A Guide to Understanding Mental Health Systems and Services in Texas

2nd Edition - 2014
The foundation would like to acknowledge Graduate Research Assistants Amanda Ackerman, Stephanie Brosig and Ted Wilson, and Policy Fellow Jemila Lea, for the many hours of research and writing needed to update this guide. Their commitment to developing a quality product illustrates their commendable work ethic and professionalism.

HOGG FOUNDATION FOR MENTAL HEALTH

The Hogg Foundation for Mental Health has been promoting mental health in Texas since 1940, when the children of former Texas Governor James S. Hogg established the foundation at The University of Texas at Austin.

Over the years, the foundation has awarded millions of dollars in grants to continue the Hogg family’s legacy of public service and dedication to improving mental health in Texas. Other donors have established smaller endowments at the foundation to support its mission. Today the foundation continues to support mental health services, research, policy analysis and public education projects in Texas. The foundation focuses its grant making on key strategic areas in mental health and awards grants through a competitive proposal process.

The foundation is part of the Division of Diversity and Community Engagement at The University of Texas at Austin. For more information, visit www.hogg.utexas.edu.

LANGUAGE USAGE

Behavioral health is the term typically used when referring to mental health and substance use. The foundation acknowledges the ongoing discussions and differing perspectives about utilizing the term “behavioral health” and “mental health.” In this document, the Hogg Foundation uses the term “behavioral health” when referring to both mental health and substance use services and supports. Our belief is that the priority goal of behavioral health policy must be recovery.

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SUGGESTED CITATION:


The Hogg Foundation has made every effort to ensure the accuracy of the information and citations in this report. The foundation encourages and appreciates comments and corrections as well as ideas for improving this guide. Specific comments should reference the applicable section and page number(s). Please include citations for all factual corrections or additional information. All comments and recommendations should be emailed to Hogg.Guide@austin.utexas.edu.

The online version of this resource guide is available at: www.hogg.utexas.edu
DEDICATION

In memory of Dr. Susan Stone, a fierce visionary and a sensitive soul, who was relentlessly dedicated to improving mental health systems and services in Texas.
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Overview

Behavioral health services in Texas are provided through a complex maze of programs that vary widely across the state. The range of available services may be different depending on an individual’s location, age, individual and family income, access to private or public insurance, type of symptoms, severity of condition, and the availability of health care providers who can provide the needed care within a reasonable distance. Navigating this system is often frustrating even for the most informed providers and clinicians who support individuals on a daily basis. For policymakers, family members and individuals receiving mental health services, especially those with little experience or knowledge of this system of care, understanding the complexities of the patchwork of behavioral health care services can be particularly challenging.

The purpose of the guide is to provide a general overview of the behavioral health care delivery system and the services provided under various state agencies that are funded in full or in part with state appropriations. To ensure this document is a useful reference tool, it does not provide significant detail on the various programs but instead focuses on the general infrastructure, funding and services provided. The report is designed to provide the reader with a basic understanding of how behavioral health services are provided, the populations that are served, and the challenges of meeting the growing and often unmet needs of Texans with mental health or substance use conditions. For policymakers, advocates and other stakeholders who struggle with many complex matters and decisions, we hope this report will be a useful guide, providing practical and accurate information on mental health services in Texas.

The report is divided into the following four categories:

· **National Context**: A basic overview of national activities and initiatives related...
to behavioral health care services, including a discussion of federal requirements that impact the types of benefits provided and the populations served under the Patient Protection and Affordable Care Act (ACA).

- **The Texas Environment**: A discussion of current issues and recent developments at the state level, including a description of new programs and organizational approaches to care, some of which are being implemented and others of which may require further legislative action during the 2015 session of the Texas Legislature.

- **Public Behavioral Health Services in Texas**: An overview of the multiple Texas state agency programs that provide a wide range of behavioral health services for clients, including programs provided by Health and Human Services agencies and services administered by juvenile and criminal justice agencies, school districts and the Texas Education Agency, the Texas Department of Housing and Community Affairs, and the Texas Veterans Commission.

- **Best Practices**: A discussion of best practices for providing behavioral health services, including a discussion of such topics as: the integration of primary and behavioral health care services to provide a more efficient and coordinated level of care, peer-support services, prevention and early intervention initiatives, and the behavioral health needs of individuals accessing services through the criminal justice system.

The second edition of the guide offers various improvements to help navigate the vast amount of information provided. Each agency described in the Public Behavioral Health Services in Texas section starts with an “At-a-Glance” overview. This overview outlines topics covered, provides an organizational context, details policy concerns and highlights specific statistics relevant to the agency and behavioral health. The agencies also contain a section on the “Changing Environment” for that particular agency, emphasizing recent major system changes within the organization and affecting the organization.

Included in the Appendix of the report is a list of figures, a list of acronyms, additional resources, and a glossary of commonly used behavioral health terms. Some programs are subject to very specific, technical definitions in state or federal statutes that may vary from the more commonly used definitions included in this report. For that reason, readers may want to refer to additional resources noted throughout this document for more comprehensive information about a specific program. Additionally the Appendix has information on managed care organizations (MCOs) in Texas, advisory committees, and the August 2014 Sunset Committee recommendations on the Health and Human Services agencies.

The Hogg Foundation wants to emphasize that this report focuses primarily on state programs for treating behavioral health care needs in Texas. Many communities and providers throughout the state are equally engaged in the development, implementation and oversight of locally operated (and often locally funded) programs and services that are more specifically designed to serve the needs of local residents. Due to the variations in programs and the lack of a central database that identifies these various resources, this report generally does not include programs created at the local level unless funded by the state. However, we recognize that there are many valuable and effective programs that provide critical services that supplement the programs described in this report.
The Hogg Foundation offers this guide to help policymakers in Texas understand the array of behavioral health services currently available, the multiple access portals and the numerous funding streams. We want to reiterate that this area of health care is extremely complex and constantly evolving. While the information in this report is the best available at the time, new innovations in health care, and new legislation and programs, are continually changing the landscape of behavioral health care services in Texas. We hope that this report serves as a useful introduction, reference and guidebook illustrating the critical need for a long-term, coordinated, sufficiently funded approach to providing effective behavioral health care services.
Mental health, as defined by the World Health Organization (WHO), is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” Mental health and well-being are essential to an individual’s ability to properly think, interact and have a quality life. Therefore, mental health inevitably has a direct impact on economic productivity, educational attainment, and public health and safety. Ultimately, the promotion of mental health should be prioritized for individuals, communities and societies throughout the world.

Meeting the mental health care needs of Texans requires critical policy analysis and decision-making to ensure a coordinated system of supports and services that are effective, appropriate and fiscally responsible. The maze of behavioral health services in Texas is complex, making it difficult to understand and, consequently, difficult to improve.

Behavioral health is the term typically used when referring to mental health and substance use. The goal of behavioral health policy should be recovery. Recovery from mental illness and substance use is possible. Recovery is not synonymous with a cure. It is an ongoing process that enables individuals experiencing mental health challenges to become empowered to manage their illness and take control of their lives. Recovery does not happen in isolation but requires holistic support from peers, family, friends and other stakeholders in the healthcare system, especially mental health professionals and supports provided by public mental health systems.

Although the recovery journey will look different for each individual, effective supports, interventions and evidence-based
treatments are widely recognized as beneficial in the recovery process. While crisis intervention often relies heavily on the support of mental health professionals, long-term recovery focuses on personal responsibility, peer and family support and self-direction of services and treatment. Psychosocial supports such as assertive community treatment, peer support and Wellness and Recovery Action Planning (WRAP®) often provide long-term stabilization and increased quality of life beyond the short-term impact of medical interventions.

Public behavioral health services in Texas are dispersed among many programs and agencies. Individuals needing treatment may receive care through a variety and combination of state agencies, including:

- Health and Human Services Commission
- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services
- Texas Department of Criminal Justice
- Texas Department of Juvenile Justice
- Texas Education Agency
- Texas Department of Housing and Community Affairs
- Texas Veterans Commission

A discussion of behavioral health supports available at each agency is provided in Section IV. Public Behavioral Health Services in Texas.

In addition to state entities, behavioral health services are provided at the local level in jails, hospital emergency departments, schools, local mental health authorities, various nonprofit agencies, public health clinics and other settings, with people frequently moving between service systems. For example, the Texas Public Policy Foundation has reported that 17% of the 1 million Texans jailed in 2011 had previously received services through a local mental health authority.\(^2\) A 2012 Travis County analysis\(^3\) found:

> Adults with multiple inpatient psychiatric hospitalizations had serious mental illness (major depressive disorder, bipolar disorder or schizophrenia), very high rates of co-occurring substance use, an average of 40 emergency department visits each, and much higher rates of homelessness.

Due to system fragmentation and the lack of data across state agencies, it is difficult to identify the total amount spent on behavioral health services in Texas. Data gathered across state agencies is not congruent and there is no ongoing mechanism to collect and analyze financial data solely related to behavioral health services. While the total cross-agency spending on behavioral health services is not clear, the Kaiser Family Foundation has determined that mental health spending per capita in Texas by the primary state mental health agency (the Department of State Health Services) is one of the lowest in the nation. The study found that annual per capita mental health spending in Texas is estimated at $38.99, while the national average is $122.56.\(^4\)
Over the past decade, the low level of spending and the underfunding of preventive, community and crisis services have resulted in higher costs in jails, prisons and hospitals, which in turn, has led to higher spending for other health conditions such as diabetes and heart disease. Chronic homelessness is also often the result of untreated mental illness, further adding to societal costs and creating additional challenges for both the individual and the community. Increased funding during the 83rd legislative session enabled a significant enhancement of service accessibility, treatment and infrastructure. Despite this funding increase, however, more needs to be done to fully address the behavioral health need of Texans. Failure to do so is costly in terms of personal impact as well as economic consequences. The following statistics illustrate some of these costs:

- Adults with untreated mental health conditions are eight times more likely to be incarcerated.\(^5\)
- Between 60% to 70% of youth in contact with the juvenile justice system meet criteria for a mental health disorder. Sixty percent of these youth have a co-occurring substance use disorder.\(^6\)
- For every dollar spent by federal and state governments on substance use services, 95.6 cents covered costs to public programs outside of the behavioral health agency, such as criminal justice, and only 1.9 cents funded prevention and treatment programs.\(^7\)
- One in five school-age children has a mental health condition and 5% have a mental health condition that results in significant functional impairment.\(^8\)
- Serious mental illness costs America $193.2 billion in lost earnings per year.\(^9\)
- Suicide is the tenth leading cause of death in the U.S. (more common than homicide) and the third leading cause of death for those ages 15 to 24 years. More than 90 percent of those who die by suicide had one or more mental disorders.\(^10\)
- In Texas, people with severe mental illness served in the public mental health system die an average of 29 years earlier than the general population.\(^11\)

Insufficient access to mental health treatment, supports and services remains one of the most pressing policy issues in Texas. Many Texans are unable to obtain services due to lack of access to private or public insurance coverage and insufficient public mental health safety net services. Over time, these shortages have led to persons receiving services through a confusing, uncoordinated and inefficient system of state and local agencies, often resulting in poorer health outcomes at greater expense.

Fortunately, the current Texas policy environment offers new options for expanding and improving the delivery of behavioral health services in Texas, providing opportunities to develop a system that is less fragmented and more accessible to consumers of behavioral health services. The federal Patient Protection and Affordable Care Act (ACA), Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver, the expansion of Medicaid managed care and the 83rd legislative session increase in behavioral health appropriations all could lead to the development of a more comprehensive, integrated and coordinated approach to the delivery of behavioral health services. With multiple initiatives in play, the potential for improvement is significant.
The National Context

Behavioral health policy decisions made at the federal level can have significant impact on programs and services in Texas. Currently, two major pieces of federal legislation are having a significant impact on the access, service delivery and financing of mental health services in Texas. The combination of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (ACA) have influenced the design of health insurance benefits for both public and private health plans that insure the majority of Texans. The impact of these acts on behavioral health is discussed later in this section.

A national paradigm shift is underway to transform behavioral health delivery systems. Initiatives supported at the federal level by key federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) emphasize recovery, wellness and self-directed care and encourage the use of innovative, evidence-based service delivery strategies, such as expanding the use of certified peer specialists and integrating primary care and behavioral health care. This movement in treatment strategy, combined with the expanding role of affected individuals and their families in policy discussions and the decision-making process, offers a new approach to treatment that is designed to provide the right care at the right time and in the right setting.

The roots of this movement can be traced back many decades, but were clearly articulated in the report of the New Freedom Commission on Mental Health (created in 2002 by President George W. Bush). They have continued today in recent initiative and grant opportunities made available by SAMHSA and through services funded by Medicaid.12

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services charged with advancing behavioral health and reducing the impact of substance abuse and mental illness throughout the nation.

SAMSHA also retains the responsibility for administering a combination of competitive innovation mental health and substance use grants and block grants to states, as well as collecting data, conducting and publishing research, and running a variety of behavioral health programs and campaigns. For more information about SAMHSA’s publications, grants and resources, visit www.samhsa.gov/home.com.
Recent Federal Health Care Initiatives Impacting Behavioral Health

**THE NEW FREEDOM COMMISSION AND TRANSFORMATION OF BEHAVIORAL HEALTH CARE**

In 2002, President George W. Bush created the President’s New Freedom Commission on Mental Health to study the mental health system and to identify goals and strategies that would significantly improve the lives of children and adults with serious behavioral health conditions. Despite the report being over a decade old, the New Freedom Commission’s goals address a number of issues that are still highly relevant today, including:

- An emerging systemic shift in behavioral health services toward recovery from mental illness.
- The benefits of providing opportunities to consumers and families for more self-directed care.
- The importance of peer-operated programs and services.
- The overall lack of access to behavioral services.
- The role of stigma as a barrier to seeking treatment.
- The need for housing and supported employment for persons with serious mental illness.
- The complexity of the public multi-agency safety net system and how that hinders access to services.
- The importance of screening and early intervention through integrated primary and behavioral health care approaches.
- The need to address racial, cultural and linguistic disparities in access to care.
- The increased use of technology, including telemedicine/telehealth and electronic health records, to increase access to services in rural and underserved areas and to improve provider coordination.
- The need to more quickly move research-based interventions into common provider practice.

The New Freedom Commission’s philosophy and strategies have positively influenced the priorities of federal agencies, especially the Substance Use and Mental Health Services Administration (SAMHSA) and state public mental health agencies, including agencies within the Texas Health and Human Services enterprise, discussed in Section 4. Public Behavioral Health Services in Texas.

**PRESIDENTIAL MENTAL HEALTH INITIATIVES**

The Newtown shootings and other recent tragedies have again brought the conversation about mental health to the national level. On June 3, 2013, the White House hosted a National Conference on Mental Health, the first conference of this type and magnitude in 14 years, with the goal of increasing awareness and understanding of mental health services. The conference brought together an array of stakeholders, including consumers of mental health, their families, mental health
advocates, health care providers, educators, faith leaders, veterans and local, state, and federal representatives to explore how people can work together to reduce stigma and create an environment which encourages people experiencing mental health issues to seek help.

During the conference, President Obama highlighted the following four goals necessary to address challenges in the nation’s mental health system:

- Improve the recognition of mental health issues in children and make it easier for Americans of all ages to seek treatment.
- Ensure the availability of mental health treatment to those who seek it.
- Invest in science and basic research to make it easier to detect and treat disease early.
- Improve mental health services for troops and veterans.

The President’s National Conference on Mental Health was intended to mark the beginning of an increased national effort to address mental health concerns. Following the conference, SAMHSA launched a series of community conversations to increase understanding about mental health. Part of the effort to increase open dialogue is called Creating Community Solutions (CCS). More information about CCS can be found at http://www.creatingcommunitysolutions.org/.

Over his tenure, President Obama has shown a strong commitment to supporting young people in addressing their mental health needs. The President’s FY2014 budget allocated $130 million for the following new initiatives: 1) supporting teachers and other adults to recognize signs of mental illness in students and make appropriate referrals, 2) supporting innovative state-based programs to improve mental health outcomes for people ages 16-to-25, and 3) helping train 5,000 additional mental health professionals with a focus on serving students and young adults. Additionally, the President’s proposed budget for 2015 includes $164 million to support the “Now is Time” initiative, which expands mental health treatment and prevention services across SAMSHA and the Centers for Disease Control and Prevention (CDC). The proposed funding for Now is the Time includes $55 million for Project AWARE (Advancing Wellness and Resilience in Education), which provides resources to enhance proper referral for children with behavioral needs to appropriate services. It also provides Mental Health First Aid training in schools and communities.

As a result of increased national attention for the mental health of U.S. veterans, the Department of Veteran Affairs (VA) hosted 150 conferences focusing on mental health and issues related to mental health throughout the country between July and September of 2013. These summits helped build or sustain collaborative efforts with community providers to enhance mental health and well-being for veterans and their families. The goal of the summits was to identify and link community-based resources to support the mental health needs of veterans and their families, as well as to help increase awareness of available VA programs and services.

For more information about national mental health initiatives, supports and goals visit, www.mentalhealth.gov/. This website also provides tools and tips around the basics of mental health, how to recognize the signs of mental illness, how to talk about mental health, and how to locate help and other resources.
The 2010 Patient Protection and Affordable Care Act (ACA) includes a number of provisions that have the potential to significantly change access to both public and private mental health and substance use health care services. The law includes specific benefit requirements and more general insurance reforms that will affect all enrollees, not just those in need of behavioral health care.

**KEY FEATURES**

As of January 1, 2014, most provisions applying to individual and group health insurance plans had been put in place. There are a number of key features of the Affordable Care Act that seek to contribute to the overall goal of the ACA to give more Americans access to affordable and quality health insurance while reducing the amount of health care spending in the U.S. Below are the key features of the ACA.

1. Improving quality and lowering health care costs through:
   - Free preventive care.
   - Prescription discounts for seniors.
   - Protection against health care fraud.
   - Small Business Tax Credits.
2. Consumer protection:
   - Prohibits lifetime limits and annual limits on covered health care services.
   - Provides an appeals process for consumers.
   - Prohibits rescinding coverage once a plan has been issued.
3. Young adult coverage:
   - Extends dependent coverage, allowing children to stay on a parent’s policy until they reach the age of 26.

A number of the reforms are particularly important for individuals with a history of mental health or substance use conditions, including the following:

- Provides coverage for any preexisting health conditions (including mental or substance use).
- Prohibits using health-status factors as a basis for eligibility for coverage or to deny coverage, including preexisting physical and mental illness, genetic information, receipt of health care for a prior or current condition, disability, or any other health status factor.
- Requires acceptance of any applicant regardless of age, gender or health status and prohibits cancellation or non-renewal under limited circumstances (such as financial solvency issues or loss of the company’s license).
- Includes comprehensive behavioral health services as required essential health benefits.

A fundamental provision of the ACA requires people to obtain insurance that meets “minimum essential coverage” requisites or pay a penalty for noncompliance. This is often referred to as the “individual mandate.” Although a number of states challenged the constitutionality of the individual mandate, in June 2012 the Supreme Court upheld this provision of the law.19
ESSENTIAL HEALTH BENEFITS

The Affordable Care Act requires that health plans sold in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. In order to satisfy the requirement of offering essential health benefits, a health plan must at least include items and services within the 10 essential health benefit categories, noted below. Mental health and substance use disorder services, including behavioral health treatment such as counseling and psychotherapy, are included as one of the 10 essential health benefits:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

Millions of Americans will therefore have better access to behavioral health treatments, which may in turn result in higher job productivity, lower overall healthcare costs, and savings in the criminal justice system.20

ESTABLISHMENT OF “BENCHMARK PLANS”

The ACA established a process to require that health plans adequately cover all 10 essential benefits. This process relies on the use of a “benchmark” plan that is used to set a standard of coverage for each of the 10 broad categories of essential health benefits. Each state is directed to select a benchmark plan from delineated options while retaining some discretion on what specific services will be included in each essential benefit category.

The federal government has identified 10 plans from which states may select their benchmark plan: the state’s three largest small-group plans, three largest state employee health plans, three largest federal employee health plans, and the largest non-Medicaid health maintenance organization. If the benchmark plan selected by the state does not include all of the required essential health benefits, the state must supplement the missing benefits by using benefits from other benchmarks to fill in gaps in coverage. For example, if a benchmark plan does not cover maternity services, the state must select maternity benefits from another benchmark plan to supplement coverage in the state’s selected plan.

Regardless of whether a state sets up its own exchange or participates in a
federal exchange, the state will determine the benchmark plan and any required supplemental benefits. Selection of a benchmark plan and determination of essential health care benefits will strongly impact how insurers define “behavioral health services” and the specific services that will be available through the exchange.

HEALTH INSURANCE MARKETPLACE

The ACA requires every state to provide a Health Insurance Marketplace, also called the health exchange, (either federal or state-operated), through which people may purchase insurance that meets the federal standards. All health exchanges were required to be fully operational on January 1, 2014. To assist people in paying for their health insurance, the law provides subsidies in the form of tax credits for individuals and families earning between 100 percent and 400 percent of the federal poverty level. (The ACA does not extend the tax credits to individuals below 100 percent of the federal poverty level (FPL) because the law as drafted also included a requirement that states would expand Medicaid coverage to the all legal residents with incomes below 138 percent FPL.)

Consumers are able to buy approved health insurance plans from the Health Insurance Marketplace. States may opt to operate their own marketplace (state-based marketplace) or choose a hybrid called the State Marketplace Partnership wherein the federal government operates the marketplace but states are still able to run certain functions to tailor the marketplace to local conditions and needs. A state that does not choose either of the state-run options will default to a federally-facilitated marketplace, which will be operated by the U.S. Department of Health and Human Services (DHHS). During the 2013-2014 enrollment period, there were 17 state-based marketplaces, seven partnership marketplaces, and 27 federally-facilitated marketplaces.21 The State of Texas had a federally-facilitated marketplace. As of April 2014, over 8 million persons nationwide have enrolled in a health insurance plan through the Health Insurance Marketplace, of whom 733,757 were from Texas.22

MEDICAID EXPANSION

In addition to the individual mandate, the ACA requires states to expand Medicaid coverage to adults and children up to 133 percent of the federal poverty level. In Texas this expansion would primarily cover low-income adults generally not eligible for Medicaid unless they are receiving social security income (SSI) as a result of a disability. The Supreme Court’s decision, however, prohibited the federal government from withholding Medicaid payments to states for non-compliance with the expansion provision. Consequently, states may choose whether or not to expand their Medicaid program. If a state chooses to expand coverage, the federal government pays 100 percent of the cost for the first three years starting in 2014 and no less than 90 percent of the cost in future years.

Following release of the Supreme Court decision, Governor Rick Perry announced that Texas would not participate in the Medicaid expansion. This decision has created a gap in coverage for adults below 133 percent of the federal poverty level.
the Medicaid expansion. This decision has created a gap in coverage for adults below 100 percent of the federal poverty level. See ACA in Texas Environment for more information.

Because Congress assumed that all U.S. citizens below 100 percent would be covered under the Medicaid expansion, the ACA does not provide tax credits for people below the poverty line (i.e., 100 percent of poverty). While many of these individuals will be exempt from the individual mandate based on their financial status, they are also likely to remain uninsured since they will not be eligible for Medicaid and will be unable to afford private coverage without the subsidy.

As of June 10, 2014, 27 states, including D.C. have decided to expand their Medicaid coverage. According to the Kaiser Family Foundation, 21 states decided to not move forward with the Medicaid expansion, and three states are in “open debate” (states noted as ‘Open Debate’ are based on analysis of state addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature). It is estimated that a total of five million very low income, uninsured adults will be affected in the states that do not expand Medicaid. Because these five million individuals have incomes below the threshold to qualify for Marketplace premium tax credits but are not eligible for Medicaid either because their income is too high or because they don’t meet Medicaid’s categorical eligibility requirements (e.g. have a disability), they fall into a “coverage gap” and are likely to remain uninsured.

EXPANDING THE HEALTH CARE WORKFORCE

The ACA provides incentives to address the insufficient supply of professionals providing behavioral health services. These include increasing the number of primary care physicians (who provide a great deal of behavioral health care) and educating existing primary care staff about behavioral health care. Other provisions seek to increase the supply of behavioral health professionals through loan repayment and expanded residency training programs and increased use of certified peer specialists.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

In 2008, Congress enacted the Mental Health Parity and Addiction Equity Act (MHPAEA) to further expand the mental health parity requirements included in the 1996 Mental Health Parity Act. The MHPAEA also added coverage requirements for substance use services. In addition to the restriction on annual or lifetime limits enacted under the 1996 law, MHPAEA prohibits insurers or health plans that offer mental health services from imposing lower limits on the scope or duration of mental health services than those imposed on other medical or surgical services. This includes frequency of treatment, number of visits, days of coverage, or any other limits that are less than the limits imposed on coverage for physical health care.

Previously, the MHPAEA did not require that behavioral health services be included in every group plan. However, the Affordable Care Act (ACA) expanded the parity law by requiring the inclusion of mental health and substance use services as Essential Health Benefits in all group and individual health plans beginning January 2014. Under the ACA, mental health and substance abuse services will be treated like other
health services and insurance markets will no longer be able to exclude these services from benefit plans. Thus, more Americans will be able to receive services for the prevention, intervention and care of their mental health needs.

The Departments of Labor, Health and Human Services, and Treasury released the final MHPAEA rules in November 2013. Below are the most notable aspects of the final rules:28

- Health plans must cover the treatment of mental illness or drug or alcohol abuse at the same level (co-payments, deductibles and limits on visits to health care providers cannot be more restrictive or less generous) as they cover other health care treatment, although it does not mandate mental health benefits.
- States may choose to mandate specific mental health benefits, and MHPAEA requires that such benefits must be in parity with medical/surgical benefits in the same policy.
- The general parity requirement applies separately for each type of financial requirement (deductibles, co-payments, co-insurance and out-of-pocket maximums) or treatment limit.
- Offers clarity on how parity applies to residential treatments and outpatient services, where much of the care for addictions or mental illness occurs.
- Mental health parity provisions do not apply to coverage provided under Medicaid or Medicare.

Established Federal Health Care Programs Impacting Behavioral Health

**MEDICARE**

Over 3 million Texans get their health insurance coverage through Medicare. For these individuals, Medicare coverage is typically the deciding factor in what mental health services they will be able to access.

Medicare is a federal health care program that provides inpatient and outpatient care for individuals age 65 or older. Medicare also covers people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).29 In 2012, 2,613,612 Texans were eligible for Medicare because of their age, while 573,720 were eligible for Medicare because of a disability.30 The program also provides prescription drugs for individuals who enroll. The program is funded and administered by the federal government and is divided into four coverage areas (parts A, B, C and D), described below.
<table>
<thead>
<tr>
<th>Medicare Coverage Areas Related to Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A (Hospital Insurance)</strong></td>
</tr>
<tr>
<td>Medicare Part A provides inpatient hospital insurance and covers inpatient mental health care if provided in a general or psychiatric hospital. The care includes semi-private rooms, meals, nursing, medication as part of the inpatient treatment, and other related services and supplies. Part A pays for up to 190 days of inpatient psychiatric care during a lifetime. Most Americans over age 65 automatically qualify for Part A based on their work history and payroll deductions for the program. People who do not qualify can pay to enroll.</td>
</tr>
<tr>
<td><strong>Part B (Medical Insurance)</strong></td>
</tr>
<tr>
<td>Medicare Part B covers outpatient diagnostic and treatment services provided by physicians, including psychiatrists, as well as clinical psychologists, social workers, psychiatric nurse specialists, nurse practitioners, and physician assistants. Medicare reimburses these clinicians only if they are certified as participants accepting Medicare. Medicare covers mental health diagnostic and lab testing, a yearly depression screening, psychiatric evaluations, individual and group psychotherapy, family counseling that relates to the individual’s treatment, and medication management. Substance use treatment in an outpatient treatment center is covered if the treatment center has agreed to participate in the Medicare program. Medicare also covers partial hospitalization programs including those that offer intensive psychiatric treatment. Medicare reimbursement is limited to partial hospitalization programs that are located in hospital outpatient departments or community mental health centers. Partial hospitalization services must be provided under the direct supervision of a physician according to an individualized treatment plan, and the services must be essential for treatment of the person’s condition. Individuals must actively enroll in Part B and must pay a monthly premium. For low-income individuals who qualify, Medicaid pays the monthly premium.</td>
</tr>
<tr>
<td><strong>Part C (Medicare Advantage)</strong></td>
</tr>
<tr>
<td>Medicare Advantage is run by Medicare-approved private insurance companies. It is not available statewide, but is offered in most urban areas of Texas. Availability depends on the willingness of managed care organizations in a particular geographic area to provide Medicare Advantage. Part C includes all benefits from Part A and Part B, and it often includes benefits from Part D. Enrollees volunteer to participate in Part C. In addition to a Part B premium, Part C participants may pay a monthly premium for their Medicare Advantage Plan. Medicare Advantage plans may offer extra coverage for vision, hearing, dental, and health and wellness programs. Medicare Advantage Plans must follow Medicare rules, but they may charge different out-of-pocket costs and have additional rules.</td>
</tr>
<tr>
<td><strong>Part D (Medicare Prescription Drug Coverage)</strong></td>
</tr>
<tr>
<td>Medicare Prescription Drug Coverage was created in 2003 and is available to all Medicare eligible individuals, but requires premium payments that vary depending on the plan the enrollee selects. Medicare drug plans must cover antidepressant, anticonvulsant and antipsychotic medications that may be necessary for mental health treatment. For dual eligible enrollees in both Medicare and Medicaid, prescription drug benefits are paid primarily under Part D, but Medicaid continues to pay some drugs not covered by Part D.</td>
</tr>
</tbody>
</table>

While Medicare covers a broad array of mental health services, special rules limit the scope of coverage and reimbursement. Medicare coverage of mental health benefits is not as extensive as coverage for other services. Though some benefits are arranged through Medicaid, a state-run program, the Medicare program is funded and administered by the federal government.

### MEDICARE AND MEDICAID (DUAL ELIGIBILITY)

People who are eligible for both Medicare and Medicaid, commonly referred to as being dually eligible, typically have lower income and greater functional disability than other Medicare beneficiaries. Older people who are eligible for both programs are more likely to have physical health problems than those who are eligible only for Medicare. People less than 65 years of age who meet eligibility criteria for both Medicare and Medicaid are less likely to have physical health problems but much more likely to have a mental health condition than people who meet dual eligibility and are over 65 years old.31

If a person is eligible for both Medicare and Medicaid, Medicaid pays the Medicare cost-sharing obligations and provides certain Medicaid services not covered under Medicare. Dual eligible individuals can be fully or partially dual eligible. Fully dual eligible individuals have a lower income and receive their state’s full Medicaid package. Partially dual eligible individuals have a higher income than fully dual eligible and receive some assistance with Medicaid premiums, deductibles, and cost-sharing responsibilities but do not receive their state’s full Medicaid package. In 2010, 7,267,210 individuals were fully dual eligible nationally. In 2012, 328,500 people were fully dual eligible in Texas.33

Medicare and Medicaid are two separate systems that often do not communicate information about a person’s care with each other. This directly affects people who are dual eligible because their care is not coordinated between the two systems. According to the Centers for Medicare & Medicaid Services, this fragmented system of care has compromised the quality and efficiency of care for many people who are dual eligible. Additionally, the lack of coordination between the two structures has caused a financial misalignment.34

Figure 1 details the number of Texans enrolled in Medicare and the number of Texans that are fully dual eligible.

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicare</td>
<td>2,852,000</td>
<td>3,044,936</td>
<td>3,187,332</td>
</tr>
<tr>
<td>Fully Dual Eligible</td>
<td>396,649</td>
<td>327,530</td>
<td>328,500</td>
</tr>
</tbody>
</table>

**Figure 1. Texas Medicare Enrollment and Fully Dual Eligible**

Visit the HHSC section in Public Behavioral Health Services in Texas and www.medicaid.gov, for more information on Medicaid and the State Medicaid Program.

Medicaid is a jointly funded federal/state health care program authorized in Title XIX of the Social Security Act. It was created as a way to provide health care benefits primarily to children in low-income families, pregnant women, and people with disabilities.
To address the concerns of the fragmented system that dual eligible people have to navigate, the Centers for Medicare & Medicaid Services (CMS) is working with states to test models focused on aligning the financing of the two systems and integrating primary, acute, behavioral health, and long-term services and supports for dual eligible individuals.35

On May 23, 2014, Texas and CMS entered a partnership to test a new model intended to better coordinate and provide a more person-centered care experience for dual eligible individuals.36 This demonstration project is called “Texas Dual Eligibles Integrated Care Demonstration.”37 Texas and CMS will contract with managed care organizations to work toward the goal of a more enhanced, coordinated system for fully dual eligible individuals who reside in specific parts of the state. The demonstration project will begin no sooner than March 1, 2015.38

All of the following criteria must be met to participate in the Texas demonstration project:39

- Age 21 or older at the time of enrollment.
- Entitled to receive Medicare Part A, and enrolled in Medicare Parts B and D.
- Receiving full Medicaid benefits.
- Receiving services through the STAR+PLUS program.
- Residing in one of the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo, or Tarrant. See Figure 2 below.

Figure 2. Texas Dual Eligibles Integrated Care Demonstration

Legend
- Dual Demonstration County

The Demonstration will be implemented in the following 6 counties:
- Bexar
- Dallas
- El Paso
- Harris
- Hidalgo
- Tarrant


**SUPPLEMENTAL SOCIAL INCOME (SSI) AND SOCIAL SECURITY DISABILITY INSURANCE (SSDI)**

Supplemental Social Income (SSI) and Social Security Disability Insurance (SSDI) have close ties to health insurance for people with disabilities. SSI is administered by the Social Security Administration (SSA) and falls under Title 16 of the Social Security Act. SSI is for people with limited income who have a qualifying disability or are over 65. SSI is funded by general funds from the U.S. Treasury, not Social Security taxes. In most states, including Texas, individuals who receive SSI benefits are also immediately eligible for Medicaid under the same eligibility requirements. In 2011, the nation had 8,112,773 SSI beneficiaries and Texas had 640,422 SSI beneficiaries. The monthly maximum SSI federal amounts for 2014 are $721 for an eligible individual and $1,082 for an eligible individual and an eligible spouse. In January 2013, 8.3 million individuals received monthly SSI benefits averaging $536.

SSDI is also administered by SSA and falls under Title 2 of the Social Security Act. SSDI is for people who have a disability, have worked in a job covered by Social Security, and have paid enough money into the Social Security program. In 2012, the total number of SSDI beneficiaries was 9,306,256 nationally and 610,328 in Texas. The national average monthly benefit for SSDI recipients in 2012 was $1,078. Most people receiving SSDI benefits have not been able to work due to their disability for at least one year. SSDI beneficiaries have to undergo a two-year waiting period before they can receive Medicare benefits. During those first two years of SSDI enrollment, SSDI beneficiaries may be able to obtain health insurance through their former employer or Medicaid, and some will be uninsured during that waiting period.

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

Figure 3 below details the major difference between the two programs.
## Figure 3. SSI and SSDI Differences

<table>
<thead>
<tr>
<th>Program</th>
<th>Supplemental Social Income (SSI)</th>
<th>Social Security Disability Insurance (SSDI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>Financed through general revenue from taxes. Benefits are not based on prior work history.</td>
<td>Financed through Social Security taxes paid by workers, employers and self-employed persons.</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Have limited income and resources to meet cost of living. Must be a U.S. citizen or have eligible noncitizen status.</td>
<td>Worker must earn sufficient credits based on taxable work to be insured for Social Security purposes.</td>
</tr>
</tbody>
</table>
| Benefit Recipients | Benefits are payable to:   
  - individuals over 65
  - adults and children with a disability or blindness | Benefits are payable to:   
  - workers with a disability
  - their children
  - widow(er)s
  - adults who have had a disability since childhood |
| Payment         | Payment amount varies up to the maximum federal benefit rate, which may be supplemented by the state. | Payment amount is based on the Social Security earnings record of the insured worker.                      |


A primary barrier to effective and efficient mental health services in Texas is the fragmentation of services and lack of coordination among multiple funding silos. Texas should carefully evaluate all of the opportunities to improve behavioral health services to ensure the development of a comprehensive and cohesive system. Toward this end, a number of major initiatives and reform efforts that could impact behavioral health service delivery and financing are being implemented or are currently under consideration. It is critical that these initiatives and opportunities are considered in the context of the entire state system and not in isolation.

Impact of the Affordable Care Act on Behavioral Health Services in Texas

FEDERAL HEALTH INSURANCE MARKETPLACE

Open enrollment in the federal Health Insurance Marketplace began on October 1, 2013. The federal Health Insurance Marketplace, or Healthcare.gov, is an online portal where individuals and small businesses can buy qualified health benefit plans in a new, transparent and competitive insurance marketplace. Prior to the marketplace opening, states had the choice to develop their own marketplace, use the federal marketplace, or use a system that involves collaboration between the state and the federal government. Texas elected to use the federal marketplace. Texas has the option to move to a state partnership or state-based marketplace at any time, and can do so through either legislation or an executive order from the Office of the Governor. Approximately 733,757 Texans signed up for health insurance through the federal marketplace during the first enrollment between October 1, 2013 and March 31, 2014.44,45 Open enrollment for 2015 starts November 15th, 2014.46
Plans in the marketplace are divided into five categories: catastrophic, bronze, silver, gold, and platinum. Catastrophic plans are only available to people under the age of 30 or those eligible for a hardship exemption. Hardship exemptions are granted to people based on income or other factors that prevent an individual from accessing health care coverage. Each type of plan pays a different percentage of the average overall cost of providing essential health benefits to members. The overall cost includes the insurance plan’s monthly premium, deductibles, copayments, coinsurance, and out-of-pocket maximums. The average amount each type of plan pays are as follows: catastrophic, less than 60%; bronze, 60%; silver, 70%; gold, 80%; platinum, 90%. The actual percentage a person pays in total or per service depends on the services used in a year. In general, individuals pay a higher monthly premium for gold and platinum plans but pay less of the cost when services are used. With bronze, silver, and catastrophic plans, individuals have a lower monthly premium but pay more of the cost when services are used. Individuals whose income is less than 250% of the federal poverty level can also get additional assistance in paying for out of pockets costs, such as copayments. Purchasing the Silver Plan is required to access this additional assistance.

Figure 4 shows the average costs of silver plan premiums and all category plan premiums that Texans paid in 2014. Figure 5 breaks down the costs of monthly premiums and shows the percentage of Texans within specific ranges of monthly premium costs paid in 2014.

**Figure 4. Federal Marketplace in Texas: Silver Plan Averages and All Categories Averages Monthly Premium Costs**

<table>
<thead>
<tr>
<th></th>
<th>Average Monthly Premium Before Tax Credit</th>
<th>Average Monthly Premium After Tax Credit</th>
<th>Average Tax Credit Amount</th>
<th>Average Percent Reduction in Premium after Tax Credit</th>
<th>Percent of Individuals Who Selected Account with Tax Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver</td>
<td>$314</td>
<td>$68</td>
<td>$246</td>
<td>78%</td>
<td>94%</td>
</tr>
<tr>
<td>All Categories</td>
<td>$305</td>
<td>$72</td>
<td>$233</td>
<td>76%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Figure 5. 2014 Federal Marketplace in Texas: Percentage of Individuals Separated by Monthly Premium Costs After Tax Credits

<table>
<thead>
<tr>
<th>Percent</th>
<th>$50 or less</th>
<th>$51-$100</th>
<th>$101-$150</th>
<th>Greater than $150</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
<td>24%</td>
<td>12%</td>
<td>14%</td>
</tr>
</tbody>
</table>


TEXAS DEPARTMENT OF INSURANCE AND RULES FOR NAVIGATORS

Under the Affordable Care Act (ACA), the federal government provides training, certification, and funding for navigators to help people enroll in health insurance through the Health Insurance Marketplace. Navigators provide important assistance to individuals who are trying to understand their health insurance options, some for the first time.

Effective on September 1, 2013, SB 1795 of the 83rd Legislative Session (Watson) directed the Texas Department of Insurance (TDI) to determine if federal navigator regulations were sufficient to ensure navigators could perform their required duties. If not, TDI was to establish state standards and qualifications. In December 2013, TDI released proposed rules for navigators that many health care advocates felt were restrictive and burdensome. After receiving feedback from community stakeholders, TDI made revisions to the proposed rules and released final rules for navigators that went into effect on February 10, 2014. Advocates felt that many of the changes were helpful, but were still concerned about the timeline imposed on navigators. These rules required navigators to complete registration with TDI by March 1, 2014. It also required navigators to complete 20 hours of state mandated training in addition to the 20-30 hours of federal training required for federal navigators by May 1, 2014.

MEDICAID EXPANSION

Texas elected not to expand Medicaid in 2013, an option available to all states through the ACA. During the 83rd legislative session legislators failed to pass any Medicaid expansion initiatives. Specifically, HB 3791 (Zerwas), known as the “Texas Solution,” attempted to create a state alternative to Medicaid expansion. This bill would have pulled down federal health care funds to subsidize private health insurance for low income individuals. Parties interested in a “Texas Solution” contend that any agreement reached for the expansion of Medicaid would allow the state to develop a tailored insurance product for the expansion population that could leverage private markets by building on Texas’ current Medicaid managed care model.

ACA Medicaid expansion would provide coverage to people with incomes up to 138% of the federal poverty level, an annual income of about $32,900 for a family of four in 2014. In states that expand Medicaid, the federal government pays 100% of the increased cost through 2016 and no less than 90% of the increased cost after 2019. By choosing not to expand Medicaid, Texas may be missing out on as much as an estimated $100 billion federal dollars between 2013 and 2023. As of June 2014,
27 states (including the District of Columbia) were in the process of implementing Medicaid expansion, 3 states were having open debates, and 21 states were not moving forward with Medicaid expansion.57

Advocates argue that whether by expanding traditional Medicaid or developing a “Texas Solution,” the available federal health care funds could benefit Texas taxpayers in the following ways:

· “Save local property tax dollars that currently cover local health programs and unpaid emergency room bills for the uninsured.
· Reduce insurance premiums that currently compensate for the high number of uninsured and unhealthy Texans.
· Create more than 200,000 jobs in three years, including many high-paying health jobs.
· Prevent Texas employers from paying tax penalties that could total $339 million for failing to insure their employees.
· Provide insurance for low-wage workers who typically don’t have access to preventive care, mental health services, cancer treatment, and other services that save lives and money.
· Provide insurance for more than 66,000 veterans and their spouses.
· Prevent an estimated 9,000 deaths per year.
· Ensure healthier workers, healthier parents raising children, and healthier mothers deliver healthier babies.”58

In addition, the National Association of State Mental Health Program Directors (NASMHPD) points out that if Medicaid were expanded, many of the individuals receiving state funded mental health and substance use services could receive Medicaid, increasing the amount of general revenue available to support other state priorities.59

In addition to providing states the option to expand Medicaid, the ACA, as noted previously, provides premium subsidies through tax credits for people with an income between 100%-400% of the federal poverty line to buy private health insurance on the Health Insurance Marketplace. However, since childless adults do not qualify for Medicaid at any income level and those who are parents are eligible only if their income is below 15% of the federal poverty level (3,577.50 for a family of four), over one million adult Texans who have an income less than 100% of the federal poverty line fall do not quality for premium tax subsidies or Medicaid coverage. This is known as the “coverage gap.”60 The American Mental Health Counselors Association estimates that nearly a quarter of all individuals eligible for Medicaid expansion or an alternative solution have a mental health or substance use condition.61

In addition to the benefits people with mental health conditions receive from timely treatment, increasing access to health care coverage for those falling in the gap can have a positive economic impact on Texas. Untreated mental health conditions can lead to expensive crisis and inpatient care for those who are uninsured, as opposed to less costly preventive care available to individuals with health coverage.62
Section 2703 of the ACA allows states to amend their Medicaid plans to provide care coordination services through health homes for beneficiaries with chronic conditions, including serious and persistent mental health conditions. This section of the ACA provides an opportunity for states to improve care by providing federal funding for certain Medicaid-covered health home services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, beneficiary and family support services, and referral to community and social support services. A health home can be a health team or a single provider within a team of health professionals. The health home services should provide a holistic care approach for individuals with multiple chronic health conditions or serious and persistent mental health conditions.

A Commonwealth Fund study found, even before the Centers for Medicare and Medicaid Services (CMS) issued guidance, “the health home initiative attracted great interest across states, with the majority of state Medicaid directors indicating on a nationwide survey that they would likely establish health homes under this new authority.” As of June 2014, 30 states have established or are planning to establish a home health system. Implementation of Medicaid health homes is still in the beginning stages, but data from Missouri’s health home initiatives suggest improved health care outcomes. Preliminary data concerning people enrolled in Missouri’s health home initiatives showed a reduction in hospital admissions by 12.8% per 1,000 people and a reduction in ER usage by 8.2% per 1,000 people during the first year of implementation in 2012. This same preliminary data revealed a net savings of approximately $82 per member per month. This data suggests that health homes have the potential to reduce state dollars spent on Medicaid services.

Texas has not established health homes through the ACA, but health homes have been created as a part of Medicaid managed care organizations (MCOs). During the 82nd Legislation Session in 2011, SB 7 (Nelson) required Medicaid MCOs to provide health home services, such as comprehensive care coordination, family-centered care, and data management. However, without seeking a Medicaid State Plan Amendment to add the health home benefit to the Texas Medicaid plan, Texas cannot draw down the additional federal match for these health home services.

More information on the Affordable Care Act is available in the National Context section.
In recent years, Texas Medicaid has moved towards the managed care approach in an attempt to improve service delivery and access to healthcare services for Medicaid recipients. Under the Medicaid managed care system, the Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to arrange, manage and deliver acute and long-term services and supports (LTSS) for Medicaid beneficiaries. HHSC pays the MCO a “capitated” or predetermined rate for each member enrolled every month, eradicating the traditional fee-for-service payment method. A Medicaid recipient chooses a health plan or MCO and receives services through the health plan’s coordinated network of providers. The health plan must provide all required services and assumes the financial risk if actual costs exceed the capitated rate paid by HHSC.

There are six Texas Medicaid managed care programs available or under development for differing populations, including: STAR, STAR Health, STAR+PLUS, NorthSTAR, CHIP, and STAR Kids (beginning in September 2016). For more information about these managed care programs refer to Figure 14 in the HHSC section.

Several initiatives have resulted in the growth of the managed care system in Texas. The Texas Healthcare Transformation and Quality Improvement Program, known as the 1115 Transformation waiver, is a five-year demonstration waiver beginning in 2011 that has transitioned nearly 1 million Medicaid enrollees from the traditional fee-for-service Medicaid into privately run managed care plans. The 1115 waiver expanded STAR and STAR-PLUS programs to new areas of the state and extended managed care’s role in the delivery of the prescription drug benefit. As a result of the 1115 waiver, managed care has become the primary vehicle through which most Medicaid recipients receive services. More information on the 1115 waiver is available below in 1115 Waiver: Texas Health Care Transformation and Quality Improvement Program. Additionally, during the 83rd legislative session in 2013 the Texas Legislature furthered the expansion of the Medicaid managed care system, most significantly through SB 58 (Nelson) and SB 7 (Nelson) described below. (See HHSC and DADS for a more in-depth look at these bills.)

**SENATE BILL 58 (SB 58)**

SB 58 requires targeted case management and mental health rehabilitative services to be integrated into Medicaid managed care with the goal of better care coordination for individuals enrolled in Medicaid. Prior to SB 58, Medicaid managed care already included several mental health services, such as medication management, counseling, and physician services. However, targeted case management and rehabilitative services for people with Medicaid were managed through local mental health authorities (LMHAs), not through MCOs. The delivery of services from two different systems made it difficult to seamlessly coordinate physical and behavioral...
health treatment for individuals requiring both health services.

SB 58 requires MCOs to develop a network of providers for behavioral health services and ensure availability of services for adults with serious mental illness and children with serious emotional disturbance. SB 58 also requires HHSC and DSHS to develop the Behavioral Health Integration Advisory Committee. This committee must include people who have experience and/or expertise in the behavioral health field such as consumers, MCO representatives, public providers, private providers, Medicaid providers, and Medicaid-Medicare dual eligible providers. The committee has been tasked with addressing the planning and development of the behavioral health services network, seeking input from the behavioral health community for the implementation of SB 58, and issuing formal recommendations to HHSC.

SENATE BILL 7 (SB 7)

SB 7 is a multifaceted piece of legislation generating major system delivery changes that also significantly expand Texas Medicaid managed care. Major managed care expansion efforts mandated by SB 7 include: 1) expansion of STAR+PLUS Medicaid Rural Service Areas (MRSA), 2) nursing facility carve-in, and 3) integration of acute care for adults with intellectual and developmental disabilities (IDD).

As a result of the legislation, by September 2014 STAR+PLUS will expand statewide (adding 164 rural counties) to deliver acute and long-term services and supports through the managed care system. Currently, 412,000 are being served by STAR+PLUS. An estimated 80,000 additional members will be served due to the STAR+PLUS expansion. By March 2015, approximately 56,800 nursing facility residents will transition into STAR+PLUS. The goal of the carve-in is to improve the quality of care in the least restrictive and most appropriate setting. Additionally, adults with IDD receiving services in community-based Intermediate Care Facilities (ICF-DD) and/or individuals receiving services in certain DADS 1915(c) waiver programs will transition into STAR+PLUS for acute care services. Children with disabilities under the age of 21 are exempted from this requirement and may continue to receive acute care services through a fee-for-service delivery option until the implementation of STAR Kids or they may voluntarily elect to enroll in STAR+PLUS. Acute care services include physician visits, short term hospital stays and urgent care.

SB 7 also requires the development and implementation of one or more managed care capitation pilots for delivery of long term services and supports for people with IDD no later than September 2016; the development of a cost effective option for delivery of attendant and habilitation services through the STAR+PLUS program (Community First Choice); and the establishment of the STAR Kids capitated managed care program to provide Medicaid benefits to children with disabilities not voluntarily enrolled in STAR+PLUS. Implementation of the STAR Kids program is currently scheduled for September 1, 2016. In addition, the legislation establishes multiple advisory committees to make recommendations relating to implementation of these changes.

The above is a listing of some of the major components of SB 58 and SB 7. For more information about the bills and to view copies of the legislation visit www.capitol.state.tx.us. Additionally, a copy of the Hogg Foundation summary of the legislation can be found www.hogg.utexas.edu/uploads/documents/83rd%20Leg%20Summary3.pdf.
In December 2011, Texas was approved by the Centers for Medicare & Medicaid Services (CMS) for a waiver of certain federal Medicaid regulations under section 1115 of the Social Security Act. This waiver is granted to states that apply in order to test alternate methods of financing and delivering Medicaid. The aim of the program is to improve managed care delivery while maintaining hospital supplemental payments. The five-year Medicaid 1115 demonstration waiver, also known as the Texas Healthcare Transformation and Quality Improvement Program, will run from September 2011 to September 2016.

The waiver creates two different funding pools— the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pool—with funds totaling $29 billion over the five-year period. The UC Pool will replace upper payment limit funding for hospitals and will offset costs by allowing hospitals to receive payments for uncompensated care for Medicaid eligible patients and other uninsured patients. Funding through the DSRIP incentivizes the improvement of healthcare delivery systems through the creation of regional healthcare partnerships (RHPs). The goal of the 1115 waiver is to provide funding necessary to develop innovative care models focused on improving care for individuals, overall health and the efficiency of healthcare service delivery in the state. In order to receive funding from the DSRIP pool, projects must meet their project-specific performance metrics. Metrics should demonstrate improved patient outcomes, quality improvement, and the development of project infrastructures through the expansion of space, hours, and staff. Providers report on these performance metrics twice per year in order to earn DSRIP payments.

The waiver creates 20 RHPs across Texas. As of August 2014, there were 1,491 approved and active DSRIP programs across the RHPs. RHPs are local collaborations that fund the state share of all waiver payments. Counties and other entities providing the state share will determine how their funds are used in the RHP consistent with waiver requirements. Each provider able to provide local match retains control of its own fund use and commitments. While RHPs cannot dictate how local match is provided or how it is used, local matches are expected to promote collaboration and system transformation (improved access, quality, cost-effectiveness, and coordination).

Mental health services are being significantly expanded under the waiver. Texas made behavioral health a priority by allocating 10% of the DSRIP funds to community mental health centers and including many behavioral health-focused project options in the DSRIP menu. Importantly, the waiver creates the option for local communities to expand behavioral health services without having to conform to the narrow eligibility requirements that exist for state-funded services in local mental health centers. In Texas, currently all 39 LMHAs...
are participating in the program, and there are around 400 behavioral-health related projects. These projects are eligible to earn up to $937 million in DSRIP payments in the period from October 2012 to September 2014.

Examples of current behavioral health projects include additional crisis intervention response teams, the establishment of campuses for children with emotional problems and developmental delays, the integration of behavioral health into obstetrics outpatient services for the treatment of postpartum depression, and the integration of primary care and substance abuse services. Examples of performance metrics for behavioral health projects may include showings of reduced admission/readmission into the criminal justice system, reduced emergency department visits, and improved quality of life.

The DSRIP projects are still in their early implementation phase; it is expected that more will be known about the efficacy and success of the projects in the next two years as data on performance metrics becomes available.

1915(i) STATE PLAN AMENDMENT: HOME AND COMMUNITY-BASED SERVICES—ADULT MENTAL HEALTH PROGRAM (HCBS-AMH)

DSHS was granted an exceptional funding request during the 83rd Legislative Session through Rider 81, Home and Community-Based Services, and was appropriated approximately $2.7 million for FY 2014 and $5.2 million for FY 2015 from general revenue funds. These funds are to develop a Home and Community-Based Services (HCBS) program for adults with complex needs and extended or repeated stays in state inpatient psychiatric hospitals. The funds will also be used for DSHS to seek federal approval from Centers for Medicaid and Medicare Services (CMS) for a Medicaid 1915(i) State Plan Amendment to allow federal financial participation in the HCBS program. DSHS informally submitted the state plan amendment for the program to the CMS early in 2014 and received feedback. In the summer of 2014, DSHS worked with HHSC to refine the state plan amendment based on the feedback from CMS and formally to submit the plan to the CMS. DSHS hopes to receive approval from CMS and to begin the HCBS-AMH by late fall of 2014.

With appropriated funds, DSHS will establish the HCBS-AMH as a mechanism to address issues in the psychiatric hospital system. Some individuals are forced to remain in inpatient facilities after they no longer need acute inpatient services due to the lack of community options. HCBS-AMH will provide a variety of support services to these individuals so their needs can be met in the community, instead of an inpatient psychiatric hospital. Individual homes, apartments, adult foster homes, assisted living facilities, and small (3-4 beds) community-based residences are all considered home and community based settings where HCBS-AMH services can be provided.

The Medicaid Services Unit at DSHS will administer the HCBS-AMH program. DSHS will contract with provider agencies using an open enrollment process to perform initial and ongoing independent assessments and evaluations of candidates and enrollees, oversee quality assurance, recruit and enroll HCBS-AMH providers, manage claims payment, and conduct program oversight.

The HCBS-AMH program is anticipated to serve a maximum of 106 people at any
point in time. In order to receive services, these individuals must demonstrate that HCBS-AMH will help them maintain stability, improve functioning, prevent relapse to an acute inpatient level of care, and maintain residence in the community. Eligibility will be determined by an individual assessment and history of extended inpatient psychiatric commitments. DSHS anticipates that many of these individuals will have a history of unstable housing/homelessness, co-occurring physical illness, cognitive-related issues, and low/no family support.

HCBS-AMH services will be individualized so that participants will receive the specific support they need. This process will be facilitated through an individualized recovery plan (IRP). A recovery manager will be responsible for creating the IRP. A team, including the individual, will actively participate in the development of the IRP. The individual receiving services will have the ability to choose who will be a part of their recovery team. This may include significant others, friends, families, providers, and others to be on their team. DSHS will perform quality assurance reviews of IRPs to ensure the IRPs are individualized and to address goals and needs that were identified by the individual and an assessment. IRPs will be reviewed annually with the ability to be revised as needed between the annual reviews.

The following array of services will be provided through HCBS-AMH:

- Adaptive aids
- Community-based residential assistance services
- Community psychiatric supports and treatment peer support
- Employment assistance
- Home delivered meals
- Minor home modifications
- Nursing
- Recovery management
- Rehabilitation service
- Respite care (short term)
- Substance abuse services
- Transition assistance
- Transportation services

In addition to these services, other state plan services will be provided as medically necessary and will be coordinated with the HCBS-AMH services. For more information about these services or HCBS-AMH, visit www.dshs.state.tx.us/mhsa/hcbs-amh/.

**HEALTH AND HUMAN SERVICE COMMISSION SUNSET REVIEW**

For the first time since 1999, the Health and Human Services Commission (HHSC), along with the state agencies regulated by HHSC (DSHS, DARS, DFPS and DADS), are under review by the Texas Legislature per requirement of the Texas Sunset Act. The Act, created in 1977, mandates the Sunset Advisory Commission, comprised of ten legislators and two public members, to periodically evaluate state agencies in order to determine that an agency’s functions are still needed and that they operate efficiently and effectively. Over the two-year Sunset reauthorization process, the Sunset Commission staff closely research the agencies, looking for needs, strengths and potential improvements. The Commission will report agency recommendations to the 84th Legislature. The Legislature will in turn make final determinations about
the agencies’ continuation or changes in agency structure and/or operation. Figure 6 details the sunset evaluation process and Figure 7 provides a general timeframe and sequence of events for the agencies up for review in 2015.

**Figure 6. Sunset Evaluation Process**

Figure 7. Sunset Evaluation Timeframe

<table>
<thead>
<tr>
<th>September 2013</th>
<th>Agencies submit Self-Evaluation Reports.</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2013 to January 2015</td>
<td>Sunset Commission conducts extensive research and analysis in order to evaluate agencies and prepare reports. Sunset Commission holds public hearings and makes decisions.</td>
</tr>
<tr>
<td>February 2015</td>
<td>Sunset Commission submits reports to the 84th Legislature with recommendations on each agency under review.</td>
</tr>
<tr>
<td>February 2015 to May 2015</td>
<td>84th Legislature considers reports and makes final determinations</td>
</tr>
</tbody>
</table>


For more information on the Sunset process and the Commission’s roles and responsibilities, visit https://www.sunset.texas.gov. To view the Commission’s agency recommendations on HHSC, DADS, DFPS, DSHS and DARS, visit page 318.

MENTAL HEALTH WORKFORCE SHORTAGES

People experiencing mental illness can achieve recovery and wellness when appropriate mental health services and supports are available. Through recovery, they can live meaningful, productive lives in their community. Recovery, however, does not happen in isolation. It may require treatment and support from family, friends and mental health professionals such as psychiatrists, licensed professional counselors, social workers, psychologists, psychiatric nurses or advance practice registered nurses, and certified peer-to-peer specialists and community health workers. These professionals have specialized education, training and skills to serve a broad range of mental, behavioral, emotional and psychosocial needs.

The individual and societal benefits of achieving mental wellness are obvious. The economic value of providing appropriate mental health services can be measured in avoided costs to hospitals and criminal justice and juvenile justice systems and improved workplace productivity. The need for mental health services is high. Nationally, 46.4% of adults experience mental illness in their lifetime and 26.2% of adults experience mental illness annually. On an annual basis, 5.8% of adults in the United States experience a serious mental illness. Nationwide, only 39% of persons with mental illness receive needed mental health treatment.

As of November 2013 and shown in Figure 8, 207 of Texas’ 254 counties in Texas were designated by the federal government as whole or partial Health Professional Shortage Areas for mental health. Factors contributing to the critical shortages include limited education opportunities, high turnover, an aging mental health workforce, insufficient diversity, low compensation and an inadequate reimbursement system.
The information below provides an overview of the current workforce of mental health professionals and the challenges they face in providing services to a growing population with complex conditions. It includes strategies for addressing the problem and a discussion of future needs that must be addressed to ensure Texans have access to the mental health services they need.

**WORKFORCE AVAILABILITY IN TEXAS**

While the population in Texas has increased and become more diverse and health care needs have grown more complex, the supply of mental health professionals has not kept pace. As of November 2013, 207 of Texas’ 254 counties in Texas were designated by the federal government as whole or partial Health Professional Shortage Areas for mental health.

Even when accounting for psychiatrists and other related professions such as clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and family therapists, (often referred to as Core Mental Health Professions) 23.3% of the 2013 Texas population lived in 199 different counties with mental health workforce shortages.

Factors that contribute to and exacerbate the mental health workforce shortage in Texas include:

- An aging workforce that is beginning to retire.
- Recruitment and training challenges for mental health professionals.

**As of November 2013, 207 of Texas’ 254 counties were designated by the federal government as whole or partial Health Professional Shortage Areas for mental health.**
· Lack of Texas mental health professional internship sites.
· Inadequate pay and reimbursement rates in the public mental health system.
· Lack of cultural and linguistic diversity in the workforce, causing a significant shortage of mental health providers with the knowledge, training and skills to serve people who speak languages other than English or are of racial or ethnic minority populations.
· Increasing demand for behavioral health services.

Culturally competent and linguistically diverse mental health professionals are particularly difficult to access in Texas. As of 2013, 65.5% of all psychiatrists were white, 5.3% were African American, and 12.4% were Hispanic. A 2011 report by the Hogg Foundation for Mental Health and Methodist Healthcare Ministries states that “without cultural competency in treatment, recovery and wellness can remain unreachable for many people with mental illness.” The problem is especially apparent in Hispanic communities along the border, where residents juggle two languages and cultures. Urban areas like Houston and Dallas struggle to meet demands of a diverse population that often includes a large number of immigrants and minorities.

The supply of health professionals in rural and border areas is even lower than in urban and non-border areas. As of September 2013, there were 1,393 active licensed psychiatrists in Texas who were offering direct patient care. This ratio equals approximately 13,394 Texans per psychiatrist. However, psychiatrists are disproportionally located in metropolitan counties: Harris, Dallas, Tarrant, Bexar, and Travis. Non-metropolitan, border areas have a population of 126,821 persons per psychiatrist. The majority of rural Texas lacks psychiatrists, primary care physicians, pediatricians, obstetricians, gynecologists and other providers. The difficulty of recruiting doctors to rural areas means many people must often travel long distances for even basic health care services that could prevent more costly illnesses in the future.

**BEHAVIORAL HEALTH PROFESSIONALS IN TEXAS**

Mental health services in Texas are provided by a number of different mental health professionals including:

- Psychiatrists
- Psychologists
- Social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Psychiatric nurses
- Licensed chemical dependency counselors
- Peer support specialists
- Promotores
- Psychiatric rehabilitation providers
- Pastoral counselors
- Occupational therapists

For a description of the professions, including data on the numbers of professionals in the state, refer to the DSHS Mental Health Workforce Report at: [https://www.dshs.state.tx.us/chs/hprc/](https://www.dshs.state.tx.us/chs/hprc/)
During the 83rd legislative session, Representative Burkett authored HB 1023. Passage of this bill indicated that the legislature recognized the need to address the mental health workforce shortage. HB 1023 required the Department of State Health Services to conduct a study and produce a report on the mental health workforce shortage in Texas. To view the full report, visit https://www.dshs.state.tx.us/chs/hprc/. Additionally, the Select Committee on Health Care Education and Training held a hearing in Houston in September 2014. The recommendations developed by this committee will be made available to the 84th Legislature.

At the request of the Department of State Health Services, in February 2014 the Hogg Foundation for Mental Health presented workforce recommendations to the Statewide Health Coordinating Council in response to HB 1023. These recommendations can be found on the foundation’s website at http://www.hogg.utexas.edu/uploads/documents/MH%20Workforce%20Recommendations_031213-1.docx.

TEXAS MENTAL HEALTH CODE

In 2010, a report released by the state Continuity of Care Task Force recommended an overhaul of the Texas Mental Health Code that delineates rules for both voluntary and involuntary mental health commitments in Texas. No major changes to the code have been made since 1985 and many provisions in the current code are outdated, obsolete, or contradictory.

In 2011, the Hogg Foundation for Mental Health awarded a grant to Texas Appleseed to study and make recommendations on changes needed to the Mental Health Code. Psychiatrist/attorney Dr. Susan Stone was the lead researcher, facilitator and coordinator of the grant. A comprehensive and inclusive process was used to garner input from a vast number of stakeholders across Texas. Dr. Stone facilitated approximately 45 public meetings around the state to gather information and recommendations for change. Stakeholders attending the meetings included individuals living with mental illness, family members, law enforcement, mental health advocates, judicial representatives, lawyers, administrators, hospital executives and more. The forums were held throughout Texas with an emphasis on identifying differences in urban and rural areas. A report, Recommendations for Updating the Mental Health Code: A response to decades of dramatic changes in Texas’ mental health system, was developed. As a result of this report and the information gathered throughout the process, a number of legislative initiatives were proposed during the 83rd legislative session. While some significant changes were proposed, there was no comprehensive omnibus bill filed to amend the mental health code and only few changes actually made it through the legislative process. The Texas Appleseed report can be found at http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=855&Itemid=.

HB 3793 – MENTAL HEALTH ADVISORY PANEL

HB 3793 (Coleman), passed by the 83rd Legislature, has a number of elements related to increasing mental health service in Texas, including the creation of an advisory panel that will assess the needs, access, and availability of services in Texas, with an additional request to assess the forensic population in order to reduce the number of persons with mental health disorders entering the criminal justice system. The advisory panel will oversee the development of a state hospital allocation plan.
for voluntary civil commitments and forensic commitments. The legislation also asks DSHS to develop a procedure for raising awareness of alternate options to incarceration for persons with mental health disorders. DSHS will collaborate with the advisory panel to develop a framework and plan to improve mental health services and to allocate voluntary and forensic outpatient and inpatient services. The plan is statutorily required to address the following elements:\(^95\)

1. Determine the needs for outpatient mental health services of the two groups of patients.
2. Determine the minimum number of beds that the state hospital system must maintain to adequately serve the two groups of patients.
3. Create a statewide plan for the allocation of sufficient funds meeting the outpatient mental health service needs and for the maintenance of beds by the state hospitals two groups of patients.
4. Create a process to address and develop, without adverse impact to local service areas, the accessibility and availability of sufficient outpatient mental health services and beds provided by the state hospitals to the two groups of patients based on the success of contractual outcomes with mental health service providers and facilities (under Sections 533.034 and 533.052 of the Health and Safety Code).

