

# Short- and Long-Term Treatment Subcommittee

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## The Past

### Positive Changes

**Resources:** Service providers practice better stewardship of public dollars than in the past.

**Attitudes:** The community has greater awareness and knowledge of mental health issues and greater expectations. Consumer awareness and responsiveness is valued and promoted.

**Programs:** Positive programmatic changes include:

- Better knowledge and understanding of treatment that works, i.e., evidence-based practices.
- Briefer treatment models are being used.
- Patient “rights” are being re-defined and patients have more control over their own treatment process.
- More persons with mental disorders are accessing behavioral health services through their primary care physicians.
- More consumer advocacy groups exist today.
- Higher expectations regarding cultural sensitivity.

### Negative Changes and Causes for Concern

**Resources:** Fewer services are available through Medicaid and other financial resources are decreasing.

**Attitudes:** The stigma of mental illness persists.

**Programs:** Concerns about programmatic changes include:

- Insufficient case management is available. Fewer intact families mean less family support for consumers.
- The mental health field has moved away from supports and more toward medical interventions, primarily medications.
- Treatment decisions are now driven by insurance limits, causing rationing of treatment.
- Fewer patients are in hospitals, more are incarcerated - the deinstitutionalization of consumers has led to jails becoming de facto providers of treatment.
- New generation medications are better, but there are fewer treatment options for follow-up support.

## THE MAYOR'S MENTAL HEALTH TASK FORCE

- The criteria for institutional commitment have become very narrow.
- The population is aging and few geriatric services exist that focus on mental health.
- Clients are expected to function more in the mainstream, which may be difficult for some clients.

## The Present

### Strengths

**Infrastructure:** The strengths fall primarily into two categories:

*Organizations and entities:* The following are assets to the community:

- Austin Travis County Mental Health Mental Retardation Center.
- The location of Austin State Hospital.
- State agencies and research/data/public policy organizations are headquartered here.
- Pharmaceutical research companies within the city.
- Private residential care such as Meridell.
- Children's System of Care Initiative.
- Texas Mental Health Consumers.
- Indigent Care Collaboration.
- Faith-based community.
- Travis County Hospital District.
- Texas Federation of Families for Children's Mental Health.
- The E-Merge program.\*
- SIMS Foundation.
- VA clinic.
- Community-based substance abuse programs.
- PLAN of Central Texas (provides long-term support).
- Self-Help Advocacy Center (SHAC).
- Private not-for-profit treatment center in hospitals (e.g. Seton Shoal Creek).
- National Alliance of the Mentally Ill (NAMI) Education Programs (e.g. Family to Family courses).
- Texas Mental Health Association.
- Hogg Foundation for Mental Health.

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\* The E-Merge program teams Austin Travis County Mental Health Mental Retardation behavioral health providers with primary care providers at Austin-Travis County Community Health Center sites to improve assessment and treatment of primary care patients with depression, anxiety, and other common mental health disorders.

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*Communication and coordination:* The following are examples of coordination among organizations involved in mental health services:

- A good relationship exists between the Austin Travis County Mental Health Mental Retardation Center and the Austin State Hospital.
- The emphasis on collaborations evidenced by the Children's Partnership, Community Action Network, and the National Alliance for the Mentally Ill (Austin Chapter).
- A good relationship exists between the Austin/Travis County Community Mental Health Centers and the Austin Travis County Mental Health Mental Retardation Center.
- Databases exist for law enforcement, the homeless, and behavioral health.
- Judge Herman's monthly meetings involving involuntary admissions.
- Collaborative relationships between private providers.
- A good relationship exists between the Austin Travis County Mental Health Mental Retardation Center and the Austin/Travis County Health and Human Services and Veterans Services Department.

In addition, Austin has an educated workforce because of the multiple educational resources and a residency program for psychiatrists.

**Training:** The proximity to the Capitol and the Legislature provides opportunities to educate elected officials.

**Resources:** Private resources are available.

**Attitudes:** Positive attitudes are demonstrated by:

- High knowledge levels within the community about mental health due to institutions of higher education and their faculty.
- Awareness of the need for mental health services.
- The community's commitment to diversity.
- Community willingness to address mental health issues, particularly demonstrated by government support and community forums.
- Compassion within the community, i.e., the Crisis Intervention Team\* and the creation of the Mayor's Mental Health Task Force.

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\*The Crisis Intervention Team (CIT) is a joint program of the Austin Police Department (APD) and the Travis County Sheriff's Office (TCSO). The CIT is charged with responding to calls involving people with mental illness, following up with mental health consumers after their initial contact with law enforcement through phone calls and home visits, transporting patients to mental health facilities across the state, and training officers locally and across the state. The CIT is housed at the Austin State Hospital and is staffed by 9 full-time sheriff's deputies and 6 full-time APD officers. An additional 150 APD officers are designated as mental health officers. Each of these officers receives 40 hours of CIT Training (basic mental health peace officer certification). All TCSO deputies have received 8 hours of mental health training and some deputies have attended an additional 40-hour mental health certification training.

