THE RATIONING OF PUBLIC MENTAL HEALTH SERVICES IN HOUSTON

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

PREFACE 5

I. INTRODUCTION 6

II. MENTAL ILLNESS IN HOUSTON 8

III. MENTAL HEALTH SERVICES IN HOUSTON 9

IV. MENTAL HEALTH SERVICE RATIONING IN HOUSTON 14

V. RATIONING RATIONALE 24

VI. RATIONING WEAKNESSES 27

VII. ALTERNATIVES TO CURRENT RATIONING STRATEGIES 30

VIII. RECOMMENDATIONS 33

APPENDICES

A. EXECUTIVE SUMMARY OF “THE CONSEQUENCES OF UNTREATED MENTAL ILLNESS IN HOUSTON” 43

B. EXECUTIVE SUMMARY OF “PUBLIC FUNDING FOR MENTAL HEALTH SERVICES IN HOUSTON: A FINANCIAL MAP” 44

C. AREAS OF CONCERN 45

THE RATIONING OF PUBLIC MENTAL HEALTH SERVICES IN HOUSTON

EXECUTIVE SUMMARY

This report analyzes the rationing of public mental health services in Houston. The substantial shortage of these services necessitates that they be rationed. Medicaid entitlements and Children's Health Insurance Program (CHIP) benefits are rationed according to income level (indigency) and/or the severity of the disability. Texas general revenue (GR) funds are largely dedicated to children with serious emotional, behavioral, or mental disorders and adults with diseases of schizophrenia, depression or bipolar disorder, and/or have a Global Assessment of Functioning (GAF) score of 50 or below. The Harris County Hospital District rations care by providing services on a first come-first served basis and by scheduled appointments as treatment staff becomes available. In Houston (as in Texas) mental health services are rationed in favor of the severity of conditions and indigency. This policy results in late term interventions when early intervention would have been much more clinically effective and cost effective.

This report finds that the most important actions needed to address rationed services are those actions that make rationing unnecessary. The following recommendations are made: 1) expand access to Medicaid and CHIP, 2) create an organized continuum of care between the Mental Health and Mental Retardation Authority (MHMRA) and the Harris County Hospital District (HCHD), 3) increase access to K through 12 school-based mental health care, 4) divert all nonviolent people with severe mental illness from the Harris County Jail to mental health services, and 5) expand MHMRA's role as a convener of Houston's major mental health service providers in order to promote greater service coordination.

Each of these recommendations is revenue neutral for Texas and Harris County. They do involve major cost shifts to achieve greater service capacity. If aggressively implemented, these recommendations will greatly reduce the need to ration public mental health services in Houston.

PREFACE

This report is the third in a Mental Health Policy Analysis Collaborative (MHPAC) series that collectively analyze the status of services for people with mental illness in Houston. The first report entitled, “The Consequences of Untreated Mental Illness in Houston” reviewed the substantial insufficiency of services in the Houston area. Over 93,000 Houstonians with severe mental illness cannot access public or private service systems. Untreated, they suffer consequences including the increased likelihood of suicide; a shortened lifespan (by 25 years), poor performance in school, job loss and increased juvenile and criminal justice involvement. Furthermore, all Houstonians are affected by mental illness in some way. More than 1.4 million Houstonians (or over 1/3 of the total population) are within the close social network of a person with a severe mental illness. Marriages, families, schools, jobs and businesses are all negatively impacted. Houston loses more than $5.6 billion dollars yearly in productivity and annual earnings as a result of severe mental illness.

MHPAC’s second report entitled, “Public Funding for Mental Health Services in Houston: A Financial Map” analyzed federal, state, county and city funding of public mental health services. It found that these funding streams are dedicated almost exclusively to support services for people who are indigent and severely mentally ill or emotionally disturbed. Most importantly it found that by devoting almost exclusive funding to support (downstream) late-term services to people who are severely ill, (upstream) early intervention for these people is either underfunded or non-existent. The report stated that “this has created a largely crisis and criminal justice driven mental health service system that forces people to cycle from crisis to crisis” (p.13).

This current report entitled, “The Rationing of Public Mental Health Services in Houston” analyzes the public policy rationing mechanics that drive the funding streams described above. After a review of these policies along with an overview of the current thinking on health service rationing, this report provides recommendations that, if implemented, would greatly reduce the need to ration mental health services in Houston.

I. INTRODUCTION

The rationing of health services is a common practice affecting all people irrespective of their economic or insurance statuses. All private insurance policies contain information on covered conditions and treatments (i.e., benefits). These policies also specify which conditions and treatments are not covered. The extent to which a medical treatment is covered by insurance determines an insured person's economic access to treatment. Public insurance (Medicaid, CHIP, Medicare, etc.) follows the same model as private insurance. Both private and public insurance are, in essence, medical service rationing methodologies.

Public (tax supported) health service systems such as the Harris County Hospital District (HCHD) and the Mental Health and Mental Retardation Authority (MHMRA) have four primary sources of revenue support. These are private insurance, public insurance, personal patient resources and state and Harris County tax-based appropriations. Private insurance and personal resources represent a very small portion of the budgets of these organizations. By far, federal benefit programs together with state and county appropriations make up the majority of operating revenues for these public health agencies.

Public policies define how these public revenues are to be spent. Like insurance benefit packages, these policies designate who will have access to which services, under what conditions and for how long. **Health service rationing is primarily accomplished by regulating service eligibility (access) and available types of services (capacity).** An understanding of eligibility and service policies is imperative to the understanding of rationing.

This report will primarily describe Texas General Revenue (GR), HCHD and Federal (Medicaid and CHIP) mental health service rationing policies and methodologies. It will provide an overview of the magnitude of treated and untreated mental illness in Houston, the legislative, state and county administrative contractual directives for service rationing and the rationale for these directives. An evaluative analysis will provide an assessment of the strengths and weakness of rationing methodologies, and some proposed remedies to these current approaches.

It is hoped that this report will stimulate broad-based public discussions on the positive and negative aspects of Texas' current mental health policies and procedures. Improvements in Texas mental health services will be expedited by a better informed, more vigorous, outcome oriented dialog between elected officials, advocacy organizations, service consumers and their families, service providers and the general public.

II. MENTAL ILLNESS IN HOUSTON

In the greater Houston area[1] in a given year there are over 660,000 people with some form of mental illness. Of these over 181,000 have a mental illness that seriously impairs their ability to effectively function in their daily lives. Over 93,000 of these children and adults with serious mental illness cannot access needed mental health services from either the public or private service sectors. The two primary reasons for this access failure are the lack of personal funds to purchase services and a shortage of public mental health services for people who are indigent (Schnapp, Burruss, Hickey, Mortensen, & Raffoul, 2009b).

The consequences of insufficient mental health treatment include an increased severity of illness, familial and societal disruption, a loss of employment (concurrent loss of income and health insurance), homelessness, juvenile and adult criminal justice involvement and shortened life span (Schnapp, Burruss, Hickey, Mortensen, & Raffoul, 2009a).

An awareness of the inadequacy of appropriated funds to meet the needs of all people with mental illness has caused elected officials to develop policies that prioritize mental health benefit eligibility and ration service access.

[1] In this report the term Houston and Greater Houston Area refer to Harris County, Texas

III. MENTAL HEALTH SERVICES IN HOUSTON

Mental health services in Houston are funded by private and public sources. Private funds come primarily from “out of pocket” payments and private health insurance. Public funds come from federal, state, county and city tax-based sources and philanthropic organizations.

Texas ranks 49th in the country in mental health service expenditures per capita (Aron, L., et. al., 2009). MHMRA, Houston’s primary state-supported mental health service provider, ranks 35th out of 38 community mental health centers in Texas in per capita funding. Thus it is not surprising that Houston is substantially underfunded from public sources. It is generally believed that people with adequate insurance and/or private resources can acquire the mental health services they desire. Their needs are presumably met by a sufficient private mental health service sector. Indigent and/or underinsured people must try to obtain services from the limited public sector sources. This report will focus on public sector services and their rationing methodologies.

In order to evaluate the adequacy of Houston’s mental health services it is necessary to compare the need with Houston’s capacity to meet that need. The following is a review of Houston’s major pubic mental health service sector components. While other smaller providers of mental health services collectively offer important care, the following organizations are by far the largest.

Houston’s major primary public mental health service providers include the MHMRA, the University of Texas Harris County Psychiatric Center (UTHCPC), the HCHD, the Michael E. DeBakey Veteran’s Affairs Medical Center (VA), the Harris County Jail, Rusk State Hospital (RSH) and the public schools. While other agencies provide some public mental health services, these agencies deliver the overwhelming amount of tax-supported care. It should be noted that Medicaid and CHIP pay for a substantial amount of services. People with Medicaid or CHIP may choose to receive services from any of these public providers or from the limited group of private providers who will accept Medicaid. The services of MHMRA, HCPC, RSH, and HCHD are all subject to rationing. Through eligibility criteria Medicaid and CHIP are also subject to rationing. These agencies and benefit programs will be examined in this report.

