

**Mental Health Mental Health Authority
of Harris County**

LOCAL PLAN REVIEW

FY 2006-2007

PART III

MENTAL HEALTH AUTHORITY

I. VISION, MISSION, AND PHILOSOPHY STATEMENTS

In accordance with The State's Guidelines for Local Service Area Planning, developed in accordance THSC §533.0354; and DSHS's jail diversion strategies, developed in accordance with THSC §533.0354(d) and THSC §533.108, the Harris County Mental Health Authority (HCMHA) ensures that (a) a continuum of services, as mandated by the Department of State Health Services (DSHS) is available to residents of Harris County, (b) service fees are affordable and (c) services and benefits are not denied to eligible persons because of their inability to pay. The HCMHA provides assistance to eligible persons by developing a comprehensive range of accessible cost effective services for persons who need treatment, supported care, intervention, prevention, education, or rehabilitation and seeks to minimize duplication and share financing through the coordination and collaboration among governmental and private entities.

The HCMHA oversees responsibilities that include:

- the coordination of resources and benefits through the ongoing planning and assessment of community needs and the identification of resource gaps;
- policy development to address identified needs and gaps with due consideration of the public input, best value, and consumer issues,
- community-wide coordination of services that include collaboration with other agencies, criminal justice entities, and adult and child serving agencies, family advocacy organizations, local businesses, and community organizations, and
- ensuring that services are coordinated among and between network providers; and other persons, and provides consumers a choice among all eligible network providers.

Description of Population Served

HCMHA is committed to serving residents of Harris County whose lives are affected by mental illnesses and other related emotional crises, deficits and disabilities. Our target population consists of persons in Harris County who are directly affected by these conditions including their families and caregivers; however due to funding constraints we are only able to focus on the priority populations as defined by DSHS. Throughout its history, HCMHA seeks *additional funding* to the extent possible to provide services to those who fall outside the priority populations but are in need of our services. The local planning report describes various sources of Non-General Revenue funding.

History and Organizational Overview of MHMRA

Please refer to Section I for the history and overview of the Organization of MHMRA.

Vision

The vision of the MHMRA is that the public mental health and mental retardation system will act in partnership of consumers, family members, service providers and policy makers which creates options responsive to individual needs and preferences.

This vision includes recognition of these values:

- The individuals MHMRA serves share common human needs, rights, desires and strengths.
- MHMRA celebrates cultural diversity and individual uniqueness and is committed to support individual choices and preferences.
- MHMRA is committed to developing an environment that inspires and promotes innovation, fosters dynamic leadership and rewards creativity among our staff, volunteers, and consumers.

Mission

The HCMHA embraces the mission as adopted by the MHMRA Board of Trustees:

“It shall be the mission of the Mental Health and Mental Retardation Authority of Harris County, within the resources available, to provide or ensure the provision of services and supports that are as high quality, efficient, and cost-effective as possible such that persons with mental disabilities may live with dignity and fully functioning, participating, and contributing members of our community, regardless of their ability to pay or third-party coverage.

- Persons with severe mental illness should be able to live in homes of their own, develop relationships, work, and remain out of hospitals and jails.
- Persons with mental retardation or developmental delays should be able to acquire the skills and access community resources to develop networks of human relationships, learn, work, and live in environments of their choosing.
- Children and adolescents with serious emotional disturbances should be able to live in homes with families, develop normal relationships with their peers, attend school, and remain out of hospitals, residential, and juvenile justice facilities.”

HCMHA under the auspices of MHMRA of Harris County is fully aware of the challenge to do more and better with fewer resources. But its workforce, its management, its Planning Advisory Councils and its Board of Trustees are prepared to meet, with the support and collaboration of the widest variety of individuals and institutions, whatever challenge is required to assure that its mission is fulfilled.

Philosophy

The HCMHA embraces the overarching values adopted by the MHMRA to guide the operational support and service delivery of the MHMRA of Harris County. These values are:

- **Integrity**: Honesty. Firm adherence to a set of values and principles.
- **Accountability**: Accepting responsibility for one’s actions and the outcomes of those actions. Doing what you say you will do.

- **Consumer-driven**: Developing and implementing services based on consumer needs, priorities, and choices within the resources available.
- **Quality**: Providing services that make a measurable difference. Best value.
- **Efficiency**: Optimizing the use of available resources to achieve the desired results.

Strengths, Weaknesses, Opportunities, and Threats

The following summarizes the perceived Strengths, Weaknesses, Opportunities, and Threats of the MHMRA of Harris County. These were identified during the Strategic Planning process begun by the Board of Trustees in August 2002 and updated to reflect changes that happened since.

A. Strengths

- Infrastructure for services basically sound.
- Some customers able to direct own recovery.
- Core staff/supporters strongly committed.
- Excess volunteer capacity to be tapped.
- Dominant position of influence.
- Knowledgeable staff is flexible.
- Increased collaboration with physical healthcare
- Close collaboration with the criminal justice agencies
- Harris County Commissioners' Court is supportive

B. Weaknesses

- Continuing stigma of the MHMR population.
- Budget depends on external actors/conditions.
- Population to serve not a matter of choice.
- Less Freedom to determine how services to be provided due to State-mandated Resilience and Disease Management (RDM) processes
- Insufficient funding for addressing co-occurring disorders.
- State funding does not address the total spectrum of mental disorders.
- Large proportion of county population that are international immigrants.

C. Opportunities

- Technologies and therapies improving.
- Consumer empowerment fits recovery goals.
- Pressure increases support for innovation and creativity.
- Closer cooperation and coordination with local agencies and maximizing community resources.

