Dallas County Behavioral Health Leadership Team
Thursday, September 14, 2017
Henry Wade Juvenile Justice Center
2600 Lone Star Drive, Dallas, TX
Room 203-A at 9:30am -11:00am.

I. Welcome and Call to Order

II. Review/ Approval of Minutes from last meeting*
- Minutes August 10, 2017*

III. Presentations
- **1115 Waiver Update**
  Christine Mintner, V.P. and Anchor - Parkland Health & Hospital System
- **Delivery System Reform Incentive Payment**
  Shannon Winburn and Megan Wylder - Green Oaks Hospital
- **The Economics of the Evolving System**
  Tom Collins, CEO - Medical City Green Oaks Hospital

IV. Strategic Planning
- PEER Groups

V. NTBHA Update

VI. The Stepping Up/ Caruth SMART Justice Initiative Update

VII. Dallas County Behavioral Health Housing Workgroup

VIII. 1115 Waiver Crisis Services Project Update

IX. Legislative Update

X. Funding Opportunities
- SAMSHA Residential Treatment Grant Update
- Community Courts Grant Update (Public Defender's Office)

XI. Upcoming Events and Notifications
- Saturday, September 16, 2017, Rally for Recovery hosted by APAA and UNT
- Wednesday, September 27, 2017, Free Symposium on Assisted Outpatient Treatment, hosted by NAMI Texas
- Saturday, September 30, 2017, Free Mental Health Symposium hosted by St. Luke "Community" United Methodist Church

XII. Public Comments

XIII. Adjournment

* Indicates items requiring approval from Dallas County Behavioral Health Leadership Team

The following reports from BHLT Committees are included for your records: *ACOT, FACT, BHSC, Legislative Committee, PD Mental Health Stats*. Unless action is required, there will be no verbal updates from those committees.

Dallas County
Behavioral Health Leadership Team
Meeting Notes
Thursday, August 10, 2017

Welcome and Call to Order
The meeting was called to order by Commissioner John Wiley Price at 9:33 AM.

Introductions and Absent BHLT Members: Commissioner Price Opened up the floor for introductions from new attendees. In attendance was Annie Lord, City Square and Dan Corles, Lake Regional. Judge Wade requested that Lee Pierson with the District Attorneys office be allowed to sit at the table to represent the DA's office in the absents of DA Faith Johnson.

Review/Approval of Minutes
The minutes of the BHLT meeting held on July 13, 2017 were included in the meeting packet. A motion was made by Gordon Hikel to accept the minutes and was seconded by Commissioner Theresa Daniel. The committee members voted to approve the minutes with no modifications. Commissioner Price presented resolution 06-2017, which recommended that Dallas Behavioral Health would be added as a residential facility hospital.The resolution also recommended adding James Miller as the representative for Timberlawn and Patrick LeBlanc as the representative for Child and Family Advocate as voting members of BHLT. The resolution also included the removal of Value Options as payers/funders of the Behavioral Health Leadership Team. The committee members approved the resolution with the additions and changes to be made with a motion made by Commissioner Daniel and seconded by Mr. Hikel.

Presentation
Joe Powell, President of Association of Persons Affected by Addiction (APAA), made a presentation on the APPA program. APAA is a program about the nature of addiction/mental health recovery and provides recovery support services (RSS) to individuals, families and the recovering community. APAA started back in 1998 which made it one of the first 20 SAMSHA/CSAT/RCSP recovery community support projects grantees in the U.S. APAA became involved in the BHLT initiative in 2011. In 2016 Commissioner Daniel attended the Big Texas Rally for Recovery which was hosted by APAA and had 4,000 individuals in attendance. Meadows Mental Health Policy Institute (MMHPI) has used Value Options supplied data to estimate the effectiveness of peer support services in reducing inpatient hospitalizations. Data tracked 1,103 individuals received APAA peer-support services between October 2015 and January 2016. The reduction in inpatient days and inpatient hospitalization admissions represents an estimated four million dollars in total savings from avoided inpatient bed-day cost. Over 11,500 participants received RSS between May 14 and February 17. Over 42,000 hours of recovery support were provided. Recovery Coaches engaged 1,265 individuals in long-term (minimum 12 months) one on one recovery coaching. As of February, 2017 2,199 individuals had engaged in long term recovery. Mr. Powell went over a few of the APAA spreading recovery oriented communities of care opportunities (example, the Mayor and City Council recovery education, integrated recovery model with the HOGG Foundation and Dr. Ken Minkoff, ROSC Coordinator for the South Dallas area (75215), current trainers for Texas targeted OPIOID response and SAMSHA MARS facilitator). Some of the APAA recovery opportunities are Texas Certification Board for Addiction Professionals (TCBAP) (PEER Committee), Managed Care Organizations (MCO), and MAT to MARS they use trainers to spread Opioid recovery response and these are Substance Abuse and Mental Health Services Administration (SAMSHA) trained facilitators. Peer recovery coaches work in a range of settings, including recovery community centers, recovery residences, drug courts, jails, prisions, hospital emergency departments, ministries, child welfare agencies, homeless shelters, treatment centers, behavioral healthcare agencies, and primary care settings. In the APAA recovery community, they have several areas that are covered: groups/workshops, drug court, STAC, Divert court, re-entry, community courts. Other APAA Recoveries include peer navigators, educational trainings, 12-step fellowship and social engagement and

activation. Mr. Powell stated that as a whole, the current body of research suggests that people receiving peer recovery support experience: decreased criminal justice involvement, decreased emergency service utilization, reduced relapse rates, reduced re-hospitalization, reduced substance use, decreased costs to hospitals and mental health systems. APAA services are effective for recovery oriented systems of care with increased patient/peer empowerment and hope, increased social functioning, increased engagement and activation in treatment, increased community engagement, and increased quality of life and life satisfaction. Jane Metzinger requested that HB1486 be used to allow more participation from individuals around the state. HB 1486 which was signed into law on June 15, 2017, is an act relating to peer specialists, peer services, and the provision of those services under the medical assistance program. ftp://ftp.legis.state.tx.us/bills/85R/billtext/html/house_bills/HB01400_HB01499/HB01486H.htm

Strategic Planning:
Commissioner Daniel Stated that the presentation by Mr. Powell was related to the lack of communication targeted in the strategic plan. BHLT will continue to have updates from individuals and providers regarding performance improvements. Mr. Powell requested the committee reestablish the BHLT PEER Group. Commissioner Price informed him we would add it to the September Agenda.

NTBHA Updates:
Carol Lucky, informed the committee that the North Texas Behavioral Health Authority (NTBHA) is currently in the contracting process with the state and their providers. NTBHA received their state Mental Health contract which was an amendment to last years contract. HHSC is currently behind on getting their new contracts finished. NTBHA does not currently know what the new outcome measures will be;however, they know that they will change. NTBHA also has not received the 8.1 million promised by the legislature; however, they have been informed that they should receive it when the new contract is completed. NTBHA continues to wait on the Substance Abuse contracts and has extended the contracts for 3 months to all outpatient providers. NTBHA is in the RFP process with hospitalization and have requested alternate proposals. The intent is to buy capacity where NTBHA owns the bed. Ms. Lucky stated that NTBHA needs to do more community planning and extend the contracts for an additional 3 months and work with the community on how they want to handle the process for psychiatric emergency beds. NTBHA currently receives 5.5 million dollars for private psychiatric (inpatient) beds/chairs at Green Oaks and are currently spending 7 million. NTBHA has a concern because 77% of the patients do not receive a follow-up with outpatient services. Ms. Lucky stated we see we have a break in our recovery system so we need to do a system readjust to determine how we get these clients connected and stabilized in the community as well as improve discharge planning. NTBHA needs to have all the players who are impacted by the system sit down and decide what they can do to move forward on this issue. Commissioner Price, Ms. McNaughten and Mr. Collins had some additional discussions on the 77% that do not have follow-up encounters and continuum of care.

Stepping Up Initiative Update/Caruth Grant:
Dr. Jaqcualene Stephens, with Meadows Mental Health Policy Institute (MMHPI) gave a short update and stated that MMHPI is currently working on the ACT and FACT teams which have been identified and trained. The ACT and FACT initiative should start in September (Fall). Dr. Stephens also announced and invited the members to attend their Annual Engage & Excel Conference that will be held in Austin, Texas on September 20-22, 2017.

Behavioral Health Housing Work Group (BHHWG) Update:
Commissioner Daniel stated that Homeless Management Information System (HMIS) continues to run smoothly with the data collection. The HMIS is prioritized according to HUD guidelines but has the ability to filter prioritization using specific indicators such as jail and homelessness, the target population of the BHHWG. Also the BHHWG reported that Atlantic Housing Foundation awarded $525,000 dollars in scholarships to students from low-income backgrounds for college and vocational programs. Commissioner Price acknowledged that the Dallas Housing Authority (DHA) had also awarded $1.5 million dollars in scholarships to students.

1115 Waiver Crisis Services Project (CSP) Update:
Mrs. Charlene Randolph, Manager of the 1115 Project, stated that project metrics had been included in the packet (page 10-18). Mrs. Randolph also confirmed that Christina Mintner, Vice President and Anchor for the 1115 Waiver would attend the September BHLT meeting to give an update on the Project. CSP is currently working with Dallas County Health Human Services (HHS), to develop a plan for their projects if the 1115 Waiver Project is extended.

