

# Overview and National Context

## Overview

### HOGG FOUNDATION FOR MENTAL HEALTH: OUR MISSION

#### TRANSFORM HOW COMMUNITIES PROMOTE MENTAL HEALTH IN EVERYDAY LIFE.

*Mental health is not solely an individual responsibility, but is also a product of community conditions. The places where people live, learn, work, play, and pray can have a significant impact on improving mental health. Some mental health conditions are exacerbated by medical or clinical barriers, such as the lack of mental health professionals in the state. However, many poor outcomes stem from challenging environmental factors like housing stability, neighborhood infrastructure, and conditions at home, work and school.*

*Mental health should be a concept that is promoted beyond the walls of health clinics and integrated into everyday life. Community members, leaders, and professionals—from teachers and preachers, to police officers and judges—should understand the importance of mental health and the factors that influence it. Children should be supported by their families, teachers, peers, counselors, and administrators in ways that enhance social connection and resiliency.*

#### PURPOSE OF THIS GUIDE

The primary purpose of this guide is to help inform mental health and substance use policy analysis, development, and decision-making. The maze of behavioral health services in Texas is complex, making it difficult to understand and consequently difficult to improve. The intended audience for this guide includes legislators, legislative staff, state agency staff, advocates with lived experience, family advocates, mental health providers, and other stakeholders interested in mental health and substance use policy.

Understanding the complex system of treatment, supports, and services is essential

to making well-informed decisions affecting access to public mental health services and the quality of services delivered. This 4<sup>th</sup> edition of *A Guide to Understanding Mental Health Systems and Services in Texas* is divided into the following sections:

- Overview and a National Context – offers the intended purpose of the guide and general information on mental health policy from the national perspective
- Texas Environment – provides an overview of the mental health and substance use issues currently being discussed by a broad spectrum of Texas stakeholders
- Public Mental Health Services – presents detailed information on public mental health and substance use services provided by the following Texas state agencies:
  - Texas Health and Human Services Commission
  - Texas Department of Family and Protective Services
  - Texas Education Agency
  - Texas Workforce Commission
  - Texas Department of Criminal Justice
  - Texas Juvenile Justice Department
  - Texas Department of Housing and Community Affairs
  - Texas Veterans Commission
- Appendices – includes additional information that helps to both maneuver this guide and supplement users’ research and learning efforts, including:
  - List of guide figures
  - Glossary of mental health terms
  - Additional resources

At the beginning of each section (see tabs) this guide will include a listing of the acronyms used in that section. We are hopeful that this will make for easier reading.

While this guide focuses primarily on state policies and programs for addressing mental health and substance use needs in Texas, the foundation recognizes the important role of communities. Many communities and local providers throughout the state are engaged in the development, implementation, and oversight of locally funded and operated programs and services that are specifically designed to meet the needs of those communities. We encourage communities to engage in local collaborative efforts aimed at addressing the mental health needs of Texans from a population health perspective. We encourage communities to place particular emphasis on identifying and supporting individuals who have been historically underrepresented in mental health policy discussions and those who experience significant health disparities.

Finally, The Hogg Foundation offers this guide to help policymakers and other stakeholders in Texas understand the array of mental health and substance use services currently available, the multiple access portals, and the numerous funding streams. While the information in this report is the best available at the time of its writing, the landscape is fluid and continually changing. We hope this guide serves as a useful introduction and a valuable resource that illustrates the critical need for a long-term, coordinated, sufficiently funded approach to providing effective mental health and substance use services in Texas.

# The National Context

## NATIONAL CONTEXT ACRONYMS

ACA – Affordable Care Act	RTC – Residential treatment center
CFCIP – Chafee Foster Care Independence Program	SAMHSA – Substance Abuse and Mental Health Services Administration
DFPS – Department of Family and Protective Services	SED – Serious emotional disturbance
FFPSA – Family First Protection Services Act	SMI – Serious mental illness
HHS – Health and Human Services Administration (US)	SSA – Social Security Administration
HHSC – Health and Human Services Commission	SSDI – Social Security Disability Income
IDU – Injectable drug use	SSI – Supplemental Security Income
LMHA – local mental health authority	SSP – Syringe Services Program
MHPAEA – Mental Health Parity and Addiction Equity Act	STR – State targeted response
	QRTP – Qualified residential treatment program

## SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

SAMHSA is the mental health and substance use agency within the U.S. Department of Health and Human Services. The 21<sup>st</sup> Century Cures Act created a new position at HHS – Assistant Secretary for Mental Health and Substance Use. Through grants, contracts, and technical assistance, SAMSHA is the country’s leading mental health and substance use agency supporting states’ efforts to improve mental health and substance use services. The agency’s primary objectives include mental health and substance research dissemination, dissemination of evidence-based programs, awarding grants with strong performance criteria, and strong collaboration with stakeholders and other federal agencies.<sup>1</sup> SAMHSA’s ten regional administrators conduct efforts throughout the country to support SAMHSA’s mission.

SAMHSA also offers services aimed at connecting people to the services they need. Some of these initiatives include:

- Behavioral Health Treatment Services Locator - <https://findtreatment.samhsa.gov/>
- National Helpline - <https://www.samhsa.gov/find-help/national-helpline>; 1-800-662-HELP (4357)
- National Suicide Prevention Lifeline - <https://suicidepreventionlifeline.org/>; 1-800-273-TALK (8255)
- Disaster Distress Helpline - <https://www.samhsa.gov/find-help/disaster-distress-helpline>; 1-800-985-5990
- Veteran’s Crisis Line - <https://www.veteranscrisisline.net/>; 1-800-273-TALK (8255); Text 838255
- Opioid Treatment Program Directory - <https://www.colleaga.org/tools/united-states-opioid-treatment-program-directory>

## MENTAL HEALTH AND SUBSTANCE USE BLOCK GRANTS

SAMHSA awards mental health and substance use block grants to states to “establish, expand or enhance an organized, community-based system for providing mental health services for adults with serious mental illness (SMI), children with serious emotional disturbances (SED), and adults and adolescents with or at risk for substance use disorder (SUD).”<sup>2</sup> In previous years, separate applications for mental health and substance use block grant funds were submitted. The current practice, however, is for the applications to be combined. While these community mental health funds only account for approximately 5 percent of Texas’ expenditures for community mental health (offered through a network of local mental health authorities or LMHAs), approximately 87 percent of the state’s expenditures for substance use services are provided through the block grant. The amounts awarded to Texas for FY 2018-19 were \$43 million for community mental health services and \$145 million for substance use services.<sup>3</sup> These funds are distributed throughout the 11 health and human services regions in Texas.

In recent years, Texas has attempted to coordinate the federal requirements for the block grant funds with the Texas Statewide Behavioral Health Strategic Plan to help develop more coordinated services at the local level. The FY 2018-19 block grant application can be accessed at <https://www.dshs.texas.gov/mhsa/blockgrant/>.

## MEDICAID

Medicaid is a joint state and federal healthcare program designed for individuals with low household income, as well as the elderly and people with disabilities. Medicaid is the largest funder of mental health services in the public mental health system and also supports substance use funding, albeit not at the same level.<sup>4</sup>

Medicaid offers a broad array of mental health benefits including mental health evaluation, diagnosis, and treatment. Treatment options include individual therapy, group therapy, family therapy, detoxification, medication management, and more. In addition to Medicaid state plan services, mental health and substance use treatment and services can be offered through 1115 waiver projects, as well as 1915(c) waivers.

While Medicaid is a vital funding stream for mental health and substance use services, some federal proposals being considered may put these services at risk. Some of these potential risks include:

- Medicaid block granting – would give each state a set amount of funding for all Medicaid recipients. Currently each state is given a federal funding match per Medicaid enrollee. Medicaid block grants are often discussed as a way to reduce federal spending, but this funding change could result in a significant reduction of services available by not providing states a per enrollee funding allotment.
- Repeal of Medicaid expansion – while Medicaid expansion was not enacted in Texas, people with mental illness and substance use conditions have been the largest beneficiary of expansion benefits in other states.<sup>5</sup> If Medicaid expansion were repealed, people with mental illness and substance conditions across the nation would lose access to health care.

- Sustainability of 1115 waiver funding – while Texas recently was granted a multi-year extension of its 1115 waiver funding, long-term sustainability is questionable with the gradual elimination of DSRIP funding; more than 400 of the original 1115 waiver projects in Texas were dedicated to mental health and/or substance use projects statewide.