## THE MAYOR'S MENTAL HEALTH TASK FORCE

**Programs:** Several specific program strengths are cited by subcommittee participants, including:

- Development of the Crisis Intervention Team.
- Strong victims services organizations.
- Strong network of support groups.
- Early intervention in schools.
- Mental health expertise levels are high.
- A variety of resources exist.
- Austin psychiatric residency program.
- Children's mental health services.
- Managed services model using public dollars.
- Bluebonnet Trails Mental Health and Mental Retardation Center.
- Integrated mental health, substance abuse, and primary care services for the medically indigent (E-Merge).
- Variety of substance abuse services ranging from outpatient to residential.
- Dual diagnosis counseling program at the YWCA.
- Universities and colleges involved in training future mental health professionals.

The entities in the community that are responsible for these strengths include, but are not limited to:

- Austin Travis County Mental Health Mental Retardation Center
- Community Action Network
- Faith-based organizations
- Private foundations
- State programs
- Austin Child Guidance Center
- Lifeworks
- The Children's Partnership
- Safeplace
- City of Austin and Travis County
- Seton Shoal Creek Hospital

The services that the community needs more of include, but are not limited to:

- More of all of the services that already exist.
- More intermediate counseling/therapy (e.g., 10 sessions or less).
- More services for non-priority populations.
- More access to medication for non-priority populations.

### Challenges and Gaps

The majority of the gaps identified are services and strategies that Austin does not have, or are not implementing in a consistent way across the community. The following were highlighted in the discussion:

**Infrastructure:** Participants acknowledge a need for improved coordination between social service agencies and more collaboration between the public and private sector. Some participants are especially critical of the level of communication between organizations. A mobile population is cited as one reason that effective communication is vital. Without effective communication, consumers have difficulty traversing the system.

Participants indicate that there are not enough detox beds in Austin and that the supply of doctors and nurses to work with mentally ill patients is limited.

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**Policies:** Participants on this subcommittee are concerned about the balance between accountability and oversight and the ability to be flexible. The commitment process is cited as one example where mental health professionals may have too little flexibility. A similar issue is raised regarding data shared through information technology, where concerns over privacy issues may supercede the need to share information to improve service delivery. Another policy issue that impacts the delivery of mental health service delivery is the lack of parity in insurance coverage of physical health and mental health.

Texas House Bill 2292 has made significant changes in the delivery of mental health services. The new eligibility requirements of HB 2292, passed by the Texas Legislature effective September 1, 2004, effectively limit services provided by local mental health authorities to individuals diagnosed with one of three disorders: bipolar disorder, schizophrenia, or clinically severe depression (for adults only, the target population for children was not changed, although the target population now refers to children with “severe emotional illness” rather than “severe emotional disturbance”). In addition to denying services to many other individuals with conditions that are treatable and have a high rate of recovery, Task Force participants believe that this use of diagnostic category rather than functional ability to determine service eligibility promotes stigmatization. The new law also requires that a disease management approach be used to treat the three priority disorders, which may result in funds being expended on the first individuals to walk in the door, with little or no funding left for others with the same diagnosis. HB 2292 eliminates therapy provided by psychologists, licensed professional counselors, licensed marriage and family therapists, and social workers to adults under Medicaid. Only psychiatrists are funded under Medicaid, and their services consist primarily of medication management, not counseling. Along with budget cuts to local mental health authorities, the effect of these legislative changes is to limit access to services and place the burden of care on local communities.

**Training:** This subcommittee indicates that education in general is a challenge, but raises two specific training needs: training in dealing with mental illness for non-mental health personnel who are providing services in the community (i.e., training for Meals on Wheels and More volunteers) and educating legislators about mental health.

**Resources:** Funding for mental health services is a challenge -- there are limited resources and a growing population. Among the challenges are recent changes in the Medicaid program that eliminated funding for mental health services for adults provided by psychologists, social workers, licensed professional counselors, case managers, and marriage and family therapists in most settings; local salary scales that do not pay market rates for mental health professionals; the inability of the community to adequately serve the indigent or the 25 percent of the population that has no health insurance; and the high costs of medication.

**Attitudes:** The stigma of mental illness persists. Although consumers can live successfully and productively in recovery, hope for recovery is not often communicated to those experiencing mental illness. The public needs to understand that mental illness is treatable and that recovery is possible.

