Texas Environment

Texas Environment Acronyms

ACA – Affordable Care Act

ACH – All Church Home

AMFI – Average median family income

AMI – Area median income

CMHC – community mental health center

CMS – Centers for Medicaid and Medicare Services

CSC – Coordinated specialty care

DADS – Department of Aging and Disability Services

DARS – Department of Assistive and Rehabilitative Services

DEA – Drug Enforcement Agency

DFPS – Department of Family and Protective Services

DSHS – Department of State Health Services

DSRIP – Delivery System Reform Incentive Payment Program

ED – Emergency department
ERPO – Extreme risk protective order
ESC – Education service center
FEMA – Federal Emergency Management Agency
FEP – First episode psychosis
GLO – General Land Office
HHSC – Health and Human Services Commission (Texas)
HUD – Housing and Urban Development
IDD – Intellectual and other developmental disabilities
LBHA – Local behavioral health authority
LCSW – Licensed clinical social worker
LMHA – Local mental health authority
LMI – Low and moderate income
LPC – Licensed professional counselor
MCO – managed care organization
MH – Mental health
MHPAEA – Mental Health Parity and Addiction Equity Act
MLIU – Medicaid and low-income or uninsured
NCA – Needs and capacity assessment
NQTLs – Non-quantitative treatment limits
PBIS – Positive behavior interventions and supports
PREPS – Partial Repair & Essential Power for Sheltering Program
PTSD – Post-traumatic stress disorder
QTLs – Quantitative treatment limits
RHP – Regional healthcare partnership
SAMHSA – Substance Abuse and Mental Health Services Administration
SAPT – Substance Abuse Prevention and Treatment
SDA – Service delivery area
SHR – Supportive housing rental assistance
SSCC – Single Source Continuum Contractor
SU – Substance use
SUD – Substance use disorder
TDI – Texas Department of Insurance
TEA – Texas Education Agency
THECB – Texas Higher Education Coordinating Board
TJJD – Texas Juvenile Justice Department
TMB – Texas Medical Board
TTOR – Texas Targeted Opioid Response
TVC – Texas Veterans Commission
UC – Uncompensated care
UPL – Upper payment limit
VA – Veterans Administrations

Leadership Changes at the Texas Health and Human Services Commission

On May 31, 2018, Charles Smith retired as Executive Commissioner of the Texas Health and Human Services Commission. On August 23, 2018, Governor Greg Abbott announced that Courtney Phillips would assume the role of Executive Commissioner on October 19, 2018. In her previous role, Ms. Phillips served as the chief executive officer for the Nebraska Department of Health and Human Services.[1] Mr. Smith's departure is one of a number of HHSC leadership positions that have been vacated over the past several years, leaving what many consider to be a significant dearth of historical knowledge of the health and human services system. Additionally, due to the January 2017 hiring freeze put in place by Governor Abbott, hundreds of positions at HHSC remain vacant even though the freeze has been lifted.

Health and Human Services System Transformation

The Health and Human Services Commission and the health and human services system continues the transformation directed by the Texas Legislature through S.B. 200 (84th, Nelson/Price). The most recent Addendum to the August 2016

Transformation Plan was submitted to the Legislative Transition Oversight Committee on October 4, 2017. Some of the adjustments in that report included:

- Establishment of the Department of Family and Protective Services as an independent agency while retaining the DFPS commissioner as a member of the HHSC executive council.
- The Department of State Health Services remains a separate agency under the HHSC umbrella. Additional organizational structure changes were made to more appropriately address the core mission of public health.
- Requires HHSC and DFPS to share administrative support services related to procurement, purchasing, contracting, information resources, payroll, and rate setting.
- The External Relations Division that previously reported to the executive commissioner was eliminated with those specific functions now reporting to the chief of staff.
- The Transformation and Policy and Performance unit that previously reported to the chief operating officer now reports to the Chief Policy Officer who reports directly to the executive commissioner. The Chief Policy Officer also has responsibility for system innovation, performance management, policy development, and data analysis.[2]

The entire October 2017 Addendum and the 2016 Transformation Plan is available at https://hhs.texas.gov/sites/default/files/documents/about-hhs/transformation/october-2017-addendum-and-august-2016-plan.pdf.

Additionally, the Transition Oversight Committee met to receive agency updates on September 12, 2018. At that hearing, HHSC announced the creation of the Joint Operations Coordinating Committee, an internal committee comprised of representatives from HHSC and DSHS. The purpose of the committee is to increase transparency, communications, and coordination between the two agencies.

Transforming Inpatient Psychiatric Services in Texas

The 85th Texas Legislature prioritized the transformation of the Texas state hospital system by appropriating more than $300 million to various hospital replacement and upgrading projects. An additional $160 million was appropriated for state hospital repairs.[3] HHSC developed and submitted a *Comprehensive Inpatient Mental Health Plan* to the governor and the legislature on August 23, 2017. Since that time, significant work has been done to move the plan forward. The plan is available at https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/comprehensive-inpatient-mental-health-plan-8-23-17.pdf. Mental health stakeholders contend that any transformation of the inpatient system should be designed in tandem with the community services system to ensure the critically needed continuum of care.

Ten state-operated psychiatric hospitals offer treatment, support, and services to

individuals needing forensic or civil inpatient treatment and services. Not every person with a mental illness is eligible for services within a state hospital. In order to meet eligibility for state hospital services, people must meet a number of criteria based on functionality and financial assets. More information on the state psychiatric hospital eligibility criteria is detailed in the HHSC section of this guide.

As identified by mental health stakeholders and legislators, the system is in need of major changes to meet the needs of Texans. Some of the recent challenges associated with the state hospital system include:

- Aging infrastructure in need of extensive repairs
- Staff shortages resulting in available beds being taken offline
- Increased demand for inpatient services creating long waiting lists often resulting in long waits in jail for forensic patients awaiting competency restoration
- Reduced access to inpatient services for those entering the system through civil commitments
- Growing Texas population[4]

Another significant shift requiring consideration throughout the transformation process is the shift in Texas to a more forensic-based system compared to a civil-based system. Forensic commitments occur when an individual enters the system through the criminal justice or juvenile justice systems. In the past 12 years, there has been a drastic shift of state hospital beds being used for forensic placements, from 28 percent to the current 60 percent.[5] This population shift generates policy and systems considerations on how best to ensure that the appropriate services are available to people entering the system under a civil commitment.

The state plans to address the system transformation in three phases. Phase 1 is well underway and is based on three guiding principles identified by HHSC including:[6]

- Patients should receive high-quality, evidence-based treatment,
- Individuals should be able to easily access state-funded inpatient care, and
- A successful mental health care system requires true integration between various partners across the state.

Phase I projects are expected to add approximately 328 beds to the state operated facilities.[7] Phase I projects in the pre-planning, planning, or construction stages include:[8]

- Austin State Hospital – planning is underway to replace the current facility with a 240-bed facility
- Kerrville State Hospital – planning for a $30.5 million renovation to add 70 maximum security unit beds
- Rusk State Hospital – procurement activities for $178 million additional 100-bed maximum security unit and 100-bed non-maximum security unit replacements
- San Antonio State Hospital – planning for $14.5 million 300-bed replacement hospital and renovation of 40-bed non-maximum security unit
- UT Health Houston – planning and construction of a 228-bed continuum of care campus
- Dallas and Panhandle Projects – pre-planning is scheduled to begin in 2019

Planning projects for each facility are typically coordinated by institutions of higher education with a wide variety of stakeholders participating through steering committees, subcommittees, and workgroups.

Phases II and III are expected to build on Phase I, moving Phase I projects into the construction phase and will consider additional projects not initiated in Phase I. According to the Comprehensive Plan, Phase II will also "consider options for how to rebuild or replace the North Texas – Vernon and Terrell State Hospitals." Implementation of future plans however, are obviously dependent on the funds appropriated by the legislature.

At the September 12, 2018, Senate Health & Human Services Committee hearing, Chairman Schwertner stressed the need to look at the continuum of services needed and not simply focus on additional bed capacity. Systems changes should include a continuum of housing and service needs, as simply adding more beds without simultaneously addressing the need for out-of-hospital housing options will simply continue a system of people cycling in and out of the hospitals with limited opportunities for recovery. The best way to reduce demand on hospital beds is to help people stay out of the hospital. To accomplish this we must look at a continuum of housing options that are affordable while offering the right combination of support and independence. This continuum might include step-down housing options in the community, permanent supportive housing, and the housing subsidies the legislature has made available through HHSC.

Community Mental Health

An individual's recovery is influenced by his or her resources, as well as the environment in which they are recovering.[9] The places where people live, learn, work, play, and pray have an impact on improving mental health, and can alternatively provide environmental barriers. When the community around an individual is supportive, healthy, and provides equal opportunity, there are opportunities extended to improving individual mental health and well-being. Mental health challenges can be experienced at higher rates because of a community's conditions. Research has shown community characteristics influence its well-being, including diversity, poverty, education, access to health and mental health care, and housing.[10,11] Communities have a big impact on an individual's health and well-being, and in order to build toward healthier communities, collaborative efforts across all domains and consideration of all populations is imperative.

Disparities in mental health play outsized roles in our society. People from racial and ethnic minority populations, as well as those from lower socioeconomic strata, and those who live in rural communities, are less likely to have access to mental health care and more likely to receive lower quality care. There have been recent investments in community mental health centers and the expansion of Medicaid, but more work is needed to eliminate these disparities. To address mental health disparities, we need to identify and understand the contributing factors and study the efficacy of programs to remedy them.

- Dr. Joshua A. Gordon, Director of National Institute of Mental Illnesses

A 1999 U.S. Surgeon General report stated that mental health is "plagued by disparities in the availability and access to its services," and identified disparities found across race, culture, financial status, age, and gender, proving that mental health disparities have been evident for almost two decades. The report identified barriers for minorities including treatment lacking cultural competence and insufficient diversity among mental health providers.[12] Unfortunately, these concerns have not disappeared and still exist today. Currently, some minority groups face disparities such as poor access to health care, culturally incompetent or poor health care, stigma and discrimination, unaffordable treatment services, and delayed treatment resulting in worse outcomes.[13]

Rural areas of Texas face mental health disparities that have become a prominent concern in Texas. Of the state's 254 counties, 172 (68 percent) are designated as rural. In 2016, the prevalence of generally poorer health and lack of health care coverage was greater in rural populations than in urban areas.[14] Disparities across the mental health workforce decreases access to mental health care. Two-thirds of Texas' licensed psychologists and over half of the licensed psychiatrists and social workers practice in the five most populous counties, leaving the remaining 249 with a significant lack of mental health providers.[15] This disproportionate workforce prohibits many Texans from having access to care, creating a disparity based on geography. More information on Texas' mental health workforce can be found later in this section.

