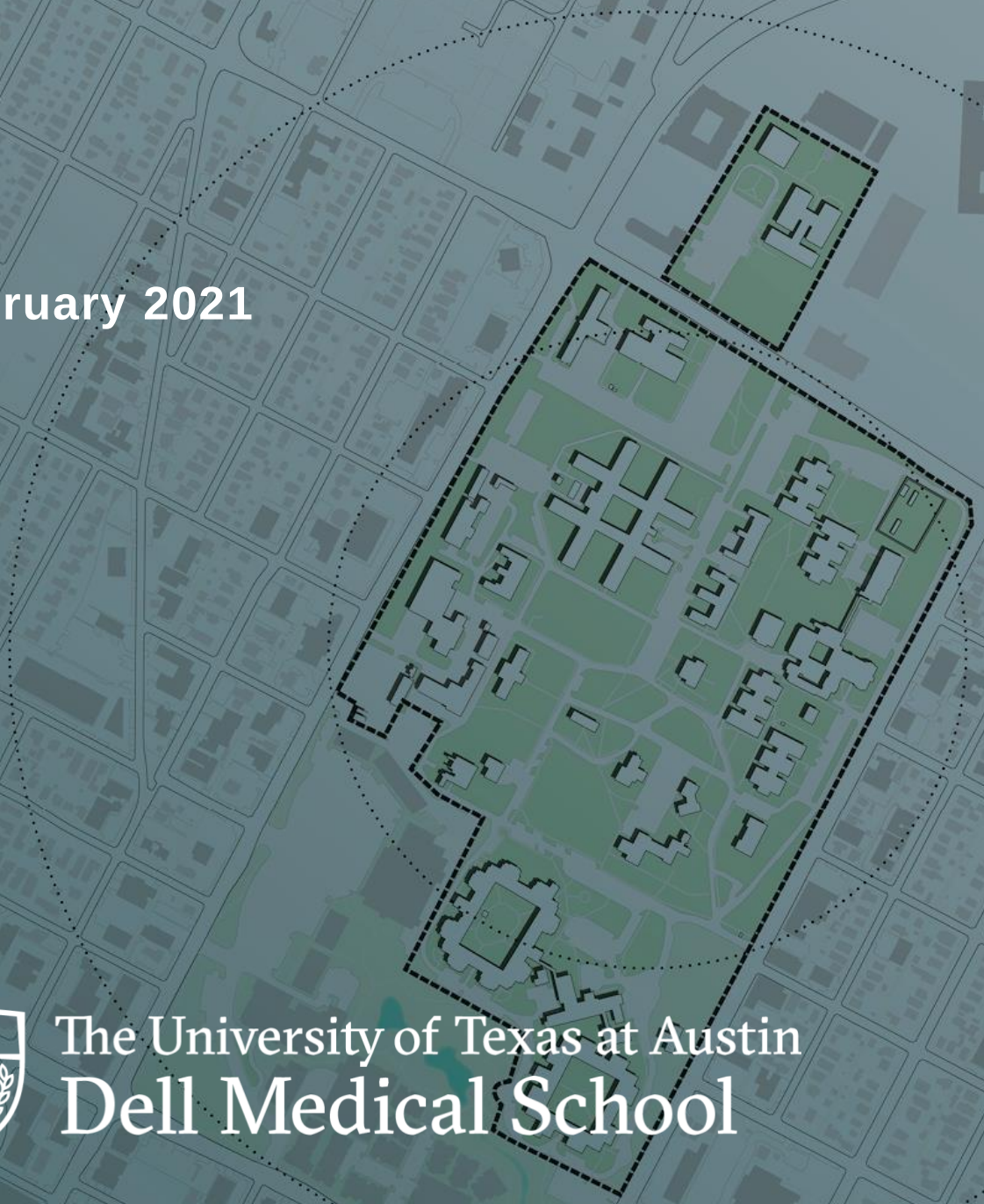
AUSTIN STATE HOSPITAL

ASH Redesign



February 2021

The University of Texas at Austin
Dell Medical School

AUSTIN STATE HOSPITAL

ASH Redesign

Report

As Requested by

Senate Bill No. 1, Riders 145, 147
Eighty-fifth and Eighty-sixth Texas Legislature

The University of Texas at Austin Dell Medical School

February 2021

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1

Executive Summary

Austin State Hospital Redesign

Executive Summary

Texas has committed to improving public mental (brain) health care with several years of significant investments. Toward that commitment, the 85th Legislative Session initiated replacement of the Austin State Hospital (ASH) with the new facility then serving as a platform to improve the entire continuum of care linked to the hospital. Support from the Texas Legislature led the Health and Human Services Commission (HHSC) to partner with Dell Medical School (Dell Med) of the University of Texas at Austin to lead the ASH Redesign. The initial investment of $15.5M produced a Master Plan in December 2018 to guide ongoing advances in Central Texas mental health care (ASH Redesign report). The Master Plan proposed several solutions with an HHSC request and Legislative decision to build a modern ten unit, 240-adult bed hospital on the campus that will support the ASH service area.

The ASH Redesign continued with support and investment from the 86th Legislature, appropriating $165M of the total $304.6M cost for the new hospital in order to initiate construction. The 3-year construction timeline presented the Legislature an opportunity to fund the project across two biennia. The plan, then, is to appropriate the final $124.1M during the 87th Legislative Session in order to complete the hospital.

With these considerations in mind, the ASH Redesign team established four recommendations for the next two years to optimize the function of the new hospital investment.

1. **Complete the new Austin State Hospital construction**
    - Obtain the **final funding, $124.1M,** of the **total project cost of $304.6M.**
    - **Complete** construction of the **new ASH** and **open in June 2023.**
2. **Increase Functional Bed Capacity – i.e., optimize the use of the new hospital**
    - ***Strategy 1*:** **Increase opportunities for hospital discharge by rapidly creating alternative residential care and housing options** by identifying private, philanthropic, or alternative public funding to support the growth of the continuum of care.

- ***Strategy 2*:** **Reduce forensic hospitalizations by creating a roadmap** that provides alternatives to ASH for competency restoration.
- ***Strategy 3*:** **Engage academic and service area experts** to optimize efficient, evidence-based treatment in ASH that facilitates recovery in order to support smooth transitions to care in the **least restrictive environment** necessary, thereby returning people to their community.

3. Expand Peer Engagement

- ***Strategy 1*:** Continue to enhance engagement into the ASH Redesign process of people from diverse ethnic, racial, sexual orientation, gender identity, and disabilities background.
- ***Strategy 2*:** Work to ensure that ASH has a robust financially sustainable peer support program.

4. Sharing the History of ASH

- ***Strategy 1*:** Share the history of ASH with the community.
- ***Strategy 2*:** Create a space for collection management and interpretation.
- ***Strategy 3*:** Preserve environmental aspects of the campus.

The remaining funding is a top priority of the ASH Redesign as opening the new hospital on time is the critical next step toward improving mental health care in Central Texas. Concurrently, increasing the functional bed capacity efforts must continue in order to create a more efficient system and one that will support an optimal use of the hospital investment.

The combination of these efforts will establish Texas as a leader in brain health care for all.

2

Overview and Background

Overview and Background

Phase I ASH Redesign

Texas aims to be a national leader in mental health care and so to that end made substantial investments during the past decade. Significant progress began when the Cannon Report (2014) identified that most of Texas' adult public psychiatric hospitals were in "poor" and "critical" condition, and five needed to be razed and replaced, which included the Austin State Hospital (ASH). The Cannon Report (Appendix 1) and HHSC's *A Comprehensive Plan for State-Funded Inpatient Mental Health Services* (Appendix 2) established the basis for replacing the current ASH. The 85th Texas Legislature invested $300M to create construction planning of the outdated public psychiatric hospital system. The legislature encouraged partnerships with academia to complete the construction planning. This encouragement and investment led to a partnership between the University of Texas at Austin's Dell Medical School (Dell Med) and Texas Health and Human Services Commission (HHSC) to develop the plan for a new ASH facility and a continuum of care for the regions served by ASH.

The initial investment ($15.5M) from the 85th Texas Legislature established Phase I of the ASH Redesign, namely to develop a Master Plan (Appendix 3) and a blueprint of the ASH service area continuum of care (Appendix 4). The full report can be found at ashredesign.org. Phase I established a Steering Committee to lead the efforts of the ASH Redesign, which then created a first round of subcommittees (116 members) to gain insight and strategies toward an efficient system for a new ASH. Through qualitative research, the team learned that the term "brain health" was less stigmatizing than "mental health" by clarifying that these conditions impact brain function and have a physiological component. However, the term "mental health" is more commonly used and understood. Throughout the report, then, we will interchangeably use both terms as a step toward decreasing stigma.

"…we will interchangeably use both terms, 'brain health' and 'mental health', as a step toward decreasing stigma."

World Class Hospital

Phase I included designing a new world class hospital for Texans on the ASH campus. Following the procurement processes of the University of Texas, Page Southerland Page, Inc. (Page/) was subcontracted to complete the hospital design in partnership with architecture+; the latter are experts in the design and planning of advanced psychiatric facilities.

The new ASH design will enhance healing and recovery for people by improving the physical space to allow modern evidence-based care. The new hospital will be comprised of ten 24-bed living units, each with three 8-bed sub-clusters, totaling 240 beds. The living units constitute a "neighborhood" that includes a large dining hall, porches, activity and quiet rooms, and an open care desk. People receiving care will have their own bedroom and bathroom, providing privacy and space to recover. The building takes advantage of the slope of the land, allowing the hospital to be two- and three-stories at different parts of the site, which is a more cost-effective use of space than the current 1-story design. The new hospital provides access to eleven court yards. Most units will be only one flight of stairs from courtyard access; outdoor access is known to facilitate recovery. People receiving care will progress through the hospital in a way that mirrors the recovery process. A person will experience their individual space, the neighborhood of their living unit, a treatment mall and finally the downtown gathering space. All of these steps will help them return to their community to continue recovery.

"The new ASH design will enhance healing and recovery for people by improving the physical space to allow modern evidence-based care."

Phase II ASH Redesign

In the 86th Legislative Session, over $445M was approved to improve the state hospital system. HHSC was appropriated $165M to begin construction of the new ASH and continue the ASH Redesign. After completion of Phase I, the Steering Committee continued to meet and support the planning and design efforts for the new ASH. Since our initial report, many of the same stakeholders remain engaged in the ASH Redesign efforts, detailed in Table 1 and the Steering Committee Charter (Appendix 5). Following procurement processes of the University of Texas, Turner Construction Company (TCCO) was subcontracted as the construction manager at risk to build the new hospital.

The Steering Committee created work groups linked to previous report recommendations. A total of 69 members volunteered their expertise and time in six work groups:

- Competency Restoration
- Hospital Clinical Strategies
- Campus & Continuum Clinical Strategies
- Campus Planning Partnerships
- Peer & Family
- History of ASH

Table 1. ASH Brain Health System Redesign Steering Committee

- **Health Institution:**
  Committee Chair – Steve Strakowski, M.D., Associate Vice President Regional Mental Health, Dell Medical School
- **Health & Human Services Commission:**
  Tim Bray, MA, JD, Associate Commissioner, State Hospitals; Robert Dole, LCSW-S, Deputy Associate Commissioner, System Integration, IDD-Behavioral Health Services.
- **Local Mental Health Authority:**
  David Evans, CEO Integral Care (Travis), Andrea Richardson, Executive Director Bluebonnet Trails (Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee and Williamson)
- **Healthcare Districts:**
  Mike Geeslin, CEO Central Health (Travis)
- **UT Design Institute for Health:**
  Diana Siebenaler
- **University of Texas System:**
  David Lakey, M.D., Vice Chancellor for Health Affairs
- **Texas Hospital Association:**
  Sara Gonzalez, Vice President of Advocacy/Public Policy
- **Law Enforcement:**
  Sheriff Dennis Wilson (Limestone)
- **Peer/Family Representative:**
  Karen Ranus, Executive Director, NAMI Austin (Travis) & Jason Johnson, Director Peer Support, Hill Country MHDDC (Kerr)
- **Ex Officio:**
  Jim Baker, M.D., MBA (UT Southwestern), Sandy Hentges Guzman (Austin Area Research Organization), Octavio Martinez, M.D. (Hogg Foundation), Lisa Owens (Central Health), Judge Nancy Hohengarten (Travis County), Melissa Shearer (Travis Co. MH Defender), Sherley Spears (Cultural Consultant)

Charters were developed for each work group to establish guidelines and goals to coordinate efforts to develop the recommendations provided in this report (Appendix 6):

