



Texas Mental Health and Substance Abuse

*Crisis
Services
Redesign*

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CITATION

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Introduction

OVERVIEW

THE NEED TO REDESIGN CRISIS MENTAL HEALTH SERVICES IN TEXAS

In December 2005, Texas Department of State Health Services (DSHS) Commissioner Eduardo Sanchez established the Crisis Services Redesign Committee (see Appendix 1) to develop recommendations for mental health and substance abuse crisis services that are delivered through the local mental health authorities in the State of Texas. Its purpose was

to develop recommendations for a comprehensive array of specific services that will best meet the needs of Texans who are having a mental health and/or substance abuse crisis. In order to accomplish this, the committee will gather and analyze information from mental health literature, medical experts, members of the public, and staff. The recommended redesign will address the necessary elements of crisis services (including substance abuse), rural issues, clinical competencies, finance (cost), and important collaborations and partnerships.

Steven P. Shon, M.D., DSHS Medical Director for Behavioral Health Services, and Joe Vesowate, DSHS Assistant Commissioner for Mental Health and Substance Abuse Services, were named co-chairs of the committee. Individuals and organizational representatives of law enforcement, the courts, psychiatry, emergency medicine, community services, and advocacy, consumer, and professional and provider organizations were invited to participate. A roster of committee members and subcommittee members can be found on the inside front cover.

THE PROCESS OF GATHERING INFORMATION AND MAKING RECOMMENDATIONS

In order to help the committee with its work, an evaluation of existing crisis services in Texas (See Appendix 2) by the DSHS Community Mental Health and Substance Abuse Services Quality Management division was performed. Thirty-two local mental health authorities (LMHAs) and ValueOptions, a behavioral health organization (BHO), were evaluated on the accessibility of their crisis services, the competency of their crisis service providers, availability of local community alternatives to hospitalization, and the crisis screening and assessment tools used. The evaluation included surveys mailed to sheriff departments, police departments, and licensed hospitals throughout Texas to obtain information about their experience with coordination and delivery of crisis services. A total of 258 out of 570 surveys sent to hospitals were returned for a response rate of 45%. A total of 442 out of 1030 surveys sent to law enforcement were returned for a response rate of 43%.

The responses were generally critical of current crisis services with emphasis on the following areas:

- Timeliness of crisis service provider response;
- Training and competency determination for crisis service providers;

- Availability of community resources and crisis alternatives to hospitalization or incarceration;
- Provision of ongoing intervention until the crisis is resolved or individuals are placed in a clinically appropriate environment;
- Inappropriate use of “no harm” contracts;
- Crisis response for individuals who are intoxicated or under the influence of substances;
- Communication, problem-solving, and coordination of efforts between LMHAs, law enforcement and hospitals and other community resources; and
- Oversight systems to monitor the effectiveness (outcome) of crisis services.

Committee members and staff also surveyed current biomedical and social services literature and in the month of February conducted hearings throughout the state, inviting public testimony in areas representing the border (Harlingen), rural (Big Spring and West Texas), and urban areas (San Antonio). A hearing concerning statewide issues was held in Austin.

Subcommittees were created in order to define essential crisis services and recommend appropriate service standards; identify considerations affecting the state’s rural areas; define necessary collaborations and linkages for an efficient, effective crisis system; and estimate the costs of recommendations for the system redesign.

CORE CRISIS SERVICES RECOMMENDATIONS

The Crisis Services Redesign Committee concurred that the following core services should be the centerpiece of the mental health system of care for individuals in crisis:

1. Crisis hotline services
2. Psychiatric emergency services with extended observation services (23- to 48-hours)
3. Crisis outpatient services
4. Community crisis residential services
5. Mobile outreach services
6. Crisis intervention team (CIT)/mental health deputy/peace officer program

A recurring statewide concern was the lack of medical transportation for individuals requiring mental health services, which results in the requirement that law enforcement provide transport for individuals to state hospitals. This has resulted in needless delays in treatment for citizens experiencing mental health crises, unnecessary incarceration, and inconvenience and local expense for already burdened law enforcement. Lack of readily available, medically appropriate transportation for people experiencing mental health crises contributes to poor consumer outcomes, stigma, and inefficient use of limited public funds. The committee agrees that addressing these transportation issues is critical to meaningful transformation of crisis services in Texas.

UNDERSTANDING THE ISSUES

Data developed by the massive Global Burden of Disease study, conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, ranks second in the burden of disease in established market economies, such as the United States.
Mental Health: A Report of the Surgeon General, 1999¹

In the US, the annual economic, indirect cost of mental illnesses is estimated to be \$79 billion.

Most of that amount—approximately \$63 billion—reflects the loss of productivity as a result of illnesses....

In 1997, the latest year comparable data are available, the United States spent more than \$1 trillion on health care, including almost \$71 billion on treating mental illnesses.

Mental health expenditures are predominantly publicly funded at 57%, compared to 46% of overall health care expenditures.

Between 1987 and 1997, mental health spending did not keep pace with general health care

because of declines in private health spending under managed care and cutbacks in hospital expenditures.

New Freedom Commission on Mental Health, 2003²

Whether the source of information is statistics, the conclusions of experts, or the personal stories of people affected by mental illness, it is evident that more people need mental health services than services exist for them to access. This is true worldwide, nationally, and certainly in Texas.

In the wide array of activities that are called “mental health services,” the most essential element is immediate availability of crisis services, the services provided to individuals who are experiencing a mental health emergency. These individuals, if left untreated, could hurt themselves or others, could be hurt by others, or could end up in jail or homeless due to worsening symptoms of chronic mental illness. Crisis services are frequently the gateway to ongoing mental health services, and the experience with crisis services often determines whether a person will continue with mental health services and their attitude (positive or negative) toward the mental health system.