D. Threats

- Budgets are tight & may get even tighter.
- Public/private network may constrict & close during current budget crisis, thus add to MHMRA pressures.
- Unpredictability of "compassion fatigue."
- Laws and regulations that do not recognize current treatment environments, e.g. NPC.
- Provider of Last Resource Mandate.

- The impending CMS requirement for proof of citizenship in order to qualify for Medicaid programs.
- Unforeseeable emergency/crisis situation arising from natural (e.g. storms) and political (e.g., CHIP) forces .

For the Adult Mental Health (AMH) components *waiting list tracking and analyses* are critical for planning, while for the Children and Adolescent Services (CAS) components *referral pattern analyses* play a crucial role in its attempt to reach out to children and families in needs. All three divisions pay close attention to the *cultural and linguistic diversity* of the county population as they strive to maximize the cultural and linguistic staffing patterns and cultural diversity skills to meet the needs of this population. *Inpatient utilization*, both locally and at the state hospital, is closely monitored for trends and signs that may necessitate changes in the service priority and delivery structure.

Market place and funding realities force constant reassessment of the Agency's plan concerning its infrastructure and its service delivery mechanisms. For example, salary competition emanating from private or public sector salary increases for certain groups of employees forces frequent salary adjustments, leading to re-budgeting and reprogramming of services. *Outsourcing versus in-house staffing* is another issue that the Board of Trustees and senior management must frequently consider. *Real estate and technological changes* also force the Agency to weigh different options regarding leasing versus purchasing infrastructure components. *New methods of revenue enhancement* are constantly explored. Besides grant applications, the Agency solicits financial contribution to its programs (such as for the Furniture Bank) or develops new product lines, such the CBHN (see below).

All anticipated or planned adjustments are shared in a timely manner with our *advisory councils* for reaction and input before implementation. Programmatic impacts, as anticipated or felt, are shared with the PACs during the "educational" segment of the PACs' agendas. *Special community forums* are also conducted to address major planned programmatic changes.

Overall, then, Agency's consumers, staff, contractors, and the Board of Trustees are involved in ongoing discussion about the key concerns of customers and the Agency's commitment to continual improvement in services. Annually and on special as-needed bases, the Center actively solicits information from external customers, the general public, members of advocacy groups, representatives of sister agencies, as well as consumers and staff. The purpose of this information gathering is to gain *a better understanding the perception* of these groups about services and gather their suggestions for practical improvements in services.

The following sections provide summaries concerning the internal planning processes involving planning advisory councils and administrative approaches, and the external planning efforts inclusive of the initiatives and collaborators.

II. PLANNING PROCESS

Planning Process

Planning at the HCMHMRA and the HCMHA is multidimensional. It encompasses internal as well as external processes. It is also pragmatic. It focuses on state and local policies and on national, state, and local forces that impact the Agency, its consumers, and its personnel—the major resource upon which our treatment, services, and support depend. Analyses of socio-demographic characteristics of consumers as well as the general Harris County population, coupled with market penetration data and prevalence data, provide further major input into the process of planning.

Planning Advisory Councils (PACs)

Community advisory councils have existed since the beginning of the Agency's founding. During the 1990's a more formal restructuring of the community advisory process was implemented by the Board, resulting in four planning advisory councils (PACs). The PACs provide advice and recommendations to the Board of Trustees regarding community priorities for services and best practices. The pertinent mental health issues related PACs are:

1. The adult mental health planning advisory council (AMH PAC),
2. The children and adolescent services planning advisory council (CAS PAC),
3. The medical planning advisory council (Medical PAC).

The AMH PAC and the CAS PAC are supported by staff from the offices of the HCMHA. Each of these three program PACs is composed of 50 percent consumer and advocate representation. These three PACs meet monthly.

The Medical PAC (which is not mandated by the TDMHMR contract) is composed of representatives of the major public and private medical organizations in Harris County that serve or are interested in the welfare of persons with mental illnesses and disabilities. The Office of the Executive Medical Director provides staff support for the Medical PAC. The Medical PAC meets bimonthly.

The Mental Health Deputy Director and key administrative and program staff attend all meetings of the PACs. This process ensures that the PACs are routinely apprised of critical strategic issues, program achievements, and operational challenges. Information made available to the PACs comes from divisional staff as well as from special investigations by the Executive Decision Support (EDS) department. Special studies, as requested by the PACs, are conducted by the EDS in collaboration with and with input from the appropriate program division staff. The EDS Director and his representatives attend PAC meetings as appropriate or needed.

The Board of Trustees maintains a close and continuous connection with its planning advisory councils. First, all PAC meeting minutes are submitted for review and acceptance to the Board of Trustees through its Program Committee. Second, one or more Trustees are also assigned to serve as "Board Liaison" to each PAC. The Board Liaison is the person who formally presents the PAC's official recommendations or requests for clarification to the Board of Trustees on behalf of the PACs. Third, and finally, the PAC chairs are regularly invited to present to the Program Committee his/her PAC's processes, issues, and progress.

The PACs have been extremely active in seeking opportunity to receive and provide information necessary for the planning process or to review the progress of the plan implementation.

Plan Review

The plan review process is meshed within the planning process. Planning issues constitute a standing item on each PAC's monthly agenda. Progress towards expanding, exploring in-depth, initializing, reconsidering, or implementing different aspects of the local plan is constantly reviewed with the PACs. Additionally, the share regularly with their respective PACs the Center's progress in meeting the state contract, which incorporates performance data relative to the plan.

