



# TURNING THE CORNER

TOWARD BALANCE AND REFORM  
IN TEXAS MENTAL HEALTH SERVICES

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# TURNING THE CORNER

## TOWARD BALANCE AND REFORM IN TEXAS MENTAL HEALTH SERVICES



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## **DEDICATION**

In fond memory of Robert Anthony (Tony) Proffitt, whose passion for improving mental health care for Texans prompted this landmark report.

## **ACKNOWLEDGEMENT**

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*Mental illnesses are shockingly common; they affect almost every American family. It can happen to a child, a brother, grandparent, or a co-worker. It can happen to someone from any background. It can occur at any stage of life, from childhood to old age. No community is unaffected by mental illness, no school or workplace is untouched.*

*- President's New Freedom Commission  
on Mental Health, July 2003.*



## ***EXECUTIVE SUMMARY***

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## EXECUTIVE SUMMARY

Texas is a big state, and there's no room for small talk when it comes to mental health services.

The Governor is anticipating a budget surplus. The Comptroller is forecasting a continued economic recovery. Voters recently signaled their instructions to restore funding cuts made last legislative session. The Lt. Governor, Speaker and leading lawmakers all say they got the message.

The time is now. Texas is turning the corner, and we have it within our reach to combine our economic opportunity with our moral obligation. Will we do the right thing? Or will Texans with mental illness continue to face closed doors in their quest for care?

State government's ability to reflect our common values and most positive impulses is at stake. Surely, in a land with such wide horizons, where independence is so prized and fairness so fundamental, we can find the will to include everyone as we turn the corner toward a future of progress and prosperity.

### **Background**

In 2003, the Texas Legislature radically reorganized the state's health and human services system and cut its budget by \$1 billion. Under the state appropriations act, mental health services funding dropped by about 3.5 percent, or \$50 million, from the previous two-year budget period. Funding for local mental health and mental retardation centers (CMHMRCs) was slashed.

H.B. 2292 restricted access to state mental health services by redefining the state's eligibility criteria, cutting funding for psychotropic medications by \$5 million, and creating a "Preferred Drug List" that limited patient access to certain atypical anti-psychotics.

Lawmakers abolished funding for mental health services for children covered under the state's successful Children's Health Insurance Program (CHIP), a cut that was partially restored in early 2004. They eliminated Medicaid coverage for therapy provided to adults by mental health professionals other than psychiatrists, and discontinued the In Home and Family Support Program run by the state for individuals with mental illness.

All of this took place at a time when one in five Texans was facing some form of mental illness.

The debate among Texans over bigger government versus smaller government is unlikely to end any time soon. But no matter where we come down on that question, the overwhelming majority of us want better government.

To achieve this goal in the area of mental health services, the Mental Health Association in Texas engaged MGT of America, Inc. and its partners TXP, Inc. and RH2 Consulting, to evaluate and quantify the impact of current and past public mental health policy and funding decisions. The study evaluates both the economic (focused on employment, earnings, and worker productivity) and fiscal (focused on government tax revenues) impact of Texas policy and funding decisions.

What has emerged from this comprehensive analysis are findings and recommendations that, if implemented, will go a long way toward helping achieve balance and reform in Texas' mental health services.

### **Key Findings**

➤ ***Texas' public mental health system has been chronically under-funded.***

Texas opened its first mental hospital, the State Lunatic Asylum, in Austin in 1861. In less than a decade, the asylum's superintendent began complaining of overcrowding and under-funding. And the more things changed, the more they stayed the same. Complaints lodged by state hospital superintendents in the late 1800's echo through the corridors of power at the State Capitol today. Chronic under-funding pushes people with mental illness into prisons, jails or overcrowded emergency rooms-or on to the streets of our communities.

In fiscal 2002, Texas spent \$38.46 per client on mental health services, placing us 49th in the nation. Texas' per capita spending was a mere 44 percent of the national average. And after adjusting for inflation, we spent nearly 15 percent less on mental health in fiscal 2002 than we did two decades earlier in 1981. Texas lost ground at a higher rate than most other states.

In fact, Texas has consistently ranked in the bottom 10 percent of states for per capita mental health spending in all program areas except for research.

➤ ***Mental illness costs the state and local taxpayers \$1.5 billion in 2003.***

The total economic cost of mental illness in Texas during 2003 was \$16.6 billion, a figure that includes \$13.3 billion in lost income due to reduced workforce participation, \$2.6 billion for mortality costs and more than \$700 million for lost income due to family care giving.

The total fiscal impact to state and local governments of mental illness in Texas during 2003 was \$1.5 billion, including \$934.5 million in unrealized state revenue and \$620.9 million in unrealized local government revenue.

➤ **The chronic under-funding of Texas' mental health system shifts unfunded mandates to local government, especially in criminal justice.**

In general, cuts in mental health care funding create unintended economic consequences. For those with severe mental illness, inadequate treatment can lead to an increase in indirect public costs related to crime and criminal justice, homelessness and uncompensated health care. Although data is unavailable to consistently measure the impact of state funding cuts on local government, anecdotal evidence clearly suggests that local governments pick up the burden of state cutbacks.

Deinstitutionalization, inadequate community mental health programs, and limits imposed by private insurance plans have all combined to increase the likelihood that persons with mental illness will wind up in the criminal justice system. People with mental illness are not inherently more crime-prone or violent than other individuals; for some, however, a lack of access to treatment and medications increases the likelihood of their engaging in behavior that breaks the law.

Today, the criminal justice system is the de facto provider of last resort for individuals with untreated mental illness. The federal government estimates that persons with untreated mental illnesses compose about 16 percent of the total U.S. jail and prison population. Jails and prisons are ill equipped to deal with the growing number of inmates with mental illness-and the cost of providing care is staggering, especially compared to other treatment.

The foster care system has also become a provider of last resort for Texas children with mental illness who do not qualify for care under other public programs or who have exhausted benefits under a private insurance plan. As a result, families of some 250 Texas children each year are forced to opt for relinquishing their parental responsibilities to the state in a desperate effort to make sure their children receive the mental health care they need.

➤ **Texas lags in critical policy areas.**

In recent years, many state mental health systems have implemented policy initiatives to control costs and improve patient outcomes. Popular reforms include closing down state hospitals and shifting resources to the community, co-locating mental health and substance abuse agencies in a single agency, incorporating evidence-based practices into the delivery of mental health services, and using behavioral managed care.

Texas has made some progress in these areas. H.B. 2292 combined mental health and substance abuse services into one agency, and mandated a disease management model of service for those that are eligible. However, much remains to be done before Texans with mental illness are able to take advantage of the

promises of this service delivery model.

All of the states reviewed for this study have adopted eligibility criteria for publicly funded mental health services. Texas' criteria are particularly narrow and restrictive. In 2003, the omnibus health and human services reorganization bill (H.B. 2292) changed the criteria governing who is eligible for mental health services. Lawmakers narrowed the state's eligibility criteria for adults by limiting services to a target population of those with bipolar disorder, schizophrenia, or clinically severe depression, with few exceptions.

Only about half of Texas adults with mental illness and fewer than 28 percent of children with emotional disturbance were eligible for publicly funded services before the changes to the eligibility criteria-and only a quarter of those actually received services. An estimated 14,000 Texans with mental illness became ineligible for most public mental health services once the state's eligibility criteria were changed.

## **Looking Forward**

With the introduction of life-altering psychotropic medications and the application of new, proven treatment protocols, Texans with mental illness can recover and return to productive lives. Those with mental illness have a greater choice of providers and types of care than ever before.

The consensus among mental health advocates, providers and public policy researchers is that sweeping reforms such as those identified in the President's New Freedom Commission on Mental Health and a renewed funding commitment could dramatically improve the nation's public mental health system.

The challenge facing Texas policymakers is to seize on this unique moment to provide life-saving treatments to Texans with mental illness-and to invest in reaching more, rather than fewer, Texans in need.

## **Recommendations**

### ***1. Reverse policy decisions that have had negative, sometimes unintended, consequences.***

We strongly recommend that state leaders consider implementing the following changes in an effort to reverse the negative, unintended consequences of policy decisions implemented by the Texas Legislature in 2003.

- **Restore the "priority" population based on need rather than diagnosis.** The state's new restrictions on who is eligible for publicly funded mental health services seriously limits access to services for Texans with mental health needs. Local agencies,

## *Executive Summary*

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especially emergency rooms and jails, are already reporting a sharp increase in patients with mental illness that have nowhere else to turn.

- **Remove restrictions on the use of cutting-edge psychotropic drugs.** The savings produced by a preferred drug list are short-term and will be more than offset by other expenses, including the cost of increased hospitalizations. According to a 1994 study published in the *New England Journal of Medicine*, limiting access to effective psychotropic medications can increase overall costs 17-fold due to increased hospitalization costs.
- **Remove the 90-day waiting period for CHIP services.** For every dollar spent on CHIP, the federal government contributes about 72 cents to the state's 28 cents. Eliminating the 90-day waiting period for mental health services would allow the state to use federal dollars for early, crucial treatment.
- **Restore full mental health benefits to the Children's Health Insurance Program.** Reduced CHIP mental health benefits shift certain costs to pure state dollars without federal match. An insufficient benefit results in delayed care leading to increases in illness severity, which in turn increases treatment costs and decreases positive outcomes. Patients with untreated mental health conditions incur higher physical health costs than those who receive timely mental health services.
- **Restore authorization and funding for optional Medicaid mental health services for adults.** Reinstate Medicaid coverage for therapy provided to adults by mental health professionals other than psychiatrists.
- **Resist further funding cuts and restrictions to mental health services.** Lawmakers are always under pressure to reduce state expenditures and improve efficiencies. Cuts that decrease the amount and availability of mental health services, however, will only further exacerbate the current crisis and send more individuals to jails and emergency rooms to receive any level of care at all.
- **Restore funding cuts to mental health services made by the 78th Legislature in 2003.** Funding for services provided by the state's mental health agency were reduced by approximately 3.5%, or \$50 million, for the 2004-2005 biennium as compared to the 2002-2003 biennium. As discussed earlier, these cuts meant the loss of services for thousands of people.
- **Increase funding for mental health services.** Texas currently serves only a quarter of those estimated to be eligible for public mental health services. Gradual increases in the total amount of funds dedicated to providing mental health care must occur in each biennium in order to effectively treat more Texans in need of public mental health services.

***II. Expand use and funding of cost-effective programs.***

- **Expand statewide behavioral health managed care programs.** Improved patient outcomes and reduced costs can be achieved, using lessons learned from the implementation of the NorthSTAR model. It is critical to note that NorthSTAR itself is in jeopardy due to funding cuts and corresponding reductions in reimbursement rates, which have made it more difficult to retain providers in the managed care network.
- **Invest in jail diversion programs.** These programs, which divert offenders with mental illness to community-based treatment rather than incarceration, are increasingly critical in reducing prison and jail overcrowding and improving overall public safety. A number of local governments have initiated such programs, but the state has made only modest investments in them. Federal and state lawmakers should consider providing matching grants to jurisdictions with such programs.

***III. Adopt best practices from other states.***

- **Create purchasing cooperatives.** New Mexico has received national attention for its ongoing efforts to consolidate public funding for mental health services. Under the proposal, "interdepartmental behavioral health purchasing collaboratives" would contract with a single statewide entity to manage public mental health and substance abuse programs, including those financed by Medicaid. Key goals of this reform include reducing administrative costs and freeing up dollars to increase provider reimbursement rates as well as moving toward requiring that all dollars spent on mental health care be used to purchase services and treatments with solid or emerging evidence-based positive outcomes.
- **Consolidate reporting for mental health expenditures.** Few of the state agencies that provide mental health services as an adjunct to their primary missions track their expenditures in this area. Without a comprehensive accounting of all mental health expenditures, Texas is almost certainly missing opportunities to make the system more effective and efficient.
- **Consider ways to increase Medicaid funding of mental health services.** A review of several states comparable to Texas found that they have all been more successful than Texas in funding their mental health systems with Medicaid dollars. Because the federal government matches Medicaid funding, boosting the use of these dollars allows the state to stretch limited taxpayer resources and serve more Texans in need. In particular, lawmakers should consider using Medicaid waivers to fund home and community-based services for Texans under 21 years of age and over 65 to reduce out-of-home placements.

**Toward Lasting Balance and Reform**

*Turning the Corner: Toward Balance and Reform in Texas' Mental Health Services* takes a detailed view across the broad spectrum of the Texas Department of State Health Services (DSHS), and the entire mental health system. We hope it presents a starting point for state lawmakers to save taxpayers money and improve the services that Texans demand -- and deserve.



***CHAPTER 1.0***  
***INTRODUCTION***

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## 1.0 INTRODUCTION

### Background

In 2003, the Texas Legislature radically reorganized the state's health and human services system. This landmark legislation, H.B. 2292, consolidated the state's 12 health and human services agencies into four new agencies or "departments," and divided the services previously provided by the former Texas Department of Mental Health and Mental Retardation (TDMHMR) between two of the new agencies. The new Department of Aging and Disability Services (DADS) received responsibility for mental retardation services, while the Department of State Health Services (DSHS) absorbed the state's mental health programs.

This consolidation was accompanied by a substantial funding cut for health and human services. According to the Center for Public Policy Priorities, the Legislature reduced state and federal health and human service funding for the 2004-2005 biennium by more than \$1 billion compared to the previous biennium. Appropriations to the Texas Department of State Health Services for mental health services fell by approximately 3.5 percent, or about \$50 million.<sup>1</sup>

Community mental health and mental retardation centers (CMHMRCs), the quasi-governmental entities that serve as local mental health authorities and provide many federal and state-funded mental health services, saw a \$55 million reduction for 2004-2005, including \$5 million less for psychotropic medications. In addition, the Legislature capped their administrative costs at 10 percent, resulting in a loss of another \$24.3 million in state funds. These cuts were in addition to the reductions experienced by DSHS.

The Legislature also eliminated funding for the In-home and Family Support services program, which provided about 3,000 Texans with mental illness with community-based respite, family counseling, healthcare and other support services. Mental health training and research funds were cut entirely, for a savings of \$18.5 million. The 2004-2005 budget also reduced mental health benefits provided under the Texas Children's State Health Insurance Program (CHIP) and eliminated counseling services for adult Medicaid recipients unless provided by a psychiatrist.<sup>2</sup>

Finally, Texas policymakers enacted two other significant changes to the delivery of public mental health services. First, they modified the eligibility criteria for publicly funded mental health services, resulting in a reduction in the number of Texans qualified for public mental health services. Second, the state restricted access to prescription drugs by adopting a Preferred Drug List, making it more difficult for persons with mental illness to obtain new and more effective medications.

## **Study Purpose and Scope**

In light of recent funding cuts and a long history of inadequate funding in the Texas mental health system, the Mental Health Association in Texas engaged MGT of America, Inc. and its partners TXP, Inc. and RH2 Consulting to evaluate and quantify the effects of current and past policies and funding on the Texas economy and state and local government revenues.

This report is designed to provide a comprehensive overview of current and historical funding patterns for Texas mental health services, and to determine the degree to which these patterns have affected both local governments and other state spending, such as funding for corrections and foster care. It also documents the direct effects of current mental health policies on individuals in need and their families.

## **Overview and Organization of the Report**

This study is the culmination of a series of activities, including:

- a review and description of Texas' mental health system and historical and current funding;
- a review of the literature on the cost-effectiveness of mental health spending and a summary of findings on the indirect costs of mental illness;
- a comparative analysis of mental health spending in Texas and selected states;
- an in-depth analysis of state and local mental health funding beyond services included in the state's mental health system; and
- the development of an economic model to estimate the fiscal and economic effects of past and current state funding of mental health programs.

*Chapter Two* discusses the prevalence and costs of mental illness in the U.S. and Texas; defines key terms; describes the laws and service delivery models governing Texas mental health services; and reviews key medical, judicial and legislative actions affecting the system.

*Chapter Three* examines the cost-effectiveness of mental health expenditures and summarizes research findings on the indirect costs of mental illness and the impact of state budget cuts on local mental health services. In addition, the chapter provides a brief overview of recent developments and best practices in public mental health policy.

*Chapter Four* compares the organizational and funding structures of selected states' mental health systems with those of Texas. It also compares these states' per capita spending, sources of mental health funding and eligibility criteria for mental health services.

## ***Introduction***

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*Chapter Five* discusses the interaction of a variety of Texas state agencies with persons with mental illness, including the Texas Department of State Health Services, Texas Department of Families and Protective Services, Texas Education Agency, Texas Department of Assistive and Rehabilitative Services, Texas Department of Criminal Justice, Texas Probation Commission, Texas Juvenile Probation Commission and the Texas Youth Commission. This chapter also examines the effect of mental illness on local jurisdictions, including police departments and jails.

*Chapter Six* examines the economic effects of mental illness (and substance abuse, where appropriate) and estimates the total economic impact of mental illness on the Texas economy. The chapter also discusses the costs and benefits of treatment and the impact of declining funding on state and local governments.

*Chapter Seven* provides key findings and recommendations to address the issues identified in previous chapters.



**CHAPTER 2.0**  
**TEXAS MENTAL HEALTH SYSTEM:**  
**OVERVIEW**

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## **2.0 TEXAS MENTAL HEALTH SYSTEM: OVERVIEW**

### **Background**

During the first five months of 2004, the number of patients with mental illness seeking care from Central Texas' "safety net" providers—those caring for the uninsured and indigent—rose by 62 percent over the same period in the previous year.<sup>3</sup>

This surge was unlikely to be an isolated event. Houston's Ben Taub Hospital has seen steady increases in its number of patients seeking mental health care over the last few years, and expects its caseload to jump sharply due to recent cuts in state spending on mental health programs.<sup>4</sup> Recently, a public mental health provider in the Rio Grande Valley ceased operations entirely, leaving 100 patients with severe mental illness without services. Dozens of stories like these have appeared in newspapers throughout Texas, documenting the real-life impact of decisions on mental health funding and services made by Texas lawmakers in 2003.<sup>5</sup>

Texas has never adequately funded its mental health system. The 2003 Legislature's H.B. 2292, which radically reorganized the Texas HHS system and reduced its funding by more than \$1 billion, exacerbated an already serious problem. In addition, H.B. 2292 also changed the eligibility criteria for mental health services, costing some 14,000 Texans with mental illness their access to community-based treatment. The bill reduced funding for services provided by the state's mental health agency by about 3.5 percent, or \$50 million less than in the previous biennium.<sup>6</sup>

Legislators also eliminated funding for children's mental health services covered under the state's Children's Health Insurance Program. (This benefit was only partly restored in October 2004.)

H.B. 2292 consolidated the state's 12 health and human service agencies into four agencies, and divided the responsibilities of the former Texas Department of Mental Health and Mental Retardation (TDMHMR) between two new agencies or "departments." Mental retardation services were given to the Department of Aging and Disability Services (DADS), while the Department of State Health Services (DSHS) absorbed the state's mental health programs. These organizational changes are described in more detail below.

### **What is Mental Illness?**

The U.S. Surgeon General defines mental illness as follows:

*Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.<sup>7</sup>*

In 2003, about one in five Texans, or 3.1 million adults and more than 1.2 million children and adolescents were at risk for developing some form of mental illness.<sup>8</sup> This included persons with major depression, anxiety disorders and phobias, as well as schizophrenia, bipolar disease and other mental disorders.

Mental illness is widely misunderstood and remains stigmatized by society. A 2002 survey by the National Mental Health Association highlights a number of superstitions regarding mental illness that unfortunately persist among many members of the public. For example, among those surveyed:

- 71 percent thought mental illness was caused by emotional weakness.
- 65 percent believed bad parenting caused mental illness.
- 35 percent felt mental illness was caused by sinful or immoral behavior.
- 43 percent thought people bring their mental illness upon themselves in some way.

Texas mental health officials note that many people harbor such misconceptions, and emphasize that mental illness is not caused by an “emotional weakness” or bad parenting; most persons living with mental illness, moreover, are not dangerous and respond well to treatment.<sup>9</sup> A growing body of research suggests that major mental illnesses such as schizophrenia and bipolar disease (also known as manic-depressive disorder) are physiological disorders from which people can recover if they receive the appropriate medications, therapies and rehabilitation.

### **History of the Texas Mental Health System**

Texas first funded mental health services in 1857 when it began construction on the state’s first state hospital, which opened in Austin in 1861. The State Lunatic Asylum was meant to be just that—a place of asylum, safety and peace to promote the healing of emotionally disturbed Texans. But the asylum, later renamed the Austin State Hospital, and the other hospitals that followed it rarely lived up to this ideal.

As early as 1870, the asylum’s superintendent complained of overcrowding and under funding. Dr. J. A. Corley wrote in a report to the Legislature that although a new building had opened on the State Lunatic Asylum grounds in August of that year, it was already full to capacity (with 352 patients). He noted:

*Our sister state of California, though younger than Texas, has provided accommodations for over one thousand of her insane. Tennessee, with little, if any more numerous population, in addition to her present Asylum, capable of accommodating five hundred inmates, at the last meeting of the legislature took steps for immediate establishment of two others.<sup>10</sup>*

Although the state built another six mental hospitals over the next 70 years, the pattern of inadequate funding and overcrowding did not change significantly.

## ***Texas Mental Health System: Overview***

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In 1942, the governing board of state mental hospitals attempted to reduce a 1,400-person waiting list for state hospital services—most of them kept in Texas jails—by increasing the number of beds per room and adding additional beds to hospital hallways and porches.<sup>11</sup> The picture did not begin to change until the 1960s, with the development of community-based services that—in theory, at least—offered care that allowed patients to leave the hospitals.

In 1963, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act, which provided grants to states to construct community mental health and mental retardation centers. In response, the 1965 Legislature abolished the state's Board for Texas State Hospitals and Special Schools, created the Texas Department of Mental Health and Mental Retardation and authorized the establishment of local boards of trustees to organize and administer community mental health and mental retardation centers and establish guidelines for their funding.<sup>12</sup>

A 1974 class-action lawsuit filed by Texas state hospital patients and their families, *R.A.J. v. Gilbert*, highlighted poor conditions in the hospitals and pressed for better access to less restrictive treatment settings. The resulting court orders committed Texas to a strategy of “deinstitutionalization,” returning most patients from state mental hospitals to their communities. The average daily census in state hospitals declined from 5,482 in 1978 to just 2,408 in 1997, when the lawsuit's orders ended.<sup>13</sup>

In 1981, and again in 1987, legislators further reduced the state's role in direct care, emphasizing that mental health services were to be provided by local agencies and organizations to the greatest degree possible. Some former state hospital patients did receive adequate care in community. Many others, however, ended up in the criminal justice system; others simply found themselves living on the streets, because neither state nor local funding was available to pay for their services. Today, about 2,200 patients are housed in the state's in-patient facilities on any given day.<sup>14</sup>

### **Current System Structure and Operations**

The Department of State Health Services, formed on September 1, 2004, administers Texas' mental health system as well as its programs for alcohol and substance abuse prevention and treatment. The tasks are related; studies suggest that at least half of all persons with serious mental illness also misuse alcohol or drugs.<sup>15</sup>

By placing mental health under the same agency that oversees alcohol and substance abuse treatment, the state believes that its resources can be better focused on treatments that address both conditions.

DSHS serves Texans with mental illness who meet the state's eligibility criteria. Unlike other publicly funded programs such as Medicaid, which funds health care only for individuals meeting certain income standards, Texas' mental health programs base

eligibility on specific mental health diagnoses and the availability of funding. Services are provided to non-indigent patients for fees based on a sliding scale related to income.<sup>16</sup>

DSHS directly operates nine state mental hospitals, two state centers that offer a range of mental health services, three community hospitals and the Waco Center for Youth, a residential treatment center. DSHS also contracts for services with the state's 41 community mental health and mental retardation centers for mental health services. In addition, one CMHMRC, Dallas Area NorthSTAR Authority (DANSA), contracts with a behavioral health managed care organization as part of a Medicaid pilot program. (This arrangement is discussed at greater length in Section 2.4.)<sup>17</sup>

Burke Center is at capacity. The patients who we've stabilized through our outpatient program could be discharged to their family doctor, but there are no payment sources to cover that care. So we're running the "Hotel California" here-you can check in, but you can't check out and get the care you need. Texas can do better.

