Legislative Oversight Committee on Mental Health and Mental Retardation

Report to the Texas Legislature February, 1985

Volume I: Mental Health

Volume I: Mental Health

Legislative Oversight Committee on Mental Health and Mental Retardation

Report to the Texas Legislature February, 1985

Reports available March, 1985
- Volume I: Mental Health
- Volume II: Community Residential Survey
- Volume III: Mental Retardation

Coordinated and staffed by:
Mental Health Association in Texas
1111 W. 24th Street
Austin, Texas 78705
(512) 476-0611

TABLE OF CONTENTS

LEGISLATIVE OVERSIGHT COMMITTEE

ON

MENTAL HEALTH AND MENTAL RETARDATION

Volume I: Mental Health

EXECUTIVE SUMMARY

Texas is facing a crisis in the delivery of mental health services. The state is under federal court order to improve the care and treatment in state hospitals; many communities lack the basic services which individuals need to avoid inappropriate hospitalization and to function in the community at optimal levels; the service delivery system has failed to keep pace with the growth of the population of the state; the state legislature is facing its most severe budget limitations in decades. In this atmosphere of increasing demand for more and better services coupled with severe financial stress, the old ways of doing business are no longer adequate.

In response to this crisis, in June, 1984, Lieutenant Governor William P. Hobby and House Speaker Gibson D. Lewis appointed the Legislative Oversight Committee on Mental Health and Mental Retardation. The Committee was charged with advising the 69th Legislature about future directions for mental health and mental retardation services in Texas and about policy recommendations to support implementation of those directions. The Committee, comprised of lawmakers, service providers, advocates and other experts, has studied the existing service delivery system to determine how available resources can best be utilized to address client needs now and in the future.

Among the findings and recommendations of the Legislative Oversight Committee:

- The first dollar spent for mental health services in Texas must be for *screening and emergency services.* A survey shows that many Texas communities are lacking in this capability.

- *Case management* must be implemented as a fundamental method of service delivery for clients with long term and multiple needs.

- The *organization and management of the mental health service delivery* system must be strengthened to encourage coordination and accountability at all levels. Specific recommendations in this regard include replacing the current state grant-in-aid system of funding community mental health and mental retardation centers with legally binding contracts, increased coordination with substance abuse providers and stronger quality assurance monitoring.

- There is a lack of *community residential alternatives* throughout the state. A goal of 60 alternate care beds per 100,000 population must be pursued.

- There is no operational *long range strategic plan* that enables compliance with provisions of the Settlement Agreement in the R.A.J. vs. Miller federal lawsuit. The Texas Department of Mental Health and Mental Retardation must implement such a plan by August 31, 1985. Included in the plan must be the setting of priority populations to insure that those in greatest need receive services first. Appropriate services to meet the needs of these individuals must also be outlined.

The report contains recommendations of the Legislative Oversight Committee on Mental Health and Mental Retardation regarding mental health issues only. Companion documents, one addressing mental retardation issues and the other a survey of community residential alternatives, will be issued at a later date.

February, 1985

RECOMMENDATIONS

CHAPTER 1: COMPLIANCE

RECOMMENDATION 1 The Texas Department of Mental Health and Mental Retardation must initiate a strategic plan for full compliance, including timetables and delineation of responsibilities.

RECOMMENDATION 2 The Texas Department of Mental Health and Mental Retardation must identify and project the costs related to incremental implementation of elements of the plan.

RECOMMENDATION 3 The Texas Department of Mental Health and Mental Retardation must insure full implementation of the Commissioner's Rules on Clients' Rights.

RECOMMENDATION 4 The Legislature must appropriate sufficient funds in the Texas Department of Mental Health and Mental Retardation budget to insure compliance.

CHAPTER 2: ESTIMATING THE AT RISK POPULATION

NO RECOMMENDATIONS

CHAPTER 3: PRIORITY POPULATIONS

RECOMMENDATION 5 The Texas Department of Mental Health and Mental Retardation must adopt a method to prioritize the populations to be served by the mental health system and must redesign the service delivery system to serve the priority populations appropriately and in the most cost-effective manner possible. The prioritization method must be based on the one described in this report.

RECOMMENDATION 6 The Texas Department of Mental Health and Mental Retardation must initiate data collection to determine the number of individuals in the various priority groups as a basis for service planning.

RECOMMENDATION 7 The TDMHMR budgeting, funding, and expenditure process, including the awarding of service contracts, must be tied directly to the provision of services to priority populations.

CHAPTER 4: SERVICES

RECOMMENDATION 8 The Texas Department of Mental Health and Mental Retardation must insure that appropriate services are implemented for each priority group. To accomplish this, a plan for incremental implementation, and for a redirection of funds will be necessary.

RECOMMENDATION 9 The Texas Department of Mental Health and Mental Retardation must assure that people within each service area have access to (1) 24-hour emergency screening and rapid stabilization services; (2) crisis hospitalization; (3) initial assessment performed in the community, with that assessment including the development of a multi-disciplinary treatment plan.

RECOMMENDATION 10 TDMHMR's funding to a service area must be contingent upon certification of the availability of screening/emergency services or the inclusion of such services within the budget of the funds being allocated.
RECOMMENDATION 11 For persons not charged with a criminal offense, jails are not acceptable holding facilities. Appropriate alternatives for mental health crisis stabilization and substance abuse detoxification must be developed.
RECOMMENDATION 12 Each Designated Provider must coordinate the provision of services with other agencies concerned with the care and treatment of individuals with drug or alcohol problems.
RECOMMENDATION 13 Having assured the availability of screening and emergency services, TDMHMR shall contract, using existing funds, with each Designated Provider to make case management services available in each service area.
RECOMMENDATION 14 The definition, standards and job descriptions as developed by the Task Force on Case Management shall serve as self-monitoring tools and TDMHMR auditing instruments.
RECOMMENDATION 15 The Legislature should amend the Mental Health and Mental Retardation Act (Article 5547-201 et seq., V.T.C.S.) to strengthen the requirement for the Texas Department of Mental Health and Mental Retardation to have a discharge plan for every patient leaving the hospital. This discharge plan must include the assignment of a case manager when appropriate and a description of the appropriate community-based services which have been obtained for the individual.
RECOMMENDATION 16 The Texas Department of Mental Health and Mental Retardation must, as part of a comprehensive strategic planning process, initiate a plan for the future role of state hospitals, with consideration of size, function, and specialization. This plan must include criteria for phasing out uneconomical and unneeded beds.
RECOMMENDATION 17 The Mental Health Code Committee should investigate revisions of the Code which would increase appropriate utilization of commitments to community-based services in lieu of commitments to hospitals.
RECOMMENDATION 18 The Texas Department of Mental Health and Mental Retardation should initiate respite services for the natural support system of people who are mentally ill.
RECOMMENDATION 19 The Texas Department of Mental Health and Mental Retardation must insure that regional needs assessments include information about the availability of services of public and private agencies, their eligibility requirements, location, and other factors, and that regional planning for services include input from public and private providers beyond the TDMHMR service delivery system.

CHAPTER 5: COMMUNITY RESIDENTIAL ALTERNATIVES
RECOMMENDATION 20 The Legislature should establish a certification authority for small congregate living facilities that offer a safe home-like environment and are permitted to offer training and support in daily living skills, including medication "monitoring". These "enhanced boarding homes" would require consultation and support from the Designated Provider.
RECOMMENDATION 21 The Texas Department of Mental Health and Mental Retardation and the Legislature must continue to develop incentives for community-based residential programs, both public and private.
RECOMMENDATION 22 The Texas Department of Mental Health and Mental Retardation must establish a goal of 60 community residential beds per 100,000 population.

RECOMMENDATION 23 The Texas Department of Mental Health and Mental Retardation and the Insurance Commission must work with the insurance industry to develop a plan for reimbursement of the expenses for rehabilitative residential care in lieu of more costly alternatives.
RECOMMENDATION 24 The Texas Department of Mental Health and Mental Retardation, the Department of Human Resources, the Texas Education Agency, and the Texas Rehabilitation Commission must develop a specific plan of action to determine how resources from Title XIX, Title XX, and the Vocational Rehabilitation Act could be more effectively utilized to assist the mentally disabled.

CHAPTER 6: PLANNING
RECOMMENDATION 25 The Texas Department of Mental Health and Mental Retardation must initiate a long-range strategic plan of at least six years' length. The plan should be completed by August 31, 1985 and should be updated every two years. Funding for the 1988-89 biennium should be based on a tactical plan derived from this long-range plan. A comprehensive needs assessment and resource inventory must be undertaken as a part of this plan. The biennial budget should be based on the results of this process with both new program funding and continuation funding based on demonstrated needs.
RECOMMENDATION 26 The Office of Strategic Planning of the Texas Department of Mental Health and Mental Retardation should undertake development of the six-year plan described in Recommendation 25. Adequate and appropriate staff must be available to plan and assess the outcomes of programs designed to meet the needs of clients in the priority populations previously identified. Without being excessively prescriptive, the Committee recommends the inclusion of individuals with special expertise in sociology, economics, epidemiology, and data analysis within this planning staff.
RECOMMENDATION 27 The Texas Department of Mental Health and Mental Retardation must insure that the senior administrative staff responsible for service delivery at the system, regional, or community level receive the necessary support for their individual planning efforts from the TDMHMR planning staff. This support must include current literature reviews and timely needs assessment information, as well as appropriately organized planning documents and forms.
RECOMMENDATION 28 An information data base appropriate to this planning effort should be developed and maintained by the TDMHMR Office of Strategic Planning to assure timely access to current and historical needs and resource information.
RECOMMENDATION 29 The Texas Department of Mental Health and Mental Retardation must insure that information related to needs and resources is maintained in a way that makes it accessible for tactical planning by both public and private service providers.

RECOMMENDATION 30 The Texas Department of Mental Health and Mental Retardation must insure that, at minimum, the following elements are included in this long-range planning effort:

A. Quantifiable output and outcome indicators must be identified.
B. The plan must include
    1) identification of priority populations,
    2) identification of the minimum array of necessary services, and
    3) a description of the appropriate use of facilities.
C. Every two years, assessment of the progress made toward achieving the goals identified in the plan must be undertaken as a part of the budget preparation process.
D. Biennial budget requests must be directly tied to the long-range plan.
E. All stages of the long-range planning activities of the Department must be accomplished with the oversight of a citizens planning advisory council.

RECOMMENDATION 31 The Committee acknowledges that funding for services is a prerogative exercised by the Legislature every two years and the plan must be modified to conform to this reality. The Texas Department of Mental Health and Mental Retardation must initiate regular updates of the plans preceding a biennium to identify quantified increments of movement toward long-term goals and to reassess the impact of the prior budgeting process.

RECOMMENDATION 32 Regional and community planning must be undertaken and should be under the general direction and enjoy the support of TDMHMR's Office of Strategic Planning.

RECOMMENDATION 33 Uniform data collection in all regions should be implemented to provide an accurate assessment of client needs and the array of services available. The Texas Department of Mental Health and Mental Retardation should be responsible for the development of appropriate data collection tools and for assisting regions and communities in this data recovery and must insure that at the regional level provisions are made for the input to and from the system planning group and those individuals responsible for individual client planning.

RECOMMENDATION 34 Planning at the regional/community level should address the coordination of efforts among mental health, alcohol and substance abuse, and other service workers in providing client services.

CHAPTER 7: MANAGEMENT

RECOMMENDATION 35 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-201 et seq. V.T.C.S.) to give authority to the Texas Department of Mental Health and Mental Retardation to select among candidates for Designated Providers, with selection based on past performance and/or capacity to deliver required services to priority populations, as determined by the TDMHMR Board.

RECOMMENDATION 36 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-204 V.T.C.S.) to replace the grants-in-aid program with legally binding contracts for services between the Texas Department of Mental Health and Mental Retardation and community-based service providers. These contracts should include the kinds of services to be developed, designation of priority populations, expected performance standards and outcome measures.

RECOMMENDATION 37 The Commissioner of the Texas Department of Mental Health and Mental Retardation should be required to withhold funds from a Designated Provider when the terms of a contract are not met.

RECOMMENDATION 38 The Texas Department of Mental Health and Mental Retardation must give equal emphasis and recognition to the state mental hospitals' community-based services and the community mental health and mental retardation centers.

RECOMMENDATION 39 The Texas Department of Mental Health and Mental Retardation must retain the option of contracting for services with another provider in a Service Area if the community mental health and mental retardation center is not responsive to state policy direction or is not performing in a satisfactory manner.

RECOMMENDATION 40 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-201 et seq., V.T.C.S.) to require that community mental health and mental retardation centers develop policies which are not in conflict with policies developed by the Board of the Texas Department of Mental Health and Mental Retardation.

RECOMMENDATION 41 The Texas Department of Mental Health and Mental Retardation must develop a system of accountability at the regional level to allow for funding to flow with the client population. This requires both regional service planning and budget flexibility. The Department should, therefore, inititate regional budget development. The Department should also consider increasing the number of regions to facilitate accountability and communication. Thirdly, the Department should develop policies which enhance regional planning and service coordination; examples may include:

- procedures to serve an individual outside the service area,
- mechanisms to buy goods and services in a cost-effective manner,
- prompt response to crisis situations which require policy interpretation.

RECOMMENDATION 42 The Texas Department of Mental Health and Mental Retardation must implement a standardization of qualifications for positions throughout its system and must fill those positions with individuals who meet the stated qualifications.

RECOMMENDATION 43 For key administrative positions (including Commissioner, Deputy Commissioners, Assistant Deputy Commissioners, State Hospital Superintendents, State Center Directors, Community MHMR Center Executive Directors), the Texas Department of Mental Health and Mental Retardation must develop more specifically defined job descriptions with requirements which balance clinical/programmatic knowledge and demonstrated successful management experience.

RECOMMENDATION 44 Mechanisms must be implemented which hold key administrative personnel of the Texas Department of Mental Health and Mental Retardation accountable for successful outcomes of their efforts, as well as for appropriate process.

RECOMMENDATION 45 Executive Directors of community mental health mental retardation centers should be appointed by the center's Board of Trustees and confirmed by the TDMHMR Board.

RECOMMENDATION 46 Further study should be given to the costs of making state benefits accessible to center staffs.

RECOMMENDATION 47 The Legislature should direct the appropriate officials of the Texas Department of Mental Health and Mental Retardation, the Department of Human Resources and the Health Department to address the problems of jurisdictional overlap and areas of ambiguous authority and to recommend statutory changes as appropriate. Most urgently needed is resolution to the problems of alternate care licensure and certification, funding, and utilization described in Chapter 5.

RECOMMENDATION 48 The alcohol commitment law must be updated to make it consistent with the Mental Health Code. The law should mandate screening of alcohol commitments by the community mental health centers.

RECOMMENDATION 49 Coordination among the Texas Department of Mental Health and Mental Retardation, the Texas Commission on Alcoholism, and the Texas Department of Community Affairs should be implemented which requires consistent goal setting, coordination of programs and service funding, appropriate referral mechanisms, the removal of unclear lines of authority, and common patient identification which allows tracking of clients through the various programs funding by the three agencies.

RECOMMENDATION 50 The Texas Commission on Alcoholism must design a system to eliminate the admission of alcohol patients to state hospitals. Funding should be provided to replicate these programs, initially in areas of highest state hospital admission rates, and then expanded as rapidly as possible to the balance to the state, in two-year increments. These programs should be developed jointly with local Designated Providers of mental health services.

RECOMMENDATION 51 The Texas Department of Mental Health and Mental Retardation must implement a centralized system of current and historical information on clients, services, and funds. This requires that community mental health centers and other contract providers report information in a manner consistent both in content and timeliness with other elements of the system. This approach should allow the tracking of individual clients through the total system.

RECOMMENDATION 52 The Texas Department of Mental Health and Mental Retardation must implement a uniform cost-reporting system which includes identification of standard units of service.

CHAPTER 8: FUNDING AND FISCAL ACCOUNTABILITY

RECOMMENDATION 53 Modify the Mental Health and Mental Retardation Act (Article 5547-203 V.T.C.S.) to permit fiscal audits of CMHMRCs to be conducted in a more cost-effective way. Possible alternatives: a) fiscal audit by TDMHMR, b) regional contracting for auditing of several agencies by private firms, or c) interagency agreement to audit cooperatively.

RECOMMENDATION 54 The Legislature should include in the TDMHMR Appropriations Bill language which reinforces the state's control over the use by CMHMRCs of TDMHMR contract funds and funds used as match. Expenditures of other local funds is the prerogative of the local Board of Trustees.

RECOMMENDATION 55 The Mental Health and Mental Retardation Act (Article 5547-203, V.T.C.S.) should be modified to reflect that, unless the agency is prohibited from fee collection by contracts with other agencies or by another state law, all clients of CMHMRCs and outreach centers should be requested to pay at least a nominal amount for services they receive.

RECOMMENDATION 56 The Texas Department of Mental Health and Mental Retardation must establish a uniform fee collection policy for community mental health and mental retardation centers and state hospital outreach programs that would increase local revenues. Implementation of the policy should be monitored by TDMHMR Internal Audit Staff.

RECOMMENDATION 57 TDMHMR Appropriations legislation should require fee collection by CMHMRCs and outreach centers, at a level based on an appropriate percentage of their assessed fees.
RECOMMENDATION 58 To facilitate collection by CMHMRCs, TDMHMR's claims legislation must be reviewed to determine its applicability to Centers.
RECOMMENDATION 59 The Committee urges enactment of the Legislative Budget Board's recommendations regarding ways to increase state hospital collections. The Legislature should consider an incentive system allowing retention by TDMHMR facilities of fee collections over a set amount.
RECOMMENDATION 60 The Legislature through its appropriate standing committees should clarify state law regarding county legal responsibility for medical care, including mental health care, for their indigent residents.
RECOMMENDATION 61 The Texas Department of Mental Health and Mental Retardation must clarify the issue of "county of residence" and the residents rights to services and establish a policy regarding the availability of services to "non-residents".
RECOMMENDATION 62 The Legislature or other appropriate entity must undertake a study of optional services provided under the State Medicaid Program to determine the potential savings to the state of providing certain mental health services.

CHAPTER 9: QUALITY ASSURANCE
RECOMMENDATION 63 The Legislature should modify the Mental Health and Mental Retardation Act (Article 5547-203, V.T.C.S.) to allow for more cost-effective means of obtaining program audits for CMHMRCs, including interagency agreements to audit cooperatively or to accept one anothers' audits.
RECOMMENDATION 64 The Texas Department of Mental Health and Mental Retardation must develop standards of care and monitoring mechanisms which insure consistent quality whether the service is provided by a Texas Department of Mental Health and Mental Retardation facility or a contract service provider.
RECOMMENDATION 65 The Texas Department of Mental Health and Mental Retardation must provide direct quality assurance monitoring and evaluation. This should not be delegated.
RECOMMENDATION 66 In designing a quality assurance system, the Texas Department of Mental Health and Mental Retardation must identify outcome measures and must insure that performance evaluation encompasses both quality and cost-effectiveness.
RECOMMENDATION 67 The designation and/or redesignation of the Designated Provider of mental health services for a Service Area must be based on performance evaluation and capacity.
RECOMMENDATION 68 The Texas Department of Mental Health and Mental Retardation must establish a mechanism to insure that the screening and emergency services recommended in Chapter 4 of this report are available and accessible to clients throughout the state.
RECOMMENDATION 69 The Texas Department of Mental Health and Mental Retardation must require that needed services are accessible to the priority populations.
RECOMMENDATION 70 The Texas Department of Mental Health and Mental Retardation must institute a well-publicized centralized telephone access for individual clients' complaints, for information, and for problem-solving.

RECOMMENDATION 71 The Texas Department of Mental Health and Mental Retardation must require that quality assurance staff in all portions of the service delivery system receive ongoing training to insure consistent interpretation of standards.