¹ US Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

² New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America: Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

I am astounded that we are trying to separate mental illness from cardiac illness from broken toes....The revolving door at Austin State Hospital and other facilities is not a solution—it's a bandaid—

Family Member of Mental Health Consumer³

Suicide deaths outnumber homicide deaths by five to three. It has been estimated that there may be from 8 to 25 attempted suicides for every suicide death.

According to a report released by the United States General Accounting Office, in the year 2001, over 12,700 children with mental health needs were voluntarily placed in child welfare and juvenile justice systems solely for the purpose of accessing treatment.

³ Public Testimony. Hearing of the Crisis Services Redesign Committee. Austin, Texas: February 15, 2006.

Individuals in crisis cannot wait for attention. As President Bush stated in the speech announcing the formation of the New Freedom Commission on Mental Health (Albuquerque, New Mexico, April 29, 2002), "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a health system that treats their illness with the same urgency as a physical illness." Suicide deaths outnumber homicide deaths by five to three. It has been estimated that there may be from 8 to 25 attempted suicides for every suicide death. Individuals at risk for suicide often present with symptoms of mental illness or untreated substance abuse.⁴ Risk factors for attempted suicide in adults include depression, alcohol abuse, cocaine use, and separation or divorce.⁵ Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior.⁶

The failure to provide adequate crisis services can lead to unnecessary incarceration or hospitalization of the individual, the disruption and separation of families, and the costly involvement of other community services, including law enforcement and the courts. According to a report released by the United States General Accounting Office, in the year 2001, over 12,700 children with mental health needs were voluntarily placed in child welfare and juvenile justice systems solely for the purpose of accessing treatment.⁷

Communities face growing demands for crisis care at the same time they are experiencing reductions in qualified medical personnel, outpatient programs, inpatient beds, and public funding. National and state data tell the same story. Inpatient psychiatric beds per capita have significantly declined. Between 1990-2000, the number of state and county psychiatric beds declined 44 percent nationally. The number of private beds declined 43

⁴ National Institute of Mental Health. *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed January 2001. Revised April 2004.

⁵ National Institute of Mental Health. *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed January 2001. Revised April 2004.

⁶ National Institute of Mental Health. *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed January 2001. Revised April 2004.

⁷ Child Welfare and Juvenile Justice. *Federal agencies should play a stronger role in helping states reduce the number of children placed solely to obtain mental health services*. United States General Accounting Office GAO-03-8651: 2003.

percent in freestanding hospitals and 32 percent in general hospital psychiatric units.⁸ In Texas, the average daily census in state hospital beds decreased 25 percent from 1994-2004,⁹ with similar decreases in the private sector.

The decline in beds has corresponded with an overall reduced length of stay which is in part driven by federal and state financing strategies that include disincentives and penalties related to inpatient bed use. The lack of a quickly responsive system with appropriate range of crisis services has contributed to the increased incarceration of mentally ill individuals in jails. Just as emergency medical services (EMS) responds to medical crises for all individuals in a community, all Texans rely on hospital emergency rooms or the local mental health authority to respond to mental health crises.

The systems for responding to mental health crises in Texas are uniformly inadequate to meet community needs. Other systems called on to serve as alternative sources of help, such as law enforcement, jails, emergency rooms of general hospitals, and social services, are not appropriate, cost effective, or able to provide the level and type of services that people in mental health crises need in order to recover.

Model programs and best practices *for mental health crises* need to be identified, integrated into a system of care, and replicated statewide in Texas. Determining how best to do this is the subject of this Crisis Services Redesign Committee report.

The lack of a quickly responsive system with appropriate range of crisis services has contributed to the increased incarceration of mentally ill individuals in jails.

⁸ New Freedom Commission on Mental Health. *Subcommittee on Acute Care: Background Paper*. DHHS Publication No. SMA-04-3876. Rockville, MD: 2004.

⁹ Texas Department of State Health Services. 2006.

WHAT THE PUBLIC HAD TO SAY

Four public hearings were held in February 2006 at locations chosen to represent rural areas (Big Spring), urban areas (San Antonio), and border areas (Harlingen), as well as a statewide hearing in Austin. The hearings commenced with invited testimony and proceeded to public testimony in the early evening. The hearings were well attended and major issues affecting crisis services were found to be similar across the state without regard to geographic location or demographics.

Written and oral comments were provided by consumers and family members as well as police officers, sheriffs, judges, hospital administrators, and mental health and substance abuse professionals. More than 200 citizens testified statewide.

1. TRANSPORTATION
 - huge unfunded mandate for local government
 - confusion over governmental responsibility
 - lack of availability of transportation due to distance and cost, especially in rural areas

2. RURAL ISSUES
 - critical shortages of qualified mental health and health care professionals
 - fewer trained law enforcement personnel
 - need for accessible telemedicine as an alternative

3. ADMISSION CRITERIA FOR STATE HOSPITALS
 - widespread misunderstanding about requiring involuntary status as an admission criterion for state hospitals
 - admissions resulting from treatment delays when community resources are not available
 - need to identify and eliminate incentives for unnecessary commitments

One of the greatest challenges facing our county and in our state is transportation. The Health and Safety Code is vague when it comes to who is responsible for what in the crisis system. This results in multiple agencies taking the position that they cannot or will not transport patients in some or all situations. . . . Many of our police departments are understaffed and as you can imagine, it is extremely difficult for a . . . small municipal police department to take an officer off duty for three hours to transport a patient with mental illness around.

