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IMPACT

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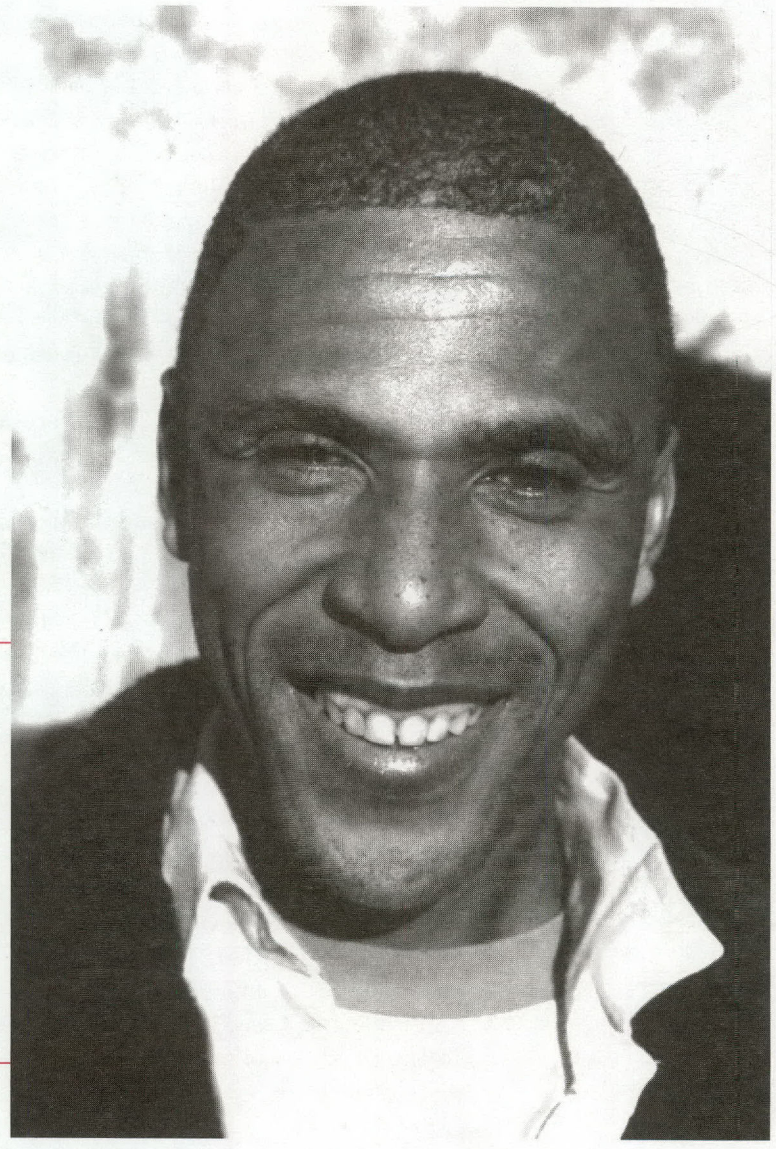

Photo by Carla Daws

Sebron Polk is one of the individuals who have been aided by the unique Corpus Christi State School Angelfish Project.

VIEWPOINT

ViewPoint ViewPoint VIEWPOINT ViewPoint

Commissioner Don Gilbert

Ask someone who has never been to our state, "What is Texas like?", and you are likely to hear a description conjured by Hollywood films: It is wide-open spaces sparsely populated by roving cowboys, cattle and cactus, with a handful of wealthy oil barons thrown in. Ask that person what Texas contributes to the nation, and you may hear anything from bluebonnets and western swing to rattlesnakes and fire ants. Inquire as to the impact of the state on the lives of people with mental illness and mental retardation and you are almost certain to get a blank "Huh?"—even from Texas oldtimers.

Most people know that Texas is near the top of the states in geographic size and oil and cattle production, but they don't know the state is becoming a visible, national force for advancement of mental health and mental retardation services. This issue of *IMPACT* offers a glimpse of the variety of ways in which Texas Department of Mental Health and Mental Retardation (TXMHMR) is establishing a national presence.

For example, TXMHMR is becoming known by participation of its staff in national efforts to improve services, such as the development of an outcome-based "report card" to evaluate the quality of mental health services as providers increasingly compete for state and federal dollars. The agency is part of an international trend to apply outcome-based performance measures to ensure quality of mental retardation services as well.

Another way in which TXMHMR is making its mark is through successful application for and use of federal grants for projects ranging from innovative housing and employment supports to development of collaborative networks of consumer and family groups, all of which enhance the lives of individuals.

This agency and its partners—consumers, families, advocates, private providers, universities and other state agencies—are in the national eye also because of a variety of exciting projects that have potential to become models for the rest of the country. Pilot sites are testing a process whereby individuals with certain severe mental illnesses can be more accurately and successfully treated with medications. Innovative programs are underway for persons with dual diagnoses of mental illness and substance abuse, or mental illness and mental retardation. TXMHMR is even experimenting with how to best plan, administer and deliver services throughout the state by means of an organized network of providers.

Realistically, it's unlikely the word "Texas" will come to elicit comments like, "Oh, that's where they have those great mental health and mental retardation programs!" That's not important. What is important is for the staff of this agency, consumers and other partners within and outside the state to know that TXMHMR has the determination and know-how to move steadily to the forefront of innovation in mental health and mental retardation services.

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Moving Forward with Outcomes for People with Mental Retardation

Since 1995, TXMHMR has been in transition from traditional inspection-based methods of quality management to using outcomes for people as the ultimate measure of quality. The design and development of the Quality Assurance and Improvement System (QAIS) reflects an international trend away from reliance on process standards to guide services. (See related articles, pages 5-6 and page 19.) QAIS incorporates *Outcome Based Performance Measures,* developed in 1993 by The Council on Quality and Leadership in Supports for People with Disabilities (known as The Council; formerly The Accreditation Council).

Organizations use *Outcome Based Performance Measures* in three ways:

- In education, the measures focus attention on people and outcomes rather than services. Meeting and communicating with individuals about their personal outcomes helps staff see people as people, not just as "clients" of the system. Services that do not facilitate outcomes for people are reexamined.
- In self-assessment, the measures enable organizations to determine the extent to which they can assist people in achieving personal outcomes. The measures also challenge organizations to identify processes that facilitate outcomes for people.
- As an evaluation tool, the measures track changes in people's lives, as well as the organization's response through its services. Data produced by reviews based on outcomes are very different from that gathered through other evaluations. Evaluations based on personal outcomes identify resources that are not producing intended benefits. Service systems use such measures to ensure dollars spent for services result in positive changes in lives.

What Next?

Efforts to implement outcome measures reveal the degree to which organizational process measures remain embedded in definitions of quality. Many people continue to confuse the ends (outcomes people want in their lives) with the methods, techniques or programs promoting outcomes. The managed care movement has produced evaluations that measure "outcomes" reflecting service delivery and frequency, clinical practice and other process-related events; while meeting the broad definition of outcome, these evaluations do not differ significantly from the traditional process approach to quality management.

Using process outcomes or "output" measures as indicators of quality threatens advances in quality associated with person-centered planning and outcomes. The result can be managed care systems based on compliance with organizational processes or standardized expectations of individualized behavior and performance. The use of personal outcome measurement ensures that response to individuals' needs remains the primary criterion for quality. Outcomes for people are the critical indicator that resources are being used effectively and efficiently.

Measuring outcomes for people provides great clarity in examining services, supports and professional methodologies for people with diverse needs in varied settings. The same personal outcomes can be produced by different services and professional methodologies. The challenge we face as we move forward is to ensure that individuals remain at the center of our efforts to quantify and evaluate the results of our services.