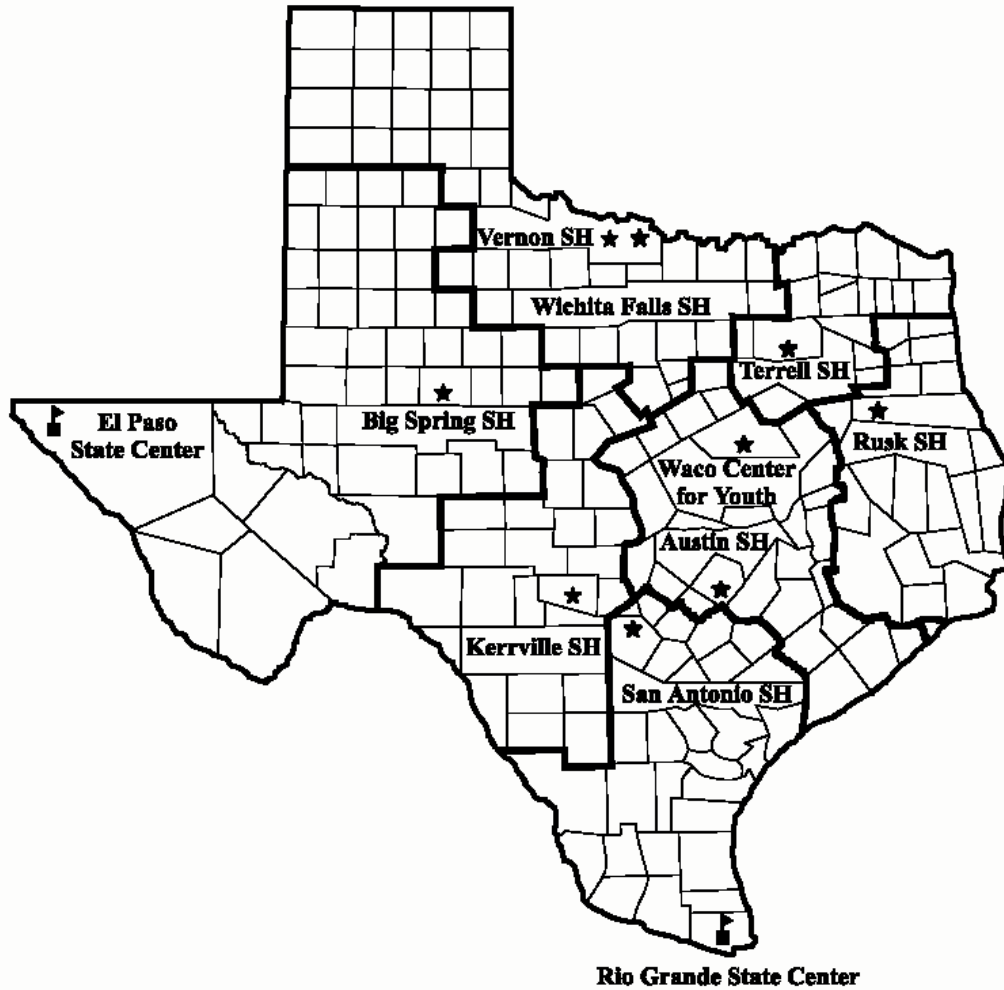
-Susan Rushing,  
East Texas, CMHMRC Director

Together, the state's mental hospitals can serve up to 2,136 Texans in crisis at any time. They have remained at more than 95 percent of capacity for the past several years. The hospitals provide intensive inpatient treatment for persons with severe mental illness. The Waco Center for Youth serves adolescents between the ages of 13 and 17 with 77 inpatient beds. The Rio Grande State Center in South Texas has 55 short-term crisis stabilization beds; this is the only state-operated inpatient facility south of San Antonio.

**Exhibit 2-1** illustrates the locations of the state mental hospitals, state centers and the Waco Center for Youth.

**EXHIBIT 2-1  
LOCATION OF STATE MENTAL HOSPITALS AND STATE CENTERS**

**State Hospitals and State Centers**



*Source: Texas Department of State Health Services.*

Community hospitals operated in conjunction with a teaching hospital and a major university in Galveston, Houston and Lubbock provide another 240 inpatient psychiatric beds for Texans with mental illness. In addition, DANSA has arranged with private psychiatric hospitals in its service area to provide inpatient services for qualified patients.

**Exhibit 2-2** lists the total number of publicly funded inpatient psychiatric beds in Texas.

**EXHIBIT 2-2  
PUBLIC INPATIENT PSYCHIATRIC BEDS**

<b>FACILITY</b>	<b>NUMBER OF BEDS</b>	<b>POPULATION SERVED</b>
State Hospitals	2136	Adults and Children <sup>1</sup>
State Centers	55	Adults and Children
Community Hospitals	240	Adults and Children
Waco Center for Youth	77	Adolescents 13-17
NorthSTAR	Variable, based on Contracts <sup>2</sup>	Adults and Children

**1. Not all state hospitals have children or adolescent units.**

**2. North Star contracts with multiple private psychiatric hospitals and general hospitals with psychiatric services**

**Source:** Texas Department of State Health Services.

***Community Mental Health and Mental Retardation Centers***

Together with the state-operated facilities, CMHMRCs form the core of Texas' publicly funded mental health system. CMHMRCs serve every Texas county. CMHMRCs are political subdivisions of the state, each governed by a board of trustees. These boards are appointed by the CMHMRC's sponsoring agency or agencies, which may include counties, municipalities, hospital districts or school districts. CMHMRCs receive federal, state and local funding as well as reimbursements from Medicaid, the state's Children's Health Insurance Program and private insurers.

All but one of the CMHMRCs have dual roles as mental health authorities (MHAs) and providers of mental health services. In their role as MHAs, CMHMRCs are responsible for arranging and managing services provided by contractors. In their provider role, they directly provide services to eligible patients. The sole exception is DANSA, which serves a seven-county North Texas region. DANSA operates as an authority only; all services in its region are provided through a behavioral managed care organization.

The CMHMRCs' dual roles—as overseers and direct service providers—have come under a great deal of scrutiny in recent years. A 1996 report by the Texas Comptroller of Public Accounts, *Special Delivery: New Models of Care*, raised questions about the potential conflicts of interest inherent in the two roles.<sup>18</sup> Attempts by the state Legislature in 2000 and 2001 to clarify the provider and authority roles failed, however.

The CMHMRCs must offer state-funded mental health services specified in state law and managed through performance contracts with the state. These contracts, introduced in the 1980s, are funded prospectively—that is, in advance of service delivery and based on the previous year's cost data. Again, CMHMRCs may provide the services directly or contract for them.

The 2003 Legislature tried once again to clarify the two roles by designating CMHMRCs as “providers of last resort.” The Council of CMHMRCs, the state organization representing CMHMRCs, maintains that “provider of last resort” still is not clearly defined, however.

***Texas Mental Health System: Overview***

**Exhibit 2-3** lists the services current performance contracts require CMHMRCs to provide.

**EXHIBIT 2-3  
REQUIRED CMHMRC SERVICES**

<b>REQUIRED SERVICES</b>	<b>DESCRIPTION</b>	<b>POPULATION SERVED</b>
Crisis Hotline	A continuously available telephone service providing support and referrals to callers 24 hours per day.	Children & Adults
Screenings	Activities for the purpose of gathering triage information to determine whether in-depth assessments are needed.	Children & Adults
Initial Eligibility Assessment	A face-to-face clinical assessment designed to obtain and evaluate relevant information from the individual or family seeking services. This service must be provided to all persons screened who appear to have a need for services from the local mental health authority.	Children & Adults
Case Management	Activities that assist eligible individuals in gaining access to medical, social, educational and other appropriate services.	Children & Adults
Treatment Planning	Activities intended to determine clinically necessary treatment reflecting the individual's needs and preferences and building on his or her strengths.	Children & Adults
Respite Services	Services provided for temporary, short-term periodic relief of primary caregivers looking after children or adult family members.	Children & Adults
Family Training	Training to broaden the family's knowledge of the effects and treatment of a child's disorder; and face-to-face interaction provided to parents or other primary caregivers of a child to improve the symptoms of the child's emotional/behavior disorder. (Note: As of fiscal 2004, family training is no longer a separate category. Instead, it has been merged with "skills training," which can be provided to individual children, groups of children or families.)	Children
Medication Related Services	Services related to the administration and monitoring of medication and the training of individuals and families in proper medication use.	Children & Adults
Skills Training	Training that furthers an adult's independent living and community skills or a child's ability to acquire and improve skills.	Children & Adults
Supported Employment	Activities that provide individual assistance in choosing and obtaining employment.	Adults
Supported Housing	Activities designed to help consumers with severe and persistent mental illnesses live independently.	Adults
Assertive Community Treatment	Multidisciplinary teams that provide treatment, rehabilitation and support services to consumers with severe and persistent mental illnesses and a history of multiple hospitalizations and involvement with the judicial system and homeless shelters.	Adults
Inpatient Services	Around-the-clock supervision and assistance, usually provided in a state psychiatric hospital.	Children & Adults
Intensive Crisis Residential	24-hour residential services, usually short-term in nature, offered to consumers in a psychiatric crisis that cannot be stabilized in a less restrictive setting.	Children & Adults

**Source:** Texas Department of State Health Services, January 2005.

Other than the controls contained in its performance contracts, the state has no direct authority over CMHMRC activities. Both CMHMRCs and mental health advocates, moreover, have contended that the contracts' service targets may create undesirable disincentives—the state's "priority population" often requires intensive services and a substantial commitment of resources, making it difficult for the centers to meet their target goals.

Texas created the priority population concept to ensure that persons with the greatest needs receive preferential access to limited public resources. As noted, however, the 2003 Legislature imposed a requirement on DSHS giving preferential access to people with specific diagnoses, rather than those "most in need" in terms of their ability to function within society.

### ***DANSA/NorthSTAR***

DANSA was created by the joint efforts of the Health and Human Services Commission, the Texas Department of Mental Health and Mental Retardation and the Texas Commission on Alcohol and Substance Abuse. It began accepting patients for the NorthSTAR behavioral health managed care program in 1999.<sup>19</sup> NorthSTAR serves residents of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties. In September 2003, this area included about 1.2 million Texans; any resident of the seven-county region with a persistent mental illness could qualify for services through NorthSTAR. Unlike other community-based mental health services, which may be administered by the state or a CMHMRC, DANSA and TDSHS oversee NorthSTAR jointly. Value Options, a private behavioral health organization contracting with DANSA, ensures an adequate provider network and the availability of contracted behavioral health services.

The guiding principles for the NorthSTAR initiative have been community involvement and empowerment, consumer choice, efficiency and accountability. One of the features making this program unique is its blending of mental health and chemical dependency treatment services to offer clients a "seamless" approach to treatment. In other parts of the state, Texans with dual diagnoses of mental illness and substance abuse may have to seek services from multiple programs, although the recent consolidation of mental health and substance abuse services under TDSHS may help to minimize this problem in the future.

Now in its fifth year of operation, NorthSTAR has met the objectives of consumer choice, efficiency and accountability that state agencies identified at its inception. The NorthSTAR network includes more than 400 providers plus 11 specialty provider networks (SPNs) that include five CMHMRCs, giving consumers a broad selection of providers. The SPNs provide service coordination, specialized care and more intensive levels of service than other network providers. NorthSTAR's data management system tracks patients individually and in the aggregate, enabling DANSA to monitor and evaluate their care.

## ***Texas Mental Health System: Overview***

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An evaluation of NorthSTAR conducted by the University of Texas' LBJ School of Public Affairs found the program to be highly efficient. The LBJ School study found that DANSA, through NorthStar, has served more people than other public mental health regions on a per capita basis, and without compromising its quality of care. The study also attributes NorthSTAR with producing more than \$20 million in Medicaid savings over a four-year period, through better management of patient care.<sup>20</sup>

Recent state funding cuts, however, have placed NorthSTAR's provider network in jeopardy because of the negative impact the cuts have had on provider reimbursement rates. According to Dallas County, state budget cuts have forced Value Options to cut reimbursement rates four times.<sup>21</sup>

### ***Medicaid***

Texans with mental illness who are enrolled in the state's Medicaid program may obtain care from CMHMRCs or other Medicaid providers.

Medicaid is a joint state-federal funded program that provides health services for low-income and indigent Texans who meet certain eligibility criteria. Because it is an "entitlement" program, anyone who qualifies financially and meets other state criteria can receive services.

Medicaid offers children special consideration. Federal law requires states participating in Medicaid to provide eligible children with any medically necessary service they require, even if the states do not cover such services for other Medicaid populations. As a result, Texas children are entitled to additional mental health services not covered by the state's Medicaid plan.

The legislative actions of 2003 included a restriction on mental health counseling benefits for adults that made psychiatrists the only providers eligible to deliver Medicaid reimbursed counseling services. This change became effective as of September 1, 2003. Medicaid-enrolled children still have access to psychologists and other counseling services because of their special status under the program.

Mental health services available through Texas Medicaid for both adults and children include:

- *Medications.* A three-prescription limit at any one time applies to most adult Medicaid recipients. Medicaid participants with mental illness who also have physical illnesses may not receive coverage for all the medications they need.
- *Physician services,* including consultation and medication management.
- *Counseling services* (provided by psychiatrists only for adults).
- *Rehabilitation services.* NorthSTAR and the CMHMRCs are the only authorized Medicaid rehabilitation service providers in Texas.

- *Targeted case management.* This service helps individuals obtain the medical, social, educational and other services they need.
- *Inpatient psychiatric care,* limited to children until the age of 21 and adults aged 65 and over.

The federal government does not pay for inpatient psychiatric services for individuals aged 21 to 65 if it is provided in what it defines as “institutes of mental disease” (IMDs). State operated and funded mental hospitals are considered IMDs and therefore are ineligible for federal Medicaid matching funds. As a result, Medicaid does not pay for any of the services delivered in Texas’ state hospitals and state centers.

### **Changes Affecting the Texas Mental Health System**

A number of recent legislative, technological and market changes have affected Texas’ mental health care system. These include the 2003 Health and Human Services reorganization and restrictions as well as improved medications, the arrival of new private mental health facilities and the advent of behavioral health managed care.

### ***The Priority Population and Disease Management***

When the 1965 Legislature created the Texas Department of Mental Health and Mental Retardation, lawmakers knew that the state would not be able to pay for everyone who might need mental health services. Therefore, the Legislature restricted access to publicly funded mental health services to those most in need by creating a “priority population.” State law, however, designates the “priority population” simply as those “identified...as being most in need of mental health or mental retardation services.<sup>22</sup>” TDMHMR further defined the priority population in its strategic plans.

Before the 2003 legislative changes, state agencies and CMHMRCs identified members of the priority population through a combination of medical diagnosis and an assessment of the degree of the person’s functional impairment. Specifically, they used screening processes that varied from location to location and a clinical interview to determine whether a person’s mental disability, regardless of the specific diagnosis, was severe enough to warrant inclusion in the priority population. Individuals identified in the priority were then assigned a set of services that were intended to address their particular needs for care and treatment: medications, therapy, substance abuse treatment, employment support, etc.

The state did not have in place any quantifiable measures to guide assessment and level of care recommendations. The services a person in one city with a certain diagnosis and level of functioning might get could be vastly different than the services a different person in another city – with the very same diagnosis and level of functioning – might get.

The 2003 Legislature responded to this concern by incorporating the concept of “disease management” into the health and human services reorganization. Disease management is a technique originally employed by managed care organizations to improve the cost-effectiveness of treatments for chronic illnesses such as diabetes, heart disease, and asthma. Disease management employs systematic, standardized diagnostic techniques

## ***Texas Mental Health System: Overview***

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and measurements and “evidence-based” clinical guidelines to guide the provider in mapping out an appropriate course of treatment or “management” of the individual’s disease.

Texas adopted an instrument called the “TRAG,” Texas Recommended Authorization Guidelines, to assist CMHMRCs in measuring the mental health service needs of a consumer based on his or her principal diagnosis and nine dimensions (risk of harm, support needs, psychiatric-related hospitalizations, functional impairment, employment problems, housing instability, co-occurring substance use, criminal justice involvement and response to medication treatment for major depressive disorder). The TRAG is a systematic process for determining mental health service needs based on the individual’s diagnostic profile and unique clinical characteristics. It proposes a methodology for quantifying the assessment of service needs to allow reliable recommendations for authorization into various levels of care (“service packages”) with specified types and amounts of services.<sup>23</sup>

State mental health officials believe the TRAG, combined with the Texas Medication Algorithm Project, an evidence-based method used to assess the effectiveness of medication protocols in treating schizophrenia, bipolar disease, and major clinical depression, should ensure people with these mental illness diagnoses receive the treatment they need.

Treatment and services are monitored and measured and guidelines are developed based on objective evidence reflecting the results of specific treatments and services. Performance is evaluated on an ongoing basis, weighing medical results and cost data to gauge the effectiveness of the treatments being used. Obviously, for this approach to be effective, the persons being assessed must be diagnosed correctly and their treatment subject to accurate measurement and assessment. Adequate funding is also needed to ensure that all necessary treatments are provided.

In addition to the adoption of disease management techniques, however, the 2003 Legislature changed the criteria for eligibility for services under disease management. Regardless of the severity of their conditions, virtually all patients now must belong to one of three specific diagnostic groups—schizophrenia, bipolar disease or major clinical depression—to qualify for state-funded, community-based services.

This quiet definitional change may have been one of the most significant actions of the 2003 Legislature. As many as 14 percent of those previously eligible for community-based mental health resources—14,000 people—no longer qualify for services. DSHS officials note that CMHMRCs can override this diagnosis requirement, but many advocates are concerned that, since limited resources make it difficult for CMHMRCs to serve all persons, they will in practice generally follow the requirements restricting the pool of eligible clients.<sup>24</sup>

### ***Improved Medications***

The advent in the 1950s and 1960s of psychotropic drugs such as Haldol and Thorazine spurred much of the movement toward deinstitutionalization in Texas and across

America. Before the introduction of these drugs, patients with certain forms of mental illness such as schizophrenia had little hope of leading a normal life outside the hospital. With the widespread use of psychotropic medications, such diseases became treatable and thousands of patients were able to leave the mental institutions.

Unfortunately, the early psychotropic medications often had severe side effects such as tardive dyskinesia, muscular contractions that can cause breathing difficulties. These and other serious side effects made patients reluctant to use the drugs, reducing their effectiveness. In addition, the original psychotropics treated only the “positive” or visible side-effects of mental illness, such as hallucinations and delusional behavior, rather than the “negative” impacts such as apathy and social and emotional withdrawal.<sup>25</sup>

The 1990s saw the introduction of a new generation of psychiatric medications such as Clozaril, Risperdal and Zyprexa. These drugs have fewer side effects than the older medications and treat a broader range of symptoms and effects.

Research on the new drugs suggests that, while they are more expensive initially, they are more cost-effective over time. They reduce symptoms, both positive and negative, and carry fewer side-effects to discourage patient compliance. This in turn reduces the number of relapses and thus inpatient hospitalization costs.

A study of Texas state mental patients found that treatment with the new generation of anti-psychotic medications produced average hospital savings of \$27,850 per patient annually.<sup>26</sup> Another study completed in 1998 found that these “atypical” anti-psychotic medications significantly reduce what the study called the “downstream” costs of mental illness, such as those related to incarceration, hospital emergency room usage and welfare-related expenses.<sup>27</sup>

In spite of such evidence, Texas lawmakers reduced funding for these medications in 2003 by \$5 million. The Legislature also placed an additional barrier to the use of some atypical anti-psychotics and antidepressants by limiting state payment for medications to a “preferred drug list” or PDL for Medicaid recipients. To receive drugs not on the PDL, patients first must “fail treatment” with a PDL drug. Both mental health practitioners and advocates have criticized this policy decision. Psychiatrists note that anti-psychotics are *not* interchangeable; each has a different molecular structure, dosing level, effectiveness, safety and patient response.<sup>28</sup>

The degree of success produced by medications therapy, moreover, can be directly linked to how quickly patients obtain appropriate medications. In fact, some research suggests that delays in the use of appropriate medications can result in permanent neurological damage.<sup>29</sup>

### Medication - One Size Doesn't Fit All

Mental illness strikes Texans from all walks of life. Don, a former police officer, was diagnosed with bipolar disorder, amplified by post-traumatic stress disorder, stemming from several life-threatening incidences on the job.

After years of struggling with his illness and navigating the maze of programs and medications, Don is back on his feet. He is married and works part-time, and was recently selected as a board member of the Texas Mental Health Consumers.

Recently, however, while trying to refill a prescription, Don learned that he would be receiving a generic substitute, due to budget cutbacks and new state rules (the Preferred Drug List). This change in state policy weighs heavily on Don because the generic drug has never worked for him.

## ***Texas Mental Health System: Overview***

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This research includes a 1998 study funded by the federal government and conducted by the Lewin Group. This study found that any savings generated by excluding more effective medications from coverage usually is more than offset by increases in expenditures for other services such as hospitalization. Another study, published in 1994 in the *New England Journal of Medicine*, found that limiting access to effective psychotropic medications can increase overall costs *seventeen-fold*, due to increased hospitalization costs.<sup>30</sup>

### ***Expansion of the Private Sector***

When the CMHMRCs first were created in the mid-1960s, Texas had few community-based private mental health providers. In the intervening 40 years, however, the number of private providers willing to work with state systems has grown significantly. The number of practitioners enrolled in the NorthSTAR behavioral health network provides evidence of their number and level of interest.

This growth has made it possible to offer clients in many areas of the state a choice of providers, and has increased state policymakers' interest in clarifying the CMHMRCs' dual roles as administering authority and care provider. State legislation of the mid-1990s stipulated that the CMHMRC's role is not necessarily to provide services, but rather to "ensure the provision of services" and "manage a coordinated system of mental health care."<sup>31</sup> Today, an increasing number of CMHMRCs contract with private providers to fulfill their responsibilities.

### ***Managed Care***

Texas began converting its Medicaid program from a fee-for-service to a managed care basis in 1993. When providers are reimbursed under fee-for-service system, they bill individually for each service delivered. In a managed care system, providers receive a "capitated" fee, an amount per person treated. The passage of the 74<sup>th</sup> Legislature's H.B. 2377 introduced managed care to the state's mental health system by authorizing the development of a provider network and allowing the "authority" and "provider" roles to be separated.

Today, 27 states deliver at least some of their mental health services through managed care networks. As of 2002, about 14.7 million persons were covered under state behavioral health managed care plans; 1.4 million persons in 21 states received publicly funded mental health services through a behavioral health organization using managed care techniques.<sup>32</sup>

According to a report by the Bazelon Center for Mental Health Law, states that have adopted managed care approaches in their public mental health systems have achieved the following positive results:

- increased access;
- decreased use of inappropriate inpatient care;
- an expanded array of services;

- greater flexibility in service delivery;
- greater consistency in clinical decision-making;
- more focused, goal-directed treatment; and
- increased emphasis on accountability and outcomes.

The states also may experience some negative effects, including:

- undertreatment or under-serving of people with serious disorders;
- an overemphasis on acute care and neglect of rehabilitation and other services that could provide significant long-term payoffs in improved functioning;
- difficulties in serving the non-Medicaid population, which may lose any means of access to public mental health services;
- billing and payment difficulties (particularly during the startup of a new system); and
- difficulty ensuring consistency of treatment across regions.<sup>33</sup>

Texas' behavioral health plan avoids some difficulties in providing services to non-Medicaid eligible clients by requiring DANSA/NorthSTAR to serve anyone in its service area, regardless of their ability to pay. DANSA did experience billing and payment difficulties early on, but these have been resolved.<sup>34</sup>

### **The Road to Recovery - Two Steps Forward ...and Three Steps Back?**

Most Texans with mental illness desperately want to recover and get their life back. But state funding cutbacks, which restrict access to services such as individual and group counseling, are a serious roadblock in the road to recovery. State funding cuts mean that patients like Monique (23), a mother of three, diagnosed with bipolar disorder, is allowed to talk to her caseworker only once a month, instead of anytime she has a problem. Her group counseling sessions have been cancelled-indefinitely. *"I was going to group, and meeting new people that were sick like me. Without group, I don't feel like being around other people because they don't understand what I'm going through. At least my counselor and the people in group helped me and could understand me, and really made me feel comfortable. Now, I don't have anyone or anything."*

### **Funding History**

Due to the cuts of 2003, DSHS officials estimate that Texas will serve fewer children and adults with mental illness in the community in fiscal 2005 than in previous years. Texas will spend less per capita on mental health services in 2005 than it did in 2000.

DSHS' estimated number of people receiving services in 2005 represents just 27 percent of those estimated to be eligible. It is important to note that the "priority" or "target" population represents only 15 percent of Texans diagnosed with a mental illness in any given year.

**Exhibit 2-4** illustrates the number of children and adults served by the state's mental health system, total funding and per capita spending from 2000 to 2005 (projected).

The number of adults and children served in the state's mental health system declined in 2004 and is expected to decline further in 2005. Not surprisingly, the number served as inpatients is expected to rise over the same period, even as the total number of individual served declines. When persons with mental illness lose their access to community-based services their mental health problems often reach a crisis requiring hospitalization.

**EXHIBIT 2-4**  
**CHILDREN AND ADULTS SERVED, FUNDING AND PER CAPITA**  
**MENTAL HEALTH SPENDING BY YEAR, 2000-2005**

YEAR	CHILDREN	ADULTS	FUNDING	PER CAPITA
2000	30,157	124,252	\$387,694,430	\$15.17
2001	31,063	136,458	\$424,439,173	\$16.06
2002	27,928	146,021	\$440,662,204	\$16.28
2003	31,303	147,064	\$439,194,379	\$16.12
2004	22,499	153,815	\$431,183,217	\$15.31
2005	22,239	147,045	\$431,008,789	\$14.77

*Source: Texas Department of State Health Services*

The state mental hospitals demonstrate similar trends. Spending for the hospitals peaked in 2003 and then declined (**Exhibit 2-5**).