And that's if they're trying to get them to some place locally. Imagine what it is if they are going to a city far away. It can be 11 hours plus. As is the case in many areas throughout the state these small agencies just simply do not have the resources to pay excessive amounts in overtime to fund this activity on an ongoing basis. What's more, it can become a public safety concern if this officer is one of only two that is working night shift when they may get a call to transport a patient.—Veronica Gonzales, Texas State Representative, District 41¹⁰

[A member of NAMI] stated that he would have voluntarily gone to be observed for a couple of days by a doctor who could then determine if he needed to stay. He felt he would have done better if he had been given that option.—Cindy McGee, President, Andrews NAMI¹¹

¹⁰ Public Testimony, Hearing of the Crisis Services Redesign Committee, Harlingen, Texas: February 27, 2006.

¹¹ Public Testimony, Hearing of the Crisis Services Redesign Committee, Big Spring, Texas, February 23, 2006

A lack of funding means that publicly funded preventative or early intervention mental health services are minimal or nonexistent and that patients often don't receive mental health services until they face a crisis. A lack of funding at the state level often means that local governments and local mental health authorities are perpetually in a state of crisis as they struggle to cope with demand for mental health services and the burden that untreated mental illness creates in other programs such as corrections. As with so many state policies, the burden of mental health services underfunding falls most heavily on local government, the two big areas being transportation and corrections.—Judge Gilberto Hinojosa, Cameron County¹²

When people emigrate from Mexico... It is common to see women isolated culturally and socially. Depression is common in the colonias. Undertreated and untreated mental illness, particularly depression and anxiety, are prominent with the men in the work that they do— isolated, not really fitting into the culture, "culture shock."—Bryan Smith, Harlingen Regional Director, Texas Department of State Health Services¹³

...mental health in regard to health care overall is ignored very much throughout the state. Everything is interrelated. If a person is mentally ill, it could lead to crime, it could lead to overcrowdedness in jails, and it could lead to wait times in the ER. It's a domino effect throughout the system.—Texas State Representative Veronica Gonzales, District 41¹⁴

¹² Public Testimony. Hearing of the Crisis Services Redesign Committee, Harlingen, Texas: February 27, 2006.

¹³ Public Testimony. Hearing of the Crisis Services Redesign Committee, Harlingen, Texas: February 27, 2006.

¹⁴ Public Testimony. Hearing of the Crisis Services Redesign Committee, Harlingen, Texas: February 27, 2006.

4. FINANCIAL RESOURCES
 - inadequate state resources to provide mental health crisis services for the indigent population
 - widespread belief that responsibility falls disproportionately on local communities
 - lack of understanding that crisis mental health services, like emergency medical services, are used by community at large
5. TRAINING
 - need for training of law enforcement (CIT, MH deputies) and crisis workers (assessment, suicide, substance abuse) to obtain good outcomes
 - training for first responders
 - need for more training for crisis hotline workers, i.e., telephone crisis counseling
6. INTEGRATION WITH HEALTH
 - little done to integrate mental health and other health care
 - training needed for other medical practitioners and public health workers to respond to mental health crisis calls
7. MEDICAL EVALUATIONS/CLEARANCE
 - law enforcement spends hours waiting for the medical evaluation of patients at acute care facilities before taking the patient for evaluation by the mental health authority
 - lack of understanding that the requirement for medical evaluations/clearance pertains to patients going to state hospitals only
 - provision of crisis mental health services unnecessarily delayed in order to obtain "medical clearance" first
8. ATTENTION TO FAMILIES
 - family input not solicited or is disregarded by mental health and law enforcement
 - misunderstanding of confidentiality laws results in exclusion of the family
 - little consideration given to families' concern for/knowledge of their loved ones
 - displacement issues, especially for children

9. MOBILITY ORIENTATION
- need for way to serve individuals who cannot locate or access a crisis emergency clinic
 - lack of mobile crisis outreach teams results in unnecessary costs to local and state government
 - lack of mobile crisis outreach teams results in bad outcomes for consumers and their families
10. INFORMATION ABOUT OBTAINING SERVICES
- information about available services for people in crisis and processes for accessing them not freely and easily available to the public at large
 - individuals seek assistance from law enforcement when a mental health intervention would be the appropriate response
11. ATTITUDE OF PROVIDERS
- lack of respect for consumers and family members, e.g., phone calls not returned
 - knowledgeable family input concerning the loved one's illness not heeded
 - responses to consumers and families colored by concerns about resources
 - use of inappropriately qualified and/or trained staff as first point of contact for people in crisis
12. SPECIALISTS
- need for competent, well trained specialists with professional and caring attitudes
 - need for more resources as well as better strategies for allocating resources
 - inability to attract and retain appropriate specialists leads to less clinically effective and fiscally efficient care

Individuals seek assistance from law enforcement when a mental health intervention would be the appropriate response.

No harm contracts were uniformly criticized by law enforcement, hospitals, consumers, and family members.

13. NO HARM CONTRACTS
- this practice uniformly criticized by law enforcement, hospitals, consumers, and family members
 - used statewide to buy time when crisis services are not immediately available
 - individuals asked to promise in writing that they will not kill themselves and then given an appointment at a later date
 - there is no evidence that suggests that no harm contracts deter individuals from suicide attempts

14. STANDARDIZED APPROACH
- lack of agreed-upon, shared interpretations of laws and rules governing crisis assessment and services
 - confusion surrounding key elements of crisis care
 - clearer standards and rules needed and should be promulgated, distributed, and explained

15. TYPES OF SERVICES
- evidence-based models are not being implemented
 - need for adequate resources
 - need to adopt models that work for all, that is, law enforcement, for courts, for providers, and for consumers and family members

Mental health services often are not available or accessible so that the only placement, other than the street, is jail.