Contributed by Tina Campanella, vice president, ProLerna, The Council on Quality and Leadership in Supports for People with Disabilities, Towson, MD.

External Validation:

QAIS Monitors Mental Retardation Services

Photo by Karen K. Roop

TXMHMR service recipient Patricia Goolsby (right) discusses her goals and preferences with Burke Center staff member Stacy Lindsey.

In December 1996, TXMHMR began implementing the external validation component of the Quality Assurance and Improvement System (QAIS), TXMHMR's mechanism for monitoring services received by people with mental retardation. (See *IMPACT* Winter 1995 - 96, pages 22 -23.) Although external validation follows the local authorities' self-assessments and may seem the last stage in the QAIS sequence, it—like the entire QAIS system—remains a work in progress whose boundaries shift and expand in response to national as well as local demands.

External validation is the way the department verifies the local authorities' self-assessments, which includes analysis of health, safety, rights, and abuse and neglect issues, and identifies areas in which the authority requires technical assistance or training. Visits are conducted by members of the QAIS core team (eight Central Office staff), peer reviewers from various mental retardation authorities (MRAs) and consultants from The Council on Quality and Leadership in Supports for People with Disabilities (known as The Council; formerly The Accreditation Council).

Although the process includes an examination of quality improvement plan documents, the visits depend primarily on interviews with MHMR consumers. To measure the self-assessment team's "interrater reliability" (accuracy in determining the presence or absence of outcomes), external validation team members accompany center or state-operated community services (SOCS) staff on interviews with service recipients. The staff member and the external validation team member decide independently from one another whether the individual's outcomes have been met.

According to Bette Mobley, The Council's director of Learning and Improvement Services, members of the self-assessment teams generally make appropriate decisions with the information they have, but that information sometimes is insufficient. Mobley cited an instance in which an interviewer's questions garnered answers suggesting many of the consumer's outcomes had been met. However, a closer examination uncovered issues yet to be addressed.

The need for comprehensive data is most pronounced for individuals who are nonverbal and depend on others to speak for them. Mobley maintains that even in these instances it is possible to determine whether the person's outcomes are present. However, to develop a complete picture, the interviewers must talk with additional people, especially family members and staff closest to the individual.

"Staff who work with people can tell you all kinds of things, but that information often is unused," Mobley said.

The visits are structured to prompt interviewers to dig deeply for information. During half of the interviews, the external validation team member may ask questions and suggest additional follow-up activities, and thus uncover information the self-assessment team member did not. The other interviews are conducted solely by the self-assessment team members with an external validation team member present.

A December 1996 interview involving Mobley and Stacy Lindsey, a member of Burke Center self-assessment team, served two purposes. Besides verifying the center's self-assessment, it also marked the second stage of Lindsey's progress toward QAIS trainer certification. Should she achieve an acceptable interrelater score, she would move to the last step to certification: conducting a QAIS workshop for Burke Center staff. Consequently, Lindsey was among those staff members responsible for eliciting all of the necessary information. At the outset, Lindsey knew only that she would interview a 29-year-old woman who lives in her own apartment and isn't employed.

The product of national as well as local trends, **QAIS** is emerging as a national force in its own right. In May 1997, three **QAIS** leaders—core team member Corinne Reutebuch, guidance team member Carole Smith, and peer reviewer Sharon Coutryer—traveled to New York City to deliver a 90-minute presentation on the system at the 121st conference of the American Association on Mental Retardation. For more information, contact Corinne Reutebuch at (512) 206-5808.

Consumer Patricia Goolsby quickly revealed she considers her life in the community to be rich in personal relations and possessions. Her mother, uncle and boyfriend all play important roles in her life, and Goolsby obviously is important to them. In fact, she briefly interrupted the interview to remind her uncle, a regular visitor to her home, to take his medicine. She also cherishes her belongings, especially a Christmas music box that announces the hours with a carol. Ultimately, the interview highlighted a major QAIS tenet: Outcomes are an individual matter informed by each person's value system. "This [interview] is an example of the need to set your own values aside. What is important to me isn't necessarily to the individual," Mobley said.

However, as Stacy Lindsey learned, desired outcomes are not limitless. For instance, Lindsey and Mobley differed in their decisions concerning the outcome "people choose where they work." Since Goolsby had said she preferred to stay at home and not work, Lindsey concluded the outcome had been met. In discussing this with Mobley, Lindsey realized other options needed to be explored.

"The external validation process gives you tips on how to look at things," Lindsey said. "Kim [Deckard, Goolsby's case manager] said that Social Security is changing its policy and able people will be required to work. Work is a strong reality for [Goolsby], for she could work at home."

Lindsey did progress to the final stage of training certification and remains a staunch supporter of QAIS. But she left the external validation interview with a few concerns. Most problematic for her was her belief about its subjectivity. In her view, "The decision about whether an outcome has been met or not is still an opinion. How do you decide who is right?"

The issue of subjectivity has been addressed. To promote full exploration of issues and objectivity during the self-assessment, the entire self-assessment team is encouraged to participate in reaching consensus on the presence or absence of outcomes and processes for the 30 outcomes for each of the interviews conducted during the self-assessment. Conciliation also occurs among those present during external validation interviews.

QAIS' greatest strength may be that this and other questions have not been discounted. Instead, they are channeled to The Council, the QAIS guidance team, the external validation team and others who work to ensure the continued evolution of the system itself.

Contributed by Karen K. Roop, former managing editor of IMPACT.

Trend Toward Managed Care Makes Mental Health Outcomes More Vital

Across the nation, a quiet but sweeping revolution of managed care is occurring in the delivery of mental health services, in both the private and public sectors. From 1992 to 1996, the number of Texans whose mental health care is covered through a managed care arrangement rose from 2.3 million to 4.2 million.

The major reason for the dramatic changes in mental health systems is the search for a solution to the problem of spiraling costs of health care. Managed care in America's private sector has addressed this issue with spectacular success: Mental health expenditures in the private sector decreased from $30 billion in 1993 to $14 billion in 1996. Thus, government officials have turned to managed care as a way to increase public health care budgets. Since the primary motivation for the introduction of managed care is the lowering of health care costs, the contract for services quite often goes to the lowest bidder.

There is danger in applying this model to the public sector. The private sector population is, for the most part, healthy and employed. The public sector, on the other hand, includes many individuals who are unemployed and in the system because they are seriously ill, in crisis or experiencing a combination of acute problems. Persons in the public sector are among the most disabled, and, in many cases they are receiving public services because the private sector can no longer afford to provide needed services. The focus on cost control in managed care can result in a decline in quality of services, especially when savings are expected from systems already inadequately funded.

In such an environment, mental health outcomes—the result of individuals' mental health treatments—are of vital importance. Therefore, performance indicators, outcome measures and report cards related to access, quality and cost of services have increasing significance. From a state (or payor) perspective, performance indicators define the services and quality of services being purchased. For a managed care company or provider, such measures can be used to assure payors that quality will not be sacrificed to savings.

This trend toward outcomes has resulted in information sharing and program development at state and national levels. TXMHMR is involved in a number of initiatives to develop a standardized set of measures for monitoring quality of care. As chairman of the national MHSIP (Mental Health Statistics Improvement Program) Advisory Committee and as chairman of the task force that developed the MHSIP Report Card (see related articles, pages 8 and 9), Vijay Ganju has provided leadership to several of these efforts. Recently, Ganju, TXMHMR's director of Strategic Planning and Resource Development, was invited to present some of this work at Harvard University, and he will be working with several organizations—including managed care organizations, accreditation agencies and federal agencies—on these efforts. A few of these endeavors are featured on the following pages of this issue of IMPACT.

TXMHMR on the Front Line in National Outcomes Standards Development

TXMHMR currently is involved at the cutting edge of national efforts to develop a set of outcomes standards for the mental health care industry.