An initial plan was released in January 2014 and implementation will begin no later than August 31, 2014. In December 2014, DSHS must produce a report for the legislature and governor that includes an updated plan, the status of the implementation, and the impact of the plan on the delivery of services.

**ADDRESSING THE MENTAL HEALTH NEEDS OF INDIVIDUALS WITH INTELLECTUAL AND OTHER DEVELOPMENTAL DISABILITIES (IDD)**

It has been estimated that the rate of mental health conditions for individuals with intellectual disabilities is two to three times higher than for the general population.\(^96\) Research findings have varied widely with prevalence rates for co-morbidity of IDD and mental health conditions ranging from 13.9% to 75.2%.\(^97\) The variation in prevalence rates is likely due to lack of consistency regarding diagnostic definitions and assessment instruments, small sample sizes, lack of studies using non-IDD comparison groups and overuse of administrative samples, level of disability (IQ) and type of disability.\(^98\)

For individuals with autism spectrum disorder (ASD) the numbers appear to be more defined, with a 2011 study of 4,343 children with ASD finding the psychiatric co-morbidity rate by age 16 to be 49%.\(^99\)

Individuals with IDD exhibiting challenging behaviors often do not receive state-of-the-art mental health treatment; their care is often focused on managing behaviors and promoting compliance. Professionals, caregivers and family members who are accustomed to seeing their client or loved one through the lens of the disability can misinterpret behaviors that are in fact the result of mental illness, distress, past trauma or possibly an unidentified acute medical condition.

When challenging behaviors are attributed solely to the disability, opportunities for recovery are missed. It is not uncommon, however, for professionals and other caregivers to fail to look beyond the disability and assess for possible mental health conditions and appropriate interventions.
health conditions. Cultures of care in both residential and community or family settings have historically had a similar goal of reducing maladaptive behaviors by removing antecedents and replacing undesirable behavior with behaviors deemed “appropriate.” While behavior supports and services can be effective in addressing challenging behaviors, if underlying mental health conditions are not addressed, the likelihood of positive outcomes is greatly reduced.100

Some steps have been taken to begin drawing attention to this important issue, but much work is still needed to create meaningful systems change. In June 2014, the House Human Services Committee held a public hearing on an interim charge to address crisis intervention needs of people with IDD. As a result of that hearing, the Department of State Health Services is researching options for basic mental health/IDD training for direct support providers. Additionally, the Department of Aging and Disability Services (DADS) has conducted a number of trainings across the state on trauma-informed care for individuals with IDD. Also, in partnership with DADS, the Hogg Foundation for Mental Health recently completed a two-year project providing trauma-informed care training and technical assistance at two state supported living centers in an attempt to reduce the use of restraint. The foundation is currently partnering with the National Child Traumatic Stress Network to develop a toolkit to be used for training providers and families on trauma-informed care for children with IDD.

BOARDING HOMES

A boarding home is a business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the owner. A point in time study commissioned by HHSC in 2008 found 854 boarding homes throughout Texas.101 However, this number is likely to be greatly underestimated because homes can be difficult to find and locate due to the lack of regulation or licensing in many parts of the state. Many people with serious behavioral health conditions have limited income and finding affordable housing can be a challenge.102 As a result of the severe shortage of affordable housing throughout Texas, many times the only viable option for people with behavioral health conditions is to reside in a boarding home. In most cases, a resident’s Social Security stipend funds their stay in a boarding home. The same 2008 study mentioned above found that 29% of boarding home residents in Texas had a mental health condition. This was not a comprehensive survey, however, and may under-represent the percentage of individuals living in boarding homes who have a mental illness.103

While boarding homes offer an alternative to homelessness and some homes provide safe and affordable living quarters for their residents, others offer poor living conditions and have been found to engage in abusive and exploitative behavior.104 During the 81st Legislative Session in 2009, HB 216 (Menendez) directed HHSC to develop and publish state model standards for the operation of boarding home facilities. Additionally, the Hogg Foundation for Mental Health awarded a grant to

As a result of the severe shortage of affordable housing throughout Texas, many times the only viable option for people with behavioral health conditions is to reside in a boarding home.
Mental Health America (MHA) of Texas and six affiliate chapters to work with policy makers in the development of new state regulatory standards for boarding homes. Those model standards define boarding homes as facilities that:

- Furnish, in one or more buildings, lodging to three or more persons with disabilities or elderly persons who are unrelated to the owner of the establishment by blood or marriage.
- Provide community meals, light housework, meal preparation, transportation, grocery shopping, money management, laundry services, or assistance with self-administration of medication but do not provide personal care services to those persons.

The full boarding home model standards are available at http://www.hhsc.state.tx.us/BoardingHouseModelStandards.pdf.

The legislation, however, did not require cities to implement the model standards. Consequently many problems with this type of housing continue to exist. The grant also supported Mental Health America of Texas to work with city and county public officials to develop and establish boarding home regulations on a local level. The most substantial impact of this work with city and county public officials occurred in the greater Dallas area, Tarrant County, and Southwestern Texas (Beaumont area).

In June 2012, an affiliate chapter of MHA of Texas, MHA of Greater Dallas, had a significant impact in the unanimous passing of a city ordinance that implements boarding home standards in accordance with HHSC’s Texas Boarding Home Model Standards. Additionally, in June 2013, MHA Houston helped pass a city ordinance regulating boarding homes for the first time in Houston. Even though boarding home model standards are not mandated across the state, in the past few years some cities, including El Paso, Dallas, DeSoto, Brenham, San Antonio and Houston, have passed ordinances to require standards for boarding homes.

Subsequently, in 2013, the Hogg Foundation for Mental Health funded MHA of Greater Dallas to create a website that summarized its efforts to improve the quality of boarding homes, provides tools and resources pertaining to regulating boarding homes, and provides a list of boarding homes in the city of Dallas. MHA of Greater Dallas continues to help cities in the greater Dallas community pass boarding home regulations, and in February 2014 the city of DeSoto passed boarding home regulations.

In 2013, the 83rd Legislature took steps toward improving the availability of housing information for people with mental health by passing HB 1191 (Burkett, Zedler). HB 1191 requires HHSC to add information about housing options for mental health consumers, including boarding homes, on the Texas Information and Referral Network Site, the state’s 2-1-1 website. The website’s mission is to assist Texans with obtaining necessary health and human services. Prior to this bill, this information was not available through the website. This bill provides a central location for mental health consumers to locate appropriate housing. HB 1191 requires the website to include definitions of the different types of housing, a searchable listing of available housing, and an explanation of the general populations served with the specific type of housing. This bill intends to further assist mental health consumers to reach
appropriate resources. The information about housing options for mental health is intended to be updated on the 2-1-1 website by September of 2014. However, the lack of statewide regulation for boarding homes has made it difficult for HHSC to compile a comprehensive and accurate list of boarding homes throughout the entire state. Therefore, a list of available boarding homes will not be available with the initial implementation of HB 1191.

**PEER SUPPORT SERVICES**

According to the Centers for Medicare and Medicaid Services (CMS), “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.” According to research sponsored by SAMHSA to assess the effectiveness of peer support services, “peers are individuals with histories of successfully living with serious mental illness who, in turn support others with serious mental illness.”

Adding peers to traditional services or having them deliver structured curriculum has shown promising outcomes, although more rigorous effectiveness research is needed.

Certified peer specialists have both lived experience and have achieved the relevant education and examination requirements for certification. Peer support services generally fall into three categories:

- 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.
- Activities that are delivered as part of a [recovery] team that may include non-peers (for example, an assertive community treatment team).
- Traditional activities that are delivered in a way that is informed by a peer’s personal recovery experience (case management, information and referral, etc.).

Texas has undergone a thorough process to develop certification requirements for mental health peer specialists and substance use recovery specialists. Via Hope is the organization sanctioned by the Department of State Health Services (DSHS) to certify peer specialists and is jointly funded by DSHS and the Hogg Foundation for Mental Health. Substance use recovery specialist certification is provided by the Texas Certification Board of Addiction Professionals. There are currently more than 500 certified mental health peer specialists and over 300 certified recovery specialists in Texas.

Mental health peer support services are currently being provided at all 39 local mental health authorities and a number of state psychiatric hospitals. Peer substance use recovery services are often offered at halfway houses, addiction centers and substance use rehab facilities. Due to current reimbursement rules however, the services provided by mental health peer specialists and recovery specialists are only reimbursable through Medicaid when offered at the local mental health authorities, reducing opportunities for recovery for those seeking treatment through other entities.

Peer specialists assist individuals experiencing mental illness or substance use conditions by helping them focus on recovery, wellness, self-direction, responsibility...
and independent living. Peer and recovery specialists play an important role in supporting individuals experiencing mental health/substance use conditions who are working toward recovery. According to one study conducted in 2008, peer support services include services to promote hope, socialization, recovery, self-advocacy, development of natural supports and maintenance of community living skills. The inclusion of peer support services in the service array increases the likelihood of recovery which reduces the high costs associated with people cycling through emergency rooms, county and city jails and state mental health facilities.

**YOUTH EMPOWERMENT SERVICES (YES) WAIVER**

Youth Empowerment Services (YES) is a Medicaid 1915(c) home and community-based waiver program for children ages 3 to 19 years old, intended to reduce Medicaid psychiatric hospital expenses and out-of-home placement for children with serious emotional disturbance. A full range of Medicaid services and non-traditional services and family supports are available to create an intensive, comprehensive and individualized child and family plan of care.

The YES Waiver was developed in part to help reduce the need for parental relinquishment, in which parents are forced to give up custody of their children in order to obtain intensive behavioral health services that are not otherwise available or that families cannot afford. The waiver disregards parental income and deems children to be financially eligible if they meet the same eligibility standards for psychiatric institutions.

The Texas Department of State Health Services (DSHS) and the Texas Health and Human Services Commission (HHSC) submitted the YES Waiver proposal to the federal Centers for Medicare and Medicaid Services (CMS) in June 2008 and received approval in February 2009. In April 2010, pilots began in Bexar and Travis Counties, expanding to Tarrant County in July 2012. The waiver was renewed in April 2013 authorizing expansion of YES waiver services to Harris, Brazoria, Fort Bend and Galveston counties in February 2014 and Cameron, Hidalgo and Willacy counties in June 2014.

DSHS contracts with the local mental health authorities (LMHAs) in the aforementioned counties to manage YES waiver services in each of these respective service regions. The LMHAs then contract with community service providers to ensure all needed services are available. The waiver is authorized to serve up to 400 youth at any time (100 per county). As of August 2014, 373 youth were enrolled in the YES waiver.

Further expansion of the YES Waiver is anticipated, as Rider 80 in SB 1 of the 83rd Legislature directs HHSC and DSHS to develop a plan for the statewide expansion of the waiver during the 2014/2015 biennium. YES Waiver updates and information are available at www.dshs.state.tx.us/mhsa/yes/.

**TRAUMA-INFORMED CARE**

Trauma-informed care (TIC) is an organized treatment framework and strengths-based delivery approach that incorporates understanding, recognizing and appropriately responding to the emotional impact of trauma. TIC emphasizes
physical, physiological and emotional safety for everyone involved in treatment and works to empower trauma survivors to rebuild a sense of control over their own life.

A trauma-informed system is one in which all the components of a service system are evaluated and reframed with an understanding of the role that trauma and violence play in the lives of people seeking behavioral health services.

In recent years, TIC has grown as an evidence-based method and national movement. For example, SAMHSA’s National Center for Trauma Informed Care (NCTIC) has provided on-site training and technical assistance in order to develop and improve trauma-informed environments to a variety of health service agencies in all 50 states. Additionally, the National Council for Behavioral Health has held three national TIC learning communities from 2011-2013, with participation from over 120 organizations. The National Child Traumatic Stress Network (NCTSN) also serves as a national advocate for TIC, providing a collection of resources, research and expertise on TIC focusing on children and families.

In Texas, a number of TIC-based initiatives have been implemented. At the statutory level, the Texas legislature has mandated TIC training for Child Protective Services staff and foster parents as well as specific juvenile justice workers. Additionally, the Department of Aging and Disability Services partnered with the Hogg Foundation for Mental Health on a two-year project to provide on-going TIC training and technical assistance at two state supported living centers for individuals with intellectual disabilities. An evaluation of the project indicates a decline in the use of restraints and a shift in how staff support the residents. Currently, the foundation is partnering with the NCTSN to develop a tool-kit to support trauma-informed care training for children with intellectual disabilities.

For additional information on TIC, see the Best Practices section

**FORENSIC RESTORATION OF COMPETENCY LAWSUIT**

Competency restoration in the criminal justice system is the process used when people with mental illness or intellectual disabilities are charged with crimes but are deemed incompetent to stand trial because they lack the capacity to participate in their own defense. Before the legal process can continue the person must be restored to competency and be able to participate in his or her defense. Competency restoration generally takes place in state psychiatric hospitals and state supported living centers, although in recent years local mental health authorities and the legislature have made a significant commitment to providing competency restoration services in the community.

The number of inpatient forensic commitments has grown dramatically in recent years, but the number of available beds in state hospitals has not increased. Consequently, defendants may be held in local jails for an extended period, until a hospital bed is available. Defendants with a mental illness spend an average of 41 days in local jails, untreated and unable to go to court while waiting for a forensic bed at a state hospital. Meanwhile, increasing demand for forensic beds at state-operated psychiatric hospitals continues to reduce the number of beds available for civil commitments.
In 2011, the 82nd Texas Legislature enacted HB 748 and HB 2725, limiting incarceration time while waiting for competency restoration to periods no longer than the maximum penalty for the crime charged. Such bills were efforts to ensure that the rights of individuals with mental illness were still protected even when charged with a criminal offense.

In 2007, Disability Rights Texas filed a lawsuit against the Department of State Health Services (DSHS) on behalf of individuals waiting in jail following a finding of incompetency. The case challenged the policy and practice of placing individuals found incompetent on a clearinghouse wait list due to lack of capacity in the state hospitals. In January 2012, a Travis County District Court judge ruled that a defendant found incompetent to stand trial cannot be held in jail more than 21 days before admission to a competency restoration program.120

The Department appealed and implementation of the order was stayed. However, the Department concurrently sought to increase bed capacity to comply with the 21 day ruling. DSHS has allocated additional forensic beds at the state hospitals and is contracting for civil beds in local communities in an attempt to facilitate transfer within 21 days and still maintain sufficient civil beds.121 Additionally, the state has expanded the number of outpatient competency restoration sites and is initiating a jail-based restoration program to reduce the number of people waiting for inpatient services. More information on Texas outpatient competency restoration services is provided in Best Practices.

In May 2014, the Third Court of Appeals in Austin issued a decision overturning the 21 day ruling. The Court found that the plaintiffs “failed to demonstrate that the continued confinement of some individuals on the list who may be dangerous may be justified as the purpose of their confinement extends beyond restoring them to competency for trial.”122 The court characterized the case as a facial challenge to the clearinghouse wait list and found that, because some defendants may have been transferred to a state hospital for restorative treatment in a constitutionally permissible timeframe, the plaintiffs had not shown that the waiting list was unconstitutional as to every defendant.

The plaintiff requested a rehearing on the court’s decision, which was denied. While the lawsuit was pending, significant headway was made to ensure that individuals in need of restorative treatment are transferred within 21 days. While there is currently no requirement to transfer within a certain amount of time, the Department must continue to accept individuals for restorative treatment in a timely manner to avoid future liability. Counsel for the plaintiffs continues to closely monitor the timelines for transferring individuals to inpatient settings following a finding of incompetency to proceed.
A 2003 report by the President’s New Freedom Commission on Mental Health characterized mental health systems across the nation as follows:

“The mental health system is fragmented and in disarray—not from lack of commitment and skill of those who deliver care, but from underlying structural, financing and organizational problems. Many of the problems are due to the ‘layering on’ of multiple, well-intentioned programs without overall direction, coordination or consistency.”

Over a decade later, these problems still exist across agencies in the Texas behavioral health system, although recent efforts have been made to improve coordination of, and access to, needed services. During the 83rd Legislative session, following several national tragedies attributed to untreated mental health conditions, efforts to increase funding for behavioral health programs and services were successful. The increase of critical funds enabled the creation of a variety of new and expanded behavioral health programs discussed in detail in the following section. These programs include a public awareness campaign, state-wide expansion of the Youth Empowerment Services (YES) Waiver, allocation of one full time Health and Human Services Commission employee devoted to overseeing mental health coordination state-wide, initiatives to help veterans, jail-diversion pilot program in Harris County, and expansion of Medicaid managed care. With the many changes to the public behavioral health system, it is essential to ensure that resources dedicated to behavioral health services are maximized across systems through effective coordination that minimizes duplication of services.

Depending on the need and population, behavioral health services and funding can be provided by any one of the following agencies:

- Health and Human Services Commission (HHSC)
- Texas Department of State Health Services (DSHS)
- Texas Department of Family and Protective Services (DFPS)
With services dispersed across so many agencies, even the most sophisticated providers, consumers and family members encounter problems receiving or coordinating proper care. This lack of coordination not only creates confusion but also reduces the cost-effectiveness of the limited funds available to provide critical care.

Despite recent funding increases, Texas still sits near the bottom of national rankings for per capita mental health spending by a state mental health agency. Failure to adequately fund behavioral health services results in substantial economic and societal costs. The human toll is impossible to measure, but the consequences of limited funding and access to community and preventive mental health services means that individuals with behavioral health needs are inadequately served in jails, hospital emergency departments, adult and juvenile criminal justice agencies, schools, child protective services, and other social service settings where services are often more costly and less effective.
Texas Health and Human Services Commission: At A Glance:

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### POLICY CONCERNS

- Coordination of mental health and substance use services across agencies
- Adequacy of reimbursement rates for behavioral health services
- Progress of 1115 Transformation waiver and coordination of 1115 initiatives with mental health systems planning
- Consideration of sunset recommendations
- Implementation of the Affordable Care Act
- Integration of behavioral health services and expansion of Medicaid managed care
- Complex regulations and laws governing information sharing between agencies

### FAST FACTS

- For the 2014-2015 biennium, the HHSC budget is approximately 27 percent (over $53.1 billion) of the entire state budget while the Health and Human Services budget, comprised of HHSC, DFPS, DADS, DARS and DSHS, accounts for approximately 39 percent of the entire state budget.124
- In 2013, roughly one in seven Texans (3.6 million out of 26.6 million) relied on Medicaid for acute and long-term services each month.125 The Texas Medicaid program caseload is projected to reach 4.2 million by 2015.126
- In 2011, 55% of the Medicaid population was female and 77% was under the age of 21. Children without disabilities account for nearly 66% of all Medicaid recipients, however they represent only 33% of spending on direct health-care services.127
There are 70 FQHCs in Texas with more than 300 sites delivering services. In 2011, these sites served 975,509 individuals.
The Texas Health and Human Services Commission (HHSC) is the umbrella agency overseeing Medicaid, the Children’s Health Insurance Program (CHIP), a handful of other programs, and the operation of four major departments:

- Department of State Health Services (DSHS)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)

HHSC is divided into 11 service regions displayed in Figure 10. HHSC and the departments under it are sometimes referred to as the Health and Human Services (HHS) “enterprise.” In FY 2013, the enterprise employed approximately 53,473 full-time and part-time employees and provided services to more than 3.4 million Texans.
In addition to providing oversight for the health and human services enterprises, HHSC also operates the following programs: Medicaid, Children’s Health Insurance Program (CHIP), Disaster Assistance, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and the Medical Transportation Program.131

**Funding**

The HHSC budget is approximately 27 percent (over $53.1 billion) of the entire state budget while the HHS budget, comprised of HHSC, DFPS, DADS, DARS and DSHS, accounts for approximately 39 percent of the entire state budget for the 2014-2015 biennium.132 The FY2014-2015 biennium appropriated funds included a 14.2 percent increase in funding granted from the 2012-2013 biennium. A total of over $58 billion is requested for HHSC in FY 2016 and 2017.133

In 2014 and 2015, a total of $77.6 billion of combined state and federal funds were appropriated to Health and Human services (including all funds to each of the four sub-agencies).134 Figure 11 below demonstrates the funding appropriated to each of the HHSC agencies. Figure 12 shows the funding sources for the FY2014-2015 budget.
Figure 11. HHS System Request by Agency

HHS System Request by Agency
Base and Exceptional Item Request
All Funds for FY 2014 - 2015
$77,611.9 million

HHSC
$53,161.5
68.5%

DADS
$14,056.4
18.1%

DARS
$1,321.4
1.7%

DFPS
$2,963.7
3.8%

DSHS
$6,108.7
7.9%


Figure 12. Methods of Financing

HHS System Method of Financing
Base and Exceptional Item Request
All Funds for FY 2014 - 2015
$77,611.9 million

Federal Funds
$44,252.3
57.0%

Other Funds
$1,485.3
1.9%

GR-Related Funds
$31,874.2
41.1%

Changing Environment

The Health and Human Services Commission and the entire enterprise are in a period of significant change. The 83rd Legislature directed some major changes that have already begun but will take years to be fully implemented. The most significant changes relate to the expansion of managed care as required by SB 58 (83rd/Nelson) and SB 7 (83rd/Nelson).

In a managed care system, an eligible individual selects a health plan (managed care organization) and is asked to identify a primary care physician from that plan’s provider network. The health plan is then responsible for care coordination and administration of each member’s services. The state of Texas pays each health plan a capitated rate for each member enrolled. A capitated rate is a predetermined payment made for each member, every month. The health plan must provide all required services and bears the financial risk if their actual costs exceed the state capitated payment.

Eligible individuals have a choice between at least two, and sometimes more, health plans in each region. Once enrolled in a particular health plan, members have the option to change plans if not satisfied. In addition to the contract requirements and state monitoring, the members’ ability to switch plans generates some level of competition between health plans that is expected to result in higher quality services.

Following are brief descriptions of major changes currently underway.

**SB 58 - INTEGRATION OF BEHAVIORAL HEALTH SERVICES**

In Texas, the providers eligible to receive Medicaid reimbursement for rehabilitation and targeted case management services have historically been limited to Local Mental Health Authorities (LMHAs). These services have been provided outside of Medicaid managed care under a separate payment arrangement with LMHAs. However, because of SB 58, effective September 1, 2014, targeted case management and mental health rehabilitative services for individuals with mental health conditions who are eligible to receive Medicaid benefits will be delivered through the state managed care programs STAR and STAR+PLUS.

STAR is the statewide managed care program that provides Medicaid acute care services to eligible participants. STAR+PLUS is a statewide managed care program that provides both acute and long term services and supports to people with disabilities and elderly participants needing these services. Additional information on these specific managed care programs is available in Figure 14. A description of mental health rehabilitative services and targeted case management is available in the DSHS section.

HHSC will contract with the various health plans to oversee delivery of these services. Initially, the health plans will primarily be contracting with the local mental health authorities (LMHAs) to provide these services throughout Texas. This is referred to as “phase one,” as it changes the flow of the funding but does not expand...
the provider base and does not create an integrated system of care.

HHSC has indicated that plans for phase two of this initiative will broaden the provider base, increase access to services, and focus on systems changes needed to truly integrate behavioral health and acute care services. The Behavioral Health Integration Advisory Committee, created by SB 58 to make recommendations to HHSC on integrating care, has developed recommendations to help guide phase two of this initiative.

SB 58 also directed HHSC to:

- Develop two health home pilots.
- Bring together local groups to provide services for people who are homeless and have mental illness or a substance use condition.
- Develop a mental health and substance use treatment public reporting system.

### SB 7 – MANAGED CARE EXPANSION AND INTELLECTUAL/DEVELOPMENTAL DISABILITY REDESIGN

SB 7 was a complex piece of legislation that is generating major service delivery changes across multiple systems and programs. Many changes in SB 7 impact individuals with intellectual and development disorders (IDD) and the method through which long-term services and supports are delivered. Individuals with IDD are three times more likely to experience a mental health condition. Therefore, legislation set forth in SB 7 will likely improve the mental health and wellness of this population. Some of the changes resulting from SB 7 include:

- Design and implementation of a system of acute care and long-term services and supports for individuals with intellectual and other developmental disabilities (IDD).
- Development and implementation of one or more managed care capitation pilots for delivery of long term services and supports for people with IDD.
- Transition of the Texas Home Living waiver services to managed care by September 2016.
- Transition of Intermediate Care Facility (ICF) and IDD waiver services to managed care no later than September 2020.
- Provision of all Medicaid acute care services through a managed care model, including services to people with IDD receiving long term services and supports through a 1915(c) community-based waiver and individuals residing in intermediate care facilities for people with IDD. Children with disabilities under the age of 21 are exempt from this requirement and may continue to receive acute care services through a fee-for-service delivery option until the implementation of STAR Kids (see below) or may voluntarily elect to enroll in STAR+PLUS.
- Development of a cost effective option for delivery of attendant and habilitation services through the STAR+PLUS program.
- Expansion of the STAR+PLUS managed care program to all areas of the state.
- Transition of nursing facility services to managed care. Implementation of this provision has been postponed until March 2015.
- Establishment of the STAR Kids capitated managed care program to provide
Medicaid benefits to children with disabilities not voluntarily enrolled in STAR+PLUS. Implementation of the STAR Kids program has been postponed until September 1, 2016.

- Establishment of multiple advisory committees to make recommendations relating to implementation of these changes.
- Development of a comprehensive functional assessment to be used to determine the appropriate scope and duration of services to be delivered as well as a process for resource allocation.
- Expansion of housing support options for people with IDD.
- Subject to the availability of federal funds, development of specialized behavior support for individuals with IDD.
- Development and implementation of outcome-based performance measures and incentives in managed care contracts.
- Development of quality-based payment systems.

In addition to the major components described above, SB 7 directs additional policy changes. A copy of the legislation can be found online at www.capitol.state.tx.us. A copy of the Hogg Foundation summary of the legislation can be found at www.hogg.utexas.edu/uploads/documents/83rd%20Lege%20Summary3.pdf.

**Medicaid**

Medicaid is a jointly funded federal/state health care program authorized in Title XIX of the Social Security Act. It was created as a way to provide health care benefits primarily to children in low-income families, pregnant women, and people with disabilities. The federal government defines mandatory services that must be provided and populations that must be served. States have the option to expand both the services offered and the people eligible to receive those services through state plan amendments and Medicaid waivers. Medicaid is an entitlement program meaning that anyone meeting the eligibility criteria has a right to receive needed services and cannot be placed on waiting lists. The federal government and states cannot limit the number of eligible persons who can enroll in the program.136

**STATE MEDICAID AGENCY**

HHSC is the designated state Medicaid agency. Texas Medicaid serves over three million low-income children, pregnant women, older adults and adults with disabilities by providing medical care and services. Medicaid guidelines are primarily determined by the federal government, though several important tasks are apportioned to the states, including:137

- Establishing eligibility beyond the minimum eligibility groups set forth by the federal government.
- Determining the scope of services.
- Setting the rate of payment for services.
In Texas, the Medicaid state plan services are overseen and administered by HHSC. Medicaid behavioral health services, however, are also delivered to eligible individuals through multiple health and human services departments. The following chart (Figure 13) details various department programs offering Medicaid-funded services. These services will be elaborated in each respective agency section in the guide.

**Figure 13. Medicaid Funded Programs Across HHSC Agencies**

<table>
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<tr>
<th>State Agency</th>
<th>Medicaid Program Responsibilities</th>
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<tbody>
<tr>
<td>Health and Human Services Commission</td>
<td>Texas Medicaid state plan services</td>
</tr>
<tr>
<td>Department of Aging and Disability (DADS)</td>
<td>DADS administers the following long-term services and supports for the Medicaid program: Medicaid 1915(c) waivers: - Community-Based Alternatives (CBA)- Community Living Assistance and Support Services (CLASS)- Medically Dependent Children Program (MDCP)- Deaf-Blind with Multiple Disabilities (DBMD)- Home and Community-Based Services (HCS)- Texas Home Living (TxHmL) Entitlement programs - Primary Home Care (PHC) - Community Attendant Services (CAS) - Day Activity Health Services (DAHS) Nursing Facilities Intermediate Care Facilities for individuals with intellectual disabilities or related conditions</td>
</tr>
<tr>
<td>Department of State Health Services (DSHS)</td>
<td>DSHS administers: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Texas Health Steps Case management for pregnant women and children NorthSTAR managed care program Youth Empowerment Services (YES) waiver</td>
</tr>
<tr>
<td>Department of Family and Protective Services</td>
<td>DFPS administers: Superior Health Systems (STAR Health) Former Foster Care Children Program (FFCC) Medicaid for Transitioning Foster Care Youth</td>
</tr>
<tr>
<td>Department of Assistive and Rehabilitative Services (DARS)</td>
<td>DARS administers: Early Childhood Intervention Program (ECI) Case management for children who are blind or visually impaired Vocational rehabilitation services</td>
</tr>
</tbody>
</table>


The Texas Medicaid Program was first established in Texas in 1967. In 2013, roughly one in seven Texans (3.6 million out of 26.6 million) relied on Medicaid for acute and long-term services each month. The Texas Medicaid program caseload is projected to reach 4.2 million by 2015.

Starting in the early 1990s, Texas Medicaid has been offered...
through two service models: fee-for-service and managed care. The traditional fee-for-service delivery option (providers receive payment based on the unit of service delivered) is now limited to very few Medicaid participants (e.g. individuals new to the program who have not yet chosen or been assigned to a managed care plan). Under the Medicaid managed care system, the overall care of an individual is overseen by a single provider organization with the state paying a monthly capitated rate for each individual enrolled. Because of recent expansions of Medicaid managed care to include more services and populations, it has become the primary platform for delivering Medicaid services.

Medicaid managed care services are delivered through managed care organizations (MCOs) under state contract. Each MCO maintains a provider directory of contracted network physicians and other healthcare specialists. Approximately 2.8 million members (86 percent) of the Medicaid population were enrolled in managed care as of June 2013. This number is anticipated to grow with the passage of SB 7 (83rd Legislature, Nelson) that expands mandatory participation in the existing STAR+PLUS managed care program and the new STAR Kids managed care program.

The following chart describes the six Texas Medicaid/CHIP managed care programs. These programs include STAR (State of Texas Access Reform), STAR+PLUS, NorthSTAR, STAR Health, CHIP and STAR Kids.

**Figure 14. Texas Medicaid/CHIP Managed Care Programs**

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Eligible Population</th>
<th>Mental Health Utilization (FY 2011)</th>
</tr>
</thead>
</table>
| STAR (start date: 1991) | Provides acute care services for low-income families, non-disabled children and pregnant women. Beginning September 1, 2014 also includes the integration of behavioral health rehabilitative services and targeted case management. Services available statewide. | Mandatory for TANF Population; and low income pregnant women and children. Voluntary for SSI children age birth through 20 years of age. | Inpatient services: 0.3%  
Intensive outpatient or partial hospitalization services: 0.1%  
Outpatient or ED services: 8.7% |
| STAR+PLUS (start date: 1998) | Integrates delivery of acute and long-term care services into the managed care system. Individuals with intellectual and developmental disabilities receiving Medicaid 1915(c) waiver services will receive basic acute care services through the STAR+PLUS Medicaid managed care program starting Sept. 1, 2014. Beginning September 1, 2014 also includes the integration of behavioral health rehabilitative services and targeted case management. Services available statewide as of Sept. 1, 2014. Nursing facility services are expected to transition to STAR+PLUS March 1, 2015. | Mandatory for adults 21 or older receiving SSI; individuals receiving 1915(c) Medicaid waiver services (acute care only). Voluntary for children 20 and under eligible for SSI and Medicaid. | Inpatient services: 3.9%  
Intensive outpatient or partial hospitalization services: 0.7%  
Outpatient or ED services: 32.3% |
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Eligible Population</th>
<th>Mental Health Utilization (FY 2011)</th>
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</thead>
</table>
| NorthStar (start date: 1999) | Provides mental health and substance use services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties as a behavioral health carve out. (Acute and long term care services are provided by other Medicaid managed care plans (e.g. STAR, STAR+PLUS). NorthSTAR is under the direction of the Department of State Health Services. | Mandatory for individuals who are Medicaid eligible and for persons deemed medically indigent in need of behavioral health services. Must be eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall, and Kaufman counties. | Inpatient services: 0.5%  
Intensive outpatient or partial hospitalization services: 0.0%  
Outpatient or ED services: 78.1% |
| STARHealth (start date: 2008) | Provides integrated healthcare to children in foster care. Also provides case management and training to families, caregivers, clinicians, case-workers, advocates and members of the judiciary. Services available statewide. | Children in the Department of Family & Protective Services guardianship; youth in child protective services extended foster care; youth ages 18-21 previously in foster care and receive Medicaid for Transitioning Youth; former foster care youth ages 21-23 | Inpatient services: 7.0%  
Intensive outpatient or partial hospitalization services: 1.6%  
Outpatient or ED services: 9.4% |
| Children’s Health Insurance Program (CHIP) (start date: 1999) | Managed care program that provides acute health care services to uninsured children living in families with low income. | Uninsured children in families with income under 200% of the Federal Poverty Level. | Inpatient services: 0.2%  
Outpatient or professional services: 5.2%  
ED services: 0.2% |
| STARKids (expected start date: Sept. 2016) | Will provide services to children and youth with disabilities. When implemented, this program will provide both acute care and long term services and supports. Services will be available statewide. | Mandatory for children with disabilities eligible for SSI or Medicaid waiver services. | N/A |

Sources:

Texas Department of State Health Services. Medicaid Services Unit: NorthSTAR. Retrieved from [https://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm](https://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm)


Texas Health and Human Services Commission. (2014, August, 12). Data request: Texas Children’s Health Insurance Program (CHIP) mental health utilization
MEDICAID FUNDING

The federal and state government jointly fund the Texas Medicaid program. Nationally, Medicaid is rapidly becoming the largest source of funding of public mental health services for children, youth, and adults living with mental health conditions or serious emotional disturbance. Total Medicaid expenditures for FY 2011 at the state level were estimated to represent 26 percent ($24.8 billion) of all state expenditures.141

The federal share of the Medicaid program, known as the federal medical assistance percentage (FMAP), is determined on an annual basis and is dependent primarily on the average state per capita income compared to the U.S. average.142 Texas’ matching rates for FYs 2013 and 2014 are 59.30 and 58.69 percent; that is, the state must pay 40.70 and 41.31 percent of all costs respectively.

Small changes in the FMAP can result in funding fluctuations of millions of dollars. Texas’ rate of federal participation has been steadily declining over the last decade as the states’ average per capita income has increased relative to the national average. This decline was mitigated by three years of enhanced federal funds due to the American Reinvestment and Recovery Act, but those funds are no longer in place. As an illustration of Texas’ overall trend of decreasing federal portion of funding for the Medicaid program, Texas’ FMAP in 1998 was 62.28 percent, compared to the FY 14 FMAP of 58.69 percent.
ELIGIBILITY FOR MEDICAID SERVICES

Medicaid was originally only available to recipients of cash assistance programs such as Temporary Assistance for Needy Families (TANF) and/or Supplemental Security Income (SSI). However, during the late 1980s and early 1990s, the federal government expanded the program to meet the needs of a broader population, including pregnant women, the elderly and people with disabilities, de-linking Medicaid eligibility from receipt of cash assistance.

In determining program eligibility, Texas considers a variety of factors such as income and family size, age, disability, pregnancy, citizenship and state residency requirements. Medicaid covers the three primary categories:

- Low-income parents, pregnant women and children.
- People over 65 years old and people with disabilities.
- Cash assistance recipients.

A common misperception is that being poor is sufficient to qualify for Medicaid. However, to be eligible for Medicaid, an individual must meet income and categorical requirements.

The income eligibility requirements for each Medicaid category are as shown below in Figure 15.

**Figure 15. Subsidized Coverage in Texas & Annual Income Levels: 2014**

<table>
<thead>
<tr>
<th>Federal Poverty Level</th>
<th>Individual</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>$1,750</td>
<td>$3,577</td>
</tr>
<tr>
<td>100%</td>
<td>$11,670</td>
<td>$23,850</td>
</tr>
<tr>
<td>133%</td>
<td>$15,521</td>
<td>$31,720</td>
</tr>
<tr>
<td>200%</td>
<td>$23,340</td>
<td>$47,700</td>
</tr>
<tr>
<td>400%</td>
<td>$46,680</td>
<td>$95,400</td>
</tr>
</tbody>
</table>

There are over 30 different Medicaid eligibility categories in Texas. Some of the primary categories include:

- Individuals/families receiving Temporary Assistance for Needy Families (TANF).
- Individuals receiving Supplemental Security Income (SSI).
- Pregnant women with infants and children.
- Older adults and people with disabilities.
- Individuals who are medically needy.
- Certain working individuals with disabilities.

Texas’ decision to not expand Medicaid as allowed under the ACA means that the categorical nature of Medicaid will continue to exclude many individuals, such as childless adults or working low-income parents. A helpful statistic to describe the role of categorical eligibility in the Medicaid program is that the number of non-disabled, non-pregnant adults in the Medicaid program is 0.

Eligible Medicaid recipients, including adults and children, have access to mental health and substance use services included in the Medicaid State Plan, such as psychiatric services, counseling, and medication and medication management. Medicaid also funds mental health safety net services provided through DSHS and local mental health authorities. These services are described in the DSHS section.

A comprehensive description of the covered behavioral health services is provided in the Figure 16 below.

---

**Figure 16. Medicaid-Funded Behavioral Health Services**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Medicaid Behavioral Health Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Mental health assessment and diagnosis</td>
</tr>
<tr>
<td>Services</td>
<td>Therapy by psychiatrists, psychologists, licensed clinical social workers licensed professional counselors and licensed marriage and family therapists</td>
</tr>
<tr>
<td></td>
<td>Inpatient psychiatric care in a general acute hospital</td>
</tr>
<tr>
<td></td>
<td>Inpatient psychiatric hospitals for persons under 21 and those 65 and older</td>
</tr>
<tr>
<td></td>
<td>Prescription medications</td>
</tr>
<tr>
<td></td>
<td>Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance</td>
</tr>
<tr>
<td></td>
<td>Ancillary services required to diagnose or treat behavioral health conditions</td>
</tr>
<tr>
<td></td>
<td>Behavioral services provided by a primary care physician</td>
</tr>
<tr>
<td></td>
<td>Comprehensive community services for YES waiver participants (see DSHS section)</td>
</tr>
</tbody>
</table>

---

“Currently in Texas, childless adults are not eligible for Medicaid at any income level. Parents are eligible only if income is below 15% of the federal poverty level ($3,577 annual income for a family of 3). People with disabilities receiving Social Security Income (SSI) are only eligible if income does not exceed 74% of the federal poverty level ($8,266 annual income for an individual).”

**Service Type** | **Medicaid Behavioral Health Services:**  
---|---  
Substance Use Services | Outpatient adolescent chemical dependency counseling by state-licensed facilities  
| Assessment and diagnosis  
| Medication assisted therapy  
| Outpatient and residential detoxification  
| Outpatient counseling and treatment  
| Residential treatment  


## DEMOGRAPHICS OF MEDICAID RECIPIENTS

Women and children account for the majority of the individuals receiving Medicaid benefits. In 2011, 55% of the Medicaid population was female and 77% was under the age of 21. Children without disabilities account for nearly 66% of all Medicaid recipients, but they represent only 33% of spending on direct health-care services. In contrast, individuals who are elderly or have a disability only account for 25% of the Medicaid population but represent over 58% of total estimated expenditures. Figure 17 below displays percentage of Medicaid populations by demographic category and their estimated corresponding expenditures.

### Figure 17. Texas Medicaid Beneficiaries and Expenditures, 2011


FEDERALLY QUALIFIED HEALTH CENTERS

Many of the services listed in Figure 16 are provided by federally qualified health centers (FQHCs), which are health care entities that receive grants through Section 330 of the Public Health Services Act. FQHCs play an important role in providing comprehensive health care services for people with public health insurance such as Medicaid, or people who are otherwise low-income and uninsured or underinsured. There are 70 FQHCs in Texas with more than 300 sites delivering services. In 2011, these sites served 975,509 individuals.

While FQHCs receive grant funding from the federal government, they also receive enhanced reimbursements for providing services to individuals receiving Medicaid and Medicare services. These reimbursements are designed to cover the additional costs associated with provided comprehensive care to both uninsured and publicly funded patients. Increasingly, FQHCs are transforming their practices to health homes or comprehensive medical homes to improve the coordination and integration of care for clients with multiple chronic conditions, including mental health and substance use.

MEDICAID BUY-IN PROGRAMS (ADULTS AND CHILDREN)

The Texas Medicaid buy-in programs allow adults and children with disabilities to enroll in Medicaid when their income levels exceed normal eligibility limits. Participants must meet certain income criteria and may be required to pay a monthly premium. The health care services provided are the same as in the traditional Medicaid program.

The Texas Medicaid buy-in program for adults is available to persons with a disability who are working and who do not live in a state institution or nursing home. The Texas Medicaid buy-in for children is available to families who have a child with a disability who is age 18 or younger, a U.S. citizen or legal resident, and not married. Most families are required to pay monthly premiums, copays or deductibles. Cost-sharing is based on income, the number of people in the family, and access to employer-provided insurance or the Medicaid Health Insurance Premium Payment Program (HIPP).

MEDICAID HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP)

The Health Insurance Premium Payment Program (HIPP) is a Medicaid program that covers the expenses of medical premiums. The program reimburses Medicaid-eligible employees for payments for health insurance received through their employer. The Texas Medicaid and Healthcare Partnership (TMHP) establishes the actual Medicaid costs for the Medicaid recipient.

In order to qualify for the program recipients must remain Medicaid eligible and employer-provided policies must be considered cost effective. Past Medicaid payments are compared with the cost of the premiums, coinsurance, deductibles and cost sharing for the best policy covered by the recipient’s employer. If the cost of insurance is less than what TMHP or HHSC would spend in Medicaid payments, then the policy is deemed cost effective.
The Texas Medicaid and Healthcare Partnership (TMHP) is a coalition of companies operating under a single contract with HHSC to carry out the state’s Medicaid claims payments process for the traditional, fee-for-service system. TMHP does not process claims for services provided by managed care organizations (MCOs), but does collect encounter data from MCOs to use for the evaluation of quality and utilization of managed care services.

As a result of concerns about improper billing, the lead contractor in the TMHP coalition switched from Affiliated Computer Services to Accenture. At present, HHSC is planning to break the large contract into smaller, separate contracts to make it easier to take action against a vendor without disrupting medical care for people with Medicaid.

### Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act. As with Medicaid, CHIP is jointly funded by the state and federal governments. State participation in CHIP requires approval of a CHIP plan by the Centers for Medicare and Medicaid Services (CMS). While CMS allows states to combine both the Medicaid and CHIP programs, Texas currently administers these programs separately.

### Eligibility for CHIP

CHIP is available for children aged 0–19 with income up to 200 percent of the federal poverty level (annual income of $47,700 for a family of four) so that low-income children can have access to health care, including inpatient and outpatient mental health and substance use services. CHIP was developed to provide health insurance coverage for children whose families had too much income or assets for Medicaid, but not enough to access individual or family insurance through employment or on their own. CHIP requires cost-sharing with enrollment fees and co-payments based on family income.

### Enrollment, Utilization and Costs

In 2011, the mean age in CHIP was 10 years old, with 17 percent of the population below the age of 5 and 61 percent of the population between 6 and 14 years old. Monthly enrollment levels in CHIP have increased steadily over the past decade, reaching more than 602,000 members per month in 2013 (Figure 18). Recently, however, there has been a noticeable dip in enrollment figures, with 495,187 children enrolled in CHIP as of April 2014. This is partially a result of the ACA, which allows the CHIP population from 100 percent to 133 percent of the federal poverty level to transition into Medicaid.
Although CHIP spending has experienced sporadic growth up until 2013, the FY 2016-2017 LAR predicts a decline in funding. It is estimated that 71 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services; 19 percent on prescription drugs; and the remaining 10 percent on administration.\(^\text{148}\)

**Figure 18. CHIP Enrollment**

![CHIP Enrollment Chart]


**Figure 19. Legislative Appropriations Request FY 2016-2017: CHIP Services**

![Legislative Appropriations Chart]

Behavioral Health Quality of Care Measures

Texas contracts with the Florida Institute for Child Health Policy to perform the external quality review for the Texas Medicaid Managed Care programs. Outcomes are compared to national Healthcare Effectiveness Data and Information Set (HEDIS) standards, when available, or to benchmarks that HHSC establishes. The national HEDIS standards are used across the country to measure performance in important areas of health care, including behavioral health services.

Statistics for selected Medicaid and CHIP behavioral health quality of care measures are presented in Figure 20 and selected behavioral health performance measures are shown in Figure 20.

**Figure 20. Selected Behavioral Health Quality of Care Measures for Medicaid and CHIP Programs**

<table>
<thead>
<tr>
<th>Program</th>
<th>Measure</th>
<th>Performance</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STAR</strong></td>
<td>After dispensing new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 7 days</td>
<td></td>
<td>40%</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 30 days</td>
<td></td>
<td>68%</td>
<td>72%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>Readmission within 30 days - Adults</td>
<td></td>
<td>21% (all ages)</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Readmission within 30 days - Children/Adolescents</td>
<td></td>
<td>Not available separately</td>
<td>10%</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>STAR+PLUS</strong></td>
<td>Antidepressant medication management within 3 months (follow-up visit after dispensed)</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antidepressant medication management within 6 months (follow-up visit after dispensed)</td>
<td>Not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 7 days</td>
<td></td>
<td>40%</td>
<td>46%</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 30 days</td>
<td></td>
<td>67%</td>
<td>72%</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Readmission within 30 days - Adults</td>
<td></td>
<td>24% (all ages)</td>
<td>25%</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Readmission within 30 days - Children/Adolescents</td>
<td></td>
<td>Not available separately</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Program</td>
<td>Measure</td>
<td>Performance</td>
<td></td>
<td></td>
<td></td>
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<td>---------</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>2010</td>
<td>2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>83%</td>
<td>89%</td>
<td>86%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR Health</td>
<td>After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)</td>
<td>91%</td>
<td>94%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 7 days</td>
<td>61%</td>
<td>70%</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 30 days</td>
<td>88%</td>
<td>92%</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Readmission within 30 days - Adults (represents only 5% of STAR Health population)</td>
<td>28%</td>
<td>28%</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>CHIP</td>
<td>After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)</td>
<td>Not available</td>
<td>45%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 7 days</td>
<td>Not available</td>
<td>45%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up care after hospitalization for mental illness within 30 days</td>
<td>Not available</td>
<td>74%</td>
<td>71%</td>
<td></td>
</tr>
</tbody>
</table>


Texas Department of State Health Services: At A Glance

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<td>NorthSTAR Services</td>
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<td>NorthSTAR Service Utilization and Costs</td>
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<td>Quality of Care Measures</td>
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<td>Access</td>
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<td>117</td>
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<td>Priority Populations</td>
<td>117</td>
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</tbody>
</table>
POLICY CONCERNS

- Increased access to quality community-based services through integrated health care service delivery
- Expansion of peer specialist/recovery coach support services
- Funding for diversion services to prevent relinquishment of children
- Accountability and meaningful performance measures
- Integration of behavioral health services into managed care
- Inpatient capacity shortage and the need for forensic services
- Need for system wide coordination of forensic issues, perhaps through a DSHS forensic director
- Evaluation of jail-based competency restoration pilot
- Length of incarceration while waiting for competency restoration services
- Statewide expansion of YES waiver services
- Critical mental health workforce shortage
- Deteriorating inpatient physical plant with archaic design
- Reduction of restraint and seclusion in state hospitals and other settings

FAST FACTS

- Texas entered the 83rd legislative session ranking 49th in per capita mental health spending, or $34.57 per resident.
- Realizing that transformative actions were imperative to expand access to mental health services, nearly $350 million more was appropriated for FY 2014 and 2015 than was allotted in the previous biennium.
- In FY 2013, 156,642 (31 percent) of the 499,389 adults with serious and persistent mental illness were served by DSHS-funded community mental health centers and NorthSTAR. Similarly, only 47,086 (27 percent) of the 175,137 children with serious emotional disturbances were served by DSHS-funded community mental health centers and NorthSTAR.\(^{150}\)
- In Texas during FY 2013, 54,914 (3 percent) of the 1,776,671 adults and 6,928 (4 percent) of the 187,837 youth with chemical dependence and medical indigence were served by DSHS-funded substance abuse providers, including the NorthSTAR program.\(^{151}\)
- Public mental health services are primarily provided through 39 local mental health authorities (LMHAs), commonly known as community mental health centers.
- NorthSTAR is a managed care carve-out program created to improve the delivery of behavioral healthcare in seven North Texas counties.
Texas Department of State Health Services

Texas Department of State Health Services (DSHS) is the state mental health and substance use authority for Texas. Within DSHS, the Mental Health and Substance Abuse Services Division (MHSA) oversees the public behavioral health service delivery system.

Public behavioral health services, comprised of community mental health services, substance use services and hospital services, are provided in each of the 254 counties distributed across the state’s 11 health and human service regions. The MHSA Services Division provides oversight, monitoring, and strategic direction for these public behavioral health services. The division also manages activities associated with NorthSTAR, the behavioral health managed care program in the North Texas service area.

Changing Environment

The 83rd Legislative session brought significant changes to the delivery and management of the state’s behavioral healthcare system. Restoration of critically necessary funds and the approval of numerous behavioral health initiatives during the last session play a pivotal role in increasing the provision of and timely access to behavioral health services for individuals with mental health conditions.

SB 58 (Nelson) established a new strategy in Texas for the delivery of behavioral health treatment. SB 58 will integrate funding for key behavioral health services, specifically psychosocial rehabilitation and targeted case management, within Texas’ Medicaid managed care system by September 2014. These two Medicaid services are a core component of the service array for people with serious mental illness, but have historically been delivered outside of Medicaid managed care under a payment arrangement that limited the provider network eligible to receive Medicaid reimbursement to the local mental health authorities. Although it will be difficult to determine the full impact of SB 58 until proper data collection and outcome evaluation have been conducted, the goal of the integration is to streamline the coordination of services and continuity of care as well as improve health outcomes for Medicaid populations.

The additional major legislative actions are comprised of new and expanded mental health projects. One notable legislative directive is Rider 80, which directs HHSC and DSHS to expand the Youth Empowerment Services (YES) waiver statewide. The expansion of the waiver will allow more youth with serious emotional disturbance to access intensive community behavioral services and decrease the number of children relinquished to Department of Family and Protective Services (DFPS) solely to access needed mental health services. Additionally, DSHS is funding 10
beds in private residential treatment centers (RTCs) for youth at risk for parental relinquishment due to a severe emotional disturbance (SED) and inability to access necessary RTC services. Due to high demand, additional funds were allocated to support 3 more beds in FY 2014. There are currently 13 children placed with 20 children on the waitlist.153

The implementation of the 1915(i) Home and Community Based Services (HCBS) state plan amendment option will be the first HCBS program for adults with a mental health condition with lengthy state psychiatric hospital stays. DSHS, in coordination with HHSC, is seeking federal approval for a 1915(i) state plan amendment. Formal submission of the plan will take place in the summer of 2014 and program implementation is anticipated for November 2015, contingent on Center for Medicare and Medicaid Services (CMS) approval.154

The session also directed the creation of a statewide mental health public awareness campaign to increase public understanding of behavioral health and reduce the stigma of mental health and substance use conditions. The campaign targets adolescents and young adults (14-24) as well as their support systems to demystify and provide resources for mental health and substance conditions throughout Texas. The campaign, which began in June 2014, includes marketing tactics such as a website (speakyourmindtexas.org), online media and broadcast media on television and radio available in both Spanish and English. As of August, 2014, more than 30,000 individuals visited the website for information and resources, averaging 5,000 visitors each week. Additionally, as of August, 2014, six of the 16 community conversations were held in an effort to bring stakeholders together to create local forums and action plans.155

Another initiative that has increased opportunities for recovery for individuals experiencing behavioral health conditions is the use of certified peer support specialists throughout Texas. Deemed an evidence-based practice by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), peer support programs allow individuals who have both lived experience and relevant training to aid in the recovery of others experiencing mental health conditions by focusing on recovery, wellness, self-direction, responsibility and independent living. Peer support specialists are a cost-effective and clinically effective intervention to reduce the frequency of other more intensive and more expensive services, resulting in lower costs and better outcomes. Texas has undergone a thorough process to develop certification requirements for mental health peer specialists and substance use recovery specialists. Via Hope is the organization sanctioned by DSHS and jointly funded by DSHS and the Hogg Foundation for Mental Health to train, educate and certify peer specialists.

Additionally, Rider 83 of SB 1(83rd) requires DSHS, in conjunction with DADS, to develop and implement a 10-year plan on the future of state hospitals and state supported living centers. This plan will outline operational needs, infrastructure needs, capacity issues and methods for serving individuals in their community. The plan will also include best practices within inpatient settings and transitional services for individuals returning to the community. The plan will be submitted to the Governor and Legislative Budget Board (LBB) by December 1, 2014.

Other significant initiatives that are further discussed in this section include state
hospital infrastructure repairs, initiatives to eliminate wait lists for community mental health services, expansion of the priority populations served by Local Mental Health Authorities (LMHAs), creation of a jail-based restoration pilot in Dallas, and expansion of crisis service programs.

## Trends and Prevalence

### FUNDING

In 2013, DSHS health strategies were funded by the following major sources:

- State general revenue dedicated (17 percent) (includes a one-time transfer of $137,860,100 to the EMS-Trauma general revenue dedicated account for the Medicaid disproportionate share hospital program).
- State general revenue (36 percent).
- Federal funds (38 percent) (including both Medicaid dollars from CMS and block grant funding from SAMHSA).
- Other funds (9 percent).

Texas entered the 83rd legislative session ranking 49th in per capita mental health spending, or $34.57 per resident, well below the national average of $103.53. The Sandy Hook Elementary and Aurora movie theater shootings in 2012 turned the country’s attention to failures in the nation’s mental health system. Realizing that transformative actions were imperative to expand access to mental health services, nearly $350 million more was appropriated for FY 2014 and 2015 than was allotted in the previous biennium. This increase put an end to a decade of flat funding for behavioral health. The FY 2014–2015 DSHS budget contains an unprecedented $2.6 billion for the public mental health system, with $1.7 billion from the state general revenue. Every line item detailed in Figure 21 received significant funding gains for FY 2014/2015.
The following figure details DSHS funds for FY 2013 expenditures and FY 2014/2015 appropriations by budget strategy.

**Figure 21. Texas Public Behavioral Health Spending: Annual Spending 2003-2015**

![Graph showing annual spending from 2003 to 2015 for different categories of public behavioral health spending.](image)


**Figure 22. FY 2013 State Expenditures, FY 2014 – 2015 Appropriations and FY 2016-2017 Legislative Appropriations Request (all funds)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services-Adults</td>
<td>$285,828,525</td>
<td>$343,855,680</td>
<td>$314,370,271</td>
<td>$324,546,422</td>
<td>$324,546,421</td>
</tr>
<tr>
<td>Mental Health Services-Children</td>
<td>$59,732,529</td>
<td>$96,581,563</td>
<td>$108,430,662</td>
<td>$105,798,676</td>
<td>$105,798,674</td>
</tr>
<tr>
<td>Community Mental Health Crisis Services</td>
<td>$84,006,025</td>
<td>$106,716,332</td>
<td>$115,155,291</td>
<td>$110,829,718</td>
<td>$110,829,717</td>
</tr>
<tr>
<td>NorthSTAR Behavioral Health Waiver</td>
<td>$123,383,334</td>
<td>$122,834,933</td>
<td>$119,228,465</td>
<td>$130,626,310</td>
<td>$130,626,308</td>
</tr>
<tr>
<td>Substance Use, Prevention, Intervention and Treatment</td>
<td>$136,191,615</td>
<td>$157,893,764</td>
<td>$149,956,982</td>
<td>$150,011,077</td>
<td>$150,011,076</td>
</tr>
<tr>
<td>Mental Health State Hospitals</td>
<td>$405,014,273</td>
<td>$433,612,004</td>
<td>$419,788,110</td>
<td>$420,992,251</td>
<td>$420,992,249</td>
</tr>
<tr>
<td>Mental Health Community Hospitals</td>
<td>$67,501,308</td>
<td>$77,675,356</td>
<td>$79,971,621</td>
<td>$79,971,621</td>
<td>$79,971,620</td>
</tr>
<tr>
<td>Total</td>
<td>$1,161,657,609</td>
<td>$1,339,169,632</td>
<td>$1,306,901,402</td>
<td>$1,322,776,075</td>
<td>$1,332,776,065</td>
</tr>
</tbody>
</table>

From FY 2008 through FY 2013, roughly 1.1 million adults and children received community mental health services in Texas through local mental health authorities (LMHAs) and NorthSTAR. The unduplicated number of persons provided mental health services through these entities has increased by approximately 40 percent during this period, and is largely driven by increased utilization from adults.\(^{159,160}\) While the amount of funding per person has increased as a result of mental health appropriations during the 83rd session, the previous decade of stagnant funding was unable to keep pace with the increased cost of services, resulting in fewer services being available and a smaller percentage of persons receiving services.\(^{161}\)

As illustrated in Figure 23, there are many more adults and children who require mental health services than are currently being served in the public mental health system. In FY 2013, 156,642 (31 percent) of the 499,389 adults with serious and persistent mental illness were served by DSHS-funded community mental health centers and NorthSTAR. Similarly, only 47,086 (27 percent) of the 175,137 children with serious emotional disturbances were served by DSHS-funded community mental health centers and NorthSTAR.\(^{162}\)

**Figure 23. Unmet Needs for Community Mental Health Services**

Adults (FY 2013)  

- **Texas Population (age 18+)**: 19,031,914  
- Estimated number with serious and persistent mental illness: 499,389  
- Number served in DSHS funded community mental health services including NorthSTAR: 156,642 (31% Need Met)

Children (FY 2013)  

- **Texas Population (age 9-17)**: 3,618,748  
- Estimated number with Severe Emotional Disturbance: 175,137  
- Number served in DSHS funded community mental health services including NorthSTAR: 47,086 (27% Need Met)

Source: Texas Department of State Health Services. (2014). Presentation to senate health and human services committee: Overview mental health and substance abuse services [PowerPoint slides]. www.dshs.state.tx.us/legislative/default.shtm
When LMHAs have exhausted their funding, non-Medicaid eligible individuals who require mental health services are added to a waitlist. However, individuals who are on Medicaid must be admitted into services because federal law prohibits waitlists for Medicaid. Additionally, if the individual is approved for Medicaid while on the waitlist, the LMHA has 60 days to expedite the individual into services. All other individuals who are eligible for mental health services but do not have Medicaid are placed on the waitlist due to lack of capacity. These individuals are contacted every 90 days by a mental health professional to ensure there is no additional mental health deterioration. If clinical deterioration is assessed and immediate intervention is required, the individual may be placed into services.

From FY 2009 to FY 2012, the number of adults on waitlists for community mental health services increased by 85 percent, while the average monthly number of adults served remained constant. Children on waitlists for community mental health services decreased by 24 percent during the same period due to a special appropriation in FY 2010; however waitlists still remained a significant barrier to accessing timely services. Like the population of adults served by community mental health services, the average monthly number of children served has remained constant.

Recent legislative attempts have successfully addressed waitlist issues. Portions of the supplemental mental health funding appropriated by the 83rd legislature fully funds adults and children requiring mental health services and children with special health care needs who were on the waitlist as of May 2012. Additionally, Rider 92 included in SB 1 (appropriations bill) appropriated over $48.2 million to eliminate wait lists for adult and child community mental health services. DSHS was also appropriated $43 million through Rider 85 to expand community health service and address the needs of individuals who are underserved due to resource limitations as well as to address the demands of a growing population and surge in demand for services.

At the end of FY 2013, 7,947 adults and 241 children were on the waiting lists. As a result of passed legislation, by the end of May 2014 these numbers decreased drastically, with 285 adults and zero children on waitlists. Additionally, as of March 2014, 1,435 adults had been moved into an appropriate level of care (LOC).
Figure 24. Impact of Adult Waiting List by Adults Served - FY 2012 - FYTD May 2014


Figure 25. Impact of Child Waiting List by Children Served - FY 2012 - FYTD May 2014

Timeline of Mental Health Service Initiatives

Despite limited funding over the past decade, DSHS has made sustained efforts to implement innovation in service delivery through major system initiatives presented in the timeline below. The following initiatives reflect a shift towards a modern delivery system which emphasizes services that are person-centered, rooted in recovery and resilience, offer alternatives to institutionalization, improve access and provide a full continuum of care.

2004
- DSHS begins roll out of the resiliency and disease management (RDM) model which created fundamental changes in the type and amount of services delivered to people with mental health conditions. The RDM model relies on evidence-based practices and principles of recovery to obtain the best possible consumer outcomes and maximize available dollars.

2007
- The 80th Texas Legislature appropriates $82 million to address problems in the state’s mental health and substance use crisis service delivery system. Funds were intended to create statewide access to more effective crisis services.

2008
- Outpatient competency restoration (OCR) pilot serves its first clients. OCR helps individuals with serious mental illness who have been charged with a crime to receive restoration services in their own communities rather than in more restrictive settings.

2009
- Center for Medicaid Services (CMS) approves DSHS and HHSC Youth Empowerment Services (YES) waiver proposal, allowing greater flexibility in the funding of community-based services and supports for youth with serious emotional disturbances. Pilot programs began in Bexar and Travis Counties in 2011, Tarrant County in 2012, Harris, Brazoria, Fort Bend and Galveston counties in February 2014 and Cameron, Hidalgo and Willacy counties in June, 2014.

2010
- DSHS begins statewide implementation of a recovery-oriented system of care (ROSC) initiative. The initial elements of the ROSC initiative are developed in communities to help ensure that persons affected by substance use and mental health conditions are provided a continuum of services and a continuous path to recovery.

2011
- Texas receives a federal approval to implement a 1115 Transformation Waiver to transform the state’s mental health infrastructure across agencies through “innovative, consumer-focused, practical and sustainable infrastructure solutions to systemic problems that hinder mental health effectiveness.”

2012
- DSHS begins implementing system changes to RDM, including a name change to Texas Resiliency and Recovery (TRR). The system further emphasizes recovery-oriented system of care focusing on fidelity and evidence-based practices.
2013
- The 83rd Legislative session appropriates roughly $350 million additional funds for mental health services and initiatives including housing services, expanded treatment capacity of alternatives to institutionalization, expansion of YES Medicaid waiver, as well as expanding the breadth of behavioral health services included in Medicaid managed care.

2014
- The transition of behavioral health rehabilitative services and targeted case management into Medicaid managed care begins as of September 1, 2014.

Access

DSHS prioritizes access to services for persons with serious mental health conditions who are eligible for Medicaid, determined to be indigent or fall under the Department’s priority populations (see below). Resources, eligibility and service delivery systems are the primary determinants of access and quality. Texas continues to seek ways to improve access so that individuals with mental health conditions can receive the appropriate level of care and support.

Medicaid

Medicaid is a federal and state funded program that serves low income individuals who also meet other categorical eligibility requirements (e.g. have a disability). Medicaid covers acute health care and long-term services and supports for families, children, pregnant women, older adults and people with disabilities. Only U.S. citizens or legal permanent residents who live in Texas meet the necessary categorical eligibility requirements and have an income less than the federal poverty level (FPL) shown in Figure 26 may qualify for Texas Medicaid.

Figure 26. Subsidized Coverage in Texas & Annual Income Levels: 2014

<table>
<thead>
<tr>
<th>FPL</th>
<th>Individual</th>
<th>Family of 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>$1,750</td>
<td>$3,577</td>
</tr>
<tr>
<td>100%</td>
<td>$11,670</td>
<td>$23,850</td>
</tr>
<tr>
<td>133%</td>
<td>$15,521</td>
<td>$31,720</td>
</tr>
<tr>
<td>200%</td>
<td>$23,340</td>
<td>$47,700</td>
</tr>
<tr>
<td>400%</td>
<td>$46,680</td>
<td>$95,400</td>
</tr>
</tbody>
</table>


On average, 3.6 million adult and 2.6 million child Texas residents are enrolled in Medicaid. Most of these Texans will receive health services through Medicaid managed care (discussed in the Service Providers section). The state has no current

Hogg Foundation for Mental Health | A Guide to Understanding Mental Health Systems and Services in Texas
plans for expanding Medicaid coverage through the state-optional Affordable Care Act (ACA) provision to adults below 100 percent of the FPL who do not have access to insurance through the Marketplace.\textsuperscript{169} If Texas expanded Medicaid coverage to adults up to 138 percent of the FPL, the majority of medically indigent individuals requiring mental health and substance use services served by LMHAs would have access to health insurance.\textsuperscript{170}

**MEDICALLY INDIGENT PEOPLE**

According to the Texas Health and Safety Code, an indigent person is “an individual who: (1) possesses no property; (2) has no person legally responsible for the patient’s support; and (3) is unable to reimburse the state for the costs of the patient’s support, maintenance and treatment.”\textsuperscript{171} Medically indigent individuals who meet the priority population criteria (explained below) are eligible to receive DSHS-funded services through the DSHS system.\textsuperscript{172}

Within the first 30 days of rendering mental health services, a LMHA conducts a financial assessment of an individual’s ability to pay for services and assesses a maximum monthly fee or no fee, depending on the individual’s income.\textsuperscript{173} Individuals whose adjusted income is at or below 200 percent of the FPL are eligible for full funding of substance use services. Individuals whose adjusted income is at or below 150 percent of the FPL are eligible for full funding of other mental health services; otherwise, they are assessed on a sliding fee basis.\textsuperscript{174}

The County Indigent Health Care Program (CIHCP) is one program offering services to individuals who are indigent. CIHCP provides health services through counties, hospitals districts and public hospitals throughout the state to eligible residents whose income does not exceed 21-50 percent (depending on the county) of the Federal Poverty Guideline (FPG) and whose household resources do not exceed $3,000.\textsuperscript{175} As of January 2014, 143 of Texas’ 254 counties operated CIHCPs.

