THEY DESERVE BETTER:

A LOOK INTO THE LIVES OF THE MOST VULNERABLE TEXANS

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by

Kayla A. Sohns

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Kayla A. Sohns

Thesis Supervisor:

_____

Rose M. Pulliam, Ph.D.
School of Social Work

Approved:

_____

Heather C. Galloway, Ph.D.
Dean, Honors College

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ABSTRACT

The mentally incapacitated are the most vulnerable population. Due to their vulnerability, they are unable to advocate for themselves, so others must advocate on behalf of them and their well-being. This thesis, rooted in experience serving as a Court Visitor on behalf of the Travis County Probate Court, argues that mental health parity would provide equitable funding for facilities to afford proper care and staff, would lessen accidental deaths, and would encourage screening for mental illness in children to offer preventative care. This position is supported by detailed observations and research into the effects of the lack of mental health parity. This thesis discusses the blatant differential in care across the gradient of facility funding from purely Medicare and Medicaid funded facilities, to purely high-end private pay facilities observed through visits conducted on behalf of the Travis County Probate Court. These disparities were identified by the author when she visited mentally incapacitated wards and spoke with guardians of mentally incapacitated people. This thesis also discusses data related to the number of individuals who are affected by mental illness in this country, the number of forensic commits, and prevalence of mental illness in criminals, and makes the case that the state would actually save money if preventative mental health care was a priority.

I. Introduction

Preface

My thesis research journey began as a social work and honors college student, who wanted to find more honors classes that would count toward the social work major. I stumbled upon the Psychology & Law: Protecting the Vulnerable service learning class, and it piqued my interest. The class is an Honors service-learning course consisting of a handful of students who agree to become court visitors on behalf of the Travis County Probate Court. Each student in the class is assigned fifteen cases within the Travis County region who they then visit and write a report based on their observations on the treatment and conditions of the ward's living situation.

Upon acceptance into the Spring 2017 class, we received a debrief on the types of people we would be visiting, how to conduct these visits and fill out the reports, and our caseload of fifteen wards of the Travis County Probate Court. We were required to make a visit to the Austin State Supported Living Center for a tour to acclimate us to our impending duties before completing any visits. We also visited the Austin State Hospital to witness the guardianship and involuntary commitment hearings. We learned about changes in the societal treatment of the mentally ill over the years. We also discussed what we personally observed during our visits that could be improved. Our duty was to spot injustices, maltreatment, and wrongdoing to ensure the best standard of living for the wards. Once the semester ended and I had a chance to reflect on my experiences with the wards, their guardians, and the residences, I decided that I wanted to continue this work over the summer to gain more experience, as well as more material for this honors thesis, so I completed twenty more visits Summer 2017.

I realized I had adopted a perpetual probate court perspective when I heard the news story of Sterlin Milam. Sterlin Milam was a thirty-eight-year-old man who had mental retardation, down syndrome, and pica according to Sterlin's sister and guardian, Renee Milam (Cargile, 2017). Sterlin was supposed to be under twenty-four-hour supervision at the group home he resided in, run by D & S Community Services (Cargile, 2017). Tragically, Sterlin died on Thursday, September 7, 2017, at approximately 5:50 AM, down the street from his group home when he was struck by a vehicle while attempting to cross the street unsupervised (Cargile, 2017). This is inexcusable and truly proves how imperative proper care of the mentally incapacitated, and oversight by the probate court are. If proper and consistent care was taken, Sterlin Milam would still be alive today.

Social Work Perspective

From a social work perspective, the protection of the mentally incapacitated is essential to uphold all six of the cardinal values of social work: service, social justice, the importance of human relationships, dignity and worth of every person, integrity, and competence (National Association of Social Workers, 2008). In regard to service, this is a population that is underserved and needs attention from the entire community to thrive (NASW, 2008). Social justice is a multi-faceted concept, one piece of which justifies that the mentally incapacitated must be advocated for, and policy be written to protect them (NASW, 2008). Importance of human relationships comes into play with the guardians of the wards, as well as the staff at the facilities the wards reside in; these relationships are essential for the wards to thrive (NASW, 2008). Throughout history, the mentally incapacitated have been seen as lesser, and other; however, with the perspective that

every person has worth and is deserving of dignity, the mentally incapacitated are seen as equals to the general population (NASW, 2008). Integrity comes into play as a high quality of life for wards is sought through the honest reports that court visitors fill out to assess living conditions (NASW, 2008). Lastly, competence is shown when each ward gets the placement and services that they and their specific condition warrants (NASW, 2008).

Background

In 2015, approximately 9.8 million adults, aged 18 or older in the United States, had reported living with a serious mental illness, which represented 4.0% of all U.S. adults (National Institute on Mental Health, 2015). The National Survey on Drug Use and Health is the tool that was utilized during data collection and defined serious mental illness as:

- A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders);
- Diagnosable currently or within the past year;
- Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV); and,
- Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (National Institute on Mental Health, 2015).

Approximately 20% of the population (non-institutionalized persons over 18 who have a permanent address within the United States of America) are estimated to be living with any mental illness, but it can be inferred that many more individuals are experiencing

mental illness than might be expected due to the stigma surrounding mental health and mental illness in the United States. (National Institute on Mental Health, 2015).

To expand, there were approximately 43.4 million adults aged 18 or older in the United States with any mental illness within the past year, which represented 17.9% of all U.S. adults (National Institute on Mental Health, 2015). Any mental illness includes serious mental illnesses, as well as mental, behavioral, or emotional disorders (excluding developmental and substance use disorders) that are diagnosable currently or within the past year and are of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (National Institute on Mental Health, 2015). Near twenty percent of the population, or one of out every five American adults, is experiencing some sort of mental illness, and that is more than enough cause for proper funding and policies to encourage mental health parity.

