An Impact Evaluation of the Texas Department of Mental Health and Mental Retardation Performance Contract-Incentive Recoupment Program

By

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ABSTRACT

This paper evaluates the effectiveness of a government performance contract which utilizes incentives and penalties to improve performance. In addition, it traces the evolution of privatization and contracting out of government services. It also discusses government contracting with other governmental entities and non profit organizations. The evaluation of the Texas Department of Mental Health and Mental Retardation Performance Contract is divided up into three hypotheses, all of which argue that a system of incentives and penalties improves contractor performance. The results generally support all three hypotheses.

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Chapter One

Introduction

Frederica S----- Admitted: July 6, 1861
Died at 11:40 O'clock, August 12th, 1886
Above these lines a simple record stands
that tells of dim, closed eyes, and still cold hands;
No interest to the casual eye it gives,
Only the time and place and date now lives;
But to this noble charity, an eventful transition
It leads---lets hope--- to heaven and full fruition;
In the freshness of its early morning tide
This was its fair, its first acceptable bride;
And now this house in mourning bows its head
Over its first female admission, its latest dead;
Her entrance was in days of trembling hopes and fears,
When noble southern women were bowed in salty tears,
Beneath the burning rays of a memorable July sun,
In that well remembered year of 1861,
She came with glaring eyes, and wild disheveled hair
With shout and shriek, she essayed a maddening air;
To bide within these walls no one could know how long
To mingle with the desolate, to join the madman's song;
From away beyond the ocean, her native land decries,
To seek a brighter clime, a home neath southern skies;
No doubt— with joys o'erflowing, and hopes that ran full high,
She bid adieu to fatherland, and turned away with many a sigh
But alas. What consummation of hopes so fair and bright,
What evil day hath blasted and turned them into night.
Full five and twenty years, long, weary, changing years,
She dwelt beneath this roof, 'twixt many hopes and fears"
But at last the end has come, as come to all it must
And she like all mankind must be consigned to dust;
Physician's constant care and skill were ever tried in vain
And physic did not heal the mind but only eased the pain.
But then, no loved one stood besides her dying bed;
No ties of blood were near, no tears of grief were shed.
By a stranger's hand her dying eyes were closed,
By a stranger's hand her dead cold form composed,
Only strangers around her bier with vain regret,
But then, how soon her form these strangers will forget.
This last report of her with holy thought is penned;

Let no unhallowed hand its sacredness transcend.

Only one word more, one little word I ask,
And then my hand is staid, I've done my task.
O' Father in that far off world, where dwelleth thou, Oh Lord
Will minds estranged in this sad life be there by Thee restored?
(Written by Dr. J. T. Wilson, Asst. Physician, 1876-1886)

History

The above poem, written by Dr. Wilson, was essentially the final discharge summary of the first female patient admitted to Austin State Hospital in 1861. In the one hundred and thirty eight years since her admission, thousand of other patients have come and gone virtually all victims of mental illness. One can still walk through the basement of the Austin State Hospital; look at the heavy metal rings embedded in the limestone blocks and imagine the pain and suffering of the human beings who were chained to the rings.

From 1861 until the late 1950s, state hospitals provided whatever public mental health services were available, not only in Texas but throughout the country. For the most part, mentally ill patients were given little effective treatment but were simply contained in conditions that were often horrendous. Overcrowding, poor staffing and lack of treatment were the standard throughout much of the twentieth century. Conditions were particularly deplorable in Texas, which had a long history of underfunding for social services. In 1939, Texas state government had an average patient cost per day of sixty-two cents. At that time the state was ranked 28th in per capita spending for mental health. By 1949, Texas was spending one dollar and forty one cents per day, giving a national ranking of 38th (LBJ School of Public Affairs, 1990: 4)

Purpose of Study

During the last thirty-six years, great progress has been made in the care and treatment of people with mental illness. State hospitals now play a secondary role, with the majority of patients treated and supported in community settings. New drugs that can dramatically improve functioning, skills training and in home crisis services are a few of the treatment modalities that have transformed care, particularly for people with serious and persistent mental illness.

It is community based mental health programs that are the focus of this paper, particularly programs provided in Texas under the auspices of the Texas Department of Mental Health and Mental Retardation (TDMHMR). The purpose of the paper is to evaluate the effectiveness of a system of penalties and incentives that were implemented by TDMHMR to achieve greater accountability in the provision of community based programs. Through the six chapters of this paper, it is hoped that some insights are gleaned regarding the process of assuring proper accountability for public mental health programs.

Chapter two, **the setting** chapter, describes the public mental health environment in Texas and how it has been shaped by state and federal legislation over the last several years. It also discusses the evolution to a system of greater accountability which includes performance contracting. Chapter three, **the review of literature**, traces the development of contracting in government, examines issues related to privatization of government services and looks at organizational considerations which affect government contracting. It then articulates the conceptual framework of the paper. Chapter four, **methodology**, outlines the research design which is used to test the hypothesis and explains some of the weaknesses inherent in the design. Chapter five, **results**, discusses the findings of the

empirical research. Chapter six, **conclusion,** attempts to summarize the results and evaluate the possible implications of the research. Throughout the paper, public accountability is the consistent theme being discussed.

Not only is it necessary to ensure that the taxpayers dollars are utilized effectively and efficiently, but to assure in the process, that the pain and anguish of people with mental illness is ameliorated. For Frederica S----------, the advances in treatment have come far too late. However, it is our remembrance of her and the millions of others who suffered that should guide us as we move forward.

Chapter Two

Setting

Community Mental Health Care in Texas

Public mental health, like many other taxpayer funded programs, has been influenced by the movement to achieve greater accountability in government. Ensuring effective oversight of the expenditure of public mental health dollars is a responsibility that has primarily fallen on state government. In Texas, this responsibility is assigned to the Texas Department of Mental Health and Mental Retardation (TDMHMR).

As in most states, the public community mental health system in Texas was germinated by passage of the Community Mental Health Center Act of 1963. This piece of legislation, proposed and signed in law by President Kennedy, provided grant dollars that enabled creation of community based mental health and mental retardation programs. Initially, virtually all of the federal grant dollars went directly to local community organizations. In many states, community centers were created as private non-profit entities. In Texas, community centers were designated as units of local government (Texas Health and Safety Code, Chapter 534.001).

Despite the fact that community centers were considered units of local government and agencies of the state, TDMHMR had very little influence over them since virtually all of their funding came directly from the federal government. However, as the federal grants began to decrease, community centers were forced to turn to state government to provide additional funding.

The funding that was provided to community centers during the 1960s, 1970s and early 1980s was called state grant in aid. There were no performance measures tied to expenditure of the dollars and there was no contractual relationship between TDMHMR and the individual community centers.

As expenditures of state general revenue dollars continued to expand, the Texas Legislature became more concerned with the lack of oversight and accountability. In 1984, the Speaker of the Texas House of Representatives and the Lieutenant Governor established a legislative Oversight Committee (LOC) to study future directions for TDMHMR. After extensive review, the LOC made 93 recommendations which were eventually enacted in laws as Senate Bill 633 in 1985. The primary elements of the bill included requirements that TDMHMR define its priority population, or those most in need of services, replace the state grant in aid system with performance contracts and require community centers to provide five core services (LBJ School of Public Affairs, 1990: 11).

Performance Contracting

Beginning in 1987, TDMHMR began developing a performance contract process with community centers. As per legislative mandate, the contract spelled out specific program requirements that each community center had to meet. However, since there was no unit cost accounting system to tie specific costs to discrete services, there was wide variation among community centers in how many people were served. Community centers negotiated individually with TDMHMR over how many people would be served with the available dollars. Failure to serve the negotiated number of people resulted in no

monetary sanctions. The lack of accountability in tying dollars to services in the performance contract resulted in strong criticism from State Comptroller John Sharp (Texas Performance Review, 1996: 121). In response to such criticism, TDMHMR created the Performance Contract Coordination Office (PCCO).

Beginning in fiscal year 1997, the performance contract was rewritten as a legally binding document. In addition to assigning an overall target to be achieved in adult mental health and children's services, each community center was assigned a target for number of people to be served in innovative new programs called best practices. Although the contract had language that allowed for fines for failure to meet targets, TDMHMR made the decision not to impose fines in fiscal year 1997.

As previously stated there were three best practice services required under adult mental health services. Mental health centers were given best practice targets which represented three percent of their total adult target. See table **2.1** for definitions of the best practices.

Table 2.1 Mental Health Best Practices

Program Category	**Description**
Assertive Community Treatment (ACT)	self-contained program which provides treatment, rehabilitation and support to individuals with the greatest need.
Supported Employment (SE)	services which help people choose, obtain and maintain regular community jobs.
Supported Housing (SH)	services which help people choose, get and keep regular integrated housing.