**EXHIBIT 2-5**  
**NUMBER SERVED AND SPENDING IN**  
**STATE MENTAL INSTITUTIONS, 2000- 2005**

YEAR	NUMBER SERVED	FUNDING	PER CAPITA
2000	14,203	\$245,250,368	\$11.76
2001	15,106	\$255,649,887	\$11.98
2002	15,636	\$298,527,943	\$13.73
2003	16,880	\$308,788,714	\$13.96
2004	15,942	\$291,121,140	\$12.91
2005	16,880	\$286,278,349	\$12.30

*Source: Texas Department of State Health Services.*

As with most states, Texas spends a greater portion of its mental health budget on community-based services than on inpatient services. Inpatient hospitalization can provide critical assessments and crisis stabilization; while it is expensive, there will always be a need for it. Ideally, though, an effective community mental health system with adequate access to appropriate medications and providers should minimize the need for—and the costs of—inpatient services.

**Exhibit 2-6** compares the cost of serving persons with mental illness in the community with the costs of treatment in a mental hospital. On average it costs six times more to treat someone in an inpatient setting than in the community.

**EXHIBIT 2-6  
COSTS OF COMMUNITY-BASED MENTAL HEALTH SERVICES  
VS. INPATIENT SERVICES, 2000-2005**

YEAR	# SERVED IN COMMUNITY	COMMUNITY COST/PATIENT	# SERVED AS INPATIENTS	INPATIENT COST/PATIENT
2000	154,409	\$2,511	14,203	\$17,268
2001	167,521	\$5,534	15,106	\$16,924
2002	173,949	\$2,533	15,636	\$19,092
2003	178,367	\$2,462	16,880	\$18,293
2004	176,314	\$2,446	15,942	\$18,261
2005	169,284	\$2,546	16,880	\$16,960

*Source: Texas Department of State Health Services.*

**Mental Health Services Outside the Mental Health System**

One of the consequences of a chronically underfunded mental health system is that some persons with mental illness end up in systems ill-suited for their treatment needs, such as jail, prison or foster care. At least eight Texas state agencies other than DSHS pay for mental health services or serve people with mental illness in their programs, including:

- Texas Correctional Office on Offenders with Medical or Mental Impairments;
- Texas Department of Criminal Justice;
- Texas Juvenile Probation Commission;
- Department of Family and Protective Services;
- Texas Education Agency;
- Health and Human Services Commission;
- Texas Department of Assistive and Rehabilitative Services; and
- Texas Youth Commission.

In addition, many local government programs also serve persons with mental illness. For instance, many counties and municipalities fund mental health services either directly, through appropriations to CMHMRCs, or through community-based programs such as homeless shelters. They also may serve people with mental illness in local jails or indigent health programs.

The impact of current mental health funding patterns on state and local governments will be described in more detail in **Chapter 5**.

**Conclusion**

In spite of the many challenges they face, there has never been a time of greater hope for Texans with persistent mental illness.

A new generation of promising medications can help even those with the most severe disorders return to productive lives. Texas has developed evidence-based treatment protocols for specific mental disorders, including schizophrenia, bipolar disease and major depression, which show great promise. Texans with mental illness have a greater choice of providers and types of care than ever before.

Yet in too many ways, Texas' system has not remedied the faults of more than a century ago. Complaints lodged by state hospital superintendents in the late 1800s are echoed today: chronic underfunding and penny-pinching pushes people with mental illness into prisons, jails or overcrowded emergency rooms—or on to the streets.



**CHAPTER 3.0**  
**LITERATURE REVIEW**

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## **3.0 LITERATURE REVIEW**

### **Chapter Purpose and Methodology**

This chapter reviews the present literature on the cost-effectiveness of mental health spending, and summarizes findings from available research on the indirect costs of mental illness and the local effects of state budget cuts on mental health services. In addition, it provides a brief overview of important developments and recommended best practices in public mental health policy.

To prepare this analysis, the research team began with an Internet-based search to identify relevant studies and potential sources of information. In addition, the review team contacted policy experts at a wide range of national organizations and federal agencies, including the:

- National Mental Health Association;
- National Association of State Mental Health Program Directors;
- American Psychological Association;
- National Alliance for the Mentally Ill;
- Bazelon Center for Mental Health Law;
- Substance Abuse and Mental Health Services Administration;
- U.S. General Accounting Office; and
- Hogg Foundation for Mental Health.

In addition, the team contacted state mental health and local government organizations in several states including California, New York, Florida and Ohio.

### **Cost-Effectiveness of Mental Health Care Spending**

A significant body of medical literature supports the notion that ready access to mental health care significantly reduces other health care expenses, such as hospitalizations and medical office visits. These “cost offsets,” as researchers call them, make a powerful case for investments in mental health services.<sup>35</sup>

The earliest reported study on cost offsets for mental health services was published in 1962, and convinced insurance company giant Kaiser Permanente to offer a prepaid psychotherapy benefit for enrollees in its health maintenance organization. More than 20 years later, a group of researchers analyzed 58 controlled studies and verified the cost-offset effect for outpatient mental health treatment. They also studied utilization data from a large private insurance company and found positive medical cost offsets, primarily due to reductions in hospitalization. A more recent 1997 study found that total health care costs fell by 23 to 55 percent following treatment for alcoholism, a condition often associated with mental illness.<sup>36</sup>

Some general findings drawn from the literature include:

- **Patients with mental illness are intensive users of medical services.** A study published in 1985 found that patients with diagnosable mental disorders average twice as many visits to their primary care physicians as those without a mental disorder.<sup>37</sup> Another study published in 1992 found that individuals who need but do not receive mental health care treatment visit medical doctors for unnecessary reasons twice as often as those who do.<sup>38</sup>

Proponents of the cost-offset hypothesis argue that diagnosis (particularly early diagnosis) and treatment for mental disorders reduces overall health care costs by reducing unnecessary usage of medical services. As already noted, the hypothesis is supported by numerous studies, including an analysis of Kaiser Permanente patients who received psychotherapy. The study's authors documented that patients receiving psychotherapy had fewer hospitalizations and emergency room visits, shorter hospital stays, fewer office visits and fewer prescriptions.<sup>39</sup>

- **Mental health care treatment can improve medical outcomes for patients with both health and mental health conditions.** Research has demonstrated, for instance, that patients with depression and a medical condition such as diabetes or cancer experience better medical outcomes if their mental health issues are treated.<sup>40</sup>
- **The amount of the cost offset depends on the severity of the illness.** Many studies suggest that cost offsets are greater for the treatment of less severe diagnoses such as depression. However, cost-offset effects also have been achieved in the treatment of patients with serious mental illness, by reducing their use of expensive medical interventions such as hospitalization. For example, one study found that over ten years, diagnosing and treating patients with multiple personality disorder resulted in net savings of \$84,900 per patient in direct medical costs alone.<sup>41</sup>
- **Cost offsets are more likely to occur in “organized settings” such as managed care plans.** Some researchers have proposed that cost offsets are greatest in settings already focused on containing costs, such as managed care.<sup>42</sup>

Cost offsets also may be realized through reduced spending on indirect expenditures associated with untreated mental illness. A 1993 study by the National Institute of Mental Health found that the cost of covering mental illness on the same basis as medical illness (through “mental health parity” laws) would cost only \$6.5 billion annually and that this expenditure would save U.S. taxpayers \$8.7 billion per year in indirect costs associated with untreated mental illnesses, such as incarceration.<sup>43</sup>

### ***Limitations of Cost-Offset Research***

Not all researchers embrace the cost-offset hypothesis. In a June 2001 article of the journal *Psychiatric Services*, for example, a researcher argued that:

*...there is no evidence that increased mental health expenditures—through more generous behavioral health insurance coverage, [a] higher quality of mental health care for a general population, or expansions of behavioral health care services—are offset to any meaningful extent by reductions in general medical spending.<sup>44</sup>*

The Evaluation Center at the Human Services Research Institute has noted that cost-offset studies have at least two major problems. First, most studies use a simple “pre-” and “post-” research design; lower “post-” costs may simply reflect the fact that medical costs often are at their highest during periods in which mental health treatment is initiated—no cause-and-effect relationship, and thus no actual cost offset. A second problem is that studies using experimental and non-experimental groups to compare costs do not randomly assign subjects to groups, which may lead to selection bias.<sup>45</sup>

### **Cost-Effectiveness of Psychotropic Drug Therapy**

Some studies address the fiscal impact of restricted access to psychotropic medications. These reflect a similar premise to the cost-offset studies: that short-term savings realized by restricting access to medications are more than offset by additional costs for hospital stays, emergency room visits and the like.

A federally funded 1998 study conducted by the Lewin Group, for instance, found that the exclusion of the more effective drugs from coverage results in expensive increases in the use of other services such as hospitalization. As noted above, a 1994 study published in the *New England Journal of Medicine* found that limiting access to effective psychotropic medications boosted overall costs seventeen-fold.<sup>46</sup>

### **Indirect Costs of Mental Illness**

#### ***General Estimates***

In 1999, the U.S. Surgeon General issued a landmark report on mental illness in the United States. The report estimated that in 1990, mental illness imposed a loss on the U.S. economy of nearly \$79 billion. The report attributed most of that amount, \$63 billion, to losses in productivity caused by illness. The remaining \$16 billion included \$12 billion from lost productivity due to premature death and nearly \$4 billion in productivity losses for the incarcerated and for informal family caregivers who must leave or reduce their employment because of family obligations.<sup>47</sup>

In 2001, a National Mental Health Association report estimated that untreated and mistreated mental illnesses annually cost the U.S. \$113 billion, including \$105 billion in lost productivity and \$8 billion in crime and welfare costs. The report also found that the economic cost of untreated and mistreated mental illness in the U.S. had tripled over the last decade.<sup>48</sup>

Researchers also have studied the indirect economic and social costs of specific afflictions such as depression and schizophrenia. According to one estimate, clinical depression costs the U.S. an estimated \$43.7 billion annually, including \$23.8 billion for workplace related costs; \$12.4 billion in direct treatment and rehabilitation costs; and \$7.5 billion in lost earnings due to depression-induced suicides. An official publication of the American College of Neuropsychopharmacology found that the annual direct and indirect costs of schizophrenia (\$33 billion) were comparable to the cost of arthritis (\$38 billion) or coronary artery disease (\$43 billion).<sup>49</sup>

Mental disorders account for more than 15 percent of the burden of disease in established market economies. Four of the top ten leading causes of disability worldwide are mental disorders.

*Source: The World Bank and World Health Organization.*

### **Impact on Criminal Justice Spending**

Although the vast majority of individuals with serious mental illness are no more dangerous than members of the general public, some people with mental illness do represent a danger to themselves and others.<sup>50</sup> The National Mental Health Association estimates that at least 16 percent of the inmates in state prisons and local jails suffer from mental illness.<sup>51</sup> Jails, prisons and juvenile justice facilities often become providers of last resort when more appropriate treatment is unavailable.

In 1996, the Pacific Research Institute for Public Policy published a study on the fiscal impact of people with mental illness on California's corrections and criminal justice systems, including its courts.<sup>52</sup> The study's authors estimated that during 1993-94, people with mental illness cost the state's criminal justice and corrections systems from \$1.2 billion to \$1.8 billion.<sup>53</sup>

A number of national organizations have focused on the relationship between mental health and criminal justice. The American Psychiatric Association's Committee on Jails and Prisons convened a policy summit in February 2004 to address what it perceives as an epidemic of persons with mental illness in the criminal justice system. The committee plans to launch various initiatives, including an evaluation of the potential for long-term savings through programs that divert persons with mental illness from incarceration to community-based treatment (generally referred to as jail diversion programs, and discussed at greater length at Chapter 5.8).<sup>54</sup>

The Council for State Governments' Criminal Justice/Mental Health Consensus Project is another example of a collaborative approach to the development of specific policy recommendations. The project included partners from the Association of State

## ***Literature Review***

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Correctional Administrators, the Bazelon Center for Mental Health Law, the Center for Behavioral Health, Justice & Public Policy and the National Association of State Mental Health Program Directors. The project's final report of 2002 provides a comprehensive overview of the problem and details a range of potential solutions including 200 recommendations.<sup>55</sup> Examples of these include:

- expand priority service definitions to include more individuals with mental illness who have a history of or are at risk of criminal behavior;
- draw funding from a variety of public sources;
- incorporate evidence-based practices into the public mental health system;
- form community-based partnerships to provide housing for individuals with mental illness; and
- recruit members of the minority community into clinical and administrative positions involving regular client contact.

## **Impact on Health Care Access**

Researchers also have reviewed the impact of mental health cutbacks on the health care sector, particularly hospital emergency rooms. In 2004, the American Psychiatric Association, the National Alliance for the Mentally Ill, the National Mental Health Association and the American College of Emergency Physicians released a survey on the topic, with findings such as these:

- two-thirds of surveyed emergency physicians attributed recent spikes in the number of psychiatric patients arriving in emergency rooms to state budget cutbacks and a decreasing number of psychiatric beds.
- seventy percent reported an increase in the practice of "boarding" people with mental illness (this occurs when patients are admitted to hospital, but required to wait in ER until inpatient beds become available to them).
- more than 80 percent of surveyed physicians reported that "boarding" mental health patients in ERs negatively affects the care of other patients.<sup>56</sup>

A Washington state study found a strong relationship between frequent emergency room visits and mental illness and alcohol or drug disorders. An analysis of aged, blind and disabled clients found that 56 percent of those who visited emergency rooms 31 or more times in fiscal 2002 had been diagnosed with both mental illness and alcohol or drug abuse problems.<sup>57</sup>

### **Impact on Other Public Services**

Less research is available on the impact of state budget cuts on mental health care in other sectors of local government, such as child welfare, although it is widely recognized that some parents in Texas and elsewhere have been forced to relinquish custody of their children to secure treatment for them.

The media, advocacy groups and research organizations have demonstrated a great amount of interest in the subject of “local impacts.” A 2001 study by the Bazelon Center for Mental Health Law, *Disintegrating Systems: The State of States’ Mental Health Systems*, offers specific examples of the local impact of poorly funded mental health services, although the evidence presented is largely anecdotal.<sup>58</sup>

The National Alliance for the Mentally Ill recently launched a “Campaign for the Mind of America” to raise awareness about the need for mental health reform and increased funding. The campaign seeks to link this cause to broader social issues, and reportedly is working with a variety of other organizations including the American College of Emergency Physicians, the National Association of Counties, the National Association of County and City Health Officials, the Society of Adolescent Medicine and the National Association of Social Workers. The campaign intends to conduct a comprehensive literature review to identify the best information available about the costs of inadequate access to mental health care, including the impact of inadequate treatment on private business and government health care, law enforcement and education.<sup>59</sup>

### **Best Practices and Developments in Public Policy**

A considerable body of literature details the best practices, innovations and trends in mental health care policy. Mental health reform has been the centerpiece of many policy summits, state “blue ribbon” task forces and national commissions. The media covers the issue extensively as well. This section reviews some major developments and trends.

#### ***Surgeon General Report***

The U.S. Surgeon General’s landmark 1999 study, *Mental Health*, challenged the nation to move mental health into the mainstream of health care—and to reduce stark disparities in mental health care access and quality. This study, a collaboration between the Substance Abuse and Mental Health Services Administration and the National Institutes of Health, has been widely credited with raising awareness about progress made in the treatment of mental illness and the critical relationship between mental and physical health.<sup>60</sup>

In 2001, a supplement to the report, *Mental Health: Culture, Race, and Ethnicity*, highlighted striking racial and ethnic disparities in access, availability and quality of care, and concluded that, while effective treatments for mental illnesses are available, minorities are less likely than the general population to receive quality care.<sup>61</sup>

## ***New Freedom Commission on Mental Health***

*Governing* magazine recently called *Achieving the Promise: Transforming Mental Health Care in America*, the final report of President Bush’s New Freedom Commission on Mental Health, “perhaps the most important document in mental health care in recent years.” *Achieving the Promise* details six major goals and related strategies for building a “consumer and family centered and recovery oriented” mental health care system.<sup>62</sup>

The report cites “fragmentation” as a critical and chronic problem facing the restructuring of mental health services. Fragmentation is the result of multiple funding streams and agencies becoming involved in mental health service delivery and management, a tangle that often alienates individuals who need help and produces duplicative administrative structures and procedures.

Although the report was well-received by mental health advocates and professionals, most agree that a renewed federal commitment to funding will be needed to achieve its goals.

For the purpose of analysis, we have reviewed evidence-based practices, best practices and promising practices in mental health. “Evidence-based practices” refers to specific mental health programs and services that have been recognized by national mental health experts, including academics and practitioners, as effective tools to improving mental health outcomes. “Best practices” may be defined as proven policies and programs that have been positively recognized by national and state mental health policy experts. The term “promising practices” includes those policies and programs that are viewed as having potential to become “best practices” in the future.

### ***Evidence-Based Practices***

One of the most promising trends in community mental health is the application of a series of “evidence-based” practices resulting from the deliberations of a panel, sponsored by the Robert Wood Johnson Foundation, which assembled researchers, families, consumers and mental health administrators to identify scientifically proven, cost-effective strategies for adults with severe mental illness. These practices included:

<b>Achieving the Promise</b>	
In a transformed mental health care system...	
Goal 1	Americans understand that mental health is essential to overall health.
Goal 2	Mental health care is consumer- and family-driven.
Goal 3	Disparities in mental health services are eliminated.
Goal 4	Early mental health screening, assessment and referral to services are common practice.
Goal 5	Excellent mental health care is delivered and research is accelerated.
Goal 6	Technology is used to access mental health care and information.

*Source: Presidents’s New Freedom Commission on Mental Health. Full report and related resources available at [www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov).*

- **integrated treatment for persons with severe mental illness and substance use disorders.** Research has demonstrated that integrating mental health treatment with substance abuse treatment specifically tailored for those with mental illness is more effective than separate substance abuse and mental health services.
- **supported employment.** This practice places individuals with severe mental illness in competitive, “real-world” jobs. Supported employment services include individual assistance in selecting and securing jobs as well as support services such as transportation, job coaching and follow-up assistance after placement.
- **medication.** To optimize the use and effectiveness of mental health treatment with medication, experts recommend a systematic, evidence-based approach to selection and use; measurement of treatment response and side effects; and efforts to increase patient adherence to medication regimen.
- **assertive community treatment.** This approach to case management uses multidisciplinary teams (including psychiatrists, psychologists, social workers and nurses) to provide treatment, rehabilitation and support services. Unlike traditional case management, “assertive” treatment involves small caseloads, regular multi-disciplinary team meetings and around-the-clock service availability.
- **illness self-management.** Also called “wellness self-management,” this practice involves various strategies designed to help patients manage their symptoms. Consumers are offered information about their illnesses, social skills training, cognitive behavioral therapy and coping skills training.
- **family education.** This practice provides education, support, and coping skills to families to support them in the recovery process.<sup>63</sup>

The Department of State Health Services plans to phase in a requirement that 100 percent of its funding be used to support evidence-based practices such as these. Standardized assessments and disease specific treatment protocols, however, have been developed by DSHS for only three serious mental illnesses: schizophrenia, bipolar disease and clinically severe depression. Obsessive-compulsive disorder (OCD) is one of the top 10 leading causes of disability, according to the World Health Organization, and many people in jails and prisons suffer from depression and post-traumatic stress disorder. Advocates argue that Texas officials should develop appropriate protocols for these and other illnesses before restricting state funds to evidence-based practices only.

Another evidence-based Texas practice is the nationally recognized Texas Medication Algorithm Project developed by the former Texas Department of Mental Health and Mental Retardation. This project uses evidence-based methods to determine the most effective medication protocols for treating schizophrenia, bipolar disease and major clinical depression.

### **Best Practices**

A recent National Mental Health Association (NMHA) report, *Can't Make the Grade: NMHA State Mental Health Assessment Project, 2003*, provides a snapshot of best practices in the field from across the nation. Three particularly important recommended practices are:

- **track funding for mental health services across state agencies.** The NMHA report raised concerns about the integrity and relevance of mental health expenditure data currently collected by the states. Few if any states track mental health funding across state agencies, making it difficult to make informed spending decisions.
- **divert individuals with mental illness from the criminal justice system.** NMHA recommends a range of preventative programs, including pre-arrest, pre-booking and post-booking efforts.
- **expand community-based services through Home and Community-Based Services Medicaid waivers.** This little-known federal program for community-based mental health care can be used to expand community-based services for children under the age of 21 and adults over 55. Colorado, Kansas, New York and Vermont have used the waiver to fund care for children or older adults.<sup>64</sup>

### **New Mexico**

*"Mental health care is so widely dispersed that most states can't even pinpoint how much they spend on the services."*

- *Governing*, February 2004.

Mental health experts interviewed for this study identified New Mexico as a leader in innovative mental health service delivery.

New Mexico recently received national attention for its ongoing efforts to restructure its Medicaid managed care program (called *Salud*, the Spanish word for health) and reform the delivery of state-funded mental health services through consolidated public funding. This ambitious reform comes largely in response to recommendations made by the President's New Freedom Commission on Mental Health, and a state assessment of the state's mental health services.

In September 2003, Governor Bill Richardson charged all New Mexico state agencies that finance mental health and substance abuse services with developing "interdepartmental behavioral health purchasing collaboratives" to administer, coordinate and oversee service delivery. The collaboratives will contract with a single "statewide entity" (to be selected through a competitive bidding process) to manage public mental health and substance abuse programs, including those financed by Medicaid. In May 2004, the New Mexico legislature created this purchasing collaborative.

One of the key goals of this reform is to reduce administrative costs and redirect resources from “bureaucracy to services.” A related goal is to free up dollars to increase provider reimbursement rates, since low Medicaid reimbursements have significantly reduced the number of providers willing to accept Medicaid patients.

The New Mexico reforms have not been fully implemented, but the state’s efforts to address the “fragmentation” issue offer great promise and may serve as a model for other states.<sup>65</sup>

### **Promising Practices in Children’s Mental Health**

Although a full discussion of best practices in children’s mental health care is outside the scope of this report, it is important to note that children around the nation have benefited from reforms and innovative treatment advances. Two trends growing in popularity and frequently highlighted as promising practices are “Systems of Care” and “Wraparound Services.” The two practices are related and are described briefly below.

Beth Stroul and Robert Friedman coined the term “Systems of Care” in their 1986 book, *Systems of Care*.<sup>66</sup> At the core of the systems of care concept is the premise that, since children with problems have needs that concern various systems (such as mental health, juvenile justice, schools and child welfare), requiring these systems to work together will produce better outcomes.

“Wraparound services” is both an approach to treating children with mental health needs and a range of services provided. Wraparound services are comprehensive and highly individualized to the individual child and family. Authors John VanDenBerg and Mary Grealish defined wraparound in 1996 as follows:

*Wraparound efforts occur in the community, where services are individualized to meet children’s and families’ needs. Parents are included in every stage of the process and the approach must be culturally sensitive to the unique racial, ethnic, geographical and social makeup of children and their families. The process of wraparound is designed and implemented on an interagency basis using an interdisciplinary approach in which providers have access to flexible, non-categorical funding. Wraparound services must be delivered on an unconditional basis where the nature of support changes to meet changes in families and their situations. Finally, wraparound involves the measurement of child and family outcomes to determine the effectiveness of services that ensure that appropriate populations are being served.<sup>67</sup>*

Texas lawmakers wisely embraced the systems of care approach in 1999 by passing the Texas Integrated Funding Initiative (TIFI). Under the TIFI legislation, six child-serving state agencies each contribute \$70,000 per year into a blended-fund pool that supports the development, demonstration and implementation of systems of care in four communities for children with serious emotional disturbances and their families.

The Center for Social Work Research at the University of Texas at Austin has been involved in TIFI from the beginning, gathering information, evaluating data and reporting outcomes for the communities involved in the program. According to an analysis by the Texas Health and Human Services Commission, TIFI children generally improved in behavior and emotional strength after participating in the system of care for three to six months. And their improvement exceeded trends observed nationally. Furthermore, both caregivers and youths in the program reported high levels of satisfaction with many aspects of their wraparound and system of care experience.

One of the program sites is Family Connections, which offers wraparound services to children and families seeking alternatives to residential treatment. Programs like these help children get better while saving tax dollars; the cost of 22 months in residential treatment has been estimated at \$75,000, versus \$15,350 for in-home and community care (excluding case management and related costs). The savings (about \$60,000) is enough to provide care to four more children in need.

### Summary and Conclusions

Although researchers may debate the extent to which mental care pays for itself through reduced costs elsewhere, a broad consensus has emerged that untreated mental illness entails a heavy cost—tangible and intangible, economic and social.

The Surgeon General's 1999 report estimated that untreated mental illness cost the U.S. \$79 billion in 1990. A more recent analysis by the National Mental Health Association put the cost at \$113

### Some States to Watch

**Nevada** earmarked a substantial portion of a \$900 million tax increase to boost funding for the state's mental health department by almost \$90 million, increasing the department's budget by 31 percent in 2004.

**Nebraska** appropriated \$12 million from its tobacco settlement funds in 2001-02 to expand mental health and substance abuse programs.

**South Carolina** responded to a state supreme court order by awarding \$1.7 million to 10 community mental health centers to keep people out of emergency rooms and make room for patients who are able to leave state psychiatric hospitals. This action followed massive funding cuts to mental health programs that made headlines across the state; at one point 70 people waited in jail because there was no space for them to receive court-ordered treatment.

