HB 3793 Plan for the Appropriate and Timely Provision of Mental Health Services: Initial Plan

Legislative Mandate

HB 3793 (83rd Legislature, Regular Session, 2013) directs the Department of State Health Services (DSHS) to develop a plan to ensure the appropriate and timely provision of mental health services and to allocate mental health outpatient and hospital resources for the forensic and civil/voluntary populations.

It currently appears that the public mental health system has serious limitations at all levels of care, both in capacity and in the array of services and supports to address the needs of Texas residents and achieve positive clinical and recovery outcomes that avoid unintended consequences, such as over-reliance on emergency and inpatient services and criminal and juvenile justice involvement. Although recovery is optimal and possible, serious mental illnesses tend to be chronic conditions requiring ongoing availability of an array of services depending on individual needs. Because of this, capacity demands are likely to grow over time, and all levels of care should be readily accessible when needed.

This initial plan provides a framework that will be revised as new information becomes available through the community assessment and the ongoing work of the HB 3793 Advisory Panel. It is intended as a dynamic document that will guide the community assessment and the development of standards and methodologies appropriate for the varied delivery systems within Texas. DSHS will begin implementing the plan no later than August 31, 2014. Panel members have noted, however, that even after that point the plan may need to be revised as new information becomes available. In December 2014, DSHS will submit a report to the legislature and governor that includes the plan, the status of the plan's implementation, and the impact of the plan on the delivery of services.

The statute requires the plan to include four elements. The elements and key provisions of the plan that address them are summarized below.

(1) A determination of the needs for outpatient mental health services of the two groups of patients

- Sections 1-4 describe the array of services needed by both populations, including outpatient, crisis, and hospital services.
- Section 12 identifies additional community-based service needs specific to the forensic population, including competency restoration services, services for individuals found Not Guilty by Reason of Insanity, and intensive services for individuals with a history of forensic involvement.

- Section 6 provides a preliminary estimate of the need for outpatient services based on available data. In 2013, an estimated 499,389 adults in Texas were living with a serious and persistent mental illness, and there were an estimated 175,137 children with severe emotional disturbance. A community needs assessment will be completed to provide a more complete picture of needs for adults and children, and further analysis will be carried out to determine how changes currently being implemented in the healthcare system will impact the total number who will require publicly funded mental health services. The community-based needs assessment will provide vital information to determine the specific configuration of services, capacity, and workforce required to provide individuals with prompt access to the services they need.

(2) A determination of the minimum number of beds that the state hospital system must maintain to adequately serve the two groups of patients

- Section 6 addresses the need for hospital beds. Based on long-term trends in the DSHS hospital utilization data, a preliminary estimate is that the DSHS-funded system will need to add approximately 17 beds per year simply to keep pace with current utilization trends. In 2020, this would equate to 3,056 total state-funded beds. However, the available data has significant limitations, and can only reflect current capacity and practices—if individuals are not admitted, they cannot be counted. The data does not, therefore, capture the true demand or unexpressed need. Advisory Panel members describe a substantial unmet need for acute care that is severely impacting local emergency services, hospitals, and jails. Community level data quantifying this demand is vital to provide a more complete estimate of the statewide need for adults and children. In addition, the analysis must anticipate the surge in demand that may occur if significant new capacity is added to the system.

(3) A statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients

- As noted above, Section 6 provides a preliminary estimate of the need for services and beds, and these figures will be refined through the community assessment and subsequent analysis.
- Section 14 summarizes the process that will be used to determine the funding needed to appropriately address the identified needs.
- Section 10 describes the allocation methodology for outpatient services, which calls for existing funds to be distributed based on past funding levels. DSHS will work with the HB 3793 Advisory Panel to determine if the methodology needs to be modified.
- Section 11 describes the allocation methodology for hospital beds. Bed days are allocated among local service areas on a per capita basis. Although the state hospitals have designated forensic and civil beds, DSHS is under a court order to accommodate all forensic patients, which necessitates some degree of flexibility in the number of beds assigned to each population at any given time. This allocation methodology will be reviewed in collaboration with the HB 3793 Advisory Panel, including consideration of what may be considered an acceptable level of

flexibility to ensure access and availability for both populations and to promote efficient capacity utilization.

(4) A process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052

- Section 7 sets out activities that are critical to ensure individuals can access and maintain the outpatient and other community-based services and recovery supports they need to have healthy and stable lives in the community. These activities include outreach, engagement, continuity of care, care coordination, and crisis response. Standards and methodologies for strengthening these activities will be developed beginning in 2014.
- Section 8 identifies a framework for ensuring access and availability of hospital beds through an improved capacity management system. The plan has two key elements: admission and discharge criteria based on clinical or legal necessity, and the development of new mechanisms to promote more efficient and effective use of existing hospital beds. The specific standards and methodologies will be developed beginning in 2014.
- Section 8 also calls for long-term community residential services for individuals currently residing in the hospital who no longer need hospital level care. Finding community placements for these individuals would provide them with more appropriate services and free up significant capacity in the state hospital system.
- Section 11 identifies several strategies that could reduce inpatient commitments through the criminal justice system. These include strengthening collaboration with the criminal justice system, establishing community-based alternatives, engaging with judges, prosecutors, and defense attorneys to promote appropriate use of these alternatives, and identifying statutory and regulatory revisions to permit more efficient use of existing resources.

