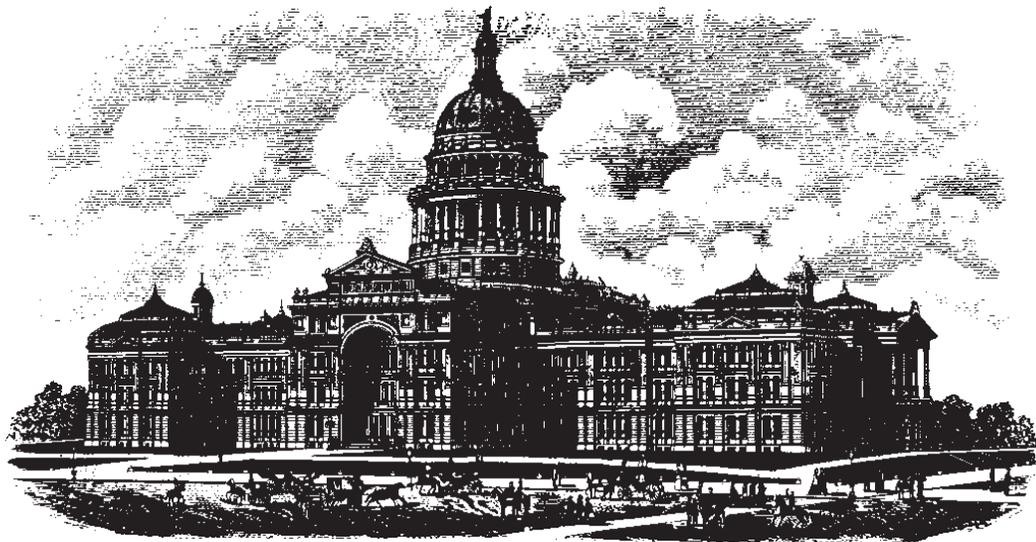


Sunset Advisory Commission



TEXAS STATE CAPITOL BUILDING

E.E. Davis architect

Texas Department of Mental Health
and Mental Retardation



Staff Report

1998

SUNSET ADVISORY COMMISSION

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In 1977, the Texas Legislature created the Sunset Advisory Commission to identify and eliminate waste, duplication, and inefficiency in government agencies. The 10-member Commission is a legislative body that reviews the policies and programs of more than 150 government agencies every 12 years. The Commission questions the need for each agency, looks for potential duplication of other public services or programs, and considers new and innovative changes to improve each agency's operations and activities. The Commission seeks public input through hearings on every agency under Sunset review and recommends actions on each agency to the full Legislature. In most cases, agencies under Sunset review are automatically abolished unless legislation is enacted to continue them.

**TEXAS DEPARTMENT OF MENTAL
HEALTH AND MENTAL RETARDATION**

SUNSET STAFF REPORT

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EXECUTIVE SUMMARY

Executive Summary

The Texas Department of Mental Health and Mental Retardation (TDMHMR) oversees and provides services to some of the state's most vulnerable citizens — persons with mental illness and persons with mental retardation. The mission of the Department is “to improve the quality and efficiency of public and private services and supports for Texans with mental illness and mental retardation so that they can increase their opportunities and abilities to lead lives of dignity and independence.”¹ To that end, the Department provides services through 22 campus-based facilities and 10 state-operated community services and funds and oversees locally-operated community services through performance contracts with 38 community centers across the state. During 1997, an estimated 2.8 million Texans were diagnosed with some form of mental illness and 530,000 with mental retardation. Of these totals, approximately 490,000 of those with mental illness and 79,000 of those with mental retardation fall into TDMHMR's priority population — those individuals most in need of services. In 1997, approximately 19,000 persons received services through the campus-based facilities and 168,000 persons received services through community-based services.

1. Increase planning for the future of campus-based resources.

The Department's service delivery system has evolved from a system of providing services almost exclusively in institutional settings to one that emphasizes community-based treatment. However, the Department continues to operate 22 campus-based facilities, which are budgeted at more than \$1 billion this biennium. While the Department has focused on providing an increasing array of services in the community, it has not fulfilled its responsibility to develop a long-range vision for facilities and link them with community-based services. Planning for the best use of facilities has not been conducted, local authorities have little voice in planning for the institutions that they will use, and resources may not be effectively targeted.

Recommendation: Require the Department to conduct long-range planning for its state-operated institutions. This plan should include estimates of future bed requirements in state schools and state

hospitals, differences in anticipated expenses if the current number of state schools and state hospitals is maintained, potential savings of any consolidation, and estimates of how many unserved persons in the community could be served with the potential savings. The Department should also seek input from local authorities on the use of state facilities. The plan will be provided to the Governor, the Legislature, the Health and Human Services Commission, the Governor's Budget Office and the Legislative Budget Board. Improved planning and better data will become the basis for future decisions about the use of State resources by both the Department and the Legislature.

2. Improve the delivery of mental health and mental retardation services by supporting further development of the state-local relationship.

The State's relationship with local mental health and mental retardation authorities is continuing to evolve. Benefits derived from delegating state power and

responsibility to the local level include better identification of client needs and enhanced accountability. Although the Department is making progress in developing the state-local relationship and has followed legislative directives to improve accountability, local authorities are limited in their ability to meet identified community needs. Current ad hoc processes for dealing with local issues needs improvement. Local authorities lack the opportunity to participate in a process that provides for consideration of decisions that affect local operations. A forum is needed to resolve operational issues faced by local authorities and service providers.

Recommendation: The Commissioner should appoint a nine-member local authority advisory committee to review existing and proposed rules and requirements, advise the Department in evaluating and coordinating initiatives, assist in developing a proposal-based method of performance contracting with the local level, and coordinate and monitor workgroup activities. In addition, the Department should strengthen the connection between the local authorities' plans and needs assessments and the Department's strategic plan and performance contract.

3. Consider the recommendations of the HB 1734 committee.

House Bill 1734, passed in 1997, sought further definition of the role and responsibilities of the local authority. The bill directed the TDMHMR Commissioner to appoint a committee to study and make recommendations concerning the scope and responsibilities of the local authorities as well as their number and size. The committee began meeting in October 1997 and will present their recommendations to the TDMHMR Board in June 1998. The Board will consider their recommendations and present an approved plan to the Senate Health and Human Services Committee and the House Public Health Committee in September 1998. However, the

timetable of the committee prevents Sunset staff from considering these recommendations in this report.

Recommendation: Allow the Sunset staff to review and comment on the recommendations that result from the work of the H.B. 1734 Committee.

4. Clarify the grounds for renewal of community services contracts.

The Legislature has clearly stated its intent that the Department move toward a system that improves the effectiveness and quality of services delivered in the community. One aspect of improving services is the expansion of the provider network and increasing consumer choice. The current contract renewal statute for local authorities represents a barrier to the achievement of an improved system. Local authorities need to be able to consider the best use of state funds when renewing contracts and be held to State contracting standards.

Recommendation: Change the criteria for renewal of community services contracts to conform to State contracting guidelines. Eliminate existing ambiguous criteria for renewal and require local authorities to consider best value as required in State contracting guidelines. Allow local authorities to include other factors such as consumer choice, expansion of provider network, and client needs when evaluating a contract for renewal.

5. Clarify revolving door provisions placed on former employees of community centers.

Changes in the mental health and mental retardation service delivery system of Texas include an expectation that local authorities will develop a network of providers and limit their role in providing services. To accomplish this change, local authorities must be able to recruit providers to a system with limited resources. Former employees represent an experienced and willing source of potential service providers. However, broadly written and ambiguous

restrictions against contracting with former employees act as a barrier to accessing this source.

Recommendation: Change the revolving door provisions for former community center employees to conform to the State's general revolving door provisions. Allow former employees to provide a needed service while still forbidding former employees from bidding on a contract they designed.

Fiscal Impact Summary

The recommendations contained in this report would have no immediate or minimal fiscal impact. Improved planning for campus-based institutions will help to ensure that the State's resources are being spent in the most effective way and should result in a positive fiscal impact in the future. The local authority advisory committee could be supported by existing staff resources and should only result in minimal travel costs for committee members.

¹ Texas Department of Mental Health and Mental Retardation, *Strategic Plan Fiscal Years 1997-2001*, (Austin, Texas, September, 1996), p. 10.

APPROACH AND RESULTS

Approach and Results

Approach

The Texas Department of Mental Health and Mental Retardation (TDMHMR) and the State's system of mental health and mental retardation services have undergone tremendous changes in recent years. The transition from campus-based to community-based services, the two federal class action lawsuits filed against the Department, the development of both the local and state authority roles, the advances in medications and treatment, as well as the advent of managed care, have all had a tremendous impact on the Department and the mental health and mental retardation system.

Several recent legislative initiatives — H.B. 2377 in 1995 and H.B. 1734 in 1997, both of which sought to further define the state and local relationship and their respective authority roles through pilot sites and a committee — have brought about further changes for the Department to implement. Additionally, a comprehensive review of the Department by the Texas Performance Review staff in 1996 made numerous recommendations to the Department for change. The potential for future change is also great depending on the outcome of the H.B. 2377 pilot sites, the recommendations of the H.B. 1734 committee, and the possibility of certain new initiatives, such as providing treatment for sex offenders. For more information on the evolution of and changes to the Department and the system, please see the Introduction to the Issues section of this report, page 11.

Given the magnitude of past change at the Department and the potential for future changes, the Sunset review did not attempt to evaluate these changes, but focused instead on the impact of these changes on the management and operations of the Department. The review found an agency that takes seriously its fundamental mission to serve and support Texans with mental illness and mental retardation. However, the review also found an agency that operates in an environment of intense change, with multiple pilots and initiatives and constantly changing directives from several sources: the Legislature, stakeholders, providers, advocates, and consumers. The Sunset review decided not to inject any more change into this environment, but focused instead on providing the agency with tools to manage change.

The Department and the State's MHMR system have undergone tremendous changes in recent years.

In addition, this phase of the Sunset review did not focus on any reorganizational options or broader health and human service, cross-agency issues. The Legislature has scheduled most of the state's health and human service (HHS) agencies for Sunset review in 1999. This provides the Commission with the opportunity to study organization of this area of government and assess issues that cross traditional agency boundaries — types of services provided, types of clients served, and funding sources used. Once these reviews are completed, the information gathered can be used to determine whether the Legislature should consider any restructuring of the agencies in the health and human services area.

Review Activities

In conducting the review of TDMHMR, the Sunset staff:

- Worked extensively with agency staff;
- Attended TDMHMR Board and advisory committee meetings, including strategic planning meetings with the TDMHMR Board, the Citizens' Planning Advisory Committee, the Mental Health Planning Advisory Committee, and the Mental Retardation Planning Advisory Committee;
- Met, upon request, with TDMHMR Board members;
- Attended monthly H.B. 1734 committee meetings and accompanied the committee on field visits to H.B. 2377 pilot sites in Austin, Lubbock and Tarrant County;
- Attended the Board of Directors' meeting of the Texas Council of Community Mental Health and Mental Retardation Centers;
- Attended meetings of the Texas Medical Association's subcommittee on Sunset issues;
- Attended Children's Policy Team meetings;
- Attended STAR + PLUS (Medicaid Managed Care) Behavioral Health Subcommittee meeting in Houston;
- Surveyed interest and advocacy groups about their concerns with the delivery of mental health and mental retardation services and the operations of TDMHMR;
- Visited state schools for the mentally retarded in Austin, San Antonio, Lubbock, and Lufkin;
- Visited state hospitals for the mentally ill in Austin, San Antonio, Rusk, and Big Spring;

- Visited the Waco Center for Youth and the El Paso State Center;
- Visited community psychiatric hospitals in Houston, Lubbock and El Paso;
- Visited community centers in Austin, Amarillo, Ft. Worth, Houston, Lubbock, El Paso, Jacksonville and Lufkin. Interviewed community center staff, clients and advocates and toured various sites and programs;
- Visited the Panhandle Substance Abuse Pilot site in Amarillo;
- Toured a Harris County MHMRA jail-based treatment program and a Tarrant County MHMRA forensic program;
- Reviewed agency documents and reports including the agency's Self-Evaluation Report, strategic plans, operating plans, internal audits, advisory committee reports, H.B. 2377 evaluations, and literature published by the community centers;
- Reviewed State Auditor reports, Texas Performance Review recommendations and reports related to TDMHMR, other legislative reports, other states' information, and information available on the Internet;
- Reviewed state and federal statutes, past legislation, relevant cases, and Texas Attorney General Opinions; and
- Attended hearings of the House Public Health Committee and Senate Interim Committee on Home Health and Assisted Living, the Senate Health and Human Services Committee, the House Appropriations and Senate Finance Committees, and the Senate Interim Committee on Sex Offenders.

Results

The Sunset review of TDMHMR began by addressing the threshold question of whether the functions performed by the agency continue to be needed. An estimated 2.8 million Texans were diagnosed with some form of mental illness and 530,000 with mental retardation in 1997, and, as the general population increases, these numbers should increase as well. In contrast to traditional physical and public health services, the nature of mental illness and mental retardation is such that effective treatment is not a "cure" for mental illness or mental retardation, nor will education or prevention initiatives diminish the number of people needing treatment. Effective treatment and support for persons with mental illness and mental retardation will increase their abilities and opportunities to lead successful lives in their communities, but will not limit their need for these services. Because of this ongoing need for these services, the State should play a continuing role in the lives of its citizens with mental illness and mental retardation.

Effective treatment is not a "cure" for mental illness or mental retardation, thus the need for services is ongoing.

However, many services provided by TDMHMR overlap with those provided by other health and human service agencies, and an assessment of organizational alternatives needs to be performed before a decision can be made to continue the Department in its current form. The Sunset review focused on what tools could be used to manage the multitude of changes at the Department and in the MHMR system. These tools are needed at several levels within the system: at the state level with the Department as it manages the entire system of mental health and mental retardation, as provider of services at state-operated institutions, and at the local level as they try to implement new initiatives.

The Sunset review focused on providing tools to manage the multitude of changes at the agency and in the system.

Managing the transition from state to community-based services and targeting the state's resources effectively — As a result of several factors, including changes in philosophy and treatment for persons with mental illness and mental retardation and two class-action lawsuits, the system now emphasizes treatment in the community as opposed to in campus-based institutions. In 1997, approximately 168,000 people received services through community services, while 19,000 were served in campus-based institutions. The State provides these campus-based services in eight state hospitals for the mentally ill, eleven state schools for the mentally retarded, and two state centers. Although the census has declined dramatically at these institutions, the Department has not conducted long-range planning for what these institutions should be used for in the future, given the declining census. Additionally, even though community services plays a larger part in the service delivery system, the local communities have little input into what types of services these institutions should offer and how the institutions should complement services offered in the community. ***Issue 1*** requires the Department to increase its long-range planning efforts for these facilities so that state resources are managed and directed towards their most efficient use.

Further developing the state-local relationship — The evolution of the mental health and mental retardation system has led to a complex balancing of state and local responsibility. ***Issue 2*** examines the relationship between the state and the local level and how this relationship affects operations at the local level. The staff recommends a tool to assist the Department in achieving the appropriate balance of state and local responsibility and provide a forum for resolving operational issues.

As the role of the local authority has expanded, the relationship between the local authority and the state authority has received recent legislative attention and several initiatives are underway to further define and develop the state and local authority roles. ***Issue 3*** recommends that the Sunset Commission consider the outcome of the work of one of these initiatives, the H.B. 1734 Committee,

which is charged with recommending the scope and responsibilities of local authorities as well as their number and size.

Removing barriers to service delivery at the local level and ensure provisions unique to community centers conform to existing State standards —

Community services have become more important in the mental health and mental retardation service delivery system. The system has placed an emphasis on ensuring consumer choice and has moved towards developing a network of service providers and implementing other managed care practices. Additionally, the State has already spoken in certain areas, such as contracting and revolving door employment issues, which differ from provisions found in the community center statutes. *Issues 4 and 5* examine certain statutory barriers that prevent or hinder community centers from achieving these system initiatives, compare the statutes to general State statutes, and recommend changes to remove these barriers and differences.

Recommendations

1. Increase Planning for the Future of Campus-Based Resources.
2. Improve the Delivery of Mental Health and Mental Retardation Services by Supporting Further Development of the State-Local Relationship.
3. The Sunset Commission Should Consider the Recommendations of the H.B. 1734 Committee.
4. Clarify the Grounds for Renewal of Community Services Contracts.
5. Clarify Revolving Door Provisions Placed on Former Employees of Community Centers.
6. Decide on Continuation of the Texas Department of Mental Health and Mental Retardation as a Separate Agency after Completion of Sunset Reviews of all Health and Human Service Agencies.

Fiscal Impact

The recommendations contained in this report would have no immediate or minimal fiscal impact. Improved planning for campus-based institutions will help to ensure that the state's resources are being spent in the most effective and efficient way and should result in a positive fiscal impact in the future. The local authority advisory committee could be supported by existing staff resources and should only result in minimal travel costs for committee members.

ISSUES

Introduction

The State's system of providing services to persons with mental illness and mental retardation has been evolving since the Texas Department of Mental Health and Mental Retardation (TDMHMR) was first established in 1965. The primary result of this evolution has been a transition from a system based on serving persons in institutional settings to one which emphasizes and prioritizes treatment in the community.

Several factors have driven this transition. First, the nation's philosophy concerning the care and treatment of persons with mental illness and mental retardation has changed. Whereas once treatment philosophy dictated that persons with mental illness and mental retardation were to be separated from society, now the emphasis is on their inclusion and acceptance into society. Second, federal legislation pushed this transition by providing grants for the construction and operation of community mental health and mental retardation centers (community centers). Finally, two class action lawsuits filed in the 1970's against the State also required TDMHMR to provide treatment in the least restrictive environment, which often meant in the community. The net result of these factors has been a dramatic increase in the number of people being served in the community, as well as an increase in the amount of Department funding allocated to community services.

As this transition occurred, the Department's role as the State's primary provider of mental health and mental retardation services has decreased significantly. As options for treatment in the community grew, fewer people were served in state hospitals and state schools. As a result, the census for state-operated facilities has declined dramatically over the years. Although the Department still provides some community-based services through State Operated Community Services, by the year 2001 all community services will be provided by local service providers. After 2001, the Department will only provide services through the state hospitals and state schools.

In place of the Department, services are provided primarily on the local level by community mental health and mental retardation centers. Community centers have become the focal point of the local mental health and mental retardation system and have also integrated the efforts of many other state and local entities. When community centers began developing as a result of federal legislation and grants in the mid-1960's, few providers other than the State offered services. However, in 30 years, the number of other service providers has increased significantly. As a result, more options for treatment

The State's system of providing services to persons with mental illness and mental retardation has changed from one based on serving persons in institutional settings to one emphasizing treatment in the community.

exist in the community and the community centers may no longer be the only provider of services.

As the community centers have taken over most of the provider responsibilities from the State and as the number of other community service providers has increased, the focus of the system has shifted to the authority roles at both the state and local levels. Because both the state and local level have focused on their roles as service providers for so long, their authority role remained relatively undeveloped as distinct from their role as provider. The concept of *authority* entails defining, planning, and overseeing the system and ensuring the provision of services through contracts rather than providing the services directly. Several factors such as the growth of private providers interested in working with the system, the new responsibilities of the Department as a State Medicaid operating agency, and the advent of managed care have prompted both the Department and the Legislature to further define the authority roles at both the state and local levels.

