

Analysis for Ten-Year Plan for the Provision of Services to Persons Served by State Psychiatric Hospitals (SPHs)

Consulting Services for DSHS Rider 83 RFP No. 529-14-0066



Report Prepared for the Department of State Health Services (DSHS)

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Consulting Services Regarding DSHS Rider 83 RFP

Final Report

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Section 13. Appendices

Appendix A: Methodology, List of Interviewees and Stakeholders

This report presents data from several sources, including extensive data collection, onsite facility tours and interviews, focus groups, surveys and interviews with DSHS staff. The full methodology is described in greater detail below, including survey and interview protocols, data collection techniques, and data analysis as presented in this report.

Interview Process

The team also interviewed a number of people at each SPH, totaling 88 interviews. The purpose of the interviews were two-fold: (1) to verify and clarify data analysis and (2) to collect additional descriptive information about SPH priorities, policies, and programs. Almost all interviews were conducted in person or onsite. When possible, interviews were conducted with two members of the project team present, to allow for more detailed notes and follow-up questions.

Data Collection

An exhaustive data request was issued at the beginning of this engagement, requesting data from the system, facility, and campuses. Data regarding historical trends, census, financials, campus, and building information, staffing, resident demographics, quality measures, and previous reports and assessments was reviewed as part of the report production.

Onsite Tours and Observations

Facility tours of all SPHs were conducted: North Texas State Hospital – Vernon, North Texas State Hospital – Wichita Falls, Terrell State Hospital, Big Spring State Hospital, El Paso Psychiatric Center, Kerrville State Hospital, Austin State Hospital, San Antonio State Hospital, Rio Grande State Hospital, Rusk State Hospital, and the Waco Center for Youth. In depth facility and real estate assessments were conducted at Rusk State Hospital, North State Texas – Vernon, and San Antonio State Hospital.

Electronic Survey and Data Capture

In addition to interviews and focus groups, CannonDesign fielded an electronic survey (e-survey). The e-survey was designed to corroborate the key findings that emerged from the focus groups and to broaden the number of stakeholders who gave input into the ten year “vision” for Texas State Hospitals. The online survey was completed by 648 stakeholders.

Focus Group Protocol and Process

CannonDesign completed 7 focus groups with 47 stakeholders and conducted interviews with four Senior Department of State Health Services (DSHS) staff. The organizations CannonDesign invited to participate in focus groups follows below. The focus group sessions lasted for 1.5 hours and were limited to 15 participants.

The organizations that received an invitation to have their constituents participate in a focus group included:

- Behavioral Health Advocates of Texas
- County Judges and County Commissioners Association of Texas (CJCCAT)
- Disability Rights, Inc.
- HB3793 Workgroup
- Local Authority Network Advisory Committee (LANAC)
- Mental Health America of Texas (MHA/TX)
- National Association for the Mentally Ill of Texas (NAMI/TX)
- Texas Council of Community Centers (Local Authorities)
- Texas Association of Counties (TAC)
- Texas Catalyst for Empowerment
- Texas Council of Urban Counties (CUC)
- Texas Hospital Association
- Texas Medical Association
- Texas Sheriffs Association
- Texas Society of Psychiatric Physicians
- The Central Texas Regional Planning Workgroup

CannonDesign drafted focus group moderator guides and reviewed these with DSHS staff. During focus groups, the moderator asked participants to provide their perspectives on accessibility to behavioral health services, safety in State Hospitals, and quality of care. Specifically the moderator asked participants what they thought Texas' behavioral health system's greatest needs are, what barriers to obtaining needed services exist, and what role State Hospitals should play in Texas' behavioral health system in the next ten years. The focus group moderator also asked participants whether changes to current state law or policies were needed in order to meet Texan's behavioral health needs.

Weekly Updates and Prioritization Meetings

Weekly meetings throughout the duration of this project were held with the DSHS leadership. The purpose of these meetings was to review work to date and recommendations. In addition, several onsite visits in Austin took place in July 2014 to present initial forecast impact factors, prioritize key impact factors, and determine the future vision.

Appendix B-1: Qualitative Findings – Focus Groups

In the sections that follow, the themes that emerged related to current and future care model(s), human capital, and community needs are discussed. It is important to note that stakeholders' qualitative perceptions and priorities did not always align with the quantitative data collected by the CannonDesign team.

Care Model Themes

A number of themes related to current and future models of care emerged. Inadequate funding was a primary theme voiced by virtually every stakeholder who participated in a focus group. The next most frequently cited care model themes were the limited availability of services in the community for individuals leaving SPH (i.e., continuum of care) and lack of coordination between physical health services, substance abuse treatment, and behavioral health services both within SPHs and in the community. Other themes included the growing demand for forensic (i.e., criminal justice-related) commitments to SPHs and the need for housing and meaningful employment for persons with behavioral illness.

“Why isn’t our mental health system funded like our medical system? The lack of funding has become a public safety issue, not just a public health issue.”

Psychiatrist

Funding

When asked about Texas greatest behavioral health system need virtually every focus group participant cited the need for increased funding. Participants often noted the fact that Texas remained 50th in the nation for behavioral health funding per capita in fiscal year 2013.

Many participants believe funding constraints have resulted in SPHs being in a perpetual state of diversion because the facilities are at capacity. Several participants also noted that although some state-funded inpatient behavioral health facilities may have empty-beds, these beds could not be filled because of insufficient funding to “staff the beds.”

Many participants stated that the lack of funding caused inefficiencies in the system. Noting that the failure to fund sufficient community-based services, both preventive and intensive services, resulted in behavioral health services being delivered in the two of the most expensive settings for behavioral health services: SPHs and county jails. With additional funding for more intensive community-based services such as crisis management/stabilization and jail diversion programs people could remain in the community where treatment is much less costly than services provided in state funded inpatient facilities participants emphasized.

“State hospital beds were cut with the promise that people [with mental illness] would be able to get services in the community. We have turned our backs on these people.”

County Official

Finally, a number of focus group participants laid the blame for insufficient funds on a lack of vision and leadership. One participant put it this way, “We have a political climate that looks at

two-year returns. So if they don't see cost avoidance in that time they don't want to fund it. It takes five to ten years to show cost reductions."

Medicaid Waivers and Incentives

Participants made quite a few suggestions to improve the Texas' funding situation. Several focus group participants suggested Texas obtain a Medicaid Waiver like the Home and Community-based Services (HCS)

Waiver for persons with Intellectual and Development Disabilities (IDD). The HCS Waiver allows persons with IDD to receive services in the community based on a plan of care. Services under the HCS Waiver may include housing, medical, and special therapies to meet the needs of those enrolled in the Waiver.

"Looking 10 years down the road, these adults with SMI were children once. We have to start there."

Psychiatrist

Affordable Care Act

Focus groups with medical providers, acute care hospital representatives, and advocacy organizations all mentioned the Affordable Care Act (ACA). These participants pointed out that behavioral health services are covered under ACA and stated that Texas' failure to partake in ACA put Texans with serious behavioral illness at a great disadvantage.

A parent of a daughter with serious behavioral illness said:

ACA would have made a huge difference for the behaviorally ill adult population. My daughter gets \$730 month and if she gets \$56 more she's knocked off Social Security Disability Income (SSDI). She's stuck in poverty. As the saying goes, "She can't pay for eats or sheets."

Family Member

Continuum of Care

Stakeholders noted that Texas' behavioral health system lacks a range of services or continuum of care to appropriately serve the state's severely behaviorally ill population. This theme is closely related to the lack of funding in the system.

Participants stated that the current care model focuses on inpatient services making few resources available to stabilize people in the community. Participants noted there are many

"Had [persons with mental illness] been able to get the right services at the right time, we would have a robust and price-effective system."

Behavioral Health Provider

diverse options for keeping people out of the hospital all requiring better access to community services with more levels of care so that people get the right care at the right time.

Among the services the participants believe are absent or in short supply in the community are:

- Crisis Residential Services/ Beds

- Community-based Crisis Stabilization Units
- Day and Half-day Programming
- (Jail) Diversion Programs
- Half-way Housing
- Pre-employment/Job Skills Training
- Life-skills Training
- Mobile Outreach
- Navigators
- Peer Support
- Recovery-Oriented Treatment
- Step-down Residential
- Targeted Case Managers
- Telemedicine

The absence or shortage of short-term crisis beds, results in many more people being admitted to SPHs for short-term stabilization, even though, the participants stated, these services can be provided more cost-effectively in the community. There was widespread agreement that the state needed to change its focus and fund services like telemedicine and other technologies and programs that would provide more treatment options particularly for rural communities.

The lack of appropriate services in the community like half-way houses, follow up care after an ED visit, and crisis respite, participants said, often leads to consumers cycling in and out of SPH or jails.

Limiting Factors

Stakeholders stated that Texas' strict licensure limitations on who can provide what services hampered the development of community services. For example, a Texas hospital cannot provide crisis treatment outside of an emergency room because regulations do not permit them to do so. This prevents the use of hospital-based crisis management teams going into a person's home.

One psychiatrist raised the issue of a federal law that prohibits medical providers from prescribing drugs via telemedicine. Thus, preventing a private physician from managing a resident's medication remotely. It should be noted that clinics and hospitals are exempt from this prohibition.

“The key barrier is money. The little state money there is goes to inpatient beds. The balance needs to shift back toward more funding for crisis stabilization and other community services.”

Community MH Advocate

Finally, participants urged the state to include preventive services starting in childhood in the behavioral health continuum of care. They cited the model Texas uses for to address obesity, diabetes, and smoking which provides education and prevention services starting in childhood.

Coordination of Care

Participants listed coordination of care among the entities that touch the lives of people with serious mental illness (SMI) as one of the keys to improving the effectiveness of Texas' behavioral health system. They identified the need for improved coordination between DSHS or the SPHs and other state agencies including the Texas Department on Aging and Disability Services (DADS), the Texas Department of Protective and Family Services (DPFS), Texas Workforce Commission (TWC), Texas Department of Assistive and Rehabilitation Services (DARS), and Texas Veterans Commission (TVC). Participants also suggested that DSHS' Behavioral Health Services and the Hospital Services Units do not coordinate or collaborate sufficiently with the agency's own Substance Abuse Services Unit.

Further focus group participants asserted little communication or coordination between DSHS and the local mental health authorities exist. Many stakeholders including local authority representatives, sheriffs, and county officials, felt inadequate communication between the local authorities and DSHS made it much more difficult for individuals transitioning from the SPHs back to the community to do so successfully.

Participants also cited the lack of coordination and collaboration between private behavioral health entities and public entities as a significant problem. This is problematic because those with SMI often exhaust their insurance coverage. These individuals may be transferred to a SPH for care from a private facility. The lack of continuity from one system to the other causes inefficiencies and may result in diminished treatment outcomes.

“We need to coordinate and integrate [mental health] with the medical community. Now if there is a medical emergency the SH has to call 9-1-1.”

Psychiatrist

Participants contended DSHS also needs do a better job of coordinating with local law enforcement, schools, and acute care hospitals. They identified a need for widespread education and training for law enforcement officials and school faculty and staff. However, one participant noted the Texas Legislature passed legislation last session requiring schools to provide training to teachers, counselors, and others in the detection of behavioral or emotional disorders,

but the training requirement did not come with funding.

Participants talked about the lack of access to the medical services at some SPHs. One participant noted that consumers used to be able to get whatever they needed on the SPH campus. However, the state dismantled that system and now when someone needs medical or dental care they have to go to the community. This participant noted that it is very costly to do this and claimed this resulted in SPHs refusing to take individuals with serious medical issues because they cannot provide the medical services needed.

Privatization and Private Sector Incentives

In order to increase the numbers and types of community services participants suggested encouraging and incentivizing the private sector. Many thought that financial incentives would encourage acute care hospitals to staff both short and long term psychiatric beds. They stated that even with incentives it would cost less for the private sector to deliver short-term crisis care than for a SPH to do so and the resident could be served closer to home.

Participants also suggested tax incentives and limiting liability to make Texas a more attractive market for private firms to develop needed psychiatric services.

Safety

County officials, sheriffs, and medical providers struck a theme of public safety or mitigation of risk. The perception in the community is that the system is not addressing safety issues when the judge releases someone with behavioral health issues. While there was overall consensus among participants that individuals with SMI should be served in the community, county officials expressed concerns about serving forensic consumers (i.e., those with a criminal history) in the community because of potential liability.

County officials claimed that when a judge releases someone with behavioral health issues the perception in the community is that the system is not addressing safety issues. County officials expressed the need for “secure” or locked facilities for such individuals thus eliminating true “step-down” facilities as these are not generally locked. Others said if services were available when and where people needed them, safety issues would be significantly reduced.

“When Harris County jail is the largest mental health facility in the state, it says something about our priorities.”

County Official

Many participants expressed concern about people with SMI who assault a peace officer or commit a second offense against a family member because these are felony offenses. A felony offense makes it harder for the individual to obtain work or housing, two key factors for successful reintegration in the community.

Further, a felony conviction may limit opportunities to pursue a higher education. Individuals can be effectively shut out of opportunities for recovery and pushed to depend on public aid or become involved in illegal activity as a result of a conviction. This has led some defense attorneys to avoid felony charges by pushing for competency restoration in SPHs.

Forensic Commitments

Focus group participants reported significant growth in forensic commitments in the past five years. Many participants blamed the lack of community-based alternative services for increased forensic or criminal justice related commitments.

Other reasons cited for this included lack of understanding or education among law enforcement regarding potential alternatives and a shortage of civil commitment beds at SPHs. At least one community advocate suggested that the pressure to reduce crowding in jails and prisons has resulted in prosecutors seeking behavioral health commitments for “nuisance misdemeanors” to lower jail populations.

“We can’t always get a civil commitment for someone in crisis, so we’ll charge the person with a crime to get him out of the community to where he can get some help.”

County Sheriff

Focus group participants stated that the system is under bedded, particularly for voluntary civil commitments. This leads to long stays in emergency rooms and treatment in jail settings, as opposed to appropriate treatment settings.

Participants said some Judges simply do not bother trying to make civil commitments because the difficulty in finding a bed in a SPH. The hospitals are at capacity and often on “diversion.” A sheriff may have to take two people out of rotation and send them hundreds of miles away to place someone in an open bed.

One local authority representative stated that about seventy percent of beds or 77 out of 111 state inpatient beds they used in the last month were forensic beds. He stated “Consumers who need civil commitments and who can’t get into the SH end up in our jail or end up as “forensic” commitments.”

Local Authorities discussed how they are held accountable for “days of service” in SPH noting that forensic commitments removed their ability to manage bed usage. Local Authorities have no control over which SPH a forensic resident is assigned to.

“With the reduction in SH beds, the new “SH” is the jail.”

Local Authority Representative

Focus group participants cited the need for a wider-range of community services and alternatives for forensic consumers, specifically the need for locked or secure “step-down” facilities. Some communities have started to provide “re-entry services” to help behavioral ly ill offenders reintegration back to the community more successful.

They also indicated that counties and public official need legislative relief from potential liability to make it easier to move behaviorally ill offenders back to the community once competency is restored or whatever sentence has been served.

Participants suggested taking class C misdemeanors off the table and diverting consumers to an outpatient competency program with dismissal of charges noting that Montana and California have taken inpatient diversion off the table for all but felony cases.

Housing

Participants identified housing with proper supports for persons with behavioral illness as a critical need. Having a place to return to correlates directly with successful reintegration into the community.

Participants cited the need to expand long-term care support services for people for behavioral illness, noting that those who need long-term support services are the ones who cycle in and out of jail and inpatient care.

Community advocates strongly favored three to four bed housing units designed for step down services. However, others cautioned that the state would need to consider both therapeutic effectiveness and economies of scale. Participants suggested that a Medicaid Waiver with a housing component would help address the need for housing and allow consumers to obtain only the services they needed.

These could be provided by the private sector much like the HCS Waiver for individuals with develop behavioral disabilities.

One community advocate noted that DARS provides housing supports for persons with disabilities. However, DARS only supports individuals who meet specific criteria. For example housing supports are limited to a year, but an individual with SMI may need housing support for a longer period or may cycle in and out of the system. State rules would need to be revised to support the needs of individuals with serious behavioral illness.

“20 years ago SHs had substance abuse units, but they were eliminated. That was a mistake.”

Community Advocate

Substance Abuse Services

Participants cited a seventy percent co-morbidity between behavioral illness and substance abuse making the lack of substance abuse services a major issue for the behavioral health system. In spite of this stakeholders noted that only Kerrville and Wichita Falls State Hospitals offer co-occurring services for substance abuse. North Star, the state’s behavioral health managed care organization also combines substance abuse/behavioral health services.

“There is no [mental health] service model that works effectively if people have no place to live.”

Community Advocate

NorthStar has combined funding for Behavioral Health and Substance Abuse services through multiple contracted providers and has successfully eliminated their waiting list for services.

Special Populations

Participants discussed the need for special units and care for special populations like geriatric, adolescents, and individuals with dual diagnoses of behavioral illness and a developmental disability. In particular, they discussed that nursing homes often would not take a person with behavioral illness. At least one advocate stated that funds should not be spent on institutions for geriatric care, rather funding should be made available for community-based programs like the HCS so services could be customized to meet the individual’s needs.

One participant noted that the closure of the State Supported Living Centers (SSLC) would have an impact on individuals with a dual diagnosis of behavioral illness and IDD. Participants agreed that the closure of SSLCs would result in State Hospitals serving people who would be better served in SSLCs.

Technology/Data

Participants stated that data on demand for behavioral health services is wholly inadequate because data on individuals who are turned away for services are not collected. Lack of interconnectivity and resident level data are barriers to providing effective care. For example, a hospital without an ER or community provider at capacity may send consumers to the local mental health authorities.

“We need to attract and retain competent providers who can provide integrated care.”

Local Authority Representative

Without service demand data it is difficult to plan, although there is a lot of anecdotal information about service demand. However, without solid information, participants reported, it is difficult to determine where services and what types of services are most needed.

Participants also discussed the software system used by the state, saying that the Columbus software is so out of date, it is unworkable. None of the existing data systems, participants claim, interface to any other data system. Columbus is unmanageable, unwieldy, and the process for changing or updating anything in the system is very difficult to do.

When a person transitions to the community from jail or an SH, information about the individuals treatment or condition does not follow them into the community. If the person is in the public system, there may be some data although law enforcement in Texas cannot get diagnosis information.

“State hospitals have become de facto nursing homes for the aging mentally ill population ”

Local Authority Representative

One stakeholder said the IT situation was so bad that the Centers for Medicaid and Medicare Services (CMS) asked Texas to postpone the roll out of the Youth Empowerment Services (YES) Waiver because of problems with the State’s IT infrastructure.

Human Capital Themes

Personnel Shortages

Participants noted that most Texas counties are medically underserved generally and that medical personnel shortages are particularly acute for psychiatrists and psychiatric nurses and for all types of medical and specialty services in rural areas. However, participants noted personnel shortages at all levels in the system in state hospitals and the community.

Poor pay and working conditions were cited often as reasons for personnel shortages in the SPH hospital system. Participants called for increased pay and better career advancement opportunities within the SPH system. They also called on the state to re-establish medical

residency programs and add loan-reduction programs for those willing to develop competencies in behavioral health.

Poor pay, particularly for unlicensed direct care staff, leaves the SPH open to competition for these employees. Participants claimed the VA and private psychiatric hospitals have expanded and are hiring staff away from the SPHs.

Investments in Telemedicine

Participants recognized that many parts of the state were not likely to attract needed medical specialists. They raised the need for the development and funding of technologies like telemedicine, but noted that many hospitals especially rural ones, would not be able to make such an investment without help.

Other Staffing Models

Several participants mentioned the use of paraprofessionals as staff “extenders.” Trained paraprofessionals could go out into the community and help those on the streets. This model has been used successfully elsewhere.

Community Themes

Many participants cited an inequity in funding and service distribution in the system. In particular they noted that rural communities often lack any resources – funds or services to meet the needs of consumers with behavioral illness.

“Diversion at the SH’s has become an issue resulting in people being treated far from home or not at all.”

County Official

One local authority representative from a small community noted that they have no psychiatrist in the county; their regional hospital does not have a psychiatric unit; and the nearest SH is 145 miles away.

Participants suggested that instead of large, remote SPHs, the state could develop smaller regional facilities. Serving individuals closer to home relieves the financial burden on families and enables them to provide better

support to their family member

Ideally participants wanted a holistic model of care with hubs of care, mobile outreach, crisis respite, multi-county crisis centers, and telemedicine.

Appendix B-2: Qualitative Findings – E-Survey Results

The Department of State Health Services (DSHS) Rider 83 online survey was conducted on July 1 through July 11, 2014. The survey addressed potential barriers in the current behavioral health services system. A link to the survey was posted on DSHS web site and communicated to a range of advocacy groups. Six hundred and thirty-nine (639) people responded to the survey.

The respondents were grouped into eight categories, as shown in **Exhibit B-1**. The largest groups of respondents consisted of behavior health and physical health providers (25.4 percent) and family members/consumers (17.2 percent). Survey respondents were located in urban (42.1 percent), suburban (23.6 percent), and rural (33.3 percent) areas.

Exhibit B-1. Respondents' Affiliations

Organization	Number (N=639)	Percent
Behavioral Health/Physical Health Providers	162	25.4%
Family Members/Consumers	110	17.2%
Local Mental Health Authorities (LMHAs)	84	13.1%
Hospital/Long Term Care (LTC)	78	12.2%
Law Enforcement/County Government	76	11.9%
State Agency	69	10.8%
Advocacy Organizations	39	6.1%
Other	21	3.3%

Source: *The Department of State Health Services (DSHS) Rider 83 online survey*

Survey Highlights

Among ten potential barriers to behavioral health services in Texas inadequate funding emerged as the most significant barrier overall. It was the major barrier regardless of respondents' rural, suburban, and urban location and regardless of respondents' group/organizational affiliation. More than 44 percent of the respondents selected it as the most significant barrier. All the other potential barriers were selected by 0.6 to 12.8 percent as being of most significant. Technology was identified as the least significant barrier.

Potential barriers in order of significance, as measured by mean rankings with a lower mean pointing to greater significance, included:

- Inadequate funding (2.68)
- Lack of care coordination (3.86)
- Insufficient crisis stabilization services (4.13)
- Lack of or insufficient availability of medical care for people with behavioral illness (5.22)
- Lack of housing options (5.31)
- Imbalance between service availability and demand (5.98)
- Insufficient staff at SPHs (6.09)
- Lack of job opportunities and supports (6.48)

- Unavailability of substance abuse services in SPHs (6.65)
- Outdated technology (8.60)

The rural, suburban, and urban location of respondents made some differences in respondents’ assessment of potential barriers. Typically, the differences were small. **Exhibit B-2** shows the barriers each group ranked as higher and lower than the other two groups.

Exhibit B-2. Most and Least Significant Barriers by Respondents’ Location

Location	Highest Ranked Barriers	Lowest Ranked Barriers
Rural	<ul style="list-style-type: none"> ▪ Insufficient crisis stabilization services ▪ Insufficient medical care for persons with behavioral illness ▪ Imbalance between where behavioral health services are located and the need for such services. 	<ul style="list-style-type: none"> ▪ Lack of employment opportunities and supports ▪ Insufficient staffing at state hospitals
Suburban	<ul style="list-style-type: none"> ▪ Insufficient staffing at state hospitals ▪ Unavailability of substance abuse services in state hospitals 	<ul style="list-style-type: none"> ▪ Lack of care coordination ▪ Outdated technology.
Urban	<ul style="list-style-type: none"> ▪ Lack of care coordination ▪ Lack of housing options ▪ Lack of employment opportunities and supports ▪ Outdated technology 	<ul style="list-style-type: none"> ▪ Insufficient medical care for people with behavioral illness ▪ Imbalance between where behavioral health services are located and the need for such services ▪ Unavailability of substance abuse services in state hospitals

Increased funding emerged most prominently (83.9 percent) as the best way to address the current system’s barriers. Other strategies, in order of their selection by respondents as the most effective strategies to address current system barriers included:

- Fund and/or encourage the development of private inpatient and outpatient services (52.0 percent)
- Create partnerships with universities and medical schools, hospitals, and other public and private entities (49.3 percent)
- Change how the state distributes state funds to local mental health authorities (49.3 percent)
- Increase private sector participation in the delivery of behavioral health services (46.2 percent)
- Increased access to civil commitment beds at SPHs (45.7 percent)
- Redistribution of resident beds statewide to match demand (25.8 percent)
- Increase availability of technology (e.g., Internet, tablets, etc.) and/or improve medical record and data collection tools at SPHs (24.4 percent)

Potential Barriers to Behavioral Health Services

Survey respondents were asked to assess the significance of potential barriers to an effective behavioral health system in ten areas (**Exhibit 3**). The ten areas included:

- Funding
- Care coordination

- Crisis stabilization
- Medical care
- Housing
- Service availability
- Staffing
- Employment
- Technology

Overall, inadequate funding emerged as the most significant barrier outstripping all other potential barriers: 44.1 percent of the respondents selected it as the most significant barrier. All the other barriers were identified by 0.6 to 12.8 percent of the respondents as the most significant barriers (**Exhibit 3**). Outdated technology was seen as the least significant barrier: only 0.6 percent of the respondents considered it the most significant barrier while 42.9 percent identified it as the least significant barrier and 28.3 percent assessed it as the second lowest barrier.

Respondents ranked the significance of the barriers from the most to the least, as follows:

- Inadequate funding (most significant barrier)
- Lack of care coordination
- Insufficient crisis stabilization services
- Lack of or insufficient availability of medical care for people with behavioral illness
- Lack of housing options
- Imbalance between service availability and demand
- Insufficient staff at SPHs
- Lack of job opportunities and supports
- Unavailability of substance abuse services in SPHs
- Outdated technology (least significant barrier)

Exhibit B-3. Potential Barriers to an Effective Behavioral Health System

Potential Barriers	Ranking of Barriers										Mean*
	1 st Most	2 nd Most	3 rd Most	4 th Most	5 th Most	6 th Most	7 th Most	8 th Most	9 th Most	10 th Most	
1-Care Coordination: Lack of coordination of care between behavioral health, substance abuse, criminal justice and/or medical systems	82 12.8 %	117 18.3 %	118 18.5 %	105 16.4 %	73 11.4 %	58 9.1%	43 6.7%	28 4.4%	10 1.6%	5 0.8%	3.86
2-Crisis Stabilization: There are not enough crisis stabilization services available statewide	77 12.1 %	112 17.5 %	87 13.6 %	112 17.5 %	77 12.1 %	74 11.6 %	47 7.4%	21 3.3%	18 2.8%	14 2.2%	4.13
3-Employment: lack of job opportunities and supports	9 1.4%	37 5.8%	46 7.2%	54 8.5%	65 10.2 %	89 13.9 %	88 13.8 %	104 16.3 %	76 11.9 %	71 11.1 %	6.48

4-Funding: Inadequate funding to meet the needs of Texas' population with behavioral health and substance use disorders	282 44.1 %	90 14.1 %	93 14.6 %	53 8.3%	50 7.8%	30 4.7%	18 2.8%	8 1.3%	8 1.3%	7 1.1%	2.68
5-Housing: Lack of housing options for the behaviorally ill population	47 7.4%	65 10.2 %	58 9.1%	81 12.7 %	82 12.8 %	80 12.5 %	85 13.3 %	64 10.0 %	52 8.1%	25 3.9%	5.31
6-Medical Care: Availability of medical care for people with behavioral illness in state hospitals or the community	52 8.1%	64 10.0 %	68 10.6 %	72 11.3 %	73 11.4 %	77 12.1 %	96 15.0 %	83 13.0 %	37 5.8%	17 2.7%	5.22
7-Staffing: There are not enough staff or not enough of certain types of staff at state hospitals	23 3.6%	46 7.2%	55 8.6%	38 5.9%	70 11.0 %	79 12.4 %	116 18.2 %	104 16.3 %	87 13.6 %	21 3.3%	6.09
8-Substance Abuse: Substance abuse treatment services are not available in state hospitals	11 1.7%	28 4.4%	41 6.4%	52 8.1%	70 11.0 %	71 11.1 %	67 10.5 %	131 20.5 %	121 18.9 %	47 7.4%	6.65
9-Technology: Outdated technology (e.g. wireless Internet access, electronic medical records, data capture and reporting, mobile devices) at state hospitals	4 0.6%	7 1.1%	9 1.4%	22 3.4%	19 3.0%	26 4.1%	36 5.6%	61 9.5%	181 28.3 %	274 42.9 %	8.60
10-Service Availability: Imbalance between where behavioral health services are located and where they are needed across Texas	52 8.1%	73 11.4 %	64 10.0 %	50 7.8%	60 9.4%	55 8.6%	43 6.7%	35 5.5%	49 7.7%	158 24.7 %	5.98

Note: Means were calculated by averaging the rankings each barrier received, with "1" referring to the most significant, "2" to the second most significant, ... "10" to the least significant.

The ranking of the barriers varied slightly by respondents' rural, suburban, or urban location (**Exhibit 4**). Regardless of location, all respondents agreed that insufficient funding was the most significant barrier and outdated technology the lowest barrier.

Respondents located in rural areas attributed greater significance than respondents from urban or suburban areas to:

- Insufficient crisis stabilization services
- Insufficient medical care for persons with behavioral illness
- Imbalance between where behavioral health services are located and the need for such services.

Rural respondents attributed lower significance than urban or suburban respondents to lack of employment opportunities and supports and to sufficient staffing at SPHs.

Respondents located in urban areas attributed greater significance than respondents in suburban or rural areas to:

- Lack of care coordination
- Lack of housing options
- Lack of employment opportunities and supports
- Outdated technology

Urban respondents attributed lower significance than respondents from rural and suburban areas to:

- Insufficient medical care for people with behavioral illness
- Imbalance between where behavioral health services are located and the need for such services
- Unavailability of substance abuse services in SPHs

Respondents in suburban locations attributed greater significance than rural or urban respondents to:

- Insufficient staffing at SPHs
- Unavailability of substance abuse services in SPHs

Suburban respondents attributed lower significance than rural or urban respondents to lack of care coordination and outdated technology.

Exhibit B-4. Potential Barriers to an Effective Behavioral Health System by Rural, Suburban, Urban Location of Respondents

Potential Barriers	Mean Ranks*			
	Rural	Suburban	Urban	All Respondents
1-Care Coordination: Lack of coordination of care between behavioral health, substance abuse, criminal justice and/or medical systems	3.91	4.09	3.73	6.62
2-Crisis Stabilization: There are not enough crisis stabilization services available statewide	3.85	3.90	4.46	4.13
3-Employment: lack of job opportunities and supports	6.73	6.62	6.26	6.48
4-Funding: Inadequate funding to meet the needs of Texas' population with behavioral health and substance use disorders	2.78	2.73	2.58	2.68
5-Housing: Lack of housing options for the behaviorally ill population	5.59	5.29	5.10	5.31
6-Medical Care: Availability of medical care for people with behavioral illness in state hospitals or the community	4.98	5.13	5.44	5.22
7-Staffing: There are not enough staff or not enough of certain types of staff at state hospitals	6.33	6.07	5.89	6.09
8-Substance Abuse: Substance abuse treatment services are not available in state hospitals	6.54	6.48	6.81	6.65
9-Technology: Outdated technology (e.g. wireless Internet access, electronic medical records, data capture and reporting, mobile devices) at state hospitals	8.77	8.66	8.43	8.60
10-Service Availability: Imbalance between where behavioral health services are located and where they are needed across Texas	5.54	6.03	6.30	5.98

*Note: *Respondents were asked to rank the 10 statements from 1-most significant barrier, 2-second most significant barrier, to...10-tenth most significant barrier. Mean rankings were calculated by averaging all rankings each barrier received.*

Regardless of respondents’ group/organizational affiliation, funding emerged as the most significant barrier and outdated technology as the least significant barrier (**Exhibit B-5**).

The seven groups differed slightly in their ranking of the other barriers. For example:

- Behavior and physical health providers considered the imbalance between service location and service needed a greater barrier (fifth) than the other groups; the state agencies and LMHAs considered it a low barrier (ninth among ten).
- State agencies and LMHAs considered limited or unavailability of care for people with behavioral illness in SPHs or the community less as a barrier (seventh) than other groups.
- State agencies and LMHAs considered the lack of job opportunities and supports a barrier of greater significance (sixth) than other groups.
- LMHAs considered lack of housing (third) and lack of substance abuse treatment services in SPHs(fifth) as greater barriers than members of other groups.
- Lack of staffing in SPHs was considered a greater barrier by state agencies (fourth) than by other groups/organizations.

Exhibit B-5. Potential Barriers to an Effective Behavioral Health System by Respondents’ Affiliation

Potential Barriers	Mean Ranks*							Overall Mean Rank (N=639)
	Behavioral/ Physical Health Providers (N=162)	State Agency (N=69)	Hospital/ LTC (N=78)	Law Enforcement/ County Government (N=76)	LMHA (N=84)	Family/ Resident (N=110)	Advocacy Org (N=39)	
1-Care Coordination: Lack of coordination of care between behavioral health, substance abuse, criminal justice and/or medical systems	3.91	4.12	3.81	4.08	3.94	3.64	3.51	3.86
2-Crisis Stabilization: There are not enough crisis stabilization services available statewide	4.27	4.45	3.83	3.79	4.86	3.82	3.28	4.13
3-Employment: lack of job opportunities and supports	6.57	5.83	7.41	7.15	6.11	6.03	6.54	6.48
4-Funding: Inadequate funding to meet the needs of Texas’ population with behavioral health and substance use disorders	2.96	2.26	2.68	2.88	2.12	2.95	2.69	2.68
5-Housing: Lack of housing options for the behaviorally ill population	5.88	4.75	5.39	4.74	4.71	5.49	5.18	5.31

6-Medical Care: Availability of medical care for people with behavioral illness in state hospitals or the community	4.72	6.70	4.63	5.04	6.11	4.96	5.39	5.22
7-Staffing: There are not enough staff or not enough of certain types of staff at state hospitals	6.10	4.71	6.31	6.55	6.16	6.11	6.82	6.09
8-Substance Abuse: Substance abuse treatment services are not available in state hospitals	6.77	6.74	6.32	6.25	5.87	7.33	7.10	6.65
9-Technology: Outdated technology (e.g. wireless Internet access, electronic medical records, data capture and reporting, mobile devices) at state hospitals	8.47	8.36	8.92	8.75	8.21	8.86	8.44	8.60
10-Service Availability: Imbalance between where behavioral health services are located and where they are needed across Texas	5.35	7.09	5.71	5.78	6.92	5.84	6.05	5.98

Note: *Respondents were asked to rank the 10 statements from 1-most significant barrier, 2-second most significant barrier, to...10-tenth most significant barrier. Mean rankings were calculated by averaging all rankings each barrier received.

Strategies to Address Barriers

Increased funding emerged most prominently (83.9 percent) as the best way to address the system’s current barriers (**Exhibit B-6**). Redistribution of beds statewide to match demand (25.8 percent) and increasing the availability of technology (24.4 percent) were perceived by survey respondents as least effective in removing barriers and increasing system effectiveness.

Exhibit B-6. Best Ways to Address the Barriers

Addressing Barriers	Number (N=639)	Percent
1-Redistribution of resident beds statewide to match demand	229	25.8%
2-Increased access to civil commitment beds at state hospitals	292	45.7%
3-Fund and/or encourage the development of private inpatient and outpatient services	332	52.0%
4-Increase availability of technology (e.g. Internet, tablets, etc.) and/or improve medical record and data collection tools at state hospitals	156	24.4%
5-Create partnerships with universities and medical schools, hospitals and other public and private entities	315	49.3%
6-Increase funding for behavioral health and substance abuse services	536	83.9%
7-Change how the state distributes state funds to local mental health authorities	315	49.3%
8-Increase private sector participation in the delivery of behavioral health services	295	46.2%

While the most and least effective ways of addressing barriers did not vary by respondents’ rural, suburban, or urban location, the three groups showed some differences in the relative effectiveness they attributed to the strategies listed in **Exhibit B-7** for addressing barriers. The largest difference among the three groups was associated with the strategy of ‘increased access to civil commitment beds at state hospitals.’ Rural respondents considered this strategy second most effective for addressing existing barriers compared to suburban and urban respondents who rated it sixth for effectiveness among eight strategies.

Urban respondents considered ‘creating partnerships with universities and medical schools, hospitals, and other public and private entities’ the second best strategy for addressing current barriers. This strategy was assessed as being less effective by suburban (ranked as fourth) and rural (ranked as fifth) respondents.

‘Increasing private sector participation in the delivery of behavioral health services’ was ranked third by suburban respondents but considered less effective by urban (ranked fifth) and rural (ranked sixth) respondents.

Exhibit B-7. Best Ways to Address the Barriers by Rural, Suburban, Urban Location of Respondents

Addressing Barriers Through	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
1-Redistribution of resident beds statewide to match demand	37.6%	33.8%	35.7%	25.8%
2-Increased access to civil commitment beds at state hospitals	57.3%	42.4%	38.3%	45.7%
3-Fund and/or encourage the development of private inpatient and outpatient services	53.1%	55.0%	49.1%	52.0%
4-Increase availability of technology (e.g. Internet, tablets, etc.) and/or improve medical record and data collection tools at state hospitals	19.2%	24.5%	27.9%	24.4%
5-Create partnerships with universities and medical schools, hospitals and other public and private entities	45.1%	49.7%	53.2%	49.3%
6-Increase funding for behavioral health and substance abuse services	80.8%	84.1%	86.2%	83.9%
7-Change how the state distributes state funds to local mental health authorities	51.2%	47.0%	48.7%	49.3%
8-Increase private sector participation in the delivery of behavioral health services	40.8%	51.7%	46.5%	46.2%

Regardless of group/organizational affiliation, respondents considered increased funding as the best strategy for addressing current barriers and increased availability of technology as the least significant strategy (**Exhibit 8**). The groups/organizations varied somewhat in their assessment of the effectiveness of each strategy. The groups/organizations associated with the highest and lowest effectiveness assessment (represented by percentages) of each strategy are listed below:

Redistribution of resident beds statewide to match demand:

- Highest percentage: law enforcement/county government (52.6 percent);

- Lowest percentage: state agencies (23.2 percent)

Increased access to civil commitment beds at SPHs:

- Highest percentage: law enforcement/county government (64.5 percent) and hospitals/LTCs (64.1 percent)
- Lowest percentage: behavioral/physical health providers: (34.0 percent)

Fund and/or encourage the development of private inpatient and outpatient services:

- Highest percentage: hospitals/LTCs (66.7 percent)
- Lowest percentage: state agency (31.9 percent)

Increase availability of technology (e.g. Internet, tablets, etc.) and/or improve medical record and data collection tools at SPHs:

- Highest percentage: LMHAs (28.6 percent)
- Lowest percentage: law enforcement/county government (18.4 percent)

Create partnerships with universities and medical schools, hospitals, and other public and private entities:

- Highest percentage: behavior/physical health providers (63.6 percent)
- Lowest percentage: law enforcement/county government (31.6 percent)

Increase funding for behavioral health and substance abuse services:

- Highest percentage: advocacy organizations: (97.4 percent)
- Lowest percentage: hospital/LTC (78.2 percent)

Change how the state distributes state funds to local mental health authorities:

- Highest percentage: advocacy organizations: (59.0 percent)
- Lowest percentage: state agency (40.6 percent)

Increase private sector participation in the delivery of behavioral health services:

- Highest percentage: family/consumers: (55.5 percent)
- Lowest percentage: LMHAs (35.7 percent)

Exhibit B-8. Best Ways to Address the Barriers by Respondents’ Groups

Addressing Barriers Through	Behavioral / Physical Health Providers (N=162)	State Agency (N=69)	Hospital/ LTC (N=78)	Law Enforcement/County Government (N=76)	LMHA (N=84)	Family/ Resident (N=110r)	Advocacy Org (N=39)	All (N=639)
1-Redistribution of resident beds statewide to match demand	33.3%	23.2%	48.7%	52.6%	29.8%	33.6%	33.3%	25.8%
2-Increased access to civil commitment beds at state hospitals	34.0%	43.5%	64.1%	64.5%	47.6%	37.3%	46.2%	45.7%

3-Fund and/or encourage the development of private inpatient and outpatient services	56.8%	31.9%	66.7%	51.3%	44.0%	55.5%	48.7%	52.0%
4-Increase availability of technology (e.g. Internet, tablets, etc.) and/or improve medical record and data collection tools at state hospitals	25.9%	26.1%	24.4%	18.4%	28.6%	21.8%	23.1%	24.4%
5-Create partnerships with universities and medical schools, hospitals and other public and private entities	63.6%	40.6%	46.2%	31.6%	44.0%	48.2%	51.3%	49.3%
6-Increase funding for behavioral health and substance abuse services	82.1%	81.2%	78.2%	80.3%	90.5%	82.7%	97.4%	83.9%
7-Change how the state distributes state funds to local mental health authorities	43.8%	40.6%	56.4%	53.9%	47.6%	51.8%	59.0%	49.3%
8-Increase private sector participation in the delivery of behavioral health services	54.9%	24.6%	48.7%	43.4%	35.7%	55.5%	48.7%	46.2%

Respondents were also asked to identify a service or improvement that would most reduce the impact of each of the barriers identified. In addition to the specified response categories, respondents were allowed to offer additional suggested strategies under the “other” category.

In the area of **care coordination**, increasing coordinated planning among Local Mental Health Authorities, county officials, law enforcement, and medical providers was considered the major strategy (69.0 percent) for removing lack of care coordination as a barrier (**Exhibit B-9**).

Exhibit B -9. Service or Improvement That Would Most Help Remove Care Coordination as a Barrier

	Number (N=639)	Percent
Substance abuse and behavioral health hotline integration	70	11.0%
Physical health care integration	128	20.0%
More coordinated planning among Local Mental Health Authorities, county officials, law enforcement and medical providers	441	69.0%

A larger percentage of rural respondents than urban or suburban respondents considered more coordinated planning the major strategy for addressing care coordination (**Exhibit 10**).

Exhibit B-10. Service or Improvement That Would Most Help Remove Care Coordination as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Substance abuse and behavioral health hotline integration	11.7%	13.2%	8.9%	11.0%
Physical health care integration	16.9%	19.9%	22.7%	20.0%
More coordinated planning among Local Mental Health Authorities, county officials, law enforcement and medical providers	71.4%	66.9%	68.4%	69.0%

In the area of **crisis stabilization**, the establishment of psychiatric emergency centers (45.7 percent) and the expansion of mobile crisis teams/interventions (34.6 percent) were perceived as the two major strategies (**Exhibit 11**).

Exhibit B-11. Service or Improvement That Would Most Help Remove Crisis Stabilization as a Barrier

	Number (N=639)	Percent
Increased participation of the private sector in the delivery of local crisis stabilization beds	126	19.7%
Expanded mobile crisis teams/interventions	221	34.6%
Psychiatric Emergency Centers	292	45.7%

A larger percentage of rural than urban or suburban respondents considered the establishment of psychiatric emergency centers as the most effective strategy for removing crisis stabilization as a barrier (**Exhibit B-12**).

Exhibit B-12. Service or Improvement That Would Most Help Remove Crisis Stabilization as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Increased participation of the private sector in the delivery of local crisis stabilization beds	19.2%	23.2%	17.8%	19.7%
Expanded mobile crisis teams/interventions	31.0%	35.8%	36.4%	34.6%
Psychiatric Emergency Centers	49.8%	41.1%	45.7%	45.7%

In the area of **employment**, respondents (54.8 percent) considered services to stabilize consumers’ living situation to facilitate job retention the key strategy for removing employment as a barrier (**Exhibit B-13**).

Exhibit B-13. Service or Improvement That Would Most Help Remove Employment as a Barrier

	Number (N=639)	Percent
Increased access to job supports	198	31.0%
Employment assistance	152	23.8%
Services to stabilize the consumers’ living situation to facilitate job retention	350	54.8%

A larger percentage of urban than suburban or rural respondents considered ‘services to stabilize the consumers’ living situation to facilitate job retention’ the key strategy for addressing employment as a barrier (**Exhibit 14**).

Exhibit B-14. Service or Improvement That Would Most Help Remove Employment as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Increased access to job supports	31.0%	32.5%	30.1%	31.0%
Employment assistance	23.9%	25.7%	22.3%	23.8%
Services to stabilize the consumers’ living situation to facilitate job retention	51.8%	53.0%	59.1%	54.8%

In the area of funding, increased general funding emerged as the key means (54.0 percent) to remove funding as a barrier (**Exhibit B-15**).

Exhibit B-15 Service or Improvement That Would Most Help Remove Funding as a Barrier

	Number (N=639)	Percent
Increased general funding	345	54.0%
Redistribute state funding to local mental health authorities	207	32.4%
Submission of a state Medicaid behavioral health Waiver	174	27.2%

A larger percentage of suburban than urban or rural respondents considered ‘increasing general funding’ the key strategy for removing funding as a barrier (**Exhibit B-16**).

Exhibit B-16. Service or Improvement That Would Most Help Remove Funding as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Increased general funding	50.2%	57.0%	55.4%	54.0%
Redistribute state funding to local mental health authorities	32.9%	33.8%	30.9%	32.4%
Submission of a state Medicaid behavioral health Waiver	26.3%	30.5%	26.8%	27.2%

In the area of **housing**, increased availability of respite or temporary housing emerged as the main strategy (51.8 percent) to address housing as a barrier (**Exhibit B-17**).

Exhibit B-17. Service or Improvement That Would Most Help Remove Housing as a Barrier

	Number (N=639)	Percent
Increased availability of respite or temporary housing	202	31.6%
Creation of small (4-6 bed) community-based group homes	331	51.8%
Increased availability of subsidized housing	220	34.4%

Respondents differed in their assessment of the three strategies for removing housing as a barrier (**Exhibit B-18**). More rural than suburban or urban respondents considered ‘increased availability of respite or temporary housing’ as an effective strategy for removing housing as a barrier. A smaller percentage of rural than suburban or urban respondents considered availability of subsidized housing as a strategy for removing housing as a barrier.

Exhibit B-18. Service or Improvement That Would Most Help Remove Housing as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Increased availability of respite or temporary housing	36.6%	31.8%	28.3%	31.6%
Creation of small (4-6 bed) community-based group homes	49.8%	54.3%	51.7%	51.8%
Increased availability of subsidized housing	24.4%	36.4%	41.3%	34.4%

In the area of **lack of service options**, more coordinated planning (42.3 percent) and increased innovation in programming (41.5 percent) emerged as the key strategies for addressing lack of service options (**Exhibit B-19**).

Exhibit B -19. Service or Improvement That Would Most Help Remove Lack of Service Options as a Barrier

	Number (N=639)	Percent
Increased innovation in programming (e.g., peer support services, assertive community treatment (ACT), rehabilitation services, etc.)	265	41.5%
More coordinated planning among Local Mental Health Authorities, county officials, law enforcement, and medical providers	270	42.3%
Partnerships of funding to encourage private sector participation in services delivery	210	32.9%

Respondents differed in their assessment of the three strategies for removing lack of service options as a barrier (**Exhibit B-20**). A higher percentage of rural than urban or suburban respondents considered ‘more coordinated planning’ as an effective strategy. A smaller percentage of rural than suburban or urban respondents considered ‘increased innovation in programming’ an effective strategy for removing lack of service options as a barrier.

Exhibit B-20. Service or Improvement That Would Most Help Remove Lack of Service Options as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Increased innovation in programming (e.g., peer support services, assertive community treatment (ACT), rehabilitation services, etc.)	36.6%	42.4%	44.6%	41.5%
More coordinated planning among Local Mental Health Authorities, county officials, law enforcement and medical providers	46.0%	37.7%	42.0%	42.3%
Partnerships of funding to encourage private sector participation in services delivery	29.6%	39.7%	32.0%	32.9%

In the area of **lack of staffing**, development or increase of behavioral health education and training programs within universities and medical schools (54.8 percent) emerged as the key strategy for addressing lack of staffing (**Exhibit B-21**).

Exhibit B-21. Service or Improvement That Would Most Help Remove Lack of Staffing as a Barrier

	Number (N=639)	Percent
Development of/increases in behavioral health education and training programs within universities and medical schools	288	45.1%
Better employee compensation	350	54.8%
Better employee working conditions	160	25.0%

Respondents differed in their assessment of the three strategies for removing lack of staffing as a barrier (**Exhibit B-22**). A lower percentage of rural than suburban or urban respondents considered ‘better employee compensation’ as a key strategy. A higher percentage of rural than urban or suburban respondents considered ‘development of/increases in behavioral health education and training programs within universities and medical schools’ as an effective strategy to address lack of staffing. Rural respondents considered this to be the key strategy while suburban and urban respondents considered ‘better employee compensation’ the key strategy.

Exhibit B-22. Service or Improvement That Would Most Help Remove Lack of Staffing as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Development of/increases in behavioral health education and training programs within universities and medical schools	50.7%	44.4%	40.1%	45.1%
Better employee compensation	49.3%	56.3%	59.1%	54.8%
Better employee working conditions	21.1%	30.5%	25.7%	25.0%

In the area of **lack of medical care**, developing financial incentives of new funding sources to encourage local providers to serve low-income Texans with behavioral health conditions (58.8 percent) emerged as the key strategy (**Exhibit B-23**).

Exhibit B-23. Service or Improvement That Would Most Help Remove Lack of Medical Care as a Barrier

	Number (N=639)	Percent
Involve local hospitals, medical societies, and medical providers in behavioral health planning efforts	264	41.3%
Develop financial incentives of new funding sources to encourage local providers to serve low-income Texans with behavioral health conditions	376	58.8%
Medical provider education to raise awareness about the needs of persons with behavioral illness	144	22.5%

A larger percentage of urban than suburban or rural respondents considered ‘developing financial incentives of new funding sources to encourage local providers to serve low-income Texans with

behavioral health conditions’ the key strategy for removing lack of medical care as a barrier (**Exhibit B-24**).

Exhibit B-24. Service or Improvement That Would Most Help Remove Lack of Medical Care as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Involve local hospitals, medical societies, and medical providers in behavioral health planning efforts	43.2%	46.4%	37.2%	41.3%
Develop financial incentives of new funding sources to encourage local providers to serve low-income Texans with behavioral health conditions	54.0%	55.6%	64.7%	58.8%
Medical provider education to raise awareness about the needs of persons with behavioral illness	16.0%	30.5%	23.4%	22.5%

In the area of **lack of substance abuse treatment services**, the integration of substance abuse detox/treatment and behavioral health treatment in state hospitals and the community (57.6 percent) and increased access to substance abuse treatment in the community (49.9 percent) emerged as the key strategies (**Exhibit B-25**).

Exhibit B-25. Service or Improvement That Would Most Help Remove Lack of Substance Abuse Treatment Services as a Barrier

	Number (N=639)	Percent
Substance abuse and behavioral health hotline integration	61	9.5%
Increased access to substance abuse treatment in the community	319	49.9%
Substance abuse detox/treatment and behavioral health treatment integration in state hospitals and the community	368	57.6%

A larger percentage of suburban than rural or urban respondents considered ‘integration of substance abuse detox/treatment and behavioral health treatment in SPHs’ as the key strategy for removing lack of substance abuse treatment services as a barrier (**Exhibit 26**).

Exhibit B-26. Service or Improvement That Would Most Help Remove Lack of Substance Abuse Treatment Services as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Substance abuse and behavioral health hotline integration	4.7%	10.6%	12.6%	9.5%
Increased access to substance abuse treatment in the community	52.1%	47.7%	50.2%	49.9%
Substance abuse detox/treatment and behavioral health treatment integration in state hospitals and the community	55.4%	66.2%	54.3%	57.6%

In the area of **outdated technology**, funding to update technology (64.5 percent) emerged as the key strategy to remove outdated technology as a barrier (**Exhibit B-27**).

Exhibit B-27. Service or Improvement That Would Most Help Remove Outdated Technology as a Barrier

	Number (N=639)	Percent
Funding to update software used for data reporting and medical records in state hospitals	412	64.5%
Equip medical professionals and counselors with tablets or other mobile record keeping devices	221	34.6%
Ensure every state facility has wireless Internet	120	18.8%

A larger percentage of suburban than rural or urban respondents considered ‘equipping medical professionals and counselors with tablets or other mobile record keeping devices’ as a strategy for removing outdated technology as a barrier (**Exhibit B-28**).

Exhibit B-28. Service or Improvement That Would Most Help Remove Outdated Technology as a Barrier by Rural, Suburban, and Urban Location of Respondents

	Rural (N=213)	Suburban (N=151)	Urban (N=269)	All Respondents (N=639)
Funding to update software used for data reporting and medical records in state hospitals	62.9%	64.9%	65.8%	64.5%
Equip medical professionals and counselors with tablets or other mobile record keeping devices	34.3%	40.4%	31.6%	34.6%
Ensure every state facility has wireless Internet	17.4%	22.5%	17.8%	18.8%

Appendix B-3: State Psychiatric Hospital Summaries

Appendix B-3 provides high-level summaries by State Psychiatric Hospital.

AUSTIN STATE HOSPITAL

Austin State Hospital provides psychiatric care to a 38-county region in Central Texas. The hospital is the first psychiatric facility to be built west of the Mississippi river (1857) and has been in continuous operation since opening. In effort to support its mission of “Partnering to support a person’s recovery,” ASH admits between 3600-3700 patients annually and has an average length of stay between 7-21 days. The focus of recovery is stabilization for people with acute psychiatric illness and support of their return to the community. The hospital is a fully accredited facility by the prestigious Joint Commission a distinction it has earned and maintained since 1958.

ASH provides care through three large program services - Adult Psychiatric Services, Specialty Adult Services, and Child and Adolescent Psychiatric Services. The general adult services program consists of eight acute adult admission units and one forensic unit. Specialty adult programs include the older adult unit, longer-term cognitive behavioral and multiple disabilities unit, including deaf services and longer-term behavioral unit. Child and adolescent programs offer services to children to the ages 5-12, an adolescent girls unit, and an adolescent boys unit.

Treatment is provided through multidisciplinary teams made up of psychiatrists, social workers, nurses, direct care staff, education /rehab staff, psychologists, and other specialty services. Patients with co-occurring substance abuse disorders receive treatments and referral for specialized treatment addressing these underlying issues. Additional clinical support for these patients is provided through the medical and dental clinics, x-ray and laboratory services, and other consultative services. The recovery care program at ASH has received reference in national recovery literature to include conference presentations on a national and international stage.

The hospital infuses best practices into its recovery care delivery. Treatment focus is person-centered care using recovery principles and trauma informed care. Person-centered recovery care is reinforced by peer support staff that work with patients to assist them in understanding treatment options and embracing a recovery path leading to discharge. The facility is Medicare-certified, Medicaid-approved, and has been accredited by the Joint Commission since 1958.

ASH’s primary challenges are around recruiting and maintaining non-professional staff with an increasingly aging workforce, a very inefficient and ineffective IT infrastructure (specifically as it relates to the EHR) and lack of a system wide HIM strategic plan that integrates ASH with the larger health care community (HIE), an aging infrastructure/physical plant, and a dynamically **growing** complex patient population. The following describes these challenges in greater detail:

Recruitment of clinicians is a challenge.

- There are a limited amount of accredited internships in Texas. Students seek internships in alternate states and often do not return.

- The demand and salary opportunities in the private sector are growing, making it less enticing for clinicians to want to practice in the state hospital setting. This also impacts career choices of the interns who complete internship with the hospital.
- ASH is beginning to re-establish and expand a teaching hospital accreditation to promote a “feeder system” of clinicians into the system.

The ASH workforce is aging and work demands are increasingly complex.

- Significant numbers of doctors and nurses delivering care are aging into retirement. As they retire, they are becoming more challenging to replace.
- Significant competitiveness for both the clinician and nursing salaries is a challenge. Nursing salaries are lower than market demand.
- Inability to fill critical patient care vacancies is jeopardizing the safety and quality of the health care delivery system hospital wide. Prolonged serious acuity in the patient population further exacerbates the vacancy issues in effect multiplying the threats to safety and quality.

Human resource processes were placed on direct care supervisors with no FTE augmentation.

- Responsibilities for HR related duties compress an already taxed supervisory staff. This is particularly onerous, as positions responsible for these duties were never replaced after consolidation.
- Lack of authority to act in nearly all HR matters creates long delays sometimes months in completing the HR process thus leaving many positions filled but unavailable due to administrative leave while the matter is in process.