Legislative Update:
Janie Metzinger stated there has been no action taken on the two House Bills passed since August 1, 2017. Mrs. Metzinger said that she has received complaints about the lack of responsiveness from the Managed Care Organizations, to providers. At the next Coalition On Mental Illness (COMI) meeting they will be having a providers only listening session. COMI would like to know where the patterns are, so they can talk to HHSC, Legislators and MCO's about what improvements they would like to see made. NAMI will also be holding a listening session for consumers and family members about how difficult it is to find providers.

Funding Opportunities:

- **SAMSHA Grant Update**:

Laura Edmonds with the Criminal Justice Department stated that the numbers were located in the packet. The program goal is to send as many clients involved in the Specialty Courts to Nexus. The program has reached its yearly targeted goal of 36 people and so far this year they have provided sevice to 43 women.

- **Community Courts Grant Update (Public Defender's Office):**

Chief Public Defender Lynn Richardson reported that the Community Court is operating well and following best practices. Chief Richardson recognized Michaela Himes with the Public Defenders office who represents clients at the South Dallas Drug Courts.

Upcoming Events and Notifications:
Sam Bates, NAMISSD announced a free Mental Health Symposium on September 30, at St. Luke "Community" United Methodist Church. Joe Powell, announced the Rally for Recovery which will take place September 16, 2017. Sherry Cusumano also informed the team that NAMI Texas is sponsoring a free symposium on assisted outpatient treatment, September 27. Charlene Stark announced Emmit Smith would be the Keynote speaker at luncheon, Meal for the Minds, benefiting Metrocare. Judge Wade acknowledged Joyce White for the Housing training that was held on July 21st. Ms. Randolph informed the team that another training would be held at Frank Crowley in the Jury Room on Aug 25, 2017. Commissioner Daniel stated that Dallas County was one of 14 counties selected to go to Maryland to participate in a Data Driven Justice Institute in September.

Adjournment:
The meeting was adjourned at 11:04 am with a motion made by Commissioner Daniel and seconded by Mr. Hikel.

<table>
<tr><th>RHP Plan Update</th><th colspan="4">DY7-8 (October 1, 2017 - September 30, 2019)</th></tr>
<tr><td>DSRIP Funding Distribution</td><td colspan="2">DY7</td><td colspan="2">DY8</td></tr>
<tr><td rowspan="2">20% RHP Plan Update Submission in DY7</td><td>0% Category A</td><td>55 or 65% Category C</td><td>0% Category A</td><td>75 or 85% Category C</td></tr>
<tr><td>10% Category B</td><td>15 or 5% Category D</td><td>10% Category B</td><td>15 or 5% Category D</td></tr>
<tr><td colspan="5">Category A - Required reporting to be eligible for payment of Categories B-D.</td></tr>
<tr><td rowspan="2">Describe transition from DY2-6 to DY7-8 activities including new activities</td><td colspan="4">DY7 - reported during DY7 Round 2
DY8 - reported during DY8 Round 2</td></tr>
<tr><td colspan="4">• Core Activities - Report on progress and updates to Core Activities
• Alternative Payment Methodology (APM) - Report on progress toward or implementation of APM arrangements
• Costs and Savings - For Performing Providers with ≥$1M total valuation, submit costs of at least one Core Activity and forecasted/generated savings
• Collaborative Activities - Attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting</td></tr>
<tr><td colspan="5">Category B - Medicaid and Low-Income or Uninsured (MLIU) Patient Population by Provider (PPP)</td></tr>
<tr><td rowspan="2">Submit DY5 and DY6 total number of individuals and MLIU individuals served by the Performing Provider system to establish baseline and DY7-8 MLIU PPP goal.</td><td colspan="4">DY7 - reported during DY7 Round 2 or DY8 Round 1 (no carryforward of achievement, only delayed reporting date)
DY8 - reported during DY8 Round 2 or DY9 Round 1 (no carryforward of achievement, only delayed reporting date)</td></tr>
<tr><td colspan="4">• Maintain or increase number of MLIU individuals served each DY within allowable variation based on Performing Provider size, type, and the MLIU percentage of Total PPP served in the baseline years.
• Report Total PPP each DY and explanation for any change in the ratio of MLIU PPP to Total PPP from the baseline
• Partial achievement available for MLIU PPP, paid at 100% (with allowable variation from goal), 90%, 75%, 50%, or 0% of milestone value</td></tr>
<tr><td>Category C - Measure Bundles</td><td></td><td colspan="2">DY7</td><td>DY8</td></tr>
<tr><td rowspan="4">Selection of Measures or Measure Bundles.

Hospitals and physician practices - must select Measure Bundles to meet or exceed the Minimum Point Threshold (MPT). HHSC assigns each hospital or physician practice a MPT based on:
• DY7 valuation/standard point valuation of $500,000; or
• MPT cap of 75; or
• Accounts for Medicaid and uninsured inpatient days and outpatient costs (hospitals only)</td><td>Measurement Period*</td><td colspan="2">P4P Baseline: Calendar Year (CY) 2017
P4P Performance Year (PY) 1: CY 2018
P4R Reporting Year (RY) 1: DY7</td><td>P4P PY2: CY 2019
P4P PY3: CY 2020
P4R RY2: DY8</td></tr>
<tr><td colspan="4">*A measure may be eligible for a shorter baseline measurement period ≥ 6 months or may be eligible for a delayed measurement period that ends no later than 9/30/2018. Measures with an approved delayed measurement period would not have a PY1 measurement period and PY2 will immediately follow the baseline measurement period.</td></tr>
<tr><td>P4P Measure**</td><td colspan="2">25% baseline reporting milestone - may be reported during DY7 Round 1 or DY7 Round 2
25% PY1 reporting milestone &
50% DY7 goal achievement milestone - may be reported during DY8 Round 1 or DY8 Round 2</td><td>25% PY2 reporting milestone &
75% DY8 goal achievement milestone - may be reported during DY9 Round 1 or DY9 Round 2; or PY3 during DY10 Round 1</td></tr>
<tr><td colspan="4">**Carryforward of achievement available so that DY7 goal achievement milestone may be achieved in PY1 or PY2 and DY8 goal achievement milestone may be achieved in PY2 or PY3. For measures with an approved delayed measurement period, DY7 goal achievement milestone may be achieved in PY2 only.</td></tr>
</table>

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<tr>
<td rowspan="8">• Each Measure Bundle includes required and optional measures.
• Hospitals and physician practices may adjust valuation among Measure Bundles within requirements.
• Each measure within a Measure Bundle is valued equally.

Community Mental Health Centers (CMHCs) and Local Health Departments (LHDs) - must select measures to meet or exceed the MPT. HHSC assigns each CMHC or LHD a MPT based on:
• DY7 valuation/standard point valuation of $500,000; or
• MPT cap of 40

• Select at least one standalone measure.
• All selected measures are valued equally but a CMHC or LHD may adjust valuation among measures within requirements.</td>
<td>P4R Measure</td>
<td>100% RY1 reporting milestone - may be reported during DY7 Round 2 or DY8 Round 1</td>
<td>100% RY2 reporting milestone - may be reported during DY8 Round 2 or DY9 Round 1</td>
</tr>
<tr>
<td>Goals - Quality Improvement System for Managed Care (QISMC)
Baseline below MPL</td>
<td>Minimum Performance Level (MPL)</td>
<td>10% gap closure between the MPL and High Performance Level (HPL)</td>
</tr>
<tr>
<td>Goals - QISMC
Baseline between MPL and HPL</td>
<td>The greater absolute value of improvement between: 10% gap closure towards HPL, or baseline plus (minus) 5% of the difference between the HPL and MPL, not to exceed the HPL</td>
<td>The greater absolute value of improvement between: 20% gap closure towards HPL, or baseline plus (minus) 10% of the difference between the HPL and MPL, not to exceed the HPL</td>
</tr>
<tr>
<td>Goals - QISMC
Baseline above HPL</td>
<td>HPL</td>
<td>HPL</td>
</tr>
<tr>
<td>Goals - Improvement over Self (IOS)</td>
<td>5% gap closure</td>
<td>10% gap closure</td>
</tr>
<tr>
<td colspan="3">Denominator population includes all individuals served by the Performing Provider system (facility, co-morbid condition, age, gender, and race/ethnicity subsets are not allowed unless specified in the Measure Bundle Protocol)</td>
</tr>
<tr>
<td colspan="3">• P4R and P4P measure reporting milestones - required reporting of All-Payer, Medicaid, and LIU payer types (with some exceptions to Medicaid-only or LIU-only payer type with good cause, e.g. data limitations)
• P4P measure goal achievement milestones - achievement of MLIU rate (with some exceptions to base achievement on all-payer, Medicaid-only, or LIU-only payment type with good cause, e.g. small denominator, data limitations)</td>
</tr>
<tr>
<td colspan="3">Partial achievement available for P4P goal achievement milestones, paid at 100%, 75%, 50%, 25%, or 0% of milestone value. Below are the calculations for measures with positive and negative directionality:
• DY7 achievement = (PY1 Achieved - Baseline)/(DY7 Goal - Baseline); (Baseline - PY1 Achieved)/(Baseline - DY7 Goal)
• Carryforward of DY7 achievement = (PY2 Achieved - Baseline)/(DY7 Goal - Baseline); (Baseline - PY2 Achieved)/(Baseline - DY7 Goal)
• DY8 achievement = (PY2 Achieved - Baseline)/(DY8 Goal - Baseline); (Baseline - PY2 Achieved)/(Baseline - DY8 Goal)
• Carryforward of DY8 achievement = (PY3 Achieved - Baseline)/(DY8 Goal - Baseline); (Baseline - PY3 Achieved)/(Baseline - DY8 Goal)</td>
</tr>
<tr>
<td colspan="4">Category D - Statewide Reporting Measure Bundle</td>
</tr>
<tr>
<td rowspan="2"></td>
<td colspan="3">DY7 - reported during DY7 Round 1 or 2, depending on the measure (no carryforward option)
DY8 - reported during DY8 Round 1 or 2, depending on the measure (no carryforward option)</td>
</tr>
<tr>
<td colspan="3">Report on the Statewide Reporting Measure Bundle according to Performing Provider type</td>
</tr>
</table>

