SUBJECT: Continuing Texas Department of Mental Health and Mental Retardation

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Gray, Capelo, Delisi, Glaze, Hilderbran, Maxey, McClendon

0 nays

2 absent — Coleman, Uresti

SENATE VOTE: On final passage, April 29 — voice vote

WITNESSES: *(On House companion bill, HB 1486)*
For — Terry Childress, Private Provider Association of Texas; Melanie Gantt, Mental Health Association of Texas; Susan Murphree, Advocacy, Inc.; Ted Melina Raab, Texas State Employee Union; Joe Lovelace, National Alliance for the Mentally Ill of Texas

Against — None

On — Larry Graham, Sunset Advisory Commission

BACKGROUND: The Texas Department of Mental Health and Mental Retardation (MHMR) is one of the largest state agencies, operating in fiscal 1998-99 under an employee cap of over 23,000 full-time positions and with a budget of over $3.2 billion. The department is governed by a nine-member board appointed by the governor with the consent of the Senate.

The department serves as both a provider of services and a regulator of services, and its responsibility includes designating local authorities to be the responsible entities for arranging the provision of mental health, mental retardation, and chemical dependency services in a given service area.

State law requires services to be offered first to those most in need, and MHMR dollars must be used only for services provided to the priority population, which includes:

- children under the age of 18 with a diagnosis of mental illness who exhibit severe emotional or social disabilities that are life-threatening;
- adults who have severe and persistent mental illnesses that require long-term support; and
- individuals who meet mental retardation definition in the Health and Safety Code, who are autistic or have pervasive developmental disorders, or who are eligible for Early Childhood Intervention services.

MHMR provides services through both campus-based facilities and community or in-home providers. Its campus-based facilities include for the mentally ill eight state hospitals and the Waco Center for Youth, and for the mentally retarded 11 state schools. It also operates two state centers that serve both mentally ill and mentally retarded clients.

MHMR provides community-based services for mentally ill and mentally retarded clients through contracts with 38 locally operated Community Mental Health and Mental Retardation Centers and has provided such services directly in areas not served by local centers. For services delegated to local centers, MHMR adopts rules, sets performance measures and outcomes, provides technical assistance, and monitors contract compliance with state policies and laws.

Community MHMR centers are locally created, public entities that provide mental health and mental retardation services to individuals in their defined geographic services area. Most centers have been established by counties and municipalities, though they also may be established by hospital districts or school districts or a combination of public entities. MHMR is the primary funding source for community centers, which also are required to contribute local matching funds of varying amounts. Community centers may provide services directly or through contract and must serve the priority population with state funds, but may serve others with any additional funds raised.

Parts of the state not served by community centers received community-based services through MHMR state hospitals, state schools and state centers. In September 1996, these entities were consolidated to form 13 State Operated Community Services (SOCS), and the oversight of SOCS was transferred to a new Central Office community services unit. The goal of the department is to transfer responsibility of all SOCS to locally-governed community centers by 2001.

Because their clients often have multiple conditions and problems, many community centers work with the Texas Commission on Alcohol and Drug Abuse (TCADA), the Texas Rehabilitation Commission (TRC), the Council on Early Childhood Intervention and state and local criminal justice systems.

MHMR is subject to the Sunset Act and underwent Sunset Advisory Commission review during the past interim. The agency will be abolished September 1, 1999, unless continued by the Legislature.

DIGEST:

CSSB 358 would continue the Texas Department of Mental Health and Mental Retardation until September 1, 2011, and

- enact standard sunset provisions regarding board training;
- require MHMR and the Texas Rehabilitation Commission (TRC) to define their mutual responsibilities over shared client populations;
- require MHMR to seek input from local authorities, consumers and other interested parties in its long-range planning process and make recommendations on the long-term use of state-operated institutions;
- establish a local authority advisory committee to the department;
- require MHMR to develop model program standards to improve the consistency of mental health and mental retardation services provided by or through any state agency, and require the Texas Commission on Alcohol and Drug Abuse (TCADA) to develop model program standards for substance abuse services;
- authorize the transfer of the Laredo State Center, the Amarillo State Center, and the Beaumont State Center to local community centers;
- authorize the designation of local behavioral health authorities;
- require the employment of a client services ombudsman to assist clients in gaining access to appropriate programs or waiting lists who have been denied services by MHMR, one of its facilities, or a local MHMR authority;
- remove term limit provisions for the one-county local MHMR agencies;
- conform with other state agencies' policies MHMR prohibitions against employees leaving community center employment and representing persons in matters on which they were formerly working; and
- conform contracting provisions for MHMR authorities with existing MHMR laws regarding procurement of goods and services.

