El Paso County's Behavioral Health System and the 85th Legislature: Where Are We Now and Where Might We Go?

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September 27, 2016
About the Meadows Institute

- **History**
  - The Meadows Mental Health Policy Institute traces its origins to the vision of The Meadows Foundation and its philanthropic leadership throughout the state of Texas on mental health and other vital public issues.

- **Mission**
  - To support the implementation of policies and programs that help Texans obtain effective, efficient mental health care when and where they need it.

- **Vision**
  - For Texas to be the national leader in treating people with mental health needs.

- **Key Principles**
  - Accessible & effective behavioral health care
  - Accountability to taxpayers
  - Delivery through local systems & collaboration
  - Data driven quality outcomes
  - Necessary robust workforce
Health vs. Mental Health Care

Life in the Community
Home  Family  Faith  Work  School

"Physical" Diseases
Primary Care
Coordination
Specialty Care
Coordination
Inpatient Care
Coordination
Best Practice Anchor (e.g., MD Anderson)

"Mental" Diseases
Law Enforcement
Inpatient Care
Crisis, Emergency, Hospital
Jail
If there is not access to crisis, emergency, hospital

The best Mental Health Care should be just like the best Health Care

Law Enforcement
Jail
Only if you steal, assault or harm someone

Specialty Care
Only to extent available and hard to find / access

Primary Care
Only if facilitated by specialty care

Best Practice Boutique (McLean, Johns Hopkins)
## How Many People Need Help?

<table>
<thead>
<tr>
<th>Population (2013)</th>
<th>Texas</th>
<th>El Paso County</th>
<th>Bexar County</th>
<th>Tropical TX BH (RGV)</th>
<th>TX Panhandle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Population</strong></td>
<td>26,400,000</td>
<td>830,000</td>
<td>1,800,000</td>
<td>1,250,000</td>
<td>400,000</td>
</tr>
<tr>
<td><strong>All Mental Illness</strong></td>
<td>7,000,000</td>
<td>215,000</td>
<td>475,000</td>
<td>325,000</td>
<td>105,000</td>
</tr>
<tr>
<td>Mild</td>
<td>3,000,000</td>
<td>90,000</td>
<td>195,000</td>
<td>130,000</td>
<td>45,000</td>
</tr>
<tr>
<td>Moderate</td>
<td>2,500,000</td>
<td>80,000</td>
<td>175,000</td>
<td>120,000</td>
<td>37,000</td>
</tr>
<tr>
<td>Severe</td>
<td>1,500,000</td>
<td>45,000</td>
<td>105,000</td>
<td>80,000</td>
<td>23,000</td>
</tr>
<tr>
<td><strong>Serious Mental Illness (SMI - Adults)</strong></td>
<td>1,000,000</td>
<td>28,000</td>
<td>60,000</td>
<td>43,000</td>
<td>15,500</td>
</tr>
<tr>
<td>Adults with SMI below 200% FPL</td>
<td>500,000</td>
<td>19,000</td>
<td>35,000</td>
<td>33,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Super-Utilizers (hospitals, ERs, some jail) below 200% FPL</td>
<td>22,000</td>
<td>800</td>
<td>1,500</td>
<td>1,400</td>
<td>350</td>
</tr>
<tr>
<td>Forensic (high criminogenic) below 200% FPL</td>
<td>19,000</td>
<td>700</td>
<td>1,300</td>
<td>1,200</td>
<td>300</td>
</tr>
<tr>
<td>All Super-Utilizers below 200% FPL (above 2 groups overlap)</td>
<td>36,000</td>
<td>1,300</td>
<td>2,500</td>
<td>2,250</td>
<td>550</td>
</tr>
<tr>
<td><strong>Serious Emotional Disturbance (SED - Children)</strong></td>
<td>500,000</td>
<td>20,000</td>
<td>37,000</td>
<td>35,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Children with SED below 200% FPL</td>
<td>300,000</td>
<td>14,000</td>
<td>22,000</td>
<td>27,000</td>
<td>4,750</td>
</tr>
<tr>
<td>High-Risk (&quot;school to prison&quot;)</td>
<td>30,000</td>
<td>1,400</td>
<td>2,200</td>
<td>2,700</td>
<td>475</td>
</tr>
<tr>
<td><strong>Annual Incidence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Episode Psychosis (FEP)</td>
<td>3,900</td>
<td>125</td>
<td>300</td>
<td>185</td>
<td>60</td>
</tr>
<tr>
<td><strong>Common Diagnoses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>97,000</td>
<td>2,000</td>
<td>4,000</td>
<td>4,200</td>
<td>1,500</td>
</tr>
<tr>
<td>All Mood Disorders</td>
<td>2,500,000</td>
<td>79,000</td>
<td>172,000</td>
<td>119,000</td>
<td>38,000</td>
</tr>
<tr>
<td>Major Depression</td>
<td>1,400,000</td>
<td>44,000</td>
<td>96,000</td>
<td>60,000</td>
<td>21,000</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>270,000</td>
<td>8,500</td>
<td>19,000</td>
<td>11,500</td>
<td>4,000</td>
</tr>
<tr>
<td>All Anxiety Disorders</td>
<td>4,800,000</td>
<td>150,000</td>
<td>328,000</td>
<td>225,000</td>
<td>72,500</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>680,000</td>
<td>21,000</td>
<td>47,000</td>
<td>29,000</td>
<td>10,500</td>
</tr>
<tr>
<td>Alcohol and Drug Dependence</td>
<td>850,000</td>
<td>26,000</td>
<td>57,000</td>
<td>40,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>120,000</td>
<td>4,000</td>
<td>8,000</td>
<td>5,500</td>
<td>1,750</td>
</tr>
</tbody>
</table>
Success Addressing Complex Needs