MHMRA is funded primarily from state General Revenue funds, Harris County revenues and Medicaid. It provides crisis services (the NeuroPsychiatric Center, or NPC), outpatient care, residential services and some rehabilitative services. MHMRA's estimated outpatient service capacity is 8,200 adults and 1,600 children per month. Since many of these are chronic cases engaged in ongoing care, over the course of a year fewer than 12,000 adults can be served with existing resources, and no more than 4,000 children will fit within the service agency capacity of this public mental health agency. It is important to note that this capacity estimate does not mean that these adults and children are receiving all the services that they need. These are MHMRA estimates of basic service provision. Basic services include crisis care, some outpatient care and medication if needed.

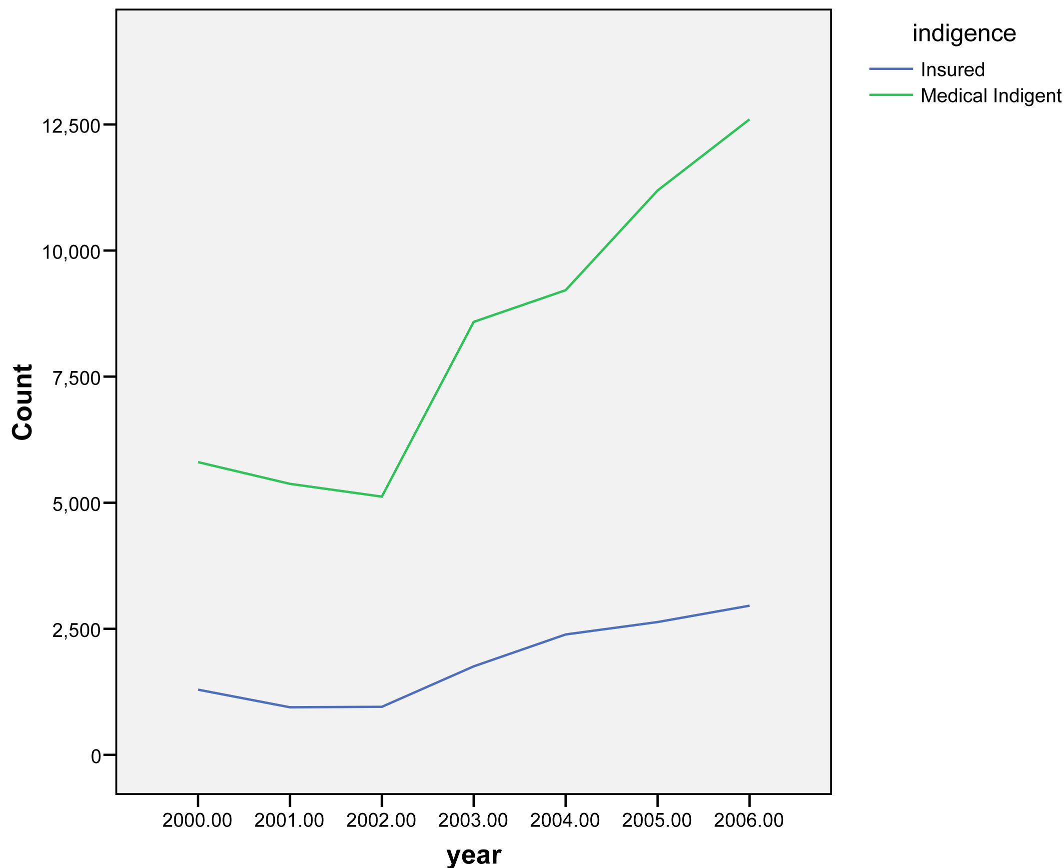
The UTHCPC is a 250-bed (maximum capacity) inpatient facility owned by the State of Texas and Harris County. In 2008, UTHCPC had 192 beds in operation. Fifty-eight beds were closed due to lack of funds. Recent legislative action will allow UTHCPC to open additional beds. MHMRA provides oversight to UTHCPC; the University of Texas, Department of Psychiatry of the Medical School at Houston, directly administers it. Various funding streams support UTHCPC. In 2008 it had an average daily census of 177 patients and had 5,077 inpatient admissions. Its average length of stay is 7.7 days for children and adolescents and 10.5 days for adults. UTHCPC offers short-term inpatient psychiatric services. UTHCPC also provides inpatient services by way of contracts with the Harris County Jail, Juvenile Probation and Children's Protective Services. These additional units have varying lengths of stay.

The HCHD offers a full range of inpatient and outpatient medical services. A large amount of mental health care is provided by primary care and other, non-psychiatric, clinicians. A 2005 analysis revealed that approximately 20 percent of all visits within the HCHD were coded with a primary or secondary behavioral health diagnosis. Specialty psychiatric services are offered at the Ben Taub Psychiatric Emergency Center (with a throughput of almost 500 acute psychiatric evaluations per month), at the Ben Taub Mental Health Service 20-bed inpatient unit, and at sixteen of the District's outpatient clinics.

There is a direct relationship between mental health service availability and the prevalence of mental illness in jails. Mental health treatment appears to reduce the prevalence of mental illness in the criminal justice system, (Abramson, 1972; Jemelka, Trupin, & Chiles, 1989; Schnapp, 1998; Torrey, 1992). Insufficient mental health services in Harris County have caused a high prevalence of mental illness in the Harris County Jail. Currently, of about 9,500 detained people, there are in excess of 2,500 people in this jail who are receiving psychiatric medication. The Jail's special psychiatric inpatient unit has a bed capacity of 143 with 24 additional dedicated beds at the UTHCPC. The prevalence of mental illness in the Harris County Jail appears to be increasing each year (see Table 1). There appears to be no rationing of mental health services in the Jail.

Rusk State Hospital (RSH) and the other state hospitals provide longer-term inpatient services to Harris Country residents through a contract with the local mental health authority. MHMRA is budgeted for 171 patients to be treated within the state hospital system on any given day. RSH is subject to the same rationing mechanisms as MHMRA and UTHCPC.

Table 1: Harris County Jail Treatment Episodes for Inmates with Mental Disorders x Year x Medical Indigence



SERVICE CAPACITY

Mental health service capacity is difficult to precisely define. Two complex issues contribute to this problem. People with mental illness exhibit a wide array of help or service-seeking behaviors. Many who need care will not seek it for many reasons such as: 1) they are not aware that they need help (due to their mental illness); 2) they find the side effects of their medications too bothersome; 3) they have sought help, but find service access to be a complex and difficult task; and 4) they find the stigma attached to being a consumer of mental health services to be negative. Each of these reasons can be addressed through client/patient and public education. A study found that less than 40 percent of people with untreated serious mental illness received stable treatment (Kessler, Avenevoli, & Ries Merikangas, 2001).

Optimal capacities are often surpassed as increasing numbers of people attempt to access services; increases in demand stress service providers. An analysis of capacity is further complicated by the interactions of various services within the mental health service continuum. Inpatient and outpatient services address differing clinical needs and levels of severity of illness. As with other forms of illness, people with mental illness may need hospitalization on occasion, though, at other times, they are best served on an outpatient basis. There is a dynamic relationship between these two services. Ideally a person in need of inpatient care would receive it and then would later be treated on an outpatient basis. Patients whose outpatient needs are not met due to limited outpatient capacity or failure to seek services at the appropriate time often become more ill and exhibit an increased need for crisis and inpatient services. Adequate outpatient capacity substantially reduces the need for inpatient services.

Insufficient inpatient and outpatient services greatly increase the need for crisis care. A system that is predominantly crisis-based is inherently ineffective. People with mental illness are often trapped in a cycle from crisis to crisis. Not only is this clinically ineffective but also cost-ineffective. As with all illnesses, a balance of inpatient, outpatient and crisis services is best for people with mental illness.

In an ideal service system, the capacity for each could be estimated more accurately. However, as has been noted, Houston's public mental health system is far from ideal. The outpatient inadequacies greatly increase the need for crisis care and inpatient care. This then causes our inpatient and crisis capacities to be inadequate. Substantial increases in Houston's public outpatient capacity would lessen the demand for inpatient and crisis services. Despite this fact, expanding outpatient care would not eliminate the need for some expanded inpatient capacity, nor would an ideal system eliminate crisis care.

All these interrelated issues confound efforts to make precise estimates of needed services. However, the Mental Health Needs Council (MHNC) in Houston has developed a model for estimating the approximate number of people in need of services who are unable to acquire them. Utilizing this methodology **it is estimated that over 14,000 children and adolescents with severe mental illness cannot access either the public or private mental health systems in Houston** (Mental Health Needs Council, 2009).