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**Programs:** Challenges include the following:

- Timely access to programs and services.
- Insufficient capacity of programs and services.
- Access to psychiatric services for private pay patients or for those with no insurance.
- Not enough services for students, including college students.
- The need for psychiatric care within the jails.
- Consumers may not get the most appropriate therapy or services based on their symptoms and conditions.
- Access to medications. The length of time to be seen by a psychiatrist for an evaluation and prescription for medications can be excessive, particularly when clients run out of their medications and need another prescription.
- Families who are aging and trying to care for adult children with mental illness now have heavier responsibilities.
- Consumers may have difficulty communicating the depth of their problems (both physical and mental).
- Given the complex and competing needs within the community, mental health is often not a priority.
- Housing, employment, and transportation are frequently encountered barriers for those with mental illness.
- Follow-up care is insufficient.
- Information about available services is sometimes difficult to obtain, making it hard for consumers to find services.
- Assistance is needed for consumers to establish and sustain self-help resources and support systems.
- The current mental health system tends to be crisis based. A better balance between early intervention and crisis intervention is needed, with increased investment in earlier intervention.
- Better coordination of treatment is needed.
- Implementation of evidence-based or best practices.

Those responsible for filling these gaps include, but are not limited to:

- All of us
- Government
- Policy makers
- Institutions of higher education
- Medical profession
- Faith-based communities
- Schools
- Providers

### The Future

Working in three groups, with one group writing their vision of the future, one group drawing their vision of the future, and one group using building blocks and other three-dimensional objects to depict their vision of the future, participants envision a future that has many interesting characteristics.

The group describing their vision with words produced the following work:

- We would have a more connected, supportive, educated community available to reach out at all levels;
- More seamless delivery of services;

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- A comprehensive continuum of services with activities and services that promote healthy behaviors, early detection, early intervention;
- An emphasis on values -- i.e., supporting family, building relationships and recovery/support systems, enhancing life skills training;
- One-stop shopping for assessment and comprehensive treatment.

The group presenting their vision in a visual format created the following vision:

- Consumer has the “key” to unlock access;
- Increased communication between all entities;
- Increased agency collaboration;
- Increased positive outcomes;
- Adequate financial resources;
- Consumers would participate in well-rounded healthy lifestyles, including recreation, employment, education, housing and spirituality;
- Basic needs such as transportation would be provided;
- Community support teams would wrap around consumers;
- The community would accept those with mental illness without judgment or stigma.

The group working on a three-dimensional scale created a “Maslow’s Village” with the following characteristics:

- Family at the center of an unbroken circle;
- “Heart” (compassion and caring) built into service delivery;
- Housing, food, basic needs, transportation are all provided;
- Multi-service healthcare system that includes mental health;
- “Movers and Shakers” are close to services to ensure funding;
- Respite services are available;
- Smaller percent of mental health population entering the criminal justice system;
- Continuing education for family and community as a part of healthy lifestyle and good mental health;
- Strong community connection with others;
- Life line for access, i.e., how to find services, how to get services;
- Old system equals “Jurassic Age,” which must be left behind to build new system to serve community better.

### Criteria for a Mentally Healthy Community

Participants were organized into three groups, with each selecting criteria for two of the six categories (infrastructure, resources, policies, programs, training, and attitudes) and developing criteria in each category. The groups were then instructed to utilize the following guidelines in prioritizing their top three choices in each of the six categories:

- At least one of the criteria must be cost-neutral;
- Must be feasible and measurable;
- Must have significant impact;
- Reflects evidence-based or best practices;

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- Is innovative/creative/out-of-the-box thinking;
- Addresses an identified gap.

Each of the groups then presented their top three choices to the whole group and explained why they had prioritized those criteria. The members of the group were each given six votes to cast for those criteria they believed were most important, with the objective of identifying the top twelve criteria. After discussion and some consolidation, ten criteria resulted and are listed below in priority order:

T 1. A mentally healthy community has at least one Psychiatric Emergency Center in an existing hospital with a detox center attached.

T 2. A mentally healthy community has access to outpatient services within one week of identified need (i.e., medications, psychotherapy, employee assistance (EAP)-type programs).

T 3. A mentally healthy community has short- and long-term residential treatment options based on population needs.

T 4. A mentally healthy community partners with consumers and families to promote hope, recovery, and self-determination.

T 5. A mentally healthy community has a policy to maintain and expand a community practice standard (e.g. practice standards in the Crisis Intervention Team\* curriculum) across law enforcement and public safety agencies for “crisis intervention” based on a clear understanding of mental illness, the law, and best practice educational curricula.

T 6. A mentally healthy community promotes parity in mental and physical healthcare benefits beginning with City and County employees and extending to enrollees in publicly funded safety-net delivery systems.

T 7. A mentally healthy community increases awareness that mental health issues affect all of us –“it is us” – and promotes the concept that mentally healthy lifestyles and a mentally healthy community are shared values.

T 8. A mentally healthy community provides training to promote optimal mental health emphasizing systems of care, hope, and recovery.

T 9. A mentally healthy community ensures ready access to routine, urgent, and emergency care for mental health and substance abuse services.

T 10. A mentally healthy community provides training for support network members in the community, inclusive of non-professionals and the faith community.

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One additional criterion was added as a result of public input:

T 11. A healthy community strengthens and expands the continuity of affordable services available for those who do not meet the criteria for the three mental health target populations (e.g. time-out services, medications, case management, follow-up care).