The IT infrastructure/automated systems are not well designed and coordinated; it is a serious limiting factor in care delivery.

- IT is outdated and patchworks systems cause inefficiencies as well as data integrity issues leading to greater risk of harm. Reliability and compatibility of systems are also issues and system down time is frequent.
- Extra FTE resources and time are needed to compensate for the inefficiencies of the IT platform.
- Continuity and follow-up in the community after discharge is a challenge. There is not an IT care management system that assists tracking of these patients.
- The IT system is not connected to the larger community, limiting case management and continuity of care. There are no plans for an HIE platform.

The ASH has an aging infrastructure with an outdated physical plant.

- The aging infrastructure is costly and expensive to maintain.
- The physical makeup of the campus is not integrated as visioning for the campus has not been approved or funded.

- Outdated building designs support patient care and are not optimal for the new model of care delivery. Re-design incorporating the existing structures to form a more integrated care system can be achieved.

The patient population is changing; becoming increasingly complex and challenging.

- Significant increasing acuity of patients with both psychiatric and complex medical issues.
- Significant increase in the forensic populations due primarily to lack of competency restoration services in the community, compressing the availability of civil beds with elongated ALOS of this population.
- Significant increase in patient populations with TBI, IDD, and dementia has elongated ALOS due primarily to the lack of adequate community resources suited for their needs.
- Significant increase in the number of patients with co-occurring substance abuse disorders, creating a desperate need for services for substance abuse in the Austin-Travis area. This is one of the leading factors in the increased re-admission rates for the hospital. An integrated inpatient/outpatient service model is desperately needed.

BIG SPRING STATE HOSPITAL

Big Spring State Hospital is a 200-bed psychiatric hospital that provides hospitalization for people 18 years of age and older with psychiatric illnesses in a 58-county area in West Texas and the Texas South Plains. More than 2.1 million people live in this vast geographic region, which includes the major metropolitan areas of Amarillo, Lubbock, Big Spring, Abilene, Midland, Odessa, and San Angelo. It is also a contract provider for the Veterans Administration VISN 18. For fiscal year 2014, the hospital is staffed to serve 200 consumers with 160 adult in the hospital and 40 adults in residential rehab (for males only).

The facilities and grounds are well kept and offer a relatively non-restrictive environment with many activities and programs. For the most part, the forensic population is not kept distinct from the non-forensic (especially for activities and programs), and they found no increase in incidents after they added this population. However, the administrators believe there is an unmet need in the civil population – especially given the large geography they cover. They would prefer to reduce the forensic population in order to meet the needs of the “local” community. The local mental health authority appears to have an excellent relationship with BSSH, and the director is an advocate for the hospital.

The primary challenges are around recruiting and maintaining non-professional staff: they are in a rural area that is also enjoying an oil boom. The undersupply of housing has led to high rents and there are prevailing high wages for relatively unskilled staff.

Recruitment and retention is the primary challenge for the organization.

- BSSH is in a rural location that is enjoying an oil boom. This has contributed to employers in the area offering high wages for unskilled workers.
- There is more of a challenge with the non-professional staff than with the professional staff.

- Leadership states that increases in salaries as well as more flexibility in pay bands will help with recruitment and retention.

BSSH has implemented initiatives to ensure continuity of care.

- Physicians provide semi-annual checkups to consumers to ensure good management of chronic disease and medications.
- There is a good relationship with the local mental health authority. The MHA has offices in the building, and the director is an advocate for the hospital.
- There is no wait time for physicians on-site. However there are wait times for specialty care physicians in the community. There were examples of wait times of 12 weeks to see a rheumatologist. It was noted that the community at large experiences these same wait times.

There is a lack of community resources to assist with discharge planning.

- There is not enough housing, group homes, step-down care, nursing homes, and crisis beds in the community.
- Outpatient services are voluntary, which contributes to some consumers being non-compliant.
- Interviewees stated that outpatient commitments are not very helpful because there is not enough structure to ensure compliance and improvement.
- “Last year we have five people die here from medical illness that should have been placed in hospice.”

EL PASO PSYCHIATRIC CENTER (EPPC)

Built in 1996, El Paso Psychiatric Center (EPPC) is a 74 bed hospital located on property leased from the El Paso County Hospital District adjacent to the west end of Thomason Hospital, the county's district hospital. Center construction was coordinated with long range planning on the medical campus, which includes the Center and Texas Tech University Regional Academic Health Center and Texas Tech Medical Center educational facilities. In 2002, EPPC became the tenth state behavioral health hospital comprising TDMHMR. Since September 1, 2004, the center is under the oversight of the Department of State Health Services (DSHS). They care for adults, children and adolescents (7 beds) and low-risk forensics.

The facility is 108,000 square feet and is essentially a resident care tower of the adjacent facility. Food services, lab services, imaging, etc. are purchased from the adjacent acute care hospital. The “hospital” site includes only an intake area, inpatient floors, hospital administration/support, and activity/program support spaces. There are no major logistical support functions or outpatient or step down care functions, and major administrative “back office” functions such as billing and human resources are provided by other agencies (state or purchased from Big Spring).

It is a relatively modern, small scale, and well-kept facility. The staff and leadership appeared dedicated to their mission in the community; there were multiple programmatic support

programs; and the stakeholders interviewed support the hospital's mission to care for the most vulnerable consumers who require longer term inpatient support. A common theme was the difficulty in recruiting and retaining licensed professionals and the lack of comprehensive community based supports—particularly transitional and diversionary services.

The facility lacks a dedicated case management and social work department.

- The therapy staff is responsible for a combination of therapy and case management.
- Interviewees stated that they would prefer to have dedicated staff for case management and social work services.

The facility lacks dedicated psychology services.

- Physicians are currently doing some of the work a psychologist would do.
- Other psychology services like neuro-psychology testing are not available for consumers.

There are not sufficient resources available to assist with the transition and discharge planning process.

- It was noted repeatedly that there are no step down services, housing, etc. “There is mostly inpatient and then community outpatient and nothing in between.”
- There is a “revolving door” for some consumers.
- There are long waiting lists for community based services.

There are challenges with being a state funded agency.

- The budget, HR decisions, pay scales, and technology are decided by outside entities. “This makes it difficult to promote staff, quickly pilot alternative processes, adjust technology, etc.”

KERRVILLE STATE HOSPITAL

Kerrville State Hospital is one of ten behavioral health facilities in the Texas Department of State Health Services system and provides care for adults with major behavioral illnesses who need the safety, structure and resources of an inpatient setting. The hospital operates 202 beds for individuals hospitalized on a forensic commitment. Most such commitments are issued when individuals are charged with a crime and they have been determined to be not competent to stand trial. Hospital programs are designed to help such individuals attain competency if possible by treating their behavioral illness. Care is also provided for individuals who have been judged to be Not Guilty by Reason of Insanity with the goal of treating their behavioral illnesses so that they may be deemed competent to stand trial. Most consumers are admitted on transfer from the secure treatment facility – North Texas State Hospital Vernon Campus – after a determination that they are not manifestly dangerous and require a long length of stay. Individuals served come from throughout the state of Texas. (Via Kerrville State Hospital Website)

KSH provides comprehensive primary care, nursing, behavioral health, and dental services to its consumers. KSH has strong ties with community health care providers as well as the community as a whole: The community is very involved with the hospital, providing volunteer and fundraising support.

KSHs leadership, clinical, and support staff provide collaborative, integrated quality care for the consumers at the facility. A key to their success has been the ability to recruit and retain quality professional staff. The administration works very hard to provide the best working environment that fulfills professional goals while providing quality treatment for consumers. For example, a pediatric psychiatrist has started a program to provide therapy not only to the consumers, but to their families as well, for a more holistic approach to care.

An effective and efficient electronic health record is desired to improve current work flow.

- Avatar EMR is used currently, but it does not work well for the providers.

Additional resources are needed to transition consumers to the community.

- More nursing homes and group homes willing to take this population upon discharge are needed.
- KSH leadership would like a transitional step-down unit on campus so that consumers can become ready for community placement upon discharge.

Need a better relationship with the State Agency (Austin).

- “Many in DSHS have never been on our campus.”
- Easier and quicker acquisition processes are needed for purchases. There should be some discretion to spend funds at the hospital level.

RUSK STATE HOSPITAL

Rusk State Hospital (RSH) is an inpatient hospital providing psychiatric treatment and care for citizens primarily from the East Texas region. It is home to approximately 325 adults, 66 percent of which are forensic commitments. The population also includes 28 consumers in a medically fragile unit (about half are forensic commitments as well). The inpatient population is expected to grow in the future

RSH provides comprehensive primary care, nursing, behavioral health, optometry, dental, pharmaceutical, and physical therapy services to its consumers. Lab draws and basic lab waived tests are performed on campus. Secondary care is provided via contracts and/or relationships with community providers. RSH has strong ties with community health care providers as well as the community as a whole: The community is very involved with the hospital, providing volunteer and fundraising support.

The campus appears to be an unusually excellent setting for providing behavioral health care; however, all of the campus buildings are quite aged, and resident care is forced to occur within footprints that are not ideal for today’s psychiatric care models and practices. Nor were they designed to accommodate the mix of forensic and civil medically fragile consumers.

The hospital is generally able to recruit and retain high quality staff, although direct care staff remains a challenge. The most significant challenge faced by the leadership and staff at RSH is providing care for two distinct resident groups (civil and forensic) with different medical, therapeutic and safety needs, using the same mandated procedures, in the same facilities.

An effective and efficient electronic health record is desired to improve current workflows.

- RSH has an electronic health record Avatar, but coordination across different software platforms is lacking (i.e., health records vs medication administration) creating additional work for nursing staff and therefore less time spent with consumers in treatment and therapy, more data entry errors due to the need for multiple entries, and the need to manually enter hand written notes.

RSH provides care for two distinct resident groups (civil and forensic) using the same mandated procedures and facilities.

- Leadership is very concerned about the management of violent/difficult consumers which are seen much more commonly at RSH now.
- Concern for resident and staff safety, due to forensic and civil consumers not being segregated.
- Part of the concern is that there are not enough limitations for the forensic consumers, creating an unsafe environment (staff cannot intervene in ways they believe they should be able to).

RSH has an ongoing strategy for renovation of its older units.

- The overall campus care setting would benefit from funding for demolition of a number of buildings that are no longer used and have fallen into significant despair.

WACO CENTER FOR YOUTH

Waco Center for Youth (WCY) is a psychiatric residential treatment facility that serves adolescents ages 13 through 17, with emotional difficulties and/or behavioral problems. It is the only facility operated by the Texas Department of State Health Services to provide these services to adolescents; therefore, the entire state is Waco Center for Youth's catchment area. The facility cannot meet current demand, as evidenced by the waiting list that averages 30 – 50 adolescents. The number of adolescents in need of residential psychiatric services is expected to grow in the future.

WCY provides comprehensive primary care, nursing, and behavioral health (psychiatry and counseling) services to its consumers. Secondary care is provided via contracts and/or relationships with community providers. Waco Center for Youth has strong ties with community health care providers as well as the community as a whole: The community is very involved with the hospital, providing volunteer and fundraising support.

With additional funding, the facility would be able to add capacity and satisfy the unmet demand for residential psychiatric services for adolescents.

- The demand for adolescent psychiatric care is expected to grow, greatly outpacing the capacity at WCY.
- The wait list is typically 6-8 months with 30-50 adolescents on it.
- There are 2 -3 admissions weekly.

The antiquated IT system is fragmented and difficult to use.

- WCY has an electronic health record, but coordination across different software platforms is lacking, creating additional work for nursing staff and therefore less time spent with consumers for treatment.
- Working with the current HER system is a major staff criticism.

WCY does not offer competitive pay for professional staff.

- The center is not able to compete with the VA hospital in town.
- An action memo must be written and approved to accomplish anything. This slow down processes and impedes decision making.

NORTH TEXAS STATE HOSPITAL

NTSH is the largest maximum security behavioral health facility in the state of Texas. It has a total of 640 beds, and employs upwards of 2,300 employees. In 1998, Vernon and Wichita Falls State Hospitals merge, and become one single behavioral health facility with two different campuses. After the merger, NTSH earned \$1.7 million in savings as a result of operating two hospitals with on administrative structure. That money went into the creation of community-based behavioral health programs.

In the year of 2013, plans to renovate a nearby airfield, Victory Field, went into works. With the renovation of Victory Field, the opportunity of decompressing the resident population and transferring the Adolescent Forensic Program (AFP) will be possible. Moving the AFP will allow the capacity for maximum security consumers to increase. Increasing the amount of consumers in small area, increases aggressiveness. This will be avoided by utilizing Victory Field.

NTSH features a variety of different resident programs. The Vernon campus houses the Forensic Psychiatric Programs, the Maximum Security Unit (MSU), and the Adolescent Forensics Program (AFP). The Vernon campus has a capacity of 354 beds and the total bed count for the Wichita campus is 289 beds. The Wichita Falls campus houses the Geri-Psychiatric Program (GPP), the Child-Adolescent Program (CAP), the Intermediate Security Program (ISP), The Short Term Assessment Recovery and Treatment Program (START), Social Behavior Program (SBP) and Environmental Engagement Program (EEP). Consumers who come to the MSU at NTSH are incompetent to stand trial, plead not guilty by reason of insanity, or are “Manifestly Dangerous”. On average, NTSH is able to restore competency and return the consumers back to trial within 87 days.

Lack of local control does not allow for expedited decision making.

- Staff is unable to add beds to increase capacity without going through the legislative process and getting approval from the state.
- Staffing models could see improvement. “Staffing levels are minimal in some areas, and with enough capital and less restriction in regards to legislation, this problem could be avoided.”
- There is a perception that they do not have enough staff to complete day-to-day operations; this is affecting the morale of the employees.

- Compensation increase requests have been very difficult to get approved by state. “Too much ambiguity and waiting for state decisions.”

Lack of technology impacts service provision and optimal work flows.

- Security cameras are not installed in all areas of the hospital thus, staff believes resident and staff safety are at risk due to the blind spots.
- Staff would like to install electronic key entry systems at both campuses. Traditional keys are utilized thus; the loss of master keys is a problem that forces continued replacement and locksmith costs.
- Electronic key access will also address the monitor staff access and address the current issue of contraband entering the hospital.

SAN ANTONIO STATE HOSPITAL

The San Antonio State Hospital (SASH) is one of ten state behavioral health facilities within the Texas Department of State Health Services (DSHS) system. SASH provides intensive inpatient diagnostic, treatment, rehabilitative, and referral services for seriously behaviorally ill persons from South Texas regardless of their financial status. Admission may be voluntary or involuntary depending on whether the resident is determined by a court to be seriously behaviorally ill, dangerous to self or others, or if left untreated would deteriorate to the point of becoming dangerous to self or others. SASH attempts to involve the resident's family in the treatment/rehabilitation process to the degree legally and clinically feasible.

SASH has units that treat forensic, adolescent, and general resident populations. Management noted that their forensic and geriatric resident population is growing; however they are not at capacity in the adolescent unit due to an insufficient staffing model. Management stated that there are insufficient beds for “civil” commitments because of the number of bed occupied by forensic commitments.

SASH does not have a formal arrangement with any San Antonio hospitals; however it does have an arrangement with a private hospital in Corpus Christi for medical services. The leadership feels the lack of formal arrangements with local hospitals is due to the fact many medical facilities do not want to serve this population.

There are concerns with the access to care due to the current staffing levels. The leadership stated that there are difficulties with hiring for all positions due to non-competitive salaries. The non-competitive salaries have resulted in in high turnover, periodic bed closures, and staffing shortages. SASH has utilized agency staff to fill the vacancies however; the agencies are not always able to assist.

SASH’s integration with the community providers, hospitals, and long term care facilities appear to be limited and in some cases non-existent. There was no mention of the SSLC that shares the campus with them in terms of coordination and /or collaboration.

During the tour staff appeared to be very comfortable and interactive with the consumers. All consumers observed during the tour were well enough to interact with staff and knew the clinical

director by name. The leadership and staff appear genuinely interested in the consumers' well-being.

The facilities were clean and neat; however outdated. Most of the units had limited common areas and were aesthetical not inviting.

RIO GRANDE STATE CENTER

Under the Texas Department of State Health Services, Rio Grande State Center (RGSC) is the only public provider south of San Antonio, Texas that offers health care, inpatient behavioral health services, and long-term services for individuals with intellectual and behavioral needs. This unique configuration of services has been provided to the Rio Grande Valley since 1956.

RGSC is accredited by The Joint Commission. Additional regulatory agencies that certify the facility include DADS, Medicare, the Mammography Quality Standards Act (MQSA), the American College of Radiology (ACR), and Clinical Laboratory Improvement Amendments (CLIA).

Rio Grande State Center (RGSC) opened in October, 1962 as the Harlingen Adult Behavioral Health Clinic. In 1972, the center added 130 beds for behavioral retardation residential services with the opening of two dorms on the campus of the South Texas Hospital. Consumers came from all over the state. The consumers participated in Adult Education and Independent Living Skills training on campus and Special Education in public schools. Intellectual Disabilities Services presently offers 110 residential beds accredited by the Department of Aging and Disability Services (DADS) and the Centers for Medicare and Medicaid Services (CMS). Many of the consumers after intensive independent living skills training graduated into group homes in the community.

July 1991 found the facility opening a new building to provide in-patient behavioral health services, adjacent to South Texas Hospital. This building named "Wayne Potter Memorial Building" in 2004 now accommodates two in-patient treatment units for persons with behavioral health illness for adults, psychologists, social services, nursing services, and admission offices.

RGSC serves an eight county area for inpatient behavioral health services, and provides long term residential care and active treatment to persons with intellectual disabilities in a 12-county area. RGSC is in the heart of one of the most economically depressed and medically underserved areas in the United States. The eight-county area served by RGSC has a population that is 83 percent Hispanic, 16 percent Anglo, and 1 percent other ethnic groups. The catchment area is approximately 10,000 square miles. RGSC currently employs approximately 566 employees.

The psychiatric hospital is a 55-bed inpatient facility certified by Medicare Services (CCMS). The admission process to RGSC requires screening and referral by the local mental health authorities. RGSC offers treatment to people who require emergency/crisis hospitalization for their behavioral illness. The population consists of individuals who suffer from persistent and disabling behavioral illnesses, such as schizophrenia, major depression, bipolar disorder or other severely disabling behavioral disorders.

In April 2013, RGSC behavioral health services began their new Forensic Program. Fifteen beds are allocated for the new Forensic Program, which will consist of competency restoration for individuals from across the state who have committed non-violent felonies or misdemeanors.

The Long-Term Program is certified for 110 residential beds but is only currently budgeted for 73 beds. RGSC offers services to consumers with intellectual and developmental disabilities, autism, dual diagnoses (Intellectual or Developmental Disability/Behavioral Illness) and related disorders. Consumers must need a structured environment and program that cannot be provided in the home or community setting.

The outpatient medical clinic provides primary care services to adults living in the lower Rio Grande Valley. The Clinic's scope of services includes: Primary Care, Women's Health, Walk-In Triage, Diagnostic, Social Services, and Pharmacy Services (Prescription Assistance Program and limited formulary). Inpatient TB hospitalization for complications is offered by TCID.

The indigent and immigrant population access the facility for services.

- “Often we get citizens who are undocumented or without Social Security numbers. We cannot receive state funding for these individuals, yet we cannot turn them away when they are in crisis.”
- “The impression is that there are a higher number of medically co-morbid conditions at this facility due to the increased population of immigrants that have had no prior medical care.”

All human resource functions including recruitment and resource planning are controlled at the state level, which does not allow for regional distinctions.

- The state has capped staffing levels. By the time our memo gets to the state asking for an exemption, the interviewee has located other employment
- Direct care employees are the hardest to recruit and retain due to the wage not being competitive with other local employers.

Technology is not currently being leveraged to improve access to care, efficiency, staff communication, and coordination.

- Lack of an electronic medical health record creates challenges to accessing information and increases the redundancy in daily tasks like printing, scanning, and signing documents.
- Due to the unique nature of this facility having both SPH and SSLC, the technology needs are not coordinated and data collection to meet requirements for separate agencies is almost insurmountable

There is a substantial gap in locations to place consumers once they are ready to transition from the facility.

- Staff continuously reported an inability to find sufficient locations to transition consumers into the community.

TERRELL STATE HOSPITAL

The Terrell State Psychiatric Hospital was built in 1885 and has had bed capacity for up to 2000 consumers during its history. Today they are funded for 288 beds yet the census is kept at 243. This is related to current underuse of beds in special population buildings such as child/adolescent and geriatric building. Plans are in place to redistribute bed assignment to other populations. CMS surveyed the facility in 2013 and reported non-compliance in 13 conditions of participation which were all cleared within four months, in October, 2013. The facility had too many consumers and not enough direct care providers resulting in the need to reduce the consumer population. Over the years a number of programs have been abandoned due to decreased funding. The leadership has some vacant positions leaving the remainder to carry the heavy administrative burden. Very recently an RFP was issued to privatize the Terrell facility. This was a huge shock to the leadership who was given no prior notice. It has caused an extreme loss of motivation among the staff, and an overall decrease in morale.

The staff is all very proud of the quality of care they provide. They feel the long term consumers are family. The aging facility creates many challenges including lack of office space, nursing stations that are too small, no areas for private conversations, increased HVAC needs of modern equipment are stressing the already limp systems, and the CMS survey citing beds and dressers as safety violations. The beds and dressers were all replaced with non-ligature risk furniture in September 2013. There are buildings on campus that have been vacant for years and are infested with pests and rodents.

All interviewees related the common themes: salaries are too low to recruit and retain, the IT system is completely ineffective and inefficient for their workload, they need more physicians on staff, the consumer population will increase in forensics, there is a dire need for transitional facilities, and the facility has a significant liability in transporting of consumers into the community to receive services.

The campus is very large with multiple buildings

- The campus is large and difficult for visitors to navigate.
- Wayfinding is lacking, buildings are numbered but not labeled as to the kind of services provided.
- Transit of consumers across campus is an area of concern for staff safety.

Professional staffing in a number of disciplines is absent or seriously understaffed.

- TSH has been unable to secure physical therapists for the facility; consumers have to go into the community for this treatment.
- Programs that used to be offered have been eliminated due to lack of funding, i.e., drug rehabilitation.

Technology is not currently being leveraged to improve access to care, efficiency, staff communication, and coordination.

- Lack of Wi-Fi creates challenges to accessing information and increases the redundancy in daily tasks like printing, scanning, and signing documents. TSH uses the statewide electronic medical health record.

- There is a sense that there are no efforts in place to attempt to get the facility current with technology needs.
- At the time of the visit there were minimal security cameras; although it was reported that several hundred were to be installed by the fall of 2014. There had been no communication about how these cameras would be monitored.

TSH is the only facility in the state that provides electroconvulsive therapy

- The schedule accommodates consumers three days per week and they provide services to consumers from all parts of the state

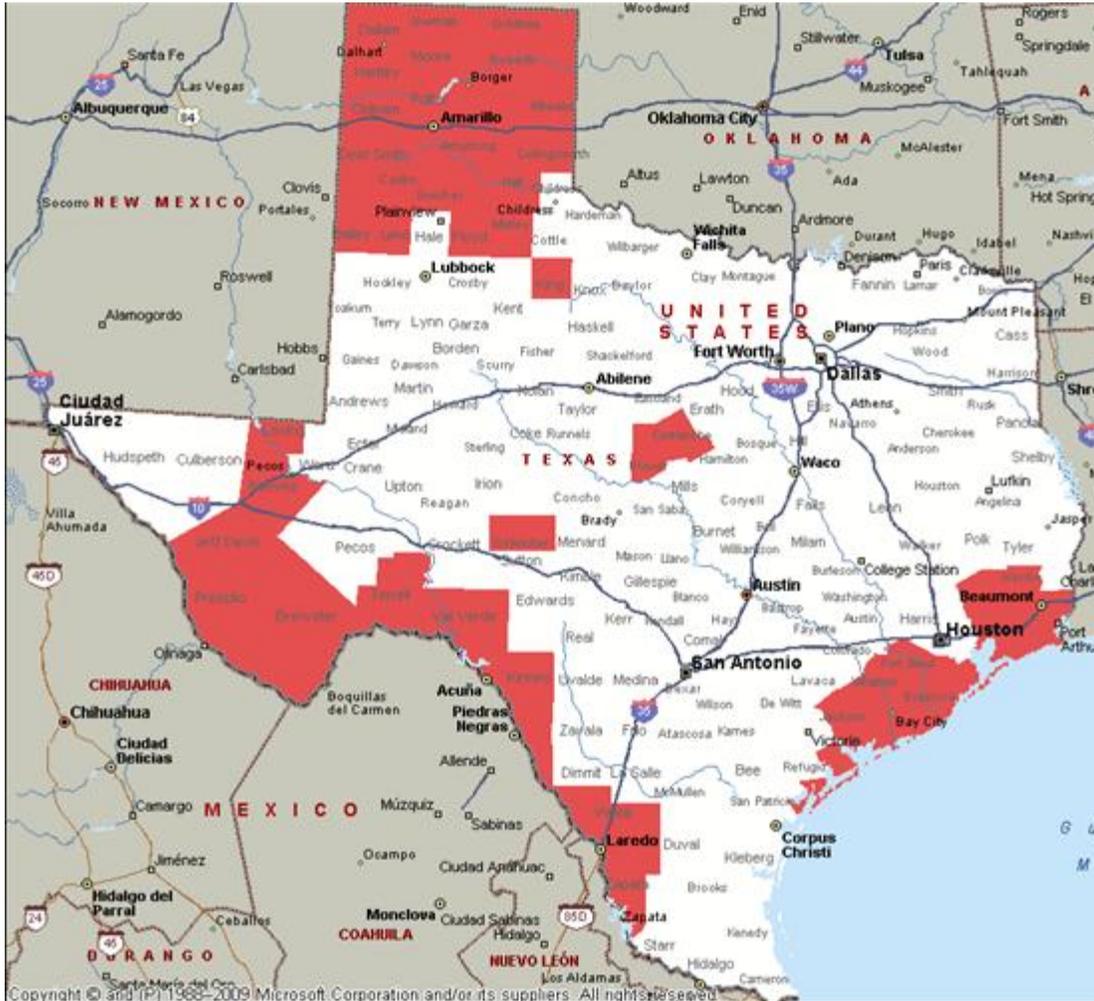
Appendix C. Future Demographics and Demand Detail

Appendix C covers data graphs and exhibits that support the key themes and recommendations in the Future Demographic and Demand section of this report. The exhibits cover data pertaining to projected SPH bed targets and volume projections by scenario.

Exhibit C-129. Current and Projected Bed Need by Bed Type

<i>Assumes 100% of Forensic Beds are Indigent/Charity</i>						
	Bed Counts		Business Mix		% of Market Treated by DSHS	
	2014	2024	2014	2024	2014	2024
Total DSHS System (SPH and State Contracted)	2,715	3,063	100%	100%	56%	56%
Indigent/Charity	1,382	1,461	51%	48%	62%	61%
Public, CMS	227	256	8%	8%	27%	27%
Public, Non-CMS	148	167	5%	5%	67%	67%
Private	140	158	5%	5%	27%	27%
Invalid / Unknown	48	53	2%	2%	30%	30%
Forensic	770	968	28%	32%	90%	90%
Locally Supported	2,140	2,400	100%	100%		
Indigent/Charity	857	954	40%	40%		
Public, CMS	624	699	29%	29%		
Public, Non-CMS	74	83	3%	3%		
Private	385	432	18%	18%		
Invalid / Unknown	114	124	5%	5%		
Forensic	86	108	4%	5%		
Total State of Texas Need	4,855	5,463	100%	100%		
Indigent/Charity	2,239	2,415	46%	44%		
Public, CMS	850	955	18%	17%		
Public, Non-CMS	222	250	5%	5%		
Private	525	589	11%	11%		
Invalid / Unknown	163	176	3%	3%		
Forensic	856	1,076	18%	20%		

Exhibit C-230. Two Hour Drive Time Service Gap Map (Excl. North Texas Vernon, Montgomery County Hospital, and Waco)



Note: Based on new service line area definition of two-hour drive time from the nearest SPH.

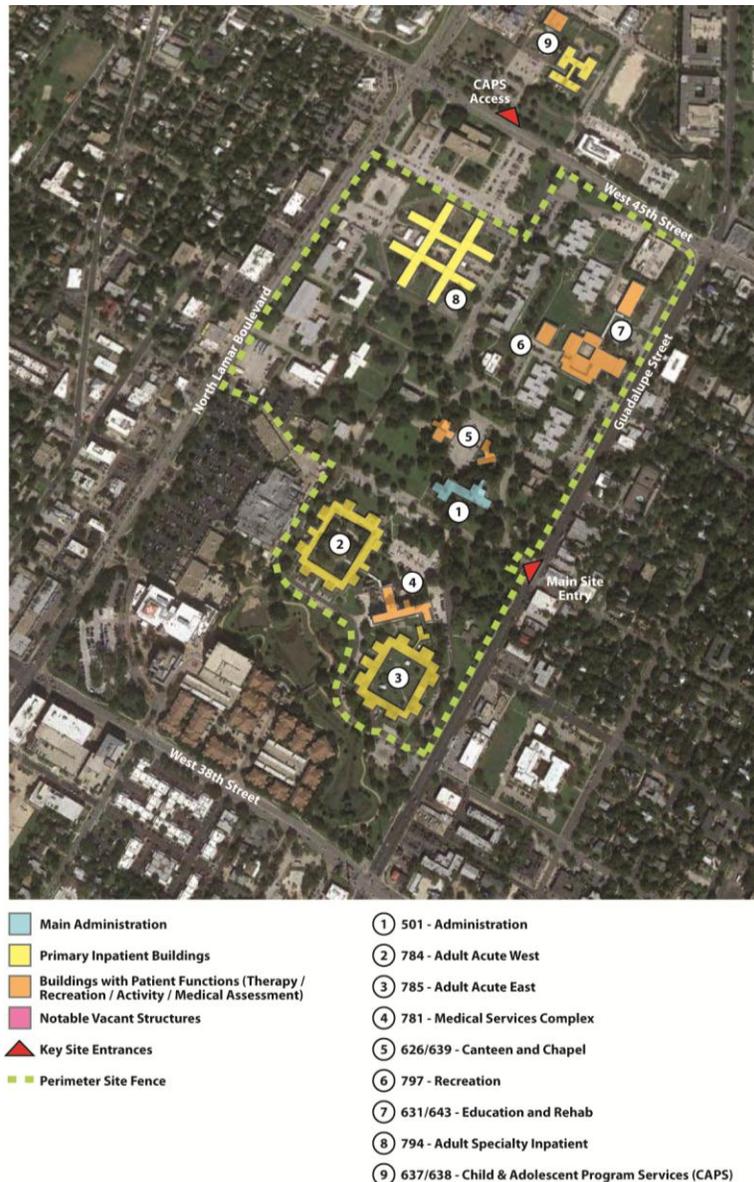
Source: CannonDesign Analysis.

Appendix D. Global Assessment of Infrastructure Detail – Facility Planning

Appendix D covers data graphs and exhibits that support the key themes and recommendations in the Global Assessment of Infrastructure – Facility Planning section of this report. The exhibits cover data pertaining to facility planning observations and findings.

DSHS Facility Planning Observations and Findings

Facility Name: Austin State Hospital, Austin, TX



This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.

Campus

General

- The campus is located within an urban setting, occupying several city blocks within the bounds of the following primary city roads: West 38th, and West 45th, and North Lamar Boulevard, and Guadalupe Street). Austin State Hospital occupies approximately 70 percent of this superblock. Primary immediate neighbors within this superblock include a public park (“Central Park”) and, a multi-family residential complex at the southeast corner, the Heart Hospital of Austin at the southwest corner (including parking garage), and a shopping plaza to the west. These adjacent properties are tight against Austin State Hospital, characteristic of an urban campus setting.
- At the north end of the site are DSHS administrative buildings for Behavioral Health and Substance Abuse Services.
- Several older buildings are utilized for storage, administration, and service (including buildings 501, 524, 540, 551, 554, and 736). Most support spaces, including the central kitchen, supplies, laundry, linen, and maintenance/grounds are located along the west edge of the site. These service areas are close to the Adult Specialty Services building (794), but more distant from the larger Adult Acute/Admissions inpatient buildings (784, 785) and Medical Services Complex (781).
- The Child and Adolescent program Services unit (CAPS, building 637) and Day School (638) are separate from the remainder of the campus by West 45th street. This separation helps to segregate this population from the adult services on the main campus, which is beneficial for these younger consumers, but may be difficult for staff or services that may be shared across the entire campus.

Wayfinding/Parking/Movement

- From the main entrance off of Guadalupe Street, wayfinding for visitors to the main Administrative building (501 – the original structure from 1860) is clear and requires minimal vehicular or pedestrian travel.
- Wayfinding throughout the remainder of the campus is complex, due to the size of the site and organization of buildings. There are very few orthogonal vehicular roads or pedestrian walkways, and nearly all building footprints are unique, contributing to complicated internal site circulation.
- Parking is scattered throughout the site, and while there is a small central lot adjacent to the Administrative building (501), most parking occurs via angled or parallel spaces along internal roads.
- The 6-story Medical Services Complex is conveniently located to serve the Adult Acute/Admissions inpatient buildings (784, 785), with an enclosed connection to each building. However, it is remote from the Adult Specialty Services building (794), which may create inefficiencies if consumers need to be transferred back and forth.
- There are a few campus buildings that may be used by consumers outside of the inpatient environment, including the Chapel (639), Recreation (797), and Education/Rehab (631). Movement of consumers to/from these buildings may create inefficiencies, and may be limited by mobility and/or security restrictions.

Outdoor Space

- Despite the urban setting, there appears to be significant open outdoor space throughout the campus, with a large quantity of mature trees and open green space.
- Large secured outdoor courtyards are provided within the center of the Adult Acute/Admissions inpatient buildings (784, 785), which include tennis courts, shade structures, and green space.
- An internal courtyard is also provided within the center of the Adult Specialty Services building (794), including a tennis court, hardscape, and green space. This building also includes additional perimeter courtyards secured by fencing, each with ample open green space.
- The CAPS area includes several distinct courtyards that feature a tennis court, play areas, shade structures, and ample green space. The courtyards are secured with perimeter fencing. One of the courtyards is linked directly to the Day School building.
- The public Central Park is immediately adjacent to the southeast boundary of the campus, next to the main Adult Acute/Admissions inpatient buildings (784, 785). While this park is not on the campus property, it is a physical and aesthetic amenity visible from the southern portion of the campus and many south/west-facing rooms in buildings 784 and 785.

Consumer Environment/Layouts

Adult Acute/Admissions inpatient buildings (784, 785)

- Each of the two Adult Acute/Admissions inpatient buildings is similar, with eight main units/wards. Each unit/ward appears to consist of two short bed wings, with a central open activity area. Staff support areas are adjacent to either side of this central area.
- Circulation linking the various units/wards appears to occur via an external covered walkway, which may be problematic in inclement weather, and compel staff to take shortcuts through units.
- Individual resident rooms have access to daylight and views. Building 785 also includes higher ceilings and clerestory windows within the central activity areas.
- Washrooms appear to be shared and accessible from outside of bedrooms. This approach is generally safer but offers less resident privacy/dignity.

Adult Specialty Services building (794)

- The layout of this building is very different from the Adult Acute/Admissions inpatient buildings. This may result in a different operational and care model, one which responds not only to the resident population, but also to the difference in the physical layout.
- An internal perimeter circulation corridor appears to afford access into each of the four individual units independently, which is a positive attribute. Entry into each unit appears to be in close proximity to a centralized staff/nursing area, which is also a positive feature.
- Each unit is organized as two bed wings emanating from a central position, assumed to be a staff care team location. This central location appears to afford good visibility down either bed wing corridor.

- There do not appear to be any security vestibules/sally ports at the pod entries, which may create elopement risks.
- Individual resident rooms have access to daylight and views.
- Washrooms appear to be shared and accessible from outside of bedrooms. This approach is generally safer but offers less resident privacy/dignity.

Child and Adolescent (CAPS, building 637)

- The Child and Adolescent unit is organized into four distinct pods. These arrangement likely aids in segregating consumers by gender, age, and/or diagnosis. The building is a single-story structure, eliminating risks associated with vertical movement.
- There do not appear to be any security vestibules/sally ports at the pod entries, which may create elopement risks.
- There is perimeter fencing around the exterior courtyard spaces, though the composition and height varies considerably. Some consists of a non-climbable design, ranging in height from 5' to 7'. Other fencing is taller with an inward angled top portion, though its composition of standard chain-link material is climbable. Still other perimeter fencing is standard chain link material at roughly 5' – 6' in height.
- Individual resident rooms have access to daylight and views, though it is limited by the very small size of the window and its positioning often in the corner of the room.
- Washrooms are shared and accessible from outside of bedrooms. This approach is generally safer but offers less resident privacy/dignity.

Physical Appearance

- The original 1860 Administration building has historic significance. The main entrance façade that faces south/southeast generally conveys a positive image to visitors arriving on the campus.
- The Adult inpatient buildings (784/785/794) were built in 1958, and are showing signs of their age. They are comprised primarily of brick and metal windows (with some glazed accent brickwork), and generally do not present a positive aesthetic presence on the campus.
- The 6-story Medical Services Building (781) has a strong physical presence on the campus due to its height, though it is very institutional in appearance, consisting primarily of brick and metal windows.
- Brick is a predominant material used on buildings throughout the campus. The age of nearly all of the buildings appears to contribute to a generally negative aesthetic.
- The CAPS building (637), which is newer than most campus buildings (built in 1973), has a bit more visual interest due to an articulated roof line.



501 – Administration



**784 – Typical Adult
Inpatient Building**



**637 – CAPS Building/fence
variety**

Facility Design Overview

Facility Name: Big Spring State Hospital, Big Spring, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



Campus

General

- The campus is located within an open/rural setting just outside of the core of Big Spring, just north of Route 20 and west of US Highway 87. Primary immediate neighbors include the VA Lamun-Lusk-Sanchez long term care facility to the southeast, and a baseball field complex to the southwest. The majority of land to the east, north, and west consists of open farmland and undeveloped greenspace.
- Several older/original 1938 buildings at the front (east) of the campus are utilized for storage and administration (including buildings 501, 502, 503, and 505). While the central kitchen (building 534) is centrally located on the campus, grounds/maintenance, environmental services/laundry, and warehouse storage is located at the west end of the site, separated from the campus core by several hundred feet.
- Consumer buildings are generally clustered in the center of the campus, including two Adult Psychiatric inpatient buildings (532 and 533), the Weaver Medical Services building (540), and the Activity/Therapy building (557 – more recently constructed in 1992).

- Building 506 is listed in the CAFM Building Data list with a sleeping occupancy, and is indicated on the 2010 building drawing as the Youth Services building. However, as the site currently houses 200 inpatient beds for adults only (18 years and older), this building is assumed to currently house functions other than inpatient care.
- At the southeast corner of the site, near the campus entrance, are several small staff and family/visitor residences, admissions and visitor information, security, and community relations functions.

Wayfinding/Parking/Movement

- From the main entrance off of US Highway 87, wayfinding for visitors to the main Administrative building (Harrison Building 502 – the original structure from 1938) is clear and direct around Rainbow Circle. Parking is available immediately adjacent to this building, as well as the Chapel (building 542) just across the street from the Harrison Building.
- Wayfinding throughout the remainder of the campus is generally simple, as the campus is designed as a roughly symmetrical site, with only a few major internal roadways that are clear and orthogonal.
- Parking is distributed across the site, adjacent to each of the main resident, administrative, residential, and service buildings.
- The various buildings occupied by consumers are fairly centralized, so exterior travel is minimized on this campus. However, the separation of functions into separate buildings does create issues, as movement of consumers to/from the Activity/Therapy building (557) and the Weaver Medical Services (540) building may be limited by mobility and/or security restrictions. Movement of staff and services between buildings also creates inefficiencies. Note that the Adult Psychiatric inpatient buildings (532 and 533) are connected by an external covered walkway, easing movement between these facilities in inclement weather.

Outdoor Space

- The rural setting offers ample access to outdoor space. The campus itself contains numerous open areas between buildings, predominantly consisting of flat lawns and scattered small trees.
- Moderately sized secured outdoor courtyards are provided at each of the two Adult Psychiatric inpatient buildings (532 and 533). These courtyards include hardscape, some greenspace, and shade structures.
- Building 506 also includes some fenced outdoor courtyards, with greenspace and shade structures. These may be remnants of when this building housed the adolescent building, prior to this population being served by North Texas State Hospital (Wichita Falls campus).
- The Activity/Therapy building (557) also include a fenced area to the south, which includes a loop walking path.
- There is significant open land on the western portion of the campus, which includes a walking/running track.

Consumer Environment/Layouts

Adult Psychiatric inpatient buildings (532 and 533)

- Each of the two Adult Psychiatric inpatient buildings is very similar, with only minor differences. Each building contains 4 units/wards, each with 6 multi-bed rooms (one unit in building 533 appears to have 7 bedrooms).
- The units consist of a double-loaded corridor, with the multi-bed bedrooms on one side, and support spaces on the opposite side. A central care station is provided centrally between each of two unit wings, with direct visibility of the unit entry. Large open activity areas are positioned adjacent to the central care stations.
- Individual resident rooms have access to daylight and views. Some of these views are directed into internal courtyards, while others open out towards the campus.
- Washrooms appear to be accessible from within the multi-bed rooms.

Physical Appearance

- The original 1938 buildings that are now used generally for administration and storage have historic significance and generally portray a positive image upon arriving at the campus. The age of these buildings, and the various renovations/alterations done to them over time, detract a bit from their historic appearance (i.e., metal fire egress stairs at the ends of many of the wings). In some of these older buildings, such as 505 and 506, many of the original windows have been in-filled and painted to match the brick, which has a negative appearance.
- The original buildings are two stories, and have a strong presence on the campus upon arrival. The inpatient facilities in the center of the campus are one-story, and tend to recede a bit behind the older historic buildings.
- The Adult Psychiatric inpatient buildings (532 and 533) were built in 1954, and are showing signs of their age. They are comprised primarily of brick and metal windows, and generally do not present a positive aesthetic presence on the campus.
- The Activity/Therapy building is much newer (built in 1992), and appears to be in good condition.
- The staff and family residences are all one-story, though some appear to be in poor physical condition and reflect poorly on the visual appearance of the campus near the site entrance (such as building 528).



502 – Harrison Administration Bldg.



533 –Adult Inpatient Building

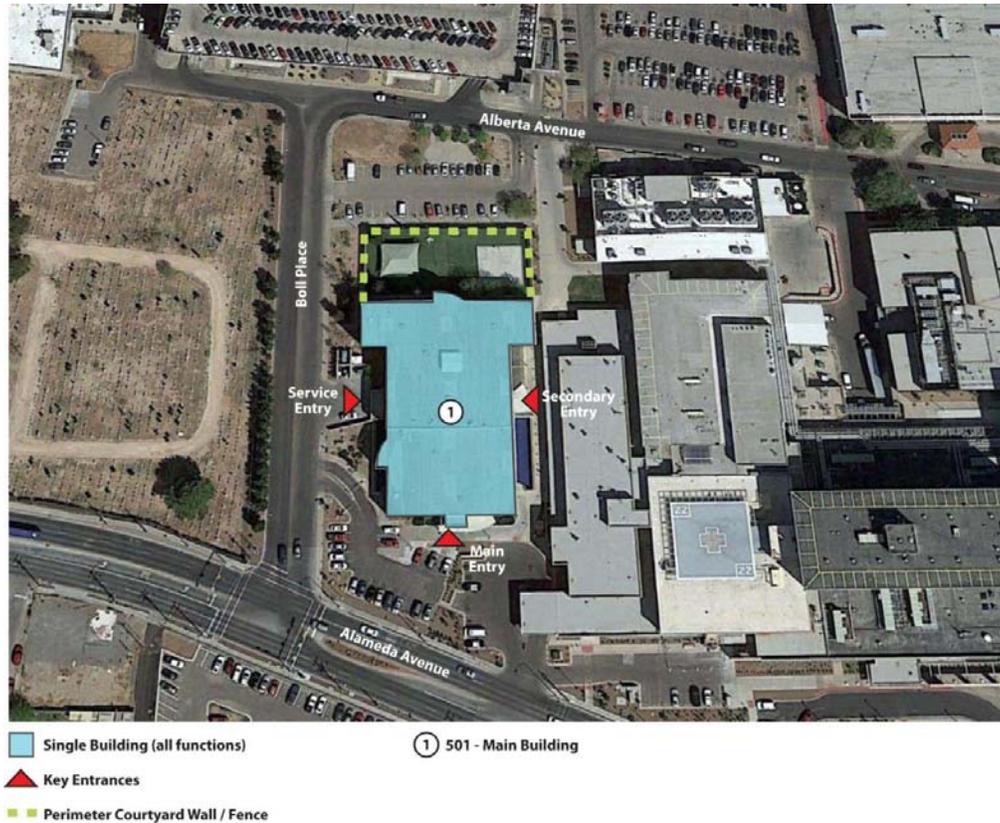


557 – Activity/Therapy Building

Facility Design Overview

Facility Name: El Paso Psychiatric Center, El Paso, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



Campus

General

- The facility is unique amongst the DSHS state hospital campuses, in that it is comprised of a single building that is relatively new (1996). The setting is relatively urban and developed.
- Immediately to the east is the University Medical Center of El Paso, the largest medical facility in the city and region (the Emergency and ambulance drop-off area is a recent addition to the medical center, and is immediately adjacent to the southeast corner of the psychiatric building). Evergreen Cemetery is located immediately to the west. Single family housing is located to the southwest, and light industrial facilities exist to the north.
- The facility includes space at the lower level for use by Texas Tech medical and psychiatry consumers, including on-call rooms. The building was originally constructed to coordinate with long range planning for the overall medical campus, which is affiliated with Texas Tech (including educational facilities). The co-location with Texas Tech includes advantages, such as access to medical care and diagnostics, and the ability to share certain support services. However, there are challenges associated with unintentional/occasional crossing of outpatient

psychiatry and neurology consumers(heading to Texas Tech space) and inpatient psychiatry consumers (moving within the El Paso Psychiatric Center).

Wayfinding/Parking/Movement

- The main entrance faces Alameda Avenue, though vehicular access to the main parking lot is off of Boll Place. The entrance is very visible to both streets, and due to the fact that it is a single building, wayfinding to the entrance is straightforward. There is a secondary entrance along the east side of the building, which has more direct access to the internal elevator core. This secondary entrance is less obvious and less visible, however, given how close the adjacent medical center is at this location.
- A service entrance is located along the west, with access off of Boll place.
- There are two gated surface parking lots on the site, though each is relatively small and inadequate to support the visitor and staff occupancy within the building. A surface parking lot across Alameda Avenue to the south and surface parking and a parking garage to the north across Alberta Street, exist as primary parking for the medical center. The primary visitor lot at the south end of the building is very small, holding only around 20 cars.
- There is also a small parking lot for emergency vehicles to the southeast of the building, though this area is utilized by the ambulance drop-off at the medical center.

Outdoor Space

- Outdoor space is provided via a single enclosed courtyard attached to the north end of the building. This courtyard measures roughly 10,000 – 11,000 sf, and includes lawn area, half-court basketball, shade structure, and a few small trees.
- The courtyard is enclosed with a stone wall approximately 7' tall, with fence material extending approximately another 3' above this. Activity within the courtyard is not visible from the outside.

Consumer Environment/Layouts

- As noted, the campus is unique in the system in that it consists of a single building housing all components. It is four stories in height, and relies on a central elevator core for vertical movement. As all components, including inpatient day/night areas, administration, and support services are housed in one building, movement of consumers, staff, and supplies is much more efficient than at other SPH sites.
- Level 1 consists primarily of office/consultation rooms at the south (near the main entrance) and group therapy/activity rooms at the north.
- Inpatient units on Levels 2 and 3 are similar and consist of a centralized staff area with resident bedrooms and support spaces around the perimeter. Visibility of bedroom entrances and open day/lounge areas is likely good given the central care team position.
- The typical resident bedroom appears to be designed to accommodate two consumers, though there are other smaller rooms that may be single occupancy (the balance is roughly 75 percent doubles and 25 percent singles). Consumer washrooms appear to be accessible from within the bedrooms, which benefits resident privacy but may create additional safety risks.
- Individual resident bedrooms rooms have access to daylight and views. Day/lounge areas that are inboard, adjacent to the central care team area, have access to some daylight via windows

at the ends of adjacent corridors that terminate at the exterior wall, though views may be limited.

Physical Appearance

- The building was constructed in 1996, and as such is a relatively new facility within the state system. It is in generally good condition, and conveys a positive visual appearance to visitors and consumers arriving at the site.



North Façade and Courtyard

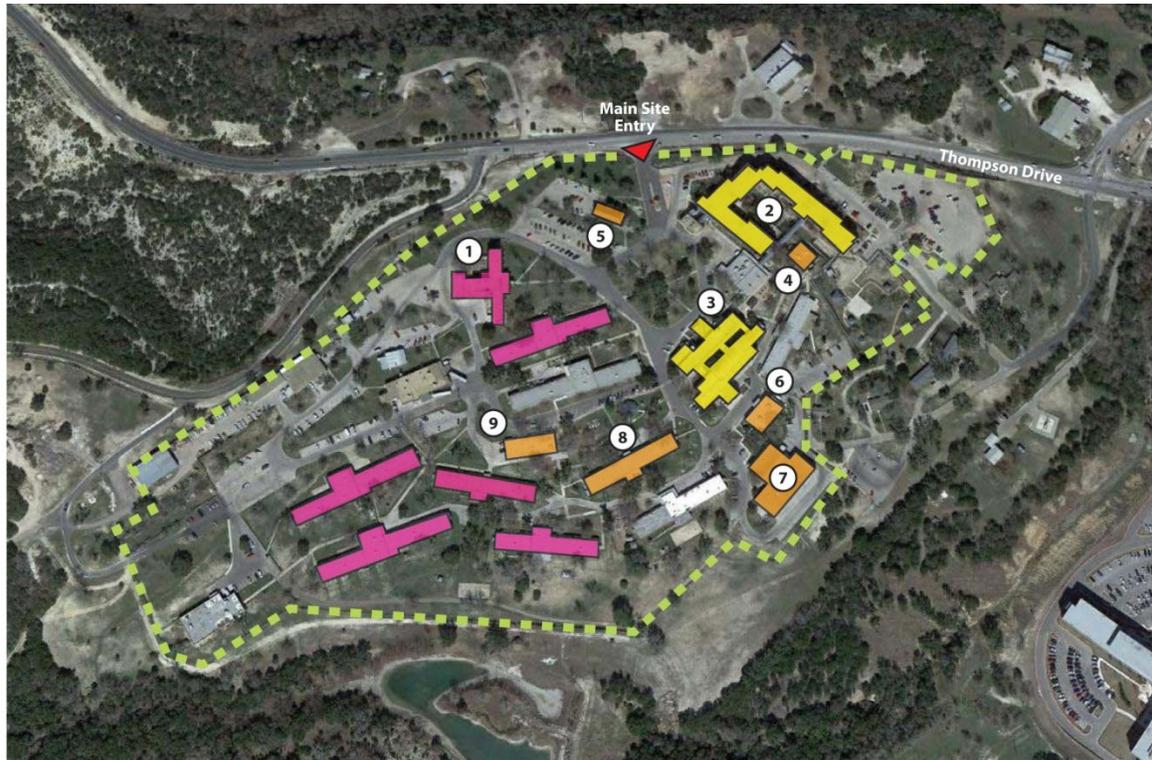


South Façade/Entrance

Facility Design Overview

Facility Name: Kerrville State Hospital, Kerrville, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



- | | |
|---|--|
| ■ Primary Inpatient Buildings | ① 501 - Original 1924 Building (now vacant) |
| ■ Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ② 630 - Ross Building (Main Inpatient Facilities) |
| ■ Notable Vacant Structures | ③ 502/502A - "Old Hospital" / "Hospital" Buildings |
| ▲ Key Site Entrances | ④ 623 - Medical Clinic Building |
| ■ Perimeter Site Fence | ⑤ 625 - Chapel |
| | ⑥ 618 - Canteen |
| | ⑦ 620 - Rehab |
| | ⑧ 601 - Psycho-social Rehab |
| | ⑨ 605 - Work Program |

Campus

General

- The facility is situated along the southwestern edge of Kerrville. It is bounded by Thompson Road and the Guadalupe River to the north, and the Petersen Regional Medical Center to the east. There is significant open land to the south and west, much of it covered with low-height trees.
- The campus occupies a large portion of land, with physical infrastructure that was designed to support far more than the +/- 200 beds that it current operates (the campus operated well

over a thousand beds in the middle of the last century). Today, resident care is generally concentrated at the eastern end of the site in the Ross building (630) and Hospital buildings (502/502A). Most of the single-story linear inpatient buildings constructed around 1955, located in the center and west end of the site, are either vacant or have been repurposed for administrative or support functions.

- Several smaller service buildings occupy the northwestern portion of the site, including equipment storage, biomedical engineering, laundry, and maintenance/grounds. The central kitchen (building 578) however, is located in close proximity to resident areas, positioned between the Ross and Hospital buildings (630, 502/502A).
- The original 1924 building (building 501) is indicated as having been abandoned.
- A series of small employee residential houses are located on the southeast portion of the campus, just outside of the perimeter fence.

Wayfinding/Parking/Movement

- There is a single entrance point off of Thompson Drive, simplifying initial access onto the site.
- Once on the site, wayfinding is complex and not straightforward within the campus. The entry drive terminates at a large landscaped roundabout. From this roundabout, several roads radiate out towards the rest of the campus, but there is no clear landmark or destination. Many of the buildings that face this roundabout are not major destinations (i.e., the chapel or abandoned building 501). Complicating this is that fact that some of the major buildings, such as the Ross building (630), actually have their service areas facing this roundabout (access to the Ross building entry actually requires driving around the building from the northern site entrance, to a building entrance on the east).
- Internal vehicular roadways and pedestrian paths are also very complex, as there is no overriding organizational concept for the campus, and nearly all buildings have a unique siting angle.
- There are two main parking areas, one of which serves the Ross building (630) and sits just east of this structure. Access from the site entrance to this lot is a bit circuitous, as described above, and would not be intuitive to first time visitors. The second large parking lot is just west of the chapel. This lot is not well positioned, as it is closest to the chapel (which is not a primary destination), the abandoned original administration building (501), and one of the vacated inpatient buildings (611). Thus significant walking is required from this lot to any of the significantly occupied buildings.
- Additional parking is available scattered throughout the campus, often as angled parking adjacent to occupied buildings.

Outdoor Space

- The low density nature of the campus results in a relatively large amount of greenspace between various buildings. There are notably large outdoor landscape areas near the chapel, the original administration building (501), and the entry roundabout. There is moderate number of mature trees in these areas and scattered throughout the site.

- Dedicated outdoor resident activity space is consolidated at the Ross building (630). There is an internal courtyard formed by the massing of the building though much of this space provides visual interest only given the steep grading and retaining walls within. The primary resident space is to the southeast of the building, and includes a half basketball court, walking loop, and shade structures. This courtyard is bounded by a perimeter security fence. It appears that some overhead power lines run directly over the secure resident courtyard on the southeast side of this building, which presents a security/safety risk.
- The entire site includes a low chain link perimeter fence. Some sections appear to have barbed wire at the top, while other sections appear as though this wire has been removed.

Consumer Environment/Layouts

Ross building (630)

- The majority of consumers are housed in the newer Ross building. The layout of this building is more conducive to contemporary care and treatment models than the original 1950s' inpatient buildings that have been vacated. The Ross building features repeated inpatient unit layouts on three levels. These units are organized with a central care station that has visibility down two bedroom corridors and an open daytime lounge space. The bedroom corridors are fairly short, keeping travel distances down.
- Consumer bedrooms have ensuite washrooms, though they are shared between adjacent bedrooms.
- Each resident bedroom and the open daytime lounge space, has access to natural daylight and views.

Hospital building (502A)

- The Hospital building is listed in the CAFM database as having a sleeping occupancy. This one story building is organized generally as a double-loaded corridor, with a central staff care station that can see down this corridor in two directions. Multi-occupancy bedrooms with ensuite washrooms line both sides of the corridor.

