

The logo for the Texas Sunset Advisory Commission is a semi-circle with a thick black border. Inside the semi-circle, the words "Texas", "Sunset", "Advisory", and "Commission" are stacked vertically in a bold, white, sans-serif font.

**Texas  
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Advisory  
Commission**

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**STAFF EVALUATION**

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*Texas Department of Mental Health  
and Mental Retardation*

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**A Staff Report  
to the  
Sunset Advisory Commission**

**1986**

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

September 1986



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## SUMMARY OF THE STAFF REPORT

The Texas Department of Mental Health and Mental Retardation (TDMHMR), established in 1965, has primary responsibility for overseeing the care and for providing services directly and through contracts to mentally ill and mentally retarded citizens of Texas. The Texas Board of Mental Health and Mental Retardation is a nine-member policy body with all members appointed by the governor for six-year terms. The board names a commissioner to administer the department's programs. The TDMHMR is one of Texas' largest state agencies, authorized to hire over 26,000 employees with a budget of over \$623 million for fiscal year 1986.

The department operates eight state psychiatric hospitals, 13 state schools for people with mental retardation, five state centers, a center for emotionally disturbed youth and a recreational rehabilitation center. In fiscal year 1986, approximately 30,000 people were inpatients in these facilities. In addition, the department provides funds to 31 community mental health and mental retardation centers and operates its own community-based outreach programs in rural areas of the state not served by a community center. Approximately 151,000 persons were served by community MHMR centers and 20,500 were served by department-run community-based programs in fiscal year 1986.

Community centers, which are an important element in the state MHMR system, are governed by local boards of trustees. They receive funds from the TDMHMR in addition to contributions from local sources.

The sunset review of the department's programs and responsibilities indicated that there is a continuing need for the state to be involved in overseeing the care of mentally ill and mentally retarded people. The review indicated that the department has generally fulfilled the purposes for which it was created and should be continued for a 12-year period.

The sunset review also determined that if the agency is continued, a number of changes should be made to improve the efficiency and effectiveness of its operations. These changes are outlined below.

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## RECOMMENDATIONS

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**THE AGENCY SHOULD BE CONTINUED FOR A 12-YEAR PERIOD WITH THE FOLLOWING CHANGES:**

### POLICY-MAKING STRUCTURE

#### Citizens' Planning Advisory Committee

- 1. The size of the committee should be reduced from 21 to 9 members. (Statutory) (p. 57)**

The 69th Legislature created the Citizens' Planning Advisory Committee (CPAC) to advise TDMHMR on the development and implementation of the agency's long-range strategic plan. Currently the CPAC has 21 members appointed by the board. Limiting the size would improve its ability to make decisions in a timely fashion. Providing input to the board in a timely manner is a necessity if the board is to use this information for key policy and budgetary decisions.

- 2. The composition of the committee should be specified in statute. (Statutory) (p. 57)**

The purpose of the committee should not be to represent any particular consumer group or special interest but rather to guide the department in its planning for the provision of a balanced array of services. This committee should be structured to provide a formal mechanism for input that would not otherwise be available in the planning process. To ensure this, the statute should be amended to require the board to appoint: a) six members who have demonstrated an interest in and knowledge about the TDMHMR system and the legal, political, and economic environment in which it operates; and b) three members who have expertise in the development and implementation of long-range plans.

- 3. The role of the CPAC should be clarified in statute. (Statutory) (p. 58)**

Currently the CPAC's responsibility to advise the department on its long-range plan is broadly stated. To ensure that the plan becomes an integral part of the decisions and policies set by the board, the following statutory changes are needed: 1) the committee shall review the development, implementation, and any necessary revisions of the department's long-range plan; 2) the committee shall

review the department's biennial budget request and assess the degree to which it allows for implementation of the plan; 3) the committee shall advise the board on the appropriateness of the plan, any identified problems related to its implementation, any revisions to the plan that are necessary, and the adequacy of the department's budget request; and 4) the committee shall provide copies of its reports to the board, as well as to the governor, lieutenant governor, speaker of the house, and the appropriate committees of the legislature.

**4. The board's and the department's responsibilities relating to the CPAC should be statutory. (Statutory) (p. 59)**

For the CPAC to fulfill its duties, the department must provide certain information and support. The statute should require the department to do the following: 1) prior to any presentation to the board related to the development, implementation or revisions of the plan, the information to be presented shall be provided to the members of the CPAC in a timely fashion; 2) prior to submitting the agency's biennial budget request to the board for discussion or approval, a copy shall be provided to the members of the CPAC in a timely fashion; and 3) the staff support necessary to allow the CPAC to fulfill its duties shall be provided.

To ensure that the input of the CPAC is given full consideration, the board should be required to: 1) review the committee's reports in conjunction with information provided by the department on the long-range plan or the biennial budget request; and 2) allow the committee opportunities to appear before the board as needed.

## OVERALL ADMINISTRATION

### EVALUATION OF ORGANIZATIONAL STRUCTURE

#### Operational Planning

- 5. The department should develop an operational plan, based on the long-range plan, with specific short-term goals, objectives, timetables, and desired outcomes. (Management improvement) (p. 62)**

The statute currently requires the development of goals and objectives as part of the department's long-range plan. To date, this has not been completed. Development of an operational plan would show the steps necessary to achieve the agency's



long-range plan. Planning and budget development by the field facilities would also be facilitated by a clear operational plan.

- 6. The office of strategic planning should be reorganized under the deputy commissioner for management and support. (Management improvement) (p. 62)**

This organizational modification would strengthen two closely related management functions by placing the activities of planning and budgeting under one deputy commissioner. Greater coordination would result which should strengthen the department's ability to develop, implement, and make necessary modifications to its long-range plan.

#### **Removal of Statutory Titles and Facility Names**

- 7. References to deputy commissioners and their qualifications should be removed from the statute. (Statutory) (p. 64)**

Currently the TDMHMR Act mandates five key positions below the commissioner. Naming administrative staff below the chief executive officer places unnecessary constraints on the organizational pattern and is not a usual practice found in state law. Removing the titles below the director of operations would provide flexibility in how the agency is structured to efficiently carry out its function.

- 8. The names of specific facilities and institutions operated by the department should be removed from statute. (Statutory) (p. 64)**

The need to maintain facility names in statute no longer exists since the appropriations bill was modified to allow the transfer of funds between facilities to meet changing agency needs. This recommendation would provide consistency between the statute and the appropriations bill. In addition, this change would facilitate any efforts to reorganize the agency in the future.

#### **Role of Assistant Deputy Commissioners**

- 9. Formal communication between regional assistant deputy commissioners and members of the department's central office executive committee should be strengthened. (Management improvement) (p. 67)**

Currently the agency has no mechanism to ensure that input from the assistant deputy commissioners, who represent the deputy commissioners' authority in the field, is given adequate consideration by the central office decision makers. Also, there is no mechanism that ensures that the assistant deputies are promptly

informed of policy, programmatic, or budget changes which are made by the executive committee. Establishing regular meetings between the assistant deputies and the department's executive committee would improve communications between the field and central office. Needs of the regions would be recognized and services improved by this change.

- 10. The regional assistant deputy commissioners' activities should be balanced between time spent in the region and time spent in central office. (Management improvement) (p. 67)**

Currently the regional assistant deputy commissioners are often involved in central office projects and spend less than 20 percent of their time in the region. Requiring greater participation in the field would facilitate a better understanding of local needs and provide more opportunities to offer needed programmatic and technical assistance.

- 11. The department should institute management and programmatic training as necessary to sharpen the skills and effectiveness of regional assistant deputy commissioners. (Management improvement) (p. 67)**

This change would ensure that assistant deputy commissioners stay up to date with developments in their respective program areas. This capability would allow the most efficient and effective programs to be implemented as human service technology improves. The training would also ensure that the assistant deputies have the management skills necessary to effectively carry out their responsibilities.

- 12. The department should revise the position descriptions for the regional assistant deputy commissioners. (Management improvement) (p. 67)**

The review identified confusion over the assistant deputy commissioners' level of authority and responsibility. A revision of job responsibilities would clarify the roles of assistant deputy commissioners so that administrative policies can be implemented more effectively.

### **Regional Planning**

- 13. The department should establish regional planning councils composed of the chief executive officers of state facilities, community centers, and designated providers of core services, to coordinate planning, budgeting, and service delivery. (Statutory) (p. 69)**

The review showed no formal mechanism to coordinate local planning and services. Establishing regional councils would maximize local efforts by reducing duplication and encouraging cooperative efforts to solve regional problems.

- 14. Each council should be chaired by the department employee who is responsible for the services in a region. The chairperson should be fully integrated into the departmental decision making framework. (Statutory) (p. 69)**

This statutory change would ensure that local input is given consideration in the development of agency policies, plans, and budgets. It would also provide a stronger management link between central office and the facilities which should encourage the implementation of department policies statewide.

- 15. Each council should develop a long-range regional plan that describes the appropriate use of facilities, the configuration of the service delivery system, and includes a comprehensive needs assessment and resource inventory that can be used by central office to revise and update the statewide long-range strategic plan. (Statutory) (p. 69)**

The need for greater regional planning that is more sensitive to various geographic, demographic, and cultural differences was identified during the review. Collectively, the long-range regional plans would be utilized in developing and modifying the statewide strategic plan required of the department. (See related recommendation on page 71.)

- 16. Each council should develop an operational plan for its region based on the department's long-range plan and the corresponding allocation of funds and responsibilities to each community center, designated provider, and state facility, as defined in their performance contracts and memoranda. (Statutory) (p. 69)**

As agency policies are developed, regional operational plans would let the people providing services decide how they can best implement the policies in their region. Regional implementation would allow for geographic, demographic and cultural differences throughout the state. (See related recommendation on page 64.)

### Better Coordination Through Local Service Area Planning

17. **All TDMHMR facilities and community centers which operate facilities in the same local service area should submit annual agreements to their regional planning council and to the TDMHMR documenting their efforts to develop a comprehensive array of services and plans to coordinate and/or integrate services to reduce duplication. (Statutory) (p. 71)**
18. **The regional planning councils should establish time frames and interim reporting requirements to ensure the completion of local service area agreements. (Statutory) (p. 71)**

Local service area planning would be required in communities where more than one MHMR agency operates. The planning would focus on the availability and use of local resources, the reduction of duplication through combined functions, and the development of a comprehensive array of services in the area. The involvement of the regional planning councils would ensure that the plans are completed.

### Relationship Between the TDMHMR and Community Centers

19. **The TDMHMR should not control programs that do not receive state funds and do not use funds that are part of the required local match. (Statutory) (p. 73)**

The TDMHMR currently controls almost every aspect of a community center's operations. This has restricted community centers' ability to respond to local needs with locally funded services. The TDMHMR's control should be limited to programs in which it has a contractual interest.

20. **Contract disputes between the TDMHMR and community programs should be subject to the Administrative Procedure and Texas Register Act. (Statutory) (p. 74)**

The TDMHMR exercises a great deal of control over community programs, yet provides a limited process for resolving disputes. For example, the TDMHMR can withhold contract funds at its own discretion. Community programs should have a fair process for resolving disputes regarding service contracts.

### Retirement Benefit Transfer

21. **The statute should allow TDMHMR employees who have been providing educational services to school-age residents to transfer accumulated benefits and service to TRS or ERS. (Statutory) (p. 75)**

To implement the Griffith vs. Bynum settlement agreement, TDMHMR and TEA have signed a memorandum of understanding. It provides that by September 1, 1987, all school-age residents of state schools will be integrated into the special education classes of the local school districts in which the state schools are located. This eliminates the need for 387 educational positions in the state schools. Elimination of these positions creates a potential retirement benefits problem for these employees since reciprocity between TRS and ERS was eliminated in 1980. If the TRS-covered employees stay with TDMHMR, they will be required to become members of the ERS system. If the ERS-covered employees go to work for a local school district, they will be required to become members of the TRS system. For both groups, this split in service will be to their disadvantage financially when they retire. Implementation of this recommendation will ensure these employees do not suffer financial harm as these educational services are transferred to local school districts.

**22. The statute should ensure that the transfer of benefits does not threaten the actuarial soundness of the ERS or TRS systems.**

**(Statutory) (p. 75)**

Setting limits on the transfer of benefits for TDMHMR employees ensures that this special provision does not threaten the retirement benefits of the current members of both systems. The limits necessary include the following: 1) TDMHMR will provide ERS and TRS with a certified list of eligible personnel; 2) the certified list will include only those TDMHMR employees who are providing educational services to school-age residents; 3) the list will not include employees who have already received a refund or who retire during the covered period; 4) an employee who has intervening employment will not be covered by this provision; 5) coverage will be limited to changes in employment that occur between September 1, 1985 and September 1, 1988; and 6) TRS and ERS, in addition to transferring all amounts in the individual member accounts, will also transfer an amount determined by the TRS and ERS actuaries that ensures the actuarial soundness of both systems.

To ensure a smooth transition in these shifts between retirement systems, the statute should also require that all TDMHMR employees covered by TRS will be transferred automatically to ERS on the effective date of the bill. In addition, all TDMHMR employees covered by ERS who are hired by an independent school district between September 1, 1985 and September 1, 1988 will be transferred automatically to TRS when the department notifies ERS of the change in their status.

## EVALUATION OF ACCOUNTABILITY REQUIREMENTS

### Reviews of Community-Based Services

- 23. The department should review the quality and program performance results of all department funded community-based services on an annual basis. (Statutory) (p. 78)**

Currently, the department's reviews of the quality of community centers' programs and the separate management audits are done in cycles of approximately three years. Contracts with community centers, however, are renewed annually. In addition, the community-based services operated by the department through state facility outreach programs are not reviewed by the department for adherence to the Community Standards. An annual review of all community-based services increases their accountability and treats the department's community-based programs the same as community center programs.

- 24. Management audits of the community centers should focus on program performance results to determine compliance with performance contracts. (Management improvement) (p. 79)**

The department's management audits of community centers currently focus on the administrative processes and procedures of the centers. Since the department is now contracting for specified performance results, the management reviews should instead focus on determining if those specified outcomes are being achieved. This shift in focus should also eliminate duplications that currently exist between the management audits and independent C.P.A. audits of community centers that are currently required (see recommendation #30). This change would enhance accountability, yet reduce the administrative burden on community providers.

- 25. The department should review the Community Standards on a biennial basis to determine if each one is necessary to ensure the quality of care. (Management improvement) (p. 79)**

There are currently over 660 department standards which can be applied to community-based programs. During the review, concerns were voiced that many of the standards are either insignificant in determining the quality of care, too costly, or process-oriented. To address these concerns, the department should review the Community Standards regularly.

### Enforcing Standards

- 26. An objective mechanism should be established for evaluating whether a community program meets the department's standards on an overall basis. (Management improvement) (p. 80)**

The department's quality assurance reviews of community centers give no overall judgement of "pass" or "fail" for a particular program or a center in general, but rather only cite deficiencies. Currently there is no way to equate the number or types of deficiencies found with an assessment of whether a program is doing the job it is funded to do. This makes it difficult to assess the appropriateness of approving or disapproving the program for continued funding. An objective mechanism is needed to define overall compliance with standards.

- 27. The department should develop and implement procedures to enforce standards by reducing or withholding funds to a program that is out of compliance. (Management improvement) (p. 80)**

Once overall compliance or noncompliance of a community-based program or service is determined, action must be taken to enforce full compliance with standards. The review found that there is currently very little to no followup action taken on deficiencies cited in program reviews and management audits. This results in findings and deficiencies repeated from previous audits. Reducing or withholding funds to programs out of compliance encourages voluntary compliance and increases the department's ability to enforce standards.

### Internal Audit

- 28. The agency's statute should be amended to require that the director of the unit that performs internal audits reports directly to the commissioner with audit reports submitted directly to the board. (Statutory) (p. 81)**

The department's internal auditor is not currently organizationally independent within the agency. He currently functions as one of seven section or division directors reporting to the executive deputy commissioner, who in turn reports to the commissioner and the director of operations. The state auditor's repeated recommendations that the director of internal audit report directly to the commissioner have not produced any results. Making this a statutory requirement assures the agency's internal auditor a necessary degree of organizational independence and removes him from controversy regarding to whom he reports.

### Department-Wide Accountability

29. **The department's internal audit section should be expanded in order to review program results and perform economy and efficiency studies of agency operations. (Management improvement) (p. 82)**

Expanded scope audits by the department's internal audit section are needed. This type of audit goes beyond looking at fiscal accountability and helps an agency show that its programs are actually achieving the purposes for which they were authorized and funded and are doing so in an economical way. Any increased costs to expand the section should be more than compensated for by savings which should be identified through these audits.

## EVALUATION OF MONITORING ACTIVITIES

### Fiscal and Compliance Monitoring Duplications

30. **The currently required annual independent fiscal and compliance audit of community centers should provide the basis for the department's fiscal review of community centers. (Management improvement) (p. 84)**

Community centers, as recipients of federal funds through the TDMHMR, are required to obtain annual independent financial and compliance audits by a certified public accountant (C.P.A.). These audits must meet the requirements for A-128 audits and are known as "single audits" because they are intended to be used as a single audit upon which all governmental agencies can rely. The review found that the department's management audits of community centers duplicate many of the areas covered by the C.P.A. audits. By properly defining the C.P.A. audit guidelines, and monitoring and following up on the performance of the independent auditors, the department's auditors would not have to duplicate the same work in the field.

31. **The internal audit section should have primary responsibility for reviewing the audited annual reports and supporting workpapers prepared by independent auditors of the community centers. (Management improvement) (p. 84)**

Currently the responsibilities for the review of the independent audits of community centers are divided among two separate divisions within the TDMHMR. The budget and fiscal services section reviews the reports themselves while the internal audit section reviews the supporting workpapers prepared by the indepen-



dent auditors. These responsibilities should be combined as a single responsibility of one organizational unit so that the independent audits can be reviewed more effectively. Since the primary purpose of the independent audit is to enhance accountability, and it provides a basis for the internal audit's reviews of community centers, the function should be consolidated under that office.

### **Program Review Duplications**

- 32. The TDMHMR should identify the other state agencies conducting reviews of programs in community centers and develop a memorandum of understanding with each of them to reduce duplication of program reviews and maximize reliance on each other's reports by December 31, 1987, and annually thereafter. (Statutory) (p. 87)**

The programs and services offered by community mental health and mental retardation centers may serve clients sponsored by other state agencies and receive funds from many state sources. As a result, a community center may undergo fiscal and program reviews by up to 11 state agency related reviewing bodies, in addition to the TDMHMR's standards and quality assurance reviews. Developing memoranda of understanding between the state agencies involved will provide a formal mechanism to address the concerns of all the agencies that currently prohibit them from relying upon each other's reviews. By not re-reviewing programs and services, the state's resources are conserved, the reviews can be better focused, and the burden on the community centers can be reduced.

- 33. Quality reviews should focus on programs funded by TDMHMR funds and the required local match. (Management improvement) (p. 87)**

Community mental health and mental retardation centers receive funds from a wide variety of federal, state and local sources in addition to funds received from the TDMHMR. In addition, funds supplied by the department to community centers are linked to performance contracts which specify the programs and services being funded. By focusing the reviews on those programs and services which the department is specifically contracting for, the department ensures that the state is buying quality services and is able to conduct reviews more frequently.

- 34. The TDMHMR should formally review its Community Standards and identify standards which go above and beyond, or are not addressed by, the Joint Commission on Accreditation of Hospitals' (JCAH) consolidated standards. In the review of community centers that receive JCAH accreditation under the consolidated standards, the department should limit its review to those identified standards and to weaknesses identified in JCAH reports. (Management improvement) (p. 87)**

The Joint Commission on Accreditation of Hospitals (JCAH) is a voluntary, nationally recognized, independent accrediting body for mental health programs and hospitals. The JCAH consolidated standards are the set of standards by which all of the TDMHMR's state hospitals are currently accredited. For the first time, JCAH has begun accrediting community centers under the same set of consolidated standards. By defining which of the department's community standards are not adequately addressed by JCAH and applying only those to a review of a JCAH accredited center, duplications are reduced which benefit both parties.

#### **Resources For Quality Assurance Reviews**

- 35. The TDMHMR should modify its quality assurance reviews by implementing a process using peer review teams that are controlled and directed by central office. (Management improvement) (p. 89)**

The sunset review indicated a need to review the quality of all community-based programs much more frequently than the present three-year review cycle. Since the quality of care in mental health and mental retardation services depends largely on the professional ability and integrity of the care givers, it appears that peer reviews can be an effective way to improve care. The peer review model for quality assurance is commonly accepted in the field and is used by both the Joint Commission on Accreditation of Hospitals and the Southern Association of Colleges and Schools. Utilization of peer review teams will ensure quality services are available and allow the department to conduct reviews of all community-based programs on a much more frequent basis without the need for additional funds.

### Evaluation Policy

36. **The TDMHMR executive committee's currently informal coordination of evaluations, monitoring activities and studies should be put into a formal evaluation policy and communicated throughout the agency. (Management improvement) (p. 90)**

The review found that the department's currently informal way of coordinating evaluation and monitoring activities could be improved by establishing a formal policy agency-wide. A comprehensive evaluation policy will benefit the agency by defining how resources are to be used, what types of activities have priority, and what types of results are expected.

### **EVALUATION OF FISCAL MANAGEMENT**

#### Fees

37. **The TDMHMR should be authorized to collect fees which recover the cost of all reviews and inspections that are necessary in the licensure of private psychiatric hospitals. (Statutory) (p. 92)**
38. **The department should be required to establish, by rule, a fee schedule for parents of minors in state facilities which ranges from no fees for persons at or below the federal poverty level and increases to a point where full costs are recovered when a family can afford it. This provision should replace the fee schedule that is currently in statute. (Statutory) (p. 92)**

In these two areas, the fees that the department can charge are established by statute and do not allow for full recovery of the state's cost. The department should have the authority to charge fees for its services that recover the state's cost in providing those services when persons receiving the services have the ability to pay. These measures are expected to generate increased annual revenues of about \$360,000.

#### Collection of Debts

39. **The TDMHMR and community MHMR centers should be authorized to file liens on all non-exempt property of clients or the parents of minor clients for the amount owed for the provision of MHMR services. (Statutory) (p. 93)**

No mechanism currently exists for the department or community MHMR centers to secure their claims on individuals that owe debts for services which have been provided. Liens are a commonly accepted way of securing debts for other purposes, and should be made available to the TDMHMR and community centers.

#### **Review of Commercial Activities**

- 40. The statute should require the TDMHMR to complete an efficiency and performance review of all management and support activities it performs that are commercially available, calculate the total state cost of each activity, solicit competitive bids, and contract for an activity if it can be purchased through contract for less than the state's cost. (Statutory) (p. 96)**

This would require the department to review the management and support activities it performs which are commonly performed by the private sector to determine whether these activities could be purchased at a lower cost than the state can perform them. These activities include data processing, food service, laundry, warehousing, accounts management (claims), mail, records management, and facility, vehicle and grounds maintenance. The process recommended for the review is modeled after the federal government's Circular A-76 requirements, which have resulted in savings and increased fiscal accountability.

- 41. The statute should require the State Purchasing and General Services Commission to assist the TDMHMR in its implementation of the required review of commercially available management and support activities. (Statutory) (p. 97)**

The commission would be required to review the department's cost estimate for retaining an activity in-house, evaluate the competitive bids and the in-house estimate, and determine which approach is most cost-effective. This provides an independent staff to evaluate the bids.

### Community Center Review of Community-Based Hospital Services

- 42. The statute should be amended to require community MHMR centers to complete an efficiency and performance review of the crisis residential or hospitalization services they provide, calculate the total cost of the service, solicit competitive bids for the service, and demonstrate the cost-effectiveness of the methods chosen for service delivery, before contracts are renewed. This process should be repeated every two years prior to contract renewal. (Statutory) (p. 98)**

This change requires centers to provide the state with assurances that community-based hospitalization services are delivered in a cost-effective manner and increases accountability for their costs. It will ensure that alternate methods of service delivery are examined before state funds are used to establish services which may duplicate existing community resources. The process required is modeled after the federal government's Circular A-76 process.

- 43. The statute should be amended to require the TDMHMR to adopt rules establishing standards for the community centers' implementation of the required cost-effectiveness review of community-based crisis residential and hospitalization services. (Statutory) (p. 99)**

This change would require the department to establish the procedures for centers to use in conducting efficiency and performance reviews to ensure that the centers' cost estimates and solicitation documents are developed consistently. While the authority to award contracts for community-based services would remain with the centers, the standards would require centers to demonstrate that the most cost-effective method of service delivery is used.

### Use of Assets

- 44. The department should be required to establish objective criteria for when facilities should be closed or consolidated. (Statutory) (p. 101)**
- 45. The department should be authorized to sell, lease, transfer, or otherwise dispose of its assets. Also, the department should be authorized to retain the proceeds from these transactions to restructure its system of facilities, subject to control by the appropriations process. (Statutory) (p. 101)**

The department's facility needs have changed dramatically in recent years, but its facilities have not kept pace with the changing needs. These two recommendations will provide statutory direction and authority to the TDMHMR to adjust its institutional capacity to more closely match its needs.

#### **State Facility Funding**

- 46. The department should be required to establish budgets for its facilities which are based on specific costs for specific types of services provided. (Statutory) (p. 101)**

There is currently a wide variation in the cost per client per day among the various state-operated facilities. The TDMHMR does not have the ability to determine whether or not these cost variations are justified. The department should be required to account for differences in cost among its facilities for similar services.

#### **ICF-MR Funding**

- 47. The department should be required to determine the degree to which the cost of operating the state schools is reduced as populations decline. As savings are realized, the funds should be used to equalize the rates paid to ICF-MR providers and to increase funding for community MR programs. (Statutory) (p. 103)**

The TDMHMR currently pays more for serving a client in one of its state schools than it pays to serve the same type of client in a community program. This is inequitable and discourages the development of new community programs for persons with mental retardation. The department should be required to flow funds from its state schools to community programs so that funding becomes more equitable between state and community programs.

#### **Funding of Mental Health Services**

- 48. The department should be required to determine the degree to which the cost of operating its state hospitals is reduced as populations decline, and distribute the funds to community mental health programs as savings are realized. (Statutory) (p. 104)**
- 49. The TDMHMR in conjunction with community programs should be required to establish the number of state hospital beds that are needed, provide no more beds than that number, and develop its budget and community contracts on that basis. (Statutory) (p. 104)**

Currently, funds used to serve patients in state hospitals do not flow with the patients when they leave the hospitals to receive treatment in community

programs. If the funds would flow in proportion to the flow of patients, community-based providers would develop programs to serve more state hospital patients. In order to maximize the role of community programs, the state hospitals should serve only patients that community programs cannot or will not serve, and the rest of the patients and related funds should be transferred to community programs.

#### **Allocation of Community Program Funds**

- 50. Additional cost savings realized by any closure or consolidation of the TDMHMR's facilities, that are not needed for facility reconfigurations or community contracts, should be used to move toward equalization on a statewide per capita basis. (Management improvement) (p. 106)**
- 51. In its budget request for fiscal years 1992-1993, the TDMHMR should be required to present to the legislature the amount needed to completely equalize funding of the system, including the ICF-MR program. (Statutory) (p. 106)**

Previous recommendations which deal with the flow of funds from state facilities to community programs will make the funding system more equitable. The above mentioned recommendations will establish a framework to complete funding equalization in a timely manner. By phasing in these changes, existing programs will not be disrupted.

- 52. The department should be statutorily required to establish local matching requirements for outreach programs that are consistent with requirements for community MHMR centers. (Statutory) (p. 107)**

Areas served by community MHMR centers are currently required to provide a local match for state funds they receive. Areas served by state facility outreach programs have no local match requirement. Local match requirements should be applied consistently across the state. It is estimated that this provision will generate increased annual revenues of approximately \$5,000,000.

## EVALUATION OF PROGRAMS

### EVALUATION OF STATE RESPONSIBILITY FOR MHMR SERVICES

#### Purpose and Policy Statement

- 53. The department's statutory purpose and policy statement should be modified to accurately reflect current state policy. (Statutory) (p. 111)**

Although the 69th Legislature directed the department to identify the priority client populations and the minimum array of services necessary to address the needs of these clients, the agency's purpose and policy statement was not modified accordingly. It indicates a state policy that does not exist, i.e. that TDMHMR will meet all the needs of all Texans who are mentally ill or mentally retarded. To ensure that the state is not held accountable for failing to meet this unrealistically high standard of service delivery, a change in the purpose and policy statement appears necessary. The recommended modification will provide guidance to the department in the development of their mission statement, goals, and objectives. Further, it will ensure that those seeking services have a clear picture of the state's intent in providing those services.

#### Broaden Minimum Services Requirements

- 54. The statute should be amended to include additional required core services. (Statutory) (p. 111)**

This change would add two mental health services which were not included in the S.B. 633 minimum service requirements, but are required by TDMHMR policy. The services include medication-related services and psychosocial programs which include vocational services, skills training, and social support. These services are necessary to enable chronically mentally ill people to remain in the community and are currently provided in all but three service areas. This change will not add to the cost of services but is instead designed to clarify what services are required.

- 55. The statute should be amended to apply the minimum service requirements to TDMHMR outreach service areas. (Statutory) (p. 112)**

This change will require that at least minimum services are available in all areas of the state, not just those served by contract with community centers. This is consistent with the original recommendations of the Legislative Oversight Committee on Mental Health and Mental Retardation which led to the current statutory requirements.



### Legally Adequate Consent

- 56. The statute should be amended to authorize the commitment of mentally retarded persons to programs providing day services. (Statutory) (p. 114)**

In order to protect the rights of mentally retarded people, legally adequate consent is required for admission to and participation in all residential or non-residential mental retardation services. If a person cannot give consent, the statute requires the appointment of a guardian or a court commitment for services. Two problems related to this requirement have been identified. First, it is not always possible to find a guardian and even when an appropriate person is available, sometimes the legal costs are prohibitive. Second, the only type of commitment authorized by the Mentally Retarded Persons Act is a commitment to a residential care facility. There are many people who do not need residential services but would benefit from day treatment and/or training.

This recommendation would ensure that people needing and wanting services are not denied services and would protect staff of community programs who provide needed services when neither a guardianship nor consent can be obtained. To ensure that client rights are protected, the statute should require an annual review of the appropriateness of the commitment and the need for it to continue. If a change is needed, the community program should be responsible for informing the court of this and providing supporting information. The statute should also require a formal discharge process and state what conditions would allow the commitment to be invalidated.

## **EVALUATION OF SERVICE GAPS AND DUPLICATION**

### Shift Some Hospital Services to Community Providers

- 57. The statute should be amended to require the TDMHMR to actively seek nursing home placement for its long-term geriatric population and solicit proposals from community providers for the operation of geriatric units in a community setting for the remaining long-term geriatric hospital population. (Statutory) (p. 116)**

This change would require the department to attempt to place its long-term geriatric patients in nursing homes, if such placement is appropriate. If such

placement is not workable for some patients, TDMHMR would solicit proposals from community providers for the development of personal care homes or residential programs, designed for this population. Requiring TDMHMR to investigate community-based geriatric services could result in annual savings of over \$8 million while ensuring that patients receive appropriate care in a setting which is less restrictive and more normalizing than a state hospital.

- 58. The statute should be amended to require the TDMHMR to actively solicit proposals from community providers for the operation of extended care units in a community setting. (Statutory) (p. 117)**

The department would be required to solicit proposals from community providers for the development of community-based residential programs for patients in state hospital extended care units. Community-based extended care programs could be more cost-effective and would complement the existing array of community services. This change could save the state \$3.3 million annually while also allowing these long-term patients to receive appropriate care in a less restrictive and more normalizing environment than a state hospital.

- 59. The statute should be amended to require the TDMHMR to actively solicit proposals from community providers for the operation of transitional living units in a community setting. (Statutory) (p. 118)**

The department would be required to solicit proposals for the development of community-based transitional living programs for patients currently served in state hospital transitional living units. These residential units teach patients the skills necessary to increase their degree of independence. If provided in the community, these services would be less costly, more effective, and would complement the existing array of community services.

- 60. The statute should be amended to require the TDMHMR to review, every two years, the types of services provided by the department and examine whether those services are available through community providers at a similar or reduced cost and submit its findings with its budget request. (Statutory) (p. 119)**

This will establish an ongoing mechanism for the department to review the services it provides directly to clients and report to both the Legislative Budget Board and the Governor's Budget Office as to whether it is necessary for the state to continue

direct service provision. This will allow the legislature to monitor whether the department is implementing its intent that local agencies and private providers be encouraged to administer services, whenever possible.

#### **TDMHMR Administration of State Centers**

- 61. The statute should be amended to require the TDMHMR to negotiate contracts for the administration and/or operation of four state centers by area community centers by January 1, 1988. (Statutory) (p. 121)**

Currently, four of the five state centers are in areas also served by community MHMR centers. Contracting for the administration and/or operation of these state centers would reduce duplication in these areas. It would encourage the development of a well planned, comprehensive array of services in these areas, instead of two parallel service delivery systems. Also, such change would bring state center administration in line with the state's policy of encouraging local agencies to assume responsibility for service delivery. Potential savings range from \$1.5 million to \$7.9 million, depending on how the recommendation is implemented.