Further, an estimated 79,300 adults with severe mental illness cannot access the public or private systems (Mental Health Needs Council, 2009). This lack of access is caused primarily by insufficient capacity, the inability to purchase needed services and the failure of some people with severe mental illness to seek services.

The overwhelming unmet needs for public mental health services have led public officials to develop rationing methodologies for accessing these services.

IV. MENTAL HEALTH SERVICE RATIONING IN HOUSTON

Public mental health services in Houston are defined by the policies that govern the various funding streams that support them (Schnapp, et al., 2009b). The primary funders of these services are federal (Medicaid and CHIP), Texas (General Revenue), and Harris County (tax revenue). The following is an overview of the policies of each of these funding sources. It should be noted that each source contains rationing directives.

CHIP and Medicaid

Medicaid is a joint federal-state public health insurance entitlement program for people who meet both the financial criteria for low-income and an eligibility category (children, parents of dependent children, pregnant women, people with disabilities, and elderly). CHIP is a state program funded by block grants to provide insurance coverage for children in families with incomes too high to qualify for Medicaid but too low to purchase private or employer-sponsored coverage. (For an expanded description of these programs please see MHPAC's report "Public Funding for Mental Health Services in Houston, 2009" (Schnapp, et al., 2009b).

Access to both of these programs is rationed in multiple ways. Both programs are means tested. For example, working parents in Texas have to earn less than 27% of the federal poverty level to be income-eligible for Medicaid; jobless parents can't have incomes higher than 13% of the federal poverty level.

Medicaid access has historically also been rationed according to the severity of one's disability. Access is limited to those people who have had a disability that reaches a level of "medical necessity" for at least one year and the disability interferes with basic work-related activities. Medical necessity is subject to medical determination. The significant variance in accepted Medicaid applications from state to state and city to city raises questions as to the consistency by which medical necessity is determined.

Perhaps the greatest factor influencing the rationing of these programs is the amount of state dollars the state chooses to spend. State expenditures on Medicaid are matched with federal program dollars according to the states Federal Medical Assistance Percentage (FMAP). Federal dollars match the dollars the state chooses to spend; if states choose to be frugal with their Medicaid spending, the overall program capacity shrinks proportionally. Similarly, a state can choose to not spend all of the block grant dollars allotted to them for the CHIP program.

States who choose to reduce their match may limit access to CHIP or Medicaid by (1) making the application process more difficult; (2) requiring frequent certification renewal applications; (3) deleting certain services from the list of those approved for payment and (4) reducing the types of service providers who can bill for CHIP or Medicaid services.

The recent enactment of The Patient Protection and Affordable Care Act (Public Law 111-148) will expand health care access to many previously uninsured Houstonians. People with mental illness are especially affected by this act in multiple ways. Two of the most important of these are the simplification and enhancement of the enrollment process for Medicaid and a substantial broadening of the eligibility criteria. Medicaid access will be simplified and expedited to a much larger number of Houstonians. Many additional people will have access to needed mental health care.

When access procedures and service benefits are appropriate, CHIP and Medicaid provide access to health care for many people who would otherwise have only limited crisis based health programs to rely on.

Texas General Revenue Funded Mental Health Services

The Texas Legislature establishes policies that define priorities for the use of state appropriated GR funds for people with mental illness. These policies govern MHMRA,UTHCPC and RSH GR funded services. The current mental health treatment priorities for state funded services were defined in House Bill 2292 which was passed into law by the 78th Session of the Texas Legislature in 2003. HB 2292 amended Section 2.75 subchapter B, Chapter 533 of the Health and Safety Code by adding Section 533.0354. **DISEASE MANAGEMENT PRACTICES AND JAIL DIVERSION MEASURES OF LOCAL MENTAL HEALTH AUTHORITIES.**

Section 533.0354 of the Texas Health and Safety Code states:

> DISEASE MANAGEMENT PRACTICES AND JAIL DIVERSION MEASURES OF LOCAL MENTAL HEALTH AUTHORITIES. (a) A local mental health authority shall ensure the provision of assessment services, crisis services, and intensive and comprehensive services using disease management practices for **adults with bipolar disorder, schizophrenia, or clinically severe depression and for children with serious emotional illnesses** (p. 170).

The current performance contract between the Texas Department of Health and the Mental Health and Mental Retardation Authority of Harris County which dictates the use of Texas GR dollars in Houston contains the following directives.

Section I: Statement of Work

B. Adult Services

2. Populations Served

a) Adult Mental Health (MH) Priority Population – Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

b) Adult MH Target Population – Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression, (page15).

Subsection I B(2c) Initial Eligibility amplifies the above directive by adding in II B(2c):

(2) "…that the individuals who have diagnoses other than those listed above (schizophrenia, bipolar disorder, and severe depression) and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services…" are also eligible for service (page 15).

Directives for children in MHMRA's Performance Contract are as follows.

Section I Statement of Work

C. Children's Services:

2. Populations Served

a) Child and Adolescent Mental Health (MH) Priority Population – children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive development disorder) who exhibit serious emotional, behavioral, or mental disorders and who:

(1) Have a serious functional impairment; or

(2) Are a risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or

(3) Are enrolled in a school system's special education program because of serious emotional disturbance" (page 20).

In addition to the policies above community mental health authorities in Texas are expected to give service access priority to people discharged from State (Hospital) Facilities, people in crisis, and people with Medicaid and people involved with either the juvenile or adult criminal justice systems. Responsibility for State Facility discharges is a long standing priority of MHMRA. The provision of crisis services has also been a traditional service for decades. Crisis services have received strong financial support by the past two general sessions of the Texas Legislature. Priority status for Medicaid beneficiaries is a Performance Contract directive. Lastly, diversion from juvenile and criminal justice involvement has been given high priority for mental health authorities for over a decade. Additional GR funds to support diversionary services are provided by the Texas Correctional Office on Offenders with Medical and Mental Impairments.

MHMRA of Harris County is directed by legislation and historical precedent to spend its GR funds on:

1. People with severe mental illness, especially people with schizophrenia, bipolar disorder, and major depression and/or have a Global Assessment of Functioning (GAF) score of 50 or below;
2. People in psychiatric crisis;
3. People who have been recently discharged from a State Facility, and
4. People with mental illness who are involved with the juvenile or criminal justice system.

Occasionally, confusion has arisen concerning which adult population MHMRA is mandated to serve with GR dollars. The MHPAC analysis of the above legislation is as follows:

1. Subsection (A) of Section 533.0354 of the Texas Health and Safety Code states in part that "…a local mental health authority (LMHA) shall ensure the provision of…services using disease management practices for adults with bipolar disorder, schizophrenia, or clinically severe depression." (page 15).
2. Subsection (A) of Section 533.0354 clearly directs LMHAs to provide services to people with diagnoses of bipolar disorder, schizophrenia or clinically severe depression.
3. While subsection (A) of Section 533.0354 does not preclude LMHAs from serving people with diagnoses other than the three mentioned disorders it does by specifically naming bipolar disorder, schizophrenia and severe clinical depression give these named disorders a certain degree of priority in ranked access to service.
4. In compliance with the above legislation the Texas Department of Health performance contract (governing the use of appropriated GR dollars) with LMHAs states: "Section I Statement of Work, B. Adult Services, Population Served a) Adult Mental Health (MH) Priority Population—Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment"(page 15).

5. Subsection 1 B c (2) states that the people who have diagnoses other than these listed above (schizophrenia, bipolar disorder and severe depression) "…and whose current Global Assessment of Functioning (GAF) score is 50 or less and need on-going MH services"… are also eligible for service (page 15).
6. While complying with Section 533.0354 these sections of the performance contract clearly opens the door permissively for LMHA's to serve people with additional heretofore unnamed mental disorders as long as they are "severely disabling…" and "…require crisis resolution or ongoing and long-term support and treatment…" and/or have a "GAF score of 50 or less" (page 15).
7. Therefore LMHA's may use GR dollars to serve people who have "severely disabling mental disorders" other than bipolar disorder, schizophrenia or major depression as long as these people have other disorders that "…require crisis resolution or ongoing and long-term support and treatment"… or have "…a GAF score of 50 or less…."
8. Restated briefly, Section I B (2a) of the LMHA performance contact allows for the use of GR dollars to pay for crisis services and ongoing and long-term support and treatment services for people with severely disabling mental disorders and/or a GAF score of 50 or less in addition to bipolar disorder, schizophrenia, and major depression.
9. However, Section I B(2a) is immediately followed by "… b) Adult MH Target Population—Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe depression…"
10. By giving the three primary diagnoses "Target" status they clearly have priority over other unnamed diagnoses.
11. This preponderance of service intent is further established by Section 533.0354 Sub Section (A) of the Health and Safety Code[2].
12. Despite the permissiveness to serve additional disorders in Section I, B 2 a) of the LMHA performance contract it is clear that "Population Served" and "Priority Population"

[2]However, the current Performance Contract (2010) has removed sanctions against serving people who do not have target status.

from the Safety Code and "Target Population" from the Performance Contract mean that bipolar disorder, schizophrenia, and major depression have service priority over other mental disorders.

