TEXAS PUBLIC POLICY FOUNDATION
PolicyPerspective

November 2011
Center for Health Care Policy

Mental Health: A Survey of State-Funded Delivery

by Spencer Harris
Health Care Policy Analyst

Key Points

- Since reform began in 1964 giving preference to community care, the average daily number of people in state hospitals has been reduced from 14,921 to 2,822 in 2009.
- 17% of Texans live with some form of mental health disorder.
- Privatize state hospitals to lower cost and realize successes in patient care.

Introduction

More than 4.3 million Texans, including 1.2 million children, live with some form of mental health disorder. Of these, 1.5 million cannot function at work, school, or in the community because of their illness.[1] Few Texans understand how our mental health care infrastructure works because of a lack of transparency in the system. Many advocate for more spending on mental health in Texas. Rather than allocating more resources to mental health financing the state should first find more efficient ways to spend the current appropriations.

Mental health constitutes a unique area of health care, complicated by the fact that there are very few "cures" for mental illness. The three major mental illnesses—schizophrenia, bipolar disorder, and clinically diagnosed depression—often require life-long and costly disease management programs.

Texas could benefit from looking at successes in other states where reforms made long-term, positive care impacts without increasing costs. These reforms include increased privatization, increased transparency, and increased provider of last resort restrictions. Providing more efficient, accountable care will result in lower costs and better care.

Background

Texas began developing its modern health infrastructure in earnest in the early 1960's with the development of the Texas Plan initially by Dr. Spencer Bayles and later by Dr. Moody Bettis. The Texas Plan came about in parallel to the national *Action for Mental Health*. The Community Mental Health Act of 1963 was a part of President Kennedy's New Frontier, and it provided federal financing for community mental health centers. The Texas Plan aimed to modernize the state's mental health care infrastructure by developing treatment and processes outside of state psychiatric facilities and following the national trend of deinstitutionalization. In 1963, the Texas Legislature passed House Bill 3 which incorporated much of the Texas Plan including the development of Comprehensive Community Mental Health and Mental Retardation Centers, now called Local Mental Health Authorities (LMHA). To oversee their development, HB 3 created the Texas Department of Mental Health and Mental Retardation (TDMHMR).[2] Granted money by the federal Community Mental Health Act of 1963, LMHAs were locally governed authorities that aim to increase community-based treatment of mental illness. The development of local mental health infrastructure moved forward reducing the number of clients served in psychiatric hospitals. The state mental hospital population declined from 14,921 in 1964 to 9,477 by August 1973 and to 8,000 by 1975.[3]

This move toward community-based services was a significant shift in Texas mental health care delivery. The LMHAs were the primary providers of community-based services along with the authority for the purchasing and coordination of local services. Clients not served through community-based services were served through state mental hospitals. This same structure would be expanded statewide

continued on next page

Today, the Texas mental health infrastructure can be divided broadly into two parts: crisis intervention and treatment. Texas has a fairly robust crisis intervention infrastructure, but the state's treatment infrastructure should be improved.

without major reforms until 2003. House Bill 2292 from the 78th Legislature, abolished TDMHMR, split the responsibility of mental health care and mental retardation care between the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS), and made LMHAs the provider of last resort. HB 2292 authorized significant moves toward privatization of services.

Today, the Texas mental health infrastructure can be divided broadly into two parts: crisis intervention and treatment. Texas has a fairly robust crisis intervention infrastructure, but the state's treatment infrastructure should be improved.

Crisis Intervention

Crisis intervention is important in mental health care because without a proper identification of mental illness clients tend to circulate through the jail and hospital system repeatedly.[4] HB 2292 required all LMHAs to develop jail diversion programs for priority mental illnesses (schizophrenia, bipolar disorder, and major depression). In 2007 and 2009 the crisis mental health system was appropriated an additional $82 million and $53 million to enhance crisis intervention programs. This funding was to reduce utilization of emergency rooms or more restrictive settings. Competitive grants with local matching dollars allowed for the maximization of funds to develop mobile outreach and crisis hotline services. It also expanded residential services, stabilization units, and observation units. These services are primarily provided to local authorities by the LMHA. These local authorities are generally first responders such as police or EMTs. Employing effective crisis intervention tools is crucial to reducing recidivism and providing effective care.

