

C. CRISIS SERVICE PLAN PHASE I SUBMISSION

EXECUTIVE SUMMARY

Per contractual agreement with DSHS, MHMRA of Harris County develops this Crisis Service Plan (CSP) which is designed to meet the needs and priorities of the community by enhancing the county's existing crisis response infrastructure.

Specifically the CSP is designed to meet the following objectives as stated by DSHS and adopted for Harris County: rapid response; local stabilization when possible; diversion from incarceration; reduction of law enforcement's burden; and decrease in the use of emergency health care resources.

MHMRA of Harris County and its stakeholders propose to deploy the crisis redesign funds to support a total of 14 projects for the biennium 2008-09. These projects are highlighted below with with high-level budgeted biannual expenditures.

The most recent DSHS instructions mandate that the Local Mental Health Authorities (LMHA) focus October plan submission on Helpline and Mobile Crisis Outreach Team (MCOT). In our situation this focus would concern only projects one through four below. However, MHMRA of Harris County believes that the reader of the plan will gain a more comprehensive perspective on our crisis redesign goals and objectives if all contemplated crisis-related projects are listed. Thus, we are also including in this plan submission projects 5 through 14, which will be fleshed out with more detail for the second stage of crisis redesign planning to be submitted to DSHS by December 31, 2007.

1. Upgrade Helpline counselors qualifications to meet standards (\$316,350)
2. Balance the budget for current MCOT programs (\$2,068,800)
3. Create a joint psychiatric and police Crisis Intervention Response Team (CIRT) by expanding the capacity of the Mobile Crisis Outreach Team (MCOT) to collaborate with HPD CIT (\$909,160)
4. Create a MCOT satellite in another quadrant of the county (\$1,401,570)
5. Expand clinical coverage for the Crisis Residential Unit (CRU--\$250,050)
6. Expand PES observation from 24 hours to 48 hours (\$1,476,000)
7. Establish a 90-day intensive residential treatment (IRTP) and wrap-around services for persons with dual mental health and substance abuse (MH/SA) conditions (\$2,200,400)
8. Deploy Peer Support Specialists to work among CPEP and IRTP programs (\$365,920)
9. Establish Critical Time Intervention (CTI) along with 90-day housing for homeless and refractory consumers (\$1,809,000)

10. Fund an adult Community Resource Coordination Groups (CRCG) coordinator for individuals who are frequent users of crisis service and criminal justice system (\$117,300)
11. Fund a special coordinator position for persons in crisis who are intellectually or developmentally disabled (IDD IC--- \$117,300)
12. Fund the development and implementation of the Psych Web EOC system to create a psychiatric filter and real-time update of inpatient psychiatric capacity (both public and private) county-wide (\$165,000)
13. Increase awareness of mental illness for individuals and families through PSAs and educational flyers, posters, and other materials (\$70,000)
14. Initiate the process of developing psychiatric emergency service within the Lyndon B Johnson (LBJ) hospital (\$775,000)

The above programs, with an additional 10% administrative overhead for the new funding, total \$13,246,244 for the current biennium. In the majority of the projects, the first year budget is only half of the second year budget, since funding will arrive later in FY08.

It is also anticipated that additional funds totaling \$10,774,720 (inclusive of 10% administrative overhead) will be needed in 2010 and beyond in order to accomplish the following expansion of the psychiatric crisis capacity of Harris County:

15. An additional psychiatric emergency service (PES) unit within the LBJ Hospital (\$4,000,000)
16. An additional CSU in conjunction with the new LBJ-based PES (\$2,100,000)
17. Expansion of the CRU capacity by 18 more beds (\$1,595,200)
18. Further expansion of MCOT or CIRT (\$1,200,000)
19. Establishment of a medical-psychiatric respite program with 16 beds (\$900,000).

Subsequent sections of this plan will provide detailed justification and timelines for the proposed activities and programs listed above.

At first reading, it may appear that this plan does not address the crisis needs of children and adolescents. That impression is not accurate, since our PES and MCOT services are not restricted to just adults. Additionally, our stakeholders are confident that the greatest needs and service deficits are with adults with mental illness in crisis. Low income children have more options than adults for community mental health services that are funded through SCHIP. The Frew lawsuit also requires that the state provide all medically necessary services to children in the EPSTD program. The Legislature further increased funding for several prevention and early intervention programs for youth. Furthermore, Harris County received a six-year grant from SAMHSA to fund a System of Hope for youth and the Joint City County Commission on Children also received a grant from the Hogg Foundation to coordinate services for youth. Thus, relative to children and adolescents, low income or uninsured adults with mental illness or crisis in Harris County have fewer resources to fall back on and therefore deserve more programmatic and intervention attention.

INTRODUCTION

Houston/Harris County has experienced tremendous population growth over the last few years, enhanced by explosive foreign immigration as well as inter-state and intra-state migration. It absorbed over 100,000 residents displaced by Hurricanes Katrina and Rita, simultaneously increasing the number of adults with mental health problems.

Insufficient funding to adequately support the behavioral health (mental health & substance abuse) system, the high rate of un-insurance, and the difficulty in accessing Medicaid and Social Security benefits results in large segments of our population being underserved or not served at all.

In 2005, it was estimated that 540,000 adults in Harris County have a mental illness. Of these, about 147,000 have a serious mental illness (SMI) of severe depression, bipolar condition, and schizophrenia. Approximately 62% (92,200) of persons with SMI lack either public or private health insurance coverage and are totally dependent upon the public mental health system for treatment. By state mandate, only these persons with SMI are eligible for state-supported community-based clinical services. State funding for this type of services is, unfortunately, so limited that the community-based adult mental clinical programs can serve only 8,800 adults per month for approximately 15,000 per year. Other persons with mental illness (such as posttraumatic stress condition, obsessive-compulsive disorder, personality disorder, etc) have no place to turn, if they are uninsured or underinsured. In addition to these systemic and policy-driven deficiencies, there is also the lack of community resources such as housing options and transportation as well as inadequate supply of inpatient psychiatric beds, residential treatment units, and programs addressing co-occurring mental health and substance abuse conditions.

In Harris County, there is a drastic shortage of inpatient psychiatric beds. Many individuals who are in need of competency restoration must wait an average of 49 days in the Harris County jail before beds are available in the state hospital system. With an average of 19 available inpatient beds per population of 100,000 (excluding VA and children's residential treatment beds), Harris County has less than half the adult inpatient beds needed to meet the national average of 42 per 100,000. In order to reach the national average, Harris County would have to add another 874 inpatient beds.¹

The net result is that law enforcement entities, emergency rooms, and other crisis services are now routinely the first line of defense for persons succumbing to the ravages of mental illness. The systemic and capacity deficiencies for appropriate mental health care and support for persons with mental illness perpetuate a costly and ineffective cycle in which persons deteriorate into crisis, receive crisis care that provides temporary stabilization, fail to receive any services for a number of weeks or months, and once again deteriorate into crisis—repeating the cycle over and over again.

In following up on 2,371 individuals who presented to the PES between January 1, 2005 and June 30, 2005, it was found that, during the subsequent 24 months, 32% returned to PES, 18% were

¹ Nguyen, TD. Estimation of Psychiatric Bed Need for Harris County, Texas. Unpublished manuscript. Executive Decision Support Services. MHMRA of Harris County, 7011 Southwest Freeway, Houston TX 77074. August 15, 2007. Obtainable from tuanguyen@mhmraharris.org.

admitted to inpatient services, and 17% received forensic treatment either in jail, indicating incarceration or in pre-trial services, indicating arrests for criminal offending.² In fact, 14% of this cohort were booked into jail at least once, accumulating a total of 1,087 bookings for an average of 1.72 bookings over the two years.³

Conversely, when we followed a cohort of 6,647 inmates who were released from jail during September 2004, we found that 2,290 (or 34%) could be matched with CARE or the local mental health service programs (we refer to them as consumer-offenders or consumer-inmates). In the subsequent 36 months, 484 out of these 2,290 consumer-offenders (or 21%) used one or more publicly funded mental health programs. From this group of 484 subsequent mental health service users, 286 or 59% were served by a forensic program, either in the jail, indicating re-incarceration or by the pretrial unit, indicating re-arrests and 11% used a crisis or inpatient service for a 36-month cost of \$302,071 for crisis services and \$633,802 for psychiatric hospitalization.⁴

For the most part, individuals who lack access to pre- and post-crisis services in the community are those who come into frequent contact with law enforcement and experience reoccurring periods of incarceration.

C.1. LISTING OF COMMUNITY STAKEHOLDERS

As shown in Table 1, more than 100 persons from over 40 different public and private agencies and major mental health, physical health, human, and criminal justice programs have participated thus far in providing input to MHMRA regarding the redesign of the crisis response system for Harris County. It is our intent to post the current plan on our website, and to reach out to a larger group of stakeholders via email to invite their review and feedback for the plan by December 1, 2007.

Table 1: Listing of Harris County Crisis Service Workgroup Participants

Jack	Callahan	Advocacy, Inc.
Julia	Wolf	Agency Council
Shelia	Savannah	Area Agency on Aging-Houston
Kim	Szeto	Asian American Family Services
John	Burruss	Baylor College of Medicine
John	Sargent	Baylor College of Medicine Child & Adolescent Psychiatry
Bianca	Walker	Community Advocate
Thomas	Gavagan	Community Health Program
Paul	Becker	CSC
Peggy	Cunningham	Cypress Creek-West Oaks Hospital
Jackie	St. Germain	DBSA of Greater Houston
Daniel	Montez	Denver Harbor CHC
Curtis	Mooney	DePelchin Children's Center
Mary Jo	May	El Centro de Corazon

² Nguyen, TD Personal Communion. MHMRA of Harris County. Tuan.nguyen@mhmraharris.org.

³ Nguyen, TD Personal Communion. MHMRA of Harris County. Tuan.nguyen@mhmraharris.org.

⁴ Nguyen, TD Personal Communion. MHMRA of Harris County. Tuan.nguyen@mhmraharris.org.

Marci	Tipton	El Centro de Corazon
Ronald	Cookston	Gateway to Care
Janet	Donath	Good Neighbor Healthcare Center
Peggy	Boice	Harris County Commissioners' Court
Belinda	Price	Harris County Commissioners' Court
Calvin	Farrria	Harris County Community Supervision CD
Kim	Valentine	Harris County Community Supervision CD
Lt. Troy	Billings	Harris County Constable's Office Precinct One
Bob	Wessels	Harris County Court Administrator
Karen	Love	Harris County Healthcare Agency Council
King	Hillier	Harris County Hospital District
David	Lopez	Harris County Hospital District
Harvey	Hetzel	Harris County Juvenile Probation Dept.
Diana	Quintana	Harris County Juvenile Probation Dept.
Matthew	Shelton	Harris County Juvenile Probation Dept.
Karen	Hebron	Harris County Office of Budget Management
Clarissa	Stephens	Harris County Office of Budget Management
Amanda	Jones	Harris County Office of Legislative Relations
Carol	Oeller	Harris County Pre-Trial Department
Marshall	Shelsy	Harris County Pre-Trial Department
Kathi	Perkins	Harris County Probate Court
Judge Rory	Olsen	Harris County Probate Court No. 3
Janice	Bane	Harris County Protective Services for Children & Adults
Linda	Courtney	Harris County Protective Services for Children & Adults
Randy	Joiner	Harris County Protective Services for Children & Adults
George	Ford	Harris County Protective Services for Children & Adults
Andrew	Harper	Harris County Psychiatric Center
Arslee	Mackey	Harris County Psychiatric Center
Herminia	Palacio	Harris County Public Health & Environmental Services
Chief Mike	Smith	Harris County Sheriff's Department
Capt. Greg	Summerlin	Harris County Sheriff's Department
Kimberly	Wisburn	HC Children's Protective Service
Jeff	Webster	HCHD Administration
Jeffery	Starke	HCHD Ben Taub General Hospital
Rebecca	Santibanez	HCHD Clinical Case Management
Marion	Scott	HCHD District Healthcare for the Homeless
Martha	Stancil	HCHD Lyndon B. Johnson General Hospital
Lois	Moore	HCPC Executive Director
Steve	Racciato	Health Center of Southeast Texas
Michael	Seale	Health Services Bureau Sheriff's Department
David	Buck	Healthcare for the Homeless-Houston
Frances	Isabell	Healthcare for the Homeless-Houston
Jennifer	Jones	Hope Clinic Asian American Health Coalition
Stephen	Williams	Houston Department Health and Human Svcs.
Barbara	Sewell	Houston Federation of Families for Children's Mental Health