In fiscal year 1998, TDMHMR implemented a completely new funding methodology whereby the target number of people to be served was tied to the allocated dollars. The new system, called the **"case rate methodology"**, attempted to create

consistency throughout the state. The basic principle behind the **case rate methodology** was that community centers across the state would have to serve a comparable amount of people based on the dollars each received. If a community center received five percent of the statewide general revenue allocation, its targets would equal five percent of the statewide target. A critical element which was added to the performance contract in fiscal year 1998 was the **incentive/recoupment** process.

Under the terms of the fiscal year 1998 performance contract, community centers were to have their performance towards achieving targets evaluated quarterly. Community centers that failed to achieve quarterly targets faced monetary penalties **(recoupment)**. The penalties were based on the number of people the center was short of its target multiplied by the **case rate** for the particular service. In addition to penalties for failure to achieve targets, community centers that exceeded targets were given the opportunity to earn additional dollars from an **(incentive)** pool. The system subsequently became know as the **(incentive/recoupment program)**. See Table 2.2 for explanation.

Table 2.2 Incentive/Recoupment Program

Targets	**Expectation: achieve 100% of target or better**	**Consequence: eligible for incentives if exceed 100%. subject to penalties for achieving less than 100%**
Number of adults to be served		
Number to be served in Assertive Community Treatment (ACT)		
Number served in Supported Employment (SE)		
Number served in Supported Housing (SH)		
Number of Children served		

Statement of Research Purpose

There has been considerable discussion over the last several years about the value of performance contracting in government. It is commonly argued, by Shields and others, that performance contracting is a useful mechanism to ensure that taxpayers are receiving the services for which they are paying. In most performance contracts, monetary rewards and penalties are tied to quantitative performance. Although previous TDMHMR performance contracts had quantitative targets that community centers were required to achieve, there was no implementation of a system of rewards and penalties. However, the fiscal year 1998 TDMHMR Performance Contract tied quantitative performance to monetary penalties and rewards for the first time. It is the intent of this research to evaluate the effectiveness of the TDMHMR Incentive/Recoupment Program in improving target performance.

The next chapter, the review of literature, traces the evolution of ideas such as privatization of government services and contracting. It also discusses organizational considerations and what impact they can have on the performance contracting process. The various ideas and concepts that are outlined in the chapter all have one thing in common. They all reflect efforts by government to improve accountability for service delivery.

Chapter three

Literature Review

Introduction

> *The introduction of contracts into the delivery of public services has rightly been seen as one of the key elements in the overall policy shift which has taken place over the past two decades and which has transformed the character of the public sector. (Deakin, 1996: p.20)*

Although contracting of government services is generally thought of as a new phenomenon resulting from the resurgence of the conservative political movement, its roots can be traced back to the later part of the nineteenth century. Ironically, it was in states traditionally considered liberal in their political bent that contracting out of services began. By the latter part of the nineteenth century, states such as Pennsylvania, California, New York, Connecticut and Maryland were contracting with private organizations that ran orphanages as alternatives to state institutions (Hill, 1983: 37).

This chapter reviews literature pertinent to privatization and contracting out government services. Over the last twenty years, evolutionary development has taken place in contracting, sometimes leading to increased accountability and efficiencies and other times leading to failure. Some of the literature reviewed argues for greater movement towards a competitive market environment in government contracting, while others question whether such an environment can be created, particularly in social services.

A critical aspect of the contracting process explored in the paper is the nature of organizations contracting with government. Particularly in the area of social service contracting, government has shown preference to non-profit organizations. Issues that

are unique to such organizations are also discussed. The special relationship that exists in Texas between state government and community centers is also examined.

Key elements necessary for effective accountability in purchase of service contracts are identified. Two elements identified in the literature that are considered critical in assuring accountability are output and outcome measures. Texas Department of Mental Health and Mental Retardation (TDMHMR), like many other state and local social service bureaucracies, has struggled with issues of accountability. In recent years, TDMHMR has developed a performance contract which utilizes output measures to evaluate success or failure. Financial incentives and penalties are tied to performance. The basic purpose of this chapter is to show the evolution of accountability in government contracting and weave this idea into the conceptual framework of the paper.

Privatization of Government Services

Over the last twenty-five years several factors have led to a decrease in direct provision of service by government and an increased use of contracting for service. According to Patricia Shields, financial crises in many states and the inflationary spiral of the 1970s created an interest in decreasing government expenditures (Shields, 1992: 279). Others noted that during the same period there was a growing perception that the public sector was having a corrosive effect on the overall society. This effect included stifling initiative and economic growth and promoting inefficiency and bloated government (Smith & Lipsky, 1992: 233).

Many of these ideas were transformed into political beliefs concerning the appropriate role of government in provision of services (Bachman, 1996: 808). Although

initial reactions to government provision of services during the 1970s and 1980s might have been reactive responses to the political climate, Shields identified a deeper current which she called the expenditure-control school of thought (Shields, 1992: 279). This perspective fundamentally questioned the role of government, particularly the need for direct provision of services. According to Shields, among the various techniques utilized to reduce governmental expenditures, contracting is the most common (Shields, 1992: 279).

Proponents of privatization argue that decoupling government's responsibility for ensuring service provision from direct government provision of service leads to the possibility of cost savings by injecting a competitive element. Shields argues that contracting has its best chance of succeeding in assuring quality services that are responsive to the citizenry if attention is paid to three conditions. There must be a competitive environment with more than one bidder before any market efficiencies can be achieved. Government must focus on assuring quality services at the same time as reducing cost. According to Shields, it is a common mistake for government, particularly in human service contracting, to ignore cost savings as a goal. The third condition considered necessary is effective oversight and monitoring of the contract on the part of government (Shields, 1992: 285).

The difficulty in creating a competitive market for social service contracting was described by Ruth DeHoog. There were several critical factors which she noted as barriers to an open competitive market. One of the most significant is the lack of agencies willing to compete for social service contracts. She ascribed this phenomenon to several factors. Social service agencies, generally run by local government or non-

profit boards, have traditionally not competed for acquisition of contracts. Unlike for profit agencies, government agencies and non-profit agencies have operated under the perception that they were meeting unmet needs in a particular community. Consequently there is a tendency to avoid head to head competition with like-minded organizations (DeHoog, 1984: p. 55).

She also cites the difficulty new agencies have in entering the market place. Since few private agencies serve disenfranchised populations such as poverty stricken elderly and people with chronic mental illness unless a government contract is in place, competing for a new contract would require significant investment of scare start up dollars (DeHoog, 1984: 56).

In a 1986 article, Robert A. Dorwart, Mark Schlesinger and Richard Pulice raise many questions about the benefits of competitive purchase of service contracting in the public mental health arena. They focused their attention primarily on the Massachusetts Department of Mental Health, which at the time had more than 2000 separate contracts with more than 500 separate vendors (Dorwart, Schlesinger & Pulice, 1986: p. 876). One of their criticisms was the lack of competitive bidding.

> *For any given contract, though, more often than not only a single agency submits a bid, reducing or eliminating many of the benefits thought to be produced by a competitive market for services (Dorwart, Schlesinger & Pulice, 1986: p. 876).*

They were also critical of the quality of care produced in the Massachusetts system. Much of the problem was ascribed to the decentralization of the contract monitoring and the large number of small provider contracts (Dorwart, Schlesinger & Pulice, 1986: p. 877).

The authors contend that the state's desire to promote innovative mental health programs was inconsistent with the desire to maintain strong public accountability. The more detailed specifications in requests for proposals, the less flexibility and room for innovation on the part of the contractor (Dorwart, Schlesinger & Pulice, 1986: p. 878).

Similar impediments to a free market environment were identified by Steven Rathgeb Smith and Michael Lipsky. They argued that in many cases alternative providers were not available due to the unattractiveness of the clientele, such as people with chronic mental illness or people suffering from AIDS (Smith & Lipsky, 1992: p. 240).

Smith & Lipsky also suggested that the competitive market environment diminishes continuity of services, often of great importance in delivery of services. They argue that the therapeutic relationship which often develops between those that are sick and the care givers can be disrupted by switching contracts (Smith & Lipsky, 1992: p. 240).

Another factor identified as a deterrent to a free market system in social service contracting is the degree of involvement by non-profit agencies in the public policy and political process. Non-profit agencies, through their boards and trade organizations frequently lobby public agencies and legislatures in an effort to improve contract reimbursement terms and to ensure their continued existence (Smith & Lipsky, 1992: p. 241).

More recent evidence suggests that competitive contracting is not a dominant force in public mental health systems around the country. Sara S. Bachman found, "no evidence that states used mental health contracting to create a competitive marketplace,

although policy makers suggested this was an intent of the contracting approach (Bachman, 1996: p. 821)." This is further reinforced by Keon S. Chi and Cindy Jasper in "Private Practices: A Review of Privatization in State Government". As reported in *Public Administration Review*, July/August 1998, the survey of state governments showed that, "Grants and subsidies are used more frequently in social services, health care, mental health and retardation and transportation (Chi & Jasper, 1998: p. 374)."