Standards and Methodologies

The initial plan establishes a basic framework that will be operationalized over the next nine months. During this period, DSHS will work with the HB 3793 Advisory Panel to develop the standards and methodologies for implementing the agenda identified in the initial plan. This agenda includes the following elements:

(1) Completing a community-based assessment of existing capacity and needs that includes stakeholder input;

(2) Projecting capacity needs for outpatient services and hospital beds at the state and community levels;

(3) Identifying gaps and quantifying resources needed to fill them;

(4) Developing new strategies to use state hospital beds efficiently and effectively to maintain appropriate access to this level of care when needed;

(5) Expanding use of community-based alternatives through engagement with local courts and enhanced collaboration with law enforcement;

(6) Identifying possible statutory and regulatory changes that could promote more efficient and effective use of community and hospital capacity; and

(7) Strengthening essential activities that facilitate access, engagement, successful transitions, and recovery.

Preamble

Core principles

1) Serious and persistent mental illness is a chronic, complex disorder with biological components influenced by social and environmental factors that have a significant negative impact on a person's ability to function.
2) Prevention, early identification, access to appropriate care, and/or ongoing services and supports across the lifespan are essential.
3) Recovery is possible, and services must be designed to promote hope, build resilience, and foster recovery.
4) Community-based, recovery-oriented, person-centered services are the foundation of the publicly funded mental health delivery system.
5) Services should be based on best practices and incorporate the principles of trauma-informed care.
6) Individuals should have timely access to an expanded array of clinically appropriate services and supports to address their psychiatric condition and promote recovery.
7) Every individual should have access to integrated or coordinated services that address the needs and preferences of the whole person.
8) Individuals should be treated in the least restrictive setting possible and as close to their community as possible. Hospitalization should be used only when clinically necessary and other levels of care are not appropriate.
9) Community-based programs that can reduce the need for hospitalization are vital.
10) The mental health service delivery system must collaborate closely with the criminal and juvenile justice systems to effectively address both the treatment needs of individuals and the public safety needs of communities.
11) The system should be transparent and accountable.
12) An effective mental health services delivery system with a full array of services and sufficient capacity is necessary to address the needs of Texas residents and achieve positive clinical and recovery outcomes that avoid unintended consequences, such as over-reliance on emergency and inpatient services and criminal and juvenile justice involvement.

Challenges

1) Demand exceeds resources. The state's mental health service delivery system is unable to meet existing needs. Approximately 2.6 percent of adults are living with serious and persistent mental illness, but less than one third of these individuals are served in DSHS-funded community mental health services. About five percent of children have severe emotional disturbance, but just over one quarter are receiving DSHS-funded services[1]. Although the Legislature has approved substantial

[1] Additional individuals may be receiving services outside of the DSHS-funded service system.

funding increases in recent sessions, local service areas continue to face significant challenges in securing adequate resources. Every local service area struggles to meet demand.

2) Growing needs. These challenges are compounded by the state's rapidly growing population. Between 2010 and 2012, the state population increased by 3.6 percent, more than double the national average. Furthermore, Texas has the highest rate of uninsured in the nation, with approximately 6 million uninsured residents.

3) Sustainability of the 1115 Healthcare Transformation Waiver projects. The state's 1115 Healthcare Transformation Waiver has funded a large increase in capacity, but the demonstration period ends in 2016 and it is not clear how those services will be continued in subsequent years.

4) Changes to the Prescription Assistance Program (PAP). PAP is a program offered by pharmaceutical manufacturers that supplies free medication to medically indigent patients. PAP currently provides the majority of funding for medication within the DSHS-funded system, but implementation of healthcare reform and the transition of a number of drugs to generic status could substantially reduce access to medication through PAP. This would require the medications to be purchased, significantly increasing pharmaceutical expenditures and diverting dollars from other services.

5) Workforce shortages. Texas has a shortage of mental health professionals, particularly psychiatrists. There are 585 designated Mental Health Professional Shortage Areas in Texas, including 202 entire counties. Peer specialists and family partners are emerging as a vital part of the workforce, and continued work is needed to recruit, train, and integrate them throughout the service system. Across the state, organizations serving the indigent population find it increasingly difficult to recruit and retain qualified staff. Until these issues are appropriately addressed, the state's ability to expand access to services will be limited by workforce shortages, and it will become increasingly difficult to provide timely access to services.