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<tr>
<th>UC only Hospital Requirements</th>
<th>Private Hospital Participation Incentive</th>
<th>Plan Modifications</th>
</tr>
<tr>
<td>• Participate in 1 learning collaborative
• Report on mandatory Category D reporting domains</td>
<td>If a region maintains its private hospital participation in the RHP Plan Update, each Performing Provider in the region may shift 10% of their total valuation from Category C to Category D.
• A 3% decrease may be allowed in each region.</td>
<td>• Certain changes to Category C measures may be allowed prior to reporting a baseline.
• Changes to MLIU PPP and system definition due 90 days prior to the next reporting period.</td>
</tr>
</table>

DALLAS BHLT, PEER COMMITTEE OVERVIEW

Goal of Peer Committee:
To provide Peer Representation, Peer leadership and lived experience on the Dallas BHLT. Assist in providing a workforce that seats "recovery first" for a recovery oriented continuum of care. Ensure that Peer supports and services are non-clinical, evidence based, culturally competent, ethically supervised and safe for mental health and substance use recovery in Dallas County.

Peer Committee Chair – Joe Powell will provide a monthly report on the status of Peers engagement in Dallas County workforce, 2) provide peer connections and workforce opportunities for BHLT provider network 3) assist in the provision of Peer, professional education, supports and provide peer leadership to the Dallas BHLT.

A Peer Recovery Specialist is a trained individual who has lived experience with mental illness and/or addiction to alcohol and/or other drugs who provides one-to-one strengths-based support to peers in recovery. Peer Recovery Specialists work in a wide range of settings including community health and mental health centers, behavioral health programs, substance use treatment facilities, peer-run organizations, community-based organizations, emergency rooms, courts, homeless shelters and outreach programs. Sometimes, Peer Recovery Specialists are referred to as Peer Support Specialists.

- Guiding principles and aspects of recovery
- Roles and core values of peer recovery specialists
- Relationship building and communication skills
- Cultural competence in recovery support
- Boundaries and ethical issues in peer recovery support
- Trauma-informed approaches
- Recovery and wellness planning
- ROSC – Recovery Oriented System of Care Readiness
- First Responder
- Strength based practice

In 2015, SAMHSA led an effort to identify the critical knowledge, skills, and abilities (leading to Core Competencies) needed by anyone who provides peer support services to people with or in recovery from a mental health or substance use condition.
SAMHSA—via its Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) project—convened diverse stakeholders from the mental health consumer and substance use disorder recovery movements to achieve this goal.
SAMHSA in conjunction with subject matter experts conducted research to identify Core Competencies for peer workers in behavioral health. SAMHSA later posted the draft competencies developed with these stakeholders online for comment. This additional input helped refine the Core Competencies and this document represents the final product of that process. As our understanding of peer support grows and the

contexts in which peer recovery support services are provided evolve, the Core Competencies must evolve over time. Therefore, updates to these competencies may occur periodically in the future.
Core Competencies are intended to apply to all forms of peer support provided to people living with or in recovery from mental health and/or substance use conditions and delivered by or to adults, young adults, family members and youth. The competencies may also apply to other forms of peer support provided by other roles known as peer specialists, recovery coaches, parent support providers or youth specialists. These are not a complete set of competencies for every context in which peer workers provide services and support. They can serve as the foundation upon which additional competencies for specific settings that practice peer support and/or for specific groups could be developed in the future. For example, it may be helpful to identify additional competencies beyond those identified here that may be required to provide peer support services in specific settings such as clinical, school, or correctional settings. Similarly, there may be a need to identify additional Core Competencies needed to provide peer support services to specific groups, such as families, veterans, people in medication-assisted recovery from an SUD, senior citizens, or members of specific ethnic, racial, or gender-orientation groups.

BACKGROUND

What is a peer worker?

The role of the peer support worker has been defined as "offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations." Peer support has been described as "a system of giving and receiving help" based on key principles that include "shared responsibility, and mutual agreement of what is helpful."[1]
Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.[2]

1 Mead, S., Hilton, D. & Curtis, L. (2001). Peer support: A theoretical perspective. Psychiatric Rehabilitation Journal, 25(2), 134-141.
2 Jacobson, N. et.al. (2012). What do peer support workers do? A job description. BMC Health Services Research. 12:205

As mentioned previously, the development of additional Core Competencies may be needed to guide the provision of peer support services to specific groups who also share common experiences such as family members. The shared experience of being in recovery from a mental or substance use disorder or being a family member of a person with a behavioral health condition is the foundation on which the peer recovery support relationship is built in the behavioral health arena.

What is recovery?

SAMHSA developed the following working definition of recovery by engaging key stakeholders in the mental health consumer and substance use disorder recovery communities:
Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.[3] Throughout the competencies, the term "recovery" refers to this definition. This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. According the SAMHSA Working Definition of Recovery, recovery can have many pathways that may include "professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches." SAMHSA has identified four major dimensions that support a life in recovery:

1. Health—Learning to overcome, manage or more successfully live with the symptoms and making healthy choices that support one's physical and emotional wellbeing;
2. Home—A stable and safe place to live;
3. Purpose—Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; and,

increased ability to lead a self-directed life; and meaningful engagement in society; and
4. Community—Relationships and social networks that provide support, friendship, love, and hope
Peer workers help people in all of these domains.

What are Core Competencies?

Core Competencies are the capacity to easily perform a role or function. They are often described as clusters of the knowledge, skills, and attitudes a person needs to have in order to successfully perform a role or job or as the ability to integrate the necessary knowledge, skills, and attitudes. Training, mentoring, and supervision can help people develop the competencies needed to perform a role or job.[4 5] This will be the first integrated guidance on competencies for peer workers with mental health and substance use lived experience.

Why do we need to identify Core Competencies for peer workers?

Peer workers and peer recovery support services have become increasingly central to people's efforts to live with or recover from mental health and substance use disorders. Community-based organizations led by people who have lived experience of mental health conditions and/or who are in recovery from substance use disorders are playing a growing role in helping people find recovery in the community. Both the mental health consumer and the substance use disorder recovery communities have recognized the need for Core Competencies and both communities actively participated in the development of these peer recovery support worker competencies.

Potential Uses of Core Competencies

Core Competencies have the potential to guide delivery and promote best practices in peer support. They can be used to inform peer training programs, assist in developing standards for certification, and inform job descriptions. Supervisors will be able to use competencies to appraise peer workers' job performance and peers will be able to assess their own work performance and set goals for continued development of these competencies.

3 Substance Abuse and Mental Health Services Administration. SAMHSA's Working Definition of Recovery. PEP12-RECDEF, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012.
4 Henandez, R.S., O'Connor, S.J. (2010). Strategic Human Resources Management in Health Services Organizations. Third Edition. Delmar Cengage Learning. P. 83.
5 Sperry, L. (2010). Core Competencies in Counseling and Psychotherapy: Becoming a Highly Competent and Effective Therapist. Routledge. P. 5.

Core Competencies are not intended to create a barrier for people wishing to enter the peer workforce. Rather they are intended to provide guidance for the development of initial and on-going training designed to support peer workers' entry into this important work and continued skill development.

Core Competencies, Principles and Values

Core Competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

RECOVERY-ORIENTED: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
PERSON-CENTERED: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.
VOLUNTARY: Peer workers are partners or consultants to those they serve. They do not dictate the types of

services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
RELATIONSHIP-FOCUSED: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
TRAUMA-INFORMED: Peer recovery support utilizes a strengths-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Dallas BHLT Peer Committee Chair
Joe Powell LCDC, PRSS
President/CEO
APAA – Association of Persons Affected by Addiction

Dallas County Behavioral Health Housing Work Group
Dallas County Administration, 411 Elm Street, 1st Floor, Dallas Texas 75202
August 23, 2017 Minutes

Mission Statement: The Dallas County BH Housing Work Group, with diverse representation, will formulate recommendations on the creation of housing and housing related support services designed to safely divert members of special populations in crisis away from frequent utilization of expensive and sometimes unnecessary inpatient stays, emergency department visits and incarceration.

Success will be measured in placement of consumers in housing and the decreased utilization of higher levels of care (hospitals and emergency care visits) and reduced incarceration in the Dallas County Jail. The Dallas County BH Housing Work Group is committed to a data driven decision-making process with a focus on data supported outcomes.

