Testimony to House Select Committee
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Current Situation for Dallas County and the North Texas Behavioral Health Authority

The waiting time for admission to the state hospital for forensic competency restoration remains unacceptable.

- 59 people waiting in jail for forensic beds as of 8/31/2016. 41 have been waiting over 60 days. The waiting list has been as long as 93 people in past six months.
- Wait time for maximum security beds has averaged 154 days this year, with some admissions waiting as long as 278 days (over 9 months).
- Wait time for non-max beds as averaged 73 days this year.

Capacity issues at the state hospitals and the need for forensic beds have limited local access to the state hospitals for both voluntary and involuntary inpatient treatment.

- Local behavioral health funding for inpatient and 23 hour observation services has grown from 30% of funding to 39% from 2012 to 2016.
- As more funding is spent on inpatient treatment, less is available for community based treatment.

The North Texas Behavioral Health Authority (NTBHA) is in process of the Sunset Commission mandated transition of the NorthSTAR service delivery system into a model that closely follows the rest of the state with indigent services the responsibility of the local authority and Medicaid transferred to the MCOs.

- NTBHA will be ready for the 1/1/2017 transition.
- The NTBHA transition is closely aligned with state and local Smart Justice initiatives.
- Participating counties will provide local match funds of $3.4M annually and contributed $500K for the transition work that had to be underway long before the allocated transition funding from the state became available 9/1/2016.
- A critical funding gap of $8.4M annually that results from Medicaid no longer supporting indigent services in the NTBHA region must be addressed in this next session. A prorated portion of the $8.4M is in the NTBHA FY 2017 budget but was not included in the HHSC LAR. That funding simply must become part of the NTBHA base funding.

State and State Hospitals' Role in Local Continuum of Care

State Hospitals are in important part of the continuum, but many complex factors are barriers to their full integration into local care systems.

- Their location in non-urban areas make coordination with local services very difficult, especially impacting discharge planning and warm handoffs to the community.
- The staffing and facility pressures make access to beds difficult to predict.
- The State Hospital Allocation Methodology (SHAM) for allocating beds among the local authorities is complex and difficult to understand and does not lead to fair access to beds across the state. NTBHA regularly has access to less than 90% of its allocation due to overuse by other parts of the state.
- Managing wait lists is a difficult challenge and leaves people who simply need care stuck in correctional settings and local community leaders frustrated with not knowing when to expect admissions.

The delivery of behavioral health services is actually becoming less integrated.

- Medicaid and indigent funding are no longer managed collectively by local authorities.
- Grant programs increasingly bypass local authorities (Healthy Community Collaboratives, TDCJ Re-entry pilot, in jail competency restoration).

The State's optimal role is contractor oversight, rather than directly administrating programs. However, HHSC continues to place administrative restrictions on local systems and maintain fragmented funding processes.

- Medicaid Waiver programs such as the 1115, 1915i, YES already have complex federal rules and state involvement does not make implementation any easier.
- In jail competency restoration pilot (SB 1475 in 2013 Legislature) and other competency restoration funds are highly prescriptive.
- TCOOMMI funding not integrated with local priorities and delivery systems.
- Except for the NTBHA region, substance abuse services are not managed by local authorities.

Local communities actually bear the bulk of the expense, risk and negative impacts of the lack of an adequately funded and locally integrated delivery system.

- Access to services start locally – either by voluntary access by consumers or involuntary access that requires local law enforcement, hospitals and local courts.
- Persons treated at the hospitals will return to their community and long term success requires strong community based support services.
- Local communities bear the cost of increased law enforcement, hospitalization, and jail use.

Solutions

Building more traditional state hospital beds is not the primary solution.

- The current model of a state hospital run by state employees in primarily non-urban areas does not meet the needs for a strong local continuum of care.
- Any new construction or significant renovation of existing facilities will be a long process and will not offer any short term relief.
- The medical industry is very dynamic in terms of workforce availability and the compensation required to attract and maintain a qualified work force. The current state hospital model will never be able to keep up with the overall industry and will likely always face staffing pressures.

State Hospitals can be an important part of the local continuum if they are focused on the appropriate target population.

- State hospitals are best positioned to treat the maximum security forensic commitments for competency restoration who need the specialized security setting and typically have longer lengths of stay.
- State hospitals can be an important option for both involuntary and voluntary civil commitments who have longer term treatment needs.
- State hospital must be more connected to local services for the quality discharge planning that is critical to long term recovery.

There are options for both short and long term reduction of state hospital waiting lists and to better integrate their services into the local continuum of care.

- Flexible funding at the local level to fill gaps in the communities where people needing services live.
- Allow funding to provide competency restoration in local inpatient facilities, which have the capacity and are willing to fill this need for non-violent offenders.
- Determine why the in-jail competency restoration pilot did not result in a contract award and make that funding available now for the purchase of other local options, such as inpatient beds or outpatient competency restoration.
- Allow funding to be used for in-jail competency restoration at the discretion of the local community, with appropriate standards of care that reflect the secure setting of jails and the existing services to inmates as required by State law and standards.
- Increased utilization and funding of outpatient services, both for forensic and civil populations.
- Increased funding for intensive treatment for super-utilizers, including step-down services as persons stabilize in their recovery process.
- Improved alignment of community treatment to the risk, needs and response to treatment for persons also involved in the criminal justice system.
- Improved alignment of state strategies for housing with local systems. The Healthy Community Collaborative funding is available to address at least part of the housing barriers. But, this grant is not aligned with local needs and priorities and has become another case of the state moving from managing contracts to micro-managing service delivery through onerous requirements.
- Increased support of law enforcement and pre-trial diversion efforts to keep people with mental illness with minor offenses who primarily need treatment out of the justice system (thereby reducing the number of people in need of competency restoration.
- Statutory reform to keep judges from sending low level misdemeanants into state hospital competency beds who are then simply released for time served once they regain competency to stand trial.

Local communities are ready to address this issue and bring key stakeholders together for both immediate action and longer term system improvements.

- Local government and philanthropy can be leveraged for funds to match state investment in solutions. Dallas and other counties are ready now to bring resources to the table if opportunities arise.
- Our medical schools are an under-utilized resource and can be important contributors to local solutions.
- There is a growing focus in our local communities on reducing the number of people who are in the criminal justice system primarily because of behavioral health treatment needs. Smart Justice projects in Bexar, Dallas and Tarrant counties, the Safety + Justice project in Harris County and other initiatives are all working on this important issue, with significant investments of local funding.
- In Dallas and other communities, the treatment services provided in the jail are greatly improved compared to the past and can serve a function more than just assessment and basic treatment. There is the capacity for more intensive services that will reduce the need for transfers to the state hospitals.