Physical Appearance

- Arrival at the campus is generally pleasant, as the first buildings encountered are the chapel and the newer Ross building. However, the mechanical equipment that serves the Ross building is highly visible at the entry drive and has a negative appearance.
- It is unclear how much of the perimeter fence includes barbed wire. Much of this fence is visible from Thompson Drive, and any barbed wire projects a negative appearance and connotation regarding the facility and its values.
- The original 1937 Old Hospital building (502) faces the entry road/loop and is one of the first buildings seen by visitors arriving on the campus. Its age and appearance create a negative image for the campus. Its counterpart, the more recently constructed Hospital building (502A) also conveys a very stark appearance, given its monolithic aesthetic and limited windows.
- The Ross Building was opened in 1994, and appears to be aging well on the exterior. This building conveys a positive impression and appearance to consumers and visitors.

- The original 1950s inpatient buildings on the western portion of the campus are all single story brick structures with metal windows (buildings 601, 602, 603, 604, 610, 611, 612, 613). Many of these buildings are vacated, but they are showing their age and generally contribute negatively to the appearance of the campus. Some of these buildings are listed in the CAFM database as resident sleeping areas in “emergency” situations.



630 – Ross Bldg. Internal Courtyard



630 – External Courtyard (power lines)

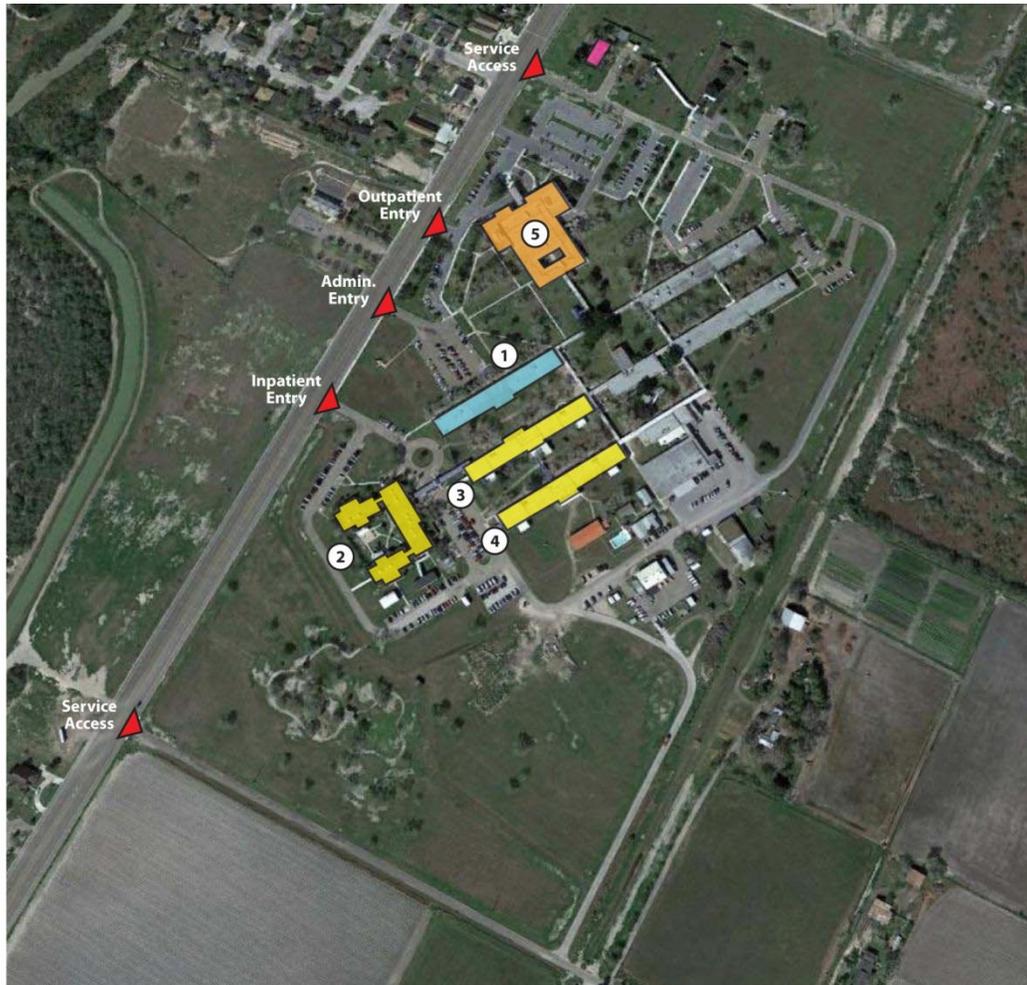


610 – Typical 1950s building

Facility Design Overview

Facility Name: Rio Grande State Center, Harlingen, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



- | | |
|---|---|
| Main Administration | ① 503 - Administration |
| Primary Inpatient Buildings | ② 515 - Wayne Potter Inpatient Building |
| Outpatient Buildings | ③ 502 - La Paloma Inpatient Building |
| Notable Vacant Structures | ④ 501 - El Paisano Inpatient Building |
| Key Site Entrances | ⑤ 500 - Outpatient Building (Primary Care, Diagnostics, Women's Health, Pharmacy Services, Social Services) |

Campus

General

- Rio Grande State Center is located along the southern edge of Harlingen. Its immediate neighbors include the Boys and Girls Club of Harlingen, Rangerville Park, Harlingen Municipal Golf Course, and moderate dense residential areas to the north. Open farmland and low density suburban residential housing extends to the east, south, and west.

- RGSC is a bit unique within the SPH system, in that in addition to the 55 behavioral health beds, the campus includes outpatient facilities geared towards primary care, women's health, diagnostics, and pharmacy. The campus also includes 73 long term care beds for individuals with intellectual disabilities.

Wayfinding/Parking/Movement

- Access onto the site is complicated by the fact that there are five curb cuts off of Rangerville Road, each more or less aligned with different functions on the site. Site Entrance 1 is roughly aligned with clinic services and access to facility support; Site Entrance 2 leads only to main administration; Site Entrance 3 leads to the Wayne Potter behavioral health building (515); the remaining two curb cuts provide access to the main outpatient building (500).
- Internal site circulation is more straightforward, as the campus does not contain a large quantity of buildings. Pedestrian walkways linking the major buildings are provided with overhead coverage to protect against the sun or inclement weather.
- Parking appears to be ample, with a large lot serving the outpatient building (500), a moderately sized lot serving the main administration building (503), a small visitor's lot serving the Wayne Potter behavioral health building (515), and a large staff lot serving the behavioral health (515) and intellectually disabilities inpatient buildings (501, 502). There are additional lots at the south and southeast portions of the site, adjacent to buildings in these areas.

Outdoor Space

- The campus is in a fairly low density suburban/rural area, and as such there is ample open space on the campus, and many of the adjacent lots surrounding the campus. There are large landscaped courtyards between all of the main buildings in the center of the campus, which include pedestrian pathways and several mature trees.
- The open outdoor spaces adjacent to inpatient buildings 501 and 502 include some limited amenities, including benches and covered patios with seating.
- The Wayne Potter behavioral health building (515) includes a large courtyard with hardscape (including a basketball hoop), shade structures, open lawn, tables/chairs, and a handful of moderate height palm trees. This courtyard is enclosed on three sides by the building. The fourth side includes a climb-resistant metal fence approximately 10' in height.
- The campus includes an outdoor pool at the south portion of the site, along with a covered picnic pavilion.

Consumer Environment/Layouts

Wayne Potter Behavioral Health building (515)

- This single-story building is organized into two resident unit wings, linked by a central common support area (which includes the main entrance into the building). Each resident unit is relatively compact and consists of a double-loaded corridor with bedrooms on both sides, and daytime spaces in the center. A separate staff area is positioned behind the core of each unit, capable of being secured from the remainder of the unit. It is unclear if the entry into the building consists of a single door or a vestibule/sally port condition to better control access and reduce risks of absconding.

- Consumer bedrooms have ensuite washrooms and appear to be primarily double-occupancy.
- Each resident bedroom and the large daytime activity spaces has access to natural daylight and views. The daytime activity spaces have direct access to the outdoor covered patios which lead to the secured courtyard.

El Paisano/La Paloma buildings (501, 502)

- These buildings are much older, dating to the 1950s. They are organized as very long, linear units with a double-loaded corridor. Consumer sleeping areas are generally located towards the ends of the corridor, with larger daytime spaces in the center. The length of the building likely creates some travel inefficiencies. The corridor lengths may also limit effective visibility.
- Consumer bedrooms appear to be multi-occupancy, with small single windows. Washrooms are shared, outside of the bedroom areas.

Physical Appearance

- The pool and patio/pavilion area appear to be in good condition. However, the series of small support buildings adjacent to them (buildings 666, 667, 519, 670) were in much poorer condition and contributed negatively to the appearance of the campus.
- The Wayne Potter building (515) was constructed in 1991 and as such is in better physical condition than the original 1950s buildings in the core of the campus. Its appearance reflects positively on the campus.
- The main outpatient building (500) received an addition to its front and other renovations within the past five years. As such, this facility now portrays an improved visual aesthetic to consumers utilizing outpatient services.
- The original 1950s inpatient buildings are single-story structures comprised primarily of brick, small metal punched-opening windows, and some aluminum storefront glazing. These buildings are showing their age and have a generally negative appearance. In some areas, there is surface mounted conduit, wiring, and piping that further contribute to a negative appearance.



515 – Wayne Potter Entry



**515 – Wayne Potter ext.
Courtyard**

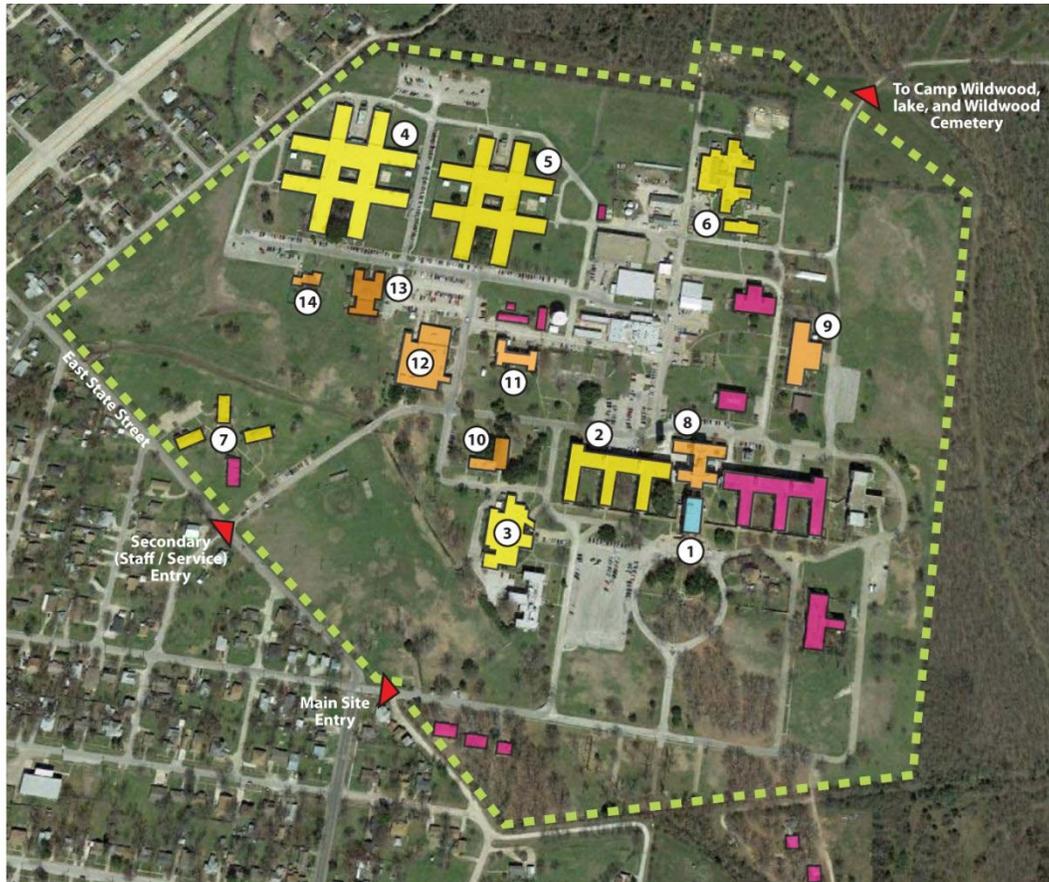


**501 – El Paisano Inpatient
Bldg.**

Facility Design Overview

Facility Name: Terrell State Hospital, Terrell, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



- | | |
|---|--|
| Main Administration | ① 500 - Administration |
| Primary Inpatient Buildings | ② 650 - Wards A, B, & C |
| Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ③ 725 - Geriatric Patient Building |
| Notable Vacant Structures | ④ 679 - Witt Hall - Adult Inpatient Building |
| Key Site Entrances | ⑤ 675 - Chambers Hall - Adult Inpatient Building |
| Perimeter Site Fence | ⑥ 518/718 - Child and Adolescent Inpatient Buildings |
| | ⑦ 727/731/732 - Transitional Living Units |
| | ⑧ 673 - Medical / Surgical Building |
| | ⑨ 682 - Child and Adolescent School |
| | ⑩ 684 - Chapel |
| | ⑪ 541 - Canteen / Dental Services |
| | ⑫ 691 - Recreation Building |
| | ⑬ 678 - Martha Allen Visitor House |
| | ⑭ 677 - Pet Therapy |

Campus

General

- The campus is located on the eastern edge of Terrell. Moderate density suburban residential neighborhoods exist to the east and southwest, while open space/farmland spreads to the southeast, east, and north. A hospital cemetery, Camp Wildwood (with covered picnic pavilion), and small lake/reservoir are located about a ¼ mile to the northeast.
- The facility includes a perimeter chain link fence, which envelops approximately 100 acres of land, creating a very large campus. There are +/- 40 primary physical structures spread across this entire area, with open space in between.
- Older buildings ranging from the 1920s – 1950s occupy the southern portion of the site. These older buildings generally house administrative and storage functions, though resident care continues in some areas. Additional buildings have been added to the campus between 1960 and 1985, occupying the west and north portions of the campus. These buildings tend to house the majority of resident functions today.
- General adult inpatient units are housed in Witt and Chamber Halls (buildings 675 and 679), located in the northwest corner of the site. Child and adolescent units are housed within buildings 518 and 718 at the northeast portion of the site. A separate geriatric unit is housed in building 725 near the southwest corner of the site. Additional resident services, such as recreation (building 691), medical/surgical services (building 673), the child/adolescent school (building 682), canteen/dental services (building 541), and chapel (building 684) are positioned within the center of the campus.
- Additional features include the Martha Allen Visitor House (building 678) and Pet Therapy building (677), located near the adult inpatient buildings (675 and 679).
- Four transitional housing units are located at the southwest corner of the site, constructed in the mid-1990s.
- The center/north portion of the campus contains many of the support services facilities, including laundry, supply warehouse, maintenance/grounds storage, and the central utility plant.
- The site contains several vacant buildings which are listed as unsuitable for use in the CAFM database.
- Overhead power lines run through many areas of the site.

Wayfinding/Parking/Movement

- Wayfinding from the main entrance to the administrative building 500 is relatively straightforward, guided by the formal forecourt and circular drive. Access to any facilities that face this forecourt is also straightforward, including the Geriatrics building (725) and Administration building (537).
- Wayfinding to other destinations on the site, including resident and staff areas on the northern side of the campus, is more complex. Internal vehicular roadways and pedestrian pathways in this area are circuitous and less direct. This is complicated by the fact that the center of the campus is occupied by support services and the central plant, forcing

resident/visitor/clinical staff movement around this area to reach more frequently accessed destinations.

- The campus is comprised of many individual buildings, and resident services are spread throughout many of these buildings. This complicates access to central functions such as recreation, the canteen, child/adolescent school, and pet therapy for consumers. Challenges include inclement weather, mobility-impaired consumers, and security/safety risks associated with movement outside of the unit. The distance between areas also burdens staff traveling to/from these destinations, including resident escort requirements.
- Visitor and administrative staff parking are generally accommodated by a large lot within the formal forecourt, adjacent to Administration building 500. There are a handful of other small-to-medium sized lots deeper into the campus, positioned to serve specific buildings such as Witt/Chambers Halls and the child/adolescent buildings.

Outdoor Space

- The large campus size results in significant amounts of outdoor space. A formal arrival court exists just in front of the 1928 administration building (500). Generous amounts of open land exist along the southwest, east, and northern edges (these areas are generally open lawn with a few scattered small trees).
- The main adult inpatient buildings (Witt and Chambers Halls) are surrounded by open greenspace. Each building includes two courtyards partially enclosed by the building on three sides, and a tall chain-link security fence (with inward angled top) on the fourth side. Each of these secure courtyards includes open greenspace, shade structure, and a basketball court.
- The Geriatric building (725) includes limited outdoor space, including a small fenced area accessed from the northwest portion of the building, with a small shade structure and seating.
- The Adolescent building (518) includes three small courtyards immediately adjacent to the building, two of which contain only hardscape, a shade structure, and some seating. The other courtyard includes open lawn. A larger outdoor area extends to the north and west, and is enclosed with a low-height standard non-secure fence.
- The Children's Cottage (building 718) includes a small fenced courtyard with lawn, shade structures, and playground equipment.
- The site includes a baseball/softball field at the southwest portion of the campus.
- As noted above, a small lake with dock, covered patio/pavilion, and open land is located about one-quarter mile to the northeast.

Consumer Environment/Layouts

Witt and Chambers Halls (675 and 679)

- These two single-story buildings were constructed in the early 1960s, and have nearly identical footprints and internal layouts, with only minor differences (presumably to accommodate specific program requirements/adjustments made over time). Each building is comprised of four L-shaped units, and each of these units include two bed wing corridors that meet at a central open area for daytime activities/dining. The bed wing corridors are simple double-loaded corridors, with bedrooms on one side and support spaces on the other.
- Individual resident rooms and the open activity areas have access to daylight and views.

- Consumer bedrooms are multi-occupancy. Washrooms appear to be shared and accessible from outside of bedrooms. This approach is generally safer but offers less resident privacy/dignity.

Adolescent Ward (519)

- This single-story building was added to the campus more recently, in 2008. The building is comprised of two resident wings, joined in the center by central staff and common areas. Each of resident wing is separated into two distinct resident units. This subdivision aids in the ability to segregate consumers by gender, age, and/or diagnosis, as needed.
- Each resident unit is organized with resident bedrooms wrapping around a central open daytime space. This arrangement keeps the overall size of the unit relatively compact, limiting travel. At one end of the unit is a staff care station, which appears to have good visibility of the unit.
- Consumer bedrooms appear to be single-occupancy, enhancing privacy. Washrooms are accessible from outside of the bedrooms. Daylight and views are provided to all resident rooms and the common daytime activity spaces.

Children's Cottage (718)

- This building is relatively small, at under 5,000sf, and has a limited occupant capacity. The layout of the building is a simple double-loaded corridor with an open common area in the center. A staff position near the center affords relatively good visibility of the center of the unit, though there may be some blind spots at either end of the building.
- Washrooms are accessible from outside of bedrooms.
- All occupied spaces have access to natural daylight and views.

Geriatric Building (725)

- This building is designed as a series of dissimilar resident units organized around a central common/staff area. It appears as though each distinct area in the building has been arranged to suit a unique function, resident population, or model of care. In contrast to Witt and Chambers Halls (which are very repetitive and modular), the Geriatric building is highly customized, and not well suited for flexibility.
- While resident rooms receive access to natural daylight and views, a large portion of the footprint sits within the internal core, with no access to daylight.

Physical Appearance

- The main administration building (500), which is the oldest building on the site (dating back to 1928), has historical significance. This building appears to have been kept in decent condition, and is an aesthetic asset to the campus. The circular landscaped forecourt and roundabout, with original fountain from the late 1800s, enhances the arrival experience at the main administration building.
- Many of the other older buildings on the campus convey a negative appearance due to their age and state of disrepair. Building 522 is visible to those arriving on site at the main administration building. This vacated building from 1934 is in a state of disrepair and conveys a significantly negative message about the campus. Building 537, which is in use as an administrative building, has some historic value, but is suffering a bit from its age and

could use an upgrade to convey a positive appearance. In many of the older buildings, the historic value of the original structure is compromised by later additions such as metal penthouse enclosures, visible rooftop mechanical equipment, exterior metal fire escape stairs, and long exterior ramps (Storage building 517 is an example). While these upgrades were necessary over time to keep the older structures functional, they have a negative impact on appearance.

- Buildings 650 and 651 also form a major portion of the appearance and atmosphere of the arrival area on the campus. These buildings were constructed around 1950, and are comprised primarily of light colored brick and a high quantity of punched metal windows. The materiality, and frequency/pattern of windows combined with operable glass panes, contributes to an industrial appearance.



500 – Administration



522 – Vacant Building

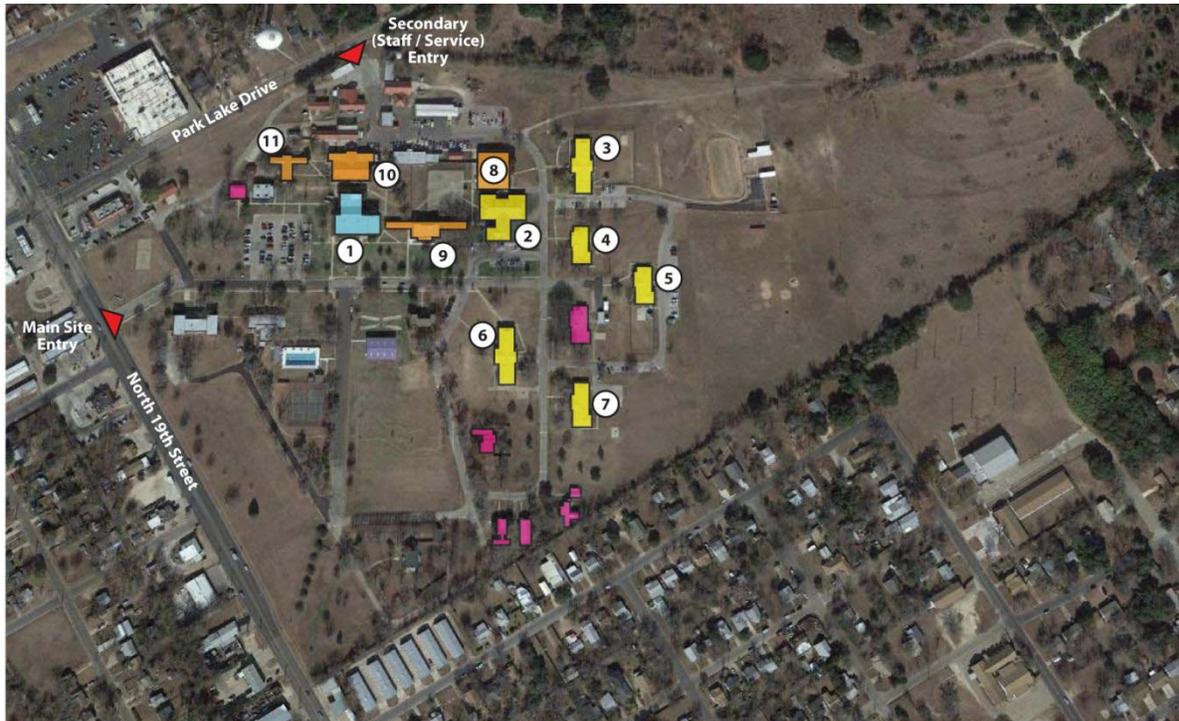


650 – Front (South) Facade

Facility Design Overview

Facility Name: Waco Center for Youth, Waco, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



- | | |
|---|--|
|  Main Administration | ① 507 - Administration |
|  Primary Inpatient Buildings | ② 501 - Brazos Residential Building |
|  Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ③ 588 - Red River Residential Building |
|  Notable Vacant Structures | ④ 566 - Pecos Residential Building |
|  Key Site Entrances | ⑤ 585 - Trinity Residential Building |
| | ⑥ 587 - Bosque Residential Building |
| | ⑦ 586 - Rio Grande Residential Building |
| | ⑧ 517 - Gym / Classroom |
| | ⑨ 503 - Education Building |
| | ⑩ 509 - Kitchen / Arts & Crafts Building |
| | ⑪ 510 - Life Skills Building |

Campus

General

- The Waco Center for Youth is located in the northern portion of Waco. Its immediate neighbors include retail establishments along North 19th Street (including restaurants and a grocery store), residential neighborhoods to the south and west, Lake Waco to the west, Cameron Park and the Brazos River to the east, and McLennan Community College to the north.

- The campus consists of three primary zones: a central staff and classroom/activity zone north of Merriwood Drive (the main internal roadway); an outdoor amenity zone to the south of Merriwood Drive; and a collection of small housing cottages along the east edge of the site.
- The staff and classroom zone includes the main administrative building (507), classrooms (503), gymnasium (517), kitchen and arts/crafts space (509), life skills training (510), and campus support functions (warehouses, maintenance shops, plant operations). The majority of the buildings in this zone were constructed between 1925 and 1940.
- The housing zone includes six small cottages built between 1957 and 1972 (one of which is listed as currently vacant). A seventh larger residential building was added in 1998 (the Brazos building – 501).
- A handful of small staff housing structures remain on the southern edge of the campus, though these are listed in the CAFM database as vacant and deteriorating (structurally unsound).

Wayfinding/Parking/Movement

- There is a single public access point onto the campus, at the northwest corner of the site, off of North 19th Street. This access point leads into Merriwood Drive, the main internal roadway on the campus. Wayfinding from the site entry to the main administration building (507) is clear and straightforward. The site's main parking lot is highly visible and adjacent to this administration building.
- Given the small/moderate size of the campus, internal wayfinding is relatively simple, supported by the simplified zoning as described above. There are a handful of small parking lots adjacent to the residential cottages, a large staff lot just north of the staff/activity zone (including a site access point off of Park Lake Drive), and some on-street angled parking adjacent to the outdoor amenity area.
- As a series of smaller buildings, movement on the site (pedestrian or vehicular) is required to get from housing to activity spaces. This creates some inefficiencies and challenges associated with inclement weather, though they are not as significant as at other SPH facilities that have additional issues with mobility impairment and/or security restrictions.
- The newest residential building (Brazos – 501) is immediately adjacent to the classroom and activity zone, and as such offers fewer challenges associated with external movement.

Outdoor Space

- The center of the campus includes a large outdoor amenity area, with a wide variety of activity options for the adolescents residing at WCY. This zone includes a pool, two tennis courts, four shuffleboard courts, a covered picnic pavilion, baseball/softball diamond, meandering walking loop, and general open lawn space.
- As the campus is a collection of several smaller buildings, there is a significant amount of greenspace throughout the site.
- There are several hard-court surfaces with basketball hoops, adjacent to each of the residential cottages. Two full basketball courts are provided in the central activity zone, within a quadrangle formed by various classrooms, recreation, and staff support buildings.

- At the eastern edge of the site is a small horse arena with stables. Beyond the horse arena is a large area of undeveloped land, which represents roughly 30 percent - 40 percent of the overall campus.
- An open lawn with a handful of small to medium-sized trees serves as a buffer between North 19th Street and the campus.

Consumer Environment/Layouts

Brazos Building (501)

- The building is separated into two distinct zones: an office and classroom zone at the front/entry, and a sleeping/residential zone at the rear of the building.
- The Residential area is broken into four distinct apartments, each with a common living area, four bedrooms (three double-occupancy and one single-occupancy), and two washrooms with shower. Washrooms are accessed from the common living area. Each of these four apartments opens into a central staff area, which has visibility into the common living areas.
- All areas in the building receive access to natural daylight. The common living areas also include some clerestory glazing and higher ceiling space for an improved environment.

Original Cottages (buildings 564, 566, 585, 586, 587, 588)

- There are two different footprints for these six buildings, one with a central entry point, and one with an entry at one end of the building. Each type generally consists of a double-loaded corridor layout.
- Bedrooms are multi-occupancy, and washrooms are accessible from outside of these bedrooms.
- All spaces in both footprint types receive access to natural daylight and views.

Other

- Education building 503 is a two-story structure, but it does not appear to have any elevator, limiting access to the upper level for consumers with mobility impairments.

Physical Appearance

- The first buildings encountered on the site are the warehouse/storage building (505) and community relations building (511). These are older structures that are showing their age, and they have a somewhat institutional appearance to them. The main administration building (507) is the primary initial visitor destination; although it is one of the oldest buildings on the campus, it appears to have been kept in decent condition and has a respectable aesthetic presence.
- The Education building (503) also has a strong presence along Merriwood Drive; although it too is an older structure dating back to the 1930s, it has been kept in good visual condition.
- The Brazos residential building (501) is the newest structure on the campus and is in good visual condition.
- The six older residential cottages (buildings 564, 566, 585, 586, 587, 588) are all similar in appearance, consisting of a fairly monochromatic palette of beige brick. They stand in contrast to the red brick used on most other structures and are in average visual condition.



507 – Administration



503 – Education Building



501 – Brazos Residential Building



566 – Typical Original Residential Bldg.



511 – Community Relations

Facility Design Overview

Facility Name: North Texas State Hospital – Wichita Falls campus, Wichita Falls, TX

This summary is based on a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings.



- | | |
|--|--------------------------------------|
| ■ Main Administration | ① 504 - Administration |
| ■ Primary Inpatient Buildings | ② 510 - Schuman Center |
| ■ Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ③ 511 - Browning Center |
| ■ Notable Vacant Structures | ④ 518 - Lincoln Center |
| ▲ Key Site Entrances | ⑤ 527 - Williams Center |
| ■ Perimeter Site Fence | ⑥ 533 - Newton Center |
| | ⑦ 508 - Hemingway Building |
| | ⑧ 514 - Sand Center |
| | ⑨ 521 - Churchill Center |
| | ⑩ 522 - Aldridge Center |
| | ⑪ 523 - Keats Center |
| | ⑫ 683 - Medical & Surgical Building |
| | ⑬ 515/516/517/539 - "Village Square" |
| | ⑭ 538/700 - Recreation and Chapel |

Campus

General

- The campus is located along the southern edge of Wichita Falls, adjacent to Lake Wichita. Residential neighborhoods lie immediately to the west and north, while land opens to the east and south.
- The campus is organized as a series of individual buildings, most of which are original structures dating to 1918 or early structures built between 1925 and 1940. There are approximately 30 – 40 primary buildings in use on the campus.
- Five original 1918 buildings create a formal crescent at the southwestern “front” of the campus. Behind these buildings lies the core of the campus, which is organized as a fairly formal array of inpatient buildings along the northwestern and southeastern edges, with common areas and support services buildings in the center. Roadways and pedestrian paths link the various buildings together.
- Common resident functions are biased towards the southwestern portion of the campus core, and support services (laundry, central kitchen, maintenance, and warehouse) are biased towards the northeast portion of the campus core. The Recreation building (700) and Chapel (538) break from this zoning, in that they are at the far northeastern end of the core.
- A family/visitor housing building and some employee housing, is located at the east side of the site, adjacent to the main site entrance.
- Unique to this facility is an indoor/outdoor therapy and treatment area termed the “Village Square,” located in the center of the campus core. This area serves as a physical and operational example of typical life skills/tasks out in the community, and is intended to serve as a treatment tool in the care model for consumers as they recover and transition back to normal life in their communities. Functions include a library, beauty salon, fashion shop, pharmacy, snack bar and movie theater.

Wayfinding/Parking/Movement

- As with other SPHs comprised of large numbers of individual buildings, movement of consumers, staff, and services is likely inefficient on such a spread out campus. Time is consumed escorting consumers from inpatient buildings to centralized recreation or therapy areas, including the central “Village Square.” Movement is also challenged during inclement weather or for consumers with mobility issues.
- The main entrance to the site is at the southwest corner, and includes a small security/guard post. Wayfinding from the site entrance to the main administrative building (504) is a bit unusual, as the vehicular roadway leads to the back side of the five formally arranged buildings at the front of the campus. The fronts of these original buildings face a formal courtyard and loop roadway. However, this formal loop road’s access to Kemp Boulevard is gated and not intended for normal visitor access.
- Visitor parking in front of the main administration building (504) is limited, with only approximately fifteen spaces. Additional parking is available on the northeast side (back) of this building, in a moderately sized lot, and in spaces along the internal roadway.

- There are a few moderately sized lots spread across the remainder of the campus, though significant parking occurs in spaces along the internal roadways. This may allow for some convenience of being able to park closely to the building being visited or worked within, but it does result in having cars nearly everywhere on the campus. Travel from some of inpatient buildings (522, 511, 518, 527, and 533) to central common areas/buildings must cross vehicular roadways, which presents a safety risk.
- There are numerous buildings housing resident care functions in operation on the campus currently. The number of active buildings results in the need to move consumers, staff, and services around the campus, which likely leads to some inefficiency due to more time spent in transit. Movement of consumers to/from different buildings may be limited by weather conditions, mobility impairments, and/or security restrictions. The Recreation building (700) in particular, at the northeast end of the site, is remote from some of the inpatient buildings.

Outdoor Space

- As noted above, the central core of the campus has been designed as a “Village Square.” This area includes outdoor space with walking paths, picnic/seating areas, and a gazebo. This is an open and unsecured area intended to replicate community life.
- There is ample greenspace throughout the rest of the campus, though most appears to be informal. There are a few very large open lawn areas across the campus, including the forecourt in front of the five original buildings at the southwest portion of the site near Kemp Boulevard, an open field with picnic shelter in the east corner, and along the northwestern edge of the campus.
- Some inpatient buildings include fenced courtyards immediately adjacent, such as buildings 511, 518, 527, and 533. These tend to be small outdoor areas, with a shade structure, minimal seating, and open lawn. Other inpatient buildings, such as 514, 521, and 523, do not appear to have any dedicated outdoor program space (there is greenspace adjacent to the buildings, though it is only open lawn, and often is bordered by parking).
- The original buildings included covered porches integrated into the massing of the structure. In most of the buildings that continue to operate as resident units, these covered porches remain in use.

Consumer Environment/Layouts

Typical resident building (508, 510, 511, 514, 518, 521, 522, 523, 527, 533)

- Each of these buildings was constructed between 1924 and 1939, and while there are differences between them, they all share the same basic footprint (a main chassis with three small wings), and each is two stories in height. The wings are relatively compact/short, generally organized as double-loaded corridors.
- As noted above, many of these buildings continue to have large integrated covered porches, though in some buildings, these have been enclosed (as with building 533).
- The original footprint and design of these buildings results in nearly all rooms receiving access to natural daylight and views. Some rooms front the protected exterior porches, offering protection from solar heat gain and glare. However, in some cases these may be resident bedrooms, and the juxtaposition of them next to the porches could compromise privacy.

- The footprint of the buildings includes some blind corners and non-visible areas, as a result of the 3-winged design. Access to the outdoor porches sometimes occurs at the end of a wing, creating a potential hiding spot for consumers.
- It appears that washrooms consist of multi-fixture facilities centralized in each building, within the middle wing. This approach offers less privacy than ensuite or individual washrooms.
- The drawings for several of these buildings indicate an elevator to access the upper levels, including buildings 510, 514, 518, and 527 (it is unclear if the other buildings have an elevator). Access to the upper floors of these buildings, for persons with mobility issues, relies on these elevators. If the single elevator is out of service, movement and care is likely severely challenged until maintenance is complete.
- Each of these buildings has been renovated over time to include an exterior ramp, as the original design elevates the ground floor a couple of feet above grade.

Physical Appearance

- The buildings that front the arrival court are all from the original facility construction and, as such, have historic value. The state of these buildings varies a bit, though their appearance is generally positive for those arriving on the site.
- The campus has retained many of the original and early buildings, constructed between 1918 and 1940. These buildings have a very consistent architectural vocabulary, consisting of a deep red brick and cream/light white moldings and detailing. This aesthetic has been repeated over time on nearly all campus buildings, lending consistency (and monotony) across the site. This repetition may cause some confusion with wayfinding, as many buildings look identical.
- The original and early buildings appear to have been maintained over the years, at least as well as could be expected for their age. Some buildings have had their external metal fire escape stairs enclosed, which improves the campus' appearance (many buildings still have these stairs exposed, however). Some buildings have had their windows replaced, improving visual appearance, though other buildings appear to still have original windows.
- Some openings in the older buildings have been boarded up and painted to match molding/trim work, presumably to accommodate interior renovations. These instances have a negative impact on campus appearance.
- The 1979 Recreation building (700) has a very different architectural vocabulary, with a post-modern appearance in stark contrast to the rest of the campus structures. While it appears to be in good visual condition, it simply stands out on a campus that has attempted to create a consistent visual language.



504 - Administration



518 – Typical Consumer Building

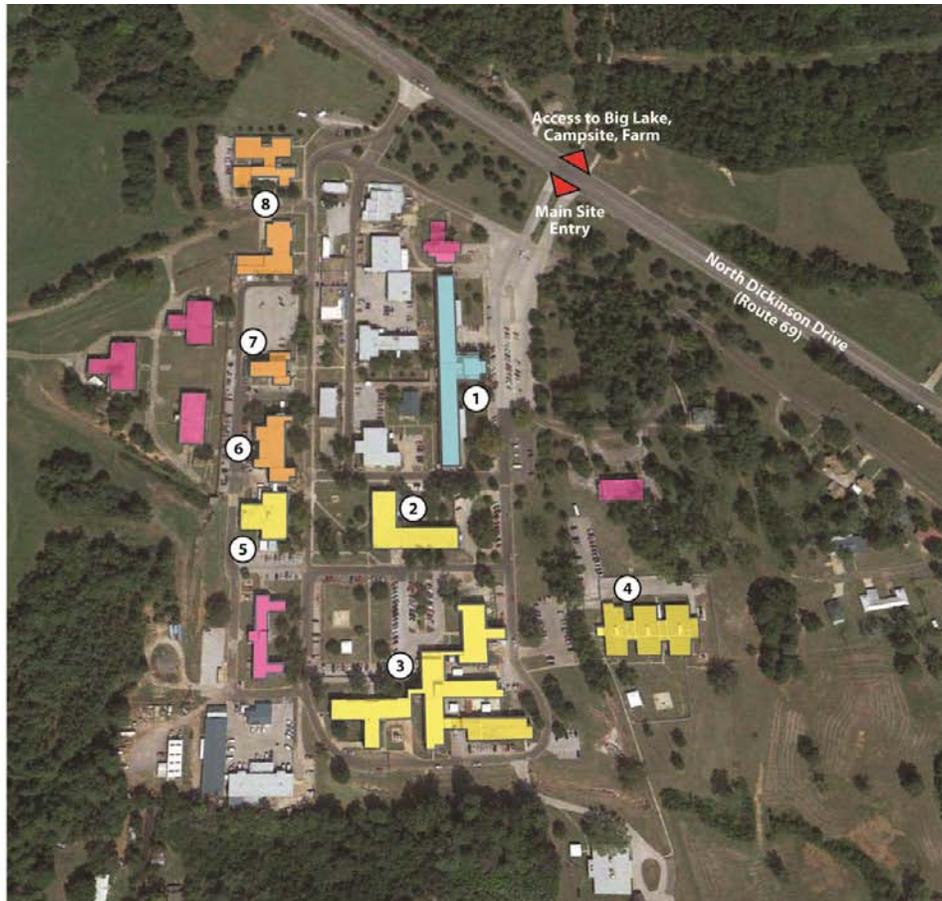


700 – Recreation Building

Facility Design Overview

Facility Name: Rusk State Hospital, Rusk, TX

This summary is based on a tour of the campus on June 4, 2014, guided by staff of Rusk State Hospital, interviews with employees of the hospital, and a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings. As this campus was physically toured, the review includes commentary and observations on both high-level issues and some detailed topics.



- | | |
|--|--|
| Main Administration | ① 501 - Administration |
| Primary Inpatient Buildings | ② 509/510 - San Jacinto Geriatric and Residential |
| Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ③ 511/512/563/605 - Nueces and Cypress (the "Complex") |
| Notable Vacant Structures | ④ 643 - Maximum Secure Forensic |
| Key Site Entrances | ⑤ 514 - Brazos Acute |
| | ⑥ 515 - Medical Services Building |
| | ⑦ 517 - Chapel |
| | ⑧ 611/617/626/630/641 - Recreation / PEAR Buildings |

Issues with General Layout

- The campus is comprised of many individual buildings that are not interconnected, which contributes to some very long travel distances; vehicles are often needed to transport materials, staff, or consumers across the campus
- Some consumer functions are in buildings remote from inpatient units (primarily the PEAR building which houses centralized activities such as music therapy, classrooms, and a canteen, which is at the north end of the campus, while inpatient units are at the south end). This separation makes it difficult and time-consuming to move patients due to weather, mobility, or security obstacles. Some patients may not have privileges to leave their unit or building, making the segregation of activities challenging and sometimes not possible for certain patients.
- The separation of buildings does however contribute to a campus with considerable outdoor landscape (greenscape and hardscape) that helps to diminish the institutional feel of the facility. Therapeutic benefits of this aspect are discussed further below.
- All of the campus buildings are quite aged, and resident care is forced to occur within footprints that are not ideal for today's psychiatric care models and practices. The majority of inpatient spaces consist of double-loaded corridors, which leads to a rather institutional environment and inadequate visibility in many areas. These outdated facility footprints likely represent the single greatest physical challenge facing RSH.

Entry Points/Security Elements

- Some inpatient units have vestibules/sally ports to help control escape risks, including the San Jacinto Geriatric unit (building 509/510) and the Maximum Security Unit (building 643). Many other inpatient units are accessed by single locked doors (i.e.: the Nueces and Cypress Complex in buildings 511, 512, 563, 605).
- All doors are locked using keys. The lack of a contemporary card access control system makes it nearly impossible to monitor staff entering or leaving secured areas, and makes general security control of inpatient environments more difficult.
- The Maximum Security Unit includes an exterior sally port through the perimeter fencing, and an internal sally port with security checkpoint and metal detection system. The perimeter fencing includes an inward angled top to help protect against climbing, though the material was standard chain-link which could be scaled by a persistent resident (though staff indicated this has not occurred).
- There is some chain-link fencing around courtyards accessed from the Nueces and Cypress inpatient units, though it is easily scaled and varies in height from approximately 6' to 10'
- The staff indicated that the entire campus at one point had a perimeter fence, which was removed to improve the non-institutional feel of the facility. With the recent increase in more aggressive forensic consumers coming from the correctional system, escape and incoming contraband risks are becoming much more of an issue. Staff indicated that a perimeter fence may again be desirable to improve overall campus security.
- Security cameras currently exist in only a couple of buildings, including the Maximum Security Unit. There is currently a capital improvement project to install interior security

cameras in a number of resident areas that do not presently have them. There is currently no plan to install any exterior cameras, though staff indicated they would be desirable.

Visible Safety Concerns

- Fixtures and hardware varied across the many inpatient buildings. Some units employed ligature-resistant door handles and lavatory “bubbler style” faucets, but the majority of areas included fixtures or hardware that presented some element of safety risk.
- The observed ensuite washroom in one of the San Jacinto Geriatric bedrooms had ligature resistant grab bars and a retrofitted enclosure around the water closet flush valve, but had accessible piping and a standard faucet at the sink.
- Examples of other safety risks due to current fixtures, fittings, hardware: forced air dryers in washrooms, lay-in acoustic tile ceilings in some bedrooms, beds that pose ligature risks or are easily damaged (or weaponized), exposed sprinkler heads in resident activity rooms, standard door handles at bedroom doors, and standard hinges on many doors.
- Newer surface-mounted plastic soap dispensers were observed in most washrooms. Staff indicated that there have not been reports of abuse or damage to these.
- Staff indicated that some of the wooden furniture components are being damaged (often by forensic consumers coming from the correctional system) and used as weapons.
- Current renovations to the Nueces/Cypress Complex buildings are making significant improvements to risks at the ceiling plane, concealing ductwork and replacing ceiling tile with gypsum board.
- Hiding areas are evident in many of the units, usually due to the existing footprints of the buildings. Examples include the pocketed bedroom doors in the San Jacinto Geriatric unit, and blind corridors in Nueces/Cypress Complex buildings 511/512.
- Visibility from a central care team position is poor in many of the inpatient units, again due primarily to the existing footprints of the buildings. The San Jacinto Geriatric and Residential units have a well-positioned care team station that can see down bed corridors and into major day activity/treatment spaces, but the Nueces/Cypress 511 and 512 buildings do not have a layout conducive to visibility (many corridors or day activity spaces are not visible from a central care team area).
- The bed clusters in the Maximum Security Unit are designed in a way that access to the two eastern pods (the ones furthest into the building) are not accessible without travelling through other bed clusters. This makes it very difficult to fully segregate clusters from one another.

Wayfinding

- Wayfinding on the main campus is generally straight-forward. Access to the main entrance (Administration – building 501) is obvious and direct from the main entrance and site security post.
- The campus is served by a loop road of sorts that provides access to the many individual buildings. There are several roads that cut through and connect buildings within the interior of the campus - the sheer quantity of buildings and the size of the campus does make it a bit difficult to fully ascertain the best way to get from one building to another.

- Some inpatient buildings have distinct and obvious external entry points (such as San Jacinto Geriatric/Residential, the Maximum Security Unit, and the main Administrative building). However, many inpatient buildings, especially the various structures that comprise the Nueces/Cypress Complex, do not have obvious access points.
- The Nueces/Cypress Complex is a series of interconnected individual structures, and the nature of the idiosyncrasies leads to very confusing connecting circulation. While it is presumed that experienced staff understands this circulation and where access points are, it would be difficult for newer staff.

Condition of Furniture/Fixtures/Space

- Nearly all furniture witnessed appeared aged and in less-than-ideal condition.
- Staff stated that they have been having issues with consumers breaking legs off of wooden furniture and using them as weapons, or minimally causing enough damage to force replacement. Wooden beds with metal frames were observed in most resident bedrooms...these beds pose serious safety risks due to their ability to be damaged, weaponized, or arranged to create ligature opportunities. RSH indicated that they are looking to purchase more appropriate behavioral health furniture in the near future to remedy this issue. Platform beds, weighted furniture, or lightweight furniture with sled-style bases should be considered in lieu of current items.
- The condition of most inpatient care space was average. The San Jacinto Geriatric and Residential building appeared to be in the best condition. The renovations to the Nueces/Cypress Complex (once complete) will bring a marked improvement to those environments, though the age of many existing-to-remain or non-replaceable components (including windows and some flooring) create a less-than-ideal visual environment.
- Many washrooms exhibited significant wear, especially in the Maximum Security Unit, where tile and toilet/shower partitions appeared to be very institutional.

Facility Maintenance

- It is clear that RSH has been making concerted efforts to maintain very old facilities, keeping them as functional, safe, and visually pleasing as the infrastructure will permit. Staff acknowledged that there is only so much that can be done given the age of the buildings.
- Durability of standard 5/8" gypsum wallboard is problematic, leading to easily damaged walls in all inpatient areas, including the Maximum Security Unit (which has a double layer of gypsum to a height of about 4', and a single layer above those...consumers quickly and easily identify vulnerable areas). RSH has been replacing damaged wallboard with impact-resistant gypsum with embedded fiberglass mesh, but it is presently too costly and disruptive to replace large sections at one time.

Aesthetic Appearance

- The exterior setting of the campus is the facility's greatest aesthetic asset, as the site and surrounding woodlands create an environment that is visually pleasing and that contributes positively to healing and recovery in a psychiatric setting.
- The campsite, farm, and lake on the opposite side of the road are a particularly positive and unique aspect of the facility. These components offer clinical staff a unique physical resource for resident care.

- The age of most buildings on the campus has a negative impact on the aesthetic quality of the facility. With the exception of the main Administrative building (501), most other structures have little or no historic value. The age of these facilities likely creates a negative perception to visitors, families, and/or consumers.
- While the main Administration building possesses historic value as the original facility on the site, its age and past function (as a prison) may not portray a positive message about contemporary treatment of behavioral illnesses.
- There are some vacant buildings on the campus that negatively contribute to the image of the facility, which would be best demolished if not economically feasible to revive/reuse. The old power plant is perhaps the first building seen as one arrives on the site, and it does not provide a welcoming aesthetic.
- Some facilities continue to be served by external fire-access metal stairs, which contributes to a negative aesthetic environment. Replacing these with enclosed stair towers is something that RSH is seeking to do in the very near future.
- The internal aesthetic of many inpatient environments is also negatively impacted by age and old materials such as glazed tile, painted brick/block, old exterior windows/frames, and old terrazzo or tile flooring.



501 - Administration



517 - Chapel



532 – Vacated Power Plant



**563 – Nueces/Cypress
“Complex”**



**511 – Metal Fire Stairs at
“Complex”**



611 – PEAR Building

Access to Natural Daylight and Outdoor Space

- Access to natural daylight and views is a very positive attribute at this campus. The grounds offer pleasing views in nearly all directions.
- Outdoor space appears plentiful, including courtyards immediately adjacent to units, on the common grounds of the site itself, or at the campsite/lake across the road.
- Overall, there is significant land available on the property.
- A baseball field is part of the main campus, and an additional field exists north of the lake/campsite.
- The courtyards directly adjacent to the Nueces/Cypress Complex generally consist of hardscape only, and lack much planting. All other outdoor areas on the campus appear to have generous planting/greenscape.
- Nearly all interior inpatient spaces, including bedrooms and daytime activity/treatment rooms, have access to natural daylight and views, which is a positive aspect of the facility.

Common Consumer Areas

- The Geriatric and Residential units in the San Jacinto building had generally adequate options for daytime activity (some open, some enclosed). These areas did not appear to be overcrowded or noisy. Some areas were centralized and easily visualized by the central care team area, while other smaller rooms were accessed off of a corridor remote from the central station and not visible.
- The Nueces/Cypress Complex generally only had one or two large open daytime activity spaces. These spaces were observed with many consumers (at times 10-15) and were generally a bit noisier. These large spaces usually overlapped the general circulation corridor. Primary activities supported by these room setups included television and general conversation.
- Part of the Nueces/Cypress Complex was currently being renovated as a central daytime activity/treatment program wing. Staff envisions more variety in these areas once complete.
- The Maximum Security Unit contained some large classrooms/daytime group rooms and some smaller lounges. Staff indicated that for the maximum 50-consumer occupancy there is a lack of daytime activity space. RSH is currently attempting to reduce the capacity in this unit to around 36, converting one of the multi-bed rooms into an additional daytime activity space.
- Generally across all units, there appeared to be a lack of smaller rooms where an individual or small group (less than 4) could go to break away from other consumers. The lack of this type of space hinders choice, and may force consumers looking to get away from a big group to go back to their bedroom as their only alternative.
- A significant concern indicated by leadership and unit directors, was the general shortage of “program” space (daytime activity, treatment, therapy) on individual units. This was most evident in the Nueces/Cypress Complex.

Privacy

- The lack of any single-occupancy rooms, including the fact that most are 5-bed rooms, contributes negatively to resident privacy.
- Nearly all washrooms are multi-stall spaces shared by several consumers, which negatively contributes to privacy. The San Jacinto Geriatric unit has some ensuite washrooms that are shared between bedrooms or dedicated to a single 2-bed room.
- The minimal amount of variety in daytime spaces on the Nueces/Cypress Complex units negatively contributes to privacy. These units generally had one or two large daytime lounge spaces that were observed to have many consumers, potentially leading to overcrowding.

Consumer/Resident Bedrooms

- Most units had 5-bed rooms, including the Maximum Security Unit and the Nueces/Cypress Complex. RSH is currently attempting to reduce the capacity in the Maximum Security Unit to around 36, converting 5-bed rooms to 4-bed rooms.
- Some areas, including the San Jacinto Geriatric unit, had 2-bed rooms.
- Most rooms were sparsely populated with only a bed and wardrobe for each resident. “Chalkboard” paint has recently been added to each resident space for an opportunity for some personalization.
- Most bedrooms had adequate finishes, hardware, and assemblies for a safe environment, including hard ceilings, protected ceiling fixtures, and polycarbonate window protection. However, some bedrooms did not include these features (lay-in ceilings noted earlier).
- Cabinet hardware on the wardrobes in the San Jacinto Geriatric bedrooms exhibited ligature risks. These wardrobes were built-in millwork and much newer than in other inpatient areas. Medical beds were used on this unit (these beds exhibit many ligature opportunities, though they may be necessary for this resident population).
- Nearly all beds and wardrobes (other than Geriatric) were comprised of wood and showed signs of age. Beds included metal frames with multiple ligature points and opportunities for weaponization.

Staff Areas

- Staff indicated that some units have immediate access to break rooms/lounges on the unit - those that do not have access to one within the building.
- Most care team stations appeared small, though it was evident that the care model included active involvement of nursing staff out in the unit with consumers.
- Lack of staff support space was not indicated to be a major concern for staff, though it was observed that support spaces (laundry, linen, equipment storage, clean supply, soiled utility, medication rooms, conference areas, charting areas, etc.) were not prevalent on the units.

Accessibility

- The age of the facilities limits accessibility to a degree. Multi-floor facilities appeared to have an elevator, though the location was not always convenient (as in the Nueces/Cypress Complex), and sometimes they opened directly into a resident environment (as in the San Jacinto building).

- Many washrooms were noted to have accessibility impediments, such as curbs at shower stalls and narrow water closet stalls in the Maximum Security Unit. The ensuite washroom observed in one of the San Jacinto Geriatric bedrooms appeared to be larger and more conducive to accessibility for those with mobility impairments.

Access to Off-Unit Therapeutic Spaces on Campus

- Access to centralized activities in the PEAR building is not convenient, creating challenges for mobility-impaired consumers, during inclement weather, or for those consumers who are not permitted to leave a unit. Moving consumers from the inpatient units to this facility often involves considerable time and effort by staff to safely and securely escort these consumers, which likely contributes to less efficient care (time wasted in movement/travel).
- The PEAR building includes a large music therapy room, several classrooms, and a canteen. A small gym exists in the adjacent recreation building, though, it is not used often (most recreational activity occurs outdoors).

Consumer Unit Layout – San Jacinto Diagram (Building 509/510)

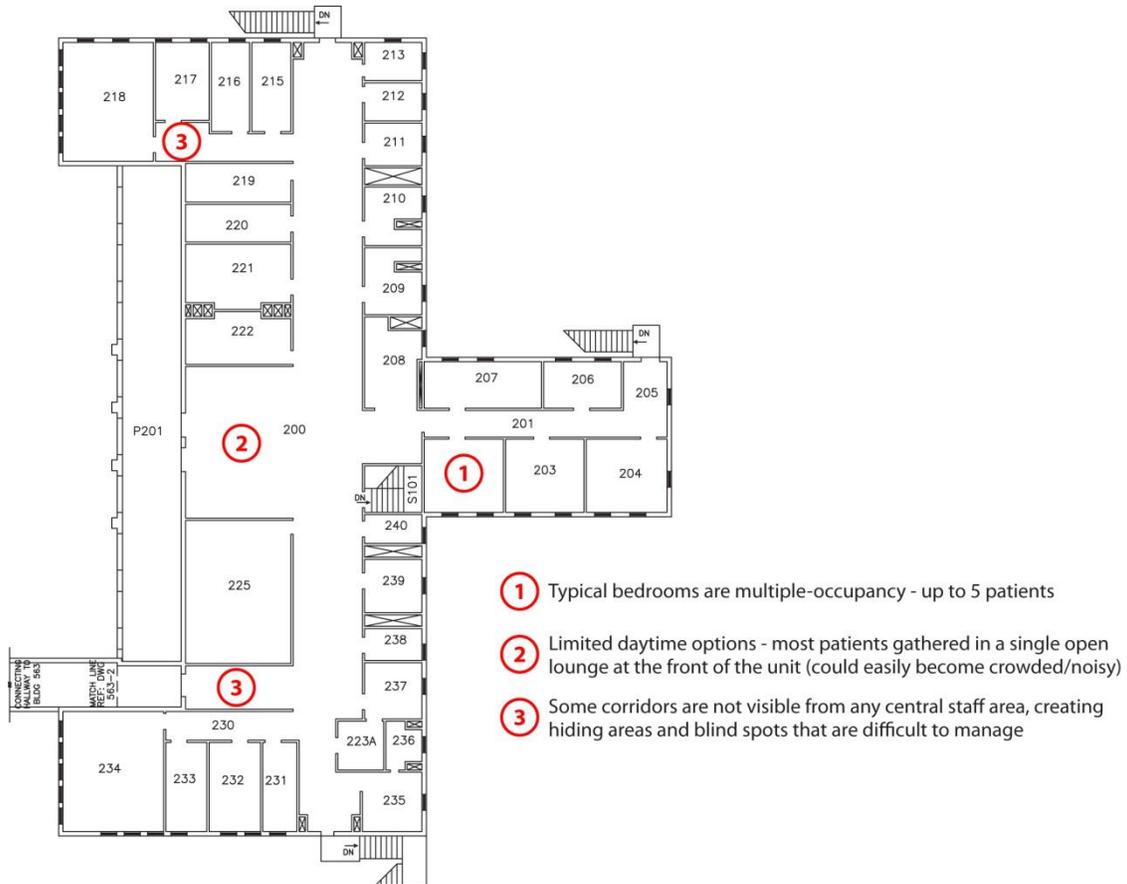


- ① Typical bedrooms are double-occupancy; washrooms are ensuite (some are shared between two rooms, others are dedicated)
- ② Staff nursing/care station is well-positioned on this unit, with sight lines down both corridors and into the main daytime spaces
- ③ This unit includes an entry vestibule / sallyport to help minimize elopement (this condition does not exist in most other units).
- ④ Open daytime space, and adjacent enclosed activity room
- ⑤ Elevator opens into patient common area, which can be inconvenient and creates risk for attempted elopement

Consumer Unit Layout – Nueces/Cypress Complex Diagram (Building 563)



Consumer Unit Layout – Nueces/Cypress Complex Diagram (Building 511)



Facility Design Overview

Facility Name: North Texas State Hospital – Vernon Campus, Vernon, TX

This summary is based on a tour of the campus on June 12, 2014, guided by staff of North Texas State Hospital, interviews with employees of the hospital, and a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings. As this campus was physically toured, the review includes commentary and observations on both high-level issues and some detailed topics.