- 62. The statute should be amended to require the TDMHMR to solicit proposals for the administration and/or operation of the Laredo State Center by January 1, 1988 and report its findings to both budget offices. (Statutory) (p. 122)**

Soliciting proposals will provide the state with valuable information as to whether continued state operation of the Laredo State Center is cost-effective. It is expected that private providers would be the primary respondents to the proposal request. The information obtained can assist the legislature in its direction of the department. This process will ensure these services are delivered in a high quality manner that maximizes cost-effectiveness and the use of local or private providers when possible.

#### **State Center Client Eligibility for TDMHMR Programs**

- 63. Mentally retarded state center residents should be eligible for the \$55.60 program. (Management improvement) (p. 124)**

Currently, mentally retarded people in long-term placement in two state centers do not have equal access to this effective placement incentive. Requiring access would encourage more cost-effective placement of these residents, when appropriate, and ensure that the areas served by state centers receive the same incentives to develop community resources as do other areas of the state. While

the previous recommendation requires TDMHMR to contract the administration of state centers to community centers, this change is needed until that can be accomplished.

- 64. State center psychiatric beds should be added to the bed day count for the \$35.50 program. (Management improvement) (p. 124)**

Currently, the incentives to treat state hospital patients in less restrictive community programs are not available for state center patients. Changing this would encourage more cost-effective treatment of these patients and ensure that the state center areas receive the same incentives to develop community resources as other areas of the state. While a previous recommendation requires TDMHMR to contract the administration of state centers to community centers, this change is needed until that can be accomplished.

#### **State-Supported Genetic Services**

- 65. An Interagency Council for Genetic Services should be created. (Statutory) (p. 128)**

The review identified inadequate coordination and an inability to evaluate the quality or cost-effectiveness of genetic services providers receiving state funds. An interagency council would bring all state funded genetic services providers together for comprehensive planning and service delivery. It would coordinate the array of services in preventing, identifying and treating genetic disorders.

- 66. The Interagency Council for Genetic Services should be responsible for the development and implementation of procedures to effectively address cost-effectiveness, identification of current and future needs, improved coordination, and guidelines for monitoring genetic services. (Statutory) (p. 128)**

This change would address specific problems that need to be satisfied before an efficient and effective statewide genetics system can be developed. It would allow the cost and quality of genetic services to be compared between various providers, promote programs that are effective, and develop an evaluation system to ensure high quality.

- 67. The Interagency Council for Genetic Services should prepare and submit a report to the 71st Legislature on recommended changes that would improve the genetic services system. (Statutory) (p. 128)**

Previous studies and the review identified a need to develop long-range planning that would ensure coordination and cost-effectiveness among the major providers of genetic services. A report to the 71st Legislature would provide a means to evaluate progress toward these goals. It would also provide the legislature with an opportunity to make any necessary adjustments to the newly created council or to the way genetic services are currently funded by the state. The council should be authorized to contract for the preparation of this report.

### Substance Abuse Services

- 68. The TDMHMR should be required to annually provide the TCADA with an analysis of hospitalization rates of substance abusers by county of residence. The TCADA should be required to consider hospitalization rates in making allocations of grant funds and include a provision in its treatment and rehabilitation grant contracts that the grant is for a program that will reduce state hospital utilization by a certain percent. (Statutory) (p. 131)**

The legislature has directed the Texas Commission on Alcohol and Drug Abuse (TCADA) and the TDMHMR to work together to develop community-based services that would reduce the use of state hospital beds for individuals with substance abuse problems. To date only minimal reductions have been made. Sharing information on the use of state hospitals by substance abusers should assist the TCADA in allocating grant funds to areas that need to develop, expand, or improve their local services and reduce their use of state hospitals. Requiring the grantee to agree to reduce utilization of state hospitals should also have a positive impact.

- 69. The TDMHMR should use existing funds for substance abuse services to develop contracts with community-based programs to reduce bed day utilization for substance abusers in state hospitals. (Management improvement) (p. 131)**

The department has developed an incentive program, known as the \$35.50 program, which encourages community centers to develop local services which will limit the need for a person to go to a state hospital. This program has been very successful and reduced state hospital bed day use by 22 percent in the first 18 months of its operation. Applying this to hospital substance abuse units should have a similar impact. However, this effort by the department should be coordinated with the TCADA to ensure a united approach in meeting the state's goal to serve substance abusers in community programs.

- 70. The TDMHMR and the TCADA should, on a biennial basis, jointly determine how many, if any, state hospital beds should be maintained for people with substance abuse problems who cannot be served in the community. (Statutory) (p. 131)**

This determination would assist the TDMHMR in the development of its biennial budget request. It would also serve as a mechanism for the legislature to evaluate the progress that has been made on reducing the use of state hospitals for substance abusers.

## **EVALUATION OF THE BALANCE IN THE ARRAY OF MHMR SERVICES**

### **Regulation of Certain Boarding Homes**

- 71. The local mental health and mental retardation authorities should be authorized to regulate boarding homes that accept referrals from the authorities. (Statutory) (p. 133)**

This recommendation would give local authorities the regulatory tools necessary to effectively monitor and improve the quality of the boarding homes where their clients live. Local mental health and mental retardation authorities currently have only informal methods of regulating the quality of these homes. This change would build on the existing information network between clients and staff and use local technical resources such as the local fire marshal and local health authority to ensure that the regulation is sensitive to local needs and resources. If the local MRA and MHA are separate providers in an area, they would be required to negotiate a memorandum of understanding to reduce duplicative regulation of the local boarding homes.

- 72. The TDMHMR should be required to adopt, in consultation with local mental health and mental retardation authorities, rules establishing a general regulatory framework consistent with the statute for the local regulation of boarding homes accepting MHMR referrals. (Statutory) (p. 133)**

The development of general procedural guidelines for local regulation will provide a degree of statewide consistency and reduce the burden on local authorities to independently establish a regulatory framework for each area. The rules would be established with information obtained from local mental health and mental retardation authorities. Such guidelines would establish acceptable methods of regulation but provide flexibility to the local authorities as to the specific standards, inspection methods, and enforcement procedures used locally.

### Zoning Restrictions

- 73. The statute should be amended to extend the current zoning exemption for group homes to those group homes which have eight residents. (Statutory) (p. 136)**

This would modify the zoning exemption for family homes adopted in 1985. That exemption defines a not-for-profit group home with no more than six residents and two staff, as a permitted use in a residential zone. The provision would be modified to allow a total of eight people living in the home. Homes that do not require 24-hour staff would be able to increase their capacity by 33 percent and increase cost-effectiveness. The basic cost of an eight-bed group home with day staff only will be \$50 less per person per month than a six-bed home. If such savings could have been realized for 50 percent of the approximately 2,800 residents of group homes operated by community centers in fiscal year 1984, approximately \$850,000 would have been saved that year without reducing services.

- 74. Group homes with 12 residents, operated by the TDMHMR or community centers, should be a permitted use in residential areas which are not zoned for single family use. (Statutory) (p. 136)**

This change will allow TDMHMR and community centers to develop group homes which are affordable to people whose only income is Social Security. The only option currently available which these people can afford is boarding homes. These group homes would only be permitted in areas zoned for multi-family or mixed use and must comply with all other requirements for group homes, including licensing requirements. The exemption is limited to homes operated by TDMHMR or community centers to ensure the state's oversight concerning the operation of the home. This change will facilitate the development of affordable homes to meet the needs of the approximately 463,000 disabled people in Texas who support themselves through Social Security.

### Alternative to State Hospital Commitments

- 75. The mental health and substance abuse commitment laws should be modified to establish a single portal of entry process beginning September 1, 1988 in areas which provide the necessary community-based services. (Statutory) (p. 139)**

This recommendation would establish a mechanism, in areas providing all necessary services, which strengthens commitment provisions that limit inappropriate admissions to state hospitals. In areas designated as single portal authorities, all

commitments that would have previously been made to the state hospital, would instead be made to the single portal authority. The judicial system would continue its role of determining whether court-ordered inpatient treatment is warranted, but treatment professionals would be given the responsibility to determine whether the treatment is provided through local programs or through the state hospital. The proposed changes would not limit the use of private providers. The provision would take effect September 1, 1988 to provide adequate time for planning, resource development, licensing, designating single portal authorities, and educating the courts and providers. The department would establish rules concerning the single portal authorities' handling of commitments and transfers, and provide for emergency admissions to state hospitals when obtaining approval of the single portal authority could endanger the patient.

**76. The statute should be amended to require the board to appoint a Single Portal Review Committee by September 1, 1987. (Statutory) (p. 140)**

The committee would provide an independent body to determine if a mental health authority provides the necessary services to function as a single portal of entry. It would be responsible for developing the standards to designate single portal authorities, deciding how applications would be evaluated, and evaluating applications. It would be composed of nine members representing the major professional and consumer groups affected by commitment procedures. When the committee reviews area applications for single portal designation, the committee would add three local area leaders to assist in evaluating the application.

**77. The TDMHMR should modify the \$35.50 program policies to ensure that TDMHMR funding of a single portal authority is provided before services are delivered and the fiscal incentive to reduce hospital use is removed. (Management improvement) (p. 141)**

This requires a change to TDMHMR's \$35.50 program when a MHA is designated as the single portal authority for an area. The \$35.50 program currently provides fiscal incentives to reduce the use of state hospitals by area residents. This incentive could inappropriately outweigh a clinical decision concerning whether a patient should be transferred to a state hospital. Also, this program funds services after hospital use is decreased. The recommended change would minimize any financial incentives that could interfere with patient-oriented clinical decisions



and ensure that single portal authorities receive adequate funding before they treat patients.

### **Regulation of Inpatient Facilities**

- 78. The statute should be amended to establish a new category within the TDMHMR's authority to license private psychiatric hospitals to regulate community-based facilities which provide court-ordered inpatient mental health treatment. (p. 143)**

The state's regulation of these facilities would provide adults who are committed to free-standing, community-based inpatient programs, regulatory protection similar to that currently provided for patients in private psychiatric hospitals. Comparable free-standing facilities which provide court-ordered inpatient treatment for children, adolescents, and substance abusers are required to be licensed. The department could establish separate standards for these facilities. All facilities licensed as a hospital by the Texas Department of Health or TDMHMR would be exempt.

- 79. The definition of inpatient mental health facility should be amended to allow commitment only to licensed inpatient facilities. (Statutory) (p. 143)**

Community centers are currently defined as inpatient mental health facilities in the Mental Health Code. This change would prevent inpatient commitments to community center facilities which do not have the capacity to provide the protection or treatment required for court-ordered mental health treatment.

### **Enhanced Compliance with Outpatient Treatment**

- 80. The statute should be amended to provide for the conversion of a court-order for inpatient mental health treatment to an outpatient order if, in the original commitment hearing, the judge finds that the person is at risk of deterioration without continued care. (Statutory) (p. 145)**

This change would streamline the existing provisions for converting inpatient commitments to outpatient commitments, thereby making them more useful. Outpatient treatment following court-ordered inpatient treatment is a critical factor in the person's ability to remain relatively symptom free in the community. The change would allow the judge to make a finding when committing a person to inpatient care as to the person's potential for deterioration if treatment is not continued for the entire period of commitment. When this finding is made and the

patient does not require inpatient care for the entire commitment period, then the commitment would convert to an outpatient commitment for the balance of the time period unless waived by the judge.

### **Interstate Compact on Mental Health**

#### **81. The State of Texas should participate in the Interstate Compact on Mental Health. (Statutory) (p. 147)**

The compact was reviewed by the 69th Legislature and was continued with minor modifications. Continued membership in the compact eliminates the problem of residency requirements and establishes a mechanism which allows people to move closer to their family when it is important to their care and treatment. It also prevents unwarranted transfers of mentally ill or mentally retarded individuals without the state's knowledge and acceptance.

### **Changes to a Major Funding Strategy**

#### **82. Provider contracts should require the \$35.50 funds to be used for mental health services. (Management improvement) (p. 148)**

The \$35.50 program funds mental health authorities based on their ability to reduce their area's use of state hospitals. There are currently no restrictions on the use of the \$35.50 funds. This approach to funding is inconsistent with recent performance-based contracting required by the 69th Legislature. Some providers did not initially allocate program funds to mental health services. The change recommended would ensure that community-based mental health services are developed as people are diverted from state hospitals and increase accountability for state funds.

#### **83. Patients sponsored by TDMHMR facilities in residential programs operated by local mental health authorities should be added to the bed day count. (Management improvement) (p. 148)**

In addition to \$35.50 funding for keeping people out of state hospitals, a mental health authority can contract with a state hospital to take patients out of the hospital and place them in its residential programs. Since these patients are sponsored in residential placement by TDMHMR facility funds, it is reasonable to conclude they are still in a state supported bed. Therefore, for these patients, the mental health authority should only receive the contract funds and not the \$35.50 program funds. Adding these patients to the bed day count for the \$35.50 program would prevent programs from receiving dual reimbursement from two parallel funding strategies, and eliminate problems the potential dual funding has created.

- 84. The disincentives to placing patients in hospital-based transitional living programs should be reduced. (Management improvement)**  
(p. 149)

This change would require TDMHMR to examine the \$35.50 program policies to correct a problem identified in the review. These policies have resulted in a decline in referrals to transitional living programs because the mental health authority loses potential \$35.50 funding by admitting the person to the hospital-based unit. Most transitional units are currently hospital-based, and are a vital component in the array of services for the chronically mentally ill. Another recommendation in the report requires TDMHMR to attempt to convert these programs to community-based operations. However, until that is done, the disincentive to use these programs should be removed.

#### Respite Programs

- 85. The TDMHMR should modify its requirements concerning the provision of in-home respite care services to promote the use of a voucher model and modify the Community Standards relating to respite services using information from providers and families involved in the services.** (p. 153)

Such modification would eliminate the currently restrictive standards applied to in-home respite services. Instead, the standards would encourage the development of a service delivery mechanism which recognizes the expertise and concern of family members and their ability to assist in the cost-effective development and monitoring of needed respite services. The use of qualified private providers would be encouraged instead of agency provided services. Varying types of in-home respite care could be established as required by the types of clients served and the length of service. Varying qualifications could be established for providers that provide the various types of care. In addition, any standards concerning this type of service would be made more responsive to those needing the service by requiring the department to seek the advice of respite providers and families when formulating any new in-home respite service requirements.

#### Vocational Rehabilitation Needs

- 86. All TDMHMR facilities and community centers should annually examine the feasibility of converting entry level support positions into sheltered employment opportunities for clients within the service area. (Statutory)** (p. 154)

This change would require the MHMR system agencies to examine their operations for potential vocational training opportunities, enabling them to maximize their sheltered employment resources. Many centers currently secure entry level positions in their community, such as custodial positions, for vocational training of their clients. With systematic planning, additional vocational training resources can be made available without any reduction in the quality of support services.

## **EVALUATION OF THE USE OF MEDICAID FUNDS FOR MR SERVICES**

### **Structure of the ICF-MR Program**

- 87. Statutory modifications should direct the TDHS to transfer the primary administrative responsibilities for the ICF-MR program to the TDMHMR and direct the TDMHMR to accept that responsibility. (Statutory) (p. 158)**

The Intermediate Care Facilities for the Mentally Retarded (ICF-MR) Program provides residential care and treatment for mentally retarded persons through a mixture of state and federal (Medicaid) dollars. The TDMHMR's state schools and outreach programs, the community centers, as well as private providers, participate in the program. Over 10,000 of the state school beds are supported by the program and an additional 4,000 community-based beds are available outside the state school system. Since the program is part of the Medicaid system the state receives a favorable match on the general revenue dollars it makes available for the program. The match has averaged about 54 percent (federal) to 46 percent (state) over the past several years. In fiscal year 1986, this match "generated" 130 million federal dollars in conjunction with state expenditures for state school facilities and provided over 36 million federal dollars for support of community-based ICF-MR beds.

The structure of the program is complicated, requiring the involvement of three major state agencies to carry out its requirements. As the designated single state agency for Medicaid, the TDHS administers the program. The Department of Health "certifies" or approves the facilities and determines whether persons are medically and programmatically eligible for the program. The TDMHMR has broad planning responsibility for programs serving mentally retarded persons and is specifically responsible for the development of standards that govern the program.

Over the years, this structure has proven cumbersome and confusing. Decisions regarding changes in the program have been slow and federal dollars have not been maximized because of the trifurcate structure. Transferring responsibility for the program to TDMHMR appears to offer a solution to the problems. The many details of the transfer are outlined on pages 159 through 161 of the report.

**88. The TDHS should modify the Medicaid State Plan to reflect the shift in responsibility for the ICF-MR program. (Management improvement) (p. 162)**

Each state's Medicaid program structure must be set out in a specific "plan" adopted by the state. This mechanical change is needed to reflect the changes made in the preceding recommendation.

**89. Statutory provisions should ensure that any future federal decisions to reduce Medicaid funding will result in proportionate cuts to all programs using Medicaid dollars. (Statutory) (p. 162)**

The state's Medicaid program expends over \$1 billion annually to support three major programs: purchased health services, nursing home care, and ICF-MR. Should the Medicaid program be capped or reduced at the federal level, as has been discussed over the years, this recommendation would ensure that all Medicaid programs would share in a proportionate reduction.

**90. The TDMHMR should appoint an ICF-MR Advisory Committee. (Statutory) (p. 162)**

The shift of responsibilities and development of ongoing control of the program at the TDMHMR will take time. It appears that providing the routine assistance of an advisory committee made up of providers, consumers and others interested in the program can be useful in working out immediate and long-range operations of the program.

**91. The TDMHMR should expand its use of the ICS waiver program. (Management improvement) (p. 163)**

The Intermediate Community Services (ICS) Program provides an alternative to traditional residential programs for mentally retarded persons by providing a range of services that help people live in the community. The program is funded through state and federal Medicaid dollars. The more centralized system proposed under these recommendations can better maximize the use of state dollars in this kind of program. As state institutional populations decline, state dollars shifted to the community can be used to draw down federal dollars available for this program.

Further, purely state funded programs, if appropriately structured, can also benefit from the available federal match.



## **AGENCY EVALUATION**



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The review of the current operations of an agency is based on several criteria contained in the Sunset Act. The analysis made under these criteria is intended to give answers to the following basic questions:

1. Does the policy-making structure of the agency fairly reflect the interests served by the agency?
  2. Does the agency operate efficiently?
  3. Has the agency been effective in meeting its statutory requirements?
  4. Do the agency's programs overlap or duplicate programs of other agencies to a degree that presents serious problems?
  5. Is the agency carrying out only those programs authorized by the legislature?
  6. If the agency is abolished, could the state reasonably expect federal intervention or a substantial loss of federal funds?
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## **AGENCY BACKGROUND**

### **Creation and Powers**

The Texas Department of Mental Health and Mental Retardation (TDMHMR) was created in 1965 by House Bill 3 and is responsible for operating a network of residential and community services for mentally ill and mentally retarded people. It provides and contracts for rehabilitative and educational programs to restore the mental health of Texas citizens and to help mentally retarded persons live as useful and productive lives as possible. The TDMHMR also supervises and helps financially support 31 community mental health and mental retardation centers governed by local boards of trustees.

In 1856, Texas established the first institution for the mentally ill in Austin with others soon to follow in Terrell, San Antonio and elsewhere. At that time, little distinction was made between mentally ill and mentally retarded people and their care consisted mainly of supplying a place to live where they could be confined to prevent injury to themselves or others. In 1915, the legislature realized that mentally ill and mentally retarded people should not be served in the same facilities and authorized the first facility for mentally retarded persons. In 1919, as more institutions for the two populations were built, the legislature created the State Board of Control consolidating 21 separate agencies. This board managed and made purchases for all asylums and eleemosynary institutions of the state. Eventually, other state laws enacted in 1949 and 1950 established a Board for Texas State Hospitals and Special Schools which did extensive building of more state facilities to relieve overcrowded conditions.

With more space available, better trained personnel, the introduction of psychotropic drugs, and the passage of the Mental Health Code in 1957, the warehousing of mentally ill patients evolved into a more therapeutic situation. At about this same time, changing public attitudes and federal policies stressed the need for treating patients in their home communities rather than secluding them in distant locations. During the 1960s, laws were passed that provided for federal matching funds to establish mental health clinics in local communities throughout the country.

Negative attitudes toward mentally retarded people slowly began to change in the early 1950s. In the late 1950s and early 1960s, as state schools were added or expanded, a change evolved in the care and treatment philosophy. The custodial

approach to care began to gradually be replaced by emphasis on developing the individual's potential through education, recreation, and training in social and vocational skills. Further improvements came with the creation of the community MHMR centers in the 1960s. These provided many mentally retarded citizens with the opportunity to be served in their local communities for the first time. The passage of the Mentally Retarded Persons Act in 1977 was another major milestone in assuring that these people have the opportunity to develop to the fullest extent possible and to live in the least restrictive environment that is appropriate for their needs. The Act also ensures that mentally retarded people, who have not been adjudicated incompetent and for whom a guardian has not been appointed by the courts, have the same rights and responsibilities enjoyed by all citizens of Texas.

The past decade has seen the decentralization of residential facilities and the expansion of community-based alternatives care for both mentally ill and mentally retarded people. Litigation in other states and Texas has reinforced this trend by articulating patient's right to treatment, education and compensation for labor. Two notable court cases affecting Texas, the Lelsz and R.A.J. suits, have had significant impact on the delivery of mental retardation and mental health services in this state. (A more detailed discussion of Lelsz and R.A.J. can be found on page 53.)

Other major changes to the service delivery system were the result of the Legislative Oversight Committee on Mental Health and Mental Retardation. This joint committee was created in June, 1984 by the lieutenant governor and the speaker of the house to deal with court mandates and to develop state policies to deal with the future direction of mental health and mental retardation services. The committee, comprised of lawmakers, service providers, advocates and other experts, was charged with advising the 69th Legislature on how resources could best be utilized to address client needs now and in the future. The recommendations of the committee were incorporated into S.B. 633 which was passed by the 69th Legislature. The major components of S.B. 633 include more citizen involvement in planning, the development of a long-range strategic plan, the identification of priority client populations, moving from grant-in-aid funding to service contracts between the department and community centers, requirements that department personnel balance clinical and programmatic knowledge with management experience, and mandating the availability of certain core services in

local service areas. The required core services include 24-hour emergency screening and rapid crisis stabilization, community-based crisis residential services or hospitalization, community-based assessments, family support services, including respite care; and case management services. If a community center cannot provide these services, the department is required to contract with another provider.

### **Board Structure**

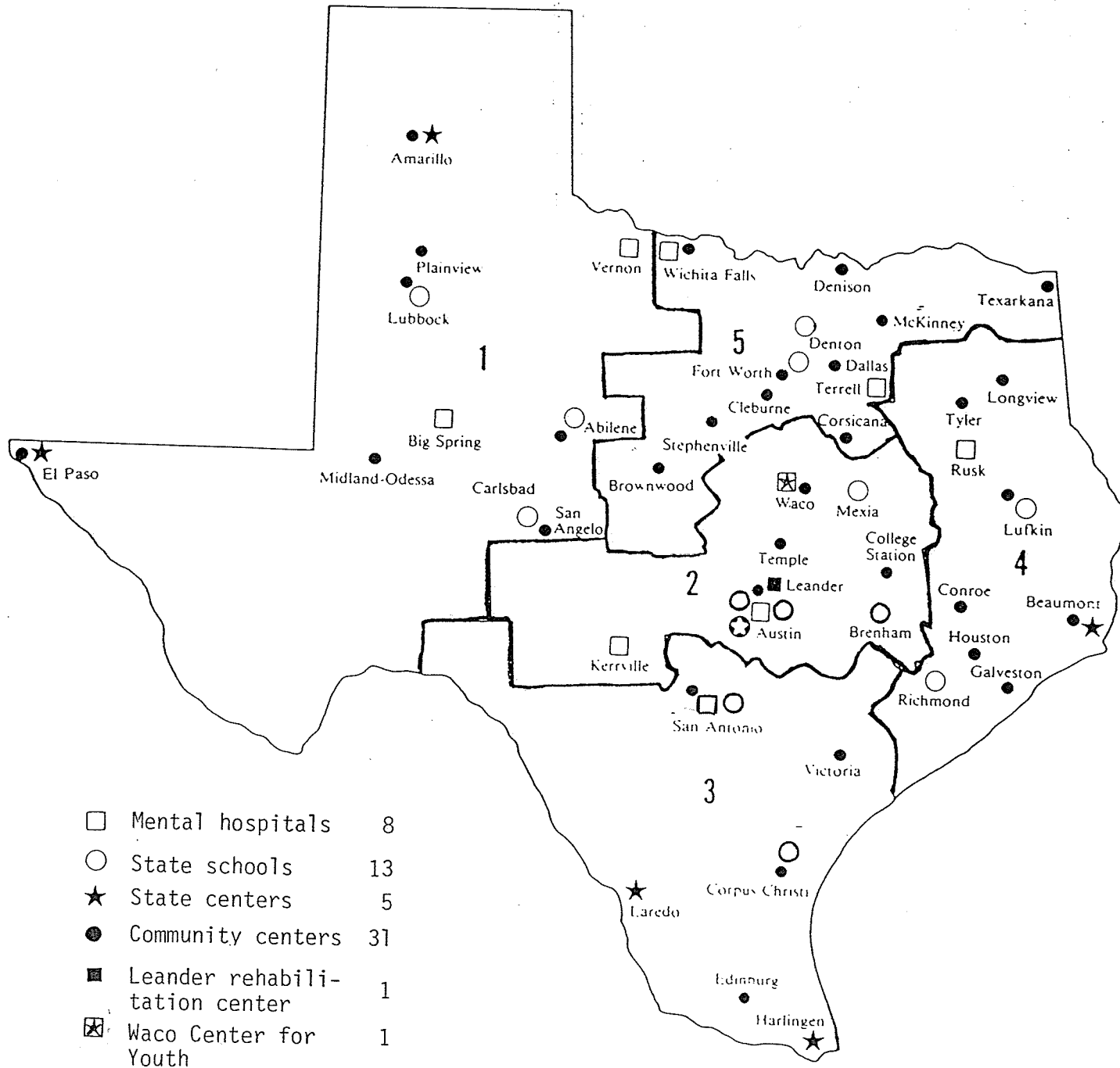
The Texas Board of Mental Health and Mental Retardation is composed of nine part-time members appointed by the governor for staggered six-year terms and one member emeritus. The board chairman is designated by the governor and five members are required as a quorum to transact business. The chairman appoints all standing and special committees of the board and serves as an ex-officio voting member on all standing committees. A committee of the board has no quorum requirements and can transact business in any manner calculated to expedite its work. There are five standing committees consisting of (a) an executive committee to address issues of broad implications that are neither purely programmatic nor fiscal, (b) a business committee to consider funding and management issues, (c) a program committee to develop programmatic policies, (d) a personnel committee to review applicants for the position of commissioner, as well as approve appointments by the commissioner of facility heads and certain central office positions, and (e) a rule review committee to review any proposed departmental rules.

### **Funding and Organization**

The TDMHMR has its administrative headquarters in Austin and operates eight psychiatric hospitals, 13 state schools for mentally retarded persons, five state centers, the Waco Center for Youth, the Leander Rehabilitation Center, genetics screening and counseling services, and eight pilot programs for persons with autism. It also provides substantial funding to 31 community centers governed by local boards of trustees. Exhibit 1 shows the locations of the state facilities and community MHMR centers. The department has 26,813 full-time equivalent positions authorized and 24,923 employees assigned as of June, 1986 with an operating budget of \$623.5 million. Exhibit 2 shows the personnel and budget for each of the department's major programs.

Exhibit 1

# Texas Department of Mental Health and Mental Retardation Delivery System



**Exhibit 2**  
**TDMHMR BUDGET/EMPLOYEES**

<u>Agency Program or Activity</u>	<u>1986 Funding (in Millions)</u>	<u>Authorized Employees (June '86)</u>	<u>Assigned Employees (June '86)</u>
Central Administration	\$ 18.7	653	588
State Hospitals	194.0	9,763	9,180
State Schools	258.8	15,025	13,906
State Centers	28.1	1,372	1,249
Contracted Community Services	101.7	(5,652.9)*	-
Statewide Support Services	17.5	-	-
Capital Outlay & Construction	4.7	-	-
<b>Total</b>	<u>\$623.5</u>	<u>26,813</u>	<u>24,923</u>

\*Community center employees not included in the total of TDMHMR employees.

**Central Office**

The Texas Department of Mental Health and Mental Retardation conducts all of its administrative activities out of the central office located in Austin. Central office has 653 authorized employees for June, 1986, however, 85 claims personnel located in the state facilities as well as 96 genetics screening and counseling service personnel located in regional clinics are included in that number. The central office appropriation for fiscal year 1986 was \$18.7 million, accounting for three percent of the agency's budget.

At the highest administrative level within the organization is the office of the commissioner which consists of the commissioner, the director of operations and administrative staff. The director of operations assists the commissioner in making sure the department is administered in an effective and efficient manner. The director of operations' position concentrates on operational matters and special assignments of the commissioner and has the full authority of the commissioner in carrying out his duties. Advisory to the office of the commissioner are special assistants for medical and dental services as well as the director of volunteer services.

Responsibility for all of the administrative activities of the agency is divided into four areas which report to three deputy commissioners and one executive deputy commissioner. These four deputy commissioners report directly to the commissioner's office and together with the commissioner and the director of operations, make up the executive committee. The division of their responsibility

can be seen on the agency's organizational chart, labeled Exhibit 3, and their functions are described in the following material.

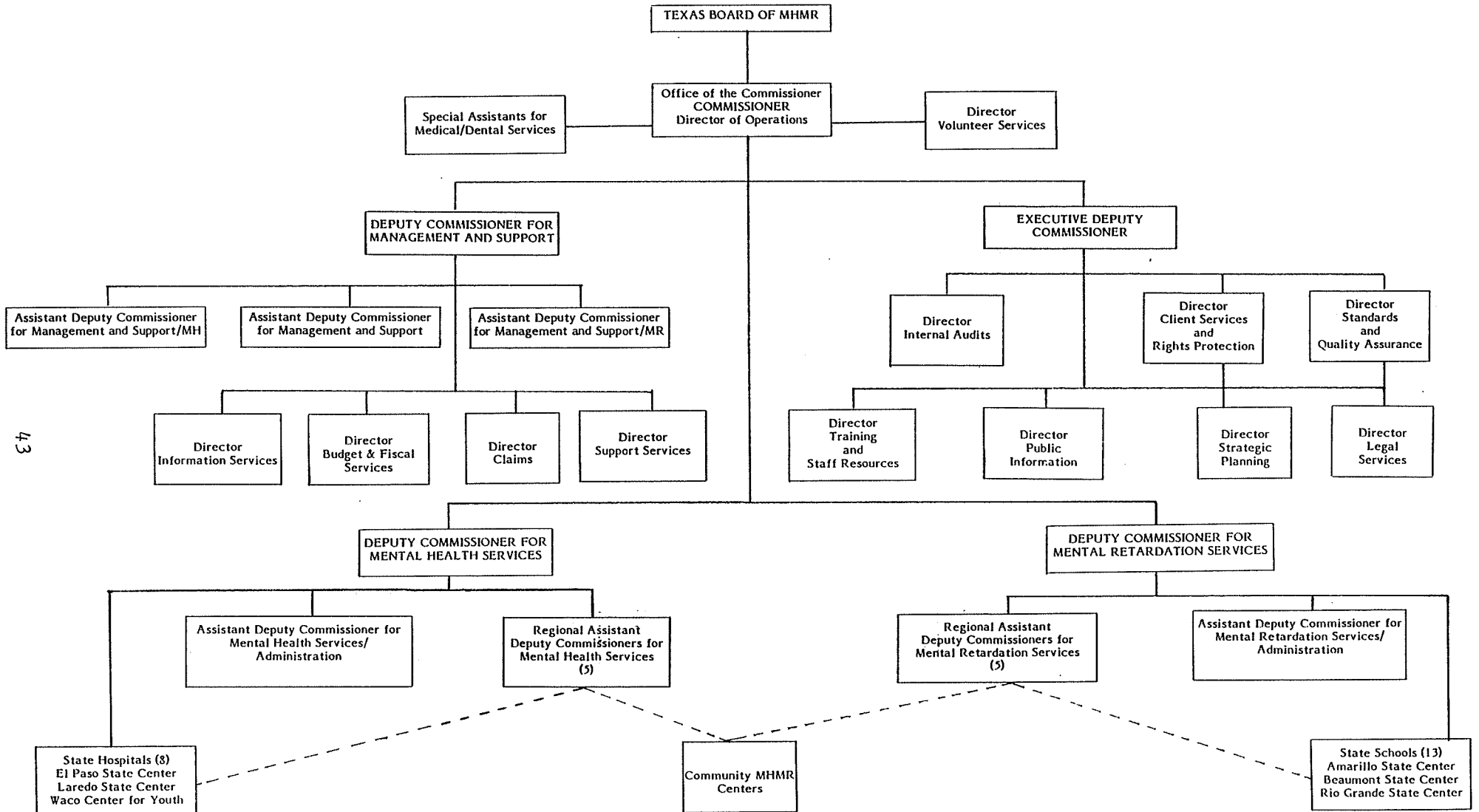
### **Quality Control and Staff Support Services**

The executive deputy commissioner is responsible for seven sections which provide quality control and staff support to all areas of the department. The client services and rights protection section investigates and resolves all reports of client abuse and neglect within the MHMR system, administers and monitors placements into TDMHMR's facilities and finds alternative community placements. The legal services section serves as legal counsel for the board, staff, and facilities of the department. It also serves as the liaison with the Office of the Attorney General which represents the department in litigation. The public information section publishes information about the department and manages the department's library and research service. The training and staff resources section administers and directs staff resources, staff development and continuing education as well as manages all personnel functions. This section also administers the statewide case management program. The strategic planning section coordinates the development of the department's long-range plan and serves as the department's principal liaison with other government agencies. The internal audit section provides information to the executive committee on the degree to which agency facilities, programs, and functions are operating in accordance with rules and regulations. Internal audit also conducts management audits of community MHMR centers. The standards and quality assurance section is responsible for reviewing the quality of care and services provided by the state facilities and community centers. This section also licenses private mental hospitals in the state, administers the rules' adoption and revision processes for the department, and conducts department-wide performance evaluation studies.

