



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

5th Edition – 2020



Hogg Foundation
for Mental Health

HOGG FOUNDATION FOR MENTAL HEALTH

Established in 1940, the Hogg Foundation for Mental Health envisions a future in which the people of Texas thrive in communities that support mental health and well-being. Using a variety of approaches, including grantmaking, convening, research, and public policy, the foundation works collaboratively to transform how communities promote mental health in everyday life. We believe that mental health is not solely an individual responsibility, but is also a product of community conditions. The places where people live, learn, work, play, and pray can have a significant impact on improving mental health.

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 and wellness in Texas. Other donors have established smaller endowments at the foundation to support its mission. To learn more, visit www.hogg.utexas.edu.

SPECIAL NOTE

The information in this guide related to the COVID-19 pandemic is as up-to-date as possible at the time of writing. We are aware that this situation and resulting data are changing on a daily basis.

LANGUAGE USAGE

Behavioral health is the term typically used when referring to mental health and substance use. The foundation acknowledges the ongoing discussion and differing perspectives about utilizing the terms “behavioral health” and “mental health.” In this document, the term “behavioral health” is sometimes used when referring to both mental health and substance use. Our belief is that whether referring to mental health, substance use, or behavioral health, the goal is recovery for the individual and wellness for the community.

Additionally, in our discussions on racism, disparities, and inequities, we have attempted to use the most appropriate language associated with the topic. We recognize that the use of language in these areas is fluid and that personal and organizational preferences may differ. Our intent is to be respectful and person-centered in our language usage.

Dedication

This guide is dedicated to the millions of individuals and families affected by the COVID-19 pandemic. We honor the suffering you are experiencing and express our heartfelt sympathy. We encourage you to seek out the mental health support you need to help you through this period of immense grief.

Additionally, we dedicate this guide to people of color who have for too long experienced the institutional racism that permeates our society. We promise to continue to work towards improving the mental health and wellness of people of color and work towards eliminating disparities and inequities in our state and community systems of treatment, supports, and services.

ABOUT THE GUIDE

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The Hogg Foundation for Mental Health 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 guide is available at www.hogg.utexas.edu.

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HHSC Blueprint for a Healthy Texas

In October 2019, HHSC unveiled the Texas Health and Human Services (HHS) *Blueprint for a Healthy Texas*, an inaugural business plan outlining their fiscal plan, goals, and initiatives. The plan is presented as a guide for long-term improvement and encompasses 12 initiatives and 72 goals for HHSC and the Department of State

Health Services (DSHS). According to HHSC, these are intended to improve operations, customer service, and workplace culture.¹

However, it is the conviction of the Hogg Foundation for Mental Health that until issues of health disparities and racial inequities are made a priority and are addressed systemically, a healthy Texas will not be possible.

During the 2020-21 biennium, the Texas Legislature appropriated \$78.5 billion to the HHS system. HHSC will receive the bulk of these funds, \$76.8 billion, while \$1.7 billion will go toward DSHS. The plan is a framework that prioritizes and guides HHS work beginning in fiscal year 2020. Additionally, it sets forth strategies for how agency divisions will accomplish each initiative's respective goals.

According to HHS, the 12 initiatives in the plan were identified through feedback received from service recipients, legislators, providers, HHS team members, and partners over the preceding year. The plan is structured to work across HHS organizational lines in effort to address system-wide areas for improvement and transformational growth.

HHS has identified a framework of five commitments that serve as the foundation for the plan's content. Each initiative, goal, measure, and deliverable focuses on one or more of the following:

- Efficiency, effectiveness, and process improvement
- Protecting vulnerable Texans

Note: This section uses various terminology to discuss race/ethnicity, based on the source of data that is cited. The language used often reflects the research and studies. In addition, this section uses the term "Latinx" in place of "Latino", as it is a more gender-neutral term. We recognize the existence of diverse preferences for language usage. Our intent is to respect the diversity of people and opinions.

- Improving the health and well-being of Texans
- Integrity, transparency, and accountability
- Customer service and dynamic relationships

HHS outlines their 2020 initiatives as:

1. Behavioral Health: Enhance Behavioral Health Care Outcomes
 - Goal 1: Expand capacity for community-based behavioral health services
 - Goal 2: Reduce negative health outcomes associated with opioid use
 - Goal 3: Increase access to state psychiatric hospitals
 - Goal 4: Transition to step-down options
2. Disabilities: Increase Independence and Positive Outcomes for People with Disabilities
3. Health & Safety: Improve Regulatory Processes that Protect Texans
4. Medicaid Managed Care: Improve Quality and Strengthen Accountability
5. Services & Supports: Connect People with Resources Effectively
6. Strengthening Advocacy: Increase Long-Term Care Ombudsman Capacity
7. Supplemental and Directed Payment Programs: Improve Accountability and Sustainability of Supplemental and Directed Payment Programs to Achieve Positive Outcomes
8. Women & Children: Improve Health Outcomes for Women, Mothers and Children
9. Team Texas HHS: Improve Our Culture, Recruitment and Retention
10. Purchasing: Improve Procurement and Contracting Processes
11. Quality Control: Identify and Mitigate HHS System Risks Through Effective Audit Activities
12. Technology & Innovation: Leverage Technology and Process Improvement

The plan in its entirety can be found at <https://hhs.texas.gov/sites/default/files/documents/about-hhs/budget-planning/hhs-inaugural-business-plan.pdf>.

Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. The term “racial and ethnic minority groups” includes people of color with a wide variety of backgrounds and experiences. But some experiences are common to many people within these groups, and social determinants of health have historically prevented them from having fair opportunities for economic, physical, and emotional health.

There is increasing evidence that some racial and ethnic minority groups are being disproportionately affected by COVID-19. Inequities in the social determinants of health, such as poverty and healthcare access, affecting these groups are interrelated and influence a wide range of health and quality-of-life outcomes and risks. To achieve health equity, barriers must be removed so that everyone has a fair opportunity to be as healthy as possible.

Center for Disease Control and Prevention, <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

Office of Health Equity

Our society is not and has never been equitable. Recent events have led many of us to not shy away from questions that must be asked and responded to, in order for us to make substantial changes to address these inequities. There is not one single policy solution, but we must first look at where we are and how we arrived at this point in history. Black people have been disproportionately dying of COVID-19; nationwide Black people are dying at 2.371 times the rate of white people from the virus.² What can we do to change these outcomes? Is structural racism a key social determinant of health? Is it a political determinant of health? How has the COVID pandemic underscored the historic racism in our healthcare system? How do structural inequities in our medical and health care systems impact the mental health and wellness of people of color? These are just a few of the questions awaiting answers. There are many more.

While there is a wealth of available information with evidence of significant inequities and disparities in our health (and other) systems, there are not many concrete policy and programmatic recommendations on how we move forward to fix the problems. The HHSC Center for Elimination of Disproportionality and Disparities/State Office for Minority Health was defunded through a rider during the 85th legislative session, which resulted in its elimination. Without a unit or office devoted to identifying the issues, collecting data, and researching solutions, the information needed to implement reforms is not available. Additionally, if no office exists that is specifically charged with responsibility and authority to address disparities and equity, the work will not get done with the same focus and attention.

An office addressing health disparities and health equity could be located in the Office of Mental Health Coordination at HHSC as that office coordinates efforts with at least 23 other state agencies. Other options for location of such an office should also be investigated. Example responsibilities a health equity office could be charged with include (but are not limited to):

- Collaborating across agencies to work to identify and eliminate systemic barriers to accessing healthcare services, including those that support mental well-being;
- Providing training and technical assistance to agencies and communities;
- Collecting and analyzing data to identify barriers and develop potential solutions;
- Providing programmatic assistance to help organizations implement changes to address inequities and disparities; and
- Disseminating information that promotes health equity.

The current environment calls for an invigorated focus within the state HHS system, including re-establishment of an office to address health equity and disparities in Texas.

The Intersection of COVID-19 and Mental Health and Wellness

As we write this section of our mental health guide, we are keenly aware of the myriad of consequences the COVID-19 pandemic has had on individuals, families, communities, and our country. We first want to express our heartfelt sadness and offer our sympathies to those who have first-hand experience of this vicious virus, especially those who have lost family members and friends to its attack. We know that your world has changed forever and the losses you have experienced are profound. It is not our intent in this guide to duplicate the multitude of information and data that is already available. The following information and data are intended to highlight the enormous impact of COVID-19 on our individual and collective mental health and well-being, both in the short-term and for years to come.

The increased need for mental health and substance use treatment and services will obviously stress our current systems already experiencing historical and continuing workforce shortages and access challenges.

The 87th Legislature will face the intersection of a historically underfunded system with insufficient provider networks, as well as an increased need for mental health and substance use services and supports.

HHSC should be commended for initial actions taken early in the pandemic to enhance access to mental health services. In March 2020, a Mental Health Support Line was created to provide all Texans access to time-limited mental health support. Additionally, telemedicine and telehealth regulations were relaxed by both the federal and state governments to allow for remote provision and utilization of mental health and substance use services, including the allowance of services through audio-only telephone. These were impressive actions taken early that will hopefully continue long term.

It doesn't seem that there is an aspect of American life that the COVID-19 pandemic hasn't affected in some way. While this world crisis has brought out the best of humanity in many cases, the destruction and devastation it has caused is undeniable. The impact of the virus will be unfolding for years to come, including the impact on individual and collective community mental health and well-being.

The pandemic will result in a behavioral health crisis with a historic rise in mental health issues and substance use disorder.

Integral Care, Transparencies, Minority Mental Health Disparities & COVID-19, July 2020 <https://integralcare.org/en/transparencies0720/>

MENTAL HEALTH CONSEQUENCES

Evidence of increased need for mental health and substance use services since the start of the COVID-19 pandemic has already been documented. A recent study published in the *Morbidity and Mortality Weekly Report* and highlighted on the CDC website (<https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>) offers insight into the mental health impact of the COVID-19 pandemic on communities.

The study indicated that:

Adults in the U.S. are experiencing considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.³

Some notable indicators revealed through the study include:⁴

- 40.9 percent of American adults reported having at least one adverse mental/behavioral health consequence resulting from the pandemic. In most pre-COVID analyses, that number was typically reported as being 20 to 25 percent.
- The primary mental health/substance use problems identified by survey participants in the study included:
 - High levels of anxiety and/or depression (30.9 percent)
 - Significant trauma (26.3 percent)
 - Increased substance use (13.3 percent)
 - Consideration of suicide (10.7 percent)

POPULATION IMPACT

The study also highlights the mental health impact on certain populations, including:

- 74.9 percent of young adults age 18-24
- 51.9 percent of adults age 25-44
- 52.1 percent of Hispanics
- 54 percent of essential workers
- 61.6 percent of unpaid caregivers
- 66.2 percent of individuals with less than a high school diploma.⁵

As has been shown in many parts of the country, the impact of COVID-19 is often worse for people of color with less access to resources and support due to socioeconomic status, less access to health care, and increased exposure due to occupations not conducive to working from home. The table below provides a representation of cases, hospitalizations, and death rates by race/ethnicity.

Table 1. COVID-19 Hospitalization and Death by Race/ethnicity

Rate ratios compared to White, Non-Hispanic Persons	American Indian or Alaska Native, Non-Hispanic Persons	Asian, Non-Hispanic Persons	Black or African American, Non-Hispanic Persons	Hispanic or Latinx Persons
Cases	2.8 x higher	1.1 x higher	2.6 x higher	2.8 x higher
Hospitalizations	5.3 x higher	1.3 x higher	4.7 x higher	4.6 x higher
Deaths	1.4 x higher	No increase	2.1 x higher	1.1 x higher

The consequences of COVID-19 on people of color provides further evidence of the damage caused by health disparities and inequities. The pandemic has provided stark evidence of the need for Texas to create an Office of Health Equity to build awareness, provide education, develop strategies, and assist with implementing corrective measures to mitigate the impact and eliminate the causes of disparities based on race, ethnicity, gender, socioeconomic status, sexual orientation, disability, and more.

NONPROFIT FALLOUT

Adding to the complexity of addressing the mental health needs of Texans during the pandemic is the reality that many nonprofit organizations that often support community well-being are also struggling. A recent survey conducted by the United Way of Texas and the OneStar Foundation provided insight into the impact of the pandemic on 501(c)(3) organizations in Texas. The survey and others were included in the development of a report *The Impact of COVID-19 on Texas Nonprofit Organizations*, released in August 2020 as part of the Built for Texas initiative. Some key findings show:

- 70 percent of organizations changed operations or services so that they could more directly support the COVID-19 response;
- 60 percent of organizations are providing services that directly support the health or basic needs of those affected by the COVID-19 pandemic;
- 18 percent are providing services that mitigate the spread of COVID-19;
- 69 percent experienced disruption of services to clients and communities;
- 62 percent experienced increased demand for services/support from clients and communities;
- 40 percent experienced increased or sustained staff and volunteer absences;
- 24 percent instituted staff lay-offs or furloughs;
- 82 percent cancelled programs or events due to reduced revenue; and
- 70 percent experienced budgetary implication related to strains on the economy.⁶

The reduction in community and individual support directly impacts current and future mental health and wellness in our communities. The full report can be viewed at <https://txnonprofits.org/wp-content/uploads/2020/08/Impact-of-COVID19-on-Texas-Nonprofit-Orgs-August-2020.pdf>.

ONGOING CHALLENGES

Additional vital considerations must be considered when policy makers, legislators and stakeholders analyze future needs and the impact on mental health, including:

- Impact of ongoing financial stressors and unemployment;
- Challenges families face in managing children, school options, employment, food insecurity, potential eviction, loss of employment, isolation, and lack of emotional

- support;
- Impact to older Texans in nursing and assisted living facilities, as well as those living alone with little external contact and minimal support;
- Loss of health insurance and the inability to obtain health care when needed;
- Over-representation of people of color in case counts, hospitalizations, and deaths; and
- Potential loss of telemedicine and telehealth flexibilities made possible during COVID-19 and impacts on people using those services for mental health and substance use treatment.

COVID-19 presents many challenges to Texas and the nation. Mental health and substance use supports, services, and treatment will be needed by more Texans in the months and years to come as a result of the pandemic fall-out.

The Intersection of Racism and Mental Health

Institutional racism, disparities, and inequities exist in Texas healthcare systems. This causes and exacerbates already existing trauma, anxiety, depression, PTSD, substance use, and other mental health conditions. Communities of color face discrimination that prevent them from accessing health care, including mental health and substance use treatment, services, and supports. The global COVID-19 pandemic and subsequent economic downturn has disproportionately impacted communities of color and heightened those disparities.^{7,8,9} Additionally, the murders and/or shootings of George Floyd, Jacob Blake, Breonna Taylor, Ahmaud Arbery, and numerous other Black Americans in 2020 has sparked global unrest against racism and police brutality. Discrimination and violence against communities of color has led to local and state leaders across the country declaring racism a public health crisis.¹⁰ Not only is racism a public health crisis, but it is also a public *mental health crisis*.

HEALTH DISPARITIES

In order to understand how racism impacts mental health, it is essential to break down how institutional racism continues to oppress communities of color. Table 2 below lists a fraction of the numerous institutional barriers that can reduce access to services and increase severity of mental health conditions for people of color (POC):

Table 2. Racial Health Disparities

Racial/Health Disparity	Explanation of Health Disparity
Lack of Healthcare Coverage	<ul style="list-style-type: none"> In Texas in 2018, 29 percent of Hispanic/Latinx people were uninsured, compared to 16 percent of Black people and 13 percent of White people.¹¹ Many non-White immigrants work in economic sectors less likely to offer health insurance.¹² Latinx children have the lowest rate of public or private health insurance coverage of any ethnic group.¹³
Economic Income	<ul style="list-style-type: none"> Black/African Americans and Hispanic/Latinx Americans are more likely to be unemployed than White Americans.¹⁴ In Texas, data from 2012-2016 shows that non-Hispanic White individuals had a poverty rate of 8.9 percent; Black or African American individuals had a poverty rate of 21.7 percent; Hispanic individuals had a poverty rate of 23.7 percent; and Asian individuals had a poverty rate of 11 percent.¹⁵
K-12 Schooling	<ul style="list-style-type: none"> For every student enrolled, the average non-White school district (>75% non-white) in Texas receives \$296 less than a White school district (>75% white). Predominantly non-White school districts in Texas have 7 percent less funding on average than predominantly White school districts.¹⁶ The average student population in high-poverty, non-White schools districts in Texas is 10,420, yet it is 611 in high-poverty White districts.¹⁷ K-12 curriculum in Texas does not accurately depict the historical origins of racial/ethnic minorities in the US.¹⁸
Housing	<ul style="list-style-type: none"> Hispanic and Black Texans are disproportionately less likely to own homes than White Texans. In addition to institutional inequalities such as redlining and higher poverty rates for Black, Latinx, and Asian Texans, housing experts link these lower home ownership rates to: a lack of affordable housing, inadequate credit scores, and the inability to save up for a home down payment.^{19,20} In five Texas metro areas, Latinx and Blacks had a higher likelihood than non-Hispanic whites of being denied a conventional mortgage loan.²¹
Immigration Status	<ul style="list-style-type: none"> Family separations due to deportations can lead to long-lasting trauma, anxiety, struggles in school, depression, constipation, trouble sleeping, fear of being alone, and toxic stress.²² It is estimated that 6 percent of the total Texas population in 2016 were undocumented immigrants, and as of March 2020, the state had 106,090 Deferred Action for Childhood Arrivals (DACA) recipients.^{23,24} In Texas, non-citizens are almost three times as likely to be uninsured as native-born US citizens. Over 45 percent of undocumented immigrants went without insurance in 2018, compared to 10 percent of US native-born US citizens and 23 percent of lawfully documented immigrants. In Texas, over 30 percent of the uninsured are non-citizens.²⁵
Food Deserts and Transportation	<ul style="list-style-type: none"> The Center for Disease Control (CDC) determined that 58 Texas counties were considered "food deserts," meaning they had a lack of available fresh produce and limited or no presence of large grocery stores.²⁶ In urban areas, POC are more likely than White people to live in food deserts in the US.²⁷ A study of Dallas showed that Black neighborhoods have significantly fewer grocery stores.²⁸ More abundant transportation systems would facilitate access to healthy foods for low-income neighborhoods in Texas.²⁹
Environmental Pollution	<ul style="list-style-type: none"> In 46 states, including Texas, communities of color are exposed to dangerously high levels of pollution compared to predominantly White communities.³⁰

Racial/Health Disparity	Explanation of Health Disparity
Criminal Justice and Juvenile Justice	<ul style="list-style-type: none"> • There are a disproportionate number of Black people and Native Americans in the Texas Juvenile Justice and Criminal Justice systems in Texas.³¹ While Black Texans made up 13 percent of the state's population in 2015, they represented 27 percent of the jail population and 33 percent of the prison population.³² • Justice-involved youth have higher rates of mental and behavioral health problems than their peers, including the onset of severe mental illness.³³ • The discriminatory intent of federal law has historically targeted imprisonment and long sentences for drugs commonly in possession of Black and Latinx Americans.³⁴ Prosecutors are twice as likely to pursue a mandatory minimum sentence for Black people as for White people charged with the same offense.³⁵
Costs of Higher Education	<ul style="list-style-type: none"> • The Texas Education Agency (TEA) reported that in 2019, graduation rates at four-year institutions were lowest for (in order): Black, American Indian, Pacific Islander, and Hispanic students.³⁶ • Historically Black Colleges and Universities (HBCUs) in Texas receive less funding than other state-sponsored schools, resulting in less funding for students' books, housing, and transportation services.³⁷
Gun Violence	<ul style="list-style-type: none"> • Eighty-three percent of all youth homicides in the US involve a firearm, as well as 90 percent of Black homicides.³⁸ Black non-Hispanic youth (ages 15-24) are seven times as likely as White non-Hispanic youth to die by homicide.³⁹ • In Texas, Black and Hispanic men make up less than 25 percent of the population but account for nearly 63 percent of the state's gun homicide victims. Black men ages 18-24 are nearly 11 times more likely than White men of the same age to be murdered with a gun.⁴⁰
Police Violence	<ul style="list-style-type: none"> • POC, especially Black Americans, are at heightened risk for experiencing criminal justice contact and police-involved harm than White Americans.⁴¹ • Native Americans, Black Americans, and Latinxs have higher rates of being killed by law enforcement in the US than other racial/ethnic groups.⁴²
Voting	<ul style="list-style-type: none"> • Targeted disenfranchisement of Black and Latinx citizens in Texas has reduced these populations' abilities to elect lawmakers dedicated to representing their policy interests, including issues related to mental health.⁴³ • Between 2012-2016, the 50 Texas counties that experienced the greatest increase in Black and Latinx residents closed 542 polling sites, despite an overall population increase of 2.5 million people. This is compared to 34 closures in the 50 Texas counties that gained the fewest Black and Latinx residents, which saw a total population decrease of over 13,000 people.⁴⁴
Child Welfare and Foster Care	<ul style="list-style-type: none"> • There are a disproportionate number of children and families who are Black or Native American involved with the Texas Child Protective Services system.⁴⁵ Youth in foster care are more likely than the general population to have a mental health concern.⁴⁶ • In Texas, a higher percentage of Black children: 1) are removed from their homes due to abuse or neglect; 2) do not return home to their families; and 3) grow up in foster care without being adopted or finding another permanent home.⁴⁷

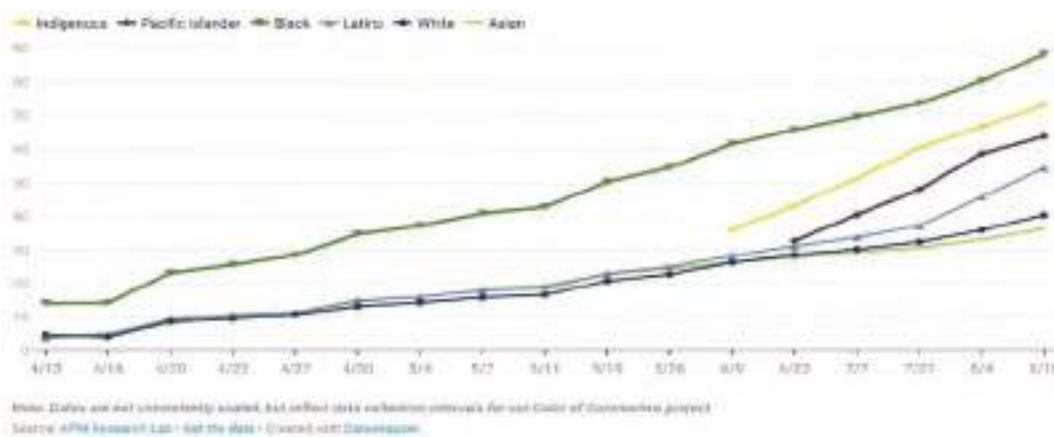
COVID-19'S DISPROPORTIONATE IMPACT

Due to racial health disparities described throughout this chapter, the COVID-19 pandemic has disproportionately affected POC. Research indicates that the pandemic is expected to increase rates of mental health and substance use disorders, as well as deaths associated with suicide, overdose, and violence.⁴⁸ The following data comes from the APM Research Lab; at the time of writing, Texas and 47 other states had not yet publicly released COVID-19 mortality data by race and ethnicity. Of the

more than 170,000 COVID-19 deaths as of August 18, 2020, race/ethnicity data was missing for about 5 percent of deaths.⁴⁹

As of August 18, 2020, Black Americans had the highest death toll from the virus at 88.4 deaths per 100,000 people, which is over two times as high as the mortality rate for White and Asian Americans.⁵⁰ Figure 1 shows how Black COVID-19-related deaths were followed by Indigenous Americans at 73.2, Pacific Islander Americans at 63.9, Latinx Americans at 54.4, White Americans at 40.4, and Asian Americans at 36.4 per 100,000 people.⁵¹

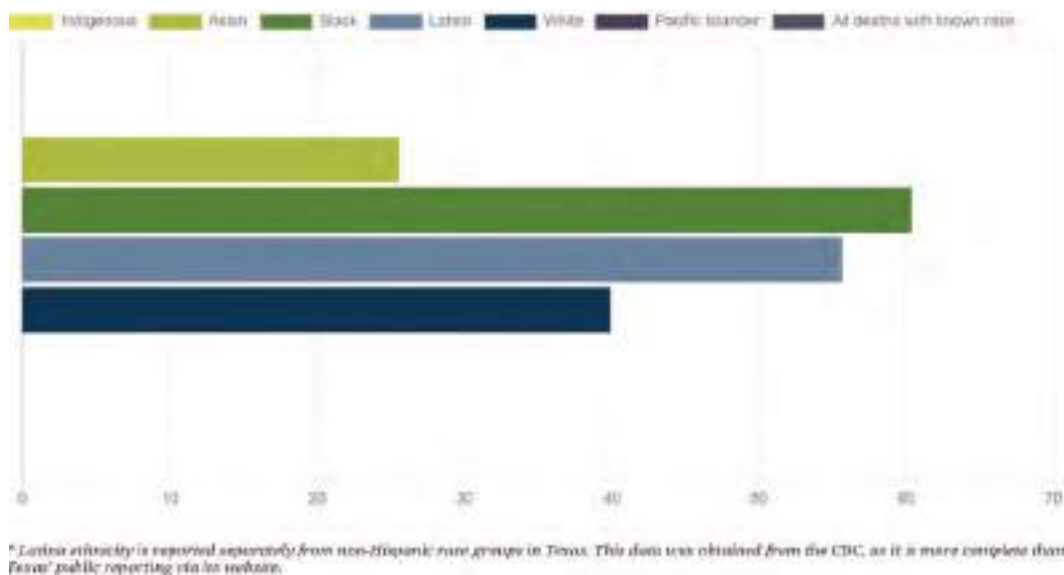
Figure 1. Cumulative actual COVID-19 mortality rates per 100,000, by race and ethnicity, April 13-Aug. 18, 2020



Source: COVID-19 deaths analyzed by race and ethnicity. (2020, August 19). Retrieved from <https://www.apmresearchlab.org/covid/deaths-by-race>

As of August 18, 2020, Black Americans had experienced 22.1 percent of all COVID-19 deaths, despite representing only 12.4 percent of the population. Indigenous Americans had experienced 2.1 percent of all deaths (in 30 states reporting one or more deaths), despite representing about one percent of the population in those states. White Americans had experienced 50.6 percent of all deaths, but represented 62.2 percent of the population.⁵² Adjusting for age differences in the race groups widens these gaps even further compared to Whites, with COVID-19 mortality rates being: 3.6 times higher for Blacks, 3.4 times higher for Indigenous people, 3.2 times higher for Latinxs, 3.0 times higher for Pacific Islanders, and 1.3 times higher for Asians. Age-adjusted data reveals how the mortality rate for Latinxs increases more than any other group when compared to the actual rate. This shows that Latinxs are dying from the virus at a higher rate than expected given the group's relative youthfulness.⁵³ Figure 2 below shows age-adjusted COVID-19 deaths in Texas.

Figure 2. Age-adjusted COVID-19 deaths in Texas per 100,000 people, through Aug. 18, 2020



Source: COVID-19 deaths analyzed by race and ethnicity. (2020, August 19). Retrieved from <https://www.apmresearchlab.org/covid/deaths-by-race>

Given that stress, depression, irritability, fear, confusion, frustration, boredom, stigma, anxiety disorders, and other emotions are prevalent during pandemics, the mental wellness of POC is at particular risk because of existing racial health disparities.⁵⁴

RACISM CAUSES TRAUMA

Racism causes trauma, making it an inherent mental health issue.⁵⁵ Racial trauma accumulates throughout a person's life, leading to activation of stress responses and hormonal adaptations. This increases the risk of non-communicable diseases and biological aging.⁵⁶ Racial trauma is also transmitted intergenerationally and affects the offspring of those initially affected through complex biopsychosocial pathways.⁵⁷ Lower rates of access to mental health services, as well as lower usage of these services for those who do have access, make the burden of trauma incredibly harmful to communities of color. The below subsections breakdown a few of the many issues that disproportionately reinforce racial trauma.

GUN VIOLENCE

Gun violence is at the root of cyclical trauma in communities of color. Black non-Hispanic youth (ages 15-24) are seven times as likely as White non-Hispanic youth to die by homicide, and 83 percent of youth homicides involve a firearm (up to 90 percent for Black homicide victims).⁵⁸ Individuals who have survived or witnessed gun violence in their communities have constant feelings of danger and vigilance that lead to many being fearful to leave their homes.⁵⁹ This can be burdensome to their mental wellness, resulting in anxiety, depression, PTSD, constant agitation, sleep

disturbances, hopelessness, and other mental health conditions.⁶⁰ Experts indicate that those routinely exposed to gun violence can behave similarly to war veterans, as they must learn to interpret potential threats to survive. This consequently leads to further psychosocial, medical, and mental health issues.⁶¹

Due to the repeated high-profile mass shootings in the US, there are also common sentiments of fear from Americans (especially POC) who are not survivors or witnesses of gun violence. According to an August 2019 study by the American Psychological Association:

- Nearly 80 percent of adults said they experienced stress as a result of the possibility of a mass shooting;
- About one-third of adults said fear of a mass shooting prevents them from going to certain places or events; and
- One-fourth had changed their livelihood because of fear of a mass shooting.⁶²

While 15 percent of non-Hispanic adults say they experience stress often or constantly related to the possibility of a mass shooting, 32 percent of Hispanic adults say the same. Hispanic (44 percent) and Black (43 percent) adults are also more likely than White non-Hispanic (30 percent) adults to say they do not know how to cope with stress caused by mass shootings. Additionally, 60 percent of Black and 50 percent of Hispanic adults feel that they or someone they know will be a victim of a mass shooting, compared to 41 percent of White adults.⁶³

Firearms are also the most lethal method of suicide. While the average suicide attempt has an 8.5 percent death rate, those with firearms have an 89.6 percent mortality rate.⁶⁴ According to 2017 CDC data, suicide was the third leading cause of death for Black youth ages 1-19, illustrating how mixing suicidology and access to lethal means for youth experiencing racial trauma can lead to increased mortality.⁶⁵

Trauma caused by gun violence is costly on the national and Texas healthcare systems. A study that focused on pediatric firearm injuries found that:

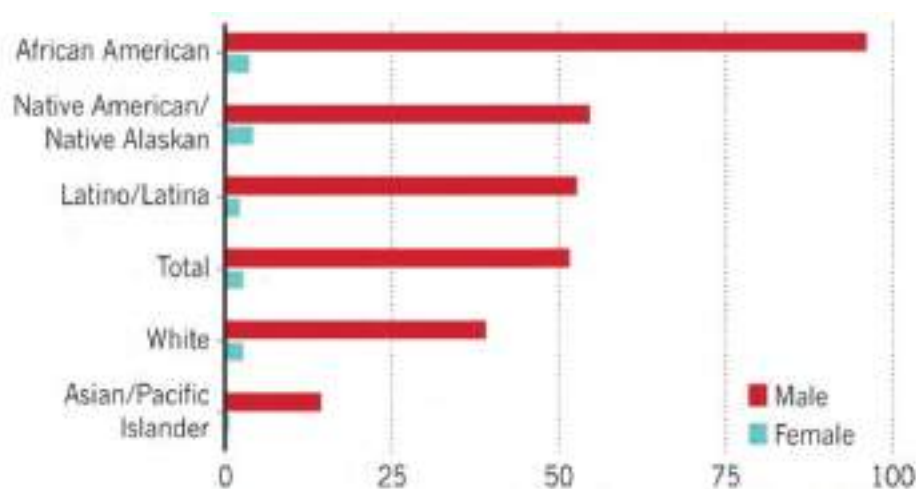
- The median cost per firearm-related hospitalization was \$10,159, a figure that does not take into account long-term mental health supports and services.⁶⁶
- About half of children hospitalized from a firearm-related injury were discharged with a disability, including cognitive and behavioral conditions.⁶⁷
- Of the youth included in this study, 44 percent of firearm hospitalizations involved Black individuals, 19 percent Hispanic youth, and 16 percent White youth.⁶⁸

POLICE VIOLENCE

What's often left out of the discussion on gun violence is the disproportionate impact that police shootings have on communities of color. From 2010-2015, police officers shot at suspects in Texas at least 656 times in 36 of the state's largest cities.⁶⁹ People with untreated psychiatric or mental health conditions are also more like to be killed by law enforcement, and due to Texas's racial disparities in access and use of mental health services, this directly impacts POC.^{70 71}

According to 1999-2015 CDC data, Native Americans, Black Americans, and Latinx Americans have higher rates of being killed by law enforcement than other racial/ethnic groups.⁷² Figure 3 below illustrates how Black males are disproportionately at a higher risk of being killed by police in the US, a rate twice as high as White Americans.⁷³ Studies show that police officers tend to associate Black people with threat, and have stronger associations between Black Americans and weapons than other ethnicities.⁷⁴ Additionally, police officers are more likely to view Black youth as having higher pain tolerance than other groups of people, a bias often used to justify forms of police brutality.⁷⁵ The prevalence of racial bias in policing puts POC at significantly higher risk of experiencing trauma because of interactions with law enforcement and the criminal justice system.⁷⁶

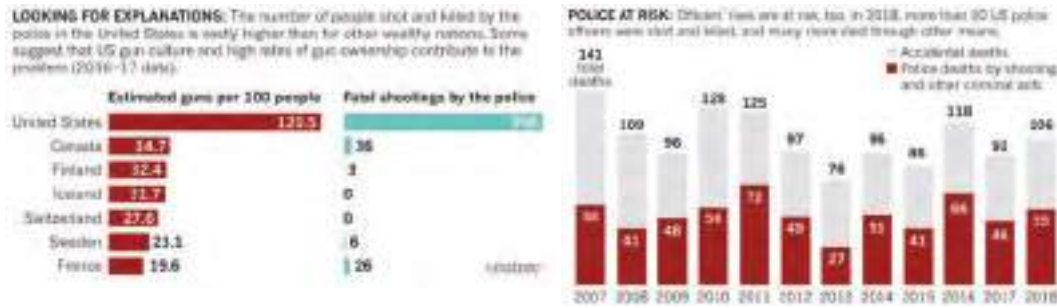
Figure 3. People at Risk of Being Killed by the Police (Per 100,000 population)



Source: Peeples, L. (2019, September 04). What the data say about police shootings. Retrieved from <https://www.nature.com/articles/d41586-019-02601-9>

While racial bias exists in every nation, including in law enforcement bodies, the US has disproportionately high rates of police killings that consequently plague communities of color with loss and trauma.⁷⁷ Fear that an individual was in possession of a weapon, and thus that an officer feared for their life, is often cited as a reason by law enforcement bodies for a police shooting. The racial bias previously described, in combination with high levels of gun ownership in the US, can in part explain this trend.⁷⁸ This is because most other countries' law enforcement bodies do not deal with the constant threats of gun violence to the same extent as in the US.⁷⁹ There are more firearms in the US than there are people, and gun ownership rates are nearly two times as high as the next highest country.⁸⁰ Texas itself has the most registered firearms in circulation of all 50 states, and had the second most police killings from 2013-2019.^{81,82} The disproportionate impact of police killings on POC reinforces trauma in communities of color. Figure 4 below shows how shootings by law enforcement in the US are over three times higher than in other developed nations, and how these fatal shootings correlate with trends of high gun ownership in the US.⁸³

Figure 4. Gun Ownership, Fatal Shootings By Police, and Police Deaths in the US



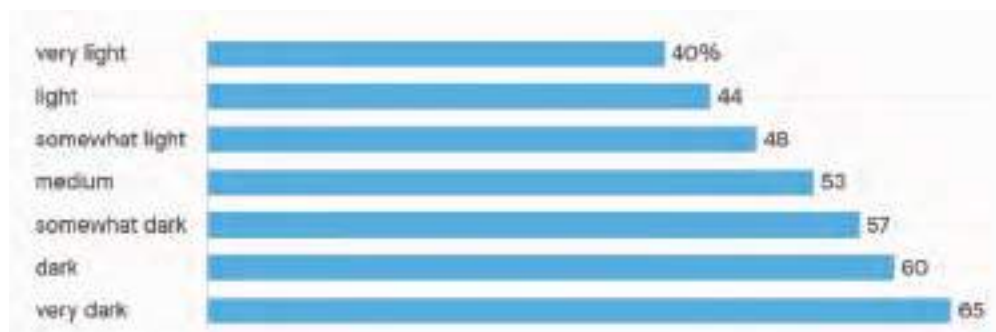
Source: Peebles, L. (2019, September 04). What the data say about police shootings. Retrieved from <https://www.nature.com/articles/d41586-019-02601-9>

Police officers themselves often face mental health conditions that are a result of dangers associated with the job such as police-involved shootings. Figure 4 above shows how, in 2018, 55 law enforcement officers were shot and killed—an increase from 46 in 2017.⁸⁴ A survey of police who were involved in shootings reported they illustrated trauma-response symptoms such as: heightened sense of danger, anxiety, flashbacks, emotional withdrawal, sleep difficulties, alienation, depression, problems with authority, nightmares, family problems, guilt, alcohol/drug abuse, sexual difficulties, and suicidal thoughts.⁸⁵ These symptoms highlight how racial targeting by law enforcement and the prevalence of weapons in the US creates violence and trauma, which not only affects mental wellness of communities of color, but those of police officers themselves.⁸⁶

COLORISM

Colorism refers to “prejudice or discrimination, especially within a racial or ethnic group, favoring people with lighter skin over those with darker skin.”⁸⁷ It is difficult to quantify the affect colorism plays in someone’s mental health, largely because of the subjectivity with how someone might identify or is perceived. A 2015 study indicated that Asian Americans have been racialized within the Black/White binary, a dichotomy that has affected how members of this community process internal self-identification based on color and skin tone.⁸⁸ Another study examined survey results of Black Americans’ complexion from 2001-2003. As is shown in Figure 5, the darker someone’s skin tone (determined by interviewers who administered the survey), the more likely they were to be arrested.⁸⁹ The author of that study, after revisiting it 15 years later, found that, “after accounting for differences like gender and level of education...(all) African Americans have an overall 36% chance of going to jail at some point in their lifetimes. Dark-skinned African Americans, meanwhile, have a near 66% chance.”^{90 91} This form of colorism is significant to the mental health conversation because frequency of trauma exposure is associated with criminal justice involvement.⁹²

Figure 5. Chance of Arrest for African Americans, by Complexion



Source: Merelli, A. (2019, October 15). Chance of arrest for African Americans, by complexion. Retrieved from <https://theatlantic.com/charts/jskmm0svz>

Additional studies have shown that:

- Black people and Latinxs who are deemed to have lighter skin tones are also significantly more likely to be seen as intelligent by White people;
- Lighter-skinned Black men with bachelor's degrees had a distinct advantage in job application processes over darker-skinned Black men who had MBAs;
- Lighter-skinned Black women in North Carolina received lighter prison sentences than their darker peers; and
- Black Americans with more education are remembered as being lighter than they actually are.⁹³

All of these socialized ways of thinking could affect POCs' life trajectories. From the opportunities one might not receive based on skin tone to the trauma one could be exposed to because of how they are treated based on their complexion, it is important to acknowledge the existence of colorism and the role that it plays in deepening racial biases. Colorism thus plays a direct role in reinforcing trauma and other forms of mental health conditions.

EXHAUSTION

An often-overlooked cause of racial trauma is the toll of exhaustion on POC. Exhaustion can be a result of a variety of different factors, including but not limited to:

- Receiving microaggressions;
- Viewing continuous streams of violence against POC or other traumatic events involving POC (i.e., footage circulating of a cop's knee on George Floyd's neck);
- Having to explain white privilege and colorism;
- Having to educate others on the history of one's culture, ethnicity, background, and values;
- Appropriation of one's culture;
- Tokenization;
- Fetishization;
- Lack of representation in positions of power and influence; and
- Intersectionality of racism and other forms of discrimination (gender, sexual orientation, disability status, religion, etc.).^{94,95,96,97,98}

These issues, which constantly affect POC daily, perpetuate exhaustion and can negatively impact mental wellness. Dealing with all of the aforementioned challenges consequently can lead to significant physical and mental health conditions such as PTSD.⁹⁹

IMMIGRATION/CITIZENSHIP STATUS

Research shows that fear of deportation and family separation can present significant harm to a child's mental health. They act as toxic stressors, which can permanently change the biology of a child's brain. In Texas, 64.8 percent of individuals born outside of the US are Latinx, 20 percent are Asian, and 5.8 percent are Black, according to the Migration Policy Institute.¹⁰⁰ About 51 percent of Texas immigrants are from Mexico.¹⁰¹

A 2018 report studied respondents in the Rio Grande Valley, where about 80 percent of people are of Mexican descent. Selected respondents were directly impacted by changing immigration policies and anti-immigrant rhetoric, and 20 percent said their child experienced post-traumatic stress disorder (PTSD) following a parent's deportation. This was compared to 5 percent for all children in the US.¹⁰² Symptoms ranged from increased anxiety, struggles in school, depression, constipation, trouble sleeping, and fear of being alone.¹⁰³ One in four children of undocumented parents in the Rio Grande Valley experienced stress because of a parent's immigration status, compared to one in ten children with parents of a legally protected status.¹⁰⁴ Immigration related stressors also impact school success, as 41 percent of undocumented respondents had children with symptoms of school avoidance anxiety. This rate was 30 percent for those with protected status, and 20 percent for parents with citizenship.¹⁰⁵ Additionally, 22 percent of undocumented parents reported their child had trouble keeping up their grades, compared to just 4 percent of protected status parents.¹⁰⁶ The survey also found that adult mental and physical health in the Rio Grande Valley is impacted by the threat of detention and deportation for those with undocumented status.¹⁰⁷

Undocumented transgender individuals also face disparities that lead to trauma and mental health conditions.¹⁰⁸ See the Discrimination and Violence Against the LGBTQIA+ Community section below for more information on the trauma faced by undocumented transgender people.

DISCRIMINATION AND VIOLENCE AGAINST THE LGBTQIA+ COMMUNITY

Individuals who are lesbian, gay, bisexual, transgender, queer, intersex or asexual (LGBTQIA) are disproportionately exposed to stressors that cause depression, substance use, and increased risk of suicide.¹⁰⁹ Survey results showed that 39 percent of transgender respondents experienced serious psychological distress in the month prior, compared with 5 percent of the US population. In addition, 40 percent had attempted suicide, a figure nearly nine times higher than the US attempted suicide rate of 4.6 percent.¹¹⁰

When combined with racism, POC in the LGBTQIA+ community often face additional mental health hurdles. The year 2020 has seen increased levels of violence

against primarily Black transgender women.¹¹¹ In just the first 7 months of 2020, there were more transgender people murdered (28) than in all of 2019 (26).¹¹² Of the 28 individuals killed, 23 were trans women, four were trans men, one was non-binary, and a majority were Black or Latinx.¹¹³

According to a survey by the National Center for Transgender Equality of over 28,000 individuals, transgender people face high levels of stigma and discrimination that negatively impact their mental health.¹¹⁴ Forty-seven percent of Black respondents and 30 percent of Latinx respondents reported being denied equal treatment, verbally harassed, and/or physically attacked in the previous year because of being transgender. Black transgender women were more likely to be physically attacked in the previous year because of being transgender, in comparison to non-binary people and transgender men.¹¹⁵ About 24 percent of transgender undocumented respondents had been physically attacked in the prior year. Half of undocumented respondents also experienced homelessness in their lifetime, and 68 percent had faced intimate partner violence.

LACK OF USE OF TREATMENTS AND SERVICES

In addition to health disparities and structural inequalities that limit POC's access to mental healthcare services, those who do have access are still less likely to receive treatment than White Americans. A 2014 study indicated that African Americans are more likely than White Americans to terminate treatment prematurely.¹¹⁶ Of all adults with a diagnosis-based need for mental health or substance abuse care, only 22.4 percent of Latinxs and 25 percent of Black people received treatment, compared to 37.6 percent of Whites. Overall spending for Blacks and Latinxs on outpatient mental health care was about 60 percent and 75 percent of White rates.¹¹⁷ The study states that efforts to eliminate these disparities have been unsuccessful in both primary care and specialty psychiatric services.¹¹⁸ Black and Latinx children also have the highest rates of unmet need for mental health services.¹¹⁹

There are several reasons POC are less likely to use clinical mental healthcare services. These include: high uninsured rates, financial and healthcare restraints caused by systemic racial oppression, long-held stigmas against seeking help within the community, preferred reliance on faith-based practices, and the inability of some healthcare providers to establish themselves as credible and reliable sources of support.^{120,121} The history of discrimination in healthcare, especially against Black women, has led many POC to hold a fundamental mistrust of some healthcare providers and services.¹²² In order to reduce disparities and treat mental health conditions within communities of color in Texas, policies should not only expand access to care, but also incentivize these services to be utilized by providing better outreach and education. Policies should also leverage the usage of spirituality and faith-based practices by many POC to better mental wellness, hire and train a more diverse mental health workforce, and work to increase the quality of mental health care.¹²³

Mental Health and Substance Use Workforce Shortage

Mental health and substance use workforce challenges are not new, and they continue to exacerbate the shortage of available treatment options. Additionally, the COVID-19 pandemic is projected to increase rates of mental health and substance use conditions, thereby significantly increasing the demand for mental health services and amplifying the workforce shortage.¹²⁴

Meeting the needs of Texans with mental health and substance use conditions requires a robust and diverse behavioral health workforce. Texas faces critical shortages for many licensed mental health professionals, including: psychiatrists, psychologists, professional counselors, clinical social workers, marriage and family counselors, and advanced practice psychiatric nurses. As of June 30, 2020, an analysis by the US Health Resources and Services Administration (HRSA) of mental health professional shortages showed that Texas had only met about 36 percent of the state's need.¹²⁵ In 2019, 173 Texas counties did not have a single licensed psychiatrist, which left over 2.7 million Texans living in counties without access to a psychiatrist. An additional 24 counties only had one psychiatrist, serving over 970,000 individuals.¹²⁶ The majority of mental health services are provided by mental health professionals other than psychiatrists, including: primary care physicians, nurses, social workers, physician's assistants, certified peer specialists and certified recovery coaches, family partners, community health workers, marriage and family therapists, and counselors. In many parts of Texas, significant shortages of all mental health providers also exist. It is important to note that primary care providers deliver more than half of all mental health services for common mental health conditions, like anxiety and depression.¹²⁷ A 2018 report from Texas's Health Professions Resource Center estimated that, due to the national shortage of mental healthcare professionals, Texas is unlikely to meet staffing needs by way of recruiting practitioners from other states. The shortage was expected to worsen as the workforce ages prior to the COVID-19 pandemic.¹²⁸

Various state and federal legislative initiatives, agency reports, and advocacy efforts have offered recommendations for addressing workforce challenges across the various mental health disciplines. Only a few of these recommendations and strategies have been funded and implemented.

Recognizing the need to proactively address the critical behavioral health workforce shortage in Texas, HHSC created the Behavioral Health Workforce Workgroup in 2019. The workgroup worked for over a year to identify recommendations and strategies included in previous studies and reports and develop a "next steps" workplan for HHSC and the legislature to use when considering future actions needed to ensure an adequate and viable behavioral health workforce for Texas. This report lays out a comprehensive set of recommendations that should be used as a blueprint for action. The workplan and recommended next steps are divided into seven categories including:

1. Retention, Recruitment, and Incentives

2. High School Pipeline
3. Higher Education
4. Licensing and Regulation
5. Innovative System Improvements
6. Medicaid Administration
7. Other

Some of the gaps and barriers contributing to the current mental health workforce shortage include:^{129,130}

- Unwillingness of mental health providers to accept patients with Medicaid;
- Inequitable distribution across the state, primarily affecting rural areas;
- An aging workforce;
- Linguistic and cultural barriers – the workforce does not reflect the culture and ethnicity of the state's population;
- Inadequate and inequitable reimbursement practices. Reimbursement rates are too low and the rating structure allows for different rates for the same services depending on the provider type;
- Limited internship sites and the cost of supervision for psychology, social work, and counseling; and
- Lack of high-quality broadband/internet access in rural communities that is needed to access telehealth/telemedicine services. The COVID-19 pandemic has further amplified the need for telehealth and telemedicine services and policy innovations.

During the 86th session, the Texas legislature took some steps to improve the mental health workforce capacity. The shortage continues, however, and much more work and funding is needed to make lasting changes. The following is a summary of workforce-related legislation passed during the 86th legislative session:¹³¹

- HB 1 allocates \$13,460,000 in general revenue for FY 2020/2021 to the University of Texas at Tyler. The funds are meant to support mental health workforce training programs in underserved areas including, but not limited to, Rusk State Hospital and Terrell State Hospital.
- HB 1065 (Ashby/Kolkhorst) creates a rural resident physician grant program to encourage the creation of new graduate medical education positions in rural and non-metropolitan areas. The intent is to place particular emphasis on the creation of rural training tracks.
- SB 11 (Taylor/Bonnen) includes provisions for increasing opportunities for integrated health care for children. It also provides funding for psychiatric residencies.
- HB 1501 (Nevarez/Nichols) establishes the Texas Behavioral Health Executive Council (TBHEC) by consolidating the Texas State Board of Examiners of Marriage and Family Therapists, Texas State Board of Examiners of Professional Counselors, and Texas State Board of Social Worker Examiners with the Texas State Board of Examiners of Psychologists. Authority to administer examinations, issue licenses, set fees, and take disciplinary action for marriage and family therapists, licensed professional counselors, social workers, and psychologists was transferred from each individual health board to TBHEC. The Psychology Interjurisdictional Compact was established to regulate telepsychology and temporary, in person practice of psychology across state boundaries.

Funding for the Loan Repayment Program for Mental Health Professionals, initially established by SB 239 (84th, Schwertner/Zerwas), was continued by the 86th Legislature. As of September 2020, it was reported that there are insufficient funds to enroll new participants during the 2020-2021 fiscal year.¹³² This program offers up to five years of student loan repayment assistance to mental health providers working in Mental Health Professional Shortage Areas, and is run by the Texas Higher Education Coordinating Board.¹³³

Peer Support Services in Texas

Peer support services are a critical component of the Texas mental health and substance use workforce. The Texas Health and Human Services Commission (HHSC) should be commended for their recognition and validation of peer support services and their continued efforts to improve, expand, and enhance these services to support recovery.

Peer supports are provided by individuals with lived experience of mental health and/or substance use conditions who are trained and certified. These individuals assist others achieve long-term recovery. Peer specialists offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities and communities of support.¹³⁴

While peer services have existed in Texas for a number of years, the Texas Legislature and HHSC continue to take steps to increase access to these valuable services. Major recent advancements include:

1. Passage of HB 1486 (85th, Price/Schwertner) directing HHSC to define peer services, identify criteria for certification and supervision, and provide Medicaid reimbursement;¹³⁵
2. Establishment of rules relating to peer training, certification, and supervision requirements, and the defining of the scope of services a peer specialist may provide. HHSC has also adopted rules that distinguish peer services from other services that a person must hold a license to provide;
3. Creation of the director of peer services position at HHSC;
4. Development of the Peer Services Programs, Planning, and Policy Unit at HHSC staffed by individuals with lived experience of mental health and/or substance use conditions;
5. Planning for and development of the Leadership Fellows Academy in partnership with the Hogg Foundation for Mental Health and the University of North Carolina. The goal of this project is to develop operational capacity of peer-operated service organizations.

The concept of peer support services may be new to some. Table 3 below highlights some key terms.

Table 3. Key Terms Related to Peer Support (1 Tex. Admin. Code §354.3003)

Terms	Definitions
Peer specialist	A person who uses lived experience, in addition to skills learned in formal training, to deliver strengths-based, person-centered services to promote a recipient's recovery and resiliency.
Recovery	A process of change through which a person: (A) improves one's health and wellness; (B) lives a self-directed life; (C) strives to reach one's self-defined full potential; and (D) participates in one's personal community.
Person-centered	The provision of services: (A) directed by the recipient; (B) aligned with the hopes, goals, and preferences of the recipient; and (C) designed to build on the recipient's interests and strengths.
Strengths-based	An approach that focuses on a person's abilities and assets, rather than shortcomings and symptoms, to cultivate recovery.
Resiliency	The ability to recover from setbacks, adapt well to change, and keep going in the face of adversity.

Source: Texas Health and Human Services Commission. Medicaid Health Services, Peer Specialist Services, General Provisions, 1 Tex. Admin. Code §354.3003 (2019)

PEER CERTIFICATION

Individuals with lived experience of mental health and/or substance use conditions can be certified through the Texas Certification Board (TCB--formerly the Texas Certification Board of Addiction Professionals) and Texas Peer Specialist Certification Board (Wales Education Services).¹³⁶ Organizations wanting to provide peer specialist training are required to be certified by the certification entities. Information about training providers/organizations is available at <http://www.tcbap.org> and <https://texaspeers.org/>. The table below illustrates the types of state certifications currently available for persons with lived experience. In addition to the certifications currently available, HHSC is working with the certification boards to develop specialized certifications for justice-involved peer specialists and family-partner peer specialists.

Table 4. Texas Peer Credentials

Credential	Description	Medicaid Billable
Mental Health Peer Specialist (MHPS)	Standardizes qualifications of those working in Recovery Support within the field of mental health and/or co-occurring disorders.	Yes
Recovery Support Peer Specialist (RSPS)	Standardizes qualifications of those working in Recovery Support Peer within the field of chemical dependency, mental health, and/or co-occurring disorders.	Yes
Peer Specialist Supervisor (PSS)	Standardizes qualifications of those who supervise peer specialists.	Yes
Training Entity	Standardizes minimum requirements for individuals or organizations that are providing peer specialist training.	

Source: "Certification Applications - Texas Certification Board Of Addiction Professionals." Tcbap.org. <https://www.tcbap.org/page/certification>.

Texas Health and Human Services Commission Medicaid Health Services Peer Specialist Services General Provisions, 1 Tex. Admin. Code §354.3003 (2019)

Peer specialists provide services at local mental and behavioral health authorities (LMHAs/LBHAs), peer-run service providers, state hospitals, substance use recovery community-based organizations, recovery organizations, emergency departments, treatment organizations, and more. Common tasks performed by peer specialists include:

- Helping individuals self-advocate
- Connecting people to resources and employment services
- Goal setting
- Facilitating support groups
- Outreach and engagement
- Face-to-face recovery coaching
- Telephone peer support

BILLING

While HB 1486 included provisions to allow Medicaid reimbursement for peer support services, the current reimbursement rates are extremely low, resulting in a number of organizations declining to use the Medicaid billing code. Some services provided by peer specialists can also be billed under the “mental health rehabilitation services” code that offers a much higher billing rate but can typically only be used by LMHAs/LBHAs authorized to provide mental health rehab services. There is no alternative billing code for substance use peer services. One study conducted in Michigan reported low wages and the lack of career advancement as barriers to peer specialists. The study states, “Our results indicate that certified peer support specialists (CPSS) in Michigan often experience financial fragility. CPSS wages are low relative to those of other health professionals.”¹³⁷

HHSC has indicated that they will be reviewing the utilization data related to peer services to determine if reimbursement rate adjustments can be made. Research

shows that peer support services can save costs by curbing crisis events, decreasing emergency room visits, and potentially decreasing state hospitalization rates.

RESEARCH AND RESULTS

Nationally, peer support is an emerging field, thus long-term studies quantifying impact and return on investment are becoming more available. Current evidence suggests that peer support and coaching:

- Reduces the admissions and days spent in hospitals and increases time in the community;
- Reduces the use of acute services;
- Increases engagement in outpatient treatment, care planning, and self-care;
- Improves social functioning;
- Increases hope, quality of life, and satisfaction with life;
- Reduces substance use;
- Reduces depression and demoralization;
- Improves chances for long-term recovery;
- Increases rates of family unification; and
- Reduces average services cost per person.¹³⁸

In Texas, one long-term study focusing on substance use disorder peer specialists (also called recovery coaches) demonstrated exciting results at 12 months:

- Housing status improved, with 54 percent of long-term coaching participants owning or renting their own living quarters after 12 months, compared to 32 percent at enrollment;
- Overall employment increased to 58 percent after 12 months from 24 percent at enrollment;
- Average wages increased to \$879 per month after 12 months from \$252 at enrollment; and
- Healthcare utilization dropped after 12 months of recovery coaching:
 - Outpatient visits dropped to 815 visits from 4,118 at enrollment
 - Inpatient care days dropped to 1,117 days from 9,082 at enrollment
 - Emergency room visits dropped to 146 from 426 at enrollment¹³⁹

In total, recovery coaching saved \$3,422,632 in healthcare costs, representing a 72 percent reduction in costs over 12 months.¹⁴⁰

Telemedicine and Telehealth in the Time of COVID-19

Patients, providers, and health/mental health care advocates have been working to expand access to and utilization of telemedicine and telehealth services for a number of years with slow but steady progress. The COVID-19 pandemic significantly

expedited this effort. Changes were approved quickly and providers adapted their practices almost overnight.

Telemedicine and telehealth is not a “service;” it is a method of service delivery (virtual visits using technology versus in-person visits). While telemedicine and telehealth works well for some services and patients, some health conditions still require in-person evaluation and testing. Telemedicine and telehealth have significantly increased access to services for many individuals with mental health and substance use conditions, but some barriers do remain.

It is important to distinguish the difference in telemedicine versus telehealth services. In Texas, telemedicine services are health services delivered via technology by a licensed physician or a provider working under the delegation of a licensed physician (e.g., nurse practitioner, physician’s assistant). Telehealth services are those services provided by licensed or certified health care practitioners other than a physician or someone working under a physician’s delegation authority.¹⁴¹ In both cases, healthcare providers are limited to the scope of services allowed under their licensure or certification.¹⁴²

In 2017, the Texas Legislature passed legislation requiring coverage parity for telemedicine and telehealth services. SB 1107 (85th, Schwertner/Perry) mandates payment for telemedicine and telehealth visits for a covered service, but it doesn’t mandate the same rate for the same service.¹⁴³ Additionally, until the changes resulting from the pandemic, many of the technology and security requirements associated with telehealth services has limited the ability (or desire) of many providers to actually provide the services via telehealth/medicine. While access to mental health care services via telemedicine/telehealth has expanded greatly as a result of the pandemic, many questions still remain related to payment, rates, and parity with in-person services. Mental health and healthcare stakeholders contend that reimbursement should be based on parity, meaning that telehealth services should be reimbursed at the same rate as in-person services. Additionally, reimbursement rates should be based on the service provided and not be differentiated by the type of provider offering the services.

As of the writing of this guide, changes in service delivery requirements were granted from both state and federal authorities. While all providers remain required to operate solely within the scope of their practice, CMS and Governor Abbott have granted significant flexibility and expansion of telemedicine/telehealth services, including relaxation of some HIPPA requirements and allowing the use of audio-only telephone. Audio-only telephone has been a helpful method for communicating with people living in rural areas without stable broadband, those without easy access to technology, people experiencing homelessness, and people living in nursing facilities.¹⁴⁴

The changes listed below have been made to the delivery of healthcare services during the pandemic and represent changes that many organizations wish to see continue after the emergency orders expire. It is important to note that this is a rapidly changing environment and that much is subject to change.

1. On March 14, 2020, the Texas Medical Board received approval of the

governor's office to suspend certain rules to the Texas Occupations Code and the Texas Administrative Code. The changes, which were to remain in effect until the disaster declaration was lifted, included:

- a. The use of telemedicine (including telephone audio-only use) to establish physician-patient relationships
 - b. The use of telemedicine for diagnoses, treatment, ordering tests, and prescribing medications.¹⁴⁵
2. Additional changes to the telemedicine/telehealth service delivery rules include:
- a. Telemedicine and telehealth services are reimbursed in parity with in-person visits
 - b. Providers have a choice of technology platforms to use for service provision
 - c. Allowing the use of telephone audio-only for service provision.

Detailed information on the changes can be found on the CMS website at <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf> and the Texas Medical Association website at <https://www.texmed.org/telemedicine/>.

Many stakeholders are urging the continuation of expanded ability to use telemedicine/telehealth service delivery for mental health and substance use services. On September 1, 2020, Congressman Roger Williams (R-TX-25) introduced the *Ensuring Telehealth Expansion Act* that would extend the expanded telehealth provisions of the CARES Act until December 31, 2025. This legislation would remove site restrictions allowing patients to receive services in their homes and would require that providers be reimbursed at the same rate as face-to-face visits.¹⁴⁶

In addition to efforts to maintain flexibility in the use of telecommunications for service delivery, strong efforts are underway to increase access to internet services by increasing broadband across Texas. As of the writing of this guide, according to the Texas Tribune, 88 lawmakers have sent a joint request to Governor Greg Abbott to “develop a plan to expand broadband access in the state.”¹⁴⁷ The COVID-19 pandemic has amplified the need to ensure statewide access to internet services for not only the provision of health care services, but also for education, business, general communications, and more. According to the lead organization trying to expand broadband access in Texas, Connected Nation Texas, as broadband speeds increase, the rural areas of Texas with less broadband infrastructure fall further behind.¹⁴⁸ This leads to increased disparities in access primarily for rural areas of the state.

State Hospital Redesign Initiatives

Texas psychiatric state hospital services are, in many instances, being provided in outdated facilities that need significant repair, renovation, or replacement. The 85th Texas Legislature invested in planning and development, and the 86th Legislature continued that commitment by investing \$745 million for new construction and

renovations at existing state hospital campuses in Austin, Kerrville, Rusk, and San Antonio.¹⁴⁹ Additionally, funds are being devoted to a new hospital in Houston. Additional funding will need to be appropriated in the 87th legislative session to complete the projects already underway.

Projects currently underway include:

1. Austin State Hospital – construction of a new facility to replace the current hospital is currently underway and is expected to open in June 2023. HHSC has estimated the total cost of the facility to be approximately \$305 million.¹⁵⁰ The new hospital will be a 240-bed facility.
2. San Antonio State Hospital – construction of a new facility to replace the current hospital and renovation of an existing building is underway and is expected to open in January 2024. HHSC has estimated the total cost of the construction and renovation to be at least \$369 million.¹⁵¹ The new hospital will be a 300-bed facility and the renovated building will provide an additional 40 beds on the campus.
3. Rusk State Hospital – new construction of a 100-bed maximum security unit, a 100-bed non-maximum-security unit, and an administration building is planned. The total increase in bed capacity is expected to be approximately 60 additional beds costing an estimated total of \$196 million.¹⁵² Although completion dates of the three projects are staggered, construction of all three projects is expected to be completed by November 2024.
4. Kerrville State Hospital – renovation of existing campus buildings is currently underway with an expected completion date of September 2021. The renovation is expected to add 70-maximum security unit beds at an approximate cost of \$30.5 million.¹⁵³
5. UTHealth Houston Continuum of Care Campus – through a partnership between HHSC and UTHealth Houston, construction is underway for a 240-bed psychiatric hospital in the Texas Medical Center. This facility is expected to be completed by December 2021 at a cost of \$126.5 million.¹⁵⁴

During the planning phases of these initiatives, it was recognized that building new hospitals and adding additional beds would be ineffective if not considered in conjunction with the continuum of housing needs. Texas needs to invest in permanent supportive housing, step-down housing, and community housing to ensure inpatient beds are used for the purpose they are designed. Without a continuum of housing available for those with serious mental illness, state hospital beds will continue to be occupied by individuals that do not need that level of care. Without the appropriate supports and services in the community, there will continue to be individuals cycling in and out of the state hospital because there is no place else for them to go.

For additional information on the state psychiatric hospital system in Texas, see the HHSC section of this guide.

Housing for People Experiencing Mental Illness and Substance Use Disorder

Housing is consistently identified as one of the biggest barriers for people in their recovery from mental health and substance use conditions. Many people experiencing serious mental illness cannot work and therefore may be eligible to receive Supplemental Security Income (SSI) benefits. This is often their only income. Research reveals a pronounced housing affordability gap for SSI recipients who are considered extremely low-income, making less than 30 percent of the Area Median Income.¹⁵⁵ In 2020, recipients of SSI could receive a maximum of \$783 a month, which is not enough to pay for the \$892 fair market housing rent of a one-bedroom apartment.¹⁵⁶ In 2018, 89 percent of extremely low-income households had a cost burden at the same time Texas had a deficit of 611,181 rental units affordable to extremely low-income households.¹⁵⁷

People experiencing mental illness often need tenant supports and services to remain in housing successfully, something that makes finding a place to live even harder. Due to a lack of supportive housing, a large number of people experiencing homelessness are also living with mental illness. The 2019 HUD count of homelessness in Texas found that nearly 19 percent of individuals who are homeless have a severe mental illness (over 4,800), and almost half of those individuals are unsheltered (individuals are unsheltered if they live in a place not meant for human habitation, such as: cars, parks, sidewalks, or abandoned buildings. A person who is experiencing homelessness but is sheltered can reside in an emergency shelter or some form of transitional, supportive, or temporary housing).^{158,159}

Some housing programs exclusively serve people with substance use conditions. Recovery housing, also known as recovery residences or sober living homes, are shared living environments that promote sustained recovery from substances and may provide a varying degree of services or supports. One example is Oxford House, which is a non-profit operating recovery homes across Texas and other parts of the country. To qualify for residency, people must contribute to the daily functions of the household and remain sober from alcohol and drugs. However, these recovery homes do not offer additional supports and services and are therefore only appropriate for those further along in their recovery. Oxford Houses receive state funding, and have expanded in Texas in recent years. Other recovery homes that offer more intensive services are available in Texas, but are less common and do not receive any state funding. In 2019, HB 1465 (86th, Moody/Menendez) was introduced but did not pass. The bill would have directed HHSC to conduct an evaluative study on the current landscape, challenges, and opportunities to expand recovery housing across the state.¹⁶⁰ More information on recovery housing can be found in the Texas Department of Housing & Community Affairs (TDHCA) and Texas Health and Human Services Commission (HHSC) sections of this guide.

While people experiencing mental health and/or substance use conditions often qualify for housing programs that serve people with disabilities, there are only a small number of supportive housing programs. More information about these programs can be found here: <https://hhs.texas.gov/services/mental-health-substance-use/>

[mental-health-crisis-services/programs-people-who-are-homeless-or-risk-becoming-homeless](#). One example is the Supportive Housing Rental Assistance (SHR) program through HHSC.¹⁶¹ This program provides rental and utility assistance to individuals with mental illness, who were experiencing homelessness or likely to become homeless, and their families. The program provides supportive housing and mental health services to individuals in need. Priority is given to individuals transitioning from hospital settings, nursing facilities, forensic units, and individuals identified as frequent users of crisis services. This program is a partnership between HHSC and LMHA/LBHAs. Currently, SHR program funding allows the program to operate at 30 of the 39 LMHA/LBHAs. In January 2020, HHSC began developing a Housing Choice Plan that is expected to be published in December 2020 or January 2021. The purpose of the plan is to improve housing options for individuals with mental health conditions, IDD, criminal justice involvement, and/or substance use conditions. To inform the plan, HHSC:

- Convened a workgroup of stakeholders consisting of state agencies, individuals with lived experience, and organizations;
- Surveyed state agencies on housing activities;
- Held focus groups; and
- Conducted a statewide survey of individuals with lived experience, caregivers, advocates, and providers. HHSC initiated over 4,000 surveys across the state and was able to procure a 90 percent completion rate. The survey revealed:
 - The largest challenge for individuals with IDD, mental health conditions, and substance use conditions was lack of financial ability to procure their desired living situation. Other common challenges were inability to find housing in their community, criminal records limiting housing options, and past landlord experiences limiting their housing options.
 - A majority of respondents reported that the most needed supports to obtain desired housing was community resources navigation, transportation, and managing money.
 - Additionally, a majority of respondents with substance use conditions reported needing recovery support services.¹⁶²

The scope of the workplan includes an environmental scan of existing housing options, gaps and barriers in the state's housing system, and recommendations. While conclusive takeaways from the workgroup had not been finalized at the time of writing, below are some areas in which the workgroup had identified housing gaps, barriers, and recommendations specific to individuals with mental health conditions.

- The identified gaps include a lack of:
 - Affordable housing;
 - Opportunities for homeownership;
 - Financing for permanent supporting housing; and
 - Development of group homes, residential treatment facilities, transitional housing, and step-down/step-up housing.
- The identified barriers include:
 - Poor quality boarding homes;

- Confusion around tax credit programs;
 - Stigmas held by the public/landlords/developers;
 - Lack of awareness of one's own mental health or substance use condition; and
 - Strict eligibility criteria for the Home & Community-Based Services — Adult Mental Health (HCBS—AMH) program.
- Overarching recommendations revolve around:
 - Creating a landlord risk mitigation fund;
 - Providing training to tenants and housing providers on reasonable accommodation;
 - Providing life skills training to individuals who need assistance maintaining housing; and
 - Developing a person-centered discharge plan that includes identification of long-term housing options.

In the 86th Texas legislative session, HB 2564 (86th, White/Lucio) passed. The bill addresses the homeless youth population by requiring TDHCA to include foster youth in their low-income housing plans.¹⁶³ HB 4468 (86th, Coleman/Whitmire) eases the match requirement for counties with less than 250,000 people for the Healthy Community Collaboratives Housing program.^{164,165} HB 1257 (86th, Rosenthal), which failed to pass, would have given counties the authority to bar discrimination against tenants receiving funds for housing assistance.¹⁶⁶ Housing is a complex issue, but Texas' rapid population growth coupled with disastrous events such as COVID-19 will continue to make it a relevant issue moving forward for the Texas legislature and mental health stakeholders.

Children's Mental Health and Well-being

Tragic school shootings and an increase in youth suicide rates brought a heightened focus to the mental health of youth in Texas. Texas children and youth experiencing mental health concerns is common across the state. These needs can range from supports and services for a diagnosable mental health disorder to a more universal need for support of social and emotional well-being.

- In 2019, 38 percent of Texas high school students reported feeling sad or hopeless for a period of two weeks or longer that resulted in decreased usual activity.¹⁶⁷
- In 2019, one in ten high school students in Texas reported attempting suicide during the 12 months before the survey.¹⁶⁸
- In 2019, suicide was the second leading cause of death in those aged 15-34 in Texas.¹⁶⁹
- In 2019, one in five children in Texas were estimated to have experienced multiple adverse childhood experiences (ACEs).¹⁷⁰

BARRIERS TO SERVICES

Lack of access to behavioral health supports can have a serious and lasting impact

across all areas of a child's life. Leaving children and their families without support and services contributes to school drop-outs, unemployment, and potential involvement with the juvenile or criminal justice systems.¹⁷¹ Approximately 70 percent of youth who need mental health treatment do not receive it.¹⁷² Of those who are able to access services, only one in five children receive mental health specialty services. Unfortunately, even when specialty services are accessible, 40 to 50 percent terminate treatment prematurely due to various barriers such as lack of transportation, financial constraints, and stigma.¹⁷³

The behavioral health workforce shortage has been a barrier to receiving supports and services. This shortage is even more dire for youth specialty services. There has been a growing recognition that many mental health needs of youth are diagnosed and treated in settings other than psychiatry due to the severe shortage of child psychiatrists and other mental health professionals throughout the state. In 2018, there were only 690 Child and Adolescent Psychiatrists (CAPs) across the entire state of Texas. Consequently, the majority of mental health services are provided by professionals other than psychiatrists in many parts of Texas where there are significant shortages of these providers. As of June 2020, Texas had only met about 36 percent of the state's need of mental health professionals and 214 counties were designated as either full or partial Health Professional Shortage Areas for Mental Health (HPSA-MH).^{174,175} While access to specialty mental health care is often limited, families without resources or insurance have even more difficulty. Unfortunately, Texas leads the country in uninsured rates of children.¹⁷⁶

One solution to address the mental health workforce shortage is to make peer support services and family partner support services more readily available to youth and their families. During the 85th Texas legislative session, HB 1486 (Price/Schwertner) passed to make peer support services a Medicaid reimbursable state plan benefit. However, during rulemaking, youth were determined to be ineligible to receive peer support services despite these services being critical for youth and young adults. HHSC specified that an individual 18 and older could be a certified peer specialist, however, an individual is required to be 21 years of age or older to receive these services.

DISPARITIES

While gaps and barriers exist for youth and families to access behavioral health services, there are often additional difficulties certain youth face. These youth are often at higher risk of behavioral health concerns, and frequently do not receive services or receive services in inappropriate settings.

- LGBTQ youth are at least twice as likely as non-LGBTQ youth to attempt suicide, and gay and bisexual male youth are 15 times more likely to face substance use issues than the general population.¹⁷⁷
- Latinx children have the lowest rate of public or private health insurance coverage of any ethnic group.¹⁷⁸
- Black and Latinx children and youth experience higher rates of entry into juvenile justice and child welfare.¹⁷⁹
- Black and Latinx children have the highest rates of unmet need for mental health

services.¹⁸⁰

- The prevalence of diagnosed mental health disorders in individuals with intellectual disabilities is estimated to be between 32 percent and 40 percent, compared with approximately 20 percent in the general population.¹⁸¹
- Foster care youth are more likely than the general population to have a mental health concern.¹⁸²
- Justice-involved youth have higher rates of mental and behavioral health problems than their peers, including the onset of severe mental illness.¹⁸³

STUDENT MENTAL HEALTH AMID COVID-19

The 2019-2020 school year presented additional challenges for students and school personnel as a result of the COVID-19 pandemic. It can be expected that those challenges will continue and evolve during subsequent school years. Students and educators will be navigating unique and changed communities, as well as classrooms and schools. While data has not been collected to analyze the effects of the pandemic on the mental health of Texas students, data that is available indicate cause for concern.

An early study in China of over 2,300 students who were in lock-down for an average of 33.7 days found that 22.6 percent reported depressive symptoms and 18.9 percent were experiencing anxiety.¹⁸⁴ Further, as Texas experiences the economic implications of COVID-19, data shows that increased unemployment is associated with increased child abuse and neglect, increased incidence of injuries, and worsening of child and adolescent mental health.¹⁸⁵ As students return to their classrooms and others remain online, supporting their mental health and well-being will be imperative.

Learning is inextricably connected to a student's mental health. Positive behavior supports and interventions, as well as various models of social-emotional learning programs within a multi-tiered system of support, can help build positive learning environments. These programs are primarily school-based initiatives aimed at prevention, but also provide increased support for children identified as being at higher risk for behavioral challenges. More information on these programs can be found in the Texas Education Agency section of this guide.

EXCLUSIONARY DISCIPLINE AND THE SCHOOL-TO-PRISON PIPELINE

Despite the lack of evidence that exclusionary discipline is an effective method of changing students' behaviors in schools, it is often used. One in ten Texas students were suspended, expelled, or placed in an alternative education program during the 2018-2019 school year.¹⁸⁶ Students with disabilities and students of color are disproportionately affected. Despite making up a smaller percentage of overall student population, they are disproportionately removed out of their classrooms more than White students and those without disabilities.

Unidentified mental health conditions, substance use, or trauma can be perceived as “bad” behavior, and punitive discipline practices may be implemented. The effects of punitive discipline often negatively affect students’ senses of safety, well-being, and abilities to learn.¹⁸⁷ Some students may attend schools in communities with few resources or have supports that serve their particular, unique needs. When there are no other resources at hand, classroom removals are often implemented.

Research shows that exclusionary discipline increases the likelihood of lowered academic performance, dropping out, antisocial behavior, and future contact with the justice system.^{188,189} School exclusion is a central element in the school-to-prison pipeline, and has been a focus in numerous studies. Evidence proves a strong relationship between exclusionary discipline and academic failure, arrest juvenile justice system involvement, criminal justice system involvement, and incarceration.

^{190,191,192,193, 194,195}

As Texas students return to their classroom post COVID-19, support and guidance to schools on how to best support the mental health and well-being of students will be essential. Rather than punitive discipline as a response to unaddressed mental health conditions or trauma, it will be imperative that kids remain in their classrooms.

Foster Care Redesign and Community Based Care

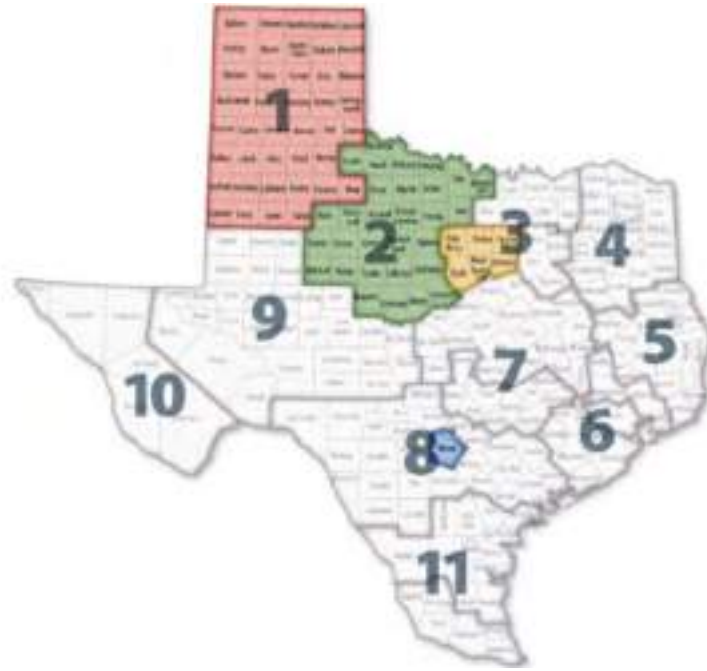
A majority of youth entering foster care have experienced some form of trauma, highlighting the need for the Texas foster care system to support youth mental health. These youth have often experienced psychological, sexual, or physical abuse, as well as neglect.¹⁹⁶ This can lead to higher rates of physical and behavioral health issues, substance use, and criminal justice involvement in adulthood.^{197 198} Symptoms of trauma are often interpreted as problematic behavior that are a result of issues unrelated to trauma. These symptoms can be worsened by inconsistency in child placements that send youth outside their home communities.^{199 200}

COMMUNITY BASED CARE

In 2010, the Texas Department of Family and Protective Services (DFPS) established the Foster Care Redesign Project known as Community-Based Care (CBC). This project is a new way of providing foster care and case management services through a community-based approach to meet the needs of children, youth, and families. CBC is meant to enhance safety, permanency, and well-being of youth in state conservatorship. DFPS contracts with a single source continuum contractor (SSCC) within a specific geographic area shown in Figure 6. Each SSCC is responsible for finding foster homes or other living arrangements and providing a full continuum of services, including mental health treatments and supports. To incentivize youth to be placed in the most appropriate service level, CBC transitioned the foster care system’s reimbursement structure. CBC funding is now performance-based and

linked to positive outcomes in a child's care rather than service level. With the assistance of DFPS's Child Protective Services and Texas CASA, SSCCs prioritize kin placements between youth and biological family members when possible.²⁰¹

Figure 6. CBC Catchment Areas in Texas



Source: Texas Department of Family and Protective Services. Community-Based Care. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

CBC is being implemented in two stages:

- Stage I – an SSCC develops a network of services and provides foster care placement services. The goal is to enhance general well-being of youth in foster care by keeping them close to home and connected to their communities.
- Stage II – the SSCC provides case management, kinship, and reunification services. The focus is on increasing services for families and permanency outcomes for youth.²⁰²

As of August 2020, CBC serves around six percent of all youth in foster care and about two percent of all forms of substitute care.²⁰³ Table 5 shows the current catchment areas currently using CBC:

Table 5. Current Status of Catchment Areas, July 2020

Region	Area covered	SSCC	Current Status	Next Step	Progress Report
3b	Seven counties around Fort Worth	Our Community Our Kids (OCOK)	Stage II	Ongoing monitoring	https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/region3b.asp

2	30 counties in North Texas (Abilene/Wichita Falls)	2Ingage	Stage I	Ongoing monitoring	https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/region2.asp
8a	San Antonio and Bexar County	Family Tapestry	Stage I	Transition to Stage II in FY 2020	https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/region8a.asp
1	Texas Panhandle (Lubbock/Amarillo)	Saint Francis	Stage I	Transition to Stage II based on legislative appropriations	https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/region1.asp
8b	TBD	TBD	TBD	TBD	N/A

Source: Texas Department of Family and Protective Services. Community-Based Care. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

For more information on CBC progress in various catchment areas, see the below reports:

View the April 2020 DFPS Rider 29 Report on CBC Implementation Status here: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-04-01_Rider_29-CBC_Implementation_Status_Report.pdf.

View DFPS's March 2020 Rider 15 report on CBC here: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-03-31_Rider_15_Community_Based_Care_Report.pdf.

DFPS's December 2019 Implementation Plan for the Texas CBC System, which reports on high-level accomplishments from FY 2018 - FY 2020, can be viewed here: https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-12-20_Community-Based_Care_Implementation_Plan.pdf.

TEXAS LEGISLATURE

The Texas Legislature passed several bills during the 86th legislative session to address concerns with the Foster Care Redesign Project:

- HB 72 (86th, White/Paxton) directs HHSC and DFPS to develop and implement a program that allows the adoptive parent or permanent managing conservator of a former foster child to receive or continue receiving Medicaid benefits under the STAR Health program or the STAR Kids managed care program.²⁰⁴
- HB 1709 (86th, Gonzalez/Menendez) allows school districts to work with DFPS to determine if a surrogate parent is unable or unwilling to act in the surrogate parent capacity for a child with disabilities.²⁰⁵
- SB 355 (86th, West/Click) directs DFPS to develop a strategic plan to identify optimal methods for providing foster care prevention services and implementing CBC, including identifying providers of mental health, substance use, and in-home

parenting support services.²⁰⁶

- SB 781 (86th, Kolkhorst/Leman) directs DFPS to develop strategies for trauma-informed protocols meant to reduce runaway incidents from residential treatment centers, and creates a plan for foster care placement facilities eligible for funding under the FFPSA.²⁰⁷

For more information on CBC, see the DFPS section of this guide.

Suicide

Rising suicide rates in Texas represent a growing concern for the state and mental health advocates. While the rate is highest in middle aged and elderly white males in rural communities, suicide impacts all demographics uniquely. People with physical and mental disabilities, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual) youth, and people of color all face particular barriers that discourage them from seeking mental health treatments. The COVID-19 pandemic is expected to amplify mental health conditions and suicide amongst other things.²⁰⁸

Since 2000, the Texas suicide rate has risen nearly 36 percent.²⁰⁹ In 2019, suicide was the 11th leading cause of death in Texas, and the 2nd leading cause for those aged 15-34.²¹⁰ In 2017, 1 in 8 high school students in Texas reported attempting suicide. Males in Texas are over 3.7 times more likely than Texas females to die by suicide, and White Texans are over two times as likely to die by suicide as Asian, Black, and Hispanic Texans.²¹¹ The rate of suicide is highest in non-Hispanic American Indian/Alaska Natives and White males, those aged between 45 and 54 and those over age 85, and those in rural communities.^{212,213,214} Rural areas in the US see high rates of suicide largely due to: residents' lack of access to mental health services, high rates of gun ownership, and long distances to hospitals which makes it difficult to provide timely medical care to isolated residences.^{215,216,217}

Figure 7. Suicide By Age - Texas, United States (deaths per 100,000 population)



Source: America's Health Rankings. (n.d.). Public Health Impact: Suicide. Retrieved from <https://www.americashealthrankings.org/explore/annual/measure/Suicide/state/TX>

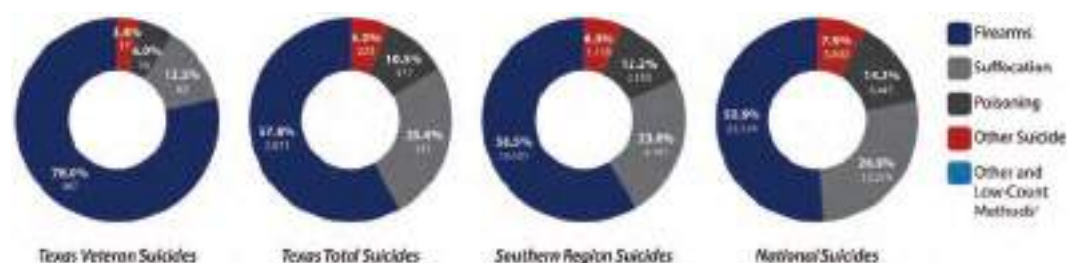
These statistics are directly correlated to the mental well-being of Texans. Living with mental health conditions does not equate to experiencing suicidology, despite existing stigmas. However, individuals with a diagnosed mental illness are at higher risk of suicide, representing about 46 percent of suicide victims according to the Centers for Disease Control and Prevention (CDC).²¹⁸ Individuals are particularly at-risk after experiencing reductions in their health care. Mental health parity laws, which facilitate access to mental health services, can help reduce suicide rates.²¹⁹

LETHAL MEANS

While all suicide attempts have an 8.5 percent death rate, those involving firearms are the number one cause of suicide death and have an 89.6 percent mortality rate.²²⁰ Reducing access to lethal means by assessing for dangerousness, rather than mental health conditions, is vital to reducing suicide death rates.²²¹ A study by the Harvard School of Public Health of all 50 U.S. states revealed that states with higher rates of gun ownership tend to have higher suicide rates, and states where gun ownership is less common have lower suicide rates.²²² This is most prevalent with the Texas veteran population who have higher rates of trauma, and among rural residents, who are nearly two times as likely to die by firearm suicides than urban residents.^{223,224} After the 89.6 percent firearm suicide mortality rate, drowning and hanging have the

highest suicide mortality rates at 56.4 percent and 52.7 percent.²²⁵ Figure 8 below illustrates the primary methods of suicide in Texas compared to in other regions and populations.²²⁶

Figure 8. Texas Veteran, Total Texas, Southern Region, and National Suicide Deaths by Method, 2017



Source: US Department of Veteran Affairs. (2019, June). Texas Veteran Suicide Data Sheet, 2017. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2017/Texas_Veteran_Suicide_Data_Sheet_2017.pdf

VETERANS

In 2017, the national suicide rate for US military veterans was 1.5 times the rate for non-veteran adults (adjusting for population differences in age and sex).²²⁷ Within Texas specifically, the veteran suicide rate (per 100,000 people) was 31.3 compared to 17.2 for the general state population. Over 95 percent of Texas veteran suicides in 2017 were males, which is far more skewed than the non-veteran average.²²⁸ As is shown in Figure 8 above, firearms are used in over 20 percent more veteran suicides than in suicides by the general Texas population.²²⁹ While veterans have the option to seek services through the Veterans Administration, long wait lists and significant travel distances can create barriers for veterans across the state, particularly in rural areas.^{230 231}

As a result of SB 578 (85th, Lucio/ Blanco), HHSC released the Short-Term Action Plan to Prevent Veteran Suicide in September 2019.²³² The goals focused on awareness, best practices, and seeking help, and are expected to be implemented by September 2021. The long-term action plan, which will include recommendations for statutory, administrative, and budget-related policy initiatives and reforms, are anticipated to be completed by September 2021 and implemented by September 2027.²³³ More information on veteran suicide prevention is available in the Texas Veterans Commission section of the guide.

LGBTQIA+ COMMUNITY

Individuals in the LGBTQIA+ community are at especially higher risk of suicide than the average population. Hostile environments, discrimination, prejudice, denial of civil and human rights, harassment, family rejection, and more can result in mental health conditions that contribute to suicidology.²³⁴ The CDC reported that LGBTQIA+ youth are more likely to seriously consider suicide than heterosexual

peers. According to data from September 2014 through December 2015, while 14.8 percent of heterosexual high school students had thought about suicide in the previous year, 42.8 percent of gay, lesbian, and bisexual students did.²³⁵ While 6.4 percent of heterosexual students reported a suicide attempt in the past year, the incidence rose to 29.4 percent amongst gay, lesbian, and bisexual students.²³⁶ Even more disparate, nearly 51 percent of transgender males and 30 percent of transgender females (ages 11-19) attempted suicide at least once in their lifetimes.²³⁷ Additionally, in 2018, men who had sex with men accounted for 69 percent of HIV diagnoses, a disease that research from 1988-2017 has shown can lead to being three times more likely to die by suicide.^{238,239} Black and Hispanic men having sex with men were the highest-diagnosed populations with HIV, making these populations particularly at-risk.²⁴⁰ LGB youth (trans, queer, intersex, and asexual youth were not included in this data) are also at high risk of being threatened, bullied (including cyberbullying), and victims of dating/physical/sexual violence and abuse.²⁴¹

LGBTQIA+ suicide can be reduced by having supportive families, peers, and mentors. Within educational organizations specifically, positive school climates are associated with decreased depression, suicidal feelings, substance use, and unexcused school absences for these youth.²⁴² See the Department of Family and Protective Services (DFPS) section for more information on LGBTQIA+ youth in Texas.

IMPACTS OF COVID-19

Due to COVID-19, researchers predict an increase in suicides.²⁴³ This is primarily due to physical and social distancing, financial hardships, and the trauma faced by loved ones of individuals who have died or become critically ill from the virus. During the 2007 Great Recession, there was a 1.6 percent increase in the suicide rate for every percentage point increase in the unemployment rate.²⁴⁴ Based on this trend, a 20 percent increase in unemployment from COVID-19 could result in an estimated 18,000 more Americans dying by suicide.²⁴⁵ When considering other pandemic-related factors not seen during the Great Recession, the suicide rate could vary broadly. Black Texans could be at even higher risk of suicide given their disproportionately higher death rates from COVID-19.²⁴⁶

Suicide rates are expected to be worse in rural parts of Texas, where mental health providers are already scarce.²⁴⁷ The expansion of telemedicine and telehealth, made possible by the waiving of cost-sharing and temporary ease of rules for providers and facilities, has allowed the state to continue serving the mental health needs of many Texans.²⁴⁸ However, there is less access to internet or technology in rural areas of the state, so telehealth is not always an option for these individuals. Therefore, the expansion of broadband internet paired with the permanent use of telehealth services could help treat the long-term ailments of Texans experiencing mental health conditions from this pandemic. This could lead to fewer suicides than otherwise anticipated.

In March 2020, the Texas Health and Human Services Commission (HHSC) launched a statewide COVID-19 Mental Health Support Line: 833-986-1919. This 24/7 statewide service provides help for Texans experiencing anxiety, stress, or

emotional challenges due to the COVID-19 pandemic.²⁴⁹ More information can be found at <https://hhs.texas.gov/about-hhs/communications-events/news/2020/03/hhs-launches-statewide-covid-19-mental-health-support-line>.

ACCESSING CARE IN COMMUNITIES OF COLOR TO REDUCE SUICIDE

Despite one in five US adults experiencing a diagnosed mental health condition each year, treatments and services are not universally available or utilized.²⁵⁰ People of color (POC) in Texas are more likely to be uninsured than White Texans.²⁵¹ Even though adult Black Americans are more likely than adult White Americans to report “feelings of sadness, hopelessness, worthlessness, or that everything is an effort,” they are less likely to seek out treatment and more likely to end treatment prematurely.^{252,253} This is likely due to financial and healthcare restraints caused by systemic racial oppression, long-held stigmas against seeking help within communities, and the inability of some healthcare providers to establish themselves as credible and reliable sources of support.²⁵⁴ The history of discrimination in healthcare, especially against Black women, has led many POC to hold a fundamental mistrust of some healthcare services.²⁵⁵ In order to treat mental health conditions and limit suicide within communities of color, it is vital that policies increase access to care and encourage services to be utilized.

SUICIDE PREVENTION LEGISLATION: 86TH TEXAS LEGISLATIVE SESSION

The 86th Texas Legislature passed several bills to address suicide. HB 3980 (Miller/Menendez/Hunter) directed HHSC and DSHS to publish a report on the prevalence of suicide in Texas and the state’s prevention efforts. The final report is expected to include recommendations to: 1) improve the collection and use of data related to suicide; 2) strengthen efforts to prevent and respond to suicide and suicide risk within state agencies; and 3) assist communities in implementing comprehensive, multi-sector suicide prevention efforts in order to reach individuals at-risk of suicide who are not engaged with state agencies.

HB 906 (86th, Thompson/Powell) created the Collaborative Task Force on Public School Mental Health Services. Among its charges, the task force was instructed to study the suicide rate of school employees, students, and family/guardians receiving state-funded mental health services.²⁵⁶

SB 11 (86th, Taylor/Bonnen) added a number of provisions related to suicide prevention, including:

- Requiring suicide prevention and mental health instruction to public school health education curriculums;
- Inclusion of a school safety allotment to be used at schools’ discretion. Possible uses of the allotment include supporting student mental health and suicide prevention strategies;
- Instructing School Health Advisory Committees to recommend grade-appropriate

policies, procedures, strategies and curriculum on mental health concerns, including suicide, as well as strategies to increase parental awareness of early warning signs of suicide risk factors;

- Requiring multi-hazard emergency operation plans (MEOP) to include strategies to ensure that there are required professional development trainings for appropriate school personnel in suicide prevention;
- Trainings on integrating psychological safety and suicide prevention into the MEOP for safety committee members, school counselors and mental health professionals, educators, and other school personnel;
- Creating the Threat Assessment and Safe and Supportive Schools Programs and Teams, which are responsible for conducting an assessment on students who make threats of self-harm. These teams also follow the district's suicide prevention protocol in order to connect them to the correct intervention and support; and
- Promoting schools' use of comprehensive suicide prevention strategies to respond to suicide attempts and deaths in order to prevent further suicidal behaviors.^{257,258}

HB 18 (86th, Price/Watson) established strategies to help school districts support the mental health needs and development of their students, including suicide prevention trainings being required in staff development. The bill also requires the Texas Education Agency (TEA) to develop best practices for all grade levels for schools to choose from that includes suicide prevention, intervention, and postvention, as well as how to best support a student returning to school following hospitalization or residential treatment for a suicide attempt.²⁵⁹

HB 4429 (86th, Blanco/Menendez) required mental health first aid training to veterans and their families, and for local mental health authorities to report how many veterans and their families completed mental health first aid each year.²⁶⁰

Many bills pertaining to suicide prevention were introduced but not passed during the 86th legislative session. If passed, HB 4193 (86th, Allison) and HB 3411 (86th, Allison) would have required school districts to have plans in place to address suicide prevention, intervention, and postvention.^{261,262} Educators would have been required to receive reoccurring suicide prevention training to better recognize students at-risk. HB 3235 (86th, Ramos) would have required suicide prevention training for educators every two years.²⁶³ While these trainings included in SB 1390 were to be conducted every five years instead of every two, when SB 1390 was amended to SB 11, this provision was defeated during conference committee.²⁶⁴ HB 471 (86th, Thierry) would have required suicide prevention training for mental health professionals.^{265,266} The final state budget excluded student mental health funding for the Texas Education Agency and suicide prevention funding that was included in the House version of the budget bill.²⁶⁷

A hearing was held on HB 517 (86th, Israel), a bill that would have banned mental health providers from engaging in “conversion therapy” for LGBTQIA+ youth.²⁶⁸ While it did not pass, DFPS did establish a workgroup focusing on needs of LGBTQIA+ youth in foster care.²⁶⁹

No legislation was passed focusing on access to lethal means, however the state did authorize and fund a suicide prevention and firearm safe storage campaign through the Texas Department of Public Safety.²⁷⁰ HHSC has promoted the U.S. Department

of Veterans Affairs’ Safe Firearm Storage Toolkit, which is part of their effort to reduce the risk for suicide or injury for service members, veterans, and families. The toolkit guides communities by way of coalition-building to increase awareness about safe storage and its connection to suicide prevention.

The Suicide Prevention Team at HHSC worked with DSHS’s Data Dissemination Team at the Center for Health Statistics to establish a webpage on youth suicides in Texas.²⁷¹ The data, which was published in May 2020, focuses on youth under the age of 25. It includes data on youth suicide mortality by demographics, the number of suicide-related calls to Texas Poison Control Centers, and at-risk populations from the Youth Risk Behavior Survey. The Youth Suicide in Texas data webpage can be found at: <http://healthdata.dshs.texas.gov/dashboard/births-and-deaths/youth-suicides>.

At the federal level, the Federal Communications Commission adopted rules in July 2020 establishing “988” as the nationwide three-digit phone number for Americans in crisis to contact the National Suicide Prevention Hotline to connect with suicide prevention and mental health crisis counselors.²⁷² HR 4194/S 2661 (116th, Gardner)—known as the National Suicide Hotline Designation Act—was passed by the Senate in May 2020.²⁷³ If passed by the House and signed into law, the bill would codify “988” as the phone number for the National Suicide Prevention Lifeline.

RESOURCES

By increasing access to care, reducing access to lethal means, dismantling stigmas against seeking mental health treatment, and reducing discriminatory disparities, the rising suicide rate in Texas can be diminished. Individuals experiencing thoughts of self-harm can call the National Suicide Prevention Lifeline at 1-800-273-8255, or visit suicidepreventionlifeline.org for more information.²⁷⁴ Select option 1 for the Veterans Crisis Line, which is also available via online chat. Support for people who are deaf and hard of hearing can be found by calling 800-799-4889, a number that is available 24/7.

Texans experiencing anxiety, stress, or emotional challenges due to the COVID-19 pandemic can call 833-986-1919 to be connected to HHSC’s statewide COVID-19 Mental Health Support Line.²⁷⁵ HHSC also offers suicide prevention resources at: <https://hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/suicide-prevention>.

Meeting the Mental Health Needs of Individuals with Intellectual Disabilities

People with intellectual disabilities (ID) experience mental health conditions and the impact of trauma at much higher rates than those without disabilities. Texas should prioritize change within the service delivery systems and promote practices

to ensure recovery-focused, appropriate mental health care, and trauma-informed care for individuals with ID.

Intellectual disabilities are a type of developmental disability that impacts cognitive and adaptive functioning. People with intellectual disabilities (ID) experience a higher rate of mental health conditions than the general population. The prevalence of diagnosed mental health conditions in individuals with ID is estimated to be between 32 percent and 40 percent, compared with approximately 20 percent in the general population.²⁷⁶ Additionally, studies have shown that diagnosed mental health conditions in individuals with ID can be more severe and more difficult to diagnose than in the general population.²⁷⁷ Yet, while people with ID are more likely to have a co-occurring mental health disorder, they often do not have access to appropriate mental health care.^{278,279,280} Service delivery is particularly fragmented for this population, as services may come from the mental health agencies or the ID agencies, but rarely both.²⁸¹ Additionally, services for people with ID often focus on behavior management rather than mental health treatment and support.

The public mental health system in Texas is based on the belief that recovery is possible, however this is rarely applied to individuals with ID and co-occurring mental health conditions. Access to evidence-based treatment and recovery support services is crucial for achieving recovery. Unfortunately, often the first line of “treatment” for an individual with ID is limited to psychopharmacology—psychotropic drugs are frequently used to control and manage behaviors, which may address the symptoms but not the illness.²⁸² This approach significantly reduces opportunities for recovery, and may serve to perpetuate any challenging behaviors.

People with ID face a “cascade of disparities” when accessing healthcare.^{283,284} Access to appropriate mental health treatment remains particularly difficult for many in this population. Barriers to receiving appropriate mental health care include lack of formal training for providers, diagnostic overshadowing (attributing behaviors to the disability and not assessing for mental health conditions), unwillingness of providers to serve people with ID, difficulty in facilitating communication between consumers and providers, and trouble navigating complex systems.²⁸⁵ In a 2014 survey, it was revealed that 90.2 percent of psychiatrists felt “they lacked specific training in treating and diagnosing mental health conditions in the ID population.”²⁸⁶

CURRENT LANDSCAPE

The Statewide Behavioral Health Strategic Plan identified “Behavioral Health Services for Individuals with Intellectual Disabilities” as a major gap (Gap 9) in our current mental health system of supports and services. The inclusion of Gap 9 in the strategic plan offers future opportunities for increasing access to quality mental health services for both children and adults with ID. While some efforts are underway to address this gap, the 2019 HHSC exceptional item #22 was significantly underfunded. This funding request proposed by the commission prior to the 86th Legislative Session offered opportunity for increasing mental health services for individuals with ID. The limited funds that were appropriated are being used to develop a learning collaborative pilot that is scheduled to be operationalized in 2021.

TRAUMA-INFORMED PRACTICES

People living with IDD experience abuse, neglect, bullying, isolation, institutionalization, and other forms of trauma at two to three times the rate of those without IDD.²⁸⁷ Research suggests nearly 30 percent of individuals with IDD have histories of physical and sexual abuse, and the actual rate may be even higher due to underreporting and lack of recognition by family and other caregivers.²⁸⁸ In one study, nearly 75 percent of participants with IDD reported having experienced at least one traumatic event in their lifetime, increasing the likelihood of developing a mental health condition.²⁸⁹ People with IDD experience the depression, anxiety, post-traumatic stress, and other symptoms associated with traumatic experiences.

As recognition of trauma and its impacts on mental health grows, individuals and organizations on the forefront of treatment and support for people with MH/IDD are shifting the conversation to include trauma-informed practices. Instead of asking “what’s wrong with this person,” we should be asking “what happened to this person, and how can we support them?”²⁹⁰ Instead of trying to manage and control behaviors, we should be offering positive support and treatment. While trauma is not the only cause of mental health challenges in people with disabilities, it is significant and requires attention.

The Hogg Foundation for Mental Health and the National Traumatic Stress Network partnered to create a comprehensive training toolkit, *The Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma*. This toolkit is now available in both English and Spanish, free of charge, on the NCTSN website. It can be found at <https://www.nctsn.org/resources/road-recovery-supporting-children-intellectual-and-developmental-disabilities-who-have>



Much more can be done to improve mental health treatment and services as well as increase opportunities for recovery for individuals with ID, including:

- Incorporating the treatment and support needs of individuals with ID into the state mental health plan;
- Devote adequate financial resources to treatment, services, and supports;
- Create a paradigm shift to move from “controlling and managing behaviors” to a culture of supporting the mental health recovery of individuals with ID;

- Create trauma-informed ID systems of care;
- Remove systemic barriers in the public mental health system that prevent individuals from receiving both ID and mental health services;
- Prioritize efforts to build awareness and foster education for providers, families, and individuals; and
- Build the workforce capacity of mental health providers willing to provide services to individuals with ID.

Mental Health and Substance Use Parity

Per federal regulations in the Mental Health Parity and Addiction Equity Act (MHPAEA), all health plans that offer mental health or substance use (MH/SU) benefits must provide those benefits at the same level (“parity”) as medical and surgical benefits. Originally passed in 2008, MHPAEA applied to only large employer plans but was expanded in 2010 through the Affordable Care Act to most private health plans, and eventually to Medicaid Managed Care Organization (MCO) plans and Children’s Health Insurance Program (CHIP) in 2016.²⁹¹ Areas requiring parity include²⁹²:

- Financial Limitations:
 - Aggregate dollar limitations (annual and lifetime)
 - Copays, deductibles and coinsurance
- Treatment Limitations – Quantitative:
 - Limits on the scope or duration of benefits expressed numerically, such as:
 - Number of visits
 - Days of coverage
 - Days in a waiting period
 - Other similar limits on the scope or duration of treatment
- Treatment Limitations - Non-Quantitative (NQTL):
 - Limits on the scope or duration of benefits not expressed, such as medical management standards, provider network admission standards, and reimbursement rates.

Parity applies to most health coverage. Plans not subject to parity protections in law include:

- TRICARE
- Medicare
- “Grandfathered” and “transitional” plans from a small employer in place before January 1, 2014; and
- State government, local government, or church-sponsored plans that opted-out of parity protections²⁹³:

During the 85th Legislative Regular Session lawmakers passed HB 10 (Price/Zaffirini) to address ongoing challenges with mental health and substance use parity protections in Texas. HB 10 required:

- The establishment of an ombudsman for behavioral health;
- The establishment of a MH/SU parity work group;
- Providing coverage for MH/SU that is under the same terms and conditions as a plan's medical/surgical benefits and coverage;
- Adopting related rules; and
- Studies from both Texas Department of Insurance (TDI) and HHSC to review and monitor NQTLs.

HB 10 became effective September 1, 2017. Completed studies by TDI and HHSC, as well as the report by the initial parity workgroup, were released in September 2018.

Key findings from the TDI report include:

- Medical/surgical claims were over two and a half times more likely to be overturned through internal appeals than MH/SU claims when originally denied;
- MH/SU inpatient claims were denied over 60 percent more often than medical/surgical inpatient claims;
- A larger proportion of prescription drugs for MH/SU were subject to step therapy requirements compared to drugs for medical/surgical use in the small group and large group markets; and
- Inpatient services were 114 percent more likely to be out-of-network for a MH/SU claim than a medical/surgical claim, and outpatient services were 30 percent more likely to be out-of-network for a MH/SU claim than a medical/surgical claim.²⁹⁴

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

Key findings from the HHSC report include:

- A higher percentage of MH/SU claims were denied as compared to medical/surgical claims for Medicaid claims but not for CHIP claims. In the CHIP program, medical/surgical claims were slightly more likely to be denied compared to MH/SU claims; and
- MH/SU claims in both Medicaid and CHIP were more likely than medical surgical claims to be subject to prior authorization.²⁹⁵

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

HB 10 directs the mental health condition and substance use disorder parity workgroup (workgroup) to study and make recommendations concerning compliance, enforcement and oversight, the parity complaint process, coordination with HHSC and TDI, and public and provider education on parity laws. Additionally, the workgroup is required to develop a strategic plan with metrics to serve as a roadmap to increase compliance with rules, regulations, and statutes. The workgroup

consists of three subcommittees:

- Subcommittee 1: Compliance, Enforcement, and Oversight
- Subcommittee 2: Complaints, Concerns, and Investigations
- Subcommittee 3: Education and Awareness

The workgroup's initial progress report was released in September 2018. The workgroup's second progress report was released in September 2020. Each subcommittee details recommendations within their scope of concentration.²⁹⁶

Subcommittee 1 recommendations include:

- HHSC and TDI develop and maintain standardized compliance tools that align with best practices to evaluate parity compliance with all products.
 - In current rulemaking as of July 2020, TDI has proposed requiring insurers to utilize the QTL compliance tools, the NQTL component of which is comparable to the 6 Step NQTL Compliance Toolkit. The subcommittee supports this approach.
- All insurance plans complete a parity analysis using the standardized tool and submit to the appropriate regulatory authority.
- Empower regulators to identify any parity compliance violation, require corrective action, and deter future violations.

Subcommittee 2 recommendations include:

- TDI and HHSC review the difficulty of locating parity complaint portals and compare with other states;
- TDI and HHSC identify effective complaint submission processes and tracking nationwide, standardize parity complaint portals, ensure portals are easy to read and understand, and minimize phone tree options on portals;
- TDI and HHSC identify options to increase the understanding of parity related denial, as well as status throughout the complaint process;
- TDI and HHSC ensure the use of best practice process and complainant satisfaction for parity complaints; and
- TDI and HHSC ensure equitable resolution of complaints across all groups.

Subcommittee 3 recommendations include:

- TDI and HHSC provide basic teaching and/or training related to parity rights and responsibilities. Strategies for accomplishing this objective may include:
 - Audience-specific parity law training modules;
 - Annual updates on parity rights and responsibilities;
 - Deeming October of each year as the recognition month of mental health and substance use disorder parity awareness;
 - Developing awareness materials for individuals without readily available internet access;
 - Shared language parity public publications; and
 - Leveraging external parity education materials.

The workgroup's Parity Strategic Plan includes a description of the current landscape of parity processes in Texas, as well as what current agency processes are in parity enforcement, investigations, education, and other areas.

The workgroup's Parity Strategic Plan includes a description of the current landscape of parity processes in Texas, as well as what current agency processes are in parity enforcement, investigations, education, and other areas. The workgroup's strategic plan is anticipated to be released by September 1, 2021.

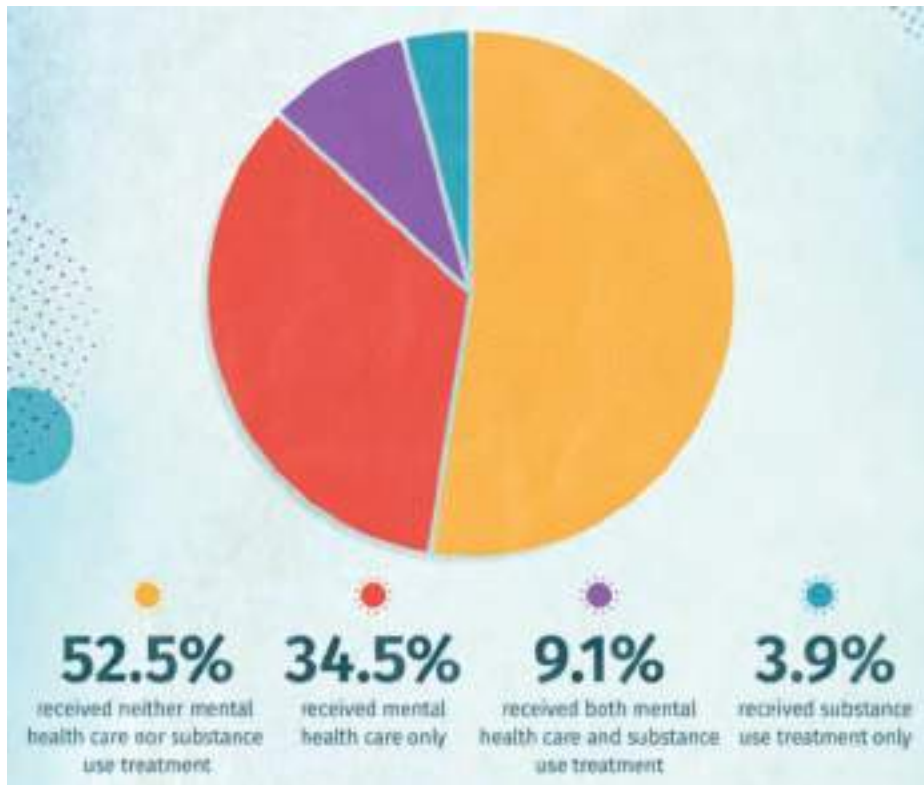
Substance Use

Substance use conditions and drug overdoses across the United States continue to evolve and cause devastating effects to individuals, families, and communities. Based on 2017 data from the National Institute on Drug Abuse, over 7.7 million Americans have co-occurring mental health and substance use concerns. Of the over 20 million adults with a substance use disorder (SUD), more than one-third also were diagnosed with a mental illness. Of the over 42 million adults with a mental illness, almost one in five also had a SUD.²⁹⁷ The emphasis on co-occurrence is important as the conversation unfolds on how to best address individuals' and communities' mental health, substance use, and overdose rates.

The statistics across the country show that a majority of individuals do not receive the appropriate care, particularly when in need of integrated care. Figure 9 illustrates the percentage of treatment received by adults with co-occurring mental health and substance use concerns. Even among those who want to find the appropriate integrated care, there are many various barriers to substance use treatment. Among adults with co-occurring disorders who did not receive substance use care, barriers identified included:

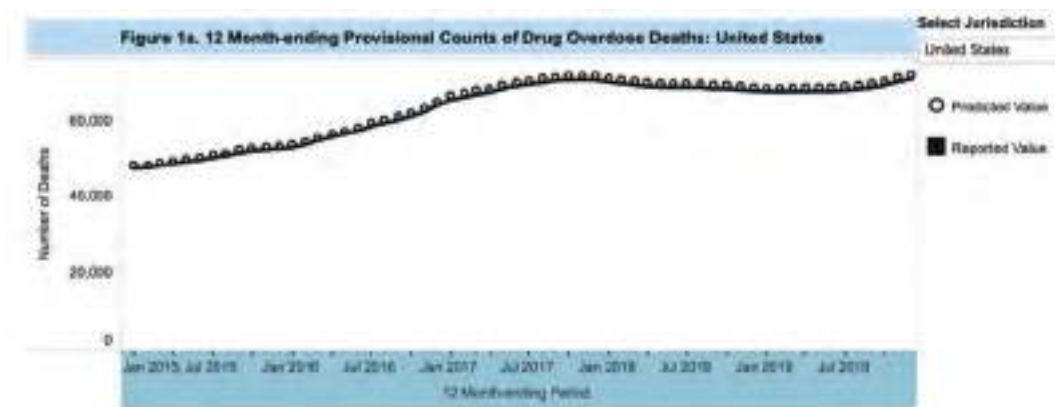
- Being uninsured and inability to afford the cost;
- Stigma from neighbors and employers;
- Lack of education on where treatment was offered;
- Insurance not covering the cost of treatment; and
- Inability to find an integrated care program.²⁹⁸

Figure 9. Types of treatment received by adults with co-occurring conditions



Source: National Institute on Drug Abuse. (August 2018). *Comorbidity: Substance use and other mental disorders*. Retrieved from <https://www.drugabuse.gov/drug-topics/trends-statistics/infographics/comorbidity-substance-use-other-mental-disorders>

In 2018, 67,367 fatal overdoses were recorded across the country, which was a decrease of 4.1 percent from 2017. This was the first decrease in 25 years, in part due to ongoing federal and state focus on the prescription opioid epidemic. While the overall number of lives lost decreased, multiple substances were increasingly responsible for deaths during this same time period. In 2018, drug overdose deaths involving synthetic opioids increased by 10 percent, those involving cocaine more than tripled, and those involving psychostimulants increased nearly 5-fold.²⁹⁹ While the overall 4.1 percent decrease resulted in saved lives and an opportunity to study states' successful initiatives, provisional data shows the overall number and rate of overdose deaths rose again in 2019, as is shown in Figure 10. Taking into account pending investigations of death and assumed underreporting, the CDC shows both the reported numbers, as well as the slightly higher predicted deaths. According to the CDC, drug overdose deaths in the US rose 4.6 percent in 2019 to 70,980.³⁰⁰

Figure 10. Drug Overdose Deaths in the U.S., 2015-2019

Source: Ahmad, F.B., Rossen, L.M., Sutton, P. (August 2020). *Provisional drug overdose death counts*. National Center for Health Statistics. 2020. Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

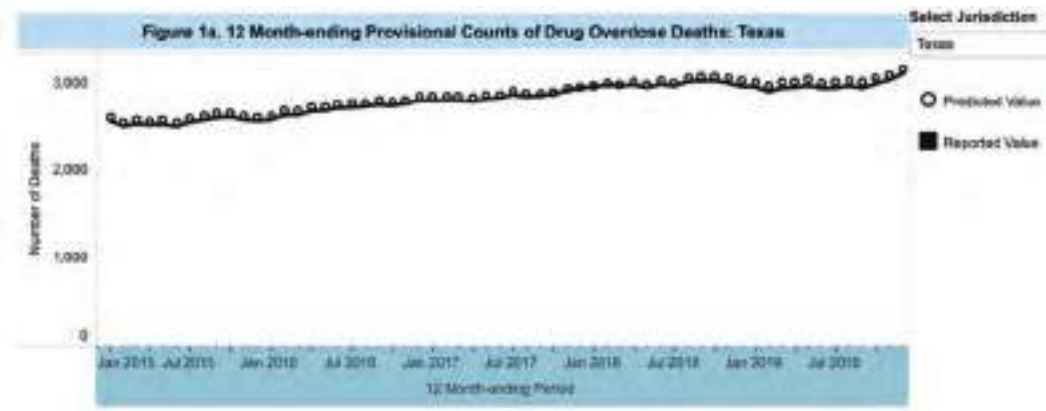
While these reported numbers are alarming, even more distressing is the data collection, reporting process of these deaths, and variance from provisional and final counts provided by the CDC:

“Drug overdose deaths often require lengthy investigations, and death certificates may be initially filed with a manner of death ‘pending investigation’ and/or with a preliminary or unknown cause of death. When the percentage of records reported as ‘pending investigation’ is high for a given jurisdiction, the number of drug overdose deaths is likely to be underestimated. For jurisdictions reporting fewer than 1% of records as ‘pending investigation’, the provisional number of drug overdose deaths occurring in the fourth quarter of 2015 was approximately 5% lower than the final count of drug overdose deaths occurring in that same time period. For jurisdictions reporting greater than 1% of records as ‘pending investigation’ the provisional counts of drug overdose deaths may underestimate the final count of drug overdose deaths by as much as 30%.”³⁰¹

SUBSTANCE USE IN TEXAS

Similar to the U.S., substance use and overdose death trends in Texas have evolved and steadily increased in recent years. Texas saw an increase in overall lives lost to overdose in 2019, as is illustrated in Figure 11. According to the CDC, Texas saw a five percent increase in deaths from 2018-2019, with over 3,100 Texans losing their lives to an overdose in 2019.³⁰² While Texas has focused its efforts largely on prescription opioids, Texas has seen increases among a number of other substances, namely methamphetamine and other stimulants.³⁰³

Figure 11. Drug Overdose Deaths Texas, 2015-2019



Source: Ahmad, F.B., Rossen, L.M., & Sutton, P. (August 2020). *Provisional drug overdose death counts*. National Center for Health Statistics. 2020. Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

GOOD SAMARITAN LAWS

There have been legislative attempts to reduce preventable overdose deaths by enacting drug overdose Good Samaritan laws in Texas. In 2015, HB 225 (84th, Guillen/Watson) passed both chambers with bipartisan support but was ultimately vetoed by Governor Greg Abbott. HB 225 would have provided legal protections to people who sought medical emergency treatment for another individual or themselves during a drug overdose. The legislation included protections related to low-level possession and paraphernalia. Governor Abbott's veto proclamation stated that the lack of "adequate protections to prevent its misuses by habitual abusers and drug dealers" led to his decision.³⁰⁴

Though the laws vary in protections, 45 states and the District of Columbia have passed overdose Good Samaritan laws. This type of law has resulted in a reduction of overdose-related deaths, specifically reducing opioid-related deaths by much as 15 percent, and even greater reductions for Black (26 percent) and Hispanic (16 percent) populations.³⁰⁵ Following the 85th session, examining the effectiveness of such laws was a charge issued to the Select Committee on Opioids and Substance Abuse. The select committee gave a recommendation to the 86th legislature to enact a Good Samaritan law. During the 86th legislative session, HB 2432 (Raney/Watson) was filed, but failed to be heard in either chamber. Advocates continue to advocate for a Good Samaritan law to pass in Texas.

ACCESS TO STATE-FUNDED AND MEDICAID SUBSTANCE USE SERVICES

Only a small portion of individuals needing substance use treatment receive the appropriate services. In FY 2019, only 32,346 Texas adults living below 200 percent of FPL with a substance use disorder were served by state-funded substance use providers.³⁰⁶ Additionally, only 4,219 children living below 200 percent of FPL with a

substance use disorder received services through HHSC; this means the majority of children living in poverty with substance use treatment needs did not receive state-funded treatment services.³⁰⁷

These figures for substance use service utilization do not show the entire picture of the substance use needs within our state. The statistics do not include the number of individuals who are not living in poverty (i.e., below 200 percent of FPL) but may still have trouble accessing HHSC-funded substance use services. Often this group of people is considered in the Medicaid “coverage gap”. They are unable to access services because their income is too high to qualify for Medicaid yet are unable to afford private insurance or pay for their services on a sliding scale. Additionally, utilization of these benefits is limited due to eligibility limitations excluding a sole diagnosis of a SUD to qualify an individual for Medicaid coverage.

This eligibility rule means that a person must have another physical or mental health condition that would qualify them for Medicaid, along with Texas’ stringent Medicaid eligibility based on an individual’s income and assets. Because of these strict criteria for services, utilization has been fairly limited in comparison with the needs of the state. In FY 2019, only 17,216 Medicaid claims were filed for substance use treatment services under Medicaid.³⁰⁸

Other low-income individuals in need of SUD support and services can receive services through the federal Substance Abuse Prevention and Treatment block grant. In order to qualify for block grant services, the individual must be unable to acquire private insurance, Medicaid, or Medicare, and have an income less than 200 percent of the FPL (approximately \$25,000/year). At any point during FY 2017, over 13,000 adults were on a waitlist to receive SAPT-funded treatment, varying from the average of 16 days to the maximum wait of 293 days.³⁰⁹

This discrepancy between need and utilization could result from a variety of policy issues, including: workforce shortages, chronically low funding, inadequate reimbursement rates, waiting lists for services, stigma surrounding seeking services for substance use, worries about having substance use reported to law enforcement, and a general perception that mental health priorities take precedence over substance use priorities.³¹⁰

In 2019, the federal government passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. Among its provisions, the SUPPORT Act removed the originating geographic site conditions and added an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.³¹¹ To increase access to substance use services, Texas lawmakers passed legislation during the 86th legislative session to increase telehealth and telemedicine utilization. HB 3285 (Sheffield/Huffman) directed the executive commissioner of HHSC to establish a program to increase opportunities and expand access to telehealth treatment for substance use disorders. SB 670 (Buckingham/Price) ensured Medicaid MCOs provide reimbursements for a covered service whether that service was provided virtually or in-person.

COVID-19 AND INCREASED SUBSTANCE USE

Across the country, there is mounting evidence pointing to a continued and exacerbated substance use and overdose epidemic as a result of COVID-19. National data suggests that overdoses have not only increased since the pandemic began, but are accelerating as it persists:

- Compared to 2019, national overdose rates (both fatal and non-fatal) increased by 18 percent in March 2020, 29 percent in April 2020, and 42 percent in May 2020.³¹²
- A national laboratory service conducted an analysis of over 500,000 urine tests from March-July 2020, and found an increase in use of non-prescribed fentanyl (31.96 percent), methamphetamine (19.9 percent), cocaine (12.5 percent), and heroin (12.5 percent).³¹³
- National alcohol sales increased by 27 percent from March to August 2020.³¹⁴
- More than 40 states have reported increases in opioid-related mortality during the COVID-19 pandemic.³¹⁵
- The federal Overdose Detection Mapping Application Program (ODMAP), which tracks overdoses nationwide, issued 191% more “spike alerts” in January to April 2020 than in the same time period in 2019. An ODMAP spike alert is triggered when ODMAP submissions increase two standard deviations above the mean in the past 24 hours for a particular county and state.³¹⁶

As the country and world navigate COVID-19 and its impact on individual and community well-being, the rise of substance use and subsequent overdoses extend to Texas. While statewide data has not been made readily available, localized data from different areas across the state confirm these challenges:

- Williamson County has seen a near five-fold increase in opioid overdose calls;³¹⁷
- Houston has seen a 31 percent increase in overdose emergency calls during January-March 2020 compared to 2019;³¹⁸
- Dallas area clinics report being overwhelmed by cases involving overdoses and relapses.³¹⁹

According to a projection and analysis completed by the Meadows Mental Health Policy Institute (MMHPI), for every increased percentage point in unemployment in Texas during the COVID-19 recession across a year, additional Texans will struggle with substance use and experience a fatal overdose. Table 6 and Table 7 further illustrate MMHPI’s projections of increased substance use and fatal overdoses in Texas as a result of COVID-19’s economic effects on the state.³²⁰

Table 6. MMHPI Overdose-related Death Projections

Percentage Increase in Unemployment	Increase of Overdose Deaths
1%	90
5%	425
10%	850
20%	1,700

Source: Meadows Mental Health Policy Institute. (2020). *MMHPI COVID-19 response briefings: Projected COVID-19 MHSUD impacts, volume 1 (appendix): Effects of COVID-induced economic recession (COVID recession) on each U.S. state*. Retrieved from <https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts-StateAppendix.pdf>

Table 7. MMHPI SUD Projections

Percentage Increase in Unemployment	Increase in Substance Use Disorders
1%	10,000
5%	50,000
10%	100,000
20%	200,000

Source: Meadows Mental Health Policy Institute. (2020). *MMHPI COVID-19 response briefings: Projected COVID-19 MHSUD impacts, volume 1 (appendix): Effects of COVID-induced economic recession (COVID recession) on each U.S. state*. Retrieved from <https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts-StateAppendix.pdf>

Emerging evidence suggests that the rise in increased substance use and number of overdoses is multifaceted. There are a myriad of contributing factors including isolation, the economy, and the drug trade. Conditions that often increase the risk of substance use, relapse, or overdose have been heightened by the pandemic.