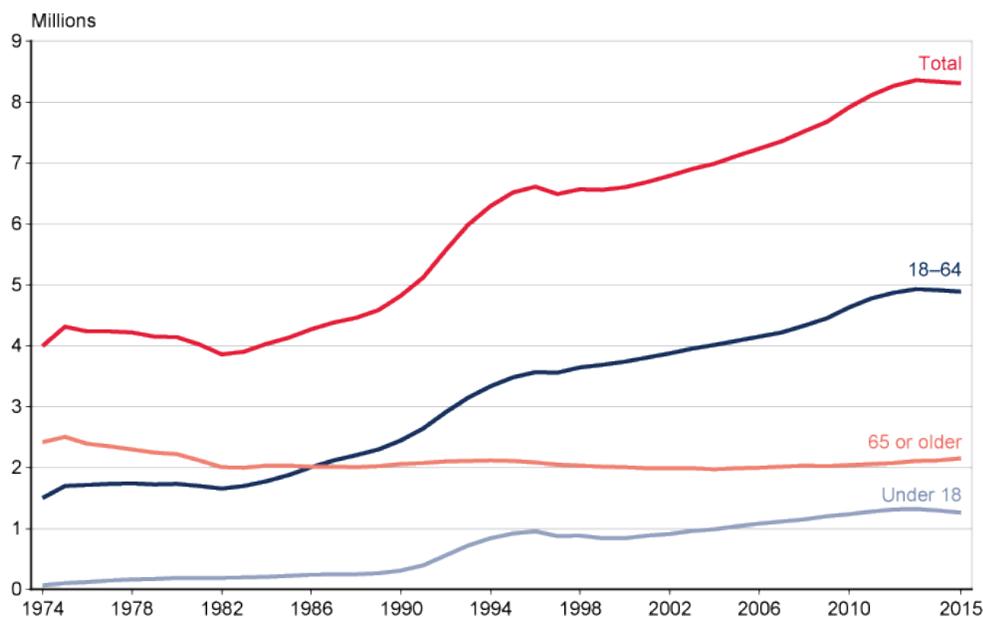
In addition to the mental health and substance use benefits offered by Medicaid, the program also offers primary medical benefits to eligible recipients. More information on Medicaid is in the HHSC section of the guide.

## SOCIAL SECURITY INCOME AND SOCIAL SECURITY DISABILITY INCOME

Supplemental Security Income and Social Security Disability Insurance have close ties to health insurance for people with disabilities. SSI is administered by the Social Security Administration and falls under Title 16 of the Social Security Act. SSI is for people with limited income who have a qualifying disability or are over 65. SSI is funded by general funds from the U.S. Treasury. In most states, including Texas, individuals who receive SSI benefits are also immediately eligible for Medicaid under the same eligibility requirements. Detailed information on SSI can be found in the Social Security Handbook, Chapter 21, at [https://www.ssa.gov/OP\\_Home/handbook/handbook.21/handbook-toc21.html](https://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-toc21.html).

Nationwide, the number of individuals receiving SSI benefits continues to rise. Figure 1 provides data on historical trends from 1974 through 2015.

**Figure 1. Number of Recipients, 1974-2015**



Source: Social Security Administration. (2018). *Facts and Figures About Social Security*. Retrieved from [https://www.ssa.gov/policy/docs/chartbooks/fast\\_facts/2016/fast\\_facts16.html](https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2016/fast_facts16.html).

To receive SSI, recipients must meet both income and asset limits. Table 1 depicts those criteria for 2018.

**Table 1. Supplemental Security Income Program Rates and Limits**

Supplemental Security Income Program Rates & Limits	2018
Monthly Federal Payment Standard (dollars)	
Individual	\$750
Couple	\$1,125
Cost-of-Living Adjustment (percent)	2.0%
Resource Limits (dollars)	
Individual	\$2,000
Couple	\$3,000
Monthly Income Exclusions (dollars)	
Earned Income <sup>a</sup>	\$65
Unearned Income	\$20
Substantial Gainful Activity (SGA) Level for the Non-blind Disabled (dollars)	\$1,180
<sup>a</sup> The earned income exclusion consists of the first \$65 of monthly earnings, plus one-half of remaining earnings.	