Rider 58 of SB 1 (83\textsuperscript{rd}) requires DSHS to improve the measurement and collection of outcome data for medically indigent individuals and individuals enrolled in Medicaid. DSHS will conduct a comparative analysis on these two populations receiving publically funded behavioral health services and submit a final report on the study findings to the Legislative Budget Board (LBB) and governor by December 1, 2014.

**PRIORITY POPULATIONS**

HB 3793 (Coleman) and SB 7 (Nelson), from the 83\textsuperscript{rd} legislative session, amend the Health and Safety Code to expand treatment services provided by LMHAs to adults with a diagnosed mental health disorder not already authorized by law.\textsuperscript{176} Although treatment services were not previously prohibited to the now expanded populations, the law only ensured the provision of services to adults with schizophrenia, bipolar disorder and major depression.\textsuperscript{177} In an effort to reduce involvement in the criminal justice system and expand access to mental health services, LMHAs are now required by DSHS to manage children, adolescents and adults and with any of the following diagnoses listed in Figure 27.\textsuperscript{178,179}
### Populations

<table>
<thead>
<tr>
<th>Populations</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>Serious functional impairment (GAF less than 50) and severe and persistent mental illness diagnosis of:</td>
</tr>
<tr>
<td></td>
<td>- Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>- Bipolar disorder</td>
</tr>
<tr>
<td></td>
<td>- Major depression, including single episode or recurrent major depressive disorder</td>
</tr>
<tr>
<td></td>
<td>- Post-traumatic stress disorder</td>
</tr>
<tr>
<td></td>
<td>- Schizoaffective disorder, including bipolar and depressive types</td>
</tr>
<tr>
<td></td>
<td>- Obsessive compulsive disorder</td>
</tr>
<tr>
<td></td>
<td>- Anxiety disorder</td>
</tr>
<tr>
<td></td>
<td>- Delusional disorder</td>
</tr>
<tr>
<td></td>
<td>- Bulimia nervosa, anorexia nervosa, or other eating disorders not otherwise specified</td>
</tr>
<tr>
<td></td>
<td>- Any other diagnosed mental health disorder</td>
</tr>
<tr>
<td>Children &amp; Adolescents</td>
<td>Children ages 3 through 17 who have a diagnosis of mental illness, exhibit serious emotional, behavioral or mental health conditions, and meet at least one of the following criteria:</td>
</tr>
<tr>
<td></td>
<td>- Have a serious functional impairment.</td>
</tr>
<tr>
<td></td>
<td>- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms.</td>
</tr>
<tr>
<td></td>
<td>- Are enrolled in a school system’s special education program because of serious emotional disturbance.</td>
</tr>
<tr>
<td></td>
<td>*Children and adolescents with a single diagnosis of autism, pervasive developmental disorder, intellectual disability or substance use do not meet the priority population criteria for mental health services.</td>
</tr>
</tbody>
</table>

### Service Providers

Publicly funded mental health services in Texas are provided by the following three major service providers:

- Medicaid Managed Care
- Local Mental Health Authorities
- NorthSTAR

**MEDICAID MANAGED CARE**

In a Medicaid managed care system, individuals get most or all of their Medicaid services from an organization under contract with the state. The state contracts with a managed care organization (MCO) and pays a capitated rate (per member, per month) for each client enrolled rather than paying the provider a fee for each individual service.
The MCOs are responsible for creating a network of public and private providers to ensure that adults and children receiving Medicaid are able to access a comprehensive variety of services. MCOs are responsible for service authorization and directly contract with and reimburse service providers.

Managed care programs in Texas include:

- State of Texas Access Reform (STAR)
- STAR +PLUS
- STAR HEALTH
- Children’s Health Insurance Program (CHIP)
- CHIP and Children’s Medicaid Dental
- STAR Kids (starting in 2016)

Additional information on managed care programs is available in the HHSC section. SB 58 (Nelson) of the 83rd legislative session directed the integration of behavioral health and physical health services into Medicaid managed care. By September 1, 2014, mental health targeted case management and mental health rehabilitative services must be included in the Medicaid managed care benefit. Targeted case managers provide face-to-face crisis planning and service coordination for Medicaid eligible individuals seeking mental health services. Case managers also regularly monitor service effectiveness. The mental health rehabilitative services include crisis intervention services, medication training and support services, skills training and development services and day programs for acute care.\(^\text{181}\)

HHSC will take responsibility for planning the operational shift from fee-for-services to managed care, the evaluation procedures, and data collection and analysis. Additionally, HHSC will pay for and monitor contracts for specialty mental health services. Data exchange and collaboration between HHSC and DSHS will be crucial in order for DSHS to continue its policy and planning role for Medicaid behavioral services.\(^\text{182}\)

**LOCAL MENTAL HEALTH AUTHORITIES**

Public mental health services are primarily provided through designated local mental health authorities (LMHAs), commonly known as community mental health centers. DSHS contracts with and oversees 39 community centers to provide or arrange for the delivery of community mental health crisis and ongoing services for medically indigent children, adolescents and adults, individuals with a priority population diagnosis as well as those eligible for Medicaid residing in specific geographic areas shown below in Figure 28. Of the 39 centers, 37 are designated LMHAs and two serve as contracted providers in the NorthSTAR service region.\(^\text{183}\)
As an authority, LMHAs are responsible for:

- Allocation of funds from DSHS to ensure mental health and substance use services are provided in the local service area for indigent populations.
- Considering community input, cost effectiveness, and care issues to ensure choice and the best use of public funds in: 1) creation and maintenance of a network of service providers; and 2) recommending the most appropriate and available treatment alternatives for individuals requiring mental health services.
- Demonstrating that the services provided directly or through subcontractors involving state funds comply with pertinent state standards.

The LMHAs are required to plan, develop and coordinate local policy, resources and services for mental health care. Additionally, LMHAs are required to develop external provider networks and serve as a provider of last resort, providing direct services when other providers are unavailable. LMHAs often find it challenging to...
establish successful contracts for services, especially rehabilitation and other routine outpatient services, in part due to extensive mental health workforce shortages in Texas, particularly in rural and Texas-Mexico border areas. Thus, LMHAs typically serve as primary service providers. DSHS oversees the quality of services provided to individuals and regularly provides both training and technical assistance to LMHAs.

A person who is indigent or Medicaid eligible arrives at the LMHA (with or without an appointment), where a psychosocial, diagnostic and uniform assessment is completed. From this process, a level of care (LOC) determination is calculated. If the LOC falls between LOC 1 and LOC 4, the individual becomes eligible for mental health services. The LOC distinctions will be further discussed under the Community Mental Health Services section.

As of September 2014, LMHAs are no longer responsible for network development and payment for Medicaid mental health rehabilitative services and targeted case management, as SB 58 mandates that these services be included in the Medicaid managed care system. However, the LMHA still retains the responsibility for planning and being familiar with resources as well as serving as the primary provider of rehabilitative and targeted case management for people in managed care. Additionally, MCOs contract with LMHAs to serve as Significant Traditional Providers (STPs) for Medicaid-eligible clients.

**NORTHSTAR**

The NorthSTAR managed care carve-out program was created in 1999 in an effort to improve the delivery of behavioral healthcare in seven North Texas counties (Dallas, Collin, Hunt, Rockwall, Kaufman, Ellis and Navarro). With the introduction of NorthSTAR, the state braided funding for mental health and substance use services across several funding streams, thereby establishing a single public behavioral health system. While evaluations of the NorthSTAR system found that the pooled funding approach has resulted in fewer administrative structures for maintaining multiple systems of care, allowing more money to be available for services, it is difficult to compare traditional LMHAs with NorthSTAR due to the vastly differing system structures.

Medicaid-eligible residents in the service region are automatically enrolled in the NorthSTAR program and provided with comprehensive mental health and substance use benefits. Individuals who are not Medicaid recipients but who reside in the service area may also be eligible to receive NorthSTAR services if they meet certain clinical criteria and have an adjusted income at or below 200 percent of the federal poverty level and lack other health insurance. In 2013, NorthSTAR recipients represented roughly 32 percent of the total population of Texas below 200 percent of the federal poverty level.

ValueOptions, a private behavioral health organization, is the Medicaid Managed Care Organization for the NorthSTAR region and is therefore responsible for service delivery, network development, utilization management and claims payment. Local oversight is provided by North Texas Behavioral Health Authority for the NorthSTAR service region. North Texas Behavioral Health Authority has the same local planning, policy and resource development functions as other LMHAs but does not provide direct behavioral health services.
In the third quarter of FY 2013, the unique count of Medicaid enrollees in NorthSTAR was 506,646. Over 74,000 individuals received services from NorthSTAR in FY 2013 in comparison to almost 48,000 in FY 2006, resulting in a 54 percent increase in numbers served over the seven-year period. Unlike the LMHAs, NorthSTAR does not have a waiting list because, by contract, the MCO is required to serve all eligible persons.

## Community Mental Health Services

The array of community mental health services for adults and children includes both ongoing services and crisis services.

### TEXAS RESILIENCE AND RECOVERY FRAMEWORK

The DSHS vision statement of “Hope, Resilience and Recovery for Everyone” aligns with the recent national movement to incorporate resiliency and recovery-based services, practices and beliefs into the public mental health system. The framework under which DSHS delivers public mental health services is known as Texas Resiliency and Recovery. This framework is an outgrowth of the shift in how public mental health services were delivered that was launched in 2004 under the name Texas Resiliency and Disease Management. In September 2012, the Texas mental health system name changed from Resiliency and Disease Management (RDM) to Texas Resiliency and Recovery (TRR) to further reflect the state’s commitment to person-, family- and community-centered recovery-based approaches. The TRR model relies on evidence-based practices (EBPs) and principles of recovery and resilience to obtain the best possible outcomes and maximize available funds.

The TRR system is responsible for:

1. Establishing who is eligible for services through a uniform assessment (Adult Needs & Strengths Assessment (ANSA) and Child & Adolescent Needs & Strengths (CANS))
2. Establishing ways to manage service utilization
3. Measuring clinical outcomes and impacts of services rendered
4. Determining service cost

Clinical needs identified by a uniform assessment (ANSA and CANS) are used to determine the appropriate level of care (LOC) and corresponding services. Within this model, the intensity of services is based on an individual’s respective place on the continuum of mental health need. The expectation is that as strengths are identified and resilience is built, individuals will transition to lower LOCs, and eventually to recovery. Figure 29 describes the adult target population and services. Figure 32 describes the child and adolescent target population and services available at each TRR level of care.
### Figure 29. Texas Resiliency and Recovery Level of Care for Adults

<table>
<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Target Population and Service Goal</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC-0: Crisis Services</td>
<td>General population in crisis. Goal is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.</td>
<td>Brief interventions to address the immediate crisis and prevent the need for more intensive services.</td>
</tr>
<tr>
<td>LOC-1M: Basic Services (Medication Management)</td>
<td>Adults who meet the DSHS definition for priority population who have attained and maintained a level of recovery in treatment except for the ongoing need for medications. Individuals are ready to transition out of the public mental health system and would make the transition if appropriate resources were available. Intended to complement natural and/or alternative supports available in the community that promote recovery. Goal is to prevent deterioration of condition through medication therapy until access to psychiatric and pharmacological resources are available in the community.</td>
<td>Pharmacological management services, routine case management, psychiatric diagnostic interview examination. Provided in outpatient, office-based settings.</td>
</tr>
<tr>
<td>LOC-1S: Basic Services (Skills Training)</td>
<td>Adults who meet DSHS priority population who present little risk of harm, have social supports, do not require more intensive intervention, and can benefit from psychotherapy. The goal of this level of care is to facilitate recovery by reducing/stabilizing symptoms, improve functioning and prevent deterioration of the person’s condition.</td>
<td>All LOC 1M services + skills and training development, engagement activities, supported housing and employment, cognitive processing therapy and peer support. Provided in outpatient and office-based settings.</td>
</tr>
<tr>
<td>LOC-2: Basic Service including Counseling</td>
<td>Adults who have symptoms of major depressive disorder (GAF at or lower than 50) who present little risk of harm, who have supports and a level of functioning that does not require more intensive service, and who can benefit from psychotherapy. Goal is to improve level of functioning and prevent deterioration and to support recovery goals.</td>
<td>All LOC-1 services + psychotherapy services.</td>
</tr>
<tr>
<td>LOC-3: Intensive TRR Services with Team Approach</td>
<td>Adults who meet DSHS priority population who entered the system with moderate to severe levels of need and require intensive rehabilitation. Goal is to support adult in recovery through a team-based approach. Engages individual to stabilize symptoms, improve functioning, develop self-advocacy skills, increase natural support and sustain improvement made in more intensive LOC.</td>
<td>All LOC-2 services + psycho-social rehabilitative services, day programs for acute needs and residential treatment. Services are provided in outpatient office-based and community-based settings.</td>
</tr>
<tr>
<td>Level of Care (LOC)</td>
<td>Target Population and Service Goal</td>
<td>Services</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>LOC-4: Assertive Community Treatment (ACT)</td>
<td>Adults receiving ACT services have severe and persistent mental illness (schizophrenia, bipolar disorder, major depressive disorder with psychotic features, etc.) and have experienced multiple psychiatric hospital admissions at the state and/or community level. Goal is to provide comprehensive array of services and merge clinical and rehabilitation staff within a mobile service delivery team to serve the person in recovery from their home.</td>
<td>All LOC-3 services not including day programs + cognitive processing therapy and cognitive behavioral therapy.</td>
</tr>
<tr>
<td>LOC-5: Transitional Services</td>
<td>Goal is to assist individuals in maintaining stability, preventing further crisis and engaging individual into the appropriate LOC or assisting individual to obtain appropriate community-based services. LOC-5 is highly individualized and service intensity and length of stay depend on individual need. LOC-5 is available for up to 90 days.</td>
<td>All LOC-3 services not including day programs + cognitive processing therapy and cognitive behavioral therapy.</td>
</tr>
</tbody>
</table>


### ADULT SERVICE UTILIZATION AND COSTS

The utilization and costs for adult community mental health services in Texas are included in Figure 30 below.

**Figure 30. Utilization/Cost for Adult Community Mental Health Services**

<table>
<thead>
<tr>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly number receiving community mental health services.</td>
<td>76,325</td>
<td>77,873</td>
</tr>
<tr>
<td>Average cost of community mental health services per adult served.</td>
<td>$372</td>
<td>$366</td>
</tr>
</tbody>
</table>


### QUALITY OF CARE MEASURES

Selected data from FY 2011 to FY 2013 on common adult outcome measures are provided in the Figure 31 below. Other quality measures are reported in the Behavioral Health Databook, available at http://www.the Department of State Health Services.state.tx.us/mhsa/databook.
### Figure 31. Selected Quality of Care Measures for Adults Receiving Community Mental Health Services

<table>
<thead>
<tr>
<th>Quality of Care Measures</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>Performance Contract FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults in community mental health services receiving first service encounter within 14 days of assessment</td>
<td>79%</td>
<td>81%</td>
<td>79%</td>
<td>77%</td>
</tr>
<tr>
<td>Percentage of adults in community mental health services avoiding crisis</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>Percentage of adults in community mental health services with improved or acceptable functioning per year</td>
<td>35%</td>
<td>37%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Percentage of adults in community mental health services admitted 3 or more times in 180 days to a state or community psychiatric hospital</td>
<td>0.38%</td>
<td>0.35%</td>
<td>0.43%</td>
<td>Not available</td>
</tr>
</tbody>
</table>

Note: Data for first three items are from each year’s fourth quarter. Source: Texas Department of State Health Services (2013). Behavioral health data book, FY 2013, fourth quarter [PowerPoint slides]. Retrieved from http://www.dshs.state.tx.us/mhsa/databook/

### Figure 32. Texas Resiliency and Recovery Level of Care for Children and Adolescents

<table>
<thead>
<tr>
<th>Level of Care (LOC)</th>
<th>Target Population and Service Goal</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOC-0: Crisis Services</td>
<td>General child and adolescent population in crisis. Goal is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.</td>
<td>Brief interventions to address the immediate crisis and prevent the need for more intensive services.</td>
</tr>
<tr>
<td>LOC-1: Medication Management</td>
<td>Children and adolescents whose only identified treatment need is medication management. Goal is to maintain stability and utilize the child/youth's and/or caregiver's natural supports and identified strengths to help transition to community based providers and resources, if available.</td>
<td>Children/youth served in this LOC may have an occasional need for routine case management services but do not have ongoing treatment needs outside of medication related services.</td>
</tr>
<tr>
<td>Level of Care (LOC)</td>
<td>Target Population and Service Goal</td>
<td>Services</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>LOC-2: Targeted Services</td>
<td>Children and adolescents must have identified needs in either emotional or behavioral treatment. In general, the child/youth will have low or no life domain functioning needs. Goal is to improve mood symptoms or address behavioral needs while building strengths in the child/youth and caregiver.</td>
<td>The targeted service is either counseling or individual skills training. The only exception occurs when counseling is the primary intervention for the child/youth but individual skills training is also provided as a component of parent skills training. Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available.</td>
</tr>
<tr>
<td>LOC-3: Complex Services</td>
<td>Children and adolescents who have identified behavioral and emotional treatment needs. May also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. Goal is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver.</td>
<td>All services available in LOC-2 + respite services. Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the child/youth and caregiver.</td>
</tr>
<tr>
<td>LOC-4: Intensive Family Services</td>
<td>Children and adolescents who have identified behavioral and/or emotional treatment needs who have significant involvement with multiple child-serving systems. The child or youth is also likely at risk of out of home placement as a result of behavioral and/or emotional needs. These behaviors and/or mood symptoms may have resulted in—or are likely to result in—juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, serious injury to self or others, or death. Goal is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver through a team approach.</td>
<td>All services available in LOC-3 + intensive case management (wraparound). Services should be provided in the most convenient location for the child/youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the child/youth and caregiver. Caregiver resilience is fostered through building upon natural supports and strengths that are identified by the caregiver and linkage to community resources through the wraparound planning process.</td>
</tr>
</tbody>
</table>
### Level of Care (LOC)  
**LOC-YC: Young Child Services**

- Children ages 3-5 with identified behavioral and/or emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions. Goal is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver.

- All service available in LOC-4. Focus of services is placed on the dyad relationship as this relationship is the primary context for young children. These primary relationship(s) set the stage for future social-emotional behavior and future relationship behavior. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services may also be provided via telemedicine, if available, and if fidelity can be maintained. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver.

### LOC-5: Transitional Services

- Intended to assist children and adolescents and their caregivers in maintaining stability, preventing additional crisis events, and engaging the child/youth and caregiver into the appropriate level of care or assisting in accessing appropriate community-based services.

- Highly individualized and the level of service intensity and length of stay is expected to vary based on individual need. Services include routine case management, psychiatric diagnostic interview examination, pharmacological management, medication training and support, counseling, skills training and development, family partner supports, family training, parent support group and engagement activity.


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### YOUTH SERVICE UTILIZATION AND COSTS

The utilization and costs for child and adolescent community mental health services in Texas are included in Figure 33. below.

**Figure 33. Utilization/Cost for Child and Adolescent Community Mental Health Services**

<table>
<thead>
<tr>
<th></th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly number receiving community mental health services.</td>
<td>18,017</td>
<td>17,628</td>
<td>17,878</td>
</tr>
<tr>
<td>Average cost of community mental health services per adult served.</td>
<td>$357</td>
<td>$383</td>
<td>$383</td>
</tr>
</tbody>
</table>

**QUALITY OF CARE MEASURES**

Selected data from FY 2011 to FY 2013 on common child and adolescent outcome measures are provided in the Figure 34 below. Other quality measures are reported in the Behavioral Health Databook, available at [http://www.the Department of State Health Services.state.tx.us/mhsa/databook](http://www.the Department of State Health Services.state.tx.us/mhsa/databook).

![Figure 34. Selected Quality of Care Measures for Children and Adolescents Receiving Community Mental Health Services](image)

<table>
<thead>
<tr>
<th>Quality of Care Measures</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>Performance Contract Target FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children and adolescents in community mental health services receiving first service encounter within 14 days of assessment.</td>
<td>77%</td>
<td>80%</td>
<td>78%</td>
<td>65%</td>
</tr>
<tr>
<td>Percentage of children and adolescents in community mental health services admitted 3 or more times in 180 days to a state or community psychiatric hospital.</td>
<td>0.02%</td>
<td>0.08%</td>
<td>0.07%</td>
<td>Not available</td>
</tr>
<tr>
<td>Percentage of children and adolescents in community mental health services with improved or acceptable functioning per year.</td>
<td>37%</td>
<td>38%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Percentage of children in community mental health services with improved school behavior.</td>
<td>68%</td>
<td>73%</td>
<td>75%</td>
<td>71%</td>
</tr>
</tbody>
</table>


**CRISIS SERVICES**

The Texas Administrative Code defines a crisis as a situation in which:

- Due to a mental health condition, an individual presents an immediate danger to self or others or is at risk of serious deterioration of mental or physical health.
An individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.

In 2007, the 80th Texas Legislature appropriated $82 million to address problems in the state’s mental health and substance use crisis service delivery system. The funds were intended to create statewide access to more effective crisis interventions and to improve responses to behavioral health crisis situations. Similar levels of funding were maintained in the 81st and 82nd legislative appropriations bills. As a result of increased funding, the number of persons using crisis intervention rehabilitation increased dramatically, from under 31,000 in FY 2007 to over 80,000 in FY 2011.

During the 83rd session, an additional $25 million was appropriated in FY 2014 to improve crisis services across the state and enhance community-based psychiatric emergency services projects to serve as alternatives to hospitalization, emergency rooms, or jails. Psychiatric emergency service projects include extended observation units, crisis stabilization units, crisis residential or crisis respite facilities. LMHAs and NorthSTAR competed for project dollars based on demonstrated local need, cost-effectiveness, collaboration with emergency rooms and the criminal justice system, clinical appropriateness, overall design and demonstrated local project support. As a result, 16 new crisis facilities were added and an additional three crisis sites were enhanced.

Crisis services are available statewide to individuals whether or not they are enrolled in ongoing care and include the following services:

### Figure 35. Crisis Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Hotline Services</td>
<td>Available 24 hours per day, seven days per week; all 39 LMHAs and NorthSTAR have or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS)</td>
</tr>
<tr>
<td>Mobile Crisis Outreach Teams (MCOT)</td>
<td>All 39 LMHAs operate a MCOT in conjunction with crisis hotlines; they respond at the crisis site or a safe location in the community</td>
</tr>
<tr>
<td>Crisis Stabilization Units (CSU)</td>
<td>Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms</td>
</tr>
<tr>
<td>Extended Observation Units</td>
<td>Provide 23-48 hours of observation and treatment for psychiatric stabilization</td>
</tr>
<tr>
<td>Crisis Residential Services</td>
<td>Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Crisis Respite Services</td>
<td>Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others</td>
</tr>
<tr>
<td>Crisis Step-Down Stabilization in Hospital Setting</td>
<td>Provides from 3-10 days of psychiatric stabilization in a local hospital setting with a psychiatrist on staff</td>
</tr>
<tr>
<td>Outpatient Competency Restoration Services</td>
<td>Provides community competency restoration treatment to individuals with mental illness involved in the legal system; reduces unnecessary burdens on jails and state psychiatric hospitals; provides psychiatric stabilization and participant training in courtroom skills and behavior</td>
</tr>
<tr>
<td>Transitional Services</td>
<td>Provides linkage between existing services and individuals with serious mental illness not linked with ongoing care; also provides temporary assistance and stability for up to 90 days; adults may be homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, or experiencing multiple psychiatric hospitalizations</td>
</tr>
</tbody>
</table>


**CRISIS SERVICES UTILIZATION AND COSTS**

The utilization and costs for crisis services are included in Figure 36 below.

*Figure 36. Utilization/Cost for Adult Community Mental Health Services*

<table>
<thead>
<tr>
<th></th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly number of persons receiving MH crisis services</td>
<td>5,529</td>
<td>5,667</td>
<td>5,039</td>
</tr>
<tr>
<td>Average monthly cost per person receiving MH crisis services</td>
<td>$401</td>
<td>$401</td>
<td>$459</td>
</tr>
</tbody>
</table>


**QUALITY OF CARE MEASURES**

Selected data from FY 2011 to FY 2013 on crisis services outcome measures are provided in the Figure 37 below. Other quality measures are reported in the Behavioral Health Databook, available at http://www.the Department of State Health Services.state.tx.us/mhsa/databook.
Figure 37. Quality of Care Measures

<table>
<thead>
<tr>
<th>Quality of Care Measures</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>Performance Contract Target FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children and adolescents in community mental health services avoiding crisis.</td>
<td>99%</td>
<td>98%</td>
<td>98%</td>
<td>98.3%</td>
</tr>
<tr>
<td>Percentage of adults in community mental health services avoiding crisis.</td>
<td>98%</td>
<td>98%</td>
<td>98%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>


NORTHEAST SERVICES

NorthSTAR offers a comprehensive array of mental health services through a broad provider network and offers a variety of choices to NorthSTAR members. In concurrence with statewide DSHS programing, NorthSTAR utilizes the TRR model to deliver mental health services to children, adolescents and adults in the priority population. Figure 38 lists NorthSTAR's available mental health services.

Figure 38. NorthSTAR Mental Health Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Treatment planning</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Outpatient counseling (provided by LMSW, LPCs)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychology services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatric services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medication training and support services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychosocial rehabilitation services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Skill training and development</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Employment related services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day program for acute needs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental health, chemical dependency civil commitment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medication services: pharmacological management</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medications</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New generation medications</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Non-Medicaid laboratory work</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient hospitalization (is not an Institution for Mental Disease)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Inpatient hospitalization (is an Institution for Mental Disease)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service</td>
<td>Adult</td>
<td>Child</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Mental health case management</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Respite Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intensive crisis residential services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential treatment centers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal care homes/ assisted living</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Therapeutic foster care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult foster care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early intervention</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>


**NORTHSTAR SERVICE UTILIZATION AND COSTS**

The most commonly utilized mental health services among adult NorthSTAR members are primarily outpatient services. The top services utilized include medication management, case management, individual counseling and group counseling.\(^9\) The following figures include the utilization and costs of services provided by the NorthSTAR program.

**Figure 39. Utilization of NorthSTAR Services By Population**

<table>
<thead>
<tr>
<th>Service</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>20,732</td>
<td>21,153</td>
<td>23,964</td>
</tr>
<tr>
<td>Indigent</td>
<td>24,028</td>
<td>22,251</td>
<td>23,143</td>
</tr>
</tbody>
</table>

Note: Data are from each year’s third quarter.


**Figure 40. FY 2013 COSTS for NorthSTAR Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost for overall mental health services</td>
<td>$131,092,179</td>
</tr>
<tr>
<td>Dollars per capita in service delivery area</td>
<td>$34.19</td>
</tr>
<tr>
<td>Dollar per capita &lt;200% FPL in service delivery area</td>
<td>$95.55</td>
</tr>
</tbody>
</table>

DSHS monitors NorthSTAR on multiple quality and performance measures. Results for selected measures are displayed in Figure 41 below.

### Figure 41. Selected Quality of Care Measures for NorthSTAR

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>NorthSTAR enrollee receiving community services within 7 days after receiving ER services or 23-hour observation</td>
<td>26%</td>
<td>24%</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>NorthSTAR enrollees receiving community services within 7 days of Community Hospital discharge</td>
<td>39%</td>
<td>38%</td>
<td>36%</td>
<td>37%</td>
</tr>
<tr>
<td>NorthSTAR enrollees receiving Emergency or Crisis services within 30 days of Community Hospital discharge</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>NorthSTAR enrollees receiving substance abuse residential treatment and returned to substance abuse residential treatment &gt;30 days with a year of treatment</td>
<td>10%</td>
<td>17%</td>
<td>18%</td>
<td>13%</td>
</tr>
</tbody>
</table>


### Inpatient Mental Health Hospital Services

Inpatient mental health services are provided by state, community and private hospitals to children, adolescents and adults experiencing a psychiatric crisis due to mental illness. Inpatient hospitalization may be necessary for a period of time so that individuals can be closely monitored to provide accurate diagnosis, to help adjust or stabilize medications, to provide intensive treatment during an acute episode where a person’s mental illness temporarily worsens, and/or to assess or restore a person’s competency to stand trial.

Chapter 411 of the Texas Administrative Code defines inpatient mental health treatment as residential care provided in a hospital that includes medical services, nursing services and social services, as well as therapeutic activities and psychological services ordered by the treating physician. Specific services include diagnostics, structured therapeutic programming, liaison with appropriate courts and law enforcement and discharge planning.

There are three types of inpatient commitments providing comprehensive inpatient mental health services: civil, forensic and maximum security.

#### CIVIL

Persons on civil commitments have symptoms of mental illness that result in being a danger to themselves or others. Civil commitments can be for 48-hour emergency detention, 30-day orders of protective custody or 90-day court-ordered mental
health services (which can be extended up to 12 months by the court). Commitments of this nature can either be voluntary or involuntary on the part of the patient.  

**FORENSIC**

Patients on a forensic commitment fall into one of the following two categories: 1) the patient has been admitted to a hospital by judicial order because they have been determined not to have the capacity to stand trial or 2) the patient has been determined to be not guilty by reason of insanity (NGRI). In May of 2014 there were 103 individuals on the forensic waitlist awaiting competency restoration services.

**MAXIMUM SECURITY**

Patients placed in maximum security commitments include: 1) persons who are civilly committed and determined to be manifestly dangerous by professional staff, 2) forensic patients who have been charged with a violent felony offense involving an act, threat or attempt of serious bodily injury and 3) patients who have been to trial and have been found NGRI. Transitional forensic programs are also available for individuals who transfer out of maximum security after they have been determined to be no longer manifestly dangerous.

Only transitional forensic programs and forensic maximum security beds are designated as forensic beds. All other psychiatric beds are available either to civil or forensic patients on a first come first serve basis.

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**Types of Inpatient Settings**

**STATE HOSPITALS**

The State Hospital Services Section of the MHSA Division provides oversight of the nine state mental health hospitals displayed in Figure 42 and one psychiatric residential treatment facility for youth. Each LMHA and NorthSTAR receive an allocation of state hospital resources to coordinate inpatient mental health services for persons residing in counties within a corresponding state hospital service area. The system handled over 22,000 cases in FY 2013.
DSHS designates LMHAs as responsible for achieving continuity of care in meeting a person’s need for mental health services. Within this continuum of care, the state hospital’s primary purpose is to stabilize people by providing inpatient mental health treatment. Each state hospital has a Utilization Management Agreement with a LMHA which requires the LMHA to screen an individual seeking mental health services to determine if the individual requires inpatient psychiatric services. If the screening and assessment determine that there is a need for inpatient psychiatric services, the LMHA decides on the least restrictive treatment setting available, with state hospitals considered as the “provider of last resort.” When the LMHA has not screened and referred the individual, a hospital physician determines if the person has an emergency psychiatric condition appropriate for admission to the state hospital or if the person requires a referral to the LMHA to coordinate alternative services

As displayed in Figure 43 below, there are a total of 2,503 beds across all bed types available for children, adolescents and adults among the state-owned inpatient psychiatric hospitals in Texas. This number excludes publicly funded beds located at community and private hospitals.

*This map excludes the Waco Center for Youth

### Figure 43. Number of Mental Health Beds, by Bed Types, at State Hospitals in Texas, FY 2012

<table>
<thead>
<tr>
<th>State Mental Health Hospitals</th>
<th>Bed Type</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin State Hospital</td>
<td>Adults, adolescents and children</td>
<td>299</td>
</tr>
<tr>
<td>Big Spring State Hospital</td>
<td>Adults only</td>
<td>200</td>
</tr>
<tr>
<td>El Paso Psychiatric Center</td>
<td>Adults, adolescents and children</td>
<td>74</td>
</tr>
<tr>
<td>Kerrville State Hospital</td>
<td>Adults only</td>
<td>202</td>
</tr>
<tr>
<td>North Texas State Hospital</td>
<td>Adults, adolescents and children</td>
<td>640</td>
</tr>
<tr>
<td>Rio Grande State Center</td>
<td>Adults only</td>
<td>55</td>
</tr>
<tr>
<td>Rusk State Hospital</td>
<td>Adults only</td>
<td>365</td>
</tr>
<tr>
<td>San Antonio State Hospital</td>
<td>Adults and adolescents</td>
<td>302</td>
</tr>
<tr>
<td>Terrell State Hospital</td>
<td>Adults, adolescents and children</td>
<td>288</td>
</tr>
<tr>
<td>Waco Center for Youth</td>
<td>Adolescents only</td>
<td>78</td>
</tr>
<tr>
<td><strong>Total, all bed types</strong></td>
<td></td>
<td><strong>2,503</strong></td>
</tr>
</tbody>
</table>

Source: Texas Department of State Health Services (2014, May 19). Data Request: State mental health hospitals


### FUNDING

The 82nd Legislature appropriated approximately $783.4 million in all funds and 7,974 full-time-equivalent (FTE) employees for state hospitals for the FY 2012 – 2013 biennium. Appropriations increased by over $52 million in the 83rd Legislative Session for the FY 2014-2015 biennium.209

Of these appropriations, $30 million has been allocated for essential infrastructure repairs and renovations, including suicide prevention renovation. Under SB 152 (Nelson), funding has also been allotted for additional protections for patients at state hospitals. Some of these protections include mandated FBI background checks on all state hospital employees, volunteers and contracted service providers, random employee drug testing, specific trainings and competency testing before being able to provide direct services, and the development of risk assessment protocols for employees to identify possible instances of abuse or neglect.210

### INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION

Due to the IMD exclusion under current federal law, Medicaid funding to hospitals, whether public or private, can only be used to serve children and adolescents age 21 and younger and eligible adults over the age 65. Due to this federal requirement, state general revenue is the primary funding source for state hospital services for adults between the ages of 22 and 64.

The IMD exclusion in Section 1905 of the Social Security Act defines an IMD as a hospital, nursing facility or other institution with more than 16 beds primarily engaged in providing diagnosis, treatment or care of persons with mental health conditions, including medical attention, nursing care and related services for
individuals under 22 years or over 64 years of age. The IMD exclusion policy has been in place since Medicaid was enacted in 1965 and was intended to promote the expansion of community services and ensure that the federal government did not have to assume financial responsibility for inpatient psychiatric care. Consequently, efforts to improve or expand public inpatient psychiatric services must be funded almost entirely by state general revenue.

STATE HOSPITAL UTILIZATION AND COSTS

In the past eight years, average cost per patient has steadily increased at state hospitals. The yearly average cost per patient served has increased from $11,912 in FY 2006 to $16,192 in FY 2013, increasing by $4,280 or 35 percent over that period.211

As shown in Figure 44, more than 14,000 individuals were admitted to state hospitals in FY 2013. The average cost per person was over $16,000 while the average cost per bed per day was just over $400. The average length of stay was 64 days. 212

<table>
<thead>
<tr>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
</tr>
<tr>
<td>Average cost per person</td>
</tr>
<tr>
<td>Average cost per bed per day</td>
</tr>
<tr>
<td>Average length of stay</td>
</tr>
</tbody>
</table>

Figure 44. Utilization and Costs for State Hospitals

The increase of forensic commitments is a key driver in the upsurge of hospital spending, as commitments of this nature are typically longer and more cost intensive than civil commitments. In FY 2013, the average length of stay for state mental health hospital forensic patients ruled NGRI was 370 days and 135 days for those found IST. In contrast, the average length of stay at discharge was 49 days for civil commitments and only 30 days for voluntary commitments. 213

RECIDIVISM RATES

Over the past decade, state hospital inpatient recidivism rates have decreased. In FY 2001, the percentage of persons readmitted to a state hospital within 30 days was 9.1 percent. By FY 2011, this same rate had decreased to 6.9 percent. As Figure 45 shows, this decrease coincides with an increase in availability of community based treatments as a result of the crisis services redesign in 2007 during the 80th Legislative session and continued support in subsequent sessions. As part of the crisis service enhancement, the number of individuals receiving transitional services increased considerably. These services allow individuals with serious mental illness, who may have already had multiple hospital admissions, 90 days of support services after experiencing crisis while transitioning into ongoing care. 214

Investments in effective community-based services led to reduced need for expensive inpatient care.
Due in part to the need for more forensic beds, DSHS has entered into contracts with community and private hospitals for additional psychiatric bed capacity. For example, in 2011 DSHS began contracting with Montgomery County Hospital, a newly-built private psychiatric hospital operated by GEO Care, in order to increase forensic bed capacity. Community and private hospitals are not owned by the state but receive state funds in order to provide mental health inpatient services to individuals within their community. Figure 46 displays contracted community hospitals, state allocated funds and the number of hospital beds available.

### Figure 46. Contracted Community & Private Hospitals, Allocated Funds and Number of Beds

<table>
<thead>
<tr>
<th>Community Hospital</th>
<th>Annual Funds</th>
<th>Number of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery County</td>
<td>$15,000,000</td>
<td>100</td>
</tr>
<tr>
<td>Harris County</td>
<td>$31,893,696</td>
<td>179</td>
</tr>
<tr>
<td>Gulf Coast Center (Galveston)</td>
<td>$3,726,006</td>
<td>18</td>
</tr>
<tr>
<td>Sunrise Canyon (Lubbock)</td>
<td>$4,126,274</td>
<td>30</td>
</tr>
<tr>
<td>Hill Country MHMR (Kerrville)</td>
<td>$2,357,120</td>
<td>16</td>
</tr>
<tr>
<td>Tri County MHMR</td>
<td>$1,104,125</td>
<td>5</td>
</tr>
<tr>
<td>Center for Health Care Services</td>
<td>$5,520,625</td>
<td>25</td>
</tr>
<tr>
<td>UTHSC-Tyler</td>
<td>$4,635,940</td>
<td>30</td>
</tr>
<tr>
<td>Tropical South Texas Behavioral</td>
<td>$2,208,250</td>
<td>10</td>
</tr>
<tr>
<td>MHMR of Tarrant County</td>
<td>$4,031,060</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$74,603,096</strong></td>
<td><strong>433</strong></td>
</tr>
</tbody>
</table>

Competency Restoration

A criminal defendant found incompetent to stand trial (IST) must be restored to competency before the legal process can continue. In order to be considered competent to stand trial, the defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings. Individuals determined to be incompetent, typically due to mental illness or intellectual disability, may be placed in inpatient psychiatric facilities or outpatient or jail-based competency restoration programs. Figure 47 displays a conceptual framework for placement in a specific program. As shown, placement determination can be dependent on the individual’s clinical complexity and safety risk but also on other additional factors.

Figure 47. Placement Determination For Competency Restoration Programs

STATE PSYCHIATRIC INPATIENT COMPETENCY RESTORATION

In FY 2012, state-run psychiatric facilities provided a total of 940 forensic beds in eight of the 10 state facilities for individuals found IST or not guilty by reason of insanity (NGRI). Individuals charged with violent felony offenses are committed to North Texas State Hospital’s Vernon Campus or Rusk State Hospital for inpatient competency restoration services. In FY 2012, 12.3 percent of all commitments to state-run psychiatric hospitals were for individuals found IST. Because those commitments have a much longer average length of stay, the average daily census for forensic patients nearly equaled that of civil patients. The average cost of competency restoration in a state hospital is over $400 per day.
OUTPATIENT COMPETENCY RESTORATION

In 2007, Texas initiated four outpatient competency restoration (OCR) pilot programs, serving their first clients in 2008. OCR provides community-based services, including mental health and substance use treatment as well as legal competency restoration services that include education to people charged with misdemeanors and non-violent felony offenses. OCR programs can allow low-risk individuals with mental illness to avoid prolonged jail stays, which are costly to local taxpayers and often have the result of exacerbating individuals’ mental illness, making treatment more difficult and generally more expensive.

DSHS developed OCR programs in response to the growing number of forensic commitments to state psychiatric hospitals. For the four pilot sites, the average cost to provide restoration services through OCR in FY 2012 was $11,894 per case, far less than the average cost of $50,520 for inpatient restoration in a state hospital. In addition to avoiding the high cost of hospitalization, OCR can reduce costs to jails and local communities by reducing the length of time individuals remain in jail and eliminating the cost of transporting an individual long distances to an available hospital bed.

At the end of 2013, there were 12 OCR sites across Texas that had served a total of 1,061 individuals. Roughly 51% of individuals had misdemeanor offenses and 49% had felony offenses. The average cost per day for outpatient competency restoration in 2013 was $229. A 2014 study by the Hogg Foundation found that a person’s likelihood of restoration increased with greater lengths of stay, up to a 21-week threshold. After that point, longer lengths of stay were not associated with greater likelihood of restoration. Rider 66 of the 83rd Legislative Session directed an allocation of $4 million in FY 2014 and FY 2015 to support to continuation of existing OCR pilot programs.

JAIL-BASED COMPETENCY RESTORATION

SB 1475 (Duncan), enacted by the 83rd Texas Legislature, authorizes the provision of competency restoration services in a jail-based competency restoration pilot program for individuals who otherwise would be committed to a mental health facility or residential care facility for those services. The bill set out conditions for operating the pilot program, including: (1) requirement of two full psychiatric evaluations not later than the 21st day and 55th day of participation in the pilot program, (2) reporting requirements upon a psychiatrist’s determination of competency restoration or that the individual is unlikely to be restored, (3) requirements upon failure to restore competency within 60 days. A workgroup was convened in September of 2013 for the purpose of establishing and promulgating rules for the pilot program developed through a contract with a private contractor or local mental health authority (LMHA).

Only one proposal was received in response to the DSHS request for proposals to implement and operate the jail-based restoration pilot. The contract was awarded to Liberty Healthcare Corporation, the same corporation that operated a program in San Bernardino, California. The pilot commenced on July 1, 2014 in Dallas, Texas. The pilot is projected to provide 20 beds for restoration purposes. Although not
much information has been released as to the program features of the Texas pilot, the Liberty Healthcare’s comparable California model features:

- Daily groups
- Twice daily 1:1 sessions
- Weekly psychiatrist follow-up sessions
- Weekly case reviews
- Psychological testing

Jails have traditionally not been therapeutic centers; however, with proper staffing ratios and numbers of licensed mental health professionals, inmates may receive the needed treatment in a timelier manner than in an OCR or state-run hospital. As demonstrated in Figure 48 below, to date Texas OCR programs provide treatment at lower costs and higher success rates than the San Bernardino jail-based competency restoration program. However, there are still remaining questions as to the efficacy and success rate of jail-based competency restoration that may be answered by the Texas pilot.

Figure 48 compares the three types of competency restoration programs based on cost, length of stay and restoration success rate.

**Figure 48. Comparison of Competency Restoration Programs**

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Cost Per Day</th>
<th>Avg. Length of Stay</th>
<th>Avg. Total Cost per Individual Served</th>
<th>Success Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Psychiatric Hospital (FY 2012)</td>
<td>$421</td>
<td>120 days</td>
<td>$50,520</td>
<td>75% restored</td>
</tr>
<tr>
<td>Outpatient Competency Restoration (FY 2013)</td>
<td>$229</td>
<td>128 days</td>
<td>$29,312</td>
<td>58% restored or improved with charges dropped*</td>
</tr>
<tr>
<td>Jail-Based Competency Restoration (San Bernadino, CA program, FY 2012)</td>
<td>$278</td>
<td>63 days</td>
<td>$17,514</td>
<td>45% restored</td>
</tr>
</tbody>
</table>

*Percentage is for cumulative success rate for FY 2008-2013.

**The length of stay and cost per individual for the community- and jail-based programs do not reflect the additional time and cost of treating defendants who are not restored to competence and are transferred to the state hospital for additional restoration services.

**Addressing the Shortage of Public Inpatient Beds**

The forensic population’s use of state mental hospital resources has grown significantly over the past decade, from 16 percent in 2001 to 37 percent in 2010. In the same period, the number of state hospital beds had not increased, resulting in corresponding shortage of beds for patients with civil commitments and for patients with forensic commitments requiring competency restoration services. Since 2012,
DSHS has added approximately 200 state-funded beds in contracted community, private, and university hospitals. Although this approach has the potential for relieving immense pressure on the state hospital system, these facilities still provide less capacity compared to state hospitals and only generally serve civil patient populations with less severe mental health conditions.231

As displayed in Figure 49, in 2014 the average daily census of forensic patients represented in DSHS’s state mental health hospitals surpassed civil patients for the first time in the state’s history.232

**Figure 49. Daily Census Snapshot for Civil and Forensic Commitments in State Mental Health Hospitals 2001-2014**

In 2006, DSHS attempted to address this growing issue by implementing a policy requiring all individuals found IST and in need of restoration services to be placed on the DSHS State Hospital Admissions Clearinghouse waitlist, capping the number of state hospital beds used for forensic commitments at 738 state hospital beds. Therefore, admission to one of the 738 designated forensic beds became contingent on availability. Because forensic commitments at state hospitals are typically longer term, bed capacity was reduced to the point that on average, 250 patients were waiting in jail for 6 months or longer for restoration services.233 Delays in receiving timely restoration and mental health services may violate speedy trial provisions in the U.S. Constitution and are extremely detrimental to mental health outcomes and likely contribute to re-offending and cycling back into the judicial system.

In 2012, a Travis County District Court judge ruled on a forensic restoration capacity lawsuit filed by Disability Rights Texas in 2007 which challenged the DSHS clearinghouse waitlist for people found incompetent to stand trial. The ruling initially stated that a defendant deemed IST cannot be held in a jail for more than 21 days prior to admission into a competency restoration program.234

In 2014 the average daily census of forensic patients represented in DSHS’s state mental health hospitals surpassed civil patients for the first time in the state’s history.
As a result of the ruling, DSHS added 40 maximum security beds to North Texas State Hospital (NTSH) and converted 60 non-maximum security forensic beds to maximum security at Rusk State Hospital (RSH). DSHS also converted 60 additional civil commitment beds at NTSH, RSH and San Antonio State Hospital (SASH) to non-maximum security forensic beds as well as purchased 60 new beds for civil commitments from private psychiatric hospitals through the LMHAs. DSHS has also created a 30-bed long-term psychiatric treatment unit housed at the University of Texas Health Science Center at Tyler.

Additionally, during the 83rd legislature, $4.4 million in general revenue was appropriated to renovate Victory Field Campus at North Texas State Hospital-Vernon in order to separate adolescent forensic patients from adult forensic patients. The utilization of Victory Field by the adolescent patients will free space and increase capacity for adult forensic patients. Construction is scheduled to be complete by the end of May 2016.

In May 2014, the Third Court of Appeals in Austin issued a decision overturning the previous order in Disability Rights Texas’ lawsuit. The court found that plaintiffs failed to demonstrate that the list operates in an unconstitutional manner for every detainee. While the court found that the DSHS practice of maintaining the list was not unconstitutional, it indicated that detention beyond a certain period would be unconstitutional.

Substance Use Services

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 25 million Americans struggle with substance use issues. Substance use can result in serious behavioral and emotional challenges. It has the potential to alter an individual’s brain chemistry, and long-term usage can negatively impact behavior, judgment, mood, thought processes and memory. Continued and persistent substance use can also lead to chemical dependency and drug addiction. Ultimately, substance abuse has a significant effect on the individual, family and the community and can both create and exacerbate mental health disorders.

The Assistant Commissioner of the MHSA Services Division serves as the State Substance Abuse Authority (SSA) in Texas for substance abuse prevention, intervention, and treatment services. DSHS provides substance abuse services for eligible youth and adults and contracts with service providers to deliver treatment. The MSHA Services Division is also responsible for creating and implementing policies regarding substance abuse services and defining optimal treatment outcomes.

The Substance Abuse Prevention, Intervention, and Treatment (SAPIT) Program’s primary goal is to provide supports and services for substance use prevention, intervention, and treatment. Major activities relating to substance use include the activities shown below.

Substance Abuse Prevention services include education, skills training for youth and families, community coalition-building and 11 Prevention Resource Centers
(PRCs) that serve as regional information clearing houses.

Substance Abuse Intervention includes outreach, screening, assessment and referral services (OSAR). This program serves as the first point of contact for individuals seeking treatment. Referrals are made for treatment and other appropriate services. Additional services include testing and case management for persons with HIV, specialized female services such as pregnant/postpartum outreach, and special initiatives such as the rural border intervention program for persons at high risk of developing substance use problems.

Substance Abuse Treatment addresses the client’s psychosocial and familial systems to understand appropriate substance use or dependency treatment needs. Treatment services are evidence-based, holistic, and emphasize coordination of care across the continuum of need. These services include both inpatient and outpatient programs. A full list of services provided is shown in Figure 50.

Recovery Support Services are being piloted in FY 2014 and provide support to individuals continuing the recovery process as they transition from treatment into the community.

Tobacco Prevention and Control works to reduce tobacco-related health problems. The program focuses on prevention of tobacco initiation, supporting cessation efforts, eliminating tobacco-related health disparities, supporting efforts to reduce youth access to tobacco, and maintaining the infrastructure throughout the state to carry out these goals.

Only a small portion of individuals requiring substance abuse treatment receive services. Nationally, between 2001 and 2011 the population aged 12 and over increased by 11 percent; during this same 10-year period, however, substance use treatment only increased by 4 percent, indicating a decline in the overall treatment rate.238

In Texas during FY 2013, 54,914 (3 percent) of the 1,776,671 adults and 6,928 (4 percent) of the 187,837 youth with chemical dependence and medical indigence were served by DSHS-funded substance abuse providers, including the NorthSTAR program.239 This discrepancy in utilization and need could be due to shortages of substance abuse providers, waiting lists for services and a perception that mental health priorities take precedence over substance use priorities.240

The level of public funding for substance use services is not sufficient to address need, creating significant barriers to treatment. DSHS has attempted to address these concerns by expanding the capacity of the substance use treatment delivery system beyond the level established by the Legislative Budget Board (LBB). DSHS is currently serving an average of 9,306 individuals monthly,
exceeding the LBB’s target goal of 8,851 individuals per month.

Substance use funding was increased by over $25 million in the 83rd session, including nearly $11 million to increase provider reimbursement rates for substance use services in an attempt to attract new and competitive providers into the service system. The introduction of competitive service providers will hopefully incentivize higher service quality, treatment, and recovery rates.

Additionally, the legislature approved an appropriation of $10 million to create additional service capacity for parents whose children are in DFPS custody due to parental substance abuse issues. Services include screening, assessment and treatment services, expanded eligibility in the pregnant and postpartum intervention programs and a newly establish fatherhood intervention program. The goal of this investment and expanded services are to reduce the number of children in DFPS care by expediting parents’ access to treatment. As of August 2014, the average monthly served through this initiative was roughly 1,448, and as of as of June 2014, approximately 1,851 CPS caseworkers had been trained in substance use services.

**ELIGIBILITY FOR SERVICES**

Adults with substance use disorders who are on Medicaid have access to outpatient services (assessment, ambulatory detoxification, counseling, and medication assisted therapy) as well as residential services (treatment, detoxification and specialized services for women) free of cost. HHSC is currently evaluating whether this Medicaid benefit generates enough savings to offset the cost. Continuation of funding for this Medicaid program will be contingent on evaluation results.

For individuals who are not Medicaid eligible, substance use program providers are required to conduct a financial assessment of individuals who seek DSHS-funded substance use services. Individuals whose adjusted income is at or below 200 percent of the federal poverty level are eligible for fully funded substance use services. If adjusted income is greater than 200 percent, individuals will be assessed a fee on a sliding scale.

**PRIORITY POPULATIONS**

Three populations receive priority for admission to substance use services before all others. They are in the following order of priority:

1. Pregnant, intravenous substance users
2. Pregnant substance users
3. Intravenous drug users

Additionally, youth aged 13-17 who meet DSM-IV-R (and soon DSM-5) criteria for substance abuse or dependence are eligible for treatment services. Adults aged 18-21 may be also admitted to a youth treatment program dependent on the individual’s needs, experiences, and behavior.

**CO-OCCURRING PSYCHIATRIC AND SUBSTANCE USE DISORDERS**

Mental illness and substance use commonly occur in persons at the same time.
Nationally, among adults with substance use disorder, 42 percent had a co-occurring diagnosed mental illness. The high prevalence of these comorbidities demonstrates the need for interventions and policies that support dual diagnosis treatment. When examining the relationship of co-occurring psychiatric and substance abuse disorders, the following scenarios should be considered:

- Drug abuse can lead to mental illness
- Mental illness can lead to drug abuse
- Drug abuse and mental illness can be results of other independent common risk factors

DSHS supports the integration of substance use and mental health services for the simultaneous treatment of co-occurring disorders. The goal of Co-occurring Psychiatric and Substance Abuse Disorder (COPSD) Services is to provide coordinated services, wherein both disorders are treated in conjunction as the primary condition. DSHS contracts with 488 outpatient substance use treatment facilities and 160 residential treatment facilities for this specialty service. In FY 2013, 4,081 individuals were served through COPSD programs.

The following figure lists substance use services DSHS makes available to eligible adults and youth.

### Figure 50. Available Substance Use Services Through DSHS

<table>
<thead>
<tr>
<th>Services</th>
<th>Service Available to Adults</th>
<th>Service Available to Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential intensive</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential intensive (specialized female)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential intensive (women and children)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential supportive</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential supportive (specialized female)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential supportive (women and children)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential detox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential detox (specialized female)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ambulatory detox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory detox (specialized female)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HIV residential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### UTILIZATION AND COSTS

The following two figures show the utilization and costs of substance use services. Figure 51 details information for adults; Figure 52 for children.

#### Figure 51. Utilization and Costs for Adult Substance Use Services

<table>
<thead>
<tr>
<th>Services</th>
<th>Service Available to Adults</th>
<th>Service Available to Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Female</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Group</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adolescent support</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Family counseling</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Family support</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Psychiatrist consultation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Outpatient services (specialized female)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individual</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Group</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Opioid substitution therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Co-occurring psychiatric &amp; substance use Conditions</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Prevention program</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number served per year</td>
<td>366,810</td>
<td>409,585</td>
<td>468,054</td>
<td>468,054</td>
<td>492,925</td>
</tr>
<tr>
<td>Avg. cost per adult per year</td>
<td>$20</td>
<td>$19</td>
<td>$16</td>
<td>$16</td>
<td>$15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention programs</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number served per year*</td>
<td>180,586</td>
<td>128,281</td>
<td>123,914</td>
<td>141,299</td>
<td>167,032</td>
</tr>
<tr>
<td>Cost per adult per year**</td>
<td>$64</td>
<td>$97</td>
<td>$89</td>
<td>$71</td>
<td>$60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment programs</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number per year</td>
<td>41,348</td>
<td>42,194</td>
<td>31,627</td>
<td>31,206</td>
<td>31,303</td>
</tr>
<tr>
<td>Cost per adult per year</td>
<td>$1,827</td>
<td>$1,888</td>
<td>$1,617</td>
<td>$1,582</td>
<td>$1,617</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number on the wait list for substance use treatment**</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,948</td>
<td>10,347</td>
<td>8,193</td>
<td>9,034</td>
<td>9,806</td>
</tr>
</tbody>
</table>
*The spike in number served in FY 2009 is due to instruction from program staff to providers of DSHS-funded substance abuse intervention services to try their best to provide DSHS with client counts, which inadvertently led to duplication. Then, in FY 2010, program staff instructed providers to try their best to provide unduplicated client counts, resulting in another dip. **Improvements to reporting in CMBHS, such as the automated calculation of clients served in the HIV Early Intervention (HEI) program, should continue to cause the numbers served to increase, thereby reducing the cost per client due to economies of scale as seen from FY 2010-2013. ***Total entered on waiting list by following substance abuse programs: COPSD, Detox, Methadone, Outpatient and Residential.

**Figure 52. Utilization and Costs for Youth Substance Use Services**

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number served per year</td>
<td>1,300,834</td>
<td>1,516,959</td>
<td>1,843,263</td>
<td>1,920,024</td>
<td>1,939,809</td>
</tr>
<tr>
<td>Avg. cost per youth per year</td>
<td>$21</td>
<td>$18</td>
<td>$14</td>
<td>$14</td>
<td>$13</td>
</tr>
<tr>
<td>Intervention programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number served per year*</td>
<td>81,878</td>
<td>33,962</td>
<td>26,519</td>
<td>58,903</td>
<td>68,977</td>
</tr>
<tr>
<td>Cost per youth per year**</td>
<td>$43</td>
<td>$93</td>
<td>$127</td>
<td>$55</td>
<td>$44</td>
</tr>
<tr>
<td>Treatment programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number per year</td>
<td>6,302</td>
<td>5,804</td>
<td>5,418</td>
<td>4,886</td>
<td>4,848</td>
</tr>
<tr>
<td>Cost per youth per year</td>
<td>$2,910</td>
<td>$3,569</td>
<td>$3,713</td>
<td>$3,645</td>
<td>$3,246</td>
</tr>
<tr>
<td>Number on the wait list for substance use treatment***</td>
<td>612</td>
<td>809</td>
<td>753</td>
<td>512</td>
<td>438</td>
</tr>
</tbody>
</table>

*The spike in number served in FY 2009 is due to instruction from program staff to providers of DSHS-funded substance abuse intervention services to try their best to provide DSHS with client counts, which inadvertently led to duplication. Then, in FY 2010, program staff instructed providers to try their best to provide unduplicated client counts, resulting in another dip. **Improvements to reporting should continue to cause the numbers served to increase, thereby reducing the cost per client due to economies of scale. ***Total entered on waiting list by following substance abuse programs: COPSD, Detox, Methadone, Outpatient and Residential.


QUALITY OF CARE MEASURES

DSHS monitors quality and performance in several areas based on the TRR framework. The following figures show representative measures tracked on a regular basis.

Figure 53. Selected Quality of Care Measures for Adult Substance Use Services

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adults completing substance use treatment programs per year</td>
<td>63%</td>
<td>58%</td>
<td>56%</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Percentage of adults completing substance use treatment programs reporting abstinence at follow-up per year</td>
<td>86%</td>
<td>85%</td>
<td>89%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of unemployed adults completing substance use treatment programs gaining employment at follow-up per year</td>
<td>62%</td>
<td>57%</td>
<td>52%</td>
<td>56%</td>
<td>59%</td>
</tr>
<tr>
<td>Percentage of adults completing substance use treatment programs not re-arrested per year</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>


Figure 54. Selected Quality of Care Measures for Youth Substance Use Services

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2009</th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of youth completing substance use treatment programs per year</td>
<td>63%</td>
<td>55%</td>
<td>54%</td>
<td>52%</td>
<td>52%</td>
</tr>
<tr>
<td>Percentage of youth completing substance use treatment programs reporting abstinence at follow-up per year</td>
<td>85%</td>
<td>83%</td>
<td>89%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of youth completing substance use treatment programs with positive school status at follow-up per year</td>
<td>93%</td>
<td>91%</td>
<td>83%</td>
<td>77%</td>
<td>75%</td>
</tr>
<tr>
<td>Percentage of youth completing substance use treatment programs not re-arrested per year</td>
<td>96%</td>
<td>97%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

PROMISING PRACTICES IN SUBSTANCE USE TREATMENT

THE TEXAS RECOVERY INITIATIVE

The goal of the Texas Recovery Initiative (TRI) is to ensure that needed services and resources are available to support individuals in their recovery from a substance use disorder. The purpose of the multi-phase TRI is to gather information and stakeholder input for creating evidence based procedures in order to implement comprehensive, recovery-oriented models of care for individuals seeking treatment. In order for a delivery system to be recovery-oriented, it must be person-centered, multi-disciplinary and use coordinated treatment plans which allow for the individuals receiving services to take responsibility for their own recovery.

Recovery assistance is provided through the Recovery Oriented System of Care (ROSC) framework, which coordinates multiple systems, services, and supports that are person-centered, self-directed and designed to readily adjust to meet the individual’s needs and chosen pathway to recovery. This framework underscores the significance of community partnerships and collaborations, including those with federal and local governmental, nonprofit and faith-based entities, to provide a continuum of care vital to the recovery process. By providing continual support, ROSC services aim to enhance individual’s strengths and functioning while building resilience and recovery management skills. DSHS is currently assisting communities statewide with initiating the ROSC framework in local municipalities across the state by:

· Conducting on-site informational trainings to organize communities, assisting them with the development of the initial phase of this systems change approach for achieving recovery.
· Providing telephone and email technical assistance to local communities regarding the ROSC concept.
· Participating in person and via teleconferencing in local ROSC community meetings.
· Adding a week-long educational track on recovery during the Texas Behavioral Health Institute.
· Assisting with development and training of recovery coaches.
Texas Department of Family and Protective Services: At A Glance

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Policy Concerns

- Implementation and expansion of the Foster Care Redesign Project.
- Parental relinquishment of children to obtain mental health services.
- Prevention of child fatalities within the CPS system.
- System-wide implementation of trauma-informed care.
- Disproportionality of minority youth in the CPS system.
- Addressing the needs of LGBTQ youth.
- Support services for transitioning youth with mental health concerns.
- Tracking the usage of the Alternative Response System in the CPS investigative process.
- Improving identification of elder abuse/neglect and provision of protective services.
- Continuing to monitor the psychotropic medication usage of foster care youth.
- Implementing alternatives to seclusion and restraint techniques.

Fast Facts

In FY 2013:

- 258,996 children were alleged victims of abuse statewide.
- CPS completed 160,240 investigations of abuse or neglect.\textsuperscript{250}
- There were 100,861 children in confirmed investigations (confirmed is defined as, “based on preponderance of evidence, staff concluded that abuse or neglect occurred”\textsuperscript{251}).
- Of this number, 17,022 children were removed from their homes.\textsuperscript{252}
- 16,676 children were in the Texas foster care system (excluding kinship care).\textsuperscript{253}
- There were 156 confirmed child abuse or neglect related fatalities.\textsuperscript{254}
- Children aged three and younger represented 80 percent of the child fatalities from abuse and neglect in Texas.\textsuperscript{255}

A frequently cited study by the U.S. General Accounting Office (GAO) estimated that in 2001, more than 12,700 children in the United States were voluntarily relinquished to state custody for the purpose of accessing mental health services.\textsuperscript{256}
Texas Department of Family and Protective Services

The Department of Family and Protective Services (DFPS) is the state agency responsible for ensuring the safety of children, elderly persons, and adults with disabilities. DFPS provides services and supports to these vulnerable populations by attempting to reduce the likelihood of abuse, neglect, and exploitation.

DFPS is comprised of four divisions:

<table>
<thead>
<tr>
<th>Division</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protective Services (CPS):</td>
<td>Investigates allegations of child abuse/neglect and responds accordingly. CPS strives to retain children in safe home conditions, but also oversees and manages the foster care system for children who are removed from unsafe home environments.</td>
</tr>
<tr>
<td>Prevention and Early Intervention (PEI):</td>
<td>Provides community outreach on mental health and other wellness services.</td>
</tr>
<tr>
<td>Adult Protective Services (APS):</td>
<td>Investigates allegations of abuse, neglect, and exploitation of older adults and people with disabilities. This entails conducting at-home investigations and facilities. APS also educates the public on adult abuse prevention.</td>
</tr>
<tr>
<td>Child Care Licensing (CCL):</td>
<td>Regulates the childcare system to ensure safety and other statewide regulations are met. Educates parents and communities on childcare and childcare facilities.</td>
</tr>
</tbody>
</table>

DFPS is divided into the same 11 regions as HHSC, each with a regional headquarters. Please see Figure 10 on page 60 for a map.

DFPS requested $1,588,538,142 for 2016 and $1,599,149,665 for 2017 in the Legislative Appropriations Requests for Fiscal Years 2016 and 2017.  

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Changing Environment

FOSTER CARE REDESIGN

Foster care is pertinent to mental health discussions because many of the youth entering the foster care system have suffered traumatic experiences, and a disconnected, uncoordinated, and otherwise unstable foster care system is likely to aggravate mental health conditions. Furthermore, the lack of permanency in childcare arrangements could also exacerbate mental health conditions.

In an effort to reduce negative outcomes (including mortality) for children in the foster care system, DFPS embarked on a Foster Care Redesign project in 2010 to improve the outcomes for children and families while using the least restrictive placement settings.

The goals of the Foster Care Redesign include the following:

- Keep children and youth closer to home and connected to their communities and siblings.
- Improve the quality of care and outcomes for children and youth.
- Reduce the number of times children move between foster homes.

One of the biggest changes of the Foster Care Redesign is the change from services-based funding to performance-based funding. Under the previous system, payment was linked to a child’s service level (basic, moderate, specialized, or intensive) and placement type (Child Placement Agency, Emergency Shelter, General Residential Operation, or Residential Treatment Center), which did not create incentives for a child to be moved to a lower authorized service level. The redesign however, does not tie payment to a child’s service level but instead to positive outcomes, thereby encouraging children’s transition to lower service levels and reductions in average-cost-per-care amounts.

Additionally, the Foster Care Redesign will restructure service delivery so that care comes from a single continuum rather than through the distribution of multiple contracts and a compilation of service providers. The state’s goal in streamlining the delivery of care is to better coordinate services for families. Under the new system, a single source continuum contractor in geographic catchment areas will provide a range of services for foster care youth, thus eliminating the risk that a child will be placed far away from home for the purposes of accessing services. Chapin Hall, a policy and research center at the University of Chicago, has been directed to conduct a quantitative analysis and track the performance of the lead redesign contractor.

The state’s initial Foster Care Redesign contract was awarded to Providence Services Corp., which began its contract on February 1, 2013. However, Providence Services Corp. voluntarily terminated its contract with the state on August 1, 2014. Providence Services Corp. had been managing and providing services for 1,100 children in the state’s foster care system in counties in North and West Texas. DFPS announced that it would take over the duties previously administered by Providence Services Corp.
The second pilot program for the Foster Care Redesign was contracted to begin on January 1, 2014. The selected contractor for this project is a nonprofit organization called ACH Child and Family Services of Fort Worth. This pilot will serve Erath, Hood, Johnson, Tarrant, Palo Pinto, Somervell, and Parker counties. The second stage will provide service to an additional seven metropolitan areas in Texas in Region 3, which spans, among others, Dallas and Denton counties.

PARENTAL RELINQUISHMENT OF CUSTODY

A frequently cited study by the U.S. General Accounting Office (GAO) estimated that in 2001, more than 12,700 children in the United States were voluntarily relinquished to state custody for the purpose of accessing mental health services. These children have serious mental health conditions and their treatment is often expensive due to the need for temporary residential treatment. Some parents have insufficient insurance coverage while others lack insurance altogether, making it difficult to afford needed and often costly mental health services. These circumstances can force parents to relinquish custody of their children in order to obtain necessary mental health treatment.