- Research shows that drug use often increases during economic downturns.³²¹
- Stress is a common trigger for those at risk of relapse.³²²
- Pandemic-related changes in drug supply chains create unknown or unfamiliar potency of substances.³²³
- Financial hardships and social distancing requirements due to the pandemic, have caused service providers to close or limit services, increasing the challenges of accessing care.³²⁴

SUPPORT FOR PATIENTS AND COMMUNITIES ACT

On October 24, 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act to address the need to support individuals with substance use concerns. The comprehensive, bipartisan legislation included a number of initiatives aimed at treatment, prevention, recovery, and enforcement. A few highlights of the legislation include:

- Allows for flexibility of federal Medicaid payments to institutions for mental disease (IMD) for substance use disorder (SUD) services. *More information on this can be found in the HHSC section of the Guide;*
- Requires states to restore a child or youth's Medicaid if it was suspended while they were incarcerated in the juvenile justice system without a new application when released;
- Directs the US Government Accountability Office (GAO) to study and submit a report on how Medicaid covers peer support services;
- Directs the Centers for Medicare & Medicaid Services (CMS) to issue guidance to states on providing SUD services via telehealth under Medicaid;
- Directs US Health and Human Services (HHS) to issue a report on innovative, Medicaid-covered housing-related services to support individuals with SUD and who are experiencing homelessness or are at risk of homelessness;
- Requires states' Children's Health Insurance Program (CHIP) to cover mental health benefits, including SUD services, for eligible pregnant women and children at parity with physical health treatment;
- Requires HHS to issue best practices for recovery housing operations and to develop indicators to identify fraudulent recovery housing operators;
- Allocates \$10 million per FY 2019-2013 for hospitals and other entities to develop discharge protocols for individuals admitted for an overdose, including naloxone access and connection to peer support;
- Reauthorizes and modifies the Building Communities of Recovery program to include peer support networks;
- Requires HHS to establish or operate a National Peer-Run Training and Technical Assistance Center for Addiction Recovery Support, providing technical assistance and support to Recovery Community Organizations and peer support networks providing peer support related to SUD;
- Reauthorizes the State Targeted Response (STR) grants to provide funding to tribes and improve flexibility for states;
- Allocates \$20 million for states to develop, enhance, or evaluate family-focused treatment programs that will later qualify for funding under Family First Prevention Services Act;
- Prohibits payment or kickbacks in return for referring a patient to a recovery home or clinical treatment facilities; and
- Directs HHS to publish a SUD Data Book inclusive of state-specific and national Medicaid and CHIP enrollment, demographics, service utilization, and payments. The first SUD Data book was released on October 24, 2019, and can be found at <https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html>. The initial SUD Data Book reports the number of Medicaid beneficiaries with a SUD and the services they received during calendar year 2017. Updated SUD Data Books are required to be released no later than January 1 of each calendar year through 2024.

The American Society of Addiction Medicine created a section-by-section overview of the 250 page legislation available at https://www.asam.org/docs/default-source/advocacy/hr6_09-28-18-final-opioid-sec-by-sec_bipart-bicam.pdf?sfvrsn=49d048c2_2.

CONFIDENTIALITY OF SUD RECORDS

42 CFR Part 2 (Part 2) is a federal law that protects confidentiality of SUD records. This includes the identity, diagnosis, prognosis, or treatment in any patient records maintained in connection with the performance of any federally assisted program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research.³²⁵ In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and unexpectedly, this piece of legislation amended Part 2 through an added rider.

Prior to the CARES Act, Part 2 required an informed consent from the individual every time their records were released and shared. The contention around privacy rights and the alignment of Part 2 closer to HIPPA has divided key players in the substance use treatment community, many of whom are otherwise aligned.³²⁶ Re-disclosure without patient consent was a staple and centerpiece of the protections provided by Part 2, however was eliminated by the CARES Act. The revised and final rules of Part 2 were published on July 15, 2020, and include the language, *“If a patient consents to a disclosure of their records under § 2.31 for payment or health care operations activities, a lawful holder who receives such records under the terms of the written consent may further disclose those records as may be necessary for its contractors, subcontractors, or legal representatives to carry out payment and/or health care operations on behalf of such lawful holder.”*³²⁷

This change allows the individual/entity that receives SUD records as a result of an informed consent, the “lawful holder,” to further disclose such records to contractors, subcontractors, and legal representatives for the purpose of payment and certain health care operations. SAMHSA included a list of 18 permissible activities considered “payment and health care operations activities,” however the list is not exhaustive and allows for “other payment/health care operation activities not expressly prohibited in this provision.” Despite opposition, the list was expanded to expressly include care coordination and case management activities.

Additional expansion of disclosing SUD records without patient consent under part 2 includes amending the definition of medical emergency. Now, declared emergencies by a state or federal authority as the result of a natural or major disaster that closes a program or prohibits the ability to obtain patient written consent will meet the definition of a “bona fide medical emergency.”³²⁸

Supporters of the rule change believe that relaxing the ability to share SUD treatment records will enhance the coordination of patients’ care across settings. According to SAMHSA, “Part 2 has been revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use.”³²⁹

However, during the period of public comment on the revised rules to Part 2, many stakeholders opposed the changes. Critics argued the changes would deter treatment, infringe on the patient-provider relationship, increase stigma, and lead to criminalization. Opponents also claimed that allowing more easily shareable

records would be detrimental to individuals who might avoid seeking care for fear of facing stigma, discrimination, or potential legal consequences.³³⁰ According to Dr. H. Westley Clark, who served as director of the SAMHSA Center for Substance Abuse Treatment from 1998-2014, “with over 90% of people with [SUD] not currently accessing treatment, weakening the current protections for patient privacy contained in Part 2 will not fix what is broken. Instead, it will drive even more people away from [SUD] treatment and penalize the over 20 million people in recovery...”³³¹

Further, changed language includes “*..that information conveyed orally by a part 2 program to a non-part 2 provider for treatment purposes with the consent of the patient does not become a record subject to this part in the possession of the non-part 2 provider merely because that information is reduced to writing by that non-part 2 provider.*” Supporters advocated for the change as a method to decrease the administratively burdensome work of redacting information in non-part 2 records or keeping SUD records separate.

Conversely, those who oppose this change argue that when records are released to non-part 2 providers, the additional legal protections against law enforcement’s ability to obtain records has been removed. While still under HIPPA protections, law enforcement authorities are able to obtain patient records with subpoenas and general court orders from non-part 2 providers.³³² Records under Part 2 requires law enforcement authorities and judicial or administrative bodies to produce a special court order for disclosure of records.³³³

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Texas Mental Health and Substance Use Funding

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Acronyms

CMS – Center for Medicaid/Medicare Services	SBHCC – Statewide Behavioral Health Coordinating Council
CPAN – Child Psychiatry Access Network	SPF-RX – Strategic Prevention Framework for Prescription Drugs
DSRIP – Delivery System Reform Incentive Payment Program	SOR – State Opioid Response
ESC – Education service centers	SSLC – State supported living center
FTE – Full-time equivalent	STR – State Targeted Response
GR – General revenue	TCHAT – Texas Child Health Access Through Telemedicine
HHSC – Health and Human Services Commission	TDCJ – Texas Department of Criminal Justice
IDEA – Individuals with Disabilities Education Act	TDHCA – Texas Department of Housing and Community Affairs
LBB – Legislative Budget Board	TEA – Texas Education Agency
LIDDA – Local intellectual/developmental disability authority	TJJJD – Texas Juvenile Justice Department
LMHA – Local mental health authority	TTOR – Texas Targeted Opioid Response
MCO – Managed care organization	YES – Youth Empowerment Services Waiver
MDCP – Medically Dependent Children’s Program	
SAMHSA – Substance Abuse/Mental Health Services Administration	

Texas Mental Health and Substance Use Funding

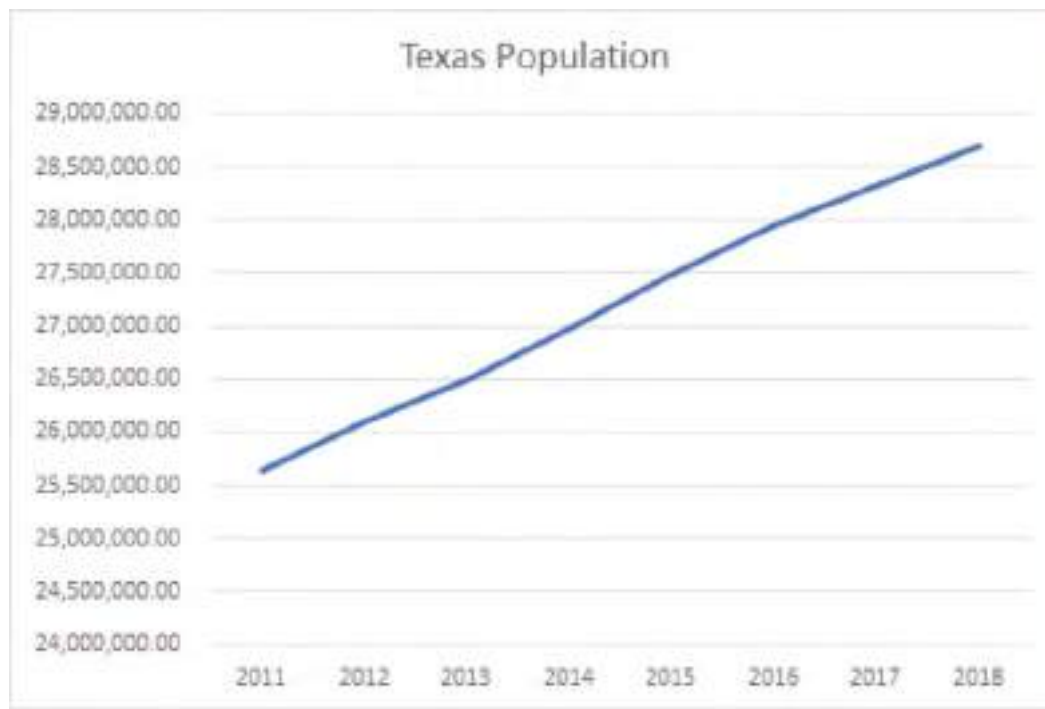
Funding mental health and substance use services in Texas is complex and includes a multitude of state agencies, institutions of higher education, community mental health centers, community health clinics, as well as a myriad of programs, providers, non-profits, private entities, and projects funded by federal, state, and local dollars. The Health and Human Services Commission (HHSC) has made great strides in identifying and coordinating behavioral health services funding through the initial development and annual updating of the Coordinated Statewide Behavioral Health Expenditure Proposal. The report identifies state funding for mental health and substance use services spread across 23 state agencies and institutions of higher education that are members of the Statewide Behavioral Health Coordinating Council. The coordinated expenditure proposal links funding to the strategies included in the Statewide Behavioral Health Strategic Plan.

The funding sources for mental health and substance use are diverse and often co-mingled with other strategic purposes, making it difficult to accurately pinpoint behavioral health funding. Some of the legislative funding directives allow enhanced spending for existing or new programs, while other directives appropriate existing funding to specific projects. In this section of the guide, we will highlight the major sources of behavioral health funding and how that funding has been allocated in recent years.

The increased demand for mental health and substance use services in Texas directly impacted the overall cost of services. One obvious reason for increased demand is

the fast-growing Texas population. According to the Texas Demographic Center, the population of Texas is projected to reach 29,677,772 in 2020.¹ This is an increase of approximately 4,532,211 over the 2010 U.S. Census.²

Figure 12. Population Growth in Texas



Source: U.S. Census Bureau. 2019. https://www.google.com/publicdata/explore?ds=kf7tgg1uo9ude_&met_y=population&idim=state:48:06&hl=en&dl=en#!ctype=l&strail=false&bcs=d&nselm=h&met_y=population&scale_y=lin&ind_y=false&rdim=country&idim=state:48&ifdim=country&hl=en_US&dl=en&ind=false

In this section of the guide, general information on the funding of mental health and substance use services will be provided as an overview. Additional funding information such as funding trends for agencies and costs for services are provided in the agency sections of the guide.

Sources of Mental Health and Substance Use Funding

Mental health and substance use services are funded through both the federal and state governments. Federal funding comes to Texas through a multitude of agencies and programs with Medicaid and the mental health/substance use block grants being the largest federal appropriation. The Centers for Medicare and Medicaid Services (CMS) funds Medicaid services in addition to state funding while the Substance Abuse and Mental Health Services Administration (SAMHSA) under the US Department of Health and Human Services funds the mental health/substance use block grants. Federal funding for mental health and substance use services is

also funneled to Texas through other agencies such as the Department of Education, Department of Justice, Department of Veterans Affairs, Department of Housing, Social Security Administration, and more.

Federal Funding

MENTAL HEALTH AND SUBSTANCE USE BLOCK GRANTS

Mental health and substance use block grant funding is distributed in a noncompetitive manner to states based on congressionally mandated formulas. States must submit applications to SAMHSA annually in order to be eligible for the funds. Block grant funding is used for prevention services and programs, treatment, and to support mental wellness and recovery. Texas block grant funding allotments for FY 2019 are shown below.

Table 8. Texas Block Grant Summaries FY 2019

Formula Funding	
Substance Abuse Prevention and Treatment Block Grant	\$145,059,714
Community Mental Health Services Block Grant	\$58,014,172
Project for Assistance in Transition from Homelessness (PATH)	\$4,996,262
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	0
Subtotal of Formula Funding	\$208,070,148
Discretionary Funding	
Mental Health	\$33,967,030
Substance Abuse Prevention	\$8,643,821
Substance Abuse Treatment	\$66,299,003
Subtotal of Discretionary Funding	\$108,909,854
Total Funding	
Total Mental Health Funds	\$96,977,464
Total Substance Abuse Funds	\$220,002,538
Total Funds	\$316,980,002

Source: SAMHSA. 2019. Texas Summaries FY 2019. Retrieved from <https://www.samhsa.gov/grants-awards-by-state/TX/2019>

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP)

Delivery System Reform Incentive Payment Program (DSRIP) provides a pool of federal funds to be used in locally driven projects aimed at improving the healthcare delivery system through the Quality Improvement Program Medicaid 1115 Demonstration Waiver. The 1115 Waiver also allows for statewide expansion of Medicaid managed care and provides uncompensated care funding for hospitals. Uncompensated care funding is used when a patient is uninsured and unable to pay for their treatment. From 2012-2019, over \$15 billion was used to serve approximately 11.7 million Texans.³ The primary areas of focus for DSRIP projects in Texas includes:

- Behavioral health
- Primary care
- Patient navigation, care coordination, and care transitions, especially for complex populations
- Chronic care management
- Health promotion and disease prevention

DSRIP projects are intended to provide opportunities for innovation while demonstrating cost neutrality. The most recent extension of the waiver provided approval through September 30, 2022.

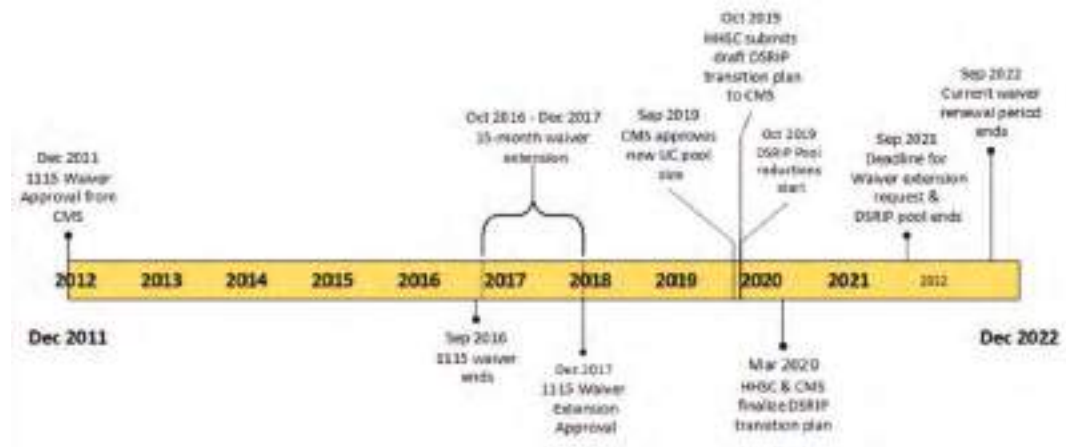
In 2020, the state was required to submit a final DSRIP transition plan to CMS. The plan describes how Texas will continue to develop and improve service delivery without the aid of federal DSRIP funding after Demonstration Year 10. Key focus areas of the transition plan include:

- Sustain access to critical health care services;
- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for patients with complex conditions that have high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Integration of public health with Medicaid;
- Telemedicine and telehealth;
- Social drivers of health.⁴

DSRIP projects have had a direct impact on both access to behavioral health services and the quality of services provided. Many of the state's DSRIP projects addressed mental health and substance use through integrated healthcare, expansion of peer support services, expanded telehealth and telemedicine, increase in outpatient locations, improvement in residential options, expansion of innovative services offered, and much more.

The figure below depicts the general timeline of the original waiver and subsequent extensions.

Figure 13. 1115 Demonstration Waiver Timeline



Source: HHSC Presentation to Senate Health and Human Services Committee. December 3, 2019. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/leg-presentations/senate-health-human-services-dec-3-2019.pdf>

The amount of funding provided to Texas for innovative healthcare projects has been significant. The table below provides estimates of funding for Demonstration Years 7-11.

Figure 14. DSRIP Pool Annual Amounts (Billions)

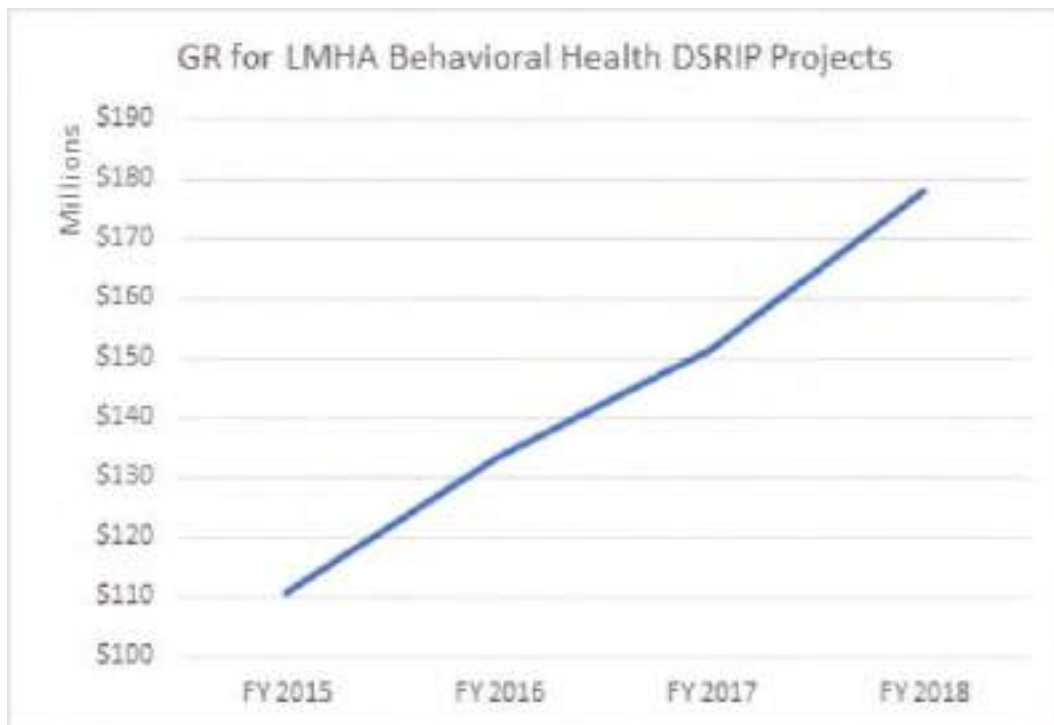
DSRIP	Demonstration Year (DY)	Pool Amount (All Funds)
DSRIP 1.0	DY1	\$0.50B
	DY2 (10/1/12 – 9/30/13)	\$2.30B
	DY3 (10/1/13 – 9/30/14)	\$2.67B
	DY4 (10/1/14 – 9/30/15)	\$2.85B
	DY5 (10/1/15 – 9/30/16)	\$3.10B
	DY6 (10/1/16 – 9/30/17)	\$3.10B
DSRIP 2.0	DY7 (10/1/17 – 9/30/18)	\$3.10B
	DY8 (10/1/18 – 9/30/19)	\$3.10B
	DY9 (10/1/19 – 9/30/20)	\$2.91B
	DY10 (10/1/20 – 9/30/21)	\$2.49B
	DY11 (10/1/21 – 9/30/22)	\$0

Source: Health and Human Services Commission. (August 27, 2020). Delivery System Reform Incentive Payment (DSRIP) Transition Plan. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrp-transition-plan.pdf>

The local mental health authorities (LMHAs) have contributed general revenue (GR) funds to draw down the federal funding since the beginning of the program. The figure below depicts the GR funds contributed through FY 2018.

Table 9. Local Mental Health Authority General Revenue Contributions to DSRIP Projects

	FY 2015	FY 2016	FY 2017	FY 2018
LMHA GR DSRIP Projects	\$110,847,628.00	\$ 133,415,160.00	\$ 151,685,701.48	\$177,761,494.15



Sources: Texas Health and Human Services. (December 2018). *Report on Mental Health Appropriations and the 1115 Texas Medicaid Transformation Waiver*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider-72-mental-health-approp-1115-waiver-fy-2018.pdf>

Texas Health and Human Services. (November 2017). *Report on Mental Health Appropriations and the 1115 Texas Medicaid Transformation Waiver*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/sb1-fy2017-mental-health-appr-1115-transformation-waiver-nov-2017.pdf>

Texas Health and Human Services. (February 2017). *Report on Mental Health Appropriations and the 1115 Texas Medicaid Transformation Waiver*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/mental-health-appropriations-1115-waiver.pdf>

Texas Department State and Health Services. (January 2016). *Report on Mental Health Appropriations and the 1115 Texas Medicaid Transformation Waiver*. Retrieved from <https://www.dshs.texas.gov/legislative/2016-Reports/Mental-Health-Appropriations-and-the-1115-Texas-Medicaid-Transformation-Waiver.doc>

Transitioning to a post-DSRIP period presents many challenges for Texas due to the

substantial funding decreases. The final, DSRIP Transition Plan released on August 27, 2020 can be viewed at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf>. Sustaining the many successful programs and services developed during the DSRIP years is essential to the quality of mental health and substance use services available to Texans. HHSC and a myriad of stakeholders have invested enormous amounts of time in developing a plan and working with CMS on how to move forward. Transition plan milestones are included in the figure below.

Figure 15. Draft Transition Plan Milestones

September 2020	December 2020	March 2021 [2021 Texas Legislative Session]	September 2021 [DY 11 (Oct. 2021 – Sept. 2022)]
<ul style="list-style-type: none"> Update the Texas Value-Based Purchasing Roadmap to address strategies to sustain key DSRIP initiative areas Identify and submit to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11 of current Waiver period 	<ul style="list-style-type: none"> Update the Texas Medicaid quality strategy to address program and stakeholder goals Review DSRIP activities as possible Medicaid state plan benefits and policy changes, and submit to CMS review results or approval requests, as necessary Assess the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps Conduct a preliminary analysis of DY 7-8 DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement 	<ul style="list-style-type: none"> Assess Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identify potential opportunities to strengthen or align incentives Complete an assessment of which social factors are correlated with Texas Medicaid health outcomes Identify options for the Regional Healthcare Partnership structure post-DSRIP 	<ul style="list-style-type: none"> Identify and submit to CMS any additional proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period

**Ongoing, Active Stakeholder Engagement
(Continues across entire timeline.)**

Source: HHSC Presentation to Senate Health and Human Services Committee. 1115 Demonstration Waiver Timeline, December 3, 2019. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/leg-presentations/senate-health-human-services-dec-3-2019.pdf>

The outstanding question remains. How will the successful projects be sustained without the federal DSRIP pool? As of the writing of this guide, many questions were unanswered.

TEXAS TARGETED OPIOID RESPONSE PROGRAM (TTOR)

Through various grants, the federal government is partnering with states to address the opioid crisis caused by decades of misuse and over-prescribing of opioid drugs with addictive qualities. The opioid crisis has a devastating impact on individuals and families in addition to an incredible adverse impact on the Texas economy. Texas has been granted four federal grants focused on addressing opioid misuse from

SAMHSA, which are implemented through the TTOR Program. TTOR encompasses four federal grants from SAMHSA

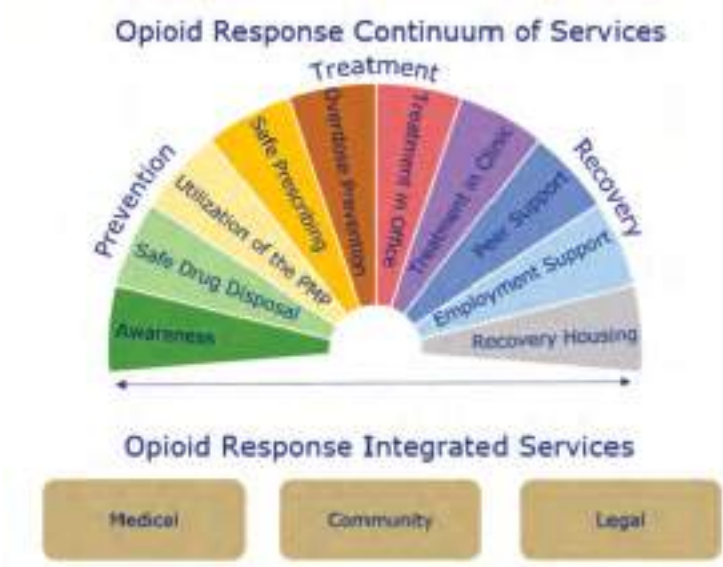
- State Targeted Response Grant (STR)
- State Opioid Response Grant (SOR)
- Strategic Prevention Framework for Prescription Drugs (SPF-Rx) - a five-year discretionary grant in the amount of \$1,858,080 aimed at raising awareness about the risks of overprescribing to young adults and bringing prescription misuse prevention activities and education to schools, communities, and parents.
- Texas First Responders – Comprehensive Addiction and Recovery Act Grant (FR-CARA) - a four-year discretionary grant in the amount of \$3.2 million. The goal of this collaborative project is to reduce opioid overdose related mortality rates, strengthen the successfulness of first response to overdose, and coordinate care for overdose survivors in Bexar County.⁵

TTOR was originally created when Texas was awarded the State Targeted Response (STR) grant in 2017, and has continued as Texas continues to receive opioid-focused federal grant funding. HHSC applied for and received a no-cost extension (NCE) of the STR funds allowing HHSC to extend federally approved projects beyond the grant term.⁶

TTOR strategies address prevention, treatment, and recovery, including medically assisted treatment which includes a combination of medication, counseling, and behavioral therapies, and integrated care shown in Figure 16. While the attention to opioid abuse is important, much of the conversation, funding, and services have historically been limited to only opioids. This restricted focus prevents attention, and potential services and supports for individuals with other substance use concerns. Fortunately, SAMHSA has begun to recognize the critical demand to recognize a wider array of needs. SAMHSA's FY 2020 SOR application allows funds to “support evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders.”⁷

The SOR formula is based on two equally weighted elements: the state's proportion of people who meet criteria for dependence or abuse of heroin or pain relievers who have not received any treatment and the state's proportion of drug-poisoning deaths.⁸ This funding formula highlights the critical importance of data collection in Texas. Accurate and adequate data not only highlights needs and gaps within the state, but also provides an opportunity for Texas to receive appropriate funding for needed services and support. While the grant is planned for 2 years, it is dependent on Congressional appropriations.

Figure 16. HHSC TTOR Strategies



Source: Texas Health and Human Services. (August 2019). Texas Targeted Opioid Response. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/tx-targeted-opioid-response.pdf>

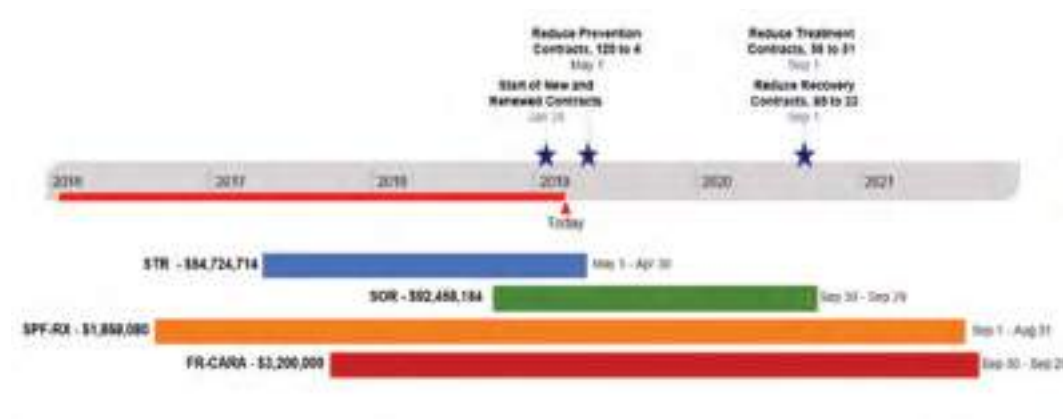
Table 10. Federal Grant Funding to TTOR

Grant Period	Grant	Amount
May 1, 2017 – April 30, 2019	State Targeted Response Grant (STR)	\$54,724,714
Sept. 30, 2018 – Sept. 29, 2020	State Opioid Response Grant (SOR)	\$92,458,184
May 6, 2019 – Sept 29, 2020	SOR Supplemental Grant	\$ 24,131,586
Sept. 1 2016 – Aug. 31, 2021	Strategic Prevention Framework for Prescription Drugs (SPF-Rx)	\$1,858,080
Sept. 30, 2017 – Sept. 29, 2021	Texas First Responders	\$3,200,000

Source: Texas Health and Human Services. (August 2019). Texas Targeted Opioid Response. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/tx-targeted-opioid-response.pdf>

The figure below provides an overview of the timeframe for TTOR Projects.

Figure 17. TTOR Project Implementation Timelines 2016-2021



Source: Texas Health and Human Services Commission. Texas Targeted Opioid Response. <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/texas-targeted-opioid-response-providers>

Anytime funds are appropriated to specific issue areas, it is vital to track the outcomes and be able to determine with confidence whether the dollars invested have been beneficial and to what extent. Indications to date show that TTOR grant funds have had significant impact on the lives of many Texans. In Texas, opioid-involved deaths totaled 1,104 in 2018.⁹ Also in 2018, Texas had the lowest prescription opioid prescribing rate since 2006 when the data became available at 47.2 opioid prescriptions per 100 people. The U.S. average was 51.4 for the same year.¹⁰ The subsequent question should be whether or not the narrow focus on opioid overuse has had unintended consequences on our ability to combat other addictive substances and has the reduction in access to opioids increased the demand for other substances.

Below are some indicators of the outcomes associated with the TTOR funding.

Table 11. Outcome Measures for TTOR Projects

Program	Outcomes Measured
<p>Texas Targeted Opioid Response (TTOR)</p> <p>132,449 served May 1, 2017 through April 30, 2019</p>	<p>Prevention Services:</p> <ul style="list-style-type: none"> • 4,589 individuals have received overdose prevention training • 84,734 medication disposal pouches have been distributed • 1,833 medical and behavioral health professionals have received overdose prevention online continuation education • 23,276 pounds of prescription drugs were disposed • More than 192,567 naloxone kits (each containing two 2mg doses) have been distributed • 106,709 individuals participated in opioid misuse prevention activities but began being funded through the SAPT block grant in September 2018 <p>Treatment Services:</p> <ul style="list-style-type: none"> • 6,230 individuals have received medication assisted treatment • 3,082 individuals receiving MAT received health screening, testing, and treatment for comorbid conditions <p>Recovery Support Services:</p> <ul style="list-style-type: none"> • 2,723 individuals with OUD have received peer coaching services • 1,855 individuals enrolled in long-term recovery coaching • 227 individuals with OUD have been authorized to receive employment services • 80 individuals with a history of opioid use have received recovery support services including overdose prevention services prior to and upon release from jail • 173 individuals with OUD have entered recovery housing <p>Integrated Services:</p> <ul style="list-style-type: none"> • 799 individuals have received overdose-related emergency response services • 311 individuals with OUD have received overdose-related services through Mobile Crisis Outreach Teams • 1,172 individuals with OUD have accessed treatment services through OSAR Priority Admissions Counselors within three days of screening.
State Targeted Response Grant (STR)	<ul style="list-style-type: none"> • Overdose reversals increased from 82 to 1,086 from year 1 to year 2, 13 times greater than the year before • Almost 100 percent increase in the proportion of opioid use disorder (OUD) admissions to medication-assisted treatment (MAT) from year 1 to year 2 • Increased the proportion of people served in evidence-based treatment for OUD from 16 percent to almost 35 percent • 110 recovery coaches have directly facilitated access to MAT services

Source: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/tx-targeted-opioid-response.pdf>

Texas State Appropriations for Mental Health and Substance Use

Note to readers: due to the COVID-19 pandemic, delays were experienced in the release of agency Legislative Appropriations Requests. The information provided in this section is what was available at the time of writing.

Over the past decade, the Texas Legislature has continued to increase overall funding for behavioral health although there have been ebbs and flows in specific budget

strategies. Below is a historical view of the mental health and substance use funding in the health and human services system.

COORDINATED STATEWIDE BEHAVIORAL HEALTH EXPENDITURE PROPOSAL

There are 23 members of the Statewide Behavioral Health Coordinating Council (SBHCC). Each of these agencies and institutions of higher education provide some level of mental health/substance use services or mental health/substance use education and training. This may be provided directly by the funded entity or through contracted services. The legislature has charged the SBHCC with developing a consolidated behavioral health expenditure proposal to promote cross-agency collaboration and prevent duplication of effort. The SBHCC is required to analyze all of the member agencies' exceptional items requests related to behavioral health to ensure that they are coordinated and non-duplicative. The coordinated expenditure proposal for FY 2020 is shown below and can be found at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-behavioral-health-expenditure-proposal-fy20.pdf>

Figure 18. Coordinated Statewide Behavioral Health Expenditure Proposal Summary (2020)

Agency	GAA, Article IX, Sec. 10.04, FY 2020 Expenditures - All Funds	FY 2020 Appropriated - General Revenue	FY 2020 Appropriated - All Funds	Variance between GAA, Article IX, Sec. 10.04 and FY 2020 Appropriated - All Funds
Office of the Governor	\$ 31,701,616	\$ 1,806,980	\$ 62,251,285	\$ 30,551,669
Texas Veterans Commission	\$ 5,769,090	\$ -	\$ 6,350,928	\$ 581,838
Article I Subtotal	\$ 37,470,706	\$ 1,806,980	\$ 68,602,213	\$ 30,832,969
Department of Family and Protective Services	\$ 38,642,498	\$ 25,508,461	\$ 28,640,885	\$ (9,999,523)
Department of State Health Services	\$ 2,661,580	\$ 2,254,586	\$ 2,888,875	\$ (147,415)
Health and Human Services Commission	\$ 1,786,890,897	\$ 5,122,291,897	\$ 3,839,981,758	\$ (2,053,091,699)
Texas Civil Commitment Office	\$ 256,621	\$ 154,611	\$ 154,611	\$ -
Article II Subtotal	\$ 1,740,349,236	\$ 1,330,569,615	\$ 2,078,566,833	\$ 322,237,587
University of Texas - Health Science Center at Houston	\$ 8,800,000	\$ 8,800,000	\$ 8,800,000	\$ -
University of Texas - Health Science Center at Tyler	\$ 6,730,000	\$ 6,730,000	\$ 6,730,000	\$ -
Texas Tech University Health Science Center	\$ 2,500,000	\$ 2,500,000	\$ 2,500,000	\$ -
Higher Education Coordinating Board	\$ 50,800,000	\$ 49,500,000	\$ 49,500,000	\$ (1,300,000)
Article III Subtotal	\$ 67,230,000	\$ 66,730,000	\$ 66,730,000	\$ (500,000)
Civil of Criminal Appeals	\$ 118,580	\$ 101,580	\$ 101,580	\$ (16,999)
Office of Court Administration	\$ 2,500,000	\$ -	\$ 2,500,000	\$ -
Supreme Court of Texas	\$ 1,800,000	\$ 1,000,857	\$ 1,000,857	\$ (799,143)
Article IV Subtotal	\$ 3,618,580	\$ 1,062,357	\$ 4,634,157	\$ 1,015,577
Texas Commission on Jail Standards	\$ 285,856	\$ 285,856	\$ 181,814	\$ (104,042)
Texas Department of Criminal Justice	\$ 292,806,546	\$ 298,212,975	\$ 292,886,848	\$ (5,373,571)
Texas Juvenile Justice Department	\$ 87,252,219	\$ 87,911,279	\$ 89,331,218	\$ 1,419,939
Texas Military Department	\$ 769,790	\$ 1,811,650	\$ 1,811,650	\$ 1,041,860
Article V Subtotal	\$ 662,611,616	\$ 687,139,630	\$ 663,696,136	\$ (24,475,484)
Texas State Board of Dental Examiners	\$ 112,240	\$ 112,240	\$ 112,240	\$ -
Texas State Board of Pharmacy	\$ 343,284	\$ 343,284	\$ 343,284	\$ -
Texas Board of Veterinary Medical Examiners	\$ 45,000	\$ 45,000	\$ 45,000	\$ -
Texas Osteopathy Board	\$ 36,000	\$ 36,000	\$ 36,000	\$ -
Texas Board of Nursing	\$ 1,025,458	\$ 1,025,458	\$ 1,025,458	\$ -
Texas Medical Board	\$ 643,581	\$ 651,377	\$ 651,377	\$ 7,796
Article VIII Subtotal	\$ 2,136,343	\$ 2,148,339	\$ 2,148,339	\$ 11,996
Grand Article Total	\$ 2,212,585,236	\$ 1,849,065,741	\$ 2,588,723,078	\$ 376,237,818

- Office of the Governor (OOG) - OOG's behavioral health funding included in this proposal differ from amounts included in Section 10.04 for several reasons. 1) The Edward Byrne Memorial Justice Assistance Grant Program, Crime Victim Assistance Program, Violence Against Women Program, and the Juvenile Justice & Delinquency Prevention Program are federal formula grant programs. The annual award amounts provided to OOG are based on congressional appropriations and federal formulas that are subject to change year-to-year. 2) These fund sources are also competitive grant programs that support a wide array of initiatives including behavioral health and non-behavioral health services. Actual expenditures related to behavioral health will vary every year based on the grant applications submitted, state and local priorities, and whether or not those projects intend to support behavioral health-related activities.
- Texas Veterans Commission (TVC) - TVC's behavioral health funding amounts included in this proposal differ from amounts included in Section 10.04 because amounts listed in Section 10.04 were based on estimates included in TVC's Legislative Appropriations Request (LAR). The amounts included in this proposal are actual amounts.
- Department of Family and Protective Services (DFPS) - DFPS' behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 due to exclusion of substance abuse testing expenditures from previously reported amounts.

- iv Department of State Health Services (DSHS) - DSHS' behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 because amounts listed in Section 10.04 were based on estimates included in DSHS's Legislative Appropriations Request (LAR). The amounts included in this proposal are actual amounts.
- v Health and Human Services Commission (HHSC) - HHSC's behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 due to certain differences in the following programs:
 - State Hospitals
 - Substance Use Disorder programs
 - Child Advocacy Programs
 - Children with Special Needs
 - Regional Medical, Behavioral, and Psychiatric Technical Support Team
 - Enhanced Community Coordination
 - Promoting Integration of Primary and Behavioral Health Care
 - Advancing Wellness and Resilience in Education
- vi Texas Higher Education Coordinating Board (THECB) - THECB's behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 because this proposal includes the amounts included in THECB's funding appropriated in Article III of the 2020-21 General Appropriations Act (GAA), 86th Legislature, Regular Session, 2019.
- vii Supreme Court of Texas - The Supreme Court's behavioral health funding amounts in this proposal differ from the amounts included in Section 10.04 due to the Supreme Court's plan to hire an additional employee to support the Judicial Commission on Mental Health.
- viii Texas Military Department (TMD) - TMD's behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 due to additional appropriation for the Sexual Assault Response Coordinator program.
- xi Texas Medical Board (TMB) - TMB's behavioral health funding amounts included in this proposal differ from the amounts included in Section 10.04 because the amounts referenced above are included in TMB's GAA strategy B.1.2.

Source: Texas Health and Human Services Commission. (2019). Coordinated Statewide Behavioral Health Expenditure Proposal, Fiscal Year 2020. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-behavioral-health-expenditure-proposal-fy20.pdf>

The table below provides a breakdown of the consolidated expenditures by Service Type.

Table 12. Summary by Service Type Category

Summary by Service Type Category	Proposed FY 2020 Expenditures – All Funds
Education and Training	\$7,764,000
Information Technology	\$250,000
Infrastructure	\$448,606,377
Mental Health Services – Outpatient	\$632,561,163
Mental Health Services – Inpatient/Residential	\$551,931,413
Mental Health Services – Other	\$399,534,579
Mental Health Services - Prevention	\$26,882,681
Research	\$9,849,000
Staff	\$80,603,815
Substance Use Disorder Services – Detox	\$25,453,533
Substance Use Disorder Services – Outpatient	\$15,385,328
Substance Use Disorder Services – Intervention	\$10,825,338
Substance Use Disorder Services – Other	\$304,913,300
Substance Use Disorder Services – Prevention	\$72,162,551
Cross Service Type Total	\$2,586,723,078

TEXAS GENERAL APPROPRIATIONS FOR MENTAL HEALTH/SUBSTANCE USE SERVICES

The general appropriations bill is the only piece of legislation that the legislature is required to pass each biennium. It must be approved by both the Texas House of Representatives and the Texas Senate, certified by the Comptroller, and signed by the Governor. The majority of state mental health and substance use funding is appropriated through Article II, Texas Health and Human Services Commission. The general appropriations bill includes funds from a variety of sources, both state and federal.

Table 13. Mental Health and Substance Use Funding Trends Included in Article II of the General Appropriations Bill

Strategy	FY 12/13 82nd	FY 14/15 83rd	FY 16/17 84th	FY 18/19 85th	FY 20/21 86th
MH Adults	\$553,129,071	\$664,999,081	\$663,920,027	\$703,362,864	\$764,100,202
MH Children	\$153,465,918	\$200,976,804	\$204,650,668	\$166,373,576	\$184,635,596
Community Mental Health - Crisis	\$164,953,850	\$221,182,624	\$255,313,022	\$325,430,552	\$343,263,746
NorthSTAR	\$5,224,965	\$226,593,318	\$174,064,540	\$0	\$0
Substance Use/ Prevention and Treatment	\$283,285,699	\$315,625,153	\$325,110,656	\$380,160,933	\$464,363,294
State Hospitals	\$783,400,983	\$835,796,441	\$872,639,869	\$875,536,372	\$898,738,475
Community MH Hospitals	\$107,406,192	\$153,140,973	\$209,943,241	\$243,830,476	\$270,620,452
Repair/ Renovations MH Facilities			\$24,046,914		\$230,905,776
Behavioral Health Waivers				\$103,351,236	\$104,599,388

Source: Hogg Foundation Legislative Summaries, 2019. Retrieved from <https://hogg.utexas.edu/wp-content/uploads/2019/09/86th-Legislative-Summary.pdf>. Note: Blank cells in the table above reflect that the data was not available at the time of this writing.

TEXAS MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Texas Medicaid and the Children's Health Insurance Program (CHIP), both of which are managed care and fee-for-service programs, provide significant funding for behavioral health services. In 2018 the Texas Legislative Budget Board (LBB) estimated:

Medicaid expenditures for behavioral health services total \$3.5 billion in All Funds for the 2018–19 biennium, and estimated Children's Health Insurance Program (CHIP) expenditures total \$48.7 million in All Funds. These amounts include cost growth that is not funded for both programs and Medicaid caseload growth for fiscal year 2019, which also is not funded. Total behavioral health funding, including estimated Medicaid and CHIP expenditures, is estimated to be \$7.6 billion in All Funds for the biennium.¹¹

Figure 19. Estimated Behavioral Health Expenditures in Texas Medicaid: FY 2015-2020

Medicaid³

Fund Type	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
General Revenue	\$ 613,670,032	\$ 602,507,730	\$ 645,352,684	\$ 659,182,304	\$ 641,387,009	\$ 636,352,990
Federal Funds	\$ 882,626,993	\$ 843,513,968	\$ 871,885,266	\$ 910,239,806	\$ 890,609,890	\$ 1,013,771,830
Total	\$ 1,496,297,025	\$ 1,446,021,698	\$ 1,517,237,950	\$ 1,569,422,110	\$ 1,532,000,000	\$ 1,650,124,820

³ Estimates are based on actual behavioral health cost data reported for fiscal years 2009–18. A ratio of behavioral health cost to total acute care cost was calculated based on actual history. This percentage was applied to forecasted total acute care cost for fiscal year 2019 and forward.

Source: Texas Health and Human Services Commission. (2019). Coordinated Statewide Behavioral Health Expenditure Proposal, Fiscal Year 2020. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-behavioral-health-expenditure-proposal-fy20.pdf>

Figure 20. Estimated Behavioral Health Expenditures in Texas CHIP:

Children's Health Insurance Program (CHIP)³

Fund Type	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
General Revenue	\$ 11,940,070	\$ 12,916,922	\$ 14,175,023	\$ 15,707,364	\$ 17,374,886	\$ 19,012,660
Federal Funds	\$ 28,928,091	\$ 38,167,497	\$ 41,484,723	\$ 47,601,363	\$ 49,823,326	\$ 45,122,818
Total	\$ 40,868,161	\$ 51,084,419	\$ 55,659,746	\$ 63,308,727	\$ 67,198,212	\$ 64,135,478

³ Estimates are based on actual behavioral health cost data reported for fiscal years 2009–18. Medicaid expenditures are based on costs reported by managed care organizations (MCOs) in annual Periodic Statistical Reports (PSRs) and actual psychotropic drug expenditures. Behavioral Health Per-Member-Per-Month (PMPM) and created using CHIP capitation cost trend for fiscal year 2019 and forward.

Source: Texas Health and Human Services Commission. (2019). Coordinated Statewide Behavioral Health Expenditure Proposal, Fiscal Year 2020. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-behavioral-health-expenditure-proposal-fy20.pdf>

HB 1, 86TH LEGISLATURE - GENERAL APPROPRIATIONS (ZERWAS/NELSON)

As with several previous legislatures, the 86th Texas Legislature made efforts to

improve mental health funding in Texas by increasing resources to expand access to services. As discussed above, mental health programs, services, and education span many state agencies. The following tables depict the primary funding strategies.

Article II, Health and Human Services Commission (HHSC) Mental Health and Substance Use Funding

Table 14. Mental Health and Substance Use Strategies in Article II

Budget Strategy	SB 1 FY 2018/19 (85th)	HB 1 FY 2020/21 (86th)	Difference
D.2.1 Community Mental Health – Adults	\$703,362,864	\$764,100,202	\$60,737,338
D.2.2 Community Mental Health - Children	\$166,373,576	\$184,635,596	\$18,262,020
D.2.3 Community Mental Health Crisis	\$325,430,552	\$343,263,746	\$17,833,194
D.2.4 Substance Abuse Services	\$380,160,933	\$464,363,294	\$84,202,361
D.2.5 Behavioral Health Waivers	\$103,351,236	\$104,599,388	\$1,248,152
G.2.1 State Mental Health Hospitals	\$875,536,372	\$898,738,475	\$23,202,103
G.2.2 Community Mental Health Hospitals	\$243,830,476	\$270,620,452	\$26,789,976

Source Hogg Foundation Legislative Summaries, 2019. Retrieved from <https://hogg.utexas.edu/wp-content/uploads/2019/09/86th-Legislative-Summary.pdf>. Note: Blank cells in the table above reflect that the data was not available at the time of this writing.

Article II - HHSC Mental Health and Substance Use Related Budget Riders

Budget riders are legislative directives that instruct agencies on how to spend certain appropriated funds. Riders do not typically provide additional or new funding.

Article II HHSC Rider #	Description
14	Community Integration Performance Indicators - allows HHSC to collect data for community integration outcomes to include measures of opportunity, community participation, community presence, well-being, and recovery for STAR+PLUS and STAR KIDS programs. Requires that annual data be published online.
18	Medically Dependent Children Program (MDCP) – includes funding for MDCP and Youth Empowerment Services (YES) waiver services for clients enrolled in the STAR Kids program. This does not create an entitlement to waiver services.
20	Expansion of Community-Based Services – appropriates \$66,661,790 in all funds for reducing interest lists for 60 MDCP, 240 Community Living and Support Services, 1,320 Home and Community-based slots, and 8 Deaf-Blind Multiple Disabilities waiver slots, with end-of-year targets for FY 21. The plan for increasing enrollment is due by October 1, 2019, with progress reports due by March 1, 2020, September 1, 2020, and March 1, 2020.
24	General Revenue Funds for Medicaid Mental Health and Intellectual Disability Services - provides governance relating to the appropriate use, classification, and expenditure of funds for mental health and intellectual disability services including, but not limited to, funds appropriated to mental health and local intellectual and developmental disability authorities (LIDDAs). Also certifies match for certain inpatient mental health Medicaid services.

Article II HHSC Rider #	Description
32	Intensive Behavioral Intervention – contingent on HHSC adding intensive behavioral intervention as a Medicaid benefit, this allows for the expenditure of appropriated funds for those services for individuals with autism under the age of 20.
33	Managed Care Organization (MCO) Services for Adults with Serious Mental Illness – directs the commission to identify data by MCOs for recipients of STAR+Plus with serious mental illness (SMI) to evaluate any inappropriate variation in delivery of service to individuals with SMI. Requires HHSC to identify performance measures to hold MCOs accountable for outcomes related to Medicaid spending. Also requires a legislative report by August 31, 2020.
34	Evaluation of Opioid Drug Prescribing Practices Under Medicaid – directs HHSC to evaluate the prescribing practices for opioid drugs under Texas Medicaid and assess to ensure practices align with CDC guidelines. Requires a legislative report by September 1, 2020.
38	Cost Effectiveness of Delivery System Reform and Incentive Payment Program – directs HHSC to submit report on outcomes of providers in the DSRIP program for demonstration years 7 and 8 by December 1, 2020.
41	Regional Advisory Council Diversion Evaluation – directs HHSC to evaluate the feasibility of requiring trauma service area regional advisory councils to implement a program to allow emergency medical services providers to transport medically stable psychiatric emergency detention patients to the most appropriate setting. Requires a legislative report by October 1, 2020.
42	Medicaid Waiver Program Interest Study – directs HHSC to collaborate with the Intellectual and Developmental Disability System Redesign Advisory Committee to conduct a study of interest and waiting lists for waiver programs, submit a legislative report by September 1, 2020, and update the Statewide IDD Strategic Plan to align with the Statewide Behavioral Health Strategic Plan.
51	Contingency for Behavioral Health Funds – prohibits the expenditure of mental health appropriations if the LBB provides notification to the Comptroller if an agency's planned expenditure does not satisfy the requirements of the Statewide Behavioral Health Strategic Plan and Coordinated Expenditures.
52	Client Services – states it is the intent of the legislature that HHSC and DFPS enter into a memorandum of understanding for the provision of outpatient substance use treatment services by HHSC to referred DFPS clients.
53	Screening for Offenders with Mental Impairment – directs HHSC and community centers to identify offenders with mental impairments in the criminal justice system, collect and report prevalence data, and accept and disclose information relating to special needs offenders.
54	Mental Health Outcomes and Accountability – requires HHSC to place 10 percent of the funds allocated to local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) at risk. Allows HHSC to recoup funds for failure to achieve outcome targets set by HHSC.
55	Mental Health Appropriations and the 1115 Medicaid Transformation Waiver – requires that HHSC include in contract provisions for mental health services (adults, children, and crisis services), and that funds be used as much as possible to draw down additional federal dollars through the 1115 Transformation Waiver or other federal matching opportunities. Requires a legislative report every December 1st of each fiscal year.
56	Healthy Community Collaboratives – directs HHSC to allocate up to \$25 million of amounts appropriated over the biennium to fund grants to Healthy Community Collaboratives. Also allows for up to \$10 million of these funds to be allocated to collaboratives in rural areas contingent on the availability of the required matching funds. Requires a legislative report by December 1, 2020.
57	Mental Health Peer Support Re-entry Program – directs HHSC to allocate up to \$1 million in GR for the biennium to maintain a mental health peer support re-entry program. Requires these programs use certified peer support specialists to ensure inmates successfully transition from jail into clinically appropriate community-based care. Requires a legislative report by December 1, 2020.

Article II HHSC Rider #	Description
58	Semiannual Reporting of Waiting Lists for Mental Health Services – requires HHSC to submit semiannual reports to the LBB and the governor providing data on waiting lists and related expenditures for community adult mental health services, community children’s mental health services, forensic state hospital beds, and maximum-security hospital beds.
59	Mental Health Program for Veterans – allocates \$5 million in GR each fiscal year for the purpose of administering the mental health program for veterans. Requires a legislative report December 1st of each fiscal year.
60	Synar Results Notification for Local Communities – directs HHSC, or a contractor, to use funds from budget strategy D.2.4, Substance Abuse Services to notify the Comptroller of Public Accounts tobacco law enforcement grantee and the local sheriff department when tobacco products are sold to an underage purchaser per the federal Synar Amendment.
61	Mental Health for Veterans Grant Program – allocates \$20 million in GR in FY 2020 to operate a grant program to support community mental health programs providing services and treatment to veterans and their families. Requires a legislative report by December 1, 2020.
62	Mental Health Grant Program for Justice-Involved Individuals – allocates \$25 million in GR each year of the biennium for administering the grant program to reduce recidivism, arrests, and incarceration among individuals with mental illness and to reduce wait times for forensic commitment. Also directs that \$5 million in GR each year be allocated to the Harris County jail diversion program. Requires each grantee to report twice annually to the SBHCC.
63	Increased Access to Community Mental Health Services – allocates \$23,416,350 in GR and \$1,667,735 in federal funds each fiscal year to address waitlists and to increase capacity of outpatient mental health services at LMHAs and LBHAs.
64	Substance Abuse Treatment Services – allocates \$677,004 in GR in FY 2020 and \$4,322,996 in GR in FY 2021 to provide rate increases for substance abuse treatment services. Additionally allocates \$23,634,844 in FY 2020 to reduce waitlists for pregnant women and women with children treatment programs.
65	Funding for Mental Health Programs – allocates \$871,348 in GR each fiscal year to fund clubhouses at FY 2019 levels. Also allocates \$5,446,612 in GR each fiscal year for funding to prevent child relinquishment due to the need for intensive mental health treatment, with \$328,131 in GR for program support and administration.
66	Consolidated Reporting of Opioid-Related Expenditures – directs the Executive Commissioner of HHSC to submit a legislative report of annual expenditures from the previous fiscal year for all opioid abuse and misuse-related programs at HHSC, DFPS, and DSHS no later than October 1st of each year.
67	Proposal to Enhance Efficiency of Substance Abuse Treatment Services – directs HHSC to develop a proposal to improve administration of substance abuse treatment services and expand capacity of services. In developing the proposal, HHSC shall consult with providers, the Behavioral Health Advisory Committee and the SBHCC and submit a report to the Governor, the LBB, and the human services committees in the House and Senate. Requires a legislative report by December 1, 2020.
68	Unexpended Balance Authority within the Biennium for the Community Mental Health Grant Program – allocates \$20 million in GR each fiscal year for the Community Mental Health Grant Program and allows unexpended funds from FY 2020 to be used in FY 2021 for same purposes.
69	Study on Substance Abuse Treatment Services – directs HHSC to evaluate reimbursement methodology and rates for substance use treatment services and submit a legislative report no later than November 1, 2020.
94	Pediatric Health Tele-Connectivity Resource Program for Rural Texas – allocates \$1,210,808 in GR and \$1,289,193 in federal funds in FY 2020 and \$1,234,177 in GR and \$1,265,823 in federal funds to establish a tele-connectivity resource program for rural Texas.
103	Behavioral Support Specialists at State Supported Living Centers – directs San Angelo and Mexia State Living Centers to provide behavioral health supports to any residents with specialized education needs.

Article II HHSC Rider #	Description
108	State Hospital and State Supported Living Center (SSLC) Workforce – directs HHSC to evaluate workforce conditions and patterns at state hospitals and SSLCs and submit a legislative report no later than August 1, 2020.
109	Expenditure Reporting at the State Hospitals – directs HHSC to provide monthly state hospital expenditure data to the LBB on a biannual basis no later than April and October 1st of each fiscal year.
110	State Supported Living Centers Planning – directs HHSC to develop a plan to maximize resources at SSLCs and submit it to the legislature no later than December 1, 2020.
113	Lock-In for Controlled Substances – directs the Office of Inspector General and MCOs to maintain a lock-in program for controlled substance to prevent substance abuse.

Major Behavioral Health Grant Programs Included in Article II Riders

Rider 56 - Healthy Community Collaboratives – directs HHSC to allocate up to \$25 million of amounts appropriated over the biennium to fund grants to Healthy Community Collaboratives. Also allows for up to \$10 million of these funds to be allocated to collaboratives in rural areas contingent on the availability of the required matching funds. Requires a legislative report by December 1, 2020.

Rider 61 - Mental Health for Veterans Grant Program – allocates \$20 million in GR in FY 2020 to operate a grant program to support community mental health programs providing services and treatment to veterans and their families. Requires a legislative report by December 1, 2020.

Rider 62 - Mental Health Grant Program for Justice-Involved Individuals – allocates \$25 million in GR each year of the biennium for administering the grant program to reduce recidivism, arrests, and incarceration among individuals with mental illness and to reduce wait times for forensic commitment. Also directs that \$5 million in GR each year be allocated to the Harris County jail diversion program. Requires each grantee to report twice annually to the SBHCC.

Rider 68 - Unexpended Balance Authority within the Biennium for the Community Mental Health Grant Program – allocates \$20 million in GR each fiscal year for the Community Mental Health Grant Program and allows unexpended funds from FY 2020 to be used in FY 2021 for the same purposes.

Article II - Special Provisions Relating to all HHS Agencies

Special Provisions are instructions included in the appropriations bill that apply to multiple agencies within one or multiple articles. Typically, these provisions are used to restrict the amount and conditions under which appropriations may be expended.

Special Provision #	Description
Sec. 19	Prohibition on the Use of Appropriations for the Private Operation of a State Hospital – prohibits the state from soliciting bids for the private operation of a state hospital without approval from the LBB.
Sec. 24	Patient or Client Assistance – allows compensation to be paid to patients or clients of a state hospital or SSLC who assist in the operation of the facility as part of their therapy.
Sec. 32	Foster Care Methodology – increased access to Medicaid benefits including mental health rehabilitation and targeted case management is required to be included in the issues considered in the new foster care rate methodology.

Article III (86th) - Texas Education Agency (TEA) School Climate/Safety Funding

Following the shooting at Santa Fe High School, Governor Greg Abbott announced school safety as an emergency item and prioritized mental health as a component of securing schools' safety. While no funding was specifically allocated for student mental health by the 86th legislature, funds for programs and services located within these strategies directly affect school climate and can be used toward efforts that improve student and teacher well-being and safety.

Description	HB 1 FY 2020/21
Amachi Texas: A.2.2 Achievement of Students at Risk (program to mentor youth of incarcerated parents in coordination with Big Brother/Big Sister Lone Star and other community-based resources for training, services, and funding)	\$4,000,000
Disability Community-Based Support: A.2.3 Students with Disabilities	\$1,974,600
School Safety Allotment: A.1.1 Foundation School Program	\$100,000,000
Communities in Schools: A.2.4 School Improvement & Support	\$61,043,632
Best Buddies: A.2.4 School Improvement and Support	\$500,000
Customized School Safety Programming: B.2.2 Health and Safety	\$2,000,000

It is important to note that the largest of the above funding, the School Safety Allotment, is based on average daily attendance and is spent at a school district's discretion. The funds can be used to support student and staff mental health, including: prevention and treatment related to adverse childhood experiences (ACEs), providing mental health personnel and support, or programs related to suicide prevention, intervention, and post-intervention. However, schools may prioritize the funds towards other allowable uses, such as physicality of buildings, employing security, or establishing threat reporting systems.

Article III, TEA School Climate/Safety Related Riders

Article III TEA Rider #	Description
16	Non-educational Community-based Support Services – allocates \$987,300 each fiscal year to non-educational community-based support services for certain students with disabilities.
17	Professional Development for the Provision of Access to the General Curriculum for Students with Disabilities in the Least Restrictive Environment – directs TEA to use 10.5% of federal discretionary funds awarded through IDEA during the biennium for professional development and support for school districts to provide learning in the least restrictive environment for students with disabilities and Response to Intervention processes. Requires legislative reports no later than August 21, 2020 and 2021.
22	Communities in Schools - allocates \$30,521,817 in GR and \$3,898,450 in Temporary Assistance for Needy Families (TANF) funds in FY 2020 and \$30,521,815 in GR and \$3,898,450 in TANF funds in FY 2021 to the Communities in Schools Program. Additionally, \$943,892 in TANF funds each fiscal year will be allocated for administrative purposes of the program. Transfer of GR funds for providing administrative support may not exceed \$100,000 for the 2020-21 biennium.
34	Funding for Regional Education Service Centers (ESCs) – allocates \$11,875,000 each fiscal year to be distributed to each ESC for providing professional development and other technical assistance services required to school districts, with additional distributions to school districts serving less than 1,600 students. A legislative report on expenditures, savings, services, staff, programs, and funding transferred from TEA is due no later than December 1st of each even-numbered year.
50	Amachi Texas – allocates \$2 million in GR each fiscal year to the Amachi Texas program to mentor youth of incarcerated parents in coordination with Big Brother/Big Sister Lone Star and other community-based resources for training, services, and funding.
71	Best Buddies – allocates \$250,000 each fiscal year to support the Best Buddies program, which serves youth with intellectual disabilities.
74	Report on the Effectiveness of Certain TEA Programs - directs TEA to study the effectiveness of programs that receive funding and are administered by non-governmental organizations; report to the finance and education committees in the House and the Senate, the Governor, and the LBB no later than May 1, 2020.
79	Funding for Customized School Safety Programming - TEA Commissioner shall allocate \$1 million in GR each fiscal year to a non-governmental organization with an established safe school institute to provide customized school safety programming.

Article III (86th) – Higher Education School Climate/Safety Funding

Description	HB 1 FY 2020/21
Texas Higher Education Coordinating Board (THECB)	
F.1.8 Mental Health Professionals Loan Repayment Program	\$2,125,000
F.1.10 Child Mental Health Care Consortium	\$99,000,000
Texas State University (TSU)	
C.1.2 School Safety Center	\$10,990,944
C.1.3 Advanced Law Enforcement Rapid Response Training (“ALERT”)	\$ 4,000,000
Texas Tech University Health Sciences Center (TTUHSC)	
D.4.1 Rural Health Care – Telemedicine Wellness Intervention Triage and Referral (“TWITR”) Project	\$5,000,000
The University of Texas at Tyler (UT Tyler)	
D.1.1 Mental Health Workforce Training Programs	\$13,460,000

The Texas Child Mental Health Care Consortium, created by SB 11 (86th, Taylor/Bonnen), is intended to enhance access to mental health services for children and adolescents through collaboration with health-related institutions of higher education. The primary components of this legislation include:

- Child Psychiatry Access Network (CSPAN)
- Texas Child Health Access Through Telemedicine (TCHAT)
- Community Psychiatry Workforce Expansion
- Funding for child and adolescent psychiatry fellowships

More information can be found at <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/vbpqi/sept-2019-vbpqi-agenda-item-3.pdf>.

Article III (86th), Higher Education School Climate/Safety Contingency Riders

Article III Rider #	Description
HECB #56	Mental Health Loan Repayment Program – allows unexpended balances at the end of FY 2020 to be carried over to FY 2021 for the Mental Health Loan Repayment Program.
HECB # 58	Contingency for Senate Bill 11 – creates the Texas Child Mental Health Care Consortium (TCMHCC) funding strategy and appropriates \$49.5 million in GR each fiscal year. This rider identifies the members to be appointed to the TCMHCC, the initiatives, oversight, and expectations related to implementation and reporting. More detailed information can be found under bill description. *SB 11 passed
TTUHSC # 8	Contingency for Behavioral Health Funds – prohibits expenditure of mental health appropriations if the LBB provides notification to the Comptroller that an agency's planned expenditure does not satisfy the requirements of the Statewide Behavioral Health Strategic Plan and Coordinated Expenditures.
UTHSC Tyler #7	Mental Health Workforce Training for Underserved Areas– allocates \$6,730,000 in GR each fiscal year to support mental health workforce training programs in underserved areas including, but not limited to, Rusk State Hospital and Terrell State Hospital.

Article III (86th) - Special Provisions Relating Only to Higher Education

Special Provision #	Description
Sec. 24	Participation in Drug Development Research Projects – prohibits public universities receiving state funding, including grants or gifts, from conducting a drug development research protocol involving an individual receiving mental health services under a protective custody order.

Article IV (86th) – The Judiciary

Supreme Court of Texas	GR FY 20-21
B.1.2 Judicial Commission on Mental Health: Provides grants for coordinated policy initiatives between the Supreme Court and the Court of Criminal Appeals for the improvement of the court's interaction with children, adults, and families with mental health needs.	\$2,000,000

Article V (86th) – Public Safety and Criminal Justice

Texas Department of Criminal Justice (TDCJ)	GR FY 2020-21
A.1.3. Community Corrections – Behavioral Health: Provide formula funding to Community Supervision and Corrections Departments for substance abuse services to serve primarily as diversions from prison.	\$15,677,497
C.1.10 Correctional Managed Health Care – Pharmacy – Behavioral Health: Provide pharmacy services, both preventative and medically necessary care, consistent with standards of good medical practice for mental health cases.	\$7,937,888
C.1.8 Correctional Managed Health Care – Unit & Psychiatric – Behavioral Health: Provide mental health care for incarcerated offenders.	\$104,483,832
A.1.2. Diversion Programs – Discretionary Grants Substance Abuse Programs: Provide grants to local CSCDs for outpatient programs to divert offenders with substance abuse disorders from further court action and/or prison.	\$ 17,577,003
A.1.2. Diversion Programs – Residential Services Substance Abuse: Provide grants to local CSCDs for outpatient programs to divert offenders with substance abuse disorders from prison through residential treatment beds.	\$ 100,244,498
A.1.2. Diversion Programs – Specialized Mental Health Caseloads: Specialized community supervision caseloads for offenders with special mental health needs.	\$7,257,507
C.2.5. Driving While Intoxicated (DWI) Treatment: A variety of educational modules, treatment activities, and group and individual therapies that accommodate the diversity of needs presented in the DWI offender population. The six month in-prison program includes an aftercare component upon release.	\$7,661,537
C.2.5. In-Prison Therapeutic Communities: A 6-month substance abuse program for offenders within 6 months of parole release. Upon completion, offenders are paroled and must complete a Transitional Treatment Center for 3 months of residential or intensive outpatient care followed by 9-12 months of outpatient counseling.	\$41,266,152
E.2.3 Intermediate Sanction Facilities – Behavioral Health: Provides substance abuse and/or cognitive treatment slots for Intermediate Sanction Facility beds.	\$12,525,429
C.2.3 Parole Special Needs – Behavioral Health: Specialized parole supervision and services for offenders with mental illness, intellectual disabilities, developmental disabilities, terminal illness, and physical disabilities.	\$3,588,058
E.2.1. Parole Supervision – Behavioral Health: Provide outpatient substance abuse counseling to parolees.	\$3,493,089

C.2.3. Reentry Initiatives – Transitional Coordinators – Behavioral Health: Provide for ten designated reentry transitional coordinators for individuals with special needs.	\$809,874
B.1.1. Special Needs Programs and Services – Juvenile- Behavioral Health: Grants for community-based treatment programs for juvenile offenders with special needs (mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities). Funds a continuity of care program and responsive system for local referrals from various entities.	\$7,328,006
B.1.1 Special Needs Programs and Services – Adult – Behavioral Health: Grants for community-based treatment programs for adult offenders with special needs (mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities). Funds a continuity of care program and responsive system for local referrals from various entities.	\$44,356,972
C.2.5. State Jail Substance Abuse Treatment: A substance abuse program designed to meet the needs of the diverse characteristics of TDCJ's state jail population for offenders who have been convicted of a broad range of offenses. Offenders targeted for this program are within four months of release.	\$5,462,501
C.2.4. Substance Abuse Felony Punishment Facilities (SAFPF): A 6-month substance abuse program for offenders sentenced by a judge as a condition of community supervision or as a modification to parole or community supervision.	\$99,409,016
A.1.2 SAFPf Aftercare: Grants to local community supervision and corrections departments for aftercare of felony substance abuse probationers after their release from a TDCJ SAFPf.	\$4,521,789
C.2.5 Substance Abuse Treatment and Coordination: Alcoholism and drug counseling programs for offenders. Provides support services for treatment programs, continuity of care services, and medical and psychiatric services for diagnosed clients released from substance abuse facilities.	\$10,963,685
A.1.4. Treatment Alternatives to Incarceration Program – Behavioral Health: Grants to local community supervision and corrections departments for treatment to divert offenders from incarceration. Programs must include screening, evaluation, and referrals to appropriate services.	\$20,747,951
Texas Juvenile Justice Department (TJJD)	
B.1.1. Assessment, Orientation, And Placement – Mental Health Related: Psychiatric services provided by contract psychiatric providers for services to youth who are assigned to intake and an assessment unit or to youth who later develop a mental health need while in TJJD residential facilities.	\$827,222
A.1.3 Community Programs – Mental Health Related: Provides assistance to local juvenile probation departments for community-based behavioral and mental health services.	\$73,803,783
B.1.8 General Rehabilitative Treatment – Mental Health Related: General rehabilitation activities include case management, skills building groups, use of motivational interviewing techniques in individual and group settings, and other curriculum-based treatment programs provided by the agency and contract providers.	\$13,897,185
B.1.8 Chemical Dependency Treatment: Specialized rehabilitation treatment programs for youth with moderate or high needs with individualized interventions related to alcohol and drug abuse.	\$2,808,108
B.1.7 Institutional Psychiatric (Mental Health) Services: Mental health care services provided by contract psychiatrists to juveniles residing in state facilities.	\$1,865,521
A.1.7 Mental Health Services Grants: Provides grants to local juvenile probation departments for mental health services.	\$28,356,704

B.1.8 Psychiatric Treatment: Specialized rehabilitation treatment programs for youth with moderate or high needs with individualized interventions related to mental illness.	\$2,288,235
A.1.8 Regionalization Services – Mental Health Related: Provides grants to local juvenile probation departments to keep adjudicated youth as shallow in the justice system as possible in lieu of commitment to secure facilities operated by TJJD, within the context of a regionalization plan.	\$3,000,000
A.1.3 Special Needs Diversionary Program: Provides mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system.	\$3,790,350
Texas Military Department (TMD)	
C.1.3 Mental Health Services: The mental health initiative supports service members and TMD employees who require mental health services.	\$1,999,100

Article VII (86th) – Business and Economic Development

Texas Department of Housing and Community Affairs (TDHCA)	GR FY 20-21
B.1.1 Home and Community Based Services – Adult Mental Health Program: Interagency Agreement with HHSC for a pilot program to provide rental assistance to adults with severe mental health issues that are receiving services through the HHSC-administered Home & Community-Based Services – Adult Mental Health Program.	\$800,000

Article IX (86), Contingencies and Other Special Provisions

Contingency riders are legislative directives that instruct agencies on how to spend certain appropriated funds if/when legislation passes. Contingency riders typically do not provide additional or new funding. Special Provisions are instructions included in the appropriations bill that apply to multiple agencies within one or multiple articles. Typically, these provisions are used to restrict the amount and conditions under which appropriations may be expended.

Special Provision #	Description
Sec. 10.04	<p>a. Statewide Behavioral Health Strategic Plan and Coordinated Expenditures – Informational Listing of Behavioral Health and Substance Abuse Services Appropriations across state agencies totaling \$2,212,505,239 for FY 2020 and \$2,146,796,234 for FY 2021.</p> <p>b. Statewide Behavioral Health Coordinating Council - Consists of a representative from each state agency that funds behavioral health programs or services related to the research, prevention, or detection of mental health conditions, as well as all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental health condition, including individuals living with alcohol or drug addiction.</p> <p>c. Statewide Behavioral Health Strategic Plan - The purpose of the Statewide Behavioral Health Coordinating Council shall be to implement the five-year Statewide Behavioral Health Strategic Plan and provide annual reports including the progress of implementation.</p> <ul style="list-style-type: none"> i Collaborating with the Board of Pharmacy and Medical Board, the Council shall create a sub-plan related to substance abuse including challenges of existing prevention, intervention, and treatment programs, evaluation of substance use disorder prevalence, service availability gaps in current services, and strategies for working with state agencies to expand treatment capacity. <p>d. Coordination of Behavioral Health Expenditures - The coordinating council shall submit to the executive commissioner of HHSC and the LBB a coordinated statewide expenditure proposal for each agency. The Comptroller of Public Accounts shall not allow the expenditure of GR-related funds identified in subsection (a) to a particular agency if the LBB provides notification to the Comptroller that the agency's expenditure proposal has not satisfied the requirements of this provision.</p>
Sec. 18.09	Contingency for House Bill 19 – appropriates \$2.3 million in GR each fiscal year in grants for HHSC to support 20 non-physician mental health professionals at each LMHA to serve as mental health and substance use resources for ESCs, contingent on the enactment of HB 19. *HB 19 passed
Sec. 18.68	Contingency for Senate Bill 633 – appropriates \$274,173 in GR and \$23,517 in federal funds in FY 2020 and \$237,163 in GR and \$20,343 in federal funds in FY 2021, as well as 3.3 FTEs to increase capacity of LMHAs in certain counties to provide mental health services. *SB 633 passed
Sec. 18.83	Contingency for Senate Bill 340 – appropriates \$500,000 to the Trusteed Programs Within the Office of the Governor for FY 2020 to assist law enforcement agencies to purchase opioid antagonists, contingent on enactment of SB 340. *SB 340 passed
Sec. 18.85	Contingency for Senate Bill 362 – appropriates \$850,000 each fiscal year to implement provisions of court-ordered mental health services, contingent on enactment of SB 362. *SB 362 passed
Sec 18.95	Judicial Training Program – appropriates \$250,000 each fiscal year in GR for the development of a training program to inform and educate judges and staff on mental health resources in the state to both the Supreme Court of Texas and the Court of Criminal Appeals.
Sec 18.104	Human Trafficking Signage – appropriates \$200,000 in GR to the Texas Department of Transportation in FY 2020 for signage at public transportation areas (buses, bus stops, trains, airports, etc.) promoting the availability of services and assistance to victims of human trafficking.
Sec. 18.112	Additional Funding for School Safety – includes an informational list of the appropriated amounts for school safety across agencies for fiscal years 2020-21, totaling \$139.9 million, with an additional \$203.6 million that is contingent on the passing of legislation.
Sec. 18.117	Contingency for Senate Bill 11 – School Safety Allotment – appropriates \$9.72 per student in average daily attendance to TEA, estimated to be \$49,672,915 in GR in FY 2020 and \$50,327,085 in GR in FY 2021 for school safety and mental health promotion in public schools, contingent on enactment of SB 11. The same amounts of GR will be reduced from HHSC's Medicaid Prescription Drugs strategy per fiscal year. *SB 11 passed

SB 500 (86TH, NELSON/ZERWAS) – SUPPLEMENTAL APPROPRIATIONS BILL

Funding for important mental health and substance use services was included in the supplemental appropriations bill, including essential funding to continue state psychiatric hospital redesign projects. Also included were funds to support school safety.

Item	Amount	Description
Section 21 – HHSC, State Hospital Funding – Phase II of Redesign Efforts	\$165,000,000 \$190,300,000 \$ 90,054,363	Begins the Austin State Hospital Replacement (construction) Begins the San Antonio State Hospital Replacement (construction) Rusk State Hospital Non-Maximum Security Unit Replacement (construction)
Section 25 – HHSC, Mental Health State Hospitals	\$31,700,000	Symbolizes appropriated funds for mental health state hospital services under Strategy G.2.1., Mental Health State Hospitals
Section 30 – TEA, Special Education Support and Maintenance of State Financial Support	\$33,302,428 \$74,626,551 \$111,625,833	Offsets federal funds withheld as a result of the state's failure to maintain financial support during FY 2012 Settles with the federal government for the state's failure to maintain financial support during FY 2017-18 Prevents future failure to maintain financial support
Section 31 – TEA, Post-disaster school safety	\$10,930,000	Creates a grant for a school district that experienced a school shooting resulting in one or more fatalities after FY 2019
Section 32 – TEA, School Safety – Physical Hardening of Schools	\$100,000,000	Appropriates funds from the economic stabilization fund for public schools to fund school hardening activities, limited to: <ul style="list-style-type: none"> • Exterior doors with push bars • Metal detectors at school entrances • Erected vehicle barriers • Security systems that monitor and record entrances, exits, and hallways • Campus-wide active shooter alarm systems (separate from fire alarms) • Two-way radio system • Perimeter security fencing • Bullet-resistance glass or film for school entrances • Door locking systems

Sources for General Appropriations:

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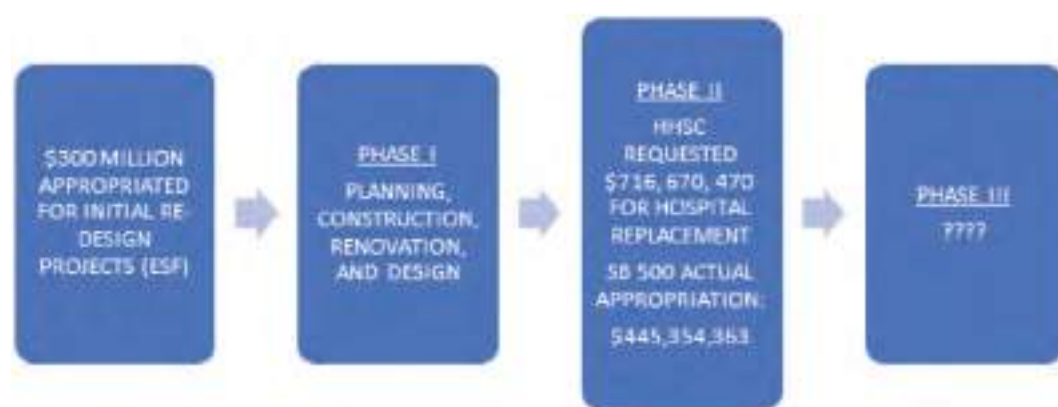
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State Hospital Redesign

The physical condition of the state psychiatric hospitals and the state supported living centers (SSLCs) continues to be a priority for policymakers. Much of the inpatient infrastructure is old, outdated, and in need of immediate repair or renovation. HHSC was directed to develop a three-phase plan to address the immediate infrastructure needs of the state hospital system. Planning and renovation was the priority for Phase I, and new construction was approved in Phase II. Currently, two new state hospitals are under construction (Austin State Hospital and San Antonio State Hospital) as well as a new maximum-security unit at Rusk State Hospital. While construction has started, only approximately half of the needed funding for the new Austin State Hospital and the San Antonio State Hospital has been appropriated.

Figure 21. SH redesign phases:



Source: http://www.lbb.state.tx.us/documents/publications/fiscal_sizeup/fiscal_sizeup.pdf

- **Phase I:**

- Planning and design
- \$10.3 million to increase maximum security forensic bed capacity at the North Texas State Hospital – Vernon Campus;

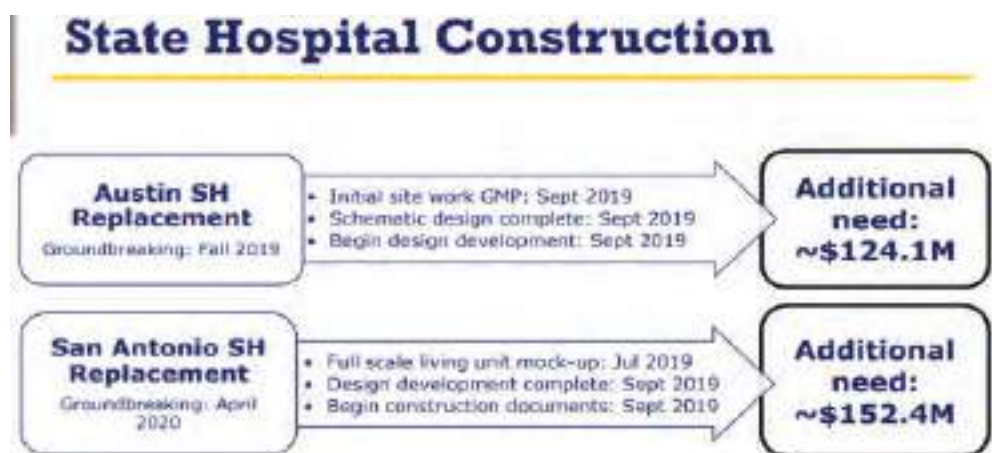
- \$24.8 million to maintain purchased inpatient bed capacity and state hospital bed capacity HHSC opened an additional 20 beds at Terrell State Hospital in Summer 2019. (<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/sb1-quarterly-report-waiting-lists-mhs-apr-2019.pdf>)

• **Phase II:**

- \$90,054,363 for construction of a 100-bed MSU at Rusk State Hospital
- \$165,000,000 to begin construction of a 240-bed replacement campus of ASH
- \$190,300,000 to begin construction of a 300-bed replacement campus of SASH

According to a presentation made by HHSC to the Transition Legislative Oversight Committee in August 2019, the figure below depicts the additional funding needed to complete the redesign/construction of ASH and SASH.

Figure 22. ASH and SASH Construction



Source: Health and Human Services Commission, Presentation to the Transition Legislative Oversight Committee, August 26, 2019. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/leg-presentations/presentation-transition-legislative-oversight-committee-aug-26-2019.pdf>

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Policy Concerns

- Providing low-income Texans with mental health and/or substance use conditions who are ineligible for Medicaid access to supports and services.
- Expanding Medicaid to ensure individuals with mental health and/or substance use conditions have access to treatment, services, and supports.
- Ensuring adequacy of Medicaid reimbursement rates for mental health, substance use, and primary care services and providers.
- Planning for the discontinuation of Medicaid 1115 Transformation Waiver funding and the sustainability of Delivery System Reform Incentive Payment (DSRIP) projects providing behavioral health services.
- Continuing efforts to enforce mental health and substance use parity within Medicaid and CHIP.
- Addressing Texas having the highest uninsured rate of both adults and children in the country.
- Monitoring and ensuring mental health, substance use, and primary care network adequacy in Medicaid managed care.
- Ensuring access to quality community-based mental health and substance use services through integrated service delivery and managed care models that emphasize recovery, prevention, and continuity of care.
- Protecting state funding for substance use services to keep Texas from being penalized for the required Maintenance of Effort (MOE) requirement for federal block grant funding.
- Addressing mental health and substance use workforce shortage issues, particularly the lack of diverse providers and availability in rural areas.
- Expanding opportunities for peer support specialist, recovery coach, and family partner support services.
- Addressing the Medicaid reimbursement rates for peer services to reflect their importance and incentivize utilization by providers.
- Ensuring the ongoing success and improvement of services for children and youth available through the YES Waiver.
- Monitoring efforts of the state hospital redesign to ensure a comprehensive continuum of supports and services.
- Improving individual outcome performance measures to focus more on behavioral health outcomes and patient-centered recovery, and less on easy-to-measure outputs.
- Expanding access to coordinated specialty care teams for individuals experiencing first episode psychosis.
- Addressing the RTC bed wait list of children experiencing serious emotional disturbances (SEDs) who are at risk of being relinquished into the custody of Child Protective Services in order to receive mental health treatment.
- Coordinating cross-agency efforts to address the mental health needs of individuals with intellectual disabilities.
- Improving access to trauma-informed training across HHSC divisions specific to children and adults with intellectual disabilities.
- Accessing crisis services, including emergency respite.
- Implementing systems-wide trauma-informed care, positive behavior interventions and supports, and person-centered recovery-focused practices.
- Improving mental health and substance use services in state-supported living

- centers and community-based waiver programs.
- Improving wait list time for inpatient and community-based mental health and substance use services.
- Ensuring access to broadband and needed technology for telehealth and telemedicine
- Ensuring access to mental health and substance use services through telehealth and telemedicine, and across the state, particularly in rural and low-income areas; ensuring parity with in-person services and allowing the use of audio-only telephone
- Addressing the behavioral health needs of pregnant and postpartum women.
- Improving availability to affordable, safe, and supportive housing for individuals living with mental health and/or substance use conditions.
- Ensuring access to appropriate recovery support services for individuals receiving medication-assisted treatment (MAT).
- Monitoring the implementation of the All Texas Access project and its' regional plans addressing mental health services.
- Expanding eligibility for Medicaid reimbursed peer support services to youth under the age of 21.
- Improving recovery-oriented supports with increased availability of peer recovery coaches, Recovery Community Organizations (RCOs), and community-based aftercare.
- Increasing access to school and community-based substance use prevention programs.

Fast Facts

- The 2020-2021 HHSC appropriation of all funds was over \$76 billion and comprised 30 percent of the state's entire budget.¹
- In January 2020, 3,870,036 individuals were enrolled in Medicaid and 352,725 enrolled in CHIP in Texas.²
- Children without disabilities account for 69 percent of Medicaid enrollment but only 30 percent of program spending on direct healthcare services.³
- In 2018, Medicaid covered approximately 53 percent of births, 44 percent of children across the state, and 62 percent of nursing home residents in Texas.⁴
- Texas has 73 Federally Qualified Health Centers (FQHCs) serving over 1.4 million Texans at more than 300 sites statewide.^{5,6}
- The population growth in Texas between 2010 and 2019 (15.3 percent) was more than double the national average (6.3 percent), resulting in increased demand for HHSC-funded services.^{7,8}
- As of June 2020, Texas had only met about 36 percent of the state's need of mental health professionals and 214 counties were designated as either full or partial Health Professional Shortage Areas for Mental Health (HPSA-MH).^{9,10}
- As of August 2020, Texas has 506 people trained as certified mental health peer specialists (MHPS), 246 certified recovery support peer specialists (RSPS), and 222 peer specialist supervisors (PSS), enabling them to use their lived experiences with behavioral health issues to help recipients of HHSC-funded services.¹¹
- In 2018, over 12 million adults in the United States were living with a co-occurring

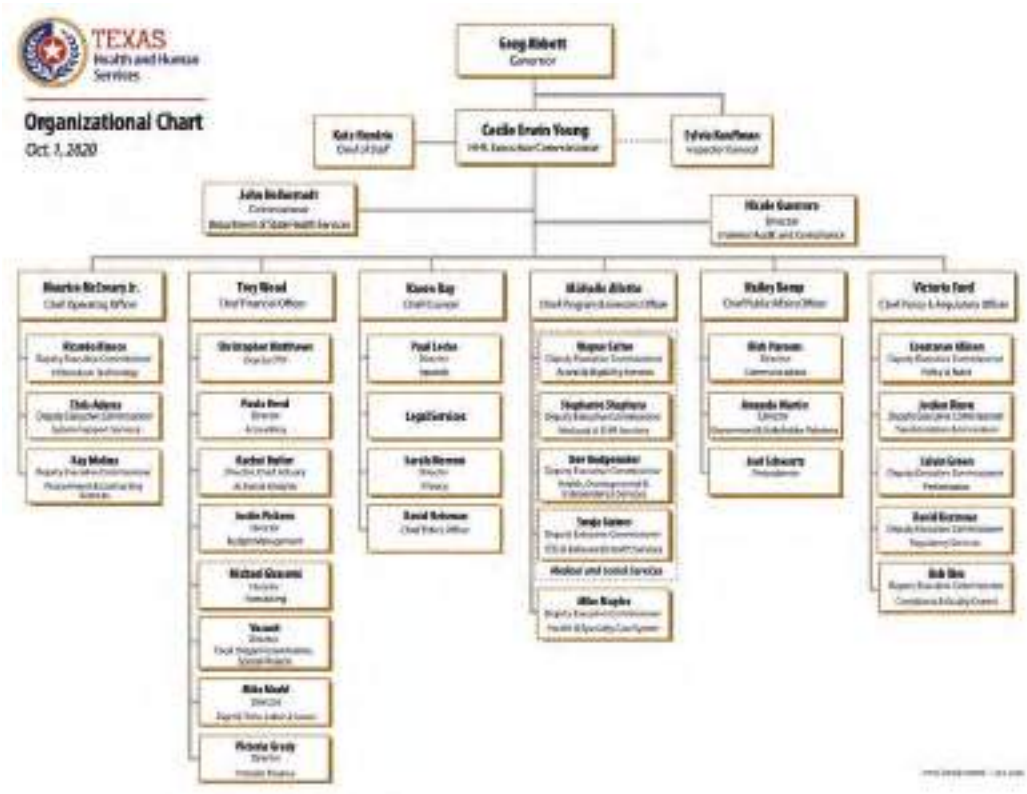
- substance use and mental health condition.¹²
- Almost half of individuals who live with a mental health condition also live with a substance use condition.¹³
- Over 60 percent of adolescents receiving community-based substance use treatment also meet diagnostic criteria for a mental illness.¹⁴
- It is estimated that as many as 30 to 40 percent of persons with intellectual disabilities are diagnosed with a mental health condition,¹⁵ and are three to five times more likely to have a co-occurring mental health condition than the general population.¹⁶
- Children with intellectual and other developmental disabilities (IDD) are more likely to have experienced traumatic events when compared to those without disabilities.¹⁷ However, the known rate of abuse may be higher due to underreporting or lack of recognition by family and other caregivers.¹⁸
- Individuals with IDD who have a dual diagnosis or who present behavioral “challenges” are more likely to be institutionalized and are often the last to be released to a community-based setting.¹⁹ Additionally, community services and supports are frequently incapable of meeting the behavioral health needs of these individuals, leading to less successful outcomes when transitioning into the community.²⁰
- Individuals aged 18-25 are at the highest risk of overdose as they are more likely than any other age group to misuse a prescription medication, use an illicit drug, or use heroin.²¹
- As of April 2020, there were 449 individuals waiting for a maximum-security forensic state hospital bed, with the average of 289 days on the waiting list.²²
- As of April 2020, there were 451 individuals waiting for a non-maximum-security forensic state hospital bed, with the average of 76 days on the waiting list.²³

HHSC Acronyms

ACA – Affordable Care Act	COVID- 19 – Coronavirus disease of 2019
ACT – Assertive Community Treatment	CPS – Child Protective Services
ANSA – Adult Needs and Strengths Assessment	CRS – Comprehensive rehabilitation services
APS – Adult Protective Services	CSC – Coordinated specialty care
APS PI – Adult protective services provider investigations	DADS – Department of Aging and Disability Services
ASD – Autism spectrum disorders	DARS – Department of Assistive and Rehabilitative Services
BHAC – Behavioral Health Advisory Committee	DDS – Disability Determination Services
CANS – Child and Adolescent Needs and Strength Assessment	DFPS – Department of Family and Protective Services
CBT – Cognitive Behavioral Therapy	DSM-V – Diagnostic and Statistical Manual of Mental Disorders, 5th edition
CHIP – Children’s Health Insurance Program	DSRIP – Delivery System Reform Incentive Payment
CIHCP – County Indigent Health Care Program	ECI – Early Childhood Intervention
CIL – Centers for Independent Living	IDEA – Individuals with Disabilities Education Act
CLOIP – Community living options information process	FEP – First Episode Psychosis
CMS – Centers for Medicaid and Medicare Services	FFCC – Former foster care children
COPSD – Co-occurring psychiatric and substance abuse disorders services	FMAP – Federal medical assistance percentage
	FPG – Federal poverty guidelines

FPL – Federal poverty level	PASRR – Preadmission screening and resident review
FQHC – Federally Qualified Health Center	QTLs – Quantitative treatment limits
GAO – Government Accounting Office	RHP – Regional healthcare partnership
GR – General revenue	ROSC – Recovery-oriented systems of care
HCBS-AMH – Home and Community-based Services – Adult Mental Health	RSS – Recovery support services
HCS – Home and community-based services	RTC – Residential treatment center
HCSSA – Home and community support services agency	SAMHSA – Substance Use and Mental Health Services Administration
HEDIS – Healthcare Effectiveness Data and Information Set	SBIRT – Screening, brief intervention, and referral to treatment
HHS – Health and Human Services	SCI – Spinal cord injury
HHSC – Health and Human Services Commission	SED – Serious emotional disturbance
HPSA – Health professional shortage area	SH – State hospital
HPSA-MH – Health professional shortage area for mental health	SMI – Serious mental illness
ICF/IDD – Intermediate care facility-intellectual and developmental disabilities	SNAP – Supplemental Nutrition Assistance Program
ICM – Intensive case management	SOC – Systems of care
ICR – Inpatient competency restoration	SPA – Medicaid state plan amendment
IDD – Intellectual and other developmental disabilities	SPMI – Serious and persistent mental illness
IL – Independent living	SSA – Social Security Administration
IMD – Institutions for Mental Diseases	SSDI – Social Security Disability Income
IST – Incompetent to stand trial	SSI – Supplemental Security Income
JBCR – Jail-based competency restoration	SSLC – State-supported living center
LAR – Legally authorized representative	STAR – State of Texas Access Reform
LBB – Legislative Budget Board	STAR Health – State of Texas Access Reform program for children in CPS system
LBHA – Local behavioral health authority	STAR Kids – State of Texas Access Reform program for children with disabilities eligible for SSI
LIDDAs – Local intellectual/developmental disability authorities	STAR+Plus – State of Texas Access Reform program that includes long-term services and supports
LMHAs – Local mental health authorities	SUD – Substance use disorder
LOC – Level of care	TANF – Temporary Assistance for Needy Families
LOC-A – Level of care-authorized	TAS – Transition assistance services
LOC-EO – Level of care-early onset	TBI – Traumatic brain injury
LOC-R – Level of care-recommended	TCCP – Texas Code of Criminal Procedures
LOS – Length of stay	TDCJ – Texas Department of Criminal Justice
LTSS – Long-term services and supports	TDHCA – Texas Department of Housing and Community Affairs
MAT – Medication-assisted treatment	TDI – Texas Department of Insurance
MCO – Managed care organization	TEA – Texas Education Agency
MCOT – Mobile crisis outreach teams	TJJD – Texas Juvenile Justice Department
MDCP – Medically Dependent Children's Program	TMHP – Texas Medicaid Healthcare Partnership
MOU – Memorandum of Understanding	TOPDD – Texas Office of Prevention of Developmental Disabilities
MOE – Maintenance of Effort	TRI – Texas Recovery Initiative
MSU – Maximum security unit	TRR – Texas Resiliency and Recovery
MTFCY – Medicaid for Transitioning Foster Care Youth	TVC – Texas Veterans Commission
NQTLs – Non-quantitative treatment limits	TWC – Texas Workforce Commission
NWI – National Wraparound Initiative	YES Waiver – Youth Empowerment Services Waiver
OCR – Outpatient competency restoration	
ODPC – Office of Disability Prevention for Children	
OSAR – Outreach, screening, assessment, and referral center	

Texas Health and Human Services System Organizational Chart



Source: Texas Health and Human Services Commission. (2020, October 1). *Health and Human Services system organizational chart* [PDF file]. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/leadership/hhs-org-chart.pdf>

Overview

The Texas Health and Human Services Commission (HHSC) is the umbrella agency providing a multitude of services and programs to Texans. HHSC programs and services include Medicaid, Children’s Health Insurance Program (CHIP), long-term services and supports, Supplemental Nutrition Assistance Program (SNAP) food benefits, temporary assistance for needy families (TANF) cash benefits, mental health and substance use services, and services for older Texans, women, and people with disabilities. Services are delivered through a complex system of programs and benefits. HHSC also oversees certain regulatory functions such as nursing facility licensing and credentialing, licensing of childcare providers, certain professional licensing and certification, and management of state supported living centers and state psychiatric facilities.

The Texas Department of State Health Services (DSHS) is also under the HHSC agency umbrella but operates as a separate department. DSHS focuses on public

health functions such as vital statistics, compiling and disseminating health data, prevention of chronic and infectious diseases, maternal and child health, laboratory testing, and licensing and regulating certain facilities and operations.

Over the last 17 years, the Texas Health and Human Services system has undergone extensive reorganization in an attempt to produce a more efficient, effective, and responsive system. The HHSC transformation began in 2003 as the umbrella agency overseeing multiple programs and departments. After the 2015 Sunset Review Commission review and subsequent recommendations through SB 200 (85th, Nelson/Price), reorganization efforts prioritized agency consolidation. Several client services were transferred to HHSC, including state hospital inpatient services, SSLCs, and some regulatory and administrative services. This transfer eliminated both the Department of Assistive and Rehabilitative Services (DARS) and the Department of Aging and Disability Services (DADS). Additionally, behavioral health and regulatory functions (previously administered by DSHS and the Department of Family and Protective Services (DFPS)),²⁴ the Office of Mental Health Coordination, and the Forensic Director position were transferred to HHSC over the next few years. As transformation continued, DFPS became an independent agency, and the Health and Human Services system consequently became solely comprised of HHSC and DSHS.

Additionally, the HHSC Executive Council was established during the transition. The primary purpose of the council is to obtain public input and to advise the HHSC executive commissioner on policies relating to the health and human services system.²⁵ Information on the HHSC Executive Council is available at <https://hhs.texas.gov/about-hhs/leadership/councils/health-human-services-commission-executive-council>.

Transformation planning and implementation continues within the HHS system and is led by the Transformation, Policy and Performance Office, which reports to the Chief Policy Officer. The Chief Policy Officer reports directly to the executive commissioner and is responsible for innovation, performance management, policy development, and data analysis.

The transformation of the HHS system is overseen by the Joint Health and Human Services Transition Legislative Oversight Committee. The committee is made up of four members of the Texas Senate, four members of the Texas House, three governor-appointed public members, and the HHSC Executive commissioner as an ex officio member. According to Chairwoman Nelson, the committee's charges are to ensure easier access to services for individuals, remove blurred lines of authority, remove barriers to system-wide improvements, and improve overall efficiency.²⁶

Changing Environment

Prior to the Texas Legislature's 86th session, leadership committed to prioritize major initiatives including school finance reform and local property taxes. Additionally, mental health and substance use continued to garner significant attention, with school safety/mental health and opioid use highlighted as important policy agenda. The Texas Legislature continued to invest resources to improve access to both adult and youth behavioral supports and services, address the mental health workforce shortage, and re-design the state's hospital system. The investment made to continue the redesign and construction of inpatient mental health services is imperative to ensure that critical mental health services needed by Texans are available.

HB 1 (ZERWAS/NELSON) GENERAL APPROPRIATIONS TO HHSC FOR MENTAL HEALTH AND SUBSTANCE USE FUNDING

HB 1 funding for mental health and substance use supports and services administered by HHSC are allocated in Article II of the state's budget. ***Additional funding information can be found in the Funding section of this guide.*** The legislature made a number of decisions to improve access to mental health and substance use services. Some highlights include:

- An appropriation to reduce waiting lists for mental health community-based services (Rider 20);
- An appropriation to maintain a mental health peer support re-reentry program (Rider 57);
- An increase in funds to women and children's substance use treatment services (Rider 64);
- Funding to increase the number of RTC beds available to avoid child relinquishment due to the needs of intensive mental health services (Rider 65);
- Continued funding of grants created through HB 13 (85th, Price/Schwertner) and SB 292 (85th, Huffman/Price) focused on mental health supports and services for communities and justice-involved individuals; and
- Continued funding for clubhouses across the state (Rider 65).

SB 500 (NELSON/ZERWAS) - SUPPLEMENTAL APPROPRIATIONS TO HHSC

SB 500 appropriated over \$450 million for renovations and construction on state hospitals across the state.

SB 11 (TAYLOR/BONNEN) - TEXAS CHILD MENTAL HEALTH CONSORTIUM

SB 11 was filed to address safe and supportive schools, with mental health as one component of the legislation. It also includes provisions related to school hardening strategies and staff training on how to respond during an emergency.

Additionally, SB 10 (Nelson) was amended onto this bill through swift legislative action near the end of the legislative session. SB 10 created the Texas Children's Mental Health Care Consortium (Consortium). The goal is to leverage institutions of higher education's expertise and capacity to enhance collaboration between institutions, improve access to behavioral health care for youth, and address the youth psychiatric workforce shortage. The bill creates four major initiatives: Child Psychiatry Access Network (CPAN), the Texas Child Access Through Telemedicine (TCHAT), Child Psychiatry Workforce Expansion, and Child and Adolescent Psychiatry Fellowship. To implement and establish the initiatives, the Texas Legislature appropriated \$99 million.

More details on SB 11 and other school mental health legislation can be found in The TEA Section of this guide, and The Hogg Foundation's *School Climate Legislation from the 86th Legislative Session* brief found at https://hogg.utexas.edu/wp-content/uploads/2020/01/FINAL_86th-Lege_Policy-Brief_School-Climate.pdf.

HB 253 (FARRAR/KOLKHORST) POSTPARTUM DEPRESSION STRATEGIC PLAN

HB 253 directs HHSC to create develop and implement a five-year strategic plan to improve access to postpartum depression (PPD) screening, referral, treatment, and support services. The strategic plan is required to include strategies to:

- Increase awareness among state-administered program providers who may serve women who are at risk of or are experiencing PPD about the prevalence and effects of PPD on outcomes for women and children;
- Establish a referral network of community-based mental health providers and support services addressing PPD;
- Increases women's access to formal and informal peer support services, including access to certified peer specialists who have received additional training related to PPD;
- Raise public awareness of and reduce the stigma related to PPD; and
- Leverage sources of funding to support existing community-based PPD screening, referral, treatment, and support services.

SB 633 (KOLKHORST/LAMBERT) TEXAS ALL ACCESS PROJECT

SB 633 directs HHSC to create regional authority groups of local mental health authorities serving populations of less than 250,000 in order to increase access to mental health services. HHSC is required to develop a mental health services development plan for each local mental health authority group that will increase the

capacity in the group to provide access to needed services. The plans are required to focus on reducing the costs of mental health crisis services, transportation costs for those served by the local authorities to mental health facilities, incarceration of individuals with mental illnesses in county jails, and hospital emergency room visits for individuals with mental illnesses.

SB 670 (BUCKINGHAM/PRICE) TELEHEALTH INITIATIVES

SB 670 requires HHSC to encourage health care providers and health care facilities to provide telemedicine medical services and telehealth services, including mental health and substance use services. Requires HHSC to implement a number of changes to ensure that Medicaid managed care organizations reimburse for telemedicine and telehealth services at the same rate as in-person services.

SB 750 (KOLKORST/BUTTON) HEALTHY TEXAS WOMEN'S PROGRAM

SB 750 contains many provisions aimed at improving health care services for women in both the state Medicaid program and the Healthy Texas Women Program, including:

- Prenatal care and postpartum care;
- Both physical health care and behavioral health care services including requiring HHSC to develop statewide initiatives to improve the quality of maternal health care services and outcomes for women in Texas;
- A study to assess the feasibility of providing Healthy Texas Women Program services through managed care; and
- Mental health and substance use services, including provisions for HHSC:
 - To apply for federal funding to implement a model of care that improves the quality and accessibility of care for pregnant women with opioid use conditions during the prenatal and postpartum periods, and their children after birth; and
 - To develop and implement a postpartum depression treatment network for women enrolled in either program in collaboration with Medicaid managed care organizations.

SB 1177 (KOLKHORST/ROSE) "IN LIEU OF" MEDICAID BILL

SB 1177 instructs HHSC to update Medicaid managed care contracts to include language permitting an MCO to offer medically appropriate, cost-effective, and evidence-based services from a list approved by the state Medicaid managed care advisory committee "in lieu of" mental health or substance use conditions services specified in the state Medicaid plan.

HB 2813 (PRICE/NELSON) STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

HB 2813 establishes the statewide behavioral health coordinating council for a strategic statewide approach to behavioral health services. The bill codifies the council's requirement to develop and monitor the implementation of a five-year behavioral health strategic plan, develop a biennial expenditure report, and publish an inventory of state-funded services and programs.

HB 3980 (HUNTER/MENENDEZ) SUICIDE PREVENTION EFFORTS ACROSS STATE SYSTEMS

HB 3980 directs HHSC and DSHS to publish a report on the prevalence of suicide in Texas and prevention efforts across state systems and agencies, including:

- Available state and regional data of the prevalence of suicide-related events, including thoughts, attempts, and deaths caused by suicide. Data is disaggregated by county and is longitudinal as able;
- Identification of the highest categories of risk with correlational data;
- State statutes, agency rules, and policies related to suicide prevention, intervention, and postvention; and
- Agency initiatives since 2000 addressing suicide, including funding sources and years of operations.

Additionally, HB 3908 directs the Statewide Behavioral Health Coordinating Council to establish a stakeholder workgroup to assist in preparing a legislative report. The report is required to identify opportunities and make recommendations to improve statewide data collection related to suicide, to use data to guide and inform decisions and policy development, and to decrease suicides while targeting the highest risk categories.

HB 3285 (SHEFFIELD/HUFFMAN) OMNIBUS SUBSTANCE USE BILL

HB 3285 is a comprehensive bill addressing substance use across a number of agencies. While the bill addresses various initiatives, the following are brief descriptions of a few changes requiring HHSC or DSHS involvement. This is not a complete summary of the provisions of the bill:

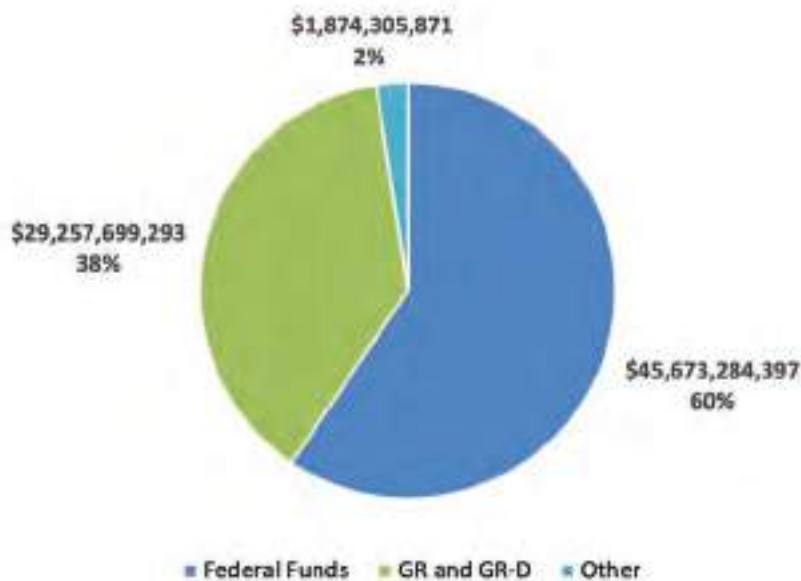
- Requires the executive commissioner of HHSC to establish a program that increases opportunities and expands access to telehealth treatment for substance use across Texas;
- Requires the Statewide Behavioral Health Strategic Plan to include a subplan for substance use issues;
- Requires DSHS to create an opioid misuse public awareness campaign;
- Requires the executive commissioner of DSHS to ensure the data collection of opioid overdose deaths, co-occurrence of substance use and mental illness, and

- evaluation of the current treatment capacity for individuals with co-occurring substance use and mental health concerns; and
- Requires Medicaid reimbursement for medication-assisted treatment (MAT) without prior authorization or pre-certification, with the exception of methadone.

Funding

HHSC funding continues to be a major component of the State of Texas biennial budget comprising approximately 30 percent of the total budget for the FY 2020-21 biennium.²⁷ Mental health and substance use funding has historically been underfunded, including reimbursement rates for providers. This impacts provider willingness to participate in the state Medicaid program which in turn directly impacts access to services. The Texas Legislature has increased mental health funding over the last several biennia, but many programs and services remain underfunded. In the most recent budget, Texas increased substance use funding, however was only a small fraction of HHSC’s request, and was the first increase in the last decade.

Figure 23. Health and Human Services Commission Budget by Method of Finance (FY 2020-21)



Source: Texas Legislature Online (2019). H.B.1, General Appropriations Act, 86th Legislature, FY 2020-21. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Table 15 below shows the HHSC All Funds funding trends over the last three budget cycles.

Table 15. HHSC All Funds Funding Trends

	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
HHSC	\$56,590,220,901	\$72,319,466,827	\$76,805,289,561

*Note: this amount was prior to the Health and Human Services System Transformation and consolidation of state agencies

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

HHSC Advisory Committees

After the Sunset Commission reviewed all Health and Human Services advisory committees, the continuing committees were re-established in rule; a list is available on the HHSC website at <https://hhs.texas.gov/about-hhs/leadership/advisory-committees>.

Several of the continuing committees have a direct impact on mental health and substance use policies, including but not limited to:

- Behavioral Health Advisory Committee
- Drug Utilization Review Board
- E-Health Advisory Committee
- Early Childhood Intervention Advisory Committee
- Medical Care Advisory Committee
- Policy Council for Children and Families Committee
- STAR Kids Managed Care Advisory Committee
- State Medicaid Managed Care Advisory Committee
- Texas Autism Council
- Texas Council on Consumer Direction
- Texas School Health Advisory Committee

HHS Regions

For service delivery administration, the state is divided into 11 HHS regions, displayed in Figure 24. As of August, 2019, the HHS system employed over 36,346 full-time employees.²⁸

Figure 24. Health and Human Services Regions



Source: Texas Health and Human Services Commission. (2016). *Health and Human Services offices by county*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/hhs-regional-map.pdf>

Medical and Social Services Division

The Medical and Social Services Division is responsible for:

- Medicaid and CHIP Services
- IDD and Behavioral Health Services Division
- Health, Developmental & Independence Services Division
- Access and Eligibility Services

OFFICE OF MENTAL HEALTH COORDINATION

In recent years, mental health and substance use (often referred to as “behavioral health”) have become major topics of both state and national dialogue. The Texas Legislature took steps to increase and improve cross-agency planning, coordination, and collaboration in effort to be more strategic with behavioral health service delivery and funding. In 2013, the legislature created the Office of Mental Health Coordination tasked with providing broad oversight for state mental health policy as well as managing cross-agency coordination of behavioral health programs, services, and expenditures.²⁹ The office reports directly to the deputy executive commissioner for IDD & Behavioral Health Services. The office developed a website to provide consumers, families, and providers with up-to-date information on mental health and substance use programs and services. More information is available at <http://www.mentalhealthtx.org>.

STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

In 2015, the legislature established the Statewide Behavioral Health Coordinating Council (SBHCC). The HHSC assistant commissioner, who oversees the Office of Mental Health Coordination at HHSC, serves as chair of the council.³⁰ Agencies and departments work together under the direction of the Office of Mental Health Coordination to ensure a strategic statewide approach to behavioral health services. During the 86th legislative session, Texas lawmakers passed House Bill 2813 (Price/Nelson), codifying the SBHCC. While other state agencies or institutions may be authorized to serve on the SBHCC, the agencies required to be represented are:

- Texas Health & Human Services Commission
- Office of the Texas Governor
- Texas Veterans Commission
- Texas Department of State Health Services
- Texas Department of Family and Protective Services
- Texas Civil Commitment Office
- University of Texas Health Science Center at Houston
- University of Texas Health Science Center at Tyler
- Texas Department of Criminal Justice
- Texas Correctional Office on Offenders with Medical or Mental Impairments

- Texas Juvenile Justice Department
- Texas Military Department
- Texas Health Professions Council (includes six member agencies)
- Texas Education Agency
- Texas Tech University System
- Texas Commission on Jail Standards
- Texas Workforce Commission
- Texas Department of Housing and Community Affairs
- Texas Indigent Defense Commission
- Texas Court of Criminal Appeals

The SBHCC is responsible for developing and implementing the five-year Statewide Behavioral Health Strategic Plan, a biennial Coordinated Statewide Expenditure Proposal, and publishing an annual inventory of behavioral health programs funded by the state. The Coordinating Council also has a number of goals, and coordinating agencies collaborate on a number of activities shown in Figure 25.

Figure 25. Statewide Behavioral Health Coordinating Council Activities



Source: Texas Health and Human Services Commission. (March 2018). Presentation to the *Senate Finance Committee: Statewide Behavioral Health Coordinating Council*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/leg-presentations/senate-finance-hearing-march-20-2018.pdf>

THE STATEWIDE BEHAVIORAL HEALTH STRATEGIC PLAN

The Statewide Behavioral Health Strategic Plan identifies 15 primary gaps in behavioral health services in Texas. The plan’s framework and goals are intended to address gaps and challenges within the behavioral healthcare system, as well as

improve access to care and outcomes. The second edition of the plan is available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

The most recent progress report as of September 2020 was printed in December 2019 and is available at <https://hhs.texas.gov/reports/2019/12/texas-statewide-behavioral-health-strategic-plan-progress-report-fiscal-year-2019>

Chairwoman Jane Nelson has indicated that any legislative proposals directed toward behavioral health should address one or more of these identified gaps. The gaps include:

- Access to appropriate behavioral health services
- Behavioral health needs of public school students
- Coordination across state agencies
- Veteran and military service members supports
- Continuity of care for individuals exiting county and local jails
- Access to timely treatment services
- Implementation of evidence-based practices
- Use of peer services
- Behavioral health services for individuals with intellectual disabilities
- Consumer transportation and access to treatment
- Prevention and early intervention services
- Access to housing
- Behavioral health workforce shortage
- Services for special populations
- Shared and usable data³¹

As a result of the passage of HB 3285 (Sheffield/Huffman), SBHCC is required to create a subplan specifically addressing substance use, including:

- Addressing challenges of existing prevention, intervention, and treatment programs;
- Evaluation of substance use conditions prevalence;
- Identifying substance use treatment services availability and gaps; and
- Collaborating with state agencies to expand substance use treatment service capacity in the state

According to HHSC, as of August 2020, the agency has organized an internal workgroup with plans to engage stakeholders moving forward. The development of the substance use subplan will be developed in tandem with the full Statewide Behavioral Health Strategic Plan to be due December 2021.³²

THE COORDINATED STATEWIDE BEHAVIORAL HEALTH EXPENDITURE PROPOSAL

The SBHCC develops the Coordinated Statewide Behavioral Health Expenditure

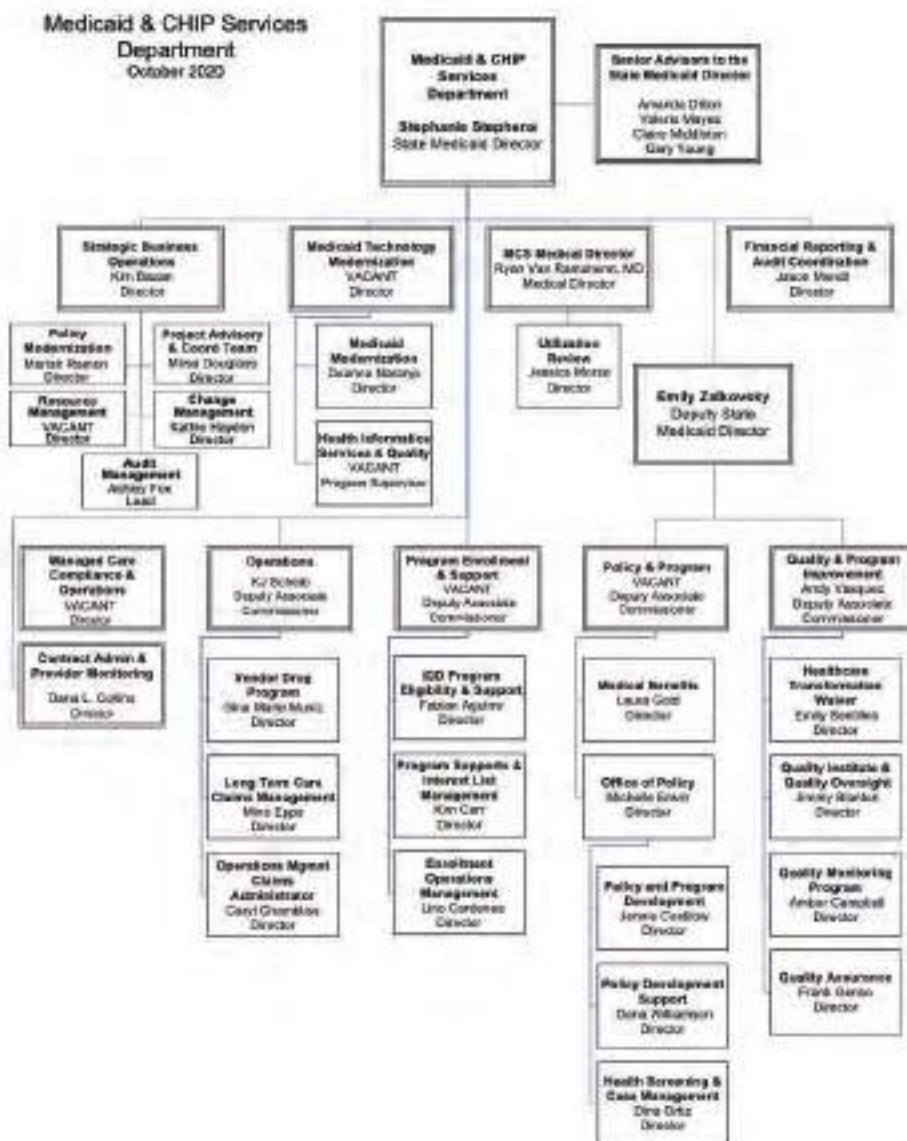
Proposal. The proposal identifies the total behavioral health funding proposed by each agency for the upcoming fiscal year. Expenditures are linked to various strategies in the strategic plan to demonstrate how state appropriations will be used to further its goals during the fiscal year. The full proposal is available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-behavioral-health-expenditure-proposal-fy20.pdf>

HHSC compiles a consolidated report of behavioral health funding across agencies, a summary of which can be found in the funding section of this guide.

VETERAN SERVICES DIVISION

The Veteran Services Division within HHSC was created in 2013 to coordinate, strengthen, and enhance veteran services across state agencies. The division's focus is to review and analyze current programs, engage the charitable and nonprofit communities, and create public-private partnerships to benefit these programs.³³ The Veterans Services Division is an active participant in the Texas Coordinating Council for Veterans Services.³⁴ The HHS Enterprise offers Texas veterans services through several agencies including but not limited to the Department of State Health Services, Texas Veterans Commission (TVC), and Texas Workforce Commission. More information on veterans can be found in the TVC section of this guide.

Medicaid & CHIP Services



Source: Texas Health and Human Services Commission. (October 2020). *Public Information Request, October 2020*.

MEDICAID

Medicaid is a jointly funded federal and state health care program authorized in Title XIX of the Social Security Act. It was created to provide health care benefits primarily to children in low-income families, pregnant women, and people with disabilities. The Texas Medicaid Program was first established in Texas in 1967. In January 2020, total Texas Medicaid and CHIP enrollment was 3,870,036 with 3,176,504 child enrollees.³⁵

Medicaid is an entitlement program, meaning that anyone who meets the eligibility criteria has a right to receive needed services and cannot be placed on waiting lists. Medicaid primarily serves low-income individuals who meet certain financial and

non-financial criteria to be eligible for services. Neither the federal government nor states can currently limit the number of eligible persons who enroll in the program.³⁶

The federal government defines the mandatory services that state Medicaid programs must provide and required eligible populations. States have the option to expand both the services offered and eligible populations through State Plan Amendments (SPAs), Medicaid waivers, and the Affordable Care Act (ACA). As of September 2020, 38 states and Washington, D.C. have adopted Medicaid expansion. Texas is one of 12 states that has chosen not to adopt this expansion.³⁷ As federal requirements and state policies change over time, updates are made via SPAs. States can choose to submit SPAs to make changes to their programs; for example, to change a provider payment methodology or add coverage of an optional service.³⁸ States can also make programmatic and eligibility changes by participating in Medicaid waiver programs to waive basic federal Medicaid requirements. Waivers can allow flexibility with mandated eligibility or required benefits in order to develop service delivery alternatives that improve cost efficiency or service quality. States can participate in three types of Medicaid waivers:

- **Research and Demonstration 1115 Waivers** give the state leniency to experiment with new service delivery models.
- **Freedom of Choice 1915(b) Waivers** allow the state to require clients to enroll in managed care plans and use the cost savings to enhance the Medicaid benefits package.
- **Home and Community-based Services 1915(c) Waivers** allow the state to provide community-based services to individuals who would otherwise be eligible for institutional care.³⁹

STATE MEDICAID AGENCY

HHSC has been the designated state Medicaid agency since 1993, administering the program and acting as a liaison between Texas and the federal government on related issues. The federal government establishes most Medicaid guidelines but grants several important tasks to the states, including:

- Administering the Medicaid State Plan, which functions as the contract between the agency and the federal government;
- Establishing Medicaid policies, rules, and provider reimbursement rates; and
- Establishing eligibility beyond the minimum federal eligibility groups⁴⁰

MEDICAID MANAGED CARE

Since the early 1990s, Texas has offered Medicaid coverage through two service models: fee-for-service (FFS) and managed care. In a traditional FFS model, providers receive payment for each individual service delivered. The FFS model is now limited to very few Medicaid participants, primarily those who are dually eligible for Medicaid and Medicare. As of November 2019, approximately 94.4 percent of Medicaid services in Texas were provided through managed care.⁴¹ In a Medicaid managed care system, individuals access services through a Managed Care Organization (MCO), also known as a health plan. HHSC contracts with MCOs and

pays them a monthly amount (capitated rate) per Medicaid enrollee to coordinate health services for each member enrolled in their health plan. All CHIP services are delivered through managed care.

MCOs are responsible for creating a network of public and private providers to ensure that adults and children receiving Medicaid can access needed services. MCOs are responsible for service authorization and reimbursement to service providers. With support from the Medicaid 1115 Transformation Waiver, Texas has incrementally expanded its Medicaid managed care system to include more services and populations.

In a managed care system, the Medicaid member selects a health plan and identifies a primary care physician from that plan's provider network. Individuals have a choice between two or more health plans in each HHS service region. Members have the option to change plans if they are unsatisfied. In addition to contractual requirements and state monitoring, members' ability to switch plans generates some level of competition between health plans that is intended to result in higher quality services.

Managed care programs in Texas include:

- STAR: serves children, newborns, pregnant women, and some families and children;
- STAR+PLUS: serves individuals with a disability and who are older than 65 (including those with dual eligibility for Medicare), and women with breast or cervical cancer;
- STAR HEALTH: serves children who receive Medicaid through DFPS and former foster care youth;
- STAR Kids: serves children and young adults 20 years of age and younger with a disability; and
- CHIP: serves children in families who do not meet income requirements for Medicaid, but who are unable to afford private health insurance.⁴²

Recently, more Texas Medicaid clients have enrolled in managed care, an increase from 86 percent in 2016 to approximately 94 percent in July 2019. This is in large part due to the implementation of SB 7 (83rd, Nelson/Raymond), which expanded mandatory participation in the existing STAR+PLUS managed care program beginning in September 2013. STAR+PLUS is specifically for people who have disabilities or are age 65 or older. People in STAR+PLUS get Medicaid healthcare and long-term services and support.

Senate Bill 7 directed the design and implementation of a comprehensive system of acute care and long-term services and supports for adults and children, including those with disabilities. The bill generated immediate system delivery changes in Medicaid by expanding STAR+PLUS to serve all areas of the state, as well as transitioning nursing facility services and acute care services for individuals with IDD into STAR+PLUS.

Many of the changes instituted by SB 7 address coverage for individuals with IDD, who are three times more likely to experience a mental health

condition than the general population.⁴³ To advise HHSC through the system redesign of transitioning long-term services and supports (LTSS) to Medicaid managed care, the IDD System Redesign Advisory Committee was created. More information on the advisory committee can be found at <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/intellectual-developmental-disability-system-redesign-advisory-committee>.

Between 2014 and 2016, HHSC completed the transition of acute services from Medicaid FFS to STAR+PLUS, STAR Kids, and STAR Health managed care programs for all eligible recipients of Medicaid IDD waiver programs and intermediate care facilities (ICFs) for individuals with IDD.⁴⁴ STAR Kids provides Medicaid managed care to children and adults 20 and younger who have disabilities, while STAR Health provides services for children and youth in the foster care system, including youth up to age 26 who have aged out of care.

In early 2019, HHSC completed and published evaluations to inform managed care on the transition of LTSS to managed care for individuals with IDD.⁴⁵ Prior to the 86th legislative session, SB 7 required these services to be provided through managed care by 2020-21. However, HB 4533 (Klick/Kolkhorst) passed, extending the transition timeframe for TxHmL to 2027, CLASS to 2029, and HCS and DBMD to 2031. Additionally, HB 4533 requires HHSC to establish a pilot program prior to the transition, as well as establishes a Pilot Program Workgroup to provide assistance in developing and advising HHSC on the operation of the pilot program.

In addition to expanding care in STAR+PLUS, SB 7 established a new managed care program for children with disabilities called STAR Kids which launched in November 2016. Figure 26 depicts the growth of Medicaid managed care in Texas from 2000 through 2017.

Figure 26. Growth of Managed Care Model: 2000 to 2017



Source: Texas Health and Human Services Commission. (2018). Texas Medicaid and CHIP in perspective twelfth edition. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf>

Table 16 describes the four Texas Medicaid and the CHIP managed care programs.