RECOMMENDATION 72 The Texas Department of Mental Health and Mental Retardation must pursue systematic training and retraining effort of direct care staff to insure that the quality of care is uniform throughout the system.

I N T R O D U C T I O N

Texas is facing a crisis in the delivery of mental health services. Individuals who suffer from mental illness, and who need the services provided by the state, are too often victimized by the lack of availability and accessibility of appropriate and needed services. Among the issues:

- the state is under federal court order to improve the care and treatment in state hospitals for the mentally ill;
- many communities lack the basic services which individuals need to avoid inappropriate hospitalization and to function in the community at their optimal levels;
- individuals in greatest need are often those least able to negotiate the complex services system and are thus effectively denied services;
- as the population of Texas continues to grow, demands on the mental health services system will undoubtedly increase;
- the state legislature is facing its most severe budget limitations in decades.

In this atmosphere of increasing demand for more and better services coupled with severe financial stress, the old ways of doing business are no

longer adequate. It is time for Texas to take a serious look at how to use available resources to address the need for improved patient care in the most effective and efficient manner possible with the goal of building a services system which will not only resolve the current crisis but also meet the future needs of the citizens of Texas.

RESPONSE FROM THE LEGISLATURE

In response to this crisis, in June, 1984 Lieutenant Governor William P. Hobby and Speaker of the House Gibson D. Lewis appointed the Legislative Oversight Committee on Mental Health and Mental Retardation. The Committee was charged with advising the 69th Legislature about future directions for mental health and mental retardation services in Texas and about policy recommendations to support implementation of those directions. The Committee, comprised of lawmakers, service providers, advocates and other experts, has studied the existing service delivery system to determine how available resources can best be utilized to address client needs now and in the future.[1]

This report contains the recommendations of the Legislative Oversight Committee on Mental Health and Mental Retardation regarding mental health issues. Companion documents, one addressing mental retardation and the other a survey of community residential alternatives, will be issued at a later date.

---

[1] The Charges to the Committee and a roster of Committee members appear as Appendix A.

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

The Texas Department of Mental Health and Mental Retardation (TDMHMR) was created by the Texas Legislature in 1965, with the passage of House Bill 3, the Mental Health and Mental Retardation Act. TDMHMR replaced the Board for Texas State Hospitals and Special Schools. In addition, the Act authorized local agencies to create community mental health and mental retardation centers.

This Act was the initiation of the state's efforts to provide mental health services in community settings. Two major factors predicated this move:

(1) the increased utilization of psychotrophic medications, which stabilized certain conditions, and

(2) a major federal initiative to develop additional community alternatives.

The trend towards community services has continued, in spite of lessened federal support and funding, because of a generally held belief that community-based care is both more humane and more cost-effective.

TDMHMR is charged with providing a broad range of services to the mentally impaired citizens of Texas. TDMHMR provides these services through the operation of eight mental hospitals, the Waco Center for Youth, thirteen state schools, the Texas Research Institute of Mental Sciences, five human development centers and a rehabilitation/recreation center. The agency also has responsibility for the development and oversight of thirty-one community mental health and mental retardation centers (CMHMRCs).

State Hospitals

State hospitals are located in Austin, Big Spring, Kerrville, Rusk, San Antonio, Terrell, Vernon and Wichita Falls. In Fiscal Year 1984, there were 19,144 direct admissions to Texas state mental hospitals and 19,216 discharges. At the end of the year, there were 4,928 patients in residence, a reduction of 9.09% from the end of 1983. The average daily population of the hospitals was 5,228.

Although this number of admissions to and discharges from state hospitals indicates a large turnover in the patient population, there appears to be a a substantial population of long-term residents in the facilities. According to a study completed by TDMHMR, in May, 1984, at the end of Fiscal Year 1983, the resident population was 5,376; of this number 2,275, or 42.3%, had been hospitalized for more than one year. Of the total population, 50.6% were hospitalized for more than five years; 30.1% were hospitalized for more than ten years; 54.4% were diagnosed with schizophrenia; 27.9% were admitted prior to their 30th birthday; 56.4% had only one admission to the hospital.[2]

In Fiscal Year 1984, $170,828,607 was spent to operate state hospitals including the Waco Center for Youth. Of the total amount spent, $167,049,414 was from the General Revenue Fund. There were 8,856 authorized full-time equivalent positions. The average daily cost per state hospital resident was $84.68.

State Schools

TDMHMR operates state schools for the mentally retarded in Abilene,

---

[2] Virginia Mickel, The Long Term Client in State Mental Hospitals (TDMHMR Office of Strategic Planning,) May, 1984.

Austin (Austin State School and Travis State School), Brenham, Corpus Christi, Denton, Fort Worth, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio. In Fiscal Year '84, there were 353 admissions (of all kinds) to Texas state schools and 538 separations (discharges, transfers and deaths). The total population at the end of the year was 9,474, or a reduction of 2.3% from the end of 1983. The average daily state school population was 9,474. In Fiscal Year '84, $237,964,653 was spent to operate state schools, of which $228,195,255, came from the General Revenue Fund. There were 14,068 full-time equivalent positions. The average daily cost per state school resident was $67.66.

State Centers

State Centers are found in Amarillo, Beaumont, El Paso, Laredo, and the Rio Grande Valley. They provide a variety of educational, training, respite and residential services to both mentally ill and mentally retarded individuals.

In Fiscal Year '84, a total of $25,066,238 was spent to operate the five state centers, of which $22,945,071 were General Revenue funds. There were 1,209 full-time equivalent positions funded.

Community Mental Health Mental Retardation (MHMR) Centers

The thirty-one Community MHMR Centers serve individuals either directly or by contract in 137 Texas counties. They offer a wide range of mental health, mental retardation, and substance abuse services. In Fiscal Year '83, the centers served 135,370 clients. It is estimated that a total of $142,959,228 was expended by community centers in Fiscal Year '84, of which $85,582,533 (or 59.8%) were state grant-in-aid funds. The state grant-in-aid

was comprised of $76,225,480 General Revenue Funds and an estimated $9,357,053 in federal block grant funds.

Other Services

In addition to these services, TDMHMR operates a variety of other programs, services and speciality units, as well as program administration, through the Central Office. These include centralized food purchases, Leander Rehabilitation Center and Texas Research Institute of Mental Sciences (TRIMS). In Fiscal Year '84, the aggregate total spent on these other activities was $49,490,297. With the addition of $14,832,833 expended for construction, the total TDMHMR expenditures in Fiscal Year '84 were $583,765,161. Of this, $554,418,236 were General Revenue Funds.

WHERE TEXAS RANKS AMONG STATES

Although it is recognized that the budget of TDMHMR is a large portion of the state budget, it is useful to identify where Texas ranks among the states in allocations for mental health services. A January, 1984, study conducted by the National Association of State Mental Health Program Directors produced the following results (based on Fiscal Year '81 data):

1. Texas ranks 9th among the states in overall program expenditures for mental health services, but 48th in per capita expenses.

2. Texas ranks 20th in the percentage of its mental health dollars used for state hospitals, 39th in per capita expenditures for state hospitals.

3. Texas ranks 34th in the percentage of its mental health dollars used on community-based programs, 43rd in per capita expenditures for community-based programs.

4. Texas ranks 6th in combined expenditures for research, training, and administration as a percentage of total mental health expenditures (20th per capita).[3]

Texas is the third most populous state in the nation and therefore requires large expenditures for services provided to its residents. The low rankings in per capita expenditures for mental health services raise concern about the level of effort in maintaining the state-sponsored service delivery system.

R.A.J. VS. MILLER

Filed as a class action in 1974 in the U.S. District Court for the Northern District of Texas, this lawsuit alleged inappropriate and inadequate care and treatment of patients in Texas' state hospitals. The lawsuit was settled in April, 1981. In April, 1982, Federal District Judge Barefoot Sanders appointed the R.A.J. Review Panel to monitor compliance and ensure implementation of the Settlement Agreement.

The plaintiffs included all former, present, and future patients at the eight state mental hospitals.

The defendants are the Board and executives of the State of Texas Department of Mental Health and Mental Retardation. The United States Justice Department is involved as amicus curiae.

The specific subject matter of the lawsuit includes the following issues:

- Patients' rights
- Safety of physical facilities
- Inappropriate, excessive use of drugs
- Inaccessibility of buildings to handicapped patients

---

[3] Robert Glover, Ph.D., Noel A. Magade, Ph.D., Theodore Luttman, Harry C. Schnebbe, Final Report Funding Sources and Expenditures for State Mental Health Agencies: Revenue/Expenditure Study Results (Washington, D.C.: National Association of State Mental Health Program Directors, Jan. 1984).

- Treatment and placement of mentally retarded mental patients
- Programs for geriatric patients
- Transitional services and continuity of care
- Accreditation of facilities
- Transfer of prisoners to state hospitals, and
- Funding

Issues currently being monitored include:

- Individualized treatment planning
- Placement of clients with mental retardation who no longer need inpatient hospitalization
- TDMHMR 1986-1987 budget request as it applies to the R.A.J. Settlement Agreement
- Staffing requirements
- Aggressive behavior in state hospitals
- Use of psychotrophic medications

The Legislative Oversight Committee on Mental Health and Mental Retardation has received regular reports on the status of the implementation of the Settlement Agreement. Taken collectively the Committee's recommendations constitute a long term approach to implementation of the stipulations in the Settlement Agreement and the principles they represent.

CHAPTER 1

COMPLIANCE

The requirements of the settlement in the R.A.J. vs. Miller lawsuit involve a variety of issues related to the quality of care and appropriateness of services in the Texas public mental health facilities. As discussed, the Texas Department of Mental Health and Mental Retardation is in compliance with the requirements of the Settlement Agreement on several of these issues. It is the position of the Legislative Oversight Committee on Mental Health and Mental Retardation that compliance with the provisions of the Settlement Agreement as determined by the court must be the highest priority for the Department. To do so the Committee offers several recommendations.

In order to achieve full compliance:

RECOMMENDATION 1 The Texas Department of Mental Health and Mental Retardation must initiate a strategic plan for full compliance, including timetables and delineation of responsibilities.

RECOMMENDATION 2 The Texas Department of Mental Health and Mental Retardation must identify and project the costs related to incremental implementation of elements of the plan.

RECOMMENDATION 3 The Texas Department of Mental Health and Mental Retardation must insure full implementation of the Commissioner's Rules on Clients' Rights.

In addition, the Committee recognizes the necessity of adequate funding as a means of addressing these concerns. While recognizing the difficult

financial situation faced by the state, the Committee is concerned that the budget as reported out of the Legislative Budget Board in December, 1984, is not adequate to address either the lawsuits or the needs of the priority populations identified in this report. We believe that there must be budget flexibility (1) to address the litigation and (2) to move towards systematic implementation of the directions we identify in this report. In addition, we are concerned that significant decreases in the budgets of other agencies may adversely affect the capability of The Texas Department of Mental Health and Mental Retardation to deliver needed services.

RECOMMENDATION 4 The Legislature must appropriate sufficient funds in the Texas Department of Mental Health and Mental Retardation budget to insure compliance.

CHAPTER 2

ESTIMATING THE AT RISK POPULATION

In order to accomplish its goals, the Legislative Oversight Committee gathered information on a number of aspects of the current mental health delivery system. One of the key pieces of information was an estimate of the number of Texans who are at risk of mental disorder. In describing this population, it is especially important to know the number who are at risk of needing care from public sources. This chapter is intended to provide estimates of the at risk population in Texas as well as a description of the problems and issues raised by such estimates.[4]

Estimating the mental health population at risk is at best an imprecise task. We cannot predict which individual will become mentally ill because we do not know enough about the causes of mental illness. Despite this individual uncertainty, it is possible to make increasingly useful estimates of the number of persons in a defined population who are suffering from mental disorder and who are likely to benefit from mental health services.

It is difficult to obtain reliable estimates of the at risk population

---

[4] The information in this Chapter is based on the research done for the Legislative Oversight Committee on MHMR by Michael Zent, The Hogg Foundation for Mental Health, The University of Texas, Austin.

at any given point in time. Researchers do not always agree on how to go about estimating the at risk population or what type of mental health problems should be included in such estimates. Frequently estimates are made on the basis of the number of persons who have utilized services. However, the past is not necessarily the best predictor of future need because the definition of who is eligible for what type of services may change as well as the general level of psychiatric resources available.

Planners for public mental health services must find answers to the following questions:

- How many mentally ill people desire or will use such services?
- How many are so ill that public policy requires that they must be treated even if treatment is involuntary?
- Of these people who are likely to benefit from treatment, how many are unable to obtain such care from private sources?

As we shall see, answers to the questions are beginning to be available.

Overview of Techniques

There are basically three ways to estimate the number of persons at risk for mental disorder. The first approach is to interview a carefully selected sample of individuals from the community at large about their mental health problems and needs. Typical surveys use trained interviewers to ask extensively tested questions of persons selected by modern sampling techniques. Such surveys yield the most reliable information when well done but are very costly to perform, especially at the state level.

The second major approach uses social indicators to determine the relative need of different geographic areas in the state. These indicators include such information as extent of poverty, level of unemployment, divorce, etc., which are likely to be highly correlated with rates of mental

disorder. This approach frequently assumes a set rate of mental disorder and then attempts to adjust that rate according to the characteristics of an area. However, while the relative need can be reflected in the indicators, it is difficult to estimate the absolute need. We have not attempted to use either of these approaches in this report.

A third method uses demand or utilization-based measures to estimate the need. Typically we try to estimate the need based on past history of utilization of mental health services. This approach has the advantage of using data that is generally available. Furthermore, since it concerns who actually uses mental health services, it can be more directly related to other factors such as requirements for programs and staff, and costs.

Whenever estimates are made it is important to keep in mind the distinction between incidence and prevalence of disorder. Incidence refers to the number of new cases occurring during a given period of time, usually a year, while prevalence refers to the total number of cases that exist during given time period. Most mental health services planning is done on a yearly basis, and therefore the most practical information is the number of persons who are likely to need mental health treatment during the year, or so called annual prevalence estimates.

Methodology

The estimates presented in this report are based on several considerations. The estimates apply to the total population of Texas. Those persons who have significant chance of being placed in state institutions are all those individuals in any given year who are at risk of mental disorder. However, while this group has a significant risk of placement in a state institution compared to the no-disorder group, only a small portion of this

at risk population actually is placed in state institutions.

Mental Health Service Areas were used as the geographic unit of analysis. These sixty areas have been designed for planning purposes by TDMHMR and are a logical basis for subdividing the state into areas for prevalence estimates.

Estimating Techniques: Prevalence Task Force.

In 1976 a task force of mental health professionals across the state worked on developing estimates of the at risk population in Texas. This group dealt with a number of important issues including making estimates by age group and proposing service levels. The work of this group appears sound and no more recent attempt at a similar task has been made for the state as a whole.

After examining the existing research and consulting with experts in the field, the task force established estimates for separate age groups. These estimates are 3% for the 0-3 age group, 10% for the 4-12 age group, 11.5% for the 13-17 age group, 10% for the 18-64 age group, and 10% for the over-65 age group. These estimates are annual period prevalence estimates and indicate the proportion of the total population in each group that are likely to suffer mental disorder in any given year. Substance abuse problems are excluded.

Based on the work of this task force, estimates were derived for 1985 and 1990. Table 1 presents 1985 estimates for four age groups for each Service Area in the state. Table 2 presents 1990 estimates.

[Insert TABLES 1 and 2 about here]

TABLE 1

ESTIMATED NUMBER OF PERSONS WITH MENTAL DISORDERS BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP FOR THE YEAR 1985*

Service Area	Mental Health Authority	Age Groups, Years				
		0-12	13-17	18-64	65+	TOTAL
ALL	STATE TOTAL	346,066	196,226	726,124	146,371	1,416,991
1	Abilene Regional MHMR Center	2,891	1,724	8,742	1,772	15,129
2	Amarillo MHMR Regional Center	7,434	4,484	20,859	3,301	36,078
3	Austin-Travis County MHMR Center	9,376	5,121	31,043	3,555	49,095
4	Bexar County MHMR Center	25,495	14,239	63,534	8,734	112,002
5	MHMR Authority of Brazos County	3,746	2,185	11,988	2,655	20,574
6	Central Counties Center for MHMR Services	5,043	3,207	18,353	2,749	29,352
7	Central Plains Comprehensive MHMR Center	2,668	1,552	6,064	1,144	11,428
8	Central Texas MHMR Center	1,577	1,039	5,588	2,270	10,466
9	Concho Valley Center for Human Advancement	2,217	1,318	6,514	1,271	11,320
10	Dallas County MHMR Center	37,289	19,160	1,127	11,722	69,298
11	Deep East Texas Regional MHMR Services	6,189	3,825	17,566	4,531	32,111
12	MHMR Regional Center of East Texas	5,078	3,168	15,168	3,847	27,261
13	El Paso Center for MHMR Services	13,919	7,571	31,349	3,363	56,202
14	Gulf Bend MHMR Center	3,697	2,267	9,155	1,858	16,977
15	Gulf Coast Regional MHMR Center	8,914	5,109	23,519	2,687	40,229
16	MHMR Authority of Harris County	62,866	33,344	66,065	17,071	179,346
17	Heart of Texas Region MHMR Center	5,021	3,326	16,335	4,603	29,285
18	Lubbock Regional MHMR Center	6,141	3,347	16,710	2,004	28,202
19	Navarro County MHMR Center	663	439	2,080	755	3,937
20	North Central Texas MHMR Services	8,279	4,302	25,185	4,064	41,830
21	Northeast Texas MHMR Center	2,579	1,551	7,291	1,847	13,268
22	Nueces County MHMR Community Center	6,943	3,997	16,733	1,937	29,610
23	Pecan Valley MHMR Region	2,162	1,318	7,382	1,860	12,722
24	Permian Basin Community Centers for MH and MR	5,473	3,287	13,685	1,221	23,666
25	Sabine Valley Regional MHMR Center	5,525	3,491	15,973	3,910	28,899
26	MHMR of Southeast Texas	8,028	4,853	21,620	3,054	37,555
27	Tarrant County MHMR Services	20,106	11,110	56,406	7,162	94,784
28	MHMR Services of Texoma	2,810	1,738	8,461	2,259	15,268
29	Tri-County MHMR Services	5,466	3,329	15,819	2,563	27,177
30	Tropical Texas Center for MHMR	16,408	9,504	31,701	5,345	62,958

* Based on 1976 TDMHMR Prevlalence Task Force. Excludes substance abuse disorders.

TABLE 1, Continued

ESTIMATED NUMBER OF PERSONS WITH MENTAL DISORDERS BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP FOR THE YEAR 1985*

Service Area	Mental Health Authority	Age Groups, Years				
		0-12	13-17	18-64	65+	TOTAL
31	Wichita Falls Community MHMR Center	2,402	1,353	7,360	1,231	12,347
32	Austin State Hospital	914	553	3,432	516	5,415
33	Austin State Hospital	754	473	2,538	680	4,445
34	Austin State Hospital	1,593	932	4,454	1,054	8,033
35	Austin State Hospital	4,179	2,299	9,275	1,321	17,074
36	Austin State Hospital	3,713	2,663	10,894	3,682	20,952
37	Big Spring State Hospital	3,312	2,078	8,812	1,709	15,911
38	Big Spring State Hospital	1,878	1,120	4,491	669	8,158
39	Kerrville State Hospital	194	124	506	117	941
40	Kerrville State Hospital	1,389	908	4,504	1,917	8,718
41	Rusk State Hospital	1,518	1,005	4,863	1,537	8,923
42	Rusk State Hospital	1,242	734	3,070	556	5,602
43	San Antonio State Hospital	1,287	662	2,900	345	5,194
44	San Antonio State Hospital	2,740	1,699	7,766	1,841	14,046
45	San Antonio State Hospital	7,735	4,465	16,455	2,993	31,648
46	San Antonio State Hospital	2,247	1,418	5,543	1,146	10,354
47	San Antonio State Hospital	2,017	1,213	4,710	1,102	9,042
48	San Antonio State Hospital	836	569	2,271	717	4,393
49	Terrell State Hospital	4,185	2,498	12,428	3,612	22,723
50	Terrell State Hospital	238	147	619	198	1,202
51	Terrell State Hospital	1,698	949	4,398	1,119	8,155
52	Vernon State Hospital	221	151	720	257	1,349
53	Vernon State Hospital	127	87	455	179	848
54	Vernon State Hospital	358	237	1,169	414	2,178
55	Vernon State Hospital	720	480	2,281	801	4,282
56	Wichita Falls State Hospital	237	160	840	320	1,557
57	Wichita Falls State Hospital	1,379	858	4,171	1,307	7,715
58	El Paso State Center	507	298	1,271	221	2,297
59	Laredo State Hospital	4,483	2,393	8,793	1,488	17,157
60	Rio Grande State Center	2,270	1,318	5,684	764	10,036

* Based on 1976 TDMHMR Prevlalence Task Force. Excludes substance abuse disorders.