Lt. Mike	Lee	Houston Police Department Crisis Intervention Team
Dr Aijaz Ali	Khowaja	Ibn Sina Foundation Clinic
Jennifer	Posten	InterFaith Ministries
Katy	Caldwell	Legacy Community Health Services
Fred	Ramirez	Memorial Hermann Crisis Response Team
Cindy	Gunn	Memorial Hermann Hospital
Andrea	Hinckson	Mental Health Association-Houston
Laura	Laviage	Mental Health Association-Houston
Betsy	Schwartz	Mental Health Association-Houston
William	Schnapp	Mental Health Needs Council
Vernell	Jessie	MHMRA Administration
Don	Carruthers	MHMRA Consumer Advisory Council Northwest
Sylvia	Fitzgerald	MHMRA Consumer Advisory Council Ripley
Alexandria	Foote	MHMRA Consumer Advisory Council Southeast
Betty	Harvey	MHMRA Consumer Advisory Council Southwest
Avrim	Fishkind	MHMRA CPEP Crisis Residential Unit
Mende	Snodgress	MHMRA CPEP Crisis Residential Unit
Penny	Hipp	MHMRA CPEP Crisis Stabilization Unit
Jennifer	Battle	MHMRA CPEP HelpLine
Daryl	Knox	MHMRA CPEP Medical Director
Jodel	Oshman	MHMRA CPEP Special Projects
Barbara	Dawson	MHMRA Deputy Director CPEP
Tuan	Nguyen	MHMRA Executive Decision support
Steven	Schnee	MHMRA Executive Director
Herb	Bateman	MHMRA Mental Health Services
John	Cox	MHMRA Mental Health Services
Jennifer	Decubellis	MHMRA Mental Health Services
Mike	Downey	MHMRA Mental Health Services
Scott	Hickey	MHMRA Mental Health Services
Sylvia	Muzquiz	MHMRA Mental Health Services
Jennifer	Ray	MHMRA Mental Health Services
Rose	Childs	MHMRA Mental Health Services Deputy Director
Sarah	Flick	MHMRA Mental Retardation Services
Maria	Quintero	MHMRA Mental Retardation Services
Carson	Easley	MHMRA Nurse Manager
Jim	Everett	MHMRA NW ACT Team
Victor	Ndando-Ngoo	Motherland Clinic
Leslie	Gerber	NAMI Metropolitan Houston
Carolyn	Hamilton	NAMI-Metropolitan Houston
Martin	Woodard	South Central Houston Community Health Center
Anganette	Young	South Central Houston Community Health Center
Ted	Blanchard	Spring Branch Community Health Care Center
Robin	Harrison	Systems of Hope
Dee	Wilson	TCOOMMI
Mel	Taylor	The Council on Alcohol & Drugs Houston
Thomas	Mitchell	US Veterans Initiative-Houston

Jose	Bayona	UT Medical School-Houston
Ray	St. Germain	West Oaks MAT

C.2. PROCESS USED TO DEVELOP AND IMPLEMENT THE PLAN

In anticipation of legislative funding for and DSHS directives regarding the development and implementation of a crisis service system in Harris County, MHMRA convened an ad hoc planning group, known as the Crisis Service Workgroup (CSW), to review the current crisis capacity of Harris County and develop short, mid and long-term solutions to the need for more comprehensive and connected mental health crisis services for Harris County. This CSW built on the existing work of the community, including many of the recommendations emanating from the Jail Diversion Task Force (established since 2003) in order to develop a plan to strengthen and expand local mental health crisis services.

As shown in Section C1 of this plan, about 100 people representing county and city departments, health, human, and law enforcement agencies and organizations as well as consumers and advocates participated in the planning process. The CSW reviewed existing mental health services to identify gaps in care; analyze recent financial and utilization data related to crisis mental health services; examine the cross-over of persons using crisis services and other restrictive and intensive services such as state hospitalization, local inpatient, and jail; and develop suggested solutions to enhance crisis services and recommend various metrics/performance measures to be used to evaluate and monitor future crisis services. In addition, the Director of MHMRA's CPEP monitored the DSHS' efforts to redesign the requirements for state-funded crisis services to help ensure that the CSW's work would be aligned with the new State requirements.

After the second meeting, a number of sub-groups were created in order to focus on key issues that the CSW had previously identified as having a high priority. The charges to the CSW sub-groups are to:

- Prioritize, if several options are considered
- Describe the proposed program, including how to refer to the program and from the program.
- Reference/describe any evidence based practices, or similar successful programs elsewhere
- Suggest performance and/or outcome measures and timeframe for measuring success
- Suggest actions to be taken if the proposed program is not successful within timeframe
- Provide preliminary estimated budget and estimate how long to implement the program
- Consider what other services/programs are needed to help make your program a success
- Address concerns regarding: Are there other changes (legislative or otherwise) that would facilitate the success of the program? Are there other barriers to success?

The CSW sub-groups are:

- Treatment/Jail Diversion
- Medical – Respite
- Telemedicine – PES
- MR Liaison (IDD)
- Crisis Outpatient – Peer Support

- MCOT – CIT
- Transportation
- CRCG Adult Coordinator
- Criminal Justice

The preliminary sub-group reports are included in Attachment A to this plan.

To date, an overall general frame of reference could be derived from the CSW's work regarding an ideal crisis service system for Harris County:

A mental health crisis is not an isolated incident. It is one of the many possible manifestations of acute or chronic mental illness. It has predisposing as well as precipitating psychosocial and environmental conditions. An efficient, comprehensive, and effective mental health crisis response system (CRS) therefore does not deal with just the event. Such a system must also identify and address the triggers, risk factors, or critical events that lead to a state of mental and behavioral crisis.

The CRS objectives are: rapid response, local stabilization when possible; jail diversion and reduced burden on local law enforcement; decreased utilization of emergency healthcare resources; and realignment of existing crisis services to provide an integrated crisis system built around the recommended best practices. This Harris County CRS model is congruent with the DSHS's directive, namely: "[w]hile the new funding must be directed to the array of initial crisis services identified in the [State's] Crisis Services Redesign Report, the specific mix of services to be implemented will be based on a community's needs, priorities, and existing resources. . . . Additional services to be provided will be determined by the LMHA based on local needs and priorities, existing infrastructure, available funds and current collaborative activities." (p. 5).

The CSW identified major components of an ideal CRS, and arrayed them into three categories of PRE-CRISIS, DURING-CRISIS, and POST-CRISIS programs or activities, as follows:

Pre-Crisis (Early intervention) Activities or Programs

- CIT type training in school districts coupled with more training for school personnel
- Caregiver development program
- Funding for families seeking guardianship
- Peer support groups and education
- Staff training /development of staff
- Improve/increase access to services by establishment of multiple access locations
- Education of public as well as mental health caretakers and caregivers
- Transitional services for adolescents soon to become adults

During-Crisis Activities or Program Capabilities

- Adequate PES services that are co-located with other health, human, and law-enforcement agencies or in neighborhoods coupled with telemedicine
- Co-location of PES with hospital services (at LBJ or other major inpatient locations)
- Adequate and expedient access to MCOT services through co-locations, home based, and telemedicine (also can serve briefly during post-crisis to help link and prevent cycling through again)
- Full availability (24/7) of MCOT services that are also coordinated or integrated with law-enforcement CIT activities
- Adequate crisis stabilization capacity or short-term crisis residential program capacity
- Availability of outpatient program for the restoration of competency
- Availability of data base (data warehouse) that allows real time access to person's history with crisis services and jail prior to booking so that service providers can see the person's history of mental health services
- Availability of a diagnostic unit at the front door of the jail
- Dedicate funding for the Psych WebEOC design and execution (this is a psych bed capacity website hosted by SETTRAC to deliver real-time capacity driven psych beds for the community)
- Capacity to meet the special needs of persons with intellectual and developmental impairments who experience mental health crisis
- Longer psychiatric emergency observation time (from 23 to 48 hours) in order to promote stabilization, thus avoiding inpatient admission
- Improved and extended integration of mental health and substance use services for persons experiencing both conditions
- Outpatient crisis services for appropriate populations such as persons needing restoration of competency, court-mandated outpatient treatment, etc.

Post-crisis Activities or Programs

- CRCG type committee/program for specific adult population, for example, those who cycle through crisis services frequently. This type of program might serve as a focal point to coordinate efforts with other initiatives such as Medicaid Reform, Health Opportunity Pool, TYC funding, etc.
- Reassurance calls for those coming out of crisis
- Longer term residential/treatment center for persons in crisis with dual diagnosis conditions, with or without court order for those coming through the criminal justice system
- Post-jail-release programs to prevent relapse leading to use of crisis services or re-incarceration
- Peer support groups and education
- Availability of transportation options so that consumers can access appropriate outpatient services post-crisis

C.3. CURRENT GAPS AND NEEDS RELATED TO CRISIS SERVICES IN HARRIS COUNTY

Section C.5.b and the CSW preliminary sub-group reports included in Attachment A provide more detailed discussion regarding the gaps and needs that prompted each action plan that is recommended and designed with specific budgets. In reviewing the CRS components listed in section C.2, the CSW group was in agreement that all of the components were totally lacking (particularly among the pre-crisis and post-crisis categories) or need significant expansion or improvement in order to meet the access, quality, or response time of an adequate CRS for Harris County. Attachment B summarizes the CSW rating for each CRS component.

C.4. DESCRIPTION OF CURRENT CRISIS RESPONSE SYSTEM

Prior to 1999, MHMRA, with input from community stakeholders, developed a plan for a Comprehensive Psychiatric Emergency Program (CPEP) serving Harris County. The CPEP model represents the standard of care in large, urban settings in the United States. The CPEP is intended to allow MHMRA and the community to utilize less expensive and less restrictive alternatives to hospitalization and incarceration whenever possible.

In October 1999, MHMRA of Harris County opens the doors to the Neuropsychiatric Center (NPC).

To date, MHMRA, with strong support and collaboration from the community, has implemented **all** of the CPEP components, which are:

- Crisis HelpLine
- Mobile Crisis Outreach Team (MCOT)
- Psychiatric Emergency Services (PES)
- 23-Hour Observation Unit (23 Obs)
- Crisis Stabilization Unit (CSU)
- Crisis Residential Unit (CRU)
- Crisis Counseling Unit (CCU)
- Program to Assist Transition from Homelessness (PATH) and Community Liaison Services.

Adjacent to the Ben Taub General Hospital (GTGH), the NPC is open 24-hour a day, seven days a week. The NPC houses the psychiatric emergency services (PES) which provides triage and 23-hour observation on the first floor for as many as 50 adults, children, and adolescents per day. This facility resulted from collaborative planning dating back to 1995 by a task force, which included representatives from MHMRA, HCPC, the University of Texas Health Science Center at Houston, the Harris County Hospital District, Rusk State Hospital, Baylor College of Medicine, Harris County AMI, the MHA of Houston and Harris County, the Mental Health Needs Council. The task force also received input and advice from other agencies and concerned consumers and citizens.

The NPC became the focal interfacing point with law enforcement agencies for voluntary and involuntary mental health interventions and diversion of persons with mental illness from the jail.

The Crisis Stabilization Unit (CSU) was opened on the second floor of the NPC to provide short-term inpatient care averaging three to five day stay.

Recognizing the need to offer outreach services designed to stabilize or increase insight into illness for individuals in the community who are unable to participate in outpatient treatment without intervention, MHMRA began operating a Mobile Crisis Outreach Team (MCOT) in February 2003. MCOT is available 7 AM to 10 PM week days and 9 AM to 9 PM week-nights. On the weekend and in the evening, MCOT staff also screens voluntary walk-in patients at HCPC. The flexibility of a clinical team traveling on a vehicle to the consumer offers an alternative resource to assessment and treatment to which the outpatient clinics does not have access. Undoubtedly, a major advantage, compared to the clinics, is the capability of MCOT to fill service gaps by linking the individual to outpatient clinic services if deemed appropriate.

In 2004, a Crisis Residential Unit (CRU) was established as a component of the CPEP. The CRU is designed for people who are chronically and seriously ill who frequently come seeking emergency services and are not improving on their own. The majority of these people suffer dual conditions of mental illness and substance abuse or use. CRU consumers stay anywhere from 3 days to 4 weeks. The average CRU stay is 10 to 14 days.

Below, in greater detail, are summaries for each current emergency and diversionary service provided through MHMRA's CPEP and the location of each service.