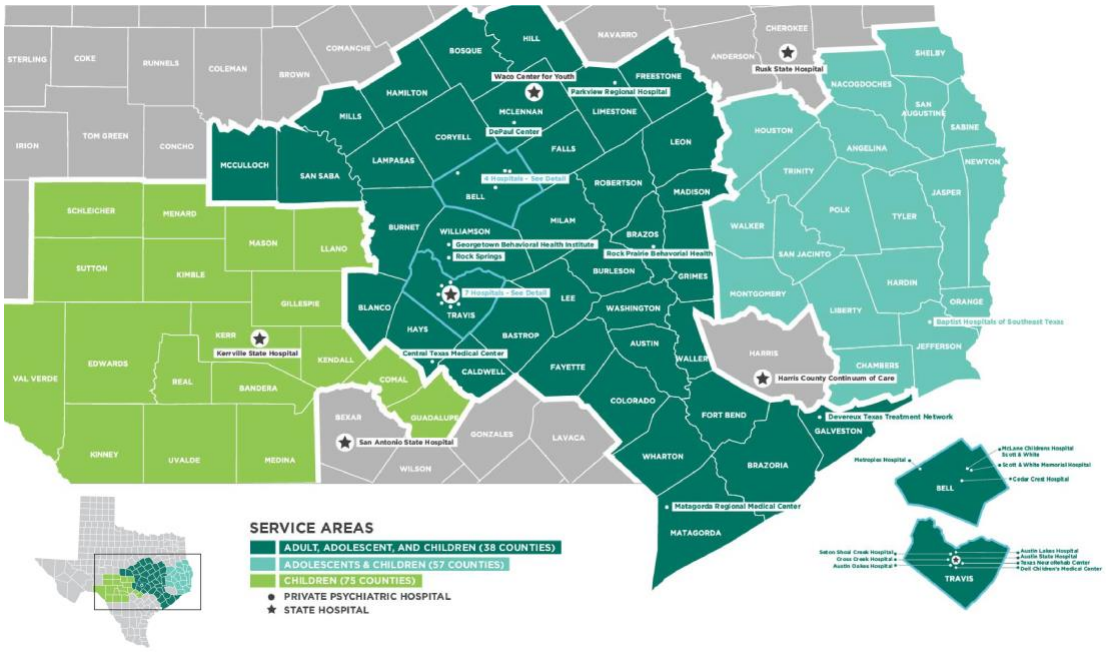
Key Points – ASH Redesign Phases:

- Texas lawmakers invested over $745M in mental health.
- ASH Redesign Phases I and II establish recommendations to create an efficient system to support the new ASH.
- Page/ with architecture+ designed and Turner Construction Co. is building the new ASH.

ASH Service Area

Texas state hospitals accept referrals from any region in Texas; however, each hospital primarily serves a designated area. The ASH service area extends from the eastern border of Newton County to the southwestern boarder of Val Verde County, covering 75 counties. The 75 counties are separated by age group as illustrated in Figure 1.

Figure 1. ASH Service Area



Specifically, 38 counties refer adults, adolescents and children needing hospital care, 19 refer adolescents and children (not adults), and 18 refer only children. ASH is located in Central Austin on approximately 95 acres. Under typical circumstances, ASH has ~263 available beds divided among four hospital buildings. On the main campus, care for adults is provided in two hospital buildings (152 total beds), care for elderly and intellectual disabilities is provided in one building (83 total beds) and children and adolescent care is provided in a fourth building across 45th street (28 total beds). The hospital's response to the global health pandemic has required many of these beds to be managed differently while we wait for the crisis to resolve.

The Master Plan (Appendix 3) established key goals, calculated capacity and determined a biennial budget for a new facility. Two factors that played into the final physical capacity of the new adult ASH were:

1. ASH's budget has remained flat for several years, and routinely operates within a budget ($50M annually) that can maximally operate only 265 beds for adults and children. Consequently, the redesign could not increase the capacity in the absence of assurances of more operating funds; and
2. The redesign team worked with other sites in Texas where hospital expansions and construction were occurring as part of a statewide strategy to diminish the waitlists.

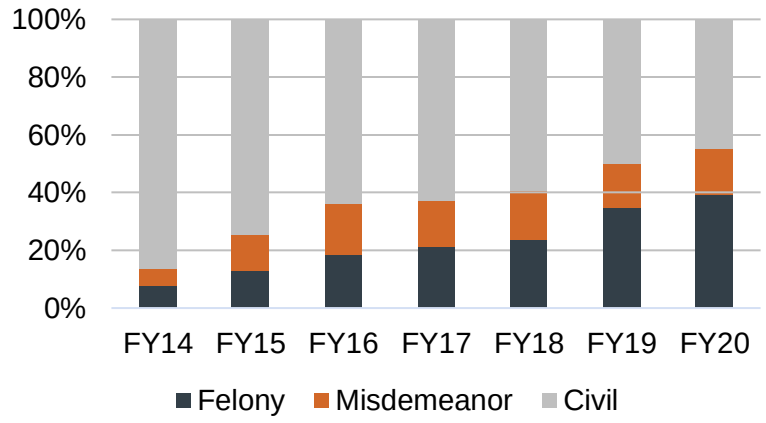
Our first ASH Redesign report presented three different facility options for the ASH Campus: A) 240-bed adult hospital costing $283M, B) 216 – 240 bed adult hospital with 48 – 70 bed residential facility costing $288-330M, and C) 264 – 288 adult bed hospital costing $311-330M. Based on the two guidelines listed, option A was selected to move forward.

Phase I of the ASH Redesign also reviewed the children and adolescent hospital; however, the building was found to be in fair condition and rarely has a waitlist for admittance. HHSC has continued to maintain the building to provide quality care. Consequently, no new construction was recommended for the children's hospital building at this time while we identify alternative solutions to providing better child psychiatric care (e.g., as provided by the statewide networks created by SB11 in the 86th legislative session).

ASH Admissions

ASH treats approximately 900 people annually. Most individuals admitted to ASH are on a forensic commitment; i.e., the process used to raise a person's ability to participate in his or her own legal defense through inpatient competency restoration (further details are found in the section *Forensic Roadmap Strategy*). Figure 2 illustrates the growing percentage of people at ASH on a forensic commitment, with a corresponding decreasing percentage of civil admissions. Civil commitment is a process in which people unable to care for themselves or who are an imminent risk to themselves or others, are involuntarily referred for inpatient psychiatric care. Both civil and forensic commitments deserve care in the least restrictive setting based upon their level of care needed. The increase in forensic bed use and decrease of civil bed use at ASH reflects statewide and national trends, so is not unique. The National Association of State Mental Health Program Directors reported a 76% increase of forensic referrals in state hospitals from 1999 – 2014 (2017). Subsequently within this report, we propose strategies to assist in the efficiency of how the new ASH might support the forensic pathway and develop tactics to improve processes at the intersection of legal and mental health systems.

Figure 2. FY14 – FY20 ASH Admissions



"ASH treats approximately 900 people annually."

The ASH service area includes a total of twelve local mental health authorities (LMHAs), nine of which support the core 38 counties. Based on CY 2019 estimates from the US Census Bureau, ASH and LMHAs in the adult counties supported a population of 4,180,000 people, a twelve percent increase from 2018. When people experience a crisis leading to the emergency room or jail, LMHAs are one community resource responsible for referring people needing hospital-level care to ASH. LMHAs are key components of mental health care in the ASH service area; they provide critical services to ensure people remain in their communities for care as much as possible to continue their recovery. Nearly always, individuals referred to ASH experience a delay before admittance.

ASH is always full, so when a bed becomes available it is provided to a person on the waitlist. As of the time of this publication, there are more than 1,000 people waiting for a state psychiatric bed in Texas, and about 95 people are waiting for a bed at ASH specifically. Most people on the waitlist are waiting in jail or in an emergency room. Table 2 is a snapshot of ASH's waitlist in July 2020; as can be seen, Travis County (47) had the most people waiting, followed by McLennan County (19).

"As of the time of this publication, there are more than 1,000 people waiting for a state psychiatric bed in Texas, and about 95 people are waiting for a bed at ASH specifically."

This waitlist is managed by HHSC, tracking available beds for the state and then notifying emergency departments, law enforcement, or LMHAs when a bed becomes available. Although a service area is designated to provide care somewhat closer to a person's community, as noted previously, some people receive care from a state hospital outside of their service area if a bed is available more readily than one locally. From FY15 – FY20, out of district counties use 13% of ASH bed days.

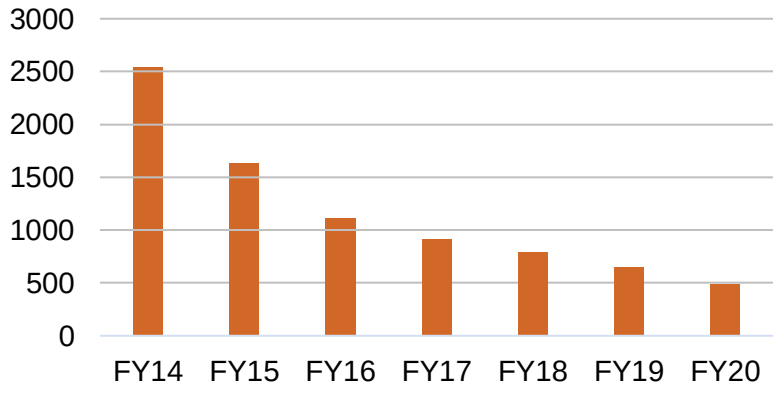
Table 2. ASH July Snapshot Waitlist

ASH Waitlist 7/27/20			
County	**46B Felony**	**46B Misdemeanor**	**Civil**
Bastrop	2	0	0
Bell	0	2	0
Bexar	2	0	0
Brazoria	2	0	0
Brazos	2	1	0
Burnet	0	0	1
Caldwell	1	0	0
Coryell	1	0	0
Fort Bend	3	1	0
Freestone	1	0	0
Galveston	1	0	0
Harris	1	0	0
Hays	4	0	0
Lampasas	2	0	0
McLennen	10	9	0
Nueces	0	1	0
Travis	24	21	2
Waller	1	0	0
Wharton	2	0	0
Williamson	2	0	0
Total	**61**	**35**	**3**

The state hospital system is the most intensive level of public mental health care available to Texans. The ASH Redesign is one of five current State Hospital construction projects. The other four projects include: 1) Rusk State Hospital, which is converting 60 existing beds to maximum-security beds (MSU); 2) Kerrville State Hospital, which is adding 70 new MSU beds; 3) UTHealth in Houston, which is adding a new hospital tower (UT Health Behavioral Sciences Center) of up to 264 short-term beds adjacent to Houston's Harris County Psychiatric Center; and 4) San Antonio State Hospital, which is replacing the current hospital and separately adding 40 new beds. These additional beds, especially the new hospital in Houston, provide an opportunity to realign service areas to care for more people closer to their home communities. For example, a person from Galveston or Brazoria Counties needing inpatient care might currently bypass the facility in Houston to be brought to Austin. In the future, they would receive care in the new hospital in Houston rather than come to ASH. The unnecessary extended drive is cumbersome, inefficient and costly, as well as suboptimal care for a vulnerable person.

Notably, admission rates to ASH have decreased throughout the last several years. Figure 3 presents the change in new admissions from FY14 through FY20. Several factors contribute to this trend. The average length of stay for adults is increasing for both civil and forensic populations. Specific to the forensic population, many of the patients are experiencing extended commitments, requiring them to stay beyond their initial 60-day commitment to, at times, greater than 120 days (details in *Forensic Roadmap Strategy*). For the civil population, the acuity level of admissions exceeds what may be available by local psychiatric hospitals and crisis units, resulting in extended lengths of stay at ASH. Additionally, persistent barriers to discharge from ASH contribute to the hospital continually operating at capacity. Together, these factors combine to decrease the functional capacity of ASH (and each of the state hospitals).

Figure 3. ASH Admissions FY14 – FY20



Barriers to Discharge

ASH identifies and monitors individuals who have been in the hospital for more than 365 days to define reasons they are unable to successfully discharge from the facility. At the date of this writing, over 60 people experience a barrier to discharge from the hospital into a more appropriate, less restrictive level of care. Among the various barriers to moving a person who is on a civil commitment into a less restrictive setting are: a lack of guardian or supported decision maker; a lack of and inability to qualify for benefits; and/or no willing or appropriate nursing home placement. People with forensic commitments face multiple barriers, particularly when it is unlikely further hospitalization will restore competency.

"At the date of this writing, over 60 people experience a barrier to discharge from the hospital into a more appropriate, less restrictive level of care."