State child welfare officials in 19 states and county juvenile justice officials in 30 counties who responded to surveys estimated that in FY 2001, parents in their jurisdictions placed over 12,700 children—mostly adolescent males—into the child welfare or juvenile justice systems so that these children could receive mental health services.

The emotional turmoil resulting from the decision to relinquish parental custody affects both parents and children. Parents may experience feelings of humiliation and powerlessness surrounding their relinquishment. Relinquishment can also irreparably damage the child-family bond and result in insecure attachment of the child to parents or other caregivers.

In addition to the trauma it causes parents and children, parental relinquishment of custody to obtain critically needed mental health services creates an additional challenge for parents. When parents relinquish custody of their child to the state under these circumstances, they are deemed to have “refused to accept parental responsibility,” which is considered a form of neglect. The parents’ names are then added to the Texas child abuse/neglect registry. This can have serious consequences for parents’ future employment opportunities. Parental relinquishment labels the parent as abusive or neglectful when in reality, these are parents who typically have done everything possible for the health and safety of their children and families.

The 83rd Texas legislature addressed parental relinquishment in Texas, most notably through the passage of Senate Bill 44 (Zaffirini). In addition to ordering investigations and data reports on parental relinquishment in the state, SB 44 also calls for a series of alternative options to parental relinquishment. One option espoused by the legislature is the use of joint conservatorships, which would allow...
parents to continue sharing in major decisions affecting their child’s life. The bill also charged the Council on Children and Families to make recommendations on how to keep the names of parents who relinquish custody off the child abuse and neglect registry. Parents may also petition the family court to have their names removed from the child abuse and neglect registry if the sole reason behind their addition was relinquishment for mental health services. Other legislative action towards reducing instances of parental relinquishment included the expansion of the Youth Empowerment Services (YES) waiver and additional funding for 13 beds at Residential Treatment Centers (see DSHS section).

**SPECIALTY COURTS**

Once CPS makes a determination that a child is unsafe in his or her home environment and must be taken into state custody, the judiciary serves as the ultimate authority on what happens to the child and where he or she goes.\(^{270}\) CPS works with regional and district courts to obtain court orders for removals, as needed. An alternate solution that seeks to alleviate the waiting period and difficulties faced by youth in the CPS system is the establishment of a CPS court where a designated judge would hear CPS cases. This solution has been explored at the local and county level, for example in San Antonio and in Harris County.\(^{271}\) Specialty courts can ease the backlog of cases and achieve permanency more quickly. Under the current system, CPS cases are heard at county or district courts. Centralizing all CPS hearings in one location could reduce caseworkers’ travel time between hearings, thereby providing them with more time to check up on clients and to be in the field. Figure 55 below illustrates the location of CPS courts and the counties they cover in Texas:
Figure 55. Child Protection Courts and Covered Regions

Child Protective Services

Child Protective Services (CPS) is responsible for responding to and investigating allegations of child abuse and neglect, providing at-home services for families and youth in need, removing children from unsafe environments, managing the foster care system, and successfully transitioning youth out of the CPS system. Thus, CPS interacts with children at three stages: investigating abuse allegations, placing youth, and transitioning youth.

Trauma inflicted by experiencing (physical, psychological, or sexual) violence or chronic neglect has a profound effect on children. The effects of trauma can last a lifetime; adults who experience significant childhood abuse and family discord as children have a higher incidence of physical and behavioral health problems. A traumatized youth is at higher risk of substance abuse, mental health issues (such as depression and suicide), promiscuity, and criminal behavior.

Children in CPS nationally and in Texas are at greater risk for trauma-related mental health and substance use conditions than children in the general population. Nearly half of youth in child welfare have clinically significant emotional or behavioral problems. Rates of behavioral problems, developmental delays, and need for psychiatric intervention for foster care youth range from 60–80 percent. Professionals who come into contact with these children must therefore be cognizant of the potential mental health needs of children and youth in foster care. During an investigation, a CPS worker will screen the child's behavioral health and make referrals for behavioral health needs assessments as necessary. These assessments are repeated if a child enters the foster care system.

In FY 2013, 258,996 children statewide were alleged victims of abuse. There were 100,861 children in confirmed investigations (confirmed is defined as, “based on preponderance of evidence, staff concluded that abuse or neglect occurred”). Of this number, 17,022 children were removed from their homes.

CPS investigates abuse and neglect allegations and makes a determination of whether a child has been abused or neglected and whether there is a threat to the safety of the children in the home. If the caseworker determines that the children are not safe, then the caseworker initiates protective services. This could include family-based protective services, a court petition to remove a child from the home, or legal action to terminate parental rights.

A child is placed in foster care after other options have been exhausted. In FY 2013, 16,676 children were in the Texas foster care system. When it is unsafe for the child to remain in his or her home and there are no appropriate family or friends who can provide care, CPS is given temporary legal custody. CPS then places the child either in a group foster home, an individual foster home, another state agency facility, or a residential group facility.

Figure 56 illustrates the CPS investigation process upon receipt of an allegation:
Figure 56. CPS Investigation Process

Note: This chart is for reference only and does not necessarily represent the flow of a case.

Accessing Mental Health Services

SUPERIOR HEALTH SYSTEM (STAR HEALTH)

In 2008, the STAR Health program was created to provide children in foster care with primary care and behavioral health services using a managed care organization delivery model. Superior Health Plan manages the STAR Health program. The program is statewide and was designed to better coordinate and improve access to health care for children in the foster care system.

In FY 2013, 31,834 children (including those in kinship care, foster youth up to age 22, and former foster youth receiving transitional Medicaid services) were enrolled in STAR Health.282 STAR Health operates a healthcare model that provides each foster care child with access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services, and more.283 Behavioral health services offered by Superior include:284

- Psychiatric services.
- Psychological testing (including screening, assessment, and diagnosis).
- Rehabilitation skills training.
- Detoxification services.
- Depression Disease Management Program.

FORMER FOSTER CARE CHILDREN PROGRAM (FFCC)

Many foster children who age out of the foster care system lose health insurance coverage. As a component of the ACA effective January 1, 2014, the Former Foster Care Children Program (FFCC) provides extended health insurance coverage to former foster care children under the age of 26. Unlike Medicaid or other foster care insurance plans, FFCC has no asset, income, or educational requirements. There are two FFCC insurance plans based on age of the applicant: STAR and STAR Health. The services provided by each of these plans vary, although they both provide integrated medical coverage.285

Effective January 2014, Former Foster Care Children receiving healthcare services from one of the existing insurance plans — Medicaid for Transitioning Foster Care Youth (MTFCY) or Former Foster Care in Higher Education Program (FFCHE) — will be transitioned to FFCC.286 Those who do not qualify for FFCC will still be covered under MTFCY as long as they meet MTFCY income requirements. See Figure 57 for an overview of existing health insurance programs for former foster care children.
### Figure 57. Health Insurance Programs for Former Foster Care Children

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Eligibility</th>
<th>Income or Other Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Former Foster Care in Higher Education (FFCHE) [Prior to integration into FFCC]</td>
<td>Be age 21 through 23. Have been in any state’s conservatorship or voluntary agency conservatorship on their 18th birthday. Be enrolled in an institution of higher education located in Texas. Not have adequate health coverage as defined by HHSC.</td>
<td>Have countable income of less than or equal to 400% of the Federal Poverty Income Limit (FPIL). Have countable resources of less than or equal to $10,000. Meet all other medical programs eligibility criteria such as citizenship or alien eligibility.</td>
</tr>
<tr>
<td>Medicaid for Transitioning Foster Care Youth (MTFCY) [For those ineligible for FFCC]</td>
<td>Are age 18 up to 21 A U.S. citizen or qualified non-citizen. Aged out of Texas conservatorship at age 18 or older. Do not have adequate health coverage.</td>
<td>Have income at or below $3,955 per month for an individual.</td>
</tr>
<tr>
<td>Former Foster Care Children Program (FFCC)</td>
<td>Anyone who has aged out of foster care or the Unaccompanied Refugee Minor Resettlement Program in the state of Texas at age 18 or older. Are ages 18 up to 26. Received federally funded Medicaid when they aged out of foster care. Meet all other Medicaid eligibility criteria such as U.S citizenship, alien status, and residence.</td>
<td>No asset, income, or educational requirements.</td>
</tr>
</tbody>
</table>


With the implementation of the FFCC plan, a larger number of former foster care adults will have health insurance coverage up to age of 26. Many children in foster care experience instances of trauma or other mental health conditions. Some of these conditions may impact former foster care children even after they have left the welfare system. Foster care alumni are more likely than young adults in the general population to rely on public assistance, to struggle in finding and keeping a stable home, and to be at high risk for physical and mental health concerns. Thus, retaining health insurance for former foster care children for a longer period of time can lead to better outcomes by ensuring that they have better access to the
mental health care services and supports necessary for their recovery and long-term wellbeing.288

There are two groups of young adults previously in CPS conservatorship that may not have access to post-care health services. Those originally from Texas who have aged out of the foster care system in another state are ineligible, as are those who have aged out of Texas foster care and have since moved to another state.289 Those who do not qualify for FFCC may purchase health insurance through the Health Insurance Exchange if they have sufficient resources or may still qualify for Medicaid.

INSTITUTIONAL RESIDENTIAL SERVICES

While the state recognizes that it is preferred that children grow up in families, some children in the custody of the state are placed in congregate care facilities. Prior to placing a child in foster care, the court is required to consider temporary placement with a relative.290 If this option is not available or appropriate, the child may be placed in a foster home with foster parents, a foster family group home, or a general residential operations (GRO) facility.291 A GRO is a congregate care facility that provides residential services for 13 or more children up to the age of 18 years. GROs are licensed by DFPS and include long-term residential facilities providing basic childcare, emergency shelters in which children may be placed for up to 30 days, and residential treatment centers (RTC). An RTC provides care and treatment services exclusively for children with emotional disturbances.

There are a total of 253 licensed GROs in the state, and almost 80 of these are RTCs.292 121 GROs provide treatment services for children with emotional disorders.293 As of August 2013, 1,508 children were living in RTCs and 1,353 children were placed in other GROs.294 For a list of child-care operations in the state visit https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp

ALTERNATIVE RESPONSE SYSTEM

The CPS Alternative Response System aims to ameliorate the stress of a CPS investigation and provide services to more families in need. The Alternative Response System (ARS) adapts the typical CPS process to address low-risk allegations. In doing so, CPS will provide a non-adversarial means of dealing with less serious cases of abuse and neglect. ARS, also known at the national level as differential response, place an emphasis on family strengthening, parental involvement, and the development of support systems.295 The ARS is characterized by the following features:296

- Conducts assessments, not investigations.
- Does not declare a formal finding of abuse or neglect.
- Won’t designate an alleged perpetrator in these cases.
- Connects families with appropriate service providers.
- Encourages collaboration with families.

Research has found that ARS or differential response systems lead to more positive outcomes related to child safety, family engagement, community involvement, and worker satisfaction.297 Despite higher initial investment, this approach is more cost effective in the long run as it reduces the need for long-term services and
ARS engages parents, prompts them to identify their strengths, and connects them to community service providers to reduce the risk of behavior that is harmful to a child's cognitive, social, emotional, and physical development. Slated for rollout beginning September 2014, this program is expected to be fully implemented statewide in two to three years.

**SYSTEM OF CARE**

System of Care refers to an organizational framework that is strength-based and collaborative. Care for youth with intensive support needs is coordinated across agencies, private and public organizations, and families so that children can overcome the barriers that prevent them from accessing the services they need. This framework is sensitive to a youth and his or her family’s cultural and linguistic preferences as well as their mental health needs. A system of care framework delivers services and supports to reduce entrances into hospitals, the juvenile justice system, and the child welfare system. Implementation of this framework has resulted in lower findings of delinquent behavior, lower caregiver strain, increase in protective factors, and more attention to cultural needs.

The Texas System of Care Consortium, established during the 83rd legislature, is an interagency consortium that aims to improve the delivery of mental health services for high-needs youth in Texas by expanding the system of care services throughout the state. There are currently eight communities in Texas that have implemented this framework and serve families from the following counties: Travis County, Fort Worth, El Paso, Harris County, Tarrant and surrounding counties, and Lamb, Floyd, Hale, Briscoe, Motley, Dickens, Bailey, Palmer, Castro, Swisher, and Crosby County. The Texas System of Care Consortium expects to have a total of nine communities in Texas with the System of Care framework in place by 2017.

**Continuing Issues**

**CHILD FATALITIES IN THE CPS SYSTEM**

Children aged three and younger represented 80 percent of the child fatalities from abuse and neglect in Texas in FY 2013. Child fatalities continue to occur in the Texas child welfare system, as discussed in a Texas Senate Health and Human Services hearing held on February 20, 2014. Figure 58 and Figure 59 below provide details on the child fatalities in Texas in FY 2013.
In 2013, 46 percent of families with child fatalities had prior involvement with CPS. High caseloads for CPS workers may lead to failures to conduct routine visits, identify risks, and intervene appropriately. Lower caseloads for CPS caseworkers would allow them to be more effective and to provide needed attention to vulnerable children. The current average caseload is 32 cases, significantly higher than the recommended 17 cases per caseworkers. Moreover, youth see
high turnover in caseworkers, reducing the likelihood that they have a reliable and consistent advocate ensuring that neglect and abuse is not occurring while they are in foster care.

In addition to the instability that high caseworker turnover creates for foster children, low retention rates also diminish cohesion within CPS. Almost a quarter (24.1 percent) of agency employees leave CPS employment within a year. In 2012, CPS hired 1,704 caseworkers. However, turnover rates in some CPS regions were as high as 34.3 percent. Lower-tenured workers require more supervision and training, so turnover among caseworkers affects the department’s overall efficiency and timeliness with cases.

In FY 2012, two children died from abuse/neglect while in foster care placement. In FY 2013, this number rose to 8. DFPS passed new regulations designed to enforce stricter monitoring of foster care homes, effective September 1, 2014. These new safety rules require:

- An additional interview of a family member not living in the home.
- Two additional interviews of neighbors, clergy, school employees, and/or other community members.
- Interviews of all adult children of foster parents.
- An assessment of personal relationships of foster parents and review of household finances.
- Review of any law enforcement agency calls to the foster home for the past two years.
- Verification of identity and background checks for any person designated as an emergency caregiver.

Child Placing Agencies will also be expected to monitor more closely changes in the foster home, such as job losses, marriages, divorces, frequent visitors, and family additions. These steps were put in place to protect and provide more oversight of foster care children to prevent child fatalities.

**DISPROPORTIONALITY**

Since 2004, CPS has been striving to reduce the disproportionate representation of African American and Native American children and youth represented in the CPS system. A number of theories have offered explanations for disproportionality within the child welfare system including:

- Parent and family risk.
- Poverty and neighborhood risk and other social factors.
- The impact of child welfare policy on children of color.
- Racial bias among child welfare workers.

Figure 60 breaks down the ethnic and racial profile of Texas children in the CPS system:
LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER YOUTH

The stigma associated with LGBTQ identity makes this population more vulnerable to mental health conditions such as depression, substance abuse, and heightened risk of suicide.\footnote{321} Due to a lack of reporting and the fact that sexual orientation is self-identified, it is difficult to determine the actual number of LGBTQ youth in the foster care system. However, the National Resource Center for Youth Development reports that LGBTQ youth represent anywhere from 5–10 percent of youth in foster care.\footnote{322} LGBTQ youth who reported experiencing family rejection had a greater chance of mental health issues in adulthood and were significantly more at risk for attempting suicide, depression, and substance abuse.\footnote{323} Additionally, one study found that over 30 percent of LGBTQ youth reported suffering physical violence at the hands of a family member after coming out.\footnote{324} For this reason, increasing family and caregiver support is essential for promoting the well-being of LGBTQ children and reducing their safety risks and entrance into the foster care system.

LGBTQ foster youth may be more at risk for negative outcomes because of negative social attitudes towards their sexual orientation or gender identity, and thus may face higher rates of harassment, may receive unfair treatment, and may have difficulty finding a foster family that is understanding and responsive to their needs. A study by the Urban Justice Center revealed that up to 78 percent of LGBTQ youth who were placed in foster care ended up being removed or ran away from their foster placements as a result of encountering hostility toward their sexual orientation or gender identity.\footnote{325} Supportive policies for youth in the foster care system should ensure that these youth are free from harassment and abuse, and have equal access to safe, supporting, and inclusive environments within the foster care system.\footnote{326} Disparity for LGBTQ youth in the foster care system continues upon their exit, as national studies show that LGBTQ former foster care youth are less financially stable than their heterosexual peers.\footnote{327} There are currently no policies in Texas specifically addressing the needs of LGBTQ youth in the state’s foster care system.
Foster children are disproportionately treated for their behavioral health needs with psychotropic medications (drugs that affect the mind, emotions, and behavior). A 2011 report by the U.S. Government Accountability Office (GAO) showed that in Texas children in foster care were prescribed psychotropic drugs at rates 2.7 to 4.5 times higher than children not in foster care. In FY 2012, almost 32.5 percent of Texans in foster care were prescribed at least one psychotropic medication (see Figure 61 below). The GAO report points out that high psychotropic prescription rates do not necessarily indicate improper action on behalf of states; nevertheless, Texas has undertaken a series of steps to better regulate the prescription of psychotropic medications for foster care children.

Psychotropic medications can be effective in treating mental disorders, but psychotropic medications are not always clinically appropriate or necessary. Even when effective in treating mental health conditions, psychotropic medications also carry significant and potentially long-lasting side effects, including trembling, decreased/increased appetite, headaches, nausea, and increased risk of suicidal thinking. Usage of psychotropic medications may also result in long-term effects such as stunted physical development. One research study showed that nationally 10 percent of foster kids received antipsychotic medications, a powerful subset of psychotropics with significant side effects in children.

Children in foster care have undergone abuse and neglect and, as a result, experience several degrees of trauma. Mental health conditions are one of the consequences arising from traumatic experiences. However, children’s symptoms of trauma may be misinterpreted as deliberate problematic behavior. In many instances, non-pharmacological alternatives could successfully help children with their behavioral health issues. Additionally, psychotropic medication prescriptions are costly to the state. In state fiscal year 2011, a total of about $42,000,000 was paid out for psychotropic drugs to foster care clients.

Psychotropic medication prescriptions reached a peak in 2004, when almost 42 percent of all children in foster care were on a psychotropic medication. In response to the alarming rates of psychotropic medication prescriptions for foster care children and the media spotlight on this issue at both the state and federal level, in 2005 Texas released Psychotropic Medication Utilization Parameters, which established standards and requirements for prescriptions of psychotropic medications. The goal of the parameters is to encourage clinically appropriate and informed usage of psychotropic medications. As shown in Figure 61, psychotropic medication prescriptions declined steadily thereafter. In 2011, a little over 30 percent of children in foster care were prescribed psychotropic medications.
The 83rd Legislature revisited the issue of preventing overmedication of foster care youth. H.B. 915 (Kolkhorst) resulted in new policies and duties to improve the monitoring of medication by implementing client-based approaches that involve youth in their own treatment. These include minor developments such as the creation of a medical consenter informational brochure, a youth transition plan for youth taking prescription medication, and the notification of biological parents of their child’s placement on psychotropic medication. Most notably however, H.B. 915 created provisions to strengthen the role of informed consent in the psychotropic medication prescription process.

Guardians ad Litem and Attorneys ad Litem are now required to discuss with children and youth the medical and mental health care they are receiving and to ask for their input. Attorneys ad litem are required to explicitly inform youth ages 16 and older that they may petition the court to be their own medical consenter, a legal right that is typically delegated to legal caregivers such as foster parents, relative and kinship caregivers, and certain DFPS staff.

H.B. 915 also clarified what constitutes informed consent with respect to consent for psychotropic medications for children/youth in state custody. In order to meet the definition of informed consent, the following elements must be provided either verbally or in writing:

- Specific condition to be treated.
- Beneficial effects on that condition expected from medications.
- Probable health and mental health consequences of not consenting to medications.
- Probable clinically significant side effects and risks associated with the medications.
- Generally accepted alternative medications and non-pharmacological interventions to the medication, if any.
- Reasons for the proposed course of treatment.
By involving medical consenters, the child, and the judiciary system, all actors are kept abreast of the child’s medical history. Moreover, consent for psychotropic medication may be denied or discontinued. The intention of the measures implemented by H.B. 915 is to improve accountability and regulation of appropriate psychotropic prescriptions and to ensure that non-pharmacological means have been properly explored, thereby lessening the risk of overmedication.

On a national level, President Obama’s budget for FY 2015 addresses the alarming rates of foster care children on psychotropic medications. The requested appropriation of $750 million to curb the usage of psychotropic medications for foster care youth is two-pronged: 1) it provided funding to allow states to pursue non-medicinal approaches to mental health care, and 2) provided incentives to states who successfully implement those strategies to reduce the psychotropic prescriptions.\textsuperscript{338} Even though Congress rejected the budget in May 2014, President Obama’s budget highlighted the critical needs of foster care youth.

**TRAUMA-INFORMED CARE**

Trauma-informed care recognizes the effects of trauma on the individual, and provides care that is evidence-based and tailored to an individual’s needs. It therefore provides a non-pharmacological approach to healing that decreases reliance on psychotropic medications and increases placement stability.\textsuperscript{339}

Awareness of an individual’s trauma-inducing experiences can avoid re-traumatization that may occur within the scope of the delivery of traditional services. Many children in the foster care system have been exposed to multiple forms of trauma stemming from family physical, sexual, or emotional violence, sexual abuse, substance abuse, and removal from the home. Understanding the effects of trauma can provide more insight into a child’s coping mechanisms, behavioral tendencies, and developmental and cognitive development. As a result, trauma-informed care can provide communities, parents, schools, and caseworkers a better grasp on how to approach traumatized children and provide them the services and supported needed.

The 83rd Legislative Session recognized the need for trauma-informed care and passed a series of bills (including S.B. 1356 – Van de Putte, S.B. 460 – Deuell) to expand education on trauma and trauma-informed care for educators, administrators, and juvenile justice staff. In the previous session, the Legislature authorized DFPS to maintain its own trauma-informed care program and to assist in the development of similar programs throughout the child welfare system as funding permitted. As outlined in S.B. 219 (82\textsuperscript{nd}), DFPS should assist in the development of trauma-informed programs to the extent resources are available for court-appointed special advocates, children’s advocacy centers, local community mental health centers, and domestic violence shelters. S.B. 219 also mandated that providers under STAR Health managed care had to offer trauma-informed care training.
In an effort to promote behavioral management techniques that encourage well-being and decrease the risk of traumatization and injury, staff from RTCs across Texas have received training in reducing the use of seclusion and restraint. Seclusion and restraint refers to techniques used by administrators and staff to isolate (seclude) or hold (restrain) individuals believed to be at risk of harming themselves or others; this may include physical, mechanical, or chemical restraints. Emotional and physical trauma is common among youth in RTC settings and seclusion and restraint techniques may exacerbate their trauma. Thus, instituting alternatives to seclusion and restraint techniques may help reduce the likelihood that a resident youth will be re-traumatized.

Prevention and Early Intervention (PEI)

This division partners with communities to prevent abuse, neglect, and juvenile delinquency. Community-based early intervention strategies and programs can address mental health conditions by providing timely access to services, as well as reducing disparities for low-income and minority populations who may not have access to private providers. Additionally, these programs may identify youth at risk of developing mental health and behavioral health conditions and link them to treatment to prevent negative outcomes such as homelessness, poverty, a child’s removal from the home, incarceration, and school dropout. Programs and outreach efforts coordinated through this division address negative outcomes and provide services for youth. Figure 62 lists the various programs and services provided under PEI.

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Services</th>
<th>Regional Availability</th>
<th>Numbers Served</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services to At Risk Youth (STAR)</td>
<td>Contracts with community agencies to offer short-term services to youth up to age 17 who experience conflict at home, have been truant or delinquent, or have run away.</td>
<td>Family crisis intervention counseling, short-term emergency residential care, and individual and family counseling.</td>
<td>All Texas Counties.</td>
<td>Average monthly youth served = 5,351 Average yearly youth served = 23,677</td>
</tr>
<tr>
<td>Program</td>
<td>Program Description</td>
<td>Services</td>
<td>Regional Availability</td>
<td>Numbers Served</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Community Youth Development</td>
<td>Contracts with community organizations to develop juvenile delinquency prevention programs in zip codes that have a high incidence of juvenile crime.</td>
<td>Varies across communities but may include mentoring, youth-employment programs, career preparation, and alternative recreational activities.</td>
<td>Potter, Travis, Nueces, Dallas, El Paso, Tarrant, Galveston, Harris, Lubbock, Hidalgo, Harris, Bexar, McLennan.</td>
<td>Annual youth served = 16,767 345</td>
</tr>
<tr>
<td>Texas Families: Together and Safe</td>
<td>Funds community-based programs designed to alleviate stress and promote parental competencies and adoption of behaviors that increase the ability of families to successfully nurture their children and work toward family self-sufficiency.</td>
<td>Vary across communities but may include outreach, family interventions, and promoting support networks.</td>
<td>Community-based programs in select Texas counties.</td>
<td>Annual number of families served = 1,736</td>
</tr>
<tr>
<td>Community-Based Child Abuse Prevention</td>
<td>Uses federal grant dollars to develop and support local partnerships to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services.</td>
<td>Respite, parent education, fatherhood services, parent leadership, home visitation, and various special initiatives, including public awareness campaigns.</td>
<td>Funds distributed to communities across Texas.</td>
<td>Annual number of families served = 990</td>
</tr>
<tr>
<td>Program</td>
<td>Program Description</td>
<td>Services</td>
<td>Regional Availability</td>
<td>Numbers Served</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Texas Runaway and Youth Hotlines</td>
<td>Volunteers operate the toll-free Texas Runaway Hotline (1-888-580-HELP) and Texas Youth Hotline (1-800-98-YOUTH). Callers raise a variety of situations including family conflict, delinquency, truancy, and abuse and neglect.</td>
<td>Crisis intervention, telephone counseling and referrals to troubled youth and families.</td>
<td>Widespread availability.</td>
<td>2013 incoming calls = 7,462</td>
</tr>
<tr>
<td>Statewide Youth Services Network</td>
<td>Supports statewide networks of community-based prevention programs that provide evidence-based juvenile delinquency prevention services.</td>
<td>Teaches children and youth age 6 to 17 social and personal skills to prevent juvenile delinquency and risky behavior such as sexual activity, drug usage, and drinking.</td>
<td>Available in each DFPS region.</td>
<td>Annual number of youth served = 4,384</td>
</tr>
<tr>
<td>Preparation for Adult Living Program</td>
<td>Prepares older foster youth in substitute care for their departure from the child protective services system.</td>
<td>Classes to provide youth with necessary social and financial skills to lead a successful life, such as personal and interpersonal skills, job skills, housing and transportation, health, planning for the future and money management</td>
<td>All DFPS Regions</td>
<td>Number of youth served in 2013 = 7,265</td>
</tr>
</tbody>
</table>

In addition to the existing programs, two new initiatives are designed to prevent child abuse: Project Health Outcomes through Prevention and Early Support (Project HOPES) and Project Help through Intervention and Prevention (Project HIP). Project HOPES is intended to prevent child abuse and neglect for children.
0–5 years old and contracts will be dispersed to select target counties (Potter, Webb, Gregg, Ector, Cameron, Hidalgo, Travis, El Paso).\textsuperscript{351} The strategy behind Project HOPES is to encourage the development of protective factors that will reduce the likelihood of child abuse and neglect.\textsuperscript{352} Project HIP is a more targeted intervention strategy designed to increase protective factors and prevent child abuse; the target consumers are families who have had their parental rights previously terminated due to child abuse and neglect, families who had a child who died with a cause identified as child abuse or neglect, and foster youth who are pregnant or who have given birth within the last four months.\textsuperscript{353}

### Adult Protective Services (APS)

The APS division investigates allegations of abuse, neglect, and exploitation of adults aged 65 and older and of adults with disabilities regardless of age who are living in residential settings or in state-operated or state-contracted facilities. Allegations include self-neglect, abuse of parents by their adult children, abuse by caregivers, physical as well as emotional abuse, financial exploitation, and other types of abuse, neglect or exploitation. In the at-home context, the investigative scope of APS is limited to financial exploitation. In facilities however, other types of exploitation may be investigated.\textsuperscript{354} All of these services help to protect the mental health and wellness of persons with disabilities and aging Texans.

The population of Texans aged 65 and older is projected to reach 3,029,847 in 2014 and 3,148,771 in 2015 and is expected to continue increasing.\textsuperscript{355} This increase in the elderly population could indicate a higher need for services in the future. There were 87,257 reports made of in-home abuse/neglect of adults in FY 2013, 22 percent of which were reported by medical personnel.\textsuperscript{356} The total of the completed in-home and facility investigations in FY 2013 are enumerated below.\textsuperscript{357}

- 69,383 completed in-home investigations.
- 48,393 in-home validated allegations.
- 10,818 completed facilities investigations.
- 1,373 confirmed allegations.

One possible reason behind the higher percentage of validated in-home allegations than validated facilities allegations is that most in-home cases involve self-neglect and are thus more readily validated than allegations involving a perpetrator.\textsuperscript{358}

Figure 63 illustrates the APS flow of a case once an allegation is received:
If allegations are confirmed, APS provides emergency service intervention but does not have the capability or resources to provide ongoing supports or services after an affirmative finding. Whereas CPS can provide services regardless of whether there have been affirmative findings of abuse or not, APS is not statutorily authorized to do so. The APS division of DFPS works with other state agencies to coordinate care and services for victims of abuse. Those who are incapable of consenting to services are referred to the Department of Aging and Disabilities Services (DADS) for guardianship services. If the suspected abuse may constitute criminal conduct, DFPS alerts law enforcement to the case.

In addition to the investigations conducted by APS, this division also educates the general public about elder abuse via public outreach campaigns.
Child Care Licensing

The Child Care Licensing (CCL) division regulates childcare operations and approves permits for residential childcare facilities (including RTCs), childcare centers, and at-home daycares. Regulating the childcare system in Texas reduces the risk of injury, abuse, and the transmission of communicable diseases. Figure 64 below describes key childcare operations overseen by this department:

**Figure 64. Child Care Operations in Texas**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Care or Licensed Child Care Center</td>
<td>Children from birth through 13 years of age who attend childcare centers and childcare homes for part of the 24-hour day.</td>
</tr>
<tr>
<td>At-home day cares also known as group daycare homes or a Licensed childcare home</td>
<td>Provide care in the caregiver’s own residence for children from birth through 13 years. The total number of children in care at any given time, including the children related to the caregiver, must not exceed 12.</td>
</tr>
<tr>
<td>Residential child care</td>
<td>Children through 17 years of age, for 24 hours a day in a place other than the child’s own home across the State of Texas.</td>
</tr>
</tbody>
</table>


The number of children living in regulated, residential childcare in Texas is approximately 41,420.\textsuperscript{360} In 2013, there were 21,980 daycare centers and homes in Texas, with a total capacity of 1,085,366.\textsuperscript{361} It is therefore imperative that the quality of that care is regulated to ensure healthy physical, mental, and emotional development and to prevent the onset of mental health conditions and adverse childhood experiences.
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Policy Concerns

- Addressing the mental health needs of individuals with disabilities
- Coordination of services between DADS and DSHS
- Access to crisis services including emergency respite
- System-wide implementation of trauma-informed care, positive behavior supports and person-centered practices
- Improved psychiatric services in state supported living centers
- Significant wait time for community-based services
- Reduction of restraint in SSLCs

Fast Facts

- The rate of mental health conditions for people with IDD is two to three times higher than for the general population. Research findings have varied widely with prevalence rates for co-morbidity of IDD and mental health conditions ranging from 13.9 percent to 75.2 percent.\(^{362}\)
- The higher rate of mental health conditions among people with disabilities may
be due to psychological stress related to a disability, social isolation, trauma, institutionalization, bullying, low self-esteem, and other factors.\textsuperscript{363, 364}

- Adults and children with disabilities experience abuse, neglect, institutionalization, abandonment, bullying and other types of trauma at rates higher than the general population. In one study, nearly 75 percent of participants with IDD experienced at least one traumatic event in their lifetime, increasing the likelihood of developing a mental health condition.\textsuperscript{365}

- Over the past decade, evidence has shown a high prevalence of mental health conditions in people with autism spectrum disorder (ASD). Recent research indicates that for 10-to 14-year-old children living with autism, 70 percent had at least one co-occurring mental health disorder and 41 percent had two or more mental health diagnoses.\textsuperscript{366}
Texas Department of Aging and Disability Services

The Texas Department of Aging and Disability Services (DADS) is responsible for providing long-term services and supports for aging Texans, people with physical disabilities and people with intellectual and other developmental disabilities (IDD). Long-term services and supports help individuals to remain in their communities and avoid long-term institutionalization.

Many individuals with long-term service and support needs have co-occurring mental health conditions. In recent years, DADS has devoted more attention to addressing the unique support needs of those with challenging behaviors. Developmental disabilities can often overshadow existing mental health or medical conditions. Professionals, caregivers and family members who are accustomed to seeing an individual through the lens of a primary disability can misinterpret behaviors that may be associated with mental health conditions, distress, acute medical conditions or past trauma.

Many systems of care for people with IDD continue to focus on controlling and managing challenging behaviors without adequate consideration of the potential for underlying mental health or medical conditions as the cause of the behavior. The focus of treatment has often been the development of behavior management plans to promote compliance or the use of medications to control the behaviors. In both cases, the treatment is targeting the behavior and not the actual mental health or medical condition. This significantly reduces opportunities for recovery.

Research indicates that depression and anxiety are two of the most frequently identified mental health conditions in people with IDD.\textsuperscript{367} Research has also indicated an over-representation of schizophrenia in people with IDD compared to the general population.\textsuperscript{368} Post-traumatic stress has also been identified as a significant cause of mental health concerns in people with IDD.\textsuperscript{369} While trauma is not the only cause of mental health challenges in people with disabilities, it is significant and requires attention. Adults and children with disabilities experience abuse, neglect, institutionalization, abandonment, bullying and other types of trauma at rates higher

In the DADS section of this guide, the term “disability” is used to refer to people with physical disabilities and people with intellectual and other developmental disabilities. It should be noted that some mental health conditions can constitute a disability under some program eligibility criteria and legal protections even though the term is not typically used when referring to people with behavioral health conditions. People living with mental illness often prefer not to be identified as having a disability while people with physical disabilities and people with intellectual and other developmental disabilities often prefer the terminology.
than the general population. In one study, nearly 75 percent of participants with IDD experienced at least one traumatic event in their lifetime, increasing the likelihood of developing a mental health condition.\textsuperscript{370} Texas policymakers have recognized the impact of trauma on development and behavior and have statutorily mandated trauma-informed care training in the child welfare and the juvenile justice systems, but not within DADS programs and facilities.

### Prevalence of Behavioral Health Conditions for People with Disabilities and Aging Texans

#### People with Disabilities

Individuals with disabilities can experience all types of mental health conditions and require access to quality mental health services. People with disabilities, while at a higher risk of having mental health conditions than the general population, often experience significant disparities in their ability to access needed services.

It has been estimated that the rate of mental health conditions for people with IDD is two to three times higher than for the general population. Research findings have varied widely with prevalence rates for co-morbidity of IDD and mental health conditions ranging from 13.9 percent to 75.2 percent.\textsuperscript{371} The variation in prevalence rates is likely due to lack of consistency regarding diagnostic definitions and assessment instruments, small sample sizes, lack of studies using non-IDD comparison groups, overuse of administrative samples (versus population samples), level of disability (IQ) and type of disability.\textsuperscript{372} The higher rate of mental health conditions among people with disabilities may also be due to psychological stress related to a disability, social isolation, trauma, institutionalization, bullying, low self-esteem, and other factors.\textsuperscript{373, 374}

Over the past decade, evidence has shown a high prevalence of mental health conditions in people with autism spectrum disorder (ASD). Recent research indicates that for children living with autism, 10–14 years old, 70 percent had at least one co-occurring mental health disorder and 41 percent had two or more mental health diagnoses.\textsuperscript{375}

#### Aging Texans

Persons who are aging also experience under-recognized and under-treated behavioral health conditions. A July 2012 report by the Institute of Medicine warned of an upcoming “silver tsunami” of unmet mental health and substance use treatment needs among the senior population.\textsuperscript{376} Approximately 20 percent of the current elderly population has some form of behavioral health condition, most commonly depression, alcoholism or dementia-related
behavioral or psychiatric symptoms.377 An estimated two million seniors in the United States have serious mental illness.378 Older Texans meeting the medical criteria for nursing home services may be eligible for community-based services funded by DADS if they also meet financial eligibility criteria.

**Changing Environment**

As is the case with other agencies in the health and human services (HHS) enterprise, DADS is currently in a period of significant change. As discussed in the Health and Human Services Commission (HHSC) section, many services provided by the various HHS departments are either being provided, or will be provided, through a system of managed care programs.

Additionally, as a result of directives from both the 83rd Texas Legislature and HHSC leadership, departments are seeking new ways to provide more effective, appropriate and cost efficient services to the people who need them. Following are descriptions of some of the major change initiatives taking place at DADS.

**SB 7**

As a result of directives included in SB 7 (Nelson), major changes are expected in the delivery of both acute care services and long-term services and supports to people with disabilities. See the HHSC section for more detailed information on the changes currently being implemented and those under development that will be operationalized in the next few years. Many of these changes involve the expanded use of managed care for the delivery of services to people with disabilities. The SB 7 IDD System Redesign Advisory Committee is assisting HHSC and DADS in the development of future service delivery systems.


**SB 45**

In an effort to standardize the Medicaid waiver programs, SB 45 (Zaffirini) required the inclusion of employment assistance and supported employment services in all of the 1915(c) Medicaid home and community-based waivers. This will increase opportunities for individuals with disabilities to obtain meaningful integrated employment.

**SB 1226**

SB 1226 (Zaffirini) established competitive employment as the desired outcome for people with disabilities. The bill created the Employment First Taskforce to advise the state on their efforts to promote competitive employment for individuals with disabilities. The task force will be comprised of self-advocates, employers, providers and others interested in seeing opportunities increase for individuals with disabilities to find employment in competitive settings.
TRAVMA-INFORMED CARE AND PERSON-CENTERED PLANNING, TRAINING AND TECHNICAL ASSISTANCE AT SAN ANGELO AND MEXIA STATE SUPPORTED LIVING CENTERS

From 2012 to 2014 the Hogg Foundation for Mental Health partnered with DADS to provide ongoing trauma-informed care training and technical assistance at San Angelo and Mexia State Supported Living Centers through a grant-funded project. The goal of this two-year project was to reduce the use of restraint and create changes in how staff at the centers relate to and support the residents. An evaluation of the project indicates significant improvements in the culture of care as a result of the training and in the organizational awareness of the impact of trauma on residents.

2013 TRAUMA-INFORMED CARE TRAININGS AT DADS WAIVER CONFERENCES

Recognizing the importance of trauma-informed care for individuals with intellectual disabilities and co-occurring mental health conditions, DADS included trauma-informed care training at five regional waiver conferences held across the state during the summer of 2013. The training was conducted by Dr. Karyn Harvey and funded by the Hogg Foundation for Mental Health. This training helped to build awareness of the need to recognize and treat mental health conditions experienced by people with IDD, including those conditions resulting from trauma.

Programs and Services for People with Disabilities Who Have Co-occurring Behavioral Health Conditions

DADS serves persons who are aging, people with physical disabilities, and people with intellectual and other developmental disabilities, including those who have co-occurring behavioral health conditions. Services and supports are provided through a variety of community-based and institution-based programs. The services are funded through various federal and state funding sources.

Community Long-Term Services and Supports

DADS is responsible for the administration and regulation of community long-term services and supports not provided through managed care. Many of these programs provide needed services to people with disabilities and co-occurring behavioral health challenges. Some of the major community service programs are described below.
MEDICAID 1915(C) WAIVER SERVICES

DADS administers the 1915(c) Medicaid home and community-based services waiver programs designed to provide community supports and services to individuals eligible for institutional care (i.e. nursing facilities or intermediate care facilities (ICFs)). These waivers prevent the institutionalization of people with disabilities by providing appropriate community services and supports.

As opposed to institution-based care, access to these waiver services is not an entitlement and each program currently has a significant interest list. Legislative appropriations determine the number of people receiving services in these programs (funded waiver slots). The wait time for services varies by program but ranges from three to more than 10 years. Individuals receiving Medicaid waiver services are also eligible to receive Medicaid state plan mental health and substance use services.

Figure 65 provides basic information about eligibility and services for three primary waivers for persons with intellectual and other developmental disabilities.

### Figure 65. Community-Based Waiver Eligibility and Behavioral Health-Related Services Disabilities

<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Behavioral Health Services Provided (in addition to Medicaid state plan services)</th>
</tr>
</thead>
</table>
| Home and Community-based Services (HCS) | Individuals of any age with an intellectual disability diagnosed before age 22. Must have an IQ score below 70 or a related condition and an IQ score below 75. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300 percent of the SSI limit and countable resources of no more than $2,000. Parental income is not considered. | Case management  
Behavioral support, including social work and psychology  
Residential assistance including:  
- supported home living  
- foster/companion care  
- supervised living (group home)  
- residential support  
Respite  
Day habilitation  
Nursing services  
Employment services  
Supported employment |
<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Behavioral Health Services Provided (in addition to Medicaid state plan services)</th>
</tr>
</thead>
</table>
| Community Living Assistance Supports and Services (CLASS)             | Individuals of any age with a primary disability other than intellectual disability that originated before age 22 and affects the person’s ability to function in daily life. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300 percent of the SSI limit and countable resources of no more than $2,000. Parental income is not considered. | Case management  
Psychological and behavioral support services  
Respite  
Specialized therapies such as aquatic, music, recreational  
Nursing services  
Employment services  
Supported employment                                                                 |
| Texas Home Living (TxHmL)                                              | Individuals with an IQ below 70 or a related condition with an IQ below 75. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300 percent of the SSI limit and countable resources of no more than $2,000. This is the only waiver that considers parental income when determining financial eligibility for children. | Case management  
Specialized therapies  
Behavioral support  
Community support  
Respite  
Day habilitation  
Employment services  
Supported employment  
Habilitation                                                                 |
| Medically Dependent Children's Program (MDCP)                         | Individuals under 21 years of age who meet the medical necessity requirements for nursing facility care. Must meet financial eligibility requirements including income limit up to 300 percent of the SSI limit and countable resources of no more than $2,000. Parental income is not considered. | Case management  
Respite  
Adaptive aids  
Flexible family support services  
Nursing services  
Employment services  
Supported employment                                                                 |
| Deaf/Blind/Multiple Disabilities (DBMD)                                | Individuals with deaf-blindness and one or more other disabilities who meet eligibility for intermediate care facilities.                                                                                   | Case management  
Day habilitation  
Residential habilitation adaptive aids  
Behavioral support services  
Assisted living  
Nursing services  
Chore services  
Employment services  
Supported employment                                                                 |
Program Eligibility Behavioral Health Services Provided (in addition to Medicaid state plan services)

Community-Based Alternatives (CBA) Individuals with disabilities over the age of 21 who meet the criteria for nursing facility care. Must meet financial eligibility including income limit up to 300 percent of the SSI limit and countable resources of no more than $2,000. Case management Emergency response Nursing Adaptive aids Assisted living Personal assistance services Respite care Home delivered meals Transition assistance services Employment services Supported employment


Figure 66 below shows the number of people receiving services in the waiver programs in FY 2014, the number of individuals on the interest list as of March 31, 2014 and the average cost of each community-based program.

**Figure 66. Utilization and Costs for DADS HCS Waivers**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Community-Based Services (HCS)</td>
<td>20,903</td>
<td>70,117</td>
<td>$3,530</td>
</tr>
<tr>
<td>Community Living Assistance and Support Services (CLASS)</td>
<td>4,712</td>
<td>50,035</td>
<td>$3,723</td>
</tr>
<tr>
<td>Texas Home Living Waiver (TxHmL) (TxHmL)</td>
<td>5,845</td>
<td>Uses the HCS Interest List</td>
<td>$813</td>
</tr>
<tr>
<td>Medically Dependent Children’s Program (MDCP)</td>
<td>2,361</td>
<td>27,575</td>
<td>$1,429</td>
</tr>
<tr>
<td>Deaf/Blind/Multiple Disabilities (DBMD)</td>
<td>169</td>
<td>480</td>
<td>$4,302</td>
</tr>
<tr>
<td>Community-based Alternatives Program (CBA)</td>
<td>9,939</td>
<td>6,040</td>
<td>$1,302</td>
</tr>
</tbody>
</table>

ROLE OF LOCAL AUTHORITIES IN CONNECTING PEOPLE TO WAIVER SERVICES

The 39 Texas local authorities, also referred to as community centers, serve as the point of entry for many publicly-funded waiver programs for persons with physical, intellectual and developmental disabilities, as well as for general revenue safety-net services, intermediate care facilities, nursing facilities and state supported living centers. Depending on the program, local authorities have varying levels of responsibility for determining eligibility and enrollment, conducting assessments, developing service plans, coordinating and providing services, and maintaining wait lists. Local authorities are also responsible for permanency planning for individuals less than 22 years of age who live in institutional settings including intermediate care facilities, state supported living centers and group homes under the HCS waiver program.

Institutional Long-Term Services and Supports

Persons with disabilities residing in nursing facilities, privately operated intermediate care facilities, or in large state-operated supported living centers often experience co-occurring behavioral health conditions. Funding for these residential services is provided primarily through Medicaid.

SKILLED NURSING FACILITIES

Texas nursing facilities provide institutional care for older Texans and people with disabilities whose medical condition requires skilled licensed nursing services. While nursing facility eligibility criteria requires medical necessity for admission, many individuals residing in nursing facilities also have co-occurring mental health conditions. Starting in March 2015, nursing facility services will be integrated into STAR+Plus, a Texas Medicaid managed care program that provides both acute care and long-term services and supports.

Nursing facilities provide room and board, social services, medical supplies and equipment, over-the-counter drugs and personal needs items. Skilled behavioral health services are provided by psychiatrists and other medical and behavioral health professionals.

In order to ensure that the mental health needs of individuals being considered for a nursing home placement are identified and addressed, the federal government mandates Pre-admission Screening and Resident Review (PASRR) Level 1 screening prior to admission to a nursing facility. PASRR screening is intended to identify the following:

- Individuals who have a mental illness, an intellectual disability or a developmental disability (also known as related conditions).
- The appropriateness of placement in the nursing facility.
In 2013, the Centers for Medicare and Medicaid Services directed Texas to make changes to the PASRR program. Three major changes included:

- Eliminate the role of nursing facilities in the PASRR Evaluation (PE) determination process by introducing local authorities (LA) as the party that will complete the PE.
- Require specific, specialized services to be identified before nursing facility admission.
- Require an automated communication to local authorities that is triggered when a Resident Review is required.

**COMMUNITY INTERMEDIATE CARE FACILITIES**

Intermediate care facilities (ICFs) services are optional services permitted in Medicaid state plans. However, once a state chooses to include ICF services as a Medicaid benefit, those services become an entitlement to all those meeting eligibility criteria. Community-based ICFs can be licensed to provide services to people with intellectual disabilities or other developmental disabilities, sometimes referred to as related conditions. These facilities provide residential services similar to the state supported living centers but are privately owned and operated. Community ICF facilities vary in size from six beds to over 160 beds; most community-based ICFs are small, with eight or fewer beds.

**STATE SUPPORTED LIVING CENTERS**

State supported living centers (SSLCs) are large institutions that provide 24-hour residential services. Behavioral health treatment is a required service that must be provided by the facilities. The SSLCs are licensed and certified ICFs owned and operated by the state (community ICFs are privately owned). SSLCs operate in 13 locations: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo and San Antonio. Rio Grande State Center is also a licensed inpatient psychiatric hospital, serving persons with intellectual and developmental disabilities and mental illness. Individuals seeking placement in an SSLC must meet both financial and functional eligibility requirements.

Approximately 3,450 individuals reside in these facilities. Although the SSLC population has dropped significantly over the past decade, any discussion related to closure or consolidation of facilities has been met with strong legislative opposition. In Texas, only the Texas legislature can direct closure of a state supported living center. Due to fixed costs and the deteriorating aging facilities, as the census in these facilities declines, the per person costs increase.
As part of a 2009 settlement agreement with the U.S. Department of Justice over conditions at SSLCs, DADS agreed to improve health, safety and quality of care for consumers living in them. The agreement included increased access to psychiatric care, increased access to psychological services, and improved policy and practices designed to reduce the use of restraints. Despite the agreement, monitoring reports continue to identify significant deficiencies at the SSLCs.381

Figure 68 provides information on the eligibility requirements and the services provided by institutional providers of DADS services.
<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Behavioral Health Services Provided (in addition to Medicaid state plan services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care Facilities for Individuals with Intellectual</td>
<td>Have a diagnosis of intellectual disability with a full-scale IQ score of below 70 and an adaptive</td>
<td>24-hour residential care and services that include:</td>
</tr>
<tr>
<td>Disabilities and Related Conditions</td>
<td>behavior level with mild to extreme deficits, or</td>
<td>Physician services.</td>
</tr>
<tr>
<td></td>
<td>Have a full-scale IQ score of 75 or below and a primary diagnosis by a licensed physician of a</td>
<td>Behavioral health services.</td>
</tr>
<tr>
<td></td>
<td>related condition (manifest before age 22 years), and an adaptive behavior level with mild to</td>
<td>Medication management.</td>
</tr>
<tr>
<td></td>
<td>extreme deficits, or</td>
<td>Nursing.</td>
</tr>
<tr>
<td></td>
<td>Have a primary diagnosis of a related condition (manifest before age 22)</td>
<td>Skills training.</td>
</tr>
<tr>
<td></td>
<td>diagnosed by a licensed physician regardless of IQ and an adaptive behavior level with moderate</td>
<td>Occupational, physical and speech therapies.;</td>
</tr>
<tr>
<td></td>
<td>to extreme deficits, AND</td>
<td>Services to maintain connections between residents and their families/natural</td>
</tr>
<tr>
<td></td>
<td>Be in need of and able to benefit</td>
<td>support systems.</td>
</tr>
<tr>
<td></td>
<td>from the active treatment provided</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in the 24-hour supervised residential setting of an ICF.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Be eligible for SSI or be determined financially eligible for Medicaid.</td>
<td></td>
</tr>
<tr>
<td>State Supported Living Centers</td>
<td>Meet ICF/ID eligibility requirements.</td>
<td>24-hour residential care and services that include:</td>
</tr>
<tr>
<td></td>
<td>(1) Have severe or profound intellectual and developmental disabilities, OR (2) Have</td>
<td>Physician and nursing services.</td>
</tr>
<tr>
<td></td>
<td>intellectual and developmental disabilities and be medically fragile, OR (3) Have intellectual</td>
<td>Behavioral health services.</td>
</tr>
<tr>
<td></td>
<td>and developmental disabilities and be medically fragile, or (4) Represent a substantial risk of</td>
<td>Skills training.</td>
</tr>
<tr>
<td></td>
<td>physical injury to self or others.</td>
<td>Occupational therapies.</td>
</tr>
<tr>
<td></td>
<td>As an adult, be unable to provide</td>
<td>Vocational programs and employment.</td>
</tr>
<tr>
<td></td>
<td>for the most basic personal physical needs.</td>
<td>Services to maintain connections between residents and their families/natural</td>
</tr>
</tbody>
</table>
<pre><code>                                                                                                                                                   | support systems.                                                               |
</code></pre>

Figure 69 shows the projected number served and average net costs per month per client for nursing facilities, ICFs and state supported living centers described above.

**Figure 69. Utilization and Costs of Residential Programs for Persons with Disabilities**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Estimated Average Number Served per Month FY 2014</th>
<th>Estimated Average Monthly Cost per Client FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facilities</td>
<td>55,915</td>
<td>$3,390</td>
</tr>
<tr>
<td>Intermediate Care Facilities</td>
<td>5,227</td>
<td>$4,356</td>
</tr>
<tr>
<td>State Supported Living Centers</td>
<td>3,439</td>
<td>$16,034</td>
</tr>
</tbody>
</table>


Average per person costs vary greatly between the DADS long-term services programs. While the costs shown above are average costs, it should be noted that per person costs within each program can also vary greatly depending on the level of need of the individual. The Center for Medicaid and Medicare Services requires that each waiver program be cost neutral in the aggregate.

The following tables provide some comparison data between the various community and institutional programs and services offered by DADS. The information provided includes total spending, data on enrollees with behavioral health conditions, and monthly cost trends.

Figure 70 provides data on total spending for the past three years.

**Figure 70. Total Cost of Programs Serving Individuals with Disabilities (Data on costs for behavioral health services in these programs is not available)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based alternatives (CBA)</td>
<td>$146,443,637</td>
<td>$155,249,965</td>
<td>0 (Transferred to STAR+Plus)</td>
<td>0 (Transferred to STAR+Plus)</td>
<td>0 (Transferred to STAR+Plus)</td>
</tr>
<tr>
<td>Community Living Assistance and Services Supports (CLASS)</td>
<td>$202,065,579</td>
<td>$209,977,202</td>
<td>$225,301,068</td>
<td>$231,050,814</td>
<td>$231,050,814</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>---------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Home and Community-Based Services (HCS)</td>
<td>$844,768,822</td>
<td>$885,501,250</td>
<td>$977,566,068</td>
<td>$968,625,479</td>
<td>$968,625,479</td>
</tr>
<tr>
<td>Deaf-blind with multiple disabilities (DBMD)</td>
<td>$7,690,746</td>
<td>$8,783,912</td>
<td>$11,776,215</td>
<td>$12,643,008</td>
<td>$12,643,008</td>
</tr>
<tr>
<td>Medically dependent children’s program (MDCP)</td>
<td>$39,639,172</td>
<td>$40,486,431</td>
<td>$44,001,299</td>
<td>$41,749,547</td>
<td>0</td>
</tr>
<tr>
<td>(transfers to STAR kids)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Home Living Waiver (TxHmL)</td>
<td>$48,462,288</td>
<td>$57,075,024</td>
<td>$80,883,385</td>
<td>$82,211,947</td>
<td>$82,211,947</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals with ID (ICFsID)</td>
<td>$286,527,175</td>
<td>$280,912,477</td>
<td>$281,011,219</td>
<td>$282,671,837</td>
<td>$282,570,235</td>
</tr>
<tr>
<td>Nursing Facilities</td>
<td>$2,257,033,016</td>
<td>$2,286,729,014</td>
<td>$1,284,604,394*</td>
<td>$145,040,486*</td>
<td>$144,224,828*</td>
</tr>
<tr>
<td>State supported living centers (SSLCs)</td>
<td>$661,866,854</td>
<td>$677,050,452</td>
<td>$679,774,904</td>
<td>$682,860,733</td>
<td>$682,860,733</td>
</tr>
</tbody>
</table>


**The reduction in nursing facility payments is due to the transition of these services into managed care as of 3/1/15.**
Figure 71 shows the trends over the past three years of the number of individuals in the Medicaid 1915(c) waiver programs with a co-occurring mental health condition.

**Figure 71. Percentage of People Enrolled in Dads Programs with a Behavioral Health Diagnosis**

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2011 Enrolled</th>
<th>FY2011 BH Diagnosis %</th>
<th>FY2012 Enrolled</th>
<th>FY2012 BH Diagnosis %</th>
<th>FY2013 Enrolled</th>
<th>FY2013 BH Diagnosis %</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBA</td>
<td>28,874</td>
<td>4,747</td>
<td>25,675</td>
<td>3,514</td>
<td>14,631</td>
<td>2,296</td>
</tr>
<tr>
<td>CLASS</td>
<td>4,954</td>
<td>1,105</td>
<td>4,910</td>
<td>1,102</td>
<td>4,828</td>
<td>1,080</td>
</tr>
<tr>
<td>HCS</td>
<td>20,829</td>
<td>7,644</td>
<td>21,102</td>
<td>7,856</td>
<td>21,404</td>
<td>8,201</td>
</tr>
<tr>
<td>DBMD</td>
<td>156</td>
<td>16</td>
<td>155</td>
<td>16</td>
<td>158</td>
<td>16</td>
</tr>
<tr>
<td>MDCP</td>
<td>6,394</td>
<td>2,138</td>
<td>6,257</td>
<td>2,445</td>
<td>6,407</td>
<td>2,486</td>
</tr>
<tr>
<td>IxFsIoD</td>
<td>6,500</td>
<td>2,630</td>
<td>6,265</td>
<td>2,583</td>
<td>6,169</td>
<td>2,535</td>
</tr>
<tr>
<td>Nursing Facilities*</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Nursing Facilities*</td>
<td>Not Available</td>
</tr>
<tr>
<td>SSLCs</td>
<td>4,294</td>
<td>2,468</td>
<td>4,084</td>
<td>2,386</td>
<td>3,907</td>
<td>2,257</td>
</tr>
</tbody>
</table>

Source: Department of Aging and Disability Services. (2014, May 15). Data Request: People enrolled in DADS programs

*Nursing facility counts only include individuals receiving full Medicaid daily care in order to match with the average monthly costs provided. The MDS data available for behavioral health diagnoses prior to FY 2013 is unreliable. Consequently only FY 2013 data is available.

Figure 72 provides a comparison of the average monthly, per person cost for the various long-term services and supports programs.

**Figure 72. Program Cost Trends - Average Monthly Cost Per Individual for Dads Waiver and Institutional Programs**

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2010</th>
<th>FY2011</th>
<th>FY2012</th>
<th>FY2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBA</td>
<td>$ 1,564</td>
<td>$ 1,600</td>
<td>$ 1,458</td>
<td>$ 1,265</td>
</tr>
<tr>
<td>CLASS</td>
<td>$ 3,592</td>
<td>$ 3,444</td>
<td>$ 3,502</td>
<td>$ 3,610</td>
</tr>
<tr>
<td>HCS</td>
<td>$ 3,527</td>
<td>$ 3,464</td>
<td>$ 3,433</td>
<td>$ 3,489</td>
</tr>
<tr>
<td>DBMD</td>
<td>$ 4,083</td>
<td>$ 4,195</td>
<td>$ 4,175</td>
<td>$ 4,256</td>
</tr>
<tr>
<td>MDCP</td>
<td>$ 1,537</td>
<td>$ 1,491</td>
<td>$ 1,475</td>
<td>$ 1,444</td>
</tr>
<tr>
<td>IxFsIoD</td>
<td>$ 664</td>
<td>$ 668</td>
<td>$ 799</td>
<td>$ 870</td>
</tr>
<tr>
<td>Nursing Facilities*</td>
<td>$ 4,535</td>
<td>$ 4,495</td>
<td>$ 4,361</td>
<td>$ 4,338</td>
</tr>
<tr>
<td>SSLCs</td>
<td>$ 12,257</td>
<td>$ 13,588</td>
<td>$ 14,286</td>
<td>$ 15,112</td>
</tr>
</tbody>
</table>

Source: Department of Aging and Disability Services. (2014, May 15). Data Request: People enrolled in DADS programs
Additional Programs for People with Disabilities and Aging Texans

NON-MEDICAID SERVICES

DADS administers several non-Medicaid funded programs providing direct long-term services and supports to individuals with disabilities. These include:

- Adult Foster Care
- Client Managed Personal Attendant Services
- Day Activity and Health Services (DAHS)
- Emergency Response
- Family Care
- Home Delivered Meals
- Special Services to Persons with Disabilities
- In-Home and Family Support Program
- Intellectual Disability Community Services

For more information on these programs and the services offered, please visit http://cfoweb.dads.state.tx.us/ReferenceGuide/guides/FY13ReferenceGuide.pdf.

GUARDIANSHIP PROGRAM

Guardianship is a legal method to protect individuals' wellbeing when they cannot protect themselves. A guardian is a court-appointed person or entity who makes decisions on behalf of an individual who lacks the capacity to make important life decisions. The DADS self-evaluation submitted to the Sunset Commission in 2013 indicates that in 2012 there were, on average, 913 individuals receiving guardianship services from DADS at an average monthly cost of $432 per adult individual.383

The purpose of the guardianship program under Human Resources Code Section 161.101 is to provide guardianship services to:

- Incapacitated children upon reaching the age of 18 who have been in CPS conservatorship.
- Incapacitated adults age 65 or older, or between the ages of 18-65 with a disability, who were referred by Adult Protective Services (APS) following an investigation in which abuse, neglect, or exploitation was confirmed, and no other means of protecting the person is available and there is some indication the individual lacks capacity.
- Incapacitated individuals referred directly to the program by a court with probate authority under certain criteria established in statute or rule.384

PROMOTING INDEPENDENCE INITIATIVE

The Texas Promoting Independence Initiative began in January 2000 in direct response to the U.S. Supreme Court ruling in *Olmstead v. L.C.*, in which the court ruled that states must provide community-based services for persons with
disabilities under the following conditions:

- The person would otherwise be entitled to institutional services.
- The state’s treatment professionals deem community-based placement to be appropriate.
- The affected person agrees to receiving community-based services.
- The placement can be reasonably accommodated given the resources available to the state and the needs of others who are receiving state-supported disability services.  

As part of the Promoting Independence Initiative, a number of supports are available to help individuals remain in or return to their communities of choice, including the Money Follows the Person program for nursing home residents.

In addition, statewide relocation assistance, housing opportunities and community transition teams are available to assist nursing facility residents in their transition to community-based services. Similar relocation services are not currently available to individuals leaving state psychiatric facilities. Efforts to address this gap through a Balanced Incentive Program project were denied by CMS due to the “institutions of mental disease exclusion.” This exclusion prohibits the use of Medicaid funding for individuals between the ages of 22 through 64 years in a hospital, nursing facility or other institution of 17 beds or more which is primarily engaged in providing mental health care (see DSHS section for more information).

**MONEY FOLLOWS THE PERSON PROGRAM**

Among the many DADS initiatives impacting individuals with co-occurring conditions, DADS participates in a federally funded national demonstration program known as Money Follows the Person. This program makes it possible for persons living in nursing facilities to transition back to their communities with appropriate community-based services and supports by allowing the money being used for institutional care to be used to provide community services. The money-follows-the-person model developed in Texas has been replicated in multiple states around the country. Since the inception of the program in Texas, more than 21,300 individuals have transitioned from nursing homes to community living with supports and services. The age span of individuals taking advantage of the Money Follows the Person program ranges from less than one to more than 100 years old.
Texas Department of Assistive and Rehabilitative Services: At A Glance

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<td>179</td>
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</tbody>
</table>

POLICY CONCERNS

- Cost-sharing barriers for families seeking Early Childhood Intervention (ECI) services
- Impact of reduced eligibility for ECI services
- Accountability for outcome-based vocational rehabilitation services for individuals living with mental illness
- Lack of expertise needed to support individuals living with mental illness

FAST FACTS

- The national employment rate for the general population in 2012 was 63.9 percent. Comparatively, the employment rate for persons with a disability was 17.8 percent.
- A 2013 report by the Texas Workforce Investment Council stated that based on 2011 data, Texas had the second largest number of individuals with disabilities in the nation.
- In 2013, almost one-fifth (14,428) of the total individuals served by the Vocational Rehabilitation program were individuals whose primary disabilities were mental/emotional/psychosocial.
The federal maximum monthly payment standard for SSI as of January 2014 is $721 per eligible individual and $1,082 per eligible individual with an eligible spouse.\textsuperscript{391}
Texas Department of Assistive and Rehabilitative Services

The Texas Department of Assistive and Rehabilitative Services (DARS) works “in partnership with Texans with disabilities and families with children who have developmental delays to improve the quality of their lives and to enable their full participation in society.” DARS seeks to reduce the need for long-term support from other public programs and services. The Early Childhood Intervention and Vocational Rehabilitation programs administered under DARS are of special relevance to the promotion of mental health for Texans. The nurturing of a child’s healthy emotional, behavioral, and social development can prevent the future development of mental health conditions. Employment can help adults with mental or behavioral health conditions obtain independence, become integrated into society, and achieve social, emotional, and general well-being.

The agency consists of four service divisions:

**Division for Early Childhood Intervention Services:** Offers state and federally funded services statewide to children ages 0 to 3 who have disabilities and developmental delays.

**Division for Rehabilitation Services:** Administers a series of programs to promote independence and self-sufficiency for persons with disabilities via therapy, peer counseling, advocacy support, employment services, and transition services for students with disabilities.

**Division for Disability Determination Services:** Makes Social Security disability determinations for Texans with severe disabilities who apply for Social Security Disability Insurance or Supplemental Security Income.

**Division for Blind Services:** Assists blind or visually impaired persons and their families. Two unique programs offered by this division include the Blindness Education, Screening and Treatment Program, and the Criss Cole Rehabilitation Center (CCRC), an Austin-based residential facility that provides independent living training for Texans who are living with visual impairments and blindness.

Early interventions have the potential to mitigate the impact of developmental delays that can lead to later behavioral challenges when not addressed. Providing services to families and children at an early stage in development can reduce the cost of special needs services, enable families to provide support to their special needs children, and counter environmental risk factors. In Texas, as a result of ECI services:

- 75 percent of children experienced increases in acquisition and use of knowledge and skills (thinking, reasoning, problem solving, early literacy, and math skills).
- 52 percent left the program functioning equal to their typically-developing peers in the acquisition of knowledge and skills.
- 84 percent of families reported improvements in their ability to help their children develop and learn.

ECI is authorized by Part C of the Individuals with Disabilities Education Act; Part C is a federal grant program that assists states in operating a statewide early intervention program for infants and toddlers ages 0 to 3. State general revenue funds are required to draw down federal funding. In 2013, the 83rd Legislature approved the ECI budget to continue current service levels, as well as to support projected caseload increases. The operating budget for ECI in FY 2013 was $128,836,309 and $150,256,901 in FY 2014.

A Child’s Journey through ECI:

Getting Started
1. Referral
2. First Visit
3. Evaluation and Assessment

Next Steps: ECI Services
4. Individualized Family Service Plan Meeting and IFSP Development
5. ECI Service Delivery Begins
6. Review of Child’s Progress

Future Steps: Leaving ECI
7. Children must transition out of ECI by their third birthday.