TABLE 2

ESTIMATED NUMBER OF PERSONS WITH MENTAL DISORDERS BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP FOR THE YEAR 1990*

Service Area	Mental Health Authority	Age Groups, Years				
		0-12	13-17	18-64	65+	TOTAL
ALL	STATE TOTAL	415,974	235,770	812,714	175,595	1,640,053
1	Abilene Regional MHMR Center	3,287	1,963	9,939	2,034	17,223
2	Amarillo MHMR Regional Center	8,544	5,135	23,890	3,741	41,310
3	Austin-Travis County MHMR Center	11,496	6,278	38,058	4,358	60,190
4	Bexar County MHMR Center	30,360	16,957	75,638	10,401	133,376
5	MHMR Authority of Brazos County	4,662	2,685	14,859	3,219	25,385
6	Central Counties Center for MHMR Services	6,045	3,864	22,060	3,291	35,260
7	Central Plains Comprehensive MHMR Center	3,125	1,815	7,080	1,326	13,346
8	Central Texas MHMR Center	1,835	1,210	6,498	2,636	12,179
9	Concho Valley Center for Human Advancement	2,600	1,542	7,622	1,482	13,246
10	Dallas County MHMR Center	42,836	22,010	16,170	13,465	94,481
11	Deep East Texas Regional MHMR Services	7,444	4,602	21,139	5,462	38,647
12	MHMR Regional Center of East Texas	6,192	3,865	18,508	4,709	33,274
13	El Paso Center for MHMR Services	17,405	9,468	39,202	4,206	70,281
14	Gulf Bend MHMR Center	4,311	2,641	10,665	2,152	19,769
15	Gulf Coast Regional MHMR Center	10,374	5,950	27,355	3,078	46,757
16	MHMR Authority of Harris County	76,717	40,692	2,657	20,833	140,899
17	Heart of Texas Region MHMR Center	5,810	3,853	18,911	5,350	33,924
18	Lubbock Regional MHMR Center	7,188	3,917	19,482	2,362	32,949
19	Navarro County MHMR Center	769	509	2411	875	4,564
20	North Central Texas MHMR Services	10,694	5,540	32,393	5,195	53,822
21	Northeast Texas MHMR Center	2,940	1,770	8,313	2,113	15,136
22	Nueces County MHMR Community Center	8,122	4,676	19,572	2,265	34,635
23	Pecan Valley MHMR Region	2,561	1,575	8,771	2,256	15,163
24	Permian Basin Community Centers for MH and MR	6,450	3,874	16,128	1,438	27,890
25	Sabine Valley Regional MHMR Center	6,557	4,142	18,958	4,640	34,297
26	MHMR of Southeast Texas	8,898	5,376	23,933	3,370	41,577
27	Tarrant County MHMR Services	23,156	12,795	64,964	8,248	109,163
28	MHMR Services of Texoma	3,131	1,939	9,427	2,520	17,017
29	Tri-County MHMR Services	7,163	4,361	20,628	3,335	35,487
30	Tropical Texas Center for MHMR	21,388	12,385	41,322	6,964	82,059

* Based on 1976 TDMHMR Prevalence Task Force. Excludes substance abuse disorders.

TABLE 2, Continued

ESTIMATED NUMBER OF PERSONS WITH MENTAL DISORDERS BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP FOR THE YEAR 19[illegible]*

Service Area	Mental Health Authority	Age Groups, Years				
		0-12	13-17	18-64	65+	TOTAL
31	Wichita Falls Community MHMR Center	2,542	1,431	7,786	1,302	13,061
32	Austin State Hospital	1,149	695	4,312	646	6,802
33	Austin State Hospital	933	585	3,144	837	5,499
34	Austin State Hospital	1,963	1,148	5,485	1,298	9,894
35	Austin State Hospital	5,706	3,139	12,664	1,804	23,313
36	Austin State Hospital	4,744	3,374	13,873	4,680	26,671
37	Big Spring State Hospital	3,914	2,454	10,339	2,012	18,719
38	Big Spring State Hospital	2,246	1,341	5,373	796	9,756
39	Kerrville State Hospital	253	162	656	150	1,221
40	Kerrville State Hospital	1,731	1,131	5,620	2,397	10,879
41	Rusk State Hospital	1,843	1,220	5,891	1,864	10,818
42	Rusk State Hospital	1,038	614	2,567	465	4,684
43	San Antonio State Hospital	1,032	531	2,326	276	4,165
44	San Antonio State Hospital	2,197	1,362	6,224	1,474	11,257
45	San Antonio State Hospital	6,254	3,614	13,354	2,431	25,653
46	San Antonio State Hospital	1,906	1,205	4,706	975	8,792
47	San Antonio State Hospital	1,669	999	3,878	908	7,445
48	San Antonio State Hospital	732	499	1,989	628	3,848
49	Terrell State Hospital	3,532	2,106	10,483	3,056	19,168
50	Terrell State Hospital	203	126	530	170	1,029
51	Terrell State Hospital	1,407	790	3,664	933	6,794
52	Vernon State Hospital	200	183	657	235	1,230
53	Vernon State Hospital	112	77	401	158	748
54	Vernon State Hospital	425	281	1,388	491	2,585
55	Vernon State Hospital	795	531	2,523	888	4,737
56	Wichita Falls State Hospital	280	189	989	376	1,834
57	Wichita Falls State Hospital	1,618	1,008	4,891	1,527	9,044
58	El Paso State Center	640	376	1,573	273	2,862
59	Laredo State Hospital	5,935	3,169	11,633	1,964	22,701
60	Rio Grande State Center	2,673	1,555	6,666	901	11,795

* Based on 1976 TDMHMR Prevalence Task Force. Excludes substance abuse disorders.

Estimating Techniques: State Hospital Utilization

Based on past utilization, estimates were made of future utilization of state hospitals. These projections are at best crude since they assume that the future will be like the past. Nevertheless, they are useful as a standard of comparison for they represent what the future may look like if no changes occur in the mental health delivery system.

The year 1980 was used as a point of reference. The number of state hospital patients seen as determined for each area by age and sex groups. Estimates for 1985 and 1990 were made by considering changes in the age and sex composition of the areas and applying the same rate as occurred in 1980 to each age and sex group. The age and sex specific rates were then summed to present the figures in Table 3.

[Insert TABLE 3 about here]

Estimating Techniques: Epidemiologic Catchment Area Estimates

The most recent and most sophisticated epidemiologic estimates come from the Epidemiologic Catchment Area (ECA) surveys conducted by the National Institute for Mental Health. These surveys are described as "third generation" to denote their inclusion of features present in earlier studies.

There are five important features that distinguish the ECA surveys:

1. the size of the survey is larger than all other comparable earlier studies combined; each of the five project sites has about 3,500 respondents;

2. the survey is based on the Diagnostic Interview Schedule which uses the major categories of DSM III (the most recent diagnostic classifications);

3. the survey includes reinterviews after one year. This allows determination of various factors that occurred during the year;

4. the survey is linked to utilization data; and

5. the scientific rigor of the estimates is increased by replication in several sites across the nation.

TABLE 3

STATE HOSPITAL CLIENTS SERVED
IN FISCAL YEAR 1980
AND PROJECTED FIGURES FOR
FISCAL YEAR 1985 AND
FISCAL YEAR 1990

Service Area	Mental Health Authority	FY 1980	FY 1985	FY 1990
ALL	STATE TOTAL	20,513	23,521	27,521
1	Abilene Regional MHMR Center	347	384	433
2	Amarillo MHMR Regional Center	549	587	650
3	Austin-Travis County MHMR Center	1,285	1,531	1,846
4	Bexar County MHMR Center	2,060	2,375	2,777
5	MHMR Authority of Brazos County	225	260	310
6	Central Counties Center for MHMR Services	340	390	457
7	Central Plains Comprehensive MHMR Center	163	169	191
8	Central Texas MHMR Center	187	208	239
9	Concho Valley Center for Human Advancement	253	265	327
10	Dallas County MHMR Center	2,186	2,476	2,836
11	Deep East Texas Regional MHMR Services	567	671	802
12	MHMR Regional Center of East Texas	530	633	767
13	El Paso Center for MHMR Services	252	300	367
14	Gulf Bend MHMR Center	225	250	284
15	Gulf Coast Regional MHMR Center	184	212	247
16	MHMR Authority of Harris County	1,669	1,989	2,390
17	Heart of Texas Region MHMR Center	295	333	380
18	Lubbock Regional MHMR Center	428	485	559
19	Navarro County MHMR Center	98	111	127
20	North Central Texas MHMR Services	475	584	731
21	Northeast Texas MHMR Center	149	170	196
22	Nueces County MHMR Community Center	222	253	296
23	Pecan Valley MHMR Region	195	209	233
24	Permian Basin Community Centers for MH and MR	263	297	344
25	Sabine Valley Regional MHMR Center	477	558	659
26	MHMR of Southeast Texas	561	615	680
27	Tarrant County MHMR Services	620	712	823
28	MHMR Services of Texoma	340	377	424
29	Tri-County MHMR Services	264	328	415
30	Tropical Texas Center for MHMR	68	87	110

TABLE 3, Continued

STATE HOSPITAL CLIENTS SERVED
IN FISCAL YEAR 1980
AND PROJECTED FIGURES FOR
FISCAL YEAR 1985 AND
FISCAL YEAR 1990

Service Area	Mental Health Authority	FY 1980	FY 1985	FY 1990
31	Wichita Falls Community MHMR Center	666	689	718
32	Austin State Hospital	76	94	117
33	Austin State Hospital	41	48	59
34	Austin State Hospital	58	70	86
35	Austin State Hospital	73	98	133
36	Austin State Hospital	321	392	492
37	Big Spring State Hospital	546	572	633
38	Big Spring State Hospital	172	183	207
39	Kerrville State Hospital	18	24	35
40	Kerrville State Hospital	378	429	511
41	Rusk State Hospital	298	334	394
42	Rusk State Hospital	93	110	130
43	San Antonio State Hospital	53	65	81
44	San Antonio State Hospital	148	180	223
45	San Antonio State Hospital	441	527	650
46	San Antonio State Hospital	154	180	214
47	San Antonio State Hospital	137	160	195
48	San Antonio State Hospital	102	110	123
49	Terrell State Hospital	459	528	615
50	Terrell State Hospital	15	16	18
51	Terrell State Hospital	87	100	115
52	Vernon State Hospital	45	46	49
53	Vernon State Hospital	46	48	50
54	Vernon State Hospital	81	93	109
55	Vernon State Hospital	219	225	242
56	Wichita Falls State Hospital	36	42	50
57	Wichita Falls State Hospital	138	215	250
58	El Paso State Center	41	46	53
59	Laredo State Hospital	24	27	34
60	Rio Grande State Center	30	31	35

ECA estimates were recently published in the Archives of General Psychiatry (October, 1984). These estimates were applied to Texas and the results are presented in Table 4. The figures are based on arithmetic averages of prevalence rates at three ECA sites. Severe cognitive impairment was excluded and dysthymia was included with the rate for this disorder being established based on ratios of six-months to lifetime rates. The figures in Table 4 reflect six-months rates and annual rates are likely to be slightly higher by 1-to-2% of the total population for each area.

[Insert Table 4 about here]

The Relationship Between Prevalence and Utilization

Examination of the data in the Tables 1 thru 4 indicates that the demand for mental health services in Texas is likely to increase dramatically. The estimates in Table 3 alone show that without a change in the services delivery system, demand for state hospital beds will increase by 34% by 1990.

A first approximation of the need for public mental health services can be made by multiplying each prevalence estimate in Table 4 by 0.5 since ECA survey results show the other half do not choose to receive help. Then multipling that result by 0.45 since the other 55% of potential patients are treated by private resources[5] gives an approximation of the maximum population at risk from which the public service care load will come. These gross estimates can be refined each year based on the experience in each service area. Willingness to accept treatment and utilization of private services will undoubtedly be different in each area. ECA findings permit calculation of prevalence by diagnostic group. Differences in willingness to receive

---

[5] Based on data compiled by the Mental Health Needs Council of Harris County 1976-83.

TABLE 4

ESTIMATED NUMBER OF PERSONS AT RISK

BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP
FOR THE YEARS 1985 AND 1990

Service Area	Mental Health Authority	Age Groups, Years					
		1985			1990		
		0-64	65+	TOTAL	0-64	65+	TOTAL
ALL	S T A T E T O T A L	2,609,714	275,356	2,885,070	3,110,375	351,433	3,461,807
1	Abilene Regional MHMR Center	24,173	2,671	26,844	27,387	3,170	30,553
2	Amarillo MHMR Regional Center	57,254	6,879	64,133	64,636	8,816	73,452
3	Austin-Travis County MHMR Center	78,673	8,884	87,557	95,563	11,781	107,343
4	Bexar County MHMR Center	184,239	15,879	200,118	219,106	19,199	238,305
5	MHMR Authority of Brazos County	33,141	3,460	36,600	40,934	4,246	45,180
6	Central Counties Center for MHMR Services	46,810	5,410	52,220	55,621	7,107	62,728
7	Central Plains Comprehensive MHMR Center	18,530	1,888	20,418	21,414	2,437	23,851
8	Central Texas MHMR Center	16,739	1,659	18,398	19,614	1,799	21,413
9	Concho Valley Center for Human Advancement	18,246	1,834	20,080	21,351	2,153	23,504
10	Dallas County MHMR Center	270,443	33,186	303,629	305,090	43,703	348,793
11	Deep East Texas Regional MHMR Services	51,909	5,107	57,016	63,042	5,579	68,620
12	MHMR Regional Center of East Texas	43,959	4,299	48,258	54,199	4,707	58,906
13	El Paso Center for MHMR Services	93,217	7,619	100,836	115,905	10,192	126,097
14	Gulf Bend MHMR Center	27,401	2,741	30,143	31,768	3,331	35,099
15	Gulf Coast Regional MHMR Center	64,029	7,602	71,631	73,175	10,093	83,268
16	MHMR Authority of Harris County	446,943	53,412	500,355	535,044	75,564	610,607
17	Heart of Texas Region MHMR Center	46,996	4,613	51,609	54,829	4,954	59,783
18	Lubbock Regional MHMR Center	45,171	5,268	50,439	51,732	7,192	58,924
19	Navarro County MHMR Center	6,342	602	6,945	7,420	629	8,048
20	North Central Texas MHMR Services	67,056	7,762	74,818	86,065	10,226	96,290

TABLE 4, Continued

ESTIMATED NUMBER OF PERSONS AT RISK

BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP
FOR THE YEARS 1985 AND 1990

Service Area	Mental Health Authority	Age Groups, Years					
		1985			1990		
		0-64	65+	TOTAL	0-64	65+	TOTAL
21	Northeast Texas MHMR Center	21,361	2,199	23,561	24,512	2,366	26,878
22	Nueces County MHMR Community Center	48,705	4,229	52,934	56,742	5,175	61,916
23	Pecan Valley MHMR Region	20,384	2,159	22,544	24,450	2,403	26,853
24	Permian Basin Community Centers for MH and MR	37,522	4,573	42,095	43,210	6,398	49,608
25	Sabine Valley Regional MHMR Center	46,519	4,698	51,217	55,579	5,202	60,781
26	MHMR of Southeast Texas	59,740	6,943	66,683	65,596	8,238	73,834
27	Tarrant County MHMR Services	150,678	18,721	169,399	170,701	24,397	195,099
28	MHMR Services of Texoma	24,349	2,652	27,002	27,239	2,851	30,090
29	Tri-County MHMR Services	43,361	4,707	48,069	56,785	5,983	62,767
30	Tropical Texas Center for MHMR	106,506	6,668	113,174	139,077	8,433	147,510
31	Wichita Falls Community MHMR Center	19,548	2,328	21,875	20,500	2,641	23,140
32	Austin State Hospital	8,832	781	9,613	11,172	901	12,073
33	Austin State Hospital	7,199	654	7,853	9,000	718	9,717
34	Austin State Hospital	12,845	1,408	14,253	15,864	1,688	17,551
35	Austin State Hospital	27,825	2,773	30,598	37,903	3,877	41,780
36	Austin State Hospital	34,034	2,931	36,965	43,916	3,151	47,067
37	Big Spring State Hospital	25,645	2,642	28,287	29,988	3,300	33,288
38	Big Spring State Hospital	13,165	1,388	14,553	15,591	1,830	17,421
39	Kerrville State Hospital	1,530	142	1,672	1,978	188	2,166
40	Kerrville State Hospital	14,035	1,294	15,329	17,678	1,445	19,123

TABLE 4, Continued

ESTIMATED NUMBER OF PERSONS AT RISK

BY MENTAL HEALTH AUTHORITY, SERVICE AREA, AND AGE GROUP
FOR THE YEARS 1985 AND 1990

Service Area	Mental Health Authority	Age Groups, Years					
		1985			1990		
		0-64	65+	TOTAL	0-64	65+	TOTAL
41	Rusk State Hospital	14,415	1,319	15,734	17,690	1,387	19,078
42	Rusk State Hospital	7,478	856	8,334	8,935	1,031	9,966
43	San Antonio State Hospital	6,972	533	7,505	8,695	662	9,357
44	San Antonio State Hospital	18,348	1,634	19,982	23,087	1,847	24,934
45	San Antonio State Hospital	42,736	3,246	45,982	52,859	3,875	56,735
46	San Antonio State Hospital	14,268	1,339	15,607	16,869	1,516	18,385
47	San Antonio State Hospital	12,296	973	13,269	15,020	1,099	16,119
48	San Antonio State Hospital	6,226	573	6,800	7,133	628	7,761
49	Terrell State Hospital	30,989	3,036	34,024	37,106	3,224	40,330
50	Terrell State Hospital	1,666	161	1,827	1,966	167	2,133
51	Terrell State Hospital	10,994	1,109	12,103	13,252	1,276	14,528
52	Vernon State Hospital	1,947	211	2,157	2,133	232	2,365
53	Vernon State Hospital	1,190	120	1,309	1,356	130	1,486
54	Vernon State Hospital	3,483	337	3,819	4,186	350	4,536
55	Vernon State Hospital	6,831	714	7,545	7,564	784	8,348
56	Wichita Falls State Hospital	2,505	242	2,748	2,979	254	3,234
57	Wichita Falls State Hospital	12,339	1,273	13,611	14,600	1,362	15,962
58	El Paso State Center	3,807	301	4,108	4,735	383	5,118
59	Laredo State Hospital	29,425	1,516	30,942	39,143	1,797	40,940
60	Rio Grande State Center	16,745	1,196	17,940	19,716	1,367	21,082

treatment and private service utilization may very well exist by diagnosis. This progressive detailing and refinement of prevalence and at risk estimation should be incorporated in to the TDMHMR planning process (see Recommendations in Chapter 6).