Many people have more than one barrier, with the most common overlapping barriers being ties to the legal system for competency restoration, lack of benefits, and the need for a guardian. People who no longer need inpatient level care, but are unable to discharge, create a situation of inefficient use of hospital capacity that could otherwise serve individuals from the waitlist. The Statement of Need section of this report addresses how the system might improve to overcome these barriers and support people receiving the right care at the right place at the right time.

State Efforts

In addition to hospital enhancements and redesign efforts, Texas is focusing on strategies to eliminate gaps in order to increase access to outpatient mental health care. Two such initiatives include the Statewide Behavioral Health Strategic Plan (SWBHSP) (SWBHSP update) and the All Texas Access. The Strategic Plan is a five-year plan to address gaps in the mental health system. The All Texas Access focuses on LMHAs/LBHAs that serve at least one county with a population <250,000, i.e. rural counties. Its goal is to create regional plans to reduce the costs on local and state government while improving service delivery. The recent All Texas Access overview report, established the following legislature recommendations:

- Consider amending Texas Health and Safety Code§573.012(h) to streamline emergency detentions,

- Consider reducing grant match percentage for rural areas to allow greater participation,
- Enhance collaboration among community mental health partners,
- Consider building on the Broadband Development Council,
- Evaluate innovations around telehealth in behavioral health services,
- Increase support and training for mental health professionals,
- Incentivize mental health deputy program and LMHA/LBHA collaboration, and
- Continue to assess inpatient capacity for civil commitments.

Combined, the Strategic Plan, the All Texas Access, ASH Redesign and other state hospital projects collaboratively and with legislative support, can improve mental health care for Texans.

Pandemic Impact

"Prior to the pandemic, research showed that one in five adults experience mental illness each year."

While writing this report during a pandemic, it would be remiss to not mention how COVID-19 has impacted the current state of brain and mental health care and the capacity of the care continuum. Prior to the pandemic, research showed that one in five adults experience mental illness each year (Substance Abuse and Mental Health Services Administration, 2018). These rates are increasing with the lengthening pandemic. Texans are experiencing isolation, different daily patterns, job loss, stress from concern of contracting the virus, and stress of the economic downturn. Kaiser Family Foundation reported people struggling with mental health increased from 32% in March 2020 to 53% in July 2020 (2020). Meadows Mental Health Policy Institute projects that for every five percentages the unemployment rate increases in Texas throughout a year, an additional 725 Texans die from suicide and drug overdose (2020). The ongoing impact of COVID-19 will likely be felt for many years, even after the spread is contained by vaccines and other interventions. The increased need in brain (mental) health care caused by COVID will place pressure on a system in the midst of a redesign to care for the current needs, emphasizing the continued support and collaboration throughout Texas. The recommendations in this report will continue to support the growing mental health needs of Texans regardless of the cause.

With these considerations in mind, the remainder of this report focuses on priorities and recommendations to complete the new Austin State Hospital, increase the functional hospital bed capacity to optimize the use of the new hospital facility, and strengthen Peer engagement to expand the care continuum.

Key Points – Service Area & Admissions:

- The ASH service area covers 75 counties: 38 counties for adults, adolescents, and children; 19 additional counties for adolescents and children; 18 more counties for children only.
- The percentage of admissions for forensic needs is continually increasing resulting in a corresponding decreasing capacity available for civil admissions.
- The total numbers of annual admissions is declining due to increasing lengths of stay.
- At the time of this publication, an average of 95 people are waiting for a bed at ASH, from a total of 1,000 waiting for a bed statewide.
- There are more than 60 people typically waiting to discharge from ASH each month, but are unable to discharge for a variety of primarily administrative reasons.

3

Statement of Need and Recommendations

Statement of Need and Recommendations

RECOMMENDATION 1:

Complete the new Austin State Hospital

- Obtain the **final funding, $124.1M,** of the **total project cost of $304.6M.**
- **Complete** construction of the **new ASH** and **open on-time in June 2023.**

In 2013, the Department of State Health Services (DSHS), which operated the state hospitals at that time, engaged CannonDesign to study the state's psychiatric hospital infrastructure. With their report, referenced as the "Cannon Report" (Appendix 1) several state hospitals were deemed to be in significant disrepair such that replacement was determined to be much more cost-effective than attempting renovation. These facilities are also architecturally outdated and do not provide appropriate space for clinical teams to provide modern mental health care.

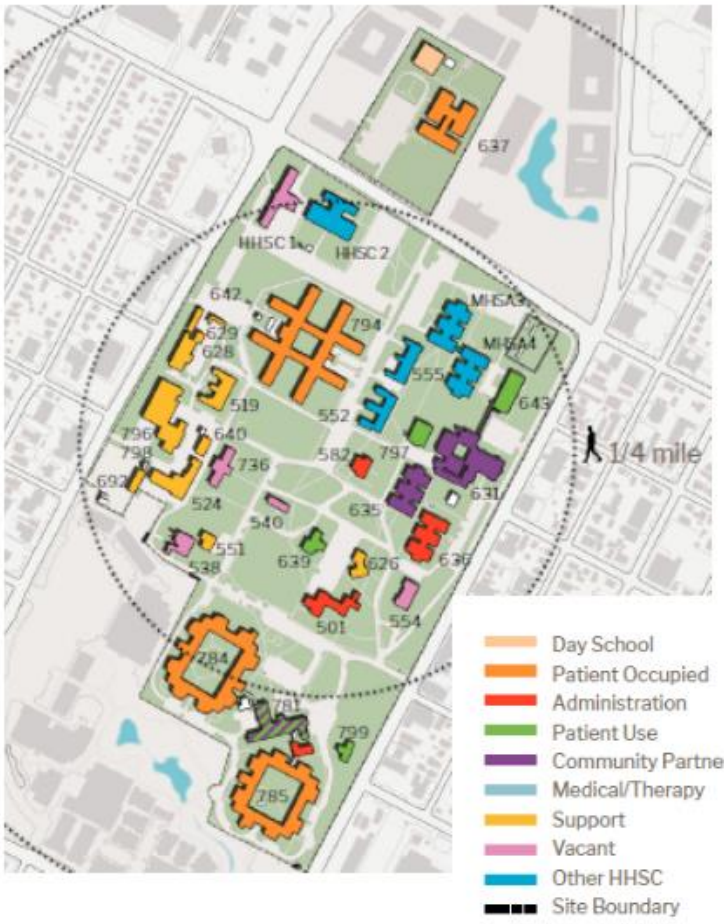
"… several state hospitals were deemed to be in significant disrepair such that replacement was determined to be much more cost-effective"

"The intention is to complete the new hospital by providing initial funding ($165M) in the 86th session and final funding ($124.1M) in the 87th session."

Based on this information, the 86th Legislature approved funding to begin building a new adult Austin State Hospital (ASH). The total construction cost for the new ASH, including $15.5M for preplanning, is $304.6M with a construction timeline of three years. This timeline provided an opportunity for lawmakers to consider splitting funding between two legislative sessions and decrease the expense impact to the state's budget in a given biennium. The intention was to complete the new hospital by providing initial funding

($165M) in the 86th session and final funding ($124.1M) in the 87th session. This split funding approach increased the original construction cost from $283M to $289M, adding an additional $6M due to cost escalation and delay of buyout process of construction with this decision. The construction began in late 2019 and is expected to be completed on time and on budget in spring of 2023 as long as the remaining funding is provided by the 87th legislature as planned.

Figure 4. Current ASH Campus Building Use



The initial funding ($165M) began two construction packages, the Early Release Package (ERP) and the hospital construction. The ASH Campus is not only the location for the hospital, but also the location of supportive services needed to operate ASH and other state buildings supporting HHSC's operations (e.g. kitchen, linen, maintenance). Figure 4 displays the ASH campus' building use prior to construction. The ERP consisted of clearing a 15-acre site for the new hospital, rerouting and establishing new utility infrastructure, renovating existing buildings to relocate support services and building a new warehouse.

Figure 5. Warehouse Rendering

Figure 5 is a photograph of the new warehouse located on the corner of Lamar and 45th street. The new warehouse will support ASH and became operational January 2021. The ERP is on schedule to complete by March 2021, overlapping with the start of the new hospital building that began in November 2020.

"HHSC has requested the remaining $124.1M to complete the new ASH construction and to ensure an opening date of June 2023."

Securing the investment toward a new psychiatric hospital reflects the strong support Texas lawmakers have for improving the mental health system to provide the best care possible for our most vulnerable citizens. Therefore, HHSC has requested the remaining $124.1M to complete the new ASH construction and to ensure an opening date of June 2023.

RECOMMENDATION SUMMARY:

Complete the Construction of the new Austin State Hospital:

- The current Austin State Hospital needs significant repair and must be replaced.
- The Cannon Report found it more cost efficient to build a new hospital than repair the old one.
- The 86th Legislative Session approved funding to build a new adult hospital on the ASH campus.
- Texas lawmakers provided an initial $165M to begin construction with the remaining $124.1M planned to be appropriated in the 87th session to complete construction on time.
- Additional residential treatment and housing options in the service area ultimately decreases expenses of higher level of care and provides opportunities for people to recover in a more appropriate and less restrictive setting.

New ASH on Lamar Street

Statement of Need and Recommendations

RECOMMENDATION 2, STRATEGY 1:

Increase Functional Bed Capacity – Housing Options

Strategy 1: **Increase opportunities for hospital discharge by rapidly creating alternative residential care and housing options** by identifying private, philanthropic, or alternative public funding to support the growth of the continuum of care.

- Prioritize housing in regions of the ASH service area that currently have limited options; and
- Continue to work with HHSC to optimize performance of the HCBS-AMH program.

"Functional bed capacity begins by optimizing the use of ASH for what it is designed and its existing cost structure, namely acute and subacute inpatient care."

As we complete the new hospital, we next focus on optimizing its performance by increasing its functional bed capacity. Functional bed capacity begins by optimizing the use of ASH for what it is designed within its existing cost structure, namely acute and subacute inpatient care. To accomplish this goal, we must **first** create a continuum of alternative residential treatment and housing options that include step-down and rehabilitative facilities, quarter- or halfway houses, and other forms of housing with a range of affiliated wrap-around services. For this report, we will refer to this range of housing types as 'housing options' with the intent that they provide recovery support in the least restrictive, best-designed setting possible. Although progress is being made toward creating these housing options, it is still not adequate to manage the need as evidenced by the hospital waitlists.

Increasing functional capacity of both the new ASH and the care continuum requires referring people needing care to the most appropriate and least restrictive setting possible so that the hospital and each different housing option is used at the top of its capabilities; i.e., for the

hospital, it is used only for individuals needing inpatient-level services. Distributing available resources efficiently across a continuum can lead to a broader array of residential services than can be achieved if every situation and individual is simply placed in the most expensive environment, namely the hospital. For the ASH region, there are three considerations to address. First, local communities need more and broader housing options in their communities that can be used in lieu of ASH. Second, once a person's clinical condition has improved so that inpatient care is no longer necessary, there must be clear and straightforward processes available to refer people into the right setting. Third, to make these plans work, the financing of these services needs to be structured to incentivize and reward best practices, based on value, i.e., providing the highest quality, most appropriate services at the right price. To work towards these goals during the next biennium, three strategies are presented, and if implemented, we believe will increase the functional capacity of the new ASH and the care continuum throughout the service area, thereby: 1) offering solutions to the growing waitlist for state hospital beds, 2) referring people in the hospital who are appropriate for alternative care venues, and 3) supporting care for people in the least restrictive setting necessary. To begin, we therefore recommend **rapidly developing and implementing increased housing options for people who no longer need (or never required) state hospital level care,** but are not yet well enough for standard community outpatient services.

Phase I Recommendation

The need for a larger scope and variety of residential treatment and other housing options in the service area has been emphasized throughout the ASH Redesign process; current progress is not meeting demand. Even with this progress, stakeholders within the service area identified the lack of housing options as perhaps the single most important barrier to better managing services for people with severe mental illness in the community (i.e., out of the hospital). Consequently, people are maintained in the state hospital who would be better served in less intensive and restrictive treatment environments designed for longer-term, rehabilitative and chronic care and recovery in the community.