The Executive Director and the The Mental Health Deputy Director also share with the PACs emerging or anticipated issues and seek their assessment and advice. MHMRA staff continuously and regularly conducts special studies to clarify the issues and to gather basic information needed by upper management, the Board of Trustees, the Advisory Boards, and even with external, independent planning groups (such as the Mental Health Needs Council) for planning and making decision purposes. This information not only covers internal data (relating to the Agency's capacities, service performance, clientele profile, operational capacities and processes, compliance with state contracts, and assets) but also external forces (such as market trends, market penetration potentials, unmet needs, collaborative readiness on the part of other agencies, etc.) and constraints (such as market saturation, salary competition, human resource availability or scarcity, regulations, judicial edicts, etc.) Analyses of these data and trends are shared freely with the advisory councils and the Board of Trustees so that they can provide input and guidance regarding new actions and programmatic changes, not only in order to meet new challenges, but also to stay true to the strategic priorities.

Thus, the plan review occurs monthly at the meetings of the advisory councils and the Board of Trustees, and quarterly or more often at community forums and other focus groups.

The Executive Director continues to expose and discuss major issues relating to new directions or new challenges in a lead article in our *Interface* magazine.

In summary, the openness of the Agency's planning process and the collaborative nature of this process with the community are the Agency's trademarks. This openness becomes easily evident when one reads about the large number of collaborative programs that the Agency has implemented since its inception in 1965.

III. EXTERNAL/INTERNAL ASSESSMENT

Internal Processes For Assessing Key Factors

Four administrative venues provide support for assessing key factors that affect the planning process: (1) the program division staff, (2) the Executive Decision Support Department, (3) the Quality Improvement (QI) department, and (4) the Operations Division.

Program Division Staff Role. The HCMHA's Administrative staff usually provides first-line responses to the data needs and information requests made by their respective PACs or other interested parties. These responses take the forms of reorganizing operational data, identifying DSHS and federal mandates, data reports, or issues relative to their programmatic areas, or obtaining input through special committee meetings or community forums.

The Role of the EDS. When efforts to gather and analyze planning data become more intensive or extensive and/or involve complex techniques (e.g., literature review, surveys, statistical analyses), special projects are created and carried out by the EDS department with input and consultation from program staff as well as from PAC members, concerned citizens, and other experts from the surrounding academic institutions.

The Role of the Quality Improvement (QI) Department. The Quality Improvement department routinely monitors various aspects of the MHMRA programs (e.g., incidents, rights violations, consumer satisfaction, etc.). From this monitoring the QI department provides regular reports that profile the performance of each program. These profiles are shared with the PACs so that they could provide informed input and recommendation regarding processes that may improve the quality and efficiency of the programs. The same information is also shared with the Network Advisory Council.

The Role of the Operations Division. The various Operations departments provide information concerning the Agency's performance vis-a-vis the contractual targets, financial status of the Agency, personnel issues and challenges, technological challenges and implementation goals and design, and infrastructure (building, grounds, rentals). These reports are critical in assessing the strength and weakness of the various aspects of the Agency's performance, financial viability, needs for infrastructure improvement or upgrade, and major challenges for resource management and maximum efficiency.

External Processes For Assessing Key Factors

Administrative Interface with Other Agencies and Institutions. The Agency has maintained and continues a long history of collaboration with all major health, mental health, substance abuse, law enforcement, social service and educational agencies and institutions in Houston and Harris County.

External Assessment via The Mental Health Needs Council Needs Council. Unlike other areas of Texas where the mental health needs assessment must be undertaken exclusively by the mental health mental retardation authorities, the Harris County's Commissioners' Court has established two needs assessment councils: the Mental Health Needs Council, which has been in existence since 1976 and the Mental Retardation Needs Council, which was established in 1999. MHMRA and the HCMHA are an integral participant in the assessment process conducted by the Mental Health Needs Council and contributes effort, data analytic support and expertise as needed to ensure that the needs

assessment process conducted by the MHNCNC are comprehensive, relevant, and methodologically sound. The Mental Health Needs Council can be reached at mhneedcl@hal-pc.org

IV. LOCAL AUTHORITY ASSESSMENT COMPONENTS

A. Populations

MHMRA and the HCMHA are committed to serving residents of Harris County whose lives are affected by devastating **mental illnesses, and other related emotional crises, illnesses and disabilities** whether or not the State of Texas provides funding for such services. Our clientele consists of persons in Harris County who are directly affected by these conditions including their families and caregivers. Due to funding constraints, our capacity allows us to focus primarily only on the DSHS priority mental health populations. However, to the extent possible and throughout its history, MHMRA seeks **additional funding** to provide services to those who fall outside the priority populations but need of our services. Thus many of MHMRA programs are supported by non-state funds to address the needs of persons who, although not qualifying as priority population, nonetheless suffer emotional distress and mental illness. Examples of programs that expand funding beyond that provided by DSHS are during the last two years include the Bristow Homeless Center, the Jail Psychiatric Services, the Pharmaceutical Assistance Program, the Mobile Crisis Program, the Neuropsychiatric Center, and the TCOOMII programs.

We have also sought to **increase our linguistic capacity** to reach out to two major cultural groups that have traditionally underused mental health and mental retardation services: Hispanics and Asians. These two groups have grown at the fastest rates among all cultural and ethnic groups in Harris County. Numerically, the Hispanic population in Harris County is the largest compared to any other county in Texas. In addition, 68% of the Harris County population increase in the last decade is Hispanic. We have set up special task forces to solicit advice from representatives of these groups regarding making our services more culturally appropriate and acceptable. From the census data, we identified that, although Harris County shares only 17% of the Texas general population, it shares 26% of international immigrants residing in Texas.