ATTENDEES: Dr. Theresa Daniel, Commissioner; Courtney Clemmons, NTBHA; Bill Turner, Outlast Youth; Blake Fetterman, Salvation Army; Amy Gill, VOA TX; Zachary Thompson, DCHHS; Thomas Lewis, DCHHS; Atoya Mason, VA; James McClinton, MDHA; Shenna Oriabure, CJ; Sandy Rollins, Texas Tenants Union; Kendall Scudder, Atlantic Housing Foundation; Charletra Sharp, City of Dallas; Dr. Jacqualene Stephens, MMHPI; Ron Stretcher, MMHPI; Dr. David Woody, The Bridge; Joyce White, Transicare; Brianne Brass, CJ; Sibi Powers, NTBHA; David Woodyard, Catholic Charities; Jacky Sylvie, CPSH; Annie Lord, CitySquare; Deanna Adams, City of Dallas; Claudia Vargas, Dallas County; Walter Taylor, Dallas County; Cimajie Best, Dallas County; and Terry Gipson, Dallas County

CALL TO ORDER: Minutes approved with no change.

GOVERNANCE

Dallas Area Partnership to End and Prevent Homelessness: The City of Dallas has had significant staffing changes since the new City Manager took office. New city staff is being briefed on the partnership and the plans to move forward.

Legislative Environment: The state changed the distribution of Healthy Communities Collaborative Grant funding which primarily went to large urban areas with homeless centers. A large portion of funds will be allocated to rural collaborative efforts of 2 or more counties. Larger urban areas have to find ways to supplement reduced funding.

PRESENTATIONS

Homeless Youth Count: "Count Me In Dallas 2018" is a collaborative effort between Outlast Youth and the MDHA Youth Committee to count homeless youth. The count is modeled after a successful approach is Austin, Texas and will take place over a 2-week period: January 18-20 and January 25-27. Homeless youth don't readily identify as being homeless and are more difficult to find because they typically stay with friends or family. Dallas ISD will assist with identifying homeless youth. Currently, not much data exists on homeless youth so it is unclear exactly what resources are needed to assist this population. "Count Me In Dallas 2018" is recruiting volunteers and will begin training sessions in October 2017 through January 2018.

DEVELOPMENT

Crisis Residential and Respite Services: Salvation Army and NTBHA are partnering on a pilot program for respite beds for individuals leaving psychiatric emergency rooms. Agency staff will visit the medical respite beds program at the Fort Worth Salvation Army. Additionally, NTBHA reached out to Austin Street Shelter to include them in the pilot program. Both Salvation Army and Austin Street will start with four beds and the pilot is scheduled to begin as soon as contracts are finalized.

TDHCA 2016 Housing and Services Partnership Academy: James McClinton reported that the housing services partnership team held a final technical assistance event focused on housing landlord engagement, nationally and locally, and community partnerships. Plans to continue the academy have not been announced. Event participants learned tangible strategies to put into practice such as how to build their housing teams. The housing services partnership team successfully engaged with a local builder to set aside 10 beds that were filled. New opportunities with other builders are being cultivated.

RESOURCES

Shelter Discussions: The Shelter Collaborative has an upcoming meeting to review the inclement weather policy, identify ways to streamline general shelter policies, and how to improve upon the HMIS user experience. NTBHA plans to attend the upcoming meeting to share ongoing efforts and new developments. Local shelters will review a report provided by Family Gateway that reveals a greater demand for family housing than is available. Shelters are discussing ways to accommodate more families without displacing individuals and ways to maximize available resources. BHHWG members are interested is hearing more about Family Gateway's coordinated access efforts as well as current counts of sheltered and unsheltered individuals.

NTBHA: The following updates were reported:

- Extra PSH funding will be spent by the August 31st deadline.
- Some contracts were received from the state. Still waiting on a few more, including the contract for the additional 8 million dollars.
- Myrl Humphrey, NTBHA's Housing Specialist, and Joyce White, Transicare Housing Navigator, are working on waiver projects and helping outpatient providers understand PSH and how to use the housing toolkits. Ms. Humphrey is providing support to surrounding counties with their housing and homeless efforts.
- Extended most contracts for outpatient mental health and substance use providers and residential substance use providers.
- Submitted an RFP for inpatient psychiatric providers for set number of beds to be able to have better control of services provided to individuals and to contract with fewer hospitals. NTBHA's Board approved to move forward with contracts for RFP applicants. Sundance, Medical City at Green Oaks, and Dallas Behavioral hospitals will decide if they can each accommodate 10 beds. The extra capacity is crucial as NTBHA works to restructure its crisis respite system. Contracts will begin on September 1, 2017.
- Board voted to extend using Medical City at Green Oaks psychiatric services for extra 90 days to have time to evaluate crisis services and assess where inefficiencies and gaps in crisis services exist. Moving towards comprehensive high quality system of care and adopting best practices for a continuum of care and proactively addressing what drives individuals into crisis. Looking to establish crisis hubs to effectively triage people or to use as sobering centers. Moving towards a system that is recovery oriented and trauma informed and outcome based to make best use of state funds.
- Still searching for an existing service to partner with that has available space to lease. Long-term plans include the possibility of securing a facility. In the meantime, NTBHA will evaluate start-up costs and sustainability of services and potentially partnering with MCO's.

Housing Navigator: Housing resource training for DCCJ attorneys is scheduled for August 25th and will focus on helping them understand the housing process, resources available for their clients going through the criminal justice system, and how to better engage with their client. Attorneys will also learn about the differences between crisis and sustainable housing and how to identify where their client is on the housing spectrum.

HMIS testing for the DCCJ continues. Joyce White is working with MDHA to explore whether Continuum of Care (CoC) funding might be accessible to assist high utilizers from the jail population. MDHA is working on prioritizing high utilizers from the jail population into HMIS. Housing resource training for the general community will be scheduled at a later date.

Caruth Smart Justice: Efforts are focused on law enforcement diversion, expansion of screening assessment and PR bonds, and expanded ACT capacity in the community. Screening is going very well for the county. Law enforcement teams are working through policies and securing appropriate medical and law enforcement clearances. Connection meetings for expanded ACT teams took place and as a result three contracts were executed. Improved ACT teams will be prepared to take referrals from the jail.

MMHPI is working on how to best process CSJ efforts through coordinated access because it is a best practice. Some funding is available to help with housing assistance. It was initially discussed that it might be distributed through a

flexible funding account however the correct measures for a flexible funding account are not in place. Other alternatives to provide the housing assistance funds will be explored.

PROJECTS AND INDUSTRY UPDATES

Homeless Jail Dashboard: Overall jail population is going down but the homeless population is going up. A new set of high utilizers has been identified in the jail population.

The Cottages: There are a few vacancies and new clients are in the process of being vetted. A number of existing clients are engaging in services with Metrocare, CitySquare, and UT Southwestern. It is estimated that three quarters of the current residents are considered stable and thriving in 9 categories. Directors are meeting monthly to review policies and procedures, implementation, integration of programming, data collection, etc.

Catholic Charities: Closing on the facility is expected to take place when funding from DHA is released to the project. The second phase of space planning is in process. January 2018 opening is still expected to happen. About 48% of the facility is designed for common areas and delivery of services. Catholic Charities has moved to a new office location that has some available space to possibly expand for services or service providers. Catholic Charities will reach out to service providers who may benefit from the available space.

Updates:

- Commissioner Daniel announced that Dallas County was one of fourteen counties selected to participate in the DDJ initiative.
- Charletra Sharp reported that the City of Dallas has distributed notices of closure to Harwood and MLK encampment residents. More security measures will be in place for this encampment closure due to more violent nature of this group of encampment residents.

Next Meeting: Wednesday, September 27, 2017, at 10:00 am

Dallas County Administration Building, 411 Elm Street, 1st Floor, Allen Clemson Courtroom
If you need parking, please contact Claudia Vargas