HOGG FOUNDATION FOR MENTAL HEALTH COLLABORATIVE APPROACHES TO WELL-BEING IN RURAL COMMUNITIES

In order to help address mental health disparities in Texas, the Hogg Foundation developed the Collaborative Approaches to Well-Being in Rural Communities grant project. The grant project awarded five grants to rural counties with the purpose of developing or building on community collaboratives. Partnering with the foundation, the grantees will partake in assessing, planning, and implementing strategies to cultivate healthier communities. Thriving, healthy communities support resilience, mental health, and well-being. The grant project aims to use a

population health approach where contributing factors of mental health disparities will be addressed to advance toward mental health equity and community wellness. "The lack of understanding of how communities support resilience and mental health, the significant inequities that exist in Texas, the community conditions that contribute to mental health disparities, and how people come together to create and implement community-driven solutions" will be explored through the projects.[16]

Grantees were funded to facilitate collaboration within their communities in which all local partners contribute expertise, share decision-making and ownership of project outcomes, increase understanding of community conditions, and integrate knowledge gained with the goal of improved community well-being. Ultimately, the goal is that all people in Texas thrive in communities that value and support their resilience, mental health, and well-being.[17] The grantees selected include Bastrop County, Brooks County, Morris County, Nacogdoches County, and Victoria County. More information can be found at http://hogg.utexas.edu/texas-rural-communities.

BEHAVIORAL HEALTH COLLABORATIVE MATCHING GRANT PROGRAMS

During the 85th session, the Texas legislature advanced efforts aimed at strengthening mental health supports and services while supporting recovery in communities through two behavioral health collaborative matching grant programs:

1. **HB 13 (Price/Schwertner)** – created the Community Mental Health Grant Program to cultivate community collaboration, reduce duplication of services, and strengthen a diverse local provider network that provides continuity of care for individuals receiving services. Outlined in the *Texas Statewide Behavioral Health Strategic Plan*, the applicants must address one or more of the 15 identified gaps. The strategic plan is available at https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf

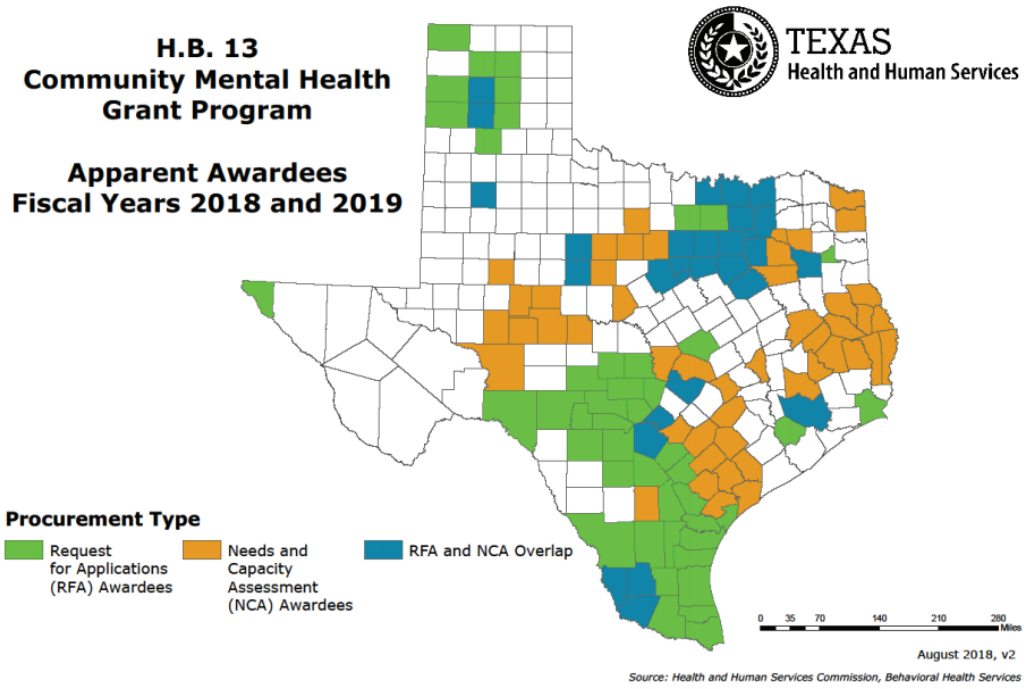
   HHSC will award funding through either a Needs and Capacity Assessment or Requests for Application. NCAs are to be completed by LMHAs and LBHAs to determine awards, with half of the awards allocated to counties with populations under 250,000. RFAs are to be completed by non-profit and other governmental entities, with half of the awards allocated to counties with populations under 250,000.

   For FY 2018 appropriated through Rider 82, the grant program will be funded by $10 million in GR and then by $20 million in FY 2019, with funds dispersed evenly between LMHA/LBHAs applicants and non-profit/governmental applicants. Community collaborative awards are contingent on matching funds (exclusionary of state or federal funds), which is determined by county population; counties with populations greater than 250,000 are required to match 100 percent of the grant amount, while those with populations less than 250,000 are required to match 50 percent.[18]

   Twenty-five LMHAs and LBHAs applicants were awarded grants, including 16 with rural service areas, to address gaps identified in the Statewide Behavioral

Health Strategic Plan; the gaps targeted for improvement are access to appropriate behavioral health services, use of peer services, and services for special populations. Thirty-one non-profit/governmental were awarded grants, of which 7 have rural service areas, to address gaps of behavioral health needs of public school students, and access to timely treatment services. Figure 4 shows the geographical distribution of these grants across Texas.[19]

Figure 4. Map of HB 13 Grant Awards



2. **SB 292 (Huffman/Price)** – created the Mental Health Grant Program for Justice-Involved Individuals to reduce recidivism rates, arrests, and incarceration among individuals with mental illness, as well as reduce wait time for forensic commitments. These grants will be awarded to community collaboratives that consist of at least a county, an LMHA in the county, and each hospital district within the county. A community collaborative may apply for a grant by submitting an NCA. Similar to HB 13, county populations dictate matching amounts (non-state) with populations less than 250,000 requiring a match of 50 percent for Rural Grant Awards, and populations greater than 250,000 requiring a match of 100 percent for Urban Grant Awards.[20]

   For FY 2018 appropriated through Rider 82, the grant program will be funded with $12.5 million in GR for Urban Grant Awards and $25 million during FY 2019 for both Urban and Rural Grant Awards.

   Acceptable uses of the grant are:

   - Continuation, expansion or establishment of a mental health jail diversion program;
   - Alternatives to competency restoration in a state hospital (outpatient,

inpatient outside of a state hospital or jail-based);
- Provision of assertive community treatment or forensic assertive community treatment with an outreach component;
- Provision of intensive mental health services and substance use treatment;
- Provision of continuity of care services for an individual being released from a state hospital;
- Establishment of interdisciplinary rapid response teams to reduce law enforcement's involvement with mental health emergencies; and
- Provision of local community hospital, crisis, respite, or residential beds.[21]

Fourteen LMHAs and LBHAs were awarded Urban Grant Awards for FY 2018-19 to support projects including forensic assertive community treatment teams, jail-based competency restoration programs, and continuity of care programs for individuals leaving state hospitals. Ten LMHAs were awarded Rural Grant Awards for FY 2019 to support projects to include interdisciplinary rapid response teams, local community hospital, crisis, respite or residential beds, and substance use treatment.[22] Figure 5 and Figure 6 illustrate where each of the grants were awarded.

Figure 5. Map of SB 292 Urban Grant Awards

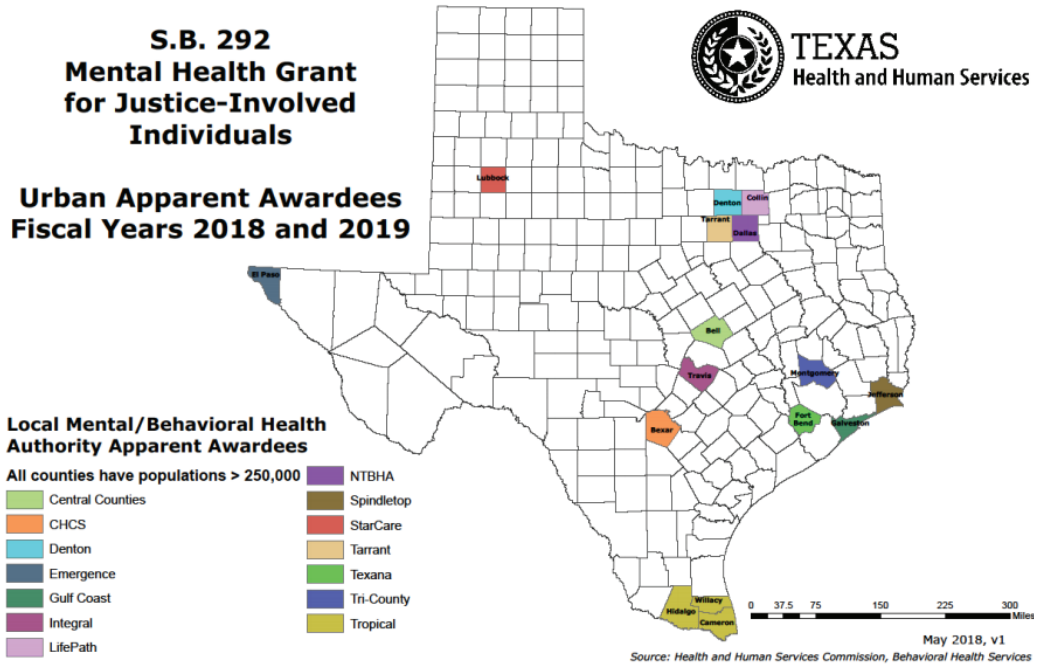
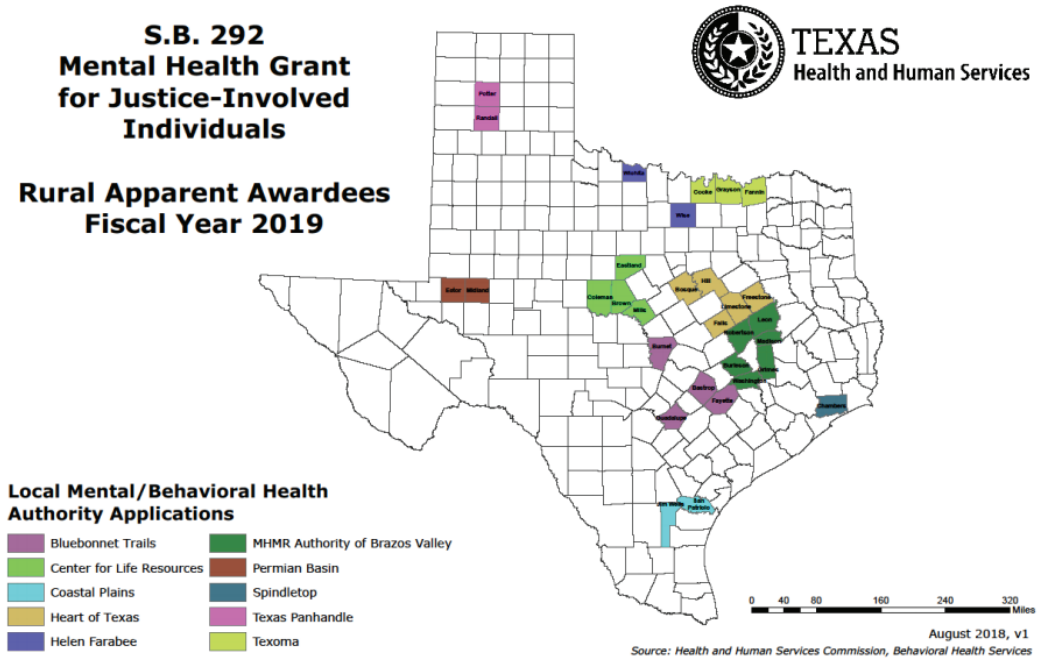


Figure 6. Map of SB 292 Rural Grant Awards



School Safety and Children's Mental Health

Recent tragedies around Texas and the nation have put a spotlight on the safety of our children, their teachers, and the need to support their whole health, including their mental health and mental well-being. There are many viewpoints and complexities to this discussion and many decision points along the way to creating meaningful policies. Often what initially may appear to be a clear issue turns very gray when unintended consequences are considered. We recognize that this can be a contentious conversation but urge stakeholders to remain thoughtful and open during these conversations.