The concept of *authority* entails defining, planning, and overseeing the system and ensuring the provision of services through contracts rather than providing the services directly.

The Department initiated a formal evaluation of these roles in 1994 with the creation of the Authority/Provider Task Force. The TDMHMR Board assembled this 16 member “blue ribbon” task force to explore the role of the state mental health and mental retardation authority and to recommend needed changes to ensure that the Department can implement this role in a way that supports its vision for the future.

Many of the recommendations made by the Authority/Provider Task Force influenced the passage of H.B. 2377 in 1995 by the 74th Legislature. The bill designated the TDMHMR Board as the state mental health and mental retardation authority with responsibility for planning, policy development, resource development and allocation, and oversight of mental health and mental retardation services. The bill also permits the Department to delegate its authority in these areas to a designated local authority.

In addition, the bill recognized that a community center’s role as a local authority is distinct from its role as a provider and clarified that a local authority is not responsible for providing services, but for ensuring the provision of services. One of the primary activities of the local authority is to develop and manage a coordinated system of mental health and/or mental retardation services in its service area. In doing so, the local authority, as required by H.B. 2377, must consider public input, ultimate cost-benefit, and client care issues to ensure consumer choice and the best use of public money in assembling a network of providers and in determining whether to provide a service or contract for that service.

Because H.B. 2377 required changes in the way local authorities do business, the bill authorized the use of pilot projects to study a new local authority organizational structure that clearly distinguishes a community center's authority and provider roles. The pilots are also intended to create an objective method by which a local authority assembles a network of providers. Development of the pilot sites began in September 1996 and is scheduled to conclude September 1999.

Another piece of legislation with the potential to have a significant impact on the Department, as well as on the local authorities, is H.B. 1734, passed in 1997 by the 75th Legislature. This bill required the Commissioner of TDMHMR to appoint a committee to study and make recommendations concerning the scope and responsibilities of the local authorities, as well as their number and size. One of the most notable aspects of this bill was to remove the preference traditionally granted to community centers to act as the local authority.

While the Department is responding to these recent legislative initiatives, the system is also being significantly affected by the development of managed care. Like many other states, Texas is converting its Medicaid system from a fee-for-service system to a managed care system. As managed care programs are implemented across the state, local centers are assuming a new role in this new Medicaid system. The H.B. 2377 initiatives are also bringing many managed care principles into TDMHMR's system. Cost accounting, utilization management and utilization review, and quality management are being introduced to the community centers as new ways of doing business.

Taken together, the evolution of the system, the recent legislative initiatives, and the influence of managed care has resulted in a system based on a philosophy of local control and a goal of balancing quality, choice, access, and cost to produce optimum outcomes. But the evolution is not yet complete. The outcome of the H.B. 2377 pilots is still unknown and the H.B. 1734 committee has yet to make its final recommendations to the Board. The impact of managed care on this system and the State's system of health and human services has yet to be determined.

In light of the changes the Department has been and is still going through, the Sunset review focused on what tools could be used to more effectively manage these changes and their results. The review identified tools needed by the Department on several levels — at the state level as a provider of services, at the current relationship between the state and local authority, and at the local level as they try to implement new initiatives. The ultimate goal of the recommendations that follow is to ensure the delivery of quality services throughout the system at all levels.

The influence of recent legislation and managed care is causing a significant evolution of the MHMR system.

Issue 1

Increase Planning for the Future of Campus-Based Resources.



Background

Since the 1960s, the Department has been evolving from a system which delivered services almost exclusively in institutional settings — state schools for persons with mental retardation and state hospitals for persons with mental illness — to a system that emphasizes and prioritizes community-based treatment. Federal initiatives, class action lawsuits, and a changing philosophy which stresses treatment over custodial care and a preference for providing treatment in the least restrictive environment have all contributed significantly to this evolution. While changes are still occurring, stakeholders agree that TDMHMR now provides a higher quality of care and is much more responsive to consumer input than it was in the past.

Although the Department has greatly expanded community mental health and mental retardation services, it still operates 22 campus-based institutions throughout the State. While community services account for the majority of expenditures, TDMHMR will still spend over \$1 billion during the current biennium on its campus-based institutions. In addition, the Legislature appropriated \$26 million in general obligation bonds and \$9.1 million in general revenue dedicated funds for capital projects at these 22 institutions.¹

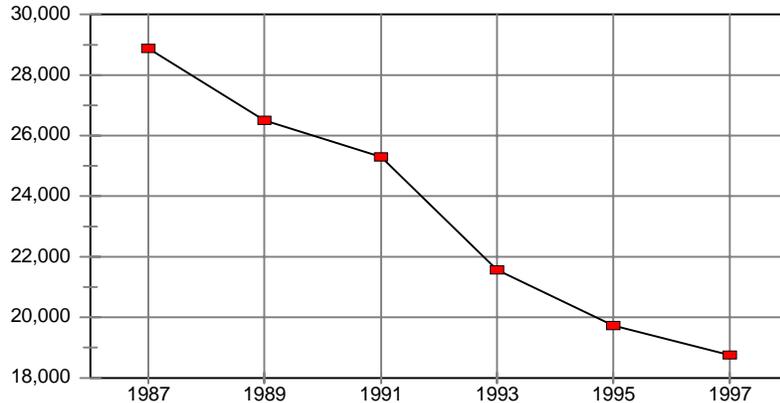
In view of the large state expenditures on campus-based institutions and the decreased need for these same institutions, the Sunset review focused on the need for improved long-range planning for these facilities.

Findings

- ▼ **As more persons with mental illness and mental retardation are served in the community, fewer are being served in the state-run institutions.**
 - ▶ Persons served in the community have increased by 39 percent between 1987 and 1997, from 120,929 persons to 168,091 persons. Meanwhile, during that same time period, persons served in state-run institutions decreased 35 percent from 28,879 to 18,754.

While community services account for the majority of expenditures, TDMHMR will still spend over \$1 billion over the current biennium on its campus-based institutions.

Decrease in Number of Persons Served in Campus-Based Facilities



Between fiscal years 1986 and 1996, the average daily census at state schools and state centers serving persons with mental illness decreased 34 percent, from 8,656 to 5,724.² During that same period, the average daily census at state hospitals and state centers serving persons with mental illness decreased 40 percent, from 4,510 to 2,694.³

- Between fiscal years 1986 and 1996, the average daily census at state schools and state centers serving persons with mental illness decreased 34 percent, from 8,656 to 5,724.² During that same period, the average daily census at state hospitals and state centers serving persons with mental illness decreased 40 percent, from 4,510 to 2,694.³

The greatest decline in census has occurred at the eight state hospitals. The average daily census of the eight state hospitals decreased from 5,482 in fiscal year 1978 to 2,408 in fiscal year 1997, a 56 percent decrease⁴. The chart, *Decline in Average Daily Census at State Hospitals*, provides examples of the large decline in census at each state hospital.

State Hospital	Decrease in Average Daily Census from 1978-1997
Kerrville	74%
Austin	69%
Rusk	66%
Terrell	58%
San Antonio	54%
Big Spring	45%
Wichita Falls	44%
Vernon	26%
All State Hospitals	56%

- The future need for state hospital beds, as outlined in the Department’s draft Strategic Plan for 1999 - 2003, is predicted to diminish while the need for state school beds will be stable or experience a modest decrease.⁶ Because the Department’s

planning efforts are not fully developed, a more accurate picture of the need for state hospitals and state schools is not available.

▼ **The Department has not reacted to the declining census with adequate long-range planning for the future of its state-operated facilities.**

- ▶ The Department has not devoted staff or resources to long-range planning of campus-based institutions despite having planning and oversight responsibility over the entire mental health and mental retardation system. Instead, the Department focuses on state hospital and school facilities from a service-provider perspective. Department staff that provide all day-to-day operations of the state facilities cannot be expected to also view the facilities from a broad, system-wide perspective, conduct necessary planning, and develop a vision for the future of state facilities that successfully links state and community-based services.
- ▶ Also problematic for long-range planning is the lack of input from the local mental health and mental retardation authorities. Although these local authorities serve as the gatekeepers of the state mental health and mental retardation system, they have little, largely informal, involvement in planning the future of the state hospital and state school system. The local authorities should help to project the number of people that will need to be served by the state hospital and school facilities, the future bed capacity, number of facilities, types of services, and treatments to be offered. Optimum and long-range development of a state-local system cannot occur without improved input from local authorities on use of state facilities.
- ▶ The Department does not have a long-range plan for what its 22 campus-based institutions will look like in the future. The Department does not currently collect and analyze data to develop projections for future use of state hospital and school facilities, specifically the numbers of persons who will need to use these facilities or the types of services that these institutions will need to provide. The Department needs to take steps to ensure that campus-based facilities will adequately serve the future needs of persons with mental illness and mental retardation.

The Department does not have a long-range plan for what its 22 campus-based institutions will look like in the future.

Legislative Authority Over State Facilities

The prospect of consolidating or closing state-operated facilities has proven to be difficult and emotionally charged for the Department, the Legislature, and the affected communities. In rural areas, state schools and state hospitals are often the largest employer. Family members of residents of facilities, especially family of state school residents, have effectively advocated to keep all facilities open to ensure that a safe and secure home will continue to be available for long-term residents of facilities. As a result of these and other factors, the Legislature has proceeded cautiously in making changes to state-operated facilities.

Only two state-operated facilities have been closed since the beginning of the state's mental health and mental retardation system in the mid 19th century. The Ft. Worth State School was closed in 1995 and the Travis State School was closed in 1996 as part of the settlement agreement to end the *Lelsz* lawsuit, a class action lawsuit filed against the Department and the state schools. As part of the settlement of the lawsuit, legislation was passed creating a Task Force appointed by the Governor and charged with making recommendations to provide for the closure of two state schools. In March 1992, the Task Force recommended closing Mexia State School and Travis State School. The Governor accepted the recommendation to close the Travis State School and rejected the recommendation to close Mexia, with concerns about the economic impact to the community. The Task Force later recommended closing the Ft. Worth State School and the Governor accepted this recommendation. The Task Force did not recommend closure or consolidation of any state hospitals. However, the Task Force did recommend evaluating whether all eight hospitals would still be needed once sufficient community resources were in place.

The Department has the responsibility to manage and operate state facilities, but the Department's statute clearly places the authority to close or consolidate a state hospital, school, or state center with the Legislature. While it is appropriate for the Department and the Legislature to share responsibility, this sharing requires that decisions on the long-term viability of state facilities involve reliable information from the Department, community centers, and the public.

Additionally, the Department has not followed a current statutory requirement relating to planning for facilities. The statute requires TDMHMR to "establish objective criteria for determining when a new facility may be needed and when a facility may be expanded, closed, or consolidated."⁷ The Department has not established these criteria for use in its or the Legislature's planning process. Although the Department does not have statutory authority to expand, close or consolidate any state-operated facility, the need to provide the Legislature with information it needs to make informed decisions on the status of state hospitals and schools. For more information on the Legislature's involvement with changes at state-operated facilities, see the text box, *Legislative Authority Over State Facilities*.

▼ Increased planning for the future of campus-based facilities could help the Department and the Legislature allocate resources more efficiently and effectively.

- ▶ By increasing its planning efforts in this area, the Department can begin to collect and analyze data to use as a basis for developing long-term plans for the future need for state schools and state hospitals. The Department can determine the future need for campus-based institutions and the types of services that the institutions will need to offer to complement community services. Once the Department has this information, it can adjust services at hospitals and schools and present the information to the Legislature and the budget entities where tough decisions can be made about the future of state-operated facilities.
- ▶ Reducing the future size and funding for these facilities could make additional dollars available for other services. Pressing needs exist in the community, such as the 4,000 persons waiting for community mental health services, the 10,000 persons waiting for mental retardation services, and the 34,000 persons the Department estimates could benefit from the new generation of psychotropic medications.

Conclusion

Although the Department operates 22 campus-based facilities, it is also responsible for planning, developing policy, and managing publicly-funded mental health and mental retardation services throughout the state. While the Department has focused on providing an increasing array of services in the community it has neglected its responsibility to develop a long-range vision for facilities and link them with community-based services. In addition, the number of facilities has not been adjusted to reflect current demand. As a result, planning for the best use of facilities has not been conducted, local authorities have little voice in planning for the institutions that they will use and refer persons to, and resources may not be effectively targeted. The Department needs to increase long-range planning for the future use of its campus-based systems, taking into account the needs of the community system for these institutions. By improving its planning efforts, TDMHMR can provide the Legislature with the information needed to make tough decisions about the future of campus-based facilities.

Recommendation

Change in Statute

- **Require the Department to conduct long-range planning for its state-operated institutions. This plan should:**
 - **project estimates of future bed requirements in the state school and state hospital system and document the methodology used to derive these numbers;**
 - **show differences in anticipated expenses if the current number of state schools and hospitals is maintained and the potential savings of consolidating state schools and state hospitals;**
 - **project estimates of how many unserved people in the community could be served with these potential savings, including those needing new psychotropic medications; and**
 - **use the Department's Computer Assisted Facilities Management program (CAFM) projections on the costs to maintain facilities and recommendations on which buildings are too costly to repair.**
- **Require the Department to seek input from community centers on the use of state facilities through the annual local plan submitted to the Department.**

- **Require the Department to present or provide a biennial plan to the Governor, the Legislature, and the Health and Human Services Commission with data and recommendations that focus on the most efficient long-term use of its campus-based facilities.**
- **Require this report to also be provided to the Governor's Budget Office and the Legislative Budget Board for consideration in the Department's legislative appropriations.**

This recommendation will require the Department to develop an objective and complete source of information for Legislative consideration of the future needs of state hospitals, state schools, and state centers. The Department shall develop a methodology for determining future needs of campus-based institutions based on projected membership in the priority population, levels of community services, external forces, such as managed care, and structured input from community centers.

All local authorities are required to submit annual local plans to the Department. The purpose of these local plans is to provide the Department with meaningful information from which to make decisions and plans relating to allocation of funds and provision of community services. The Department should solicit the input of local authorities on the numbers of persons estimated to need institutional services, the types of services needed, and conditions that could affect the overall use of these facilities. This information would be used in the overall planning efforts for campus-based facilities.

The Department should submit its facilities report to the Governor, Lieutenant Governor, Speaker of the House, and the Legislature along with its Legislative Appropriations Request. The data contained in the report shall also be submitted to the Governor's Budget Office and the Legislative Budget Board so the information is available during budget deliberations. In addition, the report should be submitted to the Health and Human Services Commission to help the Commission develop an effective state-wide strategic planning and budgeting document for all health and human services agencies. The report should help TDMHMR and members of the Legislature make more informed funding decisions for services to persons with mental retardation and mental illness.

Improved planning and better data will become the basis for future decisions about the use of state resources in the TDMHMR system to be made by both the Department and the Legislature. The Department has the responsibility to perform long-range planning, provide information, and make recommendations for reconciling future need for institutions with the existing network of institutions. Sunset staff recognize that the Department does not have authority to close state facilities and limited authority over many aspects related to facility governance. This fact does not relieve the Department from providing information to the Legislature but rather underscores its importance. To protect large state expenditures and ensure best community-based services in the future, the Department must develop and report long-range planning information so that the State plans a course to make today's

institutions meet tomorrow's needs. Establishing a long-range planning process will allow the Department to carefully plan for any changes in the role of an institution and mitigate any negative impacts that these changes could have on the Department, its employees, the Legislature, and the local communities that are home to these institutions.

Fiscal Impact

These recommendations would have no immediate fiscal impact. The Department would use existing staff resources to develop the required data and recommendations. However, as a result of these recommendations, a positive fiscal impact should result in the future. The Department and the Legislature will have a better understanding of the demand for campus-based institutions and take the necessary steps to ensure that the state's resources are being spent in the most effective and efficient way. Any savings that result should be redirected to meet community service needs.

¹ Legislative Budget Board, *Fiscal Size Up 1998-99 Biennium*, (Austin, Texas, January 1998), p. 5-25.

² Ibid.

³ Ibid.

⁴ Texas Department of Mental Health and Mental Retardation, Governmental Affairs Office, "State Hospital Average Daily Census FY 1978-1997," Austin, April 8, 1998 (fax).

⁵ Ibid.

⁶ Texas Department of Mental Health and Mental Retardation, *Strategic Plan Fiscal Years 1999-2003, Draft*, (Austin, Texas, March 4, 1998), p. 84.

⁷ Tex. Health & Safety Code Ch. 533, Sec. 533.083, (Vernon 1992).

Issue 2

Improve the Delivery of Services by Supporting Further Development of the State-Local Relationship.



Background

A complex balancing of state and local power and responsibility has been evolving for mental health and mental retardation services in Texas. The role of local entities has grown significantly starting with local community centers being designated as local mental health and mental retardation authorities by the Department in the mid 1980s. This designation initially required a community center to provide services in its geographic area. Over time, the role of local authorities has expanded and today they are responsible for coordinating and managing the provision of services, not for delivering services. The chart, *State-Local Powers and Duties*, shows the division of power and responsibility between the state and local levels.

With the evolution of the relationship between the state and local level, the Department has struggled to define what powers, duties and responsibilities it should retain and what it should delegate to the local level. The Sunset review focused on the state and local relationship to see if an appropriate balance of power and responsibility is being achieved between the Department and the local mental health and mental retardation authorities to promote the delivery of quality services.

TDMHMR has struggled with what powers and duties it should delegate to the local level.

Findings

- ▼ **The State's mental health and mental retardation system benefits from the delegation of power and responsibility to the local level.**
 - ▶ Client needs in the MHMR system are better identified at the local level because of the governance structure of local authorities. Appointed by locally-elected officials, these governing boards are composed of local citizens who are in the best position to understand the special needs of their community. By providing a direct connection between clients and service providers, the governing boards are better able to identify and respond to client needs.

State-Local Powers and Duties	
Texas Department of Mental Health Mental Retardation	Local Mental Health and Mental Retardation Authority
<ul style="list-style-type: none"> • Defines priority population • Defines service array • Establishes performance expectations • Imposes sanctions • Establishes service delivery guidelines • Establishes documentation/reporting requirements • Approves local community center's plan and any modifications • Defines board membership and term limits • Requires advisory committees and details their membership • Establishes guidelines for fee collection and fee schedule • Establishes employee training standards • Establishes guidelines for contract procurement and management 	<ul style="list-style-type: none"> • Hires/fires employees • Chooses service providers and monitors performance contract • Coordinates with local entities and other state agencies • Appoints board and advisory committee members • Applies for grants funding • Develops budget

► To increase opportunities for client participation, each local authority must have separate advisory committees for mental health and mental retardation that reflect the perspective of consumers and their families on the provision of services and support. These committees advise the local authority on the development of its strategic and operational plan, review reports from the local authority regarding local plan implementation, and report to the local authority board on issues related to the needs and priorities of the service area and the implementation of plans and contracts. The committees are composed of at least 50 percent consumers, family members, and advocacy groups. Other public agencies, public and private providers, local businesses, and civic organizations may be represented on the committee, which is intended to reflect the ethnic, cultural, and social diversity of the community.