Source: Social Security Administration. (2018). *OASDI and SSI Program Rates & Limits, 2018*. Retrieved from [https://www.ssa.gov/policy/docs/quickfacts/prog\\_highlights/index.html](https://www.ssa.gov/policy/docs/quickfacts/prog_highlights/index.html).

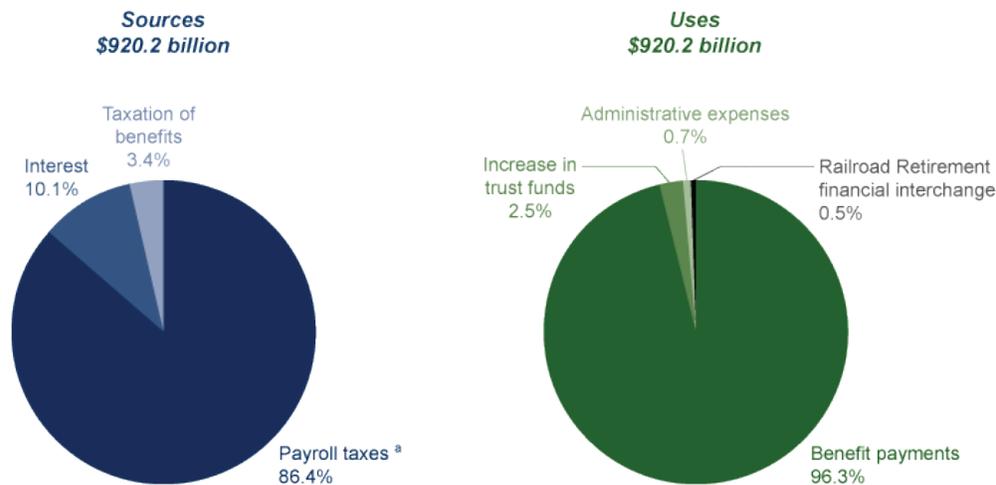
At the federal level, there is continued conversation regarding the sustainability of various social security programs. Figure 2 provides general information on how social security is financed.

**Figure 2. How Social Security is Financed**

***How Social Security Is Financed***

Social Security is largely a pay-as-you-go program. Most of the payroll taxes collected from today’s workers are used to pay benefits to today’s recipients. In 2015, the Old-Age and Survivors Insurance and Disability Insurance Trust Funds collected \$920.2 billion in revenues. Of that amount, 86.4% was from payroll tax contributions and reimbursements from the General Fund of the Treasury and 3.4% was from income taxes on Social Security benefits. Interest earned on the government bonds held by the trust funds provided the remaining 10.1% of income. Assets increased in 2015 because total income exceeded expenditures for benefit payments and administrative expenses.

### Sources and uses of Social Security revenues in 2015



Source: 2016 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table II.B1.

NOTE: Totals do not necessarily equal the sum of rounded components.

<sup>a</sup>Includes General Fund reimbursements, which accounted for less than 0.1% of Trust Fund income.

Social Security Disability Income is also administered by SSA and falls under Title 2 of the Social Security Act. SSDI is for people who have a disability, have worked in a job covered by Social Security, and have earned enough credits in the Social Security program.

At the beginning of 2018, Social Security paid an average monthly disability benefit of \$1,197 to all disabled workers. That is barely enough to keep a beneficiary above the 2017 poverty level (\$12,060 annually). For many beneficiaries, their monthly disability payment represents most of their income. SSDI payments allow people to meet basic needs and the needs of their families. Even these modest payments can make a huge difference in the lives of people who can no longer work.

Source: Social Security Administration. (2018) *The Faces and Facts of Disability*. Retrieved from <https://www.ssa.gov/disabilityfacts/facts.html>

Most people receiving SSDI benefits have not been able to work due to their disability for at least one year. SSDI beneficiaries are required to undergo a two-year waiting period before they can receive Medicare benefits. During those first two years of SSDI enrollment, SSDI beneficiaries may be able to obtain health insurance through their former employer or Medicaid, and some will be uninsured during that waiting period.

