



The Growing Crisis in Inpatient Psychiatric Care: Forensic Crowd-out and Other Access Barriers

The Texas Legislature has made significant investments in recent years to increase access to inpatient psychiatric care, outpatient mental health treatment, crisis stabilization services and other alternatives to hospitalization. Yet demand for mental health treatment continues to outpace available resources.

From 1964 to 2016, the Texas population rose from 10.3 to 28.2 million people¹, almost tripling in just over fifty years. Despite astounding population growth, the number of inpatient psychiatric beds in Texas State Hospitals shrank by almost 80% during this time, from 14,921 to 3,013 beds. Demand for both forensic and civil psychiatric beds far outpaces current State Hospital system capacity, placing severe strain on local communities, jails and hospital systems.

In October 2016, the Texas Council of Community Centers surveyed its members on inpatient access, capacity, and funding issues. Results are summarized in Attachment A, and demonstrate an urgent need to increase access to inpatient care, including maximum security capacity at State Hospitals, and to provide additional resources for locally-contracted community psychiatric beds.

What happens when State Hospitals are full?

Lack of inpatient psychiatric bed capacity in State Hospitals creates a host of issues, including a growing backlog of individuals in county jails waiting for court-ordered forensic services, and inappropriate stays in emergency rooms, extended observations units, crisis stabilization units and local private psychiatric hospitals. When State Hospitals are full and an alternate private psychiatric bed is either not available or is unable to provide the clinically appropriate level of care, people remain in the community without needed intervention and cycle into emergency rooms or jails.

Who is using State Hospital beds?

Today, more than half of all State Hospital admissions are forensic commitments. From 2001 to 2016, forensic commitments grew rapidly, from 16% to 52% of all inpatient psychiatric admissions. As a result, there has been a substantial decline in civil commitment capacity in State Hospitals, known as “forensic crowd-out.”

What are “civil” and “forensic” commitments?

A common misconception is that forensic commitments include everyone receiving court-ordered inpatient psychiatric services. By law, forensic commitments are limited to individuals determined “incompetent to stand trial” or “not guilty by reason of insanity.” All other inpatient psychiatric commitments, whether voluntary or involuntary, are considered “civil” commitments. A majority of people with mental illness in our jails therefore do not meet the criteria for forensic commitment.

| Type | Admission Categories |
|-----------------|--|
| Forensic | Incompetent to Stand Trial Not Guilty by Reason of Insanity |
| Civil | Peace Officer Emergency Detention Order of Protective Custody Court-ordered Temporary MH Services Court-ordered Extended MH Services Voluntary Commitments |

Do forensic and civil populations have similar lengths-of-stay?

Patients admitted to the Vernon and Rusk Maximum Security Units (MSUs) for forensic commitments have a much longer length-of-stay than those in non-maximum security and civil commitments. Within the civil population, however, two distinct groups are emerging: those who can complete treatment

¹ Texas Center for Health Statistics, <https://www.dshs.texas.gov/chs/popdat/ST2016p.shtml>

with a brief or acute care stay (less than 30 days), and those who need an extended stay (30-60 days). While most State Hospitals are equipped for extended stays, private hospitals generally are not.

What additional treatment capacity would provide the most clinically-appropriate services for adults?

60% of survey respondents chose acute care stays of 11-30 days in State Hospitals or private psychiatric beds.

What factors contribute to inpatient psychiatric access challenges?

Historically, people in mental health crisis who were detained by law enforcement were admitted to State Hospitals through the civil commitment process. This level of access does not exist today. Population growth, substantial reductions in State Hospital beds, forensic crowd-out, provider workforce shortages, high maintenance costs for aging State Hospital facilities, and lawsuits against the State have significantly diminished system capacity. Increased public awareness of mental health issues has also led to higher demand.

When asked which factors most significantly cause demand for inpatient services to exceed local service capacity, Community Centers most commonly cited the increase in people seeking services with co-occurring mental health and substance use disorders, and the increase in new clients in acute mental health crisis.

Why is there a need for both State Hospital and private psychiatric beds?

As forensic utilization in State Hospitals has grown, meeting the clinically necessary inpatient treatment needs of the civil population has become a significant challenge. Although most Community Centers say funding to support additional inpatient psychiatric bed capacity is the most urgent need in communities they serve, there is also an identified need for increased civil capacity in the State Hospital system. Over two-thirds of Community Centers indicate they do not have sufficient state funds to locally purchase private psychiatric beds, and therefore rely on other funding sources intended for outpatient treatment and other community-based interventions (i.e., Crisis General Revenue, Center reserves, hospital district and 1115 Waiver dollars).

The numbers tell the story.

| Fiscal Year 2016 | |
|-----------------------|--|
| \$608 | Average Cost per Private Psychiatric Bed Day (31 Centers) |
| 71,930 | Total Private Psychiatric Beds Purchased (31 Centers) |
| \$11.4 Million | Non-allocated/Other Funds Spent on Private Psychiatric Beds (10 Centers) |

Survey results for FY16 demonstrate the urgent need for base and exceptional item funding for inpatient psychiatric care. In FY16, 31 Centers report purchasing approximately 72,000 beds at an average cost of \$608 per day. Additionally, 10 Centers report using more than \$11 million (collectively) to purchase private psychiatric beds from funds intended for outpatient treatment and other community-based interventions. Reliance on funds

intended for community-based interventions to purchase inpatient beds places great strain on current systems and funding streams. For example, a Center with no other option but to use outpatient funds to purchase inpatient beds may struggle to provide the level of care necessary to divert people with mental illness from jail and local emergency rooms. Without action to address forensic crowd-out and other access barriers, the crisis in inpatient psychiatric capacity will continue to grow.