As evident throughout our history, MHMRA and HCMHA have constantly kept an unwavering **commitment to expand services to children and adolescents**, particularly those with emotional and/or mental disorders who are involved with juvenile justice system or the juvenile probation department. We have striven constantly to reach children at the youngest possible age in order to assess and recommend or provide services to them and their families such that developmental challenges can be met as early as possible, thwarting as much as possible deleterious subsequent damages.

Although the state funding streams have been strictly categorical (impeding the ability to effectively and efficiently serve consumers with multiple needs), MHMRA has times and again **innovatively and successfully combined services to serve persons suffering concurrently from multiple disorders**, i.e., from mental retardation and mental illness or from mental illness and chemical dependency. These programs have times and again been showcases of positive outcome on the lives of consumers and positive impact on the whole service delivery system. These results have convinced us to develop and implement not only multidisciplinary but also multi-specialty approaches to achieve maximum programmatic efficiency and effectiveness. Our mental health substance abuse dual diagnosis program, while receiving only about one-fourteenth of the funding for all such programs in Texas,

served as many consumers as the combined number of consumers served by the other 13 programs, and *with demonstrable, data-based evidence of positive outcomes*¹.

Below are tables depicting population priorities using the categories defined by TDMHMR for persons with mental illnesses. Tables 1 concerns the adult groups and Table 2 relates to children and adolescents. These priorities were reviewed with the PACs as part of the Plan Review Process and changed to reflect the current and anticipated situations.

Table 1: Ranking of Priority for Adult Population Groups

New Priority		Old Priority
1	Persons with mental illness who are uninsured	4
2	Persons with mental illness who are involved with the Criminal Justice System	1
3	Homeless persons with mental illness	1
4	Persons who are dually diagnosed with mental illness and chemical dependence	1
5	Persons with mental illness needing intensive and/or ongoing supports	6

Table 2: Ranking of Priority for Children and Adolescent Population Groups

New Priority		Old Priority
1	Youths with serious emotional disturbances	1
2	Young children (ages 3-6) who are in need of early intervention	2
2	Youths 7-18 needing early intervention services	3
2	Youths with a dual diagnosis of emotional and developmental disorders or co-occurring emotional and substance abuse disorders	2
2	Youths who are sexual offenders	2
3	Youths experiencing emotional/ behavioral problems in school	3

¹ Hickey, John Scott, Ph.D. Nguyen, Tuan D., Ph.D. [Dually Diagnosed Consumers: A Fine-Grained Analysis of Outcomes](http://www.mhsip.org/presentations.html), presented at the 50th Annual Conference on Mental Health Statistics, Washington, DC, 2001. Accessible at <http://www.mhsip.org/presentations.html>.

B. Services and Supports

MHMRA provides the full range of services authorized and mandated by the State Contract. The present service array facilitates a system of care that is readily accessible to all individuals of any age requiring MHMR services. Our website <http://www.mhmraofharriscounty.org/index.asp> provides a complete listings of available services, with explanation of how to qualify and a listing of contact information and addresses. The following is a brief review:

For adults with mental illness, the following services are available:

Community and clinic based services:

- Medication Related Services
- Counseling and Psychotherapy
- Medication Training and Support
- Employment Related Skills Services
- Assertive Community Treatment
- Housing Related Skills Services
- Coordination of Services
- Other Independent Living Skills Services

Specialty Adult services include:

- Forensic (Jail Services)
- Pre-Trial
- The Newstart Program ²
- Short-term Crisis Stabilization Unit
- Crisis Residential Unit
- The Mobile Crisis Outreach Team (MCOT)

For children and adolescents with emotional disorder and/or mental illness, available services include:

- **Assessment:** Determines what your child needs.
- **Medication:** Provided by a psychiatrist based upon the child's diagnosis and health issues.
- **Case Management:** Individual help to guide children and families through MHMRA and other community programs.
- **Skills Training:** Teaching children and families how to cope with the child's behavior and learn new ways tackle problems.
- **Counseling:** Individual or Family Therapy to discuss serious emotional issues and ways to overcome them.
- **Medication Training:** Teaching children and families the best way to use medications and side effects to look for.
- **Parent Partner:** Parents with children with mental health and behavioral issues reaching out to MHMRA's families to provide support and advocacy.
- **School-Based Program:** Providing services at a child's school, especially to help with classroom performance and behavior.
- **Special children and adolescent services, not funded by DSHS, include a series of services to assess and stabilize youths who are victims or perpetrators of crimes.**

² funded by the Texas Correctional Office for Offenders with Mental Impairments

Psychiatric Emergency Services (at the NPC) are available to all persons in crisis and consist of:

- medication administration,
- reinforcement of coping skills,
- close observation by clinical staff,
- family meetings, and,
- determination of appropriate community supports.

C. Local Authority Service Priorities (Strategic Issues)

Drawing upon their previous four years of operational reviews, plan review, and issues identification and discussion, the two mental health program PACs formally summarized their recommendations for the overriding, highest level of service and program priorities for their respective divisions between during Spring of 2006, after receiving the guidelines from the State Authority. Each PAC formed a planning subcommittee to draft the summaries, which were reviewed and discussed by the full PAC before submission to the Program Committee of the Board of Trustees for review and acceptance.

Figure 1 includes the overarching strategic priorities from the AMH PAC.
Figure 2 contains the set of programmatic priorities from the CAS PAC.

All two sets were submitted to the Program Committee of the Board of Trustees, which recommended their adoption by the Full Board of Trustees.