Table 16. Texas Medicaid and CHIP Managed Care Programs

Program	Description	Eligible Population
STAR Start date: 1991	<p>Provides primary care, acute care, and pharmacy services to children, infants, and pregnant women in families with limited income.</p> <p>Includes behavioral/mental health rehabilitative and targeted case management services.</p> <p>Operates statewide.</p>	<p><i>Mandatory:</i></p> <ul style="list-style-type: none">• Income-eligible pregnant women, infants, and children• TANF recipients• Young adults eligible for Medicaid for Former Foster Care Children (FFCC) will continue coverage through the STAR Medicaid Managed Care plan of their choice from age 21 through the month of their 26th birthday <p><i>Optional (choose STAR or STAR Health):</i></p> <ul style="list-style-type: none">• Former foster care children (18-20)
STAR+PLUS Start date: 1998	<p>Provides acute and LTSS to individuals age 65 or over or those who have a disability.</p> <p>Integrates primary care, pharmacy services, behavioral health care, and long-term care services. Service coordination is main feature.</p> <p>Operates statewide.</p>	<p><i>Mandatory:</i></p> <ul style="list-style-type: none">• Adults with Supplemental Security Income (SSI) (≥ 21)• Income-eligible adults with a disability (≥ 21)• Individuals in nursing facilities covered by Medicaid <p><i>Long-term care only:</i></p> <ul style="list-style-type: none">• Medicare/Medicaid dual-eligible individuals <p><i>Acute care only:</i></p> <ul style="list-style-type: none">• Individuals with IDD in an intermediate care facility or Medicaid 1915(c) waiver program
STAR Health Start date: 2008	<p>Provides all medically necessary services such as acute care, dental, vision, behavioral health, and pharmacy services to children currently or formerly under conservatorship of DFPS.</p> <p>Provides case management and training to families, caregivers, clinicians, caseworkers, advocates, and members of the judiciary.</p> <p>Operates statewide.</p>	<p><i>Mandatory:</i></p> <ul style="list-style-type: none">• Children (≤ 17) under DFPS conservatorship, including foster and kinship care• Young adults (18-22) in extended foster care placements• Young adults (18-21) in voluntary foster care placements <p><i>Optional (choose STAR or STAR Health):</i></p> <ul style="list-style-type: none">• Young adults (18-20) receiving Medicaid under the FFCC or MTFCY titles.• Young adults eligible for Medicaid for Former Foster Care Children (FFCC) will continue coverage through the STAR Medicaid Managed Care plan of their choice from age 21 through the month of their 26th birthday

Program	Description	Eligible Population
STAR Kids Start date: Nov. 2016	Provides acute and community-based services to children and young adults with disabilities. All children enrolled in the Medically Dependent Children's Program will transition to STAR Kids. Operates statewide.	Children and young adults (<20) who are covered by Medicaid and: <ul style="list-style-type: none"> • Receive SSI; • Receive SSI and Medicare; • Receive services though MDCP waiver; • Live in a community-based ICF/IDD or nursing facility; or • Receive services through any of the 191(c) waivers^a
CHIP Start date: 1999	Provides acute health care services to uninsured children living in low-income families who do not qualify for Medicaid. Operates statewide.	Uninsured children (<21) in families with income up to 201% of the Federal Poverty Level who are ineligible for Medicaid.

^a Medicaid 1915(c) waiver programs for adults and children include Home and Community-based Services (HCS), Community Living Assistance & Support Services (CLASS), Texas Home Living (TxHmL), and Deaf Blind with Multiple Disabilities (DBMD). Youth Empowerment Services (YES) serves children and youth.

Sources: Institute for Child Health Policy at the University of Florida. (2016). *Texas Medicaid managed care and Children's Health Insurance Program, summary of activity and trends in healthcare quality, Contract Year 2016*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/External-Quality-Review/tx-medicaid-mngd-care-chip-egro-contract-yr-2016.pdf>

Texas Department of Family and Protective Services. (n.d.). *STAR Health – a guide to medical services at CPS*. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Medical_Services/default.asp

Texas Health and Human Services Commission. (n.d.). *STAR+PLUS*. Retrieved from <https://hhs.texas.gov/services/health/medicaid-chip/programs/starplus>

Texas Health and Human Services Commission. (n.d.). *STAR+PLUS expansion*. Retrieved from <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/expansion-managed-care/starplus-expansion>

Texas Health and Human Services Commission. (n.d.). *STAR Kids*. Retrieved from <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>

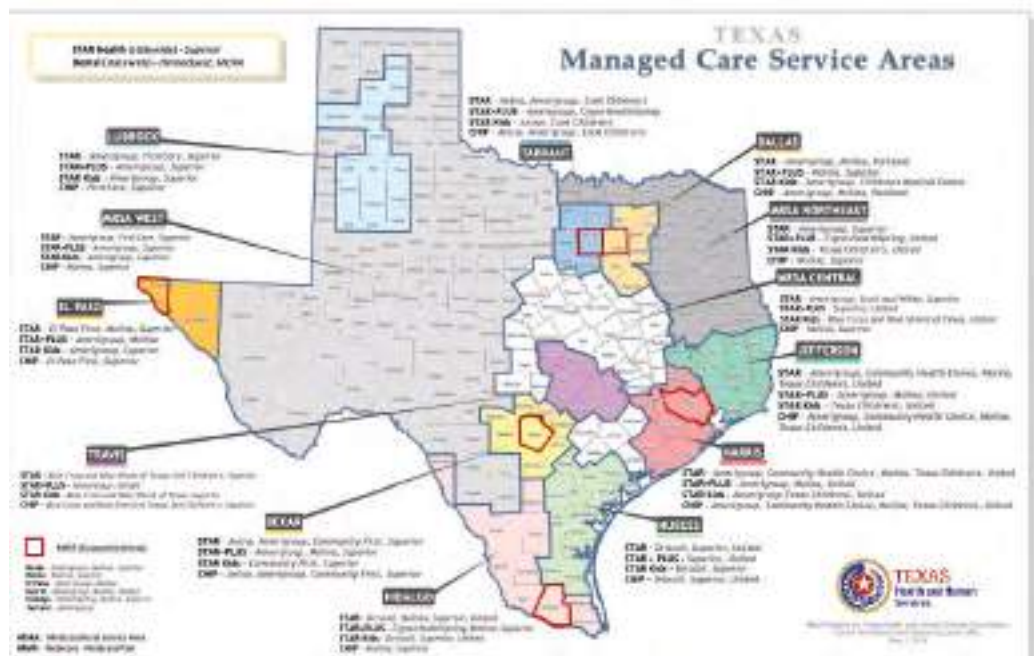
Texas Health and Human Services Commission. (n.d.). *Medicaid Managed Care quality strategy 2012-2016*. Retrieved from <http://texasrhp9.com/uploads/public/documents/Texas%20Medicaid%20Managed%20Care%20Quality%20Strategy%202012-2016.pdf>

Traylor, C. & Ghahremani, K. (August, 2014). *Presentation to the Senate Health and Human Services Committee: SB 7 implementation*. Texas Health and Human Services Commission. Retrieved from <https://hhs.texas.gov/reports/2014/08/presentation-senate-health-and-human-services-committee-sb-7-implementation>

Texas Health and Human Services Commission. (2017). *Texas Medicaid and CHIP in perspective eleventh edition*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>

Eighteen MCOs and two dental maintenance organizations (DMOs) provide services to Texas Medicaid and CHIP enrollees. Texas administers services in STAR, STAR+PLUS, STAR Kids, and CHIP in 13 service areas across the state illustrated in Figure 27.⁴⁶

Figure 27. Texas Managed Care Service Areas



Source: Texas Health and Human Services Commission. (December 2019). *Annual report on quality measures and value-based payments*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb-1629-quality-measures-value-based-payments-dec-2019.pdf>

MEDICAID FUNDING

The Texas Medicaid program is jointly funded by the state and the federal government. Medicaid is the largest source of public funding for mental health services nationwide, comprising a quarter of all public behavioral health expenditures.⁴⁷

Table 17 below shows Medicaid funding trends over the last three budget cycles.

Table 17. Medicaid Funding Trends

	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
Medicaid	\$50,337,662,810	\$57,424,319,977	\$61,648,507,884
Medicaid Contracts & Admin.	\$1,252,253,544	\$1,258,481,152	\$1,250,821,441
Total	\$51,589,916,354	\$ 58,682,801,129	\$ 62,899,329,325

*Note: these amounts were prior to the Health and Human Services System Transformation and consolidation of state agencies

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

The federal share of the Medicaid program, known as the federal medical assistance percentage (FMAP), is determined on an annual basis and by a formula that takes into account each state's income per capita compared to the U.S. average. Medicaid is one of the five grant programs administered by the U.S. Health and Human Services that uses the FMAP to determine reimbursements and payments to states.⁴⁸

The FMAP rate is also in-part calculated based on the U.S. Census count completed every 10 years. Small changes in the FMAP can result in millions of dollars in funding fluctuations. Anticipating the next census count to occur following the 86th legislative session, lawmakers filed bills to create a statewide census outreach committee. This initiative failed to pass, as did efforts to include dedicated funds in the budget for grants targeting local outreach efforts. In effort to address concerns from lack of coordinated state efforts, non-profit organizations, grassroots groups, and local governments have partnered on local outreach to ensure Texas has an accurate census count.⁴⁹ On August 26, 2020, the Texas secretary of state's office announced an allocation of \$15 million from federal funding meant to address COVID, toward an advertising campaign to urge residents to completed the census.⁵⁰

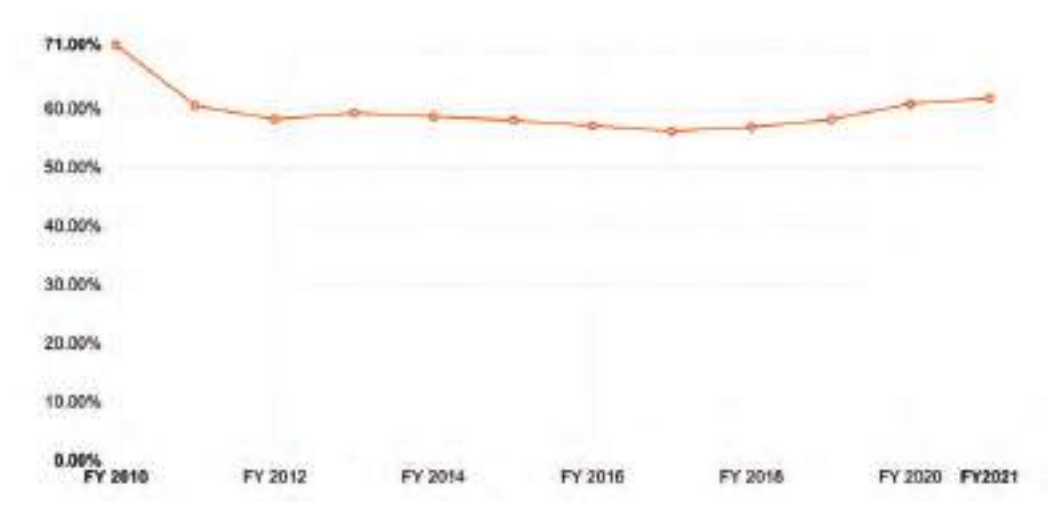
On April 13, 2020, The U.S. Department of Commerce Secretary and the U.S. Census Bureau Director announced a 2020 Census operational plan adjustment due to COVID-19. The announcement stated the new plan "would extend the window for field data collection and self-response to October 31, 2020, which will allow for apportionment counts to be delivered to the President by April 30, 2021, and redistricting data to be delivered to the states no later than July 31, 2021."⁵¹ However, on August 3, 2020, the Census Bureau Director released a contradictory plan stating field data collection would end by September 30, 2020.⁵²

In response, a lawsuit was filed by voting and civil rights groups, as well as local governments, challenging the Trump administration's order to complete the census count by the end of September. On September 5, 2020, a temporary restraining order was issued by U.S. District Judge Lucy Koh which required the Census Bureau and Commerce Department to continue operations as planned until a later hearing.⁵³ Despite this injunction, the Commerce Department announced an October 5th end date. As of October 2, 2020, Judge Koh directed the 2020 census counting to continue until October 31st. Additionally, she directed the Census Bureau to send all employees a text message "stating that the October 5, 2020 'target date' is not operative, and that data collection operations will continue through October 31, 2020." She cited contradictory messages from some supervisors of field employees as the reason for the wide message and that releasing an October 5th 'target date' violated her order.⁵⁴

Texas’ Medicaid federal matching rates for FY 2020 and 2021 are 60.89 percent and 61.81 percent; in other words, the state must pay 39.11 percent and 38.19 percent of all costs, respectively.⁵⁵ In Texas, Medicaid represents over 25 percent (over \$62 billion) of the state budget for 2020-2021.⁵⁶

To illustrate Texas’ trend of federal Medicaid funding, Figure 28 below shows Texas’ FMAP from 2004 to 2021.

Figure 28. Texas Federal Medical Assistance Percentage (FY 2010-2021)



Source: Kaiser Family Foundation, State Health Facts. (2020). *Federal Medical Assistance Percentage (FMAP) for Medicaid and multiplier (Timeframe: FY 2010-2020)*.

Retrieved from <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?activeTab=graph¤tTimeframe=0&startTimeframe=17&selectedDistributions=fmap-percentage&selectedRows=%7B%22states%22:%7B%22texas%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

On March 18, 2020 the federal government passed the Families First Coronavirus Response Act (FFCRA) in response to COVID-19. FFCRA immediately increased states’ FMAP percentage by 6.2 percent. This increase is expected to be active through the end of the quarter in which the federal emergency ends and was retroactively applied from January 1, 2020.⁵⁷ For Texas, this increase resulted in an FMAP of 67.09 percent. In order for Texas to keep the funding, MOE provisions were required, including:

1. Refrain from cutting Medicaid eligibility standards or imposing enrollment procedures that are more restrictive;
2. Keep all Medicaid enrollees covered who were eligible and receiving services as of March 18, 2020 or who newly enroll during the public health emergency; and
3. Cover COVID-19 testing services and treatment in Medicaid, including vaccines, specialized equipment, and therapies, without cost-sharing.⁵⁸

MEDICAID ELIGIBILITY

Medicaid was originally only available to recipients of cash assistance programs such as Temporary Assistance for Needy Families (TANF) and Social Security Income (SSI). However, during the late 1980s and early 1990s, the federal government decoupled Medicaid eligibility from the receipt of cash assistance and expanded the program to meet the needs of a broader population, including pregnant women, older adults, and people with disabilities.⁵⁹

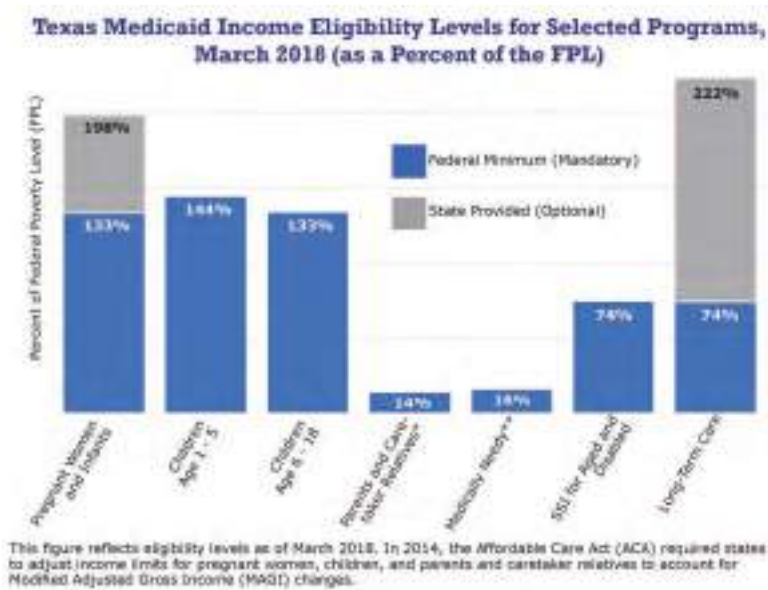
In determining program eligibility, Texas considers a variety of factors such as income and family size, age, disability, pregnancy status, citizenship, and state residency requirements. To be eligible for Medicaid in Texas, an individual must meet income *and* categorical eligibility requirements. Categorical eligibility requires that beneficiaries be part of a specific population group.

There are multiple Medicaid eligibility categories in Texas. Some of the primary categories include:

- Children age 18 and under
- Pregnant women and infants
- Families receiving TANF
- Parents and caretaker relatives
- Individuals receiving SSI
- Adults over age 65 and people with disabilities
- Children and pregnant women who qualify as medically needy
- Former foster youth under 26 years old⁶⁰
- Individuals receiving Medicaid 1915(c) waiver services

As of January 2019, extremely low-income parents are eligible to receive Medicaid only if their household income is 17 percent of FPL or below, about \$307 per month for a family of three.⁶¹ Federal law requires states to cover certain groups and allows states the option to expand eligibility beyond minimum federal standards. Texas Medicaid covers a limited number of optional groups. Because Texas chose not to expand Medicaid eligibility through the Affordable Care Act, the program does not serve the majority of low-income, working adults. Thus, childless adults who are below age 66 and do not have a disability are currently ineligible for Medicaid.⁶² Figure 29 shows the income eligibility requirements for each Medicaid category.

Figure 29. March 2018 Texas Medicaid Income Eligibility Levels for Selected Programs (as a Percent of the FPL)



Source: Texas Health and Human Services Commission. (2017). *Texas Medicaid and CHIP in perspective eleventh edition*. Page 4. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf>

*For Parents and Caretaker Relatives, the maximum monthly income limit in SFY 2018 was \$230 for a family of three (one-parent household), which is the equivalent of approximately 14 percent of the FPL.

**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2018 was \$275 for a family of three, which is the equivalent of approximately 16 percent of the FPL.

Table 18 below shows the 2020 federal poverty level guidelines for families of households of different sizes.

Table 18. 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/ Household	Poverty Guideline
1	\$12,760
2	\$17,240
3	\$21,720
4	\$26,200
5	\$30,680
6	\$35,160
7	\$39,640
8	\$44,120

Source: U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2020). *U.S. federal poverty guidelines used to determine financial eligibility for certain federal programs*. Retrieved from <https://aspe.hhs.gov/poverty-guidelines>.

MEDICAID SERVICES

Medicaid recipients, both adults and children, have access to the mental health and substance use services included in the Medicaid State Plan, such as psychiatric services, counseling, medication, and medication management. Medicaid also funds rehabilitative and targeted case management services by approved providers, primarily the local mental health authorities (LMHAs) operating under HHSC. In addition, HHSC administers several Medicaid-funded waiver programs that offer behavioral health or long-term services and supports to specialized populations. These services and eligibility criteria are further described later in this section.

Behavioral health screening services are an important component of services offered. Following are approved screening services:

- Health and Behavior Assessment and Intervention (HBAI) – eligible to youth 20 and younger designed to identify psychological, behavioral, emotional, cognitive, and social factors that contribute to preventing, treating, or managing physical symptoms. This screening is available to individuals who have underlying physical illness or injury. HBAI services are provided through licensed practitioners of the healing arts (LPHAs) co-located in the same building or office as the PCP to promote integrated care.
- Screening, Brief Intervention and Referral to Treatment (SBIRT) – eligible to individuals 10 years of age and older who are at risk of, or who have a substance use concern. Prevention and early intervention services are eligible to be delivered in community-based services and hospitals.⁶³

Approved Medicaid mental health treatment services include:

- Psychiatric diagnostic evaluations and psychotherapy performed by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists;
- Psychological and neuropsychological testing performed by psychologists and physicians;
- Inpatient psychiatric care in a general acute care hospital;
- Inpatient care in psychiatric hospitals (for persons age 20 and younger, and age 65 and older);
- Psychotropic medications and pharmacological management of medications;
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbances;
- Peer Support Services provided by a Certified Peer Specialist;
- Care and treatment of behavioral health conditions provided by a primary care physician; and
- Comprehensive community services for YES waiver participants (see YES waiver information later in this section).⁶⁴

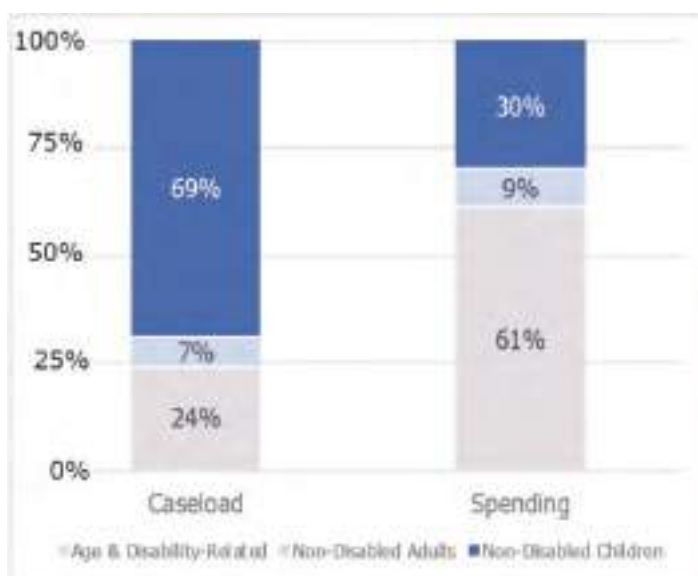
Approved Medicaid substance use services include:

- Assessments to determine an individual's need for services;
- Individual and group outpatient substance use counseling;
- Outpatient detoxification;
- Residential detoxification;
- Ambulatory detoxification;
- Residential treatment⁶⁵; and
- Peer Support Services provided by a Certified Recovery Coach.⁶⁶

Medication-assisted therapy (MAT) services are approved to be delivered by licensed chemical dependency treatment facilities (CDTFs), opioid treatment programs, or qualifying practitioners. During the 86th legislative session, SB 1586 (West/Klick) expanded prescribing ability. The legislation aligned Texas Medicaid policy with federal law by using the federal definition of “qualifying practitioner,” which includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. MAT is primarily used for opioid use conditions but can be provided for alcohol use conditions through the pharmacy benefit. Medications used for MAT are FDA-approved, recommended by the Texas Drug Utilization Review Board, approved by the HHSC Executive Director, and contained in the Preferred Drug List (PDL). Updated PDL and coinciding prior authorization criteria can be found here: <https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs>.

DEMOGRAPHICS OF MEDICAID RECIPIENTS

As of January 2020, 3.5 million Texans across the state received services through Medicaid.⁶⁷ A large number of Medicaid recipients are children and young adults, with 27 percent of enrollees are ages 0-5, 35 percent are ages 6-14, and 15 percent are ages 15-20. Non-disabled children make up 69 percent of Medicaid's client caseload and 30 percent of Medicaid spending.⁶⁸ In contrast, individuals who are elderly, blind, or have a disability account for 24 percent of the Medicaid population, but represent 61 percent of total estimated expenditures.⁶⁹ Figure 30 displays the population of Medicaid enrollees and program expenditures by age and disability status.

Figure 30. Texas Medicaid Caseload and Expenditures (2018)

Source: Texas Health and Human Services Commission. (2018). *Texas Medicaid and CHIP in perspective twelfth edition*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.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 <https://hhs.texas.gov/reports/2018/12/texas-medicaid-chip-reference-guide-twelfth-edition-pink-book>

TEXAS MEDICAID AND HEALTHCARE PARTNERSHIP

The Texas Medicaid and Healthcare Partnership (TMHP) is a group of subcontractors operating under the consulting firm Accenture, which contracts with HHSC to administer the state's Medicaid fee-for-service claims payments and all Medicaid enrollment activities. All Medicaid managed care providers must first be enrolled in Medicaid through TMHP before they can be credentialed and part of an MCO network.⁷⁰ TMHP does not process claims for services provided by MCOs, but it does collect encounter data from MCOs to use for the evaluation of quality and utilization of managed care services.⁷¹

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The federal government created the Children's Health Insurance Program (CHIP) in 1997 under Title XXI of the Social Security Act. As with Medicaid, CHIP is jointly funded by state and federal governments.⁷² State participation in CHIP requires that the state develop a state CHIP plan for approval by the Centers for Medicaid and Medicare Services (CMS).⁷³ While CMS allows states to combine their Medicaid and CHIP programs under a single administrative umbrella, Texas administers these programs separately. In September 2017, federal funding for CHIP expired.⁷⁴ Initially in 2018, Congress extended CHIP funding for six years as part of a short-term resolution.⁷⁵ Later during budget negotiations, Congress extended CHIP funding

further through fiscal year 2027.⁷⁶ Funds have been allocated for the first six years of the extension. Specific allotments were not included for FY 2024-27, but instead specifies that “such sums” as necessary will be available. Changes made that will impact the future of the program include:

- A decrease in the enhanced FMAP (as provided by ACA) from the current 23 percentage point enhancement to 11 in 2020 and down to traditional FMAP levels in 2021 and beyond;
- On October 1, 2019, states with CHIP eligibility levels above 300 percent FPL will have the option to lower eligibility to 300 percent FPL.⁷⁷ States with CHIP eligibility levels below 300 percent (including Texas, 201 percent FPL) must maintain current eligibility levels until September 30, 2027; and
- Beginning in FY 2024, states will be required to annually report a set of core pediatric quality measures to CMS that were previously voluntary, including performance of primary care access and preventative care and behavioral health care.^{78,79}

CHIP FUNDING

Table 19 below shows CHIP funding trends over the last three budget cycles.

Table 19. Medicaid Funding Trends

	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
CHIP	\$1,755,853,383	\$2,048,468,477	\$2,009,760,515
CHIP Contracts & Admin.	\$28,661,738	\$30,335,216	\$33,629,550
Total	\$1,784,515,121	\$2,078,803,693	\$2,043,390,065

*Note: these amounts were prior to the Health and Human Services System Transformation and consolidation of state agencies

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

CHIP ELIGIBILITY

The federal government developed CHIP to provide a health insurance coverage option for children whose families had too much income or too many assets to qualify for Medicaid, but not enough to afford private insurance through their employer or through the individual market.⁸⁰ CHIP is available to children under age 19 who are ineligible for Medicaid, who are living in households with an income at or below

201 percent of the FPL, and who have been uninsured for at least 90 days or have a good cause exemption.⁸¹ For these children, CHIP provides access to health care, including inpatient and outpatient mental health and substance use services. In contrast to Medicaid, CHIP requires cost sharing through enrollment fees and co-payments based on a family’s income. Families may pay up to a \$50 enrollment fee for a 12-month period.⁸² Texas also opted to administer a CHIP perinatal program which covers perinatal services, including labor, delivery, and postpartum care for women and their unborn child with household incomes of up to 202 percent of the FPL.⁸³ The majority of CHIP clients are over age five, with 11 percent being between the ages of 6 and 14, and 41 percent between the ages of 15 and 18.⁸⁴

The table below provides monthly household income limits for CHIP eligibility in Texas.

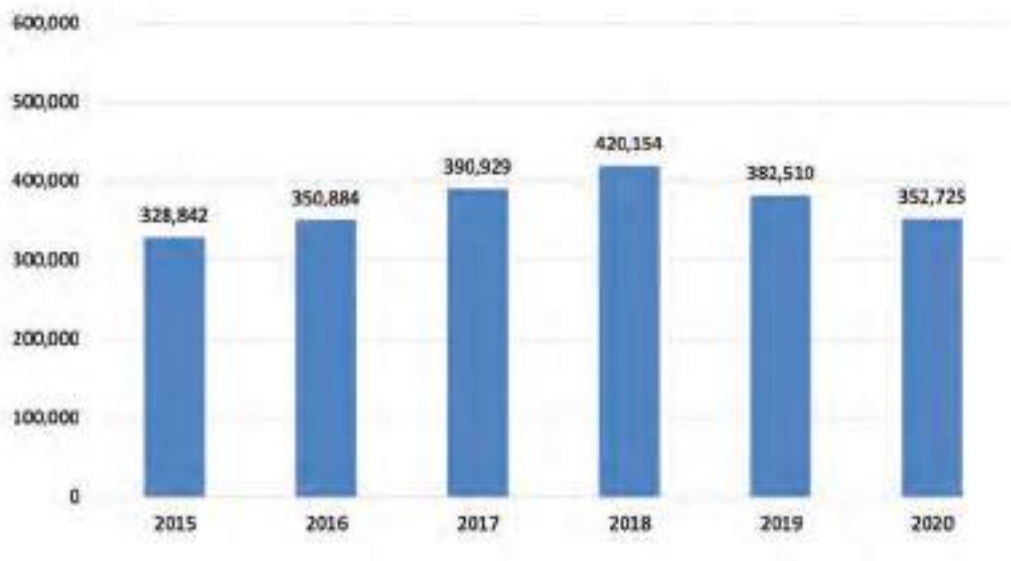
Table 20. CHIP Maximum Monthly Income Limit by Household Size in Texas

Household Size	Maximum Income Level Per Month
1	\$2,034
2	\$2,758
3	\$3,481
4	\$4,205
5	\$4,928
6	\$5,652
7	\$7,099
8	\$7,099

Source: Texas Health and Human Services Commission. (2018). *Texas Medicaid and CHIP in perspective twelfth edition*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/medicaid-chip-perspective-12th-edition/12th-edition-complete.pdf>

Figure 31 below shows the monthly CHIP enrollment numbers in Texas from 2015 to 2020.

Figure 31. Monthly CHIP Enrollment (2015-2020)



Note: Data is from January of each year.
Source: Texas Health and Human Services Commission. (September 2020). *CHIP monthly enrollment detail (September 2014-June 2020) (XLS)* [data file]. Retrieved from <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics>

CHIP SERVICES

The CHIP program offers many of the same services to children as those enrolled in Medicaid, including mental health care and substance use services.

Mental health treatment services include:

- Neuropsychological and psychological testing;
- Medication management;
- Rehabilitative day treatments;
- Residential treatment services;
- Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment)
- Skills training; and
- Inpatient mental health services in a free-standing psychiatric hospital, psychiatric unit of a general acute care hospital, or state-operated facility.

Additionally, the following substance use treatment services are available to CHIP members:

- Inpatient treatment, including detoxification and crisis stabilization;
- Outpatient treatment services, including group and individual counseling;

- Intensive outpatient services;
- Residential treatment;
- Partial hospitalization; and
- Prevention and intervention services by physician and non-physician providers.

Medication assisted treatment (MAT) is not a covered benefit through CHIP, however can be provided as a prescription drug benefit.

HHSC QUALITY OF CARE REVIEW AND THE HEALTHCARE QUALITY PLAN

Texas contracts with the University of Florida Institute for Child Health Policy as the external quality review organization (EQRO) to review the Texas Medicaid Managed Care programs. The annual quality of care evaluation compares Texas' performance to the national Healthcare Effectiveness Data and Information Set standards, or alternatively to benchmarks that HHSC establishes. The national Healthcare Effectiveness Data and Information Set (HEDIS) standards are used across the country to measure performance within health care, including behavioral health services.

The latest review of Texas managed care programs for FY 2018 was released in May 2019. The report found that HHSC has done significant work to improve the quality of care within behavioral health. HHSC asked the EQRO to complete quarterly topic reports examining the following:

- Factors leading to potentially preventable service use among Medicaid members with co-occurring behavioral and physical health conditions,
- Ways to integrate behavioral and physical health services, and
- Investigations of opioid prescribing measures.⁸⁵

The review also included evaluations and surveys of STAR, STAR+PLUS, STAR Health, and STAR Kids. A number of behavioral health findings offer the opportunity for improvement including:

- In all programs, the rates of members who were hospitalized for mental illness and received follow-up visits (within 30 days and within 7 days) were low compared to national benchmarks and state standards.
- Among health plans, the percentage of in-network providers excluded from members' lists to schedule an appointment due to "no answer after three attempts" or "wrong number/unreachable provider" ranged from 48 percent to 61.1 percent.
- Providers identified psychiatric care as the most difficult referral type for both children and adult patients, with referrals for both children and adults frequently taking longer than one month.
- MCOs noted that issues of network access or adequacy included shortages of behavioral health providers and other specialists.⁸⁶
- Based on the findings, the report offered a number of recommendations including:
- Programs should give considerable attention to efforts to establish, improve, and monitor behavioral and physical health care integration practices.

- Recruitment of specialized providers should include negotiating reasonable and appropriate payment rates.
- MCOs should improve access to care through transportation assistance and telemedicine services in rural areas where shortages of behavioral health and specialist providers are common.⁸⁷

Improved performance, improved measurement of performance, and payment mechanisms based on performance appear to be a priority for both the legislature and HHSC. There are six strategic priorities incorporated in the HHSC Healthcare Quality Plan as required by SB 200 (84th, Nelson/Price) including:

- Keeping Texans healthy
- Providing the right care in the right place, at the right time
- Keeping patients free from harm
- Promoting effective practices for chronic disease
- Supporting patients and families facing serious illness
- Attracting and retaining high performing providers and other healthcare professionals⁸⁸

SB 200 (84th, Nelson/Price) granted the HHS Executive Commissioner authority to establish the Value Based Payment and Quality Improvement Advisory Committee. The Committee submits a report to the Texas Legislature and to HHSC each December, including recommendations on “value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services.”⁸⁹ The committee’s report to the 86th legislature included the following behavioral health recommendations:

- Sustaining innovative behavioral health models, including DSRIP projects funded through the 1115 waiver and use of the Certified Community Behavioral Health Clinics (CCBHC) model;
- Expanding substance use treatment;
- Studying value-based options for substance use identification; and
- Recommend Medicaid to evaluate bundle rates for MAT for more efficiency. (Note: The SAPT block grant reimbursement rate includes counseling in addition to medication, whereas Medicaid has separate reimbursement for medication and counseling).⁹⁰

More information on the committee can be found at <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee>

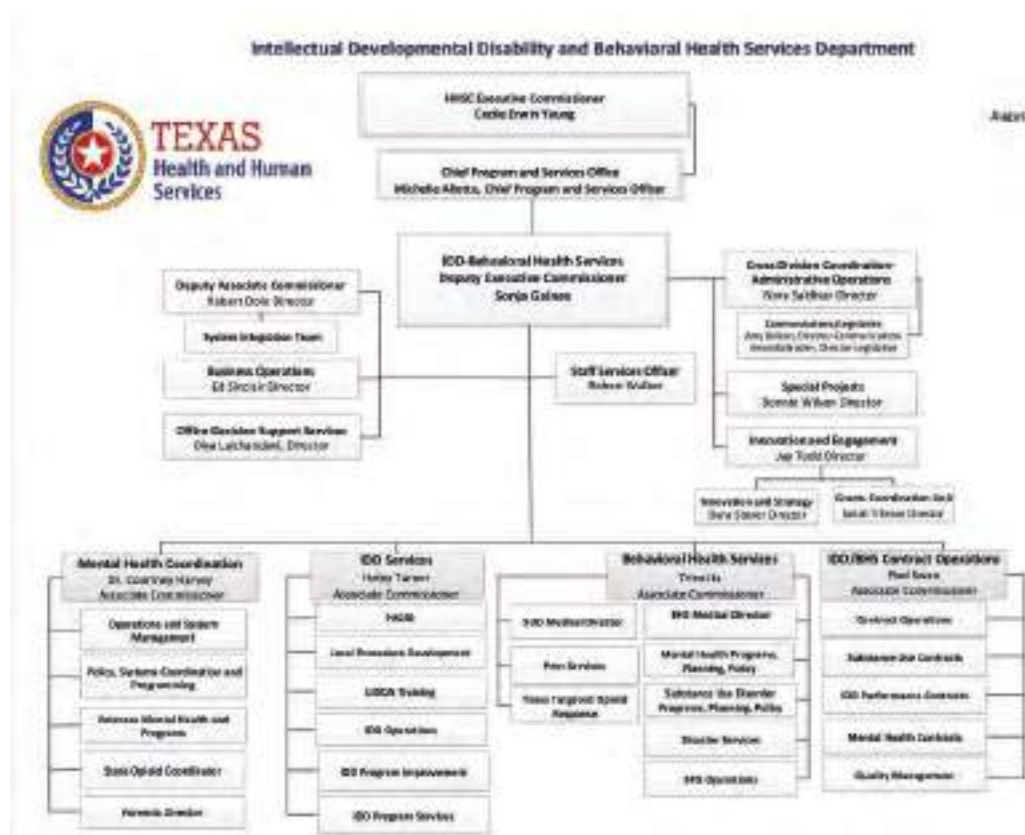
In addition to the Value Based Payment and Quality Improvement Advisory Committee, HHSC has a number of value-based care programs and initiatives, including:

1. MCO/DMO Pay-for-Quality (P4Q)
2. MCO Alternative Payment Models (APM)
3. Hospital Quality Payment Program
4. DSRIP Program
5. Nursing Home Quality Incentive Payment Program (QIPP)
6. Uniform Hospital Rate Increase Program (UHRIP)

7. Network Access Improvement Program (NAIP)
8. HHS Quality Webpage
9. Texas Healthcare Learning Collaborative Portal
10. Advisory Committees and Workgroups⁹¹

The Texas Legislature continues to direct HHSC to prioritize value and transparency in the Medicaid program. Among the budget riders included in Article II of HB 1, Rider 43 required HHSC to implement an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency, and effectiveness of service provision and performance. Appropriations for FY 2021 were contingent on HHSC implementing this program by September 1, 2020⁹².

Intellectual and Developmental Disabilities & Behavioral Health Services Division



Source: Texas Health and Human Services Commission. (August 2020). *Public Information Request, October 2020*.

The Intellectual and Developmental Disabilities and Behavioral Health Services Department combines responsibility for community services for individuals with intellectual and other developmental disabilities and those living with mental health and substance use conditions under one deputy executive commissioner authority.

Public behavioral health services are mainly comprised of community mental health, substance use, and inpatient psychiatric services. These services are provided to residents through the 39 local mental health authority (LMHA) regions and 20 Regional Health Partnerships (RHPs) in all of Texas' 254 counties. The Medical and Social Services Division has oversight responsibility for community behavioral health services while the Health and Specialty Care has oversight of state-run and contracted inpatient services.

MENTAL HEALTH

HHSC prioritizes access to treatment and services for individuals with a serious

mental health condition, who are eligible for Medicaid, determined to be indigent, or who fall under the priority populations criteria (major depression, bipolar, and schizophrenia). Resources, eligibility for services, and service delivery systems are the primary determinants of the accessibility and quality of services. Texas continues to seek ways to improve access so that individuals with mental health and substance use conditions can receive the level of care and support that are clinically appropriate for their level of need. HHSC maintains a central website, www.mentalhealthtx.org, to improve access to information. Individuals can enter their zip code and find available mental health and substance use services in their area.

Since November 2018, leadership from leadership from Intellectual and Developmental Disability and Behavioral Health Services, the Health and Specialty Care System, Medicaid, Regulatory, and Aging Services Coordination have worked together to form the HHSC Continuum of Care Workgroup. The Workgroup is responsible for addressing issues and solutions to improve the continuum of care within behavioral health services across the human services system. The objectives of the work group include:

1. Ensuring the most effective and efficient communication and coordination between state hospitals and local mental health authorities (LMHAs), to provide seamless care;
2. Identifying gaps and barriers to continuity of care, and more specifically to successful discharge from state hospitals; and
3. Identifying short-term and long-term goals to address the identified gaps and barriers.⁹³

As of October 2019, the Workgroup made progress on several initiatives to meet these goals including:

- Transitioning the nine state hospital patients with IDD who had been hospitalized for over one year to a less restrictive settings in the community;
- Address licensing barriers to provide integrated Co-occurring psychiatric and substance abuse disorders (COPSD) services by working to revise substance use treatment standards of care in the Texas Administration Code Title 25, Chapter 448;
- Beginning in FY 2020, LMHAs/local behavioral health authorities (LBHAs) will be required to have a dedicated Continuity of Care Worker as outlined in their FY 20 performance contracts. The worker will be solely responsible for ensuring effective transitions from inpatient or residential care to the community; and
- Creating collaborative clinical review teams at HHSC hospitals responsible for reviewing individuals who have been in inpatient care for more than a year and are deemed to no longer meet criteria for inpatient level of care.⁹⁴

MENTAL HEALTH FUNDING

Mental health services are provided through a number of programs across multiple state agencies. Efforts to provide these services can lead to diverse funding and often unclear delineation. HHSC has attempted to better identify and monitor funding for mental health services through the Statewide Behavioral Health Coordinating Council and a statewide consolidated expenditure report. For a more in-depth overview of the expenditure report and behavioral health funding across state

agencies, please refer to the **Funding section** of this guide.

This section is meant to provide historical context to funding and show trends. The information provided in this section refers only to the funding appropriated to the behavioral health section of the Medical and Social Services Division.

Much of the increased demand for behavioral health services in Texas is due to the state's rapidly growing population from 25,145,561 in 2010 to 28,995,881 in 2019.⁹⁵ The population growth rate in Texas was 15.3 percent between 2010 and 2019, more than double the national average of 6.3 percent.^{96,97}

While the amount of funding per person has improved as a result of recent increases in mental health appropriations, the preceding decade of stagnant funding has been unable to keep pace with the increased cost of services and the continued state population growth. This culmination has resulted in less service options and a decreased rate of persons receiving services.⁹⁸ Table 21 below shows historical trends and appropriated amounts of all funds for mental health services over the last three budget cycles.

Table 21. Mental Health Funding Trends

Strategy	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
Adult Mental Health Services	\$663,920,027	\$703,362,864	\$764,100,202
Children Mental Health Services	\$204,650,668	\$166,373,576	\$184,635,596
Community Mental Health Crisis Services	\$255,313,022	\$325,430,552	\$343,263,746
NorthSTAR Behavioral Health	\$174,064,540	\$0	\$0
Behavioral Health Waivers	\$0	\$103,351,236	\$104,599,388
Mental Health State Hospitals	\$872,639,869	\$875,536,372	\$898,738,475
Community Mental Health Hospitals	\$209,943,241	\$243,830,476	\$270,620,452
Total	\$2,380,531,367	\$2,417,885,076	\$2,565,957,859

*Note: these amounts were prior to the Health and Human Services System Transformation and consolidation of state agencies, and were under DSHS.

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

SERVICE PROVIDERS

Publicly funded mental health services in Texas are provided by three types of service providers:

- Medicaid Managed Care providers;
- Federally Qualified Health Centers (FQHCs) and other community health centers; and
- Local mental health authorities (LMHAs).

Medicaid Managed Care Providers

Medicaid is the largest funder of behavioral health services in Texas. Texas continues to expand the managed care model within the Medicaid system state-wide, including for behavioral health services.

Prior to 2013, public mental health services in Texas were available through contracts between the Department of State Health Services (DSHS) and the network of local mental health authorities (LMHAs). SB 58 (83rd, Nelson/Zerwas) directed the integration of physical health and behavioral health services into the managed care system. SB 58 (83rd, Nelson/Zerwas) allowed targeted case management and rehabilitative services to be delivered through Medicaid managed care by private comprehensive providers outside of LMHAs. However, the requirement to offer a full array of comprehensive services limited the number of providers able to bill for these services. Local authorities continue to serve as the primary providers of rehabilitative services and targeted case management for the majority of people in managed care.

Rehabilitative services coordinated through targeted case management include:

- Crisis intervention services;
- Medication training and support services;
- Skills training; and
- Developmental services and day programs for acute care.

Federally Qualified Health Centers

In addition to state-funded LMHAs/LBHAs and Medicaid managed care providers, individuals in Texas may also receive behavioral health services from federally qualified health centers (FQHCs) or other non-federally funded community health centers. The goal of FQHCs is to provide underserved communities with comprehensive healthcare, and some centers offer additional services such as mental health or substance use treatment.⁹⁹ While the FQHC benefit was first added to Medicare in 1991, the passage of the ACA allocated \$11 billion in new funding to build and expand health centers nationwide. FQHCs have since become a central component of the ongoing shift toward integrating behavioral health services with primary healthcare.^{100,101} In Texas, there are 73 FQHCs with more than 300 service delivery sites statewide. Additionally, there are 3 “FQHC-lookalikes,” that provide similar services without the benefits of a FQHC status.¹⁰²

FQHCs often provide healthcare services to Texans who are indigent, underinsured or uninsured. Services are provided to Medicare, Medicaid, and CHIP recipients, as well as insured and uninsured individuals. Individuals may be eligible for services based on their family income and on a sliding fee schedule. FQHCs receive federal grants through Section 330 of the Public Health Services Act. Section 330 of the Public Health Service Act created and authorized the health center program and permits the Health Resources and Services Administration (HRSA) to make grants to health centers.¹⁰³

FQHCs also play an important role in providing comprehensive health care services to individuals with public health insurance such as Medicaid and CHIP. FQHCs receive enhanced reimbursements for providing services to individuals enrolled in Medicaid and Medicare.¹⁰⁴ These reimbursements are designed to cover the additional costs associated with providing comprehensive care to those who are uninsured and publicly funded. As a result of policy changes in 2010 made by the ACA, many FQHCs are transforming their practices to place individuals within health homes or comprehensive medical homes to improve the coordination and integration of care for multiple chronic conditions, including mental health and substance use concerns.

Being certified as an FQHC brings a number of benefits, including:

- Cost-based (enhanced) payment for recipients of Medicare and Medicaid;
- Access to medical malpractice coverage through the Federal Tort Claims Act;
- 340b (reduced) drug pricing; and
- The ability to participate in the National Health Service Corps (NHSC).¹⁰⁵

Beyond the basic certification requirements of providing comprehensive services and having a quality assurance program, FQHCs must also meet the following requirements in order to receive federal funding under Section 330 of the Public Health Service Act:

- Serve an underserved area or population;
- Offer a sliding fee scale (i.e., individuals do not get turned away for inability to pay); and
- Have a governing board of directors with the majority of members receiving care at the FQHC.^{106,107}

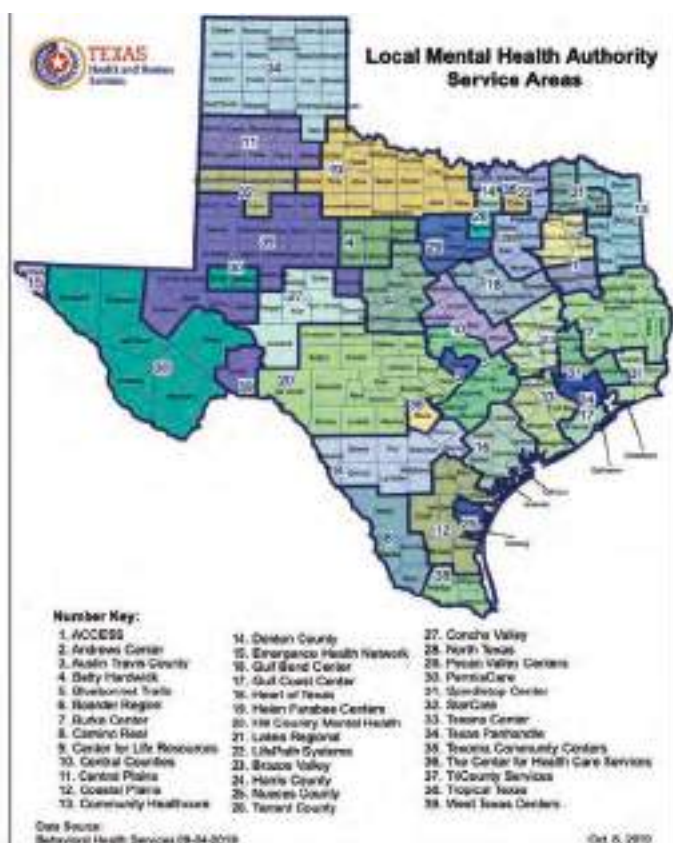
Finally, many community health centers in Texas are affiliated with charitable, nonprofit organizations or hospitals, and typically serve as the public health safety net for individuals who are uninsured, underinsured, do not have the financial means to pay for services, or are in geographic locations where access to care is severely limited.¹⁰⁸ While the central mission of most community health centers is to provide effective and affordable primary healthcare, many community health centers have started to partner with LMHAs/LBHAs and other providers to offer behavioral health services in their clinics.^{109,110} Due to FQHCs funding methods, there is less mandated reporting on client outcomes compared to LMHAs/LBHAs and Medicaid managed care providers. Thus, FQHCs are quickly becoming an integral part of the health safety net in many parts of Texas.

Local Mental Health Authorities and Local Behavioral Health Authorities

Public mental health services are primarily provided through HHSC contracts with 37 designated LMHAs and two LBHAs, often referred to as LMHAs, community mental health centers, or local authorities. The HHS System contracts with these authorities to provide or arrange for the delivery of both crisis and ongoing community mental health and substance use services for:

- Children, adolescents, and adults meeting medically indigent criteria;
- Individuals with a priority population diagnosis (schizophrenia, bipolar depression and major depressive order); and
- Any individuals eligible for Medicaid who reside in that LMHA's designated geographic area, shown below in Figure 32.

Figure 32. Map of LMHAs/LBHAs and 39 Service Regions



Source: Texas Health and Human Services. (2019.). *Local mental health authority service areas*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/local-mental-health-authority-service-areas.pdf>

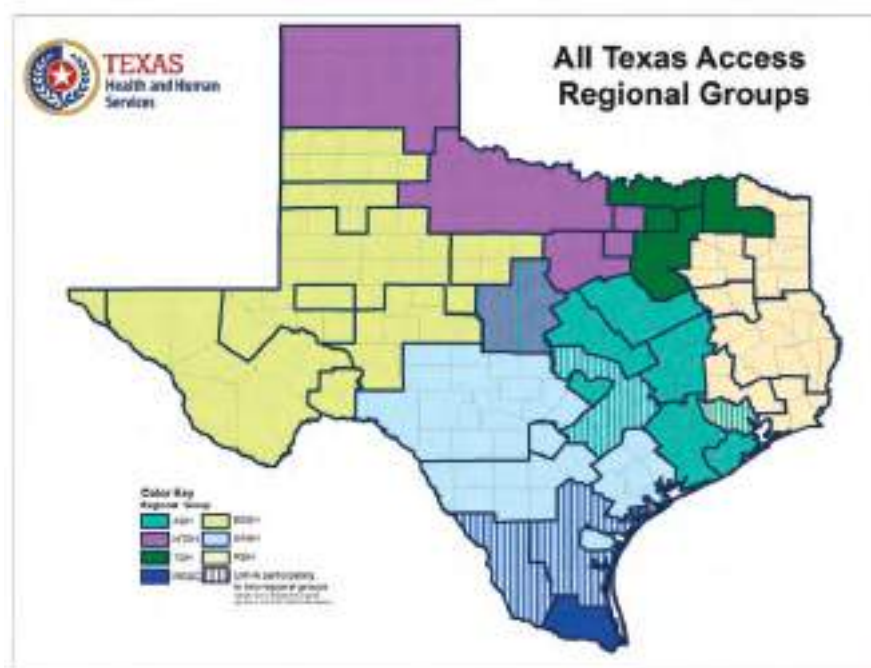
All Texas Access

During the 86th legislation session, SB 633 (Kolkhorst/Lambert) was passed, creating the All Texas Access project. SB 633 directed HHSC to create regional authority groups of LMHAs to improve access to mental health care in rural areas. HHSC divided the LMHAs into seven regional areas aligned with the state hospital catchment areas depicted in Figure 33. While SB 633 only directed LMHAs in

counties with a population of 250,000 or less to be assigned to a regional group, all 39 LMHAs across the state opted to be a part of this initiative. Each regional group is required to develop plans to increase the region's capacity for mental health services with goals to reduce:

- Local government spending in providing mental health crises services;
- Transportation from LMHAs to mental health facilities;
- Incarceration of individuals in county jails due to a mental illness; and
- Emergency room (ER) visits as a result of a mental illness.

Figure 33. All Texas Access Regional Groups



Source: Texas Health and Human Service Commission.(2020). *HHSC All Access Texas presentation to the Behavioral Health Advisory Committee, June 23, 2020.*

In addition to the plan development, each region is responsible for assessing the regional group's capacity to provide needed services. HHSC and each region will evaluate:

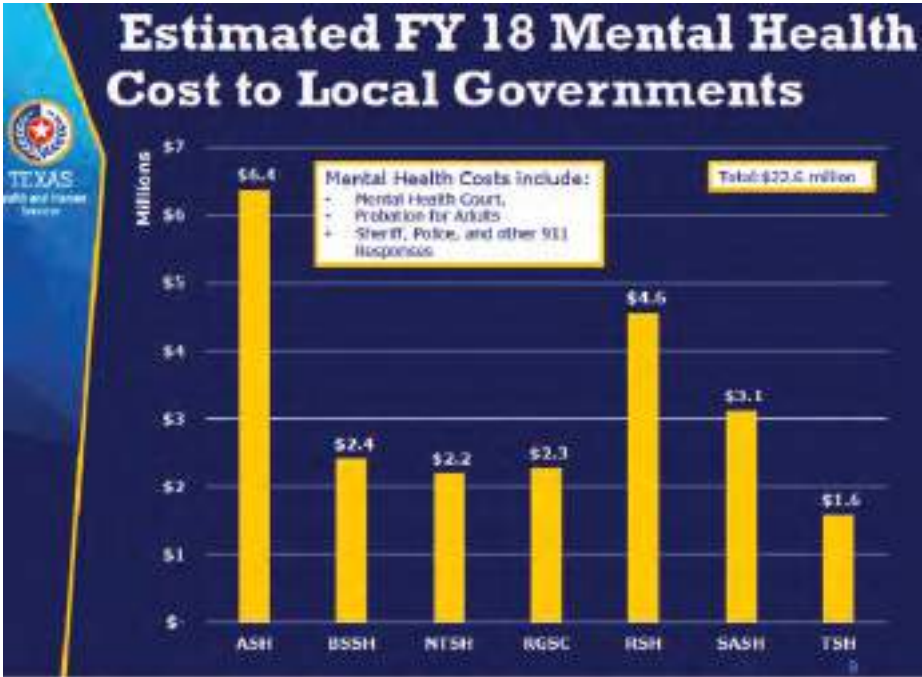
- If (or to what degree) increasing the regions' capacity to provide mental health services would offset costs to state or local government due to transportation, inpatient hospitalizations, ER visits and incarceration;
- Whether or not available state or grant funding could be used to carry out the regions' plans; and
- How each plan aligns with the statewide behavioral health strategic plan and the comprehensive inpatient mental health plan.

Beginning in early 2020, HHSC began the process of developing the regional plans through focus groups, administration of a statewide input survey, discussions with

LMHAs, and system mapping. Through the regional conversations and system mapping, themes emerged across the state including: the need for community education on how to access services, increased access to care, community and agency collaboration, transportation, telehealth, and housing. The statewide survey garnered over 2,600 respondents and key findings included rural Texans need basic access to mental health services. The direct service needs identified were counseling, crisis services, and transportation. Additionally, the top three barriers identified were lack of services in rural areas, transportation, and lack of community awareness of available services. HHSC planning timeline anticipates the All Access Texas report to be published online by December 1, 2020.¹¹¹

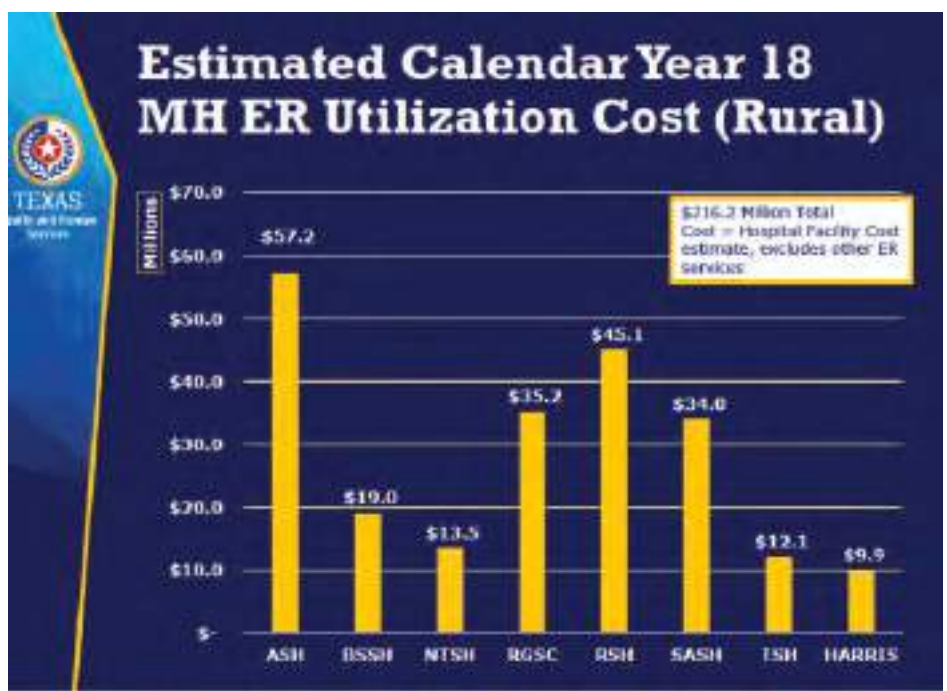
Additionally, HHSC worked to estimate the mental health costs to state or local government due to transportation, inpatient hospitalizations, ER visits and incarceration. Figure 34, Figure 35, and Figure 36 illustrates the estimation of costs HHSC determined.

Figure 34. FY 18 Estimated Mental Health Costs to Local Governments



Source: Texas Health and Human Service Commission. (2020). *HHSC All Access Texas presentation to the Behavioral Health Advisory Committee*, June 23, 2020.

Figure 35. FY 18 Estimated Mental Health Costs from ER Utilization from Rural Areas



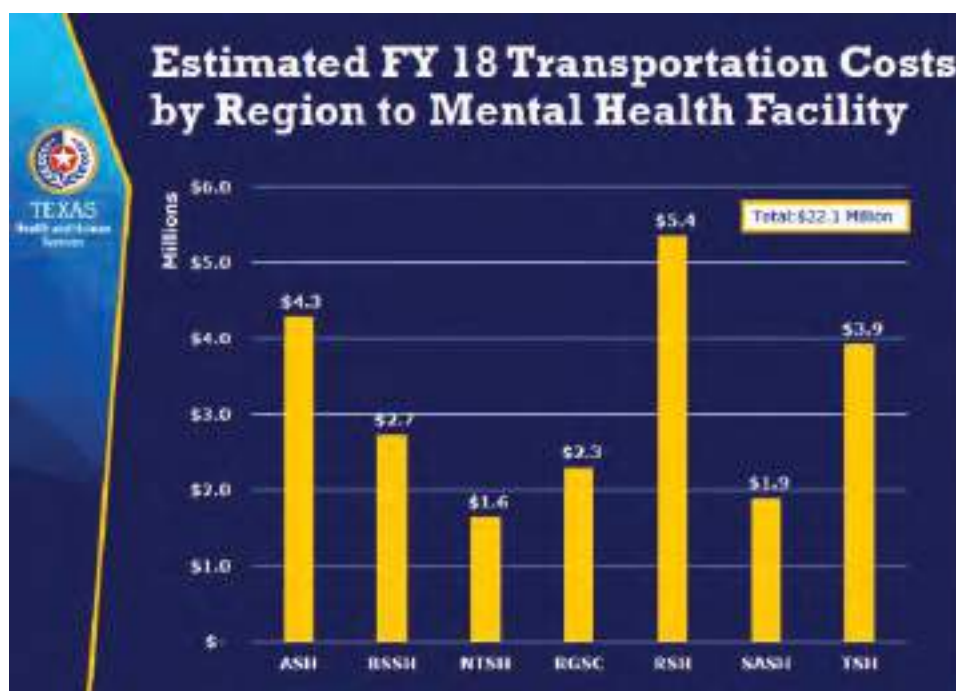
Source: Texas Health and Human Service Commission. (2020). *HHSC All Access Texas presentation to the Behavioral Health Advisory Committee*, June 23, 2020.

Figure 36. FY18 Estimated Mental Health Costs to County Jails



Source: Texas Health and Human Service Commission. (2020). *HHSC All Access Texas presentation to the Behavioral Health Advisory Committee*, June 23, 2020.

Figure 37. FY 18 Estimated Mental Health Costs for Transportation



Source: Texas Health and Human Service Commission. (2020). *HHSC All Access Texas presentation to the Behavioral Health Advisory Committee*, June 23, 2020.

The Medical and Social Services Division oversees and regulates the quality of services provided to individuals through LMHAs/LBHAs and regularly provides LMHA/LBHA staff with training and technical assistance. LBHAs typically refer to local authorities that provide behavioral health services to include a broader range of substance use services than historically provided by LMHAs.

As an authority, LMHAs/LBHAs are responsible for:

- Allocating funds from the HHS Medical and Social Services Division to ensure mental health and substance use services are provided in the local service area for indigent populations;
- Balancing community input, cost effectiveness, and quality of care issues to ensure choice and the best use of public funds;
- Creating and maintaining a network of service providers;
- Recommending the most appropriate and available treatment alternatives for individuals requiring mental health services; and
- Demonstrating that the services provided comply with state health and regulatory standards, whether those services are provided directly by LMHA employees or through subcontractors and other private community providers involving state funds.¹¹²

Each LMHA/LBHA is required to plan, develop, and coordinate local policy, resources, and services for mental health care. Additionally, LMHAs/LBHAs are required to ensure the best use of state funding to create a network of providers. LMHAs/LBHAs determine whether to provide a service, or contract that service to an outside organization.¹¹³ Some LMHAs have found it challenging to establish successful contracts for services, especially rehabilitation and other routine

outpatient services, in part due to provider reimbursement rates and extensive behavioral health workforce shortages in rural counties and in the Texas-Mexico border regions. In such cases, LMHAs/LBHAs typically serve as primary service providers.

Individuals seeking mental health services can arrive at an LMHA/LBHA with or without an appointment. The first step to services is for a qualified mental health professional to provide a brief mental health screening to verify that each individual is seeking services that the LMHA/LBHA is equipped to provide. If so, the individual then works with licensed staff to complete a full psychosocial and diagnostic standardized assessment — youth are given the Child and Adolescent Needs and Strengths (CANS) assessment and adults are given the Adult Needs and Strengths Assessment (ANSA). An adult client's score on the ANSA is combined with a supplemental assessment specific to the individual's diagnosis. For example, the Quick Inventory of Depressive Symptomology is used with individuals who have a diagnosis of major depression to determine appropriate level of care (LOC). For children, no supplemental assessments are used in conjunction with the CANS, thus the LOC is based solely on the child's diagnoses and the score obtained from the CANS. Local authorities serve children ages 3 to 17 who have a mental health diagnosis and are at risk of being removed from their home or school or enrolled in special education services.¹¹⁴

Individuals may also enter LMHA/LBHA services by first utilizing crisis services (via Mobile Crisis Outreach Teams, mental health deputies, or a crisis hotline). Once an individual is enrolled in LMHA/LBHA services, providers regularly update the CANS and ANSA to verify that the LOC is still appropriate. The state also tracks LOC changes over time to estimate how individuals are responding to treatment.

Individuals seeking substance use services are referred to Outreach Screening Assessment and Referral (OSAR) providers, which are often located within an LMHA/LBHA. More information on OSAR and substance use services can be found later in the **Substance Use Services** section of this guide.

Adult mental health services provided by LMHAs/LBHAs may include:

- Case management
- Medication management
- Counseling (Cognitive Behavioral Therapy and Cognitive Processing Therapy)
- Medication training and support
- Psychosocial rehabilitative services
- Skills training and development
- Peer support services

Child and Family services provided by LMHAs/LBHAs may include:

- Crisis intervention
- Skills training and development
- Counseling
- Supportive employment
- Medication training and support

- Case management
- Family partner support services

TEXAS RESILIENCY AND RECOVERY FRAMEWORK

The state's vision for behavioral health services of "Hope, Resiliency, and Recovery for Everyone" aligns with a broader national movement to incorporate resiliency and recovery-based services, practices, performance measures, and beliefs into the public mental health system.¹¹⁵ The framework that guides HHSC's public mental health service delivery is Texas Resiliency and Recovery (TRR), a shift in mental health service delivery from the disease-focused model to a person-centered approach. The TRR model relies on evidence-based practices and principles of recovery and resiliency to obtain the best possible outcomes and maximize the therapeutic impact of available resources.¹¹⁶

The TRR system is responsible for:

1. Establishing who is eligible for services through a uniform assessment (ANSA and CANS);
2. Establishing methods to manage service utilization;
3. Measuring clinical outcomes and impacts of services rendered; and
4. Determining service cost.¹¹⁷

Clinical needs are identified through a psychosocial assessment and a uniform clinical instrument. ANSA and CANS assessments are used to determine the appropriate LOC and corresponding eligibility for services and specialty treatments. Within this model, the intensity of services is based on an individual's continuum of active symptoms and corresponding mental health needs. The expectation built into the model is that as a person's strengths are identified and resilience is built, the majority of individuals transition to lower LOCs, and eventually into sustained recovery in the community. The TRR system empowers people toward their own recovery by building on their strengths rather than focusing on "fixing" their symptoms. Table 22 describes the adult target population and services provided at each TRR LOC. Table 23 describes the same for children and adolescents.¹¹⁸

Table 22. Texas Resiliency and Recovery Levels of Care for Adults

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-0: Crisis Services	The services in this LOC are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.	These services do not require prior authorization. However, utilization management staff must authorize the crisis service within two business days of presentation. If further crisis follow-up and relapse prevention services are needed, then the individual may be authorized for LOC-5. <i>Services include:</i> <ul style="list-style-type: none">• Psychiatric diagnostic interview examination• Crisis intervention services• Pharmacological management• Crisis transportation• Safety monitoring• Day programs for acute needs• Extended observation• Crisis residential treatment• Crisis stabilization unit• Crisis flexible benefits• Respite services (community-based and program-based)• Inpatient hospital services• Inpatient psychiatric services• Emergency room services
LOC-1M: Basic Services (Medication Management)	Individuals appropriate for this level of care are those who meet the HHSC definition for priority population. Services in this LOC are generally intended for adults who have attained and maintained a level of recovery in treatment such that, except for the ongoing need for medications, they would be eligible for discharge from services. This level of service is intended only to complement natural and/or alternative supports available in the community that promote the individual's recovery and his or her continued pursuit of goals related to social inclusion and participation, independence, and/or productivity. Individuals appropriate for this level of care are ready to transition out of the public mental health system and would make that transition except for the limited, necessary community resources available (i.e., no available physicians in the community, no pharmacological resources available to this individual).	The general focus of this LOC is to prevent deterioration of the individual's condition, specifically through medication therapy, until such time that he or she is able to access psychiatric and pharmacological resources in the community. Treatment is provided in outpatient, office-based settings and is limited to medication therapy and routine case management. <i>Services include:</i> <ul style="list-style-type: none">• Pharmacological management• Adjunct services• Psychiatric diagnostic interview examination• Routine case management• Screening brief intervention and referral to treatment• Crisis services

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-1S: Basic Services (Skills Training)	Services in this LOC are generally intended for those who meet the HHSC definition of priority population. Individuals at this level of care present with very little risk of harm, have supports and a level of functioning that does not require higher levels of care.	<p>The general focus of this array of services is to facilitate recovery by reducing or stabilizing symptoms, improve the level of functioning, and/or prevent deterioration of the individual's condition. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings, and are primarily limited to medication, rehabilitative services, and education. <i>Services include:</i></p> <ul style="list-style-type: none">• All LOC-1M services• Skills training and development (individual and group)• Medication training and support services (individual and group)• Supported employment• Supported housing• Engagement activity• Cognitive processing therapy• Flexible funds/community supports• Peer support services
LOC-2: Basic Services including Counseling	Services in this LOC are intended for individuals with symptoms of major depressive disorder with or without psychosis (GAF ≤ 50 at intake) who present very little risk of harm, have supports, have a level of functioning that does not require more intensive levels of care, and can benefit from psychotherapy.	<p>The overall focus of services in this LOC is to improve level of functioning and/or prevent deterioration of the individual's condition so that the individual is able to continue to work towards identified recovery goals. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings and include psychotherapy services in addition to those offered in LOC-1. <i>Services include:</i></p> <ul style="list-style-type: none">• All LOC-1S services• Cognitive behavioral therapy (individual and group)

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-3: Intensive TRR Services with Team Approach	The general focus of services in this LOC is to support the individual served in his or her recovery through a team approach that: engages the individual served as a key partner; stabilizes symptoms that interfere with the person's functioning; improves functioning; develops skills in self-advocacy; increases natural supports in the community; and sustains improvements made in more intensive LOCs. Service focus is on leveraging identified strengths and amelioration of functional deficits through skill training activities focusing on symptom management; independent living; self-reliance; non-job-task specific employment interventions; impulse control; and effective interaction with peers, family, and community. Services are provided in outpatient office-based settings and community settings.	<p>Services in this LOC are generally intended for individuals who enter the system of care with moderate to severe levels of need (or for those whose LOC-R has increased), who require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school). This may include maintaining the current level of functioning. A rehabilitative case manager who is a member of the therapeutic team must provide supported housing and COPSD services, if indicated. Supported employment services must be provided by a rehabilitative case manager or a supported employment specialist. It is highly recommended a dedicated employment specialist provide the supported employment services. <i>Services include:</i></p> <ul style="list-style-type: none"> • All LOC-1S services • Psychosocial rehabilitative services (individual and group) • Day programs for acute needs • Residential treatment
LOC-4: Assertive Community Treatment	The purpose of ACT is to provide a comprehensive program that serves as the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses. Persons receiving ACT services may have a diagnosis of schizophrenia or another serious mental illness such as bipolar and have experienced multiple psychiatric hospital admissions either at the state or community level. Using an integrated services approach, the ACT team merges clinical and rehabilitation staff expertise (e.g., psychiatric, substance abuse, employment, and housing) within a mobile service delivery team that works in partnership with the person in recovery from his or her home. Accordingly, there will be minimal referral of individuals to other programs for treatment, rehabilitation, and support services. Limited use of group activities designed to reduce social isolation or address substance use/abuse issues is also acceptable as part of ACT.	<p><i>Services include:</i></p> <ul style="list-style-type: none"> • All LOC-3 services • Cognitive behavioral therapy

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-5: Transitional Services	The major focus for this LOC is to provide flexible services that assist individuals in maintaining stability, preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay varies by individual need. This LOC is available for up to 90 days. The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for a change in the LOC authorized. A Recovery/Treatment Plan is required. In the event that an additional LOC-5 post-initial 90 days is required, a new plan would be required for every 90 day LOC-5 authorization.	LOC-5 is designed to flexibly meet the needs of the individual prior to admission into ongoing services. All services are available in this LOC. <i>Services should reflect the individual's needs and can include:</i> <ul style="list-style-type: none"> • Routine case management • Psychiatric Diagnostic Interview examination • Pharmacological management • Medication training and support services (group and individual) • Skills training and development (group and individual) • Supported employment • Supported housing • Flexible funds • Flexible community supports • Engagement activity • Screening • Counseling (cognitive processing therapy) • Crisis intervention services • Crisis transportation • Safety monitoring • Day programs • Extended observation • Crisis residential treatment • Crisis stabilization • Respite services • Inpatient hospital services • Inpatient psychiatric services • Emergency room services (psychiatric) • Crisis follow-up & relapse prevention
LOC-6: Individual Refuses Services	ANSA indicates an LOC-R of 1M-4; however, the individual refuses services. These individuals will be authorized into LOC-A 6.	
LOC-8: Waiting for all Authorized Services	All providers who maintain a waitlist must adhere to the standards outlined in the performance contract. For information related to managing a waitlist, please refer to the performance contract.	
LOC-9: Not Eligible for Services	ANSA indicates an LOC-R of 9. A provider may request a review from each provider's utilization management department if, based on the individual's clinical presentation and the provider's clinical judgment, it is determined that a different level of care may be clinically appropriate. The necessary clinical information will be reviewed in accordance with the provider's utilization management policy and procedures for those individuals with an LOC-R of 9. If it is determined the individual is clinically appropriate to receive services the individual may be authorized into a level of care.	

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-EO: Early Onset	The purpose of LOC-EO is to provide a specialized treatment approach for those experiencing their first episode of psychosis. Individuals in this level of care will have a diagnosis that includes psychotic features and will vary in terms of need and severity. The LOC-EO's goal is to identify and help individuals before their symptoms and/or diagnosis are the primary feature of his/her life. Due to the early intervention model, many individuals may be entering behavioral health services for the first time and require a comprehensive array of available services. The team-based approach is a vital aspect of the assistance an individual will receive when they participate in LOC-EO. Coordinated specialty care teams are trained in the CSC model and provide an individual with all clinical and support services so care is provided efficiently and with a focus on recovery.	<p><i>Services include:</i></p> <ul style="list-style-type: none"> • Psychiatric diagnostic interview examination • Routine case management • Psychosocial rehabilitation (individual and group) • Peer support • Pharmacological management • Administration of an injection • Medication training and support (individual and group) • Family counseling • Individual psychotherapy • Group counseling • Supported housing • Supported employment • Engagement activity • Flexible funds • Adjunct services • Flexible community supports • Screening brief intervention and referral to treatment (SBIRT) • Crisis services

Source: Texas Health & Human Services Commission. (2017). *Texas resilience and recovery utilization management guidelines: Adult mental health, effective April 2017*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf>

Table 23. Texas Resiliency and Recovery Levels of Care for Children and Adolescents

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-0: Crisis Services	The services in this LOC are brief interventions provided in the community that ameliorate the crisis situation. Services are intended to resolve the crisis, avoid more intensive and restrictive intervention, and prevent additional crisis events. Any service offered must meet medical necessity criteria.	<p>These services do not require prior authorization. However, utilization management staff must authorize the crisis service within two business days of presentation. If further crisis follow-up and relapse prevention services are needed beyond the authorization period, the youth may be authorized for LOC-5. Services include:</p> <ul style="list-style-type: none">• Crisis intervention services• Adjunct services• Psychiatric diagnostic interview examination• Pharmacological management• Safety monitoring• Crisis transportation• Crisis flexible benefits• Respite services• Extended observation• Children's crisis residential• Family partner supports• Engagement activity• Inpatient hospital services• Inpatient psychiatric services• Emergency room psychiatric services• Crisis follow-up and relapse prevention
LOC-1: Medication Management	The services in this LOC are intended to meet the needs of youth whose only identified treatment need is medication management. 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. While services delivered in this LOC are primarily office-based, services may also be provided at school, in the community, or via telemedicine.	<p>The purpose of this LOC is to maintain stability and utilize the youth's and/or caregiver's natural supports and identified strengths to help them transition to community-based providers and resources, if available. Services include:</p> <ul style="list-style-type: none">• Psychiatric diagnostic review• Pharmacological management• Adjunct services• Medication training and support (individual and group)• Routine case management• Parent support group• Family partner supports• Family case management• Crisis services• Transition age youth additional adjunct services

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-2: Targeted Services	The purpose of this LOC is to improve mood symptoms or address behavioral treatment needs while building strengths in the youth and caregiver. The services in this LOC are intended to meet the needs of youth with identified emotional or behavioral treatment needs. The youth must not have identified needs in both areas. In general, the youth will have low life domain functioning needs.	<p>The targeted service in this LOC is either counseling or individual skills training and targets a specific, identified treatment need. The only exception occurs when counseling is the primary intervention for the 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 youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available. Individuals in LOC-2 can receive all of the LOC-1 services but generally receive interventions more frequently than LOC-1 clients. The targeted services specific to LOC-2 are:</p> <ul style="list-style-type: none"> • Counseling (individual, group, or family) • Skills training (individual or group) • Family training (individual or group) • Skills training and development (delivered to the caregiver or LAR)
LOC-3: Complex Services	The services in this LOC are intended to meet the needs of youth with identified behavioral and emotional treatment needs. The youth may also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. This may indicate a need for interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or further exacerbation of symptoms and/or behaviors.	<p>The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and caregiver. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the youth and caregiver. Services include:</p> <ul style="list-style-type: none"> • All LOC-2 services • Respite services, both community-based and program-based

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-4: Intensive Family Services (Wraparound)	The services in this LOC are intended to meet the needs of youth with identified behavioral and/or emotional treatment needs who are involved with multiple child-serving systems, or who are at risk for removal from their home or community. The identified behavioral or emotional treatment needs may have resulted in—or are likely to result in—juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, or serious injury to self, others, or animals. Providers will need to consider flexible office hours to support the intensive needs of the youth and his/her caregiver. Caregiver resilience is fostered using the Wraparound planning process to identify and build upon existing natural supports and strengths, as well as through referrals and support in accessing other needed community-based services and resources.	<p>HHSC has identified the National Wraparound Initiative (http://nwi.pdx.edu/) model for the provision of wraparound planning in the delivery of intensive case management services. The wraparound team is meant to reduce the risk of out-of-home placement for the youth. Therefore, due to the high level of symptom severity of the youth, the wraparound team – specifically a member of the treatment team – shall be accessible to the youth and his/her caregiver 24 hours a day, 7 days a week. Wraparound child and family team meetings shall take place at least monthly to achieve wraparound fidelity and comply with ICM provisions in TAC §412.407. When a crisis has been identified by any member of the wraparound team, a team meeting shall occur within 72 hours or at the earliest time available to the youth and family team members following the crisis. All wraparound team meetings must include the youth and his/her caregiver. While some of the services are the same as LOC-3, children and adolescents in LOC-4 packages receive interventions more frequently because they have a higher level of need. Providers will likely need to maintain flexible office hours to support the complex needs of the child in services and their caregivers. Individuals in LOC-4 packages are eligible to receive:</p> <ul style="list-style-type: none"> • All LOC-3 services • Stronger emphasis on family partner services and integrated care • Intensive case management, also known as “wraparound”
LOC-YC: Young Child Services	The services in this LOC are intended to meet the needs of the young child (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. All services are available in this level of care and the recovery plan should be developed based on the individual needs of the child. The provider may recommend any core service that will help address the developmental, behavioral, and emotional needs of the child. In this level of care, the participation of the caregiver in all services is strongly recommended and most services will require the participation of both the caregiver and the child in treatment.	<p>The purpose of this LOC is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver. The 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 telehealth/telemedicine, if available. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver. Young children in the LOC-YC package are eligible to receive the following services:</p> <ul style="list-style-type: none"> • All LOC-4 services

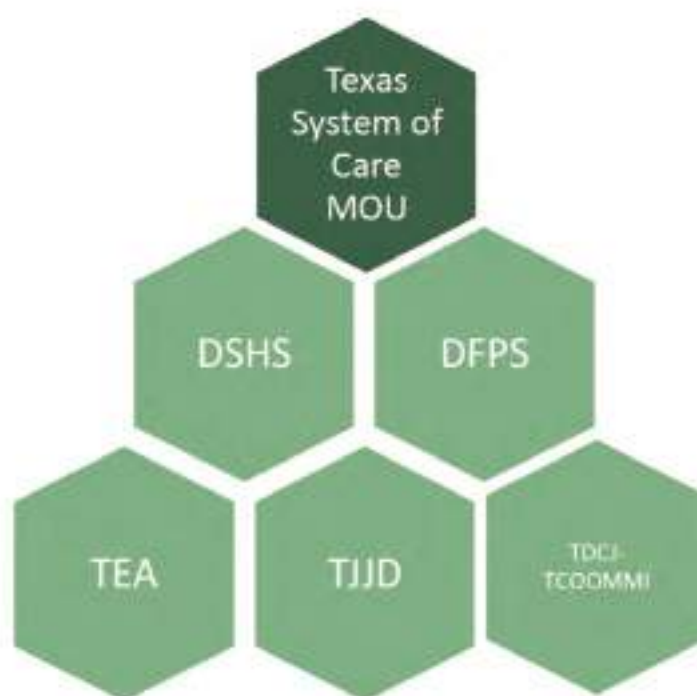
Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-5: Transitional Services	The services in this LOC are intended to assist youth and their caregivers in maintaining stability, preventing additional crisis events, engaging youth and their caregivers into the appropriate level of care, and/or assisting in accessing appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary based on individual need.	LOC-5 may only be used for a youth who is not currently assigned to an LOC and does not have an active CANS LOC-R. Services include: <ul style="list-style-type: none"> • Routine case management • Psychiatric Diagnostic Interview examination • Pharmacological management • Medication training and support services (group and individual) • Counseling (individual, group, or family) • Family partners supports • Family training (individual or group) • Parent support group • Engagement activity • Flexible funds • Flexible community supports

Source: Texas Health and Human Services. (2016). *Texas resilience and recovery utilization management guidelines: Child and adolescent services*, updated 2016. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf>

TEXAS SYSTEMS OF CARE

Systems of care (SOC) is a spectrum of effective community-based services and supports for children, youth, and young adults who are experiencing, or at risk for mental health and related challenges, and their families. A SOC framework is also sensitive to the youth and their family’s cultural and linguistic preferences. This framework delivers highly individualized services such as wraparound and YES waiver supports to reduce youth admissions into hospitals, the juvenile justice system, and the child welfare system.¹¹⁹ Care for youth with intensive support needs is coordinated across state agencies, private and public organizations, and families so that children can overcome the barriers that prevent them from accessing the services they need.

HHSC and the Texas Institute for Excellence in Mental Health at the University of Texas at Austin lead the Texas System of Care, in collaboration with child-serving state agencies, family and youth advocacy organizations, and other stakeholders within the Texas children’s mental health service delivery system. The mission of the Texas System of Care is to “strengthen the collaboration of state and local efforts to weave mental health supports and services into seamless systems of care for children, youth and their families.”¹²⁰ There are five state agencies that have entered into the Texas System of Care Memorandum of Understanding (MOU) depicted in Figure 38. Essentially, the MOU outlines strategies that each of the agencies can employ to integrate the system of care values and principles into their work. These strategies aim to create more family-driven, youth-guided, and culturally and linguistically responsive agencies.

Figure 38. Texas Systems of Care MOU

Source: Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behvh-hlth-idd-plan-feb-2019.pdf>

In the early 2000s, the Texas legislature established the Texas Integrated Funding Initiative (TIFI). TIFI brought together many child- and youth-serving state agencies to provide systems of care grants to a handful of local communities. In 2011, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) began granting HHS system of care grants across the country. Texas was a recipient of these grants to fund the development, planning, and implementation of a statewide and local systems of care plan. In 2017, Texas was awarded a four-year grant to further expand and sustain the System of Care framework across the state.¹²¹ The process and outcome evaluation for Year 1, including more information on work around the project's goals and objectives, can be found at: <https://txsystemofcare.org/wp-content/uploads/2019/09/TxSOC-2-0-Evaluation-Report-Year-1-FINAL.pdf>

HHSC currently contracts with LMHAs to oversee the implementation of systems of care in local communities. As of March 2020, Burke in East Texas and LifePath Systems in Collin County were participating in the Texas Systems of Care framework. In 2019, HHSC conducted a Needs and Capacity Assessment to identify two additional Texas System of Care communities. Through that process, the Harris Center in Harris County and Coastal Plains Community Center in the Gulf Coast region were selected and began implementation on September 30, 2019.¹²²

COMMUNITY MENTAL HEALTH SERVICES

A majority of community mental health services focus on outpatient community-based services designed to support adults' movement toward independence and recovery, as well as support the recovery and resilience of children and their

families. These services include medication-related services, rehabilitation services, counseling, case management, peer support services, family support services, crisis intervention services, and special programs such as Clubhouses.

According to HHSC, “over the past decade, LMHAs have been challenged to meet the growing demand for community-based outpatient mental health services. At the beginning of fiscal year 2012, over 7,000 adults and children were waiting for services. In each of the following three biennia, the Legislature made significant investments to expand outpatient capacity. This funding supported a steady expansion of services and in the past four years, tens of thousands of individuals have been brought into service.”¹²³

However, even with the continued investments, only 69 percent of adults with SMI and 58 percent of children with SED that HHSC estimates are eligible for services were enrolled in services. Over the next biennium, an estimated 9,085 new residents will be added to the population of indigent individuals needing long-term mental health services. Timely access to care is essential; data show that individuals who wait more than 30 days for service are unlikely to be admitted to care. Fortunately, individuals who are linked with appropriate and timely services are less likely to be incarcerated or admitted to inpatient services.¹²⁴

During the 86th legislative session, lawmakers increased both adult and children community mental health funding to a total of \$948,735,798 in the 2020-2021 biennium, an increase of \$78,999,358 from the 2018-2019 biennium.¹²⁵

Priority Populations

During the 83rd Legislative session, HB 3793 (83rd, Coleman/Hinojosa) amended the Health and Safety Code to expand access to community mental health services to individuals with a variety of mental health conditions. Although providing treatment services to individuals with other diagnoses was not prohibited prior to 2013, the law had previously mandated the provision of services only to adults with the “big three diagnoses”: schizophrenia, bipolar depression and major depressive disorder.¹²⁶ As a result of HB 3793, LMHAs/BMHAs with sufficient resources can provide services for individuals with any of the diagnoses listed in Table 24. Despite this change in code to allow for more individuals served, LMHAs continue to provide services primarily for adults with schizophrenia, bipolar, or major depression with psychosis due to funding constraints. During FY 2017, 95 percent of diagnoses for adult clients in ongoing treatment related to one of these diagnoses.¹²⁷

Table 24. LMHA/LBHA Client Population

Populations	Eligibility Criteria
Adults	Serious functional impairment and severe and persistent mental illness diagnosis of: Major depressive disorder, including single episode or recurrent major depressive disorder; <ul style="list-style-type: none">• Post-traumatic stress disorder;• Schizoaffective disorder, including bipolar and depressive types;• Obsessive compulsive disorder;• Anxiety disorder;• Attention deficit disorder;• Delusional disorder;• Bulimia nervosa, anorexia nervosa, or other eating disorders not otherwise specified; or• Any other diagnosed mental health disorder.
Children & Adolescents	Children ages 3 through 17 who have a diagnosis of mental illness, exhibit symptoms of serious emotional, behavioral, or mental health conditions, and meet at least one of the following criteria: <ul style="list-style-type: none">• Have a serious functional impairment;• Are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; and/or• Are enrolled in a school system's special education program because of SED. *Children and adolescents with a single diagnosis of autism, pervasive developmental condition, intellectual disability, or substance use do not meet the priority population criteria for mental health services and are instead served through other programs developed for special populations.

Sources: Texas Legislature Online. (2013). *House Bill 3793*. Retrieved from <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=HB3793>

Texas Legislature Online. (2013). *Senate Bill 7*. Retrieved from <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=SB7>

System Utilization

From FY 2013 through FY 2017, the average monthly number of adults receiving community mental health services through LMHAs increased steadily, reaching 117,792. However, during the next two years, the average monthly number dropped to 89,752. The average number of children receiving community mental health services also increased during FY13 through FY 2017, but like adults being served, the number of children declined over the following two years. Table 25 shows trends for the number served and the average cost per client from 2013-2019.

Table 25. Utilization of Community Mental Health Services for Adults and Children, 2013-2019

Utilization Measure	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Average monthly number of adults receiving community mental health services	79,611	90,658	94,776	98,502	117,792	86,800	89,752

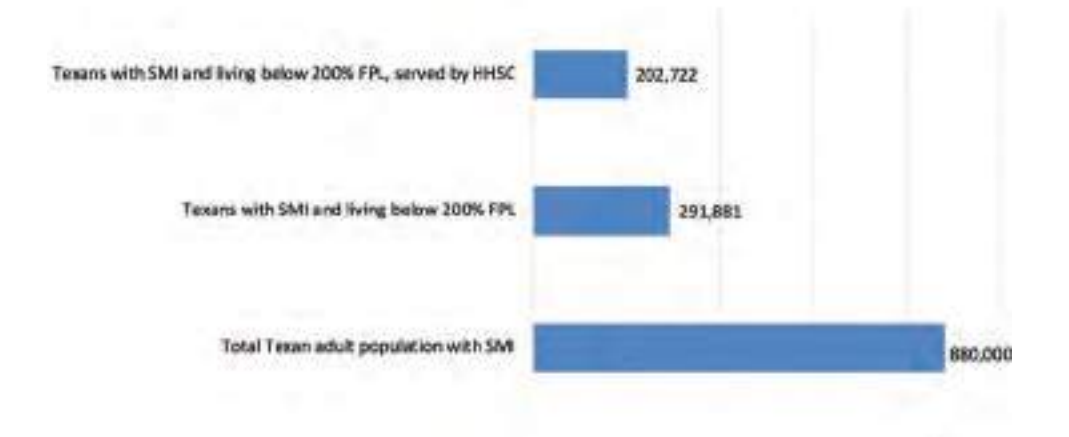
Average cost of community mental health services per adult served	\$352	\$422	\$438	\$418	\$420	\$435	\$480
Average monthly number of children receiving community mental health services	17,878	20,240	23,376	23,887	30,064	27990	28519
Average cost of community mental health services per child served	\$383	\$441	\$441	\$407	\$404	\$390	\$387

Sources: Texas Health & Human Services Commission. FY 13-17 Data request August 8, 2018. Data received from Michele Neal.

Texas Health & Human Services Commission. FY 18-19 Data Request. Data request May 20,2020. Data received from Sonja Gaines.

As illustrated in the figures below, there are significantly more adults and children in Texas who require mental health services than are currently being served in the public mental health system. The most recent data from FY 2018 illustrates that there were 291,881 adults in Texas who had a serious mental illness (SMI) and were living below 200 percent of the FPL; 202,722 of them—69.5 percent—received services at HHSC-funded community mental health centers. Similarly, there were 113,011 children with serious emotional disturbance (SED) living below 200 percent of the FPL in 2018; 66,216 of them—or 58.6 percent—received services through HHSC-funded community mental health centers.¹²⁸

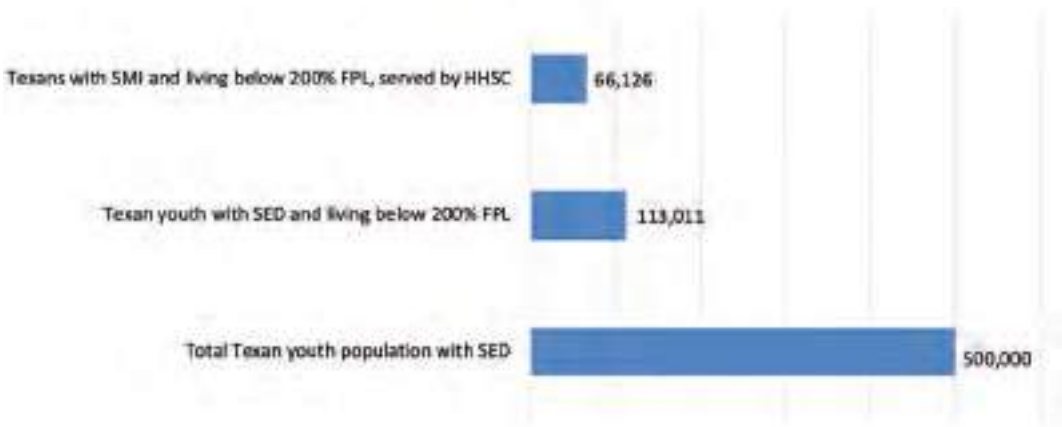
Figure 39. Unmet Need for Community Mental Health Services: Adults in FY 2018



Sources: Texas Health and Human Services Commission. Data Request. Data request May 20, 2020. Data received from Sonja Gaines

Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

Figure 40. Unmet Needs for Community Mental Health Services: Children and Adolescents in FY 2018



Sources: Texas Health and Human Services Commission. Data Request. Data request May 20, 2020. Data received from Sonja Gaines

Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

Quality of Care Measures

Table 26 and Table 27 shows selected data on common adult and child/adolescent outcome measures for FY 2016-2019.

Table 26. Selected Measures for Adults Receiving Community Mental Health Services

Quality of Care Measure	FY 2016	FY 2017	FY 2018	FY 2019
Percentage of adults in community mental health services receiving at least one hour of mental health services per month	75.10%	70.20%	56.4%	55.3%
Percentage of adults in community mental health services admitted three or more times in 180 days to a state or community psychiatric hospital	0.13%	0.12%	0.14%	0.15%
Percentage of adults in community mental health services who experienced improved employment	19.50%	19.80%	61.4%	59.6%
Percentage of adults in community mental health services who experienced reliable improvement in at least one domain	43.00%	42.40%	44.1%	42.55%

Sources: Texas Health and Human Services Commission. FY16-17 Data request: Michelle Neal, August 8, 2018.

Texas Health and Human Services Commission. FY 18-19 Data Request. Data request May 20,2020. Data received from Sonja Gaines.

Table 27. Selected Measures for Children and Adolescents Receiving Community Mental Health Services

Quality of Care Measure	FY 2016	FY 2017	FY 2018	FY 2019
Percentage of children and adolescents in community mental health services receiving at least one hour of services per month	83.10%	79.90%	77.20%	76.50%
Percentage of children and adolescents in community mental health services who experienced improved community tenure	99.74%	99.68%	99.68%	99.68%
Percentage of children and adolescents in community mental health services meeting or exceeding the Reliable Change Index in one or more domains	57.70%	55.80%	55.90%	54.90%

Sources: Texas Health and Human Services Commission. FY 16-17 Data request: Michelle Neal, August 8, 2018.

Texas Health and Human Services Commission. FY 18-19 Data Request. Data request May 20,2020. Data received from Sonja Gaines.

Waitlists

When LMHAs exhaust their funding, non-Medicaid eligible individuals who require mental health services are added to a waitlist. Individuals who are on Medicaid must be admitted into services because federal law prohibits waitlists for Medicaid.¹²⁹ As of April 2020, 172 adults were “waiting for all services,” and 1,043 underserved adults were waiting for additional services.¹³⁰

On the other hand, in April 2020 there were no eligible children waiting for services and 155 underserved children waiting for additional services.¹³¹

The factors identified by LMHAs as impacting waiting lists are shown in Table 28.

Table 28. Factors Impacting Community Mental Health Waiting Lists

Issue	Long or Short-term	Description
As Texas’s population grows, so will the number of people likely to qualify for state-supported mental health services	Long-term	<ul style="list-style-type: none"> • Texas population to increase to over 40.5 million by 2050 • 811,000 adults are likely to qualify for state-supported mental health services in 2050, compared to 576,226 in fiscal year 2020 • 320,000 youth are likely to qualify for state-supported mental health services in 2050, compared to 262,318 in fiscal year 2020
Mental health workforce shortages	Long-term	<ul style="list-style-type: none"> • Shortages cause challenges to recruiting and retaining psychiatrists, licensed clinicians, nurses, and qualified mental health professionals • Challenges are even greater in rural and underserved areas

Other workforce issues	Short-term	<ul style="list-style-type: none">• Loss or retirement of a prescribing provider• Limited funding for recruitment, retention, and training• Low reimbursement rates
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Source: Texas Health and Human Services Commission. (2020). *Semi-annual reporting of waiting lists for mental health services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-semi-annual-waiting-lists-mhs-april-2020.pdf>

Factors contributing to the ongoing waitlists for mental health services include the growing Texas population, significant mental health workforce shortages (especially in rural areas), and low reimbursement rates for mental health providers.

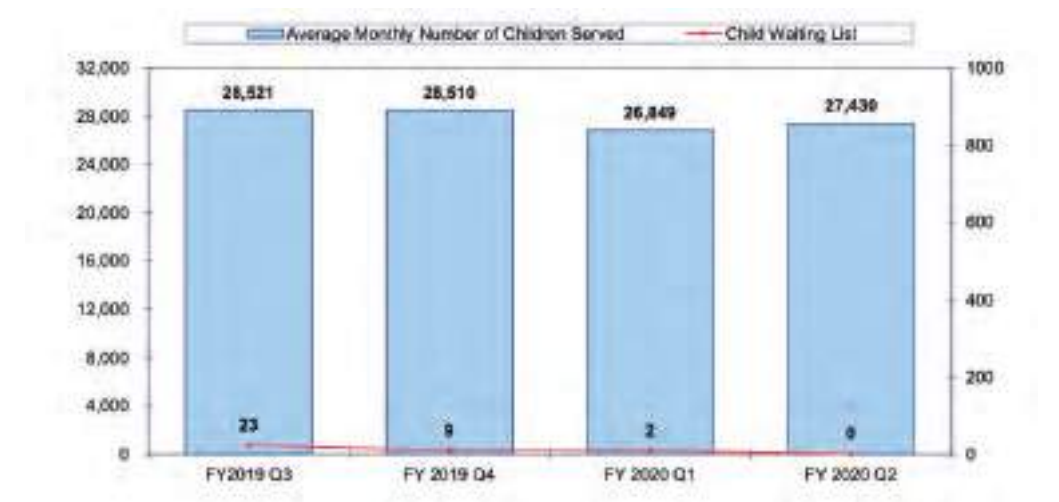
The 86th Legislature appropriated additional funding of approximately \$59 million specifically to address the waiting lists for adult and children’s services to avoid future wait lists and increase outpatient treatment capacity at LMHAs/LBHAs.

Figure 41. Adult Waiting List and Adults Served Through Community Mental Health Centers



Source: Texas Health and Human Services Commission. (2020). *Semi-annual reporting of waiting lists for mental health services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-semi-annual-waiting-lists-mhs-april-2020.pdf>

Figure 42. Child and Adolescents Waiting List and Children Served Through Community Mental Health Centers



Source: Texas Health and Human Services Commission. (2020). *Semi-annual reporting of waiting lists for mental health services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-semi-annual-waiting-lists-mhs-april-2020.pdf>

Youth Empowerment Services (YES) Waiver

The YES Waiver is a Medicaid 1915(c) home and community-based waiver program for children ages 3 to 18 years old who have serious mental, emotional, and behavioral difficulties (including serious emotional disturbance or SED), are at risk of being removed from their home due to a mental health concern, and meet the requirements to be in a psychiatric hospital. A full range of Medicaid services, non-traditional services, and family supports are available to create an intensive, comprehensive, and individualized child and family plan of care.¹³² As with other 1915(c) waivers, YES waivers do not take family income into account when determining eligibility. With all Medicaid 1915(c) waivers, the individual may gain Medicaid eligibility as a result of receiving waiver services. They may not meet standard Medicaid eligibility, but if they meet waiver financial eligibility (up to 200 percent of FPL), they are eligible for the waiver which makes them eligible for Medicaid.

The YES waiver program offers an alternative to inpatient treatment by providing community-based coordinated care for youth with particularly complex or severe behavioral health needs. The program uses a wraparound approach that combines direct services with family supports to help the child stay safely within their community. The average length of time services are delivered is typically 11-18 months, but can be extended if there is still clinical need for the services provided. As with traditional Medicaid, YES waiver services are jointly funded by the state and the federal government.

HHSC contracts with LMHAs to manage YES waiver services in each of their respective service regions. Table 29 shows the capacity of each LMHA across the state.

Table 29. YES Waiver Capacity as of April 2020-March 2021

Provider	Capacity Maximum
Anderson/Cherokee	14
Andrews Center Behavioral Health System	67
Austin-Travis County Mental Health and Mental Retardation Center	145
Bluebonnet Trails Community MHMR Center	207
Abilene Regional MHMR Center dba Betty Hardwick Center	87
Behavioral Health Center of Nueces County	46
Border Region MHMR Community Center	139
Burke Center	69
Brazos Valley	19
Central Counties Center for MHMR Services	19
Center for Health Care Services, The	140
Central Texas MHMR Center dba The Center for Life Resources	10
Central Plains Center	10
Coastal Plains	64
Community Healthcore	55
Camino Real Community Center	80
Denton County	38
Emergence	42
Gulf Coast Center, The	26
Gulf Bend MHMR Center	10
Harris	328
Helen Farabee	10
Hill Country	54
Heart of Texas	88
LifePath Systems	87
Lakes Regional	10
Concho Valley	28
Child and Family Guidance Center (NTBHA) (FCG)	186
Permian Basin	15
Pecan Valley	34
Spindletop Center	87
StarCare Specialty Health System	21
Tarrant	285
Texana	104
Texoma	14
Texas Panhandle	25
Tri-County Services	29

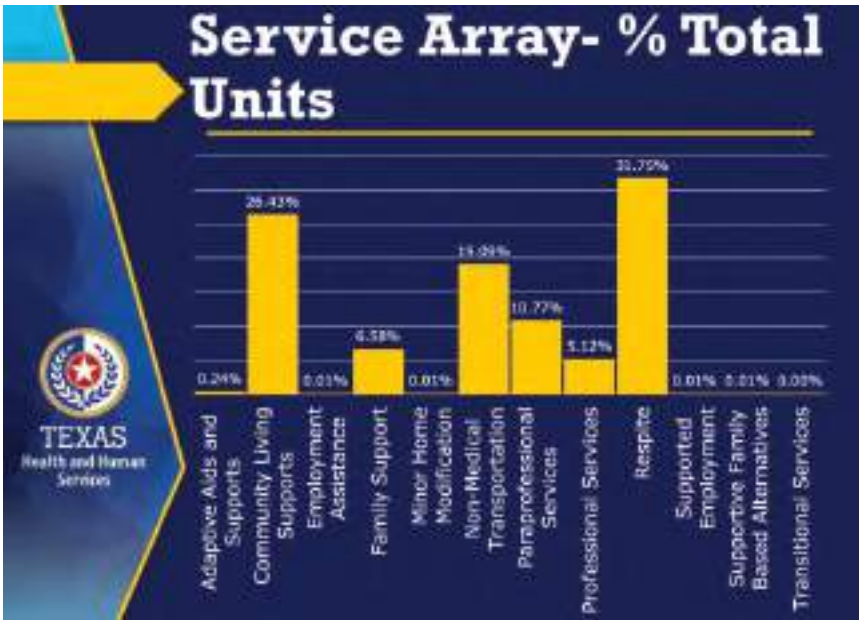
Provider	Capacity Maximum
Tropical Texas Center for MHMR	338
West Texas	10
TOTAL	3040

Source: Texas Health and Human Services. (April 2020). YES Waiver data. Retrieved from <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/yes-waiver-data>

LMHAs contract with community service providers to ensure all required YES waiver services are available, though some are utilized and provided at much higher rates than others, while some are not yet utilized as depicted in Figure 43. Utilization and access to services depends on what is available across the state, leaving some rural and underserved areas with fewer offerings. Services offered through the YES waiver program include:

- Comprehensive case management
- Adaptive aids and supports
- Community living supports
- Family supports
- Minor home modifications
- Non-medical transportation
- Professional and paraprofessional services
- Respite
- Supportive family-based alternatives
- Transitional services¹³³

Figure 43. YES Waiver Services



Source: Texas Health and Human Services Commission. (2018). Youth empowerment services waiver data dashboard February 2018. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/yes-waiver/yes-data-dashboard-feb-2018.pdf>

The YES waiver program was approved for statewide expansion during the 84th legislative session through Rider 60.¹³⁴ Table 30 shows the steady increase in YES waiver enrollments over the past seven years.

Table 30. Youth Empowerment Services Waiver Enrollment: 2011-2019

Year	Number of Children and Youth Enrolled in YES Waiver Services
2011	46
2012	63
2013	167
2014	294
2015	722
2016	1,237
2017	2,260
2018	3,031
2019	3,140

Sources: Lewis, L., & Jesse, G. (March 22, 2016). *Presentation to the Select Committee on Mental Health: Children’s mental health services*. Texas Department of State Health Services. Retrieved from <http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590006580>.

Texas Health and Human Services Commission. (April 16, 2018). FY 2017 data stakeholder meeting.
Texas Health and Human Services Commission. FY 18-19 Data Request. Data request May 20, 2020. Data received from Sonja Gaines.

The expansion of the YES waiver program should allow more youth with SED to access intensive community behavioral health services in effort to decrease the number of children who receive inpatient care and/or are relinquished to the DFPS solely because of an inability to access needed mental health services.¹³⁵ However, due to a high need and specific number of allocated waiver slots for regions across the state, individuals must call their LMHA to be added to the YES Waiver inquiry list. HHSC determines the vacancy allocations based on population size, community, need, and local infrastructure. HHSC re-evaluates allocations at least annually, or more often as needed. Areas with greater service demands receive unused vacancies from other areas.¹³⁶

In February 2016, DSHS required that children at “imminent risk” of being relinquished to the state be prioritized for YES waiver services.¹³⁷ The YES waiver sets aside a reserve of five percent of waiver slots specifically for these children.¹³⁸ In recent years, the YES waiver was amended to allow children who are in state conservatorship (in foster care through DFPS) to be eligible to receive YES waiver services.

More information on the YES Waiver can be found at: <https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver>.¹³⁹

Supportive Housing Rental Assistance Program

Since 2013, the Supportive Housing Rental Assistance (SHR) program has provided short- and long-term rental and utility assistance to individuals who are experiencing homelessness or who at risk of homelessness. Through the program, these individuals receive services at one of 20 LMHAs. SHR funds can be used for various assistance including rent, utilities, deposits and other move-in expenses. To qualify, individuals must be working with their case manager to apply for permanent housing vouchers and create an income stability plan. In FY 17-18, \$11.6 million in GR funds was allocated to the program, which provided services to 2,119 people in FY 2018.¹⁴⁰

In FY 2018, after receiving SHR assistance, recipients experienced a 57 percent reduction in the average number of psychiatric hospitalizations and a 48 percent reduction in the number of crisis encounters.¹⁴¹ Additionally, after receiving SHR assistance recipients experienced a 39 percent reduction in criminal justice involvement and an overall 79 percent reduction in homelessness.¹⁴² Table 31 summarizes outcomes of the SHR program during FY 17-18.

Table 31. FY 2017-2018 SHR Program Outcomes

Outcomes	FY 2017	FY 2018
Number of unique recipients	2,358	2,119
Average award amount	\$2,390	\$2,336
Average time for assistance	5.3 months	4.7 months
Hospitalizations before	114	103
Hospitalizations after	50	44
Change in hospitalizations	56% reduction	57% reduction
Crisis encounters before	6,943	7,064
Crisis encounters after	4,851	3,658

Change in crisis encounters	30% reduction	48% reduction
Criminal justice involvement before	259	201
Criminal justice involvement after	131	122
Change in criminal justice involvement	49% reduction	39% reduction
Homelessness before	442	493
Homelessness after	101	104
Change in homelessness	77% reduction	79% reduction

Source: HHSC information request, Feb. 21, 2019

Table 32. FY 18 SHR Program Utilization and January 2019 PIT count comparison

Number of people served by SHR in FY 18	2,119
Number of people identified as homeless across all 39 LMHA/LBHAs in Jan. 2019	5,281
Percentage of eligible people across Texas served by SHR in FY 2018 compared to current need	40%

Source: HHSC information request, Feb. 21, 2019

Peer Services Programs, Planning, and Policy Unit

Mental health and substance use peer support services are critical to supporting the recovery of many people with mental health and/or substance use conditions. HHSC has illustrated the importance of these services by creating the Peer Services Programs, Planning, and Policy Unit within the commission. The unit’s first Director of Peer Services, Noah Abdenour, launched the unit in February 2019. The unit now includes the director, five program specialists, and an administrative assistant. Creation and development of this unit was a significant advancement in validating the importance of these services.

Peer Services

According to HHSC, “peer support is when someone with lived experience gives encouragement and assistance to help someone with mental illness or a substance use condition achieve long-term recovery. Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities and communities of support.”¹⁴³

A peer is a person with lived experience of recovery from mental health and/or substance use conditions. By combining this experience with skills learned in formal training, peer specialists (e.g., certified peer specialist, peer support specialist, recovery coach) deliver services in behavioral health settings to support long-term recovery.¹⁴⁴ Peer support is non-clinical and recovery focused, and often works on a team with other mental health professionals. While peer support is a deliverable service, it is not a provider type. Peer specialists can be found in LMHAs/LBHAs, peer run service providers, state hospitals, community-based organizations, recovery organizations and treatment organizations. Common tasks performed by peer specialists include helping people self-advocate, connecting people to resources and work, goal setting, facilitating support groups, outreach and engagement, face-to-face recovery coaching, and telephone peer support.¹⁴⁵

Peer support is becoming more widely recognized as an important support service for individuals with mental health and substance use conditions. As these services are more widely available and utilized, so is the data on impact and cost savings. Current evidence suggests that peer support and recovery coaching:

- Reduces the admissions and days spent in hospitals and increases time in the community;
- Reduces the use of acute services;
- Increases engagement in outpatient treatment, care planning and self-care;
- Improves social functioning;
- Increases hope, quality of life, and satisfaction with life;
- Reduces substance use;
- Reduces depression and demoralization;
- Improves chances for long-term recovery;
- Increases rates of family unification; and
- Reduces average services cost per person.¹⁴⁶

Recognizing the importance of peer services, lawmakers passed HB 1486 (85th, Price/Schwertner) during the 85th Texas Legislature, which required HHSC to create a Medicaid reimbursable state plan benefit for peer support services. To define the new Medicaid benefit and operationalize this directive, HHSC created a Peer Support Stakeholder Workgroup, consisting of providers and people with lived experience from the peer support community. The workgroup provided input on the development and adoption of rules related to peer specialists, peer services, and the provision of those services under Medicaid. The workgroup met frequently between November 2017 through July 2018, and:

1. Established training requirements for peer specialists;
2. Established certification requirements for peer specialists;
3. Defined the scope of services peer specialists may provide;
4. Distinguished peer services from other services that a person must hold a license to provide; and
5. Developed any other rules necessary to protect the health and safety of persons receiving peer services.¹⁴⁷

For Peer Support as a Medicaid Benefit, HHSC designated two entities to certify peers, peer supervisors, and peer/peer supervisor training entities: The Texas Certification Board (formerly The Texas Certification Board of Addiction

Professionals) and Wales Education Services.

To be eligible to receive Medicaid peer support services, a person must:

- Be at least 21 years old;
- Be a Medicaid recipient;
- Have a mental health condition and/or substance use condition; and
- Have peer specialist services included in the person's person-centered recovery plan.¹⁴⁸

To be eligible to become a Medicaid peer specialist provider, a person must:

- Be at least 18 years of age;
- Have lived experience with a mental health condition and/or substance use condition;
- Have a high school diploma or general equivalency degree (GED);
- Appropriately share their own recovery story;
- Demonstrate current self-directed recovery; and
- Pass criminal history and registry checks.¹⁴⁹

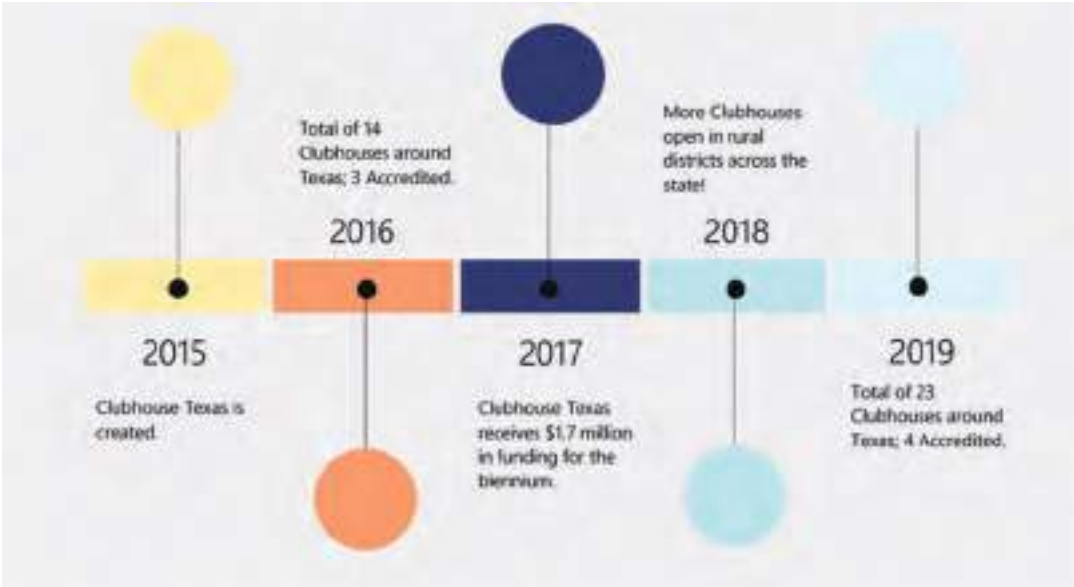
Certified peers must deliver services in conjunction with a facility, provider group, community center, etc., as they cannot yet separately enroll in Medicaid as a Medicaid provider, or be separately credentialed by an MCO. Alternatively, peer specialists without certification are able to provide mental health rehabilitative services and provide peer services through the 1915i and YES Waivers. HHSC provides information on peer support services, the certification process, and benefits of peer supports which can be found at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/peer-support-services>

More information on peer services in Texas can be found in the Policy Environment Section, and information specific to substance use peer specialists (also called recovery coaches) can be found later in this section.

Clubhouses in Texas

One example of a recovery-oriented program within the Peer Services Programs, Planning, and Policy Unit is Clubhouse. The Clubhouse model is a recovery-oriented program for adults diagnosed with a mental illness. The model has been adopted in Texas and continues to expand to new regions of the state. The purpose of the Clubhouse programming is to improve an individual's ability to function successfully in the community through involvement in a peer-focused environment. Clubhouse members are encouraged to participate in the everyday operations of the Clubhouse such as clerical duties, reception, food service, transportation, and financial services. Members are also encouraged to participate in activities to promote outside employment, education, meaningful relationships, housing, and an overall improved quality of life. According to a 2018 survey of Clubhouse members, 91 percent of members reported an improvement in their mental health, 70 percent reported having a job or receiving job training/education, and reported a 6 percent jail recidivism rate compared to the general population's 60 percent.¹⁵⁰

Figure 44. Clubhouses in Texas from 2015-2019



Source: Clubhouse Texas. (n.d.) *Clubhouse Texas*. Retrieved from <http://clubhousetexas.org/#top>

WHAT IS A CLUBHOUSE?

Clubhouses provide a caring, supportive community and meaningful work to individuals living with mental illness. Often diagnosed as children or adolescents, people with a chronic mental illness can spend a lifetime in and out of emergency rooms, jails and psychiatric hospitals. Membership and participation with the Clubhouse can help members avoid the crises that often result in hospitalization or incarceration.

Once individuals with mental illness are stabilized, they are often sent home. They are often isolated there, left to manage their illness alone. The Clubhouse surrounds the person with a community of peers, working side-by-side with professional staff. In addition to meaningful work, the Clubhouse has an employment program that helps members find jobs in their community.

Members show up for work every day, doing volunteer tasks and contributing to the maintenance and operations of the Clubhouse. Most participants avoid further hospitalizations as a direct result of attending and working at the Clubhouse.

Source: Clubhouse Texas. (n.d.) *Clubhouse Texas*. Retrieved from <http://clubhousetexas.org/#top>

During the 86th legislature, Texas lawmakers recognized the value of Clubhouses and continued their \$1.7 million funding through Rider 65. Of the 23 Clubhouses across the state, HHSC contracts with four: Austin Clubhouse, San Angelo Clubhouse, San

Antonio Clubhouse, and St. Joseph Clubhouse. Additionally, the Hope Fort Bend Clubhouse is a recipient of a HB 13 Community Mental Health grant.^{151,152}

Certified Community Behavioral Health Clinics (CCBHC) Initiative

In 2014, the federal government passed the Protecting Access to Medicare Act of 2014 (PAMA). Section 223 of PAMA creates a two-year demonstration program for states to certify community behavioral health clinics. According to SAMHSA, CCBHCs are certified community behavioral health clinics that meet federally developed criteria. PAMA directs the care provided by CCBHCs be “patient-centered.” CCBHCs are expected to offer care that is person-centered and family-centered in accordance with the ACA, trauma-informed and recovery-oriented, as well as integrate physical and behavioral health care.¹⁵³

The criteria are based on a review of Medicaid state plans, FQHC standards, Medicaid Health Homes, and other state quality measures. The criteria consist of standards for:

- Staffing;
- Availability and accessibility of services;
- Care coordination;
- Scope of services;
- Quality and other reporting; and
- Organizational authority, governance, and accreditation.¹⁵⁴

In 2015, Texas was awarded a CCBHC planning grant from SAMHSA. The planning grant allowed HHSC to partner with MCOs, providers, and stakeholders to certify clinics, and develop an integrated service delivery framework.¹⁵⁵ The 2015 grant provided one year funds for states to certify community behavioral health clinics, establish a Prospective Payment System (PPS) for Medicaid reimbursable behavioral health services provided by the certified clinics, and prepare an application to participate in a two-year demonstration program.¹⁵⁶ The grant was the first of two phases. While Texas was not selected for phase 2 as a national demonstration site, HHSC continues to use the CCBHC framework as a best practice model for the delivery of behavioral health services.

CCBHCs help address gaps in the human services system of care for individuals with serious and persistent mental illnesses, emotional disturbances, and substance use conditions. The goal of expansion across the state is to improve capacity and outcomes for community-based behavioral health services. CCBHCs typically incorporate MOUs with community partners to establish a network of community supports. These partners include primary care providers, local veterans’ services organizations, school districts, individual providers, and others. To ensure a level of consistency across CCBHCs, a list of evidence-based practices (EBPs) was developed as minimum standards. The list of EBPs reflect statewide needs assessment findings and support other Texas program initiatives:

- Adult Specific EBPs:
 - SAMHSA Assertive Community Treatment (ACT)
 - Cognitive Behavioral Therapy (CBT) and Cognitive Processing Therapy

- (CPT)
 - SAMHSA Illness Management and Recovery (IMR)
 - SAMHSA Integrated Treatment for Co-occurring conditions
 - SAMHSA Supported Employment and Permanent Supportive Housing
- Child/Adolescent Specific EBPs:
 - Nurturing Parent Training
 - Trauma Focused CBT
 - Case Management using the NWIC Wraparound model, when indicated
- EBPs applicable to all populations:
 - Screening, Brief Intervention, and Referral to Treatment (SBIRT) model
 - Motivational Interviewing
 - Person-Centered Recovery Planning
 - Seeking Safety¹⁵⁷

In order to become certified as a CCBHC, a community clinic must go through an extensive application process. Once approved, certification is valid for 3 years. In FY 19, Texas had 12 CCBHCs with plans to increase to 19 during FY 20, as indicated in their inaugural business plan, *Blueprint for a Healthy Texas*. ***More information on HHSC's plan can be found in the Policy Environment Section of this Guide.***

CRISIS SERVICES

The Texas Administrative Code defines a psychiatric crisis as a situation in which an individual presents the following risk factors due to a mental health condition:

- Presents an immediate danger to self or others;
- Is at risk of serious deterioration of mental or physical health; and/or
- 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.¹⁵⁸

During the 86th legislative session, lawmakers increased community mental health crisis funding to a total of \$343,263,746 in the 2020-2021 biennium, an increase of \$17,833,194 from the 2018-2019 biennium.¹⁵⁹ Crisis services funding is used to enhance community-based psychiatric emergency services projects that serve as alternatives to divert individuals from hospitals, emergency rooms, and/or jails.

In 2020, HHSC created a COVID-19 hotline specifically to assist Texans dealing with mental health needs related to the pandemic. The hotline is staffed by mental health professionals employed at the Harris County MHMR and helps to refer callers to needed services based on their individual situation.

Crisis services are available statewide to individuals regardless of if they are enrolled in ongoing mental health care. Table 33 lists most of the crisis services available through state-funded programs and providers:

Table 33. Crisis Services

Service	Description
Crisis Hotline Services	<p>Available 24 hours per day, seven days per week, all 39 LMHAs/BMHAs either operate their own crisis line or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS).</p> <p>In 2020, HHSC created a COVID-19 hotline specifically to assist Texans dealing with mental health needs related to the pandemic. The hotline is staffed by Harris County MHMR and helps to refer callers to needed services based on their individual situation</p>
Mobile Crisis Outreach Teams	Mobile Crisis Outreach Teams (MCOTS) provide face-to-face help to people who are at risk of harm to self or others. MCOTs provide counseling services to people at their home, school, or other location. The services are available 24/7, 365 days a year.
Crisis Stabilization Units	CSUs provide immediate access to emergency psychiatric care and short-term residential treatment for the resolution of acute symptoms for individuals with a high to moderate risk to themselves or others. CSUs can accept individuals on a protective custody order or an emergency detention.
Extended Observation Units	EOUs provide up to 48 hours of psychiatric observation in a controlled and locked environment, with a goal of short-term stabilization and diversion from costlier and intensive inpatient services if appropriate. EOUs can accept individuals on emergency detention.
Crisis Residential Services	This voluntary service provides up to 30 days of crisis-level services in a safe, clinical, residential setting for individuals who present moderate to mild risk of harm to self or others.
Crisis Respite Services	Crisis respite provides a short period of relief from the individual's normal environment and typical stressors. Services can last up to 7 days for short-term crisis care for individuals with low risk of harm to self or others. Also allows for more focused treatment planning.
Crisis Step-Down Stabilization Services in Hospital Setting	Provides three to 10 days of psychiatric stabilization in a local hospital setting with a psychiatrist on staff working to stabilize an individual's symptoms and prepare them for maintaining continuity of care while transitioning to community-based services.

Service	Description
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, and provides psychiatric stabilization and participant training in courtroom skills and behavior.
Transitional Services (LOC-5)	Provides linkage between existing services, ongoing care, and temporary assistance to individuals post-crisis for up to 90 days. Individuals may be homeless, in need of substance use treatment or primary health care, involved in the criminal justice system, experiencing multiple psychiatric hospitalizations, and/or have a non-priority diagnosis.

Source: Texas Department of State Health Services. (2010). *Crisis services*. Word document retrieved from <https://www.dshs.texas.gov/mhsacsr/Mental-Health-and-Substance-Abuse-Crisis-Services-Redesign.pdf>

Texas Health and Human Services Commission. (2020). *Crisis units*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/mental-health-crisis-services/crisis-units>

and Texas Department of State Health Services. (2016). *Presentation to Select Committee on Mental Health: The behavioral health system* [PowerPoint slides]. Retrieved from <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/5fc9614b-41a4-436e-9eba-67b14f00ad22.PDF>

Utilization and Costs

The utilization and cost for residential and outpatient crisis mental health services are included in Table 34 and Table 35 below.

Table 34. Annual Utilization/Cost for Residential Crisis Services

	FY 2016	FY 2017	FY 2018	FY 2019
Persons Receiving Crisis Residential Services Per Year Funded by GR	22,051	24,400	25,315	24,480
Average GR Spent Per Person for Crisis Residential Services	\$2,886	\$2,862	\$2,294	\$2,220

Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

Table 35. Annual Utilization/Cost for Outpatient Crisis Services

	FY 2016	FY 2017	FY 2018	FY 2019
Persons Receiving Crisis Outpatient Services Per Year Funded by GR	82,124	84,606	92,561	97,207
Average GR Spent Per Person for Crisis Outpatient Services	\$522	\$568	\$376.75	\$438.50

Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

INDIVIDUALS CONSIDERED MEDICALLY INDIGENT

According to the Texas Health and Safety Code, a person is defined as medically indigent if they are under the following circumstances:

1. Possesses no property
2. Has no person legally responsible for their support
3. Is unable to reimburse the state for the costs of support, maintenance, and treatment.¹⁶⁰

Individuals who are deemed to be medically indigent are eligible to receive services through the public mental health system without the state receiving compensation or reimbursement for service, and cannot be denied services on their ability to pay.^{161,162}

Within the first 30 days of rendering mental health services, LMHA/LBHA staff (typically benefits coordinators or office managers) conduct a financial assessment of an individual's ability to pay for services and calculate a maximum monthly fee (or no fee) depending on the individual's gross income, family size, and extraordinary expenses paid in the last 12 months or expected in the next 12 months.¹⁶³

The County Indigent Health Care Program (CIHCP) was created by the Texas Legislature in 1985 and provides health care services to individuals who do not qualify for other state or federal health care programs. CIHCP provides health services through counties, hospital districts, and public hospitals to eligible residents who:

- Live in Texas;
- Have income at or below 21 percent of FPL;
- Have resources less than \$2,000; and
- Are not eligible for Medicaid.¹⁶⁴

For more information on CIHCP, please see <https://hhs.texas.gov/services/health/county-indigent-health-care-program>.