13. The priority status of these three disorders is especially important in a rationed service system.

Clearly according to legislation and GR Performance Contracts LMHA's should not serve people with non-target diagnoses while there are substantial numbers of people with target diagnoses on wait lists for services.

Harris County Hospital District

The HCHD is funded through a combination of federal (Medicare, Upper Payment Limit, Disproportionate Share Hospital, Direct and Indirect Medical Education), state (Medicaid/CHIP, tobacco settlement, traffic fine program), and local (Harris County ad valorem taxes) resources. In comparison to state GR dollars in the MHMRA system, these funding streams have fewer policies specifying the manner in which they are used. Medical necessity and standard-of-care are always important considerations driving the decisions about diagnoses to be included or excluded and treatment paradigms. Local service needs are then taken into account and balanced against the available budgetary resources to establish the exact quantity and variety of care that is available. The array of diagnoses and treatments is formalized in a Schedule of Benefits. The Schedule of Benefits, coupled to the quantity and location of providers, determines the HCHD's rationing of all healthcare, including mental healthcare.

The design of the HCHD model for routine care does not call for waiting lists. In fact, there is not now, nor has there ever been, a list created on which potential patients await their turn to engage the system, though there may be waiting lists for specific services such as elective surgery. The distribution of care would best be characterized as a **"first come, first served" model in which anyone eligible for services can receive an appointment for care, but that appointment might**

be some time away in the remote future. The advantage of this strategy is that it provides for some care for anyone who is willing to wait his/her turn. No one is excluded from care all together. A drawback is that it does not ensure a minimum level of care for anyone.

Of course, there is at all times a relief valve for the most acutely ill. The emergency services of the HCHD evaluate and treat approximately 8000 patients with exacerbations of their mental illnesses on an annual basis.

Funding Source Interaction

Federal funding streams, begun largely in the 1960s, have evolved as primary insurance programs for indigent people who are disabled. State funding patterns were largely developed in isolation from federal policies. **While sharing a federal indigence orientation, state eligibility has largely been diagnostic and severity driven.** Federal-state funding policy coordination may be evident in the desire of most states to shift the cost of state funded programs to federal resources. Cost shifting occurs when states seek to shift the expense of service provision from state (i.e., GR) to federal funds (i.e., Medicaid and CHIP). State funded budgets are offset by the acquisition of federal funds. This common state practice began in the late 1990s. A direct consequence of cost shifting occurs when states' mental health budgets decrease or fail to increase when additional federal funds are acquired. The result is often a zero sum gain.

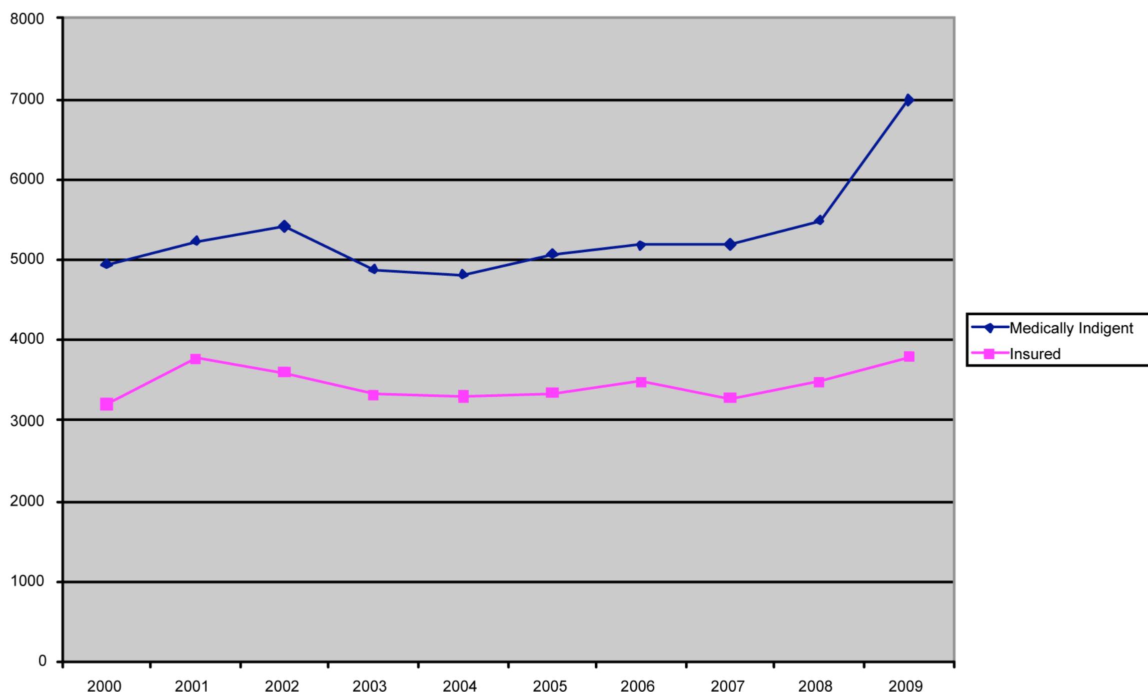
County funds are only partially coordinated with federal and state funds. The County matches (at a reduced rate) state GR funds. These matching dollars fund MHMRA and UTHCPC and are primarily directed to serve GR target populations. However, the HCHD and jail mental health funds are for the most part directed to people who are indigent and mentally disabled. Anecdotal evidence suggests that, in general, the HCHD serves a more acutely ill population than MHMRA's and UTHCPCs traditional chronic patients.

The consequences of the above described disparities in funding directives include substantial differences in service access, type and duration depending on which funds a person with mental

illness can access. **At virtually all service sites, people with Medicaid or CHIP benefits enjoy easier access to services than their non-Medicaid or non-CHIP peers.** Hospital District patients need not fit the rigid diagnostically driven criteria that GR patients must meet. People with severe mental illness leaving the Harris County Jail may or may not acquire Medicaid or be eligible for GR driven services. These discrepancies tend to increase service fragmentation and consequently reduce needed service continuity and collaboration.

When closely examined federal, state, and county funds primarily serve people who are indigent and severely ill. The demand for needed services is growing with Houston's increasing population and with a rapidly expanding group of uninsured people. As demand increases and service system capacity remains stable access is diminished. Service waiting lists grow, causing service wait time to increase proportionately. MHMRA now has a waiting list for outpatient services that exceeds 800 people. Most of these people will wait in excess of 3 months for an outpatient appointment. Denied access to needed service, people with already severe mental illnesses go into crisis, seek services in already strained emergency trauma centers (Begley, Burau, Courtney, Hickey, & Rowan, 2008) and are at increased likelihood of criminal justice involvement (Abramson, 1972; Schnapp, 1998).

Table 2: Individuals Served in Crisis Programs x Medical Indigence x Year



As the number of unserved and underserved people grows so grows the demand for services. Traditionally policy makers (such as the Texas Legislature in its past two sessions) have met this challenge by increasing funds for crisis services. As the number of people being served in mental health crisis grows, the need to provide these new patients with inpatient and outpatient care grows proportionately. Without concurrently expanding needed non-crisis mental health core and wrap-around services (medication, case management, outpatient, and rehabilitation services), people are forced into a repeated cycle of crisis. This cycle is both clinically ineffective and cost ineffective. This cycle begins when mental health services are built on a policy foundation that restricts access to services only to the people who are the most severely ill and indigent. Most of the funding streams mentioned above are prescriptive concerning who can be served, how they can be served, and for how long. This rigidity is often inappropriate for a population of people who are generally not 'cured' (they are chronically ill), often unstable (the severity of their illnesses fluctuates), and often have comorbid conditions (i.e., chemical dependence and other physical illnesses)) requiring treatment. The challenges posed by these illnesses are often exacerbated by homelessness and criminal justice involvement, which necessitate an even more complex policy and funding stream coordination.

INSUFFICIENT UP STREAM SERVICE INTERVENTIONS = **High utilization of more costly less effective interventions such as crisis care and juvenile and criminal justice involvement**

Exclusively focusing on people with severe illnesses, while inadequately addressing the needs of the moderately ill, creates an ever increasing population of severely ill people.

V. RATIONING RATIONALE

When demand for public services exceeds the supply of services public officials have several options. First, they may increase funding for services in order to expand the capability of the service system to meet the increased demand. Second, they can establish a policy of ‘first come --first served’ and turn excess people away or delay their treatment. Long waits for service may result in deterioration in health status or death raising concurrent health, ethical, legal and political dilemmas. The third option available to public officials who are confronted with shortages of health services is to develop a system to ration care. This third option—rationing—is more viable than the first option when health funding is insufficient and is potentially more structured than option two.

