



A Guide to
**Understanding Mental Health
Systems and Services in Texas**

2nd Edition - 2014

75
YEARS



Hogg Foundation
for Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

ACKNOWLEDGEMENT

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.

First Edition: November 2012

Second Edition: November 2014

SUGGESTED CITATION:

Hogg Foundation for Mental Health. (Month, 2014). A guide to understanding mental health systems and services in Texas. Retrieved from <http://www.hogg.utexas.edu>

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.



Contents

Overview	11
Introduction	15
The National Context	19
Recent Federal Health Care Initiatives Impacting Behavioral Health	20
The New Freedom Commission and Transformation of Behavioral Health Care	20
Presidential Mental Health Initiatives	20
The Patient Protection and Affordable Care Act (ACA)	22
Key Features	22
Essential Health Benefits	23
Establishment of “Benchmark Plans”	23
Health Insurance Marketplace	24
Medicaid Expansion	24
Expanding the Health Care Workforce	25
Mental Health Parity and Addiction Equity Act	25
Established Federal Health Care Programs Impacting Behavioral Health	26
Medicare	26
Medicare and Medicaid (Dual Eligibility)	28
Texas Dual Eligibles Integrated Care Demonstration Project	29
Supplemental Social Income (SSI) and Social Security Disability Insurance (SSDI)	30
The Texas Environment	33
Impact of the Affordable Care Act on Behavioral Health Services in Texas	33
Federal Health Insurance Marketplace	33
Texas Department of Insurance and Rules for Navigators	35
Medicaid Expansion	35
Health Homes	37
Behavioral Health Implications of Health and Human Service Initiatives	38
Medicaid Managed Care Expansion in Texas	38
Senate Bill 58 (SB 58)	38
Senate Bill 7 (SB 7)	39
1115 Waiver: Texas Health Care Transformation and Quality Improvement Program	40
1915(i) State Plan Amendment: Home and Community-Based Services–Adult Mental Health Program (HCBS-AMH)	41
Health and Human Service Commission Sunset Review	42
Mental Health Workforce Shortages	44
Workforce Availability in Texas	45
Behavioral Health Professionals in Texas	46
Texas Mental Health Code	47
HB 3793 – Mental Health Advisory Panel	47
Addressing the Mental Health Needs of Individuals with Intellectual and Other Developmental Disabilities (IDD)	48
Boarding Homes	49
Peer Support Services	51
Youth Empowerment Services (YES) Waiver	52
Trauma-Informed Care	52
Forensic Restoration of Competency Lawsuit	53

Public Behavioral Health Services in Texas 55

Texas Health and Human Services Commission 57

Funding	60
Changing Environment	62
SB 58 - Integration of Behavioral Health Services	62
SB 7 - Managed Care Expansion and Intellectual/Developmental Disability Redesign	63
Medicaid	64
State Medicaid Agency	64
Medicaid Funding	68
Eligibility for Medicaid Services	69
Demographics of Medicaid Recipients	71
Federally Qualified Health Centers	72
Medicaid Buy-In Programs (Adults and Children)	72
Medicaid Health Insurance Premium Payment Program (HIPPP)	72
Texas Medicaid and Healthcare Partnership (TMHP)	73
Children's Health Insurance Program (CHIP)	73
Eligibility for CHIP	73
Enrollment, Utilization and Costs	73
Behavioral Health Quality of Care Measures	75

Texas Department of State Health Services 77

Changing Environment	80
Trends and Prevalence	82
Funding	82
System Utilization	84
Waitlists	85
Timeline of Mental Health Service Initiatives	87
Access	88
Medicaid	88
Medically Indigent People	89
Priority Populations	89
Service Providers	90
Medicaid Managed Care	90
Local Mental Health Authorities	91
NorthSTAR	93
Community Mental Health Services	94
Texas Resilience and Recovery Framework	94
Adult Service Utilization and Costs	96
Quality of Care Measures	96
Youth Service Utilization and Costs	99
Quality of Care Measures	100
Crisis Services	100
Crisis Services Utilization and Costs	102
Quality of Care Measures	102
NorthSTAR Services	103
NorthSTAR Service Utilization and Costs	104
Quality of Care Measures	105
Inpatient Mental Health Hospital Services	105
Civil	105
Forensic	106
Maximum Security	106
Types of Inpatient Settings	106
State Hospitals	106
Funding	108
Institutions for Mental Diseases (IMD) Exclusion	108
State Hospital Utilization and Costs	109

Recidivism Rates	109
State-Funded Community and Private Hospitals	110
Competency Restoration	111
State Psychiatric Inpatient Competency Restoration	111
Outpatient Competency Restoration	112
Jail-Based Competency Restoration	112
Addressing the Shortage of Public Inpatient Beds	113
Substance Use Services	115
Access	116
Funding	116
Eligibility for Services	117
Priority Populations	117
Co-occurring Psychiatric and Substance Use	117
Disorders	117
Services	118
Utilization and Costs	119
Quality of Care Measures	121
Promising Practices in Substance Use Treatment	122
The Texas Recovery Initiative	122

Texas Department of Family and Protective Services **123**

Changing Environment	126
Foster Care Redesign	126
Parental Relinquishment of Custody	127
Specialty Courts	128
Accessing Mental Health Services	132
Superior Health System (STAR Health)	132
Former Foster Care Children Program (FFCC)	132
Institutional Residential Services	134
Alternative Response System	134
System of Care	135
Continuing Issues	135
Child Fatalities in the CPS System	135
Disproportionality	137
Lesbian, Gay, Bisexual, Transgender, Queer Youth	138
Psychotropic Medications	139
Trauma-Informed Care	141
Seclusion and Restraint	142
Prevention and Early Intervention (PEI)	142
Adult Protective Services (APS)	145
Child Care Licensing	147

Texas Department of Aging and Disability Services **149**

Prevalence of Behavioral Health Conditions for People with Disabilities and Aging Texans	152
People with Disabilities	152
Aging Texans	152
Changing Environment	153
SB 7	153
SB 45	153
SB 1226	153
Trauma-informed care and person-centered planning, training and technical assistance at San Angelo and Mexia State Supported Living Centers	154
2013 Trauma-informed care trainings at DADS waiver conferences	154
Programs and Services for People with Disabilities Who Have Co-occurring Behavioral Health Conditions	154
Community Long-Term Services and Supports	
Medicaid 1915(c) Waiver Services	155
Role of Local Authorities in Connecting People to Waiver Services	158
Institutional Long-Term Services and Supports	158
Skilled Nursing Facilities	158
Community Intermediate Care Facilities	159

State Supported Living Centers	159
Additional Programs for People with Disabilities and Aging Texans	165
Non-Medicaid Services	165
Guardianship Program	165
Promoting Independence Initiative	165
Money Follows the Person Program	166

Texas Department of Assistive and Rehabilitative Services **167**

Division for Early Childhood Intervention Services	170
Eligibility for Services	170
Services, Utilization, and Costs	171
Division for Rehabilitation Services	172
Vocational Rehabilitation Program	173
Program Overview	173
Eligibility Process	174
Services	174
Independent Living Services	175
Expansion	175
Eligibility	176
Services	176
Division of Disability Determination Services (DDS)	176
Process for Admission and Eligibility	178
Utilization	179
Division for Blind and Visually Impaired	179

Texas Department of Criminal Justice and Local Criminal Justice Agencies **181**

Changing Environment	184
83rd Session Criminal Justice and Mental Health Legislation	184
Overview of Texas Criminal Justice System	185
Texas Department of Criminal Justice	187
Financial Summary	188
Behavioral Health Services and Programs in the State Criminal Justice System	190
Access to Services	191
Behavioral Health Services	191
Post-Incarceration Community-Based Services	193
Medically Recommended Intensive Supervision	194
Release on Parole Special Programs	194
Special Concerns for Female Inmates	195
Local Criminal Justice Systems	195
Texas Commission on Jail Standards	196
Incarceration Prevention Programs	197
Jail Diversion	197
Specialty Courts	198

Texas Juvenile Justice Department (TJJD) and Local Juvenile Justice Agencies **201**

Changing Environment	205
Legislation	205
Trauma-Focused Cognitive Behavioral Therapy Pilot	205
Corsicana Residential Treatment Center	206
Juvenile Justice System Overview	206
Office of the Independent Ombudsman for the Texas Juvenile Justice Department	208
Disproportionality in the Texas Juvenile Justice System	208
Behavioral Health Services in the Juvenile Justice System	210
Behavioral Health Services in State Secure Facilities	210
Behavioral Health Services in County-Level Secure Facilities	212
Behavioral Health Services for Youth on Parole	213

Community-Based Behavioral Health Services Offered by Local Juvenile Probation Departments	213
Funding Sources	215
State-Funded Programs Available to Local Juvenile Probation Departments with Behavioral Health Service Components	215
Prevention and Intervention Programs	216
Community-Based Services	216
Diversion Programs for Youth with Behavioral Health Conditions	217
Specialty Juvenile Courts	218
Special Needs Diversionary Program	218
Other Privately and Federally Funded Diversion Programs	219
The Front-End Diversionary Initiative	219
Identifying Youth with Brain Injuries	219

Texas Education Agency and Local School Districts **221**

Delivery of Mental Health Services in Schools	224
Changing Environment	225
Special Education Services	226
Special Education Funding through IDEA	227
Special Education Funding through Medicaid	227
Eligibility for Special Education	228
Special Education Services and Service Utilization	228
Mental Health Support Systems for Schools	230
Education Service Centers	230
Coordinated School Health Model	231
Communities in Schools	232
Holistic Approaches to Student Mental Health	232
School Wide Positive Behavioral Interventions and Supports	232
Social and Emotional Learning	234
Trauma-Informed Care	234
Exclusionary Discipline in Schools	235
In-School Suspensions (ISS) and Out-of-School Suspensions (OSS)	236
Disciplinary Alternative Education Programs (DAEPs)	236
Mandatory v. Discretionary Removal	236
Juvenile Justice Alternative Education Programs (JJAEPs) / Expulsion to the Streets	237
School Ticketing – Class C Misdemeanors	239
Use of Force in Schools	241
Alternatives to Exclusionary Discipline	242

Texas Department of Housing and Community Affairs **245**

Changing Environment	249
Affordable Housing	250
Funding	251
Permanent Supportive Housing	252
Housing and Service Programs for People with Behavioral Health Conditions	253
Poverty and Homeless Prevention Programs	254
Emergency Solutions Grants Program	254
Homeless Housing & Services Program	254
Community Services Block Grant Program	254
Programs for Persons with Disabilities	255
HOME: Texas Homebuyer Assistance Program	255
Home Tax Credit Program	255
Multifamily HOME Direct Loan Program	255
HOME: Tenant-Based Rental Assistance	255
Section 8 Housing: Project Access Program	256
Section 811 Supportive Housing for People with Disabilities	257
Real Choice Systems Grant	257
Amy Young Barrier Removal Program	258
Impediments to Fair Housing Choice	258

Texas Veterans Commission 261

Claims Representation and Counseling Program	264
Eligibility for VA Benefits	264
TVC Employment Services	265
Fund for Veterans' Assistance (FVA)	266
Other Programs	266
Women Veterans	266
Veterans Support Networks	267
Specialty Courts	267

Best Practices 269

Best Practice: Recovery and Peer Support	270
Mental Health Certified Peer Specialists and Substance Use Certified Recovery Specialists	271
Family Partner Certification	271
Military Veteran Peer Support	272
Consumer-Operated Service Providers	272
Wellness Recovery Action Plan (WRAP®) Self-Directed Planning	272
Recovery-Oriented Systems of Care for Substance Use	272
Recovery to Practice Curriculum	272
Best Practice: Clubhouse International Clubhouse Model	273
Best Practice: Outcome Measures	274
Best Practice: Integrated Primary, Mental Health, and Substance Use Care	275
Best Practice: Prevention and Early Intervention	275
Best Practice: Seclusion and Restraint Alternatives	277
Best Practice: Trauma-Informed Approach	278
Best Practice: Jail Diversion	279
Best Practice: Outpatient Competency Restoration	280
Best Practice: Child and Family Mental Health System of Care	281
Best Practice: Telemedicine/Telehealth	281
Best Practice: Suicide Awareness and Prevention	282
Best Practice: Housing	283
Housing First	283
Permanent Supportive Housing	284
Oxford House	285

Appendices 287

List of Figures	289
List of Acronyms	292
Additional Resources	296
Agency Websites	296
Certified Peer Specialists	296
Child Welfare	296
Children's Mental Health	296
Civil Rights	297
Consumer and Family Organizations	297
Criminal/Juvenile Justice and Mental Health	297
Cultural and Linguistic Competency	297
Early Childhood and Mental Health	298
General Information on Mental Health and Substance Use	298
Housing	298
Integrated Physical and Mental Health Care	298
Intellectual Disability with Co-occurring Mental Health Conditions	298
Mental Health in Schools	299
Mental Health Workforce Development	299
Promotores(as)	299
Recovery and Wellness	299
Suicide Prevention	300
Telemedicine and Telehealth	300
Veterans Services	300
Glossary: Common Behavioral Health Terms	301
Texas Medicaid Managed Care Plans	310

Advisory Committees	313
Texas Health and Human Services Commission (HHSC)	313
Texas Department of Aging and Disability Services (DADS)	315
Texas Department of State Health Services (DSHS)	316
Texas Department of Family and Protective Services (DFPS)	317
Texas Sunset Advisory Commission Recommendations Impacting Mental Health	318
Health and Human Services Commission (HHSC)	318
Department of State Health Services (DSHS)	319
Department of Aging and Disability Services (DADS)	320
Department of Family and Protective Services (DFPS)	320
Endnotes	323

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

Individuals can enter the behavioral health system through multiple points of entry.

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.

Introduction

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.”¹ 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

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 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.”

Source: Substance Abuse and Mental Health Services Administration. (2011, December 22). SAMHSA announces a working definition of “recovery” from mental disorders and substance use disorders. Retrieved from <http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>

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 analysis³ 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.

SAMHSA 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:¹³

- 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:¹⁴

- 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.¹⁵ 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.¹⁶ 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.^{17,18}

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 PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

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

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.

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

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).²³ 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.²⁴ 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.²⁵

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.²⁶

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 2014.²⁷ 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.

Medicare Coverage Areas Related to Mental Health	
Part A (Hospital Insurance)	<p>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.</p> <p>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.</p>
Part B (Medical Insurance)	<p>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.</p> <p>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.</p>
Part C (Medicare Advantage)	<p>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.</p> <p>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.</p>
Part D (Medicare Prescription Drug Coverage)	<p>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.</p>

Source: Texas Health and Human Services Committee. (2013, January). *Texas Medicaid and CHIP in Perspective*. Retrieved from <http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf>

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

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.

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.

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.³² 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.

Figure 1. Texas Medicare Enrollment and Fully Dual Eligible

	2010	2011	2012
Total Medicare	2,852,000	3,044,936	3,187,332
Fully Dual Eligible	396,649	327,530	328,500

Sources: Kaiser Family Foundation. (2012). Texas: Medicare enrollment. Retrieved from <http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries/?state=TX>, Millwee, B. (2012). *Texas dual eligible integrated care demonstration project: Application*. Retrieved from Centers for Medicare and Medicaid website: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf>

TEXAS DUAL ELIGIBLES INTEGRATED CARE DEMONSTRATION PROJECT

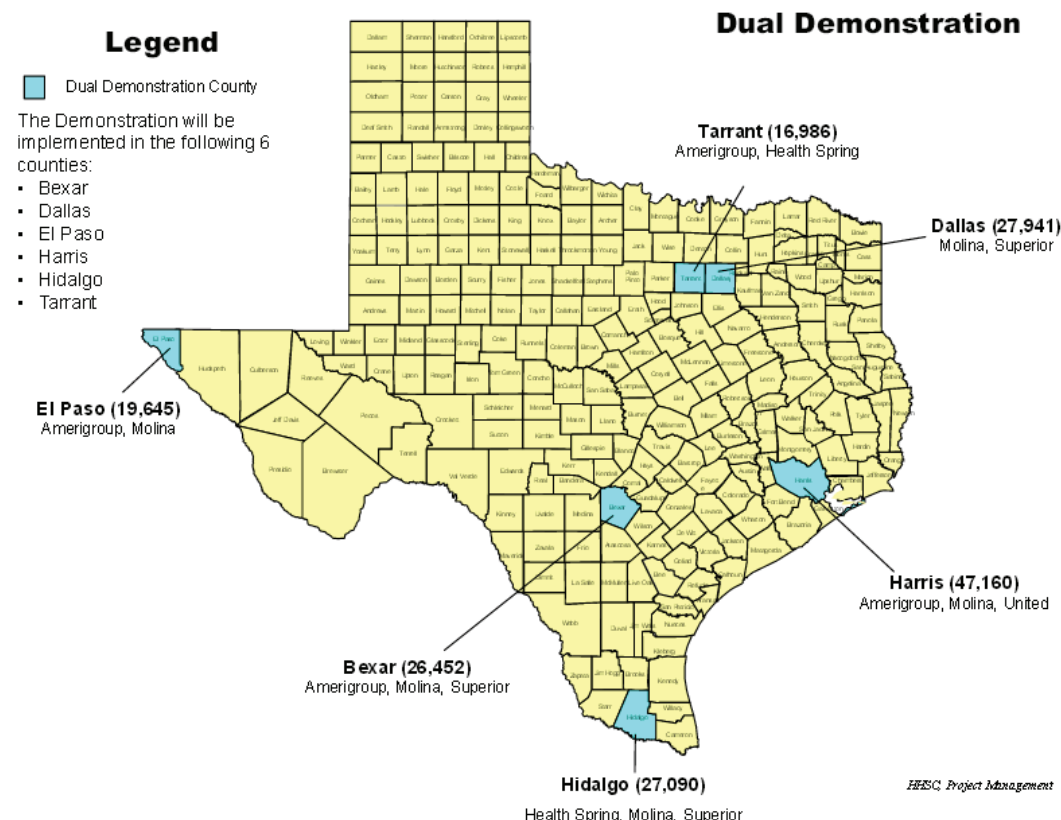
To address the concerns of the fragmented system that dual eligible people have to navigate, the Centers for Medicare & Medicaid Services (CMS) is working with states to test models focused on aligning the financing of the two systems and integrating primary, acute, behavioral health, and long-term services 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



Source: Traylor, C., & Ghahremani, K. (2014). *Presentation to the Senate Health and Human Services Committee: SB 7 implementation* [PowerPoint slides]. Retrieved from <https://www.hhsc.state.tx.us/news/presentations/2014/SB-7-implementation.pdf>

For more information about the Texas Dual Eligibles Integrated Care Demonstration Project, view the Memorandum of Understanding (MOU) between the CMS and Texas at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXMOU.pdf>

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.⁴⁰ 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 \$536.⁴¹

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.⁴² The national average monthly benefit for SSDI recipients in 2012 was \$1,078.83.⁴³ 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

Program	Supplemental Social Income (SSI)	Social Security Disability Insurance (SSDI)
Funding	Financed through general revenue from taxes. Benefits are not based on prior work history.	Financed through Social Security taxes paid by workers, employers and self-employed persons.
Eligibility	Have limited income and resources to meet cost of living. Must be a U.S. citizen or have eligible noncitizen status.	Worker must earn sufficient credits based on taxable work to be insured for Social Security purposes.
Benefit Recipients	Benefits are payable to: -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.

Source: The United States Social Security Administration. (2012). *Federal Benefit Rates, Total Annual Payments, and Total Recipients*. Retrieved from http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2012/sect01.pdf

The United States Social Security Administration. (2012). *Texas SSI*. Retrieved from http://www.ssa.gov/policy/docs/statcomps/ssi_sc/2012/tx.pdf

The Texas Environment

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

733,757 Texans signed up for health insurance through the federal marketplace during the first enrollment between October 1, 2013 and March 31, 2014

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%.⁴⁷ 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

	Average Monthly Premium Before Tax Credit	Average Monthly Premium After Tax Credit	Average Tax Credit Amount	Average Percent Reduction in Premium after Tax Credit	Percent of Individuals Who Selected Account with Tax Credits
Silver	\$314	\$68	\$246	78%	94%
All Categories	\$305	\$72	\$233	76%	84%

Source: U. S. Department of Health and Human Services. (2014). *Premium affordability, competition, and choice in the health insurance marketplace, 2014*. Retrieved from <http://www.aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf>

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

	\$50 or less	\$51-\$100	\$101-\$150	Greater than \$ 150
Percent	50%	24%	12%	14%

Source: U. S. Department of Health and Human Services. (2014). *Premium affordability, competition, and choice in the health insurance marketplace, 2014*. Retrieved from <http://www.aspe.hhs.gov/health/reports/2014/Premiums/2014MktPlacePremBrf.pdf>

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.⁴⁸ In December 2013, TDI released proposed rules for navigators that many health care advocates felt were restrictive and burdensome.⁴⁹ 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, 2014.⁵⁰ 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, 2014.⁵¹ 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, 2014.⁵²

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.^{53,54} 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 2019.⁵⁵ By choosing not to expand Medicaid, Texas may be missing out on as much as an estimated \$100 billion federal dollars between 2013 and 2023.⁵⁶ 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 qualify 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, 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.

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

HEALTH HOMES

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.⁶³ 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.”⁶⁴ As of June 2014, 30 states have established or are planning to establish a home health system.⁶⁵ 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 2012.⁶⁶ This same preliminary data revealed a net savings of approximately \$82 per member per month.⁶⁷ 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.⁶⁸ 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.

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.

Behavioral Health Implications of Health and Human Service Initiatives

MEDICAID MANAGED CARE EXPANSION IN TEXAS

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.⁶⁹ 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-IDD) 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.⁷⁰

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%20Lege%20Summary3.pdf.

1115 WAIVER: TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM

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.⁷¹ 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 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.

The waiver creates 20 RHPs across Texas. As of August 2014, there were 1,491 approved and active DSRIP programs across the RHPs.⁷² 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.⁷³ 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.⁷⁴ 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.⁷⁵

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.⁷⁶ 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 2014.⁷⁷

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.⁷⁸ 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:⁷⁹

- 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

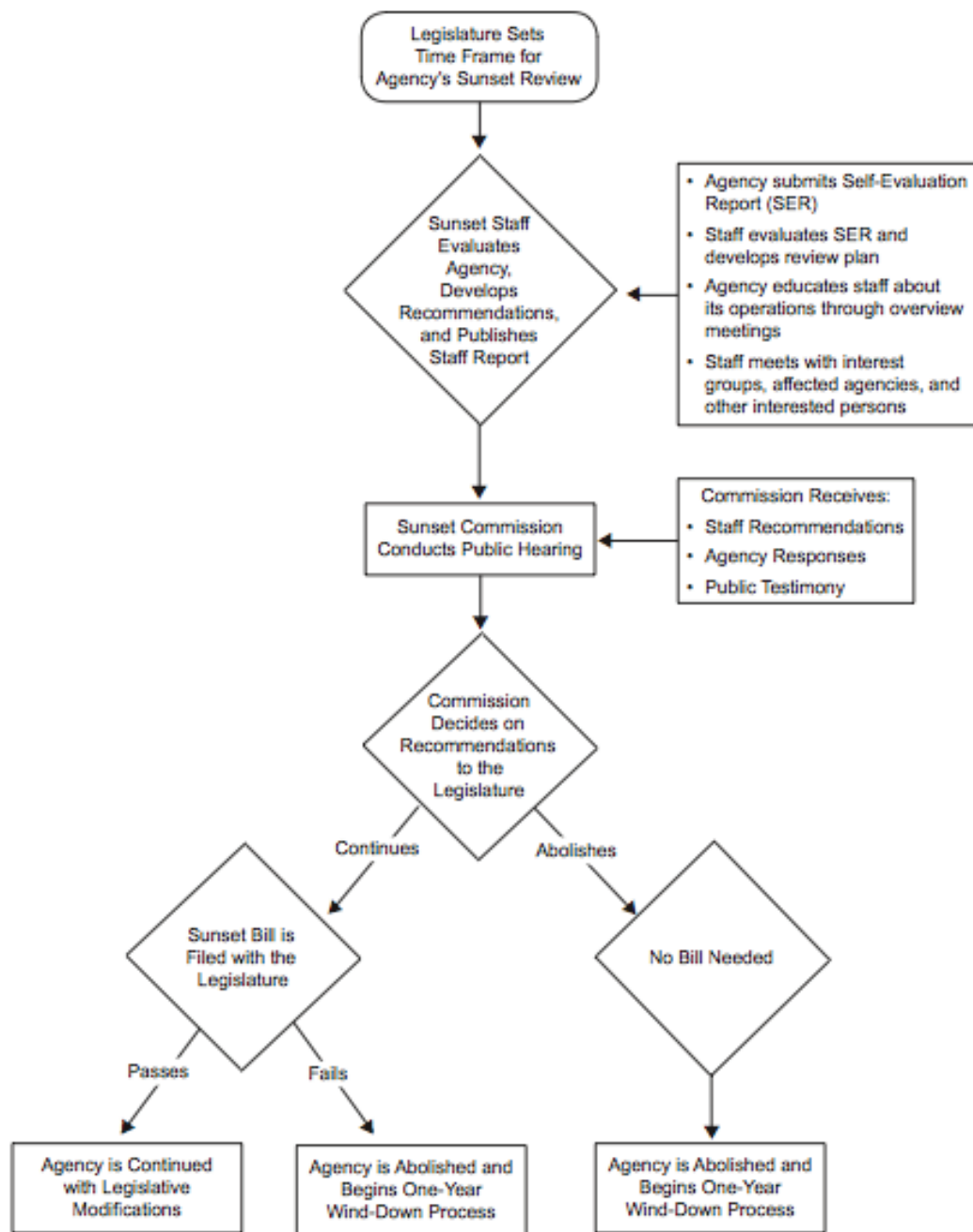
In addition to these services, other state plan services will be provided as medically necessary and will be coordinated with the HCBS-AMH services. For more information about these services or HCBS-AMH, visit www.dshs.state.tx.us/mhsa/hcbs-amh/.

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



Source: Sunset Advisory Commission. (2013). *Sunset in Texas*. Retrieved from <https://www.sunset.texas.gov/public/uploads/files/reports/Sunset%20in%20Texas%202013-2015.pdf>

Figure 7. Sunset Evaluation Timeframe

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

Source: Sunset Advisory Commission. (2013). *Sunset in Texas*. Retrieved from <https://www.sunset.texas.gov/public/uploads/files/reports/Sunset%20in%20Texas%202013-2015.pdf>

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.

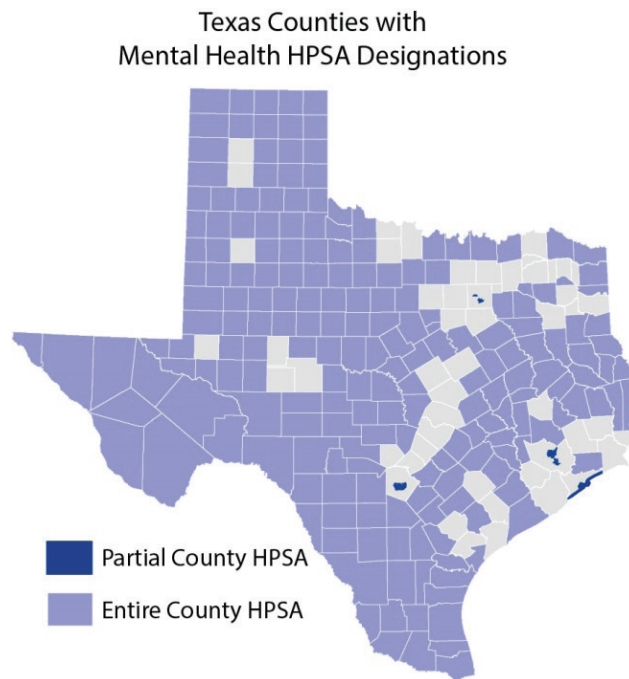
MENTAL HEALTH WORKFORCE SHORTAGES

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.⁸⁰

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.⁸¹ 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.⁸² Nationwide, only 39% of persons with mental illness receive needed mental health treatment.⁸³

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.⁸⁴ 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.

Figure 8. Federally Designated Mental Health Professional Shortage Areas as of November 2013



Source: Texas Department of State Health Services. (2014). *The mental health workforce shortage in Texas*. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB0QFjAA&url=https%3A%2F%2Fwww.dshs.state.tx.us%2Fmhhsa%2Fannouncements%2FHB1023_Final.doc&ei=0c-pU-yVGlycQAd24HgAw&usg=AFQjCNHDpebUBePZuUQPG8KruBSg43QTUA&bvm=bv.69620078,d.b2k

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.⁸⁵ 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.⁸⁶ 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.⁸⁷

Factors that contribute to and exacerbate the mental health workforce shortage in Texas include:⁸⁸

- 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.⁸⁹ As of 2013, 65.5% of all psychiatrists were white, 5.3% were African American, and 12.4% were Hispanic.⁹⁰ 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.⁹¹ However, psychiatrists are disproportionality located in metropolitan counties: Harris, Dallas, Tarrant, Bexar, and Travis. Non-metropolitan, border areas have a population of 126,821 persons per psychiatrist.⁹² The majority of rural Texas lacks psychiatrists, primary care physicians, pediatricians, obstetricians, gynecologists and other providers.⁹³ 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:⁹⁴

- 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/>

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. 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.¹⁰⁵ Those model standards define boarding homes as facilities that:¹⁰⁶

- 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.¹⁰⁷ 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.¹⁰⁸

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.¹⁰⁹ MHA of Greater Dallas's website about boarding homes can be found at www.boardinghome.org.

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.”¹¹⁰ 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.”¹¹¹ Adding peers to traditional services or having them deliver structured curriculum has shown promising outcomes, although more rigorous effectiveness research is needed.¹¹²

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.).¹¹³

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.¹¹⁴ 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.¹¹⁵ 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.¹¹⁶

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 2014.¹¹⁷

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.¹¹⁸

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.¹¹⁹ 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.

Public Behavioral Health Services in Texas

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.”¹²³

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)

- Texas Department of Aging and Disability Services (DADS)
 - Texas Department of Assistive and Rehabilitative Services (DARS)
- Texas Department of Criminal Justice (TDCJ)
 Texas Juvenile Justice Department (TJJD)
 Texas Education Agency (TEA)
 Texas Department of Housing and Community Affairs (TDHCA)
 Texas Veterans Commission (TVC)

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:*

Texas Health and Human Services Commission	59
Funding	60
Changing Environment	62
SB 58 - Integration of Behavioral Health Services	62
SB 7 - Managed Care Expansion and Intellectual/Developmental Disability Redesign	63
Medicaid	64
State Medicaid Agency	64
Medicaid Funding	68
Eligibility for Medicaid Services	69
Demographics of Medicaid Recipients	71
Federally Qualified Health Centers	72
Medicaid Buy-In Programs (Adults and Children)	72
Medicaid Health Insurance Premium Payment Program (HIPP)	72
Texas Medicaid and Healthcare Partnership (TMHP)	73
Children's Health Insurance Program (CHIP)	73
Eligibility for CHIP	73
Enrollment, Utilization and Costs	73
Behavioral Health Quality of Care Measures	75

POLICY CONCERNS

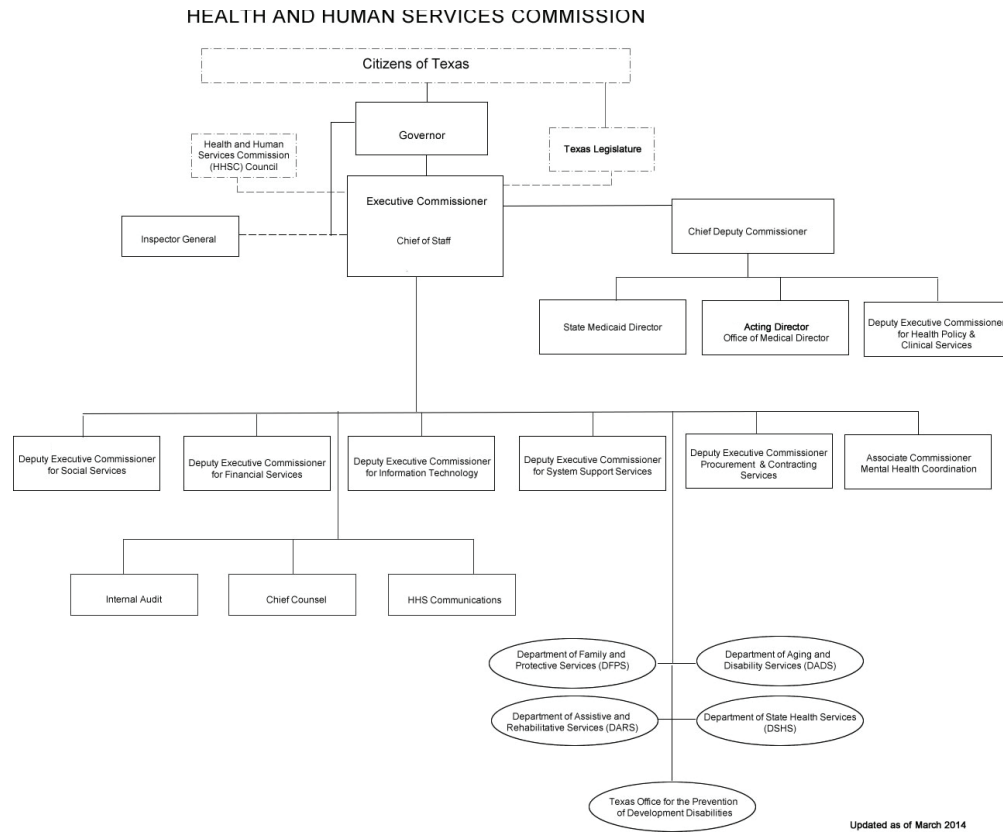
- Coordination of mental health and substance use services across agencies
- Adequacy of reimbursement rates for behavioral health services
- Progress of 1115 Transformation waiver and coordination of 1115 initiatives with mental health systems planning
- Consideration of sunset recommendations
- Implementation 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.¹²⁸ In 2011, these sites served 975,509 individuals.¹²⁹

ORGANIZATIONAL CHART



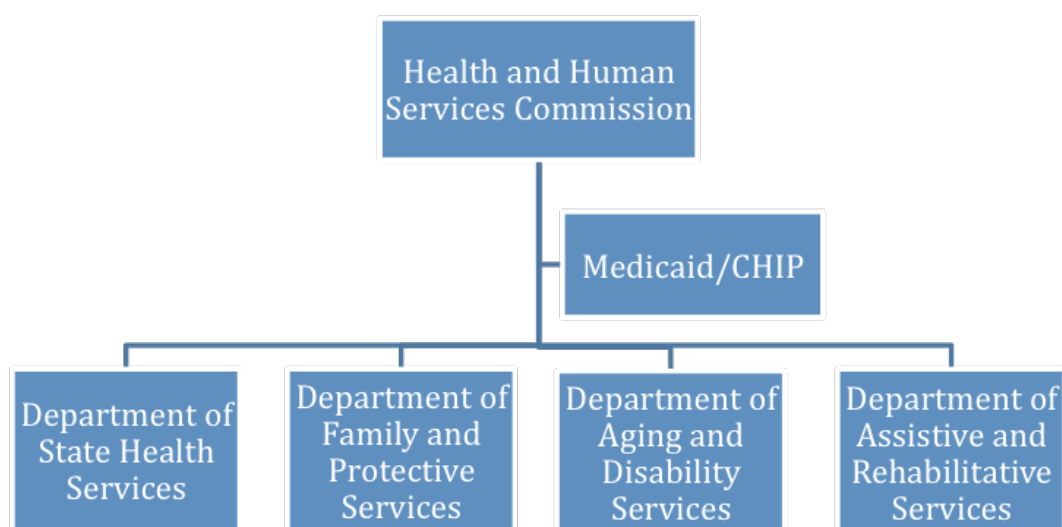
Updated as of March 2014

Texas Health and Human Services Commission

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:

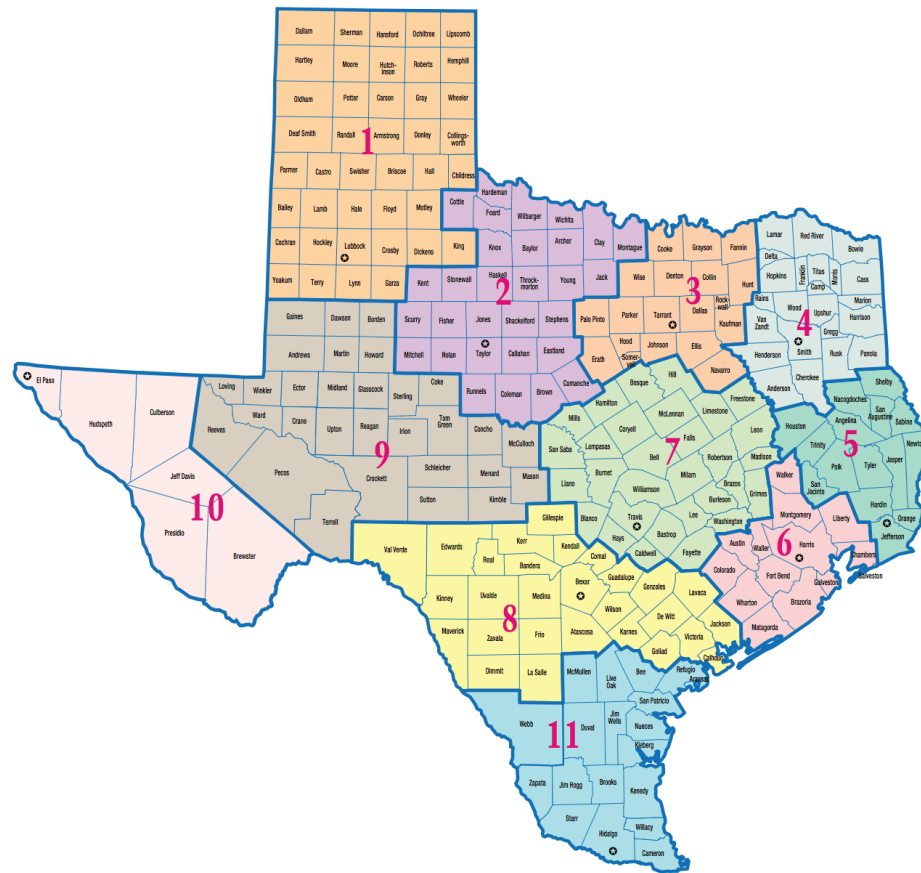
- Department of State Health Services (DSHS)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)

Figure 9. Health and Human Services Enterprise



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.¹³⁰

Figure 10. Health and Human Services Regions



Source: Texas Health and Human Services Commission. (2014). *Health and Human Services Regions*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/Regions/

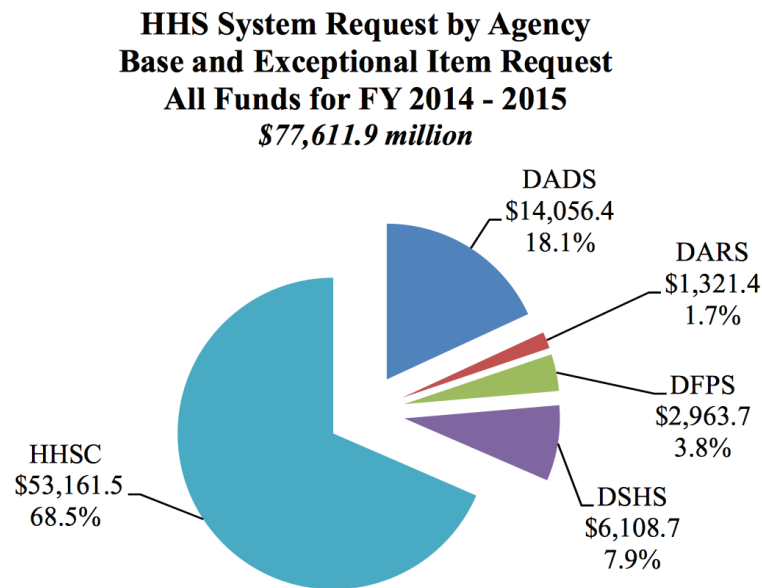
In addition to providing oversight for the health and human services enterprises, HHSC also operates the following programs: Medicaid, Children's Health Insurance Program (CHIP), Disaster Assistance, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and 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

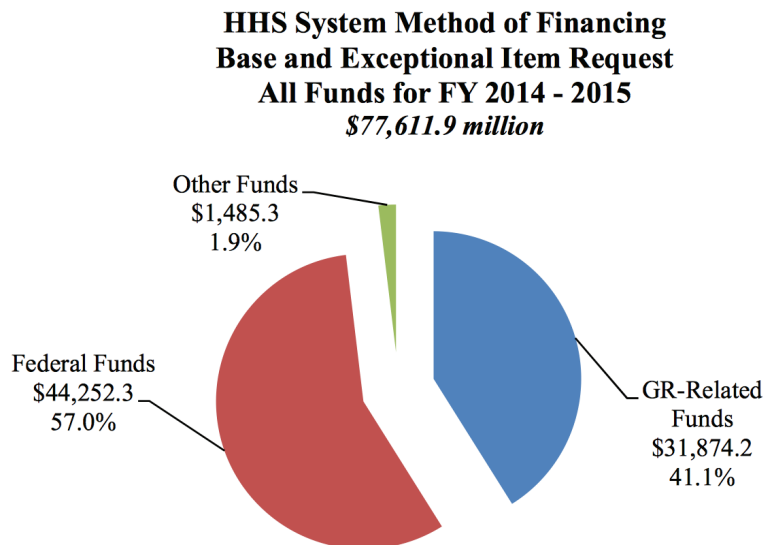
In 2014 and 2015, a total of \$77.6 billion of combined state and federal funds were appropriated to Health and Human services (including all funds to each of the four sub-agencies).¹³⁴ Figure 11 below demonstrates the funding appropriated to each of the HHSC agencies. Figure 12 shows the funding sources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

Figure 11. HHS System Request by Agency



Source: Texas Health and Human Services Commission. (2012). *Health and Human Services consolidated budget for fiscal years 2014-2015*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/finance/2014-2015.pdf

Figure 12. Methods of Financing



Source: Texas Health and Human Services Commission. (2012). *Health and Human Services consolidated budget for fiscal years 2014-2015*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/finance/2014-2015.pdf

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:¹³⁵

- 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.

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

State Agency	Medicaid Program Responsibilities
Health and Human Services Commission	Texas Medicaid state plan services
Department of Aging and Disability (DADS)	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
Department of State Health Services (DSHS)	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
Department of Family and Protective Services	DFPS administers: Superior Health Systems (STAR Health) Former Foster Care Children Program (FFCC) Medicaid for Transitioning Foster Care Youth
Department of Assistive and Rehabilitative Services (DARS)	DARS administers: Early Childhood Intervention Program (ECI) Case management for children who are blind or visually impaired Vocational rehabilitation services

Source: Texas Health and Human Services Commission. (September, 2013) *Sunset Self-Evaluation Report*. Retrieved from <http://www.hhsc.state.tx.us/sunset/Evaluation-Report.shtml>.

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.¹³⁸ The Texas Medicaid program caseload is projected to reach 4.2 million by 2015.¹³⁹

Starting in the early 1990s, Texas Medicaid has been offered

The Texas Medicaid program caseload is projected to reach 4.2 million by 2015.

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 2013.¹⁴⁰ 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

Program	Description	Eligible Population	Mental Health Utilization (FY 2011)
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%

Program	Description	Eligible Population	Mental Health Utilization (FY 2011)
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 conservatorship; 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 Health & Human Services Commission.(n.d.) *STAR+PLUS expansion*. Retrieved from <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/> Texas Department of State Health Services. *Medicaid Services Unit: NorthSTAR*. Retrieved from <https://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm>

Texas Health & Human Services Commission. (n.d.). *Medicaid Managed Care quality strategy 2012-2016*. Retrieved from <http://www.hhsc.state.tx.us/medicaid/about/QIS-1115.pdf>

Texas Department of Family & Protective Services. (n.d.). *STAR Health – A guide to medical services at CPS*. Retrieved from http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-star.asp

Institute for Child Health Policy at the University of Florida, & Texas Eternal Quality Review Organization (2014). Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of Activities and Trends in Healthcare Quality. Retrieved from <http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>

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.

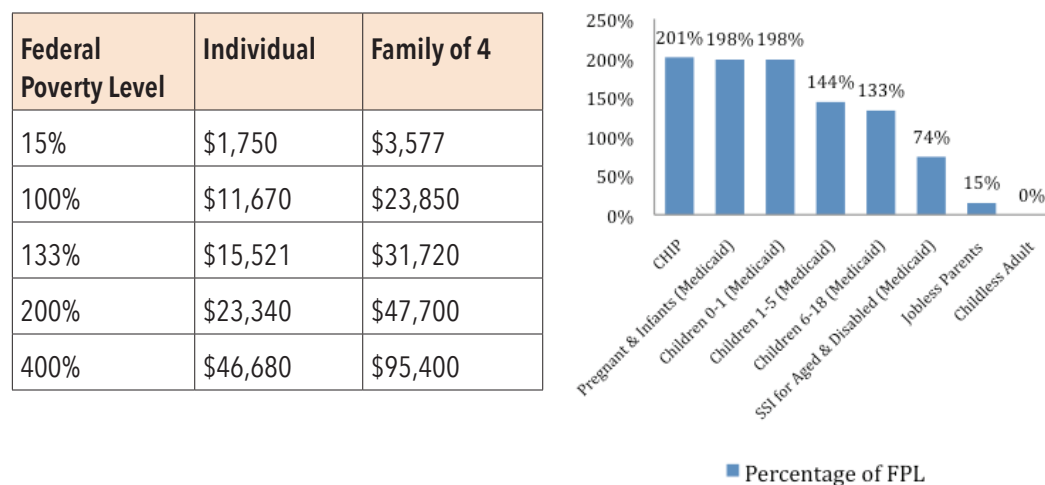
In determining program eligibility, Texas considers a variety of factors such as income and family size, age, disability, pregnancy, citizenship and state residency requirements. Medicaid covers the three primary categories:

- 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



Source: Center for Medicare & Medicaid Services (2014). *State Medicaid and CHIP income eligibility standards effective July 1, 2014*. Retrieved from <http://www.medicare.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>

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.

“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).”

Center for Medicare & Medicaid Services (2014). State Medicaid and CHIP income eligibility standards effective July 1, 2014. Retrieved from <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>

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

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

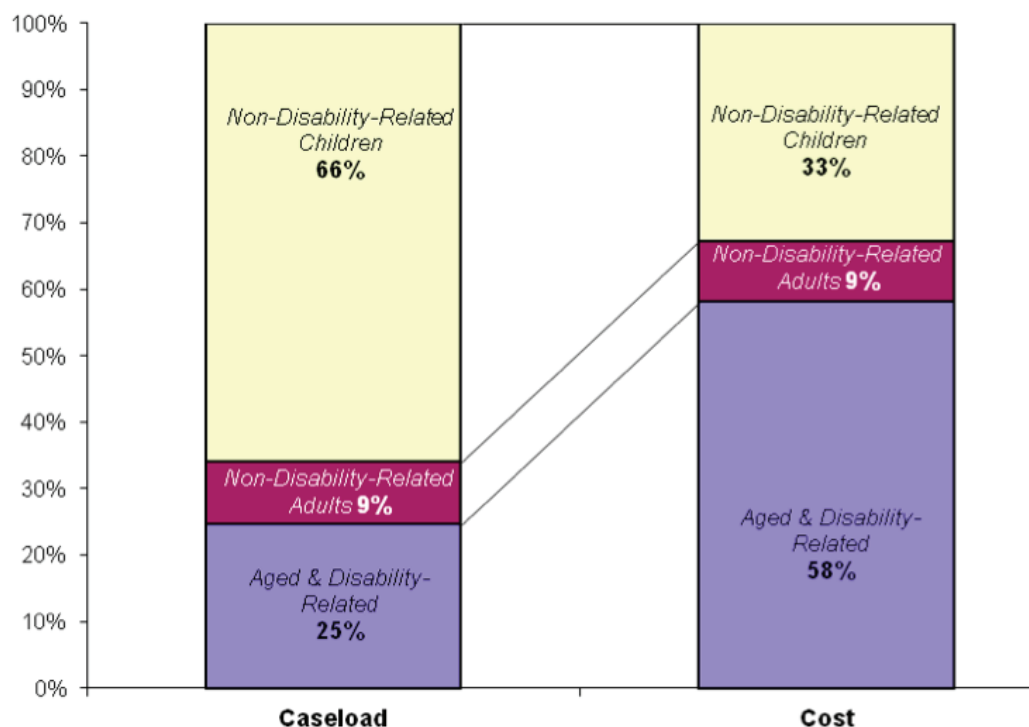
Service Type	Medicaid Behavioral Health Services:
Substance Use Services	Outpatient adolescent chemical dependency counseling by state-licensed facilities Assessment and diagnosis Medication assisted therapy Outpatient and residential detoxification Outpatient counseling and treatment Residential treatment

Source: Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf.

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.¹⁴³ Figure 17 below displays percentage of Medicaid populations by demographic category and their estimated corresponding expenditures.

Figure 17. Texas Medicaid Beneficiaries and Expenditures, 2011



Source: Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf.

For more information regarding Medicaid, consult HHSC's latest edition of *Texas Medicaid and CHIP in Perspective*, commonly known as the "Pink Book", available at http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf.

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.¹⁴⁴ In 2011, these sites served 975,509 individuals.¹⁴⁵

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, co-pays 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.

TEXAS MEDICAID AND HEALTHCARE PARTNERSHIP (TMHP)

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.¹⁴⁶

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

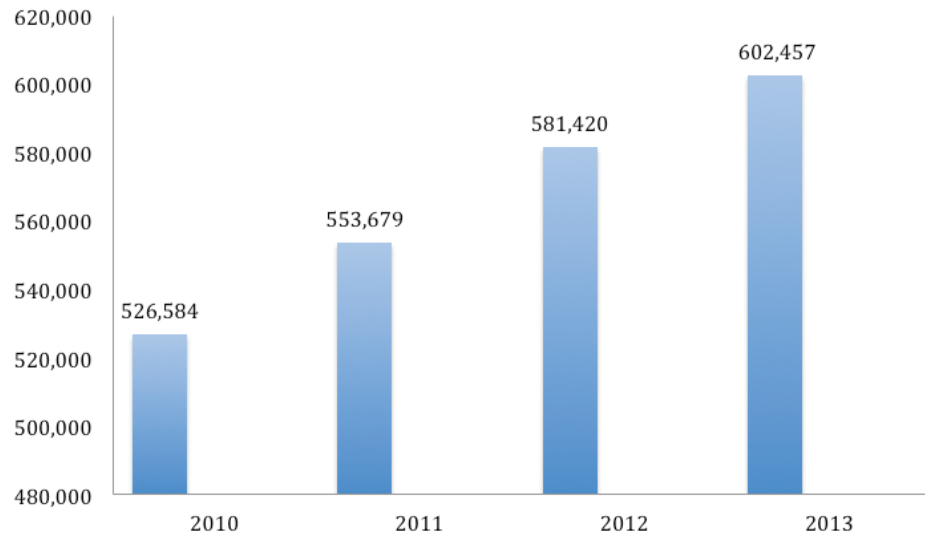
CHIP is available for children aged 0–19 with income up to 200 percent of the federal poverty level (annual income of \$47,700 for a family of four) so that low-income children can have access to health care, including inpatient and outpatient mental health and substance use services. CHIP was developed 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 2014.¹⁴⁷ 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.