MENTAL HEALTH NEEDS OF AGING TEXANS

Texas is home to a large number of aging individuals. According to the Texas Demographic Center, in 2018 there were over 3.6 million people in Texas age 65 or older (12.6 percent of the total population).¹⁶⁵ Between 2010 and 2018, the 65 plus age category had the greatest increase (slightly more than one million) and grew at the fastest rate compared to the younger age groups.¹⁶⁶ By 2050, this population is expected to more than double, growing to more than 8 million.¹⁶⁷

Aging Texans require mental health and substance use services to meet their unique needs. People who are aging often have under-recognized and undertreated behavioral health conditions. Approximately 20 percent of the older population has some form of neurological or mental health condition, the most common including dementia, depression, anxiety, and substance use.¹⁶⁸ An estimated 1.4 to 4.8 percent of the over 49 million adults over the age of 65 in the United States have serious mental illness.¹⁶⁹ It's also estimated that two-thirds of these older adults with mental health conditions do not receive the services and support they need due to a lack of services focused on this age group.¹⁷⁰ The suicide rate among Texans 65 and older reached

almost 25 a day in 2018 in the United States, with people over 85 years old with the highest suicide rate of any age group.¹⁷¹

It is important to know that depression is not a normal part of aging.¹⁷² However, depression often co-occurs with other serious illnesses, such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.¹⁷³ Many health professionals mistakenly conclude that depression is a consequence of these problems, leaving the condition widely unrecognized and undertreated among older adults.¹⁷⁴

SUBSTANCE USE

The national opioid crisis has brought the dire need for an array of substance use supports and services to the forefront of behavioral health conversations. According to SAMHSA, in 2018 an estimated 20.3 million Americans aged 12 and older self-reported needing support for substance use in the past year.¹⁷⁵ SAMHSA also estimates that the impact of individuals not having ready access to supports and services cost the nation more than \$600 billion each year.¹⁷⁶

Prior to 2010, Medicaid reimbursement for substance use services in Texas was only available to individuals under the age of 21, and those benefits were limited in scope. In 2009, the 81st Texas Legislature directed HHSC to develop Medicaid state plan substance use condition benefits for adults. Implementation of these services began in 2010. Subsequently in 2015, the legislature directed HHSC to develop a methodology for evaluating the cost benefits of these services. The 85th Texas Legislature then directed HHSC to submit a report on the findings of the evaluation by December 1, 2017.¹⁷⁷

The December 2017 report showed that the average monthly Medicaid costs for individuals with a SUD diagnosis receiving SUD services (\$1,410) was lower than the average monthly cost for individuals with a SUD diagnosis (\$1,559) who did not receive treatment. The data also showed that people who received SUD services had a decrease in homelessness and arrests, two outcomes which often generate costs in other systems.¹⁷⁸ This report is available online at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/substance-abuse-disorder-treatment-nov-2017.pdf>.

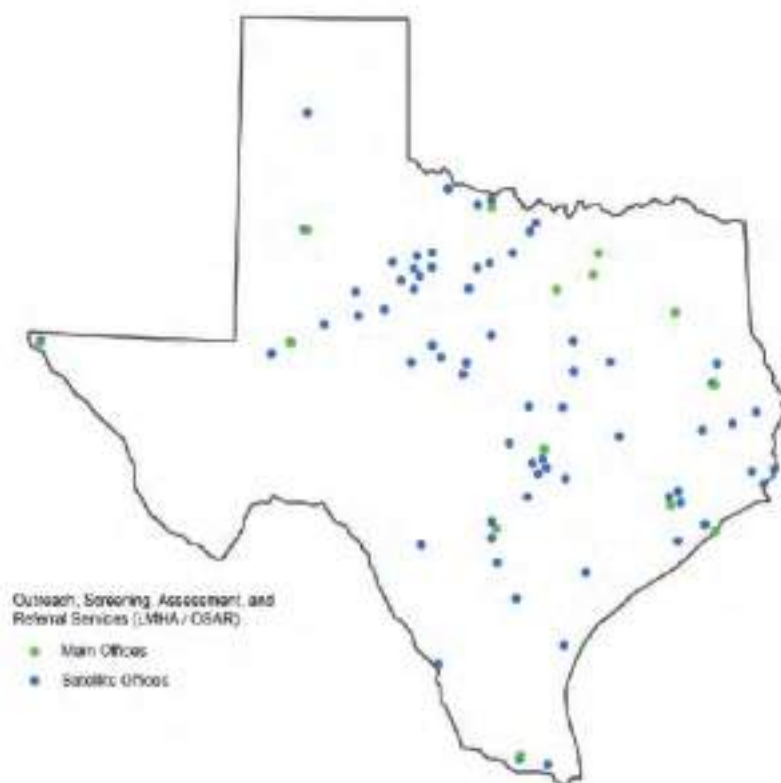
OUTREACH, SCREENING, ASSESSMENT, AND REFERRAL (OSAR)

OSAR providers are often the first point of contact and serve as the front door for those seeking substance use condition treatment service. As a result of SB 1507 (84th, Garcia/Naishtat), OSAR providers are responsible for substance use outreach, screenings, assessments, and referrals for substance use services free of charge and are now co-located within LMHAs/LBHAs across all of Texas.¹⁷⁹ While LMHAs are the only entities that can now act as OSAR providers, they are authorized to subcontract with substance use providers to provide OSAR services.^{180,181}

As of March 2020, there were 14 main OSAR offices, with at least one operating in each of the 11 Texas Health and Human Services regions.¹⁸² Figure 45 displays

the location of the OSARs across the state. OSARs serve approximately 30,000 individuals annually funded by approximately \$7 million per year.¹⁸³ OSARs are able to serve adults and adolescents. While many LMHAs attempted to address OSAR accessibility through satellite offices, there were some administrative and logistical challenges. For example, assessments and screenings often require appointments, offices are open for limited hours and days of the week, and services are available based on counselor availability.

Figure 45. OSAR Site locations across Texas



Source: Gaines, S. & Ramirez, L. (2018). *Presentation to the Senate Health and Human Services Committee on substance use disorder in Texas*. Texas Health and Human Services Commission. Retrieved from <https://hhs.texas.gov/reports/2018/03/presentation-senate-health-human-services-committee-substance-use-disorder-texas>

SUBSTANCE USE SERVICES

The HHS System provides substance use services for eligible youth and adults through contracts with service providers. These treatment services differ from OSAR services as they cover a continuum of care after receiving a screening, assessment, or referral and are not required to contract with the LMHAs. The HHSC Mental Health and Substance Use Division is responsible for creating and implementing policies regarding substance use services and defining optimal treatment outcomes. Table 36 highlights HHSC's non-Medicaid indigent substance use care programs across a continuum of care.¹⁸⁴ The varying treatment levels of care for adults and youth are outlined in Table 37.

Table 36. Major Substance Use Programs Within the Mental Health and Substance Use Division

Service Array	Program
Prevention	<ul style="list-style-type: none"> Youth Prevention Education Prevention Resource Centers Community Coalition Partnerships
Intervention	<ul style="list-style-type: none"> Outreach, Screening, Assessment and Referral Pregnant and Postpartum Intervention Parenting Awareness and Drug Risk Education Rural Border Initiative HIV Outreach HIV Early Intervention
Treatment	<ul style="list-style-type: none"> Adults: Detox, Residential, Outpatient, Specialized Women, Medication Assisted, Co-Occurring, HIV Residential Youth: Intensive Residential; Supportive Residential, Outpatient
Recovery	<ul style="list-style-type: none"> Recovery Support Services Peer Support and Peer Recovery Services
Initiatives	<ul style="list-style-type: none"> Neonatal Abstinence Syndrome Strategic Prevention Framework for Prescription Drugs Texas Targeted Opioid Response First Responders – Comprehensive Addiction Recovery Act Statewide Youth Treatment Implementation H.B. 13 Community Mental Health Grant Program S.B.292 Mental Health Grant Program for Justice-Involved Individuals

Source: Gaines, S. & Ramirez, L. (2018). *Presentation to the Senate Health and Human Services Committee on Substance Use Disorder in Texas*. Texas Health and Human Services Commission. Retrieved from <https://hhs.texas.gov/reports/2018/03/presentation-senate-health-human-services-committee-substance-use-disorder-texas>

Table 37. Available HHSC Substance Use Treatment Services

Substance Use Service	Description
Adult Services	
Detoxification	<p>Detoxification is a service that helps individuals withdraw from substances that require medical support in a safe and effective manner.</p> <p>Eligibility</p> <ul style="list-style-type: none"> Texas residents 18 years and older Physically dependent or withdrawing from alcohol or other drugs. Financial eligibility is based on income and expenses, and the consumer may need to pay for some services <p>Detoxification services include counseling, education, case management, and referrals to treatment and other community services. There are two types of detoxification:</p> <ul style="list-style-type: none"> Ambulatory (requires travel to a licensed site daily to receive medication) Residential (individuals live at the licensed site that has 24-hour monitoring)

Residential	<p>Intensive Residential</p> <p>Individuals in an intensive residential level of care for substance use conditions receive services while living in licensed facilities for a specific period of time. Treatment includes counseling, case management, education, and skills training. Intensive residential treatment provides at least 30 hours of intensive services per week.</p> <p><i>Eligibility</i></p> <ul style="list-style-type: none">• Texas residents 18 years and older• A moderate or severe substance use condition diagnosis• Financial eligibility is based on income and expenses, and the individual may need to pay for some services <p>Supportive Residential</p> <p>Individuals in a supportive residential level of care stay at a licensed treatment center, but are allowed to leave and seek employment or job training. Treatment includes counseling, case management, education, and skills training. Supportive residential services are delivered at least six hours per week.</p> <p><i>Eligibility</i></p> <ul style="list-style-type: none">• Texas residents 18 years and older• A moderate or severe substance use condition diagnosis• Financial eligibility is based on income and expenses, and the consumer may need to pay for some services <p>HIV Residential</p> <p>The Texas HIV residential treatment program has specialized services for those diagnosed with HIV and a substance use condition. This statewide program helps an individual understand how HIV works and provides medical care and treatment for substance use conditions.</p> <p><i>Eligibility</i></p> <ul style="list-style-type: none">• Texas residents 18 years and older• A substance use condition diagnosis and HIV positive• Financial eligibility is based on income and expenses, and the consumer may need to pay for some services <p>Women and Children</p> <p>Women and Children Residential Treatment provides substance use treatment services for women in a licensed residential facility whose children are allowed to live with them. The services include counseling, parenting education, health education, skills training, and case management services.</p> <p><i>Eligibility:</i></p> <ul style="list-style-type: none">• Texas women 18 years and older• A moderate or severe substance use condition diagnosis• Are in at least their third trimester of their pregnancy or• Have dependent children who can attend treatment; or• Have children in custody of the state, if the children are allowed to enter treatment with the mother• Financial eligibility is based on income and expenses, and individuals may need to pay for some services
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Outpatient	<p>Individuals receiving services in an outpatient treatment level of care are determined by a clinician to not require residential care to maintain sobriety. Outpatient treatment services offer an array of services individualized including counseling, education, and support services.</p> <p><i>Eligibility</i></p> <ul style="list-style-type: none"> • Texas residents 18 years and older • A substance use condition diagnosis • Financial eligibility is based on income and expenses, and the consumer may need to pay for some services
Medication Assisted Therapy	<p>Medication-assisted treatment (MAT) is the use of prescribed medications in combination with counseling. MAT works by reducing psychological and physical withdrawal symptoms and provides help with recovery.</p> <p><i>Eligibility</i></p> <ul style="list-style-type: none"> • Texas residents 18 years and older • A moderate to severe opioid use condition diagnosis for at least 12 months in a row • Financial eligibility is based on income and expenses, and the consumer may need to pay for some services <p><i>Available medications include:</i></p> <ul style="list-style-type: none"> • Buprenorphine • Methadone • Naltrexone
Co-occurring Psychiatric and Substance Use	<p>Co-occurring services coordinate resources and care between mental health and substance use professionals or agencies.</p> <p>Participants go through a clinical screening process that considers several aspects of an individual's situation to be eligible for co-occurring services. Financial eligibility for the services is based on income and expenses and may require an individual to pay for some services.</p>
Youth Services	
<p>Texas residents ages 13 to 17 with a substance use condition diagnosis are eligible for treatment. The severity of the youth's condition determines treatment based on the DSM-V, a clinician's assessment, and medical necessity.</p> <p>Young adults 18 to 21 may be admitted to a youth treatment program if screening shows the person's needs, experiences, and behavior are similar to those of youth clients.</p> <p><i>Eligibility:</i></p> <ul style="list-style-type: none"> • Texas residents who: • Are ages 13 to 17 • A substance use condition diagnosis • Meet financial eligibility condition requirements 	

Prevention programs	<p>Youth and their families participate in youth prevention activities in schools and community sites. Activities are conducted by trained professionals and carried out or monitored by certified prevention specialists.</p> <p>Services are delivered to the following priority populations and their families:</p> <ul style="list-style-type: none">• Youth prevention universal is offered to young people in general. There are no special requirements.• Youth prevention selective is offered to young people who may be at higher than average risk for substance misuse.• Youth prevention indicated is offered to young people who face certain challenges – such as truancy, failing grades or experimental substance misuse – and could use extra support.• More information about these prevention programs can be found below in the School and Community Based Prevention section. <p><i>Eligibility:</i></p> <ul style="list-style-type: none">• Youth Prevention: youth in grades K-12• Families of youth participating in youth prevention programs
Residential Treatment Services	<p>Intensive residential Delivered at least 45 hours per week in a dormitory-like environment during the treatment process, licensed facilities provide residential treatment to youth ages 13-17 years with a substance use condition diagnosis and help them learn skills for recovery. Treatment includes counseling, case management, education, and skills training.</p> <p>Supportive residential Delivered at least 21 hours per week in a dormitory-like environment during the treatment process, licensed facilities provide supportive residential treatment to youth ages 13-17 years with a substance use condition diagnosis and help them learn skills for recovery. Treatment includes counseling, case management, education, and skills training.</p>
Outpatient Services and Supports	<p>Delivered at least 15 hours per week in a community setting, outpatient services are for youth who are determined not to need a highly structured environment and can live at home. Treatment includes counseling, case management, education, and skills training.</p>

Sources: Gaines, S. & Ramirez, L. (2018). *Presentation to the Senate Health and Human Services Committee on Substance Use Disorder in Texas*. Texas Health and Human Services Commission. Retrieved from <https://hhs.texas.gov/reports/2018/03/presentation-senate-health-human-services-committee-substance-use-disorder-texas>

Texas Health and Human Services Commission. (n.d.). *Adult substance use detoxification services*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-detoxification-services>

Texas Health and Human Services Commission. (n.d.). *Adult substance use intensive residential treatment*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-intensive-residential-treatment>

Texas Health and Human Services Commission. (n.d.). *Adult substance use HIV services*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/hiv-services>

Texas Health and Human Services Commission. (n.d.). *Adult substance use women & children in residential treatment*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-women-children-residential-treatment>

Texas Health and Human Services Commission. (n.d.). *Adult substance use outpatient program*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-outpatient-program>

Texas Health and Human Services Commission. (n.d.). *Adult substance use medication-assisted treatment*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/>

Texas Health and Human Services Commission. (n.d.). *Co-occurring psychiatric & substance use disorder*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/co-occurring-psychiatric-substance-use-disorder>

Texas Health and Human Services Commission. (n.d.). *Youth substance use*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/youth-substance-use>

Texas Health and Human Services Commission. (n.d.). *Youth substance use prevention programs*. Retrieved from <https://hhs.texas.gov/services/mental-health-substance-use/youth-substance-use/youth-substance-use-prevention-programs>

Co-occurring Mental Health and Substance Use Conditions

Many individuals experience mental health and substance use concerns simultaneously. According to SAMHSA, in 2018 across the United States:

- 47.6 million adults received a mental health diagnosis;
- 5.9 million adolescents received a mental health diagnosis;
- 20.3 million adults received a substance use diagnosis;
- 916,000 adolescents received a substance use diagnosis;
- 12.4 million adults received both a mental health and substance use diagnosis; and 358,000 youth a mental health and substance use diagnosis¹⁸⁵

Individuals living with mental health conditions are more likely than those without to have a co-occurring substance use condition.¹⁸⁶ Often someone with a mental health condition who is not engaged in any supports or treatment may “self-medicate” with alcohol or drugs, which can lead to misuse and ultimately a substance use condition. Integrating physical and behavioral health care is the best way to ensure that any co-occurring conditions are addressed. Additionally, early detection, intervention, and treatment offer the best potential for positive outcomes and recovery.

State agencies and organizations are increasingly using the term “behavioral health” in place of “mental health” to more accurately represent the co-occurrence of mental health and substance use conditions. In an effort to improve integrated care, there has also been increased focus on how LMHAs can better integrate substance use services with the mental health services typically provided by LMHAs/LBHAs. The Texas program aimed at addressing co-occurring mental health and substance use conditions is the Co-Occurring Psychiatric and Substance Use Disorders Services, or COPSD. These programs emphasize the need to address both conditions as simultaneous, primary conditions. As of September 2020, HHSC was reviewing substance use treatment standards of care rules in the Texas Administration Code Title 25, Chapter 448 to address barriers in licensing that prevent facilities’ ability to provide integrated COPSD Treatment.

SUBSTANCE USE FUNDING

The level of public funding for substance use services is not sufficient to address need, creating significant barriers to treatment. In Texas, substance use treatment

is funded through a variety of sources, including health insurance, self-pay, federal grants including the Substance Abuse Prevention and Treatment (SAPT) Block Grant, state general revenue, Medicaid (if applicable), and federal funds through 1115 waiver projects. A large amount of federal funds awarded to states are to be used to address opioid use known at State Opioid Response (SOR) and State Targeted Response (STR) grants. In Texas, these dollars are collectively awarded through the Texas Targeted Opioid Response (TTOR). For a more in-depth overview of substance use funding, please refer to the **Funding section** of this guide.

Per HHSC, federal funds account for 73 percent of total HHSC funding for substance use prevention, intervention, treatment, and recovery in Texas– while 27 percent comes from state general revenue.¹⁸⁷ Table 38 shows All Funds funding trends allocated to substance use over the last three budget cycles.

Table 38. All Funds Funding Trends for Substance Use Services

	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
Substance Abuse Prev/ Intervention/Treatment	\$325,110,656	\$380,160,933	\$464,363,294

*Note: This was before the Health and Human Services System Transformation and consolidation of state agencies, and was under DSHS.

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

Block Grant Priority Populations

Federally, SAMHSA identifies populations that receive priority for admission for substance use services before anyone else, in the following order of priority:

- 1. Pregnant women who use substances intravenously (must be admitted immediately)
- 2. Other pregnant women (must be admitted immediately)
- 3. Individuals using substances intravenously (must be admitted within 14 days)¹⁸⁸

Additionally, Texas has identified two additional priority populations (must be admitted within 72 hours):

- 4. Individuals identified as high risk of overdose
- 5. Individuals referred by Department of Family and Protective Services (DFPS)¹⁸⁹

UTILIZATION AND COSTS

The following two figures show the yearly utilization and costs of substance use services; Table 39 details information for adults and Table 40 is for youth.

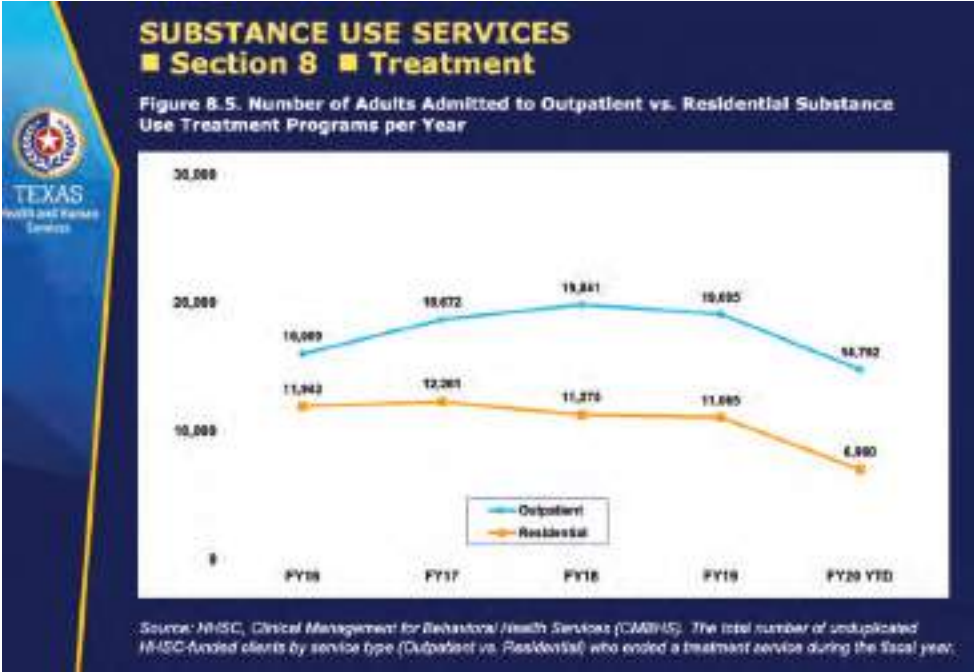
Table 39. Utilization and Costs for Adult Substance Use Services per Year

		FY 2017	FY 2018	FY 2019
Prevention programs	# Adults Served	535,584	573,401	511,711
	Cost per Adult	\$24	\$24	\$25
Intervention programs	# Adults Served	130,300	151,007	128,492
	Cost per Adult	\$164	\$162	\$210
Treatment programs	# Adults Served	36,796	38,496	38,214
	Cost per Adult	\$1,830	\$2,036	\$2,154

Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

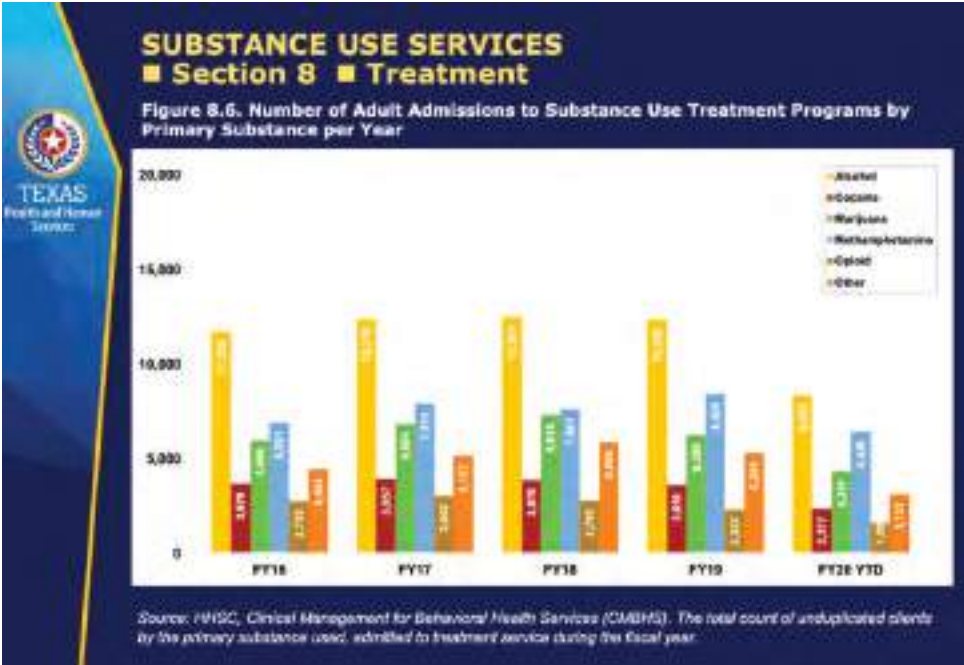
Figure 46 and Figure 47 further details treatment program admissions for adults; Figure 48 and Figure 49 details this information for youth.

Figure 46. Adult Outpatient and Residential Substance Use Treatment Program Admissions per Year



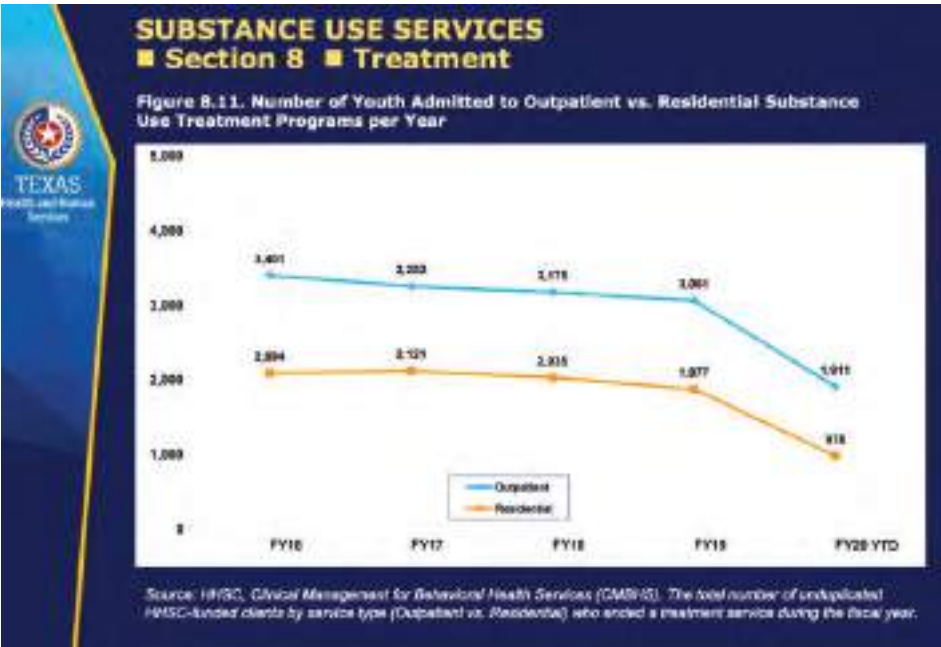
Source: Texas Health and Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

Figure 47. Adult Admissions to Substance Use Treatment Programs by Primary Substance per Year



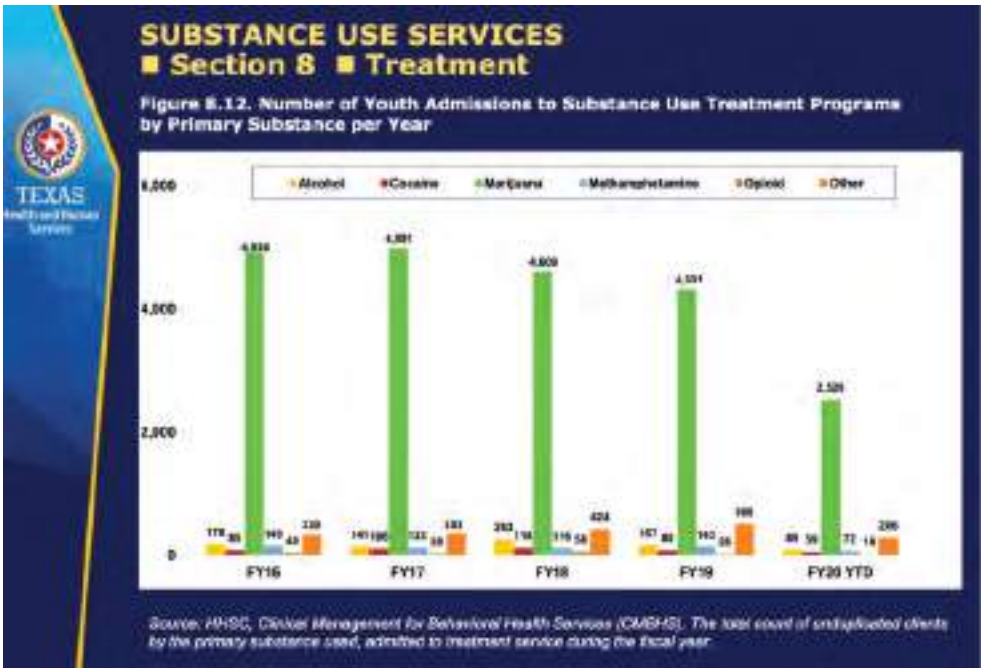
Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

Figure 48. Youth Outpatient and Residential Substance Use Treatment Program Admissions per Year



Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

Figure 49. Youth Admissions to Substance Use Treatment Programs by Primary Substance per Year



Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

Table 40. Utilization and Costs for Child & Adolescent Substance Use Services per Year

		FY 2017	FY 2018	FY 2019
Prevention programs	# Youth Served	1,681,045	1,762,885	1,676,191
	Cost per Youth	\$17	\$17	\$19
Intervention programs	# Youth Served	22,827	24,113	20,500
	Cost per Youth	\$369	\$329	\$445
Treatment programs	# Youth Served	4,631	4,599	4,407
	Cost per Youth	\$3,190	\$3,152	\$3,060

Source: Texas Health and Human Services Commission. (2020). *IDD-BHS data book*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/idd-bhs-data-book.pdf>

QUALITY OF CARE MEASURES

HHSC monitors quality and performance in several areas based on the Texas Resilience and Recovery framework. More information on the TRR Framework is available under the Community Mental Health Services section. Table 41 shows some of the measures tracked on a regular basis for adult substance use services and Table 42 shows the same for youth services.

Table 41. Selected Quality of Care Measures for Adult Substance Use Services (2014-2019)

Adults Entering a Substance Use Treatment Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Percentage completing a program per year	52%	49%	53%	47%	48%	52.4%	52.9%
Percentage completing a program who report abstinence at discharge	90%	91%	92%	94%	92%	93%	95.4%
Percentage of those unemployed completing a program who have gainful employment at discharge	59%	58%	51%	58%	54%	58%	49.8%
Percentage completing a program not arrested	100%	100%	100%	100%	100%	98.6%	99.1%

Sources: Texas [Health](#) and Human Services Commission. Data request. Received 8/15/18.
Texas Health and Human Services Commission. FY 18-19 Data Request. Data request May 20,2020. Data received from Sonja Gaines.

Table 42. Selected Quality of Care Measures for Youth Substance Use Services

Youth Entering a Substance Use Treatment Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Percentage completing substance use treatment programs per year	52%	44%	51%	55%	50%	55.8%	51.5%
Percentage completing substance use treatment programs reporting abstinence at discharge	90%	89%	91%	91%	92%	94.1%	94.3%
Percentage completing substance use treatment programs with positive school status at follow-up per year	75%	75%	78%	77%	74%	80.8%	84%
Percentage completing substance use treatment programs not arrested	99%	99%	99%	99%	100%	97.5%	98.5%

Sources: Texas [Health](#) and Human Services Commission. Data request. Received 8/15/18.
Texas Health and Human Services Commission. FY 18-19 Data Request. Data request May 20,2020. Data received from Sonja Gaines.

RECOVERY HOUSING

Recovery housing is one evidence-based resource that empowers individuals to achieve and maintain a life in recovery from substance use conditions. Recovery housing is a shared living environment that promotes sustained recovery from substance use. Recovery houses allow for integration into the surrounding community and provides a setting that: connects residents to supports and services, is centered on peer support, and is free from substance use. Individuals living in recovery housing have a greater chance of achieving long-term recovery than those who do not live in recovery-oriented environments.¹⁹⁰ Living in recovery housing has been associated with positive outcomes including decreased substance use, reduced probability of relapse/reoccurrence, and lower rates of incarceration.¹⁹¹

Because federal disability policy within the Social Security Code does not classify substance use condition as a disability, people with substance use condition are ineligible for many benefits available to people with serious mental illness or other disabilities, including: income, employment, and housing benefits. Further, individuals in recovery from substance use conditions cannot access Medicaid coverage through the Aged, Blind, and Disabled category, the Project Access Program, disability income, vocational rehabilitation services, or Section 8 rental assistance.¹⁹² The federal definition of disability per Section 223 of the Social Security Code, specifically excludes substance use, stating “an individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would be a contributing factor material to the Commissioner’s determination that the individual is disabled.”¹⁹³

Identified through Gap #12 in the Texas Statewide Behavioral Health Strategic Plan, access to housing is a critical issue across the state, but more so for those with

substance use conditions in our public behavioral health system.

Distinguished by the National Association of Recovery Residences (NARR), there are four widely accepted and defined levels of recovery housing:

- Level I – Run democratically, peer-ran, and self-sufficient with typical open length of stay
- Level II – Level I with a house manager or senior resident who is responsible for oversight
- Level III – Structured or semi-structured with paid staff, like certified staff or case managers
- Level IV – Inclusive of clinical services or residential treatment centers with credentialed staff¹⁹⁴

A resource for more information on specific standards of each level can be found at <https://narronline.org/wp-content/uploads/2014/02/NARR-Standards-20110920.pdf>

Oxford House, Inc.

The Oxford House program is a democratically operated, peer-run recovery model intended to be self-supporting after an initial start-up investment. Residents are expected to contribute to rent and expenses during their stay in order to be self-sustaining. HHSC reports that 62 percent of Oxford House residents have previously experienced homelessness.¹⁹⁵ As of July 2020, there were 288 Oxford Houses in Texas operating at approximately 81 percent capacity across 22 counties, with 407 of the 2,159 beds vacant.¹⁹⁶ Of the 288 houses, 174 were specified homes for men, 8 allowed children, and 103 for women, with 37 of those homes allowing children¹⁹⁷

In 2020, Oxford House, Inc. was the sole-entity receiving any state funding for recovery housing in Texas. Oxford House, Inc. administers start-up loans from the state funds to individuals who are interested in starting an Oxford House (Level I). To qualify for residency, individuals must contribute to rent and expenses and the daily functions of the household, as well as remain sober from alcohol and drugs. However, individuals are not provided any additional supports. Other level II, III, and IV recovery homes that offer more intensive services are available in Texas but remain less common. Often, individuals complete a residential or detoxification program prior to residency. Individuals who have financial barriers and who have completed an HHSC-funded program are eligible for stipends to offset move-in fees.

Other recovery housing data is not collected across the state for homes that are provided through the private sector, or public-private partnerships. During the 86th legislative session, HB 1465 (Moody/Menendez) was filed to study and evaluate recovery housing. The study would have required details on the current status, opportunities, challenges, and needs of recovery housing throughout the state. While passed in the House, HB 1465 was unable to pass the Senate before the conclusion of the legislative session. Without legislative direction, HHSC distributed a housing survey in May 2020 to collect data on the housing needs of people with mental health conditions, substance use histories and/or intellectual and developmental disabilities to create a Texas Housing Choice Plan.

RECOVERY SUPPORT SERVICES

In 2010, Texas began to shift from addressing substance use conditions with an acute care model and instead focus on recovery. HHSC established a series of local community networks to collaborate in identifying strengths and obstacles for individuals in recovery, and to improve the local environment to support recovery. These local Recovery-Oriented Systems of Care (ROSCs) were the framework for a long-term systems transformation. Beginning with an initial effort in Houston, HHSC facilitated meetings to organize and support ROSCs in communities throughout Texas. Currently there are 22 ROSCs operating across the state. The Houston ROSC was planned and supported by HHSC and the University of Texas Addiction Research Institute (ARI), and has served as a model for other sites across Texas. A report of this initial Houston ROSC effort may be found at <https://socialwork.utexas.edu/dl/files/cswr/institutes/ari/pdf/Houston-ROSC-Phase-I.pdf>

Recovery Support Service (RSS) Project¹⁹⁸

In 2014, HHSC continued the transition to a recovery-focused system by issuing an RFA to provide recovery support services to individuals across the state. The RFA was open to SUD treatment organizations (TOs), peer-run Recovery Community Organizations (RCOs), and other community-based organizations (CBOs) that have a history of providing SUD services to individuals and family members. The result was a network of 22 recovery support service organizations (RSSOs), collectively known as the Recovery Support Services (RSS) Project.

RSSOs deliver a wide array of non-clinical, peer-provided services to help individuals initiate, support, and maintain recovery. Services are provided by peers, including peer support specialists and peer recovery coaches, that help initiate services like counseling, sober housing, transportation and medications. Individuals with a history of substance use or abuse, including co-occurring mental health conditions, who are in or seeking recovery, along with their family members and significant others are eligible to receive recovery support services at an RSSO.¹⁹⁹

One of the key elements in the project was the recruitment and utilization of peer recovery coaches. Services also include peer-run groups; development and/or use of recovery homes and recovery schools; life skills training such as financial management, parenting, employment and stress management; educational support; recovery check-ups; and connections to mutual aid support groups. HHSC contracted with the Addiction Research Institute at the Steve Hicks School of Social Work at UT to evaluate the RSS Project from May 2014-July 2018. The number of services provided by the 22 RSSOs are shown through Figure 50, Figure 51, Figure 52, and Figure 53. The full report can be found at <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2018.pdf>

Figure 50. RSS Participants Served, May 2014-July 2018

	CBO	RCO	TO	STATEWIDE
Participants Served - Unduplicated				
Direct Recovery Support Services	10118	2037	34053	46208
Educational Services	7420	751	21591	29762
Indirect Recovery Support Services	3645	1136	15997	20778
Participants Served - Duplicated				
Direct Recovery Support Services	27614	4860	82043	114517
Educational Services	17398	1287	42804	61489
Indirect Recovery Support Services	8458	2684	28558	39700

Source: Mangrum, L., Spence, R., Nichols M., & Petersen, C. (2018). *HHSC contract no. 2017-049621-001, recovery support services project, fiscal year 2018 interim process evaluation report*. The University of Texas Steve Hick School of Social Work, Addiction Research Institute: Austin, TX. Retrieved from <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2018.pdf>

Figure 51. Type of Direct Recovery Support Services Provided, May 2014-July 2018

	CBO	RCO	TO	STATEWIDE
Recovery Support Groups	3864	1876	18039	23779
Face-to-Face Recovery Coaching	5352	704	17202	23258
Telephone Recovery Coaching	2126	228	7365	9719
Traveling Companion Recovery Coaching	349	49	3116	3514
Internet Recovery Coaching	241	0	2208	2449

*Participants may be counted in more than one service category.

Source: Mangrum, L., Spence, R., Nichols M., & Petersen, C. (2018). *HHSC contract no. 2017-049621-001, recovery support services project, fiscal year 2018 interim process evaluation report*. The University of Texas Steve Hick School of Social Work, Addiction Research Institute: Austin, TX. Retrieved from <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2018.pdf>

Figure 52. Education Services by Service Type Provided, May 2014-July 2018

	CBO	RCO	TO	STATEWIDE
Recovery	3065	395	11860	15320
Life Skills	3456	139	5609	9204
Alcohol/Drug	1062	85	7255	8402
Other	396	32	2617	3045
Employment	515	28	1594	2137
Volunteer Services	178	222	528	928
Computer Skills	112	32	404	548
GED Preparation	28	0	286	314

*Participants may be counted in more than one service category.

Source: Mangrum, L., Spence, R., Nichols M., &Petersen, C. (2018). *HHSC contract no. 2017-049621-001, recovery support services project, fiscal year 2018 interim process evaluation report*. The University of Texas Steve Hick School of Social Work, Addiction Research Institute: Austin, TX. Retrieved from <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2018.pdf>

Figure 53. Indirect Recovery Support Services by Service Type Provided, May 2014-July 2018

	CBO	RCO	TO	STATEWIDE
Community-Wide Events	6519	2945	26576	36040
Alcohol and Drug Free Social Activities	1316	271	5716	7303
Transportation	743	419	3700	4862
Health and Wellness Supports	1021	497	2565	4083
Career/Clothing Closet	236	495	2517	3248
Housing	379	111	1901	2391
Other	456	96	1729	2281
Community Service Projects	102	17	1076	1195
Financial Assistance/Family Needs	196	73	721	990
Food Pantry	130	47	635	812
Mental Health/Co-Occurring Peer Services	217	71	480	768
Child Care	86	2	332	420
Veteran's Services	6	7	165	178

Participants may be counted in more than one service category.

Source: Mangrum, L., Spence, R., Nichols M., &Petersen, C. (2018). *HHSC contract no. 2017-049621-001, recovery support services project, fiscal year 2018 interim process evaluation report*. The University of Texas Steve Hick School of Social Work, Addiction Research Institute: Austin, TX. Retrieved from <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2018.pdf>

As of May 2020, 21 RSSOs continue to operate across the state of Texas. HHSC provides a list of the RSSOs in Texas that can be accessed at <https://>

hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/adult-substance-use-recovery-support-service-organizations

Recovery Support Peer Services

Recovery coaches are an integral part of recovery support services for someone in recovery. After the passage of HB 1486 (85th, Price/Schwertner), services offered by certified recovery support peers became eligible for Medicaid reimbursement. As of August 2020, there were 246 certified recovery coaches across the state.

In Texas, one long-term study focusing on substance use condition peer specialists in Texas, also called recovery coaches, demonstrated exciting results at 12 months:

- Housing status improved, with 54 percent of long-term coaching participants owning or renting their own living quarters after 12 months, compared to 32 percent at enrollment.
- Overall employment increased to 58 percent after 12 months from 24 percent at enrollment.
- Average wages increased to \$879 per month after 12 months from \$252 at enrollment.
- Healthcare utilization dropped after 12 months of recovery coaching:
 - Outpatient visits dropped to 815 visits from 4,118 at enrollment
 - Inpatient care days dropped to 1117 days from 9,082 at enrollment
 - Emergency room visits dropped to 146 from 426 at enrollment²⁰⁰

In total, recovery coaching saved \$3,422,632 in healthcare costs, representing a 72 percent reduction in costs over 12 months.²⁰¹

HHSC provides information on peer support services, the certification process, and benefits of peer supports which can be found at <https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/peer-support-services>

Additional information on peer services in Texas can be found in the Policy Environment Section.

SCHOOL AND COMMUNITY BASED PREVENTION

School and community-based substance use prevention programs are funded through HHSC's Medical and Social Services Division-Behavioral Health Services section. HHSC currently funds 225 programs statewide to address the state's four prevention priorities: underage alcohol use, underage tobacco and nicotine products use, marijuana and other cannabinoid use, prescription drug misuse, and the use and misuse of other drugs and substances. The following description of available programs was captured from the HHSC website: <https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/behavioral-health-services/substance-use-misuse-prevention>

Substance Use and Misuse Prevention

Community Coalition Partnerships - Programs that work in the community to engage and mobilize various sectors to implement evidence-based environmental strategies with a primary focus on changing policies and influencing social norms related to substance use and misuse.

Prevention Resource Centers – Centers work to increase the capacity of the statewide substance use and misuse prevention system by enhancing community collaboration, increasing community awareness and readiness, providing information and resources on substance use and related behavioral health data, supporting professional development of the prevention workforce, and providing resources for evaluation activities within each service region. Prevention Resource Centers also support the federal Synar requirement by conducting voluntary tobacco retail compliance checks throughout the state to help reduce youth access to tobacco and other nicotine products.

Youth Prevention Indicated – Provide strategies and interventions aimed to address people with initiative behaviors and related risk factors with an elevated risk for substance use and misuse. While the target population might show early signs of substance use and misuse, indicated services are not designed for people with a diagnosable substance use condition.

Youth Prevention Selective – Provide strategies and interventions that address specific subgroups of the general population known to have risk factors that increase the likelihood of substance use and misuse.

Youth Prevention Universal – Provide strategies and interventions that address the general public or a segment of the entire population with average probability of developing a substance use condition, risk or condition.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SERVICES

The Intellectual and Developmental Disabilities Services division oversees intellectual and developmental disability services provided by Local Intellectual and Developmental Disability Authorities (LIDDAs).²⁰² Prior to the HHS system transformation required by the 2015 legislature, IDD services were located within the Department of Aging and Disability Services (DADS). DADS functions moved to HHSC and the Texas Workforce Commission (TWC) and the agency dissolved.

MENTAL HEALTH NEEDS OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Intellectual and developmental disabilities (IDD) 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 their disability can misinterpret behaviors that may be associated with mental health conditions, distress, acute medical conditions, or trauma.

Many systems of care for people with IDD continue to focus on controlling and managing behaviors without considering whether underlying mental health conditions, medical conditions, or trauma cause the behaviors. 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. Often, the first line of “treatment” is psychopharmacological; psychotropic drugs are frequently used to control behaviors, which may address the symptoms but not the illness.²⁰³ Psychotropic medications also have the potential to exacerbate existing challenges, which significantly reduces opportunities for recovery.

Individuals with disabilities can experience all 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. People with IDD frequently experience trauma, yet rarely are systems, programs, or policies for people with IDD developed based on recovery and trauma-informed principles. Further, goals and objectives of state agency and healthcare systems rarely address or promote a focus on mental wellness. The mental health needs of people with intellectual disabilities are routinely overlooked in the research and these individuals often do not receive quality mental health treatment.²⁰⁴

Further, while HHSC has integrated recovery-focused interventions into its mental health system, the HHS enterprise has not yet incorporated the principles of recovery into the service provision culture for individuals with IDD. Individuals with IDD and older adults who have mental health conditions can benefit from recovery-focused interventions that are embedded in a culture of hope and resilience.

PREVALENCE OF MENTAL HEALTH CONDITIONS FOR PEOPLE WITH DISABILITIES

The coexistence of an intellectual or developmental disability along with a mental health condition is one type of dual diagnosis. Persons with IDD often experience dual diagnoses at higher rates than the general public.²⁰⁵ As many as 30 to 40 percent of individuals with intellectual disabilities are diagnosed with mental health conditions, and they are three to five times more likely to have a dual diagnosis with a psychiatric disability.^{206,207} Individuals with IDD who have a dual diagnosis or who present behavioral “challenges” are more likely to be institutionalized and are often the last to be released to a community-based setting.²⁰⁸ Additionally, community services and supports are frequently incapable of meeting the behavioral health

needs of these individuals, leading to less successful outcomes when transitioning into the community.²⁰⁹

Children with IDD are more likely to have experienced traumatic events including emotional, physical, or sexual abuse, neglect, and maltreatment when compared to able-bodied peers.²¹⁰ While many individuals with IDD have known histories of abuse (some research suggesting nearly 30 percent), the rate may be higher because of underreporting or lack of recognition by family and other caregivers.²¹¹

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 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.²¹²

The higher prevalence of mental health conditions among people with disabilities may also be linked to psychological stress related to a disability, social isolation, trauma, institutionalization, bullying, low self-esteem, and other factors.^{213, 214}

CHANGING THE PARADIGM

The conversation continues to shift from simply trying to “manage” behaviors to prioritize, recognize and address the mental health and trauma needs of individuals with IDD. The Hogg Foundation for Mental Health partnered with the National Child Traumatic Stress Network to develop *The Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma*. This is a two-day, training curriculum and toolkit that is available free of charge online. The Hogg Foundation previously funded a three-year grant to provide the training statewide. A current grant awarded to the Center for Disability Studies at the University of Texas at Austin will develop “master trainers” to ensure that the training is available statewide. The toolkit is available on the NCTSN website at <https://learn.nctsn.org/enrol/index.php?id=370>. Registration and login are required, but the product is available to the public.

HHSC has begun to recognize the importance of addressing the mental health needs of individuals with IDD. Two web-based training series have been developed and are offered free of charge online. The series, *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD)*, includes a series of six modules for direct service workers and a series of three modules for healthcare professionals. All modules are available at <http://training.mhw-idd.uthscsa.edu/>.

The course for direct service workers consists of the following six modules:

- Co-occurring conditions: Intellectual and Developmental Disabilities and Mental Illness
- Trauma Informed Care for Individuals with IDD
- Functional Behavioral Assessment and Behavior Support
- Overview of Genetic Syndromes Associated with IDD

- Overview of Other Medical Diagnoses Associated with IDD
- Putting it all Together: Supports and Strategies for Direct Service Workers

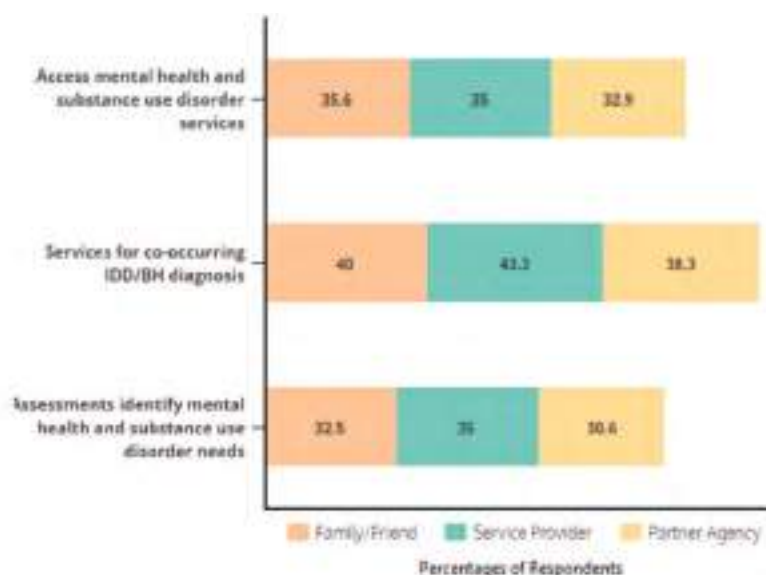
The series for healthcare professionals includes:

- Integrated Healthcare for Individuals with Intellectual and Developmental Disabilities
- Communicating with Individuals with Intellectual and Developmental Disabilities
- Trauma-Informed Care for Clinical Providers

STATEWIDE IDD STRATEGIC PLAN

HHSC worked with stakeholders across Texas and identified a need to develop a comprehensive Statewide IDD Strategic Plan, given the unique challenges faced by people with IDD across the state’s human services systems. A *Foundation of the Statewide IDD Strategic Plan* was developed alongside the second edition of the Texas Statewide Behavioral Health Strategic Plan. The *Foundation of the Statewide IDD Strategic Plan* is the first phase in order to lay the groundwork for the full plan and includes an overview of the IDD population in Texas; statewide IDD gap survey results; and an IDD program inventory. Through the gap survey, behavioral health services were identified. Figure 54 shows the largest gap identified was enhanced services and service coordination when an individual has co-occurring IDD and behavioral health concerns.²¹⁵ The Statewide IDD Strategic Plan is expected to be finalized by late 2020.

Figure 54. Gaps in Behavioral Health Services



Source: Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES WHO HAVE CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS

Prior to the 86th legislative session, HHSC identified that providing coordinated behavioral health care for individuals with disabilities was an important initiative for the state in their legislative appropriations request. HHSC requested an exceptional item for funding the establishment of new IDD community outpatient mental health services at local intellectual/developmental disability authorities (LIDDAs) to provide integrated physical and behavioral health services for people with IDD. Only a small fraction of the commission’s legislative exceptional item request to fund these community mental health services for individuals with IDD was actually funded.

Long-term Services and Supports (LTSS) programs serve populations that are aging, have physical disabilities, and have IDD, 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.

Long-term Services and Supports Funding

Funding for LTSS programs and services comes from both the federal and state governments. These figures include funding for an array of LTSS services, both community-based and institutional care, and are not limited to funding for mental health services.

Table 43. LTSS Funding Trends and Requests

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
Day Activity & Health Services	\$9,083,658	\$8,130,528	\$8,872,746	\$9,123,267	\$9,393,590
Nursing Facility Payments	\$281,393,474	\$242,118,593	\$322,787,787	\$317,279,079	\$316,673,611
Medicare Skilled Nursing Facility	\$55,258,698	\$37,500,935	\$54,602,673	\$53,542,560	\$54,020,171
Hospice	\$248,441,636	\$229,147,835	\$269,311,743	\$276,958,763	\$280,652,492
Intermediate care Facilities – IDD	\$256,016,951	\$282,128,616	\$260,278,862	\$259,984,727	\$260,313,984
Home and Community-based Services	\$1,102,175,534	\$1,070,740,677	\$1,137,810,107	\$1,140,285,551	\$1,140,161,616
Community Living Assistance	\$265,860,600	\$264,651,917	\$281,987,530	\$282,216,735	\$281,963,460
Deaf-Blind Multiple Disabilities	\$13,362,419	\$12,137,020	\$14,381,918	\$14,355,801	\$14,357,532

Texas Home Living Waiver	\$121,720,554	\$106,942,647	\$118,855,251	\$119,608,072	\$119,452,116
All-Inclusive Care – Elderly (PACE)	\$41,085,792	\$43,581,641	\$44,802,940	\$44,841,243	\$44,841,336
Medically Dependent Children's Program	\$41,343,421	0	0	0	0
State Supported Living Centers	0	\$694,036,425	\$688,787,866	\$694,036,429	\$694,036,429
Total	\$2,435,742,737	\$2,991,116,834	\$3,202,479,423	\$3,212,232,227	\$3,215,866,337

Source Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*.

Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

Note: The funding reflected in this table is included in the total Medicaid appropriation provided in the Medicaid section. Note: Data on costs for behavioral health services in these programs is unavailable.

In addition to Medicaid and Medicaid waiver services, HHSC is responsible for the administration of community LTSS. The majority of Texans with disabilities receive services in a community-based setting. Many of these programs provide needed services to people with disabilities and co-occurring behavioral health challenges. Older Texans meeting the medical criteria for nursing home services may also be eligible for community-based services funded by HHSC if they meet financial eligibility criteria. Some of the major community service programs are described below.

Medicaid 1915(c) Waiver Services

HHSC administers the 1915(c) Medicaid Home and Community-based Services waiver programs, which are designed to provide community supports and services to individuals eligible for institutional care (i.e., nursing facilities or intermediate care facilities). 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 (i.e., funded waiver slots). The wait time for services varies by program but can be anywhere from one to fifteen years. Figure 55 provides the number of years percentages of individuals have been on a waitlist as of July 2020 for each program.

Figure 55. July 2020 Years on Waitlist for 1915(c) Waiver Services

Years on List	CLASS		DDMD		HCS		MDCP		STAR+		Total
	Individuals	Percent	Individuals	Percent	Individuals	Percent	Individuals	Percent	Individuals	Percent	
0-1	5,118	6.6%	289	32.7%	7,473	6.9%	2,915	43.3%	16,748	99.8%	7,437
1-2	6,810	7.8%	206	23.3%	8,608	8.0%	3,110	46.4%	19	0.1%	8,695
2-3	6,293	8.1%	154	17.4%	8,729	8.1%	666	9.9%	1	0.0%	8,833
3-4	6,026	7.8%	133	17.3%	8,623	8.0%	2	0.0%	1	0.0%	8,767
4-5	5,608	7.3%	82	9.3%	8,309	7.7%	2	0.0%	7	0.0%	8,372
5-6	4,712	6.1%	-	-	7,361	6.3%	1	0.0%	-	-	6,932
6-7	4,716	6.1%	-	-	6,777	6.3%	-	-	-	-	6,894
7-8	5,021	6.5%	-	-	7,573	7.0%	1	0.0%	-	-	7,622
8-9	5,418	7.0%	-	-	7,983	7.4%	-	-	-	-	7,938
9-10	6,615	8.6%	-	-	8,034	7.5%	-	-	-	-	7,825
10-11	6,431	8.3%	-	-	8,201	7.6%	-	-	-	-	7,815
11-12	5,742	7.4%	-	-	6,760	6.3%	-	-	-	-	3,175
12-13	5,180	6.7%	-	-	5,574	5.1%	-	-	-	-	8
13-14	4,229	5.5%	-	-	4,526	4.2%	-	-	-	-	11
14-15	123	0.2%	-	-	3,167	2.9%	-	-	-	-	11
15-16	-	-	-	-	5	0.0%	-	-	-	-	11
Totals	77,282	100%	884	100%	107,607	100%	6,697	100%	16,776	100%	90,348

Source: Texas Health and Human Services. (2020). *Interest list reduction*. Retrieved from <https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction>

Table 44 provides basic information about eligibility and services for the primary waivers for persons with intellectual and other developmental disabilities.

Table 44. Community-Based Waiver Eligibility and Behavioral Health-Related Services for people with Disabilities

Program	Eligibility	Services Provided (beyond 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 ID diagnosis or a related condition and an IQ score of 75 or below. Must have functional limitations that qualify for intermediate care facility services. Must be able to get Medicaid services before enrolling. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than \$2,000. Parental income is not considered.	<ul style="list-style-type: none">• Case management• Behavioral support, including social work and psychology• Day habilitation• Respite• Nursing services• Employment services• Supported employment• Residential assistance including:<ul style="list-style-type: none">• supported home living• foster/companion care• supervised living (group home)• residential support

Program	Eligibility	Services Provided (beyond 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% of the SSI limit and countable resources of no more than \$2,000. Parental income is not considered.	<ul style="list-style-type: none"> • Case management • Psychological and behavioral support services • Habilitation • Respite • Nursing services • Employment services • Supported employment • Specialized therapies such as aquatic, music, recreational
Texas Home Living (TxHmL)	Individuals with an IQ 69 or below 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% 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.	<ul style="list-style-type: none"> • Case management • Behavioral support • Day habilitation • Habilitation • Community support • Respite • Employment services • Supported employment • Specialized therapies
Deaf/Blind/Multiple Disabilities (DBMD)	Individuals with deaf-blindness and one or more other disabilities who meet eligibility for intermediate care facilities.	<ul style="list-style-type: none"> • Case management • Behavioral support services • Day habilitation • Residential habilitation adaptive aids • Assisted living • Nursing services • Employment services • Supported employment • Chore services
Day Activity and Health Services	Individuals with a functional disability related to a medical diagnosis, a physician's order requiring care or supervision, and who need help with one or more personal care tasks. Must meet eligibility criteria for Medicaid (to get Title XIX services) or not exceed specified income and resource limits to get Title XX services.	<ul style="list-style-type: none"> • Noon meal and snacks • Nursing and personal care • Physical rehabilitation • Social, educational and recreational activities • Transportation

Sources: Texas Health and Human Services. (2017). *Texas Long-Term Service and Supports (LTSS) Waiver Programs*. Retrieved from <https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/providers/resources/ltss-waivers.pdf>

Navigate Life Texas. (n.d.). Waivers. Retrieved from <https://www.navigatelifetexas.org/en/insurance-financial-help/texas-medicaid-waiver-programs-for-children-with-disabilities>

Paying for Senior Care. (2018). *Day Activity and Health Services (DAHS) Program: Texas Medicaid Adult Day Care*. Retrieved from <https://www.payingforseniorcare.com/adult-day-care/tx-dahs-program.html>

As part of the 2020-21 biennial budget, the 86th Legislature passed Rider 20 directing HHSC to create a plan for slot enrollment and allocated \$66,661,790 in All Funds, with \$24,792,919 in General Revenue to expand community-based services. New waiver slots were allocated as follows:

- 1,320 HCS slots;
- 240 CLASS slots
- 8 DBMD slots; and
- 60 Medically Dependent Children Program slots.²¹⁶

Table 45. depicts HHSC’s planned slot enrollment for the 2020-21 biennium.

Table 45. HHSC Planned Slot Enrollment, by Waiver Program, 2020-21 biennium.

Program	Purpose of Slots	Fiscal Year (FY) 2020-21 Current Appropriated Enrollment	Current Number of Appropriated Pending Enrollment ²	FY 2020 Planned Enrollment	FY 2021 Planned Enrollment	Total Appropriated Enrollment for Biennium
CLASS	For reducing the statewide interest list	240	0	120	120	240
DBMD	For reducing the statewide interest list	8	0	4	4	8
HCS	For reducing the statewide interest list	1,320	0	660	660	1,320
MDCP	For reducing the statewide interest list	60	0	30	30	60
Total		1,628	0	814	814	1,628

Source: Texas Health and Human Services. (October 2019). *Waiver slot enrollment plan report*. Retrieved from <https://hhs.texas.gov/reports/2019/10/waiver-slot-enrollment-plan-report>

The demand for community-based services and supports often outweighs available resources, and applicants’ names are placed on an interest list until services are available. However, some needs may be met through other programs until an applicant’s name comes to the top of the list. Senate Bill 1207 (86th, Perry/Krause) required HHSC to change what is considered in the enrollment process for the MDCP and DBMD programs. The legislation also required HHSC to permit an individual who is no longer eligible for MDCP to be placed either at the top of the MDCP interest list or be placed on another interest list using the date they originally applied for the MDCP interest list.²¹⁷

The 86th Texas Legislature also directed funds to be used to conduct a study of the interest or other waiting list for the HCS, CLASS, DBMD, MDCP, and TxHmL waivers, as well as STAR+PLUS. Figure 56 shows the waiting list reduction summary for July 2020. The total of interest list counts in the below table is a duplicated count. The unduplicated count across all six Interest Lists is 163,998.²¹⁸ HHSC was directed to study interest lists and consider how other states are addressing these waitlists, policies impacting the lists, demographic data of individuals on the lists, and strategies HHSC could employ to eliminate the lists. The report from HHSC was submitted to the Legislative Budget Board (LBB) and the Governor in September 2020 and can be found at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-waiver-programs-interest-list-study-sept-2020.pdf>

Figure 56. July 2020 Wait List Summary of Interest List Releases

Item		CLASS	DBMD	HCS	MDCP	STAR+	TxHmL	Totals
Previous Biennium Counts	As of August 31, 2019	74,013	673	102,933	10,082	7,327	83,711	278,739
Released/Removed from Interest List 2	Enrolled 4	42	7	459	837	2,962	0	4,307
	Denied/Declined/Withdrawn 4	240	35	332	6,283	21,995	0	28,885
	Pipeline	571	79	739	1,233	1,801	0	4,423
Total Releases This Biennium3	Since September 1, 2019	853	123	1,529	8,406	28,629	0	39,540
Added This Biennium	New Requests	4,592	271	6,895	2,641	21,616	6,797	42,814
Current Interest List Counts	As of July 31, 2020	77,280	884	107,607	6,696	16,776	90,346	299,589

Source: Texas Health and Human Services. (2020). *Interest list reduction*. Retrieved from <https://hhs.texas.gov/about-hhs/records-statistics/interest-list-reduction>

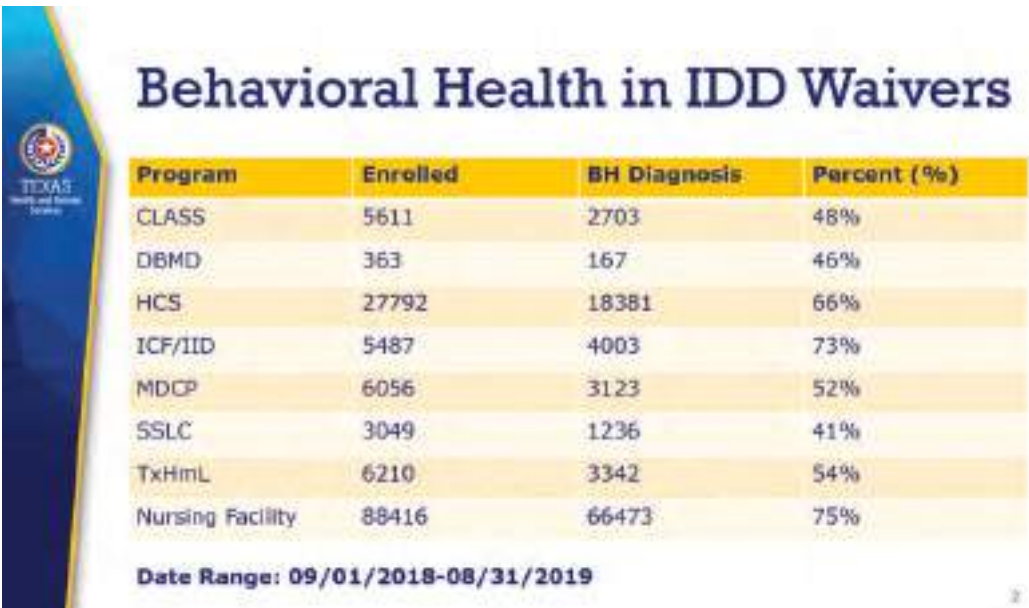
Table 46 shows a three-year trend of each Medicaid 1915(c) waiver program serving individuals with a co-occurring mental health condition from FY 2013-2105. This was previously the most updated data However, in July 2020, the Behavioral Health Advisory Council requested an update and HHSC was able to provide data for 09/01/18 -08/31/19 shown in Figure 57.²¹⁹

Table 46. Behavioral Health in IDD Waivers, FY 2013-2015

	FY2013				FY2014				FY2015		
Program	Enrolled	BH Diagnosis	%	Enrolled	BH Diagnosis	%	Enrolled	BH Diagnosis	%		
CLASS	4,828	1,080	22.37%	5,011	1,105	22.05%	5,222	1,169	22.39%		
HCS	21,404	8,201	38.32%	22,265	8,568	38.48%	25,331	9,320	36.79%		
DBMD	158	16	10.13%	189	25	13.23%	263	32	12.17%		
MDCP	6,407	2,486	38.80%	6,462	1,987	30.75%	6,626	2,014	30.40%		
TxHmL	5,997	1,522	25.38%	6,928	1,859	26.83%	9,078	2,580	28.42%		
ICFs/ID	6,169	2,535	41.09%	6,101	1,897	31.09%	5,961	1,348	22.61%		
Nursing Facilities	93,032	56,227	60.44%	92,844	58,983	63.53%	86,140	58,560	67.98%		
SSLCs	3,912	2,196	56.13%	3,715	1,745	46.97%	3,475	1,455	41.87%		

Source: Department of Aging and Disability Services. (2016, October 3). Data Request: People enrolled in DADS programs.

Figure 57. Behavioral Health in IDD Waivers, 09/01/18-08/31/19



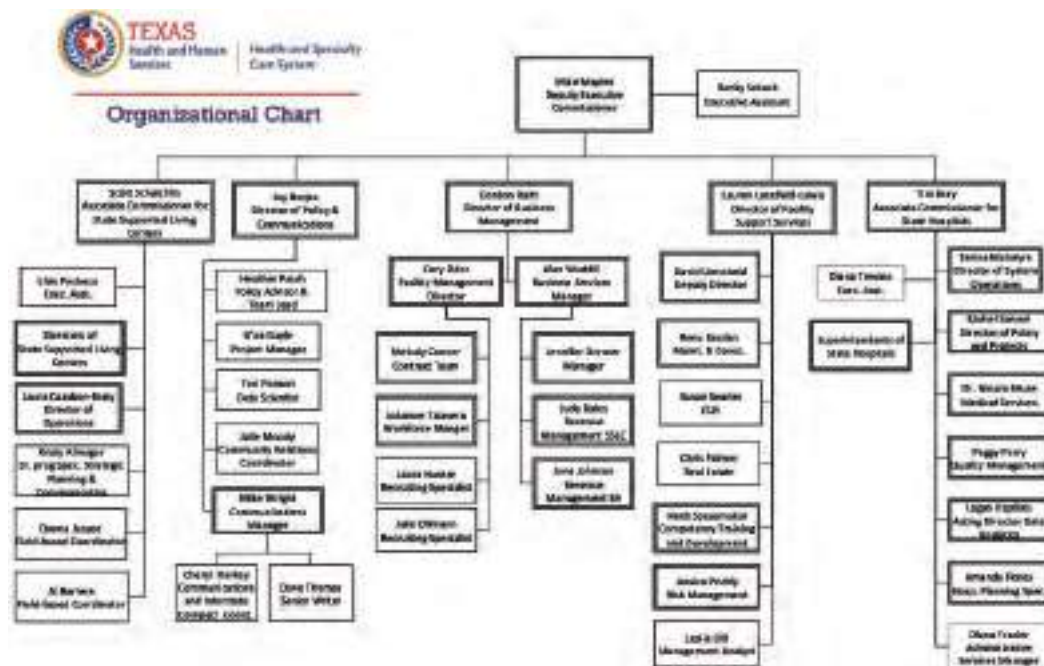
Source: Turner, H. (2020, October 9). *Intellectual and developmental disabilities update to the Behavioral Health Advisory Committee*. Texas Health and Human Services Commission.

Role of Local Intellectual and Developmental Disability Authorities in Connecting People to Waiver Services

There are 39 local intellectual and developmental disability authorities (LIDDAs) in Texas that cover all 254 counties to serve as the entry point for long-term services and support programs for people with IDD, including those who also have co-occurring mental health conditions. While the LIDDAs may co-locate with LMHAs across the state, the two entities have separate administrative authorities. LIDDAs connect individuals with IDD to long-term services and supports, which include SSLCs, waiver programs, safety net services, and Community First Choice.²²⁰

LIDDAs are responsible for program eligibility, waiver program enrollment, and determination of intellectual disability or a related condition as part of establishing the IDD priority population. Additional LIDDA responsibilities include developing service plans, providing targeted case management services, maintaining interest lists for IDD Medicaid waivers, conducting PASRR evaluations for persons with IDD seeking admission to a nursing facility, providing continuity of care, and completing Community Living Options Information Process (CLOIP) for persons residing in state supported living centers (SSLCs). LIDDAs are also responsible for permanency planning for individuals less than 22 years of age who live in intermediate care facilities, SSLCs, nursing facilities, and HCS group homes.

Health and Specialty Care System



Source: Texas Health and Human Services Commission. (October 2020). *Public Information Request, October 2020*.

The Health and Specialty Care System, formerly known as the State Operated Facilities Division, is in charge of the state hospital system and state supported living centers (SSLCs). Both state hospitals and SSLCs serve as short or long-term inpatient or residential care options for people with serious mental illness or people with IDD.

INPATIENT SERVICES AND THE ADMISSIONS PROCESS

The state's inpatient psychiatric services received priority attention during the 85th legislative session, generating significant interim activity. The momentum to improve and transform the state hospital system continued during the 86th legislative session. The 86th legislature partially funded \$745 million for the construction and renovation for state hospitals, anticipating further funding during the FY 2022-23 biennium. **For more information, see the *State Hospital Redesign update in the Policy Environment* section of this guide.**

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 in order to:

- Provide accurate diagnosis and review of past diagnoses and treatment history;

- Adjust, stabilize, discontinue, or begin new medications;
- Provide intensive treatment during acute episodes during which a person's mental health worsens; and/or,
- Assess or restore a person's mental competency to stand trial.²²¹

As discussed earlier in this section, HHSC designates LMHAs/LBHAs as responsible for achieving continuity of care in meeting a person's need for mental health services. Within this continuum of care, the state hospitals' primary purpose is to stabilize people by providing inpatient mental health treatment. Each state hospital has a utilization management agreement with a partnering LMHA/LBHA that requires the LMHA/LBHA to screen all individuals seeking mental health services to determine if inpatient psychiatric services are required. If the screening and assessment determine that there is a need for inpatient psychiatric services, the LMHA/LBHA decides on the least restrictive treatment setting available, with the most restrictive setting of a state hospital considered the provider of last resort. When the LMHA has not screened and referred the individual for inpatient services, a hospital physician can determine if the person has an emergency psychiatric condition appropriate for admission to the state hospital.

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, social services, therapeutic activities, and any other psychological services ordered by the treating physician.²²² Specific services include:

- Diagnostic interviews;
- Structured therapeutic programming;
- Collaboration with appropriate courts and law enforcement;
- Suicide safety planning; and
- Discharge planning.

Currently, the Health and Human Services Commission manages three different waiting lists:

- Forensic – maximum security unit
- Forensic Clearinghouse – non-maximum security unit
- Civil – non-forensic adults, adolescents and children²²³

There are two types of inpatient commitments in which individuals are provided comprehensive inpatient mental health services: civil and forensic.

During the 86th legislative session, SB 362 (Huffman/Price) was passed to address multiple issues related to civil, court-ordered mental health services. The bill:

- Reforms procedures relating to court-ordered outpatient and inpatient mental health services;
- Amends provisions relating to the early identification of a defendant suspected of having mental illness or an intellectual disability;
- “Adds a roadmap in the Code of Criminal Procedure for prosecutors and trial court judges” to release an individual with mental illness or IDD on bail after receiving an Article 16.22 report and transfer them to the appropriate court for court-ordered outpatient mental health services.²²⁴ The judge may only do this if the

offense charged does not involve serious bodily injury.

- Allows the dismissal of the pending charges after the defendant complies with services requirement;
- Requires the Court of Criminal Appeals to ensure that judicial training related to court-ordered mental health services is provided at least once every year; and
- Requires an inpatient treatment facility administrator to assess the appropriateness of transferring the patient to outpatient mental health services not later than 30 days after the patient is committed to the facility, among other provisions.²²⁵

Additionally, SB 362 amended the standard for outpatient commitment to a more provable standard. Previously, courts were required to find that an individual's mental health condition made it "impossible" for them to submit to voluntary outpatient treatment. Now, a court must find that the patient's condition "significantly impairs" that ability.²²⁶

Provisions relating to the early identification of a defendant suspected of having mental illness or an intellectual disability were also amended. The bill allows a trial court to release a defendant on bail and transfer the defendant to the appropriate court for court-ordered outpatient mental health services if the offense does not involve serious bodily injury. The bill also allows the dismissal of the underlying charges after the defendant complies with such treatment in certain circumstances.²²⁷

CIVIL INPATIENT COMMITMENTS

Civil commitments to a state hospital can happen through a variety of entry points.²²⁸ Although voluntary admission is possible, the majority of civil patients are committed involuntarily. Generally, LMHAs screen referrals (from individuals and others in the community such as family members or law enforcement officials) to determine the best and least restrictive placement for services.²²⁹ If the LMHA does not screen the referral, the state hospital conducts an emergency psychiatric screening to determine whether admission is appropriate.

Voluntary admission is initiated by a request from a person at least 16 years old or a person responsible for a minor under age 18.²³⁰ The individual seeking admission must have "symptoms of mental illness" and would benefit from the services.²³¹ If a person voluntarily admitted to a facility later requests discharge and the responsible physician believes the person meets the criteria for involuntary admission, the facility may file an application for emergency detention or court-ordered services.²³²

Peace officers or the guardian of an adult can detain an individual involuntarily without a warrant and present them to the state hospital for screening.²³³ This process can also be initiated by other people who can file an application for a warrant with the county clerk or district attorney (DA) stating that the person is "mentally ill" and presents a substantial risk of serious harm to themselves or others that is imminent unless the person is immediately restrained.²³⁴ The application must have specific details supporting these statements. If the judge or magistrate reviewing the

application finds that emergency detention is needed, the court will issue a mental health warrant and a peace officer will attempt to detain the individual and transport them to a facility. The individual must be examined by a physician within 12 hours (to provide a medical certificate for the court to determine if it should issue an order of protective custody) and can be detained for no more than 48 hours without a hearing on an order of protective custody.²³⁵

An order of protective custody will be issued by the court if an examining physician states that the individual is a person with mental illness and presents a substantial risk of serious harm, or is experiencing substantial deterioration and cannot make a rational and informed decision to enter treatment, and cannot be at liberty while waiting for a judicial hearing on court-ordered services.²³⁶ Within 72 hours of detention under an order of protective custody, the court will hold a probable cause hearing for a more thorough review of the evidence supporting the order.²³⁷ The hearing for court-ordered inpatient services must occur within 14 days of the original filing.²³⁸ The hearing allows for testimony from the individual involved, medical experts, and other people in the individual's life.

Court-ordered inpatient services may occur under an order for temporary commitment, not to exceed 45 days, or 90 days if the judge finds it necessary.²³⁹ After a jury trial or review by a judge, extended inpatient treatment must include a definitive time period not to exceed 12 months.^{240,241} Within that time period, a facility still must release a person if he or she no longer meets commitment criteria, even if the court mandated time period has not elapsed.²⁴² Additionally, inpatient treatment facility administrators are required to assess the appropriateness of transferring the patient to outpatient mental health services no later than 30 days after the patient is committed to the facility.²⁴³

FORENSIC COMMITMENTS

Justice-involved individuals needing forensic inpatient services are admitted to all the state hospitals. Individuals who require maximum security beds are admitted to either Rusk State Hospital or the Vernon Campus of North Texas State Hospital. Forensic commitments happen for two reasons:

- Individuals have been admitted to a hospital by judicial order because they have been determined incompetent to stand trial and are in need of competency restoration services so that they can better consult with legal counsel and understand the charges against them; or
- Individuals have been determined to be not guilty by reason of insanity and were ordered to a state hospital for a period of time not exceeding the maximum sentence length of the crime they committed.²⁴⁴

Maximum vs. Non-Maximum Security Placements

Patients placed in maximum security commitments include individuals who are:

- Civilly committed and determined by professionals to be manifestly dangerous to self and/or others; or

- May have been charged with a violent felony offense involving an act, threat, or attempt of serious bodily injury.²⁴⁵

As a result of SB 562 (86th, Zaffirini/Price), not all cases involving serious bodily injury, imminent threat of harm, or use of a deadly weapon are sent to a maximum security unit (MSU).²⁴⁶ If an individual is charged with any of these offenses and in need of competency restoration, a court is required to enter an order committing the individuals to a facility designated by HHSC.²⁴⁷ MSUs are more expensive to operate than traditional state hospital units and a statewide shortage of MSU beds has contributed to the increasing waitlists for forensic beds in state hospitals.²⁴⁸ SB 562 streamlined the process of competency restoration so that individuals with mental illness who have been found incompetent to stand trial are less likely to wait in jail for long periods of time before receiving services. Additionally, SB 562 requires a determination of dangerousness prior to an individual being sent to an MSU after they have been found incompetent to stand trial.²⁴⁹

INPATIENT CARE

FUNDING

The 86th Legislature appropriated over \$890 million in all funds to operate the state hospital system for the 2020-21 biennium. An additional \$270 million was appropriated for community hospital beds.²⁵⁰

Table 47. Inpatient Mental Health Funding Trends

Strategy	HB 1 FY 2016-17*	SB 1 FY 2018-19	HB 1 FY 2020-21
Mental Health State Hospitals	\$872,639,869	\$875,536,372	\$898,738,475
Community Mental Health Hospitals	\$209,943,241	\$243,830,476	\$270,620,452
Total	\$1,082,583,110	\$1,119,366,848	\$1,169,358,927

*Note: these amounts were prior to the Health and Human Services System Transformation and consolidation of state agencies, and were under DSHS.

Sources: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Texas Legislature Online (2017). *S.B. 1, General Appropriations Act, 85th Legislature, FY 2018-19*. Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

Texas Legislature Online (2015). *H.B. 1, General Appropriations Act, 84th Legislature, FY 2016-17*. Retrieved from <https://capitol.texas.gov/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0>

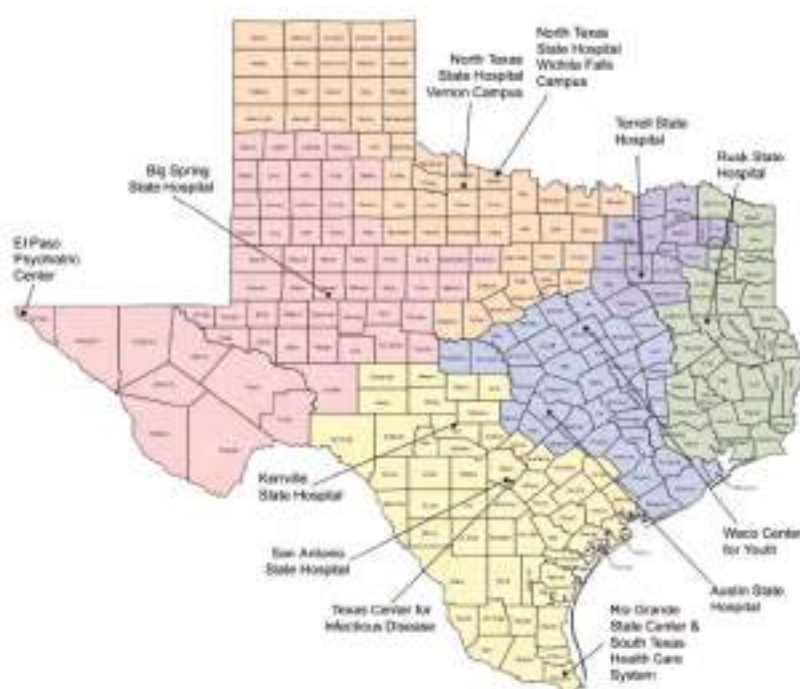
Legislative Appropriations Request, FY 2020-21. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

STATE HOSPITALS

The State Hospital Services Department provides oversight of the ten state mental health hospitals and one psychiatric residential treatment facility for youth (the Waco Center for Youth) displayed in Figure 58. Each LMHA receives an allocation of state hospital resources to coordinate inpatient mental health services for residents of their specific state hospital service area.

Hospitals in Austin, Big Spring, El Paso, Rusk, San Antonio, Terrell, Wichita Falls and the Rio Grande Center in Harlingen provide services to both civil and forensic patients. The Vernon Campus of the North Texas State Hospital offers inpatient psychiatric services to both adults and adolescents needing a maximum-security facility, and the Kerrville State Hospital provides adult forensic inpatient services. The state also operates the Waco Center for Youth as an adolescent residential treatment facility.²⁵¹

Figure 58. State Mental Health Hospitals and Waco Center for Youth



Source: Texas Department of State Health Services. (2016). *Presentation to Select Committee on Mental Health: The Behavioral Health System* [PowerPoint slides]. Retrieved from <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/5fc9614b-41a4-436e-9eba-67b14f00ad22.PDF>

Capacity

As of September 30, 2020, there were a total of 2,263 state hospital beds in Texas. Table 48 shows the total number of beds at each of the state-operated psychiatric hospital facilities as of September 2020. These numbers do not include the community and private hospital beds in facilities that contract with HHSC. In FY 2020, the state hospital network is increasing its capacity by 5.5 percent (390 patients).²⁵²

Table 48. State-Operated Inpatient Psychiatric Beds In State Hospitals: 2018

State Mental Health Hospitals	Bed Type	Number of Beds
Austin State Hospital	Adults, children, and adolescents	Adults: 235 Children: 8 Adolescents: 20
Big Spring State Hospital	Adults only	160
El Paso Psychiatric Center	Adults, children, and adolescents	Adults: 64 Children: 2 Adolescents: 5
Kerrville State Hospital	Adults only	220
North Texas State Hospital – Vernon	Adults only	262
North Texas State Hospital – South	Adolescents only	32
North Texas State Hospital – Wichita Falls	Adults, children, and adolescents	Adults: 244 Children: 6 Adolescents: 18
Rio Grande State Center	Adults only	52
Rusk State Hospital	Adults only	288
San Antonio State Hospital	Adults and children	262
Terrell State Hospital	Adults, children, and adolescents	Adults: 276 Children: 9 Adolescents: 26
Waco Center for Youth	Adolescents	74
Total, all bed types		2,263

*Note: Per, HHSC, A child is defined as 0 through 12 years and 11 months. An adolescent is 13 years through 17 years and 11 months.

Source: Texas Health and Human Services Commission. Data request. Received from Rachel Samsel, October 1, 2020

Staffing and Functional Capacity of State Hospitals

It is important to note that a hospital’s functional capacity is typically lower than their total bed count when determining the number of psychiatric inpatient beds in state hospitals. Functional capacity is impacted for a number of reasons, including: high staff turnover, poor building designs, aging infrastructure, and increased resources and supervision needed for patients with complex medical and/or behavioral problems.²⁵³ As of September 2020, the state-operated hospital system as a whole had a functional capacity as follows:²⁵⁴

- Average daily census for FY 20 – 1,992
- Number of beds available for children and adolescents – 200
- Total number of maximum-security beds – 302

Staff turnover in state hospitals has been an issue across all positions; state hospitals have had particular difficulty with staffing shortages in skilled nursing positions.²⁵⁵ On top of the already-stressful work environment of state hospitals, salary caps for nurses working in state hospitals make it difficult for nurses to earn as much as they would in the private sector. The shortage of skilled nurses has a disproportionate impact on individuals with complex needs and individuals in maximum-security

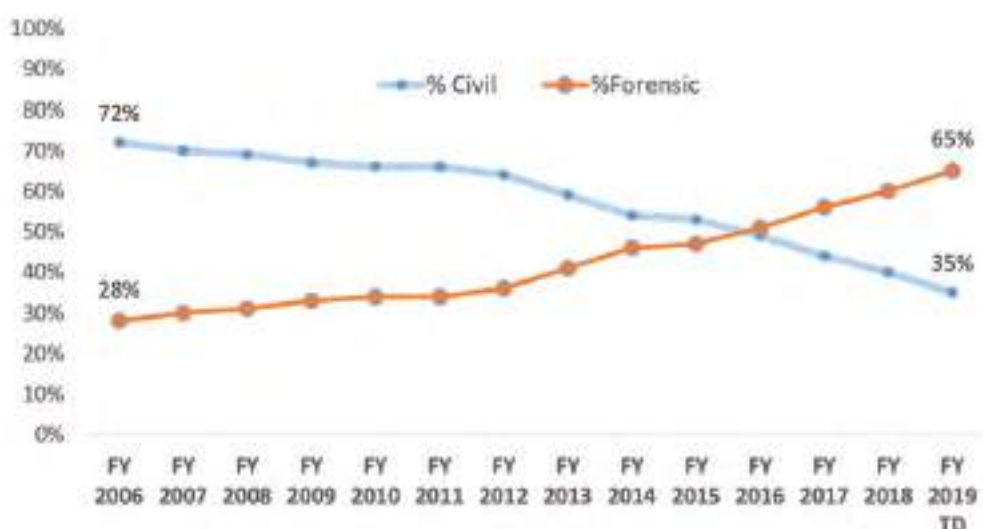
units because they require higher staff-to-client ratios and more frequent interventions to remain safe and healthy. Many available units and inpatient beds cannot be utilized for treatment because they do not have the proper staff skill sets and required staffing ratios in place. In FY 2017, general turnover was 36.34 percent, but specific positions, such as direct care workers, experienced even higher rates in part due to low wages. According to HHSC, some direct care workers are paid less than \$13/hour.²⁵⁶ Psychiatric nursing assistants at the state hospitals have an annual turnover rate of 32.7 percent, with 43.8 percent of the entry level positions turning over annually.²⁵⁷

HHSC was directed by the 86th Legislature to improve culture, recruitment, and retention efforts. HHSC was allotted additional funding for reducing turnover and vacancy rates at state hospitals and SSLCs by increasing direct care pay rates for targeted positions.²⁵⁸ Additionally, Rider 108 directs HHSC to evaluate compensation levels, turnover and vacancy rates and patterns, use of contractors and position type, and recruiting efforts at the state hospitals and SSLCs. Using the collected data, HHSC is required to develop recommendations to reduce turnover and vacancy rates, and submit a report to the LBB and the Governor's Office by August 31, 2020.²⁵⁹

Forensic Shift

In the last decade, the state hospital population shifted from mostly civil patients to a majority forensic patient population. In FY 2006, civil patients were 72.3 percent of the state hospital population. As of August 2019, only approximately 35 percent of all state hospitals patients were there through civil commitments.²⁶⁰ See Figure 59 below.

Figure 59. State Hospital Forensic Shift



Source: Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

The impact of a growing forensic population lead to less available capacity for all patients, increased waiting lists, and a changing focus for hospital staff.²⁶¹ Waitlists

for forensic beds increased steadily between FY 2006 and FY 2019. In December of 2018, there were 731 individuals on the wait list. By April 2020, the waitlist for all forensic beds had increased to 900, with 449 individuals on the waitlist for maximum security beds.²⁶² Figure 60 outlines the forensic waitlist information for Texas state hospitals during the first two quarters of 2020.

Figure 60. Forensic State Hospital Bed Waiting List, 1st and 2nd QTRs FY 2020

Table 6. Forensic State Hospital Bed Waiting List (Non-Maximum Security)

Data Elements	Numbers	
	Q1	Q2
People Added to the Waiting List	605	577
People Remove from the Waiting List	551	612
People on the Waiting List ¹⁸	501	451
Average Number of Days People Remained on Waiting List	66	76

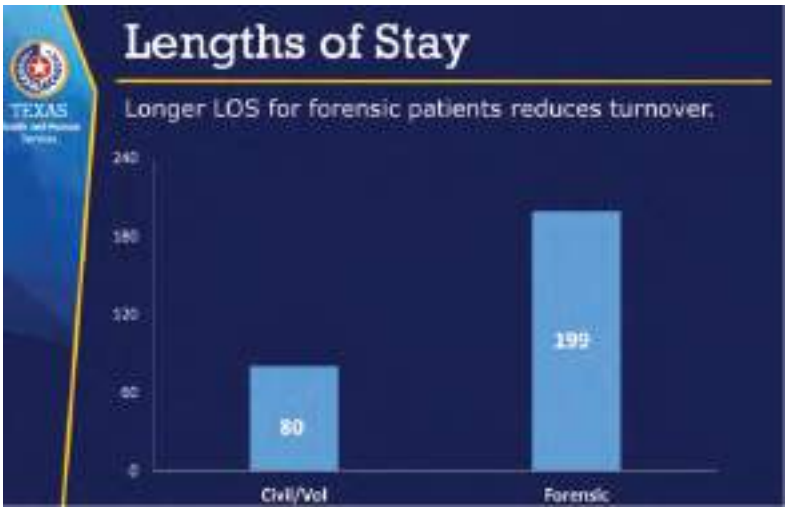
Table 7. Maximum Security Forensic State Hospital Bed Waiting List

Data Elements	Numbers	
	Q1	Q2
People Added to the Waiting List	168	97
People Remove from the Waiting List	145	147
People on the Waiting List ²¹	506	449
Average Number of Days People Remained on Waiting List	281	289

Source: Texas Health and Human Services Commission. (2020). *Semi-annual reporting of waiting lists for mental health services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-semi-annual-waiting-lists-mhs-april-2020.pdf>

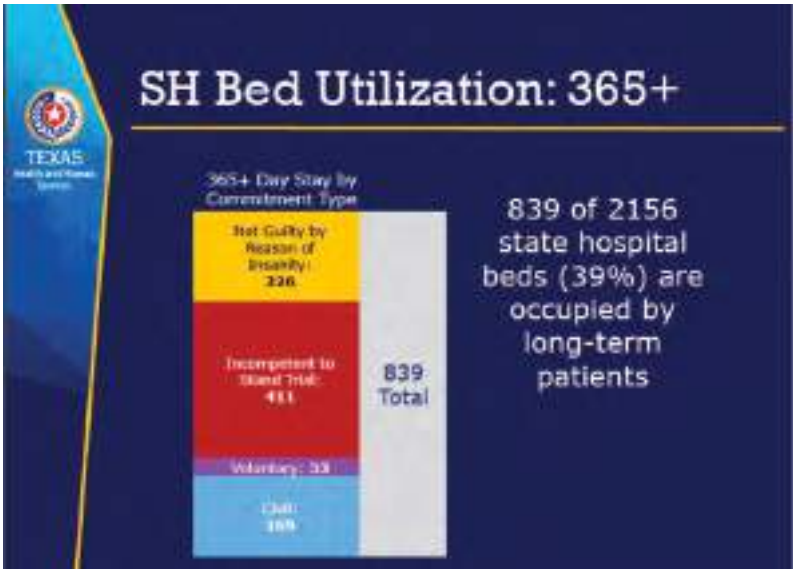
The shift to a majority of the state hospital beds serving forensic patients with longer lengths of stay compared to civil patients compounds the waiting list dilemma. Shown in Figure 61, forensic patients found incompetent to stand trial have an average length of almost 200 days which is significantly longer than the average of 80 days for civil patients.²⁶³ As patients stay in the hospital longer, there is less bed availability for new admissions. Almost 40 percent of individuals within the state hospital remain for one year or more shown in Figure 62.

Figure 61. State Hospital Lengths of Stay, October 2019



Source: Maples, M., & Gaines, S. (Oct. 2019). *Texas Health and Human Services presentation to the Joint Commission on Forensic Services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/jcafs/oct-2019-jcafs-agenda-item-4.pdf>

Figure 62. State Hospital Beds Utilized for 1 Year or More, October 2019



Source: Maples, M., & Gaines, S. (Oct. 2019). *Texas Health and Human Services presentation to the Joint Commission on Forensic Services*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/jcafs/oct-2019-jcafs-agenda-item-4.pdf>

The shift to a larger forensic population and the longer lengths of stay in state-operated facilities has resulted in significant reductions in admissions. See Figure 63 below:

Figure 63. State Hospital Facilities Declining Admissions



Source: Texas Health and Human Services, Statewide Behavioral Health Coordinating Council. (February 2019). *Texas statewide behavioral health, fiscal years 2017-2021: Strategic plan update and the foundation for the IDD strategic plan*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>

State Hospitals Utilization and Costs

Despite a shortage of inpatient psychiatric beds, the average daily censuses of all hospitals are below their total funded capacities. This is partly because hospitals must retain some open bed capacity in case of emergencies, but also because staffing shortages and high turnover have made it difficult for many hospitals to utilize the total number of beds they have.

Whether due to an individual’s especially intensive mental health needs or their lack of access to community-based treatments and services, many individuals have trouble remaining in the community after discharging from a state hospital. Since inpatient hospitals serve as a safety net for many individuals who receive inadequate or no community-based treatment, the availability and quality of community-based services has a direct impact on inpatient hospital capacity.²⁶⁴

Improvements to Aging State Hospital Infrastructure

In June 2016 Dr. David Lakey, the Chief Medical Officer for the UT Health System, identified the following key challenges present in the Texas mental health hospital system:

- Lack of facility capacity
- Hospitals are poorly designed for modern healthcare
- Current condition of hospitals

- Cost of replacing hospitals
- Increasing medical complexity of patients
- Lack of integration between physical and mental health
- Lack of strong partnerships with academia
- Rural facilities are frequently the sole “industry” of the local community
- Recruiting and retaining staff
- Increasing outside medical care costs
- Role in disproportionate share hospital funding
- Current mental health hospital system is underfunded.²⁶⁵

The 85th legislature appropriated \$300 million to HHS for the construction or significant repair of the state hospitals. In August 2017, HHS submitted a comprehensive plan for state hospital system transformation to the governor and the legislature, including a request to expend funds. On December 18, 2017, the Legislative Budget Board and the governor approved the use of \$47.7 million for various projects. HHS started the projects in spring 2018. Phase I projects include: Rusk State Hospital, Kerrville State Hospital, Continuum of Care Campus in Houston, Austin State Hospital, and the San Antonio State Hospital. More information is available in the Policy Environment section of this Guide.

The 86th Texas Legislature took significant steps to address the infrastructure needs of the state hospital system. The following amounts were appropriated in SB 500 (86th, Nelson/Zerwas), the supplemental appropriations bill:

- | | |
|-----------------|--|
| • \$165,000,000 | Begin construction of a new Austin State Hospital |
| • \$190,300,000 | Begin construction of a new San Antonio State Hospital |
| • \$ 90,054,363 | Construct replacement unit at Rusk State Hospital |

Additional information on the state hospital redesign efforts are included in the Funding Section of this guide.

COMPETENCY RESTORATION SERVICES

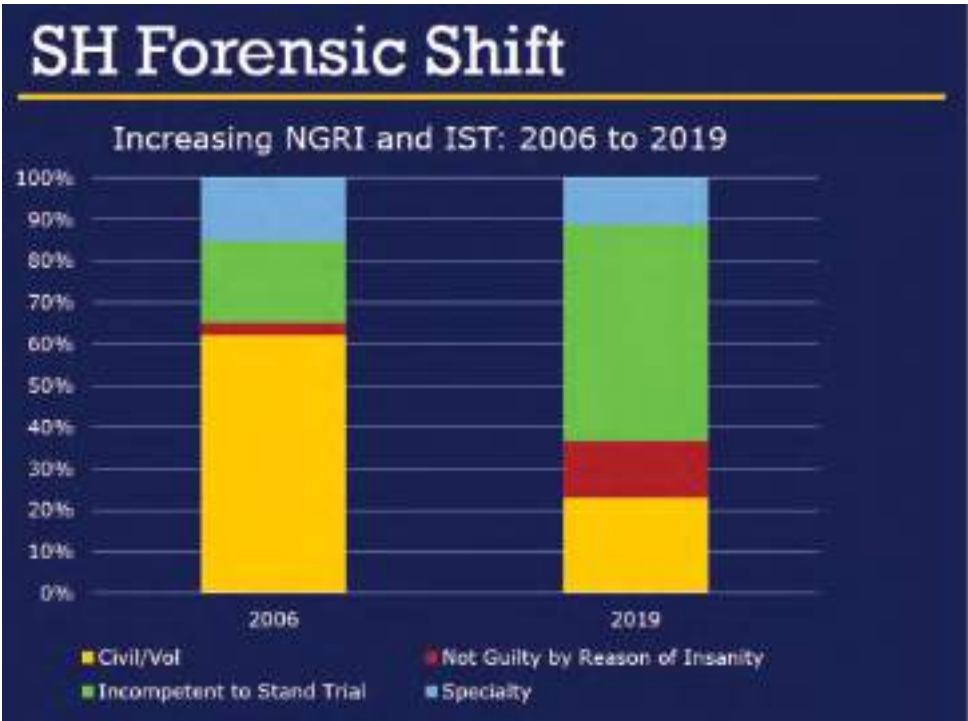
A person charged with a crime who is found incompetent to stand trial (i.e., unable to competently understand court proceedings) must be restored to competency before the legal process can continue. In order to be considered competent to stand trial, that person must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.^{266,267} Individuals determined to be incompetent, typically due to mental illness or an intellectual disability, may be placed into inpatient competency restoration programs, jail-based competency restoration programs, or outpatient competency restoration programs. Placement into these specialty programs is determined by a mixture of factors, including an individual’s clinical complexity, criminal history, and the safety risk they pose to the community and to other individuals placed in their program.²⁶⁸

SB 562 (86th, Zaffirini/Price) intends to improve the competency restoration process by streamlining the process to reduce backlog for individuals who have been found incompetent to stand trial who are waiting in jail for services. The bill also required determination of dangerousness for an individual who has been found incompetent to stand trial upfront before a being sent to a maximum security unit (MSU).²⁶⁹

Inpatient Competency Restoration

Individuals found incompetent to stand trial may be committed to a state hospital forensic unit to receive treatment in effort to restore their competency to stand trial. Before 2004, inpatient competency restoration was the only option for individuals found incompetent to stand trial.²⁷⁰ Recently there has been a steady and significant increase in the percentage of forensic commitments for inpatient competency restoration services. Because those commitments have a much longer average length of stay within state hospitals than civil or voluntary commitments, the average daily census for forensic patients has now surpassed that of civil patients.²⁷¹ Individuals who are forensically committed to state hospitals have longer lengths of stay, averaging 199 days for forensic patients versus 80 days for civil patients.

Figure 64. State Hospital Forensic Shift



Source: Maples, M., & Gaines, S. (2019). Texas Health and Human Services presentation to the Joint Commission on Forensic Services. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/jcafs/oct-2019-jcafs-agenda-item-4.pdf>

Jail-Based Competency Restoration

SB 1475 (83rd, Duncan/Zerwas) created a jail-based competency restoration (JBCR) pilot program for individuals who otherwise would be committed to a mental health facility or residential care facility for inpatient competency restoration services.

In 2017, the HHSC JBCR pilot program report stated that the program experienced delays in implementation due to a “lack of strong interest in the procurement opportunity and a competitive pool; however, rules governing the provision of JBCR services were adopted in January 2016”.²⁷² In 2019, SB 1326 (85th, Zaffirini/Price)

passed to address a multitude of areas related to individuals with mental illness or IDD who are involved with the criminal justice system, including provisions to the JBCR program. More details on SB 1326 can be found in the Hogg Foundation 85th legislative Session summary: <http://hogg.utexas.edu/wp-content/uploads/2017/08/UPDATED-Legislative-Summary-2017.pdf>

Outpatient Competency Restoration

Outpatient competency restoration (OCR) is a process of providing community-based competency restoration services, including mental health and substance use treatment services and legal education training for individuals found incompetent to stand trial. The goal of OCR is to give individuals the resources and services they need to maintain a level of psychiatric stability and be able to understand the legal process so that they can proceed through the court system while remaining in the community.²⁷³ OCR programs can allow low-risk individuals with mental illness to avoid prolonged stays in jails or state hospitals, which are costly to local taxpayers and often have the result of exacerbating individuals' mental illness.

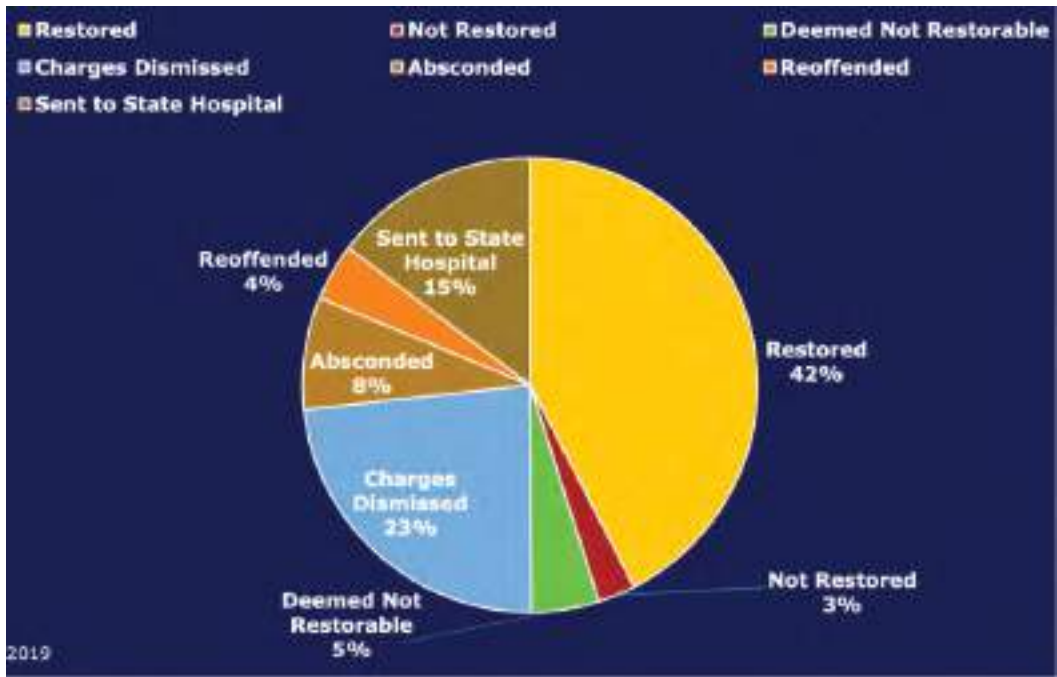
The Texas Code of Criminal Procedures began allowing referrals to OCR programs in 2003.²⁷⁴ In 2007, the Code of Criminal Procedure 46B was amended to permit outpatient treatment. Texas initiated four outpatient competency restoration pilot programs in response to the growing number of forensic commitments in state psychiatric hospitals and was allocated \$4 million each year to support expanding the number of OCR pilot sites.²⁷⁵ As of November 2019, there were 12 operating OCR sites.

Current Texas OCR sites include:

- Integral Care (Austin)
- Center for Health Care Services (San Antonio)
- MHMR Tarrant County (Fort Worth)
- Value Options-NorthSTAR (Dallas)-now North Texas Behavioral Health Authority
- Tri-County Behavioral Healthcare (Conroe)
- Behavioral Health Center Nueces County (Corpus Christi)
- Emergence Health Network (El Paso)
- Community Healthcore (Longview)
- StarCare Specialty Health System (Lubbock)
- Andrews Center Behavioral Healthcare System (Tyler)
- Heart of Texas Region MHMR Center (Waco)
- Central Counties Services (Belton)²⁷⁶

Between 2010 and 2019, 1,723 individuals had been served in an OCR site for an average length of 176 days.²⁷⁷ Outcomes of OCR show that the majority of individuals either restored competency or have ultimately had their charges dismissed. HHSC's outcome data is depicted in Figure 65.

Figure 65. HHSC OCR Outcome Data

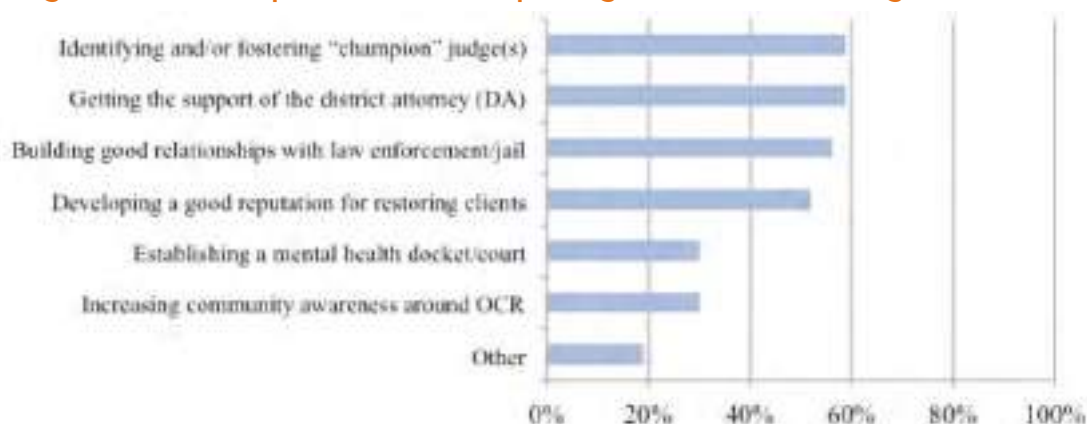


Source: Swan, L. and Pierre-Carr, L. (November 2019). *Texas competency restoration: Outpatient and jail-based*. Texas Health and Human Services presentation to the Judicial Summit on Mental Health. Retrieved from <http://texasjcmh.gov/media/1751/ocr-and-jail-based-cr-combined-pp.pdf>

In addition to avoiding the high cost of hospitalization, OCR can reduce overall costs to local communities and jails. Cost-savings are demonstrated through reducing the length of time individuals remain in jail and eliminating the cost of lengthy transportation to an available hospital bed. In 2015, the Hogg Foundation for Mental Health, in collaboration with the Department State Health Services, conducted an of OCR programs. The report found:

- A person’s likelihood of restoration increased with greater lengths of stay in an OCR program, up to a 21-week threshold;
- After the 21-week mark, longer lengths of stay were not associated with greater likelihood of restoration;
- Prior hospitalizations were shown to have a significant effect on a person’s likelihood to be restored to competency in an OCR program; and
- Individuals in OCR programs who had zero or one prior psychiatric hospitalizations were more likely to be successfully restored to competency than individuals who had two or three or more prior hospitalizations.²⁷⁸

Figure 66 below shows some of the most important components of successful OCR programs.

Figure 66. Most Important Factors Impacting Success of OCR Programs

Source: Graziani, C., Guzmán, M.R., Mahometa, M., & Shafer, A. (July 2015). *Texas outpatient competency restoration programs: Evaluation report*. The Hogg Foundation for Mental Health and Department and State Health Services. Retrieved from <http://www.tidc.texas.gov/media/57883/texas-outpatient-competency-restoration-programs-evaluation.pdf>

More recent research on OCR programs across the country concluded that OCR programs have “promising outcomes in terms of high restoration rates, low program failure rates, and substantial cost savings.”²⁷⁹ OCR program evaluations in multiple states have shown a number of benefits to OCR, including:

- An average rate of 70 percent competency restoration (77 percent in Texas);
- An average of 149 days to be restored to competency (70 days in Texas); and
- Total cost of OCR averaged \$215 per individual per day (\$140 in Texas).²⁸⁰

Between July 2018 and August 2019, a group of stakeholders met to develop standards and rules for governing the provision of OCR services in the Texas Administration Code. Workgroup members included judges, prosecutors and defense attorneys, OCR providers, policy and advocacy groups, as well as HHSC staff. OCR rules were drafted for:

- Eligibility and ineligibility criteria for admission
- Recommendation regarding OCR program admission
- General service requirements
- Assessment, reassessment, and court reporting
- Preparation for discharge
- Outcomes
- Written policies and procedures
- Staff member training
- Rights
- Compliance with statutes and rules²⁸¹

INSTITUTIONAL LONG-TERM SERVICES AND SUPPORTS

Persons with disabilities residing in institutional providers of long-term services and supports (LTSS) services, including skilled nursing facilities, privately operated intermediate care facilities, or large state-operated supported living centers (SSLCs), often experience co-occurring behavioral health conditions. Funding for these residential services is provided primarily through Medicaid. SSLCs are administered through the Health and Specialty Care System Division HHSC.

Table 49 presents information on the eligibility requirements and services provided by institutional providers of LTSS services.

Table 49. Institutional Care Eligibility and Behavioral Health-Related Services

Program	Eligibility	Behavioral Health Services Provided (beyond Medicaid state plan services)
Nursing Facilities	<ul style="list-style-type: none">Have a medical condition that requires the skills of a licensed nurse on a regular basis. <p>Beginning May 1, 2015, people who are covered by Medicaid and living in a nursing facility receive their basic health services (acute care) and long-term services through STAR+PLUS. People who get Medicaid and Medicare (dual-eligible) receive their basic health services through Medicare and their long-term services through STAR+PLUS.</p>	<p>24-hour residential care and services that include:</p> <ul style="list-style-type: none">PASRR (see above)Behavioral health servicesMedication managementSkilled nursingSpecialized therapies/servicesRehabilitative therapies
Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions	<ul style="list-style-type: none">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, orHave a full-scale IQ score of 75 or below and a primary diagnosis by a licensed physician of a related condition (manifested before age 22 years), and an adaptive behavior level with mild to extreme deficits, orHave a primary diagnosis of a related condition (manifested before age 22) diagnosed by a licensed physician regardless of IQ and an adaptive behavior level with moderate to extreme deficits, ANDBe in need of and able to benefit from the active treatment provided in the 24-hour supervised residential setting of an ICF.Be eligible for SSI or Medicaid.	<p>24-hour residential care and services that include:</p> <ul style="list-style-type: none">Physician servicesBehavioral health servicesMedication managementNursingSkills trainingOccupational, physical and speech therapiesServices to maintain connections between residents and their families/natural support systems

Program	Eligibility	Behavioral Health Services Provided (beyond Medicaid state plan services)
State Supported Living Centers	<ul style="list-style-type: none"> • Meet ICF/ID eligibility requirements. • Have severe or profound intellectual and developmental disabilities, or • Have intellectual and developmental disabilities and be medically fragile, or • Have intellectual and developmental disabilities and behavioral challenges, or • Represent a substantial risk of physical injury to self or others. • As an adult, be unable to provide for the most basic personal physical needs.²⁸² 	24-hour residential care and services that include: <ul style="list-style-type: none"> • Physician and nursing services • Behavioral health services • Skills training • Occupational therapies • Vocational programs and employment • Services to maintain connections between residents and their families/natural support systems

Source: Texas Department of Aging and Disability Services. (2015). *Reference Guide 2015*. Retrieved from <http://dadsco.dads.state.tx.us/ReferenceGuide/guides/FY15ReferenceGuide%28revised%29.pdf>

Skilled Nursing Facilities

Texas nursing facilities provide institutional care for older Texans and people with disabilities whose medical condition requires skilled licensed nursing services. As of March 2020, there were 1,208 licensed nursing facilities in Texas.²⁸³ While Medicaid nursing facilities require medical necessity for admission, many individuals residing in nursing facilities also have co-occurring mental health conditions. In March 2015, nursing facility services were 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 nursing home residents are identified and addressed, the federal government mandates Preadmission 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 other developmental disability (also known as related conditions);
- The appropriateness of placement in the nursing facility; and
- Eligibility for specialized services.²⁸⁴

In 2013, CMS directed Texas to make changes to the PASRR program. The three major changes included:

- Eliminating the role of nursing facilities in the PASRR evaluation determination process by introducing local authorities as the party that will complete the PASRR evaluation;

- Requiring specific, specialized services to be identified before nursing facility admission; and
- Requiring an automated communication to local authorities that is triggered when a Resident Review is required.²⁸⁵

In February 2020, CMS announced its revision of the PASRR regulations. From February-April 2020, CMS accepted comment on the proposed rule changes. According to CMS, this proposed rule would “modernize the requirements for PASRR, currently referred to in regulation as Preadmission Screening and Annual Resident Review, by incorporating statutory changes, reflecting updates to diagnostic criteria for mental illness and intellectual disability, reducing duplicative requirements and other administrative burdens on State PASRR programs, and making the process more streamlined and person-centered.”²⁸⁶ Proposed changes include updating mental illness and ID definition, streamlining the screening process, allowing the use of telehealth, and emphasizing individual preference related to long-term services.²⁸⁷

Community Intermediate Care Facilities (ICF)

The federal government gives states the option to include intermediate care facility (ICF) services in their Medicaid state plans. However, once a state chooses to include ICF services as a Medicaid benefit, those services become an entitlement to all individuals who meet eligibility criteria. Community-based ICFs can be licensed to provide residential and habilitation services to people with intellectual disabilities or other developmental disabilities, or related conditions. As of September 2020, there were 784 licensed ICFs in Texas, 70 are state owned/managed and 714 are privately owned.²⁸⁸ These facilities provide residential services similar to the SSLCs but can be 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 (SSLCs)

State supported living centers (SSLCs) are large institutions that provide 24-hour residential services for people with intellectual and developmental disabilities (IDD). Individuals seeking placement in an SSLC must meet both financial and functional eligibility requirements. Behavioral health treatment is a required service that must be provided by the facilities, as some residents have both a mental health condition in addition to an IDD. The SSLCs are licensed and certified ICFs owned and operated by the state. Approximately 58 percent of the SSLC operating funds come from the federal government, and 42 percent from state revenue and third-party revenue resources.²⁸⁹ SSLCs operate in 13 locations: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo, and San Antonio. Abilene, Brenham, and Lufkin serve adult and children residents, while all other campuses serve only residents who are 18 years of age or older.²⁹⁰

As of August 2019, 185 SSLC residents were alleged criminal offenders. Although many SSLCs serve a small number, 77 percent of alleged offenders reside at Mexia

SSLC which has been designated by the legislature to provide forensic services, and 10 percent of alleged offenders reside at San Angelo State Supported Living Center.²⁹¹

In FY 2019, over 2,900 individuals resided in these facilities. Approximately 62 percent of individuals served were diagnosed with a severe or profound intellectual disability, 69 percent were diagnosed with a behavioral health need, and over half (56 percent) had a co-occurring intellectual disability and mental health condition.²⁹² The majority of residents have lived in an SSLC for more than a decade, with 58 percent residing in an SSLC for more than 15 years. Since FY 2015, individuals' average length of stay has remained at almost 24 years.²⁹³

Although the SSLC population has declined significantly over the past decade, any discussion related to closure or consolidation of facilities has been met with strong legislative opposition. There was significant debate around SSLCs during the 84th legislative session due to the DADS Sunset Recommendations to close six centers, including closing the Austin SSLC by September of 2017. The legislature ultimately voted to keep the Austin SSLC and all other SSLCs operational. In Texas, only the legislature can direct closure of an SSLC. In the 85th legislative session, Senator Hinojosa introduced a bill, SB 602, which would have required a commission to review each SSLC.²⁹⁴ The legislation would have given the commission authority to recommend which SSLCs should be consolidated or closed. The bill did not pass during the 85th legislative session. During the 86th legislative session, SB 1552 (Lucio/Hinojosa) was filed but failed to pass. The bill addressed recent Office of the Independent Ombudsman for SSLCs reports that have highlighted the lack of local and statewide training requirements for staff at these centers, as well as the benefits of specialized training for staff in supporting the needs of center residents. Additionally, SB 1552 would have required the executive commissioner of HHSC to develop processes and procedures required for SSLC staff to follow, and to develop specialized training for such staff.²⁹⁵

Due to fixed costs and continued deterioration of aging facilities, the per person costs increased despite the overall census decline. According to a 2015 Sunset Commission final report, maintaining the large system of state-run facilities is costly, involving more than thousands of employees and a budget of \$661.9 million a year.²⁹⁶

An HHSC report in 2018 revealed that delivering services in 2017 to a person in an SSLC cost an average \$26,767 per month.²⁹⁷ The report also shows that SSLCs in Texas employ 11,496 people or full-time equivalents.²⁹⁸ Further, maintaining the SSLCs' dilapidated infrastructure contributes to significant state costs.²⁹⁹

The 85th legislature appropriated approximately \$80 million to help address infrastructure improvements and maintenance needs for SSLCs.³⁰⁰

Figure 67 below shows the SSLC enrollment trend from FY10- FY19

Figure 67. FY10-19 SSLC Enrollment Trend

Table 2: Total Enrollment, FY 2010 through FY 2019

SSLC	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Ablene	454	442	412	386	356	321	293	282	269	263
Austin	377	355	328	288	266	192	184	180	177	179
Brenham	340	315	298	288	283	279	264	259	254	248
Corpus Christi	292	274	258	242	224	221	220	208	205	188
Denton	545	516	494	484	460	458	458	447	449	448
El Paso	136	131	124	116	110	106	107	95	94	95
Lubbock	230	225	214	209	203	201	191	185	184	188
Lufkin	405	377	361	342	322	308	295	298	289	280
Mexia	417	390	372	331	288	256	256	246	240	246
Richmond	407	378	352	339	335	330	328	319	321	315
Rio Grande	72	71	70	62	67	71	61	60	62	63
San Angelo	251	239	229	210	208	214	217	213	202	191
San Antonio	281	278	275	250	240	229	229	227	223	206
Statewide	4,207	3,994	3,787	3,547	3,362	3,186	3,103	3,019	2,969	2,910

Source: Texas Health and Human Services Commission. (July 2020). *Reimagining the future: A report on maximizing resources and long-term planning for state supported living centers*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/maximizing-resources-long-range-planning-sslc-july-2020.pdf?fbclid=IwAR2ca08kPGvWggsWw6-ZAfRP3nR-88pjEYcnyf8O9EzApjUCyDM6UUolepA>

As part of a 2009 settlement agreement with the U.S. Department of Justice over conditions at SSLCs, the state agreed to improve health, safety, and quality of care for residents. The agreement included increased access to psychiatric care and psychological services, as well as improved policies and practices to reduce the use of restraints. DADS was required by the 83rd legislature to submit a plan to achieve targeted improvements in services and supports for residents. Since the submission of this plan, DADS was abolished and all functions, including the operation of the SSLCs, were transferred to HHSC. Independent monitors were assigned in mid-2014 to visit and report on conditions at all 13 SSLCs.³⁰¹ Despite the 2009 agreement, the November 2019 monitoring report for the Austin SSLC continued to identify deficiencies. Other monitoring reports in 2019 identified deficiencies at the SSLCs related to psychiatric and psychological services, including individual residents not progressing toward psychiatric goals and not maintaining psychiatric stability. However, reports indicated that when an individual was not making progress toward psychiatric goals revisions to treatment were made.³⁰² Updated reports for all 13 SSLCs were released in 2019 as the centers continue to be evaluated by independent monitors every nine months.³⁰³

HHSC implemented a new initiative in FY 2019 to help SSLCs increase compliance with the settlement agreement. Every year, members of the state office Quality Review Team (QRT) visit each center for three days to:

- Validate SSLC monitoring data;
- Identify best practices to share with other centers; and

- Provide feedback and technical assistance.³⁰⁴

During the 86th legislature, Rider 110 was included in Article II of the 2020-21 state budget, directing HHSC to create *Reimagining the Future: A Report on Maximizing Resources and Long-Range Planning for State Supported Living Centers*. According to HHSC, “its purpose is to promote the development of a comprehensive, statewide approach toward long-range planning for SSLCs and maximize resources to support the continuum of care for people with IDD.” According to the report, transitions from SSLCs back to the community have decreased by 65 percent in the last ten years. Figure 68 and Figure 69 show the top obstacles to transition and referral. In partnership with stakeholder engagement, HHSC conducted an analysis of the overall strengths and opportunities for improvement. The report developed a list of objectives to accomplish:

- Enhance resident services and supports to support individualized care for people served by an SSLC;
- Strengthen employee services and supports to provide guidance in business practices that improve recruitment and retention of staff at SSLCs and compliment the agency’s values to create a workplace culture that is innovative, skilled, and diverse; and
- Expand community-based services and supports to align with the agency’s vision and mission and long-term objectives that promote independence and positive outcomes for people with IDD.³⁰⁵

Figure 68. FY 2019 Obstacles for transition from SSLC to Community

Table 14: Obstacles to Transition, FY 2019

Obstacles to Transition	
Limited Residential Opportunities in Preferred Area	29.84%
Specialized Medical Supports	11.81%
Environmental Modifications	11.44%
Individual/LAR Indecision Regarding Provider Selection	9.96%
Behavioral Supports	9.96%
Specialized Therapy Supports	7.38%
Scheduling (For Referrals < 200 days)	3.32%
Provider delay in opening home	3.32%
Employment/Supported Employment	2.21%
Transportation Modifications	2.21%
Illness during transition period	1.85%
Criminal Court Issues	1.48%
Medicaid/SSI Funding	1.48%
Specialized MH Supports	1.48%
LAR reluctance to choose a provider	0.74%
Services/Support for Forensic Needs	0.74%
Provider closed home; search for new provider	0.37%
Family Chose to Pursue Guardianship	0.37%

Source: Texas Health and Human Services Commission. (July 2020). *Reimagining the future: A report on maximizing resources and long-term planning for state supported living centers*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/maximizing-resources-long-range-planning-sslc-july-2020.pdf?fbclid=IwAR2ca08kPGvWggsWw6-ZAfRP3nR-88pjEYcnyf8O9EzApjUCyDM6UUolepA>

Figure 69. FY 2019 Obstacles for referral from SSLC to Community

Table 12: Reasons for Non-Referral, FY 2019

Reasons for Non-Referral	
LAR Choice	43.40%
Behavioral Health/Psychiatric Needs	21.19%
Medical Issues	16.72%
Individual Choice	15.78%
Funding	1.69%
Evaluation Period (Chapter 55/46b commitments only)	0.70%
Court Will Not Allow Placement (Chapter 55/46b)	0.52%

Note: "LAR" refers to legally authorized representative

Source: Texas Health and Human Services Commission. (July 2020). *Reimagining the future: A report on maximizing resources and long-term planning for state supported living centers*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/maximizing-resources-long-range-planning-sslc-july-2020.pdf?fbclid=IwAR2ca08kPGvWggsWw6-ZAfRP3nR-88pjEYcnyf8O9EzApjUCyDM6UUolepA>

INSTITUTIONS FOR MENTAL DISEASES EXCLUSION

The Institutions for Mental Diseases (IMD) exclusion in Section 1905(a)(B) of the Social Security Act defines an IMD as “a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”³⁰⁶ Until 2016, the Social Security Act excluded funding inpatient services for individuals between 21 and 64 years of age in IMDs. Since Medicaid was enacted in 1965, the intention of the IMD exclusion policy was to promote community services expansion and ensure the federal government did not have to assume financial responsibility for inpatient psychiatric care. The federal restriction on funding for inpatient hospital services resulted in state general revenue as the primary source of funds for state hospital services for adults between ages 22 and 64. Additionally, efforts to improve or expand public inpatient services are funded almost entirely by the state without federal matching.³⁰⁷

On May 6, 2016, Medicaid managed care coverage rules regarding the IMD exclusion were entered into the Federal Register.³⁰⁸ The new rules permitted “Federal Financial Participation (FFP) for a full monthly capitation payment on behalf of an enrollee aged 21 to 64 who is a patient in an IMD,” so long as the individual elects to receive services in a public or private IMD and the IMD in question provides psychiatric inpatient care, substance use condition inpatient care, or behavioral health crisis residential services.³⁰⁹ Federal Financial Participation also only applies to short-term IMD stays of less than 15 days in one month, but stays can exceed the 15-day limit if the days are spread out over two months (e.g., 10 days at the end of July and 10 days at the beginning of August). Before this rule change, stand-alone

psychiatric facilities could not deny admission to individuals referred to them. However, they also did not receive federal Medicaid match payments, creating the risk of lower quality care and premature discharge.³¹⁰ The objective of the rule change was to mitigate the IMD exclusion and address shortages in short-term inpatient behavioral health treatment by providing more flexible financing options.³¹¹

In recent years, the federal government has provided new mechanisms for states to finance IMD services for individuals between 21 and 64 years of age through Medicaid in certain situations. There are now four options for states to cover these services: Section 1115 demonstration waivers, managed care “in lieu of” authority, disproportionate share hospital payments, and the SUPPORT Act state plan option.

Section 1115 Demonstration Waivers

In November 2017, states were able to apply for an 1115 waiver to receive FFP for the continuum of services for substance use conditions, including services provided to Medicaid enrollees residing in residential treatment facilities typically ineligible due to the IMD exclusion. As part of this initiative, states need to indicate how inpatient and residential care will supplement and coordinate with community-based care in a robust continuum of care in the state. CMS guidance encourages states to maintain their current funding levels for a continuum of services, without reducing or diverting state spending on mental health and substance use treatment services as a result of available federal funding for services in IMDs.^{312b} As of September 2020, 28 states had approved 1115 waivers, with an additional eight pending, to receive federal Medicaid dollars for SUD services in IMDs. As of September 2020, Texas was not one of the states with approved or pending waivers.³¹³

In November 2018, CMS issued guidance regarding opportunities to design innovative systems for adults with SMI and children with SED, allowing states to provide Medicaid coverage through Section 1115 waivers for short-term stays in IMDs as mandated by the 21st Century Cures Act. The waiver would require a statewide average length of state of 30 days, be budget neutral, and a commitment to continued funding of outpatient community-based mental health services. The goals of the waiver are to reduce individuals’ utilization and length of stay in emergency departments while waiting to receive services in a specialized setting, reduction of preventable admissions to acute care, improved crisis stabilization services, improved accessibility to community-based services, and improved care coordination and continuity of care. As of March 2020, four states had approved 1115 waivers, with an additional three pending, to receive federal Medicaid dollars for mental health services in IMDs. In February 2020, HHSC began assessing options and fiscal impacts of an SMI/SED 1115 waiver and expressed consideration of funding for the waiver through the exceptional item process.³¹⁴

Health, Developmental, and Independence Services



- Office of Disability Prevention for Children
- Rehabilitative & Social Services
- Health & Developmental Services

The Office of Disability Prevention for Children (ODPC) was created after Governor Greg Abbott vetoed a bill that would have moved the Texas Office of Prevention of Developmental Disabilities (TOPDD) to the University of Texas. Since the legislation was vetoed and TOPDD was eliminated, the Office of Disability Prevention for Children (ODPC) was created within HHSC.