### **Management and Support Services**

The deputy commissioner for management and support is responsible for the overall management of the department's finances and budget as well as providing facility support services such as food, transportation, and construction. The deputy is assisted by three assistant deputy commissioners for management and support. Two of the three assistant deputies assist both state facility superintendents as well as community center executive directors with their financial management and budget concerns. The third assistant deputy is in charge of a small staff and provides management analysis services, oversees the telecommunications system,

Exhibit 3



Legend

Line Relationships \_\_\_\_\_  
 Represents Deputy Commissioner Regarding  
 Program Directors/Monitoring of Service  
 Contracts and Memoranda of Agreement - - - - -



and conducts special projects. In addition, there are four sections which report to the deputy commissioner for management and support. The claims section is responsible for administering state and federal laws and regulations that provide for reimbursement to the state for mental health and mental retardation services provided by the department. The information services section provides data processing support to the department, develops new systems, and provides training and technical support for users of automated data processing systems. The budget and fiscal services section provides the accounting, budgeting, payroll, and general financial management services for the central office and supervises those activities for the facilities. The support services section assists central office and the facilities in the areas of purchasing, transportation, food service, maintenance, and construction.

The department has recently created the position of "contracts manager" to coordinate and monitor all the activities associated with the department's performance contracts with community MHMR centers. That position is supervised by the deputy commissioner for management and support also.

#### **Mental Health Services**

The deputy commissioner for mental health is responsible for overseeing the application of the Mental Health Code in the state and directly supervises the state hospital superintendents and mental health services provided by state centers. The deputy is assisted by six assistant deputy commissioners for mental health. Five of the six are assigned to regions to serve as representatives of the deputy in the regions. However, the assistant deputies are officed in central office and have no line authority. The assistant deputies also negotiate the performance contracts between the department and community MHMR centers, as well as the performance memoranda between the department and state hospitals. The sixth assistant deputy serves as an administrative assistant to the deputy. The only other staff in this section are three secretaries and a director of alcohol and drug abuse services.

#### **Mental Retardation Services**

The deputy commissioner for mental retardation is responsible for providing programmatic direction and coordination of MR services in state facilities and the community centers. He directly supervises the state school superintendents and mental retardation services provided by state centers. The deputy is assisted by six assistant deputy commissioners for mental retardation. Five of the six are assigned to regions to serve as representatives of the deputy in the regions, but are

officed in the central office. They have no line authority. They also negotiate the performance contracts between the department and community centers as well as the performance memoranda between the department and the state schools and centers. The sixth assistant deputy serves as an administrative assistant to the deputy. In contrast to the mental health division, there are additional programmatic areas and staff associated with MR services. These include the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) program, the Intermediate Community Services (ICS) program, the Early Childhood Intervention program, the pilot projects for autism, the federal liaison worker program and a foster grandparent program. Many of these programs are partially or entirely federally funded. There are also eight regional monitors assigned out of MR services to monitor the community placements of the Lelsz class members.

### **The Service Population**

The department is responsible for providing and coordinating services for people with mental retardation and mental illness in Texas. Mental retardation and mental illness are separate conditions although they can occur in the same person. Both of these conditions range in severity from mild impairments to total and lifelong incapacitation. The department places a priority on serving people who are the most severely disabled by mental retardation or mental illness.

Mental illness is often temporary and reversible although, for many people, problems recur throughout life. It may strike at any time during a person's life. There are several factors that contribute to the development of mental disorders including psychological, biological, and genetic factors. Mental illness can cause people to lose touch with reality and often emotions interfere with their normal responses. The major psychoses, which include schizophrenia, are the most severe form of mental illness. These conditions often result in periodic episodes of acute mental illness which are usually controllable through medication. However, many have problems with employment and with maintaining a home due to the persistent effects of mental illness.

Mental retardation on the other hand is usually present from birth or early childhood. The person with mental retardation remains mentally handicapped throughout life, although special education, training, rehabilitation services, and proper care can assist the person in attaining his maximum potential. The mentally retarded person develops mentally at a consistently below average rate and has

unusual difficulty with learning and social adjustment. The degree of adjustment, as well as the ability to learn, varies with the degree of mental retardation. Mental retardation has a variety of causes including heredity, biological factors, and brain injury due to trauma or disease in early childhood.

### **Public MHMR Services**

The legislature created TDMHMR in 1965 to provide for the effective administration and coordination of mental health and mental retardation services at the state and local level. The legislature also authorized the development of community MHMR centers and charged them with developing services locally as alternatives to treatment in large state residential facilities. This combination of state and local initiatives has resulted in the development of a wide array of services for the mentally ill and mentally retarded people of Texas. The effective operation and expansion of this array of services requires a close working relationship between TDMHMR, community centers and other community providers.

### **Service Areas**

The department has developed several types of service regions throughout the state for the management of the service delivery system. As indicated by Exhibit 4 on page , the state is divided into 60 local service areas. For each local service area, TDMHMR has designated a mental health authority (MHA) and a mental retardation authority (MRA). These can be either a state facility or a community MHMR center. The local authority is responsible for either mental health or mental retardation services or for both types of services within the local service area. The state's 60 local service areas are divided into eight state hospital service districts, and 13 state school service districts. The service districts are used to determine which facility provides services to people living in the various service areas of the state.

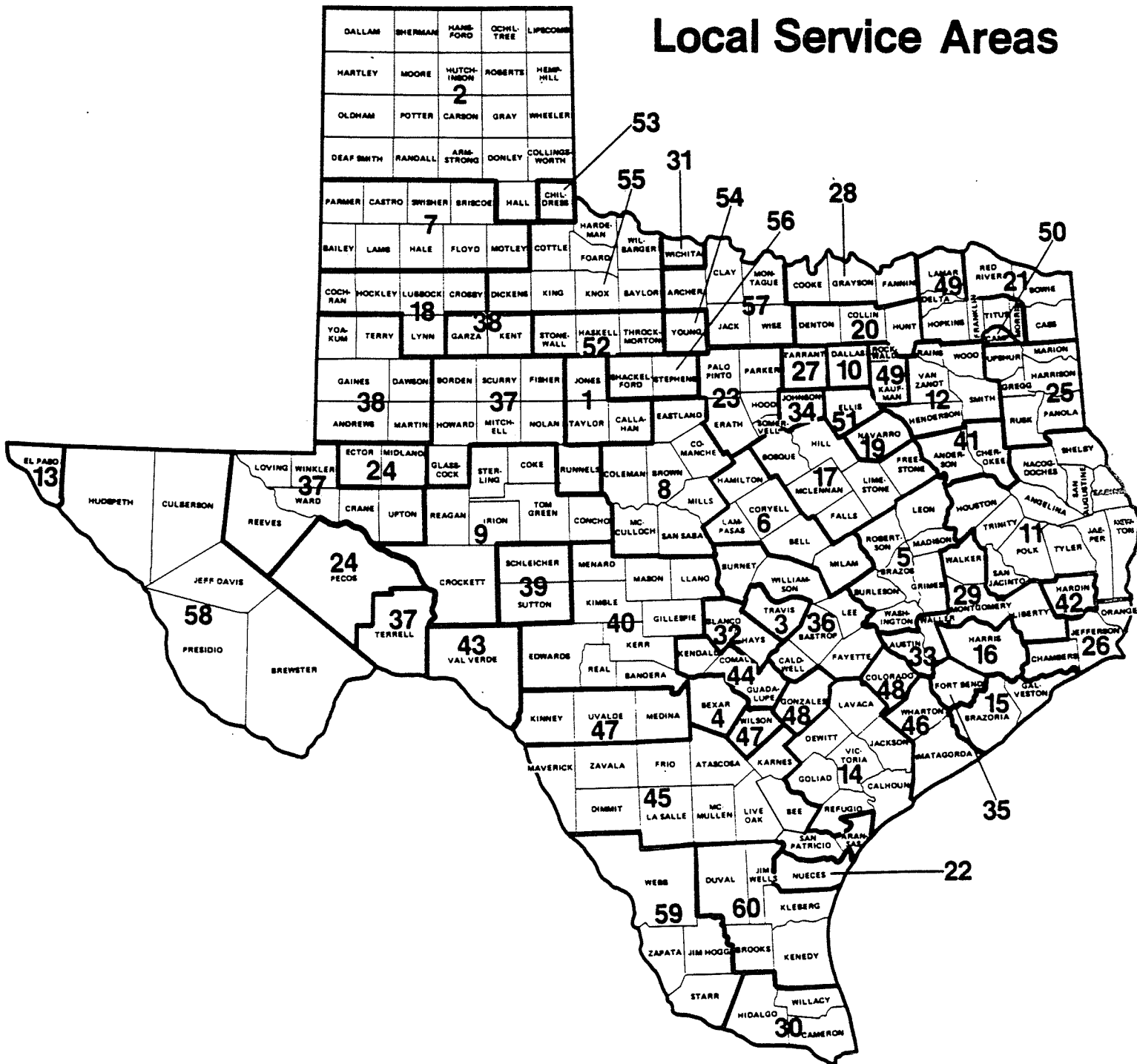
### **The State's Role in the Direct Provision of Services**

The state offers a wide variety of services through the operation of state residential and community-based treatment facilities and the funding of community MHMR centers. The state's main roles in direct service delivery include: 1) long-term residential care for people with mental retardation; 2) hospital-based psychiatric care for people with mental illness; and 3) community-based mental health and mental retardation services in areas of the state that do not have community MHMR centers.



# Texas Department of Mental Health and Mental Retardation

## Local Service Areas



The state judicial system has been given authority to order people to participate in both inpatient and outpatient treatment through TDMHMR. There are separate commitment procedures for people needing mental retardation services, mental health treatment, and substance abuse treatment. The TDMHMR is required to provide court-ordered services for mental health and substance abuse treatment, however, it must only provide residential mental retardation services when there is space available for the person. In fiscal year 1986, of the 18,314 people admitted to TDMHMR facilities, 11,179 were court committed for mental health services, 2,001 were committed for substance abuse services, 90 were committed for residential mental retardation services and 5,044 were admitted for services at their own request.

### Residential Services

The department provides its residential services through the operation of 13 state schools, eight state hospitals, and five state centers. State schools and state hospitals are facilities which range in size in fiscal year 1986 from Mexia State School with a census of 1,027, a staff of 1,600 employees, and a budget of \$28.2 million, to Big Spring State Hospital with a census of 337, a staff of 770 and a budget of \$14.9 million. In addition to rehabilitative treatment, most facilities operate the following services for the maintenance and operation of the facility: laundry, food service, pharmacy, laboratory, infirmary, barber shop and clothes supply, and ground, vehicle, and building maintenance. State centers operate residential services similar to state schools and hospitals but are much smaller. They will be discussed later.

### State Schools

The department provides residential care for people with mental retardation through the operation of 13 state schools and four state centers. These facilities provide rehabilitative services for people of all ages with various degrees of mental retardation. Their services include education, specialized therapies, basic skills training, health care and recreation. These are provided in a year round residential setting. Many of the residents have secondary physical handicaps. Provisions are made to correct or cope with the residents' physical handicaps. Currently, 12 of the 13 state schools operate a special independent school district for its residents. However, as of September 1, 1987, education services for school-age residents will become the responsibility of the local school district in which the state school is located.

In fiscal year 1986, the 13 state schools and the four state centers provided residential services to a daily average of 9,093 mentally retarded people. Of those residents, 89 percent had lived in a state facility over five years. In fiscal year 1986, TDMHMR had 13,750 employees in state schools with a total budget of \$246.3 million.

#### State Hospitals

The department provides hospital-based psychiatric care for people with mental illness and substance abuse problems through the operation of eight state hospitals and three state centers. People who are acutely mentally ill or suffer severe substance abuse problems sometimes require psychiatric hospitalization to protect them from harming themselves or others and to provide necessary treatment to control their illness sufficiently to return to community living. The courts are authorized to order people to participate in inpatient treatment in state hospitals for periods of time up to one year. The objectives of state hospital services include: 1) to provide each patient with high quality mental health, substance abuse, and medical services in a safe and humane environment; 2) to enhance the patient's ability to successfully function in the community; and 3) to expeditiously place each patient in the most appropriate least-restrictive environment possible. To meet these objectives each state hospital provides psychiatric, substance abuse, and medical treatment, specialized therapies, independent living skills training, and social services in a hospital-based setting.

Patients in state hospitals often have a very short hospital stay when compared to residents of state schools. People entering a state hospital in 1986 had an average stay of 35 days. In fact, approximately 40 percent of the people in the state hospitals have a length of stay of less than three months. However, a significant number have been in the hospital for much longer. Approximately 40 percent have been in the hospital for more than one year and 20 percent have been hospitalized over five years. In fiscal year 1986, the eight state hospitals had an average census of 4,164 patients, employed 8,875 staff, and had a total budget of \$172.9 million.

#### Waco Center for Youth

The department operates one facility which specializes in psychiatric residential treatment for children and youth. This facility is the Waco Center for Youth. In fiscal year 1986, it had an average census of 82 children. Children usually remain in treatment at the Waco Center for approximately four months. In

fiscal year 1986, TDMHMR employed 218 employees at this facility with a total budget of \$4.1 million.

### State Centers

The department operates five state centers which provide residential and hospital services much like state schools and state hospitals. However, state centers are much smaller than state hospitals and schools and provide a higher proportion of outpatient services. The five state centers include the Amarillo State Center, Beaumont State Center, El Paso State Center, Laredo State Center, and the Rio Grande State Center which is located in Harlingen. State centers are designed to offer a variety of services and may emphasize either mental health or mental retardation services depending on the other services available in the area. For example, Amarillo and Beaumont State Centers provide services only to people with mental retardation while the local community center provides mental health services. The other three state centers provide services to both populations. Services provided by the state centers include short-term residential services, skills training, education, outpatient treatment, and specialized therapies. Some state centers also provide long-term residential services and psychiatric hospitalization. In fiscal year 1986, TDMHMR employed 1,250 people in the five state centers. They had an average inpatient census of 344 and provided outpatient services to 3,600 people. They had a total fiscal year 1986 budget of \$25.6 million.

### Facilities Being Developed

The 67th Legislature appropriated \$12 million for the construction of a new Houston Psychiatric Hospital. Harris County contributed an additional \$12 million. When opened, the facility will be operated by the University of Texas System as a teaching hospital and will be jointly funded by the state and Harris County. The facility will provide 250 psychiatric beds at a total cost of \$16 million per year, of which 92 percent is supported through general revenue. This facility is scheduled to open in November of 1986.

The 68th Legislature appropriated \$3 million for the planning and construction of the Fort Worth Psychiatric Hospital with a capacity for 56 patients. The hospital operations will be contracted to Tarrant County MHMR center when opened. The hospital will provide a full range of psychiatric inpatient services to children and adults who live in Tarrant County with an annual budget of \$3.5 million. This facility is scheduled to open in May 1987.

### **State Facility Community Programs**

State facilities are designated as the mental health authority (MHA) or mental retardation authority (MRA) for a local service area if there is no community center in the area. State facilities are the MHA in 119 counties and the MRA in 142 counties in Texas. In those counties, the state facility is responsible for providing community-based services to people in the local service area as well as residential services. While S.B. 633 only established core service requirements for areas served by community programs that contract with TDMHMR, the department is working to make the core services available to people in all local service areas of the state.

State facility community programs often provide services through small satellite clinics in the counties they serve. In fiscal year 1986, state facilities provided community-based services to 20,500 people through 150 clinic sites. The total budget for facility provided community programs in fiscal year 1986 was \$56.1 million.

### **Volunteer Services**

Volunteers make many important contributions to the TDMHMR's state hospitals, schools and centers. Not only are volunteers helpful to the facilities in such traditional areas as fund raising and publicity, but volunteers also serve in many roles critical to the clients' welfare. For example, volunteers monitor the civil rights of clients, serve on client abuse committees, advocate for clients and serve as federally mandated surrogate parents for school-age clients. Many are also involved directly in client care and serve on interdisciplinary teams. The Volunteer Services State Council was established 27 years ago and coordinates the efforts of 27 local Volunteer Services Councils located at each of the state facilities. Each local council is a chartered, non-profit organization. In fiscal year 1985, approximately 12,000 volunteers donated over 894,000 hours of service and brought in contributions exceeding \$8.5 million. These contributions represent an almost five-fold return on the state's investment in the TDMHMR's volunteer services budget. A long-range goal of the Volunteer Service Council is to extend their services to the community mental health and mental retardation centers.

### **The Community Provider's Role in Services**

The department's enabling legislation established the state's policy with regard to direct service provision. This policy is to encourage local agencies and private organizations to assume responsibility for direct service delivery when



possible. As a result, a number of different types of community providers now offer services to people with mental retardation and mental illness in Texas. Community providers in Texas include charitable organizations, proprietary corporations, community MHMR centers, private ICF-MR providers, individuals who operate boarding homes, private practitioners, independent school districts, and others.

The 119 private ICF-MR facilities in Texas offer a significant resource for long-term residential services for people with mental retardation. The 55 private psychiatric hospitals in Texas have a capacity to treat approximately 5,300 patients. In addition, there are a wide range of privately operated group homes, boarding homes, and schools which provide a significant amount of mental health and mental retardation services in the state.

### **Community MHMR Centers**

Approximately 83 percent of the state's population lives in the 112 counties where the 31 community MHMR centers provide services. Each community center receives a majority of its funding through TDMHMR but is managed locally through a board of trustees. Community centers must operate through policies which are consistent with those developed by TDMHMR. Community centers range in size from 700 employees with a total budget of \$34 million to 15 employees with a total budget of \$510,000. The community center is usually designated as the mental health authority (MHA) and mental retardation authority (MRA) and is responsible for the provision of all core services for its local service area as a condition of state funding. As mentioned before, these services include crisis services, community-based crisis hospitalization, evaluation services, family support services, and case management. In addition, many community centers provide other services such as outpatient therapy, referral services, day programs, sheltered workshops, group homes, and consultation services for other community agencies. Three community centers only provide mental health services, MHMR of Southeast Texas in Beaumont, Navarro County MHMR Center, and the Texas Panhandle Mental Health Authority in Amarillo. The other 28 centers provide both mental health and mental retardation services.

Community centers provide many residential services for mentally ill and mentally retarded people. All are required to provide crisis residential services since it is a core service. Many also operate long-term beds in group homes, short-term respite care, detoxification units for substance abusers, ICF-MR facilities, halfway houses, and supervised apartment programs.

Community centers provide the majority of their services on an outpatient basis. Crisis services, diagnostics and evaluation, family support services, and case management are core services which are usually provided on an outpatient basis. In addition, many centers provide referral services, medication management services, vocational rehabilitation, social services, and skills training.

In fiscal year 1986, the 31 community centers provided services to approximately 151,000 individuals with a total budget of \$183.6 million. The department provided an average of 60 percent of the community center's total operating funds. They had a total work force of approximately 5,650 employees.

### **Summary of Major Law Suits**

The policies, operations, and budget of the TDMHMR are greatly impacted by two federal class action law-suits. One suit, R.A.J. vs. Miller involves mental health services and the other, Lelsz vs. Kavanagh involves mental retardation services. Both suits were filed in 1974. The R.A.J. vs. Miller suit was settled in 1981 and the Lelsz vs. Kavanagh suit was settled in 1983. The agency is currently operating under settlement agreements in both cases.

The R.A.J. suit covers all eight state hospitals. The key issues in the R.A.J. Settlement Agreement and subsequent court orders involve requirements for individual treatment plans for clients, staffing levels, patient safety, the prescription of medication, and the level of programming.

The Lelsz case involves some of the same types of issues, but specifically names only three out of thirteen state schools. In addition the Lelsz Settlement Agreement requires that clients be placed in the "least restrictive environment". The court has ordered the department to place in the community 279 clients residing in the three named state schools, Austin State School, Fort Worth State School, and Denton State School. This order has created a controversy over the court's ability to establish quotas for community placements, an issue which the department has taken to the Fifth Circuit Court of Appeals.

As a result of these law-suits, the department has asked for and received additional funds to achieve compliance with the settlement agreements. These funds have been used primarily to provide incentives to community programs to serve people who are currently being served in state schools and state hospitals. In the area of mental health, community programs receive \$35.50 for each reduction in state hospital bed day utilization for which they are responsible. On the mental retardation side, community programs receive \$55.60 per day for each individual client that is placed from a state school.

A third federal law suit, Griffith vs. Bynum, is having a significant impact on services in state schools. The Griffith suit was filed in 1982 and settled in 1985. It alleged that school age residents of state schools were not receiving an appropriate or adequate education. The settlement of the suit requires the integration of these residents into the special education classes of the local school districts in which the state schools are located.



## REVIEW OF OPERATIONS

### Explanation of the Focus of the Sunset Review

The size of the agency, as well as its involvement in two federal court suits dictated a need to carefully select areas for the review of TDMHMR. To determine those areas, a number of activities were undertaken, including:

- overview discussions with key staff people in TDMHMR's central office;
- site visits to five state hospitals, five state schools, three state centers, twelve community centers, and the Waco Center for Youth;
- review of past legislation and reports prepared by the Legislative Oversight Committee on Mental Health and Mental Retardation, as well as other studies of the department; and
- group and individual meetings with advocacy groups, associations, and other persons knowledgeable of the agency.

These activities provided a general understanding of the various components of the mental health and mental retardation service system and the problems faced by both the service providers and the service recipients. Some of the identified problems could not be addressed because of their relationship to the R.A.J. and Lelsz law suits. Others are more appropriately addressed by the appropriations process. The remaining problems were related to the following five key questions.

- Who should be served by the state?
- What organizational structure could best provide those services?
- What services are needed?
- How can the agency's limited resources be maximized?
- How can accountability be increased while eliminating duplicative or unnecessary monitoring?

To answer those questions it was necessary to examine the direction the state was moving in the provision of mental health and mental retardation services and how that should be modified. The goal was two-fold. First, the development of a streamlined organization with clear policies and plans for providing a balanced array of services to those people with the greatest needs was desired. Second, to ensure this could occur, improvement was needed in both funding mechanisms and public accountability. The following recommendations were developed to achieve this goal.



## POLICY-MAKING STRUCTURE

The evaluation of the policy-making structure was designed to determine if the current statutory structure contains provisions that ensure adequate executive and legislative control over the organization of the board, a proper balance of interests within its composition, an effective means of selection and removal of its members, and the proper structure and use of the policy-making body's advisory committees. The review of the policy-making structure indicated that the TDMHMR board's utilization of the Citizens' Planning Advisory Committee could be improved. Greater utilization of this committee would ensure that the board has adequate information necessary for key policy and budgetary decisions.

### The Lack of Specificity in the Statute Regarding the Citizens' Planning Advisory Committee's Size, Composition, and Role has Hampered its Performance.

The Legislative Oversight Committee on Mental Health and Mental Retardation identified the need for the department to develop a long-range plan to ensure that services are provided in a responsive, efficient, and cost-effective manner. To assist in this process, the 69th Legislature created the Citizens' Planning Advisory Committee (CPAC). The statute requires the CPAC to advise the department on all stages of the development and implementation of the agency's long-range strategic plan. During the review it was determined that the committee's size, composition, and lack of clear role definition had hampered its ability to advise the department. To correct this problem, the following recommendations are made.

- **The size of the committee should be reduced from 21 to nine members.**

Currently the CPAC has 21 members appointed by the board. The size has impaired the committee's ability to make decisions in a timely fashion. Providing input to the board in a timely manner is a necessity if the board is to use this information for key policy and budgetary decisions.

- **The composition of the committee should be specified in statute.**

The committee currently consists of two representatives of the department's mental health advisory committee; two representatives of the

mental retardation advisory committee; 11 consumers, providers, and advocates of MHMR services; and six ex-officio members representing other state agencies. This committee should be structured to provide a formal mechanism for input that would not otherwise be available in the planning process. Eliminating the representatives of the mental health and mental retardation advisory committees, as well as the state agency representatives, would not eliminate input to the department from any of these entities.

The purpose of the committee should not be to represent any particular consumer group or special interest but rather to guide the department in its planning for the provision of a balanced array of services. To ensure this, the statute should be amended to require the board to appoint: a) six members who have demonstrated an interest and knowledge about the TDMHMR system and the legal, political, and economic environment in which it operates; and b) three members who have expertise in the development and implementation of long-range plans.

- **The role of the CPAC should be clarified in statute.**

Currently the CPAC's responsibility to advise the department on its long-range plan is broadly stated. To ensure that the plan becomes an integral part of the decisions and policies set by the board, the following statutory changes are needed: a) the committee shall review the development, implementation, and any necessary revisions of the department's long-range plan; b) the committee shall review the department's biennial budget request and assess the degree to which it allows for implementation of the plan; c) the committee shall advise the board on the appropriateness of the plan, any identified problems related to its implementation, any revisions to the plan that are necessary, and the adequacy of the department's budget request; and d) the committee shall provide copies of its reports to the board, as well as to the governor, lieutenant governor, speaker of the house, and the appropriate committees of the legislature.



- **The board's and the department's responsibilities relating to the CPAC should be statutory.**

For the CPAC to fulfill its duties, the department must provide certain information and support. The statute should require the department to do the following: a) prior to any presentation to the board related to the development, implementation or revisions of the plan, the information to be presented shall be provided to the members of the CPAC in a timely fashion; b) prior to submitting the agency's biennial budget request to the board for discussion or approval, a copy shall be provided to the members of CPAC in a timely fashion; and c) the staff support necessary to allow the CPAC to fulfill its duties shall be provided.

To ensure that the input of the CPAC is given full consideration, the board should be required to: a) review the committee's reports in conjunction with information provided by the department on the long-range plan or the biennial budget request; and b) to allow the committee opportunities to appear before the board as needed.



## OVERALL ADMINISTRATION

The evaluation of the overall agency administration was designed to determine whether the management policies and procedures and the monitoring of agency management practices were consistent with the general practices used for internal management of time, personnel and funds. To evaluate the administration of an agency as large as TDMHMR, it was necessary to focus our efforts on issues that related to the four broad areas of organizational structure, accountability, monitoring, and fiscal management. The review indicated improvements could be made to enhance the TDMHMR system in those areas. Recommendations were needed to 1) provide an organizational structure that is more responsive to the needs of the individuals receiving services and the various components of the system; 2) improve public confidence in the TDMHMR system by increasing accountability; 3) reduce monitoring that is duplicative or unnecessary and determine where monitoring efforts could be more effective; and 4) maximize the agency's use of its limited resources by improving funding mechanisms and ensuring that support functions and services are obtained in the most cost-effective fashion. Recommendations to address those areas are described in the following material.

## EVALUATION OF ORGANIZATIONAL STRUCTURE

The review of the department's organizational structure was designed to determine whether it provided management flexibility, adequate coordination, a sound planning structure, and clear and balanced lines of communication and authority. This review indicated that improvements could be made in a number of areas which would allow the agency to function more smoothly. Recommendations are made which would clarify the role of the assistant deputy commissioners, strengthen the department's planning function, eliminate unnecessary controls, increase input from the local level, simplify administrative compliance with the Griffith suit, and clarify the relationship between the department and community MHMR centers. A discussion of each individual recommendation is contained in the material that follows.

**Modifications in the Organizational Structure and the Development of an Operational Plan Would Improve TDMHMR's Ability to Carry Out Its Long-Range Plan.**

Senate Bill 633, passed by the 69th Legislature, requires TDMHMR to initiate a long-range plan of at least six years' length and update the plan every two years. It is vital that a long-range plan be operationalized in order to effectively carry out the mission and goals of the agency. However, the department's original timetable of March, 1986 for modifying its goals and objectives, as stated in the Initial Strategic Plan, has not been achieved but is scheduled for board action in October 1986. The operational plan should be developed expeditiously since the lack of a plan adversely affects the staff of central office, the state facilities, community centers, and others in their organizational planning and implementation responsibilities.

The difficulty in operationalizing the long-range plan may be compounded by the current organizational structure and division of responsibility. Currently, the office of strategic planning is responsible to the executive deputy commissioner while the budgetary functions are the responsibility of the deputy commissioner for management and support. It would be useful to reorganize these related functions under one deputy commissioner to enable the budget to be more closely tied to the planning process. The following recommendations address the two identified problems.

- **The department should develop an operational plan, based on the long-range plan, with specific short-term goals, objectives, timetables, and desired outcomes.**

An operational plan would delineate the steps the agency should take to achieve its long-range plan. Developing clear objectives, timetables, and outcome measures allows the department to assess its progress in reaching these long-range goals. An operational plan should be developed annually in conjunction with the development of the agency's operating budget.

- **The office of strategic planning should be reorganized under the deputy commissioner for management and support.**

This change would allow closely related activities to be linked together in a more efficient manner.

### **Statutory Titles and Facility Names Reduce Management Flexibility.**

The Texas MHMR Act defines the composition of the department by listing the key components (Article 5547-202, Section 2.01.). The elements of the department now mandated by the Act currently include the Board of Mental Health and Mental Retardation, the commissioner, the director of operations, an executive deputy commissioner and three deputy commissioners. Furthermore, the Act names all 30 facilities and institutions currently and formerly operated by the department. In the past, these provisions may have been beneficial in determining where and how appropriations could be made but they no longer appear useful. Factors facing the agency today, such as the prevailing economic conditions, unsettled litigation and the continuing shift of clients into community programs, require a responsive central organization that can meet changing demands with efficiency.

One area where more statutory latitude may improve management efficiency would be in removing the abundance of administrative titles named in Section 2.01 and the qualifications of the deputy commissioners found in Section 2.08. The review showed that the naming of administrative staff or their qualifications below the chief executive officer was not a usual practice found in state law. For example, the statutes creating the Department of Health and the Department of Human Services refer only to their board, the commissioner and an "administrative staff" or "other officers and employees" required to efficiently carry out their statutory purpose. Naming administrative staff below the chief executive officer places unnecessary constraints on the organizational pattern since any change or reorganization must include all those listed in statute even if their function is no longer needed.

An agency should have flexibility to change its organizational pattern to most efficiently carry out its purpose. Any limits on this flexibility should be based on a specific problem or need. The 69th Legislature addressed such a specific need at TDMHMR with the addition of the director of operations position. The review indicated that position title should be retained in statute because it was specifically added to assure "... the effectual and efficient administration of the department" (Article 5547-202., Section 207.(e), V.T.C.S.). The need or importance of this function has not diminished over the last biennium.

A second and related area where improvement could occur is by removing the title of the facilities and institutions currently named in the Act. They are out of

step with the consolidated appropriations bill pattern which was initiated during the 67th legislative session. The appropriations pattern was changed to allow the department greater budget flexibility in order to transfer funds between facilities or institutions as necessary. Furthermore, the Legislative Budget Board staff is currently considering an additional change to the appropriations bill to remove references to each facility or institution. To address the identified problems, the following recommendations are made.

- **References to deputy commissioners and their qualifications should be removed from the statute.**

This change would add management flexibility and be more consistent with other state agencies.

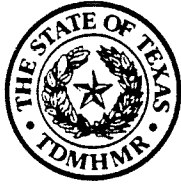
- **The names of specific facilities and institutions operated by the department should be removed from statute.**

The effect of this change would not only allow the transfer of funds between facilities to continue, but facilitate any need on the part of the agency for reorganization purposes. A statutory change in the TDMHMR Act is needed if the intent of the appropriations bill and statute are to be consistent.