Development of Purchase of Service Contracts

According to Peter Kettner and Lawrence Martin, early purchase of service contracts were unsophisticated and weak. They were designed more as a partnership arrangement than a strict contract (Kettner & Martin, 1986: p. 30). Since that time purchase of service contracts have grown in their scope of use and from the perspective of legal enforceability and accountability.

Kettner and Martin, describe the variations in use of purchase of service contracts along a continuum. At one end of the continuum is the partnership arrangement. Such a contract would be used for building a strong relationship between the provider and payer. It would be flexible and compromising with regard to specific enforcement of the contract (Kettner & Martin, 1986: p. 35).

At the other end of the continuum is the pure market model. In a pure market purchase of service contract, competition and price are critical factors. In addition, the purchaser of service would focus on efficiency and effectiveness in the contract design (Kettner & Martin, 1986: p.36).

Kettner and Martin also identified key administrative aspects of purchase of service contracts which differ, depending on where a contract might fall on the continuum. Whereas a partnership model might use a request for proposal to attract providers, the market model would use an invitation for bids. A partnership model might utilize a cost reimbursement contract, while a market contract would be more likely to utilize unit cost, fixed administrative cost and performance incentives (Kettner & Martin, 1986: p.37).

In the field of public mental health, implementing a model based on a market contracting process could prove difficult. Keith Provan and H. Brinton Milward argue that such a system would be unlikely to work with a population of seriously and persistently mentally ill due to the difficulty in providing continuity of care. Although a normal population might be able to navigate between a network of community providers, because of the nature of their illness, people with chronic mental illness would do so with great difficulty (Provan & Milward, 1994: p. 866).

John Rehfuss suggests that government generally wants to contract social services to other governmental entities through intergovernmental contacts or to non-profit organizations. He argues that non-profits often have a particular devotion to their clientele and the services they provide. In addition, non-profits generally have the support of the broader community and are not seen as taking advantage of the system (Rehfuss, 1989: p. 142).

The Texas Department of Mental Health and Mental Retardation (TDMHMR) purchase of service contract combines elements from the market model and the partnership model. The contract is not open for competitive bidding but is arranged

every year with existing community centers. However, it does utilize market elements such as unit cost, fixed administrative fees and performance penalties and incentives. Although it contains performance specifications, it also mandates that certain services, called best practices are to be provided (TDMHMR, 1998).

The earliest forms of purchase of service contracts focused a great deal of attention on process. Process, in this sense, can be described as rules, regulations and structure which dictate the service delivery. The focus in the process approach is on the mechanics of the service delivery (Kettner & Martin, 1993: p.63). This method of doing business resulted in significant criticism of government. The common charge made was that much time, money and energy was expended on the process of service delivery but virtually none on performance. In response to such criticisms, purchase of service contracts began looking more at performance factors, such as volume of service, unit cost, service completion rate and the condition of clients after service delivery (Kettner & Martin, 1993: p. 63).

> *Given the scarce resources projected for human services in the 1990s, a reassessment of the process approach to purchase of service contracting (POSC) accountability is perhaps in order. The performance approach to POSC accountability may be an idea whose time has come. A break with the long history of process accountability in POSC is both feasible and perhaps long overdue. The mechanism to achieve this breakthrough lies in the use of performance contracting (Kettner & Martin, 1993: 64).*

Organizational Considerations in Public Mental Health

Over the last twenty-five years there has been a steady movement away from direct provision of services by government. This has also been true in the public mental health field. Under the old system of care organizational structure was centralized through state hospital systems. However, with the movement to depopulate state

institutions, new organizational structures began to emerge (Frank & Gaynor, 1994: p.83).

With the passage of Public Law 88-164, also know as the Community Mental Health and Mental Retardation Act of 1963, new local structures began to develop around the country (LBJ School of Public Affairs, 1990: p.8). In some states, community centers were simply created as private non-profit entities. As long as centers met the criteria stipulated in the federal grant to serve the indigent population, they were free of significant state regulation.

However, during the 1970s and 1980s the federal grants began to decrease and on going funds were funneled through state government. Glenn Yank, David Hargrove and King Davis were harshly critical of the public mental health system during this period of time because of its fragmented nature. In a sense, the public system of care had made a break from the old centralized state system but nothing had yet emerged to pull the many local organizational pieces together in a coherent manner. One idea, which began to grow in popularity, was the concept of creating local or regional mental health authorities with the responsibility of ensuring service provision at the local level (Yank, Hargrove & Davis, 1992: p. 102).

During the last ten years, there has been lively debate over the role and responsibility of the local mental health authority (LMHA). States have experimented with various models, many of which have led to transferring the locus of power and responsibility from the state to the LMHA. One proponent of strong local control is David Mechanic, who argues for a capitated funding system. Under such a scenario, a LMHA has control over all mental health dollars and is 'at risk' for ensuring efficient and

effective services to all those in need (Mechanic & Aiken, 1989). According to Keith Provan and H. Brinton Milward, such a system generally means little fiscal control by the state funding agency. They contend that the end result may be that "the core agency may have little incentive to play a major integrating role because there will be few pressures for any centralized monitoring of outcomes (Provan & Milward, 1994: p. 872)."

In contrast, the current public mental health system in Texas can be described as centralized. [1] The central focus is maintained through the Texas Department of Mental Health and Mental Retardation (TDMHMR) performance contracts with local community centers. Community centers in Texas are more than simply private non-profit entities. They are designated in statute as governmental entities.

> *(c) A community center is:*
> *(1) An agency of the state, a governmental unit, and a unit of local government, as defined and specified by Chapters 101 and 102, Civil Practice and Remedies Code; and*
> *(2) a local government, as defined by Section 791.003, Government Code (Chapter 534, Subchapter A. Texas Health and Safety Code).*

Although the state of Texas has steadily moved away from direct provision of services by contracting with community centers, which have been designated as units of local government, there has been a concomitant increase in control exerted by the state authority through the performance contract mechanism.

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1 It is interesting to note that the current system of centralized control in Texas is being questioned. House Bill 2377 allows TDMHMR to experiment with various models involving regional authorities which are separate entities than existing community centers. In addition, managed care pilots involving capitated payments to for profit managed care companies are now in the trial process.

Accountability and Performance Measures

There are a variety of ways to measure performance in social service contracts. However, most fall under two broad categories. According to Kettner and Martin those categories are outputs and outcomes. Outputs reflect the volume of services provided, such as number of units of service or number of people served. Outcomes are more reflective of the results, or the impact that the service has had on the client (Kettner & Martin, 1995: p. 54).

Although many compelling arguments have been made on the greater value of outcome measures, Kettner and Martin note that progress has been slow in moving towards such measures, in part because of the difficulty in creating measures that are valid, reliable and widely accepted. (Kettner & Martin, 1995: p. 56). Mario Hernandez and Sharon Hodges, in a discussion of outcome measures related to children's mental health services, acknowledge the difficulty in developing uniformly acceptable outcomes that are easily understandable. They also stress the fact that often more than one social service agency is involved in trying to help a distressed child, therefore outcomes which reflect interagency approaches should be developed (Hernandez & Hodges, 1998: p.4).

TDMHMR performance contract utilizes a combination of output measures and outcomes. However, penalties and incentives tied to performance on outputs are treated differently than performance on outcomes. Output targets in the contract include total adults served, number served in assertive community treatment, number served in supported housing, number served in supported employment and total children served (TDMHMR, 1998).

Outcome measures include a requirement that at least 95 percent of the adults have a uniform assessment completed, that per capita admissions to state hospitals total less than .08 percent of the population of the local service area, the average length of stay in the community by adults who are receiving case management services before they return to the state hospital is greater than 260 days, 95 percent of people discharged from state hospitals have community support plans, percentage of people receiving In-Home & Family Support dollars admitted to state hospitals within two years is less than 8 percent, readmissions to state hospitals for the year total less than 20 percent, overall utilization of state hospital beds is within the allocated amount, at least 75 percent of people leaving state hospitals have a follow-up appointment with 7 days and the community tenure for people leaving state hospitals is greater than 161 days during a year (TDMHMR, 1998).

Incentives and Penalties in Performance Contracting

Performance contracting in the public mental health field began gaining acceptance in the late 1980s. Part of this process included developing incentives and penalties that were tied to performance. The Colorado public mental health system began developing an incentive contract during this time period.

The Colorado performance contract concentrated on the number of target clients to be admitted to service during the year. Target clients were considered those most in need, which for adults meant those with serious and persistent mental illness and for children meant those with serious emotional disturbances who were at risk of out of home placement. Targets for individual community centers were tied to the amount of state dollars available for each service provider and the rate to be paid for each unit of service.

Although the contract did not have incentives built into it, it did have financial sanctions for failure to meet required targets (Barrett, Berger, & Bradley, 1992: p. 75).

During the same time frame, the Oklahoma Department of Mental Health developed a similar performance contract. In addition to financial penalties for failure to meet output targets, the Oklahoma contract had financial incentives for community centers that exceeded their targets (Wedel & Colston,1988: p. 77).