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education, promotion of public policy, working with state agencies and stakeholders, development of long-term plans, and evaluating state efforts. These areas of focus include:

- Preventing disabilities caused by prenatal alcohol or substance exposure
- Preventing disabilities caused by maternal health issues during pregnancy
- Preventing acquired brain injury in children
- Early identification and diagnosis of disabilities to ensure early intervention and services
- Promoting mental health and wellness for children with an intellectual or developmental disability.³¹⁵

One of the initial projects of this office was to facilitate trainings using *The Road to Recovery: Supporting Children with Intellectual Disabilities Who have Experience Trauma* developed by the National Child Traumatic Stress Network and the Hogg Foundation for Mental Health.

REHABILITATIVE AND SOCIAL SERVICES UNIT

The Rehabilitative and Social Services Unit includes programs and services transferred from Department of Assistive and Rehabilitative Services (DARS) to HHSC. The programs in this unit that offer services to individuals living with mental health conditions include:

- Independent Living Services Programs
- Comprehensive Rehabilitation Services
- Guardianship

INDEPENDENT LIVING SERVICES PROGRAM

There are 30 independent living centers in Texas. As of August 2016, all independent living services were outsourced to and provided by centers for independent living (CILs) located across the state. A list of centers is available at <http://www.ilru.org/projects/cil-net/cil-center-and-association-directory-results/TX>. The Independent Living Services Program is intended to promote self-sufficiency for individuals with a disability that results in substantial barriers in ability to live independently, including mental health and substance use conditions.³¹⁶ Services within the Independent Living Program seek to provide the individual with “consumer control, peer support, self-help, self-determination, equal access and self-advocacy.”³¹⁷

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 services. CILs partner with HHSC and community-based organizations and are funded either privately or with state and federal funds.

Eligibility

In order to be eligible for independent living services, an individual must be certified

by a counselor to have a significant disability that results in a 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.³¹⁸

Independent living core services include:

- Information and referrals
- Independent Living skills training
- Counseling
- Advocacy
- Transition services

Additional services available from CILs that have contracted with HHSC to provide may include:

- Counseling
- Orientation and mobility
- Recreation and socialization
- Rehabilitation technologies
- Examinations³¹⁹

COMPREHENSIVE REHABILITATION SERVICES

The Comprehensive Rehabilitation Services program serves people 15 years and older who have experienced traumatic brain injuries and/or traumatic spinal cord injuries.³²⁰ The program is intended to ensure that consumers who have traumatic brain injuries (TBIs) and/or spinal cord injuries (SCIs) receive individualized services to improve their functioning within their homes and communities to promote independence.³²¹

The following are basic statistics available relating to the CRS program for FY 2019:

- Number of individuals serviced – 740
- Number of new applications received – 401
- Number of successful case closures – 116
- Average monthly cost per individual – \$2,686
- Traumatic Brain Injury – 379 individuals
- Spinal Cord Injury – 333 individuals
- Both TBI and SCI – 28³²²

GUARDIANSHIP PROGRAM

The Guardianship Services program provides guardianship services to youth aging out of conservatorship referred by DFPS as having a continued need for a guardian, or by a court under limited circumstances as described in the Estate Code. The court appointment of guardianship over an individual is intended to provide protection for adults whom the courts deem incapacitated. Often guardianship is appropriate and works as intended, ensuring guardians effectively manage the affairs of older adults and people with disabilities fairly, honestly, and appropriately. Guardianship

profoundly limits a person's decision-making rights and therefore must be considered carefully. Guardianship may include, but is not limited to, overseeing services, arranging for community or institutional placement, managing estates, and making medical decisions.

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 and appear to meet the adult definition of incapacity;
- Incapacitated adults age 65 or older, or between the ages of 18-65 with a disability, who were referred by APS following an investigation in which abuse, neglect (including self-neglect), or exploitation was confirmed, and no other means of protecting the person is available and there is some indication the individual lacks capacity; and
- Incapacitated individuals referred directly to the program by a court with probate authority under certain criteria established in statute or rule.³²³

In order for HHSC to provide guardianship services, less restrictive alternatives must not be available; an appropriate and qualified alternate guardian must not be available and willing to serve; the individual under guardianship must have resources available to fund the services, including long-term care; and there must be an expectation that guardianship will meet the person's needs.³²⁴

During the 86th legislative session, the following bills passed related to the guardianship process in Texas:

- SB 31 (Zaffarini/Smithee) directed the Office of Court Administration of the Texas Judicial System to establish and maintain a guardianship abuse, fraud, and exploitation deterrence program designed to provide additional resources and assistance to courts that have jurisdiction over guardianship proceedings.³²⁵
- SB 536 (Zaffirini/Murr) and SB 667 (Zaffirini/Thompson) both passed but were ultimately vetoed by the Governor.
 - SB 536 would have created a system of regional specialized courts with jurisdiction over guardianship proceedings and protective services proceedings to be served by associate judges appointed by the presiding judge of each administrative judicial region. The Governor's veto stated that the bill was "misguided in its attempt to create an expensive new system," and the legislature needs to "find a better way to address the issue."³²⁶
 - SB 667 would have revised and updated provisions governing probate and guardianship matters, and procedures for persons who are incapacitated or have a mental illness. Additionally, it would have authorized the commissioners' court of a county to create an office of public guardian to provide certain guardianship services to incapacitated persons or enter into an agreement with a person operating a nonprofit guardianship program or private professional guardianship program to act as a public guardian for such purposes.

The Governor’s veto stated that while the bill made improvements to the probate and guardianship process, the creation of new public guardianship offices controlled by counties was unnecessary because “private attorneys are capable of handling these cases without the expense of this new bureaucracy.”³²⁷

HEALTH AND DEVELOPMENTAL SERVICES

EARLY CHILDHOOD INTERVENTION (ECI) SERVICES

Early interventions have the potential to mitigate the impact of developmental delays that can lead to later physical, cognitive, and behavioral challenges. Providing Early Childhood Intervention (ECI) services to families and children at an early stage in development can reduce the cost of special needs services later in the child’s life, as well as enable families to provide support to their special needs children and counter environmental risk factors.³²⁸

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 zero to three.³²⁹ State general revenue funds are required to draw down federal funding for ECI programs. Direct state appropriations for ECI in Texas decreased 11 percent from \$166 million in FY 2011 to \$148 million in FY 2018. Prior to the 86th legislative session, HHSC requested an increase of \$72.6 million for ECI. While the legislature decided to fund a partial increase of \$31 million, the increase was the largest in many years.³³⁰

In 2019, Texas lawmakers also attempted to pass legislation that would have improved access to ECI services. HB 12 (Davis), and similarly SB 2225 (Zaffirini), would have created an ECI telehealth pilot program, required some health plans to cover specified ECI services that are Medicaid-reimbursable, and created a provider ombudsman in the HHSC. HB 1635 (Miller) and SB 1956 (Zaffirini) would have extended insurance coverage to require most private insurance companies to cover certain ECI services. However, these legislative actions did not pass.³³¹ The COVID-19 pandemic created some flexibility in ECI services provided remotely through telehealth, although HHSC has not indicated any long-term continuation of this method.

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 (IFSP) Meeting and Individualized Family Service Plan Development (must be written within 45 days of the ECI referral)
5. ECI Service Delivery Begins (within 28 days of signing the IFSP)
6. Review of Child's Progress (occurs regularly, but family can request at any time)

Future Steps: Leaving ECI

7. Children must transition out of ECI by their third birthday (or when deemed no longer necessary; transition planning should begin after age 2)

Source: Texas Health and Human Services. (n.d.). *ECI parent handbook*. Retrieved from http://www.mhmtc.org/Portals/0/PDF/ECI_Document_ParentHandbook_English.pdf

Eligibility

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 determined by a child meeting at least one of following three criteria:³³²

- **Medically diagnosed condition:** Children with medical diagnoses that are likely to cause developmental delays and have a need for services. For a list of diagnoses that qualify for ECI see <https://diagsearch.hhsc.state.tx.us/>
- **Auditory or visual impairments:** Children with auditory or visual impairments as defined by the Texas Education Agency (TEA).³³³
- **Developmental delays:** Children with developmental delays of at least 25 percent that affect function in one or more areas of development (social emotional, self-help, communication, motor functions, or cognitive skills).³³⁴

An ECI team evaluates a child for developmental delay using the Battelle Developmental Inventory, 2nd edition. If the child qualifies for services, a team identifies the family's daily routine and the child's strengths and needs. Based on the results of this evaluation, ECI professionals and the child's family work as a team to develop an individualized family service plan. The plan may include a range of services such as evaluation, service planning, family counseling, therapy services (such as occupational, physical, and speech therapy), nutrition services, and psychological and social work services. The services provided are meant to be family-centered and be provided in familiar settings.³³⁵

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, IFSP development, and translation and interpreter services.³³⁶ ECI is a cost share program, meaning that families with the ability to pay are expected to contribute financially to the cost of services. Children on Medicaid or in foster care or kinship care receive all ECI services free of charge. State regulations require ECI

to collect payment through the child’s private or public health insurance or charge up to a maximum amount. Some families pay for ECI services on a sliding scale basis. Family income, family size, the child’s foster care status, and public and private health 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.³³⁷ In FY 2019, 60,596 children of the 88,195 children referred received comprehensive ECI services.³³⁸ Table 50 provides data on recipients of ECI services.

Table 50. Early Childhood Intervention, FY 2019

Reasons for eligibility	
Medically diagnosed	15.7%
Developmental delays	82.9%
Auditory or visual impairment	1.4%
Number of children in each age group receiving services	
0-12 months	34.4%
13-24 months	33.6%
25-36 months	32.0%
Services used	
Service Coordination	100%
Specialized Skills Training (Developmental Services)	78.5%
Speech Language therapy	58.6%
Occupational therapy	30.3%
Physical therapy	23.8%
Nutrition	4.5%
Psychological/social work	1.9%
Vision services	1.4%
Audiology	1.9%
Behavioral Intervention	0.4%
Race/Ethnicity of child*	
Hispanic/Latino	53.3%
White	35.9%
Black/African American	8.6%
Asian/Pacific Islander	2.8%
American Indian/Alaskan	0.2%
Two or more races	0.8%

Other Information	
Males	64.0%
Females	36.0%
Medicaid	65.2%
Primary Language English	86.0%
Primary Language Spanish	13.5%
Primary Language Other	0.5%
Referral Source	
Medical/Health Services	59.0%
Parent/Family/Friends	22.8%
Social Services	11.7%
ECI Programs	4.6%
Educational	1.8%

Source: Texas Health and Human Services Commission (2020). *ECI data & reports*. <https://hhs.texas.gov/doing-business-hhs/provider-portals/assistive-services-providers/early-childhood-intervention-eci-programs/eci-data-reports>

AUTISM PROGRAM

The following description was captured from the HHSC website (retrieved from <https://hhs.texas.gov/services/disability/autism>):

Autism spectrum disorder (ASD) is the fastest growing serious, developmental disability, affecting an estimated 1 out of 59 children in the United States. With this number growing at a significant rate, there continues to be an unmet need for services. The Health and Human Services Autism Program champions excellence in the delivery of services for families of children with autism. Services are provided through grant contracts with local community agencies and organizations that provide applied behavioral analysis (ABA) and other positive behavior support strategies. The program helps improve the quality of life for children on the autism spectrum and their families.

The Autism Program started as a pilot project in FY 2008 and was intended to extend treatment services, including applied behavior analysis (ABA), to children ages 3 through 8 with a diagnosis on the autism spectrum. On September 1, 2014, rules were adopted with two ABA services for children: comprehensive ABA services for children aged 3 through 5 years and focused ABA services for children aged 3 through 15 years. Other changes included parent participation, child attendance, and additional staff training requirements. The Comprehensive ABA treatment services were phased out during the 2016-2017 biennium and no longer existed after August 31, 2017. During the 86th legislature, over \$14 million for FY 20-21 was allocated for ABA treatment services. However, those funds were directed to only be available for children enrolled in the focused program. Additionally, Rider 32 stated that if HHSC

moved forward with adding intensive behavioral intervention (IBI) as a Medicaid benefit for persons under age 20 with a diagnosis of Autism spectrum condition, funds would be allowable to reimburse for provision of IBI services.³³⁹

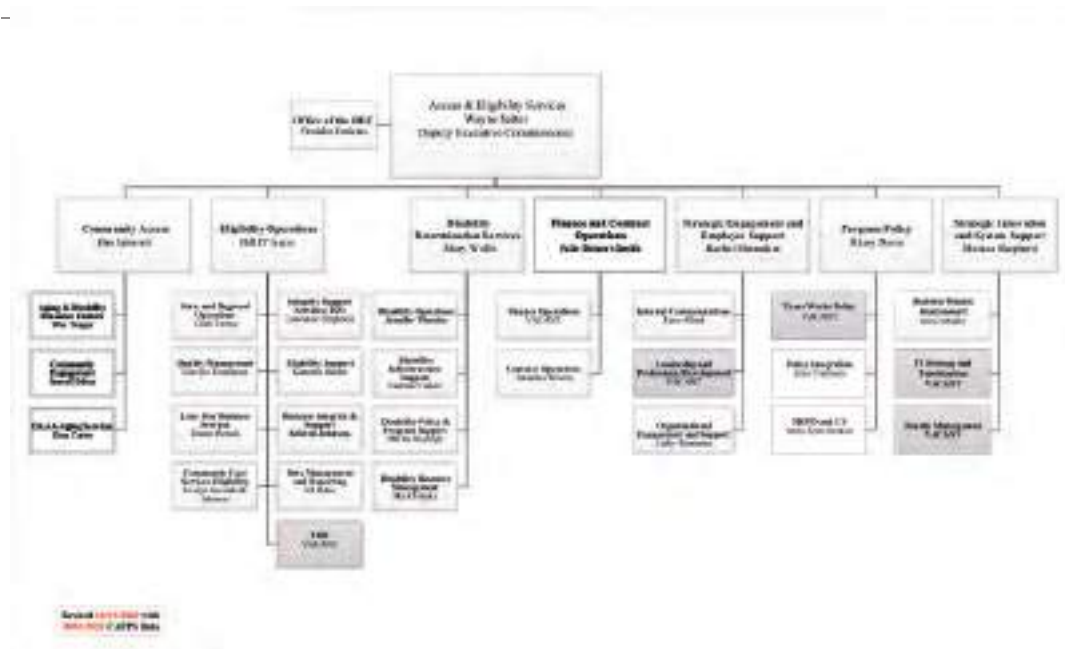
Table 51 provides data on the number of children served, the average cost per child, and the number of program sites in Texas.

Table 51. Autism Program, FY 2020-21

Autism Program	
Average monthly number of children served	470
Average monthly cost per child	\$518
Number of children served per year	1,150

Source: Texas Legislature Online (2019). *H.B. 1, General Appropriations Act, 86th Legislature, FY 2020-21*. Retrieved from <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00001F.pdf#navpanes=0>

Access and Eligibility Services



Source: Texas Health and Human Services Commission. (October 2020). *Public Information Request, October 2020*.

Individuals living with mental health and substance use conditions are often eligible for federal disability benefits. However, accessing those benefits can be a challenging and confusing process. While Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are federally funded programs, disability determination for these services is conducted by the state through contracts with the federal government. Responsibility for disability determination is housed in the Access & Eligibility Services Division of HHSC.

In addition to conducting disability determination reviews for federal benefits, the division also partners with community organizations that assist low-income families applying for basic services such as obtaining food subsidies, temporary assistance to needy families, and Medicaid and CHIP services. With the assistance of Regional Community Relations specialists, communities work to improve access to the Medicaid and CHIP services often needed by individuals living with serious mental illness or children/youth with SED. A directory of these Regional Partnership Specialists can be found at <https://hhs.texas.gov/about-hhs/community-engagement/office-community-access-services>.

DISABILITY DETERMINATION SERVICES

The disability decision-making process begins when an individual files an application for benefits. Determination is then made if the applicant meets the nonmedical requirements for benefits, such as age and work credits. If those requirements are met, the application is sent to the Disability Determination Services (DDS) office. The DDS then decides whether an individual is disabled under Social Security

law. The definition of disability under Social Security differs from other disability programs and does not pay benefits for partial or short-term disability. Section 223(d)(1) of the Social Security Act defines disability as an:

- A Inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, or
- B In the case of an individual who has attained the age of 55 and is blind (within the meaning of blindness as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which the individual has previously engaged with some regularity and over a substantial period of time.³⁴⁰

Benefits are available for both adults and children who meet eligibility include Social Security Disability Income (SSDI) and SSI.³⁴¹ Both SSI and SSDI are cash assistance programs administered by the federal Social Security Administration (SSA). HHSC staff makes the initial disability determination for Texans applying for SSDI and/or SSI. Assistance applying for these cash assistance programs can be found at <https://www.ssa.gov/disability/determination.htm>.

Some people with serious mental health conditions will qualify for either SSDI or SSI. Qualifying for both SSDI and SSI benefits at the same time is called “concurrent benefits,” according to the Social Security Administration. While concurrent benefits are not common, they are possible if an individual worked enough at some point in his or her life to have the required number of work credits.^{342,343}

SOCIAL SECURITY DISABILITY INSURANCE

SSDI is governed by rules set out in Title II of the Social Security Act and covers workers age 18 to 65 who have a disability, widows/widowers of workers with a disability, and adult children (with a disability) of workers with sufficient work histories.³⁴⁴ People become eligible for SSDI throughout their working lives by paying social security taxes.³⁴⁵ Approval for SSDI payments results in eligibility for Medicare coverage after a two-year waiting period.³⁴⁶

SUPPLEMENTAL SECURITY INCOME

SSI is governed by rules set out in Title XVI of the Social Security Act. SSI provides monthly stipends to qualifying low-income adults who have a disability, are blind, or are over the age of 65.³⁴⁷ Additionally, an individual must meet additional requirements including having limited resources and cannot be in a government-funded hospital or prison.³⁴⁸ Children who have a disability or are blind may also qualify for SSI when they are not married nor head of a household, under the age of 18, or under the age of 22 while regularly attending school.³⁴⁹ Unlike SSDI, SSI is not based on an individual’s work history.³⁵⁰ The monthly maximum amounts for 2020 are \$783 for an eligible individual and \$1,175 for an eligible individual with an eligible

spouse.³⁵¹ Once approved for SSI, participants are eligible for Medicaid.³⁵² According to the Social Security Administration, in January 2019 approximately 7.97 million individuals were receiving SSI benefits in the U.S, a decrease of 98,000 recipients from 2018. It is estimated that by 2043, the number of recipients will be closer to 8.7 million.³⁵³

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

- **Reconsideration:** Another disability examiner and medical team reviews the case to determine if the decision was proper. Claimants may submit additional evidence to support their case.
- **Administrative Hearing:** Claimants may present witnesses and evidence at a formal, private hearing with an administrative law judge.
- **Social Security Appeals Council Hearing:** Reviews decisions by judges at the administrative hearing level.
- **U.S. Federal District Court:** A hearing at the federal court level; very few cases reach this level.³⁵⁴

According to a report by the SSA that tracked SSDI outcomes from 2008-2017, the number of applicants who were granted awards upon initial review averaged 22 percent.³⁵⁵ Of those who appealed their denial, 2 percent of applicants were subsequently granted benefits at the reconsideration state and 9 percent through a hearing.³⁵⁶

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. Like serious physical conditions, mental health conditions can be considered a disability and may allow an individual to access SSDI or SSI cash benefits if they meet other eligibility criteria. Initial disability determinations are made by disability officers within the DDS Division.³⁵⁷

According to a 2019 report by the SSA, mental health conditions constituted about one-quarter of the national SSDI diagnoses in 2018.³⁵⁸ Disability determinations for SSDI on the basis of a mental health condition are categorized as:

- Neurocognitive conditions
- Schizophrenia spectrum and other psychotic conditions
- Depressive, bipolar and related conditions
- Intellectual disability
- Anxiety and obsessive-compulsive conditions
- Somatic symptom and related conditions
- Personality and impulse-control conditions
- Autism Spectrum conditions
- Neurodevelopmental conditions
- Eating disorders
- Trauma-and-stressor related conditions³⁵⁹

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 SSA makes the final admission decision on eligibility after consideration of a more exhaustive set of eligibility criteria.³⁶⁰ To be eligible for SSI, adults and children must meet strict financial and functional criteria in addition to having a disability (including mental health conditions).³⁶¹

Additional information on eligibility criteria and how to apply is available on the Social Security website at <http://www.ssa.gov>.

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Policy Concerns

- Effects of COVID-19 on the agency's operations and on children in state conservatorship, also known as foster care.
- Maintaining quality, accessible mental health treatment and support services for both children and their families during the agency's transition to community-based care.
- Tracking the usage and effectiveness of the Alternative Response (AR) system in the Child Protective Investigations (CPI) process.
- Increased focus on housing, employment, and normalcy as crucial parts of recovery for foster youth, including those aging out of foster care.
- Continued monitoring and prevention of child fatalities within the Child Protective Services (CPS) system.
- Addressing disproportionality of minority and LGBTQIA+ youth in the CPS system and providing adequate services to meet the needs of these children and youth.
- More individualized interventions and treatment plans for youth with dual diagnoses (i.e., mental health and substance use or intellectual/developmental disabilities).
- System-wide integration of trauma-informed practices into all levels of care, including accessible trainings for all mental health professionals, caregivers, and staff working within the system.
- Improving support for youth transitioning from child to adult services (ages 17-24).
- Ongoing review of the barriers to implementation for the Foster Care Redesign/Community Based Care Project and outcomes of regions already in Community Based Care.
- Implementation of the Family First Prevention Services Act in Texas in effort to draw down funding for additional mental health and substance use treatment, support, and prevention efforts.
- Combatting human trafficking and child exploitation for children within the foster care system and young adults who have aged out.
- Continuing innovative practices for families in effort to prevent the need for child relinquishment to obtain mental health services
- Preparing for a potential increase in family violence and child abuse cases during the COVID-19 pandemic and the need for robust prevention services to meet families' needs.
- Continuing to focus on supporting and providing treatment for parents at risk of engagement with CPS due to mental health and substance use issues.

Fast Facts

- In FY 2019, a record 6,107 children in state care found permanent homes, an increase from 5,678 in FY 2018. More than half of these adoptions were by relatives.¹
- In FY 2019, more children left foster care (20,343) than entered it (18,615) for the

first time in the state's history.²

- In FY 2019, the Statewide Intake (SWI) division of DFPS received over 449,000 reports related to allegations of abuse and neglect.³
- In FY 2019, there were 67,313 confirmed and 199,298 unconfirmed victims in abuse/neglect investigations.⁴
- In FY 2019, there were 18,615 children removed from their homes by CPS, or 2.51 per 1,000 children.⁵
- In FY 2019, there were 153,260 children and adults served by CPI's AR system.⁶
- Adult Protective Services (APS) completed 84,439 in-home investigations, with 49,284 of those investigations validated and 37,346 completed in-home service delivery stages.⁷
- An estimated 234,000 people in Texas are victims of labor trafficking, and an estimated 79,000 youth are victims of sex trafficking in the state at any given time.⁸
- Of the 51,417 children and youth in DFPS conservatorship in FY 2019, 2,122 children and youth were reported missing at some point.⁹
- Texas had 235 confirmed child abuse and neglect-related fatalities in FY 2019, an increase from 211 in FY 2018.¹⁰
- Experts predict that the COVID-19 pandemic may stimulate family violence and child abuse in families where it has not occurred before and worsen situations where violence and mistreatment is already an issue.¹¹
- 17,500 children were in DFPS Substitute Care as of August 31, 2018. Of those in foster care, 11,906 were in Child Placing Agency (CPA) foster homes, 1,516 in DFPS foster homes, 845 in basic child care, 1,747 in residential treatment centers (RTCs), 731 in emergency shelters, and 754 in other types of foster care.

DFPS Acronyms

DFPS Acronyms

ACA – Affordable Care Act

ACH – All church home

APS – Adult Protective Services

APS PI – Adult Protective Services provider investigations

AR – Alternative response system

CAC – Children's Advocacy Center

CANS – Child and Adolescent Needs and Strengths assessment

CASA – Court appointed special advocate

CBCAP – Community-based child abuse prevention

CCL – Child Care Licensing

CFE – collaborative family engagement

COVID-19 – Coronavirus disease of 2019

CPD – CPS professional development

CPS – Child Protective Services

CYD – Community youth development

DFPS – Department of Family and Protective Services

DSHS – Department of State Health Services

FFCC – Former Foster Care Children

FFPSA – Family First Prevention Services Act

FGCM – Family group decision making

GAO – Government Accounting Office

GRO – general residential operations

HHSC – Health and Human Services Commission

HIP – Help through intervention and prevention

HOPES – Health outcomes through prevention and early support

HTCE – Human Trafficking and Child Exploitation

IDD – Intellectual and other Developmental Disabilities

JMC – joint managing conservatorship

LGBTQIA+ – Lesbian, gay, bisexual, transgender, queer, intersex, and asexual

LMHA – Local mental health authority

MCO – Managed care organization

MTFCY – Medicaid For Transitioning Foster Care youth

NPP – Nurturing Parent Program

OCOK – Our Community Our Kids

PAL – Preparation for adult living

PEI – Prevention and early intervention

PMC – Permanent managing conservatorship

QRTP – Qualified residential treatment program

RCCL – Residential child care licensing

RTC – Residential treatment center

SNAP – Supplemental Nutrition Assistance Program

SSCC – Single source continuum contractor

STAR – Services to at risk youth

SWI – Statewide intake

SUD – Substance use disorder

TANF – Temporary Assistance for Needy Families

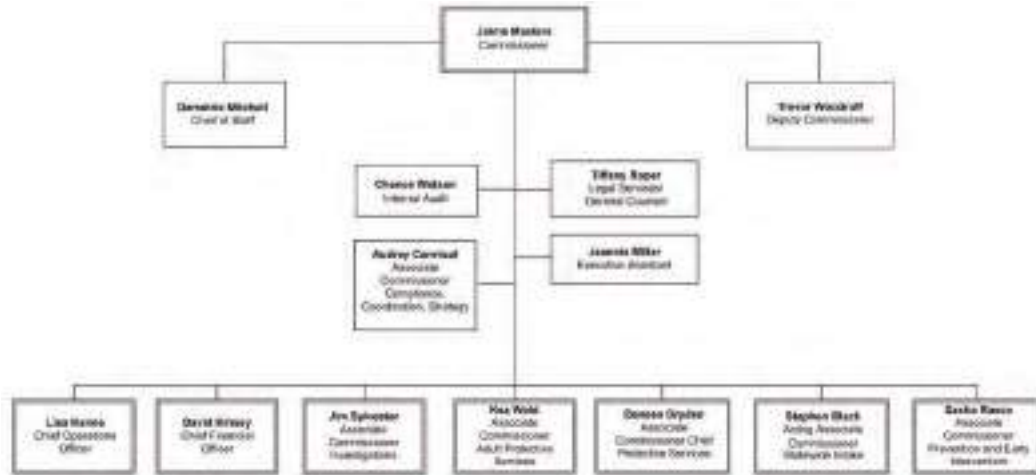
TEA – Texas Education Agency

TFFC – Treatment Foster Family Care

TFTS – Texas families together and safe

YES – Youth Empowerment Services waiver

Organizational Chart

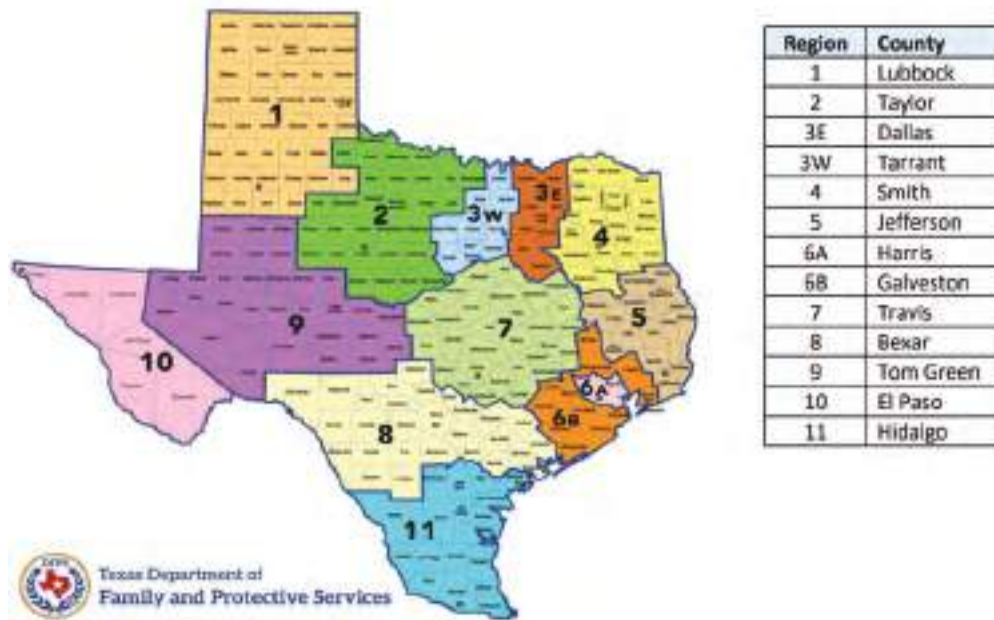


Source: Department of Family and Protective Services. (2020, May 10). DFPS Org Chart. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Executives/DFPS_Org_Chart.pdf

Overview

The Department of Family and Protective Services (DFPS) is the state agency responsible for ensuring the safety of children, older adults, and adults with disabilities. DFPS is an independent agency that provides services and supports to these vulnerable populations to reduce the likelihood of abuse, neglect, and exploitation. Its headquarters are in Austin and included more than 12,000 employees that work in 328 local offices in 11 geographic regions as of August 31, 2019. DFPS geographic regions are shown in Figure 70.¹²

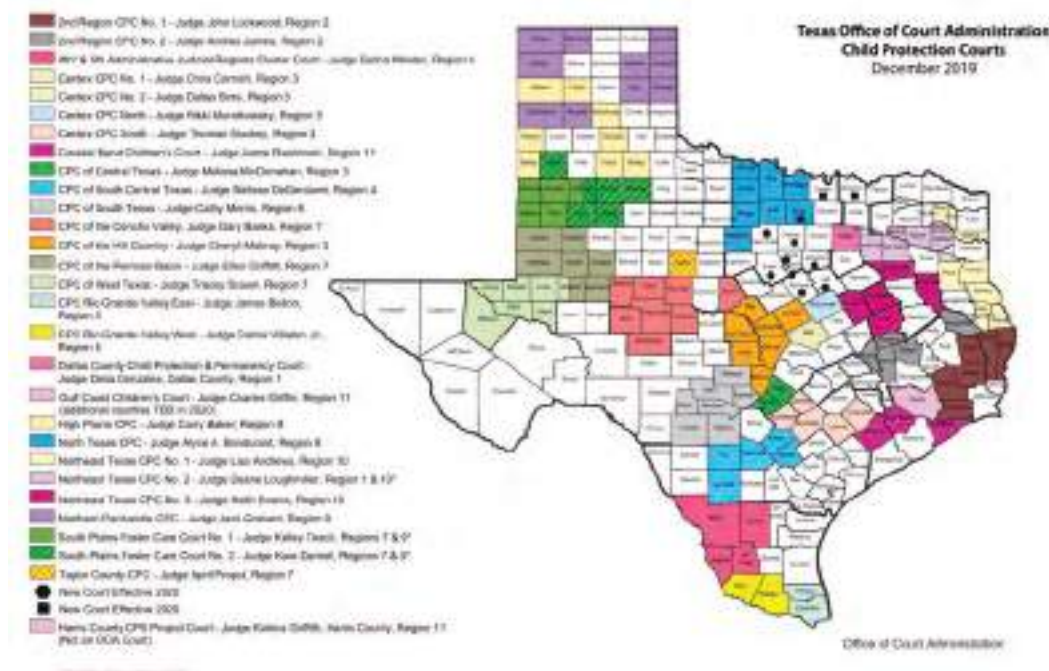
Figure 70. DFPS Region & County Map



Data obtained from: Texas Department of Family and Protective Services. "Agency Strategic Plan Fiscal Years 2021-2025," June 1, 2020. https://www.dfps.state.tx.us/About_DFPS/Strategic_Plans/documents/2021-2025-DFPS_Strategic_Plan.pdf.

As Figure 71 below illustrates, Texas is also divided into several regional networks of child protection courts.

Figure 71. Map of Child Protection Courts and Covered Regions



Data obtained from: Child Protection Courts. (2019, December). Retrieved from https://www.txcourts.gov/media/1445466/childprotectioncourts_december2019-11x17.pdf

As Table 52 shows, DFPS is comprised of five separate divisions. In 2017, Child Care Licensing (CCL) was transferred to Health and Human Services (HHS).¹³ During that transition, DFPS created an Investigations division.¹⁴

Table 52. Department of Family Protective Services (DFPS) Divisions

Division	Description
Statewide Intake (SWI)	Operates the Texas Abuse Hotline to process reports of abuse, neglect, and exploitation for both adults and children. Reports include allegations of abuse and neglect by those providing services for individuals living with mental illness or intellectual disabilities. SWI also runs the Texas Youth Hotline, which offers counseling, resources, and referrals for youth and their families in an attempt to prevent dangerous and harmful situations. ¹⁵
Prevention and Early Intervention (PEI)	Provides community outreach on mental health and other wellness services to help prevent child abuse, neglect, delinquency and truancy of Texas children. PEI runs its own prevention programs in addition to funding and supporting community providers of early prevention services. ¹⁶
Child Protective Services (CPS)	Responds to investigations of child abuse and neglect. CPS strives to strengthen and stabilize families to keep children in their own home. CPS also oversees and manages the foster care system for children who are removed from unsafe home environments and placed into foster care homes or state custody. ¹⁷
Adult Protective Services (APS)	Investigates allegations of abuse, neglect, and exploitation of older adults (age 65 and over) and people over age 18 who have physical or mental disabilities. Services include investigations of abuse in client's homes, state-contracted community settings, and state facilities. APS also educates the public on adult abuse prevention with programming that includes a public outreach campaign. ¹⁸
Child Protective Investigations (CPI)	Examines reports of child abuse or neglect to determine if any child in the family has been abused or neglected. Investigators decide if there are any threats to the safety of all children in the home. If so, they determine whether the parents are willing and able to adequately manage those threats to keep children safe. If DFPS decides that children aren't safe, the investigator starts protective services. ¹⁹

Sources: Texas Department of Family and Protective Services. *Learn about DFPS*. Retrieved from http://www.dfps.state.tx.us/About_DFPS/default.asp

Texas Department of Family and Protective Services. DFPS Annual Report 2019. (2020). Retrieved from https://www.dfps.state.tx.us/About_DFPS/Annual_Report/2019/DFPS_2019_Annual_Report.pdf

Changing Environment

The mental health needs of children and their parents involved with the child welfare system are far-reaching. CPS has been plagued for years with serious issues including child fatalities, overburdened caseworkers, and systemic issues in the treatment and care of foster youth. This was bolstered by a 2015 Supreme Court ruling that stated the system had “violated the constitutional rights of children living in foster care.”²⁰ The most significant system-wide change occurred during the 85th legislative session when the Texas Legislature voted to shift the child welfare system to embrace community-based care in order to keep children closer to home and connected with their communities and families. Due to critical issues within the child welfare

system, transforming CPS continued to be a legislative priority in the 86th legislative session. The state has also spent significant time focused on preparing for the implementation of the Family First Prevention Services Act (FFPSA), which was passed by Congress in 2018. Certain provisions will not go into effect in Texas until 2021.^{21,22} Due to the COVID-19 outbreak within Texas in 2020, the 87th Texas legislative session will likely be focused on aiding the families and children served by DFPS whom have been affected by the pandemic.

In June 2020, DFPS released their Agency Strategic Plan for FY 2021-2025, which listed the following goals:

- Goal 1: Client Services - Improve direct delivery services to meet client, family, and community needs
- Goal 2: Workforce Stability and Development - Increase workforce stability and retention of institutional knowledge by focusing on attracting, retaining, and developing highly qualified staff
- Goal 3: Process Improvement - Strengthen internal processes by better analyzing agency operations and identifying and correcting areas for more efficient and effective operations
- Goal 4: Teamwork - Enhance internal communications to ensure cohesion among divisions
- Goal 5: Community Relations - Improve external communications and outreach to better inform the public and assist with protecting clients, families, and communities²³

CHILD WELFARE LEGISLATION PASSED BY THE 86TH TEXAS LEGISLATURE

Various bills passed in the 86th legislative session that directly affected children involved in the DFPS system. The General Appropriations Bill, HB 1 (Zerwas/ Nelson), includes several budget riders affecting the agency. Article II, Rider 52 directs the Health and Human Services Commission (HHSC) and DFPS to enter into a memorandum of understanding for the provision of outpatient substance use treatment services by HHSC to referred DFPS clients.²⁴

Rider 66 mandates an annual legislative report on all opioid abuse and misuse-related programs at HHSC, DFPS, and the Department of State Health Services (DSHS) to be submitted by HHSC.²⁵

Rider 24 requires DFPS to submit quarterly reports on whether foster children are being placed in appropriate service levels.²⁶ The April 2020 report stated that two residential treatment centers (RTCs) were contracted to provide Intense Plus services, with three providers in the process of becoming certified providers.²⁷ Intense Plus services are intended to address chronically serious to severe emotional and/or behavioral management problems that interfere with a child's ability to function in a family, school, or community setting outside of a therapeutic environment. Additionally, between September 1, 2018 and April 17, 2020, 133 children received placement through Treatment Foster Family Care

services. These services hold providers accountable for decreasing the acuity of need and administering placements into less restrictive, more family-like settings.²⁸ More detailed information on the April 2020 report can be found here https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-04-30_Rider_24_Report.pdf.

SB 195 (86th, Perry/Parker) requires DFPS to publicly report state-level data related to parental substance use, prenatal substance exposure, and postnatal treatment.²⁹

HB 72 (86th, White/Paxton) directs HHSC and DFPS to develop and implement a program that allows the adoptive parent or permanent managing conservator of a former foster child to receive or continue receiving Medicaid benefits under the STAR Health program or the STAR Kids managed care program.

HB 2764 (86th, Frank/Hughes) mandates that DFPS and single source continuum contractors (SSCCs) limit trainings for potential caregivers to a maximum of 35 hours, and requires SSCCs to meet the training requirements of the FFPSA.³⁰

Amongst many other provisions, SB 781 (86th, Kolkhorst/Leman) directs DFPS to develop a strategy for trauma-informed protocols aimed at reducing runaway incidents from RTCs, as well as a plan for foster care placement facilities eligible for funding under the FFPSA.³¹

HB 1709 (86th, Gonzalez/Menendez) requires school districts to notify DFPS if a surrogate parent has been appointed to a child with disabilities and is in the conservatorship of the state. It also clarifies that if a school district determines that a court-appointed surrogate parent is not properly performing their required duties, then the district shall consult with DFPS. If the agency agrees with the school district that the court-appointed surrogate parent is unable or unwilling to act in the surrogate parent capacity, then DFPS must request that the court review the appointment of the individual.³²

HB 811 (86th, White/West) requires schools to consider students' status in the conservatorship of DFPS, as well as if they may be experiencing homelessness, before issuing suspensions, removals, expulsions, or placements in alternative education programs.³³

LEGISLATION THAT FAILED TO PASS IN THE 86TH TEXAS LEGISLATURE

Several bills failed to pass that would have reformed child welfare or DFPS policies and procedures.

HB 517/SB 1251 (Israel/Menendez) would have defined unprofessional conduct by a mental health professional to include attempts to change a child's sexual orientation, gender identity, and attractions or feelings towards the same sex.³⁴

HB 2926/SB 951 (Hinojosa/Watson) would have created the Family First Prevention Services Task Force in order to assess the readiness of Texas to implement the FFPSA and make recommendations to support the state in its transition and reformatations.³⁵

HB 1536/SB 2419 (Miller/Fallon) would have required DFPS to implement and expand trauma-informed care across the child welfare system, including staff and caregiver training requirements. It included the establishment of a task force consisting of nine DFPS-appointed members that work in the trauma-informed care field, a House Member appointed by the Speaker, and a Senator appointed by the Lieutenant Governor, to improve trauma-informed practices and policies throughout DFPS.³⁶

CHILD RELINQUISHMENT TO OBTAIN MENTAL HEALTH SERVICES

Child relinquishment to obtain mental health services refers to the process in which a parent or guardian terminates parental rights of their child and relinquishes those right to the state, solely to help their child get the intensive mental health services he/she needs. Legislation passed in the 83rd, 84th, and 85th sessions addressed the need to provide joint managing conservatorship (JMC) so that a family can stay connected to their child, and disallowed placement of the parents' name on the abuse/neglect registry if the child was relinquished solely to obtain mental health services. Recent experiences of families indicate that significantly more work still needs to be done to support the children who need these services and their families.

To help prevent these relinquishments, the Texas Legislature created the Child Relinquishment RTC Diversion Project as an alternative way to access intensive services. In January 2020, a group of HHSC and DFPS staff, provider organizations, parents, and children's mental health and child welfare stakeholders conducted a process mapping exercise of the Diversion Project to identify areas needing improvement. This program was originally developed as a way to prevent parents from relinquishing custody of their child to the state when less restrictive mental health services were unsuccessful in meeting the intensive needs of the child. The results of the process mapping and a letter with recommendations to improve the system were sent to the executive commissioner of HHSC in May 2020, and again in September 2020 after the appointment of a new executive commissioner.

The group collectively identified potential bottlenecks in the current processes, discussed both positive and unintended outcomes that result from some of the program policies, and developed preliminary recommendations that are listed below:

- Enhance intensive community-based services and supports that families need in order to prevent the difficult decision to relinquish custody
- Allow children who are post-adoption to have access to the diversion project services to enable adoptive families to access a broader range of state-funded behavioral health services needed to support the family and prevent custody relinquishment
- Shorten the wait-time to obtain diversion project placement
- Reform the process so that a CPI investigation is no longer needed to obtain

services

- Create a centralized point-of-contact for CPS caseworkers handling mental health relinquishment cases
- Evaluate JMC standards across the state
- Increase the awareness of CPS workers, local mental health authority (LMHA) staff, and families of the diversion project
- Enhance data collection of programs to ensure that gaps and barriers can be identified and addressed

LAWSUIT AGAINST DFPS/CPS

In 2011, the DFPS foster care system came under increased public scrutiny after a class-action lawsuit was filed against DFPS on behalf of all Texas children in foster care on a long-term basis. The case was originally brought forth by two advocacy groups — Children’s Rights and A Better Childhood. Over a dozen other advocacy organizations joined as plaintiffs in the case.³⁷ The lawsuit focused on how CPS treats children in the state’s Permanent Managing Conservatorship (PMC) program, specifically children who have been unable to find a permanent placement within a year of their initial removal from their home.³⁸ In 2011, when the lawsuit was first brought against CPS, there were approximately:

- 12,000 children in PMC, of which there were:
 - 6,400 children in PMC for three or more years;
 - 500 children in PMC for more than 10 years; and
 - More than one-third of children in PMC experiencing five or more placements.³⁹

In December 2015, U.S. Federal District Judge Janis Graham Jack of Corpus Christi issued a ruling on the case, finding that the state had systematically violated the constitutional rights of children in PMC foster care. Judge Jack described the foster care system run by DFPS as one “where rape, abuse, psychotropic medication and instability are the norm,” where children “often age out of care more damaged than when they entered.”^{40,41} Several of the ruling’s reforms to improve the PMC program were implemented in the beginning of 2016. These changes include:

- Addressing caseworker turnover and caseload size issues by directing DFPS to hire enough caseworkers to “ensure that caseloads are manageable” across the state⁴²
- Addressing concerns of child safety in foster care placements by prohibiting placement of children in foster group homes without 24-hour awake supervision and addressing regulatory lapses in the state’s “broken” residential licensing division⁴³

Judge Jack appointed two special masters in March 2016 to help guide and oversee the changes to DFPS’ foster care system.⁴⁴ The two transition masters, mediator and specialist attorney Francis McGovern and Kevin Ryan, former Commissioner of Children and Families for New Jersey, began their new roles working with DFPS on April 1, 2016.⁴⁵ The co-transition masters created a plan to address the capacity

issues, defining “manageable” caseload sizes, and resolving other problems with the PMC program identified in the lawsuit. Their plan guided Judge Jack’s ruling in January 2018, which required DFPS to implement nearly 100 changes to the CPS system. According to Texas CASA, some of the most important were a reduction in caseloads for conservatorship caseworkers, creation of a new comprehensive data system, expansion of placement capacity to meet regional needs, and payment of attorneys ad litem by DFPS while children are in PMC.⁴⁶ After the final ruling was issued, the 5th U.S. Circuit Court of Appeals upheld Attorney General Ken Paxton’s request for a temporary halt on Judge Jack’s order.⁴⁷

In November 2019, Judge Jack found the state of Texas in contempt of court, ruling that they had failed to comply with prior orders.⁴⁸ The judge’s ruling resulted in \$150,000 in paid fines for the state’s failure to require large foster homes and institutions to have 24-hour awake supervisions. From July 2019 to February 2020, the special masters billed the state for about \$3.2 million.⁴⁹

In June 2020, a report was released by independent federal monitors appointed by Judge Jack to look into Texas’ child welfare system.⁵⁰ The report included several violations and stories of children being exposed to harm because: the state frequently moved too slowly to investigate abuse and neglect allegations, inappropriately downgraded allegations against staff, and failed to investigate certain workers accused of harming youth. As of June 2020, state attorneys had not responded to the report. Judge Jack can potentially hold the state in contempt of court again for continuing to be in violations of her orders. According to the Texas Tribune, the report also found that:

- Texas did not adequately inform children in the system about their rights for reporting abuse allegations. A majority of the youths interviewed for the report were unaware of the foster care ombudsman.
- A fragmented system of managing state data makes it difficult to track investigation histories about children and facilities and identify patterns of maltreatment.
- Dozens of new case workers were assigned more children than they should have been responsible for, under a court order designed to limit caseloads to manageable levels.
- Awake-night staff, who are required to monitor homes that house more than six children, were often suspected to be sleeping or drowsy when inspectors arrived. Often, inspectors found that the census sheet of children at the facility did not accurately reflect the children who were there.
- The state failed to comply with the judge’s orders about preventing sexual abuse, leaving children at risk. “The State may be prioritizing identification of victims and aggressors, but not prevention of sexual abuse,” the monitors wrote.⁵¹

FOSTER CARE REDESIGN/COMMUNITY-BASED CARE

Foster care and mental health delivery systems overlap because the youth entering into foster care have suffered traumatic experiences. Trauma inflicted by experiencing physical, psychological, or sexual abuse or chronic neglect has a

profound effect on children.⁵² The effects of trauma can last a lifetime and can play out differently depending on each person's individual experiences. Individuals who experience significant childhood abuse and family discord in their youth have a higher incidence of physical and behavioral health problems as adults.⁵³ A youth who has experienced trauma is at higher risk of having issues with substance use, mental health (such as depression and suicide), promiscuity, and criminal behavior.⁵⁴ Children in foster care often experience abuse and neglect, and as a result experience different degrees of traumatization. Mental health conditions are one of the consequences that typically result from traumatic experiences.⁵⁵ However, children's symptoms of trauma may sometimes be misinterpreted as deliberate problematic behavior or indicative of a condition unrelated to trauma.⁵⁶ It is important to know that children and youth who experience traumatic events can and do heal with proper mental health supports and treatment. Further, providers and caregivers who work from a trauma-informed lens can help children and youth health in a supportive space.

Disconnected and uncoordinated foster care with multiple placements is likely to aggravate childhood trauma and any other mental health conditions, especially if mental health needs are not properly addressed with timely and appropriate care. Lack of permanency and consistency in childcare placements, including receiving a high number of placements, is traumatic and exacerbates mental health conditions for children in foster care.⁵⁷ These symptoms are worsened by placements outside a child's home community. In order to best serve the needs of children and youth in the foster care system, CPS practices need to be embedded with trauma-informed care principles.

In an effort to reduce negative outcomes for children in the foster care system, DFPS embarked on a Foster Care Redesign project in 2010. Now known as Community-Based Care, the initiative was launched in effort to improve outcomes for youth in the areas of safety, permanency, and overall well-being. This community-focused approach involves contracting out to select nonprofits and government agencies, who are then responsible for finding services such as living arrangements or foster homes for children under the care of the state.⁵⁸

One of the biggest changes resulting from Community-Based Care has been the switch from service-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 RTC). This reimbursement structure did not create incentives for a child to be moved to a lower service level. Through the redesign effort, payments are now tied to positive outcomes in the child's care instead of their current service level, thereby encouraging children's transition to lower service levels and corresponding overall reductions in the average cost-per-child.⁵⁹

Community-Based Care also restructures service delivery so that care is coordinated from an SSCC rather than a compilation of DFPS contracts with over 300 private service providers. Texas law requires SSCCs to be either government entities or nonprofits focused on child welfare. The goal of streamlining the delivery of care is to better coordinate services for families so that services are more consistent across the state and readily accessible close to a child's home and community, regardless

of what part of the state they live in.⁶⁰ Under the new system, an SSCC is required to provide a range of services for foster care youth in specific geographic catchment areas.⁶¹ As of October 2019, Texas had 17 catchment areas established by DFPS. Areas where community-based care has not yet been implemented are referred to as being part of the “legacy system,” meaning DFPS still dictates both placement and case management over these areas.⁶² In 2017, the Texas Legislature passed SB 11 (85th, Schwertner/Thompson, Senfronia) to expand the Community-Based Care model to include both foster care and relative or kinship care and services, and give the SSCC sole responsibility for case management.⁶³

A recent partnership between CPS and Texas CASA has been formed to provide collaborative family engagement (CFE) in the child welfare process. CFEs are made up of a CPS caseworker, a CPS supervisor, a Court-Appointed Special Advocate aka “CASA” volunteer, and a CASA supervisor. They work with SSCCs to enhance the well-being of children by maintaining their relationships with biological family members to prioritize a kinship placement. In Phase 1 of CFE, the family is invited into the planning and decision-making process for the children in foster care. Phase 2 involves the shift of case management from CPS to a SSCC caseworker, who will search for permanent placements for the child.⁶⁴

In 2019, SB 355 (86th, West/Click) directed DFPS to identify a network of service providers to provide mental health, substance use, and in-home parenting support for children at risk of entering foster care, the parents and caregivers of children at risk of entering foster care, and pregnant or parenting youth in foster care. SB 355 also required a strategic plan to identify optimal methods for: 1) statewide implementation of foster care prevention services, 2) identification of necessary resources for the department to implement community-based care, and 3) coordinating community-based care implementation with foster care prevention services.⁶⁵

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

- In Stage I, the SSCC will develop a network of services and provide foster care placement services. The focus in Stage I is on improving the overall well-being of children in foster care by keeping them closer to home and connected to their communities and families.
- In Stage II, the SSCC will provide case management, kinship, and reunification services. The focus of Stage II is on expanding the continuum of services to include services for families and to increase permanency outcomes for children.⁶⁶ By the end of FY 2018, Community-Based Care was active in Bexar County, all counties in Region 2, and seven North Texas counties. DFPS grew Community-Based Care in FY 2019 by awarding Saint Francis Ministries in Region 1 a contract to expand the initiative into 41 counties around the Texas Panhandle.

REGION 3B

The first SSCC was awarded to All Church Home (ACH) Child Services in Region 3b in 2013. ACH’s Our Community Our Kids (OCOK) program serves as the SSCC foster

care provider for a seven-county region that includes Erath, Hood, Johnson, Palo Pinto, Parker, Somervell, and Tarrant counties.⁶⁷ The results of the implementation of Stage I of the Community-Based Care program in Region 3b have been positive, as DFPS found an improvement in outcomes for children in Community-Based Care in that region, compared to children in the legacy system outside the region.⁶⁸ In 2019, 81 percent of days in the Community-Based Care area were in foster homes, rather than treatment centers or shelters. Additionally, 74 percent of youth were placed close to their home communities, compared to 62 percent in non-Community-Based Care areas.⁶⁹ OCOK took responsibility for Stage II services in March 2020, where they have provided case management services following a transition with DFPS.^{70,71} OCOK has developed more placements for youth with complex needs in foster homes by increasing placements in foster homes within 50 miles and keeping siblings together. For more information, see the DFPS Rider 15 report provided at the bottom of this section.

Using data from the Region 3b service area (including Fort Worth and Dallas County), one study from the Perryman Group estimates that every dollar invested in the state's Community-Based Care program will return \$3.44 in state revenue and \$1.66 in local revenue.⁷²

REGION 2

As of December 2019, DFPS had contracted to enter Stage II in Region 2, which includes 30 Texas counties. The 2INGage partnership between the New Horizons Ranch & Center and the Texas Family Initiative has been responsible for providing services to this area since December 2018. 2INGage began providing case management services as Stage II commenced, and assumed responsibility for Stage II in June 2020.⁷³ As of March 2020, services were provided through 2INGage to about 750 youth.⁷⁴

REGION 8A

A contract for Region 8a, which includes all of Bexar County, was awarded in August 2018 to the Children's Shelter in San Antonio to serve as the catchment area's SSCC. As of March 2020, services were provided through Family Tapestry to about 1,720 youth. The Children's Shelter dealt with fiscal management concerns in 2019, which delayed the implementation of Stage II. This was planned to be corrected and verified by DFPS in May 2020, allowing for Stage II negotiations to take place.⁷⁵

REGION 1

A contract for Region 1 was awarded to St. Francis Community Services in Texas, Inc. which served as the SSCC for the catchment area since July 1, 2019. After a six-month start up period, St. Francis's readiness was certified by DFPS, and on January 6, 2020 they started accepting placement referrals. As of March 2020, St. Francis was serving about 740 youth through their continuum of care.⁷⁶

REGION 8B

Region 8b, which includes all counties in Region 8 except Bexar County, had a procurement closed on August 2, 2019 for the catchment area.⁷⁷ As of September 2020, a Request for Application was set to close on December 1, 2020.⁷⁸

View the April 2020 DFPS Rider 29 Report on Community-Based Care Implementation Status here: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-04-01_Rider_29-CBC_Implementation_Status_Report.pdf.

View DFPS's March 2020 Rider 15 report on Community-Based Care here: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2020/2020-03-31_Rider_15_Community-Based_Care_Report.pdf.

DFPS's December 2019 Implementation Plan for the Texas Community-Based Care System, which reports on high-level accomplishments from FY 2018 - FY 2020, can be viewed here: https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/documents/2019-12-20_Community-Based_Care_Implementation_Plan.pdf.

FAMILY FIRST PREVENTION SERVICES ACT

In February 2018, Congress passed the FFPSA, which restructured how the federal government funds child welfare services.⁷⁹ The legislation aims to help families in crisis safely stay together and reduce the foster care population by prioritizing prevention of entry into foster care, and increasing the number of children successfully exiting foster care by reducing reliance on congregate care in favor of more family-like settings.⁸⁰

Although intended to go into effect October 1, 2019, Texas has an alternative timeline for the law's implementation to allow time to prepare. The FFPSA was delayed two years and will not go into effect state-wide until October 1, 2021.⁸¹ SB 355 required DFPS to submit a strategic implementation plan to the legislature by September 1, 2020.⁸² Most funding changes from the 87th Texas Legislative Session will go into effect by September 1, 2021, followed by full implementation of the law one month later. Under FFPSA, many of Texas' congregate care placements are ineligible for funding. States such as Texas that chose to delay implementation cannot draw down any of the newly available prevention dollars until they are in full compliance with the law.⁸³

The largest federal source of child welfare funding comes from Title IV-E of the Social Security Act, which provides states with funds to support foster care, adoption assistance, guardianship assistance, and the Chafee Foster Care Independence Program, a grant program that helps foster youth gain self-sufficiency. With the exception of Chafee, children must meet Texas's eligibility requirements for guardians to be reimbursed for IV-E funded programs. On October 1, 2019 the FFPSA changed Title IV-E funding to provide more flexibility to invest in prevention

programs, as well as to remove funding from certain congregate care placements.⁸⁴

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

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

- Facilities for pregnant and parenting youth
- Supervised independent living for youth 18 and older
- Specialized placements for youth who are victims of or at risk of becoming victims of sex trafficking
- Family-based residential treatment facilities for substance use conditions
- Qualified residential treatment programs (QRTP)

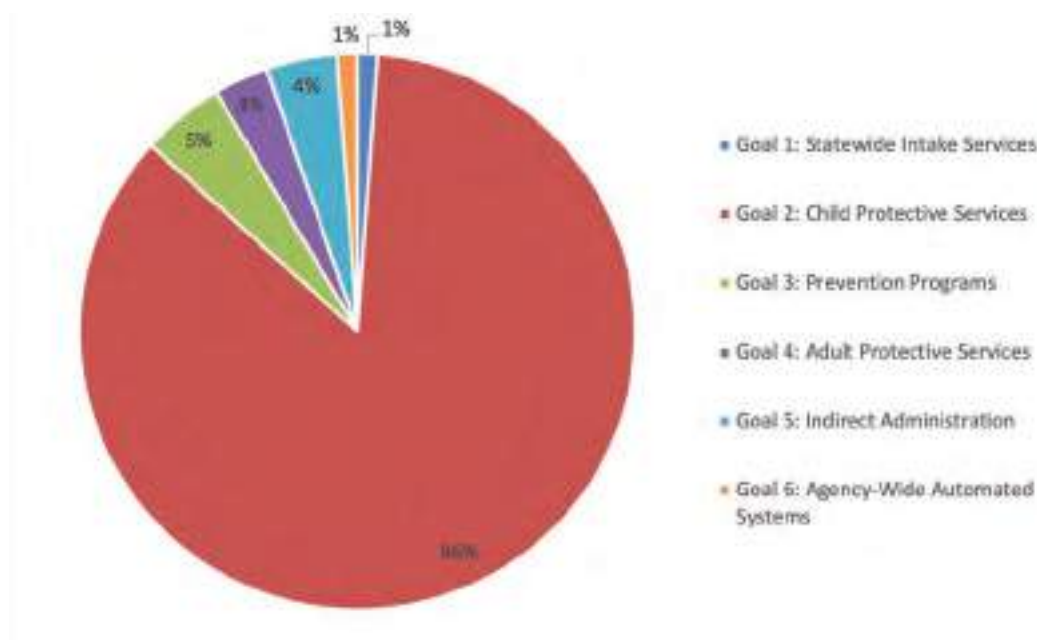
A QRTP is a new standard for congregate care settings. The term refers to a program that has a trauma-informed treatment model designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.⁸⁵ Appropriately, licensed clinical staff must be available to provide care 24 hours a day under this standard.

Funding

DFPS is jointly funded by both state and federal dollars. The agency’s budget was roughly \$4.185 billion for FY 2018-19 and \$4.428 billion for FY 2020-21— an almost 5.8 percent increase in two years.^{86,87} In FY 2018-19, 42 percent of DFPS funding came from federal sources while the other 58 percent came from state sources (e.g., general revenue funds, GR-dedicated funds and other funding sources such as child support payments).⁸⁸ In FY 2020-2021, the federal share of funding for DFPS slightly decreased to 41 percent and state funding increased to 59 percent.⁸⁹ As Figure 72 shows, the vast majority of the DFPS budget (85.53 percent) goes towards the department’s CPS-related mission of protecting children by operating an integrated service delivery system.

Figure 72. DFPS Budget by Strategy for FY 2020-21

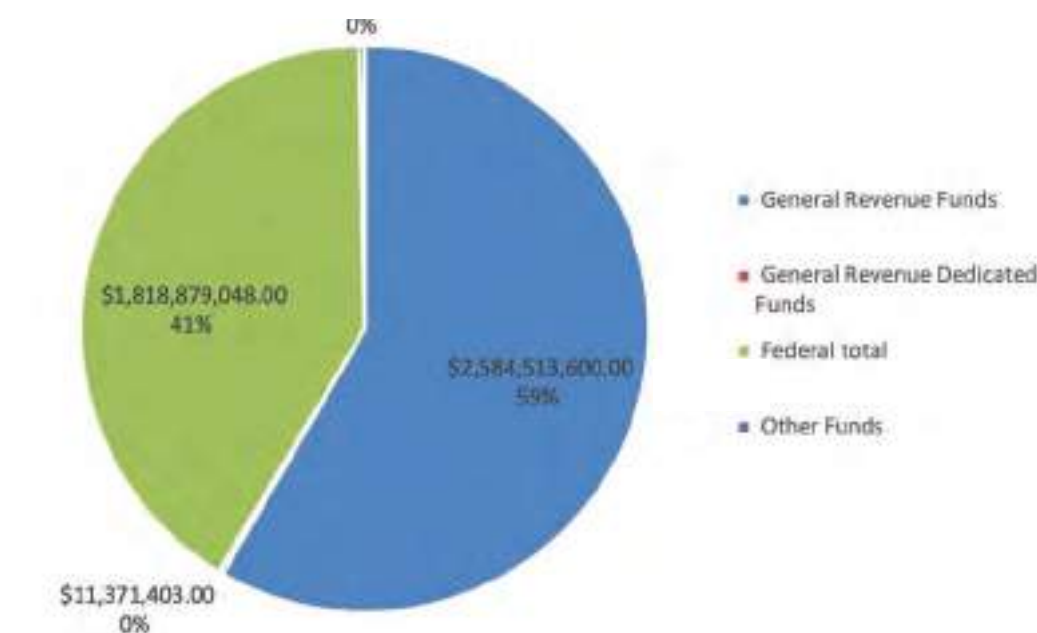
Total DFPS Budget for FY 2020-21: \$4,427,950,809



Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Figure 73. DFPS Budget by Method of Finance for FY 2020-21

Total DFPS Budget for FY 2020-21: \$4,427,950,809



Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Child Protective Investigations (CPI) Division

CPI is responsible for investigating allegations of child abuse and neglect, which are reported to the CPS division if they meet certain criteria. Feeling unsafe in a household can harm the mental health of children, and state intervention is sometimes used to further trauma. In addition to investigating allegations of child abuse and neglect, CPI works with law enforcement on joint investigations, taking custody of children who are in unsafe environments, referring children to community resources that promote their safety and well-being, and assisting in the fight against human trafficking. Investigators typically attempt to complete investigations within 30 days of the agency receiving a report, but extensions can be provided.⁹⁰

After conducting interviews and inquiring into the details of a case, including whether there is a reasonable likelihood that a child will be abused or neglected in the foreseeable future, DFPS makes a ruling on each allegation. This ruling is called a disposition, which according to DFPS's CPI webpage, can result in any of the following verdicts:

- Reason to believe: Abuse or neglect occurred based on a preponderance of the evidence. This means when all evidence is weighed, it is more likely than not that abuse or neglect occurred.
- Ruled out: Staff determines that it is reasonable to conclude that the abuse or neglect has not occurred based on the information that is available.
- Unable to Complete: The investigation cannot be concluded. Often this verdict is This is usually because the family could not be located to begin the investigation or the family was contacted but later moved and could not be located to complete the investigation or the family refused to cooperate with the investigation. DFPS policy outlines several actions that the investigator must complete to make this disposition.
- Unable to determine: DFPS concludes that none of the dispositions above is appropriate.
- Administrative closure: DFPS intervention is unwarranted based on information that comes to light after the case is assigned for investigation.⁹¹

CHILD ABUSE/NEGLECT AND CPI INVESTIGATIONS

CPI investigates abuse and neglect allegations to decide whether there is a threat to the safety of the children in their home environment. During child abuse and neglect investigations, an agency caseworker screens the child's behavioral health, basic physical condition, and the safety and livability of their living environment. Based upon in-person interviews with alleged victims, photographs of injuries (if present) and documented conversations with other adults in the child's life (e.g., teachers and siblings), the worker will assess the mental health and psychosocial functioning of each child and make referrals for additional behavioral health services

and assessments as necessary. If the caseworker determines that a child is not safe, then the caseworker initiates protective services. Next steps could include family-based protective services such as outpatient engagement while the child remains in the home, a court petition to remove the child from the home, and/or legal action to terminate parental rights.

A child is placed in foster care after other parent engagement services and outpatient treatment options have been exhausted. In FY 2019, more than 49,525 children were in DFPS custody at some point.⁹² According to DFPS language, FY 2019 data showed that Hispanic (about 40 percent) and Anglo children (nearly 29 percent) make up the majority of children in foster care, with African-American children (about 21 percent) as the third most prevalent racial/ethnic group.⁹³ However, when you take into account the racial demographics of Texas children as a whole, African-American children (who made up 12 percent of the Texas child population in 2018) are overrepresented in the foster care system — see the Disproportionality and Racial/Ethnic Diversity of Children and Youth section in this chapter for further information.^{94,95}

In FY 2019, the total number of cases/intakes was 294,739, with 266,611 children suspected victims of abuse or neglect statewide. Of those cases, 67,313 were confirmed (defined as “based on a preponderance of evidence, staff concluded that abuse or neglect occurred”).⁹⁶ Confirmed victims of child abuse/neglect in FY 2019 was up about 1.62 percent from FY 2018, and about 4.06 percent higher than in FY 2016.⁹⁷

As of August 31, 2019, 37.71 percent of children in DFPS conservatorship were in kinship placements (family or fictive kin such as family friends).⁹⁸ When it is unsafe for a child to remain in his or her home and there are no appropriate kin or fictive kin who can provide shelter and care for that child, CPS will petition the court for temporary legal conservatorship. When family and kinship placements are unavailable, CPS may place a youth in a variety of different settings, including:

- Emergency children’s shelters;
- Foster group homes;
- Foster family homes;
- Residential group care facilities; and
- Facilities overseen by another state agency.⁹⁹

Parental substance use can be a contributing factor in CPI cases. A report from Texas CASA showed that 94 percent of removals in substance use-related cases were due to neglectful supervision, 14 percent to physical abuse, two percent to medical neglect, and less than one percent to emotional abuse (more than one reason could be listed).¹⁰⁰ The report also indicated that substance use alone rarely leads to removals. Rather, there are typically multiple risk factors, co-occurring problems, or socioeconomic factors that raise the probability of a removal. These include: housing instability, poverty, social networking gaps, mental health conditions, and structural racism that affect investigative and judicial decision-making. Interviews also found that parental substance use of marijuana often led to what the agency defined as child abuse or neglect, even if the child was not endangered.¹⁰¹

A report from Texans Care for Children concluded that Texas is a “low-removal state,” removing a smaller percentage of children from their families compared to the national average. However, the rate of removals in the state is increasing, and parental substance use is a contributing factor in most removals.¹⁰² The report also shared barriers present for parents seeking substance use treatments. In 2017, there were over 100 mothers on a waitlist for a spot at a women and children residential treatment center, waiting an average of 18 days before a spot became available. This has a direct effect on removals, as access to community services is critical to family preservation. When DFPS determines whether a child is in danger, the agency weighs possible safety interventions that could alleviate the danger, including community services. However, DFPS is not allowed to consider long-term therapy, treatment, or placement on a waiting list for services as a “safety intervention” since these would not immediately resolve the safety concern.¹⁰³

Because there are often significant barriers to receiving substance use services, in 2019 the Texas Legislature passed HB 1780 (86th Miller/Kolkhorst). This bill requires courts to consider a parent’s good faith attempt to complete substance use services or treatment when deciding whether to grant a 6-month extension before terminating parental rights. In light of the overwhelming majority of neglectful supervision cases that involve substance use and the complexity of treatment and recovery, the bill allows parents a chance to seek the services they need and keep families together when appropriate.¹⁰⁴

ALTERNATIVE RESPONSE (AR) SYSTEM

The CPI AR system aims to ameliorate the stress of a CPI investigation and provide prevention services to more families in need by adapting the typical investigation process when workers identify a lower-risk allegation. In doing so, the agency provides a non-adversarial means of dealing with less serious cases of abuse and neglect in a more client-centered and less intrusive manner. When considering if AR is appropriate for a case, staff reviews the type and severity of the allegation, any history of previous reports, and the willingness of the family to participate and be involved with support services. AR, also known at the national level as “differential response,” places an emphasis on reinforcing family strengths, fostering parental involvement, and the development of support systems.¹⁰⁵

AR interventions do not name the parent or guardian as a perpetrator of abuse or neglect, which avoids negative impacts on future employment. This approach differs from typical investigations, where they are named. The AR approach builds upon a family’s strengths and supports already in existence in order to ensure child safety. During AR interventions, CPI runs rigorous screening of lower priority cases to single out families that could potentially benefit from this method.¹⁰⁶

National research has found that differential response systems have demonstrated generally positive outcomes related to child safety, parent satisfaction, service delivery, and improved worker satisfaction.¹⁰⁷ Despite higher initial investments, this approach is more cost-effective in the long run due to lower costs for case management and prevention services.¹⁰⁸ AR engages parents, prompts them to identify their strengths, and connects them to providers to help address behaviors

that may be harming a child's cognitive, social, emotional, or physical development.

In FY 2018, Texas expanded AR into the San Antonio and southeast areas of the state. In FY 2019, CPI expanded AR in Region 2, which includes 30 North Texas counties. By the end of FY 2020, Harris County is expected to receive AR services, making AR available statewide.^{109,110,111} More information on AR in Texas can be found at: https://www.dfps.state.tx.us/Investigations/alternative_response.asp.

CHILD FATALITIES IN TEXAS DUE TO ABUSE/NEGLECT

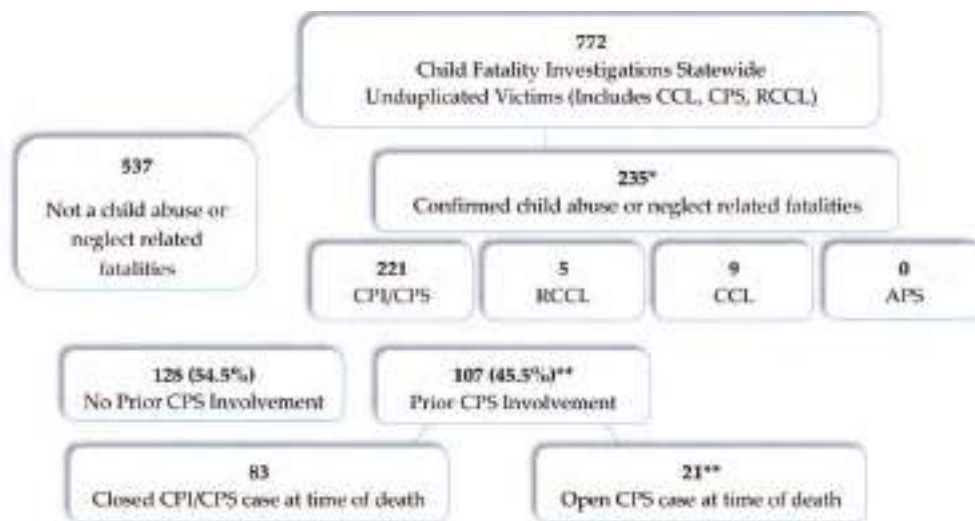
Child fatalities continue to occur in Texas. DFPS reports that a total of 235 children in Texas died as a result of child abuse or neglect in FY 2019, up from 211 in FY 2018 and 172 in FY 2017.^{112,113} The increase was largely due to neglectful supervision, which led to a significant increase in drownings, vehicle related deaths, and ongoing concerns of unsafe sleep practices combined with substance use. CPS had no contact with the child or perpetrator in over 91 percent of abuse/neglect fatalities in FY 2019. The number of child fatality investigations continued its trend of decreasing since 2010, as the 785 reported in FY 2018 went down to 772 in FY 2019.¹¹⁴

It is important to look at trends in past child deaths in order to understand the risk factors that can be used by DFPS to prevent child abuse and neglect-related fatalities in the future. Some of the most salient risk factors for child abuse or neglect-related fatalities can be drawn from the following pieces of information:

- According to DFPS language, the highest number of the child abuse/neglect deaths involved Hispanic children. Of the 235 child fatalities in FY 2019, 82 were Hispanic, 69 were African American, and 69 were Anglo.¹¹⁵ However, African American youth were disproportionately represented in child abuse and neglect-related death statistics, with a 7.85 per capita fatality rate compared to 2.23 for Hispanic children and 2.98 for Anglo youth.¹¹⁶
- A history of child maltreatment and domestic abuse increases child fatality risks; 45.5 percent of families who had a confirmed child abuse or neglect-related fatality in FY 2019 had a history of prior involvement with CPS.¹¹⁷
- 21 abuse and neglect-related fatalities involved families and/or perpetrators with an open and active CPS case at the time of death.¹¹⁸
- Children three years and younger have accounted for roughly 80 percent of all confirmed child abuse and neglect-related deaths in the past ten fiscal years.¹¹⁹

Figure 74 provides data on the child fatalities in Texas in FY 2019:

Figure 74. Child Fatalities in Texas: FY 2019



*Note: prior history can involve the victim or the perpetrator or both in any previous CPS stage of service. Includes duplication.

CPI: Child Protective Investigations

CPS: Child Protective Services

RCCL: Residential Child Care Licensing

CCL: Child Care Licensing

APS: Adult Protective Services

Source: https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/PEI/documents/2020/2020-03-01_FY2019_Child_Fatality_and_Near_Fatality_Annual_Report.pdf

MISSING CHILDREN, HUMAN TRAFFICKING, AND CHILD EXPLOITATION

The Texas Attorney General's office estimates that there are around 234,000 victims of labor trafficking and 79,000 youth in sex trafficking in Texas at any given time.¹²⁰ Global research indicates that victims of human trafficking commonly report suffering from the following mental health conditions: depression, anxiety, post-traumatic stress disorder, self-harm, and attempted suicide. When combined with physical health problems, researchers have concluded that services and interventions are urgently needed to support this population, especially regarding mental health.¹²¹

MISSING CHILDREN AND YOUTH TRAFFICKED IN STATE CONSERVATORSHIP

In May 2020, DFPS published their FY 2019 annual report on Children and Youth Missing from DFPS Conservatorship & Human Trafficking Initiatives. The report found that of the 51,417 children and youth in DFPS conservatorship, 2,122 children and youth were reported missing at some point during FY 2019.¹²² Of these 2,122 individuals:

- 1,837 (87 percent) were located as of August 31, 2019.
- 175 (8 percent) were still missing on August 31, 2019. Of these, 75 (43 percent) had gone missing during August 2019.
- 110 (5 percent) children and youth exited conservatorship while missing. Of these:
 - 63 youth turned 18 while on missing status; and
 - 47 had legal responsibility terminated while on missing status before they turned 18.¹²³

The percent of children and youth in conservatorship who were missing at some point has slightly increased over the past three fiscal years, from 3.4 percent in FY 2017 to 3.8 percent in FY 2019. According to survey results, the top reasons individuals went missing in FY 2019 were: anger at CPS or the system (19 percent); desire to be on one's own (18 percent); desire to see family/relatives (15 percent); frustration/anger with caregivers (15 percent); desire new placement (13 percent); and desire to be with boyfriend or girlfriend (11 percent). Youth between the ages of 15 and 17 made up 66 percent of first-time missing incidents in FY 2019. Of all children missing in this time period, 53 percent were classified as female and 47 percent as male. In terms of race/ethnicity, DFPS reported that 42 percent of those missing were Hispanic, 30 percent were Anglo, and 21 percent were African American. With regards to living arrangements, 19 percent of youth and children missing were living in RTCs, 19 percent in emergency shelters, 18 percent in therapeutic foster homes, and 12 percent in kinship care. Harris County had the highest number of children and youth in placements during the individual's first missing event, with 439 children missing from care in FY 2019. This was followed by Bexar County with 169 missing children, Dallas County with 149, Travis County with 95, and Fort Bend with 81.¹²⁴

Of the 1,837 children and youth who were recovered in FY 2019, Figure 75 shows that 109 (5.9 percent) were victimized while missing. Of these individuals, 72 were sexually abused, 46 were sex trafficked (44 females and 2 males), and 19 were physically abused.¹²⁵

Figure 75. Overview of Texas Children and Youth in DFPS Conservatorship

FY 2019	Number
Total number in DFPS Conservatorship at some point in FY 2019	51,417
Total number missing from DFPS Conservatorship	2,122
Total number recovered during FY 2019	1,837
Number victimized during missing episode	109
Number victimized - sex trafficking	46
Number victimized - labor trafficking	0

Source: Texas Department of Family and Protective Services. "Children and Youth Missing from DFPS Conservatorship & Human Trafficking Initiatives Fiscal Year 2019 Annual Report," May 2020. https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Agencywide/documents/2020/2020-05-29_Children_Youth_Missing_from_DFPS_Conservatorship_and_Human_Trafficking_Data_FY2019.pdf.

STATEWIDE REPORTS AND INVESTIGATIONS OF SEX AND LABOR TRAFFICKING

Allegations of sex trafficking and labor trafficking are investigated by DFPS when the alleged perpetrator is responsible for a child or youth's care, custody, or welfare. In FY 2019, there were 732 reports of sex trafficking and 102 of labor trafficking, 859 alleged victims of sex trafficking and 125 of labor trafficking, and 549 reports of sex trafficking investigated and 64 of labor trafficking.¹²⁶

Upon investigation, DFPS confirmed 29 victims of sex trafficking and 11 cases of labor trafficking in FY 2019. While 59 percent of confirmed victims of sex trafficking investigations were between 15 and 17 years old, 21 percent were under the age of 12. For labor trafficking, 63 percent were between the ages of 15 and 17. The agency reported that Hispanic youth and children were confirmed victims in 48 percent of sex trafficking investigations, followed by African Americans at 28 percent and Anglos at 24 percent. With labor trafficking investigations, 55 percent of confirmed victims were Anglo and 27 percent Hispanic. 93 percent of confirmed sex trafficking victims were females, and 73 percent of confirmed labor trafficking victims were males.¹²⁷

More information on DFPS's May 2020 report on Children and Youth Missing from DFPS Conservatorship & Human Trafficking Initiatives can be found at: https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Agencywide/documents/2020/2020-05-29_Children_Youth_Missing_from_DFPS_Conservatorship_and_Human_Trafficking_Data_FY2019.pdf

In June 2020 Texas HHSC published a Provider Guidebook on Services for Victims of Human Trafficking in Texas, which can be viewed here: <https://hhs.texas.gov/sites/default/files/documents/services/safety/human-trafficking/provider-guidebook-services-victims-human-trafficking-texas.pdf>

CPI ACTIONS

The Human Trafficking and Child Exploitation (HTCE) team was established in Texas by DFPS in June 2017. The team was tasked with building relationships between law enforcement and community leaders to develop services for children who have experienced sex trafficking. Additionally, HTCE aims to identify and increase reporting of human trafficking, support children with lived experience, and educate children on how to avoid trafficking.¹²⁸ Located under the CPI division of DFPS, an additional 7,159 staff completed human trafficking awareness training, increasing the total number of staff trained to over 14,000.¹²⁹

DFPS also established the Light the Way to Freedom to End Human Trafficking: Sunday Prayers. This is an awareness campaign intended to bring together communities of faith annually during Human Trafficking Awareness Month. The Light the Way to Freedom to End Human Trafficking 2019 Summit was launched by the agency to serve as a statewide conference for anti-human trafficking advocates and stakeholders, as well as DFPS staff. Over 850 people attended the 2019 summit, where they discussed awareness, identification, and prevention of human trafficking. The conference also focused on restoration and support for survivors of trafficking.¹³⁰

DFPS established the Commercial Sexual Exploitation-Identification Tool and the Human Trafficking Response Protocol in March 2019. This program, which launched in Bexar, Dallas, Harris, Tarrant, and Travis counties, provides caseworkers with information needed to detect risks of sexual exploitation.¹³¹

Child Protective Services (CPS) Division

CPS is responsible for: responding to CPI's inquiries of child abuse and neglect allegations, providing at-home services for families and youth in need, removing children from unsafe environments when deemed necessary for child safety, helping identify and coordinate with family members to provide kinship placements, managing the foster care system, and assisting youth to successfully transition out of the CPS system and into safe and permanent living situations. Thus, CPS interacts with children at three stages: reviewing investigations of abuse allegations, placing youth in emergency custody or inpatient treatment, and transitioning youth back into normalcy and a healthy environment.

CPS Handbook Policies on Behavioral & Mental Health Section 11600 of DFPS' CPS Handbook states the agency's policies for youth in need of mental health services. Subsection 11611.1 states that youth in DFPS's conservatorship can be placed in an inpatient psychiatric facility if a physician states both of the following are true: 1) the child has a mental illness or shows symptoms of a serious emotional disturbance; and 2) the child risks serious harm to self or others if not immediately restrained or hospitalized. Youth may also be admitted if one of the following occurs: 1) DFPS applies for court-ordered mental health services for the child; 2) DFPS requests emergency detention; or 3) a court grants a protective custody order.¹³²

Under subsection 11611.2, youth aged 16 or older may request to be voluntarily admitted to an inpatient psychiatric facility or to receive outpatient mental health treatment services. This can be done by filing a request directly with a facility's administrator. Admission can occur without the consent of a parent/managing conservator/guardian, and a facility is not required to accept the youth.

Subsection 11611.4 states that in order for youth to receive mental health treatment, a caseworker must provide a mental health facility with the name and contact information for the child's medical consentor, who must approve of treatments (unless the youth is authorized to consent themselves).

In subsection 11612, it's noted that law enforcement can be called if a caseworker or residential child care provider believes that a child needs a temporary involuntary mental health commitment and the child will not willingly be evaluated by mental health professionals.

Finally, subsection 11613 states that DFPS staff or a residential childcare provider may contact an LMHA for assistance with involuntary inpatient mental health services.

More information on DFPS's CPS guidelines can be found in their Mental Health Resource Guide at https://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/Mental_Health_Resource_Guide.pdf.

TREATMENT FOSTER FAMILY CARE (TFFC) PROGRAM

CPS established the TFFC program to grow the state's foster care capacity, reduce the number of youths under the age of 10 in RTCs, and have youth in a family environment. By the end of July 2019, there were 39 youths placed in 53 TFFC homes across the state. CPS also created the Nurturing Parent Program (NPP) in Lubbock, Potter, Val Verde, Burnet, and Smith Counties. This trauma-informed, evidence-based program intended to prevent, intervene in, and treat child abuse and neglect. Faith-based initiatives were supported and expanded by CPS. Congregations participated in the CarePortal, an online platform that allows churches to provide goods and services to children and families in need. As of August 31, 2019, 1,929 congregations were partnering with DFPS, 535 faith partners were enrolled in the CarePortal, and the CarePortal had given aid to 7,645 children with an estimated economic impact of \$2,381,487.¹³³

ACCESSING MENTAL HEALTH SERVICES

STAR HEALTH (SUPERIOR HEALTH SYSTEM)

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 delivery

model (intended to reduce healthcare costs and improve access to services). Superior Health Plan contracted with the state to run the STAR Health program and has been operating the program since its inception.¹³⁴ The statewide program was designed to improve the continuity and coordination of care by improving data sharing and access to health services for children in the foster care system.

Children who reach adulthood in foster care can be covered by STAR Health until their 26th birthday. Youth in Extended Foster Care can be covered by STAR Health until their 22nd birthday, and those in the Former Foster Care Children (FFCC) and Medicaid for Transitioning Foster Care Youth (MTFCY) programs can be covered until age 21. Those eligible for Medicaid for FFCC can choose which managed care plan under STAR Medicaid that they want to continue coverage with from age 21-26.¹³⁵ In addition to medical and development strengths tests, youth entering DFPS custody must take the Child and Adolescent Needs Assessment (CANS) to evaluate any behavioral health needs and if there are any impacts from past trauma. This assessment helps guide recommendations for youths' services, living arrangements, and supports under STAR Health.¹³⁶

In FY 2017 (the soonest year data was available), the STAR Health average monthly enrollment was 32,091.¹³⁷ The state provides immediate STAR Health eligibility for children in DFPS conservatorship and for former foster care children up to age 21. Youth aged 18 to 22 who sign extended foster care agreements are also eligible.¹³⁸ In FY 2017, 53 percent of children in STAR Health had a diagnosis of a mental health condition or a substance use condition. Texas spent \$174 million on those children and youth, which accounted for 68 percent of STAR Health total expenditures in FY 2017.¹³⁹

STAR Health requires that each foster care child has access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services, and more.¹⁴⁰ Behavioral health services offered by Superior include:

- Education, planning, and coordination of behavioral health services;
- Outpatient mental health and substance abuse services;
- Psychiatric partial and inpatient hospital services (for members 21 and under);
- Non-hospital and inpatient residential detoxification, rehabilitation and half-way house (for members 21 and under);
- Crisis services 24 hours a day, 7 days a week;
- Residential care (for members 21 and under);
- Medications for mental health and substance abuse care;
- Lab services;
- Referrals to other community resources; and
- Transitional health care services.^{141,142}

Historically, the lack of a central medical records system for children in DFPS care created serious problems, including the over-prescribing of medications or the sudden discontinuation of medications when a child's placement changed. To help solve this continuity of care issue, DFPS began using a computer-based system called the Health Passport to track and monitor the medical information of every child enrolled in the STAR Health program.¹⁴³ The Health Passport follows

children to each placement so that every caregiver, DFPS staff member, and medical professional working with a child has a full understanding of his or her past and current treatments. The Health Passport allows access to that information in one central, easy-to-find location. Each child's Health Passport is available online through a password-protected website and can be accessed by DFPS staff and medical consenters. While the Health Passport is not a full and complete medical record, it provides claims data on pharmacy, dental, vision, physical, and behavioral health services provided to each child. Information on a child's drug allergies can also be directly uploaded to the Health Passport website and the system can alert medical professionals and caregivers if there is a potentially unsafe drug interaction or allergy.¹⁴⁴

FORMER FOSTER CARE CHILDREN'S (FFCC) PROGRAM AND MEDICAID FOR TRANSITIONING FOSTER CARE YOUTH (MTFCY)

Many children lose health insurance coverage when they age out of the foster care system. Many children in foster care experience trauma or other mental health conditions that impact them even after they have left the child welfare system. Foster care alumni are more likely than young adults in the general population to rely on public assistance, experience difficulties in finding and keeping a stable home, and have a high risk for physical and mental health concerns.¹⁴⁵ Thus, retaining health insurance for former foster care children for a longer period of time may lead to better outcomes by ensuring that they have more consistent and reliable access to the mental health care services and supports needed for recovery and long-term well-being.¹⁴⁶

As a component of the Affordable Care Act (ACA), the FFCC program provides extended health insurance coverage to former foster care children under the age of 26 who were on Medicaid while in foster care.¹⁴⁷ With the implementation of the FFCC plan, more adults formerly in the foster care system will have health insurance coverage up until their 26th birthday, as is discussed in the preceding STAR Health section. Effective January 2014, former foster youth receiving healthcare services transitioned to FFCC or, for those ineligible for FFCC because they were not enrolled in Medicaid while in care, to MTFCY.¹⁴⁸

Unlike Medicaid or other foster care insurance plans, FFCC has no asset, income, or educational requirements for coverage. There are two FFCC insurance plans based on the age of the applicant: STAR and STAR Health. The services provided by each of these plans vary — see the HHSC section for more information on STAR and STAR Health services and eligibility.¹⁴⁹

There are some groups of young adults who will not qualify for either program, including young adults who aged out of the Texas foster care system and moved to another state, and young adults who were not in foster care when they turned 18.^{150,151} Young adults who do not qualify for FFCC may purchase health insurance through the Health Insurance Exchange if they have sufficient resources and/or federal marketplace subsidies, or they may still qualify for Medicaid. See Table 53 for an overview of existing health insurance programs for former foster care children.

Table 53. Health Insurance Programs for Former Foster Care Children

Plan Name	Eligibility	Income or Other Requirements
Former Foster Care Children Program (FFCC)	<ul style="list-style-type: none"> • Be age 18 through 25; • Have been in Texas foster care on his or her 18th birthday or older; • Be receiving Medicaid when he or she aged out of Texas foster care; and • Be a US citizen or have a qualified alien status, such as a green card. 	No asset, income, or educational requirements.
Medicaid for Transitioning Foster Care Youth (MTFCY)	<ul style="list-style-type: none"> • Be age 18 through 20; • Have been in Texas foster care on his or her 18th birthday or older; • Not have other health coverage; • Meet program rules for income; and • Be a US citizen or have a qualified alien status, such as a green card. 	Income limit of \$4,392 per month (with an added \$1,542 for each additional person in a family)

Source: Texas Department of Family Protective Services. *Medical Benefits*. Retrieved from https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/medical_benefits.asp

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INSTITUTIONAL RESIDENTIAL SERVICES

While the state recognizes that it is preferred that children grow up in family, home-based environments, 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 if possible (kinship placement).¹⁵² If kinship placement 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. A GRO is a congregate care facility that provides residential services for 13 or more children up to the age of 18 years.¹⁵³ GROs are licensed by DFPS and include short-term residential facilities that provide basic childcare, emergency shelters in which children are typically placed for less than 30 days, and RTCs. An RTC provides care and treatment services exclusively for children with complex emotional and psychological needs.¹⁵⁴ DFPS provides an online search tool that lists childcare facilities in the state, which can be found at: www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp.

CONTINUING ISSUES

In addition to child fatalities detailed in the CPI section, CPS has several continuing issues that need to be addressed. Two primary issues are the disproportionality and diversity of children and youth in CPS (which encompasses the racial/ethnic/sexual/gender identities of foster youth), as well as the ongoing need for comprehensive trauma-informed care within the system and for those who work with children and youth.

DISPROPORTIONALITY AND DIVERSITY OF CHILDREN AND YOUTH IN CPS

Racial and Ethnic Disparities

There has historically been a disproportionate number of African American and Native American children, youth, and families involved in the Texas CPS system according to DFPS. This is consistent within the national child welfare landscape.¹⁵⁵ A higher percentage of African American and Native American children are removed from their homes due to abuse or neglect. These groups also spend more time in foster care, and face longer waits to be adopted and to find other permanent placements.¹⁵⁶

A number of theories have been offered as to why there is disproportionate representation of certain racial and ethnic groups in the child welfare system, including:

- Increased parent and family risks;
- Increased rates of poverty and exposure to neighborhood risks and harms;
- Societal disparities that make it difficult for parents to obtain mental health and substance use treatment, stable housing, and employment;
- Racial biases among CPS workers and individuals who report abuse and neglect; and/or
- Lack of comprehensive cultural competence and cultural humility among CPS investigators and caseworkers.^{157,158,159}

According to 2019 DFPS data, African American children were less likely to be adopted than Hispanic or Anglo children. While African American children made up 22 percent of those waiting to be adopted as of August 31, 2019, they made up only 18 percent of children adopted in 2019. The 44 percent of Hispanic children waiting to be adopted roughly matched the percent adopted (45 percent) and the percent of Anglo children waiting to be adopted (27 percent) was less than the percent adopted (31 percent). As of August 31, 2019, there were a total of 6,806 children waiting to be adopted in Texas.^{160,161,162} Figure 76 shows the ethnic and racial profiles of children successfully adopted in Texas.

Figure 76. Disproportionality in Adoptions: Racial and Ethnic Differences in FY 2019

FY 2019 (As of Aug 31)

	Unkown	Anglo	Black	Hispanic	Other	Asian	Native Am.	Total
Intended Permanent	53	989	786	1703	207	7	4	3749
Not intended permanent	22	857	734	1258	176	7	3	3057
Both	75	1846	1520	2961	383	14	7	6806
Percent wanting adoption	1%	27%	22%	44%	6%	0%	0%	100%
Adoption placements	79	1874	1117	2737	327	17	6	6157
Percent adoption placements	1%	30%	18%	44%	5%	0%	0%	100%
Adoptions completed		1868	1077	2731	407	18	6	6107
Percent adoption completions		31%	18%	45%	7%	0%	0%	100%

Sources: Texas Department of Family and Protective Services (DFPS). (2019). CPS Permanent Managing Conservatorship (PMC): Children Waiting for Adoption on August 31. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Adoption/Children_Waiting_Adoption.asp

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Texas Department of Family and Protective Services (DFPS). Child Protective Services (CPS): Adoptions Consummated. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Adoption/Adoptions_Consummated.asp

While DFPS' main method to address disproportionality is through providing comprehensive and quality services through its regular programming and service delivery for all children, CPS has made some attempts in recent years to reduce racial and ethnic disparities in the child welfare system. DFPS developed courses on working with African American, Latinx, and impoverished families. In FY 2013, CPS established Poverty Simulations trainings for staff and external stakeholders. These exercises are meant to enhance participants' understanding of impoverished families by showing how racial oppression and poverty are interconnected.¹⁶³

Another key component to addressing racial and ethnic disproportionality is CPS increasing support for kinship care — placing the child with a relative or someone close to the family so that children maintain connections to their community, family, support network and culture. Unfortunately, individuals who take on this kinship responsibility are not eligible to receive many supports available to foster and adoptive parents. For example, social services like Temporary Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits are not available for kinship caregivers. CPS provides limited financial help to encourage kinship placements.¹⁶⁴ Once kinship placements begin, programs like the Family Group Decision Making (FGCM) model are essential support services that can help strengthen bonds and support a successful transition to the kinship placement so

that the child does not have to deal with the trauma and instability associated with having to move multiple times.¹⁶⁵ In 2019, the Texas Legislature passed SB 355 (86th West/Klick), which directed DFPS to develop a strategic plan that would identify a network of service providers to inform parents and caregivers of children at risk of entering foster care with mental health, substance abuse, and in-home parenting support.¹⁶⁶ Additional information on kinship care can be found at <https://texascasa.org/casa-deep-dive-kinship-care/>.

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual Youth

With the increasing national focus on the rights of same-sex couples following the Supreme Court's ruling in *Obergefell v. Hodges*, the conversation over disproportionality has expanded to include lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) youth who are also overrepresented in the child welfare system. The stigma associated with LGBTQIA+ identity makes this community more vulnerable to both trauma and mental health conditions such as depression, substance use, and heightened risk of suicide.¹⁶⁷ Stigma can also lead to an under-utilization of social supports (e.g., family or church clergy) and services (e.g., school-based counseling) if the child feels discriminated against or not accepted. Due to a lack of reporting and the fact that sexual orientation is self-identified and gender identity is fluid, it is difficult to determine the actual number of LGBTQIA+ youth in the foster care system. However, the National Resource Center for Youth Development reports that LGBTQ youth (those identifying as intersex or asexual were not included in this study) are overrepresented in foster care, accounting for between 5 and 15 percent of all youth in foster care.¹⁶⁸

Research shows that LGBTQIA+ youth have an increased risk of experiencing several negative situations and outcomes compared to their heteronormative peers. A 2017 study by the University of Connecticut and Human Rights Campaign Foundation found the following statistics (youth identifying as intersex or asexual were not included in this study):

- 78 percent of youth not out to their parents as LGBTQ hear their families make negative comments about LGBTQ people.
- 73 percent of LGBTQ youth have experienced verbal threats because of their actual or perceived LGBTQ identity.
- Trans youth are over twice more likely to be taunted or mocked by family for their LGBTQ identity than cisgender LGBTQ youth.
- LGBTQ youth of color report hearing family express negativity about LGBTQ people more frequently than their white peers.
- 85 percent of LGBTQ youth rate their average stress level as '5' or higher on a 1-10 scale.
- 77 percent of LGBTQ youth report receiving unwanted sexual comments, jokes, and gestures in the past year.
- 11 percent of LGBTQ youth report that they have been sexually attacked or raped because of their actual or assumed LGBTQ identity.¹⁶⁹
- Additional research from various sources shows (certain identities are excluded from studies):
- LGBTQ youth are at least twice as likely as non-LGBTQ youth to attempt suicide, and gay and bisexual young men face substance abuse issues at a rate 15 times that of the youth population as a whole.¹⁷⁰

- LGBT youth who experience family rejection have a greater chance of having mental health issues in adulthood and are significantly more at risk for suicide attempts (8.4 times more likely), depression (5.9 times higher), and substance use (3.4 times more likely).¹⁷¹
- LGBTQ youth report a more negative experience with the child welfare system, are more likely to be moved or hospitalized for emotional reasons, and are more likely to live in group settings.¹⁷²
- Disparities for LGB foster care youth continue into adulthood, as studies show that LGB former foster care youth are less financially stable as adults than their heterosexual peers.¹⁷³

The National Survey of Child and Adolescent Well-Being – II (NSCAW-II) showed that LGBT youth (those identifying as queer, intersex, or asexual were not included in this study) in the foster care system suffer from placement instability at higher rates than the rest of the population. While 19.6 percent of LGB youth in out-of-home care were moved from their first placement at the request of their caregiver or foster family, this rate was 8.6 percent for heterosexual youth. Additionally, 44.8 percent of LGB youth were moved from their first placement because of perceived needs for lower levels of care, compared to 65.5 percent of heterosexual youth. Alternatively, 12.6 percent of LGB youth were moved from their first placement to higher levels of care, while 9.8 percent of heterosexual youth were moved for the same reason.¹⁷⁴

There are currently no policies in Texas specifically addressing the needs of LGBTQIA+ youth in the state's foster care system, and there is no required data reporting on the number of LGBTQIA+ youth awaiting adoption in comparison to their heteronormative peers. Increasing family and caregiver support services to encourage acceptance will likely support the well-being of LGBTQIA+ children in Texas and reduce both their safety risks and likelihood of entering into the foster care system.

There are mixed efforts to improve the system for LGBTQIA+ youth. DFPS established a workgroup made up of external advocates to focus on the needs of LGBTQIA+ youth in foster care. The agency also offers staff trainings on best practices for serving LGBTQIA+ youth.¹⁷⁵ However, a rule prohibiting discrimination based on a person's sexual orientation, gender identity, and other characteristics was challenged by DFPS, Archdiocese of Galveston-Houston, and the Texas Attorney General's office. Per the unsettled 2019 lawsuit, the archdiocese would like to serve as a foster care provider, but only if they can be exempt to anti-LGBTQIA+ discrimination.¹⁷⁶ Advocates remain concerned that the lawsuit could have negative impacts on LGBTQIA+ youth, foster and adoptive parents within the state.

In the 85th session, Texas passed HB 3859 (Frank/Perry), which protects child welfare providers from retaliation if they assert their “sincerely-held religious beliefs.” Among other things, the bill allows child welfare organizations to preclude certain people from participating in programs and to refuse to enter into contracts with providers that do not share their religious beliefs.¹⁷⁷

TRAUMA-INFORMED CARE

Youth who are in child welfare systems nationally and in Texas are at greater risk for trauma-related mental health and substance use conditions than children in the general population. The overwhelming majority of children who enter the foster care system experience trauma as a result of neglect or abuse.¹⁷⁸ Further, being removed from your family of origin is a trauma in and of itself, so every child or youth within the foster care system is living with the trauma of removal. Many children in foster care also experience additional trauma as a result of multiple removals and placements in different foster homes and shelters. Reports show that nearly half of youth aged 2-14 with completed child welfare investigations have clinically significant emotional or behavioral problems.^{179,180} Rates of behavioral problems, developmental delays, and need for psychiatric intervention for foster care youth reach up to 80 percent.^{181,182} Professionals who interact and work with foster and adoptive children must therefore be cognizant of youths' trauma-related needs and how they impact mental wellness.

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 and unique experiences. It therefore provides a non-pharmacological approach to healing that decreases reliance on psychotropic medications and increases placement stability.¹⁸³ Trauma-informed care is not a discrete intervention, but rather a treatment framework that strengthens service delivery at all levels of care. In a trauma-informed system, every component of the service system is evaluated and reframed with an understanding of the role that trauma and violence play in the lives of people seeking behavioral health services.

Awareness of an individual's trauma-inducing experiences can help CPS staff, mental health professionals, and caregivers to avoid any re-traumatization that may occur during the delivery of traditional services or daily living. Understanding the effects of trauma can provide better insight into a child's trauma reminders, stress signals, coping mechanisms, behavioral tendencies and cognitive development. As a result, trauma-informed care can provide communities, parents, schools, and caseworkers with a better set of skills for understanding how to approach traumatized children and provide them the services and supports needed.

The push for trauma-informed care in Texas gained traction in 2013 with bills that expanded education and training. In 2015, SB 125 (84th West/Naishtat) mandated that children entering into DFPS care receive a comprehensive assessment.¹⁸⁴ This evaluation would include a screening for trauma within 45 days of the child's entry into services in an effort to learn more about their trauma history. The assessment is used by substitute caregivers, case managers, clinicians, care coordinators, and conservatorship workers to gather information needed to make decisions about the best course of action to take to address a child's needs.¹⁸⁵

DFPS continues to promote trauma-informed practices by operating and maintaining its own trauma-informed care training program for a number of different groups, including:

- Court-appointed special advocates (CASA workers),
- Child advocacy centers (CACs),
- Foster parents and kinship caregivers,
- Adoptive parents, and
- DFPS caseworkers and supervisors.¹⁸⁶

The 2018 shooting at a high school in Santa Fe, TX brought trauma-informed practices into the forefront during the 86th Legislative session, and several bills impacted DFPS. SB 11 (86th, Taylor/Bonnen) required schools to have a trauma-informed policy to integrate trauma-informed practices into schools. Under the bill, DFPS must be consulted for development of a rubric and a list used by regional education service centers to identify resources related to student mental health that are available to schools in their respective regions.¹⁸⁷ SB 781 (86th, Kolkhorst/Leman) directed DFPS to develop a strategy for trauma-informed protocols aimed at reducing runaway incidents from residential treatment centers.¹⁸⁸ HB 1536 (86th, Miller/Raymond/Parker/Davis) would have required DFPS to develop trauma-informed care across the child welfare system. Foster parents, adoptive parents, and kinship caregivers would receive specialized, tailored training in trauma-informed care that could vary depending on what best suits the child.¹⁸⁹ However this bill failed to pass. Had SB 488 (86th, Watson) passed, it would have created policies and procedures for a trauma-informed juvenile justice system.¹⁹⁰

Prevention and Early Intervention (PEI) Division

The PEI division of DFPS partners with community providers and families to prevent abuse, neglect, truancy, runaway youth, and involvement with law enforcement. Community-based early intervention strategies and programs can address mental health conditions by providing timely access to services and reducing disparities for low-income and minority populations who may not have access to private providers or specialists (including parents at risk of engagement with DFPS). 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, family separation, poverty, removal from the home, incarceration, gaps in school enrollment and attendance, or complete dropout from school.¹⁹¹ Programs and outreach efforts coordinated through this division address negative outcomes and try to provide services for youth before they are in crisis.

Due to the COVID-19 pandemic, PEI program specialists also spent 2020 compiling family/caregiver resources and public health information for mental healthcare providers, stakeholders and advocates. These resources can be found here: https://www.dfps.state.tx.us/About_DFPS/Coronavirus/pei.asp

In FY 2019, 48,391 youth and 10,356 families were served by PEI programs. This represents an increase from the 47,013 youth and 9,369 families served in FY 2018, but a decrease from FY 2017 totals, when over 64,000 youth and 15,964 families received PEI services.^{192,193} Table 54 lists the various programs and services provided

through the PEI division of DFPS.

Table 54. Prevention and Early Intervention (PEI) Programs and Services in Texas

Program	Program Description and Service	FY 2019 Regional Availability & Populations Served
Community-Based Child Abuse Prevention (CBCAP)	Uses federal grant dollars to develop and support current service providers 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. Services provided through CBCAP contracts include: respite, parental education, fatherhood services, parent leadership, home visitation, and public awareness campaigns.	929 families received services in Andrew, Bexar, Brazos, Burleson, Caldwell, Cameron, Collin, Cooke, Cuberson, Dallas, Denton, Ector, El Paso, Ellis, Fannin, Fort Bend, Grayson, Harris, Hidalgo, Hudspeth, Johnson, Leon, Lubock, Maddison, McLennan, Midland, Montague, Nueces, Palo Pinto, Parker, Pecos, Rains, Reeves, Robertson, Rockwall, Tarrant, Taylor, Travis, Wichita, Williamson, and Wise counties
Community Youth Development (CYD)	Contracts with community organizations in zip codes that have a high incidence of juvenile crime to implement juvenile delinquency prevention programs. Services offered vary across communities but may include mentoring, youth employment programs, career preparation, recreational activities, and youth leadership development.	Served 19,619 youth in Bexar, Cameron, Dallas, El Paso, Galveston, Harris, Hidalgo, Lubbock, McLennan, Nueces, Potter, Tarrant, Travis, Webb, and Willacy counties
Health Outcomes through Prevention and Early Support (HOPES)	HOPES aims to prevent child abuse and neglect for children age 0 to 5 by encouraging the development of protective factors that will reduce the likelihood of child abuse and neglect. Services target specific counties and include a home-visiting component.	Served 7,312 families in Atascosa, Bastrop, Bell, Bexar, Bosque, Brazoria, Brazos, Callahan, Cameron, Clay, Coryell, Dallas, Denton, Ector, El Paso, Ellis, Fort Bend, Galveston, Gregg, Harris, Harrison, Hidalgo, Hudspeth, Jefferson, Johnson, Jones, Kleberg, Lampasas, Liberty, Lubbock, McLennan, Medina, Midland, Montgomery, Nolan, Nueces, Potter, Randall, San Patricio, Shackelford, Tarrant, Taylor, Travis, Upshur, Waller, Webb, Wichita, Williamson, and Wilson counties
Military Families and Veterans Pilot Prevention (MFVPP) Program	Through parenting, education, counseling, and support services, this program seeks to: <ul style="list-style-type: none"> • Improve the well-being of Texas military and veteran families by promoting positive parental involvement in their children's lives. • Educate, facilitate, and otherwise support the abilities of parents to provide continued emotional, physical, and financial support for their children. • Build a community coalition of local stakeholders who are focused on the prevention of child abuse and neglect. • Prevent child abuse and neglect occurrences in military communities 	Services offered around the state

Program	Program Description and Service	FY 2019 Regional Availability & Populations Served
Project Help through Intervention and Prevention (Project HIP)	Project HIP is a targeted intervention strategy designed to increase protective factors and prevent child abuse in high-risk families who have had parental rights previously terminated due to child abuse and neglect, had a child who died with a cause identified as child abuse or neglect, or a foster youth who is pregnant or has given birth within the last four months. Services are individualized to each family's needs and include extensive family assessment, home visiting programs, parent education, and basic needs support.	Served 320 foster youth around the state
Services to At Risk Youth (STAR)	Addresses family conflict and everyday struggles while promoting strong families and youth resilience. Every STAR provider offers one-on-one coaching or counseling with a trained professional and group-based learning for youth and parents. STAR programs also operate a 24-hour hotline for families having urgent needs.	Served 25,208 youth around the state
Statewide Youth Services Network (SYSN)	Creates a statewide network of youth programs aimed at juvenile delinquency prevention and positive youth development for youth ages 6 to 17. PEI funds allow state-level grantees to identify areas of high need and vulnerability, and target specific support to local communities. Therefore, the level and extent of services by county varies. Services include school and community-based mentoring programs, such as Big Brothers Big Sisters and Texas Alliance of Boys and Girls Clubs.	Served 3,964 clients around the state
Texas Home Visiting (THV)	Texas Home Visiting (THV) is a free, voluntary program through which early childhood and health professionals regularly visit the homes of at-risk pregnant women or families with children under age six.	Reached 8,796 families in Bastrop, Bexar, Cameron, Collin, Dallas, Ector, Gregg, Harris, Hays, Hidalgo, Midland, Montgomery, Nueces, Potter, Randall, San Patricio, Smith, Starr, Tarrant, Tom Green, Travis, Victoria, Wichita, and Willacy counties.

Sources: Texas Department of Family and Protective Services. DFPS Annual Report 2019. (2020). Retrieved from https://www.dfps.state.tx.us/About_DFPS/Annual_Report/2019/DFPS_2019_Annual_Report.pdf

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Adult Protective Services (APS) Division

The APS division of DFPS investigates allegations of abuse, neglect, and exploitation for individuals age 65 or older and adults with a mental, physical and/or intellectual/developmental disability.¹⁹⁴ Investigations by APS involve both in-home investigations and facility investigations. Reported allegations can include self-neglect, abuse of parents by their adult children, physical and emotional abuse by caregivers, financial exploitation (e.g., taking social security checks or misusing

a joint bank account), sexual assault, and any other forms of abuse, neglect or exploitation. These investigative and support services help to protect the mental health and wellness of persons with disabilities and aging Texans.

The primary APS program is the In-Home Investigations and Services Program. The In-Home program investigates allegations of abuse, neglect, and financial exploitation of adults age 65 and older and adults age 18-64 who have a substantial physical or mental disability and live in their own homes or other community settings.¹⁹⁵ This program also investigates allegations of financial exploitation of adults living in nursing homes, assisted living facilities, or adult foster care homes who may be financially exploited by someone from outside the facility.

The state also conducts investigations into allegations of adult abuse within facilities called the Adult Protective Services Provider Investigations (APS PI) program. APS PI investigates allegations of abuse, neglect, and exploitation of people served by certain providers in a facility setting. As of September 1, 2017, the APS PI program transferred to the Regulatory Division in HHSC.

The incidence of validated adult abuse, neglect and exploitation per 1,000 Texans aged 65 or older was 1.6 in 2019, which is consistent with past years' rates dating back to 2010.¹⁹⁶ There were 118,717 reports made of in-home abuse/neglect of adults in FY 2019, with the majority of reports initiated by medical personnel (23 percent), relatives (14 percent), community agencies (14 percent) and the victims themselves (10 percent).¹⁹⁷ In addition to the investigations of abuse and neglect conducted by APS, this division also educates the general public about elder abuse via public outreach campaigns; Elder Abuse is Everyone's Business is one such public awareness campaign.¹⁹⁸ APS also distributes literature about health risks for the elderly, including dangers related to excessive summer heat.

In FY 2019, APS established a mentor program as part of their employee retention efforts. The program allowed experienced APS staff to connect with and support new caseworkers, meeting biweekly. From October 2018 – August 2019, the mentor program had 138 new APS caseworkers participating, with the turnover rate declining from 50.2 percent to 44.3 percent.¹⁹⁹

A February 2020 DFPS report showed projected turnover rates for APS, however these estimations were made before the widespread outbreak of COVID-19 in Texas.²⁰⁰ The report showed that APS caseworker turnover fell from 25.2 percent in FY 2018 to 20.7 percent in FY 2019. Based on first-quarter data (September, October, November), FY 2020 turnover was projected to be below 17 percent. The turnover rate for new APS caseworkers was 50.8 percent. In 2020, first-year turnover was expected to be about 31 percent. The 86th legislative session led to APS caseworkers and front-line supervisors receiving a \$750 per month raise, as well as 40 additional caseworkers being added to the workforce.²⁰¹

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Policy Concerns

- Funding needs for mental health services post-COVID-19, to assist students dealing with trauma, anxiety, and stress related to the pandemic and its aftermath.
- Addressing the need for more recovery-oriented educational supports, such as schoolwide positive behavioral interventions and support, in addition to classroom-based social and emotional learning
- Addressing the disproportionate amount of exclusionary disciplinary measures for students receiving special education services and students of color.
- Addressing the disproportionate use of corporal punishment on students with disabilities or special needs.
- Lack of trauma-informed care training among teachers and other school personnel.
- As a result of the 86th legislative session, there is no longer a limit on the number of school marshals per student ratio.
- Monitoring threat assessment team outcomes, as other states have disproportionate assessments completed for students of color and students with disabilities.
- Ensuring appropriate resources and supports for teachers and staff to promote and support their mental health and well-being.
- Inadequate funding prioritized for mental health professionals in schools, leading to a severe gap in professional-to-student ratios across the state.
- Providing a definition of school social work services to the Texas Education Code.
- Lack of transparency in statewide discipline data.
- Lack of knowledge surrounding students' classroom removals due to the disproportionality of classroom removals coded as a violation of local code of conduct.
- School districts' inability to enroll as a Medicaid provider to receive reimbursement for and provide mental health services to any student who is a Medicaid recipient. Currently, only schools enrolled in the School Health and Related Services (SHARS) program are able to bill Medicaid for certain services only for children receiving special education services.
- Ensuring provisions and policies related to school safety are not disproportionately impacting students with disabilities and students of color.
- Address current policies that allow foster care and youth experiencing homelessness who may be struggling with substance use to be removed from the classroom and given out of school suspension or an expulsion without other interventions or supports.
- Ensuring the revision of the health TEKS curriculum adequately educates students on mental health, substance use, suicide prevention, and overall well-being and wellness.
- Increasing state funding for Communities in Schools, which is yet to implemented across the entire state.

Fast Facts

- According to Texas Education Agency's (TEA) Texas Academic Performance Report, 10.8 percent of school-aged children were enrolled in special education services in 2018-19.¹
- In 2017-18, the number of students experiencing homelessness rose substantially, as over 46,000 of the students identified as homeless were affected by hurricanes that year. In 2018-19, 1.3 percent of students were identified as homeless, the same percentage reported in 2016-17.²
- The COVID-19 pandemic is expected to impact rates of evictions as families face prolonged unemployment and economic hardships, placing more families and children at risk of homelessness.³
- Between 2008-09 and 2018-19, the percentage increase in the number of students identified as economically disadvantaged (22.5 percent) was greater than the percentage increase in the student population overall (14.4 percent)⁴
- Roughly 31 percent of students eligible for special education services in 2019-20 had a primary diagnosis of a learning disability, 14 percent had a primary diagnosis of autism, and 6 percent had a primary diagnosis of emotional disturbance.⁵
- In the 2018-19 school year, students enrolled in special education services represented 16.9 percent of expulsions to Juvenile Justice Alternative Education programs (JJAEPs), 17.6 percent of expulsions to Disciplinary Alternative Education programs (DAEPs) and 20.7 percent of out of school suspensions⁶
- The majority of expulsions to DAEPs and juvenile JJAEPs continued to be discretionary in 2018-19 (i.e., expulsions that were not mandated by state law but instead involve local codes of conduct).⁷
- The majority of students in Texas identify as Hispanic (52.6 percent) and many of those students in Texas—nearly one million—are still learning English as their secondary language.⁸
- During the 2017 academic year, more than half of school districts in the state did not require health education as part of requirements for graduation.⁹
- One in five Texas high school students report using a prescription drug that was not prescribed to them.¹⁰
- One in eight Texas high school students reported attempting suicide in 2018, almost twice the national average.¹¹
- Texas teens are more likely than the national average to have been offered, sold, or given illegal drugs at school in the last year.¹²
- During the 2016-2017 school year, Texas schools had a student-to-school social worker ratio of 7,548:1, well above the recommended ratio of 400:1.¹³
- During the 2016-2017 school year, Texas schools had a student-to-Licensed Specialist in School Psychology (LSSP) ratio of 2,890:1, well above the recommended ratio of 1,000:1.¹⁴
- During the 2016-2017 school year, Texas schools had a student-to-school counselor ratio of 442:1, well above the recommended ratio of 250:1.¹⁵

Overview

The Texas Education Agency (TEA) provides oversight and administrative functions for all primary and secondary public schools for the 1,201 school districts and 179 open-enrollment charter school campuses in the state of Texas.¹⁶ According to TEA, 5,431,910 students were enrolled in Texas public schools in the 2018-19 school year.¹⁷ Over a ten-year period, total enrollment in Texas schools increased by roughly 14.4 percent, or 682,339 students.¹⁸

Unrecognized or poorly supported mental health conditions can negatively impact a child's academic performance, classroom behavior, and school attendance.^{19,20} The most recently available data from the National Survey of Children's Health (2018) reveals over 13 million children in Texas ages 3-17 years old had a mental, emotional, developmental, or behavioral need, however only 557,501 report receiving any support from a mental health professional.^{21,22}

In Texas, mental health supports and services may be provided in school settings by a number of trained professionals, including school counselors, nurses, school psychologists, and social workers. Despite the professional title, school counselors have many duties that are only tangentially related to mental health. Yet, 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."²³ Although the American School Counselor Association recommends a ratio of 250 students per school counselor, the ratio in Texas is almost double that number: there were 442 students per counselor for the 2016-17 school year.²⁴ However, there are additional, non-counselor personnel that can provide much needed support and services in schools. These mental health workers can play a crucial role in strengthening a positive school climate, and ensuring mental health concerns are addressed for both students and teachers. Mental health professionals can include licensed clinical social workers, licensed school psychologists, occupational therapists, and other mental health professionals such as art and music therapists. Texas also has a special credential for Licensed Specialists in School Psychology, yet only 3,522 LSSPs worked across all Texas public schools in 2019.²⁵ Texas does not have an adequate mental health professional workforce within the school system for any of the aforementioned professionals.

Changing Environment

Funding and legislative initiatives reflected a major focus on how to best keep schools safe throughout the 86th session. For more detailed information on the legislation passed, the Hogg Foundation completed a policy brief detailing the legislative provisions focused on mental health, school safety, and school climate. The brief can be found at: https://hogg.utexas.edu/wp-content/uploads/2020/01/FINAL_86th-Lege_Policy-Brief_School-Climate.pdf

House Bill 18 (Price/Watson)

HB 18 is a comprehensive school mental health bill focused on providing resources, training, and education to students and school employees. This bill is aimed at improving the school climate, and adds mental health, trauma, and substance abuse education (inclusive of students with intellectual disabilities) to required staff development training for school counselors, teachers, and principals. HB 18 also adds mental health and more expansive substance use information to the health curriculum.

House Bill 19 (Price/Watson)

HB 19 requires each local mental health authority (LMHA) to employ a non-physician mental health professional to serve as a regional mental health and substance abuse resource to school districts located within the education service centers (ESC).

House Bill 65 (Johnson/West)

HB 65 requires school districts to include data on out-of-school suspensions in the reports they are mandated to submit to TEA.

House Bill 906 (Thompson/Powell)

HB 906 creates the Collaborative Task Force on Public School Mental Health Services to study and evaluate the impact of state-funded mental health services provided to students, their family/guardians, and school employees. The task force will also evaluate training provided to school employees.

House Bill 1387 (Hefner/Creighton)

HB 1387 removes the limitation of school marshal-to-student ratio.

House Bill 2184 (Allen/Huffman)

HB 2184 outlines requirements for school districts when a student transitions from an AEP, including a DAEP, JJAEP or other residential program or facility operated by TJJD or other governmental entity, to a traditional classroom. A personal transition plan must be included for the student.

Senate Bill 11 (Taylor/Bonnen)

SB 11 is a comprehensive bill that focuses on expanding mental health initiatives, strengthens safety and emergency protocols, and provides funding to districts to increase safety and security on campuses. SB 11 addresses a multitude of areas related to school safety and mental health including physical hardening and building standards, as well as mental health and other supportive initiatives. These include

the creation of Safe and Supportive School Program and Teams, and the creation of the Texas Child Mental Health Care Consortium and other telehealth and telemedicine programs after Senate Bill 10 (Nelson) was amended onto SB 11 during the legislative process.

Senate Bill 2432 (Taylor/Sanford)

SB 2432 expands mandatory student removal to DAEPS to include harassment as defined by the Penal Code.

House Bill 3 (Huberty/Taylor) – School Funding

HB 3 is a comprehensive education bill that has many provisions and changes to the school finance system. The bill includes \$11.6 billion measure to which \$6.5 billion is dedicated to public education spending, and \$5.1 billion is dedicated to lowering property taxes. TEA provided multiple resources to help understand the bill in its entirety that can be found at <https://tea.texas.gov/about-tea/government-relations-and-legal/government-relations/house-bill-3>.

A few highlights of the bill include:

- Requires full-day Pre-K
- Funds an optional 30-day, half-day summer program
- Increases resources for students living in low-income families and for whom English is a second language
- Increases funding for special education
- Basic Allotment (BA) increase
 - Tied to the Minimum Salary Schedule (MSS)
 - 30 percent of increase must go to salary increase:
 - 75 percent of the 30 percent must go to classroom teachers (more for 5+ yrs experience), librarians, school counselors, and school nurses;
 - 25 percent may be used to provide an increase for full-time employees (except administrators) as determined by school district;
 - Districts will have to report to legislature on each salary increase by position and amount; and
 - Cannot use new hires towards 30 percent requirement, funding is for pay increases for current full-time employees.

COVID-19

The COVID-19 pandemic presented new and unexpected challenges for communities, and greatly impacted schools. TEA recognizes that “as a result of school closures and remote learning due to the COVID-19 pandemic, students have been at higher risk of exposure due to adverse childhood experiences and first hand exposure to the effects

of pandemic.”²⁶ These incredible challenges will continue and evolve throughout the current school year and likely beyond. In response to the pandemic, TEA worked on a number of activities focused on supporting the mental health and well-being of students, their families, teachers, and the overall school. Some of these activities include:

- TEA posted information on their COVID-19 web page on remote counseling, a statewide mental health resource list, Multi-Tiered Systems of Support (MTSS) interventions, and how to contact hard-to-reach students. This website can be found at <https://tea.texas.gov/texas-schools/health-safety-discipline/covid/coronavirus-covid-19-support-and-guidance>
- TEA created a series of six trauma-informed care videos for educators during school reopening. These videos can be found at <https://www.texasprojectrestore.org/>
- TEA issued a *To the Administrator Addressed* letter with updates on the Safe and Supportive School Program (SSSP) required by Texas Education Code Sec. 37.115 as amended by SB 11. As of October 2020, TEA was working on the rulemaking process on SSSP and trauma-informed care, with guidance expected by summer 2021.
- In July 2020, TEA staff conducted virtual “listening tours” with school districts and Education Service Centers (ESCs) with expertise in providing student support services and well-being supports in a MTSS, including Project Advancing Wellness and Resiliency in Education (AWARE) Texas. TEA reports that their staff will use this input to develop guidance for providing supports for students and school staff in the recovery from COVID-19.
- In July 2020, the Project AWARE interagency partners hosted virtual office hours twice a month for the ESCs to support the well-being of students and school staff in their regions during COVID-19. Many ESCs have likewise initiated Professional Learning Communities with school counselors and district leaders to share resources from the Texas Education Code Sec. 38.253 inventories, MTSS school mental health lessons provided by Project AWARE, and new resources to support staff and student well-being as additional resources are identified.
- TEA collaborated with ESCs to establish voluntary School Mental Health Teams at each ESC.
- In July 2020, TEA coordinated with a therapist who volunteered to provide Trauma Informed Care: Circle of Support for Schools virtual sessions that were attended by over 500 district and ESC staff. TEA reports they will continue their efforts to bring virtual training and technical assistance consultation to districts.²⁷

CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY (CARES) ACT

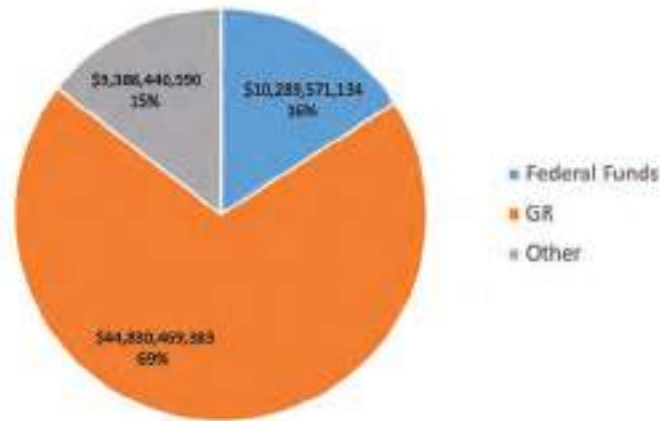
According to the Office of Elementary & Secondary Education within the U.S. Department of Education, Congress set aside approximately \$13.2 billion through the CARES Act for the Elementary and Secondary School Emergency Relief Fund (ESSER Fund). The funds are “emergency relief funds to address the impact that COVID-19 has had, and continues to have, on elementary and secondary schools across the Nation.”²⁸ TEA calculated the entitlements following the statutory formula and guidance provided by USDE. The formula states that a local education agency (LEA) will receive the same proportionate share of the total ESSER formula grant as

it received in proportion to the state's Title I, Part A grant in 2019-2020. According to TEA, a minimum of 90 percent of the ESSER grant to TEA will be allocated to LEAs that received Title I, Part A funding in school year 2019-2020. Providing mental health support and services are allowable use of these funds. All allowable uses of the grant funding include:

1. LEA discretion for any purpose under:
 - Elementary and Secondary Education Act (ESEA)
 - Individuals with Disabilities Education Act (IDEA)
 - Adult Education and Family Literacy Act (AEFLA)
 - Perkins Career and Technical Education Act
 - McKinney-Vento Homeless Education Act
2. Activities related to coordination of preparedness and response to improve coordinated responses among LEAs with state and local health departments and other relevant agencies to prevent, prepare for, and respond to coronavirus;
3. Provide principals and others school leaders with the resources necessary to address the needs of their individual schools;
4. Address the unique needs of low-income children or students, children with disabilities, English learners, racial and ethnic minorities, students experiencing homelessness, and students in foster care, including how outreach and service delivery will meet the needs of each population;
5. Developing and implementing procedures and systems to improve the preparedness and response efforts of LEAs;
6. Training and professional development of LEA staff on sanitation and minimizing the spread of infectious diseases;
7. Purchasing supplies to sanitize and clean facilities operated by the LEA;
8. Planning for and coordinating during long term closures, including for how to provide meals to eligible students, how to provide technology for on line learning to all students, how to provide guidance for carrying out requirements under IDEA, and how to ensure other educational service can continue to be provided consistent with all federal, state, and local requirements;
9. Purchasing educational technology (including hardware, software, and connectivity) for students who are served by the local educational agency that aids in regular and substantive educational interaction between students and their classroom instructors, including low-income students and students with disabilities, which may include assistive technology or adaptive equipment;
10. Providing mental health services and supports;
11. Planning and implementing activities related to summer learning and supplemental afterschool programs, including providing classroom instruction or online learning during the summer months and addressing the needs of low-income students, students with disabilities, English learners, migrant students, students experiencing homelessness, and children in foster care; and
12. Other activities that are necessary to maintain the operation of and continuity of services in LEAs and continuing to employ existing staff.²⁹

Funding

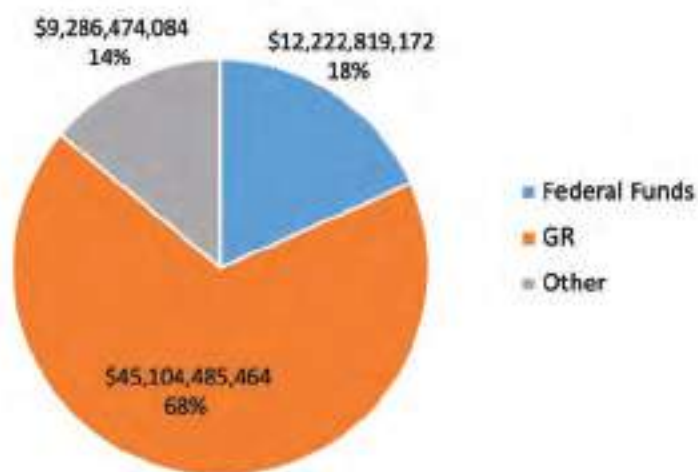
Figure 78. TEA Legislative Appropriations Request by Method of Finance FY 2022-23



Source: Legislative Budget Board. (October 2020). *Texas Education Agency, fiscal year 2022-2023 legislative appropriations request, October 2020 - volume 1 of 2*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2022>

The total requested TEA budget for FY 2022-23 is \$64,508,481,207. If included in the budget, the Exceptional Items Requests would add an additional \$25,711,500.