In 2001, **Minnesota** adopted a "rehab option" that authorizes the state to spend Medicaid dollars on a broad range of community-based services instead of hospitals or day treatment centers. This policy shift attracted an additional \$13 million in federal funding to the department in the 2001-2002 biennium.

Policymakers in **Virginia**, a state that has never closed any of its 15 state hospitals, launched a "Community Reinvestment Project" designed to shift more than \$11 million from state hospitals to the state's 40 community service boards, which provides mental health services to Virginia residents.

In 2002, **California** set aside \$190 million from a \$2.1 billion voter-approved housing bond to construct new living space for the disabled, including people with mental illness. In November 2004, Californians voted in favor of Proposition 63, a 1 percent income tax increase for individuals earning more than \$1 million a year that will fund statewide mental health services. This will raise an estimated \$275 million in fiscal 2005 and \$800 million annually thereafter for a wide range of mental health services.

**Arizona** recently increased provider reimbursement rates for the first time in ten years, following concerns that providers would follow the trend in other states and leave its mental health care system.

**Source:** Governing, February 2004, "The Government Performance Project: A Case of Neglect, Mental Health."

billion, and according to the World Health Organization, every year suicides cause more deaths than homicide or war.<sup>68</sup>

The research team did not locate any studies specifically detailing how state budget cutbacks affect local governments, a focus of this report. The team did learn of several ongoing efforts to analyze the costs imposed on local governments. In addition, it identified several studies examining the impact of untreated mental illness on two of the most expensive and important public services, criminal justice and health care.

As previously noted, the criminal justice system has become a *de facto* provider of last resort for individuals with untreated mental illness. The federal government estimates indicate that individuals with untreated mental illness comprise about 16 percent of the total American jail and prison population. Research has demonstrated that prisoners with mental illness spend twice as much time in jail as other individuals and are more likely to commit suicide. According to a 1996 Justice Department report, prisoners with mental illness in jails and prisons cost an estimated \$15 billion in 1996.<sup>69</sup> A California study concluded that the total impact of persons with mental illness on that state's criminal justice and corrections systems ranged from \$1.2 billion to a high of \$1.8 billion during 1993-94.<sup>70</sup>

Emergency rooms are experiencing a surge in patients with mental illness and a sharp increase in the practice of "boarding" people with mental illness. More than 80 percent of emergency room physicians surveyed by NMHA reported that the practice of boarding mental health patients negatively affects the care of other ER patients.<sup>71</sup>

The consensus among mental health advocates, providers and public policy researchers alike is that sweeping reforms, such as those identified in the President's New Freedom Commission on Mental Health, and a renewed funding commitment are needed to dramatically improve the nation's public mental health system.

**CHAPTER 4.0**  
**COMPARATIVE ANALYSIS**

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## 4.0 COMPARATIVE ANALYSIS

### Chapter Overview

This chapter compares Texas' investments in mental health services with those of other states. This analysis is based on the premise that a public mental health system cannot and should not be judged solely on spending alone, but that it is equally important to examine factors such as the "reach" of the system—the share of persons identified with mental illness actually being served—and the extent to which its resources are targeted to community treatment and prevention.

Since the organizational and funding structures of state public mental health systems vary so widely, our analysis begins with a brief overview of the selected systems and funding sources. Although each state's system is unique, most states face serious funding challenges and many are responding in similar ways, closing state institutions and shifting resources to the community; testing or fully adopting behavioral managed care; and coordinating mental health and substance abuse services. Many states also are embracing the evidence-based practices outlined in **Chapter 2** to improve patient outcomes and to stretch limited financial resources.

Following the individual state snapshots, the chapter compares Texas with selected states based on the following key indicators:

- current and historical mental health spending;
- eligibility for mental health services;
- percent of at-risk population being served; and
- program expenditures by type.

The chapter concludes with a discussion of key findings and conclusions.

### Methodology

The research team selected seven states for in-depth comparative analysis with Texas:

- Arizona;
- California;
- Florida;
- Illinois;
- New York;
- Ohio; and
- Pennsylvania.

These states were selected for a combination of reasons, including comparability in terms of population and economic and demographic characteristics. Some states resembled Texas in more than one criteria. For example, Arizona, like Texas, has a large Hispanic population and has experienced rapid population growth (**Exhibit 4-1**).

**EXHIBIT 4-1  
SELECTED STATE DEMOGRAPHICS, 1999–2003**

State	2003 POPULATION ESTIMATE	% CHANGE POPULATION (1990-2000)	% HISPANIC/ORIGIN 2000	% AFRICAN- AMERICAN 2000	MEDIAN HOUSEHOLD INCOME 1999	% BELOW POVERTY 1999
Arizona	5,580,811	40.0%	25.3%	3.1%	\$40,558	13.9%
California	35,484,453	13.6%	32.4%	6.7%	\$47,493	14.2%
Florida	17,019,068	23.5%	16.8%	14.6%	\$38,819	12.5%
Illinois	12,653,544	8.6%	12.3%	15.1%	\$46,590	10.7%
New York	19,190,115	5.5%	15.1%	15.9%	\$43,393	14.6%
Ohio	11,435,798	4.7%	1.9%	11.5%	\$40,956	10.6%
Pennsylvania	12,365,455	3.4%	3.2%	10.0%	\$40,106	11.0%
Texas	22,118,509	22.8%	32.0%	11.5%	\$39,927	15.4%
U.S	290,809,777	13.1%	12.5%	12.3%	\$41,994	12.4%

*Source: U.S. Census Bureau.*

MGT used a variety of sources for comparative data, including national information available from the federal Center for Medicare and Medicaid Services and information from the National Association of State Mental Health Program Directors (NASMHPD). The brief overview of individual state organizational structures and funding sources is based on information posted on individual state Web sites and follow-up telephone interviews with agency personnel. The comparisons also made use of state data profiles for fiscal 2002 developed by NASMHPD.

Spending and expenditure data come from NASMHPD’s fiscal 2001 Revenue and Expenditure Study, the most recent information available to the public. Revenues reported in the survey include only those that are directly controlled by the state’s mental health authority.

**State Organizational and Funding Profiles**

**Exhibit 4-2** illustrates the different locations of mental health programs within government and the degree to which these programs are co-located with substance abuse services.

**EXHIBIT 4-2  
STATE MENTAL HEALTH AGENCY STRUCTURE  
SELECTED STATES**

STATE	STATE MENTAL HEALTH AGENCY (SMHA)	SUBSTANCE ABUSE AND MENTAL HEALTH UNDER SAME AGENCY
Arizona	Arizona Department of Health Services	Yes
California	California Department of Mental Health	No
Florida	Florida Department of Children and Families	Under same umbrella department
Illinois	Department of Human Services	Under same umbrella department; active interagency agreement in place
New York	The New York State Office of Mental Health	Located in different state department; active interagency agreement in place
Ohio	Ohio Department of Mental Health	Located in different state department; active interagency agreement in place
Pennsylvania	Pennsylvania Department of Public Welfare	Alcohol Abuse Department is part of state mental health agency; substance abuse agency located in different state department
Texas	Department of State Health Services	Yes

*Source: National Association of State Mental Health Program Directors Research Institute, Inc.*

**Exhibit 4-3** compares the use of managed care for the delivery of behavioral health services. Five of the eight comparison states as well as Texas use managed care for some or all of their mental health services.

**EXHIBIT 4-3  
USE OF BEHAVIORAL MANAGED CARE BY SELECTED STATES**

STATE	BEHAVIORAL MANAGED CARE
Arizona	Yes
California	Yes
Florida	Yes
Illinois	No
New York	No
Ohio	Yes
Pennsylvania	Yes
Texas	Yes

*Source: National Association of State Mental Health Program Directors Research Institute, Inc.*

**Exhibit 4-4** illustrates the degree to which publicly funded mental health services in the comparison states are paid for with state general funds; federal funds including Medicaid and Medicare; and block grants and other sources.

**EXHIBIT 4-4  
STATE MENTAL HEALTH AUTHORITY-CONTROLLED  
MENTAL HEALTH REVENUES, BY REVENUE SOURCE  
FISCAL 2002**

State	STATE GR	MEDICAID	MEDICARE	MH BLOCK GRANT	OTHER FEDERAL	LOCAL GOV'T	1ST & 3RD PARTY	OTHER REVS.
Arizona	28%	63%	0%	1%	1%	0%	6%	1%
California	36%	46%	1%	1%	0%	0%	1%	15%
Florida	62%	11%	0%	4%	23%	0%	0%	0%
Illinois	65%	32%	1%	2%	0%	0%	0%	0%
New York	19%	61%	6%	1%	2%	0%	5%	4%
Ohio	60%	34%	1%	2%	2%	0%	0%	0%
Pennsylvania	65%	25%	1%	1%	6%	0%	1%	1%
Texas	65%	23%	3%	3%	1%	3%	2%	0%

*Source: National Association of State Mental Health Program Directors Research Institute, Inc.*

**Arizona**

The Arizona Department of Health Services' Division of Behavioral Health Services (ADHS/DBHS) is responsible for administration, planning, coordination, regulation and monitoring of the state's public behavioral health system.

ADHS/DBHS contracts with community-based organizations, known in Arizona as regional behavioral health authorities (RBHAs), to provide behavioral health services throughout the state. RBHAs function like health maintenance organizations, contracting with a network of providers to deliver a full range of services.

The state is divided into six geographical service areas served by five RBHAs. In addition, ADHS/DBHS has executed intergovernmental agreements with some of Arizona's Native American tribes to deliver behavioral health services to individuals living on reservations.

The state recently modernized and upgraded its only state hospital, adding a new 16-bed inpatient adolescent facility and a new 200-bed inpatient adult civil (i.e. non-criminal) facility.

In fiscal 2002, state general funds accounted for about 28 percent of all funding for Arizona's public mental health system; Medicaid accounted for 63 percent. County funds and tobacco litigation/settlement funds also are significant revenue sources.

## ***California***

The California Department of Mental Health is an independent agency charged with overseeing the state's mental health programs. The governor appoints its director and deputy director.

California has a decentralized service delivery system that places responsibility for most services with county mental health systems. Counties receive state funding that can be used for care delivered through state hospitals or community mental health services, and may retain any savings derived from lower usage of state hospital services. California has eight state hospitals, two of them inside state prisons.

In 1995, California began a managed mental health care demonstration project for Medi-Cal (the state's Medicaid program) recipients under a special federal waiver. Specialty mental health services—those requiring a mental health specialist—are “carved out” from the rest of the Medi-Cal managed care system. County mental health departments must develop their own mental health plans and are responsible for providing specialty mental health services in their areas, either directly or through contracted providers.

The California Department of Human Services oversees the state's mental health services. State general funds accounted for 36 percent of California's public mental health funding in fiscal 2002, while Medicaid paid for 46 percent; the remainder came from other sources including a portion of vehicle license fees.

In November 2004, California voters approved a Proposition 63, which established a 1 percent income tax increase for individuals earning more than \$1 million a year that will fund a wide range of mental health services throughout the state. The tax is estimated to raise about \$275 million during its first year and \$800 million annually thereafter.<sup>72</sup> The tax became effective on January 1, 2005.

## ***Florida***

The Mental Health Program Office within the Florida Department of Children and Families oversees the state's public mental health system.<sup>73</sup>

The office operates five state mental hospitals as well as 80 beds designated as state mental health treatment beds in another facility. Fifteen district mental health program offices located around the state coordinate community-based care. These district offices are similar to Texas' CMHMRCs in that they contract with local, community-based providers, agencies, facilities and hospitals to serve people with mental health, mental illness, behavioral or other issues.

In the area of managed care, Florida has implemented a statewide utilization management program to reduce Medicaid behavioral health spending for patients not enrolled in public HMOs. Local districts reportedly are integrating managed care techniques into their community-based services.

One initiative recently launched in Northeast Florida, the Florida Adult Mental Health Self-Directed Care program, allows persons with serious mental illness to control public mental health funds allotted for their treatment and directly purchase services from the vendor of their choice.

The major funding source for Florida's mental health system is state general funds, which accounted for 62 percent of revenues in fiscal 2002. Medicaid funds accounted for only 11 percent, with the remainder derived from other federal funds.

### ***Illinois***

The Illinois Department of Human Services' Division of Mental Health (DMH) is responsible for the state's mental health services. DMH funds 10 regional "Community Service Networks" to operate state hospitals and manage contracts with private providers who deliver community-based mental health programs. Illinois does not use managed care for behavioral health services.

Illinois Governor Rod Blagojevich recently proposed several major changes to the state's public mental health system, including a fee-for-service model for community services that would provide providers with a set fee for each specific service delivered; requests for proposals to select community mental health providers; and the elimination of funding for 120 state hospital beds.

In response, during the recent legislative session, mental health advocates, providers, and consumers organized a group called the Mental Health Summit.<sup>74</sup> The Mental Health Summit successfully fought a proposed 1 percent cut in community mental health funding; won a 4 percent "cost of doing business" increase for community providers serving persons with mental illness and developmental disabilities; and blocked a state proposal to convert the entire community mental health system to a fee-for-service model (a pilot program was adopted instead). Nonetheless, the governor used his veto power to cut more than \$20 million from the mental health budget, including funding for 120 state hospital beds.<sup>75</sup>

State general funds pay for the overwhelming majority of Illinois' public mental health system, accounting for 65 percent in fiscal 2002. Medicaid provides 32 percent of the state's mental health services and federal CMHS Mental Health Block Grant supply the remaining two percent.

### ***New York***

The New York State Office of Mental Health operates psychiatric centers across the state and also regulates, certifies and oversees more than 2,500 programs operated by local governments and nonprofit agencies.

Like most states, New York's mental health system has evolved from one relying primarily on state hospitals to a community-based system. Today, 99 percent of New Yorkers with mental illness who receive public services are served in the community.

## ***Comparative Analysis***

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In 2000, the Office of Mental Health began implementing Governor Pataki's "New Initiatives for Mental Health" program, which significantly increased funding for community-based mental health services in fiscal 2000 and 2001. These funds targeted programs such as high-intensity case management and housing services for adults with serious mental illnesses and children with serious emotional disturbances and their families.

In recent years, housing for persons with mental health needs has become a major issue in New York. The state has built thousands of housing units in the community.<sup>76</sup> The governor recently called for the establishment of a bipartisan Commission for the Closure of State Psychiatric Centers.<sup>77</sup>

Medicaid and Medicare funds pay for nearly two-thirds of the cost of New York's public mental health system, with Medicaid accounting for 61 percent and Medicare another 6 percent. State general funds accounted for only 19 percent of funding in fiscal 2001. Insurance companies and other payers account for another 14 percent.

### ***Ohio***

The Ohio Department of Mental Health (ODMH) oversees the state's public mental health system, including 50 county and multi-county boards and nearly 500 community mental health agencies. The boards, which usually oversee both mental health and addiction services, do not provide services directly. Instead, they act as local mental health authorities, funding, planning, monitoring and purchasing services from private providers and behavioral healthcare organizations (BHOs) operated by ODMH.

The BHOs provide inpatient services to adults at nine sites across Ohio's 88 counties, as part of an integrated system first introduced in the late 1990s. Outpatient Community Support Network services, another part of the system, are available to adults and children in 39 counties.

Ohio, too, has shifted from a state-hospital model to one emphasizing community care. Since 1988, the state has closed two ODMH hospitals and converted five, including three children's hospitals, to other uses. Three others were consolidated with other hospitals. Nine remaining campuses provide inpatient services across the state.

In response to a threatened funding crisis for mental health services, ODMH's director appointed the Ohio Commission on Mental Health Services in November 1999. In January 2001, the commission produced a comprehensive study and action plan called *Changing Lives: Ohio's Action Agenda for Mental Health*.<sup>78</sup> Since that time, Ohio policymakers have taken steps to respond to the commission's recommendations and have, for example, increased prevention activities, particularly those related to suicide.

State general funds provided 60 percent of Ohio's mental health revenues in fiscal 2002, while Medicaid accounted for about 34 percent. Other sources consisted of federal funds including Medicare and the CMHS Mental Health Block Grant.

## ***Pennsylvania***

The Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the delivery of public mental health services in the state.

OMHSAS operates nine state hospitals for persons with serious mental illness who require extended inpatient treatment. The department also operates a nursing home to provide long-term care for older people who no longer require psychiatric services but need nursing care.

County mental health/mental retardation program offices administer community mental health services, determine eligibility, and provide referrals for appropriate treatment. Local providers who contract with the county offices deliver most services.

Pennsylvania's mandatory Medicaid managed care program, HealthChoices, is the state's largest Medicaid program. HealthChoices includes a behavioral health program overseen by OMHSAS that provides mental health and substance abuse treatment services to eligible Pennsylvania residents. HealthChoices is being phased in across the state. For a variety of reasons, including their experience with mental health services, Pennsylvania county governments are being offered the "right of first opportunity" to contract with the state to manage the delivery of local mental health services.<sup>79</sup>

In 2004, the Pennsylvania Department of Public Welfare created a Children's Behavioral Health Taskforce to develop recommendations to improve the delivery, management and financing of its child behavioral health services. The task force includes providers, family members, mental health advocates, government officials, staffers, educators and others involved with children's mental health issues. The secretary of the Pennsylvania Department of Public Welfare has set a goal that at least half of the task force members be clients who use the state's mental health system.

In 2002, state general revenue (65 percent) and Medicaid (25 percent) supplied most of Pennsylvania's public mental health funding.

## ***State Profile Summary***

Most of the comparison states' mental health services either are co-located with the state's substance abuse program or work closely with the agencies overseeing these services. This approach seems to allow states to better serve individuals with both conditions. The 2003 reorganization of Texas' health and human service agencies also integrated mental health and substance abuse programs.

Six of the eight comparison states use managed care to deliver at least some mental health services, supporting a larger trend in healthcare to use "gatekeepers," providers who coordinate and manage patient care to manage costs and guarantee quality. The degree to which states use managed care varies, but most that do employ the technique to a greater extent than Texas.

## ***Comparative Analysis***

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Several comparison states exceed Texas in the use of federal funding for mental health services. Medicaid accounts for just 23 percent of Texas' mental health funds, compared to 34 percent in Ohio, 63 percent in Arizona, 46 percent in California and 61 percent in New York. Medicaid can help stretch state dollars further, allowing more people to receive the services they need.

### ***Current Mental Health Spending***

Given its large population, Texas can be expected to be among the top states in its total spending on mental health services. At \$833.0 million, Texas' mental health agency expenditures ranked fourth among the comparison states and seventh among all states in fiscal 2002 (**Exhibit 4-5**). Texas' total mental health expenditures were almost 70 percent higher than the national mean and more than three times higher than the national median.

The picture changes significantly, however, when the expenditure level is adjusted for population. In fiscal 2002, Texas ranked last among the eight comparison states and 49<sup>th</sup> among all states in per capita mental health spending. The per capita amount for Texas (\$38.46) was only 44 percent of the national mean and 55 percent of the national median.

Across the nation, state mental health agency expenditures represent a relatively small portion of total state expenditures, with the highest share among the comparison states being Pennsylvania's 4.7 percent (**Exhibit 4-6**). In 2002, Texas' mental health expenditures represented only 1.5 percent of all state spending, less than the share spent by six of the eight comparison states, and just 75 percent of the national average of two percent.

**EXHIBIT 4-5  
STATE MENTAL HEALTH AGENCY ACTUAL MENTAL HEALTH DOLLAR  
AND PER CAPITA EXPENDITURES, FISCAL 2002**

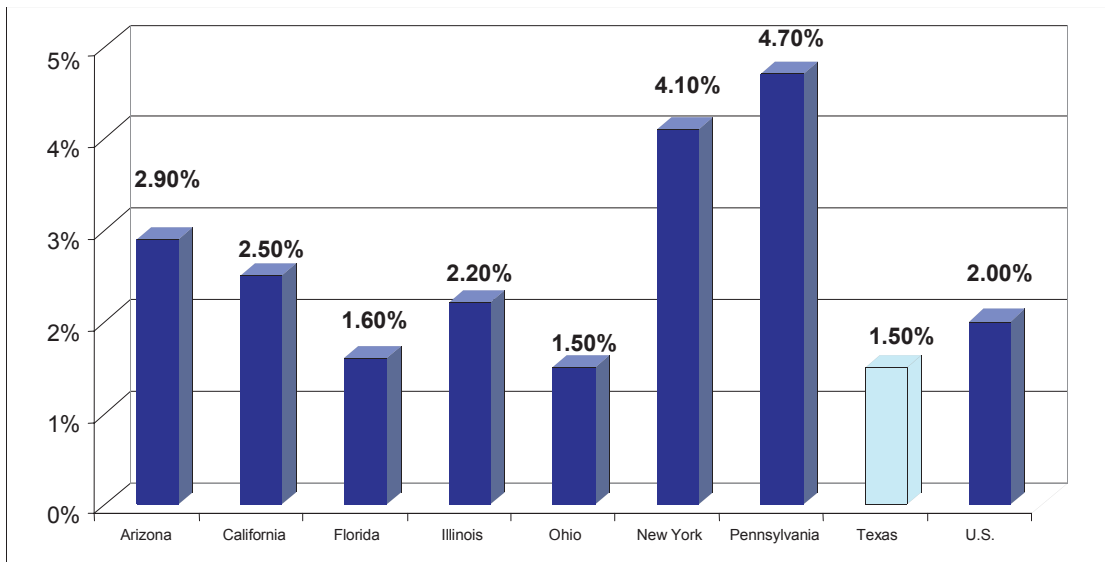
State	SMHA EXPENDITURE	NATIONAL RANK	PER CAPITA EXPENDITURE	NATIONAL RANK	NOTES
Arizona	\$553,200,000	14	\$101.78	15	b, d
California	\$3,656,318,656	1	\$104.61	14	b
Florida	\$736,268,491	9	\$44.24	46	NR
Illinois	\$865,200,000	6	\$68.79	31	
New York	\$3,526,800,000	2	\$184.32	2	b
Ohio	\$698,658,954	10	\$61.21	35	
Pennsylvania	\$2,052,809,103	3	\$166.48	3	a, c
Texas	\$833,000,000	7	\$38.46	49	b
U.S.	\$25,166,362,181				
U.S. Mean	\$493,458,082		\$87.65		

*Source: The National Association of State Mental Health Program Directors Research Institute, Inc.*

**NOTES:**

- a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
- b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
- c = Children's mental health expenditures are not included in SMH-controlled expenditures.
- d = SMHA-controlled expenditures include the "majority" of public housing provided to adults with serious mental illness and/or children with serious emotional disturbance.
- NR = No response from state.

**EXHIBIT 4-6  
MENTAL HEALTH EXPENDITURES AS A PERCENT OF  
TOTAL STATE EXPENDITURES, FISCAL 2002**



*Source: The National Association of State Mental Health Program Directors Research Institute, Inc.*

**Comparative Analysis**

**Historical Mental Health Spending**

Whether Texas' spending is compared in terms of current or constant dollars, from 1981 to 2002 the state ranked either last or second to last among the comparison states in per capita mental health spending. Texas also remained well below the national average (**Exhibit 4-7**).

In current dollars, Texas' per capita spending almost tripled from 1981 to 2002. The *actual* value of that spending, however, declined by 15 percent after inflation.

Between 1981 and 2002, states across the nation lost an average of 5.4 percent in inflation-adjusted per capita spending for mental health services. In that period, Texas and four of the comparison states experienced declines in inflation-adjusted per capita spending, while three comparison states reported increases.

**EXHIBIT 4-7  
STATE MENTAL HEALTH AGENCY PER CAPITA EXPENDITURES 1981-2002**

State	CHANGE 1981 TO 2002 CURRENT DOLLARS				CHANGE 1981 TO 2002 CONSTANT "1990" DOLLARS			% CHANGE '81 TO '02	NOTES
	FY'81	FY'90	FY'02	% Change '81 to '02	FY'81	FY'90	FY'02		
Arizona	\$9.99	\$27.27	\$101.78	273.3%	\$19.61	\$27.27	\$57.94	195.5%	
California	\$28.41	\$42.32	\$104.61	147.2%	\$55.79	\$42.32	\$59.55	6.7%	
Florida	\$19.89	\$37.49	\$44.24	18.0%	\$39.06	\$37.49	\$25.18	-35.5%	NR
Illinois	\$17.83	\$34.43	\$68.79	99.8%	\$35.02	\$34.43	\$39.15	11.8%	
New York	\$66.84	\$118.34	\$184.32	55.8%	\$131.24	\$118.34	\$104.92	-20.1%	a, b
Ohio	\$24.72	\$40.93	\$61.21	49.6%	\$48.53	\$40.93	\$34.84	-28.2%	
Pennsylvania	\$40.54	\$56.85	\$166.48	192.8%	\$79.61	\$56.85	\$94.76	19.0%	c
Texas	\$13.08	\$22.72	\$38.46	69.2%	\$25.69	\$22.72	\$21.89	-14.8%	b
U.S. Average	\$26.86	\$48.14	\$87.65	80.5%	\$52.73	\$48.14	\$49.89	-5.4%	

**Source:** *The National Association of State Mental Health Program Directors Research Institute, Inc.*

**NOTES:**

a = Medicaid Revenues for Community Programs are not included in SMHA-controlled expenditures.

b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.

c = Children's mental health expenditures are not included in SMHA-controlled expenditures.

d = SMHA-controlled expenditures includes the "majority" of publicly supported housing provided to adults with serious mental illness and/or children with serious emotional disturbance.