The TDMHMR 1998 performance contract was developed with a combination of financial sanctions and incentives. Output targets are tied to a specific case rate methodology. A case rate is formulated statewide based on allocation of general revenue dollars and the number of people to be served in each service category. Failure to achieve a specific target each quarter of the year leads to recoupment of general revenue dollars by TDMHMR based on the number short of the target multiplied by a quarter of the annualized case rate. If a community center was short in the number served by ten adults during a quarter and the annual case rate was $2448, the center would be recouped $6,120 for the quarter (TDMHMR, 1998).

Financial incentives were awarded to community centers based on dollars available for this purpose. TDMHMR, at the beginning of fiscal year 1998, placed $1,000,000 in the incentive fund. Incentives, like financial sanctions, were tied to performance on output measures and were distributed quarterly (TDMHMR, 1998).

Conceptual Framework

There continues to be considerable discussion about the value of incentive and penalties in performance contracting. In the three examples of state mental health

performance contracts cited, no research was found regarding the results. Therefore, it is deemed an area worthy of further study. Three hypotheses are tested in an explanatory research model which evaluates the effectiveness of the TDMHMR **incentive/recoupment program.**

H1: Incentive/recoupment (I/R) has a positive effect on overall performance of community centers in meeting or exceeding mental health targets.

H2: Incentive/recoupment (I/R) has a positive effect on performance of community centers that previously achieved an overall mean of 100 percent in both FY 96 & FY 97.

H3: Incentive/recoupment (I/R) has a positive effect on performance of community centers that previously failed to achieve an overall mean of 100 percent in both FY 96 & FY 97.

Chapter four, Methodology, gives an overview of the research design. It also discusses subject selection, data retrieval and data analysis. The primary purpose is to clearly articulate the research method utilized in testing the hypotheses.

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter describes the methodology used to test the hypotheses. Part of the description includes the mechanics of data retrieval, subject selection, the research design and operationalizing the hypotheses. In addition, some of the strengths and weaknesses of the research design are discussed.

Subject Selection and Data Retrieval

Although there are currently forty-three mental health authorities throughout the state of Texas, this study evaluates the performance of thirty-three. Several factors justify this approach. Over the last several years, TDMHMR has systematically attempted to transfer community mental health programs that are operated directly by the state. In order to accomplish this goal, TDMHMR has facilitated the development of new locally governed community mental health and mental retardation centers to assume responsibility for state operated programs. During the formation of these new community centers, TDMHMR agreed to hold them harmless under the performance contract. Consequently the decision was made to exclude them from the study because they would not experience the financial consequences of the incentive/recoupment program.

In addition to promoting new community center development, TDMHMR has encouraged existing community centers to take over state operated programs. Since 1995, this process has led to the transition of previously freestanding state operated community programs over to the control of existing community centers. Since data is analyzed for the period fiscal years 1996, 1997 and 1998, it would be difficult to evaluate community centers who assumed responsibility for additional programs (affecting performance targets) at varying points during the three year period.

The other local mental health authorities that were excluded from the study were state operated community services that remained operational. Although they operated during the entire three-year study period, it is argued that TDMHMR has a fundamentally different relationship with programs it operates directly and those operated under a legal contract with locally governed community centers.

The remaining thirty-three community centers served the same service area during the period studied. They all provided mental health services under the requirements stipulated in the TDMHMR performance contract. In addition to prescribing the number of people to be served in various program categories, the performance contract also requires the community centers to report performance activity on a quarterly basis through the TDMHMR statewide management information system, CARE. The actual performance data for each community center for the three-year period of the study came from CARE. See table 4.1 for the operationalization of the variables.

Table 4.1 Operationalizing Variables

Program category	percent of target achieved FY 96 & 97. Before I/R	percent of target achieved FY 98. After I/R	percent of change
Adult			
Assertive Community Treatment (ACT)			
Supported Employment (SE)			
Supported Housing (SH)			
Children			
Cumulative percent total for each center			

Research Design

A reflexive one group pretest-posttest design was used to test the hypotheses. A **mean percentage of target achieved** (by combining FY 96 & FY97) was determined for each program category by each mental health authority. In order to determine the overall effect by each program category, a **total mean** was calculated by combining the mean scores for all thirty-three mental health authorities. The overall mean pre-test (FY 96 & FY 97) was then compared with the overall mean post-test (FY 98) for each program category. The comparison of means was accomplished utilizing the independent t-test.

In addition, a **total mean** for each mental health authority was established by combining FY 96 & FY 97 percent of targets achieved by program category into an **overall achieved** category. In other words, for each mental health authority, the mean scores from combining FY96 & FY 97 for Total Adult, ACT, SH, SE and Children were added together and divided by five to achieve an overall mean for each mental health authority. The overall means achieved pre-test (FY 96 & FY 97) were then compared

with the overall means achieved post-test (FY 98). The comparison of the means was accomplished utilizing the independent t-test.

The same methodology was used to test two sub-groups. The **first sub-group** was composed of mental health authorities that achieved an overall mean percentage of one hundred percent or better in **both** FY 96 & FY 97. This group was referred to as the **over-achievers.** The **second sub-group** was composed of mental health authorities that **failed to achieve** an overall mean of one hundred percent or better in **both** FY 96 & FY 97. Consequently, the data analysis looked at the effects on three groups, the **overall** (composed of **thirty-three** community centers), the **over-achievers** (composed of **twenty-five** community centers achieving an overall mean percentage of one hundred percent or better in both FY 96 and FY 97) and the under-achievers (composed of **eight** community centers that failed to achieve an overall mean of one hundred percent or better in **both** FY 96 and FY 97). **Please note** that it was possible for centers in the under-achievers category to have a combined mean score for FY 96 & FY 97 above one hundred percent since they could be above one hundred percent in one year but below one hundred percent the next year. See table 4.2 for operationalizing the hypotheses.

Table 4.2 Operationalizing the hypotheses

Category	FY 96&97 before I/R mean percent	FY 98 after I/R mean percent	Percent change
H1: overall centers n= 33			
H2: over achievers n= 25			
H3:underachievers n= 8			

Strengths and Weaknesses of the Design

According to Richard D. Bingham and Claire L. Felbiner (1989: p.175), a reflexive design is generally used when a program is implemented in such a way that control groups cannot be constructed and no alternative design model is possible. This was the case with the TDMHMR Incentive Recoupment Program which was implemented throughout the state of Texas at the beginning of fiscal year 1998. Consequently, it was not possible to utilize a true experimental design with a randomly selected control group, or even a quasi-experimental design. The one group pretest-posttest design is essentially a before and after study. It is considered a weak design due to the fact that other variables cannot be excluded as possibly affecting the outcome (Bingham & Felbiner, 1989: 175). Because of the research design the possibility exists that a variety of factors, other than the Incentive Recoupment Program, impacted the outcomes achieved. Identified factors impinging on the internal validity are discussed in the results chapter.

CHAPTER FIVE

RESULTS

Introduction

This chapter presents and discusses the results of the empirical research. The three hypotheses, which make up the conceptual framework, are the essential elements considered in the review of results and subsequent discussion.

Hypothesis 1: Overall impact of Incentive/Recoupment

The first hypothesis argued that the TDMHMR Incentive Recoupment Program had a positive overall effect on the percentage performance of the community centers studied. Thirty-three community centers were included in the study. The overall pretest (96 & 97) mean target rate achieved was **115%.** After introduction of the incentive recoupment program in FY 98, the overall mean target rate achieved jumped to **130%** (significant at .00 level). It can be inferred from this result that the Incentive Recoupment Program had positive overall effect in improving target performance.

The same process was utilized in comparing the means for each of the five program categories. For the total **adult** target category, the FY 1996 percentage score achieved for each community center was added to the FY 1997 percentage score and a mean score was produced. All of the thirty-three mean scores for FY 1996 and FY 1997 were added together and an overall total adult mean score was produced. The overall mean adult score was then compared to the FY 1998 mean score produced when the independent variable (Incentive Recoupment Program) was implemented. The pretest

overall adult mean percentage of target achieved was **95%.** After the incentive recoupment program was implemented the overall adult mean percentage of target achieved increased to **122%** (significant at the.00 level). It can be inferred that the Incentive Recoupment Program had a positive overall effect on **adult** target performance.

For each of the categories discussed, the same process was utilized. For the **Assertive Community Treatment (ACT)** category, the overall pretest mean percent of target achieved was **105%.** After implementation of the incentive recoupment program, the mean percent of target achieved leaped up to **132%** (significant at the .00 level).

However, the same process did not produce the same results when looking at the category of **Supported Employment (SE).** The overall mean percent of target achieved in **SE** in FY 96 & FY97 was **132%** of the target. After implementation of the incentive recoupment program in FY 98 it increased only slightly to **134%** of target.