#### **Better Definition of the Role of Assistant Deputy Commissioners Would Improve Overall Management.**

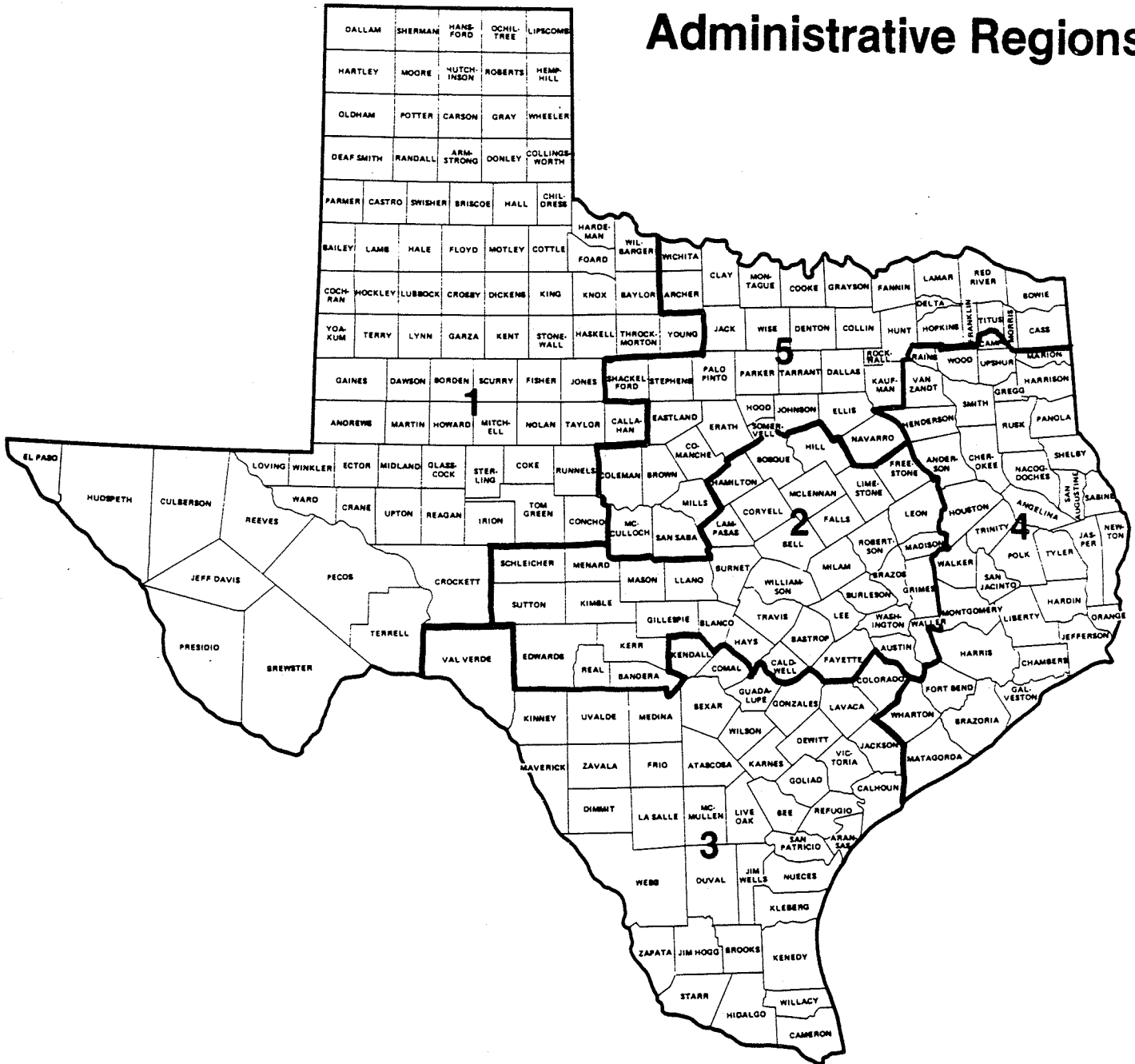
Currently, the department has 15 assistant deputy commissioners working out of the central office. Ten of the 15 are assigned to the department's five administrative regions. (See Exhibit 5 for administrative regions.) Each region has two assistant deputy commissioners who individually represent the deputy commissioner for mental health services and the deputy commissioner for mental retardation services. In addition, each region is supported by two assistant deputy commissioners for management and support, who assist in budget and fiscal matters. Collectively, these 12 assistant deputies are responsible for all state facilities and community centers. Their primary role is to monitor all performance contracts and agreements, provide programmatic guidance, implement state policies, and assist in budget development and ongoing financial management.

During the review process, three problems with the current structure were identified. First, there is a great deal of confusion over the assistant deputy



# Texas Department of Mental Health and Mental Retardation

## Administrative Regions



commissioners' level of authority and responsibility. Second, there are two assistant deputy commissioners per region dealing with programmatic issues plus two assistant deputies dealing with management matters. This requires communication with multiple individuals to get a question answered or problem resolved. Often they do not have access to the information or the technical expertise needed to answer the question nor the authority to resolve the problem. Third, the current structure does not encourage regional coordination of services or allow for adequate consideration of local input in the development of departmental policies, plans, and budgets. These problems were identified by numerous facility and community center staff, central office staff, including some assistant deputy commissioners, survey results, review of travel records, and findings from the agency's management study group.

In addition to the number of assistant deputies per region, a compounding problem was found in the excessive amount of time assistant deputy commissioners were assigned to central office projects. Frequently their efforts were allocated to task force problems, policy development, or internal coordination with other divisions. The review showed that less than 20 percent of their time was spent in the region. This creates three problems. It impedes the assistant deputies' ability to carry out their primary roles. It limits their ability to determine the needs of their region and how services could be coordinated better. In addition, it limits their ability to provide technical assistance to the community centers and state facilities in their assigned region. However, a survey of the assistant deputy commissioners showed a strong systemwide need for additional technical assistance in programmatic areas such as how best to serve rural populations, improving vocational training, utilizing special adaptive equipment and networking services in the community.

The review indicated a disparity between the multifaceted needs of the field facilities and community centers and what and how assistance is provided through central office. To correct this disparity, the following changes are needed to clarify the role and improve the effectiveness of the assistant deputy commissioners.



- **Formal communication between regional assistant deputy commissioners and members of the department's central office executive committee should be strengthened.**

The department should revise its meeting schedule to ensure that assistant deputy commissioners have the opportunity to interact at least once every two weeks with the central office executive committee (commissioner, director of operations, and deputy commissioners). In addition, the deputy commissioners should ensure that their assistant deputies stay up to date with developments in their respective program areas.

- **The regional assistant deputy commissioners' activities should be balanced between time spent in the region and time spent in central office.**

The responsibilities of and subsequent allocation of time for the regional assistant deputy commissioners should be modified so that at least three-fifths of their time is spent in the regions and two-fifths in central office. This arrangement will free up the assistant deputies to spend more time in the regions, while assuring that sufficient time is spent in central office to remain in close touch with developments there.

- **The department should institute management and programmatic training as necessary to sharpen the skills and effectiveness of regional assistant deputy commissioners.**

The department's Office of Training and Staff Resources should work with the deputy and assistant deputy commissioners to establish individual staff development plans for each assistant deputy commissioner. The staff development plans should prescribe training and educational experiences to improve management capability and provide for specialized training that can increase programmatic assistance to field operations. A mechanism should be established by the department to ensure that the staff development plans are implemented.

- **The department should revise the position descriptions for the regional assistant deputy commissioners.**

Such revision should provide further clarification of the responsibilities and level of authority of the assistant deputy commissioners. The job

descriptions should be reviewed annually to determine if further modifications are needed.

### **Services Could be Strengthened by Regional Planning.**

For many years, the TDMHMR service delivery system has been the subject of much debate. Much of it has been the result of the shift from institutional services to serving more people through community-based programs. This shift has resulted in a wider array of services being available throughout the state, requiring increased coordination to achieve an integrated service delivery system.

Texas, being a large and diverse state with numerous geographic, demographic and cultural differences, requires a management strategy that is sensitive to these factors. The TDMHMR uses several existing methods that involve dividing programs along various regional boundaries. As described in the previous recommendation, the facilities and community centers are monitored by 10 assistant deputy commissioners assigned to one of five administrative regions. While a regional framework appears to be a useful management tool, field visits, interest groups and management studies have shown inadequate regional coordination and consideration of regional input in the development of agency policies, plans and budgets.

Currently, there are no formal policies requiring facilities and centers within a given region to develop a regional service plan although the benefits to such an approach have been demonstrated. One known example involves the efforts among eight centers and facilities in the east Texas area who cooperatively developed a comprehensive mental health and mental retardation delivery system. In December of 1979, the "East Texas Roundtable" of chief executive officers formed a management team to address the issues of continuity of care, joint budget planning, and overall enhancement of MHMR services. Through financial incentives developed by TDMHMR, the roundtable was able to start new programs and strengthen existing ones while assisting the department in complying with the R.A.J. Settlement Agreement. Overall, they were responsible for 21 percent of the state's community mental health placements, although they account for only about 10.5 percent of the state's population. Results like these suggest that additional benefits could be realized through regional coordination and planning if it was done on a statewide basis. The following recommendations would assure the implementation of this concept.

- **The department should establish regional planning councils composed of the chief executive officers of state facilities, community centers, and designated providers of core services, to coordinate planning, budgeting, and service delivery.**

This statutory change would assure those involved in service delivery could assist the department in developing a plan that would make the most efficient use of limited resources to provide the most effective services possible. This would include determining where joint efforts to provide services would be productive.

- **Each council should be chaired by the department employee who is responsible for the services in a region. The chairperson should be fully integrated into the departmental decision making framework.**

This statutory change will facilitate joint planning and coordination of services in a region, in a manner that is consistent with the department's goals. It will give the department the flexibility to select, as the chairpersons, the primary representatives of the central administration to the field operations. Selecting a person included in the decision making process, will assure that local concerns are recognized at the highest administrative levels.

- **Each council should develop a long-range regional plan that describes the appropriate use of facilities, the configuration of the service delivery system, and includes a comprehensive needs assessment and resource inventory that can be used by central office to revise and update the statewide long-range strategic plan.**

Receiving local input from all regions of the state should assist the department in meeting its statutory mandate to develop and update its long-range plan. It should also ensure that local service plans are implemented. (See related recommendation on page 71.)

- **Each council should develop an operational plan for its region based on the department's long-range plan and the corresponding allocation of funds and responsibilities to each community center, designated provider, and state facility, as defined in their performance contracts and memoranda.**

This statutory change ensures that the department continues to provide policy direction and to define what services are needed statewide while giving the regional councils the authority to implement the policies and

services in the manner best suited to their clients' needs. (See related recommendation on page 64.)

**Better Coordination Between Multiple Agencies Serving People with Mental Illness and Mental Retardation is Needed.**

In many urban areas of the state, TDMHMR facilities, community centers and private providers offer services to people with mental illness and mental retardation. Often, providers in an area develop or reduce services without sufficient knowledge of how other area providers plan to change their services. Participation from state, local, and private providers in formalized area service planning could allow providers to ensure that the new services they develop will compliment rather than duplicate the existing services available. Local service planning can also identify similar support functions which are performed by various agencies. Such functions can present opportunities for savings when performed jointly or through contract with another agency.

While other recommendations in the report address the need for regional planning, additional benefits can be gained when formal planning also focuses on services provided within a smaller area. The Austin area provides a good example of potential benefits possible through local service area planning. The Austin service area consists of Travis County. In this service area, there are three state facilities, Austin State School, Travis State School, and Austin State Hospital, as well as Austin-Travis County MHMR Center. Each facility, as well as the community center, operates similar facility administration services such as claims, personnel, data processing, printing, and staff development. The three state facilities each operate support services such as laundry, food service, and building maintenance, and specialized treatment programs such as dental services, laboratories, pharmacies, recreation programs, sheltered workshops, and infirmaries. Despite the potential duplication and apparent need to carefully plan the Austin service delivery system, the agencies have not developed any formal local planning mechanism. Recognizing the potential savings available through local planning, the 69th Legislature attached a rider to TDMHMR's appropriation which requires the agency to identify functions of the three state facilities located in Austin which could be performed either through contracts with the private sector or through combination into one functional unit.

The Texas Department of Mental Health and Mental Retardation has divided the state into 60 local service areas. Most TDMHMR local service areas that have both facilities and community centers are urban, single county service areas. Focusing additional planning on these local service areas can highlight opportunities which are available solely because of the facilities' close proximity. The following recommendation is designed to maximize the benefits available from local planning by formalizing the process. The products of these local efforts will assist the regional planning councils by providing a detailed analysis of potential changes needed in areas with many service providers.

- **All TDMHMR facilities and community centers which operate facilities in the same local service area should submit annual agreements to their regional planning council and to the TDMHMR documenting their efforts to develop a comprehensive array of services and plans to coordinate and/or integrate services to reduce duplication.**

This will require 17 local service areas to develop annual plans. The local service area plans will focus on the resources available in the area, the reduction of duplication through combined functions, and the development of a comprehensive array of services in the area. This planning should concern client services as well as support functions, whenever appropriate. It will be submitted to the department, and presented to the regional planning councils for inclusion in the regional plan. (See recommendation on page 69.)

- **The regional planning councils should establish time frames and interim reporting requirements to ensure the completion of local service area agreements.**

This will allow each regional council to establish local requirements that address the specific needs of an area.

#### **Relationships Between the TDMHMR and Community MHMR Centers Should be Clarified.**

In recent years many questions have been raised regarding the relationship between community MHMR centers and the TDMHMR. The statute specifies that the community centers are "agencies of the state". It also specifies, however, that they are created by one or more local political subdivisions, and that their employees are to have rights, privileges and benefits consistent with those

available to employees of the governing bodies which establish the centers. A local board is responsible for the policy-making and administration of the centers, but the department is authorized to prescribe rules, regulations and standards for community centers. Some feel the relationship between the TDMHMR and community MHMR centers should be strictly a contractual one, while others see community centers as an extension of the department. This lack of consensus regarding the role of community centers with respect to the TDMHMR has resulted in a number of problems and unanswered questions. Many of these problems and questions involve the degree of control exercised by the TDMHMR over programs and funds of community centers.

The review indicated that some statutory adjustments should be made to further define and clarify the relationship between the TDMHMR and community MHMR centers. These adjustments are needed because community centers play a much greater role within the statewide service delivery system today than they did just a few years ago. This trend is expected to continue into the foreseeable future.

Along with the greater role played by community centers has come an increased number of requirements and responsibilities from the TDMHMR and the legislature. As a general rule, an increase in authority should accompany an increase in responsibilities. While some of the recommendations in the report that deal with regional planning and single portal of entry do enhance the authority of community centers, two additional changes are necessary to achieve a proper balance.

First, TDMHMR currently controls almost every aspect of a community center's operations. This control can be exercised by requiring services to be of a certain type, patterned after a certain model, or meeting certain standards, but not fully funding these requirements. By doing this, the TDMHMR can force local resources to be shifted from local programs to programs the department wants the centers to operate. If centers refuse to comply, the TDMHMR can withhold contract funds. This has resulted in community centers being required by the TDMHMR to discontinue services that were either locally funded or supported by client fees. When this happens, community centers have indicated that sponsoring counties or cities become more reluctant to support their community MHMR centers because they do not feel the centers are responding to local needs. A community center should be able to provide a service to its community if the

community is willing to fund that service over and above its local match requirement for state funds.

Second, the TDMHMR has the authority to allocate and withhold funds from a community MHMR center at its own discretion. The discretionary allocation of funds makes it difficult for centers to plan, and withholding funds can have a devastating effect on the operations of a community center. Once a center has negotiated a contract with the central office of TDMHMR, an operating budget is developed on the assumption that funds will come into the center from TDMHMR as agreed upon under the contract. If those funds are withheld, a center may not be able to meet its financial commitments, such as the payroll, insurance premiums, or lease agreements. This situation could negatively impact the care that clients receive. Other state agencies which use service contracts extensively, such as the Department of Human Services and the State Purchasing and General Services Commission, resolve disputes regarding their contracts through the process outlined by the Administrative Procedure and Texas Register Act (APTRA). The APTRA is not followed by the TDMHMR because the department was specifically exempted from that act when it was written. However, at that time, the TDMHMR funded community programs through grants-in-aid to community MHMR centers as opposed to the performance contracts currently being used. Since other primary users of service contracts consider service contracts to be subject to APTRA, and since it was grants-in-aid which were exempted from APTRA requirements and the TDMHMR no longer uses grants-in-aid, the APTRA should apply to the department's service contracts.

The following recommendations will address the problems identified regarding the TDMHMR's level of control over community centers and the need for due process in resolving disputes between the department and community programs.

- o **The TDMHMR should not control programs that do not receive state funds and do not use funds that are part of the required local match.**

This would encourage local support of community centers and reduce the cost to the TDMHMR of overseeing these programs. (See related recommendation, page 87.) The TDMHMR would still have the authority to investigate any programs for due cause.

- **Contract disputes between the TDMHMR and community programs should be subject to the Administrative Procedure and Texas Register Act.**

This would provide a fair mechanism for addressing disputes between the TDMHMR and its community providers regarding service contracts.

### **Transfer of Retirement Benefits Would Provide Equity.**

Currently 12 of TDMHMR's state schools are considered independent school districts and are responsible for providing appropriate educational services to school-age residents. However, in 1982, the Griffith vs. Bynum suit was filed in U.S. District Court on behalf of a resident of Brenham State School and others similarly situated. The suit alleged that school-age residents of state schools for the mentally retarded were not receiving an appropriate education as that term is used in the Texas Constitution or an adequate education as required by P.L. 94-142. A settlement agreement was obtained in 1985. The terms include an agreement by the Texas Education Agency (TEA), for itself and on behalf of all local independent school districts, that TEA would assume responsibility for educating the school-age residents of TDMHMR's state schools. This involves all of the state schools except San Angelo since it does not have any school-age residents. A memorandum of understanding between TDMHMR and TEA provides that by September 1, 1987, all school-age residents will be integrated into the special education classes of the 12 local school districts in which the 12 named state schools are located.

The review of this change in responsibility from TDMHMR to TEA and the local school districts revealed a related administrative problem. There are currently 126 employees of TDMHMR who are covered by the Teacher Retirement System (TRS). These employees are either certified teachers, teacher supervisors, or non-certified teachers who provide educational services to school age clients in the special education departments of state schools. In addition, there are 261 TDMHMR employees providing educational services, primarily as teacher's aides, who are covered by the Employees Retirement System (ERS). Elimination of these 387 positions creates a potential retirement benefits problem for these employees since reciprocity between TRS and ERS was eliminated in 1980. If the TRS covered employees stay with TDMHMR, they will be required to become members of the ERS system. If the ERS covered employees go to work for a local school district, they will be required to become members of the TRS system. For both



groups, this split in service will be to their disadvantage financially when they retire.

The state faced a similar situation when the Texas Research Institute of Mental Sciences (TRIMS) was transferred to the University of Texas System by the 69th Legislature. To deal with this, the Texas Education Code was amended to allow the ERS service credit of TRIMS' employees who went to work for the UT System to be transferred to TRS. A similar statutory provision appears appropriate for the TDMHMR employees who are losing their jobs because of the Griffith vs. Bynum settlement agreement. However, this must be carefully drafted to protect the financial integrity and actuarial soundness of the TRS and ERS systems.

- **The statute should allow TDMHMR employees who have been providing educational services to school-age residents to transfer accumulated benefits and service to TRS or ERS.**

This will ensure that these employees do not suffer financial harm as these educational programs are transferred to local school districts.

- **The statute should ensure that the transfer of benefits does not threaten the actuarial soundness of the ERS or TRS systems.**

Setting limits on the transfer of benefits for TDMHMR employees ensures that this special provision does not threaten the retirement benefits of the current members of both systems. The limits necessary include the following: 1) TDMHMR will provide ERS and TRS with a certified list of eligible personnel; 2) the certified list will include only those TDMHMR employees who are providing educational services to school-age residents; 3) the list will not include employees who have already received a refund or who retire during the covered period; 4) an employee who has intervening employment will not be covered by this provision; 5) coverage will be limited to changes in employment that occur between September 1, 1985 and September 1, 1988; and 6) TRS and ERS, in addition to transferring all amounts in the individual member accounts, will also transfer an amount determined by the TRS and ERS actuaries that ensures the actuarial soundness of both systems.

To ensure a smooth transition in these shifts between retirement systems, the statute should also require that all TDMHMR employees covered by TRS will be transferred automatically to ERS on the

effective date of the bill. In addition, all TDMHMR employees covered by ERS who are hired by an independent school district between September 1, 1985 and September 1, 1988 will be transferred automatically to TRS when the department notifies ERS of the change in their status.

## **EVALUATION OF ACCOUNTABILITY REQUIREMENTS**

In addition to developing an organizational structure that responds to the needs of the clients and those who serve the clients, the agency must also be able to respond to the general public's need to be assured that agency funds are spent appropriately and effectively. Accountability to the public is achieved by demonstrably producing effective programs that respond to public needs and by using agency resources economically and efficiently. The review found that public confidence in the MHMR system could be improved by increasing accountability in two main areas. The first area is to increase the accountability of community-based MHMR programs and services. The second area involves changes to the agency's internal audit section which could enhance that unit's ability to monitor the agency internally to help bring about operational improvements. Recommendations for these two areas follow.

### **Increased Reviews with More Emphasis on Outcome and Performance Measures Would Improve Community-Based Services**

Community MHMR services in Texas are provided through outreach programs of state schools, centers, and hospitals or by community MHMR centers. Presently 31 of the state's 60 local service areas for mental health and mental retardation are served by community centers. State school, hospital, or center outreach programs provide community-based MHMR services in the remaining areas.

All community-based MHMR services, whether provided directly by state outreach programs, or through contracts with community centers, are required to comply with the rules, standards and other provisions established by the TDMHMR. In addition, the department negotiates performance contracts with community centers and performance memoranda with the state institutions regarding their outreach programs. These agreements specify certain performance measures which must be met. These measures relate to the number and types of patients to be treated in the community. The department has the authority to review these

programs to see if the various requirements, standards, and contracts are being met.

The TDMHMR's reviews of community center programs generally fall into two categories. One focuses on program quality and the other evaluates the center's management. Currently both the program quality and management audits of community centers are done in cycles of approximately three years. As more and more MHMR services are being delivered by community centers, it becomes increasingly important for the department to review those services to be assured of the level of quality. It is also very important to determine whether the terms of the performance contracts are being met before the next year's contract is negotiated. The current three-year schedule of reviews for community centers is not frequent enough to ensure continued compliance with the performance contracts and quality of care standards.

The state institutions' outreach programs are not reviewed in the same manner as the community centers. Although these outreach programs are supposed to adhere to the department's Community Standards, no program reviews have been conducted to determine if outreach programs are actually in compliance with these standards. In addition, outreach programs are not reviewed by the department as separate community programs but instead are reviewed in conjunction with the overall fiscal and management audits of state hospitals and state schools. Fiscal audits of facilities are conducted annually by the state auditor, but management audits are approximately three years apart. Thus, community center programs are reviewed for compliance with their performance contracts but the state outreach programs have no such regular reviews. The department should not hold the community centers to a higher standard than they require of their own outreach programs.

In addition to problems identified with the frequency of reviews of community-based services, the review found that the current focus of those reviews should be modified. As mentioned previously, there are two separate reviews of community centers. The internal audit section of the department is responsible for conducting management audits of the community MHMR centers. The standards and quality assurance section has the responsibility of reviewing the quality of all community-based services. Management audits of the community centers review the center's financial statements, systems of accounting controls, compliance with applicable rules and regulations, and the overall efficiency and

economy of the community center's organization. The standards and quality assurance reviews of community centers utilize the department's Community Standards.

One major focus of S.B. 633 was to define a relationship between the department and community providers based on performance contracts. The intent was to move away from specifying processes which must be followed and focus more on making sure the state receives the services for which it contracts. The department's management audits of community centers currently focus more on the ways in which centers operate than on the performance outcomes of the community programs being paid for by state contracts. Since the department is now contracting for specified performance results, the department should define measurable outcomes for community programs. The focus of the management audits should then be to check and verify if those specified outcomes are being achieved.

The Community Standards used by the department to establish the quality of community-based services should similarly be in line with the intent of S.B. 633 in that they should focus on elements important to quality of care and not on administrative or paperwork requirements. Throughout the sunset review process concerns were voiced that the Community Standards may be too process and paperwork oriented, are not significant in assuring the quality of care, or have an unreasonably high cost to implement. It was not possible for the sunset staff to determine the validity of these concerns. It is important for the department, however, to be sure that the Community Standards represent elements important for quality of care without requiring unnecessary administrative compliance or unreasonably costly procedures. Regular reviews of these standards should be conducted, with input from community-based service providers, to work toward this goal.

By reviewing all community-based services more frequently and changing the focus of those reviews as outlined in the following recommendations, accountability is enhanced and all community service providers are treated more equitably.

- **The department should review the quality and program performance results of all department funded community-based services on an annual basis.**

Annual reviews of all community programs increase their accountability and treat community center programs the same as the department's own community-based programs.

- **Management audits of the community centers should focus on program performance results to determine compliance with performance contracts.**

This would shift the focus of audits toward measurable outcomes and eliminate duplications between internal audit's review of community centers and the independent C.P.A. audit required of community centers (See recommendation, page 84.) This would enhance accountability, yet reduce the administrative burden on community providers.

- **The department should review the Community Standards on a biennial basis to determine if each one is necessary to ensure the quality of care.**

This will focus attention on the quality of care instead of administrative compliance. Input should be obtained from community-based service providers and the cost of implementing standards should also be considered in any revisions to the current standards.

#### **Additional Action is Needed to Prevent Non-compliance with Standards**

The preceding recommendations to increase the frequency of reviews and to focus the reviews will increase accountability only if there is sufficient action taken when noncompliance is found. The sunset review found two areas where the department's ability to ensure compliance with standards and contracts could be improved.

First of all, while the TDMHMR's reviews identify if a specific rule or standard is being met, there is no overall judgement of "pass" or "fail" for a particular program or a center in general. This is very important because of the way in which the Community Standards are designed. The Community Standards are composed of 20 different chapters representing over 660 different standards. Different chapters, or sets of standards, are applied depending on the type of program offered. Plus the sets of standards are applied to each particular location of a program. For example, if a community center has ten group homes, the set of standards for group homes would be applied ten times. In addition, there is no weighting of the standards to show which are more important than others. Thus a long list of deficiencies in a report could reflect a minor problem identified in many separate locations or programs, or it could represent a series of serious problems. Under the present system, there is no objective way to equate the

number or types of deficiencies found with an accurate assessment of whether a program is really doing a good job or not.

The other problematic area is that there is no formalized, consistent and timely follow-up on areas of weakness or noncompliance found in the reviews. Nor are there well defined consequences or penalties for specific areas of non-compliance. The assistant deputy commissioners are charged with the responsibility of following up on corrective plans of action submitted by community centers in response to audit reports. A review of a sample of deficiencies cited in program and management audit reports found that little or no follow-up compliance checks had been conducted by the assistant deputies. Major problems, such as the absence of a particular service, are currently addressed through the contract renewal negotiation process, but even in those cases the problems were identified up to two and three years ago. For the majority of program quality deficiencies identified, there is no follow-up action taken other than to negotiate a plan of correction with the center and have the center submit its own progress reports. In the case of management audit findings, there is even less follow-up. The consequences of this lack of follow-up have been noted in the state auditor's recent draft report to the department which stated that management audits of community centers revealed a range of findings and deficiencies which were repeated from previous audits. In order to make departmental reviews and audits more effective, specific actions should be taken when standards are not met.

- **An objective mechanism should be established for evaluating whether a community program meets the department's standards on an overall basis.**
- **The department should develop and implement procedures to enforce standards by reducing or withholding funds to a program that is out of compliance.**

These recommendations will provide a way to determine whether a community program passes or fails the review. Reducing or withholding funds to programs that do not pass encourages voluntary compliance and increases the department's ability to ensure compliance with standards.

#### **The Department's Internal Audit Section Should be Given More Independence.**

The internal audit section is responsible for conducting all audits and investigations into the operations of the department. The director of internal audit

functions as one of seven section or division directors reporting to the executive deputy commissioner, who in turn reports to the commissioner and the director of operations. This creates a potential conflict of interest if the auditor should identify problems in any of his supervisor's other six divisions. It is critical that the internal auditor be organizationally independent and free from the influence of anyone who could be criticized in an audit report.

In a recent survey of Texas state agencies which have internal audit departments, 29 of 34 agencies indicated that the internal auditor reports directly to the agency head. The state auditor has repeatedly recommended that TDMHMR's director of internal audit report directly to the commissioner.

- **The agency's statute should be amended to require that the director of the unit that performs internal audits reports directly to the commissioner with audit reports submitted directly to the board.**

By making this a statutory requirement, the TDMHMR's internal auditor will be assured of a generally accepted degree of independence and be removed from controversy regarding to whom he reports.

#### **Department-Wide Accountability Efforts Should be Expanded.**

According to the U.S. General Accounting Office, there are three main areas in which a government agency is held accountable by public officials, legislators and private citizens. First, there should be assurance that government funds are handled properly and in compliance with laws and regulations. This is properly addressed currently through fiscal audits of the department done annually by the state auditor.

Second, the purposes for which programs were authorized and funded should be demonstrably achieved. The review showed that the department needs to make improvements in this area. The department has a small "performance evaluation unit" located within the standards and quality assurance section that conducts studies, surveys and analysis of various programs. For example, it reports on numbers of incidents of aggressive behavior in the state hospitals and average daily census. However, these types of reviews are mainly analysis of what situations currently exist. What the department lacks is a systematic definition of outcomes or goals that state what management is trying to achieve and an information system designed to collect and analyze information to see if those specified goals are actually being achieved.

Third, program results should be achieved economically and efficiently. The review found that while individual institutions have internal auditors that do reviews in this area, there should be system-wide reviews of major functions such as laundry, as well as reviews of central office functions. The state auditor has repeatedly recommended this but the department has done only a few reviews over the last several years. To correct the problems regarding department-wide accountability, the following recommendation is made.

- **The department's internal audit section should be expanded in order to review program results and perform economy and efficiency studies of agency operations.**

Expanding the department's internal audit section will allow it to address the main areas of concern over the department's accountability for its operations. Expanded scope audits conducted by internal auditors are in agreement with federal guidelines for accountability of government agencies. Any increased costs that this would entail should be more than compensated for by savings realized by identifying non-productive work, overstaffing or understaffing, or procedures which are inefficient.

## **EVALUATION OF MONITORING ACTIVITIES**

Reviewing the quality and results of MHMR programs and accounting for how agency funds are spent are major and essential activities of the TDMHMR. Like other agency programs, monitoring and evaluation activities should also be cost-effective and aim to get the greatest return from the limited resources usually available to such activities. The review identified improvements that could be made to enhance the agency's monitoring and evaluation activities. The recommendations that follow generally involve eliminating monitoring that is duplicative or unnecessary, relying on the work of other auditors when possible, and establishing a clear evaluation policy within the agency.

### **Duplications of Effort in Fiscal and Compliance Monitoring of Community Centers Should be Eliminated.**

Community centers are required to have an annual independent financial and compliance audit of their entire operation by a certified public accountant (C.P.A.). This independent audit is necessary because of the amount of federal



funds the community centers receive through the TDMHMR. This audit must meet the federal requirements for A-128 audits which are established for state and local governments. These requirements include the review of all of the center's financial reports as well as the center's compliance with financial laws and regulations that affect federal and state programs.

The review found the department's management audit of community centers looks at many areas that the C.P.A. audit also looks at such as accounting, client accounts receivable, and internal controls. In addition, the department's management audits review many compliance areas that would be possible for an independent auditor to check. The federal government's intent for A-128 audits is that they be used as a single audit which all federal departments and agencies can rely upon. The guidelines are broadly stated so that state governments can use their own procedures to demonstrate accountability for federal funds. Since the TDMHMR issues the instructions for the annual C.P.A. audits of community centers, the department could require the independent auditors to also check the areas of financial compliance currently checked by the department. Examples of such areas that the independent auditors could review are the performance contract requirements for local matching funds and restrictions on the transfer of funds between categories of contract services. The C.P.A. audits could then be reviewed by department staff.

However, the review identified one problem within the TDMHMR which hinders the effective monitoring of the C.P.A. audits. Currently, the department's accounting and management section of budget and fiscal services has the responsibility for reviewing the C.P.A. audit reports to ensure that they are properly prepared. The internal audit section of the department, on the other hand, has the responsibility for reviewing the supporting workpapers prepared by the independent auditors when they review the community centers.

The responsibilities for review of both the audit report and the supporting workpapers should be combined as a single responsibility of one organizational unit. The state auditor's draft report to TDMHMR for fiscal year 1985 recommended that these functions be consolidated. Since the primary purpose of the independent audit is to enhance accountability, and it provides a basis for the internal audit's reviews of community centers, the function should be consolidated under that office. Recommendations to improve the use of the independent C.P.A. audits follow.

- **The currently required annual independent fiscal and compliance audit of community centers should provide the basis for the department's fiscal review of community centers.**

By properly defining the audit guidelines, and monitoring and following up on the performance of the independent auditors, the department's auditors would not have to duplicate the same work in the field. Instead, department auditors should review the C.P.A.'s work papers and perform additional work as needed on an exception basis.

- **The internal audit section should have primary responsibility for reviewing the audited annual reports and supporting workpapers prepared by independent auditors of the community centers.**

Placing the primary responsibility for reviewing the independent audits of community centers within the internal audit section would allow for a more coordinated and effective review of them. This is important because the previous recommendation calls for those independent audits to provide the basis for further audit work done by internal audit in the field. This recommendation does not, however, preclude other sections or individuals of the department from access to the reports as needed for other informational purposes.