NR = No response from state to the footnote questions.

**Prevalence Rates**

“Prevalence rates” represent the share of the population with a serious mental illness or, in the case of children, a serious emotional disturbance. As such, they are a primary indicator of the need for mental health services. Texas’ prevalence rates are in line with those reported by most of the comparison states and with the national median (**Exhibit 4-8**).

**EXHIBIT 4-8  
PREVALENCE RATES FOR ADULTS WITH SERIOUS MENTAL ILLNESS  
AND CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE, 2002**

STATE	ADULTS	CHILDREN
Arizona	2.6%	5.9%
California		9.0
Florida		7.9
Illinois	5.4	7.0
New York	1.5	2.0-5.0
Ohio	5.6	
Pennsylvania	6.45	5.7
Texas	5.4	9.0-13.0
US Median	5.4	8.0

**NOTE:** Rates presented are estimates used by each state in developing mental health block grant application.

**Source:** National Association of State Mental Health Program Directors Research Institute, Inc.

**Eligibility for Mental Health Services**

Although prevalence rates do not vary widely among the states, the share of the population with mental illness that actually qualifies for publicly funded mental health service varies significantly.

All states use specific criteria to determine eligibility for mental health services. These criteria vary within and across states based on the source of funding for each service or type of service.

For example, eligibility criteria for Medicaid services differ from those for services available through the Children’s Health Insurance Program. And eligibility requirements for specific services such as crisis services may be very different from those for ongoing rehabilitation or case management.

## ***Comparative Analysis***

Most states limit eligibility for state-funded mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Factors such as specific diagnoses, functional levels and prior histories are used to define these terms. In 2002, Texas and most of the comparison states used specific diagnoses and assessments of functional level to determine eligibility for state-funded mental health services (**Exhibit 4-9**).

As noted earlier, however, the 2003 Texas Legislature adopted a more restrictive definition of eligibility, eliminating consideration of functional levels and with few exceptions limiting services to adults with bipolar disorder, schizophrenia or clinically severe depression.

### **EXHIBIT 4-9 STATE MENTAL HEALTH AGENCY ELIGIBILITY CRITERIA FOR MH SERVICES, 2002**

STATE	SMI ADULTS	SED CHILDREN
Arizona	Specific Diagnoses & Functional Level	Specific Diagnoses
California	Varies	Varies
Florida	Specific Diagnoses & Functional Level	Specific Diagnoses & Functional Level
Illinois	Specific Diagnoses & Functional Level	Specific Diagnoses & Functional Level
New York	Specific Diagnoses & Functional Level	Specific Diagnoses & Functional Level
Ohio	Specific Diagnoses & Utilization Pattern	Specific Diagnoses & Functional Level
Pennsylvania	Specific Diagnoses, Functional Level, Treatment History, Homelessness, & Criminal History	Specific Diagnoses, Functional Level, and Treatment History
Texas*	Specific Diagnoses	Specific Diagnoses

**NOTE:** Texas' criteria reflect 2003 legislative change limiting criteria for eligibility to specific diagnoses.

**Source:** *National Association of State Mental Health Program Directors Research Institute, Inc.*

**Exhibit 4-10** compares the estimated share of adults and children in Texas and the comparison states who meet each state's criteria for publicly funded mental health services. In some states, all persons with mental illness are potentially eligible for publicly funded services. Others define the eligible population so that only a subset receives help.

Of the states that reported information on eligibility, Texas' criteria are among the narrowest, qualifying less than half of the adult population with a potential need for mental health services. The share of children qualified is even lower, at 28 percent.

Texas' eligibility criteria for services were stringent before the changes of 2003. Now they are even narrower.

**EXHIBIT 4-10  
ELIGIBILITY FOR STATE MENTAL HEALTH SERVICES, 2002**

STATE	# OF ELIGIBLE ADULTS	% OF ADULTS W/MENTAL ILLNESS	# OF ELIGIBLE CHILDREN	% OF CHILDREN W/MENTAL ILLNESS
Arizona	306,389	N/A	364,271	N/A
California	N/A	N/A	N/A	N/A
Florida	782,770	87%	295,306	100%
Illinois	494,543	100%	97,741	85%
New York	N/A	N/A	N/A	N/A
Ohio	473,760	100%	163,648	100%
Pennsylvania	N/A	N/A	N/A	N/A
Texas	403,016	48%	150,994	28%

NOTE: N/A = data not available.

Source: RH2 Consulting.

**Clients Served**

In 2002, Texas—the nation's second most-populous state—ranked sixth among the comparison states in its number of adults receiving state-funded mental health services, and fourth in the number of children served (**Exhibit 4-11**). In terms of the *share* of the eligible population served, Texas ranked roughly in the middle among the comparison states that provided estimates. As we have seen, however, Texas defines eligibility to include fewer than half of the adults and only about a quarter of the children considered to have a diagnosable mental disorder.

Therefore, although Texas serves about 25 percent of its “priority population,” it serves only 12 percent of adult Texans with a diagnosable mental illness, and about 6 percent of its children with emotional disturbance.

**EXHIBIT 4-11  
UNDUPLICATED COUNT OF CLIENTS WITH ANY  
MENTAL ILLNESS RECEIVING MENTAL HEALTH SERVICES, 2002**

State	# ELIGIBLE ADULTS	ADULTS SERVED	% OF ELIGIBLE ADULTS SERVED	# ELIGIBLE CHILDREN	CHILDREN SERVED	% ELIGIBLE CHILDREN SERVED
Arizona	306,389	65,903	22%	364,271	15,599	4%
California	N/A	413,182	N/A	N/A	214,849	N/A
Florida	782,770	140,010	18%	295,306	25,667	9%
Illinois	494,543	130,425	26%	97,741	36,480	37%
New York	N/A	36,119	N/A	N/A	2,551	N/A
Ohio	473,760	36,119	8%	163,648	2,551	2%
Pennsylvania	N/A	170,201	N/A	N/A	98,478	N/A
Texas	403,016	112,700	28%	150,994	39,212	26%

**Source:** National Association of State Mental Health Program Directors Research Institute, Inc.

**Expenditures by Program Type**

**Exhibit 4-12** examines total mental health expenditures by type of program in the eight comparison states and the nation. Consistent with its population size and total spending, Texas ranks in the top ten among *all* states in each category of mental health expenditure. But the picture changes dramatically when *per capita* expenditures are examined. On a per capita basis, Texas ranked 49th overall in 2002.

**Exhibit 4-13** examines per capita expenditures by type of program. In fiscal 2002, Texas spent 39 cents of every mental health care dollar on state hospital inpatient services, and 58 cents on community-based programs (**Exhibit 4-13**). The national average, by contrast, was 30 cents for state hospitals and 67 cents for community programs. Texas' share of funding spent on state hospitals was higher than in all but one of the comparison states; the share spent on community-based programs was lower than in all but one.

In fiscal 2002, Texas spent about two cents of every mental health dollar on prevention, research and training, and ranked second only to New York, both nationally and among the comparison states, in this category. The 2003 Legislature, however, cut funding for research, and Texas' relatively high ranking is likely to drop significantly.

***Administrative Costs***

Texas spends only two cents of every dollar on administration, which is comparable to the national average and the amounts spent by half of the comparison states. At 72 cents, the per capita amount spent for administration in Texas is lower than all but one of the comparison states.

**EXHIBIT 4-12**  
**TOTAL STATE MENTAL HEALTH AGENCY CONTROLLED**  
**MENTAL HEALTH EXPENDITURES BY TYPE OF PROGRAM, FISCAL 2002**  
**(\$ MILLIONS)**

Arizona	\$55.80	32	10%	\$485.40	9	88%	\$0.30	16	0%	\$11.70	18	2%	\$553.20	14
California	\$625.94	2	17%	\$2,997.15	1	82%	\$0.00	0	0%	\$33.23	2	1%	\$3,656.32	1
Florida	\$390.51	4	53%	\$336.21	15	46%	\$0.00	0	0%	\$9.55	21	1%	\$736.27	9
Illinois	\$280.40	9	32%	\$566.30	6	65%	\$0.90	14	0%	\$17.60	8	2%	\$865.20	6
New York	\$1,052.80	1	30%	\$2,327.60	2	66%	\$58.10	1	2%	\$88.30	1	3%	\$3,526.80	2
Ohio	\$188.28	12	27%	\$481.65	10	69%	\$2.26	10	0%	\$26.47	6	4%	\$698.66	10
Pennsylvania	\$398.73	3	19%	\$1,638.52	3	80%	\$3.50	7	0%	\$12.06	15	1%	\$2,052.81	3
Texas	\$325.60	6	39%	\$479.50	11	58%	\$12.50	3	2%	\$15.40	11	2%	\$833.00	7
U.S. Average	\$149.90		35%	\$331.04		61%	\$2.40		1%	\$10.16		3%	\$493.46	

**Source:** *The National Association of State Mental Health Program Directors Research Institute, Inc.*

**NOTES:**

Note: "Community Services" includes expenditures from state mental hospitals for ambulatory and residential services.

a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures

b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.

c = Children's mental health expenditures are not included in SMHA-controlled expenditures.

**EXHIBIT 4-13  
PER CAPITA STATE MENTAL HEALTH AGENCY  
CONTROLLED EXPENDITURES BY PROGRAM TYPE, FISCAL 2002**

Arizona	\$10.27	50	10%	\$89.31	8	88%	\$0.06	19	0%	\$2.15	14	2%	\$101.78	15
California	\$17.91	41	17%	\$85.75	9	82%	\$0.00			\$0.95	31	1%	\$104.61	14
Florida	\$23.46	32	53%	\$20.20	47	46%	\$0.00			\$0.57	39	1%	\$44.24	46
Illinois	\$22.29	33	32%	\$45.02	25	65%	\$0.07	18	0%	\$1.40	26	2%	\$68.79	31
New York	\$55.02	3	30%	\$121.65	4	66%	\$3.04	2	2%	\$4.61	6	3%	\$184.32	2
Ohio	\$16.50	44	27%	\$42.20	28	69%	\$0.20	16	0%	\$2.32	13	4%	\$61.21	35
Pennsylvania	\$32.34	15	19%	\$132.88	2	80%	\$0.28	13	0%	\$0.98	29	1%	\$166.48	3
Texas	\$15.03	45	39%	\$22.14	43	58%	\$0.58	8	2%	\$0.71	35	2%	\$38.46	49
U.S. Average	\$26.63		30%	\$58.80		67%	\$0.82		1%	\$1.84		2%	\$87.65	

**Source:** *The National Association of State Mental Health Program Directors Research Institute, Inc.*

**NOTES:**

Note: "Community Services" includes expenditures from state mental hospitals for ambulatory and residential services.

a = Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures

b = SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

c = Children's Mental Health Expenditures are not included in SMHA-Controlled Expenditures

## **Summary of Findings and Conclusions**

The research team's comparisons yielded the following key findings:

- In recent years, many state mental health systems have resorted to similar policy initiatives to control costs and improve patient outcomes. Popular reforms include the use of evidence-based practices and the use of managed care (six of the eight comparison states have adopted some level of behavioral managed care).
- The eight comparison states use a variety of sources to finance their public mental health systems, the two most significant being general revenue and Medicaid. Several states, including Pennsylvania and Illinois, are similar to Texas in that Medicaid accounts for a relatively small portion of their total funding for public mental health services.
- Mental health programs accounted for a relatively small portion of total state expenditures in all the states reviewed. Texas, however, spends a smaller share of its state funds on mental health services than all of the comparison states except Florida, and spends only 75 percent of the national average.
- Due to its large population, Texas is near the top of the list in total dollars spent for mental health services (\$833 million in fiscal 2002). The picture changes dramatically, however, when expenditures are placed on a per capita basis. In fiscal 2001, Texas spent \$38.46 per client on mental health services, placing the state last among the eight comparison states and 49<sup>th</sup> among in the nation. Texas' per capita spending was only 44 percent of the national average.
- Whether spending is compared in current or constant dollars, from 1981 to 2002, Texas ranked either seventh or eighth among the eight comparison states in per capita mental health spending. Texas per capita expenditures remained well below the U.S. average during this period.
- After adjusting for inflation, Texas spent almost 15 percent less on mental health in fiscal 2002 than it did in 1981. While many states lost ground in a similar fashion, Texas' inflation-adjusted losses were higher than the national average.
- All of the eight comparison states have adopted eligibility criteria for publicly funded mental health services. Texas', however, are particularly narrow and restrictive. As a result of changes enacted in 2003, less than half of Texas adults with mental illness and fewer than 28 percent of the state's children with emotional disturbance are eligible for services. Of those eligible, only about a quarter actually receive services.

## ***Comparative Analysis***

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- Despite extensive deinstitutionalization, Texas spends more of its mental health funding on state hospital services and less on community-based programs than the national average. Of every dollar spent in Texas in fiscal 2002, 39 cents went to state hospital inpatient services and 58 cents to community-based programs.
- Texas has consistently ranked in the bottom five among the comparison states for per capita mental health spending in all program areas except for research. Cuts made in 2003 should wipe out even this modest distinction.
- Several of the comparison states funded a greater percentage of their mental health services with Medicaid dollars than did Texas. Increasing the use of Medicaid funds for mental health services may allow Texas to help more people.



**CHAPTER 5.0**  
**MENTAL HEALTH CARE OUTSIDE**  
**DSHS**

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## 5.0 MENTAL HEALTH CARE OUTSIDE DSHS

### Chapter Purpose and Overview

While the Department of State Health Services is Texas' lead mental health agency, other state agencies and programs play important roles as well. This chapter describes them, with a special focus on criminal justice.

As noted above, DSHS assumed responsibility for mental health and substance abuse services in 2004, following the state's HHS reorganization. For fiscal 2004, the Legislature appropriated about \$722.3 million to DSHS. This amount appropriated to DSHS, however, represents *less than a third* of the state's total direct costs for mental health care.

Some of these "outside" costs support services or programs, such as school-based mental health counseling, which enhance or complement services provided by DSHS. But just as many costs arise because the system failed to provide services at crucial junctures. For example, thousands of Texans with mental illness who do not receive care for their illnesses end up being cared for in the criminal justice system or local emergency rooms.

This has been an ongoing problem for the hospital, but it seems that it's gotten much worse in the past year. It seems the state doesn't view psychiatric problems as "real" problems. We'll call a state hospital and they'll tell us they have no room. We then have to call in law enforcement to transport a patient across the state. Everybody loses. The patients aren't getting the care they need and the community is incurring costs it can't afford.

-Quinn Robinson, M.D.,  
Emergency Room Physician.

The first section of this chapter reviews the programs and expenditures of four HHS and education agencies:

- Texas Health and Human Services Commission (HHSC);
- Texas Education Agency (TEA);
- Texas Department of Assistive and Rehabilitation Services (DARS); and
- Texas Department of Family and Protective Services (DFPS).

Due to the special relationship between mental illness and the criminal justice system, the issue is addressed separately. The second section examines mental health-related programs and expenditures at:

- the Texas Department of Criminal Justice (TDCJ);
- the Texas Juvenile Probation Commission (JPC);
- the Texas Youth Commission (TYC); and
- the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).

Local governments also must care for persons with mental illness, funding their services directly, through community clinics or homeless shelters, or indirectly, through jails and public safety-related activities.

While there are no comprehensive, consistent data documenting local spending on mental health services, the review team analyzed selected county budgets to gather examples. It found that a number of facilities and programs provide psychiatric and mental health counseling services, including county mental health mental retardation centers, juvenile detention centers, homeless shelters, substance abuse programs, hospital districts and victim services programs.

For instance:

- Harris County spent \$22,786,886 in fiscal 2004 to fund its Mental Health Mental Retardation Authority, which provides counseling services and a 24-hour emergency psychiatric hospital serving Harris County.
- In fiscal 2003, Dallas County spent \$4,781,306 on its Health and Social Service Department's mental health program. In addition, the county shares certain mental health responsibilities with Dallas MetroCare Services, an agency whose board is appointed by the county commissioner's court. The county also participates in the state's NorthSTAR program for managed mental health care.
- The city of Austin budgeted \$1,950,744 for mental health services delivered through its Health and Human Services Department in fiscal 2004. This did not include spending by other areas of city government such as, for example, the Police Department's Victim Services Division.

The research team also conducted a brief e-mail survey of local government budget officers, asking a series of specific questions related to local mental health spending and the impact of recent state budget actions. Due to a low response rate, however, the review team instead conducted telephone interviews with officials of several large Texas counties. Highlights of those interviews include the following:

- Harris County reported that state funding cuts and unfunded mandates have made it difficult to support an adequate HHS infrastructure. The county described the increased impact of mental health costs on the sheriff's budget as "staggering" and estimated that it is experiencing 25 percent annual increases in spending on psychotropic and anti-depressant medications.

I am encouraged by the Legislature's desire to find ways to save money in the administration of health and human service. I am hopeful that any cost savings will be shared with counties in an effort to increase the volume of mental health services in those areas. As it is, Harris County continues to struggle to maintain services while meeting state requirements, all with fewer dollars. I want to partner with the state to meet the needs in our community, but there must be a change. The current situation results in inequitable funding allocations, a revolving door between emergency services and outpatient waiting list, growing numbers of consumers turning up in our jail, and fewer services to meet these growing needs.

-Judge Robert Eckels  
Harris County

- Dallas County reported that state providers are dropping out of the NorthSTAR behavioral managed care network because Value Options (the NorthSTAR contractor) has reduced reimbursement rates four times in response to state budget cuts. A growing number of providers believe that it costs them more to participate in NorthSTAR than they can earn through reimbursements.
- Bexar County has developed a federally funded and nationally recognized program to keep persons with mental illness out of its jail. The program involves a partnership with University Health System, which operates a 24/7 crisis unit to treat minor offenders. Last year, the program screened about 30,000 individuals, of whom about 20 percent required hospitalization. Before the program's creation, minor offenders that appeared to have a mental illness were transferred to the jail or local emergency room. Previously, the county spent an estimated \$400,000 annually in overtime to pay law enforcement officers to wait with offenders in emergency rooms. The program has reduced these costs, as well as the number of homeless people with mental illness in jail.

### **Methodology**

Discussions with experts on Texas' public mental health system helped the research team identify a number of state agencies that supply mental health services.

To collect general information on each agency's purpose, programs and clients, as well as its services and expenditures, the team reviewed agency and consultant publications and documents and conducted in-person and telephone interviews with state agency staff. The team also submitted special data requests to state and local agencies to gather expenditure data.

With few exceptions, however, the team found that agencies other than DSHS do not routinely collect or report specific information about clients with mental health needs or expenditures for such services.

There are several reasons for this lack of data. First, serving people with mental illness is not these agencies' primary mission, and capturing client and expenditure data specific to mental health services is not a feature of their information and reporting systems. Second, the cost of mental health services may be intermingled in expenditures that cover an array of services, such as Medicaid managed care and CHIP provider reimbursements. Similarly, funding for programs that include mental health services may be distributed to service providers in aggregate or via a formula that does not separately consider mental health services, such as special education funding.

Also, agency clients may receive mental health services that are administered and funded by another agency; expenditures for these clients would not be included in the budget of the agency overseeing the client's services. This applies to Medicaid-eligible clients of the Department of Family and Protective Services. Finally, mental health services may be such a small component of expenditures that the costs are simply folded into a larger general budget for client services.

To assess the intersection between mental illness and the criminal justice system, MGT interviewed several officials and former officials of state and local criminal justice agencies, including the director of the Texas Correctional Office on Offenders with Medical or Mental Impairments. These officials described the burdens placed on their agencies by persons with mental illness. They noted that for many offenders, jail or prison is simply not an appropriate treatment setting, although there may be no alternative to incarceration for some.

### **State Agency Mental Health Spending (Other than Criminal Justice)**

State agencies other than DSHS come into contact with individuals who need mental health services for a variety of reasons. For example, children may receive mental health services through public school, if their conditions interfere with their ability to succeed academically.

This section briefly describes the populations served and encountered by selected Texas state agencies; the services they receive; the amounts spent on these services (when available); and the way in which these services fit into the agencies' larger missions.

### ***Health and Human Services Commission***

HHSC oversees the policies and operations of HHS agencies involved in the delivery of mental health services and directly administers Medicaid and the Children's Health Insurance Program.

**Medicaid:** In February 2004, Medicaid provided about 2.5 million Texans with health insurance or long-term care services.<sup>80</sup> HHSC expects state and federal funding for Texas Medicaid to total about \$15.5 billion in fiscal 2004, representing 26.1 percent of all state spending.<sup>81</sup> The federal government provides about 60 percent of Medicaid costs.

Medicaid funds a wide range of medical and long-term care services for various low-income groups who meet specific eligibility criteria. The three primary categories of Medicaid-eligible clients are families and children; the aged and disabled; and cash assistance recipients (such as those receiving Temporary Aid to Needy Families or Supplemental Security Income). Medicaid benefits include a mandatory set of services required by federal law and a set of optional benefits that states may choose to provide.

Behavioral health benefits available through Texas Medicaid include:

- therapy by psychiatrists;
- therapy by psychologists, licensed professional counselors, advanced clinical practitioners, and licensed marriage and family therapists for persons under age 21;
- inpatient care in a general hospital;
- inpatient care in psychiatric hospitals, for persons under the age of 21 and 65 and older;
- outpatient chemical dependency counseling;
- prescription medicines (limit of three);
- rehabilitative and targeted case management services for people with severe and persistent mental illness and children with severe emotional disturbance;
- services required to diagnose or treat behavioral health conditions; and
- the care and treatment of behavioral health conditions by a primary care physician.

**Exhibit 5-1** illustrates expenditures related to mental health services paid under Medicaid's fee-for-service program only. It does not include Medicaid managed care or vendor drug expenditures. Managed care expenditures represent a capitated (per-patient) rate covering other expenses as well, making it difficult to separate those specifically related to mental health. Vendor drug expenses for mental health are unavailable. As a result, the exhibit captures only a part of HHSC's costs for Medicaid-covered mental health services.

Both expenditures and client rolls for Medicaid fee-for-service mental health expenditures rose steadily from fiscal 1999 through 2003.

**EXHIBIT 5-1  
MEDICAID FEE-FOR-SERVICE EXPENDITURES AND MENTAL HEALTH  
CLIENT COUNTS, FISCAL 1999-2003  
(Amounts in millions)**

	ADULTS INPATIENT		ADULTS OUTPATIENT		CHILDREN INPATIENT		CHILDREN OUTPATIENT	
	Expenditures	Clients	Expenditures	Clients	Expenditures	Clients	Expenditures	Clients
1999	\$36.5	6,944	\$76.2	86,262	\$9.1	1,341	\$37.1	59,904
2000	\$35.9	6,693	\$86.6	89,337	\$9.0	1,366	\$47.7	61,517
2001	\$38.0	7,167	\$97.4	96,952	\$13.4	1,956	\$52.0	64,665
2002	\$39.6	8,718	\$86.9	107,619	\$13.3	2,444	\$62.5	76,150
2003	\$42.1	9,657	\$95.4	117,108	\$13.2	2,412	\$74.6	90,971
Total	\$192.1	39,179	\$442.5	497,278	\$58.0	9,519	\$273.9	353,207

*Source: Texas Health and Human Services Commission.*

**Children’s Health Insurance Program:** Like Medicaid, CHIP is funded through a state and federal partnership. The federal government supplied 72.15 percent of CHIP costs in fiscal 2004.

CHIP serves children whose families earn too much to qualify for Medicaid, but cannot afford private health insurance. To qualify, a child must be uninsured, under 19 years of age, a Texas resident and an American citizen; in addition, his or her family must meet specific asset and income requirements. Most families participating in CHIP pay a monthly premium to cover all their children. Some also must provide co-payments for physician visits, brand-name prescription medications and emergency care. CHIP covers an array of health care services, but does not include dental or vision care.

Between fiscal 1999 and 2003, the state’s CHIP caseload rose steadily. In fiscal 2003, the caseload averaged 506,968 children per month, but dropped by almost 20 percent, to a monthly average of 409,865, in fiscal 2004.<sup>82</sup> This reduction reflected several of the 2003 Legislature’s cost-cutting measures, such as a shift from a 12-month to six-month eligibility period for services and a new 90-day waiting period imposed between the determination of eligibility and the beginning of coverage.

CHIP originally allowed mental health benefits including 45 inpatient days and 60 outpatient visits per child per year. The 2003 cuts, however, eliminated mental health services from the CHIP benefit package. As a result, nearly 57,000 children lost their mental health coverage on September 1, 2003.<sup>83</sup> **Exhibit 5-2** describes the changes in CHIP benefits in 2003 in more detail.