The LMHAs also have many resources devoted to crisis intervention and management. Every LMHA operates a mobile crisis intervention team. Consisting of a range of mental health experts, from psychiatrists to nurses to psychologists to counselors and social workers, these crisis teams provide onsite emergency assistance as part of LMHA services and are on-call 24 hours a day, 7 days a week. They respond to calls for emergency care from patients themselves, law enforcement officers, families, friends, or anyone who sees a critical psychological crisis occurring. Numerous scientific studies (as far back as 1993[5]) have been performed regarding the effectiveness of these types of programs, and the conclusions have been very positive: "community-based forms of crisis intervention, such as . . . mobile crisis response teams, have been found to be highly effective and cost-efficient relative to inpatient-based acute treatment."[6] By using trained professionals to make contact with someone in a mental health crisis, these teams can lower the rates of both emergency room use and unnecessary incarceration.

One study of emergency cases found that 55 percent of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28 percent of the emergencies handled by regular police intervention.[7] But, the same study discovered that the average cost per case was 23 percent less for persons served by the mobile crisis team than a trip to the ER.[8] The study did not address the cost of the mobile team itself, but the per diem cost of care is significantly less. DSHS found that the "average monthly cost per person receiving mental health crisis services" in 2011 was $392, or about $13 per day.[9] Compare this with the average daily cost of $401 for treatment in a state hospital. Another study found similar results: "when all other independent variables were controlled for, a consumer in the hospital-based intervention group was 51 percent more likely to be hospitalized than a consumer in the community-based mobile crisis intervention group."[10] Crisis intervention times are not intended to eliminate the use of hospitalization rather they are used to reduce unnecessary hospitalization. It is uncertain whether the costs of mobile crisis intervention teams are offset by reduced jail and hospitalization rates. However, the dramatically lower per diem costs combined with better, proper care for individuals provide a compelling case for utilization of mobile crisis intervention teams.

Treatment

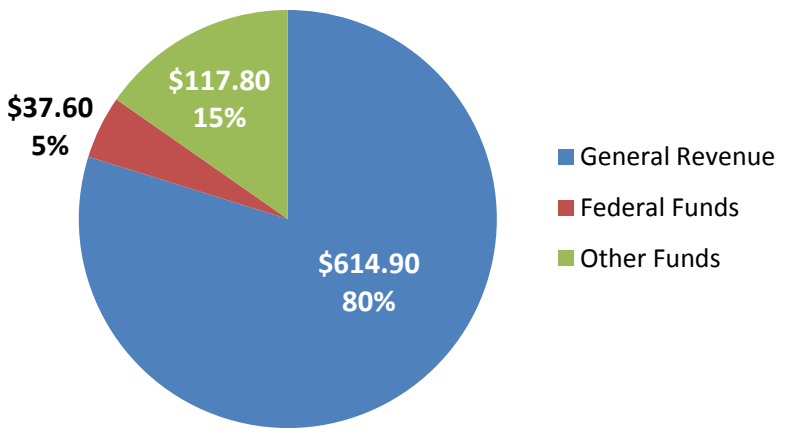
After an individual presents for treatment through crisis intervention services they must be stabilized and treated. Mental health treatment is different from traditional health care because treatment is ongoing disease management. Treatment services in the state are delivered through a number of providers, but government spending is through three main entities: state mental hospitals (SMH), community hospitals, and LMHAs.

Texas operates nine different adult psychiatric hospitals in Austin, San Antonio, El Paso, Harlingen, Kerrville, Terrell, Rusk, Big Spring, and Vernon, along with the Waco Center for Youth that focuses on adolescent care. These are residential facilities designed to accommodate long-term patients, both voluntarily and involuntarily admitted. One of the modes of admission to a state mental hospital is through the patient's LMHA. The LMHA conducts all relevant psychological screening and assessments and refers patients with acute needs to hospitals. The hospitals themselves can also conduct emergency admission screening for voluntary patients. However, a large percentage of mental hospital patients are involuntarily committed through the criminal justice system. According to the Legislative Budget Board, "in fiscal year 2010, the total number of beds at SMHs was 2,461 including 1,558 civil beds and 903 forensic beds."[11] Thirty-seven percent of Texas state hospital space is specifically assigned to criminal offenders with mental health issues who have been committed by court order. Services include psychological assessment, medication management, various therapeutic programs, and others. Much like LMHAs, the funding for state hospitals comes largely from Texas' General Revenue, but Federal Funds and other funds (such as grants or private donations) do supplement state money (**see Figure 1**).