Figure 1: Adult Mental Health Strategic Priorities

New Priority		Old Priority
ISSUE 1	Inequity of State Funding	1
ISSUE 2	Transition from Inpatient to Community-Based Outpatient Services	3
ISSUE 3	Persons with Co-occurring Chemical Dependency and Mental Illness	7
ISSUE 4	Residential Services	6
ISSUE 5	SSDI/SSI Eligibility Application	10
ISSUE 6	Consumer Employment	8
ISSUE 7	Consumer-Run Alternative Programs	9
ISSUE 8	Waiting List Services	2

ISSUE 1: Inequity of State Funding

The cost of services continues to increase while revenue continues to decrease. This diminishes further the service capacity of a system that is already providing only minimum services to only a small portion of the priority population needing public mental health services. The following factors have had and continue to have deleterious, negative impact on the service capacity of MHMRA:

A. Inequity in state funding for mental health services to Harris County residents continues to exist in terms of:

- * Per-capita state funding for mental health services county wide and
- * Inability of TDMHMR to make the dollars follow the patients as MHMRA uses fewer state allocated bed days

B. Being a large urban center, the Houston Metropolitan Area and Harris County also have a greater preponderance of dually diagnosed (i.e., mentally ill and substance abusing) persons, homeless persons, undocumented residents, and immigrants compared to other centers in Texas. The per-consumer cost of providing services to these special populations is higher because of special considerations (e.g., interpreters, no show) and circumstances (e.g., the need to detoxify before being able to be certain of the mental illness diagnosis). Thus a flat case rate contract is inherently inequitable.

RECOMMENDATION 1:

Funding for mental health services to Local Mental Health Authorities should be based on objective criteria of population, prevalence of priority populations, and presence of special populations.

ISSUE 2: Transition from Inpatient and Community-Based Outpatient Services

Recent hospital use data indicates that there is an emerging trend for adults with severe mental illness to be readmitted to inpatient more frequently although the length of stay per admission tend to become shorter. This may indicate that the linkage between the inpatient facilities and the clinics are not as efficient as it should be. More frequent readmissions and discharges from the hospital increase the overall cost of services because of increases in paperwork, time to coordinate continuity of care, reevaluation and reassessment, and, quite often, changes in medications.

RECOMMENDATION 2:

Improvements must be developed and implemented in order to better engage consumers who are discharged from inpatient facilities into community-based mental health services. This effort should, at the minimum, incorporate the following approaches:

- a. Immediate linkage of the discharged consumer with the clinic or physician for medication prescription, filling, or replenishment;
- b. Telephone follow-up with the discharged consumer once he/she is back in the community;
- c. Linking the discharged consumer with a structured environment (such as residential services, consumer-run respite programs, or drop-in centers), so that the consumer remains away from street people;
- d. Providing transportation to the initial clinic appointments (or, at the minimum, the first scheduled appointment);
- e. Linking the discharged consumer to peers for peer support and/or peer training;
- f. Providing encouragement to the discharged consumer to find positive activities, such as using his/her special, individual talents and participating in vocational training and support, preferably in a consumer-run or consumer-operated program;
- g. Special funding should be earmarked for the above mentioned and related efforts.

ISSUE 3: Persons with Co-occurring Chemical Dependency and Mental Illness

Persons with severe mental illness who also abuse substances or are dependent on them (dually diagnosed consumers) are putting a strain on the mental health service system.

An analysis of the cost estimates for services received by dually diagnosed consumers over a six month period indicated that they cost 37% more than consumers with a single diagnosis of mental illness. When examining their service utilization by clinic service type, their use was statistically higher for all categories with the exception of EKG Tracing. This was true regardless of whether the mental illness diagnosis was schizophrenia, bipolar disorder, major depression, or other severe mental illness. Compared to consumers with a single mental illness diagnosis, dually diagnosed consumers also present twice as frequently to the crisis center, are jailed more than twice as often, and are hospitalized one and a half times more frequently. Despite such

higher use of more expensive services, they have poorer outcomes, particularly in terms of their ability to stay with the treatment plan. Unfortunately, there is little knowledge about what would constitute an effective intervention and treatment regime for this population.

Thus, there is an urgent need for a more effective service model.

RECOMMENDATION 3:

The state and local mental health authorities should intensify efforts to determine empirically an effective service model for dually diagnosed persons. At the minimum, attention and funding must be paid to:

- a. establish a comprehensive case management system for persons dually diagnosed with mental illness and chemical dependence;
- b. increase partnership among providers of mental health and substance abuse providers, particularly within the context of the behavioral health provider network; and
- c. increase efforts for diverting from the criminal justice system offenders who are diagnosed with mental illness and chemical dependence.

ISSUE 4: Residential Services

There is a paucity of residential services, despite indication from the literature that such services are affective both as a treatment modality and as alternative to hospitalization for many types of consumers.

Residential services provide consumers with safety, an opportunity to learn independence, daily support either from peers or operators, a structured environment, group activities, and opportunities for self-development and recovery. Residential programs can range from the most structured environment to the truly independent living arrangement. However, with the advent of the “managed care” ideology, the system of care has increasingly ignored these longer-term treatment and support approaches and is narrowing the focus almost exclusively on short-term, acute care. The consequence is that persons with chronic and serious mental illnesses will be revolving in and out of the acute care system without being able to recover from their illnesses.

Furthermore, in recent years, there has been a steady decrease of publicly financed and subsidized housing stock for persons with disabilities, including those with mental disabilities. This situation could only worsen the opportunity for person with severe and persistent mental illness to seek stable housing in order to maximize their functional recovery.