Key Components:

- State-Local Cost Sharing
- Required Local Collaboration
- Best-Practices for Targeted Populations
- Outcome-Driven

83(R) SB 58 – Healthy Communities Collaboratives

83(R) SB 1185 – Harris County Jail Diversion Pilot

84(R) SB 55 – Texas Veterans + Family Alliance
PROGRESS DEVELOPING A “SYSTEM” IN TEXAS
Where Have We Been? A Decade of Progress

CRISIS REDESIGN

• Investment in crisis redesign began with the 80th Legislature.

• Additional investments have been made each session since as well as through the Medicaid 1115 Waiver ($195M in DY 4).

• Texas crisis redesign has become a national model (e.g., Colorado implemented the Texas model post-Aurora).
COMMUNITY MENTAL HEALTH AND ADDICTION SERVICES

- 81st Legislature added funding for Transitional / Intensive Services ($55M) and created Medicaid Substance Abuse benefit.
- 83rd Legislature funded waitlists ($160M) and initiated 1915i SPA.
- 84th Legislature kept pace with population growth ($9M), provided a per capita adjustment ($37M), and expanded 1915i risk groups (jail, inpatient).

Note: All figures biennial unless otherwise noted
Where Have We Been? A Decade of Progress

INPATIENT SERVICES

- 83rd and 84th Legislatures expanded community inpatient services.

TARGETED POPULATIONS

- 83(R) SB 58 – Healthy Communities Homeless Collaboratives
- 83(R) SB 1185 – Harris County Jail Diversion Pilot
- 84(R) SB 55 – Texas Veterans + Family Alliance
Statewide Behavioral Health Strategic Plan

BUDGET RIDER

• Targeted coordination of behavioral health services and expenditures across state government, pursuant to Article IX, Section 10.04, General Appropriations Act.

• Included 18 state agencies.

• Statewide Behavioral Health Coordinating Council created to submit a five-year strategic plan (FY 2017-21).

• Completed in May 2016.
State Behavioral Health Spending

• Texas is not “49th in funding,” now that we have found the Medicaid money we spend.
• Billions more in physical health spending (*study in progress*).

<table>
<thead>
<tr>
<th>State Agency BH-Related Spending per Biennium</th>
<th>FY16-17 GR</th>
<th>FY16-17 All Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>From LBB 84R Cross-Article BH-Related Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of State Health Services (DSHS)</td>
<td>$1.966 Billion</td>
<td>$2.712 Billion</td>
</tr>
<tr>
<td>Department of Criminal Justice (TDCJ)</td>
<td>$491 Million</td>
<td>$500 Million</td>
</tr>
<tr>
<td>Juvenile Justice Department (TJJD)</td>
<td>$231 Million</td>
<td>$250 Million</td>
</tr>
<tr>
<td>Health and Human Services Commission (HHSC) Non-Medicaid</td>
<td>$32 Million</td>
<td>$80 Million</td>
</tr>
<tr>
<td>Department of Family and Protective Services (DFPS)</td>
<td>$23 Million</td>
<td>$30 Million</td>
</tr>
<tr>
<td>Department of Aging and Disability Services (DADS)</td>
<td>$18 Million</td>
<td>$20 Million</td>
</tr>
<tr>
<td>All Other Agencies</td>
<td>$28 Million</td>
<td>$40 Million</td>
</tr>
<tr>
<td>HHSC Medicaid</td>
<td>Not Available</td>
<td>$3.1 Billion</td>
</tr>
<tr>
<td>1115 DSRIP BH Projects (federal and local funds)</td>
<td>Not Available</td>
<td>$440 Million</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td></td>
<td><strong>$7.15 Billion</strong></td>
</tr>
</tbody>
</table>

