

From: [Sunset Advisory Commission](#)
To: [Janet Wood](#)
Subject: FW: Form submission from: Public Input Form for Agencies Under Review (Public/After Publication)
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-----Original Message-----

From: sundrupal@capitol.local [<mailto:sundrupal@capitol.local>]
Sent: Monday, June 30, 2014 4:47 PM
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Agency: DEPARTMENT STATE HEALTH SERVICES DSHS

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State: Texas

Your Comments About the Staff Report, Including Recommendations Supported or Opposed:

Sen. Jane Nelson, Chair
Texas Sunset Advisory Commission
1501 N. Congress Avenue,
6th Floor—Robert E. Johnson Building
Austin Texas 78701

Dear Senator Nelson and Members of the Texas Sunset Advisory Commission:

Attached please find comments from Mental Health America of Greater Dallas related to the Texas Sunset Advisory Commission Staff Report on the Department of State Health Services. Thank you very much for this opportunity, and your diligence in seeking public comment on this document.

If you or your staff have any questions, I can be reached by telephone at (214) 871-2420, Ext. 114, or by e-mail at JMetzinger@mhadallas.org

Respectfully,

Janie Metzinger
Public Policy Director
Mental Health America of Greater Dallas

Comments on
Texas Sunset Advisory Commission Staff Report on Texas Department of State Health Services

Summary

Page 1—“DSHS still carries out several of its duties in pre-consolidation silos, most obviously in its mental health and substance abuse programs, making it more of a nesting doll of agencies within agencies, instead of the truly integrated health services organization envisioned more than a decade ago”.

Mental Health America of Greater Dallas shares the Sunset Commission Staff’s dismay that after more than a decade, even mental health and substance abuse treatment and services remain in silos in much of the Department of State Health Services (DSHS) despite overwhelming evidence of the interconnectedness of the two conditions. The 2012 SAMHSA National Survey on Drug Use and Health: Mental Health Findings reported that 40.7% of adults with substance use disorder had a co-occurring mental illness, reinforcing the worthiness of the goal of integration of these services.

DSHS’ failure to effectively co-ordinate mental health and substance abuse treatment and services statewide wastes human lives and taxpayer dollars.

Page 2—“...DSHS tends to get mired in bureaucratic processes and meaningless outputs rather than working collaboratively with a clear focus on achieving specific, desired outcomes, particularly relating to how it distributes and evaluates funding for local mental health authorities and local health departments”.

Mental Health America of Greater Dallas agrees with this assessment and finds it and the related problem of a lack of transparency at DSHS to be a significant concern. For example, in DSHS Legislative Appropriation Request, the estimated number to be served by DSHS Strategy B.2.1-Mental Health Services-Adults is listed as 52,484 per month and B.2.2- Mental Health Services-Children is listed as 12,206 per month, while the numbers served by NorthSTAR, Strategy B.2.4, is listed as 60,500 per year. This difference might be quite confusing to legislators, members of their staffs, other stakeholders and the public. The uninitiated might think that to calculate the number served per year by Strategies B.2.1 and B.2.2 one would merely have to multiply times twelve. However, since most individuals receive services on an ongoing basis, clearly that would yield a grossly incorrect result. It would likely be more helpful to policymakers if all strategies

were listed in terms of the numbers served per year. In fact, in preparing for the 83rd Legislative session, we were informed by DSHS that if expressed annually for the year 2012, the numbers actually served by each of the aforementioned strategies would be:

DSHS Strategy B.2.1 Mental Health Services-Adults:

Total Number of Individuals Served in 2012: 112,709

DSHS Strategy B.2.2 Mental Health Services-Children:

Total Number of Individuals Served in 2012: 30,436

DSHS Strategy B.2.4 NorthSTAR

Total Number of Individuals Served in 2012: 71,997*

* This number reflects the 68,089 people who received mental health services, and the 3,906 individuals who received substance abuse treatment services only in NorthSTAR in 2012.

In addition to numbers served, Mental Health America of Greater Dallas agrees that the focus should be on the desired outcomes of healthier lives for the individual Texans receiving services through DSHS, including:

- Engagement and follow-up in therapeutic services
- Engagement in the community and socialization
- Housing stability
- Engagement in employment or education
- Reduced repeat hospitalizations
- Reduced arrest rate, criminal justice system involvement
- Reduced incarceration recidivism
- Nationally normed and vetted outcome and quality of life measures

ISSUE 1

Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now.

Page 17--“The state mental health hospital system treats people with serious mental illness who cannot obtain needed care in the community and/or have been committed through the court system”.

This opening sentence to Issue 1 is telling. It certainly highlights the importance of early intervention and the need in Texas to develop more robust access to community-based services.