#### **Duplications in the Program Quality Reviews of Community-Based Programs Should be Eliminated.**

Community mental health and mental retardation centers receive funds from many federal, state and local sources, though the majority of their funds are usually received from the TDMHMR. The programs and services offered by community centers may serve a wide variety of clients, some of whom are sponsored by other state agencies such as the Texas Rehabilitation Commission or the Texas Department of Human Services. The standards and quality assurance section of the TDMHMR has the authority to review the quality of all community-based mental health and mental retardation programs. These program reviews attempt to determine whether the community-based services are complying with applicable rules and standards of the department regarding quality of treatment. In looking at these reviews, three problems were identified.

First, in addition to MHMR standards and quality assurance reviews, a community center may undergo other fiscal and program reviews by up to 11 other

state agency related reviewing bodies. Five of these 11 are directly connected to TDMHMR and include TDMHMR management audits, the TDMHMR autism project reviews, Early Childhood Intervention program reviews (an interagency monitoring effort which includes TDMHMR), TDMHMR Intermediate Community Services certification reviews (a federally funded pilot project), and TDMHMR Title XIX Liaison Worker Program contract compliance reviews (federally mandated). In addition, the Texas Department of Human Services licenses and/or reviews ICF-MR facilities, day care programs, and foster care homes. The Texas Rehabilitation Commission reviews community center programs where their clients are placed, such as sheltered workshops. The Texas Commission on Alcohol and Drug Abuse licenses substance abuse programs. The Texas Department of Health conducts the federally required reviews of Intermediate Care Facilities for the Mentally Retarded (ICF-MR) and reviews personal care homes. The Texas Education Agency reviews approved non-public schools and federal Chapter 1 services. And finally, the Texas Board of Pharmacy licenses pharmacies that many community centers have.

The review found that these numerous reviews by so many agencies are very burdensome to the centers being audited. They require significant staff time and effort to prepare for and assist reviewing staff during each review. This takes away from the time that center staff have to focus on client needs. While each review has a worthwhile and legitimate purpose, there are some steps that can be taken to increase cooperation in this area and reduce the burden on the centers. Auditors should rely upon the work of other auditors to the extent feasible if they satisfy themselves as to the other auditors' independence, capability, and performance. In order for the TDMHMR to be able to rely upon the work of other state agencies' reviews of community centers' programs and vice versa, a formal mechanism is needed to address the concerns that currently prohibit them from relying upon each other's reviews. The department should develop memoranda of understanding with other state agencies that also review community centers' programs in order to establish procedures to reduce duplications in reviews and to maximize the extent to which the agencies involved can rely upon one another's reports.

The second problem in this area relates to the TDMHMR's desire to review all programs and services provided by a community center. It is understandable that the TDMHMR wants to be assured that any program run by a community center is

of high quality. This is because it sees itself as the final authority for all mental health and mental retardation services and because all programs of a center are associated in the public's mind with the department. However, since there is a great need to review community-based services much more frequently, the department should focus its reviews on those programs for which it is contracting. Other programs could be reviewed on a "spot check" basis, or when there is reason to believe a major problem exists, or when TDMHMR funds for a particular program are so comingled with funds from other sources that no primary funding source can be identified.

The third and final problem in this area was related to the Joint Commission on Accreditation of Hospitals (JCAH). This commission is a voluntary, nationally recognized, independent accrediting body for mental health programs and hospitals. The JCAH consolidated standards are the set of standards by which all of the TDMHMR's state hospitals are currently accredited. There is no funding attached to JCAH accreditation and a program is accredited for up to three years, depending on how many deficiencies are identified. Often, the reviewers will issue a six-month contingency approval and return after that time period to determine if deficiencies have been corrected. The R.A.J. Settlement Agreement requires state hospitals to meet applicable requirements for a two-year JCAH accreditation in order to assure the court of the hospitals' quality.

For the first time, JCAH has begun accrediting community centers under the same set of consolidated standards. Previous to 1986, community centers were reviewed by JCAH using a different set of standards that are less clinically oriented than the consolidated standards. Now, however, it is possible for a community center to be certified by an independent organization as meeting the same quality of care standards as the state hospitals. Since this is now a possibility, it would appear appropriate for the department not to duplicate quality of care reviews when a community center already has been certified by JCAH. However, there may be some areas in which the department has standards that are higher than those of JCAH or which involve areas not covered in JCAH reviews, such as requirements of lawsuit settlement agreements. Because of those possibilities, the department can not simply deem JCAH accreditation as acceptable and exempt the community centers from any further reviews. The department maintains that it considers JCAH accreditation of a community center before it conducts a program review. This consideration should be more formalized

so there is a clear definition of which community standards are covered by JCAH and which go above and beyond or are not addressed by JCAH requirements. Community centers which are accredited by the JCAH consolidated standards would then only be subject to reviews of those areas identified as exceptions. The department could also re-review areas that the JCAH identified as weaknesses. This approach will benefit the department by having a formal mechanism to limit areas for review and not having to redefine the focus of a review on an ad hoc basis. It will benefit community centers by creating an incentive for them to receive JCAH accreditation knowing that the same review would not be duplicated by the department.

To correct the three problems regarding duplicative program quality reviews of community programs, the following recommendations are made.

- **The TDMHMR should identify the other state agencies conducting reviews of programs in community centers and develop a memorandum of understanding with each of them to reduce duplication of program reviews and maximize the reliance on each other's reports by December 31, 1987, and annually thereafter.**

This would help to eliminate unnecessary duplication and reduce the cost of overseeing community centers without reducing accountability. In addition, a previous recommendation (see page 78) has called for the department to review community-based services much more frequently. This recommendation should help accomplish this without increasing resources.

- **Quality reviews should focus on programs funded by TDMHMR funds and the required local match.**

By focusing on those programs and services for which the department is specifically contracting for, the department ensures that the state is buying quality services and is able to conduct reviews more frequently. Non-funded programs would be still reviewed on a random basis, in response to complaints, or when the funding can not be attributed to any single source.

- **The TDMHMR should formally review its Community Standards and identify standards which go above and beyond, or are not addressed by, the Joint Commission on Accreditation of Hospitals' (JCAH) consolidated standards. In the review of community centers that receive JCAH accreditation under the consolidated standards, the department should limit its review to those identified standards and to weaknesses identified in JCAH reports.**

This recommendation will formalize what is currently an informal practice of the department and will benefit the department by having a mechanism to limit areas for review and thus reduce duplication to the maximum extent possible. It will benefit community centers by creating an incentive for them to receive such third party, independent accreditation knowing that the same review would not be duplicated by the department.

**The Department's Quality Assurance Reviews of Community-Based Programs Could Make Better Use of Existing Resources.**

As mentioned previously, the standards and quality assurance staff in central office conduct quality reviews of community center programs. In addition to the department's standards and quality assurance section in central office, each state hospital, school and center, as well as each community center has its own quality assurance staff which serve as the first line check on quality.

The sunset review indicated a need to review all community-based programs much more frequently than the present three-year review cycle. Rather than greatly increase funding for this area however, it was found that other actions that do not require additional expenditures could and should be taken to improve performance in this area. The Texas Council of Community Mental Health and Mental Retardation Centers has advised the TDMHMR that a peer review model for program reviews of community centers could be used to increase reviews without increasing central office staff. The council has stated that they would support such a model, which is important because under a peer review model, individual community centers cover the travel expenses and allow leave time to their staff who participate in reviews of other programs.

The review of the quality of a program lends itself by its very nature to a process conducted by peers. The peer review model for quality assurance is commonly accepted in the field and is used by both the Joint Commission on Accreditation of Hospitals and the Southern Association of Colleges and Schools. The review of clinicians should be conducted by other clinicians, be specific to the client and service provider, and take a qualitative approach tailored to the unique characteristics of the individual patients. Applying this approach to TDMHMR's program quality reviews appears appropriate if properly structured. The peer review teams should be composed of community center and state outreach staff

who volunteer their help and are coordinated, monitored and directed by central office quality assurance staff. For example, one or two central office quality assurance staff would organize and participate in the review of a center, yet solicit professionals from other centers to assist in reviewing case files or filling out checklists. The central office staff would compile the work of all the volunteers, make the decisions regarding the center's quality, and issue the final report, always reserving the right to re-review any area that appears necessary.

Since the quality of care in mental health and mental retardation services depends largely on the professional ability and integrity of the care givers, it appears that peer reviews can be more effective in improving care than the current system. The outcomes and recommendations of peer reviews, when fed back to the responsible clinicians, would be more likely to get a positive reception than recommendations of central office evaluators. This is because of the natural resistance of professionals to advice or direction given by persons outside of that profession. Members of the peer review teams also gain insight into how others provide services. This benefits their own programs and helps to contribute to a more unified system. In addition, by utilizing peer review teams, quality reviews of all community-based services can be conducted more often without increasing the costs.

- **The TDMHMR should modify its quality assurance reviews by implementing a process using peer review teams that are controlled and directed by central office.**

Utilization of peer review teams will ensure quality services are available, create a more cooperative atmosphere, and allow the department to conduct reviews of all community-based programs on a much more frequent basis without the need for additional funds. The department would still maintain full control over the review process.

#### **The Department's Management of its Limited Resources for Evaluations and Studies Could be Improved.**

Like many large government agencies, the TDMHMR conducts a great many evaluations, studies, and surveys in areas related to the delivery of mental health and mental retardation services and programs. The persons who currently conduct evaluations and studies in the agency are located in various sections throughout central office. In addition, in many areas the department conducts separate

program monitoring reviews in the field that could be combined. For example, there are separate reviews of autism programs, case management, regional monitors and federal liaison workers that in many instances review the same personnel and/or data for different purposes.

Currently, the department's executive committee coordinates these types of activities. The review found, however, that this informal practice should be put into a formal policy to guide the entire agency. Such a policy would provide more direction as to what types of analysis and evaluations should be conducted, by whom, and for what purposes. The current lack of a formal comprehensive policy means that department resources may not be used in the most economical and efficient manner possible. Changes in the organizational structure should be considered where they would benefit the development of a comprehensive approach toward evaluation and monitoring activities.

Once a policy is established, the implementation of it should be monitored. Like most programs, evaluation activities, studies, and monitoring should also be monitored to ensure their quality and relevance and to avoid duplication. The recommendation on page 82 addresses the role of the internal audit section in conducting program results reviews and economy and efficiency studies throughout the department. Thus, the internal audit section should also monitor the implementation of this policy.

- **The TDMHMR executive committee's currently informal coordination of evaluations, monitoring activities and studies should be put into a formal evaluation policy and communicated throughout the agency.**

A comprehensive evaluation policy will benefit the agency by defining how resources are to be used, what types of activities have priority, and what types of results are expected from the evaluations.

## **EVALUATION OF FISCAL MANAGEMENT**

The review of the department's funding mechanism was designed to determine whether changes were necessary in order for the department to make the best use of existing resources. This review indicated that several changes are needed in two major areas. First, it appears that state funds could be "stretched" by increasing revenues from fees in several areas, improving the collection of debts, making better use of the department's assets, reviewing its performance and funding of commercial activities, and applying more uniform local matching



requirements across the state. Second, the department could allocate funds more equitably and by so doing, could provide a broader range of services to a greater number of clients. Specific recommendations for improvements in these two areas are contained in the material that follows.

### **Fees Should be Increased.**

The review of the TDMHMR's fee collection policies was designed to identify areas where fees charged were insufficient to cover the state's cost. This review identified two areas where fees should be increased or expanded.

The first relates to fees for licensing private psychiatric hospitals. State law requires psychiatric hospitals to be licensed by the TDMHMR. Before a license is issued the agency does an administrative and programmatic review of the application, reviews construction plans, and conducts on-site inspections of the facility. If the hospital is seeking Medicare certification or accreditation by the Joint Commission on Accreditation of Hospitals, the programmatic review for certification or accreditation satisfies the TDMHMR's program review requirement. The TDMHMR is required by statute to collect an application fee of \$1,000 plus \$10 per bed, and an annual fee of \$200. Current fees cover the administrative and program review costs, but not the cost of construction plan reviews and on-site inspections.

As a general rule, licensing by the state is considered to be a service and should be made self-supporting through fees. This principal was applied to the licensure of medical hospitals by the Texas Department of Health (TDH) during the last legislative session. The TDH was granted specific statutory authority to collect fees for processing applications, reviewing construction plans, and making on-site inspections of hospitals. These fees were based on the estimated cost of performing those functions.

The second area where fees should be modified relates to fees charged to parents of minors who receive residential care and treatment in a state school or a state hospital. These fees are limited to \$170 per month regardless of family income. These fees are based on a sliding scale established by state law for state school residents in 1968. The department adopted a similar fee schedule by rule for minors in state hospitals shortly thereafter.

This fee system is no longer appropriate for several reasons. First, the value of \$170 per month is much less today than it was in 1968 due to inflation. The average cost per day of serving an individual in a state school has risen from about \$200 per month in 1968 to over \$2,500 per month today. In addition, the average

family income has increased dramatically since 1968, and today \$170 per month is a much smaller percentage of the average family's income than it was 18 years ago. Second, the \$170 per month limit favors high income families over low income families. For example, a family with an annual income of \$25,000 must pay the same as a family that earns \$250,000 or more annually. Third, it is the policy of the state that fees for services should be set to recover the cost of providing those services whenever possible. The current fee schedule conflicts with this policy. To correct the problems identified with the current statutory limits on fees, the following recommendations are made.

- **The TDMHMR should be authorized to collect fees which recover the cost of all reviews and inspections that are necessary in the licensure of private psychiatric hospitals.**

This would require specific authorization to collect fees for construction plan reviews and on-site inspections in addition to the fees currently authorized by statute. These fees should be adopted as rules of the department and reflect the cost to the agency of performing the various licensing reviews and inspections. It is estimated by the agency that this authorization will generate additional revenues of about \$60,000 annually.

- **The department should be required to establish, by rule, a fee schedule for parents of minors in state facilities which ranges from no fees for persons at or below federal poverty level and increases to a point where full costs are recovered when a family can afford it. This provision should replace the fee schedule that is currently in statute.**

This would make the fee system more equitable and allow full cost recovery from families with high incomes. According to estimates of the department, this change would result in increased annual net revenues of about \$300,000.

### **The Department's Debt Collection Authority Is Inadequate.**

The TDMHMR and the 31 community MHMR centers are currently directed by statute to charge and collect fees for the services they provide. The review indicated that in general, both the department and community centers make a concerted effort to collect all fees possible. There are cases, however, when statutory authority for debt collections is inadequate. This problem occurs in two

primary areas. First, a client or the parents of a client who is a minor, sometimes have little or no income from which fees can be collected, but may own property, such as a homestead. For these clients the department and community centers generally accumulate the charges and file a claim against the estate upon the death of the client or the last surviving parent of a minor client. The Probate Code, Sec. 322, V.T.C.S., requires that claims against the estates of deceased persons be paid according to a specific priority: first, expenses of funeral and last sickness up to \$5,000; second, expenses of administration and management of the estate; third, claims secured by mortgage or other liens; and fourth, claims for taxes, penalties and interest due. The TDMHMR and community centers are considered as claimants in a fifth category, "All other claims legally exhibited..".

The second area where problems have been encountered relates to assets owned by clients or responsible parties of which the department or the community center has no knowledge. No mechanism exists to identify these assets and place a claim against them.

One of the most commonly used techniques for securing a claim for debts which are owed is to file a lien on the assets of the individual who is responsible for the debt. This remedy is available to private health care organizations under certain circumstances, and is also used for securing delinquent taxes and other debts. By attaching a lien on the property, the claim is given a higher priority in the disposition of an estate. The existence of a lien on a person's property will also help to identify assets upon which a claim can be filed. This is due to the fact that insurance companies and lending institutions routinely check for liens when insurance is applied for or properties are sold. The property title can not change hands and insurance will not be issued until the lien is removed. Debts owed to TDMHMR currently constitute a lien, by statute, for parents with minors in state schools. This provision should be expanded to apply to the entire MHMR service delivery system.

- **The TDMHMR and community MHMR centers should be authorized to file liens on all non-exempt property of clients or the parents of minor clients for the amount owed for the provision of MHMR services.**

Under this provision, homesteads would continue to be exempt as long as the responsible party is alive. The level of revenues collected from clients would be increased by securing a higher priority in the disposition of estates, and by identifying assets against which a claim can be filed.

## Requiring TDMHMR to Review its Performance of Commercial Activities Could Produce Savings.

For many years, the federal government has had an initiative to reduce government's intrusion on the private sector's provision of services. This initiative began in 1955 with a policy statement referred to as Circular A-76 which said, "Government will not start or carry on any commercial activity to provide a product or a service for its own use if such product or services can be procured from private enterprise through ordinary business channels." The policy today is much the same but, in 1979, emphasis was added on improving government productivity, seeking the least costly methods to perform a function, and implementing those methods regardless of who performs the activity.

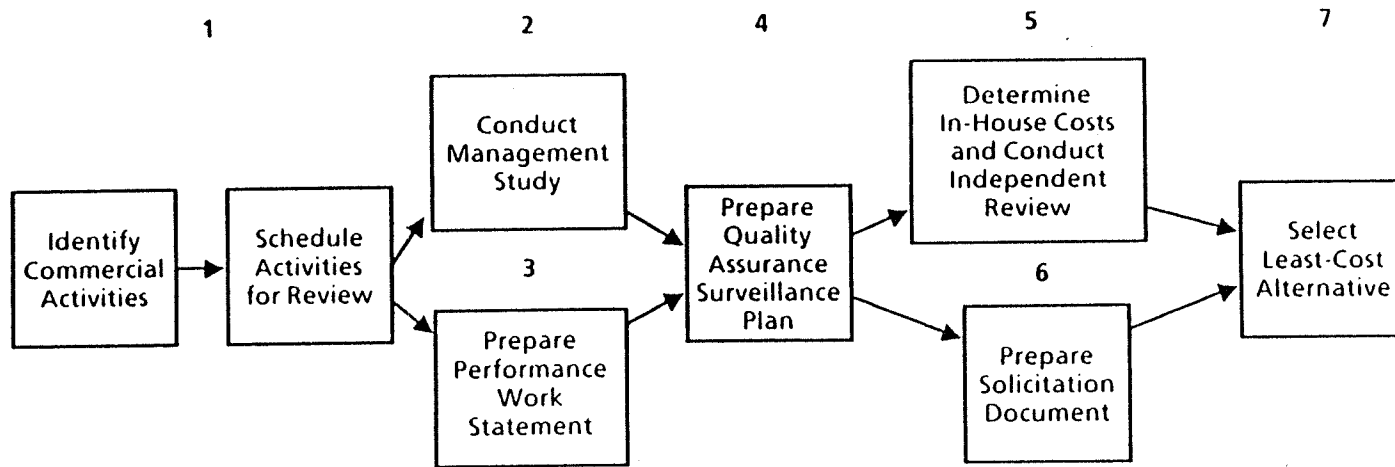
In essence, the A-76 policy requires governmental agencies to analyze any commercial activities which they perform and accept competitive bids on the activities. It allows the activity to be retained in-house only if the government can provide it at a cost which is less than the total cost of contracting for the activity. An agency's cost estimate to retain the activity in-house receives a 10 percent cost advantage to account for any temporary reduction in productivity or unpredictable costs which could be incurred in converting to private industry operations. All costs of contract administration are considered when the private sector bid is compared to the agency bid. Exhibit 6 is a flowchart that depicts the process.

The A-76 policy is founded on the belief that competition enhances productivity, and the federal government's experience has shown this to be true. The Office of Management and Budget indicates that, since the 1979 changes were made to the requirements, 1,700 cost comparisons through the A-76 process have been conducted on activities. These studies have resulted in an average savings of 20 percent over the previous cost of the activity to the government regardless of whether the operations were retained as government functions or contracted out to the private sector. This savings of 20 percent when the activity is retained in-house is thought to occur because of the thorough management study required and the factor of competition which is new to government in estimating its cost to provide the activity. Experience shows that the government is able to provide the service or product more economically than private industry, and the activities are retained in-house, in approximately 45 percent of the cases. Some reasons governmental agencies are able to retain the activity in-house at a lower cost than private industry include avoiding the costs of contract administration, retaining

Exhibit 6

The A-76 Process

Phases



Source: Pete Marwick  
A Guide to Implementing  
OMB Circular A-76  
June 1985

volume purchase discounts, and avoiding material or labor related costs of converting or transferring the activity to another entity. The federal government indicates that when contracting is chosen, the contract default rate is very low, approximately one percent over five years.

Contracting for services is not new to state government either. Many services are regularly contracted for through the private sector. For example, Florida and Kentucky have contracted with the private sector for the operation of state MHMR facilities. However, states are now looking to the federal government's experience with the A-76 process as a model to strengthen their contracting processes. Tennessee passed legislation in 1986 to allow competitive bidding for a state prison through a process similar to A-76. Along with Tennessee, three other states, Maryland, Delaware, and Rhode Island, are working with the Council of State Governments to develop state contracting procedures which are modeled after the federal government's implementation of the A-76 policy.

While the A-76 procedures provide a useful framework for contracting, they are also useful to ensure an agency's accountability. Often, state agencies cannot accurately specify what the state's cost is to provide a specific service. Instead governmental cost reports reflect the budget appropriated to provide the service. For example, TDMHMR can often state what it was appropriated to provide a service but rarely can identify what the actual total cost is to provide the service. The A-76 process increases agency accountability for its costs by requiring an agency to systematically review certain activities, perform management studies to determine the essential products of the activity, find the most efficient and effective method by which government can provide the service, and identify the total costs of those methods. By systematically completing a similar process, TDMHMR's accountability concerning its costs will be increased.

The following recommendations propose to initiate a process in TDMHMR which is similar to the federal government's A-76 policy. To provide for an independent agency to assist TDMHMR's implementation of the review process, the assistance of the State Purchasing and General Services Commission is proposed.

- **The statute should require the TDMHMR to complete an efficiency and performance review of all management and support activities it performs that are commercially available, calculate the total state cost of each activity, solicit competitive bids, and contract for an activity if it can be purchased through contract for less than the state's cost.**

The department regularly performs many management and support activities which are commercially available including data processing, food services, laundry, warehousing, accounts management (claims), mail, records management, and facility, vehicle and grounds maintenance. A systematic review of these activities, similar to the federal government's A-76 process, can result in significant cost savings to the state. For example, if the analysis of TDMHMR's computer activities results in a 20 percent savings, as studies have averaged with the A-76 process, the state could save \$1.4 million annually, regardless of whether TDMHMR retains the computer operations in-house or not. If, however, the private sector was able to operate the system for less and those services were contracted out, not only would there be an average 20 percent cost savings but also the state would increase its revenues since the private sector company would be paying state taxes. When these potential savings and revenue generating factors are applied to all the commercial activities that TDMHMR performs, the savings could be very significant.

- **The statute should require the State Purchasing and General Services Commission to assist the TDMHMR in its implementation of the required review of commercially available management and support activities.**

The commission would be required to review the TDMHMR cost estimate for retaining an activity in-house, evaluate the competitive bids, and determine which approach is the most cost-effective. To accomplish these additional functions, the commission may require additional staff or training. However, any additional cost to the commission should be offset by the savings to the state that will result from the process.

#### **Requiring Community Centers to Review Their Provision of Community-Based Hospital Services Could Produce Savings.**

Senate Bill 633, which was adopted in 1985, requires all community MHMR centers to have available community-based crisis residential services or hospitalization to be eligible for TDMHMR funding since it is one of the "core services". In many areas, appropriate services can be purchased from either local general hospitals or private psychiatric hospitals. While many community centers do contract for these services, others establish free-standing inpatient facilities.

The review of the department examined the way in which the TDMHMR ensures the cost-effectiveness of services which are delivered by community centers with state funds. Department policy requires the community centers to allocate state funds for core service development before they are used for other services. The amount the department allocates to centers for services is based on their historical funding through TDMHMR and then negotiated, according to local need, by the centers and department staff. It is not necessarily based on the actual cost of providing the service.

The most expensive core service to develop is the crisis residential service. A significant portion of state funds are used to either contract for, or develop, these local hospitalization services. Also, these services are the most likely of the core services to be available through existing local providers. Therefore, these services were identified as requiring the highest degree of accountability for costs and as having the greatest potential for increased cost-effectiveness.

The previous recommendation proposes to increase the department's accountability and promote cost-effectiveness by requiring the TDMHMR to conduct a thorough review of all management and support services that are commercially available and compare the state's cost of providing the service against competitive bids from the private sector. (See recommendation on page 96.) This process is modeled after the federal government's A-76 process. Requiring the community centers to complete a similar cost review and accept bids from area providers would provide assurance to the state that these community-based hospitalization services are delivered in the most cost-effective manner. In addition, it would increase accountability for the use of state funds.

- **The statute should be amended to require community MHMR centers to complete an efficiency and performance review of the crisis residential or hospitalization services they provide, calculate the total cost of the service, solicit competitive bids for the service, and demonstrate the cost-effectiveness of the method chosen for service delivery, before contracts are renewed. This process should be repeated every two years prior to contract renewal.**

This change will increase the community centers' accountability concerning the cost of local services. It will ensure that alternate methods of service delivery are examined before state funds are used to establish services which duplicate existing community resources. This requirement focuses on crisis residential services and community hospitalization services because they are the most costly of the core



services to establish and most communities have existing hospitals which could provide these services.

The implementation of this requirement would be modeled after the provisions recommended for TDMHMR's implementation of the A-76 process on page 96. However, TDMHMR would be required to establish standards for the use of community centers in implementing the reviews. Also, TDMHMR would assume the role of the independent review body to oversee the center's completion of the process. The community center would be required to solicit bids and demonstrate to TDMHMR that the most cost-effective method of service delivery was selected before TDMHMR renews the center's contract. The center should be required to repeat the solicitation process every two years.

- **The statute should be amended to require the TDMHMR to adopt rules establishing standards for the community centers' implementation of the required cost-effectiveness review of community-based crisis residential and hospitalization services.**

The department would be required to establish standards for the community centers' use in conducting cost-effectiveness reviews. These standards should establish the procedures used to conduct efficiency and performance reviews so that a consistent method is used to develop the centers' cost estimates and solicitation documents. The standards should also establish a consistent method for the bids to be reviewed along with the centers' estimates. Finally, while the authority to award the contract should remain with the community center, the standards should require the center to demonstrate to TDMHMR that the most cost-effective method of service delivery is used before the department's contract with the center is renewed.

### **The Department's Facilities Do Not Meet Its Needs.**

The department's institutional needs have changed dramatically in recent years but its facilities have not kept pace with the changing needs. The average population in state schools has decreased from 11,229 to 9,093 from 1976 to 1986. In state hospitals the average population has gone from 6,124 to 4,164 over the same period. This decrease in census has created several problems that need to be corrected. First, the decline in population has resulted in a number of vacant

buildings and in buildings being used for different purposes than those for which they were originally constructed. At the same time however, these buildings even when unoccupied, require maintenance, lawn care, and a certain degree of climate control. These costs are estimated at over \$100,000 annually in maintenance alone.

Second, if the population in state facilities continues to decline, the need for these facilities will be reduced to the point where one or more of them should be closed or consolidated. This point was recognized by the 69th Legislature, which directed the department to develop a plan for "phasing out uneconomical and unneeded beds". The department has indicated that the political difficulties associated with selecting specific facilities for possible closure have been tremendous. As a result, this plan has not been developed. Since it appears likely that at some point the depopulation of state facilities will render one or more of them economically unfeasible, the department should establish objective criteria for facility closings. The criteria could include such factors as average daily census, cost per day, or per capita bed day utilization.

The third problem is that some of the facilities have undeveloped or vacant real estate which could possibly be put to better use. The Rusk State Hospital, for example, sits on 1,033 acres of land, but only 434 are used for patient care. The General Land Office has evaluated TDMHMR's properties and concluded that it would be in the state's best interest to sell or lease some of its property.

The fourth and final problem that exists with the department's facilities is that most are not located near the state's population centers. Because of this, clients and families are required to travel great distances to receive in-patient care or to visit relatives receiving care.

The department has indicated that it could finance a restructuring of its facilities to more closely match its needs, in whole or in part, by disposing of assets that are no longer needed. In addition, the TDMHMR could help other state agencies that need additional space, such as the Texas Department of Corrections, by transferring unneeded institutional space to them. The department has indicated that specific statutory authorization would be necessary before it could begin the process of adjusting its institutional assets to more closely match its needs. Prior to such an adjustment, the department needs to develop an objective way to determine how the existing institutional structure should be modified. The following recommendations would provide a framework for this process.

- **The department should be required to establish objective criteria for when facilities should be closed or consolidated.**

This will prevent very important management and treatment decisions from becoming politicized, and prevent the TDMHMR from unnecessarily maintaining very costly institutions that are no longer needed.

- **The department should be authorized to sell, lease, transfer, or otherwise dispose of its assets. Also, the department should be authorized to retain the proceeds from these transactions to restructure its system of facilities, subject to control by the appropriations process.**

This authority would provide an incentive to the department to phase out unneeded or uneconomical beds. It should produce substantial cost savings, help other state agencies needing institutional space, and provide a better service delivery system in the long run while maintaining the legislature's control over the development of any new facilities or programs.

#### **Funding of State-Operated Facilities is Inequitable.**

The cost per client per day varies significantly among the different TDMHMR facilities, even for clients with similar diagnoses or handicaps. Numerous explanations for this variation have been proposed, including different cost factors for different areas, the different ages of the facilities, a variation in the quality of care provided by the facilities, and simply the historical support some facilities have received from the legislature. Although there may be valid reasons for some cost variations, the department should be accountable for cost variations and be able to demonstrate that some facilities are not being overfunded at the expense of other facilities. The legislature has recognized this principal and, through a rider in the Appropriations Bill, has directed the department to develop an equitable formula for funding its facilities. While a formula has been developed by the department, it has not been operationalized. The following recommendation would require a more equitable method of funding state facilities.

- **The department should be required to establish budgets for its facilities which are based on specific costs for specific types of services provided.**

Budgeted costs should be similar from one facility to the next, unless there are legitimate and documented reasons for differences. This

would increase accountability of facility directors and eliminate the criticism that some facilities are overfunded or underfunded.

**Allocation of Funds for Services in State Schools and Community-Based Programs is Inequitable.**

The state is currently modifying the way it delivers services to mentally retarded people. This includes a shift from caring for most mentally retarded clients in an institutional setting to serving many of them in the community. To ensure that quality services are available wherever a client is served, funds should flow with clients as they move from state facilities to community programs. This shift in dollars has not occurred in proportion with the shift in clients, partially because of court-ordered staff to client ratios and other requirements outlined in the Lelsz Settlement Agreement. However, changes in the current structure would provide a more equitable funding structure without additional funds.

Currently, there is a wide discrepancy in the rates paid to ICF-MR providers depending on whether the services are provided in a state school or in the community. The following chart shows this discrepancy.

<u>Level of Care</u>	<u>Per Day Rates</u>		<u>Difference</u>
	<u>State School</u>	<u>Community Facility</u>	
ICF-MR I	\$ 63.51	\$ 56.19	\$ 6.96
ICF-MR V	77.21	45.46	31.75
ICF-MR VI	85.13	53.96	31.17

The primary reason for this variation is that the rates are calculated on a historical cost basis. Since state schools have historically had higher costs and the legislature limited the amount that could be used for community facility reimbursements, the state schools receive a higher rate. However, all providers have to meet the same standards. This situation places the private providers in an unfair position which is compounded by a restriction on private providers that any new ICF-MR facility cannot have more than six beds. These limitations on funds and size have discouraged the development of new facilities. Private providers agree that the small facilities cannot provide the required services, especially for the more severely disabled clients, on the current level of funding. Equalization of the rates should result in an increased number of ICF-MR beds in the community. This will help the department comply with board policy and the statutory requirement that clients be served in the least restrictive environment that is appropriate to their needs. It will also allow the development of a sufficient number of beds so

that if one provider ceases operation, other appropriate alternatives will be readily available.

Establishing a more equitable rate structure would ensure that mentally retarded people receive comparable services whether served in a TDMHMR facility or in a community-based program. Equalizing the rates without additional revenue requires the department to identify how the costs of the state schools decrease as their population declines. Once identified, the money should be allocated for an equalization of ICF-MR rates. After the rates are equalized, any additional funds available should be shifted to other community programs providing core services to mentally retarded people.

- **The department should be required to determine the degree to which the cost of operating the state schools is reduced as populations decline. As savings are realized, the funds should be used to equalize the rates paid to ICF-MR providers and to increase funding for community MR programs.**

The equalization of rates and increased funding of community programs ensure that adequate funds are available wherever a client is served. It also negates the criticism that the department will pay more to serve a client in its own facilities than it will pay to serve the same client in the community.

### **Allocation Between State Hospitals and Community Mental Health Programs is Inequitable.**

In recent years an increasing number of mentally ill people are being treated in the community rather than in an institutional setting. To ensure the availability of quality services, funds should flow with patients from state facilities to community programs. This shift in dollars has not occurred in proportion with the shift in patients, partially because of court-ordered staff to patient ratios and other requirements outlined in the R.A.J. Settlement Agreement. However, two areas were identified where changes in the current structure would provide a better flow of the funds.