**EXHIBIT 5-2  
PARTIAL RESTORATION OF MENTAL HEALTH AND SUBSTANCE ABUSE  
BENEFIT TO CHIP**

<b>CHIP MENTAL HEALTH BENEFIT PRIOR TO 9/1/03 (BASED ON ANNUAL ENROLLMENT)</b>	<b>CHIP MENTAL HEALTH BENEFIT AS OF 9/1/03 (BASED ON 6-MONTH ENROLLMENT)</b>	<b>PARTIAL MENTAL HEALTH BENEFIT RESTORATION 2/1/04</b>
<p>60 days outpatient/year for crisis stabilization, evaluation and treatment.</p> <p>45 psychiatric inpatient days plus 60 days rehabilitative day treatment per year.</p> <p>25 days of inpatient benefits can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient mental health services (partial hospitalization or rehabilitative day treatment) on the basis of financial equivalence with the inpatient per diem cost. (20 of the inpatient days must be held in reserve for inpatient use only.)</p> <p>The 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalency against the day treatment per diem cost.</p>	<p>One psychiatric consultation after stabilization of an emergency situation</p> <p>Six medication management visits (psychiatrist)</p>	<p>30 outpatient visits per 12-month period</p> <p>30 psychiatric facility inpatient days per 12-month period</p> <p>Allowance for community mental health centers to provide care above these limits with certified match drawing federal CHIP funds</p> <p>Allow cost-neutral conversion between inpatient and outpatient visits. Must hold in reserve 10 hospital days for emergency (i.e., cannot convert to additional outpatient visits).</p>

**Source:** *Mental Health Association in Texas, January 2005.*

These benefits were partially restored on February 1, 2004, to allow 30 days of inpatient mental health treatment and 30 outpatient mental health visits per year. Retroactive coverage became available to children enrolled in CHIP from September 1, 2003 through January 31, 2004. The 90-day waiting period remains.

The CHIP mental health benefit allows for some flexibility, in that unused inpatient days can be converted to extra outpatient visits and vice versa, as long as the conversion does not increase the state's costs. This flexibility helps ensure that mental health care can be structured in a way that best meets each child's needs.

### ***Texas Education Agency***

Schools play a key role in the early identification of mental health problems among students and can provide links to needed services.

TEA funds and oversees special education services provided by local independent school districts to children with serious emotional disturbance, or SED. Students referred for special education services must meet eligibility criteria established by the federal Individuals with Disabilities Education Act (IDEA). These funds are available for students with mental retardation, SED, autism, traumatic brain injury, certain learning disabilities and other conditions not related to mental impairment. The federal government allocates IDEA funds to the states based on a formula in federal law which includes consideration of the total child population in the state between the ages of three and 21, and the state's poverty rate. Federal law allows states to determine how they will distribute federal and state funds to local districts.<sup>84</sup>

In Texas, funds are distributed to school districts based on the "instructional arrangement" (or placement) the child is in. Instructional arrangements include mainstream, resource room, self-contained, hospital class, residential care and treatment facility, and others.<sup>85</sup>

A multi-disciplinary team assesses each referred child's condition and needs. The results of this assessment are presented to the student's Admission, Review and Dismissal (ARD) committee, which determines whether the child has a disability and an educational need. If a child's disability does not impair their academic performance, they do not qualify for IDEA-funded services.

If the student is eligible for special education services, the ARD committee develops an individual education plan for the student listing the school-based services and educational accommodations he or she will receive. These services, tailored to the needs of the individual student, are available without charge to the student or family. Ideally, the services provide students with the least restrictive educational environment possible, and allow them to remain at the appropriate grade level with their peers.

According to TEA, enrollment in Texas public school districts totaled 4,239,911 at the beginning of the 2003-04 school year. Students receiving special education services accounted for 509,401 or 12 percent of total enrollment. A total of 36,444 students were identified as qualifying for special education services on the basis of a primary disability of emotional disturbance. Students with SED accounted for 7.15 percent of the special education services population and 0.9 percent of total enrollment in Texas public schools.<sup>86</sup> Interestingly, students who have a secondary diagnosis of SED and another primary diagnosis are counted under the primary diagnosis, and therefore, these figures may underrepresent the number of Texas schoolchildren needing mental health services.

The share of special education students compared to total students enrolled has remained fairly steady in the last few years, as has the share of special education students with a primary disability of SED (**Exhibit 5-3**).

**EXHIBIT 5-3**  
**TEXAS STUDENTS IN SPECIAL EDUCATION, 1999-2004**

SCHOOL YEAR	# ENROLLED IN SPECIAL EDUCATION	% OF TOTAL ENROLLMENT	# WITH SED	% TOTAL ENROLLMENT	% SPECIAL EDUCATION ENROLLMENT
1999-00	490,220	12.2	35,728	0.9	7.3
2000-01	492,391	12.1	35,367	0.9	7.2
2001-02	493,771	11.9	35,475	0.9	7.2
2002-03	500,579	11.8	35,748	0.8	7.1
2003-04	509,401	12.0	36,444	0.9	7.1

*Source: Texas Education Agency.*

***Department of Assistive and Rehabilitative Services***

DARS became operational on March 1, 2004. The agency absorbed all the powers and duties of the former Texas Rehabilitation Commission, Texas Commission for the Blind, Texas Commission for the Deaf and Hard of Hearing and Interagency Council on Early Childhood Intervention.

The agency's Vocational Rehabilitation Program (VR) helps people with physical or mental disabilities prepare for, find and maintain employment. Persons may be eligible for the program if they:

- have a disability making it difficult to obtain employment;
- need vocational rehabilitation services to prepare for, secure or maintain a job; and
- are able to secure or maintain a job after receiving services.

Mental illness qualifies as a disability for the purposes of receiving VR services. DARS provides functional assessments for persons with mental illness to determine the nature and degree of disability and the individual's job capabilities. Although it is not routine, DARS may pay for short-term therapeutic treatment consisting of up to 15 outpatient visits for a VR client with mental illness, if the treatment is directly related to obtaining or maintaining employment. VR clients also may be eligible for mental health services provided and funded by other entities.

In fiscal 2004, DARS served 126,195 VR clients.<sup>87</sup> The fiscal 2004 budget for the VR program was about \$170 million. Of that amount, \$105.1 million was budgeted for client services.<sup>88</sup>

DARS' Independent Living Services (ILS) Program also may serve individuals with mental illness. ILS offers an array of services, including counseling and guidance, to help individuals live independently. To qualify for ILS, persons must:

- have a significant physical or mental disability that interferes with their ability to function independently in the family or the community;
- have a reasonable chance of living more independently as a result of ILS; and
- be ineligible for VR services.

The fiscal 2004 ILS budget was \$2.6 million, with \$2.3 million of that allocated to services for 2,237 individuals.<sup>89</sup>

### ***Department of Family and Protective Services***

DFPS was created from the Texas Department of Protective Services on February 1, 2004. The agency's mission is to protect children, the elderly and persons with disabilities from abuse, neglect and exploitation. These persons often need mental health services because of abuse or neglect they have suffered.

The agency's Child Protective Services (CPS) Division investigates reports of abuse and neglect of children. CPS also:

- provides or contracts for in-home family safety services designed to reduce the risk of future abuse and neglect while the child remains in the home;
- arranges for placement outside the home when necessary to protect a child's safety;
- provides independent living services for children aging out of foster care; and
- places children in adoptive homes.

DFPS recorded 58,473 child abuse or neglect cases in fiscal 2003 (**Exhibit 5-4**). In addition, the agency tracks a "refusal to accept parental responsibility category," which includes situations in which parents relinquish custody to the state to obtain otherwise unavailable mental health care for their children. There were 846 of these cases recorded in fiscal 2003.

Some of these families have private insurance that does not adequately cover their children's needs. DFPS has estimated that families relinquished custody of 244 children in 2002 to obtain mental health services.<sup>90</sup> This number, sadly, is about average for any recent year.

### ***A Child Relinquishment Story***

While away on a business trip for a major global company, Jim received the startling news that his eight-year old daughter Meredith had attempted to drown her two-year old half-sister. Despite being only eight years old, Meredith had a long history of mental illness. She had been abused by her biological mother and removed from her home by Children Protective Services (CPS). Jim received custody of Meredith about a year later.

After the attempted drowning, Jim called upon CPS, but they declined to help. Meredith was placed in a local residential treatment center, but was released after a week following pressure from the insurance company paying for the treatment. Meredith's doctors challenged the insurance company and managed to have her transferred to another residential treatment facility. After a couple of weeks, the insurance company renewed its push for Meredith's release, despite the fact that she remained a serious threat to herself and others. Nonetheless, one morning Jim's insurance company told him that they would only pay for Meredith's care for another five days. The insurance company maintained that Meredith's problem required long-term care and that it was not covered.

In the span of five days, Jim made about 60 phone calls, both inside and outside Texas, to find a hospital or residential treatment center that would admit Meredith and accept payments on a sliding scale basis. He simply couldn't afford \$400 a day. He had no luck, and again turned to CPS for help. Again, CPS offered no help, but told Jim: *"You need to do your duty as a father. But, if you do bring her home, we will take your two younger children out of your house."*

The staff at the treatment center informed Jim that he could get Meredith the care she needed by refusing to pick her up and take her home. Although the state would charge Jim with abandonment and he would lose his parental rights, he felt forced to make the anguishing decision faced by hundreds of Texas families each year-to relinquish custody of his child so that she could receive long-term mental health care services.

Now 13, Meredith is currently in a facility that only accepts CPS cases. Her official diagnosis is ADHD, major depression, post-traumatic stress disorder and obsessive-compulsive disorder. Jim pays the state \$480 per month in child support, as required by law. Jim and his second wife are actively involved in Meredith's treatment plan and regularly participate in family counseling sessions. Meredith comes home for weekends, and has spent extended periods of time at home during the holidays.

Jim hopes to bring Meredith home within the year. To do so, Jim will first have to file a lawsuit against the state to regain his parental rights.

Jim believes strongly in insurance parity laws and believes that *"if we had an insurance parity bill in place before this happened, I wouldn't have to break up my family."* He also believes that the Department of State Health Services should provide a safety net for children with mental health needs, and not rely on the criminal justice system or CPS to provide needed intervention and treatment. He points to other states that provide help to families without requiring custody relinquishment. In his words, *"All it comes down to is dollars and the bottom line."*

**EXHIBIT 5-4**  
**VICTIMS OF ABUSE/NEGLECT BY TYPE, FISCAL 2003**

TYPE	NUMBER	PERCENT OF TOTAL
Neglectful Supervision	26,338	44.4
Physical Abuse	13,608	22.9
Sexual Abuse	7,473	12.6
Physical Neglect	7,198	12.2
Medical Neglect	2,371	4.0
Emotional Abuse	1,087	1.8
Refusal to Accept Parental Responsibility	846	1.4
Abandonment	420	0.7
Total	59,318	100.00

*Source: Department of Family and Protective Services.*

DFPS purchases a variety of mental health services for children under its protection and their families, including individual, family and group counseling, psychological and developmental assessments and psychiatric evaluations. These services are intended to prevent abuse and neglect, allow children to remain at home, if possible, and identify and address children's needs while in foster care.

CPS spending for mental health services fell from \$13 million in fiscal 2001 to \$10.7 million annually in fiscal 2002 and 2003. The latter figure accounted for less than two percent of total CPS spending in fiscal 2003. Depending upon individual circumstances, CPS clients also may receive mental health services paid for by Medicaid, CHIP and private insurance, or by cash payments made by their families; these expenditures are not included in the DFPS budget.

DFPS' Adult Protective Services (APS) Division investigates reports of abuse, neglect and exploitation of elderly people and persons with disabilities. The division also provides or arranges for protective services to prevent further maltreatment, such as referral to other programs, respite care, guardianship, emergency assistance with food, shelter and medical care, transportation and counseling. APS only rarely provides such assistance directly, however, and could not provide information on its mental health spending.

**The Criminal Justice System and Mental Illness**

Deinstitutionalization, a lack of adequate community programs and limits imposed by private insurance plans all have increased the likelihood that the people with mental illness will enter the criminal justice system. Unfortunately, jails, prisons and juvenile facilities have become a primary source of treatment for many people with mental illnesses.

## ***Mental Health Care Outside DSHS***

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As noted previously, prior to the 1960s, people with serious mental illness generally were hospitalized in state institutions. With the advent of modern psychotropic medications, many medical experts and advocates believed that such individuals no longer needed to be locked away in institutions. A federal interagency committee appointed by President Kennedy in 1961 recommended that 2,000 community mental health and mental retardation centers be built over the next 20 years. Three years later, Congress passed the Community Mental Health Act of 1964, which provided block grants to states to establish and run CMHMRCs.<sup>91</sup>

Despite good intentions, however, adequate community mental health services never materialized in many areas, even as state hospitals continued closing their doors. Former patients often found themselves on the streets, sometimes with severe drug and alcohol problems. The homeless—frequent perpetrators of nuisance crimes and other misdemeanors—are increasingly housed in jails and prisons. It can be argued that deinstitutionalization really amounted to a “re-institutionalization,” as many persons with mental illness were simply shifted from state hospitals to county jails and state prisons.<sup>92</sup>

In 1955, the U.S. population stood at about 165 million, and state mental hospitals nationwide held about 559,000 patients.<sup>93</sup> Since that time, the population has risen by 80 percent, to nearly 295 million; assuming the prevalence of mental illness has remained more or less the same, the number of patients in mental hospitals might have been more than 1 million today—if they had not closed. The actual number of patients currently in state mental hospitals across the nation is only about 70,000.<sup>94</sup>

Over the same period, the number of prison inmates rose by a staggering 800 percent, from 185,000 in 1955 to more than 1.4 million in 2003.<sup>95</sup> Not all offenders have a mental illness, of course, nor are all people with mental illness criminals, but it is clear that many individuals with mental illness have found themselves in state prisons or county jails.

Deinstitutionalization took place as dramatically in Texas as elsewhere. According to a Criminal Justice Policy Council report, the number of patients in Texas state mental health institutions fell by 81 percent between 1970 and 1999, from 12,413 to 2,309.<sup>96</sup> Over the same period, the Texas prison population soared from 14,331 to 146,930, an increase of more than 900 percent.<sup>97</sup>

Despite the widespread failures of deinstitutionalization, the community *is* the most efficient place to provide services to offenders with mental illness. Treatment costs less in the community because it avoids the additional costs of hospitalization—or incarceration. More funding can go toward services rather than facilities and security.

Furthermore, since offenders with mental illness generally commit nuisance and other minor crimes, often they return to the streets soon after arrest, only to be arrested again within days or weeks. This cycle ties up the time and resources of police and county sheriffs while doing nothing to help the offender.

The following summarizes how people with mental illness and criminal justice systems in

Texas and the nation interact, and how government and private concerns are addressing the problem.

## **State Criminal Justice Agencies and Mental Health**

### ***Texas Department of Criminal Justice***

Upon sentencing, adult felony offenders become the responsibility of the Texas Department of Criminal Justice or of local supervision and correction departments, more commonly known as probation departments.

TDCJ's statutory missions are to protect Texas citizens; assist crime victims; and to promote offender rehabilitation and help them rejoin society. These charges are the responsibility of three divisions, the Correctional Institutional Division (CI), Community Justice Assistance Division (CJAD) and the Parole Division.

The CI Division is responsible for confining adult felony and state jail offenders who have been sentenced to prison. CJAD does not incarcerate or supervise offenders, but administers adult probation. Offenders on community supervision serve their sentences in the community, under various terms and conditions, rather than in prison or jail. More than 440,000 offenders are on community supervision in Texas, under the supervision of local Community Supervision and Correction Departments (CSCDs). The Parole Division supervises offenders who have been released from prison on parole or mandatory supervision to complete their sentence in communities.

The 1987 Legislature established the Texas Council on Offenders with Mental Impairments within TDCJ, to address the multifaceted needs of juvenile and adults offenders with mental illness, mental retardation and developmental disabilities. Recently renamed the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), it provides a formal structure through which criminal justice and health and human services organizations can communicate and coordinate policy and program decisions concerning offenders with special needs. These include persons with serious mental illness, mental retardation, serious medical conditions and physical disabilities, as well as the elderly.

TCOOMMI operates several specialized offender programs involving a number of state agencies, including TDCJ, the Texas Youth Commission and the Texas Juvenile Probation Commission. TCOOMMI also has contracts with local mental health authorities to obtain outpatient services for offenders with mental illness living in the community.

The Legislature has directed TCOOMMI to assume key responsibilities, including:

- determining the status of offenders with special needs in the criminal justice system;
- identifying appropriate services for offenders with special needs;
- developing a plan for meeting the treatment, rehabilitation and

## ***Mental Health Care Outside DSHS***

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educational needs of impaired offenders, including a case management system and community-based alternatives to incarceration;

- evaluating various programs in Texas and elsewhere and recommending improvements for the state's system;
- collecting and disseminating information about available programs to judicial officers, law enforcement officers, probation and parole officers, social services and treatment providers and the general public;
- developing and implementing a special-needs parole program; and
- monitoring and coordinating the establishment of a "continuity-of-care" system for offenders with special needs.<sup>98</sup>

### ***Texas Youth Commission***

The Texas Youth Commission provides for the care, custody, rehabilitation and reestablishment in society of Texas' most chronically delinquent or serious juvenile offenders. Texas judges commit youths to TYC mostly for felony offenses committed between the ages of 10 and 17.

TYC can maintain jurisdiction over these offenders until their 21st birthdays. The agency has programs for offenders with mental illness, such as its Emotionally Disturbed Treatment Program and a specialized stabilization unit.

*"In the last ten years, the proportion of youth with serious mental health problems at time of commitment to the Texas Youth Commission (TYC) has increased from 27 percent to 42 percent. Their mental health needs are deeply intertwined with their delinquency and are often further compounded by substance abuse. The absence of adequate mental health services during their developmental years undoubtedly contributed to their eventual involvement with the juvenile justice system. The juvenile system now mirrors the adult system with far more individuals with mental problems in criminal justice systems than in mental health systems. Early intervention has always been the answer because it is more cost effective in every way-less money, fewer victims, more productive citizens."*

-Linda Reyes  
Deputy Director of the Texas Youth Commission

### ***Texas Juvenile Probation Commission***

The Texas Juvenile Probation Commission works in partnership with local juvenile probation departments to support and enhance their services by:

- providing funding, technical assistance, and training;
- establishing and enforcing standards;
- collecting, analyzing and disseminating information; and
- facilitating communication between state and local entities.

**Offenders with Mental Illness in the Criminal Justice System**

No one knows how many persons under the custody or supervision of the criminal justice system have a mental illness. No one has produced definitive figures for basic measures such as the number of individuals assessed with a mental illness upon intake into the system. Policymakers and advocates can only estimate the number.

The numbers in the following section are educated guesses, based on an assortment of data sources, including:

- the National Commission on Correctional Health Care;
- the Bureau of Justice Statistics (BJS); and
- the Texas Criminal Justice Policy Council.<sup>99</sup>

Based on data including current jail population numbers and a BJS estimate of the number of offenders with mental illness in jail nationally, MGT estimates that the 2004 jail population in Texas included 10,706 offenders with mental illness (**Exhibit 5-5**).

**EXHIBIT 5-5  
TEXAS JAIL ESTIMATES, 2004**

JAIL POPULATION 2004	ESTIMATED NUMBER OF OFFENDERS BOOKED	ESTIMATE OF NUMBER OF INMATES TAKING PSYCHOTROPIC DRUGS (10%)	ESTIMATED INMATES WITH MENTAL ILLNESS (16.2%)
66,087	1,200,000	6,609	10,706

*Source: MGT and the Texas Commission on Jail Standards.*

Using a 16 percent figure that emerged in several studies, MGT estimated the number of offenders with mental illness incarcerated in the state criminal justice system to be approximately 24,000. The Texas prison population was 148,152 at the end of fiscal year 2003, see **Exhibit 5-6**.<sup>100</sup> This includes all adults serving sentences in prison, state jails, substance abuse treatment facilities and other TDCJ facilities.

**EXHIBIT 5-6  
TDCJ ESTIMATES, 2004**

TDCJ POPULATION 2004	NUMBER OF OFFENDERS ADMITTED IN 2004	ESTIMATED INMATES WITH MENTAL ILLNESS (16.2%)
148,152	74,022	24,000

*Source: MGT and the Texas Department of Criminal Justice.*

The number of offenders with mental illness under community supervision in Texas is considerably larger than the number in prison. (Estimates of that population are shown in **Exhibit 5-7**).

**Agency Interaction with Persons with Mental Illness**

***Prisons***

Upon conviction and transfer from the court or from a jail, felons enter the custody of the state or federal prison systems to serve their sentences. Federal and state adult correctional authorities had 1,470,045 persons under their jurisdiction as of December 2003.<sup>101</sup>

The federal Bureau of Justice Statistics has noted offenders with mental illness tend to serve more time than other offenders. A 1999 BJS report stated that:

*...mentally ill state prison inmates were sentenced to serve an average of 171 months in prison, or about 12 months longer than other offenders. On average violent offenders with a mental illness were sentenced to 230 months (5 months longer than other violent inmates) and property offenders 128 months (10 months longer than other inmates).<sup>102</sup>*

In 2000, one in every eight prisoners nationwide (13 percent) was receiving mental health therapy or counseling services; nearly one in ten were prescribed psychotropic medications.<sup>103</sup> In some states, as many as 20 percent of inmates received psychotropic medications. Based on their reports, U.S. state prisons held an estimated 191,000 inmates with mental illness in 2000, or 16.2 percent of the state prisoner population.<sup>104</sup>

**Exhibit 5-7** shows more detail on the type of mental illnesses that inmates suffer. It is based on a survey conducted in the early 1990s to generate the estimated prevalence rate for various psychiatric diagnoses. The difference between the estimated prevalence rates for jail inmates versus prison inmates is due to a common pattern in mental illness, with periods of quiet followed by periods of activity. The rates at any point in time—for example, during a short jail stay—are lower than lifetime prevalence rates. To reflect this consideration, the calculations based on the National Comorbidity Study used 6-month prevalence rates for jail inmates and lifetime prevalence rates for prison inmates.<sup>105</sup>

**EXHIBIT 5-7  
NATIONAL ESTIMATES OF PSYCHIATRIC DISORDERS AMONG PRISON  
AND JAIL INMATES AND PREVALENCE IN THE U.S. POPULATION, 1995**

DISEASE	JAIL (SIX-MONTH ESTIMATED PREVALENCE) (N=500,483 INMATES)*		TOTAL U.S. POPULATION (SIX-MONTH PREVALENCE)	STATE PRISON (ESTIMATED LIFETIME PREVALENCE; N=1,010,228 INMATES)*		TOTAL U.S. POPULATION (LIFETIME PREVALENCE)
	N	%		N	%	
Schizophrenia/ Psychosis	4,955- 5,589	1.0- 1.1	0.4	22,994- 39,262	2.3- 3.9	0.8
Major Depression	39,690- 76,229	7.9- 15.2	8.4	132,619- 188,259	13.1- 18.6	18.1
Bipolar (Manic)	7,755- 12,920	1.5- 2.6	1.0	21,468- 43,708	2.1- 4.3	1.5
Dysthymia**	13,644- 21,040	2.7- 4.2	2.0	85,018- 135,121	8.4- 13.4	7.1
Post Traumatic Stress Disorder	19,770- 41,509	4.0- 8.3	3.4	62,388- 118,071	6.2- 11.7	7.2
Anxiety	70,613- 100,098	14.1- 20.0	14.6	222,147- 303,936	22.0- 30.1	N/A

\*'n' represents number in universe from which estimate of prevalence was made.

\*\* Dysthymia is a chronic form of depression.

**Source:** B. M. Veysey and G. Bichler-Robinson, "Prevalence Estimates of Psychiatric Disorders in Correctional Settings," a paper submitted to the National Commission on Correctional Health Care, Chicago, Illinois, October 1999, found in National Commission on Correctional Health Care, The Health Status of Soon-to be-Released Inmates, a Report to Congress, Volume 1, March 2002, p. 24.

***Parole/Probation***

Upon release from prison, nearly all Texas offenders are placed under the supervision of a parole officer for some period of time. Many jail diversion programs place offenders on probation. Both forms of community supervision cost only a few dollars per day. In Texas, community supervision costs the state about 97 cents per person per day, and local governments \$1.16. Prison, by contrast, costs more than \$44 per prisoner per day.<sup>106</sup>

In 2002, Texas' prison population averaged 164,222, with 63,446 admissions and 64,720 releases.<sup>107</sup> Applying the estimated number of people with mental illness in prison (16.2 percent) to the number of prisoners released each year (and again, virtually all will spend time on parole) produces an estimate of about 10,500 parolees with mental illness released from prison each year. In view of the BJS study cited earlier, which indicated that offenders with mental illness tend to serve longer sentences, this figure could be overstated, but not significantly.

***Mental Health Care Outside DSHS***

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In a 2003 report, TCOOMMI cited a Criminal Justice Policy Council estimate on the number and rate of offenders with mental illness under community supervision. **Exhibit 5-8** below shows that the rate and number of offenders with mental illness in the criminal justice system far outweighed those receiving mental health services in the community.