6) Lack of affordable housing. Many communities, particularly in fast-growing areas, face severe shortages of affordable housing. This is compounded by barriers individuals with mental illness or a criminal record often face when they seek housing, particularly in a competitive environment when landlords can be more selective.

7) Inadequate supply of substance abuse treatment and other health services. There is a dearth of substance abuse providers in many areas, with detoxification and residential services in particularly short supply. There are also shortages of primary care and dental services for low income individuals.

8) Limited transportation. Many areas lack a public transportation system, and additional options are needed to ensure access to services within the community and in more distant locations.

9) Priorities and perspectives in the legal system. Judges, prosecutors, and defense counsel have major roles in directing the flow of court-ordered patients in and out of the system, and they must consider the safety of their communities and the rights of individuals involved in the court system. Many view state hospitals as the only setting that can provide an adequate level of security and protection for individuals requiring commitment, and they are often reluctant to place individuals in less restrictive community alternatives.

(b) The plan developed by the department under Subsection (a) must include:
(1) a determination of the needs for outpatient mental health services of the two groups of patient.[2]

Service Needs

Every local service area should provide access to an array of essential services and supports. These services should be readily available, robust, and easily accessible. However, regional variation and resource limitations may limit the degree to which this goal can be achieved. Local service areas may also identify the need for specific programs, such as recovery-oriented day programs or walk-in medication clinics.

1. **Outpatient mental health services**
   1.1. Texas Resilience and Recovery (TRR) services. Texas Resilience and Recovery is a patient-centered system of care designed to promote resilience and recovery. It offers evidence-based and promising practices that include, for adults, Illness Management and Recovery, Supported Employment, Supported Housing, Assertive Community Treatment (ACT), Cognitive Behavioral Therapy, and Motivational Interviewing. Evidence-based and promising practices for children and adolescents include Nurturing Parenting, Aggression Replacement Training, Preparing Adolescents for Young Adulthood, Seeking Safety, Wraparound Process Planning for Intensive Case Management, Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Barkley's Defiant Child, and Barkley's Defiant Teen. Services are provided through defined levels of care based on an assessment of individual needs. Each level of care provides an array of services and supports, such as engagement, medication and pharmacological management, medication training and support services, skills training, counseling, psychosocial rehabilitation, supported housing and employment, and peer support services. Services are provided where needed and may be delivered in an office, via telemedicine, or in the client's home or other community setting.
      1.1.1. Assertive Community Treatment (ACT). ACT, the most intensive level of care for adults, is a team-based program for clients who have a history of multiple hospitalizations. It uses an integrated approach blending clinical and rehabilitation expertise within a single mobile delivery system. ACT clients are prioritized for supported housing, supported employment, and Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD) as needed.

      1.1.2. Services for Co-Occurring Psychiatric and Substance Use Disorders (COPSD). A significant portion of individuals with mental health diagnoses also have co-occurring substance use disorders. COPSD services provide a coordinated or integrated approach to address both disorders.

[2] Content related to this element is also found in the Capacity Needs and Forensic sections of the plan.

1.2. Appropriate living environments. Safe, secure, and affordable housing is essential for successful recovery and stability in the community. Individuals may also need community living environments that provide supervision and security on a short- or long-term basis.

1.3. Employment assistance. Although not all individuals will be able to pursue employment, a stable job and financial independence can contribute to long-term stability and recovery.

1.4. Peer support services and recovery supports. Peer-provided services are an integral part of the full continuum of services in a recovery-oriented system of care, including hospital services. Recovery supports help individuals become meaningfully involved with their communities and develop natural support systems.

1.5. Service coordination. Service coordination is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs. It involves a partnership with the individual receiving services and includes identification of desired outcomes and proactive crisis planning and management, as well as assistance in navigating the complex network of services. Peer navigators can be invaluable in providing advocacy, facilitating access, and supporting successful transitions.

2. **Other health services**.

Recovery requires a holistic approach to services. Individuals living with mental illness die many years earlier than the general population[3], usually from untreated and often preventable chronic diseases. In addition, a significant portion also struggle with substance use problems. These are critical issues that can only be addressed through strong and effective partnerships that span service system boundaries. Robust collaborative and integrated care models are needed to provide access to essential services and ensure care is effectively coordinated. Sound financing models will be required to ensure healthcare is both available and affordable.

2.1. Substance abuse services. Essential treatment services include detoxification, residential, and outpatient programs, with linkages to recovery support options in the community.

2.2. Primary healthcare. All clients need access to primary care services, including access to screening and immunization, dental services, and after-hours triage and treatment.

3. **Local crisis stabilization and hospital alternatives**.