Mental health community hospitals are the second, and smallest, of the three major parts of our mental health infrastructure. These are made up of relatively small psychiatric hospitals in three regions of the state. The largest of these facilities is the 214-bed Harris County Psychiatric Center which works in coordination with the UT Health and Science Center. These facilities provide a variety of needs based on local demand, but generally they are accessed for inpatient hospitalization including assessment, crisis stabilization, and medication stabilization. Some also serve the role of teaching hospitals for psychiatry students. Mental health community hospitals are funded entirely through General Revenue (GR), and in 2011-12 they received $107 million in appropriations.

LMHAs are the third major portion of the mental health infrastructure. LMHAs are the nexus of our state's non-institutional mental health care. They were the cornerstone of both the federal Community Mental Health Act of 1963 and the state's HB 3 in 1963. The Texas Department for State Health Services (DSHS) currently contracts with 39 LMHAs in the state, each defined as the "entity designated by the department to direct,

Figure 1: State Mental Hospital Funding, 2010-2011 Biennium (millions)



Source: "Managing and Funding State Mental Hospitals in Texas: Legislative Primer," Legislative Budget Board, Feb. 2011.

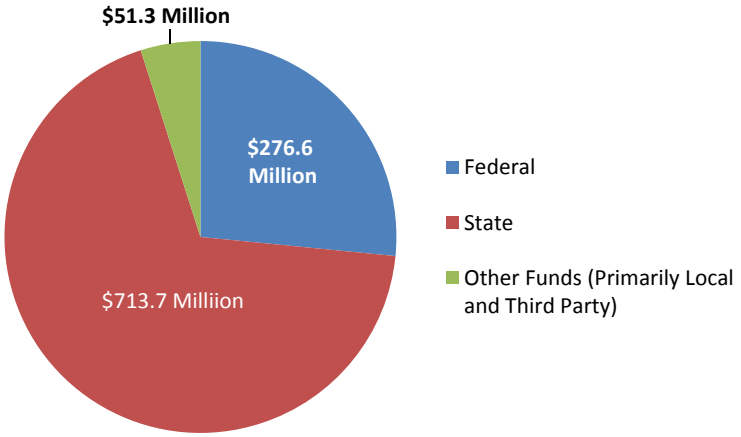
Since 2007 LMHAs have increased their role as network coordinator and point of referral for care. However, LMHAs still serve the role of provider, especially in areas that have little resources in the private market.

operate, facilitate, or coordinate such services to mentally ill persons as are required to be performed at the local level by state law and by the department."[12] Adult services primarily fall under five categories: Assertive Community Treatment (ACT), supported employment, supported housing, Co-occurring Psychiatric and Substance use Disorders (COPSD), and homelessness.[13] Outside of these five categories LMHAs develop a slate of mental health benefits to suit their region's needs. Prior to 2003 the LMHAs were the primary provider of these services, among others, for the state's local mental health needs. Since 2003 LMHAs have been under direction to be the provider of last resort, meaning in principle that all cases must be referred to private providers if at all possible. In 2007, LMHAs were given the directive to produce Local Network Development Plans—to "develop a local network development plan to guide the configuration and development of the LMHA's provider network. The plan shall reflect local needs and priorities and shall be designed to maximize consumer choice and consumer access to services provided by qualified providers."[14] Since 2007 LMHAs have increased their role as network coordinator and point of referral for care. However, LMHAs still serve the role of provider, especially in areas that have few resources in the private market.

Utilizing local authorities and providers for any health care delivery, mental health included, has common issues. Variation in the quality of care is one issue that occurs in the LMHA system, depending on local resources. Also, employing 39 authorities "with multiple funding sources" makes accountability more difficult. This structure lacks policies that encourage the LMHA to compete against each other.