ELIGIBILITY FOR SERVICES

To determine eligibility for ECI services, a team of at least two professionals from different disciplines performs a comprehensive evaluation of a child’s abilities. Generally, eligibility is conditioned on a child meeting at least one of following three criteria:

- **Medically diagnosed condition:** Children with medical diagnoses that have a
high probability of resulting in developmental delays. For a list of diagnoses that qualify for ECI see [http://www.dars.state.tx.us/ecis/resources/diagnoses.asp].

- **Auditory or visual impairments**: Children with auditory or visual impairments as defined by the Texas Education Agency.406
- **Developmental delays**: Children with developmental delays of at least 25 percent that affect function in one or more areas of development.

**Figure 73. Percentage Enrolled by Reason for Eligibility**

![Pie chart showing percentage enrolled by reason for eligibility]


ECI evaluates a child for developmental delay using the Battelle Developmental Inventory, which includes an assessment of the child’s social and emotional delays. Based on the results of this evaluation, ECI professionals and the child’s family work as a team to develop an individual family service plan. The plan may include a range of services such as evaluation, service planning, family counseling, and psychological and social work services.407

**SERVICES, UTILIZATION, AND COSTS**

Eligible children can participate in ECI regardless of their income level and certain ECI services are free of charge, including evaluation and assessment, case management, development of an Individualized Family Service Plan (IFSP), and translation and interpreter services.408 ECI is a cost share program, meaning that families with the ability to pay are expected to financially contribute to the cost of services. Children on Medicaid receive all ECI services free of charge. Other families pay for ECI on a sliding scale basis. Family income, family size, the child’s foster care status, and public and private insurance are taken into account when arriving at a maximum monthly charge for ECI services. Families will not be turned away due to an inability to pay.409

Rider 31 (82nd Legislative Session) implemented changes to the family cost-share
provisions that increased the cost of ECI services to some families as of May 1, 2014. Families with an adjusted gross income above 400 percent of the federal poverty level will be required to cover the full cost of ECI services. However, their contribution to the costs of ECI cannot exceed five percent of a family’s adjusted monthly income.

Figure 74. Characteristics of Individuals utilizing ECI Services

<table>
<thead>
<tr>
<th></th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total children referred</td>
<td>68,172</td>
</tr>
<tr>
<td>Total children who received comprehensive services</td>
<td>48,193</td>
</tr>
<tr>
<td>Average monthly cost per consumer</td>
<td>$421*</td>
</tr>
</tbody>
</table>

* based on comprehensive services


The distribution of enrollment in the ECI program by age is fairly evenly split among the three key age groups, as follows:

- 0 to 12 months: 36%
- 13 to 24 months: 34%
- 25 to 36 months: 30%

The percentage of enrolled children using each of the major types of services is:

- Developmental services: 84%
- Speech language therapy: 55%
- Occupational therapy: 30%
- Physical therapy: 24%
- Nutrition: 9%
- Psychological/social work: 6%
- Vision services: 2%
- Audiology: 2%

Note: Total planned service types sum to more than 100 percent because children may receive multiple types of services.

The 83rd Legislature restored some of the ECI funding reductions passed in 2011. However, long-term sustainability of the current ECI structure in Texas is challenged by the significant growth in the number of children and families receiving services, resource levels that do not support adequate service levels, and a complex contract payment structure with multiple federal, state, and local funding sources. For ECI advocates, securing funding to support the growing caseload and maintain service levels for children already in the ECI system will likely continue to be a key issue during the 84th legislative session.

Division for Rehabilitation Services

The Division for Rehabilitation Services (DRS) encompasses an array of social
services and programs meant to improve the quality of life for individuals living with physical, developmental, mental, or intellectual disabilities. Life skills, vocational rehabilitation, and independent living services are key elements to self-sufficiency. Self-sufficiency is linked to self-esteem, which is correlated with greater overall psychological health.  

The national employment rate for the general population in 2012 was 64 percent. Comparatively, the employment rate for persons with a disability was 17.6 percent. In the same year, 34 percent of workers with a disability were employed part time, compared to 19 percent of individuals without a documented disability. Unemployment rates (percentage of people who are jobless, available for work, and looking for jobs) for the general population and for persons with disabilities were 7.1 percent and 13.2 percent, respectively. According to research from the National Institute on Disability and Rehabilitation Research, employment rates for persons with mental illness are 20 to 30 percent lower than for those with no mental health conditions. Yet for persons living with mental illness, employment can help promote recovery. Individuals with disabilities or mental health conditions are a valuable resource for employers and can contribute to the economic growth of Texas when provided with the appropriate opportunities and supports.

A 2013 report by the Texas Workforce Investment Council stated that based on 2011 data, Texas had the second largest number of individuals with disabilities in the nation. Within DRS, the Vocational Rehabilitation and Independent Living Services programs are especially pertinent to the delivery of services for Texans living with disabilities and mental illnesses.

**VOCATIONAL REHABILITATION PROGRAM**

**PROGRAM OVERVIEW**

The purpose of the Vocational Rehabilitation (VR) program is to help people with physical, mental or developmental conditions or disabilities prepare for, find and keep employment. The VR program takes into account individuals’ needs and abilities and develops a service portfolio to help identify appropriate job opportunities, establish employment goals, and access support to maintain and succeed in the workforce. Services offered in this program are individualized and can include counseling, training, medical services, assistive devices, and job placement assistance.

The program partners with businesses to develop new employment opportunities. Program staff also work with public school districts to target students with disabilities who need services to help them transition from secondary education to post-secondary school or work. To locate a DRS office an individual can call the inquiry line at 1-800-628-5115. A list of local offices is also available at www.dars.state.tx.us.

In 2013, almost one-fifth (14,428) of the total individuals served by the VR program...
were individuals whose primary disabilities were mental/emotional/psychosocial.429

ELIGIBILITY PROCESS

A counselor is assigned to discuss the eligibility process and requirements, explain the services available, and determine if an individual’s disability makes it difficult to work. The goal is to determine how rehabilitation services will enable the individual to become and remain employed. If needed to make the determination, additional information may be requested from doctors, schools and other providers who have information about how the person’s disability impacts the ability to work. The rehabilitation counselor may also require additional assessments, which are paid for the department.

Eligibility is based on meeting the following conditions:430

· The person has a disability that results in substantial problems in gaining employment.
· Vocational rehabilitation services are required to prepare for, get or keep a job.
· The person is able to get or keep work after receiving services.

SERVICES

Vocational rehabilitation services are intended to support people with disabilities in the community and also support their movement from nursing homes and other institutions to community-based settings.

Vocational rehabilitation services are based on individual needs and may include:431

· Medical, psychological and vocational evaluation to determine the nature and degree of the disability and the individual's job capabilities.
· Counseling and guidance to help the individual and family identify and plan for vocational goals and adjust to the working world.
· Training to learn job skills in trade school, college, university, on the job, or at home.
· Medical treatment and therapy to lessen or remove the disability.
· Rehabilitation technology devices and services to improve job functioning.
· Training in appropriate work behaviors and other skills to meet employer expectations.
· Job placement assistance to find jobs compatible with the person’s physical and mental ability.
· Follow-up after job placement to ensure job success.
· Supported employment.

The supported employment program is intended for people who need extensive assistance to learn skills related to getting and keeping a job but who, after training, can perform satisfactorily without long-term one-on-one support. Individuals with intellectual and development disabilities who transition to 1915(c) home and community-based waiver services may continue to receive supported employment through the waiver program. DARS-supported employment services are intended to be short term. However, if an individual requires waiver services they can continue
to receive supported employment through the waiver after DARS-supported employment services are no longer available. Continuing services may include consulting with the employer about problem areas, ensuring natural supports such as assistance from co-workers are in place, and providing supportive services such as transportation and self-care management.432

Approximately 15 percent of individuals served by the DARS vocational rehabilitation program in 2013 succeeded in obtaining employment. However, many more individuals had their cases closed for reasons other than achieving their planned employment goals. Individuals who had their cases closed due to reasons such as moving away, losing contact, determined to be unemployable, or who were otherwise unable to continue with their planned VR services are considered to have completed VR services; Thus, an individual may be considered to have completed VR services even though that individual was not ultimately placed in appropriate employment.

Figure 75 details individuals served in Texas for FY 2012 and 2013.

**Figure 75. Outcomes for Individuals utilizing Vocational Rehabilitation Services**

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals served</td>
<td>83,930</td>
<td>79,578</td>
</tr>
<tr>
<td>Average cost per consumer</td>
<td>$2,551</td>
<td>$2,569</td>
</tr>
<tr>
<td>Total successful closures (people getting jobs)</td>
<td>11,686</td>
<td>12,102</td>
</tr>
</tbody>
</table>


---

**INDEPENDENT LIVING SERVICES**

Independent Living Services offered by DRS are designed to “promote self-sufficiency and enhanced quality of life for people with significant disabilities by focusing on mobility, communications, personal adjustment and self-direction.”433 In FY 2013, 5,342 persons received services from Independent Living Centers.434

**EXPANSION**

The Independent Living Services program partners with Centers for Independent Living (CILs) located around the state. These CILs are private, nonprofit, nonresidential centers that provide an array of independent living programs. CILs partner with DARS, DADS and community-based organizations and are funded either privately or with state and federal funds.435 There are currently 27 CILs across Texas, 15 of which are funded by DARS. These 27 CILs serve 157 counties located in: Odessa, Austin, Round Rock, San Marcos, Bryan, Corpus Christi, Houston, Sugarland, Angleton, Crockett, Tyler, Belton, Lubbock, Abilene, San Angelo, League City,
Amarillo, Palestine, Dallas, Denton, Fort Worth, Plano, Beaumont, San Antonio, McAllen, Laredo, El Paso. Based on 2010 U.S. Census Data, there are an estimated half a million state residents with disabilities currently living in areas that are not served by a CIL. Expansion plans seek to increase access to independent living center services by establishing locations in the following target centers: Texarkana, Sherman, Big Spring, Wichita Falls, Liberty, and Rockwall. DARS requested 1 million dollars in each year for fiscal years 2014 and 2015 to expand independent living center services to underserved areas. DARS requested $2,689,283 for fiscal year 2016 and $2,689,283 for fiscal year 2016 for CILs.

**ELIGIBILITY**

In order to be eligible for independent living services, an individual must be certified by a DRS counselor to have a significant disability that results in substantial impediment to the person’s ability to function independently in the family or community. There must also be a reasonable expectation that assistance will result in the person’s ability to function more independently.

**SERVICES**

Independent living services may include:

- Counseling and guidance.
- Training and tutorial services.
- Adult basic education.
- Rehabilitation facility training.
- Telecommunications, sensory and other technological aids for people who are hearing-impaired.
- Vehicle modification.
- Assistive devices such as artificial limbs, braces, wheelchairs and hearing aids to stabilize or improve function.
- Other services as needed, such as transportation, interpreter services and maintenance, in order to achieve independent living objectives.

**Division of Disability Determination Services (DDS)**

The federal Social Security Administration operates two income stability programs for children and adults with disabilities: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Some people with serious mental health conditions will qualify for either or both SSDI and SSI; approximately a third of individuals receiving SSDI assistance qualify on the basis of a mental health diagnosis.

Both SSI and SSDI are cash assistance programs. DARS staff make the initial disability determination for Texans applying for SSDI and/or SSI. Approximately
364,428 disability cases were determined in FY 2013. DDS is completely federally funded with funding totaling $113,224,755 in FY 2012.

SSDI is governed by rules set out in Title II of the Social Security Act and covers workers age 18 to 65 who are disabled, disabled widows/widowers, and disabled adult children of workers with sufficient work histories. People earn eligibility for this program throughout their working lives by paying social security taxes. Approval for SSDI payments results in eligibility for Medicare coverage after a two-year waiting period.

Supplemental Security Income (SSI) is governed by rules set out in Title XVI of the Social Security Act. SSI provides monthly stipends to qualifying children and adults under the age of 65. Once approved for SSI, participants are eligible for Medicaid.

Figure 76 below details the disability claims process to receive SSI or SSDI benefits.

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Figure 76. Disability Claims Process for SSI and SSDI Benefits

---

People who disagree with their SSI or SSDI determination have a legal right to appeal the decision. There are four levels of appeal:

- Reconsideration: Another disability examiner and medical team reviews the case to determine if the decision was proper. Claimants may submit additional evidence to support their case.
- Administrative Hearing: Claimants may present witnesses and evidence at a formal, private hearing with an administrative law judge.
- SSA Council Hearing: Reviews decisions by judges at the administrative hearing level; up to 70 percent of the decisions remain unchanged.

---


446

447
U.S. Federal District Court: A hearing at the federal court level; very few cases reach this level.

According to a report by the SSA that tracked SSDI outcomes from 2002–2010, the number of applicants who were granted awards upon initial review averaged 26 percent. Of those who appealed their denial, 3 percent of applicants were subsequently granted benefits at the reconsideration state and 13 percent through a hearing.448 A new report is scheduled to be released in November 2014.

**PROCESS FOR ADMISSION AND ELIGIBILITY**

Eligibility for both SSDI and SSI is conditioned on the determination that an individual has a disability that prevents his or her ability to work. Initial disability determinations are made by disability officers within DARS. Like serious physical conditions, mental health conditions can be disabling and may allow an individual to access SSDI or SSI cash benefits if they meet other eligibility criteria.

According to a 2010 report by the SSA, mental health conditions constitute about a third of national SSDI diagnoses.449 Disability determinations for SSDI on the basis of a mental health condition are categorized as: organic mental disorders; schizophrenic, paranoid, and other psychotic disorders; affective disorders; intellectual disability; anxiety-related disorders; somatoform disorders; personality disorders; substance addiction disorders; and autistic disorder and other pervasive developmental disorders. Each of these categories includes a set of criteria that must be satisfied in order to qualify for SSDI. Monthly benefits for SSDI are dependent on the social security earnings record of the worker. There is no minimum SSDI monthly benefit; the monthly maximum benefit depends on the age at which a worker left the workforce due to his or her disability. The 2014 monthly benefit for a person retiring at age 70 is $3,425.450 The SSA makes the final admission decision and considers a more exhaustive set of eligibility criteria.

To be eligible for SSI, in addition to having a disability (this includes mental health conditions), adults and children must meet strict financial and functional criteria. The federal maximum monthly payment standard for SSI as of January 2014 is $721 per eligible individual and $1,082 per eligible individual with an eligible spouse.451

Additional information on eligibility criteria can be found on the Social Security website at http://www.ssa.gov.
Utilization

Figure 77 shows statistics about the number of cases received and determined, along with program outcomes on the percent of initial disability cases allowed, average case process time, and accuracy against the SSA's final decision.

**Figure 77. Utilization of Disability Determination Services in Texas**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SSI and SSDI cases received</td>
<td>333,549</td>
</tr>
<tr>
<td>Total cases determined</td>
<td>336,908 *</td>
</tr>
<tr>
<td>Percent of initial disability cases allowed</td>
<td>34%</td>
</tr>
<tr>
<td>Average initial case process time (in days)</td>
<td>70</td>
</tr>
<tr>
<td>Accuracy with regards to ultimate SSA decision</td>
<td>96%</td>
</tr>
</tbody>
</table>

*This is the number reported in the DARS annual report. It is unclear why the number of total cases determined exceeds the number of cases received.


**DIVISION FOR BLIND AND VISUALLY IMPAIRED**

The Division for Blind and Visually Impaired Services (DBS) provides services to achieve increased quality of life outcomes for Texans who are blind or have visual impairments. Figure 78 provides an overview of the programs and services operating under DBS.
## Figure 78. DBS Services

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Services</th>
<th>Number Served</th>
<th>Average Cost Per Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blind Children's Vocational Discovery and Development Program</td>
<td>Assists children up to 22 years old in developing the confidence and competence to become fully active members of their community.</td>
<td>4,417[^452]</td>
<td>$108 monthly</td>
</tr>
<tr>
<td>Vocational Rehabilitation Services</td>
<td>Helps people with blindness or visual impairments obtain employment by providing assistive technology, transition services, and vocational training.</td>
<td>10,066[^453]</td>
<td>$4,650</td>
</tr>
<tr>
<td>Specialized Telecommunications Assistance Program</td>
<td>Provides financial vouchers for Texans with hearing impairments to acquire assistive equipment such as two-way pagers, amplified telephones, and big button telephones.</td>
<td>26,781 vouchers issued[^454]</td>
<td>Voucher values range from $90 to $8,420 depending on the device.</td>
</tr>
<tr>
<td>Blindness Education, Screening and Treatment Program</td>
<td>Program goal is to prevent blindness. Also assists uninsured adults with paying for urgently needed eye-medical treatment.</td>
<td>4,428[^455]</td>
<td>$98</td>
</tr>
<tr>
<td>Criss Cole Rehabilitation Center</td>
<td>Residential facility located in Austin, Texas provides independent living training for blind and visually impaired adults in the form of orientation and mobility training, braille, daily living, and advanced career guidance.</td>
<td>200[^456]</td>
<td>N/A</td>
</tr>
<tr>
<td>Business Enterprises of Texas</td>
<td>Provides employment assistance in the form of food management opportunities for blind Texans.</td>
<td>1,584[^457]</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Texas Department of Criminal Justice and Local Criminal Justice Agencies: At A Glance

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POLICY CONCERNS

- Lack of Crisis Intervention Training in rural jurisdictions to guide law enforcement in interactions with people in psychiatric crisis
- Need to divert low-level offenders with mental illness or addictions into treatment settings rather than correctional settings
- Cursory or no training for jailors and correctional staff on mental health issues, suicide risk, and de-escalation
- Use of prolonged administrative segregation, repeated restraints, and other aversive interventions on inmates with mental illness
- Gap in benefits eligibility upon re-entry
- Need for intensive support in transition from jail or prison to community, including jail in-reach programs, Forensic Assertive Community Treatment, and forensic peer support
- Need for coordination on forensic issues, perhaps through a DSHS Forensic
Director

FAST FACTS

- Studies estimate that half of all adult inmates in U.S. prisons have at least one mental health condition and that 15% to 24% have a serious mental illness.458
- On August 31, 2013, there were 136,340 offenders in Texas prisons.459 The average cost per day of housing and feeding an inmate was $50.04.460
- The average cost per day per prisoner for medical care in Texas is between $42 and $49 per day.461 The average cost per day for an inmate in a psychiatric correctional facility is $138.462
- On December 1, 2013, Texas county and city jails were collectively operating at 69.95% capacity with a total jail population of 66,807.463

ORGANIZATIONAL CHART

[Diagram of Texas Department of Criminal Justice Organizational Structure]
Texas Department of Criminal Justice and Local Criminal Justice Agencies

A significant number of individuals residing in Texas criminal justice settings are living with one or more mental health conditions and many have a co-occurring substance use disorder. Studies estimate that half of all adult inmates in U.S. prisons have at least one mental health condition and that 15% to 24% have a serious mental illness. County- and city-run jails house a similar population, with one study showing that 14.5% of male jail detainees and 31% of females had symptoms of a serious mental illness.

People living with mental health conditions sometimes become involved with the criminal justice system as a result of conduct that is directly or indirectly related to their condition. Recent research indicates that this “criminalization of mental illness” may be a modest phenomenon, with only 7% of individuals in one setting entering the criminal justice system because of behavior linked to a mental illness instead of behavior linked to other factors like hostility, disinhibition, or emotional reactivity. Nonetheless, the significant and growing number of people with serious mental illness in criminal justice settings raises important challenges for the rehabilitation of these individuals, the management of the facilities, and state and county budgets.

The extent to which the presence of a serious mental illness is linked to dangerous behavior is unclear. In some cases it seems mental illness is linked to violent behavior. Research shows, however, that this link is weak and in the vast majority of cases, the presence of mental illness does not increase the risk of violent behavior towards others. The research suggests risk factors for crime and violence are the same for persons with mental illness as persons in the general population. The risk of violent behavior is increased when a substance use disorder is present. Contrary to the impression created by highly publicized shootings, persons with serious mental illness commit only a small proportion of violent homicides in which a gun is used. The vast majority of people with a diagnosable serious mental illness never engage in violence. Unfortunately, the science of risk assessment has not advanced sufficiently to enable us to identify which individuals will commit violent acts; psychiatrists can rule out who is not going to be violent better than they can identify who will be violent.
Legislators addressed a number of mental health concerns within the criminal justice system during the 83rd legislative session. Figure 79 below offers an overview of the criminal justice and mental health-related legislation:

### 83RD SESSION CRIMINAL JUSTICE AND MENTAL HEALTH LEGISLATION

**Figure 79. 83rd Session Criminal Justice and Mental Health Legislation**

<table>
<thead>
<tr>
<th>Passed</th>
<th>Author and Description</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB 213</td>
<td>Whitmire, Nichols – Relating to the continuation and functions of the Texas Board of Criminal Justice and Texas Department of Criminal Justice, and the Windham School District and to the functions of the Board of Pardons and Paroles and the Correctional Managed Health Care Committee.</td>
<td>Extends Sunset Review (the legislature’s assessment of the efficacy and performance of TDCJ) to 2021. Makes numerous changes to reentry and reintegration service delivery by TDCJ and related agencies. For individuals seeking parole, the department is now required to develop and submit an individual treatment plan to the Board of Pardons and Paroles before the board considers the inmate’s release. Also requires local Community Justice Assistance Departments to utilize the risk and needs assessment instrument developed by TDCJ upon placement of an individual in a community supervision program. Changes composition of Correctional Managed Health Care Committee to include two licensed mental health professionals appointed by the governor. Authorizes TDCJ to establish a managed health care provider network of physicians and hospitals to provide health care to people confined by TDCJ and sets out requirements for these contracts. Note: SB 213 is complex and includes many details and directives. The above is simply a summary of the mental health aspects of the bill.</td>
</tr>
<tr>
<td>SB 1003</td>
<td>Carona – Relating to a review of and report regarding the use of adult and juvenile administrative segregation in facilities in this state.</td>
<td>Requires the Texas Juvenile Justice Department (TJJD) to collect data about the number of placements in disciplinary seclusion lasting at least 90 minutes. Requires the Criminal Justice Legislative Oversight Committee “subject to the availability of funds from gifts, grants and donations” to appoint an independent third party to conduct a review of adult and juvenile administrative segregation practices. As of September 2014, the Criminal Justice Legislative Oversight Committee has not been called to meet and no work has been done on the review of administrative segregation.</td>
</tr>
<tr>
<td>Passed</td>
<td>Author and Description</td>
<td>Summary</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>SB 1185</td>
<td>Huffman – <em>Relating to the creation of a mental health jail diversion pilot program.</em></td>
<td>Creates a mental health jail diversion pilot program in Harris County that will serve no fewer than 500 or more than 600 individuals.</td>
</tr>
<tr>
<td>SB 1475</td>
<td>Duncan – <em>Relating to a jail-based restoration of competency pilot program.</em></td>
<td>Authorizes the provision of competency restoration services in a jail-based competency restoration pilot program for individuals who otherwise would be committed to a mental health facility or residential care facility for those services. Authorizes DSHS to contract with public or private providers of a jail-based competency restoration services for pilot programs in up to two counties. The Executive Commissioner of DSHS shall establish a stakeholder workgroup to participate in the development of rules for the pilot program. Sets out conditions for the operation of a jail-based competency restoration pilot program, including: (1) requirement of two full psychiatric evaluations not later than the 21st day and 55th day of participation in the pilot program, (2) reporting requirements upon psychiatrist’s determination of competency restoration or that the individual is unlikely to be restored, (3) requirements upon failure to restore competency within 60 days.</td>
</tr>
</tbody>
</table>

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**Overview of Texas Criminal Justice System**

Individuals involved in the criminal justice system may be placed in a variety of settings. Many offenders convicted of lower-level offenses and defendants awaiting trial are in local jails operated by counties or municipalities. The Texas Commission on Jail Standards (TCJS) acts as the regulatory agency for all county and privately operated municipal jails. The Texas Department of Criminal Justice (TDCJ) manages individuals who have been convicted of more serious offenses who are sentenced and are residing in state jails, state prisons and private correctional facilities that contract with TDCJ.

Figure 80 contains a glossary of terms typically used in the criminal justice system.
Figure 80. Common Criminal Justice Definitions

<table>
<thead>
<tr>
<th>Community Supervision (previously known as adult probation)</th>
<th>An alternative to a prison sentence whereby an individual is released to the community and ordered to a continuum of programs and sanctions for a specified period of time. The individual must also meet with their Community Supervision Officer on a regular basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parole</td>
<td>A discretionary release of a person from prison, by the Board of Pardons and Paroles, to serve the remainder of a sentence under supervision in the community.</td>
</tr>
<tr>
<td>Local jails</td>
<td>Designed to house offenders awaiting trial or serving short-term sentences for misdemeanor convictions.</td>
</tr>
<tr>
<td>State jails</td>
<td>Designed to house offenders convicted of felonies with punishment ranges from 180 days to two years.</td>
</tr>
<tr>
<td>Prisons</td>
<td>Designed to house offenders convicted of third-degree felonies or higher with punishment ranges from two years to death.</td>
</tr>
<tr>
<td>Restitution</td>
<td>Monies that a court orders an individual to pay to a family of a victim. Payment is usually done in monthly installments.</td>
</tr>
</tbody>
</table>


A study by the Mental Health and Mental Retardation Authority of Harris County (MHMRA) and Harris County's Office of Budget and Management examined all people released from jail between January 1, 2004 and January 29, 2008 and found persons with mental illness represented 25% of all offenders but accounted for 37% of the cost of jail stays. The study also found that Harris County's annual costs for jail inmates with mental illness was $7,017 per year, compared to $2,599 annually for other inmates (excluding police and court costs).

People who become involved with the criminal justice system also make up a sizeable portion of the total population receiving public behavioral health services. Between 2007 and 2009, 19% of all adults receiving behavioral health treatment or services from DSHS were involved in the criminal justice system. In addition, this population is characterized as having less family and community support, deeper impairment from a mental illness, and housing instability.

During the 83rd Texas Legislature, Rider 43 of the Appropriations Bill directed the Department of State Health Services (DSHS), along with community centers, to identify, collect and report data to the Legislative Budget Board on individuals in the criminal justice system with mental health conditions. That report examined queries by local and county jails in the DSHS mental health database to calculate the number of jail inmates who had contact with the public mental health system. The report showed that all local or county jails used the Continuity of Care Query (CQQ) for a total of 1,122,091 unique queries for adults in 2013. Approximately 5 percent (58,356) of the queries were exact matches with information maintained in the DSHS mental health database; approximately 47 percent (527,148) were probable matches; and approximately 48 percent (536,587) had no match. The exact and probable matches alert the local mental health authority to exchange pertinent data.
Texas Department of Criminal Justice

The aim of TDCJ is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime. In addition to confining convicted felons, TDCJ provides community-based jail diversion programs and administers options for felons’ reintegration into society following their sentence. The agency also provides funding and certain oversight of community supervision (previously known as adult probation), and is responsible for the supervision of offenders released from prison on parole or mandatory supervision. TDCJ is responsible for providing health services, including behavioral health services, to people who are convicted and sentenced to state jails, state prisons and private correctional facilities. The Correctional Managed Health Care Committee (CMHCC) oversees and coordinates health care services for persons in the TDCJ system.

TDCJ has a number of facilities throughout the state and has headquarters in both Austin and Huntsville. Figure 81 below depicts the population distribution and capacity by type of facility.

![Figure 81](http://www.tdcj.state.tx.us/documents/finance/Agency_Strategic_Plan_FY2015-19.pdf)

A complete list and map of TDCJ facilities is available at: [http://www.tdcj.state.tx.us/unit_directory/unit_map.html](http://www.tdcj.state.tx.us/unit_directory/unit_map.html)

The placement and confinement of inmates can have a serious impact on their mental health. In addition to any mental health conditions existing prior to incarceration, an inmate may have his or her condition exacerbated by the conditions of confinement. Isolation is a form of confinement that may have particularly detrimental psychological effects. TDCJ housed 8,784 inmates in isolation (colloquially called “solitary confinement”) in 2011. More than 2,000 of those
inmates had a diagnosis of either serious mental illness or intellectual disability. TDCJ uses several types of isolation. Disciplinary segregation is typically short term and is for punitive purposes. With administrative segregation (which is used for inmates who are considered dangerous to themselves, other inmates or staff), individuals are held in an isolated cell for up to 23 hours a day for an extended period of time. People with mental health conditions are overrepresented in this population and the practice itself can have long-term effects on an inmate’s mental health.

Traumatic experiences during incarceration can impact an inmate’s mental health. A 2008 study by the Bureau of Justice Statistics ranked 5 Texas prisons among the 10 U.S. prisons with the highest inmate-reported sexual assault complaints. The Prison Rape Elimination Act (PREA), a federal law passed in 2003, seeks to address prison rape by instituting a zero-tolerance policy in correctional settings. Within TDCJ, the PREA Ombudsman is responsible for ensuring that TDCJ is in compliance with federal regulations to monitor and implement efforts to eliminate sexual assaults in the facilities. In FY 2013 the PREA Ombudsman Office reviewed 742 administrative investigations of offender-on-offender sexual abuse allegations. Disciplinary cases for convictions of assailants may be sexual misconduct, sexual fondling, or sexual abuse.

**FINANCIAL SUMMARY**

On August 31, 2013, there were 136,340 offenders in Texas prisons. The average cost per day of housing and feeding an inmate was $50.04. The TDCJ operating budget for FY 2013 was $3,118,728,577. See Figure 82 below for a breakdown of the budget by agency goal.
Figure 82. TDCJ Operating Budget for FY 2013


TDCJ is comprised of several sub-divisions that provide for the administration and operation of the agency, the supervision of convicted felons, and services for crime victims.

Within TDCJ, there are several offices and agencies that have responsibility for meeting the health and behavioral health needs of inmates. A brief description of each follows.

**Figure 83. Behavioral Health Related Divisions within TDCJ**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Services Division</td>
<td>Responsible for ensuring that incarcerated persons have access to health care services and monitors quality of care. The division also investigates grievances and conducts service audits. This division works with health care contractors and the Correctional Managed Health Care Committee (CMHCC).482</td>
</tr>
<tr>
<td>Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI)</td>
<td>Comprised of representatives from 21 agencies and organizations, TCOOMMI provides a formal structure for criminal justice, health and human services, and other affected agencies to communicate and coordinate on policy, legislative and programmatic issues affecting offenders with special needs.483</td>
</tr>
<tr>
<td>Office of Mental Health Monitoring and Liaison</td>
<td>Monitors mental health services provided to offenders, and provides expert guidance to other TDCJ offices on mental health-related issues.</td>
</tr>
<tr>
<td>Correctional Managed Health Care Committee (CMHCC)</td>
<td>The oversight and coordination authority charged with developing a managed health care plan—called an offender health services plan—for all people confined by TDCJ. The committee manages a partnership arrangement between the department’s Health Services Division, the University of Texas Medical Branch at Galveston (UTMB) and Texas Tech University Health Sciences Center (TTUHSC). UTMB is responsible for health care services in facilities in the eastern half of Texas and TTUHSC is responsible for facilities in the western half.484 TDCJ may contract with any entity to implement the managed health care plan (SB 213).</td>
</tr>
</tbody>
</table>

Providing basic medical care for an inmate’s serious health condition is mandated by the federal Constitution. In line with the nationwide trend, state prison facilities are seeing an increase in the number of inmates requiring psychiatric care.485

Texas operates medical care for inmates on a managed health care plan rather than a fee-for-service plan. The average cost per day per prisoner for medical care in Texas is between $42 and $49 per day.486 The average cost per day for an inmate in a psychiatric correctional facility is $138.487
ACCESS TO SERVICES

The offender health services plan developed by the Correctional Managed Health Care Committee (CMHCC) describes the levels of health care services made available to offenders incarcerated within TDCJ. The plan contains two classifications of health services for medical, dental and mental health needs, as listed in Figure 84 below.488

Figure 84. Level of Health Service

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Description of Level of Health Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I Medically Mandatory</td>
<td>Care that is essential to life and health and without which rapid deterioration is expected. The recommended treatment intervention is expected to make a significant difference or is very cost effective.</td>
<td>authorized and provided to all.</td>
</tr>
<tr>
<td>Level II Medically Necessary</td>
<td>Care [the absence of which] is not immediately life threatening, but without which the patient could not be maintained without significant risk of serious deterioration or where there is a significant reduction in the possibility of repair later without treatment.</td>
<td>is provided to all, but evolving standard and practice guidelines controls the extent of service</td>
</tr>
</tbody>
</table>


Additionally, each TDCJ facility must develop a process for individuals who are incarcerated to gain access to medical, mental health, substance use and dental care. Inmates are provided information on how to obtain health care services at intake by the facility to which they are assigned. Facilities may also identify people with mental illness during the intake process, or upon referrals, from security staff who receive training in identifying mental illnesses.489

BEHAVIORAL HEALTH SERVICES

Mental health diagnostic and treatment services available to incarcerated individuals when recommended by a qualified mental health provider include:490

- Emergency mental health services, available 24 hours a day, seven days per week
- Continuity of care services
- Outpatient services
- Psychosocial services as indicated
- Crisis management/suicide prevention
- Inpatient services provided by a correctional health care approved facility, including as necessary diagnostic evaluation, acute care, transitional care and extended care
- Professional services such as medication monitoring and management

TDCJ also administers specialized mental health and substance abuse programs for certain inmates. Figure 85 and Figure 86 describe these programs.
Figure 85. Specialized Mental Health Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program for the Aggressive Mentally-Ill Offender</td>
<td>Located at the William P. Clements, Jr. facility in Potter County. The treatment program utilizes a multi-disciplinary approach through specific therapeutic modalities. The offender must have at least 2 years left to serve of his sentence in order to complete the program.</td>
</tr>
<tr>
<td>Developmental Disabilities Program</td>
<td>Offenders suspected of having an intellectual disability or [borderline intellectual functioning] diagnoses, and whose adaptive functioning is judged significantly impaired, may be referred to a DDP facility for further evaluation.</td>
</tr>
</tbody>
</table>
| Chronic Mentally Ill Program – Inpatient Treatment Track | To provide a step down inpatient treatment track specific for the Administrative Segregation offenders (those who are separated from the general population) and other offenders [with chronic mental health needs or an offender of any classification that requires housing in a single-cell for mental health reasons.]


TDCJ operates a number of programs to serve people with substance use conditions within its Rehabilitation Programs Division, as described in Figure 86.

Figure 86. Substance Use Service Descriptions

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Felony Punishment Facility and In-Prison Therapeutic Community (IPTC)</td>
<td>Six-month in-prison treatment programs, followed by up to three months of residential aftercare, six to nine months of outpatient aftercare, and up to one year of support groups and supervision. Judges can sentence individuals to a program in lieu of prison or state jail time, or the Board of Pardons and Parole can require the program as a condition of parole. A nine-month in-prison program provided for people with co-occurring mental health and/or medical diagnoses.</td>
</tr>
<tr>
<td>Pre-Release Substance Abuse Program and Pre-Release Therapeutic Community</td>
<td>Intensive six-month programs intended for individuals who are incarcerated with serious substance use conditions, chemical dependency and criminal ideology. Inmates are placed in the program prior to release from confinement on a vote by the Board of Pardons and Parole.</td>
</tr>
<tr>
<td>State Jail Substance Abuse Program</td>
<td>Eligible inmates are placed in a 30-, 60- or 90-day track based on an Addiction Severity Index assessment and their criminal history and are provided rehabilitation, counseling and related services designed to meet the needs of the state’s diverse incarcerated population.</td>
</tr>
<tr>
<td>Driving While Intoxicated In-Prison Program</td>
<td>A six-month program with an aftercare component that uses a variety of education and treatment activities, including group and individual therapy, family education and counseling.</td>
</tr>
</tbody>
</table>

The Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI) is part of the TDCJ’s Reentry and Integration Division and provides a variety of institutional and community-based services to facilitate reentry of older adults and people with special needs from incarcerated settings into the community. Special needs offenders include offenders with serious mental illness, terminal or serious medical conditions and/or intellectual disabilities.492,493

Continuity of care programs are designed to conduct pre-release screenings of detainees and referrals for aftercare psychiatric treatment services, which are typically delivered by LMHAs. Upon release from incarceration, people with mental illness are referred to their LMHAs for services, including case management, rehabilitation services, psychological services, psychiatric services, medication and monitoring, and benefit eligibility services including federal entitlement application processing.

Transitional supports for inmates after prison or jail can be instrumental in reducing recidivism. Inmates with mental health and substance use problems need help once they return to their communities. Linking inmates to community supports and services can help address the root causes behind a former inmates’ criminal behavior in order to prevent reentry into the criminal justice system. Establishing a continuum of care for the mental health, health, and substance abuse needs of inmates can prevent an interruption of services for inmates. Examples of community-based services that can help former inmates avoid re-incarceration include substance use treatment, health care, insurance coverage, social services, job finding and training, housing assistance, and mental health services.494

The recidivism rate for overall parolee populations was 24% for 2010-2012.495 During the same reporting period, the recidivism rate for parolees that TCOOMMI served was 4.2% although 13% of adults with serious mental illness who received TCOOMMI services were re-incarcerated within three years of release.

In FY 2013, 5,229 parolees with serious mental illnesses were referred for continuity of care services. Of this number, 1,023 parolees received TCOOMMI-funded intensive case management and treatment services after release.496 TCOOMMI contracts with select communities in the state for offender programs, targeting offenders on parole supervision and offenders on community supervision.497

Continuity of care provides pre-release screening and referral to aftercare services for incarcerated people with special needs. Services and supports include:

- Identifying incarcerated people with special needs who require aftercare treatment services.
- Participating in joint treatment planning with the department.
- Providing a positive transition from incarceration to the community.
- Identifying and securing resources in the community for all offenders referred with special needs.
- Working to improve coordination among state criminal justice and other agencies.
- Providing post-release follow-up through monthly reports.
In 2013 the 83rd Legislature appropriated $3 million annually for mental health services and continuity of care for adult offenders. This allows TCOOMMI to expand treatment of mentally ill offenders being supervised in the community through contracts with local mental health authorities throughout the state. The additional funding enables TCOOMMI to provide services to approximately 1,800 additional parolees. Twenty-seven additional case management caseloads were added for parolees. A licensed professional of the healing arts was also added to every halfway house for parolees to ensure there are no gaps in continuity of care for parolees.

**MEDICALLY RECOMMENDED INTENSIVE SUPERVISION**

Medically recommended intensive supervision is an early parole and release program that serves incarcerated people with special needs, including those with mental and developmental disabilities, terminal illnesses, illnesses requiring long-term care, or physical disabilities. The purpose of the program is to release offenders who pose minimal public safety risk as a cost-effective alternative to incarceration.

**RELEASE ON PAROLE SPECIAL PROGRAMS**

The division on the review and release on parole of offenders operates a series of special programs for offenders with mental health and behavioral health issues. Figure 87 below provides an overview of these programs:

![Figure 87. Special Programs for Offenders with Behavioral Health Conditions](image)

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Monthly Average Number of Offenders in Supervision Program in FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Needs Offender Program</td>
<td>Supervises [offenders with intellectual disabilities, mental impairments, terminal illnesses, or physical disabilities].</td>
<td>136 medically recommended intensive supervision offenders, 156 [offenders with intellectual disabilities], 6,295 [offenders with mental impairments], 820 [offenders with terminal illnesses or physical disabilities].</td>
</tr>
<tr>
<td>Sex Offenders Program</td>
<td>Services are provided throughout the state through contract vendors. A significant component of this treatment is polygraph testing</td>
<td>4,360 offenders.</td>
</tr>
<tr>
<td>Therapeutic Community Program</td>
<td>Offers continuity of care services for offenders with substance abuse problems. Consists of a three-phase program for offenders who participated in an in-prison therapeutic community or a substance abuse felony punishment facility.</td>
<td>6,341 offenders received services.</td>
</tr>
<tr>
<td>Substance Abuse Counseling Program (SACP)</td>
<td>Provides relapse prevention services to offenders with substance abuse problems.</td>
<td>A total of 34,544 offenders in FY 2013.</td>
</tr>
</tbody>
</table>
**Special Concerns for Female Inmates**

Female inmates have distinct and possibly greater health and mental health needs as compared to male inmates. A significant portion of incarcerated females report a history of sexual, emotional, and physical abuse. Additionally, women in prison are also more likely than men to have chronic health conditions, including HIV, sexually transmitted diseases, and Hepatitis C. The physical, emotional, and health effects of experiencing pregnancy or giving birth while incarcerated is also unique to women. It is estimated that in Texas each year, 250 women give birth while incarcerated. Though shackling is still permitted in a large number of states throughout the country, in 2009 Texas passed anti-shackling legislation to prohibit the shackling of women in labor.

Recognizing the many special needs of female offenders, TDCJ has a number of programs designed to address this population. One such program is the Baby and Mother Bonding Initiative (BAMBI). The program is an alternative to the immediate separation of the baby and mother, seeking to combat recidivism by teaching new mothers the basics of parenting and encouraging healthy behaviors. Typically, eligible females are those who are within six months of their release when they deliver their baby. They must also meet other eligibility criteria, including that the offender have no past or current conviction for a violent offense. It is hoped that encouraging a mother-child bond will aid in reducing recidivism rates.

**Local Criminal Justice Systems**

Local criminal justice systems consist of local law enforcement agencies, prosecutors, jails, courts and probation departments that are responsible for promoting public safety by enforcing state and local law in a specified region. Local systems are responsible for criminal cases from the point of arrest through the trial and sentencing stages. Local jails hold defendants awaiting trial and those convicted of low level offenses sentenced for short durations. Individuals convicted of an offense and waiting for transportation to state facilities may also be held in local jails.

On December 1, 2013, Texas county and city jails were collectively operating at 69.95% capacity with a total jail population of 66,807. Even with some unused capacity, jails face challenges in providing services. Of all inmate complaints received in 2013 by the agency responsible for overseeing Texas jails, 56% of the grievances filed were regarding medical services.

Many jail detainees are non-violent offenders with co-occurring mental health and

---

**Table: Drug Testing Program**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Monthly Average Number of Offenders in Supervision Program in FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Testing Program</td>
<td>Instant-read drug testing.</td>
<td>156,411 drug tests conducted monthly.</td>
</tr>
</tbody>
</table>

substance use issues whose untreated mental health needs can lead to behavior that results in their entrance into the jail system. Though jails are legally mandated to provide health services to inmates while they are incarcerated, mental health services vary widely between facilities. Some jails provide treatment and successfully link inmates to community-based social services to prevent re-entrance into the criminal justice system. Other inmates however, may experience deterioration of their mental health while in jail. Despite the high proportion of people with mental health needs in jails, jail officials often lack the training to provide these individuals with the mental health treatment and support they need. Moreover, county and local jail systems may lack the adequate resources to implement policies and best practices for meeting the treatment needs of inmates with mental health conditions. Untreated mental health needs and a lack of post-incarceration planning for access to treatment can lead to an individual’s cycling in and out of jail, which is costly to local counties and cities.  

### TEXAS COMMISSION ON JAIL STANDARDS

The Texas Commission on Jail Standards (TCJS) is a separate regulatory agency for all county jails and privately operated municipal jails. TCJS establishes minimum standards for the management and operation of jails. TCJS also monitors and is responsible for enforcing compliance with adopted standards through on-site inspections.

The principal operation of the TCJS is to perform on-site inspections of jails to verify compliance with minimum standards for jail construction and operations. TCJS reviews proposed construction and renovation plans to assess conformity to standards, and provides technical assistance and training regarding jail management. It also audits and reports on inmate populations, provides resolution of inmate grievances, provides management consultation, and performs other various activities relating to policy development and enforcement. Out of the 254 counties in Texas, all but 19 operate at least one jail; therefore TCJS travels to 235 counties in addition to 9 privately operated facilities. Each county is visited at least once each fiscal year.

The standards include requirements for the custody, care and treatment of inmates. Upon admission to jail each individual receives a “health tag.” The tag notes a special medical or mental health need in the medical record and these are to be brought to the attention of health personnel and/or the supervisor on duty at admissions to the jail. Each facility should have and implement a written health services plan for inmate medical, mental health and dental services. This includes maintaining a separate health record on each inmate. The record is to include a health screening procedure administered by health personnel or by a trained booking officer upon admission. It should at a minimum contain current medical and mental treatment, and behavioral observation, including state of consciousness and mental status.

Comprehensive national data show that suicide occurs roughly three times more frequently in jail than among the general population. Each sheriff or jail operator is responsible for developing and implementing a mental disabilities/suicide prevention plan, in coordination with the available medical and mental health officials. Upon admission to the jail each inmate is supposed to be screened
immediately utilizing the TCJS approved mental disabilities/suicide prevention screening instrument. In 2013 TCJS, in collaboration with multiple state agencies including TCOOMMI, introduced a new training program titled “Assessing for Suicide, Medical and Mental Impairments.” Staff from local mental health authorities was included in teaching the course, which provided training to 352 participants in 12 classes.

Incarceration Prevention Programs

The Department of State Health Services (DSHS) provides community-based interventions, and TCOOMMI also collaborates to provide multi-service alternatives to incarceration for offenders with special needs through contracts with 37 community centers. The goal of these programs is to prevent unnecessary incarceration, which is costly to the state and often fails to address the underlying causes behind an offender’s criminal behavior, such as a mental health condition. Community services can retain individuals in their communities, ensure that they receive the supports and services they need, and help individuals become productive members of society.

The Substance Abuse and Mental Health Services Administration (SAMHSA) promotes a sequential intercept model with a comprehensive set of opportunities for diversion throughout the criminal justice process. The Sequential Intercept Model developed by Munetz and Griffin in conjunction with the GAINS Center gives communities a structural framework to target strategies at each level an individual intersects with the criminal justice system.

![Sequential Intercept Model Diagram](http://www.nami.org/Template.cfm?Section=cit2&template=/ContentManagement/ContentDisplay.cfm&ContentID=101341)

### JAIL DIVERSION

Typically, jail diversion models seek to identify an underlying mental health condition at the point a person enters the criminal justice system. Upon a positive identification of a mental health condition, jail diversion models rely on mental health professionals to examine the detainee and identify possible treatment options. The jail diversion model encourages collaboration between local mental health authorities, law enforcement, and the court system in order to identify alternatives to incarceration. The goal is to link the client to community-based...
mental health treatment and services in lieu of incarceration so that recovery can be achieved. Jail diversion efforts can save money, improve public safety, and improve the health of individuals by providing them with the treatment they need.\footnote{519}

Section 533.108 of the Texas Health and Safety Code permits the prioritization of funds by local mental health authorities (LMHAs) to create a variety of collaborative jail diversion programs with law enforcement, judicial systems and local personnel. Programs and services available to defendants with mental health conditions vary from county to county. For example, Dallas County offers an array of diversion-oriented programming including misdemeanor mental health jail diversion coordination, mental health court programs for misdemeanor and felony cases, a dedicated mental health prosecutor, mental health public defenders, and individual case management.\footnote{520} In contrast, a misdemeanor/low-level felony mental health court is the only major diversion initiative for defendants with mental health conditions in Tarrant County.\footnote{521}

Bexar County’s jail diversion was implemented in 2003 and is seen as a model for Texas. It employs both pre-booking and post-booking diversion methods.\footnote{522} First, mobile crisis outreach teams and law enforcement crisis intervention teams work to identify individuals with mental illness for whom diversion is appropriate (those whose behavior is more a symptom of their illness than an act driven by criminal intent) before they are arrested or booked. Second, the program identifies people with mental illness already in the system and recommends appropriate alternatives to jail, such as community-based treatment or mental health bonds. Finally, it gives priority to providing services when people are released from jail or prison. Jail diversion programs, combined with falling crime rate, reduced the jail population in Bexar County by 14 percent in recent years, from a high of 4,259 to 3,676 in 2012.\footnote{523}

SB 1185 (83rd Legislature) provided for the creation of a mental health jail diversion pilot in Harris County, where 20-25% of the jail population in the Harris County jail is on psychotropic medications.\footnote{524} The key aims of the program are to promote and sustain recovery by expanding services in the areas of housing, education and training, supportive employment, and peer advocacy. Moreover, the advisory panel has recognized that individualized treatment plans, systems, and services should be culturally competent and sensitive to the specific needs of men, women, and veterans.\footnote{525}

The Jail Diversion Pilot Program had an anticipated start date of August 2014. The pilot target is to serve at least 200 frequent recidivists with serious mental illness per year. DSHS is legislatively mandated to submit an evaluation on the Harris county jail diversion pilot to the legislature by December 1, 2016.\footnote{526}

**SPECIALTY COURTS**

Specialty courts often are utilized as one piece of a locality’s larger jail diversion plan, serving people with serious mental illness and substance use conditions. These courts utilize problem-solving processes to provide community-based alternatives to incarceration and operate under a model that requires the collaboration of judges, prosecutors, defense attorneys, law enforcement and mental health professionals. According to a 2013 Criminal Justice Advisory Council report, there are
approximately 140 operational specialty courts in Texas. In Texas, specialty courts have been credited with a reduction in incarcerated offenders; however, the state has not allocated the necessary resources to measure the performance and outcomes of specialty courts.

The most common types of specialty courts relevant to criminal law and mental health/substance use are mental health courts, drug courts, family drug courts, DWI courts, and veterans courts.

**Mental Health Courts**

Mental health courts have been developed across the country as an alternative, for people with mental illness, to the standard adjudication process. These specialty courts are designed, in part, to reduce the cycling in and out of the justice system that is often the result of untreated mental illness by attempting to address the root cause for criminal behavior. Court staff and mental health professionals collaborate to develop a judicially supervised treatment plan for the participant.

Harris County implemented a felony mental health court, originally funded by a grant from the federal Bureau of Justice Assistance, and began screening applicants for admission to the program in March 2012. People who qualify for the specialty court follow a program lasting at least 18 months. The program is characterized by the following components:

- Comprehensive evaluation to determine the participant’s strengths and needs.
- Frequent appearances before the felony mental health court judge.
- Regular visits with specially trained community supervision officers.
- Intensive treatment by mental health professionals.
- Substance use treatment for participants with co-occurring mental health and substance use conditions.
- Random alcohol and drug testing.

As of July 2013 the court had served a total of 88 participants. Of the participants 86.3% had a mental illness and co-occurring substance use disorder. Thirteen participants successfully graduated and another ten participants were on track to graduate by the fall of 2014. The court’s usual caseload is around 60-65 cases. The court team is comprised of two district court judges, a project director, three full-time licensed mental health clinicians, two dedicated part-time assistant district attorneys, four dedicated part-time assistant public defenders, three dedicated full-time community supervision officers, a clerk, a bailiff and the participant.

Prospective participants undergo a criminogenic risk assessment, which helps to predict likelihood of engaging in criminal behavior, as well as a comprehensive psychosocial evaluation to help identify their strengths and needs to assist the clinical team in developing the client’s individualized re-entry plan.

More information on mental health courts is available at https://www.bja.gov/Publications/mhc_essential_elements.pdf

**Drug Courts**

Drug courts provide supervision that is more comprehensive and intensive than other forms of community supervision. In 2001, the 77th legislature via HB 1287
TDCJ mandated all Texas counties with populations exceeding 550,000 to apply for federal and other funds to establish drug courts. There are currently approximately 100 drug courts in counties throughout the state. The drug court model assumes supervised treatment in combination with judicial monitoring is more effective in reducing drug usage and crime than either treatment or judicial sanctions operating separately.

**Mental Health Public Defender**

Criminal cases involving people with mental health conditions often present unique legal issues that require specialized knowledge and skills. There are 23 counties in Texas that provide a public defender’s office, whether in-house, specialized for juvenile, mental health or appellate court. Some counties without designated county-wide public defenders have established specialized Mental Health Public Defender Offices (MHPD), in contrast to mental health courts, to better serve defendants with mental health conditions. The mission of the MHPD is to:

- Minimize the number of days a person with mental illness spends in jail.
- Increase the number of dismissals among defendants with mental illness.
- Reduce recidivism by providing intensive case management services.
- Enhance legal representation by providing attorneys with specialized knowledge needed to defend persons with mental illness.

In Texas there are currently three MHPD identified in Bexar, Travis and Ft. Bend counties. The three counties all have MHPD representing defendants charged with misdemeanors. The Travis and Ft. Bend MHPD also provide referrals for a variety of social services for defendants charged with felonies.

A cost benefit analysis of the performance of the Travis County MHPD, published in 2011, revealed that 41.2% of misdemeanor (no felony charges included) clients who were provided assistance remained out of custody and/or had not returned to jail in one to five years since the inception of the MHPD in 2007. There was also a 38% decrease in bookings and 13% decrease of jail bed days consumed post-MHPD involvement.

**Forensic Peer Support**

Successful integration in the community can be a challenge for individuals with a criminal record. For individuals leaving prisons and jails, re-entry is a particularly challenging time. Although the state provides re-entry assistance for some inmates with mental illness through the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), only one of four former inmates with a diagnosis of schizophrenia, bipolar disorder or major depression is currently receiving TCOMMMI services. As peer support becomes an established service in other contexts, interest is growing in using peer support for justice-involved individuals with mental illness. According to a recent report by the Center for Public Policy Priorities, “peer support provided to and by justice-involved individuals with mental illness is called forensic peer support and is a young, but growing field.”
Texas Juvenile Justice Department (TJJD) and Local Juvenile Justice Agencies: At A Glance

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POLICY CONCERNS

- Adequate independent oversight of residential placements
- Assessment of outcomes for state secure facilities and community interventions
- Diversion of youth with behavioral health needs from secure confinement facilities
- Prolonged isolation of youth in secure confinement facilities
- Restraint use in secure confinement facilities
- Youth in adult correctional facilities
- Adjustment to the upper and lower age limits of juvenile court jurisdiction based
on science of adolescent development
- School-to-prison pipeline for youth in special education
- Overcriminalization of youth for status offenses

**FAST FACTS**

- Youth in the juvenile justice system are more likely than children in the general population to have mental health and substance use conditions.548 Nationally, 22.2% of youth have a mental health condition causing severe impairment.549
- 70% of juveniles in community-based programs, detention centers and secure residential facilities were assessed as having at least one mental health condition, based on a 2006 multi-state study of Texas, Louisiana and Washington.550
- As of April 2014, there were 1,058 youth committed to state secure facilities in Texas at an average cost of $366 per day.551
- Texas has 34 post-adjudication secure facilities operated at the county level. These facilities are for youth adjudicated for misdemeanor offenses and felony offenders not dangerous enough to need placement at a state-level secure facility. Of these 34 county-level post-adjudication facilities, 23 offer programs for youth with mental health conditions and 28 identify themselves as providing programs for youth with substance use conditions.552
- In FY 2013, counties funded 70% of probation services while state and federal funding accounted for only 30% of total funding.553
- The juvenile justice system is a civil system designed to emphasize rehabilitation.
- Misdemeanor offenses make up the majority of juvenile probation referrals.
- Local juvenile probation departments use a mix of local, state and federal funds to provide mental health or substance use services.
Texas Juvenile Justice Department (TJJD) and Local Juvenile Justice Agencies

Texas’ juvenile justice system is comprised of the Texas Juvenile Justice Department (TJJD) and local juvenile probation departments throughout the state that work in partnership to provide a continuum of services designed to rehabilitate youth and plan for their successful futures. In 2011, the 82\textsuperscript{nd} Texas Legislature abolished the Texas Juvenile Probation Commission (TJPC) and the Texas Youth Commission (TYC), the two state agencies that previously managed the state’s juvenile justice system. In their place, Senate Bill 653 (Whitmire) created TJJD, charged with “increasing the proportion of youths in local custody, rather than committed to state lockups.”\textsuperscript{554} To this end, TJJD funds and provides oversight to local juvenile probation departments across Texas while continuing some of the functions of the former TYC, including the operation of a limited number of secure facilities for youth. The ultimate goal of TJJD is to prevent the youth’s entrance into the adult criminal justice system by providing a unique treatment plan tailored to each youth’s needs and strengths.

Youth in the juvenile justice system are more likely than children in the general population to have mental health and substance use conditions.\textsuperscript{555} Nationally, 22.2\% of youth have a mental health condition causing severe impairment.\textsuperscript{556} In comparison, 70\% of juveniles in community-based programs, detention centers and secure residential facilities were assessed as having at least one mental health condition, based on a 2006 multi-state study of Texas, Louisiana and Washington.\textsuperscript{557} The number of youth with a condition serious enough to require immediate and significant treatment is almost 30\%.\textsuperscript{558} Furthermore, over 60\% of youth experiencing a mental health disorder also struggle with a substance use disorder.\textsuperscript{559} The majority of youth in the juvenile justice system have experienced prolonged trauma.\textsuperscript{560} In addition, not only do they have higher prevalence of chronic abuse and neglect, they are also often exposed to domestic violence, community violence and substance use.\textsuperscript{561} This section will describe the behavioral health services available to youth at different levels of involvement with the juvenile justice system.

70\% of juveniles in community-based programs, detention centers and secure residential facilities were assessed as having at least one mental health condition
Changing Environment

LEGISLATION

House Bill 144 (83rd-Raymond), also passed in 2013, allows parents and guardians to request evaluations for mental illness, intellectual disability and chemical dependency when their child becomes involved in the juvenile justice system. Previously, only the juvenile court had the ability to make such a request.

In an effort to reduce the criminalization of youth with mental health conditions, Senate Bill 393 (83rd-West) refers young people facing Class C misdemeanor charges to juvenile court if a previous complaint was dismissed because of a determination of mental illness, disability or lack of capacity. Class C misdemeanors usually are tried in municipal or JP courts, which are adult criminal courts. In contrast, in juvenile court a youth may have access to a social worker, community services, and mentors, and may be recommended for services instead of detention. Thus, a referral to a juvenile court may divert the youth from unnecessary entrance into the criminal justice system. SB 393 also requires courts to dismiss a complaint if the court determines that there is probable cause to believe that a young person facing potential Class C misdemeanor charges lacks capacity to understand the proceedings or lacks substantial capacity to either appreciate the wrongfulness of the conduct or to conform their conduct to the requirements of the law. A Class C misdemeanor is the most basic offense and does not include a jail term, only a fine of not more than $500 if found guilty by a judge. Under SB 393 students can no longer be issued tickets for Class C misdemeanor misbehavior. The school can file a complaint, but a prosecutor decides whether to charge the student.

Senate Bill 1356 (Van de Putte), passed in 2013, requires the board of TJJD to implement and oversee trauma-informed care training for juvenile probation officers, juvenile supervision officers and court-supervised community-based program personnel. As directed in the same senate bill, TJJD is also required to evaluate the practices of juvenile probation departments for early identification of young people who are victims of sex trafficking.

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY PILOT

In response to SB 1356 (83rd–Van de Putte), TJJD is piloting Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) at Ron Jackson State Juvenile Correctional Complex, McLennan County State Juvenile Correctional Facility, and Giddings State School in partnership with the University of Texas Center for Social Work Research. TF-CBT is an evidence-based treatment designed to reduce negative emotional and behavioral responses following traumatic events. Treatment focuses on distorted beliefs and attributions related to trauma and provides a supportive environment to discuss traumatic experiences. Training in TF-CBT has been provided to 18 clinical staff and ongoing coaching is being provided. The pilot is expected to be completed and a report developed by the end of July 2015.
During the 2013 legislative session TJJD was ordered to reduce the number of state-operated secure facilities from six to five. In June 2013, the agency recommended the closure of the Corsicana Residential Treatment Center, a facility located south of Dallas in Navarro County designated solely for committed youth with significant mental health needs. Services offered at Corsicana Residential Treatment Center included evidence-based psychotherapy and behavioral skill-building interventions, chemical dependency treatment, assessment, medication management and other services provided on-site by licensed mental health professionals. Advocates had long argued that Corsicana should be closed due to its long-standing failure to meet the treatment needs of youth, staffing challenges, high incidence of self-harming behavior and safety concerns. In 2012 the facility housed only 10 percent of the agency’s juveniles, yet it experienced 32% of all violent incidents in TJJD.

In the years leading up to the closure, the population at the facility continued to drop. In addition, TJJD reviewed each youth in the months prior to closure to determine whether their needs could be met in a less restrictive setting. In December 2013, 65 youth were transferred to the McLennan County State Juvenile Correctional Facility in Mart, Texas. Though Corsicana was closed as a normal operations facility at the end of 2013 and no longer housed any youth, 25 employees remained at the facility to maintain grounds, inventory property, process records, and complete other administrative duties. Effective July 31, 2014, all but three staff positions at Corsicana were eliminated. The other employees were given the option to request transfers to other TJJD facilities throughout the state. The remaining three staff members are responsible for maintaining the grounds and continuing an employee training partnership with Navarro College while awaiting a decision from the LBB on the fate of the Corsicana facility.

Juvenile Justice System Overview

Admission into the TJJD is one of the most serious placements for a youth in the state of Texas, but helps to avert the even more consequential result of having the court certify the youth as an adult and assign the youth for entrance into the adult criminal justice system. Typically, a juvenile court judge makes the determination on whether a youth is introduced into the TJJD system. A juvenile court can either deal with the juvenile informally and allow the juvenile to remain in his or her community or it can sentence the youth to TJJD custody. In theory the most serious youth offenders are those that get sent to adult criminal court, although the data show that the primary difference is the county of conviction, not the criminal offense or the youth’s criminal history. Within the juvenile justice system, the TJJD facilities are reserved for youths who are considered chronic offenders and in need of more restrictive and higher level of intervention. Figure 89 below shows the number of referrals and dispositions of youth involved in the juvenile justice system in fiscal years 2012 and 2013.
In contrast to the adult criminal justice system, which emphasizes punishment and public safety, the juvenile justice system is a civil system that places an emphasis on rehabilitation. As a result, the legal terms and concepts used in juvenile justice procedures differ from those used in the adult criminal justice setting. Figures 89 and 90 below offer a point of reference for the terms in the adult and juvenile criminal justice systems, as well as common definitions for terms used in the juvenile justice system.

### Figure 89. Referrals and Dispositions of TJJD youth in 2012 and 2013

<table>
<thead>
<tr>
<th>Referrals and Dispositions</th>
<th>Fiscal Year 2012 and Fiscal Year 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
</tr>
<tr>
<td>Formal Referrals to Juvenile Probation Departments</td>
<td>72,474</td>
</tr>
<tr>
<td>Juveniles Referred</td>
<td>51,605</td>
</tr>
<tr>
<td>Total Dispositions</td>
<td>75,174</td>
</tr>
<tr>
<td>Juveniles Committed to TJJD</td>
<td>875</td>
</tr>
<tr>
<td>Juveniles Certified as an Adult</td>
<td>166</td>
</tr>
</tbody>
</table>


### Figure 90. Terms and Concepts

<table>
<thead>
<tr>
<th>Juvenile Justice Term/Concept</th>
<th>Analogous Criminal Justice Term/Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delinquent Conduct</td>
<td>Criminal Conduct</td>
</tr>
<tr>
<td>Detention hearing</td>
<td>Arraignment</td>
</tr>
<tr>
<td>Pre-adjudication facility</td>
<td>Local jail where individuals are detained prior to trial</td>
</tr>
<tr>
<td>Adjudication hearing</td>
<td>Trial</td>
</tr>
<tr>
<td>Finding of “true/not true” at adjudication hearing</td>
<td>Finding of “guilt/innocence” at trial</td>
</tr>
<tr>
<td>Disposition</td>
<td>Sentence</td>
</tr>
<tr>
<td>Committed (also “placed”)</td>
<td>Incarcerated</td>
</tr>
<tr>
<td>County-run post-adjudication facility</td>
<td>Local or state jail where offender serves short sentences</td>
</tr>
<tr>
<td>State secure juvenile correctional facility</td>
<td>Prison</td>
</tr>
</tbody>
</table>

*In contrast to the adult criminal justice system, which emphasizes punishment and public safety, the juvenile justice system is a civil system that places an emphasis on rehabilitation.*
Figure 91. Common Juvenile Justice Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juvenile</td>
<td>A person who was at least 10 years old but not yet 17 at the time he or she committed an act defined as “delinquent conduct” or “conduct in need of supervision.”</td>
</tr>
<tr>
<td>Delinquent conduct</td>
<td>Generally conduct that, if committed by an adult, could result in imprisonment or confinement in jail.</td>
</tr>
<tr>
<td>Conduct in need of supervision (CINS)</td>
<td>Generally conduct that, if committed by an adult, could result in only a fine or conduct that is not a violation if committed by an adult, such as truancy or running away from home.</td>
</tr>
<tr>
<td>Adjudication</td>
<td>Is a finding that a youth has engaged in delinquent or CINS conduct. It is similar to a “conviction” in adult court.</td>
</tr>
<tr>
<td>Chronic Serious Offender</td>
<td>A youth whose TJJD classifying offense is a felony and who has been found to have committed at least one felony in each of at least three separate and distinct due process hearings.</td>
</tr>
<tr>
<td>Minimum Length of Stay</td>
<td>Minimum period of time an indeterminate sentenced youth must stay in TJJD. This is set by TJJD policy.</td>
</tr>
<tr>
<td>Juvenile Probation</td>
<td>A mechanism used by juvenile justice agencies that serves as a sanction for juveniles adjudicated in court, and in many cases as a way of diverting status offenders or first-time juvenile offenders from the court system. Some communities may even use probation as a way of informally monitoring at risk youth and preventing their progression into more serious problem behavior.</td>
</tr>
<tr>
<td>Individual Case Plan</td>
<td>Youth’s individualized plan for treatment and education, based on his or her specific strengths and risks.</td>
</tr>
<tr>
<td>Halfway House</td>
<td>A residential center or home where drug users, sex offenders, the mentally ill, or convicted felons are placed immediately after their release from a primary institution such as a prison, hospital or rehabilitation facility. The purpose of a halfway house is to allow the persons to begin the process of reintegration with society, while still providing monitoring and support; this is generally believed to reduce the risk of recidivism or relapse when compared to a release directly into society.</td>
</tr>
</tbody>
</table>


For a full list of terms and definitions commonly used throughout TJJD, see: http://www.tjjd.texas.gov/about/glossary.aspx

Office of the Independent Ombudsman for the Texas Juvenile Justice Department

The Office of the Independent Ombudsman (OIO), created in 2007, is a separate state agency responsible for investigating, evaluating and securing the rights of juveniles in state facilities and on parole.671 The independent ombudsman investigates a variety of complaints including medical and mental health concerns, abuse allegations, and suicidal attempts and ideation. The OIO provides information regarding grievance procedures and regularly visits and inspects secure TJJD facilities.572

Disproportionality in the Texas Juvenile Justice System

Youth who are members of racial or ethnic groups are disproportionately represented in the juvenile justice system at both the federal and state level. In Texas,
African American youth, and to a lesser extent Hispanic youth, are overrepresented in the juvenile justice system relative to Anglo youth. The likelihood of experiencing confinement or of being tried as an adult is higher for African American youth than for youth of any other racial or ethnic background. Though all ethnic groups are equally likely to receive probation, Hispanic youth are also confined at higher rates than Anglo youth. In fiscal year 2013, 48,275 juveniles were formally referred to juvenile probation departments throughout the state; 49% of these juveniles were Hispanic. Additionally, of the 206 youths certified as adults in 2013, 17 percent of these were from four juvenile probation departments along the Texas-Mexico border, a heavily Hispanic region that is still experiencing ongoing drug trafficking problems. Additionally, African American and special education students are more likely to be disciplined outside the classroom and to be overrepresented in Class C Misdemeanor ticketing on school campuses.