"… lack of housing options as perhaps the single most important barrier to better managing services for people with severe mental illness in the community…"

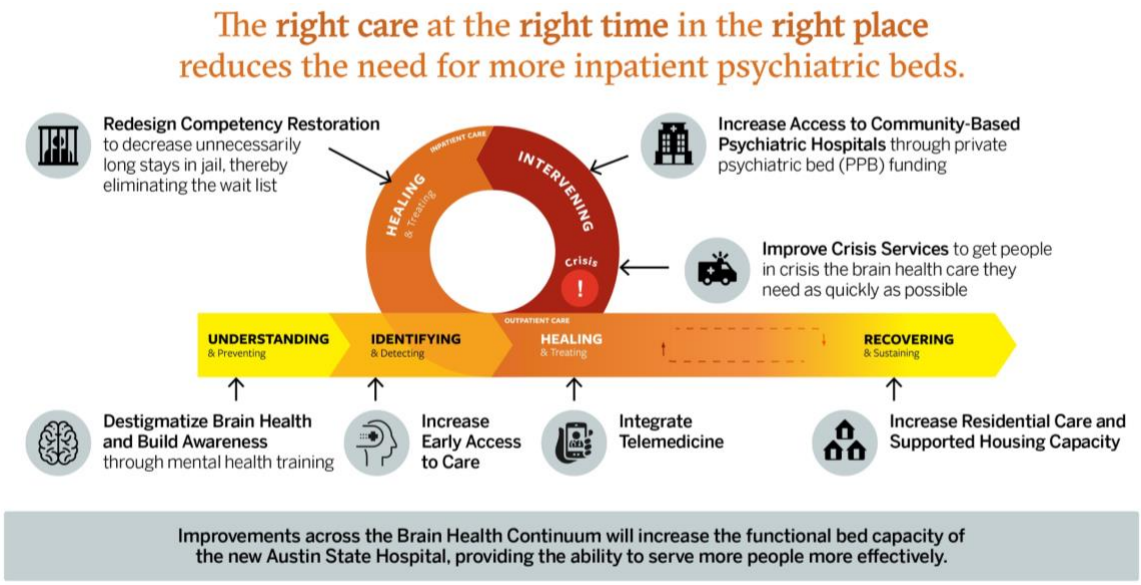
Table 3. Phase I Facility Options

	Option A: 240 bed adult hospital	Option B: 216 or 240 bed adult hospital + 48 or 70 bed residential facility	Option C: 264 to 288 bed adult hospital
Component	**Cost**	**Cost**	**Cost**
Hospital	$264M	$234-246M	$272-291M
Site Preparation	$37M	$39M	$39M
Long-stay placement team	$0.3M	$0.3M	$0.3M
Residential Facility	N/A	$15-45M	N/A
Total	**$283M**	**$288 300M**	**$311 330M**

During Phase I, we recommended increasing residential care and supported housing capacity to enhance the continuum of care and optimize the use of a new hospital. The initial ASH Redesign report presented three different options for the campus, see Table 3. Of these three, Option B was preferred, namely, to build a 216 – 240 adult bed hospital with a 48 – 72 bed residential facility. The latter would have established a step-down option on the ASH campus and better focused the hospital on acute care. With the combination of a hospital and residential facility, the campus would have immediately increased the functional bed capacity by 70 or more beds and initiated creation of a model care continuum on the campus. However, Option A was selected, namely building a 240 adult bed acute/sub-acute hospital only. This option was selected in part because of funding limitations to support operations of a larger hospital as well as multiple other commitments statewide for inpatient hospital facilities construction and repair. Nonetheless, although the total physical bed capacity will only marginally expand on the ASH campus, we propose to work toward increasing the **functional** capacity by establishing a stronger care continuum, like that illustrated in Figure 6.

Currently, there are limited housing options for the large region supported by ASH, particularly in rural counties. The ASH Redesign Phase I identified seven LMHAs offering some form of residential treatment and housing options, involving only 18 of the 38 primary counties served. The diverse landscape of the ASH region creates an unbalanced ecosystem. Urban counties tend to have opportunities for more infrastructure and interlocal support than rural counties. Additional housing option initiatives must therefore consider both urban and rural housing needs.

Figure 6. Continuum of Care



Housing options with various levels of clinical care and wrap-around social supports provide alternative venues to continue a person's recovery following (or in lieu of) inpatient care while integrating the individual back into the community. The care provided within each setting will vary on a person's level of need. Services needed include individual and group therapy, access to case management, peer services, medical care, and even transportation and employment services. Together, these wrap-around services provide better support for the transition from acute and crisis care to long-term recovery in the community. Many people get stuck in the intervening crisis loop of the continuum of care, returning to multiple emergency rooms, jail cells or extended hospital stays (Figure 6). Increase in community housing options throughout an expanded residential care continuum will decrease people stuck in this loop. The previous ASH Redesign report found that in the ASH service area during the years 2015 – 2016 a total of $163,000,000 was

"Providing additional residential treatment and housing options following discharge from the hospital will transition people back into their community for care and support more smoothly."

spent on emergency rooms for unmet mental health and substance use needs rather than a person receiving care elsewhere in their community. Providing additional residential treatment and housing options following discharge from the hospital will transition people back into their community for care and support (or at times in lieu of the hospital) more smoothly. A person returning to their community with appropriate housing and wrap-around services can be managed more cost effectively than the expenses of trying to provide care in less appropriate settings (e.g. emergency departments or jail), thereby allowing limited resources to serve more people.

Housing on Campus and in Continuum

A key strategy to increase the functional capacity of the new ASH, is to discharge people who no longer need hospital level care to a more appropriate and less restrictive setting. These settings, then, need to be built and funded. For example, discharging one person who has been at ASH for a year and is ready for a less restrictive setting would allow four people to be served under the current typical 75-day length of stay. This improvement would provide long-stay individuals with a more appropriate care setting and more independence, while also opening capacity for people needing intensive inpatient care. Doing so would help to reduce the current waitlists for people trying to enter the statewide hospital system. Establishing a variety of housing options on and off campus could also be used to transition people from the acute hospital until they are ready to return to their homes and outpatient care (when available) or alternative less expensive and more appropriate residential settings; doing so would consequently serve both rural and urban regions of the ASH service area.

ASH provides care to individuals with a primary diagnosis of a serious mental illness. However, in addition to serious mental illness, ASH commonly serves people with co-occurring substance use disorders, intellectual or developmental disabilities, and other health conditions. Therefore, as housing on the ASH campus is developed, ideally it would need to support services for these common comorbid conditions.

There is sufficient space on the ASH campus to create housing options as part of building a brain (mental) health campus. During Phase I, HHSC posted a request for information (RFI) to solicit interested partners to join the campus, either by building on the land or renovating one of the existing buildings. Although the community expressed interest, HHSC and the planning process was not yet able to pursue partnerships at that time.

"The long-term goal remains to expand partnerships on campus to create a model brain-health care continuum that supports expanded services throughout the ASH service area."

Consequently, HHSC will be issuing a new RFI during this next phase of planning to identify partners who can join the campus and potentially operate housing facilities. Figure 7 illustrates potential locations for these partnerships. The campus will aim to be a diverse setting of mental health services operated in combination of government, local, non-profit and private organizations. The long-term goal remains to expand partnerships on campus to create a model brain-health care continuum that supports expanded services throughout the ASH service area.

Figure 7. ASH Brain Health Campus – Future Partners

Table 4 identifies potential approaches to these partnerships. A phased approach will create organization to the campus and limit disruptions of daily operations.

Table 4. Examples of phased "grey boxes" on ASH Campus

Phase I: On campus soon after hospital is completed	Phase II: 2 3 years after hospital is completed	Phase III: Future builds, 5+ years out from hospital opening
Residential treatment	**Short-term acute care**	Academic research
Long-term care facilities	Behavior health crisis services	Housing for visiting family and/or support system
Outpatient brain healthcare	**Physical health care services**	
Peer led services and supports	Other behavioral health and wellness recovery-oriented services, features and innovative uses	
Family services and supports		

Several different housing types are recommended to improve the functional capacity of ASH. To begin, creating alternatives for counties that most commonly use the hospital would create the largest impact toward increasing functional capacity. If successful, doing so would improve access for the entire ASH service area. Currently, Travis

County is the highest user of ASH with an average of 32% bed-day occupancy from FY14 – FY20. By increasing alternative treatment options for Travis County patients, we would create capacity for the rest of the region. Alternatively, and additionally, these housing options do not necessarily need to reside on the ASH campus, but could be located near the next highest county utilizers. Counties within Bluebonnet Trails, Heart of Texas and Central Counties LMHA service areas all averaged bed-day use of 10% annually from FY14 – FY20 and represent good starting points for this approach.

Funding Collaborations

To build housing options, multiple funding models will be explored by the ASH Redesign team. Over the next two years of the redesign, a subcommittee will focus on developing a list of available funding models to create the needed housing continuum. This timeline aligns with opening the new ASH. The subcommittee will engage other groups working on housing options for people with mental illness, substance abuse, intellectual disabilities, and other brain health care needs to align efforts. As an example of this approach, New York developed a database for organizations in need of funding to build or operate supported housing. The extensive list developed by The Network of NY is updated and maintained with the most recent available funding (the Network). A similar funding matrix for Texas would streamline work and collaborations to build a housing infrastructure.

Models to Build Upon

Recent additions to the care continuum in Travis County include the Terrace at Oak Springs, a permanent supported housing complex that opened in 2019 and is operated by Integral Care (the Travis County LMHA). A braided funding mechanism was used to build this facility to support both capitalization and operations. This example can inform how the region might establish more, similar opportunities.

During 2020, in partnership with HHSC, Bluebonnet Trails developed one of two pilot sites in Texas for a State Hospital Step-Down Program. Partnering with all state hospitals, this pilot project supports the transition of people with complicated cases from state hospitals across Texas to a community-based setting. The pilot uses a regional collaboration approach (rather than simply a local focus) to expand housing options across counties. Both programs are models for replication throughout the ASH service area if proven successful.

HCBS-AMH Program

In addition to expanding available housing for people transitioning from ASH, the current Home and Community-Based Services Adult Mental Health (HCBS-AMH) 1915(i) Medicaid Program presents an opportunity to increase the functional capacity of ASH. The HCBS-AMH program provides home and community services for adults with serious mental illness to maintain their recovery in their community. A person must meet Medicaid eligibility and also one of three criteria to qualify for waiver services. These are:

- **Long-term psychiatric hospitalization** – three or more cumulative years in an inpatient psychiatric hospital within a five-year span.
- **Jail diversion** – four arrests and two psychiatric crises within a three-year span.
- **Emergency room diversion** – fifteen or more emergency room visits for any reason and two psychiatric crises within a three-year span.

ASH uses the HCBS-AMH program as a discharge option for people that meet these eligibility criteria, although its capacity is somewhat limited within the restrictive criteria. The ASH Redesign team will continue to work with HHSC to optimize and expand the use of the HCBS-AMH program.

RECOMMENDATION SUMMARY

Increase Functional Bed Capacity – Housing Options & HCBS-AMH

- Additional residential treatment and housing options in the service area ultimately decreases expenses of higher level of care and provides opportunities for people to recover in a more appropriate and less restrictive setting.
- Increased housing options are needed throughout the region.
- The ASH Redesign team will continue to support HHSC in optimizing and potentially expanding the HCBS-AMH program.

RECOMMENDATION 2, STRATEGY 2:

Increase Functional Bed Capacity – Create a Forensic Mental Health Roadmap

Strategy 2: **Reduce forensic hospitalizations by creating a roadmap** that provides alternatives to ASH for competency restoration. Key strategies include:

- Creating alternative mental health treatment options to refer people from the legal system:
    - Prior to arrest, by health-driven crisis management into treatment rather than incarceration;
    - Following arrest, within the legal system through mechanisms such as civil commitment and assisted outpatient treatment to refer individuals into treatment rather than incarceration;
- Referring people experiencing acute mental health needs to the least restrictive clinical and legal environments necessary to provide care, avoid arrest and incarceration, and safely and efficiently resolve any necessary criminal charges;
- Establishing a consistent, best evidence forensic assessment process that responds quickly to court requests and working with the judiciary to help the courts implement best practices;
- Initiating mental health evaluation, peer support and treatment as quickly as possible, even in jail if necessary, rather than waiting for state hospital resources to become available;
- Expanding competency restoration capabilities outside the state hospital; and
- Referring Class A nonviolent and all Class B misdemeanants to appropriate community-based treatment rather than prosecution (and hospitalization) whenever possible.

Increasing the functional bed capacity of the new ASH requires changes in how the mental health and legal systems currently intersect. As a reminder, functional bed capacity refers to optimizing the use of the hospital for what it was designed to provide (i.e., acute and subacute inpatient care) within a broader continuum of emergency, inpatient, and community-based clinical care. People often enter the mental health care system when they experience a crisis and law enforcement is called to assist; at times these situations lead to arrest and criminal prosecution of the person experiencing mental illness. The occurrence of this legal and clinical intersection is common. For example, 2019 prevalence estimates found that 1.8 million people with a mental illness are arrested and booked annually (Leifman, 2019). The individual is then thrust into the intersection of the treatment and legal systems with adjudication of competency at times leading to unnecessary hospitalization rather than community-based care settings.