Rationing is the most common health care delivery strategy in America. In the private service sector a person’s ability to pay (through insurance and/or private funds) is often the primary determinant of access to care. In the public sector (where people typically do not have private insurance and have limited personal resources) access to care is generally determined by publically funded entitlements (e.g., Medicaid, Medicare, CHIP) and/or the public system’s capacity to serve indigent people who have insufficient resources.

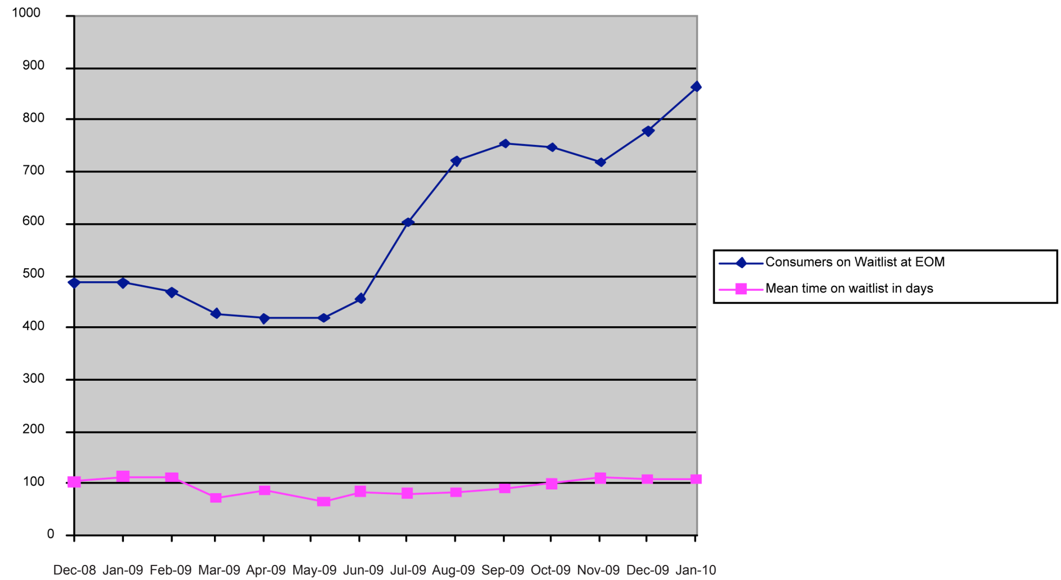
The rationing of limited public health resources is usually driven by two strategies. The first strategy is based upon the severity of the illness and the likelihood of survivability. In time of low to moderate demand for public services, simple logic often suggests that people with the most life threatening conditions are given priority treatment status. In times of high demand for health services the concept of ‘triage’ is sometimes relevant. Triage divides patients into three groups “1) those who cannot be expected to survive even with treatment; 2) those who will recover without treatment; and 3) the highest priority group of those who need treatment in order to survive” (Steadman’s Medical Dictionary (1990), 25th edition, p. 1628). Groups 1 and 2 are made as comfortable as possible while group 3 receives the majority of medical attention and resources. Current high demand for medical services by people who are indigent together with current service inadequacies cause a variant of triage to be practiced in Houston at this time. The most dramatic evidence of this can be found in the high utilization of trauma (emergency) services in Houston over the past decade.

Paradoxically, by giving highest priority to the treatment of people with the most severe forms of mental illness (Schnapp, W.B., Burruss, J. W., Hickey S., Mortensen, K., P.R. Raffoul, 2009b) Texas practices a form of triage that addresses the needs of people that could be said to be in Group 1[3]. While the rationale for this policy is obviously more humane (treatment of the most in need) it creates an ever expanding population of increasingly ill people as groups 2 and 3 are given low service priority access. The consequences of this policy are analyzed in the next section of this report.

The second rationing strategy common to public health services are policies and procedures that give people with federal benefits (Medicaid, Medicare, CHIP, etc.) increased access to care. These people utilize their federal benefits to pay for needed services. In addition, Texas legislation (The Health and Safety Code) gives them direct access to care. By utilizing federal dollars (actually combined federal and state matching dollars) Texas shifts the costs of health care for these people. By giving high access priority to people with benefits they become more desirable patients than people without benefits. People with these benefits can access private sector services. Public service systems (like all health service systems) have a capacity determined caseload. While some flexibility exists in most systems, all systems can eventually reach a point of maximum capacity. Many public health services in Houston operate at close to maximum capacity at all times.
The service waiting list data supports this fact. By quickly accessing services people with benefits consume services that could have been utilized by another (potentially more ill) person. It is in this manner that benefits status affects service rationing.

[3]While most of these people will certainly survive, in the literal sense, their illnesses may prevent the return to pre-morbid levels of functioning even with the most effective treatment.

Table 3: Adult Consumers on Waitlist and Length of Time on Waitlist x Month



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10
Consumers on Waitlist at EOM	486	486	468	427	417	419	456	603	721	754	747	718	778	863
Mean time on waitlist in days	104	114	112	72.6	87.4	64.7	85.4	81.3	83.2	91.2	101	112	109	109

Triage and benefits both define public health care rationing. They both affect who will access treatment and who will not. Both of these strategies affect public mental health service rationing in Texas. In Section III it was noted that in Texas we also ration public mental health services by type of diagnosis, crisis status, recent inpatient discharge and juvenile or criminal justice involvement. While there are possible justifications for all of these rationing strategies there are also negative, predictable, unintended consequences incumbent in each approach. In rationed health care there are, by definition, beneficiaries and non-recipients of service for each policy. There are human and economic costs and benefits. In the rationing of mental health care the informed, thorough, open and exhaustive evaluation of policies is an ethical and humane imperative.

VI. RATIONING WEAKNESSES

The primary weakness of publically supported mental health services in Houston is their profound insufficiency to meet the current service needs of many Houstonians who are the most severely ill. More than half of the 181,000 children and adults with serious mental illness cannot access either public or private services. The primary reason for this lack of access is insufficient funding. The amount of public mental health services in Houston is simply not adequate to meet treatment needs. This creates the necessity for rationing policies. The enormity of our mental health service needs demand that our rationing methodologies:

- Maximize our service capability within current budgetary constraints
- Utilize evidence-based best service delivery and treatment practices
- Provide the greatest good for as many people as possible
- Are ethically determined and applied.

Our current approach to rationing publically GR supported mental health services are for the most part based upon the following assumptions:

- Service access is based upon severity of need.
- Severity for adults is primarily defined (for MHMRA, UTHCPC and RSH) by diagnosis (the target population is designated as having schizophrenia, depression or bipolar disorder) and low Global Assessment Functioning score (50 or below).
- Severity for children and adolescents is defined as serious emotional illnesses with functional impairments.
- These severity based criteria often are synonymous with policies that give high priority to the treatment of people during the acute phase of chronic disorders.
- By emphasizing severity of illness as a primary service access criteria people whose illnesses appear to be less severe (as is sometimes the case with the early stages of diseases which increase in severity over time) are given low service access priority.
- Some people must wait for their illnesses to substantially worsen before they can receive treatment (see Table 3).

- Current GR funding strategies give high priority to crisis services. This practice has resulted in mental illness crisis services being the most accessible (least rationed) public mental health service in Houston.
- People with severe mental illnesses who are involved with either the juvenile or criminal justice systems are given high priority for GR supported mental health services.

HCHD services are rationed on a “first-come-first served” basis. While HCHD does not maintain a service waiting list, long waits for certain treatments are not uncommon.

All rationing of health services has consequences. The primary consequence of the current Texas GR rationing policy is that it gives highest service access priority to people who are the most severely ill. While there are medical and ethical principles (i.e., utilization of limited resources for those most in need) that support this policy, it is potentially flawed and produces consequences. Medical triage illustrates this flaw. As noted above, triage is a rationing strategy for situations in which medical resources are insufficient to meet the needs of large groups of people with varying levels of illness severity. In traditional triage people with severe but treatable illness are given higher service priority than those with terminal illnesses or those with minor illness.

The ways in which triage is applicable to mental health GR policies in Houston are as follows:

- Public services are certainly insufficient to treat all people with mental illness in Houston; therefore, certain people will most certainly go unserved.
- Many mental illnesses become progressively more severe without treatment
- Early treatment intervention produces the best health outcomes.

The logic of the three points above suggests that our current rationing policy that emphasizes priority treatment for the most severely ill (while neglecting those with less severe illness) creates a vicious cycle. This practice results in an ever increasing population of people with moderate mental illness who are unserved (because they have not yet reached target population severity status). Many of these people will become more severely ill and then be allowed to access treatment.

Many will lose their jobs, their families (through divorce) and their homes. The likelihood of their involvement in the juvenile or criminal justice systems will increase.

This practice is clinically ineffective. It is inhumane. It is very costly. It violates the principle of triage by refusing to treat those people who could most benefit from early treatment intervention.