What is often misunderstood after a violent tragedy is that mental illness is not a primary predictor of dangerousness. While some violent crimes are committed by individuals with a diagnosable mental illness, many are not. According to Dr. Joel Dvoskin, an expert in the field of forensic psychology at the University of Arizona, violence is perpetrated by people who are extremely angry, people who are experiencing an overwhelming sense of despair, and people who suffer from deep loneliness.[23] He states, "The problem is not mental illness. The problem is emotional crises fueled by rage, fear, and despair."[24]

Following are summaries of some of the issues relating to school and child safety and the discussions rising on the policy agenda during the interim period.

SCHOOL AND FIREARM SAFETY ACTION PLAN

On May 30, 2018, Governor Greg Abbott released a School and Firearm Safety Action Plan. The plan included 40 recommendations that the governor characterized as a "starting point" for discussions on school safety.[25] A summary of the recommendations and the full plan can be accessed at https://gov.texas.gov/news/post/governor-abbott-unveils-plan-to-address-school-safety-in-texas.

INTERIM LEGISLATIVE HEARINGS

Multiple hearings in both the Texas House and Senate have been conducted to discuss the multitude of strategies being considered. Some of the committees participating in these discussions include:

- House Public Health
- House Public Education
- House Criminal Jurisprudence
- House Homeland Security and Public Safety
- Senate Select Committee on Violence in Schools and School Security
- It is anticipated that numerous recommendations for legislative actions will be included in committee interim reports.

EXTREME RISK PROTECTIVE ORDERS

In light of recent mass shootings across the nation and Texas, extreme risk protective orders, often referred to as "red flag laws," received significant attention during the legislative interim. Approximately 13 states across the nation have enacted some form of these statutes allowing the judicial system to prohibit firearm possession by individuals deemed to be dangerous to themselves or others. Many believe that removing access to firearms from individuals meeting certain risk profile criteria could reduce suicide and homicide threats. Implementation of such laws requires careful consideration of a number of decision points including:

- Due process for individual rights
- Penalties for knowingly filing false petitions
- Access to mental health treatment, supports, and services where appropriate
- Ex parte (temporary emergency) versus longer term removal
- Integration with current laws addressing firearm possession and emergency detentions
- Implementation complexities
- Return of or disposal of firearms after expiration of the order
- Risk factors to be considered or threat assessments to be used

SCHOOL-BASED MENTAL HEALTH SERVICES

To help reduce future risk of school violence, many stakeholders advocate for increased attention to mental health and well-being in the school setting. Previous legislation attempted to increase awareness of teachers and other educators with respect to identifying students who may be at risk.

Increased professional development has been a key driver including legislative funding to provide Mental Health First Aid to educators and others at the local campus level. According to the USA Mental Health First Aid official website, "Mental Health First Aid is an 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis."[26] Texas law already allows public school educators, district employees, and other staff to receive MHFA training through an LMHA.

Mental Health First Aid has been referred to as "CPR for mental health." The training's goal is to reduce fear and stigma surrounding mental health and substance use, and equips individuals to recognize when someone is experiencing a crisis and needs help. The course teaches the risk factors and warnings signs of a developing mental illness, and offers strategies for helping individuals in a variety of crisis and non-crisis situations.[27] More information on Mental Health First Aid, including locating a training session, is available at https://www.mentalhealthfirstaid.org/take-a-course/what-you-learn/.

Positive behavior supports and interventions and various models of social-emotional learning programs continue to be used in many schools to help build positive learning environments. These programs are primarily school-based initiatives aimed at prevention, but also provide increased support for children identified as being at higher risk for behavioral challenges. More information on these programs can be found in the Texas Education Agency Section of this guide.

Peer Support Services

According to the Centers for Medicare and Medicaid Services, "peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with recovery from mental illness and substance use disorders."[28] Also research sponsored by SAMHSA stated, "peers are individuals with histories of successfully living with serious mental illness who, in turn, support others with serious mental illness."[29] Certified peer specialists and certified substance use recovery coaches have both the lived experience and have achieved the education and examination requirements for certification. Peer support services generally fall into three categories:

1. A distinct set of activities or a curriculum that includes education and the development of coping and problem-solving strategies to facilitate self-management of a person's mental illness and reinforce daily living skills (i.e. rehabilitative services);
2. Activities that are delivered as part of a [recovery] team that may include non-peers (for example, an assertive community treatment team); and
3. Traditional activities that are delivered in a way that is informed by a peer's personal recovery experience (i.e., case management, information and referral, etc.).[30]

Peer specialists assist individuals experiencing mental illness and substance use conditions by helping them focus on recovery, wellness, self-direction, personal responsibility, and independent living. While peer services are not intended to supplant other existing mental health or substance use services, the frequency of other services can be reduced when an individual is supported by a peer, often resulting in lower costs and better outcomes.[31] Peer support services are an integral part of the mental health and substance use workforce; the behavioral health service array is not complete unless these services are included. Peer and recovery specialists play a critical role in supporting individuals experiencing mental health and/or substance use conditions who are working toward recovery.

The 85th Texas Legislature passed HB 1486 (85th, Price/Schwertner) which required HHSC to create a Medicaid reimbursable state plan benefit for peer support services. To operationalize this directive, the legislation directed HHSC to develop rules that:

1. Establish training requirements for peer specialists;
2. Establish certification requirements for peer specialists;
3. Define the scope of services peer specialists may provide;
4. Distinguish peer services from other services that a person must hold a license to provide; and
5. Develop any other rules necessary to protect the health and safety of persons receiving peer services.[32]

In addition to the rules identified above, HB 1486 directed HHSC to establish a stakeholder workgroup to provide guidance on the development of the rules. The peer services workgroup met regularly from fall of 2017 through spring of 2018 to provide input as the rules were developed. The workgroup continued to meet after the draft rules were proposed to provide guidance on the certified peer services training curriculum and the peer services supervision training curriculum, as well as other implementation issues. It is anticipated that the new Medicaid benefit will be available on or around January 1, 2019.

Mental Health and Substance Use Parity

Per federal regulations in the Mental Health Parity and Addiction Equity Act, all health plans that offer mental health or substance use benefits must provide those benefits at the same level ("parity") as surgical and medical benefits. Originally passed in 2008, MHPAEA applied to only large employer plans but was expanded in 2010 through the Affordable Care Act to most private health plans, and eventually to Medicaid MCO plans and CHIP in 2016.[33]

In 2011, the Texas Department of Insurance adopted rules in response to MHPAEA requiring mental health and substance use benefits be offered at a comparable level to medical and surgical benefits. The TDI rules did not address certain federal parity guidelines, including non-quantitative treatment limitations. While quantitative treatment limitations are numerical, like the number of visits per year or the number of days covered for inpatient treatment, NQTLs include "non-numerical limitations" like step-therapy or pre-authorization. An MHPAEA rule issued in 2013

required parity in NQTLs, but TDI rules did not reflect this federal update.

Parity is meant to ensure the equal treatment of mental health and substance use condition benefits to medical and surgical benefits, but consumers continue to report issues in accessing services. Although Texas had its own parity rules and regulations, many consumers continued to struggle to receive mental health and substance use services through their health plans. National reports indicate that the nation had serious barriers to true mental health parity. For example, a 2015 NAMI report found that people report being denied mental health care nearly twice as often as they report being denied general medical care.[34] Consumers face parity-related barriers including denials based on medical necessity, lack of access to an adequate provider base, and prescription cost and accessibility.[35] However, TDI reported that the agency only received seven total complaints related to parity in 2014 and ten complaints through June 2016.[36] This could be due to individuals reporting parity complaints to the Department of Labor or not labeling a complaint as a violation of parity.

During the 84th interim, Speaker Joe Straus appointed Representative Four Price to chair and Representative Joe Moody to vice-chair the House Select Committee on Mental Health. After eight hearings, the select committee released its interim report and made recommendations related to parity, as well as emphasized the importance of providing coverage for mental health and substance use. Parity was recognized as a challenge in the report, citing TDI's limited authority or enforcement capabilities and individuals' reports of insurance plans not providing equal coverage. In response, the committee made specific parity-related recommendations including: provide TDI with authority and resources to enforce federal parity laws, require mental health parity and protections, and enact a state mental health parity law. The full report is available at https://house.texas.gov/_media/pdf/committees/reports/84interim/Mental-Health-Select-Committee-Interim-Report-2016.pdf.

The 85th legislative session included a strong focus on mental health related legislation, in part due to the appointment of the House Select Committee on Mental Health. In order to address consumer concerns and issues related to the gaps in national and state regulations, the Texas legislature passed HB 10 (85th, Price/Zaffirini) during the 2017 regular session. The enactment of HB 10 moves Texas toward ensuring individuals with mental health and substance use challenges can access needed services equally with those with medical concerns by:

1. Creating a Behavioral Health Access to Care Ombudsman within the existing HHSC Office of the Ombudsman whose responsibilities include but are not limited to access to care, tracking insurance benefits, receiving and reporting parity violations, referrals to services, and aiding consumers and providers in the filing of complaints and appeals.
2. Requiring coverage for mental health conditions and substance use disorders be provided under the same terms and conditions that apply to the plan's medical and surgical benefits and coverage, without more restrictive limitations. HB 10 provided authority to TDI to enforce and regulate all state-regulated plans, including parity protections for both NQTLs and QTLs. HB 10 did not require any plans to cover mental health or substance use condition benefits if they were not already doing so.

