

CHRONIC CONSUMER STABILIZATION INITIATIVE

**A Multi-Agency collaboration between the City of Houston
Health and Human Services Department, the Houston Police
Department and the Mental Health Mental Retardation
Authority of Harris County**



**Submission for 2010 Herman Goldstein Award for Excellence
in Problem-Oriented Policing**

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CHRONIC CONSUMER STABILIZATION INITIATIVE

Houston Police Department, Houston, Texas

Scanning: In 2007, the Houston Police Department had three deadly force encounters with persons with a history of severe mental illness and numerous prior contacts with officers. Department statistics indicate that annually, Houston police increasingly respond to calls-for-service involving persons in serious mental health crises.

Analysis: Statistical data collected by the Houston Police Department's Mental Health Unit identified a small number of problematic chronic consumers with a disproportionately high number of encounters with police.

Response: A partnership was formed between the Houston Police Department, Mental Health Mental Retardation Authority of Harris County, and the City of Houston Health Department. The strategy of this partnership was to evaluate and research the root causes for these chronic consumers having frequent encounters with law enforcement. City funding was provided for two licensed caseworkers to work with the 30 most chronic mentally ill persons that the police department responds to most frequently.

The goals of the program are:

- Reduce the number of interactions between individuals diagnosed with serious and persistent mental illness and the Houston Police Department.
- Identify unmet needs and barriers in the community that contribute to an individual's inability to engage and remain in mental health treatment.
- Link and coordinate individuals with mental health treatment and other social service needs.
- Provide support and education to individuals and family members to minimize contact with law enforcement from noncompliance with mental health treatment.

Assessment: The Chronic Consumer Stabilization Initiative was piloted for six months in 2009. Statistical data on police calls to these 30 chronic consumers was compared for a six month period prior to the pilot and then compared after completion of six months of intense engagement by a caseworker during the pilot. As a result of this six month initiative, there was a 70% decrease in contacts between these persons with chronic mental illness and the Houston Police Department. Statistics reveal that 972 police manpower hours were diverted as a result of this decrease in contact. In addition to the reduced police contact, there was a significant reduction in involuntary hospitalizations with this population.

2 BACKGROUND

Traditionally, the Houston Police Department's response to individuals in serious mental health crises has been reactive: the patrol officer is dispatched, responds to the location, assesses the situation, and takes the appropriate steps to resolve the issues. In the vast majority of cases, the mental health consumer is taken for emergency mental health evaluation. The consumer is typically stabilized and released, in 24 to 72 hours, to the same environment/conditions he came from, quickly de-compensates, and the cycle of police intervention continues. The reasons/problems causing the consumer to go into crisis are not addressed.

3 SCANNING

Over the last several years, the City of Houston has experienced a dramatic increase in calls involving individuals in serious mental health crises. In 2007, Houston Police responded to just over 15,000 of these calls...by 2009 that number had increased to over 23,000 (Appendix A). Unfortunately, along with the increase in calls-for-service there has also been an increase in tragic encounters involving deadly force and persons with serious mental illness. During a six month period in 2007, the Houston Police

Department was involved in three deadly force incidents involving persons with a history of serious mental illness and numerous prior contacts with law enforcement.

As a result of these three incidents, a Mental Health Task Force was formed in September 2007. The goal of this task force was to closely examine the three tragic encounters in which Houston Police Officers utilized deadly force on persons with mental illness. This task force was comprised of members of law enforcement, community leaders, and mental health advocates.

The Mental Health Task Force met three times over a six-week period and examined each of the three cases involving deadly force. The Task Force was able to quickly determine that each of the three cases had two things in common:

- (1) Each of the individuals fatally wounded by officers had a lengthy history of severe and persistent mental illness;
- (2) Each of the individuals fatally wounded by officers had a prior history of mental health crises and contact with police during these crises.

With these findings, the Task Force formed a plan of action to identify the 30 most chronic mentally ill persons in the City of Houston who also had the most frequent contact with law enforcement. This plan of action involved utilizing Houston Police offense reports involving persons with mental illness to identify the candidates for this program. The second part of the plan was to assign these 30 individuals to two licensed mental health caseworkers to provide intensive supervision with the goal of reducing future interaction with the police. The Task Force recommended a six-month pilot period for this concept, followed by a thorough evaluation.

4 ANALYSIS

The Chronic Consumer Stabilization Initiative (CCSI) is an innovative, collaborative, proactive partnership of the Houston Police Department, Houston Health Department and the Mental Health Mental Retardation Authority of Harris County with the following goals:

- 1 Reduce the number of interactions between individuals diagnosed with serious and persistent mental illness and the Houston Police Department.
- 2 Identify unmet needs and barriers in the community that contribute to an individual's inability to engage and remain in mental health treatment.
- 3 Link and coordinate individuals with mental health treatment and other social service needs.
- 4 Provide support and education to individuals and family members to minimize contact with law enforcement from noncompliance with mental health treatment.

4.1 Methods of Analyzing the Problem

Prior to implementing the CCSI project, task force partners conducted in-depth research including:

- (1) Houston Police offense report reviews involving persons with mental illness;
- (2) Review of statistical data on individuals requiring repeat Emergency Detention Orders by Houston Police Officers and/or frequent calls to 911;
- (3) Interviews with family members to examine clinical and community support (or lack thereof) in incidents that resulted in a fatality; and
- (4) Site-based, community education (conducted by a public health nurse, social worker, and police officer) with personal care home administrators with extensive histories of law enforcement contact for mental health crises.

4.2 Identifying Clients for the CCSI Project

To collect and analyze the data needed for this project, the Houston Police Department's Mental Health Unit (MHU) developed a statistical database that identifies the most problematic mental health consumers coming into contact with officers on a regular basis.

We found that over 200 individuals in mental health crises had repeated interactions with police officers since 2006 (the beginning of the compilation of data). In order to narrow the focus on the most chronic persons and to limit the number for the pilot project, the task force partners decided only those persons who had been taken for an Emergency Detention Order four or more times in the last six months would be considered for placement in the CCSI program. In addition to Emergency Detention Orders, the number of HPD calls-for-service involving these persons was considered as criteria for placement on CCSI. Using the agreed upon screening requirement, HPD's MHU was able to identify 57 individuals who met this criteria.

The next step involved providing this list of 57 individuals to the CCSI caseworkers who were then tasked with attempting to locate and engage them in CCSI services. The caseworkers were unable to locate 16 of the individuals on the list. Eleven of the individuals were found to have been placed in state schools, hospitals or jail for an extended period of time and were excluded as candidates for the CCSI project. After conducting an exhaustive search, caseworkers were able to locate and engage 30 of the individuals identified by the database who became clients for the six month CCSI pilot period.

4.3 CSSI Client Profile

The client profile indicates an almost even distribution of gender. Sixteen of the thirty (53%) clients are female and fourteen (47%) are male. Ten clients (33%) are between twenty and thirty years of age. The increased contact with emergency services at this age may be attributed to the following: recent diagnosis, previously under family care and emancipated at legal adult age, incapable and not aware of community services. Nine clients (30%) are between forty-one and fifty years. The higher percentage in this age group could be attributed to the following: ostracized from family and support systems, alienated from various personal care homes due to disruptive behavior, and continued non-compliance with treatment (Appendix B).

Thirteen of the thirty clients (43%) have a diagnosis of schizophrenia. Eight (27%) have a diagnosis of schizoaffective disorder. Seven (23%) have a diagnosis of bipolar disorder with psychotic features. Eleven of the thirty clients (37%) have substance abuse dependence. Six (20%) have a diagnosis of mental retardation. Additionally, fifteen (50%) have significant medical issues (i.e. diabetes, HTN, seizure disorder, and injuries resulting from trauma).