Attachment A: Community Center Inpatient Survey

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Introduction

The Texas Council of Community Centers conducted a survey on inpatient mental health services in October 2016. All 39 Community Centers responded to the survey, including the 37 Centers that serve as Local Mental Health Authorities.

Adult Service Needs

The survey asked Community Centers to identify adult services not available or not sufficiently available in their communities that would alleviate demand for State Hospital admissions. All 39 Community Centers responded to this question, ranking priorities from 1 to 5 (most important first).

As seen in Table 1, almost 62% of respondents indicate that “funds for purchasing private psychiatric beds (PPBs)” is their top priority. The need for extended observation units (priority 2 and 4) and crisis respite services (priority 3) also ranked high. Funds for short-term skilled nursing facility (SNF) admissions was ranked as the lowest priority for most respondents (priority 5).

| | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 |
|--|------------|------------|------------|------------|------------|
| Extended Observation Unit | 3 | 13 | 7 | 12 | 3 |
| Crisis Respite Services | 4 | 8 | 14 | 3 | 8 |
| Crisis Stabilization Unit | 6 | 11 | 11 | 7 | 3 |
| Funds for Purchasing Private Psychiatric Beds (PPBs) | 24 | 5 | 2 | 7 | 1 |
| Funds for Short-term Admissions to Skilled Nursing Facilities (SNFs) | 1 | 1 | 5 | 8 | 21 |

The survey also asked respondents to identify other items that will reduce demand for State Hospital admissions. Centers indicate a need for extended acute care service capacity; crisis residential, forensic competency restoration, and detoxification services; and long-term treatment focusing solely on substance abuse.

“The greatest need is for hospital beds for more long term, more serious acute patients.” Shena Timberlake, Texana Center.

“Our number one priority is for extended acute care services. Having an inability to admit civil patients to the State Hospitals and ALL civil admissions being referred to private facilities, we are seeing that more of our patients require more long term stabilization services than is accomplished in a 7-14 day stay. Individuals beyond the typical 14 day inpatient stay are ending up on the inpatient care wait list (ICWL), waiting for extended acute care services that are only available at the State Hospitals.” Shelley Smith, West Texas Centers.

“We don’t need short term skilled nursing as much as we need longer term skilled nursing or other supervised living environments.” Terry Crocker, Tropical Texas Behavioral Health.

Children Service Needs

The survey asked a similar question about children’s services not available or not sufficiently available in communities. Again, all 39 Community Centers responded to this question.

To alleviate the demand for State Hospital admissions for children, more than half (51%) of respondents say that funds to purchase private psychiatric beds is their most important priority. Service availability in crisis stabilization units (priorities 2-3) also ranked high. Extended observation units (priority 4) obtaining funds for short-term admissions to SNFs (priority 5) were the lowest ranked priorities for a majority of respondents.

| | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 |
|---|------------|------------|------------|------------|------------|
| Extended Observation Unit | 3 | 8 | 11 | 14 | 1 |
| Crisis Respite Services | 12 | 11 | 9 | 7 | 0 |
| Crisis Stabilization Unit | 4 | 12 | 13 | 9 | 0 |
| Funds for Purchasing PPBs | 20 | 6 | 4 | 7 | 1 |
| Funds for Short-term Admissions to SNFs | 0 | 0 | 1 | 0 | 35 |

For “other” priorities, Community Centers most commonly cite a need for residential treatment facilities that accept children with histories of self-harm and hospital beds for high acuity children. Some Centers indicate that most area children have Medicaid or another type of insurance that covers inpatient services, but recommend more funding for preventative outpatient services.

“Our community resources seem sufficient to meet the overall inpatient need for children. Recommendations to address children’s needs are less about inpatient care resources and more about outpatient resources (e.g., therapeutic foster care, shared parenting arrangements, intensive school based services, YES Waiver/access to specialized therapies, and early identification and prevention of behavioral health issues). These types of services assist the child and family in avoiding the situations that devolve into multi-systemic involvement.” Lesa Brown-Valades, Austin Travis County Integral Care.

Adult Treatment Capacity

Next, the survey asked if additional psychiatric treatment capacity was available for adults, what type of service would provide the most clinically-appropriate care. Thirty-eight Community Centers responded.

Over 60% of respondents indicate additional capacity for acute stays (11-30 days) in either State Hospital or private psychiatric beds is the most appropriate form of care (priority 1). Respondents identify sub-acute stays (4-10 days) in private psychiatric beds as priorities 2 and 4, and sub-acute stays in State Hospitals as priority 3. Brief stays in private psychiatric beds is ranked as the lowest priority (priority 5) by 39% of respondents.

| TABLE 3 | | | | | |
|---|------------|------------|------------|------------|------------|
| | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 |
| State Hosp. Beds – Sub-acute Stay (4-10 days) | 4 | 9 | 11 | 7 | 3 |
| State Hosp. Beds – Acute Stay (11-30 days) | 14 | 8 | 4 | 7 | 5 |
| PPB -- Brief Stay (1-72 hours) | 8 | 2 | 9 | 4 | 15 |
| PPB – Sub-acute Stay (4-10 days) | 5 | 13 | 4 | 13 | 2 |
| PPB – Acute Stay (11-30 days) | 9 | 4 | 9 | 8 | 9 |

Additional services falling into the “other” category include detoxification, long-term treatment focusing solely on substance abuse, forensic competency restoration, and ACT services.