3. Charging studies from both TDI (commercial health plans) and HHSC (Medicaid managed care organizations) to review and monitor NQTLs (i.e., benefits subject to pre-authorization or utilization review, denials due to medical necessity, appeals, justification of denial of appeals, and report on how benefits of medical and MH/SUD differ in managed care health care plans).
4. The creation of the Mental Health Condition and Substance Use Disorder Parity workgroup as part of The Office of Mental Health Coordination. The workgroup operates as a subcommittee of the existing Behavioral Health Advisory Committee. The 18 appointed stakeholders meet to increase understanding of rules and regulations, improve compliance, and develop a framework to implement and enforce mental health parity in Texas.[37]

House Bill 10 became effective September 1, 2017 with its implementation to be monitored by the House Committee on Public Health during the 85th Interim Session. Completed studies by TDI and HHSC were released in September 2018. The initial report from the parity workgroup is expected in September 2018 as well.[38]

TDI's report is available: https://www.tdi.texas.gov/reports/documents/Final-draft-HB-10-report-8.31.18.pdf

HHSC's report is available: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/hb10-assess-medical-surgical-benefits-sept-2018.pdf

Services for Individuals with Intellectual/Developmental Disabilities Experiencing Co-occurring Mental Health Conditions

Individuals with intellectual and other developmental disabilities often experience mental health conditions as well as the harmful consequences of trauma. Analysis of recent data from the National Core Indicators suggests that approximately 34 percent of adults living with IDD also have a co-occurring mental health condition.[39] People with IDD experience abuse, neglect, exploitation, isolation, institutionalization, bullying, restraint, seclusion, violence, and other forms of trauma. Yet rarely are IDD or special education systems and policies built on recovery and trauma-informed principles, with goals and objectives to address mental wellness. While we know that recovery from mental illness and trauma is possible, the focus on IDD too often overshadows attention to potential mental health conditions or consideration of the impact of past trauma.

Depression and anxiety are two of the most frequently identified mental health conditions in people with IDD but are certainly not the only ones.[40] Research has also indicated an over-representation of schizophrenia in people with IDD compared to the general population. Post-traumatic stress disorder has also been

identified as a significant cause of mental health concerns in people living with IDD.[41] Studies indicate that individuals with reduced developmental levels are more at risk for experiencing PTSD and that their symptoms can be more severe.[42]

There can be challenges associated with assessing and treating individuals with IDD who experience mental health conditions include: communication differences, time required for assessment, lack of mental health providers who understand the IDD population, limited resources, professional biases, overuse of pharmacology, and the lack of consideration of people with IDD when developing state mental health policies. The challenges, however, are not insurmountable and both the state and national dialogue indicate a recognition of the need to take action.

Texas has recognized the current gap in our systems of supports and services for individuals with IDD living with co-occurring mental health conditions. The Statewide Behavioral Health Strategic Plan identified the lack of mental health services for individuals with IDD as a significant gap in the system.

Gap 9: Behavioral Health Services for Individuals with Intellectual Disabilities

Depression and anxiety are the most frequently identified mental health conditions among individuals with IDD, but the prevalence of schizophrenia is disproportionately high in this population. Additionally, individuals with IDD frequently have behavioral health needs that are the result of post-traumatic stress.

Often, the symptoms of untreated mental health needs among individuals with IDD can be mischaracterized as "challenging behaviors." Recently, the behavioral health system in Texas has begun to focus more specifically on the mental health and wellness of this population. While this increased focus on individuals with dual diagnoses certainly represents a step in the right direction, more extensive efforts will be needed. Individuals with IDD should have access to quality behavioral health services, trauma-informed care, and opportunities for recovery. Additionally, supports should be adequate in both their approach and intensity to avoid unnecessary hospitalizations or incarcerations. When individuals with dual diagnoses end up in the hospital or in jail, appropriate interventions and supports must be targeted to their specific needs.

Source: Texas Health and Human Services Commission. (2016). Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2017 – 2021. Retrieved from https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf

The inclusion of Gap 9 in the Statewide Behavioral Health Strategic Plan offers future opportunities for increasing access to quality mental health services for both children and adults with IDD. Current efforts to address this gap include:

- HB 2789 (84th, Raymond/Zaffirini) required web-based trauma-informed care training for new employees hired at state-supported living centers and intermediate care facilities for people with intellectual disabilities. As a result of the legislation, the Department of Aging and Disability Services and the

Department of State Health Services developed a series of web-based training modules designed to help families and providers consider the mental health and wellness support needs of individuals with IDD as opposed to limiting their efforts to managing "challenging behaviors."

- Efforts have also been made in Texas to address the need for crisis intervention services for individuals with IDD experiencing a mental health crisis through the establishment of eight regional "transition teams." This is a start but does not address the inability of individuals with IDD to access quality mental health treatment and supports that could prevent a crisis.
- HHSC Office of Mental Health Coordination produced a six-module series of web-based trainings focused on helping caregivers and direct care workers by providing useful information to guide their support of individuals with IDD and co-occurring mental health conditions. The training entitled Mental Health Wellness for Individuals with an Intellectual or Developmental Disability includes the following modules:
  - Co-occurring Disorders: Intellectual and Developmental Disabilities and Mental Illness
  - Trauma Informed Care for Individuals with IDD
  - Functional Behavioral Assessment and Behavior Support
  - Overview of Genetic Syndromes Associated with IDD
  - Overview of other Medical Diagnoses Associated with IDD
  - Putting it all Together: Supports and Strategies for Direct Service Workers
- The HHSC Health, Developmental, and Independent Services Division has identified the mental health needs of children with IDD as a priority area and is planning initiatives to address the unmet needs of these children. First steps in this endeavor included stakeholder meetings and trauma training specific to children with ID who have experience trauma. The commission has sponsored several trainings using *The Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma*.
- Hogg Foundation for Mental Health partnered with the National Child Traumatic Stress Network to develop a training toolkit, *Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma*. The toolkit was developed over two years with the guidance of national mental health experts and IDD experts. The toolkit is designed to be a two-day train-the-trainer resource and is available free of charge at http://nctsn.org/products/children-intellectual-and-developmental-disabilities-who-have-experienced-trauma.

The dearth of mental health services and supports for individuals with IDD requires ongoing efforts at the national, state, and local levels. Efforts to increase awareness, build capacity, and increase access to quality mental health services should be part of the state's overall mental health plan.

1115 Waiver: Texas Health Care Transformation and Quality Improvement Program

In December 2011, Texas was approved by the Centers for Medicare & Medicaid Services for a waiver of certain federal Medicaid regulations under section 1115 of the Social Security Act.[43] These waivers were designed to improve managed care delivery and access to services while maintaining supplemental payments to assist hospitals in covering the costs of uninsured patients during the initial implementation of the Affordable Care Act. Several parts of the 1115 waiver aim to improve primary healthcare services and coverage more generally (e.g., improving access to primary care physicians and chronic care management), but this section focuses specifically on the 1115 waiver's impact on improving behavioral health services.[44]

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver – commonly known as the "1115 Waiver" — has five main objectives:

- Expand Medicaid managed care statewide
- Develop and maintain a coordinated care delivery system
- Improve health outcomes while containing costs
- Leverage federal Medicaid match dollars with local and state funding
- Transition health services to innovative, quality-based payment systems.[45]

The Texas 1115 Waiver accomplishes these goals through the statewide expansion of Medicaid managed care through the STAR, STAR Kids and STAR+PLUS programs, and through the creation and utilization of two unique funding sources:

- **The Uncompensated Care pool**, which replaces the Upper Payment Limit program for reimbursing physicians and hospitals for Medicaid shortfalls and care provided to individuals who do not have third party coverage (i.e., health insurance).
- **The Delivery System Reform Incentive Payment pool**, which provides incentive payments to fund infrastructure improvements and test innovative models of healthcare delivery for Medicaid recipients and low-income, uninsured individuals.[46]

RENEWAL

In December 2017, CMS approved a five-year renewal of the 1115 Waiver to continue the program through September 2022. The extension continues Medicaid managed care, the UC pool, and the DSIRP pool, though includes new standards and requirements for the funding pools. The renewal of the 1115 Waiver outlines a phase out plan for DSRIP funding and the new method of figuring and distributing UC payments. Following the renewal, CMS approved HHSC's new Program and Funding Mechanics protocol that modifies the requirements for participation in DSRIP beginning October 1, 2017 through September 30, 2019.[47] The CMS approval letter of the 1115 Waiver renewal is available at https://hhs.texas.gov/sites/

default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/1115renewal-cmsletter.pdf

For the first two years, $3.1 billion per year will be allocated to the UC pool to account for Hurricane Harvey's impact on healthcare providers' operational and financial stability. CMS will then transition to a new method of distributing UC payments to hospitals that will account for all provider types, be based upon uncompensated charity care costs, and will no longer cover Medicaid shortfall. The phase out plan for the DSIRP funding pool will begin with maintained level funding through FY 2019 of $3.1 billion per year, decreased through FY 2021, and then discontinued in FY 2022. During this phase out of funding, HHSC will be required to submit a transition plan.[48]

THE UNCOMPENSATED CARE POOL

The UC Pool replaces Upper Payment Limit funding for hospitals and physicians and allows them to receive payments for uncompensated care for low-income Medicaid eligible patients and others who are uninsured. While payments through the 1115 waiver UC pool initially helped Texas cover gaps in healthcare coverage that resulted from the state's decision not to expand Medicaid under the Affordable Care Act, a policy passed by CMS in 2015 no longer allows for federal Medicaid funds to cover uncompensated care for individuals who would have been covered by statewide Medicaid expansion or a coverage waiver.[49] As of August 2016, Texas has paid out an estimated $17.5 billion in payments from the UC pool.[50]