To avoid unnecessary hospitalization, communities must have a range of local alternatives for both adults and children, including options for crisis stabilization and longer-term settings for individuals transitioning out of a hospital setting. The front door to local crisis services must be convenient and easily accessible to law enforcement and other community partners. The role of peers is particularly important in time of crisis and transition from the hospital, so peer providers should be an integral part of the service delivery team. Warm-lines and other peer-run crisis services are also emerging as promising new models within the service array.

[3] In 2006, a study of public mental health service delivery systems published by the National Association of State Mental Health Program Directors Medical Directors Council found that in Texas, individuals with severe and persistent mental illness die 29 years earlier than the general population.

3.1. Crisis Hotline. The Crisis Hotline is a 24/7 telephone service that provides information, support, referrals, screening and intervention. A well-publicized hotline serves as the first point of contact for mental health crisis in the community, providing confidential telephone triage to determine the immediate level of need and to mobilize emergency services if necessary. The hotline facilitates referrals to 911, the Mobile Crisis Outreach Team (MCOT), or other crisis services.

3.2. Mobile crisis intervention. MCOTs are clinically staffed mobile treatment teams that are available 24/7, providing prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up, and relapse prevention services for individuals in the community. Working closely with local emergency responders and law enforcement, they can divert individuals in crisis from local emergency departments and the criminal justice system and link them with appropriate crisis stabilization services.

3.3. Local crisis facilities. The array and configuration of crisis facilities will be based on local needs and characteristics. Multiple service options may be housed in a single, one-stop facility, or may be located at various sites across the service area. Crisis programs may also be established in hospitals or share space with other local institutions. While the design will vary, every local service area should provide access to a sufficient array of services to treat all but the most severely impaired individuals outside of the hospital. The following may be included as individual components:

3.3.1. Crisis Respite. Short-term, community-based residential crisis treatment for individuals who have low risk of harm to self or others and may have some functional impairment. Services may occur over a brief period of time, such as two hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons for whom they care to avoid mental health crisis. Crisis respite services are both facility-based and in-home, and may occur in houses, apartments, or other community living situations. Facility based crisis respite services have mental health professionals on-site 24/7.

3.3.2. Crisis Residential Services. Up to 14 days of short-term, community-based residential, crisis treatment for individuals who may pose some risk of harm to self or others, who may have fairly severe functional impairment, and who are demonstrating psychiatric crisis that cannot be stabilized in a less intensive setting. Mental health professionals are on-site 24/7 and individuals must have at least a minimal level of engagement to be served in this environment. Crisis residential facilities do not accept individuals who are court ordered for treatment.

3.3.3. Crisis Stabilization Units (CSUs). Crisis Stabilization Units are licensed facilities that provide 24/7 short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected, clinically staffed, psychiatrically supervised, treatment environment that complies with a Crisis Stabilization Unit licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code. Licensed facilities such as CSUs may

accept individuals who are court ordered for treatment and those who have a moderate to high risk of harm to self or others.

3.3.4. Extended Observation Units (EOUs). Emergency services of up to 48 hours provided to individuals in behavioral health crisis, in a secure and protected, clinically staffed, psychiatrically supervised environment with immediate access to urgent or emergent medical evaluation and treatment. These individuals may pose a moderate to high risk of harm to self or others. EOUs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital. EOUs may also accept involuntary individuals such as those on emergency detention. Individuals with a court order for mental health treatment may only be served in a licensed facility.

3.3.5. Rapid Crisis Stabilization Beds. Hospital services staffed with medical and nursing professionals who provide 24/7 professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff provides intensive interventions designed to relieve acute symptomatology and restore the individual's ability to function in a less restrictive setting. Unlike crisis residential or crisis respite programs, licensed facilities such as those that provide rapid crisis stabilization beds may accept individuals who are court ordered for treatment and those who have a moderate to high risk of harm to self or others.

3.3.6. Psychiatric Emergency Service Centers (PESC). Psychiatric Emergency Service Centers provide immediate access to assessment, triage and a continuum of stabilizing treatment for individuals with behavioral health crisis. PESCs are staffed by medical personnel and mental health professionals who provide care 24/7. PESCs may be co-located within a licensed hospital or CSU, or be within close proximity to a licensed hospital. PESCs must be available to individuals who walk in, and must contain a combination of programs.

3.4. Emergency/Transitional Housing. Immediate access to housing is often critical to achieve crisis stabilization and successful transition to long-term housing.

4. **Hospital services**

Hospital beds must be available when clinically or legally necessary for voluntary, civil, and forensic patients.

4.1. State hospital beds. The state operates psychiatric hospitals that provide acute and long-term inpatient psychiatric services for voluntary, civil, forensic, and residential patients.

4.2. State funded community beds. The state also purchases beds from the private sector through contractual arrangements with service providers.

4.3. Indigent care beds. In addition to the state-funded hospital capacity, local hospitals provide indigent care through general and psychiatric beds.