The lack of consistent treatment generally cannot be attributed to a lack of benefits. Twenty four of the thirty clients (80%) receive SSI benefits. Six (20%) have a guardian and eight (27%) receive case management. Six (20%) of the thirty clients are homeless. Eleven (37%) reside on their own or in a family home and thirteen (43%) reside in personal care homes (Appendix C).

5 RESPONSE

The objective of this proactive strategy is to directly engage these chronic mentally ill individuals through an intensive and interactive program by employing mental health professionals trained in the field of case management and social services. These case managers, commonly thought of as case workers, conduct a comprehensive background investigation by researching previous psychiatric services of the clients, learn about known diagnoses, prescribed medications, previous encounters with law enforcement, and whether or not these individuals have been cycled through mental health and social service programs. The case managers then reach out to these persons in the field by making contact with their families, the individuals themselves, and offer every type of mental health and social service available. The case managers work closely with these persons and guide them on a path to a more stable way of life.

5.1 Pilot Phase

The Chronic Consumer Stabilization Initiative officially began as a six-month pilot program on February 15, 2009. Two licensed case managers, with professional backgrounds in mental health services, were hired by the Mental Health Mental Retardation Authority of Harris County (MHMRA) and funded by Mayor Bill White, with approval of the Houston City Council.

Staff meetings were held bi-weekly between the case managers and the Houston Police Mental Health Unit to discuss their progress, problems encountered, and other barriers or issues that needed to be resolved. The CCSI pilot was supervised by a civilian manager from the Mental Health Mental Retardation Authority and the sergeant and lieutenant from the Houston Police Department's Mental Health Unit.

5.2 Contacts and Linkages

After initial contact was established with the CCSI clients, case managers made daily contact to get the client into needed services. This included, but was not limited to, housing, household furnishings, adequate clothing, linkages to mental health/medical providers, food stamps, and other necessities for daily living. The average number of contacts per month was 253. There were twelve average contacts per day. Each client received an average of nine contacts per month.

One hundred and seventy contacts (34%) were made to facilitate inpatient mental health treatment for the clients. One hundred and fifty-three contacts (31%) were made to facilitate outpatient mental health services and counseling. Three hundred and twenty-three (65%) of case manager contacts were an effort to obtain needed mental health treatment for these clients. One hundred and nineteen contacts (24%) were made to obtain primary healthcare. Twenty-three contacts (5%) were made to assist with substance abuse (Appendix D).

Three hundred and fifteen contacts (58%) were made to assist clients with housing. Additionally, ninety-nine contacts (18%) were made to help locate and enroll clients in available community services. Eighty-one contacts (15%) were made to help clients in navigating the legal system. Forty-seven of the contacts (9%) were made to help clients obtain available financial funds. The vast majority of the case manager contacts were attempts to provide basic quality of life resources for these clients who may not have adequate skills to obtain these independently without an advocate (Appendix E).

5.3 Identified System Barriers

Throughout the CCSI pilot, the clients and the case managers encountered numerous barriers that interfered with the clients' ability to get their needs met. These barriers have inhibited the clients' ability to access adequate housing, primary medical and dental care, as well as psychiatric treatment in the least restrictive environment. It was apparent these identified barriers were contributing to the high number of law enforcement interactions. Availability and access to these resources is vital for an individual with serious and persistent mental illness to successfully live in the community.

5.3.1 Barrier #1: Housing

Safe, adequate housing for this population is extremely limited. Although the majority of clients have Social Security benefits, it is difficult to retain housing for them. This population is very transient and difficult to locate at times. Many of these clients would benefit from a structured residential setting, staffed with mental health professionals 24 hours/365 days a year.

Attempts to Resolve:

CCSI Case Managers worked very closely with the personal care home operators to locate housing, problem solve housing issues, and advocate for the clients when needed.

5.3.2 Barrier #2: Culture of Living Environment

In many of the family homes and personal care homes in which the clients reside, the family and/or providers call the police to manage the behavior of the client. Typically, the personal care home staff would not assist the client with compliance with physician appointments, getting prescriptions filled or with monitoring to make sure they were compliant with the medications on hand. Many families and private providers wait until

the client's behavior escalates or the client becomes out of control and they would call the police.

Attempts to Resolve:

CCSI staff members have worked closely with the personal care home staff to request that they call the CCSI Case Managers if they need assistance with the client, BEFORE the situation escalates such that the police are required. This has been extremely successful as the staff and the clients call the Case Manager as issues come up instead of waiting until the situation escalates.

5.3.3 Barrier #3: A Lack of Early Intervention Prior to Clients Decompensating to the Point of Becoming Dangerous

Under Texas law, peace officers have the authority to take a person involuntarily for an emergency mental health evaluation if the officers believes the person is mentally ill and because of that illness the person poses a substantial risk of serious harm to self or others and believes that risk is imminent. We have a very good system for getting these individuals evaluated. The problem is getting help for the serious mentally before they pose this risk of harm.

Attempts to Resolve:

The case managers on the CCSI program have done a stellar job assisting the mental health consumers on the program with obtaining the services available, convincing the consumers they need care and treatment, and educating family members about mental illness. For those consumers not in the CCSI program, attempt to educate family members with printed educational material, community forums, and working with advocacy groups like the National Alliance on Mental Illness (NAMI). Also, lobby state legislators regarding the need to amend the state mental health code to allow commitment

of the seriously mentally ill who meet specific criteria: history of dangerousness, history of interactions with law enforcement, repeated hospitalizations.

5.3.4 Barrier #4: Lack of Legal Motivation for Clients to Comply with Mental Health Treatment

Unless a client is on parole or probation, there is no process to legally compel a client to take medications and/or comply with treatment. Consequently, it is difficult, if not impossible to involve many clients in mental health treatment outside of the jail or hospital setting.

Attempts to Resolve:

Continue to point this out as a major issue and lobby legislators for the need for Outpatient Commitment Treatment that allows for compulsory medications.

5.3.5 Barrier #5: Client's History

Most of the CCSI clients have been in the community and mental health system for many years and are well known to the public system and many private providers. Many treatment providers are unwilling to readmit them due to their history of being uncooperative, reluctant to participate and difficult to manage. Consequently, it is difficult to access treatment programs, day programs and housing programs for these clients, based on past behavior.

Attempts to Resolve:

CCSI case managers advocate with the various program staff on behalf of their clients. They assure the staff that they are available to assist with the clients if necessary. In many cases, this arrangement has worked out and the programs admit the clients.

6 ASSESSMENT: RESULTS THROUGH INNOVATION

The Chronic Consumer Stabilization Initiative (CCSI) has proven to be very successful and met the goals set forth at the beginning of the pilot. The clients selected for the pilot were clients who, by history, had the most documented number of calls for service from the Houston Police Department and/or had the highest number of Emergency Detention Orders (EDO's) filed on them by Houston Police Department Officers. These clients also had extensive histories of utilizing emergency crisis mental health services and psychiatric hospitalizations. Finally, many of these clients lacked the support and advocacy of family and/or the community, to assist them with successful independent living.

Evaluation of the CCSI project was conducted by:

- Clemelia Richards, P.h.D. Houston Health and Human Services
- Kim Kornmayer, M.A., L.M.S.W. MHMRA of Harris County
- Lieutenant Mike Lee, M.A. Houston Police Department

Data was collected and entered into two MHMRA databases and one HPD database.