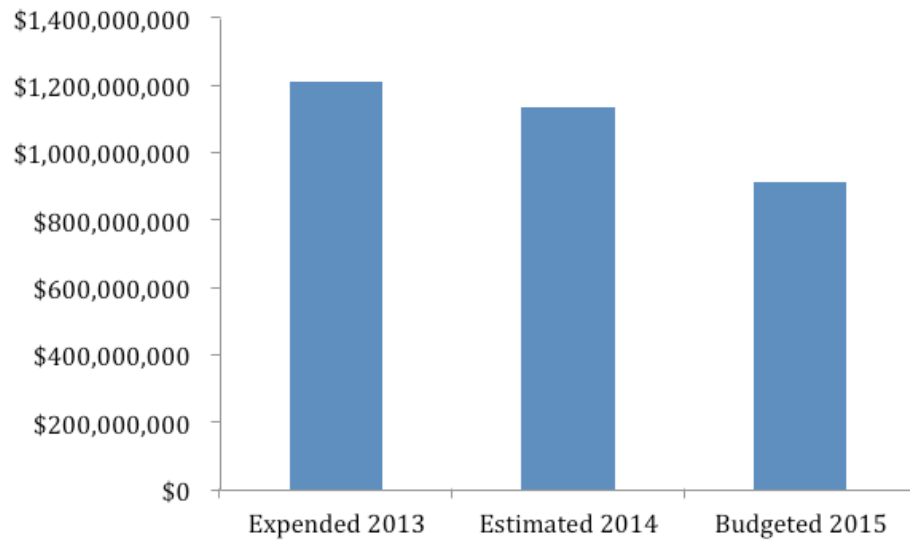
Although CHIP spending has experienced sporadic growth up until 2013, the FY 2016-2017 LAR predicts a decline in funding. It is estimated that 71 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services; 19 percent on prescription drugs; and the remaining 10 percent on administration.¹⁴⁸

Figure 18. CHIP Enrollment



Note: Data is from October of every year. Source: Texas Health and Human Services Commission. (2014). *CHIP enrollment, renewal and disenrollment by month*. Retrieved from <http://www.hhsc.state.tx.us/research/CHIP/ChipDataTables.asp>

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



Source: Texas Health and Human Services Commission. (2014). *2A. Summary of base request by strategy -84th Regular Session* [Data file]. Retrieved from <http://www.hhsc.state.tx.us/LAR/2016-2017>

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

Program	Measure	Performance		
		2009	2010	2011
STAR	After dispensing new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	Not available	47%	50%
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	Not available	58%	66%
	Follow-up care after hospitalization for mental illness within 7 days	40%	45%	43%
	Follow-up care after hospitalization for mental illness within 30 days	68%	72%	71%
	Readmission within 30 days - Adults	21% (all ages)	13%	13%
	Readmission within 30 days - Children/Adolescents	Not available separately	10%	Not available
STAR+PLUS	Antidepressant medication management within 3 months (follow-up visit after dispensed)	Not available	50%	53%
	Antidepressant medication management within 6 months (follow-up visit after dispensed)	Not available	36%	36%
	Follow-up care after hospitalization for mental illness within 7 days	40%	46%	48%
	Follow-up care after hospitalization for mental illness within 30 days	67%	72%	74%
	Readmission within 30 days - Adults	24% (all ages)	25%	Not available
	Readmission within 30 days - Children/Adolescents	Not available separately	19%	19%

Program	Measure	Performance		
		2009	2010	2011
STAR Health	After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	83%	89%	86%
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	91%	94%	90%
	Follow-up care after hospitalization for mental illness within 7 days	61%	70%	69%
	Follow-up care after hospitalization for mental illness within 30 days	88%	92%	91%
	Readmission within 30 days - Adults (represents only 5% of STAR Health population)	28%	28%	Not available
CHIP	After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	Not available	45%	43%
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	Not available	56%	58%
	Follow-up care after hospitalization for mental illness within 7 days	Not available	45%	43%
	Follow-up care after hospitalization for mental illness within 30 days	Not available	74%	71%

Sources: Institute for Child Health Policy at the University of Florida. (2011). *Texas Medicaid Managed Care and STAR Program, EQRO quality of care report - FY 2010*. Retrieved from <http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf>

Institute for Child Health Policy at the University of Florida. (2009). *Texas Medicaid Managed Care STAR Quality of Care Measure - Annual chart book, FY 2008*. Retrieved from http://www.hhsc.state.tx.us/reports/2010/CareReportSTAR_FY08_0310.pdf

Institute for Child Health Policy at the University of Florida. (2009). *Texas Medicaid Managed Care STAR+PLUS Quality of Care Measures - Annual chart book, FY 2008*. Retrieved from http://www.hhsc.state.tx.us/reports/2010/Annual_Quality_Care_FY08.pdf

Institute for Child Health Policy at the University of Florida. (2012). *Texas Medicaid Managed Care and STAR+PLUS, EQRO quality of care report - FY 2010*. Retrieved from <http://www.hhsc.state.tx.us/reports/2012/ann-qual-care-rep-STAR+PLUS-fy2010.pdf>

Institute for Child Health Policy at the University of Florida. (September 26, 2011). *Texas Medicaid STAR Health Program, EQRO quality of care report, FY 2010*. Retrieved from <http://www.hhsc.state.tx.us/reports/2012/ann-qual-care-rep-STAR-fy2010.pdf>

Institute for Child Health Policy at the University of Florida. (2009). *Texas Medicaid Managed Care STAR Health Quality of Care Measures - Annual chart book, FY 2008*. Retrieved from http://www.hhsc.state.tx.us/reports/2010/Quality_Care_ReportFY08.pdf

Institute for Child Health Policy at the University of Florida. (2014). *Texas Medicaid Managed Care and Children's Health Insurance Program, EQRO summary of activities and trends in healthcare quality - FY 2011*. Retrieved from <http://www.hhsc.state.tx.us/reports/2014/EQRO-Summary.pdf>¹⁴⁹

Texas Department of State Health Services: *At A Glance*

Texas Department of State Health Services	80
Changing Environment	80
Trends and Prevalence	82
Funding	82
System Utilization	84
Waitlists	85
Timeline of Mental Health Service Initiatives	87
Access	88
Medicaid	88
Medically Indigent People	89
Priority Populations	89
Service Providers	90
Medicaid Managed Care	90
Local Mental Health Authorities	91
NorthSTAR	93
Community Mental Health Services	94
Texas Resilience and Recovery Framework	94
Adult Service Utilization and Costs	96
Quality of Care Measures	96
Youth Service Utilization and Costs	99
Quality of Care Measures	100
Crisis Services	100
Crisis Services Utilization and Costs	102
Quality of Care Measures	102
NorthSTAR Services	103
NorthSTAR Service Utilization and Costs	104
Quality of Care Measures	105
Inpatient Mental Health Hospital Services	105
Civil	105
Forensic	106
Maximum Security	106
Types of Inpatient Settings	106
State Hospitals	106
Funding	108
Institutions for Mental Diseases (IMD) Exclusion	108
State Hospital Utilization and Costs	109
Recidivism Rates	109
State-Funded Community and Private Hospitals	110
Competency Restoration	111
State Psychiatric Inpatient Competency Restoration	111
Outpatient Competency Restoration	112
Jail-Based Competency Restoration	112
Addressing the Shortage of Public Inpatient Beds	113
Substance Use Services	115
Access	116
Funding	116
Eligibility for Services	117
Priority Populations	117

Co-occurring Psychiatric and Substance Use Disorders	117
Services	118
Utilization and Costs	119
Quality of Care Measures	121
Promising Practices in Substance Use Treatment	122
The Texas Recovery Initiative	122

POLICY CONCERNS

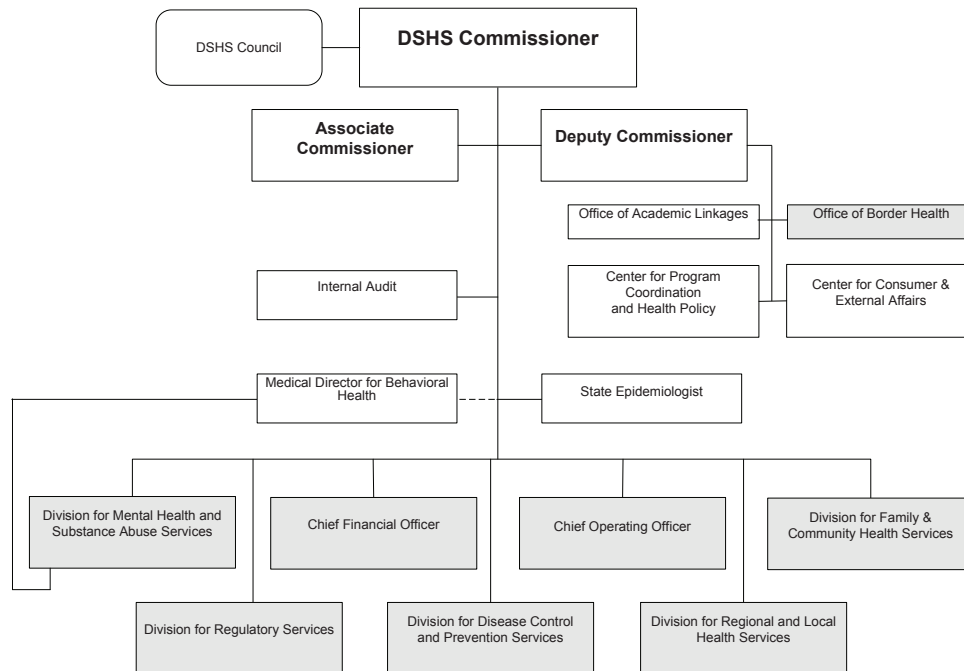
- Increased access to quality community-based services through integrated health care service delivery
- Expansion of peer specialist/recovery coach support services
- Funding for diversion services to prevent relinquishment of children
- Accountability and meaningful performance measures
- Integration 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.

ORGANIZATIONAL CHART

Department of State Health Services Organizational Chart April 17, 2014



DSHS

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.¹⁵² 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:¹⁵⁶

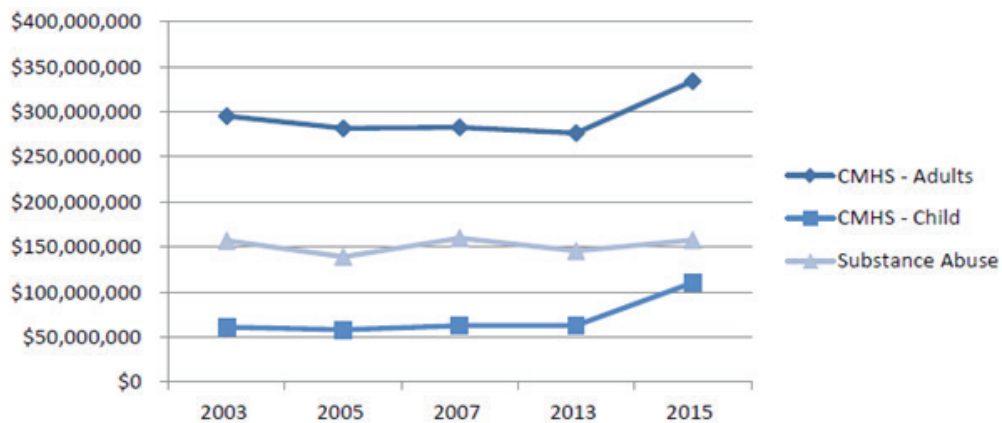
- State general revenue dedicated (17 percent) (includes a one-time transfer of \$137,860,100 to the EMS-Trauma general revenue dedicated account for the Medicaid disproportionate share hospital program).
- State general revenue (36 percent).
- Federal funds (38 percent) (including both Medicaid dollars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

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.

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 \$103.53.¹⁵⁷ 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 2014/2015.¹⁵⁸

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



Source: Ligon, K. (October 21, 2013). Sizing up the 2014-2013 Texas Budget: Mental Health. *Center for Public Policy Priorities*. Retrieved from http://forabettertexas.org/images/2013_10_PP_Budget_MentalHealth.pdf

The following figure details DSHS funds for FY 2013 expenditures and FY 2014/2015 appropriations by budget strategy.

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

Budget Strategy	FY 2013 Expended	FY 2014 Estimated	FY 2015 Budgeted	FY 2016 Requested	FY 2017 Requested
Mental Health Services-Adults	\$285,828,525	\$343,855,680	\$314,370,271	\$324,546,422	\$324,546,421
Mental Health Services-Children	\$59,732,529	\$96,581,563	\$108,430,662	\$105,798,676	\$105,798,674
Community Mental Health Crisis Services	\$84,006,025	\$106,716,332	\$115,155,291	\$110,829,718	\$110,829,717
NorthSTAR Behavioral Health Waiver	\$123,383,334	\$122,834,933	\$119,228,465	\$130,626,310	\$130,626,308
Substance Use, Prevention, Intervention and Treatment	\$136,191,615	\$157,893,764	\$149,956,982	\$150,011,077	\$150,011,076
Mental Health State Hospitals	\$405,014,273	\$433,612,004	\$419,788,110	\$420,992,251	\$420,992,249
Mental Health Community Hospitals	\$67,501,308	\$77,675,356	\$79,971,621	\$79,971,621	\$79,971,620
Total	\$1,161,657,609	\$1,339,169,632	\$1,306,901,402	\$1,322,776,075	\$1,332,776,065

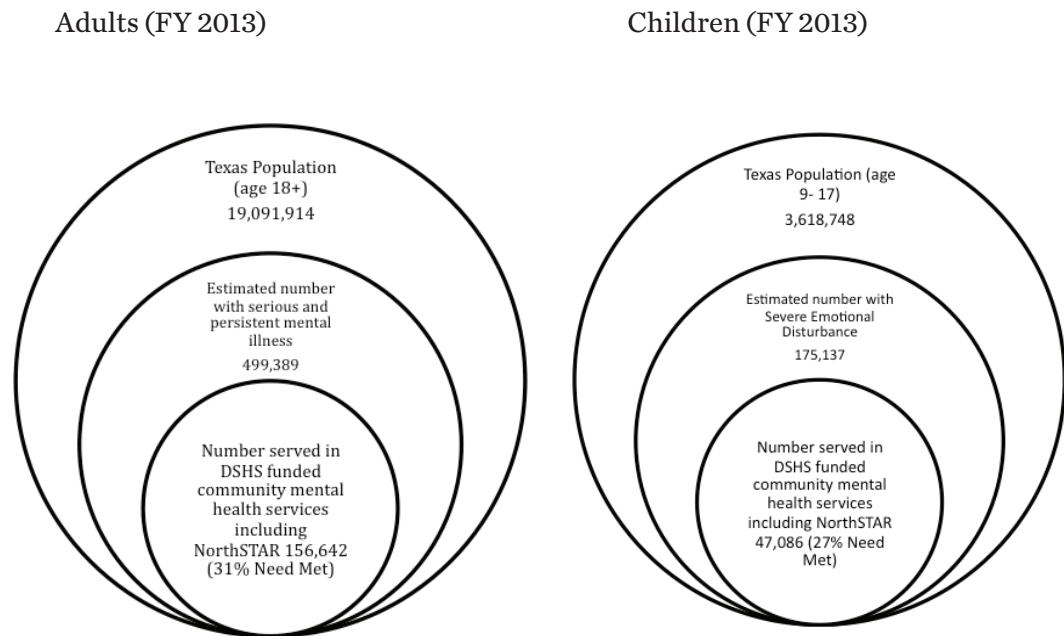
Source: Texas Department of State Health Services. (August 11, 2014). *FY 2016-2017 Legislative Appropriations Request*. Retrieved from <http://www.dshs.state.tx.us/budget/lar/default.aspx>

SYSTEM UTILIZATION

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.¹⁵⁹¹⁶⁰ 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



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

WAITLISTS

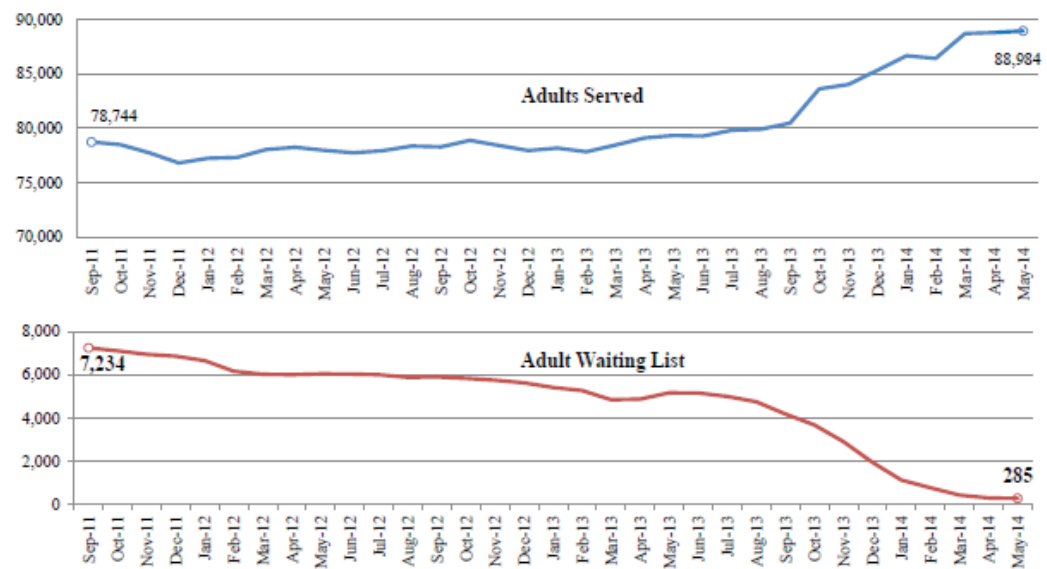
When LMHAs have exhausted their funding, non-Medicaid eligible individuals who require mental health services are added to a waitlist. However, individuals who are on Medicaid must be admitted into services because federal law prohibits waitlists for Medicaid. Additionally, if the individual is approved 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.¹⁶³

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.¹⁶⁴

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.

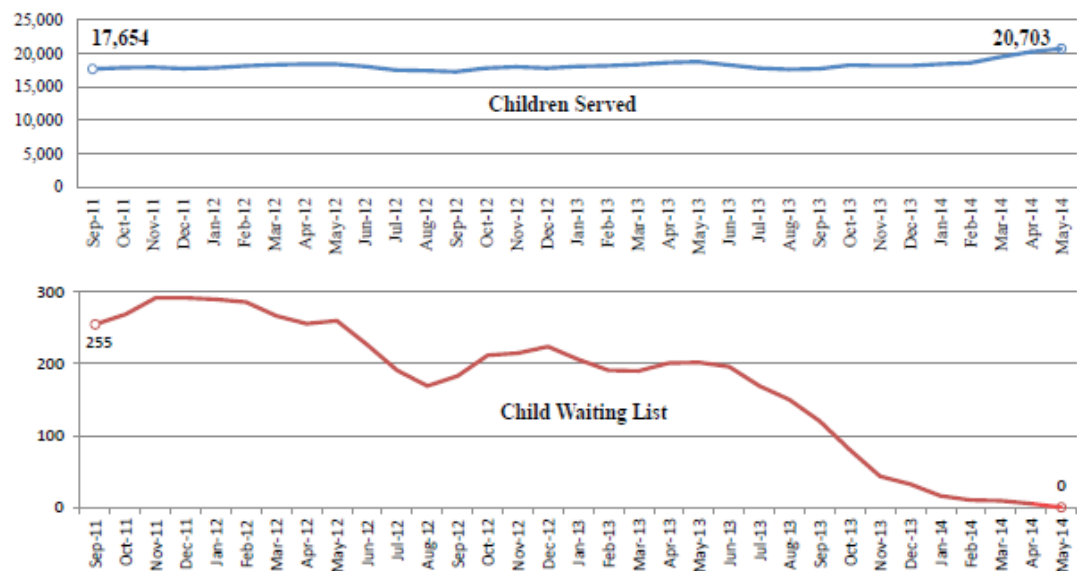
At the end of FY 2013, 7,947 adults and 241 children were on the waiting lists.¹⁶⁵ As a result of passed legislation, by the end of May 2014 these numbers decreased drastically, with 285 adults and zero children on waitlists. Additionally, as of March 2014, 1,435 adults had been moved into an appropriate level of care (LOC).

Figure 24. Impact of Adult Waiting List by Adults Served - FY 2012 - FYTD May 2014



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]. Retrieved from www.dshs.state.tx.us/legislative/default.shtm

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



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]. Retrieved from www.dshs.state.tx.us/legislative/default.shtm

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.

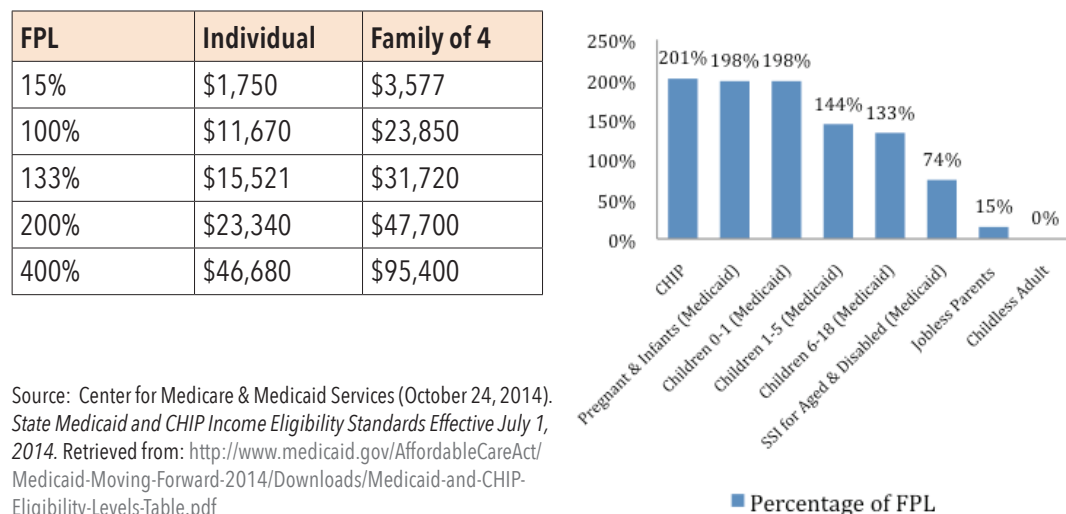
Access

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.¹⁶⁶ 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.¹⁶⁷

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



Source: Center for Medicare & Medicaid Services (October 24, 2014). *State Medicaid and CHIP Income Eligibility Standards Effective July 1, 2014*. Retrieved from: <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>

On average, 3.6 million adult and 2.6 million child Texas residents are enrolled in Medicaid.¹⁶⁸ Most of these Texans will receive health services through Medicaid managed care (discussed in the Service Providers section). The state has no current

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.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.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.”¹⁷¹ Medically indigent individuals who meet the priority population criteria (explained below) are eligible to receive DSHS-funded services through the DSHS system.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.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.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 \$3,000.¹⁷⁵ As of January 2014, 143 of Texas’ 254 counties operated CIHCPs.

Rider 58 of SB 1 (83rd) 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 83rd 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.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.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.^{178,179}

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.

DSHS

Figure 27. LMHA Priority Population

Populations	Eligibility Criteria
Adults	<p>Serious functional impairment (GAF less than 50) and severe and persistent mental illness diagnosis of:</p> <ul style="list-style-type: none"> Schizophrenia Bipolar disorder Major depression, including single episode or recurrent major depressive disorder Post-traumatic stress disorder Schizoaffective disorder, including bipolar and depressive types Obsessive compulsive disorder Anxiety disorder Delusional disorder Bulimia nervosa, anorexia nervosa, or other eating disorders not otherwise specified Any other diagnosed mental health disorder
Children & Adolescents	<p>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:</p> <ul style="list-style-type: none"> Have a serious functional impairment. Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms. Are enrolled in a school system's special education program because of serious emotional disturbance. <p>*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.</p>

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.¹⁸⁰ 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.¹⁸¹

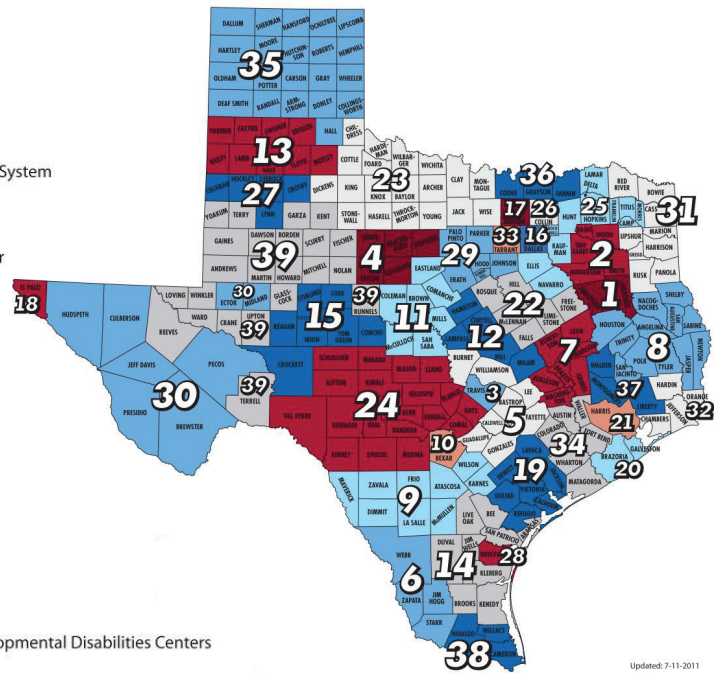
HHSC will take responsibility for planning the operational shift from fee-for-services to managed care, the evaluation procedures, and data collection and analysis. Additionally, HHSC will pay for and monitor contracts for specialty mental health services. Data exchange and collaboration between HHSC and DSHS will be crucial in order for DSHS to continue its policy and planning role for Medicaid behavioral services.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.¹⁸³

Figure 28. Map of LMHAs and 39 Service Regions

1. ACCESS
2. Andrews Center Behavioral Healthcare System
3. Austin Travis County Integral Care
4. Betty Hardwick Center
5. Bluebonnet Trails Community Services
6. Border Region Behavioral Health Center
7. MHMR Authority of Brazos Valley
8. Burke Center
9. Camino Real Community Services
10. The Center for Health Care Services
11. Center for Life Resources
12. Central Counties Services
13. Central Plains Center
14. Coastal Plains Community Center
15. MHMR Services for the Concho Valley
16. Metrocare Services
17. Denton County MHMR Center
18. Emergence Health Network
19. Gulf Bend Center
20. Gulf Coast Center
21. MHMR Authority of Harris County
22. Heart of Texas Region MHMR Center
23. Helen Farabee Centers
24. Hill Country Mental Health and Developmental Disabilities Centers
25. Lakes Regional MHMR Center
26. LifePath Systems
27. StarCare Specialty Health System
28. MHMR of Nueces County
29. Pecan Valley Centers for Behavioral & Developmental HealthCare
30. Permian Basin Community Centers
31. Community Healthcore
32. Spindletop Center
33. MHMR of Tarrant County
34. Texana Center
35. Texas Panhandle Centers
36. Texoma Community Center
37. Tri-County Services
38. Tropical Texas Behavioral Health
39. West Texas Centers



Source: Texas Department of State Health Services. (2013). Overview of Public Mental Health System. Presentation to House Public Health Committee. Retrieved from www.dshs.state.tx.us/legislative/default.shtm

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.¹⁸⁴ 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.¹⁸⁵ 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).¹⁸⁶ 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.¹⁸⁷

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.¹⁸⁸ In 2013, NorthSTAR recipients represented roughly 32 percent of the total population of Texas below 200 percent of the federal poverty level.¹⁸⁹

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.¹⁹⁰ 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.¹⁹¹

The TRR system is responsible for:¹⁹²

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.¹⁹³

Figure 29. Texas Resiliency and Recovery Level of Care for Adults

Level of Care (LOC)	Target Population and Service Goal	Services
LOC-0: Crisis Services	General population in crisis. Goal is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.	Brief interventions to address the immediate crisis and prevent the need for more intensive services.
LOC-1M: Basic Services (Medication Management)	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.	Pharmacological management services, routine case management, psychiatric diagnostic interview examination. Provided in outpatient, office-based settings.
LOC-1S: Basic Services (Skills Training)	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.	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.
LOC-2: Basic Service including Counseling	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.	All LOC-1 services + psychotherapy services.
LOC-3: Intensive TRR Services with Team Approach	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.	All LOC-2 services + psychosocial rehabilitative services, day programs for acute needs and residential treatment. Services are provided in outpatient office-based and community-based settings.

Level of Care (LOC)	Target Population and Service Goal	Services
LOC-4: Assertive Community Treatment (ACT)	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.	All LOC-3 services not including day programs + cognitive processing therapy and cognitive behavioral therapy.
LOC-5: Transitional Services	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.

Source: Texas Department of State Health Services. (2012). *Adult Utilization Management Guidelines-FY 2014*. Retrieved from: <http://www.dshs.state.tx.us/mhsa/trr/documents/>

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

	FY 2011	FY 2012	FY 2013
Average monthly number receiving community mental health services.	76,325	77,873	79,611
Average cost of community mental health services per adult served.	\$372	\$366	\$352

Note: Data 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/>

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

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

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

Level of Care (LOC)	Target Population and Service Goal	Services
LOC-0: Crisis Services	General child and adolescent population in crisis. Goal is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.	Brief interventions to address the immediate crisis and prevent the need for more intensive services.
LOC-1: Medication Management	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.	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.

Level of Care (LOC)	Target Population and Service Goal	Services
LOC-2: Targeted Services	Children and adolescents must have identified needs in either emotional <u>or</u> 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.	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.
LOC-3: Complex Services	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.	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.
LOC-4: Intensive Family Services	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.	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.

Level of Care (LOC)	Target Population and Service Goal	Services
LOC-4C: 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.

Source: Texas Department of State Health Services. (2012). *Child & Adolescent Utilization Management Guidelines-FY 2014*. Retrieved from: <http://www.dshs.state.tx.us/mhsa/trr/documents/>

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

	FY 2011	FY 2012	FY 2013
Average monthly number receiving community mental health services.	18,017	17,628	17,878
Average cost of community mental health services per adult served.	\$357	\$383	\$383

Note: Data 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/>

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>.

Figure 34. Selected Quality of Care Measures for Children and Adolescents Receiving Community Mental Health Services

Quality of Care Measures	FY 2011	FY 2012	FY 2013	Performance Contract Target FY 2013
Percentage of children and adolescents in community mental health services receiving first service encounter within 14 days of assessment.	77%	80%	78%	65%
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.	0.02%	0.08%	0.07%	Not available
Percentage of children and adolescents in community mental health services with improved or acceptable functioning per year.	37%	38%	38%	38%
Percentage of children in community mental health services with improved school behavior.	68%	73%	75%	71%

Note: Data for first two 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/>

CRISIS SERVICES

The Texas Administrative Code defines a crisis as a situation in which:¹⁹⁴

- 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.¹⁹⁵ 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 2011.¹⁹⁶

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.¹⁹⁷ 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

Service	Description
Crisis Hotline Services	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)
Mobile Crisis Outreach Teams (MCOT)	All 39 LMHAs operate a MCOT in conjunction with crisis hotlines; they respond at the crisis site or a safe location in the community
Crisis Stabilization Units (CSU)	Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
Extended Observation Units	Provide 23-48 hours of observation and treatment for psychiatric stabilization
Crisis Residential Services	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

Service	Description
Crisis Respite Services	Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others
Crisis Step-Down Stabilization in Hospital Setting	Provides from 3-10 days of psychiatric stabilization in a local hospital setting with a psychiatrist on staff
Outpatient Competency Restoration Services	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
Transitional Services	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

Source: Department of State Health Services. (2010). *Crisis Services*. Retrieved from <http://www.dshs.state.tx.us/mhsacsr/>

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

	FY 2011	FY 2012	FY 2013
Average monthly number of persons receiving MH crisis services	5,529	5,667	5,039
Average monthly cost per person receiving MH crisis services	\$401	\$401	\$459

Note: Data 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/>

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

Quality of Care Measures	FY 2011	FY 2012	FY 2013	Performance Contract Target FY 2013
Percentage of children and adolescents in community mental health services avoiding crisis.	99%	98%	98%	98.3%
Percentage of adults in community mental health services avoiding crisis.	98%	98%	98%	97.7%

Note: Data 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/>

NORTHSTAR 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 programming, NorthSTAR utilizes the TRR model to deliver mental health services to children, adolescents and adults in the priority population.¹⁹⁸ Figure 38 lists NorthSTAR's available mental health services.

Figure 38. NorthSTAR Mental Health Benefits

Service	Adult	Child
Assessment	X	X
Treatment planning	X	X
Outpatient counseling (provided by LMSW, LPCs)	X	X
Psychology services	X	X
Psychiatric services	X	X
Crisis Services	X	X
Medication training and support services	X	X
Psychosocial rehabilitation services	X	
Skill training and development	X	X
Employment related services	X	X
Day program for acute needs	X	X
Mental health, chemical dependency civil commitment	X	X
Medication services: pharmacological management	X	X
Medications	X	X
New generation medications	X	X
Non-Medicaid laboratory work	X	X
Inpatient hospitalization (is not an Institution for Mental Disease)	X	X
Inpatient hospitalization (is an Institution for Mental Disease)	X	X

Service	Adult	Child
Mental health case management	X	X
Supported Employment	X	X
Respite Services	X	X
Supported Housing	X	X
Intensive crisis residential services	X	X
Residential treatment centers		X
Personal care homes/ assisted living	X	
Therapeutic foster care		X
Adult foster care	X	
Early intervention		X

Source: Department of State Health Services. (2014). *ValueOptions Contract and Appendices September 1, 2013 – August 31, 2015*. Retrieved from <http://www.dshs.state.tx.us/mhsa/northstar/contract13-15/>

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.¹⁹⁹ The following figures include the utilization and costs of services provided by the NorthSTAR program.

Figure 39. Utilization of NorthSTAR Services By Population

	2011	2012	2013
Medicaid	20,732	21,153	23,964
Indigent	24,028	22,251	23,143

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

Texas Department of State Health Services. (2013). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/>

Figure 40. FY 2013 COSTS for NorthSTAR Services

	FY 2013
Cost for overall mental health services	\$131,092,179
Dollars per capita in service delivery area	\$34.19
Dollar per capita <200% FPL in service delivery area	\$95.55

Source: Texas Department of State Health Services. (2014). *NorthSTAR service trends*. Retrieved from <http://www.dshs.state.tx.us/mhsa/northstar/databook.shtm>

QUALITY OF CARE MEASURES

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

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

Source: Texas Department of State Health Services. (2013). *NorthSTAR Data Book, Q3 2013*. Retrieved <http://www.ntbha.org/reports.aspx>

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.²⁰⁰ 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.²⁰¹

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.²⁰²

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.²⁰³ 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.²⁰⁴

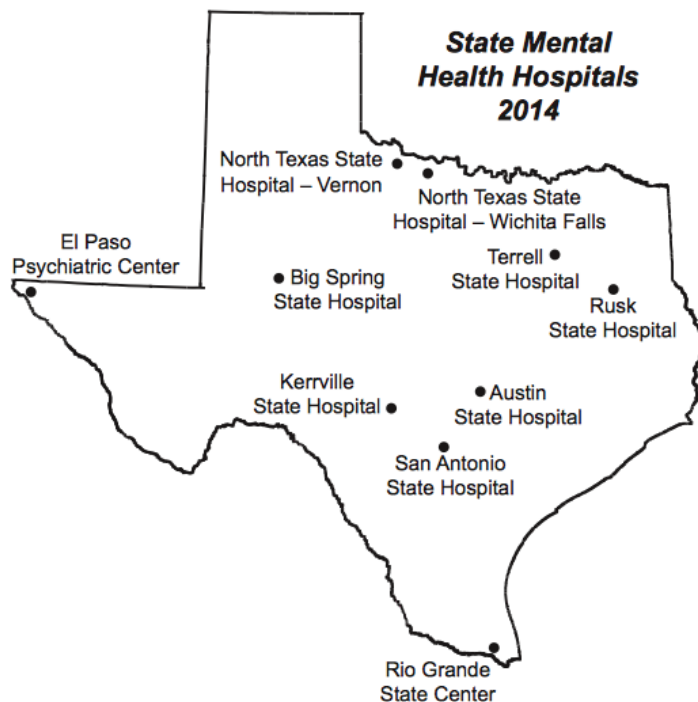
Only transitional forensic programs and forensic maximum security beds are designated as forensic beds. All other psychiatric beds are available either to civil or forensic patients on a first come first serve basis.²⁰⁵

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 2013.²⁰⁶

Figure 42. State Mental Health Hospitals: 2014*



*This map excludes the Waco Center for Youth

Source: Sunset Advisory Commission. (2014, August). *Staff report with decision material: Department of State Health Services*. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Decision%20Material_0.pdf

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 services²⁰⁷.

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.²⁰⁸

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

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

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

Texas Department of State Health Services. (2012) *Mental Health State Hospitals* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589966342>

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

Figure 44. Utilization and Costs for State Hospitals

	FY 2013
Total admissions	14,029
Average cost per person	\$16,192
Average cost per bed per day	\$401
Average length of stay	64 days

Sources: Texas Department of State Health Services, State Hospitals Section. (2014). *Statewide Performance Indicators 1st quarter FY 2014*. Retrieved from http://www.dshs.state.tx.us/mhreports/PIMHpub_2.shtm

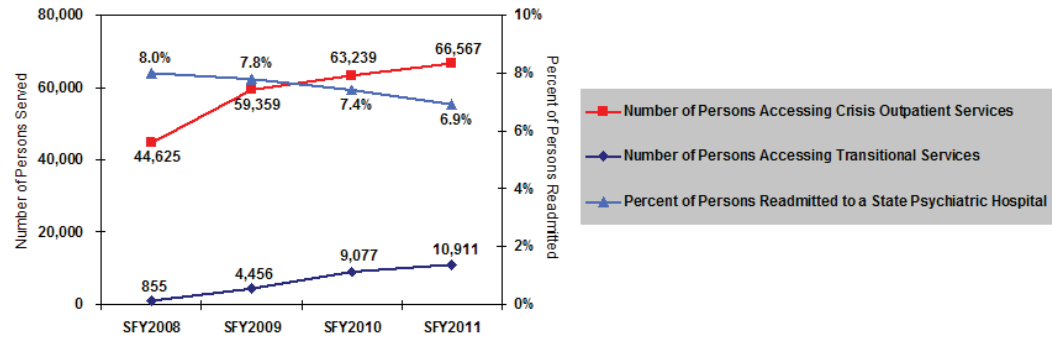
The increase of forensic commitments is a key driver in the upsurge of hospital spending, as commitments of this nature are typically longer and more cost intensive than civil commitments. In FY 2013, the average length of stay for state mental health hospital forensic patients ruled NGRI was 370 days 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.

Figure 45. Number of persons accessing crisis outpatient services and transitional services at DSHS-funded community centers compared to percent of persons readmitted to a state psychiatric hospital within 30 days.



Source: DSHS client assignment registration system. Retrieved from http://www.dshs.state.tx.us/sa/_BHNH

STATE-FUNDED COMMUNITY AND PRIVATE HOSPITALS

Due in part to 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

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

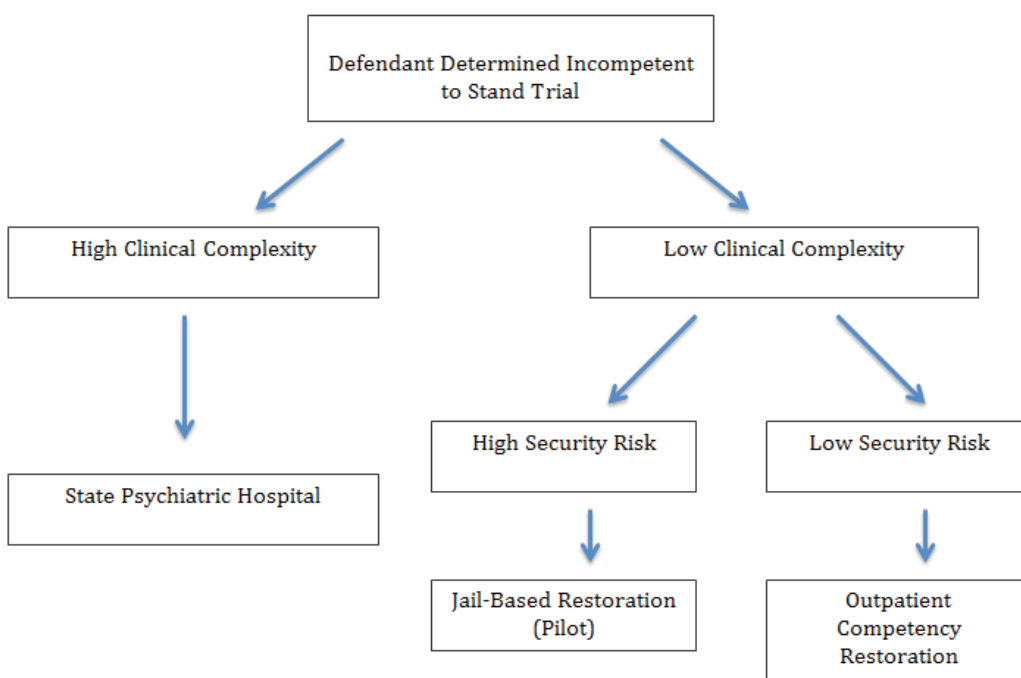
Source: Texas Department of State Health Services. (2013). *Overview of the Public Mental Health System. Presentation to the House Public Health Committee*. Retrieved from <http://www.dshs.state.tx.us/legislative/default.shtm>

Texas Department of State Health Services. (2014, May, 19). Personal communications: Community Hospitals

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.²¹⁵ 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).²¹⁶ 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.²¹⁷ In FY 2012, 12.3 percent of all commitments to state-run psychiatric hospitals were for individuals found IST.²¹⁸ Because those commitments have a much longer average length of stay, the average daily census for forensic patients nearly equaled that of civil patients.²¹⁹ The average cost of competency restoration in a state hospital is over \$400 per day.²²⁰

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.²²¹ 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.²²² Roughly 51% of individuals had misdemeanor offenses and 49% had felony offenses. The average cost per day for outpatient competency restoration in 2013 was \$229.²²³ 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.²²⁴ 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).²²⁵

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:²²⁶

- 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**

Type of Program	Cost Per Day	Avg. Length of Stay	Avg. Total Cost per Individual Served	Success Rate
State Psychiatric Hospital ²²⁷ (FY 2012)	\$421	120 days	\$50,520	75% restored
Outpatient Competency Restoration ²²⁸ (FY 2013)	\$229	128 days	\$29,312	58% restored or improved with charges dropped*
Jail-Based Competency Restoration ²²⁹ (San Bernadino, CA program, FY 2012)	\$278	63 days	\$17,514	45% restored

*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.

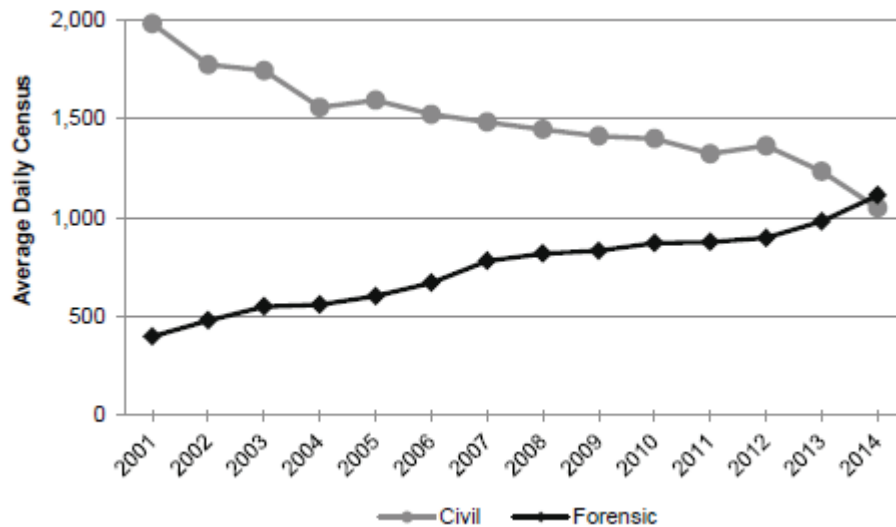
Addressing the Shortage of Public Inpatient Beds

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 2010.²³⁰ 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



Source: Sunset Advisory Commission (2014). *Department of State Health Services: Staff Report*. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Staff%20Report_1.pdf

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 LMHAs²³⁵. 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.²³⁶ 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 MSHA 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.²³⁷

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.

ACCESS

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.

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

FUNDING

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.²⁴¹

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:²⁴²

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.²⁴³

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.

Nationally, among adults with substance use disorder, 42 percent had a co-occurring diagnosed mental illness.²⁴⁴ 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:²⁴⁵

- 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.²⁴⁶ In FY 2013, 4,081 individuals were served through COPSD programs.²⁴⁷

SERVICES

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

Figure 50. Available Substance Use Services Through DSHS

Services	Service Available to Adults	Service Available to Youth
Screening	X	X
Assessment	X	X
Referral	X	X
Residential intensive	X	X
Residential intensive (specialized female)	X	X
Residential intensive (women and children)	X	X
Residential supportive	X	X
Residential supportive (specialized female)	X	X
Residential supportive (women and children)	X	X
Residential detox	X	
Residential detox (specialized female)	X	
Ambulatory detox	X	
Ambulatory detox (specialized female)	X	
HIV residential	X	
Outpatient services	X	X

Services	Service Available to Adults	Service Available to Youth
Individual	X	X
Female	X	X
Group	X	X
Adolescent support		X
Family counseling		X
Family support		X
Psychiatrist consultation		X
Outpatient services (specialized female)	X	X
Individual	X	X
Group	X	X
Opioid substitution therapy	X	
Co-occurring psychiatric & substance use Conditions	X	X

Source: Texas Department of State Health Services (2013). *Substance Abuse Treatment Contract Performance Measure Report – FY 2014*. Retrieved from <http://www.dshs.state.tx.us/mhsa/prs/>

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

		2009	2010	2011	2012	2013
Prevention program	Number served per year	366,810	409,585	468,054	468,054	492,925
	Avg. cost per adult per year	\$20	\$19	\$16	\$16	\$15
Intervention programs	Number served per year*	180,586	128,281	123,914	141,299	167,032
	Cost per adult per year**	\$64	\$97	\$89	\$71	\$60
Treatment programs	Number per year	41,348	42,194	31,627	31,206	31,303
	Cost per adult per year	\$1,827	\$1,888	\$1,617	\$1,582	\$1,617
Number on the wait list for substance use treatment**		10,948	10,347	8,193	9,034	9,806

*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 of adults entered on waiting list by following substance abuse programs: COPSD, D

Detox, Methadone, Outpatient and Residential.

Sources: 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/>

Texas Department of State Health Services. (2010). *Behavioral health data book, FY 2010, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/>

Figure 52. Utilization and Costs for Youth Substance Use Services

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

*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.

Sources: Texas Department of State Health Services. (October 11, 2013). *Behavioral health data book, FY 2013, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/> and Texas Department of State Health Services. (October 7, 2010). *Behavioral health data book, FY 2010, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/>

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

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

Sources: Texas Department of State Health Services. (October 10, 2013). *Behavioral health data book, FY 2012, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/> and Texas Department of State Health Services. (October 7, 2010). *Behavioral health data book, FY 2010, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/>

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

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

Sources: Texas Department of State Health Services. (October 10, 2013). *Behavioral health data book, FY 2012, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/> and Texas Department of State Health Services. (October 7, 2010). *Behavioral health data book, FY 2010, fourth quarter* [PowerPoint slides]. Retrieved from <http://www.dshs.state.tx.us/mhsa/databook/>

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.²⁴⁸ 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.²⁴⁹

Texas Department of Family and Protective Services: At A Glance

Texas Department of Family and Protective Services	125
Changing Environment	126
Foster Care Redesign	126
Parental Relinquishment of Custody	127
Specialty Courts	128
Accessing Mental Health Services	132
Superior Health System (STAR Health)	132
Former Foster Care Children Program (FFCC)	132
Institutional Residential Services	134
Alternative Response System	134
System of Care	135
Continuing Issues	135
Child Fatalities in the CPS System	135
Disproportionality	137
Lesbian, Gay, Bisexual, Transgender, Queer Youth	138
Psychotropic Medications	139
Trauma-Informed Care	141
Seclusion and Restraint	142
Prevention and Early Intervention (PEI)	142
Adult Protective Services (APS)	145
Child Care Licensing	147

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

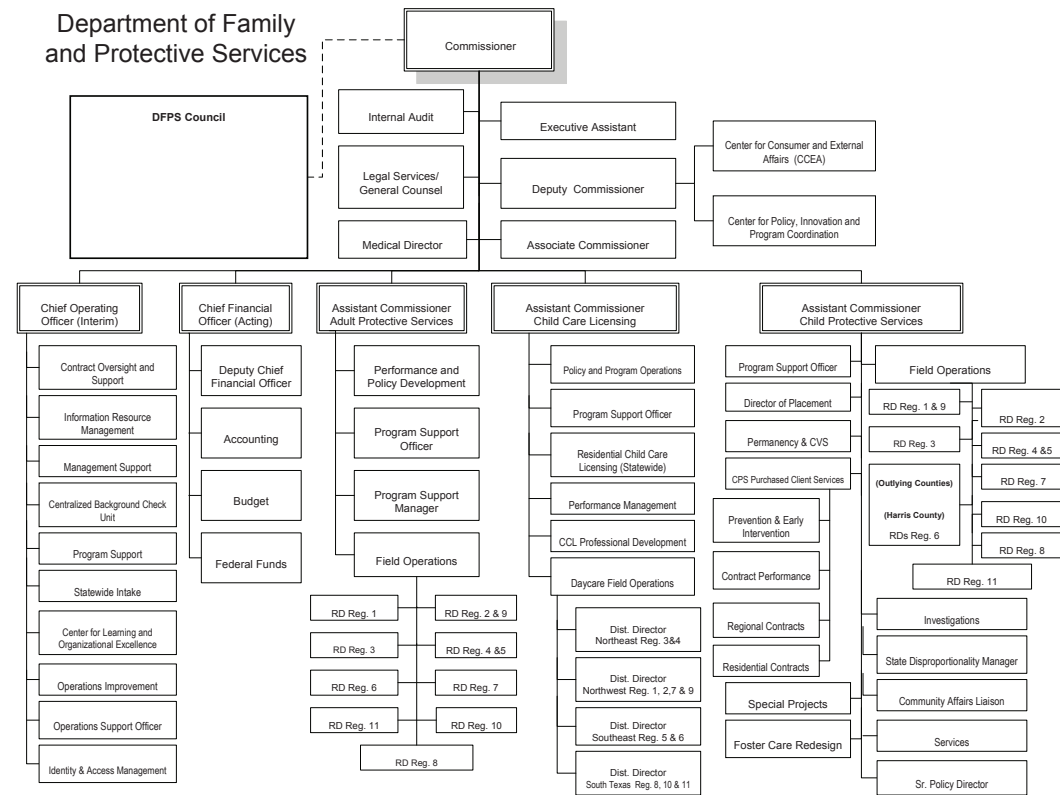
In FY 2013:

- 258,996 children were alleged victims of abuse statewide.