The agency is working with the National Association of State Mental Health Program Directors (NASMHPD) to formulate a "core set" of measures for performance indicators and outcomes for public systems. Texas was among five states selected to participate.

To develop a framework that reflects the priorities of public systems, NASMHPD's Task Force on Performance Measures is studying Best Practices of various initiatives related to mental health performance indicators and outcomes. Using aggregate data, the task force intends to develop comparable data across all states and territories.

In formulating the national measures, which will be flexible to address individual state and territorial concerns, the task force is working closely with consumer constituencies, the National Alliance for the Mentally Ill, the Substance Abuse and Mental Health Services Administration and other groups.

In the works: methodological standards for outcomes

Besides deciding which outcomes will be monitored, standards also need to be established for the ways in which the data used for

continued, next page

The MHSIP Consumer-Oriented Mental Health Report Card

In April 1996, the release of the MHSIP (Mental Health Statistics Improvement Program) Consumer-Oriented Report Card garnered the collective attention of mental health agencies and providers nationwide. The idea of the report card was similar to the school report cards your child brings home: The difference was that the scores rate the performance, quality and cost of mental health systems.

Front Line, continued

such monitoring are collected, analyzed and reported. Once outcomes standards are set, how are outcomes measured? How reliable are outcomes measurement techniques? For example, what should the minimum acceptable response rate be in surveying consumers?

While a standard for mental health consumer outcomes is the goal, the *process* of measuring those outcomes also must be determined. Development of methodological standards for tasks such as data collection, sampling, surveying and follow-up of consumers is a priority of the federal Center for Mental Health Services (CMHS).

TXMHMR staff and mental health researchers are working with CMHS to develop minimum criteria for such methodological standards.

In a recent report, CMHS proposed that consumers, family members, and mental health providers and researchers actively participate in establishing methodological standards. CMHS also recommended that external audits or reviews be used to certify that outcomes measurement systems meet the standards' minimum criteria.

What set the MHSIP Report Card apart from the many other mental health report card models was that it measured factors that matter most to mental health consumers. The report card model was developed by a task force of mental health stakeholders—consumers, family members, researchers and agency representatives from across the country.

According to Vijay Ganju, task force chairman and TXMHMR director of Strategic Planning and Resource Development, the report card model that resulted from the input of these divergent groups is (1) consumer-oriented, (2) based on research and explicit values, (3) focused on, but not limited to, serious mental illness, (4) designed to emphasize the outcomes of mental health treatment, and (5) conscious of related costs and staff burden.

The MHSIP Report Card consists of four major components:

- **Domains** —the major areas the report card is designed to address (access, outcomes, appropriateness, prevention and cost).
- **Concerns** —value statements related to each Domain.
- **Indicators** —specific operational aspects to be monitored to assess how an organization is performing relative to a Concern.
- **Measures** —specific methodologies used to derive and calculate the Indicators.

"Think of Consumer Reports rating a mental health system instead of a car or appliance," said Ganju. "The Concerns are the critical features. While a car's critical features may be gas mileage or capacity, a mental health system's critical features are related to such factors as the ability to provide a full range of service options and achieve specific outcomes."

Each Concern in the MHSIP Report Card has identified Indicators and Measures. For example, if the Concern is "increased access to general health care," the corresponding Indicator would be the "percentage of persons with mental illness who are connected to primary health care." The Measure would be the "total number of persons with mental illnesses who received a physical exam during the past 12 months

divided by the total number of persons with mental illness who received services during the past 12 months."

The MHSIP Report Card received numerous accolades during the past year. The National Association of State Mental Health Program Directors endorsed the values and concerns in the report card model and its use as a guide in developing mental health report cards and measurement systems. The report card model also was endorsed by the Association of State Mental Health Planning Councils and the Association of Ambulatory Behavioral Healthcare. The recent draft report by the National Academy of Sciences acknowledged the contribution of the MHSIP Report Card.

Many states are using the MHSIP Report Card to develop their performance measures and report card capacities. Sixteen of the 20 states receiving 1996 MHSIP grants are implementing the MHSIP Report Card or systems based on the report card model. Some states are using components of the report card model in contracts with managed care organizations. Many managed care organizations also have sought permission to use the MHSIP Report Card in their operations.

"Report cards will help assess strengths and weaknesses (of systems) based on consumer needs and priorities. This should really make a difference in our quality improvement and accountability systems," Ganju said.

Texas Mental Health Outcomes System evolves from report card efforts

Through the research and consumer input gathered for the MHSIP Report Card, TXMHMR has developed its own Texas Mental Health Outcomes System (Adults).

"A value-based outcomes system is necessary for adult treatment planning, developing performance measures, contract monitoring, and service report card development," said Ganju. (A similar system for children with mental health problems was implemented several years ago.)

Like the MHSIP Report Card, the outcomes system was designed by a committee of consumers and family members, advocates, and representatives from the TXMHMR Central Office and community MHMR centers. It includes a number of priority outcomes: symptom reduction, reduced symptom distress, increased functioning, increased performance in work/school, increased self-esteem, increased independent living, increased natural supports, reduced hospitalization, reduced criminal justice involvement, reduced impairment from substance abuse, and reduction in negative treatment outcomes.

Several of the priority outcomes already are measured with instruments proposed for the statewide uniform assessment system implemented this year. The remaining outcomes will be measured through a consumer survey.

Implementation of the consumer survey, which is being tested using innovative techniques such as touchscreen computer systems and consumers interviewing consumers, will be aided through a recent state reform grant from the Substance Abuse Mental Health Service Administration (SAMHSA). The grant funds also will be used to develop a report card for Texas mental health services.

Ganju said the SAMHSA grant recently was augmented to enable Texas to participate in a five-state assessment of uniform performance measures for a national system.

"There is a lot of pressure on mental health systems to have uniform, standardized measures," Ganju said. "I think Texas is in a good position to lead the way."

MHSIP's Goal: Service Improvement

The MHSIP (Mental Health Statistical Improvement Program) is committed to improving data use, performance measures and information systems at local, state and national levels. Sponsored by the federal Center for Mental Health Services, the program provides leadership in developing and implementing numerous national mental health initiatives.

TXMHMR Employs Best Practices
The Texas Approach

Effective psychiatric rehabilitation services see consumers not as passive recipients of services but as individuals who actively collaborate in their own treatment and development. Treatment is not generic or menu-driven; it is consumer-driven and focuses on the individual's potential for recovery and the enhancement of the quality of his or her life.

The consumer's personal rehabilitation plan is designed to help him or her develop the necessary social skills, vocational skills and supports to achieve the most independent lifestyle possible. To reach this goal, a "partnership" is formed among the doctor, consumer, other treatment team members, and—when desired by the consumer—family members and significant others. The consumer, who shares equal responsibility for the success of the rehabilitation plan, must be given enthusiastic coaching and continual challenges, encouragement and positive feedback. The rehabilitation plan is evaluated on an ongoing basis. Members of the consumer's rehabilitation partnership understand that equal priority must be given to:

- Managing symptoms through techniques such as medication, lifestyle changes and reduction of stressors.
- Developing skills that enable individuals to cope with the demands in his or her chosen environment (living, learning, work and social settings).
- Modifying/adapting the individual's environment to assist in his or her recovery.
- Developing a social network of emotional supports through the individual's family members, significant others, friends, coworkers and organized support groups; providing these sources of support with information on mental illness and coping skills is crucial.

Key to the recovery of individuals with mental illnesses is the education of the public in order to dispel myths and reduce the disabling effects of the stigma of mental illness. Individuals with mental illnesses should not be isolated; they should have opportunities for social interaction, to acquire gainful employment and to contribute to society.