► The connection between local authorities and locally-elected officials also serves to enhance the accountability for state- and locally-funded mental health and mental retardation services. Working at the local level with both clients and providers allows the local authorities to better monitor and assess whether services have been appropriately delivered and meet quality standards. Local authorities are also held accountable to the community they serve by the locally-elected officials who appoint them.

Local authorities are in a good position to identify and address local needs.

▼ **Although the Department’s current performance contracting process ensures accountability, the process is not working as effectively to delegate power and authority to the local level.**

► Consistent with legislative directive, the Department has focused well on building accountability and monitoring performance at the local level through its performance contracting process. However, the Department’s current contracting process still has two weaknesses. First, the local authority has limited opportunity for input into the

development of the performance targets. Generally, the terms of the performance contract are non-negotiable. The Department sets service expectations in the performance contract, but does not give the local authority an opportunity to comment on the feasibility of meeting those expectations. This occurs despite the fact that the Department requires local authorities to develop a local plan based on the needs identified in their community.

- ▶ The second problem is that the performance contract contains conflicting directives. On one hand, the performance contract delegates broad powers and responsibilities to local authorities including the power to plan, coordinate, develop policy, develop and allocate resources, supervise contracts with other providers, and ensure services are provided in their local area. However, in contradiction to granting these powers, the performance contract then establishes many specific requirements that a local authority must meet. The performance contract defines who is eligible for services, specific services that must be provided, and how many clients must be served in 12 defined categories of service. The performance contract also contains numerous detailed administrative and operational requirements ranging from data reporting to client screening and assessment.
- ▶ The granting of state authority through the performance contract implies that the local service providers have the ability to make decisions and determine the necessary service array. The Sunset review found, however, that the local authorities often have difficulty meeting their needs due, in part, to the performance contract's numerous requirements and fixed performance measures. Local authorities claim that this lack of flexibility adversely affects their ability to execute their role as delegated by the state and to design and implement a system based on local needs and priorities.

▼ **Problems at the local level are being addressed through ad hoc processes, an unstructured, fragmented approach by the State.**

- ▶ A range of problems are being experienced at the local level while the Department continues to work on defining the state-local relationship. Sunset staff received significant input from the local level about problems with service delivery, flexibility,

Local authorities must meet local needs and State service expectations which often do not match.

Sunset staff received significant input from the local level about service delivery, flexibility, and administrative problems.

Problems at the Local Level	
State Practice	Local Problem
The State prescribes the fundamental components of the service delivery system.	Local authorities assess local needs, set priorities, publish a local plan, and develop local resources, however, their ability to design a system that addresses their community's needs is limited.
To meet performance targets set by the Legislature, the Department dictates how many consumers a local authority must see per month and how often a consumer must be seen.	Local authorities lack flexibility to respond to their unique circumstances. For example, as local authorities prepare to assume certain managed care functions, they need the flexibility to provide care for clients based on clients' individual needs.
The State has instituted administrative requirements that hinder local authorities from performing more effectively in a changing health care environment.	Local authorities report difficulty attracting and retaining providers given the amount of paperwork and reporting requirements placed on providers by the Department.
The Department sometimes changes the performance contract requirements.	Local authorities report that Department changes often have unintended consequences. For example, the local authorities report notable impact on staff time which sometimes detracts from client care.

and administrative burdens. The chart, *Problems at the Local Level*, provides a sampling of the difficulties experienced by local mental health and mental retardation authorities, community centers, and other service providers.²

By forming numerous committees and workgroups at the Department level, local authorities have tried to resolve problems and informally influence the rules and requirements that affect local operations. These groups have worked to address problems in implementing the financial, programmatic, and reporting directives of the Department.

The progress and results of all the Department's ad hoc work groups are difficult to assess. Oversight and

management of the work groups has been informal and unstructured. No established process ensures that these recommendations are reviewed by the Department or implemented. Local authorities report that often the only changes coming from these groups are minor and incremental through current means.³

Use of ad hoc work groups has led to only minor and incremental change.

▼ **Other state agencies have developed processes that allow for more structured consideration of local input and assessment of local needs.**

- ▶ The Texas Department of Health uses a proposal-based method to solicit offers to provide both Maternal and Child Health services and Primary Health Care services. This method requires the vendor to propose a plan that meets the objectives of the Health Department, but also allows for services to be tailored to meet regional needs and maximize regional resources.
- ▶ The Texas Commission on Alcohol and Drug Abuse (TCADA) has expanded its proposal-based method to include a regional needs assessment based on local input for its Statewide Service Delivery Plan. This needs assessment is intended to drive

funding decisions and find the best ways to provide a continuum of care for the agency's clients. Based on the information gained through this process, TCADA develops a network of providers to meet the region's service needs.

- D The proposal-based process and local needs assessments promote negotiation and an ongoing dialogue that can help to identify strengths and weaknesses in service delivery systems and allow for targeted development of regional services over time. This process also does not diminish contractor accountability. Once an agreement is reached on the services to be delivered under a proposal, a detailed performance contract can then be written to hold the local provider accountable for meeting all conditions of the proposal.

▼ **The State commonly uses the advisory committee structure to allow formal consideration of local input and suggested improvements to state agency operations.**

- D For many years, advisory committees have been used by state agencies to augment agency and board expertise in particular policy areas. Advisory committees are a special management technique used to support agencies attempting to improve government services and understand the potential impacts of an agency's decisions.
- D The State's health and human service agencies have used advisory committees extensively to assist agencies in obtaining service provider and consumer viewpoints. Advisory committees provide the opportunity to receive increased amounts of input in a more structured way and allow state agency staff and stakeholders to meet and conduct advanced-level discussions of complex issues.

Advisory committees are particularly helpful to state agencies when a new area of state policy and agency operations is being developed. The creation of new standards, procedures, and requirements may be difficult to implement or may be costly to stakeholders so advisory committees can bring forward solutions and ideas that otherwise may not be developed by the agency.

Advisory committees
are particularly
helpful when new
state policy is being
implemented.

Implementation and operational issues at the local level will continue to be a major challenge for the Department's foreseeable future.

▼ **The evolving state-local relationship is a complex policy and operational issue that requires continuing attention, examination, and refinement.**

- ▶ The Legislature focused significant attention on examination of the state-local relationship last legislative session by creating the Department's *H.B. 1734 Committee* to further define the role and responsibilities of local authorities. This committee will provide recommendations in the form of a plan to the Legislature in June 1998. The plan will provide the optimal number of local authorities, the scope of a local authority's responsibility, the process for selecting a local authority and criteria for ensuring competitive and best-value contract bidding. However, the committee will not be ongoing and its focus has been limited to policy issues and not on the operational issues at the local level. Implementation and operational issues will continue to be major challenges for the Department's foreseeable future.

Conclusion

The State's relationship with local mental health and mental retardation authorities is continuing to evolve. Clear benefits are derived from delegating state power and responsibility to the local level. Clients are better served and accountability is often enhanced. Although the Department is making progress in developing the state-local relationship and has followed legislative directives to improve accountability, the current performance contracting process used by the Department to define the state-local relationship needs further attention.

Local authorities are experiencing a range of problems and the Department's current ad hoc processes for dealing with these problems needs improvement. Local authorities lack the opportunity to participate in a process that provides for structured and continuing consideration of decisions that affect local operations. The following recommendations provide for a statutory framework as well as management direction to assist the Department in achieving the appropriate balance of power and responsibility between the state and local levels, and provide a forum for resolving operational issues faced by local authorities and service providers.

Recommendation

Change in Statute

- **The Commissioner should appoint a nine-member local authority advisory committee to:**
 - **review existing and proposed rules and requirements related to local authorities;**
 - **advise the Department in evaluating and coordinating initiatives that directly affect local operations;**
 - **advise and assist the Department in developing a proposal-based method of performance contracting with the local authorities; and**
 - **coordinate and monitor workgroup activities whose actions may affect the future of local service delivery.**

Members of this committee should be representatives of local authorities. In appointing these members, the Commissioner should ensure equal representation from different geographic regions, rural and urban counties, and multi-county authorities. The local authority advisory committee should be appointed as soon as possible after the effective date of the Sunset legislation. The committee should remain in existence until September 1, 2007 after which time the Department may continue the advisory committee by administrative rule.

This recommendation provides local authorities with a formal avenue of input into decisions that directly affect local operations. The committee should ensure that rules and requirements result in the administration of efficient, effective and quality services. Input will assist the Department in streamlining administrative and procedural requirements, thereby allowing for the best use of state funds. The committee's input on the evaluation of current and future initiatives will also assist the Department in designing a system that results in the effective delivery of quality services at the local level.

The Department should consider a proposal-based method of contracting with local authorities to improve communication and local input and provide for a greater degree of local decision making. Before implementing a proposal-based contracting method, the Department must ensure the capacity of the local authorities to conduct a reliable local needs assessment and build a dependable local plan, as is discussed in the management action below.

The committee's coordination of workgroups will involve determining the need for and issuing a charge to current and future workgroups, monitoring their progress, and sharing information and recommendations with the Department and the TDMHMR Board. The Department should provide a response to the committee concerning any action, or reasons for inaction, taken on recommendations made by the committee.

Management Action

- **The Department should strengthen the connection between local authorities' plans and needs assessments, and the Department's strategic plan and performance contract.**

Decisions regarding the expenditure of state dollars should be more closely connected to efforts of local authorities, the formal community-wide needs assessment, and other focused local planning activities conducted throughout the year. This recommendation would help ensure that the Department takes necessary steps to developing a performance contract that is based on locally identified needs and priorities.

Department efforts should include committing additional staff time and resources needed to build the capacity of local authorities to develop local plans with reliable needs assessments. The Department should also work to eliminate any barriers to developing a performance contract based on locally identified needs and priorities, and establish an approximate time line for completing this process. To maximize existing resources, the Department needs to first address the variability of local authorities' capacity to assume planning responsibilities.

Fiscal Impact

Creation of the local authority advisory committee would have minimal fiscal impact. Existing staff resources could be used to support the committee. These resources should be available since the creation of this committee will help to streamline the activities of existing committees and workgroups and the resulting staff support needed. Travel costs for the committee should be minimal. Travel expenses of other Department committees range between \$1,200 and \$13,000.

¹ Interviews with representatives of local mental health and mental retardation authorities, January through April, 1998.

² Ibid.

³ Ibid.

Issue 3

The Sunset Commission Should Consider the Recommendations of the H.B. 1734 Committee.



House Bill 1734, passed in 1997 by the 75th Legislature, sought further definition of the role and responsibilities of the local authority. Most notably, the bill repeals the statutory preference given to community mental health and mental retardation centers as the designated local authority. It then directs the Commissioner to appoint a committee to develop a plan that recommends:

- the most efficient and effective number of local authorities;
- the scope of responsibilities to be delegated by the State authority to the local authority;
- criteria by which local authorities shall be selected;
- the process of selection;
- criteria to ensure that contracts between local authorities and providers are competitive and result in the selection of the best bid;
- a time frame for implementation; and
- strategies to ensure that services are not disrupted.

The Commissioner appointed a committee composed of consumers, family member, advocates, and public and private provider representatives. The committee has been meeting monthly since October. In addition to their regular monthly meetings, the committee also visited the five H.B. 2377 pilot sites. The group is currently in the process of finalizing its recommendations and will hold public hearings throughout the state to receive comment on its draft product. A final report must be submitted to the TDMHMR Board by June 30, 1998. The Board will consider the committee's recommendations and must submit an approved plan to the Senate Health and Human Services Committee and the House Public Health Committee by September 1, 1998.

The H.B. 1734 committee is composed of consumers, family members, advocates, and public and private provider representatives, and has been meeting monthly since October 1997.

The staff concluded that the Sunset Commission should consider the committee's work once completed.

The outcome of the work of the H.B. 1734 committee will greatly affect the operations of TDMHMR and the entire system of mental health and mental retardation services in Texas. The committee is charged with defining what the local service delivery system will look like in the future, and their recommendations will not only require significant operational changes, but extensive statutory and rule changes as well. The timing of the committee's work and issuance of its recommendations preclude its consideration for this report. The Sunset staff concluded that the Sunset Commission should consider the committee's work once completed.

Recommendation

- **Allow the Sunset staff to review and comment on the recommendations that result from the work of the H.B. 1734 committee.**

Sunset staff recommends that we review the H.B. 1734 committee's recommendations to the TDMHMR Board and the Board's recommendations to the House and Senate committees. The staff will advise the Sunset Commission as to whether any of these recommendations should be considered by the Commission as additional recommendations to the Legislature concerning TDMHMR.

Issue 4

Clarify the Grounds for Renewal of Community Services Contracts.



Background

Local mental health and mental retardation authorities are responsible for ensuring the provision of services at the community level for persons with mental illness and mental retardation. Currently, local authorities are providing some of these services in their role as local community centers. However, one of the changes occurring in the service delivery system encourages local authorities to develop a network of service providers and rely less on providing the services themselves.¹ Additionally, the Department requires the local authorities to negotiate the contracts for these services with goals of best value and providing more choices for consumers by expanding the provider pool.²

Once a local authority awards a contract to a service provider, the authority must follow certain statutory guidelines for renewal of that contract. The statute grants a preference to current providers of community services by requiring authorities to renew a contract if certain conditions are met.³ (See text box, *Renewal of Certain Contracts for Community Services*.) The policy reasons behind this statutory preference are to facilitate continuity of services and prevent disruption of services in the renewal process.

The Sunset review focused on the impact these statutory provisions have on the ability of the local authorities to negotiate the renewal of contracts considering such factors as best value, client choice, developing and expanding provider networks, and ultimately, the delivery of the best services to all consumers.

Renewal of Certain Contracts for Community Services Health and Safety Code § 534.065
<p><i>A mental health or mental retardation authority shall review a contract scheduled for renewal that:</i></p> <ul style="list-style-type: none"> • is between the authority and a private provider; • is for the provision of mental health or mental retardation services at the community level, including residential services; and • involves the use of state funds or funds for which the state has oversight responsibility. <p><i>The mental health or mental retardation authority shall renew the contract if the authority finds that:</i></p> <ul style="list-style-type: none"> • funding is available; • the authority plans to continue the services; • the provider is in substantial compliance with each material provision of the contract, unless the authority determines that the provision is not legal and enforceable under applicable state and federal law; • the provider is providing a reasonably adequate level of service in accordance with the contract and at a reasonable cost; • the provider agrees to a renewal contract that is substantially in compliance with a model contract developed by the Department; • the provider was during the term of any contract with the authority and is at the time of renewal in compliance with applicable laws governing the subject matter of the contract; and • neither the provider nor any of its officers, directors or principal employees has been convicted or found by a final administrative decision to have been guilty of fraud or abuse in the provision of health care services under a contract with a state or federal agency. <p><i>The mental health or mental retardation authority and private provider shall negotiate a contract renewal at arms length and in good faith.</i></p> <p><i>This section applies to a contract renewal regardless of the date on which the contract was initially executed.</i></p>

Findings

▼ **The process for renewal of community services contracts conflicts with State and Department contracting goals.**

- ▶ All health and human services agencies are required to procure goods and services that provide for best value.⁴ “Best value” is a state procurement standard that requires state agencies to consider relevant factors such as price, quality and reliability of the vendor, and past performance of the vendor when purchasing goods or services.⁵ This requirement is also found in the statute that applies to community centers.⁶

The Department has designed a model contract that all local authorities are required to use when initially contracting for community services that requires local authorities to ensure best value. However, the statutory renewal provision only requires that the contracts meet other criteria such as “providing a reasonably adequate level of service...at a reasonable cost” and being in “substantial compliance with each material provision of the contract,” not that they continue to ensure best value.

- ▶ Additionally, other statutory provisions require local authorities to consider the “best use of public money” in assembling a network of service providers and determining who the provider of services should be.⁷ Again, the renewal statute requires only meeting certain criteria, which do not include best value or best use of public money.

All health and human service agencies are required to procure goods and services that provide for best value.

▼ **The statute limits the ability of the local authorities to expand the provider network and ensure consumer choice.**

- ▶ The Legislature has directed the Department to encourage local authorities to expand the provider network. An increase in providers is seen as a means to furnish the competition needed to control costs and ensure quality of service within the system.⁸ However, by requiring the local authorities to renew contracts that meet only the statutory criteria, the statute limits the ability of the local authority to expand the provider base by contracting with new providers. For example, without the statutory renewal criteria, an authority could consider the need for competition and the need for developing the provider network when considering a contract for renewal.

- ▶ The idea of consumer choice plays an important role in the development of services within the Department.⁹ The Legislature has also emphasized the importance of consumer choice in recent legislation,¹⁰ and statute requires local authorities to ensure client choice in developing and choosing providers.¹¹ One means local authorities have of increasing client choice is to expand the provider pool. Thus, as local authorities consider awarding contracts, a major consideration becomes the effect on consumer choice. Because preference is given to the current provider, local authorities are limited in their ability to expand the provider pool.

▼ **The statute is ambiguous and places the burden on the local authority to prove non-compliance with the statutory criteria to not renew a contract.**

- ▶ The language of the statute requires local authorities to review a contract with a private provider, and renew the contract if the provider agrees to a contract in substantial compliance with the model contract and the contractor is in substantial compliance with each material provision of the contract. Phrases such as “substantial compliance” and “material provision” are legally subjective and offer no instruction for granting renewal. For example, local authorities do not know whether 85 percent compliance should be considered “in substantial compliance” or what constitutes a “material provision” of the contract.
- ▶ Since the statute requires renewal if certain criteria are met, a local authority must show a contractor did not meet the statutory criteria, such as “substantial compliance,” to not renew a contract. Further, it must do so without knowing definitively what these phrases mean. If a local authority plans to avoid a renewal, it must seek legal advice to learn its legal position. This can be costly and time consuming and, because of the ambiguity of the provisions of the statute, no definitive position can be asserted.

Consumer choice is an important factor for the Department and the State in designing a service delivery system.

Local authorities should be able to not renew a contract without having to prove non-compliance.

Conclusion

Through the passage of House Bills 2377 and 1734, the Legislature has clearly stated its intent that the Department move toward a system that increases the effectiveness and quality of services. Included in this intent is the expansion of the provider network and the importance of consumer choice. The contract

renewal statute for local authorities represents a barrier to the achievement of this system of service delivery. Furthermore, the ambiguity of the statute may cause additional problems. At a time when the Department is searching for ways to expand services at the local level, local authorities should be required to consider the best use of state funds when renewing contracts. They can only accomplish this, while continuing to ensure continuity of services, if they are held to State standards in contract renewals.

Recommendation

Change in Statute

- **Change the criteria for renewal of community services contracts to conform with State contracting guidelines.**

This recommendation would eliminate the existing ambiguous criteria for renewal and would require local authorities to consider best value as required in state contracting guidelines. Additionally, local authorities would not be required to automatically renew a contract unless it can show non-compliance, but would have the *option* to renew if the contract still provided the best value for the services provided. These changes would also allow local authorities to include other factors in contract renewal decisions such as consumer choice, expansion of the provider network, and client needs, and allow for market forces to work toward increasing customer satisfaction, lowering cost, and improving quality.

Fiscal Impact

This recommendation would not result in a fiscal impact to the State.

¹ Texas MHMR, *HB 2377 Implementation*, Report to the Legislature, January 1997, p.1. (“[I]mportant among these is the expectation that each local authority develop and implement a network of service providers.”)