Figures rounded for simplicity
BEHAVIORAL HEALTH SYSTEM ASSESSMENT UPDATE
• Developed vision/mission statements,
• BHC structure with three Leadership Councils (LCs),
• BHC and LCs are cooperating to share information, identify partnership opportunities, and fill in the system of care (but are not yet at the full collaborative level of functioning goal).
• Addressing high-risk youth in foster care
• Work with MCOs
• Child-placing agencies and use of Mental Health First Aid (MHFA)

• Examined workforce & policy issues that need to be addressed to develop PBHCl
• Examined professions to be drawn on for PBHCl

• Developed a Sequential Intercept Model
• Established pretrial services office
• Encouraged establishment of inter-local agreement with Sheriff’s office and Emergence Health Network (EHN)
Progress in Filling System of Care Gaps Since TriWest’s 2014 Report

- Multisystemic Therapy (MST) Team
- Supported Housing
- Extended Observation Unit
- Family/Youth Partners-Based Peer Support
But There Is Still More To Do...

Selected Intensive Community-Based Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Intensive Family-Based Services for Children/Youth</th>
<th>Estimated % of Need Met</th>
<th>Assertive Community Treatment for Adults (and LOC3*)</th>
<th>Estimated % of Need Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>0</td>
<td>0%</td>
<td>106 (LOC3=2,847)</td>
<td>8%</td>
</tr>
<tr>
<td>2015</td>
<td>82</td>
<td>6%</td>
<td>59 (LOC3 = 2,006)</td>
<td>4%</td>
</tr>
</tbody>
</table>
Develop an Online Dashboard of Priority Performance Metrics *(Examples below)*

- **Number of children/youth sent out of region for residential treatment**
- **Number of people with mental illness re-entering jail after release**
- **Percent in need who receive Assertive Community Treatment (adults) and Multisystemic Therapy (youth)**
- **Number of people with access to primary and behavioral care integration services**
Child/Youth System of Care – 2014

Juvenile Justice Facility (Commitment)
State Hospital Services
Inpatient Psychiatric Hospital Services
Residential Treatment Center (RTC) – DFPS
Residential Treatment Center – MH/SA
Treatment Foster Care (TFC)
Out-of-Home Crisis Continuum (RTC, TFC, runaway shelter, emergency shelter, etc.)
Respite (Crisis)
Local Emergency Rooms (General)
Psychiatric ER Services
EHN Crisis Team
Crisis Follow-Up/Relapse Prevention
Juvenile Justice Diversion and Reentry
Wraparound Planning / Coordination
Day Treatment / Partial Hospital
Law Enforcement Contact

• Agency-Based MH/SA Child Outpatient
  – Respite (Community)
  – Intensive In-Home Services / MST / FFT
  – Intensive Case Management
  – Case Management
  – Psychiatric Diagnostic Interview
  – Pharmacological Management
  – Medication Training/Support
  – Skills Training and Development
  – Individual / Group Therapy
  – Family Therapy
  – Parent / Family Support Groups
  – Family / Youth Partners (Peer Support)

• EHN Intake
• Non-DSHS Clinic
• MH/SA Services in Public Schools
• HCO Program with outpatient / FQHC / health clinic based BH services
• Advocacy Education / Prevention
Child/Youth System of Care – 2016

Juvenile Justice Facility (Commitment)
State Hospital Services
Inpatient Psychiatric Hospital Services
Residential Treatment Center (RTC) – DFPS
Residential Treatment Center – MH/SA
Treatment Foster Care (TFC)
Out-of-Home Crisis Continuum
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  – Family Therapy
  – Parent / Family Support Groups
  – Family / Youth Partners (Peer Support)

• EHN Intake
• Non-DSHS Clinic
• MH/SA Services in Public Schools
• HCO Program with outpatient / FQHC / health clinic based BH services
• Advocacy Education / Prevention
What’s Next for the El Paso BH System?