Because mental health is best served by a disease management model, Texas created the Resiliency and Disease Management Initiative (RMD) to better utilize the limited resources allocated to Texas mental health. The program is aimed at "establishing who is eligible to receive services, establishing ways to manage the use of services, measuring clinical outcomes or the impact of services, and determining how much these services should cost."[15] This initiative also encouraged uniform assessment of needs, development of packaged services, utilization management, quality management, data management, and improved funding strategies.[16] The RMD has led to an improvement in resource allocation, and it has been generally well received by stakeholders. However, there is still a problem with capacity limitations.[17] For instance, the Travis County MHMR had a monthly average of 550 individuals on the waiting list in FY

Figure 2: Total LMHA Funding FY 2008-09



Source: Public Information Request, Department of State Health Services, Oct. 2011.

Figure 3: Breakdown of LMHA Funding, FY 2008-09

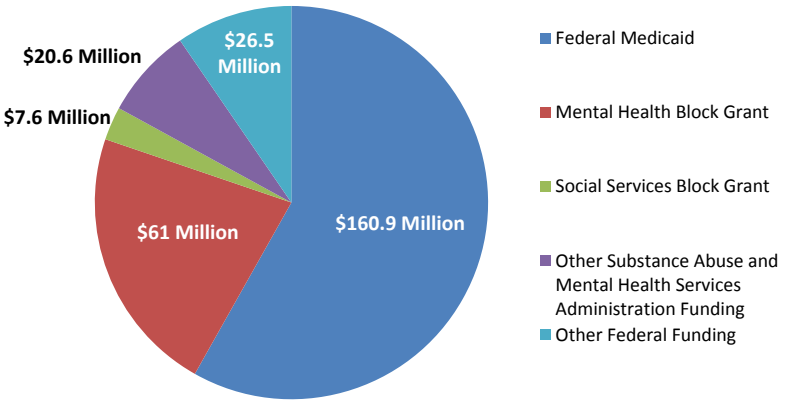
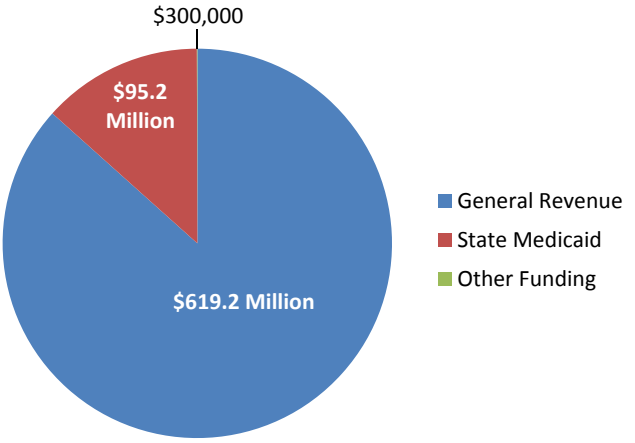


Figure 4: Total State LMHA Funding, FY 2008-09



Source: Public Information Request, Department of State Health Services, Oct. 2011.

2007.[18] This can amount to 13 months that an individual stays on the waiting list.[19] LMHA financing is broken down in Figures 2, 3, and 4.

NorthSTAR

The NorthSTAR behavioral health waiver was established in 1999 to replicate the success found in Medicaid managed care (STAR/STAR+) in the behavioral health arena. North Star is different from other providers around the state because it "utilizes at-risk model, behavioral health care services carved out of the physical health service delivery system, integration of mental health and substance abuse services, blended local, state, and federal funding, and authority provider separation (i.e., the entity responsible for authorization is not the provider of services)."[20] NorthSTAR contracts with private behavioral health organization ValueOptions for program management. However, NorthSTAR has not found the level of success that STAR and STAR+ have.

NorthSTAR has only contracted with one behavioral health organization (BHO), which is the behavioral health equivalent of a managed care organization, that being ValueOptions. In STAR and STAR+, at least two providers are required in each service area. NorthSTAR has not exhibited the ability to attract new providers. Currently, ValueOptions is required to spend 88 percent of state funds on direct services. The eligibil-

ity for this program was also expanded beyond the traditional level to all indigent behavioral health needs, and it was required that all eligible individuals be served without a waiting list. Spending per adult in NorthSTAR was $2,303 compared with a range of $1,872 to $4,410 elsewhere in the state. While NorthSTAR is generally lower in costs their clients are more likely to be underserved and receive fewer core services.[21] One criticism of NorthSTAR is that outcome data is incomplete.[22] NorthSTAR outcome data does not include emergency room visits or inpatient LMHA services. The NorthSTAR concept has promise for the future, but with limited care success and without adequate outcome data, it should not be considered for statewide expansion at this time.