² Ibid.

³ Tex. Health & Safety Code Ann. ch. 534, sec. 534.065 (Vernon 1992 & Supp. 1998).

⁴ Tex. Gov't Code Ann. ch. 2155, sec. 2155.144 (Vernon Pamphlet 1998).

⁵ Ibid.

⁶ Tex. Health & Safety Code Ann. ch. 533, sec. 533.016 (Vernon 1992).

⁷ Tex. Health & Safety Code Ann. ch. 533, sec. 533.035 (Vernon 1992, Vernon Supp. 1998).

⁸ Policy Research project on Mental Health Managed Care 1998, *Community Mental Health Centers Under Managed Care: Authority or Provider?*, (Austin, Tex.: Lyndon B. Johnson School of Public Affairs, Policy Research Project Report Number 128, 1998), p. 7.

⁹ Texas Department of Mental Health and Mental Retardation, *Report on House Bill 2377 and House Bill 1*, 75th Legislature Rider 34.

¹⁰ Tex. HB 1734, 75th Leg. (1997), Tex. HB 2377, 74th Leg. (1995)

¹¹ Tex. Health & Safety Code Ann. ch. 533, sec. 533.035 (Vernon 1992, Vernon Supp. 1998).

Issue 5

Clarify Revolving Door Provisions Placed on Former Employees of Community Centers.



Background

Revolving door statutes restrict future employment of government officers or employees. The policy underlying these statutes is to prevent illegal or unethical conduct of current and former employees. For example, an employee might design a Request for Proposal and then bid on the contract granted under that proposal. The provisions usually relate to specific areas of employment and are time limited.¹

Texas has a general revolving door statute that contains two separate revolving door provisions.² The first prohibits a former Board member or Executive Director of a regulatory agency from communicating with the agency to influence agency action for two years after leaving the agency. The second forbids a former officer or former employee of a regulatory agency, who was compensated at or above a specified level at the time of leaving state employment, from ever receiving compensation for working on a matter the former officer or employee worked on as a state employee. The Texas Ethics Commission has interpreted “matter” to refer to “a procedural matter rather than to general subject matter.”³ Therefore, under the second revolving door prohibition, a former employee who developed a contract proposal could not bid on that proposal.⁴ However, the former employee could contract with the agency to do the same type of work he or she performed at the agency, as long as the employee did not work on the contract proposal. Another revolving door provision, found in the General Appropriations Act, forbids former agency employees from contracting with their former employers for one year after leaving service.⁵

Revolving door prohibitions relating to community centers are much broader and more restrictive than the State's general revolving door prohibitions.

Although similar, the prohibitions contained in the statutes relating to community centers are much broader and more restrictive than those for state agency employees.⁶ These statutes prohibit a former community center employee from directly or indirectly attempting or aiding in the attempt to procure a contract with the community center. The restrictions are not limited to a particular contract, but rather, extend to contracts in any area *related* to a program or service in which the individual was concerned. Therefore, unlike the situation covered by the Government Code, the former employee of a

local center could not contract to do the same type of work. This broad restriction on former employees is significant for the community centers given the changes taking place in the Texas mental health and mental retardation system.

The Sunset review focused on the barriers the statutes present to community centers as they try to develop a provider network.

Findings

▼ **The statute limits the ability of community centers to develop and expand the provider network.**

- ▶ The community center statute forbids former employees from contracting with their previous employers for one year after leaving employment. This restriction limits a community center's ability to develop a network of providers.

For example, in their role as provider, community centers have traditionally employed clinical professionals, such as psychiatrists or counselors, on a part-time basis. As community centers move away from directly providing services, they would prefer to move these part-time employees to contract status or include them within a network of service providers. However, because these professionals were former employees of a community center, the revolving door statute prevents them from going to contract status for one year.

Former employees have experience with mental health and mental retardation consumers and have shown a willingness to work with the difficulties the clients present.

▼ **The statute eliminates potential providers willing to provide services from an already limited pool of providers.**

- ▶ The number of providers willing to provide certain community services is limited. The restricted amount Medicaid pays for services combined with the problems of “no shows” for appointments makes the consumers difficult to work with and hard to manage from a business perspective. As a result, community centers have difficulty recruiting psychiatrists and other professional staff to work with these individuals.⁷
- ▶ Former employees have experience with and knowledge of the consumers needing services and have shown a willingness to work with the difficulties the clients present. However, because the statute forbids community centers from contracting with former employees, they are eliminated as possible providers for up to one year after they leave employment.

▼ **The statute is unclear about what actions the former employee is forbidden to take, yet it provides for a criminal penalty.**

- ▶ Unlike the general revolving door provisions in the Government Code, the specific provisions related to community center employees contain no clear pronouncements of forbidden actions. “Attempt or aid in the attempt to procure” can be broadly interpreted to include actions of which the employee was unaware. For example, a potential contractor could list a former employee’s name in a proposal as a qualified provider of a service. Even if the employee was unaware that their name was used in the proposal, this could be seen as a violation if using the name aided in the procurement of a contract.
- ▶ The statute further provides for strict liability without regard to an employee’s intention. In contrast, the Government Code provisions require specific “intent to influence” former board members or executive directors when communicating with their former agency.⁸ As in the above example, the employee does not have to intend to aid in the procurement of a contract, that only need be the result, for the employee to be found in violation of the statute and subject to a criminal penalty.

The revolving door provisions related to community center employees contain no clear pronouncements of forbidden actions.

Conclusion

The mental health and mental retardation service delivery system of Texas is undergoing significant changes. Local authorities are being asked to rethink their roles as service providers. The expectation is that local authorities will develop a network of providers and limit the services they provide. Although the statute does not prohibit former employees from all contractual activities, it does act as a barrier to the goals and changes in the service delivery system. To facilitate the changes needed and eliminate ambiguities in the law, the statute should be changed to reflect the current philosophy and direction of the State regarding revolving door situations.

Recommendation

Change in Statute

- **Change the revolving door provisions for former community center employees to conform to the State's general revolving door provisions.**

This recommendation would prohibit former community center employees from bidding on a contract they designed, while allowing them to provide similar services within their former program areas. In addition to changing the restrictions placed on community center employees to conform to general state law, this change will allow the community centers to fully implement a system that will meet the goals and changes expressed by the Legislature. In particular, local authorities will be free to fully develop a network of providers, which will provide for maximum consumer choice and ultimately the highest quality services available.

Fiscal Impact

This recommendation will not result in a fiscal impact to the State.

¹ Sarah Woelk, "Application of Ethics Laws to Private Contractors Performing Government Services," (paper presented at Council on Governmental Ethics Laws, 18th Annual Conference, December 11, 1996), p. 7.

² Tex. Gov't Code Ann. ch. 572, sec. 572.054 (Vernon 1994).

³ *Application of Ethics Laws to Private Contractors Performing Government Services*, p. 8.

⁴ *Ibid.*

⁵ Tex. H.B. 1, 75th Leg. (1997), Article IX, Sec. 52.

⁶ Tex. Health & Safety Code Ann. ch. 534, sec. 534.007 and ch. 532, sec. 532.008 (Vernon 1994).

⁷ Interview with Doug Rudd, Community Services Department, TDMHMR, March 30, 1998. Also, as related from various interviews with community center staff throughout review process (including Lubbock Regional MHMR, Tarrant County MHMR, and Austin Travis County MHMR).

⁸ Tex. Gov't Code Ann. ch. 572, sec. 572.054(a) (Vernon 1994).

Issue 6

Decide on Continuation of the Texas Department of Mental Health and Mental Retardation as a Separate Agency after Completion of Sunset Reviews of all Health and Human Service Agencies.



Background

The Legislature scheduled most of the State's health and human service agencies for Sunset review in 1999. Health and human services (HHS) is the second largest function of State government. With a combined appropriation of \$26.1 billion for the 1998-99 biennium, these agencies account for almost 30 percent of State government's budget.

With most HHS agencies under review together, the Sunset Commission has an unprecedented opportunity to study how the State has organized this area of government. Currently, 13 separate agencies have primary responsibility to carry out the numerous state and federal programs, services, assistance, and regulations designed to maintain and improve the health and welfare of the citizens of Texas. Reviewing these agencies together will enable a look across agency lines — at types of services provided, types of clients served, and funding sources used. Assuming any organization changes are needed, this information will prove valuable in the analysis of how best to make those changes.

Central to the Sunset review of any agency is determining the continuing need for the functions it performs and whether the current agency structure is the most appropriate to carry out those functions. Continuation of an agency and its functions depends on certain conditions being met, as required by the Sunset Act. First, a current and continuing need should exist for the State to provide the functions or services. In addition, the functions should not duplicate those currently provided by any other agency. Finally, the potential benefits of maintaining a separate agency must outweigh any advantages of transferring the agency's functions or services to another agency.

The Sunset staff evaluated the continuing need for the Texas Department of Mental Health and Mental Retardation (TDMHMR) and its functions in

TDMHMR is one of the 13 health and human service agencies under Sunset review.

light of the conditions described above. This approach led to the following findings.

Findings

▼ Texas has a continuing need for the services provided by TDMHMR.

- ▶ The Department provides and oversees services to some of the state’s most vulnerable citizens — persons with mental illness and persons with mental retardation. The mission of the Department is to improve the quality and efficiency of public and private services and supports for Texans with mental illness and mental retardation so that they can increase their opportunities and abilities to lead lives of dignity and independence. During 1997, an estimated 2.8 million Texans were diagnosed with some form of mental illness and 530,000 with mental retardation. Of these totals, approximately 490,000 of those with mental illness and 79,000 of those with mental retardation fall into TDMHMR’s priority population.
- ▶ The Department provides services through 22 campus-based facilities and 10 state-operated community services and funds and oversees locally-operated community services through performance contracts with 38 community centers across the state. In 1997, approximately 19,000 persons received services through the campus-based facilities and 168,000 persons received services through community services.

▼ While the agency’s current functions should continue, organizational alternatives exist that should be explored.

- ▶ TDMHMR is one of 13 separate agencies that perform the State’s health and human service functions. These agencies’ responsibilities are generally unique, but the types of services offered, clients served, and funding sources used are sometimes very similar. For example, responsibility for mental retardation services is fragmented based on a person’s age. The Interagency Council on Early Childhood Intervention is responsible for children with mental retardation 0-3 years of age, the Texas Education Agency is responsible for services to persons of school age, and TDMHMR is responsible for those persons after they leave school.

The Department provides and oversees services to some of the state’s most vulnerable citizens — persons with mental illness and persons with mental retardation.

Many other agencies, in addition to TDMHMR, also share authority for or provide mental health services such as the Texas Rehabilitation Commission, the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse, the Texas Department of Protective and Regulatory Services, the Texas Juvenile Probation Commission, the Texas Youth Commission, and the Texas Department of Criminal Justice.

- Because of these similarities, many options to the current system have been and should continue to be considered. For example, the interim work of the Legislature during the past four years has yielded more than 550 recommendations for change in HHS policies and operations. Many of these recommendations have not been implemented and should be considered in the Sunset process.
- Continuation of an agency through the Sunset process hinges on answering basic questions about whether duplication of functions exists between agencies and whether benefits would result from consolidation or transfer of those functions. The Sunset staff has identified several instances where organizational change may be warranted. Examples include consolidation of core administrative functions, collocation of field offices, collapsing of contracting functions, better alignment of similar services to similar clients, and a close look at how planning and budgeting could be improved. These changes should be looked at before the Sunset Commission makes decisions to continue an HHS agency under review.

Continuation of
TDMHMR as a
separate agency
should be decided
after completion of
all HHS agency Sunset
reviews.

▼ **Continuation of TDMHMR as a separate agency should be decided after completion of all HHS agency Sunset reviews.**

- The Sunset reviews of the HHS agencies are scheduled for completion at various times before the end of 1998. The Sunset staff will use the results of this work in its review of the Health and Human Services Commission, the umbrella agency for HHS. The staff will also study the overall organizational structure of this area of government. Finally, the staff will evaluate issues that cut across agency lines, such as the need for a single agency for long-term care, consolidation of services to persons with disabilities, the need for a single agency to

administer Medicaid services, and streamlining regulatory functions.

- ▶ The Commission's schedule sets the review of the Health and Human Services Commission and HHS organizational and cross issues for the Fall of this year (1998). Delaying decisions on continuation of all HHS agencies, including TDMHMR, until that time allows the Sunset staff to finish its work on all the agencies and base its recommendations on the most complete information.

Conclusion

Most of the State's health and human service agencies are currently under Sunset review. While these agencies serve many unique purposes, they also have many similarities that should be studied as areas for possible improvement through organizational change. This analysis should occur before decisions are made to continue the HHS agencies as separate entities, including the Texas Department of Mental Health and Mental Retardation.

Recommendation ---

- **Decide on continuation of TDMHMR as a separate agency upon completion of Sunset reviews of all health and human service agencies.**

Sunset review of several other HHS agencies are ongoing. Sunset staff recommends that the Sunset Commission delay its decision on continuation of TDMHMR as a separate agency until those reviews are completed. The results of each agency review should be used to determine whether changes are needed in the overall organization of health and human services.

The staff will issue a report to the Commission in the Fall of this year (1998) that will include recommendations for each HHS agency to continue, abolish and transfer functions, or consolidate specific programs between agencies. This report will also include, for possible action, three agencies under the HHS umbrella not scheduled for specific review this cycle, the Department of Protective and Regulatory Services, the Texas Commission on Alcohol and Drug Abuse, and the Texas Juvenile Probation Commission. These agencies were reviewed by the Sunset Commission in 1996 and continued by the Legislature last year. Possible reorganization of health and human services may affect the continuation of these agencies as independent entities.

ACROSS-THE-BOARD RECOMMENDATIONS

Texas Department of Mental Health and Mental Retardation	
Recommendations	Across-the-Board Provisions
	A. GENERAL
Already in Statute	1. Require at least one-third public membership on state agency policymaking bodies.
Already in Statute	2. Require specific provisions relating to conflicts of interest.
Already in Statute	3. Require that appointment to the policymaking body be made without regard to the appointee's race, color, disability, sex, religion, age, or national origin.
Already in Statute	4. Provide for the Governor to designate the presiding officer of a state agency's policymaking body.
Already in Statute	5. Specify grounds for removal of a member of the policymaking body.
Already in Statute	6. Require that information on standards of conduct be provided to members of policymaking bodies and agency employees.
Apply	7. Require training for members of policymaking bodies.
Already in Statute	8. Require the agency's policymaking body to develop and implement policies that clearly separate the functions of the policymaking body and the agency staff.
Already in Statute	9. Provide for public testimony at meetings of the policymaking body.
Already in Statute	10. Require information to be maintained on complaints.
Update	11. Require development of an equal employment opportunity policy.

BACKGROUND

Background

AGENCY HISTORY

Texas has operated a system of institutions to care for persons with mental illness and mental retardation since the mid-1800s. The Legislature established the first institution in the state for persons with mental illness in 1856 in Austin. The first separate institution for mentally retarded persons was opened in 1917. Like many other states, Texas met its obligation to provide services to mentally ill and mentally retarded persons by offering “asylum” in large, state-run institutions until the 1960s. The mentally ill were housed in state hospitals while the mentally retarded were housed in state schools. These facilities were governed first by a State Board of Control and, beginning in 1949, by a Board for Texas State Hospitals and Special Schools.

However, the passage of federal legislation in 1963, which provided grants for the construction of community mental health and mental retardation centers, prodded Texas to begin providing services in the community. In 1965, House Bill 3 abolished the Board for Texas State Hospitals and Special Schools and consolidated all mental health functions in various agencies in the newly created Texas Department of Mental Health and Mental Retardation (TDMHMR). The bill also authorized the creation of local boards of trustees to organize and administer these community centers and to set up guidelines for funding the community centers. (See text box, *Important Dates in TDMHMR’s History*)

As a result of having its enabling statute amended over several decades, TDMHMR has evolved from an operator of large institutions to an agency that ensures the provision of many different mental health and mental retardation services in primarily community settings. The statute was amended to respond to changes in thinking and practice about the treatment of persons with mental illness and mental retardation. Senate Bill 791, in 1981, stated that the purpose of the agency was to provide for a continuum of services and, more importantly, that the policy of the State was to treat mentally ill and mentally retarded persons in their own communities first. In 1987, Senate Bill 257 took that policy one step further by making the provision of services the responsibility of local agencies and organizations to the greatest extent possible. This bill also stated that funds would be provided first to those in the most need of services, the priority population.

Texas' mental health and mental retardation system dates back to 1856, when the Legislature established the first state mental health institution.

Important Dates in TDMHMR's History

1856	Texas Legislature established the first institution for persons with mental illness, located in Austin and named "State Lunatic Asylum."
1915	Texas Legislature established the "State Colony for the Feeble-minded," now Austin State School. It was Texas' first institution established solely for persons with mental retardation.
1919	The Legislature created the State Board of Control by consolidating 21 state agencies. The Board of Control performed the purchasing for and management of the state's five asylums and charitable institutions.
1925	The Legislature removes the words "lunatic" and "insane" from the names of the state hospitals.
1942	The Board of Control initiated a program to reduce the waiting list of 1,400 persons seeking admission to state hospitals, most of whom were in jail, by increasing the number of beds per room and setting up beds in hallways and porches.
1945	Texas public schools began special education classes that included many children with mental retardation.
1949	The Legislature established a nine-member Board of Texas State Hospitals and Special Schools. Governor Shivers invites media to tour the hospitals and requests the U.S. Public Health Service to survey the hospitals. Surveyors declare Texas hospitals fall further below American Psychiatric Association standards than every other state.
1957	The Texas Mental Health Code and Commitment of the Criminally Insane became law. The code defined mental illness and set up procedures for voluntary and involuntary commitment.
1963	The Federal Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 provided matching grants to Texas for construction of community MHMR centers.
1965	House Bill 3 created TDMHMR and assigned to it most of the duties formerly belonging to the Board for Texas State Hospitals and Special Schools. House Bill 3 also authorized the creation of local boards of trustees to organize and administer community MHMR centers and set up guidelines for funding the centers.
1968	The Regional Programs Division of TDMHMR was created to develop community programs, particularly in rural areas.
1973	TDMHMR became responsible for licensing private mental hospitals.
1974	<u>Jenkins v. Cowley</u> (now <u>R.A.J. v. Gilbert</u>) class action lawsuit was filed on behalf of patients in state hospitals, alleging that the hospitals failed to provide adequate treatment in the least restrictive environment and that the hospitals were inadequately staffed. The <u>Lelsz v. Kavanagh</u> class action lawsuit was filed against the state schools to protect the rights of persons with mental retardation in state facilities, especially in regards to right to treatment and quality of life.
1981	A settlement agreement was reached in the <i>R.A.J.</i> litigation and approved by the Court. The Court created a <i>R.A.J.</i> review panel to monitor compliance with settlement.
1983	A Resolution and Settlement was signed by Plaintiffs and Defendants and approved by the Court in the <i>Lelsz</i> lawsuit.
1985	Senate Bill 633 changed the relationship between the Department and community service providers from a grant-in-aid arrangement to a contractual relationship.
1988	The Office of Children's Mental Health Services was established.
1991	TDMHMR enters into a second settlement agreement in the <i>Lelsz</i> federal class action lawsuit.
1992	A new settlement agreement in the <i>RAJ</i> litigation was approved by the Court. This agreement included the Quality Services Oversight (QSO) System as the method for measuring TDMHMR's compliance.
1995	<i>Lelsz</i> lawsuit is dismissed. The Legislature passes HB 2377 which requires TDMHMR to implement a pilot project to study the authority structure for service delivery at the local and regional levels to clearly delineate between the roles of authority and provider.
1997	<i>R.A.J.</i> lawsuit is dismissed. The Legislature passes HB 1734 which requires the Commissioner to appoint a committee to develop a plan with recommendations on the optimal number of authorities, the scope of the responsibilities to be delegated to local authorities, and the criteria by which local authorities shall be selected.