SB 501 created the Interagency Council on Addressing Disproportionality in 2011. The aims of the agency are to examine best practices for addressing disproportionality in the human health and services agencies and to make recommendations on the best means of eliminating disproportionality in the long-term. The agency was tasked with developing a report to the legislature examining the current status of children of racial or ethnic minority groups in the health and human services and to make appropriate recommendations for the reduction of disproportionality. The full report, released on December 1, 2012, can be found here: http://www.hhsc.state.tx.us/hhsc_projects/cedd/11-29-2012-Report-to-the-83rd-Legislature1.pdf

The report highlighted the “Texas model” to address disproportionality through the following model components:

- Data driven strategies
- Leadership development
- Culturally competent workforce
- Community engagement
- Cross systems collaborations
- Training defined by anti-racist principles
- An understanding of the history of institutional racism and the impact on poor communities and communities of color.

The Texas model had been utilized in DFPS settings and had shown to be effective in reducing disparities in outcomes for African American and Hispanic children.

The Interagency Council on Addressing Disproportionality will release a new report on the status of the implementation of the Texas model for addressing disproportionality and disparities in December 2014.
Behavioral Health Services in the Juvenile Justice System

TJJD, the Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI), and local juvenile probation departments provide services for youth with mental health and substance use conditions in a variety of juvenile justice settings, including state secure facilities, specialty secure residential treatment centers, and county secure facilities. They also provide services to youth in the community on probation or parole. The following section describes the services available in these settings.

BEHAVIORAL HEALTH SERVICES IN STATE SECURE FACILITIES

Texas has five state secure facilities for youth adjudicated for felony offenses. Figure 92 below shows the name and location of these facilities.

Figure 92. TJJD Secure Facilities

<table>
<thead>
<tr>
<th>Facility</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evins Regional Juvenile Center</td>
<td>Edinburg</td>
</tr>
<tr>
<td>Gainesville State School</td>
<td>Gainesville</td>
</tr>
<tr>
<td>Giddings State School</td>
<td>Giddings</td>
</tr>
<tr>
<td>McLennan County State Juvenile Correctional Facility &amp; McLennan Residential Treatment Center</td>
<td>Mart</td>
</tr>
<tr>
<td>Ron Jackson State Juvenile Correctional Complex</td>
<td>Brownwood</td>
</tr>
</tbody>
</table>


As of April 2014, there were 1,058 youth committed to these facilities at an average cost of $366 per day. Of all new admissions of youth committed to state-operated facilities in FY 2013, 44% committed non-violent felony offenses.

The Ron Jackson State Juvenile Correctional Complex in Brownwood is the only state secure facility that serves girls. Programming and services at this facility are similar to those now offered at the McLennan County Residential Treatment Center, but modified to reflect the unique individual needs and abilities of the girls. The facility typically serves an average of 100 girls with 5% in short-term placements units that consist of orientation and assessment. In FY 2013, the facility served 190 girls. The facility also serves youthful male offenders. A male intake unit is scheduled to open a program for boys under 15 years of age in October 2014.

All state secure facilities use a multi-faceted rehabilitation program called CoNextions, which includes life skills training and workforce and education development. This therapeutic framework emphasizes skills building in order to reduce risk factors and increase protective factors with the goal of decreasing recidivism and criminal behavior among youth.
Psychiatric and psychological services also are available at all facilities. Youth who are identified as having a high need for specialized services or who are at high risk for violent reoffending are assigned to specialized treatment services within TJJD. These specialized treatment programs are designed specifically for serious violent offenders, sex offenders, chemically dependent offenders, offenders with mental health impairments, and offenders with intellectual disabilities. Figure 93 below highlights the specialized treatment programs in the state.

**Figure 93. Specialized Treatment Programs in Texas**

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location</th>
<th>Participants</th>
<th>Treatment Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Serious Violent Offender Treatment Program</td>
<td>Giddings State School</td>
<td>Youths who are committed for murder, capital murder, and offenses involving the use of a weapon or deadly force.</td>
<td>Helps young people connect feelings associated with their violent behavior and to identify alternative ways to respond when faced with risky situations in the future. Participants are required to reenact their crimes and to play the role of both perpetrator and victim.</td>
</tr>
<tr>
<td>“High Intensity” and “Moderate Intensity” Residential Sex Offender Treatment Program (SOTP) Note: High Intensity treatment programs are dorm based residential intensive program for special needs offenders with a high need for these services. Moderate Intensity Treatment Programs consist of treatment delivered by licensed or trained staff to address youth with a moderate need for specialized treatment. The treatment is provided to youth in the general rehabilitation program.</td>
<td>High Intensity SOTP: Giddings State School, McLennan County State Juvenile Correctional Facility, and Ron Jackson State Juvenile Correctional Complex. Moderate Intensity SOTP: Gainesville State School, Giddings State School, Mart Residential Treatment Center, McLennan County State Juvenile Correctional Facility – Long term, and Ron Jackson Juvenile Correctional Complex.</td>
<td>Sex offenders.</td>
<td>Builds on the TJJD’s treatment program using cognitive-behavioral strategies and a relapse prevention component. Youths receive additional individual and group counseling interventions that focus on the youth’s deviant sexuality, in particular, and on deviant arousal patterns and deviant sexual fantasies, which contribute to the youth’s sexual abusiveness. Additional program components include psychosexual education and, for those with histories of abuse, trauma resolution therapies.</td>
</tr>
<tr>
<td>Program Name</td>
<td>Location</td>
<td>Participants</td>
<td>Treatment Services</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Alcohol or Other Drug Use Treatment Programs</td>
<td>Services available at all the institutional facilities and several halfway houses. Residential programs are offered at all five state secure facilities and McFadden Ranch.</td>
<td>Chemically dependent offenders.</td>
<td>Program components include evidence-based treatment curriculum and substance use education, social skills training, group and individual counseling, and relapse prevention. The criminal behavior is addressed through linking the use of drugs to the youth’s life story and offense; participants examine their life stories, offense histories, and relapse cycles.</td>
</tr>
<tr>
<td>Mental Health Programs</td>
<td>Mental health professionals provide services at all the institutional facilities in the state.</td>
<td>Youths with mental health conditions.</td>
<td>The immediate goal for this group is treating the basic mental health problem or illness and allowing the youths to regain control over their behavior. Once this is accomplished, the young person is better prepared to benefit from treatment that focuses on changing the delinquent and criminal patterns of behavior. The final goal concerns reintegrating the young person with his or her family and community in a program that addresses his or her mental health and correctional therapy needs.</td>
</tr>
</tbody>
</table>


From 2010 to 2012 the enrollment in specialized treatment programs for juveniles identified with high or moderate mental health needs increased from 49.2% to 83.7%. The number of youth completing a specialized program increased from 19.2% to 53.0%. TJJD has increased the provision of specialized treatment programs by 86% from FY 2009 to FY 2012, significantly increasing the number of youth receiving these services. In FY 2013, 48% of youth in state juvenile facilities were determined to have a need for mental health treatment.

**BEHAVIORAL HEALTH SERVICES IN COUNTY-LEVEL SECURE FACILITIES**

Texas has 34 post-adjudication secure facilities operated at the county level. These facilities are for youth adjudicated for misdemeanor offenses and felony offenders not dangerous enough to need placement at a state-level secure facility. Of these 34 county-level post-adjudication facilities, 23 offer programs for youth with mental health conditions and 28 identify themselves as providing programs for youth with substance use conditions.
In addition, there are 51 pre-adjudication facilities operated by counties to detain youth unsafe to release back to the community while awaiting adjudication. Sixteen of these facilities have mental health programs and seventeen have substance use programs for detained individuals. Approximately 400 Texas youth spent over 100 days in secure pre-adjudication facilities at the county level in 2013. About 32 percent of these individuals were formally referred with non-felony offenses.

Because local juvenile justice systems rely heavily on county and local funding sources, the type and availability of treatment and support services vary across the state. For a registry of all county-level juvenile justice facilities and the services offered by each, visit: http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx.

**Behavioral Health Services for Youth on Parole**

TCOOMMI provides continuity of care services to youth released on parole after placement in a secure facility. Paroled youth with mental illness also can be placed in therapeutic foster or group living arrangements or residential treatment facilities.

Services targeted for youth released on parole who have a serious mental illness that requires post-release treatment include:

- Individualized assessments
- Service coordination
- Medication monitoring
- Advocacy services
- Transitional services to other treatment programs
- Benefit eligibility

**Community-Based Behavioral Health Services Offered by Local Juvenile Probation Departments**

By law, all Texas youth are screened for mental health needs at first contact with local juvenile probation departments using a nationally recognized instrument, the Massachusetts Youth Screening Instrument (MAYSI-2). If a screening indicates that further assessment is appropriate, the department requires local juvenile probation departments to refer youth for further evaluation. Approximately sixteen percent of Texas referrals screened in FY 2013 were recommended for further mental health assessment.

In FY 2013, 48 percent of juveniles served by local probation departments were identified as having at least one behavioral health referral. Twenty-seven percent of juveniles who were referred to juvenile probation had a mental health need. Youths charged with misdemeanor offenses made up the majority of referrals at 52 percent. Youth charged with felonies accounted for 21 percent of referrals, violations of probation for 16 percent, and child in need of supervision (CINS) offenses accounted for 11 percent.
Youth with mental health needs receive services from local juvenile probation departments, or Community Resource Coordination Groups (CRCGs), for a variety of reasons. Some may be diverted from the probation system and provided supervision to include mandated behavioral health services. Youth may also be offered deferred adjudication and provided treatment as a condition of dismissing charges. Youth who are adjudicated and placed on probation may be required to participate in either residential or community-based treatment programs.

Access to mental health treatment is not an entitlement but is based on available resources and providers. Challenges in gaining access to appropriate mental health services spill over into the juvenile justice system, since there is a high prevalence of mental health needs among the youth in the juvenile justice system, but few youth access mental health services prior to entering the juvenile justice system. Approximately 44 percent of juveniles on deferred prosecution or probation supervision were identified as having a mental health need during FY 2013. In FY 2013, approximately 29 percent of formally referred juveniles were identified as having a mental health need.

Figure 94 indicates the number of youth discharged who were linked to community services through TCOOMMI or CRCGs, including behavioral health treatment, care management, and support services in FY 2013. Discharge refers to the ending of all TJJD custody, supervision, and/or services. Youth on parole for example, have been released but not discharged.

![Figure 94. Youth Discharged and linked to Community Services, including Behavioral Health treatment, care management and support services in FY 2013](image)

<table>
<thead>
<tr>
<th>Type of Discharge</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred to TCOOMMI or CRCG services</td>
<td>288</td>
</tr>
<tr>
<td>Received mental health aftercare services in the community</td>
<td>178</td>
</tr>
<tr>
<td>(includes youth released on TJJD parole, as well as youth released to a non-secure residential facility (hallway house))</td>
<td></td>
</tr>
<tr>
<td>TJJD parole receiving mental health aftercare services in the community</td>
<td>125</td>
</tr>
</tbody>
</table>

Source: Texas Juvenile Justice Department. (2014, August). Data Request: Mental Health Services

Figure 95 indicates the number of youth with behavioral health conditions served in the community in FY 2013.
Figure 95. Youth with Behavioral Health Conditions and Juvenile Justice Involvement Served in the Community, FY 2013

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health programs and mental health court programs</td>
<td>2,758 out of 30,781</td>
</tr>
<tr>
<td></td>
<td>(9% of total juveniles served)</td>
</tr>
<tr>
<td>Behavioral health services for a mental health problem (ex. drug treatment programs, drug education, and prevention programs)</td>
<td>657 out of 1,487</td>
</tr>
<tr>
<td></td>
<td>(44% of total juveniles served)</td>
</tr>
<tr>
<td>Counseling programs</td>
<td>5,100 out of 30,781</td>
</tr>
<tr>
<td></td>
<td>(16% of total juveniles served)</td>
</tr>
<tr>
<td>Drug treatment programs</td>
<td>2,737</td>
</tr>
<tr>
<td>Drug education/prevention programs</td>
<td>3,965</td>
</tr>
</tbody>
</table>

Source: The Texas Juvenile Justice Department. (2014, August). Data Request: Mental Health Services

Definitional Note: “Services” are typically one-time events designed to meet a juvenile’s immediate need, such as a medical appointment, an assessment, or psychological testing. “Programs” are planned activities or interventions with specific goals and curricula. These include counseling, anger management and Special Needs Diversionary Program.

FUNDING SOURCES

TJJD distributes general revenue funds appropriated by the Texas Legislature to local juvenile probation boards to underwrite a number of probation activities, including special services to juveniles with mental health conditions and substance use conditions. For foster care youth involved in juvenile justice, federal Title IV-E funding is a key resource. However, counties provide the majority of funding for community-based juvenile probation services. In FY 2013, counties funded 70% of probation services while state and federal funding accounted for only 30% of total funding.

Using a mix of local, state and federal funds, local juvenile probation departments provide a wide array of mental health and substance use services, including counseling, intensive in-home family services, substance use prevention and intervention, anger management and intensive case management.

STATE-FUNDED PROGRAMS AVAILABLE TO LOCAL JUVENILE PROBATION DEPARTMENTS WITH BEHAVIORAL HEALTH SERVICE COMPONENTS

TJJD funds programs in local juvenile probation departments via various initiatives and grant funding. The initiatives are aimed at serving youth in their local communities and keeping them from being committed to state-operated secure institutional facilities. The following section describes a variety of programs available to local juvenile probation departments with a behavioral health service component.
PREVENTION AND INTERVENTION PROGRAMS

Prevention and intervention programs were funded by the 82nd Legislature (2011) to prevent or intervene in at risk behaviors that can lead to delinquency, truancy, school dropout, or referral to the juvenile justice system. In 2012, TJJD approved the initial investment of $1.5 million for 24 prevention and early intervention programs. The programs are designed to serve youth ages 6-17 and their families. In 2013 there were 21 programs in operation. The total amount budgeted for prevention and early intervention services in 2013 was $2.6 billion dollars. At an average expense of $575 per youth, 3,418 youth participated in a funded prevention program in FY 2013. The average age of the participants was 11 years old. The programs offer a range of services from mentoring, skills building programs, character development, and educational programs for at risk youth aimed at teaching skills and services to better manage challenging behaviors. The programs are located in the following counties: Comal, Ellis, El Paso, Fort Bend, Guadalupe, Hale, Tarrant, Randall, Tom Green, Travis, Van Zandt, Webb, Wharton, Willacy, Williamson, Zapata, and Karnes/Wilson.

COMMUNITY-BASED SERVICES

The use of community-based juvenile justice programs has continued to grow steadily with new offerings by juvenile probation departments each fiscal year. At the end of FY 2012, 1,562 community-based programs had been identified within the TJJD Program & Services Registry and listed as active. The ten urban juvenile probation departments have the most programs, with an average of 42 per department. These departments offer various programs, including specialized counseling and educational programs as well as mental health courts and drug courts. In medium to large departments an average of 11 and 18 programs are offered, respectively. While small departments offer an average of 5 programs per department, they often do not offer targeted programs such as mental health courts. Instead, they may offer counseling and educational programs meant to serve the needs of a wide array of juveniles. The size of a department is crucial to whether a program is offered and who provides it. Generally, departments provide 39% of programs in their jurisdiction and contract for 45% of their programs. Local mental health authorities provide 39% of the mental health programs.

Program duration varies widely from lasting one afternoon to the entirety of the supervision. Intensive supervision programs will last longer than early-intervention/first referral programs.
Figure 96. Average Expected Length of Stay in Various Community Programs

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Days in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>109</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>70</td>
</tr>
<tr>
<td>Mental Health Court</td>
<td>170</td>
</tr>
<tr>
<td>Other Mental Health programs</td>
<td>161</td>
</tr>
</tbody>
</table>


Community Corrections Diversion Program

In 2009, the 81st Legislature created the Commitment Diversion Program (Grant C) through Rider 21 in the general appropriations bill. The program provides state funds to local probation departments that decrease their commitments by diverting offenders from state-based incarceration. These funds also are used to support a range of community-based services. Probation departments typically use these funds for counseling, life skills, and educational programs. In fiscal year 2013, 7,596 juveniles participated in a commitment diversion program or received a service funded completely or in part with these funds.

Mental Health Services

For fiscal years 2014 and 2015, $12,804,748 was allocated each year to fund mental health services provided by local juvenile probation departments. These funds are to only be used to provide mental health services to juveniles and may not be used for administrative expenses or to supplant local funding. Funding is provided in two tiers. Tier 1 funding goes to departments with secure pre- or post-adjudication facilities. Departments with one or more facilities with fewer than 80 beds receive funding for one-full-time mental health professional to provide screening, assessment, diagnosis, evaluation and/or treatment to youth with mental health or emotional conditions. If a department has more than 80 beds they receive funds for two full-time mental health professionals. Departments without a facility receive funding to secure mental health services. Tier 2 funding goes to all probation departments to provide resources for screening, assessment, diagnosis, evaluation and treatment.

Diversion Programs for Youth with Behavioral Health Conditions

Diverting youth with mental health conditions from incarceration and further involvement with the juvenile justice system has significant human and cost benefits. Texas has a number of initiatives scattered around the state, but no statewide diversion effort exists. Following is information on currently operating diversion programs.
**SPECIALTY JUVENILE COURTS**

Specialty courts serve individuals who will benefit from programs designed to address the underlying causes of juvenile justice involvement and for whom residence in a secure facility may be inappropriate. They often operate as one piece of a larger continuum of diversion services for youth with behavioral health conditions. Juvenile Mental Health Courts utilize individual treatment plans, case management, and judicial supervision, and immediately link youth to treatment services in the community.

As of 2012, there were approximately 50 juvenile mental health courts across the country. In Texas, there are five such specialized courts. The first began in Austin, followed by San Antonio, El Paso, Houston, and Dallas. A 2011 evaluation found that juvenile mental health courts are an effective alternative to placement in psychiatric and detention facilities because they reduce recidivism rates among juveniles with mental illness and are a more efficient use of public resources.

Collaborative Opportunities for Positive Experiences (COPE) is a Travis County juvenile court project funded through the federal Bureau of Justice Assistance. A multi-disciplinary team whose members include a court representative, a legal representative for the youth, the district attorney, a probation officer, a case manager, and mental health professionals work with youths with a mental illness who are eligible for deferred adjudication and have committed family involvement. The youths must cooperate with probation supervision and mental health treatment and successfully meet program requirements to get charges dismissed.

Similar specialty courts exist for juveniles charged with drug related crimes. As of 2013 there were 458 identified juvenile drug courts nationwide. In that same year, 20 of those juvenile drug courts were located in counties throughout Texas.

**SPECIAL NEEDS DIVERSIONARY PROGRAM**

The 77th Texas Legislature established the Special Needs Diversionary Program to prevent the removal of youth with mental health conditions (excluding substance use, intellectual disability, autism, and pervasive development disorder) from their home and to reduce further involvement with the juvenile justice system. TJJD, in coordination with the TCOOMMI and in cooperation with local mental health authorities, has worked to implement this program with specialized caseloads. Services from these programs are provided to juveniles under the supervision of 22 local juvenile probation departments. Typical services include mental health services (including individual and group therapy), probation services (including life skills, anger management, and mentoring), and parental support and education.

In FY 2012, the program served 1,009 juveniles. The one-year re-offense rate was 59% for all program participants. Only 2% of youth in the program were sent to a secure state facility. In FY 2013, the program served 1,444 juveniles across 22 juvenile probation departments. The total amount appropriated for FY 2013 was $1,974,034. Sixty-nine percent of those served by this program (1,002) received mental health treatment prior to entry into the program.

In FY 2013, 70% of enrolled youth completed the program. Referrals to secure state facilities and re-offense rates are measured as indicators of program effectiveness.
Other Privately and Federally Funded Diversion Programs

Youth with mental health needs may be diverted from the adjudication process and provided supervision, including mandated treatment in lieu of adjudication. Youth going through adjudication may be offered the opportunity or be required to participate in treatment as a condition of probation. In either case, youth with mental illness or substance use conditions may receive community-based outpatient services or residential treatment.

Federal and foundation grant funds have underwritten projects that divert youth with mental illness from formal adjudication or incarceration through several local probation departments in Texas.643

The Front-End Diversionary Initiative

The Front-End Diversionary Initiative, funded through the MacArthur Foundation’s Models for Change initiative in 2007, links first-time offenders with a mental illness diagnosis to a specialized juvenile probation officer who helps the youth and family access community services. It also includes workforce development and family and youth engagement activities. Texas demonstration sites were initiated in Austin, Dallas, Lubbock, San Antonio and expanded to Houston.644 The sites continue to maintain the program and served 92 youth during FY 2013.645 In 2014 the Initiative was designated a “Promising Program” by the National Institute of Justice.646

Identifying Youth with Brain Injuries

Research has identified a high level of traumatic brain injury among juvenile justice populations; one key study showed that over 18% of juveniles had a “significant” head injury with loss of consciousness of at least 20 minutes.647 TJJD collaborated with HHSC on a research based grant from the U.S. Department of Health and Human Services to identify youth in the Texas juvenile justice system with undiagnosed brain injuries that contribute to delinquent behavior. Beginning with pilot communities that included Brownsville, El Paso, Houston, Lubbock, San Antonio, and the state youth corrections facilities, youth are screened for Traumatic Brain Injury (TBI) utilizing the Brain Injury Screening Questionnaire (BISQ) provided by the grant from FY 2011-2014. Youth
identified with a probability of TBI are provided appropriate services and case plan objectives that address the youths’ special needs.\textsuperscript{548}
Texas Education Agency and Local School Districts: At A Glance

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POLICY CONCERNS

- Potential impact of budget reductions on school mental health services
- Expansion of school wide Positive Behavioral Interventions and Support (PBIS) and classroom-based Social and Emotional Learning (SEL)
- Disproportionate representation of students receiving special education services and racial/ethnic minorities in ISS, OSS, DAEPs, and JJAEPs
- Disproportionate use of corporal punishment on students with disabilities
- Lack of accountability and training of school district law enforcement, including a need for Children’s Crisis Intervention Training (CCIT)
- Negative side effects from bullying
- Use of ticketing for minor disciplinary infractions and truancy
- Training and reporting on Taser and pepper spray use in schools
- Reduction of restraint in schools
FAST FACTS

- A 2011-2012 report found that on average, 12.9 percent of students are in special education across all states. During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country.

- Approximately 25,663 of Texas students, or 0.5 percent, received special education services with a primary diagnosis of emotional disturbance.

- Among Texas kids with a diagnosed mental illness, serious emotional disturbance or at risk of being removed from their homes or classrooms for mental health reasons, only 18 percent receive the mental health treatment for which they qualify.

- In a study of 250 middle school students, 90 percent of the students who were bullied experienced negative side effects as a result of the bullying.

- In 2012-2013, 8.7 percent of all students in Texas public schools received special education services but they represented 14 percent of all students sent to ISS and 17.8 percent of all students sent to OSS.

- In the 2012-2013 school year, Texas school districts placed over 2,800 students into JJAEPs and expelled 893 students to the streets.

ORGANIZATIONAL CHART

Texas Education Agency

Texas Governor

Commissioner of Education

Chief Deputy

Education Service Centers

Deputy Commissioner, Policy & Programs

Deputy Commissioner, Finance & Administration

Director of Communications

Director of Communications

General Counsel

Chief Financial Officer

Human Resources

Deputy Commissioner

Purchasing, Contracts & Agency Service

Educator Leadership & Quality

Education Service Centers

Instructional Materials & Educational Technology

Standards & Programs

Assessment & Accountability

Federal & State Education Policy

Curriculum

Effective Date: January 29, 2014
Texas Education Agency and Local School Districts

The Texas Education Agency (TEA) provides oversight and administrative functions for all primary and secondary public schools for the 1,245 school districts in the state of Texas. According to TEA, 5,151,925 students were enrolled in Texas public schools during the 2013-2014 academic year. Approximately 25,663 students, or 0.5 percent, received special education services with a primary diagnosis of emotional disturbance.

An estimated one in ten school-aged children and youth have an undiagnosed or untreated mental health condition that can negatively impact academic performance, classroom behavior and school attendance. In 2009, Texans Care for Children reported that “among Texas kids with a diagnosed mental illness, serious emotional disturbance or at risk of being removed from their homes or classrooms for mental health reasons, only 18 percent receive the mental health treatment they qualify for.” The 2011-2012 National Survey of Children’s Health revealed that an estimated 500,000 children in Texas have mental health needs, but 40 percent of these children did not receive the needed services.

Schools have a long history of providing mental health services to students; 75 percent of children receiving mental health services receive them in school. The President’s New Freedom Commission on Mental Health recognized the critical role that schools can play in the continuum of mental health services. Schools can provide convenient access to services for children and families in an environment less stigmatizing than a traditional mental health setting. Though access to various types of mental health services varies by school characteristics such as region, urban/rural location, academic level, and student population, most schools offer some level of mental health screening, referral or services.

In Texas, school mental health services may be provided by a number of professionals who have a variety of training, including school counselors, nurses, school psychologists, and social workers. Texas also has a special credential for Licensed Specialists in School Psychology (LSSPs). Despite their name, school counselors have many duties that are only tangentially related to mental health.
Texas law, “the primary responsibility of a school counselor is to counsel students to fully develop each student’s academic, career, personal, and social abilities.”

Although the American School Counselor Association (ASCA) recommends a ratio of 250 students per counselor, Texas had a ratio of 440 students per counselor for the 2010-2011 school year and a ratio of 462 students per counselor in the 2011-2012 school year.

Delivery of Mental Health Services in Schools

School-based mental health services encompass a wide variety of program approaches. While these services are available across the state, many districts are unable to provide access to mental health services due to lack of resources, stigma associated with mental health conditions, and a failure to recognize mental health conditions. A December 2011 Texas A&M University-Kingsville study on access to mental health services found that rural schools struggle to provide mental health services to students. Nearly half of the counselors in the study said less than 25 percent of their students received adequate counseling services. The study also referenced prior research that said depression, substance use and suicide rates among children are higher in rural areas and that school counselors play a critical role in providing mental health services to students. Barriers schools face in mental health service delivery lead to inconsistent mental health care from school to school. The different methods of service delivery include the services described below in Figure 97.

Figure 97. Mental Health Service Delivery Methods

<table>
<thead>
<tr>
<th>School-Based Mental Health Service Delivery</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Financed</td>
<td>Typically include mental health prevention programs and basic treatments such as counseling that are provided on-site by licensed school personnel, such as counselors, psychologists and social workers.</td>
</tr>
<tr>
<td>Formal Connections with Community Mental Health Services</td>
<td>Agreements made with community mental health agencies to provide services at the school or the community agency.</td>
</tr>
<tr>
<td>School District Mental Health Units or Clinics</td>
<td>School districts may operate their own mental health units or health clinics to provide psychosocial and mental health services, staff training and consultation.</td>
</tr>
</tbody>
</table>
### School-Based Mental Health Service Delivery

<table>
<thead>
<tr>
<th><strong>School-Based Mental Health Service Delivery</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom-Based Curricula</td>
<td>Schools may make available prevention-oriented materials provided through teacher instruction and designed to enhance learning through social and emotional growth for all students.</td>
</tr>
<tr>
<td>Comprehensive, Multi-Faceted and Integrated Approaches</td>
<td>Districts can bring together multiple activities and community agencies to provide a full range of services to students with mental health needs.</td>
</tr>
<tr>
<td>School-wide Behavioral and Emotional Support Frameworks</td>
<td>Models or frameworks utilized by an entire school that take a holistic approach to meeting the needs of all students. Some examples of these approaches are Positive Behavioral Interventions and Supports (PBIS), Social Emotional Learning (SEL), and Trauma-Informed Care. Each of these frameworks will be discussed in more detail throughout the remainder of this section.</td>
</tr>
</tbody>
</table>

### Changing Environment

Texas legislators and others have recognized the negative impact of bullying in schools. In a study of 250 middle school students, 90 percent of the students who were bullied experienced negative side effects as a result of the bullying. Examples of these side effects include anxiety, low grades, and social rejection. The Texas Education Code requires each school district to have an anti-bullying policy that ensures educators enforce appropriate measures and methods to prevent bullying. TEA has developed a webpage to provide administrators, educators, parents, and students with resources about bullying: [http://www.tea.state.tx.us/CSH_Bullying.html](http://www.tea.state.tx.us/CSH_Bullying.html). Research indicates that bullies and victims share many of the same risk factors and could benefit from interventions to improve their problem-solving skills and social interactions. Interventions to address bullying show moderate success. The most effective were intensive programs that avoided peer-based approaches and included parent meetings, firm discipline, and better playground supervision.

Several bills passed during the 83rd Legislative Session have the potential to improve mental health support in Texas public schools. SB 460 (Deuell) requires all certified public school teachers to be trained in detecting and educating students who are at risk for suicide or have other mental health needs. This bill also specifically requires the inclusion of mental health concerns in coordinated school health efforts.

Among other important changes, HB 3793 (Coleman) created two grant programs making Mental Health First Aid training available to interested individuals and educators throughout Texas. This training teaches individuals about the signs of addiction and mental health conditions, the impact of substance abuse and mental health conditions, how to help in a crisis, a 5-step action plan to assess a situation and help, and local resources for additional support. Training teachers in Mental Health First Aid (MHFA) can strengthen the mental health support for all students.
While some of the interest in MHFA is driven by fear over school shootings, recent data shows that less than 1 percent of homicides among school-aged youth occur at school.\textsuperscript{680} Training teachers to support and recognize mental health needs and crisis has the potential to better prepare schools in the US to identify and meet students’ needs as well as to prevent acts of violence by intervening sooner. TEA has authorized Continuing Education Units for educators who complete the MHFA training, and the Department of Aging and Rehabilitative Services (DARS) will provide MHFA training in 2015 for staff who serve students with emotional and behavioral health conditions.\textsuperscript{681} As of June 2014, 1,829 educators had been trained in MHFA, and as of July 2014, 353 staff or contractors were certified as MHFA trainers.\textsuperscript{682} The Department of State Health Services (DSHS) estimates 479 staff and 12,295 educators will undergo MFHA training in FY 2014.\textsuperscript{683}

Schools are increasingly moving to proactive, coordinated approaches to meet the needs of all students. Positive Behavioral Interventions and Supports (PBIS) is an example of this type of approach. Legislative attention to support state-wide PBIS implementation is expected in 2015 for the 84\textsuperscript{th} Legislative Session.\textsuperscript{684} More information about PBIS can be found later in this chapter in the Alternatives to Exclusionary Discipline and the School-wide Positive Behavior Interventions and Support sections.

SB 831 (83\textsuperscript{rd}, Taylor) requires TEA, education centers, and the Department of State Health Services (DSHS) to work together to create a list of recommended best-practice programs for public schools that can be implemented in the general education setting. This list should provide information on best practice-based recommendations, mental health promotion, positive youth development, suicide prevention and substance abuse prevention and intervention programs. The intent of the bill is to provide a way for school districts to access information from a central location. The emphasis on prevention and mental health promotion in the bill has the potential to reduce the cost of reactionary interventions for existing issues by identifying and addressing problems before they escalate. This best practice-based programs list is to be updated annually and can be found on the DSHS website http://www.dshs.state.tx.us/mhsa/sb831/.

Special Education Services

A 2011-2012 report found that on average, 12.9 percent of students are in special education across all states. During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country.

A 2011-2012 report found that on average, 12.9
percent of students are in special education across all states. During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country. From the 1999-2000 school year to the 2011-2012 school year, the population of Texas students receiving special education services decreased by 3.6 percent, while the national average of students decreased by only 0.3 percent. Additionally, the percentage of students identified with emotional disturbance in the special education population has decreased nationally and in Texas. The reason for the percentage decrease in special education enrollment in Texas is unclear and further research on this topic is needed to better understand discrepancies between state and national enrollment levels and to ensure Texas is doing all it can to provide services to all children who need them.

### SPECIAL EDUCATION FUNDING THROUGH IDEA

IDEA first passed in 1975 (as the Education for All Handicapped Children Act, PL 94-142) and was reauthorized multiple times. When IDEA was created, the expected cost of educating students with special needs was projected to be twice as much as the national average of educating students who do not require special education services. To support schools with increased costs, the federal government committed to contributing up to 40 percent of this anticipated additional cost. Despite this commitment, the federal government has given less than half of their committed financial support since IDEA's first year of funding in 1981. Overall, spending for special education programs has increased since the inception of IDEA and its predecessor, but national and state funding for special education has not increased proportionately. As shown in Figure 98, local funding for schools must make up this increase in necessary spending to meet the funding for services required by IDEA.

**Figure 98. Declining State Support for Special Education**

![Image of Figure 98](http://febp.newamerica.net/background-analysis/individuals-disabilities-education-act-cost-impact-local-school-districts)


### SPECIAL EDUCATION FUNDING THROUGH MEDICAID

In addition to funding from the federal and state government through IDEA, schools can bill Medicaid for certain eligible services. School Health and Related Services (SHARS) is made available by the coordination of the Texas Education Agency and Texas Health and Human Services Commission (HHSC). SHARS is a Medicaid...
financing program that allows local school districts/shared services arrangements (ssa’s) to obtain Medicaid reimbursement for certain health-related services provided to students in special education. The state match requirement for SHARS Medicaid funding is met by using state and local special education allocations that already exist. School districts/ssa’s must enroll as Medicaid providers and employ or contract qualified professionals to provide these services. SHARS services include assessment, audiology, counseling, school health services, medical services, occupational therapy, physical therapy, psychological services, speech therapy, special transportation and personal care services. SHARS services must be provided to students who are Medicaid eligible, qualify to receive special education services under IDEA, and have an IEP.

**ELIGIBILITY FOR SPECIAL EDUCATION**

Eligible children and adolescents ages 3-21 with disabilities are entitled to receive free and appropriate public education under IDEA. A number of students who receive special education services are diagnosed with emotional disturbance or other mental health conditions. Over 25,000 Texas students were identified as having serious emotional disturbance for the 2013-2014 school year. There are other students who receive special education based on other primary disabilities (e.g. intellectual disabilities and autism) that also have mental health needs, such as anxiety or depression, that are not reflected in these numbers. Nationwide, students identified as having serious emotional disturbance have the highest rate of school failure, with half of this population dropping out of high school.

Eligibility to receive services for serious emotional disturbance is based on the student exhibiting one or more of the following characteristics to a marked degree over an extended period of time in ways that adversely affect the student’s educational performance:

- An inability to learn that cannot be explained by intellectual, sensory or health impairments.
- An inability to relate appropriately to peers and teachers.
- Inappropriate types of behaviors or feelings under normal circumstances.
- A general mood of unhappiness and depression.
- A tendency to develop physical symptoms, pains or fears associated with personal or social problems.

In determining whether special education services will be provided, school personnel also seek evidence that the student’s behavior and need for services is not the result of a temporary reaction to home, school or community situations.

**SPECIAL EDUCATION SERVICES AND SERVICE UTILIZATION**

Special education and related services can include a wide range of supports depending on the student’s needs. Some examples of services related to behavioral health include assessment, medical services to diagnose or evaluate a student’s
disability, counseling, case management, parent counseling and training, skills training, specialized classes and residential treatment for educational reasons. In addition to behavioral health services, there are multiple services available to students that are related to developmental delays, physical conditions, and other types of disabilities. The types of special education services and supports provided are determined through an annual admission, review, and dismissal (ARD) meeting with the student, parents or caregivers, and school personnel. An individualized education plan (IEP) is developed to specify the behavioral supports and interventions to be provided by the school district for the student.

It is often difficult to diagnose a young child, and there are children without a specific diagnosis who would still benefit from early intervention. To bridge the gap for young children who do not have a specific diagnosis and would often not receive services before entering school in Kindergarten, IDEA allows for children between the ages of three and nine to qualify for special education services under a broader category called “developmental delay” if diagnosed with the proper instruments and procedures. The following are possible diagnostic areas that can fall under the broad category of developmental delay: physical development, cognitive development, communication development, social or emotional development, or adaptive development. States decide what to call this category, how to define it, and what ages to include in this category.

Texas names this development delay category “Non-Categorical Early Childhood” (NCEC) and designates children between the ages of three and five as able to qualify under this developmental delay category. Children who fall under the NCEC category are provided services through a program called Preschool Program for Children with Disabilities (PPCD). In addition to eligibility through the NCEC category, children in Texas may also qualify for PPCD services under the following specific diagnoses: Intellectual Disability, Emotional Disturbances, Specific Learning Disability, or Autism. PPCD services are provided in a variety of settings such as pre-kindergarten, resource classrooms, self-contained classrooms, or community settings such as Head Start and pre-school.

Texas has also worked to bridge a gap for students with special needs transitioning out of high school. To assist students who receive special education services with a successful transition from school to appropriate post-school activities, such as postsecondary or vocational education, or integrated employment and independent living, schools must begin individual transition planning with students and their families by age 14. Schools are required to identify needed courses and related services for postsecondary education and to develop adult living objectives through the IEP. The availability, comprehensiveness and quality of transition services available in Texas vary widely across the state. The 83rd Legislature passed HB 617 (Rodriguez) which requires school districts to assign at least one employee to provide transition and employment services to students receiving special education services. The bill also requires districts to make transition information available through their website http://www.transitionintexas.org/site/default.aspx?PageID=1.
Mental Health Support Systems for Schools

Mental health services are required by law to be provided for students who receive special education services if those services are part of their Individual Education Plan (IEP). Mental health services are not required for the general education population. Although schools are not required to provide these services unless stated in an IEP, there are students in the general population who receive mental health services. Mental health supports and services vary between individual schools and districts, but there are certain mental health services available across the state. Those mental health service structures and related programs are described below.

EDUCATION SERVICE CENTERS

Created in 1965, 20 regional educational service centers in Texas provide support and technical assistance to all school districts throughout the state in a variety of areas, including special education and behavioral support. A map of service center regions is shown in Figure 99. This infrastructure also supports schools in complying with IDEA. Service centers may also specialize in a particular area and offer that expertise to schools across the state. For example, the Region IV Education Service Center in Houston specializes in Positive Behavioral Interventions and Support (PBIS) with the goal of enhancing the education experience for all students and addressing the needs of students with behavior challenges. For more information, refer to the Region IV website at http://www.esc4.net/default.aspx?name=ses.behavior. Additionally, the Region XIII Education Service Center in Austin has a Behavior Team that has general and special education specialists who focus on providing campuses with technical assistance in the area of behavior supports. For more information, visit the Region XIII website at http://www4.esc13.net/behavior/.
Counseling and mental health services are a core element of TEA’s Coordinated School Health Model.\textsuperscript{704} The Department of State Health Services (DSHS) defines coordinated school health as “an integrated, systematic set of planned, sequential, school-affiliated strategies, activities and services designed to advance student academic performance and promote their optimal physical, emotional, social and educational development.”\textsuperscript{705} The Coordinated School Health Model is directed by a mandatory, multidisciplinary team, known as the School Health Advisory Council (SHAC). SHAC members are appointed by the school district to serve on the district level and make recommendations for the district’s Coordinated School Health Model. SHAC is accountable to the community for program quality and effectiveness.

The 8-Component Model for Coordinated School Health consists of eight health-related areas covering all aspects of the school environment that are linked together to function and coordinate as a unified, effective system to the benefit of the entire school community. “Counseling and Mental Health Services” is one of the core components, demonstrating the importance of mental health services in schools.
Communities in Schools (CIS), is a national dropout prevention program funded through state and local support. CIS provides individualized case management, counseling, and other mental health-related services. In the 2012-2013 school year, CIS served 603,697 students with schoolwide basic support and 63,730 students with case management in 129 school districts throughout Texas. All but 2 percent of the students receiving case management services from CIS stayed in school during the 2012-2013 school year. CIS received over $6 million less from the 82nd Legislative Session for the 2012 and 2013 fiscal years, dramatically reducing the number of students able to receive case management from CIS by more than 50,000 students from the previous biennium. During the 83rd Legislature, $5 million of the $6 million cut in the previous session was restored for CIS for the 2014 and 2015 fiscal years. This restored funding allows CIS to serve more students in 2014 and 2015 than the previous biennium; however, funding is still too short to serve the same amount of students as in the 2010 and 2011 fiscal years.

Holistic Approaches to Student Mental Health

While some students with mental health needs require tailored interventions and trained professionals, there are also models that provide holistic support for all students’ developmental needs. Schools are increasingly moving to proactive, coordinated approaches to meet the needs of all students. These initiatives generally include campus wide prevention activities, targeted early intervention for students with risk factors, and individualized services for students with extensive needs. Several key classroom-based strategies for all students seek to build respectful, positive environments and bolster students’ social and emotional competencies. A number of states including Texas are promoting positive approaches to preventing mental and emotional problems in children.

School Wide Positive Behavioral Interventions and Supports

A well-known example of a proactive framework of school-based services is School-wide Positive Behavioral Interventions and Supports (SWPBIS). See Figure 100 for an illustration of this model.

SWPBIS is an evidence-based framework that uses a three-tiered approach to teach and reinforce appropriate behaviors for all students. SWPBIS programs are designed to replace a punishment-oriented system with a campus culture based on respect and individual responsibility. The program consists of the following three tiers:

- Tier 1, the primary prevention tier, is for 80 percent to 90 percent of students. Teachers use a curriculum to teach social skills and expectations that all students and school personnel are expected to follow.
- Tier 2, the secondary prevention level, focuses on the 10 percent to 15 percent of
students who have risk factors such as exposure to violence or loss of a loved one that cause them to have a higher-than-normal risk of developing mental health conditions. Interventions focus on developing skills and increasing protective factors for students and their families.

- Tier 3, the tertiary prevention level, focuses on the 1 percent to 5 percent of the student population who need an in-depth system of support and includes comprehensive, individualized intervention for students with the most severe or chronic issues.

**Figure 100. Continuum of School-wide Instructional & Positive Behavior Support**


The Texas Education Agency recommends that school districts utilize SWPBIS to address student behavior, but schools are not required to use it or other related approaches. Technical assistance to implement SWPBIS is available through regional educational service centers and the Texas Behavior Support Initiative (TBSI). TBSI was designed to build capacity in Texas schools for the provision of positive behavioral interventions and supports to all students. TBSI training modules assist campus teams in developing and implementing a wide range of behavior strategies and prevention-based interventions. In 2009, more than 800 schools were actively participating in the PBSI trainings facilitated by TBSI. Schools that implemented the model have achieved favorable outcomes including reduced disciplinary referrals and less use of physical restraints.

Texans Care for Children, a child advocacy organization, recommends SWPBIS as an
evidenced-based approach to support all students, especially those with challenging behavior.719 With a grant from the Hogg Foundation for Mental Health, Texans Care for Children organized experts across the state to explore how Texas can facilitate the support of SWPBIS implementation on a state-wide level. The experts are in the planning stage and are expected to make recommendations for next steps to move toward statewide support for SWPBIS. These recommendations are expected to be made during the 84th Legislative Session in 2015.720

Positive Behavior Intervention and Supports is a model that often serves as a key organizing framework for other interventions, several of which are described below. The cost to implement a school wide PBIS program could be as low as $23,000 per year.721 This cost includes compensation for staff, training, and resources to implement a PBIS program. There are variables that can affect this number, and information on potential costs can be found in the Texas Appleseed report, *Breaking Rules, Break Budgets*, at http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=867&Itemid=.

### SOCIAL AND EMOTIONAL LEARNING

Social and Emotional Learning’s (SEL) main goals are to help students work well and productively with others, develop positive relationships, cope with their emotions, appropriately settle conflicts, work more efficiently, and make decisions that are safe and ethical.722 Effective SEL programs can be implemented from preschool through high school and have the ability to improve dropout rates, truancy, substance abuse, and conduct problems.723 SEL is not a specific program; rather it is a framework to help change the school’s approach to working with students.724 Schools can choose from a variety of proven, effective SEL programs, but it is not necessary to hire additional staff to implement SEL in a school.725 The primary costs associated with an SEL program are staff training and student surveys.726 Austin Independent School District (AISD) has committed to incorporate SEL in its schools, one of the first districts in the country to make this commitment.727 In 2013-2014, 73 schools implemented SEL with over half of the total students enrolled in AISD.728 AISD’s goal is to have all schools using SEL as a framework to holistically meet the needs of all of its students by the 2015-2016 school year.729 More information about SEL can be found at http://www.casel.org/social-and-emotional-learning/.

### TRAUMA-INFORMED CARE

Many children in Texas public schools have experienced trauma in some form.730 Children who have experienced trauma may see the world as a threatening place, and this can lead to anxious behavior that interferes with the child’s ability to learn and properly socially interact with their peers.731 Trauma-informed care is when an entire organization takes steps to understand how trauma affects the life of an individual.732 An organization that is trauma-informed also understands the vulnerabilities or triggers of trauma survivors, and uses this understanding to ensure its approach in working with individuals does not re-traumatize them.733 Trauma-informed care is an overarching concept that can be implemented through the education and training of teachers and other school personnel who interact with children. In general, trauma-informed organizations recognize that survivors need to be respected and given hope relating to their own recovery; that there is a connection between trauma
and trauma symptoms (e.g., substance abuse or depression); and that collaborative work needs to be done with the survivor, their friends and family, and other human service organizations. For more information about trauma-informed care, refer to the Texas Environment and Best Practices sections.

Exclusionary Discipline in Schools

Exclusionary discipline in schools includes practices that remove students from the classroom. Removal from the classroom excludes students from common, daily experiences that are often helpful in student development. Under state law, schools have the option to remove or expel students, even those in special education, to disciplinary alternative education programs (DAEPs) or juvenile justice alternative education programs (JJAEPs). In the 2012-2013 school year, thousands of Texas students were removed from the classroom and sent to the following:

- 549,305 students sent to In-School Suspension (ISS)
- 248,266 students sent to Out-of-School Suspension (OSS)
- 81,104 students sent to Disciplinary Alternative Education Programs (DAEPs)
- 2,819 students sent to Juvenile Justice Alternative Education Programs (JJAEPs)
- 915 students expelled to the streets

Referrals to these disciplinary structures can be mandatory or discretionary. Mandated referrals, determined by state code, occur when a student performs a specific act that automatically requires the removal from the classroom. Discretionary referrals, determined by school district policy, vary widely from district to district. Discretionary referrals are made by teachers or administrators based on policies in their local student code of conduct. These policies can be vague, allowing for wide interpretation when determining what and how behaviors should be disciplined. A large majority of disciplinary referrals are not mandated by law; instead, they are authorized at the discretion of school districts.

Breaking School Rules: A Statewide Study of How School Discipline Relates to Student Success and Juvenile Justice Involvement, a key 2011 Texas study conducted by The Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University, found that three-fourths of students who qualified for special education had been suspended or expelled at least once. Students diagnosed with emotional disturbance were even more likely to be suspended or expelled. The researchers also found that students who had been suspended or expelled were significantly more likely to drop out of school or become involved in the juvenile justice system. The over-representation of students who receive special education services among the population of students removed from classrooms for disciplinary reasons received legislative attention during the 83rd Session but the efforts to legislate change were unsuccessful. The proposed legislation would have required TEA to examine data on the number of students who receive special education
services and were disciplined based on discrepancy action at school.

**IN-SCHOOL SUSPENSIONS (ISS) AND OUT-OF-SCHOOL SUSPENSIONS (OSS)**

A disruptive student can be removed from the regular classroom and assigned one or more days to a separate ISS classroom to complete his/her class assignments or may be required to remain off campus for a specified period of time. According to the Texas Education Code, the principal or other appropriate administrator may also suspend a student from school for engaging in conduct identified in the school’s code of conduct.

In 2012-2013, 8.7 percent of all students in Texas public schools received special education services but represented 14 percent of all students sent to ISS and 17.8 percent of all students sent to OSS. ISS and OSS can lead to significant, negative cost impact on schools. If a student misses nine days in the 180-day school year, the school receives 5 percent less funding for that student than they do for a student with perfect attendance.

**DISCIPLINARY ALTERNATIVE EDUCATION PROGRAMS (DAEPS)**

Every Texas school district is required to provide a DAEP. Districts may operate their own or may join together to support a cooperative program. In smaller, rural districts, a DAEP may be a separate classroom on the school campus, but more frequently DAEPs are housed at separate campuses. Additionally, a DAEP that serves a student with an individualized education program (IEP) must provide the services outlined in the IEP. The *Breaking School Rules* study found that “because there has been little monitoring and oversight of DAEPs, the quality of the programming and instruction varies among districts, with some students in DAEPs poorly served by under-resourced programs.” Students receiving special education services are also overrepresented in referrals to DAEPs. TEA’s data for 2012-13 shows that 8.7 percent of all Texas public school students received special education services but 17.5 percent of students referred to DAEPs were students receiving special education services.

**MANDATORY V. DISCRETIONARY REMOVAL**

For DAEPs, certain infractions require mandatory removal according to the Texas Education Code. A student’s removal to a DAEP is mandated for the following infractions:

1. Committing a felony or engaging in conduct punishable as a felony.
2. Assaulting another student or school employee.
3. Selling, giving, possessing or being under the influence of a dangerous drug or alcohol.
4. Committing an offense that involves volatile chemicals, public lewdness or retaliation against a school employee.
5. Making a terroristic threat or a false alarm/report.
As with suspensions, Texas schools also have wide discretion to send students to a DAEP for other offenses listed in their student code of conduct. Depending on the school district, these offenses can range from “fighting and gang activity to disrupting class, using profanity, playing a prank such as throwing a tennis ball in the hallway and narrowly missing another student, misusing a school parking decal, inadvertently bringing a prescription or over-the-counter drug to school, or doodling in class when the drawing contains a weapon.” Many school districts have exercised the latitude under the Texas Education Code to enforce their own student codes of conduct and, as a result almost 61 percent of Texas DAEP student placements are discretionary.

Questions have been raised about the quality of education services provided in DAEPs. In 2011, the Legislative Budget Board expressed the following concerns about DAEPs:

- Failure to staff the DAEP with certified teachers.
- Failure to provide a learning environment equivalent to mainstream campuses.
- Inadequate training for DAEP instructors and staff.
- Lack of instructional alignment between DAEP and mainstream campuses.
- Insufficient communication between a student’s home campus and DAEP.
- Absence of transitional programming upon a student’s return from a DAEP.

**JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS (JJAEPS) / EXPULSION TO THE STREETS**

Juvenile Justice Alternative Education Programs (JJAEPs) were created during the 74th Texas Legislature in 1995 to provide ongoing educational services for students who have been expelled. Every county with a population of more than 125,000 residents must have a JJAEP. JJAEPs are operated by juvenile boards with oversight provided by the Texas Juvenile Justice Department; thus, when a student is expelled to a JJAEP, they enter the juvenile justice system. Legislative intent in creating JJAEPs was “to provide continuing educational opportunities for students expelled from school for the most serious offenses.” The primary goals of JJAEPs are to “reduce delinquency, increase offender accountability and rehabilitate offenders through a comprehensive, coordinated community-based juvenile probation system.” Students younger than 10 cannot be sent or expelled to a JJAEP; instead, they are to be sent to a DAEP for conduct that would result in expulsion for children 10 years and older. School districts without a JJAEP may send expelled students to DAEPs or opt to send them “to the street” by having students serve the length of their expulsion unsupervised and outside a school setting.

There are no statewide standards that set minimum or maximum amounts of time of expulsion; thus, there is wide variation across school districts regarding time spent in a JJAEP. However, the Texas Juvenile Justice Department publishes data that provides some understanding of how long students spend in a JJAEP. In 2012-2013, the average length of stay for all students in a JJAEP was 80 days.
In the 2012-2013 school year, Texas school districts placed over 2,800 students into JJAEPs and expelled 893 students to the streets. Some school districts use JJAEPs at a higher rate than others. Moreover, the size of the school district does not correlate with the number of student expulsions. Of the more than 1,000 school districts in Texas, about half did not expel any students in 2007-08. Similar to removal to DAEPs, students can be expelled for mandatory or discretionary reasons. Mandatory expulsions occur when a student uses, exhibits, or possesses a weapon or engages in serious criminal behavior. Discretionary expulsions vary widely from serious criminal offenses that occur within 300 feet from the school, to assault on a teacher or employee, to “serious or persistent misbehavior in a DAEP.” The majority of expelled students are sent to a JJAEP, and 55 percent of JJAEP placements are for discretionary reasons. The majority of expulsions occurring for discretionary reasons suggest a wide variation in school districts’ policies governing discretionary expulsion of students.

Discretionary expulsions for “serious or persistent misbehavior” represent the largest percentage of discretionary expulsions. Texas Appleseed found that “placing students in JJAEPs for ‘serious or persistent misbehavior’ not only fails to correct behavioral problems, but leads to increased risk for future involvement in the juvenile justice system.” About 71 percent of students who were initially expelled to a JJAEP for “serious or persistent misbehavior” re-offended within two years. The most recent national data shows that while Texas educates about 9 percent of all school-aged children in the U.S., the state is responsible for approximately 12 percent of the students expelled from the nation’s public schools. In 2012-2013, students receiving special education made up only 8.7 percent of the student population in Texas but accounted for 15.6 percent of all expulsions. A 2010 report by Texas Appleseed revealed that compared to the whole student population, African American special education students are three times more likely to be expelled and Hispanic special education students are more than 2.5 times as likely to be expelled.

While total expulsions, whether to a JJAEP or to the street, increased approximately 38 percent during the five-year period between 2002 and 2007, there was a 26 percent decrease in expulsions from Texas schools between 2007 and 2009. From a high of 11,135 total expulsions in 2006-07, expulsions dropped to 8,202 in 2008-09. Expulsions continued to decrease in 2012-2013 to a total of 3,831 expulsions. Figure 101 shows the trend of expulsions between the 2002-2003 and 2012-2013 school years.
Figure 101. Texas Public School Expulsions from 2002-2013

Many experts agree that there is a school-to-prison pipeline for many students who are referred to exclusionary discipline practices. Despite the goal of JJAEPs being to rehabilitate and reintegrate students back into a mainstream school environment, the mentioned alternative education programs have been linked to increased levels of delinquency. For example, students who have been sent to ISS, OSS, or a DAEP are more likely to be sent to a JJAEP than those who are not referred to one of these exclusionary discipline actions. Furthermore, students sent to a DAEP or a JJAEP are more likely to drop out of school and enter the adult criminal justice system. About 80 percent of adults in the criminal justice system dropped out from school. While these correlations do not imply a direct causation of exclusionary discipline resulting in incarceration, these statistics call into question the effectiveness of ISS, OSS, DAEP, and JJAEPs in successfully rehabilitilitating students back into a mainstream educational setting. The report Texas’ School-to-Prison Pipeline: School Expulsion, provides greater detail on Texan expulsions, and is available at http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid=m

SCHOOL TICKETING – CLASS C MISDEMEANORS

Under Texas law, school resources officers can issue tickets to students for low level misbehavior. These tickets are citations in lieu of arrest for Class C misdemeanors and require the student and a parent to appear in municipal or J.P. court. The proceedings are public criminal proceedings and the student does not have a right to an attorney because Class C misdemeanors are not punishable by jail time.

In April 2010, a Senate Criminal Justice Committee hearing focused on school disciplinary practices including the high use of ticketing. During the hearing...
committee members expressed concern that the use of ticketing was not effective. Others expressed concern that the justice system was becoming a substitute for school discipline. In 2012, the Texas Supreme Court estimated that 300,000 Class C misdemeanor tickets were issued to students. Data suggests that students receiving special education services are overrepresented in the number of students receiving Class C misdemeanors. Only two school districts’ reports of school ticketing included a breakdown of the special education population. In both of these districts, students receiving special education were ticketed at a rate more than double their representation of the total student population. These tickets were issued for behaviors such as disrupting class, inappropriate language, and in-school fighting. Not only do these tickets insert students into the criminal justice system, they can also cost up to $500, a financial burden many families of students receiving tickets cannot afford. Failure to pay fines could result in a warrant for arrest upon the student’s 17th birthday.

During the 83rd Legislative Session, two bills were passed that addressed the increasing number of students receiving Class C misdemeanors for minor misbehavior. SB 393 (West, Hinojosa, and Whitmore) and SB 1114 (Whitmore and West) work together to prohibit school officers from issuing tickets for Class C misdemeanors, excluding traffic violations, by only allowing complaints (as opposed to tickets) for Class C misdemeanors to be issued by school officers. A criminal complaint states the facts of the alleged criminal offense and requires additional paperwork to be submitted with the complaint. Once the complaint is evaluated by the court, the complaint can then be filed as a criminal charge or dismissed. The bills also require that schools explore alternatives to issuing tickets, for example referring students to first-time offender programs if engaged in activity at the level of a Class C misdemeanor, and that prosecutors consider disposing of an offense through other non-court options such as tutoring or counseling.

A particularly troubling type of ticket is for Failure to Attend School (FTAS), or truancy. According to the Texas Education Code, youth commit FTAS if they miss ten of more days in a six month period or three or more days in a four week period. FTAS can be charged as a Class C Misdemeanor to be processed in an adult criminal court forum, where students are not given many of the protections available in a juvenile court. Texas Appleseed found that 34 percent, or about 76,000 of Class C Misdemeanors in 2011, were for FTAS. Criminalization, the use of formal courts, and fines do not appear to be an effective method in addressing FTAS. Students may be further alienated from school while going through the formal court system. Some students end up with a criminal conviction on their record, which has the possibility of negatively impacting future schooling and/or employment. The burden of fines usually falls on families that are already under financial strain.

The Office of Juvenile Justice and Delinquency Prevention published a literature review that found the most effective approaches to reduce truancy were those that addressed the root causes underlying FTAS. There is a wide variety of school, family, community, and student factors that might cause a student to meet the criteria for FTAS, such as unsafe school environment; poor school climate; inadequate identification of students with special needs; financial, social, medical, or other factors that pressure students to stay at home with family; child abuse or neglect; family disorganization; teen pregnancy; poor academic performance;
The variety of root causes that may lead to school truancy requires a multi-faceted approach to address FTAS. The specific techniques used in an approach to address truancy differ from case to case, but there are some common themes each approach should incorporate.

The Center for Children & Youth Justice recommends the following six components for effective truancy reduction programs:

- Community collaboration
- Family involvement
- Comprehensive approach: Prevention, intervention & retrieval
- Incentives and sanctions
- Supportive context: school, agency, community, public education, political climate, laws and policies, systemic advocacy
- Program evaluation


The 83rd Legislature passed three bills that begin to address the need to improve approaches used to reduce cases of FTAS. HB 1470 (Villarreal) established the requirement for a committee in certain counties to recommend uniform truancy policies. SB 1419 (West) provided funding for juvenile case managers through court costs and established a truancy prevention and diversion fund. SB 1234 (Whitmire) amended previous law related to the prevention of truancy and the offense of FTAS. While these bills attempt to improve policies related to truancy prevention, schools are still authorized to issue Class C Misdemeanors for FTAS.

**USE OF FORCE IN SCHOOLS**

In Texas, school districts determine whether corporal punishment is permitted. According to federal Office of Civil Rights data, Texas leads the nation with the highest number of students receiving corporal punishment and student with disabilities being punished disproportionately. Corporal punishment can cause serious injury, psychological harm, and academic disengagement; it is not an evidence-based practice.

Use of force by school police officers is also a concern. School police officers often do not have required training in trauma-informed care, age appropriate discipline for youth with cognitive or emotional disabilities, or appropriate techniques for de-escalation specific to child-centered settings. Additionally, police officers are not required to have restraint training. TEA requires each school to have a team of school staff trained in restraint that is appropriate for youth. Specific school staff positions are required to be a part of this team, but current law does not mandate participation of school officers.

Crisis Intervention Teams (CIT) for children and youth are designed to divert individuals with mental health needs to appropriate health services and supports
instead of referring them to the juvenile justice system. Building community partnerships to support youth in accessing services and supports is the foundation to a successful program. Bexar County created the Children’s Crisis Intervention Training (CCIT) for use in schools. The 40-hour training is approved by the Texas Commission on Law Enforcement Officer Standards and provides Continuing Education Units (CEUs) for school resource officers who have not previously received any CIT training. The CCIT includes education on officer tactics and safety in school campus environment; active listening and de-escalation techniques; mental, learning and developmental disorders and substance abuse in children and youth; psychotropic medications; family perspective and community resources; legal issues relating to school environment and minors and emergency detention; and role-play scenarios that allow officers to gain practical experience in active listening and de-escalation techniques specific to students experiencing a crisis.

Texas Appleseed requested information from schools about the use of force by school officers, but was only able to obtain information from four school districts—Austin ISD, Edinburg ISD, El Paso ISD, and Houston ISD—and this data varied widely in the information it provided. Texas Appleseed found that most school police departments follow the best practice to have some form of policy about use of force, according to the Texas Police Chiefs Association (TCPA). The policies are not shared with the public.

A particular concern is the use of Tasers and pepper spray in schools. Although there was an unsuccessful legislative attempt to ban Tasers and pepper sprays in schools during the 83rd Legislative Session, SB 1556 (Davis) created a School Safety Task Force. The task force was charged with studying multi-hazard school safety practices and making recommendations of best practice based on study results. The task force report was due September 1, 2014.

**ALTERNATIVES TO EXCLUSIONARY DISCIPLINE**

Not only do exclusionary discipline practices have developmental, behavioral, and academic costs, they also have a high financial cost. In their report *Cost of School Discipline in Texas*, Texas Appleseed identifies the cost of exclusionary discipline in Texas Public Schools. Statewide, school districts spent $232 million on DAEPs in 2008-2009 and more than $327 million on security and monitoring services in 2010-2011. The total amount that counties and school districts spent on JJAEPs was $31 million in 2010-2011. Best practices such as School-wide Positive Behavioral Interventions and Supports, Social and Emotional Learning, and Trauma-Informed Care provide evidence to support the social and emotional development of students and improvement of student behavior and have proven to be more cost effective than the exclusionary discipline practices currently being used by Texas public schools.

Restorative justice is a framework that views bad behavior as more than an infraction of the school’s rule; it sees the behavior as harming people, relationships, and the school community. A restorative justice framework can be applied to the entire school setting. When used in a school setting, it focuses on the impact of harmful student behavior on others and how to recover in a healthy way. Restorative justice can be implemented by using restorative circles in the classroom. In these circles, students can deal with student misbehavior and the effects it has on the classroom.
or entire school. A restorative circle allows the students to use community values to collectively address the problem and communicate with each other. While the circles take place in classrooms, the framework is intended to be used by the entire school and has the goal of improving the overall school community while strengthening connections between students and the school as an institution. Restorative justice allows schools to address and improve school culture as a whole rather than just seek to change behavior individually. Cost to implement restorative justice can vary between schools. A school in San Antonio implemented this concept for $16,000 in one year. The costs were related to staff training, consultations, and materials. This school found an 84 percent decrease in off-campus suspensions after switching to restorative justice from a zero tolerance policy.803 Prior to implementing restorative justice to handle conflicts, this school had one of the highest rates of discipline in its district.804

For more information on cost-effective discipline alternatives, visit http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=848&Itemid.
Texas Department of Housing and Community Affairs: At A Glance

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POLICY CONCERNS

- Lack of affordable housing options available to people with disabilities, including individuals living with mental illness
- Housing supports for veterans
- Section 8 housing wait list
- Development of permanent supportive housing options

FAST FACTS

- In 2013, TDHCA served 559,032 individuals, or 11.85 percent of the people living with homelessness and/or in poverty.805
- A significant number of people who are homeless also have a mental health condition. A survey collected by 363 organizations in over 2,600 cities across the United showed that 26.2 percent of homeless adults housed in a shelter had a
- Most Texans who are eligible for supplemental security income (SSI) in 2014, including many people who are unable to work due to serious mental illness, receive $721 a month from their SSI income.\textsuperscript{807} The 2012 average monthly rent in Texas was $677.\textsuperscript{808}

- Project Access is part of TDHCA's Section 8 Housing Choice Voucher Program to assist low-income persons with disabilities to transition from institutions into the community by providing access to affordable housing. TDHCA served 88 persons with $518,313 through Project Access in FY 2013.\textsuperscript{809}
The Texas Department of Housing and Community Affairs (TDHCA) performs functions related to the development and operation of several major affordable housing programs. TDHCA disperses federal funds for housing and community services and serves as a finance agency for the state’s Low Income Housing Tax Credit Program (LIHTC) and other housing funds. TDHCA ensures compliance with federal and state laws governing various housing programs and acts as a financial and administrative resource by providing essential services and affordable housing opportunities to low-income Texans. TDHCA is also a Public Housing Agency (PHA), a governmental entity that is responsible for the operation of subsidized housing and rental assistance programs. The U.S. Department of Housing and Urban Development (HUD) directly funds PHAs for affordable housing programs.

In addition to supporting low-income residents, TDHCA has programs and policies that specifically serve people with disabilities and those experiencing homelessness. A significant number of people with disabilities face extreme housing needs.\textsuperscript{810} TDHCA furthered its commitment to serving people with disabilities by implementing the \textit{Integrated Housing Rule} in 2003. TDHCA and advocates worked together to create the following policies that promote the full integration of people with disabilities in the community:\textsuperscript{811}

- Large housing developments with 50 units or more may set-aside no more than 18 percent of their units for people with disabilities.
- Small housing developments with fewer than 50 units may set aside no more than 36 percent of their units for people with disabilities.