**EXHIBIT 5-8  
MENTAL HEALTH/CRIMINAL JUSTICE OFFENDERS AND OFFENDERS  
RECEIVING SERVICES, FISCAL 2001**

	<b>OFFENDERS UNDER SUPERVISION</b>	<b>MENTALLY ILL POPULATION (EST.)</b>	<b>OFFENDERS RECEIVING MHMR SERVICES</b>	<b>OFFENDERS RECEIVING JUSTICE SYSTEM MENTAL HEALTH SERVICES</b>
Adult Probation	464,856	61,655 (13.3%)	12,244 (19.9%)	3,320 (5.4%)
TDCJ Parole	110,692	29,948 (27.1%)	5,029 (16.8%)	4,969 (16.6%)
Totals	575,548	91,603 (15.9%)	17,273 (18.9%)	8,289 (9.0%)

*Source: Texas Correctional Office on Offenders with Medical or Mental Impairments.*

According to TCOOMMI, 27.1 percent of the parole population had mental illness, but only 33 percent of those parolees with mental illness received mental health services. For probationers, the figures were 13.3 percent and 25.2 percent, respectively.

Texas is the only state with a continuity-of-care program for offenders with special needs, including mental illness. Continuity of care includes services such as identifying and securing federal, state and community resources for offenders being released from prison and certain county jails. The program also includes post-release follow-ups. It has proved to be an effective strategy for ensuring immediate access to medical, psychiatric or rehabilitative services for parolees, a factor that can be important in reducing recidivism.

TCOOMMI provides funding for community-based services including pre-release screening, referrals and placements, vocational rehabilitation, crisis stabilization and rehabilitation. It has contracts in place to fund 36 programs with local MHMR providers. These programs are intended to ensure that those being released from prison can quickly secure any federal benefits for which they are eligible upon release, such as Social Security.

**Juveniles**

Exhibit 5-9 illustrates TCOOMMI's estimate of juveniles in community corrections programs in fiscal 2001.

**EXHIBIT 5-9  
JUVENILE OFFENDERS RECEIVING MENTAL HEALTH SERVICES  
FISCAL 2001**

	<b>OFFENDERS UNDER SUPERVISION</b>	<b>MENTALLY ILL POPULATION (EST.)</b>	<b>OFFENDERS RECEIVING MHMR SERVICES</b>	<b>OFFENDERS RECEIVING JUSTICE SYSTEM MENTAL HEALTH SERVICES</b>
TJPC	44,496	9,962 (22.4%)	3,572 (35.8%)	43 (<1%)
TYC Parole	6,241	2,775 (44.5%)	99 (3.6%)	262 (9.4%)
Totals	50,737	12,737 (25.1%)	3,671 (28.8%)	305 (2.4%)

*Source: Texas Correctional Office on Offenders with Medical or Mental Impairments.*

"It is often said that 'a civilization can be measured by how it treats its children.' If this is true, we have to ask ourselves what it says about us today, in 2005, when parents are looking to the juvenile justice system for services for their children with mental illness. What does it say that other social service professionals and law enforcement officials tell them to look to juvenile probation services for assistance with their children with mental illness? When did it become a crime to be mentally ill?"

-Vicki Spriggs, Executive Director  
Texas Juvenile Probation Commission

The National Alliance for the Mentally Ill has estimated that between 50 and 75 percent of criminals under the age of 17 suffer from a diagnosable mental health disorder.<sup>108</sup> The Texas Youth Commission reports that the number of youths in its facilities with severe mental health problems has increased greatly in recent years, as has the severity of their problems.<sup>109</sup>

Juveniles diagnosed with severe mental health problems who are not judged to be dangerous to themselves or others may receive specialized treatment at TYC, while those judged dangerous receive care at TYC's Corsicana Stabilization Unit.<sup>110</sup>

**Local Criminal Justice and Persons with Mental Illness**

**County Jails**

While awaiting trial or sentencing for low-level crimes, offenders either are housed in county jails or released to live in the community under certain court-imposed conditions. State law requires Texas counties to provide jail inmates with certain mental health

## ***Mental Health Care Outside DSHS***

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services, and the Texas Commission on Jail Standards has established uniform mental health screening standards for jails. State requirements on county jails include:

- jails must have a mental disabilities/suicide prevention plan, including provisions for staff training, appropriate housing and supervision and crisis intervention for mentally ill offenders;<sup>111</sup>
- the Code of Criminal Procedure requires jails to obtain a psychiatric assessment on offenders suspected of having a mental illness within 72 hours of detention;<sup>112</sup>
- the Code of Criminal Procedure also requires courts to release pre-trial defendants with mental illness (except those charged with a capital offense) on personal bond if they can obtain outpatient or inpatient mental health services; and<sup>113</sup>
- the Government Code requires the establishment of a specialized mental health deputy training and certification process for peace officers.<sup>114</sup>

Generally, small and medium-sized jails are not able to provide services beyond the state minimum requirements.

Unless a county has a jail diversion program, offenders with mental illness normally are taken to jail following arrest. The goal of jail diversion programs is to avoid arresting and incarcerating individuals when possible, instead directing them to more appropriate services—sometimes, depending upon the severity of the offender’s condition, to a hospital, mental hospital or mental health treatment facility. There are two basic types of jail diversion programs:

- **Pre-booking diversion** occurs before formal charges are brought.
- **Post-booking diversion** operates in arraignment courts and jails with the goal of developing plans to handle the cases outside of jail. This can result in reduced charges and/or the imposition of bail or probation with conditions requiring the offender to receive community-based services.

Offenders with mental illness cost more to detain and house in jails than the general population. They often require separate housing, and more medical and psychological treatment than other offenders. They are more likely to be disruptive, requiring greater staff resources. And, as noted above, they typically spend more time in jail than other offenders for the same crime.<sup>115</sup>

It is cost-effective, therefore, to keep these offenders out of the criminal justice system whenever possible, and to provide them with community-based services instead. Community-based mental health programs also are a more effective way to offer an integrated array of mental health, substance abuse and other support services, and ultimately break the cycle of criminal behavior.

*"It seems like we're constantly 'on diversion'-being sent out of area to take a mental patient to a hospital because this one (Austin State Hospital in Travis County) is full. Transporting mental patients directly affects our budget and our resource deployment. When an officer is off transporting a patient we may have to bring in an off-duty officer to cover the person involved in the transfer- sometimes as far away as Big Spring. This isn't good for our budget and isn't good for the mental health consumer. They're in crisis-and spending 3 or 4 hours restrained in the back of a squad care isn't going to help."*

-Sergeant Darren Long  
Travis County Sheriff's Office  
Crisis Intervention Team

## ***Police***

Police officers usually are the first persons within the criminal justice system to encounter individuals with mental illness. A 1998 study revealed that nationwide, police departments in large cities estimate that seven percent of all police contacts involve persons with mental illness.<sup>116</sup> In another 1998 survey of 450 police officers in three U.S. cities, police officers reported fielding about six calls per month each involving persons with mental illness in crisis.<sup>117</sup>

The time involved in addressing the needs of offenders with mental illness places a significant burden on law enforcement. Waiting times are notoriously long at local mental health facilities and emergency rooms. And all too often, after waiting for hours, the offender is turned away and the police officer in charge must take the individual to jail after all. This process can take police officers off the streets for hours, or even for entire days.

A Texas sheriff interviewed by MGT described a serious gap between the supply and demand of community and state mental health resources. Law enforcement officers often cannot find space for offenders with mental illness in local facilities, and must take them to state hospitals in Austin, Vernon and El Paso—where they still may be turned away for lack of space. Jails may provide released offenders with referrals to a CMHMRC, but unless the offender is already a CMHMRC client, they may be turned away, and even existing patients sometimes must wait 30 to 45 days for an appointment. Without medications or treatment, offenders simply cycle back into the criminal justice system.

One state official interviewed for this study cited the case of an offender with mental illness who was arrested in Houston but eventually transported by Houston police to an El Paso facility for care. Neither the Harris County MHMR facility nor the Harris County jail would accept the offender. Officers then took the individual to Rusk State Hospital, where they were advised that Rusk had no space, but that the El Paso state hospital did—more than 800 miles away from Houston. This required police officers to drive more than 2,000 miles and took them off of the streets for several days.

Police departments across the country have developed several approaches to mitigate the burden placed on them by offenders with mental illness, including the jail diversion programs described earlier. Some departments also train their officers to quickly assess offenders' problems and needs. Still others have established special police task forces to support or relieve patrol officers who encounter offenders with mental illness. In some communities, patrol officers work with specially trained groups of social workers who help them handle people with mental illness. Each of these approaches has merit.

To provide a sense of the magnitude of the state's criminal and juvenile justice systems, **Exhibit 5-10** shows the overall numbers of offender populations in Texas' state and local criminal justice agencies in 2003.

**EXHIBIT 5-10  
TEXAS CRIMINAL JUSTICE AGENCIES  
POPULATIONS AS OF AUGUST 31, 2003**

	<b>AUGUST 31, 2003</b>
TDCJ	148,152
Parole	76,427
Community Supervision	434,701
TYC	4,825
TJPC Referrals	105,910*
Local Jails	65,000

\* Calendar Year 2002.

**Sources:** *Texas Juvenile Probation Commission, The State of Juvenile Probation Activity in Texas – Calendar Year 2002; Texas Department of Criminal Justice, Fiscal Year 2003 Statistical Report; and Texas Commission on Jail Standards, Monthly Population Report.*

**The Financial Burden on Criminal Justice**

In addition to the cost of medication, large county jails and prisons must pay for counseling, specialized housing, additional staff, targeted staff training and other support services. When persons with mental illness are incarcerated in prison or jails, the cost to house them must be added to the direct services they receive, if any. The Texas Criminal Justice Policy Council has estimated housing costs in Texas at about \$45 per day in prison.<sup>118</sup>

Jail costs vary widely by county but are believed to range from \$25 to \$50 per day in jails for typical inmates. A reasonable estimate of the statewide average cost per day for jails is the amount that TDCJ pays county jails for contracted beds, \$40 per day in 2002. One sheriff estimated the average cost per day to jail an inmate with mental illness at \$100, twice what it costs to house members of the general jail population.<sup>119</sup>

Juvenile offenders are even more expensive. The state spends more than \$151 per day to house a single juvenile offender in a TYC facility. The cost of specialized caseloads for offenders on parole from TYC is \$15.32 per offender per day.<sup>120</sup> The average cost per day for each offender under the authority of the Texas Juvenile Probation Commission is about \$16.

The 1999 Legislature appropriated only about \$10.5 million over the 2000-2001 biennium for community mental health services within the Texas criminal justice system. Of this, CJAD received \$1.1 million and TCOOMMI received \$9.4 million for the two-year period. These funds were used to provide specialized caseload and/or mental health case management services. In case management, a case manager maintains contact with an offender with mental illness to help him or her access and receive needed services and support. Case managers also provide clients with assessments, advocacy, service planning and monitoring.<sup>121</sup>

This funding, however, was grossly inadequate. Of an estimated 104,000 offenders with mental illness under Texas community supervision in 2001, only about eight percent (8,600) received specialized health services through the criminal justice system.<sup>122</sup>

Responding to the need for community mental health services for offenders, the 2001 Legislature increased funding by \$35 million over the 2002-2003 biennium. This additional

## ***Mental Health Care Outside DSHS***

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money brought total criminal justice mental health funding to \$45.5 million for the two-year budget period. The funds went to TCOOMMI, TJPC and CJAD to provide community-based services for adult and juvenile offenders. Youth paroled to the community from TYC receive services funded through TCOOMMI and administered by 32 local CMHMRC providers.<sup>123</sup> The 2001 legislation provided enough funding to serve an additional 3,700 juvenile and adult offenders with mental illness in the community. In all, however, the additional funding only reduced the gap by four percent.

The 2003 Legislature gave TYC \$5.9 million for 2004 and 2005 (or about \$15.40 per youth per day, based on a 1,045 average daily population) for specialized treatment for juvenile offenders. In addition, TYC's biennial appropriation includes \$3.2 million for psychiatric services—about 90 cents per day per offender. TJPC receive an additional \$4 million for mental health services.

The gap is far from closed.

### ***Federal Involvement***

The federal government is beginning to help finance jail diversion programs for offenders with mental illness. On October 30, 2004, President Bush signed into law the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. This law (public law 108-414) is the first truly comprehensive federal initiative to promote the diversion of non-violent offenders with mental illness from jail.

The act establishes grants to be used by communities for a variety of purposes, including:

- mental health courts or other court-based programs;
- community-based treatment programs (or in-jail treatment);
- programs that offer specialized training to officers and employees of criminal or juvenile justice agencies and mental health personnel who serve offenders with both mental illness and substance abuse problems;
- programs that support cooperative efforts by criminal and juvenile justice agencies and mental health agencies to promote public safety by offering mental health treatment; and
- intergovernmental programs among state and local governments that support offenders with mental illness.<sup>124</sup>

The grants can be awarded for up to \$75,000 each and require local matching funds. Congress authorized \$50 million to fund the initiative in fiscal 2005.

### **Summary of Findings and Conclusions**

MGT's research and analysis yielded the following major conclusions.

- Mental health-related appropriations to the Texas Department of State Health Services account for less a third of all state mental health-related expenditures.
- Existing data do not permit a comprehensive, systematic assessment of mental health service needs, gaps, duplications and costs related to the delivery of mental health services.

- State agency mental health services often are secondary to the agency's primary purpose, such as those offered by the Texas Education Agency. The mental health needs of these agencies' clients may go unidentified and unaddressed unless they are specifically related to an agency's primary mission, such as public education or vocational rehabilitation.
- Mental health services offered by state agencies usually are contracted for rather than provided directly. No state mechanism coordinates the use of contracted mental health services across agencies or considers whether contract coordination could yield savings that could be committed to the expansion of services.
- Many people do not qualify for various types of public mental health funding, and even those with private insurance often find their coverage unable to address serious mental health crises. As a result, some the families of some 250 children each year are forced to relinquish their parental responsibilities so that their children can receive desperately needed mental health care.
- Criminal offenders with mental illness represent an enormous burden on prisons, jails and police forces. One sheriff interviewed for this study estimated that it costs twice as much to house inmates with mental illness as other offenders.
- The cost of incarcerating offenders with mental illness hits small and medium-sized counties particularly hard, since these jurisdictions typically lack funds to pay for special housing areas, psychiatric care or special training for deputies.
- Keeping offenders with mental illness out of the jails and prisons by providing them with community-based mental health services is both humane and cost-effective. These jail diversion programs work well if the community has the resources for treatment. If community treatment capacity is insufficient, however, offenders may be turned away or forced to travel across the state to find hospitals that will accept them.
- The Texas Legislature has begun to commit more funding to provide mental health treatment through the criminal justice system, but the gap in services remains enormous.
- Eligible state and local criminal justice and mental health agencies should work collaboratively to secure as much funding as possible that has been recently made available by Congress in the Mentally Ill Offender Treatment and Crime Reduction Act of 2004. This will require state and local agencies to seek funds for matching purposes.

**CHAPTER 6.0**  
***ECONOMIC AND FISCAL IMPACT***  
***OF MENTAL ILLNESS***

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## 6.0 ECONOMIC AND FISCAL IMPACT OF MENTAL ILLNESS

### **Chapter Purpose and Overview**

Obviously, mental illness is most devastating for the afflicted and those closest to them. But governments bear a significant portion of the financial cost, paying enormous sums for social services and criminal justice agencies. And the government and economy alike suffer from the loss of each productive citizen. This chapter summarizes those costs.

Although estimates vary, experts report that some 23 to 30 percent of the population experiences some symptoms meeting the diagnostic criteria for a behavioral health disorder in any given year. About one in 20—5.4 percent—have a “serious mental illness,” and 2.6 percent a “severe and persistent mental illness.”<sup>125</sup> These figures imply profound economic effects.

### **The Economic Effects of Mental Illness**

Serious mental illnesses, including schizophrenia, bipolar disease and certain forms of major depression, affect between four and six percent of the nation’s population each year. This has obvious implications for the economy. A 1999 National Bureau of Economic Research (NBER) report noted:

*Severe forms of mental illness reduce an individual’s ability to function in the consumer role, and interfere with the maintenance and creation of social networks (family and friends), weakening the connection with others who might serve as caregivers or proxy decision-makers.<sup>126</sup>*

The report also states that about 30 percent of the nation’s population has a diagnosable episode of mental illness at some point during the year, yet only about a quarter of these receive some form of treatment (17.3 percent from medical providers and an additional 7.4 percent from a human services agency or self-help group).<sup>127</sup>

### **Types of Economic Effects**

Mental illnesses are costly both in terms of medical and behavioral care and also in lost economic activity. Many of these costs can be attributed to the effects of nonexistent or ineffective mental health treatment. A 2001 report by the advocacy group Connecticut Voices for Children states:

*Given the prevalence of mental health problems in children and adults, and the proportion of such problems going untreated, it is not surprising that the direct and indirect costs of mental illness are so high.<sup>128</sup>*

These costs, direct and indirect, are described in more detail on the following pages.

## **Direct Costs**

As we have seen, the direct costs of mental illness involve costs for treatment in a variety of settings, including public health facilities and the criminal justice system. The Surgeon General's report on mental health stated that the United States spent about \$69 billion in 1996 on mental health services, an amount representing more than seven percent of all health spending.

The public sector bore the majority of these costs: 53 percent came from government (Medicaid, Medicare and other federal, state and local programs), while the balance came from private sources (private insurance and individual out-of-pocket expenditures). Thus although 63 percent of the population had private insurance, it covered less than half of the expense.

The Surgeon General's report states that:

*...insurance coverage of mental health services is typically less generous than that for general health, and government plays a larger role in financing mental health services compared to overall health care.*<sup>129</sup>

And many individuals who have private insurance end up in the public system once their benefits have been exhausted.

## **Indirect Costs**

The indirect costs of mental illness are significant and varied.

**Employment and earnings:** Persons with mental illness do not participate in the labor force at the same rates as those who do not suffer from it. Using data on 2,225 men and 2,401 women from the *National Comorbidity Survey*, a 1997 NBER study examined the impact of psychiatric disorders on employment and conditional work hours and income. The study found that 93.3 percent of men with no mental disorders were employed, but the share fell to 86.9 percent for those with major depression and 87.6 percent of those with schizophrenia.<sup>130</sup> Furthermore, study subjects with mental illness who were

### **When Private Insurance Falls Short**

Chance (13) and Joshua (5)

Many Texas children suffer from mental illness so severe that they are uninsurable in the private market. Public programs and private grants offer the only hope for recovery and a productive future.

Chance, a 13-year old diagnosed with bipolar disorder, has spent a big part of his short life in psychiatric hospitals. A school-based grant funded program has helped him resume a normal life at home with his family. A state program has helped him access life-altering medications that cost about \$1,500 per month. The grant funds are expected to run dry in August 2005, however, and the threat of future state funding cuts haunts Chance's parents, who can't afford their son's medications.

Joshua, only five years old, also is uninsurable. He has multiple diagnoses, including bipolar disorder, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder and severe anxiety disorder. His parent's private insurance paid for a few months of Josh's medications (which average \$450 per month) before imposing a medication cap. And the insurance doesn't cover weekly psychiatric and counseling visits that cost \$300 and \$150 respectively.

Joshua's mother was forced to scale back her hours at work so that her son could qualify for Medicaid and receive the treatment he needs to get better. Without medications and therapy, Joshua's behavior was violent and unpredictable and he was required to be home-schooled. Today, Joshua is back in school and doing better.

## ***Economic and Fiscal Impact of Mental Illness***

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employed tended to earn less; men with no disorder earned an average of \$33,245, while those with major depression earned \$30,309 and schizophrenia \$32,656.<sup>131</sup> Women with no disorder earned \$18,586 on average, while women with major depression earned \$17,782 and those with schizophrenia \$8,466.<sup>132</sup>

These findings were echoed in another study reported by NBER that used data from a national epidemiological survey of the U.S. population. It found that the presence of a diagnosable mental illness reduced employment by about 11 percent for both males and females. For those who worked, the estimated loss of income attributable to mental illness was about 20 percent for women and ten percent for men.<sup>133</sup>

**Productivity:** Psychiatric disorders often reduce the productivity of those who have them. The NBER report states:

*[E]ven after accounting for differences in early life experiences such as schooling, persons with a psychiatric disorder may experience lower productivity on the job as a result of impaired concentration, reduced cognitive abilities, or absenteeism.*<sup>134</sup>

A study reported in 1997 in *Psychological Medicine* states:

*The effects on reduced work hours are especially important in that they represent costs both to workers and to their employers. Data from the Epidemiologic Catchment Area (ECA) Study (Robins & Regier, 1991) suggest that these costs are substantial. Three percent of men and 4.5 percent of women in the ECA Study reported that they had one or more days when they were unable to work or carry out their usual activities because of emotional problems during the past 3 months (Kouzis & Eaton, 1994).*

*Work impairments as common as these have enormous implications for the economy. For example, a recent analysis of the economic burden of depression, the psychiatric disorder thought to have the largest impact on work disability (Conti & Burton, 1994; Kouzis & Eaton, 1994), estimated that this disorder leads to an annual loss of \$17 billion due to work absenteeism in the U.S. alone (Greenberg, et al., 1993).*<sup>135</sup>

The *American Journal of Public Health*, reporting on the prevalence and predictors of these “emotional disability days,” found them particularly common among persons with untreated depression and panic disorders. Persons with major depression were 27 times more likely to miss work than those without the disability. Forty-four percent of persons with depression reported at least one emotional disability day within three months, compared to two percent of the general population.<sup>136</sup>

The 1997 *Psychological Medicine* study cited above examined the impact of psychiatric disorders on work loss days by examining data from the *National Comorbidity Survey*, a survey of 2,225 men and 2,401 women ages 15-54. The study found that mental health and substance abuse accounted for about six workdays lost per month per 100 workers.

Of the employed workers in the study, 14.5 percent had a single psychiatric disorder; 3.7 percent had two or more; and 81.8 percent had no psychiatric disorder. Unsurprisingly, the workers with two or more—“co-morbid disorders”—were more severely impaired, losing 49 workdays per month per 100 workers (equivalent to 15 million lost days per year nationally). Those with a single disorder lost 11 days per 100 and those with no disorder lost two days per 100.<sup>137</sup>

A 1993 study cited in the *Journal of Clinical Psychiatry* placed the annual costs of depression in 1990 at \$43.7 billion.<sup>138</sup> Of this amount, 55 percent represented indirect costs associated with reduced productivity at work; 28 percent were direct costs for medical, psychiatric and pharmacological care; and 17 percent were mortality costs related to suicide. Another study estimated the annual costs of anxiety disorders in 1990 at \$42.3 billion, or \$1,542 per patient, 88 percent of which represented lost work productivity.<sup>139</sup>

**Health care costs:** Other research suggests that restrictions on access to timely and appropriate mental health care increase costs for a variety of other services.

A Yale School of Medicine faculty study examined the impact of one large national manufacturing corporation’s use of cost-containment measures for health care. The measures included increased deductibles and co-payments as well as considerably stricter review procedures. The total cost of mental health services per user fell dramatically, by 37.7 percent. Interestingly, though, this was fully offset by a concurrent 36.6 percent increase in other medical costs and a 21.9 percent rise in the use of sick days.

The report concluded:

*Savings in mental health care were offset by a concomitant increase in non-mental health service use and also were accompanied by an increase in sick days among mental health service users. It thus appears that in this corporation reducing mental health care was associated with potentially adverse consequences for employees with mental health problems, with no gain for the employer’s “bottom line.”<sup>140</sup>*

**Costs to families:** Caregivers also lose productive time at work while caring for relatives and friends with mental illness. A 1990 study published by the University of California’s Institute for Health and Aging states that:

*The value of time spent by caregivers for care provided to mentally ill family members is estimated by Franks (1987) in a study conducted for the National Institute for Mental Health. Included is time spent in...caregiving, work issues, time with lawyers, clergy, professionals; recreation, and other. Franks estimates a total value of time spent by caregivers at \$2.5 billion nationally based on a survey of the membership of the Massachusetts Alliance for the Mentally Ill, a family support and advocacy group.<sup>141</sup>*

Untreated mental disorders affect the relationships and well-being of the next generation. Connecticut Voices for Children reports that young women who have experienced psychiatric disorders before the age of 18 are more likely to marry early (young men, interestingly, are less likely to *ever* marry); have a disrupted marriage; have a child too early; get divorced; and then either remain a single parent or marry and divorce multiple times.

Children exposed to parental psychopathology are at a greater risk of disorders involving mood, anxiety, addiction and “acting out,” which involves socially unacceptable behavior.<sup>142</sup> The impact persists beyond childhood; one analysis of 17 studies from 1980-1993 found that children of parents with bipolar disorder were nearly 2.7 times more likely than their peers to develop a mental disorder of some kind, and four times more likely to develop an affective disorder.<sup>143</sup> (Affective disorders are mood disturbances such as major depression, bipolar disease, seasonal affective disorder and postpartum depression, among others.)

### **Statewide Economic Impact**

The Surgeon General’s report *Mental Health* estimated 1990 costs to the national economy at nearly \$79 billion:

*Most of that amount (\$63 billion) reflects morbidity costs—the loss of productivity in usual activities because of illness. But indirect costs also include almost \$12 billion in mortality costs (lost productivity due to premature death) and almost \$4 billion in productivity losses for incarcerated individuals and for individuals providing family care.<sup>144</sup>*

Note also that these figures measure net costs to the entire economy and therefore do not include treatment costs, since an expenditure on treatment represents both a cost and a source of revenue. Obviously, they also account in no way for the pain and suffering mental illness inflicts on those it touches.