“In my mind, there are two very distinct civil adult populations. The first includes individuals that require short term 7-14 days, and the second includes those that require 14-60 days. If we assume all civil patients require the same service we are making a mistake. We do not have the extended services that were traditionally offered by State Hospitals.” Shelley Smith, West Texas Centers.

“We have a DSHS-funded 20 bed facility and the current level of service (LOS) is eight days; however, when clinically indicated the LOS is ‘exceeds 30 days’ since State Mental Health Facilities are often on diversion. We work to provide inpatient care for extended periods at the local level in lieu of transfer to the SMHF.” Sarah Holt, Gulf Coast Center.

“A great deal of our population has involvement with the criminal justice system. As such, additional resources for ACT services (or FACT services) would help maintain individuals in the community setting while allowing inpatient to be used for crisis events or periods of decomposition/medication adjustment.” Lesa Brown-Valades, Austin Travis County Integral Care.

Child Treatment Capacity

Thirty-eight Community Centers responded to a similar question regarding children’s treatment capacity for clinically-appropriate inpatient care.

A majority of Centers (63%) identify additional private psychiatric beds for sub-acute stays as their first or second highest priorities. Centers identify private psychiatric beds for acute stays as the third priority. Finally, most respondents rank State Hospital beds for sub-acute stays and private psychiatric beds for brief stays as priorities 4 and 5.

| TABLE 4 | | | | | |
|---|------------|------------|------------|------------|------------|
| | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 |
| State Hosp. Beds – Sub-acute Stay (4-10 days) | 1 | 9 | 9 | 13 | 6 |
| State Hosp. Beds – Acute Stay (11-30 days) | 9 | 4 | 6 | 9 | 10 |
| PPB -- Brief Stay (1-72 hours) | 9 | 5 | 6 | 3 | 15 |
| PPB – Sub-acute Stay (4-10 days) | 12 | 12 | 5 | 9 | 0 |
| PPB – Acute Stay (11-30 days) | 7 | 8 | 12 | 4 | 7 |

“Other” priorities for additional services include residential treatment and specialized services for clients with complex needs. Finally, some Centers identify a need for additional inpatient capacity for children waiting for Child Protective Services placements.

Jail Diversion

The survey asked Community Centers to identify services not available or not sufficiently available in the community that would most effectively divert people from jail into treatment. All 39 Centers responded, again with close results.

Table 5 demonstrates that a majority of Community Center (62%) rank law enforcement partnerships with Local Mental Health Authorities (LMHAs) as their first or second priorities. These partnerships pair first responders with mental health professionals, and often prove effective in diverting clients with mental illness or substance use disorders to treatment settings. Additionally, Mental Health Deputy Programs and having a Mental Health Unit in Law Enforcement Agencies were each ranked as the first or second priority by 46% and 50% of Centers, respectively. Although fewer Centers ranked Law Enforcement Training and Funds for Transportation as the highest priority, they are clearly identified as initiatives important to effective diversion in certain local service areas.

| TABLE 5 | | | | | |
|---|------------|------------|------------|------------|------------|
| | Priority 1 | Priority 2 | Priority 3 | Priority 4 | Priority 5 |
| Mental Health Deputy Program | 10 | 8 | 7 | 8 | 3 |
| Mental Health Unit in Law Enforcement Agencies | 10 | 9 | 7 | 6 | 6 |
| Law Enforcement and LMHA Partnerships Pairing MH Professionals & 1 st Responders | 13 | 11 | 5 | 6 | 2 |
| Law Enforcement Training | 2 | 5 | 7 | 14 | 8 |
| Funds for Transportation | 3 | 4 | 11 | 3 | 16 |

Several Centers indicate that emergency detoxification and long-term programs focused on substance abuse are also needed for effective jail diversion. Others indicate that transportation vouchers help clients keep outpatient mental health appointments and avoid decompensation.

“This was difficult to prioritize. All are important.” Shelley Smith, West Texas Centers.

“There are not enough law enforcement personnel to meet the crisis demand in jails. Additional dollars are need to hire more law enforcement to assist with mental health issues in jails and for transportation to treatment.” Leo Trejo, Coastal Plains Community Center.

“The system needs more vouchers for existing transportations systems (taxis, Uber, Lyft) and to develop new systems to ensure clients attend appointments and achieve recovery goals. Point-to-point systems are demonstrated to be more effective in reducing no shows and canceled appointments than transportation systems with extraordinary wait times.” Andrea Richardson, Bluebonnet Trails Community Services.

“EMS conducts majority of transfers from local emergency departments to inpatient care. This is costly.” Sarah Holt, Gulf Coast Center.