First, the TDMHMR should develop a mechanism for funds to flow with patients from state hospitals to community programs. While detailed information regarding how much a state hospital's costs decrease as its population declines is not available, there is a consensus that the TDMHMR is not currently shifting the full cost reductions resulting from declining facility populations to community

programs. Second, the number of state hospital beds that are needed in Texas should be established and the TDMHMR should maintain only that number. There is no commonly accepted number of total state hospital beds needed in Texas, but the TDMHMR has been criticized for serving clients in the hospitals that could be served in the community to avoid closing facilities.

If the full amount of the savings realized in the census reduction of state hospitals was transferred to community programs, there would be a base on which community programs could plan and budget. A community program would know in advance the amount of funds it would receive by reducing the number of bed days it uses in state hospitals. This knowledge could assist the program in estimating how many state hospital bed days it should be allocated. This information could be included in the contract for core services between the department and the community program. If a community provider contracts with TDMHMR to decrease the total number of bed days used by people from its service area, the provider would be budgeted additional funds to serve those clients and the state hospital budget would be reduced by the same amount. If the local mental health authority used more bed days than it was allocated, it would be required to pay the state hospital for them. If it used less than its allocation, it would receive additional funds from the state hospital budget.

These bed day allocations should be finalized by regional planning councils to make sure that opportunities for resource sharing and cooperation between providers have been explored. In addition, this would provide a mechanism for the TDMHMR to participate in the process since it is represented on all regional planning councils, as proposed on page 69. The sum of all the local bed day allocations could then be the basis for a state-wide total of state hospital beds needed. In order to encourage the development of local programs and avoid maintaining unneeded hospital beds, the TDMHMR should be limited to providing only the number of state hospital beds that are actually needed.

- o **The department should be required to determine the degree to which the cost of operating its state hospitals is reduced as populations decline, and distribute the funds to community mental health programs as savings are realized.**
- o **The TDMHMR in conjunction with community programs should be required to establish the number of state hospital beds that are needed, provide no more beds than that number, and develop its budget and community contracts on that basis.**

These recommendations will ensure that funds will flow with the patients from state hospitals to community programs and vice versa. They will provide community programs a mechanism to serve state hospital patients, when appropriate, and receive an equitable amount of funds for providing those services. In addition, the recommendations limit the services provided directly by the state to those that are actually needed.

### **Allocation of Funds Among Community Programs is Inequitable.**

As is the case for state-operated facilities, there is a significant variation in the amount of funds per capita spent on MHMR services across the state's 60 local service areas. This variation occurs in both state funds and local funds spent.

State funding for mental health services varied from zero to over \$14 per capita across the 60 local service areas in fiscal year 1985. The range for mental retardation services during the same period was between zero and about \$12 per person. Currently, the major metropolitan areas are among the lowest paid in per capita funding while serving the most clients. Due in part to low funding, many of their clients must be served in the state facilities.

The TDMHMR's method of funding community services has been criticized for a number of reasons. Major complaints include allocating more funds to some areas than others for providing the same services, and causing financial considerations to affect treatment decisions. Previous recommendations regarding the flow of funds from state facilities to community programs will address these concerns to a certain extent and will make the funding more equitable. However, additional modifications to the funding mechanism should be made to provide for complete equalization, and at the same time protect existing programs from funding cuts.

With respect to local funds, the amount spent on MHMR services varies between zero and about \$8 per capita annually across the 60 local service areas. The primary reason for this variation is that some areas are served by community centers while others are served by outreach programs administered by state facilities. Currently, 31 of the state's 60 local service areas are served by community MHMR centers. These 31 areas include about 83 percent of the state's population and about 50 percent of the state geographically. The rest of the state is served by state facility outreach programs. Community MHMR centers are required by statute to provide a local match for state funds they receive. The

local match required varies from one center to the next, but the average local match requirement is about 19 percent.

There is currently no local matching requirement when MHMR services are provided through state outreach programs. It is inequitable when some areas of the state are required to provide local support for MHMR services, while others are not. The local match requirement for community MHMR centers also discourages areas from creating or maintaining MHMR centers because of the local match requirement. These requirements should be consistent across the state to ensure that each area contributes its fair share and to encourage the creation and continued operation of community MHMR centers.

The following recommendations will establish a framework for equalization of funding for community programs.

- **Additional cost savings realized by any closure or consolidation of the TDMHMR's facilities, that are not needed for facility reconfigurations or community contracts, should be used to move toward equalization on a statewide per capita basis.**

This would serve to move the department closer to statewide equalization. Equalization should be implemented in a way that brings underfunded areas up to the funding level of areas which receive higher per capita funding. This "hold harmless" provision will allow the changes to be implemented without requiring funding cuts that could eliminate or limit existing services. This could be done by calculating the average per capita funds received by each local service area and flowing the first available equalization funds to areas that are below the average. Once each area reaches the average, a new average is computed. This process is then repeated until all areas are equalized.

- **In its budget request for fiscal years 1992-1993, the TDMHMR should be required to present to the legislature the amount needed to completely equalize funding of the system, including the ICF-MR program.**

This would give the legislature an opportunity to make a determination regarding funding equity once the recommended changes have been implemented.



- **The department should be statutorily required to establish local matching requirements for outreach programs that are consistent with requirements for community MHMR centers.**

This match should come from fees, in kind contributions, third party billings, and donations first, with counties making up deficiencies if they occur. It is estimated that this provision would result in increased revenues to the state of about \$5,000,000 annually.



## EVALUATION OF PROGRAMS

To evaluate the programs of an agency the size of the Texas Department of Mental Health and Mental Retardation in a meaningful way, it was necessary to focus carefully on the areas to be emphasized in the review. Several guidelines were developed for this purpose. These guidelines attempted to select areas of review that would address the major issues facing the MHMR service delivery system and involve the majority of agency services, but not duplicate the activities of the federal courts in their attempts to resolve the R.A.J. and Lelsz lawsuits.

This focusing effort yielded the selection of four major areas of analysis. These include clarifying the state's responsibility for serving mentally ill and mentally retarded individuals, eliminating gaps and duplication in services when multiple agencies are serving the same population in an area, strengthening the department's efforts to provide a balanced array of services within the financial capacity of the state, and improving the state's use of federal Medicaid funds for services to mentally retarded individuals. These areas of analysis span the activities of most TDMHMR facilities and programs as well as the activities of the community MHMR centers.

The analysis of the four major areas identified needed changes to state law, TDMHMR policy, and methods of service delivery. These changes are explained in the material that follows and are potential methods of improving the MHMR service delivery system for all Texans by increasing the efficiency and effectiveness of the system.

### EVALUATION OF STATE RESPONSIBILITY FOR MHMR SERVICES

A major element of the review process was to determine if the responsibility of the state for serving mentally retarded and mentally ill individuals was clear and unambiguous. The analysis identified areas where statutory changes are needed to the TDMHMR policy and purpose statement, the requirements for community services, and provisions for obtaining legally adequate consent for mentally retarded individuals. The proposed changes would clarify the services available through the state and local MHMR agencies, make service requirements more consistent throughout the state, and enhance the ability to provide services to people with mental retardation. These recommendations are described in the following material.

**The TDMHMR's Purpose and Policy Statement Does Not Accurately Reflect Current State Policy.**

As reflected in the report by the Legislative Oversight Committee on Mental Health and Mental Retardation, scarce resources and a growing demand for services require that hard choices be made as to whom the services of the state's mental health and mental retardation system should be directed. Although S.B. 633 directed the department to identify the priority client populations and the minimum array of services necessary to address their needs, the agency's purpose and policy statement was not modified accordingly. It indicates a state policy that does not exist, i.e. that TDMHMR will meet all the needs of all Texans who are mentally ill or mentally retarded.

To ensure that the state is not held accountable for failing to meet this unrealistically high standard of service delivery, a change in the purpose and policy statement appears necessary. Any change in policy must be carefully constructed to ensure that certain key elements are included. This would include a statement that the purpose of the Act is to provide for effective administration and coordination of services at the state and local levels. It should set a goal for the state to provide a comprehensive range of services for mentally ill and mentally retarded people who need publicly-supported care, treatment, and/or rehabilitation. These services should be coordinated to minimize duplication. The policy statement should maintain that when appropriate and feasible, mentally ill and mentally retarded persons will receive treatment in their own communities. This will be encouraged by a public policy that MHMR services will be the responsibility of local entities to the greatest extent possible. The TDMHMR will assist by coordinating implementation of a statewide service system which includes the direct provision of services, as well as providing funding, technical assistance, and monitoring of services to programs that receive state funding through contracts. Finally, to ensure the intent of the Legislative Oversight Committee and S.B. 633 is carried out, the statute should provide that it is the public policy of the state to offer services first to those most in need. This will require that funds appropriated for MHMR services be expended only on services to the priority populations designated by the department.

- **The department's statutory purpose and policy statement should be modified to accurately reflect current state policy.**

This modification will provide guidance to the department in the development of its mission statement, goals, and objectives. Further, it will ensure that those seeking services have a clear picture of the state's intent in providing those services.

### **Broadening the Definition of Minimum Services and Requiring Uniform Application Would Improve Service Delivery.**

The Legislative Oversight Committee on Mental Health and Mental Retardation identified a major problem with MHMR services in Texas. The problem was that many communities did not provide the basic services that mentally ill and mentally retarded people need to function in the community and avoid inappropriate institutionalization. The committee's report to the 69th Legislature recommended that TDMHMR be required to assure that people in each service area of the state have access to certain minimum services in their own community. These "core" service requirements were incorporated into S.B. 633 to require each local service area to ensure that people in the area have access to a minimum set of services. These services include community-based 24-hour screening and stabilization services, crisis hospitalization, multi-disciplinary assessments, case management, and family support services. The department can not contract with a local provider if that provider can not ensure the availability of these services.

Two problems in implementing these services were identified during the review. To correct these problems, the following changes should be made.

- **The statute should be amended to include additional required core services.**

In practice, the TDMHMR has expanded the list of required minimum services to include other services that are necessary for chronically mentally ill people to live in the community. These include services related to maintaining people on medications such as lab and pharmacy, and psychosocial rehabilitation services. Psychosocial programs provide an array of services, including vocational services, independent living skills training, and social support. They address the broad needs of the chronically mentally ill in their reintegration into the community. Agency staff indicate that both medication-related services and

psychosocial programs have a major impact on the ability of people with chronic mental illness to remain in the community.

The TDMHMR has required both services in all service areas for over two years. Currently, all areas have medication-related services available, and 57 out of 60 service areas provide some component of psychosocial services. Adding medication-related services and psychosocial rehabilitation services to the list of core services would not add to the current cost of services because they are already available in most areas. Instead this amendment is designed to clarify the list of required core services.

- **The statute should be amended to apply the minimum service requirements to TDMHMR outreach service areas.**

While S. B. 633 was an attempt to establish minimum services in all areas of the state, the requirements for these services were placed in the section of the statute which relates only to eligibility for performance-based service contracts. Since state hospital outreach units are responsible for community services in 119 counties of the state and state school outreach units are responsible for community services in 142 counties, the array of core services available in these areas was examined to determine whether the agency was fulfilling the intent of the minimum core service requirements without statutory mandate.

The analysis of service availability indicated that each of the five core services are available through 28 of the 31 community centers. However, in the state hospital outreach service areas, only Rusk State Hospital outreach provides some component of all five required core services. The Terrell State Hospital, San Antonio State Hospital and Rio Grande State Center service areas have access to only three of the five core services. In state school outreach areas, most core services are available. However, in areas served by Brenham State School and Mexia State School only three of the five core services are available.

Expanding the application of the minimum service requirements to TDMHMR outreach service areas brings the statute in line with the original recommendations of the Legislative Oversight Committee.

This change will require that minimum services be provided in all areas of the state, not just in areas served by contracts with community centers. Such revision will provide the TDMHMR outreach programs with the same statutory direction as that given to the community centers.

**Better Methods for Obtaining Legally Adequate Consent for Mental Retardation Services Would Improve Access to Services.**

Legally adequate consent is defined as consent given by a person who a) has the legal capacity to give consent; b) has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of the service he is consenting to; and c) is free from coercion and undue influence when giving consent (Article 5547-300, Section 3(20), V.T.C.S.). The Mentally Retarded Persons Act (MRPA) expressly requires consent in three situations. However, Attorney General Opinion MW-339 provides a much broader interpretation of when consent is required. This opinion states that consent is required for admission to all residential or non-residential mental retardation services. It goes on to say that if a prospective adult client has not been declared incompetent, has no guardian, and can not give legally adequate consent for admission to mental retardation services, he must be denied the services. In a survey of 15 community centers, four state centers, and 13 outreach programs, it was determined that 23 people had been denied services for this reason in the past two years.

In addition, the attorney general's opinion requires that if an adult has been admitted to services and it is then determined that he has no guardian and can not give legally adequate consent, he must be discharged from services. If this was enforced, the survey indicated that 1,428 people would no longer be able to obtain services from the community programs where they are currently served.

When the MRPA was passed, the intent of the consent provision was to protect the rights of mentally retarded people. It was believed that if these individuals did not have the capacity to give consent, a guardian should be obtained or the person should be court committed for services. Two problems exist, however. First, it is not always possible to find a guardian and even when an appropriate person is available, sometimes the legal costs are prohibitive. These costs can go as high \$2,000 depending on where a person lives, the attorney's fees, and whether or not the case is contested.

The second problem involves court commitments. The only type of commitment authorized by the MRPA is a commitment to a residential care facility. There are many retarded people who do not need residential services but would benefit from day treatment and/or training. This type of outpatient commitment is authorized for mentally ill people, but not mentally retarded people.

- **The statute should be amended to authorize the commitment of mentally retarded persons to programs providing day services.**

This change would provide a mechanism to ensure that people needing and wanting services are not denied services. It would protect the more than 1,428 clients currently receiving services from any chance of being dropped due to their inability to give consent. It would also offer a means of protection to the staff of those community programs who, based on the results of a comprehensive diagnosis and evaluation, provide needed services when neither a guardianship nor legally adequate consent can be obtained.

Although there would be legal costs involved in this process, the costs should be less than those related to obtaining a guardian. A lower burden of proof would be required since providing day services is considered less intrusive. However, to ensure that client rights are protected, the statute should require an annual review of the appropriateness of the commitment and the need for it to continue. This should be part of the development of the client's individual program plan. If a change is needed, the community program should be responsible for informing the court of this and providing supporting information. The statute should also require a formal discharge process and state what conditions would allow the commitment to be invalidated. This should include obtaining a guardianship, completion of the appropriate training program, consistent failure to attend or refusal to participate in services, and/or lack of appropriate services to meet the needs of the client.

## **EVALUATION OF SERVICE GAPS AND DUPLICATION**

One focus of the analysis of the MHMR service delivery system examined gaps and duplication in services when multiple agencies serve similar populations.



Changes to state law, agency policy and the methods used for service delivery were identified which can reduce both gaps in services and duplication. Several recommendations in this area address the need for the state to examine the cost-effectiveness of contracting current state functions to existing local providers to reduce duplication and strengthen the array of services provided in the community. Other recommendations propose changes to two state service funding programs to remove identified gaps in service eligibility, disincentives for care, and duplicative funding. In addition, changes are recommended which clarify the responsibilities of the various agencies involved in genetic counseling and services to people with substance abuse problems. The individual recommendations are described below.

**Community Providers Could Deliver Certain Types of Care at a Lower Cost Than State Hospitals.**

The statute which authorizes the creation of the department sets out the policy of the state. Part of this policy is to encourage local agencies and private organizations to assume responsibility for the administration of services with the assistance of TDMHMR, and when appropriate and feasible, to treat people with mental illness and mental retardation in their own communities. This policy statement is consistent with the general direction in which the department is moving. The department's goal is to have a broad array of services available in each community, and for the state facilities to focus on the needs of clients who can not be appropriately treated by community providers.

Over the last few years, the department has made great efforts toward shifting the MHMR system in Texas from facility-based to community-based treatment. For example, an incentive program developed by the department, known as the \$35.50 program, lead to a 22 percent reduction in state hospital use. This allowed \$13 million to be shifted to community services over 18 months. During the review, several specific types of treatment provided in state hospitals were identified by department staff and through interviews with community providers which could be converted to community-based service provision resulting in reduced costs and less restrictive treatment.

Three types of services provided by state hospitals which the department should examine more closely include geriatric, extended care, and transitional living services. Geriatric units provided general psychiatric and nursing services to a total of 1,769 people over the age of 65 in fiscal year 1986. That year the units

served an average daily population of 820 people at an average cost of \$95 per day. Extended care units provide similar services to people who have been hospitalized for over five years, whose needs are primarily for supportive services, and whose conditions are fairly stable. State hospitals treated a total of approximately 1,124 people through extended care units in fiscal year 1986 at an average cost of \$91 per day. Transitional units are short-term treatment units designed to ready the patient for community living by providing vocational and independent living skills training. Transitional units served an average daily population of 87 patients in fiscal year 1986 at an average cost of \$85 per day. In total that year, 747 people received services on these units.

The following recommendations address the need for TDMHMR to review specific services provided in state hospitals which can be provided through community providers. The recommendations bring the department's operations more in line with the policy set out by the legislature in the agency's authorizing legislation and encourages the use of community providers when services of the same quality can be purchased at a lower cost. In addition, an ongoing mechanism is proposed which will require the department to periodically review the types of services it provides directly to clients and examine whether those services could be provided more cost-effectively in the community.

- **The statute should be amended to require the TDMHMR to actively seek nursing home placement for its long-term geriatric population and solicit proposals from community providers for the operation of geriatric units in a community setting for the remaining long-term geriatric hospital population.**

Many patients on the geriatric units could be candidates for nursing home placement, although some may require additional day programming or psychiatric services. Others could be treated in specialized residential facilities. In a June 1986 presentation of the 1988-1989 budget request, the department stated that under level one funding, the state could save \$14.5 million a year by placing 700 of their geriatric patients in nursing homes. If these patients were placed in nursing homes through Medicaid, then additional day programming and psychiatric services could be funded through the current \$35.50 program. If, however, nursing home placement is determined to be unworkable for some patients, they could be treated through personal care homes or residential programs with 24-hour staffing developed by

community providers to meet the needs of the geriatric patient. The average cost of personal care homes and similar residential programs provided by community centers was approximately \$62 per day in fiscal year 1985. Placing the 700 patients in facilities at this rate would result in an annual savings of \$8.4 million. With either approach, the state can realize major savings and patients can receive appropriate care in a community setting which is less restrictive and more normalizing than a state hospital.

- **The statute should be amended to require the TDMHMR to actively solicit proposals from community providers for the operation of extended care units in a community setting.**

Patients treated on extended care units are generally patients who have been hospitalized over five years and whose conditions are stable but involve severe mental disabilities. Some have secondary medical conditions. These patients are mostly under 65 and therefore would not be appropriate for nursing home placement. In fiscal year 1986, there was an average of 315 patients living on extended care units in state facilities. Services provided through extended care units generally include supportive services and medication management.

While the average state cost of a bed in an extended care unit is \$91, community centers' average fiscal year 1985 cost for intermediate residential programs was \$62 per day. The implementation of this recommendation can save the state \$3.3 million annually if all patients on extended care units were transferred to community-based programs designed as either personal care homes or specialized residential units with 24-hour staffing.

Few community facilities of this type currently exist since few public programs financially support such services in the community. However, given a stable source of funding, it is reasonable to expect that this type of unit could be established and function well in a community setting. Currently, community residents in need of such services can look only to nursing homes, foster care, or boarding homes to find alternatives to state hospitals for extended care services. The development of community-based extended care units would not only be more

cost-effective and complement the existing array of services in the community, but will also allow patients to receive treatment in a less restrictive and more normalizing setting than a state hospital.

- **The statute should be amended to require the TDMHMR to actively solicit proposals from community providers for the operation of transitional living units in a community setting.**

Many community centers currently operate transitional living units. These residential programs teach people the skills necessary to increase their degree of independence. The cost of these programs can be funded in part by federal funds through the Texas Rehabilitation Commission (TRC).

Most state hospitals also operate transitional living units to assist their patients in returning to the community. The average cost per day per patient on these units is \$85 which cannot be funded through TRC since services are provided through a state hospital. In July 1986, the six hospital-based transitional living units had an average daily census of 87 patients. However, throughout the year, 747 people received services on these units.

Several community centers have developed proposals to assume the operation of the transitional living units that are currently operated by state hospitals. They propose to provide similar services in the community at a lower rate. Moving these services to the community could also offer significant therapeutic benefits. People with chronic mental illness have difficulty in applying skills learned in one situation to another setting. Therefore, community living skills training is generally more effective when done in the community. Since transitional living services can be less costly and more effective when provided in the community, some community centers have expressed a desire to operate these units in the community, and federal rehabilitation funds are available for community training, it is no longer appropriate for these services to be retained in state hospitals.

- **The statute should be amended to require the TDMHMR to review, every two years, the types of services provided by the department and examine whether those services are available through community providers at a similar or reduced cost and submit its findings with its budget request.**

This will establish an ongoing mechanism for the department to review the services it provides directly to clients and report to both the Legislative Budget Board and the Governor's Budget Office as to whether continued state provision of the service is necessary. Such analysis can then be used in the development of the agency's biennial appropriation. This will also allow the legislature to monitor the department's implementation of its intent that services be provided through community providers, whenever possible.

#### **TDMHMR Administration of State Centers Is Inconsistent with State Policy and Should be Phased Out.**

State centers were originally created in the mid 1960s with federal funds as state-operated, community-based service providers, much like the community centers which developed about the same time. The department currently operates five state centers: Beaumont, Amarillo, El Paso, Laredo, and Rio Grande State Centers. State centers operate community programs much like those operated by the community centers including crisis stabilization, substance abuse services, case management, group homes, sheltered workshops, and respite care. Two state centers, Amarillo and Beaumont, only provide mental retardation services while the other three centers, El Paso, Rio Grande, and Laredo State Centers, provide both mental retardation and mental health services. The Rio Grande and El Paso State Centers, unlike the other three state centers, operate small scale facilities, of 60 to 130 beds, which resemble the residential services provided by state hospitals and state schools. They also provide the standard state center services. The total annual budget of the five state centers is \$25.6 million. All state centers except the Laredo State Center are located in the same area as a community center.

The review examined whether duplication exists and whether the state should continue to directly operate the state centers now that community centers have been established in the same areas. Also, the review examined whether private providers could be considered for the administration and/or operation of the Laredo

State Center where there is no community center. The agency's authorizing legislation sets out the state's policy with regards to direct service provision by the state. The policy is to encourage local agencies and private organizations to assume responsibility for the effective administration of mental health and mental retardation services with the assistance, cooperation, and support of TDMHMR. This policy is consistent with general government practice. The continued operation of the four state centers by TDMHMR when viable community centers are available to administer the services appears duplicative and inconsistent with the state's policy in this area. In addition, private provider operation of the Laredo State Center should be examined for feasibility and cost-effectiveness.

Interviews were conducted to determine whether TDMHMR had considered converting the administration of state centers to community centers or private providers. Department staff indicated that, although significant cost savings have been identified, the agency has no current plans to contract any of the state center functions. Two community centers indicated that they had presented various proposals to TDMHMR staff concerning the possibility of merging the operations to varying degrees to reduce both administrative and programmatic duplication. However, no proposal has been approved and none of the state center functions have been converted to community center operations. Agency staff indicate there has been no formal review of private provider operations of the state centers.

One proposal did result in TDMHMR's appointment of a task force to study the feasibility of transferring a state center to a community center. The task force conducted public hearings in the area. While there was little testimony in support or opposition to the merger, the most often stated needs in the area were for more services, improved cooperation between the two providers, and the integration of all resources. However, the task force did not recommend the transfer because of problems which related primarily to the proposed methods by which the merger would take place and the proposed time frame for the merger. Another community center indicated that, while it had not submitted a formal proposal, there is substantial administrative duplication between a state center and community center located in the same area. In addition, there was concern that the public perceived the agencies as duplicative since there were two MHMR providers in one town and people were confused as to where to turn for help.

Several benefits are possible through the operation of state center services by community centers. Community centers are able to obtain certain federal

grants which state agencies can not obtain. Community centers regularly obtain considerable community support in the way of facilities and funding. They are able to use their funds with greater flexibility which often leads to greater efficiency. Some services provided by both agencies could be integrated to increase cost-effectiveness. And finally, having one agency responsible for administration of community mental health and mental retardation services for an area would allow for the development of a well planned comprehensive array of services instead of two parallel service delivery systems.

Other potential benefits are possible by examining private operation of a state center. As stated in previous recommendations concerning the federal government's A-76 process, such examination requires the government to analyze cost-effective service delivery, which increases accountability and often results in significant cost savings. If private providers can operate a service adequately, at a savings, the state should contract with them.

In summary, the review found that community centers are located in four of the five areas in which TDMHMR operates state centers and that community centers operate many of the same services and have very similar administrative structures as the state centers. Indications of administrative duplication, as well as service duplication, were identified. Benefits, in addition to reducing that duplication, have been identified which would accompany the administration of state center services by community centers. In addition, the review indicated that TDMHMR should formally examine whether private providers are available that can administer and/or operate Laredo State Center appropriately but more cost-effectively. Therefore, the following changes are recommended which increase cost-effectiveness and are consistent with state policy.

- **The statute should be amended to require the TDMHMR to negotiate contracts for the administration and/or operation of four state centers by area community centers by January 1, 1988.**

Contracting with existing area community centers is recommended to increase cost-effectiveness, reduce duplication, and unify the responsibility for community-based mental health and mental retardation services in local service areas. Several methods of accomplishing this transfer of responsibility were examined. The recommendation leaves TDMHMR the flexibility to either contract just the administration or the entire operation of the state center.

If the department chose to only contract for the administration of the state centers, the TDMHMR staff indicated that the state could save from \$1.5 million to \$3 million a year by reducing duplicative administrative costs. This would allow state center employees to continue as state employees but give the community center the authority for all state center operations. While such an arrangement is unusual, it is working in local health departments with 400 Texas Department of Health staff.

If, in contrast, the total appropriation for the state center was contracted to the community center and the community center was responsible for employing the staff as community center staff, there would be an additional savings to the state of \$4.9 million in state benefits that would not transfer. In addition, there is a potential for increased local revenue which cannot accurately be estimated at this time.

If the department is unsuccessful in contracting the entire state center operations to the community centers, then an attempt should be made to contract out discrete functions. Finally, if the department retains the direct administration of any state center service, it should attempt to contract again with the community center every two years to determine whether the community center has developed the capacity to administer the services.

- **The statute should be amended to require the TDMHMR to solicit proposals for the administration and/or operation of the Laredo State Center by January 1, 1988 and report its findings to both budget offices.**

Soliciting proposals will provide the state with valuable information as to whether continued state operation of the Laredo State Center is a cost-effective decision. It is expected that private providers would be the primary respondents to the proposal request. The information obtained can assist the legislature in its direction of the department. This process will ensure these services are delivered in a high quality manner that maximizes cost-effectiveness and the use of local or private providers when possible.



### Making State Center Clients Eligible for Two Major TDMHMR Programs Would Improve Services.

Two incentive programs are available to community centers and outreach programs for funding new community services as people leave institutions. Both programs were developed in response to the two federal lawsuits. State school residents and people on the waiting list are eligible for a \$55.60 per day sponsorship for community placement (\$55.60 program). For the state hospital patients, a community program is reimbursed \$35.50 for each bed day which is not used by its area residents (\$35.50 program). These programs have resulted in a major shift of the clients and funds from institutional to community-based services. Approximately nine percent of the people eligible for the \$55.60 program have been moved to community placements through the program. Similarly, bed days provided by state hospitals have been reduced by approximately 22 percent in the first 18 months that the \$35.50 program was in operation. As a result, funds have been transferred and services which reduce the need for institutionalization are now available in many communities.

While both programs offer placement incentives for most state facility residents, state center clients are ineligible. Two state centers, El Paso and Rio Grande State Centers, provide long-term residential services which are similar to state school services and psychiatric services similar to those in state hospitals. The TDMHMR staff indicate that the clients in these facilities are ineligible for incentive programs because they are excluded from the R.A.J. and Lelsz staffing ratio requirements and the agency defines state centers as community facilities. However, a July 1986 ruling on the Lelsz case brings into question whether state center residents are excluded from the court-ordered staffing ratio.

All TDMHMR long-term residential mentally retarded clients and patients in state psychiatric hospitals should be given equal access to the placement incentives. In general, services should be allocated equitably, based on client needs. Further, the state should attempt to treat clients in the least-restrictive, cost-effective placements that are appropriate. Excluding state center clients from these two programs is inequitable and not cost-effective.

A previous recommendation proposes that TDMHMR contract the operations of the state centers to the local community centers. (See page 121.) When that change is implemented, the state center residential clients may no longer be considered TDMHMR clients but instead clients of the community center. There-

fore, the clients will not be included in the \$35.50 or \$55.60 program funding. However, until these facilities are contracted to the community centers, the following changes are needed.

- **Mentally retarded state center residents should be eligible for the \$55.60 program.**

Of the 10,000 mentally retarded people in long-term residential treatment, 211 are placed in two TDMHMR State Centers, the El Paso and Rio Grande State Centers. The average cost for residential mental retardation services is approximately \$147 per day. Based on the utilization rate of the current \$55.60 program, it is estimated that, if eligible for participation, approximately 19 state center residents would be sponsored in community placements at a cost of \$385,500 per year. The average cost of serving 19 residents in a state residential facility for one year is \$1 million. Therefore, implementation of this recommendation could result in more appropriate services being available for these clients at an annual cost savings of approximately \$614,500.

- **State center psychiatric beds should be added to the bed day count for the \$35.50 program.**

The TDMHMR has found that as bed day use in state hospitals has reduced through the \$35.50 program, the use of the state center beds has increased. The average cost of a psychiatric bed provided by a state center is \$163 per day. The two state centers provide approximately 45,500 bed days of service per year, currently. It is reasonable to expect that applying the \$35.50 program to state centers would produce similar reductions in state centers as the 22 percent reduction observed in state hospital bed use. Given similar reductions, after 18 months the state would realize a savings of \$1.3 million per year by implementing this recommendation. Further, including the two state centers in the \$35.50 program will ensure that equal incentives are available to develop adequate community-based resources in the El Paso and Harlingen areas.

**Better Assessment of the Quality and Cost-Effectiveness of State Supported Genetic Services Could Increase the Numbers of Clients Served.**

Genetic screening and counseling services are now provided throughout the nation utilizing many service delivery configurations. The general goal is to provide a medical evaluation of individuals and families to determine the presence or absence of inherited genetic problems and to provide appropriate treatment and follow-up care. In Texas, genetic services are provided and funded through various public and private sources including TDMHMR, the Texas Department of Health (TDH), medical schools and private laboratories. There is concern that because funding for these services comes from different sources and is spent in various ways, the provision of services is fragmented, duplicative and not cost-effective. The validity of these concerns is hard to ascertain since no standard method for comparing the costs of genetic services exists. In addition, the way in which services are delivered and the range of those services varies between genetic providers. To date, there has not been a comprehensive examination of this range of services to determine which approach is most effective in preventing birth defects and in minimizing the impact of certain genetic disorders.

To understand the publicly-supported system of genetic services in Texas, the basic components of the three primary state funded providers must be examined. These three include TDMHMR's Genetic Screening and Counseling Service (GSCS), TDH, and the state's medical schools.

The GSCS has a fiscal year 1986 appropriation of \$2.35 million and delivers genetic services to the public at large through a statewide network of 23 regional clinics. (See Exhibit 7.) Many of these clinics are located in rural areas and all provide testing, diagnosis, prognosis, counseling, psychosocial support, medical intervention, and a link to other support services. They also provide community education to non-medical groups.

The Texas Department of Health has two subdivisions of service. The first is a regulatory blood testing program with an appropriation of \$1.8 million in fiscal year 1986. It screens all newborns for four genetic diseases that can cause mental retardation if undetected. This service was provided to 308,000 babies in fiscal year 1985. The second service is the Texas Genetics Network (TGN) and Sickle Cell Screening program which contracts with university-affiliated medical schools and private foundations to provide genetic screening and counseling. It is funded at \$417,000 for fiscal year 1986.

Exhibit 7

Genetics Screening And Counseling Service  
Texas Department of Mental Health and  
Mental Retardation



The Texas medical schools are a major provider of genetic services in the metropolitan and surrounding areas of the state. They receive approximately \$3.7 million in state funds to provide education to medical students and expand knowledge of genetics through research. In general, medical schools are capable of more sophisticated research and have diagnostic laboratories which can identify relatively rare and difficult to diagnose genetic disorders.

The review of TDMHMR attempted to compare costs between the various genetic providers. This issue was addressed by an earlier study, known as the "Campbell Report", which was recommended by the Legislative Budget Board in 1980 and commissioned in 1983. This report was critical of TDMHMR's Genetic Screening and Counseling Service for high administrative costs, low output and lack of coordination. In addition, the TDH's decentralized approach in administering the Texas Genetic Network was criticized for its failure to provide adequate program structure, guidance, and performance requirements. Examination of the continuing validity of these concerns was intensified by the desire of the private sector to consolidate TDMHMR funds with TDH funds in the belief that contracted genetic services would be more cost-effective.