16. JAIL AS AN OPTION
- mental health services often are not available or accessible so that the only placement, other than the street, is jail
 - long waiting times that law enforcement officers experience when escorting patients to health facilities result in jail placement so that officers can return to their other duties
 - committee members and commenters statewide in agreement that jail for people whose need is for mental health services should not be an option

Probably about 20 percent of the inmates in any given jail or prison are going to be mental health patients. That's about the percentage here in Austin.

We need a system to treat people in a humane environment where they are going to get proper care and it will keep them from rotating in and out of the system.—Larry Hauser, MD, Chief of Psychiatry, Brackenridge Hospital, Austin¹⁵

My son is 40 years old...he's been sick since he was 12. I retired two years ago and moved out in the country...My crisis was that [my son] got into drugs. He got angry and very aggressive. He's hit on me. He's torn things up in my house.

He's kicked my animals.... I only called [the deputies] five times in 2005 because most of that time he spent in jail. He just got out of jail two weeks ago and we're going to start this over again...I don't feel like I'm capable of handling him. He's well over 200 pounds. He'll come to my house and terrorize me. It's a crisis to me. Some people might can handle that, I don't know. I don't feel like it's fair for the sheriff's office, the deputies, and the jail system to take care of him. He's sick. He's not a mean person. He's not a bad person. He's sick. He needs to be in a hospital. He needs to be receiving medical care.- Family Member of Mental Health Consumer¹⁶

17. FORENSIC SYSTEM

- need for a forensic system that can handle individuals who, when they are very ill, become violent
- current forensic hospital system inadequate for state as large and populated as Texas
- commitment to supporting a forensic system would take pressure off law enforcement in everything from transportation to evaluation to timely clearance
- need a more rational system for individuals who do, at times, violate the law, but whose violations are due to their mental illness.

18. CHILDREN

- shortages in crisis services and problems in transportation more pronounced for children
- failure to respond to the needs of children and adolescents sets in motion a lifetime of chronic disability due to mental illness
- emphasis on children's special needs statewide called for

19. MENTAL HEALTH & SUBSTANCE ABUSE COURTS

- special courts supported by county and probate judges, district attorneys, law enforcement personnel, and families
- people with mental illness who commit misdemeanors stay in jail longer and use more criminal justice resources than others not mentally ill
- mental health courts and specific substance abuse courts have better legal dispositions and medical and mental health outcomes
- whether an individual is taken into the criminal justice system or the mental health system often depends on availability of beds

¹⁵ Public Testimony. Hearing of the Crisis Services Redesign Committee. Austin, Texas: February 15, 2006.

¹⁶ Public Testimony. Hearing of the Crisis Services Redesign Committee. Austin, Texas: February 15, 2006.

20. COLLABORATION
- lack of state resources for crisis services makes the collaborative effort at the local level a central strategy in communities
 - need for close and ongoing relationships between mental health, health, and law enforcement to give communities more options
 - best practices models of successful collaboration to maximize resources need to be exported statewide
21. CULTURAL COMPETENCY
- need for crisis services for non-English-speaking people will continue and increase with demographic trends
 - special need in border and urban areas
22. DATA
- comprehensive and uniform data is needed on existing crisis services and related patient outcomes

Eight hours a day, five days a week, I'm sitting on my bench, looking ...at somebody who's been charged with a criminal offense. In the case of seriously mentally ill folks, I've got lots of cases... criminal trespass, public intoxication that got elevated past the JP level, an occasional assault, and the occasional indecent exposure case that the guy I am looking at I know is a seriously mentally ill patient You know, I really wish that there was more that we could do...."—Judge Rusty Ladd, County Court at Law #1, Lubbock¹⁸

Section 1. Clinical Design of Core Crisis Services

I am scared that the next time I might not make it through by myself. That's what happened to two of my friends who had mental illness.

One didn't have any place to live. She was walking in the night with no place to sleep.

A car hit her and she died.

Another friend took too many medicines with drugs.

When he was too [physically] sick to be in the [mental] hospital, he died....

We don't have anyplace... for those who are mentally ill and have a drug problem.

We don't have anyplace for those who are mentally ill and homeless.

We need help.

Mental Health Consumer, 2006¹⁷

¹⁷ Public Testimony. Hearing of the Crisis Services Redesign Committee. Harlingen, Texas: February 27, 2006.

¹⁸ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

One of the foundations of a successful disease management approach to mental health treatment is immediate intervention and rapid stabilization of symptoms. Immediate, effective, evidence-based intervention during a mental health crisis can reduce the clinical seriousness of the event and the likelihood that a person will experience effects of chronic disease and need long-term supports. Most important, immediate clinically appropriate intervention and rapid stabilization can deter completed suicides, arrest, violence, and inpatient hospitalization, improving the quality of life for Texans. A disease management approach was required to be used in services by the Texas Legislature in 2003 through House Bill 2292. This committee's effort is a result of this mandate.

CORE CRISIS SERVICES

Members of the clinical subcommittee of the crisis redesign committee were charged with recommending core clinical elements of an evidence-based crisis response model. The committee work was accomplished by reviewing medical literature, reviewing existing nationally recognized standards of care as well as standards in other states, and relying on the collective expertise of the group to develop consensus around a clinically competent design. Each community in Texas is employing one or more of these elements with some success, but no community is funded to fully provide all of the identified elements in a comprehensive array of services. The recommended core elements are:

1. CRISIS HOTLINE SERVICES

The subcommittee identified hotline services as a core component and endorsed the American Association of Suicidology (AAS) guidelines as the clinical standards for this service. **This service provides around-the-clock immediate toll-free telephone access to a trained crisis counselor or a referral to a trained crisis counselor within one minute of receiving a call.** The call center or referral center would be accredited by the American Association of Suicidology at one of four levels of proficiency. Additionally, it is recommended that the Texas crisis hotline system participate in the National Suicide Prevention Hotline network administered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). See Appendix 3.