(b) The plan developed by the department under Subsection (a) must include:

(1) a determination of the needs for outpatient mental health services of the two groups of patients

(2) a determination of the minimum number of beds that the state hospital system must maintain to adequately serve the two groups of patients

Capacity Needs

In fiscal year 2013, the publicly funded mental health service delivery system had insufficient capacity to meet the demand for community and hospital services. Because serious mental illness is often a chronic condition, there is also an urgent need for an extended provider base in the community to allow individuals to transition out of the state's mental health delivery system without losing access to needed services.

5. **Current Capacity.**

5.1. Community Services.

5.1.1. Outpatient services. In August 2013, an average of 110,583 adults and 33,418 children received services in a full level of care through the DSHS-funded mental health service system. With additional funds appropriated by the 83rd Legislature, it is anticipated that services will be provided to approximately 6,700 more adults and 900 more children.

5.1.2. Local crisis facilities. Currently, DSHS funds 456 Crisis Residential beds, 127 Crisis Respite beds, 60 Extended Observation beds, 32 CSU beds, and 259 Rapid Crisis Stabilization beds.

5.1.3. Forensic programs. There are eleven state-funded Outpatient Competency Restoration (OCR) Programs. In 2013, 291 individuals were served in these programs; and 158 of them were discharged. However, a number of these programs are currently underutilized.

5.2. Hospital services.

5.2.1. State-operated beds.[4] The current capacity of the state-operated hospital system is 2,503 beds, with approximately 893 beds designated for the forensic population. However, because DSHS is under a court order to accommodate all forensic patients, the beds assigned to the forensic population at any given time may exceed the designated number. Of the 2,503 beds, 204 are segregated to provide acute services for children and adolescents. Another 116 beds are designated as residential beds for individuals who no longer need hospital-level care but have no appropriate community alternatives available.

[4] The first analysis presented to the HB 3793 Advisory Panel during the standards and methodologies phase of work will be a refined breakout of hospital capacity that more clearly differentiates forensic and civil/voluntary beds for adults and children.

5.2.2. State-funded beds. The current number of purchased beds is 427. This includes community hospital beds, private psychiatric hospital beds, and the Montgomery County Mental Health Treatment Facility.

6. **Projected Needs**.

6.1. Initial plan based on available data. This initial plan includes preliminary estimates of current needs based on available prevalence and utilization data. However, these data sources have significant limitations and must be supplemented with information at the local level to provide a more complete picture of needs across the state. As described in Section 14, a community assessment will be carried out to determine the need for outpatient, hospital, and other services for children and adults. The community assessment will also identify gaps across the array of services and determine the configuration of service capacity that is most appropriate to serve the needs of the forensic, civil, and voluntary populations. A third area of focus will be workforce needs, including peers and professionals. The assessment will be updated as new information becomes available to provide the most accurate information possible for the legislative report due in December 2014. As required by HB 3793, the needs assessment and plan will be updated at least biennially.

6.2. Capacity is changing. The needs reflected in 2013 data will be significantly affected by new resources and initiatives entering the system in 2014. Additional funding may be needed to ensure an appropriate array of services is available in each region of the state. This determination is contingent on a number of factors, including new funding appropriated by the 83rd Legislature and the 1115 Healthcare Transformation Waiver projects currently in development. A more accurate determination will be possible when the new programs have been fully implemented and their impact can be assessed. While these new resources add much-needed capacity, planning should recognize that ongoing funding for projects established under the 1115 Transformation Waiver is not assured.

6.3. Need for outpatient mental health services. In 2013, an estimated 499,389 adults in Texas were living with a serious and persistent mental illness, and there were an estimated 175,137 children with severe emotional disturbance. Only 31.4 percent of these adults and 26.9 percent of the children were served in DSHS-funded community mental health services.[5] Further analysis will be needed to determine how changes being implemented in the healthcare system will impact the total number who will require publicly funded mental health services.

6.4. Goal for community capacity. Local service areas will have sufficient capacity to ensure that services are available on demand. A community-based assessment will be completed to determine the specific configuration of services and capacity required to provide individuals with prompt access to the services they need.

6.5. Need for inpatient mental health services. Based on long-term trends in the DSHS hospital utilization data, a preliminary estimate is that the DSHS-funded system will need to add

[5] Additional individuals may be receiving services outside of the DSHS-funded service system.

approximately 17 beds per year simply to keep pace with current utilization trends. In 2020, this would equate to 3,056 total state-funded beds. However, the available data has significant limitations, and can only reflect current capacity and practices—if individuals are not admitted, they cannot be counted. The data does not, therefore, capture the true demand or unexpressed need. Advisory Panel members describe a substantial unmet need for acute care that is severely impacting local emergency services, hospitals, and jails. Community level data quantifying this demand is vital to provide a more complete estimate of the statewide need for adults and children. In addition, the analysis must anticipate the surge in demand that may occur if significant new capacity is added to the system.