Crisis HelpLine. Located at MHMRA, 7011 Southwest Freeway, this 24-hour-a-day telephone service provides a crisis hotline and information and referral services for all Harris County residents needing emergent or urgent psychiatric services. It began operations in June of 2003. For many consumers needing psychiatric services, it serves as the first point to obtain the necessary and appropriate services. HelpLine staff work with the caller to determine the appropriate next step then make referrals to the necessary services. The Crisis HelpLine helps decompress the NeuroPsychiatric Center and Ben Taub psychiatric emergency services by triaging non-emergent problems to routine outpatient treatment centers. During the past 12 months, the program has answered an average of over 2,250 crisis calls per month, with approximately 150 of those calls being placed by people in a very high degree of crisis. The HelpLine staff provided telephone assessments, screenings, crisis counseling, and appropriate referrals, including MCOT and PES referrals when indicated. The HelpLine also answered about 15,000 calls per month addressing consumer questions and providing information about MHMRA or other community resources, and routine business calls. **Sixty-two percent of the total call time was spent on crisis/service calls, 30% on consumer-related business calls, and 8% on business calls.**

Psychiatric Emergency Services (PES). Located at the NeuroPsychiatric Center (NPC), 1502 Taub Loop, this is a 24-hour a day psychiatric emergency room. In the past twelve months PES has served 10,882 Harris County residents (duplicated count). Fifty-three percent of PES users were indigent or uninsured. Over 3,400 people were brought in by law enforcement (an increase from the previous year of 600), and 1,025 were children or adolescents. PES has had a profound impact on emergency care in Harris County, as those 10,882 consumers would have inundated the Harris County Hospital

District emergency rooms (Ben Taub and LBJ) and the jail system. **Seventy percent of PES consumers were able to return to the community without incurring the cost of inpatient hospitalization.**

23-Hour Observation Unit (23 Obs). Located at the NeuroPsychiatric Center (NPC), 1502 Taub Loop, this is a psychiatric intensive care unit within the PES, and staffed by PES clinicians. This component has served 961 Harris County residents in the last 12 months. This unit is designed to treat and stabilize acutely mentally ill consumers who upon admission to the unit meet full criteria for psychiatric hospitalization. Many of the consumers treated in this program were brought in by law enforcement on an involuntary basis. **Seventy percent of the consumers served in the 23 Obs program in the past twelve months returned to the community without incurring the cost of an inpatient hospitalization.**

Crisis Stabilization Unit (CSU): The CSU is a 16 bed program located at the NeuroPsychiatric Center (NPC), 1502 Taub Loop. The CSU provides hospital-like services in a less costly, less stigmatizing, and less restrictive setting than inpatient hospitalization. The program is designed to serve voluntary patients who can be stabilized within a three to five day length of stay, and who can then be linked to community supports. During the past twelve months the unit provided services to 1,452 Harris County residents. **An average of 120 consumers per month have received treatment in the CSU, with an average length of stay of 3.5 days, compared to 10 days average length of stay at a psychiatric hospital. In addition, the number of voluntary adult admissions to HCPC has averaged 50 consumers or less per month. Consequently, there has been a significant increase in relative bed availability at Harris County Psychiatric Center for uninsured persons needing involuntary treatment.**

Crisis Residential Unit (CRU) Located at Bristow Center, 2627 Caroline Street, the CRU provided community-based crisis residential services for approximately one-third the cost of traditional inpatient hospital beds to 527 people during the past twelve months. The program has been designed to serve voluntary consumers who could be stabilized and linked to community supports within seven to fourteen days of treatment while living in residential settings. CRU's are well established nationally as effective alternatives for many consumers experiencing a psychiatric emergency who do not need the more restrictive settings of inpatient or crisis stabilization units. Therapeutic interventions include cognitive behavior therapy, psychosocial rehabilitation, Good Chemistry (a nationally recognized program for alcohol and drug addiction), skills training, and individual therapy. The physician located at the CRU site may also provide brief consultations to consumers in the co-located Bristow Homeless Program. **The program has served an average of 40 consumers per month, with an average length of stay of 11.2 days. Of those served, 51% were linked to an MHMRA clinic, 19% were linked to substance abuse treatment, and 9% were linked to HCHD clinics or medical treatment.**

Crisis Counseling Unit (CCU). This service is located at Bristow Center, 2627 Caroline Street and is operated in conjunction with the CRU. (The cost for Crisis Counseling is included in the cost of the Crisis Respite Beds and the CRU staff provides the

services.) CCU staff provide time-limited outpatient therapies during the initial days of the psychiatric crisis, preventing deterioration leading to a full-blown psychiatric illness. The clinical social workers provide services to consumers in the CRU as well as those needing short-term crisis counseling who have received emergency services at the NPC.

Mobile Crisis Outreach Team (MCOT): Located at Bristow Center, 2627 Caroline Street, MCOT served 2,352 Harris County residents in the past twelve months. The program provides emergency and urgent crisis outreach and follow-up by traveling to locations and evaluating persons, both adults and children, in the community who cannot or will not access traditional psychiatric emergency room care. Teams frequently go to schools to provide interventions, which allow the student to stay in school. Inpatient hospitalization is avoided through the use of preventative medicine, reducing the likelihood that a person would become dangerous to self and others before getting help. Follow-up visits are provided to insure linkage into outpatient services. This program interfaces with and complements the Harris County Crisis Intervention Team Programs (CIT) by intervening with those consumers who do not warrant detention, or before emergency detention becomes necessary. They also assist HCPC by providing on-site evaluation/screening of consumers who “walk in” to HCPC seeking hospitalization after hours, with the expectation that a percentage of those consumers can be diverted to a less restrictive and less expensive level of care. In the last twelve months, MCOT has provided mobile crisis outreach to an average of 185 consumers per month, with an average of six services provided per consumer. Services provided included triage, assessment, rehabilitation and counseling, medication/nursing, and monitoring and linkage. **The preponderance of MCOT consumers (42%) were linked into MHMRA outpatient clinic services, 22% to other agencies or providers and 3% to substance abuse programs. Only 4% required linkage to a higher, more intensive level of care (inpatient hospitalization).**

Program to Assist Transition from Homelessness (PATH). Located at Bristow Center, 2627 Caroline Street, this program is frequently referred to as the Bristow Homeless Program. It is a federal grant to MHMRA. The program provides PATH services to persons in Harris County who are literally and marginally homeless and experiencing serious mental illness. Any individual claiming to live in Harris County is eligible to receive services, and services are provided in a variety of locations throughout Harris County, including the streets, the MHMRA drop in center, local shelters, domestic violence shelters, churches, schools, and other social service agencies. Staff provide services in any location, whenever the client is ready and willing to receive them. Services include: Outreach, Screening and Diagnostic Treatment, Habilitation and Rehabilitation Services, Community Mental Health Services, Case Management, Supportive and Supervisory services in residential settings, Referrals for Primary health Services, Job Training, Education services and Relevant Housing Services. MHMRA provides PATH Services to an average of 800 enrolled adult clients and 50 enrolled children and adolescents. **At least 75% of the clients enrolled are literally homeless and 25% are marginally homeless. MHMRA also provides a minimum of 1,500 outreach adult contacts and 100 outreach children and adolescents contacts throughout the year.**

Community Liaison Services (CLS). Historically known as HCPI this service is located at the Harris County Psychiatric Service (HCPC). CLS staff assist complainants for the Probate Court and provides histories to the court based on the interviews. The department also screens all walk-in voluntary consumers seeking admission to the hospital and allocates HCPC general revenue beds to the Probate Court. It provides liaison and related services to the court in the areas of medication and furlough orders, and the physician assigned to the program serves as the Single Portal Authority for medical clearances to Rusk State Hospital.

C.5. a. DESCRIPTION OF ACTIVITIES TO MEET THE AAS REQUIREMENTS

AAS has certified CPEP's hotline operation since it began operating in 2003. In January 2007, AAS surveyed the program and recertified it for 5 years, which is the longest certification they will give. Thus, in terms of AAS requirements, Harris County crisis response system (CRS) is in compliance. However, DSHS has established new standards for crisis hotline. Project # 1 in the next section is planned in response to this DSHS standard.

Generally, all CPEP staff must follow a rigorous training program, above and beyond their clinical training and certification or licensing, prior to assuming duties in any of the CPEP programs. Each CPEP's component has its own training curriculum. These training curriculae are too wiely to include as part of this plan. Included in Attachment C, as an example, is the outline of a training program specific to new employees at one major CPEP component.

C.5.b. DESCRIPTION OF ACTIVITIES AND PROGRAMS TO MEET THE DSHS REQUIREMENTS

MHMRA of Harris County is proposing 19 projects where new Crisis Redesign funding can be deployed. Fourteen (14) are new or expanded programs or activities that are proposed to be funded during the current biennium funding cycle. Five (5) expansion or modification areas are also anticipated for funding after 2009. Each is listed below with some background information, justification of need, description of essential functional and programmatic activities, and anticipated funding needs. Projects 1 through 4 address directly the DSHS-mandated phase I planning to be submitted October 31, 2007. Projects 5 through 14 will be reviewed and redesigned as appropriate for phase II planning to be submitted December 31, 2007 to DSHS.

C.5.b.1 Current Biennium Projects

1. Upgrade Helpline counselors qualifications to meet standards (biennium total: \$316,350; FY08: \$105,450; FT09: @210,900)

The proposed DSHS standards require that all HelpLine counselors that do assessments be at least QMHPs. This standard means that we must upgrade those positions that currently do not meet the bachelor degree requirement.

2. Balance the budget for current the MCOT component of CPEP (biennium total: \$2,068,800; \$1,034,400 per year)

Neither the state nor county has provided cost of living increases in funding since the initial allocations were made, the majority of which dating back to 1999. Also, many of the positions within our CPEP programs are considered shortage occupation positions (such as psychiatrists, RNs and clinical social workers). The competition for attracting qualified professionals to fill these shortage occupation positions has compelled MHMRA to increase the salaries and compensation for those positions significantly in the past four years. Other costs have also continued to rise, some of them dramatically, such as the cost of utilities and gasoline.

3. Create a joint psychiatric and police Crisis Intervention Response Team (CIRT) by expanding MCOT capacity to collaborate with HPD CIT (biennium total: \$909,160; FY08: \$240,000; FY09: \$661,160)

Expand MCOT to specifically include one LPHA per shift who will be team up full-time with a Houston Police Department's CIT officer to create a Crisis Intervention Response Team (CIRT). This proposal is also being presented to Houston Police Department's Chief Hurtt, along with a request to expand and redefine the CIT program.

If the program is successful, the number of LPHA's assigned could double in the second year.

4. Create a MCOT satellite in another quadrant of the county (biennium total: \$1,401,570; FY08: \$588,250; FY09: \$813,320)

Harris County is the most populous county in Texas and the third most populous county in the United States. The county has a total area of 1,778 square miles. Crossing it diagonally takes easily one full hour or longer. Many sub-sections of the county, such as Baytown, La Porte, League City, are actually isolated from the rest of the county because of water ways or lack of surface roads. There are 31 different cities and 23 independent school districts in Harris County. Each of these entities has a police department. Consequently there are, in addition to the eight (8) constable precincts covering the unincorporated areas, over 50 law enforcement (police) agencies. Thus, the coordination of MCOT with law enforcement agencies in order to effect greater jail diversion when there is a crisis is a challenging and complicated task. Establishment of additional MCOT sites will assist in reducing this complexity and result in faster response time. This expansion will begin with the selection of one additional quadrant of the county for the establishment of a second MCOT unit.

Greater detail regarding projects 3 and 4 are presented in section C.5.b.2.

5. Expand clinical coverage for the Crisis Residential Unit (biennium total: \$250,050; FY08: \$83,350; FY09: \$166,700)

The proposed standards require that in a CRU clinical staff must be on duty 24/7. There are also very short time constraints on how quickly an RN assessment must be completed, even after hours, and that 4 hours programming be provided on weekends.

We currently do not have clinical staff on duty before 7:00 am and after 8:00 pm weekdays. At those times the unit is staffed with psychiatric technicians, which is a common practice within these types of programs. Those positions would need to be converted to QMHP positions. On the weekends one clinical social worker is on the unit to provide programming for 6 hours each day. Not every resident receives a full four hours of programming on Saturday and Sunday. Many receive 2-3 hours. The program director and psychiatrist are on call if needed.

6. Expand PES observation from 24 hours to 48 hours (all in FY09: \$1,476,000)

Expanding from 24 Hour Observation to 48 Hour Observation is a priority endorsed by the CSW, with the expectation that longer observation will lead to a greater percentage of crisis consumers being sufficiently stabilized so that they need not be referred to the CSU or HCPC.