- | | |
|---|---|
| ■ Main Administration | ① 501/502/503/504/521 - Administration |
| ■ Primary Inpatient Buildings | ② 508 Hollis (Assessment) |
| ■ Buildings with Patient Functions (Therapy / Recreation / Activity / Medical Assessment) | ③ 536 - Mooney Building (Stimulus Seeking Patients) |
| ■ Notable Vacant Structures | ④ 516 - Spruce Building (Competency Program Patients) |
| ▲ Key Site Entrances | ⑤ 517 - Cottonwood Building ("Gateway"/Transition Patients) |
| - - - Perimeter Site Fence (Security Fencing) | ⑥ 518 - Maples Building (Stimulus Avoiding Patients) |
| | ⑦ 509 - Pines Building (Multiple Disability Patients / Infirmary) |
| | ⑧ 533 - Williams Building (Adult Recreation / Activity) |
| | ⑨ 510 - Oaks Building (Female Adolescent Patients) |
| | ⑩ 511 - Elms Building (Male Adolescent Patients) |
| | ⑪ 512 - Cedars Building (Male Adolescent Patients) |
| | ⑫ 537 - Heatly Building (Adolescent Recreation / Activity) |

Issues with General Layout

- The campus is comprised of three distinct areas: an unsecured zone including administration and central services (laundry, supplies, grounds support, etc.), a secured adult zone, and a

secured adolescent zone. These zones are clearly defined due to the perimeter fencing that envelops the two individual secured areas.

- Each of the secured zones is comprised of multiple individual buildings (Eight in the adult zone and five in the adolescent zone).
- At this campus, the composition of individual buildings offers advantages and disadvantages: individual buildings allow distinct consumer populations (i.e., stimulus seeking vs. stimulus avoiding) to be housed in separate areas, allowing programming and care/treatment models to be more easily designed around each distinct population. On the other hand, the separation of the central activity/therapy building from the inpatient sleeping areas has challenges related to consumer mobility, inclement weather restrictions, and inefficiencies associated with travel or escorted consumer movement.
- The adult inpatient sleeping buildings are organized as follows:
 - Mooney building (536): Stimulus-seeking consumers; manifestly dangerous civil consumers from other SPHs
 - Spruce building (516): Competency (to stand trial) Restoration consumers
 - Cottonwood building (517): “Gateway” consumers (consumers with increased privileges and advanced recovery... a transition unit prior to discharge)
 - Maples building (518): Stimulus-avoiding consumers
 - Pines building (509): multiple disorders consumers (including those with intellectual disabilities); medically frail/infirmity unit
- The site offers considerable outdoor space in both the adult and adolescent zones. This is a positive attribute of the campus. Some outdoor areas are further separated by low-profile fences to segregate incompatible resident populations (i.e., the multiple disorders Pines building, housing consumers with intellectual development disorders, has its own dedicated outdoor courtyard).
- The admissions/assessment building (Hollys, building 508) is located within the vehicular sallyport in the adult secure zone. This position allows for the admission process to occur without impact on the operations and activities in the remainder of the adult secure zone.
- The adult and adolescent secure zones are immediately adjacent, separated by their respective perimeter fences. The general transparency of the fences does allow adult patients to look into the adolescent zone along a large stretch of their shared boundary. This visual adjacency is not ideal.
- The Mooney building (536) is designed to house manifestly dangerous stimulus-seeking consumers, often those most likely to be aggressive and seek to cause damage to themselves or others. As such, there are times when a single resident is so disruptive that they must be cared for in a unit all to themselves, which reduces capacity and efficiency. Staff indicated a desire for more flexibility to segregate one or more of these most aggressive consumers in a way that does not reduce efficiency or capacity (on the date of the tour, the west wing of the Mooney building was occupied by a resident with extreme aggressive behavior that prohibited co-locating other consumers there).

Entry Points/Security Elements

- The adult and adolescent secure zones are enveloped by their own perimeter fence, which is approximately 12' – 14' high and slopes inward to minimize climbing risks. The fence is of a chain link design, though the top 1/3 is covered by a climb-resistant mesh. Staff noted that attempts to scale this fence have generally not been an issue.
- The adult and adolescent secure zones include a vehicular sallyport with electrically-operated doors that are controlled by a security guard tower.
- The adult and adolescent secure zone also has a pedestrian sallyport that is secured with magnetic locks controlled by the same security guard tower.
- -The adult pedestrian sallyport is accessed through Security building 523, which includes the central monitoring area and a metal detection system.
- The adolescent pedestrian sallyport does not go through a security building or a metal detection system. This sallyport is therefore less secure and makes it more difficult to control contraband. There is also a greater risk of a resident attempting to “piggyback” through the secured fence doors in an effort to escape.
- Camera coverage is fairly extensive, requiring a number of large monitors in Security building 523 to display all camera images. Staff indicated that there are some blind spots in the outdoor secured areas, and that there is currently a request for additional camera coverage to improve this.
- Due to the aggressive nature of the consumers housed in the Mooney building (536), this unit includes a staff zone at the front of the building that serves as a vestibule of sorts between the building entry and the resident areas to assist with security and control.
- Consumer areas, including building entry/exit points within the secure zone, are key locked; leadership indicated a preference for electronic card access to better monitor and control entry and egress through these locked transition points.

Visible Safety Concerns

- Generally, the campus exhibited appropriate safety and security measures due to the manifestly dangerous resident population being treated. Most areas were “hardened” (gypsum ceilings, concrete block walls, security screens on exterior windows, televisions enclosed in protective cabinets, etc.).
- Visibility within the Mooney building (536) is good - each of three bed clusters and a daytime activity spaces are organized around a central care station.
- Visibility within the Spruce/Cottonwood/Maples buildings (516, 517, and 518) is less successful. The arrangement of the building (similar building designs exist on other SPH campuses) creates pockets that are not easily observed. Each of the bed wings must be observed from its own central common area.
- Visibility within the Oaks/Elms/Cedars buildings (510, 511, and 512) is also less than ideal. Visibility from a central position to the daytime lounge is good, but visibility down some corridors is poor.

- The Cottonwood building (517), which serves as the “Gateway” or transitional unit, is intentionally designed with more “normal” fixtures and fittings. The staff acknowledges that these items may pose increased safety or ligature risks, but the intent as part of the care model is to assess consumers’ response within a more normalized setting. Examples include: exposed horizontal blinds, unlocked front door to the unit, acoustic tile lay-in ceilings, standard millwork pulls, standard mechanical diffusers/grilles.
- Plumbing fixtures are varied throughout the facility. Some areas (Cottonwood and Williams buildings) include standard faucets that could serve as ligature points.
- Standard sprinkler heads with exposed mechanisms were observed in some resident areas.
- Standard door hardware was observed in the adolescent inpatient areas (in the Oaks building). Rubber base material was also observed in this building, which is not ideal as it can be pried from the wall by consumers and used as a weapon or simply to cause damage to the facility.

Wayfinding

- The distinct separation of zones on the campus generally makes site wayfinding fairly easy. There is a fairly straightforward perimeter road that runs around the outside of the secure zone, linking the support services buildings.
- There is also a vehicular road network inside of each of the secured zones, with access to building service areas for deliveries, etc.
- Within each of the secured areas, the relatively small number of buildings makes wayfinding for consumers fairly easy (i.e., travel from an inpatient building to a central therapy building).
- Each of the individual buildings is single-story, and each has a fairly simple layout making internal wayfinding relatively easy.

Condition of Furniture/Fixtures/Space

- Furniture was relatively similar across the various inpatient buildings. Lounge/day activity seating generally comprised of heavy wood-framed bases with vinyl upholstery. The general condition of furniture was adequate, showing moderate wear expected within a forensic environment.
- Some of the washroom fixtures were showing their age, and could stand to be replaced and upgraded to safer products. One example of this was in the central lounge area within bed clusters in the Cottonwood building (517 – the “Gateway” unit), where sink faucets were older standard manual taps with sink bowls showing signs of age.
- Even in the newer Williams building (533), consumer multi-stall washrooms would benefit from finish and fixture upgrades. Toilet flush valves were retrofitted with tamper-resistant covers; however, stall doors showed signs of age and damage, and air diffusers and standard faucets present ligature risks.
- The campus has some relatively recent buildings, including the Mooney and Heatly buildings (buildings 536 and 537, constructed in 1996/1997) and the Williams building (building 533, constructed in 1989). Each of these buildings is generally in good condition. Block wall

construction in each of these buildings likely has resulted in ease of upkeep and more limited repair due to resident damage.

- Most of the inpatient sleeping buildings date to the original campus establishment in the late 1960s/early 1970s. These buildings show a bit more age, though they appear to be functioning appropriately for the resident populations they serve.

Facility Maintenance

- Generally, all buildings appeared to be maintained well. More recently constructed buildings (Mooney, Heatly, Williams) appeared to be in the best physical condition.
- Many internal walls are constructed of concrete block, which has a high durability rating. Staff did not indicate major issues with wall damage in corridors or common areas.
- One seclusion room in the Mooney building (536) was observed on the site visit, and this room had padded surfaces comprised of what appeared to be an outdated material. Staff indicated that this padding is frequently damaged. Consideration should be given to a more contemporary padded wall system that provides improved durability in environments with highly aggressive consumers.
- The resident unit in the Mooney building has carpet flooring. Staff indicated that while it aids in sound absorption, it is more difficult to clean. Other areas have more traditional hard flooring surfaces such as terrazzo or vinyl composition tile. Consideration should be given to sheet vinyl or linoleum flooring that may strike a better balance between durability/cleanability/sound than carpet.

Aesthetic Appearance

- As the maximum security facility for the state, the NTSV Vernon campus caters to the most aggressive and manifestly dangerous consumers in the state. As such, there are obvious signs of security required for this population, including guard towers and perimeter security fencing. The nature of the fencing is relatively non-intimidating, as it does not have any razor-wire or barbed-wire, except at a portion of the Hollys Building. (However, its inward sloped design and height do make it obvious as something “different”).
- The buildings in both the secured and unsecured zones are comprised primarily of brick, and are one story. While there is nothing particularly noteworthy about the design/aesthetics of any of the buildings, they also do not convey an overbearing aura of security.
- Internal use of concrete block walls, while good for durability, does contribute to a bit of an institutional environment, though this is likely an acceptable compromise for limiting damage.
- Mechanical equipment serving some individual buildings is exposed at grade, protected by horizontal and vertical chain-link fencing. This has a negative aesthetic impact on the campus.



**Perimeter Security Fence
(Inside)**



501 - Administration



**508 – Hollys/Vehicular
Sallyport**



**517 – At-Grade Mechanical
Equipment**



537 – Heatly Building Entry



**533 – Williams
Building/Patio Areas**

Access to Natural Daylight and Outdoor Space

- Access to natural daylight is plentiful. Consumer bedrooms and activity/treatment areas all receive access to daylight and views via exterior windows, with noted exceptions below.
- The internal core of the typical adolescent buildings does not receive much access to daylight. This was cited as a specific deficiency by staff.
- The daytime lounges within the Mooney building do not receive any, or very little, access to natural daylight.
- There is ample outdoor space available to consumers on the campus. There are smaller dedicated outdoor spaces for populations that cannot or should not mix with other consumers.
- Covered outdoor porches/patios are provided at the adult inpatient buildings, with immediate access from internal resident areas.
- There are ropes courses for both the AFP and the MSU.
- Much of the grounds consists of seeded lawn, though there are a handful of mature trees. There are also several shade structures with seating areas/tables.
- The adult secure zone includes a greenhouse, though its use is limited in very hot or cold temperatures.
- The adolescent secure zone also includes a volleyball court, basketball court, and large open field to the west of the Heatly building.

Common Consumer Areas

- Every unit has its own dining and food preparation area, with buffet style meals. Staff indicated that they used to supply trayed meals from a central kitchen, but that the current arrangement has been functioning better, and gives consumers more choice and control over meal selection.
- The campus includes a fairly rich variety of activity/therapy/treatment spaces within both the adult and adolescent zones. This is a strong asset of the campus and is characteristic of best practice in behavioral health care.
- In the adult secure zone, the Williams building (533) serves as the central treatment mall, and includes a full gymnasium, movie theater, beauty salon, library, canteen, chaplain office, fitness/recreation room, music therapy room, computer lab, classrooms, ADL rooms, clothing store, arts/crafts room, mock courtroom (which also serves as an operational hearing room with remote capabilities), and sheltered workshops (including print shop, woodworking shop, and upholstery shop).
- In the adolescent secure zone, the Heatly building serves as the central treatment mall, and includes a full gymnasium with stage, movie theater, beauty salon, canteen, fitness/recreation room, music therapy room with recording booth, classrooms, and arts/crafts room. The classroom space consists of several areas within one large room...the preference would be for more solid physical boundaries for better sound control and minimized distractions.
- Due to the resident population served in the Mooney building, this adult unit contains several activity areas that are duplicated in the Williams building, including a small movie theater, classrooms, music therapy room, and art therapy room. On the unit itself, each of the three bedroom pods includes a large open day lounge.
- The Cottonwood building (517) includes various daytime treatment spaces, including a comfort room, large open day lounge, and group therapy rooms.
- Throughout the campus, there is a general lack of smaller daytime spaces that would support individuals or small groups of 2-4 consumers who may seek a quieter environment (to make a phone call, read a book, etc.).
- Leadership cited that an all-faiths spiritual space would be desirable.

Privacy

- The prevalence of multi-occupancy bedrooms, especially 6-bed rooms in some adult units, contributes negatively to resident privacy (although this is balanced against safety risks within the forensic population).
- No bedrooms had ensuite washrooms...all washrooms were shared amongst consumers, which contributes negatively to resident privacy (although this is balanced against safety risks within the forensic population).
- The general lack of smaller interior daytime spaces where consumers could go to read or be in a smaller group, contributes negatively to resident privacy. Nearly all daytime activity options included large spaces with higher occupancies. Examples of makeshift phone alcoves were observed (these alcoves were created to partially compensate for the lack of any smaller, permanent, private, safe/visible spaces).

Consumer/Resident Bedrooms

- Mooney building – adult (536): mostly double occupancy bedrooms; some single occupancy rooms; shared washrooms
- Cottonwood building – adult (517): 6-person bedrooms with shared multi-stall washrooms; Spruce (516) and Maples (518) buildings are similar
- Pines building – adult (509): mostly double-occupancy rooms; some single occupancy rooms; shared washrooms
- Oaks building – adolescent (510): all double occupancy rooms, although some rooms may only have one resident at a time depending on daily census; shared washrooms; Elms (511) and Cedars (512) buildings are similar

Staff Areas

- The staff indicated that the amount of staff lounge/“decompression” space is limited. Given the high aggression level of the forensic resident population, this space is desirable to maintain positive employee performance and morale.

Accessibility

- The campus consists of single story buildings, so physical accessibility is generally accommodated without the need for stairs, ramps, or elevators.
- There were no obvious accessibility obstacles other than the necessary security features associated with the forensic resident population.

Access to Off-Unit Therapeutic Spaces on Campus

- As noted above, access to these types of spaces for the highly aggressive consumers occur within the inpatient units, in the Mooney building. Access here is very close to the sleeping and daytime living areas
- Access for the remainder of the adult population is via the Williams building (533). This building is central within the adult secure zone, in relatively close proximity to all units. Access may be challenging during inclement weather or for those with mobility impairments. Access is also limited for those consumers who do not have permission to leave their units.
- Access for the adolescent population is via the Heatly building (537). This building is in close proximity to all units. Access may be challenging during inclement weather or for those with mobility impairments (although mobility impairments are infrequent amongst the adolescent population).

Other

- The Adolescent Forensic Program is scheduled to move to the former Victory Fields campus in the near future, in part to eliminate the visual adjacency between adults and adolescents at the current site. NTSH leadership would like to be able to reuse part or all of the adolescent buildings to improve on shortcomings of the current adult site, with the following options cited:
- Creation of a small unit to handle “super violent” consumers, removing them from the rest of the adult population and reducing disruption

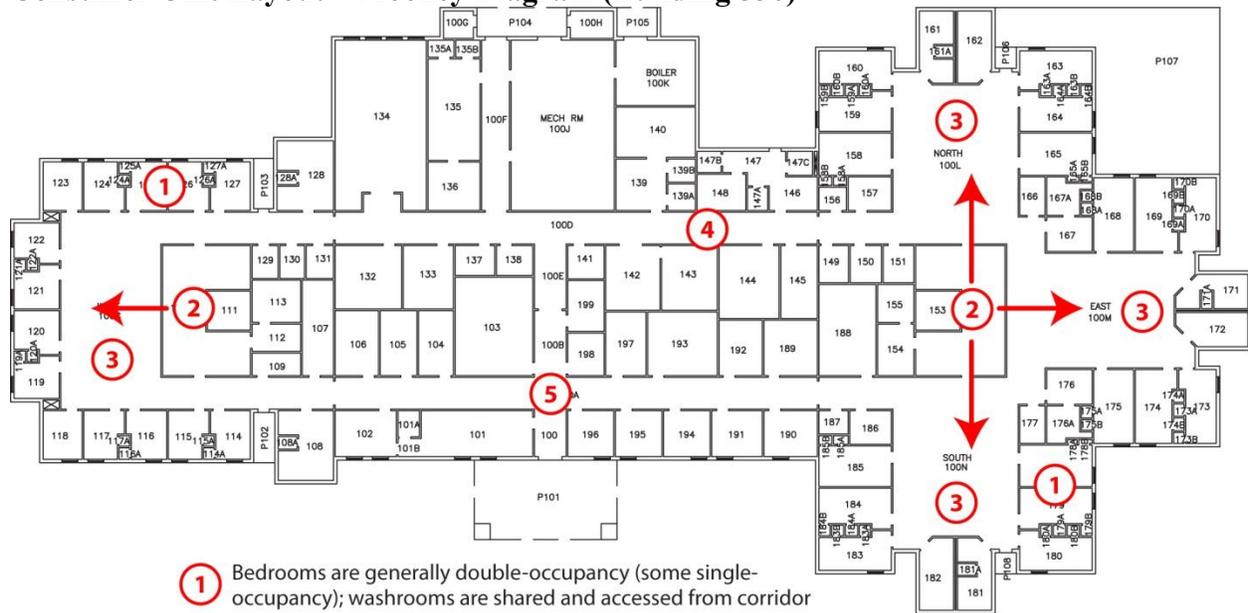
- Utilizing the separate secure zone as an area for “Gateway” consumers who are further along the path to recovery
- Re-purpose of some space to create an all-faiths spiritual center that is lacking on the campus
- Any notion that shifts beds to this zone would have a corresponding decrease in bedroom/unit occupancy (i.e., 6-bed rooms in some adult units could be reduced to more manageable 4-bed or 2-bed rooms), improving privacy and safety

Consumer Unit Layout – Oaks Diagram (Building 510)



- ① Bedrooms are double-occupancy; washrooms are shared and accessed from corridor
- ② The central staff nursing/care position has good visibility of the day lounge, but only portions of the corridor system
- ③ There is a large open daytime lounge space that can get crowded / noisy; there is limited daylight into this room
- ④ There is a large dining room with servery in one of the bed corridors
- ⑤ These corridors are more difficult to monitor and observe

Consumer Unit Layout – Mooney Diagram (Building 536)



- ① Bedrooms are generally double-occupancy (some single-occupancy); washrooms are shared and accessed from corridor
- ② The central staff nursing/care positions have good visibility of the day lounges and bedrooms
- ③ There are large open daytime lounge spaces that can get crowded / noisy; there is limited daylight into these rooms
- ④ There are several treatment/therapy spaces adjacent to the bedroom zones
- ⑤ The entry corridor serves as a vestibule to minimize elopement risks

Consumer Unit Layout – Cottonwood Diagram (Building 517)



- ① Typical bedroom pod, consisting of four 6-bed rooms and a small common area (65 - 70 patients in this building)
- ② Washrooms are shared multi-stall facilities accessed from common circulation
- ③ The central staff nursing/care position has good visibility of the day lounge, but cannot see down corridors or into bed pods
- ④ Large open daytime space, and adjacent enclosed dining room
- ⑤ Activity pod with Sensory Room and Group Rooms

Facility Design Overview

Facility Name: San Antonio State Hospital, San Antonio, TX

This summary is based on a tour of the campus on June 1, 2014, guided by staff of San Antonio State Hospital, interviews with employees of the hospital, and a review of the facility site plan/aerial, individual building plans, and exterior photography of current campus buildings. As this campus was physically toured, the review includes commentary and observations on both high-level issues and some detailed topics.



Issues with General Layout

- The campus is separated into three distinct areas: the primary resident zone at the southeast portion of the site, an older resident/administrative zone at the northwest portion of the site, and a service/support area in the middle. The separation of the two resident zones creates significant operational challenges, exacerbated by the fact that some unique therapy/activity/support functions exist at the less populated northwest zone (such as the canteen and the beauty shop). Use of these functions is limited by weather, mobility issues, security restrictions, and operational impacts associated with the long travel.
- The fact that the admissions functions occur within the older northwest portion of the campus, contributes to the operational hurdles caused by the spread out facility.
- The primary resident zone is comprised of nine repetitive building modules, most of which house inpatient units (buildings 646, 647, 648, 649, 653, 654, 655). Each inpatient unit houses 40 consumers, split into two 20-bed sections. The center of the unit includes a large open daytime space, flanked by a central staff support area. Shared multi-stall washrooms and various unit support functions also occupy the central area. A major issue with this unit design is the fact that visibility, from the central staff position to the bed corridors, is not provided. This has led to increased need for dedicated staff positioned in the bed corridors to achieve proper visibility.
- The central service/support zone includes a central kitchen, motor pool, warehouse, and grounds/maintenance buildings that serve the entire campus (including the SSLC and TCID).
- In the typical inpatient buildings (646, 647, 648, 649, 653, 654, 655), the close proximity of the seclusion rooms to the bedrooms may create acoustic and general disturbance issues.
- The typical 40-bed units are too large for containing/controlling more aggressive forensic consumers. Staff expressed a desire for one smaller unit (perhaps ten consumers) that would be more appropriate for these types of consumers.

Entry Points/Security Elements

- The campus relies on a traditional key-lock system. An electronic access control system would be beneficial to better secure and monitor entry/exit points.
- Elopement issues were cited by staff as an issue – no sallyport or vestibule conditions to help contain consumers who do not have privileges to leave a unit.
- Staff noted that the large campus is very difficult to adequately cover from a security perspective. Contraband coming from offsite is difficult to control because of the size of the site and the ease of pedestrian access onto and through the site.
- There is a +/- 6' tall fence at the primary inpatient zone, which consisted of a roller top. While the fence's design and height are not institutional, they are too short to fully prevent elopement. Staff cited elopement attempts that resulted in resident injuries/falls.

Visible Safety Concerns

- Products and fixtures did not generally exhibit tamper-resistant/vandal-resistant attributes. Staff indicated that damage to light fixtures and glass is too frequent.

- Many products exhibited ligature risks, including exposed plumbing piping, faucets, and door hardware. Staff indicated that some changes to these items have been made recently (i.e., continuous hinges), but they acknowledge that there continue to be several unsafe conditions.
- Weaponization risks were evident and/or cited by staff, including metal thermostat covers.

Wayfinding

- The campus includes two other significant medical functions – the San Antonio SSLC, and the Texas Center for Infectious Disease. Arrival on campus, and subsequent travel to an intended destination, is complicated by the multiple tenants on the site. The fact that the SPH portion is further divided into three distinct zones as described above, contributes to challenging on-site wayfinding for visitors and family members. Campus signage was cited by staff as being insufficient to delineate the various areas.
- The standardization of adult inpatient buildings helps with internal wayfinding in each of the units. Each of these buildings is comprised of a fairly straightforward “H-shape” that is easily navigable.

Condition of Furniture/Fixtures/Space

- The bedrooms in the adolescent building include plastic institutional furniture that is weighted and/or fastened to building structural components (i.e.: floor). This is generally safer, but contributes to an institutional appearance.
- Staff commented that furniture in general has not been standardized across the facility.

Facility Maintenance

- Courtyards at the main adult inpatient zone appeared well-maintained and well-utilized by consumers.

Aesthetic Appearance

- The older portion of the campus (northwest) contains buildings that have a generally negative appearance. There are abandoned buildings (i.e., building 537) in this zone which further contribute to a negative visual aesthetic. Most of these buildings have external open metal fire escape stairs, which contribute to a negative appearance.
- The main inpatient area consists of buildings constructed more recently, though they do date back to 1971. These one-story repetitive structures neither add nor detract from the aesthetic of the campus.
- The courtyard spaces within the main inpatient zone have a positive impact on the visual aesthetic of the campus.

**509 – Adolescent Building****645 – Typical Inpatient Building****644 – Typical Entry Canopy****652 – Goldsmith Admin. Bldg.****553 – Beauty Shop****518 – Goyens Hall**

Access to Natural Daylight and Outdoor Space

- Consumer access to natural daylight is provided for throughout the various inpatient buildings. In general, the older campus buildings (with double-loaded corridors) include daylight to nearly all spaces. The newer inpatient buildings (646, 647, 648, 649, 653, 654, and 655) include some spaces in the core that do not receive access to natural daylight.
- Many of the primary inpatient buildings (646, 647, 648, 649, 653, 654, and 655) are very close to one another, which limits the exterior view from some resident bedrooms.
- The campus includes ample open land, though much of it is barren lawn. The courtyards associated with the primary inpatient zone are well-kept.

Common Consumer Areas

- The primary inpatient buildings (646, 647, 648, 649, 653, 654, 655) include a single common dining area with servery for the 40 consumers (tray service is provided). These units include a comfort/exercise room in one bed wing, and a group room in the other bed wing. The primary daytime space is the large open area in the center of the building.
- The lack of adequate overall common space, and minimal variety for consumers (i.e.: no smaller daytime spaces to simply read or engage in quiet conversation with 2-3 consumers), is a significant negative cited by staff. There are limited options to allow staff to help de-escalate a resident, or consumers to self-manage problem situations.

- The main inpatient area includes off-unit therapy in separate, adjacent buildings. These are proximal and convenient to consumers and staff in this area.
- Classrooms and activity space are available to the adolescent unit in buildings 591 and 598 in the northwest zone.
- The northwest zone also includes a canteen (601) and beauty shop (553). However, access to these functions (or the activity building – 598) is very inconvenient for staff/consumers in the primary inpatient zone to the southeast.

Privacy

- The prevalence of 4-bed rooms in the adult units contributes negatively to resident privacy.
- No bedrooms had ensuite washrooms...all washrooms were shared amongst consumers, which contributes negatively to resident privacy (although this is balanced against safety risks).
- The general lack of smaller interior daytime spaces where consumers could go to read or be in a smaller group, contributes negatively to resident privacy. Nearly all daytime activity options included large spaces with higher occupancies.

Consumer/Resident Bedrooms

- The primary inpatient buildings (646, 647, 648, 649, 653, 654, and 655) are standardized in their general design and layout. Each building houses 40 beds, separated into two 20-bed sections. Each 20-bed section is comprised of multi-bedded rooms, typically with four consumers per bedroom. Washrooms are shared and multi-stall – one large area for each 20-bed section. There is generally one seclusion room per 20-bed section as well, though there is no associated ante room or washroom to support the seclusion rooms.
- Staff input included anecdotal commentary that oftentimes consumers are witnessed napping during the day, which may be indicative that nighttime sleep patterns are disrupted by noise or activity.
- The adolescent building (509) contains double-occupancy rooms, though some are occupied by only a single resident, offering some private accommodations. Washrooms are shared.

Staff Areas

- Lack of appropriate staff support space for consultation and group meetings was observed and indicated by leadership. Staff also cited a general shortage of respite areas, including break rooms/lounges to decompress from difficult, high-risk responsibilities.
- There are no code white buttons, or any personal alarm system for the campus. Distress calls are broadcast via the PA system.
- Parking associated with the main inpatient zone in the southeast was cited by staff as a shortcoming.

Accessibility

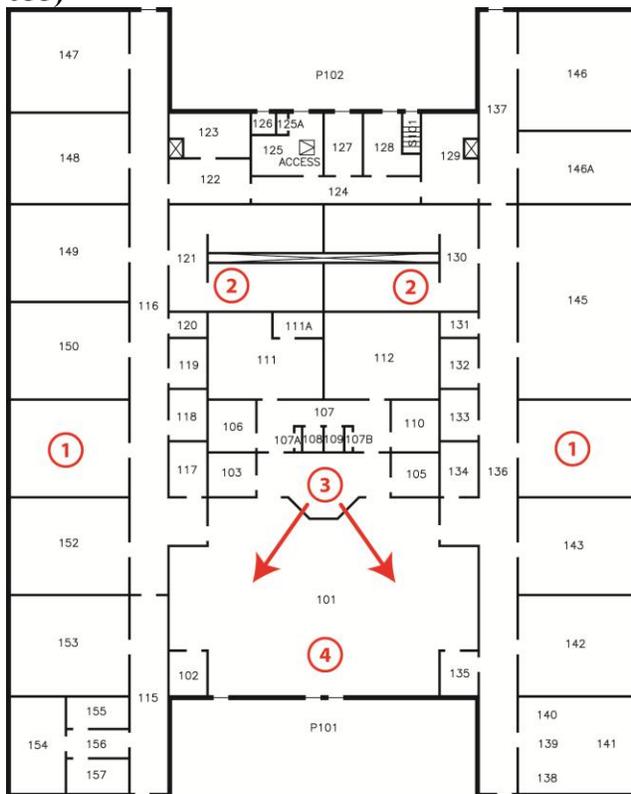
- Visitors arriving by bus have a particularly long journey to reach the facility, and there are no internal sidewalks linking the main site entry to the main administration building (652).

- Access to medical treatment or imaging facilities in the Medical Center (599) or at TCID requires vehicular travel and consumes valuable staff resources and time. This travel also introduces additional security/safety risks, and is complicated by inclement weather.
- The older campus buildings are multiple stories, and although they have been retrofitted with elevators and exterior wheelchair ramps, they do make travel for those with mobility issues more challenging.

Access to Off-Unit Therapeutic Spaces on Campus

As noted above, access to some off-unit spaces is quite convenient. However, travel to/from one zone of the campus to another is a significant inconvenience and operational tax.

Consumer Unit Layout – Typical Unit Diagram (Buildings 646, 647, 648, 649, 653, 654, 655)



- ① 40-bed units are split into two 20-bed sections, with 4 patients per bedroom
- ② Washrooms are shared multi-stall facilities accessed from common circulation
- ③ The central staff nursing/care position has good visibility of the day lounge, but cannot see down bed corridors
- ④ Large open daytime space at the entry to the building / unit

Appendix E. Global Assessment of Infrastructure Detail – Facility Infrastructure and Systems

Appendix E covers data graphs and exhibits that support the key themes and recommendations in the Infrastructure detail section of this report as it pertains to the facility infrastructure and systems. The exhibits cover data collected and analyzed in an in-depth assessment of three SPH facilities – Rusk, North Texas and San Antonio. Items covered in this section include the asset portfolio, funding scenarios, system and asset summary and needs detail and comparison of VFA 2004 data vs. 2014 data.

Rusk SPH

- Asset Portfolio
- Funding Scenarios
- Funding Needs and Systems List
- System Summary List
- Asset Summary List
- System Needs Detail
- Project Plans
- Comparison of VFA 2004 data with CannonDesign 2014 data

North Texas – Vernon SPH

- Asset Portfolio
- Funding Scenarios
- Funding Needs and Systems List
- System Summary List
- Asset Summary List
- Project Plans
- Comparison of VFA 2004 data with CannonDesign 2014 data

San Antonio SPH

- Asset Portfolio
- Funding Scenarios
- Funding Needs and Systems List
- System Summary List
- Asset Summary List
- Project Plans
- Comparison of VFA 2004 data with CannonDesign 2014 data

Please see separate Appendix E attachment for details.

Appendix F. Global Assessment of Real Estate Detail

Appendix F contains the full summary reports for the real estate assessments of three SPH campuses – Rusk, North Texas – Vernon, and San Antonio State Hospitals. The detailed reports cover data pertaining to determination of resourceful use of real estate holdings, site analyses and evaluation of current and future land use needs, evaluation of current and future building and infrastructure uses, inventory of medical and non-medical office spaces in the surrounding areas, and review of adjacent properties.

Rusk SPH – CBRE Report

North Texas – Vernon SPH – CBRE Report

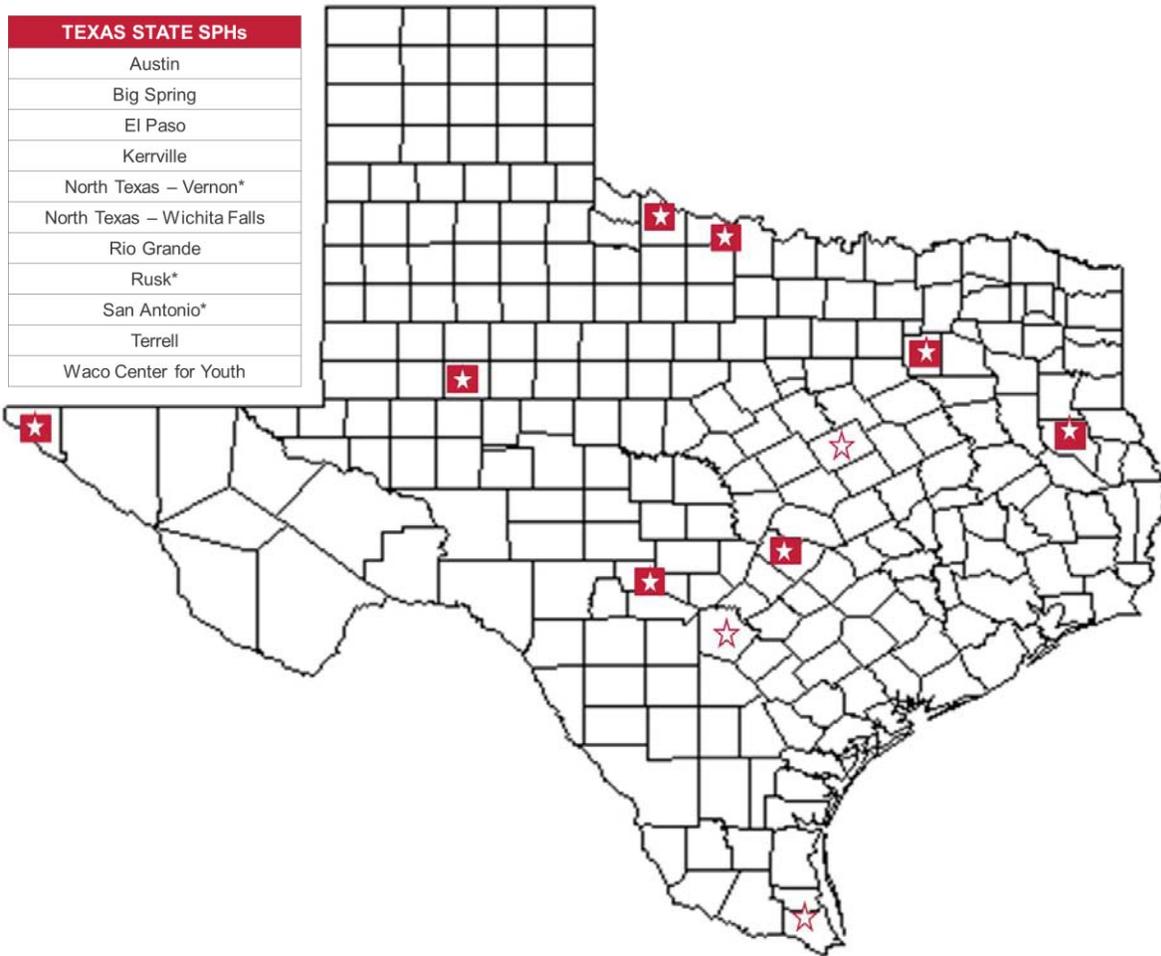
San Antonio SPH – CBRE Report

The real estate reports are included as a separate attachment labeled as Appendix F.

Appendix G: Global Assessment of Care Model Detail

Appendix G covers data graphs and exhibits that support the key themes and recommendations in the Global Assessment of Care Model section of this report. The exhibits cover data pertaining to the care model analysis.

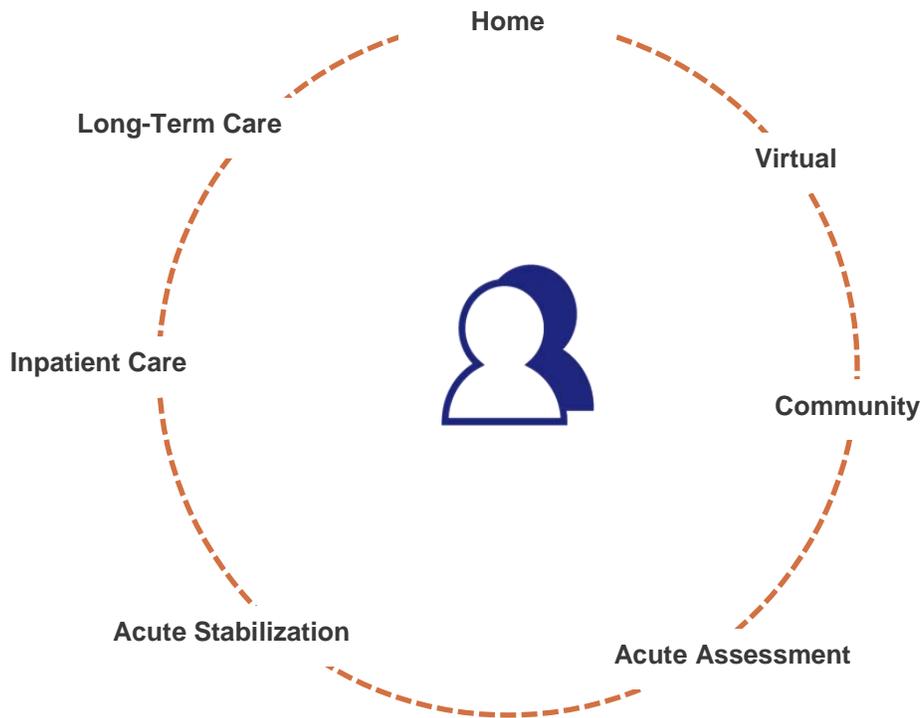
Exhibit G-131. Texas' State Psychiatric Hospital Locations



*Notes: *Indicates SPHs selected for detailed onsite facility and infrastructure evaluation*

An assessment of every SPH in Texas was conducted. Three SPHs (North Texas-Vernon, Rusk and San Antonio) were selected for a detailed facility and infrastructure evaluation process.

Exhibit G-2. Integrated Continuum of Care Model



Behavioral health integrated continuum of care that seamlessly coordinates home, community, ambulatory, acute stabilization, and long-term management of resources.

Exhibit G-32. Comparing Texas Behavioral Health Metrics with Other Large States

	AZ	CA	FL	IL	NY	PA	TX	United States
Utilization Rates/Number of Consumers Served								
Community Utilization of Behavioral Health Services per 1,000 population	22.22	16.18	15.31	10.57	33.19	49.02	11.90	21.67
State Hospital Inpatient Adult Admissions	0.24	0.38	0.60	0.91 ¹	0.65	0.43	1.01	0.90
Community Hospital Adult Admissions	0.37	17.63	0.60	-	0.89	1.00	0.60	2.28
Percent Adults with SMI and Children with SED	49%	89%	87%	69%	73%	62%	94%	70%
State Hospital LOS Discharged Adults (Median)	431 days	150 days	166 days	-	75 days	238 days	17 days*	63 days
State Hospital LOS for Adult Resident consumers in facility <1 year (Median)	128 days	106 days	115 days	-	86 days	93 days	37 days	69 days
Hospital Readmissions								
State Hospital Readmissions: 30 Days - Civil Consumers only	0%	3.3%	0.3%	14.3%	7.6%	1.6%	6.7%	8.9%
State Hospital Readmissions: 180 Days - Civil Consumers only	0%	11.9%	6.0%	23.5%	18.1%	6.5%	15.6%	19.6%
Resident Perception Survey Measures								
Access to Services	81%	85%	92%	-	90%	85%	77%	86%
Quality/Appropriateness of Services	83%	88%	92%	-	90%	83%	79%	89%
Participation in Treatment Planning	84%	78%	92%	-	80%	84%	65%	82%
Outcomes from Services	70%	70%	89%	-	80%	63%	56%	72%

Notes: Utilization reflects data prior to Illinois closing multiple state-operated psychiatric hospitals

**Though SAMHSA reports 17 days for Texas State Hospital LOS, this may have been incorrectly reported. Reporting Error. LOS for Fiscal Year 2010 = 52 days and LOS for Fiscal Year 2012 = 56 days*

Sources: 2012 SAMHSA Behavioral Health State Reporting Measures; CannonDesign analysis 2014.

Texas ranks below other highly populated states, as well as the national average, in many key behavioral health measures. Utilization of behavioral health services per 1,000 population is lower than the other comparative states, though state hospital inpatient adult admissions is slightly higher than the national average. Additionally, in surveys measuring resident perception of behavioral health services, Texas scores lower in resident perception of access to services, quality of services, participation in treatment planning, and outcomes from services as compared to other populous states and the national average.

Exhibit G-4. Average ED Length of Stay for Consumers with Behavioral Health Needs

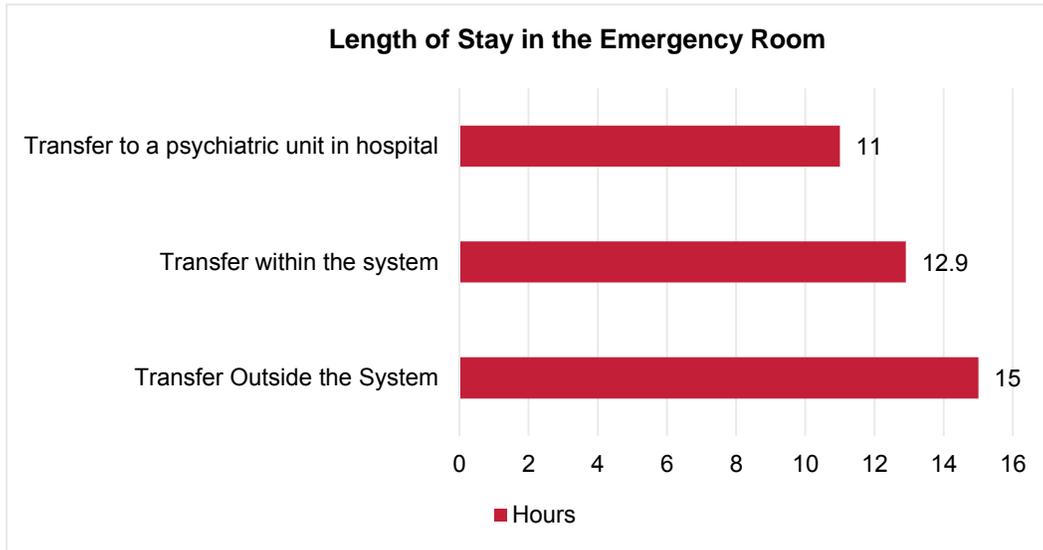
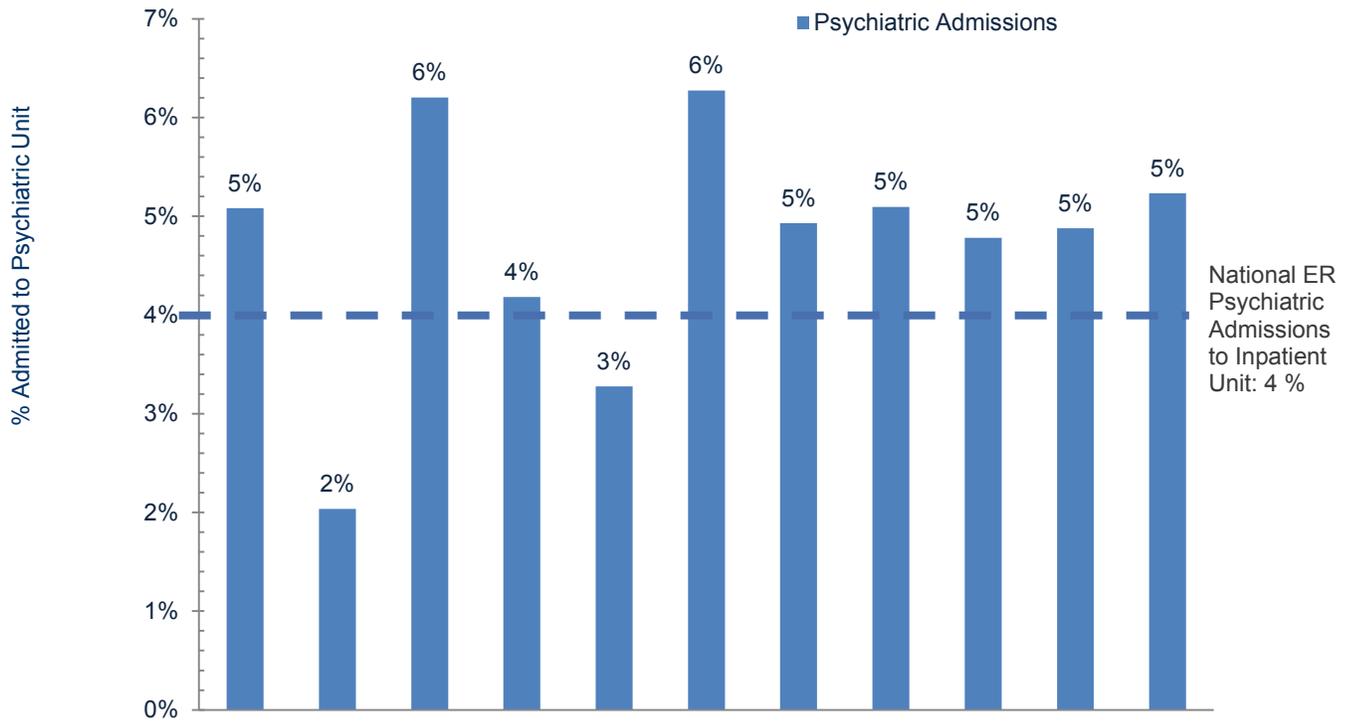


Exhibit G-5. ED Visits Resulting in Psychiatric Admissions in Texas, FY12

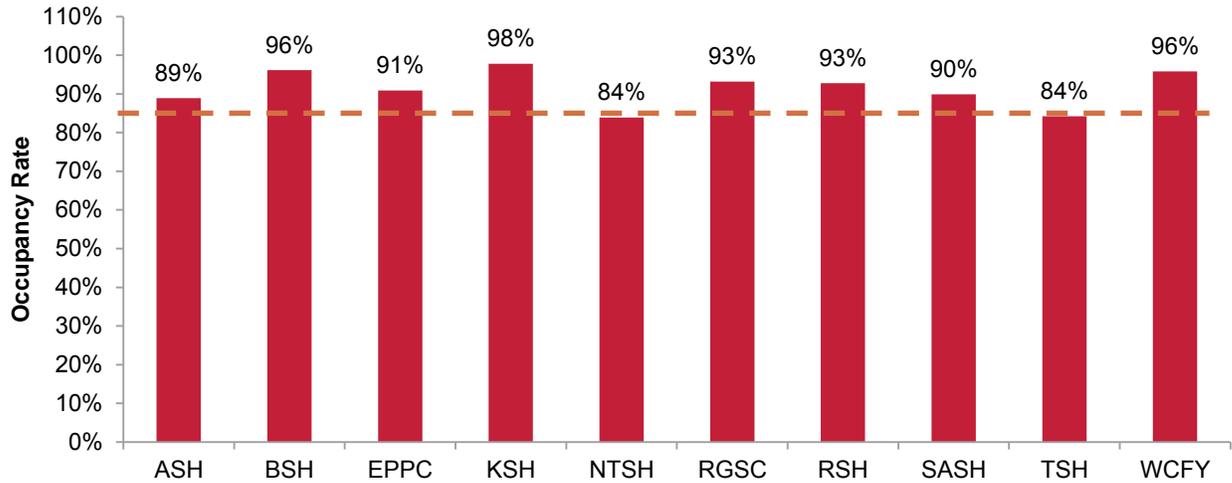


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Psych Admits*	6,248	1,246	44,262	6,311	2,664	41,413	13,553	15,195	2,909	4,423	12,065

Note: Data is representative of community hospitals responding to American Hospital Associate Psychiatric Data Survey. The graph denotes psychiatric admissions less than 30 days and psychiatric admissions more than 30 days. ER benchmark utilized from CannonDesign subject experts. Excludes psychiatric admissions to State Hospitals
Sources: 2012 AHA Psych Data; CannonDesign analysis 2014.

Texas ranks higher than the national average in nearly every health region in the percent of consumers with emergency department visits resulting in admissions to an inpatient psychiatric unit. Regions 2 and 5 are both under the national average while regions 3 and 6 show the highest percent of consumers admitted to psychiatric units from the emergency department.

Exhibit G-6. Texas State Psychiatric Hospital Occupancy Rates, FY14 YTD



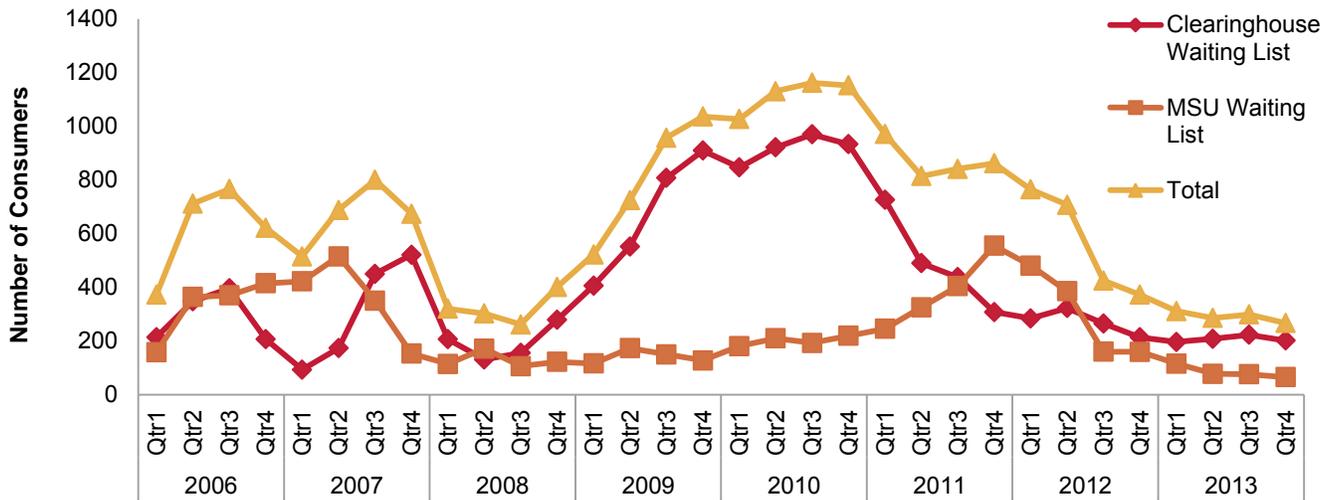
	ASH	BSH	EPPC	KSH	NTSB	RGSC	RSH	SASH	TSH	WCFY
Avg. Daily Population	266	192	67	198	537	51	339	272	243	75
Operating Beds	299	200	74	202	640	55	325*	302	288	78

Note: As of July 1, 2014, 30 beds (UTHC-Tyler) removed from RSH totals. Ten additional maximum security beds removed due to overcrowding.

Source: IS "Occupancy Rates" CannonDesign analysis 2014.

Nearly every SPH in Texas is operating over the recommended 85 percent occupancy with the exception of North Texas State Hospital and Terrell State Hospital. Kerrville State Hospital has the highest occupancy rate, operating at 98 percent occupancy. Waco Center for Youth and Big Spring State Hospital also have high occupancy rates operating at 96 percent occupancy.

Exhibit G-7. Forensic Waitlist Trends for All State Psychiatric Hospitals, FY06 – FY13

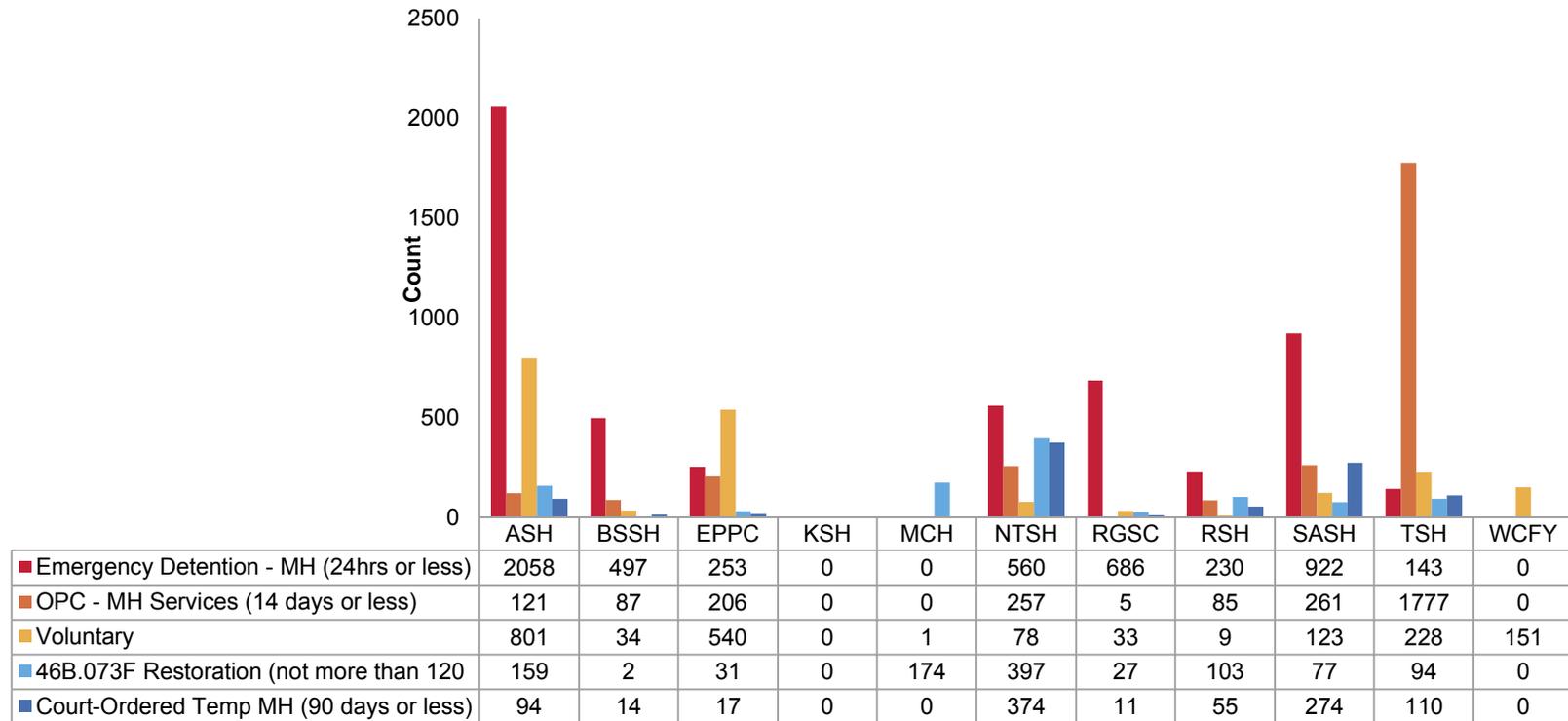


Note: Maximum Security Unit (MSU)

Source: "Forensic Waiting List" provided by Bill Manlove, CannonDesign analysis 2014

The total number of consumers placed on forensic waiting lists for admissions into SPHs was under 400 for the majority of 2008. Beginning in Quarter 4 of 2008, an upward trend began to emerge in the number of consumers on these waiting lists, peaking at nearly 1,200 in 2010. Since 2010, this number has declined, steadily returning to similar numbers experienced in 2008.