Logic (and triage) appears to tell us to give highest priority to those who will most readily (and effectively) respond to our limited treatment resources. However, to do so would mean abandoning the people who are the most severely mentally ill and therefore the most vulnerable. This action would almost certainly mean substantial increases in suicide, trauma utilization, involuntary psychiatric commitment and juvenile and criminal justice involvement. Clearly it is an action we are unwilling to take.

Texas' current GR rationing methodology does effectively target people with severe mental illness by emphasizing the three specific diagnoses. Some feel that the target population should be expanded by including Post Traumatic Stress Disorder or by disregarding diagnoses altogether and replacing them with functionality measures. The problem with each of these ideas is that they increase the number of people eligible for GR supported services. This defeats the purpose of rationing. In order to minimize access to a system that currently has waiting lists the target population should shrink, not expand.

VII. ALTERNATIVES TO CURRENT RATIONING STRATEGIES

It is important to note that the best action that Texas can take concerning the rationing of mental health services is to sufficiently fund these services so that rationing is not necessary. Numerous reports of the Mental Health Needs Council, advocacy organizations and MHPAC have all documented Houston's huge unmet mental health service needs and the individual and community consequences of an insufficiently funded treatment system. Our current highly restrictive rationing approach of publically funded services, together with MHMRA's growing service waiting list, are undeniable evidence of the substantial underfunding of public mental health services in Houston. **The best action we can take on service rationing is to make it unnecessary by increased access to needed services for all people who need them.**

The second most important step we can take on mental health service rationing is to utilize our current funding more effectively.

We should also consider the wisdom of triage. We do not recommend abandoning people with the most severe mental conditions. We do suggest that providers of mental health services give high priority to strategic early intervention as a primary treatment orientation for all mental health care. Certainly greater attention should be given to early illness detection and intervention for both children and adults. Not only is this more clinically effective, it is also more cost effective as well. Over time substantial savings should be realized in reductions in inpatient utilization and juvenile and criminal justice involvement.

Early intervention should not just be a concern in the treatment of children and adolescents. **Early intervention should be an orientation that permeates all mental health services.** Early intervention should include early detection, rapid effective service response, interagency coordination to insure appropriate timely service, and services structured to facilitate the movement of people to services of varying intensity. Early intervention is an orientation that should be applied to any person with mental illness regardless of the severity of their illness or the point in time of

their first contact with mental health services. **Rapidness of response with aggressive treatment intervention should be the guiding principle of Houston's public mental health services.**

Obviously more funding would increase the effectiveness of the service orientation described above. However, the current downturn in the economy will almost certainly obviate increases of new dollar appropriations. **The challenge is to implement early aggressive intervention without additional dollars. Revenue neutral service change is rarely an easy process.**

New important revenue neutral activities include: increased mental health and health interagency strategic planning, coordination and collaboration (especially between MHMRA and HCHD), increased coordination between the mental health service system and K-12 school-based services, increased coordination between the mental health and juvenile and criminal justice systems, increased integration of the mental health and substance abuse service systems and increased communication and collaboration between the public mental health service sector and academic institutions involved with health and social service education and research. We can do much more with current levels of funding by increasing multi-institutional and agency communication and collaboration.

Early intervention initiatives can be greatly facilitated by shifting revenues from ineffective practices to activities that produce positive results. Possibly, the area of the greatest waste of public dollars lies in direct and indirect activities involving the incarceration of non-violent juvenile and adult offenders with mental illness. Incarceration is one of the most expensive activities funded by public dollars. Prosecution and court costs are also expensive activities.

Houston has been a leader in addressing this problem for over forty years. Arguably Houston has the best mental health service and criminal justice interface in America. However, well over 25% of the people in the Harris County Jail have a mental illness. The majority of our allotment of State (hospital) Facility inpatient beds is filled with people pending trial competency restoration. The majority of dollars that support the incarceration and competency restoration of non-violent

offenders with mental illness could be better spent treating people more effectively. Houston's past expertise in this area coupled with the current leadership of the Harris County Judge, the District Attorney and MHMRA should continue and complete their current efforts to redesign our approach to treating people with mental illness who become involved in the judicial system.

Great unrealized opportunities for improvement in early intervention exist in our K through 12 school systems. Most mental illnesses show some symptoms by age 14. Well trained and resource supported teachers and schools could make a huge impact on the early recognition and treatment of mental illness. Numerous reports such as " Disrupting the cradle to prison pipeline" (American Leadership Forum, 2009); "Texas' School-to-Prison Pipeline, " (Texas Appleseed, 2007) have mapped the path from unrecognized and untreated mental illness in K through 12 schools to juvenile and adult criminal justice involvement. Schools have a federal mandate (PL 94-142) to provide an appropriate education to all children regardless of their disability. Many teachers receive little or no training in cognition and behavior disorders. Often children with mental illness are inappropriately labeled as 'bad' and are punished. This practice only exacerbates a child's mental illness and may hasten juvenile justice involvement.

All school teachers should be trained to recognize mental illness. Teachers should be trained to effectively manage children with less severe mental illnesses. **Schools should create internal (in school) social service and mental health treatment capabilities.** Federal, state and local educational public funding streams should be examined to identify the funds necessary to implement this already legislatively mandated activity. Adequately resourced, well-trained teacher led mental health sensitive academic activities would produce healthier children who will become healthier adults. Appropriate schools would substantially reduce the numbers of people in need of GR supported mental health services. This in turn would reduce the need for mental health rationing.

The following section utilizes the above alternatives to craft recommendations to reduce the need for mental health service rationing in Houston.

VIII. RECOMMENDATIONS

Rationing of mental health care in Houston is necessary because of substantial underfunding of services. The current economic downturn likely will cause reductions in many Texas GR funded activities. United States health care reform legislation has recently been signed by President Obama. A review of current reform efforts suggests that even with the most positive of outcomes, indigent people with severe mental illness may continue to experience difficulties in accessing health care, housing and basic social services. The substantially unresolved situations in Austin and in Washington make accurate policy prediction and analysis difficult. However, it is possible to formulate basic recommendations that could greatly improve mental health services in Houston which would reduce the need for rationing irrespective of what actions Austin or Washington might take. **Each of the following recommendations will save money by capturing increased funding and/or improving service delivery effectiveness. By spending the money we have more wisely we can exponentially increase our treatment capability.**

Entitlements for Houstonians

All Houstonians who are eligible for CHIP and Medicaid benefits should receive them. These benefits pay for needed health services. They are funded through a federal-state matching mechanism which produces a greater return on Texas dollars. As a result of Medicaid's matching arrangements , the benefits of spending on Medicaid are larger than state spending alone (Marks & Rudowiz, 2009). Federal Medicaid matching dollars support jobs and generate income in the state, creating a multiplier effect. Each dollar that Texas spends on Medicaid is matched by $2.33 in federal funds. This figure is currently closer to $3.40 due to temporary stimulus funding (Marks & Rudowiz, 2009). This produces a 233 percent gain. People with Medicaid or CHIP funding access a rich array of mental health services that negate the need for Texas to pay for most of their care.

The new health care reform legislation (P.L. 111-148) is especially economically attractive to states in that federal funding for new eligible recipients starts at 100 percent and phases down to 90 percent by the year 2020. This means that Texas will be completely reimbursed for Medicaid

enrollment and services for new enrollees for at least several bienniums and will pay only a 10 percent match by 2020.

It is true that both of these programs require states to pay up front dollars. However, past experiences in Texas and other states have shown the positive effects of funding these programs as well as the negative effects of underfunding them (Marks & Rudowiz, 2009).

The newly enacted health care reform legislation does broaden the eligibility to Medicaid. However, historically a large percentage of people with severe mental illness have had difficulty in negotiating the Medicaid eligibility process. PL 111-148 mandates that programs to assist all people who are eligible are to be expanded and/or created.

Medicaid and CHIP support both their beneficiaries and the programs that serve them. **Potentially the most important action that Texas public officials can take to reduce the need to ration health care is to expand and enable access to these entitlement programs.** Increased access to the entitlements should be a legislatively mandated and funded strategy.

Service Access and Expansion

The service capacities of MHMRA and HCHD could be substantially expanded by increased collaboration between these agencies. One of the primary reasons for MHMRA's growing waiting list is that it does not have sufficient services to which stabilized patients may be referred for ongoing care. Even with MHMRA's current GR rationing methodology, the number of eligible people seeking care far exceeds MHMRA's service capacity. As more people seek care and fewer people are discharged, MHMRA's capacity fills and its waiting list continuously expands. This situation could be rectified.

A natural division of labor exists between MHMRA and the HCHD. MHMRA specializes in the stabilization and ongoing treatment of people who are severely mentally ill and need intensive treatment. The Hospital District can easily treat patients who are stable and require little more than medication maintenance. MHMRA and the HCHD could collectively create a continuum of care

whereby MHMRA stabilizes and treats patients who require intensive treatment and HCHD cares for patients who need little more than ongoing medication maintenance.