In **Supported Housing (SH),** the overall pretest mean percent of target achieved was **138%.** After implementation of the incentive recoupment program the percent of target achieved was **128%.**

However dramatic results were seen in the overall mean target performance of **Children.** Pretest (FY 96 & 97) overall mean percent of target achieved was **102%.** Overall mean percent of target achieved in FY 98 jumped to **141%.** See table 5.1.

Table 5.1- Overall results (n=33)

H1:	Pre-test FY 96&97 mean % of target	Post-test FY 98 mean % of target	Percent change + or -	P.
overall	115%	131%	+ 16%	.00
Adult	95%	122%	+27%	.00
Assertive Community Treatment (ACT)	105%	132%	+27%	.00
Supported Employment (SE)	132%	134%	+2%	.38
*Supported Housing (SH)	138%	128%	-10%	.16
Children	102%	141%	+39%	.00

+ Results positive and statistically significant
* Two tailed test.

Hypothesis 2: Impact of incentive/recoupment on overachievers

The second hypothesis concerned community centers that achieved an overall mean level of performance during both FY 1996 and FY 1997 that was 100 percent or better. The hypothesis was that the Incentive Recoupment Program (the independent variable), implemented in FY 1998, had a positive effect on the target performance of overachievers.

There were twenty-five community centers that achieved an overall mean percentage of 100 percent or better during both FY 1996 and FY 1997. The overall mean percent of target achieved during FY 96 & 97 was **119%**. The overall mean percent of target achieved in FY 98 was **136%**. This represents a **17% increase.** The t-test score was significant at the .01 level. Therefore, it can be inferred that the Incentive Recoupment program had a positive overall effect on overachievers.

The pretest mean percent of target achieved for **adults** was **97%.** After implementation of the incentive recoupment program in FY 98, the mean percent of target achieved for **adults** increased to **127%,** a **30% increase**. The independent t-test produced a score which was significant at the .00 level.

A dramatic improvement was seen in the performance of the overachievers in the **ACT** program. Pretest (FY 96 & 97) mean percent of target achieved was **106%.** In FY 98 the mean percent of target achieved in **ACT** increased to **140%,** a jump of **34%** in one year.

However results for **SE** and **SH** were different. In fact the mean percent of target achieved in FY 98 for both of these categories actually decreased. Therefore the findings did not support the hypotheses in these two program categories.

In the program category of **Children**, a tremendous improvement was seen between FY 96& 97 and the implementation of the incentive recoupment program in FY 98. The pretest percent of target achieved by the twenty five overachievers for **Children** was **107%.** After implementation of the incentive recoupment program in FY 98, the percent of target achieved skyrocketed to **146%**, an increase of **39%.** See Table 5.2 for results of overachievers.

Table 5.2 Results for overachievers (n=25)

H2 overachievers	Pre-test FY 96&97	Post-test FY 98	Percent change + or -	p.
Overall	119%	136%	+17%	.01
Adult	97%	127%	+30%	.00
Assertive Community Treatment (ACT)	106%	140%	+34%	.00
*Supported Employment (SE)	140%	134%	-6%	.61
*Supported Housing (SH)	143%	135%	-8%	.98
Children	107%	146%	+39%	.00

+ Results positive and statistically significant
* two tailed test.

Hypothesis 3: Impact of incentive recoupment program on underachievers

The third hypothesis proposed that the Incentive Recoupment Program had a positive effect on the performance of those centers who failed to achieve an overall mean of one hundred percent or better in **both** FY 96 and FY 97. There were eight community centers that were in that category labeled the **underachievers.**

The pretest (FY 96 & 97) overall mean percent of target achieved was **101%**. After implementation of the incentive recoupment program, the overall mean percent of target in FY 98 climbed to **119%**, an improvement of **18%**.

In the category of **adult**, significant improvement was seen. The FY 96 & 97 overall mean percent of target achieved for the underachievers was **91%**. In FY 98, this increased to **109%.**

In the **ACT** program, the FY 96 & 97 mean percent of target achieved was **101%.** In FY 98 the mean percent of target achieved in this category jumped to **115%**

The pretest (FY 96 & 97) mean percent of target achieved for **SE** was **106%. In** FY 98, it increased to **135%.**

However, the results in **SH** ran counter to the other data. FY 96 & 97 mean percent of target achieved was **121%**. FY 98 mean percent of target achieved was **106%.**

Again results in the **Children** program category were consistent with the findings in the overall group and the overachievers. The FY 96 & 97 mean percent of target achieved was **88%.** The FY 98 mean percent of target achieved was **128%,** a dramatic improvement. See Table 5.3

Table 5.3 Results for underachievers (n=8)

H3 underachievers	Pre-test FY 96&97	Post-test FY 98	Percent change + or -	p.
Overall	101%	119%	+18%	.00
Adult	91%	109%	+18%	.01
Assertive Community Treatment (ACT)	101%	115%	+14%	.02
Supported Employment (SE)	106%	135%	+29%	.03
*Supported Housing (SH)	121%	106%	-15%	.32
Children	88%	128%	+40%	.00

*** two tailed test**

Discussion

The results tend to support the hypotheses that the **Incentive/Recoupment Program** had a significant positive effect on the performance of community centers. The overall effect is significant when looking at the total sample of thirty-three community centers and when looking at the sub-groups of **overachievers and underachievers.** The effect is also significant when looking at program categories such as **Total Adult and Children.** The findings in these two categories were significant for the overall sample and the two sub-groups. However, the data regarding **Supported Employment and Supported Housing** does not support the hypotheses. The data does support the hypotheses regarding the effect of **I/R** on **ACT.**

Limitations

There are significant factors mitigating the findings of the study. One of the most obvious is the absence of a true control or comparison group. There are countless

external considerations that could have effected the performance of community centers during the period studied. Among those are changes in leadership at the community center level, local funding variations and the effect of local politics on the operation of individual community centers. Another critical factor is the size of the sample, particularly the sub-group of underachievers (eight).

The two program categories which show the least effect from the Incentive/Recoupment Program are **Supported Employment and Supported Housing.** One factor which may have influenced community centers to perform at a high level prior to the Incentive/Recoupment Program was that TDMHMR began a significant effort to develop these particular programs during the early 1990s. **Supported Housing** was promoted through development and demonstration grants to individual community centers. Therefore, it is possible that these particular programs were already well established at community centers throughout the state.

Chapter Six

Conclusion

The results of the research tend to support the basic assumptions of the TDMHMR Incentive/Recoupment Program that penalizing community centers for not achieving performance targets and rewarding community centers for exceeding targets are effective tools for ensuring accountability. See Table 6.1 for a summary of results. It is recommended that further research be conducted over a multi-year period to provide greater validity.

Table 6.1 Summary of Results

Hypotheses:the incentive recoupment program increased target performance	results for all community centers n=33	results for overachievers n=25	results for underachievers n=8
Overall	+	+	+
Adult	+	+	+
Assertive Community Treatment (ACT)	+	+	+
Supported Employment (SE)	*	*	+
Supported Housing (SH)	*	*	*
Children	+	+	+

+Results positive and statistically significant
*Results not statistically significant

The entire basis of the TDMHMR Incentive Recoupment Program has been the utilization of output measures. As noted in the review of the literature, there continues to

be considerable debate over the value of output measures compared to outcome measures. In a public system, funded through tax dollars, there will continue to be strong pressures to look at outputs instead of outcomes. Proponents of outcome measures have yet to adequately address the many concerns that have been identified, not the least of which is the add on cost of evaluating and collecting data for outcome measures. Consequently, there will continue to be a need for output measures as a way to evaluate performance and cost effectiveness. With the current public climate for "best value", output measures will continue to be a useful tool in government.

Beyond the debate about outcomes versus outputs is the real issue of whether people suffering the devastating effects of serious and persistent mental illness are getting the help they need from our public system of care. Without a doubt, we have emerged from the dark ages in terms of treatment for mental illness.

If a young Frederica S-------was somehow transformed from 1861 to 1999, she would more than likely receive most of her care and treatment in a community setting. A variety of new drugs for treating schizophrenia and major depression are available and would hopefully bring about dramatic improvement in her emotional stability and the clarity of her thinking. With appropriate treatment and care, she would possibly be able to hold down a job and live independently in a community setting. The knowledge and technology are present to fundamentally improve the lives of people with mental illness. For that reason, assuring accountability for public mental health resources is a worthy and important task. The work should continue.

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APPENDIX
TDMHMR SERVICE AND PROGRAM DEFINITIONS

MENTAL HEALTH SERVICE & PROGRAM DEFINITIONS

Mental health authorities (MHAs) are in compliance with the provisions of the performance contract only if authority responsibilities and provider services and programs are performed as defined. Service definitions in ***bold italics*** are CORE services. The MHA is responsible for all services defined in this section. The designation "authority responsibilities related to service provision" is not inclusive but is intended to identify those services that *only* the MHA *must provide*, i.e., services that *cannot* be contracted.