Exhibit G-8. Top 5 Legal Classifications, FY13



Source: DSHS Consumer Level Data, CannonDesign analysis 2014

Of the eleven SPH in Texas, Austin State Hospital houses the largest number of emergency detention and voluntary behavioral health consumers. Terrell State Hospital houses the largest number of Order of Protective Custody (OPC) behavioral health consumers.

Exhibit G-9. Medically Complex Consumers Discharged from State Psychiatric Hospitals by Year, FY12 – FY14

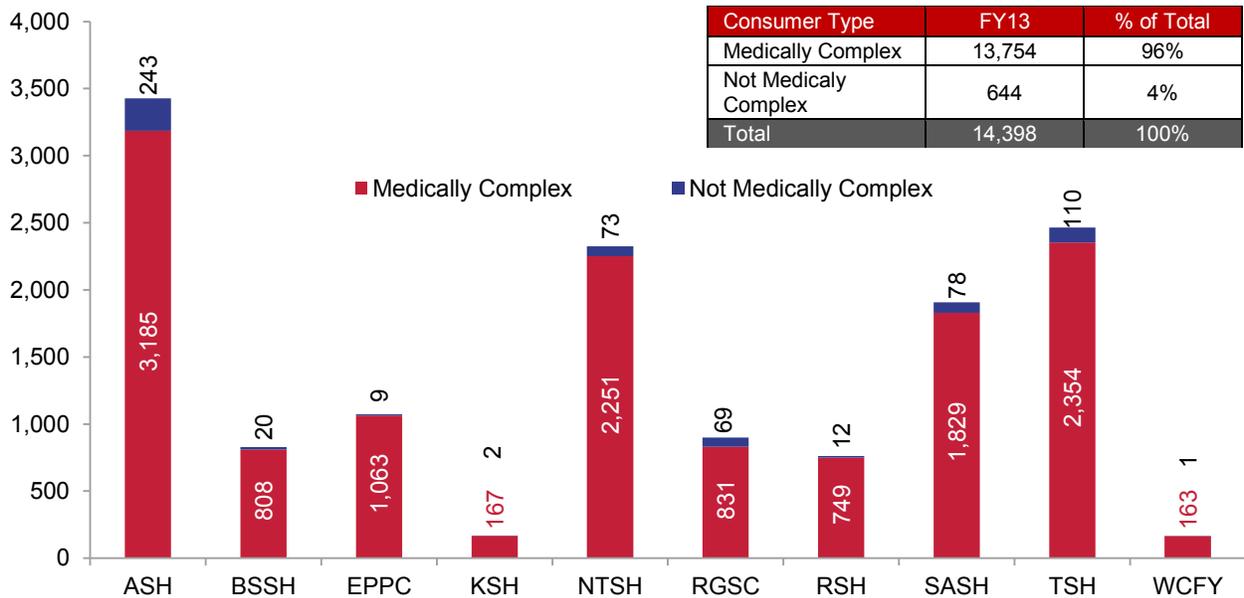


Note: FY14 annualized. Data was provided from January 2014 to April 2014. Medically Complex Consumers are those with both psychiatric and medical diagnoses.

Source: DSHS Consumer Level Data, CannonDesign analysis 2014

Volumes of consumers that have received both a psychiatric and medical diagnoses (medically complex) have been increasing over the past three years. The number of medically complex consumers admitted has increased approximately 17 percent from 2012 to 2013 and approximately 18 percent from 2013 to 2014.

Exhibit G-10. Medically Complex Population by Hospital, FY13 Discharges

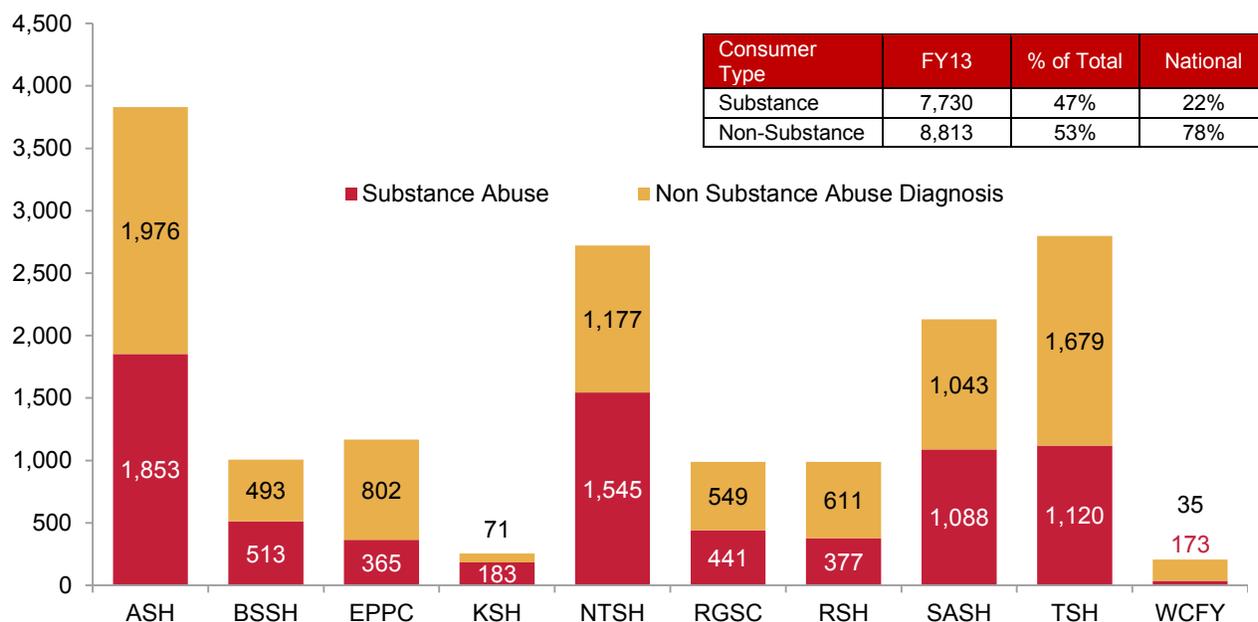


Note: Dual Medical –Psychiatric Diagnosis defined as Consumers with a medical and psychiatric diagnosis based on first ten diagnosis provided.

Source: DSHS Resident Level Detail CannonDesign analysis 2014.

Medically complex consumers made up approximately 96 percent of the total population in SPHs in 2013. The largest population is at Austin State Hospital, which admitted 3,185 medically complex consumers in 2013. El Paso Psychiatric Center has the largest ratio of medically complex consumers with less than one percent of the resident population being not medically complex.

Exhibit G-11. Substance Abuse Population by Hospital, FY13



Note: Fiscal Year 2013 Discharges include Consumers discharged in Fiscal Year 2013 and consumers still residing at an Inpatient State Psychiatric Hospital. Substance Abuse Resident defined as having one or more substance abuse diagnosis from diagnosis provided... Excludes substance abuse consumers with blanks for “admitting facility” and Montgomery County from graph.

Source: DSHS Consumer Level Detail; CannonDesign analysis 2014

Consumers admitted with a substance abuse diagnosis make up 47 percent of the total population admitted to Texas SPHs. The national average for consumers admitted with a substance abuse diagnosis is 22 percent. Kerrville State Hospital and North Texas State Hospital have the highest percent of substance abuse consumers at 72 percent and 56 percent respectively.

Exhibit G-12. Readmission to State Psychiatric Hospitals, Substance Abuse Consumers, Admission FY13



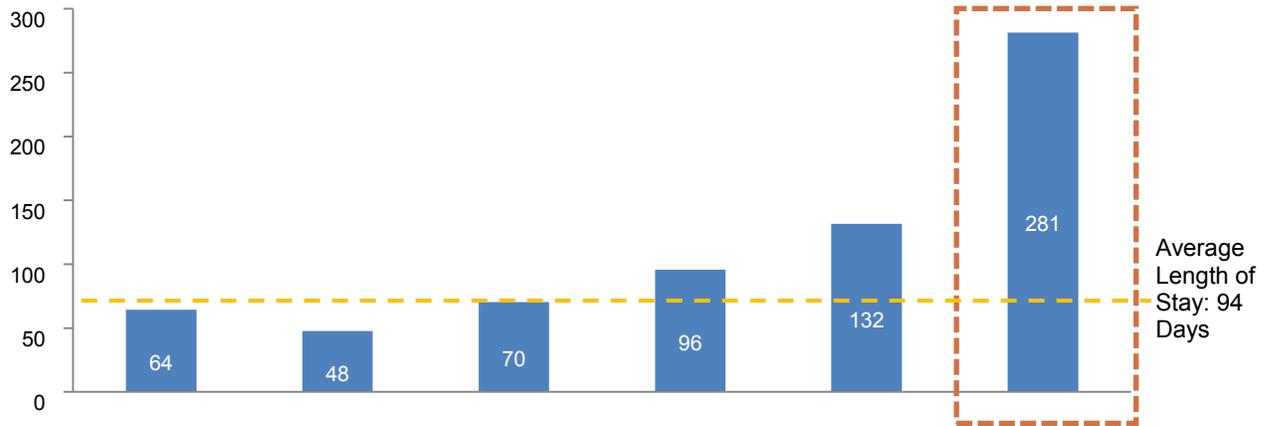
	Total Consumers Readmissions			Substance Abuse Readmissions	
< 30 Days	424	17%	> 30 Days	231	19%
31-90	852	35%	31-90 Days	431	35%
91-180	649	27%	91-180 Days	296	24%
181 Days or More	506	21%	181 Days or More	257	21%
Total Resident Readmissions	2,431		Total Substance Abuse Readmissions	1,215	20%
Total Resident Base Population	14,398		Total Resident Substance Abuse Population	6,221	100%

Note: Excludes readmission with 0 days between last admit dates. Substance Abuse Consumers defined as consumers with one or more Substance Abuse Diagnosis from 26 diagnosis provided.

Source: CannonDesign analysis 2014.

Fifty percent of the substance abuse population in Texas SPHs are readmitted after only 90 days. Extending to 180 days, approximately 71 percent of substance abuse consumers are readmitted. The trend is the same for the total population at Texas SPHs, with 45 percent of the total consumers readmitted after 90 days and 70 percent readmitted after 180 days.

Exhibit G-13. Average Length of Stay for Medically Complex Population by Age, FY13



Age	0-17	18-21	22-34	35-44	45-64	65+
Percent of Consumers	10%	9%	22%	36%	22%	1%

Notes: Admission Fiscal Year 2013 includes consumers who were admitted into a state facility in Fiscal Year 2013.

Source: DSHS Consumer Level Detail' CannonDesign analysis 2014.

The average length of stay for medically complex consumers in the Texas SPH system is 94 days. Consumers that are older than 65 have an average length of stay that is 187 days longer than the average length of stay for all age groups.

Exhibit G-14. Average Cost per Consumer for Texas State Psychiatric Hospitals, FY10 – FY13



Note: Average Cost per Consumer Inflated to reflect Fiscal Year 2013

Source: "Impact of Proposed Budget Cuts to Community-Based Behavioral Health Services" Health Management Associates, DSHS Quarter SPH Financial Summaries; CannonDesign analysis 2014.

The average cost per resident for Texas SPH has remained above the national average by approximately 25 to 30 percent from fiscal year 2010 through fiscal year 2013.

Exhibit G-15. Financial Investment in Behavioral Health Services by State, FY10

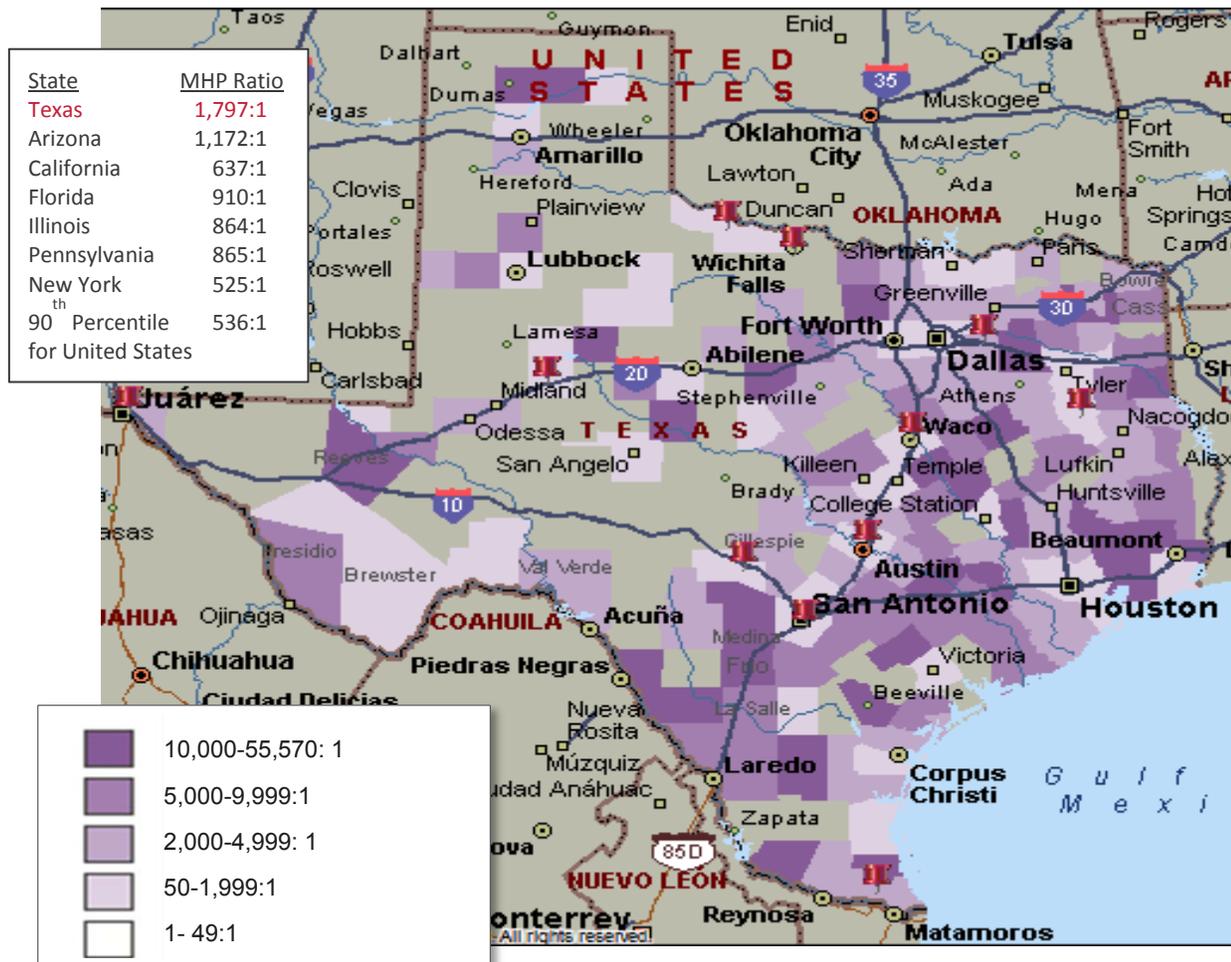
Metric		AZ	CA	FL	IL	NY	PA	TX
Total Budget	Total SMHA Expenditures	\$1,414,300,000	\$5,674,396,088	\$742,227,938	\$1,030,100,000	\$4,965,000,000	\$3,568,718,516	\$979,600,000
	Total Clients Served by SMHA System	187,044	622,116	319,190	136,047	717,075	633,624	308,032
Community Program Funding	SMHA Expenditures for Community Behavioral Health	94%	79%	51%	71%	69%	89%	59%
	SMHA COMMUNITY Expenditures	\$1,329,442,000	\$4,482,772,910	\$378,536,248	\$731,371,000	\$3,425,850,000	\$3,176,159,479	\$577,964,000
	SMHA COMMUNITY Expenditures per Client Served	\$7,107	\$7,205	\$1,185	\$5,375	\$4,777	\$5,012	\$1,876
State Program Funding	SMHA Expenditures for State Behavioral Health	6%	21%	49%	29%	31%	11%	41%
	SMHA STATE Expenditures	\$84,858,000	\$1,191,623,178	\$363,691,690	\$298,729,000	\$1,539,150,000	\$392,559,037	\$401,636,000
	SMHA STATE Expenditures per Client Served	\$453	\$1,915	\$1,139	\$2,195 ¹	\$2,146	\$619	\$1,303

Note: ¹Data reflects Illinois funding strategy prior to closure of multiple state-operated psychiatric hospitals; SMHA = State Behavioral Health Agency

Source: 2012 Behavioral Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, www.samhsa.gov

When compared to larger states, Texas spends a disproportionate amount per capita on state-operated services. In fiscal year 2010, SMHA Expenditures for State Behavioral Health was 41 percent in Texas. STATE Expenditures per client served in Texas was \$1,303.

Exhibit G-16. Population to Behavioral Health Provider Ratio in Texas

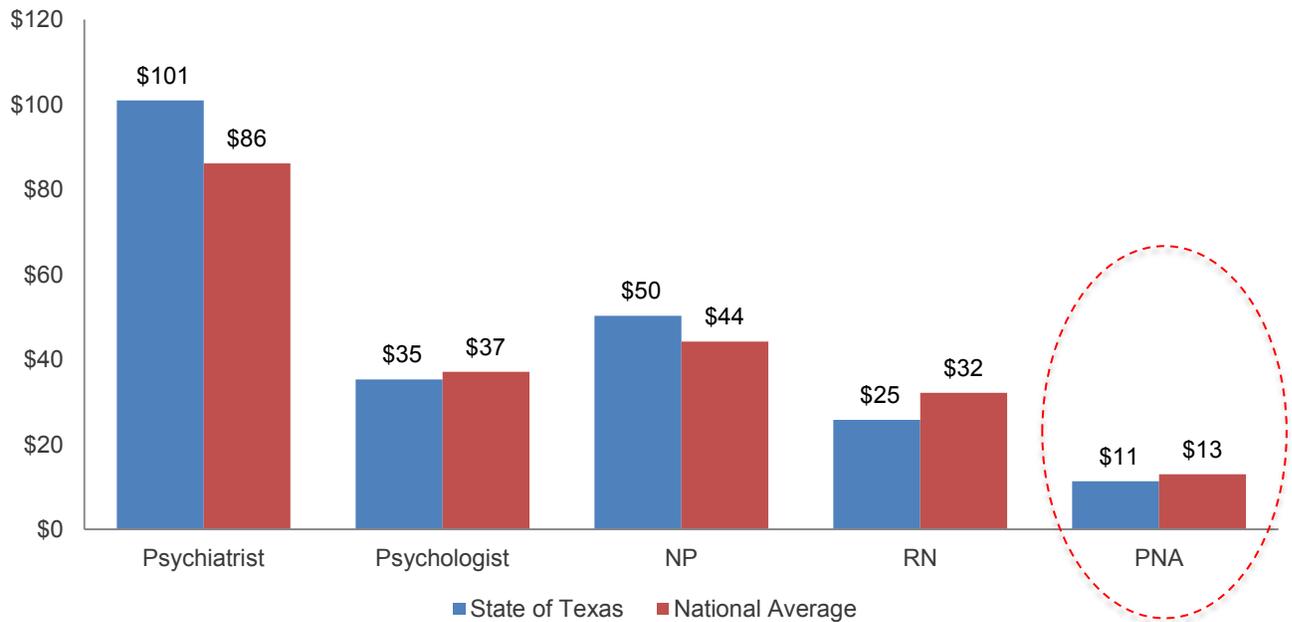


Note: Grey Areas indicate counties with no behavioral health provider to population ratio provided.

Sources: County Health Rankings, 2014; CannonDesign analysis 2014

The state of Texas has a behavioral health practitioner (MHP) to population ratio of 1,797:1. When compared to other large states, Texas ranks at the bottom for its MHP ratio. The 90th percentile in the United States for a MHP ratio is 536:1. Counties surrounding the highly populated urban counties in Texas tend to have the highest MHP ratio.

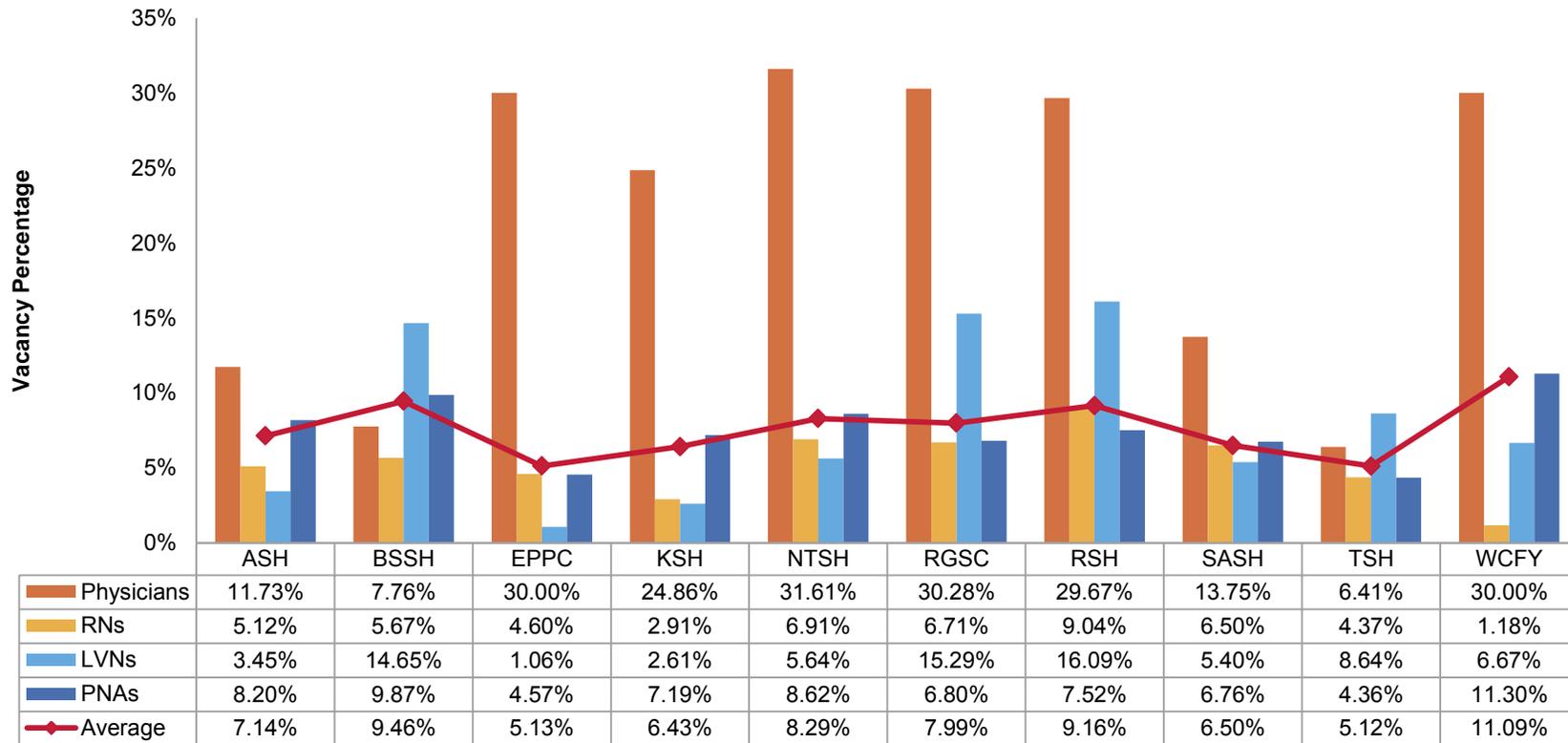
Exhibit G-17. Hourly Wages of Clinicians and Support Staff for all Texas State Psychiatric Hospitals, FY14



Source: United States Department of Labor, Bureau of Labor Statistics, May 2013. | DSHS Non-PHI Data "S4. Hourly Cost by Staff"

The majority of clinicians and support staff at Texas SPHs are paid below that of the national average. Psychiatrist and nurse practitioners make slightly more than the national average while psychologist, registered nurses, and nurse assistants make less than the national average.

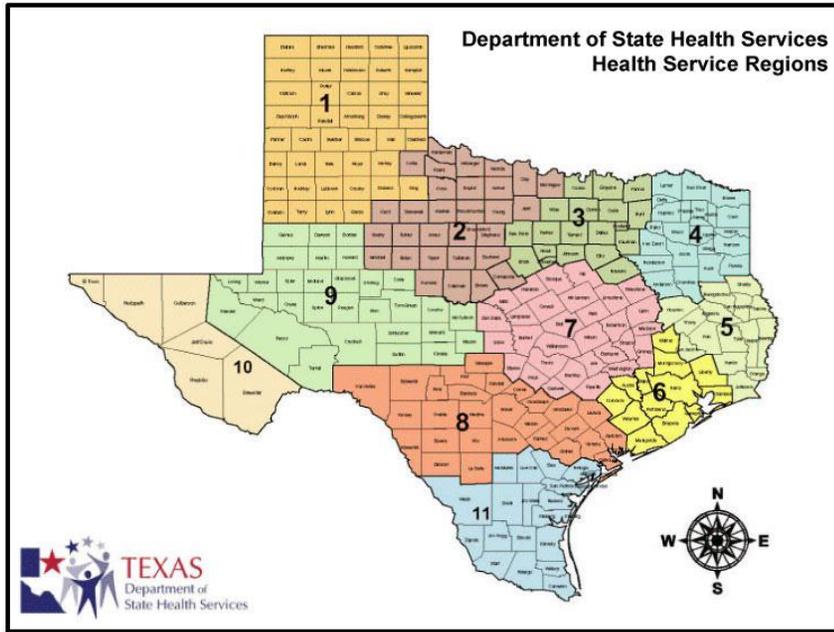
Exhibit G-18. Average Vacancy Rates for Critical Staff at each State Psychiatric Hospital, FY13



Source: DSHS Non-PHI Data “VacanciesRate-M8B”, “VacanciesRateBreakdown-M8B: from Q4 file (Bill Manlove).” CannonDesign analysis 2014.

Out of all direct care providers in Texas SPHs, physicians have the highest vacancy rates... North Texas State Hospital and Rio Grande State Center have the highest percentage of physician vacancy rate at 31.61 percent and 30.28 percent respectively. Waco Center for Youth has an average vacancy rate of 11.09 percent for all direct care providers.

Exhibit G-19. DSHS Health Service Regions



Regional Team	Facility	Service Area
Team 1	Austin SSLC	7
Team 1	Austin SPH	7
Team 1	San Antonio SSLC	8
Team 1	San Antonio SPH	8
Team 1	Texas Center for Infectious Disease	8
Team 2	Brenham SSLC	7
Team 2	Richmond SSLC	4/5S
Team 2	Corpus Christi SSLC	11
Team 2	Rio Grande State Center SPH	11
Team 3	Denton SSLC	2/3
Team 3	Lubbock SSLC	1
Team 3	NTSH - Vernon	2/3
Team 3	NTSH - Wichita Falls	2/3
Team 3	Terrell State Hospital	2/3
Team 4	Abilene SSLC	2/3
Team 4	El Paso SSLC	9/10
Team 4	San Angelo SSLC	9/10
Team 4	Big Spring State Hospital	9/10
Team 4	El Paso State Hospital	9/10
Team 5	Lufkin SSLC	4/5N
Team 5	Mexia SSLC	7
Team 5	Kerrville State Hospital	8
Team 5	Rusk State Hospital	4/5N
Team 5	Waco Center for Youth SPH	7

Exhibit G-20. High Level Service Area Comparison

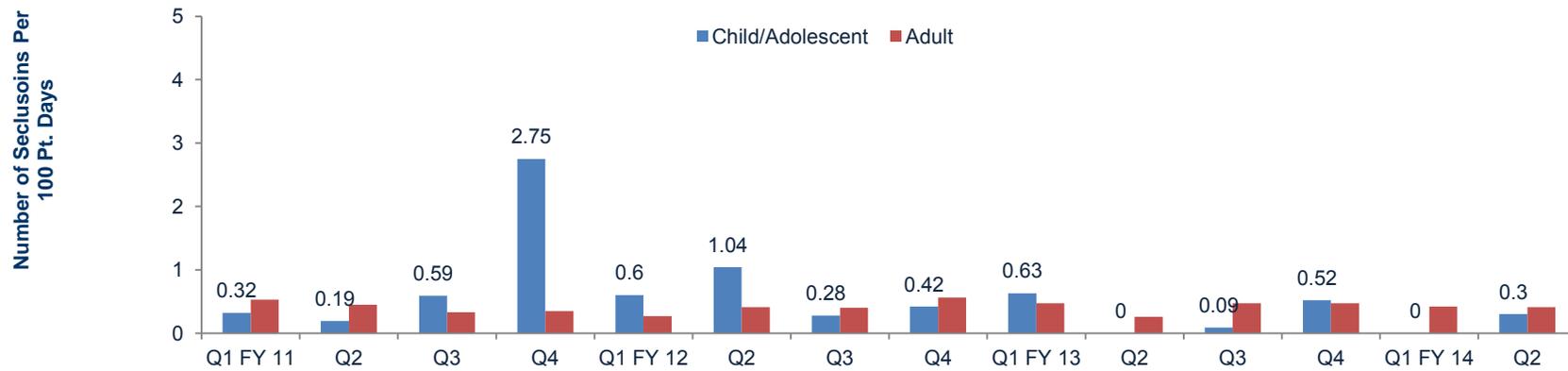
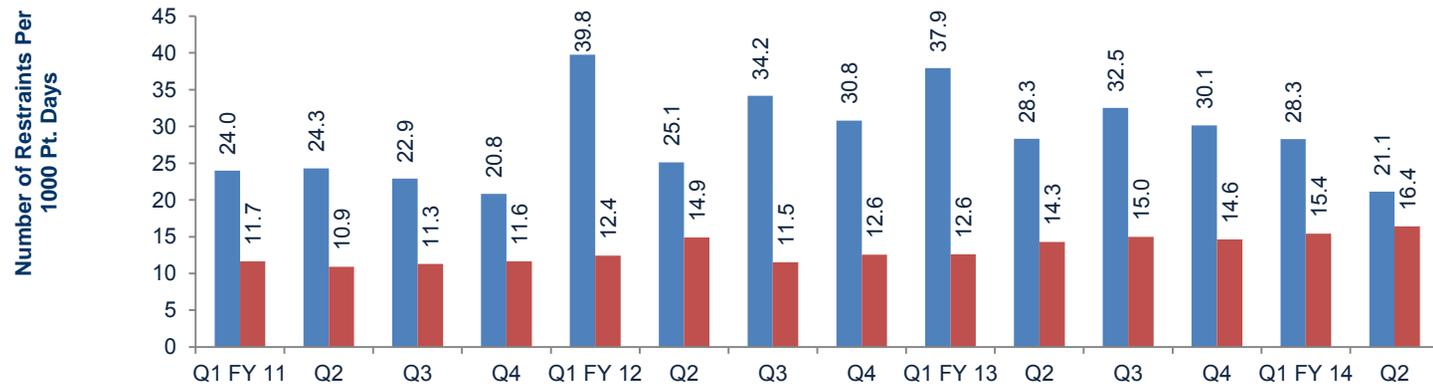
	Health Service Area 1	Health Service Area 2/3	Health Service Area 4/5N	Health Service Area 4/5S	Health Service Area 7	Health Service Area 8	Health Service Area 9/10	Health Service Area 11	Texas
Number of Counties in Area	41	49	35	16	30	28	36	19	254
Health Outcomes Ranking	7	2	8	4	1	5	6	3	---
Health Factors Ranking	5	2	7	4	1	3	6	8	---
2014 Population	862,169	7,746,864	1,508,802	6,909,351	3,185,141	2,770,393	1,480,326	2,205,876	26,668,922
Percent of Texas Population	3%	29%	6%	26%	12%	10%	6%	8%	100%
2019 Population	902,298	8,357,724	1,558,841	7,474,194	3,470,845	2,989,915	1,591,423	2,350,556	28,695,796
5 YR Population Growth (%)	5%	8%	3%	8%	9%	8%	8%	7%	8%
Percent of Population aged 65+	14%	13%	19%	12%	13%	15%	13%	12%	13%
Average HH income	\$61,034	\$75,239	\$57,945	\$77,865	\$71,594	\$66,278	\$61,827	\$50,656	\$70,565
Percent Uninsured under 65	21%	21%	21%	22%	18%	19%	24%	29%	22%
Percent of Population w/ Advanced Degree	13%	17%	12%	16%	18%	15%	12%	10%	15%
Behavioral Health Practitioners per 10,000 Population	4	6	3	5	9	7	4	3	6
Number of Disabled per 1,000	133	105	180	102	113	144	135	152	120

Service area demographics for each region are compared to the state average.

 = Below/Worse than State Avg.

 = Above/Better than State Avg.

Exhibit G-21. Consumer Restraints and Seclusions per 1000 Pt. Days, Q1 11 – Q2 14

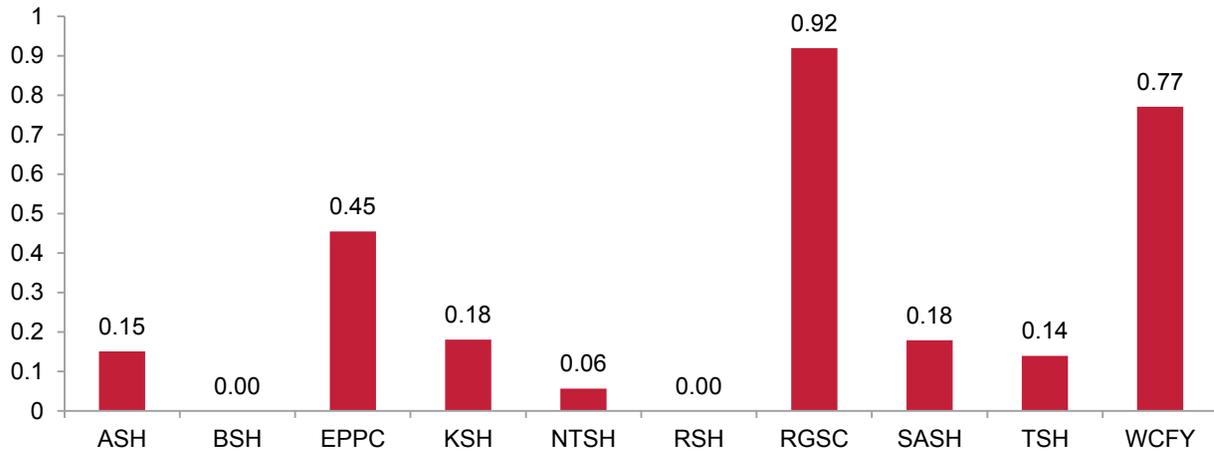


Note: Data dates from January 2011 to April 2014, grouped Quarterly. Quarter 2 of 2014 only includes the month of April.

Source: "17. Quality and Safety, Restraints and Seclusions"; CannonDesign analysis 2014.

Based on the data provided by the state, the child/adolescent population is shown to be more aggressive. Restraint levels throughout fiscal year 2011 to fiscal year 2014 are consistently higher for the child/adolescent resident population.

Exhibit G-22. Unauthorized Departure Rates per 1000 Patient Days for all SPH, Q2 12 – Q2 14 YTD

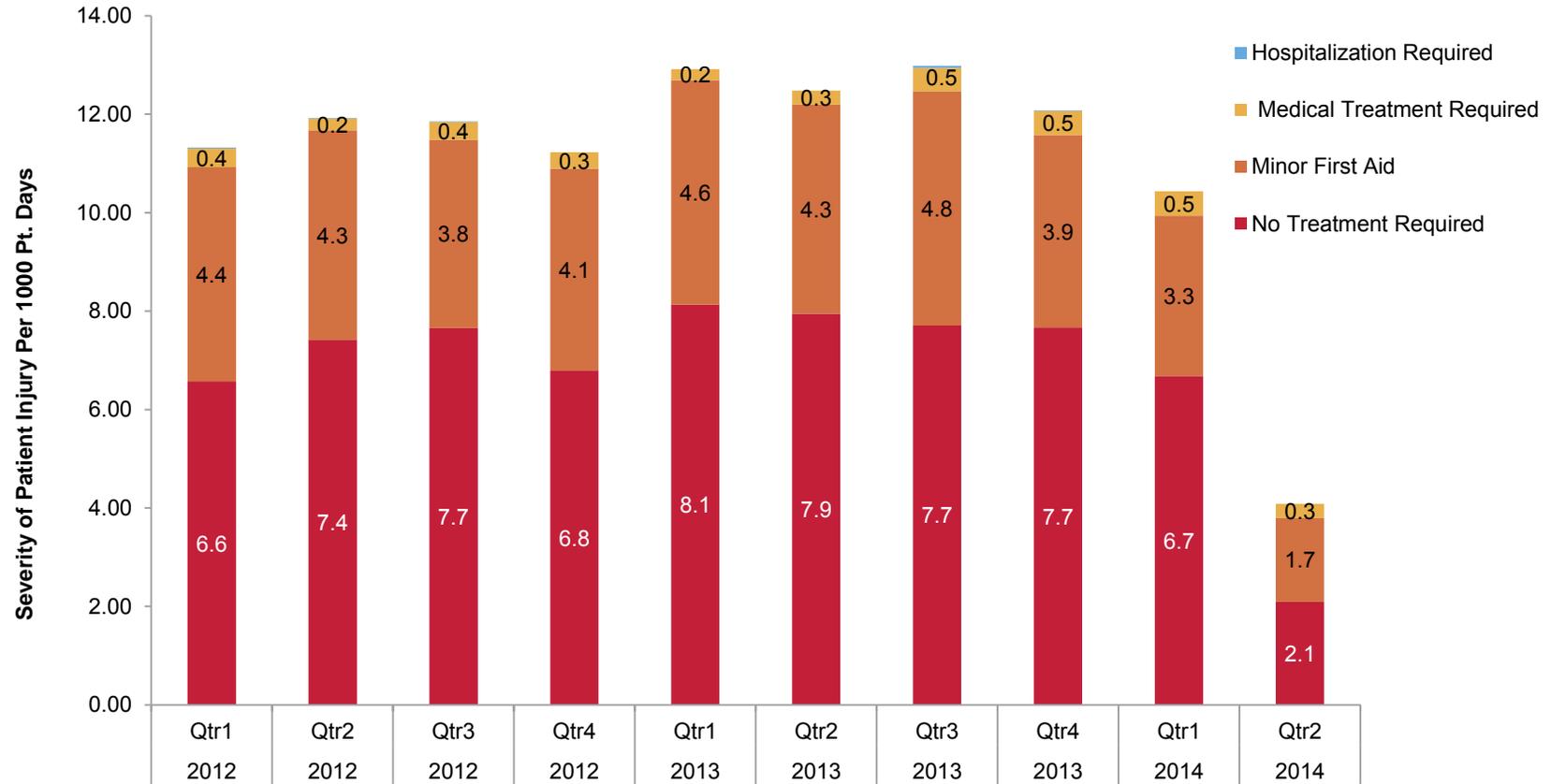


Notes: Each rate is an average by facility for the stated date range. There were a total of 66 unauthorized departures during this time period.

Source: "cd 18 client level data" CannonDesign analysis 2014.

Unauthorized departure rates for each of the state psychiatric hospitals have stayed at the lower end of the spectrum during fiscal year 2012 to fiscal year 2014. A total of 66 unauthorized departure events were documented throughout these two years.

Exhibit G-23. Severity of Resident to Resident Injury Events per 1000 Patient Days, Q1 12 – Q2 14YTD

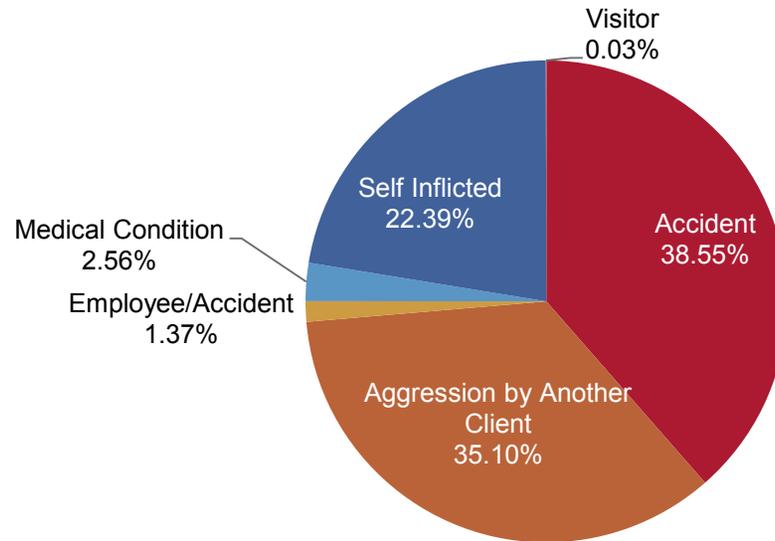


Note: Quarter 2 of 2014 only includes events from the month of April.

Source: "17. Quality and Safety, Patient injuries"; CannonDesign analysis 2014.

Amongst all state psychiatric hospitals, over 75 percent of all resident injuries require minor first aid or no treatment at all. These statistics show that the severity of resident to resident aggression events is on the low end.

Exhibit G-24. Average Percentage of Patient Injury Causation, Q3 09 – Q2 14YTD



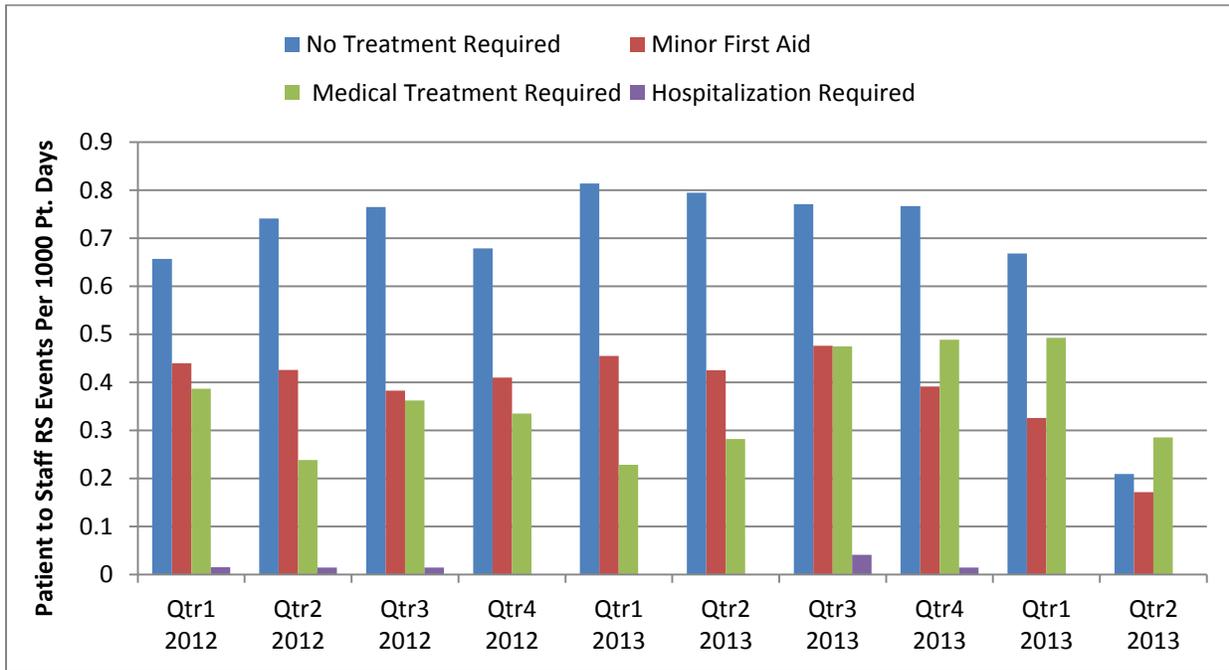
Year	Accident	Aggression by Another Client	Employee/Accident	Visitor	Medical Condition	Self-Inflicted
2009	1,106	1,044	31	0	83	545
2010	3,490	2,782	110	3	215	1,789
2011	3,634	3,105	121	4	221	1,876
2012	3,694	3,296	77	0	311	2,248
2013	3,464	3,592	176	4	205	2,236
2014	911	1,020	64	0	46	772
Total	16,299	14,839	579	11	1,081	9,466

Note: Percentages are based off of all events from Q3 09 – Q2 14YTD, excluding Null and Undetermined events.

Source: "17. Quality and Safety, Patient injuries"; CannonDesign analysis 2014.

The majority of resident injuries are caused by accident, self-inflicted, or by another resident. Steady increases are seen in both self-inflicted injuries and injuries caused by aggression due to another client.

Exhibit G-25. Patient to Staff Restraint and Seclusion Events per 1000 Patient Days for all SPH, Q2 12 – Q2 14YTD

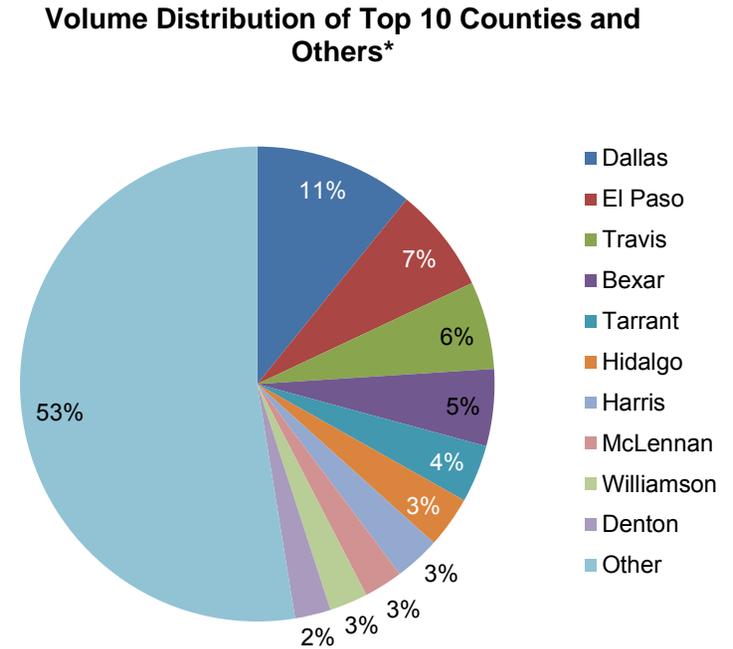
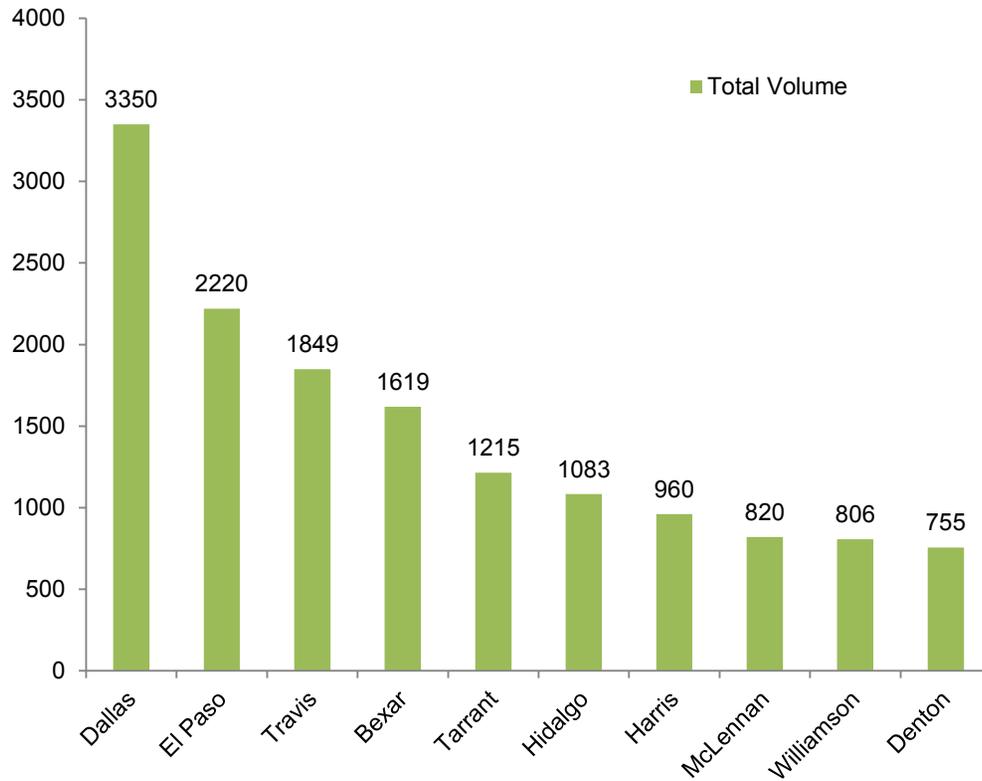


Note: Quarter 2 of 2014 only includes events from the month of April.

Source: "17. Quality and Safety, Aggression patient to staff;" CannonDesign analysis 2014.

Patient to staff aggression episodes that end in restraint or seclusion events occur about 31 times per 1000 resident days per quarter. Quarter 2 of 2014 only includes the month of April, but if it were to be extrapolated, 37.5 events would occur, following the past trend of events.

Exhibit G-26. Top 10 Counties with the Highest Client Volume



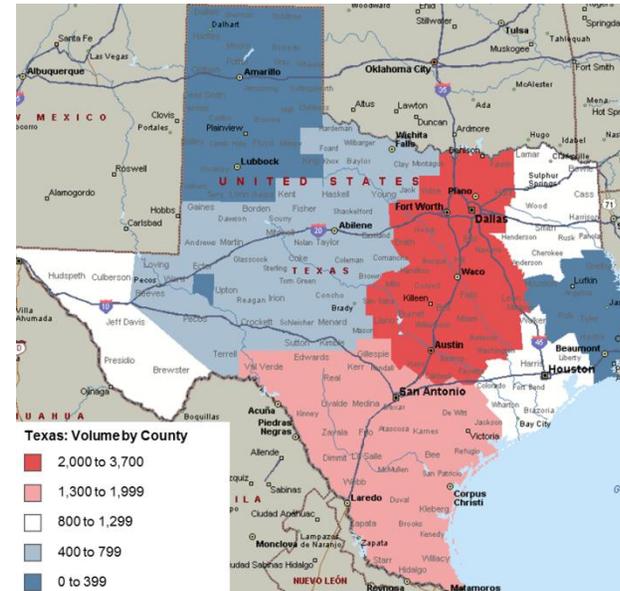
Source: DSHS Client Level Data, Provided Sample Size: 30,934, Exclusions: Unknown: -, Blanks: -, No County Information: 1,284 |

*Others include remaining counties and N/A values.

Ninety-six percent of the counties in Texas serve 53 percent of the client volume. Dallas serves the greatest volume of clients of the Texas counties, but only serves 11 percent of the State’s total client volume.

Exhibit G-27. Total Number of Consumers in Each Health Region

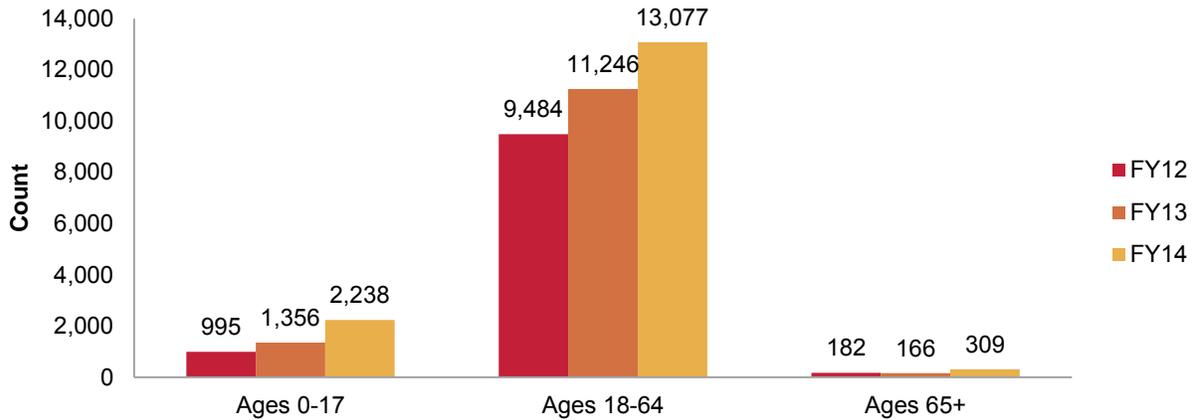
Health Service Region ID	Health Service Region Name	2014	2024	10 Year Change
1	High Plains – Lubbock	185	194	9
2	Northwest TX - Abilene	712	715	3
3	Metroplex - Grand Prairie / Arlington	3,323	3,622	299
4	Upper East TX – Tyler	866	860	-6
5	Southwest TX - Beaumont	266	265	-1
6	Gulf Coast – Houston	1,012	1,087	75
7	Central TX - Austin / Temple	3,005	3,264	259
8	Upper South TX - San Antonio	1,285	1,392	107
9	West TX – Abilene	468	489	21
10	Upper Rio Grande - El Paso	1,151	1,262	111
11	Lower South TX - Edinburg / Harlingen	1,433	1,638	205
Grand Total (All Regions Combined)		13,706	14,788	1,082



Source: iXpress Mapping and CannonDesign Forecast 2014 - 2024, Baseline Scenario

Health service regions 3, 7, and 11 show the greatest need and increase in demand for services in 2024 based on the forecasting. Health service region 3 is expected to see a growth of nearly 300 consumers by 2024. There are two health service regions, region 4 and region 5, which are forecasted to see a decline in the resident population.