Pages 10-17 profile Best Practices that have been implemented recently by TXMHMR. These programs, based on proven expertise and practices, utilize the Texas Approach in helping consumers lead rewarding, fulfilling lives.

Texas Project Leads the Way in Developing Medication Guidelines

Other states watching closely as Texas formulates and tests step-by-step guidelines

(b and a)

Just six years ago, doctors treating psychiatric disorders had few medication choices. Most drugs had been around since the 1950s, and many had serious side effects. But times have changed. Today, dozens of breakthrough psychiatric medications—with alphabet-soup names like clozapine, olanzapine, gabapentin, divalproex, risperidone and nefazodone—treat symptoms better and with fewer side effects.

While doctors and patients alike praise these "second-generation" medications for their effectiveness, more choices mean more questions: Which medication works best, at what dosage, and for which patient? When should a patient switch drugs? Should a patient, who may suffer significant side effects, have a say in choosing the appropriate medication?

And what about cost? If a new, $400-per-month drug promises the most hope for a person suffering from major depression, should it be prescribed only after the old, $30-per-month standby has failed?

Collaborative project involves TXMHMR, universities

These are tough questions, and they're being hotly debated by public sector agencies, HMOs, doctors, consumers and advocacy groups nationwide. Attention is focused on Texas, where TXMHMR and six universities are engaged in a collaborative research project that seeks to expand our knowledge and define Best Practices for doctors who prescribe psychiatric medications. Begun in 1996, the Texas Medication Algorithm Project (TMAP) has the potential to improve significantly the system of services and quality of life for individuals with major depression, schizophrenia or bipolar disorder.

"The goal of the TMAP program is to develop and implement a set of medication algorithms for these major disorders so we can improve quality of care and decrease some of the variation in psychiatric medication practice," explained Steven Shon, M.D., TXMHMR medical director.

"This project grew out of concerns expressed by consumers and family members—not only in Texas, but all over the country. We hear from consumers, 'Gee, every time I change doctors, they change my medication, even though my diagnosis is the same. If my doctor leaves and another doctor comes, they change my medication.'"

In some cases, physicians lack up-to-date information; in others, they cannot

A collaborative effort

The Texas Medication Algorithm Project (TMAP) is a major collaborative effort involving TXMHMR; the Department of Psychiatry at The University of Texas Southwestern Medical Center-Dallas as the lead academic group (A. John Rush, M.D., project director); the College of Pharmacy at The University of Texas at Austin (Miles L. Crismon, Pharm. D., project co-director); and the departments of psychiatry at four other Texas medical schools: The University of Texas Health Science Centers in San Antonio, Houston and Galveston, and Texas Tech Medical School in Lubbock.

"The collective brain power and problem-solving abilities of the academic participants are impressive," said Alexander L. Miller, M.D., director of Clinical Research at San Antonio State School and professor of psychology and pharmacology at The University of Texas Health Science Center at San Antonio.

Equally valuable, Dr. Miller said, has been the input of TXMHMR physicians and staff at community centers and hospitals.

"Academic psychiatrists are frequently frustrated by their inability to have a direct impact on the practice of psychiatry, while clinicians complain that academicians have little understanding of the realities they face," Dr. Miller emphasized. "TMAP puts these groups together and makes them hammer out real solutions."

Photo by Sherry L. Grona

Project management team members for the Texas Medication Algorithm Project (TMAP) include, from left, Marcia Toprac, Ph.D., TXMHMR; Karla Starkweather, TXMHMR; A. John Rush, M.D., University of Texas Southwestern Medical Center-Dallas; Steven Shon, M.D., TXMHMR; Miles L. Crismon, Pharm.D., University of Texas at Austin College of Pharmacy; and William Rago, Ph.D., TXMHMR. Dr. Shon co-chairs the TMAP steering committee with Kenneth Altshuler, M.D., University of Texas Southwestern Medical Center-Dallas.

The collaborative effort also includes the direct involvement of many consumers and their families, who have shared their personal insights and wisdom.

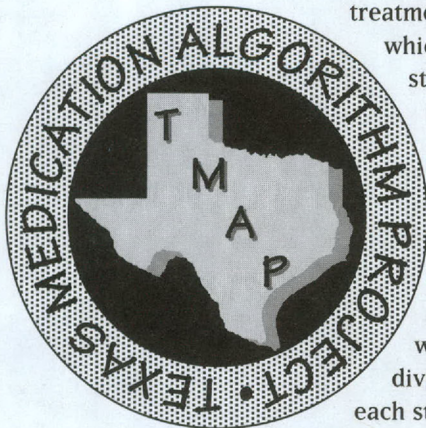
"I like the TMAP process," said Joe Lovelace, who has a family member affected by schizophrenia and who serves as president of the Texas Alliance for the Mentally Ill (TEXAMI). "Consumers and family members have been at the table from the get-go, helping construct the model around which this research is driven. You don't see this collaboration in the private sector."

prescribe a new drug because it isn't listed on the clinic's formulary, or they are swayed by a visit from a pharmaceutical representative. With so many medications on the market, it's tough for even the most diligent psychiatrist to stay current.

"These clinical algorithms will help guide physicians through this period when so many breakthroughs are happening," said Dr. Shon.

Alexander L. Miller, M.D., director of Clinical Research at San Antonio State Hospital, said TMAP also will help physicians better understand how new medications differ from each other.

What does a medication algorithm look like?



An algorithm is a series of treatment steps, each of which leads to the next step in the treatment process. The process is much like doing long division, according to Dr. Shon. "You take one step at a time, but whereas with long division you must do each step in order, with the medical algorithms, doctors have more than one option at each step, and they can skip steps—and their judgment is still very important."

For example, the strategy for the treatment of schizophrenia might suggest two alternatives as Step 1: (a) a conventional antipsychotic from a list of choices or, (b) risperidone, a newer drug. If the patient doesn't respond, Step 2 might be to switch from (a) to (b), or vice versa. If there's still no response, Step 3 might call for olanzapine, and if that fails, Step 4, clozapine.

"What we are trying to do is develop guidelines, or 'decision trees'," said Kenneth Altshuler, M.D., chairman of the Department of Psychiatry at The University of Texas Southwestern Medical Center and co-chairman of the TMAP steering committee. "Actually, they are more like 'decision bushes', because at each point, there is more than one choice. We don't know exactly what single drug is the best, so doctors may have four choices for the first step. But we'll specify the dosage levels and the length of time to use them, and then if there is no response, a partial response or a complete response, what the doctor should do next."

Dr. Miller, who also serves as a professor of psychiatry and pharmacology at The University of Texas Health Science Center at San Antonio, said TMAP continually gathers information that determines future changes in the algorithms.

"For example, if it turns out that a new medicine is very helpful for patients who have not responded to another new medicine, then the next version of the algorithm will guide clinicians to use these medications in sequence to get the best results, " Dr. Miller continued.

Dr. Altshuler explained that the goal is to have all individuals with major depression, schizophrenia or bipolar disorder treated using the best knowledge available.

"It's the first time this has ever been done anywhere in the history of psychiatry, and anywhere in the country, and I think this has the potential of being a really enormous advance in the methods of delivery of care nationwide."

Managed care and drug treatments

Nationwide, HMOs have adopted managed care models to increase efficiency and control costs. Medication guidelines in these organizations frequently are based on cost, and doctors may be expected to try the cheapest medications first and resort to more expensive (but generally better) medications only after the low-cost alternatives have failed. In contrast, TMAP algorithms are not based on cost, but rather on quality defined by scientific research and empirical evidence.

"We start with the medications we think are going to be the most effective," said Dr. Shon, who is convinced that TMAP research, which examines the cost issue, will show that a quality approach is the most cost-effective.