This expansion will require additional staff and beds. The current observation area is not adequate to accommodate these additional resources. Thus, in addition to increasing the operational cost, we will also need to plan for one-time infrastructure modification and build-out.

7. Establish a 90-day dual diagnosis (MH/SA) intensive residential treatment (IRTP) and wrap-around services (biennium total: \$2,200,400; FY08: \$740,300; FY09: \$1,460,100)

Although the state and federal funding streams have been strictly categorical (thus, impeding the ability of communities to effectively and efficiently develop programs that serve and support consumers with multiple needs), MHMRA has time and again ***innovatively and successfully combined services to serve persons suffering concurrently from multiple disorders***, whether the dual conditions include mental retardation and mental illness or mental illness and chemical dependency. The positive outcomes of these initiatives have convinced us to develop and implement not only multidisciplinary but also multi-specialty approaches to achieve maximum programmatic efficiency and effectiveness.

Using Crisis Redesign funding, we propose to establish a 90 day dual diagnosis intensive residential treatment and wrap-around service. This is accomplished by contracting with current substance abuse providers for a total of 40 slots at any given time (20 for inmates coming out of the Forensic program at Harris County Jail and 20 slots for consumers coming out of CPEP programs) at \$79/day.

One MHMRA employee with a LCDC (licensed chemical dependency counselor) certification will assist with assessments and liaison with providers. All consumers considered for this program will meet DSHS targeted population in terms of their primary mental health diagnoses. While enrolled in the program, they will also receive support through the MHMRA's regular assertive community treatment (ACT) or forensic assertive community treatment (FACT) teams. Additionally, during the first year one peer-support position (and in the second year at total of two peer support positions), see below, will be trained to address the support needs of this program residents.

We anticipate providing this type of service to at least 160 individuals over the course of a year. The first year includes some initial equipment costs.

8. Deploy Peer Support Specialists to work among CPEP and IRTP programs (biennium total: \$365,920; FY08: \$115,000; FY09: \$250,920)

According to the Center for Medicaid and State Operations, Department of Health and Human Services, Baltimore, Maryland, “Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance abuse disorders.”

Peer Support Providers are self-identified consumers who are in recovery. Peer support services are coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. The Peer Specialist performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Peer Providers are able to teach and role model the value of every individual’s recovery experience and model effective techniques and self-help strategies by lending their unique insight into mental illness.

From the Center for Medicaid and State Operations, “Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. Similar to other provider types, ongoing continuing education requirements for peer support providers must be in place.”

MHMRA proposes to establish Peer Support Specialists to work among the CPEP programs to teach and role model the value of the recovery experience and model effective techniques and self-help strategies by lending their unique insight into mental health crises and mental illness. One time equipment purchase included in the first year. There will be a total of eight (8) positions in FY08 and nine (9) total positions in FY09.

9. Establish Critical Time Intervention (CTI) along with 90-day housing for homeless and refractory consumers (biennium total: \$1,809,000; FY08: \$603,000; FY09: \$1,206,000)

Research has demonstrated that CTI significantly reduces new episodes of homelessness and that the positive effects of the intervention extend beyond the intervention period.⁵ “Over the study period, the critical time intervention group and the usual services group incurred mean costs of \$52,374 and \$51,649, respectively, for acute care services, outpatient services, housing and shelter services, criminal justice services, and transfer income. During the same period, the critical time intervention group experienced significantly fewer homeless nights than the usual care group (32 nights versus 90 nights). For each willingness-to-pay value—

⁵ Kristine Jones, Ph.D., Paul W. Colson, Ph.D., Mark C. Holter, Ph.D., Shang Lin, Ph.D., Elie Valencia, J.D., M.A., Ezra Susser, M.D., Dr.P.H. and Richard Jed Wyatt, M.D. Cost-Effectiveness of Critical Time Intervention to Reduce Homelessness Among Persons With Mental Illness. *Psychiatr Serv* 54:884-890, June 2003 © 2003 [American Psychiatric Association](http://www.psychservices.psychiatryonline.org/cgi/content/full/54/6/884). Article is fully accessible at <http://www.psychservices.psychiatryonline.org/cgi/content/full/54/6/884>

the additional price society is willing to spend for an additional nonhomeless night—greater than \$152, the critical time intervention group exhibited a significantly greater net housing stability benefit, indicating cost-effectiveness, compared with usual care.”

CTI emphasizes short-term (9 months), intensive case management for consumers who are homeless, refractory and have been unable to engage in traditional mental health services. CTI is comprised of three 3-month phases of decreasing intensity and involvement by the case manager. The case manager actively engages consumers in connecting, developing and strengthening relationships with family, friends, neighbors and community providers who will ultimately replace the role of the case manager and serve as the consumer’s primary support system.

CTI services are reserved for only RDM eligible consumers who qualify for level 3 or level 4 of DSHS’ Resilience and Disease Management (RDM) design. CTI consumers will be also recruited from among non-compliant users of emergency services or repeat offenders with a non-compliant mental health history who are released from jail.

10. Fund a coordinator for a Community Resource Coordination Group for Adults (CRCGA) who are frequent users of crisis service and criminal justice system (biennium total: \$117,300; FY08: \$40,900; FY09: \$76,400)

According to the Biennial Report to the Governor and the 80th Texas Legislature, initial legislation was passed in 1987 developing Community Resource Coordination Groups (CRCG) to deal with children and families with multi-agency needs. The CRCG concept is designed to develop customized, integrated, individual service plans. A State supported approach to serve adults using the CRCG model began in 1999. Currently the CRCG program is authorized by legislation passed by the 77th Legislature. This legislation reiterated the commitment to serving children and youth and added a requirement for State agency participation in building the capacity to serve adults through the CRCG model.

According to data collected by the Texas Health and Human Services Commission, services for adults referred to CRCG’s across Texas generally revolve around basic needs, mental health care, physical health and substance abuse services. A CRCGA Coordinator in Harris County would have a significant impact on interagency cooperation and service delivery to individuals who have a history of utilizing crisis services or services from a variety of agencies.

Within the context of this Crisis Service Plan, the adult CRCG coordinator will address the needs of individuals who are frequent users of crisis services in Harris County. The Harris County’s Office of Budget Management and MHMRA have identified a significant number of adult recidivists who have multiple needs, are involved repeatedly with many criminal justice, physical health, mental health, and social service agencies and are high users of these agencies’ services.

The full time CRCGA Coordinator would be assigned the responsibility to staff these difficult cases with representatives of agencies who are able to provide needed services in a wraparound manner. A group of about 35 extremely high utilizers has already been identified. This position would be assigned the responsibility of staffing these and other

difficult cases with representatives of agencies who may be able to provide needed services. The first year includes initial equipment costs.

11. Establish a Crisis IDD Intervention & Coordination function for persons with intellectual or developmental disabilities who are in crisis (biennium total: \$117,300; FY08: \$40,900; FY09: \$76,400)

A Crisis Intervention Coordinator with the knowledge of the different crisis service systems in Harris County and statewide is proposed to assist persons with intellectual and developmental disability (IDD, previously known as mental retardation) to navigate the systems appropriately. The coordinator will also have the authority to act quickly to move the person into a situation that resolves the crisis by any and all of the following activities:

- Accessing alternative services;
- Interfacing productively with other healthcare and human service entities;
- Educating everyone about realistic options to different situations facing a person with IDD who is in crisis.

The position incumbent shall have a Master Degree in the Human Services field, with 3 years experience preferred. Also preferred but not required are a license and bilingual skills. The position will be compensated at a salary level that gives it authority comparable to the directors and others with whom the person will be working and negotiating fast action.

The position would be part of MR Authority Services and housed at the Mental Retardation Authority (MRA) headquarter, with a secondary work station at the CPEP. The position incumbent is expected to participate in CPEP staff meetings, training, etc., as part of the CPEP team.

12. Fund the development and implementation of the Psych Web EOC system to create a psychiatric filter and real-time update of inpatient psychiatric capacity county-wide (all in FY08: \$165,000)

WebEOC is the bed capacity website hosted by SETTRAC (South East Texas Trauma Regional Advisory Council) to deliver real-time capacity driven inpatient beds for the community. SETTRAC will be able to deliver rewards and contingencies for the psychiatric hospitals to participate in a psychiatric component of WebEOC. However, SETTRAC is looking to the Network of Behavioral Health Providers (NBHP) to drive the community participation in modeling a psychiatric WebEOC prototype. SETTRAC also needs a system model in order to move forward. SETTRAC considers NBHP to be the natural leader as the WebEOC is sculpted to fit the needs of the community. SETTRAC has chosen NBHP based on its community-wide membership and hence its one-stop-shop ability to galvanize the psychiatric service community voice in to a centralized action position.

The first level of WebEOC draft will be developed and submitted to the Regional Hospital Preparedness Council. This first draft will include a request for daily updates by the psychiatry inpatient community and a special psychiatry view filter. This will make psychiatric WebEOC relevant in the first phase of operation. As the project moves forward, there will be more requests to enhance the operation. NBHP, of which MHMRA is a member, gives the community a focal point to address growth for all.

13. Increase awareness of mental illness for individuals and families through PSAs and educational flyers and posters (biennium total: \$70,000; \$35,000 each FY)

MHMRA has also established Consumer Advisory Councils (CAC) at its major community-based mental health centers. In the past the CACs played a critical role in organizing formal conferences to educate consumers as well as family members about the psychosocial and interpersonal challenges associated with persons with mental illness, about key approaches to minimize the risk of decompensation, and about effective ways to help persons with mental illness to continue their recovery. We plan to incorporate or enhance these types of educational opportunities.

For several years, NAMI has operated 2 programs, “Family to Family” and “Journey of Hope”, which have fully developed curricula to help family members understand symptoms of mental illness and how to access help. NAMI and the Depression and Bipolar Support Alliance also provide support for family members and consumers through ongoing support groups throughout the City. These programs are in need of resources to expand and meet the needs of families across Houston. Furthermore, we proposed to establish a comprehensive advertising campaign that would:

- normalize mental illness thereby encouraging people to seek help;
- provide symptom and risk management information; and
- share information to facilitate access to services.

While most advertising time (public services announcements, bill boards, etc) could be donated, a budget would include the cost of developing the campaign, including materials and staff to lead the initiative.

14. Initiate the process of developing psychiatric emergency service within the Lyndon B Johnson (LBJ) hospital (all in FY09: \$775,000)

Preliminary discussion has already started between MHMRA and HCHD about many collaborative efforts. These range from sharing of eligibility data, improving referral patterns, better coordination of psychiatric and physical emergency services, to co-location of psychiatric and mental health services within the HCHD clinics for those HCHD catchment areas from which a large number of residents access MHMRA services. Both MHMRA and HCHD are members of the Harris County Healthcare Alliance. The goal of the Alliance is to improve care coordination for indigent residents and to enhance resource and information sharing such that the Alliance’s members reach higher levels of efficiency and effectiveness. The idea of developing a psychiatric emergency service within the LBJ hospital in order to relieve the pressure on Ben Taub hospital, and improve access to PES for residents of the LBJ hospital’s catchments area has moved beyond the stage of contemplation, to the stage of feasibility analysis. This analysis will become more systematic, detailed, and comprehensive with additional funding to support its activities.

C.5.b.2 Side-by-Side Descriptions of Projects Mandated to be Submitted October 31, 2007

1. Helpline Upgrade

Current Situation	FY08 & FY09 Situations
Not all phone line counselors (15.6 FTEs) not have a bachelor degree	<ul style="list-style-type: none"> • 15.6 FTEs phone line counselors will have QMHP qualification. • The positions will be upgraded through attrition only. • The additional cost will be \$360,350 over the two fiscal years.

2. MCOT Upgrade and Expansion Projects

Current Situation	FY08 & FY09 Situations
MCOT funding deficit is \$1,034,400 annually. Without additional revenue, the MCOT capacity will have to be curtailed.	<ul style="list-style-type: none"> • Maintain current MCOT capacity by using \$1,034,400 in FY08 and \$1,034,400 in FY09 from Crisis funding allocation.
There is no Crisis Intervention Response Team (CIRT) in which MCOT and HPD team together to intervene in crisis situations involving persons with mental illness.	<ul style="list-style-type: none"> • Establish Crisis Intervention Response Team (CIRT) for \$240,000 in FY08 and \$661,160 in FY09 from Crisis funding allocation.
There is only one MCOT site in central part of Houston which limits outreach capacity and response time.	<ul style="list-style-type: none"> • Maintain current capacity (see above) • Add a second site to cover one underserved quadrant of the county for \$588,250 in FY08 (including \$83,820 in one time supply and equipment) and \$813,320 in FY09 .