Crisis Services Project- FY'17 Cash Flow Worksheet

	FY 2017	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	
CSP Expenses	**Budgeted**												**Total spent**
Adapt	1,282,428.00	108,973.83	0.00	104,843.34	129,012.44	148,899.96	106,054.21	102,040.16	90,800.87	112,941.00	128,135.98	201,740.43	1,233,442.22
Transicare	2,017,480.00	11,626.22	295,262.79	22,225.68	0.00	418,283.00	0.00	195,817.90	306,683.44	0.00	0.00	159,703.40	1,409,602.43
Harris Logic- 2nd year license	260,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Metrocare/ FDU (billed quarterly)	537,213.00	0.00	0.00	0.00	0.00	134,303.25	0.00	0.00	0.00	134,303.25	0.00	0.00	268,606.50
Cottages/ FDU	459,585.00	14,855.82	0.00	27,880.97	18,817.22	0.00	24,072.63	38,999.97	0.00	0.00	46,758.72	38,678.50	171,385.33
Value Options Care Coordinator	112,000.00	9,333.33	9,333.33	9,333.33	16,333.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	44,333.32
NTBHA Care Coordinator	82,000.00	0.00	0.00	0.00	0.00	0.00	12,147.66	6,985.00	13,200.00	0.00	6,600.00	6,600.00	45,532.66
Serial Inebriate Program (estimate)	150,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dallas County Salaries/ Benefits	300,000.00	9,522.33	19,044.62	26,528.78	13,921.17	13,171.18	15,615.96	16,838.38	18,956.45	28,278.21	18,852.13	15,155.73	195,884.94
Property less than $5,000		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Computer Hardware	10,000.00	0.00	0.00	0.00	0.00	295.20	0.00	0.00	0.00	0.00	0.00	0.00	295.20
Computer Software		0.00	0.00	590.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	590.40
Consulting Fee	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Training Supplies	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Business Travel/ Trainings	20,000.00	1,585.62	0.00	0.00	0.00	0.00	0.00	376.14	0.00	367.74	225.00	0.00	2,554.50
Bus Passes (5000 count)	15,000.00	0.00	0.00	3,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3,000.00
After-care Engagement Package	216,000.00	0.00	0.00	7,978.72	1,633.07	1,306.46	0.00	0.00	0.00	0.00	0.00	0.00	10,918.25
Speciality Court After-Care Engagement	224,000.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Army)	122,640.00	6,888.00	0.00	0.00	37,548.00	0.00	10,276.00	7,280.00	7,140.00	8,428.00	10,332.00	7,308.00	95,200.00
Transitional Housing- CSP (8 male beds at Salvation Army)	81,760.00	5,040.00	0.00	0.00	19,320.00	0.00	4,564.00	5,096.00	4,872.00	6,692.00	5,292.00	2,128.00	53,004.00
Housing Specialist (estimate)	65,000.00												
New Space Renovations/Office Supplies	20,000.00	0.00	0.00	0.00	0.00	20.52	0.00	0.00	0.00	0.00	0.00	730.96	751.48
SUBTOTAL	5,975,106.00	167,825.15	323,640.74	202,381.22	236,585.23	716,279.57	172,730.46	373,433.55	441,652.76	291,010.20	216,195.83	432,045.02	3,535,101.23

1115 Waiver DY7-8 valuation scenario

A. Total Available Funding **$6,302,327.02**

B. Category payment distribution

Category	Percentage		Valuation	
	DY7	DY8	DY7	DY8
RHP 9 Plan update	20%	NA	$1,260,465.40	NA
Category A: Core Activities, Cost Savings Pla	0%	0%	$0.00	$0.00
Category B: MLIU Patient Population by Provide	10%	10%	$630,232.70	$630,232.70
Category C: Measure Bundles and Measures	55%	75%	$3,466,279.86	$4,726,745.27
Category D: Statewide Reporting Measure Bund	15%	15%	$945,349.06	$945,349.05
	100%	100%	$6,302,327.02	$6,302,327.02

C. Category-C Valuation (Cat-C percentage: DCHHS = 30%, CJD = 70%)

Department	Measure ID	Points	DY7 Estimated VALUATION	DY8 Estimated VALUATION	Measure Title
DCHHS	L1-347	3	$945,349.08	$965,349.08	Latent Tuberculosis Infection (LTBI) treatment rate
DCHHS	TBD	1	$252,093.08	$376,139.61	TBD
CJD	**H3-257**	**1**	**$252,093.08**	**$376,139.61**	**Care Planning for Dual Diagnosis**
CJD	**M1-261**	**1**	**$252,093.08**	**$376,139.61**	**Assessment for Substance Abuse Problems of**
CJD	**M1-262**	**1**	**$252,093.08**	**$376,139.61**	**Assessment of Risk to Self/Others**
CJD	**M1-263**	**1**	**$252,093.08**	**$376,139.61**	**Assessment for Psychosocial Issues of Psychiatric Patients**
CJD	**M1-317**	**1**	**$252,093.08**	**$376,139.61**	**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling**
CJD	**M1-319**	**1**	**$252,093.08**	**$376,139.61**	**Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eMeasure)**
CJD	**M1-340**	**1**	**$252,093.08**	**$376,139.61**	**Substance use disorders: Related to patients with a diagnosis of current opioid addiction**
CJD	**M1-341**	**1**	**$252,093.08**	**$376,139.61**	**Substance use disorders: Related to patients with a diagnosis of current alcohol dependence**
CJD	**TBD**	**1**	**$252,093.08**	**$376,139.61**	**TBD**
	Units	**13**	**$3,466,279.88**	**$4,726,745.18**	

D. Total Expected Payment

Category	DY7		DY8	
	DCHHS	CJD	DCHHS	CJD
Plan Update: $1,260,465.40 x 30% = DCHHS, 70%	$378,139.62	$882,325.78	$0.00	$0.00
Category A	$0.00	$0.00	$0.00	$0.00
Category B	$189,069.81	$441,162.89	$189,069.81	$441,162.89
Category C	$1,039,883.96	$2,426,395.92	$1,418,023.55	$3,308,721.63
Category D	$283,604.72	$661,744.34	$283,604.72	$661,744.33
Total	**$1,890,698.11**	**$4,411,628.93**	**$1,890,698.08**	**$4,411,628.85**

Department of Criminal Justice
FY2017 SAMHSA Grant Project

	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sep.	FY2017 Total	FY2016 Total
Number of New Admissions	8	4	1	3	7	9	6	1	3	1	1		44	33
Number of Successful Completions	*3*	*6*	2	5	0	4	8	4	2	0	1		35	24
Number of Unsuccessful Completions	1	1	0	0	1	2	2	1	0	2	0		10	9
Average Days in Jail from Referral to Admission	5	6	3	4	6	9	10	6	8	12	7		7	4
Number of New Admissions on ELM	6	3	1	2	7	8	4	1	3	1	1		37	12
Program Referral Follow-Ups by Type (running total per grant year)														
Court Program Graduate													0	6
Active In Court Program													10	2
Active In Treatment at Nexus													2	N/A
In Jail													5	0
Re-Arrested and Released to Community													11	11
Re-Arrested and Released to Further Treatment													8	7
Released to TDCJ or State Jail													3	3
Active Warrant													10	4

	Past Year Avg	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Total Service Episodes:	768	704	717	551	694	900	1,191	959	846	806	776	**814.4**	**8,144**
Total Unique CID:	589	696	672	477	592	763	960	750	593	563	522	**658.8**	**6,588**
Total Unique SID:		695	671	474	591	762	958	748	593	563	520	**657.5**	**6,575**
% Change to DY 4 by CID		118.17%	114.09%	80.98%	100.51%	129.54%	162.99%	127.33%	100.68%	95.59%	88.62%		

Total Encounters by Type:		2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Triage		704	717	551	694	900	1,191	959	846	806	776	**814.4**	**8,144**
Care Coordination		2,736	2,532	2,304	2,626	2,588	2,943	2,239	2,330	2,689	2,225	**2,521.2**	**25,212**
F2F Encounter		242	255	252	211	237	292	301	361	403	344	**289.8**	**2,898**
Sum:		**3,682**	**3,504**	**3,107**	**3,531**	**3,725**	**4,426**	**3,499**	**3,537**	**3,898**	**3,345**	**3,625.4**	**36,254**

F2F Encounter		2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
MHPR Bond								77	163	154	141	**133.75**	**535**
Non-MHPR		242	255	252	211	237	292	224	198	249	203	**236.3**	**2,363**
Sum:		**242**	**255**	**252**	**211**	**237**	**292**	**301**	**361**	**403**	**344**	**289.8**	**2,898**

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Service Episodes:	704	717	551	694	900	1,191	959	846	806	776	**814.4**	**8,144**

Unique Consumers:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
By N* ID	602	597	423	500	530	626	529	460	445	372	**508.4**	**5,084**
By Client ID	94	75	54	92	233	334	221	133	118	150	**150.4**	**1,504**
TOTAL Unique Consumers:	**696**	**672**	**477**	**592**	**763**	**960**	**750**	**593**	**563**	**522**	**658.8**	**6,588**
TOTAL Unique Consumers as %:	**98.86%**	**93.72%**	**86.57%**	**85.30%**	**84.78%**	**80.60%**	**78.21%**	**70.09%**	**69.85%**	**67.27%**		

Unique F2F:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
By N* ID	185	186	165	117	111	154	179	208	228	176	**170.9**	**1,709**
By Client ID	40	37	30	35	66	75	63	80	69	75	**57**	**570**
TOTAL Unique F2F:	**225**	**223**	**195**	**152**	**177**	**229**	**242**	**288**	**297**	**251**	**207.18**	**2,279**
TOTAL Unique F2F as %:	**92.98%**	**87.45%**	**77.38%**	**72.04%**	**74.68%**	**78.42%**	**80.40%**	**79.78%**	**73.70%**	**72.97%**		

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	2017-08		Average:	Sum:
F2F Percentages:	34.38%	35.56%	45.74%	30.40%	26.33%	24.52%	31.39%	42.67%	50.00%	44.33%			**36.53%**	**365.32%**

Encounters by Type:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Triage	704	717	551	694	900	1,191	959	846	806	776	**814.4**	**8,144**
Care Coordination	2,736	2,532	2,304	2,626	2,588	2,943	2,239	2,330	2,689	2,225	**2,521.2**	**25,212**
F2F Encounter	242	255	252	211	237	292	301	361	403	344	**289.8**	**2,898**
TOTAL Encounters:	**3,682**	**3,504**	**3,107**	**3,531**	**3,725**	**4,426**	**3,499**	**3,537**	**3,898**	**3,345**	**3,625.4**	**36,254**

