Resiliency and Disease Management for Community Mental Health in Texas

Abstract

Resiliency and Disease Management (RDM) was implemented at all DSHS-funded community mental health centers beginning in State Fiscal Year 2005. The goal is to promote the uniform provision of services based on clinical evidence and recognized best practices to advance the recovery of adults with serious mental illness and the resiliency of children with severe emotional disturbance. In this article, the demographic and diagnostic characteristics of adults and children who received RDM are presented. The RDM model is then outlined, and each component reviewed, including assessment, evidence-based levels of care, fidelity, and outcomes. Finally, adherence to clinical guidelines is discussed as a challenge that remains to be addressed so that RDM may give rise to the best possible clinical outcomes for Texans. Descriptive statistics are presented throughout.

Introduction

The Resiliency and Disease Management (RDM) initiative was implemented in State Fiscal Year (SFY) 2004 at four DSHS-funded community mental health centers: Tarrant County MHMR; Texas Panhandle MHMR (based in Amarillo); Hill Country MHMR (based in Kerrville); and Lubbock Regional MHMR. In SFY2005, DSHS contracted with all 39 community mental health centers in Texas to provide RDM to adults with serious mental illness and children aged 3 to 17 with severe emotional disturbance, as mandated by Texas House Bill (HB) 2292.

RDM transforms the Texas public mental health system in multiple ways for adults with serious mental illness, and is intended to maximize the possibility for recovery. The goal is to promote the uniform provision of services based on clinical evidence and recognized best practices to advance the recovery of adults with serious mental illness. For children and adolescents with severe emotional disturbance, the goal is similar, but the focus is on building resiliency as a means of developing improved functioning and behavior.

In SFY2006, 109,231 adults (up almost 4% from SFY 2005 = 105,131) and 27,666 children (up almost 6% from 26,213 in SFY 2005) received RDM at DSHS-funded community mental health centers.

Table 1 shows that among adults, most were between the ages of 21 and 40 (41%) or 41 and 50 (29%), female (59%), White (53%), indigent (61%), and had a primary psychiatric diagnosis of Major Depressive Disorder (37%), Bipolar Disorder (32%), Schizophrenia (28%), or other psychiatric disorders (3%).

Among children served, **Table 2** reveals that most were between the ages of 13 and 17 (58%), male (67%), Hispanic (39%) or White (35%), had Medicaid (75%), and most had a primary psychiatric diagnosis of Attention Deficit Disorder (38%) or Disruptive Behavior Disorder (16%). Moreover, as part of RDM, children's psychiatric diagnoses are categorized as *externalizing disorders* (e.g., Attention Deficit Disorder and Disruptive Behavior Disorder), *internalizing disorders* (e.g., Major Depressive Disorder without Psychosis and Other Affective Disorders), *psychotic disorders* (e.g., Schizophrenia, Bipolar

Table 1. Demographic Characteristics of Adults Receiving RDM at DSHS-Funded Community Mental Health Centers in SFY2006 (N = 109,231)

Demographic Characteristic	Percentage
Age	
18 – 20 Years	3%
21 – 40 Years	41%
41 – 50 Years	29%
51 – 60 Years	19%
61+ Years	8%
Total	100%
Sex	
Female	59%
Male	41%
Total	100%
Ethnicity	
American Indian	0.2%
Asian	1%
Black	19%
Hispanic	25%
Multi-Racial	2%
White	53%
Total	100%
Medicaid Status	
Indigent	61%
Medicaid	39%
Total	100%
Primary Psychiatric Diagnosis	
Bipolar Disorder	32%
Major Depressive Disorder	37%
Schizophrenia	28%
Other	3%
Total	100%

Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

Disorder, or Major Depressive Disorder with Psychosis) or *other disorders* (e.g., anorexia nervosa or sleep nervosa).

As shown in **Figure 1**, the RDM model in Texas includes a streamlined assessment that is used to recommend an *evidence-based level of care*, the *fidelity* of which is monitored, followed by an evaluation of critical *outcomes*, and a *data warehouse* that houses client demographic and assessment data, service encounter data, financial data, and even Medicaid eligibility data. (Data presented in here are from this data warehouse, known as the *DSHS Mental Retardation and Behavioral Health Outpatient Warehouse* or MBOW.) Each of the components of the RDM model will be reviewed in the remaining sections of this article.