House Bill 2377, in 1995, enacted the last major change to the purpose and policy of the agency, clarifying and strengthening the state authority role and allowing the Board to delegate its authority to designated local mental health and mental retardation authorities.

Two federal lawsuits have also had a tremendous impact on the agency and influenced the quality and type of care that the agency offered in its institutions. In 1974, the R.A.J. v. Gilbert lawsuit was filed. It alleged that the state mental hospitals failed to provide adequate treatment in the least restrictive environment possible. Also in 1974, the Lelsz v. Kavanagh lawsuit was filed against the state schools. This suit was a “right to treatment” suit which alleged that TDMHMR had a responsibility to provide treatment, and not just custodial care, for persons residing in state schools. These suits forced TDMHMR to improve its physical facilities, increase staffing ratios, strengthen client rights, and, most importantly, to stop merely housing clients and begin focusing strongly on providing treatment to residents and patients of its facilities. The *Lelsz* suit was finally dismissed in 1995 and the *R.A.J.* suit was dismissed in October 1997. (See text boxes: Lelsz v. Kavanagh and R.A.J. v. Gilbert)

Two federal lawsuits tremendously affected the quality of care in institutions.

The past legislation and lawsuits helped to fundamentally shift the focus of TDMHMR from serving most of its clients in institutions to serving the majority of clients in the community. In 1970, 22 community centers were formally organized and had their boards appointed. Even with 22 community centers in operation, the Department spent the bulk of its appropriation providing services directly at its campus-based schools and hospitals. In 1998, 38 community mental health and mental retardation community centers are operating and receiving state funds. As a result of the creation of more community centers, the class-action lawsuits, legislative direction, advances in technology and treatment, and changing philosophies in treatment, TDMHMR now serves the majority of its clients in the community. The Department expended approximately 63 percent of its entire 1997 fiscal year operating budget on community services.¹

The Department serves most of its clients in the community by passing the majority of its appropriation to its 38 community MHMR centers through performance contracts. These local centers are governed by local boards, usually appointed by county commissioner’s courts, and provide or contract for services in the community for persons with mental illness and mental retardation.

The Department has two other significant responsibilities that are different from the provision of services or funding community centers. The first is regulating electroconvulsive therapy (ECT). TDMHMR designs a consent

Lelsz v. Kavanagh

In 1974, five families of residents of Texas state schools for the mentally retarded filed a class action suit in U.S. District Court. The suit, Lelsz v. Kavanagh (*Lelsz*), claimed the Texas Department of Mental Health and Mental Retardation (TDMHMR) had violated federal and state laws as well as the U.S. Constitutional civil rights of persons residing in state schools. The suit asked for improvement and change to correct problems of chronic abuse and neglect, inadequate training and habilitation, inappropriate institutionalization, and failure to expand community services.

In 1981, the *Lelsz* class was certified to include persons who had been residents of Austin, Denton and Fort Worth State Schools since November 27, 1974, future residents of those schools, and persons on the registry for state school placement since August 1981.

In 1983, the parties reached a settlement agreement entitled “Resolution and Settlement” (R&S). The R&S required TDMHMR to adhere to acceptable professional standards, maintain safe and clean conditions, provide adequate staff training, avoid physical and psychological abuse of residents, avoid excessive and improper use of medication, provide habilitation and training tailored to individual needs, strive to provide services in a living environment which is the least restrictive consistent with the persons abilities, formulate a comprehensive plan for mental retardation services, and hire an expert consultant to monitor implementation of the agreement.

Four years later, the Court found the defendants in contempt of the R&S and asked the parties to submit recommendations for remedies. In October of 1987, the parties entered into another agreement, the *Lelsz* Implementation Agreement. This agreement required, among other things, that four state schools meet Accreditation Council for Developmental Disabilities Standards as well as upgrading certain services provided to state school clients. The other state schools were required to ensure maintenance of ICF/MR certification. Additionally, quality assurance measures were implemented to ensure quality of services for clients placed from state schools into community settings.

In 1991, after additional court-ordered hearings, the parties agreed to another settlement plan. This plan, contingent upon the passage of legislation, provided for the closure of two state schools. Dismissal of the litigation would occur after the first state school closed and the state placed residents into community placements at a rate of 300 persons per year until the first school was closed. The placements had to be at a rate of 95 percent into homes with six or fewer beds.

TDMHMR placed more residents into the community than was required by the agreement; the Department designed and implemented surveys and other tools to evaluate and refine the closure process as required; and it closed two state schools. As a result of the Department’s substantial compliance with the terms of the agreement, the District Judge dismissed the Department from the *Lelsz* lawsuit on November 2, 1995.

RAJ v. Gilbert

R.A.J. v. Gilbert (RAJ) was a class action lawsuit against the Texas Department of Mental Health and Mental Retardation (TDMHMR) filed on behalf of patients with mental illness and mental retardation who were residing in Terrell State Hospital. Filed in 1974, the suit sought improved patient rights, quality of treatment, medication management and behavioral management. In addition, the suit demanded improvements in the physical facilities at the state hospital.

A negotiated settlement was first reached in 1981. Under the terms of that settlement, all state hospitals were required to implement and monitor improvements in (1) individualized treatments; (2) protection of patient rights; (3) patient safety at facilities; (4) proper use of psychotropic medications; (5) consent to medications; (6) treatment and placement of the mentally retarded; and (7) provision of adequate community aftercare services. Additionally, the settlement called for accreditation of state hospitals by the Joint Commission on Accreditation of Health Care Organizations.

Between 1982 and 1986 several court findings and agreements between the parties affected the original suit. A court-appointed panel began monitoring compliance with the agreement. In 1984, the court determined non-compliance in three areas: lack of adequate staffing, lack of individualized treatment, and a high degree of aggressive behavior in the hospitals. The Department developed an action plan to correct the problems. Included was a plan to meet the staffing requirements by reducing the number of patients in state hospitals by discharging more patients to the community. The court accepted the plan, but required the facilities and programs in the community to be adequately staffed to meet the needs of the patients. This expanded the jurisdiction of the court in the area of mental health community care. Adequate community-based aftercare for patients discharged from the state hospitals was defined as: (1) appointment with aftercare provider; (2) aftercare plan and effort made to provide the service; (3) follow-up and outreach community programs; (5) case management for all eligible clients; and (6) provision of or referral for nonclinical support services (food, clothing, and shelter).

Court panel reports continued to describe a need for improvement in the areas of individualized treatment, placement of patients with mental retardation (those who no longer needed psychiatric treatment), inappropriate habilitation settings, and community aftercare. In 1986, the parties agreed that the Department must comply with all requirements of the suit by 1987.

Although the Department did not meet the time schedule, a compliance hearing was avoided when the Department agreed to corrective actions recommended by the panel. In 1988, the court panel was replaced by a single court monitor. The parties accepted a new timetable. In 1990, a new round of negotiations between the parties began. These negotiations attempted to define what would constitute compliance with the corrective plan. In the same year, the court released some of the outstanding issues from the court's jurisdiction. Because of the litigious activity surrounding the 1981 agreement, the parties and the court monitor entered into extensive discussions and a new settlement agreement was approved by the court in 1992. This agreement established a procedure for the parties to work cooperatively and outlined an objective system for measuring compliance referred to as the Quality System Oversight. On October 14, 1997, the court dismissed the case and determined that the Department was in compliance with all remaining issues.

form for use in administering ECT, establishes reporting requirements for all ECT practitioners, and registers all ECT equipment. The Department also shares regulatory authority with the Texas Department of Health for inpatient mental health services. TDMHMR establishes standards, levels of care, rights and rules for private psychiatric hospitals, crisis stabilization units, and the psychiatric units of general hospitals. The Department of Health grants licenses and performs enforcement and compliance activities with the regulations promulgated by TDMHMR.

POLICYMAKING BODY

The Department is governed by a nine-member Board. The Board members are appointed by the Governor with the advice and consent of the Senate and serve six-year terms. Board members must be representatives of the public, have a demonstrated interest in mental health, mental retardation, developmental disabilities, or the health and human services system. At least one member must be a consumer of services for persons with mental illness or mental retardation or a family member of a consumer of those services. Currently, the Board has five members who meet this requirement. (See text box, *TDMHMR Board Members*.)

TDMHMR Board Members

Charles M. Cooper, (Chair), Dallas
Rudy Arredondo, Ed.D, Lubbock
Spencer Bayles, M.D., Houston
Andrew P. Hardin, McKinney
Harriet Marmon Helmle, San Antonio
Janelle Jordan, Houston
Rosemary Neill, El Paso
James I. Perkins, Tyler
Edward B. Weyman, Midland

The Board's principal powers include establishing policies for the Department and for the Board, appointing the Commissioner, approving the Department's Legislative Appropriations Requests and operating budget, and creating advisory panels. The Board is required to meet four times a year but generally meets more often. In fiscal year 1997, the Board met seven times and in fiscal year 1996, it met 10 times. The Board tries to hold at least one meeting per year outside of Austin.

The Commissioner is responsible for the day-to-day operations of the agency and for implementation of the Board's policy initiatives. The Commissioner appoints the superintendents of the state facilities as well as other Central Office executives and management personnel, and prepares the agency's appropriations requests and budgets.

The Board has five committees which include Planning and Policy Development, Audit and Financial Oversight, Business and Asset Management, Medicaid, and the Facilities Governance Committee. The committees generally meet the

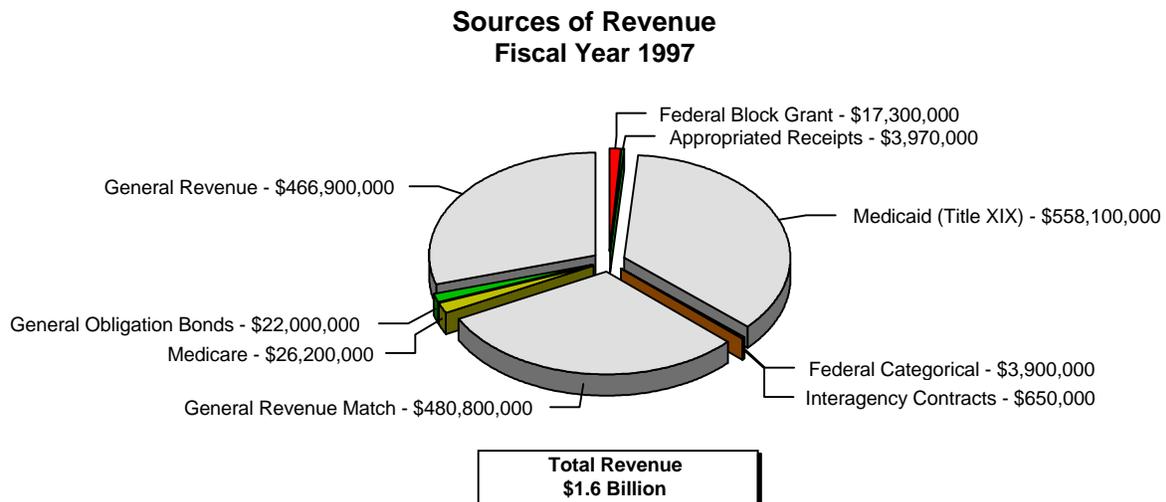
day before full Board meetings and make recommendations to the full Board in these specialized areas.

The Board has three statutorily authorized advisory committees — Medical Advisory Committee, the Citizen’s Planning Advisory Committee, and the Advisory Committee on Inpatient Mental Health Services. In addition, the Chairman may appoint an ad hoc committee to address a specific issue or problem. Ad hoc committees are discharged at the completion of their duties.

FUNDING

Revenues

All funds received by the Department are appropriated through the legislative budget process. TDMHMR receives funding from two main sources — State General Revenue and federal funds. Federal funds for fiscal year 1997 amounted to \$605.5 million or 37 percent of all appropriated funds. The majority (\$558.1 million) of these funds come from Medicaid. In addition, the Department is appropriated \$480.8 million in General Revenue Match. These are funds that the state is required to spend to receive the federal share of Medicaid. When the General Revenue Match is combined with the federal funds they account for 67 percent of the agency’s total revenue. The agency’s other federal revenues include Medicare, Federal Block Grants, and Federal Categorical. State General Revenue funds (in addition to the Medicaid match) contributed \$466.9 million, for a total from all sources of \$1.62 billion. The agency receives additional funds through appropriated



receipts, interagency contracts, and general obligation bonds. Although significant in amounts, these sources represent only a combined four percent of the Department's revenue sources.

Expenditures

The Department's appropriations are divided among the goals and strategies established in the Department's Strategic Plan and in the General Appropriations Act. Currently TDMHMR has six goals where money is to be spent — Community Mental Health Services, Mental Health Campus-Based Services, Community Mental Retardation Services, Mental Retardation Campus-Based Services, Capital Construction, and Indirect Administration.

Although the Legislature appropriates all funds to the Department, the federal government dictates some allocation of funds within different goals. This is

TDMHMR Expenditures by Goal — Fiscal Year 1997	
Goal I: Mental Health Community Services	\$380,617,461
Mental Health Assessment and Coordination	\$70,845,232
Mental Health Training and Supports	\$105,237,080
Mental Health Treatment	\$127,306,444
Community Hospitals	\$45,464,251
Texas Children's Mental Health Plan	\$31,764,454
Goal II: Mental Health Campus-Based Services	\$243,530,847
Mental Health Campus-Based Services	\$203,621,337
Mental Health Campus-Based Administration	\$39,909,510
Goal III: Mental Retardation Community Services	\$711,153,610
Mental Retardation Assessment and Coordination	\$45,112,582
Mental Retardation Vocational Services	\$54,479,684
Mental Retardation Training and Supports	\$48,894,983
Mental Retardation Community Residential	\$562,666,361
Goal IV: Mental Retardation Campus-Based Services	\$333,515,391
Mental Retardation Campus-Based Services	\$285,156,991
Mental Retardation Campus-Based Administration	\$48,358,400
Goal V: Capital Improvements	\$18,235,254
Goal VI: Indirect Administration	\$29,461,345
Central Administration	\$21,417,514
Information Resources	\$5,698,060
Support Services	\$2,345,771
Grand Total	\$1,716,513,908

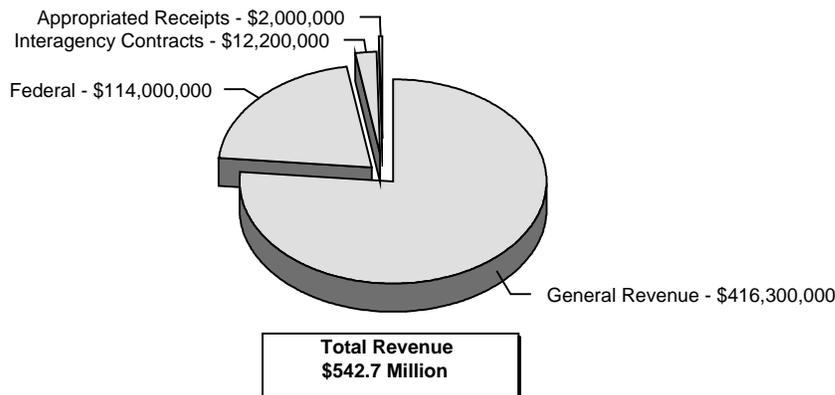
done through program requirements, set-asides or as a condition to receiving the funds. For example, to receive funds under the "Community Mental Health Services Block Grant," the Department must ensure that individuals receiving "substantial amounts of public funds or services," from this federal program will receive case management.² This restriction requires the Department to provide case management services as a condition to receiving the grant. In this way, the federal program requires the allocation of funds to case management. For fiscal year 1997, the Legislature appropriated \$1.6 billion to the Department, plus unexpended balances from 1996 appropriations. The chart, *TDMHMR Expenditures by Goal, Fiscal Year 1997*, provides detailed information on where the Department spends its appropriated funds.

The Department operates separate campus-based programs for persons with mental retardation and mental illness and operates community-based services through ten State-Operated Community Services (SOCS). In addition, the

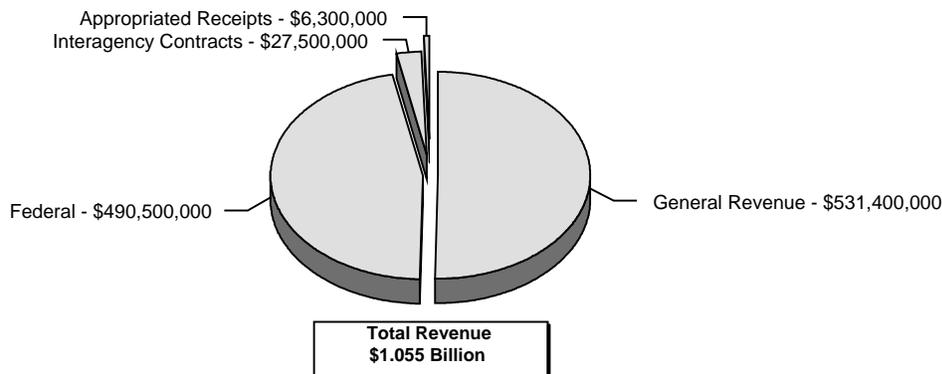
Department provides funding to the 38 community centers to provide or contract for separate programs for persons with mental illness and mental retardation in the community. Just as mental illness is different from mental retardation, the funding for these two program areas is quite different. The majority of persons with mental retardation that the Department serves are Medicaid eligible. As a result, 46 percent of all mental retardation program funding comes from the federal government. The amount of federal funding that mental retardation programs receive is significantly more than the amount that mental health programs receive, in which only 21 percent of funding comes from federal sources. The two pie charts, *Sources of Revenue for Mental Health Programs, Fiscal Year 1997* and *Sources of Revenue for Mental Retardation Programs, Fiscal Year 1997*, provide additional detail.

Just as mental illness is different from mental retardation, so is funding for these program areas.