Exhibit G-28. Medically Complex Resident Trends by Age Group, FY12 – FY14 YTD



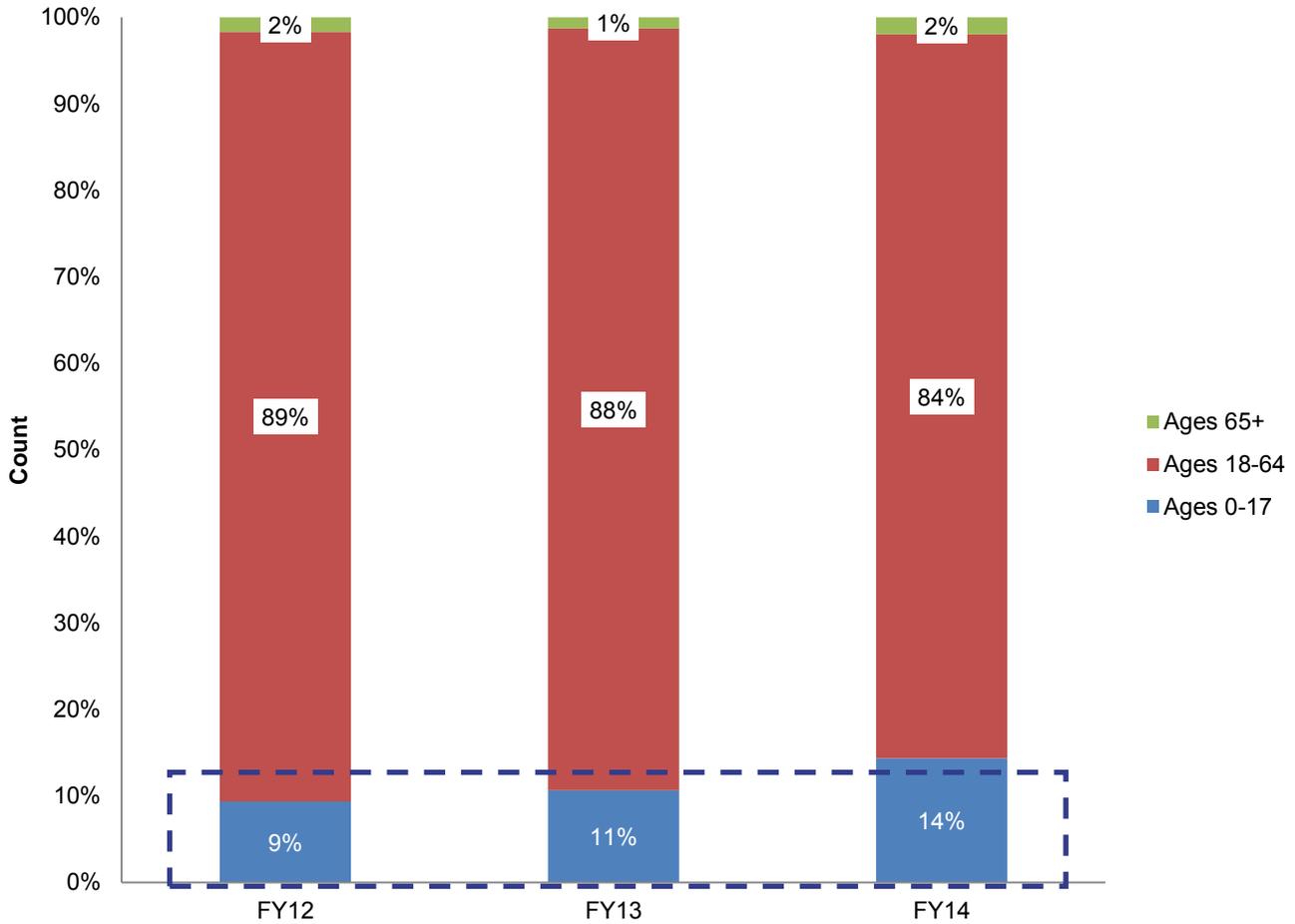
Note: FY14 was annualized. Data was provided from January 2014 to April 2014. Medically Complex Consumers are those with both psychiatric and medical diagnoses.

Source: DSHS Patient Level Data, CannonDesign analysis 2014.

The majority of the medically complex consumers in Texas SPHs fall into the 18 to 64 age bracket. The smallest numbers of medically complex consumers are over the age of 65.

Exhibit G-29. Medically Complex Trend by Age Group, FY12 – FY14 YTD

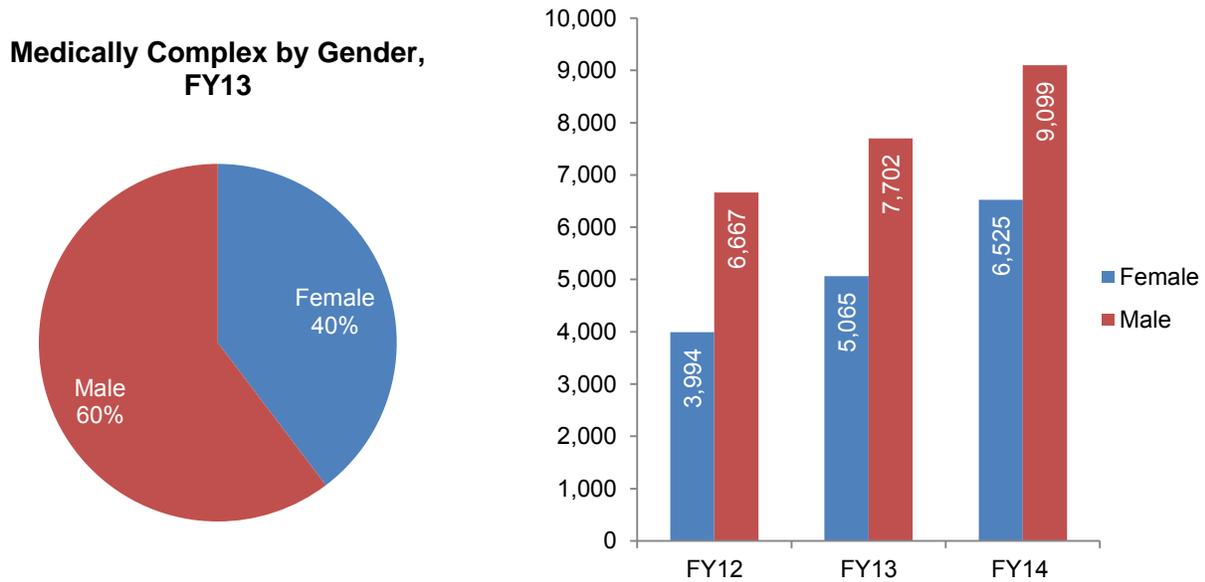
Note: FY14 was annualized. Data was provided from January 2014 to April 2014. Medically Complex Consumers are those with both psychiatric and medical diagnoses.



Source: DSHS Patient Level Data, CannonDesign analysis 2014.

Adolescent and pediatric medically complex consumers are showing the largest amount of growth over the past two years increasing from 8 percent in fiscal year 2012 to 14 percent in fiscal year 2014. Adult resident populations make up the largest percent of medically complex consumers but have decreased five percent over the past two years.

Exhibit G-30. Medically Complex Consumers by Gender, FY12 – FY14

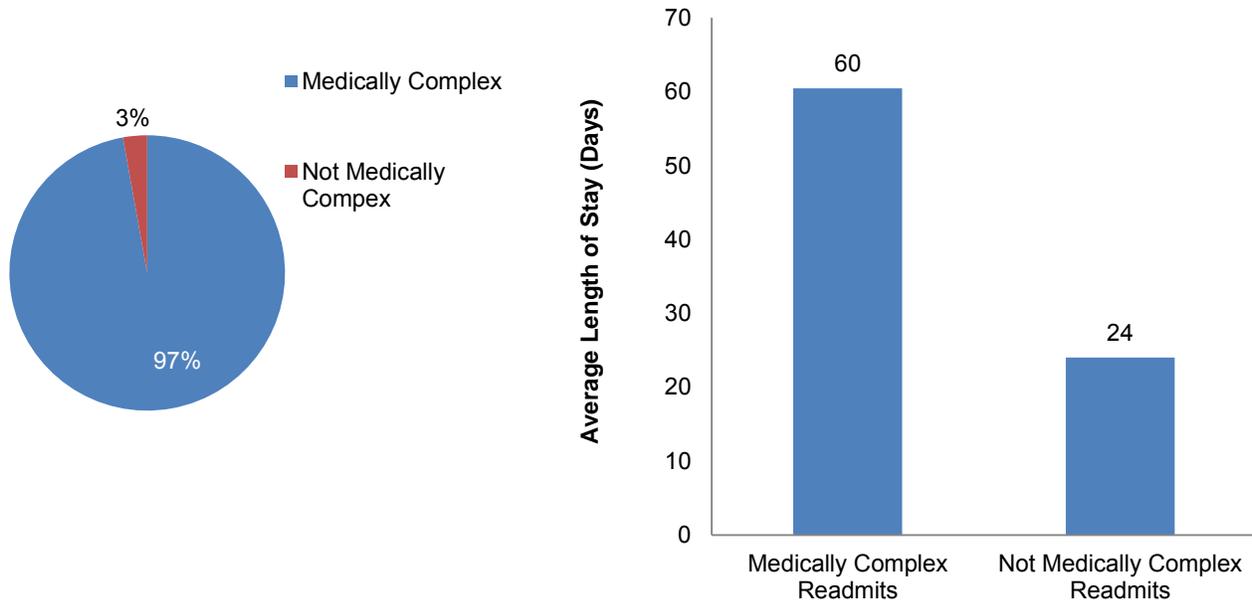


Note: FY14 was annualized. Data was provided from January 2014 to April 2014. Medically Complex Consumers are those with both psychiatric and medical diagnoses.

Source: DSHS Patient Level Data, CannonDesign analysis 2014.

Over the past two years both the male and female populations have increased; however, males make up the majority of medically complex consumers. Although there is a more medically complex male population, the medically complex female consumers are projected to grow five percent in 2014.

Exhibit G-31. Readmitted Consumers by Medical Complexity and Average Length of Stay, FY13

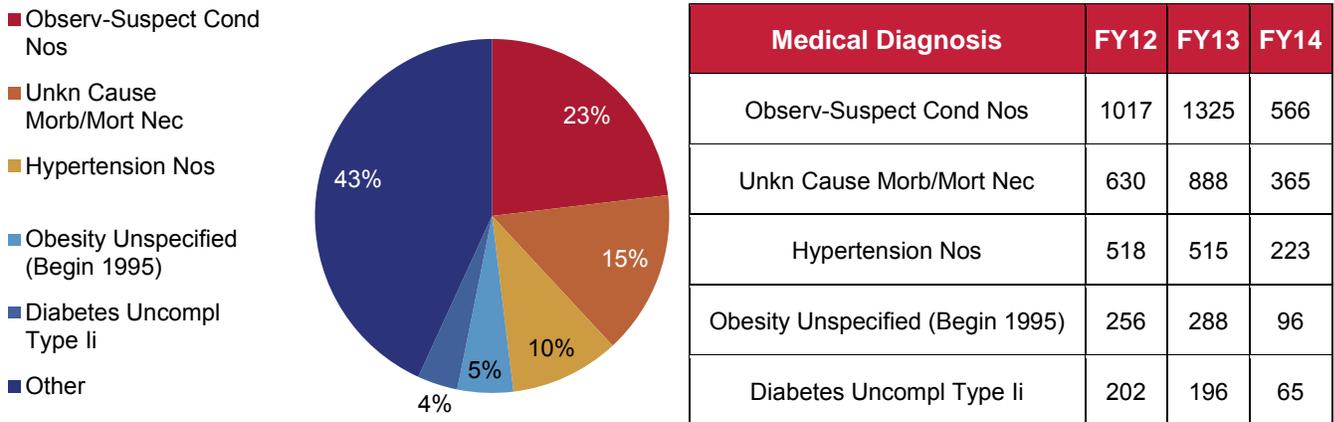


Note: Medically Complex Consumers are those with both psychiatric and medical diagnoses.

Source: DSHS Patient Level Data, CannonDesign analysis 2014.

Consumers readmitted to Texas SPHs that have a medically complex diagnosis make up 97 percent of the total readmitted population. In addition medically complex readmits have an average length of stay that is 60 days, compared to only 24 days of non-medically complex readmits.

Exhibit G-32. Top Medical Diagnoses Associated with Medically Complex Consumers, FY12 – FY14

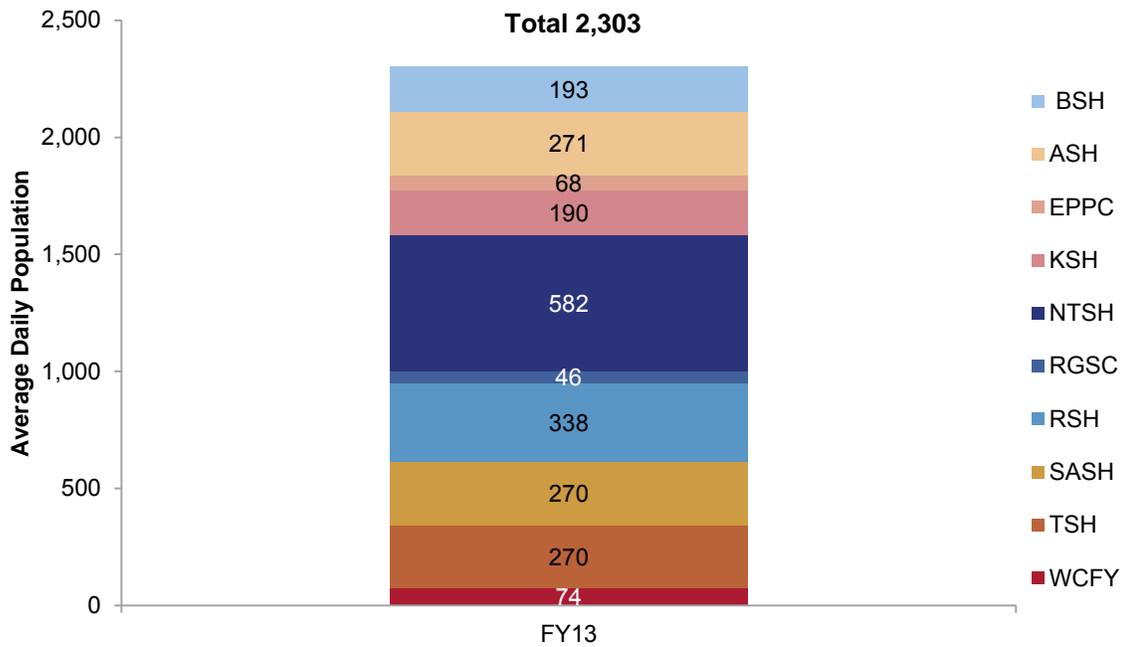


Note: Medically Complex Consumers are those with both psychiatric and medical diagnoses. The top 5 diagnoses that are included are those that make up over 3 percent of the resident population. The other 43 percent are the diagnoses that are 3 percent and below.

Source: DSHS Patient Level Data, CannonDesign analysis 2014.

The top 5 medical diagnoses associated with medically complex consumers make up 57 percent of the diagnoses the resident population receives. The other 43 percent are diagnosis given to three percent or less of the resident population. The most common medical diagnosis given to medically complex consumers over the past two years has been observation for unspecified suspected condition followed by other unknown and unspecified cause of morbidity and mortality.

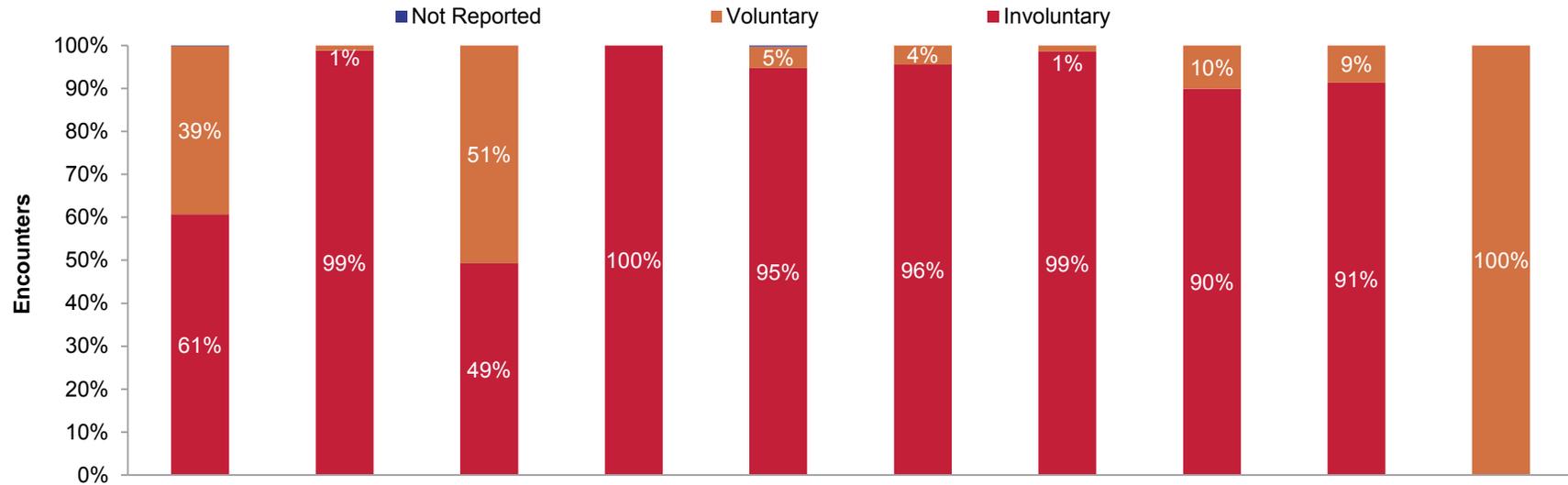
Exhibit G-33. Average Daily Population by SPH, FY13



*Note: Both Fiscal Year 2008 and Fiscal Year 2014 are not full years of data. ADC = Average Daily Census
 Source: "13. ACD by Facility"; CannonDesign analysis 2014.*

North Texas State Hospital has the largest average daily population at 582. The smallest average daily populations are coming from Rio Grande State Center and El Paso Psychiatric Center.

Exhibit G-34. Return Encounters by Legal Classification, FY13

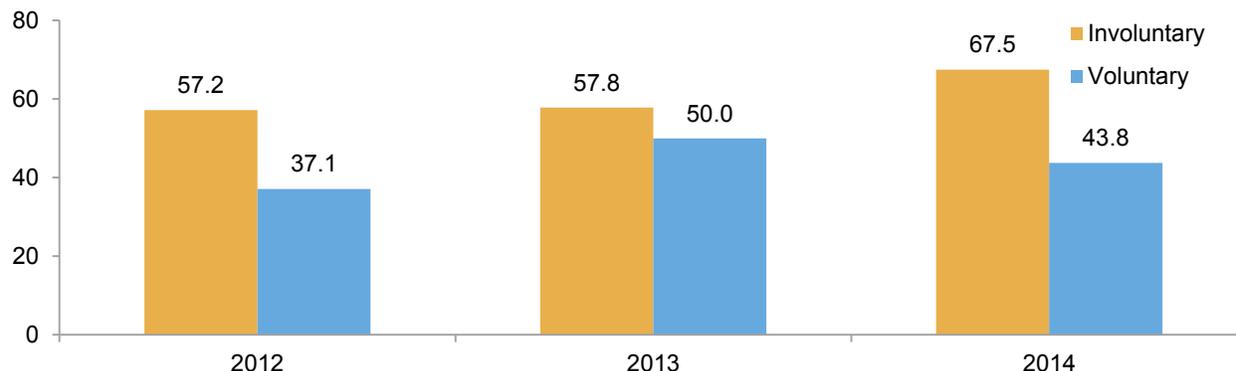


	Austin	Big Spring	El Paso	Kerrville	North Texas	Rio Grande	Rusk	San Antonio	Terrell	Waco
Involuntary	454	174	107	68	324	173	136	340	393	0
Voluntary	293	2	110	0	17	8	2	38	37	37
Not Reported	1	0	0	0	1	0	0	0	0	0
Total	748	176	217	68	342	181	138	378	430	37

*Note: Excludes Consumers with blank for Admitting Facility and consumers with “0” days between last visit.
Source DSHS Patient Level Data; CannonDesign analysis 2014.*

Involuntary readmissions make up the majority of return encounters for nearly all of the SPHs in Texas. Austin State Hospital and El Paso Psychiatric Center have the highest percentage of voluntary consumers out of the SPHs that have an involuntary resident population.

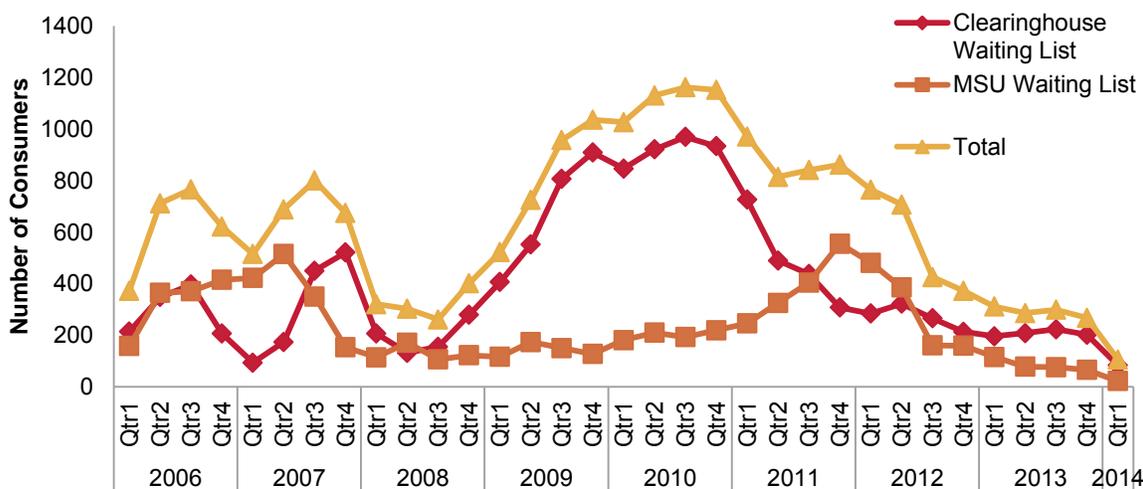
Exhibit G-35. Average Length of Stay by Legal Classification Status, Excluding Kerrville State Hospital, FY12 – FY13



Source: DSHS Client Level Data, Provided Sample Size: 30,934, Exclusions: Unknown: 5, Blanks: 2, Discharge Date Blank or After 4/30/2014, Kerrville Hospital: 2,535 | Voluntary: Others (by guardian, parents, legal system, etc.), Self | Involuntary Admissions include: Civil - Other, Incompetent to Stand Trial, Not Guilty by Reason of Insanity

The ALOS of the involuntary population continues to increase ~16.75 percent between 2013 and 2014. The voluntary resident population varied from year to year, increasing ~13 percent from 2012 to 2013 and decreasing ~6 percent from 2013 to 2014.

Exhibit G-36 Waitlist Trends for all SPH, FY06 – FY14 YTD

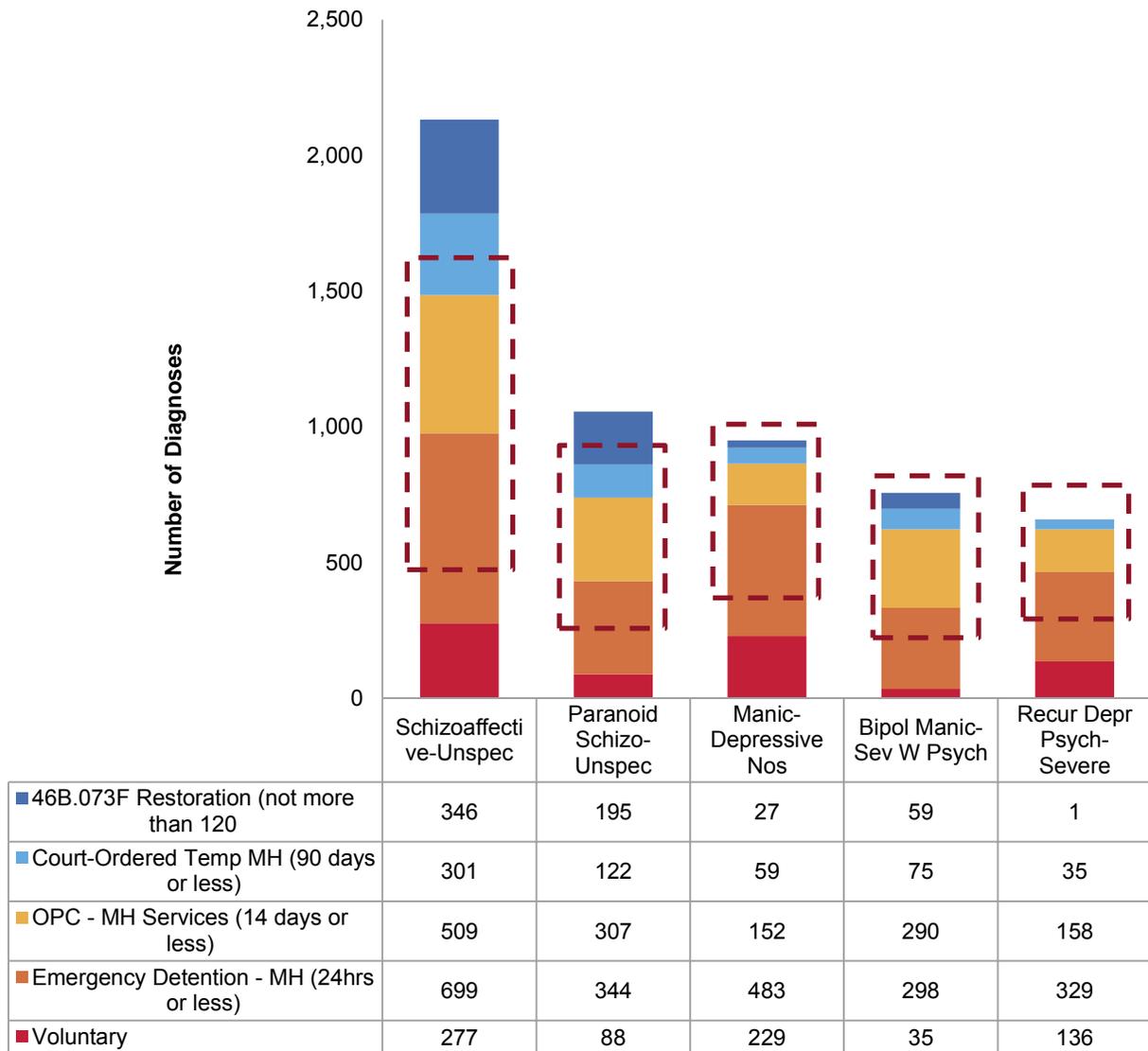


Note: Maximum Security Unit (MSU)

Source: "Forensic Waiting List" provided by Bill Manlove, CannonDesign analysis 2014.

After its peak in 2010, waitlist populations slowly decompressed. In 2010 the total number of consumers on waiting list was approximately 1200. By the beginning of 2011 this number was declining and would eventually get below 200 by Quarter 1 of 2014.

Exhibit G-37. Top 5 Diagnoses in the Top 5 Legal Classifications for Forensic Consumers, FY13

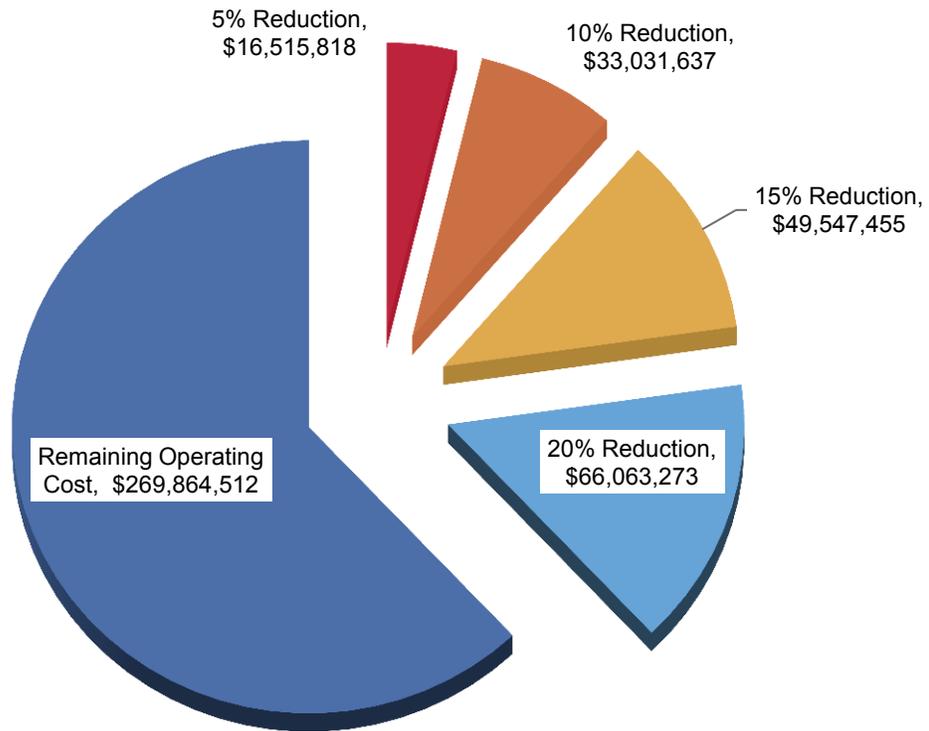


Note: All diagnosis names were provided by the client. This data includes all SPH.

Source: "13. ACD by Facility"; CannonDesign analysis 2024.

The underlying behavioral health diagnoses for most forensic consumers are fairly consistent and these consumers are often held in emergent detention or 14 days or less. The two largest diagnoses for the forensic resident population in fiscal year 2013 were types of schizophrenia followed by manic depressive.

Exhibit G-38. Breakdown of Potential Savings by Reducing the Average Length of Stay, FY14

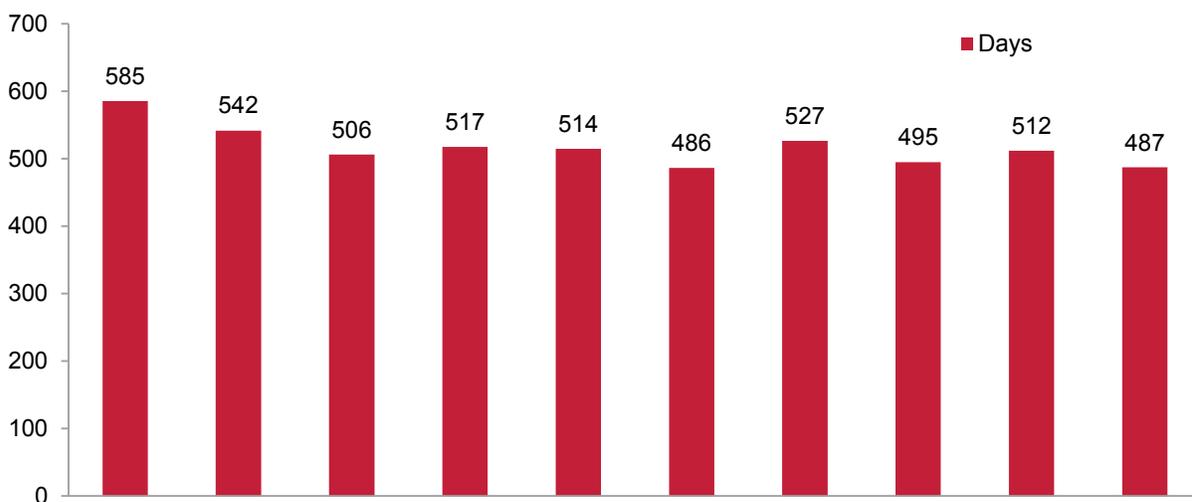


Note: Cost Per Bed Day is \$453 p/ resident day and calculated as sum of all operating expenses across all SPH. Operating cost is based of the cost per bed, multiplied by the number of resident days, and then translated to a full year.

Source: DSHS Patient Level Data; CannonDesign analysis 2014.

The potential savings by reducing the average length of stay by five percent is \$16,515,818. If the average length of stay can be reduced by 20 percent the potential savings is \$66,063,273.

Exhibit G-39. Average Length of Stay by Top Substance Abuse Diagnoses, FY13



	Poly-substance Dependence	Alcohol Use Disorder	Cannabis Use Disorder	Inhalant Use Disorder	Cocaine Use Disorder	Amphetamine Use Disorder	Tobacco Use Disorder	Opioid Use Disorder	Sedative, Hypnotic, or Anxiolytic Use Disorder	All Other
Volume	1,871	1,384	1,196	687	358	322	190	130	56	38
Percent of Consumers	30.0%	22.2%	19.2%	11.0%	5.7%	5.2%	3.0%	2.1%	0.9%	0.6%

Note: All Other includes Opioid Withdrawal, Alcohol Intoxication, Other Hallucinogen Use Disorder, Unspecified Opioid Related Disorder, and Other (or unknown) substance use disorder. Substance Abuse Resident defined as having one or more substance abuse diagnosis.

Source: CannonDesign analysis 2014.

The average length of stay for consumers with a substance abuse diagnosis ranges from 1.3 to 1.6 years across all SPH campuses. The largest percentage of consumers has received a polysubstance dependent diagnosis. Alcohol use disorder is the second largest diagnosis, with 22.2 percent of substance abuse consumers receiving this diagnosis.

Exhibit G-40. Average Overall Cost and Cost per Client for Each Adult and Child Service Package, FY13

Service Package	Resident Volume	Average Cost Per Client	Average Total Cost
Adult Assertive Community Treatment	2404	\$7,000	\$489,656
Adult Crisis	34281	\$922	\$1,007,373
Adult Major Depressive Disorders	95435	\$1,271	\$3,580,694
Adult Not Eligible	3765	\$306	\$51,023
Adult Package 5	7908	\$1,577	\$406,686
Adult Package 6	494	\$342	\$10,246
Adult Rehabilitation Supported Employment	22514	\$4,274	\$2,271,278
Adult Stabilization	7251	\$1,764	\$379,703
Adult Waiting For Services	13306	\$383	\$257,183

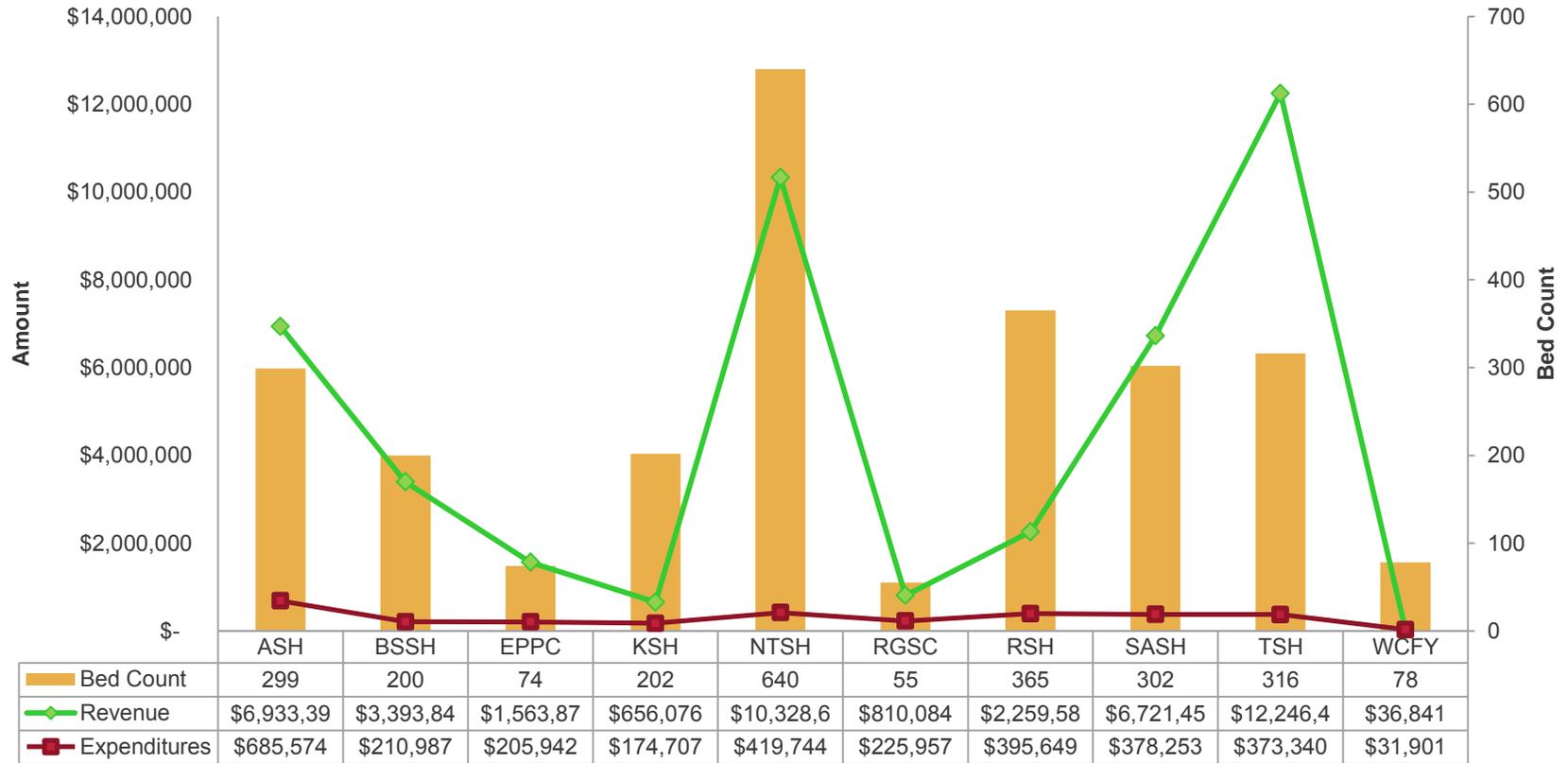
Service Package	Resident Volume	Average Cost Per Client	Average Total Cost
Child After Care Services	8041	\$684	\$164,031
Child Brief Externalizing Disorders	19943	\$2,109	\$1,136,851
Child Brief Internalizing Disorders	6205	\$1,772	\$331,603
Child Crisis	6217	\$523	\$88,241
Child Intensive Externalizing Disorders	2663	\$2,752	\$181,900
Child Intensive Internalizing Disorders	1280	\$2,706	\$88,670
Child Intensive Major Disorders	200	\$1,652	\$13,705
Child Intensive Multisystemic Disorders	16	\$609	\$1,031
Child Not Eligible	594	\$364	\$6,779
Child Package 5	558	\$1,179	\$25,754
Child Package 6	172	\$358	\$3,864
Child Waiting For Services	684	\$296	\$10,791
Child Young	240	\$4,748	\$378,264

Note: Service Package Definitions are taken from the Description of Service file, A5-A7 and C5-C7 are not defined, which is where Adult Package 5 comes from.

Source: O0. Description of Service Packages, O2 and O3. Total costs per level of care by center (Revised), CannonDesign analysis 2014.

For the adult service lines, the average total cost for adult major depressive disorders is the most expensive service package totaling \$3,580,694 in fiscal year 2013. Although the total cost is highest for adult major depressive disorders, the highest average cost per resident is for adult assertive community treatment which averages \$7,000 per resident. For the Child service lines, the average total cost for child brief externalizing disorders are the most expensive service package totaling \$1,136,851 in fiscal year 2013.

Exhibit G-41. Total Revenue and Expenditures by Facility, FY13

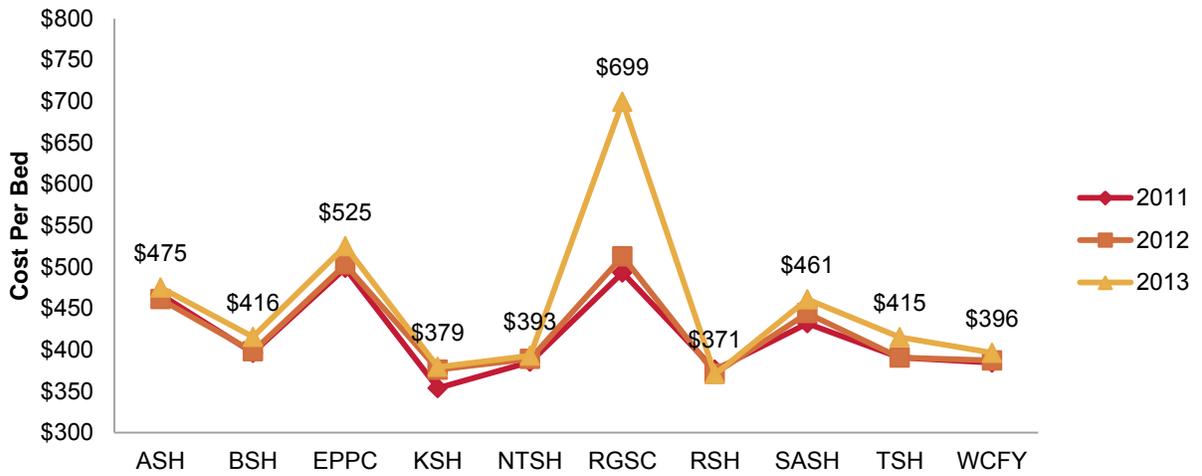


Note: Revenue totaled from each month by each facility for the 2013 fiscal year.

Source: "Revenue13" file from (Bill Manlove), O2. Claims and Expenditures by SPH Fiscal Year 2009 – Fiscal Year 2014

Terrell State Hospital is the highest total revenue in the state. North Texas State Hospital and Austin State Hospital are also in the top three total revenue generators for the state. Waco Center for Youth has the lowest amount of total revenue out of all 11 SPHs.

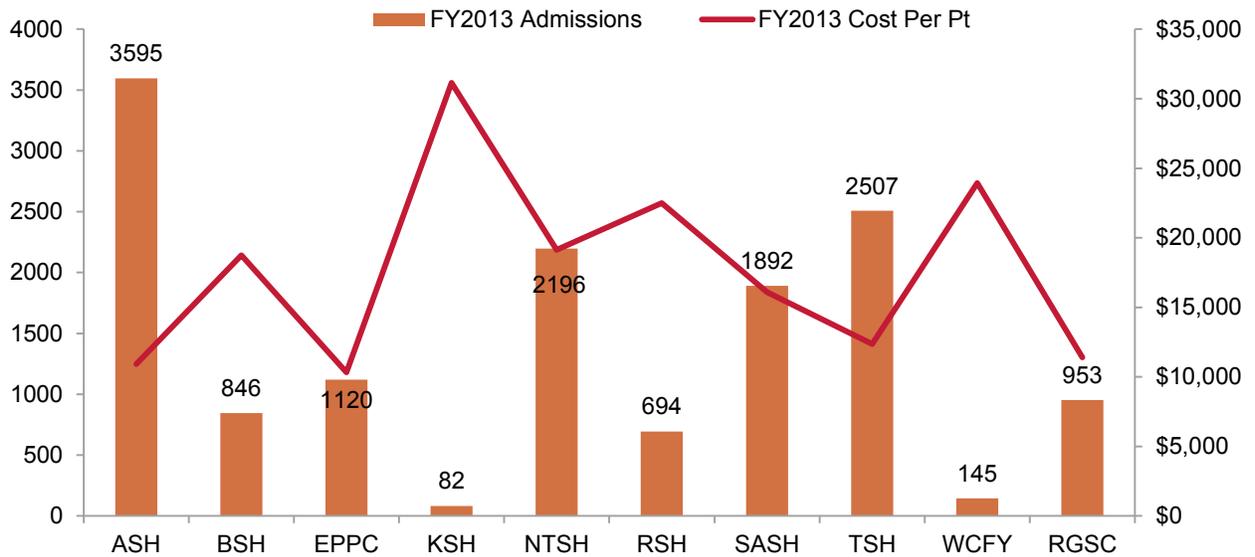
Exhibit G-42. Cost Per Bed Day by Facility, FY11 – FY13



Source: DSHS Non-PHI Data “Cost_Bed-M1B” from Q4 file (Bill Manlove). CannonDesign analysis 2014.

The cost per bed has seen a consistent trend between all SPHs, falling and rising at the same rate. The largest peak in cost per bed occurred at Rio Grande State Center in 2013.

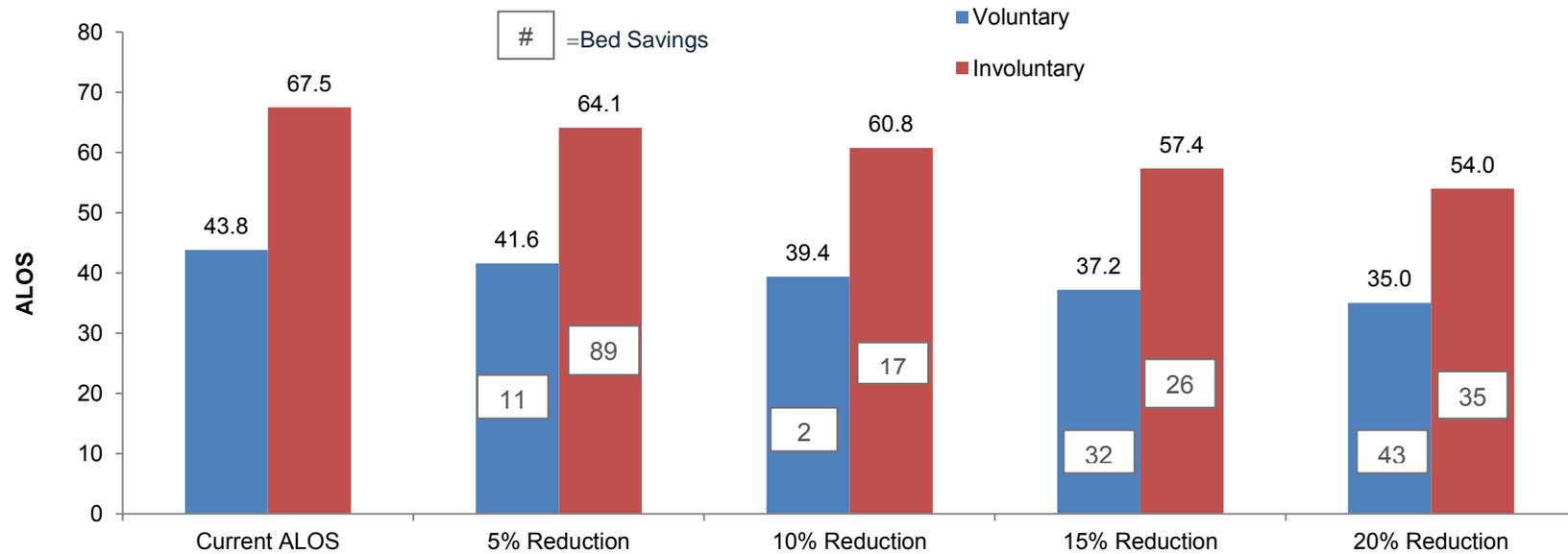
Exhibit G-43. Comparing Cost per Resident and Admissions by Facility, FY13



Source: DSHS Patient Level Data, “Cost_Pat-MIA (version 1)” from Q4 file (Bill Manlove).

Kerrville State Hospital had the highest cost per resident for fiscal year 2013 out of all 11 SPH in Texas. Both Austin State Hospital and El Paso Psychiatric Center had cost per resident averages around \$10,000, which are the lowest averages among the SPHs.

Exhibit G-44. Potential Savings by Reducing the Average Length of Stay, FY14



	Current ALOS	5 Percent Reduction	10 Percent Reduction	15 Percent Reduction	20 Percent Reduction
Vol. Pt Days		3,951	7,902	11,852	15,803
Invol. Pt Days		32,508	65,016	97,524	130,032
Total Potential Savings		\$16,515,818	\$33,031,637	\$49,547,455	\$66,063,273
Percent Savings		3.80%	7.59%	11.39%	15.19%

Note: Cost Per Bed Day is \$453 p/ resident day and calculated as sum of all operating expenses across all SPH.

Source: DSHS Patient Level Data; CannonDesign analysis 2014.

The current average length of stay for voluntary and involuntary consumers is 43.8 and 67.5 days respectively. Reducing the average length of stay could yield a cost savings ranging from \$16 million to \$66 million.

Exhibit G-45. FTE Staff per Bed by Facility, FY14

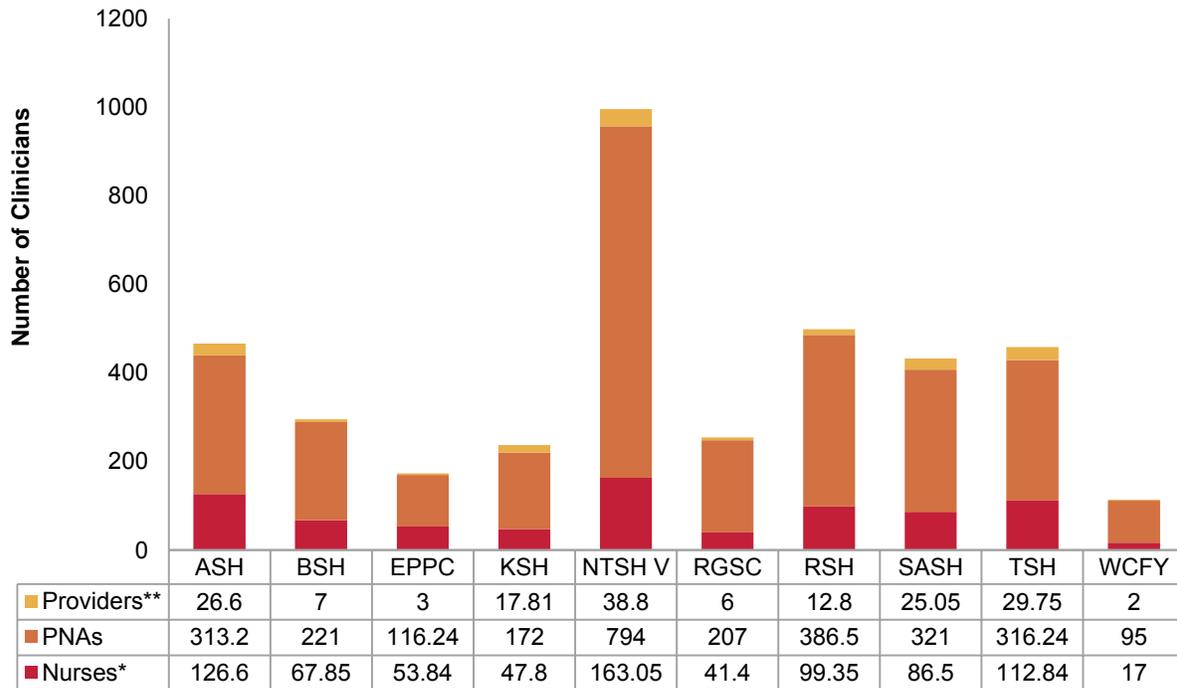


FTE Count FY14	272	195	67	193	547	50	319	276	243	75
Bed Count FY14	299	200	74	202	640	55	365	302	288	78

Source: DSHS Non-PHI Data “S1. FTE by Site”, “S6. Staffing Ratios”, CannonDesign analysis 2014.

SPHs are currently functioning from a .77 - .98 Staff to 1 Bed Ratio. Big Spring State Hospital has the highest staff to bed ratio while Terrell State Hospital has the lowest staff to bed ratio for fiscal year 2014.

Exhibit G-46. Number of FTE Clinicians per Facility, FY14



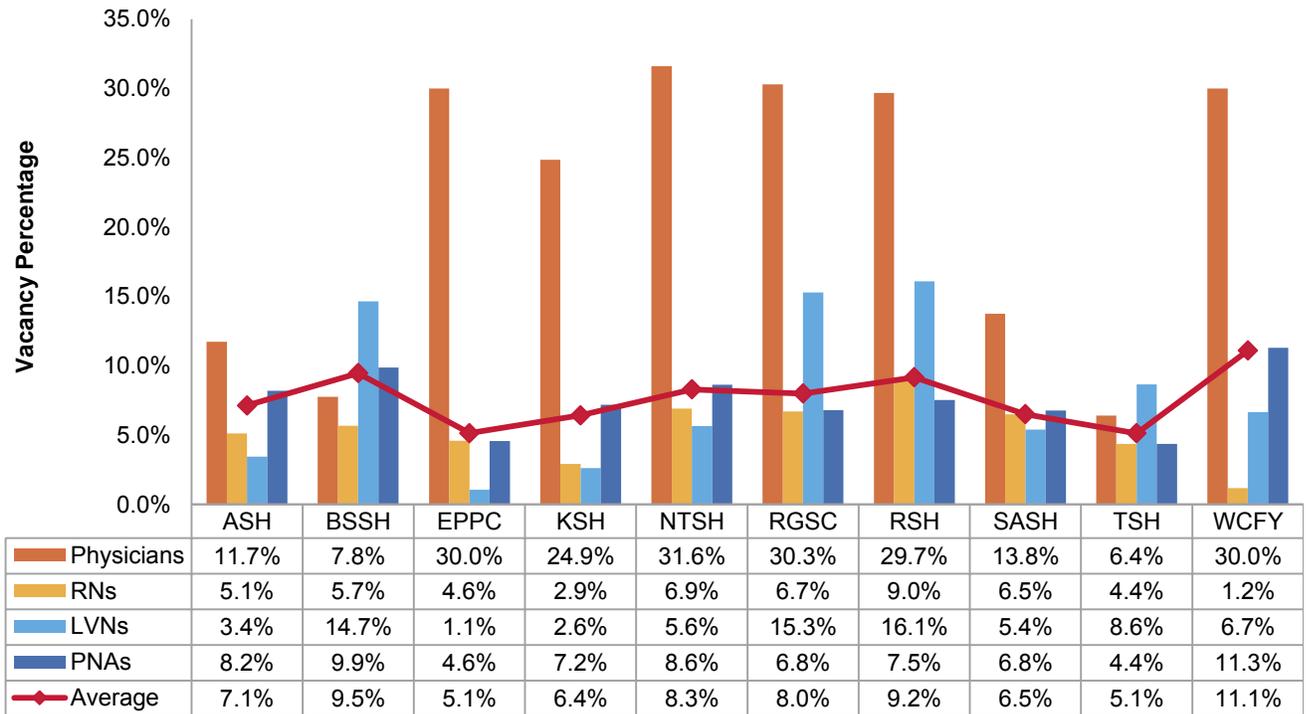
Source: DSHS Non-PHI Data “S1. FTE by Site”, CannonDesign analysis 2014.

*The Nurse Practitioners are included in the total count for the nursing staff.

**The providers consist of Psychiatrists and Psychologist at all levels.

The psychiatric nurse assistant population is the largest of the clinical staff in every SPH. The provider population ranges from 2 at Waco Center for Youth to 38 at North Texas State Hospital.

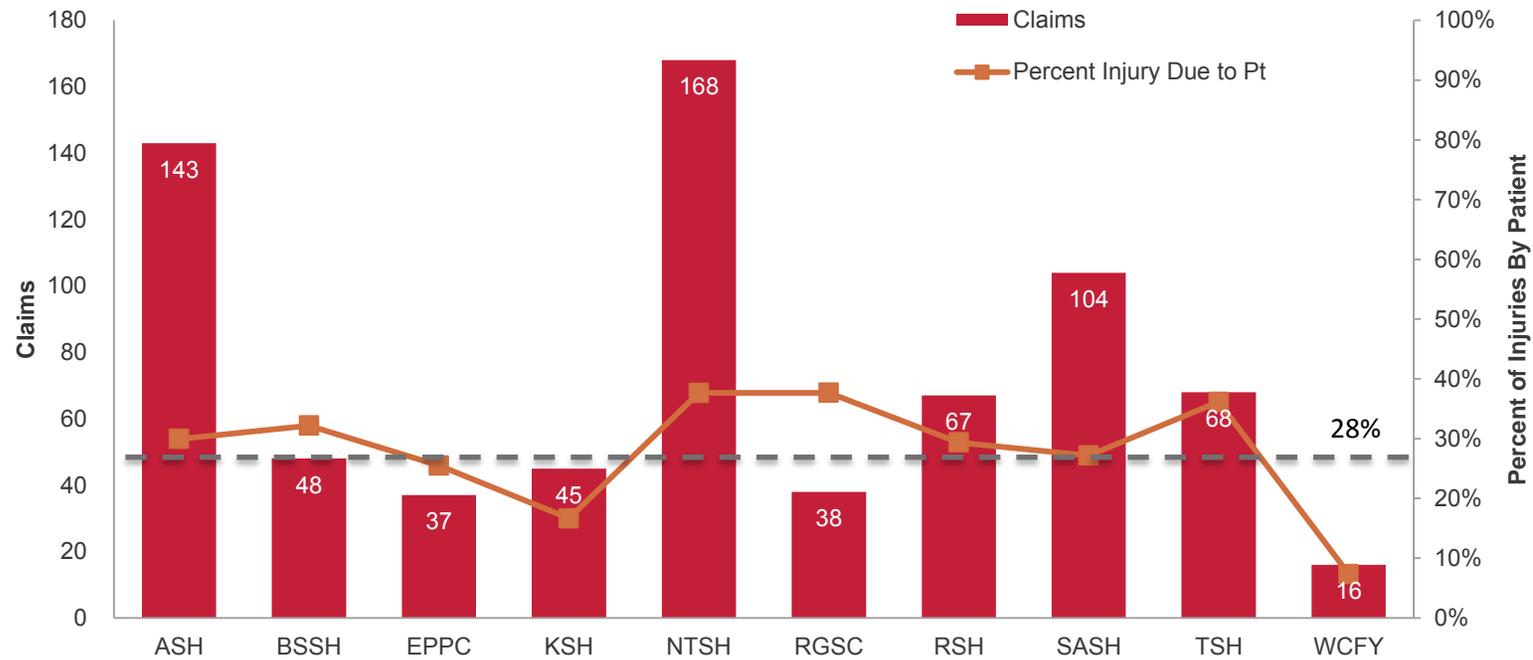
Exhibit G-47. Vacancy Rates for Critical Staff by Facility, FY13



Source: DSHS Non-PHI Data “VacanciesRate-M8B”, “VacanciesRateBreakdown-M8B: from Q4 file (Bill Manlove).” CannonDesign analysis 2014.