Key Issues

Financing and Transparency

Texas currently spends less per capita on mental health than all other 49 states.[23] Spectators have argued that this is evidence of a failing, underfunded system, but that does not tell the entire story. Texas has developed a remarkably robust mental health system for the amount of money that has been appropriated over the years. Historical financing for mental health in Texas can be seen in **Figure 3**.

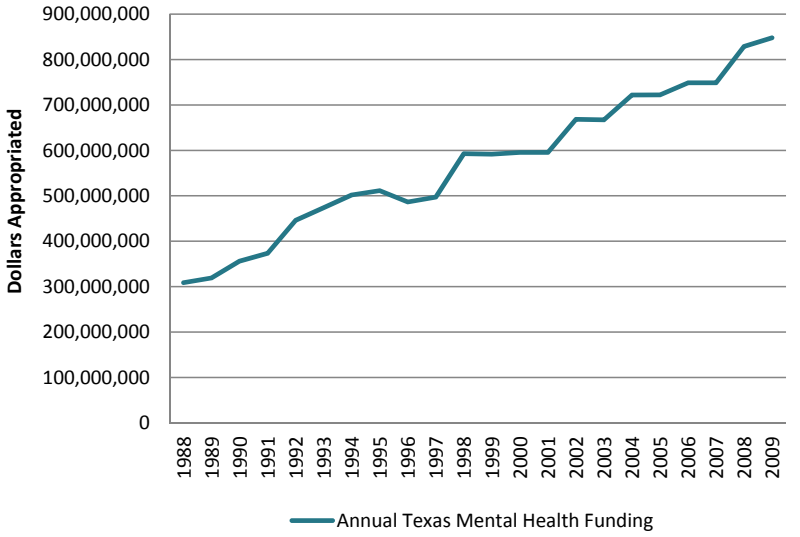
Since 1988 mental health financing has climbed 274 percent in the state of Texas. This amounted to $38.38 per capita for state sponsored mental health care in Texas in FY 2009. Compare that to the highest spending state per capita, Maine, at $345.97, and the national average of $122.90. However, Maine's mental health system is very similar to Texas. Maine's adult mental health services utilize telephone and mobile outreach services paired with psychiatric consultations as means of crisis intervention. Their crisis intervention services coordinate with multiple authorities and systems to maximize effectiveness. These are all practices employed in the Texas mental health system. However, Texas mental health care financing falls short on transparency, particularly at the LMHA level.

LMHAs must be supported by a local tax structure in order to have access to state and federal matching dollars. They are also supported by private monetary and in-kind donations. This means there are at least three, and often more than three, funding streams to each LMHA. This leaves it difficult for tax payers and stakeholders to see and understand how money is being spent.

Efficiency

While the Texas mental health system is a developed, robust system there are still areas where efficiencies can be found.

Figure 5: Annual Texas Mental Health Funding in All Funds



Source: Legislative Budget Board

In particular Texas could increase the efficiency of our state hospitals through privatization. According to the most recent performance indicators published by DSHS, six out of the nine Texas state hospitals are operating at 95 percent capacity or above, with Kerrville State Hospital completely full at 100 percent capacity.[24] As of February 2011, the average daily census was 2,326 patients and the average length of stay of these patients is 65 days, but many more patients are being denied access to care. Health Management Associates determined that during FY 2010 in Texas, the state hospital system was on "diversion," meaning at least one of the facilities was too full to accept any admissions 40 percent of the time.[25] Once a patient is finally admitted, the quality of the care they receive is often lacking. In 2010, there were 279 confirmed cases of abuse and neglect in Texas State Hospitals, and 2,347 formal investigations of abuse were filed and completed. In just the first two quarters of FY 2011, there have been 1,808 incidences of mechanical restraint (170 of which led directly to client injuries) and 196 incidences of seclusion. Finally, DSHS recorded 2,380 cases of "medication error" in the state hospital system in FY 2010 alone.[26] DSHS lists demonstrating "efforts to reduce" these various qualities of care lapses "with a goal of zero" under their explicit state hospital performance objectives, but the situation does not show signs of improvement. **Figure 4** shows a quarterly breakdown of restraint instances across all Texas mental hospitals, displaying the relatively static nature of the data.