- MHMRA Data:
 - ❖ **Anasazi System:** Records information regarding the type and quantity of services provided to clients in the program.
 - ❖ **MHMRA/HPD Collaboration Database:** Records demographic information as well as information regarding reason for involvement in program, services provided to client while in program, linkage information and discharge information.
 - ❖ **HPD Mental Health Unit Database:** Records all incidents involving Houston Police officers and individuals experiencing a mental health crisis.

The first and most important goal of the CCSI pilot was to *reduce the number of interactions between individuals diagnosed with serious and persistent mental illness and the Houston Police Department.* The data collected proves that this goal was

achieved. It was determined that the 30 consumers placed in the pilot were responsible for 194 offense reports and 165 EDO's from six of their most active months prior to being placed in the pilot program. This is a total of 359 time-consuming events which averages close to one hour of work per officer per event. After intense intervention by the two case managers, the same 30 individuals were only reported to have been involuntarily committed by officers for a total of 39 times, a significant decrease of 76.4%, while only 65 police offense reports were generated resulting in a 77.3% decrease (Appendix F). A total of 768 patrol manpower hours were saved and reallocated by the reduction in calls for service and the HPD MHU realized a reduction of 194 investigative hours (Appendix G).

Although not a stated goal of the pilot, another significant impact of the CCSI program was a decrease in the number of admissions to the local mental health emergency room (NeuroPsychiatric Center) and in the number of admissions to the Harris County Psychiatric Hospital (HCPC) during this six-month period. Fourteen of the thirty clients (45%), had a decrease in admissions to the NeuroPsychiatric Center and six clients (20%) had a decrease in admissions to HCPC. Overall, admissions to the NeuroPsychiatric Center decreased by 21%, while admissions to the HCPC decreased by 51%. The reductions in hospitalizations resulted in significant savings for each facility (Appendix H,I).

The second goal of the CCSI pilot was to *identify unmet needs and barriers in the community that contribute to an individual's inability to engage and remain in mental health treatment*. Over the six-month pilot, the CCSI staff identified five major barriers that contributed to these clients' inability to successfully engage and participate in

outpatient mental health treatment. The CCSI staff personally encountered a number of these barriers while attempting to serve their clients. In many situations, the CCSI staff was able to positively impact existing barriers through education and strong advocacy. The first challenge was to educate the clients, the community, and service providers about the staff's role and purpose of the CCSI program. The CCSI staff worked hard to educate the families, care home providers and other service providers about the program and the CCSI staffs' willingness to partner with them to assist these clients. In many cases, especially with the personal care home operators, this was extremely effective.

The third goal of the pilot was to ***link and coordinate individuals with mental health treatment and other social needs***. In order for the CCSI staff to engage the clients and establish a rapport with them, they had to meet the client "where they are." Some of the clients were receiving mental health treatment from MHMRA of Harris County. Over the six months, staff members worked diligently to link and engage the clients with mental health treatment, primary health and dental care, and when indicated, substance abuse treatment. They also worked to link and coordinate clients with safe and adequate housing, respite services, day treatment programs, social services, and access to financial benefits and entitlements. The majority of these clients had multiple needs and the CCSI staff worked persistently to assist the clients with accessing needed services. Project results are indicative that the support and advocacy of the CCSI staff has positively impacted the ability of these clients to live independently within the community.

The final goal of the CCSI pilot was to ***provide support and education to individuals and family members to minimize contact with law enforcement resulting from noncompliance with mental health treatment***. The CCSI staff has worked tirelessly to

educate their clients, their care providers, treatment providers and families about mental illness and the importance of compliance with treatment. They provided information regarding available community resources, health and legal resources and how to access them. While several of the clients had family involvement, this involvement was not always in the best interest of the client. Families resisted offers of assistance and education, choosing instead to keep their family member sequestered, allowing only minimal CCSI involvement. Once out of the hospital, the family would not follow up with having prescriptions filled, monitoring their family member's compliance with taking the medication and assisting them in getting to their clinic appointments. With this lack of family support, the client would then begin the cycle of decompensation.

Other family members welcomed the support and assistance and partnered with CCSI staff to assist the client. They wanted to help their family members but some did not know how, while others were becoming fatigued by having been the sole support for their family member for so long. The CCSI staff also provided information on various diagnoses and the signs and symptoms of these illnesses. These partnerships resulted in positive outcomes for the clients.

In the majority of cases, the clients had no family involvement or support. Some clients did not know where their families were, while others had been asked to leave and not come back. In these cases, the CCSI staff worked very closely with the clients and their housing providers. It was during this process that the CCSI staff learned that in the majority of care homes, the standing procedure for dealing with clients who became agitated and started to escalate, was to call the Houston Police Department for them to come take the client away. As with many of the families, many of the care home staff

were not proactive in assisting the client with getting prescriptions filled and attending scheduled physician appointments. It became clear that some of the homes did not know what to do to assist the client with compliance, while other homes did not see that as their responsibility and used the police department when clients began to decompensate. Some of the care homes were also participating in illegal activity and involving the clients in those activities. These clients were relocated and this information was provided to the Houston Police Department. The CCSI staff began working with the different care homes to educate them on the importance of being proactive to ensure that the clients were compliant with treatment. When the clients did begin to decompensate, the staff were encouraged to call CCSI so they could intervene before the situation escalated requiring police intervention for safety reasons. The care home providers began calling CCSI staff instead of the police and found the staff to be very helpful. The clients also began calling CCSI staff when they became agitated and felt like they were starting to decompensate. This early intervention by CCSI staff often prevented the need for crisis services or hospitalizations.

7 BENEFITS TO THE LAW ENFORCEMENT PROFESSION

CCSI is important to the law enforcement profession. It has demonstrated that law enforcement agencies can successfully utilize problem oriented policing strategies to effectively address the increasing and problematic issue of law enforcement response to the mentally ill in crises. CCSI has demonstrated that law enforcement can work collaboratively, proactively, and innovatively with its community partners to stop the cycle of crisis rather than continually respond to it. This is a tremendous benefit because encounters between police and the mentally ill continue to increase at an alarming rate

across the United States, with a corresponding increase in fatal shootings of individuals in serious mental health crises. These are also some of the most difficult, potentially dangerous, time consuming and litigious calls law enforcement officers will respond to. CCSI is a model strategy that can be implemented in any agency and community around the globe.

NOTES:

1. Program Update

CCSI has been funded through fiscal year 2011. Due to its success, additional funding is being sought to expand the program.

2. Monetary Savings/Cost Avoidance (Appendix J)

The reduction in police manpower hours equated to \$40,423. The cost savings in reduced hospitalizations equated to \$176,550.