"2019 prevalence estimates found that 1.8 million people with a mental illness are arrested and booked annually."

"Expanding health-driven rather than police-driven responses to acute mental health conditions across the ASH service area will be important"

The best response is to avoid arrest and incarceration entirely, and the new best practice multi-disciplinary response team (MDRT) framework being deployed in Travis County this year offers a solution long-term for reducing the flow of people into the legal system, based on its success in other Texas communities (Meadows Mental Health Policy Institute). Expanding health-driven rather than police-driven responses to acute mental health conditions across the ASH service area will be important, and legislation (HB 1050) has been filed to evaluate the availability, outcomes, and efficacy of strategies to expand MDRT and tailor it to the needs of diverse communities (including rural communities).

Current Forensic and Mental Health Intersection

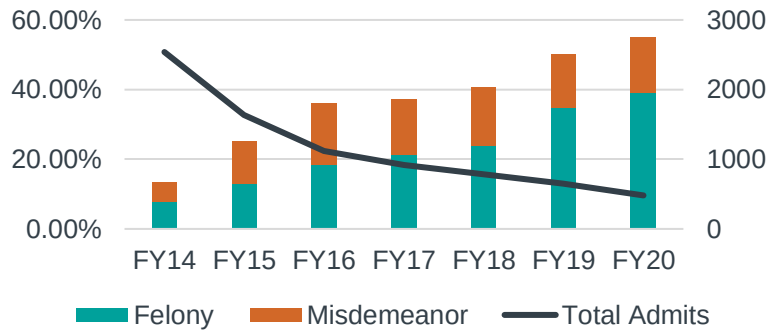
The long-term consequences of criminal prosecution are significant; consequently, the United States Constitution prohibits a person from facing prosecution if they lack the capacity to understand the proceedings against them or assist their attorney in preparing a defense (Drope v. Missouri, 420 US 162, 171 (1975). To ensure constitutional due process, when there is a suggestion that a criminal defendant lacks that capacity, they are evaluated and may be deemed "incompetent to stand trial." In Texas, the procedures that define how to establish incompetent to stand trial are provided in Article 46B in the Texas Code of Criminal Procedure. This code applies to both misdemeanor and felony charges. Article 46B defines a person incompetent to stand trial if the person does not have: 1) sufficient present ability to consult with an attorney with a reasonable degree of rational understanding; or 2) a rational and factual understanding of the proceedings against the person. The determination of whether these conditions are present is made by a qualified psychiatrist or psychologist (under Article 46B.022) after the issue of incompetence has been raised by either party or the court on its own motion. The delay between the court's request for an evaluation and the completion of such evaluation can be significant at times, especially in counties that lack access to a forensic evaluator. The intent of Article 46B is to protect people from an unconstitutional prosecution and punishment when mental health issues preclude a fair trial. The proliferation of individuals with serious mental illness facing criminal prosecution has contributed to a marked backlog within the public psychiatric hospital system and calls for an increased need for more alternatives in less restrictive (and resource limited) settings.

"The proliferation of individuals with serious mental illness facing criminal prosecution has contributed to a marked backlog within the public psychiatric hospital system and calls for an increased need for more alternatives in less restrictive (and resource limited) settings."

Once a person is adjudicated incompetent to stand trial, if the criminal charges are not dismissed by the prosecution, the court commits them to a process called "competency restoration." Competency restoration occurs in one of the three settings: jail, outpatient clinics, or a hospital. Commonly in Texas, competency restoration occurs in a hospital setting due to limited outpatient

and jail-based competency restoration programs and alternative residential treatment and housing options (please see Housing Options strategy). Moreover, with the historical perception of hospitalization being the only option, these alternative programs may not be utilized to the full extent possible. Both clinical and legal professionals strive to improve a person's mental health and ensure constitutional due process if criminal prosecution is pursued by the State. The overlap of clinical need and legal competency restoration is typically considered jointly; however clinical improvement does not guarantee competency restoration, and conversely, restored competency does not necessarily mean clinical concerns are resolved. Several non-clinical factors, including age, criminal history, and degree of violence significantly impact the likelihood of competency restoration in addition to clinical improvement (Zapf, 2011). Consequently, it remains critical to consider separate approaches to resolution of legal charges AND optimal clinical care, with a goal to manage each and their intersection optimally within the least restrictive setting possible.

Figure 8. Admissions per Year



The percentage of people committed by the court for competency restoration nationally and at ASH has steadily increased. This increase in commitments for competency restoration is decreasing available space for civil commitments (Figure 8). Civil commitment is a process for people who are unable to care for themselves or are an imminent risk to themselves or others, and are involuntarily referred for inpatient psychiatric care. The length of stay of forensic admissions is longer than their civil counterparts due at least in part to the complexities surrounding suboptimal processes in the intersection of these two systems. This difference highlights that individuals in competency restoration regularly remain hospitalized beyond the time that their clinical acuity requires inpatient care. Consequently, this situation represents a suboptimal use of an expensive and limited acute care resource, thereby decreasing the functional capacity of the hospital and leading to fewer people being served (Figure 8).

"The percentage of people committed by the court for competency restoration nationally and at ASH has steadily increased."

Part of the issue causing the decrease in functional capacity is that the potential length of commitments of persons found incompetent to stand trial. An initial commitment to determine whether the person's competency can be restored is for a maximum of 60 days for misdemeanors and 120 days for felonies, with one extension of 60 days available, whether commitment for restoration is to inpatient, jail-based or outpatient competency restoration programs. These limitations mean that a defendant completes the maximum statutorily-defined commitment period for competency restoration at ASH in a relatively reasonable time (120 days for misdemeanors, including the initial 60-day commitment and one 60-day extension; and 180 days for felonies, including the original 120-day commitment and an extension of 60 days). However, if the defendant remains incompetent to stand trial, further mandatory treatment, whether inpatient or outpatient, may be indicated and the lengths of time in the hospital expand significantly, even though many of these individuals may no longer require inpatient-level services for ongoing care (if other options are available).
To address this concern:

1. The prosecution can elect to dismiss the case completely, which would result in
    a. Release of the individual to the community or
    b. Transfer to probate court for a civil commitment under Subtitle C, Title 7, Health and Safety Code if civil commitment criteria is met, OR
2. Charges may remain pending, with the criminal court maintaining jurisdiction over the case and civilly committing the individual under Subtitle C, Title 7 Health and Safety Code if civil commitment criteria is met.

Civil commitments require the prosecution to file a petition with two certified medical examinations setting forth the civil commitment criteria met by the defendant. The physicians who complete the examinations are generally appointed by the court and not a member of the person's clinical treatment team; this break in clinical assessment may contribute to miscommunication or misinformation guiding subsequent decisions. It also limits how the hospital participates in disposition decisions.

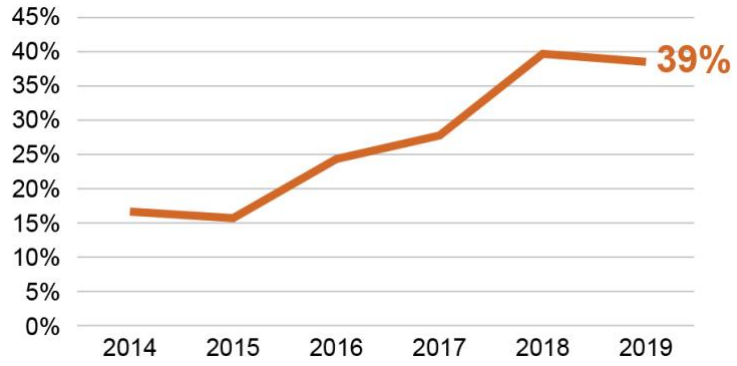
A civil commitment may be renewed annually for periods of up to 1 year at a time, with the exception that it cannot exceed the maximum sentence for the underlying criminal offense. This means that extraordinarily long commitment periods are permitted by law. For example, a person charged and indicted for aggravated assault with a deadly

"... extraordinarily long commitment periods are permitted by law."

weapon, whose case has not been dismissed, can be legally held in the hospital up to 20 years – the maximum jail sentence for such an offense – so long as civil commitment criteria are met and the defendant remains incompetent. When the decision is made to extend a person's civil commitment and continue the hospitalization, the determination is made by a criminal court judge and not a physician providing clinical care; this approach may contribute to a de facto long-term punishment for someone with mental illness without a trial.

Figure 9 illustrates the dramatic five-year increase in forensic bed days on extended commitments at ASH. It should be noted that research has shown competency restoration past the initial 60- or 90-day commitment becomes increasingly unlikely (Zapf, 2011; Gillis 2016); moreover, it is rare to have an individual whose illness requires inpatient level of care for such an extended period. Consequently, there are diminishing returns to continued use of hospital resources in these circumstances. The combination of an increasing forensic population and increasing extensions limits the number of people ASH is able to serve, thereby creating inefficient and suboptimal use of expensive and limited acute care hospital capacity. This problem is compounded by the general lack of residential treatment and other possible housing options in most Texas communities. In addition, due to limited resources, community competency restoration facilities are not designed to receive extended commitments which means there are limited community alternatives to the hospital setting, creating an over reliance on a hospital that is already fully utilized and has an ongoing waitlist for admission.

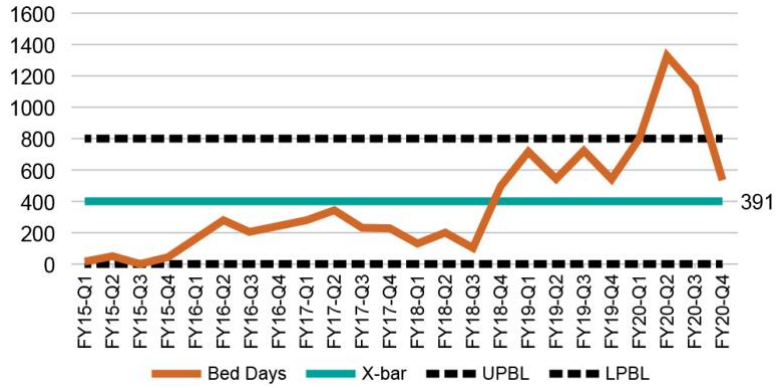
Figure 9. ASH Percentage of Forensic Bed Days on Extended Commitments



"… research has shown competency restoration past the initial 60- or 90-day commitment becomes increasingly unlikely…"

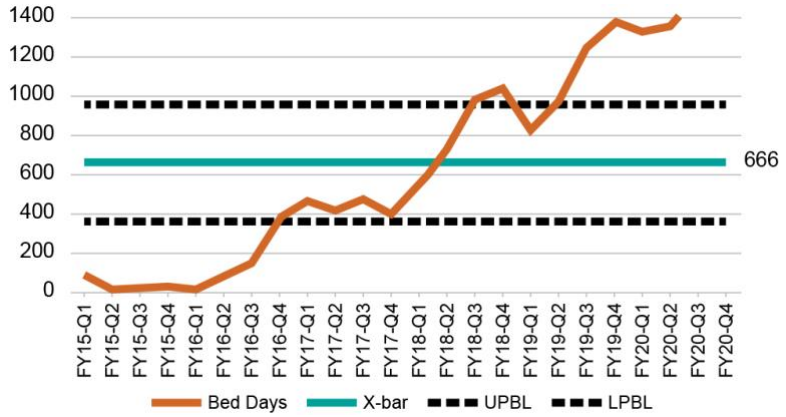
Figures 10 and 11 illustrate demand for specialty services for individuals served by ASH with co-occurring conditions such as intellectual disabilities. As with the general ASH population, the graphs demonstrate a rise in bed days for 46B initial and extended commitments.

Figure 10. Quarterly Specialty Service Bed Days on 46B Commitments



The downturn in FY20-Q2, reflects the impact of COVID-19 that decreased capacity of ASH as the hospital provided space for isolation and safety measures (although increased the waitlists). It is expected once operations return to a more pre-COVID status that increasing percentages of extended commitment will resume unless changes occur in this intersection between the legal and mental health care systems.

Figure 11. Quarterly Specialty Service Bed Days on 46B Extended Commitments



ASH beds being used for extended commitments that do not require inpatient level clinical care create delays for other individuals, civil or forensic, who require this level of clinical support. The backlog often traps individuals in alternative venues not adequately designed to manage either their clinical or legal needs, thereby inefficiently using resources and increasing overall costs of the competency restoration process. For example, as described in our previous report (ASH Report), a typical competency restoration admission at ASH costs approximately $45,000 based on a daily cost of $752 (including benefits and estimated overhead). Adding an extension for 60 more days incurs an additional $45,000 in cost to the state that may be unnecessary in many circumstances. This total expense is in addition to costs related to a person's time on the waitlist in jail, which can be excessive but preventable

through outpatient alternatives. Previous work from the ASH Redesign report found that a mixed competency restoration initiative including a rapid stabilization (short) inpatient stay, support from a Forensic Assertive Community Treatment (FACT) and intensive outpatient care costs an estimated $19,625, less than half of hospitalization costs alone in the current typical approach and significantly less than an extended commitment approach. There are clearly less expensive alternatives to provide a person a more meaningful experience within their community than the status quo. If these can be created and adopted, we can then provide more care in the right place at the right time for more Texas citizens.