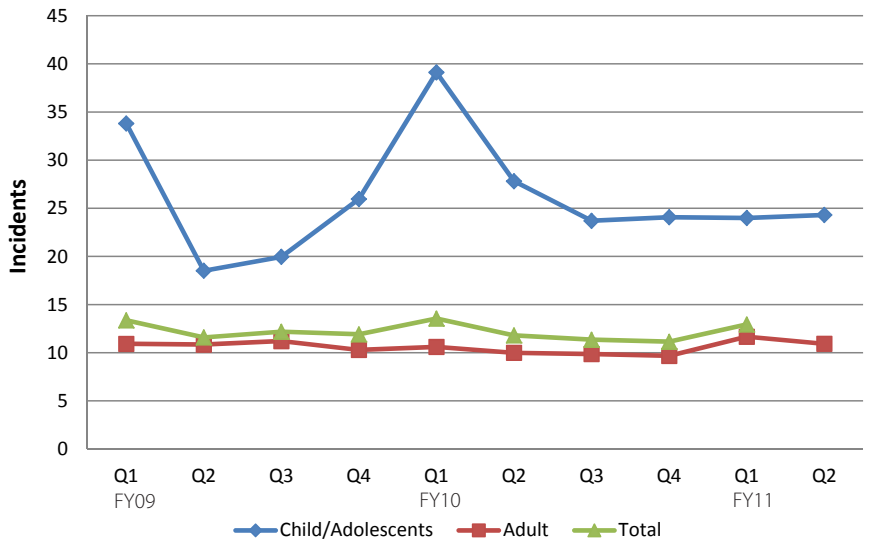
Recommendations

Privatize State Hospitals

Florida has seen the clearest, most successful results from privatizing a state facility. Advocacy groups demanded change, and the Florida Legislature chose privatization as the best solution. In 1998, the Florida Legislature awarded a contract to Atlantic Shores Healthcare Inc. (now GeoCare Inc.) to take over operations of the South Florida Psychiatric Hospital. The results were as follows:[27]

- Patients' average length of stay dropped from eight years to less than one year.
- Use of seclusion and restraint dropped from more than 15 incidents each month to less than one.
- The waiting list for beds disappeared completely, meaning the new administration served far more patients.
- Because of its greatly increased efficiency, Atlantic Shores was able to construct a new multimillion-dollar, state-of-the-art facility without receiving any additional money from the Florida Legislature.
- At the time of the transition, no state hospital had been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but within 10

Figure 6: Restraint Incidents per 1,000 Bed Days



Source: Department of State Health Services

Since 2003, LMHAs have been the provider of last resort, and since 2007 they have had clear regulations on when they can be a provider. However, LMHAs often still operate close to capacity as a provider.

months of privatization, Atlantic Shores had earned JCAHO's certification.

In 2002, the Florida Statewide Advocacy Council sent a formal recommendation letter to Governor Jeb Bush, stating that they "support[ed] the privatization of additional state facilities in Florida and passed a motion unanimously to that effect."[28] Now, the state of Florida has let several more contracts and privatization has rapidly expanding across the country as other states follow suit.

Why hasn't Texas already privatized state hospitals? In 2003, the 78th Legislature added Section 533.050 to the Texas Health and Safety Code, allowing for contracts that would bring about this solution. No private company signed a contract in pursuance of the law. While the Legislature had the right intentions in requiring a number of qualifications to win a state contract, some were too stringent. Subsection (a)(4) stated that "the private service provider is required under the contract to operate the hospital at a quality level at least equal to the quality level achieved by the department when the department operated the hospital."[29] But, too stringent was the cost-saving measure found in Subsection (a)(1), requiring that a private contractor run the hospital "at a cost that is at least 25 percent less than the cost to the department to operate the hospital," make corporations unlikely to invest resources into this kind of market.[30]

Florida's system prior to privatization was significantly different from Texas' today. For instance, the average length of stay was eight years prior to 1998 in Florida, and it is less than one year in Texas today. Nevertheless, their experience serves as an example of success in privatization, both in cost and quality of care. Atlantic Shores' resounding success in Florida did not save over 25 percent of the previous state hospital budget, but it provided immensely better care to thousands of patients, thereby helping them to recover and stay out of emergency rooms and jail cells. As such, privatization in Florida undoubtedly did save the state money, but requiring Atlantic Shores to operate at 75 percent funding levels and demonstrate direct administrative savings would have ruined the project. The state should remove the requirement for a 25 percent cost reduction and explore opportunities to privatize, including not only the operation but also the building of new facilities with private funds to replace the old, high-maintenance state facilities.