"We believe that in the long run, using the best medications, even though they are more expensive, saves money," he said. "[They result in] fewer hospitalizations and emergency room visits."

"Many clinicians have the sinking feeling that treatment choices are being determined by the goal of making patients less expensive, rather than making them better," said Dr. Miller. "TMAP provides an opportunity to show that making patients better not only is the right thing to do, it is also more cost-effective in the long run."

TMAP receives widespread support, involvement

Patient enrollment in Phase 1 of the TMAP project began in October 1996, with the algorithms being field-tested at 15 Texas pilot sites. During Phase 2—likely to begin in January 1998 and to last two to three years—doctors will test the algorithms (modified during Phase 1) for clinical and cost-effectiveness.

Already, TMAP has won widespread support. Several national health care foundations have shown interest in funding Phase 2 research, expected to cost about $3.5 million. The National Institute of Mental Health is watching the project closely, as are many states.

Teamwork and information sharing is the backbone of the TMAP process, emphasized Dr. Miller. TMAP's academic module directors construct "the best algorithms they can think of and then work with doctors in the trenches to use them, communicating by conference calls and telephone consultations.

"For example," he continued, "in the schizophrenia algorithm, the module directors, who had done research on olanzapine, were able to provide expert guidance to clinicians as soon as it was marketed as Zyprexa in October 1996. Simultaneously, the clinicians were feeding back information about the strengths and weaknesses of the algorithm to the directors."

Gretchen Megowen, M.D., a psychiatrist at Dallas County MHMR Westmoreland Outpatient Clinic, said she is part of a generation of doctors interested in being "on the front line," using the newest and best medications based on current research and analysis.

"I was very excited to see myself and a number of other practicing doctors invited to participate in the development of the guidelines and algorithms," she said. "Here's a project where people didn't just say to us, 'Here's what you do—and now go do it.' Instead, they invited us to sit down and talk."

Dr. Megowen, who works as an intake psychiatrist, making initial contact with patients, said she already has seen one important result of the TMAP project . "Some of the recommended medications were not available at MHMR sites. The development of the algorithms has been a catalyst for adding newer medications to the formularies at these locations."

Like Dr. Megowen, consumer advocate Joe Lovelace is enthusiastic about TMAP. Lovelace, president of the Texas Alliance for the Mentally Ill (TEXAMI), said, "This project involves the best of Texas psychiatrists trying to improve public health care. Too many times in the past, serious mental illness was not treated in a uniform matter.

"We're certainly not talking cookbook medicine with TMAP," continued Lovelace, whose 25-year-old son was diagnosed with schizophrenia nine years ago. "But the program does bring to the public health system a level of predictability and consistency."

Lovelace, along with other advocates, consumers, national mental health experts and TXMHMR providers, attended the two consensus conferences held in 1996 in Galveston and Dallas to discuss medication issues and develop the algorithms.

"This is a radical change of thinking—consumer and family education and choice have been built into these algorithms," said Lovelace. "My experience with my own son has now been translated into a program. And someday I hope every provider will follow these guidelines."

Cliff Gay, a computer operator who suffered from depression for over 20 years, also participated in the July 1996 consensus conference in Galveston. He shares Lovelace's enthusiasm for the algorithms and sees them as a roadmap to helping people recover—and stay recovered.

"If these algorithms had been available to me back in 1969, when I had my first depressive episode, I can assure you it wouldn't have taken me until 1992 to recover," Gay said. "TMAP has the potential to change the lives of people who suffer from mental illness, and also the people who love them and care for them."

Contributed by Diane South, Agave Publications.

ACCESS Removes Barriers to Services

If you are one of the estimated 200,000 individuals in this country who are homeless and have a mental illness, what kind of services do you need? Certainly housing, mental health treatment, health care, income supports, and vocational and legal assistance. You also may need treatment for substance abuse.

The sometimes daunting process of obtaining all these services—often provided by different agencies and across many departments and systems—deters many individuals with mental illnesses from seeking assistance. Integration of these existing federal, state, local and voluntary services is the goal of the ACCESS (Access to Community Care and Effective Services and Supports) program. (See Summer 1995 *IMPACT*, pages 12-14.)

The federal grant-funded program had its start-up in 1993 in nine states. In Texas, ACCESS programs were approved for Austin Travis County MHMR Center and Tarrant County MHMR Services in Fort Worth. The Austin program serves as the comparison site while the Fort Worth program is the experimental site. Both sites provide assertive outreach and case management; the experimental site adds systems integration, which includes an interagency management team, computer network connecting local providers with shared databases, e-mail and Internet access.

ACCESS, which was conceived by the federal Interagency Council on the Homeless and developed by the U.S. Center for Mental Health Services (CMHS) Homeless Programs Branch, seeks to coordinate services and remove barriers by using a "No Wrong Door" approach—a homeless individual with a mental illness can receive help no matter how he or she enters the system. A recent study of the program in the nine participating states indicates that, overall, consumer outcomes after one year in the program show a

TXMHMR Promotes National Consensus Building for ACT

TXMHMR has been at the forefront of national consensus building regarding programs for ACT (Assertive Community Treatment), which sends comprehensive mobile treatment teams to provide services for persons who are severely disabled by mental illness and who have a history of multiple hospitalizations.

Last October, the agency sponsored the conference, States Helping States: P/ACT and Managed Care, which provided the opportunity for researchers, state and national policy developers, program experts and advocates from over 20 states and Canada to share information, ideas and experiences about the latest issues in ACT.

The conference, conducted in collaboration with seven other public and private organizations, covered such topics as the future direction of ACT in a managed care environment and the status of ACT development, implementation, financing and research .

First developed in Wisconsin in the 1960s, ACT is a Best Practice in TXMHMR's 1996 fiscal year performance contracts with community centers. Under the program, treatment team members provide services in the consumer's natural environment. "They work within the community," said Melody Olsen, Texas coordinator for ACT. "Team members provide whatever individualized services are needed; they can be called upon to address anything from mental health-related issues to employment concerns."

Individuals at 20 community centers are interviewed upon admission to ACT services and again one year later to evaluate the impact of the program on their lives. ACT, first implemented in Texas in 1995, has helped reduce consumer hospital days by 69 percent. While the reduction rate of hospital days varies across the state, several centers helped reduce hospital days by as much as 90 percent in the first year.

TXMHMR currently is seeking grant monies to continue work begun at the October conference. The agency hopes to lead a 14-state information dissemination and consensus building process regarding national standards of care, cost accounting guidelines and performance outcome measures.

—NB

three-fold increase in days housed, an improvement in the quality of housing, and a strong connection between the number of days housed and reduced symptoms.

Annually, the Austin and Fort Worth sites each seek to reach 100 homeless individuals with serious mental illnesses who are not currently engaged in community mental health services. The goal is to reach a total of 1,000 individuals by 1999, according to State ACCESS Director Greg Gibson.

The two ACCESS sites, which will be evaluated formally by CMHS at the end of the five-year program, have been widely praised for improving the lives of their target recipients. The sites currently are evaluated on an ongoing basis, said Gibson.

Each participant is interviewed after being in the program for three months and 12 months. Collecting and analyzing the data on a program-wide basis is a complex process, explained Gibson. "There are hundreds of variables. We're just now beginning to see results from the sites."

> "Our first goal is ensuring that the program is effective."
> — *State ACCESS Director Greg Gibson*

For Gibson, providing quality services to consumers is a top priority. "Our first goal is ensuring that the program is effective," he said. "We then will work to secure the stability of the program after the federal funding runs out."

If funding sources are available, Gibson added, the program may eventually expand to the major Texas cities.