RECOMMENDATION 4:

As federal funding for residential services diminish, the state and local mental health authorities should seriously consider supplementing the funding of, or reserving a designated portion of the total funds for, residential services both in order to assist the chronic and seriously mentally ill consumers to recover from their illness and as alternative to hospitalization.

ISSUE 5: SSDI/SSI Eligibility Application

Proportionally and in comparison to other states, too few child and adult mental health consumers are using Social Security Administration (SSA) related benefit programs. Medicaid is provided to those who receive SSA's SSI benefits, those who receive both SSI and SSDI, those under special circumstances who receive only SSDI, and others who are eligible through special Medicaid programs.

Currently only about one third of adult mental health consumers can have services and medications reimbursed by Medicaid. Three out of every five adult mental health consumers also live below poverty and are not covered by any insurance program. MHMRA data shows that consumers with Medicaid coverage received service packages that are monetarily 63% richer than those who did not have such a coverage. Furthermore, since Medicaid would cover the cost of the new generation antipsychotic medications, an increase in the number of Medicaid eligible consumers will help reduce the cost overrun generated by these expensive medications.

Over the past few years, MHMRA has been experimenting successfully with two methods for helping consumers obtain eligibility for SSI/SSDI/Special Medicaid benefits. The first approach is to have a Consumer Benefits Officer assist potentially eligible consumers through out the application and appeal process. The second is to assign SSI Service Coordinators work with the consumers to better document their functional limitations and disabilities.

RECOMMENDATION 5:

The SSDI/SSI/Special Medicaid application support process must be improved in order that more persons with mental disabilities receive crucial financial supports.

a. This improvement should incorporate documentation procedures that fully reflect SSA disability evaluation criteria for all existing medical documentation formats which have the potential to influence positively the disability evaluation process. These procedures should also adopt comprehensive physical and medical assessment formats which reflect associated physical and/or functional disabilities.

b. There is a need for the local SSA office to make concerted efforts to meet the increase in the number of applications that has occurred recently.

ISSUE 6: Consumer Employment

Productive employment is both a consumer goal and the agency's mission. Although employment data is gathered as an outcome within the RDM framework, funding to train, ready, and support consumers for employment is scarce.

RECOMMENDATION 6:

a. The state and local mental health authorities should affirm and reaffirm their commitment to assist consumers with mental illness to gain full recovery and psychosocial functioning and to lead a life free from stigma and victimization. Such affirmation should be translated into a commitment to increase the number of mental health consumers among the Agency's work force.

b. The state and local mental health authorities should examine applicant and employee screening policies that put consumers with mental illnesses at a disadvantage because of the behaviors in which they previously engaged due to their clinical conditions.

c. The state and local mental health authorities should establish and/or review guidelines regarding the ADA requirements to accommodate employees with disabilities with special attention to specifying more clearly those accommodation guidelines pertaining to persons with mental disabilities.

d. There should be an implementation of a data capture mechanism in order to demonstrate compliance with Texas Mental Health Code Sec. 533.008³

ISSUE 7: Consumer-Run Alternative Programs

Consumer-run alternative programs cannot be supported with state general revenue funds. Consumer-run programs (e.g. The Rhode Island Support Program, the New Haven, Connecticut Welcome Basket Program, or other peer-support programs) have been shown to:

- Decrease hospitalization and rehospitalization, thus decreasing the overall per-consumer mental health service cost;
- Increase the self-esteem for all consumers involved—i.e., patients as well as peer consumers;
- Increase communication skills of consumers;
- Improve consumer quality of life;
- Provide participating consumers an opportunity to make a difference in another consumer's life;
- Empower consumers psychologically, socially, and financially;
- Empower consumers politically and encourage their participation in the advocacy for appropriate and effective services.

³ *EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS WITH MENTAL ILLNESS AND MENTAL RETARDATION*
Sec.533.008. (a) Each department facility and community center shall annually assess the feasibility of converting entry level support position into employment opportunities for individuals with mental illness and mental retardation in the facility's or center's service area.

(b) In making the assessment, the department facility or community center shall consider the feasibility of using an array of job opportunities that may lead to competitive employment, including sheltered employment and supported employment.

(c) Each department facility and community center shall annually submit to the department a report showing that the facility or center has complied with Subsection (a).

(d) The department shall compile information from the reports and shall make the information available to each designated provider in a service area.

(e) Each department facility and community center shall ensure that designated staff are trained to:

(1) assist clients through the Social Security Administration disability determination process.

(2) provide clients and their families information related to the Social Security Administration Work Incentive Provisions; and

(3) assist clients in accessing and utilizing the Social Security Administration Work Incentive Provisions to finance training, services, and supports need to obtain career goals.

RECOMMENDATION 7:

The State Authority should examine alternative funding mechanisms in order to implement/enhance consumer-run alternative programs.

ISSUE 8: Waiting List Services

The Department of State Health Services (DSHS) has required all local MHMR centers to implement a disease management process called Resiliency and Disease Management (RDM). Persons accessing services are assessed for level of care and placed in specific service packages in which care is authorized for a specific amount of service hours and for a specific period of time. The available revenue to provide these services and the numbers of people requiring and authorized for these services are the determining factors which may cause a waiting list to be established. As capacity for services decreases and waiting lists are established, necessary care should be taken to ensure that graver consequences do not happen to waiting list customers.

RECOMMENDATION 8:

The following procedures should be considered for funding by the state and local authorities vis-à-vis persons placed on waiting lists for mental health services:

- a. Use help line program or volunteers to provide frequent follow-up telephone contacts on the week-ends or at night for waiting list persons who are hard to reach.
- b. Ensure that persons on the waiting list know about, and know how to avail themselves of, crisis intervention services both telephonically and in person.