Further Move Toward Privatization of Local Resources

Since 2003, LMHAs have been the provider of last resort, and since 2007 they have had clear regulations on when they can be a provider. However, LMHAs often still operate close to capacity as a provider. Texas should continue the push toward providing care through private local providers. The Legislature should require LMHAs in areas without more than one private provider to produce an estimate of the cost of care per client for each service offered. If certified private providers operating elsewhere in this state can produce a lower bid for services, then they should be guaranteed a contract contingent on their establishment in the service area.

The state Legislature should further refine the parameters under which LMHAs can provide services. LMHAs are much more effective in their role as care coordinator and network developer. By reducing their role as provider Texas can reduce state subsidized competition with private providers that may be a barrier to entry. It will also alleviate LMHA resource to further improve their Local Network Development Plans.

Increase Budget Transparency and Competition

LMHAs and state hospitals both receive local, state, and federal funding. As such, it is difficult for the average taxpayer is to see where and how their tax dollars are being spent. LMHAs and state hospitals should be required to publish quarterly budgets with a breakdown of funding sources, funding allocation, and relative program costs. The increased accessibility of this data will give taxpayers and stakeholders a better idea of how and where their money is being used. This increased transparency can be leveraged for increased accountability through public forums and comments for local stakeholders.

The state should also dedicate a percentage of the total funds for LMHAs to the top performing local authorities based on quality and cost metrics such as cost per individual, average number of improper treatments, etc. This competitive financing will shed more light on lower performing LMHAs and reward those that perform better.

Improve NorthSTAR Outcome Metrics

Managed care in behavioral health holds promise for cost containment. However, a limited number of managed care providers and inadequate outcome data have restricted the ability to assess the benefits of competition and capitated or blended rates in behavioral health state wide. The legislature should improve outcome metrics based on the recommendations in the Legislative Budget Board's Texas State Government Efficiency and Effectiveness report from January of 2011.

Conclusion

The 2014-15 biennium is going to be another difficult budget session for Texas. The growth in Medicaid is crowding out other state services leaving state funding for programs limited at best. It will be crucial to keep government spending low in order to continue the state's economic prosperity. Texas also should continue the positive progress the state has made in mental health since 2003. This can be done by finding new efficiencies through privatization and transparency. ☆