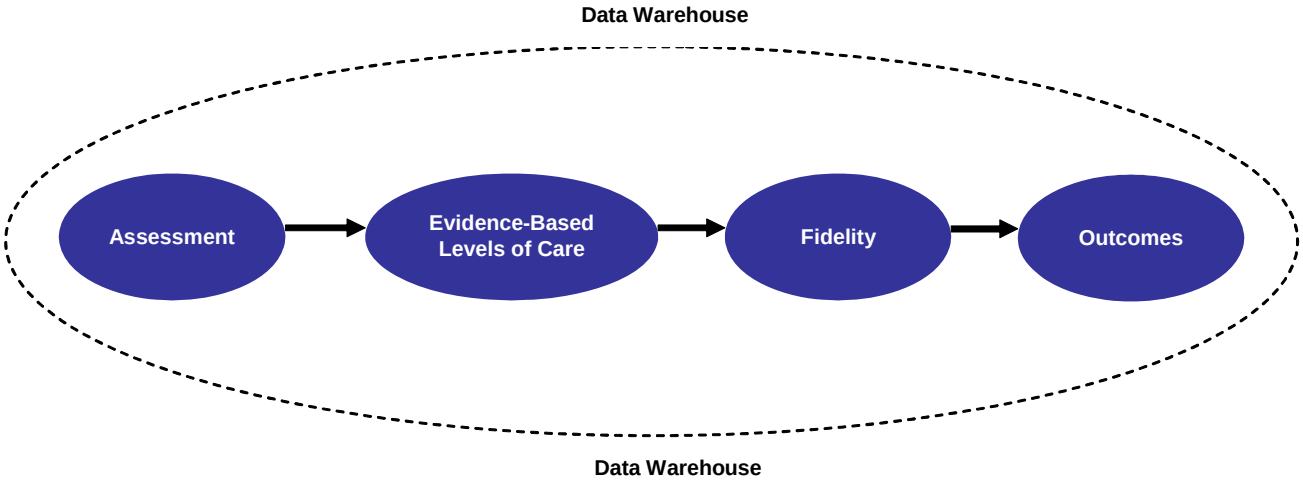
(Continued ☞)

Table 2. Demographic Characteristics of Children Receiving RDM at DSHS-Funded Community Mental Health Centers in SFY2006 (N = 27,666)

Demographic Characteristic	Percentage
Age	
3 – 6 Years	7%
7 – 12 Years	35%
13 – 17 Years	58%
Total	100%
Sex	
Female	34%
Male	66%
Total	100%
Ethnicity	
American Indian	0.2%
Asian	0.2%
Black	22%
Hispanic	39%
Multi-Racial	3%
White	36%
Total	100%
Medicaid Status	
Indigent	25%
Medicaid*	75%
Total	100%
Primary Psychiatric Diagnosis	
Attention Deficit Disorder	38%
Bipolar Disorder	12%
Disruptive Behavior Disorder	16%
Major Depressive Disorder	11%
Other Affective Disorders	10%
Other Non-Psychotic Disorders	6%
All Other	7%
Total	100%
Diagnostic Category	
Externalizing Disorders (e.g., Attention Deficit Disorder, Disruptive Behavior Disorder)	55%
Internalizing Disorders (e.g., Major Depressive Disorder without Psychosis, Other Affective Disorders)	20%
Psychotic Disorders (e.g., Bipolar Disorder, Schizophrenia, Major Depressive Disorder with Psychosis	17%
Other (e.g., Anorexia, Sleep Disorder)	8%
Total	100%

Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).
*Children with a full Medicaid benefit (*N* = 20,750) included those on Temporary Assistance for Needy Families or TANF (69%) or Supplemental Security Income or SSI (31%).

Figure 1. Resiliency and Disease Management model in Texas



Assessment

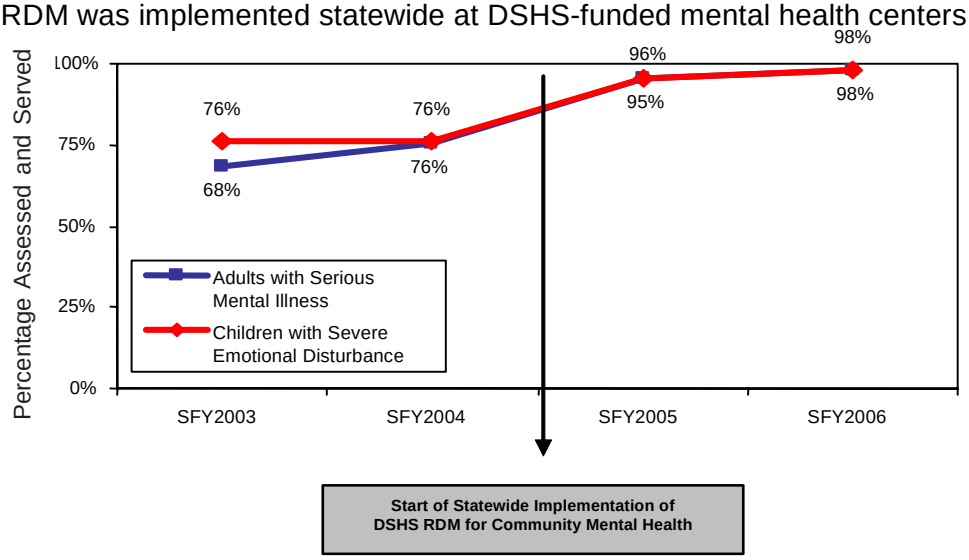
In a system constrained by limited resources, such as the community mental health system in Texas, it is critical to distribute services according to clinical need. However, the Texas community mental health system has been fraught with examples of apparent inequities in care. Prior to RDM, there was great variability in the types and amounts of community mental health services provided to adults with serious mental illness and children with severe emotional disturbance that could not be explained by differences in specific needs for care. Indeed, RDM requires that clients be assessed before being served, so that services are distributed according to clinical need.