The above policies do not prevent a higher percentage of people with disabilities choosing to reside in each of these types of developments, but an entire development may not limit their occupancy solely to people with disabilities.

A significant number of people who are homeless also have a mental health condition. A survey collected by 363 organizations in over 2,600 cities across the United States showed that 26.2 percent of homeless adults who were housed in a shelter had a mental health condition.\textsuperscript{812} Homeless individuals with mental illness are at higher risk of chronic homelessness and remaining homeless for longer periods of time than homeless people without a mental illness.\textsuperscript{813} Affordable housing programs focusing on homelessness prevention ultimately reach a significant population of people who have a mental health condition. In
2013, TDHCA served 559,032 individuals, or 11.85 percent of the people living with homelessness and/or in poverty.814

The negative stigma associated with mental illness also prevents many Texans from participating in community life and accessing affordable housing. People with a mental health condition who also have a criminal record can have a difficult time finding housing. Another challenge for mental health consumers participating in daily activities can be the general population’s fear that most people with mental illness are violent. Surveys indicate that only 45 percent of participants feel comfortable interacting with an individual with a diagnosis of bipolar disorder or schizophrenia.815 More than 70 percent of participants said they would be afraid for their safety around a person with schizophrenia who has not received treatment.816 The incidence of violence among people with serious mental illness who do not use substances is no greater than that of the general population.817 In fact, people with serious mental illness are more likely to be the victims of violent activity.818 Still, inaccurate public perception perpetuates the unwarranted assumption that people with mental illness are unworthy or incapable of living meaningful, productive lives in their community.

There is significant overlap in the population served by TDHCA’s affordable housing programs and many of the programs operated by Texas’ health and human services agencies. Despite this, some abbreviations and many of the forms of assistance that are essential to the understanding of affordable housing are not used in HHS’s programs, and vice versa. Key abbreviations and forms of assistance are described in Figure 102 below. Additionally, In April of 2011, TDHCA published the State Agency Reference Guide and Training Manual to help cross-educate housing and health services staff. The guide is available at http://www.tdhca.state.tx.us/hhscc/reference-guide.htm.

Figure 102 provides a brief explanation of some of the most important affordable housing terms and concepts.

**Figure 102. Types of Housing Assistance**

<table>
<thead>
<tr>
<th>Program type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Development Assis-</td>
<td>Development assistance funds can be used for the acquisitions of property, construction of property, and rehabilitation of existing properties. Affordable housing funds often come with use restrictions. The Low Income Housing Tax Credit Program and the Multifamily HOME Direct Loan Program, described in more detail below, are examples of development assistance provided to developers.</td>
</tr>
<tr>
<td>Program type</td>
<td>Description</td>
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<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Rental Assistance | Rental assistance funds help tenants with low incomes afford rent at or near market rate for specified housing units. Typically, rental assistance funds allow eligible tenants to pay about 30 percent of their income toward rent. A subsidy pays the difference between that amount and the market rent for the specific unit. Rental assistance comes in two basic forms:

**Tenant-based rental assistance** applies to rental assistance programs in which the entity providing the subsidy has a contract with the tenant. Tenants are responsible for finding their own housing. This allows the tenant to seek housing from more providers in more locations.

**Project-based rental assistance** applies to rental assistance programs in which the entity providing the subsidy has a contract with the housing provider. Tenants then lease the unit to which the subsidy applies from the provider.

HOME: Tenant-Based Rental Assistance (TBRA), described in more detail below, is an example of tenant-based rental assistance.

Units developed with HUD Section 811 Supportive Housing for People with Disabilities funding, described in more detail below, is an example of project-based rental assistance.

| Services Assistance | Programs that provide service funds are often specifically designed to serve people with disabilities. Some affordable housing funds come with use restrictions relating to the financing and coordination of health and human services for tenants with low-incomes. Emergency Solutions Grant Program (ESG), described in more detail below, is an example of services assistance. |

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**Changing Environment**

Boarding homes serve an important role in the continuum of care for people with mental health conditions and other disabilities, and some homes provide safe and affordable living quarters for their residents. A boarding home is a business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the owner. Securing affordable and safe housing continues to be a major challenge for many people with serious mental health conditions. Efforts have been made to better support people with mental health conditions in terms of affordable and safe housing in the past few years. Model standards for boarding homes were created by the HHSC, and a few local governments passed those standards as regulations for boarding homes in their jurisdiction. The local governments that have passed boarding home standards have generally done so as a result of strong local advocacy efforts, frequently organized by Mental Health America of Texas. HB 1191 (Burkett, Zedler), passed in the 83rd legislation session, will add support for people with mental health conditions by adding a list of available housing information that is specifically for people with mental health conditions. More information about boarding homes and HB 1191 and its potential impact can be found in the Texas Environment section.
Senate Bill 1878 (Nelson) of the 81st Texas Legislature created the Housing and Health Services Coordination Council (HHSCC), charged with increasing state efforts to offer service-enriched housing through increased coordination of housing and health services. Service-enriched housing is “integrated, affordable and accessible housing that provides residents with the opportunity to receive on-site or off-site health-related and other services and supports that foster independence in living and decision-making for individuals with disabilities and persons who are elderly.” The executive director of TDHCA chairs the council. The remaining members are either governor appointees or state agency representatives. A draft of the Housing and Health Services Coordination Council 2014-2015 Biennial Plan with housing and service recommendations can be found at http://www.tdhca.state.tx.us/hhscc/docs/14-15-BiennialPlan.pdf

**Affordable Housing**

Safe, stable and affordable housing is an essential component of support systems that facilitate recovery from mental illness. However, many Texans face a housing cost burden. A housing cost burden exists when a household pays more than 30 percent of its total income before taxes and deductions toward housing. In Texas, of all renter households that live below 100 percent of Area Median Family Income (AMFI), almost 39 percent face a housing cost burden. Of all homeowner households that live below 100 percent of AMFI, 23 percent face a housing cost burden. Together, Texas renter and homeowner households that face a housing cost burden and live below 100 percent of the AMFI compose more than 8.5 million households.

TDHCA estimates that the state meets less than 1 percent of its total affordable housing need. This has dire consequences for many Texans living with behavioral health conditions. Most Texans who are eligible for Supplemental Security Income (SSI) in 2014, including many people who are unable to work due to serious mental illness, receive $721 a month from their SSI income. Using the 2012 average monthly rent in Texas of $677, SSI recipients would have to pay 94 percent of their 2014 monthly SSI income toward housing. Without affordable housing options, people with serious mental illness are priced out of the housing market. A Travis County study found that 69 percent of people with four or more psychiatric hospitalizations within a certain period were homeless.

In order to direct resources to those most in need and facing the greatest housing cost burden, many affordable housing programs operated by HUD and TDHCA use an AMFI to determine if a person is eligible to participate in that specific program. HUD uses the most recent census data on median family income and results from the Census American Community Survey to determine AMFI in communities throughout the country. The AMFI calculation...
uses information that is unique and specific to a metropolitan area, sub-areas of a metropolitan area, and nonmetropolitan counties.

The average AMFI across all of Texas for a household of four in Texas in 2014 was $60,300.831 Low-income households are those whose income does not exceed 80 percent of AMFI. HUD breaks “low-income” down even further as follows:832, 833

- Low-income = 80 percent and below
  - $48,250 for a 4 person household in 2014
- Very low-income = 50 percent and below
  - $30,150 for a 4 person household in 2014
- Extremely low-income = 30 percent and below
  - $18,100 for a 4 person household in 2014

### Funding

TDHCA is funded through several governmental departments, most at the federal level. These funds are often given with certain specifications and restrictions related to their use, which has an impact on TDHCA's operation and ability to provide certain programs. The following is a brief description of funding that was appropriated to TDHCA for the FY 2013.

In 2013, TDHCA received $151,298,671 in federal funds, which made up 85.4 percent of total funds appropriated to TDCHA.834 The federal funds are provided through different departments including US Department of Health and Human Services (DHHS), US Department of Housing and Urban Development (HUD), US Department of Energy (DOE), and the Centers for Medicare and Medicaid Services (CMS).835 HUD and DHHS provide the largest financial support to TDHCA.836 In addition to supporting their own programs and projects, TDHCA utilizes federal funds in a variety of ways, including but not limited to: the disbursement of funds to other agencies for their projects and programs, disaster-related assistance, direct financial assistance to address energy needs, and mortgage bonds.

A second portion of TDHCA's funding comes from fees the department collects from the housing programs and its regulation of the manufactured housing industry. In 2013, this source of funding provided $18,367,246, or 10.2 percent of the total funds appropriated to TDHCA.837 This funding provides a method of finance to support and administer the housing programs and other indirect administrative costs.

TDHCA also receives general revenue funds from the state. In FY 2013, $8,177,145 was appropriated to TDHCA from the state, which made up about 4.4 percent of the total funds received by TDCHA.838 The Housing Trust Fund (HTF), created in 1993 during the 73rd Texas legislative session, is the primary program receiving state funds and the only affordable housing program funded by the state. HTF is permitted to be used in the following ways: to assist individuals and families of low and very low incomes, to provide technical assistance and capacity building to nonprofit organizations engaged in developing affordable housing, and to serve as security for repayment of revenue bonds issued to finance housing for individuals and families.
of low and very low income. This funding stream provides invaluable resources for housing developers, providers, and the individuals who ultimately utilize affordable housing, but it falls short of addressing the overall need in Texas.

Interagency contracts provide another source of funding for TDHCA’s affordable housing programs. This funding is provided by two agencies: 1) Texas Department of Agriculture via Colonia Service Centers, and 2) the Department of Aging and Disability Services (DADS). The interagency contract with the Texas Department of Agriculture supports programs serving colonias. The Office of the Secretary of State defines a “colonia” as “a residential area along the Texas-Mexico border that may lack some of the most basic living necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing.” The contract with DADS increases housing opportunities for persons with disabilities. Funding from interagency contracts accounts for less than 1 percent, $63,343, of the TDHCA’s appropriated funding. Figure 103 shows the majority of TDHCA’s funding in 2013 in a graph.

Figure 103. TDHCA’s Funding in 2013

Permanent Supportive Housing

Permanent supportive housing (PSH) is permanent, affordable housing linked to a range of support services that enable vulnerable tenants, especially people who experience chronic homelessness, to live independently and participate in community life. PSH is a cost-effective, evidence-based practice that is a key component in promoting recovery for people with behavioral health conditions.

According to SAMHSA, the core elements of permanent supportive housing are:

- A high degree of choice offered to tenants.
· Functional separation of housing management and services staff.
· Affordability.
· Integration with the surrounding community.
· Full rights of tenancy under federal and state law.
· Immediacy of access to housing.
· Available services and supports.

No permanent supportive housing project is assumed to be able to offer all of these core elements, but the extent to which they are able to do so tends to predict whether the project will be successful. For example, a particular permanent supportive housing site may require the prospective tenant to demonstrate readiness to live independently before leasing an apartment. This denies the prospective tenant immediate access to housing, but does not necessarily mean the project will be unsuccessful in promoting independence and facilitating recovery. For more information on permanent supportive housing see the SAMHSA resources at http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

In collaboration with TDHCA, the Department of State Health Services (DSHS) is working to increase the availability of permanent supportive housing for people with serious mental illness. DSHS was granted an exceptional item request in its FY 2014-2015 legislative appropriations request for state match funds for a 1915(i) state plan amendment to the Texas Medicaid program to support the development of permanent supportive housing opportunities. Funds for the 1915(i) waiver are used for the development of the Home and Community-Based Services-Adult Mental Health (HCBS-AMH) program. HCBS-AMH, operated by DSHS, will address the problem of a small number of mental health consumers who receive extended care in inpatient facilities after they no longer need acute inpatient services. HCBS-AMH will provide a wide variety of home and community-based services to these individuals so their needs can be met outside of an inpatient psychiatric hospital. HCBS-AMH is still in the planning phases, and TDHCA’s specific involvement is unclear. However, it is likely that TDHCA will coordinate housing assistance with public housing authorities to provide housing vouchers to people in the HCBS-AMH program. For more information about the HCBS-AMH and additional services offered through the program, refer to the Texas Environment section.

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**Housing and Service Programs for People with Behavioral Health Conditions**

Of the affordable housing programs TDHCA operates, some are specifically designed to serve people with disabilities, or have components that do so. These programs include 1) poverty and homeless prevention programs and 2) programs for persons with disabilities. Both categories provide some of the most significant housing and community service resources for people with mental illness currently operated by TDHCA. In addition to these programs, local housing and urban development (HUD)
programs across the state offer opportunities for housing for people with disabilities when funds are available.

The programs described below do not represent a comprehensive listing of all the affordable housing resources in Texas. A number of other federal and state programs operated by TDHCA and other public housing authorities exist throughout the state. Find out more about the programs operated by TDHCA at http://www.tdhca.state.tx.us/overview.htm. A list of all federal affordable housing programs can be found at http://www.hud.gov/funds/.

POVERTY AND HOMELESS PREVENTION PROGRAMS

TDHCA has several programs that specifically provide services to people who are experiencing homelessness.

EMERGENCY SOLUTIONS GRANTS PROGRAM

The Emergency Solutions Grants (ESG) program is funded by HUD and administered by TDHCA. TDHCA distributes ESG funds to private nonprofit organizations, cities, and counties to assist homeless persons and persons at risk of homelessness to regain stability in permanent housing. In 2013, TDHCA dispersed $11,587,009, enabling 40,889 people to receive services through the ESG program. ESG funds are intended to provide assistance by improving the quality and number of emergency shelters, rapidly re-housing homeless individuals and families, and preventing families and individuals from becoming homeless. Additionally, agencies with ESG funding may choose to prioritize specific subpopulations to serve with their ESG funds. In 2013, TDHCA favored ESG applicants who developed a plan to serve subpopulations that most commonly have higher barriers to obtain housing, including individuals with mental illness.

HOMELESS HOUSING & SERVICES PROGRAM

The Homeless Housing and Services Program (HHSP) was established by Rider 18 in the General Appropriations Bill by the 81st Texas Legislature. TDHCA administers this program in the eight largest cities in Texas – Arlington, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston and San Antonio – to provide services to individuals and families experiencing homelessness. Services include case management, housing placement and supports designed to help people retain housing. HHSP received an initial appropriation of $20 million during the 81st legislative session but did not receive a direct appropriation during the 82nd legislative session. However, the 83rd legislative session allotted general revenue funding of $10 million over the biennium. In 2013, $5,000,000 was provided to serve 13,721 people under HHSP.

COMMUNITY SERVICES BLOCK GRANT PROGRAM

TDHCA administers the Community Services Block Grant (CSBG) Program through funding from HUD. Nonprofit organizations and local units of governments are eligible to receive these funds to provide essential services and poverty programs with the aim to promote stability and self-sufficiency among low income individuals. In 2013, TDHCA provided $28,524,262 for the CSBG program so that 388,888 people received assistance under this program.
A variety of programs offered through TDHCA have policies that specifically reserve funding or space in the program for persons with disabilities. For example, TDHCA’s Texas HOME Program reserves 5 percent of the program’s funds for people with disabilities throughout Texas. These reserved funds are known as Persons with Disabilities set-aside funds. The following programs have policies that specifically allocate a specific percentage of funding and/or services for persons with disabilities.

**HOME: TEXAS HOMEBUYER ASSISTANCE PROGRAM**

The Texas Homebuyer Assistance (HBA) Program is federally funded by HUD through TDHCA’s Texas HOME Program. Nonprofits, PHAs, and units of local government are eligible to participate in the HBA program. TDHCA dispersed $3,775,918 in 2013.\(^{853}\) Organizations can use their HBA funding to provide down payment and closing cost assistance for single family homebuyers. Home ownership has the possibility of helping a low income households build equity and promote self-sufficiency.\(^ {854}\) These programs facilitate long-term investments for families.\(^ {855}\) In addition to providing financial tools, these programs offer educational opportunities to learn how to manage homeownership.

**HOME TAX CREDIT PROGRAM**

The Home Tax Credit (HTC) program, also known as Low Income Home Tax Credit (LIHTC) program, is federally funded to TDHCA by the US Treasury Department. TDHCA provides tax credits to multifamily housing developers who set aside a specific number of units of the development for affordable housing. The tax credits allow units to be leased to qualified residences below the market rate. These affordable units are reserved for people who are 60 percent of the Area Median Family Income (AMFI) and meet other requirements that are specific to the development. The cost of rent for these units is set at a reduced rental rate that is restricted by annually published rent guidelines. TDHCA provided $71,687,011 to serve 9,238 multifamily households through the HTC program in 2013.\(^ {856}\)

**MULTIFAMILY HOME DIRECT LOAN PROGRAM**

The Multifamily HOME Direct Loan Program is federally funded and is also part of TDHCA’s Texas HOME Program. Public Housing Authorities, nonprofits, and for-profits are eligible to receive funding through this program in the form of low-interest loans. This program offers funding for new construction, demolition and reconstruction, or acquisition and rehabilitation of affordable multifamily rental housing. In FY 2013, TDHCA dispersed $17,404,754 to serve 19 households in the Multifamily HOME Direct Loan Program.\(^ {857}\)

**HOME: TENANT-BASED RENTAL ASSISTANCE**

The Tenant-Based Rental Assistance (TBRA) Program is federally funded by HUD through the Texas HOME Program. These funds assist tenants with the cost of moving and provides rental subsidies to tenants seeking affordable housing in their community. TBRA provided services to 388 households with $2,724,308 in
FY 2012. The HOME rental subsidies last up to 24 months and are contingent on participation in a self-sufficiency program. Individuals may receive assistance for up to five years, pending funding. TBRA, a short-term assistance program, has the possibility to be a bridge program for Section 8 Housing: Project Access Program.

SECTION 8 HOUSING: PROJECT ACCESS PROGRAM

The Section 8 Housing Choice Voucher Program, funded by HUD, provides financial assistance to assist low income families and individuals, including older adults and persons with disabilities, to obtain safe and sanitary housing. HUD requires that a household’s annual gross income be 50 percent or below HUD’s Area Median Family Income (AMFI) guidelines to be able to participate in the program. In FY 2014, the statewide AMFI was $60,300. Furthermore, 75 percent of households participating in the voucher program must be 30 percent or below the AMFI. In addition to meeting these income requirements, several other factors are taken into account to determine eligibility, including size and composition of the household, citizenship status, assets, medical expenses, and childcare expenses. Once eligible, individuals work directly with landlords to ensure their needs are met, and TDHCA pays the approved rent amount directly to the property owner on behalf of the individual.

Project Access is part of TDHCA’s Section 8 Housing Choice Voucher Program to assist low-income persons with disabilities to transition from institutions into the community by providing access to affordable housing. TDHCA served 88 persons with $518,313 through Project Access in FY 2013. To be eligible for a Project Access voucher, an individual must have a permanent disability as defined in Section 223 of the Social Security Code or be determined to have a physical, mental or emotional disability that is expected to be of long-continued and indefinite duration and that impedes one’s ability to live independently, and meet the requirements of the criteria in either 1 or 2 below:

1) Be an at risk applicant (current recipient of TBRA assistance from the Department’s HOME Investments Partnership Program and within six months prior to expiration of assistance) and
   a) a previous resident of a nursing facility, intermediate care facility, state psychiatric hospital, or board and care facility as defined by the U.S. Department of Housing and Urban Development, or
   b) Be a current resident of a nursing facility, intermediate care facility, state psychiatric hospital or board and care facility at the time of voucher issuance as defined by HUD,

2) Be eligible for the DSHS pilot program for residents of Texas state psychiatric hospitals at the time of voucher issuance.

TDHCA works in collaboration with the Department of Aging and Disability Services (DADS) and Department of State Health Services (DSHS) to implement this program. Assistance through Project Access vouchers is not time limited. However, there is a high demand for Project Access vouchers and TDHCA has sought a temporary solution to provide assistance for individuals with disabilities who request to transition from institutions to community-based living. TDHCA began
working with DADS and DSHS on a process that allows for a person on the waitlist for Project Access to be able to relocate with the HOME TBRA program. The goal is for a person to be admitted to the Project Access Program by the time the TBRA assistance expires. While this is not a permanent fix, it allows for people to transition into community settings sooner than they would be able to otherwise.

SECTION 811 SUPPORTIVE HOUSING FOR PEOPLE WITH DISABILITIES

Section 811 is one of HUD’s supportive housing programs for people with disabilities and is authorized by the Cranston-Gonzales National Affordable Housing Act of 1990, reformed in 2010. Prior to the changes to the program in 2010, the HUD Section 811 provided interest-free development funds and operating subsidies to nonprofit developers of affordable housing for people with disabilities. With the revisions to the program, HUD now provides direct rental assistance to state housing agencies to be used in housing developed through other subsidies such as the Low Income Housing Tax Credit and HOME programs.

REAL CHOICE SYSTEMS GRANT

In 2011 DADS and TDHCA received $330,000 through the Real Choice Systems Grant: Building Sustainable Partnerships for Housing from the Centers for Medicaid and Medicare Services (CMS). DADS and TDHCA partnered together to achieve three outcomes as part of the grant, including 1) successful application for the HUD Section 811 Project Rental Assistance (PRA) Demonstration Program, 2) create and implement a Housing and Services Partnership (HSP) Academy, and 3) Housing and Services for Persons with Disabilities Online Clearinghouse.

Application for the 811 Project Rental Assistance

In February 2013, TDHCA was notified that Texas was one of 13 states awarded funds for the Section 811 program. TDHCA received $12 million, the maximum amount, to provide project-based affordable housing for extremely low income persons with disabilities. TDHCA has indicated that people with serious mental illness are a target population for this program, along with youth exiting foster care and people with disabilities exiting institutions. TDHCA and the Texas Health and Human Services Commission (HHSC) have entered an inter-agency agreement, per a requirement of the grant application. This agreement addresses the characteristics of the population that will be targeted for this program, how this population will be reached and referred to the program, and the commitments of services from the health and human service agencies. As of the summer of 2014, TDCHA and HUD are in the final process of signing a cooperative agreement so that the demonstration program can begin. In addition to preparing to start the project rental assistance program from the award received in 2013, TDHCA began the process of applying to receive funding for the HUD Section 811 Project Rental Assistance (PRA) Demonstration Program a second time. TDHCA submitted an application for the Section 811 program requesting $12 million in May of 2014.

Housing and Services Partnership Academy

As a second outcome of the Real Choice Systems Grant, TDHCA and DADS worked together to create and implement a Housing and Services Partnership (HSP) Academy. The HSP Academy was held May 14-15, 2013 in Dallas with 16 local community teams participating. The academy provided local communities with
the tools and education necessary to create safe, affordable, accessible housing for people with disabilities in their communities.875

**The Housing and Services for Persons with Disabilities Clearinghouse Website**

The third and final outcome as a result of the TDHCA’s and DAD’s collaborative efforts from the Real Choice Systems Grant was the creation of the Housing and Services for Persons with Disabilities Online Clearinghouse. In September 2013, the clearinghouse was finalized and made available on the 2-1-1 Texas.org website.876 The online clearinghouse provides an interactive resource for people with disabilities, as well as local providers, to find community-based affordable housing and services. The clearinghouse website can be found at https://211texas.hhsc.state.tx.us/211/clearinghouse/main.do

**AMY YOUNG BARRIER REMOVAL PROGRAM**

The Amy Young Barrier Removal (AYBR) Program assists persons with disabilities to increase accessibility and remove dangerous conditions in their homes by providing a one-time grant of up to $20,000 for entities to provide home modifications needed for accessibility for persons with disabilities.877 The AYBR Program is funded by the state of Texas through the Housing Trust Fund. About 3.5 million dollars were provided to 211 people in FY 2013.878 TDHCA disburses funds to nonprofit organizations and local governments who process intake applications, verify eligibility, and oversee construction. To be eligible to receive a grant from the AYBR Program, one must be a person with a disability and have a household income 80 percent or less of the AMFI. Program beneficiaries may be tenants or homeowners.

**Impediments to Fair Housing Choice**

In 1968, Congress enacted Title VIII of the Civil Rights Act, commonly referred to as the Fair Housing Act, which prohibits discrimination in the sale or rental of units in the private housing market on the basis of race, color, religion, sex, national origin, familial status and disability, including mental illness.879 As part of that law, recipients of HUD funds are under an obligation to affirmatively further nondiscrimination policies, not just prohibit discrimination. In an effort to comply with this obligation, in 2012 TDHCA contracted with BBC Research & Consulting, Inc. (BBC) to complete an analysis of impediments to fair housing choice throughout the state. Several impediments to fair housing were identified in the report, *State of Texas Plan for Fair Housing Choice*, and three of the impediments were specific to people with disabilities, including people with mental health conditions. These three impediments are lack of accessible housing and visitability standards, inadequate information about programs to assist persons with disability, and barriers to mobility and free housing choice for protected classes.890 The report states: “Visitable homes provide independent access for everyone, including people with limited mobility or those with disabilities.”881 In response to these impediments, BBC and TDHCA developed the goal of improving housing options for people with disabilities and made recommendations on the state and local government levels.
The following are recommended action steps that can be taken at the state level:

- Work with stakeholders who are knowledgeable about the housing needs of persons with disabilities to identify the specific needs in communities, provide this information to local governments, and promote local approaches to meet these needs.
- Include information about group home requirements in educational and outreach efforts.
- Educate stakeholders, local government officials, planners, and Councils of Governments (COGs) about the benefits of universal design and visitable housing.

In addition to these recommendations, the report outlines action steps for local governments:

- “Conduct an assessment of the need for affordable, accessible housing serving persons with disabilities.
- Review their zoning and land use ordinances for language that treats small group homes as commercial and industrial use.
- Build universal design concepts into their planning goals and articulate these to local developers.”

For more information on these recommendations, visit [http://www.tdhca.state.tx.us/housing-center/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf](http://www.tdhca.state.tx.us/housing-center/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf)
Texas Veterans Commission: At A Glance

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POLICY CONCERNS

- Expansion of veteran peer specialists services
- Tracking the needs of, outreach to, and services extended to women veterans in the state
- Coordination of federal and state service

FAST FACTS

- Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.884
- Women are the fastest growing group within the veteran population and are projected to make up 15 percent of all living veterans by 2035.885
- Fifty-five out of a hundred women and thirty-eight of one hundred men report having been sexually harassed, which includes behavior such as offensive comments about a person’s body or sexual activity, displays of pornographic material, and unwanted sexual advances while in the military.886
- In 2013, the 83rd legislature appropriated $5 million into the DSHS budget to increase veterans’ access to community-based mental health professionals, volunteers and peer supports to improve mental health services such as peer-to-peer counseling, suicide prevention, and jail diversion programs for veterans, current service members, and military families.887, 888
- A 2012 report by the VA estimated that there were 22 veteran suicides per day in 2010.
Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California. Veterans face a myriad of challenges as they transition from active duty to civilian life. Among these challenges is an increased risk for behavioral health conditions. Approximately 11–20 percent of veterans of the Iraq and Afghanistan wars (Operations Iraqi Freedom and Enduring Freedom) are diagnosed with Post-Traumatic Stress Disorder (PTSD). In comparison, 7–8 percent of American adults in the general population will experience PTSD at some point during their lifetime. In addition to combat trauma, sexual assault occurring while in military duty (referred to as Military Sexual Trauma) can also result in symptoms of PTSD. Among those who use Veterans Affairs (VA) healthcare, 23 out of 100 women report having been sexually assaulted (unwanted physical sexual touching that involves some form of coercion) while in the military. Additionally, 55 out of 100 women and 38 out of 100 men report having been sexually harassed, which includes behavior such as offensive comments about a person’s body or sexual activity, displays of pornographic material, and unwanted sexual advances while in the military. Thus, veterans are at higher risk for developing mental health conditions and substance use problems stemming from their military service.

Veterans with behavioral health conditions (mental illness or substance use disorder), including PTSD, have more serious legal problems, higher lifetime use of alcohol and other substances, represent more suicides, make up a large percentage of the homeless population, experience more psychiatric symptoms, and have overall worse health than the general population. An underlying behavioral health condition is the strongest predictor for homelessness after leaving active duty. Unfortunately, only about half of all veterans with a diagnosed behavioral health condition have accessed appropriate services, and even fewer have received adequate care.

The Texas Veterans Commission (TVC) serves veterans and their dependents in all matters pertaining to veterans’ disability benefits and rights. It is the designated agency of the state of Texas to represent the state and its veterans before the U.S. Department of Veterans Affairs (VA). The agency represents veterans in filing VA disability claims and during VA appeals processes, and it assists dependents with survivor benefits. The TVC focuses on the following program areas: veterans’ employment services, veterans’ education services, claims representation and counseling, and funding assistance. Both the claims representation and counseling and funding assistance programs impact veterans’ ability to access behavioral health services.
In 2013, the 83rd legislature appropriated $5 million into the DSHS budget to increase veterans’ access to community-based mental health professionals, volunteers and peer supports to improve mental health services such as peer-to-peer counseling, suicide prevention, and jail diversion programs for veterans, current service members, and military families. As of May 2014, new hired staff included 11 regional coordinators, four field clinicians, a half-time clinical supervisor, a full-time state training coordinator, and an assistant state network coordinator.

The U.S. Department of Defense Military Health System is responsible for providing health care to active duty and retired U.S. military personnel and their families. For more information, visit www.health.mil.

### Claims Representation and Counseling Program

TVC’s claims representation and counseling program helps veterans and their family members apply for disability benefits and enroll in VA health care programs. TVC employs over 75 counselors accredited by the VA to provide direct representation in claims and appeals as well as general assistance with the process of securing benefits at many veterans integrated service network (VISN) facilities. Claims counselors act as a liaison between the veteran and VA medical facilities and assist veterans with applications for VA compensation benefits.

TVC claims related to entitlements secured through service in the armed forces increased by 18 percent in FY 2011. In FY 2011, TVC counselors handled 179,981 benefit cases on behalf of veterans and family members, yielding more than $2 billion in compensation and pension benefits. Texas leads all other large states in monetary recovery of veterans’ compensation and pension benefits.

The following sections describe VA benefits eligibility and available VA behavioral health services that can be accessed with the assistance of TVC counselors.

### Eligibility for VA Benefits

Eligibility for most VA benefits, including health services, occurs upon discharge from active military service under other than dishonorable conditions. Veterans are assigned to one of eight priority groups upon enrollment. The higher priority groups include veterans with service-connected disability ratings, former prisoners of war, Purple Heart Medal recipients, Medal of Honor recipients, veterans discharged with a disability incurred or aggravated in the line of duty, and veterans awarded special eligibility due to a disability incurred during treatment or vocational rehabilitation. For a complete listing of priority groups see http://www.va.gov/
There are two types of compensation available: 1) Service-Connected and 2) Non-Service Connected. Service-Connected compensation is a monetary benefit that is paid to veterans who suffered an injury or illness incurred or aggravated during military service, regardless of combat experience. A Non-Service Connected pension is a monetary benefit paid monthly to veterans with low or no income who are aged 65 and older or are permanently disabled. Additional eligibility requirements for a Non-Service Connected pension include having served 90 days or 24 months (depending on dates of service) of active duty with 1 day during a period of war-time (combat experience is not required) and a family income lower than a specified limit (depends on spouse/dependents).

**VA Behavioral Health Services**

Nationally, veterans’ health care services are administered on a regional level by a system of 23 veterans integrated service networks (VISN), each containing a hierarchy of medical centers, on-site outpatient clinics, community-based outpatient clinics and vet centers, which provide counseling, outreach and referral services to help veterans readjust to life post-combat. Texas is divided into three VISNs with multiple clinics and vet centers throughout the state. For more information, see http://www2.va.gov/directory/guide/state.asp?State=TX&dnum=ALL.

The TVC doesn’t operate or provide behavioral health services to veterans, but it does link veterans to these services through the claims representation and counseling program described above. There is a wide array of VA settings that provide both inpatient and outpatient behavioral health services, including primary care clinics, general and specialty outpatient mental health clinics, residential care facilities and community living centers. Services and programs include specialized PTSD services, psychosocial rehabilitation and recovery services, suicide prevention programs, evidence-based psychotherapy programs and substance use services. The VA also provides behavioral health services for family members and survivors of active duty military personnel and veterans. Additionally, 300 Vet Centers nationwide provide psychological counseling for war-related trauma and other services such as outreach, case management, and social services referrals. Since beginning operation in 1979, the Vet Centers have helped 2 million veterans. There were 8.92 million veterans enrolled in the VA Health Care system in FY 2013. For a comprehensive description of federal benefits and services available to veterans, family members and survivors, visit http://www.va.gov/opa/publications/benefits_book.asp.

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**TVC Employment Services**

Unemployment among veterans can have negative mental health and economic consequences, which creates additional obstacles for veterans in securing stable housing. Gainful employment is therefore key to ensuring that veterans live independently and self-sufficiently. The TVC offers employment services to assist qualified veterans in finding and obtaining meaningful and long-term employment. Veteran employment representatives provide job coaching, job training, and resume assistance. They can also provide access to education programs, and conduct
outreach to businesses and employers to promote the hiring of veterans. Other employment-related services include vocational rehabilitation for veterans with disabilities and employment services to spouses and caregivers of active duty service members.

Fund for Veterans’ Assistance (FVA)

The Fund for Veterans’ Assistance (FVA) is operated by the TVC and is funded through a combination of state funds and private donations. The FVA awards three categories of grants to eligible organizations that provide direct services to veterans and their families. The three categories include General Assistance, Housing4TexasHeroes, and Veterans Mental Health. FVA General Assistance grants reimburse charitable organizations, local government agencies, and veterans service organizations (VSO) for providing direct support services to veterans and their families, including housing assistance, counseling for PTSD and traumatic brain injury, transportation to medical appointments, and information and referrals to other services. Housing4TexasHeroes grants support nonprofit or local government organizations that provide temporary and permanent housing assistance for veterans and their families. Veterans Mental Health Grants fund projects that provide direct mental health services to veterans and their families through a range of services such as peer counseling, PTSD services, Traumatic Brain Injury (TBI) services, group therapy, equine therapy, co-occurring disorder counseling, and others.

The FVA is funded through four primary sources: The sale of $2 scratch-off lottery tickets, online or check donations, vehicular registration donations, and the State Employee Charitable Contribution Campaign. Twenty-three organizations across the state of Texas were awarded grants totaling over $3 million for 2014. For a list of organizations and grant awards beginning January 1, 2014, visit http://www.tvc.texas.gov/About-Us.aspx.

Other Programs

Additional programs and initiatives at the state and federal level assist veterans in obtaining the services and resources they need.

WOMEN VETERANS

Women are the fastest growing group within the veteran population and are projected to make up 15 percent of all living veterans by 2035. Recognizing the growing number of female veterans, the VA has embarked on efforts to understand how to better serve woman veterans. In the general population, women are more likely to develop PTSD than men. It is unclear whether the
incidence of PTSD is higher among military women than military men. However, woman veterans are more likely to have lower incomes, lack private insurance, and to have poorer health. Additionally, female veterans earn almost $10,000 less per year than male veterans and are up to four times more likely to be homeless than nonveteran women. Because of their heightened risk for having experienced military sexual trauma, PTSD, homelessness and financial stress, it is imperative that health care, support services, and transitional resources are directed to woman veterans. The TVC created the Texas Women’s Initiative in an effort to better serve women veterans, help them obtain their benefits, increase services for women veterans throughout the state, and coordinate services and supports with local community organizations. Visit http://www.tvc.texas.gov/Women-Landing-Page.aspx for more information.

VETERANS SUPPORT NETWORKS

A 2012 report by the VA estimated that there were 22 veteran suicides per day in 2010. The Veterans Crisis Line is a resource available to veterans, their families, and friends in times of crisis, including suicide prevention. Callers can reach the hotline via telephone, text, or online chat where they will be connected with a trained VA responder. Since its inception in 2007, the Veterans Crisis Line has received over 890,000 calls and has made more than 30,000 life-saving rescues.

TexVet, an initiative by the Texas A&M Health Science Center, is a network of health providers, community organizations, and volunteers who are committed to providing veterans, military members, and their families with referrals and information to successfully access services. For more information, visit: http://texvet.org.

One of the resources available on the TexVet network is the Military Veteran Peer Network. This organization is an affiliation of veterans and family members who actively identify and advocate for community resources for veterans and provide peer counseling services. Peer Group Leaders are trained in peer support and mental health awareness and establish peer group meetings in their communities. The Military Veteran Peer Network has 36 chapters across the state and is supported by grants from the Department of State Health Services (DSHS).

SPECIALTY COURTS

Left untreated, mental health conditions may lead to involvement in the criminal justice system. Under the typical criminal justice process, a veteran facing charges is assigned to a judge who may be unfamiliar with the unique challenges faced by returning veterans, such as PTSD, TBI, depression, and substance abuse issues. A judge sitting in a specialty veterans court on the other hand, may have a better understanding of the mental health conditions that could increase risks for criminal behavior. The judge may also be more familiar with the range of community-based services for veterans and veterans benefits. Thus, veterans courts may be more capable of diverting veterans from the criminal justice system and instead can link veterans and their families to benefits, services, and supports.
The first veterans court in Texas, located in Harris County, began accepting cases in 2009. As of July 2014, there are fourteen veterans courts operating throughout the state in the following counties: Bexar, Cameron, Collin, Dallas, Denton, El Paso, Galveston, Guadalupe, Harris, Hays, Hidalgo, Nueces, Tarrant, Smith, Travis, Webb, and Williamson.934
The increasing demands placed on the behavioral health system have encouraged policy makers, service providers and other stakeholders to seek more benefit from the limited resources available. Over the past decade, considerable attention has been given to the identification, implementation and dissemination of mental health “best practices” in an attempt to establish programs that are more effective and cost-efficient. With the increased value placed on outcomes and proven practices, many funders and oversight agencies now require outcome evaluation for behavioral health programs and services that demonstrate evidence of positive health outcomes.

As we move to a recovery-based system of care we must consider the potential for conflict between “best practices” and person-centered services. True person-centered services recognize that people are individuals and they accomplish recovery in a myriad of ways. By limiting services to evidenced-based or best practices, we risk missing the “personal medicine” and strengths that people bring to their own recovery.935 If only evidence-based practices are funded, we limit choice and neglect person-centered practices. In addition, some researchers have cautioned about over-reliance on evidence-based practices, given that the evidence base too often has not included a broad mix of people from various races, ethnicities, genders, and other identities.936 These approaches are not mutually exclusive, but instead highlight important directions for new research.

In this guide the term “best practices” encompasses both “evidence-based” and “promising” practices. Evidence-based practices are prevention or treatment interventions that have undergone rigorous scientific evaluation. The Substance Abuse and Mental Health Services Administration has developed the National Registry of Evidence-based Programs and Practices (NREPP). It is a searchable online registry of interventions supporting mental health and substance use prevention and treatment. The registry can be found at http://www.nrepp.samhsa.gov/Index.aspx.
Promising practices are those that show positive outcomes but do not yet have the same level of research support. Some examples of best practices utilized in the state are described below. Further information on behavioral health best practices, including a searchable inventory of best practices offered by state agencies, is available at http://www.utexas.edu/research/cswr/tbhc.

**Best Practice: Recovery and Peer Support**

Recovery from mental illness and substance use is possible. Effective treatments and supports exist for child and adult mental health and substance use conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery from mental illness and substance use as:

>A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.⁹³⁷

State and local mental health agencies are adopting a recovery orientation at a variety of levels, including policy and planning, the provision of treatment and supports, and the promotion of peer support activities. The substance use field is also shifting from an acute care model of treatment to a recovery-oriented system of care approach.⁹³⁸

The recovery model is centered on the belief that those with serious mental illness can and do get better. The term recovery in this context does not imply “cure,” but rather the ability of an individual to have a meaningful life in their community.⁹³⁹ The recovery model represents a paradigm shift away from the medical model by encouraging consumers to define their own recovery and build capacity to cope with their own life stressors.⁹⁴⁰

Figure 104 provides some comparison between recovery-focused and traditional models of care and treatment.

**Figure 104. Recovery Focused Model vs. Traditional Clinical Model**

<table>
<thead>
<tr>
<th>Recovery Focused Model</th>
<th>Traditional Medical Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Centered</td>
<td>Diagnosis Centered</td>
</tr>
<tr>
<td>Person Centered</td>
<td>Service Centered</td>
</tr>
<tr>
<td>Trauma Informed</td>
<td>Diagnosis Informed</td>
</tr>
<tr>
<td>“What happened to you?”</td>
<td>“What is wrong with you”</td>
</tr>
<tr>
<td>“What are your needs?” “What are your strengths”</td>
<td>“What are your issues”</td>
</tr>
</tbody>
</table>

Source: Bell, S., Janov, R., Orlando, R. Implementation and uses to advance recovery.

The following are some Texas initiatives promoting recovery-oriented systems.
MENTAL HEALTH CERTIFIED PEER SPECIALISTS AND SUBSTANCE USE CERTIFIED RECOVERY SPECIALISTS

Many agencies have difficulty in recruiting and retaining mental health professionals. Peer specialists, including mental health certified peer specialists and substance use certified recovery specialists, are an additional pool of mental health workers who can augment hard-to-find licensed staff. Peer specialists’ personal experience with and recovery from mental illness and substance use provides a perspective that other mental health professionals often cannot offer. They do not replace professionals but their participation on the care team can provide a different perspective and improve outcomes. When a peer specialist provides support services, the licensed professional is available to focus on the clinical service delivery for which he or she was trained. In addition, peer specialists are an economical and effective way to address the mental health workforce shortage in Texas.

Peer specialists can assist agency administrators, clinicians, consumers and their families on aspects related to treatment. Peer specialists provide information, foster consumer empowerment, instill hope, and facilitate links to services through group facilitation, one-on-one interaction, and crisis intervention. Additionally, they educate the community about mental illness, recovery, strengths-based approaches to service delivery, and consumer involvement.

Substance use recovery specialist certification is provided by the Texas Certification Board of Addiction Professionals. Recovery specialists support individuals experiencing substance use conditions who are working toward recovery. There are more than 300 substance use certified recovery specialists in Texas. More information can about recovery specialists can be found at http://www.tcbap.org/.

Via Hope- Texas Mental Health Resource trains and certifies peer specialists in Texas with funding from the Hogg Foundation and the Department of State Health Services. A Via Hope Certified Peer Specialist (CPS) is an individual in recovery who has been trained to use their recovery story to assist others with recovery. At least 39 local mental health authorities (LMHAs), six state psychiatric hospitals and the Veteran’s Administration Heart of Texas Healthcare Network utilize certified peer support specialists. As of August 2014, 447 peer specialists were certified in Texas. More information about peer support certification can be found at http://www.viahope.org/programs/training-certification.

FAMILY PARTNER CERTIFICATION

Similar to the peer specialist role, Certified Family Partners (CFPs) are individuals who have experience parenting a child with mental, emotional or behavioral health disorders and who have had personal involvement with the public mental health system. A family partner provides information and support to other parents in similar circumstances. Via Hope developed the family partner certification curriculum in collaboration with state, regional and national stakeholders and has trained and certified more than 114 family partners.

More information about CFPs can be found at http://www.viahope.org/programs/family-partner-training-certification.
MILITARY VETERAN PEER SUPPORT

Using $3 million from general revenue funds appropriated during the 82nd Legislature, DSHS implemented the Mental Health Program for Veterans in FY 2013. DSHS is using $5 million per year in the 2014-2015 biennium from general revenue funds allocated by the 83rd Legislature to continue implementation and expansion of the program. The Mental Health Program for Veterans’ primary focus for FY 2013 was peer-to-peer support services provided by trained volunteer service members, veterans, and family members (SMVF). During FY 2013, 470 SMVF volunteers were trained in different forms of peer-to-peer counseling. Based on data provided by volunteers and estimates by volunteer coordinators, 30,000 SMVF were served as a result of 53,566 peer-to-peer encounters.

CONSUMER-OPERATED SERVICE PROVIDERS

DSHS funds seven consumer-operated service providers (COSPs) through subcontracts with LMHAs to deliver services such as peer support, outreach, education and advocacy. COSPs are independent organizations operated and governed by individuals in recovery. A fundamental component of COSPs is peer support. Via Hope works with seven COSPs by providing technical assistance to establish sustainability plans, further their organizational development, and help disseminate information to increase capacity of COSPs across Texas.

More information about COSPs can be found at http://www.viahope.org/programs/consumer-operated-service-provider-institute.

WELLNESS RECOVERY ACTION PLAN (WRAP®) SELF-DIRECTED PLANNING

An example of person-centered recovery planning is a Wellness Recovery Action Plan (WRAP®), a national evidence-based practice. Through WRAP®, consumers develop their own wellness tools, identify triggers and early symptoms, and then create action plans to manage them. They also develop strategies to address early warning signs for a personal crisis by developing a crisis plan. The East Texas Coalition for Mental Health Recovery uses WRAP as one of its tools as it strives to create and promote a community where consumers and families work together to promote recovery.

RECOVERY-ORIENTED SYSTEMS OF CARE FOR SUBSTANCE USE

DSHS is also supporting the recovery-oriented systems of care (ROSC) for substance use planning and service delivery systems change. A ROSC is a network of organizations, agencies, and individuals that coordinates services at the community level to prevent, intervene and treat substance use problems and disorders. As of August, 2014, 24 Texas communities are initiating local ROSCs.

RECOVERY TO PRACTICE CURRICULUM

The overarching goal of Recovery to Practice (RTP) is to advance the implementation of recovery-oriented practice among behavioral health practitioners through
participation in comprehensive, discipline-specific training. In 2009, SAMHSA funded the development of the Recovery to Practice curriculum across five mental health professional organizations: the American Psychiatric Association, the American Psychological Association, the American Psychiatric Nurses Association, the Council on Social Work Education and the InterNational Association of Peer Supporters. NAADAC, the Association for Addiction Professionals, was brought into the initiative one year later. Workgroups within each field, including people with lived experience with a mental health condition, developed curriculum and training materials to be delivered through web-based modules and/or in-person training. Although the curricula have been developed separately within each profession, an integrated and interdisciplinary team approach to recovery and to the materials has been encouraged. In September 2014, the Hogg Foundation for Mental Health launched a request for proposals to coordinate the dissemination of the Recovery to Practice curricula in Texas.

More information about Recovery to Practice can be found at: http://www.samhsa.gov/recoverytopractice/

Best Practice: Clubhouse International

Clubhouse Model

The Clubhouse International Clubhouse Model is a day treatment program for adults diagnosed with a mental health condition that is recognized by SAMHSA as an evidence-based program. Clubhouse participants are referred to as members. The goal of the Clubhouse Model is to contribute to an overall therapeutic environment by engaging members with responsibilities within the clubhouse (e.g., clerical duties, reception, and food service), outside employment, education, meaningful relationships, housing, and an overall improved quality of life. Each member is considered a critical part of a community engaged in important work. Membership allows open participation, choice of work activities, choice in staff, and a lifetime of reentry and access to all Clubhouse services. The “work-ordered day” structures the daily activities of the Clubhouse and is integral to the program. Clubhouses are accredited and coordinated internationally through Clubhouse International, formerly known as the International Center for Clubhouse Development (ICCD). Staff members’ backgrounds include psychology, counseling, social work, and education. Clubhouse members do not pay dues or membership fees and attendance is voluntary.

St. Joseph House in Houston was established in 1995 and was accredited by Clubhouse International in 2006. It has over 1,000 members and a comprehensive program of activities and events. During the week, programs help members develop skills and self-confidence for employment and independent living. Weekends are focused on social and recreational activities. St. Joseph’s mission is to be “a community working to maximize the quality of life for its members, who are living with a mental illness. Regular involvement in the clubhouse community provides opportunities for social growth, access to local resources, and empowerment through work and decision-making at the clubhouse and in the wider community. Central to this goal is reducing and eventually eliminating the harmful stigma associated with
mental illness." St. Joseph House was the first clubhouse accredited in Texas and recently the San Antonio Clubhouse became the second.

Best Practice: Outcome Measures

Federal and state agencies, managed care organizations, mental health providers, legislators and many other are continually seeking better ways to determine the quality and effectiveness of behavioral health services. This is typically attempted through the collection and analysis of outcome measures designed to tell us the results or impact that services, interventions and supports have on individuals or communities. Strong outcome measurement data provides significant information that can be used to make informed decisions on programs, services, and resource allocation. More importantly, however, the data can be used for program management and for ongoing quality improvement.

Over the past few years, mental health outcomes and provider accountability have become more pertinent to Texas’ behavioral health system. During the 83rd legislative session, mental health legislation incorporated an increased emphasis on the collection, reporting, dissemination and use of outcome data to evaluate mental health services. Bills and riders addressing mental health performance measures included Rider 78, SB 58, SB 7 and SB 126. SB 58 and SB 7 direct the health and human services enterprise to develop an integrated health service delivery approach. This massive restructuring project requires extensive investment in time and funds that ultimately necessitate the collection of performance measures in order to determine the return on investment. Additionally, Rider 78 requires DSHS to withhold 10% of quarterly allocations from the LMHAs to be used as performance based incentives while SB 126 requires DSHS to develop and maintain a public reporting system that allows the public to view and compare performance and outcome measures across community behavioral health providers. In addition to legislation set forth by the state government, the Healthcare Transformation and Quality Improvement Program 1115 Waiver requires Regional Healthcare Partnerships (RHPs) to track and report outcome data of their programming in order to demonstrate improved outcomes and ensure program value. These measures are ultimately used to ensure the value of community-based behavioral health services for all stakeholders.

Outcomes for people with mental health conditions should focus on features beyond traditional clinical diagnoses. Historically, outcomes have focused on clinical recovery—a decrease in symptoms—rather than personal recovery, which is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Outcomes should include both symptom reduction and concepts of recovery, such as functioning and community integration. Implicit to the recovery model is the idea that recovery is a measurable outcome of a person-centered treatment plan inclusive of consumers’ life goals. There are a number of emerging recovery outcome measures that examine both individual experiences of recovery as well as the recovery orientation of services. There are still issues to be resolved in strengthening the psychometric properties of these measures and making them more consumer-friendly with respect to length and reading level.
Best Practice: Integrated Primary, Mental Health, and Substance Use Care

Across the country, integrated health care has emerged as an effective strategy for treating the whole person by addressing primary care, mental health and substance use problems in a systemic and coordinated manner. Using primary care settings for behavioral health services enhances access to services, reduces stigma to seeking care, is cost-effective and has good outcomes. Additionally, integrating primary care services into behavioral health settings makes integrated health care available to many who otherwise would not receive it. Models of care vary based on whether the covered population has low or high physical health and behavioral health needs. They can be as simple as co-located arrangements in which primary care and behavioral health professionals work together in the same office, or as complex as full integration at the organizational level. Rural and other underserved communities have tailored integrated care approaches to serve sparsely populated geographic areas and culturally diverse populations.

In August 2012, the Hogg Foundation awarded $720,950 to ten non-profit organizations across Texas to support the planning and/or implementation of integrated behavioral and physical health care programs.

SB 58 (83rd Legislature, Nelson) takes a step toward integrating health care. SB 58 requires targeted case management and mental health rehabilitative services to be integrated into Medicaid managed care with the goal of better care coordination for individuals enrolled in Medicaid. Additional information about SB 58 can be found in the Texas Environment section.

At the local and regional level, many Delivery System Reform Incentive Payment (DSRIP) projects under the 1115 Transformation Waiver address integrated healthcare. In the first phase (4-year projects), the 20 Regional Healthcare Partnerships created through the 1115 Waiver proposed 396 DSRIP projects with a behavioral health component, and 140 of these projects plan to integrate physical and behavioral health in some way. Additional information about the 1115 Waiver can be found in the Texas Environment Section.

Best Practice: Prevention and Early Intervention

Mental health prevention is defined as a “proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.”
For persons of all ages, early identification and treatment of emerging mental health and substance use problems can help with recovery, prevent mental health problems from worsening, and mitigate the impact of serious and disabling conditions.

Early intervention for young children with mental health issues supports healthy development and improves family life. Children who enter kindergarten with effective social skills have an easier time developing relationships with peers and do better in school.\textsuperscript{967} Young children who receive effective, age-appropriate mental health services and supports are more likely to complete high school, have fewer contacts with law enforcement, and improve their ability to live independently and productively.\textsuperscript{968} Without intervention, child and adolescent disorders frequently continue into adulthood. Fifty percent of all lifetime cases of mental illness are apparent by age 14 and 75 percent are apparent by age 24.\textsuperscript{969} Screening and assessment for behavioral health conditions can occur through many venues such as primary care, mental health providers, early childhood intervention, schools, jails, and juvenile detention centers, among others.

In Texas, a 2009 report found that the annual behavioral health indirect cost due to heightened juvenile and adult criminal justice involvement, special education, mental and physical health care needs, substance use, and lost productivity to society is estimated at over $5.2 billion.\textsuperscript{970} By investing in prevention and early intervention strategies and identifying and treating people when concerns first arise, Texas has the opportunity to avoid the high costs associated with untreated mental illness and reap the benefits of a healthy, productive workforce.

Several DSHS programs focus on prevention and early intervention, including the following:

- Substance Abuse Services funds 11 prevention resource centers across the state. These centers provide communities, including schools, with prevention materials and information, resources and expertise.\textsuperscript{971}
- The Partnership for a Drug-Free Texas generates millions of dollars in advertising and media exposure to encourage Texas youth to make wise choices about alcohol and other drugs. The Texas Partnership is an alliance of The Partnership at Drug-Free.org. The Texas Partnership facilitates the delivery of public service announcements and generates creative work tailored to address concerns identified by DSHS.\textsuperscript{972}
- SB 831 from the 83\textsuperscript{rd} Legislative Session (Taylor) requires DSHS, TEA, and regional education service centers to work together to create a list of recommended best-practice programs for public schools that can be implemented in the general education setting. This list should provide information on best practice-based recommendations, mental health promotion, positive youth development, suicide prevention and substance use prevention and intervention programs. The emphasis on prevention and mental health promotion in the bill has the potential to reduce the cost of reactionary interventions for existing issues by identifying and addressing problems before they escalate.
Best Practice: Seclusion and Restraint Alternatives

Seclusion and restraint involve the use of physical force, restriction of movement, involuntary use of medication or isolation to manage behavior in emergency circumstances. Seclusion and restraint methods are used in settings such as psychiatric hospitals, criminal justice settings, residential treatment facilities and schools. The practices can be traumatic and dangerous to individuals and staff, causing physical and psychological harm, and even death. At a minimum, their use can conflict with a positive therapeutic environment and hinder consumer recovery.

In SB 325, the 79th Texas Legislature created the Behavioral Management Work Group to review and provide recommendations on best practices in policy, training, safety and risk management related to reducing seclusion and restraint use. The report of the cross-agency workgroup, issued in 2006, is available at http://www.hogg.utexas.edu/.

In 2007, Texas HHSC was awarded a federal grant from SAMHSA for the reduction or elimination of restraint and seclusion in four state psychiatric hospitals in Austin, Big Spring, San Antonio and Vernon/Wichita Falls. The project, State of Texas Alternatives to Restraint and Seclusion (STARS), was designed to advance evidence-based infrastructure improvements in these four state psychiatric hospitals to reduce and ultimately end the use of restraint and seclusion in the treatment of consumers with mental health conditions, including those with co-occurring substance use disorders or developmental disabilities.

Through the STARS grant, Texas has made significant improvements in the culture of care at the state hospitals, most notably reflected in reductions in both the numbers of incidents of restraint or seclusion, the numbers of individuals involved, and the length of time spent in restraint or seclusion per incident. One of the products resulting from the STARS grant was a toolkit designed to help reduce seclusion and restraint in any setting. Creating a Culture of Care: A Toolkit for Creating a Trauma-Informed Environment can be found at http://www.dshs.state.tx.us/cultureofcare.

The Hogg Foundation for Mental Health has been actively engaged in restraint and seclusion reduction efforts. Past initiatives include statewide trainings, seminars, and publications. Since 2006, the Hogg Foundation has sponsored a series of trainings around the state using an evidence-based curriculum for culture change called Six Core Strategies To Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint. The foundation also launched and facilitated the Texas Seclusion and Restraint Reduction Leadership Group. This group is composed...
of individuals with mental health conditions, family members, advocates, and representatives of public and private agencies.

**Best Practice: Trauma-Informed Approach**

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides the following as a working definition for trauma:

*Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.*

Many people seeking behavioral health treatment or who are in other programs such as homeless and domestic violence shelters, foster care, or juvenile or criminal justice systems have histories of physical and sexual abuse and other types of trauma-inducing experiences. Left unrecognized and untreated, these traumatic experiences can lead to mental health problems, chronic health conditions, and substance use disorders, as well as behavior leading to contact with the criminal justice system.

A “trauma-informed approach” is similar to trauma-informed care. Some sectors such as the criminal justice or employment sectors may want to use a trauma-informed approach, but they may not identify as “caregiving” organizations. SAMHSA acknowledges that sectors involved in providing caregiving services such as behavioral health care or child welfare may still use “trauma-informed care;” however, SAMHSA also recognizes that “trauma-informed approach” is a term that applies to a broader range of sectors and systems. A trauma-informed approach specifically addresses the consequences of trauma on an individual and is designed to facilitate healing.

Texas-based trauma-informed approach initiatives include the following:

- With funding from SAMHSA, DSHS started the Jail Diversion and Trauma Recovery (JDTR) Project 2010 through a pilot site in Bexar County. The JDTR project is part of a larger program operated by DSHS, the Mental Health Program for Veterans. Based on close collaboration between DSHS, LMHAs, and Veterans Affairs, the JDTR Projects seeks to create community-based practices to divert veterans with trauma-related mental health needs from incarceration. JDTR uses evidenced-based trauma treatments, including Trauma-Informed Care and Seeking Safety. By the end of FY 2013, 147 veterans had entered the pilot programs with the following results: 86 veterans completed the program and 57 veterans were still participating in the program. Assessments for reduced symptoms from trauma remain to be evaluated, but other outcome measures have been published. The 86 veterans who completed the project show the following change percentages over the course of one year: 150 percent increase in employment, 80 percent reduction in homelessness, 54 percent reduction in drug use over the preceding 30 days, 22 percent reduction in PTSD diagnoses, 29
percent reduction on PTSD severity scores, 82 percent reduction in moderate to extreme depression, 75 percent reduction in moderate to extreme self-harm, 50 percent reduction in moderate to extreme emotional liability, 64.5 percent reduction in moderate to extreme psychosis, 34.6 percent reduction in substance use, and significant improvement on the Recovery Marker Scale Score. In FY 2013, JDTR was expanded into eight additional communities: Austin, Edinburg, El Paso, Houston, Lubbock, Sequin, San Marcos, and Tyler.

- Partnering with the Department of Aging and Disability Services (DADS), the Hogg Foundation for Mental Health funded a two-year grant that provided training and technical assistance on trauma-informed care to service providers supporting individuals with intellectual and developmental disabilities. Beginning in February 2012, training and technical assistance was provided for facility staff and community service providers at two state supported living centers. An initial evaluation of the training and technical assistance project showed a reduction in the use of restraints following the implementation of the trauma-informed care training. Additionally, staff members at the service centers reported a positive shift in the culture of care in the workplace and an improved rapport between staff and individuals that resulted in overall improved conduct.

- HB 1151, (81st), requires eight hours of trauma-informed care training for Child Protective Services (CPS) case workers and supervisors, two hours for other CPS staff, and three hours for direct care givers. SB 219, (82nd), directed DFPS to expand trauma-informed care training and to study its effectiveness. It also directed HHSC to require STAR Health providers to receive trauma-informed care training. The Texas Legislature renewed its commitment to trauma-informed care by authorizing DFPS to not only maintain its own trauma-informed care program, but to assist in the development of similar programs throughout the child welfare system if funding is available. DFPS has made an online Trauma Informed Care training available to assist families, caregivers, and social service providers in developing a greater understanding of trauma informed care and child traumatic stress. This training can be accessed online at www.dfps.state.tx.us/training/trauma_informed_care/

- Also passed during the 83rd session was SB 1356 (Van de Putte) that directed the Texas Juvenile Justice Department to develop and implement trauma-informed care training for juvenile probation and jail supervision officers as well as community-based program staff.

- In 2014, the Hogg Foundation partnered with the National Child Traumatic Stress Network to develop a training toolkit to support trauma-informed care for children with intellectual and other developmental disabilities. In conjunction with development of the toolkit, the foundation awarded a grant to SafePlace to conduct trainings across the state.

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**Best Practice: Jail Diversion**

Jail diversion services are intended to divert people with serious behavioral health disorders who are charged with minor crimes (typically misdemeanors like trespassing or disorderly conduct) from further involvement in the criminal justice system by linking them to community-based services. A significant number of people with serious mental health conditions are arrested or jailed for minor offenses that are often related to their mental health condition. People with mental
health conditions often experience bad outcomes when inappropriately arrested or incarcerated.995 The cost of ineffective criminal justice measures for people with mental illness is significantly higher than jail diversion and programs that focus on recovery; furthermore, recovery provides an opportunity for people with mental health conditions to contribute to the economy.996 Jail diversion services are considered critical strategies for preventing people with mental illness who commit crimes from entering or unnecessarily remaining in the criminal justice system.997 Services vary widely because local systems differ in terms of their size, need and available treatment resources. Jail diversion may entail treatment as a condition of bail, deferred prosecution, deferred sentencing or treatment as a condition of probation following a guilty plea.998 A number of urban communities in Texas have specialty mental health or substance use courts with court dockets focused on this population. In these situations, the court maintains judicial oversight of the person’s participation in required treatment. Additional information on jail diversion services is described in the Texas Department of Criminal Justice (TDCJ) section.

Best Practice: Outpatient Competency Restoration

Outpatient competency restoration (OCR) is an effective alternative to lengthy jail stays and costly hospital commitments for some individuals with mental illness or intellectual disabilities. Competency restoration is needed when individuals are charged with crimes but found by a court to be incompetent to stand trial. To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.999

In 2007, SB 867, (80th), prompted DSHS to establish OCR pilots at four initial sites in Travis, Bexar, Dallas and Tarrant counties. Before participating in the pilot projects, defendants were fully screened to ensure they did not pose a significant risk to themselves or others in the community. About 55 percent of the defendants participating in the pilots either were restored to competency or improved enough to be enrolled in community mental health services and have their charges dropped.1000 The average per person cost in the pilot programs was $11,894, far less than the inpatient restoration average cost of $50,520.1001

The DSHS Continuity of Care Task Force Report recommended expansion of outpatient restoration services.1002 Budget Rider 78 (82nd Legislative Session) subsequently directed DSHS to allocate $4 million each year to support expanding the number of pilot sites.1003 There are currently 12 OCR sites across the state that served a total of 1,061 individuals through the end of FY 2013 with an average cost per day of $229 versus over $400 per day for restoration in a state hospital.1004,1005 Additional information is available in the Texas Department of State Health Service (DSHS) section.
Best Practice: Child and Family Mental Health System of Care

The system of care approach is the philosophical and organizational framework for the collaborative, systemic planning and delivery of child and family mental health services. Established in practice and research for over 25 years, systems of care have been proven nationally to be a cost effective approach resulting in better child and family outcomes and increased access to services and supports.1006

Programs using this approach provide coordinated care that includes community-based services and supports for children and their families. This model is based on a federal initiative that emphasizes the core value of services that are community based, child centered, family focused, and culturally competent.

Several Texas communities have received state and federal grants to support system of care programs, which receive technical support and training through HHSC’s Office of Program Coordination for Children and Youth. In 2011, HHSC received a SAMHSA grant to support the statewide expansion of the system of care approach.1007 The Achieving Successful Systems Enriching Texas Initiative (ASSET) grant was used to create Texas System of Care and is a joint project of Texas Health and Human Services Commission (HHSC), DSHS, and the Center for Social Work Research at The University of Texas at Austin. In July 2013, Texas HHSC was notified of additional funding to continue Texas System of Care.1008 This funding will provide support for an additional four years. Further information is available at http://www.txsystemofcare.org/about-us.

Best Practice: Telemedicine/Telehealth

Telemedicine (or more broadly, telehealth) is the use of technology to deliver health care services, including services for mental health and substance use. Telepsychiatry is a form of telemedicine that provides psychiatric services for individuals who live in a remote or underserved locations. The American Psychiatric Association states: “Telepsychiatry is currently one of the most effective ways to increase access to access to psychiatric care for individuals living in underserved areas.”1009 Telepsychiatry also provides an opportunity for individuals to obtain a second opinion in an area where there is only one psychiatrist, and enables healthcare professionals to work more effectively as a team.1010 Individuals who use telepsychiatry often feel the communication between their physicians has improved their outcomes, are satisfied with the care they receive, and feel their treatment from telepsychiatry is reliable.1011

Many studies with large sample sizes and sound scientific rigor have found that telemedicine can save patients, providers, and payers money when compared to traditional health care approaches.1012 Additionally, studies consistently show no difference between telemedicine and traditional health care in the provider’s ability to obtain clinical information, accurately diagnose, and create treatment plans.1013
In some instances, telemedicine has shown improved care, such as: monitoring chronic care patients or care from specialists across a large geographical area.\textsuperscript{1014} Telemedicine is typically used in Texas to provide services to rural or underserved areas using technology to connect a remote site such as a clinic or school where the consumer is located and a hub site where the consulting professional provider is located.

Telehealth increases access to care by maximizing the use of available behavioral health care professionals, especially for Texans living in federally designated mental health professional shortage areas. For some consumers, the use of telehealth eases the stigma and embarrassment of seeking behavioral health care.\textsuperscript{1015} Community health and mental health centers are using technology to increase access to specialists. In addition, the University of Texas Medical Branch (UTMB) at Galveston has a well-established telemedicine program that provides services to multiple settings, including Texas Department of Criminal Justice (TDCJ) facilities, community health and mental health centers, and schools. Further information on UTMB's extensive telemedicine program is available at http://telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf.