The implications of these findings are that 1) prioritization of the populations to be served must be undertaken, and 2) a redesign of the service delivery system must be implemented to serve the priority populations appropriately and in a cost-effective manner.

CHAPTER 3

PRIORITY POPULATIONS

Given the current range of services and kinds of people served by the Texas Department of Mental Health and Mental Retardation, one might assume that the Department's mission is to address the needs of all of these persons. Scarce resources and a growing demand for services require that hard choices be made as to whom the services of the public mental health system should be directed. But, which patients should have first call on tax supported mental health services?

The Legislative Oversight Committee is aware that the Legislature, in revising the Mental Health Code, has established criteria which, when met, would justify state intervention to permit involuntary treatment of such patients. The Committee agrees that if illness meeting these criteria were severe enough to justify involuntary treatment then such illnesses were severe enough to require first call on state resources. The Committee has used the catchword "dangerous" to mean suffering from a mental illness which causes the person to be likely to cause serious harm to himself or to others; and has used the catchword "dependent" to mean the person will if not treated continue to suffer severe and abnormal mental, emotional or physical distress, and will continue to experience deterioration of his ability to function independently. It is possible for a person to suffer from a mental illness which when untreated may reach such severity the person would meet

the criteria of being called "dangerous" or "dependent". "Potential" is defined as this possibility. Table 5 identifies the priority populations recommended by the Committee.

[Insert Table 5 about here]

Several notes are in order about the recommendation to adopt this priority population framework.

- This framework recognizes that the most severly disabled must be served first. These individuals are often the most difficult and expensive to serve.

- This prioritization acknowledges the need to make the largest financial investment in the needs of the smallest but most needful population group.

- Lack of specific data precludes making precise estimates of the numbers of individuals in these priority groups. Several general estimates should be noted because they offer insight into the implications for the service delivery system:

  ° Priority Group I-1 (patients with long-term special needs) is derived from a study of the Massachusetts mental health system in which it was concluded that these individuals are likely to need long-term treatment and care in a structured setting such as a state hospital. The Massachusetts study estimates this population at 15 per 100,000 population or 2,250 Texans.[5] Please note that applying the Massachusetts formula to Texas data can at best only result in general inferences about the service delivery system.

  ° Members of Priority Groups I-2 and II (those whose illness is episodic) are commonly individuals who use the state hospitals for short- or intermediate-term treatment. TDMHMR records indicate there are 20,000 such admissions each year in Texas. The average length of stay is 59 days.

---

[5] Jon E. Gudeman, M.D. and Miles F. Shore, M.D., "Beyond Deinstitutionalization" (New England Journal of Medicine, Volume 311, Number 13, September 27, 1984, pages 832-836).

TABLE 5

PRIORITY POPULATIONS

PRIORITY I
Current dangerous, dependent

Two sub groups:

Sub Group 1) Patients with long term special needs:

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) elderly, demented, and behaviorally disturbed	a) containment, supportive care
b) mentally retarded and psychotic	b) re-education, behavioral modification
c) brain-damaged and assaultive	c) containment, supportive care
d) psychotic and assaultive	d) security, treatment, long-term care
e) chronically schizophrenic, disruptive and endangered	e) structured milieu, long-term care

These groups, in general, need continuous in-patient care, containment, structured environment.

Sub Group 2) Patients with episodic illness:

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) severe schizophrenia	a) hospitalization, medication, out-patient treatment, supervised living
b) bi-polar disorders	b) hospitalization, medication
c) depression	c) hospitalization, medication, ECTS
d) severe alcoholism	d) psychiatric hospitalization, medical hospitalization
e) severe drug dependency	e) psychiatric hospitalization, medical hospitalization

---

PRIORITY II
Current dangerous patients with episodic or continuous illness

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) schizophrenia	a) hospitalization, medication
b) bi-polar	b) hospitalization, medication
c) severe depression	c) hospitalization, medication
d) personality disorders (explosive)	d) hospitalization or supervised living
e) severe drug abuse	e) hospitalization
f) children/adolescents with severe conduct or behavior disorder	f) hospitalization or residential treatment

---

PRIORITY III
Current dependent

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) chronic schizophrenia	a) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
b) organic disorders (primarily aged, but also substance abusers	b) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
c) severe dependent personality disorders (functioning like chronic schizophrenics	c) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.

[NOTE: The chronic schizophrenics are defined as those individuals who, prior to deinstitutionalization, would have been permanent residents of state hospitals.]

TABLE 5, Continued

PRIORITY POPULATIONS

PRIORITIES

IV: Prior dangerous, dependent
V: Prior dangerous
VI: Potential dangerous, dependent
VII: Potential dangerous
VIII: Prior dependent

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) schizophrenia	a) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
b) bi-polar disorder	b) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
c) depression	c) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
d) alcoholism	d) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.
e) drug abuse	e) full range of community-based support services, including supervised and/or protected living, day activities, medication, etc.

[NOTE: Prior is defined as "had a severe episode which required hospitalization but is functioning adequately now". These individuals have diagnoses similar to those in Priority III, and need interventions with a lesser degree of comprehensiveness. They are likely to become Priority IIIs very easily without a full range of community support services.]

PRIORITY IX
Potential dependent

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) schizonphreniform (schizophrenic-like symptoms)	a) medication, group therapy, individual therapy
b) dysthymic (depressed, potentially suicidal)	b) medication, group therapy, individual therapy
c) children of alcoholics, drug abusers, schizophrenics	c) identification, counseling

---

PRIORITY X
Other

DIAGNOSIS/CHARACTERISTICS	NEEDS
a) children or adults who have been physically or sexually abused	a) identification, counseling
b) other diagnosable conditions under the DSM III	b) identification, counseling

[NOTE: Other refers to to individuals who do not fit into the current, prior, or potential categories, but who make up the balance of the individuals identified in the NIMH study as the 20% of the population with mental health problems.]

° Members of Priority Group III (currently dependent) are described as the long term or chronically mentally ill. The National Institute of Mental Health estimates that 1% of the population, or 150,000 Texans, fall into this category. They need access to a full range of community services, from housing to training to treatment.

- A word of caution must be stated. Individuals' needs change, causing them to move among the priority groups. Failure to make available basic services to priority groups IV-IX may result in exacerbation of their situations, thus requiring more intensive intervention.

RECOMMENDATION 5 The Texas Department of Mental Health and Mental Retardation must adopt a method to prioritize the populations to be served by the mental health system and must redesign the service delivery system to serve the priority populations appropriately and in the most cost-effective manner possible. The prioritization method must be based on the one described in this report.

RECOMMENDATION 6 The Texas Department of Mental Health and Mental Retardation must initiate data collection to determine the number of individuals in the various priority groups as a basis for service planning.

RECOMMENDATION 7 The TDMHMR budgeting, funding, and expenditure process, including the awarding of service contracts, must be tied directly to the provision of services to priority populations.

CHAPTER 4

SERVICES

The Legislative Oversight Committee on Mental Health and Mental Retardation examined extensively the arena of services for mentally ill and substance-abusive persons and makes recommendations in several areas:

- identification of necessary services,
- implementation of screening and emergency services,
- implementation of case management programs,
- discharge planning,
- delineation of roles of state hospitals and community-based providers, and
- issues related to coordination with other agencies.

Identification of Necessary Services

Table 6 is a matrix of service activities which form the foundation of resources and services that are available to the priority populations identified previously. (The glossary in Appendix B contains a set of definitions of the terms used describing these services.) Some services are historically hospital-based. Others are community-based or could be made available either in a hospital setting or in the community. The matrix is a useful way of identifying services in varying combinations which must be provided to address the needs of the identified individuals.

[Insert Table 6 about here]

Although the Committee recognizes that compliance with the provisions of settlement agreements must be the immediate priority of TDMHMR, long-term

TABLE 6

NECESSARY SERVICES BY PRIORITY POPULATIONS

Priority Populations / Service Activities	24-HOUR EXTENDED SERVICES	EXTENDED MEDICAL SERVICES	DENTAL SERVICES	PHYSICAL THERAPY	SPEECH THERAPY	PASTORAL COUNSELING	DISCHARGE PLANNING	REMOTIVATIONAL THERAPY	CASE MANAGEMENT	INDEFINITE RESIDENCE	SELF-HELP SKILLS TRAINING	SCREENING	VOCATIONAL TRAINING	PREVOCATIONAL TRAINING	BEHAVIOR THERAPY	TEMPORARY EMPLOYMENT	EMERGENCY SERVICES	ADULT BASIC EDUCATION	CARE SERVICES	VERBAL THERAPIES	SHELTERED WORK	RECREATION SERVICES	FAMILY RELATIONSHIP THERAPY	SOCIALIZATION	SOCIAL TRAINING	TRANSITIONAL LIVING (24-HOUR SUPERVISED)	MEDICATIONS	HEALTH EDUCATION	24-HOUR ACUTE EMERGENCY (PROTECTIVE)	ELECTRO-CONVULSIVE THERAPY	BIOFEEDBACK	OCCUPATIONAL THERAPY	TRANSITIONAL LIVING (WITHOUT 24-HOUR SUPERVISION)	TEMPORARY RESPITE	HOMEMAKER SERVICES	CRISIS HOTLINE	24-HOUR EXTENDED TREATMENT
PRIORITY I Current dangerous and dependent																																					
(1) Patients with long-term special needs																																					
1-a) elderly, demented, and behaviorally disturbed		✓						✓				✓					✓																					
1-b) mentally retarded and psychotic		✓						✓				✓					✓																					
1-c) brain-damaged and assaultive		✓						✓				✓					✓																					
1-d) psychotic and assaultive		✓						✓				✓					✓																					
1-e) chronic schizophrenia, disruptive, endangered		✓						✓				✓					✓																					
(2) Patients with episodic illness																																					
2-a) severe schizophrenia																																					
2-b) bi-polar disorders																																					
2-c) depression																																					
2-d) severe alcoholism																																					
2-e) severe drug dependence																																					
PRIORITY II Current dangerous patients with episodic illness																																					
a) schizophrenia																																					
b) bi-polar																																					
c) severe depression																																					
d) personality disorders (explosive)																																					
e) severe drug abuse																																					
f) children/adolescents with severe conduct or behavior																																					
Current dangerous patients with continuous illness																																					
a) schizophrenia																																					
b) bi-polar																																					
c) severe depression																																					
d) personality disorders (explosive)																																					
e) severe drug abuse																																					
f) children/adolescents with severe conduct or behavior																																					

✓ = must provide

Not applicable

TABLE 6, Continued
NECESSARY SERVICES BY PRIORITY POPULATIONS

Service Activities / Priority Populations	24-HOUR EXTENDED SERVICES	EXTENDED MEDICAL SERVICES	DENTAL SERVICES	PHYSICAL THERAPY	SPEECH THERAPY	PASTORAL COUNSELING	DISCHARGE PLANNING	REMOTIVATIONAL THERAPY	CASE MANAGEMENT	INDEFINITE RESIDENCE	SELF-HELP SKILLS TRAINING	SCREENING	VOCATIONAL TRAINING	PREVOCATIONAL TRAINING	BEHAVIOR THERAPY	TEMPORARY EMPLOYMENT	EMERGENCY SERVICES	ADULT BASIC EDUCATION	CARE SERVICES	VERBAL THERAPIES	SHELTERED WORK	RECREATION SERVICES	FAMILY RELATIONSHIP THERAPY	SOCIALIZATION	SOCIAL TRAINING	TRANSITIONAL LIVING (24-HOUR SUPERVISED)	MEDICATIONS	HEALTH EDUCATION	24-HOUR ACUTE EMERGENCY (PROTECTIVE)	ELECTRO-CONVULSIVE THERAPY	BIOFEEDBACK	OCCUPATIONAL THERAPY	TRANSITIONAL LIVING (WITHOUT 24-HOUR SUPERVISION)	TEMPORARY RESPITE	HOMEMAKER SERVICES	CRISIS HOTLINE	24-HOUR EXTENDED TREATMENT
PRIORITY III Current dependent patients with continuous illness																																						
a) chronic schizophrenia		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
b) organic disorders (primarily aged but also substance abusers		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
c) severe dependent personality disorders (functioning like chronic schizophrenics)		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
Current dependent patients with episodic illness																																						
a) chronic schizophrenia		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
b) organic disorders (primarily aged but also substance abusers		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
c) severe dependent personality disorders (functioning like chronic schizophrenics)		✓		✓	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									✓
PRIORITY IV Prior dangerous dependent																																						
PRIORITY V Prior dangerous																																						
PRIORITY VI Potential dangerous dependent																																						
PRIORITY VII Potential dangerous																																						
PRIORITY VIII Prior dependent																																						
a) schizophrenia																																					✓	
b) bi-polar disorder																																					✓	
c) depression																																					✓	
d) alcoholism																																					✓	
e) drug abuse																																					✓	
PRIORITY IX Potential dependent																																						
a) schizophreniform (schizophrenic-like symptoms)																																					✓	
b) psychotic (depressed potentially suicidal)																																					✓	
c) children of alcoholics, drug abusers, schizophrenics																																					✓	
PRIORITY X Other																																						
a) children or adults who have been physically or sexually abused																																					✓	
b) other diagnosable conditions under the DSM III																																					✓	

✓ = must provide

changes in the service delivery system are needed. The recommendations in this chapter constitute the core changes needed to implement a revised system of service of service delivery.

RECOMMENDATION 8 The Texas Department of Mental Health and Mental Retardation must insure that appropriate services are implemented for each priority group. To accomplish this, a plan for incremental implementation, and for a redirection of funds will be necessary.

Screening/Emergency Services

Two kinds of services are identified in Table 6 as essential for all priority populations: screening and emergency services. The consensus of the Committee is that the first dollar spent for mental health services must be allocated to the development and implementation of screening and emergency services.

The Committee makes the following observations regarding existing screening and emergency services: (1) they operate too often on a Monday-through-Friday basis; (2) too often state hospitals are used as a substitute for community-based screening; (3) contracts with private providers should be considered an option; and (4) often in rural areas few services are available to support screening.

A study of the mental health screening and emergency services available throughout Texas was undertaken at the Committee's request by Dr. William Rago, of TDMHMR, to determine the availability of emergency services in various Texas communities. Surveys were sent to each of the 60 Mental Health Authorities. Responses were obtained from 56 in time to be included in this report.

Respondents were asked to indicate, among other items, their level of effort in providing the following kinds of emergency services:

- emergency telephone services,
- face-to-face emergency intervention, and
- 24-hour emergency residential treatment.

TABLE 7

AVAILABILITY OF EMERGENCY SERVICES
By Type of Service, Weekday or Weekend, and Type of Provider

	24-Hour Emergency Telephone		Emergency Face-to-Face		Emergency Residential Admission	
	Mon-Fri	Weekend	Mon-Fri	Weekend	Mon-Fri	Weekend
MH Authority Community MHMR Center	23	24	9	9	20	21
MH Authority Outreach Center of State Hospital	4	6	4	4	9	9
Totals	27	30	13	13	29	30

Table 7 shows the number of service areas in which these kinds of emergency services are offered. The results are described, separating those services by service area in which the Mental Health Authority is a Community MHMR Center from those in which the Mental Health Authority is an Outreach center of a state hospital. 27 of the 60 service areas (45%) have 24-hour emergency telephone services during the week. 30 service areas (50%) have this capability on weekends. In 13 service areas (21.6%) emergency face-to-face intervention can be obtained. Admissions to emergency residential

treatment can be obtained in 20 of the service areas during the week (33.3%) and in 21 (35%) on weekends.

Of the respondents, 47 (77.1%) indicated having a mutually agreed upon policy with local police, sheriffs, and judges for handling emergency situations.

Table 8 shows the ways in which respondents handle emergency cases during evening hours and weekends.

TABLE 8

TYPES OF RESPONSES TO EVENING AND WEEKEND EMERGENCIES

Type of Response	Centers	Outreach
Staff person on duty/physician backup	5	2
Staff person on call	14	20
24-hour crisis hotline/message	1	0
24-hour crisis hotline/volunteers	6	1
Other	3	17
Combination of two or more	1	1

As indicated by the data, there currently exists a wide variety in the capability of mental health authorities to provide emergency services and in the kinds of services offered.

RECOMMENDATION 9 The Texas Department of Mental Health and Mental Retardation must assure that people within each service area have access to (1) 24-hour emergency screening and rapid stabilization services; (2) crisis hospitalization; (3) initial assessment performed in the community, with that assessment including the development of a multi-disciplinary treatment plan.

RECOMMENDATION 10 TDMHMR's funding to a service area must be contingent upon certification of the availability of screening/emergency services or the inclusion of such services within the budget of the funds being allocated.

RECOMMENDATION 11 For persons not charged with a criminal offense, jails are not acceptable holding facilities. Appropriate alternatives for mental health crisis stabilization and substance abuse detoxification must be developed.

RECOMMENDATION 12 Each Designated Provider[6] must coordinate the provision of services with other agencies concerned with the care and treatment of individuals with drug or alcohol problems.

Case Management

Case management is a system in which a singly accountable individual insures that the client has access to and receives all resources and services which can help achieve his/her optimal level of functioning. The Committee supports the initiatives of TDMHMR to implement Case Management as a fundamental method for delivery of services:

1. to enhance the natural support system and to provide continuity of care, continuing service responsibility, overall program coordination, and linkage to the services of other agencies for persons with mental illness or mental retardation;
2. to establish responsibility and accountability for identified individuals in the service delivery system;
3. to provide clients with a single point of accountability in the service delivery system;
4. to implement recommendations made by the treatment personnel;
5. to provide transportation and other direct services.

---

[6] defined in Glossary (Appendix B)

Case management is required for the following clients:

- those having serious mental illness;
- those having long lasting mental illness;
- those having little or no natural support system;
- those having multiple service needs.

It must be the responsibility of the Designated Provider to assure that case management is available as an integral part of the community service system. Case managers for patients in hospitals should be based in the community.

It must be the responsibility of TDMHMR to include within their program audit a review of the following case management standards:

1. service availability and accessibility: case management services must be available 24-hours per day;

2. client accountability: individuals are assigned to case management according to established criteria for inclusion in target groups;

3. client individuality: a comprehensive face-to-face community-based intake and comprehensive treatment plan must be developed within 30 days; case managers must participate in and contribute to the development of this treatment plan;

4. service responsiveness: case management assessment must be completed within seven days and an initiation date set for service with case management level assigned;

5. client advocacy: case manager must list problems and their severity, what services have been provided and reason(s) that applicable services have not been provided;

6. service continuity and coordination: case load should not be more than 40 clients per worker, and case managers should function according to established job descriptions.

Case management is most successful when appropriate direct services are available; however, in areas where services are limited, case management can maximize existing services as well as identify needs for additional services.

RECOMMENDATION 13 Having assured the availability of screening and emergency services, TDMHMR shall contract, using existing funds, with each Designated Provider to make case management services available in each service area.

RECOMMENDATION 14 The definition, standards and job descriptions as developed by the Task Force on Case Management shall serve as self-monitoring tools and TDMHMR auditing instruments.

Discharge Planning

Many mentally ill persons require some period of hospitalization as part of their overall needs. For some patients a hospital stay should be followed by ongoing support, treatment and services.

The decision to discharge a patient from the hospital must be based on several considerations, including their medical and legal status and their potential for community return. The Committee acknowledges that there currently exists an insufficient number of community-based services to meet the needs of all individuals being discharged. The development of appropriate community resources and the methods to insure client access to them must be encouraged.

RECOMMENDATION 15 The Legislature should amend the Mental Health and Mental Retardation Act (Article 5547-201 et seq., V.T.C.S.) to strengthen the requirement for the Texas Department of Mental Health and Mental Retardation to have a discharge plan for every patient leaving the hospital. This discharge plan must include the assignment of a case manager when appropriate and a description of the appropriate community-based services which have been obtained for the individual.

Functions of the State Hospitals and Community Centers in Providing Public Mental Health Services

The identification of priority populations and the appropriate services to meet their needs clearly points the way to a substantially community-based system of care. A major area of concern regarding this is the delineation of the roles of state hospitals and community centers.