For this reason, the Texas Department of Mental Health and Mental Retardation (TDMHMR), now DSHS, developed the *Texas Recommended Assessment Guidelines* (TRAG) for Qualified Mental Health Professionals (QMHPs; i.e., Bachelor-degree-level clinicians) at DSHS-funded community mental health centers as part of RDM. The purpose is to uniformly assess the mental health service needs of adults with serious mental illness (*Adult Texas Recommended Assessment Guidelines* or Adult-TRAG) and children with severe emotional disturbance (*Child and Adolescent Recommended Assessment Guidelines* or CA-TRAG).

And as **Figure 2** shows, the percentage of served adults with serious mental illness who were assessed has increased substantially from SYF 2003 (68%) and SFY2004 (76%) to SFY 2005 (95%) and SFY 2006 (98%), after RDM was implemented statewide at DSHS-funded community mental health centers. The same is true among children with severe emotional disturbance who were served at DSHS-funded community mental health centers, with a greater percentage being assessed in SFY 2005 (96%) and SFY 2006 (98%), after RDM was implemented throughout Texas, compared to SFY 2003 (76%) and SFY 2004 (76%).

The Adult-TRAG is comprised of nine assessment dimensions: 1) Risk of Harm; 2) Support Needs; 3) Psychiatric-Related Hospitalizations; 4) Functional Impairment; 5) Employment Problems; 6) Housing Instability; 7) Co-Occurring Substance Use; 8) Criminal Justice Involvement; and 9) Response to

Figure 2. Percentage of served clients who were assessed increased substantially from SFY 2003 and SFY 2004 to SFY2005 and SFY 2006, after RDM was implemented statewide at DSHS-funded mental health centers



Source: *Source:* DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW). *Children with a full Medicaid benefit (*N* = 20,750) included those on Temporary Assistance for Needy Families or TANF (69%) or Supplemental Security Income or SSI (31%)

Medication Treatment for Persons with Major Depressive Disorder. Except for Response to Medication Treatment for Persons with Major Depressive Disorder (rated from 1 to 3), each is rated 1 (*none*), 2 (*low*), 3 (*moderate*), 4 (*significant*), or 5 (*high*), with specific criteria for each increment rating. Together, these nine assessment dimensions, along with the person's primary psychiatric diagnosis, render an Adult-TRAG Level of Care Recommendation (LOC-R).[1]

Similarly, the CA-TRAG is comprised of 10 assessment dimensions: 1) Problem Severity as measured by the *Ohio Youth Problem Severity Scale* (Ogles, Melendez, Davis, and Lunnen, 1999); 2) Functioning as measured by the *Ohio Youth Functioning Scale* (Ogles et al., 1999); 3) Risk of Self-Harm; 4) Severe Disruptive or Aggressive Behavior; 5) Family Resources; 6) History of Psychiatric Treatment; 7) Co-Occurring Substance Use; 8) Juvenile Justice Involvement; 9) School Behavior; and 10) Psychoactive Medication Treatment.

Except for Psychoactive Medication Treatment (rated 1 or 2), each is rated 1 (*no notable limitations*), 2 (*mild limitations*), 3 (*moderate limitations*), 4 (*serious limitations*), or 5 (*severe limitations*), with specific criteria for each rating. These 10 assessment dimensions, along with the child's primary diagnostic category (i.e., externalizing, internalizing, psychotic, or other disorders), elicit a CA-TRAG LOC-R.[2]

[1] Results from a study by TDMHMR, now DSHS, indicated good to excellent reliability (intraclass correlations) for the nine Adult-TRAG dimensions among clinicians at DSHS-funded community mental health centers. Validity testing also showed a relatively high level of agreement between the Adult-TRAG level of care recommendations made by clinicians compared to those made by an Adult-TRAG expert, and those made by clinicians/administrators not using the Adult-TRAG methodology. (For study details, see http://www.dshs.state.tx.us/mhprograms/AssessAdultStudyPaper.pdf)

[2] Similar reliability and validity findings emerged in a study on the CA-TRAG. (For study details, see http://www.dshs.state.tx.us/mhprograms/ReliabilityandValidityStudyCA-TRAG.pdf)

Evidence-Based Levels of Care

Four community mental health levels of care or service packages are available for adults with serious mental illness as part of RDM. Although there is some overlap between adjacent levels of care with respect to services offered, generally speaking, utilization becomes progressively more intensive as one moves from lower to higher levels of care.

Service Package 1: Pharmacological Management, Medication Training and Supports, and Routine Case Management *(Bipolar Disorder, Schizophrenia, or Major Depressive Disorder with or without Psychosis)*

Service Package 1 offers the most basic package of community mental health services, including pharmacological management, medication training and supports, and routine case management. In terms of pharmacological management, medications are provided according to the Texas Implementation of Medication Algorithms (TIMA), along with medication training and supports. Also, individuals who receive this level of care may receive routine case management in the form of assistance in accessing essential community resources. Finally, individual and small group skills training and development and supported employment are available as add-on services.

Service Package 2: Pharmacological Management, Medication Training and Supports, Routine Case Management, and Counseling *(Major Depressive Disorder with or without Psychosis)*

Service Package 2 offers pharmacological management, medication training and supports, routine case management, and counseling. As with Service Package 1, persons in Service Package 2 are provided pharmacological management in the form of medications according to TIMA, medication training and supports, and routine case management. In addition, individuals receive counseling in the form of a course of Cognitive Behavior Therapy (CBT).[3] Finally, individual and small group skills training and development and supported employment are available as add-on services.