The lack of mental health funding and clear policy on mental health facilities in Texas leads to unequal care and treatment of the mentally incapacitated. The unequal care seen across the gradient of different care facilities is glaringly obvious for those who venture to look. This topic is important because it is absolutely necessary to protect vulnerable populations and advocate to fill in gaps in services. Several questions are important to consider to adequately discuss this topic. The questions include: Would implementing more clear policy improve care? Would an increase in mental health spending improve care across the board? Would increased mental health spending lessen arrest rates and forensic commitments? The thesis will cover my experience as a court

visitor for the Travis County Probate Court, current policy and research, and possible improvements and policy recommendations.

II. Literature review

Definition of Group Home

One problem with group homes is that there is not a definition of what a "group home" is in either Texas or federal law; furthermore, under Texas law, there are twenty-four types of homes, houses, facilities, and centers that might qualify as a group home (Akers, King, 2011, p. 1). It is left to the municipal law to define what a group home looks like for that city (Akers, King, 2011, p. 2). In order to illustrate the differences this creates, following are definitions of group homes of two Texas cities.

The city of Cedar Park defines a group home as:

> Group Home: To qualify as a group home, an entity must provide the following services to persons with disabilities who reside in the home: 1) food and shelter, 2) personal guidance, 3) care, 4) habilitation services, 5) supervision. A group home must be a community based residential home operated by the Texas Department of Mental Health and Mental Retardation. The home must have not more than six (6) persons with disabilities and two supervisors residing in the home at the same time. The limitation on the number of persons with disabilities applies regardless of the legal relationship of those persons to one another. The home may not be established within one-half (1/2) mile of an existing group home. For purpose of this definition, "person with a disability" means a person whose ability to care for himself, perform manual tasks, learn, work, walk, see, hear, speak, or breathe is substantially limited because the person has: an orthopedic, visual, speech, or hearing impairment; Alzheimer's disease; pre-senile

> dementia; cerebral palsy; epilepsy; muscular dystrophy; multiple sclerosis; cancer; heart 3 disease; diabetes; mental retardation; autism; or emotional illness. (Akers, King, 2011, p. 2)

The city of Hutto describes a group home as:

> Group Home (6 or fewer persons): A home-based facility providing 24-hour care in a protected living arrangement for not more than 6 residents. This classification includes foster homes, homes for the physically and mentally impaired, homes for the developmentally disabled, congregate living facilities for seniors and maternity homes. Requires licensing by the State of Texas. Does not include post-incarceration facilities or facilities for those who are a danger to themselves or others. (Akers, King, 2011, p. 1)

The city attorney compares the city ordinance definition with the proposed group home to determine if the facility is allowed (Akers, King, 2011, p. 3).

Relevant Federal Law

The overarching law concerning group homes is the Fair Housing Amendments of 1988. These amendments prohibit housing discrimination based on familial or handicap status, which includes that a house of persons with handicaps cannot be treated differently than a house of persons with no handicaps by ordinances or any other means (The Fair Housing Amendments, 1988). It goes on to require that the municipal governments provide "reasonable accommodations" for the handicapped if necessary to gain equal housing opportunity, and considers not providing the reasonable accommodations as discrimination (The Fair Housing Amendments, 1988).

The Fair Housing Amendments limit the scale of municipal government, in order to protect the handicapped and allow reintegration in our communities of those with

disabilities. However, there remains a clause that stipulates that the city does not have to comply if it puts an "undue burden" upon the local government (The Fair Housing Amendments, 1988). The phrase "undue burden" is a vague loophole clause, and could be manipulated by the municipalities (The Fair Housing Amendments, 1988).

Texas State Law

Texas state law contributes to the guidance and specificity for cities regarding "community homes":

> A community home is a home for "persons with a disability" or, more precisely, persons with: (1) an orthopedic, visual, speech, or hearing impairment; (2) Alzheimer's disease; (3) pre-senile dementia; (4) cerebral palsy; (5) epilepsy; (6) muscular dystrophy; (7) multiple sclerosis; (8) cancer; (9) heart disease; (10) diabetes; (11) mental retardation; (12) autism; or (13) emotional illness. (Akers, King, 2011, p. 8)

To qualify as a community home, the entity must be a community-based residential home operated by either Texas Department of Mental Health and Mental Retardation (TDMHMR), a non-profit corporation, an entity certified by the Texas Department of Human Resources (TDHR) as serving persons with mental disabilities, or must be a licensed assisted living facility (Akers, King, 2011, p. 8). The community home must be State licensed as well as provide food, shelter, personal guidance, care, habilitation, and supervision to the persons with disabilities who reside in the home (Akers, King, 2011, p. 8). The community home may house a maximum of six persons with disabilities and two supervisors at a time, regardless of the legal relationship of the residents to one another

(Akers, King, 2011, p. 8). The community homes cannot be established within a one-half mile of an existing community home (Akers, King, 2011, p. 8).