Below is the detailed narrative of this major expansion and modification of the Harris County's MCOT component.

We will expand the existing MCOT capacity by adding a second team to be housed at a satellite location in Northeast Houston. The projected benefit of the MCOT expansion is to (1) Expand the number of MCOT staff available to respond to crisis calls, as well as (2) Improve the response time of MCOT staff, especially to those clients living in the northern part of the county.

The current Mobile Crisis Outreach Team is comprised of specially trained mental health professionals who provide crisis intervention, short-term (up to 4 weeks) mental health treatment and supportive services, to individuals who are experiencing symptoms of mental illness. Services are provided in the community wherever the client is located. Services include, but are not limited to crisis intervention, medication assessment and management, nursing services, counseling and psychotherapy and case management. The goal is to intervene early to provide needed mental health

services to prevent further deterioration and/or the need for services in a more restrictive environment. When a more restrictive environment *is* required, MCOT *will* facilitate admission to a higher level of care, as indicated. When MCOT services are completed, the client is linked with ongoing mental health services in the community. MCOT services are voluntary and the client must be willing to consent to services.

Harris County is comprised of 1,778 square miles and the existing MCOT Team is centrally located in downtown Houston. MCOT staff currently travel throughout Harris County to provide services to clients experiencing a mental health crisis. The addition of a second team and location will enable the existing MCOT staff to focus their responses on the central, southeast and southwest parts of the county, while the new team would focus their attention and energy on the northeast and northwest quadrants of the county.

Both teams, while housed in different locations, will function as one MCOT component of the CPEP, sharing the same administrative supervision and oversight. All MCOT staff will receive the same training and supervision and will be expected to follow the adopted program policies and procedures. The day to day operation of both teams will follow the same configuration, and the data and reporting requirements for both teams will be uniform. While having assigned work locations, staff from both teams will collaborate and provide coverage for each other, when indicated.

C.5.b.3 Flow Charts of Projects Mandated to be Submitted October 31, 2007

Below are two flowcharts. The first one describes the overall CPEP operation and the second one relates specifically to the operational flow of MCOT activities.

Figure 1: General CPEP Flowchart

MHMRA CPEP

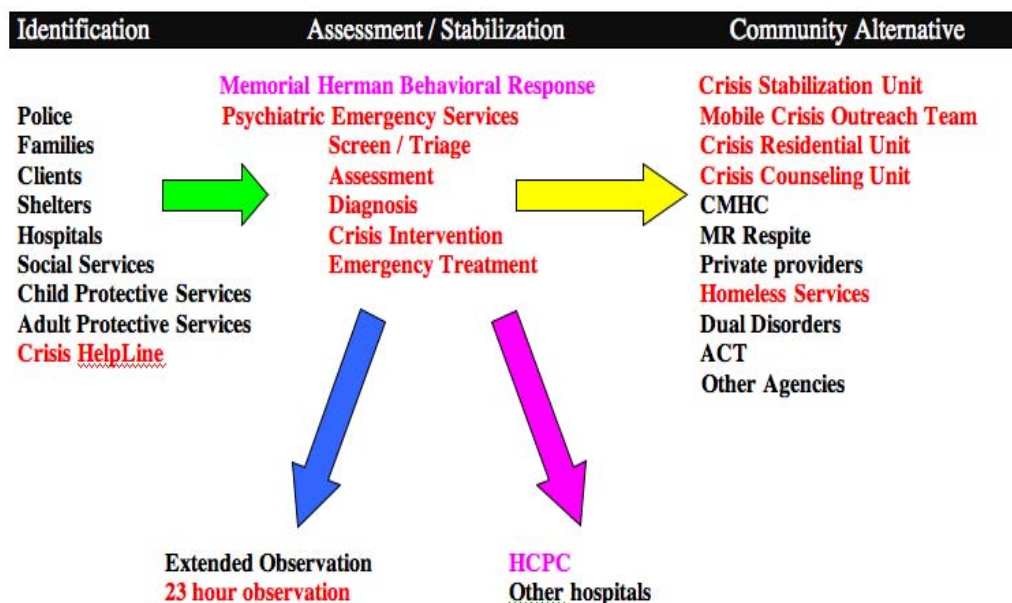
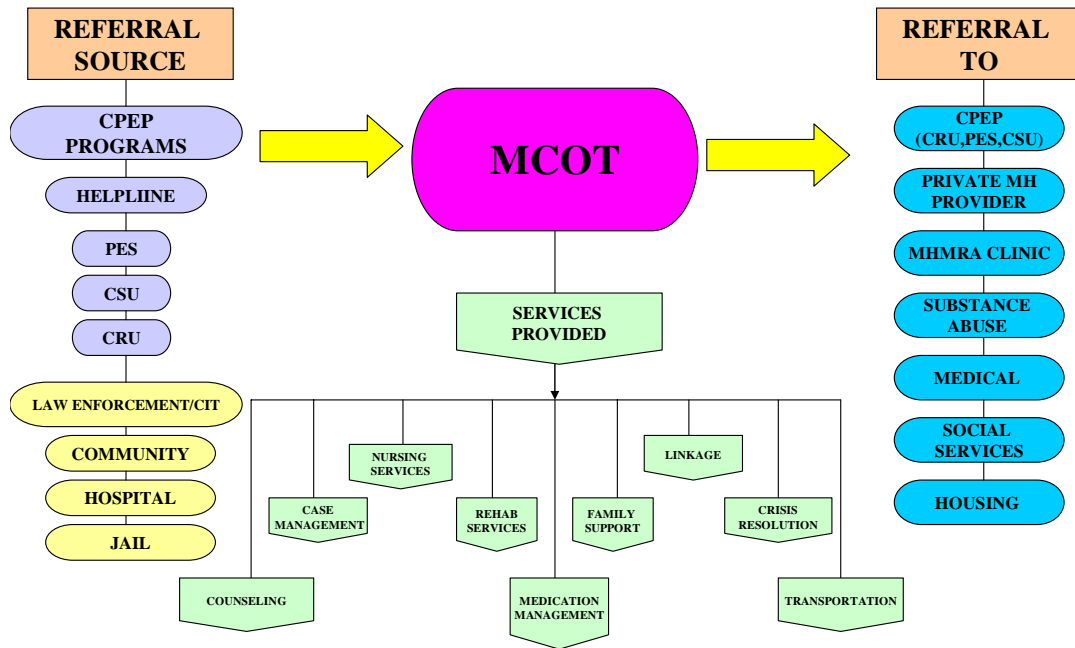


Figure 2: Specific MCOT Flowchart

Mobile Crisis Outreach Team



C.5.b.4 Post 2009 FY Projects

While we recognize that the plan to be submitted to DSHS only mandated MHMRA to develop and submit a crisis redesign plan for the 2008-2009 biennium, it behooves us to share also what we and our stakeholders already see as the next logical areas of programmatic expansion and modification in order to move Harris County closer to the ideal crisis response system that is envisioned (see Section C.2. above). These additional and anticipated expansion or modification activities include:

15. An additional psychiatric emergency service (PES) unit within the LBJ Hospital (\$4,000,000)
16. An additional CSU in conjunction with the new LBJ-based PES (\$2,100,000)
17. Expansion of the CRU capacity by 18 more beds (\$1,595,200)
18. Further expansion of MCOT or CIRT (\$1,200,000)
19. Establishment of a medical-psychiatric respite program with 16 beds (\$900,000).

C.6. DESCRIPTION OF METHODS AND APPROACHES TO INTEGRATE MENTAL HEALTH AND SUBSTANCE USE CRISIS SERVICES

MHMRA has a well-established track record in coordinating services, to the extent that funding permits, with the chemical dependency provider community. In 1998, MHMRA and the chemical dependency provider community of Harris County were awarded a \$1,250,000 grant for a fourteen-month period to operate a dual diagnosis project. This project received national recognition by the Federal Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in 2001. Unfortunately, the then-TCADA and TDMHMR departments ceased the funding for that type of program. Nonetheless, the precedent for successfully coordinating MH and SA treatment and planning exists in Harris County.

Although the state funding streams have been strictly categorical (impeding the ability to effectively and efficiently serve consumers with multiple needs), MHMRA has time and again *innovatively and successfully combined services to serve persons suffering concurrently from multiple disorders*, whether from mental retardation and mental illness or from mental illness and chemical dependency. These programs have 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.⁶

Recently, the Healthcare for the Homeless Houston Inc and MHMRA collaborated to obtain a small demonstration grant from the Medallion foundation to coordinate services targeted at recidivistic inmates in jail who have dual mental health and chemical dependence conditions and who are at high risk of homelessness upon release from jail. That effort again illustrates MHMRA's high level of awareness and sensitivity to the need to be fiscally and programmatically creative in order to address the special treatment needs of persons with dual MH/SA conditions. That awareness and sensitivity, while often thwarted by categorical funding mandates and silo-like eligibility constraints, have remained the strong commitment of MHMRA and of its stakeholders.

Time and again, our data show the deleterious impact of substance use (and homelessness) on persons with severe mental illness. Our data also show convincingly that those people need longer treatment and support periods in order to achieve sufficient housing and functional stability in order to stay out of trouble with the law and to be able to adhere to community-based services rather than relapsing into crisis and inpatient environments. This insight led not only MHMRA but also its chemical dependency sister agencies and stakeholders to forcefully ask for programmatic intervention that provide longer intensive MH and CD treatment over a longer period of residential stability.

⁶ Hickey, JS & Nguyen, TD. [Dually Diagnosed Consumers: A Fine-Grained Analysis of Outcomes](#), presented at the 50th Annual Conference on Mental Health Statistics, Washington, DC, 2001. Accessible at <http://www.mhsip.org/presentations.html>.

Consistent with the above realization for a different and more efficacious model of care and support we propose project # 7 as listed in Section C.5.b. To reiterate, we plan to establish a 90 day dual diagnosis intensive residential treatment and wrap-around service. This is accomplished by contracting with current substance abuse providers for a total of 40 slots at any given time (20 for inmates coming out of the Forensic program at Harris County Jail and 20 slots for consumers coming out of CPEP programs) at \$79/day.

Realizing the necessity to not only maintain oversight, but also to participate actively in this coordination, we also propose, as part of the same project, to employ a person with a LCDC (licensed chemical dependency counselor) certification who will assist with assessments and liaison with providers. Peer support counselors with experience and training in providing support to dually diagnosed consumers will also be relied upon to assist in providing coordination and advocacy to this special group of consumers'

Initially, all consumers considered for this program must meet DSHS targeted population in terms of their primary mental health diagnoses. While enrolled in the program, they will also receive support through the MHMRA's regular assertive community treatment (ACT) or forensic assertive community treatment (FACT) teams. If this innovative program demonstrates effectiveness and cost-efficiency, we will entertain asking for permission to extend eligibility to dually-afflicted individuals who may not qualify for priority population status. It is they who are the more intensive users of our crisis, inpatient, and criminal justice resources.

C.7. DESCRIPTION OF STRATEGIES THAT WILL MAXIMIZE THE FUNDING AVAILABLE FOR PROVIDING CRISIS SERVICES & COLLABORATIVE EFFORTS

Even before the establishment of our Crisis Response System through the CPEP program, MHMRA has a long track record of collaborating with local agencies and institutions, both private and public. Our participation in the TRIAD dates back to 1974.⁷ The NPC which houses many of the CPEP programs would not have been a reality without the support and collaboration of the Harris County Hospital District and the Harris County Commissioner's Court.

Our collaborative effort with the jail, the courts, and the Harris County Commissioners' Court vis-à-vis persons with mental illness involved with the criminal justice system dates back to 1985 with the placement of our forensic program inside the Harris County jail and the development and implementation of our pre-trial diversion program in 1999. Both of these major programmatic components are funded by the County, as is a giant share of the CPEP programs.

MHMRA is an integral, standing, and fully participating member of the Harris County Mental Needs Council.

⁷ Please refer to [website: http://www.hc-ps.org/triad_prevention.htm](http://www.hc-ps.org/triad_prevention.htm) for information about TRIAD and MHMRA integral part in it.

We have collaborated with the MHA and the HPD to develop and implement the CIT program. We have woven our crisis outreach services and well as on-site crisis services with the CIT officers to the extent permitted by law or financially.

MHMRA is a full-fledged and initial founding member of the recently established Harris County Healthcare Alliance. The Alliance aims at coordinating public and private healthcare in Harris County by pooling resources and streamlining procedures to achieve optimal coordination of care while reducing administrative, assessment, and eligibility redundancy. A major project involves MHMRA and HCHD jointly establishing eligibility processes so as to reduce bureaucratic redundancy and burden on consumers of both systems.