"… we can then provide more care in the right place at the right time for more Texas citizens."

As previously discussed, Travis County is the top referring county to ASH. The snapshot of the July 2020 waitlist (section Overview and Background) found 45 people under a 46B commitment from Travis County waiting for a bed at ASH. The average length of time between when a hospital received an order and the person was admitted in calendar year (CY) 2019 was 31 days, but some waited much longer. Moreover, these calculations do not include the amount of time an individual waited before being evaluated or the hospital was notified of an order. These delays in jail represent suboptimal management of these individual's clinical needs and legal resources highlighting the importance of creating a new roadmap for these processes as proposed. As mentioned previously, identifying ways to work with community mental health providers, namely the local mental health authorities, to intervene earlier in the process to either avoid arrest or intercept clients prior to prosecution could alleviate some of the later pressure to hospitalize individuals after they arrive in court.

Multiple Efforts Aligned

There are several efforts across Texas seeking solutions to the overly-complex entanglement of the legal and mental health systems. The Hogg Foundation for Mental Health convened leaders from several statewide and regional projects to discuss their efforts and recommendations for managing the increasing forensic population. The groups included the Joint Committee on Access and Forensic Services (JCAFS), San Antonio State Hospital (SASH) Redesign, Texas Judicial Commission on Mental Health (JCMH), and ASH Redesign. Appendix 7 provides details of the conversation. The discussion raised consensus of top priorities to implement that included:

- Establishing a statewide Office of Forensic Services to develop and implement a consistent strategic plan to eliminate or shorten unnecessary forensic hospitalizations;
- Using data sharing to enhance collaborations among stakeholders within the legal and mental health systems, including partnering with Texas' medical schools for this work; and
- Increasing alternative treatment and competency restoration options other than hospitalization throughout the state.

Nationally, similar discussions are occurring. We can learn from successes from states that have made effective changes within their forensic mental health pathways. The *Just Well: Rethinking How States Approach Competency to Stand Trial* report shares ten strategies already in operation across the country that may serve as models (Appendix 8). The ASH Redesign team and the consensus from the Hogg Foundation work align with the following strategies listed by the *Just Well* report:

- Convene diverse stakeholders to develop a shared understanding of the current competency to stand trial (CST) process.
- Examine system data and information to pinpoint areas for improvement.
- Expand opportunities for referral to treatment at all points in the legal system, including after competency has been restored.
- Conduct evaluations and restoration in the community, whenever possible.

Forensic Roadmap

With these considerations in mind, the ASH Redesign team will develop a regional roadmap with partners and stakeholders to reduce unnecessary forensic hospitalizations by identifying opportunities and solutions to provide mental health care for people engaged with the legal system in the least restrictive setting possible. The roadmap will spotlight gaps and areas for improvement within the system that will guide us to implement pilot programs to test the roadmap programs' ability to increase the new ASH's functional bed capacity. It will work within the context of HHSC and other statewide planning efforts to reduce duplication while potentially offering opportunities to test new models of managing the complex intersection of the legal and clinical mental health intersections.

To build the roadmap, data gathering is needed to understand pathways used within the mental health and legal system. A strategy to gather these data is to create a consortium with the LMHAs, county jails, probation and parole, and municipal law enforcement of the ASH service area, and to develop a collaborative process to monitor how people move through the two systems. Medical schools may be able to assist with data management and analytics, serving as so-called 'honest data brokers' among entities. This process will provide insight to the most frequent pathways leading to admittance to ASH. In addition to understanding the pathways, the team will examine ways to provide quicker access to the initial evaluation, peer support, and treatment to stabilize individuals clinically as rapidly as possible. In conjunction with these efforts, corresponding least restrictive settings for competency restoration will be identified. A potential approach toward this goal is a partnership with a medical school(s) or other providers to design a team to quickly intervene as soon as (or perhaps before) a person is booked into jail. This strategy is one that can be accomplished in person for counties close to available providers, but may also be feasible using telemedicine to provide support to rural counties that lack the necessary mental health workforce.

As part of the roadmap, we will examine currently available resources for competency restoration within the ASH service area. In the previous ASH Redesign report, 18% of the ASH 38 core counties reported having outpatient competency restoration programs provided by the LMHA, although how well utilized these services are is uncertain. It is important to incorporate additional public programs that have been contracted with HHSC as the State works to increase outpatient competency restoration capacity. Creating a map of these services will clarify which counties may need more outpatient competency support and represents a critical first step toward understanding gaps and identifying potential regional solutions.

"It is important to incorporate additional public programs that have been contracted with HHSC as the State works to increase outpatient competency restoration capacity."

Pilot programs will be implemented as gaps and needs are discovered through the roadmap development process in order to test new models of service provision. For example, there is an opportunity to decrease hospital referrals for nonviolent Class A and potentially all Class B misdemeanants to a more appropriate community-based treatment instead of prosecution. For misdemeanants in which prosecution remains necessary, it may still be preferred to refer them to a community-based competency restoration program and intensive outpatient care when clinically appropriate. By doing so, ASH functional bed capacity will be increased allowing waitlists to be reduced. When

hospitalization is clinically indicated, instead of Article 46B referral for care, the courts could opt for a civil hospital commitment while managing the legal charges separately (i.e., return to court after hospitalization or dropping non-violent charges). This approach would decrease the number of people waiting in jail for a hospital bed, eliminate unnecessary court-ordered 60-day commitments and extensions, and create more efficient use of ASH capacity and the courts. Mapping these potential strategies will guide the system to areas for improvement. Implementing pilots around these strategies will identify best practices and how to create a more functional hospital for the new ASH (and other service areas around the state, by extension).

Other State and Local Models

Other state and counties are also improving their mental health and legal system intersections. For example, Miami-Dade County's jail serves as the largest psychiatric facility in Florida. In response to the significant number of inmates in jail needing mental health services, the Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was developed by Judge Leifman to remedy the growing forensic population and criminalization of mental illness. CMPH created four programs: 1) pre-booking and 2) post-booking jail diversion programs, 3) the Miami-Dade Forensic Alternative Center (MD-FAC) program, and 4) the SOAR entitlement program. CMPH's pre-booking program includes Crisis Intervention Team (CIT) training for law enforcement and the post-booking program includes both misdemeanor and felony referral programs (Appendix 9). The MD-FAC pilot was established to show feasibility to refer people deemed incompetent to stand trial or guilty by reason of insanity from state forensic hospitals to community-based treatment and forensic services (Leifman, 2019). A fourth initiative is the SOAR Entitlement Program that uses the SOAR (SSI/SSDI, Outreach, Access and Recovery) model to expedite the process for people with mental illness to receive available social security benefits if they are experiencing homelessness (Leifman, 2019). CMPH is regarded nationally as a success and a program to replicate to reduce the criminalization of mental illness, decrease costs in counties and states, and provide care in the community rather than jail. The combination of these programs led to significant improvements in managing the growing forensic population with mental illness. For example, the CMPH model has shown that people in the misdemeanor post-

"The combination of these programs led to significant improvements in managing the growing forensic population with mental illness."

booking program decreased their recidivism rates from 75% to 25% annually (Boatwright, 2018). Additionally, the programs achieved an annual $17M cost avoidance in jail days from pre-booking crisis referrals to community crisis stabilization, and approximately a 32% decrease in cost serving people in the MD-FAC instead of state forensic treatment facilities. Finally, the expedited process of SOAR provides benefits in 40 days in comparison to the usual 9 – 12 months (Leifman, 2019). The Miami-Dade Model is for a dense urban setting, but aspects may be translatable to other settings.

Typically, rural counties must develop their mental health support differently from urban counties. In a rural setting, the necessary workforce is scarce, county funding is often limited especially for mental health services, and there may be more stigma around mental illness (Stewart, 2015). Many rural counties are joining efforts with neighboring counties to support mental health needs and a growing forensic mental health population. A widely used solution for communities is to implement telehealth services to expand rural county access to care providers; telehealth can be incorporated into crisis and diversion programs to help manage individuals prior to arrest or prosecution. A national review of 2010 – 2017 Medicaid data reported a 425% increase of telemedicine for rural beneficiaries diagnosed with schizophrenia or bipolar disorder (Patel et al, 2020). Extending telehealth into county jails is also beginning and, with the support of grants, some counties have created this infrastructure. For example, the Correctional Telepsychology Clinic (CTC) from the University of Mississippi Medical Center is a pilot model of multidisciplinary teams offering telehealth to the rural county legal system involved population (Batastini et al, 2020). This particular pilot is in early stages, but one to track for potential use in Texas.

Many states are implementing Certified Behavioral Health Clinics (CCBHC) to address unmet mental and substance use needs. The CCBHC program was established from the bipartisan Protecting Access to Medicare Act of 2014 to create a new Medicaid provider type to expand access to mental health and substance use disorder treatment for vulnerable populations (National Council for Behavioral Health, 2020). The CCBHC program began with an 8-state demonstration program that was funded through a Medicaid payment model. Programs outside of the 8-state demonstration are funded through grants. In order to qualify as a CCBHC, organizations must expand their array of services, a key aspect of which is the inclusion of 24/7 crisis response. They also must increase collaborations and partnerships in order to serve all individuals needing services regardless of a person's ability to pay (National Council for Behavioral Health, 2020). There are a total of thirty-three states operating CCBHCs, and Texas is one of these with a total of 19 certified sites (Texas CCBHC). Of the 19 Texas CCBHCs sites, there are 3 within the ASH service area. Partnerships with law enforcement that were created through the CCBHC model are providing decreases in recidivism, lower jail costs, and decreased

travel time for officers. The National Council for Behavioral Health's CCBHC impact report provided an example of the success of this approach from Oregon's rural Klamath County, which saved $2.5 million in prison costs through increased community services and decreasing recidivism (2020). As these programs prove successful, expanding them in Texas might increase access and partnerships to serve rural communities.

Improvements in forensic mental health and competency restoration processes must be supported at a state level, since both local and state resources typically are necessary. They must occur within the context of other continuum of care improvements, e.g., increased capacity of non-hospital residential treatment and other housing options. Using established best-practices in conjunction with reviewing the current system and collaborating with other groups, we will create a forensic roadmap to advance the forensic mental health system in the ASH service area and thereby increase the functional bed capacity of the facility.

RECOMMENDATION SUMMARY

Increase Functional Bed Capacity – Forensic Roadmap

- The percentage of ASH admissions for people with 46B commitments are increasing rapidly, displacing other hospital uses.
- Hospital beds encumbered by competency restoration exhibit increased lengths of stay, decreasing the functional capacity of ASH and other state hospitals, at times keeping people in the hospital past clinical need, and thereby inefficiently using expensive and scarce inpatient services.
- Texas projects focused on improving the mental health and legal system intersections are aligning efforts to decrease the forensic population in hospitals, intercept individuals for treatment referral rather than arrest and prosecution by increasing community-based services. These projects need rapid expansion.
- Developing a roadmap will identify gaps and needs within the mental health and legal systems, leading to pilot programs to create an efficient new ASH care continuum.
- Other models throughout the nation, including the Texas HHSC Forensic Strategic Plan will inform the roadmap.

RECOMMENDATION 2, STRATEGY 3:

Increase Functional Bed Capacity – Partnerships

Strategy 3: **Engage academic and service area experts** to optimize efficient, evidence-based treatment in ASH that facilitates recovery in order to support smooth transitions to care in the **least restrictive environment** necessary, thereby returning people to their community.

- Develop best evidence care models to optimize person-centered recovery plans that provide intentional and meaningful transitions through increasingly less restrictive settings;
- Implement these models within ASH and the service area to optimize health and well-being; and
- Train future clinicians within the state hospital system to attract more high-quality practitioners into public mental health.

The final strategy to increase functional bed capacity of the new ASH builds from previous recommendations to partner with academic entities. The initial ASH Redesign report recommended developing a plan to transfer management of some ASH operations to an academic partner. The ASH Redesign will continue to develop plans for ongoing meaningful academic and service area partnerships particularly focused on developing and implementing more efficient evidence-based practices using person-centered care models to facilitate recovery for individuals treated at the new ASH.