The Texas Health and Safety Code defines a licensed assisted living facility as an establishment that furnishes food and shelter, personal care services, administration of or assistance with administration of medication to four or more persons who are unrelated to the facility's proprietor (Akers, King, 2011, p. 9). The assisted living facility list does not include certain religious organization establishments for the care or treatment of the sick exclusively by prayer or spiritual means without the use of any drug, or tax-exempt retirement homes for ministers (Akers, King, 2011, p. 9). It also does not include a facility funded in whole or in part by the Department of Aging and Disability Services (DADS) (Akers, King, 2011, p. 9). The Texas Health and Safety Code permits the municipal government to create ordinances to:

> (1) prohibit a person who does not hold a license issued under this chapter from establishing or operating an assisted living facility within the municipality; and
>
> (2) establish a procedure for emergency closure of a facility in circumstances in which: (A) the facility is established or operating in violation of Section 247.021 [i.e. operating without a state license); and (B) the continued operation of the facility creates an immediate threat to the health and safety of a resident of the facility. (Akers, King, 2011, p. 9)

Although this policy is created to ensure the safety of the residents, it begs the question, where will they go should the municipality choosing to enact an emergency closure of the facility?

An unlicensed care home provides room, board, and some level of services for two or more unrelated individuals, but are not licensed or certified by the state (Greene, Lepore, Lux, Porter, Vreeland, 2015, p. v). There is extremely limited information and even more limited literature on unlicensed group homes (Greene, et al, 2015, p. ix). Much of the information that is available to gather is media reports and interviews with subject matter experts and key informants who work closely with unlicensed group homes, or those who work or reside in them (Greene, et al, 2015, p. ix). Based on the exploratory research done, the demand for unlicensed care homes mainly comes from the following four factors:

> (1) The policies that licensed care homes have against admitting residents who exhibit behavior problems and those who have substance use disorders or to discharge residents who develop these problems. (2) The modest payments made by SSI or State Supplemental Payments to residential care homes, which may be inadequate to cover expenses in licensed facilities. (3) The closure of large mental health institutions and concomitant transition of previously-institutionalized individuals with severe and persistent mental issues to community-based care settings, such as legally unlicensed care homes. (4) The financial pressure hospitals feel to free up hospital beds sometimes results in discharges to unlicensed care homes, both unintentionally and for expediency. (Greene, et al, 2015, p. viii)

An example of financial pressure to free up hospital beds is that at Austin State Hospital wards are released once a discharge plan is in place. A discharge plan is mainly the responsibility of the guardian, which details where the ward will reside once released

from Austin State Hospital, as well as what efforts will be taken to maintain the overall wellness and safety of the ward. If the discharge plan happens to be that the ward will go to live at an unlicensed care home, and it seems feasible to the judge that the ward will be alright living there, the ward will be released to free up space, as well as attempt to give the ward a less restrictive lifestyle. In an ideal world, everyone would be in a safe, caring, knowledgeable, placement, but unfortunately, this is not an ideal world. The hope is that more research will be done and more regulations to be passed so those with disabilities can get the care they have an intrinsic right to as humans.

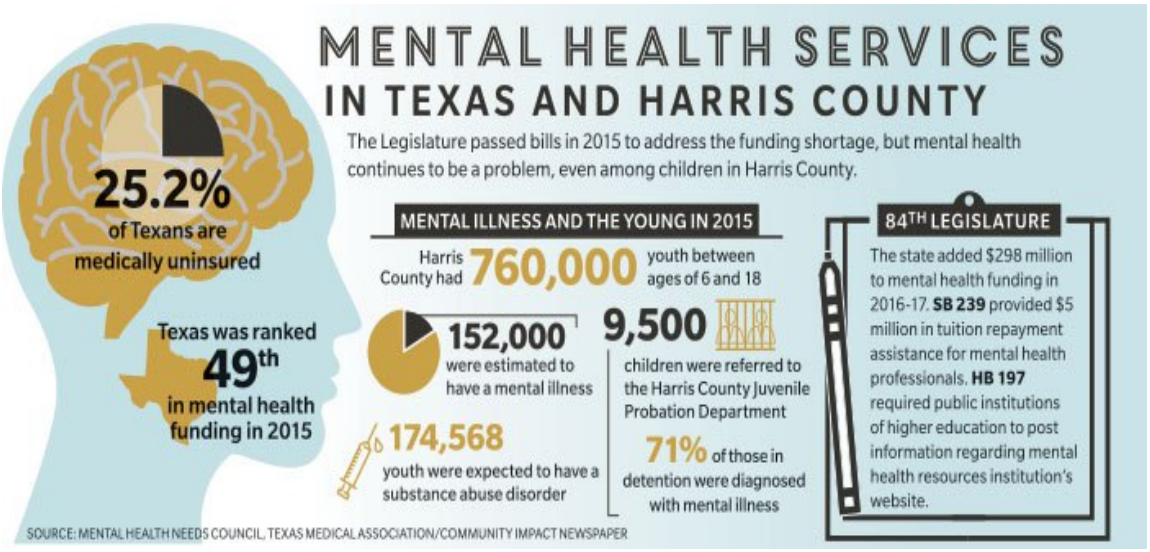
Mental Health Dilemmas

In *Mental Health in America* by Donna R. Kemp, it is noted that while 60-80 percent of people with heart disease receive treatment, a mere 25 percent of people with mental disorders receive treatment (Kemp, 2007, p. 53). Prisons and jails have become America's new mental hospitals post-deinstitutionalization with more mentally ill incarcerated than in facilities to treat and rehabilitate the mentally ill (Kemp, 2007, p. 66). Figure 1, seen below, supports this with data indicating that of the 9,500 children referred to the Harris County Juvenile Probation Department, seventy-one percent were diagnosed with mental illness (Butterfield, 2016).