- CPS completed 160,240 investigations of abuse or neglect.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”²⁵¹).
- Of this number, 17,022 children were removed from their homes.²⁵²
- 16,676 children were in the Texas foster care system (excluding kinship care).²⁵³
- There were 156 confirmed child abuse or neglect related fatalities.²⁵⁴
- Children aged three and younger represented 80 percent of the child fatalities from abuse and neglect in Texas.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.²⁵⁶

ORGANIZATIONAL CHART



Revised 02/15/2014

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:²⁵⁷

Child Protective Services (CPS):	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.
Prevention and Early Intervention (PEI):	Provides community outreach on mental health and other wellness services.
Adult Protective Services (APS):	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.
Child Care Licensing (CCL):	Regulates the childcare system to ensure safety and other statewide regulations are met. Educates parents and communities on childcare and childcare facilities.

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 2017.²⁵⁸

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:²⁵⁹

- 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.²⁶⁰

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.²⁶¹ 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.²⁶² 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.²⁶³ This pilot will serve Erath, Hood, Johnson, Tarrant, Palo Pinto, Somervell, and Parker counties.²⁶⁴ 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.²⁶⁵

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.²⁶⁶ 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.²⁶⁷

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.²⁶⁸ Relinquishment can also irreparably damage the child-family bond and result in insecure attachment of the child to parents or other caregivers.²⁶⁹

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

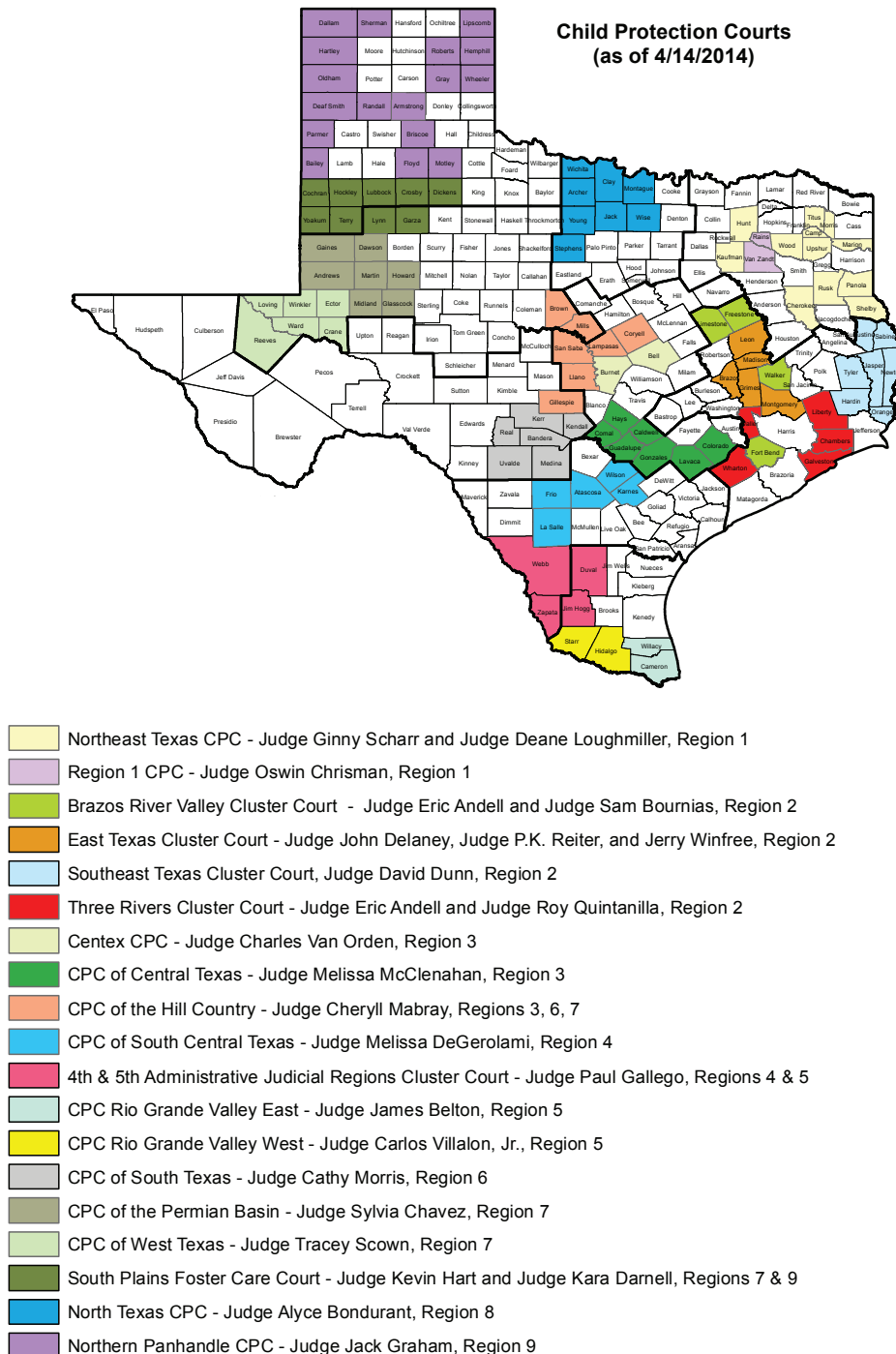
State child welfare officials in 19 states and county juvenile justice officials in 30 counties who responded to surveys estimated that in FY 2001, parents in their jurisdictions placed over 12,700 children— mostly adolescent males— into the child welfare or juvenile justice systems so that these children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

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



Source: Texas Courts Online. (2014, April 14). *Specialty Courts Program*. Retrieved from <http://www.txcourts.gov/courts/specialty.asp>

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.²⁷² 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.²⁷³ A traumatized youth is at higher risk of substance abuse, mental health issues (such as depression and suicide), promiscuity, and criminal behavior.²⁷⁴

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.²⁷⁵ Nearly half of youth in child welfare have clinically significant emotional or behavioral problems.²⁷⁶ Rates of behavioral problems, developmental delays, and need for psychiatric intervention for foster care youth range from 60–80 percent.²⁷⁷ ²⁷⁸ 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.

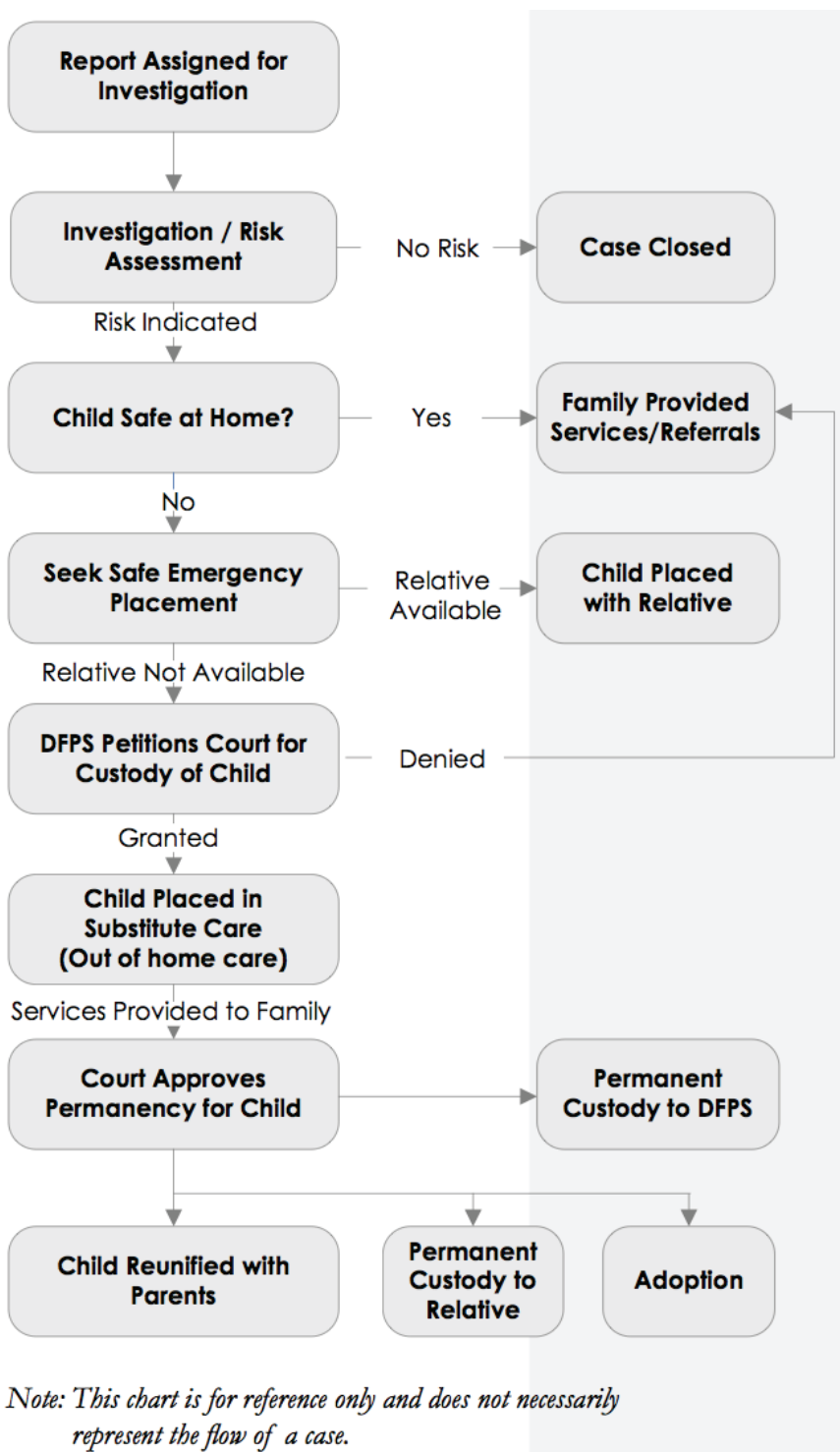
In FY 2013, 258,996 children statewide were alleged victims of abuse. There were 100,861 children in confirmed investigations (confirmed is defined as, “based on preponderance of evidence, staff concluded that abuse or neglect occurred”).²⁷⁹ Of this number, 17,022 children were removed from their homes.²⁸⁰

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.²⁸¹ 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



Source: Texas Department of Family and Protective Services. (2014). *Annual Report and Data Book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf

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

Plan Name	Eligibility	Income or Other Requirements
Former Foster Care in Higher Education (FFCHE) [Prior to integration into FFCC]	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.	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.
Medicaid for Transitioning Foster Care Youth (MTFCY) [For those ineligible for FFCC]	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.	Have income at or below \$3,955 per month for an individual.
Former Foster Care Children Program (FFCC)	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.	No asset, income, or educational requirements.

Source: Texas Human Health and Services Commission. (2014, May). *Medicaid for Former Foster Care Youth*. Retrieved from <http://www.onevoicetexas.org/2014%20HHSC%20Presentation.pdf>

Source: Texas Human Health and Services Commission. (n.d.). *Texas Works Handbook*. Retrieved from <http://www.dads.state.tx.us/handbooks/texasworks/F/100/100.htm>

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.²⁸⁷ 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

intervention.²⁹⁸ 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.²⁹⁹

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.³⁰⁰ 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.³⁰¹

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.³⁰² 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.³⁰³ 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 2017.³⁰⁴

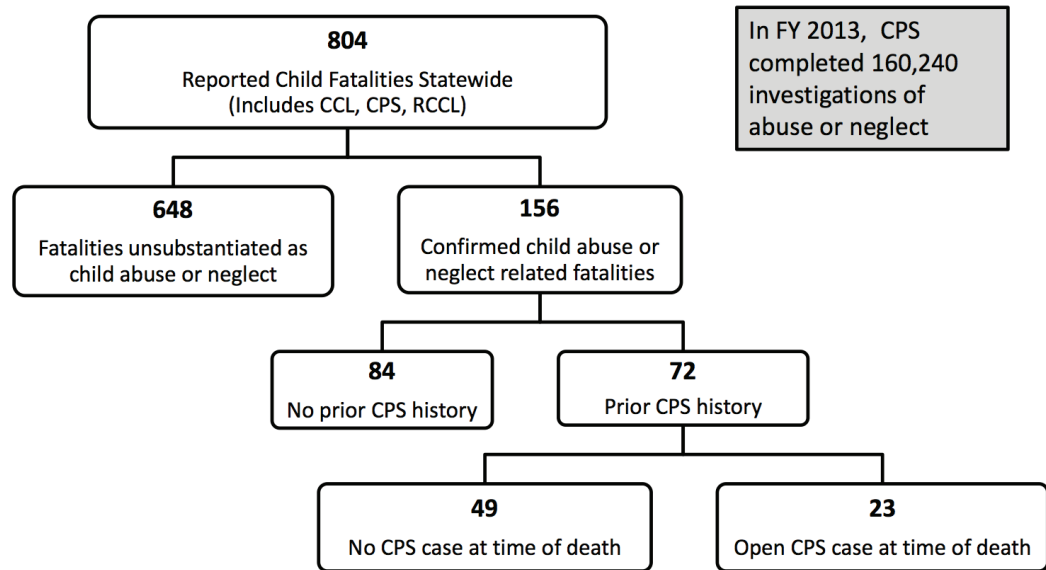
Continuing Issues

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 2013.³⁰⁵ 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:

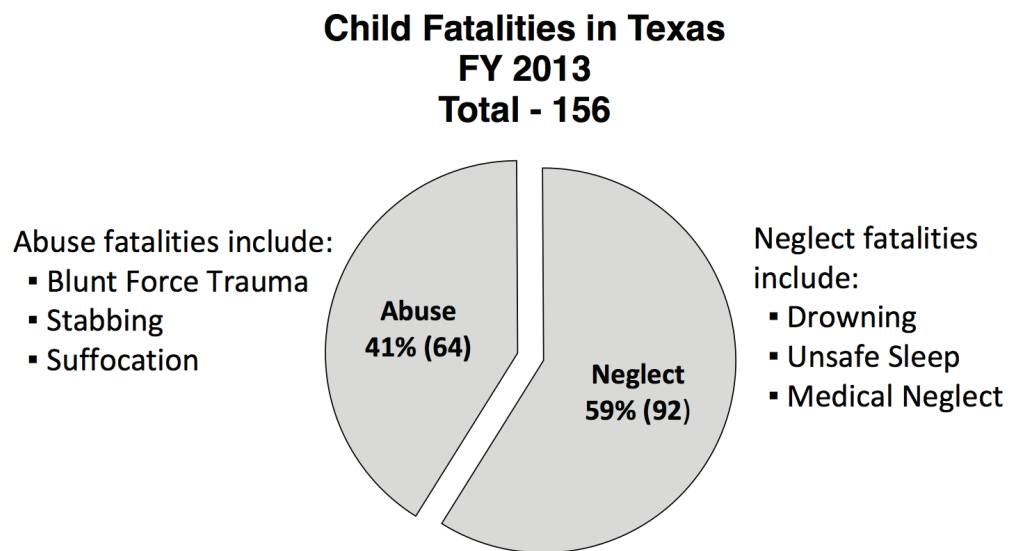
Children aged three and younger represented 80 percent of the child fatalities from abuse and neglect in Texas in FY 2013.

Figure 58. Child Mortalities in Texas



Source: Senate Health and Human Services Committee. (2014, February 20). *Interim Charges for DFPS*. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/

Figure 59. Confirmed Child Fatalities Due to Abuse or Neglect



Source: Senate Health and Human Services Committee. (2014, February 20). *Interim Charges for DFPS*. Retrieved from www.dfps.state.tx.us

In 2013, 46 percent of families with child fatalities had prior involvement with CPS.³⁰⁶ High caseloads for CPS workers may lead to failures to conduct routine visits, identify risks, and intervene appropriately.^{307, 308, 309} 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.³¹⁰ 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.³¹¹ In 2012, CPS hired 1,704 caseworkers.³¹² However, turnover rates in some CPS regions were as high as 34.3 percent.³¹³ Lower-tenured workers require more supervision and training, so turnover among caseworkers affects the department's overall efficiency and timeliness with cases.³¹⁴

In FY 2012, two children died from abuse/neglect while in foster care placement.³¹⁵ In FY 2013, this number rose to 8.³¹⁶ DFPS passed new regulations designed to enforce stricter monitoring of foster care homes, effective September 1, 2014. These new safety rules require:³¹⁷

- 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.

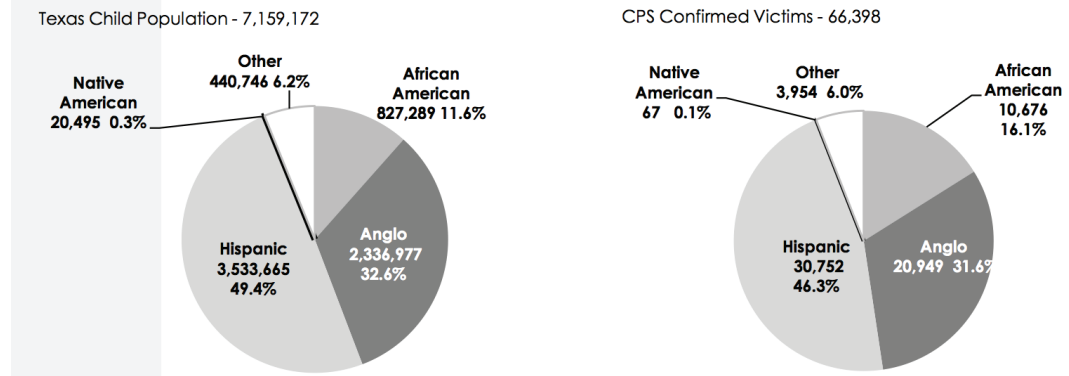
Child Placing Agencies will also be expected to monitor more closely changes in the foster home, such as job losses, marriages, divorces, frequent visitors, and family additions.³¹⁸ These steps were put in place to protect and provide more oversight of foster care children to prevent child fatalities.

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.³¹⁹ A number of theories have offered explanations for disproportionality within the child welfare system including:³²⁰

- 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:

Figure 60. Disproportionality in the CPS System**Race/Ethnicity * of Selected CPS Statistics Compared to Texas Child Population
Fiscal Year 2013**

Source: Texas Department of Family and Protective Services. (2014). *2013 Annual Report and Data Book*. Retrieved from http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/Combined13.pdf

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.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.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.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.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.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.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.³²⁷ There are currently no policies in Texas specifically addressing the needs of LGBTQ youth in the state's foster care system.

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.

PSYCHOTROPIC MEDICATIONS

Foster children are disproportionately treated for their behavioral health needs with psychotropic medications (drugs that affect the mind, emotions, and behavior).³²⁸ 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.³²⁹ 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.³³⁰ Usage of psychotropic medications may also result in long-term effects such as stunted physical development.³³¹ 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.^{332, 333}

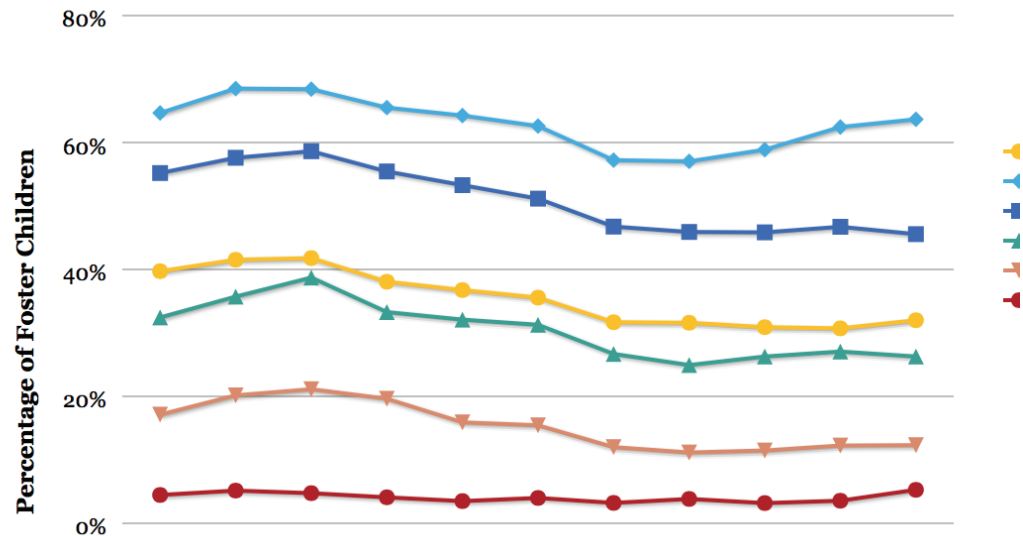
One research study showed that nationally 10 percent of foster kids received antipsychotic medications, a powerful subset of psychotropics with significant side effects in children.

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.³³⁴ However, children's symptoms of trauma may be misinterpreted as deliberate problematic behavior.³³⁵ 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.³³⁶

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.

Figure 61. Psychotropic Medication Prescriptions

Source: Health and Human Services Commission



Source: Aaronson, B. (2013, January 29). Rate of Foster Kids on Psychotropic Drugs Falls. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/2013/01/29/interactive-foster-children-prescribed-high-doses/#>

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 consentor 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 consentor, a legal right that is typically delegated to legal caregivers such as foster parents, relative and kinship caregivers, and certain DFPS staff.³³⁷

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.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.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 (82nd), 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.

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.

SECLUSION AND RESTRAINT

DFPS

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.

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.³⁴⁰ 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.³⁴¹

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.³⁴² 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.

Figure 62. Prevention and Early Intervention Programs and Services and their Costs and Availability in Texas

Program	Program Description	Services	Regional Availability	Numbers Served	Cost
Services to At Risk Youth (STAR)	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.	Family crisis intervention counseling, short-term emergency residential care, and individual and family counseling.	All Texas Counties.	Average monthly youth served = 5,351 Average yearly youth served = 23,677 ³⁴³	Average monthly cost per youth served = \$255.16 ³⁴⁴

Program	Program Description	Services	Regional Availability	Numbers Served	Cost
Community Youth Development	Contracts with community organizations to develop juvenile delinquency prevention programs in zip codes that have a high incidence of juvenile crime.	Varies across communities but may include mentoring, youth-employment programs, career preparation, and alternative recreational activities.	Potter, Travis, Nueces, Dallas, El Paso, Tarrant, Galveston, Harris, Lubbock, Hidalgo, Harris, Bexar, McLennan.	Annual youth served = 16,767 ³⁴⁵	Average monthly cost per year served = \$71.63
Texas Families: Together and Safe	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.	Vary across communities but may include outreach, family interventions, and promoting support networks.	Community-based programs in select Texas counties.	Annual number of families served 1,736	Average monthly cost per family served = \$334.79
Community-Based Child Abuse Prevention	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.	Respite, parent education, fatherhood services, parent leadership, home visitation, and various special initiatives, including public awareness campaigns.	Funds distributed to communities across Texas.	Annual number of families served = 990	Total Expenditures in FY 2012 = \$716,847 ³⁴⁶

Program	Program Description	Services	Regional Availability	Numbers Served	Cost
Texas Runaway and Youth Hotlines	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.	Crisis intervention, telephone counseling and referrals to troubled youth and families.	Widespread availability.	2013 incoming calls = 7,462 ³⁴⁷	2013 Expenditures = \$253,372 ³⁴⁸
Statewide Youth Services Network	Supports statewide networks of community-based prevention programs that provide evidence-based juvenile delinquency prevention services.	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.	Available in each DFPS region.	Annual number of youth served = 4,384	Average monthly cost per youth served = \$50.71 ³⁴⁹
Preparation for Adult Living Program	Prepares older foster youth in substitute care for their departure from the child protective services system.	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	All DFPS Regions	Number of youth served in 2013 = 7,265	Average cost per youth = \$532.63 ³⁵⁰

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).³⁵¹ The strategy behind Project HOPES is to encourage the development of protective factors that will reduce the likelihood of child abuse and neglect.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.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.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.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.³⁵⁶ The total of the completed in-home and facility investigations in FY 2013 are enumerated below:³⁵⁷

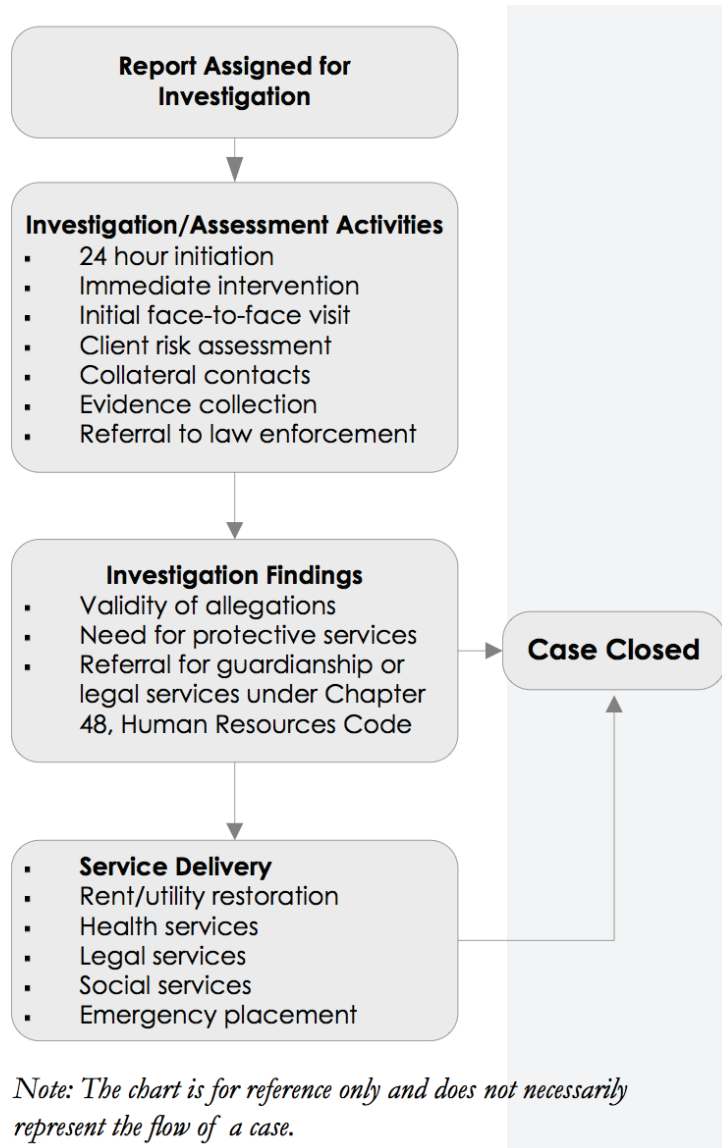
- 69,383 completed in-home investigations.
- 48,393 in-home validated allegations.
- 10,818 completed facilities investigations.
- 1,373 confirmed allegations.

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.³⁵⁸

Figure 63 illustrates the APS flow of a case once an allegation is received:

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. This increase in the elderly population could indicate a higher need for services in the future.

Figure 63. APS Investigation Process



Source: Texas Department of Family and Protective Services. (2014). *2013 Annual Report and Data Book*. Retrieved from http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/Combined13.pdf

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.³⁵⁹ 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

Day Care or Licensed Child Care Center	Children from birth through 13 years of age who attend childcare centers and childcare homes for part of the 24-hour day.
At-home day cares also known as group daycare homes or a Licensed childcare home	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.
Residential child care	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.

Source: Texas Department of Family and Protective Services. (n.d.). *Guide to Childcare in Texas*. Retrieved from https://www.dfps.state.tx.us/child_care/other_child_care_information/childcare_types.asp

The number of children living in regulated, residential childcare in Texas is approximately 41,420.³⁶⁰ In 2013, there were 21,980 daycare centers and homes in Texas, with a total capacity of 1,085,366.³⁶¹ 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.

Texas Department of Aging and Disability Services: At A Glance

Texas Department of Aging and Disability Services 151

Prevalence of Behavioral Health Conditions for People with Disabilities and Aging Texans	152
People with Disabilities	152
Aging Texans	152
Changing Environment	153
SB 7	153
SB 45	153
SB 1226	153
Trauma-informed care and person-centered planning, training and technical assistance at San Angelo and Mexia State Supported Living Centers	154
2013 Trauma-informed care trainings at DADS waiver conferences	154
Programs and Services for People with Disabilities Who Have Co-occurring Behavioral Health Conditions	154
Community Long-Term Services and Supports	
Medicaid 1915(c) Waiver Services	155
Role of Local Authorities in Connecting People to Waiver Services	158
Institutional Long-Term Services and Supports	158
Skilled Nursing Facilities	158
Community Intermediate Care Facilities	159
State Supported Living Centers	159
Additional Programs for People with Disabilities and Aging Texans	165
Non-Medicaid Services	165
Guardianship Program	165
Promoting Independence Initiative	165
Money Follows the Person Program	166

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

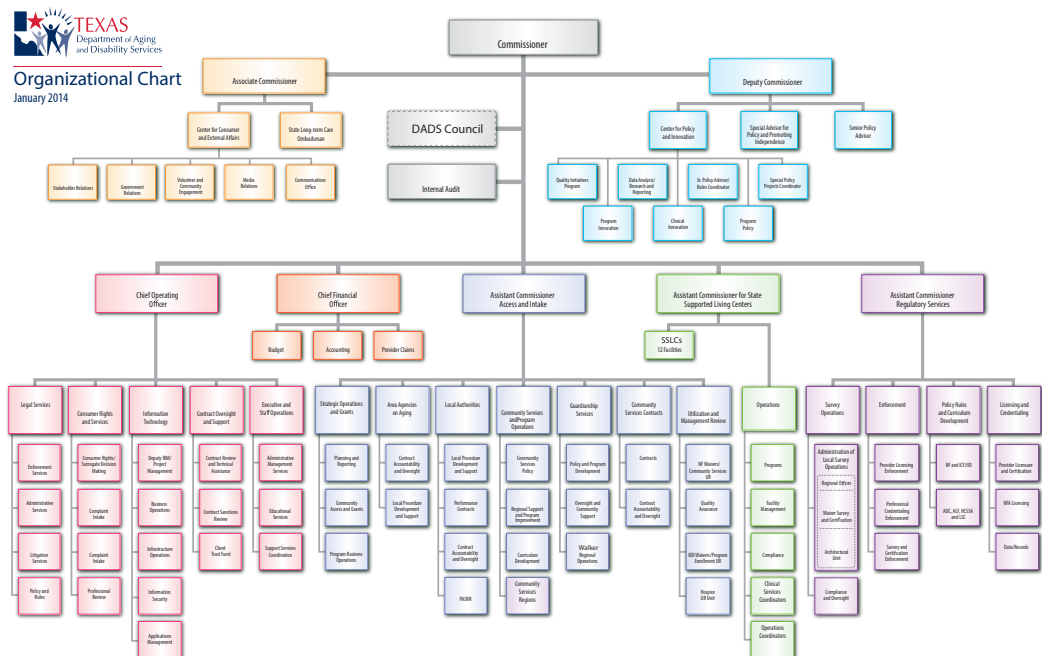
FAST FACTS

- 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.^{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.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.³⁶⁶

ORGANIZATIONAL CHART



DADS Public Services 14P150 - January 20, 2014

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.³⁶⁷ Research has also indicated an over-representation of schizophrenia in people with IDD compared to the general population.³⁶⁸ Post-traumatic stress has also been identified as a significant cause of mental health concerns in people with IDD.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.

DADS

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.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.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.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.^{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.³⁷⁵

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.

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.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.

For a more comprehensive summary of SB 7, please visit the Hogg Foundation website at <http://www.hogg.utexas.edu/uploads/documents/83rd%20Lege%20Summary3.pdf>

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.

TRAUMA-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

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
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: <ul style="list-style-type: none"> supported home living foster/companion care supervised living (group home) residential support Respite Day habilitation Nursing services Employment services Supported employment

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
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 Habilitation 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

Sources: Texas Department of Aging and Disability Services. (2013). *Reference Guide 2013*. Retrieved from <http://cfoweb.dads.state.tx.us/ReferenceGuide/guides/FY13ReferenceGuide.pdf>.

Texas Department of Aging and Disability Services. (n.d.). *Website FAQs and fact sheets*. Retrieved from <http://www.dads.state.tx.us/services/faqs-fact/index.html> and

http://www.dads.state.tx.us/providers/waiver_comparisons/LTSS-Waivers.pdf.

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

Waiver	Est. Avg. Number Served per month FY 2014 (not limited to persons with behavioral health conditions)	Avg. Monthly Interest List FY 2014	Est. Average Monthly Cost per Client FY 2014
Home and Community-Based Services (HCS)	20,903	70,117	\$ 3,530
Community Living Assistance and Support Services (CLASS)	4,712	50,035	\$ 3,723
Texas Home Living Waiver (TxHmL) (TxHmL)	5,845	Uses the HCS Interest List	\$ 813
Medically Dependent Children's Program (MDCP)	2,361	27,575	\$ 1,429
Deaf/Blind/Multiple Disabilities (DBMD)	169	480	\$ 4,302
Community-based Alternatives Program (CBA)	9,939	6,040	\$ 1,302

Sources: Department of Aging and Disability Services. (2014). *2016-2017 Legislative Appropriations Request*. Retrieved from http://cfoweb.dads.state.tx.us/lar/2016_17/volumeI.asp

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.

- The eligibility for specialized services.³⁷⁹

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.³⁸⁰

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.

Figure 67. State Supported Living Center Census Data

	Sept. 2008	Sept. 2009	Sept. 2010	Sept. 2011	Sept. 2012	Sept. 2013	Feb. 2014
Total SSLC Census	4,769	4,532	4,182	3,982	3,774	3,547	3,457

Source: Texas Department of Aging and Disability Services (2014, April 17). Promoting Independence Activity Report presented to the Promoting Independence Advisory Committee.

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.

Figure 68. Institutional Care Eligibility and Behavioral Health-Related Services Disabilities

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
Nursing Facilities	Have a medical condition that requires the skills of a licensed nurse on a regular basis.	24-hour residential care and services that include: PASRR (see above). Behavioral health services. Medication management. Skilled nursing. Specialized therapies/services.

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions	<p>Have a diagnosis of intellectual disability with a full-scale IQ score of below 70 and an adaptive behavior level with mild to extreme deficits, or</p> <p>Have a full-scale IQ score of 75 or below and a primary diagnosis by a licensed physician of a related condition (manifest before age 22 years), and an adaptive behavior level with mild to extreme deficits, or</p> <p>Have a primary diagnosis of a related condition (manifest before age 22) diagnosed by a licensed physician regardless of IQ and an adaptive behavior level with moderate to extreme deficits, AND</p> <p>Be in need of and able to benefit from the active treatment provided in the 24-hour supervised residential setting of an ICF.</p> <p>Be eligible for SSI or be determined financially eligible for Medicaid.</p>	<p>24-hour residential care and services that include:</p> <p>Physician services.</p> <p>Behavioral health services.</p> <p>Medication management.</p> <p>Nursing.</p> <p>Skills training.</p> <p>Occupational, physical and speech therapies.;</p> <p>Services to maintain connections between residents and their families/natural support systems.</p>
State Supported Living Centers	<p>Meet ICF/ID eligibility requirements.</p> <p>(1) Have severe or profound intellectual and developmental disabilities, OR (2) Have intellectual and developmental disabilities and be medically fragile, OR (3) Have intellectual and developmental disabilities and behavioral challenges, OR (4) Represent a substantial risk of physical injury to self or others.</p> <p>As an adult, be unable to provide for the most basic personal physical needs.³⁸²</p>	<p>24-hour residential care and services that include:</p> <p>Physician and nursing services.</p> <p>Behavioral health services.</p> <p>Skills training.</p> <p>Occupational therapies.</p> <p>Vocational programs and employment.</p> <p>Services to maintain connections between residents and their families/natural support systems.</p>

Source: Texas Department of Aging and Disability Services. (2013). Reference Guide 2013. Retrieved from <http://cfoweb.dads.state.tx.us/ReferenceGuide/guides/FY13ReferenceGuide.pdf>.

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

Setting	Estimated Average Number Served per Month FY 2014	Estimated Average Monthly Cost per Client FY 2014
Nursing Facilities	55,915	\$ 3,390
Intermediate Care Facilities	5,227	\$ 4,356
State Supported Living Centers	3,439	\$ 16,034

Texas Department of Aging and Disability Services. (2014). 2016-2017 Legislative Appropriations Request. Retrieved from http://cfoweb.dads.state.tx.us/lar/2016_17/volume1.asp

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)

Program	Expended 2013	Estimated 2014	Budgeted 2015	Requested 2016	Requested 2017
Community-based alternatives (CBA)	\$146,443,637	\$155,249,965	0 (Transferred to STAR+Plus)	0 (Transferred to STAR+Plus)	0 (Transferred to STAR+Plus)
Community Living Assistance and Services Supports (CLASS)	\$202,065,579	\$209,977,202	\$225,301,068	\$231,050,814	\$231,050,814

Program	Expended 2013	Estimated 2014	Budgeted 2015	Requested 2016	Requested 2017
Home and Community-Based Services (HCS)	\$844,768,822	\$885,501,250	\$977,566,068	\$968,625,479	\$968,625,479
Deaf-blind with multiple disabilities (DBMD)	\$7,690,746	\$8,783,912	\$11,776,215	\$12,643,008	\$12,643,008
Medically dependent children's program (MDCP)	\$39,639,172	\$40,486,431	\$44,001,299	\$41,749,547	0 (transfers to STAR kids)
Texas Home Living Waiver (TxHmL)	\$48,462,288	\$57,075,024	\$80,883,385	\$82,211,947	\$82,211,947
Intermediate Care Facilities for Individuals with ID (ICFID)	\$286,527,175	\$280,912,477	\$281,011,219	\$282,671,837	\$282,570,235
Nursing Facilities	\$2,257,033,016	\$2,286,729,014	\$1,284,604,394*	\$145,040,486*	\$144,224,828*
State supported living centers (SSLCs)	\$661,866,854	\$677,050,452	\$679,774,904	\$682,860,733	\$682,860,733

Source: Texas Department of Aging and Disability Services. (2014). 2016-2017 Legislative Appropriations Request. Retrieved from http://cfoweb.dads.state.tx.us/lar/2016_17/volume1.asp.

**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

Program	Enrolled	FY2011		FY2012			FY2013		
		BH Diagnosis	%	Enrolled	BH Diagnosis	%	Enrolled	BH Diagnosis	%
CBA	28,874	4,747	16.44 %	25,675	3,514	13.69 %	14,631	2,296	15.69 %
CLASS	4,954	1,105	22.31 %	4,910	1,102	22.44 %	4,828	1,080	22.37 %
HCS	20,829	7,644	36.70 %	21,102	7,856	37.23 %	21,404	8,201	38.32 %
DBMD	156	16	10.26 %	155	16	10.32 %	158	16	10.13 %
MDCP	6,394	2,138	33.44 %	6,257	2,445	39.08 %	6,407	2,486	38.80 %
TxHmL	2,557	685	26.79 %	5,363	1,410	26.29 %	5,997	1,522	25.38 %
ICFsIID	6,500	2,630	40.46 %	6,265	2,583	41.23 %	6,169	2,535	41.09 %
Nursing Facilities*	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	93,466	56,439	60.38 %
SSLCs	4,294	2,468	57.48 %	4,084	2,386	58.42 %	3,907	2,257	57.77 %

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

Program	FY2010	FY2011	FY2012	FY2013
CBA	\$ 1,564	\$ 1,600	\$ 1,458	\$ 1,265
CLASS	\$ 3,592	\$ 3,444	\$ 3,502	\$ 3,610
HCS	\$ 3,527	\$ 3,464	\$ 3,433	\$ 3,489
DBMD	\$ 4,083	\$ 4,195	\$ 4,175	\$ 4,256
MDCP	\$ 1,537	\$ 1,491	\$ 1,475	\$ 1,444
TxHmL	\$ 664	\$ 668	\$ 799	\$ 870
ICFsIID	\$ 4,535	\$ 4,495	\$ 4,361	\$ 4,338
Nursing Facilities	\$ 3,181	\$ 3,130	\$ 3,228	\$ 3,275
SSLCs	\$ 12,257	\$ 13,588	\$ 14,286	\$ 15,112

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.³⁸⁵

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.

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.³⁸⁶ 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*

TABLE OF CONTENTS

Texas Department of Assistive and Rehabilitative Services	169
Division for Early Childhood Intervention Services	170
Eligibility for Services	170
Services, Utilization, and Costs	171
Division for Rehabilitation Services	172
Vocational Rehabilitation Program	173
Program Overview	173
Eligibility Process	174
Services	174
Independent Living Services	175
Expansion	175
Eligibility	176
Services	176
Division of Disability Determination Services (DDS)	176
Process for Admission and Eligibility	178
Utilization	179
Division for Blind and Visually Impaired	179

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

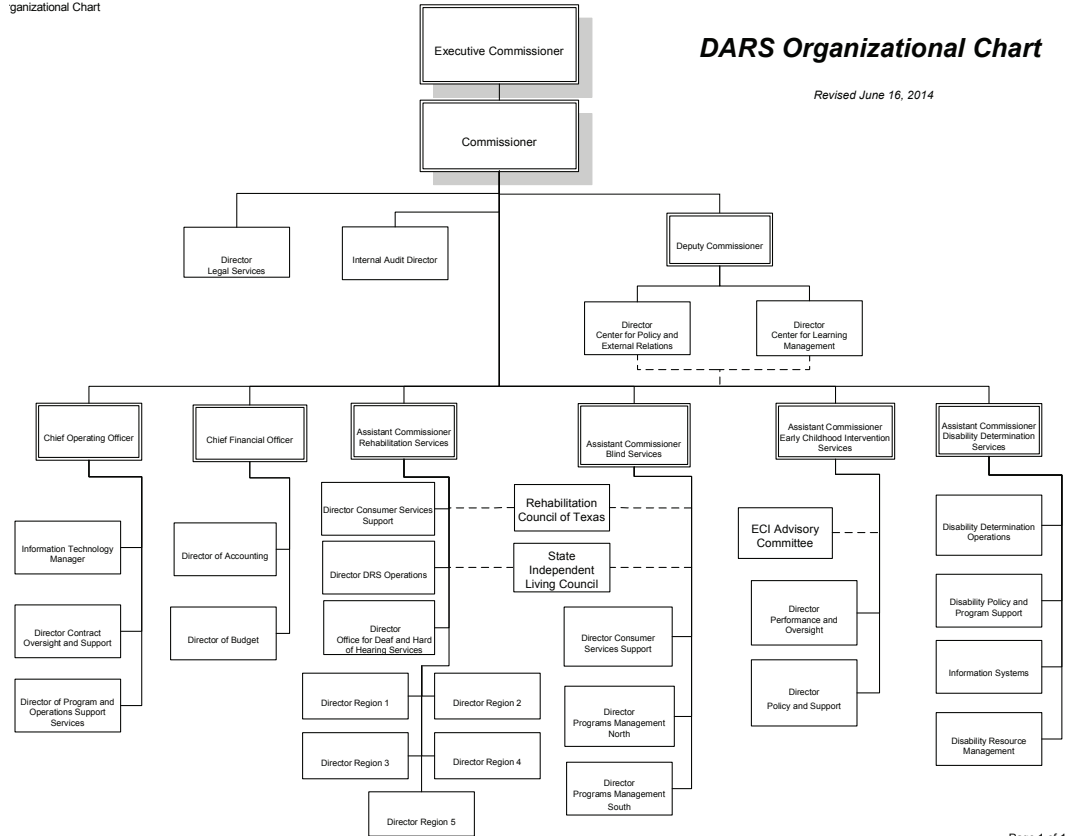
FAST FACTS

- The national employment rate for the general population in 2012 was 63.9 percent.³⁸⁷ Comparatively, the employment rate for persons with a disability was 17.8 percent.³⁸⁸
- 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.³⁸⁹
- 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.³⁹⁰

- 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.³⁹¹

ORGANIZATIONAL CHART

ganizational Chart



Page 1 of 1

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.”³⁹² 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.^{393,394} Employment can help adults with mental or behavioral health conditions obtain independence, become integrated into society, and achieve social, emotional, and general well-being.³⁹⁵

The agency consists of four service divisions:³⁹⁶

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.

DARS requested \$634,725,654 for 2016 and \$611,047,309 for 2017 in their Legislative Appropriations Request for Fiscal Years 2016 and 2017.³⁹⁷

Division for Early Childhood Intervention Services

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.³⁹⁸ 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.³⁹⁹

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 3.⁴⁰⁰ 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.⁴⁰¹ The operating budget for ECI in FY 2013 was \$128,836,309 and \$150,256,901 in FY 2014.^{402,403}

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.⁴⁰⁴

ELIGIBILITY FOR SERVICES

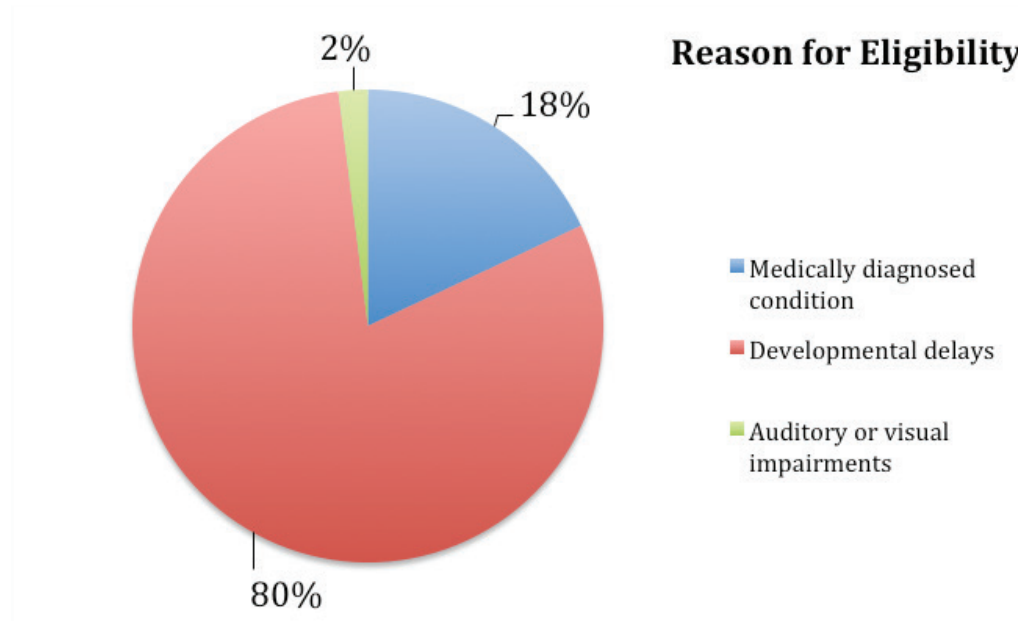
To determine eligibility for ECI services, a team of at least two professionals from different disciplines performs a comprehensive evaluation of a child's abilities. Generally, eligibility is conditioned on a child meeting at least one of following three criteria:⁴⁰⁵

- **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



Source: Texas Department of Assistive and Rehabilitative Services. (2014). *Annual report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>.

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, 2014.⁴¹⁰ 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.⁴¹¹

Figure 74. Characteristics of Individuals utilizing ECI Services

	FY 2013
Total children referred	68,172
Total children who received comprehensive services	48,193
Average monthly cost per consumer	\$421*

* based on comprehensive services

Source: Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2012/annualreport2012.pdf>.

The distribution of enrollment in the ECI program by age is fairly evenly split among the three key age groups, as follows:⁴¹²

- 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:⁴¹³

- 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.⁴¹⁴ 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.⁴¹⁵

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.⁴¹⁶

The national employment rate for the general population in 2012 was 64 percent.⁴¹⁷ Comparatively, the employment rate for persons with a disability was 17.6 percent.⁴¹⁸ 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.⁴¹⁹ 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.⁴²⁰ 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.⁴²¹ Yet for persons living with mental illness, employment can help promote recovery.⁴²² 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.^{423,424}

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.

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.⁴²⁵ 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.⁴²⁶

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.⁴²⁷ 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.⁴²⁸

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

	2012	2013
Number of individuals served	83,930	79,578
Average cost per consumer	\$2,551	\$2,569
Total successful closures (people getting jobs)	11,686	12,102

Source: Texas Department of Assistive and Rehabilitative Services. (2014). *Annual report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/2013AnnualReport/introduction.htm>.

Source: Texas Department of Assistive and Rehabilitative Services. (2013). *Annual report 2012*. Retrieved from <http://www.dars.state.tx.us/reports/annual2012/annualreport2012.pdf>

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,

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.

Amarillo, Palestine, Dallas, Denton, Fort Worth, Plano, Beaumont, San Antonio, McAllen, Laredo, El Paso.⁴³⁶ 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.⁴³⁷ 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.⁴³⁸ DARS requested 1 million dollars in each year for fiscal years 2014 and 2015 to expand independent living center services to underserved areas.⁴³⁹ DARS requested \$2,689,283 for fiscal year 2016 and \$2,689,283 for fiscal year 2016 for CILs.⁴⁴⁰

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:⁴⁴¹

- 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.⁴⁴²

Both SSI and SSDI are cash assistance programs. DARS staff make the initial disability determination for Texans applying for SSDI and/or SSI. Approximately

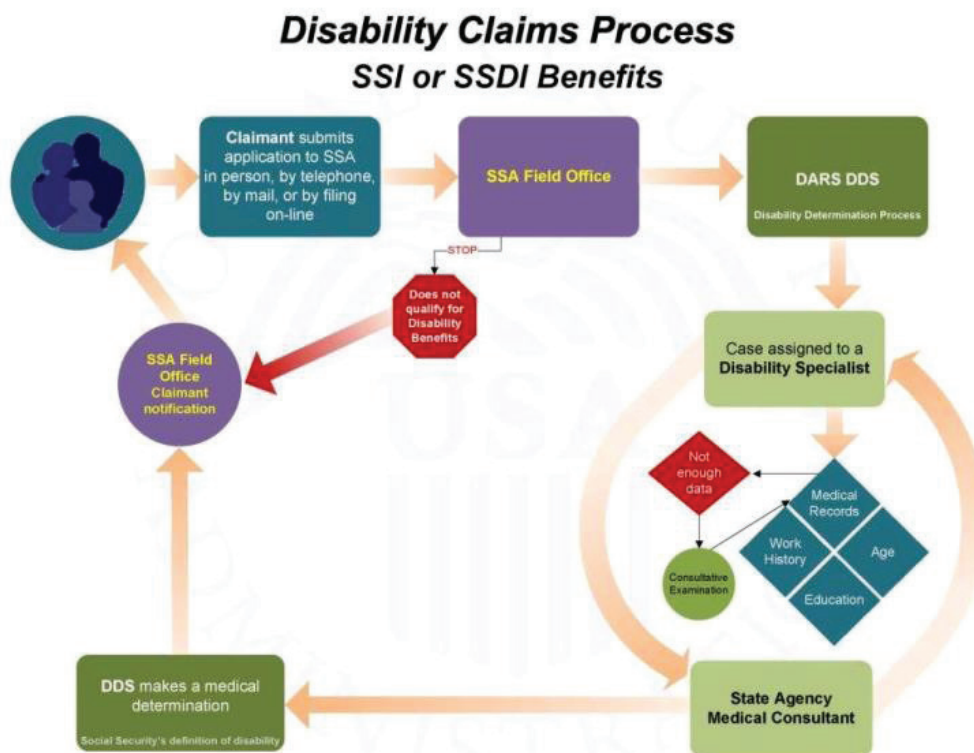
364,428 disability cases were determined in FY 2013.⁴⁴³ DDS is completely federally funded with funding totaling \$113,224,755 in FY 2012.⁴⁴⁴

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.