Academic Partnerships

Academic partnerships provide expertise to increase the workforce in the mental health system and provide the latest evidence-based practices for optimal person-centered care. In order to improve quality of care, the psychiatric workforce first must be expanded and the quality of the workforce improved through these key collaborations. There

"Academic partnerships provide expertise to increase the workforce in the mental health system and provide the latest evidence-based practices…"

are several existing successful partnerships between academic psychiatry departments and state mental health systems around the nation including in New York (Columbia University), Georgia (Emory), Ohio (multiple institutions; e.g., Case Western Reserve University, The Ohio State and the University of Cincinnati), and Virginia (University of Virginia) (Ranz et al, 2008). In Texas, HHSC has established academic partnerships throughout the state. Examples of these current academic partnerships include:

- Operational management of the Harris County Psychiatric Center and the new UT Health Behavioral Sciences Center developed through partnership between local and/or state government and the University of Texas Health Science Center at Houston;
- Partnership at San Antonio State Hospital with the University of Texas Health Science Center at San Antonio to complete the SASH Redesign;
- Management of a long-term psychiatric unit in Tyler in partnership with UT Tyler;
- Clinical staffing from Texas Tech Health Science Center at the state hospital in El Paso;
- And multiple residency programs and faculty-led programs affiliated with academic partners located in and funded by state hospitals at Rusk, Terrell, and Big Spring as well as LMHAs in the ASH region. These residency programs are specifically designed to attract psychiatrists into the state hospital system to improve the quality and quantity of the medical workforce using university affiliations to recruit good trainees.

Public-academic partnerships are not a new concept between the University of Texas at Austin or the State of Texas; however, there is no coordinated effort to collaborate between ASH and the multiple related schools, colleges, and departments across the University of Texas at Austin. In addition to training psychiatrists, training other members of the care team would provide the best care and further expand the public mental health workforce. Educational programs developed in conjunction with affiliated universities provide opportunities to train nurses, social workers, psychologists, pharmacists and others to enhance the overall public mental health workforce. University affiliations also embrace innovation to study, develop and implement state-of-the-art mental health practices.

Academic psychiatry departments consistently report the benefits that a state hospital learning experience provides to their trainees; however, many note the distance between the university and the state hospital is a disincentive (Talbott, et al, 2010;

"… the ASH provides a unique and optimal location for ongoing and additional interdisciplinary academic/public collaborations…"

Faulkner et al, 1983; Douglas et al, 1994). Located only 2 miles from the main UT campus and UT health district, the ASH provides a unique and optimal location for ongoing and additional interdisciplinary academic/public collaborations with Dell Med, UT Steve Hicks School of Social Work, College of Nursing, College of Pharmacy, and Departments of Psychology and Educational Psychology. Strengthening partnerships between ASH and UT could:

- Create a collaborative, multi-disciplinary, public-academic partnership to improve training, program innovation, and quality of mental healthcare within the ASH service area.
- Build from the collaboration between Dell Med's Department of Psychiatry and Behavioral Sciences and the interprofessional practice training programs within UT to increase internship placements at ASH for students from the University of Texas' Steve Hicks School of Social Work, College of Nursing, College of Pharmacy, and Departments of Psychology.

ASH and Dell Med's Department of Psychiatry and Behavioral Sciences will continue to collaborate with the University of Texas' Steve Hicks School of Social Work's Texas Institute of Excellence in Mental Health (Texas' center of excellence for evidence-based practice) to increase training, technical assistance, and evaluation of mental health evidence-based practice implementation throughout the region (Svendsen et al, 2005). A key to effective evidence-based practice implementation is on-going technical assistance, fidelity monitoring, and evaluation (Bond, et al, 2020; Aarons, et al, 2012; Bruns, et al, 2008).

Service Area Expert Partnerships

In addition to academic partnerships, collaborations with service area experts outside academia can help optimize the efficiency of the new ASH. An academic partner can support improving hospital operations, and by also working with external community partners can improve the care continuum. Academic partners can provide a critical bridge among the various components of public mental healthcare that often unfortunately work in silos.

"… collaborations with service area experts outside academia can help optimize the efficiency of the new ASH."

Table 5 presents examples of service area experts with whom to collaborate in the care continuum. The previously mentioned CCBHC is specifically designed to integrate these various partners, serving as an example of one approach. Another example of service area partnerships is joining primary and mental health care providers to care for the whole person, which is accomplished through collaboration between Federally Qualified Health Centers (FQHC) with mental health providers and/or clinics. FQHCs are community-based primary care clinics that provide services to underserved communities, mental health services being a part of their care; however not all FQHCs are staffed for intensive or crisis mental health needs (Kaliebe, 2016). Therefore, some FQHCs have partnered with mental

Table 5. Community & Outpatient Providers

- Clubhouses
- Donors
- Faith-based organizations
- Health & Human Services
- Housing organizations
- Local intellectual & developmental disabilities authorities
- Local brain health organizations
- Local Mental Health Authorities
- Managed care organizations
- Peer & family groups (certified peer specialists)
- Peer-run community organizations
- Primary care providers
- Private psychiatric care providers
- Public & private schools (school counselors, school nurses)
- Recovery coaches
- Recovery community organizations
- Social services organizations
- Statewide Behavioral Health Coordinating Council
- Substance use providers
- Universities and colleges
- Veteran organizations
- Workplace health & wellness

health clinics to provide this service. In a study of the rationale to increase mental health care within an FQHC, it was found that collaborative care can improve mental health care and increase access for specialty care for a community (Kaliebe, 2016). Establishing partnerships for a full continuum of care will remain a strategy to create an efficient system.

Partner Progress at ASH

In the 86th Legislative Session, Senate Bill (SB) 2111 required HHSC to establish a transition plan of some ASH operations to a contracted academic partner. HHSC worked with Dell Medical School to respond to the bill within the already established partnership for the ASH Redesign efforts. In response to SB2111, HHSC and Dell Med are working to create an academic unit at ASH. The academic unit will support training physicians, designing and testing new models of care and providing opportunity for clinical and health service quality improvement. New York and Ohio reported an infusion of qualified psychiatrists into their public system through similar initiatives (Ranz et al, 2008; Svendsen et al, 2005). We currently are planning to open the academic unit with the new hospital, but it may be established earlier within the current ASH if possible. Other developing partnerships between ASH and Dell Med's Department of Psychiatry and Behavioral Sciences include increasing residency slots to expand recruitment of new medical professionals into public mental health and perhaps the forensic population. Additionally, Dell Med will lead an advisory board focused on developing metrics that specifically meet improved care and hospital efficiency goals and then provide the analytic support to evaluate those metrics and use them to drive improvement throughout the service area.

"The academic unit will support training physicians, designing and testing new models of care and providing opportunity for clinical and health service quality improvement."

Person-Centered Care

Support from partnerships with universities and expert service providers will expand the professional workforce and create systems, structures and processes that promote person-centered recovery. Currently, structural and process barriers prevent individuals from moving through the proper levels of care as discussed throughout this document. Through better coordination across systems and organizations, leveraging information technology, and listening to patients and families, individuals will be served at an optimum level of care.

Strengths-based, mental health practice seeks to explore and emphasize the strengths and resources of individuals and their environments to help them to achieve their goals (Saleebey, 2002). While there are a number of functional and cognitive challenges, extensive research of mental health services has demonstrated that effective supports allow most individuals with mental illnesses to live independently even with these often life-long recurrent and chronic health conditions (Rog et al, 2014). In Texas, we over-emphasize state hospital care without building sufficient community supports. Through a multi-system collaboration in the continuum we will aim to improve our public psychiatry workforce and focus on a person-centered approach to providing care in the lease restrictive setting.

"Support from partnerships with universities and expert service providers will expand the professional workforce and create systems, structures and processes that promote person-centered recovery."

RECOMMENDATION SUMMARY

Increase Functional Bed Capacity – Academic and Service Area Expert Partnerships

- Established academic partnerships in Texas and other states have been successful in providing and improving brain health care.
- Collaborations between Dell Med and HHSC defined in the SB2111 plan include creating an academic unit in the new ASH, increased psychiatry resident rotations at ASH, and providing analytic capabilities to use evidence and metrics to drive process and care improvements.
- Expanding multi-system partnerships encourages person-centered care and strengths-based practice throughout the service area.

RECOMMENDATION 3:

Expand Peer Engagement

Expand peer engagement in the system of care improvement process.

- ***Strategy 1:*** Continue to enhance engagement into the ASH Redesign process of people from diverse ethnic, racial, sexual orientation, gender identity, and disabilities background.
- ***Strategy 2:*** Work to ensure that ASH has a robust financially sustainable peer support program.

The ASH Redesign project has aimed to engage people who experienced the mental health system as a person receiving care, peer support worker, family member, and/or mental health advocate. This critical engagement reflects our first "People First" core principle behind the ASH Redesign efforts, namely:

"People First"

"Taking excellent care of people is always the first priority in planning with a goal to provide the right care at the right time in the right place."

As the redesign efforts of ASH continue, this principle remains our top priority guiding project decisions. Throughout the next phase of the redesign, the peer and family work group along with the steering committee developed the following recommendation to strengthen the impact of this principle.

Peer Support Engagement

Peer support specialists provide mutually supportive relationships throughout the recovery process, for both people with a brain (mental) health illness or substance use problems. Peer support is the process of giving and receiving encouragement and assistance to achieve long-term recovery (Mead, 2003). Peer specialists offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people (Solomon, 2004). It is through this trusting relationship, which offers companionship, empathy and support, that feelings of isolation and rejection can be replaced with hope and personal control. Similar to peer support, family and/or caregiver partner services support families and caregivers who are caring for a loved one experiencing a mental health illness. Family and caregiver partners provide education on available community care, help to identify resources, and bring a personal understanding of their experience to a supportive relationship. Increasing numbers of peer and family support specialists are being employed nationally, and evidence of the effectiveness and value of these services continues to emerge (Davidson et al, 1999; Klein et al, 1998; Ochocka et al 2006). Moreover, well-developed peer support is cost-effective, in particular reducing use of more expensive, and often unnecessary, services. For example, Sledge et al (2011) reported that people partnered with a peer support service spent fewer days in the state hospital and experienced less recidivism than individuals without this support. Because of the high cost of inpatient care, savings that result from even small changes in hospitalizations quickly outweigh the costs of employing peer and family specialists. ASH has peer services within their treatment teams providing valuable services to people in the hospital. The importance of this care is also emphasized in the design of the new hospital, ensuring space for peer supports within each unit. Efforts through the redesign will continue to focus on increasing collaboration with peers, family members and advocates throughout the ASH service area.

"It is through this trusting relationship, which offers companionship, empathy and support, that feelings of isolation and rejection can be replaced with hope and personal control."

"… well-developed peer support is cost-effective, in particular reducing use of more expensive, and often unnecessary, services."

Working closely with the peer support unit at HHSC and maximizing their expertise will enhance all of the recommendations throughout future efforts in the redesign. Continuing town hall discussions with robust conversations about community needs further foster, prioritize, and actualize diversity beyond single representations of peer and family. The ASH Redesign supports increasing peer specialists throughout the system, thereby increasing peer engagement. Collaborations with peer advocacy groups and Community Based Recovery Organizations, as well as meaningful peer integration, will be a central strategy to enhance this important, cost-effective service.

Peer Service Reimbursement

"... we will prioritize approaches to sustain this workforce."

Texas is one of thirty-six states that pay for peer services through Medicaid (Myrick, 2016). Although peer services are supported by Medicaid, a national peer support workforce survey completed by Cronise et al (2016) reported that Texas and Oklahoma pay the lowest rates nationally for peer support specialists, with an average hourly wage of $11.89. In the ASH Redesign, a stakeholder collaborative will review efforts and pathways to increasing reimbursement rates for Medicaid peer services as well as identify alternative funding models to expand and maintain these services. Because of the critical impact that peers have in state hospital care and long-term recovery within the community, we will prioritize approaches to sustain this workforce.

Current funding rules inhibit effective coordination of care by LMHAs as individuals move through the state hospital system. Often care provided by peers in the state hospital ends at discharge and is then picked up by outpatient peer services, usually through the LMHA at a later time in the absence of a "warm hand-off". This hand-off has a hard cut off in funding, and payment is not available for the transition from inpatient to outpatient care. In order to better coordinate care and encourage a person-centered recovery plan, guiding intentional and meaningful transition through increasingly less restrictive settings requires navigation until the healthcare system is less fragmented. Peer navigators assist with transitions from state hospital to outpatient settings. An example of

"... guiding intentional and meaningful transition through increasingly less restrictive settings requires navigation until the healthcare system is less fragmented."

transitions from hospital to outpatient setting is the evidence-based Peer Bridger model that focuses on outreach and engagement, crisis stabilization, wellness, self-management skills, and community support (SMI Adviser, 2019). The Peer Bridger model, established by New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS), reduces hospitalization length of stay, improves quality of life, and reduces re-hospitalization rate after discharge from psychiatric hospitals. Similar navigation to help people maintain recovery and stay engaged with ongoing community-based supports can be utilized when they re-enter the community from the criminal justice setting. Navigation structures have been successfully used by other states such as Pennsylvania and in metro areas, like Miami-Dade County, known for their collaboration between the mental health and legal systems (Guevara, 2015). By allowing peer specialists to follow individuals as they transition from ASH into the community, the barriers of our fragmented system of care may be reduced and eventually eliminated. Post-hospitalization peer support services are an effective bridge from hospital to community-based supports.