Vacancy rates for physicians in 2013 were high in nearly every SPH. Over half of the SPHs were experiencing physician vacancy rates of nearly 25 percent or higher. Waco Center for Youth experienced the highest average vacancy rate in 2013 at approximately 11 percent.

Exhibit G-48. Comparing Workers Compensation Claims to Percent of Injuries Caused by Resident at each Facility, FY13



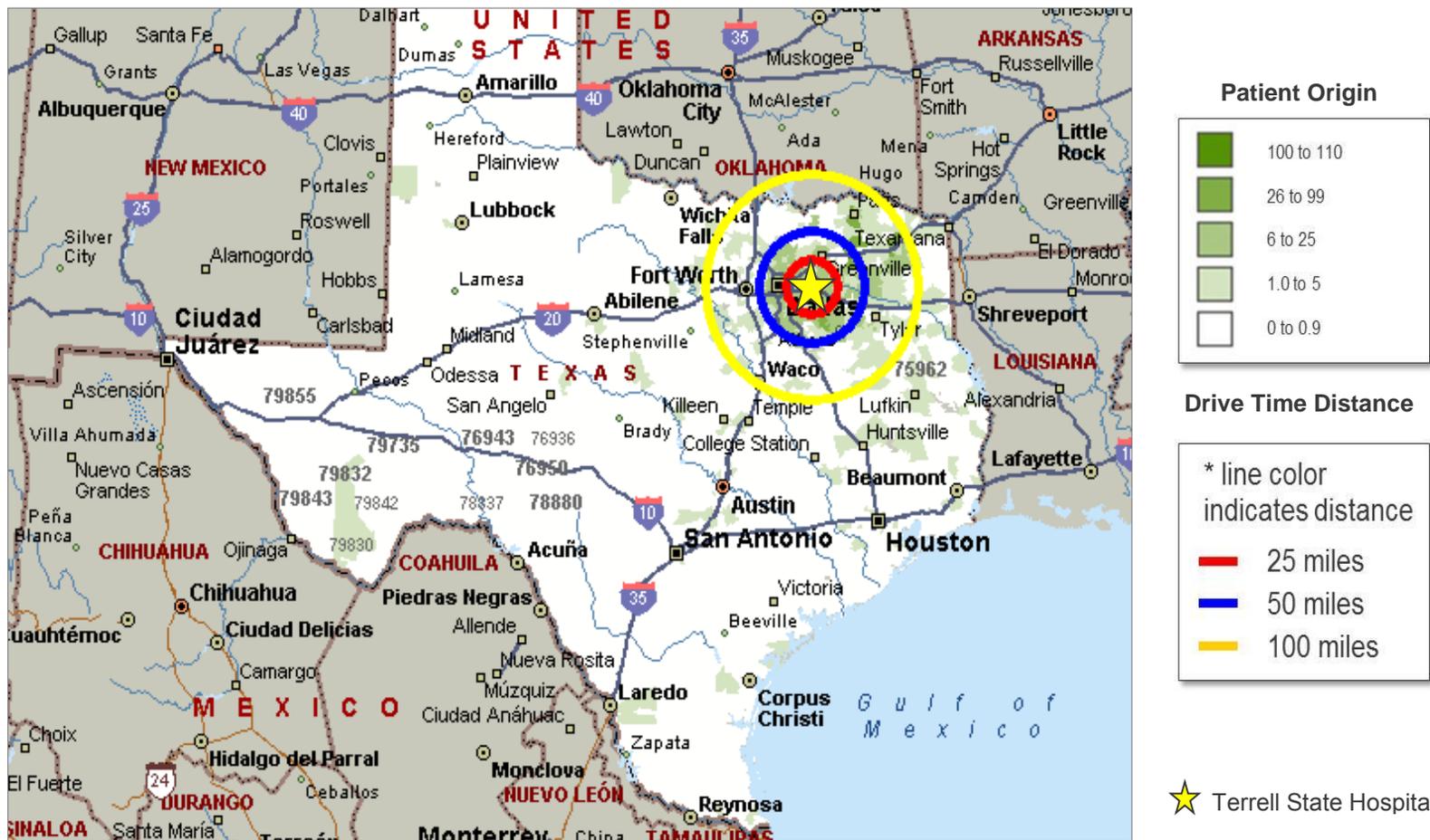
Expenditures	\$630,705	\$206,123	\$190,684	\$173,855	\$418,241	\$201,882	\$423,507	\$297,606	\$389,885	\$38,396
Percent Injury By Pt	30%	32%	25%	17%	38%	38%	29%	27%	26%	7%

Note: Workers compensation is not claimed on all injuries, which is why the percentage of injuries caused by consumers is graphically shown, not the actual amount that may not have been claimed.

Source: "WComp Claims and Expenditures" file from (Bill Manlove).

In 2013, workers compensation claims cost SPHs a total of \$2,970,884. On average, consumers cause 28 percent of all injuries throughout all SPHs. Austin State Hospital, San Antonio State Hospital, and North Texas State Hospital all experienced over 100 workers compensation claims in 2013.

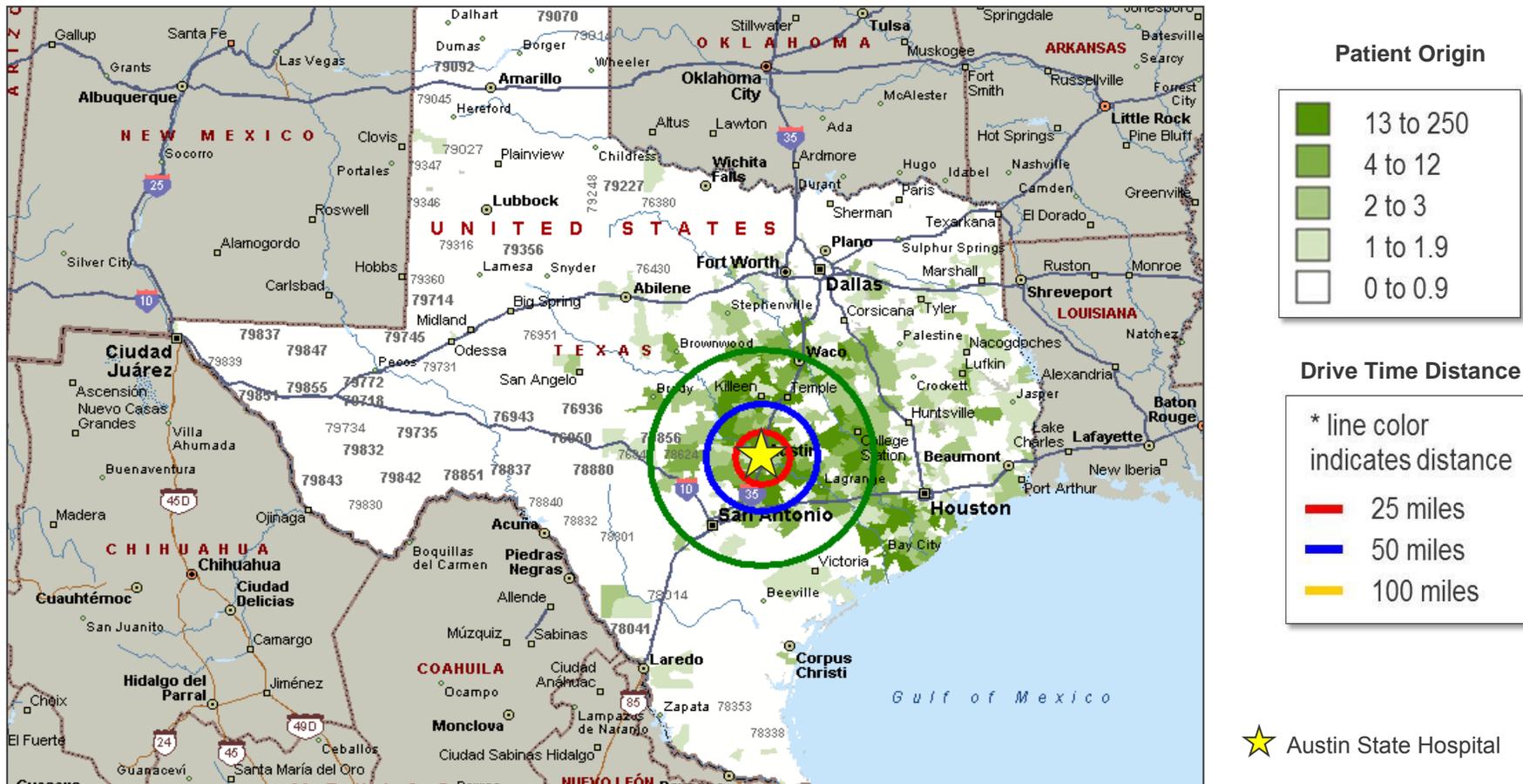
Exhibit G-49. Terrell State Hospital Patient Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Terrell State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 50 miles. There are small populations that are coming from areas greater than 100 miles from the hospital.

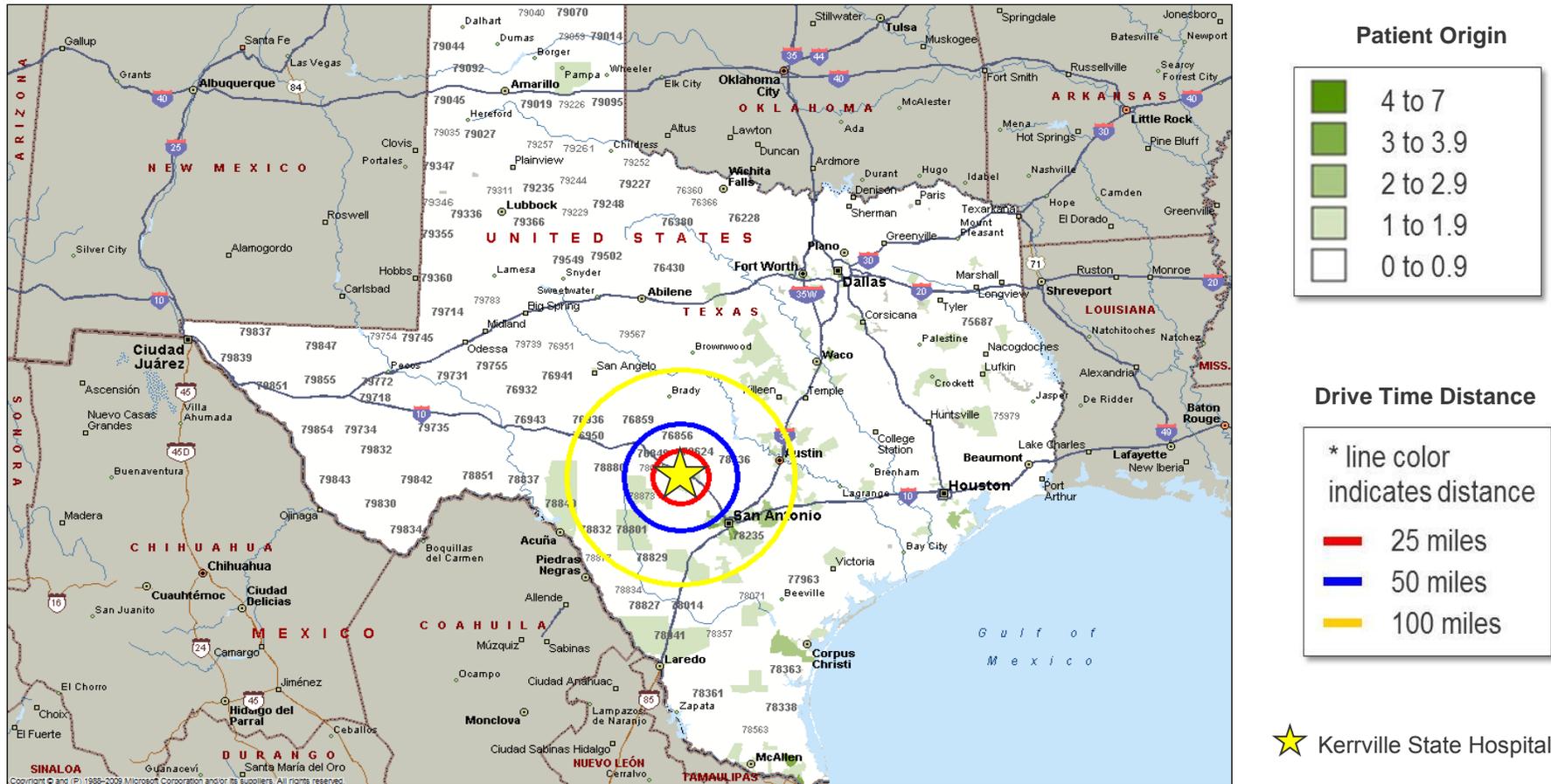
Exhibit G-50. Austin State Hospital Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Austin State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are dense concentrations of consumers that have to drive more than 100 miles to receive treatment from Austin State Hospital, with a majority of these coming from the southeast direction towards Houston.

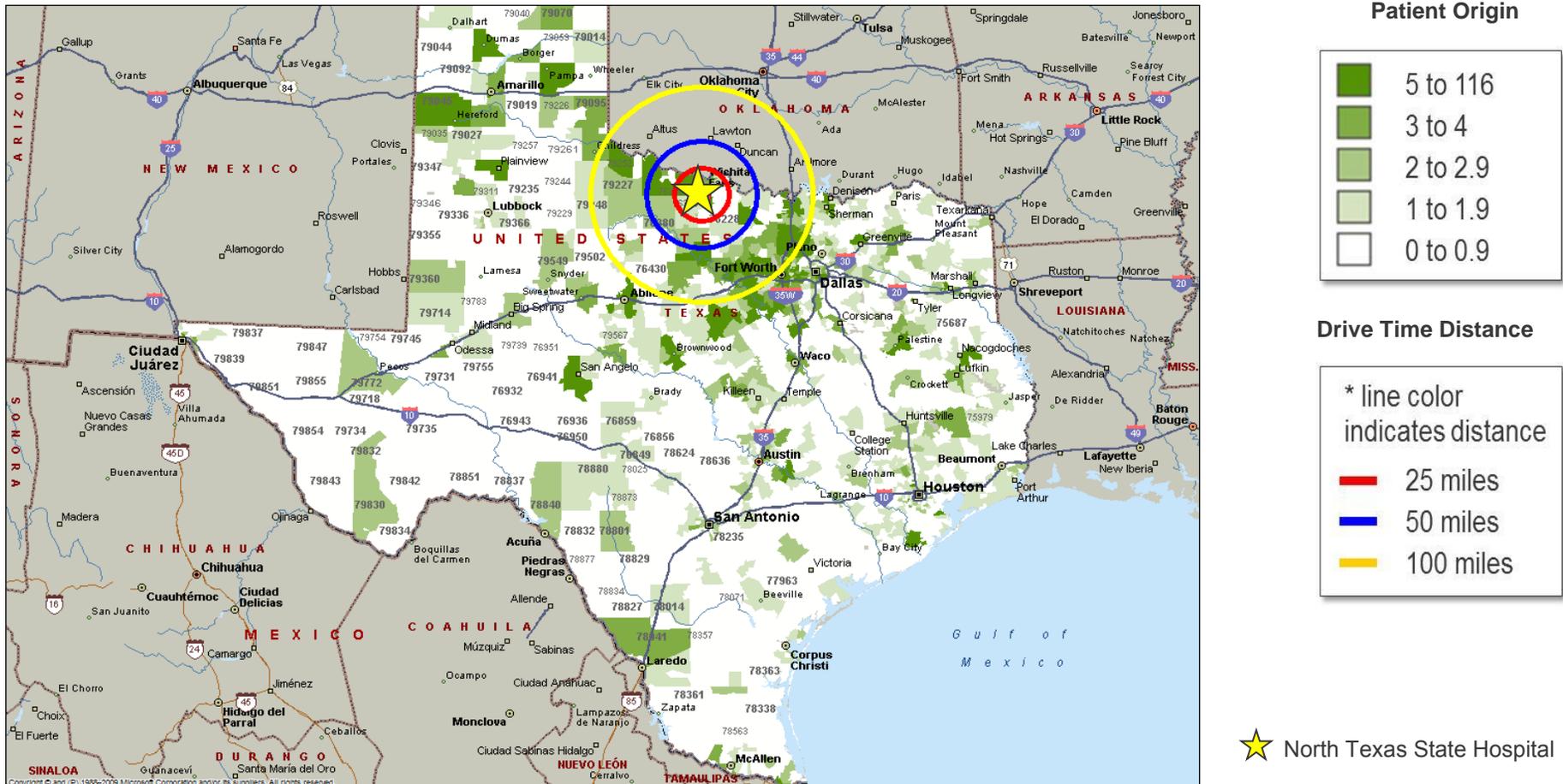
Exhibit G-51. Kerrville State Hospital Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Kerrville State Hospital’s resident origins show a variety of the consumers coming from a drive time distance within 100 miles as well as a number of consumers coming from various parts of the state with drive times significantly greater than the 100 mile parameter.

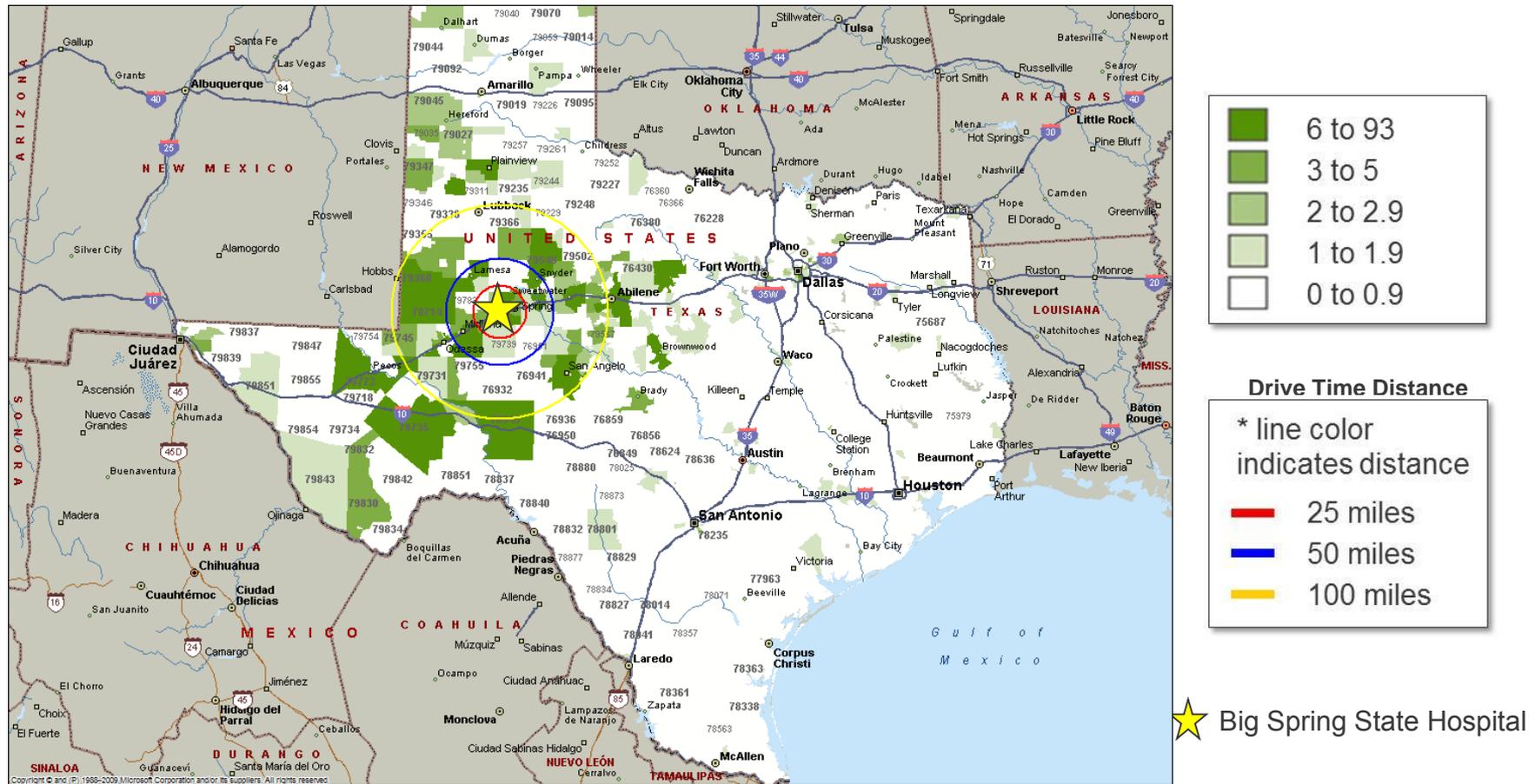
Exhibit G-52. North Texas State Hospital, Wichita Campus Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

North Texas- Wichita State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are dense concentrations of consumers that have to drive more than 100 miles to receive treatment from North Texas - Wichita State Hospital, with a majority of these coming from the southeast direction towards Dallas and the northern panhandle.

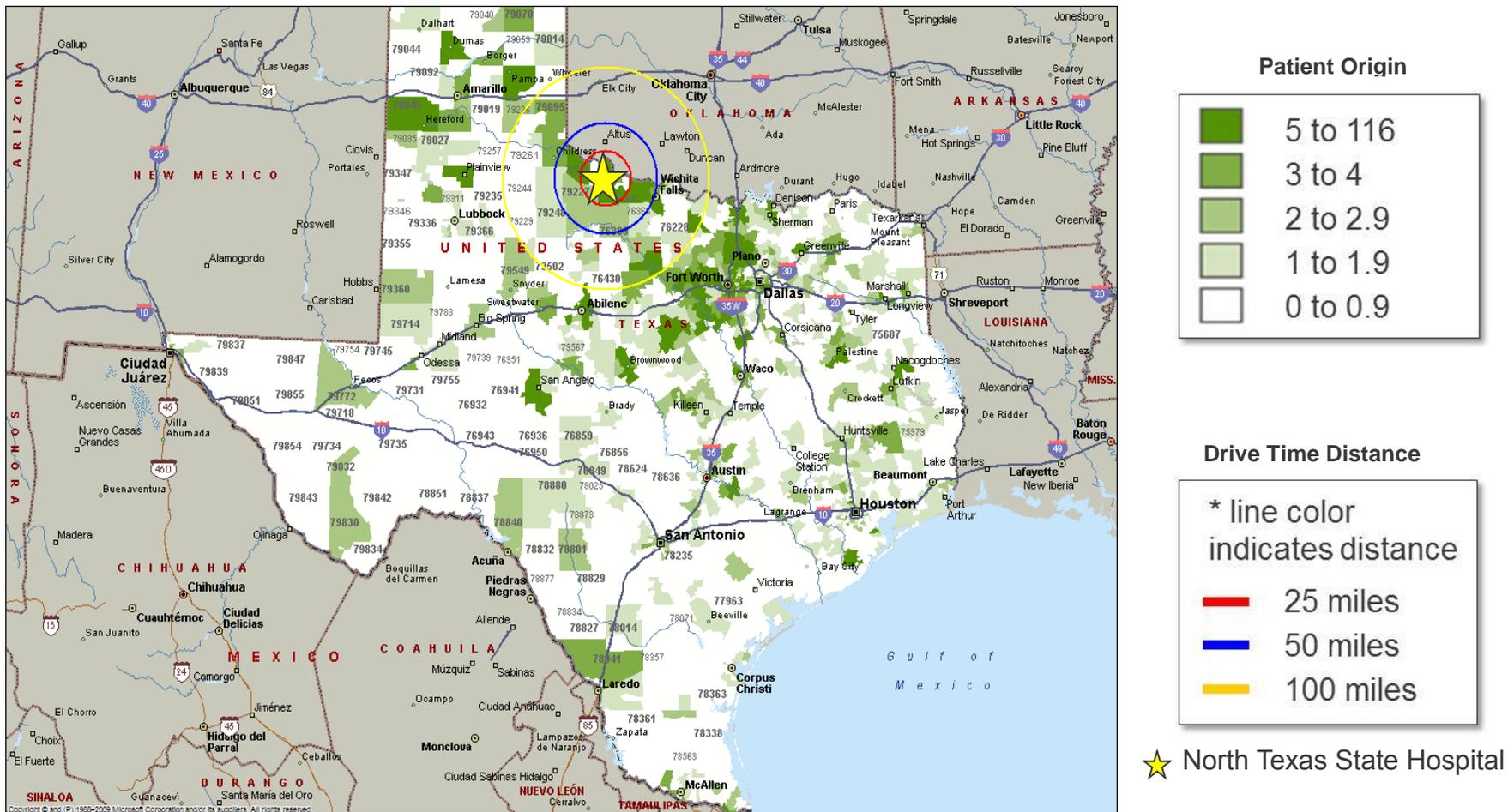
Exhibit G-53. Big Spring State Hospital Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Big Spring State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are dense concentrations of consumers that have to drive more than 100 miles to receive treatment from Big Spring State Hospital, with a majority of these coming from the southwest direction.

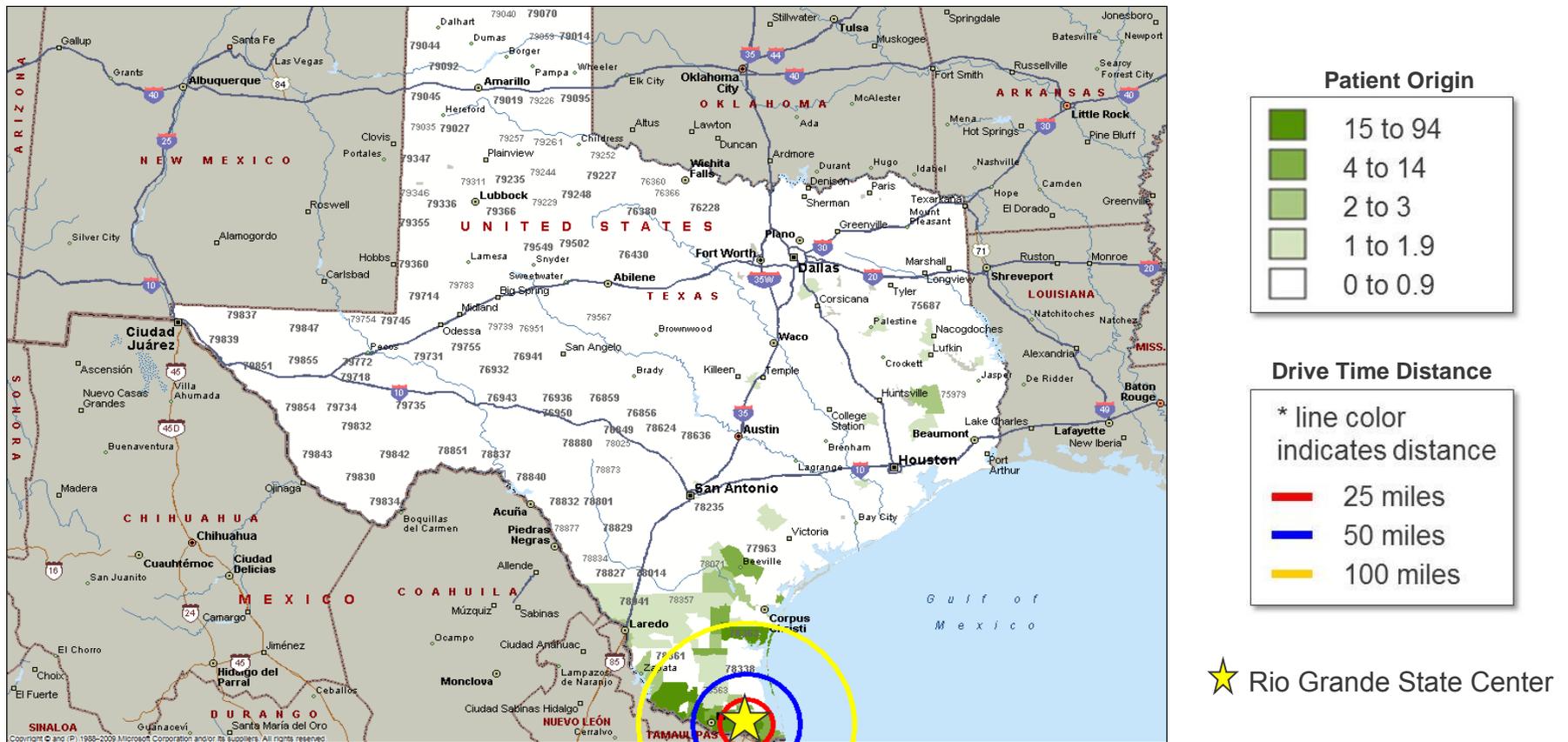
Exhibit G-54. North Texas State Hospital, Vernon Campus Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

North Texas- Vernon State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are dense concentrations of consumers that have to drive more than 100 miles to receive treatment from North Texas- Vernon State Hospital, with a majority of these coming from the southeast direction towards Dallas and the northern panhandle.

Exhibit G-55. Rio Grande State Center Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Rio Grande State Centers’ resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are some smaller resident populations that have to drive more than 100 miles to receive treatment, with a majority of these coming from the Northwest direction.

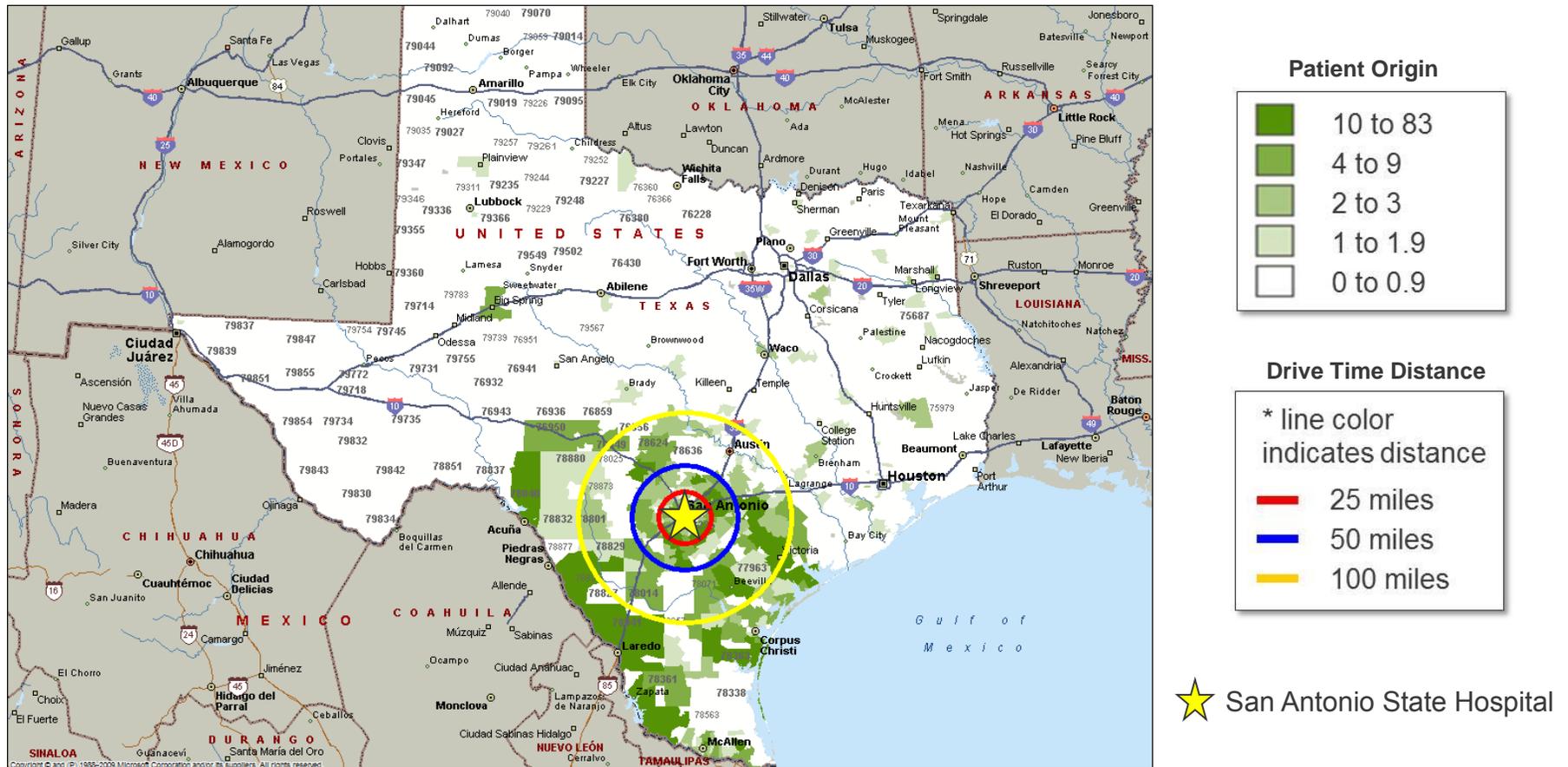
Exhibit G-56. Rusk State Hospital Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Rusk State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are small concentrations of consumers that have to drive more than 100 miles to receive treatment from Rusk State Hospital, with a majority of these coming from the southern direction towards Houston.

Exhibit G-57. San Antonio State Hospital Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

San Antonio State Hospital’s resident origins show a majority of the consumers coming from a drive time distance within 100 miles. There are large concentrations of consumers that have to drive more than 100 miles to receive treatment from San Antonio State Hospital, with a majority of these coming from the southwest direction.

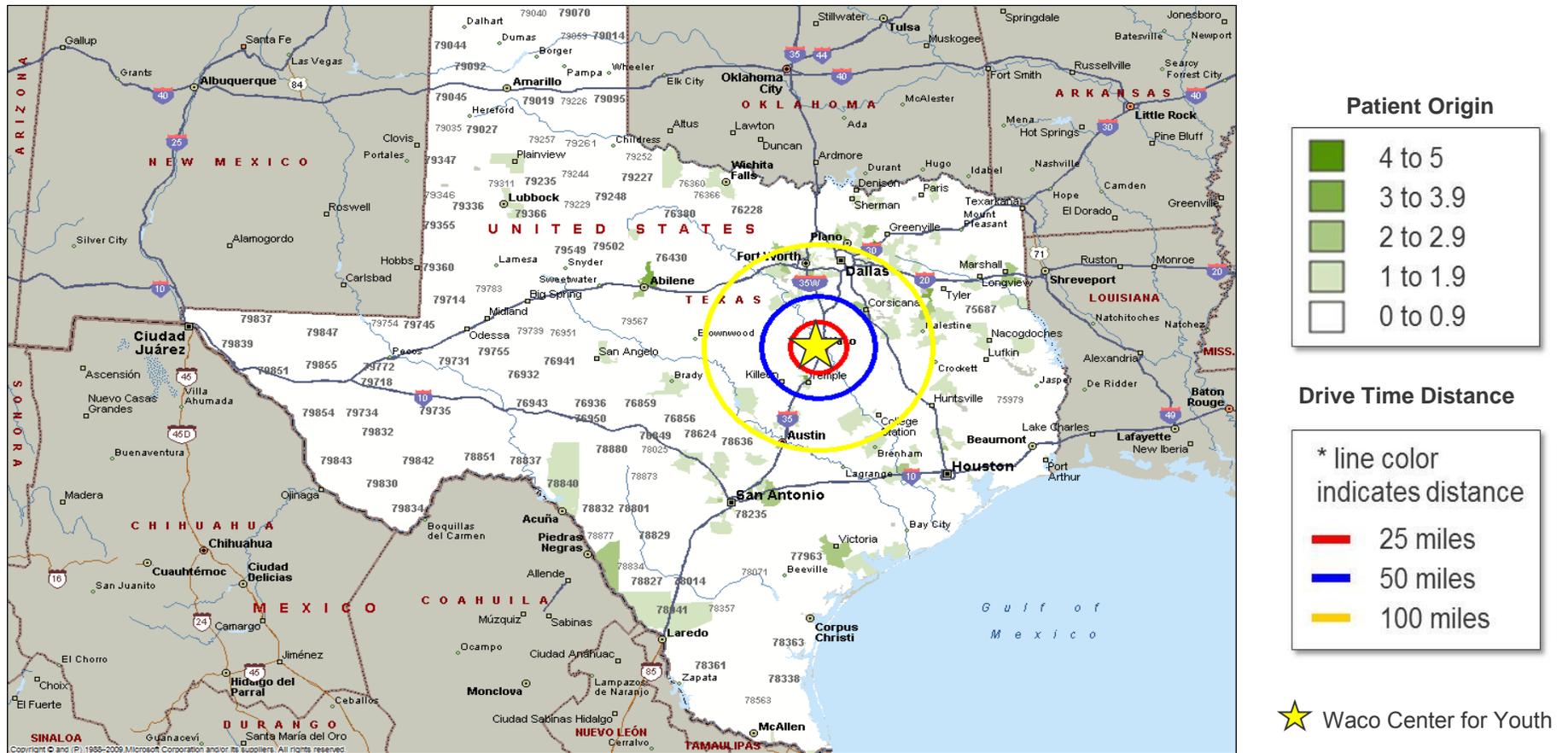
Exhibit G-58. El Paso Psychiatric Center Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

El Paso Psychiatric Center’s resident origins show consumers coming from a drive time distance within 100 miles as well as a small number of coming from various parts of the state with drive times significantly greater than the 100 mile parameter.

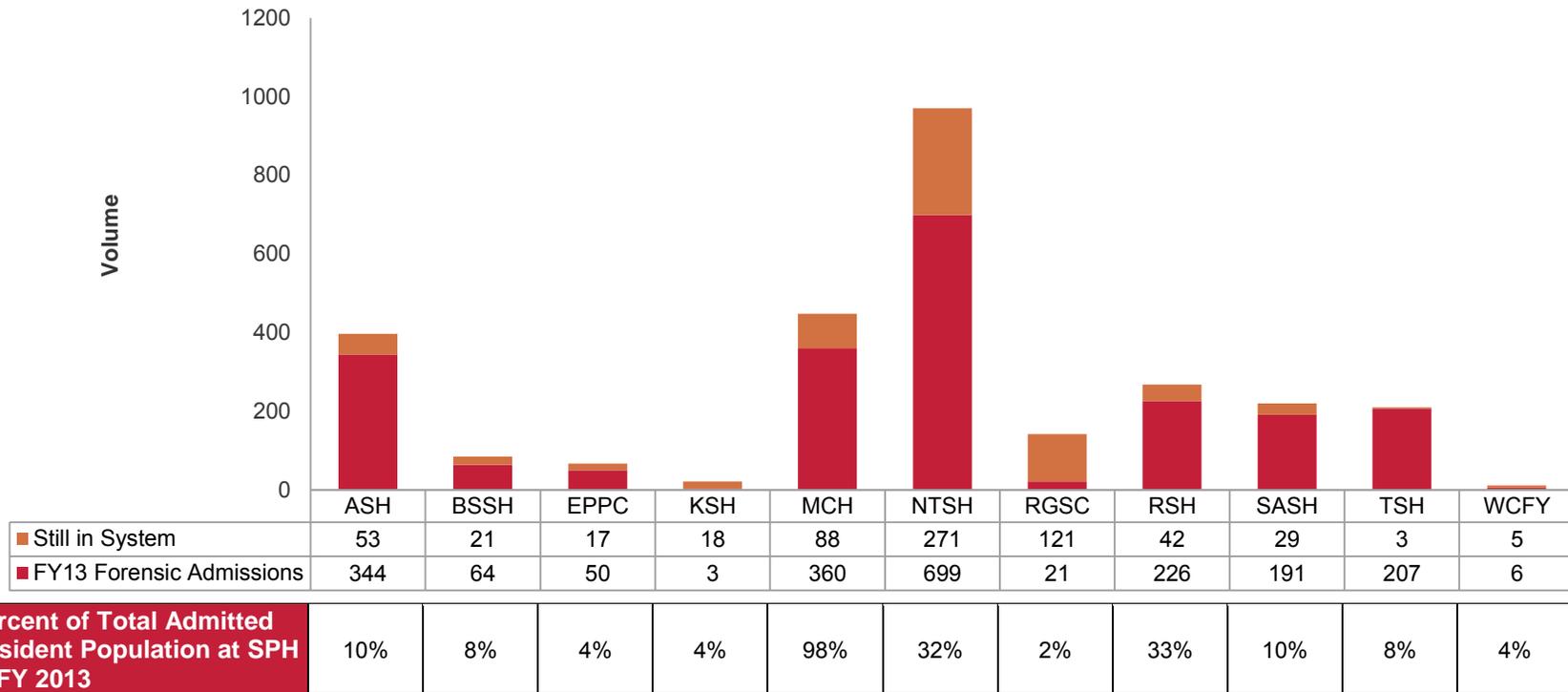
Exhibit G-59. Waco Center for Youth Consumer Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014.

Waco Center for Youth’s resident origins show a variety of the consumers coming from a drive time distance within 100 miles as well as a number of consumers coming from various parts of the state with drive times significantly greater than the 100 mile parameter.

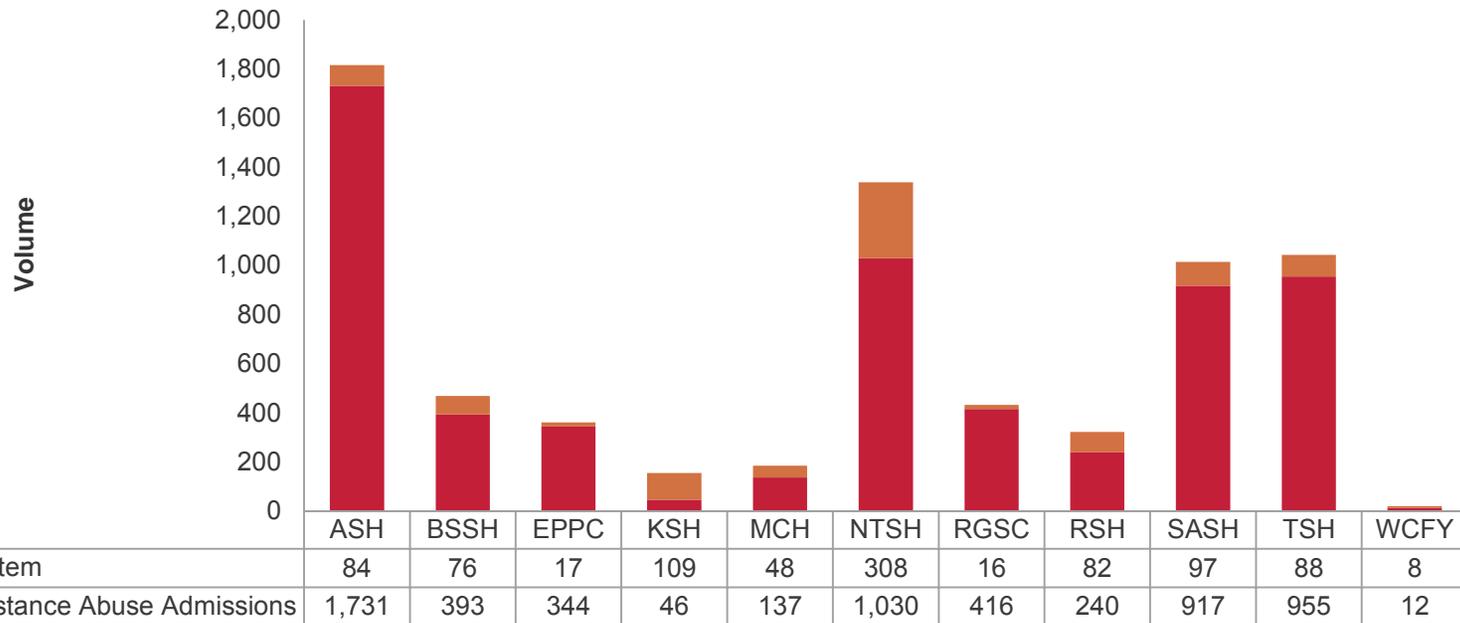
Exhibit G-60. Total Forensic Resident Volume by Facility, FY13



*Note: Consumers still in the system are those that were admitted prior to Fiscal Year 2013, and are still being treated at the facility during Fiscal Year 2013, and have not been discharged | The percentage of forensic consumers admitted takes the Fiscal Year 2013 forensic admissions / Total Fiscal Year 2013 admissions.
Source: DSHS Client Level Data, CannonDesign analysis 2014.*

The overall percent of new forensic consumers of the total admitted resident volume is 15 percent.

Exhibit G-61. Total Substance Abuse Resident Volume by Facility, FY13



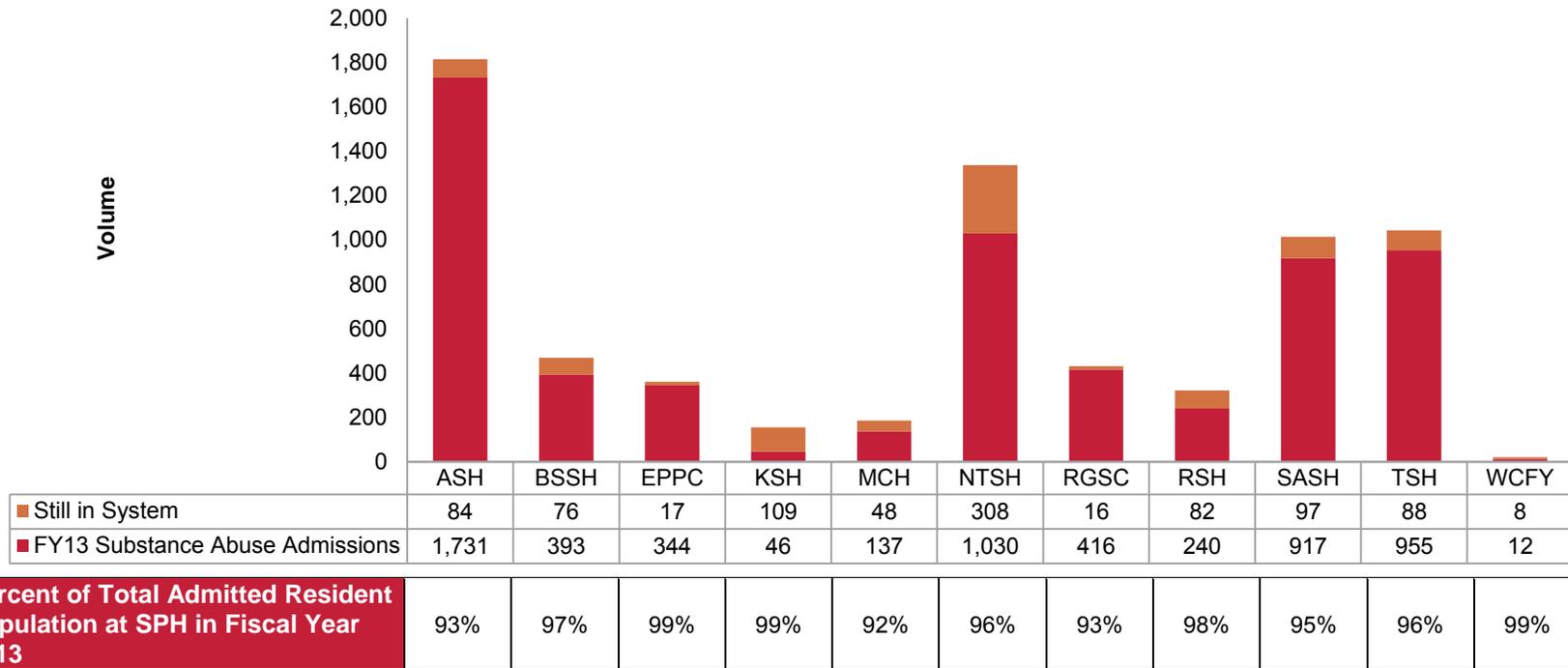
Percent of Total Admitted Resident Population at SPH in Fiscal Year 2013	ASH	BSSH	EPPC	KSH	MCH	NTSH	RGSC	RSH	SASH	TSH	WCFY
	48%	46%	31%	56%	37%	47%	44%	35%	48%	38%	8%

Note: Consumers still in the system are those that were admitted prior to Fiscal Year 2013, and are still being treated at the facility during Fiscal Year 2013, and have not been discharged | The percentage of substance abuse consumers admitted takes the Fiscal Year 2013 substance admissions / Total Fiscal Year 2013 admissions.

Source: DSHS Client Level Data, CannonDesign analysis 2014.

Kerrville State Hospital has the highest number of substance abuse consumers that remain in the system longer than one year. Waco Center for Youth has the smallest number of substance abuse consumers that remain in the system longer than one year at only 8 percent.

Exhibit G-62. Total Medically Complex Resident Volume by Facility, FY13

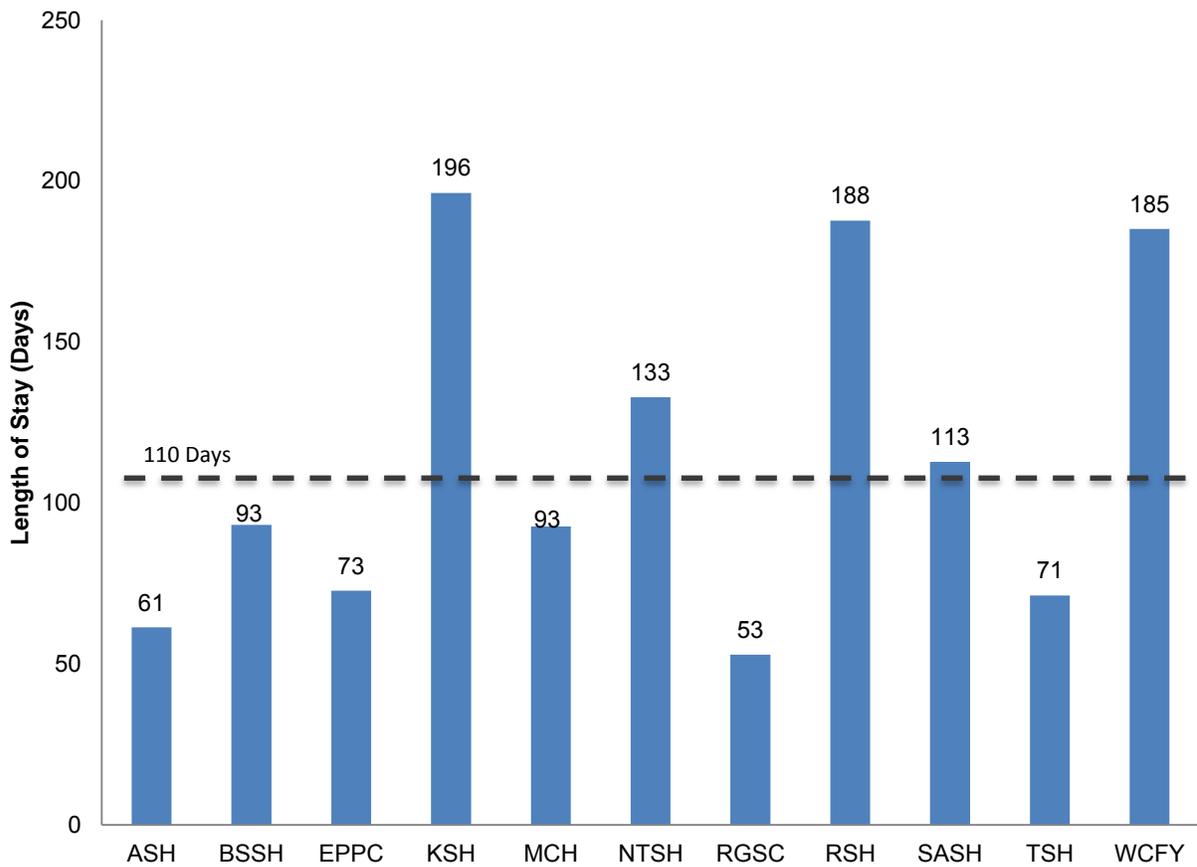


Note: Consumers still in the system are those that were admitted prior to Fiscal Year 2013, and are still being treated at the facility during Fiscal Year 2013, and have not been discharged | The percentage of medically complex consumers admitted takes the Fiscal Year 2013 medically complex admissions and medically complex consumers in system prior to Fiscal Year 2013 / Total Fiscal Year 2013 admissions.

Source: DSHS Client Level Data, CannonDesign analysis 2014.

Over 90 percent of the resident admissions at each facility were medically complex clients in 2013, which means that the client has both psychiatric diagnoses, along with medical diagnoses. Ninety-nine percent of the admissions at El Paso Psychiatric Center, Kerrville State Hospital, and Waco Center for Youth were medically complex client admissions.

Exhibit G-63. Average Length of Stay for Forensic Consumers by SPH, FY13



Note: Forensic consumers are defined as those that come directly from jail or a correctional facility.

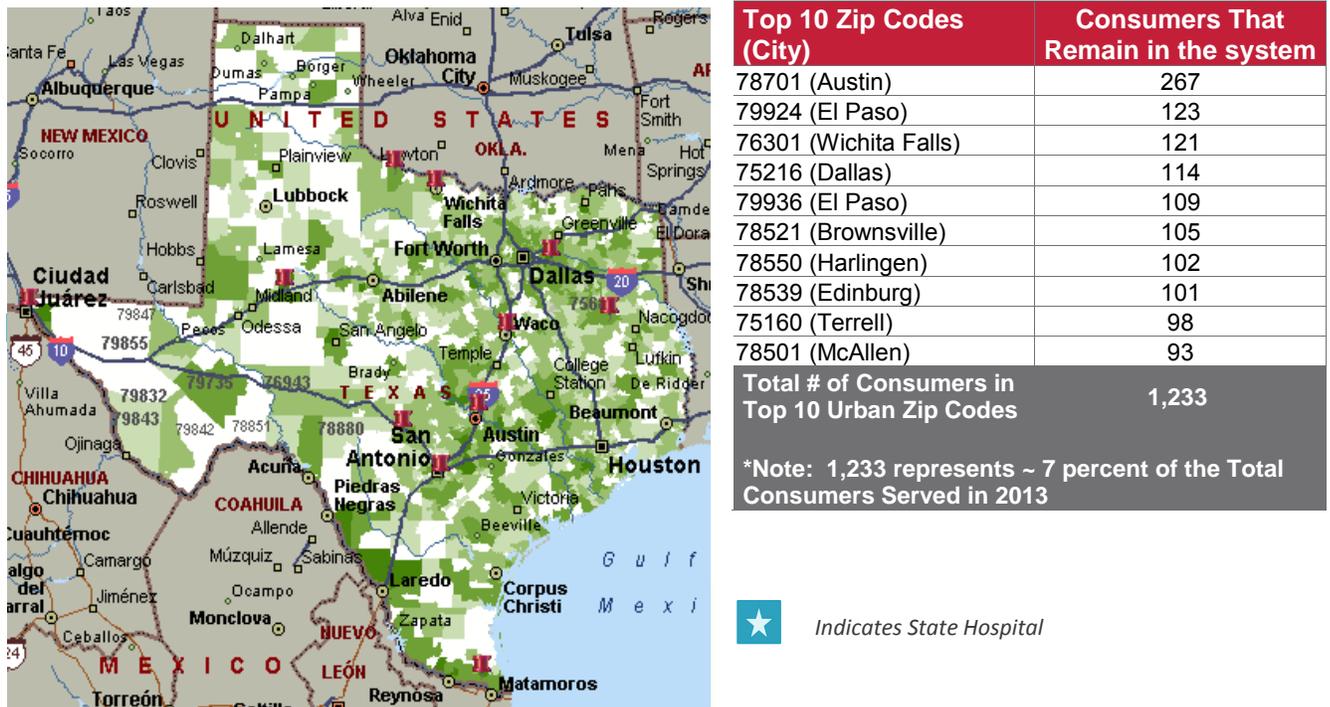
Source: DSHS Patient Level Data, CannonDesign analysis 2014.