Figure 76. Disability Claims Process for SSI and SSDI Benefits



⁴⁴⁵ Texas Department of Assistive and Rehabilitative Services. (n.d.). *Disability Determination Services*. Retrieved from <http://www.dars.state.tx.us/services/ddsClaimsProcess.shtml>

People who disagree with their SSI or SSDI determination have a legal right to appeal the decision. There are four levels of appeal:⁴⁴⁶

- 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.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

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

*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.

Sources: Texas Department of Assistive and Rehabilitative Services. (2014). *Annual report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>.

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

Program Name	Services	Number Served	Average Cost Per Individual
Blind Children's Vocational Discovery and Development Program	Assists children up to 22 years old in developing the confidence and competence to become fully active members of their community.	4,417 ⁴⁵²	\$108 monthly
Vocational Rehabilitation Services	Helps people with blindness or visual impairments obtain employment by providing assistive technology, transition services, and vocational training.	10,066 ⁴⁵³	\$4,650
Specialized Telecommunications Assistance Program	Provides financial vouchers for Texans with hearing impairments to acquire assistive equipment such as two-way pagers, amplified telephones, and big button telephones.	26,781 vouchers issued ⁴⁵⁴	Voucher values range from \$90 to \$8,420 depending on the device.
Blindness Education, Screening and Treatment Program	Program goal is to prevent blindness. Also assists uninsured adults with paying for urgently needed eye-medical treatment.	4,428 ⁴⁵⁵	\$98
Criss Cole Rehabilitation Center	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.	200 ⁴⁵⁶	N/A
Business Enterprises of Texas	Provides employment assistance in the form of food management opportunities for blind Texans.	1,584 ⁴⁵⁷	N/A

Texas Department of Criminal Justice and Local Criminal Justice Agencies: *At A Glance*

TABLE OF CONTENTS

Texas Department of Criminal Justice and Local Criminal Justice Agencies	183
Changing Environment	184
83rd Session Criminal Justice and Mental Health Legislation	184
Overview of Texas Criminal Justice System	185
Texas Department of Criminal Justice	187
Financial Summary	188
Behavioral Health Services and Programs in the State Criminal Justice System	190
Access to Services	191
Behavioral Health Services	191
Post-Incarceration Community-Based Services	193
Medically Recommended Intensive Supervision	194
Release on Parole Special Programs	194
Special Concerns for Female Inmates	195
Local Criminal Justice Systems	195
Texas Commission on Jail Standards	196
Incarceration Prevention Programs	197
Jail Diversion	197
Specialty Courts	198

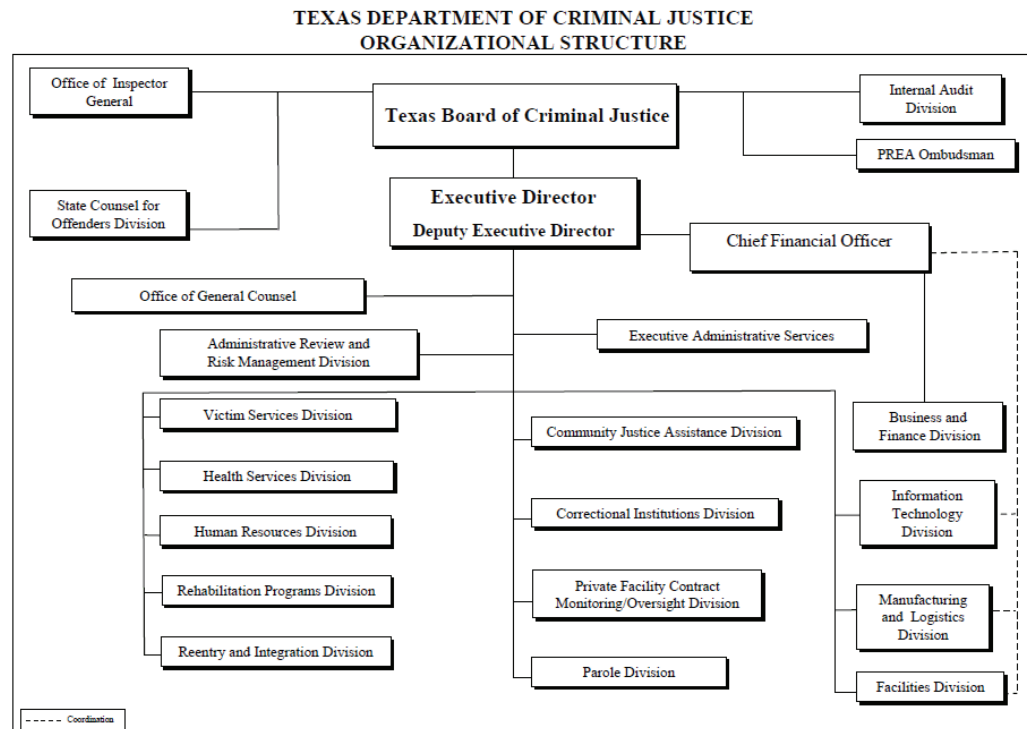
POLICY CONCERNS

- 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

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



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.⁴⁶⁴ 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.⁴⁶⁵

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.⁴⁶⁶ 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.⁴⁶⁷ The risk of violent behavior is increased when a substance use disorder is present.⁴⁶⁸ 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.⁴⁶⁹ The vast majority of people with a diagnosable serious mental illness never engage in violence.⁴⁷⁰ 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.⁴⁷¹

Changing Environment

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

Passed	Author and Description	Summary
SB 213	Whitmire, Nichols – <i>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.</i>	<p>Extends Sunset Review (the legislature's assessment of the efficacy and performance of TDCJ) to 2021.</p> <p>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.</p> <p>Changes composition of Correctional Managed Health Care Committee to include two licensed mental health professionals appointed by the governor.</p> <p>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.</p> <p>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.</p>
SB 1003	Carona – <i>Relating to a review of and report regarding the use of adult and juvenile administrative segregation in facilities in this state.</i>	<p>Requires the Texas Juvenile Justice Department (TJJD) to collect data about the number of placements in disciplinary seclusion lasting at least 90 minutes.</p> <p>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.</p>

Passed	Author and Description	Summary
SB 1185	Huffman – <i>Relating to the creation of a mental health jail diversion pilot program.</i>	Creates a mental health jail diversion pilot program in Harris County that will serve no fewer than 500 or more than 600 individuals.
SB 1475	Duncan – <i>Relating to a jail-based restoration of competency pilot program.</i>	<p>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.</p> <p>Authorizes DSHS to contract with public or private providers of a jail-based competency restoration services for pilot programs in up to two counties.</p> <p>The Executive Commissioner of DSHS shall establish a stakeholder workgroup to participate in the development of rules for the pilot program.</p> <p>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.</p>

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

Community Supervision (previously known as adult probation)	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.
Parole	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.
Local jails	Designed to house offenders awaiting trial or serving short-term sentences for misdemeanor convictions.
State jails	Designed to house offenders convicted of felonies with punishment ranges from 180 days to two years.
Prisons	Designed to house offenders convicted of third-degree felonies or higher with punishment ranges from two years to death.
Restitution	Monies that a court orders an individual to pay to a family of a victim. Payment is usually done in monthly installments.

Source: Harris County Community Supervision & Corrections Department. (n.d.). *Frequently Asked Questions*. Retrieved from <http://www.harriscountytexas.gov/cscd/faq.aspx>

Source: Bureau of Justice Statistics. *Terms and Definitions: Corrections*. Retrieved from <http://www.bjs.gov/index.cfm?ty=tdtp&tid=1>.

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).⁴⁷²

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.⁴⁷³

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.⁴⁷⁴ 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.

Type of Facility	Number of Units	Capacity	Population
Prison	50	97,940	94,538
Pre-Release	4	4,210	3,964
Psychiatric/DDP	4	3,051	2,887
Geriatric	1	566	536
Medical	2	314	590
Private Prisons	7	4,118	4,106
Multi-Use	1	836	779
Transfer	14	17,106	16,288
Pre-Parole Transfer	2	700	697
State Jail	15	20,051	18,598
Private State Jail	4	5,129	5,042
Substance Abuse	5	2,791	2,548
Total Facilities	109		
Total Population & Capacity		156,812	150,573

Note: Capacities, Populations and Facility Types are as of March 31, 2014.

Source: Texas Department of Criminal Justice. *Agency Strategic Plan Fiscal Years 2015 – 2019*. Retrieved from 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

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

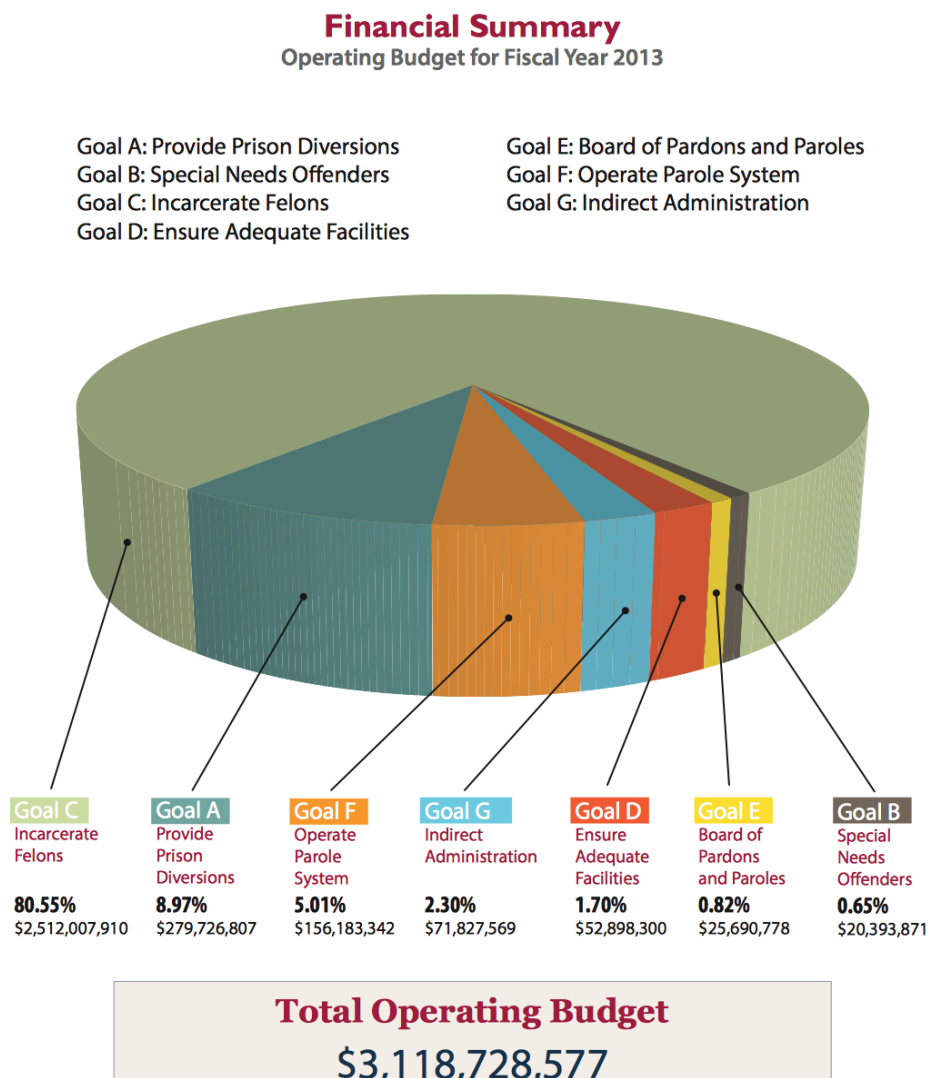
inmates had a diagnosis of either serious mental illness or intellectual disability.⁴⁷⁵ TDCJ uses several types of isolation. Disciplinary segregation is typically short term and is for punitive purposes. With administrative segregation (which is used for inmates who are considered dangerous to themselves, 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.⁴⁷⁶

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.⁴⁷⁷ Disciplinary cases for convictions of assailants may be sexual misconduct, sexual fondling, or sexual abuse.⁴⁷⁸

FINANCIAL SUMMARY

On August 31, 2013, there were 136,340 offenders in Texas prisons.⁴⁷⁹ The average cost per day of housing and feeding an inmate was \$50.04.⁴⁸⁰ The TDCJ operating budget for FY 2013 was \$3,118,728,577.⁴⁸¹ See Figure 82 below for a breakdown of the budget by agency goal.

Figure 82. TDCJ Operating Budget for FY 2013



Source: Texas Department of Criminal Justice. (2014). *Annual Review Fiscal Year 2013*. Retrieved from http://www.tdcj.state.tx.us/documents/Annual_Review_2013.pdf

TDCJ requested \$3,381,518,042 for FY 2016 and \$3,417,488,167 for FY 2017.

BEHAVIORAL HEALTH SERVICES AND PROGRAMS IN THE STATE CRIMINAL JUSTICE SYSTEM

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

Name	Description
Health Services Division	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
Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI)	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
Office of Mental Health Monitoring and Liaison	Monitors mental health services provided to offenders, and provides expert guidance to other TDCJ offices on mental health-related issues.
Correctional Managed Health Care Committee (CMHCC)	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).

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

Level of Service	Description of Level of Health Service	Availability
Level I Medically Mandatory	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.	authorized and provided to all.
Level II Medically Necessary	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.	is provided to all, but evolving standard and practice guidelines controls the extent of service

Source: Correctional Managed Health Care Committee. (2013, August). *Offender health services plan*. Retrieved from http://tdcj.state.tx.us/divisions/cmhc/docs/cmhcc_contracts_fy2014-15/696-HS-14-15-A066-Exhibit-A.pdf

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

Program	Description
Program for the Aggressive Mentally-Ill Offender	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.
Developmental Disabilities Program	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.
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.]

Source: Correctional Managed Health Care Committee. (2013, October). *Correctional Managed Health Care Policy Manual*. Retrieved http://tdcj.state.tx.us/divisions/cmhc/cmhc_policy_manual.html

TDCJ operates a number of programs to serve people with substance use conditions within its Rehabilitation Programs Division, as described in Figure 86.⁴⁹¹

Figure 86. Substance Use Service Descriptions

Program	Description
Substance Abuse Felony Punishment Facility and In-Prison Therapeutic Community (IPTC)	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.
Pre-Release Substance Abuse Program and Pre-Release Therapeutic Community	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.
State Jail Substance Abuse Program	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.
Driving While Intoxicated In-Prison Program	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.

Source: Texas Department of Criminal Justice. (n.d.). Rehabilitation programs division. Retrieved from http://www.tdcj.state.tx.us/divisions/rpd/rpd_substance_abuse.html

POST-INCARCERATION COMMUNITY-BASED SERVICES

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.⁴⁹⁸ The additional funding enables TCOOMMI to provide services to approximately 1,800 additional parolees.⁴⁹⁹ Twenty-seven additional case management caseloads were added for parolees.⁵⁰⁰ 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.⁵⁰¹

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

Name	Description	Monthly Average Number of Offenders in Supervision Program in FY 2013
Special Needs Offender Program	Supervises [offenders with intellectual disabilities, mental impairments, terminal illnesses, or physical disabilities].	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].
Sex Offenders Program	Services are provided throughout the state through contract vendors. A significant component of this treatment is polygraph testing	4,360 offenders.
Therapeutic Community Program	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.	6,341 offenders received services
Substance Abuse Counseling Program (SACP)	Provides relapse prevention services to offenders with substance abuse problems.	A total of 34,544 offenders in FY 2013.

Name	Description	Monthly Average Number of Offenders in Supervision Program in FY 2013
Drug Testing Program	Instant-read drug testing.	156,411 drug tests conducted monthly.

Source: Texas Department of Criminal Justice. (2014). *Annual Review 2013*. Retrieved from http://www.tdcj.state.tx.us/documents/Annual_Review_2013.pdf

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.⁵⁰² Additionally, women in prison are also more likely than men to have chronic health conditions, including HIV, sexually transmitted diseases, and Hepatitis C.⁵⁰³ 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.⁵⁰⁴ 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 66,807.⁵⁰⁵ 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.⁵⁰⁶

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

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.⁵⁰⁷

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.⁵⁰⁸ 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.⁵⁰⁹ 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.⁵¹⁰ Each county is visited at least once each fiscal year.⁵¹¹

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.⁵¹² 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.⁵¹³

Comprehensive national data show that suicide occurs roughly three times more frequently in jail than among the general population.⁵¹⁴ 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

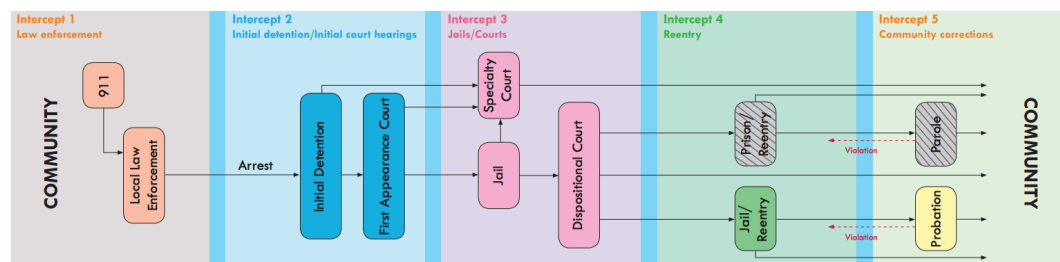
immediately utilizing the TCJS approved mental disabilities/suicide prevention screening instrument.⁵¹⁵ In 2013 TCJS, in collaboration with multiple state agencies including TCOOMMI, introduced a new training program titled “Assessing for Suicide, Medical and Mental Impairments.” Staff from local mental health authorities was included in teaching the course, which provided training to 352 participants in 12 classes.⁵¹⁶

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.⁵¹⁷ 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.⁵¹⁸ 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.

Figure 88.



Source: CMS National GAINS Center. *Developing a Comprehensive Plan for Mental Health & Criminal Justice Collaboration: The Sequential Intercept Model*. Retrieved from <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.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.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.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.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 2012.⁵²³

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.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.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, 2016.⁵²⁶

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.⁵²⁷ 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.⁵²⁸

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.⁵²⁹

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:⁵³⁰

- 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.⁵³¹ Of the participants 86.3% had a mental illness and co-occurring substance use disorder.⁵³² Thirteen participants successfully graduated and another ten participants were on track to graduate by the fall of 2014.⁵³³ 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.⁵³⁴ 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.⁵³⁵

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.⁵³⁶ In 2001, the 77th legislature via HB 1287

(Thompson) mandated all Texas counties with populations exceeding 550,000 to apply for federal and other funds to establish drug courts.⁵³⁷ There are currently approximately 100 drug courts in counties throughout the state.⁵³⁸ 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.⁵³⁹

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.⁵⁴⁰ 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:⁵⁴¹

- 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.⁵⁴² 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.⁵⁴³

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 2007.⁵⁴⁴ There was also a 38% decrease in bookings and 13% decrease of jail bed days consumed post- MHPD involvement.⁵⁴⁵

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 TCOOMMI services.⁵⁴⁶ 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."⁵⁴⁷

Texas Juvenile Justice Department (TJJD) and Local Juvenile Justice Agencies: *At A Glance*

TABLE OF CONTENTS

Texas Juvenile Justice Department (TJJD) and Local Juvenile Justice Agencies	204
Changing Environment	205
Legislation	205
Trauma-Focused Cognitive Behavioral Therapy Pilot	205
Corsicana Residential Treatment Center	206
Juvenile Justice System Overview	206
Office of the Independent Ombudsman for the Texas Juvenile Justice Department	208
Disproportionality in the Texas Juvenile Justice System	208
Behavioral Health Services in the Juvenile Justice System	210
Behavioral Health Services in State Secure Facilities	210
Behavioral Health Services in County-Level Secure Facilities	212
Behavioral Health Services for Youth on Parole	213
Community-Based Behavioral Health Services Offered by Local Juvenile Probation Departments	213
Funding Sources	215
State-Funded Programs Available to Local Juvenile Probation Departments with Behavioral Health Service Components	215
Prevention and Intervention Programs	216
Community-Based Services	216
Diversion Programs for Youth with Behavioral Health Conditions	217
Specialty Juvenile Courts	218
Special Needs Diversionary Program	218
Other Privately and Federally Funded Diversion Programs	219
The Front-End Diversionary Initiative	219
Identifying Youth with Brain Injuries	219

POLICY CONCERNS

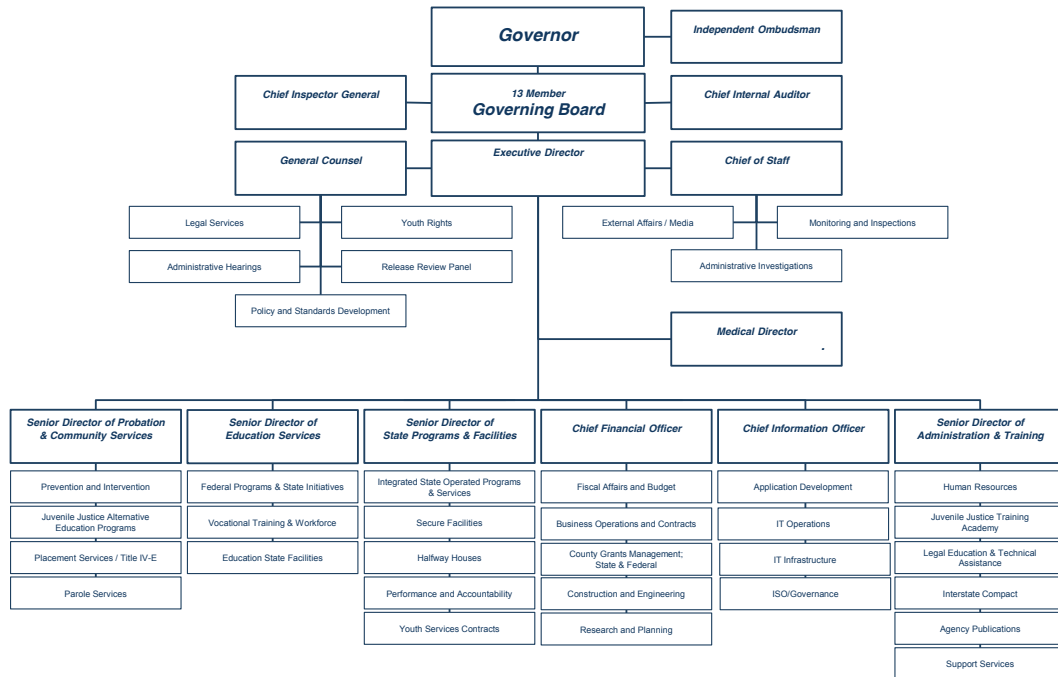
- Adequate independent oversight of residential placements
- Assessment of outcomes for state secure facilities and community interventions
- Diversion of youth with behavioral health needs from secure confinement facilities
- Prolonged isolation of youth in secure confinement facilities
- Restraint 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.

ORGANIZATIONAL CHART



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 82nd 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."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.⁵⁵⁵ Nationally, 22.2% of youth have a mental health condition causing severe impairment.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.⁵⁵⁷ The number of youth with a condition serious enough to require immediate and significant treatment is almost 30%.⁵⁵⁸ Furthermore, over 60% of youth experiencing a mental health disorder also struggle with a substance use disorder.⁵⁵⁹ The majority of youth in the juvenile justice system have experienced prolonged trauma.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.⁵⁶¹ This section will describe the behavioral health services available to youth at different levels of involvement with the juvenile justice system.

TJJD

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.⁵⁶² TF-CBT is an evidence-based treatment designed to reduce negative emotional and behavioral responses following traumatic events.⁵⁶³ Treatment focuses on distorted beliefs and attributions related to trauma and provides a supportive environment to discuss traumatic experiences.⁵⁶⁴ Training in TF-CBT has been provided to 18 clinical staff and ongoing coaching is being provided.⁵⁶⁵ The pilot is expected to be completed and a report developed by the end of July 2015.

CORSICANA RESIDENTIAL TREATMENT CENTER

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.⁵⁶⁶ 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.⁵⁶⁷

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.⁵⁶⁸ 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.⁵⁶⁹

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.⁵⁷⁰ 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.

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

Referrals and Dispositions Fiscal Year 2012 and Fiscal Year 2013		
	2012	2013
Formal Referrals to Juvenile Probation Departments	72,474	68,386
Juveniles Referred	51,605	48,275
Total Dispositions	75,174	70,251
Juveniles Committed to TJJD	875	810
Juveniles Certified as an Adult	166	206

Source: Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget Board*. Retrieved from http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf

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 X and X below offers 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.

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 90. Terms and Concepts

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

Figure 91. Common Juvenile Justice Definitions

Juvenile	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."
Delinquent conduct	Generally conduct that, if committed by an adult, could result in imprisonment or confinement in jail.
Conduct in need of supervision (CINS)	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.
Adjudication	Is a finding that a youth has engaged in delinquent or CINS conduct. It is similar to a "conviction" in adult court.
Chronic Serious Offender	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.
Minimum Length of Stay	Minimum period of time an indeterminate sentenced youth must stay in TJJD. This is set by TJJD policy.
Juvenile Probation	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.
Individual Case Plan	Youth's individualized plan for treatment and education, based on his or her specific strengths and risks.
Halfway House	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.

Source: Texas Juvenile Justice Department. (2013). *Definitions for Common TJJD Terms & Acronyms*. Retrieved from <http://www.tjjd.texas.gov/about/glossary.aspx>

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.⁵⁷¹ 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.⁵⁷³ 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.⁵⁷⁴ 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.⁵⁷⁵

In Texas, African American youth, and to a lesser extent Hispanic youth, are overrepresented in the juvenile justice system relative to Anglo youth.

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-Legislature.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.⁵⁷⁶ Figure 92 below shows the name and location of these facilities.

Figure 92. TJJD Secure Facilities

Facility	Location
Evins Regional Juvenile Center	Edinburg
Gainesville State School	Gainesville
Giddings State School	Giddings
McLennan County State Juvenile Correctional Facility & McLennan Residential Treatment Center	Mart
Ron Jackson State Juvenile Correctional Complex	Brownwood

Source: Texas Juvenile Justice Department. (n.d.). *TJJD Facilities Address List*. Retrieved from <http://www.tjjd.texas.gov/aboutus/facilities.aspx>

As of April 2014, there were 1,058 youth committed to these facilities at an average cost of \$366 per day.⁵⁷⁷ Of all new admissions of youth committed to state-operated facilities in FY 2013, 44% committed non-violent felony offenses.⁵⁷⁸

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.⁵⁷⁹ The facility typically serves an average of 100 girls with 5% in short-term placements units that consist of orientation and assessment.⁵⁸⁰ In FY 2013, the facility served 190 girls.⁵⁸¹ 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 2014.⁵⁸²

All state secure facilities use a multi-faceted rehabilitation program called CoNextions, which includes life skills training and workforce and education development.⁵⁸³ 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.⁵⁸⁴

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

Program Name	Location	Participants	Treatment Services
Capital and Serious Violent Offender Treatment Program	Giddings State School	Youths who are committed for murder, capital murder, and offenses involving the use of a weapon or deadly force.	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.
“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.	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.	Sex offenders.	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.

Program Name	Location	Participants	Treatment Services
Alcohol or Other Drug Use Treatment Programs	Services available at all the institutional facilities and several halfway houses. Residential programs are offered at all five state secure facilities and McFadden Ranch.	Chemically dependent offenders.	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.
Mental Health Programs	Mental health professionals provide services at all the institutional facilities in the state.	Youths with mental health conditions.	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.

Source: Texas Juvenile Justice Department. (2013). *Specialized Correctional Treatment*. Retrieved from http://www.tjtd.texas.gov/programs/special_treatment.aspx

TJJD

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%.

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%.⁵⁸⁵ The number of youth completing a specialized program increased from 19.2% to 53.0%.⁵⁸⁶ 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.⁵⁸⁷ In FY 2013, 48% of youth in state juvenile facilities were determined to have a need for mental health treatment.⁵⁸⁸

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.⁵⁸⁹

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.⁵⁹⁰ 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.⁵⁹¹

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.⁵⁹²

In FY 2013, 48 percent of juveniles served by local probation departments were identified as having at least one behavioral health referral.⁵⁹³ Twenty-seven percent of juveniles who were referred to juvenile probation had a mental health need.⁵⁹⁴ Youths charged with misdemeanor offenses made up the majority of referrals at 52 percent.⁵⁹⁵ 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.⁵⁹⁶

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 2013.⁵⁹⁷ In FY 2013, approximately 29 percent of formally referred juveniles were identified as having a mental health need.⁵⁹⁸

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

Type of Discharge	Number Served
Referred to TCOOMMI or CRCG services	288
Received mental health aftercare services in the community	178 (includes youth released on TJJD parole, as well as youth released to a non-secure residential facility (hallway house))
TJJD parole receiving mental health aftercare services in the community	125

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

Type of Service	Number Served
Mental health programs and mental health court programs	2,758 out of 30,781 (9% of total juveniles served)
Behavioral health services for a mental health problem (ex. drug treatment programs, drug education, and prevention programs)	657 out of 1,487 (44% of total juveniles served)
Counseling programs	5,100 out of 30,781 (16% of total juveniles served)
Drug treatment programs	2,737
Drug education/prevention programs	3,965

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.⁵⁹⁹ 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.⁶⁰⁰

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.⁶⁰¹

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.⁶⁰² In 2012, TJJD approved the initial investment of \$1.5 million for 24 prevention and early intervention programs.⁶⁰³ The programs are designed to serve youth ages 6-17 and their families.⁶⁰⁴ In 2013 there were 21 programs in operation.⁶⁰⁵ The total amount budgeted for prevention and early intervention services in 2013 was \$2.6 billion dollars.⁶⁰⁶ At an average expense of \$575 per youth, 3,418 youth participated in a funded prevention program in FY 2013.⁶⁰⁷ The average age of the participants was 11 years old.⁶⁰⁸ 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.⁶⁰⁹ 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.⁶¹⁰

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.⁶¹¹ At the end of FY 2012, 1,562 community-based programs had been identified within the TJJD Program & Services Registry and listed as active.⁶¹²

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.⁶¹³ These departments offer various programs, including specialized counseling and educational programs as well as mental health courts and drug courts.⁶¹⁴ In medium to large departments an average of 11 and 18 programs are offered, respectively.⁶¹⁵ 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.⁶¹⁶ 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.⁶¹⁷ Local mental health authorities provide 39% of the mental health programs.⁶¹⁸

Program duration varies widely from lasting one afternoon to the entirety of the supervision.⁶¹⁹ Intensive supervision programs will last longer than early-intervention/first referral programs.⁶²⁰

Figure 96. Average Expected Length of Stay in Various Community Programs ⁶²¹

Program Type	Days in Program
Counseling	109
Cognitive Behavioral Therapy	70
Mental Health Court	170
Other Mental Health programs	161

Source: Texas Juvenile Justice Department. (2013, June). *Community-Based Program Evaluation Series: Overview of Community-Based Juvenile Probation Programs*. Retrieved from <http://www.tjjd.texas.gov/statistics/CommunityBasedJuvenileProbationPrograms.pdf>

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.⁶²² 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.⁶²³ 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.⁶²⁴

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.⁶²⁵ 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.⁶²⁶ Funding is provided in two tiers. Tier 1 funding goes to departments with secure pre- or post-adjudication facilities.⁶²⁷ 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.⁶²⁸ If a department has more than 80 beds they receive funds for two full-time mental health professionals.⁶²⁹ Departments without a facility receive funding to secure mental health services.⁶³⁰ Tier 2 funding goes to all probation departments to provide resources for screening, assessment, diagnosis, evaluation and treatment.⁶³¹

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.⁶³² 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.⁶³³

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 representatives 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.⁶³⁴ In that same year, 20 of those juvenile drug courts were located in counties throughout Texas.⁶³⁵

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.⁶³⁶ Services from these programs are provided to juveniles under the supervision of 22 local juvenile probation departments.⁶³⁷ 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.⁶³⁸

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.⁶³⁹ In FY 2013, the program served 1,444 juveniles across 22 juvenile probation departments.⁶⁴⁰ The total amount appropriated for FY 2013 was \$1,974,034.⁶⁴¹ Sixty-nine percent of those served by this program (1,002) received mental health treatment prior to entry into the program.⁶⁴²

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

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.

TJJD

identified with a probability of TBI are provided appropriate services and case plan objectives that address the youths' special needs.⁶⁴⁸

Texas Education Agency and Local School Districts: *At A Glance*

TABLE OF CONTENTS

Texas Education Agency and Local School Districts	223
Delivery of Mental Health Services in Schools	224
Changing Environment	225
Special Education Services	226
Special Education Funding through IDEA	227
Special Education Funding through Medicaid	227
Eligibility for Special Education	228
Special Education Services and Service Utilization	228
Mental Health Support Systems for Schools	230
Education Service Centers	230
Coordinated School Health Model	231
Communities in Schools	232
Holistic Approaches to Student Mental Health	232
School Wide Positive Behavioral	232
Interventions and Supports	232
Social and Emotional Learning	234
Trauma-Informed Care	234
Exclusionary Discipline in Schools	235
In-School Suspensions (ISS) and Out-of-School Suspensions (OSS)	236
Disciplinary Alternative Education Programs (DAEPs)	236
Mandatory v. Discretionary Removal	236
Juvenile Justice Alternative Education	237
Programs (JJAEPs) / Expulsion to the Streets	237
School Ticketing – Class C Misdemeanors	239
Use of Force in Schools	241
Alternatives to Exclusionary Discipline	242

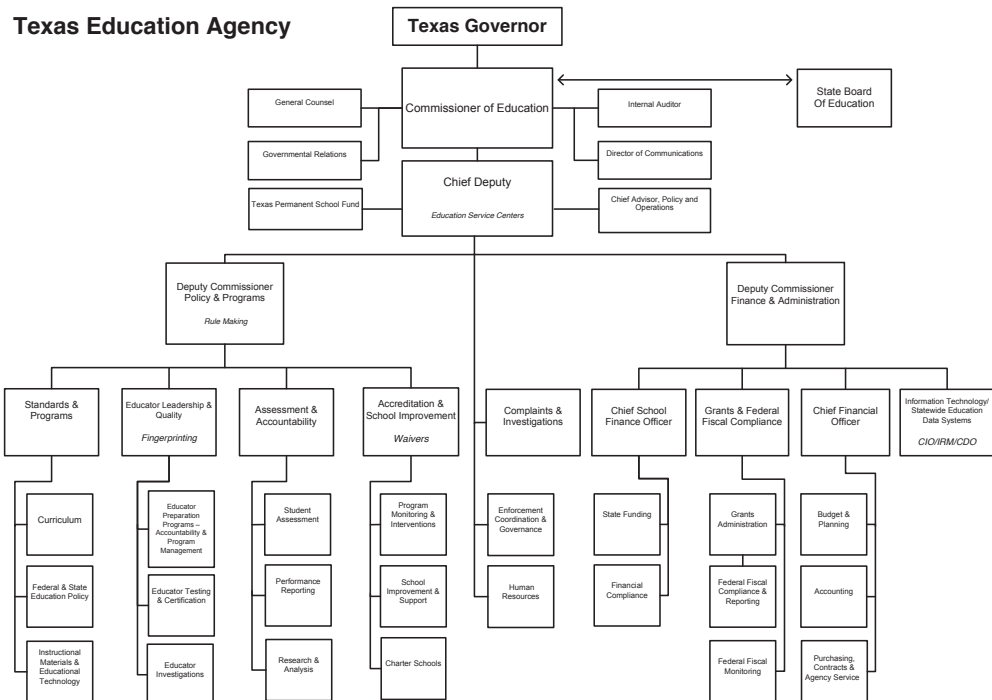
POLICY CONCERNS

- 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.⁶⁴⁹ During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country.⁶⁵⁰
- Approximately 25,663 of Texas students, or 0.5 percent, received special education services with a primary diagnosis of emotional disturbance.^{651,652}
- 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.⁶⁵³
- 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.⁶⁵⁴
- 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.⁶⁵⁵
- In the 2012-2013 school year, Texas school districts placed over 2,800 students into JJAEPs and expelled 893 students to the streets.⁶⁵⁶

ORGANIZATIONAL CHART



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.⁶⁵⁷ According to TEA, 5,151,925 students were enrolled in Texas public schools during the 2013-2014 academic year.⁶⁵⁸ Approximately 25,663 students, or 0.5 percent, received special education services with a primary diagnosis of emotional disturbance.^{659,660}

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.^{661,662} In 2009, Texans Care for Children reported that “among Texas kids with a diagnosed

“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.”

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.”⁶⁶³ 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.⁶⁶⁴

Schools have a long history of providing mental health services to students; 75 percent of children receiving mental

health services receive them in school.⁶⁶⁵ The President’s New Freedom Commission on Mental Health recognized the critical role that schools can play in the continuum of mental health services.⁶⁶⁶ 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.⁶⁶⁷

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. According to

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.”⁶⁶⁸ 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.⁶⁶⁹

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.⁶⁷⁰ 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.⁶⁷¹ 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.⁶⁷² 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

School-Based Mental Health Service Delivery	Description
School Financed	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.
Formal Connections with Community Mental Health Services	Agreements made with community mental health agencies to provide services at the school or the community agency.
School District Mental Health Units or Clinics	School districts may operate their own mental health units or health clinics to provide psychosocial and mental health services, staff training and consultation.

School-Based Mental Health Service Delivery	Description
Classroom-Based Curricula	Schools may make available prevention-oriented materials provided through teacher instruction and designed to enhance learning through social and emotional growth for all students.
Comprehensive, Multi-Faceted and Integrated Approaches	Districts can bring together multiple activities and community agencies to provide a full range of services to students with mental health needs.
School-wide Behavioral and Emotional Support Frameworks	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. ^{673, 674}

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.⁶⁷⁵ Examples of these side effects include anxiety, low grades, and social rejection.⁶⁷⁶ 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. 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.⁶⁷⁷ 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.⁶⁷⁸

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.⁶⁷⁹ 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.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.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.⁶⁸² The Department of State Health Services (DSHS) estimates 479 staff and 12,295 educators will undergo MFHA training in FY 2014.⁶⁸³

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 84th Legislative Session.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 (83rd, 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

Schools are accountable for the academic performance of all students, including those with emotional disturbance or mental health conditions. When academic performance is impacted due to a student's disability, the Individuals with Disabilities Education Act (IDEA) requires schools to provide special education and related services based on an individualized educational plan (IEP), which may include mental health treatment and supports.⁶⁸⁵

A 2011-2012 report found that on average, 12.9

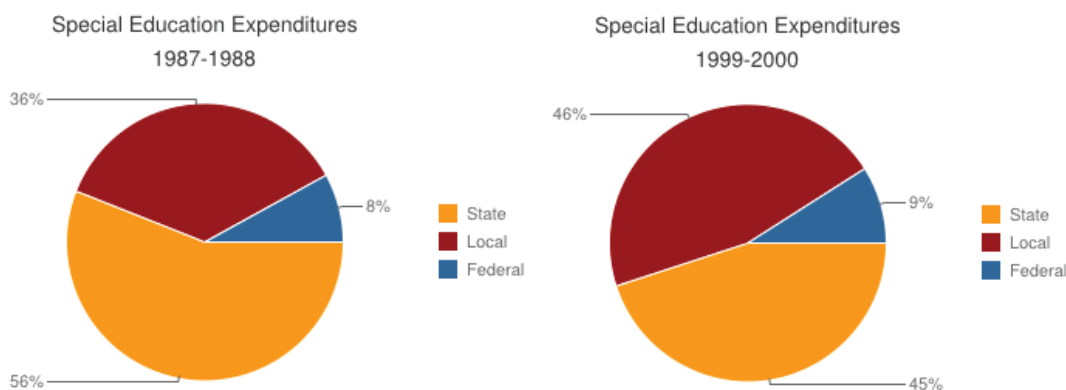
A 2011-2012 report found that on average, 12.9 percent of students are in special education across all states. During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country.

percent of students are in special education across all states.⁶⁸⁶ During the same years, 8.7 percent of the student population in Texas received special education services, the lowest percentage in the country.⁶⁸⁷ 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.⁶⁸⁸ Additionally, the percentage of students identified with emotional disturbance in the special education population has decreased nationally and in Texas.⁶⁸⁹ 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.⁶⁹⁰ To support schools with increased costs, the federal government committed to contributing up to 40 percent of this anticipated additional cost.⁶⁹¹ Despite this commitment, the federal government has given less than half of their committed financial support since IDEA's first year of funding in 1981.⁶⁹² 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.⁶⁹³ 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.⁶⁹⁴

Figure 98. Declining State Support for Special Education



Source: New America Foundation. (2013). *Individuals with Disabilities Education Act – cost impact on local school districts*. Retrieved from <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.⁶⁹⁵ School districts/ssa's must enroll as Medicaid providers and employ or contract qualified professionals to provide these services.⁶⁹⁶ 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.⁶⁹⁷ 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.⁶⁹⁸ 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.⁶⁹⁹ There are other

Over 25,000 Texas students were identified as having serious emotional disturbance for the 2013-2014 school year.

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.⁷⁰⁰

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:⁷⁰¹

- 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.⁷⁰² 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.⁷⁰³ 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/>.

Figure 99. Map of Education Service Center Regions



Source: Texas Education Agency. (2012). *Snapshot 2012 service tables: Education service center region*. Retrieved from <http://ritter.tea.state.tx.us/perfreport/snapshot/2012/region.srch.html>.

COORDINATED SCHOOL HEALTH MODEL

Counseling and mental health services are a core element of TEA's Coordinated School Health Model.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.”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

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.^{706,707} All but 2 percent of the students receiving case management services from CIS stayed in school during the 2012-2013 school year.⁷⁰⁸ 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.^{709,710} 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.⁷¹¹ 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.⁷¹²

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.⁷¹³

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.

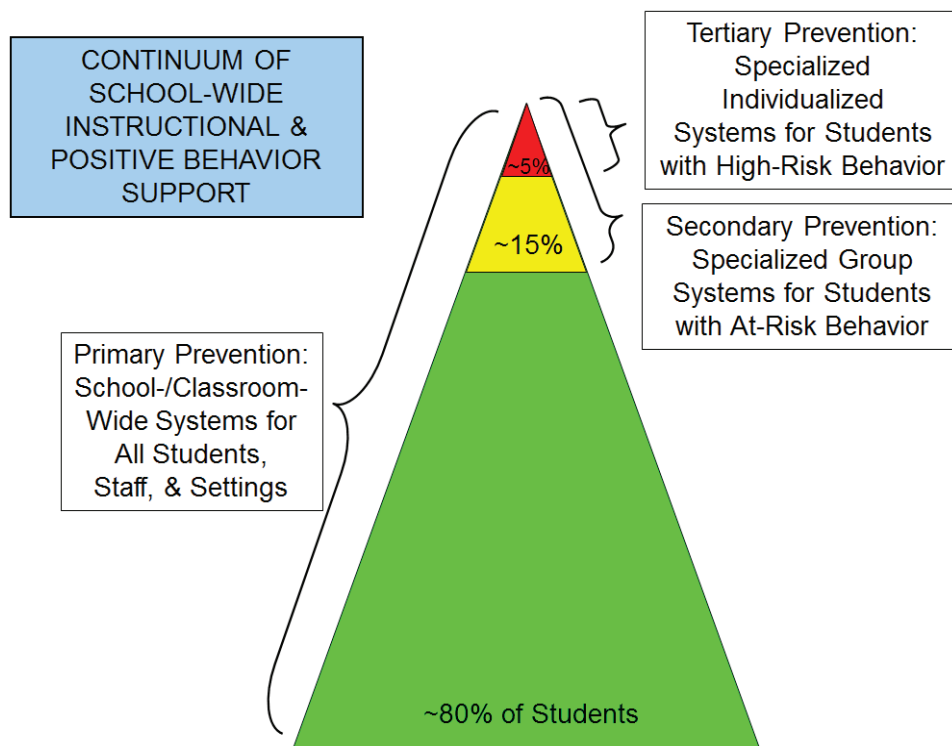
SWPBIS is an evidence-based framework that uses a three-tiered approach to teach and reinforce appropriate behaviors for all students. SWPBIS programs are designed to replace a punishment-oriented system with a campus culture based on respect and individual responsibility. The program consists of the 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



Source: Technical Assistance Center on Positive Behavioral Interventions and Supports, U. S. Department of Education, & Office of Special Education Programs. (2010). *Implementation blueprint and self-assessment: Positive behavioral interventions and supports*. Retrieved from https://www.pbis.org/Common/Cms/files/pbisresources/SWPBS_ImplementationBlueprint_vSep_23_2010.pdf.

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.⁷¹⁴ Technical assistance to implement SWPBIS is available through regional educational service centers and the Texas Behavior Support Initiative (TBSI).⁷¹⁵ 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.⁷¹⁶ In 2009, more than 800 schools were actively participating in the PBSI trainings facilitated by TBSI.⁷¹⁷ Schools that implemented the model have achieved favorable outcomes including reduced disciplinary referrals and less use of physical restraints.⁷¹⁸

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.⁷³⁴ 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:⁷³⁵

- 549,305 students sent to In-School Suspension (ISS)⁷³⁶
- 248,266 students sent to Out-of-School Suspension (OSS)⁷³⁷
- 81,104 students sent to Disciplinary Alternative Education Programs (DAEPs)⁷³⁸
- 2,819 students sent to Juvenile Justice Alternative Education Programs (JJAEPs)⁷³⁹
- 915 students expelled to the streets⁷⁴⁰

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.⁷⁴¹

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.^{742,}

⁷⁴³ 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

Three-fourths of students who qualified for special education had been suspended or expelled at least once.

TEA

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.⁷⁴⁴ 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.⁷⁴⁵

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.⁷⁴⁶ ISS and OSS can lead to significant, negative cost impact on schools.⁷⁴⁷ 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.⁷⁴⁸

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.⁷⁴⁹ In smaller, rural districts, a DAEP may be a separate classroom on the school campus, but more frequently DAEPs are housed at separate campuses.⁷⁵⁰ Additionally, a DAEP that serves a student with an individualized education program (IEP) must provide the services outlined in the IEP.⁷⁵¹ 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.”⁷⁵² 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.⁷⁵³

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:⁷⁵⁴

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.”⁷⁵⁵ 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.⁷⁵⁶

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:⁷⁵⁷

- 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.

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.

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.⁷⁵⁸ Legislative intent in creating JJAEPs was “to provide continuing educational opportunities for students expelled from school for the most serious offenses.”⁷⁵⁹ The primary goals of JJAEPs are to “reduce delinquency, increase offender accountability and rehabilitate offenders through a comprehensive, coordinated community-based juvenile probation system.”⁷⁶⁰ 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.⁷⁶¹ 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.⁷⁶² 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.⁷⁶³

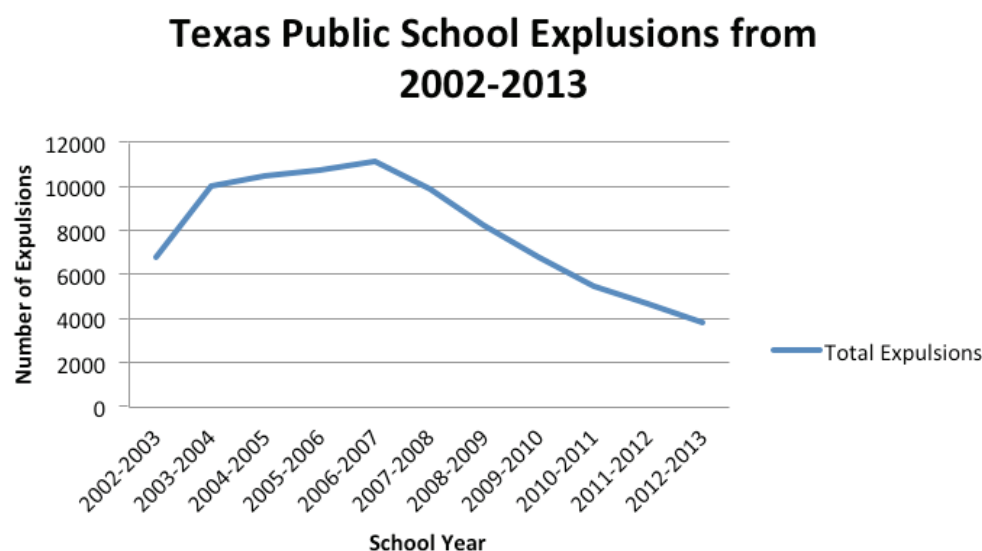
In the 2012-2013 school year, Texas school districts placed over 2,800 students into JJAEPs and expelled 893 students to the streets.⁷⁶⁴ Some school districts use JJAEPs at a higher rate than others. Moreover, the size of the school district does not correlate with the number of student expulsions. Of the more than 1,000 school districts in Texas, about half did not expel any students in 2007-08.⁷⁶⁵ 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.⁷⁶⁶ 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.”⁷⁶⁷ The majority of expelled students are sent to a JJAEP, and 55 percent of JJAEP placements are for discretionary reasons.⁷⁶⁸ 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.”⁷⁶⁹ About 71 percent of students who were initially expelled to a JJAEP for “serious or persistent misbehavior” re-offended within two years.⁷⁷⁰

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.⁷⁷¹ 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.⁷⁷² 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.⁷⁷³ 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.⁷⁷⁴ Figure 101 shows the trend of expulsions between the 2002-2003 and 2012-2013 school years.

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.

Figure 101. Texas Public School Expulsions from 2002-2013



Sources: Texas Appleseed. (2010, April). Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid; Texas Education Agency. (2005). Comprehensive annual report on Texas public schools: A report to the 79th Texas Legislature from the Texas Education Agency. Retrieved from http://www.tea.state.tx.us/acctres/Comp_Annual_2005.pdf; Texas Education Agency. (2006-2013). Discipline data products: 2006-2013 counts of students and discipline actions by discipline action groupings. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html

Many experts agree that there is a school-to-prison pipeline for many students who are referred to exclusionary discipline practices.⁷⁷⁵ Although the goal of JJAEPs is to rehabilitate and integrate students back into a mainstream school environment, the mentioned alternative education programs have been linked to increase levels of delinquency.⁷⁷⁶ 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.⁷⁷⁷ Furthermore, students sent to a DAEP or a JJAEP are more likely to drop out from school and enter the adult criminal justice system.⁷⁷⁸ About 80 percent of adults in the criminal justice system dropped out from school.⁷⁷⁹ 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 rehabilitating 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.⁷⁸⁰ In 2012, the Texas Supreme Court estimated that 300,000 Class C misdemeanor tickets were issued to students.⁷⁸¹ Data suggests that students receiving special education services are overrepresented in the number of students receiving Class C misdemeanors.⁷⁸² 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.⁷⁸³ 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.⁷⁸⁴

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.⁷⁸⁵

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 or more days in a six month period or three or more days in a four week period.⁷⁸⁶ 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.⁷⁸⁷ Criminalization, the use of formal courts, and fines do not appear to be an effective method in addressing FTAS.⁷⁸⁸ 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.⁷⁸⁹ 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;

low school attachment; lack of self-esteem; and unmet mental health needs.⁷⁹⁰

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:⁷⁹¹

- 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 full report by The Center for Children & Youth Justice, *Truancy Reduction: Research, Policy, and Practice*, can be found at http://www.ccyj.org/uploads/PPO/TRUANCY_Updated_July2012.pdf.