Mental Health America of Greater Dallas recommends that Texas take this Sunset opportunity to re-think how we develop and pay for psychiatric hospital beds. Ten hospitals in mostly remote areas (as noted on page 20) is based on an archaic, shame-based idea of mental illness from the 1800s.

Modern best practices recommend hospital services close to family and community supports when hospitalization is needed. Even very rural communities in Texas have hospitals. We recommend that DSHS expand the use of local psychiatric hospital beds and incent the development of psychiatric beds where none currently exist. We also recommend the expanded use of tele-medicine and tele-psychiatry to extend the reach of integrated medicine in Texas.

Perhaps existing state hospital structures that can be cost-effectively be rehabilitated should be brought up to current codes and re-purposed to meet the mental health and substance abuse residential and outpatient treatment needs of smaller, more local catchment regions.

This would advance DSHS’ mission of integration of mental health and substance abuse and the rest of medical care; preserve and create jobs in rural Texas; and reduce the burden on rural Sheriff’s Departments who currently are responsible for transporting individuals in need of psychiatric care to ten, now far-flung, state hospitals.

Page 18—Findings--The state’s mental health hospital system is in crisis “Individuals waiting to enter the state mental health hospital system are at risk of not being treated in a timely manner or in ways that best address their needs”.

Although the Staff Report is generally right on target, the soft-peddled tone of this sentence of this sentence is worrisome. An individual who is sick enough to be hospitalized is already a danger to self or others or in seriously deteriorated condition. If that individual has to wait to be hospitalized, there is no “at risk” about it—the individual is not being treated in a timely manner or in a way that best addresses the person’s needs. If a person is in heart failure, having a stroke, or severely insulin deficient, and is not hospitalized, would we say he/ she is merely “at risk”? Clearly not. Brain disorders just like the maladies of any other part of the human body, and Mental Health America of Greater Dallas hopes that the Sunset Advisory Commission’s final report reflects this understanding and integrated approach.

Page 21—Increased severity of mental illness in state hospitals.

Mental Health America of Greater Dallas shares the Staff Report’s concern that injuries to state hospital staff increased 35% between Fiscal years 2009 and 2013, particularly since injuries declined in other forensic settings in the same time period, notably the Texas Juvenile Justice Department and the Department of Criminal Justice. We worry that figures may indicate a culture and practice in the state hospitals that may lead to incitement rather than de-escalation of crises. Working collaboratively with local Police Departments and Sheriff’s Departments in the NorthSTAR region, we have seen a significant decrease in injuries to police officers and jail detention staff since the introduction of the 40-hour Mental Health Crisis Intervention Training in 2006. Perhaps the system revisions to the state hospital system suggested earlier in these comments combined with improved training in de-escalation techniques and mental health crisis intervention could decrease the injuries to state hospital staff as well.

Pages 22-24—Deficiencies in judicial education and poor management of human resource issues contribute to capacity issues within the state’s mental health hospital system.

Mental Health America of Greater Dallas agrees with the assessment of the Staff Report, and suggests that in addition to training for judges in the criminal courts, that prosecutors, public defenders, court-appointed attorneys, probation and parole staff also receive education on alternatives to inpatient mental health treatment or incarceration. Special problem-solving courts in Texas should be required to operate using evidence-based best practices established for such courts in order to improve the likelihood of reduced recidivism for program participants.

On the civil side, probate court judges, prosecutors and attorneys should also receive training on outpatient alternatives to hospitalization, particularly for individuals who tend to constantly cycle through psychiatric emergency services of jail.

ISSUE 2

DSHS Has Struggled to Deliver Integrated, Outcomes-Focused Community Mental Health and Substance Abuse Services.

Page 27—Background—Behavioral Health Issues in Texas—By the Numbers It appears to Mental Health America of Greater Dallas that the number of people with serious and persistent mental illness may be significantly underestimated at 500,000. For example, the National Institutes of Mental Health says that 1 in 17 Americans have a serious and persistent mental illness (SPMI). Given that according to the U.S. Census Bureau, the 2013 Texas population was 26,448,193, that would put the SPMI population at 1,555,776.

For assistance, Mental Health America of Greater Dallas consulted Richard Scotch, Ph.D., Professor of Political Economy at the University of Texas at Dallas, who enlisted the assistance of Jennifer Bridges, a doctoral candidate at UTD. Attached are their estimates based on various formulas.

If we don’t get the numbers right, then state planning and programs are not based on reality. You as the Sunset Advisory Committee, as well as your fellow Texas Senators and Representatives deserve and need a realistic picture of the state’s behavioral health needs in order to make sound policy in this very critical area. We urge you to drill down on numbers so that you have the information that you need.

Page 28—DSHS has not seized obvious opportunities to integrate hotline, screening and assessment functions for mental health and substance abuse services.