An article posted on the National Alliance on Mental Illness (NAMI) Greater Houston website stated, "Gov. Greg Abbott and state leadership have asked state agencies to scale back funding requests by 4 percent because of anticipated budget deficits related to the drop in the price of oil, said Annalee Gulley, director of public policy and government affairs for Mental Health America of Greater Houston. Exemptions to this cut have been granted for certain priority areas– including public

education, border security, Child Protective Services and mental health resources," which could indicate that Texas is finally making mental health more of a priority than in previous sessions (Butterfield, 2016). Another indicator of this shift, noted in Figure 1, is that the Texas Legislature passed a budget that increased mental health funds by $298 million before the 84th session ended in June 2015 (Butterfield, 2016). However, Gulley acknowledged that the funding increases for mental and behavioral health over the past two legislative sessions were not sufficient to compensate for the historically underfunded area especially when considering the population growth in Texas (Butterfield, 2016). Annalee Gulley also brought up the point that the Harris County Jail is often referred to as the largest mental institution in the state of Texas, which aligns with the findings in *Mental Health in America*, by Donna R. Kemp (Butterfield, 2016).

Figure 1: Mental Health Services



On Friday, December 18, 2016, the House and Senate passed, and President Barack Obama signed the 1.1 trillion 2016 budget bill (HR 2029, 2016). Benefits from this bill include a $85.4 million boost for research at the National Institute of Mental

Health (NIMH), $50 million more for services at the Substance Abuse and Mental Health Services Administration (SAMHSA), and $255 million increase for veterans' mental health treatment (H. R. 2029, 2016). This is an encouraging sign that mental health in America is taking more of a priority than it has previously.

III. Methodology

The main goal of the Travis County Probate Court is to assure the well-being of the mentally incapacitated (Travis County, 2017). This is attained through the guardianship program, an entity created by the court, which gives legal right to a guardian to take care of and make decisions for the ward (Travis County, 2017). A ward is a person who is unable to take care of themselves or make decisions, which could be the result of Alzheimer's, dementia, autism, stroke, head injuries, or intellectual and developmental disabilities (Travis County, 2017). The guardian is made accountable for their care of the ward through annual reports, as well as annual visits performed by the court via the Court Investigator, Tom Ruffner, Assistant Court Investigator, Adia Mercado-Montero, or court visitors, one of which is me (Travis County, 2017).

The annual reports the guardians fill out once each year detail the contact information for the guardian, as well as the facility or home the wards reside in. It goes on to indicate the physicians the ward has had appointments with during the year, and whether the ward's health has improved, declined, or stayed the same. The guardian is to list any and all activities the ward participates in, and how often the guardian has visited the ward. The court visitor report is all of the aforementioned information, plus much more observation-based reporting. The report I filled out during each of my visits included a checklist for the residence of the ward: access to hot water, own bed, fire

extinguisher, access to television/phone/computer/radio, clothes appropriate for the weather, cleanliness of ward, etc. I also had a checklist of abilities: able to read, able to write, able to speak, able to walk with or without assistance, cognition of time and space, etc. The report asked about the relationship between the guardian and care staff, as well as satisfaction with the care of the ward by the respective facility. Lastly, there was a comment section where I was able to add any extraneous comments I had concerning the resident's well-being.

I visited the residences of wards of the Travis County Probate Court and spoke with their guardians. I gained access through court orders via my job as a court visitor. I did approximately 35 visits and 70 interviews from February 2017 to August 2017. The visits were at private homes, group homes, the Austin State Supported Living Center, private nursing homes and assisted living facilities, as well as Medicaid/Medicare-funded nursing homes and assisted living facilities. All of the sites and wards were selected for me, but after my first 15 visits, I was allowed to state my preference for only visiting group homes, nursing homes, and assisted living facilities. I recorded my observations in my Court Reports, and I also made personal notes on my own for the purpose of this thesis. In addition to the visits, I was able to observe five involuntary commitment hearings at Austin State Hospital. The involuntary commitment hearings are the process by which the Travis County Probate Court terminates rights of the ward and appoints guardianship. This occurs through testimony of the individual ward, family and friends, as well as the social workers and psychiatrists who work at Austin State Hospital. We were given a very basic and minimal standard of living to base our assessments on;

however, through comparison of facilities after visiting, it became clearer which facilities were providing a higher standard of care.

Findings

Texas has the second lowest funding level for mental health in the United States (Kaiser Family Foundation, 2013). Figure 1 reiterates Texas' subpar status when it comes to mental health funding, ranking in at 49th in 2015 (Butterfield, 2016). The United States of America, on average, spent $119.62 per capita during the 2013 fiscal year (Kaiser Family Foundation, 2013). Maine was the most generous in their mental health expenditures during the fiscal year 2013, spending an average of $345.46 per capita (Kaiser Family Foundation, 2013). On the other end, coming in second to last, Texas spent a mere $40.65 per capita on mental health during the fiscal year 2013 (Kaiser Family Foundation, 2013).

In 2003, Texas began a new disease management approach to mental health treatment which aims to provide a continuum of care for the eighty-nine percent of the mental health population that are deemed priority (Kemp, 2007, p. 82). This approach prioritizes ongoing outpatient care to the severely mentally ill, defined as those suffering schizophrenia, bipolar disorder, and severe clinical depression (Kemp, 2007, p. 82). This population would receive psychiatric medication, more frequent visits, counseling, housing placement assistance, and job placement assistance (Kemp, 2007, p. 82). Anyone else will only receive treatment in times of crisis (Kemp, 2007, p. 82). This business mindset for mental health, in an attempt to save money, harms the population more than helps. Cross-national surveys in Brazil, Chile, India, and Zimbabwe have indicated that common mental disorders, such as depression are twice as frequent among the poor than the rich (Kemp, 2007, p. 103). Consequently, due to lack of mental health parity, as well

as the lack of health coverage in general, poor individuals are also less able to seek and afford treatment than those who have a higher socioeconomic status. In addition, the lack of preventive measures leads to crises, which yields higher forensic commits.