AUTHORITY RESPONSIBILITIES RELATED TO SERVICE PROVISION

- ***Assessment* (CORE service)** — The clinical process of obtaining and evaluating historical, social, functional, psychiatric, developmental, or other information from the individual and family seeking services sufficient to determine priority population eligibility, level of need (including urgency), specific treatment needs, and personal strengths (including the preferences of the individual seeking services). Additional assessment, if indicated, may be delegated to the provider.
  Service Code: Adult - H008 Children - TC08 (assessment only, used when no other service is open)

- **Case coordination** — Facilitation of access to resources and services as needed and coordination of the individual's treatment with the individual, family, and collateral providers, as appropriate. Coordination of services is provided by a single continuity of services staff person (CSSP) responsible for each individual served across all services authorized by the MHA. If the individual is enrolled in case management, the case manager will serve as the CSSP. Clients are not to be enrolled in case coordination and case management simultaneously.
  Service Code: Adult - H012 Children - TC21

- ***Case management* (CORE service)** — Case management activities are provided to assist eligible individuals in gaining access to medical, social, educational, and other appropriate services that will help them achieve a quality of life and community participation acceptable to each individual. Case management services are provided by staff whom are authorized and trained by the provider to deliver such services. The role of persons who provide case management activities is to support and assist the person in achieving goals. Case management activities are provided regardless of age. Clients are not to be enrolled in case coordination and case management simultaneously. Case management service codes address the following activities: Service Code: Adult - H011 Children - TC06

  - **Crisis intervention** — Locating and coordinating emergency services which are documented in writing.

  - **Monitoring** — Evaluating the effectiveness of the services and the need for additional or different services which are documented in writing.

  - **Screening and assessment** — Obtaining client-identifying information and identifying the nature of the presenting problem and the service and support needs of the individual which are documented in writing.

  - **Service planning and coordination** — Identifying and arranging for the delivery of services and supports that address the individual's needs which are documented in writing.

- ***Crisis Hotline*** **(CORE service)** — A continuously available staffed telephone service providing information, support, and referrals to callers 24 hours per day, seven days per week.

- **Family education** — Classes/workshops and individual consultations which provide information to individuals and families and the community regarding the nature and effects of treatment options for adults with severe and persistent mental illness and children who are severely emotionally disturbed. This education and training is designed to increase family coping skills, knowledge of mental illness, and awareness of community resources.

- **In-home and family support** — In-home and family support is a source of grant funds for eligible individuals and/or their families to purchase services, supports, adaptive devices, or architectural modifications necessary to maintain their functioning in their own or family home. There is a limit of $3,600 per year, with the amount granted depending upon the individual's needs and application of an adjustment for income. *An individual does not need to be enrolled as a priority population consumer to receive this service.*

  An individual who participates in respite services as a result of the use of In-Home Family Support Program grant funds should not also be reported as participating in *family support*. However, an individual who participates in the In-Home Family Support Program and also participates in family support through the mental health authority outside of that program should be recorded as having participated in *family support* in addition to the In-Home and Family Support Program.

  Enrollment in the In-Home and Family Support Program is accomplished through a CARE subsystem. Enrollment in the In-home and Family Support Program does not require use of the MH Adult Community-Based Assignment form. Participation data will be collected directly from the CARE subsystem.

- **Outreach** — An activity provided on behalf of individuals, the goal of which is to link and reach people who often have difficulty getting appropriate care due to factors such as acute behavioral symptomatology, economic hardship, homelessness, unfamiliarity with or difficulty in accessing community behavioral health care services and other support services, fear of mental illness, and related factors. This service may be provided in a variety of settings including homes, schools, jails, streets, shelters, public areas, or wherever the person is found.

- ***Screening*** **(CORE service)** — Gathering triage information by a Qualified Mental Health Professional (QMHP) to determine a need for in-depth assessment. This information is collected through interview or by phone with consumer or collateral.

- ***Treatment planning*** **(CORE service)** — Activities for the purpose of determining clinically necessary, prioritized, comprehensive, collaborative, and measurable treatment that reflects the needs and preferences of the individual and builds upon the strengths of the individual. This activity is initiated by the MHA. Details of the treatment plan elements may be delegated to the provider.

PROVIDER RESPONSIBILITIES RELATED TO COMMUNITY SUPPORT SERVICE SYSTEM

Outpatient Services

- **Consumer peer support** — Activities provided between and among individuals who have common issues and needs that are consumer- motivated,-initiated, and/or -managed and that allow an individual to live as independently as possible. Service Code: Adult - H021

- **Counseling and psychotherapy** — Problem resolution services which are provided by a licensed practitioner of the healing arts (LPHA) , practicing within the scope of their own licenses or by individuals with a graduate degree in a human services field under the direct supervision of a LPHA, in a variety of settings and in a variety of modes. Examples of this service include individual, group, or family counseling. Service Code: Adult - H013 Children - TC13

- ***Family support, including respite*** **(CORE service)** — Services provided to family members of an individual in services, based on their identified needs, for the purpose of allowing the individual to function as independently as possible. Respite services are those services provided for temporary, short term, periodic relief of primary caregivers. *Program-based respite services* involve temporary residential placement outside the usual living situation. *Community-based respite services* involve introducing respite staff into the usual living situation or providing a place for the individual to go during the day/evening or other services considered to provide a respite. Service Code: Adult - H006 Children - TC05

- **Family training** — Training provided to *family members of an individual in service*, for the purpose of broadening knowledge regarding the effects and treatment of mental illness. Generally, family training is provided utilizing a standardized curriculum and materials.
  Service Code: Adult - H005 Children - TC19

- ***Medication-related services*** **(CORE service)** — Service Code: Adult - H004 Children - TC04

  - **Medication administration** — A service provided to an individual by a licensed nurse (or other qualified and properly trained persons working under the supervision of a physician or registered nurse as provided by state law) to ensure the direct application of a medication to the body of the individual by any means including handing the individual a single dose of medication to be taken orally.

  - **Medication monitoring** — A service provided to an individual or collateral by a licensed nurse (or other qualified and properly trained persons under the direct supervision of the physician or registered nurse as provided under state law) for the purpose of assessment of medication actions, target symptoms, side effects and adverse effects, potential toxicity, and the impact of medication for the individual and family in accordance with the plan of care.

  - **Medication training** — A service to an individual and/or family member or other collateral by a licensed nurse (or other appropriately trained professional or paraprofessional) for the purpose of teaching the knowledge and skills needed by the individual/family/collateral in the proper administration and monitoring of prescribed medication in accordance with the individual's plan of care.

- **Pharmacological management** — A service provided to an individual or collateral by a physician for the purpose of determining symptom remission and the medication regimen needed to initiate and/or maintain an individual's plan of care.

Rehabilitation Services

- ***Skills training*** **(CORE service)** — Training in those skills in which the primary focus is to further an individual's independent functioning and community skills. This training promotes community integration, increases community tenure, and maintains the individual's quality of life. This service includes but is not limited to opportunities to acquire and improve skills such as activities and training designed to address the illness- or symptom-related problems and behaviors that mental illness creates which preclude a person's functioning in living, learning, and working environments. This training should occur within a natural setting whenever possible in order to further skill acquisition and community inclusion.
  Service Code: Adult H020 Children - TC10

- **Skill maintenance services** — Program-based, long-term services provided to individuals with a severe and persistent mental illness who are in need of day program services to ensure personal well being and to reduce the risk of or duration of institutionalization. The provision of skill maintenance program services is limited to individuals who, due to age or the nature of the mental illness, are unable to benefit from a more active skills-based training program. Services provided under this program have as their primary focus the maintenance of functional skills, symptom reduction, and assistance with activities of daily living.
  Service Code: Adult - H022

- **Day treatment for children** — Day program services which may be school-based or community-based which are provided to children and adolescents with serious emotional disturbances who, with instruction, guidance, and structure, are capable of increasing their level of functioning and acquiring new skills. These youth do not require more intensive short-term treatment to alleviate acute and severe psychiatric symptomology. Services provided include an integrated set of services and supports which focuses on the amelioration of functional and behavioral deficits which includes: education*; counseling (family, individual and group); family support; skills training; crisis management; etc.
  *Education is an optional component in before and after school, summer, and therapeutic nursery programs.
  Service Code: Children - TC03

- **Therapeutic foster care** — The provision of twenty-four-hour specialized living arrangements for the purpose of treatment for children with serious emotional disturbances who are unable to receive needed treatment while living with their parents or primary care givers. Services provide a family living environment with foster families specifically recruited and trained in treatment services for children. Services and supports generally provided as part of this service include Family Support (for natural parents/primary care givers), Family Support, including respite, parent networking and ongoing training (for foster parents); crisis management; and skills training. Service Code: Children - TC09

Best Practices

- ***Supported employment*** **(Best Practice/contract requirement)** — Services with the capacity to provide individualized assistance in choosing and obtaining employment, integrated work sites in regular community jobs, and long-term supports provided by identified staff who will assist individuals in keeping

employment and/or finding another job as necessary. Recommended staff-to-client ratio is 1:15. Service Code: Adult H030

- ***Supported housing*** **(Best Practice/contract requirement)** — Service activities designed to assist persons with severe and persistent mental illness choose, get and keep REGULAR INTEGRATED housing. Service Code: Adult - H029

  Services consist of

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

Required elements of supported housing service design include:

- **Housing assistance** — Service design must include funds for rental assistance or MHA must be able to provide evidence that housing is affordable for people on SSI or that rental assistance funds are guaranteed from another source. Rental assistance recipients must be willing to make application for Section 8/public housing or have a plan to increase personal income to make housing affordable without assistance. Housing assistance alone without supports and services cannot be counted as supported housing.
- **Services and supports** — The recommended staff-to-client ratio is no more than 1:15 (direct care staff, does not include administrative staff). Successful programs may use a team structure that includes case coordination activities, in-home rehabilitation services, and assistance in locating and moving into regular integrated housing.
- **Regular housing (Best practice/contract requirement)** — is defined as normal, ordinary living arrangements typical of the general population. Integration is achieved when individuals with serious mental illness choose ordinary, typical housing units that are located among individuals who do not have mental illness. For example, in an integrated apartment complex, no more than 50% of the units may be occupied by persons with serious mental illness.