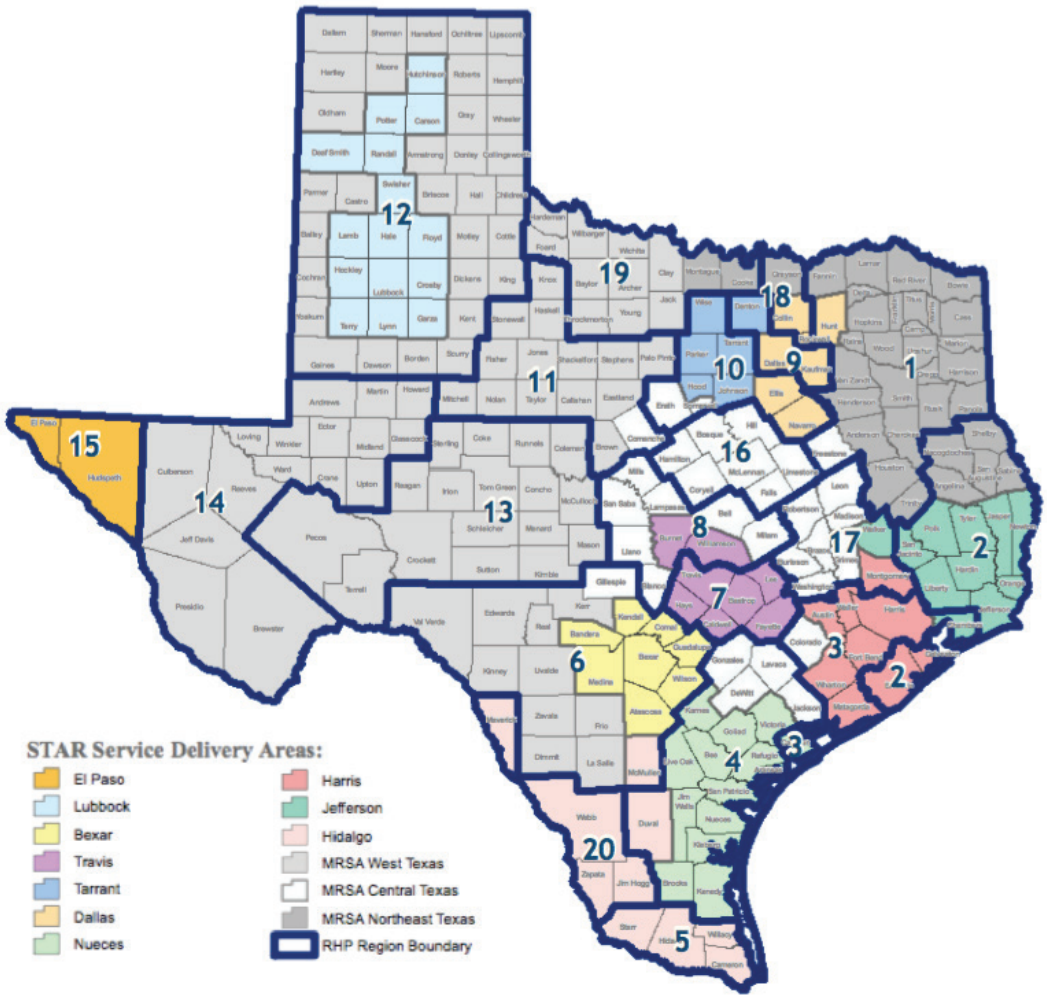
THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS POOL

The goal of the DSRIP pool is to transform healthcare delivery systems, improve individual and population health, and lower overall healthcare costs through efficiencies and innovations.[51] The DSRIP pool incentivizes innovation by freeing providers from the constraints of traditional fee-for-service payments and reimbursing providers based on the quality of their services and their patient outcomes.

The improvement of healthcare delivery systems through the DSRIP pool in Texas relies heavily on the 20 regional healthcare partnerships across the state. RHPs are local collaborations that help to identify community needs and fund the state's portion of all waiver payments.[52] The goal of RHPs is to address specific regional concerns through individualized DSRIP projects while providing an overarching framework that allows for improved coordination and resource sharing across regions. The counties and other local entities providing the state share of funds determine how their funds are used in the RHP, consistent with waiver requirements.

Figure 7 below shows a map of the 20 RHPs in charge of Texas' DSRIP programs.

Figure 7. Map of Regional Healthcare Partnerships and Managed Care Service Delivery Areas in Texas: January 2016



Source: Texas Health and Human Services Commission. (January 6, 2016). *Texas: Regional Healthcare Partnerships (RHP) and Manages Care SDAs.* Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/TX_RHP_and_SDAs_Regions_010616_Update.pdf

The new DSRIP framework replaces the previous project and measurement categories through four new categories aimed at shifting toward a "systemic effort focused on health system performance outcomes":

- **Category A: Core Activities.** Qualitative reporting that includes progress on selected core activities, alternative payment model arrangements, costs and savings, and collaborative activities.
- **Category B: Medicaid and low-income or uninsured patient population by provider.** Reporting the number of MLIU individuals and total number of individuals served by each performing provider's system.
- **Category C: Measure Bundles.** Measure bundles developed for hospitals and practices, and lists measures for community mental health centers and local health departments.

- **Category D: Statewide Reporting Measure Bundle.** Expanded set of previous hospital Category 4 measures that are required of all performing providers. Only hospitals have to report values for Category D measures. Physician practices, community mental health centers, and local health departments have to provide qualitative information on efforts to impact ascribed measures, but they do not report the measure values themselves.[53]

Now with the change in categories, the program must meet performance and reporting requirements from Category C in order to receive funding from the DSRIP pool. Instead of selecting projects, providers choose and describe "core activities" that are implemented.

As of March 2017, there were 1,451 active DSRIP programs in Texas across the state's 20 RHPs. Local mental health authorities are the most common type of providers for DSRIP services, operating 260 different DSRIP projects, but hospitals, physician groups and local health departments also serve as providers for many DSRIP projects.[54] Through Demonstration Year 5 (September 2016), DSRIP projects in Texas had received approximately $11.4 billion in total payments as a result of meeting their pre-determined, program-specific success metrics.[55]

Behavioral health services have been targeted for significant expansion under the 1115 Waiver. Texas prioritized behavioral health for its 1115 Waiver by reserving 10 percent of DSRIP funds for community mental health centers (also known as LMHAs) and including several behavioral health projects in the DSRIP menu. In 2016, behavioral health-focused projects totaled over 400 in the DSIRP program.[56] These projects' goals are centered on outcomes that improve care for individuals (access, quality and health), improve the population's health, and lower costs. DSRIP projects are required to prioritize certain transformative areas including alternatives to inappropriate care (i.e., emergency departments, jails, preventable inpatient psychiatric), improvements around behavioral health workforce, behavioral care integration with physical health and other community-based supports, and prevention around long-term and permanent out-of-home placements for children with severe emotional disturbances.[57] The 1115 Waiver also created the option for local communities to expand behavioral health services without conforming to the narrow eligibility requirements that exist for state-funded LMHA services.

Examples of current behavioral health DSRIP projects include:

- Improved and expanded crisis intervention (e.g., rapid response teams, psychiatric extended observation and stabilization units, and trainings for mental health deputies)
- Integration of behavioral health services with primary care (e.g., including behavioral health in obstetrics outpatient services to treat postpartum depression)
- Expansion of peer support services and early intervention programs
- Expanding community treatment options so that individuals experiencing a psychiatric crisis are not unnecessarily put into emergency rooms, state hospitals, prisons or jails
- Improved recovery programs that provide supportive services to increase compliance and success (e.g., transportation and meals to help individuals at a homeless shelter stay engaged and involved in their recovery)

- Expansion of providing behavioral health services through telemedicine/telehealth
- Implementation of the Family Preservation Program to provide continuity of care services for children at risk for out-of-home placements or who are returning to the community after a stay at an inpatient psychiatric hospital.[58,59]

As a result of DSHS Rider 59 in the 2016-2017 General Appropriations Act (and Rider 79 in the 84th legislative session), LMHAs are now required to use GR funds appropriated by the state to draw down federal funds through the DSRIP pool whenever possible.[60] In FY 2017, LMHAs leveraged roughly $151 million in GR appropriations and $40 million in local funds to draw down $246 million in federal funding for behavioral health services provided through the DSRIP pool.[61]

OUTCOMES OF DSRIP PROJECTS UNDER THE 1115 WAIVER

In May 2017, the Texas Health and Human Services Commission released an Evaluation Report on the 1115 Waiver, studying the five-year demonstration period of 2011-2016. The evaluation looked at the effects of Medicaid MCO expansion, changes in collaboration among organizations, stakeholders' perceptions and recommendations, DSRIP effects on health care quality, population health and costs, as well as the specific effects of DSRIPs on UC care costs. The initial report only reviewed DSRIP care navigation programs, citing program diversity as the need for its focus. Some of the conclusions and information found related to behavioral health services include:

- On average, Medicaid MCOs increased access to care and utilization for STAR and STAR+PLUS programs
- Mental health rehabilitation services and targeted case management services showed a small but statistically significant increase throughout the state
- Interviews with staff, patients, and family members revealed that care navigation programs often provided emotional, informational, and tangible support, as well as assistance with referrals and accessing services
- Increased intersectoral ties in the areas of resource and formal data sharing
- The inclusion of community mental health centers, public health departments, and other non-traditional service delivery organizations such as school districts as eligible DSRIP providers "expanded the potential for intersectoral collaboration that may be necessary for comprehensive care delivery to the state's most vulnerable populations"
- Stakeholders' reported strengths of the waiver included increases in available funding, the opportunity for innovation, the emphasis on public-private partnerships, and systems for accountability
- Stakeholders' reported weaknesses of the waiver included streamlining processes, timelines, and payment schedules; eliminating frequent changes to policy; recognizing and addressing the unique implementation challenges of different types of providers; and including more provider types that were previously excluded
- Rural communities had difficulty initiating and sustaining DSRIP projects
- More follow-up time is needed to measure the impact on UC costs on DSRIP programs due to the timing of implementation under the demonstration and the delay in UC data availability
- Providers seemed unsure in the fifth year of the Demonstration how to sustain

DSRIP projects without continued DSRIP funding [62]

The report encourages the continuation of 1115 Waivers, stating that the expansion of Medicaid MCOs and transition to incentive payment pools has resulted in Texas being more accountable for its use of public dollars and recommends the continuation of learning collaboratives as well as DSRIP projects that are meeting their goals. The full evaluation is available at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/Evaluation-Texas-Demonstration-Waiver.pdf.

A supplemental report released by HHSC was more encompassing of all DSRIP programs. Although the report describes the data as preliminary because the agency is in the early stages of gathering projects' outcome information, HHSC indicates DSRIP projects in Texas have resulted in "increased access to primary and preventative care, ED diversion and enhanced attention to individuals with behavioral health needs."[63] All DSRIP providers, including community mental health centers, had 72 percent success rates in decreasing ED visits for behavioral health/substance abuse. Additionally, of the 30 projects that reported on 7 and 30-day follow up after hospitalization for mental illness, all of them reported receiving incentive payments for improving their baseline for a full year and averaged a 12 percent improvement in 7-day follow up rates.[64] Because reimbursements for DSRIP projects are tied to achieving specific patient-centered metrics, the financial success of these projects also signals improvements at the individual level. As of March 2017, a total of 1,500 3 and 4-year DSRIP projects had been approved with a 5-year valuation surpassing $11 billion.[65]

In addition to some initial quantitative data, there is qualitative data available about the impact that DSRIP projects are having on the lives of individuals who are enrolled in services. One DSRIP project in Austin-Travis County that expands access to mobile psychiatric crisis units has successfully diverted roughly 90 percent of the individuals they have served from entering into the criminal justice system.[66] In another DSRIP project focused on integrating behavioral health services with primary care in RHP 1, one primary care physician expressed that the program has helped them to better recognize their clients' behavioral health needs — "[I'd] been treating this patient for years and never knew he was depressed. Because of our integration project, I learned he was suicidal and was able to get him treatment. DSRIP has changed how I practice medicine."[67]

At the systems level, DSRIP projects have improved collaboration between different RHPs and DSRIP providers, allowing them to increase efficiency by sharing information on best practices and barriers to implementation. As a result of the 1115 Waiver's DSRIP projects, there has been a 25 percent increase in the number of "collaborative inter-organization relationships" across the state's 20 RHPs.[68] The 400+ behavior health-related DSRIPs have increased collaboration and resource sharing between LMHAs, hospitals, and other community providers. [69] DSRIP projects have improved the mental health outcomes of thousands of Texans and laid the foundation for developing important community partnerships. As the initial 1115 extension approval letter from CMS explains, the 1115 Waiver is not a permanent solution to Texas' shortcomings in providing behavioral health services. With the phasing out of DSRIP funding, more long-term plans for coverage must be made.