[Insert TABLE 9 about here]

Table 9 shows the relationship between the services which meet the needs of priority populations and the appropriate providers of these services. Theoretically any service provided by a state hospital could be provided in the community if appropriate resources were made available. While a trend toward providing community services exists and is favored for the majority of the population, the Committee recognizes the continuing need for some in-patient hospitalization services. Inpatient hospitalization for either conditions of dangerousness or dependency should be considered necessary only for the length of time of the "episode of dangerousness or dependency".

Clients can be expected to move back and forth between priority levels. Screening and case management services can anticipate this movement and assist clients with the transitions. Screening and case management are the "glue" which holds the system together at the level of the client/patient.

RECOMMENDATION 16 The Texas Department of Mental Health and Mental Retardation must, as part of a comprehensive strategic planning process, initiate a plan for the future role of state hospitals, with consideration of size, function, and specialization. This plan must include criteria for phasing out uneconomical and unneeded beds.

TABLE 9

ROLES OF STATE HOSPITALS AND COMMUNITY PROVIDERS

FUNCTIONS	PRIORITY GROUP	PROVIDERS
Long-term hospitalization (longer than 12 months)	Priority I.1 (dangerous/dependent-continuous)	State Hospitals
	Priority II (continuous)	State Hospitals
Moderate-term hospitalization (from 3 to 24 months)	Priority I.2 (current dangerous-dependent-episodic)	State Hospitals
	Priority II (episodic)	State Hospitals
Short-term hospitalization	Priority II (episodic)	Either State Hospitals or Community Hospitals
Community Services	Priority III (current dependent)	Community Providers
	Priority IV-VIII (prior and potential dangerous and prior dependent)	Community Providers
	Priority IX (potential dependent)	Community Providers

Members of Priorities III-IX can become Priorities I and II through exacerbation of illness.

RECOMMENDATION 17 The Mental Health Code Committee should investigate revisions of the Code which would increase appropriate utilization of commitments to community-based services in lieu of commitments to hospitals.

RECOMMENDATION 18 The Texas Department of Mental Health and Mental Retardation should initiate respite services for the natural support system of people who are mentally ill.

Coordination With Other Agencies

Many of the needs of mentally ill persons are the same as those of other persons in the population. To support normalization, wherever possible "generic" services should be made available to clients of the TDMHMR services system. Table 10 is a matrix describing those essential services which should be the responsibility of non-mental health providers, with indication of availability.

[Insert TABLE 10 about here]

In reviewing Table 10, it becomes clear that barriers beyond the direct control of TDMHMR exist to the availability of services. These include:

- means tests,
- the lack of consistent availability of services in all parts of the state, and
- the temporary nature of some services which mentally ill persons need to have on an ongoing basis.

RECOMMENDATION 19 The Texas Department of Mental Health and Mental Retardation must insure that regional needs assessments include information about the availability of services of public and private agencies, their eligibility requirements, location, and other factors, and that regional planning for services include input from public and private providers beyond the TDMHMR service delivery system.

TABLE 10

SERVICES AVAILABILITY SCHEDULE

	FAMILY CARE - DHR	PRIMARY HOME CARE - DHR	MEALS-ON-WHEELS - DHR	TEXAS COMMISSION ON ALCOHOLISM	TEXAS REHABILITATION COMMISSION	TEXAS EMPLOYMENT COMMISSION	TEXAS DEPARTMENT OF HEALTH	MEDICAID	MEDICARE	FOOD STAMPS	VETERANS ADMINISTRATION	LOCAL HOUSING AUTHORITIES	HOME HEALTH CARE	HOSPITAL DISTRICTS	GOODWILL INDUSTRIES	EASTER SEAL REHAB. UNITS	SALVATION ARMY	LOCAL CHURCHES	LOCAL LEGAL AID
24-HOUR EXTENDED SERVICES											2								
EXTENDED MEDICAL SERVICES								2	2		2								
DENTAL SERVICES											2								
PHYSICAL THERAPY											2								
SPEECH THERAPY											2								
PASTORAL COUNSELING											2								
DISCHARGE PLANNING											2								
REMOTIVATIONAL THERAPY											2								
CASE MANAGEMENT																			
INDEFINITE RESIDENCE											2								
SELF-HELP SKILLS TRAINING																			
SCREENING																			
VOCATIONAL TRAINING																			
PREVOCATIONAL TRAINING																			
BEHAVIOR THERAPY																			
TEMPORARY EMPLOYMENT																			
EMERGENCY SERVICES																			
ADULT BASIC EDUCATION																			
CARE SERVICES																			
VERBAL THERAPIES																			
SHELTERED WORK																			
RECREATION SERVICES																			
FAMILY/RELATIONSHIP THERAPY																			
SOCIALIZATION																			
SOCIAL TRAINING																			
TRANSITIONAL LIVING (24-HOUR SUPERVISED)																			
MEDICATIONS																			
HEALTH EDUCATION																			
24-HOUR ACUTE EMERGENCY (PROTECTIVE)																			
ELECTRO-CONVULSIVE THERAPY																			
BIOFEEDBACK																			
OCCUPATIONAL THERAPY																			
TRANSITIONAL LIVING (WITHOUT 24-HOUR SUPERVISION)																			
TEMPORARY RESPITE																			
HOMEMAKER SERVICES																			
CRISIS HOTLINE																			
24-HOUR EXTENDED TREATMENT																			

1 = always available
2 = available if eligible
3 = available temporarily
4 = available in some areas

CHAPTER 5

COMMUNITY RESIDENTIAL ALTERNATIVES

The availability of appropriate residential services is a major factor in the development and implementation of a substantially community-based system of care. One obstacle in planning a community-based system of care is the lack of information about what services are available. The Mental Health Association in Texas, on behalf of the Legislative Oversight Committee on Mental Health and Mental Retardation, commissioned the firm of Health Consulting to study the availability of residential alternatives and the issues relating to program development. The study in its entirety is contained in Volume II, but several of the findings and recommendations of the study that are beneficial to this report are included in this chapter.

Survey Findings: Program Characteristics

352 residential programs were initially located. 33 of these programs either no longer existed or did not take in residents who have a history of mental illness. Of the remaining 319 programs:

- complete data was obtained on 205 programs,
- partial data on 80 programs,
- 25 programs were uncooperative, and
- 9 programs were cooperative but their data arrived too late for inclusion in the study, was lost in the mail, or was misplaced.

Thus complete or partial data was obtained for 285 programs.

Survey Findings: Program Type

TABLE 11

TOTAL NUMBER OF PROGRAMS

Type of Program	Number	Percent
Supervised Apartments	19	6.6
Unsupervised Apartments	7	2.8
Fairweather Lodges	11	3.8
Foster Care Programs	11	3.8
Halfway Houses	39	13.6
Personal Care Homes in Nursing Homes	36	12.6
Freestanding Personal Care Homes	26	9.1
Respite Care Programs	3	1.1
Room and Board Facilities	65	22.7
Supervised Group Homes	32	11.3
Residential Treatment Centers	20	7.0
Unknown	13	4.5
Other	3	1.0
TOTAL	285	100.0

Table 11 reports the type of program reported by respondents. Program which traditionally offer "caretaking" or custodial services (room and board facilities, personal care homes, and shelters, and single room occupancy facilities such as hotels and motels catering to the mentally ill and disabled) accounted for 48.9% of all programs. Therapeutic and rehabilitative programs serving adults accounted for 30.8% of all programs.

Survey Findings: Program Size

TABLE 12

BED CAPACITY BY TYPE OF PROGRAM

Supervised Apartments	36.0
Unsupervised Apartments	19.0
Fairweather Lodges	22.0
Foster Care Programs	13.0
Halfway Houses	29.0
Nursing Homes	104.0
Personal Care Homes	37.0
Respite Care Programs	13.0
Room and Board Programs	20.0
Supervised Group Homes	33.0
Residential Treatment Centers	49.0
Others	96.0
MEAN FOR ALL PROGRAMS	40.5

Table 12 identifies the bed capacity various of types of programs. The size of a program can also be used to determine how "normalizing" a program is for the residents. The smaller the program, the less obvious it is to the community. Foster care and both types of apartment programs generally had two-to-four clients per unit. Respite care and Fairweather lodges were also small with fewer than 12 residents in each program. (One Fairweather program has more than twelve residents in one home.) Halfway houses, free-standing personal care homes, supervised group home and room and board facilities had a mean size of 20-to-37 residents. However, a number of room and board homes are as small as seven or eight residents. Personal care homes and the "Other" category were quite large in size, averaging near 100 residents each.

Survey Findings: Number of Residential Slots Available

TABLE 13

BEDS CURRENTLY AVAILABLE
by
Type of Program

Type of Program	Total Beds	Total Occupied	Occupied by MH clients	Known Empty Beds	Known Vacancies
Supervised Apartments	683	619	363	62	9.0%
Unsupervised Apartments	137	121	94	15	10.9%
Fairweather Lodges	248	194	194	46	18.5%
Foster Care Programs	142	103	66	39	27.0%
Halfway Houses	782	618	356	176	22.5%
Personal Care Homes in Nursing Homes	2,939	1,587	156	406	13.8%
Personal Care Homes	898	634	237	99	11.0%
Respite Care Programs	39	23	15	16	41.0%
Room and Board Homes	1,292	878	538	283	21.9%
Supervised Group Homes	1,066	881	401	129	12.0%
Residential Treatment Centers	981	747	515	191	19.0%
Unknown	1,382	n/a	n/a	n/a	n/a
Other	59	55	45	4	6.7%
TOTALS	10,648	6,460	2,980	1,466	13.76%

Table 13 shows the number of available residential slots. The located programs which will accept people with a history of mental illness report a total of 10,648 residential slots. 2,980 residents with a known history of mental illness were reported as being served in the residential programs. The percent of average beds filled by mentally ill people ranged from 100% in the Fairweather Lodge program to 10.8% in personal care homes located in nursing homes. Over 1,466 empty residential slots were reported. The mean vacancy rates varied from 6.7% of beds in the "Other" category (crisis care and diagnostic centers) to 41% in respite care programs, with an overall 13.76 reported vacancy rate. Six of the program types reported mean vacancy

rates of below 15% while seven reported mean vacancy rates of over 18%. Since only a little over half of the programs reported their vacancies, the number of empty slots should be viewed as the minimum number of vacancies. Table 13 reports the total beds, occupied beds, beds occupied by persons with a known history of mental illness and the percent of vacant residential slots.

Survey Findings: Residential Beds Available by Mental Health Service Area

Of the 60 Mental Health Service Areas of the Texas Department of Mental Health and Mental Retardation, 40 have residential beds available that will accept residents with a history of mental illness. 16 services areas with a population base of 1,050,000 people have no residential beds available. Two service areas had no data available other than bed capacity for the residential programs in their area and two additional areas currently had no mentally ill clients in the residential programs located. The range of residential slots available per 100,000 population in the 60 service areas was 0 to a high of 95.98. Half of the top ranking service areas have community mental health and mental retardation centers as the service authority. 14 state hospitals, two state centers, and three mental health and mental retardation service areas have no residential services available for adult mentally ill persons. Of these only one of the mental health mental retardation service areas have residential services available for children and adolescents who are emotionally disturbed.

Survey Findings: Costs Per Day

TABLE 14

AVERAGE COST PER DAY PER RESIDENT

by Type of Program

Fairweather Lodges	$15.01
Unsupervised Apartments	18.67
Foster Care Programs	21.85
Room and Board Facilities	21.87
Supervised Apartments	23.83
Respite Care Programs	27.66
Unknown	28.57
Personal Care Homes	28.58
Nursing Homes	29.51
Halfway Houses	32.45
Supervised Group Homes	44.48
Residential Treatment Centers	76.79
Other	203.53

Costs per day of residential services varied from "free" to $365 a day, with the mean cost per day being $44. Three clusters of costs per type of program are evident. Supervised group homes, residential treatment centers, and "Other" cost more than $44 a day. Halfway houses, personal care homes of both types and respite care programs costs between $27 and $33 a day. Apartment programs, Fairweather Lodges, foster care programs, and room and board facilities were the lowest cost programs with a mean of between $15 and $24 a day.

DISCUSSION OF SURVEY FINDINGS

Program Type, Licensure, and Certification

One of the major issues that evolved was licensure and certification. The types of services offered, client characteristics and staffing patterns, appeared only partially related to the type of licensure a program had or to

the classification the program viewed itself as being. Telephone interviews suggested that programs tend to become certified or licensed primarily if it means being eligible to receive additional funds from governmental agencies. A major exception to this was private therapeutic programs that have a strong commitment to quality and use certification for marketing purposes.

A major gap in types of licensures appears to exist. Many boarding homes providers, particularly in East Texas, feel they are being pressured by the Texas Department of Health to become licensed as personal care homes, which to most would be at a considerable expense. At the same time the boarding homes are being encouraged by the mental health agencies to develop additional boarding homes. The Department of Human Resources has a limit on the number of supervised living slots it can pay for in personal care homes and therefore most providers feel they cannot recoup the extra funds needed to meet home licensure. Also a number of personal care homes and boarding homes report that the Department of Health discourages them from taking mentally ill clients, stating that they are not properly trained to treat the mentally ill. It is clear that some solutions need to be reached or the better boarding homes will have to go out of business or become more formal "health care facilities" which is not necessary to meet the needs of the long-term chronic mental patients who no longer need the support and structure of the hospital but do not have an appropriate place to live and learn community skills.

RECOMMENDATION 20 The Legislature should establish a certification authority for small congregate living facilities that offer a safe home-like environment and are permitted to offer training and support in daily living skills, including medication "monitoring". These "enhanced boarding homes" would require consultation and support from the Designated Provider.

Lack of Residential Programs

A variety of studies have concluded that a large number of mentally disabled adults are inadequately or inappropriately housed or are homeless. A conservative estimate is that one-tenth of the chronically mentally ill are in need of community residential services. In Texas that would be approximately 14,000 people or 11,000 more residential beds than are now available. Dr. Steve Leff of the Human Service Research Institute in Cambridge Massachusetts has developed a "Production Management Model" for projecting community support services for the long-term mentally ill. His work in Nebraska, Connecticut and Iowa clearly demonstrate that any strategy which aims at increasing the level of functioning of the long-term mentally ill will always result in an incremental need for community residential programs. If public policy is content to offer custodial services then a lower housing figure that is stagnant can be reached. This figure of 11,000 additional beds, even though conservative, sounds frighteningly high and one would immediately ask, if that is the case then why are there so few existing community-based beds?

The major problems in meeting housing needs appear to be:

1. A lack of clearly defined roles as to who has historically been and who currently should be responsible for developing and providing housing for this population.

2. A lack of financing sources for the development of housing

3. A lack of knowledge about state of the art residential programs on which to model.

4. A lack of clear technical assistance to public and private agencies who could develop housing programs - such assistance should include funding mechanisms, program development, community resistance, zoning and licensure issues.

5. A lack of effective advocacy at the local, state, and national levels to encourage financing, legislation, zoning changes and community acceptance.

RECOMMENDATION 21 The Texas Department of Mental Health and Mental Retardation and the Legislature must continue to develop incentives for community-based residential programs, both public and private.

Costs and Funding

There is currently little or no way to finance residential services other than through state funding mechanisms, Social Security benefits, Section 8 funds of H.U.D., and direct family payments. Private insurance rarely, if ever, will reimburse families for residential care of a mentally ill person. It is important to note in this study it was found that those that were more rehabilitative, most normalizing, and offering the most client control were also the lower cost programs. Apartment programs, foster care, and Fairweather lodges are significantly cheaper and more rehabilitative to the long-term mentally ill than are more expensive, clinical model programs. They also tend to be less expensive than most custodial programs and are less visible to the community and thus offer more community integration and acceptance. It should also be noted that less than one-third of the programs reporting in the survey had contracts with state agencies for financial assistance. It would appear that most state agencies that serve the "disabled" do not view the mentally ill as such.

RECOMMENDATION 22 The Texas Department of Mental Health and Mental Retardation must establish a goal of 60 community residential beds per 100,000 population.

RECOMMENDATION 23 The Texas Department of Mental Health and Mental Retardation and the State Board of Insurance must work with the insurance industry to develop a plan for reimbursement of the expenses for rehabilitative residential care in lieu of more costly alternatives.

RECOMMENDATION 24 The Texas Department of Mental Health and Mental Retardation, the Department of Human Resources, the Texas Education Agency, and the Texas Rehabilitation Commission must develop a specific plan of action to determine how resources from Title XIX, Title XX, and the Vocational Rehabilitation Act could be more effectively utilized to assist the mentally disabled.

CHAPTER 6

PLANNING

Systematic long-range planning and shorter-term more specific tactical planning are essential elements in the design and implementation of a responsive, efficient, and cost-effective service delivery system, particularly one the size of TDMHMR. Without such a formal strategic plan, which is regularly updated and on which short term tactical and planning is based, services tend to be developed and operated at less than optimal levels, with resulting gaps, overlaps, and duplications. Planning for mental health services must be considered at three levels although each is a part of the continuum of the mental health service delivery system: system-wide planning, regional or community planning, and individual client planning.

System-Wide Planning

Although there is a state plan for the use of federal block grant funds as prescribed in The Omnibus Reconciliation Act of 1982, there is currently no long-range operational plan for the delivery of mental health services in Texas. Unless such a plan is developed, updated regularly, and appropriately integrated with budget requests, the delivery system will lack cohesion and continuity and will be subject to inadequate funding based on a lack of understanding of the consequences of budget and appropriation decisions by both the Department and the Legislature. There currently exists only a fragmented understanding of the need for mental health services in Texas and

of the resources available to meet these needs. A comprehensive needs assessment and inventory effort is therefore a crucial part of this system plan.

RECOMMENDATION 25 The Texas Department of Mental Health and Mental Retardation must initiate a long-range strategic plan of at least six years' length. The plan should be completed by August 31, 1985 and should be updated every two years. Funding for the 1988-89 biennium should be based on a tactical plan derived from this long-range plan. A comprehensive needs assessment and resource inventory must be undertaken as a part of this plan. The biennial budget should be based on the results of this process with both new program funding and continuation funding based on demonstrated needs.

RECOMMENDATION 26 The Office of Strategic Planning of the Texas Department of Mental Health and Mental Retardation should undertake development of the six-year plan described in Recommendation 28. Adequate and appropriate staff must be available to plan and assess the outcomes of programs designed to meet the needs of clients in the priority populations previously identified. Without being excessively prescriptive, the Committee recommends the inclusion of individuals with special expertise in sociology, economics, epidemiology, and data analysis within this planning staff.

RECOMMENDATION 27 The Texas Department of Mental Health and Mental Retardation must insure that the senior administrative staff responsible for service delivery at the system, regional, or community level receive the necessary support for their individual planning efforts from the TDMHMR planning staff. This support must include current literature reviews and timely needs assessment information, as well as appropriately organized planning documents and forms.

RECOMMENDATION 28 An information data base appropriate to this planning effort should be developed and maintained by the TDMHMR Office of Strategic Planning to assure timely access to current and historical needs and resource information.

RECOMMENDATION 29 The Texas Department of Mental Health and Mental Retardation must insure that information related to needs and resources is maintained in a way that makes it accessible for tactical planning by both public and private service providers.

RECOMMENDATION 30 The Texas Department of Mental Health and Mental Retardation must insure that, at minimum, the following elements are included in this long-range planning effort:

A. Quantifiable output and outcome indicators must be identified.

B. The plan must include
   1) identification of priority populations,
   2) identification of the minimum array of necessary services, and
   3) a description of the appropriate use of facilities.

C. Every two years, assessment of the progress made toward achieving the goals identified in the plan must be undertaken as a part of the budget preparation process.