Figure 2: Children and Adolescent Services Strategic Priorities

New Priority		Old Priority
ISSUE 1:	Gross underfunding of services relative to documented needs	1
ISSUE 2:	Safety Net for Medically Uninsured or Under-insured Children	2
ISSUE 3:	Care Coordination and Transition Planning	4
ISSUE 4:	Access	3
ISSUE 5:	System responsiveness to changing demography	5
ISSUE 6:	Community Outreach and Parent Education	6

ISSUE 1: Gross underfunding of services relative to documented needs

RECOMMENDATION 1:

- 1a. Increase funding for early intervention to children ages three⁴ through six and residential services, day treatment, prevention, counseling, and assessment.
- 1b. Reinstate home based services and family preservation services.
- 1c. Continue funding for parent-professional partnership for effective service delivery. Such partnership includes three major components:
 - (i) intensive training of parents by professionals regarding the child’s illness, the care and the treatment plan, and the contribution and role of the parents in the plan;
 - (ii) intensive training of professionals by parents regarding how to better communicate and help children and adolescents and their families; and
 - (iii) intensive training of parents by parents in using the peer-training approach.
- 1d. If additional funding for the above increase in services, reinstatement of services, and implementation of new services cannot be made, total caseload should be decreased in the state contract in order to free up resources to fund them.

ISSUE 2: Safety Net for Medically Uninsured or Under-insured Children

RECOMMENDATION 2:

- 2a. The State should prioritize and provide sufficient General Funding to be the safety net for children who have no coverage or insufficient coverage from other private or public funds.

⁴ while strictly speaking, mental health funding covers children 3 years and up, the same concern applies to Early Childhood Intervention programs.

- 2b. DHHS must assess the impact of Child Health Insurance Program (CHIP) since its inception in 2000; especially regarding enrollment trends, barriers to enrollment, actual revenue within the public mental health system for children and adolescents and their families, and service utilization by CHIP members. Of critical concern is the identification of funds that had to be returned to the federal government due to overly restrictive state rules and regulations.
- 2c. The mental health services system must insure adequate general-fund revenue for children and families not covered by CHIP, children and families that are transitioning to CHIP, youths dropped from CHIP coverage, and children and families that because of psycho-social and cultural factors, are afraid of enrolling CHIP.
- 2d. Children in foster care are at particularly heightened risk of mental stress and illness. It is recommended that exploration at the state level be undertaken to design a physical and behavioral health coverage structure for them, so that preventive mental health services are available. In particular there should be a sound methodology for monitoring impact and outcome of the implementation of integration of physical and behavioral health plan.

ISSUE 3: Care Coordination and Transition Planning

RECOMMENDATION 3:

- 3a. Efforts must be made to expand and fund transitional planning for children who are not included in existing state-mandated populations (e.g., TDPRS, school district JPD, TYC). Special focus should be placed on ensuring that funding becomes available to facilitate the inter-agency Memoranda of Understanding (MOUs) that exist or that will be developed.
- 3b. In expanding transitional planning to heretofore-uncovered populations, parental involvement must be assured.
- 3c. Funding must be provided to facilitate the transitioning of children with emotional disorders and/or co-occurring disorders to adult mental health services, such that there is continuity of mental health services to extent that the disorders or illness persists.
- 3d. Effort must be made to facilitate the transitioning of hospitalized youth back to the school environment and the community such that they are not stigmatized by peers and adults. In particular a concerted effort should be initiated to distinguish the intellectual versus the emotional aspect of “special education”.
- 3e. “System of Care” principles should be applied in order to avoid fragmentation and duplication of services to multiple-need children and adolescents

ISSUE 4: Access

RECOMMENDATION 4:

- 4a. Services for children and adolescents should be co-located in order to improve access and coordination among mental health, behavioral health, and physical health providers and services.
- 4b. Special funding and efforts must be made available to improve the geographical access to mental health services for children and adolescents with mental illness and emotional disorder.
- 4c. Collaborative planning at state and local levels among mental health authorities and public and private transportation agencies and organizations should be carried out to provide financially reasonable, convenient, accommodating, and respectful means of transporting children and adolescents with mental illness and emotional disorder together with their caregivers so that they may access mental health services and supports and maximize independent living.

ISSUE 5: System responsiveness to changing demography

RECOMMENDATION 5:

- 5a. Funding for local children's mental health services should be based on objective criteria of child population, prevalence of priority child populations, and presence of special populations. Such planning must also be based on and congruent with the rapidly changing demographics of the state and its regions.
- 5b. Culturally appropriate programs that have been proven effective for specific ethnic and cultural groups should be given special considerations with respect to funding, case rate, and programmatic accommodations, particularly with the use of bilingual providers.

ISSUE 6: Community Outreach and Parent Education

RECOMMENDATION 6:

- 6a. The State Authority should consider either setting general revenue funds aside to fund parent-run services or permitting the LMHA's to do so.
- 6b. Additional funds should be allocated for community outreach and parent education to be provided by professionals. Consideration should be given to adopting educational models with proven best practice results, e.g., the NAMI Family Support Group program.
- 6c. The impact of community outreach and parent education services should be formally and systematically evaluated.
- 6d. School-based services should be expanded wherever needed, and maintained for those areas where they already exist.

V. LOCAL MENTAL HEALTH AUTHORITY GOALS

A. GOALS

The broad overarching institutional goals for MHMRA of Harris County are:

- Ensure provision of quality, cost effective, and consumer friendly services and supports.
- Deliver services and supports within the limits of resource availability, within payor requirements and constraints.
- Ensure that MHMRA consumers may become functioning, contributing, and integrated members of society.