The average length of stay for the forensic population is 110 days. Kerrville State Hospital has the longest ALOS, 196 days. Rio Grande State Center has the shortest ALOS for Forensic consumers, 53 days.

Appendix H. Global Assessment of Community Impact Detail

Appendix H covers data graphs and exhibits that support the key themes and recommendations in the Community Impact Assessment section of this report.

Exhibit H-1. Resident Origin: Consumers Remaining in State Psychiatric Hospitals by Zip Code, FY13

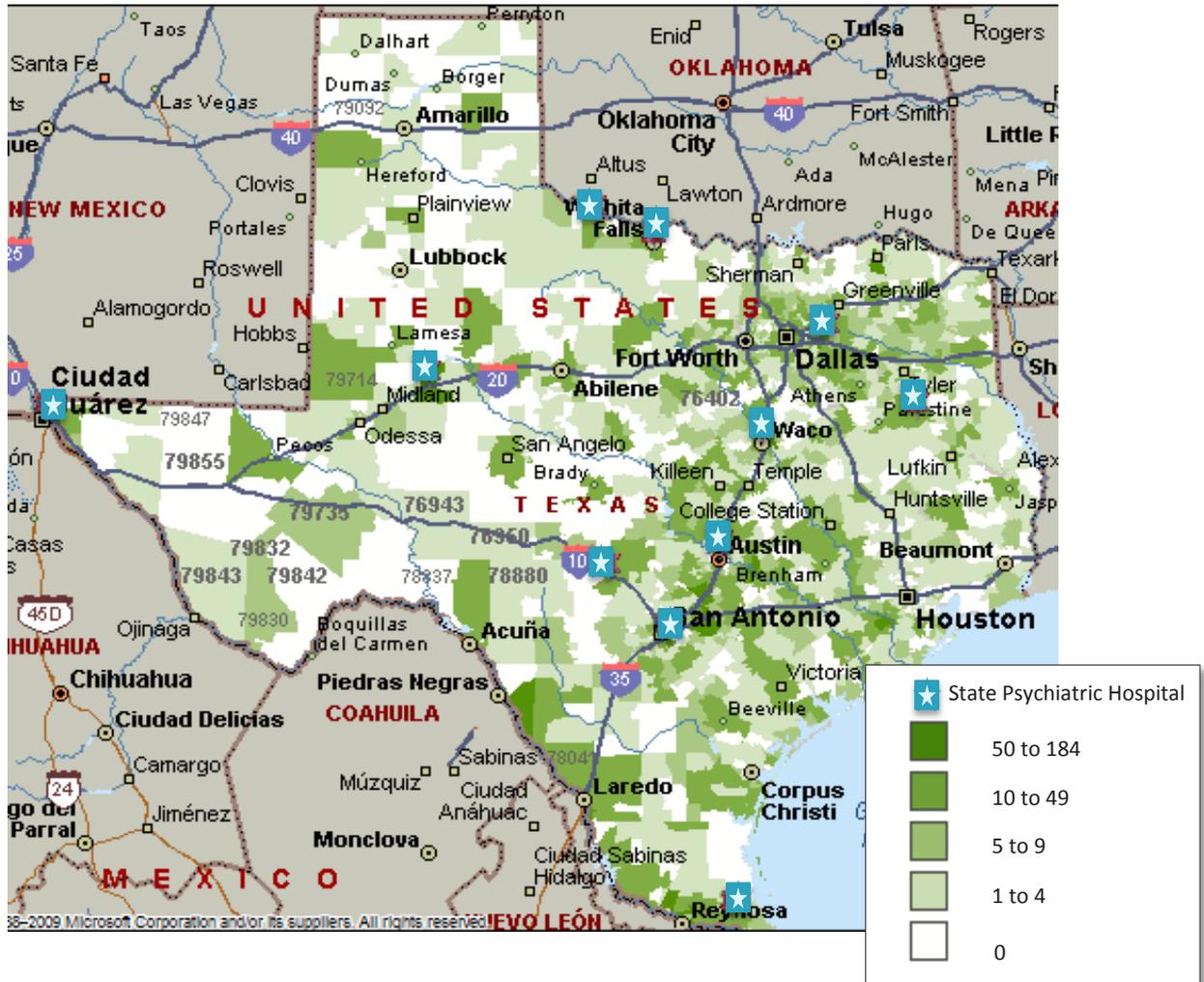


Note: Fiscal year indicates year of separation. Resident count includes separated and still in system.

Source: State Hospital Patient Data

A large number of consumers in Texas’ state psychiatric hospitals originate from the urban populations, the largest of these coming from Austin. Furthermore, while volumes originating from urban counties are high, it remains well below the majority of the total consumers served in 2013. The top 10 urban zip codes equate to 1,233 consumers, which is approximately seven percent of the total number of consumers served.

Exhibit H-2. Civil Resident Origin, FY13

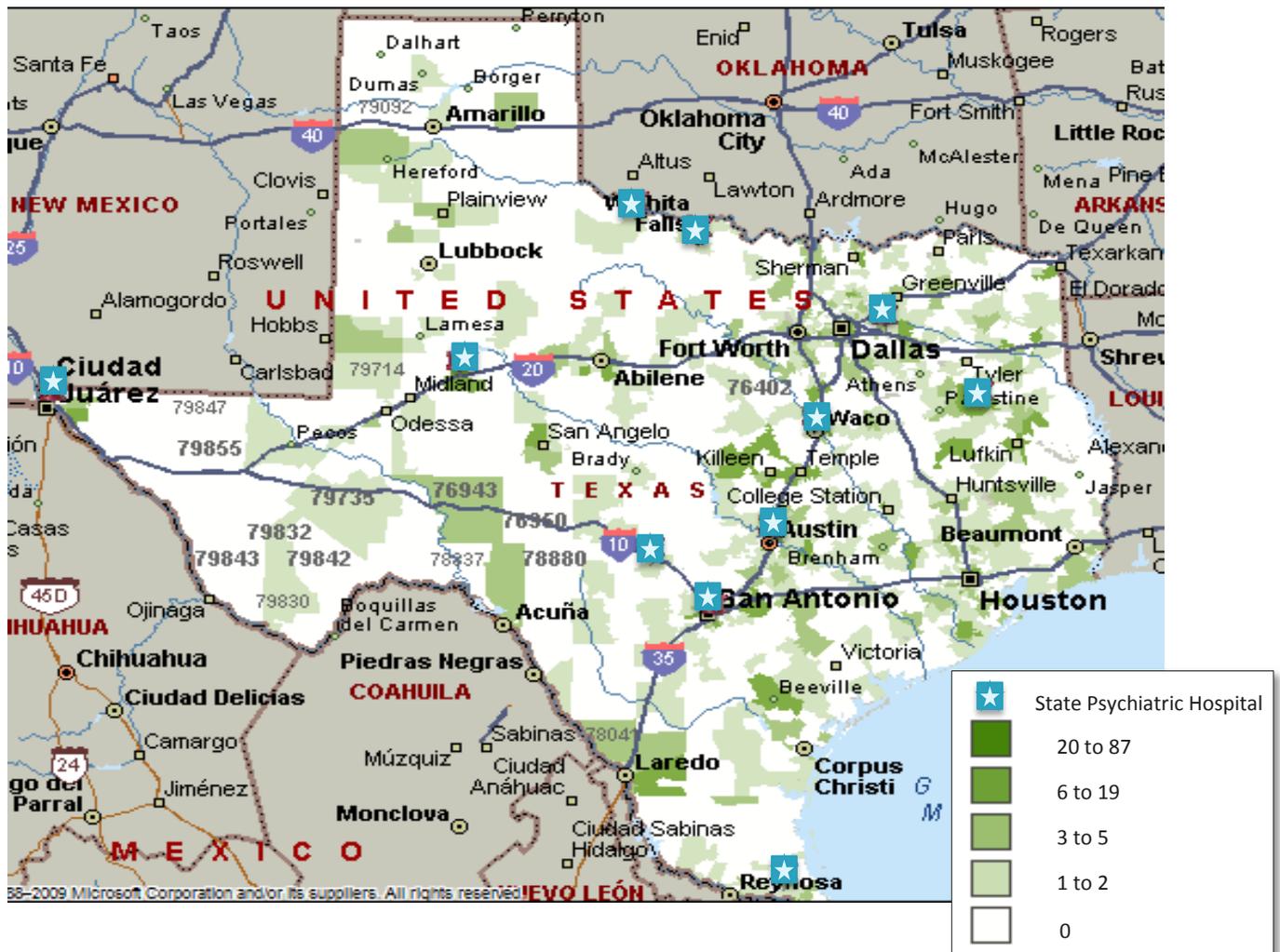


Note: Civically committed consumers identified as having admission source that is not Jail or Correctional Facility. Excludes consumers with zip codes out of Texas, PO Boxes and zip codes missing digits.

Sources: DSHS resident-level data, CannonDesign analysis 2014.

Several civil consumers are not in close proximity to a SPH. The northern panhandle and Rio Grande Valley, in particular, have civil resident populations a significant distance away from the closest facility.

Exhibit H-3. Forensic Resident Origin, FY13

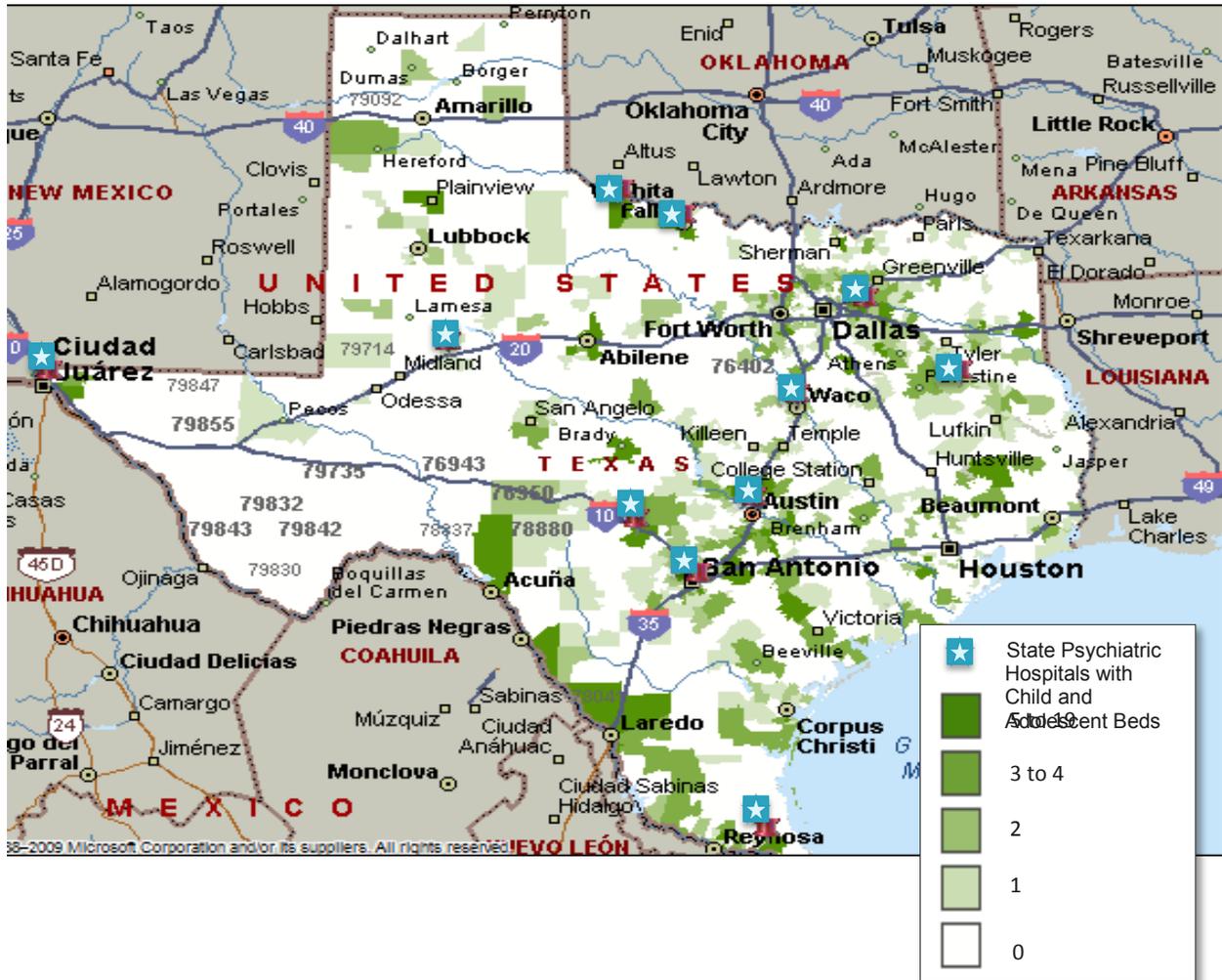


Note: Forensic consumers identified as having admission source that is Jail or Correctional Facility. Excludes consumers with zip codes out of Texas, PO Boxes and zip codes missing digits

Sources: DSHS resident-level data, CannonDesign analysis 2014.

Several forensic population bases are not in close proximity to a SPH. Laredo and the surrounding Houston area, in particular have forensic resident populations a significant distance away from the closest facility.

Exhibit H-4. Child and Adolescent Resident Origin, FY13

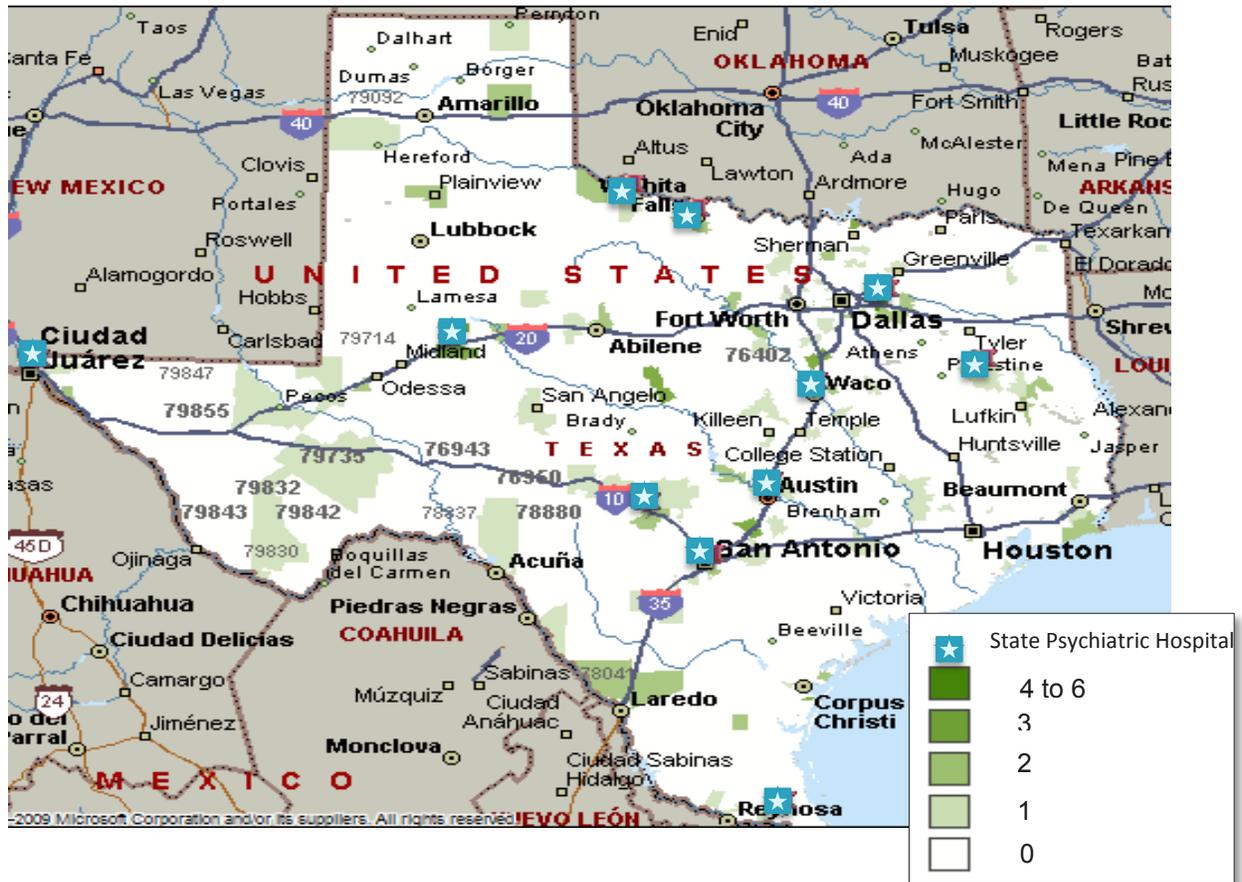


Note: Child and Adolescent consumers defined as those with admitting ages 0-17. Excludes consumers with zip codes out of Texas, PO Boxes and zip codes missing digits.

Sources: DSHS resident-level data, CannonDesign analysis 2014.

Several child and adolescent resident bases are not in close proximity to a SPH. Southwest Texas, in particular, has children and adolescents consumers a significant distance away from the closest facility.

Exhibit H-5. Geriatric Resident Origin, FY13



Note: Geriatric Consumers defined as those with admitting ages 65 or older. Excludes consumers with zip codes out of Texas, PO Boxes and zip codes missing digits.

Sources: DSHS resident-level data, CannonDesign analysis 2014.

Several geriatric resident bases are not in close proximity to a SPH. Laredo and parts of western Texas, in particular, have geriatric resident populations a significant distance away from the closest facility.

Exhibit H-6. Distance from Resident County to Admitting State Psychiatric Facility, FY13

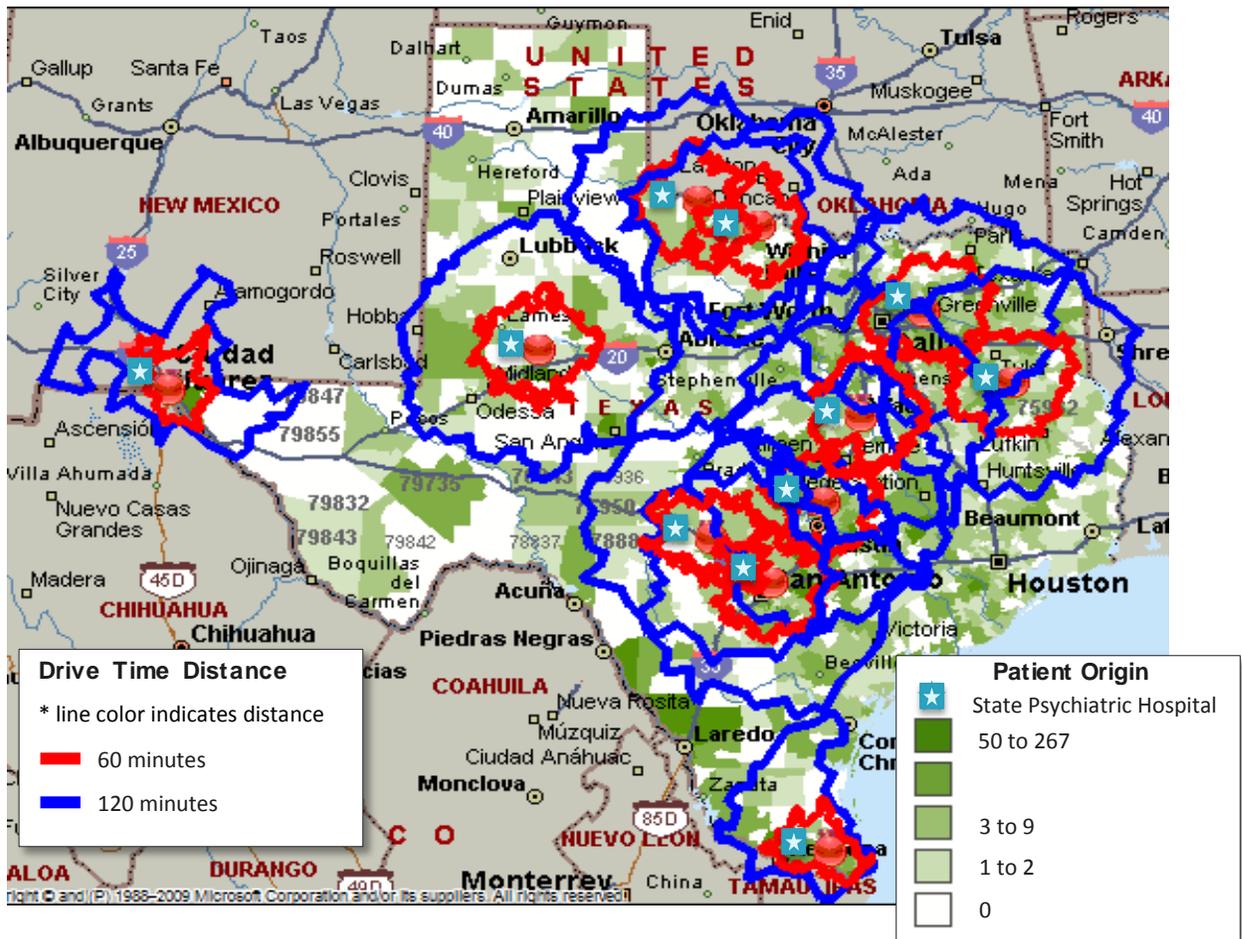
SPH	DISTANCE			
	<25 Miles	25-50 Miles	50-100 Miles	100 Miles or More
Austin	33%	11%	30%	26%
Big Spring	11%	9%	31%	49%
El Paso Psychiatric Center	99%	0%	0%	1%
Kerrville	0%	2%	43%	55%
North Texas	11%	1%	19%	69%
Rio Grande Center	1%	6%	7%	86%
Rusk	41%	40%	10%	9%
San Antonio	34%	9%	13%	44%
Terrell	34%	9%	13%	44%
Waco Center for Youth	19%	63%	14%	4%

Notes: Excludes PO Boxes, Zip Codes outside of Texas, Zip Codes labeled "N/A". Includes all consumers (84% Forensic and 16% Non-forensic)

Source: DSHS Patient Level Detail Nielson Claritas; CannonDesign analysis 2014

In Fiscal Year 2013, Over 50 percent of consumers from four facilities traveled 100 miles or more from their home county to their admitting SPH. Rio Grande Center had 86 percent of its consumers traveling 100 miles or more, the highest percentage of any SPH. Only two facilities, El Paso Psychiatric Center and Rusk, had over 40 percent of their admitted consumers traveling less than 25 miles from their home county.

Exhibit H-7. State Psychiatric Hospital Origin and Drive Time Distance, FY13



Sources: DSHS resident-level data, FY10-FY14YTD; CannonDesign analysis 2014

When examining resident origin by driving distance, the effect of distance and time on the utilization of services is even more pronounced. There are a number of cities with a moderate to high demand for services that are more than two hours away from the nearest SPH.

Appendix I. Consumer Letters for Approval

Burke Center

**Mobile Crisis Outreach Team
5002 Lotus Lane Lufkin, Texas 75904
936-674-3550 Fax 936-633-6034**

July 31, 2014

To whom it may concern,

I have received services for more than 20 years in different states and the various mental health agencies I used were all the same: cold and impersonal. Every time I would register for services, make an appointment, stay in a hospital, I felt like an inconvenience, a number on a chart. Appointments with psychiatrists were 15 minutes every several months, and counseling appointments were 45 minutes once a week at the most. I felt as if no one would listen to me or saw me as more than a diagnosis. I was told I was sick, that I couldn't recover, that I would be in and out of hospitals most of my, that I was incapable of taking care of myself. I felt dehumanized.

The turning point in my life was connecting with someone who had lived similar experiences as me, told me that I was more than a label, and that I was responsible for my recovery. I started to learn about my diagnosis and how it affected me and educated myself on treatment options. I became proactive in my recovery and refused to be a number on a chart.

Now, I have the pleasure to work as a Certified Peer Specialist. I am able to take my experiences and use them to educate, inspire, and guide others in their recovery. I conduct both individual and group sessions with clients receiving services from MCOT at Burke Center. I have seen what appears to be a faster rebound from their crisis situations, increases in self-esteem and confidence, support networks built and strengthened, and a growing sense of purpose in the individuals that I work with. They tell me that they feel like they are being heard, that they matter, and the connections being built are vital to their recovery as it helps them feel as though they are not alone.

In my opinion, peer services need to be strengthened within our mental health system. Having a peer provider gives clients a voice. My clients share things with me that they don't always feel comfortable sharing with their clinicians and therapists. This allows me to both advocate for them and teach them to advocate for themselves. It allows them a support upon which to lean until they are able to support themselves.

One way in which peer services can be strengthened is to increase funding for peer services. By doing so, it would allow agencies to increase pay rates for current peers making them more equal to the other professionals on the treatment teams. For example, where I work, a CPS makes approximately 2/3s what a QMHP makes. Though the formal education requirement is higher for a QMHP, a CPS must undergo additional trainings to receive and maintain a certification, which offsets the formal education requirement. Additional funding would also allow for the hiring of additional peers and provide trainings necessary for maintaining certifications. In addition, peer services could be expanded within some agencies to include after hour non-crisis services such as peer-run warmlines, drop-in centers, education and job skills trainings for clients, additional groups services for clients and their families, and more.

Thank you for taking the time to read our stories and consider our suggestions.

Sincerely,
Angela M. Tomlinson
Certified Peer Specialist
Burke Center Mobile Crisis Outreach Team (MCOT)
936-673-3550 Office
atomlinson@burke-center.org

Ginny Morgan
2750 S.8th Street
Beaumont, Texas 77701

The turning point in my recovery was funding that received by the Hogg Foundation that made available intensive recovery trainings. These training taught me how to manage my own mental health challenges and to have a voice concerning what I needed in my self care. It also empowered me not to be ashamed of my challenges to share with others that as an employee in the system that it was okay to disclose that you had a mental health diagnosis and that you do understand what persons we provide serves to are feeling and living with as I had many of the same challenges.

The services and interventions that have contributed to my recovery are many and I have worked inside of the system for many years supporting medication management. However medication only is not the key to wellness. Even though medication plays a big role in helping individuals in recovery it is not the answer for some and is not for me. People believe a pill will fix it and this is not always the case and the system had taught myself and has taught person with mental health challenged when something happens you just run back to the doctor and get another pill. We have not been taught that we have to be responsible for our on illness and we have expected someone else to fix it. I have found wellness in recovery tools other than medication. In researching recovery education for myself and other as a supervisor of a Consumer Run Drop In Center supported by Spindletop Center going to recovery training, learning more about the possibility of recovery instead of being stuck in my illness has had a tremendous impact on my personal recovery. I have become a Certified Peer Specialist, WRAP/WHAM/eCPR facilitator and teach my peers, clients and staff of Spindletop Center and the Community that recovery is possible. Getting involved with peers, learning from and supporting each other in our challenges together is in itself a pathway to wellness. The educational classes have empowered myself and empowered other persons with mental health challenges that have been in the system for many year and not are leading productive lives to step into the recovery and take ownership of there own recovery. Centers actively working with peer to peer relationships that are supporting of medication management and recovery tools are needed. Staff learning about recovery, treatment plans changing to recovery plans and peer to peer supports seeing individuals that have been in services for many year become medication compliant, get a job, get off their disability and lead a normal productive life is most humbling.

There is a lack of funding to support peer run initiatives, recovery training for mental health and substance use, ViaHope peer trainings, joint peer organizations across the state. There is also a need for staff trainings that promote peer to peer billable services more than just the medical model. The state needs to provide more funding for hiring peers as service providers. If I would have had access to some of the above mentioned intervention my life much sooner I could as many other achieved wellness much sooner. Our prison would not be as full, self medicating would be less of an issue, less deaths, homeless. Peer to Peer education in Texas does and will make a difference we just need more available funding for trainings

To Whom it May Concern:

I had suffered from major depression and addictions for many years, following much childhood trauma. I had severe abandonment issues and PTSD. I tried suicide when I was sixteen years old. I joined a twelve-step program in 1993. Though I had sought treatment for my mental illness, I had experienced episodes of depression and prescription drug dependency frequently. I raised my five children and had a career for a long time. My depression affected every area of my life, as did the drugs I used to self-medicate. My condition affected my economic status, relationships, my motherhood, and my personhood.

I found myself dependent on painkillers following surgery and a major illness. I went to a treatment center for detoxification in 2009. I was referred to Fredonia Place for treatment for my mental illness and drug dependency. While at Fredonia, I was introduced to Community Healthcore for psychiatric evaluation and treatment. I was introduced to the concept of dual diagnosis. I was taken to DRA (Dual Recovery Anonymous), another twelve-step program, which was more inclusive. I learned that one must treat both depression and addiction concurrently because one illness works against the other. And one recovery program is appropriate for both illnesses. I was taught that I had two no-fault diseases, which could be treated and controlled. This helped me with the shame and guilt that I experienced, thinking I was a bad person.

If I gave one instance of a turning point, I feel I would negate all the other wonderful people, counselors, programs, and institutions that had tried to help me. They kept me alive until I was able to get beyond suicide. My most recent turning point was this treatment that was prescribed for me in 2009. I had truly reached a point of hopelessness and helplessness. I was actually homeless though I was living with my sister. I believed that my life was over. I am so grateful for Community Healthcore, Fredonia Place, Oak Haven, and the Longview systems of help for a recovery that means the world to me. Community Healthcore gave me caseworkers to teach me coping skills and they visited me in my home. They provided competent psychiatrists, sent me to numerous trainings, and hired me to work in peer-to-peer activities. Fredonia gave me a safe haven. They transported us to recovery meetings, had speakers for nutrition, money management, physical fitness, taught us skills like cooking and laundry, did one on one counseling, helped with housing and benefits.

If there were things that would have helped me more, it might have been a warm hand for the transition from Fredonia to my apartment. Drop-in Centers might also have helped with the loneliness and boredom. But I stayed busy with recovery activities, meetings, and helping others. My greatest help would be the gift of becoming a peer provider for Community Healthcore when I got better. After becoming a Certified Peer Specialist, I have also become a Certified WRAP facilitator, attended Emotional CPR, The Respect Institute and other educational and helping opportunities.

Respectfully,

Linda H.

PAUL

On Monday, February 17, 2014, at approximately 3:50 p.m., Limestone County Sheriff's Office deputies were dispatched to a residence in Thornton in reference to a male suffering from a psychotic break. Paul seemed to be extremely agitated, disoriented and confused. Deputies then walked through the residence, at his request, and observed that the entire house had been destroyed. Deputies then felt Paul was a danger to himself. They spoke with a brother who had arrived on scene and he stated Paul had been doing very well the past five years. He stated they had not heard from him in a few days, so they arrived to check on him. The brother stated that he had been down to see him three times in the past few months and that each time he had become more delusional.

Deputies then spoke with Paul again and asked him if the EMTs could evaluate him. EMS evaluated him and advised that he was medically stable. Paul stood up and was advised that he was going to be transported to the hospital for a mental evaluation. He then began fighting with the deputies and was ultimately taken into custody. Deputies then contacted the Waco Crisis Center and advised them of the situation. The crisis center personnel then instructed the deputies to contact ICARE. The deputies contacted ICARE and were informed that an on-call counselor with the Mobile Crisis Team would be calling and asked where we would be so they could evaluate him there. They were advised that Paul would be taken to the sheriff's office. Paul was then transported to the sheriff's office to await the Mobile Crisis caseworker.

Upon arrival to the sheriff's office, the deputy noted they had not received a call from the caseworker as stated by the ICARE receptionist. The deputy then called ICARE back and she stated that she would call the caseworker again. Shortly after, the deputy received a call from the MCOT caseworker. She asked what was going on with Paul so the deputy briefed her on the circumstances. She stated that he would need to be taken to the crisis center and she would not be able to evaluate him in the field due to his violent behavior. The deputy advised her that the crisis center had referred us to her due to his aggressive acts. She stated that was a miscommunication. She stated the two options were to take him to the crisis center or the emergency room. The deputy advised her that he did not need medical treatment and that he had also been evaluated and treated on scene by EMS. The deputies then transported Paul to the crisis center in Waco at approximately 6:00 p.m.

Upon arrival, Paul was taken into a triage room by the staff. During the course of the triage, it was determined by the nurse that Paul had pitting edema in his ankles. The deputies were then advised that Paul would have to be taken to Providence Hospital to be medically cleared. Deputies then transported Paul back to Limestone County to Limestone Medical Center for medical clearance. Deputies arrived at Limestone Medical Center at approximately 9:00 p.m. where the medical clearance process was initiated. At approximately 4:30 a.m., the deputy informed his supervisor that Paul had been medically cleared and was awaiting acceptance into Austin State Hospital as the crisis center refused to accept Paul after he was medically cleared.

At approximately 12:30 p.m. on February 18, 2014, deputies were advised that Paul had been accepted at Austin State Hospital. Deputies then contacted the security contract company to take possession of Paul due to depleted personnel resources. They arrived and relieved deputies at approximately 1:30 p.m. The departure time for the security personnel from Limestone Medical Center was unknown. Austin is approximately two hours from the sheriff's office.

Notes:

- The initial call was received at 3:50 p.m. on February 18, 2014
- The distance from the sheriff's office to the crisis center in Waco is approximately 50 miles
- The return to the local hospital is preferable as the wait time for medical clearance is considerably shorter than the major hospital; however, it does impose a 100 mile round trip. Historically, deputies could expect to wait several hours before the medical clearance process was initiated at a major hospital. This resulted in a 6-8 hour wait time.
- The delay in mental treatment was due to swollen ankles. The swollen ankles were an ongoing medical issue that were present for approximately one year prior to our encounter.
- The patient had previously been treated and prescribed medication for his mental health issues.
- The acceptance into Austin State Hospital occurred at approximately 12:30 p.m. on February 19, 2014.
- The patient had still not received any type of mental treatment approximately 24 hours after being taken into custody by sheriff's office personnel.

SHERRI PENNINGTON

3651 Saint James Blvd. Beaumont, Texas 77705

sherri pen33@yahoo.com

My name is Sherri Pennington I am 41 years old and I was diagnosed with bipolar and major depression in 2006. Recovery started with me when I began going to The Spindletop Center of Beaumont, Texas. I had great case workers and doctor then I found a local drop in center I started going every day and found the art room and began to get in my zone painting pictures like crazy and making friends at the drop in center and also started volunteering there. I learned helping others helped me and just hearing that there is a chance for recovery gave me such hope and a purpose to help others that struggle with mental illness. In 2010 I was re-diagnosed with schizoaffective disorder because before I found the drop in center I was hospitalized in a behavior health hospital 3 times in a row the because I wanted to die all the time and couldn't get out of that mind frame. The Doctor there helped me find the right combination of medicine to make me feel so better. Then I met some great people that are to this day great supports for me and inspire me with what they have been through to keep on going. I was given the opportunity to take W.R.A.P. training and Certified Peer Specialist training. I became a CPS on August 2012. These trainings and others have really helped me in my recovery. I believe having a better behavior health hospital is desperately needed in my area. When you go in so upset and ready to kill yourself the last thing you need to do is either get sent away because there is not enough room or wait 12 hours or more to get in. The group homes here are not very good and have many issues. We need more housing for the homeless and others that have nowhere else to go. Teenagers have nowhere to go here except the streets and if you're not a woman with children or pregnant there is nowhere for you. I think if the behavior health hospital was bigger and better would be awesome and would of really helped me in my recovery sooner because when I went those 3 times it didn't help me at all I was just drugged up and I either left or was let go to deal with things on my own when I was in a zombie state.

Appendix J. Literature Review, Sources and Notes

Behavioral Health Issues Not a Priority in the ED

SOURCE: MedPagetoday.org

AUTHORS: Charles Bankhead , Staff Writer, MedPage Today
Reviewed by Zalman S. Agus, MD; Emeritus Professor, Perelman School of Medicine at the University of Pennsylvania and Dorothy Caputo, MA, BSN, RN, Nurse

LINK: <http://www.medpagetoday.com/EmergencyMedicine/EmergencyMedicine/32522>

BACKGROUND: Seeking psychiatric care in an emergency department led to a wait of more than 11 hours, and the wait was even longer for older, intoxicated, and uninsured patients, a study of five urban hospitals showed. The median wait lasted 8.2 hours. Patients discharged to home had a wait on par with the median, but a transfer outside a system of care almost doubled the wait time for patients with psychiatric emergencies. Data from the National Center for Health Statistics showed that the average wait for behavioral health services in an emergency department was 42 percent greater than the wait for non-behavioral health issues.

The final analysis involved 1,092 patients. The median age was 39 and there was even distribution between the sexes. The authors found that non-Hispanic whites constituted 71 percent of the study sample; that two-thirds of the patients had public insurance; and that 13 percent of the patients were homeless.

The most common (37 percent) presenting complaint was subjective behavioral distress (depressed or anxious), followed by suicidal ideation or nonlethal self-harm (33 percent). In about 90 percent of cases, patients provided serum or urine for a toxicology screen, which was uninformative 61 percent of the time. The substance identified most often was alcohol (33 percent of total sample), with or without other drugs.

The most common discharge diagnoses were mood disorder (69 percent) and substance use disorder (41 percent). Subsequently, 299 patients were discharged to home and 679 patients were admitted to the hospital or transferred to a psychiatric unit. The remaining 114 patients had a heterogeneous make-up.

OUTCOMES: The authors reported the following average wait times and average added times:

- Transfer outside the care system, 15 hours
- Transfer within the system, 12.9 hours
- Transfer to psychiatric unit in hospital, 11 hours
- Older age: 12.6 hours for ages 60 and older, 11.9 hours for ages 41 to 59, 10.7 hours for ages 18 to 40
- Positive screen for alcohol, +6.2 hours (14-hour average)
- Diagnostic imaging, +3.2 hours
- Use of a restraint, +4.2 hours
- Uninsured, +4 hours

The extended time associated with admission or transfer resulted from an additional 3.3 to 7.4 hours added to the time from decision disposition to the end of the emergency department visit.

Reports on the number of people served with ACT

SOURCE: NAMI
LINK: https://www.nami.org/Template.cfm?Section=ACT-TA_Center
BACKGROUND: A goal of NAMI is to make high quality ACT teams available to all who need them and to educate others about the effectiveness of this model. This site provides many data sets evaluating ACT teams and availability in many states. ACT is an effective, evidence-based, outreach-oriented, service delivery model for people with severe and persistent behavioral illnesses. NAMI seeks to educate people about ACT, expand and strengthen current ACT programs, and to ensure that the practices and values of ACT support consumer choice and meaningful participation in treatment and services.

How Many Assertive Community Treatment Teams Do We Need?"

SOURCE: Psychiatric Services (American Psychiatric Association, 2006), 1806
LINK: Gary S. Cuddeback et al.
BACKGROUND: Assertive community treatment (ACT) reduces hospitalizations for persons with severe behavioral illness. However, not everyone who needs ACT receives it. Without empirical guidelines for ACT planning, communities are likely to underestimate or overestimate the number of teams they need; thus the capacity of the programs will not meet current needs. In this study, administrative data were used to develop empirical estimates for the number of required ACT teams. These estimates were then used to examine current conceptual guidelines for developing the number of ACT teams that communities need.
METHODS: Administrative data from a large, urban county were used to enumerate all persons with a severe behavioral illness who had three or more hospitalizations within one year (ACT eligible).
RESULTS: 51 percent of persons with a severe behavioral illness were found to be eligible for ACT (743 of 1,453 persons). This figure represents 2.2 percent of the county's behavioral health users and .06 percent of its adult population.
CONCLUSIONS: Communities should develop enough ACT teams to serve approximately 50 percent of their populations of persons with severe behavioral illness or roughly .06 percent of their adult populations.

The Quality Concern: Behavioral Health Inpatient Readmissions

SOURCE: State Office of Behavioral Health.
AUTHORS: Finnerty, M. (2012). New York
LINK: http://www.omh.ny.gov/omhweb/psyckes_medicaid/initiatives/hospital/learning_collaborative_201
BACKGROUND: 3/quality_concern.pdf [Starting at p. 31, the presentation details literature (including the below citation) supporting the goal: Improve Delivery of Integrated Treatment for Psychiatric and Substance Use Disorders]

Peer Support

SOURCE: Department of Behavioral Health and Intellectual Disability Services
LINK: http://dbhids.org/peer-support
BACKGROUND: One of the greatest resources for people in recovery is the support offered by their peers. DBHIDS provides peer support programs and activities in which people with

behavioral health and/or drug/alcohol issues are assisted by peers, who use their first-hand experience to provide invaluable inspiration, motivation, encouragement and support. The website describes the types of services provided and the impact the various programs provide. A partial list of peer support programs includes: Friends Connection- a peer-run mobile psychiatric counseling service sponsored by the Behavioral Health Association of Southeastern Pennsylvania. Co-Location of Physical Health and Behavioral Health Services- convenient programs that allow people to seek services for their behavioral health and medical needs at one location. Mutual Support Groups- for individuals who share a common challenge or similar interest. Philadelphia Warmline- for individuals needing an alternative to crisis services.

Inpatient substance use treatment: what are the consequences?

SOURCE: Med Care Res Rev. 60(3):332-46.
AUTHORS: Dickey B, Normand SL, Drake R, Weiss RD, Azeni H, Hanson A. (2003) Limiting
LINK: http://mcr.sagepub.com/content/60/3/332.long
BACKGROUND: This study tested whether a managed care policy of substituting outpatient for inpatient treatment of substance use disorders shifted treatment costs to psychiatric providers. This was an observational study, based on administrative data of 25,450 adult disabled Medicaid beneficiaries treated for schizophrenia and major affective disorders. 18 percent had a diagnosis of substance use disorder. Multivariate regression was used to determine the odds of having a hospital admission and the relationship of managed care to hospital length of stay and total per person treatment expenditures. Hospital admissions and length of stay for both substance use disorder and psychiatric treatment were reduced, but adults with a dual diagnosis had higher annual expenditures compared to those with only a psychiatric diagnosis. There was no evidence of cost shifting. Although emphasis on outpatient treatment did not result in cost shifting, the combination of substance use disorder and psychiatric illness remains an expensive public health problem.

Interventions for drug-using offenders with co-occurring behavioral illness.

SOURCE: Cochrane Database Syst Rev.
AUTHORS: Perry AE1, Neilson M, Martyn-St James M, Glanville JM, McCool R, Duffy S, Godfrey C, Hewitt C. (2014).
LINK: http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2004-15452-008
BACKGROUND: A review of treatments for people with severe behavioral illness and co-occurring substance use disorders. Several interventions for people with co-occurring severe behavioral illnesses and substance use disorders have emerged since the early 1980s. This paper reviews 26 controlled studies of psychosocial interventions published or reported in the last 10 years (1994-2003). Though most studies have methodological weaknesses, the cumulative evidence from experimental and quasi-experimental research supports integrating outpatient behavioral health and substance abuse treatments into a single, cohesive package. Effective treatments are also individualized to address personal factors and stage of motivation, e.g., engaging people in services, helping them to develop motivation, and helping them to develop skills and supports for recovery. Accumulating evidence from quasi-experimental studies also suggests that integrated residential treatment, especially long-term (one year or more) treatment, is helpful for individuals who do not respond to outpatient dual disorders interventions. Current research aims to refine and test individual components and combinations of integrated

treatments. (PsycINFO Database Record (c) 2013 APA, all rights reserved)

Increasing Program Capability to Provide Treatment for co-occurring Substance use and Behavioral Disorders

SOURCE: Organizational characteristics, Journal of Substance Abuse Treatment, Volume 38, Issue 2, March 2010, Pages 160-169.

AUTHORS: Heather J. Gotham, Ronald E. Claus, Kim Selig, Andrew L. Homer

LINK: <http://www.sciencedirect.com/science/article/pii/S0740547209001238>

BACKGROUND: The Dual Diagnosis Capability in Addiction Treatment and the Dual Diagnosis Capability in Behavioral Health Treatment indexes were used to document change in the capability of 14 substance abuse and behavioral health agencies to provide services to clients with co-occurring substance use and behavioral disorders (COD). COD capability significantly increased over 2 years, with the largest improvements seen in client assessment and staff training for COD. The role of agency structural characteristics and organizational readiness for change was also investigated. The study found modest evidence that some structural characteristics (e.g., agency size) and organizational readiness for change were related to increased COD capability. Further study is needed of how these factors affect implementation and fidelity to evidence-based practices, including how programs might compensate for or modify the effects of organizational factors to enhance implementation efforts.

Service Use and Costs for Women with Co-occurring Behavioral and Substance Abuse Disorders and a History of Violence.

SOURCE: Psychiatric Services. 56(10):1223-32

AUTHORS: Domino ME, Morrissey JP, Chung S, Huntington N, Larson MJ, Russell LA. (2005).

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/16215187>

BACKGROUND: This study examined the 12-month cost of the array of services used by women with co-occurring behavioral health and substance use disorders and a history of violence and trauma who participated in the Women, Co-occurring Disorders, and Violence Study (WCDVS). The study compared costs of the intervention and external services for women in the WCDVS intervention in outpatient and residential settings-which provided comprehensive, integrated, and trauma-informed services-with the costs for women in the usual-care comparison group. The study also compared costs with recorded clinical outcomes.

METHODS:

Costs of service use were examined for 2,026 women who participated in the WCDVS (N=1,018) and in the comparison group (N=1,008). Women were interviewed three, six, nine, and 12 months after baseline about any service use in the past three months. Costs for these services, along with indirect costs (participants' time and transportation) were estimated by using a variety of sources. A number of cost estimates were analyzed by using either ordinary least squares regression or two-part models.

RESULTS:

The average participant had almost 43,000 dollars in costs related to their service use during the 12 months after baseline. Women in the intervention group had lower service costs and higher overall costs than those in the comparison group, but the null hypotheses of no difference in any cost measure between groups was not rejected. Also, the null hypothesis of no difference in the

probability of accessing services external to the study intervention was not rejected.

CONCLUSIONS:

Because no differences were detected in costs but improvements were seen in clinical outcomes, the interventions offered in the WCDVS may be more efficient than usual care.

Behavioral Health Problems of Prison and Jail Inmates

SOURCE: Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics Special Report, 2006

AUTHORS: Doris J. James and Lauren E. Glaze

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/21839518>

BACKGROUND: In 2005, more than half of prison inmates had a behavioral health problem. This report provides national statistics that indicate how many prison inmates are living with behavioral illness and indicates the prevalence of behavioral health disorders.

Examining the Impact of Behavioral Illness and Substance Use on Recidivism in a County Jail.

SOURCE: Int J Law Psychiatry. 34(4), 264-8.

AUTHORS: Wilson AB, Draine J, Hadley T, Metraux S, Evans A. (2011).

LINK: <http://www.ncbi.nlm.nih.gov/pubmed/21839518>

BACKGROUND: Examining the impact of behavioral illness and substance use on recidivism in a county jail. This paper describes the recidivism patterns over a 4 year period for a cohort of people admitted to a large US urban jail system in 2003 and analyzes how these patterns vary based on presence of behavioral illness and substance abuse. Jail detention and behavioral health service records were merged for all admissions to a large urban jail system in 2003 (N=24,290). Descriptive statistics were used to analyze the recidivism patterns for people admitted to jail in 2003 (N=20,112) over a four year period. Recidivism patterns of people without behavioral illness or substance use disorders were compared with people with serious behavioral illness, substance abuse disorders, and dual diagnoses. These analyses found that over half of the people who returned to jail during the 4 year follow-up period did so in the first year. This finding did not differ by any diagnostic category. This case analyses the number of people readmitted to the jail.

Assertive Community Treatment: Best Practice That Uses a 24/7 Multi-disciplinary Team Approach and Inpatient Psychiatric Beds

SOURCE: NAMI

LINK:

http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Findings/NAMI_GTS_09_Findings.pdf

BACKGROUND: A high-quality behavioral health system is characterized by the availability of a continuum of services across inpatient and community settings. While advances in behavioral health treatments may reduce the number and length of inpatient hospitalizations for many people with serious behavioral illness, it is clear that there will always be a need for inpatient services. 2 critical services support the continuum of care: Assertive Community Treatment that uses a 24/7 multi-disciplinary team approach and inpatient psychiatric beds. NAMI took state’s reports on the number of people served with ACT.

Innovative Practices: Georgia: Crisis and Access Line is an innovative mechanism for tracking

available psychiatric beds

Continuing Care After Inpatient Psychiatric Treatment for Patients with Psychiatric and Substance Abuse Disorders

SOURCE: Psychiatric Services. 59(9)

AUTHORS: gen, M.A., et al. (2008).

LINK: <http://ps.psychiatryonline.org/article.aspx?articleid=99692>

BACKGROUND: Objective: This observational study examined the association between continuing outpatient care for a psychiatric disorder, a substance use disorder, or both and decreased risk of readmission to psychiatric care after an index episode of inpatient psychiatric treatment. Methods: Treatment records from all patients with co-occurring substance use and psychiatric disorders discharged from an inpatient psychiatric setting in the Department of Veterans Affairs (VA) between July 1, 2004, and June 30, 2005 (N=26,826), were used to determine the impact of psychiatric and substance use disorder continuing care on readmission to inpatient psychiatric treatment in the 90 days after discharge. Results: Over 23 percent (6,280 of 26,826) of patients with both a psychiatric disorder and a substance use disorder who received inpatient psychiatric treatment in the VA were readmitted for additional psychiatric care within 90 days of discharge. Survival analyses indicated that receiving continuing care for a substance use disorder (hazard ratio [HR]=.84, 95 percent confidence interval [CI]=.77—.92, p<.001) in the 30 days after discharge from the index episode was associated with a lower likelihood of rehospitalization. Psychiatric continuing care was not associated with risk of rehospitalization. A supplementary analysis indicated that substance use disorder continuing care was still associated with a reduced risk of rehospitalization over the 12 months after discharge, although the overall magnitude of the association was diminished (HR=.92, 95 percent CI=.86—.99, p=.02). Conclusions: Readmission to inpatient psychiatric treatment was common for patients with co-occurring disorders, and these observational findings indicate that continuing care for a substance use disorder was associated with lower risk of early readmission. (Psychiatric Services 59:982—988, 2008)

Best Practices in Workforce Plans

SOURCE: NAMI

LINK:

http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Findings/NAMI_GTS_09_Findings.pdf

BACKGROUND: The six top-scoring states for overall workforce plans were Alaska, California, Connecticut, Missouri, Oklahoma, and Virginia. The five states with the best workforce diversity plans were Alaska, California, Connecticut, Maryland, and Massachusetts. In November 2004, California voters passed Proposition 63, also known as the Behavioral Health Services Act (MHSA). The MHSA increases funding, personnel, and other resources for county-run behavioral health programs by imposing a 1 percent income tax on personal income in excess of \$1 million. The new tax has generated more than \$4.1 billion in additional revenues for behavioral health services through the end of fiscal year 2007-08 and is anticipated to generate an additional \$1 billion in fiscal year 2008-09 and \$914 million in fiscal year 2009-10.

Governor Releases \$21.7M for State Hospital System, Facilities

SOURCE: Hawaii.gov
LINK: http://governor.hawaii.gov/blog/governor-releases-21-7-million-for-state-hospital-system-facilities/
BACKGROUND: \$14,321,000 – Information/Electronic Medical Record (EMR) System, statewide – Funds for system equipment that will support Acute, Long-Term Care, Ambulatory and Critical Access hospitals and will automate clinical and financial processes; allow for a substantial degree of standardization across regions; and be compliant with the Health Information Technology for Economic and Clinical Health (HITECH) Act and privacy and confidentiality mandates.

Other Data Sources

Workforce

Proposition 63

<http://prop63.org/>

http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

This study relied on a number of databases provided by each state facility, as well as state and national-level databases. The data in this report describes the use of inpatient and community services specifically for individuals served by the state psychiatric hospitals. Data for juveniles and children have been excluded from this study. It should also be noted that the community data presented does not reflect all claims filed within the publicly-funded behavioral health system as services funded by Medicare and through grant-funded contracts was not provided or available. Community claims data represents those individuals utilizing services funded through the public fee-for-service system. The lists below details these files and provides a brief description of the uses made of each in the study:

Category	Year	Source	Description
<i>Reports and Studies</i>			
Financial	FY09 – FY 14YTD	DSHS	Costs by LMHA DSHS Expenditure and Debt Analysis Description of Service Packages Budget by Facility Total Costs Per Level of Care by Center Claims and Expenditures by SPH Inpatient Average Costs FY10 Thru Fiscal Year TD14 Guarantors
Vision, Mission, Business Plans	FY13- 14YTD	DSHS	Bylaws of Medical Staff Flowchart of DSHS system DSHS Vision, Mission, and Goals House Bill Provisions of MH Services State Hospital and LA Business Model State Hospital Board Bylaws State Hospital Management Plan State Hospital Op. Proc.
Planning Studies	2011- 2014	DSHS	DSHS Sunset Staff Report Managing and Funding Texas SPH Sunset Self Evaluation
State Policies	FY12-FY 13	DSHS	FY12 Overcapacity Plan HCBS-AMH Short Utilization MGMT_Adult Behavioral Health Utilization MGMT_Child and Adolescent
List of Interviewees	2014	DSHS	ASH List of Interviewees BSSH List of Interviewees EPPC List of Interviewees

			KSH List of Interviewees NTSH List of Interviewees RGSC List of Interviewees RSH List of Interviewees SASH List of Interviewees TSH List of Interviewees WCY List of Interviewees DSHS Key Stakeholders – May 2014 State Hospital Contacts
DSHS Department Information	FY13	DSHS	DSHS Admin Contact List DSHS Org Chart Behavioral Health And Substance Abuse Org Chart
SPH Org Charts	FY14	DSHS	ASH Organizational Chart DSSH Organizational Chart EPPC Organizational Chart KSH Organizational Chart NTSH Organizational Chart RGSC Organizational Chart RSH Organizational Chart SASH Organizational Chart TSH Organizational Chart WCY Organizational Chart
Joint Commission Report		DSHS	ASH Joint Commission Accreditation Letters BSSH Joint Commission Accreditation Letters EPPC Joint Commission Accreditation Letters KSH Joint Commission Accreditation Letters NTSH Joint Commission Accreditation Letters RGSC Joint Commission Accreditation Letters RSH Joint Commission Accreditation Letters TSH Joint Commission Accreditation Letters WCY Joint Commission Accreditation Letters
Planning Studies	2010-2014	DSHS	DSHS Sunset Staff Report Managing and Funding Texas SPH Sunset Self Evaluation Continuity of Care Report Summer 2010
Service Areas	FY13	DSHS	CDI6 Service Area Map

Quality and Safety	FY10-FY 14YTD	DSHS	Restraints and Seclusions Aggression Patient to Patient Aggression Patient to Staff Patient Injuries Public Hospital Performance Measures Data Readmission Rates
Inpatient	FY10-FY 14YTD	DSHS	I1. Monthly Discharges I2. Beds by unit I3. ADC by Facility I5. Occupancy Rates I6. Service Areas by County
Outpatient	FY10-FY 14YTD	DSHS	O1. List of Location by Year O3. List of LMHAs O5. Volumes by Procedure and Site O6. Services by Medicaid or Indigent INFO Behavioral Health Service Array- AMH INFO Behavioral Health Service Array- CMH
Staffing	FY10-FY 14YTD	DSHS	S1. Field Availability Sample S1. FTE by Site S2. OT Hours by Staff S4. Hourly Cost by Staff S6. Staffing Ratios S7. Shift Schedules W Comp Claims and Expenditures HHS Employees Survey - Data Report HHS Employees Survey - Exec Summary Compensation Plan for Nurses in State Hospitals State Hospital Psychiatrist Salary Plan 140501
Supplemental	FY10-FY 14YTD	DSHS	ASH List of Partnerships BSSH List of Partnerships EPPC List of Partnerships KSH Academic Affiliations NTSH List of Partnerships RGSC List of Partnerships RSH List of Agreements SASH Hospital Contracts Fiscal Year 2014 SASH List of Partnerships TSH List of Partnerships WCY List of Partnerships

Supplemental Patient Satisfaction
2014 Customer Satisfaction Report
AHA-THA Psych Data-2012-Updated-
Stacy
ER Data for HB 3793 Workgroup Chart
Jail Match Stats Draft 2014 YTD
THCIC Hospital discharges 09-11 Pysch
DX
DSHS Expenditure and Debt Analysis 2-
28-14
Forensic Waiting List