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EARNS Helps Consumers Support Themselves

Disability—even the most severe—need not be a barrier to successful employment. Yet, we have a great deal to learn about the best ways to support the people we serve in achieving successful jobs and careers.

A federally funded research project will make a significant contribution to the level of knowledge about employment of persons with severe mental illness. Texas is among eight states participating in the Employment Intervention Demonstration Project (EIDP), a five-year project funded by the federal Center for Mental Health Services.

The states are testing different ways of supporting people with serious mental illness in achieving successful community employment. Although each of the eight projects is unique, all have common aspects. This innovative project design will allow for specific shared data to be collected from a large group of people, providing a great opportunity for learning.

The Texas project, called EARNS (Employment Assistance through Reciprocity in Natural Supports), is a partnership among TXMHMR, The University of Texas Health Science Center, and the Center for Health Care Services in San Antonio. EARNS is testing an innovative approach to assisting consumers in developing networks of support both on and off the job. In addition to an employment specialist, who helps consumers choose and get employment, every consumer in EARNS works with a system integration specialist (SIS). The SIS helps the individual determine the kinds of support needed to keep employment and helps devise individualized plans to build the necessary reciprocal relationships to provide that support. With the consumer's permission, the SIS might work directly with family, friends, coworkers or employers. The EARNS approach seeks to help consumers develop the natural relationships all people need to succeed in their jobs.

Contributed by Pam Daggett, coordinator of community employment in TXMHMR's Service System Development and Implementation Division.

Photo contributed by The Center for Health Care Services

When Edward Edmondson, right, owner of North Park Kennels, needed a hardworking employee, he contacted the EARNS program of The Center for Health Care Services and found consumer Myron Lychton, who has exceeded his expectations.

Dual Diagnosis Project Integrates Treatment

Photo by Sherry L. Grona

Patrick Haney, TXMHMR/TCADA dual diagnosis coordinator, says the interagency project is designed to provide state-of-the-art treatment for the 30 to 50 percent of priority consumers with co-occurring substance abuse and mental illness disorders.

Integrated treatment. That is the goal of the dual diagnosis project of TXMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA). The project, the largest of its kind in the nation, is the result of a resolution by the 74th Legislature that directed the two agencies to study ways to improve services for the 30 to 50 percent of their priority consumers with co-occurring substance abuse and mental illness disorders.

Believing that integrated mental health and substance abuse (MH/SA) treatment is more effective than parallel, separate care, the two agencies embarked on a project to develop methods of engagement, assessment and treatment; to create treatment partnerships; and to identify, evaluate and replicate elements in successful programs.

In January 1996, Patrick Haney was named interagency dual diagnosis coordinator for the project. Haney, who is employed by both TXMHMR and TCADA and is officed at both agencies, said that in traditional methods of dual treatment, one aspect of MH/SA treatment has been shortchanged.

"We often hear consumers who are dually diagnosed referred to as 'treatment-resistant clients', but, in regard to traditional services, what we have had is 'client-resistant treatment,'" said Haney. "We're looking at state-of-the-art treatment for *both* mental illness and substance abuse."

To encourage cooperation, those MH/SA providers wishing to participate in the project were required to form partnerships and apply together.

In April 1996, five programs spanning 33 Texas counties were selected to serve as pilots:

•The Dual Diagnosis Project of the Central Plains Center for Mental Health, Mental Retardation and Substance Abuse in Plainview.

•The Dual Diagnosis Treatment Program of the Tri-County Mental Health and Mental Retardation Center in Conroe and the Montgomery-Walker County Council on Alcohol and Drug Abuse.

•The Central Texas Partnership, coordinated by a coalition of urban and rural MH/SA treatment providers. (See related article, page 23.)

•The Ocotillo Project, operated by a coalition of MH/SA providers in El Paso.

•The Bueno y Sano Project, operated by a coalition of MH/SA providers in the counties surrounding El Paso.

The pilots will be evaluated jointly by the Public Policy Research Institute of Texas A&M University and Dartmouth University's Psychiatric Research Center. Renowned psychiatrist Robert Drake will lead the study at Dartmouth.

Haney said he would like to see the project serve more Texans. "Our hope is to expand until there is one project in every Health and Human Service region and, eventually, statewide."

—NB

Behavioral Health Pilot Fosters Cooperation

A community behavioral health organization designed to develop and contract with a network of mental health and substance abuse (MH/SA) providers is a new project being piloted by the Texas Commission on Alcohol and Drug Abuse (TCADA) with the cooperation of TXMHMR.

The project, which will be implemented at a few Texas sites this year, is a proactive response to the imminent arrival of managed care in the public sector.

"The project is designed to limit the historic practice of multiple providers competing for the same funding for the same type of program," said Patrick Haney, TXMHMR/TCADA dual diagnosis coordinator.

For the pilot programs, the community behavioral health organizations are community mental health and mental retardation centers (CMHMRCs). These CMHMRCs contract with local MH/SA providers, including those serving indigent and/or vulnerable populations with public funds. Community advisory boards, closely linked to the boards of the behavioral health organizations, foster local support and stakeholder involvement. Representation also is sought from the TCADA Regional Advisory Consortium, according to Haney.

Pilot organizers anticipate development and expansion of a community behavioral health provider network, a working alliance of local providers. An expanded provider network offers the advantages of integrated, comprehensive care management based on individual need. It also allows providers to be compensated through a greater variety of funding sources.

The first pilot to come on line, located in the Texas Panhandle, has begun subcontracting with providers, according to Dave Wanser, Ph.D., TXMHMR director of Service System Development and Implementation.

"It's encouraging to see the level of cooperation between the mental health and substance abuse providers in developing a continuum of behavioral health services."

—*John Keppler, M.D.*

John Keppler, M.D., service improvement coordinator for TCADA's Program Services Division, currently is developing clinical criteria and guidelines for the treatment of substance dependence for use in the Texas Panhandle pilot. Local treatment providers and representatives of the Texas Panhandle Mental Health Authority have had meetings regarding needed services.

"It's encouraging to see the level of cooperation between the mental health and substance abuse providers in developing a continuum of behavioral health services," said Dr. Keppler.

One of the outcomes of the community behavioral health project has been the ability to leverage additional sources of funding.

—NB

Angelfish Project: Hope for a Unique Population

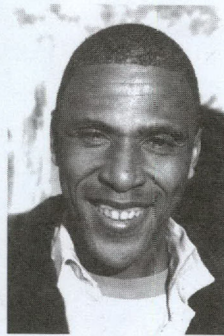

Photo by Carla Daws

Sebron Polk

TXMHMR often faces challenges that, as though cued by Noah, come in pairs. During a 20-year period, the department simultaneously tackled the *Lelsz* and *RAJ* federal lawsuits filed on behalf of the its two primary consumer populations. Now, like human service agencies across the nation, it struggles to address the needs of individuals with a dual diagnosis of mental retardation and mental illness. Many of the demands of this unique population have been met in the Angelfish Project at Corpus Christi State School.

With the 1991 *Lelsz* stipulation that 300 individuals statewide move from state schools into the community each year, the census of Corpus Christi State School began a steady decline that left Angelfish Dorm available for alternative use by 1995. That same year, the dorm became a high-security home to 15 men with mental retardation who had spent most of their lives in and out of state hospitals—consumers who, under the *RAJ* settlement, must be afforded long-term programmatic care at mental retardation facilities.

Angelfish staff have worked to stabilize the symptoms of mental illness, evaluate the abilities of each individual and provide opportunities for the men to gain self-confidence through therapy, employment and recreation. Ultimately, the dorm residents are expected to progress to a less restrictive dorm on campus and become candidates for community placement.