In 2014, the social security disability benefit paid 715,796 Texans approximately

\$8.4 billion. Individuals received an annual average benefit of \$13,728, which is only slightly more than the federal poverty threshold of \$12,316.<sup>6</sup>

Some people are approved to receive SSDI and SSI concurrently. This occurs when an individual receives a low SSDI payment, possibly due to not working in recent years or making little while working. When the SSDI payment falls below the federal benefit rate, SSI can be used to make up the difference.

Table 2 below details the major differences between the two programs.

**Table 2. SSI and SSDI Differences**

Program	Supplemental Social Income	Social Security Disability Insurance
Funding	Financed through general revenue from taxes. Benefits are not based on prior work history.	Financed through Social Security taxes paid by workers, employers and self-employed persons.
Eligibility	Have limited income and resources to meet cost of living. Must be a U.S. citizen or have eligible noncitizen status.	Worker must earn sufficient credits based on taxable work to be insured for Social Security purposes.
Benefit Recipients	Benefits are payable to: <ul style="list-style-type: none"> <li>• individuals over 65</li> <li>• adults and children with a disability or blindness</li> </ul>	Benefits are payable to: <ul style="list-style-type: none"> <li>• workers with a disability</li> <li>• their children</li> <li>• their surviving spouse</li> <li>• adults who have had a disability since childhood</li> </ul>
Payment	Payment amount varies up to the maximum federal benefit rate, which may be supplemented by the state.	Payment amount is based on the Social Security earnings record of the insured worker.

Source: The United States Social Security Administration. (2016). *Federal Benefit Rates, Total Annual Payments, and Total Recipients*.

Retrieved from <https://www.ssa.gov/policy/docs/statcomps/supplement/2015/supplement15.pdf>

The United States Social Security Administration. (2015). *Disability Benefits*. Retrieved from <https://www.ssa.gov/pubs/EN-05-10029.pdf>

## IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is federal law that prohibits certain health plans and health insurers from imposing stricter limitations on offered mental health and/or substance use benefits than on medical and/or surgical benefits. Although the law passed in 2008, changes to parity requirements were also included in the Patient Protection and Affordable Care Act (commonly referred to as the “ACA”), and the final federal parity regulations were not released until January 2014.

“The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Parity Law) promised equity in the insurance coverage of mental health and substance use disorder care, but years later mental health parity is still not a reality and too many Americans continue to be denied care when they need it the most. To fulfill the promise of the Parity law, we must hold health insurance plans accountable to comply with the letter and spirit of the law.”

*The Kennedy Forum, retrieved from <https://www.thekennedyforum.org/vision/parity/>*

While data on the implementation of parity regulations has been hard to collect, anecdotal information often indicates a disconnect between the federal government and state agencies with respect to responsibility for enforcement. The nationwide opioid crisis, however, has fueled the desire of many to ensure that appropriate treatment options are available to those who need the services.<sup>7</sup>

On April 23, 2018, the U.S. Department of Health and Human Services released its *Mental Health and Substance Use Disorder Parity Action Plan as required by the 21<sup>st</sup> Century Cures Act*. The action plan can be accessed at <https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/21st-century-cures-act-section-13002/index.html>. HHS has reiterated their commitment to parity for mental health and substance use services. As part of this commitment, HHS has created an online portal to help answer questions related to parity. The portal can be accessed at <https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html>.

For additional information on Texas-focused mental health and substance use parity initiatives, please see the Texas Environment section of this guide.

## THE FAMILY FIRST PREVENTION SERVICES ACT

In February 2018 as part of the Bipartisan Budget Act of 2018 (H.R. 1892), Congress passed the Family First Prevention Services Act (FFPSA) restructuring the way the federal government pays for child welfare services.<sup>8,9</sup> The legislation aims to help families in crisis safely stay together, reduce the foster care population by focusing on preventing entry into foster care, and increase the number of children successfully exiting foster care by reducing reliance on congregate care in favor of more family-like settings.<sup>10</sup>

The largest source of child welfare funding comes from Title IV-E of the Social Security Act, which provides states with funds to support foster care, adoption assistance, guardianship assistance, and the Chafee Foster Care Independence Program, a grant program that helps foster youth gain self-sufficiency. With the exception of CFCIP, children must meet income eligibility requirements for Texas to be reimbursed for IV-E funded programs. Beginning October 1, 2019, the FFPSA will change Title IV-E funding in two primary ways:

- More flexibility to invest in prevention programs
- Funding will no longer be available for certain congregate care placements

The FFPSA will provide states with additional funding to invest in prevention programs aimed to keep children at imminent risk of foster care placement out of the system, assist pregnant and parenting youth already in foster care, and better support kinship caregivers. Trauma-informed and evidence-based programs are required and the law allowed mental health and substance use prevention services to qualify for funds.