With respect to the current crisis response system redesign, MHMRA and the HCHD are in continuous and steady conversation about co-location of services, integration of services, and coordination of care.

A recent report, jointly developed by MHA and MHMRA, was submitted to the Chief of the Houston Police Department, outlining numerous joint projects that aim at reducing the burden of the HPD in having to repeatedly intervene with persons with mental illness and disability who recidivate.⁸

Active collaboration is on-going between MHMRA and the Harris County Management Services Office, within the Harris County Office of Budget Management Department in order to identify the cost and pathways of repeated offenders with mental illness, so that appropriate programs could be developed and funding sought to divert them from the jail-hospital-crisis-jail cycle. As indicated by the statistics in the Introduction section of this plan, these are the people who use significant crisis and inpatient resources, in addition to criminal justice resources. There is no doubt that, by focusing appropriate intervention and preventative support to help them stabilize, we will reduce the demand and burden on our crisis response system.

The specific projects for which joint funding or in-kind support will be sought are numbers 14, 15, and 16 with the HCHD and project number 3 with HPD. There are also other projects that involve collaboration and support which will ultimately relieve the pressure on the crisis response systems. However, because they do not the use of State-allocated Crisis funding, they are not listed in this plan.

⁸ The document, entitled *Increasing Access to Behavioral Health Services in Houston/Harris County*, is available from Dr. Tuan Nguyen at tuan.nguyen@mhmraharris.org.

C.8. IMPLEMENTATION TIMELINE

<i>Project and Activities</i>	<i>Description</i>	<i>Timeline for accomplishment</i>	<i>Will equipment or build out cost be needed</i>	<i>comments</i>
P1	1. Upgrade Helpline counselors qualifications to meet standards (\$316,350)		no	
P1A	Identify staff not meeting qualifications	end of 2nd quarter FY 08	no	
P1B	Plan for transition & post position	Through attrition, finalized by end of FY 09	no	
P2	2. Balance the budget for current MCOT programs (\$2,068,800)			
P2A	Identify the deficits and re-allocate.	30 days post receipt of allocation	no	
P3	3. Create a joint psychiatric and police Crisis Intervention Response Team (CIRT) by expanding MCOT capacity to collaborate with HPD CIT (\$909,160)			
P3A	Post and fill positions	Post position within 30 days	yes	
P4	4. Create a MCOT satellite in another quadrant of the county (\$1,401,570)			
P4A	Finalize location & build-out & buy vehicles	90 days after approval	yes	\$50,000
P4B	Post and fill positions	3rd quarter	yes	staff will be temporarily located at Bristow while waiting for renovation of permanent location
P5	5. Expand clinical coverage for the Crisis Residential Unit (\$250,050)			
P5A	id position/ post positions	end of 2nd quarter FY 08	no	
P5B	fill positions	end of 3rd quarter FY 08	no	

<i>Project and Activities</i>	<i>Description</i>	<i>Timeline for accomplishment</i>	<i>Will equipment or build out cost be needed</i>	<i>Comments</i>
P6	6. Expand PES observation from 24 hours to 48 hours (\$1,476,000)			
P6A	Identify feasibility with HCHD/Ben Taub	no expenditures first year		
P6B	Infrastructure modification	begins first quarter fy09	yes	
P6C	Finish build out	end 1st quarter fy09	yes	HCHD's matching contribution to be determined
P6D	Post and fill positions	end of 2nd quarter fy09	yes	
P7	7. Establish a 90-day dual diagnosis (MH/SA) intensive residential treatment (IRTP) and wrap-around services (\$2,200,400)			this addresses requirement for SA/MH coordination & collaboration
P7A	Develop contract	Within 90 days of approval	no	
P7B	Finalize contracts with providers	90 days	no	
P7C	Post and fill positions	3rd quarter	yes	for coordinator and case managers
P8	8. Deploy Peer Support Specialists to work among CPEP and IRTP programs (\$365,920)			
P8A	Post and fill positions	End of 2nd quarter	yes	
P9	9. Establish Critical Time Intervention (CTI) along with 90-day housing for homeless and refractory consumers (\$1,809,000)			
P9A	Identify appropriate housing, SRO's or other	Within 90 days of approval of the project	no	
P9B	Post and fill positions	3rd quarter	yes	

<i>Project and Activities</i>	<i>Description</i>	<i>Timeline for accomplishment</i>	<i>Will equipment or build out cost be needed</i>	<i>comments</i>
P10	10. Establish Adult CRCG coordination for individuals who are frequent users of crisis service and criminal justice system (\$117,300)			
P10A	Post and fill position	End of 2nd quarter	yes	
P11	11. Establish a Crisis IDD Intervention & Coordination function for persons with intellectual or developmental disabilities who are in crisis (\$117,300)			
P11A	Post and fill position	End of 2nd quarter	yes	
P12	12. Fund the development and implementation of the Psych Web EOC system to create a psychiatric filter and real-time update of inpatient psychiatric capacity county-wide (\$165,000)			
P12A	develop contract with WebEOC	End of 2nd quarter		
P12B	Design and implement web site	Last quarter of FY 08		
P13	13. Increase awareness of mental illness for individuals and families through PSAs and educational flyers and posters (\$70,000)			
P13A	Contract with and design one PSA	3rd quarter		
P13B	Design, print and begin distribution of posters, literature, etc	4th quarter		
P14	14. Initiate the process of developing psychiatric emergency service within the Lyndon B Johnson (LBJ) hospital (\$775,000)			
P14A	Begin discussions with Harris County Hospital District	2nd quarter FY 08	no	

P14B	Identify and implement enhancements to LBJ emergency psychiatric services	FY 09	TBA	
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C.9. IMPLEMENTATION OVERSIGHT PLAN

MHMRA assumes all responsibility for the implementation, execution, and outcome of the plan. However, input and advice will continually be sought from Harris County stakeholders and collaborating agencies, so that MHMRA will continue to demonstrate its accountability to the community which it serves.

The full Crisis Service Workgroup will meet at least twice a year to learn about the plan implementation progress and to provide input should changes or modifications seem advisable. In addition to the full CSW meetings, each CSW subgroup, as listed in section C.2, that developed the recommendations that are incorporated into this crisis redesign plan will also be asked to meet periodically with the Deputy Director of CPEP and appropriate MHMRA staff in order to provide closer examination of the implementation progress of relevant projects.

In sum, while MHMRA remains fully responsible for the plan implementation under the contractual relationship with DSHS, the Harris County's community continues to assume major advisory and even collaborative roles in ensuring that the implementation of the crisis redesign plan is faithfully executed, addresses the community's concerns, and responds to emerging needs.

ATTACHMENT A

REPORTS FROM THE SUB-COMMITTEES OF THE CRISIS SERVICE WORKGROUP

1. IDD CRISIS INTERVENTION COORDINATOR

A **Crisis Intervention Coordinator** with the knowledge of the different crisis service systems in Harris County and statewide is proposed to assist persons with intellectual and developmental disability (IDD, previously known as mental retardation) to navigate the systems appropriately. The coordinator will also have the authority to act quickly to move the person into a situation that resolves the crisis by any and all of the following activities:

- Accessing alternative services;
- Interfacing productively with other healthcare and human service entities;
- Educating everyone about realistic options to different situations facing a person with IDD who is in crisis.

The position incumbent shall have a Master Degree in the Human Services field, with 3 years experience preferred. Also preferred but not required are a license and bilingual skills. The position will be compensated at a salary level that gives it authority comparable to the directors and others with whom the person will be working and negotiating fast action. Salary would not be dependent on billing.

The position would be part of MR Authority Services and housed at the Mental Retardation Authority (MRA) headquarter, with a secondary work station at the NPC. The position incumbent is expected to participate in NPC staff meetings, training, etc., as part of the NPC team.

2. CRIMINAL JUSTICE DIVERSION TRIAGE CENTER

A Mental Health Triage Center will be staffed and located in the Detention Zone of the Harris County Jail. The center's objectives are twofold: First to divert persons with a mental illness prior to booking when appropriate and secondly to link with appropriate mental health community services as inmates with mental illness are released from jail.

Rationale:

- Prebooking diversion would appear to have the highest possibility of success
- Currently NPC is at capacity
- Anticipated increase in need due to increasing CIT efforts, increasing general booking volume and merger of booking and other inmate processing center functions with the City of Houston PD
- Need for expedited and efficient process geographically near the Combined Processing Facility
- Need for efficient referral services upon release from detention to most effectively integrate released detainees into community services

Downstream effects:

- Relieve the currently acute need for increased number of inpatient beds for crisis intervention/stabilization
- Increase the number of mobile crisis units
- Provide timely post-crisis follow-up services for appropriate persons who are not otherwise eligible for services
- Provide more timely access to outpatient treatment services for appropriate persons who have been committed (civil and forensic)
- Provide post-crisis substance abuse treatment services to those who have co-occurring disorders.

Policy Implication: Some current policies and procedures will need to be revised to increase the likelihood that defendants are not rendered ineligible because certain behaviors associated with the mentally ill (missing clinic visits, etc.)

3. ADULT CRCG COORDINATOR

Rationale

According to the Biennial Report to the Governor and the 80th Texas Legislature, initial legislation was passed in 1987 developing Community Resource Coordination Groups (CRCG) to deal with children and families with multi-agency needs. The CRCG concept is designed to develop customized, integrated, individual service plans. A State supported approach to serve adults using the CRCG model began in 1999. Currently the CRCG program is authorized by legislation passed by the 77th Legislature. This legislation reiterated the commitment to serving children and youth and added a requirement for State agency participation in building the capacity to serve adults through the CRCG model.

According to data collected by the Texas Health and Human Services Commission, services for adults referred to CRCG's across Texas generally revolve around basic needs, mental health care, physical health and substance abuse services. A CRCGA Coordinator in Harris County would have a significant impact on interagency cooperation and service delivery to individuals who have a history of utilizing crisis services or services from a variety of agencies.

Harris County has had a full time CRCG Coordinator for children and youth for over ten years funded through TRIAD funds. The CRCG Coordinator is managed by Harris County Protective Services for Children and Adults (HCPS). In 2005, the HCPS Guardianship Program developed an interagency council for adults based on the CRCG model. The group, known as CARE: Caring for Adults with Respect and Empathy, grew out of a need to collaborate with other agencies regarding the care of elderly and incapacitated adults. Unlike the CRCG for children and youth, the CARE CRCGA does not have a full time coordinator. An initiative is being considered for a full time position to perform the duties of the CRCGA Coordinator with an expansion of the adult population served by the present CRCGA.

An expanded Harris County CRCGA would include providing services to any adult with multi agency involvement over 18 years of age. This population would include the return of youthful offenders from the Texas Youth Commission (TYC). TYC is now working with CRCG's across the State to develop discharge plans for youth returning to the community. The HHSC is working to build upon the capacity to strengthen TYC's partnership with CRCGs to ensure successful reintegration of youth and young adults to the community. This initiative also includes a proposal to include a flexible funding account of (\$2 million annually) for the TYC to use with the CRCG process to provide funds for crisis services, therapeutic services, family support, vocational services and other services that would enhance the successful return of the TYC parolee to the community.

Proposed Program

Within the context of this Crisis Service Plan, the adult CRCG coordinator will address the needs of individuals who are frequent users of crisis services in Harris County. The Harris County's Office of Budget Management and MHMRA have

identified a significant number of adult “frequent flyers” who have multiple needs and multiple agency involvement and are high users of a number of services. The full time CRCGA Coordinator would be assigned the responsibility to staff these difficult cases with representatives of agencies who are able to provide needed services in a wraparound manner.

Job Summary

The CRCGA Coordinator is responsible for the coordination of staffings involving multi-problem, multi-agency serving adults with the goal of developing individualized treatment plans, advocating for services and following up on service delivery. The CRCGA Coordinator serves as a liaison to local agencies referring cases to the CRCGA; provides linkages services to the adults who are staffed by the CRCG; chairs CRCG case staffings, monitors legislation and other legal issues concerning CRCG, provides information and data to the State Health and Human Services and provides reports and documentation as required. The CRCGA Coordinator will seek out community resources for adults referred for case staffings.