2. PSYCHIATRIC EMERGENCY SERVICES WITH EXTENDED OBSERVATION (23 TO 48 HOURS)

Extended observation was identified by the subcommittee as an essential component to effectively reduce unnecessary incarceration and inpatient psychiatric interventions. **Extended observation includes provision of comprehensive psychiatric emergency services with the goal of comprehensive assessment, rapid stabilization, and appropriate aftercare planning, and can include 23-48 hours of observation and treatment.** The essential elements of this service include: immediate access to assessment; treatment, the ability to safely and appropriately manage the most severely ill psychiatric patients; and immediate access at all times to emergency medical care.

Statutory changes would be required to modify the duration of the emergency order allowing a patient to be held up to 48 hours, which would better allow for stabilization and avoidance of more restrictive treatment. This approach is part of the hub system described in Section 2 on Rural Issues.

3. CRISIS OUTPATIENT SERVICES

Psychiatric urgent care services serve two purposes: **ready access to psychiatric assessment and treatment for new patients with urgent needs, and access to same day psychiatric assessment and treatment for existing patients.** Additionally, these services provide treatment for patients who are not currently likely to hurt themselves or others but who might develop an emergency if they do not receive same-day services. Clinicians are available during appropriate hours to treat patients with fairly severe needs if a brief, moderately intensive, intervention might reduce the need for a more intensive level of care. Available services may include brief therapy, pharmacotherapy, and case management services. Outpatient services are more limited in their ability to manage medically complex patients or patients with significant substance related co-morbidity. If done effectively, outpatient services can help reduce the need as well as the costs for more intensive services.

4. COMMUNITY CRISIS RESIDENTIAL SERVICES

Crisis residential services treat patients with high risk of harm and severe functional impairment who require the highest level of care in a non-hospital environment. Most residential services are voluntary programs. These settings are not equipped to provide care for patients who do not recognize their need for treatment and are not able to consent to treatment. They are usually limited in their ability to handle severe or acute medical co-morbidity. **They manage patients with the most stressful and least supportive recovery environments and those who have had negligible response to prior treatment.** The length of stay in this service is generally short (less than a week).

Respite residential services treat individuals with moderate to high risk of harm and risk of marked impairment in functioning due to stressful or unsupportive recovery environment. **These settings provide a short-term safe environment with clinical staff on site at all times, but without continuous monitoring to ensure safety or vigorous treatment.** Patients with past minimal response to treatment will generally not receive adequately intensive treatment in these environments. Patients must want to change and to accept responsibility for recovery.

5. MOBILE OUTREACH SERVICES

Mobile services **provide immediate access to assessment and crisis resolution services and the ability to manage the most severely ill psychiatric patients at all times.** A mobile crisis outreach team (MCOT) provides temporary services in the community to individuals who need psychiatric treatment but will not use the traditional system to access care. Often these individuals have urgent needs but do not meet criteria for involuntary detention. In areas that are not densely populated, they may be the most

cost-effective means of delivering high quality psychiatric emergency care. MCOT services are an extension of services provided by comprehensive psychiatric emergency services in more populated settings.

6. CRISIS INTERVENTION TEAM (CIT)/MENTAL HEALTH DEPUTY/PEACE OFFICER PROGRAM

The Crisis Intervention Team (CIT) is a team of trained law enforcement officers who respond to calls involving individuals who have or are suspected of having a mental illness. **They receive special training to defuse emotionally charged situations which could lead to violence.** Training is developed, provided, and supported by a community-based collaboration of local law enforcement, mental health consumers, and mental health providers.. Training guidelines must be consistent with certification requirements of the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE).

The Mental Health Deputy/Peace Officer Program is supported by Texas Health and Safety Code, Section 531.001(g) (1999), which states, "It is the goal of this state to establish at least one special officer for mental health assignment in each county....the department shall assist a local law enforcement agency that desires to have an officer certified under Section 1701.404, Occupations Code." The local MHA provides training for the mental health deputy/peace officer program consistent with the TCLEOSE training guidelines.

The success of these two programs in areas of Texas that have established them has been highly praised by both law enforcement and citizens.

Section 2. Rural Issues

We are going through kind of a crisis out here in this area.

Our area is a big area. It's got lots of acres, lots of miles between here and there.

I had the opportunity and enjoyed seeing the telemedicine presentation that they did down here.

The doctor was in Crane, Texas, and he was talking about his trip to Yoakum County, where I'm from, was two hours, one way.

Well when we go through that it doesn't make any difference where we go.

Hasn't been too long ago we had a mental health crisis.

*Couldn't find a bed and finally got one assigned,
and they wanted me to transport him to Brownsville,
700 miles away.*

Don Corzine, Sheriff, Yoakum County, Texas¹⁹

¹⁹ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

*I got involved with Betty Hardwick Center because we could not get care for our patients.
Ultimately I have become a trustee for Betty Hardwick Center
and every day I learn more and more about the issues,
the funding issues, the lack of funding issues, and the lack of care issues we need to address.
The funding in our area is one of the biggest issues we have.
We are rural. We cannot find psychiatrist to come to our area.
We don't have the services or the numbers to get the grant money.
It compounds on itself.
It is difficult for our folks to get help.*

Rita Johnston, Board of Trustees, Betty Hardwick Center, Abilene²⁰

*The rural hospital staff is not trained to deal with violent behavior.
They're not prepared for these type of patients.
They need to get them out of there.
They don't have the staff availability for one, to be doing one-on-one or two-on-one for a patient. It
all comes down to funding for the rural hospitals or for MHMR.*

Tracey Williamson, Director, Social Services, Cogdell Memorial Hospital, Snyder²¹
Public Testimony, February 23, 2006

A competent, effective clinical design for crisis services that will meet the needs of all Texans will have to consider the unique needs of rural and frontier Texas. Rural Texas is a difficult challenge when designing a competent system that meets the following long-standing established principles:

1. The treatment must be safe and effective.
2. Treatment must be delivered at the least restrictive level of care consistent with safety and effectiveness.
3. Treatment should be delivered as close to home as possible.
4. Treatment should be obtained at lower, rather than higher, costs provided all other criteria are met.