Telemedicine and Telehealth Services

Telemedicine and telehealth services generally refer to medical services or treatments that are provided to distant locations using advanced telecommunication technologies (e.g., interactive digital video conferencing programs like Skype) to remotely connect a patient with a doctor or other health professional.[70] According to Texas statutes, telemedicine services are provided by physicians or other health professionals acting under a physician's delegation while telehealth services can be delivered by a number of different licensed or certified health professionals acting within the scope of their license or certification (e.g., Licensed Professional Counselors, Licensed Clinical Social Workers, or Psychologists).[71,72]

In Texas, behavioral health services provided via telemedicine/telehealth include:

- Psychiatric diagnostic evaluations
- Psychotherapy (with an individual and/or their family)
- Office visits
- Other outpatient visits including counseling, coordination of care with other physicians and decision-making
- Inpatient consultation, pharmacologic management and medication review [73]

The legislative push for the approval of telemedicine medical services in Texas began in 1995.[74] Interest in telemedicine services waned in the early 2000s but in recent years, legislators have a renewed interest in funding and expanding telemedicine and telehealth options. The following telemedicine/telehealth bills were passed by the 84th Texas Legislature in 2015:

- **HB 1878 (84th, Laubenberg/Taylor)** — ensures reimbursement for physicians providing telemedicine services to children in primary or secondary school-based settings.[75]
- **SB 200 (84th, Nelson/Price)** — abolished the telemedicine and telehealth advisory committee and transferred all duties within DADS and DARS to HHSC (as part of the larger Health and Human Services Transformation).[76]
- **HB 2641 (84th, Zerwas/Schwertner)** — extends Medicaid reimbursement for home telemonitoring services (e.g., remote monitoring to determine compliance with psychotropic medications) until September 1, 2019. HB 2641 also adds patients with "mental illness or serious emotional disturbance" as eligible for telemonitoring services.[77]

In 2017, the 85th Texas Legislature passed S.B. 1107 (Schwertner/Price), which aimed to improve opportunities for telehealth and telemedicine services. Some of the major Texas Medicaid benefits changes to the telemedicine benefits included:

- Updated delivery modalities acceptable for reimbursement
- Updated patient and distant site guidelines, as specified by TMB
- Updated patient site presenter requirements, as specified by TMB
- Updated guidelines for valid prescriptions generated from a telemedicine visit, as specified by TMB, BON, TPAB, and TSBP
- Updated guidelines concerning the practitioner-patient relationship required for a telemedicine visit[78]

Both Medicaid and Medicare now view telemedicine and telehealth services as cost-effective alternatives to traditional face-to-face appointments in a doctor's office.[79] According to the Texas Association of Health Plans:

- Eighty percent of emergency room visits are due to patients lacking access to a primary care physician; telemedicine eliminates nearly one in five emergency room visits.
- The average cost of an emergency room visit is $2,168, while the average cost of a telemedicine visit is $40.[80]

BENEFITS OF TELEMEDICINE AND TELEHEALTH SERVICES

Research indicates four main ways telemedicine and telehealth can help improve behavioral health treatment and increase access to care:

- More timely and easy access to a wider array of healthcare services and mental health specialists
- Improved and expanded televideo mental health trainings and educational opportunities for providers in rural areas
- More equitable geographic distribution of healthcare workforce and specialist skills
- Cost savings for patients, private health insurers, and public health programs such as Medicaid and Medicare through increased efficiencies, fewer redundancies, and earlier interventions during (or before) mental health crises.[81,82]

Telemedicine is increasingly being pursued as a solution to help alleviate access to care challenges experienced by certain marginalized groups, like geriatric consumers and individuals with mobility issues, in addition to consumers in rural areas. There is a national shortage of geriatric mental health care providers, and geriatric consumers often have difficulties with transportation for medical appointments. Telemedicine can help geriatric consumers in rural areas better connect with the few geriatric specialists that exist. Telemedicine can solve transportation and access to quality care issues for individuals living in rural areas or for individuals who have mobility issues or visual impairments.[83] While expanding access to telemedicine and telehealth services does not add any new mental health workers to the field, it can help to more equitably and efficiently redistribute the specialist skillsets that are currently available in the workforce.[84]

Hurricane Harvey

EDUCATION

In August 2017, Hurricane Harvey devastated portions of Southeast Texas, bringing an array of challenges to impacted communities including concerns regarding the mental health of school-aged children and recovering from the trauma of the storm. According to the latest research studying the effects of disasters on mental

health, the schools exposed to the storm will observe higher rates of mental health challenges.[85] Information learned from the aftermath of Hurricane Katrina found that children can experience PTSD after a natural disaster, and the percentage of those children struggling with their symptoms had not returned to baseline even three years after the storm.[86] Approximately 1.4 million students were directly impacted within the 60 effected counties recognized by Governor Abbott's disaster proclamation.[87]

Traumatic experiences in childhood are common among school-aged children and if not addressed, have short and long-term negative consequences. The result of untreated or mistreated trauma is not only a public health concern, but a concern for the well-being and potential for the next generation. Children who have experienced trauma can exhibit symptoms such as poor concentration and intrusive thoughts, which both effect school functioning. Studies show these negative consequences among youth can lead to decreased social competence, decreased IQ, decreased reading ability and GPA, higher rates of absences, and decreased rates of high school graduation. [88, 89]

Even before Hurricane Harvey, the Select Committee on Mental Health recognized the importance of early intervention for child and adolescent mental health. The select committee recommended expanding innovative public school-based programs that prioritize prevention and early intervention, as well as increasing school employee training on suicide and mental health. Efforts during the 85th legislative session included HB 11 (Price). HB 11 was a comprehensive approach toward mental health services and education in public schools, which passed out of the House Public Health Committee but did not receive a vote on the House floor; some sections were amended onto other bills.[90]

Another bill pertaining to mental health and education was HB 4056 (Rose/ Lucio, Eddie Jr.), which was successfully passed into law. Per the Texas Health and Safety Code, the TEA, DSHS, and ESCs are required to maintain an updated list of recommended best practice-based programs for addressing mental health concerns in schools. HB 4056 directs these agencies to expand the list to include trauma-informed practices. SAMHSA states a trauma-informed approach is a program, organization, or system which "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization."[91] Further expanding trauma-informed programs in schools, HB 3887 (Coleman) would have required trauma-informed training for school personnel, but did not pass.

Following the 85th legislative session in September 2017, Speaker Straus issued interim charges to both the House Committee on Public Education and the House Committee on Public Health related to education, mental health, and the effects of Hurricane Harvey; however, cohesion of the three was absent.[92] In October 2017, Commissioner of Education Mike Morath announced the formation of the Hurricane Harvey Taskforce on School Mental Health Supports ("Task Force"). Collaborating with the Meadows Mental Health Policy Institute, TEA led the task force in partnership with the Texas Higher Education Coordinating Board and

HHSC at the request of Governor Abbott. The Task Force was formed to "ensure coordinated responses to the needs of public school and university students, and personnel suffering from the devastation of Hurricane Harvey," as well as ensure those affected were connected with the appropriate mental health supports and other resources.[93]

During the 85th Interim, TEA presented the findings of the Task Force and indicated a distinct interest in addressing mental health in school aged children. The Task Force's recommendations to the Texas House Public Health Committee were to increase statewide infrastructure to support school-based and school-linked services, and strengthen understanding of behavioral health in schools.[94] More information on mental health in public schools can be found in the TEA section of the guide.

HOUSING

Hurricane Harvey caused an estimated $120 billion of damage.[95] The size and severity of the storm resulted in devastating flooding that destroyed the homes of thousands of Texans, many in areas that had never flooded before. The Texas General Land Office estimates that more than 1 million homes were impacted by the storm, and as of February 2018, the FEMA Individuals and Households program had received over 896,000 applications for housing and related assistance.[96]

Just as there were major losses to single-family housing, many affordable multifamily housing units, often the only affordable housing options available to people experiencing serious mental illness, sustained severe damage. More than 1,930 units tied to Public Housing Assistance, including Section 8 and Housing Choice vouchers, were lost in the storm.[97] The total cost of these losses amounts to nearly $25,600,000.[98] According to a FEMA-calculated needs assessment, approximately 46 percent of those in need of housing fall within the Low and Moderate Income category (under 80 percent of the Area Median Family Income).[99] Of those 46 percent, nearly half are people who make 30 percent or less AMFI and are considered to be extremely low income.[100]

As of April 2018, two rounds of HUD funding were proposed for Harvey recovery. At the end of 2017, HUD allocated $57.8 million in Community Development Block Grant – Disaster Recovery dollars to help address immediate housing needs.[101] These funds were left over from CDBG-DR dollars issued to Texas for floods in 2015 and 2016. The GLO submitted an action plan to HUD for these dollars in March 2018.[102] By rule, 80 percent of the money must be spent in Harris County, while the remaining 20 percent will be allocated across Aransas, Nueces, and Refugio counties for an affordable rental program.[103,104] Additionally, 70 percent of the funds must benefit LMI households.[105] In Harris County, funds will be used to buy-out single family properties for LMI households and to provide federal match for the Partial Repair & Essential Power for Sheltering program. PREPS is a program specific to Harvey recovery that provides partial home repair to displaced families, allowing them to return home until full repairs can be completed. Outside of Harris County, dollars will be spent on rebuilding affordable workforce housing.

The second round of housing-related funding for approximately $5 billion was

proposed in February 2018 and approved in August 2018. These funds are part of the 2017 national disaster aid package included in the 2018 Continuing Appropriations Act and the 2017 Supplemental Appropriations for Disaster Relief Requirements Act.[106] The plan for these dollars is broader reaching than the first, but 70% of funds must be used for LMI projects and all proposed projects must primarily consider unmet housing needs.[107] The GLO action plan includes two programs to address LMI housing needs:

- The Homeless Prevention Program - providing utility assistance, short-term mortgage assistance, and Tenant-Based Rental Assistance vouchers
- The Affordable Rental Program - providing funds for rehabilitation, reconstruction, and new construction of affordable multifamily housing projects.[108]

More information on housing-related funding, supports, and services are detailed in the Texas Department of Housing and Community Affairs section of the guide.