- **Assertive Community Treatment (ACT) (Best Practice/contract requirement)**— A self-contained program which is the fixed point of responsibility for providing treatment, rehabilitation and support services to identified consumers with severe and persistent mental illnesses and who have a history of multiple hospitalizations, involvement with the judicial system, homeless shelters or community residential homes. Using an integrated services approach, the ACT team merges clinical and rehabilitation staff expertise, e.g., psychiatric, substance abuse, employment, within one mobile service delivery system. Accordingly, there will be minimal referral of consumers to other program entities for treatment, rehabilitation, and support services.

The ACT team maintains a small consumer-to-clinician ratio (1:10). Staff- to-client ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered. Services are need-based vs. time-limited and provided out of the office 80% of the time. The ACT team maintains 24-hour responsibility and availability for covering and managing psychiatric crisis for ACT consumers. Team staffing includes 4 hours of dedicated psychiatrist time per week per 20 consumers served and there is at least 1.0 FTE registered nurse providing direct services. Seventy-five percent of the ACT team members are degreed or licensed. Service Code: Adult - H028

ACUTE SERVICES

- ***Inpatient services*** **(CORE service)** — Hospital services staffed with medical and nursing professionals which provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provide intensive interventions designed to relieve acute psychiatric symptomatology and restore patient's ability to function in less restrictive setting. Service Code: Adult - H035 Children TC07

- **Acute day treatment (adults and children)** — Program-based services focused on the short-term, acute treatment of adults with serious mental illness and children and adolescents with serious emotional disturbances who require multi-disciplinary treatment in order to stablize acute and severe psychiatric symptomology. Services are provided in a highly structured and safe environment with constant supervision. Contacts with staff are frequent, activities and services constantly available, and developmental and social supports encouraged and facilitated. Activities are goal oriented, focusing on improving peer interaction, appropriate social behavior, and stress tolerance. These services target individuals at greatest risk of placement in a more restrictive setting such as a psychiatric hospital. Service Code: Adult - H003 Children - TC20

- ***In-home crisis intervention/support*** **(CORE service)** — A program which offers face-to-face, out of the office, crisis intervention/support services to assist individuals and families in managing an identified crisis. This service is provided primarily in the individuals home but may be provided in other settings in the community. Generally, short term treatment and supports are offered on a scheduled basis. Telephone contacts may be used as part of this service to maintain contacts between face-to face contacts but not in place of face-to -face contacts. For children and adolescents with serious emotional disturbance this service focus on keeping the child with the family or primary care givers.
Service Code: Adult - H018 Children - TC01

- ***Intensive crisis residential*** **(CORE service)** — A program which offers 24-hour residential services that are usually short-term and are offered to persons who are demonstrating psychiatric crisis which cannot be stabilized in a less restrictive setting. This program element may include staffed residences and crisis stabilization units (CSUs). CSUs are licensed by the Texas Department of Health and must comply with the provisions of Texas Administrative Code, Title 25, Part II, Chapter 401, Subchapter K (relating to Licensure of Crisis Stabilization Units).
Service Code: Adult - Crisis Residential - H037, Crisis Stabilization - H036, Children - Crisis Stabilization Beds - TC07

Residential Treatment

- **Residential treatment center (RTC)** — Twenty-four-hour specialized living arrangements for children needing alternative residential care. Services are provided by staff specially trained in providing residential care and treatment to children and adolescents with serious emotional disturbances. (Placement Type Code "10" on CARE Form CP3.)

- **Treatment training residences** — Twenty-four-hour specialized living environments in which the focus is on treatment and training to facilitate individuals in moving to their chosen environment within specified time frames. Service Code: Adult - H031

- **Adult foster care** — A four-bed or less facility which meets the minimum standards and program rules for enrollment with the Texas Department of Human Services (TDHS) as an adult foster care facility. Service Code: Adult - H032

- **Personal care homes/Assisted Living** — A personal care facility means an establishment, including a board and care home, that furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment and that provides personal care services. Personal care services include assistance with meals, dressing, movement, bathing, or other personal needs or maintenance. Personal care services also include the administration of medication by a person licensed to administer medication or the assistance with or supervision of medication, or general oversight of the physical and mental well-being of a person who needs assistance to maintain a private and independent residence in a personal care facility or who needs assistance to manage the person's personal life, regardless of whether a guardian has been appointed for the person. Personal care homes are licensed by TDHS and must meet all applicable requirements. Service Code: Adult - H033

- **Other residential living arrangements under the auspices of the MHA** — Specialized housing/residential options that do not meet the definitions for personal care, adult foster care, or treatment training residences. Service Code: Adult - H034

- **Other residential services for children** — Residential options that do not meet the definition of a residential treatment center (RTC).Service Code:Children TC17

MENTAL HEALTH PRIORITY POPULATION

Definition

The priority population for mental health services consists of:

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

Service Determination

In targeting services to the priority populations, the choice of and admission to services is determined jointly by the person seeking service and the authority. Criteria used to make these determinations are the level of functioning of the individual, the need of the individual, and the availability of resources.

Initial and Continued Eligibility for Services

An individual is considered eligible for service for one year following the completion of assessments which determine need, and completion of assignment in CARE. Annual assignment in CARE will be required (by anniversary date of initial assignment). Continued need for services specified in the individual's treatment plan is determined by reassessment and reauthorization of services by the local authority. This activity is completed every 90 days and client record documentation evidence need for continued services.

Documentation Required

In order to assign a diagnosis (across all 5 axes) to an individual, documentation of the required diagnostic criteria (according to DSM-IV), as well as the specific justification of GAF score, must be included in the client record. This information must be included as a part of the required assessment information.

Guide to Operationalizing the Adult Mental Health Priority Population

Initial Criteria

Adults	18 or older	Diagnosis of : * schizophrenia * bi-polar disorder * major depression			initially eligible for TDMHMR state-funded MH services
	18 or older	diagnosis other than those listed above *except* a sole diagnosis of substance abuse or mental retardation	has a GAF of 50 or less–current	needs ongoing MH services	initially eligible for TDMHMR state-funded MH services
	18 or older	Served in children's service and meet children's priority definition prior to turning 18			initially eligible for TDMHMR state-funded MH services

Priority Population DSM-IV Codes

Any of the following:

Mood Disorders: 29600, 29601, 29602, 29603, 29604, 29605, 29606, 29640, 29641, 29642, 29643, 29644, 29645, 29646, 29650, 29651, 29652, 29653, 29654, 29655, 29656, 29660, 29661, 29662, 29663, 29664, 29665, 29666, 2967, 29680, 29689

29620, 29621, 29622, 29623, 29624, 29625, 29626, 29630, 29631, 29632, 29633, 29634, 29635, 29636

Schizophrenia: 29510, 29520, 29530, 29540, 29560, 29570, 29590

Non-Priority for Mental Health Services

Single DX of:

Substance Abuse: 2910, 2911, 2912, 2913, 2915, 29181, 29189, 2919, 2920, 29211, 29212, 29281, 29282, 29283, 29284, 29289, 2929, 30300, 30390, 30400, 30410, 30420, 30430, 30440, 30450, 30460, 30480, 30500, 30510, 30520, 30530, 30540, 30550, 30560, 30570, 30590

Mental Retardation: 317, 3180, 3181, 3182, 319

Autism / Pervasive Disorders: 29900, 29910, 29980

ADULT MENTAL HEALTH
ASSIGNMENT TO LEVELS OF NEED

The Level of Need Assignment is the method by which specific services are authorized for a particular individual. Please note that an individual may always access acute services regardless of their current level of need assignment. The assumption in this level of need assignment is that all individuals being assessed are members of TDMHMR's priority population. Please also note that the data source scores included below are meant only as guidelines. The level of need for a particular individual will be assigned by the clinician directing his or her care.