Responsibilities and tasks

- Review all cases submitted to the CRCGA
- Plan, coordinate and chair CRCGA staffings
- Gather history information prior to staffings and secure releases from the client
- Meet with representatives of agencies to explain and solicit CRCGA resources
- Report on and develop community resources and identify barriers to services
- Serve as a liaison to the State HHSC CRCG office
- Complete appropriate data forms for the State office
- Monitor follow-up case plans
- Schedule emergency CRCG staffings
- Community education on CRCG
- Work with the county agencies and resources regarding reintegration of high-risk offenders leaving the Harris County Jail
- Chair the monthly CARE meetings

4. RESIDENTIAL TREATMENT PROGRAM

Rationale

On any given day, the Harris County Jail houses over 9000 detainees with at least 25% of them having a previous history of being treated for a mental illness in the past and 10% of them being newly identified as currently needing mental health evaluation and treatment while in the jail.

Of the 35% who represent those detained in the jail with a history of mental health treatment, a small cohort of people (33) have been identified from data matches between the jail booking data and MHMRA episodes of care data. This group has repeatedly committed minor misdemeanor offenses; finding themselves frequently back in jail adding to the over crowding of the jail and the high cost of processing them through the criminal justice system and the courts. In addition, there is data to show that this same cohort of offenders has high utilization rates of local hospital emergency room beds as well as community psychiatric hospital beds and never connects with treatment providers in a long-term relationship.

What would happen if this cohort of people could be diverted from jail moved to a residential facility which provided 24-hour seven day per week supervision/support with wrap-around services focused upon maintaining transitional and permanent housing, treatment for the co-occurring mental illness and substance abuse/use disorders, and linkage to the courts to enforce out-patient participation in a treatment program? What would be the actual savings to the community and the impact upon the stabilization of symptoms upon the individual?

The following is a program design based upon a literature search of “best practices” focused upon the reduction of recidivism and represents only one part of a diversion from incarceration activities. These programs work best when there is a diversion plan where gaps in services are constantly reviewed, outcome data is produced to see the effectiveness of the diversion process

Conceptualization of Program:

Treatment of this population of non-violent offenders requires a multi-disciplinary team approach, using the CRCG strategies, with the participation of representatives from all services frequently used by the offender. As eligible offenders are identified at booking and/or just prior to release, these cases are staffed by the team to establish a course of treatment, in collaboration with the offender. Important parts of the program include housing (various levels from need for supervision to independent living); benefits acquisition; medications monitoring; linkage to healthcare; linkage to other social services; and, mandated group attendance to include substance abuse treatment, activities of daily living, anger management, information about the illness and medications, and rules for recovery. Ideally, the program works better if participation is voluntary (but, supervised by the courts); however, for those who do not want to volunteer for the program, some legal mandate needs to be in place (can

civil commitment to outpatient services be used?) to “strongly encourage” participation. Self-medication from psychiatric and physical health issues is common within populations of people who suffer from chronic mental illness.

The place of release is to a structured residential setting for 30 days. Intense programming occurs with a structured program (see activities listed in the paragraph above) during the day and support group attendance in the evening to include AA or NA or other peer support groups (based upon the resident’s needs). The first court date is scheduled for 30-days following release from jail. If there has been a positive response from the resident to the program, and based upon the recommendations of the multi-disciplinary team, the judge may order continued participation in a less restrictive setting such as:

- The participant may live at home with a responsible supportive relative while participating in required mental health treatment
- The participant may live in a Board and Care facility while participating in required mental health treatment
- The participant may reside in independent housing such as SRO, own apartment, etc., while participating in required mental health treatment

Continued oversight of the treatment process by the multi-disciplinary team is important to identify signs of “treatment failures”; to provide quick intervention and to prevent re-incarceration.

Treatment Strategies:⁹

At the point of discharge from the 30-day residential facility, the participants must receive services through an intensive case management/rehabilitation team model similar to an Assertive Community Treatment Team. Daily contact is required to ascertain whether or not the participant is following the defined treatment plan which will include combinations of the following activities: medication monitoring; daily groups (skill building and/or peer support); enrollment in an educational program; employment training; holding a job, linkage to healthcare and other social services, etc. This team provides updates to the multi-disciplinary team and the courts and ensures that participant meets all court dates and scheduled appointments or provides early notification that participant cannot be located. In addition, the team responds to all emergencies and works to decrease recidivism to jail, hospitals and emergency rooms.

Release from the program occurs when the participant has remained stable for one year and has reduced his/her recidivism into jail, psychiatric beds and emergency rooms by 85% (?).

⁹ Because, this workgroup’s report includes many features of the critical time intervention model, the CTI activities are not reported separately.

Housing:

Many housing options should be available within this program which range from the 30-day residential facility; Single Room Occupancy (SRO) subsidies; Section 8 vouchers; Shelter Plus Care slots; Assisted Living

Facilities payments; low cost apartments to the use of inexpensive motel rooms. Housing is an important factor in the participants' ability to maintain stability and avoid incarceration.

Performance Measures:

- # of days participants remained out of jail/psychiatric beds/psychiatric emergency rooms for 6 months, 12 months, and 18 months?
- Cost savings based upon per day costs for jail/ psychiatric beds/ psychiatric emergency rooms
- Percent reduction in use of jail/psychiatric beds/psychiatric emergency rooms

5. TELEMEDICINE-ENHANCED PSYCHIATRIC EMERGENCY SERVICES

Telemedicine and/or need for PES – Dr. Knox, Chair

- Need additional PES
- LBJ possible proposed site (LBJ in process of redevelopment)
- Change in law from 23-hour observation to 48-hour observation (not mandatory)
- If choose 48-hour observation, expand space, hire additional staff
- Swap space at current NPC building belonging to IPC (HCHD) with empty build out space on second floor.
- LBJ/BTGH already using telemedicine – not big need for telemedicine between PES/HCHD.
- Look at pharmacy services between PES/HCHD

This subcommittee has met on two occasions to discuss our charge to explore feasibility and necessity of expanding the PES to other locations in the county and exploring the utility of using telemedicine/tele psychiatry as another means of making PES services available at other sites e.g. medical emergency rooms. The committee met August 8 and August 13 at the NPC.

The committee discussed a wide range of topics surrounding expansion of PES services with Crisis Redesign dollars. There was a wide range of discussion concerning various topics surrounding expansion from 23 hour -48 hour observation units given the new changes in the law, effective September 1. There was discussion of creating another PES location within the county perhaps at LBJ to take advantage of the availability of medical consultation. The committee decided that we should reconvene again and a number of other meetings to explore PES expansion to LBJ, increasing to 48 hours observation and other opportunities to improve some of the other administrative obstacles in the current interface of PES with BTGH ER .

Expanding from 23 hour to 48 hour observation unit.

- Increased opportunity to divert more patients from inpatient care and free up scarcer inpatient beds.
- Space an issue unable to do appropriately in current PES space.
- Move to another floor in NPC that has build out needed for an expanded observation service however would displace existing HCHD programs that would need to relocate. Unused space is available in current NPC building suitable for HCHD programs but cost of build out is issue, would it be allowable to use crisis funds for this is unknown but can be explored.
- Require increased clinical staff (psychiatrist, nurses and social work) recruitment may be issue.

Additional PES unit in Harris County

- County our size needs more than one location
- LBJ possibility as there is need for more psychiatric coverage and consultation, although some recent telemedicine possibilities with BTGH have already been implemented. Also availability of medical consultation. LBJ is in process of

expanding and revamping their ER. There could be space available for Psychiatry but unsure if space is adequate. There is interest but wouldn't be operational for another 2 years.

- To duplicate current model very expensive but could ramp up. Would qualify for third pot of Crisis Redesign money with 25 % match from County or other entity.
- Possibility it could be run by County, HCHD, MHMRA or private sector.
- Costly to duplicate current model of staffing could approach 4 million per year.
- Current PES and BTGH ER very different models of delivering care, need to explore strengths of each.

Tele-psychiatry

- BTGH and LBJ have purchased telemedicine equipment for consults between the two staffs to include psychiatry.
- Could locate unit in PES with LBJ to collaborate for medical consults from PES physicians to LBJ as well as supplement psychiatric consultation for LBJ staff however this is less of a need for LBJ as they can utilize Psychiatric expertise at BTGH.
- PES contracts with Baylor Family medicine for consults and has option of sending to BTGH ER medical emergencies or urgent cases. Need for telemedicine consults not critical at this point.

6. ENHANCEMENT OF CIT AND MCOT COORDINATION

This is a proposal for the expansion of the existing Mobile Crisis Outreach Team (MCOT) to a second team to be housed at a satellite location in Northeast Houston. The projected benefit of the MCOT expansion is to (1) Expand the number of MCOT staff available to respond to crisis calls, as well as (2) Improve the response time of MCOT staff, especially to those clients living in the northern part of the county.

The current Mobile Crisis Outreach Team is comprised of specially trained mental health professionals who provide crisis intervention, short term (up to 4 weeks) mental health treatment and supportive services, to individuals who are experiencing symptoms of mental illness. Services are provided in the community wherever the client is located. Services include, but are not limited to crisis intervention, medication assessment and management, nursing services, counseling and psychotherapy and case management. The goal is to intervene early to provide needed mental health services to prevent further deterioration and/or the need for services in a more restrictive environment. When a more restrictive environment *is* required, MCOT *will* facilitate admission to a higher level of care, as indicated. When MCOT services are completed, the client is linked with ongoing mental health services in the community. MCOT services are voluntary and the client must be willing to consent to services.

Harris County is comprised of 1,778 square miles and the existing MCOT Team is centrally located in downtown Houston. MCOT staff currently travel throughout Harris County to provide services to clients experiencing a mental health crisis. The addition of a second team and location will enable the existing MCOT staff to focus their responses on the central, southeast and southwest parts of the county, while the new team would focus their attention and energy on the northeast and northwest quadrants of the county.

Both Teams, while housed in different locations, will function as one MCOT team, sharing the same administrative supervision and oversight. All MCOT staff will receive the same training and supervision and will be expected to follow the adopted program policies and procedures. The day to day operation of both teams will follow the same configuration, and the data and reporting requirements for both teams will be uniform. While having assigned work locations, staff from both teams will collaborate and provide coverage for each other, when indicated.

7. PEER SUPPORT PROVIDER SPECIALIST

Rationale

According to the Center for Medicaid and State Operations, Department of Health and Human Services, Baltimore, Maryland, “Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance abuse disorders.”

Functional Responsibilities

Peer Support Providers are self-identified consumers who are in recovery. Peer support services are coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. The Peer Specialist performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Peer Providers are able to teach and role model the value of every individual’s recovery experience and model effective techniques and self-help strategies by lending their unique insight into mental illness.

Training Requirements

From the Center for Medicaid and State Operations, “Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. Similar to other provider types, ongoing continuing education requirements for peer support providers must be in place.”

Program Design—Long Term

In the long range, it is recommended that Peer Specialists be placed in 12 areas of crisis and out-patient services in the community, as follows:

- Crisis Residential Unit (CRU)
- Crisis Stabilization Unit (CSU)
- PES
- Path, a drop-in day program
- Helpline
- Search
- Salvation Army
- Star of Hope
- Nami-hotline
- HCPC
- Ben Taub ER
- Mobile Crisis (on call contract work)

Program Pilot

Prior to placing Peer Specialists in the 12 areas above, it seems appropriate to conduct a pilot project for 6 to 12 months. This pilot will fund four Peer Specialists to be trained and place in:

- CRU—2 FTE
- CSU—1 FTE
- PES—1 FTE

The Quality of Life Survey will be used to assess the outcome and impact of the pilot.

If the pilot is not successful in the timeframe suggested, focus groups will be conducted to survey consumers served. Consumers as employees will need institutional and administrative support with mechanisms built in for Peer Specialist to effectively resolve internal complaints.

8. MEDICAL RESPITE SERVICES

Overview

Like many urban areas, Houston does not have adequate or available healthcare options to meet the needs of the homeless population, particularly those with mental illness, who require short term medical care for recuperation from acute or chronic illnesses. These individuals usually present in Emergency Department (ED) settings in the acute stage of illness and require hospitalization with extended lengths of stay due to being homeless. Furthermore, minor healthcare conditions among this population are not treated in a timely manner, nor, are their chronic conditions managed medically. The end result is high level of ED use and hospitalization. Persons who are homeless that are discharged from inpatient facilities following surgery or treatment for acute medical conditions cannot follow discharge plans for rest, hydration, nutrition, medications, and wound care/dressing changes within their current living environments. These deleterious conditions are exacerbated if the person also suffers from severe and persistent mental illness.

Medical Respite Services is one method of providing short-term nursing and medical recuperative care for individuals with acute medical conditions who are homeless. In this context “*respite services*” is defined as care provided to homeless persons who are in need of medical and nursing support as they recover from an acute illness. The availability of medical and nursing services is essential elements that distinguish this service from 24-hour shelter programs. Within the medical respite model intensive case management services including linkage and referral to other community and support services such as housing, disability benefits, mental health and substance abuse treatment, food stamps and primary care services can be provided.