Factors Causing Excess Demand

All 39 Community Centers responded to the next question, asking which factors most significantly cause demand for inpatient services to exceed local service capacity. The two most cited reasons for excess demand are new clients entering the system in acute mental health crisis and people with co-occurring mental health and substance use disorders seeking services. Other identified factors include psychiatrist and SUD provider workforce shortages and forensic crowd-out.

| TABLE 6 | | | | |
|--|----------|----------|----------|----------|
| | Factor 1 | Factor 2 | Factor 3 | Factor 4 |
| High Population Growth | 8 | 5 | 13 | 11 |
| Greater Public Awareness | 0 | 6 | 11 | 21 |
| Increase in People in Acute MH Crisis, New to System | 15 | 14 | 8 | 2 |
| Increase in People Seeking Services with Co-occurring MH/SUD | 15 | 13 | 7 | 4 |

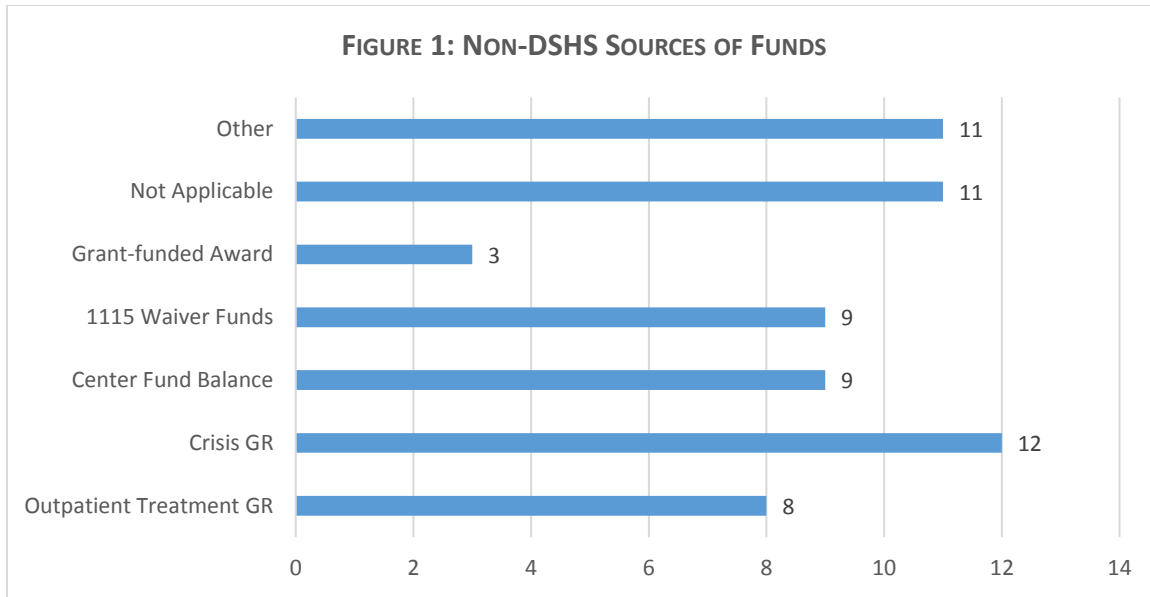
“We are now seeing an increase in the number of people seeking outpatient services who are leaving a provider when the provider no longer accepts their method of payment (private insurance, Medicaid).” Andrea Richardson, Bluebonnet Trails Community Services.

“Forensic/competency restoration causes us to exceed our inpatient capacity.” Robyn Johnson, StarCare Specialty Health Center.

“Many inpatient admissions are a result of co-occurring substance use/addiction crises and not enough recovery (SUD) services/resources to meet the demand. We’ve noted a fairly high percent of drug-induced symptomatology upon inpatient admission.” Sarah Holt, Gulf Coast Center.

Other Sources of Funds for Inpatient Care

Thirty-seven Community Centers responded to the next question, asking Centers which funding sources they use when they do not have DSHS allocations for inpatient care, or when DSHS funds are not sufficient to cover care. As shown in Figure 1, the most common sources are crisis General Revenue (32% of respondents) and 1115 Waiver funds and Center fund balances (24% each). Centers also use outpatient treatment General Revenue and grant funds to cover these costs. “Other” funding categories include county and hospital district dollars, and service organization and PESC funds.



“We have DSHS funds, but they are not sufficient. Additional cost is pushed to the Hospital District for inpatient stays.” Ramey Heddins, MHMR Tarrant.

“We rely on grant funds to pay for fee-for-service inpatient beds for youth. The grant ends in August 2017.” Sarah Holt, Gulf Coast Center.

Other Funds Spent on Private Psychiatric Beds (FY16)

For Community Centers that identified non-DSHS funding sources, the survey asked how much was spent (beyond DSHS funds) on purchasing inpatient psychiatric care from local hospitals in fiscal year 2016. Ten Centers responded, indicating they spent a total of \$11,404,207. The expenditures by Center ranged from \$5,000 (Central Counties Services) to \$7,176,053 (Austin Travis Integral Care).

All Funds Spent on Private Psychiatric Beds (FYs14-16)

The survey asked Community Centers to calculate all sources of funds spent to purchase local inpatient beds for fiscal years 2014 through 2016. Thirty-four Centers provided information for FY 14 and FY 15, and 35 provided information for FY 16.

