busy, etc.) and 1 being low risk (compliant - hotline response acceptable)

C2 **Ranking on Crisis Survey Risk for FY2002-2005**

Risk was assigned to centers with multiple generation findings, with 5 being high risk and 1 being low risk

C3 **Hospital Surveys – % with more than one hour for face-to-face assessment**

% of hospitals surveyed that indicate wait time of over one hour for face-to-face assessment. (Calculated as # of survey responses with wait times over one hour divided by # of surveys returned.)

C4 **Hospital Surveys- most negative responses**

% of surveyed hospitals with negative responses. (Calculated as # of negative survey responses divided by number of survey responses.)

C5 **Hospital Surveys – # reporting LMHA staff not competent**

% of hospitals surveyed that indicate crisis events not competently resolved. (Calculated as # of survey responses reporting crisis events not competently resolved, divided by # of survey returned.)

C6 **Law Enforcement Surveys – # with more than one hour for face-to-face assessment**

% of law enforcement surveys that indicate wait time of over one hour for face-to-face assessment. (Calculated as # of survey responses with wait times over one hour divided by # of survey returned.)

C7 **Law Enforcement Surveys – most negative responses**

% of law enforcement surveys with negative responses. (Calculated as # of negative survey responses divided by total number of survey responses.)

C8 **Law Enforcement Surveys – # reporting LMHA staff not competent**

% of law enforcement surveys that indicate crisis events not competently resolved. (Calculated as # of survey responses reporting crisis events not competently resolved divided by # of survey returned.)

C9 **% of Adult Crisis or Hospitalization Encounters per 1000 MH consumers served** [FY2005 4th Quarter]

C10 **# Crisis encounters with no follow-up encounters within the next two weeks per 1000 MH consumers served** [FY2005 3rd & 4th Quarter]

(Calculated as # of crisis encounters without an encounter for follow-up services within two weeks of the crisis encounter)

C11 **% of persons under-authorized for a benefit package with a Crisis or Hospital Service encounter**

% of persons under-authorized for an RDM service package who also have at least one Crisis or Hospital Service encounter while under-authorized (i.e., # of persons under-authorized in a SP who receive at least one Crisis or Hospital encounter divided by the total # of persons under-authorized for a RDM SP)

C12 **# of deaths per 1000 MH consumers served** [FY2005]

C13 **# of deaths by suicide per 1000 MH consumers served** [FY2005]

C14 **# of persons with 3 or more hospitalizations in 180 days per 1000 MH consumers served** [with last admit in FY2005]

C15 **# of persons with one or more crisis encounters while on the Waiting List per 1000 MH consumers served** [FY2005]