The bill would take effect September 1, 1999.

State institutions. MHMR would have to ensure that the medical needs of the most medically fragile clients were met in state-operated institutions and solicit input from local MHMR authorities and consumers in the development of the plan.

The department also would have to develop a report containing recommendations regarding the most efficient long-term use and management of the department's campus-based facilities. The report would have to be attached to the department's legislative appropriations request and submitted to the governor, the lieutenant governor, the speaker, the Legislative Budget Board, and the Health and Human Services Commission.

The board by rule would have to establish criteria regarding the uses of the campus-based facilities as part of a full continuum of services.

MHMR would have to give to people seeking residential mental retardation services a clear explanation of programs and services for which the person was eligible, including state schools and community ICF/MR services. The programs preferred by the person would have to be documented in the person's record and, if the programs are not available, the person would have to be given assistance to access alternative services and the appropriate waiting list.

MHMR would be specifically directed that it could only spend money appropriated for state schools in accordance with limitations imposed by the general appropriations act.

Local authority advisory committee. The commissioner of MHMR would have to appoint a nine-member local authority advisory committee to offer advice on technical and administrative issues that affect local authorities, such as proposed rules, the coordination of initiatives, and methods of contracting. The department would have to respond in writing to written recommendations from the committee. The committee would be abolished on September 1, 2007, unless continued by the board.

Local behavioral health authorities. MHMR and TCADA could jointly designate a local behavioral health authority to provide mental health and chemical dependency services in a local area. Local behavioral health

authorities would be delegated authority for planning, policy development, coordination, resource allocation, and resource development. MHMR or TCADA could disburse funding to the local authority by contract, case-rate, capitated, or other methods of allocation. Services would have to be provided at the same level as the level of services previously provided through the local mental health authority and TCADA.

SUPPORTERS SAY:

CSSB 358 would improve the delivery and cost-effectiveness of services to MHMR clients through:

- improved local authority participation in planning, contracting, and department rulemaking;
- improved inter-agency coordination; and
- measures that would guarantee that clients have access to information about the full range of services available to them and assistance in obtaining preferred services.

MHMR would continue as a free-standing agency, instead of being rolled into a new long-term care agency, because of the unique needs of its client population. MHMR has the necessary professional specialists and expertise to respond to the needs of people with mental retardation, which could be lost in an agency that serves other people with disabilities. Also, people with mental retardation on waiting lists for services could end up waiting even longer if additional disabled or elderly individuals were competing with them for the same community-based services. Coordination between MHMR and other state agencies would be continued by MHMR and enhanced by the new authority given to the Health and Human Services Commission this session in its sunset bill, HB 2641 by Gray.

CSSB 358 would ensure that clients statewide will be offered a full range of choices of residential or community services, through new requirements for a client ombudsman and for department explanation and documentation of client choices and preferences. The bill, by specifically linking the MHMR statute to the general appropriations act, also would ensure that state schools are not downsized or eliminated by department attempts to move funds from state schools to community programs.

The long-range planning requirements in the bill would develop an objective and complete source of information for legislative considerations about the future needs and direction of campus-based services and community-based

services, which would ensure the best use of available funds. Requiring the agency to project the "savings" in closing or consolidating state schools, as some suggest, would create an inappropriate bias toward closing such facilities, which may overlook parental demand for state schools and alternative ways they could be used to meet community needs.

The planning requirements also would give a voice to local authorities, who have had little say over the use of state-run institutions about which they depend.

Local authority input also would be improved by the appointment of a local advisory committee. Among its stated activities, the committee would help the department develop better methods of contracting that would give local authorities an opportunity to better meet performance expectations with the resources they have on hand. The Sunset Commission found that while the department's relationship with local authorities has been evolving, local authorities are limited in their ability to meet identified community needs and lack opportunities to participate in department decisions that affect local operations. Oftentimes, the contracts with local authorities contain conflicting directives and numerous administrative and operational requirements that provide the local authorities with little flexibility to respond to local needs.