Endnotes

[1] "Mental Health Funding" (accessed 18 Oct. 2011) http://www.texmed.org/Template.aspx?id=19994&ter ms=mental+health+funding.
[2] "Mental Health" (accessed 18 Oct. 2011) http://www.tshaonline.org/handbook/online/articles/smmun.
[3] Ibid.
[4] Health Management Associates, "Impact of Proposed Budget Cuts to Community Based Mental Health Services," last modified March 2011, http://www.epmhmr.org/files/Impact_of_Budget_Cuts_to_Community-based_Mental_ Health_Services_Final_3_9_11.pdf
[5] Eileen Salinksy and Christopher Loftis, "Shrinking Inpatient Psychiatric Capacity: A Cause for Celebration or Concern?," National Health Policy Forum 823 (2007) http://www.nhpf.org/library/issue-briefs/IB823_InpatientPs ych_08-01-07.pdf.
[6] Roger L. Scott, "Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction," American Psychiatric Association Other Articles (2000) http://ps.psychiatryonline.org/cgi/content/full/51/9/1153.
[7] Ibid.
[8] Shenyang Guo, David E. Biegel, Jeffrey A. Johnsen, and Hayne Dyches, "Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization," American Psychiatric Association Other Articles (2001): Section 2, http://psychservices.psychiatryonline.org/cgi/content/abstract/52/2/223.
[9] "Behavioral Health Databook: 2011 Q3" (modified 12 July 2011) http://www.dshs.state.tx.us/mhsa/databook.
[10] Shenyang Guo, David E. Biegel, Jeffrey A. Johnsen, and Hayne Dyches, "Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization," American Psychiatric Association Other Articles (2001) http://ps.psychiatryonline.org/cgi/content/full/52/2/223.
[11] "Managing and Funding State Mental Hospitals in Texas: Legislative Primer," Legislative Budget Board Staff (modified Feb. 2011) http://www.lbb.state.tx.us/Health_Services/Mental%20Hospitals%20in%20Texas%20Pri mer%20Complete%20Report%200211.pdf.
[12] "Admission Information," last modified April 8, 2011, http://www.dshs.state.tx.us/mhhospitals/AustinSH/A SH_Admissions.shtm.
[13] "Adult Mental Health Services" (modified 31 Aug. 2011) http://www.dshs.state.tx.us/mhservices/MHAdul tServices.shtm.
[14] Texas Administrative Code Title 25 Part 1 Chapter 412 Subchapter P Rule 412.756 (accessed 18 Oct. 2011) http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&p g=1&p_tac=&ti=25&pt=1&ch=412&rl=756.
[15] "Resiliency and Disease Management" (modified 1 Sept. 2010) http://www.dshs.state.tx.us/mhprogra ms/rdm.shtm.
[16] Ibid.
[17] Ross Robinson, "Update on Resiliency and Disease Management: (RDM) Re-Design Progress" (modified 15 Dec. 2010) http://www.ntbha.org/docs/Broadcast_MSG_BHP005.pdf.
[18] "UM Waiting List Summary for 2005 and 2006" (accessed 18 Oct. 2011) http://www.mmhtfmc.org/ama /orig/annual_reports/third_annual/DSHSWaitList05_06.pdf.
[19] "Behavioral Health," Community Impact Report Part 1: Community Condition Highlights (2009) http://www.co.tr avis.tx.us/health_human_services/research_planning/publications/cir/cir_2009_pt_1/07_behavioralhealth.pdf.
[20] "Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations" (accessed 18 Oct. 2011) http://www.lbb.state.tx.us/Performance%20Reporting/TX_Govt_Effective_Efficiency_Report_82 nd.pdf.
[21] Ibid.
[22] Ibid.
[23] "State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures, FY2009" (accessed 18 Oct. 2011) http://www.statehealthfacts.org/comparemaptable.jsp?cat=5&ind=278.
[24] "State Mental Health Facilities Quarterly Performance Indicators" (modified 13 July 2011) http://www.ds hs.state.tx.us/mhreports/PIMHpub.shtm.
[25] Health Management Associates, "Impact of Proposed Budget Cuts to Community Based Mental Health Services" (modified Mar. 2011) http://www.epmhmr.org/files/Impact_of_Budget_Cuts_to_Community-based_Mental_ Health_Services_Final_3_9_11.pdf.
[26] "State Mental Health Facilities Quarterly Performance Indicators" (modified 13 July 2011) http://www.dshs. state.tx.us/mhreports/PIMHpub.shtm.
[27] Betty Busbee, "Florida Statewide Advocacy Council's letter to Governor Bush, President Mckay, and the Speaker Feeney" (modified 24 Apr. 2002) http://www.geocareinc.com/FLAdvocacyCouncilLetter.pdf.
[28] Texas Health & Safety Code - Section 533.050. Privatization Of State Mental Hospital (11 Aug. 2007) http://law.onecle.com/texas/health/533.050.00.html.
[29] Ibid.
[30] "State Mental Health Facilities Quarterly Performance Indicators" (modified 13 July 2011) http://www.d shs.state.tx.us/mhreports/PIMHpub.shtm.

About the Author

Spencer Harris joined Texas Public Policy Foundation in 2010 as a Health Care Policy Analyst. His research focuses on identifying patient-centered, free market solutions for our state's health care challenges.

No stranger to Texas public policy, Spencer worked in the House of Representatives for Rep. Warren Chisum where he covered health care issues, immigration issues, and the Licensing and Administrative Committee.

Spencer is a native Texan, born and raised in Houston. He graduated from Texas A&M University with a degree in History and Anthropology.

About the Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 non-profit, non-partisan research institute. The Foundation's mission is to promote and defend liberty, personal responsibility, and free enterprise in Texas and the nation by educating and affecting policymakers and the Texas public policy debate with academically sound research and outreach.

Funded by thousands of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.

Texas Public Policy Foundation

900 Congress Ave., Suite 400 | Austin, Texas 78701 | (512) 472-2700 phone | (512) 472-2728 fax | www.TexasPolicy.com