**Sources of Revenue for Mental Health Programs
Fiscal Year 1997**



**Sources of Revenue for Mental Retardation Programs
Fiscal Year 1997**



HUB Expenditures

The Legislature has encouraged agencies to increase their use of Historically Underutilized Businesses (HUBs) in purchasing goods and services and requires the Sunset Commission to consider agencies' compliance with laws and rules

Purchases from HUBs Fiscal Year 1997				
Category	Total \$ Spent	Total HUB \$ Spent	Percent	Statewide Goal
Heavy Construction	N/A	N/A	N/A	11.9
Building Construction	\$10,001,941	\$1,037,315	10.3	26.1
Special Trade	\$14,730,202	\$1,297,342	8.8	57.2
Professional Services	\$15,846,341	\$753,910	4.75	20.0
Other Services	\$21,044,625	\$3,354,302	15.9	33.0
Commodities	\$68,559,332	\$7,755,580	11.3	12.6
Totals	\$130,182,441	\$14,198,449	14.3%	

regarding HUB use in its reviews.³ In 1997, TDMHMR purchased 14.3 percent of goods and services from HUBs. The chart, *Purchases from HUBs — Fiscal Year 1997*, provides detail on HUB spending by type of contract and compares these percentages with the statewide goal for each category. As shown in the chart, TDMHMR did not achieve any of the statewide goals for purchases

from HUBs. The only category that the Department came close to achieving the statewide goal was *Commodities* where 11.3 percent of purchases were made from HUBs, compared to the state goal of 12.6 percent.

ORGANIZATION

The Department is the second largest state agency in terms of staff size. In August 1997, the Department had the equivalent of 25,712 full-time employees (FTEs). Twenty-nine percent were employed in state hospitals, 46 percent were employed at state schools, 18 percent at state-operated community services,

and 2.3 percent worked at the central office.

Texas Department of Mental Health and Mental Retardation Equal Employment Opportunity Statistics Fiscal Year 1997							
Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	929	7%	5%	10%	8%	61%	26%
Professional	5,284	10%	7%	15%	7%	66%	44%
Technical	4,605	26%	13%	21%	14%	75%	41%
Protective Services	182	11%	13%	16%	18%	14%	15%
Para-Professionals	9,430	43%	25%	20%	30%	69%	55%
Administrative Support	2,253	10%	16%	23%	17%	90%	84%
Skilled Craft	688	6%	11%	22%	20%	5%	8%
Service/Maintenance	2,342	33%	19%	31%	32%	67%	27%

TDMHMR is subject to the General Appropriations Act, including provisions that set employment goals for minorities and women by specific job category. These goals are a useful measure of diversity and an agency's commitment to developing a diverse workforce. The chart, *Equal Employment Opportunity Statistics, Fiscal Year 1997*, shows the composition of the Department's

workforce and compliance with state goals. TDMHMR workforce percentages exceed civilian labor force levels of employment in most of the agency’s job categories.

As of 1995, the Department has been restructured. The previous organizational structure was based on mental health or mental retardation functions, while the new structure delineates Department divisions according to authority and provider functions. This new structure reflects the Department’s desire to separate its provider and authority roles. (See *TDMHMR Organizational Chart*)

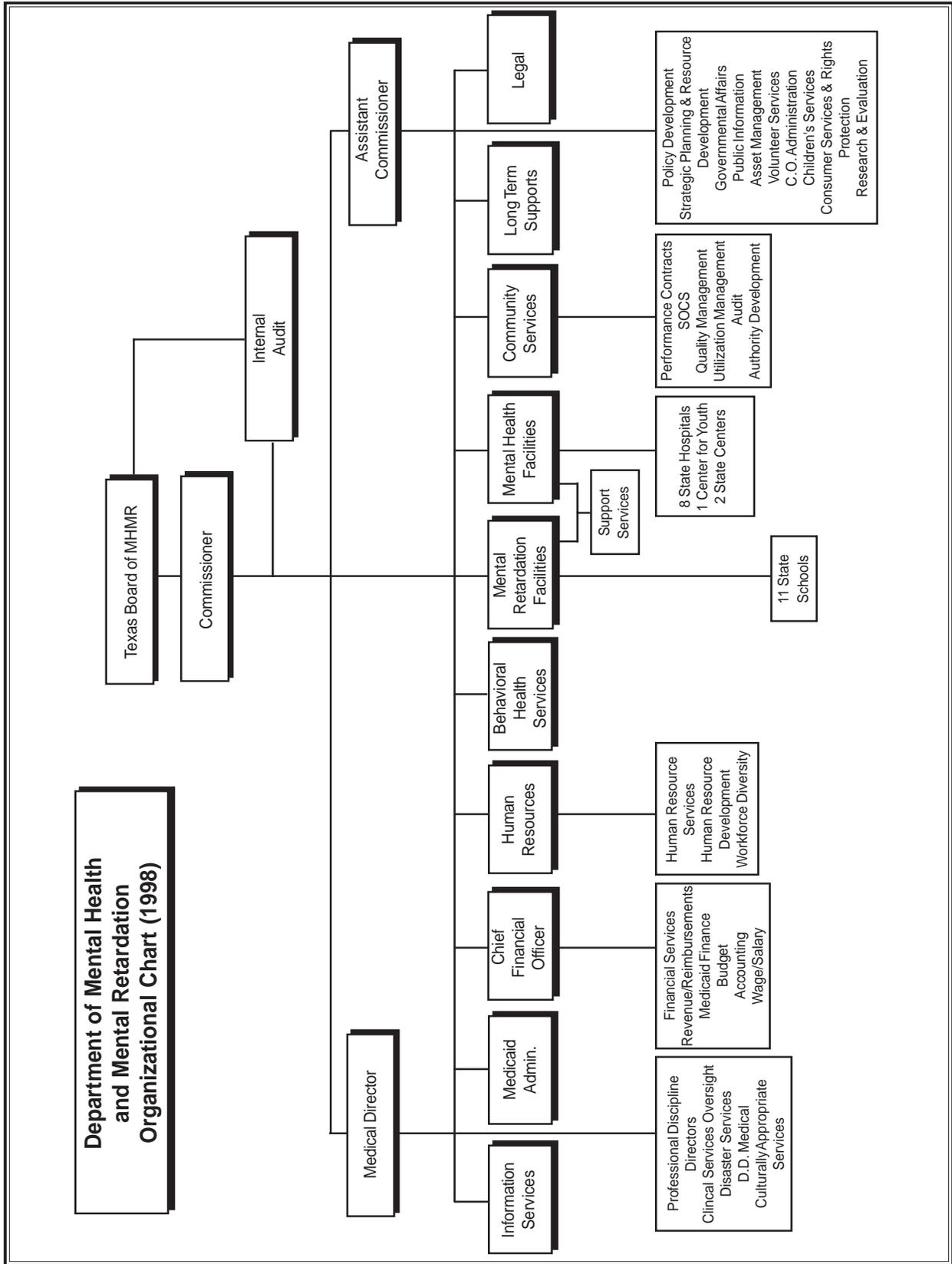
The Department’s staffing needs are continuing to change because of decreases in state school and state hospital populations and increased emphasis on providing services at the community level. The Department is reducing system-wide employment including employment at Central Office. Employment at the central office has declined from 886 FTEs in June 1995 to 613 FTEs in June 1997. The Department has stated its goal to use any money saved from reduced FTEs on increased services. For additional information, see the chart, *Full-Time Equivalents per Component*.

Full-Time Equivalents per Component As of August 1997			
Component Type	Number	Budgeted FTEs	Actual FTEs
State Hospitals	9	8,118	7,551
State Schools	11	12,773	11,933
State Centers	2	763	712
State-Operated Community Services	10	5,279	4,813
Central Office	1	637	609
Statewide Information Services	-	101	94
Total	33	27,671	25,712

AGENCY OPERATIONS

The Department is responsible for providing and coordinating services for persons with mental illness and mental retardation. The chart, *What is Mental Illness and Mental Retardation?* provides a more detailed description of mental illness and mental retardation. The Department provides services by operating campus-based facilities, such as state hospitals, state schools, and state centers, and community-based services such as the SOCS or by contracting for mental health and mental retardation services with locally operated Community Mental Health and Mental Retardation Centers (community centers). In fiscal year 1997, TDMHMR served 18,754 persons in campus-based institutions and 168,091 were served in community-based settings.⁴ The greater percentage of individuals served in the community reflects the movement that has been occurring at TDMHMR over the past several decades away from a system of institutional-based care and towards one of community-based care. The graph, *Persons Served in the Community*

Recent staff reductions in MHMR's Central Office have resulted in savings that are due to be used for increased services.



What is Mental Illness?

What is mental illness? Mental illness is a term for a group of disorders that cause severe disturbances in thinking, feeling and relating to other individuals. Persons with mental disorders are diagnosed as having a major thought disorder, an affective disorder or a personality disorder. The cognitive processes of a person with a thought disorder do not function in a logical or rational manner. They may blend fantasy and external realities, hallucinate or hear voices. Persons with an affective disorder find their moods do not fit their situations or remain within normal limits. They may become extremely euphoric or depressed. A person with a severe personality disorder displays behavior that deviates strongly from society's accepted norms. They often have inflexible patterns of thinking and feelings that are socially unacceptable.

Can mental illness be cured? In some cases, a person can have a single episode of mental illness and then be "cured." That is, they may not experience ongoing symptoms that interfere with daily living. Some symptoms of mental illness can be mitigated through counseling. Typically, however, persons with severe mental illness must control their symptoms with medication. With appropriate services and supports, most individuals with mental illness can live successfully in their communities.

Who gets mental illness? Mental illness does not respect gender, sex, race, ethnicity or age. It can strike any person at any time.

What causes mental illness? The four major known causes of mental illness include biochemical imbalances, genetic conditions, medical or physical conditions, and environmental factors.

How long does mental illness last? Mental illness can be short-term, long-term or periodic. For example, a person who experiences a major depression after the loss of a loved one may never experience such depression again. Persons with schizophrenia may experience intense disturbance of their thought patterns throughout their lives.

What is Mental Retardation?

What is mental retardation? Persons with mental retardation have a disability attributable to mental or physical impairment that occurred before age 18 and results in less-than-average intellectual functioning.

Can mental retardation be cured? No. Persons with mental retardation have a life-long disability. At present, no medical procedures or medications can eliminate mental retardation. The quality of life for such persons can be enhanced with training and other support, however, and many persons with mental retardation can live independently with assistance.

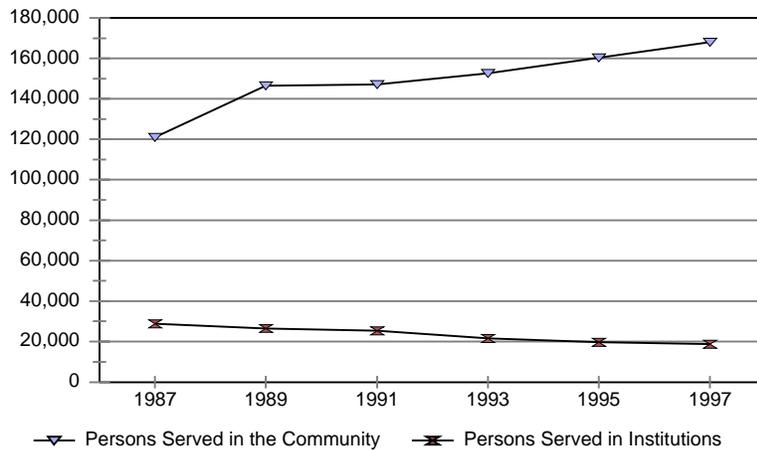
How severe is mental retardation? Mental retardation can be mild, moderate, severe, or profound. About 85 percent of all persons with mental retardation have mild retardation, and can function fairly independently in the community with minimal support. Eleven percent of persons with mental retardation have moderate retardation, and may need more training to master the skills necessary for daily living. For example, they may need assistance with paying bills, shopping, and other routine tasks. Although these persons lack sophisticated problem-solving skills, with appropriate assistance and support most are able to live relatively independent lives in the community. Four percent of persons with mental retardation have severe or profound retardation, and need constant support. Such individuals often have other disabilities in addition to mental retardation and require ongoing daily assistance for the rest of their lives.

Who gets mental retardation? Mental retardation is found in men and women of all races, ethnicities, and economic conditions.

What causes mental retardation? Among the causes of mental retardation are genetic irregularities such as the chromosomal abnormality that causes Down Syndrome; environmental factors such as malnutrition or inadequate medical care; problems during pregnancy, such as drug or alcohol abuse by the mother, inadequate prenatal care or illness of the mother; problems at birth, such as premature birth or low birth weight, and problems after birth, such as accidents involving a blow to the head or a childhood illness such as measles.

Source: Texas Performance Review, Special Delivery: New Models of Care. A Report on the Texas Department of Mental Health and Mental Retardation, February 1996, page 2.

**Persons Served in the Community vs.
Persons Served in Campus-Based Settings**



vs. *Persons Served in Campus-Based Settings* provides more detailed information on this trend.

The text boxes, *Mental Health Services* and *Mental Retardation Services* provide descriptions and examples of campus-based and community-based mental health and mental retardation services.

This shift away from institutional-based services and the decline in census at the state facilities has decreased the Department's role as

provider of services and increased its role as an authority for services. As the state authority, TDMHMR develops policies, adopts rules, and oversees community-based services by setting performance measures and outcomes, providing technical assistance, and monitoring for compliance with state policies and standards. The oversight function of the state authority serves to protect consumers as well as ensure that services are delivered appropriately and effectively.

The Department's statute allows it to delegate to the local authority responsibility for authority functions such as planning, policy development, resource development and allocation, and ensuring the provision of mental health and mental retardation services. Historically, community centers have been the designated local authority.

The dual authority/provider roles exercised at both the state and local level are currently undergoing close scrutiny. As the system has evolved, the functions and responsibilities of each role at each level has needed definition and clarity. Two bills passed by the Legislature, H.B. 2377 (74th Session-1995) and H.B. 1734 (75th Session-1997),

Mental Health Services

Campus-based Mental Health Services

Campus-based mental health services are 24-hour, in-patient treatment programs at state hospitals and state centers that promote the recovery of persons with mental illness who require specialized or long-term treatment not available in community settings. Provided in a campus setting, these are psychiatric health care and psychosocial rehabilitation services that focus on reintegrating an individual into their home community as quickly as possible. Services include:

- assessment
- treatment, including therapeutic programming and skills-building services such as job readiness training and interpersonal skills training
- medical services
- specialized services for older adults, persons with dual diagnoses of mental illness and mental retardation, persons with dual diagnoses of mental illness and substance abuse, and those with a need for behavioral management

Community-based Mental Health Services

Community-based services focus on increasing the ability of persons with mental illness to lead successful lives in their community, and to help prevent them from returning to a state hospital. Services include:

- crisis stabilization
- case management services
- diagnosis and treatment
- residential services
- family support services
- medication-related services
- psychosocial supports- skills training in such areas as medication management, employment, grocery shopping, budgeting, and socialization with the goal of helping the consumer return to independent living

Mental Retardation Services

Campus-based Mental Retardation Services

Campus-based mental retardation services are offered at state schools and state centers and are designed to promote the well-being and abilities of persons who require the most intensive, specialized long-term care. Services include:

- 24-hour residential services for people with mental retardation, especially those who are medically fragile, severely physically impaired, or have severe behavior problems, and cannot be served in the community or who choose to continue to receive campus-based services
- intensive time-limited services for persons with mental retardation living in the community such as respite (pre-arranged short term care used to provide relief to consumers or family members in home or out-of-home placements)
- specialized services for state school residents and community residents such as habilitation therapy, specialized mobility and communication systems, and physical and nutritional management

Community-based Mental Retardation Services

Community-based mental retardation services provide support for natural living arrangements in community settings. Services include:

- assessment and coordination - provide information, screening and referral, eligibility determination, and service coordination
- vocational services - assist individuals in preparing for, finding, and maintaining employment through vocational training, supported employment, and job placement assistance
- training and support services - increase an individual's ability to achieve an optimum degree of independence in the community through continuing education, building habilitation skills, family training and support, promoting community inclusion, and In-Home and Family Support
- community residential - programs are designed to maintain consumers in community settings and include Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR), Home and Community Based Services (HCS)

have directed TDMHMR to study these issues. The results of both projects should result in clearer expectations of both the state and local authorities. The text box, *Authority/Provider Role*, provides additional information on the two roles.

MHMR is required to ensure that clients have "core" services available in their local areas.

Authority/Provider Role

The Department and community centers exercise dual authority and provider roles.

TDMHMR is the state authority for mental health and mental retardation services. The state authority role is invested with broad responsibilities for the State's mental health and mental retardation system in the areas of planning, policy development, and resource development and is accountable for all the publicly funded mental health and mental retardation services in the state. The state authority is authorized to delegate certain responsibilities to an organizational entity at the local level known as the local authority. The local authority is an integral part of the service delivery system and operates as an extension of the state authority within the parameters set by the state authority. Both the authority role at the state and local level are separate and distinct from the provider role.

The evolution of the state mental health and mental retardation system has been influenced by several factors. The state is no longer the primary provider of services; the Department has taken on new roles; the number of potential providers has grown; and the state has moved towards managed care. With this evolution has come a need to clarify and perhaps redefine the responsibilities of each role. Two issues, in particular, have had an increased focus.

First, tension has resulted between the state authority and local authority in terms of what functions should be centrally controlled and what functions should be delegated to the local level. Local agencies have the ability to respond to local needs and preferences. However, the state is ultimately responsible for assuring the effective provision of mental health and mental retardation services.

Second, having the same entity acting as both an authority and a provider results in a potential conflict of interest. Authorities that also provide services may have little motivation to encourage competition. As a result, consumer choice and best value may not be guaranteed.

In the past two legislative sessions, the Legislature has attempted to address these issues through passage of two bills, H.B. 2377 (1995) and H.B. 1734 (1997).

House Bill 2377 articulated the key functions of the state authority to include planning, policy development, resource development and allocation, and oversight of mental health and mental retardation services in the state. It also authorized the state authority to delegate, at its discretion, these responsibilities to the local authority. In addition, H.B. 2377 directed the local authority to ensure consumer choice and the best use of public money in assembling a network of service providers and in determining whether to be a provider of a service or to contract for services from another organization.

The expectation is that a clear definition of authority and provider responsibilities will come from the pilot projects H.B. 2377 directs TDMHMR to conduct. The Department is currently operating five pilot sites that are attempting to create an organizational separation between the local authority and service providers. The sites include Austin-Travis County TDMHMR, Lubbock Regional TDMHMR, Tarrant County TDMHMR Services, and two regional sites in South Texas and East Texas. The projects began in September 1996 and will conclude in September 1999.

H.B. 1734 repeals the statutory preference given to community centers as the designated local authority and requires a committee to develop a plan specifying the number of local authorities, the functions that are delegated from the state to local authority, and the criteria by which a local authority should be selected. A committee consisting of consumers, advocates, community center trustees, and providers was convened in October 1997 and is expected to present a report of their recommendations to the TDMHMR Board in June 1998.

State law requires services to be offered to priority populations first — those most in need.

Services

The Department is required by statute to ensure that a minimum set of "core" services are available to clients in their local area. These services include crisis stabilization, residential services, diagnosis and treatment, family support services, case management services, medication-related services, and psychosocial supports.⁵ TDMHMR is required by law to offer their services first to those most in need. To accomplish this, the Department has identified a

Priority Population

State law requires that services be offered first to those most in need and that Department dollars be used only for services provided to the priority population.