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.⁷⁹² Corporal punishment can cause serious injury, psychological harm, and academic disengagement; it is not an evidence-based practice.⁷⁹³

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.⁷⁹⁴ Additionally, police officers are not required to have restraint training.⁷⁹⁵ 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.⁷⁹⁶ 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.⁷⁹⁷

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.⁷⁹⁸

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.⁷⁹⁹ Statewide, school districts spent \$232 million on DAEPs in 2008-2009 and more than \$327 million on security and monitoring services in 2010-2011.⁸⁰⁰ The total amount that counties and school districts spent on JJAEPs was \$31 million in 2010-2011.⁸⁰¹ 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.⁸⁰²

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

TABLE OF CONTENTS

Texas Department of Housing and Community Affairs	247
Changing Environment	249
Affordable Housing	250
Funding	251
Permanent Supportive Housing	252
Housing and Service Programs for People with Behavioral Health Conditions	253
Poverty and Homeless Prevention Programs	254
Emergency Solutions Grants Program	254
Homeless Housing & Services Program	254
Community Services Block Grant Program	254
Programs for Persons with Disabilities	255
HOME: Texas Homebuyer Assistance Program	255
Home Tax Credit Program	255
Multifamily HOME Direct Loan Program	255
HOME: Tenant-Based Rental Assistance	255
Section 8 Housing: Project Access Program	256
Section 811 Supportive Housing for People with Disabilities	257
Real Choice Systems Grant	257
Amy Young Barrier Removal Program	258
Impediments to Fair Housing Choice	258

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

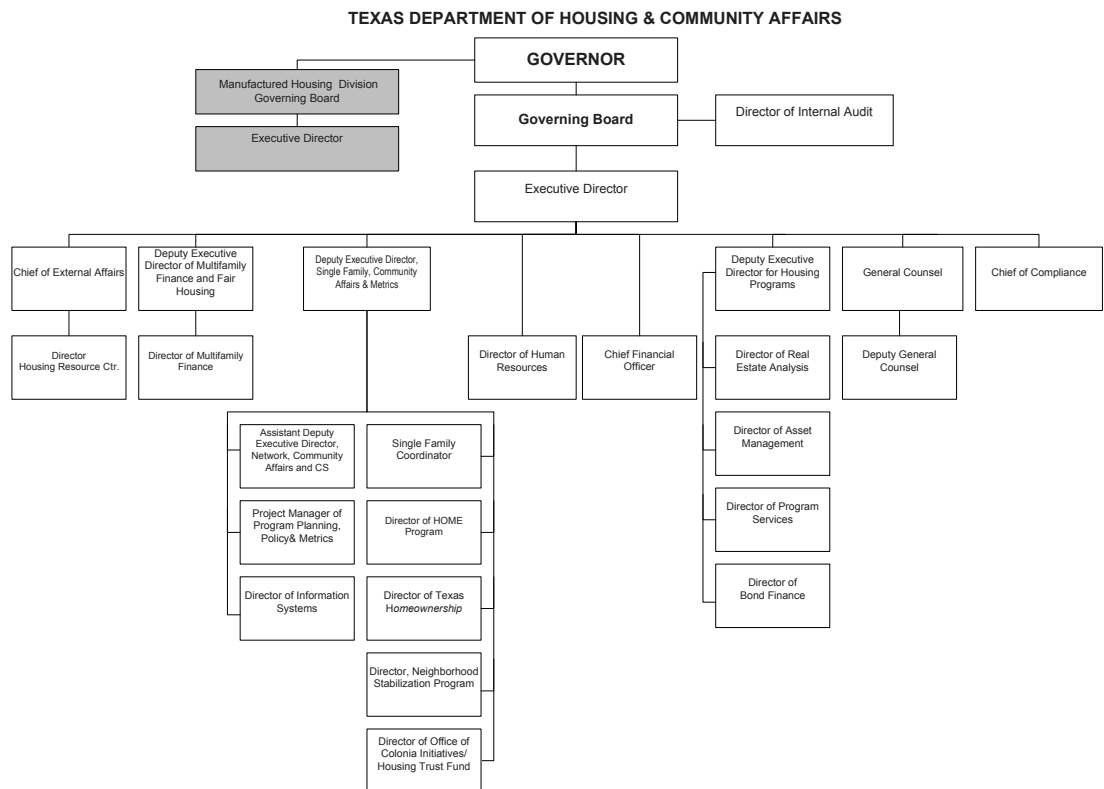
FAST FACTS

- 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 States showed that 26.2 percent of homeless adults housed in a shelter had a

mental health condition.⁸⁰⁶

- 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.⁸⁰⁷ The 2012 average monthly rent in Texas was \$677.⁸⁰⁸
- 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 2013.⁸⁰⁹

ORGANIZATIONAL CHART



Texas Department of Housing and Community Affairs

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.⁸¹⁰ TDHCA furthered its commitment to serving people with disabilities by implementing the *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: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.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.⁸¹³ Affordable housing programs focusing on homelessness prevention ultimately reach a significant population of people who have a mental health condition. In

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.

TDHCA

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

Program type	Description
Development Assistance	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.

Program type	Description
Rental Assistance	<p>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.⁸¹⁹</p> <p>Rental assistance comes in two basic forms:</p> <p>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.⁸²⁰ HOME: Tenant-Based Rental Assistance (TBRA), described in more detail below, is an example of tenant-based rental assistance.</p> <p>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.^{dccoxi} 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.</p>
Services Assistance	<p>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.</p>

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.”⁸²¹ 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/hhsc/doc/14-15-BiennialPlan.pdf>

Affordable Housing

Safe, stable and affordable housing is an essential component of support systems that facilitate recovery from mental illness.⁸²² However, many Texans face a housing cost burden.⁸²³ A housing cost burden exists when a household pays more than 30 percent of its total income before taxes and deductions toward housing.⁸²⁴ 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.⁸²⁵ 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.⁸²⁶

TDHCA estimates that the state meets less than 1 percent of its total affordable housing need.⁸²⁷ 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.⁸²⁸ 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.⁸²⁹ 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.⁸³⁰

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.

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.

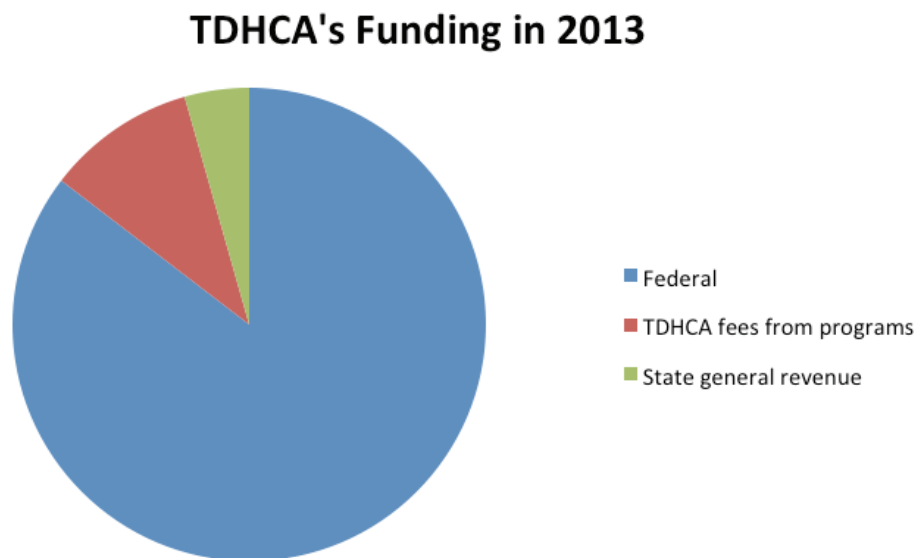
A second portion of TDHCA’s funding comes from fees the department collects from the housing programs and its regulation of the manufactured housing industry. In 2013, this source of funding provided \$18,367,246, or 10.2 percent of the total funds appropriated to TDHCA.⁸³⁷ This funding provides a method 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.⁸³⁹ 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."⁸⁴⁰ 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.⁸⁴¹ Figure 103 shows the majority of TDHCA's funding in 2013 in a graph.

Figure 103. TDHCA's Funding in 2013



Source: Texas Department of Housing and Community Affairs. (2012). *Agency strategic plan for the fiscal years 2013-17 period*. Retrieved from: <http://www.tdhca.state.tx.us/housing-center/docs/12-stratplanFY13-17.pdf>

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:⁸⁴²

- 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.⁸⁴³ 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.⁸⁴⁴

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.⁸⁴⁵ 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.⁸⁴⁶

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.⁸⁴⁷ 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.^{848,849} However, the 83rd legislative session allotted general revenue funding of \$10 million over the biennium.⁸⁵⁰ In 2013, \$5,000,000 was provided to serve 13,721 people under HHSP.⁸⁵¹

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.⁸⁵²

PROGRAMS FOR PERSONS WITH DISABILITIES

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 2012.⁸⁵⁸ 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.⁸⁵⁹ 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.⁸⁶⁰ In FY 2014, the statewide AMFI was \$60,300.⁸⁶¹ Furthermore, 75 percent of households participating in the voucher program must be 30 percent or below the AMFI.⁸⁶² 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.⁸⁶³ 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 2013.⁸⁶⁴ 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:⁸⁶⁵

- 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.⁸⁶⁶ 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 2010.⁸⁶⁷ 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).⁸⁶⁸ 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.⁸⁶⁹

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.⁸⁷⁰ TDHCA received \$12 million, the maximum amount, to provide project-based affordable housing for extremely low income persons with disabilities.⁸⁷¹ 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.⁸⁷² 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.⁸⁷³ 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.⁸⁷⁴ 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 person 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.⁸⁸⁰ 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:⁸⁸²

- 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:⁸⁸³

- “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>

Texas Veterans Commission: *At A Glance*

TABLE OF CONTENTS

Texas Veterans Commission	263
Claims Representation and Counseling Program	264
Eligibility for VA Benefits	264
TVC Employment Services	265
Fund for Veterans' Assistance (FVA)	266
Other Programs	266
Women Veterans	266
Veterans Support Networks	267
Specialty Courts	267

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

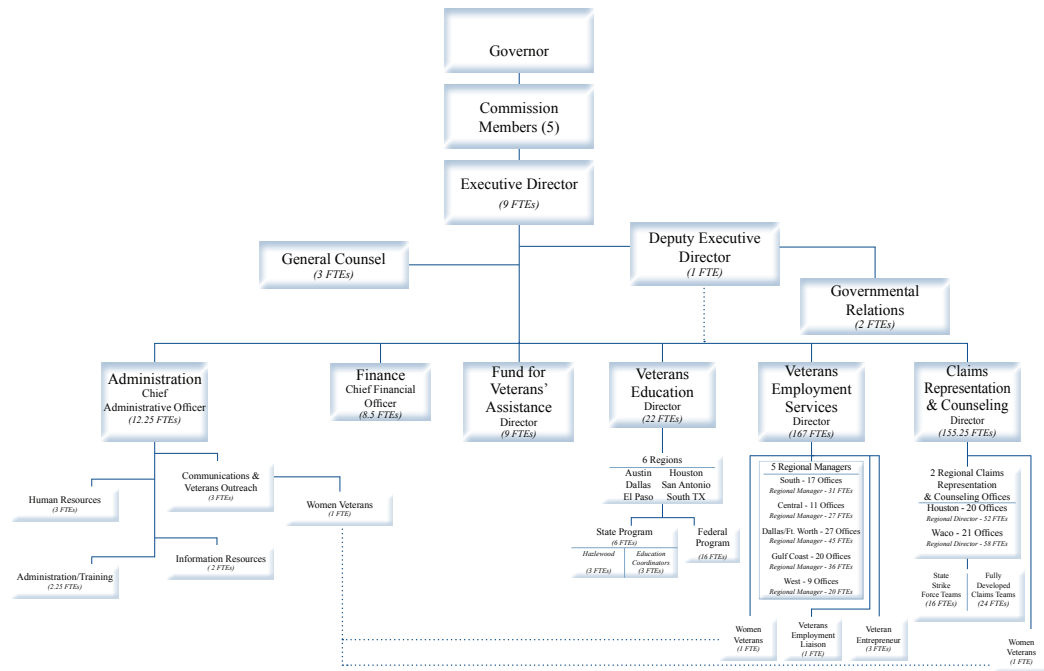
- Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.⁸⁸⁴
- Women are the fastest growing group within the veteran population and are projected to make up 15 percent of all living veterans by 2035.⁸⁸⁵
- Fifty-five out of a hundred women and thirty-eight 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.

ORGANIZATIONAL CHART



TEXAS VETERANS COMMISSION ORGANIZATIONAL CHART

FEBRUARY 2014



Texas Veterans Commission

Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.⁸⁸⁹ 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).⁸⁹⁰ In comparison, 7–8 percent of American adults in the general population will experience PTSD at some point during their lifetime.⁸⁹¹ 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.⁸⁹² 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.⁸⁹³ Additionally, 55 out of 100 women and 38 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.⁸⁹⁴ Thus, veterans are at higher risk for developing mental health conditions and substance use problems stemming from their military service.

Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.

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.^{895,896,897} An underlying behavioral health condition is the strongest predictor for homelessness after leaving active duty.⁸⁹⁸ Unfortunately, only about half of all veterans with a diagnosed behavioral health condition have accessed appropriate services, and even fewer have received adequate care.⁸⁹⁹

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.⁹⁰⁰

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.^{901,902} 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.⁹⁰³

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.

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.

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.⁹⁰⁴

TVC claims related to entitlements secured through service in the armed forces increased by 18 percent in FY 2011.⁹⁰⁵ 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.⁹⁰⁶ Texas leads all other large states in monetary recovery of veterans' compensation and pension benefits.⁹⁰⁷

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.⁹⁰⁸ 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.⁹⁰⁹ 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.⁹¹⁰ 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.⁹¹¹ 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).⁹¹²

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.⁹¹³ Additionally, 300 Vet Centers nationwide provide psychological counseling for war-related trauma and other services such as outreach, case management, and social services referrals.⁹¹⁴ Since beginning operation in 1979, the Vet Centers have helped 2 million veterans.⁹¹⁵ There were 8.92 million veterans enrolled in the VA Health Care system in FY 2013.⁹¹⁶ 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.

TVC Employment Services

Unemployment among veterans can have negative mental health and economic consequences, which creates additional obstacles for veterans in securing stable housing.⁹¹⁷ Gainful employment is therefore key to ensuring that veterans live independently and self-sufficiently.⁹¹⁸ 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.⁹¹⁹ Other employment-related services include vocational rehabilitation for veterans with disabilities and employment services to spouses and caregivers of active duty service members.⁹²⁰

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.⁹²¹ 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.⁹²² Housing4TexasHeroes grants support nonprofit or local government organizations that provide temporary and permanent housing assistance for veterans and their families.⁹²³ 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.⁹²⁴

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.⁹²⁵ Twenty-three organizations across the state of Texas were awarded grants totaling over \$3 million for 2014.⁹²⁶ 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 2035.⁹²⁷ 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.⁹²⁸ It is unclear whether the

Woman veterans are more likely to have lower incomes, lack private insurance, and to have poorer health.

incidence of PTSD is higher among military women than military men.⁹²⁹ However, woman veterans are more likely to have lower incomes, lack private insurance, and to have poorer health.⁹³⁰ 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.^{931,932} 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.⁹³³

A 2012 report by the VA estimated that there were 22 veteran suicides per day in 2010.

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

Best Practices

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

Recovery Focused Model	Traditional Medical Model
Person Centered	Diagnosis Centered
Person Centered	Service Centered
Trauma Informed	Diagnosis Informed
“What happened to you?”	“What is wrong with you”
“What are your needs?” “What are your strengths”	“What are your issues”

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.⁹⁴¹ They do not replace professionals but their participation on the care team can provide a different perspective and improve outcomes.⁹⁴² 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.⁹⁴³

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.⁹⁴⁴ 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.⁹⁴⁵ As of August 2014, 447 peer specialists were certified in Texas.⁹⁴⁶ 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.⁹⁴⁷

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 2013.⁹⁴⁸ 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.⁹⁴⁹ 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.⁹⁵⁰ 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.⁹⁵¹

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.⁹⁵²

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.⁹⁵³ 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.⁹⁵⁴ 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.⁹⁵⁵

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.⁹⁵⁶ 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 2006.⁹⁵⁷ 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.”⁹⁵⁸ 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.⁹⁵⁹ 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.⁹⁶⁰ 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.⁹⁶¹ There are a number of emerging recovery outcome measures that examine both individual experiences of recovery as well as the recovery orientation of services.^{962,963} 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.⁹⁶⁴ 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.

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.

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.⁹⁶⁵

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.”⁹⁶⁶

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

Fifty percent of all lifetime cases of mental illness are apparent by age 14 and 75 percent are apparent by age 24.

do better in school.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.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 24.⁹⁶⁹ 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.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.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.⁹⁷²
- SB 831 from the 83rd 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.⁹⁷³ 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.⁹⁷⁴

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.⁹⁷⁵

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.⁹⁷⁶ 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.⁹⁷⁷ 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*.⁹⁷⁸ The foundation also launched and facilitated the Texas Seclusion and Restraint Reduction Leadership Group. This group is composed

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.

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.⁹⁷⁹

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.⁹⁸⁰

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.⁹⁸¹ 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.⁹⁸² A trauma-informed approach specifically addresses the consequences of trauma on an individual and is designed to facilitate healing.⁹⁸³

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.⁹⁸⁴ 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.⁹⁸⁵ 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.⁹⁸⁶ 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.⁹⁸⁷ In FY 2013, JDTR was expanded into eight additional communities: Austin, Edinburg, El Paso, Houston, Lubbock, Sequin, San Marcos, and Tyler.⁹⁸⁸

- 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.⁹⁸⁹ 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.⁹⁹⁰
- 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.⁹⁹¹ 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.⁹⁹² 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.

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.⁹⁹³ 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.⁹⁹⁴ 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.¹⁰⁰⁴¹⁰⁰⁵ 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.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.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.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.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.¹⁰¹⁸

Best Practice: Suicide Awareness and Prevention

In 2011, approximately 39,500 people died by suicide in the United States.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.¹⁰²⁰ In 2012, 3,032 Texans committed suicide.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 25-35.¹⁰²² 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.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.¹⁰²⁴ While white males have the highest suicide rates, suicide

cuts across all ethnicities, ages, races and genders.^{1025, 1026}

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.texassuicideprevention.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:¹⁰²⁷

- 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 LMHAs also operate crisis hotlines. For a list of all Texas LMHA crisis hotline numbers, go to** <http://www.dshs.state.tx.us/mhsa/lmha-list/>

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.

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

supportive services and connections to the community-based supports people needed to keep their housing and avoid returning to homelessness.”¹⁰²⁸ 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.¹⁰²⁹ Many people experiencing homelessness also have a mental health condition.¹⁰³⁰ 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:¹⁰³¹

- 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 through the program, refer to the Texas Environment section.¹⁰³²

OXFORD HOUSE

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.”¹⁰³³

In 2011, SAMHSA included the Oxford House on the National Registry of Evidence-based Programs and Practices.¹⁰³⁴ 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.¹⁰³⁵

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.¹⁰³⁶ 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.¹⁰³⁷ 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.¹⁰³⁸

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.¹⁰³⁹

Federally funded research has shown that more than 80 percent of Oxford House residents avoided relapse.

Appendices

List of Figures

Figure 1. Texas Medicare Enrollment and Fully Dual Eligible	28
Figure 2. Texas Dual Eligibles Integrated Care Demonstration	29
Figure 3. SSI and SSDI Differences	31
Figure 4. Federal Marketplace in Texas: Silver Plan Averages and All Categories Averages Monthly Premium Costs	34
Figure 5. 2014 Federal Marketplace in Texas: Percentage of Individuals Separated by Monthly Premium Costs After Tax Credits	35
Figure 6. Sunset Evaluation Process	43
Figure 7. Sunset Evaluation Timeframe	44
Figure 8. Federally Designated Mental Health Professional Shortage Areas as of November 2013	45
Figure 9. Health and Human Services Enterprise	59
Figure 10. Health and Human Services Regions	60
Figure 11. HHS System Request by Agency	61
Figure 12. Methods of Financing	61
Figure 13. Medicaid Funded Programs Across HHSC Agencies	65
Figure 14. Texas Medicaid/CHIP Managed Care Programs	66
Figure 15. Subsidized Coverage in Texas & Annual Income Levels: 2014	69
Figure 16. Medicaid-Funded Behavioral Health Services	70
Figure 17. Texas Medicaid Beneficiaries and Expenditures, 2011	71
Figure 18. CHIP Enrollment	74
Figure 19. Legislative Appropriations Request FY 2016-2017: CHIP Services	74
Figure 20. Selected Behavioral Health Quality of Care Measures for Medicaid and CHIP Programs	75
Figure 21. Texas Public Behavioral Health Spending: Annual Spending 2003-2015	83
Figure 22. FY 2013 State Expenditures, FY 2014 – 2015 Appropriations and FY 2016-2017 Legislative Appropriations Request (all funds)	83
Figure 23. Unmet Needs for Community Mental Health Services	84
Figure 24. Impact of Adult Waiting List by Adults Served – FY 2012 – FYTD May 2014	86
Figure 25. Impact of Child Waiting List by Children Served – FY 2012 – FYTD May 2014	86
Figure 26. Subsidized Coverage in Texas & Annual Income Levels: 2014	88
Figure 27. LMHA Priority Population	90
Figure 28. Map of LMHAs and 39 Service Regions	92
Figure 29. Texas Resiliency and Recovery Level of Care for Adults	95
Figure 30. Utilization/Cost for Adult Community Mental Health Services	96
Figure 31. Selected Quality of Care Measures for Adults Receiving Community Mental Health Services	97
Figure 32. Texas Resiliency and Recovery Level of Care for Children and Adolescents	97
Figure 33. Utilization/Cost for Child and Adolescent Community Mental Health Services	99
Figure 34. Selected Quality of Care Measures for Children and Adolescents Receiving Community Mental Health Services	100
Figure 35. Crisis Services	101
Figure 36. Utilization/Cost for Adult Community Mental Health Services	102
Figure 37. Quality of Care Measures	103
Figure 38. NorthSTAR Mental Health Benefits	103
Figure 39. Utilization of NorthSTAR Services By Population	104
Figure 40. FY 2013 COSTS for NorthSTAR Services	104
Figure 41. Selected Quality of Care Measures for NorthSTAR	105
Figure 42. State Mental Health Hospitals: 2014*	107
Figure 43. Number of Mental Health Beds, by Bed Types, at State Hospitals in Texas, FY 2012	108
Figure 44. Utilization and Costs for State Hospitals	109
Figure 45. Number of persons accessing crisis outpatient services and transitional services at DSHS-funded community centers compared to percent of persons readmitted to a state psychiatric hospital within 30 days.	110
Figure 46. Contracted Community & Private Hospitals, Allocated Funds and Number of Beds	110

Figure 47. Placement Determination For Competency Restoration Programs	111
Figure 48. Comparison of Competency Restoration Programs**	113
Figure 49. Daily Census Snapshot for Civil and Forensic Commitments in State Mental Health Hospitals 2001-2014	114
Figure 50. Available Substance Use Services Through DSHS	118
Figure 51. Utilization and Costs for Adult Substance Use Services	119
Figure 52. Utilization and Costs for Youth Substance Use Services	120
Figure 53. Selected Quality of Care Measures for Adult Substance Use Services	121
Figure 54. Selected Quality of Care Measures for Youth Substance Use Services	121
Figure 55. Child Protection Courts and Covered Regions	129
Figure 56. CPS Investigation Process	131
Figure 57. Health Insurance Programs for Former Foster Care Children	133
Figure 58. Child Mortalities in Texas	136
Figure 59. Confirmed Child Fatalities Due to Abuse or Neglect	136
Figure 60. Disproportionality in the CPS System	138
Figure 61. Psychotropic Medication Prescriptions	140
Figure 62. Prevention and Early Intervention Programs and Services and their Costs and Availability in Texas	142
Figure 63. APS Investigation Process	146
Figure 64. Child Care Operations in Texas	147
Figure 65. Community-Based Waiver Eligibility and Behavioral Health-Related Services Disabilities	155
Figure 66. Utilization and Costs for DADS HCS Waivers	157
Figure 67. State Supported Living Center Census Data	160
Figure 68. Institutional Care Eligibility and Behavioral Health-Related Services Disabilities	160
Figure 69. Utilization and Costs of Residential Programs for Persons with Disabilities	162
Figure 70. Total Cost of Programs Serving Individuals with Disabilities (Data on costs for behavioral health services in these programs is not available)	162
Figure 71. Percentage of People Enrolled in Dads Programs with a Behavioral Health Diagnosis	164
Figure 72. Program Cost Trends - Average Monthly Cost Per Individual for Dads Waiver and Institutional Programs	164
Figure 73. Percentage Enrolled by Reason for Eligibility	171
Figure 74. Characteristics of Individuals utilizing ECI Services	172
Figure 75. Outcomes for Individuals utilizing Vocational Rehabilitation Services	175
Figure 76. Disability Claims Process for SSI and SSDI Benefits	177
Figure 77. Utilization of Disability Determination Services in Texas	179
Figure 78. DBS Services	180
Figure 79. 83rd Session Criminal Justice and Mental Health Legislation	184
Figure 80. Common Criminal Justice Definitions	186
Figure 81.	187
Figure 82. TDCJ Operating Budget for FY 2013	189
Figure 83. Behavioral Health Related Divisions within TDCJ	190
Figure 84. Level of Health Service	191
Figure 85. Specialized Mental Health Programs	192
Figure 86. Substance Use Service Descriptions	192
Figure 87. Special Programs for Offenders with Behavioral Health Conditions	194
Figure 88.	197
Figure 89. Referrals and Dispositions of TJJD youth in 2012 and 2013	207
Figure 90. Terms and Concepts	207
Figure 91. Common Juvenile Justice Definitions	208
Figure 92. TJJD Secure Facilities	210
Figure 93. Specialized Treatment Programs in Texas	211
Figure 94. Youth Discharged and linked to Community Services, including Behavioral Health treatment, care management and support services in FY 2013	214

Figure 95. Youth with Behavioral Health Conditions and Juvenile Justice Involvement Served in the Community, FY 2013	215
Figure 96. Average Expected Length of Stay in Various Community Programs	217
Figure 97. Mental Health Service Delivery Methods	224
Figure 98. Declining State Support for Special Education	227
Figure 99. Map of Education Service Center Regions	231
Figure 100. Continuum of School-wide Instructional & Positive Behavior Support	233
Figure 101. Texas Public School Expulsions from 2002-2013	239
Figure 102. Types of Housing Assistance	248
Figure 103. TDHCA's Funding in 2013	252
Figure 104. Recovery Focused Model vs. Traditional Clinical Model	270

List of Acronyms

ACA - Patient Protection and Affordable Care Act
AFSP - American Foundation for Suicide Prevention
AMFI - Area Median Family Income
ANSA - Adult Needs and Strengths Assessment
APS - Adult Protective Services
ARS - Alternative Response System
ASCA - American School Counselor Association
ASD - Autism Spectrum Disorder
ASSET - Achieving Successful Systems Enriching Texas [initiative grant]
AYBR - Amy Young Barrier Removal [program]
BISQ - Brain Injury Screening Questionnaire
CANS - Child and Adolescent Needs and Strengths [assessment]
CAS - Community Attendant Services
CBA - Community-Based Alternatives
CBT - Cognitive Behavioral Therapy
CCL - Child Care Licensing
CCRC - Criss Cole Rehabilitation Center
CDC - Centers for Disease Control and Prevention
CEU - Continuing Education Unit
CFP - Certified Family Partner
CHIP - Children's Health Insurance Program
CIHCP - County Indigent Health Care Program
CIL - Center for Independent Living
CINS - Conduct in Need of Supervision
CIS - Communities in Schools
CIT - Crisis Intervention Team
CLASS - Community Living Assistance and Support Services [waiver program]
CMS - Centers for Medicare and Medicaid Services
COG - Council of Governments
COPE - Collaborative Opportunities for Positive Experiences
COPSD - Co-occurring Psychiatric and Substance Use Disorder
COSP - Consumer-Operated Service Provider
CPS - Child Protective Services
CPS - Certified Peer Specialist
CRCG - Community Resource Coordination Group
CSBG - Community Services Block Grant
CSU - Crisis Stabilization Unit
DADS - Texas Department of Aging and Disability Services
DAEP - Disciplinary Alternative Education Program
DAHS - Day Activity Health Services
DARS - Texas Department of Assistive and Rehabilitative Services
DBMD - Deaf-Blind with Multiple Disabilities [waiver program]
DBS - Division for Blind and Visually Impaired Services
DDS - Division of Disability Determination Services
DFPS - Texas Department of Family and Protective Services
DHHS - U.S. Department of Health and Human Services
DRS - Division for Rehabilitation Services

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

LGTBQ - Lesbian, Gay, Transgender, Bisexual, Queer

LIHTC - Low Income Housing Tax Credit [program]

LMHA - Local Mental Health Authority

LOC - Level of Care

LSSP - Licensed Specialist in School Psychology

LTSS - Long-Term Services and Supports

MAYSI - Massachusetts Youth Screening Instrument

MCO - Managed Care Organization

MCOT - Mobile Crisis Outreach Team

MDCP - Medically Dependent Children Program

MDD - Major Depressive Disorder

MH - Mental Health

MHFA - Mental Health First Aid

MHPAEA - Mental Health Parity and Addiction Equity Act

MOU - Memorandum of Understanding

MRSA - Medicaid Rural Service Area

MTFCY - Medicaid for Transitioning Foster Care Youth

NAMI - National Alliance on Mental Illness

NCEC - Non-Categorical Early Childhood

NCTSN - National Child Traumatic Stress Network

NCTIC - National Center for Trauma Informed Care

NGRI - Not Guilty By Reason of Insanity

NNTY - National Network for Youth Transition

OCD - Obsessive-compulsive Disorder

OCR - Outpatient Competency Restoration

OIO - Office of the Independent Ombudsman

OSS - Out-of-School Suspension

PASRR - Pre-Admission Screening and Resident Review

PCP - Primary Care Physician

PE - PASRR Evaluation

PEI - Prevention and Early Intervention

PHA - Public Housing Agency

PHC - Primary Home Care

PPCD - Pre-school Program for Children with Disabilities

PPO - Preferred provider organization

PRA - Project Rental Assistance [demonstration program]

PRC - Prevention Resource Center

PSH - Permanent Supportive Housing

PTSD - Post-Traumatic Stress Disorder

RDM - Resiliency and Disease Management

RHP - Regional Healthcare Partnership

ROSC - Recovery-Oriented System of Care

RTC - Residential Treatment Center

SAMHSA - Substance Abuse and Mental Health Services Administration

SAPIT - Substance Abuse Prevention, Intervention, and Treatment

SED - Severe Emotional Disturbance

SEL - Social and Emotional Learning

SHAC - School Health Advisory Council

SHARS - School Health and Related Services

SMVF - Service Members, Veterans, and Family Members

SNAP - Supplemental Nutrition Assistance Program

SSA - Social Security Administration

SSA - Shared Services Arrangement
SSDI - Social Security Disability Insurance
SSI - Supplemental Security Income
SSLC - State Supported Living Center
STARS - State of Texas Alternatives to Restraint and Seclusion
STP - Significant Traditional Provider
SWPBIS - School-wide Positive Behavioral Interventions and Supports
TANF - Temporary Assistance for Needy Families
TAY - Transition-Age Youth
TBI - Traumatic Brain Injury
TBRA - Tenant-Based Rental Assistance
TBSI - Texas Behavior Support Initiative
TCOOMMI - Texas Correctional Office on Offenders with Medical or Mental Impairments
TCPA - Texas Police Chiefs Association
TDCJ - Texas Department of Criminal Justice
TDHCA - Texas Department of Housing and Community Affairs
TDI - Texas Department of Insurance
TEA - Texas Education Agency
TIC - Trauma-Informed Care
TJJD - Texas Juvenile Justice Department
TJPC - Texas Juvenile Probation Commission
TMHP - Texas Medicaid and Healthcare Partnership
TRI - Texas Recovery Initiative
TRR - Texas Resiliency and Recovery
TVC - Texas Veterans Commission
TxHmL - Texas Home Living [waiver program]
TYC - Texas Youth Commission
UC - Uncompensated Care
VA - U.S. Department of Veteran Affairs
VISN - Veterans Integrated Service Network
VR - Vocational Rehabilitation
VSO - Veterans Service Organization
WHO - World Health Organization
WRAP® - Wellness Recovery Action Plan
YES - Youth Empowerment Services [waiver]

Additional Resources

AGENCY WEBSITES

Texas Health and Human Services Commission (HHSC): www.hhsc.state.tx.us/index.shtml

Texas Department of State Health Services (DSHS): www.dshs.state.tx.us

Texas Department of Family and Protective Services (DFPS): www.dfps.state.tx.us

Texas Department of Aging and Disability Services (DADS): www.dads.state.tx.us

Texas Department of Assistive and Rehabilitative Services (DARS): www.dars.state.tx.us/index.shtml

Texas Department of Criminal Justice (TDCJ): www.tdcj.state.tx.us

Texas Juvenile Justice Department (TJJD): www.tjjd.texas.gov

Texas Education Agency (TEA): www.tea.state.tx.us

Texas Department of Housing and Community Affairs (TDHCS): www.tdhca.state.tx.us

Texas Workforce Commission: www.twc.state.tx.us

CERTIFIED PEER SPECIALISTS

Copeland Center for Wellness and Recovery: <http://copelandcenter.com/>

Georgia Certified Peer Specialist Project: <http://www.gacps.org/>

Institute for Recovery and Community Integration: <http://www.mhrecovery.org/services/peer.php>

Pillars of Peer Support: <http://www.pillarsofpeersupport.org/>

Via Hope – Texas Mental Health Resource: <http://www.viahope.org/>

CHILD WELFARE

Child Welfare Information Gateway: <http://www.childwelfare.gov/systemwide/mentalhealth/>

Child Welfare League of America: <http://www.cwla.org/>

Texans Care for Children: <http://texanscareforchildren.org/>

CHILDREN'S MENTAL HEALTH

Bazelon Center for Mental Health Law: <http://www.bazelon.org/Where-We-Stand/Success-for-All-Children/Transition-Aged-Youth/Transition-Aged-Youth-Policy-Documents.aspx>

Building Bridges Initiative: <http://www.buildingbridges4youth.org/index.html>

National Child Traumatic Stress Network: <http://www.nctsnet.org/>

National Federation of Families for Children's Mental Health: <http://www.ffcmh.org/>

National Institute of Mental Health, Child and Adolescent Mental Health: <http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml>

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

Council on State Governments Justice Center. Criminal Justice and Mental Health Consensus Project: <http://csgjusticecenter.org/mental-health-projects/report-of-the-consensus-project/>

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.texasajc.org/>

Texas Public Policy Foundation: <http://www.texaspolicy.com/>

CULTURAL AND LINGUISTIC COMPETENCY

Georgetown University National Center for Cultural Competence: <http://nccc.georgetown.edu>

Hogg Foundation for Mental Health. Enhancing the delivery of health care: *Eliminating health disparities through a culturally and linguistically centered integrated health care approach*: <http://www.hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf>

NAMI Multicultural Action Center: http://www.nami.org/Template.cfm?Section=Multicultural_Support&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=56&ContentID=25443

U.S. Department of Health & Human Services: Office of Minority Health: <http://www.minorityhealth.hhs.gov>

U.S. Surgeon General's Office Supplemental Report on Mental Health- Culture, Race, and Ethnicity: www.surgeongeneral.gov/library/mentalhealth/cre

Technical Assistance Partnership for Child and Family Mental Health (TA Partnership): <http://www.tapartnership.org/COP/CLC/default.php>

EARLY CHILDHOOD AND MENTAL HEALTH

TexProtects: <http://www.texprotects.org/about/staff/>

Texas Association for Infant Mental Health: <http://taimh.org/>

Zero to Three: <http://www.zerotothree.org/child-development/early-childhood-mental-health/>

United Way for Greater Austin: <http://www.unitedwayaustin.org/strategic-programs/success-by-6/>

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>

Meadows Texas State of Mind Policy Institute: <http://www.texasstateofmind.org>

National Association of State Mental Health Program Directors – National Research Institute: <http://www.nri-inc.org/>

National Council for Behavioral Health: <http://www.thenationalcouncil.org/>

National Institute of Mental Health: <http://www.nimh.nih.gov/index.shtml>

Substance Use and Mental Health Services Administration: <http://www.samhsa.gov/>

Substance Use and Mental Health Services Administration, Center for Mental Health Services Uniform Reporting System Output Tables: <http://www.samhsa.gov/dataoutcomes/urs>

HOUSING

Coalition for Supportive Housing: <http://www.csh.org/csh-in-the-field/texas>

Neighborhood Housing and Community Development: <http://www.austintexas.gov/department/permanent-supportive-housing-initiative>

National Alliance to End Homelessness: <http://www.endhomelessness.org/>

Technical Assistance Collaborative: <http://www.tacinc.org/>

Texas Department of Housing & Community Affairs: <https://www.tdhca.state.tx.us/>

U.S. Department of Housing and Urban Development: <http://www.huduser.org/>

INTEGRATED PHYSICAL AND MENTAL HEALTH CARE

Academy for Integrating Behavioral Health and Primary Care: <http://integrationacademy.ahrq.gov/>

Advancing Integrated Mental Health Solutions (AIMS) Center: <http://aims.uw.edu/>

Hogg Foundation for Mental Health: <http://www.hogg.utexas.edu/index.php>

Integrated Behavioral Health Project (IBHP): <http://www.ibhp.org/>

National Council on Community Behavioral Healthcare: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions

INTELLECTUAL DISABILITY WITH CO-OCCURRING MENTAL HEALTH CONDITIONS

The National Association for the Dually Diagnosed: <http://thenadd.org/>

Accessible Mental Health Services for People with Intellectual Disability: A Guide for Providers: http://3dn.unsw.edu.au/sites/default/files/ddn/page/Accessible%20Mental%20Health%20Services%20for%20People%20with%20an%20ID%20-%20A%20Guide%20for%20Providers_current.pdf

MENTAL 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 Behavior Support (TBS) Networks: <http://www.txbehaviorsupport.org/default.aspx?name=homepage>

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.umaryland.edu/>

MENTAL HEALTH WORKFORCE DEVELOPMENT

SAMSHA, An Action Plan for Behavioral Health Workforce Development prepared by The Annapolis Coalition: <http://www.samhsa.gov/workforce/annapolis/workforceactionplan.pdf>

The Annapolis Coalition on Behavioral Health Workforce Development: <http://annapoliscoalition.org/>

US National Library of Medicine National Institutes of Health, *Developing the mental health workforce*: <http://www.ncbi.nlm.nih.gov/pubmed/21190075>

Bazon Center for Mental Health Law, Promoting Employment of People with Mental Illness: http://www.bazon.org/portals/0/Where%20We%20Stand/Community%20Integration/Olmstead/Getting%20to%20Work.pdf?utm_source=Getting+to+Work+Report+&utm_campaign=Getting+to+Work+Report&utm_medium=email

PROMOTORES(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://promotorasinmentalhealth.com/>

USA Center for Rural Public Health Preparedness: <http://www.rural-preparedness.org/index.aspx?page=fd089d35-bd02-4b2a-9ad7-15fc31c99b55>

RECOVERY AND WELLNESS

National Empowerment Center: <http://www.power2u.org/>

National Council on Alcoholism and Drug Dependence, Inc.: <http://www.ncadd.org/index.php/recovery-support/overview>

Recovery Innovations: <http://www.recoveryinnovations.org/index.html>

SAMHSA: <http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>

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

A Report of the Surgeon General: 2012 National Strategy for Suicide Prevention: <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>

Preventing Suicide: A toolkit for High Schools: <http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>

SAMHSA – Suicide Prevention: <http://www.samhsa.gov/prevention/suicide.aspx>

Texas Suicide Prevention: <http://www.texassuicideprevention.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)

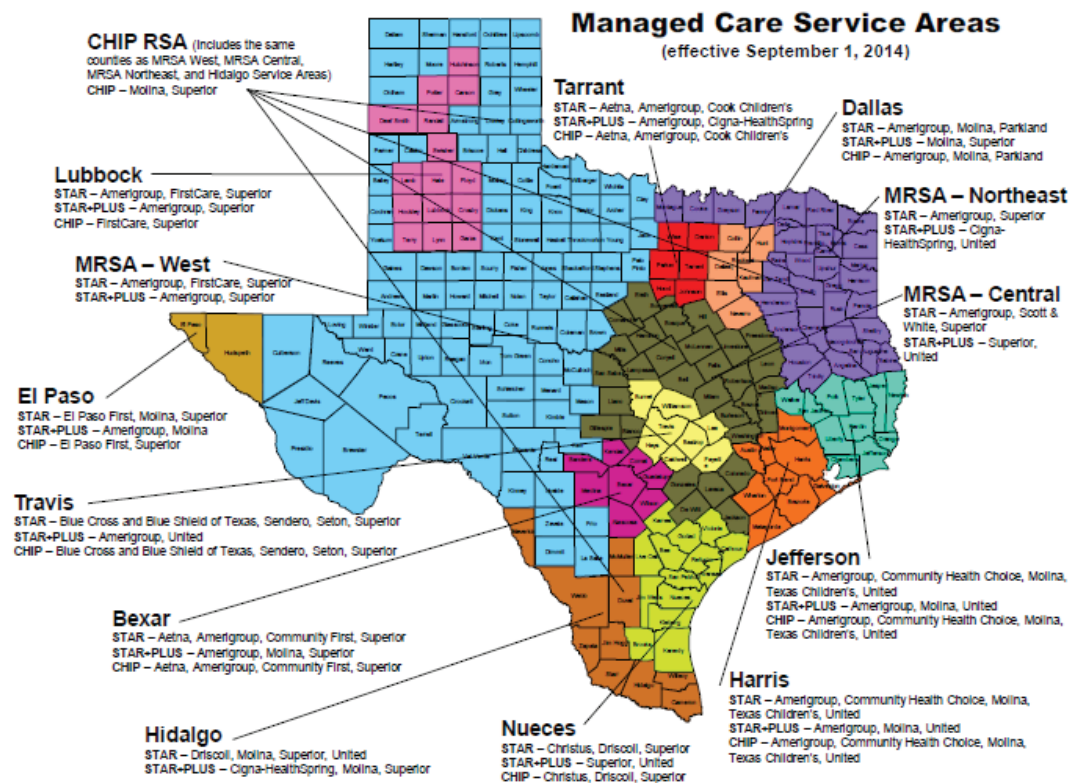
Texas Resilience and Recovery

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

Service Area	Managed Care Company
Bexar	Aetna Better Health, Amerigroup, Community First Health Plans, Superior HealthPlan
Dallas	Amerigroup, Molina Healthcare of Texas, Parkland HEALTHfirst
El Paso	El Paso First Premier Plan, Molina Healthcare of Texas, Superior HealthPlan
Harris	Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children's Health Plan, UnitedHealthcare Community Plan
Hidalgo	Driscoll Children's Health Plan, Molina Healthcare of Texas, Superior HealthPlan, UnitedHealthcare Community Plan
Jefferson	Amerigroup, Community Health Choice, Molina Healthcare of Texas, Texas Children's Health Plan, UnitedHealthcare Community Plan
Lubbock	Amerigroup, FirstCare Star, Superior HealthPlan
Nueces	Christus Health Plan, Driscoll Children's Health Plan, Superior HealthPlan
Tarrant	Aetna Better Health, Amerigroup, Cook Children's Health Plan
Travis	Blue Cross Blue Shield of Texas, Sendero Health Plans, Seton Health Plan, Superior HealthPlan
MRSA Northeast Texas	Amerigroup, Superior
MRSA Central Texas	Amerigroup, Scott & White, Superior
MRSA West Texas	Amerigroup, FirstCare, Superior

STAR+PLUS Service Areas

Service Area	Managed Care Company
Bexar	Amerigroup, Molina Healthcare of Texas, Superior HealthPlan
Dallas	Molina Healthcare of Texas, Superior HealthPlan
El Paso	Amerigroup, Molina Healthcare of Texas, Superior HealthPlan
Harris	Amerigroup, Molina Healthcare of Texas, UnitedHealthcare Community Plan
Hidalgo	Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan
Jefferson	Amerigroup, Molina Healthcare of Texas, UnitedHealthcare Community Plan
Lubbock	Amerigroup, Superior HealthPlan
Nueces	Superior HealthPlan, UnitedHealthcare Community Plan
Tarrant	Amerigroup, Cigna-HealthSpring
Travis	Amerigroup, United Healthcare Community Plan
MRSA Northeast Texas	Cigna-Healthspring, UnitedHealthcare
MRSA Central Texas	Superior HealthPlan, UnitedHealthcare
MRSA West Texas	Amerigroup, Superior HealthPlan

Children's Health Insurance Program (CHIP) or Children's Medicaid Service Areas

Service Area	Managed Care Company
Bexar	Aetna, Amerigroup, Community First, Superior
Dallas	Amerigroup, Molina, Parkland
El Paso	El Paso First, Superior
Harris	Amerigroup, Community Health Choice, Molina, Texas Children's, United
Hidalgo	Molina Healthcare, Superior HealthPlan
Jefferson	Amerigroup, Community Health Choice, Molina, Texas Children's, United
Lubbock	FirstCare, Superior
Nueces	Christus, Driscoll, Superior
Tarrant	Aetna, Amerigroup, Cook Children's
Travis	Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior
MRSA Northeast Texas	Molina Healthcare, Superior HealthPlan
MRSA Central Texas	Molina Healthcare, Superior HealthPlan
MRSA West Texas	Molina Healthcare, Superior HealthPlan

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/bhiac.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

- 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/

- 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

- 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

- 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/>

- 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

- 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/

- 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

- 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.

Traumatic Brain Injury Advisory Council: http://www.hhsc.state.tx.us/hhsc_projects/abj/Council.shtml

- Informs state leadership of the needs of people with brain injuries and their families.

Task Force for Children with Special Needs: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/TaskForce.shtml

- 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 reimburseable 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-edemployment/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

- 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>

- Helps develop rules and policies for the Department.

Rehabilitation Council of Texas: <http://www.dars.state.tx.us/councils/rct/rct.shtml>

- Advises on policy vocational rehabilitation services and eligibility requirements.

ECI Advisory Committee: <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.

State Independent Living Council: <http://www.dars.state.tx.us/councils/silc/silc.shtml>

- Is an equal partner with DARS in the development, approval, and implementation of the State Plan for Independent Living.

Board for Evaluation of Interpreters: <http://www.dars.state.tx.us/councils/BEI/bei.shtml>

- 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/>

- 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.shtml

- 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/>

- 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/>

- 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/

- 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

- Advises DSHS on rules concerning training and regulation of promotores/ community health workers.

Public Health Funding and Policy Committee: www.dshs.state.tx.us/phfpccommittee/

- 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>

- 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/>

- 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

- Provides assistance to the DSHS Council in supporting and delivering coordinated school health programs.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

DFPS Council: https://www.dfps.state.tx.us/About_DFPS/Council/

- Created in 2004 as part of the HHS Transformation

Texas Sunset Advisory Commission Recommendations Impacting Mental Health

HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

Issue 1: The Vision for Achieving, Better, More Efficiently Run Services Through Consolidation of Health and Human Services Agencies Is Not Yet Complete.

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.

Require HHSC to create policies governing hotlines and call centers throughout the health and human service system.
Clarify the role and authority of the HHSC ombudsman's office as a point of escalation for complaints throughout the system and to collect standard complaint information.
Issue 13: HHSC's Advisory Committees, Including the Interagency Task Force for Children With Special Needs, Could be Combined and Better Managed Free of Statutory Restrictions.
Removed advisory committees from statute, including those with Sunset dates, and allow the executive commissioner to re-establish needed advisory committees in rule.
Remove the Task Force for Children With Special Needs, the Children's Policy Council, the Council on Children and Families, and the Texas System of Care Consortium from statute and direct the executive commissioner to create one advisory committee in rule to better coordinate advisory efforts on children's issues.

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)

Issue 1: Despite Declining Enrollment, Skyrocketing Costs, and Questionable Quality of Care, Texas Continues to Operate 13 SSLCs.

Require DADS to close the Austin SSLC by August 31, 2017.

Establish the State Supported Living Center Closure Commission to evaluate the SSLCs and determine an additional five centers to close.

Require DADS to close the five SSLCs determined by the SSLC Closure Commission no later than August 31, 2022.

Issue 2: To Transition From SSLCs to the Community, People With Higher Behavioral and Medical Needs Require Extra Support.

Require DADS to expand crisis intervention teams to provide increased supports to people with IDD in the community.

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.

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.

Issue 3: DADS Lacks Effective Means for Ensuring Its Clients Receive Adequate Care in Day Habilitation Facilities.

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.

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

Issue 6: DADS' Consumer Information Website Lacks Clear and Consistent Information For Helping the Public Select Long-Term Care Providers.

Require DADS to maintain a consumer information site on the quality of long-term care providers in Texas.

Direct DADS to improve the quality and consistency of information available on the Quality Reporting System for all providers.

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.

Postpone decisions on continuation of DADS' functions and structure until completion of the Sunset review of the health and human services system.

DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)

Issue 1: Efforts to Reduce Turnover of CPS Caseworkers Fail to Address Key Reasons Many Staff Leave.

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.

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.