Female:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Black	99	98	86	69	110	117	96	99	94	84	**95.2**	**952**
Hispanic	17	29	17	24	33	34	29	29	26	21	**25.9**	**259**
Other			2	1	2	2	2	2			**1.83**	**11**
Unknown	1	1	2		1	1	2			1	**1.29**	**9**
White	63	51	46	46	58	86	83	64	52	53	**60.2**	**602**
TOTAL Female:	**180**	**179**	**153**	**140**	**204**	**240**	**212**	**194**	**172**	**159**	**183.3**	**1,833**

Male:	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07	Average:	Sum:
Black	285	286	188	258	325	371	286	228	234	217	**267.8**	**2,678**
Hispanic	71	57	44	51	85	146	110	52	59	48	**72.3**	**723**
Other	6	2	2	6	2	8	3	4	3	1	**3.7**	**37**
Unknown	3	9	3	9	2	5	3	3	2	2	**4.1**	**41**
White	133	123	85	126	141	187	134	111	90	94	**122.4**	**1,224**
TOTAL Male:	**498**	**477**	**322**	**450**	**555**	**717**	**536**	**398**	**388**	**362**	**470.3**	**4,703**

Recidivism Summary for 10/01/2016 to 07/31/2017

Recidivism [10012016-09302017] (CJ Hx 10012016 Forward)

Last Refresh: 8/21/17 at 3:52:26 PM GMT-05:00

Triage 12	6,563
Recidivism 12-12	1,433
Recidivism 12-12%	21.83%

Triage 6	4,148
Recidivism 6-6	554
Recidivism 6-6%	13.36%

Triage 6	4,148
Recidivism 6-12	1,180
Recidivism 6-12%	28.45%

	October	November	December	January	February	March	April	May	June	July
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07
Recidivism 12-12	9	66	128	203	345	551	745	971	1,182	1,433
Triage 12	695	1,365	1,839	2,430	3,191	4,148	4,893	5,486	6,046	6,563
Recidivism 12-12%	1.29%	4.84%	6.96%	8.35%	10.81%	13.28%	15.23%	17.70%	19.55%	21.83%

	October	November	December	January	February	March	April	May	June	July
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07
Recidivism 6-6	9	66	128	203	345	551	554	554	554	554
Triage 6	695	1,365	1,839	2,430	3,191	4,148	4,148	4,148	4,148	4,148
Recidivism 12-12%	1.29%	4.84%	6.96%	8.35%	10.81%	13.28%	13.36%	13.36%	13.36%	13.36%

	October	November	December	January	February	March	April	May	June	July
Year MO	2016/10	2016/11	2016/12	2017/01	2017/02	2017/03	2017/04	2017/05	2017/06	2017/07
Recidivism 6-12	9	66	128	203	345	551	732	906	1,044	1,180
Triage 6	695	1,365	1,839	2,430	3,191	4,148	4,148	4,148	4,148	4,148
Recidivism 12-12%	1.29%	4.84%	6.96%	8.35%	10.81%	13.28%	17.65%	21.84%	25.17%	28.45%

Transicare Reporting — Crisis Services Project

	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	2017-07
Beginning Census	115	115	107	103	98	123	127	140	133	146
REFERRALS	46	33	32	23	42	56	79	76	78	78
Admissions										
Referred Admitted	**19**	**18**	**16**	**8**	**26**	**28**	**30**	**19**	**32**	**30**
No Admit Client Refusal	2	1	1	2	0	1	2	1	2	1
No Admit Criteria	1	1	3	0	1	0	1	0	3	0
No Admit Structural	2	6	2	2	2	3	5	5	1	2
Pending	22	7	10	11	13	24	41	54	40	23
PRIOR PENDING										
Pending Admitted	**12**	**17**	**2**	**4**	**8**	**11**	**17**	**18**	**23**	18
No Admit Client Refusal	3	3	4	1	0	0	0	1	0	2
No Admit Criteria	2	1	1	1	0	0	0	1	2	1
No Admit Structural	0	4	3	4	1	1	4	2	2	2
Total Admissions	**31**	**35**	**18**	**12**	**34**	**39**	**47**	**37**	**55**	**48**
Discharges										
Success Transfer	7	3	4	3	2	4	5	6	3	1
DC Midterm Disengage	12	16	6	2	4	4	4	13	12	11
DC Rapid Disengage	6	6	2	4	2	14	5	10	9	12
DC Structural	6	18	10	9	1	13	20	15	18	11
Total Discharged	**31**	**43**	**22**	**18**	**9**	**35**	**34**	**44**	**42**	**35**
Active End Of Month	115	107	103	97	123	127	140	133	146	159
Outcome Data										
Terrell State Hospital Linkages										
≤7 Connect To Prescriber	1	6	2	1	4	6	2	4	5	3
≤30 Connect To Prescriber	0	1	0	0	0	0	0	0	0	0
Missed Metric	1	3	0	1	3	3	0	1	0	0
Total Released	2	10	2	2	7	9	2	5	5	3
Cummulative ≤7 Connect %	**50.0%**	**58.3%**	**64.3%**	**62.5%**	**60.9%**	**62.5%**	**64.7%**	**66.7%**	**70.5%**	**72.3%**
Cummulative ≤30 Connect %	**50.0%**	**66.7%**	**71.4%**	**68.8%**	**65.2%**	**65.6%**	**67.6%**	**69.2%**	**72.7%**	**74.5%**
Missed Metric	**50.0%**	**33.3%**	**28.6%**	**31.3%**	**34.8%**	**34.4%**	**32.4%**	**30.8%**	**27.3%**	**25.5%**
Unduplicated Served										
Monthly Unduplicated	**141**	**141**	**124**	**111**	**120**	**155**	**156**	**162**	**183**	**206**
DSRIP YTD Unduplicated Served	141	180	209	227	259	308	352	397	460	530
Encounter Data										
F2F Encounter	848	840	730	753	802	855	1019	1196	1333	1368
Care Coord	198	138	113	82	30	117	119	108	53	58
Total	1046	978	843	835	832	972	1138	1304	1386	1426

Forensic Diversion Unit (FDU) Report

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Beginning Census	**47**	**46**	**50**	**45**	**44**	**47**	**50**				
Number of Referrals Received from CSP											
Adapt	7	8	16	12	20	17	8				
Metrocare	0	0									
Transicare	0	0									
DA	0	0									
Number of Admissions	5	8	10	7	9	8	6				
Number Discharged	0	4	10	3	6	5	9				
Number not admitted due to:											
Client qualifies for ACT	0	0	0	2		4					
Client qualifies for other programs	1	0	0								
Client didn't meet level of need required	0	0	0				1				
Other reasons	0	0	0	3	7	5	1				
Average Service Utilization:											
Average hours seen	7.22	6.46	6.36	6.52	6.72	5.19	6.18				
Encounter Breakdown:											
Face to Face	254	275.25	245	264.25	269	240.28	298.75				
Service Coordination	193	225	215	188	296	210.25	239				
Number of clients accessing:											
Emergency Room (medical)	0	0	0		0	0	0				
23-hour observation (psych)	1	1	0	1							
Inpatient (med/ psych)	0	0	0		2	2	1				
Jail book-in	10	2	0	1	5	5	2				
Reasons for Discharge:											
Graduate		0	0		1	1	0				
Client Disengagement	2	3	0	3	3	1	7				
Extended Jail stay (case-by-case basis)		0	0		1						
Other Intervening factors		1	0	2	1	1	2				
End of Month Stats:											
Number of Active FDU clients end of month	**46**	**50**	**48**	**44**	**47**	**50**	**47**				
Number of Unique Consumers	2	0	2	0	47	50	47				
# of clients waiting to be released from jail	11	12	15	12	14	9	8				
Average Length of stay on FDU (month)	12.27	11.38	7.72	8.06	6.33	5.54	5.63				
Maximum Census	**46**	**46**	**46**	**46**	**46**	**46**	**46**				

AUGUST 2017 Monthly Report

report reflects up to August 25th, 2017

Dallas County Crisis Services Program	Program Specific and Systems Update	Summary of NTBHA's Monthly Activities	Action Items/Concerns
1	**Adapt Community Solutions (ACS)** – Targets member released from jail using ACS to ensure continuity of care	Conducted case consultations on approximately 20 referrals.	Not Applicable
2	**Transicare Post Acute Transitional Services (PATS)** – Targets high utilizers released from jail with more intensive need to ensure continuity of care	Provided case consultation and clinical support during PATS/FACT case review. Completed hospitalization/benefit inquiries for 1 client.	Not Applicable
3	**ACT Forensic Diversion Unit (FDU)** – Provides ACT services for high utilizers of the legal system. Responsible for approving evaluations of FDU referrals and FDU oversight	Clinical review of cases for appropriate LOC recommendations on 11 FDU referrals, 9 of which were approved for FDU assessment. Reviewed 5 recovery plans. There was no MD consult during this reporting period.	Not Applicable
4	**Caruth Smart Justice**	No documented activities during this reporting period.	Not Applicable
5	**CSP – Cottages Project** – Housing complex of 50 cottages that provides housing, mental health assessments and counseling for clients categorized as high utilizers of MH and judicial systems	Revised MOUs sent to representatives at Dallas County and City Square for review and approval. Reviewed hospitalization history for 1 potential program participant.	Finalize MOU between City Square and NTBHA.