Puzzling Savant

My most striking experience was at a group home in North Austin, where I met a man that could be considered a savant. A savant is a person who has an intellectual or developmental disability (IDD), but who excels in a limited field (Savant, n.d.). The most common example is people with Autism Spectrum Disorder who are magnificent musicians (Savant, n.d.). The man that I visited on behalf of the Travis County Probate Court fit both denotative criteria. The ward was diagnosed with an intellectual or developmental disability, knows very basic and minimal sign language, is mute, deaf, cannot read nor write, and cannot complete activities of daily living (ADLs) such as laundry, clothing himself, or washing properly without assistance. He is adept at mimicking staff and those around him, but for all intents and purposes, he is virtually unable to communicate with the outside world.

When I visited him at the group home, he sat at a card table with a stack of puzzles, one of which, a five-hundred-piece tiger puzzle, was sitting half-finished as he worked on it. As I stood there speaking with his caretakers, I noticed how quick and focused he was to put it together. I asked if he did these often, and was told it is one of the few things he will focus his energy on. One of the staff members went on to say that there have been multiple occasions where he gets bored and flips all five hundred separate and mixed up pieces over and proceeds to put the puzzle together with the cardboard backing facing up, rather than the picture side. Before I left, I signed one of the

very few things I know in American Sign Language, "Have a good day," to which he replicated me perfectly. I was intrigued beyond words at this interaction and made sure to tell Tom Ruffner, the Court Investigator and Attorney, about my experience. It was then that the idea of the ward being a savant was brought up, and Tom Ruffner made a note to look into any other types of services the ward may be qualified for to stimulate him further. It truly made me recognize how necessary it is for the wards to have stimulation and activities to help strengthen their weaknesses and harness their abilities. Wards have talents just as a typical person does, and their gifts need room and attention to grow and flourish.

Facilities

Medicaid and Medicare-funded facility. Oakcrest Manor is, what I consider, a prison for the incapacitated. On paper, Oakcrest Manor is a nursing home in northeast Austin, purely funded by Medicare and Medicaid. In person, Oakcrest Manor is very secluded. A fence encases the property and another fence that curves inward at the top with barbed wire to encase the facility. The residents share small quarters with two or more other residents, all with varying needs and responses to stimuli, due to their differing mental and physical illnesses. The only activities available for the residents are smoke breaks. Many of the residents have guardians provided by Family Elder Care, an agency that provides their workers with a caseload of wards that rotates due to high turnover. This leaves the wards not knowing who their guardian is, or when they will be visited by the said guardian. The staff does not always know where the residents are located and were overall unhelpful and aloof both times I visited. Oakcrest Manor has

been called the last resort by those working with the probate court, and I would agree because I would do anything I could to keep my loved ones from living there.

A high end privately funded facility. Marbridge is a completely private paid facility on the opposite side of the spectrum. Marbridge sits on a large, beautiful, green acreage and offers a plethora of amenities including, but not limited to, equine therapy, catch and release fishing, Zumba, and guinea pigs within the common areas of the residential facilities. Even though the facility is completely private pay, Marbridge has a multi-year waiting list because the facility is so outstanding in its field. The staff are dedicated and knowledgeable about the population and serve their clients diligently. If I was a guardian, I would want my ward to live at Marbridge, no question, due to the overwhelming benefits in comparison to all other facilities I visited.

A publicly funded facility. Austin State Supported Living Center has changed drastically over time. Just in the name, Austin State Supported Living Center is more dignified than the previous name, Austin State School since many state schools have negative connotations due to institutions like the infamous Willowbrook State School, which previously resided in Staten Island, New York. Even before that, Austin State Supported Living Center was called the Colony of the Feeble-Minded when it opened its doors in 1917, which is quite telling of the previous mindset society had toward the mentally ill. Along with the change of names, came a change in conditions. Austin State Supported Living Center was facing closure as near in the past as 2014 but has now celebrated its 100th birthday this past summer in June 2017. The problems associated with the institution was mainly overpopulation, as well as neglect and maltreatment accusations, partly due to the untrained staff.

Now, the resident number has been drastically diluted, and the residents all seem very well taken care of with many opportunities for growth, although no place is perfect. The wards who cannot motor themselves or speak, and are the most disabled are many times living three beds in a room meant for one or two; however, due to the amount of time the residents spend outside of their room in therapy or in common areas, it did not seem to pose a problem for their well-being. I spoke with a handful of guardians who were very satisfied with their wards' care. Furthermore, I spoke with staff at the facility, many who genuinely cared for each and every one of the residents they are responsible for, and it was apparent in the way they interacted with the residents. I was also able to sit in on an interdisciplinary conference concerning one of the wards where multiple professionals discussed the best course of action moving forward to improve and eventually eliminate a self-harming behavior. This is another sign of holistic, client-centered care at Austin State Supported Living Center. Overall, the care at Austin State Supported Living Center wins my "most improved" award.