According to David Jones, QMRP (Qualified Mental Retardation Professional), this is possible when "you . . . create a structure and set expectations for each individual according to his abilities and special needs." At Angelfish, the structure consists of two customized systems. A level system corresponding to five degrees of restrictions and privileges targets a resident's particular problem area. Each man begins at Level 3 and signs a contract to eliminate or minimize a certain behavior. When the interdisciplinary team determines the resident has met the contract, he can move to a less restrictive level. A point system based on the individual's personal traits and goals also encourages new behaviors and modifies non-compliant ones. Residents can earn points daily and bank them, or redeem them at the end of the week for rewards such as snacks.

Jones and program psychologist John Guerra agree that work is the best therapy for these individuals. According to ability and interest, the men work on janitorial, lawn and clean-up crews; assemble gravel bags, jump ropes and furniture; sort laundry; fold diapers; or wash dishes.

The life of Sebron Polk, one of the program's first participants, points to the promise Angelfish Dorm holds for individuals who are dually diagnosed. Polk has moved twice since his arrival at Corpus Christi State School and now enjoys the greater privileges of Pompano Dorm. His resumé includes on-campus assembly and dining room work and off-campus employment with a lawn crew, experience Polk hopes will earn him employment on a farm or in a bank someday. Most of all, he said, "I would like to live close to my family in a group home." A transition target date of September 1997 suggests Polk's dream—and perhaps those of others with a dual diagnosis—may soon come to pass.

Contributed by Carla Daws, Community Relations director, Corpus Christi State School.

Photo by Floyd Guyton

The Corpus Christi State School Angelfish Project for individuals dually diagnosed with mental illness and mental retardation has enabled Sebron Polk to gain the skills, self-confidence and appropriate behaviors he needed to obtain off-campus employment in lawn maintenance.

Measuring Outcomes for People

Building a Data Base

Since The Council (formerly The Accreditation Council) developed the *Outcome Based Performance Measures* as the basis of its quality enhancement and accreditation programs (such as QAIS; see pages 4-6), we have collected data on all interviews conducted during on-site quality reviews. During 1994-95, the Health Care Financing Administration (HCFA) supported The Council's efforts to establish a national outcomes data base designed to support continued improvements in the outcome measures. This data base reflects the most comprehensive informational source about the measurement of outcomes for people.

The organizations included in the data base represented a broad spectrum of service and support providers, including statewide family support and respite services and a variety of vocational, day and residential options. Organization size ranged from fewer than 10 to more than 1,000 individuals receiving services. Reviews were conducted across the United States in small rural communities as well as suburban and metropolitan areas.

The Council continues to add the results from all quality review interviews to the data base. Staff from The Council and faculty from The Johns Hopkins University in Maryland currently are studying the data to analyze the relationships between organizational processes and outcomes. This data also is used to gain a better understanding of the relationship between some processes and outcomes and why some people have fewer outcomes.

The presence of outcomes and processes may be related to any number of variables, including staffing, disability, opportunities, communication, or patience in listening, observing and learning on the part of staff. Future research will include exploration of outcomes related to different types of disability, specific categories of organizational processes and cost issues.

Mental Health Field Trials

Early this year, The Council conducted field trials using the *Outcome Based Performance Measures* to assess quality for people receiving mental health services solely. These studies were to determine how well these measures apply in mental health service settings. Although the outcomes originally were developed with participation of people diagnosed with mental illness, to date the tool has been used most frequently in organizations serving people with developmental disabilities.

Organizations in Kentucky, Maryland and North Carolina, along with Dallas County MHMR Center and Hill Country State Operated Community Services, participated with Council staff to assess the usefulness of the outcomes as a measurement tool. Primary questions used in this field experience were:

1. Could outcomes be measured for people with different mental health diagnoses?
2. Did the structure and language of the outcome measures make sense in mental health settings?
3. Was the experience and feedback from review activities useful for mental health professionals?

Results showed the field trials provided a powerful learning experience not only about the *Outcome Based Performance Measures*, but also about the preferences and desires of the people interviewed and the organization's knowledge and response to them. Most participants felt the understanding gained from this experience would assist their organization's quality enhancement efforts as they continue to use the measures to learn more about the people they serve and incorporate the concepts in their ongoing practice.

Contributed by Tina Campanella, vice president, ProLerna, The Council on Quality and Leadership in Supports for People with Disabilities, Towson, MD.

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Homeless Mentally Ill

ACCESS. The National Resource Center on Homelessness and Mental Illness; (800) 444-7415. *Newsletter discusses programs and resources to aid individuals who are homeless and suffer from mental illnesses.*

Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness, 1992. Interagency Council on the Homeless, 451 Seventh Street, S.W., Room 7274, Washington, DC 20410. *Report outlines specific ways governmental agencies and providers can improve the lives of homeless people, including those who have severe mental illness; discusses the ACCESS (Access to Community Care and Effective Services and Supports) program, designed to improve integration of existing federal, state, local and voluntary services.*

The Texas Approach

Psychiatric Rehabilitation: The Texas Approach White Paper. TXMHMR Department of Service System Development and Implementation, P.O. Box 12668, Austin, TX 78711-2668; (512) 206-5583. *Describes an effective psychiatric rehabilitation program as one that involves consumers in their own treatment and development.*

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Piloting Authority/Provider Change in the MHMR System

Throughout the country, states are experimenting with different ways of achieving cost efficiency in public services. "The basic challenge of such efforts are to retain quality services and provide desired outcomes for people with mental disabilities," according to Don Henderson, TXMHMR director of Plan Development for Strategic Planning and Resource Development.

In 1994, a task force consisting of TXMHMR staff, consumers, providers, representatives of state and local governments, and other experts took on that challenge by reviewing the agency's authority and provider roles. House Bill 2377 (HB 2377), passed by the 74th Texas Legislature in 1995, authorized TXMHMR to develop fully the concept of state and local authorities via pilot sites. The legislation designated TXMHMR the state mental health and mental retardation authority responsible for planning; developing policy; coordinating, developing and allocating resources; and ensuring provision of services.

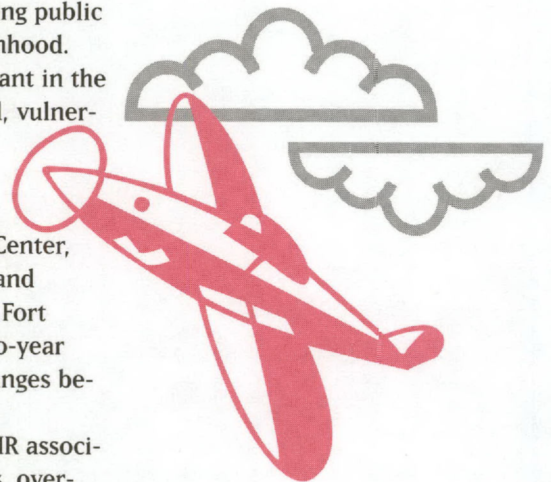
In previous years, these authority roles often had been overshadowed by the agency's function as a provider of state services. However, the authority functions had increased in importance as TXMHMR's responsibilities extended beyond direct provision of services to functions such as becoming the operating agency for Medicaid programs serving persons with mental illness and mental retardation.

HB 2377 enabled TXMHMR to more clearly articulate the concept of a local mental health and mental retardation authority to which the agency may delegate certain functions and duties, including:

- creating a local authority system;
- planning and policy development responsibilities;
- allocating resources; and
- creating and managing a provider network.

Local authorities are expected to consider public input, ultimate cost-benefit and client care issues to ensure consumer choice and the best use of public money when carrying out these activities and in determining whether to become a provider of a service or to contract that service to another organization.

"An overarching goal of HB 2377 is to maximize efficiency and effectiveness in the public sector," Henderson said. "To achieve this goal, we are adopting private sector business practices while emphasizing public sector values of dignity and personhood. These values are especially important in the long-term treatment of stigmatized, vulnerable populations."