The Cottages: Monthly Metrics Summary		
Metric Criteria	**July**	**Notes**
Property Management Overview		
Beginning Census	**45**	
Evictions	**3**	
Terminations	**0**	
Move-ins	**2**	
Ending Census	**44**	
Lease Violations	**20**	*By 10 unique residents*
***New screenings for waitlist**	**4**	
DHA Inspections	**2**	
Total residents housed since opening	**52**	
Residents in Cottages for less than 90 days	**0**	
Residents in Cottages 90-180 days	**9**	
Residents in Cottages 181 days or more	**33**	
Metrocare Cottages		
Encounter Breakdown		
Psychosocial Rehab Individual Sessions	**74**	*By 25 unique residents*
CBT sessions	**10**	*By 6 unique residents*
Psychosocial Group Sessions (clinical groups only)	**38**	*By 25 unique residents*
Appointments made with prescriber	**39**	
Appointments attended	**21**	*By 19 unique residents*
Residents that were prescribed medication	**19**	
Incident Reports by Category		
Medical	**2**	*By 2 unique residents*
Psychiatric	**1**	
Agression towards another resident	**-**	
New Behavioral Contracts	**-**	
Residents Accessing Higher Level of Care		
Emergency Room (Baylor Hospital report only)	**4**	
Psychiatric (inpatient and 23 hour obs)	**5**	
Jail Book-In	**6**	*By 4 unique residents*
SUD Treatment Centers	**2**	
CitySquare Case Management		
Residents receiving case management services	**33**	
Residents served by Community Nurse	**11**	
Residents served by CitySquare Clinic	**5**	
Residents attending Lifeskills Groups	**10**	
Residents attending Community Groups	**27**	

Dallas County Behavioral Health Leadership Team (BHLT)
Adult Clinical Operations Team (ACOT) Committee Meeting
August 3, 2017

Attendees: James McClinton (MDHA), Janie Metzinger (MHA), Kurtis Young (PHHS), Jacob Twombly (UT Police), Charlene Randolph (Dallas County), Sherry Cusumano (Green Oaks/ NAMI), Jennifer Torres (Metrocare), Ashley Williams (CSCD Clinical), Brianne Brass (Dallas County), Ellen Duke (Hickory Trail), Michael Laughlin (Dallas County), Marie Ruiz (MetroCare), Jill J-Love (Dallas County CSCD), Lauren Roth (MMHPI), Mike Ayob (Counseling Institute of Texas), Mark Karaffa (Dallas Behavioral), Jarrod Gilstrap (Dallas Fire), Becca Crowell (Nexus), Dave Hogan (DPD Crisis), John Henry (NTBHA), Herb Cotner (Dallas PD)

Introductions and Minutes Approval
- Committee members made introductions.
- Meeting minutes from June 2017 were approved.
- Becca Crowell shared that Nexus is hiring for an Adolescent Program Director.

MetroCare Presentation

- Jennifer Torres provided an overview of the services provided by Metrocare.

- Location #8 Stemmons Center & Pharmacy is no longer existent.
- The Skillman and Grand Prairie facilities serve both adults and children.

- Each facility does take daily walk-ins and schedules.

-The Samuels location serves three levels of care.

Updates

- NTBHA is continuing to build relationships with the community as contracts are set up to being September 1st.

- NTBHA reported that 2017 fiscal year will end on August 31st.

Smart Justice Update

- Lauren Roth reported that Meadows is working on subcontractor agreements with providers, and have gotten all approvals from the City of Dallas.

-Mike Laughlin reported that Dallas County has released 70 individuals from jail on Mental Health Bonds, and will begin the full Caruth launch on August 14th.

Legislative Update

- Janie Metzinger provided the legislative update.

- Legislature is focusing on 20 priorities set by Governor.

Other

-Enrique Morris, Marlene Buchanan and Amy Cunningham will be invited to present on ACT/FACT in September.

-Dr. Jill J. Love volunteered to present in October.

The meeting was adjourned at 1:29 pm.

DALLAS COUNTY, TEXAS

Minutes of the Behavioral Health Steering Committee (BHSC) Meeting

Thursday, August 17, 2017

Call to order and Introductions

The meeting was called to order by Judge Wade at 8:38 am. 25 staff and agency representatives/providers were in attendance with names recorded on the meeting sign-in sheet.

Minutes review and approval

The **minutes** from the last bi-monthly BHSC meeting held on June 15, 2017 (packet pgs. 2-5), were reviewed with motion and second by Lee Pierson and Harry Ingram for acceptance. No discussion or corrections. Motion unanimously passed with minutes approved without objection.

No guest speakers presented on this occasion.

Caruth Grant: Mike Laughlin provided a July 2017 quarterly summary update regarding the MMHPI Smart Justice Grant with materials in the packet (packet pages 6-8). The 5-year, $7 million Implementation Grant submitted by MMHPI was awarded in October 2016, leading to the $1.174 million sub-grant to Dallas Co. in Jan. 2017 to address Intercepts 2-4, and part of 5. Mike gave an update on the current status and upcoming actions related to the award. The beta test of the project began on April 17th, and all the workgroups and sub-teams for the Intercepts 2-4 continue to meet/complete pre-implementation tasks related to procedures/forms, Court orders, space/staff preparations, modified resource allocations, training curriculums/plans culminating in this week's successful implementation launch. Mike also provided program activity/performance data through June 30th in a supplemental handout highlighting 2,456 were screened positive, 484 ordered for assessment, 297 assessed, 90 presented to the Magistrate Court (60% felony), 77 granted release (5 denied/9 contested), and all 77 opened by Pretrial (13 to low level, 46 med. Level and to 18 high level bond supervision).

Lynn brought up the MH screen cue is needing to capture more people, and asked about what we do with cases whose MH assessment leads to "no" or "diagnosed deferred". Lengthy discussion on this, and it was explained that this is "point in time evaluation and diagnosis that is based on history and symptoms presented at that time. It was agreed that ADAPT will set up a training session for everyone on what this means and how to use it.

Additionally, MMHPI continues to meet and work with community providers to build up treatment resources related to Intercept 5 for referral and treatment connection upon release. Marlene reported the contracts have been routed/signed on her end, but no referrals yet. She also reports that the receiving of warm handoffs is going well, though it was a little bumpy at the beginning. MMHPI is coordinating with the City and others on Intercept 1 (police and EMT response options) with the first agreements with them are going for approval before the full City Council this month. They have established job descriptions, and are currently hiring staff for the emergency response RIGHT Care Teams.

<u>Data and Reports for BHSC</u> – Judge Wade

Program and Department Updates: The program/outcome data, updates, and workload reports were presented and accepted via relevant dept./agency staff for the SAMHSA Grant, 530 Subcommittee, BHLT/CSP, Public Defenders, District Attorneys, CJ Dept. Jail reports, as well as provider reports (The Bridge, Metrocare, and IPS), and the various Problem Solving and Specialty Courts (see packet pgs. 9-63 for details).

Laura presented the SAMHSA Grant update along with the data and activities (see packet pg. 9).

Laura Edmonds also presented a summary of current 530 Subcommittee activities and expenses. The semi-monthly June 19th Committee meeting minutes and report were presented by Laura who also advised that there was some very good planning accomplished, and that there will be some new team members joining. Additionally, the 530 Subcommittee needs approval for $2720 expenditure from budget line items for inpatient treatment at Homeward Bound for individuals currently in need of an additional funding source beyond what is currently available. Motion made and seconded by Harry Ingram/Lee Pierson. Motion unanimously passed and approved without discussion or objection.

Laura also advised there will be an increase in training opportunities and focus for FY 2018 to include the National Assoc. of Drug Court Professionals Conference coming to Texas.

The 530 Subcommittee will also have their next lunchtime <u>training</u> Delightful Discussions on services at IPS on August 18th, in the Pretrial Conference Room.

CSP stats and metrics for June/July were presented/reviewed by Charlene (see packet pgs. 9-25), and they are exceeding YTD outcomes and DY6 metrics. There continues to be an uptick in the numbers due to the new Caruth MH PR Bonds. Terrell Hospital Connection Project for improved release planning continues to go well.

Charlene and CSP providers continue to communicate with NTHBA to facilitate the recent transition planning since the care manager and Specialty Court Aftercare Engagement Packages currently go through CSP and will now be coordinated through NTBHA. Process continues to go well. HHSC has submitted request for 21 month extension of CSP funding with an announcement on that by the end of the current calendar year. The Forensic Diversion Unit had 46 unique clients engaged, with some of those while still in custody.

<u>Cottages Update</u>: 26 unique consumers engaged by Dallas Metrocare. Census is not full at this time. Referral criteria include multi-bookins, MI diagnosis, and homeless. Also they are permitted to have income, but don't have to meet HUD definition, no sex offender cases, and Arson cases are reviewed individually. Lynn asked how long it takes, and Shenna explained that DHA processing can take some time I order to process the needed documents, verify homeless status, etc. City Square case workers will interview/screen and help to gather documents, etc.