This arrangement would free up the outpatient treatment capacity at MHMRA on a continuing basis. The increased workload on the Hospital District would be minimal given that it has already increased its mental health treatment capability. The only major extra cost for the District lies in the provision of medication for the patients transferred by MHMRA. This expense could be managed by an expansion of the Prescription Assistance Program or an increase in either the MHMRA or the HCHD budgets. Budget neutral funding for this and other budgetary increases are made possible by savings realized from jail diversion.

The MHMRA-HCHD collaboration described above could be ongoing and fluid. Patients could move back and forth between both agencies as their needs shifted. Both agencies represent Harris County's largest mental health providers of public services. While MHPAC believes that both of these agencies should maintain their current administrative and budgetary integrity, their services could be better coordinated. The shared patient arrangement described above would require interagency collaboration to insure continuity of care and continued service coordination. Clearly HCHD and MHMRA working in close concert will benefit more people with better services at a lower overall cost.

Exercising the Right to Education

Federal law mandates that each child in America has a right to a free and appropriate education. Children with mental illnesses and/or other cognitive impairments that impair their ability to receive an education must receive those services necessary to enable them to be educated (PL 94-142). Simply put public schools must provide the therapeutic habilitative or rehabilitative services to children who require them to receive an education. Students with untreated mental illness obviously have a difficult time meeting the intellectual and social demands of school. These students often perform poorly in class and have trouble interacting with teachers and classmates.

It is not uncommon for these students to be inappropriately labeled as having disciplinary problems deserving of punishment and/or expulsion. Students who have problems in school are at increased odds of involvement with juvenile probation authorities. Adolescents who are involved with juvenile probation have an increased likelihood of involvement in the criminal justice system as adults. **The journey from unmet childhood mental health service needs to adult prison incarceration can be avoided by early intervention that includes early recognition and treatment of mental illness by K through 12 school teachers.**

Public schools are well situated to identify mental illnesses in children. Furthermore, they have a legal responsibility to provide these children with the therapeutic services necessary to facilitate in their educational processes.

Federal, state and local funding streams support Houston's public schools. If schools fully embraced their responsibility to provide mental health and social services to those children who need them (as mandated by PL 94-142), Houston's mental health service capacity would be increased substantially. Huge expenses involving the juvenile and criminal justice systems could be avoided.

Anecdotal evidence suggests that most public schools in the greater Houston area are not prepared to take on additional responsibilities for mental health services. Despite legal responsibility (PL 94-142) and the need for action, this area remains one of the greatest unmet mental health service opportunities in Houston.

School districts should be strongly encouraged to fully embrace their responsibilities to implement PL 94-142. This upstream action, perhaps more than any other, could positively affect Houston's mental health treatment capability.

The Decriminalization of Mental Illness

The correlation between insufficient mental health services and juvenile and criminal justice involvement has been continuously substantiated for decades (Jemelka, R., Trupin, E. & Chiles, J.A., 1989; Schnapp W. B., 1998 and Torrey, E.F., et. al., 1992). Simply put, access to comprehensive mental health services often prevents children and other people with mental illness from becoming involved in juvenile or criminal justice systems. This is especially true of those individuals who have committed misdemeanor offenses (such as trespassing, petty theft and vagrancy). Treatment prevents behaviors that otherwise cause criminal acts.

Despite the good intentions of law enforcement and mental health agencies there are currently over 2,500 people with serious mental illness in the Harris County Jail. Despite the efforts of the Houston Police Department Crisis Intervention Team (CIT) officers, front door screening at the jail, and other initiatives, many people with serious mental illness (who are guilty of non-violent offenses) continue to end up in jail. Many of these people are guilty of petty offenses that usually result in sentences requiring relatively short jail time. It is noteworthy that for each of these people the following costs accrued: police time including arrest and transportation to jail, jail intake and processing, pre-trial interviews and processing, trial activities including time spent by judges, prosecutors, defense attorneys, court recorders, sheriffs, and jurors, and jail housing and meals. Some jail inmates receive mental health services. Some of these must be assessed for their competency to stand trial. All of these activities, when aggregated across increasing numbers of people become extraordinarily expensive. Jail housing costs begin at $40 a day and escalate to over $480 per day as more intensive mental health services are provided.

Using conservative cost estimates (Harris County Office of Budget Management, “Estimated Harris County Jail Detention Costs,” December, 2008), the annual cost for caring for the County’s incarcerated people with mental illness exceeds $48,000,000. These costs are more than twice as high as the cost of outpatient care to these same people (Hickey & Nguyen, 2007). Additional incarceration costs (arrest, transportation, jail booking, pretrial and judicial—judge, prosecution and defense attorneys) greatly expand this cost estimate.

Currently certain specially trained CIT police officers divert some people directly to the mental health system (usually to the Neuropsychiatric Center (NPC), or the Ben Taub Emergency Center). Yet many people with mental illness who are guilty of nonviolent petty crimes are still arrested, incarcerated in the jail and continue through the criminal and judicial process.

An expanded police identification and diversionary process (to the mental health service system) could avoid arrest, jail and court costs. By expanding our mental health treatment capacity we could avoid more expensive non-effective criminal justice involvement. This action would build upon Houston's already existing mental health and criminal justice collaboration. Specifically, this collaboration should facilitate 1) enhanced diversionary policies; 2) increased CIT police training to promote early identification (of people with mental illness); 3) the development and implementation of the capability for officers to communicate with MHMRA in real time to determine a person's past mental health service system involvement, and 4) a step-by-step measured transfer of jail appropriated dollars to pay for needed mental health service expansion at MHMRA and HCHD. **Adoption of these recommendations would result in more positive clinical outcomes for more people, increased jail diversion (and a concurrent reduction in the jail census) and an overall Harris County criminal justice—mental health cost reduction.**

Strategic and Continuous Collaboration

People with severe mental illness often need an array of medical and social services. Usually these services are delivered at different locations from different providers and are often paid for by different funding sources. The effective coordinated management of complex service provision is imperative for good patient care.

Mental health service coordination is often best facilitated by a case manager whose primary job is to facilitate the implementation of a complex treatment plan and to promote patient compliance.

Mental health service coordination complexity increases exponentially by the size of the population to be served and the number of services and providers involved. Simply put, the effective management of a mental health service system for tens of thousands of people with severe mental illness who are often indigent and require multiple services supported by multiple funding streams is very difficult. The management of such a system requires a singularly directed entity fully committed to the delivery of services to people with mental illness.

The MHMRA is the organization in Harris County charged with the provision of safety net mental health services. As Harris County's Mental Health Authority, MHMRA is well suited to facilitate interagency communication and coordination on an ongoing basis. Houston's geographic size, large population (especially its large uninsured population) and multiple service providers and stake-holders are all factors that combine to create a pressing need for a single agency to promote interagency collaboration. The multiplicity of public funding streams supporting Houston's mental health services (See MHPAC's "Public Funding for Mental Health Services in Houston: A Financial Map (Schnapp, et al., 2009b) make interagency coordination and collaboration a vital imperative.

MHMRA should be charged with the responsibilities of: (1) routinely convening the leadership of Houston's major mental health and substance abuse providers to promote increased service collaboration and (2) the publishing of a yearly interagency strategic plan that identifies service insufficiencies, and delivery problems. It should propose solutions for identified problems. In addition, MHMRA should specifically promote mental health service and budgetary coordination between MHMRA, HCHD, UTHCPC, the Harris County Jail and Harris County Juvenile Probation. While MHMRA and other organizations currently communicate and coordinate their efforts, the implementation of the above recommendation would formalize interagency coordination and promote increased collaboration.

Conclusion

The five recommendations above address:

- Expansion of Federal benefits (CHIP and Medicaid) for children and adults
- Expansion of MHMRA's and HCHD's treatment capabilities
- Major increases in mental health services to children in school
- Diversion of nonviolent people with mental illness from the criminal justice system
- Ongoing coordination and collaboration by Houston's major providers of public mental health services.

If all eligible people received Medicaid and CHIP; if all children who need mental health treatment to facilitate their education received it; and if nonviolent people with mental illness were diverted from jail, then funding for the necessary expansion of MHMRA and HCHD services would be produced without additional GR or County revenues.

The collective implementation of these recommendations would substantially increase Houston's capability to effectively treat people with mental illness. Service waiting lists should be greatly reduced. More services should be delivered in a timely fashion to more people. Our current need for service rationing policies reflects the severe limitations of our current service capabilities.

The implementation of these recommendations along with the implementation of federal health care reform will eliminate the need for our current restrictive GR rationing methodology. When this occurs the mental health of all Houstonian's should be greatly improved.