6.6. Goal for bed capacity. Currently, there are approximately 11 state-funded hospital beds per 100,000, including state hospital beds and state-funded community beds. The national average for psychiatric hospital beds is 14 per 100,000. To achieve this number, Texas would need an additional 879 hospital beds. Pending further analysis, a goal of 14 beds per 100,000 appears to be a reasonable reference point to assess the acute and long-term needs of the population within the current statutory framework. Adding 879 hospital beds to the DSHS-funded system would cost $176.5 million. It is preferable, however, for individuals to be served close to home and in the least restrictive environments possible. Therefore, careful attention will be given to expanding local beds that provide crisis and long-term alternatives to hospitalization for adults and children. Because the availability of local options has a major impact on demand for hospitalization, the total number of beds must be considered when determining the number of beds needed, not just inpatient hospital beds. There will, however, always be individuals who need inpatient care, and more hospital beds are needed to ensure inpatient services are available when needed.

6.7. Factors influencing need. The number of inpatient beds needed in the state system will depend on steps taken to provide appropriate alternatives close to home and use capacity more effectively, as outlined under Access and Availability. These factors will be considered in the next phase of analysis.

(b) The plan developed by the department under Subsection (a) must include:
(4) a process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services provided to and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities under Sections 533.034 and 533.052

Access and Availability

In addition to expanding capacity, the following strategies will be used to improve access and availability.

7. **Community services**.
   7.1. Strengthen key activities. The following activities are critical to ensure individuals receive the services and supports they need to maintain stability in the community, build resilience, and achieve recovery. Strategies will be developed to improve quality and consistency.
      7.1.1. Outreach. Effective outreach consistent with available capacity is needed to identify individuals who need treatment but cannot or do not seek services due to incarceration, illness, stigma, or discouragement.
      7.1.2. Immediate engagement. Many clients who enter service do not become actively involved in treatment. The first step is to quickly establish a relationship with the individual to engage them in services as soon as possible.
      7.1.3. Continuity of care. Clients are also vulnerable when transitioning from one part of the service system to another. Careful continuity planning, a warm hand-off, and close support during the transition are essential.
      7.1.4. Service coordination. Individuals may need access to a range of services and supports to achieve stability and resilience. These may include primary care, housing, substance abuse treatment, transportation, and other services. Active linkages, coordinated planning, and ongoing communication are necessary.
      7.1.5. Crisis response. Prompt and effective crisis intervention services facilitate stabilization and linkage with appropriate services. This can often avoid the need for emergency department visits, hospitalization, or incarceration.
   7.2. Improve collaboration with the criminal justice system. Local service areas have made progress in implementing the Sequential Intercept Model, but gaps remain. Effective implementation can significantly reduce inappropriate involvement with the criminal and juvenile justice systems and promote appropriate treatment and intervention.
   7.3. Expand peer support services. Peers have a vital role in all aspects of service delivery, but are especially important in the points of transition identified above.
   7.4. Prioritize services and housing for high-need populations. This includes long-term hospital residents and individuals with a history of repeated hospitalization or forensic involvement.
   7.5. Outcome based incentives. 2014-15 General Appropriations Act, S.B . 1, 83rd Legislature, 2013 (Article II, Department of State Health Services, Rider 78) directed DSHS to withhold 10 percent of an LMHA's general revenue to use as a performance incentive. Initial outcome measures were implemented for fiscal year 2014, including measures relating to hospitalization and incarceration. These measures will be reviewed at the end of the year to identify what changes might be appropriate.

8. **Hospital beds.**

   One overarching strategy frames all efforts to ensure hospital beds are available when needed: provide timely access to appropriate care at the local level. Individuals requiring short-term acute stabilization should be treated in community-based facilities whenever possible. It is also important to develop long-term residential options for individuals who no longer need hospital care and can be safely discharged to community-based programs. Hospitalization is the most intensive level of care, and the state's limited capacity must be managed effectively to ensure timely access.

8.1. Utilization Management. Improving the management of existing capacity will involve two areas of focus.

8.1.1. Admission and discharge criteria will be defined based on clinical necessity or legal mandates. The goal is to treat individuals in the hospital only when there are no appropriate clinical or legal alternatives available.

8.1.2. A system will be developed to promote appropriate utilization of hospital beds. The goal is to create incentives to maximize utilization of community-based alternatives and reduce inappropriate utilization of hospital beds.

8.2. Alternatives for individuals with extended length of stay. In 2013, 701 individuals had been in the hospital for more than one year. A significant number of them no longer need hospital-based psychiatric care and would be more appropriately served in the community. Developing long-term residential alternatives in the community would free up significant hospital capacity. For example, moving 100 long-term patients into the community would provide beds for approximately 745 individuals on civil commitments. The Home and Community-based Services Program being developed through a 1915(i) Medicaid State Plan Amendment will accommodate a subset of the long-term population, but far greater capacity is needed. There are also many individuals in the community who need housing with individualized support services to avoid cycling through homelessness, emergency rooms, hospitals, and the criminal justice system. Attention must also be given to reducing barriers that prevent use of community alternatives, with attention paid to decision-making capacity.