D. Biennial budget requests must be directly tied to the long-range plan.

E. All stages of the long-range planning activities of the Department must be accomplished with the oversight of a citizens planning advisory council.

RECOMMENDATION 31 The Committee acknowledges that funding for services is a prerogative exercised by the Legislature every two years and the plan must be modified to conform to this reality. The Texas Department of Mental Health and Mental Retardation must initiate regular updates of the plans preceding a biennium to identify quantified increments of movement toward long-term goals and to reassess the impact of the prior budgeting process.

Regional or Community Planning

The size and diversity of the State of Texas requires that the general goals and directions provided by a system-wide plan be translated at the regional or community level into more specific plans for availability, delivery, coordination and funding of services. This step is imperative if individual clients in that region or community are to have access to at least the minimum array of services previously described. The regional or community plan must relate to the goals, objectives, and timetables of the statewide long-range plan.

RECOMMENDATION 32 Regional and community planning must be undertaken and should be under the general direction and enjoy the support of TDMHMR's Office of Strategic Planning.

RECOMMENDATION 33 Uniform data collection in all regions should be implemented to provide an accurate assessment of client needs and the array of services available. The Texas Department of Mental Health and Mental Retardation should be responsible for the development of appropriate data collection tools and for assisting regions and communities in this data recovery and must insure that at the regional level provisions are made for the input to and from the system planning group and those individuals responsible for individual client planning.

RECOMMENDATION 34 Planning at the regional/community level should address the coordination of efforts among mental health, alcohol and substance abuse, and other service workers in providing client services.

Individual Client Planning or Case Management

The true measure of the effectiveness of the mental health system is its

ability to provide needed services to the individual client particularly when those needs are complex and extend over a relatively long period of time. Therefore, planning efforts directed at the individual client are integral parts of the overall planning effort and are most appropriately coordinated by well-trained case managers provided direction by the system-wide and regional plans. Case management is discussed more thoroughly in Chapter 4 of this report.

CHAPTER 7

MANAGEMENT

There is concern among the Legislative Oversight Committee on Mental Health and Mental Retardation that what we call the "mental health system" functions with neither the coordination nor accountability necessary to be truly described as a system. The entire management system of the Texas Department of Mental Health and Mental Retardation should be directed toward delivery of a coordinated, integrated array of services to priority clients. Recommendations are made in the following areas: 1) building a coherent system of service delivery, 2) the regions, 3) personnel recruitment and training, 4) interagency coordination and 5) data needs.

Building a Coherent System of Service Delivery

In order to develop a system of service delivery which operates effectively and efficiently, conscious effort at system development must be undertaken. Policies must be implemented which clarify roles and responsibilities and which balance accountability and local autonomy. Since the enactment of the Mental Health and Mental Retardation Act in 1965, state responsibility and funding levels within the mental health delivery system have consistently increased. State controls must be augmented accordingly.

RECOMMENDATION 35 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-201 et seq. V.T.C.S.) to give authority to the Texas Department of Mental Health and Mental Retardation to select among candidates for Designated Providers, with selection based on past performance and/or capacity to deliver required services to priority populations, as determined by the TDMHMR Board.

RECOMMENDATION 36 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-204 V.T.C.S.) to replace the grants-in-aid program with legally binding contracts for services between the Texas Department of Mental Health and Mental Retardation and community-based service providers. These contracts should include the kinds of services to be developed, designation of priority populations, expected performance standards and outcome measures.

RECOMMENDATION 37 The Commissioner of the Texas Department of Mental Health and Mental Retardation should be required to withhold funds from a Designated Provider when the terms of a contract are not met.

RECOMMENDATION 38 The Texas Department of Mental Health and Mental Retardation must give equal emphasis and recognition to the state mental hospitals' community-based services and the community mental health and mental retardation centers.

RECOMMENDATION 39 The Texas Department of Mental Health and Mental Retardation must retain the option of contracting for services with another provider in a Service Area if the community mental health and mental retardation center is not responsive to state policy direction or is not performing in a satisfactory manner.

The Regions

In order to build a system for the delivery of mental health services which is consistent with the mission and responsibilities of the Department and also responsive to regional differences, to local situations, and, ultimately, to client needs, a clear delineation of lines of authority and division of labor must be implemented. Strengthening of regionalization is an important element. TDMHMR has divided the state into five administrative regions. The following recommendations relate to the regionalization effort.

RECOMMENDATION 40 Modify appropriate sections of the Mental Health and Mental Retardation Act (Article 5547-201 et seq., V.T.C.S.) to require that community mental health and mental retardation centers develop policies which are not in conflict with policies developed by the Board of the Texas Department of Mental Health and Mental Retardation.

RECOMMENDATION 41 The Texas Department of Mental Health and Mental Retardation must develop a system of accountability at the regional level to allow for funding to flow with the client population. This requires both regional service planning and budget flexibility. The Department should, therefore, inititate regional budget development. The Department should also consider increasing the number of regions to facilitate accountability and communication. Thirdly, the Department should develop policies which enhance regional planning and service coordination; examples may include:

- procedures to serve an individual outside the service area,
- mechanisms to buy goods and services in a cost-effective manner,
- prompt response to crisis situations which require policy interpretation.

Personnel Recruitment and Training

The operation of Texas Department of Mental Health and Mental Retardation requires well-trained, high-quality staff at all levels of the system. Several recommendations are directed towards the goal of improving the quality of staff, increasing the coordination among elements of the system, and delineating roles and responsibilities more closely.

RECOMMENDATION 42 The Texas Department of Mental Health and Mental Retardation must implement a standardization of qualifications for positions throughout its system and must fill those positions with individuals who meet the stated qualifications.

RECOMMENDATION 43 For key administrative positions (including Commissioner, Deputy Commissioners, Assistant Deputy Commissioners, State Hospital Superintendents, State Center Directors, Community MHMR Center Executive Directors), the Texas Department of Mental Health and Mental Retardation must develop more specifically defined job descriptions with requirements which balance clinical/programmatic knowledge and demonstrated successful management experience.

RECOMMENDATION 44 Mechanisms must be implemented which hold key administrative personnel of the Texas Department of Mental Health and Mental Retardation accountable for successful outcomes of their efforts, as well as for appropriate process.

RECOMMENDATION 45 Executive Directors of community mental health and mental retardation centers should be appointed by the center's Board of Trustees and confirmed by the TDMHMR Board.

RECOMMENDATION 46 Further study should be given to the costs of making state benefits accessible to center staffs.

Interagency Coordination

Meeting the needs of mentally ill Texans requires the coordinated effort of many agencies and service providers. The following recommendations relate to strategies which should be undertaken to encourage coordination.

RECOMMENDATION 47 The Legislature should direct the appropriate officials of the Texas Department of Mental Health and Mental Retardation, the Department of Human Resources and the Health Department to address the problems of jurisdictional overlap and areas of ambiguous authority and to recommend statutory changes as appropriate. Most urgently needed is resolution to the problems of alternate care licensure and certification, funding, and utilization described in Chapter 5.

The delivery of substance abuse services presents a particular challenge from the standpoint of interagency coordination. Over 30% of the admissions to state hospitals are of clients with substance abuse problems. Many of these admissions are due to the lack of detoxification services within the community. Most community-based residential programs, operated by the Texas Commission on Alcoholism and the Texas Department of Community Affairs, require that a patient be detoxified prior to admission. The state hospitals must therefore provide these residential services when local options for detoxification are not available. A full range of community alternatives, including detoxification, could result in reduced institutionalization, and these alternatives must be implemented.

RECOMMENDATION 48 The alcohol commitment law must be updated to make it consistent with the Mental Health Code. The law should mandate screening of alcohol commitments by the community mental health centers.

RECOMMENDATION 49 Coordination among the Texas Department of Mental Health and Mental Retardation, the Texas Commission on Alcoholism, and the Texas Department of Community Affairs should be implemented which requires consistent goal setting, coordination of programs and service funding, appropriate referral mechanisms, the removal of unclear lines of authority, and common patient identification which allows tracking of clients through the various programs funding by the three agencies.

RECOMMENDATION 50 The Texas Commission on Alcoholism must design a system to eliminate the admission of alcohol patients to state hospitals. Funding should be provided to replicate these programs, initially in areas of highest state hospital admission rates, and then expanded as rapidly as possible to the balance to the state, in two-year increments. These programs should be developed jointly with local Designated Providers.

Data Needs

Adequate data is a necessity for an adequately planned and monitored service delivery system. There is concern that the current data management system is neither adequate nor appropriate for the needs it should meet.

RECOMMENDATION 51 The Texas Department of Mental Health and Mental Retardation must implement a centralized system of current and historical information on clients, services, and funds. This requires that community mental health centers and other contract providers report information in a manner consistent both in content and timeliness with other elements of the system. This approach should allow the tracking of individual clients through the total system.

RECOMMENDATION 52 The Texas Department of Mental Health and Mental Retardation must implement a uniform cost-reporting system which includes identification of standard units of service.

CHAPTER 8

FUNDING AND FISCAL ACCOUNTABILITY

It is clear that in a time when demands on the mental health service delivery system continue to increase, available funds are not keeping pace. It is imperative that all available sources of funds be utilized and that accountability for appropriated funds be increased. Recommendations in this chapter relate to a variety of issues, including: a) fiscal accountability of community MHMR centers, b) fee collection, c) county responsibility, and d) third-party payments.

Fiscal Accountability of Community Mental Health Mental Retardation Centers (CMHMRCs)

The importance of fiscal accountability of CMHMRCs cannot be overestimated. The amount of state funding of community centers has increased over time. Mechanisms of accountability must be in place regarding the use of these funds.

RECOMMENDATION 53 Modify the Mental Health and Mental Retardation Act (Article 5547-203 V.T.C.S.) to permit fiscal audits of CMHMRCs to be conducted in a more cost-effective way. Possible alternatives: a) fiscal audit by TDMHMR, b) regional contracting for auditing of several agencies by private firms, or c) interagency agreement to audit cooperatively.

RECOMMENDATION 54 The Legislature should include in the TDMHMR Appropriations Bill language which reinforces the state's control over the use by CMHMRCs of TDMHMR contract funds and funds used as match. Expenditures of other local funds is the prerogative of the local Board of Trustees.

Fee Collection

A very real problem exists in the collection of fees for service by CMHMRCs and state hospital outreach programs. According to a recent review by the staff of the Legislative Budget Board, collections of patient fees during FY '84 ranged from a low of .1% of total funding to a high of 16.1% of total funding. The Legislative Budget Board has recommended that fees should be collected at the minimum level of 12% of the total agency budget, and to encourage collection a program be established that would allow retention of collections in excess of this amount.

The Legislative Oversight Committee agrees that a uniform fee collection policy for the community centers must be implemented. However, the fee collection should be tied to the assessed fees of the CMHMRC, rather than to the overall center budget. This approach acknowledges that some client groups, notably the poor and the long-term mentally ill, have a limited ability to pay fees. By relating the collection policy to assessed fees, the policy would not create a disincentive to serve these clients.

RECOMMENDATION 55 The Mental Health and Mental Retardation Act (Article 5547-203, V.T.C.S.) should be modified to reflect that unless the agency is prohibited from fee collection by contracts with other agencies or by another state law, all clients of CMHMRCs and outreach centers should be requested to pay at least a nominal amount for services they receive.

RECOMMENDATION 56 The Texas Department of Mental Health and Mental Retardation must establish a uniform fee collection policy for community mental health and mental retardation centers and state hospital outreach programs that would increase local revenues. Implementation of the policy should be monitored by TDMHMR Internal Audit staff.

RECOMMENDATION 57 TDMHMR Appropriations legislation should require fee collection by CMHMRCs and outreach centers, at a level based on an appropriate percentage of their assessed fees.

RECOMMENDATION 58 To facilitate collection by CMHMRCs, TDMHMR's claims legislation must be reviewed to determine its applicability to Centers.

RECOMMENDATION 59 The Committee urges enactment of the Legislative Budget Board's recommendations regarding ways to increase state hospital collections. The Legislature should consider an incentive system allowing retention by TDMHMR facilities of fee collections over a set amount.

County Responsibility

A study by the Task Force on Indigent Health Care documents an existing ambiguity in the law governing the role of Texas counties in the provision of health care for the indigent population. This situation has an impact on mental health services. Texas counties commonly support mental health treatment either through the use of county hospitals or through the funding of community centers and outreach programs. However, there is a large disparity among the counties in the level of support. The following tables identify county contributions to the operation of community centers and state hospital outreach programs.

[INSERT TABLE 15 about here]

Table 15 shows the FY '84 county contributions to mental health and

TABLE 15

COUNTY TAX DOLLARS APPROPRIATED
FOR TEXAS MH AND MR SERVICES
(FY 1984)

COUNTY	MENTAL HEALTH			MENTAL RETARDATION			TOTAL	
	Cash	In-kind	MH Total	Cash	In-Kind	MR Total		
A L L	$7,971,211	$2,583,045	$10,554,256	$5,359,200	$1,016,802	$1,016,802	$16,930,258	
Anderson	0	85,963	85,963	0	0	0	85,963	
Andrews	8,400	12,400	20,800	0	0	0	20,800	
Angelina (S)	24,500	0	24,500	2,682	0	2,682	27,182	
Aransas	0	0	0	0	0	0	0	
Archer	1,000	4,200	5,200	0	0	0	5,200	
Armstrong	94	0	94	0	0	0	94	
Atascosa	0	7,200	7,200	0	0	0	7,200	
Austin	0	4,009	4,009	0	0	0	4,009	
Bailey	2,021	2,290	4,311	979	1,110	2,089	6,400	
**Bastrop	0	8,700	8,700	1,500	3,600	5,100	13,800	
Baylor	4,745	0	4,745	0	50,000	50,000	54,745	
Bee	0	5,964	5,964	0	0	0	5,964	
Bell	71,000	0	71,000	106,500	0	106,500	177,500	
Bexar (H,S)	-	-	-	-	-	-	100,000	*
Blanco	0	0	0	0	0	0	0	
Borden	0	0	0	0	0	0	0	
Bosque	3,000	0	3,000	0	0	0	3,000	
Bowie	-	-	-	-	-	-	15,000	*
Brazoria	32,083	0	32,083	13,750	0	13,750	45,833	
Brazos	5,000	0	5,000	15,000	0	15,000	20,000	
Brewster	0	0	0	0	0	0	0	
Briscoe	571	0	571	277	0	277	848	
Brooks	0	4,832	4,832	0	308	308	5,140	
Brown	-	-	-	-	-	-	2,500	*
Burleson	4,950	0	4,950	200	0	200	5,150	
**Burnet	0	5,310	5,310	1,100	16,900	18,000	23,310	
**Caldwell	0	8,940	8,940	600	3,400	4,000	12,940	
Calhoun	2,436	0	2,436	600	0	600	3,036	
Callahan	2,200	0	2,200	0	0	0	2,200	
Cameron (C)	-	-	-	-	-	-	19,500	*
Camp	0	0	0	0	0	0	0	
Carson	281	0	281	0	0	0	281	
Cass	-	-	-	-	-	-	4,378	*
Castro	2,371	2,425	4,796	1,149	1,175	2,324	7,120	
**Chambers	10,635	0	10,635	30,000	1,674	31,674	42,309	
**Cherokee (H)	0	129	129	6,250	0	6,250	6,379	
Childress	0	12,040	12,040	0	0	0	12,040	
Clay	500	3,140	3,640	0	0	0	3,640	
Cochran	0	0	0	0	0	0	0	
Cole	0	0	0	0	0	0	0	
Coleman	-	-	-	-	-	-	1,200	*
Collin	4,504	0	4,504	733	0	733	5,237	
**Collingsworth	195	0	195	500	0	500	695	
**Colorado	0	5,184	5,184	3,500	12,500	16,000	21,184	
Comal	0	2,800	2,800	0	0	0	2,800	
Comanche	0	0	0	0	0	0	1,809	*
Concho	0	0	0	0	0	0	0	
Cooke	0	0	0	0	0	0	0	
Coryell	2,500	60,480	62,980	2,500	6,720	9,220	72,200	
Cottle	0	60,000	60,000	0	0	0	60,000	
Crane	0	0	0	0	0	0	0	
Crockett	0	0	0	0	0	0	0	
Crosby	0	0	0	0	0	0	0	
Culberson	0	3,305	3,305	0	0	0	3,305	
Dallam	0	0	0	0	0	0	0	
Dallas	385,000	0	385,000	165,000	0	165,000	550,000	
Dawson	7,719	3,000	10,719	0	0	0	10,719	
Deaf Smith	4,780	0	4,780	0	0	0	4,780	
Delta	0	0	0	0	0	0	0	
Denton (S)	4,504	0	4,504	733	0	733	5,237	
Dickens	4,330	0	4,330	0	0	0	4,330	
Dimmit	0	0	0	0	0	0	0	
Donley	179	0	179	0	0	0	179	
Duval	0	7,262	7,262	0	898	898	8,160	
DeWitt	4,000	0	4,000	1,200	0	1,200	5,200	
Eastland	-	-	-	-	-	-	1,200	*
Ector	26,163	6,000	32,163	26,163	0	26,163	58,326	
Edwards	0	0	0	0	0	0	0	

TABLE 15, Continued

COUNTY TAX DOLLARS APPROPRIATED
FOR TEXAS MH AND MR SERVICES
(FY 1984)

COUNTY	MENTAL HEALTH			MENTAL RETARDATION			TOTAL
	Cash	In-kind	MH Total	Cash	In-Kind	MR Total	
Ellis	0	13,920	13,920	0	0	0	13,920
El Paso (C)	-	-	-	-	-	-	64,800 *
							100,750 *
Erath	9,800	0	9,800	4,200	0	4,200	14,000
Falls	0	0	0	0	0	0	0
Fannin	0	0	0	0	0	0	0
**Fayette	0	5,640	5,640	22,800	14,000	36,800	42,440
Fisher	0	0	0	0	0	0	0
Floyd	2,435	2,088	4,523	1,181	1,012	2,193	6,716
Foard	6,720	0	6,720	0	0	0	6,720
Fort Bend (S)	0	11,614	11,614	0	25,000	25,000	36,614
Franklin	0	0	0	0	0	0	0
Freestone	0	0	0	0	0	0	0
Frio	0	2,244	2,244	0	0	0	2,244
Gaines	6,011	8,300	14,311	0	0	0	14,311
Galveston	46,667	0	46,677	20,000	0	20,000	66,667
Garza	4,800	5,100	9,900	0	0	0	9,900
**Gillespie	0	4,152	4,152	0	1,560	1,560	5,712
Glasscock	0	0	0	0	0	0	0
Goliad	720	0	720	180	0	180	900
**Gonzales	0	5,400	5,400	1,200	10,600	11,800	17,200
**Gray	3,329	0	3,329	5,700	0	5,700	9,029
Grayson	0	0	0	0	0	0	0
Gregg	44,387	25,000	69,387	26,413	0	26,413	95,800
Grimes	5,100	3,000	8,100	900	0	900	9,000
Guadalupe	0	4,400	4,400	0	0	0	4,400
Hale	7,611	0	7,611	3,689	0	3,689	11,300
**Hall	6,426	0	6,426	0	0	0	6,426
Hamilton	750	3,720	4,470	750	3,720	4,470	8,940
Hansford	1,305	0	1,305	0	0	0	1,305
Hardeman	0	75,000	75,000	0	0	0	75,000
**Hardin	0	67,190	67,190	12,970	0	12,970	80,160
Harris	5,349,008	192,000	5,541,008	1,632,209	300,000	1,932,209	7,473,217
Harrison	11,580	0	11,580	22,463	0	22,463	34,043
Hartley	0	0	0	0	0	0	0
**Haskell	0	25,000	25,000	2,000	1,500	3,500	28,500
Hays	0	18,430	18,430	0	0	0	18,430
Hemphill	0	0	0	0	0	0	0
Henderson	19,200	0	19,200	0	0	0	19,200
Hidalgo	25,000	0	25,000	5,000	0	5,000	30,000
Hill	3,000	0	3,000	0	0	0	3,000
Hockley	0	0	0	0	0	0	0
Hood	5,380	0	5,380	2,305	0	2,305	7,685
Hopkins	0	13,920	13,920	0	0	0	13,920
Houston	0	0	0	6,584	0	6,584	6,584
Howard (H)	0	0	0	0	0	0	0
Hudspeth	0	0	0	0	0	0	0
Hunt	4,210	0	4,210	685	0	685	4,895
Hutchinson	0	0	0	0	0	0	0
Irion	0	0	0	0	0	0	0
Jack	0	2,666	2,666	0	0	0	2,666
Jackson	3,600	0	3,600	900	0	900	4,500
Jasper	5,225	0	5,225	5,225	0	5,225	10,450
Jeff Davis	0	0	0	0	0	0	0
Jefferson (C)	226,925	0	226,925	0	0	0	226,925
Jim Hogg	0	8,629	8,629	0	0	0	8,629
Jim Wells	0	11,889	11,889	0	759	759	12,648
Johnson	3,000	4,320	7,320	0	0	0	7,320
Jones	0	0	0	0	0	0	0
Karnes	0	4,400	4,400	0	0	0	4,400
Kaufman (H)	0	0	0	0	0	0	0
Kendall	0	0	0	0	0	0	0
Kenedy	0	0	0	0	0	0	0
Kent	0	0	0	0	0	0	0
Kerr (H)	0	1,932	1,932	0	0	0	1,932
Kimble	0	2,640	2,640	0	0	0	2,640
King	0	0	0	0	0	0	0
Kinney	0	0	0	0	0	0	0
Kleberg	0	32,216	32,216	0	2,056	2,056	34,272