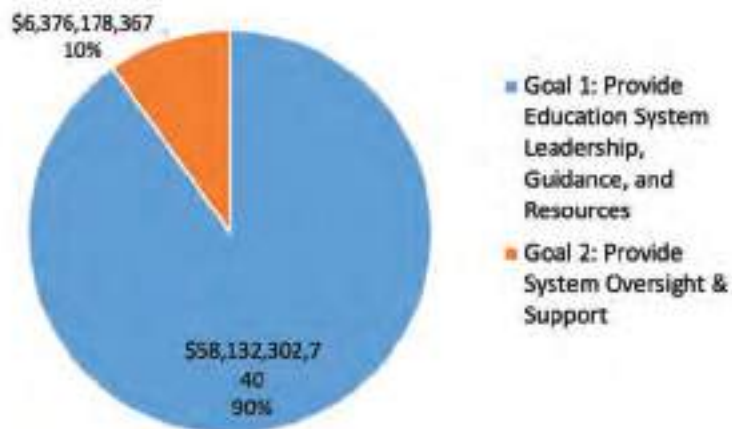
Figure 79. TEA Budget by Method of Finance FY 2020-21



Source: Legislative Budget Board. (October 2020). *Texas Education Agency, fiscal year 2022-2023 legislative appropriations request, October 2020 - volume 1 of 2*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2022>

The total TEA budget for FY 2020-21 was \$55,838,888,685.

Figure 80. TEA Legislative Appropriations Request by Strategy FY 2022-23



Source: Legislative Budget Board. (October 2020). *Texas Education Agency, fiscal year 2022-2023 legislative appropriations request, October 2020 – volume 1 of 2*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2022>

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Under the Individuals with Disabilities Education Act (IDEA), children and adolescents between the ages of 3 and 21 who have disabilities are entitled to receive a free and appropriate public education.³⁰ IDEA first passed in 1975 (as the Education for All Handicapped Children Act, PL 94-142) and has been reauthorized multiple times. In its current form, the IDEA both authorizes federal funding for special education and related services and sets out principles under which special education and related services are to be provided for states that accept the funds.

IDEA consists of four parts:

1. Part A contains the general provisions, including the purposes of the act and definitions.
2. Part B contains provisions relating to the education of school-aged children (the grants-to-states program) and the state grants program for preschool children with disabilities (Section 619).
3. Part C authorizes state grants for programs serving infants and toddlers with disabilities.
4. Part D contains the requirements for various national activities designed to improve the education of children with disabilities.

Part B is the largest part of the IDEA (nearly 95 percent of the Acts' total funding in FY 19).³¹ IDEA Part B authorizes the state grant program and stipulates the conditions for receiving funds. States are required to educate students with disabilities in the least restrictive environment, which means with their peers in a normal classroom, to the extent possible. States are also required to provide a free, appropriate public education to all disabled students, which:

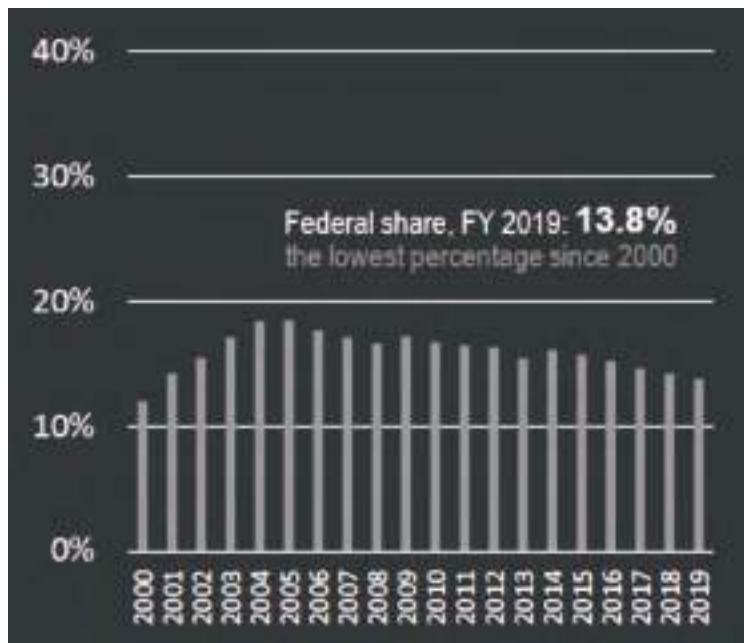
- Is provided at public expense, under public supervision and direction, and without charge;
- Meets the standards of the state education agency;
- Includes an appropriate preschool, elementary school, or secondary school in the state; and
- Is provided in conformity with the Individual Education Program established for the child.

The amount required to provide the maximum amount for each state's grant is commonly referred to as "full funding" of the IDEA. When IDEA was created, Congress' intention was that (1) states would provide every eligible child a free appropriate public education (FAPE) in the least restrictive environment, and (2) states would not take on an untenable financial burden by agreeing to provide special education and related services. At that time, 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.³² To support schools with increased costs, the federal government committed to contributing up to 40 percent of this anticipated additional cost.³³ Despite this commitment, the federal government has given less than half of its committed financial support since IDEA's first year of funding in 1981.³⁴

Overall, spending for special education programs has increased since the inception of IDEA and its predecessor, but federal and state funding for special education has not increased proportionately.³⁵ Local funding must make up the difference in funding for this increased need in order to meet IDEA's requirements for providing special education services in schools.³⁶ As Figure 81 shows, federal funding for special education through IDEA has remained relatively constant for the past 14 years and it is expected to remain constant despite an increase in the number of students eligible to receive special education.³⁷ The federal trend of under-funding special education resulted in IDEA falling more than \$10 billion short of being fully funded in FY 2014.³⁸ The federal FY 2020 budget provides \$13.8 billion in funding for IDEA, up from \$13.47 billion in FY 2019.^{39,40}

Excluding funding for preschools through IDEA, TEA received \$1,975,477,627 in federal IDEA Part B funding for the 2020-21 biennium, resulting in a decrease of approximately three percent from the 2018-19 biennium (\$2,030,489,139).⁴¹ For the 2022-23 biennium, the funding is expected to remain mostly unchanged at \$1,982,750,442.⁴²

Figure 81. Federal Share of Special Education Funding Through IDEA: 2000-2019



Source: The Advocacy Institute. (December 17, 2019). *IDEA Money Watch*. Retrieved from <http://ideamoneywatch.com/balancesheet/?p=851>

MEDICAID

In addition to funding from the federal and state government through IDEA, schools can bill Medicaid directly for certain eligible services through the School Health and Related Services (SHARS) program. Services provided by SHARS are made available through the coordination of TEA and HHSC.⁴³ SHARS is a Medicaid financing program that allows local school districts and shared services arrangements to obtain Medicaid reimbursement for certain health-related services provided to students in special education.⁴⁴ The state match requirement for SHARS Medicaid funding is met by using state and local special education allocations that already exist. School districts and shared service agreements (SSAs) must enroll as Medicaid providers and employ or contract with qualified professionals to provide these services.⁴⁵

Services covered by SHARS include:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy
- Personal care services
- Physical therapy
- Physician services
- Psychological services, including assessments
- Speech therapy
- Transportation in a school setting⁴⁶

In order to receive SHARS services, students must meet all of the following requirements:

- Be 20 years of age or younger;
- Have a disability or chronic medical condition;
- Be eligible for Medicaid;
- Be enrolled in a public school's special education program;
- Meet eligibility requirements for special education described in IDEA; and
- Have an individualized education program that identifies the needed services.⁴⁷

Delivery of Mental Health Services in Schools

For some youth, schools often serve as the first point of intervention when services or supports are needed because the majority of a young person's day is in an academic setting. For some students, it can be as simple as having someone to talk to. For students with more complex needs, child and adolescent disorders will often continue into adulthood without early intervention.⁴⁸ Many children in our public schools, while not living with serious emotional disturbance or mental illness, may be experiencing trauma or struggling with their mental health and well-being. Last year, 37 percent of Texas high school students reported feeling sad or hopeless for a period of two weeks or longer that resulted in decreased usual activity.⁴⁹

When needed, students are 21 times more likely to visit a school-based mental health service than a community mental health center.⁵⁰ According to the American Counseling Association, in order to adequately support kids and their mental well-being in schools, Texas would need to double the number of counselors, triple the number of licensed specialists in school psychology (LSSP), and increase social workers 19 times to reach national levels.⁵¹ The Texas Education Code does not currently define school social work services, one crucial first step to getting more social workers in school systems. There are benefits for increasing mental health professional ratios in schools. For the schools that did follow the recommended ratio for counselors of 250:1, there were lower disciplinary rates and absenteeism, and increased graduation rates.⁵²

Early intervention with mental health concerns supports academic achievement, increases healthy stress management skills, improves social and emotional functioning and peer interactions, and allows schools to intervene before there is significant psychological deterioration.⁵³ Furthermore, young children who receive effective, age-appropriate mental health services are more likely to complete high school, have fewer contacts with law enforcement, and improve their ability to live independently and be productive.⁵⁴

School-based mental health services encompass a wide variety of different programs and approaches. Special attention must be paid to schools in rural areas of the state. A 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 surveyed in the study said that less than 25 percent of their students received adequate counseling services.⁵⁵ According to a separate Center for Disease Control report, the percentage of children with diagnosed mental health and developmental disorders is consistently higher in rural areas.⁵⁶ In Texas, the suicide rate is roughly 15 percent higher in rural counties (less than 20,000 residents) than in metropolitan ones.⁵⁷ Barriers to delivering mental health services lead to inconsistent mental health care from school to school but even though access to services and supports varies based on a school's region (i.e., urban vs. rural), academic level, and student population, most schools offer some level of mental health screening, referral or services.⁵⁸

The different methods of delivering mental health services in schools are described in Table 55.^{59,60}

Table 55. Mental Health Service Delivery Methods

School-Based Mental Health Service Delivery	Description
School Financed	Typically includes mental health prevention programs and basic treatments such as counseling that are provided on-site by licensed school personnel (e.g., counselors, psychologists and social workers).
Formal Connections with Community Mental Health Services	Formal agreements and contracts made with community mental health agencies (e.g., LMHAs) to provide services in school or at the community agency.
School District Mental Health Units or Clinics	School districts may operate their own mental health units or clinics to provide psychosocial and mental health services, staff trainings and consultation.
Classroom-Based Curricula	Schools may address mental health needs with prevention-oriented materials provided through teacher instruction. These curricula enhance learning by promoting and fostering the social and emotional growth of all students.
Comprehensive, Multi-Faceted and Integrated Approaches	Districts can bring together multiple activities, mental health and substance use strategies, and community agencies to provide a full range of interventions and services to students with complex mental health needs.
Schoolwide Behavioral and Emotional Support Frameworks	This holistic approach to meeting every student's needs includes models and treatment frameworks used by an entire school; for example, positive behavioral interventions and supports (PBIS), social and emotional learning (SEL), and trauma-informed care.
School Based Health Centers	A school-based health center is a facility providing preventive and primary health care services to children and adolescents located on or near a school campus, inclusive of mental health services. A SBHC is staffed by a multidisciplinary team that may include nurse practitioners, physicians, clinical social workers, psychologists, nutritionists, dentists, dental hygienists and/or administrators. ⁶¹

THE TEXAS CHILD HEALTH ACCESS THROUGH TELEHEALTH (TCHATT)

The Texas Child Health Access through Telehealth (TCHATT) Program is one component of the Texas Child Mental Health Care Consortium, established through SB 11 in the 86th Legislative Session. The Consortium is made up of 13 health-related institutions (HRI) of higher education. The legislation calls on the Consortium to “establish or expand telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health care services.” The TCHATT program will create or tap into existing telemedicine or telehealth programs to assist school districts with identifying student mental health care needs and accessing services, consisting of:

- Provision of direct psychiatry through telemedicine or counseling services through telehealth to children and adolescent within schools.
- Educational and training materials for school staff to assist in assessing, supporting, and referring children and adolescents with mental health needs for appropriate treatment and supports.
- Analysis and mapping of existing telemedicine and telehealth programs that are currently providing, or can be adapted to provide, services to schools.
- Statewide data management system that will track calls and responses in order to measure both need and responsiveness.⁶²

Each HRI may provide TCHATT services differently, but each will collaborate with schools to establish a process for referral. TCHATT services can last up to four sessions and can include assessment, therapy, psychiatric care, and referral assistance. Families will not be charged for services. As of September 2020, measures of the students seen in TCHATT, the types of services and referrals provided to students, and the outcomes of these services are being standardized. Additionally, the work of the Texas Child Mental Health Care Consortium considered the impact of COVID-19 and began adjusting the process for telehealth at families’ homes in addition to schools.⁶³

EDUCATION SERVICE CENTERS

Created in 1967, 20 regional educational service centers in Texas provide services, support, and technical assistance to all school districts throughout the state in a variety of areas, including special education and behavioral support. Enacted by the 75th Legislature, ESCs are required to assist school districts in improving student performance in each region of the state, enable school districts to operate more efficiently and economically, and implement initiatives assigned by the legislature or the commissioner. A map of service center regions is shown in Figure 82.

Figure 82. Map of Education Service Center Regions



Source: Texas Education Agency. (2016). *Education Service Centers Map*. Retrieved from http://tea.texas.gov/regional_services/esc/.

ESCs specialize in specific topic areas and services, in addition to providing resources, support, programmatic assistance and general expertise to school districts or schools statewide.⁶⁴ For example, the Region IV Education Service Center in Houston specializes in Positive Behavioral Interventions and Supports with the goal of enhancing the education experience for all students by addressing the needs of students with behavior challenges.⁶⁵ Additionally, the Region XIII Education Service Center in Austin has a Behavior Team that includes general and special education specialists who focus on providing campuses with workshops, consultations, and technical assistance for behavioral supports.⁶⁶ During the 86th legislative session, House Bill 19 (Price/Watson) passed requiring LMHAs to employ a non-physician mental health professional as a mental health and substance use resource for school districts. While not providing direct services, the professional will be located at the ESC as a resource for schools to:

- Increase school personnel awareness and understanding of mental health, substance use, and their co-occurrence, as well as resources available;
- Assist in implementation of programs and initiatives; and
- Facilitate optional monthly trainings.

A total of \$23,750,000 was allocated to ESCs for Core Services in the 2020-21 biennium, with the same amount requested for the 2022-23 biennium.⁶⁷ ESCs do not possess tax levying or bonding authority and rely on grants and contracts for funding. Revenues are received from three primary sources: state funds, federal funds, and contracts with school districts.⁶⁸ The ESC infrastructure supports schools in complying with IDEA and, according to the required report from Rider 34, saved public and charter schools over \$122 million during the 2016-2017 school year. These savings are a direct result of the products/services provided by ESCs to LEAs across Texas.⁶⁹ Annual savings are mainly a result of school districts increased access

to cheaper products and services through ESCs (as opposed to the open market or running those programs internally) and reduced transportation and staffing costs provided through distance learning opportunities (as opposed to in-person trainings).⁷⁰ A total of 1,132,528 individuals were trained through ESCs in 2019, up from 949,616 trained in 2017.^{71,72} For 2022-23 TEA expects to continue training an estimated 885,000 individuals per year through the state's 20 ESCs.⁷³

Special Education Services in Texas

Schools are accountable for the academic performance of all students, including those with disabilities such as serious emotional issues 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). This may include mental health treatment and supports.⁷⁴ One of the main purposes of IDEA is to ensure that children with disabilities have a free and appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living. Special education means specially designed instruction to meet the unique needs of a child with a disability. Related services are special services needed to support students' special education services so they can make progress to meet their academic and functional goals. Related services can include services such as occupational therapy, physical therapy, speech/language therapy, counseling services, orientation and mobility services, and/or transportation services.⁷⁵

Special education services and supports provided are determined through an annual Admission, Review and Dismissal (ARD) meeting that typically includes the student, the student's parents and/or caregivers, any mental health professionals involved in the child's care, and school personnel including at least one of the child's regular and special education instructors.⁷⁶ The ARD meeting is an essential part of creating, updating, amending, and improving the individualized education plan on an ongoing basis. Students' parents may request an ARD meeting any time they believe one is necessary. The IEP is the organizing framework and plan used to specify goals, supports, and interventions to help the student experience stability and success in the classroom.⁷⁷ Schools are required by law to provide therapy services exactly as they are documented in the IEP. Schools cannot use personnel shortages, absences, or lack of funding to deny services. If the school fails to deliver services as documented in the IEP, the child may be eligible to receive "compensatory" services, including make-up services in the summer or private therapy paid for by the school.⁷⁸

Between 2004 and 2014, the population of Texas students receiving special education services decreased from 11.7 percent to 8.5 percent.⁷⁹ The decrease in the proportion of students enrolled in special education services in Texas led to a *Houston Chronicle* series revealing an 8.5 percent benchmark implemented by the state in 2004 which subsequently led to a U.S. Department of Education investigation which concluded with directives for TEA to reform special education in Texas.

FEDERAL INVESTIGATION ON TEXAS' SPECIAL EDUCATION SERVICES

For years, Texas was only identifying a very low percentage of school-age children as having special education needs, largely because of an 8.5 percent target implemented by TEA in 2004. An estimated 8.7 percent of school-aged children in Texas were identified as having special education needs in the 2015-16 school year.⁸⁰ The percentage of children in Texas schools identified as eligible for special education services was far lower than in other states with the national average being about 13 percent.⁸¹

In a 2016 series of articles in the *Houston Chronicle*, Texas was found to be limiting the number of students identified as eligible for special education services. The report by Brian Rosenthal alleged that TEA had systematically denied special education services to children across Texas by implementing an 8.5 percent target for children with disabilities served in school districts.⁸² The Chronicle disclosed that the benchmark was implemented in 2004, while TEA was facing a \$1.1 billion state budget cut, and that it has effectively led to a denial of “vital supports to children with autism, attention deficit hyperactivity disorder, dyslexia, epilepsy, mental illnesses, speech impediments, traumatic brain injuries, even blindness and deafness.”⁸³

The *Houston Chronicle* report prompted a federal investigation by the U.S. Department of Education. In 2017, the Office of Special Education Programs (OSEP) within the U.S. Department of Education released a monitoring report that found three specific areas where TEA failed to comply with the federal Individuals with Disabilities Education Act:

1. TEA failed to ensure that all children with disabilities residing in the state who are in need of special education and related services were identified, located and evaluated, regardless of the severity of their disability, as required by IDEA.
2. TEA failed to ensure that a free appropriate public education was made available to all children with disabilities residing in the State in Texas's mandated age ranges (ages 3 through 21), as required by IDEA.
3. TEA failed to fulfill its general supervisory and monitoring responsibilities as required by IDEA to ensure that independent school districts throughout the state properly implemented the IDEA's child find and FAPE requirements.⁸⁴

Beginning in November of 2016, TEA began to address concerns expressed by OSEP. Actions included:

4. Issuing a letter to every independent school district in the state reiterating their “Child Find responsibilities” under the IDEA;
5. Coordinating a series of listening sessions throughout the state which were attended by both OSEP and TEA staff;
6. Governor Abbott, with the Texas Legislature, implemented SB 160 (85th, Rodriguez/Wu) prohibiting the use of school performance indicators to solely measure total number or percentage of enrolled children receiving special education and related services under the IDEA.⁸⁵

Following the full 15-month investigation, the U.S. Department of Education

released their full report in January 2018. The investigation concluded that Texas failed to ensure students with disabilities were properly evaluated and that the state failed to provide an adequate public education for students with disabilities.⁸⁶ According to *The Texas Tribune*, the report found that TEA was “more likely to monitor and intervene in school districts with higher rates of students in special education, creating a statewide system that incentivized denying services to eligible students” and that “school district officials said they expected they would receive less monitoring if they served 8.5 percent of students or fewer.”⁸⁷ Further, school administrators delayed federally required evaluation of students suspected of having disabilities, often by providing intensive academic support.⁸⁸ The report outlined corrective action for TEA to take including documentation of special education evaluation practices, developing a plan to evaluate previously denied students and directing educators on how to identify students with disabilities.⁸⁹

STRATEGIC PLAN FOR SPECIAL EDUCATION IN TEXAS

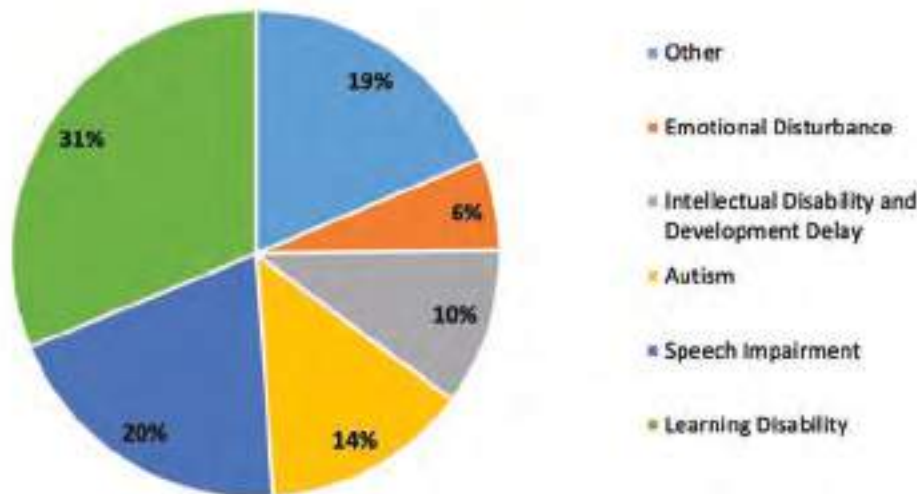
In 2018, TEA worked with various stakeholders across Texas to develop the Strategic Plan for Special Education in Texas. The plan lays out activities aimed at improving special education programs in Texas, including monitoring, training support and development, and student and family engagement. The majority of the strategic plan is funded through federal IDEA funding and state discretionary funds. This plan addresses the state’s role of monitoring and providing support and technical assistance to districts. There are no requirements for districts beyond what has been, and remains, a requirement of federal and/or state law.

The plan along with TEA’s progress in completing the activities in the plan can be found at <https://tea.texas.gov/academics/special-student-populations/special-education>.

ELIGIBILITY FOR SPECIAL EDUCATION SERVICES

Special education services encompass a wide range of interventions. Children can become eligible for these services by receiving a diagnosis for a specified condition or with general diagnosis of developmental delay, and as a result of the disability, need special education and related services to benefit from education. Figure 83 shows the various mental health diagnoses, behavioral conditions, and developmental disabilities that qualified 587,987 students in Texas for special education services in the 2019-20 school year.⁹⁰

Figure 83. Reasons for Special Education Eligibility in Texas Schools: 2019-2020



Note: "Other" includes Other Health Impairment, Auditory Impairment, Non-Categorical early childhood, Orthopedic impairment, Visual impairment, Deaf/blind and Traumatic Brain Injury.

Data obtained from: Texas Education Agency. (March 2020). *2019-2020 Special Education Reports: All Texas Public Schools Including Charter Schools, Students Receiving Special Education Services by Primary Disability*, PEIMS Data 2019-20. Retrieved from <https://rptsvr1.tea.texas.gov/adhocrpt/adser.html>

During the 2019-20 school year, over 36,000 Texas students were identified as having serious emotional disturbance — roughly 6 percent of all students identified as eligible for special education services.⁹¹ Nationwide, students served under IDEA have a drop out rate of 21 percent, which students identified as having serious emotional disturbance have the highest drop-out rate (38.7 percent) among students receiving special education or general education.⁹² However, there are students who receive special education based on other primary disabilities (e.g., intellectual disabilities and autism) who also have mental health needs, such as depression, anxiety, post-traumatic stress disorder, attention deficit disorder, and more.

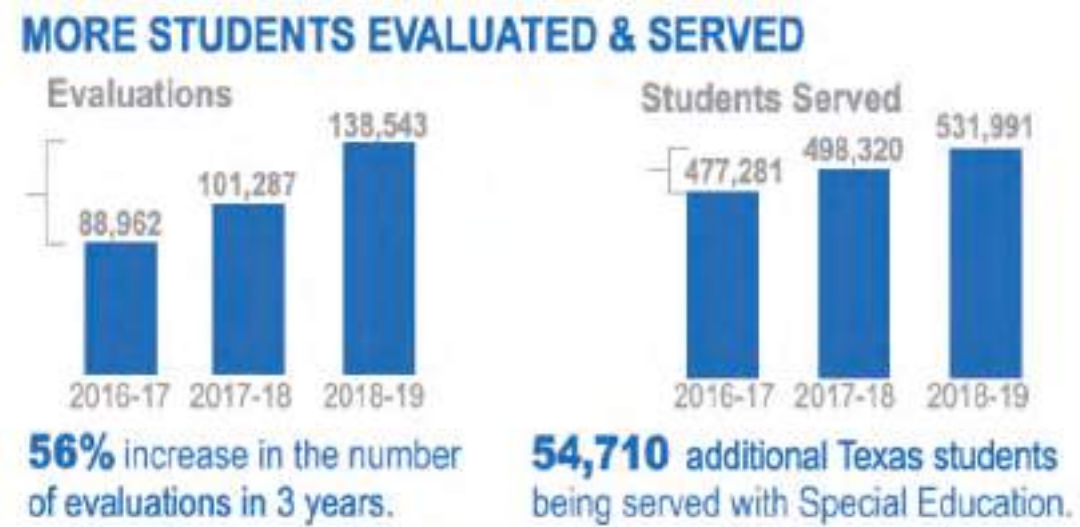
Eligibility for IDEA school-based mental health services for serious emotional disturbance is based on the student exhibiting one or more of the following characteristics to a marked degree over an extended period of time, in ways that adversely affect the student's educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health impairments
- An inability to relate appropriately to peers and teachers
- Inappropriate types of behaviors or feelings under normal circumstances
- A general mood of unhappiness and depression
- A tendency to develop physical symptoms, pains, or fears from personal or social problems⁹³

When determining whether special education services will be provided, school personnel seek evidence that the student's behavior and need for services is not the result of a temporary reaction to adverse yet normal situations at home, in school, or

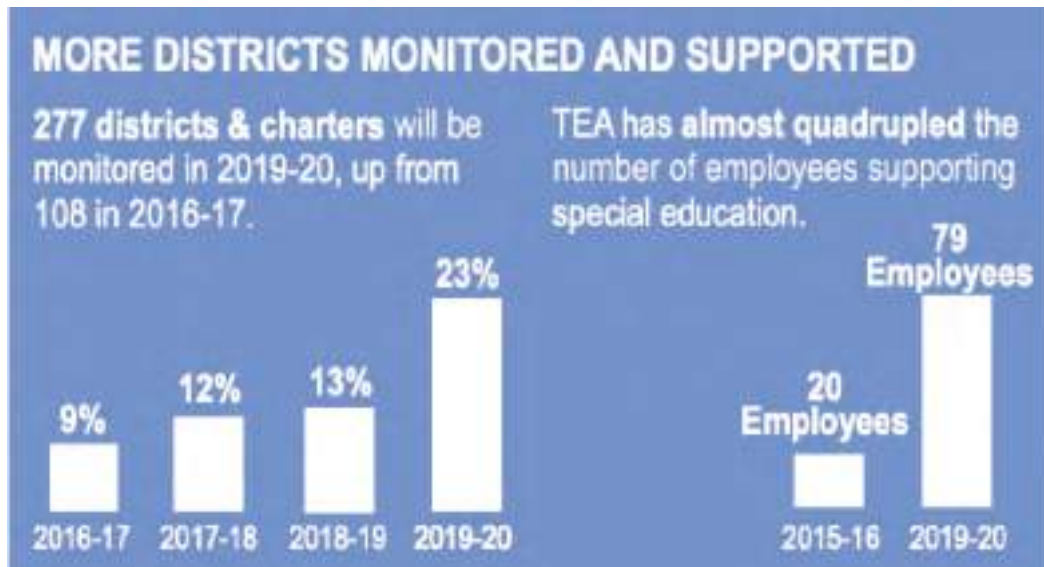
in community situations. According to TEA, the number of students evaluated and served, as well as districts monitored and supported in order to serve these students has been a priority for the agency, illustrated in Figure 84 and Figure 85.

Figure 84. Special Education Evaluations and Students Served by TEA, 2016-2019



Source: Texas Education Agency. (2020). *2018-2019 Pocket Edition*. Retrieved from https://tea.texas.gov/sites/default/files/2018-19%20Pocket_Edition_Final.pdf

Figure 85. Districts Monitored and Special Education Staff at TEA



Source: Texas Education Agency. (2020). *2018-2019 Pocket Edition*. Retrieved from https://tea.texas.gov/sites/default/files/2018-19%20Pocket_Edition_Final.pdf

FUNDING FOR SPECIAL EDUCATION SERVICES

During the 2019-20 school year, roughly 7.1 million public school students received special education services across the U.S —over 14 percent of all students nationwide.⁹⁴ During the same year, only 10.8 percent of the student population in Texas received special education services.⁹⁵

Funding for the “Students with Disabilities” strategy within TEA has gradually increased in recent years, with \$2,108,308,102 budgeted for the 2016-17 biennium, \$2,227,210,464 for the 2018-19 biennium, and \$2,232,210,464 for the 2020-21 biennium. TEA has requested \$2,163,495,650 for the 2022-2023 biennium, with federal funding accounting for 93.6 percent of the total requested funding.⁹⁶

SPECIAL EDUCATION FOR EARLY CHILDHOOD – DEVELOPMENTAL DELAYS

Because children’s brains are growing and their behaviors are constantly changing, it can be difficult to diagnose a young child with a psychological condition. There are also children without a mental health diagnosis who may still benefit from early intervention services. To bridge the gap for young children who do not have a specific diagnosis and may 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 diagnostic category called “developmental delay,” as long as the diagnosis is made using proper instruments and procedures.⁹⁷ The following types of diagnostic categories are designated as developmental delays at the federal level:

- Physical development
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development^{98,99}

States have the authority to decide what to call the “developmental delay” category, how to define it, and what ages to include as eligible. However states are not authorized to require a local education agency (LEA) to adopt or use the “developmental delay” term. Texas calls this developmental delay category “Non-Categorical Early Childhood (NCEC).” It includes children between the ages of three and five who have “general delays in their physical, cognitive, communication, social, emotional or adaptive development(s).” Because of delays, these children are in need of special education and related services.¹⁰⁰ Children who fall under the NCEC category are provided services through a program called Preschool Program for Children with Disabilities (PPCD). PPCD services are provided at no-cost by the public school systems in a variety of settings such as pre-kindergarten, resource classrooms, self-contained classrooms, or community settings such as Head Start and pre-school. In addition to becoming eligible for PPCD services through the NCEC category, children in Texas may also qualify for PPCD under the following specific diagnoses:

- Intellectual disability;
- Emotional disturbance;
- Specific learning disability; and
- Autism.¹⁰¹

EMERGING ADULTS

In recent years, Texas made efforts to bridge the gap in services and supports for students with special needs transitioning out of high school, known as “emerging adults”. To assist students who receive special education services with a successful transition from school to appropriate post-school activities, such as postsecondary and 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 each student’s IEP. The availability, comprehensiveness, and quality of transition services available in Texas vary widely across the state. Individual school districts, TEA, HHSC, and other state agencies make transition information available through a central website: www.transitionintexas.org.

The 85th Legislature passed HB 748 (Zaffirini/Allen) to update transition planning to reflect new state alternatives to guardianship. The bill updates the factors the ARD committee must consider regarding whether a student has sufficient exposure to supplementary services to help the student develop decision-making skills. The bill requires TEA to update the Texas Transition and Employment Guide with information about long-term services, community supports, and alternatives to guardianship. Additionally, the bill requires TEA to develop and post a list of services and public benefits available to an adult student.¹⁰²

Positive School Climate

Cultivating well-being at schools includes a wide array of school-wide practices that improve the school climate, including the availability of mental health services. According to TEA, a positive school climate “is the product of a school’s attention to fostering safety; promoting a supportive academic, disciplinary, and physical environment; and encouraging and maintaining respectful, trusting, and caring relationships throughout the school community no matter the setting.”¹⁰³

Additionally, utilizing trauma-informed education, positive behavior interventions and supports (PBIS), restorative discipline practices, and social emotional learning (SEL) so that all students and teachers are impacted positively, can create an overall supportive school community where students feel connected and safe. Providing a multi-tiered system of support through implementing strategies and supports that cultivate a positive school climate not only helps students and teachers feel safe and supported but also improves academic achievement.¹⁰⁴

Increasing mental health education, services, and supports in schools is an important component to improving school climate. Integration of mental health into schools can encourage normalizing discussions, discourage stigmatization, increase access to care, and provides opportunity for early identification and intervention, especially in rural schools where mental health resources in the community are more scarce.¹⁰⁵

Better integration has been shown to help increase recognition that mental health is a part of overall health rather than stand-alone items. By increasing knowledge, attitudes around mental health may improve, stigmatization may be assuaged, and the ability to recognize and appropriately respond to a mental health concern may be gained by students and educators.¹⁰⁶ When students are socially, emotionally, and mentally well, they are able to better engage in their learning. Mental health initiatives and services are related to increased test scores, commitment to school, attendance, grades, and graduation rates, while also reducing truancy and disciplinary rates.¹⁰⁷

MENTAL HEALTH SUPPORT SYSTEMS FOR SCHOOLS

Mental health supports and services vary between individual schools and districts, often dependent on availability in the community or schools' resources. Additionally, workforce issues and community or school leadership buy-in create additional obstacles for mental health professionals to be staffed within schools. For students being served through special education with individual education plans (IEPs), mental health services are required by law to be provided for students if those services are part of their IEP.¹⁰⁸ Although the availability of mental health supports and services in school is not required, some schools have implemented programs and initiatives that support student mental health, as well as create a more broad, positive school climate. This next section describes the mental health supports, services, and related programs available statewide.

COORDINATED SCHOOL HEALTH MODEL

Texas school districts are required to provide a coordinated school health program by law that coordinates education and services related to physical health, mental health education, substance abuse education, physical education and activity, and parental involvement.¹⁰⁹ House Bill 18 (86th. Price/Watson) was responsible for expanding the coordinated school health programs to include mental health and substance use education.

TEA utilizes CDC's Whole School, Whole Community, Whole Child (WSCC) framework for addressing health in schools.¹¹⁰ According to DSHS, "the WSCC model focuses its attention on the child, emphasizes a school-wide approach, and acknowledges learning, health, and the school as being a part and reflection of the local community."¹¹¹ The WSCC model is an expansion and update of the Coordinated School Health Model, previously utilized by TEA. TEA is required to make one or more coordinated school health programs available to each school. The curriculum for the programs are directed by a mandatory, multidisciplinary team, known as the School Health Advisory Council (SHAC).¹¹² SHAC members are appointed by the

school district to serve and make recommendations for the district's Coordinated School Health program.

The WSCC model includes the following components:

- Physical education and physical activity
- Nutrition environment and services
- Health education
- Social and emotional school climate
- Physical environment
- Health services
- Counseling, psychological and social services
- Employee wellness
- Community involvement
- Family engagement¹¹³

HOLISTIC APPROACHES TO STUDENT WELL-BEING AND NEEDS

Addressing students' needs in the classroom often extends beyond their learning. For a student experiencing trauma or other difficult life events such as family conflict or a natural disaster, learning can be difficult for them. When a child feels unsafe, frightened, or overwhelmed, their brain releases stress hormones, which places them in a state of “fight, flight, or freeze.” Typically, our brains and bodies subside and return to a normal state. Unfortunately, this isn't always the case when exposed to intense and stressful events or prolonged adversity, such as abuse, exposure to violence, parental substance use, or not having a safe and stable home. During this state, the brain prioritizes survival, so the events a child is currently experiencing, or has experienced in the past, interfere with thinking, learning, and behavior.¹¹⁴ Too often, unidentified mental health conditions or trauma are perceived as “bad” behavior, and punitive discipline practices are implemented. Exclusionary discipline practices have developmental, behavioral, academic, and high financial costs. The alternative models of intervention discussed in this section can support the social and emotional development of students and address their needs, while remaining more cost-effective than the resource-intensive exclusionary discipline practices (i.e., suspension and expulsion) that are often used in Texas public schools. This section will focus on five specific models and frameworks:

- Multi-Tiered Systems of Support
- Social and emotional learning
- Trauma-informed care
- Restorative justice (also known as restorative discipline)

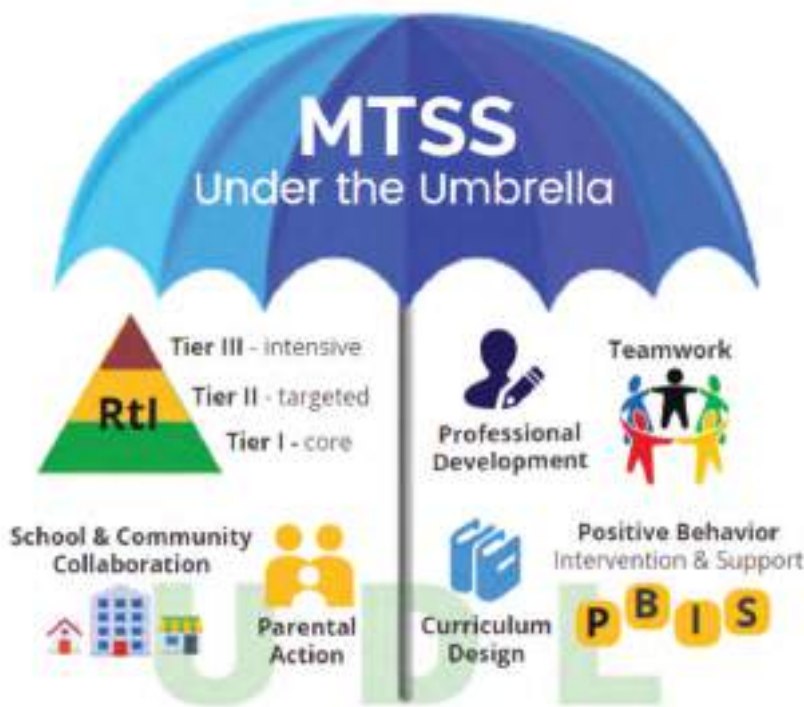
Public schools in Texas are increasingly shifting their practices to be proactive, coordinated approaches to meet the behavioral and academic needs of all students. While some students with mental health needs require tailored interventions and trained professionals, there are also intervention models that provide a more holistic approach to supporting the needs of all students within a school system. These initiatives generally include campus-wide prevention activities, targeted early intervention for students identified to need support, and individualized services for students with complex needs. Texas is among a number of states promoting positive

approaches to preventing mental and emotional problems in children.¹¹⁵

Multi-Tiered Systems of Support

A Multi-Tiered System of Support (MTSS) is a data-driven, problem-solving framework to improve outcomes for all students.¹¹⁶ MTSS is not a curriculum, nor is it an intervention. It is simply a framework of how to identify and address school-wide needs in a way that is proactive and data-driven. MTSS relies on a continuum of evidence-based practices matched to student needs. According to TEA, MTSS encompasses supports for the whole child, and takes into account academics, behavior, and social/emotional supports.¹¹⁷ MTSS is also a research-based framework for the systemic alignment of initiatives, resources, staff development, prevention, intervention, services, and supports. Figure 86 illustrates MTSS what is encompassed within a MTSS. Figure 87 shows MTSS best practices.

Figure 86. Components of a MTSS



Source: University of Florida, Cedar Center. (n.d.) *Muti-tiered system of support chapter*. Retrieved from <https://cedar.education.ufl.edu/mtssudldi-professional-development-module/mtss-chapter/#toggle-id-7>

Figure 87. MTSS Best Practices

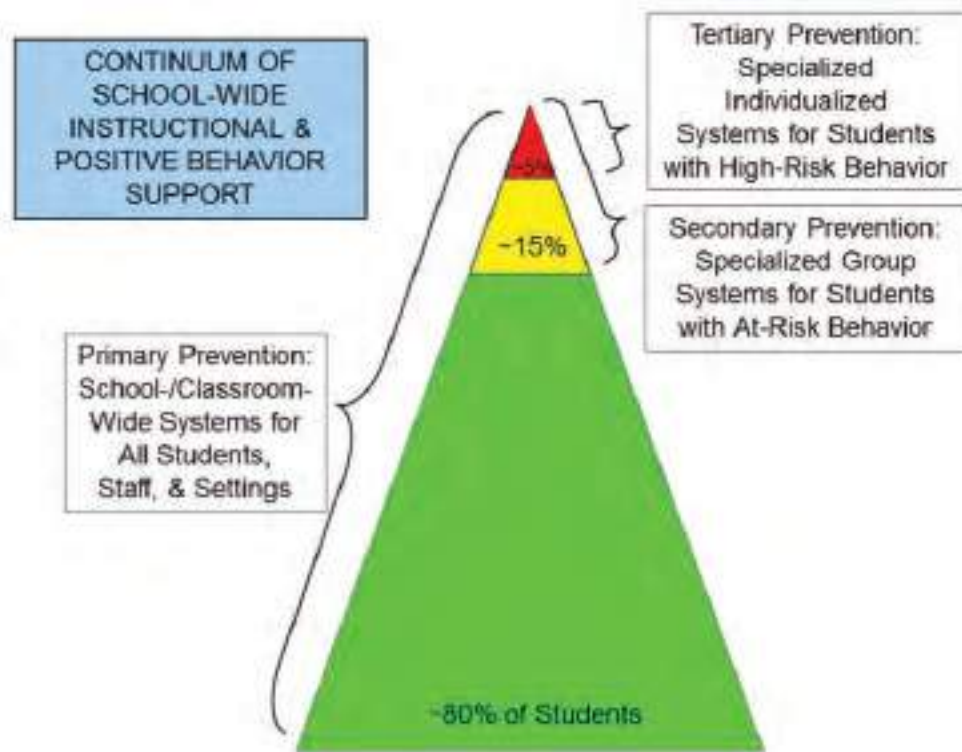


Source: Prater, S. Lee, C., Wilk, L., & Solano, F. (n.d.). *Multi-Tiered Systems of Support (MTSS) questions and answers* [PowerPoint]. Retrieved from https://tea.texas.gov/sites/default/files/TEA%20MTSS%20QA-Final_accessible%20PPT.pdf

Positive Behavioral Interventions and Supports

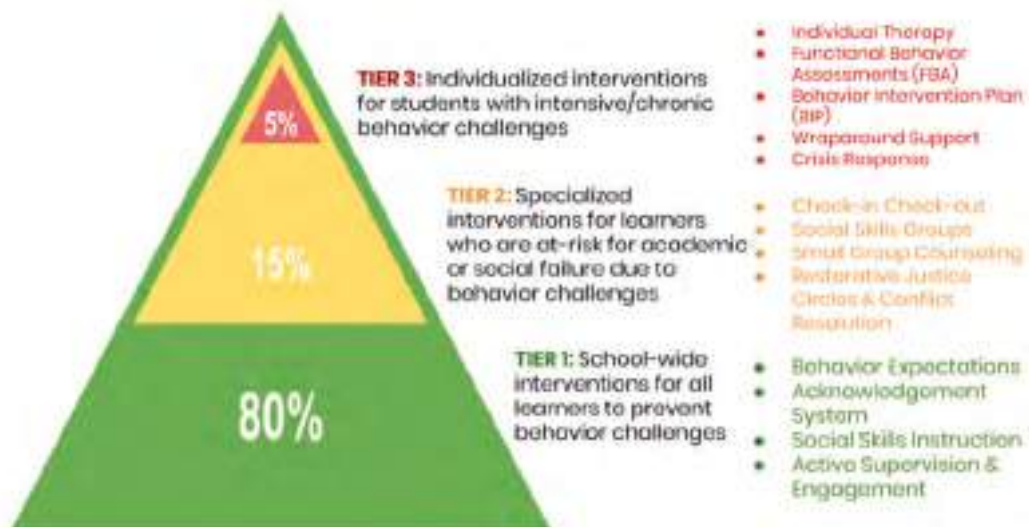
A well-known example of a tiered systems under the MTSS umbrella is positive behavioral interventions and supports (PBIS).¹¹⁸ Figure 88 illustrates the basic framework of PBIS. Figure 89 shows a more in-depth example of what types of services, interventions, and supports may be encompassed within each tier.

Figure 88. Hierarchical Model of Positive Behavioral Interventions & Supports



Source: U. S. Department of Education & Office of Special Education Programs' Technical Assistance Center on Positive Behavioral Interventions and Supports. (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

Figure 89. PBIS example



Source: Monterey Peninsula Unified School District. (2020). *MTSS and PBIS*. Retrieved from https://www.mpusd.net/apps/pages/index.jsp?uREC_ID=1012305&type=d&pREC_ID=1322797

PBIS is an evidence-based framework that uses a three-tiered approach to teach and reinforce appropriate behaviors for all students. PBIS programs are designed to replace a punishment-oriented system with a campus culture based on respect, open communication, and individual responsibility.¹¹⁹

The program's three tiers consist of the following:

- **Tier 1:** The primary prevention tier is the largest of the three, focusing on interventions for 80 to 90 percent of students. In this tier, school staff uses 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 to 15 percent of students who have risk factors such as exposure to violence, a history of trauma, or the loss of a loved one that causes them to have a higher-than-normal risk of developing mental health needs. This tier focuses on developing skills and increasing protective factors for students and their families.
- **Tier 3:** The tertiary prevention level focuses on the 1 to 5 percent of the student population who need an in-depth system of supports. This tier is focused on providing comprehensive, individualized interventions for students with the most severe, complex or chronic issues.¹²⁰

TEA recommends that school districts utilize PBIS to address student behavior but public schools are not currently required to use PBIS or other related approaches.¹²¹ During the 85th legislative session, Texas passed three bills that were related to PBIS:

1. [HB 4056 \(Rose/Lucio\)](#) – requires the inclusion of PBIS on the state's best practice list.
2. [SB 179 \(Menendez/Minjarez\)](#)- requires that if a district does develop any practices or procedures related to PBIS, it must include them in their student handbook and district improvement plans.
3. [HB 674 \(Johnson/Garcia\)](#)– allows schools to develop positive behavior programs for students in grade levels below grade three as a disciplinary alternative.
4. Continuing to improve integration of PBIS into Texas schools, the 86th Texas Legislature passed House Bill 18 (Price/Watson), which included a number of provisions inclusive of PBIS including:
 - Allowing PBIS to be part of school staff development training;
 - Requiring schools' district improvement plans to include provisions for evidence-based practices that address PBIS and integrate best practices on trauma-informed care; and
 - Requiring schools to develop practices and procedures concerning PBIS.

Technical assistance to implement PBIS is available through the network of regional educational service centers and the Texas Behavior Support Initiative (TBSI).¹²² TBSI was designed to build capacity throughout the state for the provision of positive behavioral interventions by assisting schools in developing and implementing a wide range of behavior strategies and prevention-based interventions.¹²³

Social and Emotional Learning

According to TEA, social and emotional learning (SEL) is not a specific program, but a framework that “involves the process of understanding and applying the knowledge, attitudes and skills necessary to understand and manage emotions, set and achieve goals, feel and show empathy for others, establish and maintain positive relationships and make responsible decisions.”¹²⁴ Figure 90 illustrates the core competencies of SEL.

The main goals of the SEL framework are to:

- Help students work well and productively with others;
- Develop positive relationships;
- Cope with their emotions;
- Appropriately settle conflicts with consideration for others;
- Work more efficiently and effectively; and
- Make decisions that are safe, ethical, and responsible.¹²⁵

Figure 90. SEL Core Competencies



Source: Collaborative for Academic, Social, and Emotional Learning (CASEL).(n.d.). *What is SEL?* Retrieved from <https://casel.org/what-is-sel/>

As a result of HB 18 (86th, Price/Watson), Texas schools are required to develop practices and procedures related to SEL, defined as “building student skills related to managing emotions, establishing and maintaining positive relationships, and responsible decision-making.” Schools can choose from a variety of proven, effective SEL programs, but it is not necessary to hire additional staff to implement SEL—the primary costs of an SEL program are related to staff training and student surveys.¹²⁶ SEL programs can be implemented from preschool through high school and can improve student functioning in a number of areas. Additionally, SB 504 (86th, Seliger/Beckley) included social-emotional counseling tools as a possible component of online postsecondary education and career counseling academies for school counselors.

Austin Independent School District (AISD) in Central Texas has committed to incorporate SEL in its schools—one of the first districts in the country to make this commitment.¹²⁷ AISD began implementing SEL in 2013, and by the 2015-16 school year, all 129 AISD campuses were implementing the SEL program. In 2017, AISD began an SEL 2.0 initiative to deepen their SEL work within Austin ISD and the community over the next three to five years.¹²⁸ A number of other schools districts across Texas have begun SEL initiatives including Dallas, El Paso, Houston, Round Rock, Keller, Friso, Arlington, and Northwest.

National research on the effectiveness of SEL has found:

- Improved academic performance (13 percent increase in achievement scores after SEL)
- Greater motivation to learn and increased time studying at home
- Reduced negative classroom behaviors (e.g., less noncompliance, aggression, and disruption)
- Fewer disciplinary referrals
- Reduced bullying of students with disabilities
- Reduced reports of depression, anxiety and stress
- Decrease in school dropout rates
- For each \$1 invested into SEL, there was an \$11 return^{129,130,131}

Trauma-Informed Care

Children who have experienced trauma often see the world as a threatening place, and this can lead to anxious behaviors that interfere with the child’s ability to learn and interact socially with their peers.¹³² Creating a trauma-informed environment within schools requires that all staff understand how trauma affects an individual and incorporates that understanding of trauma into every aspect of how they educate and interact with students.¹³³ An organization that is trauma-informed understands the vulnerabilities and triggers of trauma survivors and uses this understanding to ensure that staff do not re-traumatize individuals with the organization’s approach to working with them. In a trauma-informed environment, children feel safe and accepted by their peers, even when they make mistakes.

In the 86th legislative session, trauma-informed training and integration within schools gained attention through the passing of HB 18 (Price/Watson) and Senate Bill 11 (Taylor/Bonnen). The requirements of these bills are summarized below in Table 56 and Table 57.

Table 56. House Bill 18 Provisions Addressing Trauma-Informed Care

School Personnel Training and Education	<ul style="list-style-type: none"> At least 25 percent of classroom teachers' and principals' continuing education is required to include educating diverse student populations (students in special education programs with mental health or substance use conditions, students with intellectual or developmental disabilities, and students eligible for 504 services); At least 25 percent of school counselors' continuing education is required to include counseling students on mental health and substance use conditions through grief and trauma-informed interventions, and effective implementation of a comprehensive school counseling program; and At least 25 percent of principals' continuing education is required to include effective strategies for implementing a comprehensive school counseling program and mental health programs.
Staff Development Training	<ul style="list-style-type: none"> Directs schools to include in staff development training: Suicide prevention; Recognizing signs of mental health and substance use conditions; How grief and trauma affect learning; Preventing/identifying/responding to bullying; Instructing student with disabilities who also have mental health conditions; and Strategies for positive relationships with students.
District Wide Practices	<ul style="list-style-type: none"> School district's improvement plan must include provisions for evidence-based practices that address PBIS and integrate best practices on trauma-informed care. Schools are required to develop practices and procedures concerning trauma- and grief-informed practices.

Source: The Hogg Foundation for Mental Health. (January 2020). *Policy brief: School climate legislation from the 86th legislative session*. Retrieved from https://hogg.utexas.edu/wp-content/uploads/2020/01/FINAL_86th-Lege_Policy-Brief_School-Climate.pdf

Table 57. Senate Bill 11 Provisions Addressing Trauma-Informed Care

School Personnel Training	Requires schools' Multi Operational Emergency Plans (MEOPs) to include strategies to ensure required training for suicide prevention, and grief and trauma-informed professional development for appropriate school personnel
Trauma-Informed Policy	<p>Each school district is required to have a policy requiring the integration of trauma informed practices into each school environment and must be included in the district improvement plan. The policy must address:</p> <ul style="list-style-type: none"> Available counseling options for students affected by trauma and grief; Using resources developed by TEA, methods for increasing staff and parent awareness of trauma-informed care; and Implementation of trauma-informed practices by district and campus staff with: <ul style="list-style-type: none"> Training on methods and implementation being provided through a best practice program (Health and Safety Code 161.325), part of new employee orientation, offered to existing staff at intervals required by agency rule, and a record of training participants being maintained.

Source: The Hogg Foundation for Mental Health. (January 2020). *Policy brief: School climate legislation from the 86th legislative session*. Retrieved from https://hogg.utexas.edu/wp-content/uploads/2020/01/FINAL_86th-Lege_Policy-Brief_School-Climate.pdf

Mental health treatment practices (including trauma-informed care) and school-based mental health practices have yet to catch up with the reality that people with IDD can also live with serious mental health conditions including post-traumatic

stress disorder (PTSD). Individuals with IDD have a greater opportunity for experiencing traumatic events than the general population. Yet behaviors associated with any resulting mental health challenges, such as PTSD, can manifest differently than in the general population and often go unrecognized.¹³⁴ It is important that we continue to improve the accuracy of assessment tools and the effectiveness of a variety of therapies and treatments for individuals with IDD, keeping recovery at the forefront.

Too many IDD systems of care (including schools) continue to focus on controlling and managing challenging behaviors without adequate consideration of the potential for underlying mental health conditions or the impact of trauma as the cause of the behaviors. The focus of school interventions and treatment has historically been to develop 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 condition, making recovery unlikely and doing little to reduce or remove barriers to learning. To better educate school personnel on mental health concerns for students with disabilities, HB 18 (Price/Watson) allows for staff development to be inclusive of identifying and supporting students with both disabilities and a mental health condition. HB 19 (Price/Watson) requires a non-physician mental health professional employed by the LMHA to be located in the regional ESCs. The mental health professional will be responsible for facilitating optional training on a monthly basis, on the effects of grief and trauma for children with intellectual or developmental disabilities.

The Hogg Foundation for Mental Health at The University of Texas partnered with the National Child Traumatic Stress Network to develop a training curriculum and toolkit, *Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma*. The toolkit was developed over two years with contributions from national mental health experts and IDD experts. The toolkit is designed to be a two-day train-the-trainer resource and is available free of charge at <http://nctsn.org/products/children-intellectual-and-developmental-disabilities-who-have-experienced-trauma>. The toolkit includes six modules:

1. Setting the stage
2. Development, IDD, and Trauma
3. Traumatic Stress Responses in Children with IDD
4. Child and Family Well-being and Resilience
5. IDD Trauma-informed Services and Treatment
6. Provider Self-Care

The toolkit includes a facilitator's guide, videos, participant manual, case vignettes, board game/activities, slide kit, and supplemental materials. This training would be beneficial to anyone working with or supporting children with IDD. To access the toolkit requires creating an account on the website, however, the toolkit is free to anyone with an account.

Handle With Care

In 2013, Mary C. Snow West Side Elementary School in Charleston, WV piloted a program, "Handle With Care" that addressed supporting students in schools

who have been present to a potentially traumatic experience at home or in the community. Handle With Care is a partnership between law enforcement and schools. The law enforcement officer at the scene of a crime/violence/abuse, identify if children are at the scene. At a minimum, the child's name and school is sent confidentially by the officer to the child's school before the next day with no more information given except for the three words "handle with care." Figure 91 outlines the Handle With Care process.

"Handle With Care" is trauma-sensitive and identifies interventions that may help mitigate the negative effects of trauma on children. The program allows teachers and schools to be aware if a student has experienced trauma at home or in the community. This supports the child and the school if there are negative behaviors, so that more appropriate support, interventions, or mental health services may be offered rather than punitive punishment.¹³⁵

As of August 2019, over 65 cities across the US had implemented a Handle With Care program at their school districts.¹³⁶ In January 2019, three ISDs piloted the program with San Antonio Police Department (SAPD): San Antonio ISD, East Central ISD, and Northeast ISD. During the pilot program from January 2019 to August 2019, there were approximately 80 notifications sent out from the East Patrol service area. After the success of the program, the three districts permanently implemented the program district-wide, and additional districts joined as well.

All SAPD service areas were given the training and ability to make notifications from their in-car laptops. Through the Region 20 ESC, an invitation for area schools and law enforcement agencies to be a part of the program was extended. As of April 2020, the collaboration across San Antonio encompassed all Bexar County public schools, as well as some private and charter schools, four police departments, and the San Antonio Fire Department.¹³⁷ From September 2019 to March 2020, approximately 338 notifications were sent out citywide.¹³⁸

To continue the work during the closing of schools due to COVID-19, Handle With Care was able to continue due to schools' innovative initiatives. For example, San Antonio ISD created a dashboard of virtual contacts with students, inclusive of Handle With Care notifications.¹³⁹

Figure 91. Handle With Care Process



Source: Handle With Care Maryland. (n.d.) *Handle with care: Process flow chart*. Retrieved from <https://handlewithcaremd.org/docs/Handle%20With%20Care%20Flow%20Chart.pdf>

Restorative Justice Framework

Restorative justice is a prevention-oriented framework that views misbehavior as more than an infraction of the school's rule by holding the student accountable in a safe, non-court setting, leading to better outcomes for students, victims, schools, and communities.¹⁴⁰ In the school setting, restorative justice involves not only the misbehaving student but the person harmed and the community around them. Including the community in the process fosters a feeling of responsibility for the student, thereby strengthening and uniting a community around their young people.¹⁴¹ A restorative justice framework can be applied to the entire school setting by focusing on the impact of student misbehavior on others, and how that student and their school community can recover from the incident in a healthy way.¹⁴² Institute for Restorative Justice and Restorative Dialog (IRJRD) describes Restorative Discipline as "a relational approach to fostering school climate and addressing student behavior that prioritizes belonging over exclusion, social engagement over control, and meaningful accountability over punishment."¹⁴³

According to a Texas Criminal Justice Coalition report, "from the requirement of taking responsibility for the wrongdoing, to making a sincere apology, to developing a plan for restitution satisfactory to the victim, to ultimately following through on

that plan, professionals and students agree: far more accountability is required of a student making amends through a restorative justice model than one who is sent home via suspension or expulsion.”¹⁴⁴

Restorative justice can be implemented by using methods such as group conferencing, healing circles, check-ins, and mediated victim offender dialogue (VOD). Restorative justice helps the student consider the consequences of their actions, and also encourages empathy by using age-appropriate, feeling-centered language.¹⁴⁵ For example, using restorative circles in the classroom allows students to talk openly and honestly about student misbehavior and the effects it has on the classroom or entire school. A restorative circle allows the students to use community values and group expectations to collectively address the problem and make an individualized plan for restitution. While the circles take place in classrooms, the framework is intended to be used by the entire school so that the overall school community is improved by allowing school culture to be improved as a whole rather than narrowly focusing on changing individual behaviors.¹⁴⁶ Similar to PBIS and SEL, the restorative justice framework offers schools a more proactive and strengths-based framework for managing behavior and promoting academic and social-emotional growth both inside and outside of the classroom.

Costs associated with implementing restorative justice can vary between schools, but one school in San Antonio implemented a restorative justice program at an annual cost of \$16,000—costs were mainly from additional staff training, consultations, and materials.¹⁴⁷ The school experienced an 84 percent decrease in off-campus suspensions after switching from a “zero tolerance” policy to a restorative justice framework. Prior to implementing restorative justice to handle conflicts, this school had one of the highest rates of discipline in its district.¹⁴⁸ In 2015, TEA began partnering with the Institute for Restorative Justice and Restorative Dialogue through the UT Austin School of Social Work to offer training for schools and district administrators across the state in restorative justice and restorative discipline. As of the fall of 2016, 1,400 administrators and 400 coordinators received training on restorative discipline practices. TEA plans to provide training for the remaining ten regional service centers.^{149,150}

SAFE AND SUPPORTIVE SCHOOL PROGRAM AND TEAM

Following the 86th legislative session, Governor Abbott signed Senate Bill 11 directing each school district to establish a safe and supportive school program (SSSP) and team among many other provisions. An SSSP encompasses six student support components seen in Figure 92. According to the Texas State School Safety Center, “a focus on prevention and intervention strategies is critical to developing an effective, comprehensive approach to promoting safe schools. Research suggests the process of threat assessment in schools as a best practice in early prevention/mitigation and intervention toward identifying, assessing, and providing interventions to students who pose a threat of targeted violence either to themselves or others.”¹⁵¹

Figure 92. Safe and Supportive School Program Components



Source: Texas Education Agency. (July 16, 2020). *TEA Presentation to Texas State School Safety Center Conference*

SSSPs are required to include research-based best practices to provide for:

- Physical and psychological safety;
- Multiphase and multihazard approach for prevention, mitigation, preparedness, response, and recovery in a crisis situation;
- A multi-tiered support system that addresses school climate, social and emotional domains, and mental health; and
- Multidisciplinary and multiagency collaboration for risk assessment and threats in schools and provide appropriate interventions, including rules for the establishment and operation of teams.

Each Texas school district board of trustees is required to establish a safe and supportive multidisciplinary school team (“team”) to serve at one or multiple campuses in their district. The number of teams formed is at the school district’s discretion as long as a team is assigned to each campus.¹⁵² The teams are required to be multidisciplinary, with team members having expertise in counseling, behavior management, mental health and substance use, classroom instruction, special education, school administration, school safety and security, emergency management, and law enforcement.

Teams are responsible for conducting threat assessments which includes assessing and reporting a student who makes threats or exhibits “harmful, threatening, or violent behaviors.” These behaviors are defined as “verbal threats, threats of self-harm, bullying, cyberbullying, fighting, the use or possession of a weapon, sexual assault, sexual harassment, dating violence, stalking, or assault that could result in need for intervention/services or discipline.” The teams are then responsible for gathering and analyzing information on students to determine their level of risk and what the appropriate intervention is.

Additionally, each team will be responsible for:

- Providing guidance to students and staff on how to recognize harmful, threatening, or violent behaviors;
- Notifying the superintendent, who is required to immediately notify the student’s parent or guardian, if a serious risk of violence to self or others is determined;

- Following the district's suicide prevention protocol if a risk of suicide is determined, and conducting a threat assessment if a threat towards others is also determined;
- Following the district's substance use and intervention protocol if use or possession of tobacco, drugs, or alcohol is determined; and
- Developing and implementing safe and supportive school programs.

The Texas School Safety Center (TxSSC), based in San Marcos, is responsible for collaborating with TEA and schools to provide training and policies. In coordination with TEA, TxSSC is responsible for developing model policies and procedures to assist schools in establishing and training behavioral threat assessment teams, as well as rules for safe and supportive school programs. The model policies for threat assessments must include, when appropriate, procedures for:

- Referring a student to a local mental health authority or health care provider for evaluation or treatment;
- Referring a student for evaluation for special education services; and
- Anonymous reporting

When implemented with fidelity, trained professionals identify students who may exhibit concerning behaviors, and may be in need of support or services during a threat assessment. An assessment team determines what may be causing the students' concerning behaviors. The team then develops a plan—tutoring, counseling, mentoring, or other interventions—to address the root causes. Some academic research shows that when effectively applied, threat assessments can reduce bullying and suspensions, while contributing to a general sense of safety and well-being among students.¹⁵³

However, without proper training, education, or oversight, other states across the country have implemented conducting threat assessments with concerning results for students with disabilities and for students of color. According to federal data, schools with higher proportions of students of color were more likely to report using threat assessments.¹⁵⁴ In one New Mexico school district, 56 percent of their threat assessments were conducted on students in special education. These students made up just 18 percent of the total student population. The same school district saw 80 percent of their assessments conducted on black students who made up only 2.6 percent of the total student population.¹⁵⁵

EXCLUSIONARY DISCIPLINE IN SCHOOLS

Exclusionary discipline in schools refers to practices that remove students from the classroom. Despite the lack of evidence that exclusionary discipline is an effective method of changing students' behaviors in schools, it is often used. One in ten Texas students were suspended, expelled, or placed in an alternative education program during the 2018-2019 school year.¹⁵⁶

Furthermore, there is a disparity in removal practices due to violations of their schools' local codes of conduct; ninety-one percent of reported reasons for exclusionary discipline actions were due to a code of conduct violation.¹⁵⁷ Under

state law, there are incidents that require schools to remove or expel students, but schools also have discretionary authority for removal of students. In those instances, no other data is currently collected to show why students are being disciplined or what is needed to support teachers in the classroom. Classroom removals consist of removals to in-school suspension (ISS), out-of-school suspension (OSS), JJAEP, and DAEP.

Table 58 illustrates the classroom removals for the 2018-2019 school year, showing the number of removals due to a violation of schools' local codes of conduct in comparison to the next four most common reported reasons:

Table 58. 2018-2019 Top 5 Reasons for Classroom Removals

Reason for Removal	Number of Incidents	Percentage of All Reported Removals
21-VIOLATED LOCAL CODE OF CONDUCT	1,223,666	91%
41-FIGHTING/MUTUAL COMBAT	49,120	3.6%
04-CONTROLLED SUBSTANCE/DRUGS	25,483	1.8%
33-TOBACCO	19,806	1.4%
28-ASSAULT-NONDISTRICT EMPLOYEE	6,303	0.4%

Source: Texas Education Agency. (2019, September 19). State Level Annual Discipline Summary: PEIMS Discipline Data for 2018-2019. Retrieved December 10, 2019, from https://rptsvr1.tea.texas.gov/cgi/sas/broker?service=marykay&program=adhoc.download_static_summary.sas&district=&agg_level=STATE&referrer=Download_State_Summaries.html&test_flag=&debug=0&school_yr=19&report_type=html&Download_State_Summary=Next

EFFECTS OF REMOVALS

Removal from the classroom excludes students from common, daily experiences that are conducive to normal childhood and student development. Research shows that exclusionary discipline increases the likelihood of lowered academic performance, dropping out, antisocial behavior, and future contact with the justice system.^{158,159} Data shows that the impact of 9th grade suspensions is significantly related to high school and post-secondary outcomes. Additionally, each subsequent suspension decreases a student's odds of graduating high school by 20 percent, and their odds of enrolling in post-secondary schooling by 12 percent.¹⁶⁰

Further, exclusionary discipline at a young age has harmful, long-term effects academically, emotionally, and socially. Early expulsion or suspension predicts expulsion or suspension in later school grades. Young children who are expelled or suspended are as much as 10 times more likely to drop out of high school, experience academic failure and grade retention, hold negative school attitudes, and face incarceration than those who are not.¹⁶¹

HB 674 (85th Johnson/Garcia) changed the law to prohibit OSS to students below grade 3. However, students of all ages can still be given ISS and children over the age of six can still be placed in DAEPs. To better support students who may be in need of additional supports, or have experienced more adverse experiences, the Texas legislature passed House Bill 811 (White/West) during the 86th session. The bill requires schools to consider students' status in the conservatorship of DFPS or who are homeless before suspension, removal to DAEP, expulsion, or placement in JJAEP.¹⁶²

DISPARITIES

Students of color and those with disabilities experience more disproportionate rates of removals from their classrooms than white students and those without disabilities illustrated in Table 59. Youth in foster care are another group removed more often than their peers. From 2017-2018, children in foster care from pre-kindergarten to second grade in Texas were three times more likely than their peers to be suspended.¹⁶³

Table 59. 2018-2019 Demographics of Texas Discipline Responses

	Special Education	African American	Hispanic/ Latinx	White
% of Total Student Population ¹⁶⁴	9.8 %	12.6 %	52.6 %	27.4 %
% of In-School Suspensions	17.1%	25.6 %	48.9 %	21.4 %
% of Out-of-School Suspensions	20.7%	32.4 %	50.2 %	14.0 %
% of JJAEP Expulsions	16.9 %	19.5 %	57.5 %	18.6 %
% of DAEP Removals	17.6 %	22.8 %	53.3 %	20.4 %

Source: Texas Education Agency. (2019, September 19). *State level annual discipline summary: PEIMS discipline data for 2018-2019*. Retrieved December 10, 2019, from https://rptsvr1.tea.texas.gov/cgi/sas/broker?service=marykay&program=adhoc.download_static_summary.sas&district=&agg_level=STATE&referrer=Download_State_Summaries.html&test_flag=&debug=0&school_yr=19&report_type=html&Download_State_Summary=Next

Highlighted by COVID-19, the health disparities and inequities for people of color is glaring. These disparities and inequities have long been identified in schools. Research shows that while students of color do not “misbehave” more frequently or more seriously, they are disproportionately disciplined and arrested at school.¹⁶⁵ This may suggest that students of color with mental health concerns are most affected by these practices. In exploring ways to improve mental health and wellness in schools, addressing systemic inequalities and their impact on these children must be included.

IN-SCHOOL SUSPENSIONS AND OUT-OF-SCHOOL SUSPENSIONS

A disruptive student can be removed from the regular classroom and assigned one or more days to a separate in-school suspension classroom to complete their class assignments, or they may be required to remain off campus for a specified period of time.¹⁶⁶ According to the Texas Education Code, the principal or other appropriate school administrator may also suspend a student for engaging in conduct identified as prohibited in the school's code of conduct.¹⁶⁷ In addition to removing children from their regular classroom and normal interactions with their peers, ISS and OSS can also lead to significant cost increases for schools and families.¹⁶⁸ ISS and OSS place a strain on families who need to make transportation and/or childcare arrangements, and schools lose roughly \$45 in funding from the state for each day a child is absent.¹⁶⁹ During the 86th legislative session, Texas took steps to limit youth experiencing homelessness from being given out-of-school suspensions due to their lack of safe, stable housing. HB 692 (White/Alvarado) prohibits the out-of-school suspension of students experiencing homelessness unless the student engages in certain behaviors defined in the Education Code, including violent offenses, weapons, and drug use.¹⁷⁰

In the 2015-16 school year, Texas schools issued over 63,000 out of school suspensions for children in pre-k through 5th grade.¹⁷¹ Further, over 1,800 of these suspensions were given to pre-kindergarten students and over 24,000 of those suspensions were students in grades K-2.¹⁷² To address the removals of these young children, in 2017 the 85th Legislature passed HB 674 (Johnson/Garcia) to prohibit discretionary out-of-school suspensions for students below third grade.¹⁷³ The bill also allowed public schools to implement a positive behavior program with age-appropriate alternatives to out-of-school suspensions.¹⁷⁴ However, districts had significantly reduced out-of-school suspension of students in the earliest grades during the 2017-2018 school year, simultaneously some districts continued to issue out-of-school suspensions to these students. Additionally, the high number of in-school suspensions remained virtually unchanged during the same time frame. School districts issued a total of 62,557 in-school suspensions in pre-k through second grade, compared to 64,773 in-school suspensions issued in 2015-16.¹⁷⁵

REMOVALS TO DISCIPLINARY ALTERNATIVE EDUCATION PROGRAMS

Every school district in Texas is required to provide a Disciplinary Alternative Education Program (DAEP). Districts may operate their own DAEP or can join together to support a cooperative program. A DAEP in smaller rural districts may be a separate classroom on the school campus, but DAEPs are more frequently housed at a separate campus.¹⁷⁶ According to statute, the central academic mission of DAEPs “is to enable students to perform at grade level.”¹⁷⁷ Any DAEP that serves a student with an IEP must provide the services outlined in that plan.¹⁷⁸ The *Breaking Schools' 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.”¹⁷⁹ As result of the passage of SB 2432 (Taylor/Sanford) during the 86th legislative session, Texas added the offense of harassment as a mandatory reason for a student to be removed to a DAEP.

Certain infractions require mandatory removal to a DAEP according to the Texas Education Code:

- Committing a felony or engaging in conduct punishable as a felony
- Assaulting another student or school employee
- Selling, giving, possessing, or being under the influence of a dangerous drug or alcohol
- Committing an offense that involves volatile chemicals, public lewdness, or retaliation against a school employee
- Making a terroristic threat or a false alarm/report
- Harrassing an employee of the school district¹⁸⁰

Texas schools 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.”¹⁸¹ In the 2018-19 school year, more than half of removals to DAEPs were discretionary (52 percent).¹⁸² A study conducted by IDRA looked at results of DAEP policies in 1999 and 2009. Both studies found that four out of five students sent to DAEPs were sent for non-serious offenses, with some of those referrals for behaviors as minor as talking back to a teacher or chewing gum.¹⁸³

Students in DAEP facilities lose time in their regular instructional classroom and face an increased likelihood of negative effects including in-grade retention, school disengagement, and contact with the justice system. A comprehensive study of nearly 1 million Texas students found that 15 percent of students were assigned to a DAEP at least once between seventh and 12th grades. On average, those students lost 27 days of regular classroom instruction. Additionally, 31 percent of students who received one or more disciplinary actions (including suspensions and other expulsions) were held back a grade level at least once, compared to about 5 percent of their peers who received no action.¹⁸⁴

EXPULSIONS TO JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS

When children in Texas are expelled from school, they are sent to either Juvenile Justice Alternative Education Programs (JJAEPs) or expelled without placement into a program (i.e., “expelled to the streets”), and a small number of expelled students are sent to DAEPs. JJAEPs were created in 1995 to provide ongoing educational services for students who have been expelled. Every county in Texas with a population of more than 125,000 residents at the time of the 2000 census must have a JJAEP.¹⁸⁵ Counties that meet the 125,000 population requirement after the year 2000 are able to, but do not have to open a JJAEP.

JJAEPs are operated by juvenile boards with oversight provided by TJJD so when a student is expelled to a JJAEP, that referral is considered involvement in the juvenile justice system.¹⁸⁶ Legislative intent in creating JJAEPs was “to provide continuing educational opportunities for students expelled from school for the most serious

offenses.”¹⁸⁷ The primary goals of JJAEPs are to “reduce delinquency, increase offender accountability and rehabilitate offenders through a comprehensive, coordinated community-based juvenile probation system.”¹⁸⁸ Students younger than 10 cannot be sent to a JJAEP; instead, they are sent to DAEPs for engaging in conduct that would result in expulsion to a JJAEP for children over 10 years old.¹⁸⁹ School districts without a JJAEP may send expelled students to DAEPs or opt to expel them without placement, also known as expulsion “to the street” because students serve the length of their expulsion unsupervised and outside of a school setting. After the 2010-11 school year, JJAEPs entries dropped, largely in part due to the removal of “persistent misbehavior” as an expulsion reason from the Texas Education Code, Chapter 37.¹⁹⁰ However, the 2018-2019 school year saw the first increase since then, partly due to the increase of mandatory expulsions for drug offenses.¹⁹¹

During the 2018-19 school year, JJAEPs served 30 counties with 282 school districts in Texas.¹⁹² Texas school districts placed students into JJAEPs on 3,210 separate actions in 2018-19, an increase by 271 from the 2017-2018 school year.¹⁹³

A report from TJJD cited 482 entries into JJAEPs for students receiving special education services in 2018-19:

- 200 students had a primary diagnosis of a learning disability;
- 128 students had a primary diagnosis of serious emotional disturbance;
- 16 students had a primary diagnosis of an intellectual disability;
- 98 students had at least one “other health impairment.” This included attention deficit, with or without hyperactivity, or a medical issue that may interfere with academic progress; and
- 40 students had a primary diagnosis of “other”, which includes unknown, other, autism, developmental delay, deaf-blindness, speech/language impairment, or hearing impairment.¹⁹⁴

While discretionary removals to JJAEPs were slightly lower than mandatory removals for the general student population, students with disabilities were more likely to be removed to JJAEPs for discretionary reasons than mandatory. During the 2018-2019 school year, students in special education accounted for 11 percent of the mandatory removals to JJAEPs, compared to 20 percent of the discretionary removals.¹⁹⁵

Some school districts use JJAEPs at a higher rate than others, and the size of the school district does not necessarily correlate with the number of student expulsions. Similar to removal to DAEPs, students can be expelled to JJAEPs for mandatory or discretionary reasons. Mandatory expulsions occur when a student uses, exhibits, or possesses a weapon or engages in other serious behaviors. Discretionary expulsions vary widely from serious offenses that occur within 300 feet from the school, to assault on a school employee or serious misbehavior in a DAEP.¹⁹⁶ In 2018-19, 34 percent of expulsions to JJAEPs were discretionary while 55 percent were mandatory and 11 percent were non-expelled.¹⁹⁷

The vast majority (85 percent) of mandatory referrals to JJAEPs in 2018-19 were for felony drug or weapons offenses, while reasons for discretionary referrals were more varied, suggesting wide variation in discretionary disciplinary policies between

schools.¹⁹⁸ Discretionary expulsions for misbehavior and misdemeanor drug charges represent 64 percent of all discretionary expulsions in 2018-19, down 1 percent from 2017-2018.¹⁹⁹ The large number of student expulsions due to drug use provides opportunities for schools to provide substance use services and support, rather than costly, punitive removals from the classroom. There are no statewide standards that set minimum or maximum amounts of time for expulsions, so there is wide variation across school districts regarding how much time students spend in a JJAEP.²⁰⁰ However, TJJD publishes data that provides some understanding of how long students spend in JJAEPs at the macro level. In 2018-19, the average length of stay for all students who finished JJAEP was 77 days.²⁰¹

Cost of Operations

JJAEPs are funded differently than public schools in Texas. While public schools receive funds through county tax revenues, state general appropriation funds administered by TEA, and federal funds, JJAEPs receive funding from local school district revenues, county commissioners' courts, and state appropriations through TEA via Texas Juvenile Justice Department (TJJD). TJJD provides approximately 25 percent of the total JJAEP funding (i.e., \$86 per mandatory student attendance day); the remaining 75 percent is provided through the local juvenile boards and the local school districts.

Total expenditures for all JJAEPs during the 2018-2019 school year increased by approximately \$1.639 million compared to the 2016-2017 school year. The cost per school day (based on 180 student attendance days and 10 staff in-service days) varied greatly from \$1,376.86 to \$16,804.65. Four programs had a per school day cost over \$10,000 per school day: Fort Bend, Harris, Montgomery and Tarrant, and five counties had a per school day cost between \$5,001 and \$10,000 per school day: Bexar, Collin, Dallas, Denton and Williamson. Sixteen of the counties however had a per school day cost of less than \$5,000. The cost of JJAEPs vary based on an array of factors including: program size, program design, facilities, attendance, and services provided.²⁰²

Many experts agree that there is a school-to-prison pipeline for a majority of the students who are removed from the classroom using exclusionary discipline practices.^{203,204} Child advocates and school districts in Texas are increasingly utilizing methods of disciplining children without suspending or expelling them to programs like JJAEPs, but it is still important to understand the short and long-term effects experienced by children coming out of JJAEPs. Although the goal of JJAEPs is to rehabilitate and integrate students back into a mainstream school environment, alternative education programs have been linked to increased levels of delinquency and adversity.²⁰⁵ For example, students who have been sent to ISS, OSS, or a DAEP are more likely to be expelled and sent to a JJAEP than those who are not referred to one of these exclusionary discipline settings.²⁰⁶ Furthermore, students sent to a DAEP or a JJAEP are more likely to drop out of school and enter the adult criminal justice system.²⁰⁷ One study conducted by Texas Appleseed concluded that “placing students in JJAEPs for ‘serious or persistent misbehavior’ not only fails to correct behaviors, but leads to increased risk for future involvement in the juvenile justice system.”²⁰⁸ Research shows that compared to non-disciplined students, 23 percent of students who received school disciplinary actions had future contact with juvenile justice

system.²⁰⁹ While these correlations do not imply a direct causation of exclusionary discipline resulting in future incarceration, these findings call into question the effectiveness of ISS, OSS, DAEPs, and JJAEPs in successfully rehabilitating students on a long-term basis and integrating them back into a mainstream educational setting.

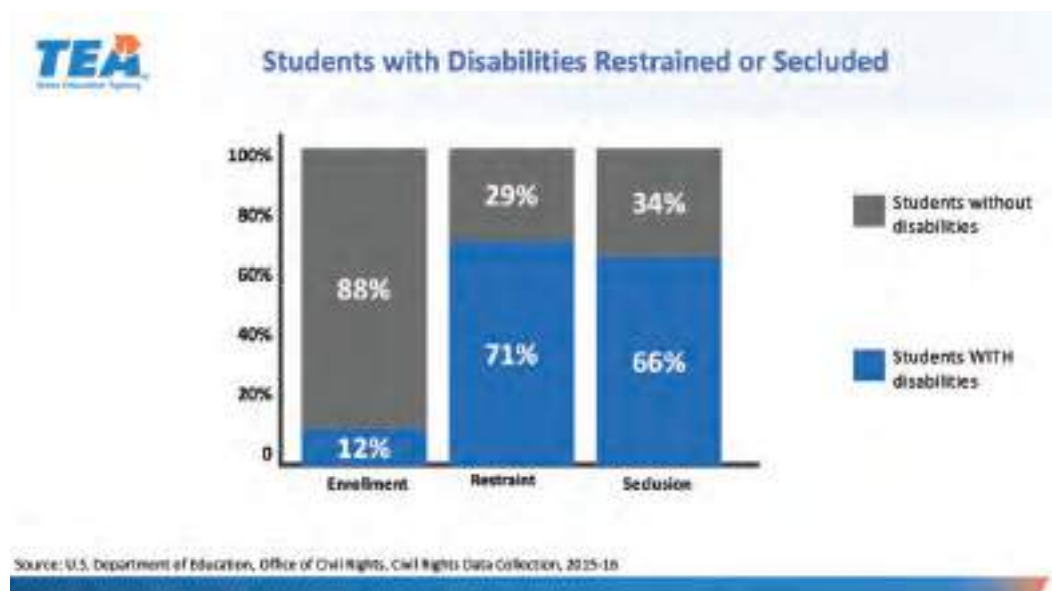
CORPORAL PUNISHMENT, RESTRAINTS, AND SECLUSION IN SCHOOLS

In Texas, each school district is allowed to determine whether corporal punishment is permitted on their campus. After Mississippi, Texas ranks second highest in paddlings across the country.²¹⁰ Educators may use corporal punishment when the board of trustees has adopted a policy allowing its use, unless the student's parent, guardian, or other person having lawful control over the student, opts out of the practice and provides a written, signed statement prohibiting the use of it.²¹¹ Nationwide and in Texas, students with disabilities and Black students are disproportionately the targets of corporal punishment.²¹² Corporal punishment can cause serious injury, psychological harm, trauma, and academic disengagement; it is not an evidence-based practice and has been banned by the majority of states (31) in the U.S. and in many school districts.²¹³

Child advocates have a serious concern with the ongoing use of restraints and seclusion as a form of discipline in schools. The Office of Civil Rights within the U.S. Department of Education has conducted a survey since 1968 that “collects data on leading civil rights indicators related to access and barriers to educational opportunity at the early childhood through grade 12 levels,” known as The Civil Rights Data Collection (CRDC). Every two years, schools are required to submit various information for the collection. The CRDC collects data from public LEAs and schools, including juvenile justice facilities, charter schools, alternative schools, and schools serving only students with disabilities.²¹⁴ The U.S. Department of Education began requiring data on the use of restraints and seclusions in the 2009-10 school year.²¹⁵

According to the most recent data collected from the 2015-2016 school year, Table 60 illustrates the number of restraints and seclusions used on students with and without disabilities. While only making up 12 percent of the total student population, students with disabilities were disproportionately subjected to restraints and seclusions.

Table 60. 2015-2016 Restraints and Seclusions reported by Texas Schools



Source: Texas Education Agency. (2020). *Behavior: Section 504 & The Americans with Disabilities Act*. Retrieved from https://tea.texas.gov/sites/default/files/Behavior%20-%20504%20webinar_accessible.pdf

During the 86th legislative session, Texas passed HB 3630 (Meyer/Lucio) in order to ensure schools were not using “aversive techniques,” defined as a technique or intervention that is intended to reduce the likelihood of a behavior reoccurring by intentionally inflicting on a student significant physical or emotional discomfort or pain. Additionally, the 86th Texas Legislature passed SB 1707 (Lucio/Allen) in order to better support schools who employ school resource officers (SROs) by clarifying that school police officers should not be involved in the routine discipline of young people on their school campuses. Under this law, school districts write out the roles and responsibilities of SROs, to be placed in student codes of conduct, district improvement plans, and the memorandum of understanding between the school district and the local law enforcement agency.²¹⁶

TEA requires each school to have a team of school staff trained in restraints appropriate for youth, with certain school staff positions required to be a part of the team. The participation of SROs is not mandated in current law. Historically, SROs who are working to protect public school environments have not had training in trauma-informed care, age-appropriate discipline for youth with cognitive or emotional disabilities, appropriate techniques for de-escalation specific to child-centered settings, or restraint training.²¹⁷ However, during the 84th legislative session, HB 2684 (Giddings/Whitmire) improved mandated training for SROs to include de-escalation techniques, positive behavioral interventions, and the behavioral health needs of children with disabilities and mental health needs if they served in a district with more than 30,000 students.²¹⁸ During the 86th legislative session, SB 11 (Taylor/Bonnen) eradicated the student population limit and required all SROs to complete specialty training (regardless of district size). In addition, current SROs who were previously exempt were given a timeline to complete the necessary training.

There are districts implementing less aversive ways to address student discipline needs. One example is crisis intervention teams for children and youth designed to divert individuals with mental health needs to appropriate behavioral health services and supports instead of referral to the juvenile justice system.²¹⁹ Building community partnerships to support youth's ability to access services and supports is the foundation of a successful CIT program.²²⁰ As an example, Bexar County created the Children's Crisis Intervention Training for use in schools in the Greater San Antonio area. The 40-hour training is approved by the Texas Commission on Law Enforcement Officer Standards and provides CEUs for SROs who have not previously received any CIT training.²²¹ Bexar County's CCIT includes education on:

- Officer tactics and safety in school campus environments
- Active listening and de-escalation techniques
- Mental illness, learning and developmental disabilities, 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
- Role-play scenarios that allow officers to gain practical experience in active listening and de-escalation techniques specific to students experiencing a crisis²²²

EFFORTS TO REDUCE BULLYING

Texas legislators and a wide range of advocacy organizations acknowledge and prioritize action to mitigate the negative impact of bullying in schools and through the Internet. In one study of 250 middle school students, 90 percent of the students who were bullied experienced negative side effects as a result of the bullying.²²³ Examples of these side effects include anxiety, low grades, and social rejection.²²⁴ 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://tea.texas.gov/Texas_Schools/Safe_and_Healthy_Schools/Coordinated_School_Health/Coordinated_School_Health_-_Bullying_and_Cyber-bullying/.

Research indicates that bullies and victims share many of the same risk factors and could benefit from interventions to improve their problem-solving skills, social interactions and interpersonal communication.²²⁵ Interventions to address bullying show moderate success; the most effective are intensive programs that avoid peer-based approaches and include parent meetings, firm discipline, and better playground supervision.²²⁶ Schoolwide efforts like PBIS and SEL also have the potential to reduce bullying by creating an environment of open communication and respect across the school campus.

In the 85th Legislative Session, SB 179 (Menendez/Minjarez), known as David's Law, was passed in an effort to address cyberbullying in public schools. The bill defines bullying and cyberbullying, requires school boards to establish procedures for reporting on bullying, and enables districts to develop policies to help prevent and mediate bullying. Building on this momentum, SB 11 (86th, Taylor/Bonnen)

required the State Board of Education to develop rules requiring school districts to incorporate instruction on digital citizenship and legal consequences of cyberbullying. Additionally, bullying and cyberbullying were codified as possible behaviors to initiate engagement with the threat assessment team. Further, HB 18 (86th, Price/Watson) required staff development training in schools to include preventing, identifying, and responding to bullying.

COMMUNITIES IN SCHOOLS AND DROPOUT PREVENTION

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.²²⁷ In the 2018-19 school year, CIS provided case management services for 88,644 students through 28 local CIS programs operating in 139 school districts on 967 campuses across Texas.²²⁸ Of the students receiving CIS case management services in grades 7 through 12, 99 percent stayed in school during the 2018-19 school year, and 96 percent of CIS participants were promoted to the next grade.²²⁹ These students also saw improved academics, graduation rates, attendance, and behavior.²³⁰

State funding cuts to the CIS program in 2013 significantly impacted service delivery, but the roughly \$5 million that was cut from the CIS budget has largely been restored in the years since, increasing annual state appropriations for CIS to an estimated \$15,521,815 from 2014 until 2019.²³¹ During the 86th legislative session, the Legislature recognized the value of these supports and funded an increase of \$15 million, appropriating \$65,538,664 in general revenue for the 2020-21 biennium.²³² In the 2018-2019 school year, these 28 programs case managed 88,644 students on 967 campuses in 139 school districts.²³³ TEA is requesting to continue this funding into the 2022-23 biennium, and estimates the additional funding will help them serve over 115,000 students a year.²³⁴ Additionally, CIS receives approximately \$4,842,342 in TANF federal funding.²³⁵

To learn more about CIS services in Texas and see a list of all CIS providers in the state, visit <https://tea.texas.gov/texas-schools/support-for-at-risk-schools-and-students/communities-in-schools>.

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Policy Concerns

- Assess the impact of COVID-19 on TDCJ operations and protect people in TDCJ care from exposure to COVID-19.
- Divert people with mental illness who commit low-level offenses away from correctional facilities and into community-based treatment settings. Improve the state courts' use of civil commitment as a diversionary tool to reinforce civil intervention before an individual ever enters the criminal justice system.¹
- Improve mental health screening, safety, and suicide prevention procedures in correctional settings.
- Decrease the use of prolonged solitary confinement, repeated restraints, and other aversive interventions on persons incarcerated with mental illness.
- Increase early identification of persons with co-occurring mental illness and substance use disorder, and connect them with needed community-based services.
- Increase early identification of people who may have an intellectual and/or developmental disability (IDD).
- Increase external oversight within prisons, jails, and other incarceration settings to ensure that people with mental health conditions experience constitutional and humane conditions, without solitary confinement.
- Improve access to mental health treatment including therapy and psychiatric medications within correctional facilities, especially in rural jail facilities.
- Implement civil commitment as an option to divert individuals with a mental illness or intellectual disability even after an individual enters the criminal justice system.
- Expand access to specialty courts, like mental health courts, drug courts, and veterans' courts, to divert people with mental health concerns and substance use issues away from correctional settings.
- Improve mental health and substance use awareness and decrease stigma through cross-system collaborations of law enforcement agencies, local jail facilities, courts, attorneys, and local mental health authorities (LMHA) in rural areas.
- Improve the mandates of the Sandra Bland Act by implementing telehealth and telemedicine mental health services inside of jail and prison facilities for people with lesser acute mental illnesses.
- Improve continuity of care for people with mental illness as they transition from incarceration settings to communities, including case management, therapy, medications, outpatient treatment plans, and reentry peer support services.

Fast Facts

- Language matters. The use of thoughtful, humanizing, and destigmatizing language helps to restore the identity and dignity of a person recovering from mental illness who has been incarcerated. The person returning to the community is a human being who also happened to have a mental illness and was involved with the justice system. Thus, we discourage using “prisoner,” “felon,” or “offender” as these terms wrongly emphasize the symptom (incarceration) over the condition (mental illness). We recommend using respectful language such as “justice-involved,” “consumer” (instead of patient), or “person in jail” which are consistent with treatment and a person’s capacity to change.²
- A study conducted from February 2011 to May 2012 found that 1 out of every 7 people in state and federal prisons (14 percent) and 1 out of every 4 people in jails (26 percent) reported having a serious mental illness. Additionally, 37 percent of prisoners and 44 percent of jail inmates had previously been told they had a mental health condition.³
- Texas incarcerates 563 people per 100,000 residents.⁴ In 2020, it is projected that the justice-involved population will be 145,553 in adult incarceration and 1,209 in juvenile secure facilities, with another 334,525 people on parole or probation.⁵
- Texas has the 7th highest imprisonment rate in the U.S. and African Americans in the state are four times more likely than Whites to be justice-involved.⁶
- In FY 2017, the average cost of incarcerating an individual in a state facility was \$62.25 per day. By comparison, the cost for an individual on parole supervision was \$4.30 per day and cost for community supervision was \$3.72 per day.⁷
- TDCJ unit and psychiatric care expenses represent the majority healthcare costs at \$194.5 million, representing 52.8 percent of its total expenses. Other healthcare costs, including hospital care, accounted for \$138.9 million or 37.7 percent. Pharmacy services were at \$35.3 million or 9.6 percent of the total expenses.⁸
- In January 2020, Texas county jails had a total bed capacity of 93,704, with 65,825 individuals in their facilities. Of that number, 65.6 percent of the individuals in Texas county jails had not been convicted of a crime.⁹
- In 2018, researchers estimated that people are booked into jails over 10.6 million times in the U.S. every year, and about 615,000 people are in a jail facility on any given day.¹⁰ If those statistics hold true for Texas, then over one million people pass through Texas jails each year.
- In 2018, 44 percent of the 2,286 written grievances submitted by people in county jails to the Texas Commission on Jail Standards involved complaints regarding medical services, including mental health services.¹¹
- In the 85th legislature, the Texas House of Representatives passed legislation that opened the door for peer support specialists to be trained, certified, and appropriately compensated through Medicaid reimbursements. Peer support services and providers assist individuals experiencing mental health or substance use disorders by helping the individuals focus on recovery, wellness, self-direction, responsibility, and independent living.¹²

TDCJ and Local Jail Acronyms

ACLU – American Civil Liberties Union

MHJDP – Mental health jail diversion pilot

BAMBI – Baby and Mother Bonding Initiative

MHPD – Mental health public defender

CCQ – Continuity of care query

MRIS – Medical Recommended Intensive Supervision

CIT – Crisis intervention team

OCR – Outpatient competency restoration

CJD – Criminal Justice Division

OMHM&L – Office of Mental Health Monitoring and Liaison

CMBHS – Clinical management for behavioral health services

PAMIO – Program for Aggressive Mentally-Ill Offender

CTI – Critical time intervention

PREA – Prison Rape Elimination Act

CMHCC – Correctional Managed Health Care Committee

PRSAP – Pre-Release Substance Abuse Program

CMI – Chronically Mentally Ill Program

PRTC – Pre-Release Therapeutic Community

DDP – Developmental Disabilities Program

SAFPF – Substance Abuse Felony Punishment Facility

DWI – Driving while intoxicated

SAMHSA – Substance Abuse and Mental Health Services Administration

FACT – Forensic assertive community treatment

TCJS – Texas Commission on Jail Standards

HHSC – Health and Human Services Commission

TCOLE – Texas Commission on Law Enforcement

IDD – Intellectual and other developmental disabilities

TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments

IPTC – In-Prison Therapeutic Community

TDCJ – Texas Department of Criminal Justice

JCHM – Judicial Commission on Mental Health

TDHCA – Texas Department of Housing and Community Affairs

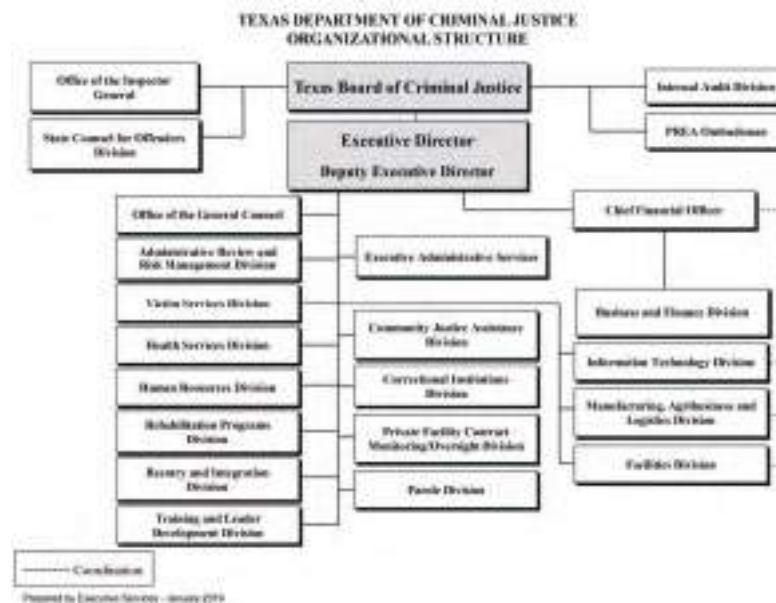
LBB – Legislative Budget Board

TTUHSC – Texas Tech University Health Science Center

LMHA – Local mental health authority

SBHCC – Statewide Behavioral Health Coordinating Council

TDCJ Organization Chart



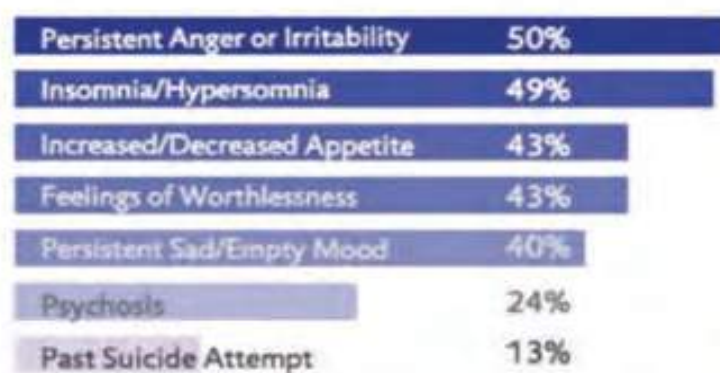
Source: Texas Department of Criminal Justice. Organizational Structure. Retrieved October, 2020 from https://www.tdcj.texas.gov/org_chart/pdfs/org_chart_tdcj.pdf

Overview

TDCJ RESPONSIBILITIES AND MISSION

Many people involved in the Texas criminal justice system live with one or more mental health condition, and many have co-occurring substance use disorders. Additionally, those with intellectual and developmental disabilities (IDD) represent 4 to 10 percent of the prison population, including a greater number in juvenile facilities and jails.¹³ The strong connection between mental health and the criminal justice system has not always existed. In the 1970s, only 5 percent of incarcerated persons in the U.S. had a serious mental illness, such as schizophrenia or bipolar disorder.¹⁴ Due to lack of funding in community-based treatment and support infrastructure, decades later we see the result those financial decisions. Recent studies estimate that 14 percent of people in prisons and 26 percent of people in jails experienced serious psychological distress in the preceding 30 days (in contrast to 5 percent of the general population).¹⁵ In 2015, about 30 percent of people in local Texas jails had at least one serious mental illness.¹⁶ The percentage of justice-involved individuals with less severe mental health issues, such as mild depression, is even greater; researchers estimate that over half of people incarcerated in U.S. prisons and jails have at least one mental health condition.¹⁷ The criminal justice system was not historically structured to provide mental health treatment and recovery services, but rather focused on punitive measures that can harm a person's path to recovery. The figure below demonstrates that a large proportion of individuals in jails across the country self-report at least one mental health symptom.

Figure 93. Self-Reporting of Mental Health Symptoms in Jails



Source: As used in Hautala, M. (2015). *In the Shadow of Sandra Bland: The Importance of Mental Health Screening in U.S. Jails*. *Texas Journal on Civil Rights & Civil Liberties*, 21(1), 98. Data derived from Bureau of Justice Statistics. (2006). [Mental Health Problems of Prison and Jail Inmates](#).

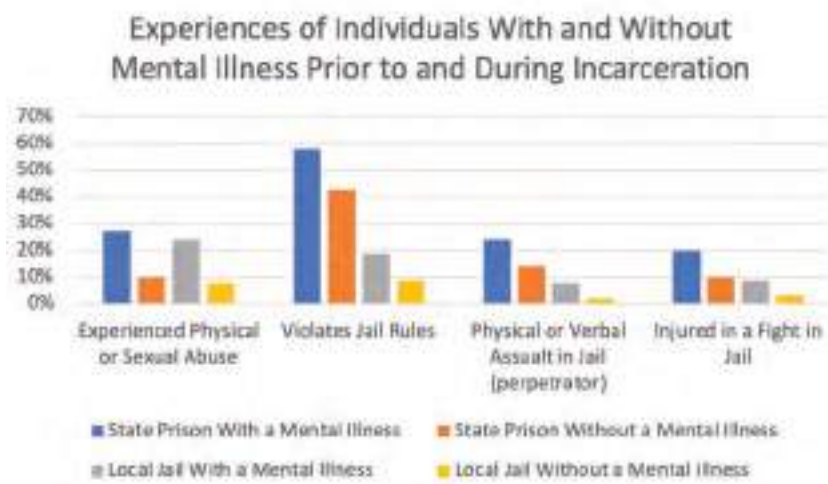
Despite the overrepresentation of people with mental illness in U.S. prisons and jails, research suggests that only 7 percent of these individuals enter the criminal justice system because of behavior linked directly to their mental illness.¹⁸ Instead, a justice-involved person with a mental illness's alleged criminal behaviors are often

tied to behavioral factors (such as hostility, disinhibition, or emotional reactivity) or to social factors (such as poverty and homelessness).^{19,20}

The extent to which serious mental illness is connected to dangerous behavior remains unclear. In some cases, it seems that mental illness may be linked to violent behavior, but research shows that this link is weak. In fact, people with mental illness only commit an estimated 4 percent of violence in the U.S.²¹ Contrary to the public fear created by highly publicized mass shootings and the predictable political discussions blaming gun violence on mental illness that often follow, people with serious mental illness commit a small proportion of homicides in which a gun is used.²² The vast majority of people with a diagnosable serious mental illness never engage in any violent activities.²³ Statistical evidence shows that, in the absence of a substance use disorder, most mental illnesses are unrelated to acts of violence.²⁴ Unfortunately, the science of risk assessment has not advanced sufficiently to allow researchers to identify which individuals will commit violent acts. Thus, despite publicity and public perception, studies show that the large majority of people with serious mental illnesses are never violent.²⁵ Misinformation about mental illness and violence has led to further stigmatization of people living with serious mental illness.

Prior to their imprisonment, justice-involved persons with mental illness are more likely than incarcerated persons without mental illness to have used drugs, experienced homelessness, or survived abuse.²⁶ Once incarcerated, they often face challenges that exacerbate their mental health conditions. People with mental illness are more likely than other incarcerated populations to experience physical abuse, solitary confinement, and sexual victimization.²⁷ These experiences further perpetuate the cycle of untreated illness and criminal justice involvement.²⁸ The figure below demonstrates some of the challenges that people with mental illness disproportionately face prior to and during their incarceration. In addition to individual mental health impacts, the growing number of people with serious mental illness in the justice system raises important challenges concerning correctional facility management, unit security, and state, county, and local community budgets.

Figure 94. Experience Prior to and During Incarceration



Source: As used in Hautala, M. (2015). In the Shadow of Sandra Bland: The Importance of Mental Health

DISPROPORTIONALITY IN THE TEXAS CRIMINAL JUSTICE SYSTEM

In recent years, national attention has focused on remarkably high rates of incarceration in the U.S. – six to ten times greater than other industrialized nations.²⁹ Strikingly, the trends in incarceration rates are independent of changes in crime rates.³⁰ Much of the increase in incarceration – and much of the racial disparities of those incarcerated – are linked to behavioral health issues, particularly substance use.

The burden of imprisonment falls disproportionately on African Americans. African Americans are sentenced to state prisons at a rate 5.1 times higher than Whites. These racial disparities are not rooted in racial differences in criminality. Much of the volume and complexion of incarceration in the U.S. is linked to the “War on Drugs” and sentences related to drug possession and sales.³¹ Research identified differences in behavior concluding that White youth are more likely to engage in drug-related crime than Black youth.³²

Research has identified three root causes for these racial disparities:³³

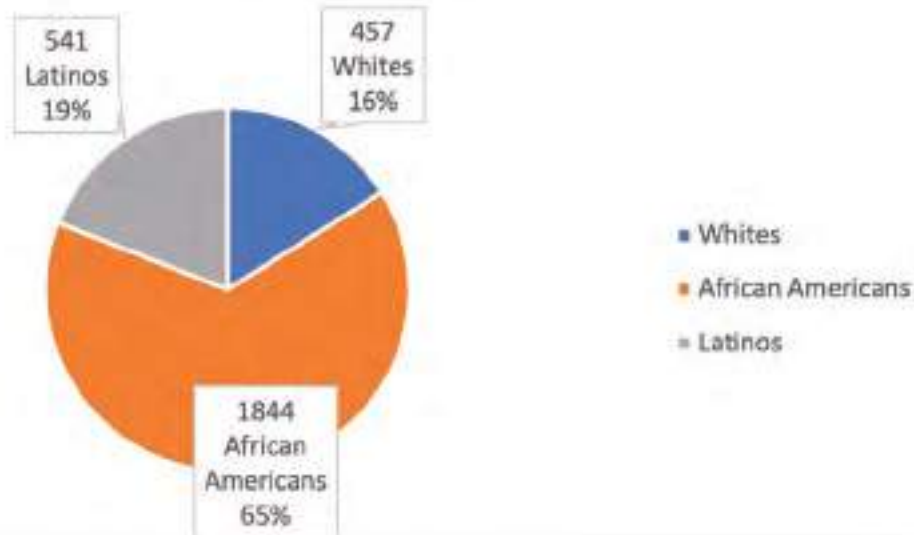
- Policies and practices (e.g., federal drug sentencing laws mandating a minimum sentence of 5 years for distribution of 5 grams of crack or 500 grams of powder cocaine)³⁴
- Implicit bias and stereotypes in decision making (e.g., disparities in court referrals to treatment versus prison)³⁵
- Structural disadvantages in communities of color, such as higher rates of poverty, housing insecurity, and exposure to trauma (what some call the social determinants of legal engagement).³⁶

Public information on racial and ethnic disparities in county jail populations in Texas is lacking. There are significant disparities between White and Black jail populations nationally, but those disparities seem to be decreasing.³⁷

In Texas, the key racial disparities are between White and Black incarceration rates. In 2016, African Americans comprised 12 percent of the Texas population, yet were incarcerated at a much higher rate than White and Latinx individuals. Texas incarcerated 457 White and 541 Latinx individuals per 100,000, while African Americans were incarcerated at a rate of 1,844 per 100,000.³⁸ The figure below depicts incarceration rates by race and ethnicity.

Figure 95. Incarceration Rate in Texas by Race

Number of People Incarcerated in Texas per 100,000 by Race



Source: Nellis, A. The sentencing Project. The Color of Justice: Racial and Ethnic Disparity in State Prisons. Page 5. <https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/> Accessed 14 Apr. 2020.

When U.S. lawmakers declared the *War on Drugs* in 1975, the criminal justice system's racial demographics shifted significantly.³⁹ Major policy decisions related to minimum sentences for drug convictions disproportionately impacted communities of color across the nation. Four decades ago, 67 percent of Texas inmates were White, 12 percent Black, and 20 percent were Latinx. Today, 1 in 20 black males are incarcerated.⁴⁰

In Harris County (Houston), stakeholders received a MacArthur Foundation Safety and Justice Challenge grant to reduce the high jail population and address significant racial disparities in the Harris County Jail. Grant strategies include implementing a pretrial risk assessment tool to increase granting personal bonds, implementing a newly designed docket system to address the large volume of drug possession cases, and hiring a Racial Disparity and Fairness Administrator to promote training, community engagement, and data-driven decision-making.⁴¹

SPECIAL CONCERNS FOR WOMEN

The U.S. incarcerates women at the highest rate in the world. Although just 4 percent of the world's female population lives in the U.S., we account for over 30 percent of the world's incarcerated women.⁴² Texas exceeds the U.S. rate by 45 percent.⁴³ The number of women in Texas prisons ballooned over 900 percent from 1980-2016 and continues to grow each year.⁴⁴ Women in correctional settings have distinct and specialized mental health needs compared to women outside of correctional

facilities. Women in jail and prison are:

- Ten times more likely to be dependent on drugs than women without experience in the justice system;⁴⁵
- Seven times more likely to experience sexual abuse prior to their imprisonment than incarcerated males;⁴⁶ and
- Four times more likely to experience physical abuse prior to their imprisonment than incarcerated males.⁴⁷

A recent survey of over 430 women in TDCJ custody reported that 55 percent of women had a mental health diagnosis, but only 27 percent had a mental health casemanager.⁴⁸ Furthermore, 70 percent of the women had a substance use disorder, but only 21 percent reported receiving substance use treatment inside TDCJ.⁴⁹

COLLABORATIONS

The death of Sandra Bland and the subsequent law changes have led to a different approach on how individuals suspected of a mental illness interact with the criminal justice system.⁵⁰ The legal community, mental health professionals, law enforcement, state agencies, courts, and nonprofit organizations meet regularly all across the state to achieve better outcomes for this population.⁵¹

In 2018, the Judicial Commission on Mental Health (JCMH) began collaborating with key stakeholders including judges, LMHAs, law enforcement, attorneys, nonprofits, and anyone working with justice-involved individuals living with a mental illness. Persons with lived experience of mental health and substance use conditions also participated.

In October 2019, the Supreme Court of Texas and Texas Court of Criminal Appeals appointed twenty-two members to the JCMH Legislative Research Committee. This committee's areas of concentration are competency restoration (including jail-based competency options), diversion, and services.⁵²

SB 362 of the 86th Legislature directed the Supreme Court of Texas to establish a task force for procedures relating to mental health in December 2019. The task force developed four areas of concentration:

- Possible technological solutions for emergency detention problems⁵³
- Standardizing common mental health forms⁵⁴
- Recommendations for the 87th Legislature⁵⁵
- Long-term policy recommendations⁵⁶

The Health and Human Services Commission (HHSC) received a SAMHSA grant for the Texas Forensic Initiatives Team (TFIT) to identify the common system stresses. Through collaborative efforts, the mental health practitioners, clinicians, legal professionals, sheriffs, nonprofits, persons with lived experience, and HHSC staff found four priority areas:

- Early identification, assessment, and treatment of those with mental health

- conditions and IDD;
- Address gaps and deficiencies in the competency to stand trial processes;
- Increase opportunities for competency evaluators, courts, attorneys, and other stakeholders to receive training in best-practice trends; and
- Expand resources for diversion from the criminal justice system.⁵⁷

Other statewide mental health and criminal justice collaborative efforts include the following:

- Justice and Mental Health Coalition, facilitated by National Alliance on Mental Illness (NAMI)-Texas
- Texas Council of Community Centers Annual Conference⁵⁸
- Texas State of Mind by the Meadows Mental Health Policy Institute
- Texas Tech Mental Health Law Symposium

Though rural, sparsely populated counties are often constrained by a lack of resources, some counties are able to send delegates to the JCMH and other statewide collaborations.

Changing Environment

Historically, Texas has been on the forefront of criminal justice reform across the U.S. In 1987, Texas created the first agency in the U.S. designed to coordinate policies between mental health and criminal justice – the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).⁵⁹ Two decades later, in 2007, the 80th Texas Legislature altered the trajectory of criminal justice policy by prioritizing diversion from incarceration over the construction of new prisons. In the 85th session, legislators passed a budget that required TDCJ to close four prisons by September 1, 2017, contributing to a total of eight facility closures. In addition to mandating the four closings, lawmakers passed significant legislation to improve jail processes and created matching grants to increase diversion and reduce recidivism. Despite the prison closures, Texas still has the 6th highest imprisonment rate in the U.S.⁶⁰

More recently, the state has allocated \$8 billion for mental health services ranging from community mental health services to substance abuse treatment, and more. Through the use of telemedicine and mental health specialty courts, individuals with mental health needs in the criminal justice system are now getting better access to treatment.⁶¹ Within mental health courts, participants are 50 percent less likely to be re-arrested compared to the regular criminal court system. The addition of telemedicine and telehealth in jails will offer access to services for those individuals while they await their day in court. Mandated as a part of the Sandra Bland Act of 2017, all 240 county lock-up facilities must be ready to provide mental health access, either in person or virtually, by Sept. 1, 2020.⁶²

MAJOR LEGISLATION FROM THE 86TH TEXAS LEGISLATURE

Legislation passed during the 86th Texas legislative session aligns with the Sequential Intercept Model (SIM). The SIM details different points in time when a person with a mental illness might encounter, and sometimes be diverted from, the criminal justice system. The 2019 Texas Legislature's focus on this model builds upon the heightened awareness of mental health conditions from the 2015 Sandra Bland death. The JCHM also prioritized the SIM to address intersection points with the criminal justice pipeline and system where diversion may be possible. Several pieces of legislation focused on different intercept points.

We have divided the legislation passed during the 86th legislative session by the intercept that it impacts. Additional information on the Sequential Intercept Model is included later in this section.

COMMUNITY SERVICES (INTERCEPT 0)

SB 633 – Regional Collaborations of Rural LMHAs

SB 633 (86th, Kolkhorst/Lambert) is an initiative to increase the capacity of local mental health authorities in under-resourced areas to provide access to mental health services. Mental health authorities in rural areas of Texas will now be grouped into regions. To assist with implementation, this bill requires HHSC to develop a plan and, in collaboration with the LMHA group, to determine a method of increasing the capacity of the authorities in the local mental health authority group to provide access to needed services using existing resources of the authorities.⁶³ HHSC made regional visits to all rural areas of the state to assist with asset mapping of each region's strengths and resources. A report is required to be published on HHSC's website by December 1, 2020.

PUBLIC HEALTH (INTERCEPT -1)

HB 2813 - Statewide Behavioral Health Coordinating Council

In the 84th Texas Legislature, a Statewide Behavioral Health Coordinating Council was established to coordinate efforts to improve mental health and behavioral health programs. HB 2813 (86th, Price/Nelson) codified what was previously enacted through a budget rider, permanently establishing the council in statute.

The following is a list of the 23 Texas entities on the Statewide Behavioral Health Coordinating Council, all of which receive funding related to mental health and/or substance use.⁶⁴

- Office of the Governor
- Veterans Commission
- Health and Human Services Commission
- Texas Civil Commitment Office
- Department of Family and Protective Services
- Department of State Health Services
- Texas Education Agency
- School for the Deaf
- Texas Tech University Health Sciences Center
- University of Texas - Health Science Center at Houston
- University of Texas - Health Science Center at Tyler
- Supreme Court of Texas
- Court of Criminal Appeals
- Military Department
- Commission on Jail Standards
- Juvenile Justice Department
- Department of Criminal Justice
- Medical Board
- State Board of Dental Examiners
- Board of Nursing
- Optometry Board
- State Board of Pharmacy
- Board of Veterinary Medical Examiners

SB 362 - Court-Ordered Mental Health Services

SB 362 (86th, Huffman/Price) reforms procedures related to court-ordered outpatient and inpatient mental health services by:

- Amending procedures for early identification of a defendant suspected of having mental illness or an intellectual disability;
- Allowing a trial court to release a defendant on bail and transfer the defendant to the appropriate court for court-ordered outpatient mental health services, if the offense charged does not involve serious bodily injury;
- Allowing the dismissal of the underlying charges after the defendant complies with such treatment in certain circumstances;
- Requiring the Court of Criminal Appeals to ensure that judicial training related to court-ordered mental health services is provided at least once every year; and
- Requiring an inpatient treatment facility administrator to assess the appropriateness of transferring the patient to outpatient mental health services not later than 30 days after the patient is committed to the facility.⁶⁵

SB 362 (Huffman/Price) received \$850,000 in appropriations for each fiscal year for implementation.

LAW ENFORCEMENT (INTERCEPT 1)

HB 3540 - Release of a Person with IDD at the Person's Residence in Lieu of Arrest

HB 3540 (86th, Burns/Hughes) focused additional attention on persons with or suspected of having IDD who encounter the criminal justice system. The legislative intent demonstrates Texas legislators' belief that confinement of the person in a correctional facility would be unnecessary to protect that person and others from harm. Police officers may use reasonable efforts to consult with staff at the residence and with the person regarding the decision to release. The law would apply only to a person with IDD who resided at a group home or an intermediate care facility.⁶⁶

INITIAL DETENTION AND COURT PROCEEDINGS (INTERCEPT 2)

HB 601 - Reporting Requirements for Persons Suspected to Have a Mental Illness or IDD

HB 601 (86th, Price/Zaffirini) clarifies that the LMHA, local intellectual and developmental disability authority, or another qualified mental health or intellectual disability expert collecting information (as directed by a magistrate) must interview a defendant and collect related information regarding a defendant's potential mental illness or intellectual disability.

Changes through HB 601 remove potential confusion during intake into a jail. The bill also:

- Permits the interview to be done in person, by phone, or by telehealth;
- Provides for reimbursement by the county for the person or LMHA conducting the interview;
- Adds persons with, or suspected of an IDD, to the early identification procedures of Tex. Code of Crim. Proc. Arts. 16.22 and 17.032; and
- Requires a copy of any mental health records, screening reports, or similar information to accompany a defendant transferred to TDCJ.
- HB 2955 - Specialty Court Reporting

In an effort to align Texas with national practices of centralized specialty courts, HB 2955 (86th, Price/Zaffirini) moves the 200 specialty courts under the purview of the Office of Court Administration. Now mental health courts, veteran courts, and others have one judiciary oversight entity to better advance quality assurance, training, funding, research, technology, and advocacy goals.⁶⁷

HB 4468 - Access to Mental Health Services in County Jails

HB 4468 (86th, Coleman/Whitmire) addresses the gaps in services available in jail for a person with mental health needs. The legislation ensures that justice-involved people with less acute symptoms who do not demonstrate the likelihood of harm to self or others have access to a mental health professional within a reasonable time. If a mental health professional is not available in-person, they will be accessed through telemedicine health services, which will be required in all Texas jails by September 1, 2020.⁶⁸

REENTRY FROM JAIL/PRISON (INTERCEPT 4)

SB 1700 - Safe Release from County Jails

Directly after some justice-involved individuals were released from jail, there were still substantial safety risks. In some situations, individuals were released during the middle of the night, without proper clothing or any familiarity with the surrounding area.⁶⁹ Persons with a mental illness or IDD were especially vulnerable.

In order to address these concerns, legislators filed SB 1700 (86th, Whitmire/Miller),

which designates specific daytime hours (6:00 a.m. – 5:00 p.m.) when any person can be released from a county jail. The bill has an exception carved out for individuals being admitted to an inpatient mental health facility or state supported living center for mental health or IDD services.

RELEVANT BUDGET RIDERS

Legislators also addressed criminal justice and mental health-related issues through riders to the budget (HB 1, 86th Nelson/Zerwas). Budget riders do not provide new funding. Rather, they are legislative directives instructing agencies how to spend certain appropriated funds. Relevant riders are listed below.

HHSC (Article II)

- Rider 53 Screening for Offenders with Mental Impairment - directs HHSC and community centers to identify offenders with mental health conditions in the criminal justice system, collect and report prevalence data, and accept and disclose information relating to special needs offenders.
- Rider 57 Mental Health Peer Support Re-entry Program - directs HHSC to allocate up to \$1 million in general revenue (GR) for the biennium to maintain a mental health peer support reentry program. Requires these programs use certified peer support specialists to ensure inmates successfully transition from jail into clinically appropriate community-based care. This rider requires a legislative report by December 1, 2020.
- Rider 58 Semiannual Reporting of Waiting Lists for Mental Health Services - requires HHSC to submit semiannual reports to the Legislative Budget Board (LBB) and the governor providing data on waiting lists and related expenditures for community adult mental health services, community children's mental health services, forensic state hospital beds, and maximum-security hospital beds.
- Rider 59 Mental Health Program for Veterans - allocates \$5 million in GR each fiscal year for the purpose of administering the mental health program for veterans. Requires a legislative report December 1st of each fiscal year. Roughly \$1 million of this funding is allocated to justice-involved veterans.⁷⁰
- Rider 62 Mental Health Grant Program for Justice-Involved Individuals - allocates \$25 million in GR each year of the biennium for administering a grant program to reduce recidivism, arrests, and incarceration for individuals with mental illness while also reducing wait times for forensic commitment. The rider also directs \$5 million in GR each year to be allocated to the Harris County jail diversion program and requires each grantee to report twice annually to the Statewide Behavioral Health Coordinating Council.

HB 1, Article IX, Contingencies and Other Special Provisions

- Special Provision Sec. 18.95 Judicial Training Program - appropriates \$250,000 each fiscal year in GR for the development of a training program to inform and educate judges and staff on mental health resources in the state to both the Supreme Court of Texas and the Court of Criminal Appeals.⁷¹

SB 500 (Nelson/Zerwas) – Supplemental Appropriations Bill

- Section 25 – HHSC, Mental Health State Hospitals - Appropriated \$31,700,000 for mental health state hospital services.

Source: "Texas 86th Legislature Summary of Mental Health and Substance Use-Related Legislation." Hogg.utexas.edu. 2019. Web. 25 Feb. 2020.

COUNTY AND LOCAL JAILS

Local jails are operated by counties or municipalities and are usually managed by a county sheriff. Jails are the first step after a person becomes involved in the criminal justice system, holding people who are awaiting trial or who have been convicted of low-level crimes. All others held in county jail are awaiting transfer to TDCJ or a state jail facility. According to data provided by the Texas Commission on Jail Standards (TCJS), 87 percent of people charged with felonies and 83 percent of people charged with misdemeanors that are currently in jail had yet to be convicted.⁷²

TCJS is the regulatory agency for local jails. As of February 25, 2020, there were 239 facilities under its purview, including seven privately operated facilities and three privately operated state jails.⁷³ TCJS is tasked with assisting local governments in providing safe and constitutional conditions of confinement for individuals who are detained across Texas, including setting jail standards and inspecting county jail facilities. However, TCJS does not provide oversight within city-operated municipal jails; municipal jails in Texas are not regulated by any external agencies.