During the review, information to accurately compare costs for comparable services was not available. However, there was some evidence to suggest that the original criticisms of GSCS cited in the 1980 Campbell Report have been corrected. For example, a recent comparison of actual test costs of GSCS, excluding follow-up, appeared equivalent to or below other genetic providers. Also, GSCS has implemented management changes that have substantially increased genetic services and the availability of clinics while reducing its administrative costs.

Despite these findings, the private providers, medical schools and GSCS currently overlap in some service areas. This may have created a confused picture to the consumer seeking genetic services. In addition, there is no formal method to coordinate services and no standard method to compare costs that can be used to determine cost-effectiveness. It would appear that these problems should be addressed if a comprehensive network of efficient services is to be achieved.

The model provided by the Interagency Council on Early Childhood Intervention (ECI) appears to have the potential for obtaining the information to make these assessments and to implement any changes to the system that may be needed. Essentially, the ECI program establishes an interagency board with public

representation to make policy decisions on how services should be most effectively implemented, and utilizes an advisory committee to provide technical assistance and support. This model should be tailored to meet the needs of the state in providing genetic services.

- **An Interagency Council for Genetic Services should be created.**

The council should be composed of representatives from TDMHMR and TDH, a medical school provider elected from within its membership, and two lay members appointed by the governor. (See Exhibit 7 for details of composition and terms.) The cost of clerical and advisory support shall be shared equally among the council representatives, excluding the lay members. The council shall select and utilize lay and professional advisors as needed. The council should promote greater coordination among genetic services providers.

- **The Interagency Council for Genetic Services should be responsible for the development and implementation of procedures to effectively address cost-effectiveness, identification of current and future needs, improved coordination, and guidelines for monitoring genetic services.**

This statutory change would address many issues mutually identified by the participating agencies. It would provide a means for long-range planning, concentrate resources where there is the greatest need, assure the availability of quality services, protect the public from inadequate laboratories, and develop a method to evaluate the cost-effectiveness of genetic services on a statewide basis. (See Exhibit 7 for details of responsibilities.)

- **The Interagency Council for Genetic Services should prepare and submit a report to the 71st Legislature on recommended changes that would improve the genetic services system.**

This would allow legislative oversight of the council's activities in achieving cost-effectiveness, improving coordination, developing guidelines for monitoring genetic services, and improving the service delivery system. The council should be authorized to contract for the preparation of this report.

**Exhibit 8**  
**INTERAGENCY COUNCIL FOR GENETIC SERVICES**

- A. Composition
  1. TDMHMR representative appointed by TDMHMR commissioner.
  2. TDH representative appointed by TDH commissioner.
  3. Representative from participating medical school providers elected from their membership.
  4. Two lay members appointed by the governor.
- B. Terms
  1. Lay members serve for two years.
  2. All departmental representatives serve at the pleasure of their respective commissioner or dean or until termination of departmental or university employment.
- C. Council members annually elect a chairperson.
- D. Actions require a majority vote.
- E. Meetings occur at least quarterly.
- F. Annual progress reports must be submitted to the departmental boards for review.
- G. Council Responsibilities
  1. Survey current resources for genetic services in Texas.
  2. Initiate a scientific evaluation indicating current and future needs for such services.
  3. Develop comparable data base among providers which will permit evaluation of cost-effectiveness and value of different genetic services and methods of service delivery.
  4. Promote a common statewide data base to study the epidemiology of genetic disorders.
  5. Assist the coordination of statewide genetic services for all Texas residents.
  6. Increase the flow of information among separate providers and appropriation authorities.
  7. Develop guidelines to monitor provision of genetic services.
- H. Advisory Support - The council shall select and utilize lay and professional advisors as needed for its work.
- I. Support Staff - The cost of clerical and advisory support will be shared equally by TDH, TDMHMR, and the medical school that is represented on the council.

**Increased Efforts Are Needed to Reduce Commitments of Substance Abusers to State Hospitals.**

The 68th and 69th Legislatures recognized the need for the Texas Commission on Alcohol and Drug Abuse (TCADA) and the Texas Department of Mental Health and Mental Retardation (TDMHMR) to work together to develop community-based services that would reduce the use of state hospital beds for individuals with substance abuse problems. To date only minimal reductions have been made. Although the actual number of admissions to state hospitals has decreased from almost 6,800 in fiscal year 1983 to just over 6,500 in fiscal year 1986, the percent of the substance abuse patients out of the total number of admissions has increased from 36 percent to 41 percent during this time period.

The department has developed an incentive program, known as the \$35.50 program, which encourages community centers to develop local services which will limit the need for a person to go to a state hospital. This program has been very successful and reduced state hospital bed day use by 22 percent in the first 18 months of its operation. However, the hospital substance abuse units are not included in this incentive program.

The Texas Commission on Alcohol and Drug Abuse is authorized by an appropriations rider to grant funds for the screening of alcoholics prior to institutionalization and to develop alternatives to hospitalization through services provided by community MHMR centers. In fiscal year 1986, TCADA allocated over \$3.5 million in grants for community-based treatment and rehabilitation of alcoholics. Since January 1, 1986, the agency has administered over \$3.1 million in drug treatment and rehabilitation grants. Two problems were identified with the way these grants are allocated. First, the current process does not include an analysis of the degree to which an area uses a state hospital for treatment of substance abusers. That type of information is available by county from TDMHMR, but is not currently provided to TCADA. Second, when TCADA enters a contract with a grantee, there is no requirement in the contract that the grantee reduce state hospital utilization.

To correct these problems and ensure that legislative intent to reduce hospitalization of substance abusers is carried out, the following recommendations are made.



- **The TDMHMR should be required to annually provide the TCADA with an analysis of hospitalization rates of substance abusers by county of residence. The TCADA should be required to consider hospitalization rates in making allocations of grant funds and include a provision in its treatment and rehabilitation grant contracts that the grant is for a program that will reduce state hospital utilization by a certain percent.**

The information from the TDMHMR should be broken out to indicate which admissions were strictly for individuals with a substance abuse problem and which were for people who were substance abusers, but whose primary diagnosis was some type of psychoses. Access to this information should assist the TCADA in allocating grant funds to areas that need to develop, expand, or improve their local services and reduce their use of state hospitals. Requiring the grantee to agree to reduce utilization of state hospitals should have a positive impact.

- **The TDMHMR should use existing funds for substance abuse services to develop contracts with community-based programs to reduce bed day utilization for substance abusers in state hospitals.**

The Texas Department of Mental Health and Mental Retardation's success with this type of program has been documented. However, this effort by the department should be coordinated with the TCADA to ensure a united approach in meeting the state's goal to serve substance abusers in community programs.

- **The TDMHMR and the TCADA should, on a biennial basis, jointly determine how many, if any, state hospital beds should be maintained for people with substance abuse problems who can not be served in the community.**

This determination would assist the TDMHMR in the development of its biennial budget request. It would also serve as a mechanism for the legislature to evaluate the progress that has been made on reducing the use of state hospitals for substance abusers.

## **EVALUATION OF THE BALANCE IN THE ARRAY OF MHMR SERVICES**

The analysis of the department's current efforts to provide a balanced array of services within the existing resources of the state identified several statutory changes that are needed to strengthen the agency's efforts. These recommendations relate to a need for the regulation of certain boarding homes and inpatient

treatment programs, changes to zoning laws and commitment procedures, and the continuation of the Interstate Compact on Mental Health. In addition, several changes to TDMHMR policy were identified which can enhance the development and operation of a balanced array of services in all Texas communities. The changes are designed to increase the efficiency and effectiveness of the array of services and make private and public services more responsive to the needs of people with mental illness and mental retardation. The recommendations are described below.

**Regulation of Boarding Homes that Accept MHMR Referrals is Needed.**

Boarding homes have addressed the need for low-cost housing for many years but only recently have they been occupied by increasing numbers of people with mental illness and mental retardation. Some disabled people turn to boarding homes because no other adequate long-term, semi-independent housing is available when they are unable to manage an apartment or a house independently.

Boarding homes are not regulated by the state unless they provide services in addition to room and board. Some cities regulate boarding homes under a regulatory scheme designed for the hotel industry. That system does not consider the conditions necessary for boarding homes accepting mentally ill and mentally retarded people. If the boarding home provides additional services such as medication supervision, then the facility can come under the state regulation of personal care homes. Application of the standards used for personal care homes to regulate boarding homes has been considered. However, this could result in raising rates to a level which is not affordable to many MHMR clients.

Case management services are now available in each area of the state. One of the main functions of case managers is to link the client with available community resources and to monitor the appropriateness of the resources used by the client. In the effort to obtain and monitor affordable, semi-independent housing arrangements for MHMR clients, case managers in many areas have developed an informal method of regulating the quality of boarding homes where their clients live. Many monitor this quality by frequent contact with the clients and encouraging them to move if conditions deteriorate. Some work with boarding home staff informally to bring about improved conditions. Some mental health authorities have recently started providing services in boarding homes through a contract with the home as a more formal way to improve the conditions and

provide more regular treatment to residents who are not keeping appointments. However, these informal methods are ineffective in cases of seriously inadequate boarding homes. The MHMR system has no authority to enter boarding homes to monitor conditions or investigate complaints. Without such authority, the MHMR system is unable to offer any real protection to these vulnerable clients.

- **The local mental health and mental retardation authorities should be authorized to regulate the boarding homes that accept referrals from the authorities.**

Such regulation will authorize the MHMR system to more closely monitor the activities in boarding homes to which clients are referred. Local mental health and mental retardation authorities would be authorized to regulate the boarding homes in their area in consultation with the local fire marshal and local health authority. In areas where the MRA and MHA are separate providers, they would be required to adopt a memorandum of understanding to reduce duplicative regulation of the local boarding homes. This plan is designed to build on the existing information network between MHMR clients and program staff and the technical resources available through other local authorities. Local regulation can allow for sensitivity to local needs and resources but should be in agreement with a general regulatory framework established by TDMHMR to ensure statewide consistency. This recommendation is designed to give the local authorities the regulatory tools necessary to effectively monitor and improve the quality of the boarding homes they are already working with or where their clients live. As such, additional costs should be minimal.

- **The TDMHMR should be required to adopt, in consultation with local mental health and mental retardation authorities, rules establishing a general regulatory framework consistent with the statute for the local regulation of boarding homes accepting MHMR referrals.**

The development of general procedural guidelines for local regulation will provide a degree of statewide consistency and reduce the burden on local authorities to independently establish a regulatory framework. The rules should be established with information obtained from local mental health and mental retardation authorities. Such guidelines should establish acceptable methods of regulation but provide flexibility

to the local authorities as to the specific standards, inspection methods, and enforcement procedures used locally.

### **Current Zoning Restrictions Limit the Availability of Affordable Group Homes.**

Group homes are a significant resource in the array of services necessary to care for severely disabled people with mental illness and mental retardation. They provide low cost room and board, therapeutic services, and a support network for the person living in the community. In 1985, the Legislative Oversight Committee on Mental Health and Mental Retardation (LOC) examined the residential needs of the chronically mentally ill in Texas and established a goal of 60 community residential beds per 100,000 population. The TDMHMR has incorporated this into its long-range goals by requiring an increase of 11,000 community beds by 1991. The LOC also recommended that two-thirds of these community beds be low cost, rehabilitative beds such as foster care and certain types of group homes. They recommended that the TDMHMR and the legislature work to develop incentives for the development of community residential resources and cited the need for changes to zoning laws to reduce restrictions to group home development.

The 69th Legislature adopted S.B. 940 which reduces the restrictions placed on group home development in residential areas. The bill allows non-profit group homes to be a permitted use of a house in a residentially zoned area. The bill does not require a home to have supervisory personnel on duty. However, it limits the capacity of a group home to six residents and two supervisory personnel. The home must maintain any required licenses and cannot be located within one-half mile of the nearest group home. The bill defined a group home as providing food and shelter, guidance, care, habilitation services, or supervision.

The size limits and distance restrictions in S.B. 940 closely mirror restrictions made by the ICF-MR program in 1982 in an effort to slow the rapid development of new ICF-MR facilities. These facilities are often like group homes, are financed through Medicaid, and only serve mentally retarded people. However, they often provide more intensive treatment than other group homes. The six-bed restriction adopted in 1982 decreased the cost-effectiveness of ICF-MR facilities and slowed development from 495 new beds in 1981 to 126 new beds in 1985.

Interviews with community center staff indicated that the zoning exemption provided in S.B. 940 has greatly aided them in the development of group homes.

However, they indicate that the development of six-bed group homes is creating many homes which are not cost-effective or affordable for residents. Factors which increase a group home's affordability are very important considerations when developing group homes because there are few public programs which subsidize such placements. In addition, the size of a group home is important because the residents of the group home provide a valuable support network for each other. Centers indicate that it is preferable to operate a group home with a few more residents than is required to financially support a home so that vacancies in the home will not result in a financial crisis or weaken the support network. When a resident's portion of expenses becomes too high because of vacancies and there are too few residents to provide a viable support network, group homes are often forced to close.

The cost of services in group homes varies a great deal. However, for the purpose of analysis, staff of the Mental Health Association provided an estimate of the cost of group homes of different sizes with two types of staffing, 24-hour staff and day staff only. The estimates consider a staffing ratio of one staff to six residents in the day and one staff to 12 residents in the evening and night. This staffing represents the average basic group home services. The estimated monthly cost per resident in each type of home is as follows:

	<b>Monthly Cost Per Resident</b>		
	<b>6 Residents</b>	<b>8 Residents</b>	<b>12 Residents</b>
<b>24-hour staff model</b>	\$966	\$ 796	\$ 691
<b>Day staff only model</b>	\$487	\$ 437	\$ 356

The resources to support the cost of group home operations were also examined. Many residents' only source of income is Social Security which provides a maximum monthly income of \$336. The only type of group home that these residents can afford is the 12-bed group home with day staff only. This would still require a small subsidy but the clients could pay most of their room and board costs. As the bed capacity of a home decreases, the types of services provided by the home remain the same, but the subsidy required increases dramatically.

The following recommendations indicate changes to Texas law which can further encourage the development of group homes, enhance their cost-effectiveness and allow the development of group homes which are affordable to people living on Social Security. The first change is designed to make a slight increase in

the capacity of group homes in areas zoned for single family dwellings. The second change is designed to encourage the development of larger group homes in residential areas which are zoned for multi-family or mixed use.

- **The statute should be amended to extend the current zoning exemption for group homes to those group homes which have eight residents.**

Senate Bill 940 does not require a group home to have supervisory staff on duty and many do not require supervisory staff. Authorizing eight people in a home, if therapeutically indicated, could increase the home's residential capacity by 33 percent and increase its cost-effectiveness. The basic cost of group homes that are developed with an eight-bed capacity and day staff only will have a monthly cost which is \$50 less per resident than a six-bed home. If such savings had been applied to 50 percent of the approximately 2,800 group home beds operated by community centers in fiscal year 1984, approximately \$850,000 would have been saved that year without reducing services.

- **Group homes with 12 residents operated by the TDMHMR or community centers should be a permitted use in residential areas which are not zoned for single family use.**

This would allow the TDMHMR and community centers to develop larger group homes in residential areas which are designated for multi-family or mixed use. With this change, a group home would be limited to a capacity of 12 people living in the home. The homes must comply with all other requirements for group homes, including licensing requirements. The exemption is limited to homes operated by the TDMHMR or community centers to ensure the state's oversight concerning the homes' operations.

This change will allow group homes to operate more cost-effectively and allow the development of homes which provide services to twice as many people as those developed under the current zoning exemption. The basic cost of groups homes that are developed with a 12-bed capacity and only day staffing could be supported by residents on Social Security with only minimal financial subsidy. This could lead to the development of group homes which are affordable to the approximate 436,000 disabled people in Texas who receive Social Security. For many

of these people, boarding homes are the only housing option currently available that they can afford.

**Commitments to State Hospitals Should Stop When Appropriate, Less Restrictive Alternatives are Available.**

The legislature has modified the mental health commitment process several times in an effort to encourage the treatment of people in less restrictive, community-based settings, whenever it is appropriate. Currently when court-ordered mental health services are applied for, the Mental Health Code requires a provider designated by TDMHMR to file a recommendation with the court indicating the most appropriate treatment of the person. The judge is required to consider that recommendation and commit the person to the least-restrictive appropriate setting. However, with the current requirements, local mental health authorities state that the courts continue to commit people to state hospitals despite the availability of appropriate and less restrictive treatment facilities in their communities.

The Legislative Oversight Committee on Mental Health and Mental Retardation recommended that revisions to the mental health commitment process be investigated that would increase the appropriate use of commitments to community-based services instead of state hospitals. That committee also recommended that the alcohol commitment law be revised to require screening by the community MHMR centers prior to admission to the state hospital. In addition, the 69th Legislature expressed a desire that substance abuse commitments be diverted from state hospital treatment into community-based programs, both through a rider to the appropriations bill and through S.C.R. 64. To address a similar goal, the TDMHMR Initial Strategic Plan proposes the concept of a "single portal of entry" as one means of ensuring that people are treated in community-based facilities when possible.

The single portal of entry concept proposes that people only be admitted to state hospitals if the person cannot be adequately treated through local resources. The review examined the current mental health delivery system in Texas to determine how the concept could be applied and what measures were needed to ensure that the transition to a single portal system is accomplished smoothly, only when adequate community services are available, and in a manner that ensures the patient's needs are the first consideration.

The recommended implementation of the single portal concept for Texas will require minimal changes to the Mental Health Code and the alcohol and drug dependence commitment provisions. The basic change proposed is that in areas where a mental health authority (MHA) is approved to serve as a single portal, all mental health commitments which previously would have been made to the state hospital will be made to the single portal authority. The single portal authority would also assume the state hospital's responsibility for receiving committed patients transferred from private hospitals. In both cases, the single portal would have the authority to transfer a patient to a state hospital if it did not have adequate services to treat the patient locally. Alcohol and drug dependence commitments would still be made to any facility approved by the Texas Commission on Alcohol and Drug Abuse other than a state hospital; however, only the single portal authority could approve the transfer of a substance abuse patient to a state hospital. The single portal authority would be authorized in all cases to approve an emergency admission to a state hospital directly from any provider when failure to do this would endanger a patient.

Designation as the single portal authority carries with it a high level of responsibility. Therefore, safeguards are warranted to ensure that MHAs are only designated as single portal authorities when they are capable of handling the accompanying responsibilities. Once the department has determined that a MHA operates or contracts for the appropriately licensed inpatient facilities and all core services required by law, then the quality and quantity of those services should be assessed by an independent review committee. If, based on objective standards developed by the committee, it is determined that adequate services are available, the committee should designate the MHA as the single portal of entry for a specified area.

Statutory direction is needed to ensure that the single portal review committee functions as an independent review body. The committee should be appointed by the TDMHMR board and include representatives of state hospital superintendents, community center directors, private psychiatric hospitals, licensed substance abuse facilities, private psychiatrists, county judges, police chiefs, and consumers. The committee should be required (a) to develop the standards by which designation as a single portal authority is determined, (b) to decide how an MHA should "apply" for the single portal authority designation, and (c) to approve the designation of the local MHAs. The standards should address the



types of services that should be available and the quality and quantity of those services. Once the standards are in place, the committee's role should focus on the evaluation of MHA applications for single portal designation. The committee should be given the flexibility to decide whether to conduct the evaluations through its members, agency staff, or consultants on contract. When reviewing individual MHA applications, the committee should involve key people from the local area by allowing the local county judge(s), state hospital superintendent, and police chief to participate in the committee's decision-making process.

The review also indicated that the TDMHMR \$35.50 program creates an incentive for a single portal authority to make decisions based on fiscal considerations rather than patient needs. The \$35.50 program provides funding incentives to MHAs for keeping patients out of the state hospital. Since it reimburses the MHA for not sending patients to the state hospital, it has been criticized for encouraging MHAs to retain patients that cannot be appropriately cared for locally. Efforts to correct this problem should be made prior to the designation of any MHA as a single portal authority.

Recommendations which establish a procedure for designating a local MHA as a single portal of entry, and safeguards addressing problems identified in the review, are described below.

- **The mental health and substance abuse commitment laws should be modified to establish a single portal of entry process beginning September 1, 1988 in areas which provide the necessary community-based services.**

This recommendation strengthens commitment provisions to ensure that patients are treated in local settings whenever appropriate. Twenty-two states currently use a single portal of entry process. It puts the decision to place a person in a state hospital on the MHA if they are designated as the single portal of entry. It is designed to give the MHMR and substance abuse systems an ability to limit inappropriate state hospital admissions when community-based services are available. The judicial system will retain the responsibility to determine whether court-ordered inpatient treatment is warranted, but will allow the treatment professionals in areas with appropriate resources to determine whether that treatment is provided locally or through a state hospital. While the MHMR system will be given greater control over patients who are treated in the public sector, the proposed changes will

not limit the current use of licensed local private providers. The provisions will take effect September 1, 1988 to provide adequate time for planning, resource development, licensing, designating single portal authorities, and educating the courts and providers concerning the new process. In order that such a change can be implemented without creating hardships for patients, the TDMHMR should be required to develop rules as to how the MHAs designated as the single portal of entry should handle commitments and transfers and to provide for emergency admission to state hospitals when obtaining the approval of the single portal MHA could endanger the patient.

- **The statute should be amended to require the board to appoint a Single Portal Authority Review Committee by September 1, 1987.**

The committee will provide an independent review body for developing the standards to designate MHAs as single portal authorities, deciding how applications should be evaluated, and evaluating the applications. It should be composed of nine members appointed by the board for staggered two-year terms. The nine members should include two members representing consumers of mental health services; and one member each representing state hospital superintendents, community center directors, county judges, police chiefs, private psychiatric hospitals, licensed substance abuse facilities, and practicing private psychiatrists. The committee should be appointed by September 1, 1987. The standards and the plan for evaluating applications should be approved by the board by September 1, 1988. The standards should be adopted through the rule-making process to ensure public input.

Once the standards are in place, the committee's activities will focus on the evaluation of MHA applications for single portal designation. The committee should be given the flexibility to decide whether to conduct the evaluations through its members, agency staff, or consultants on contract. When reviewing individual MHA applications, the committee should involve key people from the local area by adding three positions on the committee for local representatives. These positions would be voting members appointed by the board. The board should appoint one representative of the county judge(s) in the area, a

local police chief, and the director of the state hospital serving the area. These positions are for the purpose of assisting in the review and obtaining a local perspective on the application. These positions expire when a final decision is made on the application. The TDMHMR should compensate the committee members and local participants for their expenses and should provide the committee a staff budget with the option of using TDMHMR staff support or contracting for consultants to conduct site visits.

- **The TDMHMR should modify the \$35.50 program policies to ensure that TDMHMR funding of a single portal authority is provided before services are delivered and the fiscal incentive to reduce hospital use is removed.**

Two problems were identified in examining the concept of single portal of entry in light of the agency's \$35.50 program. The \$35.50 program establishes a financial incentive which could inappropriately outweigh the clinical decision as to whether a patient needs to be transferred to a state hospital. When a MHA is designated as the single portal authority, it will have more authority to control hospital admissions. Therefore, the department should minimize any financial incentives that could interfere with appropriate, patient-oriented clinical decisions.

In addition, the \$35.50 program does not fund MHAs to develop services which thereby reduce hospital use, but instead requires that bed use be reduced so that services can be funded. This retroactive funding can lead to an initial lack of services. Ensuring that single portal authorities have adequate resources in place before they treat patients should be a priority with the department and the funding strategy should be modified to reflect that priority.

### **Regulation of Facilities Used for Involuntary Inpatient Commitments is Needed.**

Until only recently, most people who needed court-ordered inpatient care were committed to either a state hospital or a licensed private psychiatric hospital. However, people are now being committed to community-based crisis stabilization units and other structured residential programs for treatment. These facilities have developed as effective ways to meet people's need for inpatient

treatment without requiring the expense and restrictiveness of hospitalization in a state facility.

For many people, inpatient psychiatric treatment has traditionally meant extended hospitalization far from home in a large state hospital. Over the last decade, community centers that were a great distance from the closest state hospital began establishing crisis stabilization units in their areas. These facilities are small community-based residential facilities designed to provide short-term hospitalization. They attempt to alleviate the crisis and avoid unnecessary admission to the state hospital. Since many people in crisis only require short-term intervention services, the crisis units enable them to return home within several days whereas admission to a state facility usually meant weeks and sometimes months of hospitalization. The importance of crisis stabilization units in reducing unnecessary hospitalization was underscored in 1985 when the legislature adopted S.B. 633 which requires all community centers to provide crisis stabilization and community-based hospitalization as a condition of eligibility for state funds.

Many communities have also developed other types of structured residential programs which can provide longer term inpatient care in the community. These facilities provide 24-hour intensive supervision and structured activities for the patients. Such facilities can often provide appropriate treatment for a person following more intensive treatment in a crisis stabilization unit or a state hospital. In some areas of the state, people are being committed to this type of program for involuntary treatment.

The rapid development of crisis stabilization units, and other structured residential facilities which provide court-ordered inpatient treatment, has uncovered a problem with the current regulatory framework. People are now being committed to facilities which have not been evaluated for health and safety factors or their capacity to provide treatment. These units could come under the current jurisdiction of TDMHMR's regulation of private psychiatric hospitals, but they do not. While these facilities are not statutorily exempt, TDMHMR does not require the facilities to obtain any type of license. In contrast, TDMHMR community standards require crisis stabilization units which treat children and adolescents to be licensed as a private psychiatric hospital. In addition, in 1985 the legislature acted on the need to regulate alcohol treatment facilities which provide court-ordered treatment. The Texas Commission on Alcohol and Drug Abuse (TCADA) is now required to license all facilities which provide alcohol treatment.

Commitments for court-ordered treatment for alcoholism can only be made to facilities licensed by TCADA.

Adults receiving involuntary court-ordered mental health treatment are no less seriously disturbed than are children, adolescents, or alcoholics who require court-ordered treatment and therefore, deserve the same degree of protection through regulation. An adult is committed to inpatient treatment only after a determination is made that the person must be held in the facility involuntarily because he is likely to be a danger to himself or others or will continue to be in distress and his condition will deteriorate if not treated. These patients occasionally need to be secluded for their own protection and entire units are sometimes locked to restrain certain patients. The state has a responsibility to ensure that any facility which provides inpatient mental health treatment through a court-order meets minimum standards of health and safety and has access to the specialized care required to provide effective treatment.

- **The statute should be amended to establish a new category within the TDMHMR's authority to license private psychiatric hospitals to regulate community-based facilities which provide court-ordered inpatient mental health treatment.**

There are currently 10 unlicensed free-standing crisis stabilization units that provide court-ordered inpatient mental health treatment to adults. These units have a capacity to treat 271 people at any one time. The regulation of these facilities, and any others accepting in-patient commitments, would ensure that the adults in these facilities receive the same level of protection as children, adolescents, and alcoholics in comparable facilities. When these services are provided by a facility otherwise licensed as a hospital by the Texas Department of Health or the TDMHMR, no additional licensing would be required.

- **The definition of inpatient mental health facility should be amended to allow commitment only to licensed inpatient facilities.**

Community centers are currently defined as inpatient mental health facilities in the Mental Health Code. This amendment will prevent inpatient commitments to community center facilities which do not have the capacity to provide the protection or treatment required for court-ordered inpatient mental health treatment.

### Provisions Are Needed to Enhance Compliance with Outpatient Treatment Following Court-Ordered Commitment.

People with chronic mental illness generally have long-term mental disabilities characterized by social isolation, disordered thoughts and occasional acute psychotic breaks requiring psychiatric hospitalization. Most of these people need continued psychiatric care throughout their lives. Primarily such care consists of medication, supportive services and rehabilitation. Outpatient treatment following hospitalization is very important to a patient's continued well-being because many find leaving the security and routine of the hospital quite stressful. Mental illness tends to become more disabling during periods of stress or when needed medication is discontinued. A chronically mentally ill patient's refusal to seek outpatient treatment following a hospitalization can result in discontinued medication and another psychotic episode during this period of stress.

Often people who are committed for temporary inpatient treatment, which is usually for 90 days, respond quickly and can be released to outpatient treatment before their commitment expires. In such cases, a facility may ask the court to change the existing court-order to an order for outpatient treatment. This requires the facility to explain to the court why the modification is requested and submit a recent Certificate of Medical Examination for Mental Illness indicating that the person continues to qualify under the legal criteria for commitment. The patient is then notified and provided the opportunity for a hearing. If the modification is approved by the court, the outpatient commitment can only extend to the end of the original period of commitment.

Interviews with community centers indicated that the commitment modification provision is rarely used because it requires another Certificate and more paperwork. Also, if the person still qualifies under the criteria for commitment then some could question whether the facility should release the patient from inpatient care. In the majority of cases the patient is discharged from his commitment and given an appointment with a community provider, a supply of medication, and is encouraged to receive outpatient aftercare. Community centers are required to provide aftercare services as a condition of their contract; however, they indicated that the failure of patients to comply with aftercare treatment is a significant problem which often leads to rehospitalization.

The 69th Legislature broadened the criteria for court-ordered mental health treatment. The criteria now include a determination of whether the person will, if

not treated, continue to suffer severe distress and experience deterioration in his ability to function independently, and is unable to make a rational and informed decision as to whether or not to submit to treatment. If the person meets this criterion, or is dangerous to himself or others, then the person may be committed for mental health treatment. The "potential for deterioration" criterion allows the courts to order treatment for people who need treatment but are not actively dangerous. This criterion is particularly useful in obtaining needed treatment for the chronically mentally ill person whose condition is deteriorating.

The following recommendation proposes to use the deterioration criterion that was adopted in 1985 to provide a rationale for increased requirements for compliance with outpatient treatment following court-ordered hospital care. It would modify the Mental Health Code to require the judge to make an additional determination during the commitment hearing if the person is found in need of court-ordered treatment. This determination would examine whether evidence indicates that the person, if not treated for the proposed period of commitment, will experience deterioration of his ability to function independently and whether the person is unable to make a rational and informed decision as to whether or not to submit to treatment. If the judge makes this finding, and the facility determines that the patient is no longer in need of inpatient care before the expiration of the commitment, then the commitment will convert automatically to an outpatient commitment for the remaining period of the original commitment. Provisions would be made for the patient, physician, facility, or community provider to request a waiver of such predetermined conversion. Any such waiver should be at the judge's discretion.

- **The statute should be amended to provide for the conversion of a court-order for inpatient mental health treatment to an outpatient order if, in the original commitment hearing, the judge finds that the person is at risk of deterioration without continued care.**

The proposed change will streamline the existing provisions for converting inpatient commitments to outpatient commitments, thereby making them more useful. No increased costs are associated with such change because TDMHMR policy currently requires community providers to attempt to provide aftercare services to these clients. Actual savings could be realized through the adoption of the recommendation by: 1) eliminating the need for additional court hearings, associated

psychiatric examinations, and paperwork; 2) increasing client compliance in aftercare services, thereby reducing some need for aggressive casework with these clients; and 3) increasing the continuity of client treatment thereby reducing recidivism.

**Continuation of the Office of the Interstate Compact on Mental Health Administrator Will Aid Client Transfers.**

Ratified by Texas in 1969, the Interstate Compact on Mental Health is an agreement among 44 states which allows a person to receive mental health or mental retardation services in the state where it would be most beneficial, irrespective of their legal residence. The interstate compact eliminates the problem of residency requirements and establishes a mechanism which allows people to move closer to their family when it is important to their care and treatment. It also prevents unwarranted transfers of mentally ill or mentally retarded individuals without a state's knowledge and acceptance.

The Office of Interstate Compact on Mental Health Administrator is located within the central office of TDMHMR. The commissioner of TDMHMR serves as the compact administrator and the functions of the compact are carried out by TDMHMR staff. In fiscal year 1986, TDMHMR used \$16,578 appropriated from general revenue to carry out the administrative duties under the compact. This covers Texas' pro rata share of compact membership expenses which were \$272 for 1986, as well as the staff time needed to process the applications for interstate transfers and payment of travel costs to the national meetings of the compact. In fiscal year 1986, Texas sent 20 persons to other states for mental health and mental retardation services and received 17 persons needing those services in Texas.

The Office of Interstate Compact on Mental Health Administrator was recently reviewed by the Sunset Commission and was continued by the 69th Legislature with minor modifications. The changes adopted by the legislature included modifying the appointment of the compact administrator, requiring notice of compact meetings, requiring an annual report on compact activities, and changing the compact's Sunset date to coincide with the Sunset review of TDMHMR. During this review, it was found that all changes recommended by the 69th Legislature are being implemented. No further changes are necessary as the compact continues to work as originally intended.



- **The State of Texas should participate in the Interstate Compact on Mental Health.**

Continued participation in the interstate compact will allow Texas to continue to receive the benefits afforded through the compact and will ensure mentally ill and mentally retarded people can be transferred when it is appropriate for their care and treatment. This will require a statutory extension of the Office of Interstate Compact on Mental Health Administrator.

**Policy Changes Are Needed in a Major Agency Funding Strategy.**

The Retrospective Reimbursement Program is a major agency strategy for funding the development of community-based mental health services. This program provides funding incentives to local mental health authorities (MHAs) to develop services which divert people from treatment in state hospitals. The TDMHMR system commonly refers to this program as the \$35.50 program because each local mental health authority is provided \$35.50 for each bed day of state hospital use that they prevent. This is the main source of new revenue available through TDMHMR for MHAs.