Service Package 3: Pharmacological Management, Medication Training and Supports, Psychosocial Rehabilitation, Supported Employment, and Medical Services *(Bipolar Disorder, Schizophrenia, or Major Depressive Disorder with Psychosis)*

Service Package 3 offers a team approach to community mental health services. Individuals are provided pharmacological management in the form of medications according to TIMA, and medication training and supports. Also, individuals are

[3] *Cognitive Behavior Therapy* (CBT) is a form of psychotherapy using imagery, self-monitoring, and related techniques to alter distorted attitudes and perceptions. CBT focuses on present thinking, behavior, and communication rather than on past experiences and is oriented toward problem-solving.

CBT is probably the most widely researched psychotherapy that exists today, and there is more research support for its efficacy than there is for any other therapy (Beck, 1995). It is designed to be as short-term as possible, though sometimes with complex cases and severe mental illness treatment takes longer.

assigned a rehabilitative case manager whose low caseload allows them to provide psychosocial rehabilitation in the form of extensive linking, advocating, and a focused course of individual and small group skills training and development, as well as supported employment. (Housing services and co-occurring substance use services are provided as part of psychosocial rehabilitation by a rehabilitative case manager.) Finally, medical services are available from licensed medical personnel.

Service Package 4: Assertive Community Treatment *(Schizophrenia or Bipolar Disorder)*

Service Package 4 offers the most extensive package of benefits or level of care delivered through Assertive Community Treatment (ACT). Individuals in ACT are provided pharmacological management in the form of medications according to TIMA, medication training and supports, psychosocial rehabilitation (i.e., rehabilitative case management including housing services and co-occurring substance use services, and skills training and development), supported employment, and medical services by a registered nurse. Services provided by an ACT team are focused on outreach, engagement, and stabilization, are all-inclusive, and made available 24 hours a day, 7 days per week.

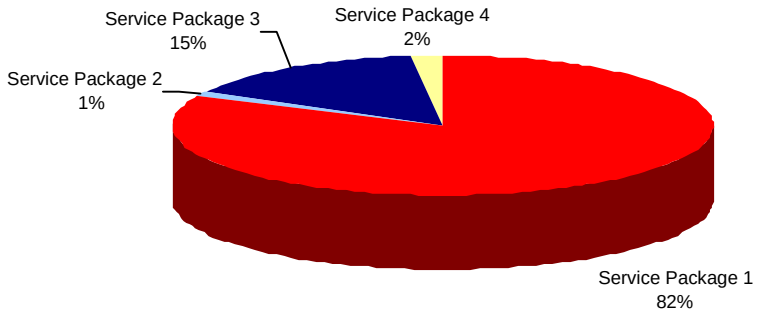
Figure 3 presents the average monthly RDM service package percentage distribution among adults served at DSHS-funded community mental health centers in SFY2006. Most adults received Service Package 1 (82%), followed by Service Package 3 (15%), 4 (2%), and 2 (1%), respectively.

Yet, as **Figure 4** reveals, the average monthly cost per adult is higher as one moves from Service Package 1 ($230), the least intensive level of care, to Service Package 4 ($1,117), the most intensive level of care. Furthermore, most individuals receive the RDM level of care that is recommended according to the Adult-TRAG. For example, 91% in SFY 2005 and 95% in SFY 2006 received the level of care recommended by the Adult-TRAG.

Seven community mental health levels of care or service packages are available for children with severe emotional disturbance as part of RDM. With the exception of Service Package 4 that is least intensive, utilization becomes progressively more intensive as one moves from brief to intensive outpatient services.

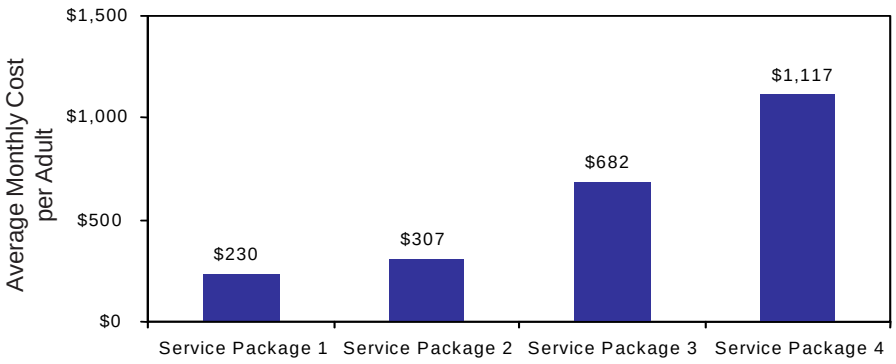
Service Package 1.1: Brief Outpatient

Figure 3. Average monthly RDM service package distribution among adults served at DSHS-funded community mental health centers SFY 2006 (N=74,813)



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

Figure 4. Average monthly cost per adult who received an RDM service package at DSHS-funded community mental health centers in SFY 2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

(Externalizing Disorders, e.g., Attention Deficit Disorder or Disruptive Behavior Disorder)

Service Package 1.1 is available to children and adolescents with externalizing disorders and a moderate level of functional impairment. The focus of the intervention is on psychosocial skill development for the child or adolescent and the enhancement of parenting skills, especially in child behavior management. Information regarding the diagnosis, medication, monitoring of symptoms, and side effects is provided. This service package is generally considered short-term and time-limited. If needed, a psychiatric evaluation, medication and medication management are available in addition to Service Package 1.1 through the Utilization Management (UM) process. Access to parent support groups is also available.