Endnotes

- 1 World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2001.
- 2 Levin, M. (2011, September 30). *The right prescription for the mentally ill in the Texas corrections system* [PowerPoint slides]. Retrieved from <http://www.texaspolicy.com/center/effective-justice/reports/right-prescription-mentally-ill-texas-corrections-system>
- 3 Stone, S. (2012, March). *Frequent utilization of behavioral health services in various service systems: Performance improvement project update*. Paper presented to the Psychiatric Services Stakeholder Committee (part of the Mayor's Mental Health Task Force on Mental Illness, Indicator Improvement Initiative), Central Health, Austin, TX
- 4 Kaiser Family Foundation. (n.d.). *State mental health agency per capita mental health services expenditures, FY2010*. Retrieved from <http://www.statehealthfacts.org/comparemaptable.jsp?cat=5&ind=278>
- 5 Treatment Advocacy Center & National Sheriffs' Association. (2010, May). *More mentally ill persons are in jails and prisons than hospitals: A survey of the states*. Retrieved from http://treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf
- 6 Substance Abuse and Mental Health Services Administration. (2012, March). *SAMHSA, MacArthur collaborate to improve how juvenile justice system responds to the behavioral health needs of youth*. Retrieved from <http://www.samhsa.gov/newsroom/advisories/1203082519.aspx>
- 7 National Center on Addiction and Substance Abuse at Columbia University. (2009, May). *Shoveling up II: The impact of substance abuse on federal, state and local budgets*. Retrieved from <http://www.casacolumbia.org/articlefiles/380-ShovelingUpII.pdf>
- 8 Bazelon Center for Mental Health Law. (2011, July). *How children with serious mental health problems are treated in our schools and how to fix it*. Retrieved from <http://www.bazelon.org/LinkClick.aspx?fileticket=N7Q53i3SdBo%3d&tabid=134>
- 9 Insel, T.R. (2008). Assessing the Economic Costs of Serious Mental Illness. *The American Journal of Psychiatry*. 165(6), 663-665.
- 10 American Association of Suicidology. (2012). *Suicide in the USA Based on 2010 Data*. Washington, DC: American Association of Suicidology.
- 11 Mauer, B. (2006). Morbidity and Mortality in People with Serious Mental Illness. *National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*. Retrieved from <http://www.nasmhpd.org/docs/publications/MDCdocs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf>
- 12 New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (DHHS Publication No. SMA 03-3832). Retrieved from <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html>
- 13 Ibid.
- 14 The White House Blog. (2013). *The National Conference on Mental Health* [Video file]. Retrieved from <http://www.whitehouse.gov/blog/2013/06/03/national-conference-mental-health>
- 15 Substance Abuse and Mental Health. (2013). Landmark Mental Health Conference Convened. *SAMHSA News*, 21(3). Retrieved from http://www.samhsa.gov/samhsanewsletter/Volume_21_Number_3/national_conference.aspx
- 16 The White House Office of the Press Secretary. (2013, June 03). Background on the National Conference on Mental Health. *The White House*. Retrieved from <http://www.whitehouse.gov/the-press-office/2013/06/03/background-national-conference-mental-health>
- 17 Petzel, R. (2013, July 11). White House, VA launch nationwide Community Mental Health Summits. *Vantage Point: Dispatches from the U.S. Department of Veterans Affairs*. Retrieved from <http://www.blogs.va.gov/VAntage/9815/white-house-va-launch-nationwide-community-mental-health-summits/>
- 18 The White House Office of the Press Secretary. (2013, June 03). Background on the National Conference on Mental Health. *The White House*. Retrieved from <http://www.whitehouse.gov/the-press-office/2013/06/03/background-national-conference-mental-health>
- 19 Congressional Research Service. (2010, April 15). *Private health insurance provisions in PPACA (P.L.111-148)*.
- 20 Community Catalyst. (2012, October). *Essential Health Benefits: Mental health and substance use disorders advocacy*. Retrieved from http://www.communitycatalyst.org/doc-store/publications/EHB_SUD_Memo_reboot_10.1.12.pdf
- 21 The Henry J. Kaiser Family Foundation. (2014). *State decisions for creating Health Insurance Marketplaces, 2014*. Retrieved from <http://kff.org/health-reform/state-indicator/health-insurance-exchanges/>
- 22 Department of Health and Human Services. (2014). *Health Insurance Marketplace: Summary enrollment report for the initial annual open enrollment period*. Retrieved from http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014apr_enrollment.pdf
- 23 The Henry J. Kaiser Family Foundation. (2014). *Status of state action on the Medicaid expansion decision, 2014*. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#note-2>
- 24 The Henry J. Kaiser Family Foundation. (2014). *The coverage gap: Uninsured poor adults in states that do not*

- expand Medicaid. Retrieved from <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>
- 25 Ibid.
- 26 Justice, D. (2010). Implementing the Affordable Care Act: New options for Medicaid home and community based services. *Briefing: A Publication of the National Academy for State Health Policy*, 1-9. Retrieved from http://www.nashp.org/sites/default/files/LTSS_SCAN-FINAL-9-29-10.PDF
- 27 Sarata, A. K. (2010). Mental Health Parity and the Patient Protection and Affordable Care Act of 2010. *Congressional Research Service*. Retrieved from <https://www.naphs.org/resourcemanager/handlerresource.aspx?id=131>
- 28 Swain, F. S., & Zook, D. R. (2013). *HHS, Labor and Treasury Departments release final Mental Health Parity rules*. Retrieved from Faegre Baker Daniels LLP. website: <http://www.faegrebd.com/20772>
- 29 Centers for Medicare and Medicaid Services. (2014). *Medicare & you 2014* (CMS Product No. 10050). Retrieved from <http://www.medicare.gov/Pubs/pdf/10050.pdf>
- 30 The Henry J. Kaiser Family Foundation. (2012). *Texas: Medicare enrollment*. Retrieved from <http://kff.org/medicare/state-indicator/distribution-of-medicare-beneficiaries-by-eligibility-category-2/?state=TX>
- 31 Coughlin, T., Waidmann, T., & Watts, M. (2009, April). *The diversity of dual eligible beneficiaries: An examination of services and spending for people eligible for both Medicaid and Medicare*. Retrieved from the Henry J. Kaiser Family Foundation website: <http://www.kff.org/medicaid/upload/7895-2.pdf>
- 32 The Henry J. Kaiser Family Foundation. (2014). *Number of dual eligible beneficiaries*. Retrieved from <http://kff.org/medicare/state-indicator/dual-eligible-beneficiaries/>
- 33 Millwee, B. (2012). *Texas dual eligible integrated care demonstration project: Application*. Retrieved from Centers for Medicare and Medicaid website: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf>
- 34 Centers for Medicare & Medicaid. (2014). *Financial alignment initiative*. Retrieved from <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>
- 35 Ibid
- 36 Centers for Medicare & Medicaid. (2014). *Texas financial alignment demonstration*. Retrieved from <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Texas.html>
- 37 Ibid
- 38 Centers for Medicare & Medicaid. (n.d.). *Memorandum of Understanding (MOU) between The Centers for Medicare & Medicaid Services and the state of Texas regarding a federal-state partnership to test a capitated financial alignment model for Medicare-Medicaid enrollees*. Retrieved from <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXMOU.pdf>
- 39 Ibid.
- 40 The Henry J. Kaiser Family Foundation. (2014). *Total SSI beneficiaries*. Retrieved from <http://kff.org/medicaid/state-indicator/total-ssi-beneficiaries/>
- 41 The United States Social Security Administration. (2013). *Annual report of the Supplemental Security Income program*. Retrieved from <http://ssa.gov/oact/ssir/SSI13/ssi2013.pdf>
- 42 The Henry J. Kaiser Family Foundation. (2014). *Total disabled Social Security Disability Insurance (SSDI) beneficiaries, ages 18-64*. Retrieved from <http://kff.org/medicare/state-indicator/total-disabled-social-security-disability-insurance-ssdi-beneficiaries-ages-18-64/>
- 43 The United States Social Security Administration. (2012). *Annual statistical report on the Social Security Disability Insurance program, 2012*. Retrieved from http://www.ssa.gov/policy/docs/statcomps/di_asr/2012/sect01b.pdf
- 44 R. Perry. (2012, November 15). *Letter to Kathleen Sebelius, former secretary of U.S. Department of Health and Human Services*. Retrieved from: <http://governor.state.tx.us/files/press-office/O-SebeliusKathleen201211150621.pdf>
- 45 U.S. Department of Health and Human Services. (2014). *Health insurance marketplace: Summary enrollment report for the initial annual open enrollment period*. Retrieved from http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf
- 46 Centers for Medicare and Medicaid Services. (n.d.). *Important health insurance Marketplace dates*. Retrieved from <https://www.healthcare.gov/what-key-dates-do-i-need-to-know/#part=1>
- 47 Centers for Medicare and Medicaid Services. (n.d.). *Marketplace insurance categories*. Retrieved from <https://www.healthcare.gov/how-do-i-choose-marketplace-insurance/plans-categories/>
- 48 Texas House Research Organization. (2013). *Bill analysis: SB 1795*. Retrieved from <http://www.hro.house.state.tx.us/pdf/ba83r/sb1795.pdf>
- 49 Texas Well and Healthy. (n.d.). Retrieved from <http://texaswellandhealthy.org/tag/navigators/>
- 50 Center for Public Policy Priorities. (2014). *Final navigators rules much improved: TDI and navigators moving ahead with registration; timelines post a challenge*. Retrieved from: http://forabettertexas.org/images/HC_2014_02_TDINavigatorRules.pdf
- 51 Ibid.
- 52 Ibid.

- 53 Centers for Medicare and Medicaid Services. (n.d.). *Affordable care act: Eligibility*. Retrieved from <http://www.medicare.gov/AffordableCareAct/Provisions/Eligibility.html>
- 54 Centers for Medicare and Medicaid Services. (2014). *2014 poverty guidelines*. Retrieved from <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2014-Federal-Poverty-level-charts.pdf>
- 55 Centers for Medicare and Medicaid Services. (n.d.). *Medicaid expansion & what it means for you*. Retrieved from <https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicare/>
- 56 Goodwyn, W. (2013, May 23). Health official decry snubbing of Texas' snubbing of Medicaid billions. *National Public Radio*. Retrieved from <http://www.npr.org/2013/05/23/186303141/health-officials-decry-texas-snubbing-of-medicare-billions>
- 57 The Henry J. Kaiser Family Foundation. (2014). *Status of state action on the Medicaid expansion decision, 2014*. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>
- 58 Texas Well and Healthy. (2014). *Texas should accept federal health care funds to close the coverage gap*. Retrieved from <http://texaswellandhealthy.org/wp-content/uploads/2014/05/Printable-One-Pager-on-Health-Coverage-Gap.pdf>
- 59 Miller, J. E., Lentz, C., Maududi, N., & Harding, J. (2013). *The waterfall effect: Transformative impacts of Medicaid expansion on states*. Retrieved from National Association of State Mental Health Program Directors' website: <http://www.nasmhpd.org/docs/publications/NASMHPDMedicaidExpansionReportFinal.pdf>
- 60 Texas Well and Healthy. (2014). *Texas should accept federal health care funds to close the coverage gap*. Retrieved from <http://texaswellandhealthy.org/wp-content/uploads/2014/05/Printable-One-Pager-on-Health-Coverage-Gap.pdf>
- 61 Miller, J. (2014). *Dashed hopes; broken promises; more despair: How the lack of state participation in the Medicaid expansion will punish Americans with mental illness*. Retrieved from American Mental Health Counselors Association website: http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf
- 62 National Alliance on Mental Illness. (2011). *State mental health cuts: A national crisis*. Retrieved from http://www.nami.org/Content/NavigationMenu/State_Advocacy/State_Budget_Cuts_Report/NAMISateBudgetCrisis2011.pdf
- 63 The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), is collectively referred to in this paper as the Affordable Care Act of 2010 (ACA).
- 64 Silow-Carrol, S. & Rodin, D. (2010). Health homes for the chronically ill: An opportunity for states. *States in Action: Innovations in State Health Policy*. Retrieved from <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx>
- 65 Centers for Medicare and Medicaid Services. (2014). *State health home CMS proposal status (effective June 2014)*. Retrieved from http://www.medicare.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v34.pdf
- 66 Substance Abuse and Mental Health Services Administration. (2013). *Medicaid health home implementation in Missouri: A year later*. Retrieved from www.integration.samhsa.gov/about-us/CIHS_Presentation_Slides_062713.pdf
- 67 Ibid.
- 68 Texas Health and Human Services Commission. (2013). *Texas Medicaid patient-centered medical home report*. Retrieved from <http://www.hhsc.state.tx.us/reports/2013/SB7-Medicaid-Patient-Centered.pdf>
- 69 Texas Health and Human Services Commission. (2014). *Presentation to the Senate Health and Human Services Committee: SB 7 implementation* [PowerPoint slides]. Retrieved from <https://www.hhsc.state.tx.us/news/presentations/2014/SB-7-implementation.pdf>
- 70 Texas Health and Human Services Commission. (2014). *Presentation to House Committee on Human Services: Medicaid Managed Care initiatives* [PowerPoint slides]. Retrieved from www.hhsc.state.tx.us/news/presentations/2014/Managed-Care-Initiatives.pdf
- 71 Texas Health and Human Services Commission. (2014). *Presentation to the House Appropriations Article II Subcommittee: Behavioral healthcare projects in the 1115 Waiver* [PowerPoint slides]. Retrieved from <http://www.hhsc.state.tx.us/news/presentations/2014/House-Appropriations-Committee-DSRIP-BH.pdf>
- 72 Texas Health and Human Services Commission. (2014). *Presentation to the Senate Committee on Health and Human Services: Medicaid and the Affordable Care Act* [PowerPoint slides]. Retrieved from <https://www.hhsc.state.tx.us/news/presentations/2014/affordable-care-act.pdf>
- 73 Texas Health and Human Services Commission. (2014). *Presentation to the House Appropriations Article II Subcommittee: Behavioral healthcare projects in the 1115 Waiver* [PowerPoint slides]. Retrieved from <http://www.hhsc.state.tx.us/news/presentations/2014/House-Appropriations-Committee-DSRIP-BH.pdf>
- 74 Texas Health and Human Services Commission. (2014). *Presentation to the House Appropriations Subcommittee on Article II: Mental health coordination* [PowerPoint slides]. Retrieved from <http://www.hhsc.state.tx.us/news/presentations/2014/Mental-Health-Coordination.pdf>
- 75 Ibid.
- 76 Texas Legislature Online. (2013). *S.B. 1 General Appropriations Bill*. Retrieved from <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB1>
- 77 Texas Department of State Health Services. (2014, July 8). Personal communication: Home and Community-Based Services—Adult Mental Health Program (HCBS-AMH)

- 78 Texas Department of State Health Services. (2014, September 9). Personal communication: Home and Community-Based Services—Adult Mental Health Program (HCBS-AMH)
- 79 Texas Department of State Health Services. (n.d). *1915(i) Home and Community Based Services – Adult Mental Health (HCBS-AMH)*. Retrieved from www.dshs.state.tx.us/mhsa/hcbs-amh/
- 80 Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011) *Crisis point: Mental health workforce shortage in Texas*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf
- 81 Centers for Disease Control and Prevention. (2013). *Making a business case*. Retrieved from <http://www.cdc.gov/workplacehealthpromotion/businesscase/>
- 82 Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011) *Crisis point: Mental health workforce shortage in Texas*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf
- 83 Hoge, M. A., Stuart, G. W., Morris, J., Flaherty, M. T., Paris, M. J., & Goplerud, E. (2013). Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 32(11), 2005-2012
- 84 Texas Department of State Health Services. (2014). *The mental health workforce shortage in Texas*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589985787>
- 85 Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011). *Crisis point: Mental health workforce shortages in Texas*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf
- 86 Texas Department of State Health Services. (2014). *The mental health workforce shortage in Texas*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589985787>
- 87 Ibid.
- 88 Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011, March). *Crisis point: Mental health workforce shortages in Texas*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf
- 89 Ibid.
- 90 Texas Department of State Health Services. (2014). *The mental health workforce shortage in Texas*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589985787>
- 91 Ibid.
- 92 Ibid.
- 93 Aronson, B. (2012, May 8). Interactive: Mapping access to health care in Texas. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/library/data/texas-shortage-health-care-providers/>
- 94 Statewide Health Coordinating Council. (n.d.). *Texas state health plan 2011-2016*. Retrieved from www.dshs.state.tx.us/chs/shcc/reports/SHP2011-2016/
- 95 Texas Department of State Health Services. (2014). *Initial plan for the appropriate and timely provision of mental health services-HB 3793*.” Retrieved from <http://www.dshs.state.tx.us/mhsa/hb3793/>
- 96 Texas Department of Aging and Disability Services. (2012). *Physical and behavioral health services in the Home and Community-Based Services and Community Living Assistance and Support Services Medicaid waiver programs*. Retrieved from http://www.dads.state.tx.us/news_info/publications/studies/hcs-class-report.pdf
- 97 Buckles, J., Luckasson, R., Keef, E. (2013). A systematic review of the prevalence of psychiatric disorders in adults with Intellectual Disability, 2003-2010. *Journal of Mental Health Research in Intellectual Disabilities*, 6(3), 181-207
- 98 Smiley, E. (2005). Epidemiology of mental health problems in adults with learning disabilities: An update. *Advances in Psychiatric Treatment*, 18, 214-222.
- 99 Rosenberg, R., Kaufmann, W., Law, K., & Law, P. (2011). Parent report of community psychiatric comorbid diagnoses in autism spectrum disorders. *Autism Research and Treatment*, 2011, 1-10. Retrieved from <http://www.hindawi.com/journals/aurt/2011/405849/>
- 100 Harvey, K. (2012). Trauma-informed behavioral interventions: What works and what doesn't. *American Association on Intellectual and Developmental Disabilities*, 1-6.
- 101 Health Management Associates. (2008). *Report on Texas boarding houses: Presented to Texas Health and Human Services Commission*. Retrieved from <http://www.lrl.state.tx.us/legis/billsearch/docs.cfm?legSession=80-0&billtypeDetail=HB&billNumberDetail=1168&startRow=1&IDlist=&unClicklist=&number=100>
- 102 Ibid.
- 103 Ibid.
- 104 Mental Health America of Greater Dallas. (n.d.). *Boarding home regulation*. Retrieved from <http://boardinghome.org/>
- 105 Hogg Foundation for Mental Health. (2009). *Mental Health America of Texas receives grant to promote boarding home reforms in Texas*. Retrieved from http://www.hogg.utexas.edu/detail/85/policy_grant_mhat.html
- 106 Texas Health and Human Services Commission. (n.d.). *Texas boarding house model standards*. Retrieved from <http://www.hhsc.state.tx.us/BoardingHouseModelStandards.pdf>
- 107 Mental Health America of Greater Dallas. (n.d.). *Regulating boarding homes*. Retrieved from <http://boardinghome.org/regulating-boarding-homes/>
- 108 Texas Health and Human Services Commission. (2012). *Boarding homes facility report: Report to the*

- Texas Legislature*. Retrieved from http://www.dads.state.tx.us/news_info/publications/legislative/boardinghomefacilities-dec2012.pdf
- 109 Mental Health America of Greater Dallas. (2014, May 15). Personal communication: Boarding home regulation
- 110 Centers for Medicare and Medicaid Services. (2007, August). State Medicaid Director Letter #07-011. Retrieved from <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>
- 111 Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphinn-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illness: Assessing the evidence. *Psychiatric Services*, 65(4), 429-441. Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleID=1832833>
- 112 Ibid.
- 113 Ibid.
- 114 Landers, G., & Zhou, M. (2011). An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization. *Community Mental Health Journal* 47, 106-112. Retrieved from http://www.countyofsb.org/uploadedFiles/admhs_new/resources/Systems_Change/Peer_Action_Team/An%20Analysis%20of%20Relationships.pdf
- 115
- 116 Substance Abuse and Mental Health Services Division Administration. (2012). *With peer support, recovery is possible*. SAMHSA News, 20(3). Retrieved at http://www.samhsa.gov/samhsanewsletter/Volume_20_Number_3/peer_support.aspx
- 117 Lakey, D., & Lewis, L. L. (2014, August 14). Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services [PowerPoint slides]. Retrieved from the Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 118 Ibid.
- 119 Deprang, E. (2012, January 30). Judge rules mentally ill prisoners must not wait. *Texas Observer*. Retrieved from <http://www.texasobserver.org/datetimehouston/judge-rules-mentally-ill-prisoners-must-not-wait>
- 120 Ibid.
- 121 Maples, M. (2012, July 12). *Presentation to the House Appropriations Subcommittee on Article II* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/legislative/default.shtm>
- 122 Disability Rights Texas. (2014, September 4). Personal communication: Forensic Restoration of Competency Lawsuit.
- 123 New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (DHHS Publication No. SMA 03-3832). Retrieved from <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html>
- 124 83rd Texas Legislature, Conference Committee. (2013). *General appropriations act*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2014-15.pdf
- 125 Texas Health and Human Services Commission. (2013) *Medicaid enrollment by county October 2013*. Retrieved from <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp>
- 126 Texas Health and Human Services Commission. (2012). *Health and Human Services System consolidated budget for fiscal years 2014-2015*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/finance/2014-2015.pdf
- 127 Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf
- 128 Texas Department of State Health Services. (2013). *Texas Primary Care Office (TPCO) – Federally qualified health centers*. Retrieved from <http://www.dshs.state.tx.us/chpr/fqhcmmain.shtm>
- 129 The Henry J. Kaiser Family Foundation. (2013). *Texas: Patients served by federally-funded federally qualified health centers*, 2011. Retrieved from <http://www.statehealthfacts.org/profileind.jsp?ind=426&cat=8&rgn=45>
- 130 Texas Health and Human Services System. (2013). *Health and Human Services System: Strategic plan 2015-2019*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/strategic-plan/2015-2019/strategic-plan-2015-19-vol-1.pdf
- 131 Texas Health and Human Services Commission. (2013). *Internal audit plan fiscal year 2014*. Retrieved from <http://www.hhsc.state.tx.us/reports/2013/FY14-Internal-Audit-Plan.pdf>
- 132 83rd Texas Legislature, Conference Committee. (2013). *General appropriations act*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2014-15.pdf
- 133 Texas Health and Human Services Commission. (2014). 2A. *Summary of base request by strategy, 84th Regular Session, agency submission, version 1, Automated Budget and Evaluation System of Texas (ABEST)* [Data file]. Retrieved from <http://www.hhsc.state.tx.us/LAR/2016-2017/2A-base-request-by-strategy.pdf>
- 134 83rd Texas Legislature, Conference Committee. (2013). *General appropriations act*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2014-15.pdf
- 135 Texas Health and Human Services Commission. (2014, April). *Expansion of Medicaid Managed Care information session* [PowerPoint slides]. Retrieved from <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/consumer-presentation.pdf>
- 136 Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf
- 137 Crosta, P. (n.d.) What is Medicare/Medicaid? *Medical News Today*. Retrieved from <http://www>.

- medicalnewstoday.com/info/medicare-medicaid/
- 138 Texas Health and Human Services Commission. (2013). *Medicaid enrollment by county October 2013*. Retrieved from <http://www.hhsc.state.tx.us/research/MedicaidEnrollment/me-results.asp>
- 139 Texas Health and Human Services Commission. (2012, October 15). *Health and Human Services System consolidated budget for fiscal years 2014-2015*. Retrieved from http://www.hhsc.state.tx.us/about_hhsc/finance/2014-2015.pdf
- 140 Texas Health and Human Services Commission. (2013). *Sunset self-evaluation report, September 2013*. Retrieved from <http://www.hhsc.state.tx.us/sunset/Evaluation-Report.shtml>
- 141 Texas Health and Human Services Commission. (n.d.). *Chapter 9: Children's Health Insurance Program*. Retrieved from http://www.hhsc.state.tx.us/medicaid/about/PB/10_PB_9th_ed_Chapter9.pdf
- 142 Peters, C. (2008). *Medicaid financing: How the FMAP formula works and why it falls short*. The George Washington University: Washington D.C. Retrieved from National Health Policy Forum website: http://nhpf.org/library/issue-briefs/IB828_FMAP_12-11-08.pdf
- 143 Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from http://www.txohc.org/PDFsPPs/Texas%20Medicaid_CHIP%20Pinkbook.2013.pdf
- 144 Texas Department of State Health Services. (2013). *Texas Primary Care Office (TPCO) – Federally qualified health centers*. Retrieved from <http://www.dshs.state.tx.us/chpr/fqhcmmain.shtml>
- 145 The Henry J. Kaiser Family Foundation. (2013). *Texas: Patients served by federally-funded federally qualified health centers*, 2011. Retrieved from <http://www.statehealthfacts.org/profileind.jsp?ind=426&cat=8&rgn=45>
- 146 Texas Health and Human Services Commission. (2014). *HHSC cancels Xerox Medicaid Contract*. Retrieved from <http://www.hhsc.state.tx.us/news/release/2014/050914-Xerox-Medicaid.shtml>
- 147 Texas Health and Human Services Commission. (2014). *Texas CHIP enrollment statistics*. Retrieved from <http://www.hhsc.state.tx.us/research/index.shtml>
- 148 Texas Health and Human Services Commission. (n.d.). *Chapter 9: Children's Health Insurance Program*. Retrieved from http://www.hhsc.state.tx.us/medicaid/about/PB/10_PB_9th_ed_Chapter9.pdf
- 149
- 150 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 151 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 152 Texas Department of State Health Services. (2013). *DSHS Sunset Self-Evaluation report, September 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 153 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 154 Texas Department of State Health Services. (2014, June 16). *Presentation to House Appropriations Subcommittee on Article II: Overview of new mental health funds in Texas* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589988644>
- 155 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 156 Sunset Advisory Commission. (2014). *Staff report with decision material: Department of State Health Services*. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Decision%20Material_0.pdf
- 157 The Henry J. Kaiser Family Foundation. (2010). *State Mental Health Agency (SMHA) per capita mental health services expenditures*. Retrieved from <http://kff.org/other/state-indicator/smha-expenditures-per-capita/>
- 158 Ligon, K. (2013). *Sizing up the 2014-15 Texas budget: Mental health*. Retrieved from Center for Public Policy Priorities website: http://forabettertexas.org/images/2013_10_PP_Budget_MentalHealth.pdf
- 159 Texas Department of State Health Services. (2013). *FY 2014–2015 SAMHSA Community Mental Health & Substance Abuse Block Grant Application*. Retrieved <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979882>
- 160 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 161 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 162 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human*

- Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 163 Texas Department of State Health Services. (2014, April 29). Personal communication: LMHA waitlists
- 164 Lakey, D. L. (2012). *Legislative Budget Board-Governor's Office of Budget, Policy and Planning Joint Hearing*. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=70651>
- 165 Texas Department of State Health Services. (2014) *Waiting list summaries*. Retrieved from <http://www.dshs.state.tx.us/mhsa/waitlist/>
- 166 Medicaid.gov. (n.d.). *Texas Medicaid moving forward in 2014*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/texas.html>
- 167 Centers for Medicare & Medicaid Services. (2014). State Medicaid and CHIP income eligibility standards (For MAGI Groups, based on state decisions as of July 1, 2014). Retrieved from <http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>
- 168 Texas Health and Human Services Commission. (n.d). *Final count – Medicaid enrollment by month*. Retrieved from www.hhsc.state.tx.us/research/MedicaidEnrollment/ME-Monthly.asp
- 169 The Henry J. Kaiser Family Foundation. (2014). *Status of state action on the Medicaid expansion decision, 2014*. Retrieved from <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- 170 Texas Council of Community Centers. (2013). *Framework for the future*. Retrieved from <http://www.txcouncil.com/userfiles/file/HOW/Framework%20for%20the%20Future%20Final%209%205%202013.pdf>
- 171 Texas Health and Safety Code, tit. 7, subtit. B § 552.012. (1991). Retrieved from <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.552.htm#552.012>
- 172 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 173 Texas Administrative Code, tit. 25, part 1 § 412.106. .
- 174 Texas Administrative Code, tit. 25, part 1 § 444.413.
- 175 Texas Department of State Health Services (2014). *County Indigent Health Care Program – eligibility criteria*. Retrieved from www.dshs.state.tx.us/cihcp/eligibility.shtm
- 176 Texas Department of State Health Services. (2014). *House Bill 3793 – 83(R)*. Retrieved from www.dshs.state.tx.us/mhsa/hb3793
- 177 Texas Health and Safety Code, tit. 7, subtit. A § 533.0354 (2014). Retrieved from <http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.533.htm#533.0354>
- 178 Texas Legislature Online. (2013). *H.B. No. 3793*. Retrieved from <http://www.capitol.state.tx.us/tlodocs/83R/billtext/html/HB03793F.htm>
- 179 Texas Legislature Online. (2013). *S.B. No. 7*. Retrieved from <http://www.capitol.state.tx.us/tlodocs/83R/billtext/html/SB00007F.htm>
- 180 Medicaid.gov. (n.d.). *Managed care*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Managed-Care/Managed-Care.html>
- 181 Thyssen, M. (n.d.). *SB 58 Behavioral Health Integration*. Retrieved from Texas Health and Human Services Commission website: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/bhiac-docs/behavioral-health-carve-in.pdf
- 182 Texas Council of Community Centers. (2013, September). *Framework for the future*. Retrieved from <http://www.txcouncil.com/userfiles/file/HOW/Framework%20for%20the%20Future%20Final%209%205%202013.pdf>
- 183 Ibid.
- 184 Texas Department of State Health Services. (2014). *Local Mental Health Authorities (LMHAs)*. Retrieved from <http://www.dshs.state.tx.us/mhsa/lmha-list/>
- 185 Texas Department of State Health Services. (2013). FY 2014–2015 SAMHSA Community Mental Health & Substance Abuse Block Grant Application. Retrieved <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979882>
- 186 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 187 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation report, September 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 188 Texas Department of State Health Services. (2014). *Medicaid Services Unit: NorthSTAR*. Retrieved from <http://www.dshs.state.tx.us/mhsa/northstar/northstar.shtm>
- 189 North Texas Behavioral Health Authority. (2013). *Local service area plan: SFY 2014 & 2015*. Retrieved from http://www.ntbha.org/docs/NTBHA_LSAP_SFY14-15_FINAL.pdf
- 190 Ibid.
- 191 Texas Department of State Health Services. (2013). *Texas Resilience and Recovery (formerly RDM): The mental health system redesigned*. Retrieved from <http://www.dshs.state.tx.us/mhsa/trr/>

- 192 Ibid.
- 193 Ibid.
- 194 Texas Administrative Code, tit. 25, Part 1, ch. 416, subch. A §416.3. (2014). Retrieved from [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3)
- 195 Public Policy Research Institute & Texas A&M University. (2010). *Evaluation findings for the Crisis Services Redesign Initiative*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589953731>
- 196 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 197 Texas Department of State Health Services. (2013). *Needs and capacity assessment: Psychiatric emergency service projects*. Retrieved from: <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589977842>
- 198 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation, September 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 199 North Texas Behavioral Health Authority. (2013). *Local service area plan SFY 2014 & 2015*. Retrieved from http://www.ntbha.org/docs/NTBHA_LSAP_SFY14-15_FINAL.pdf
- 200 Texas Legislative Budget Board. (2011). *Managing and funding state mental hospitals in Texas: Legislative primer*. Retrieved from http://www.lbb.state.tx.us/Health_Services/Mental%20Hospitals%20in%20Texas%20Primer%20Complete%20Report%200211.pdf
- 201 Texas Department of State Health Services. (2012). *Department of State Health Services efforts towards more timely treatment of patients determined incompetent to stand trial* [PowerPoint slides]. Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.tha.org%2FHealthCareProviders%2FEducation%2FCOBCBehavioralHealth08E03%2FNaranjo.asp&ei=HRb-U4zkLIHd8AH-84CgBw&usg=AFQjCNFgoK0YVzXifyP4vyvjoVyGTDtZSw&sig2=vqBLbuxuDmaPJURYWo_Gtg
- 202 Texas Department of State Health Services (2014, August 22) Personal communication: State Hospitals
- 203 Texas Department of State Health Services. (2012). *Department of State Health Services efforts towards more timely treatment of patients determined incompetent to stand trial* [PowerPoint slides]. Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.tha.org%2FHealthCareProviders%2FEducation%2FCOBCBehavioralHealth08E03%2FNaranjo.asp&ei=HRb-U4zkLIHd8AH-84CgBw&usg=AFQjCNFgoK0YVzXifyP4vyvjoVyGTDtZSw&sig2=vqBLbuxuDmaPJURYWo_Gtg
- 204 Texas Department of State Health Services (2014, August 22) Personal communication: State Hospitals
- 205 Texas Department of State Health Services (2014, August 18). Data request: State mental health hospitals
- 206 Sunset Advisory Commission. (2014). *Department of State Health Services: Staff report with decision material*. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Decision%20Material_0.pdf
- 207 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation, September 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 208 Texas Department of State Health Services (2014, August 22) Personal communication: State Hospitals
- 209 Texas Department of State Health Services (2012) *Fiscal year 2014-2015: Legislative Appropriations Request*. Retrieved from <http://dshs.state.tx.us/budget/lar/fy14-15/LARFY14-15.pdf>
- 210 Texas Legislature Online. (2013). *SB 152*. Retrieved from <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB152>
- 211 Texas Legislative Budget Board. (2011, February). *Managing and funding state mental hospitals in Texas: Legislative primer*. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/Primer/Managing%20and%20Funding%20State%20Mental%20Hospitals%20in%20Texas%20-%20Legislative%20Primer.pdf>
- 212 Texas Department of State Health Services. (2014). *State mental health facilities quarterly performance indicators: SMHF indicators-1st quarter 2014*. Retrieved from http://www.dshs.state.tx.us/mhreports/PIMHpub_2.shtm
- 213 Sunset Advisory Commission. (2014). *Department of State Health Services: Staff report*. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Staff%20Report_1.pdf
- 214 Texas Department of State Health Services. (May 25, 2011). *Behavioral health news brief*. Retrieved from <http://www.dshs.state.tx.us/sa/bhnb>
- 215 Texas Code of Criminal Procedure article 46B.003. Incompetency; Presumptions
- 216 Legislative Budget Board. (2013). *Texas state government effectiveness and efficiency report: Selected issues and recommendations*. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>
- 217 Hogg Foundation for Mental Health (2013). *Restoration for competency to stand trial*. Retrieved from <http://www.hogg.utexas.edu/uploads/documents/Competency%20Restoration%20Brief.pdf>
- 218 Legislative Budget Board. (2013). *Texas state government effectiveness and efficiency report: Selected issues*

- and recommendations. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>
- 219 Sunset Advisory Commission (2014). Department of State Health Services: Staff report. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Staff%20Report_1.pdf.
- 220 Promoting Independence Advisory Committee. (2012, June). *Interim 2012 Promoting Independence Advisory Committee Stakeholder Report*. Retrieved from http://www.dads.state.tx.us/providers/pi/piac_reports/piac-2012-interimstakeholder.pdf.
- 221 Legislative Budget Board. (2013). *Texas state government effectiveness and efficiency report: Selected issues and recommendations*. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>
- 222 Hogg Foundation for Mental Health. (2014). *Texas outpatient competency restoration programs, evaluation report*
- 223 Texas Department of State Health Services. (2014, July 14). Personal communication: Outpatient competency restoration
- 224 Hogg Foundation for Mental Health. (2014). *Texas outpatient competency restoration programs, evaluation report*
- 225 Texas Department of State Health Services. (2013). *Jail-Based Competency Restoration Workgroup*. Retrieved from <http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=35959&id=8589979768&terms=jail-based+restoration+of+competency>
- 226 Rice, K., Hazelwood, L. (2013). *Jail-based competency restoration: Findings from Liberty Healthcare's 2-year Restoration of Competency (ROC) Pilot Program* [PowerPoint slides]. Retrieved from Forensic Mental Health Association of California website: <http://www.fmhac.net/Assets/Documents/2013/Handouts/Rice.pdf>
- 227 Legislative Budget Board. (2013). *Texas state government effectiveness and efficiency report: Selected issues and recommendations*. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>
- 228 Heard, C. (July 14, 2014). DSHS Program Specialist. Personal communication.
- 229 Taylor, M. (Jan. 3, 2012). An Alternative Approach: Treating the Incompetent to Stand Trial. California Legislative Analyst's Office. Retrieved from <http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.pdf>.
- 230 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation report, 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 231 Sunset Advisory Commission (2014). Department of State Health Services: Staff report. Retrieved from https://www.sunset.texas.gov/public/uploads/files/reports/DSHS%20Staff%20Report_1.pdf
- 232 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation report, 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 233 Texas Department of State Health Services. (2012). *Department of State Health Services efforts towards more timely treatment of patients determined incompetent to stand trial* [PowerPoint slides]. Retrieved from http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.tha.org%2FHealthCareProviders%2FEducation%2FC0BCBehavioralHealth08E03%2FNaranjo.asp&ei=HRb-U4zkLIHd8AH-84CgBw&usq=AFQjCNFgoK0YVzXIfyP4vyvjoVygTDTZSw&sig2=vqBLbuxuDMaPJURYWo_Gtg.
- 234 Deprang, E. (2012, January 30). Judge rules mentally ill prisoners must not wait. *Texas Observer*. Retrieved from <http://www.texasobserver.org/judge-rules-mentally-ill-prisoners-must-not-wait/>
- 235 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation report, 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 236 Texas Council of Community Centers. (2013). *83rd Texas Legislative Session Texas Council of Community Centers legislative priorities*. Retrieved from https://www.integralcare.org/sites/default/files/files/UPDATED_Priorities_for_the_83rd_Texas_Legislative_1.pdf
- 237 Texas Department of State Health Services. (2013). *DSHS Sunset self-evaluation report, 2013: Mental health and substance abuse services*. Retrieved from <http://www.dshs.state.tx.us/sunset.aspx>
- 238 Substance Abuse and Mental Health Services Administration. (2013). *Treatment Episode Data Set (TEDS) 2001-2011: State admissions to substance abuse treatment services*. Retrieved from http://samhsa.gov/data/DASIS/TEDS2011St_Web.pdf
- 239 Texas Department of State Health Services. (2014, August 14). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589990636>
- 240 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 241 Texas Department of State Health Services. (2013). *Texas FY2014–2015 Combined Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Behavioral Health Assessment and Intended Use Plan*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589979883>
- 242 Texas Department of State Health Services (2013). *Substance abuse additional general provisions*. Retrieved from <https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589967362>

- 243 Texas Department of State Health Services. (2013). *Texas FY2014–2015 Combined Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Behavioral Health Assessment and Intended Use Plan*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589979883>
- 244 Substance Abuse and Mental Health Services Administration. (2013). *Treatment Episode Data Set (TEDS) 2001-2011: State admissions to substance abuse treatment services*. Retrieved from http://samhsa.gov/data/DASIS/TEDS2011St_Web.pdf
- 245 National Institute on Drug Abuse. (2007). *Topics in brief: Comorbid drug abuse and mental illness*. Retrieved from <http://www.drugabuse.gov/publications/topics-in-brief/comorbid-drug-abuse-mental-illness>
- 246 Public Consulting Group. (n.d.). *State of Texas Health and Human Services Commission Department of State Health Services: Analysis of the Texas public behavioral health system*. Retrieved from <http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf>
- 247 Texas Department of State Health Services. (2013). *Behavioral Health Data Book: A quarterly reference to community mental health and substance abuse services* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589982109
- 248 Texas Department of State Health Services (2008). *Texas Recovery Initiative: Substance abuse service redesign*. Retrieved from http://www.dshs.state.tx.us/sa/texasrecoveryinitiative/PDFs/TRI_DraftReview_November2008.pdf
- 249 Texas Department of State Health Services. (2013). *Texas FY2014–2015 Combined Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) Behavioral Health Assessment and Intended Use Plan*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589979883>
- 250 Senate Health and Human Services Committee. (2014). *Interim Charges for DFPS*. Retrieved from www.dfps.state.tx.us
- 251 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 252 Ibid.
- 253 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 254 Senate Health and Human Services Committee. (2014). *Interim charges for DFPS*. Retrieved from www.dfps.state.tx.us
- 255 Ibid.
- 256 Judge David L. Bazelon Center for Mental Health Law. (2003, April 21). *Parents give up custody of children for mental health services, says new government report*. Retrieved from <http://www.bazelon.org/LinkClick.aspx?fileticket=f16PipPGmEg%3D&tabid=328>
- 257 Texas Department of Family and Protective Services. (n.d.) *Learn about DFPS*. Retrieved from http://www.dfps.state.tx.us/About_DFPS/default.asp
- 258 Texas Department of Family and Protective Services. (2014). *Legislative Appropriations Request for fiscal years 2016 – 2017*. Retrieved from https://www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/16-17/16-17_LAR_Vol1.pdf
- 259 Texas Department of Family and Protective Services. (n.d.). *Foster Care Redesign*. Retrieved from http://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/redesign.asp
- 260 Texas Alliance of Child and Family Services. (2011). *Foster Care Redesign*. Retrieved from http://www.tacfs.org/Resources/Documents/2011-2_Foster%20Care%20Redesign.pdf
- 261 Ibid.
- 262 Texas Department of Family and Protective Services. (n.d.). *Foster Care Redesign*. Retrieved from http://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/redesign.asp
- 263 Ibid.
- 264 Ibid.
- 265 Ibid.
- 266 Judge David L. Bazelon Center for Mental Health Law. (2003). *Parents give up custody of children for mental health services, says new government report*. Retrieved from <http://www.bazelon.org/LinkClick.aspx?fileticket=f16PipPGmEg%3D&tabid=328>
- 267 U.S. General Accounting Office. (2003). *Child welfare and juvenile justice: Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services* (GAO-03-397). Washington, D.C.: U.S General Accounting Office. Retrieved from <http://www.gao.gov/new.items/d03397.pdf>
- 268 Judge David L. Bazelon Center for Mental Health Law. (2002). *Avoiding cruel choices: A guide for policymakers and family organizations on Medicaid's role in preventing custody relinquishment*. Retrieved from <http://www.bazelon.org/News-Publications/Publications/List/1/CategoryID/15/Level/a/ProductID/31.aspx?SortField=ProductNumber,ProductNumber>
- 269 Ibid.
- 270 Texas Department of Family and Protective Services. (2013). *Self-evaluation report: Submitted to the Sunset Commission*. Retrieved from http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/2013_SER/2013_SER_Full_Report.pdf
- 271 Collier, K. (2014, February 10). Dumas native thrives after falling through foster care cracks. *Amarillo Globe-*

- News. Retrieved from <http://amarillo.com/news/local-news/2014-02-10/dumas-native-thrives-after-falling-through-foster-care-cracks>
- 272 Substance Abuse & Mental Health Services Administration. (2012). *Part one: Defining trauma*. Retrieved from <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>
- 273 Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ..., Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am.J. Preventive Med* 14(4), 245-258.
- 274 Department of Family and Protective Services. (n.d.). *Trauma Informed Care Training*. Retrieved from http://www.dfps.state.tx.us/training/trauma_informed_care/
- 275 Child Welfare Information Gateway. (n.d.). *Mental Health*. Retrieved from <https://www.childwelfare.gov/systemwide/mentalhealth/>
- 276 Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, (43)8, 960-970.
- 277 McMillen, J.C., Zima, B. T., Scott, L.D., Auslander, W. F., Munson, M. R., Ollie, M. T., & Spitznagel, E. L. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(1), 88-95.
- 278 Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7(3), 283-296.
- 279 Texas Department of Family and Protective Services. (2014). *Annual report & data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 280 Ibid.
- 281 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 282 Texas Health and Human Services Commission. (2013). *Texas Medicaid and CHIP in perspective, ninth edition*. Retrieved from <http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf>
- 283 Superior Health Plan. (2014) *Welcome to STAR Health*. Retrieved from <http://www.fostercaretx.com/welcome-to-star-health/>
- 284 Ibid.
- 285 Texas Youth Connection. (n.d.). *Healthcare for former Texas foster youth*. Retrieved from <https://www.dfps.state.tx.us/txyouth/health/default.asp>
- 286 Ibid.
- 287 Golonka, S. (2010). *The transition to adulthood: How states can support older youth in foster care*. Retrieved from National Governors Association website: <http://www.nga.org/files/live/sites/NGA/files/pdf/1012FOSTERCARE.PDF>
- 288 Ibid.
- 289 Texas Foster Youth Justice Project. (2014). *Former Foster Care Children's (FFCC) Program – Insurance for ages 18-25*. Retrieved from <http://texasfosteryouth.org>
- 290 Texas Department of Family and Protective Services. (n.d.). *While your child is in our care: A handbook for parents*. Retrieved from http://www.dfps.state.tx.us/Child_Protection/About_Child_Protective_Services/while_your_child.asp
- 291 Texas Department of Family and Protective Services. (n.d.). *5400 Residential Child Care Licensing (RCCL)*. Retrieved from http://www.dfps.state.tx.us/handbooks/SWL_Procedures/Files/SWP_pg_5400.asp#SWP_5410
- 292 Texas Department of Family and Protective Services. (n.d.). *Search for residential (24 hour) operation*. Retrieved from https://www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp
- 293 Texas Department of Family and Protective Services. (2014, July 9). Personal Communication: General residential operations
- 294 Ibid.
- 295 FRIENDS National Resource Center for Community-Based Child Abuse Prevention. (2013). *Alternative response systems: Learning tool 13*. Retrieved from <http://friendsnrc.org/joomdocs/ars.pdf>
- 296 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 297 Child Welfare Information Gateway. (2008). *Differential response to reports of child abuse and neglect*. Retrieved from https://www.childwelfare.gov/pubs/issue_briefs/differential_response/
- 298 Ibid.
- 299 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 300 Texas System of Care. (n.d.). *A better future for Texas children: The impact of system of care*. Retrieved from http://www.txsystemofcare.org/wp-content/uploads/2013/02/TXSOC_outcomes.pdf
- 301 Ibid.
- 302 Texas 83rd Legislature. (2013). *SB 421*. Retrieved from <http://www.capitol.state.tx.us/BillLookup/History>.