Additionally, the FFPSA precludes states from using IV-E funding to support children in foster care who spend more than two weeks in “child care institutions,” a broad term that encapsulates settings like group homes and residential treatment centers. Under the FFPSA, states can only use IV-E funding for services provided to children in the following congregate care settings beyond two weeks:

- facilities for pregnant and parenting youth
- supervised independent living for youth 18 and older
- specialized placements for youth who are victims of or at risk of becoming victims of sex trafficking
- family based residential treatment facilities for substance use disorder
- Qualified Residential Treatment Programs (QRTP)

A QRTP is a new standard for congregate care settings. The term refers to a program that has a trauma-informed treatment model designed to address the needs, including clinical, of children with serious emotional or behavioral disorders or disturbances.<sup>11</sup> Appropriately licensed clinical staff must be available to provide care 24 hours a day under this standard. Due to the complexity of the new QRTP standard, the federal government has allowed states the option of delaying implementation of the law until 2021.<sup>12</sup> States that choose to delay implementation cannot draw down any of the newly available prevention dollars until they are in full compliance with the law.

Further guidance from the federal government is due October 1, 2018. See the Department of Family and Protective Services section of this guide for details on how the FFPSA will impact Texas.

## IMMIGRATION AND THE TRAUMA OF FAMILY SEPARATION

In May of 2018, the Trump Administration instituted a “zero tolerance” immigration policy, resulting in the separation of immigrant children from their families at the US border. Thus far, more than 2,500 immigrant and refugee children have been separated from their parents.<sup>13</sup>

Family separation is a traumatic event for parents, but especially for children. Separation from family is one of the most potent traumatic events a child can experience; the act of separation may increase children’s risk for developing a number of mental health diagnoses including depression, anxiety, and post-traumatic stress disorder.<sup>14</sup> The emotional and physical trauma caused by family separation can affect children long after they are reunited with their parents. Research has found that children who experienced

trauma as a result of family separation still show signs of traumatic reactions, like the inability to trust others, well into adulthood.<sup>15</sup> Additionally, many of these families were seeking legal asylum after fleeing from violence in their home countries. Cumulative exposure to trauma, including previous experiences with domestic or gang violence, increases the risk of developing traumatic reactions.<sup>16</sup>

Fortunately, with the right supports, families can recover from trauma. Children and parents must be screened to identify their specific needs, followed by full assessments and the provision of appropriate, trauma-informed care.<sup>17</sup>

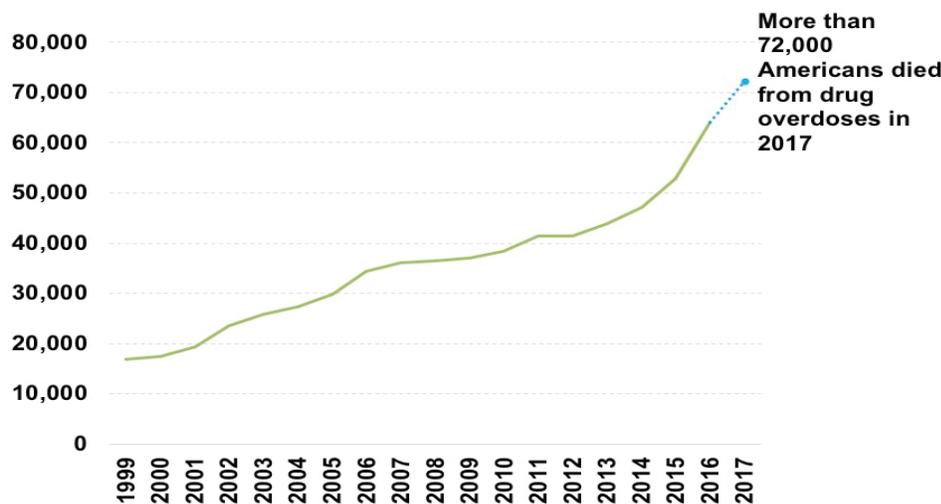
During the production of this guide, the many families remained separated and reunification efforts were still underway. As of August 10, 2018, 559 children had not been reunited with their parents.<sup>18</sup>