The simplest way to estimate Texas’ share of the \$63 billion, of course, would be to assume that Texas’ costs for mental illness were strictly proportional to its share of the national population in 1990—6.8 percent, which would result in a \$5.4 billion cost for the year.

The consulting team has produced a more refined estimate using the work of the UC-California Institute for Health and Aging, whose estimates of the national cost of mental illness rank among the most comprehensive ever performed.<sup>145</sup> Initially estimated for 1985, the institute has updated its research several times, the most recent full data being for 1990. The review team combined these data with the National Bureau of Economic Research’s research, mentioned above, on information from the *National Comorbidity Survey*. The NBER study estimated that 28.9 percent of the nation’s population suffers from a diagnosable disorder in any given year, and that those who have diagnosable disorders earn just 84.4 percent of what those without disorders do.

When compared with 2003 income data on Texas, this implies an income differential between those with a diagnosable disorder and those without of \$4,540. Given an estimate of just under three million employed Texans with a diagnosable disorder, *mental illness cost Texans \$13.3 billion in personal income in 2003.*

The Institute for Health and Aging's data can be used to further estimate the effects of mortality and lost income on family caregivers. Applying the ratios found in the original research, the mortality cost to Texas of mental illness in 2003 was \$2.6 billion, while lost income due to family caregiving was just over \$700 million.

As a result, *the total cost of mental illness to the Texas economy in 2003 was \$16.6 billion.*

### **Government Costs of Mental Illness**

Since mental illness is linked with costly social problems such as unemployment, lost job productivity, crime and homelessness, government has been forced to assume a major role in mental health care.<sup>146</sup> Much of the information in this section is based on a 1999 NBER report, *Economics and Mental Health*, which thoroughly discusses the historical role of the public sector in mental health treatment.

Historically, care for people with mental illness was not considered part of the medical domain. Local authorities confined people with disabling mental conditions to poorhouses and almshouses. Asylums as such were first created in the early part of the 19th Century to treat some of the more clearly recognizable mental illnesses. In the U.S., states gradually assumed increasing financial and operational responsibility for such facilities, and have held a primary role in mental health policy ever since.

Mental health care has an obvious public safety component that gives states a legitimate interest in assuming a degree of control over the delivery of certain forms of mental health care. And most states have laws in place that tend to favor society's interests over the individual liberties of people with mental illness.

### ***Crime and Homelessness***

Research has found clear evidence that mental illness and substance abuse are associated with higher rates of criminal activity. Although the vast majority of individuals with serious mental illness are no more dangerous than members of the general public, some people with mental illness do represent a danger to themselves and others.<sup>147</sup> In particular, persons suffering from both mental illness and substance abuse are more likely to be involved in violence than otherwise similar people with one or neither of the conditions.<sup>148</sup>

According to the National Mental Health Association, 16 percent of the total jail and prison population at any given time comprises men and women with untreated psychiatric disorders.<sup>149</sup> The Institute for Health and Aging reports that almost a third of the \$45.6

## ***Economic and Fiscal Impact of Mental Illness***

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billion spent in the criminal justice system in 1985 was associated with mental illness and substance abuse, including 35 percent of the \$22 billion spent on expenses for police protection.<sup>150</sup>

Homelessness also has been linked to mental illness and substance abuse. About 700,000 Americans are homeless on any given night; about a quarter of these people have serious mental illnesses and more than half suffer from an alcohol and/or drug problem.<sup>151</sup> A number of researchers contend that the prime cause of the increase in homelessness in the 1980s was due to the shifting of mental hospital patients to nursing homes, jails and the street after the hospitals closed.<sup>152</sup>

### ***In Texas***

The fiscal impact of failing to treat mental illness is calculated as a percentage of total costs and the overall economic impact.

The Texas Comptroller's office uses a "rule of thumb" of 5 percent when measuring the total fiscal impact of changes in economic activity, meaning that the state gains or loses five cents for every dollar of personal income created or lost. This figure is consistent with the IMPLAN economic impact modeling system of the Texas economy, which further estimates the tax impact for local jurisdictions of typical households at 1.56 cents per dollar of income.

Using these estimates, direct expenses related to mental illness other than treatment cost Texas state government \$105.6 million in 2003. Local governments spent an additional \$362.3 million.

Lower productivity exacted an even greater toll in the form of lost tax and fee revenue. Based on estimates of total foregone personal income associated with morbidity and premature mortality of those suffering from mental illness, and the lost productivity of family members who provide uncompensated care, Texas failed to realize revenue of \$828.9 million in 2003; local governments missed out on \$258.6 million in the same year.

Taken together, *the total 2003 fiscal impact of mental illness in Texas was \$934.5 million in state revenue and \$620.9 million in local government revenue, for a total impact of \$1.5 billion to state and local governments.*

To put these figures in context, the state tax impact of \$934 million is slightly above what Texas took in from mixed beverage and cigarette taxes in 2003. **Exhibit 6-1** provides a breakdown of the economic and local fiscal impacts for selected large Texas counties. Together these six counties account for about half of the impact to the state.

**EXHIBIT 6-1  
ECONOMIC AND FISCAL IMPACTS ON SELECT  
TEXAS COUNTIES IN 2003 DUE TO MENTAL ILLNESS**

<b>COUNTY</b>	<b>ECONOMIC IMPACT (BILLIONS)</b>	<b>LOCAL TAXES (MILLIONS)</b>
Bexar	\$1.1	\$41.0
Dallas	\$1.8	\$66.0
El Paso	\$0.5	\$19.3
Harris	\$2.7	\$100.3
Tarrant	\$1.1	\$43.0
Travis	\$0.7	\$25.7
Other Areas	\$8.7	\$325.6
Total	\$16.6	\$620.9

*Source: TXP, Inc., 2004*

**Implications of Funding Cuts**

Funding for mental health care can be viewed as a cost-shifting game. As the National Bureau of Economic Research has noted:

*Each of the players across levels and within levels of the game makes choices subject to rules set at a higher level. Players are presumed to be aware of the behavior of other players at the same level and below and develop policies accordingly.<sup>153</sup>*

Cuts at the federal level have implications for mental health funding at the state level. And when the state cuts mental health funding, many of the costs of mental illness inevitably shift to other state agencies and local jurisdictions. The impacts are both direct and indirect; as dollars available for treatment decline, the social costs associated with untreated illness rise.

## **Costs and Benefits of Treatment**

### *Treatment Works*

Jan, 39, is married and lives in Fort Worth with her husband and two young children. She experienced her first episode of depression in her late twenties, and seriously considered taking her own life. After undergoing therapy and starting anti-depressant drugs, Jan came out of her depression. Two years ago, though, it "kind of crept back up on me."

By summer 2003, Jan had lost all interest in people. Although she worked as a middle school teacher, she would darken her classroom, put the student's assignment on the chalkboard and pretend to read a book. She left her husband and children and moved into graduate student apartment at Texas Christian University (TCU), where she pursued a master's degree.

One night in November 2003, Jan went to several local grocery stores and purchased \$100 in sleeping pills and two bottles of wine. She sat in her car from ten in the evening until six o'clock the next morning contemplating suicide. But, at the last minute, Jan called the TCU police. She thought: *"I didn't want to live. I didn't want to die. I didn't know what to do. But I've got two kids."* Jan drove to the college police station and was met by a psychologist who, along with the police officer, drove her to All Saints Baylor Hospital. She spent six days in the hospital. Jan was diagnosed with bipolar disorder and was put on two different antidepressants and a drug called Lamictal, which works like Lithium, but has fewer side effects.

For the first full day and half, she slept. While attending group therapy during her hospital stay she realized that: *"all of the symptoms I had, were the same symptoms everyone else had. There's hope. Look where I can be in a week. I can be happy."* Jan attended a full month of support groups on an outpatient basis, five days a week for five hours a day. Afterwards, she attended meetings of the local chapter of the Depression Bipolar Support Alliance every Friday for six months.

Jan was fortunate that she had private health insurance, but her health plan only covered 50 percent of her treatment costs. She currently pays \$300 per month for her medications and \$50 for her therapy sessions. She still owes the hospital \$1,800 for her six-day hospital stay, and is paying off the hospital psychiatrist, whom she owed \$2,000, at \$100 per month. She says her treatment has wiped out her savings, but that: *"I need it. I am willing to do what it takes to pay for it. But, it's a strain."*

In May 2004, six months after her hospital stay, Jan graduated from TCU with a 4.0 G.P.A in educational administration. She sees her psychologist every six weeks and her psychiatrist every six months. She has adjusted her medications several times, but takes them regularly. Jan plans to pursue a Ph.D. in reading education. She teaches a class and no longer experiences the panic attacks that haunted her in the past. She credits her treatment and medication for making it possible for her to pursue her dream of becoming a college professor and researcher.

She sums up her experience as follows: *"There are a lot of people out there that can be happy and productive if they can get treatment. I am thankful that I had the resources. I was so lucky. But, what if I didn't have \$6,000 in my savings account?"*

A growing body of literature documents the efficacy of mental health treatment. According to the World Health Organization, effective treatment often can reduce the effects of disability by half.<sup>154</sup> Successful treatment can help even individuals with serious psychiatric impairments live fuller, more productive lives.

Until recently, most evaluations of mental health treatment focused little attention on financial outcomes. A few studies, however, have begun to address the issue, either in terms of interventions related to specific conditions or studies of the overall impact on select populations. In both cases, program costs are set against the benefits of increased labor force participation or earnings and reduced medical expenditures.

### ***Labor Force Outcomes***

In terms of financial impact, depression is the largest burden on the national economy, costing the U.S. an estimated \$33 billion annually in absenteeism and lower productivity.<sup>155</sup> These estimates are conservative, since they do not include the future lost earnings of depressed children and adolescents who fail to complete their educations or become incarcerated.

Numerous studies of the general population suggest labor force participation improves when depressive symptoms lessen.<sup>156</sup> General population studies of pharmaceutical treatment suggest that only 17 to 30 percent of depressed patients receive treatment that meets “minimal standards of adequacy.”<sup>157</sup> And poor treatment can be worse than none, since the cost is incurred even though it fails to produce any significant improvement.

A 1999 *American Journal of Psychiatry* study indicates that mental health treatment is more cost-effective in terms of lost earnings when delivered by mental health professionals rather than primary care physicians. The study found a net savings of \$877 per patient when mental health specialists rather than general health care practitioners deliver depression treatment.<sup>158</sup>

A 2001 *American Journal of Psychiatry* supported these findings. Those who received mental health treatment experienced an average of 16.7 additional depression-free days over a six-month period compared to those treated only by a primary physician. Researchers calculated the cost-effectiveness of this intervention to be \$21 per depression-free day.<sup>159</sup> Other studies have calculated the economic benefit of a depression-free day at from \$10 to \$35 per day.<sup>160</sup>

Treatments for schizophrenia have proven especially cost-effective in terms of increased employment, with significant indirect savings associated with appropriate treatment. Twenty percent of patients taking “atypical” anti-psychotic medication, the newer types of medications, were able to return to work within one year after an acute psychotic episode.<sup>161</sup> Supported employment programs also have demonstrated significant improvements in the number of hours worked and wages earned for persons with chronic mental illness.<sup>162</sup>

### ***Reduced Health Care Costs***

Research has consistently demonstrated savings in primary health care costs from mental health treatment. A study of 10,000 Aetna beneficiaries revealed that total health costs for beneficiaries receiving mental health treatment fell continuously over 36 months.<sup>163</sup> A similar analysis of 20,000 health plan enrollees over a 12-month period found that people with untreated mental illness increased their medical utilization by 61

## ***Economic and Fiscal Impact of Mental Illness***

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percent compared to persons without mental illness in the sample group, while those who received psychological treatment increased their medical expenditures by only 11 percent.<sup>164</sup>

Based on two decades of research, the American Psychological Association maintains that outpatient mental health care saves money by reducing the use of more expensive inpatient treatments.<sup>165</sup>

### ***Treatment Impact in Texas***

Until recently, most evaluations of the effectiveness of mental health treatment have focused on non-financial patient outcomes, with little to no comprehensive investigation of the overall costs and benefits. A few studies, however, have begun to address the issue, either in terms of interventions related to specific conditions, or studies of the overall impact on limited populations. These studies examine mental health treatment costs compared to participation in the workforce and reduced medical expenditures.

In the early 1990s, Congress established the National Treatment Improvement Evaluation Study (NTIES), a major, five-year nationwide study. Its major purpose was to evaluate the effectiveness of substance abuse treatment services delivered through federal grants supported by the Center for Substance Abuse Treatment (CSAT). NTIES was groundbreaking in terms of the size and diversity of its sample and the length of the follow-up period it considered.

**Exhibit 6-2** presents some of the major highlights of the NTIES. Aggregated over a wide number of separate but integrated studies, the effects of treatment options are impressive. Those who received treatment saw their incomes increase and had fewer problems with substance abuse and homelessness.

#### **EXHIBIT 6-2 TREATMENT EFFECTS ON INCOME, WELFARE AND HOMELESSNESS**

	<b>YEAR BEFORE TREATMENT</b>	<b>YEAR AFTER TREATMENT</b>	<b>PERCENT CHANGE <sup>(1)</sup></b>
Received Income	50.8%	60.3%	18.7%
Received Welfare	39.7%	35.4%	-10.8%
Homeless in Last Year	19.2%	11.0%	-42.7%
Used Primary Drug	72.8%	37.7%	-48.2%
Used Cocaine	50.4%	24.8%	-54.9%
Used Heroin	23.6%	12.6%	-46.6%

(1) All percent changes significant at the five percent level.

**Source:** U.S. Department of Health and Human Services

Unemployment, low income, receipt of welfare payments and homelessness all are key predictors of substance abuse. CSAT-sponsored demonstration projects produced substantial improvements in these factors, as well as noteworthy changes in drug abuse patterns.

In almost all cases, the percentage of clients using illicit drugs fell by half for at least a year following treatment; even the use of heroin, generally considered the most treatment-resistant of all illicit drugs, fell off by almost 47 percent in the course of a year. The findings did not, however, specifically address whether treatment programs produce more in financial benefits than they cost.<sup>166</sup>

A 1999 study by the U.S. Department of Health and Human Services' Center for Drug Abuse Treatment addressed this issue directly. In the course of the study, post-treatment health care costs declined by about 10.5 percent, while earnings increased by nearly nine percent.<sup>167</sup>

There is reason to believe that mental health treatment has similar financial effects, particularly community-based programs that address the needs of those with less severe disabilities. While the root causes of substance abuse and mental illness generally differ, the level of disability in daily life—the inability to earn a living effectively, for instance—often is quite similar. Therefore, the research team believes that the financial outcomes related to income and health care costs from the 1999 Center for Drug Abuse Treatment study can be used to estimate the costs and benefits of community-based mental health treatment in Texas.

These programs cost Texas an average of \$2,631 per patient in 2003. In the same year, the estimated average income of Texans with any diagnosable disorder was \$25,342. An income increase of nine percent would lift that figure to \$27,613 annually, a gain of \$2,272. Similarly, the average per capita cost of health care in 2003 was \$4,962; a drop of 10.5 percent in these costs would produce a savings of about \$523.

*Taken together, the increased income and reduced health care costs per person would total \$2,795, slightly more than the average cost of treatment.*

This is not meant to suggest that community-based treatment necessarily “pays for itself,” since the benefits accrue to the individual while the initial cost of the treatment falls to the provider. Even so, the illustration does make the point that the treatment of mental illness can create positive financial effects in addition to more traditional indicators such as improvements in the general sense of well-being.

When viewed from the perspective of society as a whole, community-based treatment is a cost-effective endeavor.

## **Conclusion**

The costs of mental illness affect every level of society, from individuals to communities to the nation as a whole. The research team estimates that the total economic cost of mental illness in Texas during 2003 was \$16.6 billion. Funding cuts, cost-shifting and untreated illness cost Texas state government \$934.5 million, while local governments lost \$620.9 million due to increased costs and foregone revenue. These costs are approximately equivalent to the state's alcohol and cigarette tax revenues in 2003.

## ***Economic and Fiscal Impact of Mental Illness***

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In general, cuts in mental health care funding create unintended economic consequences. For those with severe mental illness, inadequate treatment tends to lead to an increase in indirect public costs related to crime and criminal justice, homelessness and uncompensated health care. For those with less severe conditions, the economy bears much of the initial brunt of inadequate treatment, as research has shown that individuals in the labor force who suffer from mental illness are more likely to be less productive and earn less, while incurring higher overall health care costs. The public sector suffers under this scenario as well, since foregone income means a reduction in tax revenue.

A growing body of research suggests that effective treatment can have a positive cost-benefit ratio. This finding is supported by the literature on the costs and benefits of substance abuse treatment. Substance abuse often accompanies mental illness, and the net benefit associated with treatment programs implies similar results for mental illness. This is especially true for community-based programs, which target a population by definition more likely to be in the labor force, and therefore able to realize the earnings and income-related benefits of effective treatment.



**CHAPTER 7.0**  
**CONCLUSIONS AND**  
**RECOMMENDATIONS**

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## 7.0 CONCLUSIONS AND RECOMMENDATIONS

### Chapter Overview

The effects of mental illness illustrated in this study are far-reaching. Untreated mental illness has serious and costly implications for individuals, families, state and local government and the entire Texas economy. The research team estimates that mental illness cost the Texas economy \$16.6 billion in 2003, primarily due to lost worker productivity. The fiscal impact to Texas state and local government was estimated at \$1.5 billion, \$934.5 million to the state and \$620.9 million to local governments.

Texas has chronically underfunded mental health services. In fiscal 2002, Texas spent only \$38.46 per capita on mental health services, just 44 percent of the national average. After adjustment for inflation, Texas spent nearly 15 percent less on mental health in fiscal 2002 than it did 20 years before.

When we look at the results of an underfunded mental health system on the lives of Texas' children, we see human potential that will possibly never be realized. We have to find a way to demonstrate a value for all the state's citizens-especially the most vulnerable. With adequate funding we can put the emphasis where it needs to be-on prevention, intervention, and transition services for children and youth with mental illness. If we attack the problem at the front end we can get the maximum value out of the lives impacted. And we can also maximize the value of our limited dollars.

-Vicki Spriggs  
Executive Director,  
Texas Juvenile Probation Commission

The good news is that mental illness is highly treatable and that, with proper care and medications, thousands of Texans facing mental illness can become productive members of society, a step that will benefit us all.

This final chapter outlines the research team's key conclusions and presents recommendations for consideration by Texas lawmakers. The recommendations are grouped under three major conclusions.

### Key Conclusions and Recommendations

#### **CONCLUSION 1:**

**The policy decisions of the 2003 Texas Legislature carried costly unintended consequences, but these can be reversed.**

In 2003, lawmakers cut mental health funding by about 3.5 percent over the previous biennium, a substantial decrease in an already underfunded system. The omnibus health and human services reorganization bill, H.B. 2292, also narrowed eligibility for mental health services. This step eliminated consideration of individuals' functional level and with few exceptions limited services to adults with bipolar disorder, schizophrenia or clinically severe depression. This policy change cost an estimated 14,000 Texans with mental illness their eligibility for publicly funded community-based mental health care.

The 2003 Legislature also cut \$5 million in spending for proven new psychotropic medications and reduced access to them by creating a “preferred drug list” or PDL. Today, to receive these medications, patients first must “fail treatment” with a PDL drug.

**RECOMMENDATION 1:**

- **Restore the “target” or “priority” population.** The state’s new requirements determining who may receive services under the disease management model seriously limit access to mental health services. Only about half of Texas adults with mental illness and fewer than 28 percent of children with emotional disturbance were eligible for publicly funded services *before* the change, and of those only a quarter actually received services.

The new restrictions further reduce the number of Texans who can receive help. Although it is too early to evaluate the impact of the new definition, local institutions, particularly emergency rooms and jails, already report a sharp increase in patients with mental illness that have nowhere else to turn.

- **Remove restrictions on the use of cutting-edge psychotropic drugs.** The savings produced by a preferred drug list are short-term only and are more than offset by other expenditures, such as spending for increased hospitalizations.
- **Remove the 90-day waiting period for CHIP services.** The partial restoration of CHIP mental health coverage allowed Texas to restore some of its federal matching funds for mental health services. Even so, the state is still foregoing federal funding for an expensive component of mental health care. Most children with serious emotional disturbance receive a majority of their care during the first 90 days of entry into the mental health system, and presently these costs are born entirely by state and local governments. For every dollar spent on CHIP, the state contributes about 28 cents while the federal government contributes about 72 cents. Eliminating the 90-day wait period for mental health services would allow the state to use federal dollars for early, crucial treatment.
- **Restore full mental health benefit to the Children’s Health Insurance Program.** The 2003 legislature eliminated virtually all mental health benefits in CHIP. Reduced CHIP mental health benefits shift certain costs to pure state dollars without federal match. An insufficient benefit results in delayed care leading to increases in illness severity, which in turn increases treatment costs and decreases positive outcomes. Medical evidence and literature show that patients with untreated mental health conditions incur higher physical health costs than those who receive timely mental health services. A reduction in the mental health benefits (partially restored in 2/2004) is neither fiscally sound nor indicative of good health care policy. The benefits should be restored to their levels at the inception of the CHIP program.

## ***Conclusions and Recommendations***

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- **Restore authorization and funding for optional Medicaid mental health services for adults.** To cut costs, the 2003 Legislature eliminated Medicaid coverage for therapy provided to adults by mental health professionals other than psychiatrists. Although the change produced an estimated annual savings of about \$3 million in state matching funds, it *also* produced a corresponding annual loss of about \$4.5 million in federal funding. Restoring Medicaid coverage for these services would help stretch scarce state and local funds further.
- **Resist further funding cuts and restrictions to mental health services.** Lawmakers are always under pressure to reduce state expenditures and improve efficiencies. Cuts that decrease the amount and availability of mental health services, however, will only further exacerbate the current crisis and send more individuals to jails and emergency rooms to receive any level of care at all.
- **Restore funding cuts to mental health services made by the 78<sup>th</sup> Legislature in 2003.** Funding for services provided by the state's mental health agency were reduced by approximately 3.5%, or \$50 million, for the 2004-2005 biennium as compared to the 2002-2003 biennium. As discussed earlier, these cuts meant the loss of services for thousands of people.
- **Increase funding for mental health services.** Texas currently serves only a fraction of those estimated to be in need of and eligible for public mental health services. Gradual increases in the total amount of funds dedicated to providing mental health care must occur in each biennium in order to effectively treat more Texans eligible for public mental health services.

### **CONCLUSION 2:**

#### **Expand the use of existing, cost-effective mental health care practices.**

Many of these practices are already being used in Texas, such as the state's successful behavioral managed care model, NorthSTAR, which began operations in 1999. A University of Texas study found that NorthSTAR serves more people than conventional methods, for the same amount of money and without a lesser quality of care. The study also credits NorthSTAR with producing more than \$20 million in Medicaid savings over a four-year period.

### **RECOMMENDATION 2:**

- **Expand statewide behavioral health managed care programs.** Improved patient outcomes and reduced costs can be achieved, using lessons learned from the implementation of the NorthSTAR model. It is critical to note that NorthSTAR itself is in jeopardy due to funding cuts and corresponding reductions in reimbursement rates, which have made it more difficult to retain providers in the managed care network.

- **Invest in jail diversion programs.** Jail diversion programs, which divert offenders with mental illness to community-based treatment rather than incarceration, play an increasingly important role in the criminal justice system. In Texas, a number of local governments have initiated such programs, but the state has made only modest investments in them. Federal and state lawmakers alike should consider providing matching grants to jurisdictions with such programs.

**CONCLUSION 3:**

**Adopt best practices from other states that could produce new resources for mental health care.**

**RECOMMENDATION 3:**

- **Create purchasing cooperatives.** New Mexico has received national attention for its ongoing efforts to consolidate public funding for mental health services. In September 2003, Governor Bill Richardson, ordered all New Mexico state agencies that finance mental health and substance abuse services to develop interdepartmental behavioral health purchasing collaboratives. These will contract with a single statewide entity (to be selected through competitive bidding) to manage public mental health and substance abuse programs, including those financed by Medicaid.

One of the key goals of this reform is to reduce administrative costs and redirect resources from “bureaucracy to services.” A related goal is to free up dollars to increase provider reimbursement rates.

- **Consolidate reporting for mental health expenditures.** MGT found that few of the state agencies that provide mental health services as an adjunct to their primary missions track their expenditures in this area. Without a comprehensive accounting of all such expenditures, Texas may be missing opportunities to better coordinate programming and improve system efficiency.
- **Consider ways to increase Medicaid funding of mental health services.** Several comparison states reviewed by MGT have been more successful than Texas in funding their mental health systems with Medicaid dollars. Because the federal government matches Medicaid funding, increasing the use of Medicaid dollars would allow the state to stretch limited resources and serve more Texans in need. In particular, lawmakers should consider the use of Medicaid waivers to fund home and community-based services for Texans under 21 and over 65 years of age.

## ***ENDNOTES***

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## ENDNOTES

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