Substance Use in Texas

The substance use condition and drug overdose death epidemic continues to grow increasingly visible in national headlines. This epidemic has had devastating effects in Texas and across the country. From 1999-2016, drug overdoses have been responsible for over 630,000 deaths across the United States.[109] In 2016, there were a reported 2,831 overdose deaths in Texas alone, with opioid-related deaths reaching 1,375 and surpassing any previously collected data since 1999.[110] Methamphetamine accounted for 715 deaths and according to half of the DEA offices in Texas, remains the major drug threat in Texas.[111]

There have been legislative attempts to reduce these preventable deaths by enacting drug overdose Good Samaritan laws. In 2015, HB 225 (84th, Guillen/Watson) passed both chambers with bipartisan support but was ultimately vetoed. HB 225 would have provided legal protections to people who sought medical emergency treatment for another individual or themselves during a drug overdose. The legislation included protections related to low-level possession and paraphernalia. Governor Abbott's veto proclamation stated that the lack of "adequate protections to prevent its misuses by habitual abusers and drug dealers" led to his decision.[112] Though the laws vary in protections, 40 states and the District of Columbia have passed overdose Good Samaritan laws. This type of law has resulted in a reduction of overdose-related deaths, specifically reducing opioid-related deaths by as much as 15 percent.[113] Following the 85th session, examining the effectiveness of such laws was a charge issued to the Select Committee on Opioids and Substance Abuse.

Another issue exacerbating the current substance use and overdose death crisis is access to treatment for people who are low-income and do not have health coverage. While substance use disorder benefits under Medicaid were expanded as a directive from the 81st legislature, not many people qualified for these services and only 5,967 individuals were treated for SUD under Medicaid in 2015.[114] Other low-income individuals in need of SUD treatment can receive services through the Substance Abuse Prevention and Treatment block grant if the individual is unable to acquire private insurance, Medicaid,

or Medicare, and has an income less than 200 percent of the federal poverty line (approximately $25,000/year). Priority for treatment and services is given to pregnant women and those using intravenously. At any point during FY 2017, over 13,000 adults were on a waitlist to receive SAPT-funded treatment, varying from the average of 16 days to the maximum wait of 293 days.[115] In addressing access to care, all facets of care should be considered. According to SAMHSA, "recovery is built on access to evidence-based clinical treatment and recovery support services for all populations," identifying health, home, purpose, and community as the foundations of recovery.[116]

TEXAS HOUSE SELECT COMMITTEE ON OPIOIDS AND SUBSTANCE ABUSE

In October 2017, Speaker of the House Joe Straus created the House Select Committee on Opioids and Substance Abuse to address the increasing number of deaths resulting from substance use conditions and opioids in Texas.[117] Speaker Straus appointed the following legislators to serve on the committee, directing them to develop principles and action items in order to provide and present legislative solutions:

- Rep. Four Price (Chair)
- Rep. Joe Moody (Vice Chair)
- Rep. Carol Alvarado
- Rep. Garnet Coleman
- Rep. Jay Dean
- Rep. Ina Minjarez
- Rep. Andrew S. Murr
- Rep. Poncho Nevárez
- Rep. Kevin Roberts
- Rep. Toni Rose
- Rep. J.D. Sheffield
- Rep. Gary VanDeaver
- Rep. James White

The select committee was charged with reviewing data and making recommendations on the following: overdose and related health impacts, effective services, state agency prescription drug abuse prevention, diversion of addictive prescriptions, impact on first response personnel, adult and juvenile justice involvement, "Good Samaritan" laws, and substance use specialty courts.[118]

Convened for the first time in March 2018, the Texas House Select Committee on Opioids and Substance Abuse met frequently through the interim to discuss the charges and hear testimony from invested stakeholders. The select committee will release a report with its recommendations no later than November 1, 2018. More information on the committee, including archived records, is available at: https://www.house.texas.gov//committees/committee/?committee=C394

TEXAS LAWSUIT AGAINST OPIOID MANUFACTURER

Nationally, sales of prescriptions for opioid medications have quadrupled since 1999, with a total of 15.9 million prescriptions written in Texas alone in 2015.[119] Part of a

41-state coalition, Texas served subpoenas and information requests to a number of major opioid manufacturers in order to gather information about their marketing and distribution practices in September 2017. Following the investigation in May 2018, Texas Attorney General Ken Paxton announced the filing of a consumer protection lawsuit in Travis County District Court against Purdue Pharma for violating the Texas Deceptive Trade Practices Act involving its prescription opioids, namely OxyContin. The lawsuit alleges Purdue Pharma:

- Misrepresented or failed to disclose the risk of addiction
- Misrepresented the absence of a "ceiling dose," insinuating that the medication could be increased indefinitely without risk
- Claimed "pseudo-addiction"
- Falsely informed prescribers that common signs of addiction are signs a person needs a higher dose
- Falsely advertised OxyContin's formula as abuse-deterrent and reduced risks associated with the medication, including addiction.[120]

TEXAS TARGETED OPIOID RESPONSE

In December 2016, the federal government passed the 21st Century Cures Act, creating nearly $1 billion in Opioid State Targeted Response grants dispersed across states over two years. The federal grant aims to provide services to populations identified as highest risk of an opiate use disorder, including individuals in metropolitan areas, pregnant and post-partum women, and individuals with a history of prescription opioid abuse.[121] In May 2017, former HHSC Executive Commissioner Charles Smith announced that SAMHSA awarded Texas $27.4 million per year for the Texas Targeted Opioid Response program.[122] Addressing prevention, training, outreach, treatment, and recovery support services, TTOR is estimated to have helped more than 14,000 individuals over two years. TTOR objectives are to expand capacity and access to treatment, eliminate wait lists, educate providers and prescribers, enhance incorporation of peer supports, and increase outreach activities to substance use professionals and communities. TTOR funds must be used to address opioid use and are not available for treatment or services focused on other substance use.

SUBSTANCE USE IN THE CRIMINAL JUSTICE SYSTEM

Since the war on drugs was declared in the 1970s, the approach to addressing substance use conditions has been punishment. Unfortunately, consequences of this approach are evident in Texas and nationally where overly-punitive laws related to paraphernalia, drug classification scheduling, and possession continue to incarcerate many individuals. As of June 2018, drug offenses made up almost half of the number of adults in federal prison across the country.[123] This trend extends to Texas where possession charges also account for a large portion of incarcerated individuals. Of the more than 140,000 adults currently in Texas prisons, possession of less than 1 gram of a controlled substance listed in Penalty Group 1 is the second most common charge.[124] Housing people with SUD in jail and prisons fails to connect them to both SUD services and other supports that could improve their mental health or well-being. Additionally, youth who are struggling with substance use issues can enter the criminal justice system through involvement in the juvenile

justice system. From FY 2013 to FY 2016, approximately 80 percent of youth admitted into the Texas Juvenile Justice Department system were identified as being in high or moderate need of substance use treatment.[125]

The 85th legislature took steps toward prioritizing incarceration diversion for those struggling with SUD by passing SB 292(Huffman/ Price) and SB 1849 (Coleman/ Whitmire), while treatment provided to people who are already incarcerated was a focus of SB 1326 (Zaffirini/Price). SB 292 (Huffman/Price) created a grant program aimed at reducing recidivism, arrest, and incarceration for people living with mental illness. The bill included intensive substance use treatment as an acceptable use for the funds. SB 1849 (Whitmire/Coleman) required more mental health training for police and jail personnel, as well as an article requiring law enforcement to make good faith efforts to divert "persons suffering mental health crisis or substance use" from detention. SB 1326 (Zaffirini/Price) required jail-based competency services and programs to provide mental health and substance use treatment, as well as clinically appropriate medications as applicable.[126]

Recently, advocates, researchers, and experts have made efforts to shift the focus from incarceration to rehabilitation. The need to shift toward a more public health-based approach to treat SUD has garnered attention internationally. In 2016 the United Nations released the Outcome Document of the General Assembly Special Session on drugs, which stated that a "comprehensive public health approach should offer accessible evidence-based prevention, treatment, and recovery options to drug users, and engage those who commit criminal offences in evidence-based treatment during and following, or in lieu of, incarceration, to prevent relapse and recidivism."[127] More information on the criminal justice system is in the Texas Department of Criminal Justice section of the guide.

Mental Health Workforce

Nationally, the need for mental health services continues to grow in conjunction with an increased shortage of outpatient and inpatient programs. According to the National Council for Behavioral Health, "the lack of access has created a crisis throughout the U.S. health care system that is harmful and frustrating for patients, their families and other health care providers, and is becoming increasingly expensive for payers and society at large."[128] Further, mental health and substance use workforce challenges are not new, only exacerbating the shortage of available treatment options. Various state-level and federal legislative initiatives, agency reports, and advocacy efforts have offered recommendations for addressing workforce challenges across the various mental health disciplines.

Meeting the needs of Texans with mental health and substance use conditions requires a robust and diverse behavioral health workforce. A partial cause for lack of access stems from lack of qualified professionals. Texas faces critical shortages for many licensed mental health professionals including: psychiatrists, psychologists, professional counselors, clinical social workers, marriage and family counselors, and advanced practice psychiatric nurses. As of June 2017, 199 out of 254 (78 percent) Texas counties were designated as full or partial mental health professional shortage

areas.[129] 172 counties did not have a single licensed psychiatrist in 2017, which left over 2.9 million Texans living in counties without access to a psychiatrist. An additional 23 counties only had one psychiatrist, serving almost 900,000 individuals.[130] Some of the gaps and barriers contributing to the current state of the mental health workforce include: unwillingness of mental health providers to accept clients with Medicaid, insufficient reimbursement rates, limited access to peer support services, an aging mental health workforce, lack of internship sites and residency slots, insufficient recruitment and retention practices, outdated education, training practices, and requirements, lack of cultural competency and existence of linguistic barriers, and a lack of diversity among mental health providers.[131]

Both legislators and advocates focused heavily on the state's mental health workforce crisis prior to the beginning of the 85th session. Several major bills passed relating to improving mental health workforce capacity, however this is an area that will require a continued focus as not all concerns have been addressed.