8 Agency Contact:

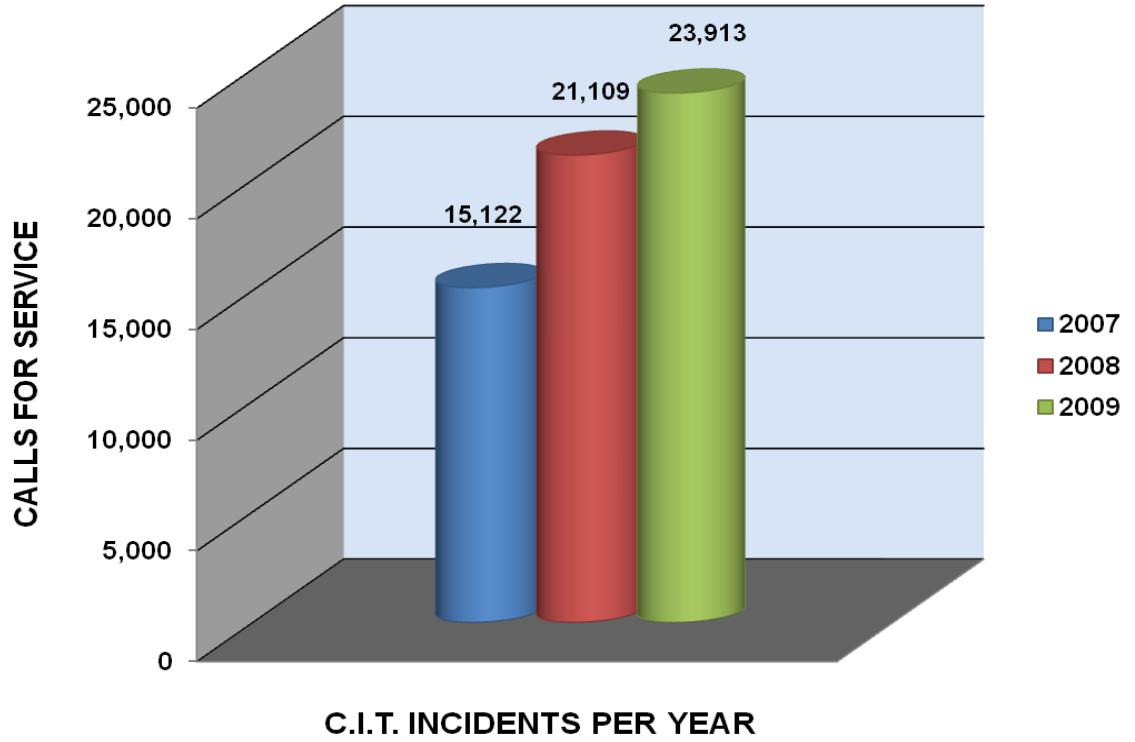
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Key Project Team Members:

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Clemelia Richards, Ph.D.	(Houston Health and Human Services)
Lt. Mike Lee, M.A.	(Houston Police)
Sgt. Patrick Plourde, B.A.	(Houston Police)
Officer Rebecca Skillern, M.A., LMFT	(Houston Police)
Janice Maire, B.S.W.	(CCSI Caseworker – MHMRA)
Chris Alas, B.S.W	(CCSI Caseworker – MHMRA)

APPENDIX A

MENTAL HEALTH CALLS 2007-09



APPENDIX B

Chronic Consumer Stabilization Initiative Client Information

I. CASELOAD INFORMATION		
Total number of clients referred for CCSI Services:	57	100%
Total number of clients Unable to Locate or Moved out of County:	16	28%
Total number of clients in jail or state hospitals/schools for an extended time period	11	19%
Total number of Clients receiving ongoing CCSI services	30	53%
II. CLIENT PROFILE		
GENDER		
Males	14	47%
Females	16	53%
Ethnicity		
Black	21	70%
White	5	17%
Hispanic	4	13%
Asian	1	3%
Age		
20 years – 30 years	10	33%
31 years – 40 years	4	13%
41 years – 50 years	9	30%
51 years – 60 years	6	20%
61 + years	1	3%
Personal Information		
Guardianship	6	20%
Family Involvement (Family involvement is <i>not</i> beneficial to client care)	18	60%
Family Support (Family involvement <i>is</i> beneficial to client care)	9	30%
Receive SSI Benefits	24	80%
Private Case Management	8	27%
Living Situation		
Family /Own Home	11	37%
Personal Care Home	13	43%
Homeless	6	20%
Mental Health Treatment Source		
MHMRA Clinics	11	11
Private Physicians	5	9
None	14	12

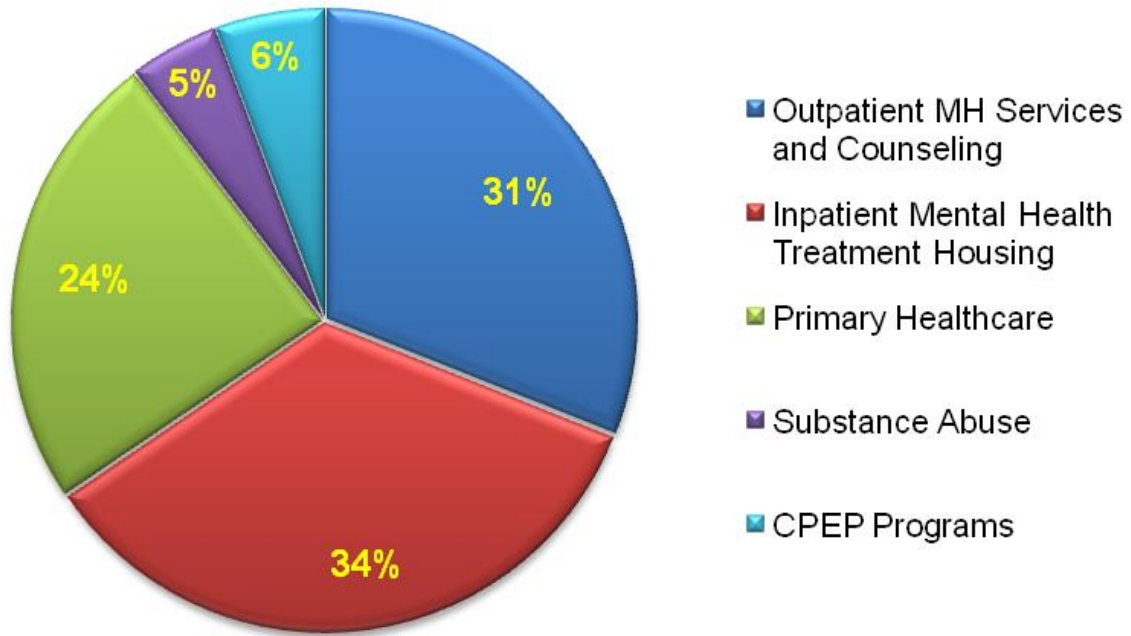
APPENDIX C

Diagnostic Summary of CCSI Clients

DIAGNOSTIC SUMMARY		
Axis I	Total	% of Total Clients
Schizophrenia, Paranoid Type	10	33%
Schizophrenia, Undifferentiated Type	3	10%
Schizoaffective Disorder	8	27%
Bi-Polar Disorder with Psychotic Features	7	23%
Major Depression with Psychotic Features	1	3%
Psychotic Disorder, NOS	1	3%
Substance Abuse/Dependence	11	37%
Axis II		
Personality Disorders		
Anti-social	2	7%
Borderline	3	10%
Mental Retardation	6	20%
Axis III		
Significant Medical Issues (includes but not limited to Diabetes, HTN, Seizure D/O, Parkinson's & Injuries resulting from trauma)	15	50%
Dental Issues	12	40%
III. Productivity		
Total Number of Contacts		
Average Number of contacts per month	253	
Average Number of Contacts per day	12	
Average Number Contacts per month per client	9	
IV. Linkages and Contacts		
Types of Treatment		
Outpatient Mental Health Services and Counseling	153	
Inpatient Mental Health Treatment Housing	170	
Primary Healthcare Including Dental	119	
Substance Abuse	23	
Community Psychiatric Emergency Programs (CPEP)	28	
Ancillary Services		
Financial	47	
Housing	315	
Community Services	99	
Legal	81	