Service Package 1.2: Brief Outpatient *(Internalizing Disorders, e.g., Major Depressive Disorder without Psychosis or Other Affective Disorders)*

Service Package 1.2 is targeted at children and adolescents with internalizing disorders and a moderate level of functional impairment. The focus of the intervention is counseling using CBT. Information regarding the diagnosis, medication, monitoring of symptoms and side effects is provided. This service package is generally considered short-term and time-limited. If needed, a psychiatric evaluation, medication and medication management are available in addition to Service Package 1.2 through the UM process. Access to parent support groups is also available.

Service Package 2.1: Intensive Outpatient *(Externalizing Disorders – Multi-Systemic Therapy, e.g., Attention Deficit Disorder or Disruptive Behavior Disorder with Juvenile Justice Involvement)*

Service Package 2.1 is aimed at youth with externalizing disorders and high levels of severe disruptive or aggressive behaviors who are in the juvenile justice system and who are at high risk of out of home placement or further penetration into the juvenile justice system due to presenting behaviors. Multi-Systemic Therapy (MST) is a comprehensive, intensive, in-home, and community-based treatment model. Service

components include intensive case management, counseling, skills training, and family-to-family peer support. The family service plan is developed using a wraparound planning approach. Extensive collaboration with juvenile probation or parole is required. If needed, a psychiatric evaluation, medication and medication management, and flexible funds are available in addition to Service Package 2.1 through the UM process.

Service Package 2.2: Intensive Outpatient *(Externalizing Disorders, e.g., Attention Deficit Disorder or Disruptive Behavior Disorder)*

Service Package 2.2 is available to children and adolescents with externalizing disorders and moderate to high functional impairment at home, school or in the community. Service components include intensive case management, skills training, and family-to-family peer support. The family service plan is developed using a wraparound planning approach. If needed, a psychiatric evaluation, medication and medication management, and flexible funds are available in addition to Service Package 2.2 through the UM process.

Service Package 2.3: Intensive Outpatient *(Internalizing Disorders, e.g., Major Depressive Disorder without Psychosis or Other Affective Disorders)*

Service Package 2.3 is aimed at children and adolescents with internalizing disorders and a moderate to high level of problem severity or functional impairment. The focus of the intervention is on counseling using CBT. Intensive case management and family-to-family peer support are also offered. The family service plan is developed using a wraparound planning approach. If needed, a psychiatric evaluation, medication and medication management, and flexible funds are available in addition to Service Package 2.3 through the UM process.

Service Package 2.4: Intensive Outpatient *(Bipolar Disorder, Schizophrenia, Major Depressive Disorder with Psychosis, or Other Psychotic Disorders)*

Service Package 2.4 is targeted at children and adolescents who are diagnosed with Bipolar Disorder, Schizophrenia, Major Depressive Disorder with Psychosis or other psychotic disorders and are not yet stable on medication. The major focus is on stabilizing the child through psychiatric evaluation and medication management. Intensive case management and family-to-family peer support are also included. The family service plan is developed using a wraparound planning approach. If needed, flexible funds are available in addition to Service Package 2.4 through the UM process.

Service Package 4: After-Care *(Any Diagnosis)*

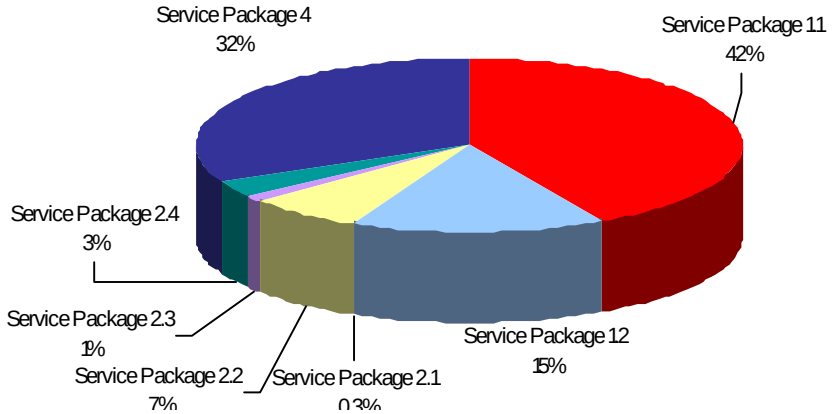
Service Package 4 is available to children and adolescents who have stabilized in terms of problem severity and functioning and require only medication and medication management to maintain stability.

Figure 5 presents the average monthly RDM service package percentage

distribution among children served at DSHS-funded community mental health centers in SFY2006. Most children received Service Package 1.1 (42%), followed by Service Package 4 (32%), 1.2 (15%), 2.2 (7%), 2.4 (3%), 2.3 (1%), and 2.1 (0.3%), respectively.