- aspx?LegSess=83R&Bill=SB421
- 303 Texas System of Care. (2012). *Strategic plan to expand systems of care for children and youth with serious mental health challenges and their families*. Retrieved from <http://www.txsystemofcare.org/wp-content/uploads/2012/11/Tx-SOC-Strategic-Plan-Overview.pdf>
- 304 Texas System of Care. (2014, June 4). Personal communication: Framework of Texas System of Care.
- 305 Specia, J. (2014, February 20). *Senate Health and Human Services Committee: Interim charge presentation* [PowerPoint slides]. Retrieved from Texas Department of Family and Protective Services website: www.dfps.state.tx.us
- 306 Ibid.
- 307 Child Welfare Information Gateway. (2010). *Caseload and workload management*. Retrieved from https://www.childwelfare.gov/pubs/case_work_management/case_work_management.pdf
- 308 Social Work Policy Institute. (2010). *High caseloads: How do they impact delivery of health and human services?* Retrieved from <http://www.socialworkpolicy.org/wp-content/uploads/2010/02/r2p-cw-caseload-swpi-1-10.pdf>
- 309 Keel, J. (2013). *An audit report on caseload and staffing analysis for Child Protective Services at the Department of Family and Protective Services* (SAO Report No. 13-036). Retrieved from State Auditor's Office website: <http://www.sao.state.tx.us/reports/main/13-036.pdf>
- 310 Texans Care for Children. (2014). *3 follow-up points to Senate Hearing on CPS and Child Fatalities*. Retrieved from <http://txchildren.org/state-of-the-children/3-follow-up-points-to-senate-hearing-on-cps-and-child-fatalities>
- 311 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved from https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf
- 312 Keel, J. (2013). *An audit report on caseload and staffing analysis for Child Protective Services at the Department of Family and Protective Services* (SAO Report No. 13-036). Retrieved from State Auditor's Office website: <http://www.sao.state.tx.us/reports/main/13-036.pdf>
- 313 Ibid.
- 314 Ibid.
- 315 Texas Department of Family and Protective Services. (2014, April 4). *New foster care safety rules approved*. [Press Release]. Retrieved from http://www.dfps.state.tx.us/About_DFPS/News/2014/2014-04-04_foster_care_rules.asp
- 316 Ibid.
- 317 Ibid.
- 318 Ibid.
- 319 Texas Department of Family and Protective Services. (n.d.). *Disproportionality in Child Protective Services System*. Retrieved from [https://www.dfps.state.tx.us/Child_Protection/Disproportionality/Papers_from_a_Research_Symposium_Convened_by_the_Center_for_the_Study_of_Social_Policy_and_The_Annie_E_Casey_Foundation_on_behalf_of_The_Alliance_for_Racial_Equity_in_Child_Welfare_\(2011\).Disparities_and_disproportionality_in_child_welfare:_Analysis_of_the_research](https://www.dfps.state.tx.us/Child_Protection/Disproportionality/Papers_from_a_Research_Symposium_Convened_by_the_Center_for_the_Study_of_Social_Policy_and_The_Annie_E_Casey_Foundation_on_behalf_of_The_Alliance_for_Racial_Equity_in_Child_Welfare_(2011).Disparities_and_disproportionality_in_child_welfare:_Analysis_of_the_research)
- 320 Child Welfare Information Gateway. (2013). *Supporting your LGBTQ youth: A guide for foster parents*. Retrieved from <https://www.childwelfare.gov/pubs/LGBTQyouth.pdf>
- 322 National Resource Center for Youth Development. (2013). *LGBTQ youth in care: Information & resources*. Retrieved from <http://www.nrcyd.ou.edu/lgbtq-youth>
- 323 Child Welfare Information Gateway. (2013). *Supporting your LGBTQ youth: A guide for foster parents*. Retrieved from <https://www.childwelfare.gov/pubs/LGBTQyouth.pdf>
- 324 Lambda Legal Defense and Education Fund, *Youth in the Margins: A Report on the Unmet Needs of Lesbian, Gay, Bisexual, and Transgender Adolescents in Foster Care*, 11, (2001) [hereinafter *Youth in the Margins*] (citing Philadelphia Lesbian and Gay Task Force, *Discrimination and Violence Against Lesbian Women and Gay Men in Philadelphia and the Commonwealth of Pennsylvania* (1996)).
- 325 Feinstein, R., Greenblatt, A., Hass, L., Kohn, S., and Rana, J. (2001). *Justice for all?: A report on the unmet needs of lesbian, gay, bisexual, and transgender youth in the New York Juvenile Justice System*. Retrieved from the National Juvenile Justice Network website: http://njjn.org/uploads/digital-library/resource_239.pdf
- 326 Dworsky, A. (2013). *The economic well-being of lesbian, gay, and bisexual youth transitioning out of foster care* (Document No. PP13-04). Retrieved from Mathematica Policy Research website: http://www.acf.hhs.gov/sites/default/files/opre/opre_lgbt_brief_01_04_2013.pdf
- 327 Ibid.
- 328 Aaronson, B. (2013, May 15). Senate backs bill on psychotropic drugs for foster kids. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/2013/05/15/house-oks-foster-advocates-informed-consent-bill/>
- 329 U.S. Government Accountability Office. (2011) *Foster children: HHS guidance could help states improve oversight of psychotropic prescriptions*. Retrieved from <http://www.gao.gov/products/GAO-12-270T>
- 330 National Institute of Mental Health. (2012). *Mental health medications*. Retrieved from <http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf>
- 331 Supreme Court Children's Commission, Psychotropic Medication Round Table. (2012). *Psychotropic medication and Texas foster care youth*. Retrieved from http://texaschildrenscommission.gov/media/15003/Final%20Psych%20Meds%20Report%20PRINT_01-10-13.pdf
- 332 DosReis, S., Yoon, Y., Rubin, D. M., Riddle, M. A., Noll, E., & Rothbard, A. (2011). Antipsychotic treatment

- among youth in foster care. *Pediatrics*, 128, 1459–e1466;
- 333 Fedorowicz, V.J., & Fombonne, E. (2005). Metabolic side effects of atypical antipsychotics in children: A
literature review. *Journal of Psychopharmacology* 19(5), 533–550.
- 334 Substance Abuse and Mental Health Services Administration. (2014). *National Center for Trauma-Informed
Care and Alternative to Seclusion and Restraint (NCTIC)*. Retrieved from <http://beta.samhsa.gov/nctic>
- 335 Texas Department of Family and Protective Services. (n.d.). *Trauma Informed Care Training*. Retrieved from
http://www.dfps.state.tx.us/training/trauma_informed_care/
- 336 Texas CASA. (2014, March 27). Personal communication: Psychotropic medications
- 337 Texas Department of Family and Protective Services. (n.d.). *Medical consent training for caregivers*. Retrieved
from http://www.dfps.state.tx.us/child_protection/medical_services/medical-consent-training.asp
- 338 Kelly, J. (2014, March 5). Obama budget calls for \$750 million to fight over-drugging of foster youths. *Chronicle
of Social Change*. Retrieved from [https://chronicleofsocialchange.org/news/obama-budget-calls-for-750-](https://chronicleofsocialchange.org/news/obama-budget-calls-for-750-million-to-fight-over-drugging-of-foster-youths/5557)
[million-to-fight-over-drugging-of-foster-youths/5557](https://chronicleofsocialchange.org/news/obama-budget-calls-for-750-million-to-fight-over-drugging-of-foster-youths/5557)
- 339 Conradi, L.; Agosti, J.; Tullberg, E.; Richardson, L.; Langan, H.; Ko, S.; & Wilson, C. (2011). Promising practices
and strategies for using trauma-informed child welfare practice to improve foster care placement stability: A
breakthrough series collaborative. *Child Welfare*, 90(6), 207–225.
- 340 Positive Behavioral Interventions & Supports (PBIS). (2009). *Considerations for seclusion and restraint use in
School-wide Positive Behavior Supports*. Retrieved from <http://www.pbis.org/seclusion-restraint>
- 341 Texas Network of Youth Services. (2014). *Creating a culture of care*. Retrieved from [http://tnoys.org/](http://tnoys.org/professional-program-development/creating-a-culture-of-care/)
[professional-program-development/creating-a-culture-of-care/](http://tnoys.org/professional-program-development/creating-a-culture-of-care/)
- 342 California Mental Health Services Oversight & Accountability Commission. (2014). *Prevention & Early
Intervention (PEI)*. Retrieved from [http://www.mhsoac.ca.gov/Counties/PEI/Prevention-and-Early-](http://www.mhsoac.ca.gov/Counties/PEI/Prevention-and-Early-Intervention.aspx)
[Intervention.aspx](http://www.mhsoac.ca.gov/Counties/PEI/Prevention-and-Early-Intervention.aspx)
- 343 Texas Department of Family and Protective Services. (2014). Annual report and *data book 2013*. Retrieved
from [https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
[AnnualRpt_Databook.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
- 344 Ibid.
- 345 Ibid.
- 346 Texas Department of Family and Protective Services. (2013). *New prevention and early intervention initiatives*.
Retrieved from [http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf)
[PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf)
- 347 Texas Department of Family and Protective Services. (2014). Annual report and *data book 2013*. Retrieved
from [https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
[AnnualRpt_Databook.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
- 348 Ibid.
- 349 Ibid.
- 350 Ibid.
- 351 Texas Department of Family and Protective Services. (2013). *New prevention and early intervention initiatives*.
Retrieved from [http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf)
[PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPE%20community%20meeting%20Webb%20County.pdf)
- 352 Ibid.
- 353 Ibid.
- 354 Texas Department of Family and Protective Services. (2014, July 9). Personal communication: Adult
Protective Services
- 355 Texas State Data Center. (n.d.). *Texas Populations Projection Program*. Retrieved from [http://txsdc.utsa.edu/](http://txsdc.utsa.edu/Data/TPEPP/Projections/Index.aspx)
[Data/TPEPP/Projections/Index.aspx](http://txsdc.utsa.edu/Data/TPEPP/Projections/Index.aspx)
- 356 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved
from [https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
[AnnualRpt_Databook.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
- 357 Ibid.
- 358 Texas Department of Family and Protective Services. (2014, July 9). Personal communication: Adult
Protective Services
- 359 Texas Department of Family and Protective Services. (2013). *Self-evaluation report: Submitted to the
Sunset Commission*. Retrieved from [http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/](http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/2013_SER/2013_SER_Full_Report.pdf)
[DFPS/2013_SER/2013_SER_Full_Report.pdf](http://www.dfps.state.tx.us/About_DFPS/Legislative_Presentations/DFPS/2013_SER/2013_SER_Full_Report.pdf)
- 360 Ibid.
- 361 Texas Department of Family and Protective Services. (2014). *Annual report and data book 2013*. Retrieved
from [https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
[AnnualRpt_Databook.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/FY2013_AnnualRpt_Databook.pdf)
- 362 Buckles, J., Luckasson, R., & Keef, E. (2013). A systematic review of the prevalence of psychiatric disorders in
adults with intellectual disability, 2003–2010. *Journal of Mental Health Research in Intellectual Disabilities*,
6(3), 181–207.
- 363 Substance Abuse and Mental Health Services Administration. (n.d.). *Co-occurring disorder-related quick facts:
Physical and cognitive disabilities*. Retrieved from [http://media.samhsa.gov/co-occurring/topics/screening-](http://media.samhsa.gov/co-occurring/topics/screening-and-assessment/PhysicalandCognitiveDisabilitiesQuickFacts.pdf)
[and-assessment/PhysicalandCognitiveDisabilitiesQuickFacts.pdf](http://media.samhsa.gov/co-occurring/topics/screening-and-assessment/PhysicalandCognitiveDisabilitiesQuickFacts.pdf)
- 364 Honey, A., Emerson, E., Llewellyn, G., & Kariku, M. (2012). Mental health and disability. *International
Encyclopedia of Rehabilitation*. Retrieved from <http://cirrie.buffalo.edu/encyclopedia/en/article/305/>

- 365 Martorel, A., Tsakanikos, E., Pereda, A., Gutierrez-Recacha, P., Bouras, N., & Ayuso-Mateo, J. L. (2009). Mental health in adults with mild and moderate intellectual disabilities: the role of recent life events and traumatic experiences across the life span. *The Journal of Nervous and Mental Disease*, 197(3), 182-186.
- 366 Simonoff, E., Pickles, A. C., Chandler, S., Loucas, T., & Baird, G. (2008). Psychiatric disorders in children with autism spectrum disorders: Prevalence, comorbidity, and associated factors in a population-derived sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 921-929.
- 367 Davis, E., Saeed, S., & Antonacci, D. (2008). Anxiety disorders in persons with developmental disabilities: Empirically informed diagnosis and treatment. *Psychiatric Quarterly*, 79, 249-263.
- 368 Cooper, S.A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *The British Journal of Psychiatry*, 190(1), 27-35.
- 369 Turk, J., Robbins, I., & Woodhead, M., (2005). Post-traumatic stress disorder in young people with intellectual disability. *The Journal of Intellectual Disability Research*. 49(11),872-875.
- 370 Martorel, A., Tsakanikos, E., Pereda, A., Gutierrez-Recacha, P., Bouras, N., & Ayuso-Mateo, J. L. (2009). Mental health in adults with mild and moderate intellectual disabilities: the role of recent life events and traumatic experiences across the life span. *The Journal of Nervous and Mental Disease*, 197(3), 182-186.
- 371 Buckles, J., Luckasson, R., & Keef, E. (2013). A systematic review of the prevalence of psychiatric disorders in adults with intellectual disability, 2003-2010. *Journal of Mental Health Research in Intellectual Disabilities*, 6(3), 181-207.
- 372 Smiley, E. (2005). Epidemiology of mental health problems in adults with learning disabilities: An update. *Advances in Psychiatric Treatment*, 18, 214-222.
- 373 Substance Abuse and Mental Health Services Administration. (n.d.). *Co-occurring disorder-related quick facts: Physical and cognitive disabilities*. Retrieved from <http://media.samhsa.gov/co-occurring/topics/screening-and-assessment/PhysicalandCognitiveDisabilitiesQuickFacts.pdf>
- 374 Honey, A., Emerson, E., Llewellyn, G., & Kariku, M. (2012). Mental health and disability. *International Encyclopedia of Rehabilitation*. Retrieved from <http://cirrie.buffalo.edu/encyclopedia/en/article/305/>
- 375 Simonoff, E., Pickles, A. C., Chandler, S., Loucas, T., & Baird, G. (2008). Psychiatric disorders in children with autism spectrum disorders: prevalence, comorbidity, and associated factors in a population-derived sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 921-929.
- 376 Institute of Medicine, National Academies, & National Academy of Science. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Washington, D.C.: National Academy Press. Retrieved from http://www.nap.edu/catalog.php?record_id=13400.
- 377 Ibid.
- 378 Ibid.
- 379 Texas Department of Aging and Disability Services. (2014). *Preadmission Screening and Resident Review (PASRR)*. Retrieved from <http://www.dads.state.tx.us/providers/pasrr/index.cfm>
- 380 Ibid.
- 381 Department of Aging and Disability Services. (2014). Compliance reports. Retrieved from <http://www.dads.state.tx.us/monitors/reports/>
- 382 Texas Department of Aging and Disability Services. (2013). *Diversion protocol: Targeted Home and Community-based Services (CBS) waiver slots protocol for individuals at imminent risk of admission to a State Supported Living Center (SSLC)*. Retrieved from http://www.dads.state.tx.us/handbooks/lah/res/HCS_Diversion_from_SSLC.pdf
- 383 Department of Aging and Disability Services. (2013). *Self-evaluation report submitted to the Sunset Commission*. Retrieved from <https://www.sunset.texas.gov/public/uploads/files/reports/Department%20of%20Aging%20and%20Disability%20Services%20SER%202013%2084%20Leg.pdf>
- 384 Texas Department of Aging and Disability Services. (2012). *Access and intake services community options booklet*. Retrieved from http://www.dads.state.tx.us/providers/community_options.pdf
- 385 Olmstead v. L.C., 527 U.S. 581 (1999).
- 386 Texas Department of Aging and Disability Services. (2014). *Money Follows the Person Demonstration Project*. Retrieved from http://www.dads.state.tx.us/providers/pi/mfp_demonstration/.
- 387 U.S. Department of Labor, Bureau of Labor Statistics. (2013, June 12). *Persons with a disability: Labor force characteristics summary*. Retrieved from <http://www.bls.gov/news.release/disabl.nr0.htm>
- 388 Ibid.
- 389 Texas Workforce Investment Council. (2013, April). *Persons with Disabilities: A Texas Profile*. Retrieved from http://governor.state.tx.us/files/twic/Disabilities_Profile.pdf
- 390 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
- 391 Social Security Administration. (2012). *SSI federal payment amounts for 2014*. Retrieved from <http://www.ssa.gov/OACT/cola/SSI.html>
- 392 Texas Department of Assistive and Rehabilitative Services. (2013, February 14). *Presentation to the House Appropriations Article II Subcommittee*. Retrieved from http://www.dars.state.tx.us/announcements/HAC_Powerpoint_02.14.13.pdf
- 393 National Institute of Mental Health. (n.d.). *Treatment of Children with Mental Illness*. Retrieved from <http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml>
- 394 Institute of Medicine of the National Academies. (2009, March 12). *Preventing Mental, Emotional, and Behavioral Disorders Among Youth People: Progress and Possibilities*. Retrieved from <http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress->

- and-Possibilities.aspx
- 395 Judge David L. Bazelon Center for Mental Health Law. (n.d.). *Employment and Unemployment of People with Serious Mental Illness*. Retrieved from <http://www.bazelon.org/LinkClick.aspx?fileticket=5F9NH12OjmM%3D&tabid=371>
 - 396 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
 - 397 Department of Assistive and Rehabilitative Services. (2014, August 4). *Legislative Appropriations Request*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=538&fy=2016>
 - 398 Adams, R.C., Tapia, C., & The Council on Children with Disabilities. (2013, September 30). Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes. *Pediatrics*, 132(4), 1073-1088. DOI: 10.1542/peds.2013-2305. Retrieved from <http://pediatrics.aappublications.org/content/early/2013/09/24/peds.2013-2305.full.pdf>
 - 399 Texas Department of Assistive and Rehabilitative Services. (2013, February 14). *Presentation to the House Appropriations Article II Subcommittee* [PowerPoint slides]. Retrieved from http://www.dars.state.tx.us/announcements/HAC_Powerpoint_02.14.13.pdf
 - 400 U.S. Department of Education. (n.d.). *Part C – Infants and toddlers with disabilities*. Retrieved from <http://idea.ed.gov/explore/view/p/%2Croot%2Cstatute%2CI%2CC%2C>
 - 401 Texas Department of Assistive and Rehabilitative Services. (2013, September). *Self-evaluation Report Submitted to the Sunset Commission*. Retrieved from http://www.dars.state.tx.us/news/sunset_eval_report.shtml
 - 402 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
 - 403 Texas Department of Assistive and Rehabilitative Services. (2013, December 1). *Operating Budget for Fiscal Year 2014*. Retrieved from <http://www.dars.state.tx.us/reports/OpBudget2014.pdf>
 - 404 Texas Department of Assistive and Rehabilitative Services. (n.d.). *ECI Parent Handbook*. Retrieved from <http://www.dars.state.tx.us/ecis/publications/EnglishHandbook.shtml>
 - 405 Texas Department of Assistive and Rehabilitative Services. (n.d.). *ECI Services and Eligibility*. Retrieved from <http://www.dars.state.tx.us/ecis/eligibility.shtml>
 - 406 Texas Education Agency Chapter 89. Adaptations for Special Populations, §89.1040 (2007). Retrieved from <http://ritter.tea.state.tx.us/rules/tac/chapter089/ch089aa.html>
 - 407 Texas Department of Assistive and Rehabilitative Services. (n.d.). *ECI Services and Eligibility*. Retrieved from <http://www.dars.state.tx.us/ECIS/eligibility.shtml#services>
 - 408 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Paying for Early Childhood Intervention Services*. Retrieved from http://www.dars.state.tx.us/ecis/FCS_booklet_Jan%201.pdf
 - 409 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Family Cost Share – Paying for Early Childhood Intervention Services*. Retrieved from http://www.dars.state.tx.us/ecis/FCS_booklet_Jan%201.pdf
 - 410 Texans Care for Children. (2013). *Session summary: Early Childhood Intervention and the Legislature* [Video file]. Retrieved from http://www.youtube.com/watch?v=UQStInSh_Fc
 - 411 Bufkin, A. (2014, March 20). *Coalition of Texans with Disabilities– ECI Guest Blog*. Retrieved from <http://www.txdisabilities.org/news-events/eci-guest-blog-alice-bufkin>
 - 412 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
 - 413 Ibid.
 - 414 Texas Department of Assistive and Rehabilitative Services. (n.d.). *ECI Evaluation*. Retrieved from <http://www.dars.state.tx.us/ecis/evaluation/index.shtml>
 - 415 Texans Care for Children. (2014, April 4). Personal communication: ECI
 - 416 Taylor, S. (2013, March 25). *Self-sufficiency: An Essential Aspect of Well-Being*. Psychology Today. Retrieved from <http://www.psychologytoday.com/blog/out-the-darkness/201303/self-sufficiency-essential-aspect-well-being>
 - 417 U.S. Department of Labor, Bureau of Labor Statistics. (2014, June 11). *Persons with a disability: Labor force characteristics summary*. Retrieved from <http://www.bls.gov/news.release/disabl.nr0.htm>
 - 418 Ibid.
 - 419 Ibid.
 - 420 Ibid.
 - 421 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Disabilities History and Awareness: Mental Health Month*. Retrieved from <http://www.dars.state.tx.us/disability/articles/20120509.shtml>
 - 422 National Alliance on Mental Illness. (2010, January). *The High Costs of Cutting Mental Health*. Retrieved from <http://www.namismd.org/storage/Unemployment.pdf>
 - 423 Ibid.
 - 424 National Council on Disability. (2007, October 1). *Empowerment for Americans with Disabilities: Breaking Barriers to Careers and Full Employment*. Retrieved from <http://www.ncd.gov/publications/2007/Oct2007>
 - 425 Texas Workforce Investment Council. (2013, April). *Persons with Disabilities: A Texas Profile*. Retrieved from http://governor.state.tx.us/files/twic/Disabilities_Profile.pdf
 - 426 Texas Department of Assistive and Rehabilitative Services. (2011). *Annual Report 2011*. Retrieved from http://www.dars.state.tx.us/reports/annual2011/2011_annual.pdf
 - 427 Ibid.
 - 428 Texas Department of Assistive and Rehabilitative Services. (n.d.) *Vocational Rehabilitation Program: A guide*

- for applicants. Retrieved from <http://www.dars.state.tx.us/publications/pdf/01856.pdf>
- 229 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
- 230 Ibid.
- 231 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Vocational Rehabilitation for Persons with Physical and Mental Disabilities*. Retrieved from <http://www.dars.state.tx.us/drs/vr.shtml>
- 232 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Services for Persons with Physical and Mental Disabilities*. Retrieved from <http://www.dars.state.tx.us/drs/>
- 233 Texas Department of Assistive and Rehabilitative Services. (2011). *Annual Report 2011*. Retrieved from http://www.dars.state.tx.us/reports/annual2011/2011_annual.pdf
- 234 Texas Department of Assistive and Rehabilitative Services. (2013, February 14). *Presentation to the House Appropriations Article II Subcommittee* [PowerPoint slides]. Retrieved from http://www.dars.state.tx.us/announcements/HAC_Powerpoint_02.14.13.pdf
- 235 Texas Department of Assistive and Rehabilitative Services. (2013, September). *Self-evaluation Report Submitted to the Sunset Commission*. Retrieved from http://www.dars.state.tx.us/news/sunset_eval_report.shtml
- 236 State Independent Living Council. (n.d.). *Texas State Plan for Independent Living 2014-2016*. Retrieved from http://www.dars.state.tx.us/councils/silc/SIPL_2014-2016.pdf
- 237 Ibid.
- 238 Texas Department of Assistive and Rehabilitative Services. (2013, February 14). *Presentation to the House Appropriations Article II Subcommittee* [PowerPoint slides]. Retrieved from http://www.dars.state.tx.us/announcements/HAC_Powerpoint_02.14.13.pdf
- 239 Ibid.
- 240 Texas Department of Assistive and Rehabilitative Services. (2014, August 4). *Legislative Appropriations Requests for Fiscal Years 2016 and 2017*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=538&fy=2016>
- 241 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Independent Living Services*. Retrieved from <http://www.dars.state.tx.us/drs/il.shtml>
- 242 The United States Social Security Administration. (2013, November). *Annual Statistical Report on the Social Security Disability Insurance Program, 2012* (Report No. 13-11826). Retrieved from http://www.socialsecurity.gov/policy/docs/statcomps/di_asr/2012/di_asr12.pdf
- 243 Texas Department of Assistive and Rehabilitative Services. (2013, February 14). *Presentation to the House Appropriations Article II Subcommittee* [PowerPoint slides]. Retrieved from http://www.dars.state.tx.us/announcements/HAC_Powerpoint_02.14.13.pdf
- 244 Texas Department of Assistive and Rehabilitative Services. (2013, September). *Self-evaluation Report Submitted to the Sunset Commission*. Retrieved from http://www.dars.state.tx.us/news/sunset_eval_report.shtml
- 245 Texas Department of Assistive and Rehabilitative Services. (n.d.). *Disability Determination Services*. Retrieved from <http://www.dars.state.tx.us/services/dds.shtml>
- 246 The United States Social Security Administration. (2013, November). *Annual Statistical Report on the Social Security Disability Insurance Program, 2012* (Report No. 13-11826). Retrieved from http://www.socialsecurity.gov/policy/docs/statcomps/di_asr/2012/di_asr12.pdf
- 247 National Alliance on Mental Illness. (2009, July). *Social Security and Disability Benefits*. Retrieved from <http://www.nami.org/Template.cfm?Section=Helpline1&template=/ContentManagement/ContentDisplay.cfm&ContentID=4857>
- 248 The United States Social Security Administration. (2013, November). *Annual Statistical Report on the Social Security Disability Insurance Program, 2012* (Report No. 13-11826). Retrieved from http://www.socialsecurity.gov/policy/docs/statcomps/di_asr/2012/di_asr12.pdf
- 249 Ibid.
- 250 The United States Social Security Administration. (2014, May 7). Data request: SSDI monthly benefit
- 251 Social Security Administration. (n.d.). *SSI federal payment amounts for 2014*. Retrieved from <http://www.ssa.gov/OACT/cola/SSI.html>
- 252 Texas Department of Assistive and Rehabilitative Services. (2014). *Annual Report 2013*. Retrieved from <http://www.dars.state.tx.us/reports/annual2013/annualreport2013.pdf>
- 253 Ibid.
- 254 Texas Department of Assistive and Rehabilitative Services. (2013, September). *Self-evaluation Report Submitted to the Sunset Commission*. Retrieved from http://www.dars.state.tx.us/news/sunset_eval_report.shtml
- 255 Ibid.
- 256 Hoffberger, C. (2013, December 20). Running to Daylight. *The Austin Chronicle*. Retrieved from <http://www.austinchronicle.com/news/2013-12-20/running-to-daylight/>
- 257 Texas Department of Assistive and Rehabilitative Services. (2013, September). *Self-evaluation Report Submitted to the Sunset Commission*. Retrieved from http://www.dars.state.tx.us/news/sunset_eval_report.shtml
- 258 Baillargeon, J., Binswanger, I., Penn, J., Williams, B., & Murray, O. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry*, 166(1), 103-109. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?articleid=100490>

- 459 Texas Department of Criminal Justice. (2014). *Agency strategic plan fiscal years 2015-2019*. Retrieved from http://www.tdcj.state.tx.us/documents/finance/Agency_Strategic_Plan_FY2015-19.pdf
- 460 Ibid.
- 461 Legislative Budget Board. (2013, January). *Criminal Justice Uniform Cost Report Fiscal Years 2010 to 2012*. Retrieved from http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/Uniform_Cost/Criminal%20Justice%20Uniform%20Cost%20Report%20Fiscal%20Years%202010%20to%202012.pdf
- 462 Center for Public Policy Priorities. (2014). *From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities*. Retrieved from http://forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf
- 463 Texas Commission on Jail Standards. (2014, January 31). *Annual Report 2013*. Retrieved from <http://www.tcjs.state.tx.us/docs/2013AnnualJailReport.pdf>
- 464 Baillargeon, J., Binswanger, I., Penn, J., Williams, B., & Murray, O. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry*, 166(1), 103-109. Retrieved from <http://ajp.psychiatryonline.org/article.aspx?articleid=100490>
- 465 Steadman, H., Osher, F., Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761-765. Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleID=100482>
- 466 Peterson, J., Skeem, J., Hart, E., Vidal, S., & Keith, F. (2010). Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis. *Psychiatric Services*, 61, 1217-1222. Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleid=101673>
- 467 Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2014) Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy. *Annals of Epidemiology*, 1-11. Retrieved from <http://www.sciencedirect.com/science/article/pii/S1047279714001471>
- 468 Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2014) Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy. *Annals of Epidemiology*, 1-11. Retrieved from <http://www.sciencedirect.com/science/article/pii/S1047279714001471>
- 469 American Psychological Association. (2013). *Gun violence: Prediction, prevention and policy*. Retrieved from <http://www.apa.org/pubs/info/reports/gun-violence-report.pdf>
- 470 Ibid.
- 471 Swanson, J., et al (2014, March 19) *Annals of Epidemiology Mental Illness and reduction of gun violence and suicide: bringing epidemiologic research to policy*. Retrieved from <http://www.sciencedirect.com/science/article/pii/S1047279714001471>
- 472 Texas Criminal Justice Coalition. (2013). *S.B. 1185 Fact Sheet 2013*. Retrieved from <http://www.texascjc.org/sites/default/files/uploads/SB%201185%20Fact%20Sheet%20%28Mental%20Illness%20Diversion%29.pdf>
- 473 Texas Department of State Health Services. (2010). *Another look at mental illness and criminal justice involvement in Texas: Correlates and costs*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589953608>
- 474 Texas Department of Criminal Justice. (n.d). *About the Texas Department of Criminal Justice*. Retrieved from http://www.tdcj.state.tx.us/about_tdcj.html
- 475 Grissom, B. (2014, January 7). Solitary confinement study approved by lacks funding. *The Texas Tribune*. Retrieved from http://www.tdcj.state.tx.us/about_tdcj.html
- 476 Texas Interfaith Center for Public Policy. (n.d.). *Administrative segregation*. Retrieved from <http://texasinterfaithcenter.org/content/criminal-justice/administrative-segregation>
- 477 Texas Department of Criminal Justice. (2014, June). *Safe Prisons Program Fiscal Year 2013*. Retrieved from http://www.tdcj.state.tx.us/documents/PREA_SPP_Report_2013.pdf
- 478 Texas Department of Criminal Justice. (2014). *Safe Prisons Program Fiscal Year 2013*. Retrieved from http://www.tdcj.state.tx.us/documents/PREA_SPP_Report_2013.pdf
- 479 Texas Department of Criminal Justice. (2014). *Agency strategic plan fiscal years 2015-2019*. Retrieved from http://www.tdcj.state.tx.us/documents/finance/Agency_Strategic_Plan_FY2015-19.pdf
- 480 Ibid.
- 481 Texas Department of Criminal Justice. (2014). *Annual review 2013*. Retrieved from http://www.tdcj.state.tx.us/documents/Annual_Review_2013.pdf
- 482 Texas Department of Criminal Justice. (n.d). *About the Texas Department of Criminal Justice*. Retrieved from http://www.tdcj.state.tx.us/about_tdcj.html
- 483 Texas Department of Criminal Justice, (n.d.). *Texas Correctional Office on Offenders with Medical or Mental Impairments: Overview of the committee*. Retrieved from http://www.tdcj.state.tx.us/divisions/rid/tcoommi/tcoommi_overview.html
- 484 Correctional Managed Health Care Committee. (n.d.). *Geographical areas of responsibility*. Retrieved from <http://www.cmhcc.state.tx.us/Files/map.pdf>
- 485 Grissom, B. (2013, September 22). Violence behind bars: A tie to mental illness. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/2013/09/22/violence-behind-bars-tie-mental-illness/>
- 486 Legislative Budget Board. (2013, January). *Criminal Justice Uniform Cost Report Fiscal Years 2010 to 2012*. Retrieved from http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/Uniform_Cost/Criminal%20Justice%20Uniform%20Cost%20Report%20Fiscal%20Years%202010%20to%202012.pdf
- 487 Center for Public Policy Priorities. (2014). *From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities*. Retrieved from http://forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf
- 488 Correctional Managed Health Care Committee. (2013) *Offender health services plan*. Retrieved from <http://>

- tdcj.state.tx.us/divisions/cmhc/docs/cmhcc_contracts_fy2014-15/696-HS-14-15-A066-Exhibit-A.pdf
- 489 Correctional Managed Health Care Committee. (n.d.). *Mental health programs and services*. Retrieved from <http://www.cmhcc.state.tx.us/Files/CMHC%20MH%20Overview.pdf>
- 490 Correctional Managed Health Care Committee. (2013). *Offender health services plan*. Retrieved from http://tdcj.state.tx.us/divisions/cmhc/docs/cmhcc_contracts_fy2014-15/696-HS-14-15-A066-Exhibit-A.pdf
- 491 Texas Department of Criminal Justice. (n.d.). *Rehabilitation programs division*. Retrieved from http://www.tdcj.state.tx.us/divisions/rpd/rpd_substance_abuse.html
- 492 Legislative Budget Board. (2014). *Fiscal size-up 2014-15 biennium*. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp.pdf
- 493 Texas Department of Criminal Justice. (n.d.). *Texas Correctional Office on Offenders with Medical or Mental Impairments: Mission statement*. Retrieved from <http://www.tdcj.state.tx.us/divisions/rid/tcoommi/index.html>
- 494 Center for Disease Control. (2001). *Helping inmates return to the community*. Retrieved from <http://www.cdc.gov/odu/facts/cj-transition.pdf>
- 495 Texas Department of Criminal Justice. (2012). *FY 2013 operating budget: Fiscal years 2014-2015 Legislative Appropriations Request*. Retrieved from http://www.tdcj.state.tx.us/documents/finance/Operating_Budget_FY2013_LAR_Summary_FY2014-15.pdf
- 496 Texas Department of Criminal Justice. (2013, August). Data request: Reentry and Integration Division TCOOMMI Overview.
- 497 Legislative Budget Board. (2014). *Fiscal size-up 2014-15 biennium*. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Fiscal_SizeUp/Fiscal_SizeUp.pdf
- 498 Texas Department of Criminal Justice. (2013). *Agency operating budget 2014 as prepared for the Texas Board of Criminal Justice*. Retrieved from http://www.tdcj.state.tx.us/documents/finance/Agency_Operating_Budget_FY2014.pdf
- 499 Texas Board of Criminal Justice. (2012). *Legislative Appropriations Request for fiscal years 2014 and 2015*. Retrieved from http://www.tdcj.state.tx.us/documents/finance/LAR_FY2014-15.pdf
- 500 Texas Department of Criminal Justice. (2014, July). Data request: Treatment of mentally ill offenders
- 501 Ibid.
- 502 Ajinkya, J. (2012). *The top 5 facts about women in our criminal justice system: Many face difficulties during and after incarceration*. Retrieved from <http://www.americanprogress.org/issues/women/news/2012/03/07/11219/the-top-5-facts-about-women-in-our-criminal-justice-system/>
- 503 The Sentencing Project. (2012). *Incarcerated women*. Retrieved from http://www.sentencingproject.org/doc/publications/cc_Incarcerated_Women_Factsheet_Sep24sp.pdf
- 504 Criminal Justice Connections. (2013). *BAMBI gives some offender mothers, newborns time to bond*. Retrieved from http://www.tdcj.state.tx.us/connections/MayJune2010/features_vol17no5.html
- 505 Texas Commission on Jail Standards. (2014, January 31). *Annual Report 2013*. Retrieved from <http://www.tcjs.state.tx.us/docs/2013AnnualJailReport.pdf>
- 506 Texas Commission on Jail Standards. (2014, January 31). *2013 Annual Report*. Retrieved from <http://www.tcjs.state.tx.us/docs/2013AnnualJailReport.pdf>
- 507 Treatment Advocacy Center and National Sheriff's Association. (2014, April 8). *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*. Retrieved from <http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>
- 508 Texas Commission on Jail Standards. (n.d.). *About TCJS Compact with Texas*. Retrieved from <http://www.tcjs.state.tx.us/index.php?linkID=110>
- 509 Texas Commission on Jail Standards. (June, 2012). *Agency Strategic Plan for the fiscal years 2013-17 by TCJS*. Retrieved from <http://www.tcjs.state.tx.us/docs/2013-2017TCJSStratPlan.pdf>
- 510 Ibid.
- 511 Ibid.
- 512 Texas Administrative Code (Dec. 2006) *Title 37 Public Safety and Corrections Part 9 Texas Commission on Jail Standards Chapter 265 Admission Rule §265.5 Health Tags* Retrieved from [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=3&ti=37&pt=9](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=3&ti=37&pt=9)
- 513 Ibid.
- 514 Noonan, M. "Mortality in Local Jails, 2000–2007," NCJ 222988 (Washington, DC: United States Department of Justice, Bureau of Justice Statistics, July 2010): 1.
- 515 Texas Administrative Code (April, 2013) *Title 37 Public Safety and Corrections Part 9 Texas Commission on Jail Standards Chapter 273 Health Services Rule §273.5 Mental Disabilities/Suicide Prevention Plan* Retrieved from [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=3&ti=37&pt=9](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=3&ti=37&pt=9)
- 516 Texas Commission on Jail Standards. (2014, January 31). *2013 Annual Report* Retrieved from <http://www.tcjs.state.tx.us/docs/2013AnnualJailReport.pdf>
- 517 Texas Department of Criminal Justice. (n.d.). *Texas Correctional Office on Offenders with Medical or Mental Impairments: Community based interventions*. Retrieved from http://www.tdcj.state.tx.us/divisions/rid/tcoommi/tcoommi_community_programs.html
- 518 Munetz, M.R. & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to the decriminalization of people with serious mental illness. *Psychiatric Services* 54(4), 544-549. Retrieved from <http://ps.psychiatryonline.org/data/Journals/PSS/3767/06ps544.pdf>
- 519 The Council of State Governments Justice Center. (2014). *A way forward: Diverting people with mental*

- illness from inhumane and expensive jails into community-based treatment that works. Retrieved from <http://csgjusticecenter.org/mental-health/publications/a-way-forward-diverting-people-with-mental-illness-from-inhumane-and-expensive-jails-into-community-based-treatment-that-works/>
- 520 Texas Task Force on Indigent Defense, Office of Court Administration. (2010, April). *Representing the mentally ill offender: An evaluation of advocacy alternatives*. Retrieved from <http://www.txcourts.gov/tidc/pdf/MHStudyFinal.pdf>
- 521 Texas Department of Criminal Justice Community Justice Assistance Division, (2014) *Texas Progressive Interventions and Sanctions Bench Manual* Retrieved from http://www.tdcj.state.tx.us/documents/cjad/CJAD_Bench_Manual.pdf
- 522 Center for Health Care Services. (2008, May). *A cost analysis of the Bexar county, Texas Jail Diversion Program, report 2: An analysis of cost-shifting between the treatment and criminal justice systems*. Retrieved from <http://www.naco.org/programs/csd/Documents/Criminal%20Justice/Jail%20Diversion%20Forum%20Materials/Cost%20Benefit%20Study.pdf>
- 523 Barajas, M (2013, January 28). *SA Daily E-N Analysis Shows More Mismanagement of Bexar County Jail Under Ortiz* Retrieved from <http://blogs.sacurrent.com/staff/e-n-analysis-shows-more-mismanagement-of-bexar-county-jail-under-ortiz/>
- 524 Hicks, Regenia. (2014, March 20). *Harris County SB 1185 Pilot Program*. Retrieved from http://webcache.googleusercontent.com/search?q=cache:_Vur1AXOObIJ:www.dshs.state.tx.us/WorkArea/linkit.aspx%3FLinkIdIdentifier%3Ddid%26ItemID%3D8589986802+&cd=1&hl=en&ct=clnk&gl=us&client=safari
- 525 Ibid.
- 526 Ibid.
- 527 Office of the Governor, Criminal Justice Division. (2013). *Criminal Justice Advisory Council Report: Recommendations for Texas specialty courts*. Retrieved from http://governor.state.tx.us/files/cjd/CJAC_Report_January_2013.pdf
- 528 Ibid.
- 529 Council of State Governments Justice Center. (2008). *Mental health courts: A primer for policymakers and practitioners*. Retrieved from <http://ojp.gov/newsroom/testimony/2009/mentalhealthcourts.pdf>
- 530 Harris County District Courts. (2012). *Felony Mental Health Court Program description*. Retrieved from <http://www.justex.net/courts/Drug/MentalHealth/Default.aspx>
- 531 Felony Mental Health Court Harris County, Texas, (2013, July) Personal communication: Felony Mental Health Court.
- 532 Ibid.
- 533 Ibid.
- 534 Ibid.
- 535 Ibid.
- 536 Texas Department of Criminal Justice – Community Justice Assistance Division. (2003) *Texas drug courts*. Retrieved from http://www.tdcj.state.tx.us/documents/cjad/CJAD_Texas_Drug_Courts_Fact_Sheet.pdf
- 537 Ibid.
- 538 The State of Texas Governor. (2013). *Texas specialty courts*. Retrieved from http://governor.state.tx.us/files/cjd/Specialty_Courts_By_County_September_2013.pdf
- 539 Criminal Justice Policy Council. (2002). *Overview of Drug Courts in Texas*. Retrieved from http://www.lbb.state.tx.us/Public_Safety_Criminal_Justice/Reports/drugcourt.pdf
- 540 Texas Indigent Defense Commission. (2014). *Public Defender Offices and Managed Assigned Counsel programs in Texas*. Retrieved from <http://www.txcourts.gov/tidc/pdoffices.asp>
- 541 Travis County Attorney's Office. (2011). *Mental Health Public Defender Office cost benefit analysis, part 1: Analysis of performance of the Texas Task Force on Indigent Defense Grant*. Retrieved from <http://www.txcourts.gov/tidc/pdf/TravisMHPDOcostanalysisMay2011.pdf>
- 542 Texas Courts Online. (2014). *Direct client services indigent defense programs in Texas*. Retrieved from <http://www.txcourts.gov/tidc/pdf/DirectClientServices4.01.14.pdf>
- 543 Fort Bend County, Texas. (2014). *Mental health public defender's office*. Retrieved from <http://www.fortbendcountytexas.gov/index.aspx?page=293>
- 544 Travis County Attorney's Office. (2011). *Mental Health Public Defender Office cost benefit analysis, part 1: Analysis of performance of the Texas Task Force on Indigent Defense Grant*. Retrieved from <http://www.txcourts.gov/tidc/pdf/TravisMHPDOcostanalysisMay2011.pdf>
- 545 Ibid.
- 546 Center for Public Policy Priorities. (2014, August 6). *From Recidivism to Recovery: The Case for Peer Support in Texas Correctional Facilities*. Retrieved from http://forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf
- 547 Ibid.
- 548 Skowyr, K. & Coccozza J. (2006, January). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- 549 Merikangas, K.R., He, J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., . . . Georgiades, K. (2010). Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, (49)(10), 980-989. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946114/#!po=3.57143>
- 550 Shufelt, J., & Coccozza, J. (2006, June). *Research and program brief: Youth with mental health disorders in the*

- juvenile justice system: Results from a multi-state prevalence study*. Delmar, NY: National Center for Mental Health and Juvenile Justice.
- 551 Legislative Budget Board. (2014, May) *Monthly Tracking of Juvenile Correctional Population Indicators*. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Info_Graphic/812_Monthly_Report_May_2014.pdf
- 552 Texas Juvenile Justice Department. (2013). *Registered Juvenile Facilities in Texas (CY2012)*. Retrieved from <http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx>
- 553 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice appropriations, riders and special diversion programs*. Retrieved from http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
- 554 Texas Public Policy Foundation. (2012, January). A Critical Look at Juvenile Offenders with Mental Illnesses: What We Know, What We Don't, and Where We Go from Here. Retrieved from <http://www.texaspolicy.com/center/effective-justice/reports/critical-look-juvenile-offenders-mental-illnesses>
- 555 National Center for Mental Health and Juvenile Justice. (2007). *Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System*. Retrieved from http://www.ncmhjj.com/wp-content/uploads/2013/07/2007_Blueprint-for-Change-Full-Report.pdf
- 556 Merikangas, K.R., He, J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., . . . Georgiades, K. (2010). Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, (49)(10), 980-989. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946114/#!po=3.57143>
- 557 National Center for Mental Health and Juvenile Justice. (2006, June). *Research and Program Brief: Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*. Retrieved from <http://www.unicef.org/tdad/usmentalhealthprevalence06%283%29.pdf>
- 558 Mental Health and Juvenile Justice Collaborative for Change. (2014, January 22). *Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System*. Retrieved from <http://www.modelsforchange.net/publications/519>
- 559 Ibid.
- 560 National Child Traumatic Stress Network, Justice System Consortium. (2009). *Helping Traumatized Children: Tips for Judges*. Retrieved from <http://www.nctsn.org/sites/default/files/assets/pdfs/JudgesFactSheet.pdf>
- 561 Ibid.
- 562 Texas Juvenile Justice Department. (2014, June 19). Personal communication: Trauma-Focused Cognitive Behavioral Treatment Pilot.
- 563 Child Welfare Information Gateway. (2012). *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma*. Retrieved from <https://www.childwelfare.gov/pubs/trauma/>
- 564 Ibid.
- 565 Texas Juvenile Justice Department. (2014, June 19). Personal communication: Trauma-Focused Cognitive Behavioral Treatment Pilot
- 566 Texas Juvenile Justice Department. (2011, December). *Annual review of treatment effectiveness*. Retrieved from <http://www.tjjd.texas.gov/Docs/treatmenteffectivenessreport.pdf>
- 567 Chammah, M. (2014, February 12). Closing Corsicana: Lessons from a Juvenile Lock-Up. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/2014/02/12/corsicana-closure-lessons-juvenile-lock-/>
- 568 Langford, T. (2014, May 15). Vacant Juvenile Facility Costing \$100,000 Monthly. *The Texas Tribune*. Retrieved from <http://www.texastribune.org/2014/05/15/lawmakers-working-repurpose-corsicana-juvenile-fac/>
- 569 Texas Juvenile Justice Department. (2014, July 09). *Executive Director Message Regarding Corsicana*. Retrieved from http://www.tjjd.texas.gov/Docs/EDMessages/ED_Message_070914.pdf
- 570 Deitch, M. (2011). *Juveniles in the Adult Criminal Justice System in Texas*. Austin, TX: The University of Texas at Austin, LBJ School of Public Affairs.
- 571 Independent Ombudsman for the Texas Juvenile Justice Department. (n.d.). *Independent Ombudsman*. Retrieved from <http://www.tjjd.texas.gov/ombudsman/index.aspx>
- 572 Ibid.
- 573 Texas Health and Human Services Commission, Center for Elimination of Disproportionality and Disparities. (2012, December 1). *The Interagency Council for Addressing Disproportionality: Report to the 83rd Legislature*. Retrieved from http://www.utexas.edu/cola/insts/iupra/_files/pdf/11-29-2012-Report-to-the-83rd-Legislature.pdf
- 574 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Retrieved from http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
- 575 Texas Appleseed. (2010, December). *Texas' School-to-Prison Pipeline: Ticketing, Arrest & Use of Force in Schools: How the Myth of the "Blackboard Jungle" Reshaped School Disciplinary Policy*. Retrieved from http://www.texasappleseed.net/images/stories/reports/Ticketing_Booklet_web.pdf
- 576 Texas Juvenile Justice Department. (2013). *TJJD Facilities Address List*. Retrieved from <http://www.tjjd.texas.gov/aboutus/facilities.aspx>
- 577 Legislative Budget Board. (2014, May). *Monthly Tracking of Juvenile Correctional Population Indicators*. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Info_Graphic/812_Monthly_Report_May_2014.pdf

- 578 Texas Juvenile Justice Department. (2014, August). Data Request: non-violent felony offenses commitments
 579 Texas Juvenile Justice Department. (2013, December). *Annual Review of Treatment Effectiveness*. Retrieved
 from http://www.tjjd.texas.gov/Docs/TER_2013.pdf
 580 Texas Juvenile Justice Department. (2014). Data request: Ron Jackson State Juvenile Correctional Complex
 581 Ibid.
 582 Ibid.
 583 Texas Juvenile Justice Department. (2013). *What is CoNEXTions?* Retrieved from [http://www.tjjd.texas.gov/](http://www.tjjd.texas.gov/programs/conextions.aspx)
[programs/conextions.aspx](http://www.tjjd.texas.gov/programs/conextions.aspx)
 584 Ibid.
 585 Texas Juvenile Justice Department (2013, December). *Annual Review of Treatment Effectiveness*. Retrieved
 from http://www.tjjd.texas.gov/Docs/TER_2013.pdf
 586 Ibid.
 587 Ibid.
 588 Ibid.
 589 Texas Juvenile Justice Department. (2013). *Registered Juvenile Facilities in Texas (CY2012)*. Retrieved from
<http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx>
 590 Ibid.
 591 Texas Juvenile Justice Department. (2014, August). Data request: juveniles at the county level
 592 Texas Juvenile Justice Department. (2014 August). Data request: juvenile mental health assessments
 593 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget*
Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. Retrieved from
http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
 594 Ibid.
 595 Ibid.
 596 Ibid.
 597 Texas Juvenile Justice Department. (2014, August). Data Request: Juveniles with identified mental health
 need
 598 Ibid.
 599 Youth Law Center (Aug. 2006). *Title IV-E for Youth in the Juvenile Justice System*. Retrieved from [http://](http://www.njjn.org/uploads/digital-library/resource_425.pdf)
www.njjn.org/uploads/digital-library/resource_425.pdf
 600 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget*
Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. Retrieved from
http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
 601 Ibid.
 602 Ibid.
 603 Ibid.
 604 Ibid.
 605 Ibid.
 606 Ibid.
 607 Ibid.
 608 Ibid.
 609 Ibid.
 610 Texas Juvenile Justice Department. (n.d.). *2014 Grant S. Prevention Funding Recipients*. Retrieved from
http://www.tjjd.texas.gov/services/prevention/docs/Web_Summary_%202014_Grant_S_T_Prevention.pdf
 611 Texas Juvenile Justice Department. (2013, June). *Community-Based Program Evaluation Series: Overview*
of Community-Based Juvenile Probation Programs. Retrieved from [http://www.tjjd.texas.gov/statistics/](http://www.tjjd.texas.gov/statistics/CommunityBasedJuvenileProbationPrograms.pdf)
[CommunityBasedJuvenileProbationPrograms.pdf](http://www.tjjd.texas.gov/statistics/CommunityBasedJuvenileProbationPrograms.pdf)
 612 Ibid.
 613 Ibid.
 614 Ibid.
 615 Ibid.
 616 Ibid.
 617 Ibid.
 618 Ibid.
 619 Ibid.
 620 Ibid.
 621 Ibid.
 622 Texas Public Policy Foundation. (2012, January). A Critical Look at Juvenile Offenders with Mental Illnesses:
 What We Know, What We Don't, and Where We Go from Here. Retrieved from [http://www.texaspolicy.com/](http://www.texaspolicy.com/center/effective-justice/reports/critical-look-juvenile-offenders-mental-illnesses)
[center/effective-justice/reports/critical-look-juvenile-offenders-mental-illnesses](http://www.texaspolicy.com/center/effective-justice/reports/critical-look-juvenile-offenders-mental-illnesses)
 623 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget*
Board: Community Juvenile Justice appropriations, riders and special diversion programs. Retrieved from
http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
 624 Ibid.
 625 State Bar Section Report Juvenile Law. (2013, August). *2013 Special Legislative Issue*. Retrieved from [http://](http://www.juvenilelaw.org/Newsletters/2013/2013%20Special%20Leg%20Issue_final.pdf)
www.juvenilelaw.org/Newsletters/2013/2013%20Special%20Leg%20Issue_final.pdf
 626 Ibid.
 627 Texas Juvenile Justice Department. (2013, Sept. 1). *Mental Health Services Grant N-2014-15 Biennium*.