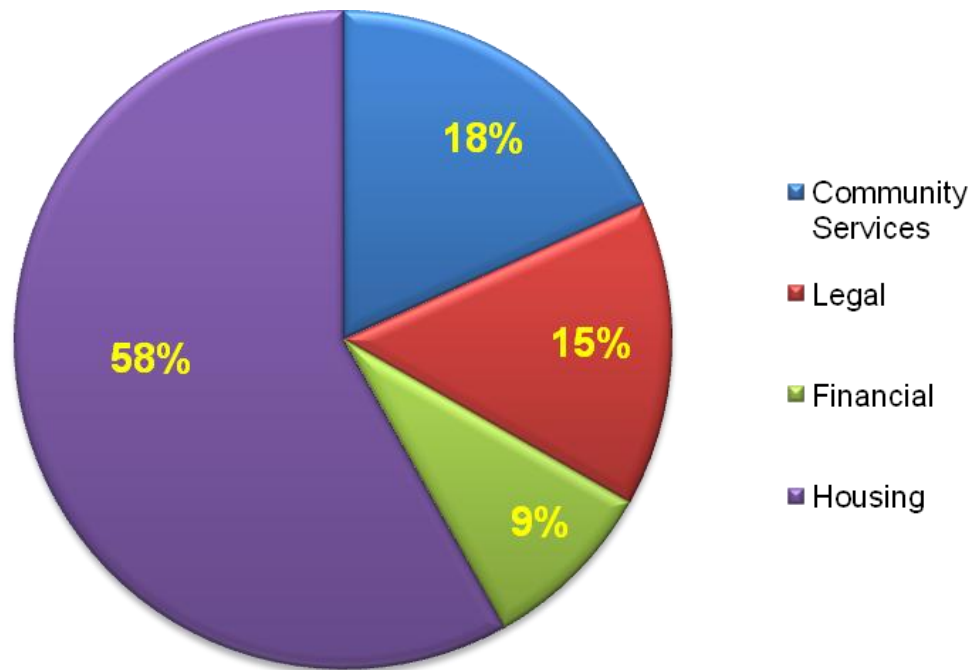
APPENDIX D

Contacts and Linkages with Various Treatment Types



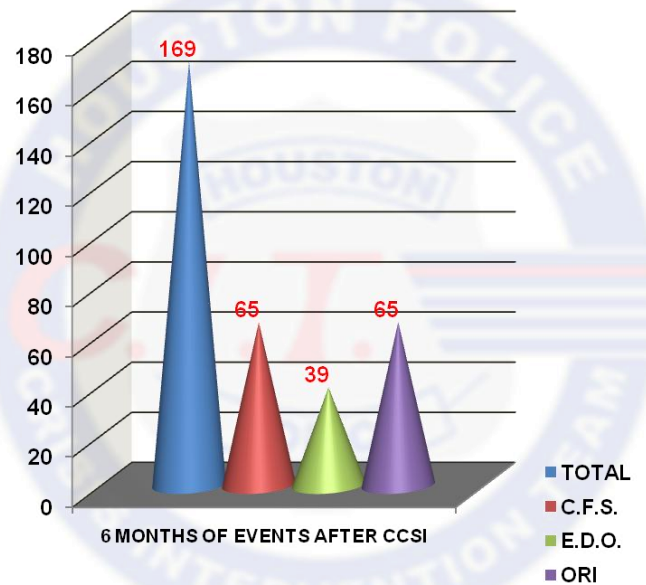
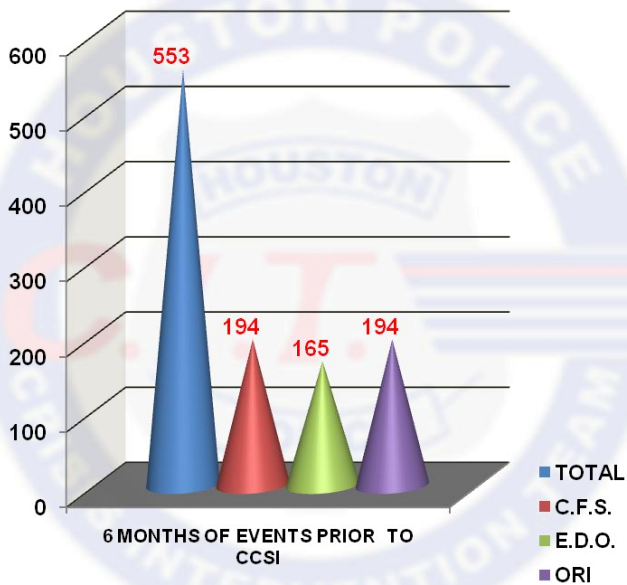
APPENDIX E

Contacts and Linkages with Ancillary Services



APPENDIX F

HOUSTON POLICE DEPARTMENT RESULTS

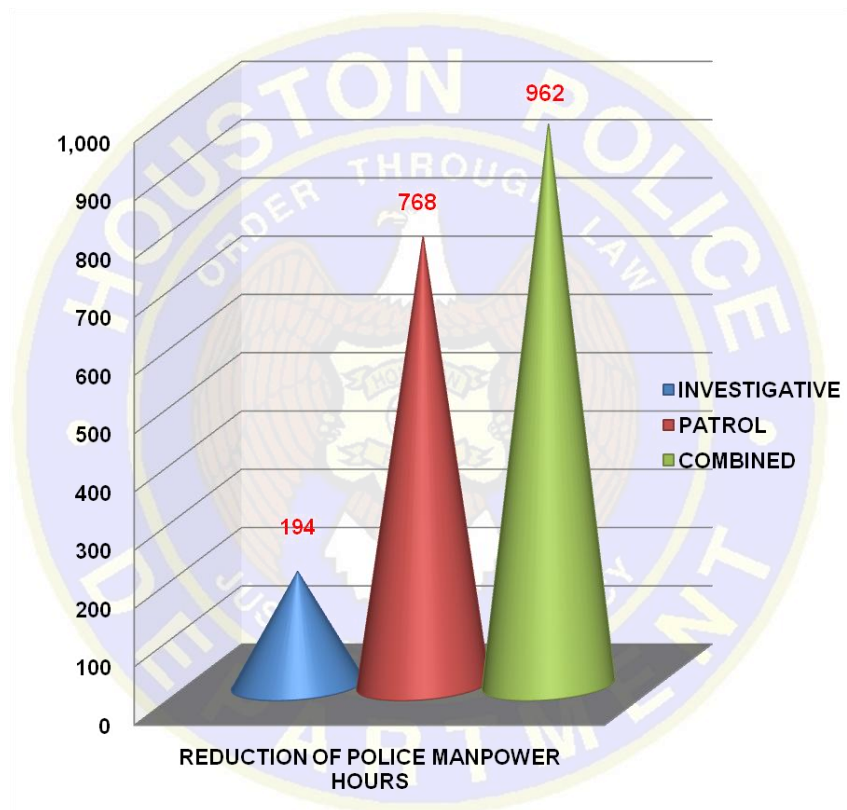


After the six-month pilot of intense engagement and interaction between the two case managers and the listed consumers, there was a 70% **DECREASE** in overall events reported by the police department. This represents a significant reduction of police contacts. Calls-for-service decreased by 67.3%, emergency detention orders (EDO) decreased by 76.4%, and offense reports also decreased by 67.3%.