## SUBSTANCE USE

Substance use conditions and drug overdoses across the United States continue to increase across the country and across demographics. The Center for Disease Control and Prevention released its in-depth analysis of drug overdoses in 2016, the most recent finalized data available. The analysis shows drug overdose deaths surpassed any previous collected data and resulted in more than 60,000 lost lives. Specifically, opioids have been synonymous with overdose conversations and accounted for over 40,000 of the reported deaths that year – five times higher than 1999. Estimates show that 116 people across the country die each day due to an opioid overdose.<sup>19</sup> The full analysis can be found at <https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html>. Though not finalized, provisional data estimated that drug overdose deaths increased again in 2017, with more than 72,000 deaths. Figure 3 illustrates the total of number of deaths per year due to drug overdoses, inclusive of the preliminary data from 2017.

**Figure 3. Number of overdose deaths in the United States - 1999-2017**

### Total U.S. Drug Deaths



Source: National Institute on Drug Abuse. (August 2018). *Overdose death rates*. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

The Comprehensive Addiction and Recovery Act (P.L. 114-198), signed into law in 2016, was the first major federal substance-use-focused legislation in over 40 years. The Act aimed to create a coordinated response through prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. While the legislation authorized over \$181 million each year in new funding, the law required that dollars be appropriated every year through the regular appropriations process.<sup>20</sup>

Also in response to the overwhelming need for action on access to substance use treatment for opioids, the 21<sup>st</sup> Century Cures Act created Opioid State Targeted Response grants. In 2017, SAMHSA announced it would award over \$485 million per year for two years to all 50 states, the District of Columbia, four U.S. territories, and the free-associated states of Palau and Micronesia in Opioid STR grants. The focuses of the program include opioid services, increased access to treatment, reducing unmet treatment needs, and reduction of overdose deaths

Further, in 2018 HHS announced \$930 million to be awarded in additional opioid STR grants, aimed at “critical gaps in availability of treatment for opioid use disorders in geographic, demographic, and service level terms,” which increased capacity for opioid related topics covered in the original STR grants. At the time of print, the granting of these funds had yet to be published.<sup>21</sup> For additional information on Texas’ Opioid STR grant funding, please see the Texas Environment section of this guide.

As the opioid epidemic has become more prevalent across the country, so has the number of individuals using substances intravenously, thus heightening the risk of communicable diseases.<sup>22</sup> While opioids are not the only substance used intravenously, the recent attention has brought awareness to the public health implications and concerns. Injectable drug use has been shown to be the most common means of transmitting hepatitis C virus other common transmittal causes include transmission during birth from an HCV-infected mother and needlesticks in health care settings.<sup>23</sup> HIV has also become more common across IDU, now accounting for 1 in 10 new HIV diagnoses in the country.<sup>24</sup>

One public health approach to combatting these issues are syringe services programs. SSPs are community-based programs that provide comprehensive harm reduction services such as sterile needles/syringes, testing, education, referrals, and counseling. SSPs have been shown to reduce needle stick injuries in first responders, reduce overdose deaths, while maintaining cost-effectiveness (\$1 invested is reported to save \$6 associated with treating HIV). Further, the individuals served by SSPs are five times more likely to enter substance use treatment, while exhibiting no increases in illicit drug use, including IDU.<sup>25,26,27</sup> Prior to 2016, federal funding was unable to be used toward SSPs in any capacity. However the Consolidated Appropriations Act of 2016 modified the restrictions. Federal funds can now be used for services at SSPs, exclusionary of sterile needles, by state and local communities under certain circumstances. In 2018, there were 318 SSPs across 39 states, D.C., and Puerto Rico.<sup>28</sup> Texas and 10 other states do not currently have an SSP for reasons such as potential legal consequences of syringes/needles considered paraphernalia.

**Endnotes**

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