An essential goal of Medical Respite Services for the homeless with mental illness is to decompress the overtaxed medical healthcare community thus reducing ED visits and reducing the length of stay for persons who are medically stable and no longer require hospitalization but are too ill to manage their medical conditions “*on the streets*”.

Successful Outcomes Related to Medical Respite for the Homeless

- Resolution of acute conditions and stabilization of chronic illnesses due to the patient being able to follow recommended treatment.
- Continuity of care.
- Linkages to needed community services.
- Reduced lengths of stay in medical facilities.
- Reduced re-entry to medical facilities from ED visits with overall reduction in medical cost to hospitals.

- Reduced stress in attempting to manage medical conditions in homeless environments.

Issues for Discussion/Review/Determination:

- Identify Stake-holders and collaborative partnerships
- Type of Model-Free Standing vs. Shelter-based
- Method of Admissions/Referrals
- Admission Criteria- including exclusionary criteria*
- Scope of medical care/services-types of conditions to addressed
- Range of services
- Length of Stay-(minimum 14-21 days)
- Staffing
 - Type- licensed nursing minimum
 - Medical- including psychiatric and number of hours
 - On-site or visit respite site
 - Hours of operation-24-7 or number of hours per day 7 days a week
- Facility and location including number of beds (number of male vs. female)
- Funding sources including ongoing revenue streams

**example admission criteria:*

- *Homeless*
- *Acute medical condition that is stable*
- *Able to perform Activities of Daily living independently*
- *Willing and able to comply with medical recommendations for treatment*
- *Continent*
- *Independent mobility*
- *Free from contagious infections*
- *Psychiatrically stable*
- *Does not require drug/alcohol detox*

Recommendations:

- Develop Medical Respite as an integral part of healthcare for the homeless
- Identify any and all stake holders
- Determine model that best meets the needs of Harris County
- Review and research current models in order to determine best fit to meet the needs of the homeless in Harris County

Resources:

National Health Care for the Homeless Council, www.nhchc.org.

“Medical Respite Services for Homeless People: Practical Models”,
www.nhchc.org/Publications/MedicalRespiteServices.pdf

ATTACHMENT B

Overall Rating of Specific Needs Relative to Crisis Response System Components

<i>Pre-Crisis (Early intervention) Activities or Programs</i>	
<ul style="list-style-type: none"> • CIT type training in school districts coupled with more training for school personnel 	Totally lacking
<ul style="list-style-type: none"> • Caregiver development program 	Totally lacking
<ul style="list-style-type: none"> • Funding for families seeking guardianship 	Totally lacking
<ul style="list-style-type: none"> • Peer support groups and education 	Totally lacking
<ul style="list-style-type: none"> • Staff training /development of staff 	Needs improvement
<ul style="list-style-type: none"> • Improve/increase access to services by establishment of multiple access locations 	Needs expansion
<ul style="list-style-type: none"> • Education of public as well as mental health caretakers and caregivers 	Totally lacking
<ul style="list-style-type: none"> • Transitional services for adolescents soon to become adults 	Totally lacking
<i>During-Crisis Activities or Program Capabilities</i>	
<ul style="list-style-type: none"> • Adequate PES services that are co-located with other health, human, and law-enforcement agencies or in neighborhoods coupled with telemedicine 	Totally lacking
<ul style="list-style-type: none"> • Co-location of PES with hospital services (at LBJ or other major inpatient locations) 	Totally lacking
<ul style="list-style-type: none"> • Adequate and expedient access to MCOT services through co-locations, home based, and telemedicine (also can serve briefly during post-crisis to help link and prevent cycling through again) 	Needs expansion
<ul style="list-style-type: none"> • Full availability (24 by 7) of MCOT services that are also coordinated or integrated with law-enforcement CIT activities 	Needs expansion
<ul style="list-style-type: none"> • Adequate crisis stabilization capacity or short-term crisis residential program capacity 	Needs expansion
<ul style="list-style-type: none"> • Availability of outpatient program for the restoration of competency 	Totally lacking
<ul style="list-style-type: none"> • Availability of data base (data warehouse) that allows real time access to person's history with crisis services and jail prior to booking so that service providers can see the person's history of mental health services 	Totally lacking
<ul style="list-style-type: none"> • Availability of a diagnostic unit at the front door of the jail 	Totally lacking
<ul style="list-style-type: none"> • Dedicate funding for the Psych WebEOC design and execution (this is a psych bed capacity website hosted by SETTRAC to deliver real-time capacity driven psych beds for the community) 	Totally lacking

<ul style="list-style-type: none"> Capacity to meet the special needs of persons with intellectual and developmental impairments who experience mental health crisis 	Totally lacking
<ul style="list-style-type: none"> Longer psychiatric emergency observation time (from 23 to 48 hours) in order to promote stabilization, thus avoiding inpatient admission 	Totally lacking
<ul style="list-style-type: none"> Improved and extended integration of mental health and substance use services for persons experiencing both conditions 	Totally lacking
<i>Post-crisis Activities or Programs</i>	
<ul style="list-style-type: none"> CRCGs type committee/program for specific adult population, for example, those who cycle through crisis services frequently. This type of program might serve as a focal point to coordinate efforts with other initiatives such as Medicaid Reform, Health Opportunity Pool, TYC funding, etc. 	Totally lacking
<ul style="list-style-type: none"> Reassurance calls for those coming out of crisis 	Totally lacking
<ul style="list-style-type: none"> Longer term residential/treatment center for persons in crisis with dually diagnosed conditions, with or without court order for those coming through the criminal justice system 	Totally lacking
<ul style="list-style-type: none"> Post-jail-release programs to prevent relapse leading to use of crisis services or re-incarceration 	Needs expansion or improvement
<ul style="list-style-type: none"> Peer support groups and education 	Totally lacking
<ul style="list-style-type: none"> Availability of transportation options so that consumers can access appropriate outpatient services post-crisis 	Totally lacking

ATTACHMENT C
EXAMPLE OF CPEP TRAINING CURRICULAE

PES Unit Training/Orientation: Activity Outline

1. Introduction to work area
 - Tour of Unit and Dock area
 - Mail Room
 - Location of employee's lounge
 - Location of rest rooms
 - Location of assessment rooms
 - Location of pharmacy, front lobby registration, consumer resource room, staff training room
 - Location of medical records/how to pull a chart
 - Using the phone system/how to park calls/overhead page/transfer calls
 - Location of fire extinguishers (including instruction in their use) & fire exits
 - Location of Fire Task Assignment
 - Codes – Special Team, Code Blue, Condition A, Condition B, Condition Orange, Code Anderson, Stat
 - Location of emergency flashlights, batteries, radio, first aid supplies
 - Orientation to safety and security of building premises

2. Introduction to staff
 - Introduction to unit personnel, explain roles/functions, location of schedules
 - Introduction to administrative staff, Executive Assistant/Safety Officer (LaShondra)
 - Introduction to medical records staff, front desk staff, supplies staff/Edwin
 - Describe links to CRU, MCOT, HCPC, CCU, private hospitals, Eligibility Center, and give key staff names
 - Introduction to Helpline
 - Introduction to IT (Will), Billing (Monica), and Insurance verification (Regina)
 - Introduction to CSU (2nd floor)
 - Teamwork – expectations of a team member

3. Review of agency P & P
 - Where to find P & P
 - Dress codes, badges
 - Scheduling of clinical social services personnel
 - Clinical Team Leader Responsibilities
 - Guidelines for Applications of Approval for Leave, location of forms
 - Call-in procedure
 - Job description
 - License validation
 - Performance Appraisal
 - Location of staff contact numbers
 - Parking, smoking

- Disciplinary Action
4. Review of Chart
 - DSL (Direct Services Log) – codes (1111, 2256, 2200, 1225)
 - Face Sheet – Patient Information Sheet/consent
 - Authorization To Disclose Health Information – how to complete
 - Consent to Treatment with Medication
 - Statement of Patient Leaving against Medical Advice
 - MD Orders section
 - TRAG (Texas Recommended Authorization Guidelines) – adult & child/adolescent
 - Crisis Intervention Assessment – how to complete
 - Discharge/Aftercare Plan – how to complete
 - Assessment Section other forms – Triage, Search, Psychiatric Assessment
 - Laboratory Section
 - Progress Notes – how to write
 - Review 23 HR OBS, Seclusion/Restraint, MAR (Medication Admin. Record)
 - MOT (Memorandum of Transfer) – how to complete
 5. Involuntary Court Commitments
 - A22/A20, F11, F25, B29, Probate Court #3 – how to complete
 - Day Court – Requesting Warrant Transfer Order (check list)
 - Night Court (also use for holidays, weekends) – A18, A19, C48
 - How to use the fax, copier, phone (park, transfer, page), white phones
 6. Hospitalizations Process
 - Preparing documents for hospital
 - How to decide choice of hospital
 - How to contact hospital admissions – location of phone numbers, staff names
 - Voluntary/involuntary process
 - Transfers to CSU – NPC Discharge Summary
 7. Community Resources and Referrals – where to find information
 8. Guardianship
 - How to process required consents for consumers that have a guardian
 - Understand guardianship vs. power of attorney
 9. Precautions-Suicide, Homicide, Close Observation, 23 hr.
 10. Consumer's Valuables and Belongings – safe, property room, documentation
 11. Visitors for consumers, consumer education, customer service
 12. Consumer's Admissions Status – emergent/routine, voluntary/involuntary
 13. Meals/snacks for consumers and requests for food based on religious/cultural beliefs

14. Incident Report – who completes, how to complete, who receives copies
15. Shift Change Report – how to give report
16. PMAB, TB testing, CPR, First Aid – routines and training location
17. Answer and/or discuss all questions new employee has about preceding items.
18. Business Office Information

**ATTACHMENT D
ACRONYMS AND ABBREVIATIONS**

AAS	American Association of Suicidology
ACT	Assertive community treatment
BTGH	Ben Taub General Hospital (a component of the Harris County Hospital District)
CARE	Client Assignment and Referral (A state-maintained database of mental health data throughout the state)
CIT	Crisis intervention team (consisting of specially trained police officers)
CJ	Criminal justice
CMHC	Community mental health center
CPEP	Comprehensive Psychiatric Emergency and Diversionary Services
CRCG	Community Resource Coordination Group(s)
CRU	Crisis residential unit
CSW	Crisis Service Workgroup (for Harris County)
CSP	Crisis service plan
CSU	Crisis stabilization unit
CTI	Critical time intervention
DPS	Department of Public Safety (Texas)
DSHS	Department of State Health Services
ER	Emergency room
FACT	Forensic assertive community treatment
FQHC	Federally qualified health center
HCHD	Harris County Hospital District
HCMS	Harris County Management Services (within the Harris County Office of Budget Management)
HCPC	Harris County Psychiatric Center (a public local psychiatric inpatient hospital)
HCPS	Harris county children protective services
HFD	Houston fire department
HHH	Healthcare for the Homeless—Houston
HPD	Houston police department
HUD	Federal Housing and Urban Development Department
IDD	Intellectual and developmental disability
JIMS	Justice Information Management System (Harris County electronic repository of all criminal justice data files)
LAPD	Los Angeles police department
LAR	Legislative appropriation request
LBB	Legislative budget board (Texas)
LBJ	Lyndon B Johnson Hospital (A hospital within the Harris County Hospital District)
LCDC	License chemical dependency counselor
LMHA	Local mental health authority
LPHA	Licensed professional of the healing arts
LSA	Local service area
MCOT	Mobile crisis outreach team
MH	Mental health
MHA	Mental Health Association of Houston
MHMRA	Mental Health & Mental Retardation of Harris County
NAMI	National Alliance for the Mentally Ill

NBHP	Network of Behavioral Health Providers
NPC	Neuropsychiatric Center (Main headquarter for many CPEP programs)
OSAR	Outreach, screening, and referral
PES	Psychiatric emergency service
QMHP	Qualified mental health professional
SA	Substance use (or abuse condition)
Section 8	A housing subsidy program of the HUD
SETTRAC	South East Texas Trauma Regional Advisory Council
SH	State hospital
SMI	Severe mental illness
SPMI	Severe and persistent mental illness
SRO	single room occupancy
TDMHMR	Texas Department of Mental Health and Mental Retardation
TRIAD	The name of a consortium of three Harris County Agency (MHMRA, HCPS, and JPD) working together to coordinate their resources to serve youth at-risk.
TYC	Texas Youth Commission
VA	Veteran's Administration
WebEOC	Web-base inventory of beds availability