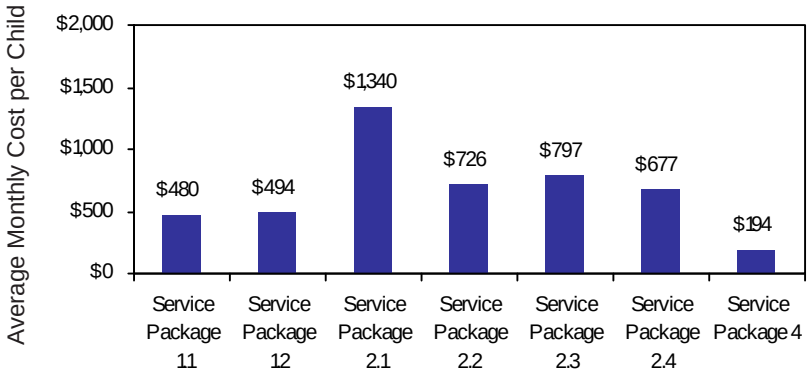
Yet, as **Figure 6** reveals, the average monthly cost per child is higher as one moves from Service Package 4 ($194), the least intensive level of care, to Brief Outpatient levels of care (Service Package 1.1 = $480; Service Package 1.2 = $494), to Intensive Outpatient levels of care, such as Service Package 2.2 ($726), 2.3 ($797), or 2.4 ($677), to Service Package 2.1 ($1,340), the most intensive level of care. Moreover, most children receive the level of care that is recommended according to the CA-TRAG. In fact, 90% in SFY 2005 and 93%

Figure 5. Average monthly RDM service package distribution among children served at DSHS-funded community mental health centers in SFY 2006 (N = 14,705)



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

Figure 6. Average monthly cost per child who received an RDM service package at DSHS-funded community mental health centers in SFY 2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

in SFY 2006 received the level of care recommended by the CA-TRAG.[4]

Fidelity

The concept of "fidelity" refers to the degree to which a program is implemented as planned or designed. More recently, as part of the national movement to implement evidence-based practices (EBPs) in healthcare, the term has been used to refer to the degree to which a service site or provider is implementing an EBP in a manner that is "faithful" to the key principles or elements of the EBP model.

A variety of fidelity scales have been developed by DSHS that are intended to measure the faithfulness with which DSHS-funded community mental health centers are implementing RDM levels of care for the purposes of quality improvement and accountability. These fidelity scales contribute to the goal of reducing variation by defining what the state expects to receive when contracting for the services included in the RDM levels of care. By defining criteria and methods for determining the degree to which the service packages are implemented, the fidelity scales also provide a means for community mental health centers to demonstrate to DSHS, and by extension, the Legislature and the citizens of Texas, that "they are getting what they paid for." Since better clinical outcomes have been linked to fidelity of implementation of EBPs (Jerrel and Ridgely, 1999; McDonell, Nofs, Hardman, and Chambless, 1989; McHugo, Drake, Teague, and Xie, 1999), another compelling reason why DSHS, as a purchaser of RDM services, is placing an emphasis on faithful implementation of the RDM evidence-based levels of care is to increase the probability of achieving positive outcomes among clients.

The following is an example scale used to assess fidelity to adult *Service Package 3* and the *skills training* component:

Definition: Effective skill training methods are utilized, including a) instructions; b) modeling; c) role play or rehearse; d) positive feedback and shaping; and e) repetition of role plays or rehearsal.

Rationale: To measure the degree to which effective skill training methods are utilized.

Information Sources: Progress notes

Item Scoring: Five-point rating based on the presence of the element.

1. No evidence of any skills training methods described in a - e.

2. Skill training methods as described in a - e are used in 25% - 49% of the progress notes.

3. Skill training methods as described in a - e are used in 50% - 74% of the progress notes.

4. Skill training methods as described in a - e are used in 75% - 94% of the progress notes.

5. Skill training methods as described in a - e are used in 95% or more of the progress notes.

[4] Importantly, a recent analysis by Strategic Decision Support at the Texas Health and Human Services Commission indicates that SFY2005 average monthly hospital Emergency Room costs (ER) among Medicaid clients receiving needed RDM community-based mental health services were $68 vs. $93 among Medicaid clients not receiving needed RDM services — an average savings of $25 per Medicaid client per month. In other words, average monthly hospital ER costs for SFY2005 were 27 percent lower for Medicaid clients receiving needed RDM community mental health services at DSHS-funded community mental health centers. (For more information, see http://www.dshs.state.tx.us/sa/BHNewsBriefVolume_1_Issue3_061906.pdf)

Here is an example scale designed to assess fidelity to *Cognitive Behavior Therapy* (CBT) within child *Service Packages 1.2* and *2.3*:

> *Definition*: As part of CBT, children and adolescents are taught *self-monitoring* — skills to recognize and record specific experiences that affect anxiety and depression. Children and adolescents are taught to self-monitor in some or all of the following critical areas: physical sensations that occur when anxiety and depression are present; thoughts that precipitate anxiety and depression; emotions experienced; events that precipitate anxiety and depression; and actions that may follow the feelings of anxiety and depression.
>
> *Rationale:* Self-monitoring is an intervention that assists children and adolescents to become self-aware of factors that contribute to anxiety and depression, and to become self-aware of the impact of their new skills on their symptoms of anxiety and depression. Self-monitoring provides the "data" upon which interventions are based. Progress can be measured over time and children and adolescents can become aware of the strengths and skills gained to manage anxiety and depression.
>
> *Information Sources:* Child record (progress notes), child interviews, supervision notes, observation, and audio or videotapes.
>
> *Item Scoring:* This item is scored "yes" if sources demonstrate that the youth was: a) instructed in how to self-monitor their experiences of anxiety and/or depression and associated elements; and b) practiced this skill either in one or more therapy sessions or as a "homework" assignment.