Table 7 includes average and total funds spent per fiscal year. The figures reflect a small growth in spending from FY 14 to 15, and then larger growth in FY 16.²

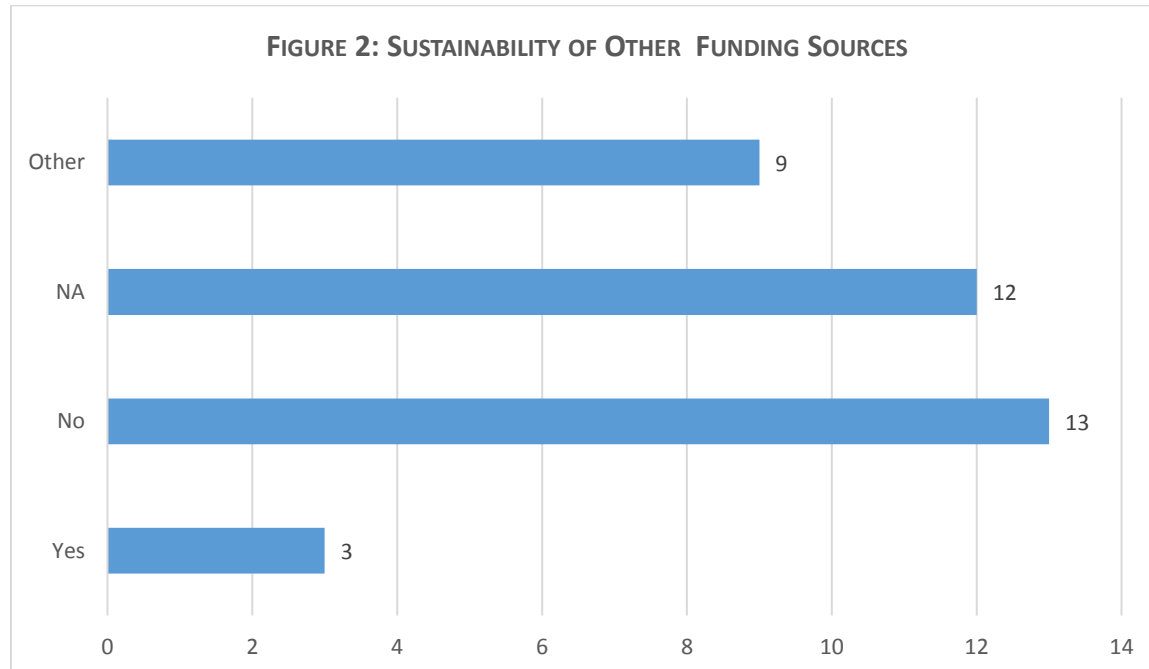
| TABLE 7 | | | |
|---------|----------|---------------------|-------------------|
| | Answered | Average Funds Spent | Total Funds Spent |
| FY 14 | 34 | \$1,723,418 | \$58,596,225 |
| FY 15 | 34 | \$1,737,331 | \$59,069,242 |
| FY 16 | 35 | \$2,063,189 | \$72,211,601 |

² One Community Center reported spending \$861,196 for FY 16, but did not include spending for FYs 14 or 15. Total spending for the remaining 34 Centers grew by approximately \$12.3 million from FY 15 to 16.

Sustainability of Other Funding Sources

Next the survey asked Community Centers whether non-DSHS funding sources are sustainable. All 39 Centers responded.

Only three Community Centers indicate other funding sources can be sustained. Thirteen indicate non-DSHS dollars are not sustainable. In the “other” category, nine Centers indicate they will either have to make cuts to other programs or services to continue purchasing inpatient psychiatric care from local hospitals, or that continued funding from local partners is questionable. For example, several Centers rely on 1115 Waiver funds, yet CMS approval is needed for funds to continue beyond fiscal year 2017.



*“We are not sure how much longer our hospital districts can subsidize funding for inpatient bed days.”
Todd Luzadder, Permian Basin Community Centers.*

“1115 Waiver funding is questionable for sustainability.” Ross Robinson, Hill Country Mental Health and Developmental Disability Centers.

*“Funding is only sustainable if I further limit outpatient services and make cuts to other programs.”
Evan Roberson, Tri-County Behavioral Healthcare.*

Local System Impact

The survey also asked Community Centers to describe the impact on local systems when funds intended for other services are used to purchase inpatient care. Thirty-seven Centers responded, many noting a negative impact on outpatient mental health services, including longer wait times for appointments. Use of funds for inpatient care also impacts Center salaries, cash flow, and reserves. Many Centers indicate that the shift in funding moves the system needle towards crisis response in hospitals and jails, instead of preventative care in outpatient settings.

“Shifting funds results in higher caseloads for outpatient services, longer wait periods to see doctor, lower salaries for outpatient providers leading to high turnover, and less funds for alternatives such as respite.” Diane Lowrance, Behavior Health Center of Nueces County.

“When funds intended for other services are used to purchase inpatient care, the ‘buying power’ of those funds is diminished. The result is the need to find alternate resources to pay for a constant rate of care or to decrease the amount of care provided. For Lubbock, the result is primarily in the diminished capacity to provide ‘flex fund’ support for non-treatment activities such as food vouchers, bus passes, utility support, etc.” Robyn Johnson, StarCare Specialty Health Center.