Middle range privately funded facility. Gracy Woods and Park Valley Inn are more expensive private pay nursing homes, whereas, Pavilion at Great Hills and Monte Siesta are less expensive private pay nursing homes. This difference is most observable in the staff because the Gracy Woods and Park Valley Inn staffs are extremely familiar with the patients, maintain frequent contact with guardians and family, and create a positive environment for visitors while upholding regulations. In contrast, the staff at Monte Siesta is difficult to locate: the nursing stations are always empty and many of those in uniform I approach pay no mind to the stranger roaming their halls. This raises questions about the safety of the residents of these facilities, who for all intents and purposes cannot

take care of themselves. My classmate was aggressively confronted by a female worker when she attempted to conduct a visit at Pavilion at Great Hills: the woman would not allow my classmate to visit the ward, and disregarded the court order my colleague was armed with. My classmate contacted our professor, who contacted the judge for the Travis County Probate Court, who ordered her to allow my colleague to see the ward, or he would order police to escort my classmate to see the ward. The staff member claimed that previously, she and the facility had gotten in trouble due to allowing a court visit to take place. This raised suspicions that perhaps the facility was providing insufficient care, or that the staff was attempting to hide malicious activity. However, other than that unfortunate instance, the care of the resident seemed to meet the standard, and the resident seemed to be in good health. The contrast is stark, unfortunate, and should not exist if mental health parity came into play.

Summary. In general, the group homes, assisted living facilities, and dayhabs that my classmates and I visited were sufficient in their care. The overall appearance of the facility, the amenities, and the number of residents per bedroom (in the case of group homes and assisted living facilities) were mostly dictated by how the facility was funded. If the facility is funded by Medicare and Medicaid, there is a greater likelihood that the facility looks older, and is perhaps in a lower income neighborhood. If the facility is funded privately by the residents or their families, the facility is more likely to have affluent amenities. These amenities, such as equine therapy, fishing, pets, occupational and physical therapy, etc. are integral to the betterment and maintenance of health and wellness. It is not fair that the residents at Marbridge, have a far better quality of life than those residing at Oakcrest Manor.

Most beds are being filled by forensic commits. Forensic commits would be less of an issue if mental health was more of a priority and people got the care they needed before doing criminal acts. I saw this during my visit to Austin State Hospital to observe the commitment hearings. Four out of the five commitments were because the individual had been arrested for erratic behavior caused by their untreated mental illness. The fifth individual undergoing a hearing was there because her family members were concerned for her well-being. She was a danger to her own well-being due to delusions of grandeur, which caused her to act erratically, not take her medications, and not eat. Her family recognized that, which led to the involuntary commitment hearing and placement within the Austin State Hospital.

IV. Discussion

Mental Health Parity

An overarching theme in Donna R. Kemp's *Mental Health in America* is mental health parity in funding, insurance coverage, and availability (Kemp, 2007, p. 53). Approximately fifty-three percent of the population is covered by state mental health parity laws (Kemp, 2007, p. 53). In California during the summer of 2001, stakeholders completed a study of the implementation of their state mental health parity legislation (Kemp, 2007, p.54). Although the law did not appear to have adverse consequences economically, stakeholders noted that "partial parity" for some, not all mental health diagnoses posed administrative challenges leading to confusion for many (Kemp, 2007, p.54). In addition, many consumers did not know about their expanded benefits, so communication needed to be improved to facilitate access (Kemp, 2007, p.54). This leads one to believe that implementing mental health parity would benefit the masses, so long as the changes are communicated effectively. Another important facet of *Mental Health*

in America is the focus on the economic burden of incarcerated persons with mental illness. At the turn of the century, crime, criminal justice costs, and property loss associated with mental illness cost six billion dollars each year (Kemp, 2007, p. 65). To expand on that notion, the total cost for the state and local governments to arrest, process, and jail people with mental illness exceeds the total state and local government mental health expenditures (Kemp, 2007, p. 65).

It is worth noting that Alzheimer's disease and dementia are mental illnesses that will soon affect the baby boomer population, who are currently in power politically (Kemp, 2007, p. 109). Approximately five percent of men and six percent of women over sixty have been diagnosed with Alzheimer's disease, and due to the aging population, it is imperative that the mental health policy and practice be revised accordingly to close the gap in services (Kemp, 2007, p. 109). Perhaps those in power will realize their possible future, and invest in mental health, if not for the greater good, for themselves.

DHHS and WHO Recommendations

The Department of Health and Human Services developed a set of goals, and objectives to meet those goals, in a program called *Healthy People 2010* in an attempt to create "an ideal system" (Kemp, 2007, p.79). The mental health goal, "to improve mental health and ensure access to appropriate quality mental health services," has three subtopics categorizing their objectives: Mental Health Status Improvement, Treatment Expansion, and State Activities (Kemp, 2007, p.79). I found the most pertinent section to this discussion to be State Activities objectives as follows:

12. Increase the number of states and the District of Columbia that track consumers' satisfaction with the mental health services they receive (Kemp, 2007, p. 80).

13. Increase the number of states, territories, and the District of Columbia with an operational mental health plan that addresses cultural competence (Kemp, 2007, p. 80).
14. Increase the number of states, territories, and the District of Columbia with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons (Kemp, 2007, p. 81).

Having the states utilize prevention and planning as a means to lessen the burden of barriers to mental wellness and successful mental health treatment is essential to providing for the mentally incapacitated and protecting our most vulnerable populations.

Community care is one of the most important facets of the mental health care system, which the World Health Organization defines as an approach including these elements:

- Services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- Interventions related to disabilities as well as symptoms;
- Treatment and care specific to the diagnosis and needs of each individual;
- A wide range of services which address the needs of people with mental and behavioral disorders;
- Services which are coordinated between mental health professionals and community agencies;
- Ambulatory rather than static services, including those which can offer home treatment;

- Partnership with carers and meeting their needs;
- Legislation to support the above aspects of care (Kemp, 2007, p. 111).