Many people who live in rural areas of Texas do not have easy, timely access to comprehensive mental health services in a mental health crisis. Most areas of rural Texas do, however, have capacity to provide some crisis services. Many of the services recommended as core components of the clinical redesign can be effectively delivered in or very near the home community while meeting the principles outlined above. Other, more specialized or involuntary services could be provided through a collaborative approach with other rural areas. Crisis care minimally requires the ability for the individual or someone concerned about an individual experiencing a mental health crisis to make contact with a trained crisis worker and receive an assessment. In sparsely populated areas, the most strategic approach may be to provide **crisis hotline services** and **mobile outreach**. This technique is currently utilized and is effective in reaching rural and frontier citizens.

A second need is the ability to receive a psychiatric evaluation or emergency assessment by a physician. Most rural areas have community hospitals which provide

²⁰ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

²¹ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

emergency medical services. These facilities report feeling ill equipped to manage mental health crises. These facilities could be supported with **telemedicine** to provide expert consultation and the opportunity for a psychiatric evaluation. This capacity will result in less distance and time spent by law enforcement transporting individuals in crisis, the ability for families to be with their loved ones at the hospital, and expanded opportunity to receive specialized medical services in rural community hospitals.

There is also a pressing need for local crisis stabilization options. **Crisis residential** and **crisis respite services** can be provided in rural communities. Many rural communities are currently providing a limited amount of these services. These services further reduce the need for citizens to travel far from their home for treatment.

There are some individuals in rural and frontier areas that need specialized care settings for evaluation due to various factors, including dangerousness, involuntary status, intoxication, criminal charges, etc. It is not practical or economically feasible for rural counties to maintain capacity or recruit and retain the necessary professionals to provide necessary security, facilities and expertise to assess and treat these individuals.

In order to access specialized crisis services, rural areas will have to collaborate with larger local authorities. **Larger areas could serve as hubs by providing specialized psychiatric emergency services to smaller local areas.** In accordance with principles outlined above, hubs could form to support the smaller authorities and their local crisis services. They could provide telemedicine support and expert consultation, crisis hotline support and backup, 23-48 hour observation, and other services that the authorities collaborate and agree on. Law enforcement who has to spend many hours traveling and waiting for mental health assessments would have a convenient, safe place to drop off citizens to receive quality psychiatric care. Transportation from the hub to the next setting of care or home community could be coordinated by the hub, resolving the need for the county to return the individual home or transport the individual to the hospital.

If hubs are to be considered a positive, viable element of crisis redesign for rural areas, hubs must be at least as close for law enforcement and families as the state hospital. Secondly, there must be adherence to the commitment of flexibility to meet the need for separate rural and urban solutions. Further, whatever is developed should enhance and not destroy the current system that allows for crisis services in each community. Hubs should be representative of the geography and cultures of Texas and should represent natural alliances and partnerships to the greatest extent possible. Many authorities are currently partnering on a variety of administrative and clinical services.

Section 3. Financing

Local mental health authorities are currently required to provide access to 24-hour crisis assessment and screening. Historically, funds have not been sufficient to provide the necessary access to clinically appropriate services needed to promptly resolve a crisis. If funded, this project will provide an enhanced array of crisis services and improved access to those services.

It is estimated that there are approximately 54,255 clients requiring crisis services annually in Texas. Of these 7,708 are children. In order to develop an estimation of funding needed for the Crisis Redesign initiative, members of the finance subcommittee worked collaboratively with Department of State Health Services (DSHS) staff to examine existing cost and utilization data from the Client Assignment and Registration System (CARE) and county data. Based on that data, the subcommittee projected an estimate of likely service demand and related costs, as follows:

ANNUAL COSTS	Estimated Costs Per Year (in millions)	Proportional Expenditures
Mobile Outreach	\$11.24	10.12%
Psychiatric Emergency Services with 23-hour Observation/48-hour Extended Observation (including physician availability enhancement)	\$37.76	34.00%
23-hour Observation/48-hour Extended Observation Rural Recruitment and Incentive	\$2.02	1.82%
Residential	\$39.04	35.15%
A. Crisis residential	26.92	24.24%
B. Respite	12.12	10.91%
Outpatient Crisis Services	\$2.15	1.94%
Transportation and Officer Wait Time	\$9.15	8.24%
Crisis Hotline: Certification; staffing and public awareness campaign	\$9.02	8.12%
Additional staff resources and associated operating costs	\$.68	0.61%
TOTAL	\$111.07	100.00%

The finance subcommittee has recommended a **phased-in approach** to the implementation of the crisis redesign initiative, **with two biennia required** to achieve full implementation. The subcommittee has recommended that crisis hotline services, psychiatric services with 23- and 48-hour extended observations services, and transportation funding be given priority for implementation during the first year of the

project. The implementation of these services will have the most immediate impact on the effectiveness of the crisis response system in Texas. Mobile outreach and crisis outpatient services will be partially implemented in the first year and fully implemented during the second year of the biennium. Crisis residential and respite services also will be rolled out in the second year.

The total estimated cost to adequately address the needs for this population would be approximately **\$222.13 million per biennium**. There will be a phased implementation of this project with 37.5% of the total cost to be requested in the first biennium. The remainder, to support full implementation of all services statewide, will be requested in the second biennium.