- **HB 1486 (Price/Schwertner)** – required, to the extent allowed by federal law, that peer services be included as a covered benefit in the Texas Medicaid program which should become effective January 2019
- **SB 1107 (Schwertner/Price)** – expanded opportunities for telehealth and telemedicine in Texas offering opportunities for improving access to mental health services, which especially helps in providing services to individuals in rural areas
- **SB 674 (Schwertner/Davis)** – aimed to address the state's low number of licensed psychiatrists by expediting the licensing process for board certified psychiatrists coming to Texas from other states
- **HB 3083 (Price/Hinojosa)** – included Licensed Chemical Dependency Counselors as eligible for the Mental Health Loan Repayment Program

Further challenges remain for mental health professionals to obtain licensure in Texas. Long wait times for licensure contribute to the workforce shortage of mental health professionals, as professionals are unable to legally perform their duties without a license. In March 2018, the Sunset Advisory Commission released their staff report to the 86th Legislature related to the licensing board of examiners for marriage and family therapists, social workers, professional counselors, and psychologists. Identified within the report, it takes an average of 107 days to process a licensing application for a professional counselor. Additionally, the report indicated present organizational dysfunction among the board which results in placing vulnerable Texans at risk.[132]

Veterans

Texas is home to approximately 1.6 million veterans, the second largest statewide population only behind California, which it is expected to surpass by 2020.[133,134] Approximately 50 percent of returning service members who need treatment for a mental health condition seek it. Among veterans who do receive mental health care, only slightly more than half receive adequate treatment. Further, veterans currently comprise over 20 percent of national suicides and are 22 percent more likely to attempt suicide than an individual who is not a veteran.[135] While veterans

have the option to seek services through the Veterans Administration, long wait lists and significant travel distances can create barriers for veterans across the state particularly in rural areas. In August 2018, within a 50-mile radius search across Austin, Texas, the average wait time for first-time mental health services was 8 or 15 days dependent on which of the two clinics were chosen. A more rural example is Bryan, Texas, where the only clinic within a 50-mile search has an average wait time of 14 days.[136]

During the 84th session, the legislature passed SB 55 (Nelson/King, Susan) to fund the Texas Veteran + Family Alliance (TV+FA), a public/private partnership for veterans and their families. During the 85th legislation, Rider 128 directed HHSC to allocate $20 million to the TV+FA. Other notable efforts during the 85th legislation impacting veterans' mental health included:

- **SB 27 (Campbell/Blanco)** – created the National Center for Warrior Resiliency at The University of Texas Health Science Center at San Antonio to research combat-related post-traumatic stress and comorbid conditions.
- **SB 578 (Lucio/Guiterrez)** – required HHSC to collaborate with other state and federal agencies to create a veteran suicide prevention plan. The suicide prevention plan must be comprehensive and inclusive of short and long-term goals, including the increase of access to and availability of professional services aimed at suicide prevention.
- **SB 591 (Lucio/Blanco)** – required the Texas Veterans Commission to conduct a community outreach campaign related to existing services for veterans, including mental health services.[137]

During the 85th Interim, both committees in the House and Senate associated with Veteran Affairs were charged with the oversight of implementation of SB 27, while the House was also charged to monitor SB 578. HHSC is expected to have goals identified for the veteran suicide prevention plan by September 1, 2018, with short-term goals implemented by September 2021 and long-term goals by September 2027.[138] More information on veterans services is available in the Texas Veterans Commission section of the guide.

Housing for People Experiencing Mental Illness and Substance Use Disorder

Housing is consistently identified as one of the biggest barriers for people in their recovery from mental illness and SUD. Many people with serious mental illness cannot work and therefore may be eligible to receive SSI benefits. For many, this is their only income. Research reveals a pronounced housing affordability gap for SSI recipients who are considered extremely low income, making less than 30 percent of the Area Median Income.[139] In 2018, recipients of SSI can receive a maximum of $750 a month, which constituted 109 percent of the average market rent for a one-bedroom housing unit.[140] Additionally, as of 2016, Texas has a deficit of 613,185 rental

units affordable to extremely low income households.[141]

People experiencing mental illness often need tenant supports and services to remain in housing successfully, something that makes finding a place to live even harder. Due to lack of supports, a large number of people who are homeless have a mental illness. The most recent point-in-time count of homelessness in Texas found that nearly 22 percent of individuals who are homeless have a severe mental illness (over 5,100), and half of those individuals are unsheltered.[142]

While people experiencing mental illness and SUD often qualify for housing programs that serve people with disabilities, there are only a small number of supportive housing programs. One example is the Supportive Housing Rental Assistance program. This program provides rental and utility assistance to individuals with mental illness who were homeless or imminently homeless and their families, and provides supportive housing and mental health services to individuals in need. Priority is given to individuals transitioning from hospital settings, nursing facilities, forensic units, and individuals identified as frequent users of crisis services. This program is a partnership between HHSC, LMHAs, and LBHAs. Currently, SHR program funding allows the program to operate at 20 of the 39 LMHAs/LBHAs.

Some housing programs exclusively serve people in recovery from SUD. Recovery residences, also known as sober living homes, are homes that provide a varying degree of services to groups of people in recovery. Oxford House is a non-profit that operates recovery homes across the country for people who are in recovery from SUD with low needs. To qualify for residency, people must contribute to the daily functions of the household and remain sober from alcohol and drugs. Oxford Houses receive some state funding, and have expanded in Texas in recent years. Other recovery homes that offer more intensive services are available in Texas but are less common and do not receive any state funding. More information on Oxford Houses and other recovery housing is in the HHSC section of the guide.

Housing is a complex issue, but Texas' rapid population growth coupled with unanticipated events like Hurricane Harvey will continue to make it a relevant issue moving forward for the Texas legislature and mental health stakeholders.

First Episode Psychosis

First episode psychosis describes a person's first psychotic episode, which often occurs in young adulthood. There are 3,000 new FEP cases in Texas every year, but due to a number of things, including a general lack of understanding of psychotic symptoms and stigma, people often end up delaying treatment for an average of five years.[143] One of the most effective ways to help a person experiencing FEP is coordinated specialty care. CSC is a recovery-oriented treatment program that promotes shared decision-making and uses a team of specialists who work with an individual to create a personalized treatment plan.[144] A variety of services can be part of CSC including case and medication management, family education, and other services and supports tailored to the individual's needs.

In 2008, the National Institute of Mental Health conducted a five-year study looking at outcomes associated with a CSC program for people with schizophrenia: the Recovery After an Initial Schizophrenic Episode (RAISE) program. The goals of the program were to help decrease the likelihood of future psychotic episodes, reduce long-term disability, and help people regain control of their lives.[145] The study found that the CSC program yielded positive outcomes: CSC is more effective than typical treatment, more cost-effective, and well received by clients. The study also identified the importance of providing treatment early to help people avoid future psychotic episodes. The findings were so positive that SAMHSA now requires states to set aside 10 percent of their Community Mental Health Services Block Grant to fund CSC programs.

In Texas, CSC programs operate in 10 of the 39 LMHAs and coordinate with schools, hospitals, and others to help identify individuals who could benefit from the services. Each CSC team serves a maximum of 30 people at an average cost of $425,000 annually. As of summer 2018, HHSC is pursuing opportunities to expand access to CSC across the state. Identifying psychosis early and providing holistic treatment options can keep people out of institutional settings and vastly improve quality of life outcomes.

Foster design/Community-Based Care

Foster care and mental health delivery systems overlap because nearly all youth entering foster care have suffered traumatic experiences. Trauma inflicted by experiencing physical, psychological, or sexual abuse or chronic neglect has a profound effect on children.[146] Children in foster care often experience abuse and neglect, and as a result, experience different degrees of traumatization. Mental health conditions are one of the consequences that typically result from traumatic experiences.[147]

A disconnected and uncoordinated foster care system is likely to aggravate childhood trauma and any other mental health condition if not properly addressed with timely and appropriate care. In 2010, DFPS embarked on a foster care redesign project, now known as Community-Based Care, in an effort to reduce negative outcomes such as victimization and fatality and improve outcomes in the areas of safety, permanency, and well-being for children in the foster care system. The overarching goals of Community-Based Care are to:

- Keep children and youth closer to home and connected to their communities and siblings;
- Improve the quality of care and positive outcomes for children and youth;
- Reduce the time to permanency for children in foster care; and
- Reduce the number of times youth move between foster homes or other placements.[148,149]

One of the biggest changes resulting from Community-Based Care has been the switch from service-based funding to performance-based funding. Through the redesign effort, payments are now tied to positive outcomes in the child's care

instead of their current service level and placement type, thereby encouraging children's transition to lower service levels and corresponding overall reductions in the average cost per child.[150]

Community-Based Care also restructures service delivery so that care is coordinated from a single source continuum contractor rather than a compilation of DFPS contracts with over 300 private service providers. The aim is to gradually shift CPS' role from direct service provision of foster care and family services to overall quality oversight; direct services will be provided by the regional SSCC.[151] DFPS will remain responsible for all investigative functions.

There are currently three Community-Based Care SSCC contracts in place:

- Region 2 (Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton, Wichita, Wilbarger and Young counties);
- Region 3b (Erath, Hood, Johnson, Palo Pinto, Parker, Somervell, and Tarrant counties); and
- Region 8a (Bexar County).

The first SSCC was awarded in 2013 to All Church Home Child Services in Region 3b. ACH's Our Community Our Kids program serves as the SSCC foster care provider for that seven-county region.[152] The initial results of the implementation of Community-Based Care in Region 3b are positive; DFPS found an improvement in outcomes for children in Community-Based Care in Region 3b compared to children in the legacy system outside the region.[153] As of December 2, 2017, ACH had 1,281 children enrolled, representing 98 percent of all foster children in Region 3b and approximately 7 percent of the overall children and young adults in paid foster care in Texas.[154] With the opening of a new 20-bed RTC and a hospital-based clinic specifically geared toward the medical needs of foster care youth, capacity for therapeutic foster care for high-needs children increased. As a result, 72 percent of children entering foster care in Region 3b live within 50 miles of their family home, compared to 62 percent statewide.[155] Due to recruitment efforts, as of August 2017 foster care capacity within Region 3b had grown by 20 percent since 2016, with a dramatic increase in rural areas such as Palo Pinto County, which saw a 150 percent increase.[156]

Using data from the Region 3b service area (including Fort Worth and Dallas County), one study from the Perryman Group estimates that every dollar invested in the state's Community-Based Care program will return $3.44 in state revenue and $1.66 in local revenue.[157]

In 2017, the Texas Legislature passed SB 11 (85th, Schwertner/Thompson, Senfronia) to expand the Community-Based Care model to include both foster care and relative or kinship care and services, and give the SSCC sole responsibility for case management.[158]

In August 2018, DFPS announced the next two Community-Based Care areas for FY 2019:

- Region 1 (Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, and Yoakum counties)
- Region 8b (Atascosa, Bandera, Calhoun, Comal, De Witt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala counties).[159]

In new regions, Community-Based Care will be implemented in two stages:

- In Stage I, the SSCC will develop a network of services and provide foster care placement services. The focus of Stage I is improving the overall well-being of children in foster care and to keep them closer to home and connected to their communities and families.
- In Stage II, the SSCC will provide case management, kinship and reunification services. The focus of Stage II is expanding the continuum of services to include services for families and to increase permanency outcomes for children.[160]

More information on Foster Care Redesign/Community-Based Care can be found in the Department of Family and Protective Services section of the guide.

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