The criteria which define community care is the optimal level of care and the goal for everyone experiencing mental illness to be provided. Major improvements to the mental health care system could occur if these bullets were always taken into consideration, due to the thorough indication of all aspects of care. Legislation and agency visibility is a definite first step for community care to take place, as well as informed and caring guardians to seek proper care. With a strong community base and the state and federal legislation to back up and fund the endeavors to provide better mental health care, much more is possible in the way of ambulatory services and interdisciplinary support of clients.

Bipartisan Mental Health

It is integral to discuss that mental health parity is a bipartisan issue. This is exemplified by the Bill Clinton and George W. Bush administrations. President Bill Clinton made an effort toward better mental health by advocating for and signing the Mental Health Parity Act of 1996 (Kemp, 2007, p. 151). The Mental Health Parity Act requires health plans to provide the same annual and lifetime spending caps for mental health benefits as they do physical health benefits (Kemp, 2007, p. 151). To further these efforts, President Clinton also worked for the 1997 Balanced Budget Act to include funds to support a strong mental health benefit to a program providing health care coverage to uninsured children (Kemp, 2007, p. 151). Lastly, President Clinton also signed an executive order in 1999 to ensure individuals with psychiatric disabilities were given the same work opportunities as people with physical disabilities (Kemp, 2007, p. 151).

President George W. Bush established the New Freedom Commission on Mental Health in April of 2002 (Kemp, 2007, p. 150). The purpose of the commission was to complete a comprehensive study on the American mental health system (Kemp, 2007, p. 150). Once the study was complete, the New Freedom Commission on Mental Health gave forth the recommendations as set forth in Figure 2.

Figure 2: New Freedom Commission on Mental Health recommendations

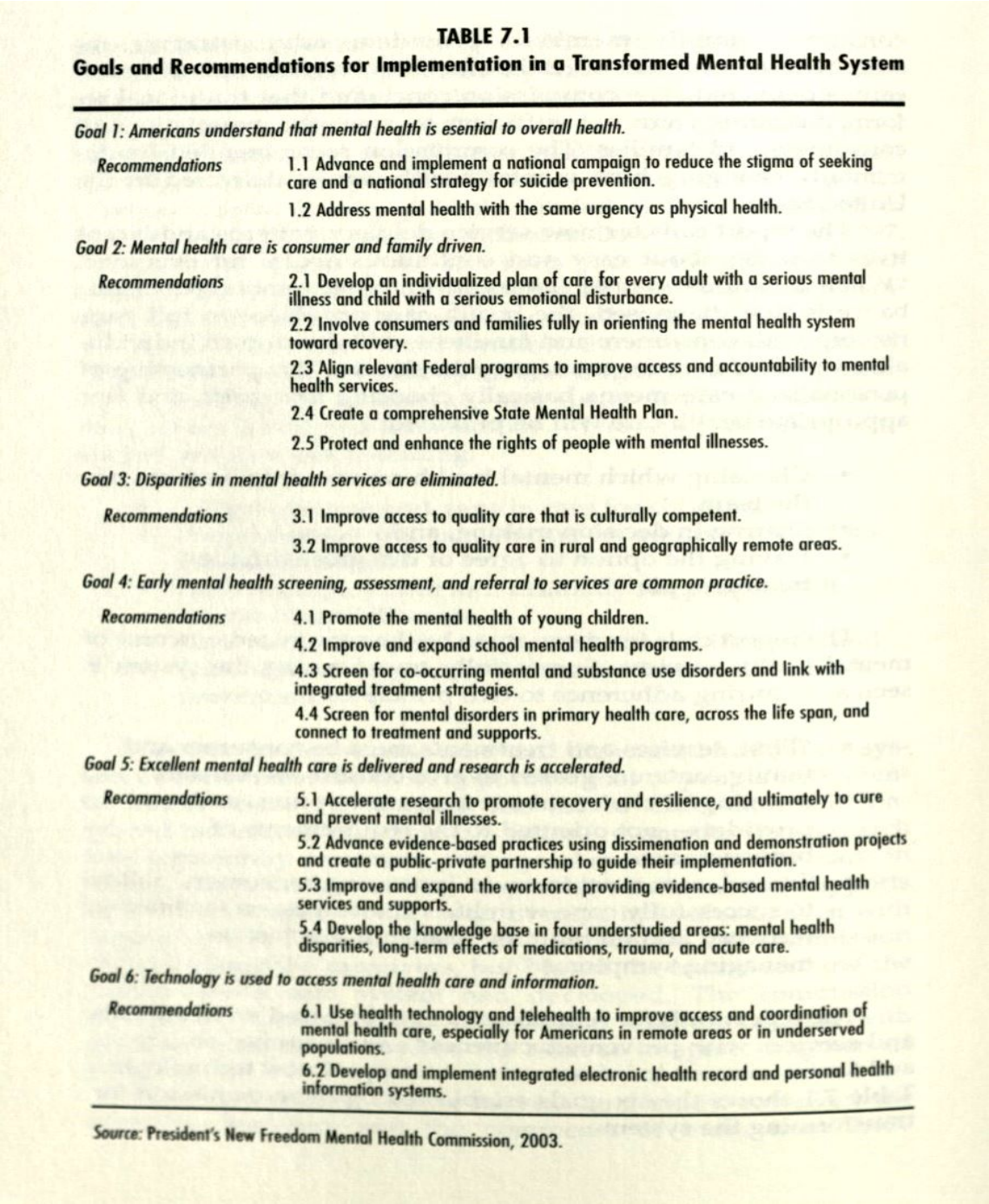


TABLE 7.1

Goals and Recommendations for Implementation in a Transformed Mental Health System