APPENDIX G

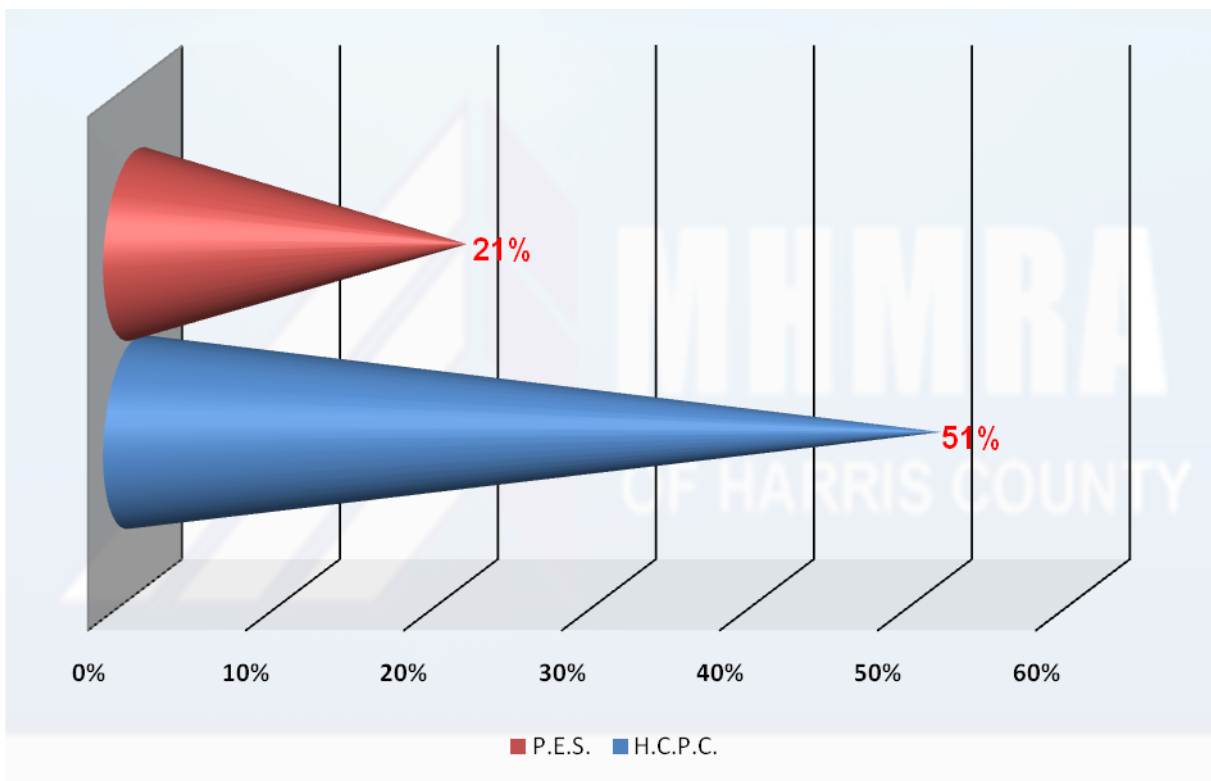
CCSI Reduces Police Manpower Hours

During the six-month CCSI pilot, a total of 768 patrol manpower hours were saved by the reduction in calls-for-service for these 30 chronic individuals. In addition, the Mental Health Unit was able to realize a reduction of 194 investigative hours due to the reduction in calls for service.



APPENDIX H

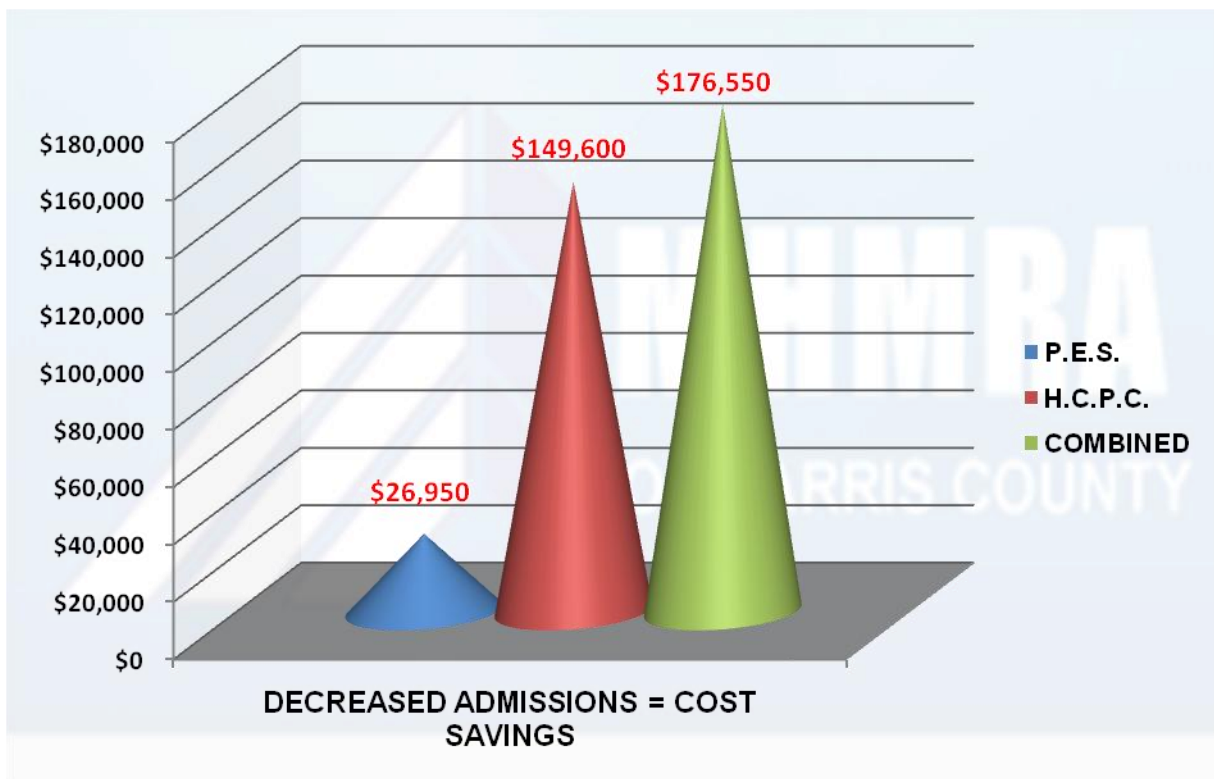
CCSI Reduces Hospitalizations



APPENDIX I

Financial Impact Resulting from Reduced Hospitalizations

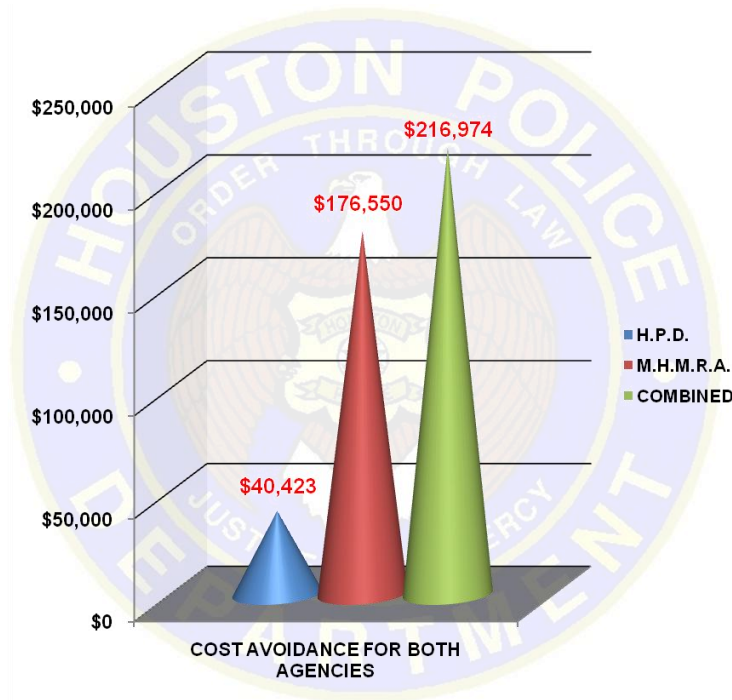
Clients enrolled in the CCSI program achieved an overall decrease in admissions to the Psychiatric Emergency Services (PES) at the Neuro-Psychiatric Center and at the Harris County Psychiatric Center (HCPC). This decrease in admissions resulted in a cost savings of \$176,550 during the six-month pilot.