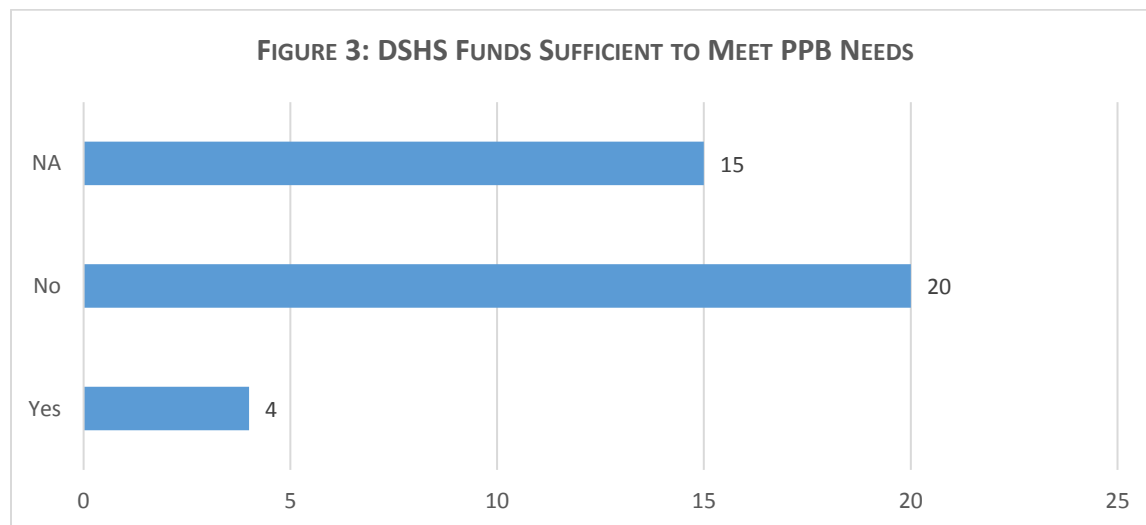
“Covering bed day costs prevents us from using these funds for needed services such as paying for medications, additional direct care providers and prescribers, and integrative health care costs.” Mike Cunyus, Burke Center.

“The system becomes a crisis driven system and takes ongoing services away that are greatly needed. You tend to be reactive instead of proactive in service delivery.” Pam Gutierrez, Denton County MHMR.

Sufficiency of DSHS Private Psychiatric Bed Allocations

The survey asked Community Centers with DSHS allocations to indicate whether these funds meet community needs for private psychiatric beds. All 39 Community Centers responded.

Fifteen Centers indicated the question was not applicable. By a ratio of 5:1, the remaining Centers indicate that DSHS private psychiatric bed allocations are not sufficient to meet their community needs.



Short-term Private Psychiatric Bed Funding and Days

Next the survey asked for estimates of the number of bed days and dollars Community Centers could put to use locally if DSHS funds for purchasing private psychiatric beds were not available (or not sufficiently available) in their communities. Twenty-seven Centers responded they could put funds to use locally. Dollar estimates range widely from \$140,000 (Central County Services) to \$13,195,000 (the Harris Center).

Table 8 shows these Centers estimate a system need of 33,574 days. The number of days varied by Center, ranging from 100 (Harris Center and StarCare Specialty Health Center) to 4380 (LifePath Systems and Denton County MHMR Center).

| TABLE 8: ANNUALIZED ESTIMATE OF SHORT-TERM RESOURCES | |
|--|--------------|
| | Total |
| Dollar Amount | \$31,313,989 |
| Bed Days | 33,574 |

Inpatient Days Purchased in Last 12 Months

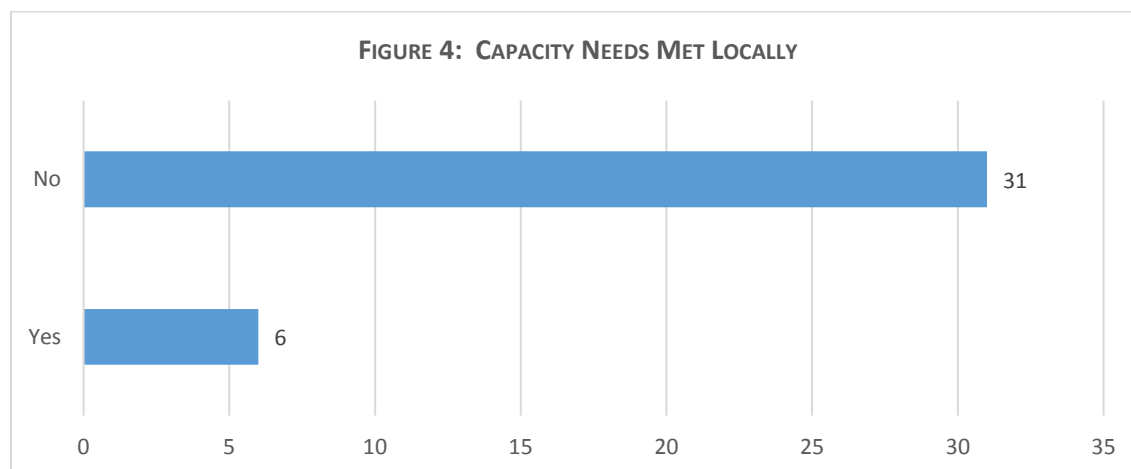
The next question asked Community Centers to identify how many psychiatric inpatient bed days they purchased during the preceding 12 months. Thirty-one Centers purchased a total of 71,930 beds. The number of days purchased ranged from 10 (Central County Services) to 11,975 (Austin Travis County Integral Care).

Cost per Bed Day

Thirty-one Community Centers provided information on the average cost per bed day in the preceding 12 months. Costs varied widely, ranging from \$375 to \$823. On average, Centers spent \$608 per psychiatric inpatient bed day.