Goal 1: Americans understand that mental health is esential to overall health.	
Recommendations	1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
	1.2 Address mental health with the same urgency as physical health.
Goal 2: Mental health care is consumer and family driven.	
Recommendations	2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
	2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
	2.3 Align relevant Federal programs to improve access and accountability to mental health services.
	2.4 Create a comprehensive State Mental Health Plan.
	2.5 Protect and enhance the rights of people with mental illnesses.
Goal 3: Disparities in mental health services are eliminated.	
Recommendations	3.1 Improve access to quality care that is culturally competent.
	3.2 Improve access to quality care in rural and geographically remote areas.
Goal 4: Early mental health screening, assessment, and referral to services are common practice.	
Recommendations	4.1 Promote the mental health of young children.
	4.2 Improve and expand school mental health programs.
	4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
	4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
Goal 5: Excellent mental health care is delivered and research is accelerated.	
Recommendations	5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
	5.2 Advance evidence-based practices using dissimenation and demonstration projects and create a public-private partnership to guide their implementation.
	5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
	5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.
Goal 6: Technology is used to access mental health care and information.	
Recommendations	6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
	6.2 Develop and implement integrated electronic health record and personal health information systems.

Source: President's New Freedom Mental Health Commission, 2003.

(Kemp, 2007, p. 206).

President Bush instructed more than twenty-five federal agencies to develop implementation plans based on the above recommendations (Kemp, 2007, p. 150).

V. Conclusion

America needs more clear policies regarding mental health to protect the vulnerable and keep providers honest and accountable. More clear policies could require more experienced staff to supervise those like Sterlin Milam, so he would still be alive today. Mental health parity can only come from clear-cut policies that emphasize the importance of honest practices and protection of our most vulnerable populations. There should be policies on multiple levels regarding types of residences, to maintain a high standard of living for the mentally ill. Mental health parity is an issue that should get legislators to reach across party lines and create a better system for all.

More funding needs to be allocated toward mental health in the United States of America, and especially in Texas to create mental health parity. The World Health Organization (WHO) recommends that 5% of overall health spending should be spent on mental health, a level that was only seen in some European countries (Garcia, 2016). In comparison, the percentage of Brazilian spending on mental health in relation to funding for health fluctuated around 2.45–2.51% between 2001 and 2012, which indicates that Brazil is in line with average levels seen worldwide (Garcia, 2016). More funding could have hired better-qualified staff at the group home to supervise Sterlin Milam and make sure he did not wander out to his death. More funding could give the residents more stimulating activities than smoke breaks. More funding could make sure that the puzzle savant could get more puzzles, more activities he might prove superior at, and testing to see what else he is capable of.

This funding could also go toward having mental health screening in elementary schools much like we have sight, hearing, Scoliosis, and lice screenings in elementary schools. Mental health parity functions on the assumption that mental health diagnoses

and physical ailments are recognized as equal and treated with the same seriousness. The Early screening will encourage appropriate treatment and care for children and adolescents. This treatment, occurring prior to psychotic breaks and episodes, will lessen the number of forensic and emergency commitments. The crime rate would also hypothetically decrease, leading to fewer inmates and fewer tax dollars going toward the incarcerated population. This not only saves money in the long run for taxpayers but also provides fringe benefits for the individuals suffering from mental illness and their family and friends supporting them through their condition.

These proposals are far too large for me to conquer alone; however, I and anyone else in or near Travis County can continue to make positive change on a small scale by becoming a court visitor with the Probate Court and taking on the responsibility of being a watchdog for the incapacitated. Even if a volunteer does one court visit, that it one more ward that is being checked on, and advocated for. In an ideal world, all 1800 wards within Travis County and all wards in other counties would be in caring environments with all their needs met, but that can only be achieved through activism. This activism can also take the form of writing and calling government officials in favor of mental health funding and regulation of care facilities. This activism can also take the form of voting for politicians that stand on a platform for positive mental health reform. This activism can also take the shape of merely being informed about what is going on in our communities concerning the vulnerable populations around us.

References

Butterfield, J. (2016, November). State mental health funding avoids cuts in 2017 following $298M budget increase in 2015. National Association on Mental Illness Greater Houston, Retrieved from https://namigreaterhouston.org/state-mental-health-funding-avoids-cuts-2017-following-298m-budget-increase-2015/

Cargile, E. (2017, September). Sister of man killed crossing the street blames group home. *KXAN*, Retrieved from http://kxan.com/2017/09/10/sister-of-man-killed-crossing-the-street-blames-group-home/

Garcia, M. L. T. (2016). An analysis of the federal funding for mental health care in Brazil. *Social Work in Health Care*. Retrieved from http://www.tandfonline.com/doi/full/10.1080/00981389.2016.1265628?scroll=top&needAccess=true&

H.R. 2029 - Consolidated Appropriations Act, 114th Congress (2015-2016)

Kaiser Family Foundation (2013). State Mental Health Agency (SMHA) per capita mental health services expenditures. Retrieved from http://www.kff.org/other/state-indicator/smha-expenditures-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

National Association of Social Workers (2008). Code of ethics. Retrieved from https://www.socialworkers.org/pubs/code/code.asp

National Institute of Mental Health (2015). Any mental illness among U.S. adults. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml

National Institute of Mental Health (2015). Serious mental illness among U.S. adults. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

Savant [Def. 2]. (n.d.). In *Merriam Webster Online,* Retrieved from http://www.merriam-webster.com/dictionary/savant

Travis County (2017). Court visitor volunteer program. Retrieved from https://www.traviscountytx.gov/probate/court-vistor