DSHS Mental Health and Substance Abuse Quality Management staff have begun to conduct fidelity reviews at DSHS-funded community mental health centers of various service packages within the RDM model, with more planned for the near future. These fidelity reviews will continue to provide an opportunity for technical assistance on RDM implementation of evidence-based levels of care.[5]

Outcomes

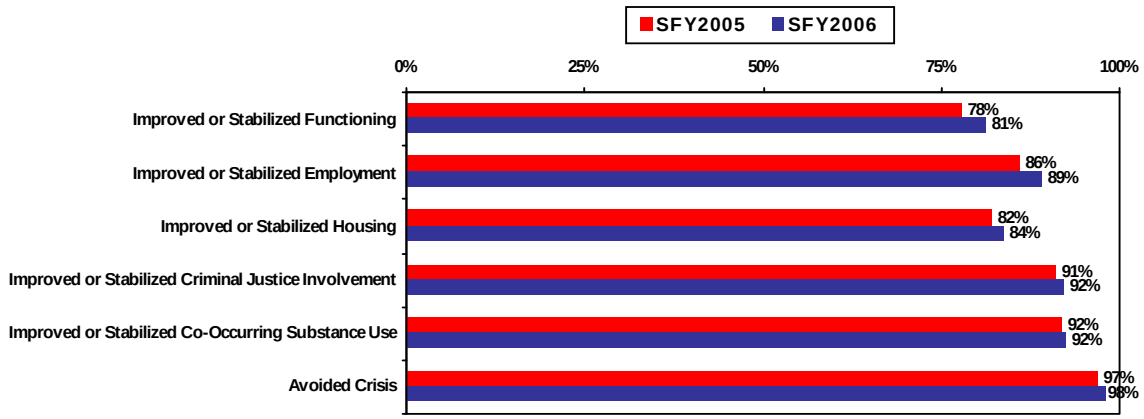
RDM was developed to ensure that adults with serious mental illness and children with severe emotional disturbance receive services demonstrated to facilitate recovery and build resiliency. It is based on the principle that adults do recover and children do become more resilient when they are given appropriate treatment and supports, as purported by the *President's New Freedom Commission for Mental Health* (New Freedom Commission on Mental Health, 2003). Therefore, the real test of success for RDM is whether adults experience positive clinical outcomes.[6]

Six clinical outcomes among adults are measured annually over the course of a state fiscal year. As **Figure 7** shows, in SFY 2005, a considerable percentage of

[5] For more information about fidelity as it relates to RDM, please visit: http://www.dshs.state.tx.us/mhprograms/RDMFidelityToolkit.shtm

[6] Since different instruments were used to assess clinical outcomes prior to implementation of RDM, and since not all of these dimensions were assessed before implementation of RDM, a comparison of clinical outcomes pre- vs. post-implementation of RDM is not possible.

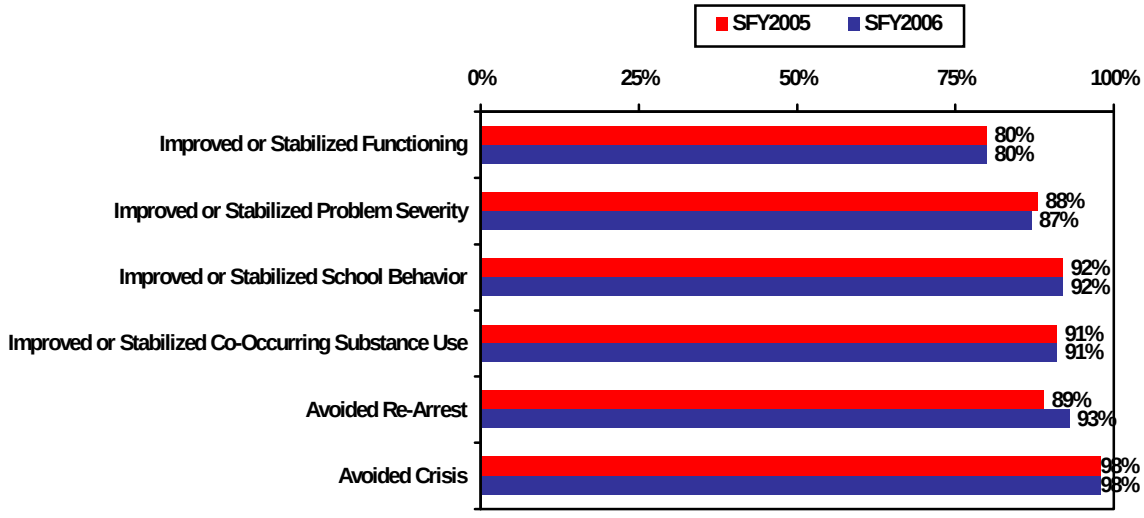
Figure 7. Percentage of adults who received an RDM service package and who experienced positive clinical outcomes at DSHS-funded community mental health centers in SFY 2005 and SFY 2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