TDCJ RESPONSIBILITIES AND MISSION

TDCJ operates state jails facilities and prisons. These facilities hold individuals who have been convicted of an offense. TDCJ operates these facilities and oversees contracts with private correctional agencies. A major distinction between county jails and juvenile facilities is that the Texas prison and state jail system is monitored by its own oversight department – the TDCJ Ombudsman Program. In recent years, legislators and advocacy groups have argued the need for effective, independent oversight of the state jail and prison system.⁷⁴

TDCJ's mission is to "provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime."⁷⁵ In addition to in-prison management, the department also manages people who are in the community on parole. TDCJ is responsible for providing health services, including mental health and substance use services, to people who are convicted and sentenced to state jails, state prisons, and private correctional facilities that contract with TDCJ. The Correctional Managed Health Care Committee must develop statewide policies regarding correctional health care services and coordinate the delivery of those services to persons in the TDCJ system. The committee is made up of nine voting members, including a TDCJ representative, medical doctors, and mental health professionals, as well as one non-voting member who is appointed by the Texas Medicaid director.⁷⁶

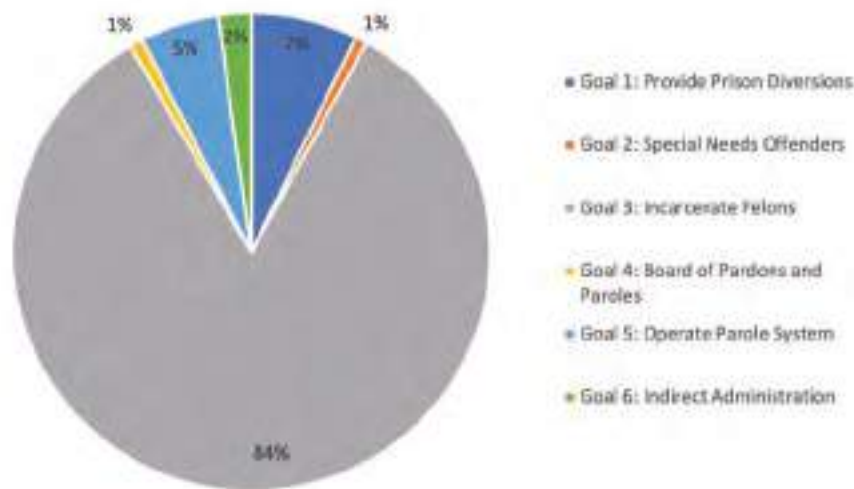
Funding

On January 31, 2020, there were 144,593 individuals incarcerated in Texas prisons, which accounted for over 97 percent of TDCJ's operating capacity.⁷⁷ The average cost of incarcerating an individual in a state facility was \$62.34 per day in 2018.⁷⁸ In contrast, individuals on parole cost was \$4.39 per day, and individuals on community supervision cost was \$3.75 per day.⁷⁹

The TDCJ budget for FY 2020-21 was about \$6.871 billion, with 6.7 billion (about 98 percent) of revenue coming from general revenue. Only a small portion of the TDCJ budget came from federal funding. With regards to agency goals, about 84 percent was allocated for incarceration. By contrast, seven percent was provided for diversion, five percent for operating parole systems, two percent for indirect administration, one percent for board of pardons and paroles, and one percent for special needs offenders.⁸⁰

The Special Needs Offender Program (SNOP) includes the Substance Abuse Felony Punishment Facilities (SAFPF) and In-Prison Therapeutic Communities (IPTC) for those with special needs inside of prisons.⁸¹ It also includes mentally impaired (MI), intellectual/developmental disabilities (IDD), terminally ill (TI), physically handicapped (PH), and medically recommended intensive supervision (MRIS) offenders on parole.⁸²

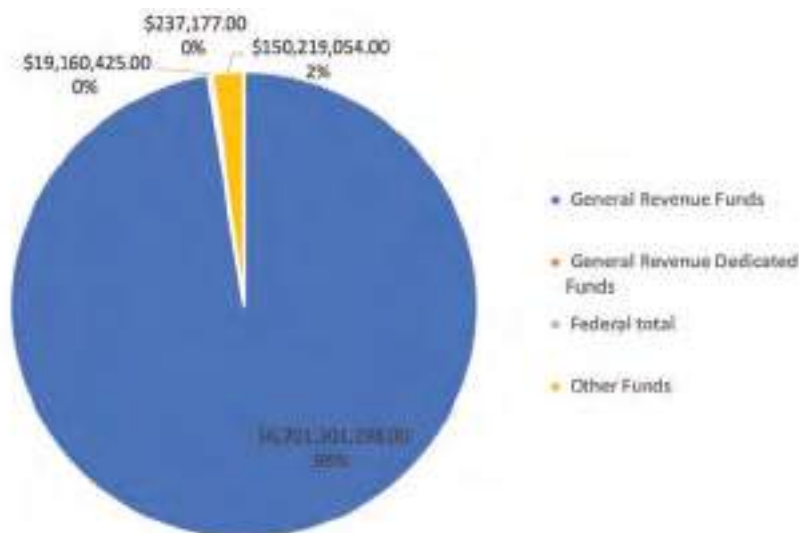
Figure 96. TDCJ Budget by Strategy for FY 2020-21



Total TDCJ Budget for FY 2020-21: \$6,870,917,954.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Figure 97. TDCJ Budget by Method of Finance for FY 2020-21



Total TDCJ Budget for FY 2020-21: \$6,870,917,954.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

TDCJ Facilities and Housing Classifications

TDCJ has facilities located throughout the state in six regions, with headquarters in both Austin and Huntsville. Each of the TDCJ Institutional Division regions has an administrative director.⁸³ Regions are pictured below.



Map Source: "Unit Directory - Region/Type Of Facility/Map." Tdcj.texas.gov. https://www.tdcj.texas.gov/unit_directory/unit_map.html

The Texas criminal justice system classifies and houses individuals based on level of felony, medical or mental health need, or programmatic need. The table below depicts TDCJ's population distribution by facility of facility.

Table 61. TDCJ's Population by Type of Facility - February 2020

Type of Facility	Number of Units	Population
Prison	49	92,856
State Jail	14	17,623
Transfer Facility	12	14,236
Private Prison	7	
Psychiatric	3	1,587
Parole Intermediate Sanction Facility (ISF)	1	41
Parole Intermediate Sanction Facility (ISF) / Transfer Unit	2	n/a
Private State Jail	3	n/a
Geriatric Facility	1	428
Pre-Release	4	3,987
Substance Abuse Felony Punishment (SAFP)	5	n/a
Developmental Disabilities Program	1	939
Medical	3	704
Private Multi-Use	1	471
Baby and Mother Bonding Initiative (BAMBI)	1	9

Sources: "Unit Directory - Region/Type Of Facility/Map." Tdcj.texas.gov. https://www.tdcj.texas.gov/unit_directory/unit_map.html

"Prison Units | Texas Prison Inmates | The Texas Tribune." The Texas Tribune. <https://www.texastribune.org/library/data/texas-prisons/units/>. Data Accessed 27 Feb. 2020.

State Jails

While all states have prisons, Texas has an unusual "state jail" category. The state jail felony system was created in 1993 by legislators seeking to address prison overcrowding by creating an alternative for people convicted of low-level, non-violent offenses.⁸⁴ State jails were intended to provide a brief term of confinement as a part of community corrections, with a focus on rehabilitation. TDCJ was mandated to create work, rehabilitation, education, and recreational programming on a 90-day cycle, the intended maximum normal term for those committed to state jails.⁸⁵ Yet the framework was dependent on courts' commitment to keep people convicted of state jail felonies on the docket for the entirety of their sentence, so that judges could

continue to supervise defendants upon release back to the community. Judges widely rejected this model and preferred to sentence defendants to determinate sentences in state jails with no post-release supervision. Moreover, the legislature never funded the rehabilitation-focused programming inside state jail, which resulted in people released from state jail to the community without rehabilitative programming. Consequently, people released from state jails have worse recidivism rates than those released from prison. In FY 2018, only 84 of the 16,941 people leaving state jail were under community supervision (0.4 percent).⁸⁶ A three-year re-arrest, reconviction, and re-adjudication finding by the LBB found rates significantly higher for people leaving state jails (63.1 percent) compared to prison (46.3 percent).⁸⁷

While “state jail” is a placement category, there are no separate facilities for state jails. In 2003, TDCJ’s State Jail Division merged into the Correctional Institutions Division. The facilities are considered “transfer facilities.” People convicted of state jail felonies are in a separate dormitory, but the transfer facilities also house people convicted of more serious felonies who are in “transfer” status for up to two years waiting for a bed in a state prison unit.⁸⁸

A complete list of facilities by region is available at http://www.tdcj.state.tx.us/unit_directory/unit_map.html.

Solitary Confinement and Mental Health

Justice-involved people who have spent time in solitary confinement (administrative segregation) are at a greater risk for lifelong mental health impacts and well-being compared to those in standard housing and classification designations. Individuals in solitary are up to eight times more likely than those in the general prison population to engage in self-harm and nine times more likely to die by suicide.⁸⁹ On September 1, 2017, TDCJ changed their policy on solitary confinement, eliminating it as a punishment. As a result of the policy change, people held in administrative segregation dropped from 7,200 in August 2013 to less than 4,000 in July 2017.⁹⁰ Despite changes in policy, TDCJ still houses a large number in solitary confinement due to gang affiliations, high escape risk, death sentence, or ongoing danger to staff or other prisoners.⁹¹ People with mental health conditions are overrepresented in solitary confinement usage. In 2014, about 30 percent of TDCJ’s isolated population was identified as having some form of mental illness treatable by outpatient care.⁹²

A 2019 report found that individuals who volunteered for a mental health diversion program said promises of therapy and time out of their cells were not fulfilled.⁹³ While TDCJ created a mental health therapeutic diversion program (MHTDP) with group counseling, individual counseling, and self-study programs, the program has proven to be a disappointment to people in custody. Individuals in the program report that it operates much like solitary confinement in that they are held in isolation almost continuously without intended services. Alarming, MHTDP participants are not included in the official count of prisoners held in solitary even though they are held in similar conditions.

Depending on the circumstances, TDCJ utilizes two types of solitary confinement for varying lengths of time. Historically, correctional officers used short-term disciplinary segregation for punitive purposes. This option was eliminated in September 2017; the ban required a change in placement for 76 people.⁹⁴ Then TDCJ shifted its use of administrative segregation to house people for an indefinite period of time when they are considered dangerous to themselves or others, holding individuals in a small, isolated cell for about 22 hours per day.⁹⁵ Administrative segregation is still common within TDCJ. In September 2017, roughly 4,000 people were in administrative segregation.⁹⁶ On average, TDCJ inmates remain in isolation for almost four years. However, in 2015, ten individuals in TDCJ custody reached 30 consecutive years in administrative segregation.^{97,98} Individuals kept in solitary confinement for even short spans of time can experience negative mental health outcomes, including major depression, cognitive disturbances, psychosis, and suicidal ideation.⁹⁹

Despite the adverse mental health outcomes of individuals held in solitary confinement, until recently individuals were frequently released directly from administrative segregation into the community. Referred to as a “flat release,” this practice occurs when incarcerated individuals finish their prison sentences while they are housed in administrative segregation. TDCJ must then release them directly from the most restrictive prison environment (i.e., isolation) to the streets without any supervision or support. Research shows that flat release is linked to higher recidivism rates, which places both formerly justice-involved individuals and their fellow community members at risk.¹⁰⁰ By the end of 2016, TDCJ no longer released people directly from administrative segregation into the community.¹⁰¹ Instead, the agency requires individuals housed in administrative segregation to complete a pre-release program that has three phases: motivational interviewing, cognitive change programming, and reentry planning in effort to reduce negative outcomes.¹⁰²

Assault and the Prison Rape Elimination Act (PREA) Investigations

Traumatic experiences such as sexual assault can impact the mental health of people incarcerated in the general prison population. In effort to protect an individual who has experienced a sexual assault, prison officials will oftentimes place a sexual assault victim in solitary or protective custody.

A 2013 survey by the Bureau of Justice Statistics ranked the U.S. prisons with the highest sexual assault complaints reported by people confined in prisons; 25 percent were located in Texas (an improvement over the 2008 survey in which Texas was home to 50 percent of those prisons).¹⁰³ People with mental illness are at a higher risk of sexual assault. One survey showed that 6.3 percent of people in prison identified with “serious psychological distress” reported sexual victimization by another person under confinement, in contrast to reported victimization by 0.6 percent of people without a mental health condition.¹⁰⁴

The Prison Rape Elimination Act (PREA), a federal law passed in 2003, intended to

institute a zero-tolerance policy for prison rape in correctional settings. The Texas PREA Ombudsman is responsible for ensuring that TDCJ follows federal regulations created to eliminate sexual assaults in prison facilities. The position investigates inmate-on-inmate sexual abuse reports, as well as staff-on-inmate sexual abuse and harassment. In 2016, the PREA Ombudsman office found 43 percent of incidents reported met the elements of the Texas Penal Code for Sexual Assault or Aggravated Sexual Assault.¹⁰⁵

Jails are also required to comply with PREA requirements, with oversight provided by the Texas Commission on Jail Standards as part of its general oversight duties.¹⁰⁶

TDCJ Behavioral Health Services and Programs

TDCJ is comprised of subdivisions that manage and operate the agency, supervise incarcerated individuals, and provide services to crime victims. Within TDCJ, there are several offices and agencies responsible for meeting the physical and behavioral health needs of people confined in prisons. The table below provides a brief description of each office or agency.

Table 62. TDCJ Behavioral Health Services and Programs

Entity	Brief Description
Health Services Division	The division must ensure that people in TDCJ custody have access to health care services; employees also monitor the quality of those services. The division investigates grievances from people in TDCJ custody or their family members, conducts service audits, and collaborates with health care contractors and the CMHCC. ¹⁰⁷
Office of Mental Health Services Liaison and Utilization Review	Within the Health Services Division, the OMHL&UR assists in screening people with mental illness for participation in programs supporting integration into the general prison population. ¹⁰⁸
Office of Mental Health Monitoring and Liaison	Within the Health Services Division, the OMHM&L monitors TDCJ's mental health services and provides expert guidance to other TDCJ offices on mental health-related issues. ¹⁰⁹
Office of Health Services Monitoring	Within the Health Services Division, the Office of Health Services Monitoring performs onsite compliance audits to monitor access to and quality of inmate health care, including mental health care. ¹¹⁰
Rehabilitation Programs Division	The division is responsible for coordinating various groups (such as the Parole Division, Community Justice Assistance Division, Health Services Division, the Windham School District, and community-based organizations) in the provision of evidence-based treatment services for individuals throughout their incarceration and supervision periods. ¹¹¹

Texas Correctional Office on Offenders with Medical or Mental Impairments	Comprised of representatives from multiple state agencies and nonprofit organizations, TCOOMMI provides a formal structure for criminal justice, health and human services, and other affected agencies to coordinate on legislative, policy, and programmatic issues affecting incarcerated individuals with special needs. ¹¹² Among other duties, TCOOMMI case managers work as liaisons between correctional staff and service providers at LMHAs to improve continuity of care, provide case management services, and facilitate adherence to treatment plans.
Correctional Managed Health Care Committee	CMHCC is the oversight and coordination authority charged with developing a managed health care plan (called the Offender Health Services Plan) for all people confined by TDCJ. The committee manages a partnership arrangement between TDCJ's Health Services Division, the University of Texas Medical Branch at Galveston, and Texas Tech University Health Sciences Center. TTUHSC is responsible for providing medical services (including mental health care) in the western part of the state where TDCJ incarcerates 22 percent of its population; UTMB is responsible for the same services in the eastern half of Texas where TDCJ incarcerates 78 percent of its population. ¹¹³ TDCJ may contract with any entity to implement the managed health care plan.

ACCESS TO SERVICES

The Correctional Managed Health Care Committee developed the Offender Health Services Plan, which provides two levels of health care services to incarcerated individuals within TDCJ. The plan prioritizes two classification levels of health services for medical, dental, and mental health needs.

Level I – Medically Mandatory care is that which 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 be very cost effective. This level of care is available to all individuals incarcerated.¹¹⁴

Level II – Medically Necessary care is that 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. Level II care may be provided to all individuals incarcerated, but evolving standards and practice guidelines control the extent of service.¹¹⁵

Each TDCJ facility must develop a process by which individuals who are incarcerated can gain access to medical, mental health, substance use, and dental care. This process is commonly referred to as “sick call.”¹¹⁶ At intake, incarcerated persons are provided information on how to obtain health care services within their assigned facility. Facilities may identify people with mental health conditions during the intake process or upon referrals from security staff who receive mental health-related training.¹¹⁷

In addition to the Correctional Managed Health Care Committee, the TDCJ parole board also plays a significant role in individuals gaining access to health services. The Medically Recommended Intensive Supervision (MRIS) Program identifies offenders who are elderly, physically handicapped, mentally ill, terminally ill, or have a condition requiring long term care for early release on parole.¹¹⁸ Referrals

are screened by TCOOMMI and must meet certain criteria for eligibility. Offenders having a sentence of death or sexual offense are not eligible.¹¹⁹

MENTAL HEALTH SERVICES

Qualified mental health providers may recommend the following mental health diagnostic and treatment services for people in TDCJ custody with behavioral health needs:

- Emergency mental health crisis services (available 24 hours a day, seven days per week)
- Professional medical services such as medication management and monitoring
- Continuity of care services
- Psychosocial services including talk therapy
- Crisis management/suicide prevention
- Inpatient services provided by a correctional health care approved facility, including diagnostic evaluation, acute care, transitional care, and extended care
- Outpatient services
- Specialized programs¹²⁰

The table below describes these programs.

Table 63. TDCJ Mental Health Programs

Level of Service	Description
Program for the Aggressively Mentally Ill Offender ¹²¹	This voluntary treatment program within TDCJ for men with mental health needs and a history of aggressive behavior is designed to prepare them for less restrictive housing. At the time of admission, the person must be in administrative segregation, G4 or G5 custody status* or at risk of increasing custody classification, and must have at least 18 months of his sentence left in order to complete the program.
Developmental Disabilities Program ¹²²	Incarcerated individuals suspected of having an intellectual disability or borderline intellectual functioning diagnosis and individuals whose adaptive functioning is judged significantly impaired may be referred to a DDP facility for further evaluation and services.
Chronic Mentally Ill Program ¹²³	The CMI program enrolls participants in one of two separate treatment tracks. The inpatient treatment track (CMI-TP) serves people with mental illness in administrative segregation or those with a G5 security status who require close monitoring and medication management. The outpatient sheltered housing track (CMI-SH) engages individuals who refuse treatment and who do not meet criteria for inpatient psychiatric commitment.

* Note: TDCJ classifies individuals housed in state prisons into six custody levels, ranging from the least restrictive to the most restrictive. These levels include: G1 (General Population Level 1), G2, G3, G4, G5, and Administrative Segregation. Individuals with a G4 security status are housed in cells rather than dorms, and they may not work outside the security fence without armed supervision. Individuals with a G5 security status who have histories of assaultive or aggressive behavior are housed in cells and may not work outside the security fence without armed supervision.
Source: Correctional Managed Health Care Committee. (September 2015). Correctional Managed Health Care Policy Manual. https://www.tdcj.texas.gov/divisions/cmhc/docs/cmhc_policy_manual/A-08.03.pdf. Accessed 14 Apr. 2020.

SUBSTANCE USE TREATMENT SERVICES

An April 2018 report revealed that 70 percent of women and 58 percent of men within TDCJ were diagnosed with a substance use disorder.¹²⁴ In addition to mental health programs, TDCJ also manages a number of programs within its Rehabilitation Programs Division to serve people with substance use conditions. The table below describes these programs.

Table 64. Substance Use Treatment Programs in TDCJ

Program	Description
Substance Abuse Felony Punishment Facility (SAFPF) and In-Prison Therapeutic Community (IPTC)	Both SAFP and IPTC are six-month, in-prison treatment programs, followed by 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 SAFP or IPTC in lieu of prison or state jail time, or the Board of Pardons and Parole can require program participation as a condition of parole.
Pre-Release Substance Abuse Program (PRSAP) and Pre-Release Therapeutic Community (PRTC)	PRSAP and PRTC are intensive six-month programs intended for individuals who are incarcerated with serious substance use conditions, chemical dependency, or “criminal ideology issues.” The Board of Pardons and Parole votes to place inmates in these programs prior to their release into the community. The PRTC involves collaboration between the Rehabilitative Programs Division, the Windham School District, and the Parole Division.
State Jail Substance Abuse Program	Eligible people in state jail are placed in either a 60- to 90-day program or a 90- to 120-day program based on an Addiction Severity Instrument assessment and their criminal history. Participants are provided rehabilitation, counseling, and related services designed to meet their unique needs.
Driving While Intoxicated In-Prison Program	The six-month program uses an aftercare component and a variety of education and treatment activities to reduce the risk of recidivism among people incarcerated for a DWI offense. Participants engage in evidence-based practices that focus on substance use disorders, victim awareness, and cognitive therapies. ¹²⁵

Source: Texas Department of Criminal Justice. (n.d.). Rehabilitation Programs Division. https://www.tdcj.texas.gov/divisions/rpd/substance_abuse.html. Accessed June 2020.

POST-INCARCERATION COMMUNITY-BASED SERVICES

Recidivism into the criminal justice system is a key concern for all people returning to the community after a period of incarceration. In the three years after leaving TDCJ custody, re-arrest rates range from 46 percent of people released from prison to 63 percent of people released from state jail. Additionally, reincarceration rates are 21 percent of people released from prison and 32 percent of people released from state jail.¹²⁶ TDCJ operates several programs aimed at supporting reentry into the community and reducing recidivism rates.

TEXAS CORRECTIONAL OFFICE ON OFFENDERS WITH MEDICAL OR MENTAL IMPAIRMENTS (TCOOMI)

Within TDCJ's Reentry and Integration Division, the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMI) program provides a variety of institutional and community-based services to facilitate the reentry of people with special needs back into the community. TCOOMI partners with LMHAs to provide three types of reentry services for people with mental illness: continuity of care, case management, and medically recommended intensive supervision.¹²⁷ In recent years, TCOOMI has expanded eligibility to include all people with serious and persistent mental illness. In FY 2016, TCOOMI provided continuity of care services to 35,305 individuals.¹²⁸

Upon their release from incarceration, TCOOMI refers clients to LMHAs for services, such as case management, psychological and psychiatric services, medication and monitoring, and benefit eligibility services (including federal entitlement application processing). In FY 2017, TCOOMI worked with LMHAs to provide 26,367 justice-involved individuals with community-based behavioral health services.¹²⁹

Efforts to reduce recidivism involve linking justice-involved individuals to community services and supports to help address the root causes underlying a person's previous criminal behavior. This is done to prevent reentry into the criminal justice system. In 2013, TCOOMI implemented the Risk Needs Responsivity model to reduce recidivism among high-risk individuals utilizing TCOOMI case management services.¹³⁰ In 2015, the three-year recidivism rate was 12.4 percent for clients with high risk and clinical needs who were served for at least one year in TCOOMI case management programs, while TDCJ's general recidivism rate was 21.4 percent.¹³¹ In FY 2017, TCOOMI provided case management services to 7,507 individuals.¹³²

TCOOMI is also involved with the Medical Recommended Intensive Supervision, described in the section on Access to Services Level II. The purpose of the program is to release individuals who pose minimal public safety risk back into the community in order to improve individual health outcomes and cut costs. If an individual is approved for early MRIS release, TCOOMI specialists will expedite the release planning process and facilitate reentry case management. In FY 2016, 86 people in prison and 9 people in state jail were approved for MRIS release.¹³³

SPECIALIZED PAROLE PROGRAMS

While the MRIS program provides services to some persons with serious mental illness leaving TDCJ custody, other specialized programs may be available for individuals with mental health and substance use issues who are released from incarceration. The table below provides an overview of the most relevant programs.

Table 65. Specialize Parole Programs

Program	Description	Monthly Average of Individuals Program in FY 2017
District Reentry Centers	Focuses on newly-released, high-risk, and high-need individuals using a comprehensive approach to promote personal responsibility and address anger management, cognitive restructuring, substance use, and victim empathy.	1,062 individuals
Special Needs Offender Program	Supervises individuals with intellectual disabilities, mental health conditions, terminal illnesses, or physical disabilities.	99 individuals with intellectual development disorders 6,169 individuals with mental health conditions 878 individuals with terminal illnesses or physical disabilities 177 individuals on medically recommended intensive supervision
Therapeutic Community Program	Offers continuity of care services for individuals within TDCJ facilities with substance use issues. Consists of a three-phase program for individuals who participated in an in-prison therapeutic community or a SAFFP	7,130 individuals
Substance Abuse Counseling Program	Provides relapse prevention services to individuals with substance use treatment needs	21,088 individuals received Level I prevention services in FY 2017 [no monthly average given] 1,289 individuals received Level II outpatient treatment services
Drug Testing Program	Provides instant-read drug testing	174,857 drug tests conducted monthly

Source: Texas Department of Criminal Justice. (n.d.). Annual Review 2017. Page 30. https://www.tdcj.texas.gov/documents/Annual_Review_2017.pdf. Accessed 7 Mar. 2020.

REENTRY SERVICES

TDCJ's Reentry and Integration Division provides both pre-release and post-release programs statewide.¹³⁴ As of September 2018, it had 128 pre-release, 8 release-dedicated, and 51 post-release case managers. Case managers can be located in correctional facilities, district parole offices, or community residential facilities (halfway houses). The remaining 10 positions were dedicated to serving the special needs offender population.¹³⁵

Returning to the community after time in a TDCJ facility is a challenging aspect of an individual's criminal justice involvement. Reentry is the reintegration back into society from jail or prison. It involves skillful planning and patience, in addition to the dual commitment from the individual and the community to achieve overall wellness. The process of reintegrating back into the community impacts many parts of a person's health and well-being, including mental health continuity of care.

Reentry programs are available in local communities through governmental, faith-based, non-profit, and for-profit programs. These programs fall into two categories: general reentry and residential reentry.¹³⁶ Cities currently listed in Texas* with local reentry programs include:¹³⁷

- Austin
- Azle
- Beaumont
- Brownsville
- Dallas
- Del Valle
- Edinburg
- Fort Worth
- Houston
- San Antonio

*Note: ReEntry Programs, a service located in Washington DC, keeps its website open for new submissions from visitors to the site.

In 2018, TDCJ launched “Website for Work,” a program to match parolees with employers, arrange for the parolee to contact the employer, and record data on the outcomes of individual members in the program. Website for Work will produce statistical reports on the overall success of the program in helping offenders obtain employment and serve the entire state of Texas, including employers who hire an ex-offender within a year of their release from prison. The employer will also qualify for the federal Work Opportunity Tax Credit (WOTC).

INCARCERATION PREVENTION AND DIVERSION PROGRAMS

Increased demand for mental health services within state prisons and county jails has pushed stakeholders to develop opportunities for diversion from incarceration for people with mental health and substance use disorders. For example, LMHAs provide community-based interventions that can prevent criminal justice involvement. TCOOMMI within TDCJ also collaborates with some of the 39 LMHAs to provide multi-service alternatives to incarceration for justice-involved individuals with special needs. For more information, see the “Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)” section of this chapter.

TDCJ awards grant funding to county stakeholders in order to pursue the first goal outlined in its 2017-21 strategic plan: “to provide diversions to traditional incarceration.”¹³⁸ The aim of these prevention and diversion programs is to use cost effective, safe, and clinically appropriate strategies that curb the over-incarceration of people with mental illness (among others) charged with low-level crimes.

Sequential Intercept Model

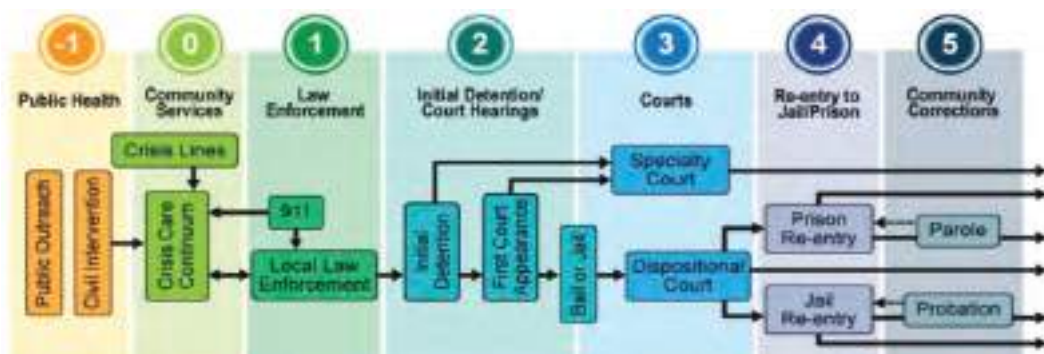
The Sequential Intercept Model (SIM) was developed as an informative model for multi-system responses to people with mental health or co-occurring substance use disorders involved in the criminal justice system.¹³⁹ Since its development in the early 2000s, the SIM has been widely accepted nationally as well as in Texas.¹⁴⁰ Within the model, there are multiple touchpoints for a person with a mental health condition to engage prior to entering into the criminal justice system, within the criminal justice system, and reintegrating back into the community. The SIM helps connect people with mental health conditions to the right care.¹⁴¹

The Substance Abuse and Mental Health Services Administration (SAMHSA) promotes the SIM as a way to organize prison and jail diversion strategies.¹⁴² The model was developed in conjunction with the GAINS Center and emphasizes “intercept points” at which individuals may be diverted from the justice system. After feedback from communities including some in Texas, the GAINS Center added an Intercept 0.¹⁴³ The JCHM also added an Intercept -1, designating public health as the first setting that an individual with a mental illness or IDD should be identified and served prior to criminal justice involvement. The intercept points include:

- Intercept -1: Public health, public outreach, and civil intervention¹⁴⁴
- Intercept 0: Community services;
- Intercept 1: Law enforcement and emergency services;
- Intercept 2: Initial detention and court hearings;
- Intercept 3: Jails and courts;
- Intercept 4: Reentry into the community; and
- Intercept 5: Community corrections and support services.

Figure 98 below illustrates the key intercept points where people with mental health conditions encounter the criminal justice system.

Figure 98. Sequential Intercept Model



Source: National Center for State Courts and Arizona Sup. (n.d.). Assessing the Mental Health and IDD Landscape by Intercept. Retrieved from <http://texasjcmh.gov/media/1436/assessing-the-mental-health-and-idd-landscape-by-intercept.pdf>.

The table below gives some examples of important questions to be asked along with diversion strategies in each intercept point.

Table 66. Intercept Model Diversion Strategies

Intercept Point	Key Questions	Diversion Strategy Examples
-1 Public Health	What public outreach on mental health & IDD currently exist? Are there public benefit assistance services?	
0 Community Services	Does your county maintain a contract with the LMHA? What potential referral sources are available?	Mobile crisis outreach teams staffed by mental health professionals who can provide on-site assistance to people with mental illness before or as they interact with police.
1 Initial Contact w/ Law Enforcement	What law enforcement/ first responder efforts exist related to crisis interventions (e.g., mobile crisis outreach, crisis intervention teams) What are challenges to intervention?	Specialty mental health deputies and crisis intervention teams staffed by local police officers who can identify and divert individuals experiencing mental crises.
2 Initial Detention and Court Hearings	What screening or assessment tools are in place to identify MH or IDD needs?	Deferred prosecution programs that allow people charged with low-level crimes to have their criminal cases dismissed.
3 Jails & Courts	Is there an LMHA liaison to connect to courts and detention facilities? Are evaluations conducted? Is there a MH court or docket? Are prosecutors, defense attorneys, and judges familiar with state laws* designed to help?	Mental health courts that prioritize therapeutic dispositions over traditional sentences. Outpatient competency restoration programs for individuals who do not pose a threat to public safety.
4 Reentry from Jail/ Prison	What treatment services are available prior to release? What community engagement strategies are provided upon reentry?	Jail in-reach programs that connect incarcerated individuals with community supports and treatment providers prior to release. Peer support services that pair justice-involved individuals with peers who have lived experience with incarceration, mental health conditions, and successful recovery.
5 Community Corrections	What post incarceration screening exist in probation/parole offices? What wellness indicators are monitored by probation/ parole? (e.g., housing, health, peer supports)	Forensic assertive community treatment teams that work with probation departments to prevent supervision revocation. Modifications of community supervision requirements to better match the needs of people with mental illness.

*Texas Code of Criminal Procedure 16.22, 17.032, and 46B

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Community Examples of Jail Diversion Strategies

At each step of the criminal justice process, the SIM encourages collaboration between LMHAs, law enforcement agencies, and the court system. Collaboration among key stakeholders helps to ensure that people with mental health conditions who commit minor offenses are linked to community-based and recovery-oriented services, supports, and treatment as soon as possible. Research shows that jail diversion efforts can then improve mental health outcomes, save money, and increase public safety.¹⁴⁵

Section 533.108 of the Texas Health and Safety Code permits LMHAs to prioritize funds for the creation of collaborative jail diversion programs with law enforcement, judicial systems, and local personnel.¹⁴⁶ The type of programs available to persons with mental illness varies from county to county. Some communities, like Bexar and Harris counties (described below), offer robust diversion opportunities that address multiple intercepts of the SIM. Other counties do not have the resources to implement any type of diversion strategy at all. As a result, only a small fraction of Texans with mental illness who are eligible for diversion programming receive any diversion services.¹⁴⁷

BEXAR COUNTY JAIL DIVERSION PROGRAM

In 2003, Bexar County implemented a jail diversion program that is now viewed as a national service model. Bexar's diversion initiative was created by the Center for Health Care Services using diverse funding sources including private donations; city, county, and state dollars; and federal block grants.¹⁴⁸ The program employs both pre-booking and post-booking diversion methods.¹⁴⁹ First, Bexar County uses a 24/7 crisis center to provide county residents with immediate intervention when they are experiencing a mental health crisis. Then, MCOTs and CITs work to divert individuals with mental health conditions away from jail settings before they are arrested and booked in a local jail. After booking, the diversion program identifies people with mental illness already in the system and recommends appropriate alternatives to jail, such as court supervised community treatments or mental health bonds. The county created two centers: The Restoration Center for integrated substance use and mental health services and The Crisis Care Center for 24-hour psychiatric emergency care.¹⁵⁰ Finally, Bexar County offers programs that provide continuity of care and housing services for people in need of assistance who are released from incarceration into the community, such as Haven for Hope.¹⁵¹

Since its implementation, the combination of Bexar County's jail diversion strategies and decreased crime rates resulted in a significantly reduced county jail population. In 2003, the jail population exceeded the jail's capacity by nearly 1,000 people, but by 2015, the county was decommissioning a privately-operated detention center in order to better use 1,000 empty beds at the Bexar County Jail.¹⁵² The program diverts about 26,000 people a year, saving an estimated \$10 million annually in jail and emergency department costs.¹⁵³ Mental health-related trainings also helped to

decrease the use of physical force by Bexar County law enforcement officers against people with mental illness. A 2016 report found that the program decreased use of physical force from approximately 50 times a year to 3 times total within two years of beginning operation.¹⁵⁴

HARRIS COUNTY MENTAL HEALTH JAIL DIVERSION PROGRAM

Harris County, which is home to the fourth largest jail in the nation, created a significant jail diversion program.¹⁵⁵ In 2013, state legislators passed SB 1185 (83rd, Huffman/Schwertner) to create the Harris County Mental Health Jail Diversion Pilot program (MHDJP). The ongoing goal of the program is to promote and sustain recovery for justice-involved individuals with mental health conditions by expanding services for housing, education, supportive employment, and peer advocacy.¹⁵⁶

In the first few years, the Harris County MHJDP program used two local providers to safely divert people with mental illness away from the criminal justice system. First, the Harris Center for Mental Health and IDD (formerly MHMR of Houston) used a jail-based team, a community and clinic-based team, and critical time intervention case management services to identify people in jail with mental illness. They also initiated pre-release treatments and linked participants to established community support networks. Second, Healthcare for the Homeless-Houston and SEARCH Homeless Services enrolled eligible participants in a Permanent Supportive Housing (PSH) program. For more information on PSH, see the TDHCA chapter of this guide.

People can spend a few hours or days at the Harris Center to get treatment and connected to a range of community-based services. At each stage of the diversion program, people with mental health concerns receive access to evidence-based services, including cognitive behavioral therapy, substance use interventions, peer support, permanent supportive housing, and intensive case management.¹⁵⁷ The Judge Ed Emmett Mental Health Diversion Center was opened in 2018, providing a 29-bed resource for pre-jail diversion of people accused of low-level non-violent offenses.¹⁵⁸

LUBBOCK COUNTY MENTAL HEALTH COLLABORATIONS

Despite being a rural county with a population of less than 300,000 by the 2010 U.S. census, Lubbock County has implemented programs to serve MH and IDD needs during incarceration. In 1997, the Lubbock County Sheriff's Office and the Lubbock Regional Mental Health Mental Retardation Center developed a Memorandum of Understanding allowing people with severe and persistent mental illness to be treated while in jail.¹⁵⁹ While considering the needs of this population, Lubbock County has continued to ration scarce resources to fund jail operations along with a myriad of other services. Collaborations between StarCare Specialty Health System, the Lubbock County Sheriff's Department, and the Lubbock Police Department serve people with mental health conditions by diverting them into health care settings rather than jail.

In December 2018, Lubbock police launched its Crisis Intervention Team (CIT) aimed at diverting people with mental illnesses from jail.¹⁶⁰ Team members' tasks include knowing how to identify mental health conditions, how to de-escalate, how to respond, as well as how to refer people in mental health crises so that they do not get involved in the criminal justice system. The creation of the crisis team has helped police and people in crisis to talk about mental illness, breaking the stigmas of mental health issues.¹⁶¹

Specialty Courts

Counties can use specialty courts to divert people with mental health concerns and substance use issues away from jail settings. These courts apply problem-solving techniques to provide community-based alternatives to incarceration. Each type of specialty court requires the collaboration of judges, prosecutors, defense attorneys, law enforcement officers, and mental health professionals. Specialty courts tend to focus on an identified issue (mental illness, substance use), an identified group (veterans, juvenile, family drug), or a specific offense (DWI, prostitution).

As of March 2020, there were approximately 147 adult specialty courts registered in Texas.¹⁶² In FY 2016, the Office of the Governor's Criminal Justice Division (CJD) allocated \$11.6 million in general revenue-dedicated funds for discretionary grants to 89 specialty courts across Texas.¹⁶³ In FY 2015, CJD-funded courts served approximately 3,570 participants, 61 percent of whom completed their program successfully.¹⁶⁴

In 2019, the Texas legislature passed HB 2955 (86th Price/Zaffirini), a bill that moved specialty courts from the purview of the governor's office to the Office of Court Administration (OCA).¹⁶⁵ Specialty courts must now register with the OCA, which provides technical assistance and monitoring for compliance with programmatic best practices.¹⁶⁶

As of 2018, there was no statewide data collected on specialty courts.¹⁶⁷ The Criminal Justice Division of the Office of the Governor, which previously had jurisdiction over Texas specialty courts, stated in 2018 that these courts have reduced the number of people with mental illness who are incarcerated in the state.¹⁶⁸

DRUG COURTS

Drug courts provide more comprehensive and intensive supervision compared to other forms of community supervision.¹⁶⁹ Research shows that the drug court model of supervised treatment, in combination with judicial monitoring, can more effectively reduce drug use and crime compared to either treatment or judicial sanctions outcomes separately.¹⁷⁰ Data shows that this model works; researchers have found that drug court participation can decrease three-year recidivism rates by up to 5 percent.¹⁷¹ In 2001, the 77th Legislature passed HB 1287 (77th, Thompson/Whitmire), which mandated all Texas counties with populations exceeding 550,000

to apply for federal and other funds in order to establish drug courts.¹⁷² As of March 2020, there were approximately 147 drug courts in counties throughout Texas. These courts covered: driving while intoxicated (DWI), veteran's treatment, co-occurring disorder, and hybrid DWI/ drug courts.¹⁷³

FAMILY DRUG COURTS

Family treatment courts, also referred to as family drug courts and dependency drug courts, use a multidisciplinary, collaborative approach to serve families with substance use disorders and who are involved with the child welfare system.¹⁷⁴

In 2005, the 79th Texas legislature defined family drug court programs as having the following essential characteristics:

- Integration of substance abuse treatment services in the processing of civil cases in the child welfare system;
- Use of a comprehensive case management approach involving Department of Family and Protective Services (DFPS) caseworkers, court-appointed case managers, and court-appointed special advocates to rehabilitate a parent who has had a child removed from the parent's care;
- Early identification and prompt placement of eligible parents who volunteer to participate;
- Comprehensive substance use needs assessment and referral to an appropriate substance use treatment agency;
- Monitoring of abstinence through periodic alcohol or other drug testing;
- Ongoing judicial interaction with program participant monitoring and evaluation of program goals and effectiveness;
- Continuing interdisciplinary education to promote effective program planning, implementation, and operations; and
- Development of partnerships with public agencies and community organizations.¹⁷⁵

Family drug courts seek to provide safe environments for children, intensive judicial monitoring, and interventions to treat parents' substance use disorders and other co-occurring risk factors.¹⁷⁶ As of July 2019, there were 14 family drug courts across the state of Texas.¹⁷⁷

MENTAL HEALTH COURTS

Mental health courts were developed across the country as an alternative to the standard adjudication process for people with mental health conditions who have committed low-level offenses. Like drug courts, mental health courts use non-adversarial, judicially-supervised treatment plans to reduce recidivism that is fueled by untreated mental illness and substance use conditions. As of July 2019, Texas had 18 mental health courts.¹⁷⁸

VETERANS COURTS

Veterans Court Programs are mental health and drug treatment courts that provide alternatives to traditional criminal prosecution for veterans who meet specific criteria and suffer from a mental health condition, including substance use conditions. The purpose of these programs is to provide treatment for mental health conditions that caused or affected the actions of the veteran in the criminal offense charged.¹⁷⁹

Veteran courts provide an alternative to criminal prosecution for certain offenses and for the proper medical treatment of veterans who have served our country. Some state veteran programs (e.g., Dallas County Veterans Court), through direct coordination with the U.S. Department of Veterans Affairs, can help to provide medical treatment, mentoring, and other services to our nation's veterans who are facing qualifying criminal charges.¹⁸⁰ As of July 2019, there were 30 veterans' courts throughout Texas.¹⁸¹

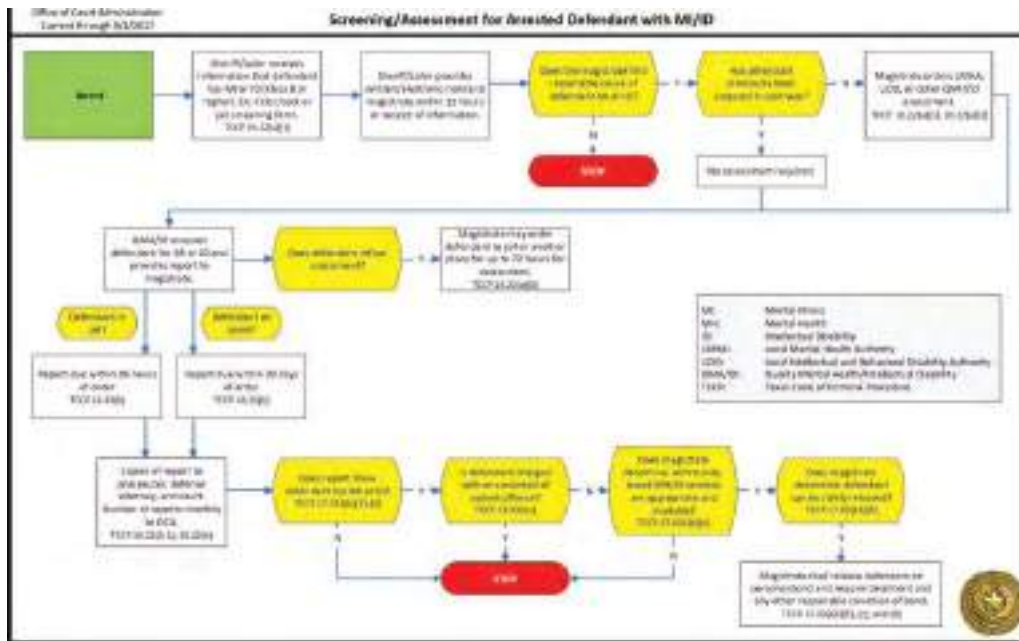
Mental Health Public Defender Offices

Criminal cases involving people with mental health conditions often present unique legal issues that require specialized knowledge and skills. Jurisdictions that have a public defender office can train attorneys on mental health-related issues in order to better serve clients. However not all counties have a public defender office. Thus, some areas without designated countywide public defenders have established a Mental Health Public Defender office that specializes in addressing the legal needs of people with mental illness who are charged with crimes.

As of 2017, there were 12 mental health defender programs in Texas: 9 public defender offices with a mental health division or specialization and 3 managed assigned counsel (MAC) programs.¹⁸² Public defender offices are those which the attorney is an employee of the office, whereas MAC office attorneys who represent indigent clients are contractors rather than employees of the office.¹⁸³

The flowchart below represents a sequence of criminal justice involvement for a person with mental illness or co-occurring conditions. A mental health public defender's office is essential to successfully navigating through the listed statutes and applying expert knowledge and skills for the mental health defendant.

Figure 99. Screening/Assessment Sequence



Source: "Screening/Assessment For The Arrested Defendant With Mental Illness Or IDD." Txcourts.gov. N.p., 2017. <https://www.txcourts.gov/media/1438893/screeningassessment-sep2017.pdf>. Accessed 20 Mar. 2020.

The Bexar County Public Defender's Office was created in 2005, first with an appellant public defender, and in 2015 it began representing defendants with mental illnesses at magistration.¹⁸⁴ It has trial, appellate, mental health, and central magistration departments with a staff of 18.¹⁸⁵ Of this number, 7 are full-time attorneys dedicated to representing clients with a mental illness.¹⁸⁶ These attorneys represent both felony and misdemeanor mental health clients from magistration to civil commitment hearings.¹⁸⁷

In FY 2016-2017, the Bexar County Public Defender's office reviewed 7,781 booking slips of defendants with an indication of mental illness.¹⁸⁸ The program presented 424 cases before magistrates at Central Magistration (CMAG) in FY 2016-2017 in an attempt to get clients a mental health personal bond.¹⁸⁹ Of the 424 presented cases, 305 were granted and effectively diverted into the Center for Healthcare Services (Bexar County's LMHA) program. It was estimated that a total of 3,615.5 days of confinement were avoided in FY 2016- 2017 as a result of this program. Since 2015, the mental health personal recognizance bond jail diversion grant has successfully avoided approximately 6,255.1 days of confinement.¹⁹⁰

Successful reintegration into the community can be a challenge for justice-involved people. Peer education and peer support have been used for decades to support people in prisons without a specific focus on people with mental health conditions.¹⁹¹ Peer support for people with mental health conditions has become an established service in other contexts (e.g., reentry from state hospitalization), and interest is growing for the use of peer support in incarceration settings. Reentry peer support programs allow people with lived mental health and criminal justice experience to mentor others in the justice system who are beginning the recovery and reentry

process.¹⁹² Certified peer support (CPS) specialists or “Peers” are able to share strategies, coping skills, and experiences with the state mental health system to help participants successfully navigate the difficult transition back into the community.

In 2015 legislators approved Rider 73 to the DSHS budget, which created a peer support reentry pilot program in Texas. In 2016 DSHS funded pilot programs in three locations: Harris County, Tarrant County, and Tropical Texas (which serves Cameron, Hidalgo, and Willacy counties); in the fourth quarter of FY 2016, the pilots had served 48 people.¹⁹³ County sheriffs and LMHAs in each location used certified peer support specialists to help individuals with mental health conditions successfully transition out of local jails and into their communities.

The Hogg Foundation for Mental Health funded the program’s evaluation and released its formal results in January 2019.¹⁹⁴ The evaluation included results of the impact of CPS specialists on recidivism and recovery of people in jail across each of the three project sites (Tarrant County, Harris County and the Rio Grande Valley).¹⁹⁵ Between 2016 and 2018, CPS staff provided mental health peer support services to facilitate successful transition from incarceration to community-based services. Peer support services included building a relationship with an individual based on mutuality and unconditional regard, guiding the individual to identify strengths and priorities for needed services, and working with the individual to reduce barriers to support successful reentry into clinically appropriate community-based services.¹⁹⁶

Results from this independent evaluation suggested that peer reentry specialists leveraged and applied lived experiences to support client reentry, although quantifiable effects were detected only for criminal behavior outcomes.¹⁹⁷ The statistics indicated that peers most often helped clients address housing and treatment needs, rather than criminal behavior directly.¹⁹⁸ Peers reported applying their personal experiences to also assist clients in seeking treatment for mental health symptomology and employment. Thus, by helping the client with other needs, peers were able to impact criminal behavior. There were a number of structural barriers, such as limited access to housing and long wait lists for clinical care, that prevented peers from addressing client needs. Despite these barriers, the evaluation showed statistically significant declines in criminal behavior identified among program participants.¹⁹⁹

Reentry Peer Support

County jails are another part of the criminal justice system within Texas, and hold four types of individuals:

- People who have not been convicted of a crime and are awaiting trial;
- People convicted of low-level offenses who are sentenced for short durations;
- People convicted of an offense who are awaiting transport to state facilities; and
- People found incompetent to stand trial who are awaiting a placement for competency restoration.

On March 1, 2020, Texas county jails operated at 72.7 percent of their collective capacity with a total jail population of 68,012.²⁰⁰ However, this population figure does not represent the total number of people who cycle through jails each year. A daily population statistic (like the one provided above) merely gives a snapshot of the number of people detained in jail on a specific day. A statistic that shows the total number of people who spend time in jail, even if only for a few hours, for one year more clearly captures the high volume of people who experience confinement in a jail over time.

In 2019, researchers estimated that people go to jail over 10.6 million times in the U.S. every year, though only about 612,000 people are jailed on any given day.²⁰¹ If those proportions hold true for Texas, over one million people pass through Texas jails each year.

Texas Commission on Jail Standards

The Texas Commission on Jail Standards (TCJS) is an external regulatory agency for all county jails and privately-operated municipal jails. TCJS's mission is to support localities in providing safe, secure and suitable local jail facilities.²⁰² A key statutorily-mandated role to fulfill this mission is to adopt minimum standards for the management and operation of these jails.²⁰³ TCJS's most recent strategic plan identifies four goals:

- Ensuring efficient and effective operations of county jails;
- Ensuring a high level of consultation, training, and technical assistance to local governments with the objective of increasing and maintaining compliance with adopted standards;
- Ensuring cost-effective construction of county jails; and
- Implementing the Prisoner Safety Fund for capital improvements to county jails such as automated electronic sensors or cameras.²⁰⁴

Out of the 254 counties in Texas, all but 15 operate at least one jail. Therefore, the five TCJS Inspection and Enforcement staff members must travel to 241 counties.²⁰⁵ Each county is visited for an unannounced compliance inspection at least once each fiscal year.

As of March 20, 2020, 12 county jails were out of compliance with minimum standards for violations in the categories of life safety, management, and construction, but this statistic can often be misleading. Reports of non-compliance are posted on TCJS's website, but once the non-compliant jail takes satisfactory remedial measures, the report is removed.²⁰⁶ In 2019, 62 reports of non-compliance were posted by TCJS, but like population counts, this number only represents a snapshot in time of how many jails are non-compliant.^{207,208} Annual cumulative counts are not currently available.

Common violations include failure to correctly conduct mental health screenings, failure to perform a Continuity of Care Query to identify a history of public mental health services, and failure to provide medical care to individuals experiencing mental health symptoms.²⁰⁹

No agency has oversight authority for municipal jails operated by local governments. The LBB noted that little statewide data exists about the operation of the 349 city jails and lockups in Texas, especially regarding people with mental health conditions.²¹⁰ An LBB survey indicated that less than a third of city jails and lockups use the TCJS intake screening form required of county jails and only 74 percent do any kind of mental health screening.²¹¹

Jail Deaths and Suicide

LOCAL JAIL CUSTODIAL DEATHS

There are over 1,000 prisoner deaths each year in U.S. jails, according to the Bureau of Justice Statistics, and one of every ten occurs in Texas. Between October 1, 2017 and July 1, 2018, some 80 prisoners died in Texas jails – a rate 22 percent above the national average over the previous 13 years.²¹²

Despite the high number of jail deaths, only about 6 percent of Texas's jails were non-compliant as of March 20, 2020. Some advocacy groups cite that one reason for the state's high death rate may be insufficient oversight.²¹³ Filed in the 86th Texas legislature, HB 363 (86th, Johnson/Bowers) would have given TCJS oversight authority over the state's prison system, but more comprehensive local jail oversight was not included. Though the bill received a favorable vote out of committee, it never reached the floor of the full House.²¹⁴ Currently, the Texas Rangers do independent investigations of jail deaths, but there remains little oversight with local county jails and the high number of deaths occurring in custody.

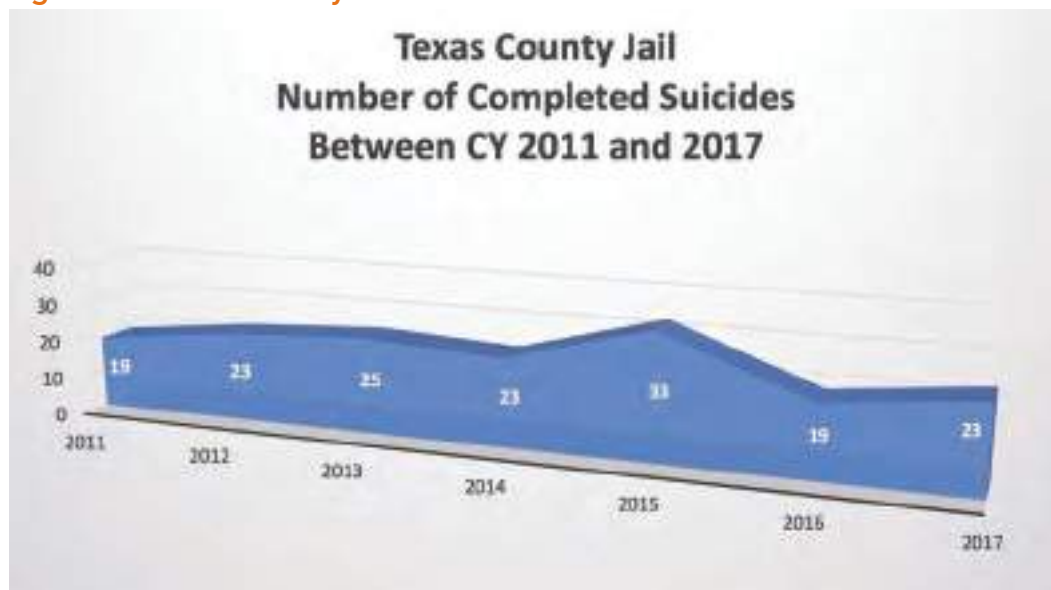
LOCAL JAIL SUICIDE

Suicide is the second leading cause of death in Texas prisons and jails. Only natural causes claim more inmate lives under custody each year.²¹⁵ National data shows that suicide occurs roughly three times more frequently in jails than in prisons.²¹⁶

Entering jail can be a traumatic experience, as even a short stay prior to trial can jeopardize a person's job, housing, social support, and sense of normalcy.²¹⁷ Jail staff typically have less information about the people who enter their facilities than do prison staff. People with mental health conditions who are awaiting trial (and thus have not been convicted of a crime) are at even greater risk. National data shows that pretrial individuals die by suicide at a rate seven times higher than their convicted peers do.²¹⁸ An older national study indicated that jails under 100 beds report a suicide rate up to five times higher than larger jails.²¹⁹

For many years, suicide has been the leading cause of death in local jails across the U.S.²²⁰ In Texas, the number of jail suicides increased by about 43 percent between 2014 and 2015. In 2016, 2017, and 2018, TCJS continued to find county jails out of compliance due to failure to conduct required observation checks.^{221,222,223} The figure below demonstrates the number of suicides that occurred within county jails between 2011 and 2017.

Figure 100. Texas County Jails - Suicide Deaths



Source: Texas Commission on Jail Standards. (May 18, 2016 and October 3, 2018). Data request: Suicides in county jails.

To decrease the prevalence of suicides in jail settings, the Texas Administrative Code requires county sheriffs and jail operators to develop and implement a mental disability and suicide prevention plan. Jail officials are given flexibility in how they construct these plans, but at a minimum, each plan must address the following:

- Staff training procedures regarding the identification, supervision, and management of incarcerated individuals who have a mental disability and/or are potentially suicidal;
- Intake training procedures to identify persons who are suicidal;
- Communication and documentation procedures to relay and maintain information about suicidal individuals;
- Intervention and emergency treatment procedures prior to the occurrence of a

- suicide and during the process of a suicide attempt;
- Reporting procedures to inform outside authorities and family members about completed suicides; and
- Review mechanisms for jail administrators and medical and mental health staff following all attempted and completed suicides.²²⁴

Jail administrators in Texas also use an approved screening tool to identify people who are at risk for suicide. Upon admission to the jail, each individual must be evaluated immediately with a TCJS-approved screening form for suicide and medical/mental/developmental impairments.²²⁵ The previous form asked newly jailed people to self-report their medical problems and mental health histories, but jail employees still had discretion when determining whether to refer the person to treatment services.²²⁶ The form that was created in 2015 removes subjectivity from the process. Jail employees must now follow explicit instructions when detained individuals provide certain responses to predetermined questions. TCJS's Executive Director, Brandon Wood, states, "The form gave the counties a fighting chance to identify these individuals. After identifying them, [jails] are required to provide mental health services."²²⁷ Since using the revised form, Texas county jails have seen a sharp decline in inmate suicides.²²⁸

Mental Health Services and Records In County Jails

SERVICES

Untreated mental health needs can lead to behavior that results in the entrance (or re-entrance) into the criminal justice system. In Texas, people receiving public behavioral health services make up a sizeable portion of the total justice-involved population. National data indicates that over half of justice-involved individuals have a mental health condition.²²⁹ Texas data shows that almost 30 percent of the people booked into a county jail have already received public mental health services.²³⁰ Though jails are legally mandated to provide health services to detainees, the quality and availability of mental health services can vary widely between facilities. Large urban jails are more likely to provide treatment and successfully link individuals to community-based social services in order to prevent recidivism. Texans detained in other facilities, particularly those in rural areas with fewer resources, may experience deterioration of their mental health status due to a lack of adequate therapeutic services.

When individuals are booked at a county jail, correctional officers are required to use a real-time identification system for persons with special needs. Continuity of Care Query (CCQ) checks each person's information against the DSHS Clinical Management for Behavioral Health Services database and instantly informs jail employees if a person has been hospitalized in a state psychiatric facility or if the

person has experienced an encounter, authorization, or assessment by the public mental health system through an LMHA within the past three years.²³¹ If a match is detected, the jail could contact the relevant LMHA in order to link the individual to available community resources.²³²

From September 1, 2017 to June 22, 2018, the 235 counties in Texas that participated in the system initiated 872,350 CCQ match requests for adults.²³³ Under 5 percent (40,949) of the queries were exact matches with information maintained in the DSHS mental health database, and about 24 percent (207,974) were probable matches.²³⁴ Both exact and probable matches alert the local jails and LMHAs to exchange pertinent information. Since the process does not identify individuals not receiving services or those who have received mental health services in the private sector or other states, it undercounts the total number of people with mental health conditions in the jail system.

RECORDS

TCJS standards include requirements for the custody, care, and treatment of people in county jail. The standards require that when a person is admitted to jail, any “health tag” identifying the person as having a special medical or mental health need must be noted in the individual’s medical record and brought to the attention of health personnel and/or the supervisor on duty.²³⁵ Each facility must also create and implement a written health services plan for the jail population’s medical, mental health, dental, and pregnant inmate services. In addition, the facility must maintain a separate health record for each person. These health records must include a health screening and a mental health evaluation administered by medical personnel or by a trained booking officer upon a person’s entry into the jail. At a minimum, each record must also contain current medical and mental health treatment information and behavioral observations, including the individual’s state of consciousness, mental health status, and risk of suicide.²³⁶

Jail administrators may use health records when individuals are transferred to or reincarcerated within different facilities across the state. State and federal laws govern exchanging people’s health records with other entities. TCJS requires jail administrators to send a Texas Uniform Health Status Update form when people are transferred from a jail to any other correctional facility.²³⁷ Additionally, HB 601 (listed above in the section on “Major Legislation from the 86th Texas Legislature”) reinforces reporting requirements to ensure mental health records are transferred with the person from jail to prison. Furthermore, the Texas Health and Safety Code requires various agencies, including local jails, TCJS, and TDCJ to disclose and accept information relating to incarcerated persons with mental illness, disabilities, and/or other special needs in order to improve continuity of care services “regardless of whether other state law makes that information confidential.”²³⁸ This information may include details about an individual’s treatment needs such as social, criminal, and vocational history, as well as supervision status and medical and mental health history.

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Policy Concerns

- Impacts of COVID-19 on TJJD operations and on the mental health of youth in state custody;
- Diverting youth with behavioral health needs away from secure confinement; facilities and into their home communities with services and supports;
- Addressing the behavioral health needs of youth in their communities;
- Assessing the negative impacts of detaining youth in adult correctional facilities, including
- adjusting policies to change the upper and lower age limits of juvenile court jurisdiction based on the science of adolescent development;
- Addressing the school-to-prison pipeline and the disproportionality for youth of color and youth with special education needs;
- Ensuring strong oversight by the Office of the Independent Ombudsman at a time of significant systems change within the Texas Juvenile Justice Department;
- Assessing and sharing outcomes for state secure facilities and community interventions (e.g., recidivism, rehabilitation); and
- Continue to reduce the number of incarcerated youths in secure confinement facilities.

Fast Facts

- Almost two million youth are arrested in the U.S. every year. Of these youth, 70 percent have a mental health condition.¹
- Very few of the youth involved in the justice system are arrested for serious offenses like aggravated assault, robbery, rape or murder (under 3,000 out of almost 50,000 arrests in 2016).²
- Re-arrest rates of youth are as high as 75 percent within three years after confinement within a juvenile justice facility.³
- From September 2019 through March 2020, there were 792 youth in institutions, 87 youth in halfway houses, and 80 youth in contract residential placements. This is a total of 959 youth in the Texas juvenile system, which represents a 12.4 percent decrease from the 1,100 totals in FY 2019 through March.⁴
- In FY 2018, the Legislative Budget Board estimated that youth in residential facilities cost \$479.56 per day, youth on parole cost \$41.07 per day, and youth on probation cost \$13.55 per day.⁵
- Texas has 45 pre-adjudication facilities operated at the county level. Seventeen of these facilities offer programs for youth with mental health conditions, and 13 provide programs for youth with substance use conditions.⁶
- Texas has 35 post-adjudication facilities operated at the county level. Twenty-nine of these facilities offer programs for youth with mental health conditions, and 31 provide programs for youth with substance use conditions.⁷
- In FY 2018, counties funded 74 percent of juvenile probation services, while the state funded 25 percent and the federal government provided only 1 percent of total funding.⁸

TJJD Acronyms

ACEs – Adverse Childhood Experiences

ART – Aggression Replacement Therapy

BISQ – Brain Injury Screening Questionnaire

CEDD – Center for Elimination of Disproportionality
and Disparities

CINS – Conduct Indicating Need for Supervision

COG – Capital Offender Group

CRCG – Community Resource Coordination Group

CSG – Council of State Governments

CSU – Crisis Stabilization Unit

CSVOTP – Capital and Serious Violent Offender Program

DFPS - Department of Family and Protective Services

FEDI – Front End Diversion Initiative

IO – Independent Ombudsman

LBB – Legislative Budget Board

MRTC – McLennan Residential Treatment Center

OMHSE – Office of Minority Health Statistics and Engagement

PAWS – Pairing Achievement with Services

PTSD - Post-traumatic Stress Disorder

SJPOs – Specialized Juvenile probation Officers

SNDP – Special Needs Diversionary Program

TBI – Traumatic Brain Injury

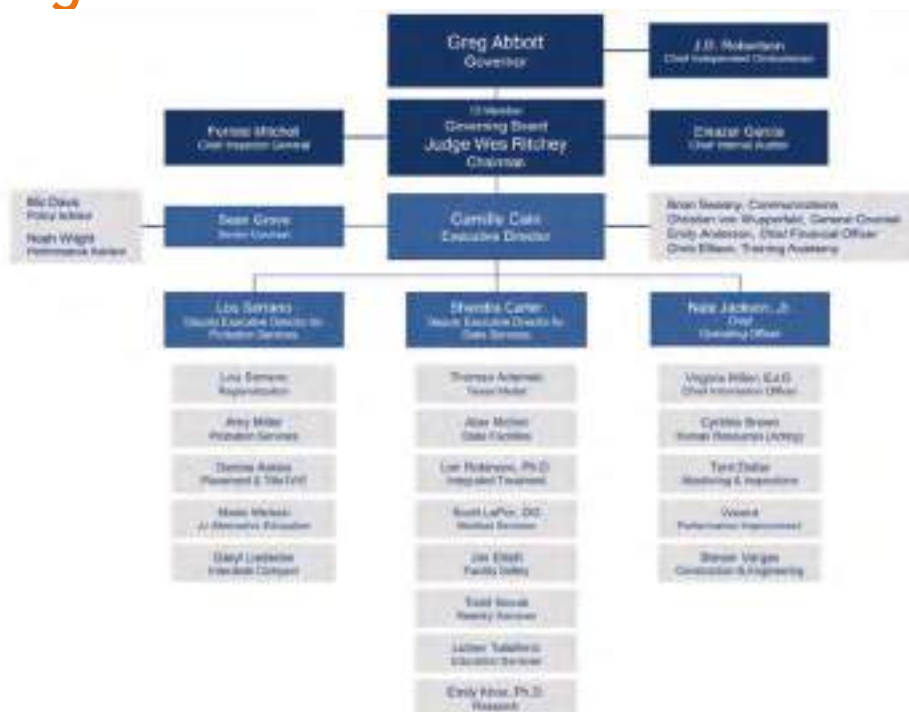
TCOOMMI – Texas Correctional Office for Offenders
with Medical and Mental Impairments

TEA - Texas Education Agency

TJJD – Texas Juvenile Justice Department

VOP – Violent Offender Program

Organizational Chart



Source: Texas Juvenile Justice Department (September 2019). Retrieved from: <https://www2.tjjd.texas.gov/docs/TJJDOrgChart.pdf>

Overview

Unfortunately, the first contact for some children or youth with an emotional or substance use problem is a police officer, rather than a mental health professional.⁹ The initial purpose of the juvenile justice system was to act as a substitute parent; the system's sole purpose was to help youth onto the right path, diverting them from later involvement in the adult criminal justice system.¹⁰ Over time, the system changed from the substitute parent role into an adversarial relationship like the adult criminal justice system.¹¹

Texas's juvenile justice system includes the Texas Juvenile Justice Department (TJJD) and local juvenile probation departments throughout the state. These agencies work together to provide services designed to rehabilitate youth between 10 and 17 years old who engage in delinquent conduct.

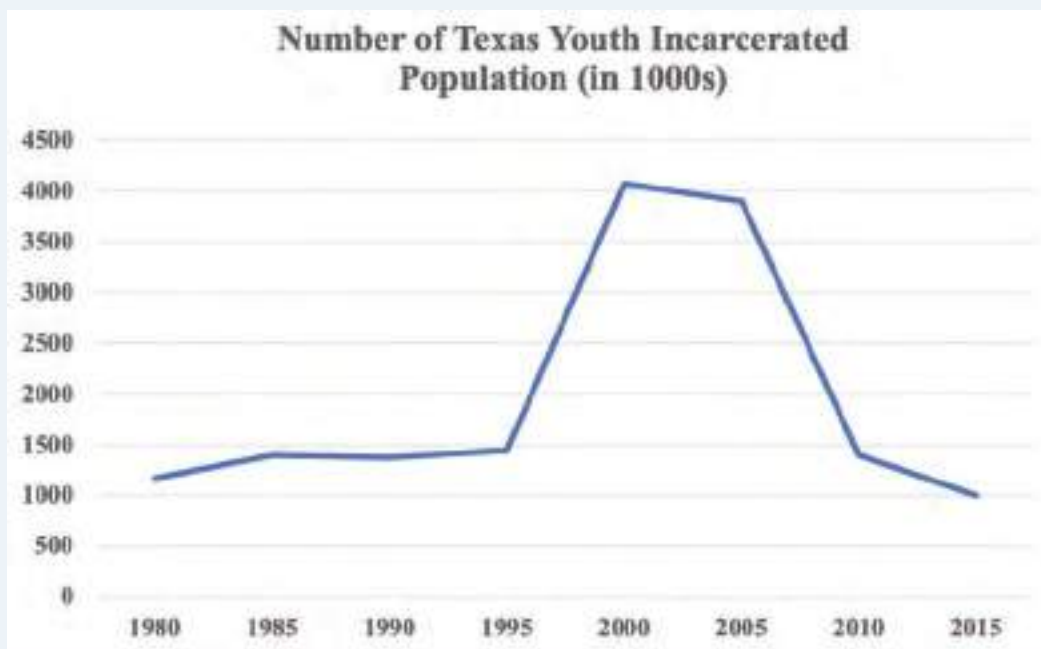
SB 653 (82nd, Whitmire/Madden) created the TJJD in 2011.¹² The agency began operations in December 2011 and the existing Texas Juvenile Probation Commission (TJPC) and Texas Youth Commission were abolished.¹³ TJJD is charged with "increasing the proportion of youth in local custody, rather than committed to state lockups."¹⁴ The department's ultimate goal is to prevent a juvenile's entrance into the adult criminal justice system by providing treatment plans tailored to each child's unique strengths and needs. TJJD provides oversight and funding to local juvenile probation departments across Texas and operates six secure state facilities for youth.^{15 16}

Changing Environment

The Texas Legislature prioritized efforts to reduce youth incarceration rates in 2017, successfully decreasing the number of youth in secure state juvenile facilities. Statewide efforts to reduce youth incarceration has brought the number of youth incarcerations below 1,000 for the first time since the 1980s.¹⁷ In April 2018, the number of youth in TJJD fell below 900 for the first time in decades.¹⁸

The figure below illustrates Texas's state secure juvenile facility population between 1980 and 2017.

Figure 101. Number of Youth Incarcerated



Source: McGaughy, L. (April 6, 2018). The number of Texas kids behind bars is suddenly at its lowest point in decades. *Dallas Morning News*. Retrieved from: <https://www.dallasnews.com/news/crime/2018/04/06/the-number-of-texas-kids-behind-bars-is-suddenly-at-its-lowest-point-in-decades/>

Chair of the Senate Criminal Justice Committee, Senator John Whitmire requested the Council of State Governments Justice Center (CSG) analyze the impact of those reform efforts.¹⁹ In 2015, the CSG released key findings, including: (1) youth confined in state-run facilities are two times more likely to be re-incarcerated within five years of release than youth sentenced to county-level probation,²⁰ and (2) while reforms have benefited state and county-level juvenile justice systems, Texas can do more to decrease recidivism rates among justice-involved youth. CSG researchers recommended that TJJD and county probation departments concentrate their interventions on youth with the highest risk to reoffend and minimize involvement with low-risk youth.²¹ In late 2017, confirmed incidents of staff abusing youth at one of the remaining five TJJD facilities became public news.²² As a result, Governor Greg Abbott replaced the TJJD executive director, board chair, and the Independent

Ombudsman positions. In June 2018, the new TJJD executive director Camille Cain submitted a letter to Governor Abbott with proposed short-term solutions and long-term goals for the agency.²³ The short-term goal was stabilizing agency operations by improving supervision ratios (both by reducing the youth population and increasing the number of employees), improving safety, and adjusting training. Later that month, TJJD approved a strategic plan for 2019-23 detailing the future direction of the agency.²⁴ More detailed information on the strategic plan can be found later in this section.

MAJOR LEGISLATION FROM THE 86TH LEGISLATURE

During the 86th legislative session, approximately 25 new bills were filed relating to juveniles or referred to the House Committee on Juvenile Justice & Family Issues. Five made it through both chambers and were signed into law, while three others made it, but were vetoed by the governor.²⁵ In the Senate, eleven bills were filed, with three being signed into law.²⁶ Legislation described below contains juvenile-related laws generally and is not an exhaustive account of juvenile justices and mental health legislation.

Juvenile Justice Bills Signed Into Law

HB 601 - Reporting Requirements for Persons Suspected to Have a Mental Illness or IDD

HB 601 (86th, Price/Zaffirini) is highlighted in the TCJC section and also applies to juveniles. HB 601 requires development of a written report assessing the youth's mental health status to strengthen front-end mental health need identification of all persons entering criminal justice settings. In addition to adult reporting, examination on the issue of fitness to proceed with juvenile court proceedings must be by an expert appointed under Chapter 51 of the Texas Family Code.²⁷

Effective September 1, 2019, the legislation required a copy of any mental health records, screening reports, or similar information to accompany a youth that may be transferred to a Texas Department of Criminal Justice (TDCJ) facility. It also mandates that youth who may have an intellectual disability also be assessed and that information be included in the report.

HB 1760 - Confidentiality, Sharing, Sealing, and Destruction of Juvenile Records

HB 1760 (86th, White/Wu) amends previous laws relating to juvenile records. It expands allowance of TJJD facility records disclosure to:

- An individual or entity referral for treatment or services and assisting in transition from release or discharge from a juvenile facility to the community;
- A prosecuting attorney;
- A parent or guardian with whom child will reside; and
- A government agency or court for administrative or legal proceeding with identifiable information redacted.

Effective September 1, 2019, the legislation also prohibits an individual or entity receiving confidential information from re-disclosing information.²⁸

HB 2229 - Relating to a Report of Information Concerning Juveniles in TJJD

In the 85th legislative session, HB 1521 (85th, White/Whitmire) and HB 932 (85th, Johnson/West) required the Texas Department of Family and Protective Services (DFPS) to share information with TJJD. The bills also required TJJD, DFPS, and local juvenile probation departments to collect and share data, including how many youth in the juvenile justice system have ever been in foster care.

Building on reports indicating many youth involved in the foster care system would later enter a federal or state correctional system, the Texas 86th legislature took further steps to address this issue with additional requirements for TJJD to collect certain data for a child in TJJD custody. Data is now collected for purposes of assisting the legislature, advocates, and TJJD in altering, targeting, and increasing services to prevent foster youth from entering the juvenile justice system.²⁹

H.B. 2229 (86th, Johnson/Whitmire) requires TJJD to submit a report to each member of the legislature not later than January 31 of each evennumbered year. Previously, this report was made to the governor, the lieutenant governor, the speaker of the house of representatives, and each standing committee having primary jurisdiction over TJJD. The legislation also requires TJJD to make the report publicly available on TJJD's website.³⁰ The bill was effective immediately upon passage.

HB 2737 - Relating to Judicial Guidance Related to Child Protective Services Cases and Juvenile Cases

HB 2737 (86th, Wu/Johnson) directs the Texas Supreme Court, in coordination with the Supreme Court of Texas Permanent Judicial Commission for Children, Youth and Families, to annually provide guidance to judges who preside over:

- Child protection cases including placements, changes in placement, and termination of parental rights; and
- Juvenile justice cases including placements for children with mental health concerns, releases, certification of standing trial as adults, commitment to TJJD, and a child's appearance before court including use of restraints and clothing worn during the proceeding.³¹

HB 3688 - Relating to the Apprehension of a Child after Escape from a Secure Juvenile Facility or Violation of Conditions of Release Under Supervision

After concerns raised regarding the limited authority of some peace officers responding to a directive issued from TJJD, HB 3688 (86th, White/Perry), was aimed to address the issue. Effective September 1, 2019, the bill extends authority to certain peace officers to apprehend juvenile offenders in TJJD care that have either escaped secure confinement or violated the conditions of their release.³²

The bill amends the Human Resources Code to include a special investigator among the persons authorized to arrest without a warrant a child who has been committed

to TJJD. The list of peace officers now includes a sheriff, deputy sheriff, constable, special investigator, or any other peace officer (police) who is authorized to, without a warrant, arrest the youth.³³

SB 562 - Relating to Criminal or Juvenile Procedures Regarding Persons or Youth Who have, or may have, a Mental Illness or IDD

Previously when a person or youth with a mental illness was charged with a violent or sexual crime and found incompetent to stand trial or not guilty by reason of insanity (NGRI), state law required judges to send them to a maximum-security unit (MSU), even when that placement was not appropriate. The Health and Human Services Commission's (HHSC) Dangerousness Review Board would then conduct an assessment of the defendant to determine whether an MSU was appropriate. Due to the inadequate number of MSU beds available statewide, a person or youth with a mental illness could be left waiting in custody without adequate treatment and without timely progress in their case.³⁴

Many defendants did not meet the clinical standard for dangerousness despite the seriousness of the alleged offense. It was inefficient to have a person in custody for months without proper mental health treatment waiting to occupy an MSU bed when it was not an appropriate placement for them.³⁵

Immediately effective on June 14, 2019, SB 562 (86th Zaffirini/Price) ensures that the best location for a person or youth to receive competency restoration would be determined at the outset, rather than waiting for the defendant to be sent to an MSU unit first before determining the adequate treatment setting. The legislation will reduce the MSU waiting list while reserving limited MSU beds for persons or youth who need those specialized beds. Persons committed to non-MSU facilities as a result of this new process should experience shorter wait times in custody and a more timely path to a state hospital or other treatment facility.³⁶

SB 1702 - Relating to the Powers and Duties of the Office of Independent Ombudsman for the Texas Juvenile Justice Department

SB 1702 (86th Whitmire/Dutton) was filed to provide safeguards ensuring that juveniles remain in safe and secure facilities, while balancing the necessary security to facilitate an effective juvenile justice system. Previously, the TJJD independent ombudsman duties included oversight and inspection of facilities in which juveniles were housed within the juvenile justice system. Traditionally the ombudsman performed duties only at the five secure facilities located throughout Texas.³⁷

After TJJD's independent ombudsman's inspection and oversight of post-adjudication and contract facilities expired on January 1, 2019, concerns were raised with the potential gap in oversight, but SB 1702 alleviates those concerns and that potential gap has now been filled.³⁸

Effective on September 1, 2019, the independent ombudsman is able to provide necessary oversight at any facility where a juvenile might be housed, including post-adjudication probation facilities and contract facilities. The expanded authority will

ensure the safety and security of all juveniles in the TJJD system.³⁹

SB 1887 - Relating to Jurisdiction over Certain Child Protection and Juvenile Matters Involving Juvenile Offenders

SB 1887 (86th Huffman/Murr) amended previous laws relating to jurisdiction over certain child protection and juvenile matters involving juvenile offenders. Because youth can interact with both the child welfare and juvenile justice systems, various conflicts hindered courts and service providers. For example, conflicts between the juvenile justice and welfare systems would have contradictory court orders, conflicting treatment plans, duplication of services and hearings, higher placement costs, and a waste of limited resources.⁴⁰

Effective September 1, 2019, this bill allows juvenile courts to transfer or refer parts of cases to the children's courts for youth involved in both the juvenile justice and child welfare systems and allows children's courts to hear these cases.⁴¹

Juvenile Justice Bills Vetoed by the Governor

HB 1771 (86th, Thierry/Huffman) - Relating to a prohibition on prosecuting or referring to juvenile court certain persons for certain conduct constituting the offense of prostitution and to the provision of services to those persons.

HB 1771 would have prevented the prosecution of individuals younger than 17 for certain prostitution offenses. This bill intended to prevent engagement in delinquent conduct, community supervision, arrests, or referrals to a juvenile court.⁴² Instead, the youth would have been returned to their parents or DFPS.⁴³ The legislation would have directed law enforcement to use their best efforts to reunite the youth with a parent/guardian, and when all options had been exhausted, to contact a local service provider in consultation with the child sex trafficking prevention unit and the governor's program for victims of child sex trafficking. The governor said the new law would have "unintended consequences" and could provide an incentive for human traffickers to exploit underage prostitutes.⁴⁴

HB 3195 - Relating to juveniles committed to the Texas Juvenile Justice Department and the transition of students from alternative education programs to regular classrooms

HB 3195 (86th, Wu/Whitmire) was filed to address concerns that TJJD lacks the flexibility to reduce the period of confinement for certain juvenile offenders who are sentenced to a residential program. The bill would have provided the flexibility for youth to be released early.⁴⁵ The bill was vetoed, in part, because it would have removed the requirement that juvenile offenders participate in certain educational programs before being eligible for parole.⁴⁶

HB 3648 - Relating to the powers and duties of the office of independent ombudsman for the Texas Juvenile Justice Department

Filed as an administrative "clean up" bill to clarify language pertaining to the duties of TJJD's independent ombudsman, HB 3648 (86th, Guillen/Whitmire) was vetoed because its goal had allegedly already been accomplished through SB 1702.⁴⁷

TJJD Funding

Cost Per Day: Juvenile System vs. Adult System

On February 29, 2020, there were 795 youth committed to six state secure facilities, 80 youth in halfway houses, and 98 youth in contact care facilities.⁴⁸ In FY 2018, the Legislative Budget Board estimated that youth in residential facilities cost \$479.56 per day. The table below illustrates the differences between the two systems in cost per day.

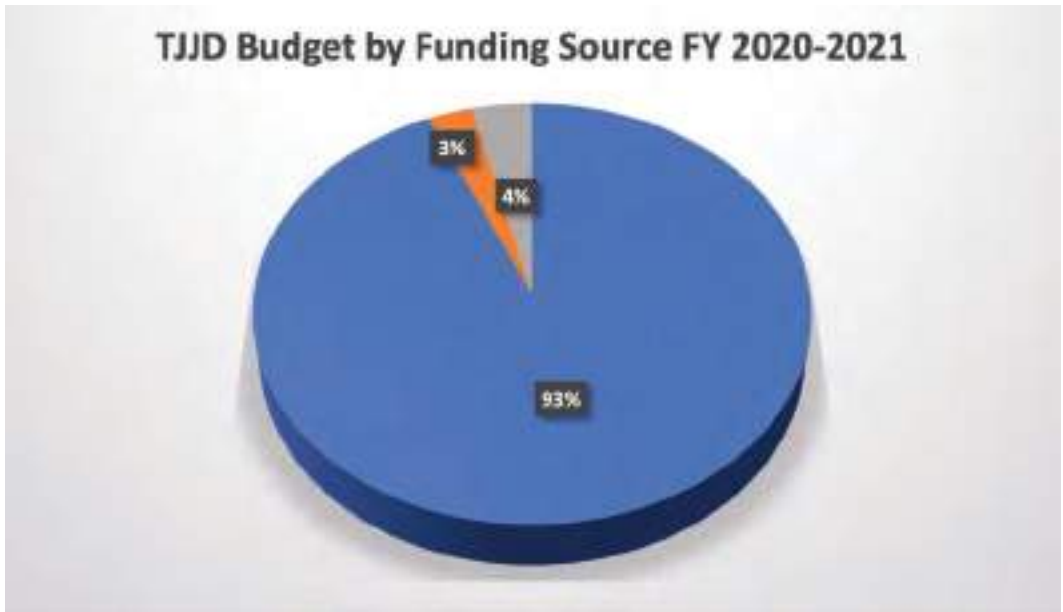
Table 67. Systems Costs

Placement (FY 2018)	Adult System Cost Per Day (FY 2018)	Juvenile System Cost Per Day (FY 2018)
Adult Prison or Juvenile Detention	\$62.34	\$479.56
Parole Supervision	\$4.39	\$41.07
Community or Probation Supervision	\$3.75	\$13.55

Source: Legislative Budget Board (February 5, 2019). Overview of Criminal and Juvenile Justice Correctional Population Projections, Recidivism Rates, and Costs Per Day. Page 12. http://www.lbb.state.tx.us/Documents/publications/presentation/5678_HAC_CJDA%20Overview.pdf. Accessed 7 Apr. 2020.

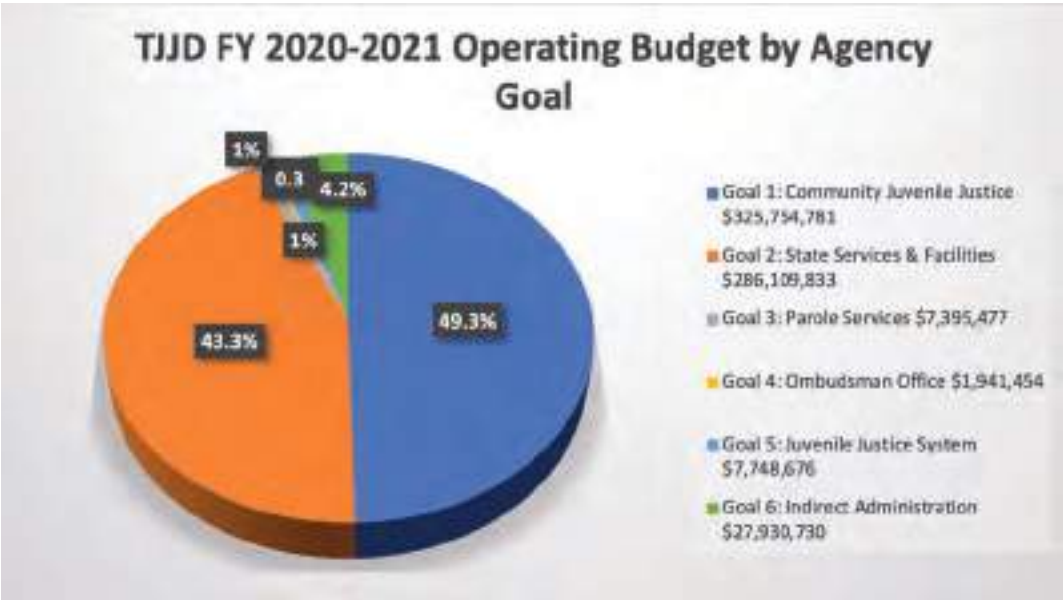
The total FY 2020/21 appropriation for TJJD for FY 2020-2021 was \$656,880,951.⁴⁹ The figure below breaks down TJJD's budget by funding source and the following figure shows TJJD's budget by agency goal.

Figure 102. TJJD Budget by Funding Source FY 2020-2021



Source: General Appropriations Act for the 2020-21 Biennium (August 2, 2019). Eighty-sixth Texas Legislature Regular Session, 2019. Text of Conference Committee Report on House Bill No. 1. [https://www.lbb.state.tx.us/Documents/GAA/General Appropriations Act 2020 2021.pdf](https://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2020_2021.pdf) Accessed 7 Apr. 2020.

Figure 103. TJJD FY 2020-2021 Operating Budget by Agency Goal



Source: General Appropriations Act for the 2020-21 Biennium (August 2, 2019). Eighty-sixth Texas Legislature Regular Session, 2019. Text of Conference Committee Report on House Bill No. 1. [https://www.lbb.state.tx.us/Documents/GAA/General Appropriations Act 2020 2021.pdf](https://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2020_2021.pdf) Accessed 7 Apr. 2020.

Many individuals in the juvenile justice system have experienced trauma and/or live with a mental health or substance use conditions. While it is difficult to cull all

the resources devoted to mental health in the TJJD, below are budget strategies and riders specifically related to mental health treatment and services in the department as depicted in HB 1 (86th).⁵⁰

- **Strategy A.1.7** – Mental Health Services Grants \$14,178,353 \$14,178,351
- **Strategy B.1.7** – Psychiatric Care \$942,670 \$922,851
- **Strategy B.1.8** – Integrated Rehab Treatment \$11,745,539 \$11,740,740

- **Rider 28 – Mental Health Services Grants** - Included in the amounts appropriated above in Strategy A.1.7, Mental Health Services Grants, is \$14,178,353 in fiscal year 2020 and \$14,178,351 in fiscal year 2021 to fund mental health services provided by local juvenile probation departments. Funds subject to this provision shall be used by local juvenile probation departments only for providing mental health services to juvenile offenders. Funds subject to this provision may not be utilized for administrative expenses of local juvenile probation departments nor may they be used to supplant local funding.

- **Rider 37 - Study on the Confinement of Children with Mental Illness or Intellectual Disabilities**- Out of the funds appropriated above, the Juvenile Justice Department shall conduct a study to develop strategies to reduce the confinement of children with mental illness or intellectual disabilities. Not later than September 1, 2020, the department shall report the results of the study to the Governor, Lieutenant Governor, Speaker of the House, and each member of the Legislature.

Texas Juvenile Justice System

Recently, TJJD has actively reformed how the youth system works.⁵¹ Guided by the central principle of putting kids first, the agency has historically focused on safety and security to improve outcomes for youth. At the same time, TJJD funnels resources to probation departments, supporting models for youth with the most intense needs and implementing trauma-informed corrections across the state. Since January 2018, the main principles of developing Texas’s unique model⁵² of youth corrections have been to:

- Keep youth from engaging with the juvenile justice system if possible;
- Increase probation resources and preserve local control;
- Focus on the needs and risks of youth;
- Provide scalable, graduated options to meet youth and system needs;
- Commit to the shortest appropriate time period for youth to be in the system;
- Have youth stay as close to their communities whenever possible according to their best interests; and
- Infuse trauma-informed care throughout the system.⁵³

TJJD also partners with local juvenile justice systems across the state. At the county level, TJJD works with local juvenile boards and probation departments to enhance community-based programming, placements, and supervision. TJJD’s responsibilities in local counties include:

- Providing funding, technical assistance, and training to county justice officials;
- Establishing and overseeing standards of operation in county facilities;
- Analyzing and disseminating data to local justice boards and probation departments; and
- Facilitating communication between state and local leaders.⁵⁴

With an emphasis on rehabilitation, the juvenile system was designed to be a civil system rather than punitive like the adult criminal justice system.⁵⁵ The tables below demonstrate the difference between the juvenile and adult systems, including a point of reference for parallel terms used in the two justice systems and common definitions for terms used in the juvenile system.

Table 68. Juvenile Justice/Adult Criminal Justice Language Comparisons

Juvenile Justice Term/Concept	Analogous Adult Criminal Justice Term/Concept
Delinquent Conduct	Criminal Conduct
Take into Custody	Arrest
Petition	Indictment
Detention Hearing	Arraignment
Pre-adjudication Facility	Local Jail where Individuals are Detained Before Trial
Adjudication Hearing	Trial
Finding of "true/not true" at Adjudication Hearing	Finding of "guilt/innocence" at Trial
Disposition	Sentence
Secure Facility	Unit

Source: Texas Juvenile Justice Department. (n.d.). Definitions for Common TJJD Terms & Acronyms. <https://www2.tjtd.texas.gov/about/glossary.aspx>. Accessed 8 Apr. 2020.

Table 69. Common Juvenile Justice Definitions

Term	Definition
Juvenile	A person between 10 and 17 years old at the time he or she committed "delinquent conduct" or "conduct indicating need for a supervision" (CINS)
Delinquent Conduct	Conduct that if committed by an adult could result in prison or confinement
Adjudication	A court finding that a youth has committed delinquent conduct or CINS. Equivalent to "conviction" in adult court.
Conduct Indicating a Need for Supervision (CINS)	Conduct that if committed by an adult, could result in only a fine, or conduct that is not a violation of law if committed by an adult, e.g., truancy or running away from home.

Term	Definition
Deferred Adjudication	A youth placed under supervision, whose adjudication is deferred to a later date. A youth in compliance and successful completion of supervision may have their case dismissed.
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 & distinct due process hearings.
Determinate Sentencing	A blended sentencing system for the most serious offenses that provides the possibility of transferring juveniles on or before their 19th birthday from TJJD to the adult system in order to complete their sentence. Transfer to the adult system depends upon the youth's behavior while he or she is under TJJD's custody. If juveniles with determinate sentences are successful in their TJJD treatments, they may be allowed to transfer from TJJD to adult parole after they serve their minimum period of confinement in a juvenile detention facility. If they are unsuccessful in their treatment, they may be transferred to an adult prison. A youth may receive a determinate sentence of up to 40 years.
Indeterminate Sentencing	A type of sentence that commits a youth to TJJD for an indefinite period, not to exceed their 19th birthday.
Minimum Period of Confinement	The minimum period of time a youth with a determinate sentence must be held in a TJJD facility before he or she is eligible for parole. This is set in state law. If juveniles do not meet their minimum period of confinement before their 19th birthday, a juvenile judge may choose to waive the minimum period of confinement and allow the youth to go on adult parole, rather than serve in adult prison.
Minimum Length of Stay	Minimum period of time youth with an indeterminate sentence must stay in TJJD, as determined by TJJD policy.
Juvenile Parole	A period of supervision beginning after release from a residential program and ending with discharge from TJJD.
Juvenile Probation	A mechanism used by juvenile justice agencies that serves as a sanction for juveniles adjudicated in court. In many cases, probation is used to divert youth who have committed their first offense or a status offense away from the court system. Some communities may even use probation as a way to informally monitor at-risk youth and prevent their progression into more serious problem behavior.
Individual Case Plan	A youth's individualized plan for treatment and education, based on their specific strengths and risks.
Halfway House	A residential center where individuals who have a mental illness, use drugs, commit sex offenses, or commit felonies 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 into the community, while still providing people with monitoring and support. Placement in a halfway house is generally believed to reduce the risk of recidivism or relapse compared to a direct release into the community.

Source: Texas Juvenile Justice Department. (n.d.). Determining How Long Youth Stay in TJJD. https://www2.tjjd.texas.gov/about/how_class.aspx. Accessed 8 Apr. 2020.

TJJD BED CAPACITY ADJUSTMENTS

- In August 2019, TJJD operating capacity decreased by 24 beds due to the closure of the Cottrell halfway house.
- In June 2018, TJJD operating capacity decreased by 149 beds. This was due to the transfer of the ownership of the Corsicana facility to the City of Corsicana.
- In September 2018 TJJD operating capacity decreased by 319 beds. This was due to the reduction in capacity at the Corsicana facility (49 beds), Giddings facility (46 beds), McLennan facility (120 beds), Ron Jackson I facility (16 beds halfway houses (40 beds), and contract residential placements (48 beds).⁵⁶

TJJD STRATEGIC PLAN

In June 2018, TJJD approved a new strategic plan for fiscal years 2019-23.⁵⁷ The plan included four goals:

1. Improve current operations at secure facilities.
2. Develop and implement a fully trauma-informed system.
3. Improve cross-functional collaboration and local control.
4. Deliver the Texas Model across the state.

The Texas Model, as articulated in a plan issued shortly before the strategic plan, includes both principles for designing the juvenile justice system and principles for programmatic interventions.

System Principles:

- A focus on need and risk levels of youth;
- A graduated set of options to meet youth and system needs, which may change over time;
- A greater focus on a single juvenile justice system as a partnership between county juvenile probation departments and TJJD;
- A commitment to the shortest appropriate length of stay;
- Youth stay closer to their communities in every possible case;
- Keep youth from engaging far into the juvenile justice system if possible; and
- Provide for scalability to meet changing or emerging needs⁵⁸
- Intervention Principles:
 - A foundation in trauma-informed care;
 - A treatment-rich environment and direct-care staff who reinforce treatment goals;
 - An approach grounded in evidence-based practices; and
 - Transparent plans between agency and youth to understand requirements and the consequences of their actions—both positive and negative—with strong accountability

HOW JUVENILES MOVE THROUGH THE JUVENILE JUSTICE SYSTEM

Texas youth who move through the entire juvenile justice system typically encounter these six major steps:

- Step One: Taken into custody by local law enforcement or referral to juvenile probation;
- Step Two: Disposition by a county juvenile court judge;
- Step Three: Fulfillment of a disposition (i.e., sentence) in a state-level facility (e.g., a detention center or halfway house), county-level facility, and/or in the community, depending upon the juvenile's committing offense and judicial discretion;
- Step Four: Appraisal by the TJJD Release Review Panel (for youth committed to a secure state-level facility);
- Step Five: Completion of parole supervision; and
- Step Six: Discharge from TJJD.

Diversion from the juvenile justice system and to community-based services is possible before any of these steps. Diversion is increasingly a focus for all youth, particularly for youth with significant trauma histories and behavioral health needs.

For more information on diversion, see the “Local Criminal Justice Systems” section in the TDCJ chapter of this guide.

The following section will describe each of the six steps in greater detail.

STEP ONE: TAKEN INTO CUSTODY OR REFERRAL TO JUVENILE PROBATION

In 2018, law enforcement agencies in the U.S. made an estimated 728,280 arrests of persons under age 18.⁵⁹ In 2018, Texas law enforcement officers made 41,208 juvenile arrests.⁶⁰ The vast majority of juveniles who come into contact with the justice system commit low-level offenses. In Texas, 59 percent (24,388) of juvenile arrests were for nonviolent offenses such as larceny-theft, motor vehicle theft, running away from home, alcohol and drug violations, and violations of curfew and loitering laws.⁶¹ The table below shows the top five arrest categories with the most common offenses for which youths are taken into custody.

Table 70. Top Five Arrest Categories for Texas Youth

Offense	Classification	Total Arrests in 2018
Non-aggravated assault	Misdemeanor	10,216
Larceny-theft (excluding motor vehicle)	Depends on the value of the property (Adult values over \$1500 are felonies)	5,319
Marijuana	Depends on weight in possession (Adult amounts over 4 oz. are felonies)	4,475

Curfew and Loitering Law Violations	Misdemeanor	1,624
Other offenses (excluding traffic violations)	Misdemeanor	8,152

Source: Texas Department of Public Safety. 2018 Crime in Texas Report: Texas Arrest Data. Page 68. <https://www.dps.texas.gov/crimereports/18/citCh9.pdf>. Accessed 10 Apr. 2020.

Many Texas youth have mental health needs at the time of their arrest. A 2011 study of youths who were either at a TJJD facility or in a juvenile probation program found that 38 percent had a mental health condition or emotional disturbance.⁶²

Both TJJD and the court system have recognized that treating mental health conditions is critical to helping youth development, including getting an education in the community safely.⁶³

Youth with mental illness are three times more likely than their peers to be arrested before graduating high school.⁶⁴ These youths are more likely to face official charges than others once they make contact with law enforcement, including the charges listed in the table above.⁶⁵ Other youth become involved in the justice system without receiving a formal charge; they are routed to the justice system in order to receive treatment or to manage disruptive behaviors that result from unidentified mental health conditions.⁶⁶

In Texas, a peace officer that decides to take a youth into custody may:

- Transport the youth to an official juvenile processing office, where he or she may be kept for up to six hours⁶⁷;
- If believing the youth to be a truant, take the youth into custody for the purpose of returning him or her to the appropriate school campus if the school agrees to assume responsibility for the youth for the remainder of the day⁶⁸;
- Return the youth to a parent or other responsible adult; or
- If the youth is not released to a parent or guardian, transport the youth to the appropriate juvenile detention facility⁶⁹.

STEP TWO: JUVENILE COURTS, DISPOSITIONS, AND PLACEMENTS

Following an arrest, juveniles are taken to a county juvenile probation department for the intake and assessment process. Afterward, most youth are released to a parent or guardian as they await more information about their disposition.⁷⁰ Other youth may be diverted away from the justice system and into community-based programs. Alternatively, their cases may be dismissed entirely. Youth who are not diverted or released to a caretaker must appear before a juvenile court judge within 48 hours of intake.⁷¹

A juvenile court judge typically makes a determination on whether a youth's case can be handled informally or if the youth must be placed under TJJD custody. For example, a juvenile court judge can allow the youth to remain in their community on a deferred prosecution.

Specialty courts serve a small number of youth by aiming to address the underlying

causes of juvenile justice involvement. Specialty courts often operate as one piece of a larger continuum of diversion services for youth with behavioral health conditions. The most common specialty courts for juveniles are drug courts and mental health courts. Both types of courts utilize individual treatment plans, case management, and judicial supervision to link youth to treatment services in the community rather than place them in a secure facility.

Juvenile Drug and Mental Health Courts

As of April 2020, there were 336 juvenile drug courts nationwide⁷², with 11 in Texas.⁷³ Currently, Texas has five counties that operate juvenile mental health courts: Dallas, Denton, El Paso, Harris, and Jefferson.⁷⁴ A 2011 evaluation of Texas specialty courts found that mental health courts are an effective alternative to placement in psychiatric hospitals and detention facilities because treatment-oriented court teams effectively address criminogenic risk factors, such as family poverty.⁷⁵ In 2015, researchers also demonstrated that individuals who participate in juvenile mental health courts experience improved psychiatric outcomes, significantly fewer rearrests, and less re-convictions than their peers with similar criminal histories.⁷⁶ Although the courts produce positive outcomes, recent data also show racial and gender disparities in access to this diversion strategy.⁷⁷ Further, attempts to gather data on the number of youth who are served within these resource-intensive programs compared to those who could potentially benefit from such services, demonstrate the need for improved data collection and analysis among existing specialty court programs.

STEP THREE: FULFILLMENT OF A DISPOSITION

If a youth is adjudicated for delinquent conduct, the youth may be placed on probation or sent to detention in a county or state facility. Placements within a detention facility are reserved for high-risk youth who judges determine need intensive intervention. Since 2007, only juveniles who commit felonies are eligible for placement in state secure facilities, while youth who commit misdemeanors must be kept in county-level facilities or in their home communities.⁷⁸ Youth who are adjudicated for certain serious offenses may receive a determinate sentence and possible transfer to adult prison depending on the youth's behavior and progress while placed in a TJJD facility.⁷⁹

Between 2007 and 2018, TJJD relied more heavily on community-based interventions for youth, causing the average daily population within residential facilities to decrease by over 80 percent.⁸⁰

Admission into a TJJD secure facility is one of the most serious placements for a juvenile in Texas. However, Texas law also allows courts to certify youth who are over the age of 13 as adults and transfer them to the adult criminal justice system. In theory, juveniles who commit the most serious offenses, such as murder, may get sent to adult criminal court. In practice, data show that the primary difference between assignment to the juvenile or the adult system is the county of conviction, not the youth's offense history.⁸¹ In a 2011 study, researchers found that court officials in six counties (Harris, Jefferson, Hidalgo, Nueces, Lubbock, and Potter) disproportionately chose to certify youth as adults, instead of giving juveniles

determinate sentences.⁸² In 2017, Harris County certified 23 youth (and declined to certify 7 youth), a 39 percent decrease from 2016.⁸³

The table below shows the number of referrals and dispositions for youth involved in the juvenile justice system in FY 2017. For more information about secure placements and the behavioral health treatments available to youth within these placements, see the “Behavioral Health Services in State Secure Facilities” section of this chapter.

Table 71. Referrals and Dispositions of TJJD Youth in 2017 through 2019

Referrals and Dispositions	FY 2017	FY 2018	FY 2019	Change
Formal Referrals to Juvenile Probation Departments	53,860	53,228	53,152	-1.3%
Juveniles Referred	38,677	38,912	38,503	-0.4%
Total Dispositions	55,110	55,185	53,795	-2.4%
TJJD Commitment Dispositions	819	758	735	-10.2%
Adult Certification Dispositions	138	156	145	+5.1%

Sources: Texas Juvenile Justice Department. (December 2018). Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. Page 13. <http://www.tjjd.texas.gov/index.php/doc-library/send/615-archive/1591-tjjd-annual-report-to-the-governor-and-legislative-budget-board-2018>

Texas Juvenile Justice Department. (December 2019). Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. Page 13. <http://www.tjjd.texas.gov/index.php/doc-library/send/338-reports-to-the-governor-and-legislative-budget-board/2285-tjjd-annual-report-to-the-governor-and-legislative-budget-board-2019>

Note: The “formal referrals” data includes the total number of times youth were referred to juvenile probation departments. The “juveniles referred” data includes the total number of youth who were referred to probation. Because one juvenile can be referred to the department more than once, the “formal referrals” data point is greater than the “juveniles referred” data point.

STEP FOUR: APPRAISAL BY TJJD REVIEW PANEL

After juveniles with indeterminate sentences complete their minimum length of stay within a TJJD facility, officials on TJJD’s Release Review Panel assess each youth’s progress. The three-member panel examines the youth’s behavior, educational accomplishments, and response to behavioral health treatments to determine if the youth can be served safely in the community.⁸⁴

STEP FIVE: COMPLETION OF PAROLE SUPERVISION OR EXTENDED STAY IN TJJD FACILITY

The Release Review Panel may choose to release the youth into the community on parole or extend their stay within a TJJD facility. In FY 2018, the Release Review Panel extended juveniles’ stays within secure facilities 63.4 percent of the time. Within those extension decisions, about 13.2 percent of the juveniles had moderate mental health needs and about 26.8 percent had high substance use treatment needs.⁸⁵

Most youth paroled from a TJJD facility are supervised by a TJJD parole officer. There are 32 statewide parole officers located at offices in key population centers across Texas. In addition to in-person visitation, they also engage with some youth and families in rural and remote areas pre- and post- release through virtual visits via videoconferencing. A small proportion (roughly 9 percent) of youth are supervised through contracts with probation staff in rural juvenile probation departments; these probation officers will typically have a caseload of 2-3 youth paroled from TJJD as well as a traditional probation caseload. Some counties have enough youth to support officers solely dedicated to TJJD youth on parole.

TJJD parole officers are in the preliminary stages of being trained in Effective Practices in Community Supervision (EPICS), an evidence-based approach designed to shift supervisory interactions from a confrontational nature to a relationship-building approach grounded in fairness, trust, and an authoritative (not authoritarian) style.⁸⁶ Using EPICS, each meeting between a parole officer and a youth includes four steps: check-in, review, intervention, and homework. Typical interventions are evidence-based and may be designed to develop motivational skills, problem-solving skills, or cognitive behavioral skills. TJJD reports that EPICS' foundation of positive relationships is complementary to TJJD's implementation of Trust-Based Relational Intervention.⁸⁷

STEP SIX: DISCHARGE FROM TJJD

When juveniles successfully complete their dispositions, TJDD may discharge them from custody. Juveniles are typically discharged when 1) they finish their treatment program, 2) they turn 19 and are no longer under TJJD's jurisdiction, or 3) they received a determinate sentence and are transferred to the adult justice system in order to complete their sentence. Similar to justice-involved adults, justice-involved youth with mental health conditions often face challenges upon reentry, including stigma and discontinuity of care.

THE OFFICE OF THE INDEPENDENT OMBUDSMAN

In 2007, following highly publicized allegations of abuse within a state secure facility, the 80th Texas Legislature created the Office of the Independent Ombudsman as a separate state agency responsible for investigating, evaluating, and securing the rights of youth committed to TJJD.⁸⁸ The independent ombudsman (IO) is responsible for investigating a variety of complaints including medical and mental health concerns, abuse allegations, and suicidal ideation and attempts.

During the 84th legislative session, lawmakers expanded the IO's oversight duties as part of a broader reform to the juvenile justice system. The IO's responsibility for inspecting state-level secure TJJD facilities, halfway houses, state contract care facilities, and parole offices was expanded to include county-level post-adjudication facilities and contract facilities where county post-adjudicated youth are placed.⁸⁹ The IO receives the majority of complaints directly from youth while inspectors visit state secure facilities and county post-adjudication facilities.⁹⁰ The table below summarizes the IO's activities during FY 2019 compared to earlier periods.

Table 72. Independent Ombudsman Activities

Activity	FY 18, Q3 ⁹¹	FY 19, Q3 ⁹²	FY 17 ⁹³	FY 18 ⁹⁴	FY 19 ⁹⁵
Site Visits (TJJD/Contract)	60	59	232	222	226
Site Visits (County Post-Adjudication/Contract)	70	75	474	347	282
Number of Youth Interviewed	1147	1132	3137	3253	3055
Number of Youth Interviews Conducted	1368	1394	6742	5598	5409
Closed Cases	9	14	145	106	52

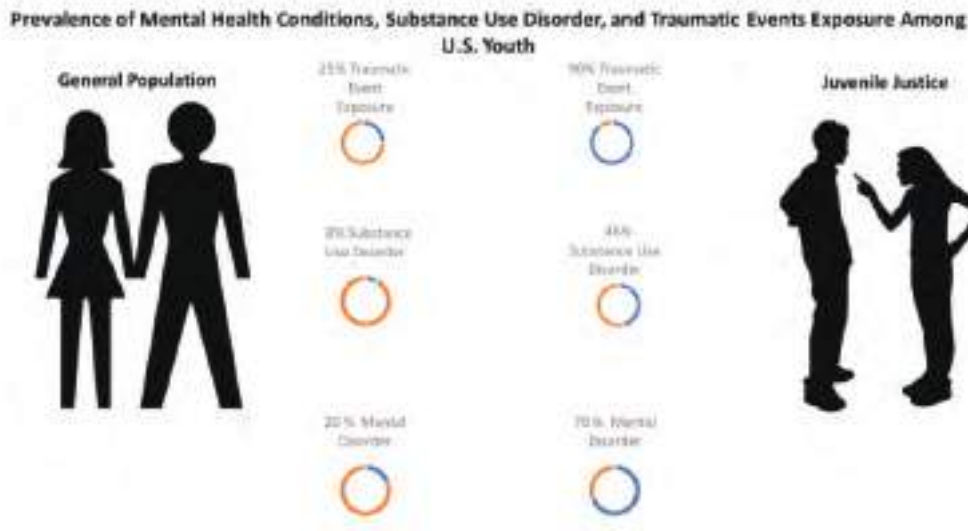
Source: See endnotes 93, 94, 95, 96, and 97.

JUVENILE JUSTICE, MENTAL HEALTH, AND SUBSTANCE USE CONDITIONS

Other than serious violent behavior, youth are processed in a separate justice system rooted in different premises about adolescent behavior compared to the adult criminal justice system focused on adult behavior. In recent decades, significant advances in developmental and brain science have been cited as support for changes in juvenile justice policy. Research documents differences in adolescents' decision-making capacity, risk taking, self-regulation, ability to delay gratification, and vulnerability to external pressure.⁹⁶ While these studies are not probative in any specific case, the research is used in many localities to support emergent juvenile justice policies.

Youth in the juvenile justice system are more likely to have mental health and substance use conditions than youth in the general public. Researchers estimate that about 70 percent of justice-involved youth have a mental illness, while 60 percent of justice-involved youth have a co-occurring mental illness and substance use condition.⁹⁷ The figure below shows a side-by-side comparison of mental health needs for youth in the general population and youth in the juvenile justice population.

Figure 104. Prevalence Data for U.S. Youth – Mental Health/Substance Use/Traumatic Events



Source: National Center for Mental Health and Juvenile Justice & the Technical Assistance Collaborative. (2015). Strengthening Our Future: Key Elements to Developing a Trauma-Informed Juvenile Justice Diversion Program for Youth with Behavioral Health Conditions. Page 1. <https://www.ncmhjj.com/wp-content/uploads/2016/01/traumadoc012216-reduced-003.pdf>. Accessed 11 Apr. 2020.

According to the Office of Juvenile Justice and Delinquency Prevention (OJJDP), a large proportion of youth in the juvenile justice system have a diagnosable mental health condition. Studies have suggested that about two-thirds of youth in detention or correctional settings have at least one diagnosable mental health problem⁹⁸ With these rates of mental illness, OJJDP estimates that more than 670,000 youths in the juvenile justice system each year would meet diagnostic criteria for one or more conditions.⁹⁹

Approximately 70 percent of justice-involved youth around the country have a diagnosable mental health condition.¹⁰⁰ In FY 2017, 99 percent of Texas youth committed to TJJD had a need for specialized mental health treatment, with 40 percent having at least a moderate level of need.¹⁰¹ The prevalence of substance use conditions is also high among youth in the juvenile justice system. A large multi-state study found a substance use diagnosis in 17 percent of youth at the point of intake, 39 percent at detention, and 47 percent at commitment to a secure facility post adjudication.¹⁰² In Texas, 78 percent of youth committed to TJJD in FY 2017 had a high or moderate need for substance use treatment.¹⁰³

Each year, millions of children are exposed to violence in their homes, schools, and communities. Left unaddressed, these traumatic experiences can lead to mental health and substance use conditions, school failure, increased risk-taking, and delinquent behaviors.¹⁰⁴ Forty percent of justice-involved adults have been exposed to family violence by the time they reach adolescence. Some estimates show up to 75 percent of incarcerated men and women have experienced violence, abuse, or childhood neglect.^{105 106}

The Texas Penal Code (Section 22.04) defines a person with a disability (statutorily referred to as “disabled individual”) broadly as a person with mental illness, autism spectrum conditions, a developmental disability, an intellectual disability, severe emotional disturbance, traumatic brain injury, or a person “who otherwise by reason of age or physical or mental disease, defect, or injury is substantially unable to protect the person’s self from harm or to provide food, shelter, or medical care for the person’s self.”¹⁰⁷ Thus, by statutory definition, any youth who has sustained brain injury trauma legally has a disability. Recent meta-analyses also demonstrate that between 30 percent and 60 percent of justice-involved youth have experienced a traumatic brain injury.¹⁰⁸ After sustaining a brain injury, juveniles are more likely than their uninjured peers to engage in delinquent activity.¹⁰⁹

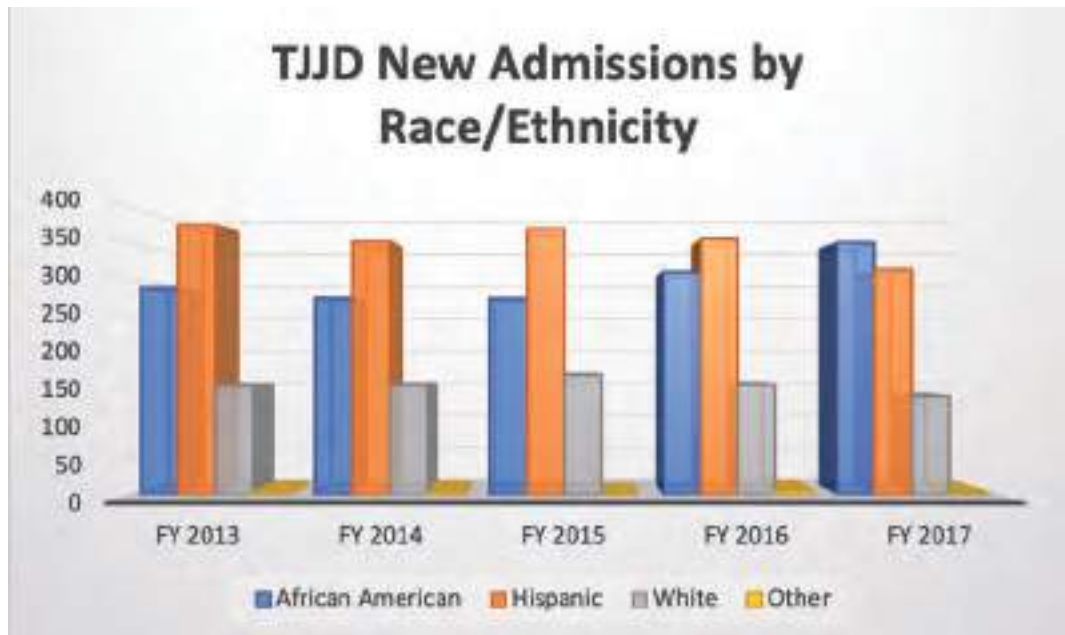
DISPROPORTIONALITY IN THE TEXAS JUVENILE JUSTICE SYSTEM

Black and Latinx youth tend to fare worse than their White peers throughout the juvenile justice process.¹¹⁰ For example, nationwide African American juveniles are more likely than White youth to be arrested, referred to juvenile court, sent to secure confinement facilities, and certified as adults.¹¹¹

The relationship between school disciplinary procedures and risk of juvenile justice contact, also known as the “school-to-prison pipeline” is the direct link to disproportionality in the juvenile justice system.¹¹² In 2014, the U.S. Department of Education reported that, though youth of different races misbehave at similar rates, minority youth are more likely to be suspended and expelled from school.¹¹³ In Texas, researchers found that after controlling for 83 different variables, African American youth are 31 percent more likely than their White and Hispanic peers to receive a disciplinary action for a discretionary violation (e.g., a behavioral violation for which school administrators have the discretion to remove a student from the classroom environment, though they are not required to do so).¹¹⁴ Such disparities in school discipline place youth of color at greater risk for becoming involved in the juvenile justice system in the future.¹¹⁵

In 2015, researchers at the Council of State Governments Justice Center analyzed Texas juvenile justice reforms. Their study found that African American youth continue to make up a disproportionate share of commitments. The reforms did not appear to disproportionately exacerbate minority contact, alternatively they did not alleviate disparities.¹¹⁶ The figure below shows that from 2013 to 2017, the proportion of African American and Latinx youth newly admitted to TJJD was significantly higher than their White peers.

Figure 105. TJJD Admissions



Source: Texas Juvenile Justice Department. Youth Characteristics. New Admissions FY 2013-FY 2017. <https://www2.tjtd.texas.gov/statistics/youth-characteristics1317.pdf>. Accessed 16 Apr. 2020.

The former Office of Minority Health Statistics and Engagement (OMHSE) was mandated to research, evaluate, develop, and recommend policies that address minority health (including in juvenile justice) to ensure equitable policies and practices in Texas. However, the OMHSE closed on September 1, 2018. Created in 2010 as the Center for Elimination of Disproportionality and Disparities, OMHSE was unique in its ability to look at systems data and identify where things weren't working for certain populations. Currently, there is no office charged with specifically addressing disproportionality in the juvenile justice or any other Texas agency.¹¹⁷ Thus, disproportionality in Texas's juvenile system continues despite overall youth population numbers declining.¹¹⁸

Community-Based Behavioral Health Services for Justice-Involved Youth

TJJD, local juvenile probation departments, and Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) provide services for youth with mental health and substance use conditions in a variety of juvenile justice settings, including: state secure facilities, secure residential treatment centers, and county secure facilities. The agencies also provide services for youth who are under probation or parole supervision in the community.

A growing proportion of Texas justice-involved youth require and receive behavioral health services. In 2017, 99 percent of the newly-admitted youth to TJJD required

at least one area of specialized mental health or substance use treatment and 87 percent had multiple areas of need.¹¹⁹ For youth admitted since FY 2009 and released by FY 2016, 61.5 percent of youth with high or moderate mental health needs successfully completed treatment.¹²⁰ Over the last decade Texas closed eight state secure juvenile facilities; TJJD shifted from an agency focused on operating state juvenile correctional facilities to an agency devoting the majority of its budget to local juvenile probation departments for community supervision and services.¹²¹ Minimizing juveniles' immersion in the justice system is the top priority in the TJJD 2017-21 strategic plan.¹²² Diverting youth with mental health conditions from incarceration and further involvement in the juvenile justice system has significant health and economic benefits. Youth who receive mental health and substance use services in the community can have the support of family and friends rather than being in an institution. Treatment is more affordable in the community compared to services within a juvenile justice facility. The FY 2019-23 strategic plan prioritizes spreading the Texas Model statewide, focusing on keeping youth as shallow as possible in the system and close to their communities, family members, friends, and support systems.¹²³

In 2015, TJJD began funding counties to ensure youth in the system stayed as close to home as possible. SB 1630 (84th Whitmire/Turner), mandated TJJD funding to shift to regionalization. The legislation also created a task force that found medium- and low-risk youth had been committed to TJJD because of high needs for specialized treatment.¹²⁴ The task force's Regionalization Plan noted a need to prioritize diverting the following youth from TJJD commitment:

- Younger offenders (those between the ages of 10-12);
- Youth with a serious mental illness;
- Youth with a developmental or intellectual disability;
- Youth with non-violent offenses; and
- Youth with low- to moderate-risk levels for re-offense.

The plan anticipates youth's specialized treatment needs and supports, encouraging counties to build out services to meet those needs. Further, the plan highlights that increasing services will ensure more youth with high- and moderately high-risk mental health and substance use needs can also be diverted from further system involvement.

NEED FOR BEHAVIORAL HEALTH SERVICES THROUGH JUVENILE PROBATION DEPARTMENTS

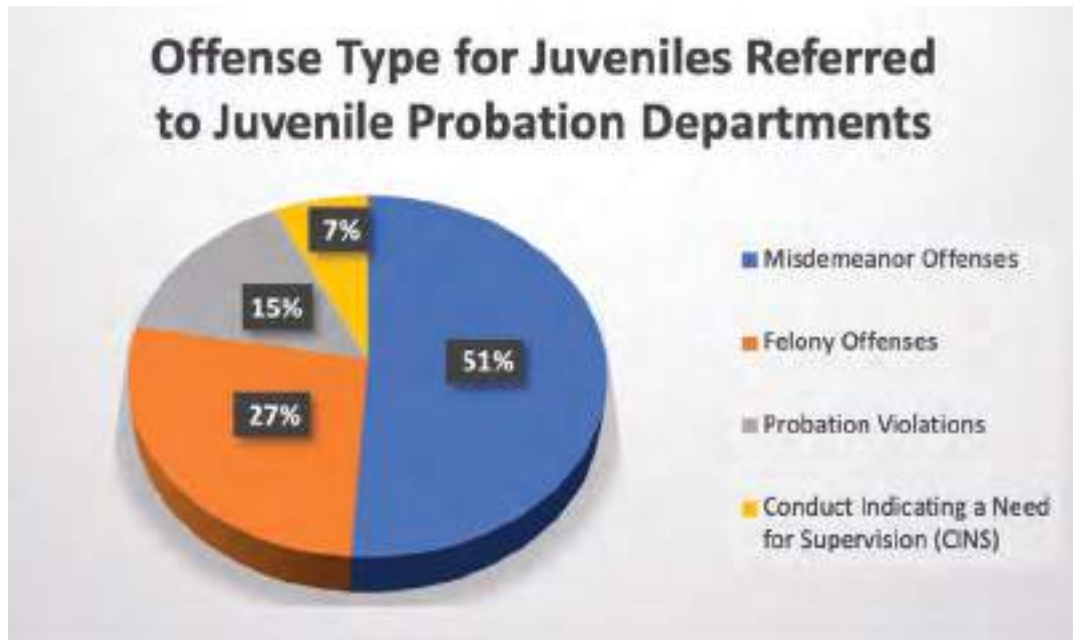
The recent juvenile justice state reforms focus on the concept that youth are different than adults, are still developing brain functionality, and are therefore less culpable. Youth are more impulsive, risk-taking, and less likely to consider the long-term consequences of their actions.¹²⁵ However, youth are also more susceptible to rehabilitation than adult offenders due to their age-associated brain development.¹²⁶

TJJD's Probation Services Division works with probation departments across the state to enhance the services offered to local youth referrals. The division works in all areas of juvenile justice by facilitating quality interaction between juvenile

boards, juvenile probation departments, and other divisions within TJJD. As a liaison between TJJD and the field, the Probation Services Division is a resource for the continued success of the departments and TJJD.¹²⁷

In FY 2018, juvenile probation departments received 53,228 formal referrals throughout the state, representing only a one percent drop from FY 2017.¹²⁸ Just over a quarter (27 percent) of referrals were for felony offenses. The figure below shows the type of offenses that precipitated referrals to juvenile probation departments.

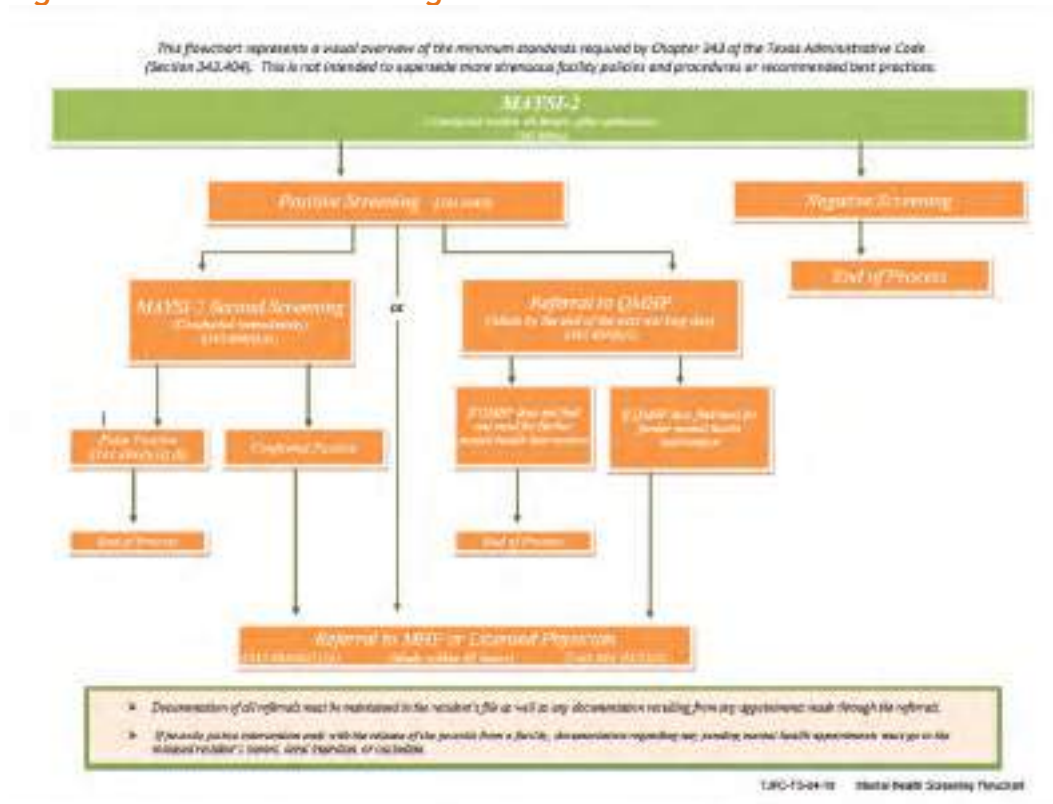
Figure 106. Offense Types for Juveniles Referred to Juvenile Probation



Texas Juvenile Justice Department. (December 2018). Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. Page 12. <https://www2.tjtd.texas.gov/publications/other/rider-report-2018.pdf>. Accessed 18 Apr. 2020.

Required by state law, local juvenile probation departments must screen all youth for mental health needs within 48 hours of the juvenile's admission to a pre- or post-adjudication facility using the Massachusetts Youth Screening Instrument (MAYSI-2).¹²⁹ If a screening indicates that further assessment is appropriate, local juvenile probation departments must either: 1) conduct a second screening and refer the youth to a licensed physician within 48 hours, or 2) forgo a second screening and refer youth to a qualified mental health professional by the end of the next working day.¹³⁰ The flowchart below demonstrates the steps taken to screen youth for mental health needs as they are referred to probation departments.