APPENDIX J

Cost Avoidance Resulting from Reduced Police Manpower Hours and Reduced Hospitalizations

During the six-month CCSI pilot, HPD realized a savings of 962 manpower hours. Calculated at \$42.02 hour, this manpower savings equates to \$40,423.24. In addition, there was a 51% decrease in HCPC hospital admissions and a 21% reduction in PES hospital admissions. This reduction in hospitalizations equates to a savings of \$176,550. The combined total costs diverted as a result of the CCSI six-month program was \$216,973.24.



At a one-year program cost of \$139,000, and costs diverted over a projected 12-month period of \$433,946, the annual net cost avoidance is \$294,946.

APPENDIX K



March 9, 2010

Houston Police Department
Attn: Special Support Services
1200 Travis
Houston, TX 77002

RE: Support for the Chronic Consumer Stabilization Initiative

It is my pleasure to write a support letter in favor of the Chronic Consumer Stabilization Initiative (CCSI) program between the Houston Police Department (HPD), the Mental Health/Mental Retardation Authority of Houston (MHMRA) and the City of Houston's Health and Human Services Department.

As Sheriff of the third largest county in the United States, I understand the impact of dealing with individuals with mental illness have on law enforcement. Identifying those in constant crisis and providing the necessary services for them assist law enforcement by reducing excessive calls to the 9-1-1 system and provide them opportunities to lead a more stabilized life.

During its six-month pilot program, the CCSI had a 71% reduction in police contacts with its identified consumers. CCSI is an outstanding example of a pro-active, community involved collaborations that address a very difficult issue facing law enforcement today.

For these reasons, I support HPD's efforts to continue funding for its CCSI program. Please feel free to contact me at 713-755-6044 should you have further questions.

Thank you,


Adrian Garcia
Sheriff

APPENDIX L

JIM LEITNER
FIRST ASSISTANT



CRIMINAL JUSTICE CENTER
1201 FRANKLIN, SUITE 600
HOUSTON, TEXAS 77002 1901

PATRICIA R. LYKOS
District Attorney
Harris County, Texas
February 24, 2010

Lt. Mike Lee
Chronic Consumer Stabilization Initiative
2627 Caroline St.
Houston, TX 77004

Dear Lt. Lee and Members of the CCSI:

Our prosecutors enjoyed meeting the team representatives from the Chronic Consumer Stabilization Initiative. Since our informal gathering last year, I have maintained a keen interest in your mission. We look forward to collaborative efforts to expand law enforcement patterned mental health service to our community. Last week we had an opportunity to consider how we can effectively utilize our staff to enhance what the Mental Health Section and CCSI have independently achieved in year 2009. While our goals are ambitious, we are inspired by the accomplishments of the past year.

Our commitment to consider prosecutorial options does not detract from traditional police models for safe communities. The quest for a comprehensive community-based mental health initiative is inclusive of the need for housing facilities, service providers, treatment specialists, and life enhancement opportunities. There is a tremendous shortage of resources to effectively confront the many obstacles to safe and successful integration of the mentally ill within our community.

We are respectful of budget concerns and limitations. However, we presently serve the same population, embrace the same premise of case management, and incorporate the same principles for case resolution. We are eager to seize the opportunity for collaboration in the spirit of responsible law enforcement and prosecution. Our request for an assigned officer liaison and designated case manager is purposeful. This vision for collaboration could include coordination of residential placement following incarceration; direction to appropriate community treatment and services; and police assistance in efforts to apprehend violators of sponsored alternative programs. Please consider our request as a genuine effort to enhance our alliance.

Thank you for the opportunity to meet and discuss our shared challenges confronting this specialized population. We recognize the impact and service you have provided to our community from the CCSI project.

Best regards,


Susan M. Bishop, ADA

Telephone (713) 755 - 5800

Facsimile (713) 755 - 6865

APPENDIX M



CITY OF HOUSTON

Houston Police Department

Annise D. Parker, Mayor

1200 Travis Houston, Texas 77002-6000 713/247-1000

CITY COUNCIL MEMBERS: Brenda Stardig Jarvis Johnson Anne Clutterbuck Wanda Adams Michael Sullivan Al Hoang Oliver Pennington Edward Gonzalez
James G. Rodriguez Stephen C. Costello Sue Lovell Melissa Noriega C. O. "Brad" Bradford Jolanda "Jo" Jones CITY CONTROLLER: Ronald C. Green

March 12, 2010

C. A. McClelland
Acting Chief of Police



Ms. Patricia Lykos
Harris County District Attorney
1201 Franklin, Suite 600
Houston, Texas 77002


Dear District Attorney Lykos:

This letter serves to show my support for and my desire to continue with the Chronic Consumer Stabilization Initiative (CCSI), which is joint initiative between our department, the Mental Health/Mental Retardation Authority of Houston (MHMRA), and the City of Houston's Health and Human Services Department.

As you are aware, mental health consumers can require much police and emergency services if not handled correctly. By identifying the 30 most chronic mentally ill consumers in Houston, CCSI members have been able to assist and monitor these individuals to help them avoid crisis. In addition, CCSI members have been able to educate consumers, their families, and other members of the communities affected by these individuals about mental health, crisis intervention/de-escalation techniques, and the availability of assistance and services. The program has been highly successful.

This type of proactive and collaborative public service is a true example of successful community policing. I strongly support further funding for this initiative.

Sincerely,


C. A. McClelland
Acting Chief of Police

cam:bkk



APPENDIX N

ED GONZALEZ

COUNCIL MEMBER ★ DISTRICT H



March 5, 2010

Lieutenant Mike Lee
Special Support Services
1200 Travis St.
Houston, Texas 77002

Re: Letter of Support for HPD Crisis Intervention Team Program (CIT)

To Whom It May Concern:

Law enforcement agencies are increasingly responding to individuals in serious mental health crises. The Houston Police Department addressed this growing problem in 1999 with the implementation of its Crisis Intervention Team (CIT) program. Houston's CIT program is considered the model program in Texas and one of the national models.

The department expanded its strategy for responding to the mentally ill in 2008 with the implementation of a Crisis Intervention Response Team (CIRT) program. This innovative program pairs a CIT officer with a licensed mental health clinician from the Mental Health Mental Retardation Authority of Harris County. These teams respond to the most serious CIT calls and to all SWAT calls.

The CIT and CIRT programs are very effective at helping keep officers and mental health consumers during police encounters. These programs are reactive, however, and do not prevent individuals from going into subsequent crisis. The Houston Police Department responded to 15,000 CIT calls in 2007. That number has almost doubled, to over 25,000 CIT calls in 2009.

As with criminal activity, a small percentage of individuals with mental illness account for the majority of CIT police calls-for-service. These are the individuals who continually go into serious mental health crises requiring repeated police response. Rather than continuing this reactionary cycle, a progressive strategy, the Chronic Consumer Stabilization Initiative (CCSI), was designed to engage individuals with serious mental illness who are in a perpetual state of crisis.