Allowing the establishment of local behavioral health authorities would be a vehicle to make permanent services coordination efforts between MHMR and TCADA that have been undertaken in recent years. A local behavioral health authority would create a local point at which funding and services could be combined to meet an area's unique mix of community needs in mental health and substance abuse services and provide a single point of access for clients. This provision would not create a duplicative administrative structure because the local mental health authorities could apply for the designation as a local behavioral health authority and public input would have to solicited before any designation was made.

By requiring MHMR and TCADA to develop model program standards, the bill would help ensure that appropriate, good quality and cost-effective mental health and substance abuse services were delivered to state clients of other programs. Mental health and substance abuse services are provided by many state agencies, such as the Texas Department of Criminal Justice,

Protective and Regulatory Services, and TRC, even though MHMR is the recognized state authority in mental health services and TCADA is the recognized state authority over substance abuse services.

This bill also would continue as planned transition of the SOCs to local management, specifically by authorizing the transfer of the Laredo State Center, the Amarillo State Center, and the Beaumont State Center to local community centers. The transition to locally controlled community services has been a long-standing policy at MHMR because it ensures area needs are appropriately met. Because these three state centers are included in a statutory list of state institutions, state law would have to be amended to authorize a transition that has been occurring in all of the other 10 regions of the state. The proposed budget for fiscal 2000-01 includes funding for state employees subject to the transition so that their jobs and benefit levels will be maintained. Increased local involvement in running community services is expected to increase the range and quality of services to clients, due to the increased participation of local officials and other interested persons.

OPPONENTS SAY:

MHMR should be consolidated into Department of Human Services (DHS) along with the programs and services from other agencies that may be consolidated this session with the enactment of SB 374 by Zaffirini, which would consolidate long-term care services. MHMR is one of five major agencies involved in delivering long-term care services to elderly and disabled Texans. MHMR should be included in this consolidation because the fragmentation of services across multiple state agencies has led to a lack of clear accountability, limited strategic planning, cost inefficiencies, and client confusion. People with disabilities need the same basic support services, regardless of their disability, and there is no need to have more than one agency administer and arrange for similar services. Many clients of MHMR also require extensive medical support services, which could be better provided if more closely coordinated with the programs and resources of the Texas Department of Health and DHS.

OTHER OPPONENTS SAY:

At least 517 people in state schools are now waiting for community-based services to become available so that they can be released from institutional care. MHMR should be required to estimate the number of dollars that could be saved through consolidation or closure of state-operated facilities to help the

state develop methods for directing and dedicating those dollars to increase community-based services for persons with disabilities.

Also, the Sunset Commission found that the population in state hospitals declined by 56 percent between 1978 and 1997 and in state schools and state centers by 34 percent between 1986 and 1996. Meanwhile, clients served in the community increased by 39 percent between 1987 and 1997, and there are waiting lists for some programs.

The transition from state-run centers to community centers should be stopped, and provisions allowing the transition of state centers in Laredo, Beaumont, and Amarillo to local management should not be included in the bill. Experience in other areas of the state have shown that these transitions result in decreased service quality and availability, and decreased accountability for the expenditure of state dollars. Experience also has shown that the community centers cut too many jobs and are unable to provide employee benefits comparable to state benefits, which makes even more difficult the demanding job of caring for mentally ill and mentally retarded individuals by the state employees who remain on staff.

NOTES:

Major changes made by the committee substitute to the Senate-passed version of the bill include:

- requiring MHMR to develop model standards for mental retardation services as well as mental health services;
- authorizing the transfer of three state centers to community centers;
- narrowing the scope of the local advisory committee to administrative and technical issues and removing consumer representation from the committee;
- removing a provision concerning local behavioral health authorities that would have required them to consider ultimate costs and benefits and client care issues to ensure consumer choice and the best use of public money;
- adding a provision requiring the department to ensure that client information regarding program and services preferences is documented and maintained;
- adding a provision directing the department to spend money on state schools only in accordance with the general appropriations act; and
- requiring the ombudsman to assist clients in gaining access to services or placement on the appropriate waiting list.

SB 374 by Zaffirini, relating to the consolidation of long-term care services and programs, passed the Senate on April 29 and was reported favorably, as amended, by the House Human Services Committee on May 4.

HB 2641 by Gray, which would continue and expand the authority of the Health and Human Services Commission, passed House on April 20 and was reported favorably by the Senate Human Services Committee on May 12.