The Statewide Health Coordinating Council reports that telehealth holds the potential for the greatest economic impact on rising health costs in Texas during this century.\textsuperscript{1016} Since Texas Medicaid began providing telemedicine medical services in 1998, services have been modified and expanded through each legislative session from 2001 to 2011. These modifications include provisions to expand eligible providers, locations and pilot projects. HHSC found the following changes in the use of telemedicine between state fiscal years 2009 and 2011: 113 percent increase in number of providers, 128 percent increase in number of clients, and 143 percent increase in expenditures.\textsuperscript{1017} These cost increases are attributed to expanded coverage of telehealth services, improved tracking of telehealth services, and other telehealth network expansion initiatives aimed at improving access to specialty and subspecialty care in Medicaid.\textsuperscript{1018}

**Best Practice: Suicide Awareness and Prevention**

In 2011, approximately 39,500 people died by suicide in the United States.\textsuperscript{1019} In 2011, there were nearly 20,000 suicide deaths as a result of the use of a firearm, almost twice as many deaths as a result of firearm homicide.\textsuperscript{1020} In 2012, 3,032 Texans committed suicide.\textsuperscript{1021} Data from 2012 shows that suicide in Texas is the second leading cause of death among male adolescents and adults ages 15-34, and is the third leading cause of death among young adult females ages 25-35.\textsuperscript{1022} Data collected from 2,171 Texas high school students through the Youth Risk Behavior Survey in 2011 revealed that 29 percent of students identified themselves as depressed, 16 percent of students were actively considering suicide, and 11 percent of students were likely to attempt suicide.\textsuperscript{1023} Although there is no one cause of suicide, over 90 percent of those who die by suicide nationally have been diagnosed with a mental illness.\textsuperscript{1024} While white males have the highest suicide rates, suicide
Suicide in Texas is a serious public health concern and one that could be addressed effectively through comprehensive and coordinated prevention practices. The Texas Suicide Prevention Council is a collaborative effort between local suicide prevention coalitions and state agencies to implement an effective suicide prevention plan in Texas. The council’s activities include an informational website, suicide prevention trainings, an annual suicide prevention conference, bilingual information packets, and public awareness campaigns. The council has published a list of Texas statutes that relate to suicide prevention, services and reporting. The council also offers free downloadable resources about suicide prevention and intervention. For more information visit the Texas Suicide Prevention website at http://www.texas-suicideprevention.org.

The American Foundation for Suicide Prevention (AFSP) Central Texas Chapter is another suicide prevention resource available for Texans. AFSP is a national nonprofit dedicated to understanding and preventing suicide through research, education, advocacy and outreach. The AFSP website provides information on suicide prevention, volunteer opportunities, educational resources, research grants and support for individuals surviving a suicide loss. More information can be found at http://www.afsp.org/centraltexas.

DSHS lists the following toll-free, 24-hour hotlines available to anyone experiencing a suicidal or emotional crisis:

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Red Nacional de Prevencion del Suicidio: 1-888-628-9454
- Veterans Suicide Prevention Hotline: 1-800-273-TALK (8255)
- Trevor Hotline (for lesbian, gay, bisexual, transgender or questioning (LGBTQ) youth): 1-866-488-7386

Texas LMHA crisis hotlines. For a list of all Texas LMHA crisis hotline numbers, go to http://www.dshs.state.tx.us/mhsa/lmha-list/

Best Practice: Housing

Housing First

The United States Interagency Council on Homelessness describes Housing First as “an approach that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the

Data from 2012 shows that suicide in Texas is the second leading cause of death among male adolescents and adults ages 15-34, and is the third leading cause of death among young adult females ages 25-35.
supportive services and connections to the community-based supports people needed to keep their housing and avoid returning to homelessness.”

With Housing First, services are offered and made available; however, participation in services is not required to remain in housing.

Research has demonstrated that permanent housing can cost less than long stays in temporary housing and repeated use of public acute care systems. Many people experiencing homelessness also have a mental health condition. Permanent housing provides a stable platform that enables people experiencing homelessness to address other needs, such as mental health needs.

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing (PSH) is permanent, affordable housing linked to a range of support services that enable vulnerable tenants, especially people who experience chronic homelessness, to live independently and participate in community life. PSH is a cost-effective, evidence-based practice that is a key component in promoting recovery for people with behavioral health conditions.

According to SAMHSA, the core elements of permanent supportive housing are:

- A high degree of choice offered to tenants.
- Functional separation of housing management and services staff.
- Affordability.
- Integration with the surrounding community.
- Full rights of tenancy under federal and state law.
- Immediacy of access to housing.
- Available services and supports.

For more information on permanent supportive housing see the SAMHSA resources at http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

In collaboration with TDHCA, the Department of State Health Services (DSHS) is working to increase the availability of permanent supportive housing for people with serious mental illness. DSHS was granted an exceptional item request in its FY 2014 -2015 legislative appropriations request for state match funds for a 1915(i) state plan amendment to the Texas Medicaid program to support the development of permanent supportive housing opportunities. Funds for the 1915(i) waiver are being used for the development of the Home and Community-Based Services—Adult Mental Health (HCBS-AMH) program. HCBS-AMH, operated by DSHS, will address the common service needs of a small number of mental health consumers who receive extended care in inpatient facilities after they no longer need acute inpatient services. HCBS-AMH will provide a wide variety of home and community-based services to these individuals so their needs can be met outside of an inpatient psychiatric hospital. HCBS-AMH is still in the planning phases, and TDHCA’s specific involvement is unclear. However, it is likely that TDHCA will coordinate housing assistance with public housing authorities to provide housing vouchers to people in the HCBS-AMH program. For more information about the HCBS-AMH and additional services offered though the program, refer to the Texas Environment section.
Oxford House Inc. runs a national network of individual Oxford Houses that serve as supportive housing for individuals in recovery from substance use issues. All Oxford Houses must adhere to the following established charter conditions: “1) the group must be democratically self-run following the policies and procedures of the Oxford House Manual, 2) the group must be financially self-supporting, and 3) the group must immediately expel any resident who returns to using alcohol or illicit drugs.”

In 2011, SAMHSA included the Oxford House on the National Registry of Evidence-based Programs and Practices. The program has proven both treatment-effective and cost-effective for individuals attempting to achieve long-term recovery from addiction and co-occurring mental illness. Federally funded research has shown that more than 80 percent of Oxford House residents avoided relapse.

The first Oxford House opened in Texas in 1991. As of May 2014, there were 115 Oxford Houses with a total of 871 available beds throughout Texas. DSHS contracts with approximately half of the Oxford Houses located in Texas for the provision of residential services in five Texas metropolitan areas. Oxford House Inc. locates housing for individuals who have successfully completed DSHS-funded substance use treatment, who are not currently employed, and who are at risk of returning to an environment that could compromise sobriety. During the 83rd legislative session, over $1.1 million was appropriated to expand the Oxford House model across the state.

Of the 115 Oxford Houses in Texas, 63 of the houses and 482 of the beds are contracted by DSHS. DSHS provides these houses with a start-up loan of $4,000, which is paid back by the Oxford House in full within two years of receipt. DSHS expends roughly $2.60 per bed each day. The cost per bed paid by the resident is around $14.29 per day, as each member pays an equal share of the expenses to maintain the house.

The Oxford House model has seen significant growth in Texas. Twenty-eight Oxford Houses opened in 2013, and in 2014 Oxford Houses are opening at an average rate of one house per week, making Texas the fastest growing Oxford House state. Due to the proven success of the program, continued growth is anticipated nationally and in Texas during the coming years.
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# List of Acronyms

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<tr>
<td>AFSP</td>
<td>American Foundation for Suicide Prevention</td>
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<td>AMFI</td>
<td>Area Median Family Income</td>
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<td>ANSA</td>
<td>Adult Needs and Strengths Assessment</td>
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<td>APS</td>
<td>Adult Protective Services</td>
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<tr>
<td>ARS</td>
<td>Alternative Response System</td>
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<tr>
<td>ASCA</td>
<td>American School Counselor Association</td>
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<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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<td>ASSET</td>
<td>Achieving Successful Systems Enriching Texas [initiative grant]</td>
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<tr>
<td>AYBR</td>
<td>Amy Young Barrier Removal [program]</td>
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<tr>
<td>BISQ</td>
<td>Brain Injury Screening Questionnaire</td>
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<td>CANS</td>
<td>Child and Adolescent Needs and Strengths [assessment]</td>
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<td>CAS</td>
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<td>CCL</td>
<td>Child Care Licensing</td>
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<td>CCRC</td>
<td>Criss Cole Rehabilitation Center</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CEU</td>
<td>Continuing Education Unit</td>
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<td>CFP</td>
<td>Certified Family Partner</td>
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<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
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<td>CIHCP</td>
<td>County Indigent Health Care Program</td>
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<td>CIL</td>
<td>Center for Independent Living</td>
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<td>CINS</td>
<td>Conduct in Need of Supervision</td>
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<td>CIS</td>
<td>Communities in Schools</td>
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<td>CIT</td>
<td>Crisis Intervention Team</td>
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<td>CLASS</td>
<td>Community Living Assistance and Support Services [waiver program]</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>COG</td>
<td>Council of Governments</td>
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<td>COPE</td>
<td>Collaborative Opportunities for Positive Experiences</td>
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<td>COPSD</td>
<td>Co-occurring Psychiatric and Substance Use Disorder</td>
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<td>COPSD</td>
<td>Consumer-Operated Service Provider</td>
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<td>CPS</td>
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<td>Certified Peer Specialist</td>
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<td>CRCG</td>
<td>Community Resource Coordination Group</td>
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<td>CSBG</td>
<td>Community Services Block Grant</td>
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<td>CSU</td>
<td>Crisis Stabilization Unit</td>
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<td>DADS</td>
<td>Texas Department of Aging and Disability Services</td>
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<td>DAEP</td>
<td>Disciplinary Alternative Education Program</td>
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<td>DRS</td>
<td>Division for Rehabilitation Services</td>
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DSHS - Texas Department of State Health Services
DM-ID - Diagnostic Manual - Intellectual Disability
DSM-V - Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition
DSRIP - Delivery System Reform Incentive Pool
EAP - Employee Assistance Plan
EBP - Evidence-Based Practice
ECT - Electroconvulsive Therapy
ECI - Early Childhood Intervention [program]
EPSDT - Early and Periodic Screening, Diagnosis and Treatment
ESG - Emergency Solutions Grants
FDA - Food and Drug Administration
FFCC - Former Foster Care Children [program]
FFCHE - Former Foster Care in Higher Education [program]
FMAP - Federal Medical Assistance Percentage
FPG - Federal Poverty Guideline
FPL - Federal Poverty Level
FQHC - Federally Qualified Health Center
FTAS - Failure to Attend School
FVA - Fund for Veterans’ Assistance
GAD - Generalized Anxiety Disorder
GAF - Global Assessment of Functioning
GAO - U.S. General Accounting Office
GRO - General Residential Operations [facility]
HBA - Texas Homebuyer Assistance
HCBS - Home and Community-Based Services
HCBS-AMH - Home and Community-Based Services—Adult Mental Health [program]
HEDIS - Healthcare Effectiveness Data and Information Set
HHS - Health and Human Services
HHSC - Health and Human Services Commission
HHSP - Homeless Housing and Services Program
HIPP - Health Insurance Premium Payment [program]
HMO - Health Maintenance Program
HTC - Home Tax Credit [program]
HTF - Housing Trust Fund
HUD - U.S. Department of Housing and Urban Development
ICCD - International Center for Clubhouse Development
ICF - Intermediate Care Facility
IDD - intellectual and developmental disabilities
IDEA - Individuals with Disabilities Education Act
IEP - Individualized Education Plan
IFSP - Individualized Family Service Plan
IMD - Institution for Mental Disease
ISD - Independent School District
ISS - In-School Suspension
IST - Incompetent to Stand Trial
JJAEP - Juvenile Justice Alternative Education Program
JDTR - Jail Diversion and Trauma Recovery
LBB - Legislative Budget Board
LGBTQ - Lesbian, Gay, Transgender, Bisexual, Queer
LIHTC - Low Income Housing Tax Credit [program]
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<td>Local Mental Health Authority</td>
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<td>Level of Care</td>
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<td>LSPP</td>
<td>Licensed Specialist in School Psychology</td>
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<td>LTSS</td>
<td>Long-Term Services and Supports</td>
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<td>MAYSI</td>
<td>Massachusetts Youth Screening Instrument</td>
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<td>Mobile Crisis Outreach Team</td>
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<td>Office of the Independent Ombudsman</td>
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<td>OSS</td>
<td>Out-of-School Suspension</td>
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<td>PASRR</td>
<td>Pre-Admission Screening and Resident Review</td>
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<td>Primary Care Physician</td>
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<td>PASRR Evaluation</td>
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<td>Prevention and Early Intervention</td>
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<td>Pre-school Program for Children with Disabilities</td>
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<td>Preferred provider organization</td>
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<td>Project Rental Assistance [demonstration program]</td>
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<td>PSH</td>
<td>Permanent Supportive Housing</td>
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<td>Post-Traumatic Stress Disorder</td>
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<td>RDM</td>
<td>Resiliency and Disease Management</td>
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<td>RHP</td>
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<td>Recovery-Oriented System of Care</td>
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<td>Residential Treatment Center</td>
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<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>SAPIT</td>
<td>Substance Abuse Prevention, Intervention, and Treatment</td>
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<td>SED</td>
<td>Severe Emotional Disturbance</td>
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<td>SEL</td>
<td>Social and Emotional Learning</td>
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<td>School Health Advisory Council</td>
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<td>School Health and Related Services</td>
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<td>Service Members, Veterans, and Family Members</td>
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<td>SNAP</td>
<td>Supplemental Nutrition Assistance Program</td>
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<td>SSA</td>
<td>Social Security Administration</td>
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<td>SSA</td>
<td>Shared Services Arrangement</td>
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<td>SSDI</td>
<td>Social Security Disability Insurance</td>
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<td>SSI</td>
<td>Supplemental Security Income</td>
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<td>SSLC</td>
<td>State Supported Living Center</td>
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<tr>
<td>STARS</td>
<td>State of Texas Alternatives to Restraint and Seclusion</td>
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<tr>
<td>STP</td>
<td>Significant Traditional Provider</td>
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<tr>
<td>SWPBIS</td>
<td>School-wide Positive Behavioral Interventions and Supports</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance for Needy Families</td>
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<tr>
<td>TAY</td>
<td>Transition-Age Youth</td>
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<tr>
<td>TBI</td>
<td>Traumatic Brain Injury</td>
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<td>TBRA</td>
<td>Tenant-Based Rental Assistance</td>
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<tr>
<td>TBSI</td>
<td>Texas Behavior Support Initiative</td>
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<tr>
<td>TCOOMMI</td>
<td>Texas Correctional Office on Offenders with Medical or Mental Impairments</td>
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<td>TCPA</td>
<td>Texas Police Chiefs Association</td>
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<tr>
<td>TDCJ</td>
<td>Texas Department of Criminal Justice</td>
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<tr>
<td>TDHCA</td>
<td>Texas Department of Housing and Community Affairs</td>
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<tr>
<td>TDI</td>
<td>Texas Department of Insurance</td>
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<tr>
<td>TEA</td>
<td>Texas Education Agency</td>
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<td>TIC</td>
<td>Trauma-Informed Care</td>
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<tr>
<td>TJJD</td>
<td>Texas Juvenile Justice Department</td>
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<td>TJPC</td>
<td>Texas Juvenile Probation Commission</td>
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<td>TMHP</td>
<td>Texas Medicaid and Healthcare Partnership</td>
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<td>TRI</td>
<td>Texas Recovery Initiative</td>
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<td>TRR</td>
<td>Texas Resiliency and Recovery</td>
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<tr>
<td>TVC</td>
<td>Texas Veterans Commission</td>
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<tr>
<td>TxHmL</td>
<td>Texas Home Living [waiver program]</td>
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<tr>
<td>TYC</td>
<td>Texas Youth Commission</td>
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<tr>
<td>UC</td>
<td>Uncompensated Care</td>
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<tr>
<td>VA</td>
<td>U.S. Department of Veteran Affairs</td>
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<tr>
<td>VISN</td>
<td>Veterans Integrated Service Network</td>
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<tr>
<td>VR</td>
<td>Vocational Rehabilitation</td>
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<tr>
<td>VSO</td>
<td>Veterans Service Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
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<tr>
<td>YES</td>
<td>Youth Empowerment Services [waiver]</td>
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## Additional Resources

### AGENCY WEBSITES


Texas Department of State Health Services (DSHS): [www.dshs.state.tx.us](http://www.dshs.state.tx.us)

Texas Department of Family and Protective Services (DFPS): [www.dfps.state.tx.us](http://www.dfps.state.tx.us)

Texas Department of Aging and Disability Services (DADS): [www.dads.state.tx.us](http://www.dads.state.tx.us)

Texas Department of Assistive and Rehabilitative Services (DARS): [www.dars.state.tx.us/index.shtml](http://www.dars.state.tx.us/index.shtml)

Texas Department of Criminal Justice (TDCJ): [www.tdcj.state.tx.us](http://www.tdcj.state.tx.us)

Texas Juvenile Justice Department (TJJD): [www.tjjd.texas.gov](http://www.tjjd.texas.gov)

Texas Education Agency (TEA): [www.tea.state.tx.us](http://www.tea.state.tx.us)

Texas Department of Housing and Community Affairs (TDHCS): [www.tdhca.state.tx.us](http://www.tdhca.state.tx.us)

Texas Workforce Commission: [www.twc.state.tx.us](http://www.twc.state.tx.us)

### CERTIFIED PEER SPECIALISTS

Copeland Center for Wellness and Recovery: [http://copelandcenter.com/](http://copelandcenter.com/)

Georgia Certified Peer Specialist Project: [http://www.gacps.org/](http://www.gacps.org/)


### CHILD WELFARE


Texans Care for Children: [http://texanscareforchildren.org/](http://texanscareforchildren.org/)

### CHILDREN’S MENTAL HEALTH


Building Bridges Initiative: [http://www.buildingbridges4youth.org/index.html](http://www.buildingbridges4youth.org/index.html)


Texans Care for Children: http://texanscareforchildren.org/
Texas Network of Youth Services: http://tnoys.org/

**CIVIL RIGHTS**

Judge David L. Bazelon Center for Mental Health Law: http://www.bazelon.org
Disability Rights Texas: https://www.disabilityrightstx.org/

**CONSUMER AND FAMILY ORGANIZATIONS**

Texas Catalyst for Empowerment: http://www.mytce.org/
Via Hope – Texas: http://www.viahope.org/
Prosumers of San Antonio: http://www.prosumersinternational.org/
Mental Health America: http://www.mentalhealthamerica.net/
Mental Health America – Texas: http://www.mhatexas.org/
National Alliance on Mental Illness: http://www.nami.org/
National Alliance on Mental Illness – Texas: http://www.namitexas.org/
National Empowerment Center: http://www.power2u.org/

**CRIMINAL/JUVENILE JUSTICE AND MENTAL HEALTH**

National Center for Mental Health and Juvenile Justice: http://www.ncmhjj.com
SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation: http://gainscenter.samhsa.gov/
Texas Appleseed: http://www.texasappleseed.net/
Texas Criminal Justice Coalition: http://www.texascjc.org/
Texas Public Policy Foundation: http://www.texaspolicy.com/

**CULTURAL AND LINGUISTIC COMPETENCY**

Georgetown University National Center for Cultural Competence: http://nccc.georgetown.edu
NAMI Multicultural Action Center: http://www.nami.org/Template.cfm?Section=Multicultural_Support&Template=/TaggedPage/TaggedPageDisplay.cfm&T-PLID=56&ContentID=25443
**EARLY CHILDHOOD AND MENTAL HEALTH**

TexProtects: [http://www.texprotects.org/about/staff/](http://www.texprotects.org/about/staff/)

Texas Association for Infant Mental Health: [http://taimh.org/](http://taimh.org/)


**GENERAL INFORMATION ON MENTAL HEALTH AND SUBSTANCE USE**

*Mental Health, United States, 2010.* Available through the Substance Use and Mental Health Services Administration: [http://store.samhsa.gov/product/Mental-Health-United-States-2010/SMA12-4681](http://store.samhsa.gov/product/Mental-Health-United-States-2010/SMA12-4681)

Meadows Texas State of Mind Policy Institute: [http://www.texasstateofmind.org](http://www.texasstateofmind.org)


Substance Use and Mental Health Services Administration: [http://www.samhsa.gov/](http://www.samhsa.gov/)

Substance Use and Mental Health Services Administration, Center for Mental Health Services Uniform Reporting System Output Tables: [//www.samhsa.gov/dataoutcomes/urs](//www.samhsa.gov/dataoutcomes/urs)

**HOUSING**


Neighborhood Housing and Community Development: [http://www.austintexas.gov/department/permanent-supportive-housing-initiative](http://www.austintexas.gov/department/permanent-supportive-housing-initiative)


Texas Department of Housing & Community Affairs: [https://www.tdhca.state.tx.us/](https://www.tdhca.state.tx.us/)


**INTEGRATED PHYSICAL AND MENTAL HEALTH CARE**

Academy for Integrating Behavioral Health and Primary Care: [http://integrationacademy.ahrq.gov/](http://integrationacademy.ahrq.gov/)

Advancing Integrated Mental Health Solutions (AIMS) Center: [http://aims.uw.edu/](http://aims.uw.edu/)


**INTELLECTUAL DISABILITY WITH CO-OCCURRING MENTAL HEALTH CONDITIONS**

Hogg Foundation for Mental Health | A Guide to Understanding Mental Health Systems and Services in Texas
The National Association for the Dually Diagnosed: http://thenadd.org/

METNAL HEALTH IN SCHOOLS

Center for Health and Health Care in Schools: http://www.healthinschools.org/
Communities in Schools (CIS) of Texas: http://www.cisoftexas.org/
Texas Education Agency: http://www.tea.state.tx.us/
Texas Education Service Centers: http://www.tea.state.tx.us/regional_services/esc/
UCLA School Mental Health Project: http://smhp.psych.ucla.edu/
University of Maryland Technical Assistance Center on School Mental Health: http://csmh.umd.edu/

METNAL HEALTH WORKFORCE DEVELOPMENT

The Annapolis Coalition on Behavioral Health Workforce Development: http://annapoliscoalition.org/

PROMOTOORES(AS)

Migrant Health Promotion Training and Support for Promotores(as): http://www.migranthealth.org/index.php?option=com_content&view=article&id=67&Itemid=65
Promotoras in Mental Health: http://promotorasimentalhealth.com/
USA Center for Rural Public Health Preparedness: http://www.rural-preparedness.org/index.aspx?page=fd089d35-bd02-4b2a-9ad7-15fc31c9b55

RECOVERY AND WELLNESS

National Empowerment Center: http://www.power2u.org/
Texas Department of State Health Services, Recovery-oriented systems of care (ROSC): https://www.dshs.state.tx.us/substance-abuse/ROSC/

Via Hope Recovery Institute: http://www.viahope.org/programs/recovery-institute

**SUICIDE PREVENTION**


Preventing Suicide: A toolkit for High Schools: http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669


Texas Suicide Prevention: http://www.texas-suicide-prevention.org/

Texas Suicide Prevention Resource Center: http://www.sprc.org/states/texas

Texas Department of State Health Services, Texas Suicide Prevention: http://www.dshs.state.tx.us/mhsa/suicide/Suicide-Prevention.aspx

**TELEMEDICINE AND TELEHEALTH**

American Telemedicine Association: http://www.americantelemed.org/

University of Colorado Denver Telemental Health Guide: http://www.tmhguide.org/

**VETERANS SERVICES**

Make the Connection: Share experiences and supports for veterans: http://maketheconnection.net/

Military Veteran Peer Network: http://www.milvetpeer.net/

Texas Veterans Commission: http://www.tvc.texas.gov/

TexVet: www.texvet.org

US. Department of Veterans Affairs: http://www.va.gov/
Glossary: Common Behavioral Health Terms

1115 Waiver: A waiver under section 1115 of Social Security Act that allows CMS and states more flexibility in designing programs to ensure delivery of Medicaid services.

Acute: Refers to a disease or condition that develops rapidly and is intense and of short duration.

Adjudication: Is a finding that a youth has engaged in delinquent conduct or “conduct in need of supervision.” It is similar to a “conviction” in adult court.

Affect: Feeling or emotion, especially as manifested by facial expression or body language.

Affordable housing: Housing units that are affordable for people who have an income below the median family income of a specific area. Affordable is often considered to be 30% or less of a person's monthly income.

Alternative therapy: Mental health care that is used instead of or in addition to conventional mental health services.

Anxiety: A sense of fear, nervousness, and apprehension about something.

Anxiety disorders: A group of chronic disorders ranging from feelings of uneasiness to immobilizing bouts of terror. Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder.

Behavioral health care: Continuum of services for individuals at risk of, or currently living with, one or more mental health conditions, substance use disorders or other behavioral health disorders.

Behavioral therapy: Therapy focusing on changing unwanted behaviors through rewards, reinforcements and desensitization. Desensitization, or exposure therapy, is a process of confronting something that arouses anxiety, discomfort or fear and overcoming the unwanted responses.

Biomedical treatment: Treatment involving medication. The kind of medication a psychiatrist prescribes varies with the disorder and the individual being treated; also referred to as psychopharmacology.

Bipolar disorder: A mood disorder in which a person alternates between episodes of major depression and mania.

Boarding home: A business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the owner.

Capitated: Relating to, participating in, or being a health-care system in which a medical provider is given a set fee per patient (as by an HMO) regardless of treatment required.

Caregiver: A person who has special training to help people with mental health conditions. Caregivers can be, but are not required to be, mental health professionals. Caregivers may include social workers, teachers, psychologists, psychiatrists, family members and mentors.

Case manager: An individual who organizes and coordinates services and supports for persons with mental health needs and their families. [Also service coordinator, advocate and facilitator.]
Centers for Medicare and Medicaid Services (CMS): The U.S. federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program.

Certified Family Partner (CFP): Individuals with experience parenting a child with mental, emotional or behavioral health disorders and have had personal involvement with the public mental health system and have received approved training and passed a certification exam. A family partner provides information and support to other parents in similar circumstances.

Certified Peer Specialist (CPS): Individuals whose personal experience and struggles with mental illness or substance use enables them to provide assistance and recovery support to other people with similar diagnoses. Certified peer specialists have received approved training and have passed a certification exam.

Children’s Health Insurance Program (CHIP): CHIP was created in 1997 under Title XXI of the Social Security Act. As with Medicaid, CHIP is jointly funded by the state and federal governments and is available for children aged 0–19 with income up to 200 percent of the federal poverty level so that low-income children can have access to health care, including inpatient and outpatient mental health and substance use services.

Chronic: Refers to a disease or condition that persists over a long period of time.

Cognitive therapy: Aims to identify and modify distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or self-destructive.

Cognitive behavioral therapy (CBT): A combination of cognitive and behavioral therapies that help people identify and modify maladaptive thought patterns, beliefs, and behaviors. Counseling is intended to be brief, time-limited and focused.

Conduct in need of supervision (CINS): Generally conduct committed by a minor that, if committed by an adult, could result in only a fine, or conduct that is not a violation if committed by an adult, such as truancy or running away from home.

Consumer: A person who is obtaining, or has obtained, conventional or alternative treatment or support for a mental health condition.

Consumer-operated service providers: Independent organizations operated and governed by individuals in recovery that deliver services through subcontracts with Local Mental Health Authorities (LMHAs), such as peer support, outreach, education and advocacy. A fundamental component of COSPs is peer support.

Crisis: A situation in which, due to a mental health condition, an individual presents an immediate danger to self or others or is at risk of serious deterioration of mental or physical health, or a situation in which an individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.

Crisis intervention services: Interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of an individual to a more restrictive environment. This service may be delivered to anyone experiencing a mental health crisis. This service does not require prior authorization.

Cyclothymia: A mood disorder characterized by periods of mild depression followed by periods of normal or slightly elevated mood.

DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition): A book published by the American Psychiatric Association that gives general descriptions and characteristic symptoms of different mental illnesses. Physicians and other mental health professionals use the DSM-V to confirm diagnoses for mental illnesses.

DM-ID (Diagnostic Manual – Intellectual Disability): A textbook of diagnoses of mental
disorders in persons with intellectual disabilities. This manual was developed cooperatively by the National Association of the Dually-Diagnosed and the American Psychiatric Association.

**Day treatment:** Treatment including special education, counseling, parent training, vocational training, skill building, crisis intervention and recreational therapy for at least 4 hours a day.

**Deductible:** The amount an individual must pay for health care expenses before insurance (or a self-insured company) begins to pay its contract share. Often insurance plans are based on yearly deductible amounts.

**Delusion:** An idiosyncratic belief or impression that is maintained despite being contradicted by what is generally accepted as reality.

**Developmental disability:** A severe, chronic disability of an individual that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is manifested before the individual attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (e) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

**Disease:** An impairment of health or functioning often characterized by physical findings and specific symptoms that are common among a number of individuals who ultimately receive a diagnosis of the disease in question.

**Disorder:** An interruption of the normal structure or function of the body or mind that is manifested by a characteristic set of physical findings or specific symptoms.

**Disproportionality:** Overrepresentation of a particular group of people in a particular group or system.

**Dose:** A quantity to be administered at one time, such as a specified amount of medication.

**Dually diagnosed:** This term refers to an individual who has co-occurring conditions. The term is often used when an individual has both a substance use disorder and a mental health condition, or an individual living with one or more developmental or intellectual disabilities and a substance use disorder or mental health condition.

**Dysthymic disorder:** A mood disorder characterized by feelings of sadness, loss of interest or pleasure in usual activities, and some or all of the following: altered appetite, disturbed sleep patterns, lack of energy, decreased ability to concentrate and feelings of hopelessness. Symptoms are less severe than those of major depressive disorder.

**Exclusionary discipline:** Disciplinary practices in schools that remove students from the classroom.

**Electroconvulsive therapy (ECT):** A highly controversial technique using electrical stimulation of the brain to treat some forms of major depression, acute mania and some forms of schizophrenia.

**Employee assistance plan (EAP):** Resources provided by employers either as part of, or separate from, employer-sponsored health plans. EAPs typically provide preventive care measures, various health care screenings and wellness activities.

**Euthymia:** Mood in the “normal” range, without manic or depressive symptoms.
Evidence-based practices (EBP): Integration of best research evidence, clinical experience, and patient values.

**Food and Drug Administration (FDA):** A federal agency whose responsibilities include protecting the public health by assuring the safety, efficacy, and security of prescription and over-the-counter drugs.

**Forensic commitment:** Patients on a forensic commitment fall into one of the following two categories: 1) the patient has been admitted to a hospital by judicial order because they have been determined not to have the capacity to stand trial, or 2) the patient has been determined to be not guilty by reason of insanity (NGRI).

**Generalized anxiety disorder (GAD):** An anxiety disorder characterized by consistent feelings of anxiety for a period of at least six months and accompanied by symptoms such as fatigue, restlessness, irritability and sleep disturbance.

**Generic:** Drugs that do not have a brand name but are typically required to be equivalent to a brand-name counterpart, with the same active ingredients, strength and dosage form and have the same medical effect. Some drugs are protected by patents and supplied by only one company. When the patent expires, other manufacturers can produce its generic version.

**Genetic:** Inherited; passed from parents to offspring through genes.

**Group-model health maintenance organization (HMO):** A health care model involving contracts with physicians organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

**Group therapy:** Therapy involving groups of usually 4 to 12 people who have similar experiences and who meet regularly with a mental health professional. The mental health professional uses the emotional interactions of the group’s members to help them get relief from distress and possibly modify their behavior.

**HMO (health maintenance organization):** A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.

**Halfway house:** A residential center or home where drug users, sex offenders, persons with mental illness, or individuals convicted of a felony are placed immediately after their release from a primary institution such as a prison, hospital or rehabilitation facility. The purpose of a halfway house is to allow the persons to begin the process of reintegration with society, while still providing monitoring and support; this is generally believed to reduce the risk of recidivism or relapse when compared to a release directly into society.

**Hallucination:** The perception of something, such as a sound or visual image, that is not actually present.

**Health and Human Services (HHS) Enterprise:** refers to state agencies under the Health and Human Services Commission (HHSC), including the Texas Department of State Health Services (DSHS), Texas Department of Family Protective Services (DFPS), Texas Department of Aging and Disability Services (DADS) and Texas Department of Assistive and Rehabilitative Services (DARS).

**Health Insurance Marketplace:** The Health Insurance Marketplace, also called the health exchange, was developed as a result of the Affordable Care Act and is accessible online. It allows a person to shop and enroll for a health plan. The Health Insurance Marketplace also lets you compare prices, coverage levels, and other details for health insurance plans.

**Health Homes:** Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid
who have chronic conditions. Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

**Home and Community Based Services (HCBS):** provides opportunities for Medicaid beneficiaries to receive services in their own home or community with the goal of preventing institutionalization.

**Homeless (USC 42 § 11302(a)):** An individual who lacks a fixed, regular, and adequate nighttime residence.

**Housing cost burden:** A housing cost burden exists when a household pays more than 30 percent of its total income before taxes and deductions toward housing.

**Housing first:** An approach that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the supportive services and connections to the community-based supports people needed to keep their housing and avoid returning to homelessness.

**Inpatient care:** The term refers to medical treatment that is provided in a hospital or other facility and requires at least one overnight stay.

**Intermediate Care Facilities (ICF-IDD):** Intermediate care facility/developmentally disabled is a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who may have a recurring but intermittent need for skilled nursing services.

**Individualized Education Plan (IEP):** A plan developed that specifies the behavioral supports and interventions to be provided by the school district for the students who receive special education services.

**Integrated health care:** The systematic coordination of primary and behavioral health services addressing the needs of the whole person.

**Juvenile defendant:** A person who is at least 10 years old but not yet 17 at the time he or she committed an act defined as “delinquent conduct” or “conduct in need of supervision.”

**Local Mental Health Authorities (LMHAs):** Also known as community mental health centers, LMHAs provide services to a specific geographic area of the state, called the local service area. LMHAs are required by the state to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area.

**Long-Term Services and Supports (LTSS):** May be provided in institutional settings or through community-based services. This may include assistance with activities of daily living, such as getting dressed, taking medication, preparing meals, habilitation, attendant care, specialized therapies, respite, managing money and more.

**Major Depressive Disorder (MDD):** A mood disorder characterized by intense feelings of sadness and hopelessness that persist beyond a few weeks.

**Mania:** Feelings of intense mental and physical hyperactivity, elevated mood and agitation.

**Manic-depression:** See bipolar disorder.

**Managed care:** An organized system for delivering comprehensive health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment. Generally, managed care controls health care costs and discourages unnecessary hospitalization and overuse of specialists. The health plan operates under contract to a payer.

**Managed care organizations (MCOs):** An organization that combines the functions of health insurance, delivery of care and administration. Services are available primarily through a network of providers contracting with the MCO.
**Medicaid**: A federal-state funded health insurance assistance program for low-income children and families and people with disabilities.

**Medicare**: A federal insurance program serving individuals with disabilities and persons over the age of 65. Most costs are paid via trust funds that beneficiaries pay into over the courses of their lives; small deductibles and co-payments are required.

**Medication training and support services**: Includes education on diagnosis, medications, monitoring and management of symptoms, and side effects.

**Medically indigent**: an individual who: (1) possesses no property; (2) has no person legally responsible for the patient’s support; and (3) is unable to reimburse the state for the costs of the patient’s support, maintenance and treatment.

**Medication therapy**: Prescription, administration, and assessment of drug effectiveness and monitoring of potential side effects of psychotropic medications.

**Mental health**: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

**Mental health prevention**: A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

**Mental health professionals**: A mental health professional is a health care practitioner who offers services for the purpose of improving an individual's mental health or to treat mental health conditions. This broad category includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, mental health counselors, professional counselors, peer professionals, pharmacists and many other professionals.

**Mental health condition**: A health condition that disrupts a person's thinking, feelings, mood, ability to relate to others or daily functioning and causes the person distress.

**Mental Health First Aid (MHFA)**: An in-person training to learn about mental illnesses and addictions, including risk factors and warning signs. The training also offers strategies on how to support individuals experiencing a mental health crisis.

**Mood disorders**: Disorders in which the essential feature is a disturbance of mood manifested as one or more episodes of mania, hypomania, depression, or some combination of bipolar I and bipolar II disorders, cyclothymic disorder, major depressive disorder and dysthymic disorder.

**Mood stabilizer**: Lithium and/or an anticonvulsant for treatment of bipolar disorder, often combined with an antidepressant.

**Neurotransmitters**: Chemicals that transmit information from one neuron to another by crossing the space between two adjacent neurons.

**NorthSTAR**: a publicly funded managed care approach to the delivery of behavioral health services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties. This service delivery model is referred to as a “carve-out,” as behavioral health services are provided through a behavioral health managed care organization and is not integrated with primary care services.

**Obsessive-compulsive disorder (OCD)**: An anxiety disorder characterized by recurrent thoughts, feelings, ideas or sensations (obsessions) or repetitive, ritualized behaviors (compulsions).

**Outcome measure**: A measure that identifies the results or impact that services, interventions and supports have on the individuals or communities.
Outpatient care: Health care that does not require an overnight stay in a hospital or health care facility.

Panic disorder: An anxiety disorder in which people have feelings of terror, rapid heartbeat and rapid breathing that strike suddenly and repeatedly without reasonable cause.

Patient Protection and Affordable Care Act (ACA): A United States federal statute established in March 23, 2010 that is characterized as the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Permanent supportive housing: An evidence-based practice that combines stable and affordable living arrangements with access to flexible health and human services designed to promote recovery for people with behavioral health conditions.

Pharmacological management services: Includes supervision of administration of medication, monitoring of effects and side effects of medication, and assessment of symptoms. Includes one psychiatric evaluation per year.

Phobia: An intense or irrational fear of something. Examples of phobias include fear of closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs and injuries involving blood.

Post-Traumatic Stress Disorder (PTSD): A mental health condition that is triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.

Primary care physician (PCP): The PCP is responsible for monitoring an individual’s overall medical care and referring the individual to more specialized physicians for additional care. Typically PCPs are included in the following specialties: group practice, family practice, internal medicine, obstetrics/gynecology and pediatrics.

Promising practice: A prevention or treatment intervention that shows positive outcomes but does not have the same level of rigorous scientific evaluation as evidenced-based practice.

Psychiatric/psychotherapeutic/psychotropic medications: Medications capable of affecting the mind, emotions and behavior that are used to treat or manage a psychiatric symptom or challenging behavior.

Psychiatrist: A medical doctor who specializes in the diagnosis, treatment and prevention of mental illness.

Psychologist: A health care professional who diagnoses and treats mental, nervous, emotional and behavioral conditions.

Psychosis: A severe mental health condition in which thought and emotions are so impaired that a person loses contact with external reality.

Psychotherapy: A treatment method for mental health concerns in which a mental health professional and a consumer discuss needs and feelings to find solutions. Psychotherapy can help individuals change their thought or behavior patterns and understand how past experiences affect current behaviors.

Public Housing Agency (PHA): A governmental entity that is responsible for the operation of subsidized housing and rental assistance programs.

Rapid cycling: Experiencing changes in mood from mania to major depression, or mixed states, within hours, days or months.

Receptor: A molecule that recognizes specific chemicals, including neurotransmitters and hormones, and transmits the message into the cell on which the receptor resides.
Recidivism: The tendency to relapse into a previous type of behavior.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Rehabilitative case management: A form of service that provides a variable level of integrated support to people including assistance in accessing medical, social, psychological, educational and other appropriate support services. Where routine case management is similar to basic service coordination and has higher caseloads, rehabilitative case management is similar to the Medicaid service of targeted case management.

Relapse: The reoccurrence of symptoms of a disease; a deterioration in health after a temporary improvement.

Rental assistance: Rental assistance funds help tenants with low incomes afford rent at or near market rate for specified housing units. Typically, rental assistance funds allow eligible tenants to pay approximately 30 percent of their income toward rent. A subsidy pays the difference between that amount and the market rent for the specific unit.

Residential treatment: Behavioral health services provided at a residential health care facility.

Routine case management: A form of service that includes basic facilitation of access to resources and services and coordination of services with the individual, as well as administration of instruments to assess treatment progress.

Seclusion and Restraint: Techniques used by administrators and staff to isolate (seclude) or restrict (restrain) movement of individuals. Restraints may be physical, mechanical, or chemical.

Serotonin: A neurotransmitter that most likely contributes to the regulation of sleep, appetite and mood. People experiencing depression or anxiety often have a serotonin deficiency.

Signs: Indications of illness that are observed by the examiner rather than reported by the individual.

Skilled Nursing Facility: Licensed healthcare facility that serves chronically ill, usually elderly patients, and provides long-term nursing care, rehabilitation, and other services.

Social Security Disability Insurance (SSDI): A federal supplemental income for individuals or their family members who have a disability, have worked in a job covered by Social Security, and have paid enough money into the Social Security program. SSDI is funded by Social Security taxes.

Social Security Income (SSI): A federal supplemental income funded by general tax revenue, not Social Security taxes. SSI is for people with limited income and who have a qualifying disability or are over 65.

Serious Emotional Disturbance (SED): A group of psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

State hospital: A hospital run by the state for the care and treatment of patients affected with acute or chronic mental illness; also called a mental health hospital or a state psychiatric facility.

State Supported Living Center (SSLC): Large institutions that provide 24-hour residential services to people with intellectual and developmental disabilities; formerly called state schools.

Stigma: A negative stereotype about a group of people.

Supported employment: A service that provides individualized assistance in choosing and
obtaining employment at integrated work sites in the community of the consumer’s choice. It includes supports provided by identified staff that will assist individuals in keeping employment and finding another job as necessary. This may include the services of a job coach to support the individual at the job site.

**Symptom:** An indication of a disease or other disorder experienced by the patient

**Syndrome:** A collection of physical signs and symptoms that, when occurring together, are characteristic of a specific condition.

**System of Care:** An organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated community-based services for youth with a serious emotional disturbance and their families

**Substance use disorder:** A medical condition that includes the abuse or dependence on alcohol or drugs.

**Sunset review:** The Sunset Advisory Council’s periodic evaluation of state agencies in order to determine whether an agency’s functions are still needed and whether it operates efficiently and effectively.

**Telemedicine/Telehealth:** The use of technology to deliver health care services.

**Trauma:** Occurs from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.

**Trauma-informed approach:** Treatment interventions that specifically addresses the consequences of trauma on an individual and are designed to facilitate healing. A trauma-informed approach has the following principles: safety, trustworthiness, peer support, collaboration and mutuality, empowerment, voice, and choice. Trauma-informed support should also consider cultural, historical, and gender issues.

**Traumatic Brain Injury (TBI):** Caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

**Third-party payer:** A public or private organization that is responsible for the health care expenses of another entity.

**Veteran:** Somebody formerly in the armed forces.

**Vocational rehabilitation services:** Services that include job finding, development, assessment and enhancement of work-related skills, as well as provision of job experience to individuals.

**Sources:**

- Institute of Medicine
- National Institute of Mental Health
- U.S. Dept. of Health and Human Services
- Substance Abuse Mental Health Services Administration (SAMHSA)
- Texas Resilience and Recovery
- Various medical dictionaries
Texas Medicaid Managed Care Plans

(Retrieved from http://www.hhsc.state.tx.us/medicaid/managed-care/plans.shtml.)

Map of service delivery areas for STAR and STAR+PLUS
## STAR Service Areas

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Managed Care Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar</td>
<td>Aetna Better Health, Amerigroup, Community First Health Plans, Superior HealthPlan</td>
</tr>
<tr>
<td>Dallas</td>
<td>Amerigroup, Molina Healthcare of Texas, Parkland HEALTHfirst</td>
</tr>
<tr>
<td>El Paso</td>
<td>El Paso First Premier Plan, Molina Healthcare of Texas, Superior HealthPlan</td>
</tr>
<tr>
<td>Harris</td>
<td>Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children’s Health Plan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>Driscoll Children’s Health Plan, Molina Healthcare of Texas, Superior HealthPlan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children’s Health Plan, UnitedHealthcare Community Plan</td>
</tr>
<tr>
<td>Lubbock</td>
<td>Amerigroup, FirstCare Star, Superior HealthPlan</td>
</tr>
<tr>
<td>Nueces</td>
<td>Christus Health Plan, Driscoll Children’s Health Plan, Superior HealthPlan</td>
</tr>
<tr>
<td>Tarrant</td>
<td>Aetna Better Health, Amerigroup, Cook Children’s Health Plan</td>
</tr>
<tr>
<td>Travis</td>
<td>Blue Cross Blue Shield of Texas, Sendero Health Plans, Seton Health Plan, Superior HealthPlan</td>
</tr>
<tr>
<td>MRSA Northeast Texas</td>
<td>Amerigroup, Superior</td>
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<tr>
<td>MRSA Central Texas</td>
<td>Amerigroup, Scott &amp; White, Superior</td>
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<tr>
<td>MRSA West Texas</td>
<td>Amerigroup, FirstCare, Superior</td>
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## STAR+PLUS Service Areas

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<td>Amerigroup, Molina Healthcare of Texas, Superior HealthPlan</td>
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<tr>
<td>Harris</td>
<td>Amerigroup, Molina Healthcare of Texas, UnitedHealthcare Community Plan</td>
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<td>Hidalgo</td>
<td>Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan</td>
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<td>Tarrant</td>
<td>Amerigroup, Cigna-HealthSpring</td>
</tr>
<tr>
<td>Travis</td>
<td>Amerigroup, United Healthcare Community Plan</td>
</tr>
<tr>
<td>MRSA Northeast Texas</td>
<td>Cigna-Healthspring, UnitedHealthcare</td>
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<tr>
<td>MRSA Central Texas</td>
<td>Superior HealthPlan, UnitedHealthcare Community Plan</td>
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<td>MRSA West Texas</td>
<td>Amerigroup, Superior HealthPlan</td>
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### Children’s Health Insurance Program (CHIP) or Children’s Medicaid Service Areas

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### STAR HEALTH

Superior HealthPlan Network (Superior) is the sole managed care company selected by Health and Human Services to provide medical and behavioral health services for children and young adults (up to age 22) in the Department of Family Protective Services conservatorship or extended foster care.
Advisory Committees

**Texas Health and Human Services Commission (HHSC)**

**HHSC Council:**
http://www.hhsc.state.tx.us/about_hhsc/hhsc_council.shtml
- Assists the executive commissioner in developing rules and policies for the commission.

**Behavioral Health Integration Advisory Committee:**
http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/bhic.shtml
- Charged with addressing initial planning and development needed to integrate Medicaid behavioral health services into managed care by September 1, 2014. Phase II recommendations will address systemic changes needed to create a truly integrated system.

**Children’s Policy Council:**
http://www.hhsc.state.tx.us/si/cpc/index.shtml
- Helps in developing, implementing, and administering family support policies and related long-term care and health programs for children. Develops recommendations for the legislature and executive commissioner.

**Consumer Direction Workgroup:**
http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/cdw/index.shtml
- Advises HHSC regarding consumer directed services in many programs providing long term services and supports and mental health services.

**Council on Children and Families:**
http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/Council.shtml
- Established during the 2009 legislative session to help improve the coordination of state services for children.

**Hospital Payment Advisory Committee:**
http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/hpac.shtml
- Advises HHSC to ensure reasonable, adequate, and equitable payments to hospital providers and to address the essential role of rural hospitals.

**Intellectual and Developmental Disability System Redesign Advisory Committee:**
http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/iddsrac.shtml
- Advises HHSC and DADS on the implementation of the acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities.
Medicaid and CHIP Regional Advisory Committees: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/MedicaidCHIP_RAC.shtml](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/MedicaidCHIP_RAC.shtml)

- Accepts public input on Medicaid and CHIP and provides recommendations on the program to HHSC.

Medicaid/CHIP Quality-Based Payment Advisory Committee: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/med-chip-qbp/](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/med-chip-qbp/)

- Advises HHSC on Medicaid and CHIP reimbursement systems, standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability of managed care organizations, health care providers and facilities.

Medical Care Advisory Committee: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/MCAC.shtml](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/MCAC.shtml)

- Federally mandated to review and make recommendations to state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs.

Physician Payment Advisory Committee: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/PPAC.shtml](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/PPAC.shtml)

- Functions as a subcommittee of the Medical Care Advisory Committee to advise the committee and HHSC about technical issues regarding physician payment policies.

Promoting Independence Advisory Committee (PIAC): [http://www.dads.state.tx.us/providers/pi/piac/](http://www.dads.state.tx.us/providers/pi/piac/)

- Advises in the development of a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities. Created in response to the U.S. Supreme Court’s *Olmstead* Decision.

Qualifications for Health Care Translators and Interpreters: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/HCT/default.shtml](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/HCT/default.shtml)

- Advises on various items related to qualifications for health care interpreters and translators.

SB 1220 Medicaid and CHIP Border Rates and Expenditures Advisory Committee: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/border-rates/](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/border-rates/)

- Advises HHSC regarding eliminating the disparities between the Texas-Mexico border region and other areas of the state in capitation rates, fee-for-service per capita expenditures and total professional services expenditures for Medicaid and CHIP enrollees under age 19.

STAR Kids Managed Care Advisory Committee: [http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/STAR-kac.shtml](http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/STAR-kac.shtml)

- Advises on the development and implementation of the STAR Kids Medicaid managed care program.
STAR+PLUS Quality Council: http://www.hhsc.state.tx.us/about_hhsc/Advisory-Committees/STARPLUS-qc.shtml
- Advises on the development of policy recommendations to ensure eligible Medicaid consumers receive quality, person-centered, consumer-directed acute care and long-term services and supports in an integrated setting.

State Medicaid Managed Care Advisory Committee: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/smmcac.shtml
- Provides recommendations and ongoing input on the statewide implementation and operation of Medicaid managed care.

- Informs state leadership of the needs of people with brain injuries and their families.

- Charged with developing a comprehensive five-year strategic plan to address the needs of children with chronic illnesses, intellectual or other developmental disabilities or serious mental illness.

Task Force on Domestic Violence: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/tfdv/
- Created during 2013 Texas legislative session to examine the effect of domestic violence on the health of mothers and children and ways to improve health services for domestic violence victims.

Telemedicine Advisory Committee: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/TelemedicineAdvisoryCommittee.shtml
- State-mandated advisory committee assists HHSC to evaluate reimbursable services and delivery processes, as well as monitor type of programs receiving these services.

Texas Department of Aging and Disability Services (DADS)

Aging Texas Well Advisory Committee (ATW): http://www.dads.state.tx.us/services/agingtexaswell/about/committee/index.html
- Advises on implementing the Aging Texas Well Initiative.

Nursing Facility Administrator Advisory Committee (NFAAAC): http://www.dads.state.tx.us/news_info/council/nfaac/
- Provides recommendations for licensure sanctions and rule changes for the Nursing Facility Administrator Licensing Program.
Employment First Task Force: [http://www.dads.state.tx.us/providers/support-educationemployment/pi/index.html](http://www.dads.state.tx.us/providers/support-educationemployment/pi/index.html)
- Promotes competitive employment of individuals with disabilities and the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as any other working-age adult.

Money Follows the Person Demonstration Advisory Committee (MDPDAC): [http://www.dads.state.tx.us/providers/pi/mfp_demonstration/committee.html](http://www.dads.state.tx.us/providers/pi/mfp_demonstration/committee.html)
- Participates in the design of the operational protocol and monitors implementation of the demonstration project throughout the five-year period.

Texas Department of Assistive and Rehabilitative Services (DARS) DARS Council: [http://www.dars.state.tx.us/councils/darscouncil/dc.shtml](http://www.dars.state.tx.us/councils/darscouncil/dc.shtml)
- Helps develop rules and policies for the Department.

- Advises on policy vocational rehabilitation services and eligibility requirements.

ECI Advisory Committee: [http://www.dars.state.tx.us/councils/eci/eci.shtml](http://www.dars.state.tx.us/councils/eci/eci.shtml)
- Advises the DARS Division for Early Childhood Intervention Services on development and implementation of policies that constitute the statewide ECI system.

- Is an equal partner with DARS in the development, approval, and implementation of the State Plan for Independent Living.

- Is responsible for testing and certifying the skill level of individuals seeking to become certified interpreters in Texas.

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)**

Council on Planning & Advising (CAP) for the Prevention & Treatment of Mental and Substance Use Disorders: [https://www.dshs.state.tx.us/mhsa/cap/](https://www.dshs.state.tx.us/mhsa/cap/)
- Monitors, reviews, evaluates and makes recommendations regarding the allocation and adequacy of mental and substance use disorder prevention, treatment, recovery and resilience support services in Texas.

DSHS Council: [www.dshs.state.tx.us/council/default.shtm](http://www.dshs.state.tx.us/council/default.shtm)
- Assists DSHS and HHSC in developing rules and policies for DSHS. Provides a forum for public input into rules, policies, and budget priorities.

Drug Demand Reduction Advisory Committee: [http://www.dshs.state.tx.us/sa/ddrac/](http://www.dshs.state.tx.us/sa/ddrac/)
- Provides information for the Governor, Legislature and public about issues relating to reducing drug demand. Charged with creating and coordinating implementation of a drug demand reduction strategy.
**Local Authority Network Advisory Committee:** [http://www.dshs.state.tx.us/mh-community/lanac/](http://www.dshs.state.tx.us/mh-community/lanac/)

- Advises on technical and administrative issues that directly affect local mental health authority responsibilities, evaluation and coordination of initiatives, and development of flexible and responsive contracts. Reviews rules related to local mental health authority operations.

**MEDCARES Advisory Committee:** [www.dshs.state.tx.us/mch/medcares.shtm/](http://www.dshs.state.tx.us/mch/medcares.shtm/)

- Advises DSHS and the HHSC Executive Commissioner in establishing rules and priorities for the use of grant funds to improve the assessment, diagnosis, and treatment of child abuse and neglect and assists in the review of the report to the Governor.

**Promotor(a) Community Health Worker Training & Certification Advisory Committee:** [www.dshs.state.tx.us/mch/chw.shtm](http://www.dshs.state.tx.us/mch/chw.shtm)

- Advises DSHS on rules concerning training and regulation of promotores/community health workers.

**Public Health Funding and Policy Committee:** [www.dshs.state.tx.us/phfpcommittee/](http://www.dshs.state.tx.us/phfpcommittee/)

- Defines core public health services a local health entity should provide in a county or municipality; evaluates public health in the state and identifies initiatives for areas that need improvement; identifies funding sources available to local health entities; establishes public health policy priorities; and makes recommendations annually.

**State Prevention Health Advisory Committee:** [https://www.dshs.state.tx.us/Advisory-Committees.aspx](https://www.dshs.state.tx.us/Advisory-Committees.aspx)

- Works with DSHS in development and implementation of state plan for the Preventive Health and Health Services Block Grant.

**Statewide Health Coordinating Council:** [http://www.dshs.state.tx.us/chs/shcc/](http://www.dshs.state.tx.us/chs/shcc/)

- The purpose of the SHCC is to ensure health care services and facilities are available to all Texans through health planning activities. Based on these planning activities, the SHCC makes recommendations to the governor and the legislature through the Texas State Health Plan (TSHP).

**Texas School Health Advisory Committee:** [www.dshs.state.tx.us/schoolhealth/shadvise.shtm](http://www.dshs.state.tx.us/schoolhealth/shadvise.shtm)

- Provides assistance to the DSHS Council in supporting and delivering coordinated school health programs.

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**TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)**

**DFPS Council:** [https://www.dfps.state.tx.us/About_DFPS/Council/](https://www.dfps.state.tx.us/About_DFPS/Council/)

- Created in 2004 as part of the HHS Transformation

Consolidate the five HHS system agencies into one agency called the Health and Human Services Commission with divisions established along functional lines and with a 12-year Sunset date.

Require formation of a transition legislative oversight committee and the development of a transition plan and detailed work plan to guide HHSC and the committee in setting up the new structure.

### Issue 3: Fragmented Administration of Medicaid Leads to Uncoordinated Policies and Duplicative Services and Could Place Future Transitions to Managed Care at Risk.

Consolidate administration of Medicaid functions at HHSC.

### Issue 4: HHSC Has Not Fully Adapted Its Processes to Managed Care, Limiting the Agency’s Ability to Evaluate the Medicaid Program and Provide Sufficient Oversight.

Require HHSC to regularly evaluate the appropriateness of data, automate its data reporting processes, and comprehensively evaluate the Medicaid program on an ongoing basis.

Adapt processes for the state’s prescription drug program, audits, and advisory committees to reflect the state’s transition to managed care.

Eliminate the Pharmaceutical and Therapeutics Committee and transfer its functions to the Drug Utilization Review Board to create a single entity to oversee these related responsibilities.

### Issue 5: Fragmented Provider Enrollment and Credentialing Processes Are Administratively Burdensome and Could Discourage Participation in Medicaid.

Require HHSC to streamline the Medicaid provider enrollment and credentialing process.

Require OIG to no longer conduct criminal history checks for providers already reviewed by licensing boards, develop criminal history guidelines for checks it will continue to perform, and complete background checks within 10 days.

### Issue 6: The State is Missing Opportunities to More Aggressively Promote Methods to Improve the Quality of Health Care.

Require HHSC to develop a comprehensive, coordinated operational plan designed to ensure consistent approaches in its major initiatives for improving the quality of health care.

Require HHSC to promote increased use of incentive-based payments by managed care organizations, including development of a pilot project.

### Issue 9: NorthSTAR’s Outdated Approach Stifles More Innovative Delivery of Behavioral Health Services in the Dallas Region.

Transition behavioral health services for both Medicaid and indigent populations in the Dallas area from NorthSTAR to an updated model, including associated legislative funding changes.

Require the state to assist with maintenance of Medicaid eligibility and ensure full integration of behavioral health services into managed care organizations statewide.

### Issue 12: HHSC’s Uncoordinated Approach to Websites, Hotlines, and Complaints Reduces Effectiveness of the System’s Interactions with the Public.

Require HHSC to create an approval process and standard criteria for all system websites.
### DEPARTMENT OF STATE HEALTH SERVICES (DSHS)

**Issue 1: Resolving the Current Crisis in the State Mental Health Hospital System Requires Action, Starting Now.**

- Require DSHS to work with the Court of Criminal Appeals to develop training to inform the judiciary about alternatives to inpatient mental health treatment, including developing a guide of alternative inpatient treatment options.
- DSHS and the Health and Human Services Commission should immediately review and streamline human resources policies to ensure state mental health hospitals are appropriately staffed, and continue expanding capacity by contracting with mental health providers in local communities whenever possible.
- Continue evaluating the management and oversight of the state mental health hospital system, including possible organizational alternatives, as part of the larger Sunset review of the health and human services system to be completed in the fall of 2014.

**Issue 2: DSHS Has Struggled to Deliver Integrated, Outcomes-Focused Community Mental Health and Substance Abuse Services.**

- Require DSHS to integrate mental health and substance abuse hotline, screening, and assessment functions.
- Require DSHS to focus funding equity efforts for local mental health authorities on targeted capacity needs rather than narrow per capita funding.
- Require DSHS to overhaul regulations for community-based behavioral health treatment facilities, including creating new license types if necessary.
- Improve DSHS’ behavioral health stakeholder input process by removing two advisory committees from statute and re-establishing another existing advisory committee.

**Issue 8: DSHS’ Numerous Advisory Committees Lack Strategic Purpose, Limiting Their Effectiveness and Wasting Resources.**

- Remove eight of DSHS’ advisory committees from statute and direct DSHS to re-establish active committee functions in rule as needed.
- Direct DSHS to review and revise its internal advisory committee policies and to regularly evaluate all of its advisory groups.

**Issue 9: The State Should Continue Protecting Public Health and Providing Basic Health Services, but Decisions on DSHS’ Structure Await Further Review.**

- Postpone the decision on continuation of DSHS’ functions and structure until the completion of the Sunset review of the health and human services system.
## Department of Aging and Disability Services (DADS)

<table>
<thead>
<tr>
<th>Issue 1: Despite Declining Enrollment, Skyrocketing Costs, and Questionable Quality of Care, Texas Continues to Operate 13 SSLCs.</th>
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<tbody>
<tr>
<td>Require DADS to close the Austin SSLC by August 31, 2017.</td>
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<tr>
<td>Establish the State Supported Living Center Closure Commission to evaluate the SSLCs and determine an additional five centers to close.</td>
</tr>
<tr>
<td>Require DADS to close the five SSLCs determined by the SSLC Closure Commission no later than August 31, 2022.</td>
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</tbody>
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<tr>
<th>Issue 2: To Transition From SSLCs to the Community, People With Higher Behavioral and Medical Needs Require Extra Support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require DADS to expand crisis intervention teams to provide increased supports to people with IDD in the community.</td>
</tr>
<tr>
<td>Require DADS and HHSC, in rule, to add a reimbursement level that incentivizes providers to open small specialized group homes for people with high medical needs.</td>
</tr>
<tr>
<td>Amend statute to require DADS to establish, in rule, the array of services an SSLC can provide to community clients and the fees for those services.</td>
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<tr>
<td>Require DADS to develop, in rule, requirements for contract provisions regarding basic safety and service requirements that its community-based IDD waiver and intermediate care facility providers should include in their contracts with day habilitation facilities.</td>
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<tr>
<td>Require DADS to compile basic information and data on day habilitation facilities providing services to persons in DADS programs, including data on violations and deficiencies found during inspections.</td>
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<tr>
<th>Issue 6: DADS’ Consumer Information Website Lacks Clear and Consistent Information For Helping the Public Select Long-Term Care Providers.</th>
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<tr>
<td>Require DADS to maintain a consumer information site on the quality of long-term care providers in Texas.</td>
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<tr>
<td>Direct DADS to improve the quality and consistency of information available on the Quality Reporting System for all providers.</td>
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<tr>
<th>Issue 8: Texas Has a Continuing Need for DADS’ Services, but Decisions on the Agency’s Structure Await Sunset’s Analysis of the HHS System Overall.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpone decisions on continuation of DADS’ functions and structure until completion of the Sunset review of the health and human services system.</td>
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</table>

## Department of Family and Protective Services (DFPS)

<table>
<thead>
<tr>
<th>Issue 1: Efforts to Reduce Turnover of CPS Caseworkers Fail to Address Key Reasons Many Staff Leave.</th>
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<tbody>
<tr>
<td>Direct DFPS to consolidate its existing workforce management functions under one operational unit and add additional critical functions to better support employees and systematically identify root causes of turnover.</td>
</tr>
</tbody>
</table>
Direct DFPS to dedicate certain existing caseworker positions to create a mentoring program to better support new CPS caseworkers.

CPS should revise its system for evaluating caseworker performance by better measuring casework quality and ensuring performance expectations are reasonable.

DFPS should develop a systematic way of using turnover, when appropriate, as a tool for judging performance of CPS regional management.

**Issue 2: A Crisis Culture Affects CPS' Ability to Focus on Day-to-Day Management Activities Needed to Successfully Perform Its Difficult Work.**

Direct CPS to implement an annual business planning process.

Direct DFPS to report to the Sunset Commission in October 2014 on changes it plans to implement in response to the CPS operational assessment currently in progress, and any statutory barriers that may impede needed changes.

Direct DFPS to comprehensively review and update the CPS policy and procedures handbook and develop a systematic approach to its policymaking process to ensure clear, updated policies and procedures.

Direct CPS to develop a systematic, comprehensive approach to evaluating and monitoring regional performance, including a process to verify implementation of recommendations for improvement.

**Issue 3: DFPS Faces Significant Challenges and Risks in Its Efforts to Reform the State's Foster Care System.**

Require DFPS to develop and maintain a long-range foster care redesign implementation plan to guide the agency’s transition efforts.

DFPS should evaluate system data and cost before broader implementation of foster care redesign.

DFPS should develop a consistent approach to measuring and monitoring provider quality and identifying risk indicators in both the legacy and redesigned systems.

**Issue 4: DFPS' Enforcement Efforts Must Be Strengthened to Best Ensure the Safety of Children in Regulated Care.**

Authorize the agency to assess administrative penalties for high-risk child care licensing violations without first pursuing non-monetary administrative sanctions.

Require DFPS to develop an enforcement policy in rule to guide child care licensing enforcement efforts, and require a specific methodology to be publicly available.

**Issue 5: CPS Does Not Capture Comprehensive Information to Adequately Address How Well It Is Protecting Children.**

Direct DFPS to improve its collection and evaluation of data by adding an additional measure of recidivism linked to the alleged perpetrator, clarifying and standardizing the use of unsure case findings, and broadening its child fatality investigation review process.

DFPS should develop a clear and consistent policy for referring families to Family-Based Safety Services and develop outcome measures linked to specific services provided.

**Issue 6: DFPS Should Elevate the Importance of Its Prevention and Early Intervention Efforts and Better Use Existing Data to Evaluate Program Effectiveness.**

Require DFPS to develop a comprehensive strategic plan for its prevention and early intervention programs and develop a strategy to use existing data to better focus its prevention efforts and report the outcomes of its programs.

Transfer HHSC's home visiting programs and DSHS' Pregnant Post-Partum Intervention and Parenting Awareness and Drug Risk Education programs to DFPS.

**Issue 7: A Lack of Administrative Flexibility and an Antiquated Fee Collection Process Limit DFPS' Ability to Recover Regulatory Costs.**

Eliminate the agency’s statutory licensing and administrative fee caps and authorize fees to be set in rule.
Direct DFPS to transition to online child care licensing fee collections.

### Issue 8: The Critical Nature of Its Work to Protect Children and Vulnerable Adults
Imposes a Higher Burden on DFPS in How It Obtains Stakeholder Input.

Require rules governing the use of advisory committees, ensuring committees meet standard structure and operating criteria, and direct DFPS to clearly define in agency policy the appropriate use of advisory committees and informal workgroups.

### Issue 9: Consider Organizational Aspects Related to Family and Protective Services as Part of an Overall Assessment of Health and Human Services Agencies.

Postpone the decision on continuation of DFPS’ functions and structure until the completion of the Sunset review of the health and human services system.
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Mission

The Hogg Foundation for Mental Health advances mental wellness for the people of Texas as an impactful grantmaker and catalyst for change.

Hogg Foundation for Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

Hogg Foundation for Mental Health
Division of Diversity and Community Engagement
The University of Texas at Austin | 3001 Lake Austin Blvd., Fourth Floor | Austin, TX 78703
512.471.5041
www.hogg.utexas.edu