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APPENDIX A

Executive summary of

The Consequences of Untreated Mental Illness in Houston

This report analyzes the effects of mental illness on the people of Houston. One of every five Houstonians (665,000) has a mental illness. Of these, 181,690 have a serious mental illness. Texas ranks 49th in state per capita mental health funding, and Harris County (greater Houston) ranks among the lowest in Texas counties. The consequences of an insufficiently funded public service system include economic loss, homelessness, increased juvenile and adult criminal justice system involvement and about a 25-year decrease in life expectancy.

Mental illness affects all Houstonians in some way. More than 1.4 million Houstonians (or over 1/3 of the total population) are within the close social network of a person with a severe mental illness. Marriages, families, schools, jobs and businesses are all negatively impacted. **Houston loses more than $5.6 billion dollars yearly in productivity and annual earnings as a result of severe mental illness.**

Serious mental illness can be effectively treated by medical and social services. Substantial scientific advances have been made in treatment and in service delivery. Houston has the technology and the methodology to greatly improve the lives of hundreds of thousands of its citizens.

It is hoped that this report stimulates discussions that will culminate in a substantially better understanding of mental illness and the reform that Houston needs and deserves.

APPENDIX B

Executive summary of

Public Funding for Mental Health Services in Houston: A Financial Map

This report reviews and analyzes the federal, state, county and city funding streams that support public mental health services in the greater Houston area. The relevance of this report is founded on the premise that public policy is implemented by funding directives that, in turn, create the policy's intended outcomes. The mechanics of these policy driven funding directives dictate service access, type, capacity, duration, delivery and administration. Simply put, policy directs funding and funding defines services and their delivery.

In Houston, the majority of federal, state, county and city mental health funding streams are dedicated almost exclusively to support services for people who are indigent and/or severely mentally ill or emotionally disturbed. Furthermore, most state and county funding streams are prioritized to support people in crisis, people recently discharged from psychiatric hospitals and children with juvenile justice involvement as well as adults who are involved in the criminal justice system.

Large numbers of people receive time and service intensity limited care that addresses their current crisis but does little to affect their long-term needs. **This has created a largely crisis and criminal justice driven mental health service system that forces people to cycle from crisis to crisis.**

Current policies and their incumbent funding streams often produce outcomes that are effective only in the short term. Ultimately they are not clinically or cost effective for meeting longer term needs of people with chronic mental illness. This situation could be alleviated by greater access to Medicaid, CHIP and increased access to a greater variety of outpatient services for longer periods of time.

APPENDIX C

Areas of Concern

This brief section addresses three policy areas of concern. A review of service delivery and funding issues in other states suggests that Texas exercise caution in the following areas of mental health public policy reform.

Budgetary Cuts

The current downturn in the economy has reduced state revenues. Many state agencies have already been asked to make a mid-biennium 5% fiscal cut in their current operations. Reports suggest that the next regular session of the Legislature will have to make major reductions in current appropriation levels.

MHPAC has documented Houston's substantial unmet mental health service needs along with the severe consequences of untreated mental illness in its report: "The Consequences of Untreated Mental Illness in Houston" (Schnapp, et al., 2009a). These consequences affect both people who are ill and those who are not. These consequences affect the physical and economic health of our city.

In 2003 the Texas Legislature faced similar (but not as severe) budgetary deficits to those facing the next session of the Legislature. In 2003 CHIP and Medicaid state matching budgets were cut. Additional cuts were made to the Health and Human Services Commission budget further reducing services and access for many disabled children and adults.

Fortunately, many of these reductions have been restored in subsequent years. CHIP and Medicaid enable many Houstonians to access health services. Without these federal-state entitlements many people with severe mental illness would be totally dependent upon Harris County resources. Harris County has suffered the same revenue short falls as Texas.

Future reductions in CHIP and Medicaid will most assuredly cause the same outcomes as were experienced from the 2003 cuts. Limited County resources will be sought by a growing population of indigent people. County and City trauma centers will be filled by people who could not acquire health services from any other source. As more people with mental illness are unable to find needed medical treatment the census of the Harris County Jail will rise proportionately.

Failure to adequately fund and implement CHIP and Medicaid will deny people the timely (early intervention) access to needed services. The likely results will be dramatic increases in the needs for more costly mental health inpatient care and juvenile and criminal justice services.

Clinical and Cost Effective Mental Health Services

Effective treatment of mental illness often requires both medical and social services. Research in support of this fact has been abundant for well over 50 years. Yet managed health care, begun in the early 1990's, largely emphasized medical care as the primary (if not only) billable expense in health care service provision. Needed social services (case management, rehabilitation, housing, transportation, etc.) were often seen as non-medical services and therefore of less importance than activities that physicians performed. This managed care phenomenon caused two negative outcomes. First, funding streams to pay for social services have been de-prioritized relative to traditional medical services. Second, primary providers of social services (social workers, nurses, physicians' assistants and psychologists) have often been viewed as being of less importance to mental health treatment than physicians.

Traditionally, these providers have been referred to as physician extenders. In ideal treatment settings they along with physicians collectively form a treatment team capable of effectively meeting the multiple needs of people with chronic mental illness. In that these physician extenders are less costly (than physicians) they are often important cost effective service providers.

The treatment of people with severe mental illness is most effective when all of their primary medical and social service needs are met. Multidisciplinary teams are well suited to meet these

multiple needs. Service systems that excessively rely on physicians to practice social work are often both cost ineffective and clinically ineffective.

A February 2006 report of the Texas Department of State Health Services entitled, “Highlights of the Supply of Mental Health Professionals in Texas” (Center, 2006) found that Texas faces a shortage of psychologists, psychoanalysts, social workers, licensed professional counselors, licensed chemical dependency counselors, marriage and family therapists, psychiatric nurses and psychiatrists (pg. 1). Perhaps most bothersome is the tendency to reduce employment opportunities for physician extenders in times of budgetary short-falls. Mental health care is most effective when it meets a person’s medical and social service needs delivered by multidisciplinary teams. Budget cuts that reduce physician extender positions are often ineffective.

Service Privatization

Public mental health services paid for with public tax dollars should be delivered by organizations that are the most capable of delivering the best services in the most cost effective manner. During the majority of the past 200 years indigent mental health services have been delivered by state or local public agencies. Often, these agencies were not funded sufficiently to care for the people they were directed to serve. Publically funded services were delivered by public (non-profit) entities largely because they were directed to do so by public policy. Furthermore, no financial incentive existed for profit driven organizations to serve this population.

By the early 1990’s states began to rely on Medicaid to support increasing amounts of public mental health care. Medicaid is an individual entitlement that allows for its recipients to receive services from any provider who will accept Medicaid. Over the past fifteen years an increasing number of states have sought to rely on “private behavioral health care companies to manage Medicaid mental health care” (Frank & Glied, 2006, p. 8).

The privatization of heretofore public mental health services has produced varied outcomes. A 2005 literature review entitled, "Overview of publically funded managed behavioral health care" (MBHC), found "while managed behavioral health care can lower costs and increase access, ongoing concerns about MBHC include potential incentives to under-treat those with more severe conditions due to the nature of risk-based contracting, the tendency to focus on acute care, difficulties assuring quality and outcomes across recipients, and a potential cost-shift to other public agencies or systems"(Coleman, 2005) p. 321). Another article found that "…states that have privatized some of their mental health services have not realized their intended results…." (Progressive States, 2010) , p. 2).

A statement of the American Academy of Child and Adolescent Psychiatry includes the following "In a climate of limited resources, many states have shifted state and federal med funds away from these community-based clinics to private insurers and managed behavioral health care organizations. This method of "privatizing" has had a number of unintended consequences. In these instances, it has led to the fragmentation of treatment services by eliminating interdisciplinary teams and interagency programs. It has shifted service burdens and costs to other child serving agencies (such as education, child welfare and juvenile justice), while diminishing the quality of services for children and adolescents. Children who are dependent on publically funded health services (particularly poor and underserved) are disproportionately affected" (American Academy of Child and Adolescent Psychiatry, 2009).

Publically funded mental health services providers should have as their highest priority the effective provision of therapeutic care to those people they are directed to serve. Both high quality clinical care and cost effective service delivery are very important.

Though always underfunded, the Texas public mental health service system consistently has sought to maximize the dollars it was given to serve as many indigent Texans with severe mental illness as possible. Privatization of substantially under-funded mental health services creates a dilemma for both service providers and service recipients. Patients, certainly not profits, have been, and should continue to be, the central focus of Texas' mental health public policy.

Texas should undertake a thorough and completely independent programmatic and financial evaluation of the benefits and complete costs of its managed mental health programs and should consider the lessons learned by other states before it makes major changes in its state mental health funding policies.

These three areas—State funding of CHIP and Medicaid, physician extenders and privatization—all affect service rationing. They each deserve increased attention by policy makers, service providers and advocates.

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