Domains to be considered in determination of the Level of Need Assignment in adults are as follows:

Symptoms

- Behavioral, emotional and cognitive symptoms interfering with functioning and contributing towards a DSM-IV diagnosis of a mental illness.
- Severity documented by the BPRS, 4.0, Expanded Version.

General Functioning

- Problems in daily functioning, usually focusing on environmental, vocational, residential, legal, (four subscales of MCAS).
- Severity documented by the MCAS and the Supplemental Community Assessment Questionnaire.

Risk Factors

- Factors that indicate potential for rapid deterioration or high system utilization.
- Documented by Intake Assessment, Supplemental Community Assessment Questionnaire and Clinician Alcohol and Drug Use Scales.

Community Support Services System: Level of Need 1

DOMAIN	LEVEL OF PROBLEM	DATA SOURCE
SYMPTOMS	• Some problems with behavior, affect, or cognition	BPRS 24-46
	• Will respond to usual outpatient treatment modalities	
	• Symptomatology likely to remain the same, regress, or relapse without treatment	
FUNCTIONING	• Moderate work or social dysfunction	MCAS 59-85
	• Stable housing, emotional support system, community resources and self-help modalities available	Sum of Community Assessment Questions #1 and #2 > 9
RISK FACTORS	• Mild to minimal substance abuse history	Sum of either Substance Abuse or Alcohol Scale < 3
	• Mild to minimal legal, victimization and hospitalization history	Community Assessment Questions # 3,4,5

Adult Mental Health
Assignment to Levels of Need

Community Support Services System: Level of Need 2

DOMAIN	LEVEL OF PROBLEM	DATA SOURCE
SYMPTOMS	• Moderate problems with behavior, affect, or cognition	BPRS 36-62
	• Will respond to rehabilitative outpatient treatment modalities	
	• Symptomatology likely to regress or relapse without treatment	
FUNCTIONING	• Moderate to severe work or social dysfunction	MCAS 48-64
	• Some community resources and self-help modalities available	Sum of Community Assessment Questions #1 and #2: 5 - 9
RISK FACTORS	• Moderate substance abuse history	Sum of either Substance Abuse or Alcohol Scale of 3
	• Moderate legal, victimization and hospitalization history	Community Assessment Questions # 3,4,5

Community Support Services System: Level of Need 3

DOMAIN	LEVEL OF PROBLEM	DATA SOURCE
SYMPTOMS	• Severe problems with behavior, affect, or cognition	BPRS 47-168
	• Failure of treatment at a lower level of need	
	• Requires intensive assistance to control symptoms	
FUNCTIONING	• Severe work or social dysfunction	MCAS 17-53
	• Minimal or no support system or community resources available	Sum of Community Assessment Questions #1 and #2 : <5
RISK FACTORS	• Significant substance abuse history	Sum of either Substance Abuse or Alcohol Scale of 4-5
	• Significant legal, victimization and hospitalization history	Community Assessment Questions # 3,4,5

Children & Adolescents
Mental Health Priority Population

Guide to Operationalizing the Priority Population Definitions

Population	If the person is...	And has a...	And...	And...	Then the person is...
Children (0-3 years)	under the age of 4 years.	DC 0-3 Axis I or Axis II or a DSM IV Axis I diagnosis other than or in addition to: -- substance abuse -- mental retardation -- autism or -- pervasive developmental disorder			initially eligible for TDMHMR state-funded MH services.
Children (4-6 years)	between the ages of 4 through 6 years.	DSM-IV Axis I diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder	is at risk of removal from preferred child care environment	*	initially eligible for TDMHMR state-funded MH services.
Children & Adolescents	under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder	has been determined by the school system to have a serious emotional disturbance	**	initially eligible for TDMHMR state-funded MH services.
Children & Adolescents	under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder	is at risk of disruption of the preferred living situation due to psychiatric symptoms	***	initially eligible for TDMHMR state-funded MH services.
Children & Adolescents	under 18 years of age	DSM-IV Axis I diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder	has a functional impairment (GAF of 50 or less -- current)		initially eligible for TDMHMR state-funded MH services.

* CARE-CE1 Form (Child/Adolescent Intake Assessment Form). CARE Action Code 170 (Child/Adolescent Intake). At Risk of Removal Child Care has been marked YES.

** CARE-REG-1C Form (Child & Adolescent Client Registration - History Section); CARE Action Code 166 (Child/Adolescent History). ED (in Special Education) has been marked YES.

*** CARE-REG-1C Form (Child & Adolescent Client Registration - History Section); CARE Action Code 166 (Child/Adolescent History). At Risk of Placement has been marked YES.

Reference:

- DSM-IV *Diagnostic And Statistical Manual of Mental Disorders, Fourth Edition*
- DC 0 - 3 *Diagnostic Classification 0 - 3: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*

CHILDREN'S MENTAL HEALTH (Ages 4-18 years)

ASSIGNMENT TO LEVELS OF NEED

The Level of Need Assignment is the method by which specific services are authorized for a particular child or adolescent. Please note, however, that children may always access acute services, regardless of their current Level of Need Assignment, and that children in Levels I-III are eligible for services in preceding levels as clinically indicated.

Four domains are to be considered when making decisions about Levels of Need for children: symptoms, general level of functioning, risk factors, and family characteristics. For FY 1998, the measurement of these domains will continue to be accomplished through the existing children's mental health evaluation protocol.

Symptoms

- Behavioral, emotional and cognitive symptoms interfering with functioning and contributing towards a DSM-IV diagnosis of a mental health problem
- Prompts referral for assistance
- Currently measured by the **Child Behavior Checklist** (CBCL)

General Functioning

- Problems in daily functioning, usually in the domains of personal, social, school and community functioning
- Prompts referral for assistance
- Currently measured by the **Global Assessment of Functioning scale** (GAF)

Risk Factors

- Factors that indicate a possible need for future help with mental health problems:

  ✓ history of out-of-home placement
  ✓ history of treatment for mental health or substance abuse problems
  ✓ history of involvement with the juvenile justice system
  ✓ history of involvement with child protective services
  ✓ behaviors such as:

  - criminal or delinquent behavior
  - property destruction
  - precocious sexual activity
  - runaway
  - use of controlled substances
  - truancy
  - school drop-out

- Currently gathered by the **History form** (CARE REG-1C) and **Intake Assessment** (CARE CE-1)

Family Characteristics

- Availability of family members for social/emotional/tangible support and for facilitating treatment
- Characteristics of the family that may adversely affect the functioning of the child
- Currently gathered by the **History form** (CARE REG-1C)

Children's Mental Health
Assignment to Levels of Need (Continued)

Community Support Services System - Level of Need 1

Domain	Level of Problem	Data Source
Symptoms	• DSM-IV MH diagnosis • Crisis or episodic • Some problems with behavior, affect or cognition • Will respond to usual out-patient treatment modalities	CBCL (total score > 60)
Functioning	• Some to moderate problems in personal, social, school and community functioning	GAF (score > 40)
Risk Factors	• Exhibits few risk factors	History Intake Assessment
Family Characteristics	• Family not overwhelmed with problems such as violence, mental illness, criminal behavior, substance abuse • Family members willing to participate in treatment	History

Community Support Services System - Level of Need 2

Domain	Level of Problem	Data Source
Symptoms	• DSM-IV MH diagnosis • Longstanding • Serious problems with behavior, affect or cognition • Require intense assistance to control	CBCL (Subscale IV >= 67) or (Subscale VI >= 67)
Functioning	• Serious problems in personal, social, school and community functioning	GAF (score 30-50)
Risk Factors	• Exhibit several risk factors, especially at risk for out-of-home placement and school-related problems	History Intake Assessment
Family Characteristics	• Family members or care givers available to participate in treatment	History

Children's Mental Health
Assignment to Levels of Need (Continued)

Community Support Services System - Level of Need 3

Domain	Level of Problem	Data Source
Symptoms	• DSM-IV MH diagnosis • Longstanding • Serious problems with behavior, affect or cognition • Require ongoing intervention to maintain decreased symptoms	CBCL (total score = > 60)
Functioning	• Serious problems in personal, social, school and community functioning	GAF (score 30-50)
Risk Factors	• Exhibit several risk factors, especially has experienced abuse, neglect, and family violence	History Intake Assessment
Family Characteristics	• Family members or care givers not available to give daily support but can participate in treatment	History

Acute Services

Domain	Level of Problem	Data Source
Symptoms	• DSM-IV MH diagnosis • Crisis situation • Serious problems with suicidal ideation, suicide attempts, homicidal action, problems with cognitive/perceptual processing • Require intense assistance to control symptoms	CBCL (total score = > 70) Intake Assessment
Functioning	• Serious problems in personal, social, school and community functioning	GAF (score < 30)
Risk Factors	• Exhibit several risk factors, especially: family requests placement, history of in-patient history	History
Family Characteristics	• Family members or care givers available to give support and participate in treatment	History