Within that context a number of sub-goals and objectives emerge and can be grouped into three distinct categories: Service-related, Infrastructure, and Linkages.

B. OBJECTIVES

A. Pertaining to the MHA responsibility, the following list of Service System objectives will be discussed and operationalized into objectives as resources permit:

1. Expand the Crisis Stabilization capacity of the NPC
2. Continue to explore opportunities for implementing consumer-run services for persons with mental illness.
3. Expand the Indigent Drug Program to assist a greater number of indigent consumers obtain free medications for psychiatric and physical illnesses.
4. Continue to restructure the adult mental health services to gain maximum efficiency and value and to ensure financial viability in the light of funding decrease such as the reduction in rehab reimbursement rate and the anticipated retrospective payment approach.
5. Continue to restructure the children and adolescent services to gain maximum efficiency and value, to ensure financial viability in the light of decrease in general revenue funds, and increase satisfaction and outcome for parents and caretakers.
6. Redirect and, if possible expand, children and adolescent service capacity in order to partner with the juvenile justice system to increase the psychiatric assessment and care for children and adolescents involved with this system.
7. Continue to explore and become involved in collaborative efforts with judicial, law enforcement, and health and human service agencies as well as medical schools and institutions in order to coordinate the comprehensive care for persons suffering from mental illness and mental retardation.

Furthermore, according to the recently finished Strategic Plan, MHMRA is committed to refine infrastructure and internal support systems and to establish external links with providers and the community.

B. Infrastructure. To refine infrastructure, the MHMRA and the HCMHA set the following objectives:

1. Continue to implement, refine, and restructure to prepare for contract performance evaluation process by TDMHMR.
2. Continue efforts to meet or exceed TDMHMR performance targets.
3. Continue to implement continuous quality improvement process.
4. Continue to streamline MHMRA system to reduce costs.
5. Define quality according to consumer, family, and stakeholder satisfaction.
6. Evaluate services according to output, outcome, and cost criteria.
7. Meet or exceed Medicaid, Medicare, and third-party usage targets.

C. Linkages. To foster linkages with the community and other providers, the the MHMRA and the HCMHA set out the following objectives:

1. Continue to build and strengthen relationships with Harris County Psychiatric Center (HCPC), Ben Taub, UT Health Science Center Hospital, Harris County Hospital District (HCHD), Baylor College of Medicine, Rusk State Hospital, and other service providers.
2. Continue to build and strengthen relationships with HCPC, HCHD, Richmond State School, and other mental retardation service providers.
3. Continue to support all efforts that lead to equalization of mental health state funding.
4. Seek new resources to enhance child and juvenile services.
5. Seek opportunities to enhance relationships with county and city institutions.

VI. NETWORK PLANNING

A review of the MHMRA's history and recent collaborative activities amply illustrates that the Agency is continuously and seriously concerned with networking with providers, funders, other agencies serving persons with mental illness and mental retardation, advocacy organizations, concerned citizens, and consumers and their families. Its CBHN, for example, provides utilization management and authorization for a local behavioral health organization. The Agency's clinical staff belongs to the provider panel of the local STAR and STAR+Plus BHO's.

Resource Development and Allocation

HCMHA continuously evaluates the effectiveness of its system and strives to increase the strength of the service system through the accrual of new resources and by increasing service efficiencies. In general, there are two primary sources of funding for HCMHA: Medicaid earned revenue and general revenue from the Department of State Health Services (DSHS). The resource development activities include the following:

Maximizing Opportunities for Existing and New Funds and Resources

- Implementation of strategies to increase the number of Medicaid eligible consumers
- Obtains additional funding through service contracts with agencies, public and private providers such as Texas Education Agency (TEA), Department of Assistive and Rehabilitation Services (DARS), and Waiver programs.
- Aggressively seeks to contract with private providers through the open enrollment process to deliver services funded by DSHS to ensure best value
- Utilization of service coordinator floaters during vacation, or extended sick leave to maximize Medicaid revenue and to ensure continuity of services to consumers
- Assignment of staff member procurement and maintenance oversight of agency vehicles, and training of drivers to increase safety of consumers and to reduce cost; thereby saving dollars to increase service capacity.
- Improve efficiencies through the use of available technology such as the Blackberry, video-conferencing, and the assignment of laptops with wireless Air Cards to staff.

Increasing Administrative and Service Efficiencies

- Implementation of strategies to evaluate existing administrative, intake, and direct consumer service activities and identify and eliminate inefficiencies, clarify staff roles and activities, and modify system and processes to increase efficiencies.
- The Cost Accounting Methodology and Encounter data are closely monitored to ensure consistency between service assignments and service entry into the DSHS' CARE system to ensure compliance with the Performance Contract and to avoid loss of funds.

The local planning for the HCMHA is a collaborative effort among the PACs, HCMHA leadership staff, administrative support staff (Quality Management, Information Technology, Financial Services) and the Board of Trustees. We are very proud of the level of expertise, support, and commitment of all parties involved in assisting HCMHA to achieve success on a consistent basis. Most importantly, HCMHA has consistently displayed leadership, innovation and a "can do" attitude as demonstrated by the history of the creation of unique programs to meet the unmet needs of Harris County residents and the ability to meet or exceed the contract performance outcomes as stipulated by DSHS with limited funds.

Attachement C
NETWORK DEVELOPMENT PLAN

Attachment D
JAIL DIVERSION PLAN (revised)