TABLE 15, Continued

COUNTY TAX DOLLARS APPROPRIATED
FOR TEXAS MH AND MR SERVICES
(FY 1984)

COUNTY	MENTAL HEALTH			MENTAL RETARDATION			TOTAL
	Cash	In-kind	MH Total	Cash	In-Kind	MR Total	
Knox	2,751	0	2,751	0	0	0	2,751
Lamar	0	69,770	69,770	0	0	0	69,770
Lamb	4,041	2,425	6,466	1,959	1,175	3,134	9,600
Lampasas	2,970	0	2,970	330	0	330	3,300
La Salle	0	0	0	0	0	0	0
Lavaca	1,150	0	1,150	5,000	0	5,000	6,150
**Lee	0	7,380	7,380	1,500	12,500	14,000	21,380
Leon	0	0	0	0	1,800	1,800	1,800
Liberty	34,375	0	34,375	0	0	0	34,375
Limestone (S)	4,887	0	4,887	0	0	0	4,887
Lipscomb	168	0	168	0	0	0	168
Live Oak	0	0	0	0	0	0	0
Llano	0	2,508	2,508	0	0	0	2,508
Loving	0	0	0	0	0	0	0
Lubbock (S)	39,000	0	39,000	0	0	0	39,000
Lynn	0	0	0	0	0	0	0
Madison	2,400	0	2,400	1,100	0	1,100	3,500
Marion	0	0	0	1,875	0	1,875	1,875
Martin	0	0	0	0	0	0	0
Mason	0	0	0	0	0	0	0
Matagorda	0	8,100	8,100	0	0	0	8,100
Maverick	0	2,640	2,640	0	0	0	2,640
Medina	0	0	0	0	4,800	4,800	4,800
Menard	0	0	0	0	0	0	0
Midland	27,363	18,000	45,363	27,363	0	27,363	72,726
Milam	1,620	42,480	44,100	180	4,720	4,900	49,000
Mills	0	0	0	0	0	0	0
Mitchell	3,350	6,700	10,050	0	0	0	10,050
Montague	1,226	2,324	3,550	0	0	0	3,550
Montgomery	98,078	15,000	113,078	0	0	0	113,078
Moore	3,485	0	3,485	0	0	0	3,485
Morris	0	0	0	0	0	0	0
Motley	381	0	381	184	0	184	565
McCulloch	-	-	-	-	-	-	1,200 *
McLennan (H)	58,990	0	58,990	0	0	0	58,990
McMullen	0	0	0	0	0	0	0
Nacogdoches	8,245	0	8,245	8,245	0	8,245	16,490
Navarro	12,864	0	12,864	0	0	0	12,864
Newton	568	0	568	5,110	0	5,110	5,678
Nolan	12,025	4,433	16,458	0	0	0	16,458
Nueces (S)	129,150	18,900	148,050	53,300	22,202	75,502	223,552
Ochiltree	6,103	0	6,103	0	0	0	6,103
Oldham	1,907	0	1,907	0	0	0	1,907
Orange	29,838	0	29,838	0	0	0	29,838
Palo Pinto	1,680	0	1,680	720	0	720	2,400
Panola	2,750	0	2,750	0	0	0	2,750
Parker	9,100	0	9,100	3,900	0	3,900	13,000
Parmer	1,637	0	1,637	793	0	793	2,430
Pecos	14,432	0	14,432	14,432	0	14,432	28,864
Polk	4,923	0	4,923	4,923	0	4,923	9,846
Potter (C)	0	32,000	32,000	0	0	0	32,000
Presidio	0	0	0	0	0	0	0
Rains	1,322	0	1,322	0	0	0	1,322
Randall	0	0	0	0	0	0	0
Reagan	0	0	0	0	0	0	0
Real	0	0	0	0	0	0	0
Red River	0	0	0	0	0	0	0
Reeves	6,219	0	6,219	0	6,555	6,555	12,774
Refugio	3,000	0	3,000	800	0	800	3,800
Roberts	0	0	0	0	0	0	0
Robertson	750	0	750	0	0	0	750
Rockwall	0	0	0	0	0	0	0
Runnels	0	0	0	0	0	0	0
Rusk	3,750	0	3,750	3,750	0	3,750	7,500
Sabine	0	0	0	2,500	0	2,500	2,500
San Augustine	0	0	0	2,500	0	2,500	2,500
San Jacinto	1,643	0	1,643	2,464	0	2,464	4,107
San Patricio	0	17,603	17,603	0	0	0	17,603
San Saba	-	-	-	-	-	-	450 *
Schleicher	0	0	0	0	0	0	0

TABLE 15, Continued

COUNTY TAX DOLLARS APPROPRIATED
FOR TEXAS MH AND MR SERVICES
(FY 1984)

COUNTY	MENTAL HEALTH			MENTAL RETARDATION			TOTAL
	Cash	In-kind	MH Total	Cash	In-Kind	MR Total	
Scurry	35,614	10,400	46,014	0	0	0	46,014
Shackelford	0	2,028	2,028	0	0	0	2,028
Shelby	3,080	0	3,080	1,320	0	1,320	4,400
Sherman	0	0	0	0	0	0	0
Smith	46,000	0	46,000	0	0	0	46,000
Somervell	4,620	0	4,620	1,980	0	1,980	6,600
Starr	0	8,730	8,730	0	0	0	8,730
Stephens	0	4,056	4,056	0	0	0	4,056
Sterling	0	0	0	0	0	0	0
Stonewall	2,750	0	2,750	0	0	0	2,750
Sutton	0	0	0	0	0	0	0
**Swisher	3,455	2,021	5,476	1,278	5,779	7,057	12,533
Tarrant (S)	463,713	0	463,713	61,182	0	61,182	524,895
Taylor (S)	23,625	0	23,625	49,374	0	49,374	72,999
Terrell	0	0	0	0	0	0	0
Terry	17,464	7,000	24,464	0	0	0	24,464
Throckmorton	0	0	0	0	0	0	0
Titus	6,840	0	6,840	0	0	0	6,840
Tom Green (S)	30,109	0	30,109	30,000	0	30,000	60,109
Travis (H, 2S)	143,979	0	143,979	16,184	0	16,184	160,163
Trinity	4,458	0	4,458	495	0	495	4,953
Tyler	3,533	0	3,533	3,533	0	3,533	7,066
Upshur	8,631	0	8,631	3,369	0	3,369	12,000
Upton	3,240	2,000	5,240	0	0	0	5,240
Uvalde	0	0	0	0	0	0	0
Val Verde	0	0	0	0	18,480	18,480	18,480
Van Zandt	12,000	0	12,000	0	0	0	12,000
Victoria	16,000	0	16,000	4,000	0	4,000	20,000
Walker	27,500	0	27,500	0	0	0	27,500
Waller	0	1,009	1,009	0	0	0	1,009
Ward	28,213	16,400	44,613	0	0	0	44,613
Washington (S)	10,000	0	10,000	1,000	0	1,000	11,000
Webb (C)	0	0	0	0	0	0	0
Wharton	0	7,260	7,260	0	0	0	7,260
Wheeler	0	0	0	0	0	0	0
Wichita (H)	83,429	0	83,429	1,571	0	1,571	85,000
Wilbarger (H)	3,517	50,000	53,517	0	0	0	53,517
Willacy	0	0	0	0	0	0	0
**Williamson	0	42,200	42,200	11,600	12,600	24,200	66,400
Wilson	0	0	0	0	6,000	6,000	6,000
Winkler	0	0	0	0	4,000	4,000	4,000
Wise	0	6,295	6,295	0	0	0	6,295
Wood	14,000	0	14,000	0	0	0	14,000
Yoakum	0	0	0	0	0	0	0
**Young	15,450	123,000	138,450	4,200	2,000	6,200	144,650
Zapata	0	5,676	5,676	0	0	0	5,676
Zavala	0	0	0	0	0	0	0

EXPLANATION OF CODES

* Indicates cash contributions without restrictions.

\+ Indicates in-kind contributions made without restrictions.

** Indicates a county government which contributes funds to more than one service provider; for example, an outreach program and a community center both receive some county funds.

H Indicates a county in which there is a state hospital.

C Indicates a county in which there is a state center.

S Indicates a county in which there is a state school.

mental retardation services provided by community MHMR centers and state hospital outreach programs. Both cash contributions and in-kind contributions are indicated.

[INSERT TABLE 16 about here]

Table 16 analyzes the county contributions based on population to provide the per capita contributions of counties for FY '84. (Based on 1982 population estimates done by the Bureau of the Census.)

Tables 15 and 16 confirm the wide disparity between individual county contributions and the lack of a uniform understanding of the counties' responsibility to provide mental health or mental retardation services for those persons residing within the county.

When examining these tables several points need to be kept in mind. These data represent only one of several sources of local funds, specifically, funds generated by county tax dollars. In the case of some community centers, particularly those community centers serving urban populations, the contribution from this source is relatively small compared to other local sources.[7] These tables are useful for making comparisons of the level of support across counties from a single source; they do not enumerate nor compare contributions from all sources of local funds. In addition, the data presented are only for services provided by the TDMHMR system.

The contributions listed in the tables as well as funds from other local

---

[7] For example, Austin-Travis County MHMR Center received $160,163 county tax dollars in FY '84 and $687,181 from other local revenue. Among the sources of other local revenue are contracts with the Texas Rehabilation Commission, the Department of Human Resources, payments made under Medicaid and Medicare, donations, interest, and income from the sheltered workshop program.

TABLE 16

FUNDS GENERATED BY COUNTY TAX DOLLARS PER CAPITA
FOR MH AND MR SERVICES
IN TEXAS
(Based on Actual FY '84 Figures)

COUNTY	MH/ PER CAPITA	MR/ PER CAPITA	TOTAL MH + MR/ PER CAPITA
Anderson	2.03	.00	2.03
Andrews	1.38	.00	1.38
Angelina (S)	.36	.04	.40
Aransas	.00	.00	.00
Archer	.69	.00	.69
Armstrong	.04	.00	.04
Atascosa	.27	.00	.27
Austin	.20	.00	.20
Bailey	.51	.25	.76
Bandera	.00	.00	.00
* Bastrop	.31	.18	.49
Baylor	.91	9.62	10.53
Bee	.22	.00	.22
Bell	.64	.65	1.29
Bexar (S, H)	-.--	-.--	.10
Blanco	.00	.00	.00
Borden	.00	.00	.00
Bosque	.22	.00	.22
Bowie	-.--	-.--	.20
Brazoria	.18	.08	.26
Brazos	.04	.13	.17
Brewster	.00	.00	.00
Brisoce	.23	.11	.34
Brooks	.55	.04	.59
Brown	-.--	-.--	.07
Burleson	.34	.01	.35
* Burnet	.28	.94	1.22
* Caldwell	.36	.16	.52
Calhoun	.11	.03	.14
Callahan	.19	.00	.19
Cameron (C)	-.--	-.--	.08
Camp	.00	.00	.00
Carson	.03	.00	.03
Cass	-.--	-.--	.14
Castro	.45	.22	.67
* Chambers	.56	1.66	2.22
* Cherokee (H)	.00	.16	.16
Childress	1.74	.00	1.74
Clay	.38	.00	.38
Cochran	.00	.00	.00
Cole	.00	.00	.00
Coleman	.11	.11	.22
Collin	.03	.00	.03
* Collingsworth	.04	.11	.15
* Colorado	.27	.82	1.09
Comal	.07	.00	.07
Comanche	1.07	.00	1.07
Concho	.00	.00	.00
Cooke	.00	.00	.00
Corvell	1.07	.16	1.23
Cottle	21.43	.00	21.43
Crane	.00	.00	.00
Crockett	.00	.00	.00
Crosby	.00	.00	.00
Culberson	.97	.00	.97
Dallam	.00	.00	.00
Dallas	.23	.10	.33
Dawson	.64	.00	.64
Deaf Smith	.23	.00	.23
Delta	.00	.00	.00
Denton (S)	.03	.00	.03
De Witt	.02	.06	.08
Dickens	1.31	.00	1.31
Dimmit	.00	.00	.00
Donley	.04	.00	.04
Duval	.56	.07	.63
Eastland	-.--	-.--	.06
Ector	.24	.19	.43
Edwards	.00	.00	.00
Ellis	.22	.00	.22
El Paso (C)	-.--	-.--	.32
Erath	.42	.18	.60
Falls	.00	.00	.00
Fannin	.00	.00	.00
* Fayette	.28	1.80	2.08
Fisher	.00	.00	.00
Floyd	.48	.23	.71
Foard	3.36	.00	3.36
Fort Bend (S)	.08	.16	.24
Franklin	.00	.00	.00
Freestone	.00	.00	.00
Frio	.16	.00	.16
Gaines	1.04	.00	1.04
Galveston	.22	.10	.32
Garza	1.76	.00	1.76
* Gillespie	.29	.11	.40
Glasscock	.00	.00	.00
Goliad	.13	.03	.16
* Gonzales	.29	.64	.93
* Gray	.12	.21	.33
Grayson	.00	.00	.00
Gregg	.63	.24	.87
Grimes	.52	.06	.58
Guadalupe	.09	.00	.09
Hale	.20	.10	.30
* Hall	1.24	.00	1.24
Hamilton	.55	.55	1.10
Hansford	.20	.00	.20
Hardeman	11.54	.00	11.54
* Hardin	1.60	.31	1.91
Harris	2.06	.72	2.78
Harrison	.21	.40	.61
Hartley	.00	.00	.00
* Haskell	3.29	.46	3.75
Hays	.42	.00	.42
Hemphill	.00	.00	.00
Henderson	.42	.00	.42
Hidalgo	.08	.02	.10
Hill	.12	.00	.12
Hockley	.00	.00	.00
Hood	.27	.12	.39
Hopkins	.53	.00	.53
Houston	.00	.28	.28
Howard (H)	.00	.00	.00
Hudspeth	.00	.00	.00
Hunt	.07	.01	.08
Hutchinson	.00	.00	.00
Irion	.00	.00	.00
Jack	.34	.00	.34
Jackson	.26	.12	.38
Jasper	.17	.17	.34
Jeff Davis	.00	.00	.00
Jefferson (C)	.88	.00	.88
Jim Hogg	1.57	.00	1.57
Jim Wells	.31	.02	.33
Johnson	.10	.00	.10
Jones	.00	.00	.00
Karnes	.32	.00	.32
Kaufman (H)	.00	.00	.00
Kendall	.00	.00	.00
Kenedy	.00	.00	.00
Kent	.00	.00	.00
Kerr (H)	.06	.00	.06
Kimble	.63	.00	.63
King	.00	.00	.00
Kinney	.00	.00	.00
Kleberg	.93	.06	.99
Knox	.49	.00	.49
Lamar	1.62	.00	1.62
Lamb	.35	.17	.52
Lampasas	.23	.03	.26
La Salle	.00	.00	.00
* Lavaca	.06	.27	.33
* Lee	.54	1.02	1.56
Leon	.00	.17	.17
Liberty	.69	.00	.69
Limestone (S)	.24	.00	.24
Lipscomb	.04	.00	.04
Live Oak	.00	.00	.00
Llano	.24	.00	.24

TABLE 16, Continued

FUNDS GENERATED BY COUNTY TAX DOLLARS PER CAPITA
FOR MH AND MR SERVICES
IN TEXAS
(Based on Actual FY '84 Figures)

COUNTY	MH/ PER CAPITA	MR/ PER CAPITA	TOTAL MH + MR/ PER CAPITA	COUNTY	MH/ PER CAPITA	MR/ PER CAPITA	TOTAL MH + MR/ PER CAPITA
Loving	.00	.00	.00	San Augustine	.00	.28	.28
Lubbock (S)	.18	.00	.18	San Jacinto	.14	.21	.35
Lynn	.00	.00	.00	San Patricio	.29	.00	.29
McCulloch	-.--	-.--	.14	San Saba	-.--	-.--	.00
McLennan (H)	.34	.00	.34	Schleicher	.00	.00	.00
McMullen	.00	.00	.00	Scurry	2.36	.00	2.36
Madison	.21	.10	.31	Shackelford	.49	.00	.49
Marion	.00	.18	.18	Shelby	.13	.06	.19
Martin	.00	.00	.00	Sherman	.00	.00	.00
Mason	.00	.00	.00	Smith	.34	.00	.34
Matagorda	.22	.00	.22	Somervell	1.10	.47	1.57
Maverick	.08	.00	.08	Starr	.29	.00	.29
Medina	.00	.20	.20	Stephens	.37	.00	.37
Menard	.00	.00	.00	Sterling	.00	.00	.00
Midland	.47	.28	.75	Stonewall	1.15	.00	1.15
Milam	1.92	.21	2.13	Sutton	.00	.00	.00
Mills	.00	.00	.00	* Swisher	.60	.77	1.37
Mitchell	1.06	.00	1.06	Tarrant (S)	.50	.07	.57
Montague	.19	.00	.19	Taylor (S)	.20	.42	.62
Montgomery	.76	.00	.76	Terrell	.00	.00	.00
Moore	.20	.00	.20	Terry	1.62	.00	1.62
Morris	.00	.00	.00	Throckmorton	.00	.00	.00
Motley	.20	.10	.30	Titus	.31	.00	.31
Nacogdoches	.17	.17	.34	Tom Green (S)	.33	.33	.66
Navarro	.35	.00	.35	Travis (H, 2S)	.32	.04	.36
Newton	.04	.38	.42	Trinity	.43	.05	.48
Nolan	.91	.00	.91	Tyler	.22	.21	.43
Nueces (S)	.52	.27	.79	Upshur	.28	.11	.39
Ochiltree	.57	.00	.57	Upton	.99	.00	.99
Oldham	.83	.00	.83	Uvalde	.00	.00	.00
Orange	.34	.00	.34	Val Verde	.00	.49	.49
Palo Pinto	.07	.01	.08	Van Zandt	.36	.00	.36
Panola	.13	.00	.13	Victoria	.22	.05	.27
Parker	.19	.08	.27	Walker	.59	.00	.59
Parmer	.15	.07	.22	Waller	.05	.00	.05
Pecos	.85	.85	1.70	Ward	2.79	.00	2.79
Polk	.19	.19	.38	Washington (S)	.42	.04	.46
Potter (C)	.31	.00	.31	Webb (C)	.00	.00	.00
Presidio	.00	.00	.00	Wharton	.18	.00	.18
Rains	.25	.00	.25	Wheeler	.00	.00	.00
Randall	.00	.00	.00	Wichita (H)	.66	.01	.67
Reagan	.00	.00	.00	Wilbarger (H)	3.28	.00	3.28
Real	.00	.00	.00	Willacy	.00	.00	.00
Red River	.00	.00	.00	Williamson	.49	.28	.77
Reeves	.37	.39	.76	Wilson	.00	.34	.34
Refugio	.32	.09	.41	Winkler	.00	.35	.35
Roberts	.00	.00	.00	Wise	.22	.00	.22
Robertson	.05	.00	.05	Wood	.55	.00	.55
Rockwall	.00	.00	.00	Yoakum	.00	.00	.00
Runnels	.00	.00	.00	* Young	7.02	.31	7.33
Rusk	.09	.25	.34	Zapata	.75	.00	.75
Sabine	.00	.28	.28	Zavala	.00	.00	.00

* Indicates a county which contributes funds to more than one service provider; for example, an outreach program and a community center both receive some county funds.