Mental Health

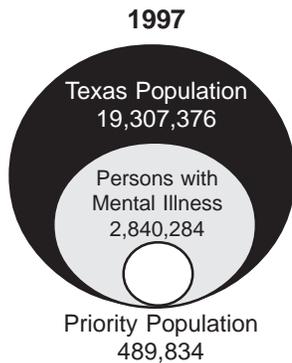
The priority population for mental health services consists of:

- children and adolescents under the age of 18 with a diagnosis of mental illness who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention
- adults who have severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment

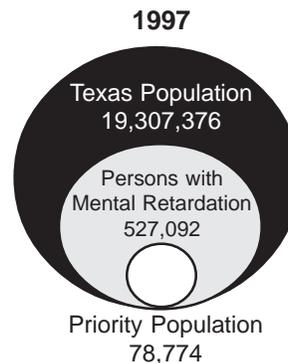
Mental Retardation

The priority population for mental retardation and autism services includes persons who request and need services and possess one or more of the following conditions:

- mental retardation, as defined by Section 591.003 (13), Title 7, Health and Safety Code
- autism and pervasive developmental disorders as defined in the current edition of the Diagnostic and Statistical Manual (DSM)
- eligibility for Early Childhood Intervention services
- eligibility for OBRA '87 mandated services for mental retardation or a related condition as per specific legislation



LBB, Fiscal Size Up 1998-99



LBB, Fiscal Size Up 1998 - 99

“priority population” in its long-range plan. The text box, *Priority Population* provides a complete description of the priority population and the numbers of persons in the priority population served in 1997.

The designation of a priority population is intended to focus services on those individuals most in need of mental health or mental retardation services and those individuals who are the most seriously affected by mental illness or mental retardation. As a result, funds appropriated by the Legislature for mental health and mental retardation services may be used only to provide services to this priority population.⁶ Only 15 percent of persons with mental retardation and 17.5 percent of persons with mental illness are included in the priority population.⁷ Eligibility for these services is determined by diagnosis and functional impairment, not income eligibility. This method

Inclusion in the priority population does not guarantee services.

of eligibility determination is a fundamental difference in how TDMHMR and most of the other health and human service agencies operate.

Membership in the priority population alone does not guarantee that an individual will receive services. In fact, only 50 percent of persons with mental retardation in the priority population received services from the Department while 29 percent of persons with mental illness in the priority population received services from the Department in fiscal year 1996.⁸ Some individuals are served by other systems such as private medical insurance, the Veterans' Administration, and others.

Community-Based Services

COMMUNITY CENTERS

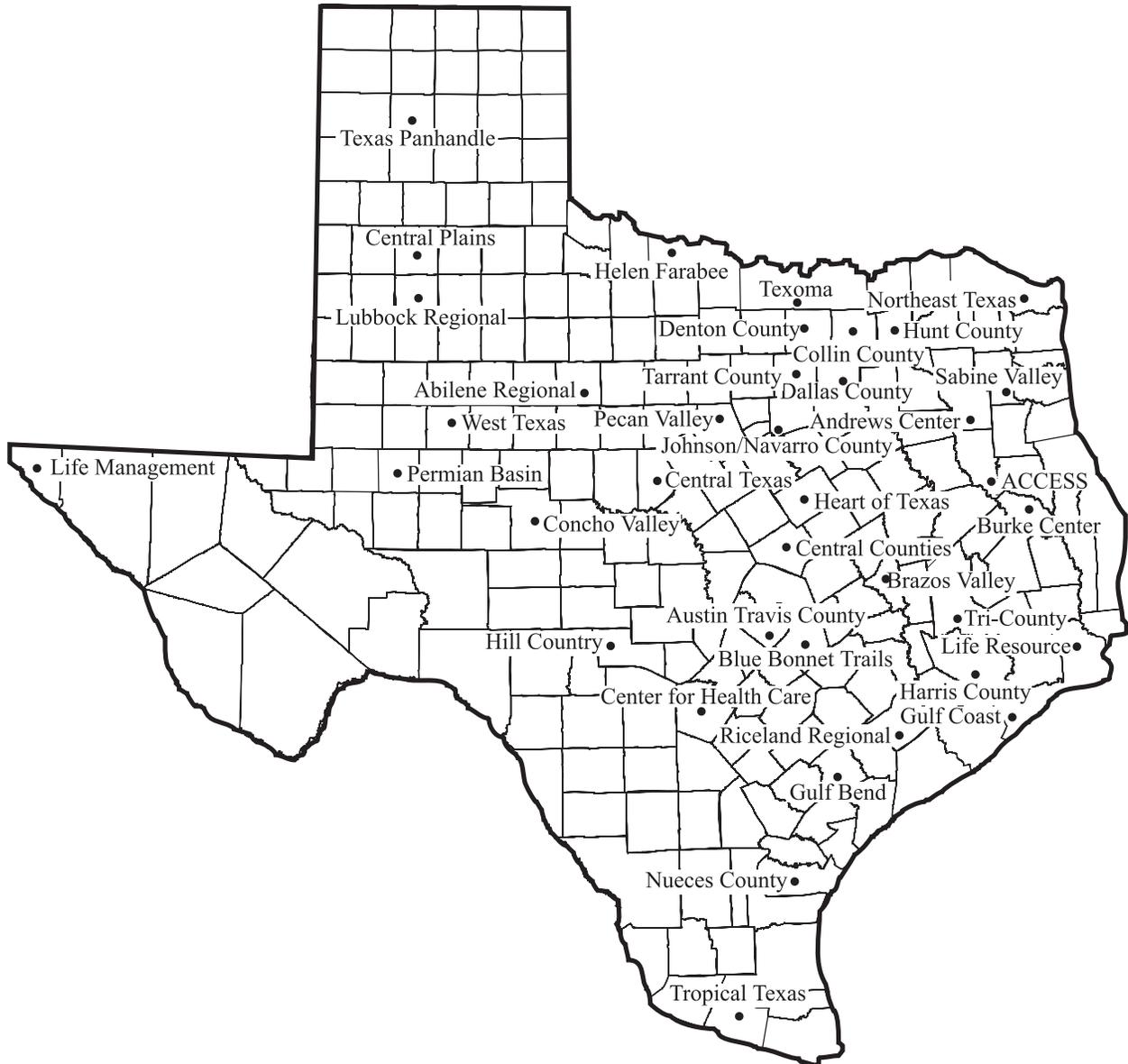
When the Legislature created TDMHMR in 1965, it also provided that "local sponsoring agencies" could establish community mental health and mental retardation centers if authorized by the Department. Community centers are locally created and operated entities that contract with TDMHMR to ensure the provision of mental health and mental retardation services to individuals in their defined geographic service area. Today, 38 community centers exist around the state. The map, *Community Mental Health and Mental Retardation Centers*, shows the location of each community center. In fiscal year 1997, these 38 community centers provided services to approximately 146,000 individuals with a total budget of \$660.4 million. The combined 13,300 staff of the 38 community centers are local employees and are not TDMHMR employees.

Today, 38 locally-created community centers provide services to 146,000 individuals.

Community centers may be established by a county, municipality, hospital district, school district or a combination of these local entities, with the majority being established by counties and municipalities and are approved by the TDMHMR Board. The establishing entities appoint a governing Board of five to nine members. Each member serves a two-year term and must be either a member of the establishing entity's governing body or a qualified voter of the community center's area. The Board sets policy for the community center and hires an Executive Director to manage the community center's day-to-day operations.

Each community center signs an annual performance contract with the Department to provide or contract for community-based mental health and mental retardation services in their geographic area. The contract specifies the amount of state and federal funds to be funneled to the community center and the performance standards the community center is expected to meet with those funds.

Community Mental Health and Mental Retardation Centers

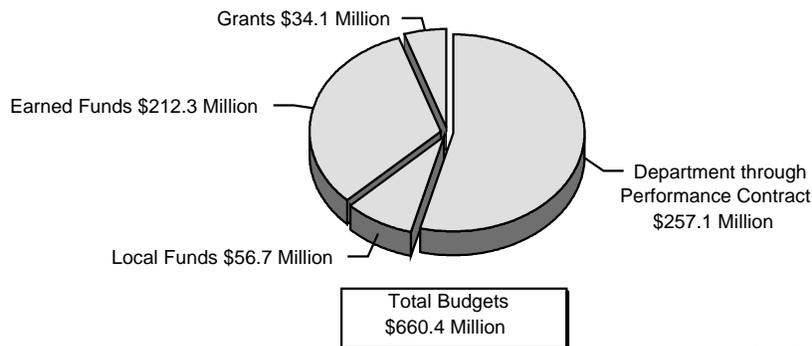


The 38 community centers vary considerably from one another in terms of budget size and number of clients served. In fiscal year 1997, community center budgets ranged from \$975,000 to \$82.3 million, and individual community centers served from 724 to 23,186 individuals.⁹ TDMHMR is the primary funding source for most community centers. In 1997, funds awarded through the annual performance contract comprised between 34 percent and 74 percent of a community center's budget.¹⁰ Community centers are also required to contribute local matching funds, with the amount varying from community center to community center. In fiscal year 1997, the required local match ranged between 5 percent and 13 percent of the amount awarded to the community center through the performance

contract.¹¹ Community centers may also receive funds from fees for services, grants, other federal sources, and contracts with other state agencies. In fiscal year 1997, 38 community centers had combined budgets of \$660.4 million. Approximately \$357.1 million came from the Department through the performance contract. This amount includes general revenue, the Federal Mental Health Block Grant, and other allocated federal funds. The remainder, \$303.3

million, came from local funds, earned income (Medicaid), fees for services, grants, other federal sources, and contracts with other state agencies and organizations. The pie chart, *Combined Budgets of Community Services* provides details on the sources of revenue for the combined budgets of the 38 community centers.

**Combined Budgets of Community Services
Fiscal Year 1997**



Locally-raised funds can be used to serve clients outside the priority population.

Community centers, as the designated local authority, can use state funds awarded through performance contracts and their required local match only on services for individuals in the priority population. However, community centers can serve individuals outside of the priority population with any additional funds raised, for example, additional dollars sponsoring counties and municipalities contribute. Local authorities are required to ensure the provision of the core services to the priority population either directly or through contracts with other providers. In addition to the core services, the performance contract also requires local authorities to ensure the provision of a set of "best practices," including supported employment, supported housing, and assertive community treatment. The text box, *Best Practices*, provides more detail on these services.

The goal of the local authorities is to ensure the provision of services that encourage and allow the highest level of independent functioning possible in the community. Upon arriving at a local authority, an individual's needs are assessed and the client is assisted with coordinating and accessing necessary services. For example, a client may receive counseling, medications, vocational services, training in social and habilitation skills, or any other services which support them in remaining in a community setting. Clients may remain in their own or their family's home or they may reside in a local residential facility.

While community centers provide all of the public community-based services as well as operate, in their role as local authority, as a gate-keeper to the mental health campus-based facilities, community centers often provide mental health and mental retardation services for other agencies that serve the same or similar populations. Because many persons with mental illness also have histories of substance abuse, many community centers work with the Texas Commission on Alcohol and Drug Abuse (TCADA). Community centers often work with the Texas Rehabilitation Commission (TRC) to coordinate vocational rehabilitation services and with the Interagency Council on Early Childhood Intervention (ECI) to provide services for children age zero to three with developmental delays. In addition, community centers often work with local and state criminal justice systems to provide services or treatment to offenders with mental illness or mental retardation.

STATE OPERATED COMMUNITY SERVICES (SOCS)

Counties, cities, and other local governmental entities in Texas began forming community mental health mental retardation centers in the mid and late 1960s. By 1972, 24 community centers had been established in Texas. However, not all parts of the state were served by a community center. Approximately 100 counties, primarily rural and sparsely populated, did not have access to a community center. TDMHMR, through its community services divisions at state hospitals, state schools, and state centers, provided community mental

Best Practices

"Best practices" are well researched service models that have been found to produce effective results. The Department develops these service models and currently requires community centers to provide three best practices. They include:

Supported Employment. Supported employment provides individualized assistance in choosing and obtaining employment, integrated work sites in regular community jobs, and long-term supports to assist individuals in keeping employment and/or finding another job as necessary.

Supported Housing. Supported housing is designed to assist persons with severe and persistent mental illness choose, get, and keep regular integrated housing. Services provided include:

- individualized assistance in finding and moving into regular, integrated housing (not agency owned or operated);
- temporary rental assistance;
- intensive, as needed, in home rehabilitation services; and
- case coordination.

Assertive Community Treatment (ACT). ACT is a mobile multi-disciplinary team that serves a defined population with severe and persistent mental illness who have a history of multiple hospitalizations, involvement with the criminal justice system, homeless shelters or community residential homes. The ACT team consists of a psychiatrist, nurse/s, and other rehabilitation staff competent in helping people with employment, housing, daily living skills development, service coordination, substance abuse counseling, and medication/symptom management. The ACT team also works with families to provide education and support. The ACT team is designed to meet with their client in community settings or wherever is convenient for the client.

Source: Texas Community Mental Health Services State Plan, 9/1/97, p. 37.

State-Operated Community Services (SOCS)

TDMHMR developed a system for providing mental health and mental retardation services in communities that were not served by a local community center. The community services divisions of state hospitals, state schools, and state community centers were given the responsibility of providing the community services where they were not available. These divisions operated like community centers, but the staff were employed by the Department without a local board. The community services divisions also acted as the local Mental Health Authority and Mental Retardation Authority.

In September 1996, these 22 divisions and 3 state centers (Amarillo, Beaumont and Laredo) were consolidated to form 13 state-operated community services (SOCS). Two state centers (El Paso and Rio Grande State Center at Harlingen) were not included in this consolidation and today they provide only campus based mental health and mental retardation services. The oversight of the newly created SOCS was transferred to a new Central Office community services unit. The long term goal of the Department is to transfer responsibility of all SOCS to existing or new community centers at the local level.

Three SOCS have made the transition to locally-governed community centers, leaving 10 state-operated SOCS serving 94 Texas counties. The goal is to have all remaining SOCS transition into community centers by 2001.

health and mental retardation services in these unserved areas. In September 1996, these 22 divisions and three state centers were consolidated to form 13 State Operated Community Services (SOCS). For more information on the history of the SOCS, see the chart, *State-Operated Community Services*.

SOCS, like community centers, offer specialized services for individuals with mental illness, mental retardation, and dual diagnosis (chemical dependency), as well as serve children and youth. However, there are important differences between SOCS and community centers. Community centers are governed by local boards, appointed by counties or cities. These boards appoint the Executive Director. SOCS do not have a board, and the Executive Director is an employee of TDMHMR who is appointed by the Commissioner. Community centers have much more flexibility than SOCS to pursue other funding sources either for mental health or mental retardation services, or to create other services that have been identified by the

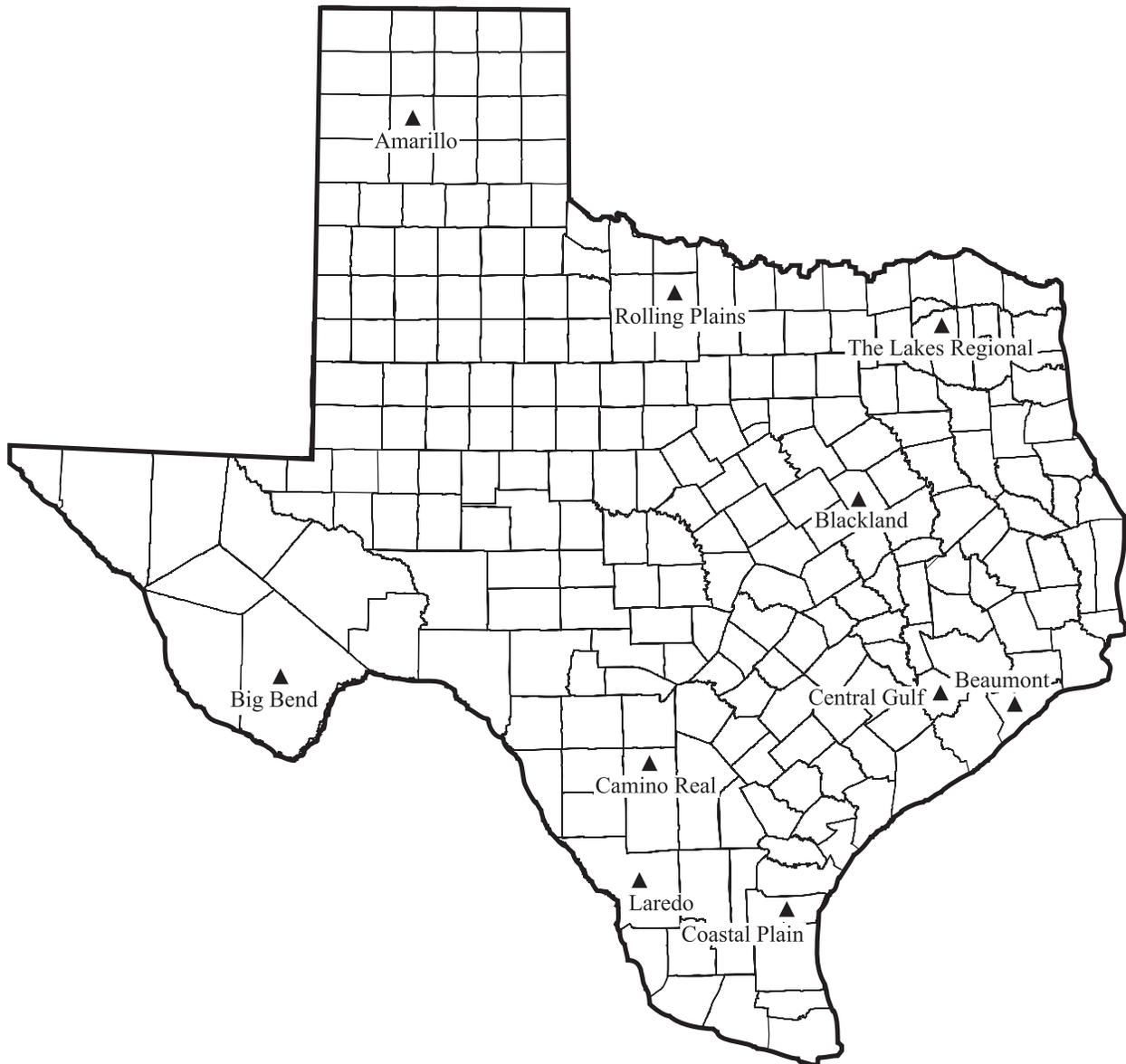
community. As a result, the SOCS are being transitioned to local community control and operations to allow decisions about services to be made that more closely match the expectations and needs of the community served. As of September 1, 1997, three of the SOCS have transitioned to community centers and the remaining ten will be converted by 2001. The map, *State-Operated Community Services*, shows the location of each SOCS.

Campus-based institutions now almost exclusively serve persons with specialized needs.

Campus-Based Services

The use of hospitals to treat the mentally ill illustrates the dramatic shifts in the thinking and treatment of mentally ill persons. In the last half of the 19th century, little was known about mental illness and almost nothing about treatment. States built hospitals and asylums more as a place to house and separate those with mental illnesses (and often those with mental retardation) than as a place to provide treatment. In Texas, the first state hospital was built in 1856 in Austin, and until 1925 was named the State Lunatic Asylum. Traditionally hospitals were large, sprawling campuses, usually in rural areas or on the outskirts of a city. Patients were admitted, usually for life, and were provided with custodial care; treatment did not exist. Until the 1960s, the public mental health and mental retardation system in Texas consisted solely

State-Operated Community Services



of the state schools and the state hospitals. Community-based services only became available in the late 1960s, and then were only available in a handful of locations in the state. As scientific understanding of mental retardation and mental illness slowly increased, along with the growth of clients' rights advocacy, the role of the state hospitals and schools in delivering services changed. Today, the prevalent legal, practical, and philosophical preference is to provide most services in the community. Community-based treatment is generally viewed as more cost efficient and the least restrictive environment for clients. As a result, campus-based institutions now almost exclusively serve persons with specialized needs that cannot be treated in the community.