Section 4. Collaboration

*Accessing services for... children I have found to be very difficult.
I have called the hotline at times and the worker has come out but it has been several hours sometime before
the workers come out there and the problem has already passed.
And the child is in a secure facility so the services aren't provided to that child.
And then when they get out, they are put back on the street without those services in place.
In my opinion that is a collaboration issue....
The agencies have competing [missions] yet many tasks are the same in nature.
Chief Juvenile Probation Officer, Garza County²⁰*

*We have the local hospitals with emergency rooms. We have 12 emergency rooms
and each of them has different rules and they interpret things differently....
We have law enforcement: 32 police departments,
and I promise you that we need a clarification or rewriting of the Health and Safety Code
because each one interprets it a different way.
Marin Garza, MD, Family Practitioner, Tropical Texas MHMR²¹*

Collaboration is difficult to achieve in an atmosphere of limited resources, yet the committee was extremely impressed that communities which have been able to forge a cooperative approach to dealing with crisis mental health issues have been the most successful in terms of successful crisis response and jail diversion. These collaborations often included the mental health system, the health system, law enforcement (police and sheriffs), judges, and county officials. All parties contributed not only their specific expertise but also limited funds which enabled the crisis system to be far more effective. It is clear that this collaboration is a key ingredient to success at the local level. In communities that do not have access to emergency mental health services planned for in a collaborative manner, the local response to a person having a mental health crisis ranges from being transported long distances to a mental health facility to being incarcerated locally to inappropriate use of emergency rooms. Today, it has become evident that **caring for people with serious mental illnesses requires collaboration with local law enforcement, emergency rooms, the courts, social service agencies, and the mental health authority.**

The centerpiece of the strategy of care for patients in the Texas mental health system is disease management, an approach to care that is dependent on the collaboration of all members of an individual's team of caregivers to share information and resources to most effectively meet clearly defined treatment goals. In many respects the approach is derivative from the treatment team model, but in disease management, the need for collaboration specifically involves patients who have serious, chronic mental disorders. The plan of care is closely matched to clinical diagnoses and outcomes are monitored on an ongoing basis, which in chronic disease means for as long as the patient remains committed to active engagement in care.

²⁰ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

²¹ Public Testimony. Hearing of the Crisis Services Redesign Committee. Harlingen, Texas: February 27, 2006.

Committee recommendations, including local authority collaboration in the training and development of police Crisis Intervention Teams, development of 24-hour psychiatric emergency rooms, and collaboration between community hospitals and rural local authorities will require sustained collaboration between local authorities and community partners. Advocates, consumers, and families will need to be included as essential partners in any sustained collaboration.

Section 5. Special Issues

Being a rural area, the area that we service and West Texas Center's 23-county catchment, everyone well knows that is a tremendous geographical area to cover.

When the nursing homes have a crisis in the middle of the night, getting someone to provide services and transportation for those patients is very very difficult.

I would love to see there be funding for transportation services.

Again, when you have systems that are underfunded but you have excellent employees working, the burnout rate can become very high

when your resources are as limited as they have been in Texas.

Mary Kay McLaughlin, Program Director, Psychiatric Nurse, Geriatric Psychiatric Unit, Scenic Mountain Medical Center²²

It is one thing for our officers to serve the mental health war or to pick up someone who is in danger to themselves or others from the street and transport them to a hospital or mental health facility.

It is quite another for our officers to transfer patients from the hospital to another mental health facility, particularly when the that facility is hundreds of miles away... And while our constable and sheriff deputies are extremely professional, they are not mental health professionals.

And a patrol car is not the ideal way to transport someone who is suffering from the illness....

I question why it is the county's responsibility to transport state patients from Harlingen to San Antonio, Kerrville, Ft. Worth, or El Paso.

As part of that, why is it also the responsibility of hospitals to bear that burden, because part of what we are doing is asking them for money to hire these deputies and provide for this transportation.

Let me remind you that the State of Texas provides transportation for state prisoners from county jails

but it won't provide transportation to those with serious mental illness, some of our most vulnerable residents.

Judge Gilberto Hinojosa, Cameron County²³

We have individuals and family members who express a lot of concern about the distances to a psychiatric hospital. It is difficult for the family to participate in the individual's care when they have to drive four or five hours to get to the hospital. The closest private care for children from [Andrews] is in San Angelo or Lubbock. If [the person is] indigent, it is a three to five hour drive farther to Wichita Falls or El Paso.

Cindy McGee, President, Andrews NAMI²⁴

²² Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

²³ Public Testimony. Hearing of the Crisis Services Redesign Committee. Harlingen, Texas: February 27, 2006.

²⁴ Public Testimony. Hearing of the Crisis Services Redesign Committee. Big Spring, Texas: February 23, 2006.

Every night we have problems with transportation—who does it and who doesn't, and we have to do it with bargaining and connections and favors and we finally get somebody to budge.

Marin Garza, MD, Tropical Texas MHMR²⁵

TRANSPORTATION

Lack of appropriate medical transportation is consistently identified by the public, including sheriffs, county officials, consumers, family members, judges, and legislators as a barrier to accessing crisis mental health services. Counties report that the burden of transporting individuals experiencing mental health crises has shifted to county law enforcement, leaving areas of Texas without police protection for hours at a time while local law enforcement officers escort individuals to the state hospital.

Currently the Texas Health and Safety Code requires a peace officer to transport an individual who refuses mental health services to a psychiatric facility deemed suitable by the local authority for evaluation. Often, police must first transport the patient to a local hospital emergency room for medical clearance, which can take hours, before the officer has to further transport the prospective patient to a suitable psychiatric facility. Due to the lack of availability of psychiatric inpatient beds, patients must sometimes be transported hundreds of miles to the nearest suitable psychiatric facility.