Mental Health America of Greater Dallas agrees with the report’s concerns that DSHS has failed to implement the legislative directives from the last Sunset review and that this lack of integration does not follow best practices to promote recovery for people with mental illness and substance abuse disorders. We would remind the Commission that NorthSTAR is an example of integration of mental health and substance abuse services, and recently efforts to integrate all of health, of which the Legislature can be proud.

Page 29—Despite years of legislative direction, state funding to mental health regions continues to be inequitable and disconnected from performance.

In our advocacy role, Mental Health America of Greater Dallas would be remiss if we did not point out the historically low levels of funding for mental health services in Texas, but agrees that the current funding formulas seem to have no logical basis. Indeed the only logic seems to be that they are mired in decades-old political patronage, so long past that even the successors of the officeholders who garnered the most-favorable allocations for their regions are no longer in office. If anything, they seem to reward inefficiency and penalize cost-effectiveness. For example, in preparation for the last legislative session, our analysis indicated that of all Texans receiving mental health services, 32.23% received those services in the NorthSTAR region, yet NorthSTAR received less than 14% of the total funding for mental health services in the state, and a recent presentation by DSHS showed that even with the increased appropriation last session, that the NorthSTAR share increased only by .6%, while the rest of the state saw double-digit increases. Other large urban centers also face an inverse relationship between the number of Texans they serve and their share of the funding.

Mental Health America believes that the current method of allocating funding should be scrapped and instead, the

state should commission an independent actuarial analysis for the purpose of allocating funding fairly which would be reported to the Legislature and to HHSC. This analysis should include the concerns of rural and urban areas, such as the higher percentage of people with serious and persistent mental illness and higher acuity levels in urban areas, and the shortage of qualified personnel in rural areas, but should also consider the efficiencies that tele-medicine and tele-psychiatry might yield, particularly in rural areas.

Page 30--Better oversight of regional resources needed "Significant overuse of allocated state beds indicates a breakdown in local service delivery and capacity. In 2013, 21 of 38 regions received above-average per-capita funding. Nine of the 21 regions also used more beds in the state mental health hospital system originally allocated by DSHS".

Mental Health America of Greater Dallas has some concerns regarding this particular section.

- Texas has historically had low levels of funding for mental health services, stressing the mental health services infrastructure at all acuity levels so that even the highest funded regions in Texas did not even match the average per-capita spending in the rest of the nation.
- Given that there are questions about DSHS estimates of the numbers of people with SMI or SPMI, can we have confidence in the number of beds they think Texas needs or the number of beds allocated per region?
- The report noted the number of days that Texas state hospitals are full or are on divert status. Might this not indicate a shortage of psychiatric inpatient beds in the state?
- Given the above, is it fair to charge any region with 'over-using' a too-scarce resource? Is it not possible that those regions are appropriately hospitalizing individuals in need of that higher level of care, and that the state has simply not provided sufficient resources at either the community-based or hospital setting?

Mental Health America of Greater Dallas does not view penalizing local mental health authorities on this basis to be fundamentally fair.

Page 30—DSHS has not developed a streamlined, outcomes-focused approach to managing the state's mental health and substance abuse programs.

Mental Health America of Greater Dallas agrees that DSHS needs meaningful, recovery-oriented outcomes measures that would allow an apples-to-apples comparison of mental health and substance abuse regions and programs.

Page 31—Pilot project design thwarts evaluation.

As an advocacy organization in the NorthSTAR region, Mental Health America of Greater Dallas strongly supports the principles upon which NorthSTAR was founded:

- Integration of mental health and substance abuse treatment and services
- Open access to all eligible persons—no waiting lists
- Consumer choice of providers within network promotes competition
- Separation of authority functions from provider functions

Since the advent of NorthSTAR in 1999, more than five times number of people are now receiving services as did under the former MHMR system, with outcomes that are in the top 15% of the state. Mental Health America of Greater Dallas also appreciates the collaborative, problem-solving culture that NorthSTAR has engendered and believes that 'this laboratory for innovation' will serve the region and the state well in the face of the changing nature of health care. Mental Health America of Greater Dallas advocates greater local control for the North Texas Behavioral Health Authority Board in governing NorthSTAR as it may allow greater participation for NorthSTAR in the 1115 Wavier program.

Page 36—Recommendation 2.2--Require DSHS to focus funding equity efforts for local mental health authorities on targeted capacity needs rather than on narrow per-capita funding.

Mental Health America has significant concerns regarding Recommendation 2.2 for the reasons we expressed about the Report on page 30. Due to the shortage of state hospital beds, it seems fundamentally unsound to base new funding decisions on an allocated share of a too-scarce resource. We believe that a far better approach to funding equity is the one we suggested in response to page 29—an independent actuarial analysis of the state on which to base funding allocations.