Are Capacity Needs Met Locally

Thirty-seven Community Centers responded to the question asking whether capacity needs are met through locally-purchased inpatient care. An overwhelming majority of Centers (84%) indicate needs are not met.

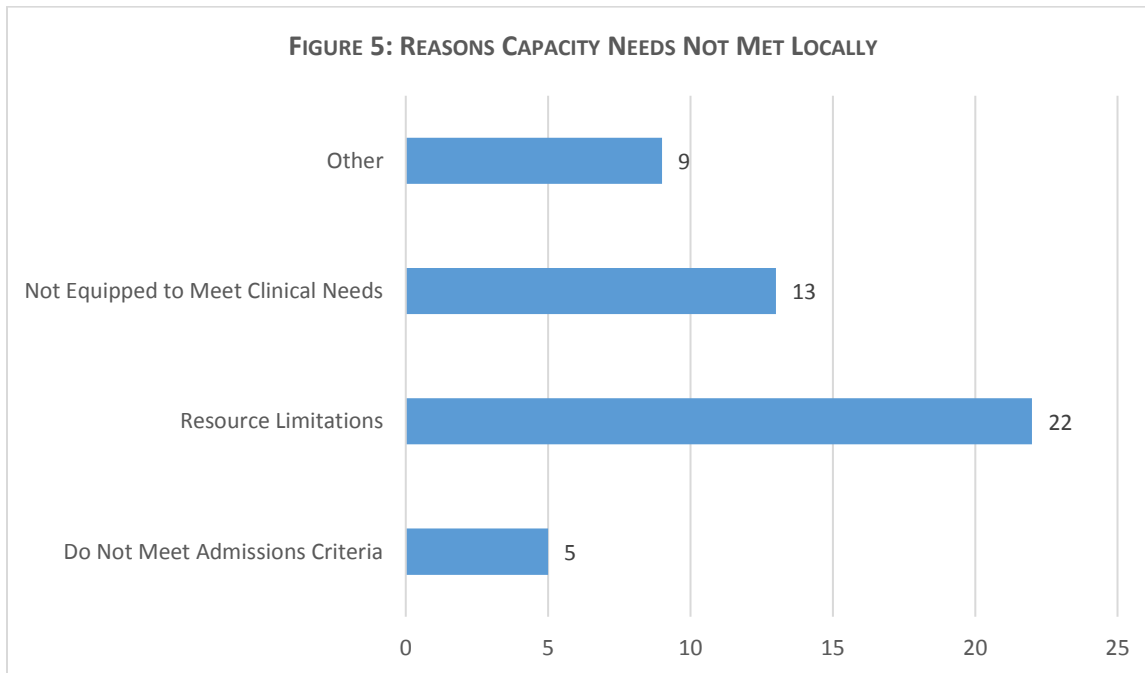


Reasons Why Capacity Needs Not Met Locally

The survey next asked Community Centers to identify the reasons why community needs cannot be met through locally-purchased inpatient care. Thirty Centers responded.

Figure 6 shows the most commonly-cited barrier to local care is resource limitations (73% of respondents), followed by providers not being equipped to meet the clinical needs of persons served (43%). A smaller number of Centers indicate clients do not meet admission criteria (17%). "Other"

factors limiting access include lack of availability for clients needing long-term services, lack of system inpatient infrastructure, and internal funding limits.



“Lack of providers reduces inpatient capacity. There is no inpatient care for children available in Nueces County.” Diane Lowrance, Behavior Health Center of Nueces County.

“None of the private psychiatric hospitals will admit individuals with IDD.” Barbara Dawson, the Harris Center.

“Beds are not available at facilities within the range of law enforcement transportation.” Evan Roberson, Tri-County Behavioral Healthcare.

Factors Contributing to Utilization above Bed Day Allocation

The survey asked Community Centers using bed days above their current State Hospital allocations to identify factors contributing to this dynamic. Twenty-six Centers responded, 17 indicating that the question was “not applicable.” The remaining 9 Centers all cite the same reason for high utilization: **forensic commitments.**

“The primary overutilization factor is due to forensic 46B commitments from the Travis County court system. We routinely have around 75% forensic admissions, and civil capacity needs are mostly being addressed in the community private psychiatric hospitals. The presence of the State Hospital within the county contributes to the ability of clients to self-present at the hospital in crisis as well, but this is a minor factor in relation to the increased need and attention to forensic admissions.” Lesa Brown-Valades, Austin Travis County Integral Care.

“The forensic population is taking up many of the State Hospital beds, and they generally have a longer length of stay in the hospital.” Ramey Heddins, MHMR Tarrant.

“Forensic admissions beyond our control drives our State Hospital admissions. With about eight days available, it is difficult to stay under the allocation.” Ted Debbs, ACCESS.

“StarCare has a unique circumstance, in that we have Sunrise Canyon Hospital. There are rare instances when we have to send people who are manifestly dangerous to a State Hospital, which puts us close to our very low State Hospital allocation. Most years, we do not exceed what little we have.” Robyn Jackson, StarCare Specialty Health Center.

Factors Contributing to Utilization below Bed Day Allocation

The survey also asked Community Centers to explain the reasons why they were not using all of their bed day allocations. Thirty-three Centers responded, 6 marking the question “not applicable.”