Establishing regional, short-term (up to 48 hours) evaluation centers to serve as suitable psychiatric facilities throughout the state to provide emergency psychiatric services would allow law enforcement to drop consumers off to be assessed, stabilized, and transported to the next setting of care if necessary. If the consumer did not need further stabilization, residential or inpatient services, transportation home could be provided by the facility. The challenge to this solution is locating such units in geographically accessible areas that are relatively convenient for law enforcement.

Funds for transportation are a necessary part of the solution for this problem. Without new funds, various entities will continue to attempt to shift cost and responsibility, all to the detriment of those in dire need of care. Transportation solutions would be in accordance with Department of State Health Services promulgated standards governing medical appropriateness and patient safety. Statutory changes under the Mental Health Code may be needed.

CHILDREN'S CRISIS SERVICES

A review of literature does not indicate a well established evidence-base for effective children's crisis services. Although this level of evidence does not exist, program research does indicate promising and effective approaches to treating children and adolescents in crisis. Most experts agree that it is important to provide services to children as close to home as possible in the least restrictive setting. Additionally, it is imperative to include families in the intervention.

²⁵ Public Testimony. Hearing of the Crisis Services Redesign Committee. Harlingen, Texas: February 27, 2006.

Types of interventions described as effective for children are not different from services recommended as effective for adults. Recommendations include availability of assessment and emergency observation, crisis respite, mobile outreach, and home-based interventions. Additionally, heavy emphasis is placed on parent training and support. A child crisis effectively translates into a parent or guardian's inability to manage the condition of the child without help. An important goal of the crisis intervention is to provide tools to increase the parent's ability to manage the child in the home environment.

Although the recommended interventions for children are consistent with services recommended as effective for adults, children's services should ideally be provided by clinicians who are trained and/or have demonstrated competency in children's mental health. Assessments for children must be developmentally appropriate and services should be provided in an environment that is appropriate for children.

FORENSIC SERVICES

Texas is the only large or medium-sized state in the country that doesn't have a developed forensic mental health system. A forensic mental health system is concerned with individuals with mental illness who, because of lack of supervised treatment, find themselves inappropriately in the criminal justice system and then released into the civil system. An appropriate forensic mental health system can handle individuals who fall in between the criminal justice and civil systems because they have a propensity for dangerousness or violence due to their mental illness. In a good, supervised forensic treatment program, most of these people will commit crimes only when their mental illness is not in control. Currently Texas has only a forensic program in a state hospital and another small program without enough resources, the TCOOMMI program, neither of which are close to what a state this size requires.

Models for such a system currently exist and if implemented would take pressure off law enforcement in areas such as transportation, evaluation, and inappropriate placements such as incarceration. Law enforcement has expressed that it feels burdened by continually dealing with individuals who do at times violate the law but whose violations are due primarily to their mental illnesses.

Most other states have forensic systems in place to deal with this highly specialized and growing population. Texas has a limited capacity to deal with manifestly dangerous patients and with some patients who have found themselves in the state system of care though civil or criminal commitment. It needs a statewide, comprehensive forensic care system as soon as possible.

Conclusions

In Texas crisis services are not accessed, provided, or available in a uniform, consistent manner. How services are accessed, the type of intervention, and the quality of care a consumer receives are highly variable from one county to the next. While each local mental health authority in Texas is required to ensure 24-hour availability of crisis mental health services, in many communities, the limited array of interventions available and access to those services are inadequate and lack necessary resources. Although there are standards governing timeframes for response and credentials of responders, the current crisis standards do not provide for a uniform, clinically effective crisis system.

Crisis services are required to be available statewide, but survey results and testimony from the public hearings indicate that this is not always the case. Reasons for lack of availability include difficulty locating and accessing services, geographical barriers, lack of resources, and the absence of a clinical design for the delivery of crisis services. In many communities, the picture is further complicated by the lack of collaboration and sharing of resources to address the problem. Lack of available crisis services in these communities has resulted in resource and regulatory burdens for law enforcement, the courts, jails, hospital emergency rooms, and schools and has reduced the quality of life for citizens in those communities.

RECOMMENDATIONS

The Crisis Services Redesign Committee recommends that the following service array is essential if effective crisis services are to be provided all Texans:

1. Crisis hotline services
2. Psychiatric emergency services with extended observation services (23- to 48-hours)
3. Crisis outpatient services
4. Community crisis residential services
5. Mobile outreach services
6. Crisis intervention team (CIT)/mental health deputy/peace officer program

Standards for most of these services have been identified and recommended (see Appendix 3).

The statewide concern over lack of medical transportation requires special attention because lack of readily available, medically appropriate transportation for contributes to poor consumer outcomes, stigma, and inefficient use of limited public funds. The committee agrees that making resources available to address these transportation issues is critical to meaningful transformation of crisis services in Texas. Without a solution to the problem the crisis system will remain crippled.

Many people who live in rural areas of Texas do not have easy, timely access to comprehensive mental health services in a mental health crisis. Most areas of rural Texas do, however, have capacity to provide basic crisis services. Delivery systems involving telemedicine must be supported in order to help compensate for difficulty recruiting and accessing trained professionals. Also, the use of tiered levels of intensity for services such as hotlines and 23-48 hour extended observation (similar to levels of trauma care centers) will enable a more efficient use of scarce resources. This intervention will help keep the consumer closer to the community during initial assessment and evaluation and reduce the costs to local government.

Collaboration is the centerpiece in the transformation of mental health crisis services statewide. In those areas in which crisis services are working especially well, it is clear that collaboration across numerous entities is a necessary ingredient. It will be essential that local mental health authorities, hospitals, courts, police, sheriffs, families, and consumers work together to build the local crisis system.