- Expansion of intensive, family- and community-based services
- Development and implementation of strategic plans for “moving the needle” on key metrics
- Clarification of highest-priority goals and focus collective efforts
DEVELOPMENT OPPORTUNITIES AVAILABLE TO THE 85TH LEGISLATURE
Population 1: Narrow the Prison Pipeline

- Texas A&M and the Council of State Governments Justice Center have shown the path to **reducing the school-to-prison pipeline**.

- 84(R) SB 1630 continued TJJD reforms, but there is still a gap in available services **prior to juvenile justice system entry**.

- **30,000 Texas children** with severe mental health needs are at high risk **before** entry into the juvenile justice system.

- **PRIORITY #1: Help vulnerable Texas children stay in school and live at home, beginning with children in foster care.**
Narrow the Pipeline for Children in Foster Care

• **4,000** of these children are in the child welfare system.

• We lack adequate, high-quality capacity in the child welfare system, particularly for children with high needs.

• The supply of “step-down settings” is dramatically lacking, as identified in the Stephen Group’s 2015 report.

• Commissioner Whitman’s **10-point plan for CPS**.

• **83(R) SB 58**: Expanded range of psychiatric rehabilitation services providers. Despite SB 58, in three years, only two new child providers have been credentialed.
Treatment Capacity is the Key Barrier

• **MMHPI local assessments** – Texas has little to offer children and families who need mental health services that are more intensive than a routine outpatient visit, but less intensive than residential care.

• **El Paso County** – Less than 100 children/youth out of the estimated 1,300 in poverty who need this level of care receive it through the local mental health authority (LMHA). This is comparable to every other part of Texas.

• **95%** of these children do not receive the intensive mental health care they need.
Population 2: “Super-Utilizers”

- **Super-utilizers** – Texas spends **$1.4 billion** in ER costs + over **$650 million** in local justice system costs **each year** because of inadequately treated mental illness and substance use disorders, disproportionately allocated to super-utilizers.

- **How many?** In Texas, there are **36,000** people in poverty who suffer from mental illness and repeatedly use jails, ERs, crisis services, EMS, and hospitals.

- Texas currently only has the **capacity** to serve **1 in 7** (3,400 super-utilizers) and less than **1 in 10** with deeper criminal justice system use.

- **Priority #2:** State-local partnerships to divert those with mental illness from our jails and eliminate forensic waitlists.
Forensic Commitment Waiting List

- **Increasing:** more than quadrupled since 2013.
- **Aren’t we spending more now on treatment?** Yes, but focus was on waitlists and overall numbers, not intensive care.
Other Barriers to Services for Super-Utilizers

Barriers to Assertive Outreach:

• Assertive Community Treatment (ACT) – 1990s fidelity standards for our most intensive treatment teams.

• Forensic Assertive Community Treatment (FACT) – no standards or systematic development efforts.

• DSHS non-statutory contract requirements add hurdles – consent prior to outreach and average of 10 hours of active treatment.

Result: Vast majority of “super-utilizers” are currently not served.
Population 3: Barriers to Care in Primary Care

Primary care patients
N=1,000

\[ q_0 = 87.5\% \]

- No depression
  N=875

\[ q_1 = 53\% \]

- Not clinically recognized
  N=66

\[ q_2 = 50\% \]

- Not treated
  N=29

\[ q_3 = 60\% \]

- Inadequately treated
  N=18

\[ q_4 = 35\% \]

- Remission not achieved
  N=4

\[ p_0 = 12.5\% \]

- Depression
  N=125

\[ p_1 = 47\% \]

- Clinically recognized
  N=59

\[ p_2 = 50\% \]

- Treated
  N=30

\[ p_3 = 40\% \]

- Adequately treated
  N=12

\[ p_4 = 65\% \]

- Remission achieved
  N=8
Barriers to Primary Care Integration in Medicaid

• 1.4 million Texans, including 160,000 children, suffer from depression, compared to the 2 million with diabetes.

• Universal screening, which can be completed by the patient or their parents in the waiting room, should be implemented for everyone over age 12. This is consistent with best practice and the only way to meet the need, given workforce limitations.

• Need to follow the recommendations proposed through the SB 58 Behavioral Health Integration Advisory Committee to remove barriers to paying for mental health care in primary care settings.

• **Priority #3: Promote integrated depression care and reduce barriers to reimbursement for integrated behavioral health.**
The truth is: mental illness affects more people than you may think, and we need to talk about it. It’s Okay to say…” okaytosay.org