Pilots Taking Off

Austin Travis County MHMR Center, Lubbock Regional MHMR Services and Tarrant County MHMR Services in Fort Worth are the pilot sites. Their two-year contracts to implement system changes began in September 1996.

Carol Houston, Ed.D., TXMHMR associate director of Community Services, oversees implementation of HB 2377 at the sites. She chairs the project core team, which developed service and business systems products for use at the sites. These include standardized contract templates for contracting with providers; a method for assessing the risk involved when contracting with providers; a data-based method of evaluating the performance of providers to determine their effectiveness and efficiency relative to the local market and whether the center should renew the contract; a plan for involving providers and consumers in continuously improving quality and efficiency of services provided; and guidelines that enable the local authority to manage services, ensuring that individuals receive the right service, at the right time.

In addition, Houston coordinates the state authority team members with local authority network members. An oversight committee provides guidance to the core team and reviews the pilot sites. The committee is composed of executive directors from the pilot centers, consumers, advocates, the TXMHMR commissioner and his executive staff.

Designing Roadmaps to Change

Several changes identified in HB 2377 are being implemented statewide via new or revised provisions in the performance contracts, Henderson noted. Examples include requirements in the areas of planning and coordination.

Separate planning advisory committees develop local plans for mental health and mental retardation services. Fifty percent of the members of each committee must be individuals with a mental disability or their family members. "The plans are designed to be a roadmap for local community services and to contribute to TXMHMR's statewide strategic plan," said Henderson.

Evaluating Effectiveness

The TXMHMR Citizens Planning Advisory Committee will oversee evaluation of the pilots in terms of outcomes for consumers, quality of care, cost-effectiveness, separation of authority and provider roles and related issues. They also will make recommendations about TXMHMR efforts to implement local planning in the pilot sites and throughout the state. In particular, they will focus on incorporating managed care principles in local planning processes as well as adequacy and appropriateness of the functioning of local planning councils.

The LBJ School of Public Affairs at The University of Texas at Austin is reviewing project implementation.

In addition, TXMHMR also will monitor implementation of the pilots through regular contract monitoring, site consultation and other informal means.

An article by the mother of a consumer in the Tarrant County MHMR Services pilot appears below.

—JM

What the Pilot Program Means to Me

Choice—that's what the authority pilot means to me.

When all services had to come through Tarrant County MHMR Services (TCMHMR), my daughter, Marci, was placed in the Career Center. I commend the center and its dedicated staff for the work they do, but that placement isolated Marci from the inclusive community environment that she needs.

Under the authority pilot concept, the Home Community Support staff members were able and willing to remove Marci from the Career Center and push out in another direction. They developed a "futures plan" for Marci's life. The plan recognizes Marci's limitations, of course, but focuses on her strengths also.

Bill Eaton of the TCMHMR staff worked out a job profile for Marci that matched her capability and body movements to possible tasks that she could enjoy and accomplish. As a result, Marci got a job with the *Fort Worth Star-Telegram*, beginning with three hours a week. A support person will be with Marci as she works.

Her work will be simple—operating a stapler—but she will benefit from work fulfillment and being around people. Marci understands 'start' and 'finish,' and absolutely loves to accomplish things. This opportunity means a great deal to her.

Photo by Claude Crowley

From left, Yolanda Ellison, Marci Garvin and Elaine Garvin.

Marci isn't going to be a miracle as a result of the pilot program. She isn't going to walk or have unlimited communication, but the pilot program has opened doors for her into the community. She now has choices and a life.

I think this is going to be the wave of the future. Clients will have more choices. Professional staffs can explore creative ideas, bringing jobs to light that will take advantage of clients' potential and give them fulfillment. People around the clients will recognize them as individual, productive persons. I think it's wonderful.

Contributed by Elaine Garvin, mother of consumer Marci Garvin and chairperson of the Tarrant County MHMR Services Mental Retardation Community Advisory Committee. Garvin was interviewed for this article by Shelley Buttgen, director of Community Relations, Tarrant County MHMR Services.

Photo by Sherry L. Grona

"I'm glad to have my health back." —Wray Morrison

Over the past decade, Wray Morrison has suffered from bipolar disorder and schizophrenia. He also has wrestled with alcoholism. That last factor is not uncommon. Persons with major mental illness are three to six times more likely to have a co-occurring substance abuse disorder than the general population; in many cases, they abuse drugs or alcohol as a means of self-medication.

In December 1996, Morrison's mental illness symptoms and alcoholism became so severe he had trouble functioning. It scared him so badly, he decided he really needed help. But like many people with mental illness, he was reluctant to go in for treatment. One of his roommates convinced him to call the Central Texas Partnership, which is being piloted in the dual diagnosis project of TXMHMR and the Texas Commission on Alcohol and Drug Abuse (TCADA). (See related article, page 16.) He entered the program in January.

At the Partnership, which is operated by a coalition of Central Texas urban and rural mental health and substance abuse treatment providers, Morrison participated in classes about his illnesses. "You learn that the illnesses are caused by chemical imbalances in the brain. The importance of taking your medication is emphasized," he said.

The educational aspect of the treatment wasn't as aggressive when Morrison went through a different program in the 1980s. Also, he wasn't consulted about his treatment or included as a member of his "treatment team"—a feature of the Partnership.

Morrison, whose family lives in a different area of the state, said the one-on-one attention and support he received from the Partnership staff was key to his rapid recovery.

"The staff members are very friendly and helpful; they've always been there when I've needed them."

Through the Partnership, Morrison joined Alcoholics Anonymous, which has helped him stop drinking. "I thought I could go out and just have a couple of drinks and not have to take my medication, but such was not the case."

He now sees a bright future ahead. His symptoms are under control. He goes to counseling and takes his medications as prescribed. He has his own apartment, as well as a home computer on which he sharpens his computer skills. He works part time while looking for full-time employment.

"I have a whole new outlook on life. The Partnership gave me new ideas on how to live my life—the importance of studying, reading and exercise.

"I can't begin to say how much it [the Partnership] has done for me," Morrison added. "It's been incredible."

—NB

Personal/Notes

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Breaking Down Barriers, Building Networks

Texas is in its third year of a four-year service system improvement grant, the state's third such grant from Community Support Programs (CSP) of the federal Center for Mental Health Services. In turn, TXMHMR has channeled CSP funds to local efforts through grants.

Mike Maples, CSP coordinator for TXMHMR, said recipients developed consumer and family networks in collaboration with local chapters of the Texas Alliance for the Mentally Ill and Texas Mental Health Consumers. "Through the grant projects, the state has involved consumers and family members in planning, policy, training and evaluation related to service provision," he explained.

TXMHMR awarded one of two demonstration grants for joint efforts by a coalition of the Gulf Coast Center, Gulf Coast Mental Health Consumers and Gulf Coast Alliance for the Mentally Ill. The South Texas Consumer and Family Consortium received the other demonstration grant.

Exemplifying the spirit of the CSP grants, Galveston's coalition members serve together on advisory committees and boards of the Gulf Coast Center, unite to participate in housing and cultural competence initiatives for persons with mental illness and develop training models, newsletters and other materials to strengthen the consumer and family groups.

CSP development grants were awarded to the Region V Psychiatric Rehabilitation and Implementation Team and Sabine Valley MHMR to promote education and support of consumers and family members through development of new support groups, educational materials and regional conferences to identify local needs.

"The CSP grant projects show that collaboration works," Maples said. "By integrating development of networks of support for consumers and families with required local planning, TXMHMR is encouraging such collaborations to become typical rather than exceptional."

—LL

Upcoming Themes

- TXMHMR and Education
- A Safe Place for TXMHMR Consumers

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