Mental Health America of Greater Dallas is grateful for this opportunity to respond to the Texas Sunset Advisory

Commission Staff Report. If we can be of any service to the Commission or Commission Staff, please contact me.

Sincerely,

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Any Alternative or New Recommendations on This Agency:

Prepared for Mental Health America of Greater Dallas by Jennifer Bridges, Bridges, Jennifer

DSHS SMI and SED estimates
6/20/2014

The Texas Department of State Health Services 2015-2019 Strategic Plan draft estimates the number of individuals with serious and persistent mental illness as 499,389. In response to MHA of Greater Dallas comments on the draft, DSHS stated that the number was estimated in accordance with the suggested methodologies found in two publications in the Federal Register:

CMHS, SAMSHA, HHS (1999). Estimation Methodology for Adults With Serious Mental Illness (SMI). Federal Register, v64 n121, pp. 33890-33897.

CMHS, SAMSHA, HHS (1998). Children With Serious Emotional Disturbance: Estimation methodology. Federal Register, v63 n137, pp 38661-38665.

The DSHS response to comments also states that their population numbers are drawn from the Texas State Data Center. The application of the stated methodology to current population numbers suggests that DSHS's number is underestimated.

Adults

According to the Texas Data Center, the 2012 Texas population over the age of 17 was 19,062,851. According to the 1999 proposed methodology in the Federal Register, "State estimates are defined as 5.4 percent of the adult population, with a 95 percent confidence interval of plus or minus 1.96 times 0.9 percent" (p. 33895). This yields an estimate of Texas adults with serious mental illness (SMI) of 1,029,394 (with a 95% confidence interval of 1,365,663 to 693,125).

Children

According to the Texas Data Center, the 2012 population of children 9-17 years of age in Texas was 3,487,725. The methodology used to determine incidence of serious emotional disturbance (SED) distinguished among states, creating three groups based on most, middle, and least child poverty. Texas was included in the group of states with the highest child poverty. More recent data indicates that this continues to be the case. For this highest child poverty group, "the estimated SED population... is calculated to be between 7-9 percent of the number of youth 9-17 years" (p. 38663). This yields an upper limit estimate of children 9-17 with SED of 31,389

Prepared for Mental Health America of Greater Dallas by Malinda Hicks, Office of Inspector General, U.S. Department of Health and Human Services

Serious Mental Illness: "Among adults with a disorder, those adults whose disorder caused substantial functional impairment (i.e., substantially interfered with or limited one or more major life activities."
(<http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm>)

U.S. Census Bureau, population estimates for Texas, using ACS 5-year estimates (2008-2012):

Estimated population 18 years and older: 18,359,568

Estimated population 65 years and older: 2,635,390

Estimated population 18-64 yrs (calculated): 15,724,178

Estimated proportion of population 18-64 yrs with income < poverty level:
15.0% +/- 0.1%

(U.S. population 18-64 yrs with income < poverty level: 13.7%, +/- 0.1%)

NSDUH (National Surveys on Drug Use and Health):

2012 estimates 9.6 million adults 18+ with SMI in past year;

This represents 4.1% of all U.S. adults

(www.nimh.nih.gov/statistics/smi_aasr.shtml)

SAMHSA: Mental Illness in past year aged 18 or older, in Texas (annual averages based on 2008 and 2009 NSDUHs):

Serious mental illness: 4.3% (95% CI, 3.7%-5.0%)

Any mental illness: 19.6% (95% CI, 18.0%-21.2%)

(http://oas.samhsa.gov/2K11/078/WEB_SR_078.cfm)

Calculated:

Using 2012 NSDUH est. adult rate of SMI on the est. adult population of Texas:

$$15,724,178 * 4.1\% = 644,691$$

Using SAMHSA est. adult rate of SMI on the est. adult population of Texas:

$$15,724,178 * 4.3\% = 676,140$$

NAMI:

2010 estimates, ~833,000 adults in Texas live with serious mental illness ("Holzer, III, C.E. and Nguyen, H.T., [psy.utmb.edu.](http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93522),

<http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93522>")

[Charles E. Holzer III, Retired professor from UTMB at Galveston; "primary focus is psychiatric epidemiology and mental health needs assessment."

www.linkedin.com/pub/charles-e-holzer-iii/1a/707/61a]

National Health and Nutrition Examination Survey (NHANES-III): prevalence of dysthymic disorder was significantly higher among Blacks and Latinos Frank and Glied (2006): "mental illness is 'uniformly highest' among the poor"

The other problem is that most mental illness/substance abuse surveys do not include persons who are incarcerated, hospitalized, or otherwise institutionalized. A study by Steadman et al (2009), reported by Torrey et al. (2010), conservatively estimates that 16% of inmates have a serious mental illness.

My Comment Will Be Made Public: I agree