(b) The plan developed by the department under Subsection (a) must include:

(3) a statewide plan for and the allocation of sufficient funds for meeting the outpatient mental health service needs of and for the maintenance of beds by the state hospitals for the two groups of patients

Allocation of Resources

9. **Community Services**

9.1. Current allocation. Each year, baseline state and federal funding is allocated to local service areas based on the previous year's funding. New funding is distributed in accordance with legislative direction. When permitted, a portion of the funding is used to achieve greater equity in funding.

9.2. Goal. The long-term goal is to achieve equitable distribution of resources.

9.3. Strategy. The plan is to continue to move towards equity in resource distribution while recognizing the need for an adequate local service array in both urban and rural areas. To the extent permitted by legislative direction, equity will continue to be a component of the allocation methodology for all new funds.

10. **State funded inpatient services**

10.1. Current allocation. Hospital bed days are allocated to local service areas on a per capita basis. A specified number of beds are designated for the forensic population and for the civil/voluntary population, but non-maximum security beds can be used for either population

based on demand. Currently, local service areas are not penalized for exceeding their allocated bed days. This allocation plan will continue until a new strategy is developed.

10.2. Goal. All local service areas will have access to hospital services when needed.

10.3. Strategy. The allocation methodology will be reviewed and revised as needed between January and August, 2014. During this period, local service areas will receive regular reports on utilization.

(b) The plan developed by the department under Subsection (a) must include:
(1) a determination of the needs for outpatient mental health services of the two groups of patients

Forensic

Timely access to appropriate services in the community is the first strategy for avoiding forensic involvement. However, additional strategies are needed to prevent inappropriate involvement with the criminal and juvenile justice systems and address the needs of individuals who do become involved.

11. **Jail diversion**

To avoid unnecessary and inappropriate incarceration, every community must have a comprehensive plan for mental health and criminal justice collaboration. All LMHAs have implemented jail diversion plans, as required by HB 2292 (78th Legislature, Regular Session, 2003). But these efforts could be enhanced through more consistent application of the Sequential Intercept Model.[6] This model identifies five points of diversion where individuals with mental illness can be targeted within the criminal justice system, and suggests strategies for effective intervention. Local plans will reflect the unique circumstances in each community, but will include strategies that target all five intercept points. Planning should recognize the unique challenges of rural areas, and develop strategies to facilitate implementation throughout the local service area. Another opportunity for increased impact is recognizing the value added by peers and integrating them into community diversion strategies.

11.1. Intercept 1: Law enforcement. Strategies may include training, Crisis Intervention Teams, Mental Health Deputy programs, and police-friendly drop-off points.

11.2. Intercept 2: Initial Detention/Initial Court Hearings. Strategies may include on-site screening at jails and courts and pretrial release with linkage to community services.

11.3. Intercept 3: Jails/Courts. Strategies may include specialized courts, court liaisons, and jail-based services.

11.4. Intercept 4: Re-entry. Strategies may include joint discharge planning and specialized re-entry programs.

[6] Details of the Sequential Intercept Model are found in an article entitled *Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness*, authored by Munetz and Griffin and published in Psychiatric Services in 2006.

11.5. Intercept 5: Community Corrections. Strategies include screening all individuals under community supervision, Forensic ACT teams, and developing graduated responses and modification of conditions of supervision.

12. **Forensic alternatives**

While forensic clients can sometimes be served in the same programs and settings as civil and voluntary clients, specialized programs must also be available to avoid unnecessary hospitalization for individuals committed to treatment through criminal courts. These programs include risk assessment and approaches to address modifiable criminogenic factors that contribute to forensic involvement.

12.1. Outpatient competency restoration (OCR). These programs provide services for individuals found incompetent to stand trial that includes intensive mental health services and legal training in non-restrictive community settings. Patients can be committed to an outpatient program on the initial court order. In addition, patients on an inpatient commitment can have their orders modified to an outpatient commitment once they are stable enough for treatment in a less restrictive setting. Outpatient competency restoration programs should be available throughout the state, and include a well-planned transition to ongoing community services. Eleven such programs are currently operating in Texas, but outpatient commitment continues to be an underutilized option.

12.2. Jail based competency restoration. The legislature directed DSHS to establish a jail-based competency restoration pilot in 2014. In 2016, DSHS will report the results to the Legislature.

12.3. Community-based options for individuals found Not Guilty by Reason of Insanity (NGRI). The average length of stay for individuals found NGRI is 370 days. When patients have been appropriately stabilized, their commitments can be modified to outpatient commitments once courts have confidence that risks have been sufficiently mitigated. If judges are to have confidence that a modification is warranted, services must be available, effective, and accountable. Long-term community residential programs should also be developed to provide permanent placement or transitional placement for many of these patients.