The Chronic Consumer Stabilization Initiative is a collaborative program between the Houston Police Department, The Mental Health Mental Retardation Authority of Harris County (MHMRA), and the City of Houston Health and Human Services Department. This joint collaboration was designed to identify, engage, and provide services to

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districth@cityofhouston.net

ED GONZALEZ

COUNCIL MEMBER ★ DISTRICT H



individuals who have been diagnosed with a serious and persistent mental illness, and who have frequent encounters with the Houston Police Department.

The main goal of this program is to divert these chronic individuals away from their repetitive encounters with law enforcement, reduce excessive calls for service to the 9-1-1 system, and provide them with opportunities to lead a more stabilized life. The City of Houston Health Department provides funding to the MHMRA. With the funding, the MHMRA employed two mental health social workers to work with 30 consumers that the police department responds to most frequently. Each social worker worked with 15 of these consumers with the goal of using all available resources to reduce subsequent crisis.

The CCSI program was piloted for six months in 2009. During the six month pilot there was a 71% reduction in police contacts with the identified consumers. Although the pilot is complete, the CCSI program is still intact and funded through April 2010. To be fully effective, it is recommended that the CCSI program become a permanent part of the Houston Police Department's Mental Health Unit (MHU), be expanded to four caseworkers, and have an HPD officer assigned to the MHU as the liaison to the CCSI caseworkers and to the District Attorney's Mental Health Section.

CCSI is an outstanding example of a pro-active, community involved collaboration, which addresses a very difficult issue facing law enforcement in our city. HPD has built one of the finest CIT programs in our nation and further strengthened these efforts with the addition of the Crisis Intervention Response Teams. CCSI builds upon these efforts and has the full support of my office.

Respectfully yours,

A handwritten signature in black ink, appearing to read "Ed Gonzalez".

Ed Gonzalez
Vice Mayor Pro-Tem
District H, Houston City Council Member

900 Bagby, 1st Floor • Houston, Texas 77002 • P: 832-393-3003 • F: 832-393-3224
districth@cityofhouston.net

APPENDIX O

HPD a forward-thinking leader in mental health

By GEORGE PARNHAM HOUSTON CHRONICLE

March 25, 2010, 8:30PM

As our nation continues to debate the merits of federal health care reform, Houstonians should realize that we have our own health care debate happening right here at home. It involves the people living with mental illness who cycle in and out of our publicly funded emergency rooms, jails and mental health crisis facilities with little hope of stabilization.

While a part of this problem involves a basic lack of access to mental health services, many of these individuals, called "frequent fliers" by law enforcement and medical personnel who have constant contact with them, have simply been receiving the wrong kinds of services. They are victims of our state's crisis-driven system, which provides temporary and limited emergency care for people experiencing a mental health crisis but often fails to provide ongoing community-based services that keep them stabilized and out of expensive acute-care facilities.

While this is a problem faced throughout our state, Houstonians should know that several of our local leaders at the county, city, state and federal levels have stepped up and taken leading roles in addressing this serious public health issue. These individuals, too numerous to name here, should be commended.

An example of this local leadership is the Houston Police Department's Chronic Consumer Stabilization Initiative, or CCSI. HPD's mental health unit, in collaboration with the Mental Health and Mental Retardation Authority of Harris County and the Houston Department of Health and Human Services, implemented the CCSI as a pilot program in February 2009. The program provides intensive case management for the 30 individuals with a serious and persistent mental illness who have the most frequent encounters with HPD, and its main goal is to divert these chronic individuals away from their routine and repetitive encounters with law enforcement, provide them with opportunities to lead a more stabilized life and reduce excessive calls for service to the 911 system.

HPD recently issued its final report of the six-month CCSI pilot. Involuntary commitments for the 30 people were reduced by 76.4 percent while offense reports and calls for service involving these 30 decreased by 67.3 percent at a total cost of less than \$3,900 per person. In contrast, an average stay at the Harris County Psychiatric Center, which is about 10 days, costs about \$3,525 per person. In addition, the number of hours HPD officers spent dealing with this particular group was reduced by almost one-third, meaning officers were better able to deal with other calls for service and criminal activity.

It does not take either a mental health or law enforcement expert to know that these results are impressive. While HPD has long been a leader on mental health issues with its Crisis Intervention Team and Crisis Intervention Response Team programs, the CCSI is different in that it is not a reactive program. CCSI prevents police encounters with people with serious mental illness in the first place, and it provides these people the services they need to have a real chance of leading stable and productive lives that include fewer expensive crisis episodes. This kind of proven and

effective program is what many of us have been asking for here in Houston and throughout the state for quite some time.

The city of Houston deserves recognition for funding and implementing such an innovative program. Continuing and expanding the CCSI program would be an additional accomplishment that all Houstonians could be proud of in the future, and I encourage our local leaders to make this a priority for the city.

Parnham is a criminal defense attorney and mental health advocate. He and his wife, Mary, founded the Yates Children Memorial Fund with Mental Health America of Greater Houston to promote women's mental health education.

APPENDIX P

Eligibility

Participants are identified and referred to the Chronic Consumer Stabilization Initiative Program (CCSI) through the Houston Police Department's Mental Health Unit. Eligible individuals have an extensive history of interactions and contacts with the Houston Police Department. These encounters generally result in admission to mental health crisis services or psychiatric hospitalization. Many of these individuals have also committed crimes due to their illness and HPD officers are able to divert them to appropriate mental health services as an alternative to automatic incarceration.



Houston Department of Health and Human Services

MHMRA
Chronic Consumer
Stabilization Initiative
2627 Caroline Houston, TX 77004
Phone: 713-970-7516
Fax: 713-970-7424
E-mail: ann.macleod@mhmrharris.org



Chronic Consumer Stabilization Initiative



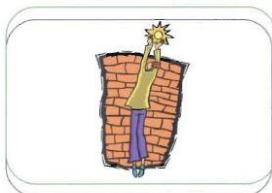
CCSI

Phone: 713-970-7516
Fax: 713-970-7424



What is CCSI?

Chronic Consumer Stabilization Initiative (CCSI) is a collaborative effort between the City of Houston Health Department, the Houston Police Department, and the Mental Health Mental Retardation Authority of Harris County. CCSI is a program designed to identify, engage and provide services to individuals who have been diagnosed with a serious and persistent mental illness, *and* have frequent encounters with the Houston Police Department either through their own initiative or by family and/collateral contact. CCSI staff work with these individuals to attempt to engage them in mental health services and provide assistance in acquiring needed social services, with the intended goal of interrupting the cycle of repeated encounters with law enforcement and repeated psychiatric hospitalizations.



Goals

- Reduce the number of interactions between individuals diagnosed with serious and persistent mental illness, and the Houston Police Dept.
- Identify unmet needs and barriers in the community that contribute to an individual's inability to engage & remain in mental health treatment.
- Link and coordinate individuals with mental health treatment.
- Provide support and education to individuals and family members, to minimize contact with law enforcement resulting from non-compliance with mental health treatment.
- Facilitate compliance with recommended mental health treatment to decrease homelessness, reduce victimization, decrease substance abuse and minimize interactions with law enforcement, while improving their quality of life.

Available Services

- Outreach and Engagement
- Intensive Case Management
- Mental Health First Aid for client, family, & other support systems
- Linkage to secure, stable housing
- Linkage to primary healthcare
- Linkage with substance abuse treatment
- Empowering client to assume responsibility for mental health compliance
- Crisis Intervention
- Advocacy