- Retrieved from http://www.tjjd.texas.gov/publications/standards/N_Mental_Health_Services.pdf
- 628 Ibid.
- 629 Ibid.
- 630 Ibid.
- 631 Ibid.
- 632 SAMHSA's GAINS Center for Behavioral Health and Justice Treatment. (n.d.). *Juvenile Mental Health Treatment Courts*. Retrieved from http://gainscenter.samhsa.gov/grant_programs/juvmtclst.asp?state=TX
- 633 Children at Risk. (2011). *Texas Juvenile Mental Health Courts: An Evaluation and Blueprint for the Future*. Retrieved from http://childrenatrisk.org/wp-content/uploads/2013/05/02_Texas-Juvenile-Mental-Health-Courts.pdf
- 634 National Criminal Justice Reference Service, Office of Justice Programs. (n.d.). *Drug Courts – Facts and Figures*. Retrieved from https://www.ncjrs.gov/spotlight/drug_courts/facts.html
- 635 Office of the Governor Rick Perry. (2013, May 1). *Texas Specialty Courts*. Retrieved from http://governor.state.tx.us/files/cjd/Specialty_Courts_By_County_May_2013.pdf
- 636 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Retrieved from http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
- 637 Ibid.
- 638 Ibid.
- 639 Texas Juvenile Justice Department. (2014, August). Data Request: Special Needs Diversionary Program.
- 640 Texas Juvenile Justice Department. (2013, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Retrieved from http://www.tjjd.texas.gov/statistics/TJJD_Dec_LBB_Rider_Report_2013.pdf
- 641 Ibid.
- 642 Ibid.
- 643 Texas Public Policy Foundation. (2012, January). A Critical Look at Juvenile Offenders with Mental Illnesses: What We Know, What We Don't, and Where We Go from Here. Retrieved from <http://www.texaspolicy.com/center/effective-justice/reports/critical-look-juvenile-offenders-mental-illnesses>
- 644 Texas Juvenile Probation Commission. (n.d.). *Probation Intake Diversion: Texas front-end diversion initiative (FEDI)*. Retrieved from http://texanscareforchildren.org/Images/Interior/mh%20forum/probation_intake_diversion.pdf
- 645 Texas Juvenile Justice Department. (2014, June 19). Personal communication: Front-End Diversionary Initiative
- 646 National Institute of Justice (2014). *Front-End Diversion Initiative*. Retrieved from http://www.crimesolutions.gov/ProgramDetails.aspx?ID=357&utm_source=email-govdelivery&utm_medium=eblast&utm_campaign=prg357-diversion
- 647 Perron, B.E. & Howard, M.O. (2008). Prevalence and correlates of traumatic brain injury among delinquent youths. *Criminal Behavior and Mental Health*, 18, 243-55. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/18803295>
- 648 Texas Juvenile Justice Department. (2014, July 9). Personal communication: Identifying Youth with Brain Injuries
- 649 U.S. Department of Education Institute of Education Sciences National Center for Education Statistics. (2013). *Number and percentage of children served under Individuals with Disabilities Education Act (IDEA), Part B, by age group and state or jurisdiction: Selected years, 1990–91 through 2011–12 (Table 204.70)*. Retrieved from http://nces.ed.gov/programs/digest/d13/tables/dt13_204.70.asp
- 650 Ibid.
- 651 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 652 Texas Education Agency. (2014). *Special education reports: 2013-2014 statewide totals* [Data file]. Retrieved from <http://ritter.tea.state.tx.us/adhocrpt/adser.html>
- 653 Texans Care for Children. (2009). *Children's mental health in Texas: Running a diagnostic test*. Retrieved from http://texanscareforchildren.org/Images/Interior/reports/texas_childrens_mental_health_report.pdf
- 654 Swearer, S. M., Wang, C., Maag, J. W., Siebecker, A. B., & Frerichs, L. J. (2012). Understanding the bullying dynamic among students in special and general education. *Journal of School Psychology*, 50(4), 503-520.
- 655 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 656 Ibid.
- 657 Texas Education Agency. (2014, February 2). Data request: School districts
- 658 Texas Education Agency. (2014). *Student enrollment reports: 2013-2014 Statewide totals* [Data file]. Retrieved from <http://ritter.tea.state.tx.us/adhocrpt/adste.html>
- 659 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 660 Texas Education Agency. (2014). *Special education reports: 2013-2014 statewide totals* [Data file]. Retrieved from <http://ritter.tea.state.tx.us/adhocrpt/adser.html>

- 661 McLeod, J. D., Uemura, R., & Rohrman, S. (2012). Adolescent mental health, behavior problems, and academic achievement. *Journal of Health and Social Behavior*, 53(4), 482-497.
- 662 Ringeisen, H., Henderson, K., & Hoagwood K. (2003). Context matters: Schools and the “research to practice” gap in children’s mental health. *School Psychology Review*, 32, 153-168.
- 663 Texans Care for Children. (2009). *Children’s mental health in Texas: Running a diagnostic test*. Retrieved from http://texanscareforchildren.org/Images/Interior/reports/texas_childrens_mental_health_report.pdf
- 664 Child and Adolescent Health Initiative. (2012). *Received mental health treatment or counseling in the past 12 months (Indicator 4.5)*. Retrieved from <http://www.nschdata.org/browse/survey/results?q=2220&r=45>
- 665 Price, O. A. (2013). *Sustaining effective behavioral health approaches: Research, practices and policy* [PowerPoint slides]. Retrieved from <http://www.healthinschools.org/Publications-and-Resources/Presentations-by-CHHCS-Staff-and-Colleagues.aspx>.
- 666 The President’s New Freedom Commission on Mental Health. (2009). *Achieving the promise: Transforming mental health care in America*. Retrieved from http://www.samhsa.gov/federalactionagenda/NFC_intro.aspx
- 667 Texas Mental Health Transformation. (2009). *Texas school-based behavioral health survey - results and recommendations*. Retrieved from http://www.mhtransformation.org/documents/pdf/sbbh/SBBH_Report_FINAL_10.2.09.pdf
- 668 Texas Education Code, tit. 2, subtitle F, Chapter 33, Subchapter A. § 33.006(a). (2013). Retrieved from <http://www.statutes.legis.state.tx.us/Docs/ED/htm/ED.33.htm#33.000>.
- 669 Texas Education Agency. (2014). *Staff FTE counts and salary reports: 2013-2014 Statewide totals* [Data file]. Retrieved from <http://ritter.tea.state.tx.us/adhocrpt/adpeb.html>
- 670 Cowell, J. (2013). Mental health services in schools: Issues for implementation. *The Journal of School Nursing*, 29(6), 406.
- 671 Bain, S., Rueda, B., Mata-Villarreal, J., & Mundy, M. (2011). Assessing mental health needs of rural schools in South Texas: Counselors’ perspectives. *Research in Higher Education Journal*, 14, 1-11.
- 672 Ibid.
- 673 Texas Appleseed. (2009). *Breaking rules, breaking budgets: Cost of exclusionary discipline in 11 Texas school districts*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=867&Itemid=
- 674 Texas Education Agency, Texas Department of Family and Protective Services, & Supreme Court of Texas Permanent Judicial Commission for Children, Youth and Families (Children’s Commission). (2013). *Foster care and student success: Texas systems working together to transform education outcomes of students in foster care*. Retrieved from www.tea.state.tx.us/FosterCareStudentSuccess/resource-guide.pdf
- 675 Swearer, S. M., Wang, C., Maag, J. W., Siebecker, A. B., & Frerichs, L. J. (2012). Understanding the bullying dynamic among students in special and general education. *Journal of School Psychology*, 50(4), 503-520.
- 676 Ibid.
- 677 Cook, C.R., Williams, K.R., Guerra, N.G., Kim, T.E. & Sadek, S. (2010). Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School Psychology Quarterly*, 25(2), 65-83.
- 678 Ttofi, M.M., & Farrington, D.P. (2011). Effectiveness of school-based programs to reduce bullying: A systematic and meta-analytic review. *Journal of Experimental Criminology*, 7, 27-56.
- 679 National Council for Behavioral Health. (n.d.) *Mental Health First Aid USA*. Retrieved from <http://www.mentalhealthfirstaid.org/cs/>
- 680 Robers, S., Kemp, J., Rathbun, A., & Morgan, R.E. (2014). Indicators of school crime and safety: 2013 (NCES 2014-042/NCJ 243299). National Center for Education Statistics, U.S. Department of Education, Bureau of Justice Statistics, Office of Justice Programs, and U.S. Department of Justice. Washington, DC.
- 681 Gaines, S. (2014). *Presentation to the Senate Health and Human Services Committee on mental health coordination* [PowerPoint slides]. Retrieved from Texas Health and Human Services Commission website: <http://www.hhsc.state.tx.us/news/present83.asp>.
- 682 Lakey, D. (2014). *Presentation to Senate Health and Human Services Committee: Overview mental health and substance abuse services* [PowerPoint slides].
- 683 Ibid.
- 684 Texans Care for Children. (2014, March 24). Personal communication: Positive Behavioral Interventions and Supports
- 685 Texans Care for Children. (n.d.). *Education*. Retrieved from <http://texanscareforchildren.org/Texas-Childrens-Mental-Health-Forum/Education>
- 686 U.S. Department of Education Institute of Education Sciences National Center for Education Statistics. (2013, May). *Number and percentage of children served under Individuals with Disabilities Education Act (IDEA), Part B, by age group and state or jurisdiction: Selected years, 1990–91 through 2011–12 (Table 204.70)*. Retrieved from http://nces.ed.gov/programs/digest/d13/tables/dt13_204.70.asp
- 687 Ibid.
- 688 Texas Education Agency: Division of Research and Analysis Department of Assessment and Accountability. (2012). *Enrollment in Texas public schools 2011-12*. Retrieved from http://www.tea.state.tx.us/acctres/enroll_index.html
- 689 Scull, J. & Winkler, A. M. (2011). *Shifting trends in special education*. Retrieved from Thomas B. Fordham Institute website http://www.edexcellencemedia.net/publications/2011/20110525_ShiftingTrendsInSpecialEducation/ShiftingTrendsInSpecialEducation.pdf
- 690 New America Foundation. (2014). *Individuals with Disabilities Education Act-funding distribution*. Retrieved from <http://febp.newamerica.net/background-analysis/individuals-disabilities-education-act-funding->

- distribution
- 691 Ibid.
- 692 Ibid.
- 693 New America Foundation. (2013). *Individuals with Disabilities Education Act – cost impact on local school districts*. Retrieved from <http://febp.newamerica.net/background-analysis/individuals-disabilities-education-act-cost-impact-local-school-districts>
- 694 Ibid.
- 695 Texas Education Agency. (2013). *School health and related services (SHARS)*. Retrieved from <http://www.tea.state.tx.us/index2.aspx?id=4456>
- 696 Ibid.
- 697 Ibid.
- 698 Texas Education Agency. (2013). *Services for Texas students with disabilities ages 3-5*. Retrieved from <http://www.tea.state.tx.us/index4.aspx?id=2147494988>
- 699 Texas Education Agency. (2014). *Special education reports: 2013-2014 Statewide totals* [Data file]. Retrieved from <http://ritter.tea.state.tx.us/adhocrpt/adser.html>
- 700 Wagner, M. M. (1995). Outcomes for youth with serious emotional disturbance in secondary school and early adulthood. *The Future of Children*, (5)2, 90-112.
- 701 Education Assistance to States for the Education of Children with Disabilities Rule, 34 C.F.R. § 300.8 (2007). Retrieved from <http://www.gpo.gov/fdsys/pkg/CFR-2007-title34-vol2/pdf/CFR-2007-title34-vol2-part300.pdf>
- 702 Texas Education Agency. (2013). *Services for Texas students with disabilities ages 3-5*. Retrieved from <http://www.tea.state.tx.us/index4.aspx?id=2147494988>
- 703 Education Assistance to States for the Education of Children with Disabilities Rule, 34 C.F.R. § 300.8 (2007). Retrieved from <http://www.gpo.gov/fdsys/pkg/CFR-2007-title34-vol2/pdf/CFR-2007-title34-vol2-part300.pdf>
- 704 Texas Education Agency. (2012). *Counseling and mental health services of the Coordinated School Health Model*. Retrieved from <http://www.tea.state.tx.us/CounselingMentalHealth.html>
- 705 Texas Department of State Health Services. (2012). *Coordinated School Health*. Retrieved from <http://www.dshs.state.tx.us/schoolhealth/csh.shtm>
- 706 Texas Education Agency. (2014). *Communities in Schools of Texas*. Retrieved from <http://www.tea.state.tx.us/index3.aspx?id=4639>
- 707 Ibid.
- 708 Ibid.
- 709 Ibid.
- 710 Legislative Reference Library. (2011). *Conference Committee report 3rd printing H.B. No. 1 General Appropriations Bill*. Retrieved from http://www.lrl.state.tx.us/scanned/ApproBills/82_0/82_R_ALL.pdf
- 711 General Appropriations Act for the 2014-15 Biennium. (2013). *Text of Conference Committee report on Senate Bill No. 1*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2014-15.pdf
- 712 Texas Education Agency. (2014). *Communities in Schools of Texas*. Retrieved from <http://www.tea.state.tx.us/index3.aspx?id=4639>
- 713 Behrens, D., Lear, J.G. & Price, O.A. (2013). *Improving access to children's mental health care: Lessons from a study of eleven states*. Retrieved from Robert Wood Johnson Foundation website: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404627>.
- 714 Texans Care for Children. (n.d.). *Child mental wellbeing*. Retrieved from http://txchildren.org/Images/Interior/reports/child_mental_wellbeing.pdf
- 715 Texas Behavior Support Network. (n.d.). *Texas Positive Behavioral Interventions and Support Project*. Retrieved from <http://www.txbehaviorsupport.org/default.aspx?name=pbs.mission>
- 716 Texas Behavior Support Network. (n.d.). *About PBIS*. Retrieved from <http://www.txbehaviorsupport.org/default.aspx?name=about.history>
- 717 Texans Care for Children. (n.d.). *Child mental wellbeing*. Retrieved from http://txchildren.org/Images/Interior/reports/child_mental_wellbeing.pdf
- 718 Texas Behavior Support Network. (n.d.). *Texas Positive Behavioral Interventions and Support Project*. Retrieved from <http://www.txbehaviorsupport.org/default.aspx?name=pbs.mission>
- 719 Texans Care for Children. (n.d.). *Child mental wellbeing*. Retrieved from http://txchildren.org/Images/Interior/reports/child_mental_wellbeing.pdf
- 720 Texans Care for Children. (2013, March 13). Personal communication: Positive Behavior Intervention Support
- 721 Texas Appleseed. (2009). *Breaking rules, breaking budgets: Cost of exclusionary discipline in 11 Texas school districts*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=867&Itemid=
- 722 Ibid.
- 723 Ibid.
- 724 Ibid.
- 725 Ibid.
- 726 Ibid.
- 727 Department of Social and Emotional Learning. (n.d.) *Social and emotional learning first*. <https://www.austinisd.org/academics/sel>

- 728 Ibid.
- 729 Ibid.
- 730 National Scientific Council on the Developing Child. (2010). *Persistent fear and anxiety can affect young children's learning and development: Working paper No. 9*. <http://www.developingchild.net>
- 731 Ibid.
- 732 Substance Abuse and Mental Health Administration. (n.d.) *Trauma-informed care and trauma-informed services*. Retrieved from <http://beta.samhsa.gov/nctic/trauma-interventions>
- 733 Ibid.
- 734 Ibid.
- 735 Texas Appleseed. (2007). *Texas' school-to-prison pipeline: Dropout to incarceration*. Retrieved from <http://www.texasappleseed.net/pdf/Pipeline percent20Report.pdf>
- 736 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 737 Ibid.
- 738 Ibid.
- 739 Ibid.
- 740 Ibid.
- 741 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 742 Justice Center, Council of State Governments, and the Public Policy Institute at Texas A & M University. (2011). *Breaking school rules: A statewide study of how school discipline relates to student success and juvenile justice involvement*. Retrieved from The Council of State Governments website: <http://justicecenter.csg.org/resources/juveniles>
- 743 Texas Appleseed. (2010, April). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 744 Texas Appleseed. (2009, January). *When my child is disciplined at school: A guide for families*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_view&gid=60&Itemid
- 745 Tex Edu Code, titl. 2, subtitle G., chapter 37, subchapter A. § 37.005 (2003). Retrieved from www.statutes.legis.state.tx.us/Docs/ED/htm/ED.37.htm
- 746 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 747 Children at Risk, Disability Rights Texas, National Center for Youth Law, Texas, Appleseed, & Thurgood Marshall School of Law's Earl Carl Institute. (2012). *30 Texas school districts disproportionately reply on out of school suspension: Leaving money behind and pushing students out of school*. Retrieved from Disability Rights Texas website <https://www.disabilityrightstx.org/files/JointOSSReportAug7-2012.pdf>
- 748 Equity Center. (n.d.) *School finance glossary (average daily attendance)*. Retrieved from <http://www.equitycenter.org/resources/school-finance-glossary>
- 749 Tex Edu Code, titl. 2, subtitle G., chapter 37, subchapter A. § 37.008 (2011). Retrieved from www.statutes.legis.state.tx.us/Docs/ED/htm/ED.37.htm
- 750 Texas Appleseed. (2007, October). *Texas' school-to-prison pipeline: Dropout to incarceration*. Retrieved from <http://www.texasappleseed.net/pdf/Pipeline percent20Report.pdf>
- 751 Tex Edu Code, titl. 2, subtitle G., chapter 37, subchapter A. § 37.008 (2011). Retrieved from www.statutes.legis.state.tx.us/Docs/ED/htm/ED.37.htm
- 752 Justice Center, Council of State Governments, and the Public Policy Institute at Texas A & M University. (2011). *Breaking school rules: A statewide study of how school discipline relates to student success and juvenile justice involvement*. Retrieved from The Council of State Governments website: <http://justicecenter.csg.org/resources/juveniles>
- 753 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 754 Texas Education Agency. (2012). Appendix E: Additional information related to discipline. *2011-2012 PEIMS Data Standard*. Retrieved from http://www.tea.state.tx.us/chapter37_reporting.html
- 755 Texas Appleseed. (2007). *Texas' school-to-prison pipeline: Dropout to incarceration*. Retrieved from <http://www.texasappleseed.net/pdf/Pipeline percent20Report.pdf>
- 756 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of DAEP and JJAEP placement reason types* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 757 Justice Center, Council of State Governments, and the Public Policy Institute at Texas A & M University. (2011). *Breaking school rules: A statewide study of how school discipline relates to student success and juvenile justice involvement*. Retrieved from The Council of State Governments website: <http://justicecenter.csg.org/resources/juveniles>
- 758 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_

- download&gid=380&Itemid
- 759 Ibid.
- 760 Texas Juvenile and Justice Department. (n.d.). *JJAEP programming*. Retrieved from <http://www.tjjd.texas.gov/services/jjaep.aspx>
- 761 Tex Edu Code titl. 2, subtitle G., chapter 37, subchapter A. § 37.008 (2011). Retrieved from www.statutes.legis.state.tx.us/Docs/ED/htm/ED.37.htm
- 762 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 763 Juvenile Justice Alternative Education Program. (2014). *Performance assessment report school year 2012-2013*. Retrieved from http://www.tjjd.texas.gov/publications/reports/JJAEP_2013_Report.pdf
- 764 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 765 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 766 Ibid.
- 767 Ibid.
- 768 Texas Education Agency. (2013). *Discipline Data Products: 2012-2013 counts of DAEP and JJAEP placement reason types* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 769 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to Dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 770 Ibid.
- 771 Ibid.
- 772 Texas Education Agency. (2012). Appendix E: Additional information related to discipline. *2011-2012 PEIMS Data Standard*. Retrieved from http://www.tea.state.tx.us/chapter37_reporting.html
- 773 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from Lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 774 Texas Education Agency. (2013). *Discipline data products: 2012-2013 counts of students and discipline actions by discipline action groupings* [Data file]. Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html
- 775 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 776 Ibid.
- 777 Texas Appleseed. (2007). *Texas' school-to-prison pipeline: Dropout to incarceration*. Retrieved from [http://www.texasappleseed.net/pdf/Pipeline percent20Report.pdf](http://www.texasappleseed.net/pdf/Pipeline%20Report.pdf)
- 778 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: School expulsion –the path from lockout to dropout*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid
- 779 Ibid.
- 780 Thevenot, B. (2010, June 2). School district cops ticket thousands of students. *Texas Tribune*. Retrieved from <http://www.texastribune.org/texas-education/public-education/school-district-cops-ticket-thousands-of-students/>
- 781 Serrano, J. (2013, August 29). School officers can no longer issue on-campus citations. *Texas Tribune*. Retrieved from the <http://www.texastribune.org/2013/08/29/class-disruption-cases-head-principals-office-not-/>
- 782 Texas Appleseed. (2010). *Texas' school-to-prison pipeline: Ticketing, arrests, and use of force in schools*. Retrieved from http://www.texasappleseed.net/images/stories/reports/Ticketing_Booklet_web.pdf
- 783 Ibid.
- 784 Serrano, J. (2013, August 29). School officers can no longer issue on-campus citations. *Texas Tribune*. Retrieved from the <http://www.texastribune.org/2013/08/29/class-disruption-cases-head-principals-office-not-/>
- 785 Texas Appleseed. (2013). *School ticketing implementation guide*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=990&Itemid=
- 786 Tex Edu Code titl. 2 subtitle E., chapter 25., subchapter A. § 25.094 (2011). Retrieved from <http://www.statutes.legis.state.tx.us/Docs/ED/htm/ED.25.htm>
- 787 Fowler, D. (2013). *Criminalization of truancy in Texas: Prosecution of "Failure to Attend School" in adult criminal courts*. Retrieved from Texas Appleseed's website: http://texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=934&Itemid
- 788 Ibid.
- 789 Development Services Group, Inc. (2009). *Truancy prevention*. Retrieved from Office of Juvenile Justice and Delinquency Prevention website: http://www.ojjdp.gov/mpg/litreviews/Truancy_Prevention.pdf

790 Ibid.

791 Cumbo, G. L. & Burden, H. (2012). *Truancy reduction: Research, policy, and practice*. Retrieved from The Center for Children & Youth Justice website: http://www.ccyj.org/uploads/PPO/TRUANCY_Updated_July2012.pdf

792 Office of Civil Rights (2006). Civil Rights Data Collection 2006.

793 Greydanus, D.E. et al. (2003). Corporal punishment in schools: Position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health*, 32(5), 385-393.

794 Texas Appleseed. (2010, December). *Texas' school-to-prison pipeline: Ticketing, arrests, and use of force in schools*. Retrieved from http://www.texasappleseed.net/images/stories/reports/Ticketing_Booklet_web.pdf

795 Ibid.

796 National Alliance on Mental Illness. (2011). *Responding to youth with mental health needs: A CIT for youth implementation manual*. Retrieved from http://www.nami.org/Content/NavigationMenu/Find_Support/Child_and_Teen_Support/CIT_for_Youth/CITYouthWorkbook_Web.pdf

797 Texas Appleseed. (2010) *Texas' school-to-prison pipeline: Ticking, arrest & use of force in schools* Retrieved from <http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll4/id/3722>

798 Ibid.

799 Texas Appleseed. (2012). *Breaking rules, breaking budgets: Cost of school discipline in 11 Texas school districts*. Retrieved from http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=867&Itemid=

800 Ibid.

801 Ibid.

802 Ibid.

803 Meckel, R.D., & Campetella, M. A. (2013) *Restorative discipline program in San Antonio middle school reduces student suspensions*. Retrieved from The University of Texas at Austin website: <http://www.utexas.edu/news/2013/12/17/restorative-discipline-san-antonio/>

804 Ibid.

805 Texas Department of Housing and Community Affairs. (2012). *Agency strategic plan for the fiscal years 2013-17 Period*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/12-stratplanFY13-17.pdf>

806 U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2011). *The 2010 annual homeless assessment report to congress*. Retrieved from <http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf>

807 Social Security Administration. (n.d.). *Understanding Supplemental Security Income SSI benefits – 2014 edition*. Retrieved from <http://www.socialsecurity.gov/ssi/text-benefits-ussi.htm>

808 Cooper, E., O'Hara, A. Singer, N., & Zovistoski, A. (2013). *The housing crisis for people with disabilities*. Retrieved from Technical Assistance Collaborative website: <http://www.tacinc.org/media/33368/PricedOut2012.pdf>

809 Texas Department of Housing and Community Affairs. (2014, August 14). Personal communication: Project Access Program

810 Texas Department of Housing and Community Affairs. (2014). *2014 State of Texas low income housing plans and annual report*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>

811 Texas Department of Housing and Community Affairs. (n.d.). *Section 811 project rental assistance program*. Retrieved from <http://www.tdhca.state.tx.us/section-811-pra/index.htm>

812 U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2011). *The 2010 annual homeless assessment report to congress*. Retrieved from <http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf>

813 National Coalition for the Homeless. (2006). *Mental illness and homelessness* (NCH Fact Sheet #5). Retrieved from http://www.nationalhomeless.org/publications/facts/Mental_Illness.pdf

814 Texas Department of Housing and Community Affairs. (2012). *Agency strategic plan for the fiscal years 2013-17 period*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/12-stratplanFY13-17.pdf>

815 Mental Health America. (2007). *10-year retrospective study shows progression in American attitudes about depression and other mental health issues*. Retrieved from <http://www.fauquier-mha.com/docs/TenYear.pdf>

816 National Alliance on Mental Illness. (n.d.). *Schizophrenia survey analysis: Public attitudes*. Retrieved from http://www.nami.org/Content/NavigationMenu/SchizophreniaSurvey/Analysis_Public_Attitudes.htm

817 Stuart, H. (2003). Violence and mental illness: An overview. *World Psychiatry*, 2(2), 121-124.

818 Insel, T. (2011). *Understanding Severe Mental Illness*. Retrieved from National Institute of Mental Illness website: <http://www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml>

819 Steffen, B. L. (2013). Worst case housing needs 2011: Report to congress. Retrieved from U.S. Department of Housing and Urban Development website: http://www.huduser.org/portal/Publications/pdf/HUD-506_WorstCase2011_reportv3.pdf

820 Texas Department of Housing and Community Affairs. (n.d.). *Tenant-based rental assistance (TBRA) program*. Retrieved from <http://www.tdhca.state.tx.us/home-division/tbra.htm>

821 Texas Administrative Code, tit. 10, part 1, rule §1.11. (2010). Definition of service-enriched housing. Retrieved from [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.viewtac](http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac)

822 Substance Abuse and Mental Health Services Administration. (2013). *Strategic initiative #4: Recovery support*. Retrieved from <http://store.samhsa.gov/shin/content/SM11-4629/06-RecoverySupport.pdf>

823 Schwartz, M., Wilson, E. (n.d.). *Who can afford to live in a home?: A look at data from the 2006 American Community Survey*. Retrieved from US Census Bureau website: <http://www.census.gov/housing/census/>

- publications/who-can-afford.pdf
- 824 Texas Department of Housing and Community Affairs. (2014). *2014 State of Texas low income housing plans and annual report*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 825 Ibid.
- 826 Ibid.
- 827 Texas Department of Housing and Community Affairs. (2012). *Legislative appropriations request for fiscal years 2014-2015*.
- 828 Social Security Administration. (n.d.). *Understanding Supplemental Security Income SSI benefits – 2014 edition*. Retrieved from <http://www.socialsecurity.gov/ssi/text-benefits-ussi.htm>
- 829 Cooper, E., O'Hara, A. Singer, N., & Zovistoski, A. (2013, May). *The housing crisis for people with disabilities*. Retrieved from Technical Assistance Collaborative website: <http://www.tacinc.org/media/33368/PricedOut2012.pdf>
- 830 Stone, S. (2012). *Frequent utilization of behavioral health services in various service systems: Performance improvement project update*. Paper presented to the Psychiatric Services Stakeholder Committee (part of the Mayor's Mental Health Task Force on Mental Illness, Indicator Improvement Initiative), Central Health, Austin, TX.
- 831 U.S. Department of Housing and Urban Development. (n.d.). *FY 2014 income limits documentation system*. Retrieved from http://www.huduser.org/portal/datasets/il/il2014/2014summary.odn?inputname=STTLT*4899999999 percent2BTexas&selection_type=county&sname=Texas&statefp=48.0&year=2014
- 832 U.S. Department of Housing and Urban Development. (n.d.). *Income limits frequently asked questions*. Retrieved from http://www.huduser.org/portal/datasets/il/il14/FAQs_14.pdf
- 833 U.S. Department of Housing and Urban Development. (n.d.). *FY 2014 income limits documentation system*. Retrieved from http://www.huduser.org/portal/datasets/il/il2014/2014summary.odn?inputname=STTLT*4899999999 percent2BTexas&selection_type=county&sname=Texas&statefp=48.0&year=2014
- 834 Texas Department of Housing and Community Affairs. (2012). *Agency strategic plan for the fiscal years 2013-17 period*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/12-stratplanFY13-17.pdf>
- 835 Ibid.
- 836 Ibid.
- 837 Ibid.
- 838 Ibid.
- 839 Texas Government Code tit. 10, Subtitle G Sub chapter I. § 2306.202(b). (2009). Use of housing trust fund. Retrieved from <http://www.statutes.legis.state.tx.us/Docs/GV/htm/GV.2306.htm#2306.202>
- 840 Texas Secretary of State. (n.d.). What is a colonia? Retrieved from http://www.sos.state.tx.us/border/colonias/what_colonia.shtml
- 841 Texas Department of Housing and Community Affairs. (2012). *Agency strategic plan for the fiscal years 2013-17 period*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/12-stratplanFY13-17.pdf>
- 842 Substance Abuse and Mental Health Services Administration. (2010). *Permanent supportive housing: Evaluating your program* (HHS Publication No. SMA 10-4509). Retrieved from <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf>
- 843 Ibid.
- 844 Department of State Health Services. (2014). *1915(i) Home and Community Based Services – Adult Mental Health (HCBS-AMH)*. Retrieved from <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>
- 845 Texas Department of Housing and Community Affairs. (2014). *2014 state of Texas low income housing plan and annual report*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 846 Ibid.
- 847 Legislative Reference Library of Texas. (2009). *Conference Committee report 3rd printing S.B. No. 1 General Appropriations Bill*. Retrieved from <http://www.lrl.state.tx.us/scanned/archive/2009/14915.pdf>
- 848 Ibid.
- 849 Legislative Reference Library of Texas. (2011). *Conference Committee report 3rd printing H.B. No. 1 General Appropriations Bill*. Retrieved from http://www.lrl.state.tx.us/scanned/ApproBills/82_0/82_R_ALL.pdf
- 850 Legislative Budget Board. (2013). *Conference Committee report 3rd printing S.B. No. 1 General Appropriations Bill*. Retrieved from http://www.lbb.state.tx.us/Appropriations_Bills/83/Conf_Bill.pdf
- 851 Texas Department of Housing and Community Affairs. (2014). *2014 state of Texas low income housing plan and annual report*. <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 852 Ibid.
- 853 Texas Department of Housing and Community Affairs, Texas Department of Agriculture, & Department of State Health Services. (2013). *state of Texas consolidated annual performance and evaluation report reporting on program year 2012*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/13-CAPER.pdf>
- 854 Texas Department of Housing and Community Affairs. (2014). *2014 state of Texas low income housing plans and annual report*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 855 Ibid.
- 856 Ibid.
- 857 Texas Department of Housing and Community Affairs. (2014, August 18). Personal communication: Multifamily HOME Direct Loan Program
- 858 Texas Department of Housing and Community Affairs. (2014). *2014 state of Texas low income housing plan and*

- annual report*. <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 859 Texas Department of Housing and Community Affairs. (2013). *Process for utilizing HOME Tenant-Based Rental Assistance to assist TDHCA's Section 8 Project access clients*. Retrieved from <http://www.tdhca.state.tx.us/section-8/project-access/docs/TBRA-Roadmap.doc>
- 860 Texas Department of Housing and Community Affairs. (n.d.). *Section 8 housing*. Retrieved from <http://www.tdhca.state.tx.us/section-8/>
- 861 U.S. Department of Housing and Urban Development. (n.d.). *FY 2014 state income limits*. Retrieved from http://www.huduser.org/portal/datasets/il/ill4/State_Incomelimits_Report.pdf
- 862 Texas Department of Housing and Community Affairs. (n.d.). *Section 8 housing*. Retrieved from <http://www.tdhca.state.tx.us/section-8/>
- 863 Ibid.
- 864 Texas Department of Housing and Community Affairs. (2014, August 14). Personal communication: Project Access Program
- 865 Texas Administrative Code, tit. 10, part 1, subchapter H, rule §5.801. (2014). Project Access Initiative. [http://info.sos.state.tx.us/pls/pub/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=10&pt=1&ch=5&rl=801](http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=10&pt=1&ch=5&rl=801)
- 866 Texas Department of Housing and Community Affairs. (2014, August 18). Personal communication: Section 8: Project Access Program
- 867 U.S. Department of Housing and Urban Development. (n.d.). *Section 811 Supportive Housing for Persons with Disabilities* Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811
- 868 Texas Department of Housing and Community Affairs. (n.d.). *State of Texas Real Choice Systems Grant*. Retrieved from <http://www.tdhca.state.tx.us/section-811-pra/real-choice/index.htm>
- 869 Ibid.
- 870 Texas Department of Housing and Community Affairs. (2014). 2014 state of Texas low income housing plans and annual report. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/14-SLIHP.pdf>
- 871 Ibid.
- 872 Ibid.
- 873 Ibid.
- 874 Ibid.
- 875 Ibid.
- 876 Ibid.
- 877 Ibid.
- 878 Texas Department of Housing and Community Affairs. (2014, August 18). Personal communication: Amy Young Barrier Program
- 879 U.S. Department of Housing and Urban Development. (n.d.). *Fair housing laws and presidential executive orders*. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/FHLaws
- 880 BBC Research & Consulting (with Morningside Research and Consulting, & Community Solutions). (2013). *State of Texas plan for fair housing choice*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf>
- 881 Manitoba Housing and Renewal Corporation (MHRC). (n.d.). *Visitable housing design*. Retrieved from http://www.gov.mb.ca/housing/pubs/visitable_housing.pdf
- 882 BBC Research & Consulting (with Morningside Research and Consulting, & Community Solutions). (2013, October). *State of Texas plan for fair housing choice*. Retrieved from <http://www.tdhca.state.tx.us/housing-center/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf>
- 883 Ibid.
- 884 U.S. Department of Veterans Affairs. (2014). *Veteran population (as of 9/30/2013)*. Retrieved from http://www.va.gov/vetdata/veteran_population.asp
- 885 U.S. Department of Veterans Affairs. (2013).. *Women veterans health care*. Retrieved from <http://www.womenshealth.va.gov>
- 886 U.S. Department of Veterans Affairs. (2014). *How common is PTSD?* Retrieved from <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp>
- 887 Texas 83rd Texas Legislature. (2013). *H.B. 2392 with Rider 86*. Retrieved from <http://www.legis.state.tx.us/billlookup/text.aspx?LegSess=83R&Bill=HB2392>
- 888 Texas Health and Human Services. (2013). *Mental Health Program for veterans fiscal year 2013 annual report*. Retrieved from <http://www.hhsc.state.tx.us/sunset/docs/V.pdf>
- 889 U.S. Department of Veterans Affairs. (2013). *Veteran population (as of 9/30/2013)*. Retrieved from http://www.va.gov/vetdata/veteran_population.asp
- 890 U.S. Department of Veterans Affairs. (2014). *How common is PTSD?* Retrieved from <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp>
- 891 Ibid.
- 892 Ibid.
- 893 Ibid.
- 894 Ibid.
- 895 Substance Abuse and Mental health Services Administration. (n.d.). *Co-occurring disorders in veterans and military service members*. Retrieved from <http://media.samhsa.gov/co-occurring/topics/military/index.aspx>

- 896 Kemp, J., & Bossarte, R. (2012). *Suicide data report, 2012*. Retrieved from U.S. Department of Veterans Affairs website: <http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf>
- 897 Williamson, V., & Mulhall, E. (2009). *Invisible wounds: Psychological and neurological injuries confront a new generation of veterans*. Retrieved from Iraq and Afghanistan Veterans of America website: http://iava.org/files/IAVA_invisible_wounds_0.pdf
- 898 U.S. Department of Veterans Affairs, Office of Inspector General. (2012). *Homeless incidence and risk factors for becoming homeless in veterans* (Report No. 11-03428-173). Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-03428-173.pdf>
- 899 Substance Abuse and Mental health Services Administration. (n.d.). *Co-occurring disorders in veterans and military service members*. Retrieved from <http://media.samhsa.gov/co-occurring/topics/military/index.aspx>
- 900 Texas Veterans Commission. (2014). *Welcome to the Texas veterans commission*. Retrieved from <http://www.tvc.state.tx.us/Home.aspx>
- 901 Texas 83rd Texas Legislature. (2013). *H.B. 2392 with Rider 86*. Retrieved from <http://www.legis.state.tx.us/billlookup/text.aspx?LegSess=83R&Bill=HB2392>
- 902 Texas Health and Human Services. (2013). *Mental Health Program for veterans fiscal year 2013 annual report*. Retrieved from <http://www.hhsc.state.tx.us/sunset/docs/V.pdf>
- 903 Department of State Health Services. (2014). *FY 2014 Legislative update*. Retrieved from <http://www.dshs.state.tx.us/cap/documents/MHSA-Legislative-Update---April-2014.doc>
- 904 Texas Veterans Commission. (2012). *Strategic plan FY 2013 - 2017*. Retrieved from http://www.tvc.state.tx.us/documents/TVC_Strategic_Plan_2012_electronic.pdf
- 905 Ibid.
- 906 Ibid.
- 907 Texas Veterans Commission. (2014). *Claims representation and counseling*. Retrieved from <http://www.tvc.state.tx.us/Claims.aspx>
- 908 U.S. Department of Veterans Affairs. (2012). *Federal benefits for veterans: Dependents and survivors, 2012 Edition*. Retrieved from http://www.va.gov/opa/publications/benefits_book/2012_Federal_benefits_ebook_final.pdf
- 909 Ibid.
- 910 Texas Veterans Commission. (2014). *Service-connected compensation*. Retrieved from <http://www.tvc.texas.gov/Service-Connected-Compensation.aspx>
- 911 Texas Veterans Commission. (2014). *Non-service connected pension*. Retrieved from <http://www.tvc.texas.gov/Non-Service-Connected-Pension.aspx>
- 912 Ibid.
- 913 U.S. Department of Veterans Affairs. (2012). *Federal benefits for veterans: Dependents and survivors, 2012 Edition*. Retrieved from http://www.va.gov/opa/publications/benefits_book/2012_Federal_benefits_ebook_final.pdf
- 914 U.S. Department of Veterans Affairs. (2014). *VA benefits & health care utilization*. Retrieved from http://www.va.gov/vetdata/docs/NCVAS_pocket_card.pdf
- 915 U.S. Department of Veterans Affairs. (2009). *Facts about the Department of Veterans Affairs*. Retrieved from http://www.va.gov/opa/publications/factsheets/fs_department_of_veterans_affairs.pdf
- 916 U.S. Department of Veterans Affairs. (2014). *VA benefits & health care utilization*. Retrieved from http://www.va.gov/vetdata/docs/NCVAS_pocket_card.pdf
- 917 Kukla, M., & Bonfils, K. (n.d.). *Barriers and facilitators to competitive employment in veterans with mental illness: A veteran-focused mixed methods study*. Retrieved from Indiana University-Purdue University Indianapolis, ACT Center of Indiana website: [http://www.psych.iupui.edu/ACT/Report percent20Card/BarriersandfacilitatorstocompetitiveemploymentinveteranswithmentalillnessAveteran-focu.html](http://www.psych.iupui.edu/ACT/Report%20percent20Card/BarriersandfacilitatorstocompetitiveemploymentinveteranswithmentalillnessAveteran-focu.html)
- 918 U.S. Department of Veterans Affairs. (2014). *Federal benefits for veterans, dependents and survivors*. Retrieved from http://www.va.gov/opa/publications/benefits_book/benefits_chap10.asp
- 919 Texas Veterans Commission. (2014). *Employment*. Retrieved from <http://www.tvc.texas.gov/Employment.aspx>
- 920 Ibid.
- 921 Texas Veterans Commission. (2014). *Fund for veterans' assistance*. Retrieved from <http://www.tvc.texas.gov/Fund-for-Veterans-Assistance.aspx>
- 922 Ibid.
- 923 Ibid.
- 924 Texas Veterans Commission. (2014). *Veterans mental health grants*. Retrieved from <http://www.tvc.texas.gov/Veterans-Mental-Health-Grants.aspx>
- 925 Texas Veterans Commission. (2014). *About us*. Retrieved from <http://www.tvc.texas.gov/About-Us.aspx>
- 926 Ibid.
- 927 U.S. Department of Veterans Affairs. (2014). *Women veterans health care*. Retrieved from <http://www.womenshealth.va.gov>
- 928 Mulhall, E. (2009). *Women warriors: Supporting she who has borne the battle*. Retrieved from Iraq and Afghanistan Veterans of America website: http://media.iava.org/IAVA_WomensReport_2009.pdf
- 929 Ibid.
- 930 Ibid.
- 931 Ibid.
- 932 Ibid.

- 933 U.S. Department of Veterans Affairs. (2014). *Mental health: Veterans crisis line*. Retrieved from http://www.mentalhealth.va.gov/suicide_prevention/
- 934 Palladino, T. P. (2014). *Texas Veterans Commission presentation to House Committee on County Affairs*. Retrieved from <http://www.legis.state.tx.us/tlodocs/83R/handouts/C2102014031010001/d3532f6b-8127-4d96-9ebc-f8e6410493c8.PDF>
- 935 Deegan, P. (2014, September). *Personal Medicine, Power Statements, and Other Disruptive Innovations*. Plenary presentation at the Hogg Foundation for Mental Health Robert Lee Sutherland Seminar XVIII, Austin, TX. Retrieved from: http://www.hogg.utexas.edu/initiatives/rls_xviii.html
- 936 Isaacs, M. R., Huang, L. N., Hernandez, M., & Echo-Hawk, H. (2005). *The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health*. Washington D.C.: National Alliance of Multi-Ethnic Behavioral Health Associations.
- 937 del Vecchio, P. (2012, March 23). SAMHSA's working definition of recovery updated [Web log post]. Retrieved from <http://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated/#.U-1ItqOFnJY>
- 938 Kaplan, L., (2008). *The role of recovery support services in recovery-oriented systems of care* (DHHS Publication No. SMA 08-4315). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
- 939 Magnabosco, J.L., & Manderscheid, R.W. (2011). *Outcomes measurement in the human services: 2nd edition*. NASW Press: Washington, D.C.
- 940 Ibid.
- 941 Via Hope. (n.d.). *What is a Via Hope Certified Peer Specialist?* Retrieved from <http://www.mhtransformation.org/documents/event-related/Benefits%20of%20Using%20Certified%20Peer%20Specialists.pdf>
- 942 Chinman, M. et al. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services* 65(4): 429-441. <http://ps.psychiatryonline.org/data/Journals/PSS/929915/429.pdf>.
- 943 Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011). *Crisis point: Mental health workforce shortages in Texas*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf
- 944 Hogg Foundation for Mental Health. (2014). *Policy recommendation: Increase access to certified peer specialist/recovery specialist services*.
- 945 Hogg Foundation for Mental Health. (2014, August 11). Data request: Certified Peer Specialist
- 946 Ibid.
- 947 Ibid.
- 948 Department of State Health Services. (2013). *Mental Health Program for Veterans fiscal year 2013 annual report*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589983685>
- 949 Ibid.
- 950 Ibid.
- 951 Ibid.
- 952 Via Hope. (n.d.). *Consumer-Operated Service Provider Institute*. Retrieved from <http://www.viahope.org/programs/consumer-operated-service-provider-institute>
- 953 Cook, J., Copeland, M., Floyd, C., Jonikas, J., Hamilton, M., Razzano, L., ... Boyd, S. (2012). A Randomized Controlled Trial of Effects of Wellness Recovery Action Planning on Depression, Anxiety, and Recovery. *Psychiatric Services*, 63(6), 541-547.
- 954 Substance Abuse and Mental Health Services Administration. (2012). *Action planning for prevention and recovery*. Retrieved from <http://store.samhsa.gov/shin/content/SMA-3720/SMA-3720.pdf>
- 955 Department of State Health Services. (2014). *Recovery-oriented systems of care (ROSC)*. Retrieved from <https://www.dshs.state.tx.us/substance-abuse/ROSC/>
- 956 SAMHSA's National Registry of Evidence-based Programs and Practices, *ICCD Clubhouse Model*. Retrieved from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189>.
- 957 St. Joseph House. (2014, September 29). Personal communication: St. Joseph House's history
- 958 St. Joseph House. (2014, September 25). Personal communication: St. Joseph House's mission
- 959 Magnabosco, J.L., & Manderscheid, R.W. (2011). *Outcomes measurement in the human services: 2nd edition*. NASW Press: Washington, D.C.
- 960 Davidson, L. (2014, September). *What you need to know about the evidence base for mental health recovery*. Plenary presentation at the Hogg Foundation for Mental Health Robert Lee Sutherland Seminar XVIII, Austin, TX. Retrieved from: http://www.hogg.utexas.edu/initiatives/rls_xviii.html
- 961 Davis, S.H. (2010). Outcomes of the implementation of the mental health recovery measure in the DeKalb community service board population. *Public Health Theses*. Paper 91.
- 962 Burgess, P., Pirkis, J., Coombs, T., & Rosen, A. (2010). Review of recovery measures. *Australian Mental Health Outcomes and Classification Network*. Retrieved from http://amhocn.org/static/files/assets/80e8befc/Review_of_Recovery_Measures.pdf
- 963 Khanan, D., McDonald, K., & Williams Neils, C. (2013) *Measuring recovery: A toolkit for mental health providers in New York City*: NYC Department of Health and Mental Hygiene.
- 964 Collins, C., Hewson, D., Munger, R., & Wade, T. (2010). *Evolving models of behavioral health integration in primary care*. New York, NY: Milbank Memorial Fund. Retrieved from <http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf>
- 965 Lopez, M. A. & Stevens-Manser, S. (2014). Texas 1115 Medicaid Demonstration Waiver: A Review of Behavioral Health Projects. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at

- Austin.
- 966 Substance Abuse and Mental Health Services Administration. (2005). *A national review of state and alcohol and drug treatment programs and certification standards for substance abuse counselors and prevention professionals*. Retrieved from http://beta.samhsa.gov/sites/default/files/fbc_i_counselor_standards.pdf
- 967 Substance Abuse and Mental Health Services Administration. (2010). *Addressing the mental health needs of young children and their families* (HHS Publication No. (SMA)-10-4547). Retrieved from <http://store.samhsa.gov/shin/content/SMA10-4547/SMA10-4547.pdf>
- 968 Ibid.
- 969 Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, 62(6). 593-602.
- 970 The Interagency Coordinating Council for Building Healthy Families. (2009). *Findings from the 2008-2009 evaluation of Child Abuse and Neglect Prevention Programs and Services*. Retrieved from http://www.dfps.state.tx.us/documents/HealthyTxFamilies/2009-12-01_ICC_Report.pdf.
- 971 Texas Department of State Health Services. (2011). *Featured prevention resources*. Retrieved from <http://www.dshs.state.tx.us/sa/Prevention/default.shtm>
- 972 The Partnership for a Drug Free Texas. (n.d.). *Partnership for a Drug Free Texas: About us*. Retrieved from <http://www.drugfreetexas.org/about/>
- 973 Hogg Foundation for Mental Health. (n.d.). *Reducing seclusion and restraint in Texas*. Retrieved from http://www.hogg.utexas.edu/initiatives/seclusion_restraint.html
- 974 Ibid.
- 975 Hogg Foundation for Mental Health. (n.d.). *State of Texas alternatives to restraint and seclusion (STARS) project: Abstract*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/stars_project.pdf
- 976 Texas Department of State Health Services. (2011). *Creating a culture of care: A toolkit for creating a trauma-informed environment*. Retrieved from www.dshs.state.tx.us/cultureofcare/toolkit.doc
- 977 Hogg Foundation for Mental Health. (2013). *Seclusion and restraint reduction initiative: Evaluation executive summary*. Retrieved from: http://www.hogg.utexas.edu/uploads/documents/SRRIEval_FINAL.pdf
- 978 SAMHSA's National Registry of Evidence-based Programs and Practices. (2014). *Six Core Strategies To Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint*. Retrieved from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=278>
- 979 Substance Abuse and Mental Health Services Administration. (2012). *Trauma definition: Part one: Defining trauma*. Retrieved from <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>.
- 980 Michelfelder, M., & Swoboda, E. (2012). *Trauma 101* [PowerPoint slides]. Retrieved from The Trauma Informed Care Project website: <http://www.traumainformedcareproject.org/resources/Trauma%20101%20Powerpoint%20PresentationV1.pdf>
- 981 Substance Abuse and Mental Health Services Administration. (2012, December). *Trauma definition: Part Two: Approach*. Retrieved from <http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx>
- 982 Ibid.
- 983 Substance Abuse and Mental Health Services Administration. (2014). *Trauma-informed approach and trauma-specific interventions*. Retrieved from <http://beta.samhsa.gov/nctic/trauma-interventions>
- 984 Department of State Health Services. (2013). *Mental Health Program for Veterans fiscal year 2013 annual report*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589983685>
- 985 Ibid.
- 986 Ibid.
- 987 Ibid.
- 988 Ibid.
- 989 Hogg Foundation for Mental Health. (2014, August 26). Personal communication: Trauma-informed approach
- 990 Ibid.
- 991 Hogg Foundation for Mental Health. (2010). *Trauma-informed care*. Retrieved from http://www.hogg.utexas.edu/uploads/documents/Trauma_Inform_Care_091410.pdf
- 992 Hogg Foundation for Mental Health. (2011). *Texas 82nd Legislative Session: Summary of mental health-related legislation*. Retrieved from <http://www.hogg.utexas.edu/uploads/documents/Hogg%20Foundation%20Legislative%20Summary%202011.pdf>
- 993 Center for Mental Health Services National GAINS Center. (2007). *Practical advice on jail diversion: Ten years of learnings on jail diversion from the CHMS National GAINS Center*. Retrieved from http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf
- 994 Ibid.
- 995 Ibid.
- 996 Ibid.
- 997 Ibid.
- 998 Substance Abuse and Mental Health Services Administration's GAINS Center for Behavioral Health and Justice Transformation. (n.d.). *What is jail diversion?* Retrieved from http://gainscenter.samhsa.gov/topical_resources/jail.asp
- 999 *Dusky v. U.S.*, 362 U.S. 402 (1960); *Drope v. Missouri*, 420 U.S. 162 (1975).
- 1000 Ibid.
- 1001 Legislative Budget Board. (2013). *Texas state government effectiveness and efficiency report: Selected issues*

- and recommendations. Retrieved from <http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202012.pdf>.
- 1002 Texas Department of State Health Services. (2010). *Mental Health and Substance Abuse Division Continuity of Care Task Force report*. Retrieved from <http://www.dshs.state.tx.us/layouts/contentpage.aspx?pageid=35959&id=67427&terms=jail+diversion>
 - 1003 Maples, M. D. (n.d.). *Presentation: Overview of the mental health system* [PowerPoint Slides]. Retrieved from Texas Department of State Health Services website: <http://wwwprod.dshs.state.tx.us/legislative/82nd/DSHS-HHSC-combined-MHOverview.pdf>
 - 1004 Texas Department of State Health Services. (2014, August). Personal communication: Outpatient competency restoration
 - 1005 Hogg Foundation for Mental Health. (2014). *Outpatient Competency Restoration evaluation report*.
 - 1006 Wotring, J. & Stroul, B. (2011). *The intersect of health reform and systems of care for children and youth with mental health and substance abuse conditions and their families* (Issue Brief). Washington, DC: Georgetown University Center for Child and Human Development & National Technical Center for Children's Mental Health.
 - 1007 Texas System of Care. (2013). *System of care expansion planning grantee final report*. Retrieved from <http://www.txsystemofcare.org/wp-content/uploads/2014/01/ASSET-Final-Report.pdf>
 - 1008 Ibid.
 - 1009 American Psychiatric Association. (2014). *Telepsychiatry*. Retrieved from <http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry>
 - 1010 Ibid.
 - 1011 Ibid.
 - 1012 American Telemedicine Association. (2013). *Examples of research outcomes: Telemedicine's impact on healthcare cost and quality*. Retrieved from <http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine%27s-impact-on-healthcare-cost-and-quality.pdf>
 - 1013 Ibid.
 - 1014 Ibid.
 - 1015 Novotney, A. (2011). A new emphasis on telehealth. *Monitor on Psychology*, 42(6), 40. Retrieved from <http://www.apa.org/monitor/2011/06/telehealth.aspx>
 - 1016 Statewide Health Coordinating Council. (n.d.). Texas state health plan 2011-2016. Retrieved from www.dshs.state.tx.us/chs/shcc/reports/SHP2011-2016/
 - 1017 Texas Health and Human Services Commission. (2012). *Telemedicine medical services: Biennial report to the Texas Legislature*. Retrieved from <http://www.hhsc.state.tx.us/reports/2013/SB789-Telemedicine.pdf>
 - 1018 Statewide Health Coordinating Council. (n.d.). Texas state health plan 2011-2016. Retrieved from www.dshs.state.tx.us/chs/shcc/reports/SHP2011-2016/
 - 1019 Center for Disease Control and Prevention. (2014). *2011, United States suicide injury deaths and rate per 100,000: All races, both sexes, all ages* [Data file]. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html
 - 1020 Consortium for Risk-Based Firearm Policy. (2013). *Guns, public health and mental illness: An evidence-based approach for federal policy* Retrieved from <http://www.efsgv.org/wp-content/uploads/2014/02/Final-Federal-Report.pdf>
 - 1021 Texas Department of State Health Services. (2014). *ICD-10 death statistics for the state of Texas* [Data file]. Retrieved from <http://soupfin.tdh.state.tx.us/death10.htm>
 - 1022 Texas Department of State Health Services. (2014). *Table 17 five leading causes of death by sex and age Texas residents* [Data file]. Retrieved from <http://www.dshs.state.tx.us/chs/vstat/vs12/t17.shtm>
 - 1023 Hellsten, J. (2011). An overview of Texas suicide [PowerPoint slides]. Retrieved from Texas Department of State Health Services website: www.dshs.state.tx.us/injury/data/suicide-overview/
 - 1024 National Alliance on Mental Illness. (2013). *Suicide fact sheet*. Retrieved from http://www.nami.org/factsheets/suicide_factsheet.pdf
 - 1025 Texas Department of State Health Services. (2014). *Table 17 five leading causes of death by sex and age Texas residents* [Data file]. Retrieved from <http://www.dshs.state.tx.us/chs/vstat/vs12/t17.shtm>
 - 1026 National Alliance on Mental Illness. (2013). *Suicide fact sheet*. Retrieved from http://www.nami.org/factsheets/suicide_factsheet.pdf
 - 1027 Texas Department of State Health Services. (2013). *Texas suicide prevention*. Retrieved from: <http://www.dshs.state.tx.us/mhsa/suicide/Suicide-Prevention.aspx>
 - 1028 United States Interagency Council on Homelessness. (2013). *Housing First*. Retrieved from http://usich.gov/usich_resources/solutions/explore/housing_first/.
 - 1029 Roman, N., & Stand, L. (2012). Housing First. *Shelterforce: The Journal of Affordable Housing and Community Building*, Spring 2012. Retrieved from http://www.shelterforce.org/article/2755/housing_first/.
 - 1030 Ibid.
 - 1031 Substance Abuse and Mental Health Services Administration. (2010). *Permanent supportive housing: Evaluating your program* (HHS Publication No. SMA 10-4509). Retrieved from <http://store.samhsa.gov/shin/content/SMA10-4510/SMA10-4510-05-EvaluatingYourProgram-PSH.pdf>
 - 1032 Department of State Health Services. (2014). *1915(i) Home and Community Based Services – Adult Mental Health (HCBS-AMH)*. Retrieved from <http://www.dshs.state.tx.us/mhsa/hcbs-amh/>
 - 1033 Oxford House, Inc. (2014). *Annual report fiscal year 2013*. Retrieved from <http://www.oxfordhouse.org/userfiles/file/doc/ar2013.pdf>

- 1034 SAMHSA's National Registry of Evidence-based Programs and Practices, *Oxford House Model*. Retrieved from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=223>.
- 1035 Oxford House, Inc. (2009). *Annual report fiscal year 2008*. Retrieved from <http://www.oxfordhouse.org/userfiles/file/doc/ar2008.pdf>
- 1036 Texas Department of State Health Services. (2013). *Texas FY2014–2015 combined Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) behavioral health assessment and intended use plan*. Retrieved from <http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589979883>
- 1037 Department of State Health Services. (2014, May 1). Personal communication: Oxford Houses in Texas
- 1038 Oxford House, Inc. (2014, May 1). Personal communication: Oxford house
- 1039 Oxford House, Inc. (2014). *Annual report fiscal year 2013*. Retrieved from <http://www.oxfordhouse.org/userfiles/file/doc/ar2013.pdf>

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