Jail and hospital movement, pregnant defendants, and homeless and Veteran data and reports were presented by Laura Edmonds, Shenna Oriabure, and Janine Capetillo and are found in the meeting packet on pages 33-48. With the pregnant patients it was noted that some of these are for probation/parole violations, and most of them have an MI diagnosis per the Stella data and MH screenings. Veteran's prevalence continues to under report, and it was also noted that the Veterans continue to rapidly cycle out of the jail making it hard to get the designated staff catching them before release due to limited staffing. No other concerns or questions from the group on those items. Montgomery Hospital has begun to take clients again, but Lynn also noted that they continue to be very selective excluding those unlikely to regain, lower level cases, and to heavily scrutinize criminal records.

Monthly CCQ match: Mike Laughlin provided the MH prevalence which according to TLETS is still high 61% (packet pgs. 51-52). Several acknowledged that the Jail MH screen was still too inclusive, and that data sources are being reviewed with IT to refine the data feeds and hopefully resolve the issue soon. The NTBHA feed will also soon be added to the data collection process which should help in more accurate triaging and identification.

All other department and agency data reports and program updates were accepted as read, and can be reviewed in the meeting packet.

Lynn Richardson presented the **Public Defender** MH case data and reports (page 34 of packet) noting they will soon have the Smart Justice numbers added also. They are now also closely tracking all specialty court participants. No other comments at this time.

Lee Pierson provided the **DA data updates and report (see supplemental packet insert)** and advised that DA has reviewed the cases for Depression diagnosis, and is now taking them again. Cases with violence elements are also being carefully scrutinized.

Provider Reports

Kelly Lane from The Bridge reported their numbers (pg. 35) with no comments/concerns expressed. She advised Jay Dunn is no longer at the Bridge, and Dr. David Woody is interim CEO. She also advised that DHA is taking briefings again for placements for the first time since November 2016.

IPS: Supplemental insert was provided by IPS with no further comments.

NTBHA: John Henry reported that engagements are up, and some good things are happening with the expansion to include increased capacity for OCR and new money/collaboration to implement SB2 Collaborative locally.

Metrocare: Crystal Garland presented Metrocare data/reports (pg. 55) advising that Atlas numbers remain low but is being addressed. DDRC remains at full capacity.

Specialty Court: Janine presented OCR Court data (pg. 57). It was noted that Governor's Office is no longer funding attorneys for Specialty Courts. DIVERT Court numbers are on **(**pg. 58)**.** Rosa Sandles was present for Ms. McNair at which time the other Specialty Court numbers (pages 59-63) were presented noting that Atlas Court numbers are down, and that Judge Hawthorne was working to resolve the issue.

Funding: Everyone is encouraged to keep good track of program/outcome numbers to ensure they are accurate and that your target population makes up most of your slots and program effort. Judge Wade asked at the June meeting for all to consider setting up a separate BHSC focus meeting in near future to improve data/outcome tracking efforts and look at a periodic reporting that maybe can go before the Commissioners Court to show impact.

Announcements

Housing recent targeted housing training for attorneys went very well, and the next one for the bigger group will be in the Central Jury Room on August 25, 2017 from 11-230pm. Several commented that Metrocare has been a big help in identifying and processing candidates, and getting the latest funding spent on more people. Enrique commented that this will also help us justify future funding requests.

Shenna and Laura announced the next monthly "Delightful Discussions" brown bag in-service with information and guidance on IPS is on the August 18, 2017, from 1130-1215pm. It will be held in the in Pretrial Conference Rm. A9 on

the 1st floor. Judge Wade promoted this and encouraged everyone to attend and participate. Desert will be provided with door prizes. RSVP to Shenna via email.

Vickie Rice thanked the DA's Office for reconsidering handling of the mental health cases with Major Depressive Disorder (MDD) diagnoses. It was also mentioned that DA and Public Defenders Office are working on a joint intake process and more will be announced soon on that. It was also mentioned that the census and referral numbers for the Specialty Courts is way too low, and we need to consider a BHSC working group to address ways to improve this. Lastly, it was agreed that a BHSC service/responsibility contract directory needs to be developed for everyone to know what each other is doing and how to contact the right people for various needs. Mike and Vickie will work on this.

Adjournment

The meeting was adjourned by Judge Wade at 940am. The next bi-meeting is set for Thursday, October 19, 2017 at 830am in the same location.   Reminder was provided to everyone to submit their monthly stats to Mike Laughlin via email by the 2nd Friday of each month for distribution.

DALLAS COUNTY
BEHAVIORAL HEALTH LEADERSHIP TEAM

BHLT Meeting Supplemental Packet

September 14, 2017

HARRY INGRAM — FY2017 ATLAS STATISTICS — 203/HAWTHORNE

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	REV	GRADUATES	PROBATION MODIFICATIONS	DISMISSALS	OTHERS	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT ATLAS PARTICIPANTS	CURRENT PARTICIPANTS IN CUSTODY	FORMER ATLAS PARTICIPANTS	BOND
August	17	11	28	0	0	0	1	1	0	0	0	2	26	20	1	0	19

HARRY INGRAM — FY2017 MISDEMEANOR MENTAL HEALTH COURT STATS — CCCAP1/WADE

MONTH	BEGINNING # OF PENDING CASES	Rediverts	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	DISMISSAL	OTHER	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT PARTICIPANTS	NUMBER OF GRADUATES	BOND***
August	127	0	9	136	0	0	8	2	2	12	124	29	2	29

HARRY INGRAM — FY2017 S.E.T. STATISTICS — 291st

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TBJ	TBC	PLEAS	REV	GRADUATES	PROBATION MODIFICATIONS	DISMISSALS	OTHERS	TOTAL DISPOSITIONS	ENDING # PENDING CASES **	CURRENT PARTICIPANTS	CURRENT PARTICIPANTS IN CUSTODY	FORMER PARTICIPANTS	BOND
August	53	0	53	0	0	0	0	0	0	3	4	7	46	20	1	0	19

August — FY2017 MHPD STATS

MONTH	BEGINNING # OF PENDING CASES	+NEW CASES RECEIVED THIS MONTH	=TOTAL CASES	TRIALS	PLEAS	COND. DISM.	REVO-CATION	DISMISSALS	INCOMPETENT	REFERRALS	OTHER COUNSEL APPT.	TOTAL CLOSED
R. LENOX	183	30	213	2	13	1	1	5	0	0	1	23
L. TAYLOR	189	15	204	0	0	0	1	1	0	0	3	5

MALCOM HARDEN — FY2017 FELONY COMPETENCY STATISTICS

	BEGINNING # OF CASES	NEW CASES THIS MONTH	TBJ	TBC	Alt. Trial Dispos.	PLEAS	REVO-CATIONS	DISMISSALS	PROBATION	COMP. HRG.	EXTENSIONS	CIVIL COMMIT.	MHMR REFERRAL	CONSULTS	OTHER	ENDING # OF PEOPLE IN OCR
August	165	13	0	0	0	2	1	3	0	8	4	0	1	0	7	14

MALCOM HARDEN — FY2017 MISDEMEANOR COMPETENCY STATISTICS

MONTH	BEGINNING # OF CASES	NEW CASES THIS MONTH	TBJ	TBC	Alt. Trial Dispos.	PLEAS	REVO-CATIONS	DISMISSALS	PROBATION	COMP. HRG.	EXTENSIONS	CIVIL COMMIT.	MHMR REFERRAL	CONSULTS	OTHER	ENDING # OF PEOPLE IN OCR
August	125	48	0	0	0	0	0	28	0	20	9	1	0	0	4	19

August — MI Court

MONTH	TOTAL NEW CASES RECEIVED	NEW CLIENTS AT GREEN OAKS	NEW CLIENTS AT MEDICAL CENTER MCKINNEY	NEW CLIENTS AT PARKLAND	NEW CLIENTS AT DALLAS BEHAVIORAL HEALTH	NEW CLIENTS AT GARLAND BEHAVIORAL	NEW CLIENTS AT ZALE LIPSHY	NEW CLIENTS AT SUNDANCE BEHAVIORAL HEALTHCARE	NEW CLIENTS AT HICKORY TRAILS	NEW CLIENTS AT METHODIST RICHARDSON	NEW CLIENTS AT DALLAS PRESBYTERIAN	NEW CLIENTS AT VA	NEW CLIENTS AT WELLBRIDGE	NEW CLIENTS AT TIMBERLAWN	PROBABLE CAUSE HEARINGS HELD	NO CONTEST COMMIT	CONTESTED COMMIT	FORCED MEDS HEARING IN COURT
L. ROBERTS	185	64	10	0	0	21	0	54	0	14	0	0	0	22	3	1	7	8
L. TAYLOR	95	0	0	23	19	9	7	31	5	0	1	0	0	0	3	0	2	2

RANDA BLACK — MI COURT

*Number of new cases decreased due to increase in 46B cases.

MONTH	NEW CLIENTS	PROBABLE CAUSE HEARINGS HELD	NO CONTEST COMMIT TO TSH	CONTESTED COMMIT TO TSH	RECOMMITMENTS	MEDICATION HEARINGS	OUTPATIENT	JURY TRIAL
August	20	2	3	17	8	22	0	0

MICHAELA HIMES — MHPR BOND STATS

MONTH	INITIAL ELIGIBILITY DAILY LIST	MHPR BOND APPOINTMENTS FROM DAILY LIST	MHPR BOND HEARING-GRANTED	MHPR BOND HEARING-DENIED	TOTAL HEARINGS
Augus	1699	225	68	11	79