Several Centers note that increased access to and utilization of outpatient services reduces the demand for bed days. Others cite partnerships with law enforcement, including Mental Health Deputy programs, for helping divert people to less restrictive settings. Centers also note that 1115 Waiver programs, community partnerships, and mental health first aid trainings all help reduce bed day demand.

Most Centers, however, indicate that the essential lack of civil bed capacity at State Mental Health Facilities makes it difficult for Centers to access bed days.

“Through the 1115 Waiver and DSHS PESC funding, we established two extended observation units (EOUs) in our service area. Both EOUs allow for step-down care from the State Hospital, allowing for beds to open at the most intensive level of care in the State. We also implemented an IDD Assertive Community Treatment Team through the 1115, which works with our mental health crisis team. The program provides immediate access to expert consultation for individuals with dual diagnoses.” Andrea Richardson, Bluebonnet Trails Community Services.

“Our Center is unique since we have a DSHS-funded 20 bed facility. We maintain individuals for extended level of service (LOS), which minimizes the need for civil beds at the State Mental Health Facility.” Sarah Holt, Gulf Coast Center.

“The vast majority of beds are being used by forensic patients coming out of the Harris County Jail.” Barbara Dawson, the Harris Center.

“We cannot get anyone into the State Hospital because the hospital is constantly on diversion.” Pam Gutierrez, Denton County MHMR.

“We can’t access SMHF beds outside our catchment area.” Terry Crocker, Tropical Texas Behavioral Health.

Notice of Jail Returns

The survey also asked Community Centers how they receive notice when defendants complete competency restoration at State Mental Health Facilities and return to jail. Thirty-five Centers responded, and most indicate that State Hospital staff contact Continuity of Care (COC) staff at the Centers. A few Centers have COC staff co-located in the hospitals or jails, and therefore have streamlined access to hospital discharge information.

“The Center COC staff who offices at State Hospital advises when discharge is planned. Jails sometimes will notify, but not reliably.” Barbara Tate, Heart of Texas Region MHMR.

“Our COC staff, located in or assigned to the State Hospitals, are members of the State Hospital treatment teams--and are informed of the status of discharge readiness to jails. In addition, our Justice Teams connect with our local jails to ensure preparedness for an individual returning to jail. However, our system misses persons discharged in the evenings and on weekends when we are not aware of an anticipated release/return to jail.” Andrea Richardson, Bluebonnet Trails Community Services.

“The Austin State Hospital social workers do an excellent job of notifying our COC and UM Liaison staff about clients discharging back to the jail once competency is restored or the individual is deemed unable to be restored to competency. ATCIC is working with the local court and jail systems to increase communication regarding discharges from the jail into the community to improve continuity of care. There is currently little communication or notification of release from the jail, which decreases appropriate access to aftercare and increases the likelihood of re-offense and/or hospitalization.” Lesa Brown-Valades, Austin Travis County Integral Care.

“The Denton County Sheriff Department notifies Center liaison staff and the 7 day follow-up is completed at the jail.” Pam Gutierrez, Denton County MHMR.

Transitional Services

The final question asked Community Centers to describe the types of transitional services that, if resources were available, would most effectively meet the needs of people transitioning from State Hospitals or local jails. Thirty-five Centers responded, identifying a variety of services and supports (Table 9).

| TABLE 9: SERVICES NEEDED BY PEOPLE TRANSITIONING FROM STATE HOSPITALS OR JAILS | | |
|--|--|---|
| Crisis Respite and Residential Services | Mental Health Deputy Programs | Skilled Nursing Facilities/Assisted Living for Persons with SMI |
| Detoxification Services/Facilities | Mental Health Staff and Services in Jails | Support with SSI/Medicaid Restoration |
| Forensic ACT Teams | Patient Navigation Services | Supported Employment |
| Intensive Case Management & Outpatient Services | Peer Supports | Telemedicine in Jails |
| Increased Outpatient MH Capacity | Pharmacological Management | Transportation Services/Vouchers |
| Legal Supports/Programs | Residential Services: transitional/sober living housing, supported housing units, permanent housing, supervised living, HCS-AMH residential care | |

With additional funds, many Centers would expand existing services or introduce new services to help these populations effectively transition to the community.

“Transition should start at the State Hospital as opposed to when the individual returns back to the community. Only focusing on crisis alleviation, and not on an adequate discharge transition planning,

promotes a rapid recycle back to a needed crisis management service.” Eddie Wallace, MHMR Services for the Concho Valley.

“We believe a ‘step-down’ program similar to a crisis residential program would assist with transition, or a modified HCBS-AMH program. Current HCBS-AMH requirements are impractical for rural/frontier Centers.” Ross Robinson, Hill County MHDD Centers.

“Individuals transitioning from jails would benefit from more intensive case management services, legal assistance and programs that address legal, social and behavioral health issues, concurrently. More financial/staff resources for Mental Health Dockets, Mental Health courts and behavioral health resources for probationers would be helpful.” Caroline Frigo, Texas Panhandle Centers.

“Housing is critical. We need step-down housing from psychiatric inpatient so folks have a chance to be stable. Many are homeless or are unable to care for themselves in a home alone.” Evan Roberson, Tri-County Behavioral Healthcare.

“The one support that would most effectively help people as they transition from jail is a QUICK restoration of their SSI and Medicaid.” Robyn Johnson, StarCare Specialty Health Center.