H Indicates a county in which there is a state hospital.

C Indicates a county in which there is a state center.

S Indicates a county in which there is a state school.

sources are frequently directed to specific client groups and services. In some cases a substantial part of local funds come from contracts between local agencies and the CMHMRCs for the provision of services to disparate groups such as the aged, substance abusers, and probationers. Such arrangements illustrate the enterprising spirit of centers in meeting local needs and generating local dollars. Expenditure of these funds by a center is limited by local preference and expenditure must adhere to the conditions of existing contracts. It cannot be assumed that centers would be able to secure local dollars for the priority groups that have been outlined by the Committee.

RECOMMENDATION 60 The Legislature through its appropriate standing committees should clarify state law regarding county legal responsibility for medical care, including mental health care, for their indigent residents.

RECOMMENDATION 61 The Texas Department of Mental Health and Mental Retardation must clarify the issue of "county of residence" and the residents rights to services and establish a policy regarding the availability of services to "non-residents".

Third Party Payments

The importance of obtaining reimbursement for services from all appropriate providers is recognized. Medicaid extension may be the most cost-effective way for this to occur for the indigent, but other third-parties must also be evaluated and utilized whenever possible.

RECOMMENDATION 62 The Legislature or other appropriate entity must undertake a study of optional services provided under the State Medicaid Program to determine the potential savings to the state of providing certain mental health services.

CHAPTER 9

QUALITY ASSURANCE

In addition to identifying populations that should be given priority and the services that those populations require, Committee members examined the issue of quality of care. The concept, "quality of care", encompasses a disparate group of standards and goals relating to such issues as a safe and adequate environment, a team of health professionals to plan and implement individualized treatment plans, medical management of patients, selection criteria for hiring staff, and many others. Assessing the quality of care is a difficult process because all aspects, both tangible and intangible, must be taken into account.

After reviewing a summary of the procedures and standards of the major standard-setting bodies involved in the assessment of hospitals and residential placements for the mentally retarded, the consensus of the Legislative Oversight Committee was that collectively there exist adequate guidelines to evaluate the quality of care. Although imperfect, these standards and regulations represent a good effort at addressing a complex issue.

Thus, the provision of quality care is defined as "being in compliance with all applicable standards and regulations". The Legislative Oversight Committee on MHMR offers recommendations related to several aspects of quality assurance including program evaluation, clients rights, and access to services and personnel.

Program Evaluation

Implementation of many of the recommendations identified previously result in a decentralized service delivery system, when viewed from the perspective location of services, auspices, and other factors. This increased decentralization makes more imperative the requirement of a centralized approach to insuring that services are provided appropriately. Services recipients and their families must have the assurance that they can realistically expect to receive a uniformly high quality of care no matter what element of the service delivery system in which they are served.

RECOMMENDATION 63 The Legislature should modify the Mental Health and Mental Retardation Act (Article 5547-203, V.T.C.S.) to allow for more cost-effective means of obtaining program audits for CMHMRCs, including interagency agreements to audit cooperatively or to accept one anothers' audits.

RECOMMENDATION 64 The Texas Department of Mental Health and Mental Retardation must develop standards of care and monitoring mechanisms which insure consistent quality whether the service is provided by a Texas Department of Mental Health and Mental Retardation facility or a contract service provider.

RECOMMENDATION 65 The Texas Department of Mental Health and Mental Retardation must provide direct quality assurance monitoring and evaluation. This should not be delegated.

RECOMMENDATION 66 In designing a quality assurance system, the Texas Department of Mental Health and Mental Retardation must identify outcome measures and must insure that performance evaluation encompasses both quality and cost-effectiveness.

RECOMMENDATION 67 The designation and/or redesignation of the Designated Provider of mental health services for a Service Area must be based on performance evaluation and capacity.

Clients Rights and Access to Services

An additional element in assuring that high quality standards are maintained involves the appropriateness of services to the need of the individual and the insurance that clients' rights are protected.

RECOMMENDATION 68 The Texas Department of Mental Health and Mental Retardation must establish a mechanism to insure that the screening and emergency services recommended in Chapter 4 of this report are available and accessible to clients throughout the state.

RECOMMENDATION 69 The Texas Department of Mental Health and Mental Retardation must require that needed services are accessible to the priority populations.

RECOMMENDATION 70 The Texas Department of Mental Health and Mental Retardation must institute a well-publicized centralized telephone access for individual clients' complaints, for information, and for problem-solving.

Personnel

The importance of well-trained, motivated staff in implementing high-quality services cannot be underestimated. Recommendations regarding personnel in Chapter 7 of this report speak of this issue. Two additional recommendations are appropriate here.

RECOMMENDATION 71 The Texas Department of Mental Health and Mental Retardation must require that quality assurance staff in all portions of the service delivery system receive ongoing training to insure consistent interpretation of standards.

RECOMMENDATION 72 The Texas Department of Mental Health and Mental Retardation must pursue systematic training and retraining effort of direct care staff to insure that the quality of care is uniform throughout the system.

A P P E N D I C E S

APPENDIX A - CHARGES TO THE COMMITTEE AND COMMITTEE ROSTER

Charges to the Legislative Oversight Committee on Mental Health and Mental Retardation

In 1974, a lawsuit was filed by a group of parents of state hospital patients who claimed that their children were unnecessarily drugged, that they were mistreated, and that they were exposed to violence from other patients. In 1981, a settlement of this class action lawsuit was reached, with the Texas Department of Mental Health and Mental Retardation agreeing to initiate policies to improve treatment for state hospital clients. Department staff were to consult patients about prescribed drug treatments and to limit drug dosage, individualized programs of treatment were to be developed for each patient, and steps were to be taken to ensure the personal safety of each patient. In April, 1984, U.S. District Judge Barefoot Sanders ruled that the Department had failed to comply with the 1981 agreement and had not adequately planned and documented individualized treatment or adequately protected patients from harm. In order to provide safe conditions and effective treatment for mental health patients, Judge Sanders ruled that the staff-to-patient ratio had to be improved, with approximately 1,200 additional direct-care staff persons needed to reach the "absolute minimum" ratios of one staff person to five patients between 7 a.m. and 11 p.m. and one staff

person to 10 patients between 11 p.m. and 7 a.m.

The budgetary restrictions that will be facing the legislature during the 1985 regular session and this legal responsibility to improve services to clients of the Texas Department of Mental Health and Mental Retardation create a difficult challenge for the state. To address those issues and to provide informed alternatives for the legislature, the Legislative Oversight Committee on Mental Health and Mental Retardation has been created, with members to include state policymakers, business professionals, mental health and mental retardation professionals and advocates. The committee is directed to study the mental health and mental retardation services system in Texas and to make recommendations concerning the use of available resources to address the current demands for improved patient care and concerning policies and funding that will effectively provide for clients needs not only now, but in the future.

Based on the findings of its study, the committee is directed to prepare a report by February 1, 1985, that includes the following:

- (1) a profile of the mental health and mental retardation service system in Texas;

(2) policy recommendations for the legislature concerning the provision of safe and adequate care and treatment for clients in state hospitals and state schools, the elements necessary for offering clients a continuum of care, the role and responsibilities of state institutions, and the scope of and funding for community alternatives to institutional care; and

(3) management suggestions to facilitate the implementation of policy recommendations.

COMMITTEE ROSTER

LEGISLATIVE OVERSIGHT COMMITTEE ON
MENTAL HEALTH AND MENTAL RETARDATION

Oswin Chrisman, Chair
Dallas

Spencer Bayles, M.D.
Houston

Senator Chet Brooks
Pasadena

W.H. Cunningham, Ph.D., Dean
School of Business
The University of Texas
Austin

Helen Farabee, President
Mental Health Association in Texas
Wichita Falls

Loyd Kilpatrick, Executive Director
Tarrant County MHMR Services
Fort Worth

Alvin LeBlanc, M.D., Vice President
The University of Texas Medical Branch
Galveston

Represenative Frank Madla
San Antonio

Gary Miller, M.D., Commissioner
TDMHMR

R. Coke Mills, Chair
Texas Board of MHMR
Waco

Theresa Mulloy, Ed.D., Executive Director
Pecan Valley MHMR Region
Stephenville

Ross Newby, Exeuctive Director
Texas Commission on Alcoholism
Austin

David Pharis, Coordinator
R.A.J. Review Panel
Austin

Representative Jack Vowell
El Paso

David Wade, M.D.
Corpus Christi

Frankie Williams, M.D., Superintendent
Vernon State Hospital

Staff
Stella C. Mullins, Executive Director
Karen F. Hale, Associate Director
Michaelyn Saukel, Research Assistant
Rachel Kates, Secretary
Mental Health Association in Texas
Austin

APPENDIX B - GLOSSARY

Adult Basic Education - The training and teaching of clients with special learning needs to increase their social and academic skills and which focuses on the teaching of basic pre-academic, academic, and functional academic skills.

Behavior Therapy - The modification of selected behaviors through the consistent and systematic manipulation of both antecedent and consequent stimuli. Behavior therapy is a formalized set of techniques and training procedures based upon the principles of learning and is intended to establish, alter or eliminate specific responses or chains of response.

CMHMRCs - see Community Centers

Care Services - Services provided which insure generic human needs on a personal basis for shelter, food, safety, transportation, exercise and supervision.

Case Finding - The active seeking of patients/clients or potential patients/clients. This requires formal contracts with public and private health, legal, education and welfare agencies along with the use of media to inform the public about the availability of services.

Case Management - A system in which a single accountable individual performs activities in the service of the client, insuring that the client has access to, and receives, all resources and services which can help achieve his/her optimal level of functioning (i.e., developing a social support network).

Community Centers - Community mental health and mental retardation centers established pursuant to House Bill 3 and operated by local boards of trustees.

Crisis Hotline - Immediately available services, activated by a telephone call, to meet the critical needs of individuals who require help in emergency situations.

Crisis Support - Activities provided in a supportive environment aimed at the reduction of acute emotional disabilities and their physical and social manifestations. Crisis support is available 24 hours a day, seven days a week. Although the service may be provided in a hospital setting, it does not necessarily involve admission to a 24-hour bed facility.

DHR - Texas Department of Human Resources.

Dental Services - Services designed to treat to to prevent disease, injury or abnormality of the teeth, gums and associated mouth structures.

Department - The Texas Department of Mental Health and Mental Retardation.

Designated Provider - An agency or organization which functions at the direction of TDMHMR as the lead agency in a local service area. This term is used in this report in lieu of "Local Mental Health Authority".

Emergency Respite - A service which provices temporary-assistance living arrangements for a brief time period either on an in or out of the home basis. The service is provided to disabled clients in order to provide temporary relief for the client or the family, or in times of crisis.

Extended Medical Services - Services which provide for the monitoring, stabilization and/or improvement of physiological functions through close supervision and treatment of clients by physicians and nursing staff.

Family or Relationship Therapy - A type of group counseling or psychotherapy conducted with families or individuals in a relationship to bring about inter- and intrapersonal changes in a client or clients.

Health Education - Services to educate, orient or provide the necessary information to a client to allow him to understand health needs. Examples of health education courses might include medication education, sex education, first aid, hygiene, etc.

Homemaker Services - In-home, direct personal supervision to provide services and/or encourage skill development and maintenance in such areas as general household activities, basic self help, and hygiene.

Indefinite Residence - Any residential, supportive environment within housing in which minimal interpersonal support are provided for an undetermined period of time. Examples include personal care homes, group homes, foster homes and boarding homes.

Job Placement - A service organized to assist clients to identify, obtain, and maintain employment commensurate with their vocational, social, psychological, and medical needs and their abilities. In addition, services may be made available to employers to facilitate the successful employment of clients with disabilities.

Legal Aid - A service that provices access for a client to needed legal services.

Local MH Authorities - Designated by the Department to direct, operate, facilitate or coordinate such services to mentally ill and mentally retarded persons as are required to be performed at the local level by state law and by the Department. The phrase "the local level" refers to the local service area. See Designated Provider.

Local Service Area - A geographic area made up of one or more counties which serves to define and delimit the responsibilities of the local MH and MR Authorities for the area.

Medications - Any substance that, when taken into a living organism, may modify one or more of its functions and is recognized as a medicine or remedy used for the treatment of illness or disease. Psychoactive medications exercise direct effect upon the central nervous system and are capable of influencing and modifying behavior, cognition, and affective state.

On-Job Training - Any industry-based activity aimed at increasing employment skills. This service provides the client an opportunity to learn and practice work behaviors while receiving support and supervision.

On-Site Training - Any activity provided in the natural environment aimed at increasing interpersonal and/or instrumental skills. It is an activity of the growth function within the service functional area.

Pastoral Counseling - The administration of pastoral services and the provision of religious consultation and education.

Physical Therapy - The administration of medically prescribed activities and procedures utilizing the restorative properties of physical agents and exercises to correct or alleviate disabilities resulting from neuromuscular or orthopedic dysfunction in order to develop the client's physiological and motor capacities to the greatest degree possible.

Prevocational Training - Training which develops skills prerequisite to learning more formal vocational skills and developing vocational abilities and talents. This training includes activities such as object identification and matching, job understanding, basic use of tools, acceptable work habits and attitudes, job responsibilities, etc.

Recreation Services - The provision of structured activities of an enjoyable nature designed to promote beneficial use of leisure time, for example, hobbies, sports, games, movies, etc. This service may also include the concept of developmental recreation which has as it's goals the physical development of the client on a programmed and monitored basis ultimately to enable the client to better participate and better enjoy recreational and sporting activities.

Remotivational Therapy - Activities provided within a protective environment aimed at mobilizing chronically institutionalized clients for community living. The essential elements of this service are the mobilization of self and the establishment of relationships with peers, renewed contacts with social organizations and agencies, as well as linkage to other individuals who are or who will become a part of the client's self-support system.

Screening - The initial process of contracting, assessing, planning for, and linking of service applicants. This includes crisis service for severely distressed applicants.

Self-Help Skills Training - Services which assist clients to acquire and maintain those life skills that enable the individual to cope more effectively with their immediate, personal environment such as bathing, personal hygiene, etc.

Service Contracts - Legally binding purchase of service contracts between TDMHMR and Community MHMR Centers. Would replace current grant-in-aid program.

Sheltered Work - A service which provides paid employment for an indefinite period of time in a sheltered workshop for clients who are incapable of performing in a competitive vocational situation.

Social Training - Training which assists the client in acquiring attitudes, values and social interaction skills that will enable the client to function in his environment. Particular emphasis is placed on emotional reactions, social experiences and attitudes towards stress.

Socialization - Activities in any supportive environment aimed at sustaining a client's capacity for social and/or recreational involvement by providing opportunities for applying these skills.

TCA - Texas Commission on Alcoholism

TEA - Texas Education Agency

TDCA - Texas Department of Community Affairs

TDOH - Texas Department of Health.

TDMHMR - Texas Department of Mental Health and Mental Retardation.

TRC - Texas Rehabilitation Commission

Temporary Employment - A time-limited job placement opportunity, agency-arranged, for the purpose of training in work-related behaviors.

Temporary Residence - Any temporary living environment that provides relief during an acute crisis or emergency situation. It is an activity of the crisis stabilization function within the service functional area, for example, temporary foster care.

Transitional Living With 24-Hour Supervision - A 24 hour transitional supervised residence providing a supportive environment for a group of clients in need of housing for a time-limited basis. The client also is provided other growth services. Examples of such residences include quarter-way, half-way, and three-quarter-way houses, as well as hospital-based transitional programs.

Transitional Living Without 24-Hour Supervision - Less than 24 hour supervised transitional residence providing a supportive environment for a group of clients in need of housing on a time-limited basis. In most cases, the clients will also be receiving other growth services. An example of such a residence includes supervised apartment living.

Twenty-four Hour Acute Emergency Protective Services - Activities provided in a 24-hour protective environment with appropriate medical/psychiatric responsibility and authority. Crisis care activities are aimed at the reduction of the client's acute emotional disabilities and their physical and social manifestations. Crisis care may be provided in a general hospital, psychiatric hospital, community mental health center or other organized facility. The function is to evaluate, diagnose, and treat patients who are acutely disabled and in need of a protective setting. A thorough physical examination and laboratory studies must be provided along with indicated consultations. Virtually all clients leaving crisis care will be transferred to another service.

Twenty-four Hour Extended Protective Services - A long-term, 24-hour, seven-days-a-week residential activity provided in a protective environment for clients who are severely disabled and who are generally unresponsive to therapeutic interventions. Primary activities such as a variety of social maintenance tasks, are frequently found in the programs of psychiatric hospitals primarily serving a chronic population.

Twenty-four Hour Extended Treatment Services - A long-term, 24-hour, seven-days-a-week residential activity provided in a protective environment for clients who may be responsive to the therapeutic intervention when applied over an extended period of time (3-24 months).

Verbal Therapies - Activities which include all formal individual and group psychotherapies and/or any face-to-face verbal contacts between provider and client. These activities are aimed at maintaining psychological and/or social functioning. In essence, these are problem-solving approaches aimed at improving an individual's role performance and may include insight, support, encouragement, coordination, and planning. Excluded from this service are talking activities that are incidental to other services.

Vocational Training - Training designed to develop vocational skills in a particular vocational area, either through classroom instruction or practical experience.

Twenty-four Hour Acute Emergency Protective Services - Activities provided in a 24-hour protective environment with appropriate medical/psychiatric responsibility and authority. Crisis care activities are aimed at the reduction of the client's acute emotional disabilities and their physical and social manifestations. Crisis care may be provided in a general hospital, psychiatric hospital, community mental health center or other organized facility. The function is to evaluate, diagnose, and treat patients who are acutely disabled and in need of a protective setting. A thorough physical examination and laboratory studies must be provided along with indicated consultations. Virtually all clients leaving crisis care will be transferred to another service.

Twenty-four Hour Extended Protective Services - A long-term, 24-hour, seven-days-a-week residential activity provided in a protective environment for clients who are severely disabled and who are generally unresponsive to therapeutic interventions. Primary activities such as a variety of social maintenance tasks, are frequently found in the programs of psychiatric hospitals primarily serving a chronic population.

Twenty-four Hour Extended Treatment Services - A long-term, 24-hour, seven-days-a-week residential activity provided in a protective environment for clients who may be responsive to the therapeutic intervention when applied over an extended period of time (3-24 months).

Verbal Therapies - Activities which include all formal individual and group psychotherapies and/or any face-to-face verbal contacts between provider and client. These activities are aimed at maintaining psychological and/or social functioning. In essence, these are problem-solving approaches aimed at improving an individual's role performance and may include insight, support, encouragement, coordination, and planning. Excluded from this service are talking activities that are incidental to other services.

Vocational Training - Training designed to develop vocational skills in a particular vocational area, either through classroom instruction or practical experience.