adults who received an RDM level of care at DSHS-funded community mental health centers experienced improved or stabilized levels functioning (78%), employment (86%), housing (82%), criminal justice involvement (91%), and co-occurring substance use (92%), with similar results emerging in SFY2006 (functioning = 81%; employment = 89%; housing = 84%; criminal justice involvement = 92%; co-occurring substance use = 92%). Computation of each of these clinical outcomes is derived from comparing a client's first and last Adult-TRAG dimension rating (separated by at least 90 days) during the state fiscal year. In addition, 97% and 98% of adults who received an RDM service package during SFY 2005 and SFY 2006, respectively, avoided

Figure 8. Percentage of children who received an RDM service package and who experienced positive clinical outcomes at DSHS-funded community mental health centers in SFY 2005 and SFY 2006



Source: DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW).

spending time in crisis (e.g., crisis respite, 23-hour observation in a hospital setting, etc.).

As with adults, six clinical outcomes are measured annually among children during the state fiscal year. **Figure 8** indicates that, in SFY 2005, a substantial percentage of children who received an RDM level of care at DSHS-funded community mental health centers experienced improved or stabilized functioning (80%), problem severity (88%), school behavior (92%), and co-occurring substance use (92%), and 91% avoided re-arrest, with similar results emerging in SFY 2006 (functioning = 80%; problem severity = 87%; school behavior = 92%; co-occurring substance use = 91%; avoided re-arrest = 93%). Computation of each of these clinical outcomes is derived from comparing a client's first and last Adult-TRAG dimension rating (separated by at least 90 days) during the state fiscal year. In addition, 98% of children who received an RDM service package during both SFY 2005 and SFY 2006 avoided time in crisis.

Challenges

No new public health initiative would be complete without challenges, and RDM

Figure 9.Recommended vs. actual average monthly service hours per adult who received an RDM service package in SFY 2005 or SFY 2006 at DSHS-funded community mental health centers

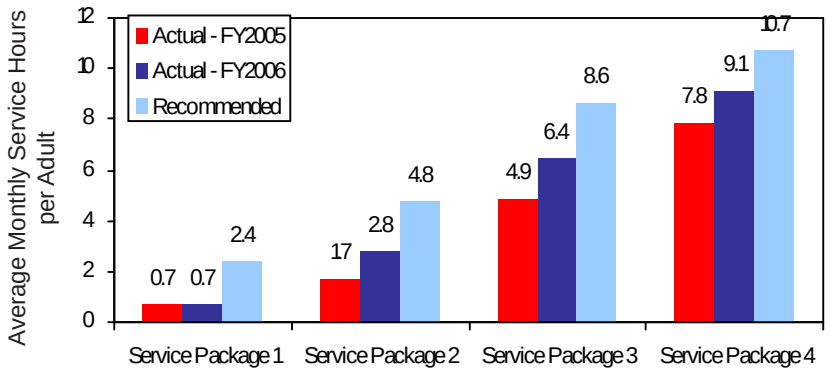
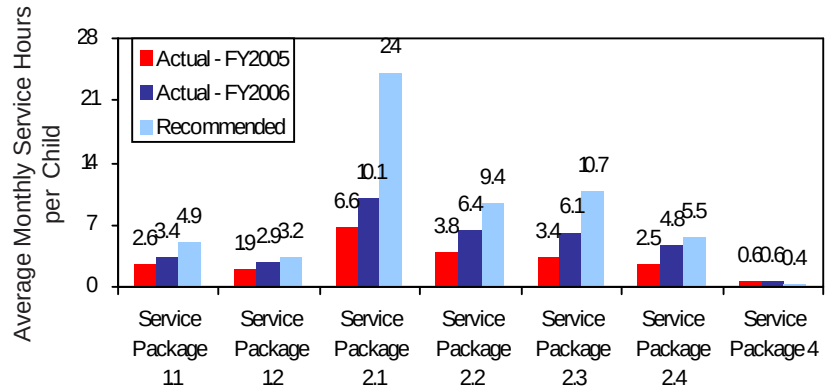


Figure 10. Recommended vs. actual average monthly service hours per child who received an RDM service package in SFY 2005 or SFY 2006 at DSHS-funded community mental health centers.



for community mental health is no exception. One important challenge involves adherence to best-practice, clinical guidelines and the recommended average monthly service hours per adult and per child. As **Figure 9** indicates, although much progress was made from SFY 2005 to SFY 2006, the actual average monthly service hours per adult for each RDM Service Package at DSHS-funded community mental health centers are still considerably lower than what are recommended by the RDM best-practice clinical guidelines, with the same being true among children (see **Figure 10**).

Clearly, if RDM is to truly give rise to the best possible clinical outcomes for adults with serious mental illness and children with severe emotional disturbance, then greater adherence is needed to ensure that clients receive the amount of services that are recommended for them to recover and build resiliency.

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