Through the \$35.50 program, each MHA is held responsible for the state hospital beds used by the patients who are residents of the counties within its service area. The TDMHMR identifies the county of residence for each hospital patient and uses that to determine the extent to which the various service areas of the state have reduced the use of state hospital beds. The amount of payment made to the local mental health authority is calculated by comparing the number of bed days used by county residents during the fourth quarter of 1983 (the baseline) to the number of bed days used in the current quarter. The mental health authority then receives \$35.50 for each bed day reduced. There is no payment or penalty if there is an increase in bed day utilization and there are no restrictions on the MHA's use of the funds.

The review of the \$35.50 program identified several problems with the program's current policies. Families voiced a concern that the only incentive in the program is to restrict access to needed hospital services. Some MHAs and TDMHMR staff state that the \$35.50 program is resulting in the decline of referrals to transitional living programs in state hospitals and many programs have had to close down or reduce services. Discussions with MHAs concerning the

program often focused on the difficulty in providing services to clients for whom they cannot get the \$35.50 program reimbursement. They state it is also difficult to provide adequate treatment for some clients on \$35.50 per day, when the state spent over \$100 per day in the hospital for their treatment. The TDMHMR staff indicate that while they have considered several changes, they have not implemented any changes to the \$35.50 program which reduce these problems.

Several specific problems with the program were targeted for correction after interviews with local MHAs. The following recommendations offer corrections for the problems which could be addressed without major conceptual changes to the program.

- **Provider contracts should require the \$35.50 funds to be used for mental health services.**

There are currently no restrictions on the use of the funds. This approach to funding is inconsistent with the recent TDMHMR performance-based contracting initiatives required by the 69th Legislature. While community services have been developed through the \$35.50 program funding, some providers did not initially allocate the funds for services. Restricting the use of the \$35.50 funds will ensure that more community-based mental health services are developed for people that are diverted from state hospitals and increase the accountability for state funds.

- **Patients sponsored by TDMHMR facilities in residential programs operated by local mental health authorities should be added to the bed day count.**

In addition to the \$35.50 per day reimbursement for reducing bed days, many state hospitals contract with local mental health authorities to place long-term hospital patients in residential programs on a rate-per-day basis. For example, Austin State Hospital could contract with Austin-Travis County MHMR Center (ATCMHMR) for one of its patients, who is an Austin resident, to be placed in the center's supervised apartment program for three months at a rate of approximately \$29 per day. In such cases, ATCMHMR would receive \$29 per day through the contract and also \$35.50 per day for keeping the client out of Austin State Hospital.

As in the example, any MHA that contracts with a state hospital for residential services for its area resident who is a long-term hospital resident, can receive both the per-day-rate and the \$35.50 reimbursement. However, if the contract is for a non-MHA area resident then the MHA can only receive the contract rate and will not receive the \$35.50 funds. The potential for receiving funds from both funding sources creates a disincentive for a MHA to accept residents from other service areas. The problem is compounded since the \$35.50 funds made possible by the MHA's program keeping the person out of the hospital, will go to the MHA located in the service area where the client lived before hospitalization. For example, if Austin State Hospital contracts with ATCMHMR to provide residential services to a Johnson County resident, ATCMHMR will get \$29 per day while Johnson County MHMR Center would get the \$35.50 funds. This can be a significant problem for patients from rural areas because most MHA programs that contract with state hospitals are located in urban areas and only want to serve the patients from their local service area.

Since these patients are sponsored in the residential placement by TDMHMR facility funds, it is reasonable to conclude they are still in a state funded bed. Adding facility contract sponsored bed days to the local MHA's bed day utilization can correct the identified problems and give a more complete indication of state supported bed use in all areas of the state.

- **The disincentives to placing patients in hospital-based transitional living programs should be reduced.**

One consequence of the current \$35.50 program is that it discourages the use of hospital-based transitional living programs. Such programs are considered effective in increasing certain patients' ability to remain outside the hospital, but some MHAs are reluctant to have their area residents referred to the hospital-based programs. Transitional living programs are designed to educate patients in the skills necessary to live outside of a hospital setting. Most of the programs in Texas are located on state hospital grounds and serve hospital patients who are ready to return to the community. The usual length of stay in a transitional

living program is three to six months, as compared to an average length of stay on a regular treatment unit of 30 days. This extended stay could cost a MHA \$3,000 to \$6,000 in loss of revenue from the \$35.50 program for each patient in a hospital-based transitional living program.

Another recommendation in the report proposes to require TDMHMR to attempt to contract with community providers to operate these programs in the community. If that recommended change is implemented, the \$35.50 program would create no disincentives to the use of a community-based transitional program. However, such change may take some time to implement and, therefore, some interim change is needed to address this problem.

Other programs located on state hospital grounds, such as substance abuse programs and units that serve people with mental retardation, have avoided the problem of disincentives by exempting the units from the \$35.50 bed day count. Either exempting the beds in transitional living programs, or some other policy change which reduces the disincentives for placing people in hospital-based transitional living programs, is indicated for the \$35.50 program.

**Respite Program Requirements Overly Regulate the Service And Do Not Maximize Cost-Effective Family Involvement In the Selection and Monitoring of Providers.**

The family is a vital component in the system of care for people with mental disabilities who live at home. Extraordinary demands can be placed on a family when a member has a mental disability. Routine activities such as bathing, feeding, and errands can become major chores. It can be very difficult for families to locate someone to care for their disabled family member in times of family illness or crises. These burdens are sometimes too great for families to manage and some seek relief by placing their family member in a state school or other facility. However, recently Texas has expanded support services to these families in an effort to provide the needed relief and maintain the family in the role as primary caregiver.

Many states have addressed the needs of families caring for disabled members by providing the families with cash subsidies and allowing them to

purchase needed services directly. There are 16 states which provide direct cash subsidies to offset the family's cost for services, equipment, and the loss of the caregiver's earning potential. Of the 16, seven provide both cash subsidies and support services. Support services include respite care, homemaker services, and specialized therapy. Seven other states provide support services, but not cash subsidies.

The Texas MHMR system has recognized the importance of providing support services, particularly respite care, to families for several years. Respite services are not treatment services but are instead intended to provide the family with a reprieve from their caregiving responsibility by making available a safe, caring environment for the temporary care of the disabled family member. Respite services are defined as providing in-home sitting or temporary living arrangements for a brief time which allows the family to be absent from the home for a period of relief. Most often in-home respite is used for an occasional day, evening, or weekend out. In 1985, S.B. 633 was adopted which established a requirement that family support services, including respite care, be available through every community center as a condition of its receipt of state funds. All community centers currently report providing some form of respite care. Most programs employ direct care staff, resemble a formalized babysitting or day care service, and provide out-of-home care through foster care families.

The review identified problems with the current TDMHMR requirements concerning the operation of these services. The TDMHMR standards increase the cost of providing respite services by requiring them to meet many of the same standards as active treatment programs. They also fail to take advantage of the family's ability to monitor and thereby control the quality of services and instead regulate quality through state monitors. For example, respite care workers must complete specific training courses, including CPR, First Aid, and TDMHMR's Prevention and Management of Aggressive Behavior training, before they can serve as respite aides. Every respite aide who administers oral medication must also complete 20 hours of medication training. The aides must have the appropriate consent forms signed by the family for each stay. The program staff are also responsible for conducting an annual site visit to inspect the client's home for safety and cleanliness. The TDMHMR's requirements may provide a logical framework for the operation of a treatment program but, when required of non-treatment respite services in clients' homes, they make the program cumbersome

to operate, increase the cost of providing the service, and generally make the program less responsive to the needs of families.

Families regularly purchase child care services such as babysitting and day care services and take full responsibility for monitoring the quality of those services. Many families purchase home health services from regulated agencies or licensed professionals. Families with a mentally retarded or mentally ill member are no less qualified to control the quality of respite care provided to their family member than families needing other in-home services. The additional regulation of respite services by TDMHMR through the Community Standards is not warranted and unnecessarily increases the cost of services. It also makes it difficult to operate in-home respite programs in rural areas.

As indicated above, 16 other states provide family support services in a very different manner, through a cash subsidy model. For example, in Nebraska it is difficult to operate programs for respite care due to the rural nature of the state, so the state gives families the money to purchase respite care from the provider of their choice. The only restriction on the provider is that it not be a relative.

Utilizing direct cash subsidies, like in the Nebraska program, would require a major change in state policy in Texas. Instead, a cash-like subsidy can be provided through a voucher model for service delivery. This model can provide the state with assurances that the funds provided for services are actually spent for the approved services. A voucher model is currently used in Texas to provide families with cash-like subsidies for the purchase of groceries through the Food Stamp and Women, Infants and Children (WIC) Programs. The voucher model allows the state to retain control over what services or goods are purchased but allows families to decide what services best meet their needs and select the providers of their choice.

Specifically, the implementation of a voucher model for respite services in Texas would require the respite program to determine the amount and type of services to be subsidized, give families a list of approved providers for the type of service authorized, and let families arrange for the care of their family member. For example, the MRA's casemanager would meet with the family and they would mutually determine that the client is eligible for 15 hours of in-home respite care and due to the client's condition a licensed nurse is needed. The casemanager would then give the family a list of approved nursing level respite providers in the area. The family could then use its vouchers to purchase the care from any provider on the list. Since the types of clients and their needs vary, several types

of in-home respite providers with varying qualifications should be established. These should range from baby sitting level care with minimum qualifications to nursing level care requiring licensed providers. The participating providers in an area could consist of private individuals, foster homes, licensed nurses, and home health agencies, approved by the respite program. The local respite program would maintain a list of participating providers in the area who provide the various types of services, investigate family complaints, maintain a back-up contact at the center for the respite provider in cases of emergency, and pay participating providers for vouchers. There should be provisions to discontinue the participation of a provider at the respite program's discretion. All standards for the operation of local respite programs should be developed through information provided by respite program directors and families participating in respite care services.

- **TDMHMR should modify its requirements concerning the provision of in-home respite care services to promote the use of a voucher model and modify the Community Standards relating to respite services using information from providers and families involved in the services.**

The implementation of this change would ensure that in-home respite care services are operated through a voucher program model which recognizes the expertise and concern of family members and their ability to assist in the cost-effective development of needed respite services. It encourages the use of qualified private providers instead of agency provided services. The local respite program should establish varying qualifications for providers as required by the types of clients served and length of service. The recommendation also seeks to make any new respite service requirements developed by TDMHMR responsive to the need for this service by requiring the department to seek the advice of respite care providers and the families needing the service.

#### **Client Needs for Vocational Rehabilitation Positions Could be Addressed Through MHMR Entry Level Support Positions.**

Vocational rehabilitation is a major unmet need for people with mental illness and mental retardation. Many need to work in a sheltered employment setting and cannot compete in the competitive job market. In this time of high unemployment, the disabled have few job opportunities.

The MHMR system has addressed this need through a variety of programs which are jointly funded by TDMHMR and the Texas Rehabilitation Commission. In most cases these services include sheltered workshops for mentally retarded individuals and Fairweather Lodges, or similar vocational programs, for people with mental illness. Sheltered workshops employ most of their clients in the workshop but some are assigned to work activities such as janitorial and ground maintenance work crews. Most of their jobs are performed on contract with local businesses. Fairweather Lodges are self-governed homes in which the residents live and work as a group. Lodges and other vocational programs for the chronically mentally ill primarily use work crews to perform janitorial work for local businesses. In fiscal year 1985, community centers provided sheltered work training to approximately 4,500 clients. However, most centers state that vocational opportunities for MHMR clients are still a much needed resource.

The TDMHMR facilities employ 1,258 people in entry level, non-client contact, support positions such as food service, ground maintenance, and laundry. The State Purchasing and General Services Commission set aside the custodial positions in several state buildings from 1978 through 1985 for the Fairweather Lodge program clients in Austin and found this to be an acceptable answer to the need for reliable employees. These lodges currently contract to provide custodial services for the Department of Human Service's Winters Building, the Texas Commission on Alcohol and Drug Abuse offices, and four Texas Highway Department buildings. An expansion of this concept to TDMHMR and community center entry level support positions could address the need for more vocational opportunities for mentally ill and mentally retarded clients in Texas.

- **All TDMHMR facilities and community centers should annually examine the feasibility of converting entry level support positions into sheltered employment opportunities for clients within the service area.**

The TDMHMR facilities and community centers employ many people in entry level, non-client contact, support positions such as food service, custodial services, ground maintenance, and laundry. While TDMHMR staff are not opposed to employing MHMR clients in these jobs, the agency has no current plan to make any of these positions available to community-based vocational programs. Yet vocational opportunities are a much needed resource for these clients. By examining the feasibility of converting these positions to employment opportunities



for clients, the agencies should be able to maximize their sheltered employment resources without experiencing any reduction in the quality of support services.

## **EVALUATION OF THE USE OF MEDICAID FUNDS FOR MR SERVICES**

Methods of improving the state's use of federal Medicaid funds for services for mentally retarded individuals were analyzed as a major focus of the review. Several changes to the state's current operations were identified which can enhance the use of these Medicaid services. The following recommendations propose changes to the policies of two of the three major state agencies which implement the ICF-MR Medicaid program in Texas.

### **The Current Structure of the ICF-MR Program Is Fragmented and Discourages New Providers From Entering the System.**

The federal government, through amendments to Title XIX of the Social Security Act, reimburses states for a significant portion of the costs of operating residential facilities for mentally retarded people. The primary purpose of these facilities, known as Intermediate Care Facilities for the Mentally Retarded (ICF-MR), is to provide health and rehabilitative services. The TDMHMR's state schools are certified as ICF-MR facilities and operate about 10,330 of the 14,395 beds in Texas' ICF-MR system. The remaining 4,065 beds are in community-based facilities. Approximately 87.5 percent or 3,557 of the community ICF-MR beds are in privately operated facilities.

The ICF-MR program is divided into three "levels of care": ICF-MR I, ICF-MR V, and ICF-MR VI. Both clients and facilities are assigned a level of care. For a client, the level of care is based on the client's intellectual functioning, adaptive behavior, health status, and whether or not he is ambulatory. For a facility to be assigned a level of care and qualify for payments, it has to meet certain standards. The standards are related to the type of care that is required to meet the needs of a particular client group.

Funds for ICF-MR programs are appropriated to the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Department of Human Services (TDHS). Currently 100 percent of the cost of operating the state schools, which are certified as ICF-MR facilities, is appropriated to TDMHMR out of general revenue. This involved an appropriation of over \$472 million for fiscal years 1986-87. The Texas Department of Human Services received a biennial

appropriation of over \$140 million for the state match of the community-based ICF-MR program and a \$10 million revolving fund that is used to draw down the federal match for the state schools. When this federal match is received, it goes into the general revenue fund. Requiring that state schools be funded out of general revenue was originally done to ensure that adequate funds would be available for services to state school clients even if the federal government reduced or discontinued the ICF-MR program. Continuation of this method of finance now appears unnecessary. The program has been in place for 12 years. Although the federal match has varied, it has never been less than 53 percent. Also, relying on a federal match is a commonly used practice in the state that has been applied to much needed services such as nursing home care, food stamps, Aid to Families With Dependent Children (AFDC), and purchased health services for aged and disabled persons. Modifying TDMHMR's method of finance would be consistent with current state practices regarding federal funds, would ensure that placement decisions are based on client needs and not funding considerations, and would simplify the comptroller's certification of the appropriations bill.

Currently, three state agencies are involved in the administration of the ICF-MR program. As the designated single state agency for Medicaid, the Texas Department of Human Services administers the program and is responsible for fiscal matters, rate-setting, client eligibility determination, promulgating rules and regulations, and ensuring compliance with state and federal requirements. The Texas Department of Health (TDH) licenses ICF-MR facilities, assigns levels of care to persons eligible for ICF-MR programs, and, through a contract with TDHS, certifies ICF-MR facilities according to the federal Health Care Financing Administration regulations. The Texas Department of Mental Health and Mental Retardation is the agency that has been given the responsibility of planning for persons with mental retardation. It develops the criteria for level of care assignments, standards for providers, and recommendations for ICF-MR policies and procedures.

The complexity of the program and its funding coupled with the involvement of three large agencies in its administration has created difficulties. One frequently heard complaint is that none of the three agencies are able or willing to accept responsibility for solving program problems. Many times this results in a provider being referred from one agency to the next without issue resolution.

Another concern identified during the review relates to the difficulty the program has in making policy adjustments as the needs of the system and the alternatives for meeting those needs have changed. For example, in April 1982, TDHS adopted the "six-bed or less" rule. This rule required new facilities to have six or fewer beds, to be no closer than three miles from another ICF-MR facility, and to be located within incorporated city limits. The rule was adopted to make sure that the growth of the program did not exceed the funds available to TDHS. Although highly successful as a cost containment measure, this rule has stymied the growth of the system. Now with the requirements placed on the TDMHMR by the Lelsz Settlement Agreement, as well as that agency's goal to serve clients in the community when appropriate, the system needs to grow. The 69th Legislature recognized this by removing the "cap" on Medicaid funds for community-based facilities and by adding a rider which stated the intent of the legislature that the TDHS adjust its rule to conform with available revenues. To date, the only change in the rule has been lowering the three mile limit to a one mile limit.

The failure to free up the system has contributed to a significant problem in the ICF-MR program. Currently, ICF-MR facilities operate at or near capacity and often have waiting lists. This coupled with the TDMHMR's efforts to limit admissions to state schools leaves little slack in the system. If an ICF-MR facility ceases operation for any reason, a crisis exists because of the lack of placement alternatives.

A third problem relates to the failure of the TDMHMR to maximize the use of federal Medicaid funds in its efforts to move clients out of state schools. The legislature appropriated \$12.2 million for each year of the 1986-87 biennium to improve the staff to client ratios in state schools. The department has used this to establish a prospective payment program, known as the \$55.60 program, to encourage mental retardation authorities to expand community-based services and move clients out of state schools. Although the \$55.60 program has been successful, it is 100 percent state funded. If the authority and funding for the ICF-MR program had been more centralized, the \$55.60 money could have been incorporated into the ICF-MR budget. This would have more than doubled its value since the federal match is 54 percent of the total.

A more centralized system could have also maximized these dollars through another Medicaid program known as the Intermediate Community Services (ICS) Program. The Omnibus Reconciliation Act of 1981 authorized the waiver of

existing Medicaid requirements to permit states to use Title XIX money for programs outside an institutional setting. Under the waiver program, states may offer the following seven services: a) case management, b) homemaker services, c) home health aid services, d) personal care services, e) adult day health services, f) rehabilitation services, and g) respite care. These are similar to many of the services currently paid for by the \$55.60 program. If the state had actively pursued a variety of waivers, these services could have been partially funded by Medicaid and further stretched the money in the \$55.60 program.

The number and complexity of the problems in the administration of the ICF-MR program indicate the need for a consolidation of authority to provide a less cumbersome, more responsive decision making structure. As the state's designated mental retardation authority, it appears appropriate to increase TDMHMR's responsibility for the program that serves over 13,000 mentally retarded persons. Concerns have been raised that allowing the single largest provider under the ICF-MR program to administer the program results in a conflict of interest. These concerns have been carefully considered and are addressed in the recommendations that follow.

- **Statutory modification should direct the TDHS to transfer the primary administrative responsibilities for the ICF-MR program to the TDMHMR and direct the TDMHMR to accept that responsibility.**

The details of this shift are outlined in Exhibit 8, on pages 159, 160, and 161. This recommendation provides for a change in the method of finance for TDMHMR which provides that agency with a funding structure that can maximize available dollars to best meet the needs of individual clients. The recommendation also provides that TDMHMR is financially responsible for any disallowances, audit exceptions, liabilities or penalties resulting from TDMHMR's actions or failure to act. In cases where punitive actions are recommended by the Health Department for TDMHMR facilities, TDHS will be required to make the disciplinary decision to ensure that a conflict of interest situation does not exist. Other potential conflicts of interest are related to rate-setting and conducting fiscal audits. The potential for conflict in these areas is limited by the federal law requiring rate-setting to be cost-based and the state requirement that the state auditor review the fiscal

Exhibit 9

SHIFT OF ICF-MR RESPONSIBILITIES

Area of Responsibility	Current Situation	Recommendation
1. Budget	<ul style="list-style-type: none"> <li>● TDMHMR requests an appropriation from the General Revenue (GR) fund for the operation of the state schools. TDMHMR is responsible for administering these funds.</li> <li>● TDHS requests an appropriation from GR for a revolving fund. This is used to draw down the federal match to the state's expenditures in the state schools. When the federal dollars are received they are deposited in GR.</li> <li>● TDHS also requests an appropriation for community-based ICF-MR facilities. The method of finance is GR and federal funds. TDHS is responsible for administering these funds.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would request an appropriation for the operation of the state schools and the community-based ICF-MR facilities. The method of finance would include state (46%) and federal (54%) funds. A revolving fund would not be necessary as the federal dollars would be appropriated to TDMHMR. Removing the revolving fund structure reduces TDHS appropriation by approximately \$10 million per year. This action is currently being considered in the special session of the legislature.</li> <li>● TDMHMR would be responsible for the administration of these funds. Any disallowances, audit exceptions, liabilities or penalties resulting from TDMHMR's actions or failures to act would be the responsibility of TDMHMR.</li> </ul>
2. Rate-setting & Cost Report Analysis	<ul style="list-style-type: none"> <li>● TDMHMR is responsible for providing direction and assistance to TDHS in the development of program cost reimbursement methodologies.</li> <li>● TDHS is responsible for setting the rates for the ICF-MR program and analyzing the cost reports submitted by the providers.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would assume responsibility for analyzing the cost reports and setting the rates.</li> </ul>

**Exhibit 9**

**SHIFT OF ICF-MR RESPONSIBILITIES**  
(cont.)

<b>Area of Responsibility</b>	<b>Current Situation</b>	<b>Recommendation</b>
3. Policy & Rule Development	<ul style="list-style-type: none"> <li>● TDMHMR is responsible for the development of facility and program standards, as well as the development of eligibility criteria and level of care standards.</li> <li>● TDMHMR is responsible for conducting public hearings and developing rules and regulations necessary to administer the ICF-MR program.</li> <li>● The TDHS Board is responsible for adopting rules regarding the ICF-MR program.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would develop ICF-MR policies and rules. The TDHS would review these only for Medicaid policy compliance and final ratification.</li> <li>● The Board of TDMHMR would be responsible for rulemaking. TDHS participates as noted above.</li> </ul>
4. Issuance and Renewal of Provider Contracts	<ul style="list-style-type: none"> <li>● TDHS issues and renews ICF-MR provider contracts.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would have administrative responsibility for issuing and renewing provider agreements between TDHS and the providers.</li> </ul>
5. Eligibility Determination	<ul style="list-style-type: none"> <li>● TDHS determines if a client is financially eligible to participate.</li> <li>● TDH determines if a client is programatically eligible to participate.</li> <li>● TDMHMR determines if a facility is eligible to apply for certification as an ICF-MR facility. TDH determines if a facility meets the certification standards.</li> </ul>	<ul style="list-style-type: none"> <li>● No change.</li> </ul>

**Exhibit 9**  
**SHIFT OF ICF-MR RESPONSIBILITIES**  
(cont.)

Area of Responsibility	Current Situation	Recommendation
6. Provider Payment	<ul style="list-style-type: none"> <li>● TDHS establishes provider payment eligibility through a computerized system that includes recipient financial eligibility data, facility admission and discharge data, and vendor payment date.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would contract with TDHS to continue to provide this service until TDMHMR sets up its own computer system to accomplish this or establishes a link to TDHS system.</li> </ul>
7. Fiscal Audit	<ul style="list-style-type: none"> <li>● TDHS conducts fiscal audits of the ICF-MR program.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR would conduct fiscal audits of the ICF-MR program.</li> </ul>
8. Billing to HCFA	<ul style="list-style-type: none"> <li>● TDHS bills HCFA for federal financial participation in Texas' ICF-MR program.</li> </ul>	<ul style="list-style-type: none"> <li>● No change.</li> </ul>
9. Enforcement of Standards	<ul style="list-style-type: none"> <li>● TDHS contracts with TDH for certification of ICF-MR programs. TDH can decertify a facility for non-compliance with standards.</li> </ul>	<ul style="list-style-type: none"> <li>● No change.</li> </ul>
	<ul style="list-style-type: none"> <li>● TDH survey teams review ICF-MR program and recommend punitive actions where necessary.</li> <li>● TDHS takes punitive actions when necessary.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR takes punitive action unless it involves a facility or program directly operated by TDMHMR. TDHS would make the disciplinary decision in such cases.</li> </ul>
10. Coordination	<ul style="list-style-type: none"> <li>● The agencies use a combination of interagency contracts and memoranda of understanding to clarify their duties.</li> </ul>	<ul style="list-style-type: none"> <li>● TDMHMR, TDHS, and TDH would review current documents and update them as needed to reflect changes made under this recommendation.</li> </ul>

audit process. Any inappropriate actions by TDMHMR would be identified and corrected through these processes.

The intent of the recommendation is to transfer to TDMHMR as much of the program as is permissible under federal law and regulations. The TDHS will need to remain the "single state agency" for the Medicaid program but interagency contracting will allow the flow of funds as described in Exhibit 8.

- **The TDHS should modify the Medicaid State Plan to reflect the shift in responsibility for the ICF-MR program.**

This change is necessary to comply with federal regulations.

- **Statutory provisions should ensure that any future federal decisions to reduce Medicaid funding will result in proportionate cuts to all programs using Medicaid dollars.**

The possibility of a federally-imposed Medicaid "cap" has long been discussed. The above instruction is needed to provide policy guidance should such a cap or a reduction in funding occur. The Texas Medicaid structure funds three major programs: purchased health services, nursing home care and ICF-MR care. The purpose of the instruction would be to ensure that all three programs would share in a proportionate reduction should the need arise.

- **The TDMHMR should appoint an ICF-MR Advisory Committee.**

This committee, appointed by the board, should include a balanced representation of providers, consumers, and other persons with knowledge and interest in the ICF-MR program. Representatives of TDHS and TDH should serve as ex-officio members. This committee should assist TDMHMR in identifying where policy or programmatic changes are needed to improve the ICF-MR program, make recommendations as to how these changes should be structured, and provide comment to the TDMHMR board regarding any proposed rules. This input should help to ensure that the needs of all clients are considered, whether they are served by the state or in the community.



- **The TDMHMR should expand its use of the ICS waiver program.**

This will allow state dollars to be matched with federal dollars thereby increasing the quantity and quality of services in the community. The state's match for this increase in service can be funded in two ways: a) through the shift of dollars from institutional settings as the population in the state school declines; and b) through the use of the money currently allocated to the \$55.60 program.



**ACROSS-THE-BOARD RECOMMENDATIONS**

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From its inception, the Sunset Commission identified common agency problems. These problems have been addressed through standard statutory provisions incorporated into the legislation developed for agencies undergoing sunset review. Since these provisions are routinely applied to all agencies under review, the specific language is not repeated throughout the reports. The application to particular agencies are denoted in abbreviated chart form.

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

Applied	Modified	Not Applied	Across-the-Board Recommendations
	X		<b>A. GENERAL</b>
X			1. Require public membership on boards and commissions.
X			2. Require specific provisions relating to conflicts of interest.
X			3. Provide that a person registered as a lobbyist under Article 6252-9c, V.A.C.S., may not act as general counsel to the board or serve as a member of the board.
X			4. Require that appointment to the board shall be made without regard to race, color, handicap, sex, religion, age, or national origin of the appointee.
X			5. Specify grounds for removal of a board member.
X			6. Require the board to make annual written reports to the governor, the auditor, and the legislature accounting for all receipts and disbursements made under its statute.
X			7. Require the board to establish skill-oriented career ladders.
X			8. Require a system of merit pay based on documented employee performance.
X			9. Provide that the state auditor shall audit the financial transactions of the board at least once during each biennium.
X			10. Provide for notification and information to the public concerning board activities.
		*	11. Place agency funds in the Treasury to ensure legislative review of agency expenditures through the appropriation process.
X			12. Require files to be maintained on complaints.
X			13. Require that all parties to formal complaints be periodically informed in writing as to the status of the complaint.
		X	14. (a) Authorize agencies to set fees. (b) Authorize agencies to set fees up to a certain limit.
X			15. Require development of an E.E.O. policy.
X			16. Require the agency to provide information on standards of conduct to board members and employees.
X			17. Provide for public testimony at agency meetings.
X			18. Require that the policy body of an agency develop and implement policies which clearly separate board and staff functions.

\*Already in statute or required.

**TEXAS DEPARTMENT OF MENTAL HEALTH  
AND MENTAL RETARDATION**  
(Continued)

Applied	Modified	Not Applied	Across-the-Board Recommendations
			<b>B. LICENSING</b>
		X	1. Require standard time frames for licensees who are delinquent in renewal of licenses.
		X	2. Provide for notice to a person taking an examination of the results of the exam within a reasonable time of the testing date.
		X	3. Provide an analysis, on request, to individuals failing the examination.
		X	4. Require licensing disqualifications to be: 1) easily determined, and 2) currently existing conditions.
		X	5. (a) Provide for licensing by endorsement rather than reciprocity.  (b) Provide for licensing by reciprocity rather than endorsement.
		X	6. Authorize the staggered renewal of licenses.
		X	7. Authorize agencies to use a full range of penalties.
		X	8. Specify board hearing requirements.
		X	9. Revise restrictive rules or statutes to allow advertising and competitive bidding practices which are not deceptive or misleading.
		X	10. Authorize the board to adopt a system of voluntary continuing education.

**MINOR MODIFICATIONS OF AGENCY'S STATUTE**

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Discussions with agency personnel concerning the agency and its related statutes indicated a need to make minor statutory changes. The changes are non-substantive in nature and are made to clarify existing language or authority, to provide consistency among various provisions, or to remove out-dated references. The following material provides a description of the needed changes and the rationale for each.

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**MINOR MODIFICATIONS TO THE  
TEXAS MENTAL HEALTH AND MENTAL RETARDATION ACT**

<u>Change</u>	<u>Rationale</u>
1. Modify language making TDMHMR responsible for the education of mentally retarded persons in Sec. 1.02(7).*	To reflect the terms of the <u>Griffith v. Bynum</u> Settlement Agreement and the agreement between the department and TEA regarding the transfer of responsibility for the education of school-age mentally retarded persons in state schools from TDMHMR to TEA.
2. Add the definition of "Priority Client Population in Sec. 1.02 (11).	To provide consistent interpretation of the term added by S.B. 633.
3. Add two new sub-sections to Sec. 1.02 which define "Local Mental Health Authority" and "Local Mental Retardation Authority."	To provide statutory definitions of the terms.
4. Delete Sec. 2.01A, Employees and Salaries.	To remove unnecessary language since this is addressed through the appropriations process.
5. Delete Sec. 2.03(b), Terms of Office.	To remove outdated language relating to dates which have passed.
6. Modify language on expenses of advisory committee members in Sec. 2.10.	To reflect current state policy.
7. Modify language referring to institutions in Sec. 2.12(c).	To reflect current terminology referring to state schools, hospitals, and centers as "facilities".
8. Modify language referring to certificate of need requirement in Sec. 2.24.	To remove outdated language since a certificate of need is no longer required.
9. Delete Sec. 3.01(a)(1) referring to kinds and number of community centers established by a combination of two or more political subdivisions.	To remove language that is not needed. One organization forms only one community center.

**MINOR MODIFICATIONS TO THE  
TEXAS MENTAL HEALTH AND MENTAL RETARDATION ACT**  
(cont.)

<u>Change</u>	<u>Rationale</u>
10. Modify language referring to "grant-in-aid" funds in Sec. 3.11(c),(e), (f) and Sec. 4.05.	To reflect current terminology referring to funds as "contract funds".
11. Modify language referring to local matching requirements so county, city or other locally-generated contributions count as part of the local match in Sec. 4.03(d).	To clarify that the current policy of TDMHMR is appropriate.
12. Modify language dealing with confidentiality of records to give access to educational information to school districts in Sec. 57(c).*	To reflect the terms of the <u>Griffith v. Bynum</u> Settlement Agreement.

\*Changes 1 and 12 should have an effective date of September 1, 1988.

**MINOR MODIFICATIONS TO THE  
TEXAS EDUCATION CODE**

<u>Change</u>	<u>Rationale</u>
1. Modify language referring to TDMHMR in per capita funding of independent school districts in Sec. 30.81.	To reflect the terms of the <u>Griffith v. Bynum Settlement Agreement</u> and the agreement between the department and TEA regarding the transfer of responsibility for the education of school-age mentally retarded persons in state schools from TDMHMR to TEA.
2. Delete definition of "mentally retarded" in Sec. 30.82.	To reflect the terms of the <u>Griffith v. Bynum Settlement Agreement</u> .
3. Modify language allocating school district per capita funds to TDMHMR in Sec. 30.83(a).	To reflect the terms of the <u>Griffith v. Bynum Settlement Agreement</u> .
4. Modify language which deals with salaries of employees of state school education programs in Sec. 30.83(b).	To reflect the terms of the <u>Griffith v. Bynum Settlement Agreement</u> .

These changes should have an effective date of September 1, 1988.