12.4. Intensive community-based programs for individuals with a history of forensic involvement. The Intensive Case Management program provided through the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) is one statewide program that addresses modifiable criminogenic risk and clinical needs to extend community tenure and reduce acute symptom expression, hospitalization, and recidivism. It uses a hybrid service delivery model increasing collaboration with criminal justice supervision authorities and clinical care providers in community centers.

12.5. Supervised living environments. Outpatient alternatives to forensic hospitalization may be underutilized when secure, supervised living environments are not available.

13. **Engagement with the legal system**

13.1. Engagement and with local officials. Increased outreach is needed to ensure judges, prosecutors, and defense attorneys are informed about and have confidence to use existing statutory alternatives to inpatient commitment. Education alone is not enough; local

stakeholders must build effective partnerships to develop strategies to maximize use of all available alternatives to hospitalization. Examples of existing opportunities include specialized mental health courts, outpatient competency restoration programs, and dismissing misdemeanor charges for non-violent individuals and placing them on a civil inpatient commitment, involuntary outpatient civil commitment, or referring them to voluntary outpatient services.

Systemic Barriers

Because DSHS must begin implementation in September 2014, the initial plan is based on existing funding and statutory authority. A plan to ensure appropriate and timely access to services cannot, however, ignore systemic barriers. A community assessment must be completed to quantify resource shortages and prioritize how additional resources would be deployed. Options and opportunities for expansion are also limited by the current statutory framework and workforce challenges, and preparation for the next legislative session will include identifying statutory changes and workforce strategies to support a more flexible and responsive mental health service system. DSHS will work with the HB 3793 Advisory Panel to complete these tasks before the 84th Legislature convenes in January 2015.

14. **Resource issues**

    This initial plan includes a preliminary estimate of needs based on currently available data. Additional analysis is needed to determine how changes currently being implemented in the healthcare system will impact the total number who will require publicly funded mental health services. Specific capacity recommendations for the various types of needed services cannot be made until a community-based assessment of existing capacity and unmet needs is completed. DSHS will work with the HB 3793 Advisory Panel to determine the best methodology for completing this phase of the analysis, including providing opportunity for stakeholder involvement. The assessment must consider the various ways additional resources could be deployed and determine which would be the most effective response consistent with the core principles that have been identified. Several components will be included in the assessment:

    14.1. Developing a work plan that includes responsibilities, tasks, and timelines.
    14.2. Collecting and analyzing data on existing and developing services and programs, including those financed through other state agencies, local governments, and the 1115 Transformation Waiver.
    14.3. Identifying gaps and barriers.
    14.4. Developing options for addressing the identified needs, including projected costs.
    14.5. Establishing criteria for evaluating options.
    14.6. Comparing, selecting, and prioritizing options.
    14.7. Developing concrete projections of the type, quantity, and cost of additional capacity required to meet identified needs.

15. **Statutory and regulatory issues**

    Existing laws and regulations restrict options available to address the increasing demand for hospital beds. DSHS will work with the HB 3793 Advisory Panel to identify and prioritize statutory and

regulatory changes relating to the two populations that could permit more efficient use of existing resources. The potential impact of changes will be assessed to estimate bed day reductions and associated savings.

16. **Workforce Issues**
    16.1. Workforce shortages. Throughout the state, organizations serving the indigent population find it increasingly difficult to recruit and retain qualified staff, including peer specialists and family partners. DSHS will work with HB 3793 Advisory Panel members to identify strategies that could be used to ameliorate workforce shortages. These strategies will be shared with other stakeholders, including but not limited to, the Center for Health Professions, which is leading the effort to develop recommendations to address mental health workforce shortages under the provisions of HB 1023 (83rd Legislature, Regular Session, 2013).
    16.2. Community providers. Another critical issue is the lack of affordable mental health services outside of the state system. Individuals who have achieved long-term stability are often unable to leave the publicly funded system because they have no other options for maintaining access to needed services. Strategies are needed to equip and support community providers, including Federally Qualified Health Centers, so individuals can be transferred out of the system, freeing capacity for others who need a more intensive level of care.

Future Plans

This initial plan provides a framework that will be revised as new information becomes available through the community assessment and the ongoing work of the HB 3793 Advisory Panel. It is intended as a dynamic document that will guide the community assessment and the development of standards and methodologies appropriate for the varied delivery systems within Texas. DSHS will begin implementing the plan no later than August 31, 2014. Panel members have noted, however, that even after that point the plan may need to be revised as new information becomes available. In December 2014, DSHS will submit a report to the legislature and governor that includes the plan, the status of the plan's implementation, and the impact of the plan on the delivery of services.