STATE HOSPITALS FOR THE MENTALLY ILL

State hospitals care for persons with serious mental illness who need intensive treatment.

State hospitals and two state centers provide in-patient care for persons with serious mental illness who need either short or long-term intensive treatment. Hospitals and state centers are phasing out services that can be provided in local communities so that they can be replaced by specialized acute, intermediate or longer-term rehabilitation and treatment programs. Increasingly, state hospitals are being reserved for those with the most challenging mental health needs such as those persons who suffer the most serious and complex cases of schizophrenia, bi-polar disorder, and major depression and those who require very specialized services. These specialized services could include medical treatment, help with a secondary diagnosis, bi-cultural services, or other services.

In-Patient Mental Health Treatments
<ul style="list-style-type: none"> • assessment and evaluation • orientation activities • health management activities • education and training (individual and group) • mental illness education/ understanding • psychotherapy • family intervention • group sessions for special concerns • prevocational and vocational training • mental awareness/ orientation • social skills development • daily living skills/ psychosocial training • physical habilitation • behavior therapy

Other services offered in the state hospitals include therapeutic programming and skills-building services based on individual needs. Treatment programs consist of scheduled structured activities involving the direct contact and/or close supervision of treatment staff with the purpose of maintaining or improving a patient's behavior or physical and/or mental functioning relevant to his/her identified needs. Patients must receive at least 20 hours of weekly treatment. A complete list of the different types of treatment may be found in the chart *In-Patient Mental Health Treatments*.

The state's inpatient mental health system currently consists of eight state hospitals, two state centers, and the Waco Center for Youth. In fiscal year 1997, the Department employed 8,482 persons to operate these facilities. Seven of the state hospitals offer an array of services to patients in their geographic service area, or what is commonly referred to as a catchment area. Each catchment area includes a number of local community centers. Each local community center is assigned a number of beds at a specific hospital or state center. The hospitals are located at Austin, Big Spring, Kerrville, Rusk, San Antonio, Terrell, and Wichita Falls. The eighth state hospital, located in Vernon, offers highly specialized services covering the entire state for forensic patients and adolescents with mental health and drug dependent problems.

The two state centers, located in El Paso and Harlingen, provide campus-based services to their service areas for persons with mental illness and persons with mental retardation. Essentially, these are versatile, multi-purpose community centers that provide both institutional and community services. The El Paso State Center is scheduled to convert its mental health beds to mental retardation beds by the end of fiscal year 1998.

In addition to the eight hospitals, the Department operates the Waco Center for Youth. The Waco Center serves seriously emotionally disturbed youth between the ages of 13 and 17. The Waco Center for Youth and the program for persons who are deaf and mentally ill at Austin State Hospital also have statewide service areas. The map, *State Hospitals and State Centers*, shows the location of each of these campus-based mental health facilities.

The Department operates a total of 2,834 beds in its eight state hospitals, two state centers and the Waco Center for Youth. The largest number of these beds (53.4%) are adult general psychiatric beds, with other beds allocated for maximum security (9.5%), geriatric (9.4%), multiple disabilities (7.1%), medical/surgical (4.6%), adolescent (4.6%), children and adolescent (3.8%), and other categories such as deaf, bi-cultural, clinical research, and drug dependent youth.

The Department funds, although does not operate, beds at seven community psychiatric hospitals. Five community centers operate hospitals themselves and receive funding from the Department through their performance contract. These five centers are El Paso (85 beds), Dallas (24 beds), Gulf Coast (20 beds), Harris County (190 beds) and Lubbock (30 beds). Community hospitals allow community center staff and family to support hospitalized individuals with primarily acute care without having to travel the extra distance to a state hospital. In addition to these 349 beds operated by community centers, the Department funds additional beds at two hospitals.

State Hospitals and State Centers



The Laredo SOCS operates beds at a community psychiatric hospital in Laredo and the Riceland Community Center uses funds from its performance contract for treatment to fund psychiatric beds at a local hospital.

The 3,226 state-funded hospital beds, consisting of state operated and state-funded beds at community psychiatric hospitals, are allocated to the 38 community centers and 10 SOCS based on a statewide formula, primarily determined by population. Each community center and SOCS is given a specific number of bed/days at a hospital and may be penalized financially for exceeding their allocation. The allocation of bed/days forces local authorities to manage their hospital population and to divert persons with mental illness from the hospital when possible.

Patients enter the state hospital either voluntarily or through a court order (involuntarily). Patients who voluntarily admit themselves into the hospital must do so through and with the permission of their local mental health authority. However, most patients are admitted to the state hospitals involuntarily, under provisions for “Emergency Detention” (Chapter 573 of the Health and Safety Code) or “Order of Protective Custody” (Chapter 574 of the Health and Safety Code). The time limit on an emergency detention is typically 24 hours while the time limit on an order of protective custody is 14 days, after which time a probable cause hearing must be held.

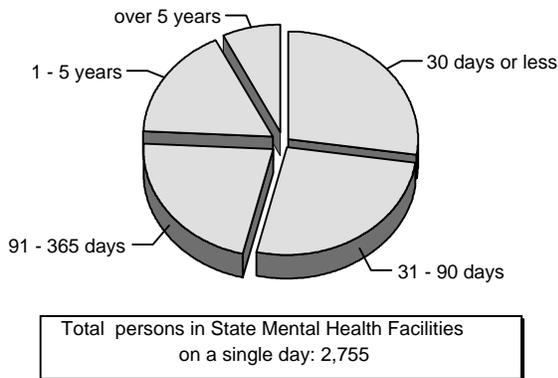
The most common reason for an involuntary admission is to provide a place to stabilize someone in a severe mental health crisis. A crisis can include paranoid delusions, suicide attempts, bouts of severe manic behavior and other behaviors. The general standard to be admitted against one’s will is to be a danger to one’s self or others. Persons admitted to a state hospital under these conditions are evaluated, receive a medical exam, are medicated (if appropriate), receive treatment, and are provided a place and time to stabilize. Much of a hospital stay is spent preparing the patient for a return to the community.

During fiscal year 1997, 12,715 persons with mental illness were admitted to the eight state hospitals, the Waco Center for Youth, and the two state centers. In contrast to only ten or twenty years ago, 58 percent of the persons served were discharged within 30 days or less. For those admitted and discharged in fiscal year 1997, their average length of stay was 33.81 days. The average length of stay for everyone discharged in the fiscal year, regardless of when admitted, jumps to almost 80 days. This demonstrates that the state hospital system is serving two very different populations. The first population is in need of acute, short-term psychiatric services. They are characterized by the high number of admissions and the relatively short length of stay. The second major population is the chronically and seriously

Most patients enter a state hospital involuntarily or through a court order.

The general standard to be admitted to a state hospital against one’s will is to be a danger to one’s self or others.

**Length of Stay, Snapshot
4th Quarter Fiscal Year 1997**



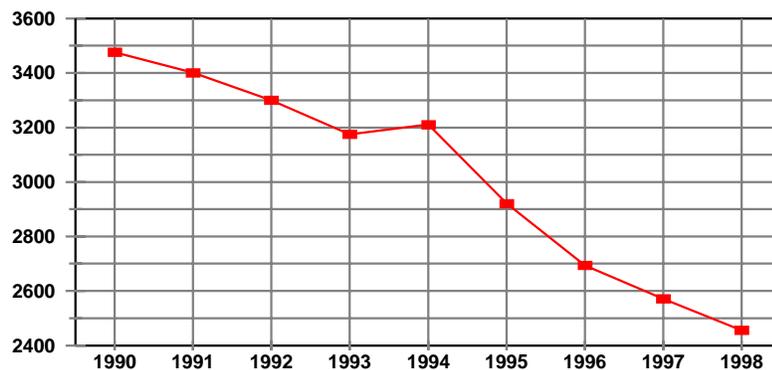
mentally ill who need longer term care. This population is characterized by few admissions and very long lengths of stay. One of the Department's challenges is to operate a system of hospitals that provides different services to these different populations.

Another way to look at length-of-stay statistics is to take a snapshot of the mental health facilities on a particular day. The pie chart shows the length of stay of the 2,755 persons in the hospitals and state community centers on one day in the 4th quarter of 1997.

State hospital populations have been steadily decreasing for years. Declining admissions and shorter average lengths of stay have contributed to the decrease. Better community treatment programs and improved anti-psychotic drugs help divert people from hospitals and decrease the amount of time required to stabilize those who are admitted. In addition, the Department's decision to allocate beds to each community center and SOCS has given them a significant financial incentive, in addition to a therapeutic incentive, to not over use their allocation of bed days. The chart, *Mental Health Facilities Facts* provides additional information. The following graph illustrates the reduction in census during this decade.

Mental Health Facilities Facts Fiscal Year 1997	
●	The Department funded 2,901 beds at the 11 state mental health facilities.
●	The average daily census for all facilities was 2,575.
●	The system operated at 88.7 percent of funded capacity.
●	The average cost per patient per day was \$307.47.

**Average Daily Census of State Hospitals and State Centers
Fiscal Years 1990 - 1998**



STATE SCHOOLS FOR PERSONS WITH MENTAL RETARDATION

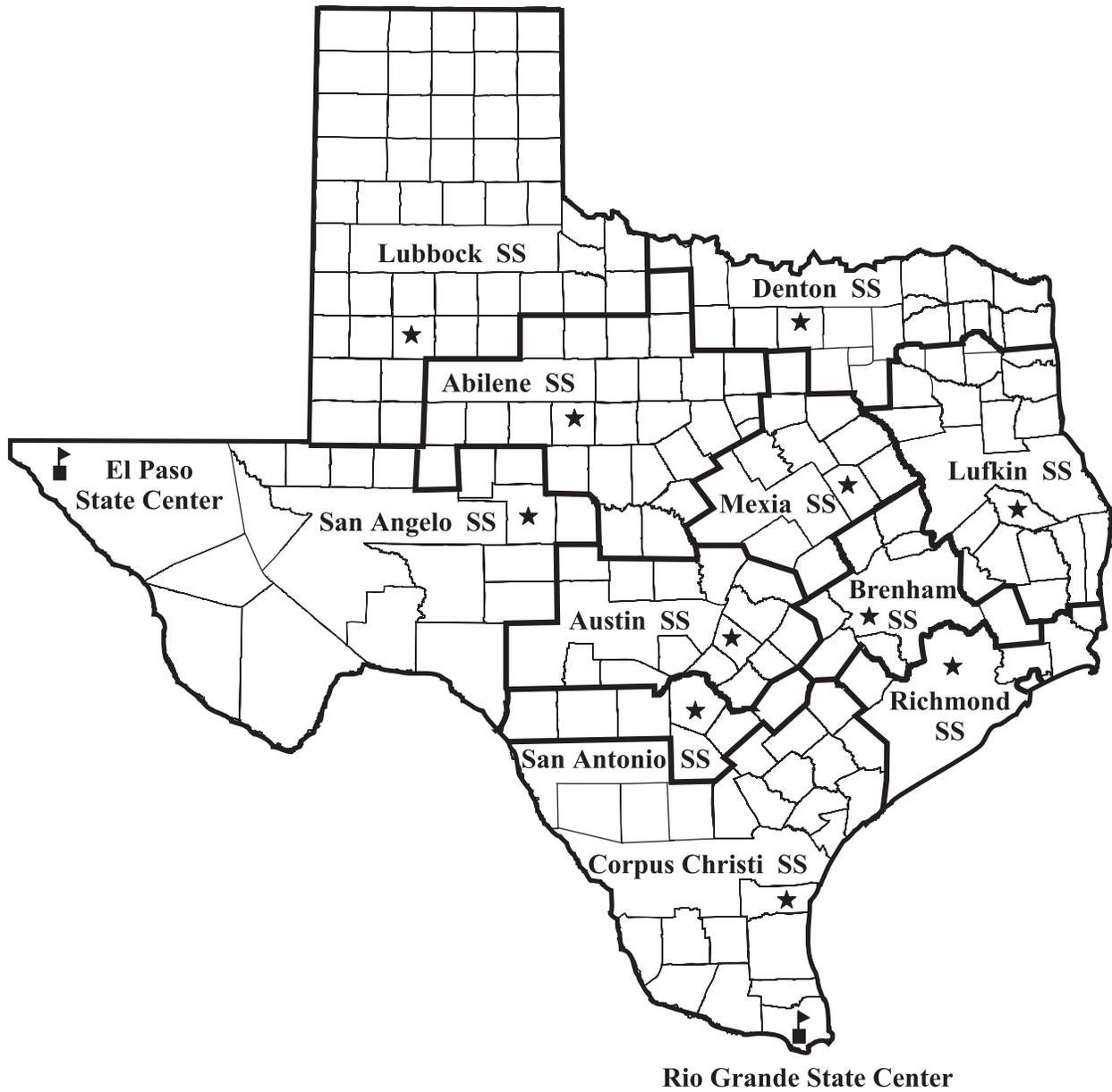
Eleven state schools and two state centers provide 24-hour residential services to persons with mental retardation who require the most intensive, specialized long-term care. The state schools are located in Abilene, Austin, Brenham, Corpus Christi, Denton, Lubbock, Lufkin, Mexia, Richmond, San Antonio, and San Angelo. The two state centers which also serve persons with mental illness are located in El Paso and Harlingen. Services include specialized assessment, treatment, support and medical services. Persons residing in a state school may be medically fragile or severely physically impaired or have severe behavioral problems and cannot currently be served in the community. Persons with mental retardation, residing in the community, are also eligible for intervention services. These time-limited services include respite, habilitation therapy, specialized mobility and communication systems, and physical and nutritional management programs. The map *State Schools and State Centers* shows the location of each of these facilities.

Residents in a state school may be medically fragile, severely physically impaired, or have severe behavioral problems.

All 11 state schools and the mental retardation beds at two state centers are federally designated Intermediate Care Facilities for the Mentally Retarded (ICF/MR). An ICF/MR is a certified group living arrangement for persons with developmental disabilities. ICF/MRs receive federal and state funding as part of the federal Medicaid program. Participation in the ICF/MR program requires compliance with federal and state standards. As a result of the ICF/MR Medicaid funding, state schools receive 72 percent from the federal government and only 20 percent from state general revenue. This contrasts with state hospitals that rely on state general revenue for 83 percent of their funding.

A request for admission to a state school or state center is made to, and evaluated by, the local community center. The community center evaluates whether an equivalent service is available in the community. If appropriate services cannot be found in the community, the application is passed on to the Department's central office. The Department, while respecting the choice of the individual or their family, seeks to place persons with mental retardation in the least restrictive environment first. Of the total 183 new admissions to state schools in fiscal year 1997, 136 were involuntary (court commitments) and 47 were voluntary. Involuntary admissions include those from the state hospital multiple disabilities units, adults in crisis without a guardian, those committed under Section 46.02 of the Code of Criminal Procedure from Vernon State Hospital (the statewide maximum security hospital), and those committed under Section 55.03 of the Family Code. The majority of the 47 voluntary admissions were made by parents or guardians for emergency situations. The text box, *Mental Retardation Facilities Facts*, provides some information on state schools.

State Schools and State Centers



All residents are evaluated for their fitness for community placement on an annual basis. Multi-disciplinary teams evaluate the residents and make recommendations primarily based on their functional level. Of those recommended for a community placement, the average wait was 872 days. Reasons for the long wait are complex, but availability of community housing options plays a significant role.

Future of Campus-Based Services

The eight state hospitals for persons with mental illness, 11 state schools for persons with mental retardation, and the two state centers operated by TDMHMR remain at the center of the state's public mental health and mental retardation system. This system is undergoing dramatic change. Improved medications, improvements in care and the delivery of services, lawsuits, the advent of managed care, and consumer choice have dramatically decreased the use of these campus-based facilities. In the 1990s alone, the average daily census has decreased at state hospitals by 26 percent and 21 percent at state schools. Further proof that the Department has decreased its reliance on campus-based institutions is the dramatic increase in funding for community mental health and mental retardation programs during the past decade. In 1986, the Department spent less than 20 percent of mental retardation program funds on community services and 30 percent of its mental health program funds on community programs. By fiscal year 1996, community funding for mental health services accounted for 61 percent of mental health program funding and community funding for mental retardation services accounted for 66 percent of mental retardation funding.¹² Nonetheless, some individuals will continue to choose campus-based institutions and the Department will continue to operate them to provide consumers with a choice. The need for the institutions has not been eliminated, only diminished. The Department's challenge for the future will be to operate the highest quality state hospitals and state schools while still maintaining the needs of clients in the community as a priority.

Mental Retardation Facilities Facts Fiscal Year 1997
<ul style="list-style-type: none"> ● The average daily census was 5,598. ● The average cost per bed day was \$189.17. ● The average annual cost per person served was \$69,047. ● Approximately 37 percent of those served were also diagnosed as mentally ill.

Despite declining census, the need for institutions has not been eliminated, only diminished.

¹ Texas Department of Mental Health and Mental Retardation, "Financial Status Report for Fiscal Year 1997," January 1998, p. 1.

² 42 U.S.C.A. § 300X-1(b)(7)(A) (West Supp. 1997).

³ By statute (Title 10, Texas Gov. Code Subtitle D, Section 2161.124) each agency is required to prepare as part of its strategic plan, a written plan for increasing the agency's use of Historically Underutilized Businesses (HUBs) in purchasing and public works contracts. The General Appropriations Act requires each agency to include a report on progress toward increasing the use of HUBs within the agency's annual report. The State does not have an overall HUB use goal. Each agency's Strategic Plan contains the agency's goal for coming year.

⁴ Because community centers must recommend placement in state hospitals and state schools or follow a client once they leave a state hospital or state school, many persons who are served in state-operated facilities are also served by community centers.

⁵ Tex. Health & Safety Code Ann. ch. 534, sec. 534.053 (Vernon 1992, Vernon Supp. 1998).

⁶ Tex. Health & Safety Code Ann. ch. 531, sec. 531.001 (Vernon 1992, Vernon Supp. 1998).

⁷ Legislative Budget Board, "Fiscal Size Up 1998-99," (Austin, TX: January 1998), pp. 5-26 - 5-27.

⁸ Ibid.

⁹ Texas Department of Mental Health and Mental Retardation, "FY 1997 Budget and Organizational Information for Community TDMHMR Community Centers Administered by Local TDMHMR Boards of Trustees and State-Operated Community TDMHMR Services," p.6.

¹⁰ Ibid.; funds awarded through the performance contract include general revenue, the federal mental health block grant, and other allocated federal funds.

¹¹ "Community Mental Health and Mental Retardation Community Center Performance Contract Notebook, Fiscal Year 1997," p. G1-5; the local match rate is determined by a methodology based on the area's population and wealth.

¹² LBB Fiscal Size Up, 1998-99, p. 5-25.

**TEXAS DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION**

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