Peer and family support, along with care and service coordinators, navigators and other professionals, bridge gaps within the mental health system, provides a critical support network to assist individuals as they move through the continuum of care. With these considerations in mind the Peer and Family Work Group established five recommendations the group will continue to work toward during the next two years. Appendix 10 provides details on the following recommendations:

1. Build a collaborative continuum of care;
2. Create alternative peer-supported programs for competency restoration;
3. Establish peer and family collaboration programs;
4. Create alternatives to hospital approaches that complement and extend the medical model;
5. Ensure diverse representation of family and peers in redesign efforts.

Encompassing the efforts of the Peer and Family Work Group, increased engagement and collaboration with peer specialists and developing a review of reimbursement support will strengthen the “People First” principle of the new ASH and the brain health continuum.

RECOMMENDATION SUMMARY

Expand Peer Engagement

- Peer support specialists provide understanding, hope, encouragement, and assistance to a person seeking recovery.
- Peer support services are cost-effective and reduce the use of more costly care while decreasing the likelihood of re-hospitalization for those engaged in services.
- ASH Redesign will expand engagement with peer specialists and people with lived experiences to further strengthen the “People First” principle of the new ASH.

RECOMMENDATION 4:

Sharing the History of ASH

- ***Strategy 1:*** Share the history of ASH with the community.
- ***Strategy 2:*** Create a space for collection management and interpretation.
- ***Strategy 3:*** Preserve environmental aspects of the campus.

Connecting the Continuums

"There is a unique opportunity at ASH to build upon the original land and transform the campus to a world-class brain health treatment platform, while providing education and connection to the past through sharing the history of the campus."

Construction of the State Lunatic Asylum (now known as the Austin State Hospital) began in 1857, and the first patients were admitted in 1861 into what is now called 'Old Main'. Old Main is the only building on campus recognized on the historic register and will remain intact on the ASH campus with the new hospital (Figure 12). The early years of ASH followed the Kirkbride design method of Moral Treatment on 395 acres on what was then outside of Central Austin (Yanni, 2007). The campus was self-sustaining and cared for up to 3,000 people at times. In 1925, the hospital changed its name to the Austin State Hospital (ASH). Throughout the life of the ASH campus, buildings have been built and removed, and the number of people served has fluctuated with changes in mental health care. There is a unique opportunity at ASH to build upon the original land and transform the campus to a world-class brain health treatment platform, while providing education and connection to the past through sharing the history of the campus.

Within this redesign phase, a group focused their efforts to identify ways to build upon existing HHSC efforts to preserve the story of ASH and develop meaningful ways to share the evolving and diverse story of the campus and mental health care in Texas. Dedicated archeologists, from Baer Engineering and Environmental Consulting, Inc., investigated areas impacted by the new building, and they gathered more than 3,000 artifacts from the campus, all of which will be

Figure 12. Evolution of Building 500, "Old Main"

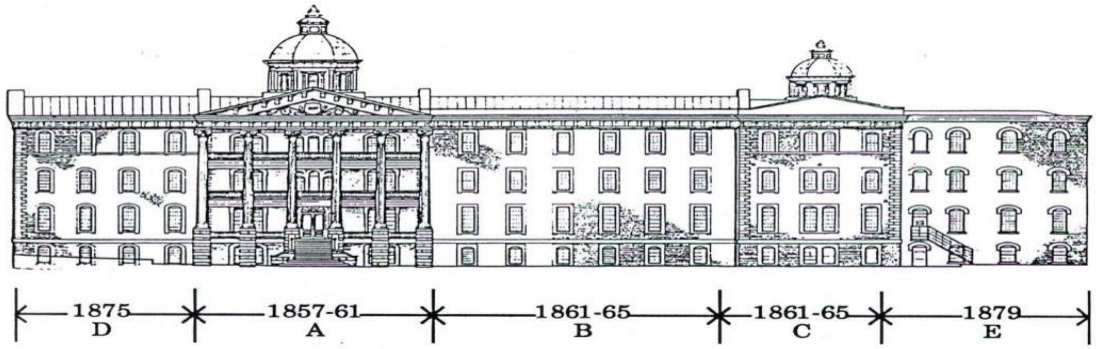


Image from ASH collection

categorized and preserved in a curation facility. The artifacts found include building debris, silverware, clothing, several keys, and buttons to name a few. All items found are small in size. The archeologists will also prepare a report of their findings for the Texas Historical Commission, and they are working jointly with HHSC to develop a website showcasing their findings and report. The website will share an in-depth review of ASH's history, including periods of racial segregation and the continued efforts since then to create health equity at ASH. Throughout this discovery phase, the project's design team, Page/, identified a meaningful representation of previous building foundations that will be displayed at the garden of the retention pond near the entrance to the new hospital. Through Page/'s research as described in Appendix 11, the foundations come from the 1883 women's ward and the operating rooms.

Along with artifacts currently being discovered, HHSC and ASH have worked to preserve collections throughout the years. The collections range from paper records and photographs to medical equipment and furnishings. HHSC is working to create a space on campus where these collections can be shared with the community to offer opportunities to learn from the history of ASH. To build upon this work, the History of ASH Work Group established four recommendations to support the preservation of the story of ASH as provided below and detailed in Appendix 12.

"... collections can be shared with the community to offer opportunities to learn from the history of ASH."

History of ASH Work Group Recommendations:

1. **Hire a project manager** to oversee implementation of the preservation, collection management, and interpretation of historical artifacts.
2. **Complete a review of the collections,** their current environments, and determine how best to preserve the items.
3. **Share ASH collections and campus history through a phased historic interpretation plan** based on the Standards and Practices for Interpretive Planning of the National Association for Interpretation and other resources and guides.
4. **Identify potential funding options** to support sharing the history of the ASH campus with the greater public.

With adoption of these recommendations, combined with current efforts, HHSC will preserve the story of ASH for future visitors to learn from and experience.

Environmental Preservation

The ASH campus is unique in location being close to the center of the city and tucked among historical neighborhoods. Many people use the ASH campus to walk through and enjoy the outdoor space. The campus has several pecan tree groves some of which had to be removed to allow room for the new hospital. To honor the heritage of the campus, pecan trees that grew within the footprint of the new hospital are being preserved, and the wood of the trees will be cured then used within the design of the front lobby desk and the care desks on the units. Figure 13, is a rendering of such a care desk within the patient unit.

Figure 13. Care Desk

"The campus will continue to remain open to the public and offer space for nature and connection to the history of ASH."

The fences of the ASH campus are trimmed with Drift rose bushes that have been on campus for years. As part of the environmental preservation efforts, some of these cherished rose bushes on the Lamar street fence – where construction of the new hospital building is occurring – were transplanted to the Guadalupe Street fence by volunteers from the design and construction teams and ASH staff. The campus will continue to remain open to the public and offer space for nature and connection to the history of ASH. The ASH Redesign will continue to develop meaningful ways to share the ASH campus with the community as it grows into a brain health campus.

RECOMMENDATION SUMMARY

Sharing the history of ASH

- Hire a project coordinator to manage the historical collection and interpretation.
- Continue to share the history of ASH in a meaningful way.
- Share the environment of the campus with the community as it becomes a brain health campus.

4

Conclusions

Conclusions

Since 2008, Texas has been investing to transform the state's public mental health system in order to provide the right care in the right place at the right time.

To solidify this transformation envisioned within HHSC's *A Comprehensive Plan for State-Funded Inpatient Mental Health Services*, it is **imperative that the final $124.1M construction funding is appropriated by the 87th Texas Legislature to complete the new Austin State Hospital (ASH).** The new facility is a world class design that is person-centered and facilitates a person's transition back to their community for recovery. Texans deserve the best mental health care possible in an evidence-based setting promoting their continued well-being. This new facility will meet that goal. Appropriating this funding during the 87th Legislative Session will keep the ASH project on budget and on schedule, with an opening date of June 2023. With the continued support of the 87th Legislature, Texas will have a world class facility serving Central and Southeastern Texas.

The new ASH will be a catalyst enhancing the mental health system of Texas. ASH is a key member of the continuum of care.

Building the new ASH will not improve the backlog of people waiting for a hospital bed, nor will it function efficiently without concurrently redesigning the continuum of care. The ASH Redesign team will continue to work with stakeholders and service area experts to increase hospital functional bed capacity. Specifically, the ASH Redesign team is emphasizing an increase in housing options; rethinking the forensic pathway to better support individuals at the intersection of mental health and the criminal legal system; and establishing partnerships increasing access to evidence-based, person-centered care. With ongoing support, work toward these goals is expected to make substantial progress while the hospital construction is being completed. The team will continue to engage peer supports and advocates to maintain our "People First" principle, as well as support HHSC in sharing the unique aspects of the history of ASH with the community. With these considerations in mind, during the next two years, the ASH Redesign team will develop strategies and solutions to increase the functional capacity of the new ASH to optimize the number of people that can be served. By doing so, we will continue improvements in brain health care in Central Texas and beyond, becoming a model for the nation.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Definitions

46B	A person deemed incompetent to stand trial, as per Texas Code of Criminal Procedures
ACT	Assertive Community Treatment
ADC	Average Daily Census
ALOS	Average Length of Stay
AOT	Assisted Outpatient Treatment
ASH	Austin State Hospital
BHSP	Behavioral Health Strategic Plan – a 5-year plan to address gaps in the mental health system
Brain Health	Commonly referred to as mental health and refers to the ability to remember, learn, play, concentrate and maintain a clear, active mind without disturbances beyond the control of the person.
CAPS	Child and Adolescent Psychiatric Services
CIT	Crisis Intervention Team
CMS	Center for Medicare and Medicaid Services
Competency Restoration	A legal educational process to ensure an individual understands the charges levied against them and can participate in their own defense
Continuum of Care	Additional supports outside of an acute care hospital that allow for continued recovery, treatment, and support
CPB	Community Psychiatric Bed
CY	Calendar Year

DBT	Dialectic Behavioral Therapy
Dell Med/DMS	Dell Medical School at the University of Texas at Austin
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
EBD	Emotional and behavioral disorders
Esprit de Corps	Morale
FACT	Forensic Assertive Community Treatment
FFT	Functional Family therapy
FQHC	Federally Qualified Health Center
Functional Bed Capacity	Optimizing the use of the hospital for what it is designed, namely acute care, by moving non-acute care to more appropriate settings
FY	Fiscal year - September 1 - August 31
HB	House Bill
HCBS-AMH	Home and Community-Based Services Adult Mental Health is a waiver that provides home and community services for adults with serious mental illness and aims to assist people with maintaining their recovery in their community
HHSC	Health and Human Service Commission
IDD	Intellectual and Developmental Delays
IDDT	Integrated Dual Disorders Treatment
IICAPS	Intensive In-Home Child and Adolescent Psychiatric Services
IOP	Intensive Outpatient
IP	Inpatient

IPS	Individual Placement and Support
IST	Incompetent to stand trial
JCAFS	Joint Committee on Access and Forensic Services
JCMH	Texas Judicial Commission on Mental Health
KEEP	Keeping Parents Supported and Training
LMHA	Local Mental Health Authority
MCOT	Mobile Crisis Outreach Team
MDFT	Multisystem Family Therapy
MMHPI	Meadows Mental Health Policy Institute
MST	Multisystem Therapy
MSU	Maximum Security Unit
N.B.	Nota bene, meaning “note well.” Used to emphasize an important point.
Page/	Architect Subcontractor
PESC	Psychiatric Emergency Service Center
PNA	Psychiatric Nurse Assistant
RFI	Request for Information
RTC	Residential Treatment Centers
SASH	San Antonio State Hospital
SB	Senate Bill
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility

SUD	Substance Use Disorder
TCCO	Construction Manager at Risk subcontractor
Telehealth	Electronic communication system utilized for physical and mental health evaluations
TJJD	Texas Juvenile Justice Department
Waitlist	The amount of time a patient has to wait for admission to the Austin State Hospital
YES	Youth Empowerment Services