Figure 107. Probation Screening for Mental Health Conditions



Source: Texas Juvenile Justice Department. (2010). Mental Health Screening Flowchart. <http://www.tjjd.texas.gov/index.php/doc-library/category/161-monitoring-inspections>. Accessed 18 Apr. 2020.

In FY 2018, 68 percent of youth under supervision by probation departments received at least one behavioral health service.¹³¹ Texas counties vary in their capacity to identify and address youth with mental health needs. Though there is a high prevalence of mental health needs among justice-involved youth, few juveniles access mental health services prior to entering the justice system. Unfortunately, many youth experience mental health treatment for the first time after they have been arrested, adjudicated, or diverted to mandated community treatment programs.

PARTNERSHIP WITH TEXAS CORRECTIONAL OFFICE FOR OFFENDERS WITH MEDICAL AND MENTAL IMPAIRMENTS (TCOOMMI)

County juvenile probation departments may partner with TCOOMMI, LMHAs, or Community Resource Coordination Groups (CRCGs) to provide justice-involved youth with behavioral health services. CRCGs are local interagency groups comprised of public and private entities that coordinate service delivery for juveniles across the state.¹³²

Youth with mental health and substance use needs may receive services for a variety of reasons. Some youth may be diverted from the probation system to

receive mandated behavioral health services. Judges could also offer youth deferred adjudication and order treatment as a condition of dismissing each juvenile's charges. Youth who are adjudicated and placed on probation may be required to participate in either residential or community-based programs, such as counseling or substance use treatment. Youth returning to the community after placement in a secure community or state facility may receive treatment as a condition of parole.

TCOOMMI coordinates continuity of care for some youth with a mental health diagnosis released on parole following their placement in a state or county secure facility. In March 2020, the average daily population on juvenile parole in Texas was 278 youth.¹³³ Depending on fluctuating needs, the state may place paroled youth with a mental illness outside of their homes in community-based therapeutic foster homes, group living arrangements, or residential treatment facilities. Some youth receive intensive and collaborative wrap-around services that may include collaborative case planning, skills training and education, psychiatric services and medication monitoring, individual and/or group therapy, early intervention, vocational services, benefits eligibility services, and parental support and education.¹³⁴ TCOOMMI also participates in the Texas System of Care and the statewide Community Resource Coordination Group Committee to address systems issues. The table below outlines TCOOMMI eligibility criteria.

Table 73. Eligibility Criteria for TCOOMMI Services

Age at Time of Release or Discharge	Eligibility Criteria
17 or younger	<ul style="list-style-type: none"> • Current or prior diagnosis of conduct disorder and one or more of the following diagnosis: intellectual disability, autism spectrum disorder, pervasive developmental disorder, attention-deficit/hyperactivity disorder, mood disorder, depression, anxiety, bipolar disorder, intermittent explosive disorder, psychotic disorder, schizophrenia spectrum, schizoaffective disorder, adjustment disorders, or similar diagnoses; or • Current prescription for psychotropic medication; or • Currently receiving care from a mental health professional or psychiatric provider or in the past six months had been under the care of a mental health professional or psychiatric provider; or • Currently assigned to the McLennan Residential Treatment Center or Ron Jackson Mental Health Treatment Program; or • Other clinical justifications (e.g., history of admission to psychiatric hospital or diagnosed with possible traumatic brain injury); or • Current complex and severe medical condition(s).
18	<ul style="list-style-type: none"> • Current or prior diagnosis of major depression, bipolar disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder, psychotic disorder, anxiety disorder, delusional disorder, or another mental health disorder that is severe or persistent in nature; or • Current prescription for psychotropic medication; or • Current complex and severe medical condition(s); or • Other clinical justifications (e.g., recent admission to psychiatric hospital).

Source: Texas Juvenile Justice Department. (2018, September 21).

COMMUNITY-BASED PROGRAMS AND SERVICES

In 2010, TJJD created its online Program and Services Registry to manage information about community-based programs.¹³⁵ The registry catalogues all active community-based programs offered by various juvenile probation departments statewide. Both juvenile probation departments and contracted agencies provide information regarding the service components of active programs, including their duration, funding, and eligibility requirements.¹³⁶

In FY 2018, local juvenile probation departments offered 1,448 community-based programs to at-risk youth, justice-involved youth, and their families.¹³⁷ These programs involved a wide array of services including counseling services, gang intervention programs, parenting classes, and employment training. In FY 2018, 34 percent of youth participants were enrolled in a treatment-based program, 39 percent were enrolled in a skill-building/activity-based program, and 27 percent were enrolled in a surveillance-based program.¹³⁸

Juvenile probation departments do not always wait until disposition to enroll a juvenile in needed programming. Across the state, 713 programs allow juveniles who are awaiting disposition to participate in programs. Of the juveniles enrolled in a predisposition program, 6,210 (55 percent) were under temporary pre-court monitoring or conditional pre-disposition supervision in FY 2018.¹³⁹

Of the juveniles served in a community-based program during FY 2018, a majority (76 percent) were under deferred prosecution or probation supervision. Half of the juveniles under deferred prosecution or probation supervision and enrolled in programming were referred for class A or B misdemeanor offenses (50 percent), while 45 percent were referred for felony offenses.

Community-based programs are not dispersed evenly across the state's 168 juvenile probation departments. The availability of community-based programs depends upon local county resources and the unique needs of youth in a particular community.¹⁴⁰ Historically, smaller probation departments offer an average of five programs per department. However, smaller departments often lack targeted programs such as mental health courts or runaway programs that are typically available in larger counties. Smaller departments provide counseling and educational programs designed to serve the needs of a wide array of juveniles, not only those with more specific behavioral health needs.¹⁴¹

The duration of community-based programs also varies widely between counties. Some programs last one afternoon while others can last the entirety of a juvenile's supervision period. The table below lists the average duration of service for community-based programs. Programs with behavioral health components as determined by a 2013 evaluation are listed on the left, all other programs on the right.

Table 74. Program Duration

Program Type	Days in Program	Program Type	Days in Program
Counseling	109	Parenting/Program for Parents	172/57
Cognitive Behavioral Therapy	70	Sex Offender Treatment	353
Mental Health Court	170	Substance Abuse Prevention	85
Mental Health Programming	161	Gang Prevention/Intervention	103
Substance Abuse Treatment	109	Anger Management	64
Drug Court	243	Life Skills	70

Source: Texas Juvenile Justice Department. (2013). Community-Based Program Evaluation Series: Overview of Community-Based Juvenile Probation Programs. Page 5. <https://www2.tjtd.texas.gov/statistics/CommunitybasedJuvenileProbationPrograms.pdf>

SPECIAL PROGRAMS AVAILABLE TO LOCAL JUVENILE PROBATION DEPARTMENTS

TJJD partially funds programs in local juvenile probation departments through diverse initiatives and grants. The programs aim to keep youth out of state-operated secure facilities and instead serve them in their local communities. The following section describes a variety of programs with behavioral health components that are available to local juvenile probation departments.

THE FRONT-END DIVERSION INITIATIVE

In 2008, TJJD used MacArthur Foundation funding to develop the Front-End Diversion Initiative (FEDI) in partnership with local probation departments to divert youth away from the justice system before they are formally adjudicated.¹⁴² FEDI links youth with mental health needs to specialized juvenile probation officers (SJPOs) with comprehensive training on mental illness, family engagement, de-escalation, and problem-solving techniques.¹⁴³ For approximately three to six months, SJPOs meet with enrolled juveniles and their families on a weekly basis to fulfill each youth's crisis stabilization plan and connect juveniles to community resources. After the supervision period, juveniles, their families, and their SJPOs create an aftercare plan that outlines ongoing support systems that youth may use once they formally exit FEDI.¹⁴⁴

Five Texas counties implemented FEDI programs: Bexar, Dallas, Lubbock, Travis, and Harris.¹⁴⁵ In 2014, the National Institute of Justice designated FEDI as a "Promising Program" for its successes with pre-adjudicated youth.¹⁴⁶ Some of FEDI's successes include:

- Within 90 days of supervision, FEDI participants were 11 times less likely to be adjudicated than their peers who received traditional supervision services.¹⁴⁷
- Four FEDI sites (Austin, Dallas, Lubbock, and San Antonio) reported a 0 percent

turnover rate among SJPOs, while most juvenile probation departments reported a 35 percent turnover rate over four years.¹⁴⁸

- FEDI officers engaged in over 10 times more collateral contacts in the community than traditional probation officers did, leading participants to use more community services than other justice-involved youth.¹⁴⁹

The figure below illustrates the difference in the use of community services among youth enrolled in the FEDI program and youth receiving traditional supervision services.

Figure 108. Access to Community Services



Source: National Center for Mental Health and Juvenile Justice. (2015). Diverting Youth at Probation Intake: The Front-End Diversion Initiative. Page 5-6. <https://www.ncmhjj.com/wp-content/uploads/2016/02/FEDI-ARIAL-508-final.pdf>. Accessed 20 Apr. 2020.

THE SPECIAL NEEDS DIVERSIONARY PROGRAM

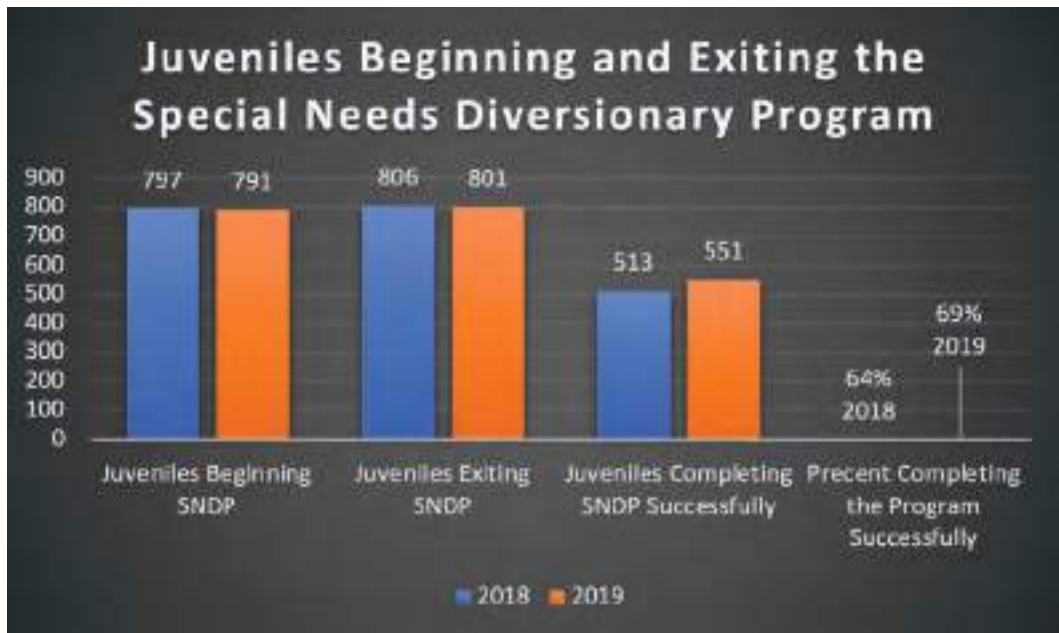
Through the Special Needs Diversionary Program (SNDP), TJJD and TCOOMMI seek to rehabilitate and prevent future justice involvement among post-adjudication youth with diagnosed mental health conditions (excluding substance use conditions, intellectual disabilities, autism, and pervasive development conditions).¹⁵⁰

Specialized probation officers partner with mental health professionals from LMHAs to provide diverse services, including mental health services such as individual and family therapy; probation services such as life skills training, anger management, and mentoring; and parental support and education services. The program requires in-home contact with the youth and family, small caseloads, and 24/7 access for crisis resolution services.¹⁵¹

In FY 2019, the Texas Legislature appropriated \$1,895,175 to SNDP, serving 1,208 juveniles with a diagnosed mental health need other than substance abuse, intellectual disability, or autism spectrum conditions¹⁵² in 19 local juvenile probation departments.¹⁵³ During the fiscal year, 791 juveniles began the program in the year, while 801 juveniles completed the program.¹⁵⁴

The figure below shows program details for youth in SNDP FY 2018-2019.

Figure 109. Special Needs Diversionary Program



Source: Texas Juvenile Justice Department. (2017). Special Needs Diversionary Program (SNDP) 2018-2019 Summary Requirements. Page 18. https://www2.tjtd.texas.gov/publications/standards/GrantsM/18-19_SummaryRequirements.pdf. Accessed 20 Apr. 2020.

PREVENTION AND EARLY INTERVENTION PROGRAMS

In 2011, the 82nd Texas Legislature funded prevention and intervention services to stop “at-risk behaviors that can lead to delinquency, truancy, school dropout, or referral to the juvenile justice system.”¹⁵⁵ Legislation required the services focus on youth ages 6 to 17 who are not currently receiving supervision services who are at high risk for referral to the justice system.¹⁵⁶ In FY 2017, over \$3.1 million was appropriated for prevention and early intervention services, and 35 counties were awarded funding.¹⁵⁷ The juvenile probation departments focused on providing youth with educational assistance, skills building, character development, mentoring services after school and during the summer, and skills, services, and supports to parents and guardians of at-risk youth.¹⁵⁸

In FY 2018, 35 counties received 37 grant awards totaling \$3,012,177 for early prevention and intervention programs.¹⁵⁹ During that fiscal year, 3,852 youth

participated in TJJD-funded prevention and intervention programs.¹⁶⁰ The average age of youth referred to a grant-funded prevention and intervention program was 11 years old, significantly younger than the average age of 15 years old for juveniles formally referred to juvenile probation departments in the fiscal year.¹⁶¹ Of those served in a grant-funded prevention and intervention program, 42 percent were Latinx and 14 percent were African American. Just over half (54 percent) of the youth served were male. Forty-six percent of the youth served in a prevention and intervention program were female, compared to youth formally referred to juvenile probation departments in the fiscal year, which were 28 percent female.¹⁶²

The 84th legislature required TJJD to partner with DFPS, TEA, and the Texas Military Department in the provision of juvenile delinquency prevention and intervention programs.¹⁶³ The workgroup shared key considerations:

- Truancy reform to shift dropout and delinquency prevention and provide needed intervention services.¹⁶⁴
- Active, untreated behavioral health concerns in students who drop out.¹⁶⁵
- School Districts of Innovation to provide opportunities for dropout and delinquency prevention and intervention efforts.¹⁶⁶

The table below shows available data outcomes for the past five years.

Table 75. TJJD Early Prevention and Intervention Programs, FY 2014-2018

	2014	2015	2016	2017	2018
Number of youths who started the year in the program	2,141	2,844	3,083	3,046	3,140
Percentage of youths completing the program successfully	92.7%	90.6%	90.6%	92.1%	92.0%
Percentage of eligible youth not referred to juvenile probation during program participation	94.8%	95.5%	96.7%	96.8%	Available Oct. 2020
Number of youths for whom consent was received (not unduplicated)	1,108	1,295	1,587	1,457	Available Oct. 2020
Percentage of youths with the same or fewer school absences	61.6%	61.3%	60.5%	55.5%	Available Oct. 2020
Number of youths with discipline referrals (not unduplicated)	717	792	804	857	Available Oct. 2020
Percentage of youths with the same or decreased number of discipline referrals at school	81.6%	80.1%	77.9%	80.3%	Available Oct. 2020

Source: Texas Juvenile Justice Department, Texas Department of Family and Protective Services, Texas Education Agency & Texas Military Department. (October 2019). Agency Coordination for Youth Prevention & Intervention Services. Page 8. <http://www.tjjd.texas.gov/index.php/doc-library/send/466-reports-on-coordination-for-prevention-intervention/2215-report-coordination-prevention-intervention-2019>. Accessed 11 May 2020.

COMMITMENT DIVERSION PROGRAM (GRANT C)

In 2009, the 81st Legislature created the Commitment Diversion Program (Grant C). The state provides funds through the program to local juvenile probation departments to develop community-based rehabilitative services and divert youth away from TJJD facilities.¹⁶⁷ The funds support a range of supportive services such as counseling, educational programs, life skills courses, and electronic monitoring – all of which are designed to keep youth out of state-operated facilities while maintaining public safety.¹⁶⁸

In FY 2018, 4,955 juveniles received a program, placement, or service funded at least in part by Community Diversion (Grant C) funds.¹⁶⁹ Ninety-five percent of juveniles received one type of service through the grant, while 5 percent received a combination of two or more types of services. Although juveniles on deferred prosecution supervision are eligible for Commitment Diversion services, juveniles served in the year were primarily on probation supervision (72 percent).¹⁷⁰

REGIONAL DIVERSION ALTERNATIVES PROGRAM (GRANT R)

The 84th legislature required TJJD to develop a plan focused on reducing commitments to state secure facilities by diverting youth of low to moderate risk of re-offending.¹⁷¹ Youth with a serious mental illness were highlighted as a focused population for diversion. Regional Diversion Alternative Program grants serve to reimburse juvenile probation departments on a case-by-case basis for services to divert eligible youth from TJJD secure placements.¹⁷² Departments can also apply for Grant R funds to increase availability of evidence-based, intensive community-based, residential, reentry, and aftercare programs that improve the department's capacity to treat youth locally.¹⁷³

MULTI-SYSTEMIC THERAPY (MST) FOR JUVENILE OFFENDERS

Multi-Systemic Therapy (MST) for juvenile offenders addresses the multidimensional nature of behavior problems in youth. Treatment focuses on those factors in each youth's social network that are contributing to their antisocial behavior.¹⁷⁴ MST is delivered in the natural environment, like the youth's home, school, or other location in their community. The typical duration of home-based MST services is approximately 4 months, with multiple weekly therapist-family contacts.¹⁷⁵ MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies.¹⁷⁶

The ultimate goal of MST is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources.¹⁷⁷ MST has documented positive outcomes for youth and their families who participate in the therapy. Compared to youth receiving usual-treatment services, those receiving MST were arrested about half as often in the post-treatment period. Recidivism rates were significantly less for MST-treated youth. Youth who received MST also had an average of 73 fewer days of incarceration.¹⁷⁸

Post-treatment reports of alcohol and marijuana use, and other drug use are typically less frequent among MST participants than those receiving usual-treatment services. Further, post-treatment assessments also show that family cohesion increased among families receiving MST therapy. Finally, reports of aggression with peers show a significant decrease for MST participants compared to those receiving usual-treatment services. The Judicial Commission on Mental Health’s legislative research committee recommended MST for more study and application for the upcoming 87th legislative session.¹⁷⁹

Behavioral Health Services in County-Level Secure Facilities

At the county level, juveniles may be placed in two types of secure facilities that offer behavioral health services: pre-adjudication detention and post-adjudication correctional facilities. As of April 2020, select Texas counties operated 45 secure juvenile pre-adjudication detention facilities for the purpose of detaining juveniles who are deemed unsafe or inappropriate for release back into the community while awaiting their adjudication and/or disposition hearings.¹⁸⁰ These juveniles can be detained until a juvenile judge provides a “true” or “not true” finding for each youth’s offense.

Texas also has 35 post-adjudication secure facilities operated at the county level.¹⁸¹ These facilities detain adjudicated youth who have committed offenses that are not severe enough to warrant placement in a state secure facility. They also may detain adjudicated youth who are waiting for placement in a treatment program for substance use or mental health challenges.¹⁸²

Because local juvenile justice systems rely heavily on county and local funding sources, the availability of treatment and support services varies across the state. The table below displays the number of pre- and post-adjudication facilities that offer specialized mental health, substance use, sex offense, and female-specific services. For a full listing of all county-level juvenile justice facilities and the services offered by each, visit: <https://www2.tjtd.texas.gov/publications/other/searchfacilityregistry.aspx>.

Table 76. Number of Texas Pre- and Post-Adjudication Facilities with Specific Services

Type of Service	Pre-Adjudication Facilities	Post-Adjudication Facilities
Mental Health	17	28
Substance Use	13	31
Sex Offense	7	17
Female Specific	8	16

Source: Texas Juvenile Justice Department. (n.d.). Registered Juvenile Facilities in Texas (CY2020). <https://www2.tjtd.texas.gov/publications/other/searchfacilityregistry.aspx>. Accessed 20 Apr. 2020.

Behavioral Health Services in State Secure Facilities

Texas operates six state secure facilities for youth adjudicated for felony offenses.¹⁸³ On April 20, 2020, there were 1,033 youth housed at the state's six secure facilities.¹⁸⁴ The table below details the state secure facilities. In FY 2018, 25 percent of newly-committed youth were adjudicated for high-severity crimes, such as capital offenses.¹⁸⁵

Table 77. TJJD Secure Facilities

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

Source: Texas Juvenile Justice Department. (n.d.). TJJD Facilities Address List. <https://www2.tjjd.texas.gov/aboutus/facilities.aspx>. Accessed 20 Apr. 2020.

INTAKE, ORIENTATION, AND PLACEMENT

A TJJD secure facility is the most serious place a juvenile offender can go within the juvenile system. Once in a secure facility, youth are in the care and custody of the state and are assigned to either high, medium, or low security facilities. The high security facilities are surrounded by fences with controlled, secure entrances monitored by law enforcement officers. The medium or low security facilities are not fenced.¹⁸⁶

The first step for a youth in TJJD is an orientation and assessment unit. For girls, it is at the Ron Jackson State Juvenile Correctional Complex in Brownwood, Texas. Boys go to the McLennan County State Juvenile Correctional Facility in Mart, Texas.¹⁸⁷ Prior to placement in a secure facility, each youth receives orientation and assessment services. During orientation and assessment, staff determines the strengths and needs of each youth. Medical, emotional, educational, and psychological needs are evaluated. The result for each youth is an individualized treatment plan that is evaluated and retooled as necessary while youth move through TJJD.¹⁸⁸

After orientation, youth are relocated to various state secure facilities depending upon the juvenile's specific treatment needs. Approximately 15 percent of youth are placed in a halfway house following orientation, while many other juveniles in state

custody fulfill their dispositions within secure detention facilities.¹⁸⁹

Prior to November 2013, the Ron Jackson State Juvenile Correctional Complex only served females. However, the facility transitioned from an all-girls complex to a co-ed complex in order to make more efficient use of the facility's existing bed space. Programming and services at Ron Jackson are designed to be similar to those offered at the McLennan County Residential Treatment Center but are modified to reflect the unique needs of female youth.¹⁹⁰

In October 2014, the Ron Jackson complex created a male intake unit for boys under 15 years old. Children under 15 who have been committed to a state secure facility remain at the Ron Jackson facility until they are about 14 years old.¹⁹¹ At that time, TJJD and juvenile court stakeholders may choose between three courses of action depending upon the individual child's treatment needs:

1. The child may remain at Ron Jackson to finish his or her assigned sentence;
2. The child may be sent to another secure facility that can meet his or her treatment needs; or
3. The child may be transferred to a halfway house or to the community if TJJD staff members determine that release is both safe and clinically appropriate.

REHABILITATION AND SPECIALIZED TREATMENT PROGRAMS

All six state secure facilities use a multi-faceted rehabilitation program called CoNEXTions, which provides life skills training, education, and workforce development services to all committed youth.¹⁹² Juvenile justice programs traditionally focus on establishing control over youth. The CoNEXTions program instead uses an evidence-based therapeutic framework that incentivizes positive behavioral change and connects youth with social support systems.¹⁹³ The program aims to reduce criminogenic risk factors, increase protective factors, and decrease recidivism among justice-involved youth.

Psychiatric and psychological services are also available within all secure facilities. Male youth with severe mental health needs are taken to TJJD's primary mental health treatment facility, the McLennan Residential Treatment Center (MRTC) in Mart, Texas. Females with severe mental health needs stay at the Ron Jackson facility in Brownwood, Texas. Youth, both male and female, with the most mental health needs and who also pose a danger to themselves or others are served within MRTC's Crisis Stabilization Unit (CSU). Equipped with eight beds, the CSU provides crisis intervention psychiatric care.¹⁹⁴ Juveniles may be admitted to the CSU only if their psychiatric crisis presents a risk of serious harm to themselves or others, the crisis could lead to deterioration if left untreated, and placement in the CSU is the least restrictive intervention that is available to and appropriate for the youth.¹⁹⁵

Youth who are identified as having a high need for specialized mental health and substance use services or who are at high risk for violent recidivism are assigned to specialized treatment programs within TJJD. These specialized treatment programs

are designed for youth who have committed serious violent or sexual offenses and/or youth with substance use conditions, mental health conditions, or intellectual disabilities. The table below highlights the specialized treatment programs that exist at the six state secure facilities.

Table 78. Specialized Youth Treatment Programs in Texas

Program	Participants	Treatment Services and Outcomes
Alcohol or Other Drug Use Treatment Programs	Youth with substance use issues or chemical dependencies.	Program components include evidence-based treatment curricula, substance use education, social skills training, counseling, and relapse prevention. Criminal behavior is addressed by linking the use of drugs to the youth's life story and offense. For youth admitted since FY 2009 and released by FY 2016, 91.5% of those with high or moderate need completed treatment. ¹⁹⁶
Aggression Replacement Therapy Program (ART)	Youth with a moderate need for treatment to address aggressive behavior.	The ART program offers treatment in 30 group sessions over ten weeks. Case managers use cognitive behavioral concepts and moral reasoning strategies to help participants develop pro-social values that help them function more safely in their relationships.
Capital and Serious Violent Offender Treatment Program	Capital Offender Group (COG): Youths who are committed for murder, capital murder, and offenses involving the use of a weapon or deadly force. Violent Offender Program (VOP): Youths who have committed a violent crime but whose offenses are not serious enough to qualify for COG.	CSVOTP helps young people understand feelings associated with their violent behavior and identify alternative ways to respond when faced with risky situations. COG participants are required to reenact their crimes and play the role of both the perpetrator and victim. VOP participants do not engage in the same role play activities; instead, they focus on self-regulation, anger management, and value-changing activities. ¹⁹⁷ For youth admitted since FY 2009 and released by FY 2016, 94% of those with high or moderate need completed treatment and only 12.2% were rearrested for a violent offense within the first year following release [almost all of this data is exclusively the COG, as VOP began in July 2015]. ¹⁹⁸
Girls' Circle	Female youth	Girls' Circle uses a support group structure to promote resilience, engage female youth in gender specific discussions, and increase self-esteem.

Program	Participants	Treatment Services and Outcomes
Mental Health Treatment Program	Youth with mental health conditions.	The goal for the program is to treat the underlying mental health problem and allow youth to regain control over their behavior. The final goal is to reintegrate the young person with his or her family and community in a program that addresses his or her mental health and correctional therapy needs. Services in addition to others in this chart include trauma groups, Trauma-Focused Cognitive Behavioral Therapy, Seeking Safety curriculum, and psychosexual groups. More intensive services are centralized at the McLennan Residential Treatment Center (boys) and Ron Jackson (girls); services for youth with moderate or low need are available at all facilities. For youth admitted since FY 2009 and released by FY 2016, 61.5% of those with high or moderate need completed treatment and only 10.1% were rearrested for a violent offense within the first year following release. ¹⁹⁹
Pairing Achievement with Service	Youth who apply and participate in psychological screening.	Youth train dogs in their care, including some dogs who are trained as service dogs for people with special needs. The dogs come from local animal shelters and earn a Canine Good Citizen Certificate. ²⁰⁰
Sexual Behavior Treatment Program	Youth who are committed to TJJD for sex offenses.	The program uses cognitive behavioral strategies and a relapse prevention component. Juveniles receive additional individual and group counseling, education, and trauma resolution therapies that focus on each youth's deviant sexuality and arousal patterns. For youth admitted since FY 2009 and released by FY 2016, 87% of those with high or moderate need completed treatment and only 4.6% were rearrested for a violent offense within the first year following release. ²⁰¹

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Texas Department of Housing and Community Affairs

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Policy Concerns

- Lack of affordable housing options for people with disabilities, including individuals living with mental illness and substance use conditions.
- Effects of the COVID-19 pandemic on Texans' financial burdens and the unemployment rate, on housing stability for all Texans with an emphasis on people experiencing homelessness, and on those living with mental health conditions.
- Lack of housing options for foster youth in juvenile detention centers during the COVID-19 crisis.
- Development of permanent supportive housing across the state, including in rural and underserved areas.
- Expansion of recovery housing to assist individuals with substance use conditions in a supportive and empowering environment.
- Availability of housing support for veterans and their families.
- Reducing the Section 8 federal program rental assistance wait list by offering more vouchers for Texans.
- Housing discrimination against Texans with mental illness and substance use conditions.
- Location of Low-Income Housing Tax Credit developments for persons with disabilities.
- Reducing barriers to permanent housing for justice-involved individuals with mental health and substance use needs.

Fast Facts

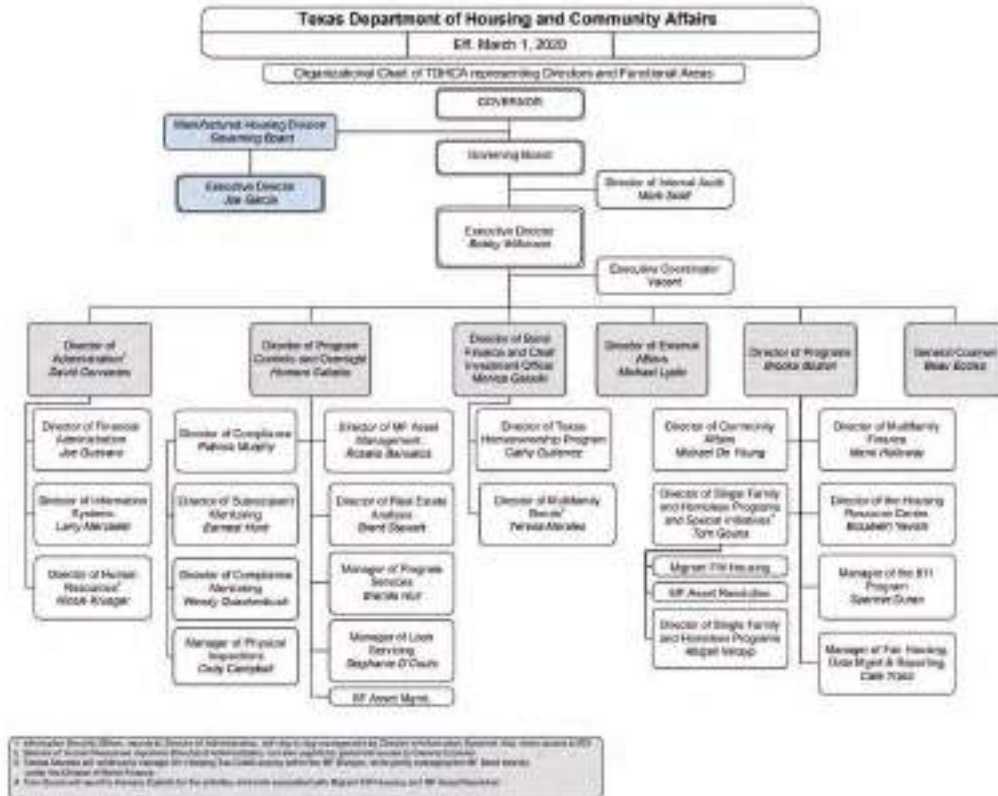
- In FY 2019, TDHCA served a total of 817,362 households and individuals through its combined programs (up from 684,864 in 2017), including 71,350 through its homeless services (up from 36,555 in FY 2017).¹
- According to the US Census Bureau, 35.7 percent of individuals in Texas were housing insecure during week 12 of the COVID-19 pandemic, the highest of any prior week. This was much higher than the US housing insecurity rate during week 12 of the pandemic, which was 26.5 percent (being housing insecure referred to adults who missed the prior month's rent or mortgage payment, or who had slight or no confidence that their household could pay the next month's rent or mortgage on time).²
- In Texas, 16.6 percent of individuals experiencing homelessness on a single night in January 2018 had a severe mental health condition, and 11.5 percent had a chronic substance use condition.³
- In Texas, nearly half of all individuals experiencing homelessness and 70 percent of veterans experiencing homelessness live with substance use conditions, and a majority of those with substance use conditions also live with moderate to severe mental health conditions.⁴
- Youth aging out of foster care are more likely to experience violence, homelessness, mental health conditions, incarceration, substance use issues, and early parenthood without a marriage partner.⁵

- Individuals experiencing homelessness with substance use conditions are more likely to be unsheltered than those with severe mental illnesses.⁶
- A 2013-2017 study showed that 17.7 percent of Texans living below the state poverty level had a disability, compared to 8.7 percent with a disability who were living at or above the poverty level.⁷
- The US Department of Housing and Urban Development (HUD) found that in 2015, 46.1 percent of all very low-income renter households with persons with disabilities were severely rent burdened, meaning they paid more than 50 percent of their income to housing. This represented a 6.1 percent increase since 2013.⁸
- In Texas, almost half of people are housing burdened, meaning they spend more than 30 percent of their income on housing.⁹
- Research reveals a housing affordability gap for Supplemental Security Income (SSI) recipients, many of whom are unable to work due to severe mental illness or disability.^{10,11}
- In 2019, recipients of SSI in Texas could receive \$771 a month, and affordable rent to SSI recipients was \$231 a month. Despite this, a one-bedroom fair market rent was \$858 a month.¹²
- As of 2018, Texas needed 611,181 available rental units affordable to extremely low-income households (0-30 percent AMFI) in order to meet the state's needs. Additionally, 89 percent of extremely low-income renters in Texas were cost burdened, with 73 percent being severely cost burdened (spending more than 50 percent of income on housing costs/utilities).¹³

TDHCA Acronyms

ACS – American Community Survey	LIHTC – Low income housing tax credit
AMFI – Average median family income	LMHA – Local mental health authority
AMI – Area median income	LMI – Low and moderate income
AYBR – Amy Young Barrier Removal Program	MHU – Manufactured Housing Units
CDBG-DR – Community Development Block Grant – Disaster Relief	PHA – Public housing authority
CEAP – Comprehensive Energy Assistance Program	PREPS – Partial Repair and Essential Power for Sheltering Program
CSBG – Community Service Block Grant	PSH – Permanent supportive housing
DADS – Department of Aging and Disability Services	TCAP – Tax Credit Assistance Program
DOE – Department of Energy	PIT – Point-in-time
DSHS – Department of State Health Services	PRA – Project rental assistance
ESG – Emergency Solutions Grants	QAP – Qualified Allocation Plan
FEMA – Federal Emergency Management Agency	SAMHSA – Substance Use and Mental Health Services Administration
GLO – General Land Office	SHC – Self-help center
HBA – Home buyer assistance	SSI – Supplemental Security Income
HHS – Health & Human Services	TBRA – Tenant-based rental assistance
HHSC – Health and Human Services Commission	TDA – Texas Department of Agriculture
HHSP – Homeless Housing and Services Program	TDHCA – Texas Department of Housing and Community Affairs
HRA – Home rehabilitation assistance	
HTF – Housing Trust Fund	
HUD – Housing and Urban Development	

Organizational Chart



Data obtained from: Texas Department of Housing and Community Affairs. (2020). TDHCA organizational chart. Retrieved from <https://www.tdhca.state.tx.us/hrdocs/org-chart.pdf>

Overview

Individuals with serious and persistent mental illness can experience significant barriers to permanent and stable housing. The most recent Point in Time (PIT) count of homelessness in Texas found that over 20 percent of individuals experiencing homelessness (116,179) have a severe mental illness, and almost 16 percent of individuals experiencing homelessness have a chronic substance use condition.¹⁴ Individuals experiencing homelessness with mental illness are at higher risk of chronic homelessness and remaining homeless for longer periods of time than those without a mental illness.¹⁵ Serious mental illness and substance use conditions may create difficulties in accessing and maintaining stable, affordable, and appropriate housing. Affordable housing programs that focus on homelessness prevention are critical to helping this population become successfully housed.¹⁶

The Texas Department of Housing and Community Affairs (TDHCA) operates several major affordable housing programs using mostly federal funding. The agency distributes federal funds for housing and community services and is responsible for allocating housing tax credits under the federal Low-Income Housing Tax

Credit program. TDHCA ensures compliance with federal and state laws governing various housing programs and provides essential services and affordable housing opportunities to low-income Texans. TDHCA is also a Public Housing Agency (PHA), responsible for operating publicly-owned multifamily housing as well as federally-funded rental assistance programs. States and cities can act as PHAs; there are over 200 PHAs in Texas, including TDHCA.¹⁷ In FY 2019, TDHCA served a total of 817,362 households and individuals through its combined programs.¹⁸

In addition to supporting the housing needs of low-income Texans, TDHCA has programs and policies that specifically serve people with disabilities. This includes people with mental illness and substance use conditions, as well as those experiencing homelessness. A significant number of people with disabilities face extreme housing needs.¹⁹ In a 2017 Congressional report, HUD reported that nearly 40 percent of low-income households with a non-elderly person with a disability experienced “worst case housing needs” – defined as paying more than half of income in rent or living in severely inadequate conditions without receiving government assistance.²⁰

Despite serving similar populations, most Texas health and human services programs are not well-integrated with affordable housing assistance, and vice versa. In 2009, the Texas Legislature established the Housing and Health Services Coordination Council (SB 1878, 81st, Nelson/Chavez) to strengthen coordination between housing and health service agencies in order to provide more service-enriched housing options.²¹ Service-enriched housing is “integrated, affordable, and accessible housing that provides residents with the opportunity to receive health-related and other services and supports that foster [independent living and decision-making] for individuals with disabilities and persons who are elderly.”²²

The executive director of TDHCA chairs the Council. Since its inception, the Council has made efforts to provide new housing and health-related resources, and add additional staff who are knowledgeable in both housing and health services.²³ In 2011, the Council published the *State Agency Reference Guide and Training Manual* to help cross-educate housing and health services staff on the programs and services available in Texas. The guide is available at <http://www.tdhca.state.tx.us/hhscc/docs/RefGuide.pdf>. The Council also submits a Biennial Plan to the legislature outlining its efforts to enhance service-enriched housing. The most recent plan is available at: <https://www.tdhca.state.tx.us/hhscc/biennial-plans.htm>.

TDHCA describes its services and activities along a “Housing Support Continuum” with five areas of need:

- Poverty and homelessness prevention
- Rental assistance
- Homebuyer education, assistance, and single-family development
- Rehabilitation and weatherization
- Disaster assistance

While some programs serve individuals with disabilities specifically, most TDHCA programs seek to expand housing opportunities for low-income Texans broadly. However, the broader housing programs benefit Texans with disabilities and mental

illness by expanding the overall stock of affordable housing and services in the state. Low-income individuals living with a disability or mental illness who experience a housing burden may be able to access rental assistance, housing rehabilitation funds, or energy assistance, for example. In addition, programs such as Section 811 and Project Access are tailored to individuals with disabilities.

Under its “rental assistance” category shown in in Table 79, TDHCA provides three different forms of assistance:

- **Tenant-based rental assistance:** Texas uses federal HOME funding to provide rental assistance to help offset the cost of market-rate rental housing for low-income renters. These programs are called tenant-based assistance because the subsidy is linked to and stays with the tenant. Tenants are required to pay up to 30 percent of their income toward rent for a market-rate housing unit, and the state makes up the remainder. Tenants select rental units themselves in the private market, though landlords must agree to accept the rental assistance from TDHCA. Tenant-based rental assistance is time-limited to 24 months but can be extended if funding is available.
- **Project-based rental assistance:** Project-based rental assistance is housing assistance that is attached to a property rather than a tenant. The HUD Section 811 program provides a rental subsidy to the housing provider directly to keep a unit affordable to extremely low-income tenants with disabilities linked to long-term services. Project-based rental assistance is not time limited.
- **Development assistance:** Lastly, the state provides subsidies to developers to construct or rehabilitate affordable multifamily rental housing. This form of assistance includes low-income housing tax credits (LIHTCs), HOME Multifamily Loan and Bond programs, and the Tax Credit Assistance Program (TCAP).

TDHCA’s non-rental programs focus on single-family homeownership, rehabilitation or construction, and services for low-income individuals or those experiencing homelessness and their families. Table 79 lists the housing assistance and services that TDHCA offers in each area of need.

Table 79. TDHCA Housing Support Continuum Activities

Continuum Activity	Program	Household Income Eligibility ^a
Poverty and Homelessness Prevention	<i>Community Service Block Grant (CSBG):</i> Local services and poverty programs.	<=125% FPL
	<i>Comprehensive Energy Assistance Program (CEAP):</i> Energy education and utility assistance.	<=150% FPL
	<i>Emergency Solutions Grants (ESG) Program:</i> Rapid assistance for persons who are homeless or at risk of homelessness.	<=30% AMFI (or homeless/at risk of homeless)
	<i>Homeless Housing and Services Program (HHSP):</i> For large urban areas to assist individuals and families who are homeless.	Moderate income level pursuant to Tex. Gov't Code §2306.152, persons experiencing homelessness or at risk of homelessness
Rental Assistance and Multifamily Development and Rehabilitation	<i>Section 811 Project Rental Assistance:</i> Project-based rental assistance for very low-income persons with disabilities, linked with long-term services.	The higher of <30% AMI or <FPL
	<i>Section 8 Housing Choice Voucher Program:</i> Tenant-based rental assistance vouchers for individuals in specific areas, or statewide for individuals with disabilities through Project Access.	<=50% AMI
	<i>Tenant-based Rental Assistance (TBRA, HOME-funded):</i> Local grants to provide tenant-based rental vouchers.	<=80% AMI
	<i>Housing Tax Credit (HTC) Program and Multifamily Bond (MF Bond) Program:</i> Financing for affordable housing developments by serving as a credit to communities.	<80% AMFI for HTC and <60% AMFI for MF Bond Programs
	<i>Multifamily Direct Loan (MF Direct Loan) Program:</i> Designed to increase and maintain the state's affordable rental housing supply for extremely low-income families and families experiencing homelessness.	The higher of <=30% AMFI or <=Federal Poverty Level for NHTF and <=80% AMFI for HOME, NSP1 PI, and TCAP RF

Continuum Activity	Program	Household Income Eligibility ^a
Homebuyer Education, Assistance and Single-Family Development	<i>Colonia Self-help Center (SHC)</i> : Funding for housing rehabilitation and construction, homebuyer assistance, and housing education in colonias.	<=80% AMI
	<i>Texas Statewide Homebuyer Education</i> : Training for nonprofits to provide homebuyer education.	No income limit
	<i>Texas Homebuyer U</i> : Satisfies the homebuyer education requirement for TDHCA's First Time Homebuyer programs.	No income limit
	<i>Homebuyer Assistance (HBA, HOME-funded)</i> : Down payment and closing cost assistance for single family buyers, can include rehabilitation or accessibility modifications.	<=80% AMI
	<i>HOME Homebuyer Assistance with New Construction or Rehabilitation (HANC)</i> : Offers low-interest loans for 1) single-family housing not currently owned and/or occupied by an eligible homebuyer, 2) the acquisition of real property, and 3) closing costs.	<=80% AMFI
	<i>Contract for Deed (funded through HOME and Housing Trust Fund)</i> : Assisting colonia residents to convert contract-for-deed to traditional mortgage.	<=80% AMFI. Funds initially set-aside for households <=60% AMFI and who reside in a colonia for a minimum of 60 days
	<i>My First Texas Home (Non-targeted Funds)</i> : Low-interest loans and down payment costs for first-time homebuyers.	<115% AMFI (100% AMFI for households of 2 persons or less)
	<i>My First Texas Home (Targeted Funds)</i> : Offers eligible homebuyers competitive interest rates, mortgage loans, and down payment assistance through a network of participating lenders in areas of chronic economic distress. The first-time homebuyer requirement is waived for borrower's purchasing properties located in targeted areas.	<140% AMFI (120% AMFI for households of 2 persons or less), households in areas of chronic economic distress
	<i>Mortgage Credit Certificate (TX MCC)</i> : Tax credit for homebuyers based on mortgage interest.	<115% AMFI (100% AMFI for households of 2 persons or less)
	<i>My Choice Texas Home (Non-targeted Funds)</i> : Offers homebuyers competitive interest rates, mortgage loans, and down payment assistance through a network of participating lenders.	<115% AMFI (100% AMFI for households of 2 persons or less)
	<i>My Choice Texas Home (Targeted Funds)</i> : Offers homebuyers competitive interest rates, mortgage loans, and down payment assistance through a network of participating lenders in areas of chronic economic distress.	<140% AMFI (120% AMFI for households of 2 persons or less), households in areas of chronic economic distress

Continuum Activity	Program	Household Income Eligibility ^a
Single Family Rehabilitation, Barrier Removal, And Weatherization	<i>Amy Young Barrier Removal (funded through Housing Trust Fund):</i> Grants to fund accessibility modifications to homes of people with disabilities.	<80% AMI, persons with disabilities
	<i>Homeowner Rehabilitation Assistance (HRA, HOME-funded):</i> Grants to fund home repair and replacement assistance.	<=80% AMI
	<i>Weatherization Assistance:</i> Grants to fund minor home repairs to increase efficiency.	<=150% (Low Income Housing Energy Assistance Program [LIHEAP]) <=200% FPL (Dept. of Energy Weatherization Assistance Program [DOE WAP])
Disaster Relief	<i>Community Services Block Grant:</i> Emergency shelter, food and clothing.	<=125% FPL
	<i>Disaster Relief (HOME-funded):</i> Home repair, rehabilitation, construction, homebuyer assistance, and tenant-based rental assistance for households affected by a disaster	<=80% AMI
	<i>9% HTC Program:</i> Provides points to applications that pledge to close their financing and begin construction much earlier than usual in counties with a presidential disaster declaration.	<80% AMI

^a FPL = Federal Poverty Level; AMFI = Area Median Family Income; AMI = Area Median Income; ELI = Extremely Low Income Limit

Data obtained from: Texas Department of Housing and Community Affairs. (2020). 2020 State of Texas Low Income Housing Plan and Annual Report, page 119. Retrieved from <https://www.tdhca.state.tx.us/housing-center/docs/20-SLIHP-Draft.pdf>

Changing Environment

During the 86th Legislative session, several bills were filed addressing housing needs or the way TDHCA operates. **HB 2564** (86th, White/Lucio) addresses the issue of foster youth experiencing homelessness by requiring TDHCA to include foster youth in their low-income housing plans.²⁴ This bill largely addresses issues identified by TDHCA's Youth Count Texas study. Data found that 39.9 percent of Texas youth reported having a mental health condition and 5.8 percent having a developmental disability. For youth experiencing homelessness, the most immediate challenge reported was finding housing. The next immediate challenge was mental health concerns, including: depression, anger, anxiety, and trouble sleeping.²⁵

HB 4468 (86th, Coleman/Whitmire) eases the match requirement for counties with less than 250,000 people for the Healthy Community Collaboratives Housing program.^{26, 27} This initiative encourages private and public sector collaboration of services to help Texans with mental health conditions, substance use conditions, or

homelessness.²⁸

Other bills were filed that did not become law. **HB 1465** (86th, Moody/Menendez) would have established a study on the state of substance abuse recovery housing in Texas.²⁹ While the bill was voted out of House and heard in the Senate, it was ultimately left pending in committee without a vote.³⁰ **HB 1257** (86th, Rosenthal) would have given counties the authority to bar discrimination against tenants receiving funds for housing assistance.³¹ This bill did not receive a hearing or a vote from the House Urban Affairs committee.³²

COVID-19

In light of the COVID-19 pandemic, TDHCA has made resources available for renters and homeowners affected by the virus.³³ Homeowners can receive reduced or suspended payments, renters may be able to receive financial assistance through nonprofits and faith-based organizations. In March 2020, the Federal Housing Finance Agency and HUD suspended foreclosures and evictions for 60 days for Federal Housing Administration-insured and Fannie Mae/Freddie Mac-backed mortgages.³⁴ More information and resources for those affected by the pandemic can be found in the COVID-19 chapter of this guide, as well as on the TDHCA website: <https://www.tdhca.state.tx.us/covid19.htm>

2020 TDHCA INITIATIVES

In January 2020, TDHCA approved \$23 million through their 4 percent LIHTC program to rehabilitate 825 multifamily units in rural parts of Texas. While this form of bond financing is typically less cost-effective for small rural properties, combining multiple small properties together made the deal practical. The financing will allow the property portfolio to maintain affordability for low-income Texans, including those with mental health conditions, for an additional 30 years.³⁵

TDHCA coordinated the 2015-2019 State of Texas Consolidated Plan, as well as preparation of the 2020-2024 State of Texas Consolidated Plan. In compliance with HUD, the agency reports on the following programs: HOME Investment Partnerships Program (HOME), Emergency Solutions Grants (ESG) program, and National Housing Trust Fund (NHTF). The HOME program included the following activities: rehabilitation of single-family housing, homebuyer assistance with possible rehabilitation, tenant-based rental assistance, single family development, homebuyer assistance new construction, multifamily new/rehab, and persons with disabilities set aside. The ESG program included emergency shelter, rapid re-housing, and homeless prevention and outreach. The NHTF program activities included new multifamily units for extremely low-income renters. Other HUD activities within TDHCA include the Veteran Assistance Supportive Housing program, Section 811, and the Mainstream Voucher Program.³⁶

HURRICANE HARVEY

On August 25, 2017 Hurricane Harvey made landfall near Port Aransas, Texas as a Category 4 hurricane. The storm lasted for four days, dropped as much as 60 inches of rain in some areas of the state and is estimated to have caused \$120 billion of damage.³⁷ The Texas General Land Office estimated that more than 1 million homes were impacted by the storm and flooding that followed.³⁸

Just as there were major losses to the single-family housing stock, many affordable multifamily housing units sustained severe damage. These units were often the only affordable housing options available to people experiencing mental health conditions. More than 1,930 units tied to Public Housing Assistance, including Section 8 and Housing Choice vouchers, were impacted by the storm.³⁹ The total cost of this destruction amounted to nearly \$25,600,000.⁴⁰

As of February 2019, three rounds of HUD funding had been provided for Harvey recovery.⁴¹ At the end of 2017, HUD allocated \$57.8 million in Community Development Block Grant – Disaster Recovery (CDBG-DR) dollars to help address immediate housing needs.⁴² These funds were left over from the CDBG-DR dollars issued to Texas for 2015 and 2016 floods.

The second round of HUD funding for approximately \$5 billion was approved in August 2018. These funds were part of the 2017 national disaster aid package included in the Continuing Appropriations Act, 2018 and Supplemental Appropriations for Disaster Relief Requirements Act, 2017.⁴³

The third round of funding, totaling about \$562 million, was provided in February 2019. These funds were also provided by the CDBG-DR Program, and were made in addition to the \$5 billion from the second round of funding in Summer 2018.⁴⁴ Collectively from the three rounds, HUD provided Texas with over \$5.7 billion in disaster recovery funds.⁴⁵

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.⁴⁶ As part of that law, recipients of HUD funds are under an obligation to “affirmatively further” nondiscrimination policies. This requirement obligates recipients of HUD funding not just to prohibit discrimination but to take proactive steps to fight housing segregation and promote inclusive and integrated communities. HUD requires agencies that receive any Community Planning and Developments funds to undertake fair housing planning; in Texas, that plan is the Analysis of Impediments to Fair Housing report.⁴⁷ The latest report was released in 2019, and can be viewed here <https://www.tdhca.state.tx.us/fair-housing/docs/19-AI-Final.pdf>.

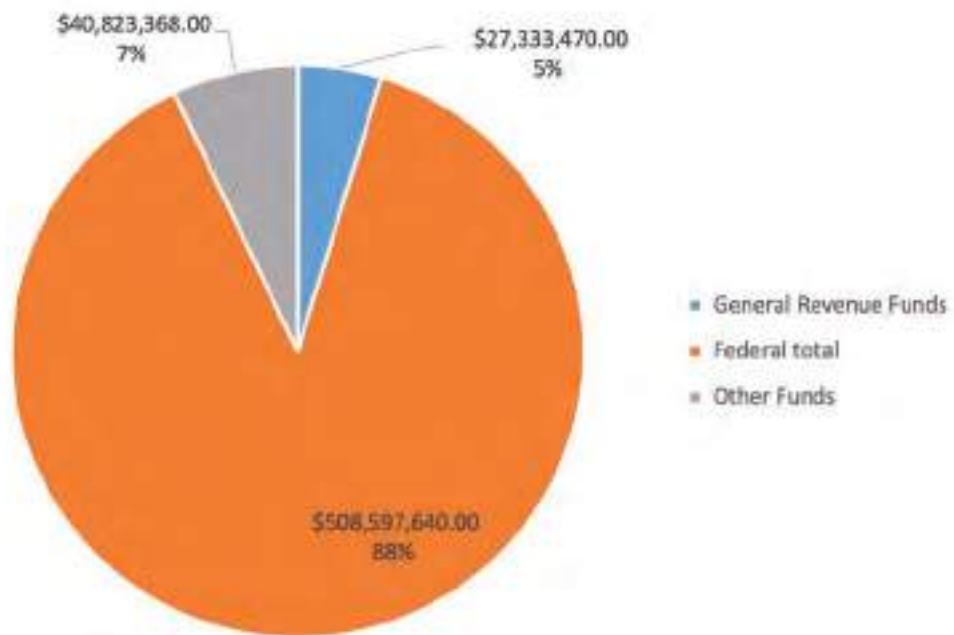
Funding

The majority of TDHCA's funding comes from the federal government, with a small percentage comprised of Texas general revenue funds. Federal housing funds often come with strict regulations and restrictions for their use, and are subject to fair housing law. The following is a brief description of TDHCA's funding for the 2020-2021 biennium.

The 2020-2021 TDHCA budget contained over \$508 million in federal funding, about 88 percent of the agency's total funding for the biennium.⁴⁸ State general revenue provided over \$27 million to TDHCA, and nearly \$41 million came from other funds such as appropriated receipts and interagency contracts.⁴⁹

Figure 110 shows TDHCA funding by method of finance.

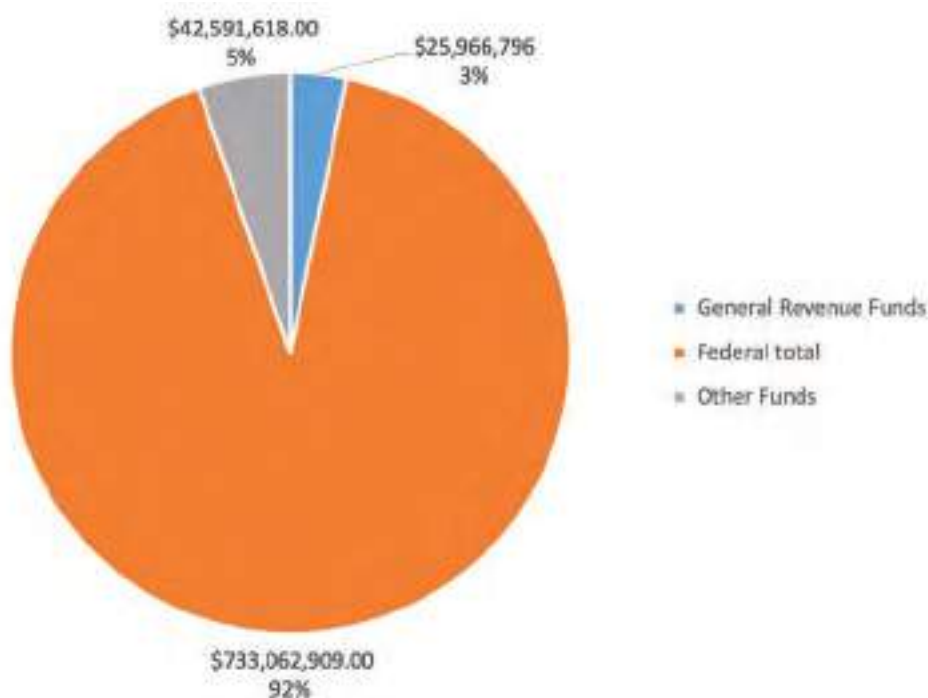
Figure 110. TDHCA Funding by Method of Finance for FY 2020-21



Total funding for TDHCA for FY 2020-21 is \$576,754,478

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Figure 111. TDHCA Requested Funding by Method of Finance for FY 2022-23



Total funding requested for TDHCA for FY 2022-23 is \$801,621,323

Data obtained from: Legislative Budget Board. (2020). Legislative Appropriations Request for Fiscal Years 2022 and 2023, Texas Department of Housing and Community Affairs. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2020>

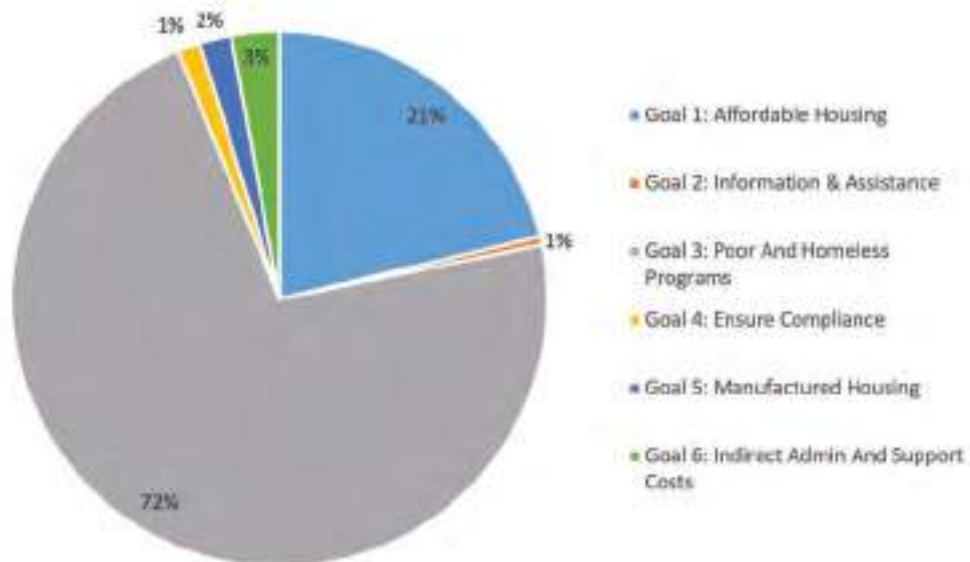
TDHCA is a unique agency in terms of its total expenditures. One of the agency's core functions is to administer and allocate funds that pass through the agency in the form of private mortgage funding and federal housing tax credits. Much of what the agency classifies as expenditures in its annual report do not appear in the biennial state budget because they are funded by indirect (often private or federal) sources for which the agency acts as an allocator or administrator.⁵⁰

In terms of direct allocations outlined in the state budget, about 72 percent of TDHCA's 2020-2021 budget goes toward homeless and poverty services.⁵¹

About 21 percent goes toward affordable housing programs, including rental assistance and subsidies to multifamily housing developers.⁵² The allocation for affordable housing programs appears small, relative to the homeless services, because it only includes the cost to administer these programs and excludes significant indirect funding sources.⁵³ Direct biennial funding to TDHCA comprises only a small portion of Texas's total budget. For 2020-2021, the agency's budget is nearly \$577 million of Texas's nearly \$251 billion budget.⁵⁴

Figure 112 below illustrates the agency's budget by programmatic earmark, as described in the biennial 2020-2021 budget.

Figure 112. TDHCA Funding by Goal for FY 2020-21



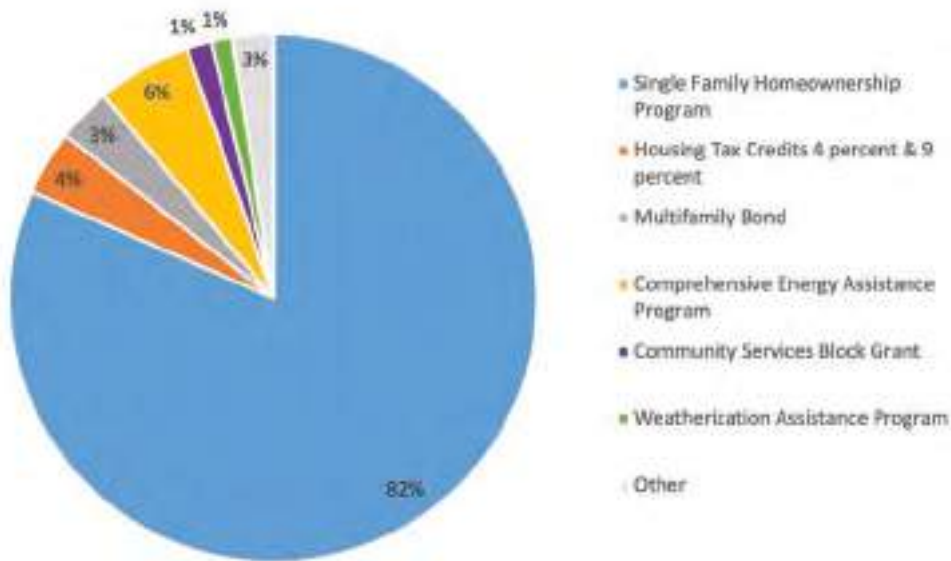
Total funding for TDHCA for FY 2020-21 is \$576,754,478

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Figure 112, however, does not reflect the amount of indirect funding that the agency *distributes* through either the federal LIHTC program or its privately financed single-family homeownership program. In FY 2019, TDHCA expended or issued over \$2 billion in total funds and tax credit assistance.⁵⁵ Over \$1.69 billion was allocated for the agency's Single Family Homeownership Program, much of which constitutes privately underwritten mortgage products that pass through but are not directly funded by the agency.⁵⁶

Figure 113 below illustrates the total direct and indirect funding expended by the agency in FY 2019, according to its most recent annual report.

Figure 113. TDHCA Expenditures, By Program (FY 2019)



FY 2019 TDHCA Expenditures by Program Total: \$2,076,285,016

*Note – "Other" category includes: HOME Investment Partnerships Program, Section 8, Emergency Solutions Grants (ESG) Program, Homeless Housing and Services Program (HHSP), Housing Trust Fund (HTF), Multifamily Direct Loan, and Section 811 PRA. Data obtained from: Texas Department of Housing and Community Affairs. (2020). 2020 State of Texas low income housing plan and annual report, Page 47. Retrieved from <https://www.tdhca.state.tx.us/housing-center/docs/20-SLIHP.pdf>

Affordable Housing

Without a safe, stable, and affordable place to live, it is nearly impossible to achieve a high level of overall health and wellness.⁵⁷ However, many Texans continue to face a housing cost burden.⁵⁸ A housing cost burden exists when a household pays more than 30 percent of its gross income towards housing.⁵⁹ In Texas from 2012-2016, almost 43 percent of all renter households and about 20 percent of all homeowners faced a housing cost burden, regardless of income.⁶⁰ Additionally, of all Texas renter households with extremely low incomes, nearly 77 percent faced a housing cost burden.⁶¹ This was compared to less than 4 percent of renter households with incomes of over 100 percent Average Median Family Income (AMFI) who were cost burdened.⁶² Overall, 2012-2016 data showed that over 2.4 million Texas renter and homeowner households with incomes below 100 percent AMFI faced a housing cost burden.⁶³

HOUSING AVERAGE MEDIAN FAMILY INCOME (AMFI) AND ELIGIBILITY

In order to direct resources to the people who face the greatest housing cost burden, most of the affordable housing programs operated by HUD and TDHCA use

household AMFI to determine whether a person is eligible to receive assistance. HUD uses the most recent census data on median family income and results from the American Community Survey to determine AMFI in communities throughout the country. The AMFI calculation uses data that are unique and specific to a metropolitan area, sub-areas of a metropolitan area, and non-metropolitan counties.

Texas's median family income in FY 2019 was \$71,200.⁶⁴ Low-income households are those whose income does not exceed 80 percent of AMFI. HUD breaks "low-income" down further, as described below. For a Texas household of four in FY 2019, HUD established the following income categories:

- Low-income ($\leq 80\%$ AMFI): $\leq \$56,950$
- Very low-income ($\leq 50\%$ AMFI): $\leq \$35,600$
- Extremely low-income ($\leq 30\%$ AMFI): $\leq \$21,350$ ⁶⁵

Barriers to affordable housing can disproportionately affect many Texans living with mental health and substance use conditions. If a person's ability to work is hindered by their mental illness or substance use condition, then it is likely that their income will not be sufficient to afford quality housing. Further, access to safe and stable housing adds to a person's supportive environment needed for their recovery.

SUPPLEMENTAL SECURITY INCOME (SSI) AND HOUSING

Supplemental Security Income is a federal program that provides a monthly income to people with little income and few resources who are blind, disabled, or elderly.⁶⁶ Many SSI recipients are unable to work due to a severe mental illness or disability.⁶⁷ Research reveals a housing affordability gap for SSI recipients. In 2019, recipients of SSI in Texas received a maximum of \$771 a month. While the rent affordable to SSI recipients was just \$231 a month, fair market rent for a one-bedroom apartment in Texas was \$858 a month.⁶⁸ Without affordable housing options, people with serious mental illness are often without community living options and are at risk of having to live in institutional settings like nursing homes or psychiatric facilities.

CONTINUING CHALLENGES WITH STIGMA

Another ongoing barrier to affordable housing for people with mental health and substance use conditions is the continued negative stigma that might prevent someone from fully participating in community life and accessing housing. People with a mental health and substance use conditions who are also justice-involved can be legally barred from a number of housing options and have an extremely difficult time finding housing due to legal eligibility issues and ongoing stigma.

INTEGRATED HOUSING RULE

In Texas, housing programs that serve individuals with disabilities must comply with the *Integrated Housing Rule*. The rule was adopted in 2003 to help ensure that people

with disabilities can live in integrated communities alongside individuals without disabilities. The rule requires that:

- Large housing developments with 50 units or more set aside no more than 18 percent of units for people with disabilities
- Small housing developments with fewer than 50 units set aside no more than 36 percent of units for people with disabilities⁶⁹

The above policies do not prevent a higher percentage of people with disabilities from choosing to reside in these types of developments, but an entire development may not limit its occupancy solely to people with disabilities. Transitional housing, which facilitates the transition of people and families who have been homeless into permanent housing, is exempt from this rule, so long as residence in the development is time-limited and there is a clear plan for transitioning residents into an integrated setting following their exit from transitional housing.⁷⁰

PERMANENT SUPPORTIVE HOUSING (PSH)

Permanent supportive housing is long-term, affordable housing linked to a range of support services geared to enable tenants, especially those 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 the Substance Abuse and Mental Health Services Administration (SAMHSA), the core elements of permanent supportive housing are:

- A high degree of choice offered to tenants;
- Functional separation of housing management and services staff;
- Affordability;
- Integration with the surrounding community;
- Full rights of tenancy under federal and state law;
- Immediacy of access to housing; and
- Available services and supports⁷¹

No PSH 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.⁷²

For trauma-controlled PSH, the functionality levels of tenants drive the design of the care models. People are grouped into different care settings based on whether their functionality is deemed high, moderately high, moderate, or low. The settings that tenants are placed in are meant to be environments for mental healing and well-being by providing comfort and community to individuals.⁷³

RECOVERY HOUSING

Stakeholder organizations in the housing, mental health, and substance use realms

have pushed for an expansion of recovery housing in Texas. The goal of recovery housing is to provide supportive transitional living in order to prevent individuals with substance use issues from experiencing relapse, recidivism, and overdose, all of which can lead to deteriorating mental wellness.^{74,75} Establishing safe and supportive living environments and providing connections to peer support are at the core of this model.⁷⁶

While recovery housing is typically utilized after an individual participates in inpatient or residential treatment, it can provide support after outpatient treatment or as an alternative to treatment.⁷⁷ While research recognizes gaps and opportunities to learn more about recovery homes in Texas, studies of residents in Oxford Houses, sober living houses in California, and treatment centers have found that recovery homes are associated with a variety of positive outcomes including abstinence from alcohol and drugs, gains in employment, and decreased involvement in the criminal justice system.⁷⁸

HB 1465 (86th. Moody/Menendez), which did not pass in the 86th Legislative Session, would have directed the Health and Human Services Commission (HHSC) to conduct an evaluative study on the current landscape, challenges, and opportunities to expand recovery housing across the state. However, SAMHSA has worked with stakeholder organizations to outline recovery housing needs. The SAMHSA 2019 Housing Best Practices Guide included guidelines to explain how recovery housing units vary based on the levels of care needed.⁷⁹

Figure 114. SAMHSA - Recovery Housing: Best Practices and Suggested Guidelines

MAHR Level	Typical Resident	On-site Staffing	Governance	On-site supports
Level 1 (e.g., Oxford Houses)	Self-identifies as in recovery, some long-term, with peer community accountability	No on-site paid staff, peer to peer support	Democratically run	On-site peer support and off-site mutual support groups and, as needed, outside clinical services
Level 2 (e.g., sober living homes)	Stable recovery but wish to have a more structured, peer-accountable and supportive living environment	Resident house manager(s) often compensated by free or reduced fees	Residents participate in governance in concert with staff/recovery residence operator	Community/house meetings, peer recovery supports including "buddy systems", outside mutual support groups and clinical services are available and encouraged
Level 3	Those who wish to have a moderately structured daily schedule and life skills supports	Paid house manager, administrative support, certified peer recovery support service provider	Resident participation varies; senior residents participate in residence management decisions; depending on the state, may be licensed; peer recovery support staff are supervised	Community/house meetings, peer recovery supports including "buddy systems", linked with mutual support groups and clinical services in the community, peer or professional life skills training on-site, peer recovery support services
Level 4 (e.g., therapeutic community)	Require clinical oversight or monitoring; stays in these settings are typically longer than in other levels	Paid, licensed/credentialed staff and administrative support	Resident participation varies; organization authority/hierarchy; clinical supervision	On-site clinical services, on-site mutual support group meetings, life skills training, peer recovery support services

Source: SAMHSA. (n.d.). Recovery Housing: Best Practices and Suggested Guidelines. Retrieved from <https://www.samhsa.gov/sites/default/files/housing-best-practices-100819.pdf>. More information on recovery housing can be found in the HHSC portion of this Guide.

HOUSING FIRST

Housing First is an approach to ending chronic homelessness that seeks to connect individuals with housing immediately. Contrary to other housing models, Housing First does not require sobriety, mental health treatment, or supportive service participation as a precondition for housing. The philosophy of Housing First is that once housing stability is achieved, people will be better positioned to effectively address serious mental illness or co-occurring substance use. The US Department of Veterans Affairs adopted a Housing First model in 2015, and an assessment of their Year One pilot showed an increase in housing retention rates and a decrease in healthcare utilization for Housing First tenants compared to those in housing with treatment requirements.⁸⁰ The United States Interagency Council on Homelessness suggests using PSH in combination with a Housing First approach to address chronic homelessness.⁸¹

For more information on the Housing First model, see the US Interagency Council on Homelessness checklist: https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf.

Housing Programs Serving People with Disabilities or Mental Health Conditions

Several of Texas's housing programs are specifically designed to serve people with disabilities or serious mental illness or have components that do so. These programs include the state's poverty and homeless prevention programs, as well as affordable housing programs specifically for persons with disabilities and mental illness. A variety of TDHCA programs have policies that specifically reserve funding or space for persons with disabilities or mental health conditions – these reserved funds are known as “set-aside” funds.

The programs described below do not represent a comprehensive listing of all the affordable housing resources in Texas. Several other federal and state programs are operated by TDHCA and other local PHAs 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 <https://www.huduser.gov/portal/sites/default/files/pdf/HUDPrograms2018.pdf>.

SECTION 8 HOUSING CHOICE VOUCHER PROGRAM

The Section 8 Housing Choice Voucher Program, funded by HUD, provides financial assistance to low-income families and individuals, including older adults and persons with disabilities, to obtain safe and sanitary housing. HUD requires that a household be Very Low Income (does not exceed 50 percent of AMFI) to participate in the program, and for 75 percent of households to be Extremely Low Income (less than

or equal to 30 percent of AMFI).^{82,83} Along with meeting these income requirements, several other factors are considered when determining eligibility, including size and composition of the household, citizenship status, and childcare expenses.⁸⁴

Eligible individuals work directly with landlords to obtain housing, and TDHCA pays the balance of the approved rent amount directly to the property owner on behalf of the individual. Families receiving the voucher are responsible for paying 30 percent of their adjusted monthly income toward rent and utilities, with the remainder paid by the agency up to a predefined payment standard for a moderately-priced dwelling unit in the area.⁸⁵

PROJECT ACCESS

Project Access is part of TDHCA's Section 8 Housing Choice Voucher Program designed to assist low-income persons with disabilities in transitioning from institutions into the community by providing access to affordable housing. In FY 2019, up to 140 of the 900 total Housing Choice Vouchers available in 34 counties could be used by people with disabilities in the Project Access program.⁸⁶ 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 impedes the individual's ability to live independently. Applicants must also meet one the following requirements:

- Be an at-risk applicant and a previous resident of a nursing facility, intermediate care facility, Texas state psychiatric hospital, or board and care facility as defined by HUD; or
- Be a current resident of a nursing facility, intermediate care facility, Texas state psychiatric hospital or board and care facility at the time of voucher issuance as defined by HUD; or
- Be eligible for a pilot program with HHSC for residents of Texas state psychiatric hospitals.⁸⁷

At-risk applicants must meet the following criteria:

- Be a current recipient of Tenant-Based Rental Assistance from the Department's HOME Investments Partnership Program; and
- Be within six months prior to expiration of assistance.⁸⁸

TDHCA works in collaboration with HHSC to implement Project Access. Assistance through Project Access vouchers is not time limited, however there is a waiting list for the vouchers.⁸⁹ TDHCA established a process that allows people on the Project Access waitlist to relocate from an institution using the HOME-funded Tenant-based Rental Assistance program (see below).⁹⁰ The goal is for a person to be admitted to the Project Access program by the time TBRA assistance expires.⁹¹ While this is not a permanent fix, it allows for people to transition into community settings sooner than they would be able to otherwise.

LOW INCOME HOUSING TAX CREDIT PROGRAM

The Low Income Housing Tax Credit (LIHTC) program is a federally-funded multifamily rental development program. TDHCA administers the program, which is funded by the US Treasury Department through the federal tax code. LIHTC is the largest affordable housing program in the history of the US and produces around 75,000 affordable housing units nationally per year.⁹² As of 2018, around 260,000 Texas families lived in more than 2,500 LIHTC properties.⁹³

TDHCA provides federal tax credits to investors in multifamily housing who set aside a specific number of units for the development for affordable housing. The tax credits require the units to be leased to qualifying low-income residents at a below-market rate. At a minimum, these affordable units must be reserved for people who are 60 percent or below AMFI and meet other requirements specific to the development. Rent for these units is set at a reduced rate, restricted by rent guidelines that are published annually. LIHTC has produced over 2.5 million affordable apartments since its inception.⁹⁴

The LIHTC program is important for renters with disabilities or mental health conditions, many of whom have limited income and are qualified for LIHTC units. Moreover, LIHTC developments are required to accept Section 8 housing vouchers. Texas codifies its requirements for the competitive tax credit award process annually in its Qualified Allocation Plan (QAP). While the 2020 QAP has yet to be approved by the Governor at this time, early drafts suggest the finalized version could include language pertaining to people with intellectual and developmental disabilities being identified as a key supportive housing population.⁹⁵

HOME INVESTMENT PARTNERSHIPS PROGRAM

The Texas HOME Investment Partnerships Program is a federally-funded set of programs that seek to expand the supply of decent, safe, affordable housing and enhance partnerships between state and local governments, public housing authorities, local nonprofits, and private housing actors.⁹⁶ HOME finances both single and multifamily programs, some of which are described in Table 80 below. The 2020-2021 budget allocates approximately \$89 million to provide affordable housing through the HOME program.⁹⁷ By state law, 95 percent of Texas HOME funds must serve jurisdictions, mostly rural, that do not receive HOME funds directly from HUD.⁹⁸ However, there is a five percent set aside for activities that serve persons with disabilities, regardless of where they live.⁹⁹

Table 80. HOME Investment Partnerships Programs

Program	Description
Persons with Disabilities Set-aside	Five percent of HOME funds are set aside for persons with disabilities which can be used for Homebuyer Assistance, Tenant-based Rental Assistance, or Homeowner Rehabilitation Assistance. Local governments, PHAs, and nonprofit entities can apply for set-aside funds with TDHCA. ¹⁰⁰
Disaster Relief	Funds that are set aside for disasters can be used by local governments, PHAs, LMHAs, and nonprofits to help individuals in need of homebuyer assistance. They can be used for relocation, rehabilitation, reconstruction assistance, or temporary rental assistance. ^{101,102}
Homebuyer Assistance with New Construction	Disaster relief funding is also available for nonprofits, PHAs, LMHAs, and entities of local government to provide mortgage financing to low-income homebuyers. Funding is provided to homebuyers as a fixed loan with terms of 15-30 years, with low or potentially no interest rates. Resources can go towards site-built housing, new Manufactured Housing Units (MHUs), or housing intended to be occupied by the homebuyer. ^{103,104}
Homebuyer Assistance Program	Nonprofits, PHAs, LMHAs, and units of local government are eligible to participate in the Homebuyer Assistance program to provide down payment and closing cost assistance to single family homebuyers. ^{105,106} The program may also help to fund rehabilitation or accessibility modifications to single family homes. In addition to providing financial tools, these programs offer educational opportunities to learn how to manage homeownership.
Tenant-Based Rental Assistance Program	The HOME-funded Tenant-Based Rental Assistance (TBRA) program provides utility deposits and rental subsidies to tenants seeking affordable housing in their community. These 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, dependent on funding. ¹⁰⁷ TBRA is a short-term assistance program that also has the possibility to be a bridge program for individuals on the waitlist for the Project Access program, which can include people with mental health conditions. ^{108,109}
Homeowner Rehabilitation Assistance Program	The Homeowner Rehabilitation Assistance program funds units of local governments, PHAs, LMHAs, and nonprofits to provide a variety of services for homeowners, including: same-site rehabilitation or reconstruction of owner-occupied housing, new construction or replacement of owner-occupied MHUs, and new construction or replacement of owner-occupied MHUs that have become inhabitable. ^{110,111}
Contract for Deed	Funds units of local governments, PHAs, LMHAs, and nonprofits that assist colonia residents earning 60 percent or less of the AMFI by converting contracts into traditional mortgages. Funds can go towards site-built housing, MHUs, and colonia housing. ^{112,113}
Single Family Development	Funds are provided for nonprofits that are certified as Community Housing Development Organizations. Resources go towards rehabilitating or building affordable single-family homes that are to be sold to low-income households. ^{114,115}
Multifamily Direct Loan	These low-interest loans fund units of local governments, PHAs, nonprofits, and for-profit institutions (LMHAs are not included) to rehabilitate or construct affordable multi-family rental units. ^{116,117}

SECTION 811 SUPPORTIVE HOUSING FOR PEOPLE WITH DISABILITIES

Section 811 is one of HUD's supportive housing programs for people with disabilities, including chronic mental illness, and is authorized by the Cranston-Gonzales National Affordable Housing Act of 1990.¹¹⁸ The program bolsters housing for people with disabilities in two ways: interest-free development funds and operating subsidies for nonprofit developers of affordable housing for people with disabilities, and rental assistance to be used in developments funded through other subsidy programs, such as the LIHTC and HOME programs.

SECTION 811 PROJECT RENTAL ASSISTANCE

The Section 811 Project Rental Assistance (PRA) program is used to provide rental assistance paired with voluntary support services to eight major metropolitan areas across Texas: Austin-Round Rock, Brownsville-Harlingen, Corpus Christi, Dallas-Fort Worth-Arlington, El Paso, Houston-The Woodlands-Sugar Land, McAllen-Edinburg-Mission, and San Antonio-New Braunfels. Unlike many of the HOME initiatives, this program does not provide funds for rehabilitation or construction.¹¹⁹ People with serious mental illness and people with disabilities exiting institutions are target populations for this program, as well as youth exiting foster care.¹²⁰ TDHCA, HHSC, and DFPS have entered an inter-agency agreement to effectively address the needs 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.¹²¹

Since the Section 811 PRA program began in 2012, two rounds of funding have been awarded; Texas received awards in both the FY 2012 and FY 2013 cycles. Combined, Texas received about \$24 million. A March 2020 Section 811 PRA program publication reported that Texas's 655 integrated housing units were the most of any state.^{122 123}

In the 2020-21 General Appropriations Act, the state budget awarded TDHCA with \$207,614 in 2020 and \$206,559 in 2021 for Section 811 PRA funding.¹²⁴ For more information on this program, please visit the TDHCA website <https://www.tdhca.state.tx.us/section-811-pra/>.

AMY YOUNG BARRIER REMOVAL PROGRAM

The Amy Young Barrier Removal Program (AYBR) provides funding for persons with disabilities to improve accessibility and remove dangerous conditions from their homes. The program provides one-time grants of up to \$22,500 for accessibility home modifications to people with a disability whose household incomes are at or below 80 percent of AMFI.¹²⁵ Accessibility modifications may include the installation of ramps, handrails, or door widening, for example. Program beneficiaries may be homeowners or renters. Funds for the AYBR Program come from the state's Housing Trust Fund. In December 2019 TDHCA announced that over \$1,545,000 million will

be available in 2020 for the program.¹²⁶ Of this total, about \$765,000 will go towards rural communities, and \$780,000 will go to urban areas.¹²⁷ TDHCA disburses funds to nonprofit organizations and local governments that process applications, verify eligibility, and oversee construction.¹²⁸

POVERTY AND HOMELESS PREVENTION PROGRAMS

TDHCA has several programs that specifically serve people who are experiencing homelessness.

HOMELESS HOUSING AND SERVICES PROGRAM

The Homeless and Housing Services Program (HHSP) was established during the 81st Texas Legislature through an appropriations rider, and codified during the 82nd Texas Legislature.¹²⁹ This state-funded program provides funding to the nine largest cities in Texas to support a variety of activities to address and prevent homelessness including:

- Construction, development, or procurement of housing for homeless persons;
- Rehabilitation of structures targeted to serving homeless persons or persons at-risk of homelessness;
- Provision of direct services and case management to homeless persons or persons at-risk of homelessness; and
- Other homelessness-related activity as approved by the Department.¹³⁰

HHSP contracted with 10 localities in FY 2020, including the cities of Arlington, Austin, Dallas, El Paso, Fort Worth, Houston, Plano, and San Antonio, in addition to the Haven for Hope facility in San Antonio and the Mother Teresa facility in Corpus Christi.¹³¹ During the 86th Legislative Session, General Revenue funds for the 2020-2021 biennium provided about \$9.8 million for HHSP in general set-aside funds and an additional \$3 million for youth experiencing homelessness. About \$4.9 million dollars in general set-aside funds and \$1.5 million dollars in youth set-aside funds was provided to cities with populations over 285,500. Amounts provided to sub-recipients was determined depending on total population, percentage of persons in poverty, population of persons with disabilities, incidents of family violence, and the Point-In-Time count of veterans, unaccompanied youth, parenting youth, children of parenting youth, and overall number of persons experiencing homelessness. HHSP provided homeless services to 6,473 individuals in FY 2019.¹³²

EMERGENCY SOLUTIONS GRANTS PROGRAM

The Emergency Solutions Grants (ESG) program is a competitive grant that awards funds to private nonprofit organizations, cities, and counties to provide the services necessary to help persons that are at-risk of homelessness or homeless quickly regain stability in permanent housing.¹³³ The ESG program is funded by HUD and provides two-year awards. Program funds can be used to support multiple activities related to preventing and mitigating homelessness, including:

- Engaging individuals experiencing homelessness and families living on the street;
- Improving the number and quality of emergency shelters for individuals experiencing homelessness and families;
- Helping operate emergency shelters;
- Providing essential services to shelter residents;
- Rapidly rehousing individuals experiencing homelessness and families; and
- Preventing families and individuals from becoming homeless.

In FY 2019 a total of 64,982 people were served by ESG, and in 2019 over \$8.7 million was allocated for ESG services.^{134,135}

RELATED SERVICES AND PROGRAMS - OTHER STATE AGENCIES

TEXAS VETERANS HOUSING ASSISTANCE PROGRAM

The veteran population is at a higher risk of mental health or substance use conditions compared to the general population.¹³⁶ As the Texas Veterans Commission chapter of this guide details, nearly 38,000 veterans were experiencing homelessness on a single night in January 2018, accounting for nearly 9 percent of all homeless adults. Of these veterans experiencing homelessness, 62 percent were staying in emergency shelters or transitional housing programs.¹³⁷ In an effort to alleviate the housing burden, the Texas Veterans Land Board offers a mortgage program to help veterans in Texas purchase homes.

The Veterans Housing Assistance Program allows veterans to purchase homes in Texas with little to no down payment with a below market low-interest loan. Those with service-related disabilities ratings of 30 percent or higher can obtain a greater discounted interest rate. Veterans, active duty members, and spouses may borrow on fixed rate loans for 15, 20, 25, or 30 year terms.¹³⁸ More information can be found here: <https://www.findmywayhome.com/assistance/texas-veterans-housing-assistance-program/>

MODEL BOARDING HOME STANDARDS

A boarding home is a business that provides basic care to at least three residents who are unrelated to the owner and who have a disability and/or are elderly. Examples of basic care services include meals and transportation. Boarding homes can serve an important role in the continuum of care for people with mental health conditions and other disabilities. While some homes provide safe and affordable living quarters for their residents, the lack of state regulation has historically left some individuals living in dangerous conditions in boarding homes with few repercussions. Legislative efforts to improve boarding homes as a better option for more Texans experiencing mental illness resulted in legislation filed in 2009. HB 216 (81st. Menendez/Shapleigh) directs HHSC to establish model boarding home standards.¹³⁹ For more information on boarding homes, view the most recent report from HHSC: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/what-are-texas-boarding-home-model-standards>.

SUPPORTIVE HOUSING RENTAL ASSISTANCE PROGRAM

In 2013, the 83rd Legislature awarded an exceptional item to the Department of State Health Services (DSHS) to provide short-term rental and utility assistance to individuals with mental illness through LMHAs. The program was originally established to act as a stopgap measure while individuals waited to receive other vouchers.¹⁴⁰ The program today provides short-term assistance for up to three months to help people maintain their current housing, and longer-term assistance of up to 12 months with extensions given on a case-by-case basis.¹⁴¹ The program now operates at 20 LMHAs across the state and is administered by HHSC.¹⁴²

In FY 2018, people who received supportive housing rental assistance experienced a 57 percent reduction in the average number of psychiatric hospitalizations and a 48 percent reduction in the number of crisis encounters.¹⁴³ Additionally, recipients experienced a 39 percent reduction in criminal justice involvement and an overall 79 percent reduction in homelessness after receiving supportive housing rental assistance.¹⁴⁴

For more information on the Supportive Housing Rental Assistance Program, see the HHSC section of this guide.

HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES THROUGH 2-1-1

Since 2013, there has been a clearinghouse available for housing and services resources on the 2-1-1 Texas website. Searchable by geographic area, this online clearinghouse provides an interactive resource for finding community-based affordable housing including subsidized and supportive options. There is also a section dedicated to services for people experiencing mental illness, including counseling and support groups. The clearinghouse website is now overseen by HHSC and is available at <https://www.211texas.org/guided-search/>.

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Texas Workforce Commission

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Policy Concerns

- Ensuring sustainable employment outcomes for people with serious and persistent mental health conditions and substance use conditions.
- Effects of COVID-19 on the Texas economy and workforce, and especially on those with mental health conditions.
- Lack of ongoing federal financial assistance for people impacted by the COVID-19 pandemic.
- Establishing accountability for outcome-based vocational rehabilitation services for individuals living with serious and persistent mental health conditions
- Lack of available information and data regarding employment outcomes for people experiencing mental health conditions.
- Long wait times for people seeking assistance accessing unemployment benefits through the Texas Workforce Commission.

Fast Facts

- The Texas unemployment rose from 2.5 percent in February 2020 to 13 percent in May 2020 and 8 percent in July 2020.^{1,2} The national unemployment rate went from 3.5 percent in February 2020 to 13.3 percent in May 2020 to 10.2 percent in July 2020.³ These numbers were impacted significantly by the

COVID-19 pandemic. The unemployment rate is the ratio of the population that is unemployed and seeking employment to the current labor force.⁴

- During a month-long period from May-June 2020, over 291,000 jobs were added into the Texas economy.⁵
- A June 2018 TWC report indicated that there were about 1.5 million Texans aged 18-64 (standard working age-range) who had a disability.⁶
- The national and state unemployment rates do not always reflect the prevalence of unemployment for people with serious mental illness or intellectual and developmental disabilities (IDD). The National Alliance on Mental Illness (NAMI) reported that the national unemployment rate for individuals receiving public mental health services was approximately 80 percent in 2012. The same year, the unemployment rate for individuals receiving services through the public mental health system in Texas was 85.6 percent.⁷
- In 2018, about 40.2 percent of Texans with disabilities living in the community (ages 18-64) were employed compared to 76.4 percent of people without a disability.⁸ In the same year, the national unemployment rate for people with a disability was 8 percent, over twice that of people without a disability who had a 3.7 percent unemployment rate.⁹

TWC Acronyms

CDC – Center for Disease Control

COVID-19 – Coronavirus disease of 2019

FUTA – Federal unemployment tax

HHSC – Health and Human Services Commission

IDD – Intellectual and other developmental disabilities

NAMI – National Alliance on Mental Illness

SEAL – Summer Earn and Learn

SNAP E&T – Supplemental Nutrition Assistance

Program Employment and Training

TANF – Temporary Assistance for Needy Families

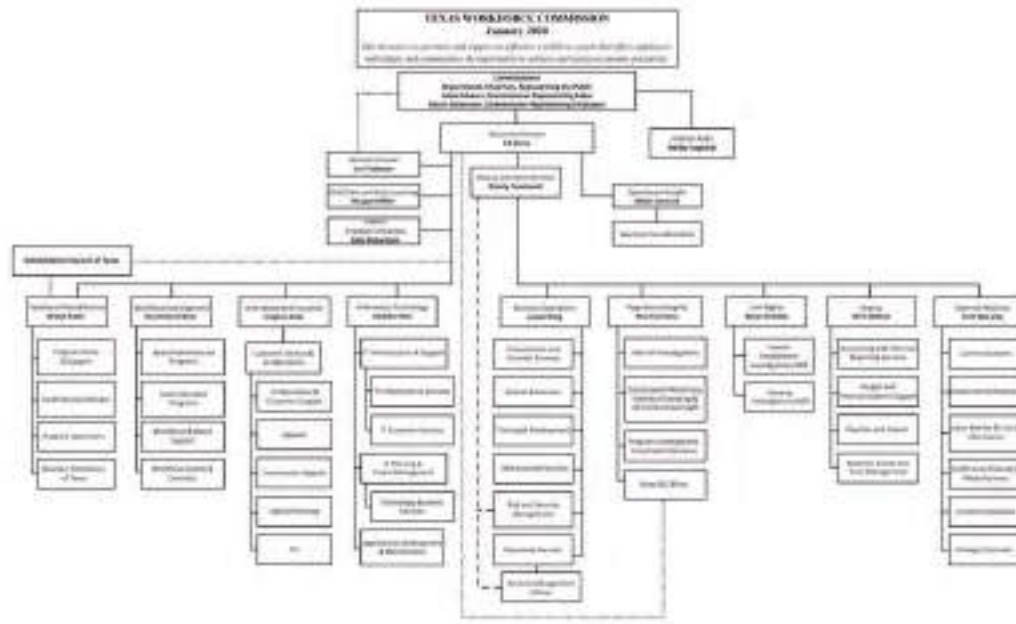
TVLP – Texas Veterans Leadership Program

TWC – Texas Workforce Commission

VR – Vocational rehabilitation

WIA – Workforce Investment Act

Organizational Chart



Source: Texas Workforce Commission (2020). Organizational Chart. Retrieved from <http://www.twc.state.tx.us/files/agency/agency-organizational-chart-twc.pdf>

Overview

The Texas Workforce Commission (TWC) is the state agency charged with overseeing and providing workforce development services to both employers and job seekers across the state. TWC works toward the end goals of the Governor's economic development strategy by providing the needed workforce development component. Three commissioners are appointed by the governor to represent the agency, each assigned to represent labor, employers, or the public.

TWC's major functions include:

- Developing the workforce;
- Providing support services, including child care, for targeted populations participating in workforce training; and
- Administering the unemployment benefits and tax programs.

TWC is part of Texas Workforce Solutions, a local and statewide network comprised of TWC, 28 Workforce Development Boards, and their contracted service providers and community partners.¹⁰ Workforce Development Boards allow for regional planning and service delivery. Through this network, TWC reaches consumers at the local level in Workforce Solutions offices across the state and five Tele-Centers.¹¹

Texas Workforce Solutions provides workforce development services that are intended to: 1) help consumers find and maintain employment, and 2) help

employers hire the skilled workers needed to conduct business. Workforce partners include community colleges, adult basic education providers, local independent school districts, economic development groups, private businesses, and other state agencies. Collaboration and coordination across these various stakeholders are both necessary to meet TWC’s overall mission to “promote and support a workforce system that creates value and offers employers, individuals, and communities the opportunity to achieve and sustain economic prosperity.”¹²

Table 81 describes four major types of beneficiaries who utilize TWC services.

Table 81. TWC Beneficiaries and Coordinated Action

Beneficiary	TWC Action
Job Seekers and Employees	<ul style="list-style-type: none"> • Provides unemployment benefits to workers who have lost their jobs through no fault of their own, including due to COVID-19. • Posts job vacancies associated with the state. • Provides vocational rehabilitation services for those with physical or cognitive disabilities, services for veterans, and more.¹³
Businesses and Employers	<ul style="list-style-type: none"> • Allows for job postings on the TWC website. • Offers recruiting, training and retaining, outplacement services, and valuable information on employment law and labor market trends and statistics. • Establishes unemployment tax accounts.¹⁴
Community and Workforce Partners	<ul style="list-style-type: none"> • Provides information on economic development resources, Workforce Development Boards, procurement opportunities, and civil rights and housing discrimination.¹⁵ • Lists resources for contractors and providers who assist Texans with disabilities through TWC programs.
Students, Parents, and Educators	<ul style="list-style-type: none"> • Offers vocational rehabilitation services for youth and students with physical or cognitive disabilities. • Provides career development and education planning resources, with focuses on science/technology/engineering/math (STEM) programs. • Offers the Adult Education and Literacy program to help adult learners achieve high school equivalency and prepare for college or career trainings.¹⁶

Source: Texas Workforce Commission. Retrieved from <https://www.twc.texas.gov/>

Individuals with disabilities, including serious mental health conditions, often experience barriers associated with joining and participating fully in the labor force (for a list of what TWC’s use of the term “disability” encompasses, see here: <https://workquest.com/wp-content/uploads/2018-Disability-Determination-Worksheet.pdf>).¹⁷ People with disabilities are more likely to work part-time and, on average, earn less than individuals without disabilities at every level of educational attainment.¹⁸ Because of the unique challenges individuals with disabilities face in the job market, national and state-level unemployment rates do not always reflect the prevalence of unemployment for people with serious mental illness or IDD. NAMI reported that the national unemployment rate for individuals receiving public mental health services was approximately 80 percent in 2012.¹⁹ The same year, the unemployment rate for individuals receiving services through the public mental health system in Texas was 85.6 percent.²⁰ Yet for persons living with serious mental illness, employment can play a primary role in recovery and well-being.²¹ In 2014, The Bazelon Center for Mental Health Law reported that at least two-thirds of people with a serious mental illness want to work, and many have been previously employed.²²

In 2018, about 11.4 percent of citizens in Texas, or over 3.2 million people, had a disability. This was the second largest total number per state in the nation.²³ Individuals with disabilities, including serious mental illness, can enhance workforce diversity and offer employers unique skill sets and perspectives when integrated into the labor force. Employing people with disabilities is advantageous to businesses as it results in lower turnover, increased productivity, and access to a wider pool of skilled workers.²⁴

For those experiencing mental health conditions, employment can promote social acceptance and community integration that leads to lifelong recovery and wellbeing. Work also gives people a sense of purpose, self-esteem, and self-worth.²⁵ The Center for Disease Control (CDC) has multiple recommendations to manage mental health and stress in the workforce. They have proposed that healthcare providers ask patients about depression or anxiety, and that health professionals be part of core treatment teams. Public health researchers can create guides that outline the implementation and evaluation of mental health programs in the workplace, including the development of mental health scorecards for employees to rank their workplace and employee training and recognition programs. The CDC recommends community leaders and businesses promote mental wellness through educational programs to working adults through different agencies, support existing community programs that reduce risks of mental illness, and establish a system to easily access these community-based programs. The Texas Legislature is encouraged by the CDC to provide resources, coursework, and decision-making tools to organizations and employers delivering mental health education. In addition, the CDC recommends that the state collect data on workers' wellbeing and on biomedical research to guide mental health innovations, and to promote techniques to help people in underserved communities to obtain mental health treatments.²⁶

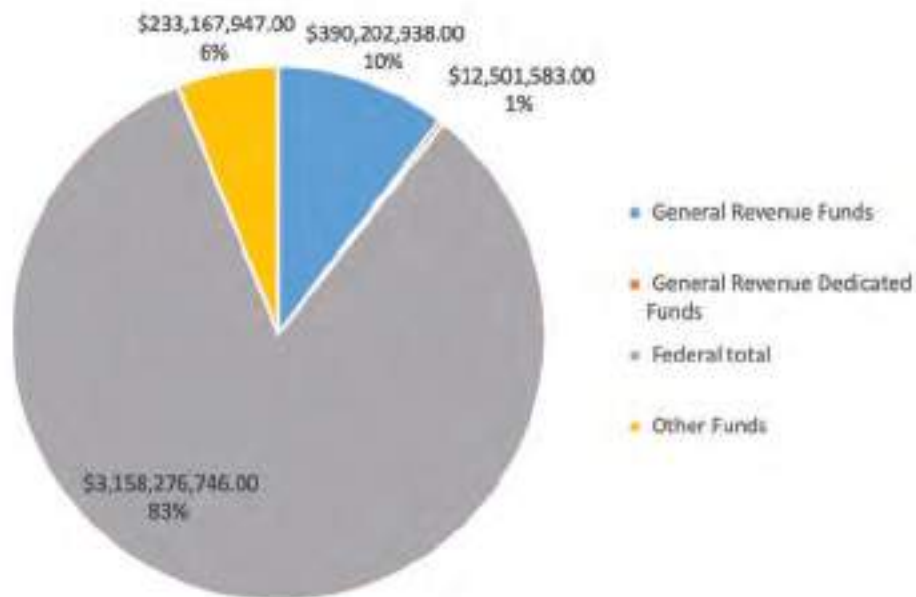
Read about the TWC and their 2019-2023 Strategic Plan here <https://twc.texas.gov/files/twc/strategic-plan-fiscal-years-2019-to-2023-twc.pdf>.

View TWC's financial reports here <https://www.twc.texas.gov/agency/texas-workforce-commission-financial-grant-information>.

Funding

TWC's funding is comprised of both federal and state dollars, with the majority of funding coming from federal sources. TWC provides grants through allocation formulas to Workforce Development Boards that plan and administer the Workforce Investment Act, Temporary Assistance for Needy Families Choices, Employment Services, Supplemental Nutrition Assistance Program Employment and Training, childcare, and other workforce and support services. Employer-paid state unemployment taxes and reimbursements pay for state unemployment benefits. The U.S. Department of Labor allocates funds from the Federal Unemployment Tax to the states to pay for administrative and operational costs.²⁷ TWC's budget from FY 2018-19 increased by about 23 percent, from almost \$3,087 billion to over \$3,794 billion in FY 2020-21.

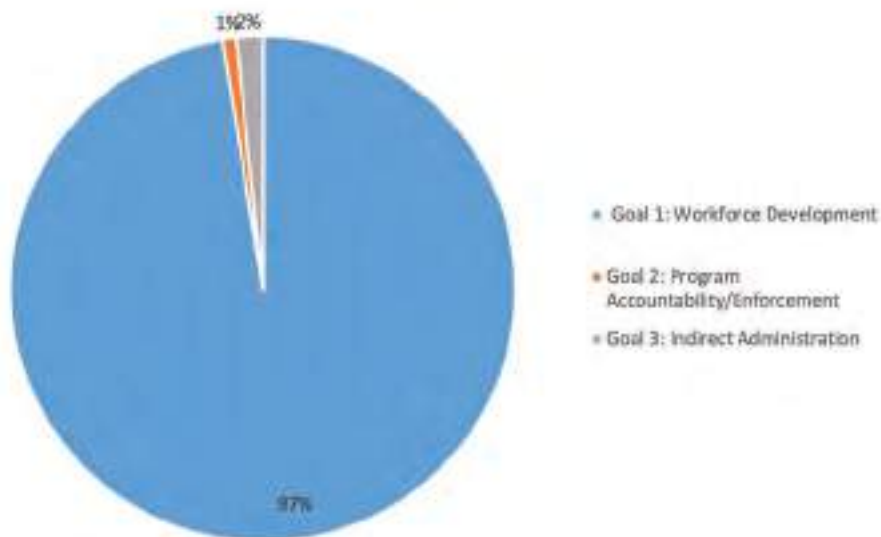
Figure 115. TWC Budget by Method of Finance FY 2020-21



Total TWC Budget for FY 2020-21: \$3,794,149,214.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Figure 116. TWC Funding by Strategy FY 2020-21



Total TWC Budget for FY 2020-21: \$3,794,149,214.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Changing Environment

Several pieces of legislation passed during the 86th legislative session that impacted TWC and Texas's mental health shortage. One such bill was HB 2813 (Price/Nelson), which requires a representative from TWC to serve on the statewide behavioral health coordinating council.²⁸ Detailed breakdowns of these bills can be found in the Hogg Foundation for Mental Health's Texas 86th Legislative Session Summary: <https://hogg.utexas.edu/wp-content/uploads/2019/09/86th-Legislative-Summary.pdf>.

TRANSFER OF SERVICES FROM THE DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES TO TWC

Prior to September 2016, TWC did not provide any direct behavioral health treatments or supports to Texans with a mental health condition. However, in 2016 the state transitioned employment-related programs from the Department of Assistive and Rehabilitative Services to TWC as part of the HHSC transformation process. As a result, TWC began to work directly with individuals with disabilities primarily through the Vocational Rehabilitation (VR) program. The VR program provides services for people with disabilities to help them prepare for, obtain, retain, or advance in employments.²⁹ More information is provided in the Vocational Rehabilitation For Persons with Physical and Mental Disabilities section of this chapter.

EMPLOYMENT TRENDS AND OVERALL OUTCOMES

Employment rates of people with disabilities had been improving prior to the COVID-19 pandemic. Nationally, labor force participation rates (the number of people available for work as a percentage of the total population) and employment rates for people with disabilities had been increasing while unemployment rates for people with disabilities had been decreasing.³⁰ However, employment outcomes for people with disabilities continued to be far worse than for people without disabilities. In 2018, about 40.2 percent of Texans with disabilities living in the community were employed compared to 76.4 percent of people without a disability.³¹ In the same year, the national unemployment rate for people with a disability was 8 percent, over twice that of people without a disability who had a 3.7 percent unemployment rate.³² Figure 117 below illustrates unemployment trends for those living with disabilities.

Figure 117. Selected National Labor Force Indicators, Persons with a Disability, 2009-2018



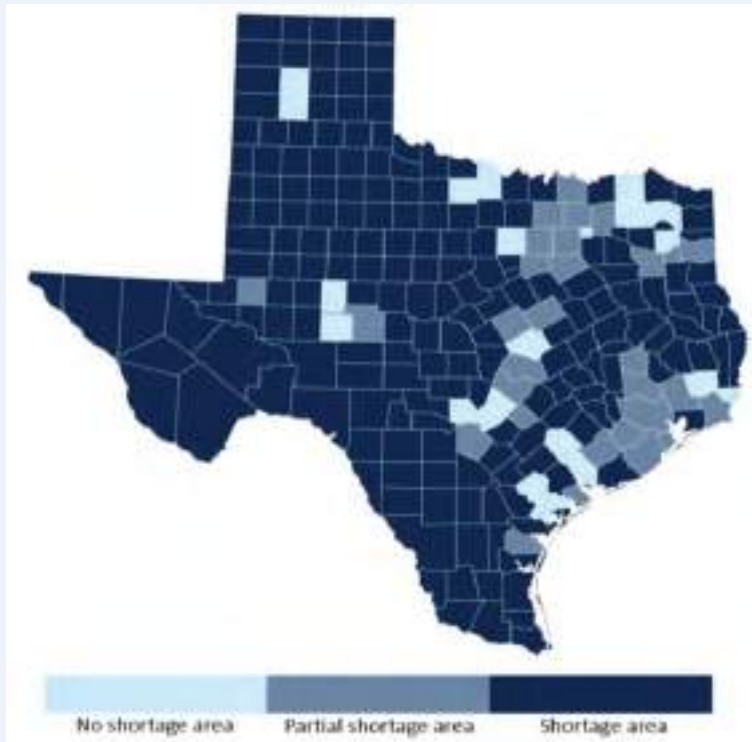
(LFPR = Labor Force Participation Rate; EP = Employment-Population Ratio; UR = Unemployment Rate)

Source: Division of Labor Force Statistics. (March 29, 2019). *Persons with a Disability, 2018*. Presentation to Office of Disability Employment Policy (ODEP). Retrieved from https://www.dol.gov/odep/pdf/DOL_ODEP_2018_Briefing_with_notes_ODEP.pdf

TEXAS MENTAL HEALTH WORKFORCE SHORTAGE

Texas has a shortage of mental health professionals in the state. As Figure 118 from the 2019 Texas Statewide Behavioral Health Strategic Plan shows, over 80 percent of counties in the state are deemed Mental Health Professional Shortage Areas, where there are more than 30,000 residents per clinician.³³

Figure 118. Federally Designated Mental Health Professional Shortage Areas



Source: (page 54) Texas Health and Human Services Commission. (2019, February). Texas Statewide Behavioral Health Fiscal Years 2017 – 2021 Strategic Plan Update and the Foundation for the IDD Strategic Plan. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behvh-hlth-idd-plan-feb-2019.pdf>

In order to address the mental health and substance abuse workforce issues in Texas, advocates have proposed a statewide, cross-agency strategic workforce plan to address these needs. In the 86th Legislative Session, HB 1669/SB 429 (Lucio/Lucio) failed to pass on a point of order in the final days of the session. The bill would have required HHSC to develop and implement a strategic plan to address workforce issues. While HHSC has moved forward independently to develop such a plan, there is currently no directive to implement the recommendations included in the workforce workplan and there are no available funds to cover the costs associated with implementation.

Two bills that did pass in 2019 to address the mental health workforce shortage are HB 1065 (86th, Ashby/Kolkhorst) and SB 11 (86th, Taylor/Bonnen). HB 1065 created a rural resident physician grant program to encourage the creation of new graduate medical education positions in rural and non-metropolitan areas. The intent was to place particular emphasis on the creation of rural training tracks. SB 11 established the Texas Child Mental Health Care Consortium that included provisions for creating new opportunities for integrated health care for children, funding for psychiatry residencies, and development of the Child Psychiatry Access Network.

See the Mental Health Workforce section in the Policy Environment chapter of this Guide for more information on efforts to reduce the Texas mental health workforce shortage.

Programs for People Experiencing Mental Illness

TWC's partnership with the Texas Governor's Committee on People with Disabilities and Texas Workforce Solutions led to the Texas HireAbility campaign.³⁴ This statewide initiative raises awareness about how hiring Texans with disabilities is beneficial to employers by highlighting their contributions to the state's workforce. During Disability Employment Awareness Month in October, the campaign plays a major part in the promotion of hiring and disability awareness events around Texas.³⁵

A Tri-Agency Workforce Initiative was initiated between TWC, the Texas Higher Education Coordinating Board, and the Texas Education Agency to support students with disabilities in their efforts to pursue educational opportunities and achieve employment goals. In support of the Tri-Agency's objectives, in FY 2017 TWC established its Summer Earn and Learn (SEAL) work-based learning program. The initiative launched with all 28 local workforce development boards and their employer partners around Texas. Over 1,500 students with disabilities gained work-readiness training and paid work experience from their participation in SEAL.³⁶

In FY 2019, a partnership between TWC's Purchasing from People with Disabilities program (known as the State Use Program) and Community Rehabilitation Programs (CRPs) employed nearly 6,000 Texans with disabilities in 106 local nonprofit CRPs.^{37,38}

VOCATIONAL REHABILITATION FOR PERSONS WITH PHYSICAL AND MENTAL DISABILITIES

For people experiencing mental illness, work can play a primary role in their lifelong recovery and well-being.³⁹ Employment promotes social acceptance, community integration, and gives people a sense of purpose, self-esteem, and self-worth.⁴⁰ People with mental illness face unique challenges to employment including stigma, discrimination, and fear of losing benefits. However, there are employment programs to help minimize these challenges, assist individuals with work readiness, and help them achieve long-term success in the workplace.⁴¹

The Vocational Rehabilitation (VR) program is a state-federal partnership designed to help individuals with disabilities (physical and developmental disabilities as well as serious mental health conditions) prepare for, find, and keep jobs. The VR program is also intended to help individuals with disabilities transition from high school to a work environment.⁴²

An individual may be eligible for VR services if they:

- Have a disability which results in substantial barriers to employment
- Require services to prepare for, obtain, retain, or advance in employment
- Are able to obtain, retain or advance in employment as a result of services⁴³

People receiving social security disability benefits also qualify for VR services.⁴⁴ People who are eligible to receive VR services work with a VR counselor to determine what services are appropriate and needed. VR services are consumer-focused, meaning that those who receive services have a voice in their services. Consumers work with their VR counselors to create an individualized plan for employment, which outlines what employment goals an individual has and how VR services can assist in achieving those goals. VR services are based on an individual's needs and vary greatly depending on disability, needs, and employment goals. Work-related services may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services.⁴⁵

Consumers can obtain these vocational rehabilitation services by applying with their local Texas Workforce Solutions – Vocational Rehabilitation Services Office; eligibility decisions are typically made within 60 days. If deemed eligible, the person will work with their assigned counselor to develop an Individualized Plan for Employment within 90 days that will include the services necessary for the person to reach their employment goals.

VR service providers partner 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.⁴⁶ In FY 2019, 69,873 Texans with disabilities received VR services, and 13,577 of them had a successful employment outcome.⁴⁷

More information on the VR program can be found online at <http://www.twc.state.tx.us/jobseekers/vocational-rehabilitation-adults>.

Programs for Veterans

The June 2020 national veteran unemployment rate was 8.8 percent, lower than the non-veteran unemployment rate was of 11.1 percent.⁴⁸ TWC provides services specifically for veterans, who are at higher risk of mental health conditions and suicide compared to the general US population.⁴⁹

TEXAS VETERANS LEADERSHIP PROGRAM

The Texas Veterans Leadership Program (TVLP) targets veterans returning from Iraq and/or Afghanistan. The program helps them find employment and transition back into civilian life.⁵⁰ TVLP Veterans Resource & Referral Specialists use referrals to help their fellow veterans address employment, training, medical/educational needs, case management, life skills, and more. Each of the 28 workforce development areas receives one specialist, who coordinates with staff from both the Workforce Solutions and Texas Veterans Commission. All TVLP Resource & Referral specialists are veterans of Iraq and/or Afghanistan, and they do the following tasks:

- Seek out veterans in need of services;

- Serve as resource and referral agents, directing returning veterans to resources tailored to their needs;
- Make referrals and coordinate with different programs ranging from employment and training to medical care, mental health and counseling, veterans' benefits, and other programs to address the varying needs of veterans; and
- Coordinate a chain of volunteer veterans familiar with the obstacles faced by returning veterans to assist in mentoring and serving returning Iraq/Afghanistan veterans.⁵¹

TWC also offers the following services for veterans:

- Priority service for all workforce services;
- Base Realignment and Closure National Emergency Grant;
- Hard-to-Serve Veterans Initiative;
- Comprehensive Veterans Initiative;
- Two-day hold on new job postings in WorkInTexas.com to ensure veterans get first viewing;
- Integration points between WorkInTexas.com and USnlx.com; and
- Veteran-specific job search portal in WorkInTexas.com via the Texas Veterans Portal.⁵²

VETERANS WORKFORCE OUTREACH INITIATIVE

TWC selectively provides services to “hard-to-serve” veterans who have one or more barriers to employment. These barriers include: homelessness, substance use history, a physical/mental/learning disability, post-traumatic stress disorder, criminal history, or recent discharge from the military. The Veterans Workforce Outreach Initiative was created to:

- Engage in outreach to hard-to-serve veterans who are not currently being served through Workforce Solutions Offices;
- Address employment barriers faced by hard-to-serve veterans; and
- Reintegrate hard-to-serve veterans into meaningful employment.⁵³

In addition to receiving employment services such as assessments, job development/placement, and case management, veterans in this initiative can also receive support services. These include: mental health assistance, clinical counseling, medical resources such as wheelchairs/crutches/medical beds, food/utility/rent/financial assistance, and transportation. In the one-year grant period starting March 2018, the project helped 816 veterans receive assessment and case management services, with 258 receiving employment.⁵⁴

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Texas Veterans Commission

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Policy Concerns

- Impacts of COVID-19 on the veteran population and TVC operations.
- Continued expansion of veteran peer specialist services for mental health and substance use.
- Long waiting lists for mental health services with the Veteran's Health Administration.
- Coordination of federal and state services.
- High risk of post-traumatic stress disorder among veterans.
- High rates of suicide and easy access to lethal means such as firearms among veterans.
- High rates of homelessness among veterans.
- Lack of supports for veterans returning to civilian life after deployment.
- Lack of access to mental health services and supports in rural areas of the state.
- Sexual assault and mental health effects on women veterans.

Fast Facts

- As of September 2017, Texas was home to over 1.6 million veterans of the armed forces, more than any other state except California.¹ While the national Veteran population is predicted to decline from 20.8 million in 2015 to 12.0 million in 2045, Texas is projected to have the most veterans of any state by 2020.^{2,3}
- The Veterans Health Administration (VHA) is America's largest integrated health care system, providing care at 1255 health care facilities, including 170 medical centers and 1074 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled veterans each year.⁴
- By September 2017, women comprised 11.2 percent of the total Veteran population in Texas, higher than the national average of 9.41 percent. By 2045, women are projected to make up 19.8 percent of all living veterans.⁵
- In 2015, post-traumatic stress disorder (PTSD) accounted for the most service-connected disabilities for women Veterans at 11.8 percent. Major depression was the second highest at 6.5 percent.⁶
- Nearly 70,000 Texas Operation Enduring Freedom and Operation Iraqi Freedom veterans will confront a mental health condition.⁷
- While serving in the military, 55 out of every 100 women and 38 out of every 100 men report having been sexually harassed (including offensive comments about a person's body or sexual activity, displays of pornographic material, and unwanted sexual advances). Additionally, 23 out of 100 women reported sexual assault. These statistics include only Veterans who use VA health care.⁸
- Veterans exhibit significantly higher suicide risk compared with the U.S. general population.⁹ About 16.8 veterans died from suicide each day in 2017.¹⁰
- Sixty-nine percent of all veteran suicides nationally occurred with the use of a firearm, compared to Texas, where over 75 percent of veteran suicide deaths occurred by use of a firearm (2012-2016).¹¹
- 41 percent of VHA patients have a diagnosed mental illness or substance use condition.¹²
- The number of veterans experiencing homelessness declined by five percent between 2017 and 2018 and has dropped by 48 percent since 2009.¹³
- On a single night in January 2018, veterans accounted for just under 9 percent of all homeless adults. Of these, 62 percent were staying in emergency shelters or transitional housing programs.¹⁴ Men accounted for about 91 percent veterans experiencing homelessness (34,412 veterans).¹⁵ A higher percentage of veterans experiencing homelessness were white (58 percent) compared to all people experiencing homelessness (49 percent).¹⁶

TVC Acronyms

COVID-19 – Coronavirus disease of 2019

HHSC – Health and Human Services Commission

PTSD – Post-traumatic stress disorder

SMVF – Service members, veterans, and families

MFVPP – Military Families and Veterans Pilot

Prevention Program

TBI – Traumatic brain injury

TVC – Texas Veterans Commission

VA – Veterans Affairs

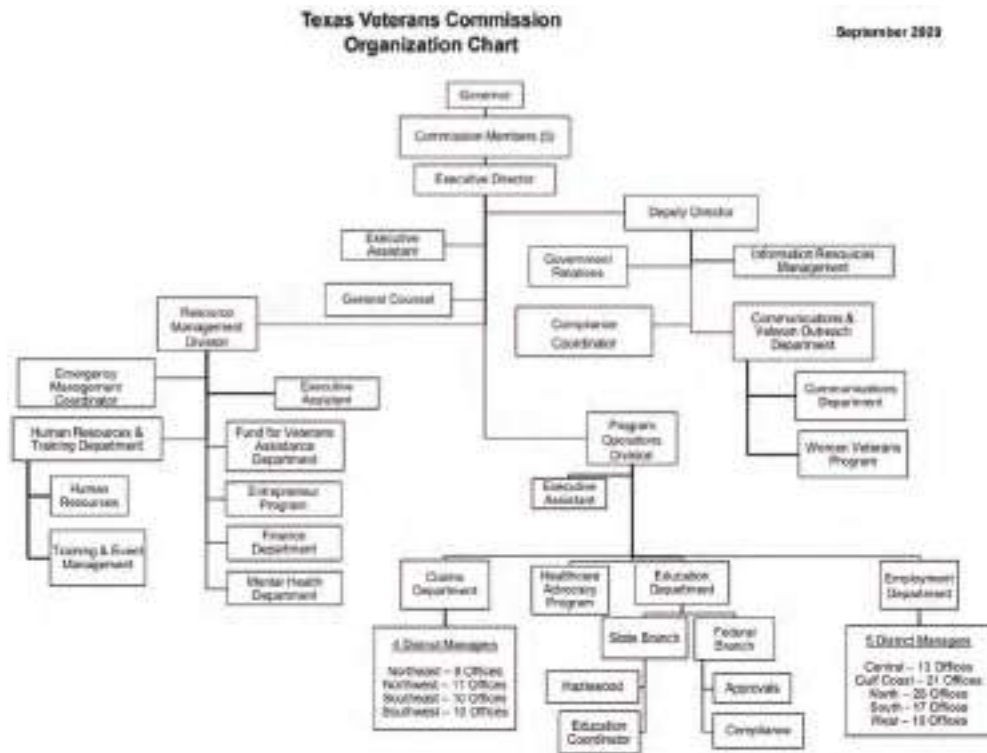
VCL – Veterans Crisis Line

VHA – Veterans Health Administration

VISN – Veterans integrated service networks

VMHP – Veterans Mental Health Program

Organizational Chart



Retrieved from Legislative Budget Board (2020). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2022-2023*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020>

Overview

The Texas Veterans Commission (TVC) serves veterans and their dependents in all matters pertaining to veterans' disability benefits and rights. TVC is Texas's designated agency to represent the state and its veterans before the US Department of Veterans Affairs, with the mission of advocating for and providing superior service to improve the quality of life for all Texas veterans, their families, and survivors.¹⁷ The Commission submitted the TVC Strategic Plan for Fiscal Years 2019-2023 to the governor in June 2018. The plan is available at https://www.tvc.texas.gov/wp-content/uploads/2018/06/TVC_Strategic_Plan_2019-2023_Final.pdf.

TVC also submitted the Operating Budget For FY 2020 to the governor and the Legislative Budget Board in December 2019. It can be viewed at <https://www.tvc.texas.gov/wp-content/uploads/2019/12/FY2020-TVC-Operating-Budget-FINAL.pdf>.

TVC represents veterans in filing Veteran Affairs (VA) disability claims and during VA appeals processes, and it vaavassists dependents with survivor benefits. Additionally, TVC focuses on the following eight program areas, which impact veterans' ability to access behavioral health services:

- Claims Representation and Counseling
- Veterans Employment Services
- Veterans Education
- Veteran Entrepreneur Program
- Health Care Advocacy
- Veterans Mental Health Program
- Women Veterans Program
- Fund for Veterans' Assistance.¹⁸

The US Department of Defense Military Health System is responsible for providing health care to active duty and retired US military personnel and their families. For more information, visit www.health.mil.

Texas is home to nearly 1.6 million veterans of the armed forces whom represent 7.94 percent of the adult population, higher than the national average of 6.6 percent.¹⁹ The national veteran population is predicted to decline from about 20 million in 2017 to around 13.6 million by 2037 and to about 12 million by 2045. Texas is soon expected to surpass California as the number one state where veterans reside.^{20,21} 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. About 14 percent of veterans of the Iraq and Afghanistan wars are diagnosed with PTSD.²² In comparison, less than 7 percent of American adults in the general population will experience PTSD at some point during their lifetime, with women being about twice as likely to develop it as men.²³ In addition to combat trauma, sexual assault while in military duty (referred to as military sexual trauma) can also result in symptoms of PTSD (the most common mental health diagnosis pertaining to military sexual trauma).²⁴

Among women who use the VA to access health care, 23 out of 100 report having been sexually assaulted (unwanted physical sexual touching that involves some form of coercion) while in the military.²⁵ Additionally, 55 out of 100 women and 38 out of 100 men report having been sexually harassed, which includes behavior such as offensive comments about a person's body or sexual activity, displays of pornographic material, and unwanted sexual advances while in the military.²⁶ Thus, veterans are at increased risk for developing mental health conditions and substance use problems stemming from their military service.

Veterans have the option to receive mental health care from the VA. PTSD, substance use conditions, and anxiety are the most commonly reported conditions for veterans receiving services through the VA.²⁷

Veterans with mental health and substance use conditions face a number of increased risk factors including: chronic homelessness, suicide, a wide range of serious medical problems, premature mortality, and incarceration.^{28,29} According to a study conducted by the RAND Center for Military Health Policy Research, less than half of returning veterans needing mental health services receive any treatment at all, and of those receiving treatment for PTSD and major depression, less than one-third are receiving evidence-based care.³⁰ While COVID-19 may have affected the number of veterans seeking services in various parts of the state, as of June 2020 there was an average wait time of:

- 22 days to be seen at the only clinic within a 50-mile radius across Sheppard Air Force Base, TX;
- 23 days to be seen at the only clinic within a 50-mile radius across Beeville, TX; and
- 68 days to be seen at the only clinic within a 50-mile radius across Leflore, TX.³¹

Long wait times contribute to higher risk of suicide among Texas veterans. A September 2019 report from the US VA's Office of Mental Health and Suicide Prevention showed that mental health conditions (including bipolar, personality disorder, substance use, schizophrenia, depression, and anxiety), inpatient mental health care, prior suicide attempts, prior calls to the Veterans Crisis Line, and prior mental health treatment were all associated with increased likelihood of suicide.³² Male suicide rates are highest, and firearms are the number one cause of suicide death. See the Veteran Suicides section below for more information.³³

Changing Environment

Veterans' mental health is a focus for many lawmakers in Texas. A variety of legislation was filed in the 86th legislative session to address veterans' access to mental health treatments and supports. Some of the veteran-related legislation that was passed impacted TVC directly, while other bills were directed toward policies and initiatives of the Texas Health and Human Services Commission (HHSC) Mental Health Program for Veterans.³⁴ In this Changing Environment section, we are including legislation impacting veterans' mental health and substance use regardless of the agency impacted. Detailed breakdowns of bills can be found in the Hogg Foundation for Mental Health's Texas 86th Legislative Session Summary: <https://hogg.utexas.edu/wp-content/uploads/2019/09/86th-Legislative-Summary.pdf>.

LEGISLATION FROM THE 86TH LEGISLATIVE SESSION

HB 4429 (86th, Blanco/Menendez) included the local delivery of mental health first aid to veterans and their immediate family members in the Mental Health Program for Veterans.³⁵ SB 822 (86th, Nelson/Flynn) shifted the administration responsibilities of the Texas Veterans + Family Alliance grant program from a nonprofit or private entity to HHSC, aligning with similar community mental health grant programs. It also created a matching requirement of 50 percent non-state funds for counties with a population of less than 250,000 and 100 percent for counties with a population of more than 250,000.³⁶

HB 1, Appropriations, Article II (86th, Zerwas/Nelson) included HHSC mental health and substance use-related riders. Budget Rider 59 allocated \$5 million in general revenue each fiscal year to administer a mental health program for veterans. Budget Rider 61 allocated \$20 million in general revenue in FY 2020 to operate a grant program to support community mental health programs providing services and treatment to veterans and their families. Both will require a legislative report by December 1, 2020.³⁷

HB 3980 (86th, Hunter/Menendez) directed the Statewide Behavioral Health Coordinating Council to create a report on suicide rates in Texas and prevention efforts.³⁸ HCR 148 (86th, Landgraf) established June as Veteran Suicide and PTSD Awareness month for 10 years. SB 601 (86th, Hall/Birdwell/Buckingham/Nichols/Watson/Flynn) mandated that TVC publish needs assessment results online.³⁹ SB 1180 (86th, Menendez/Lopez) mandated that Veteran Treatment Court statistics are reported by the TVC, including funding pertaining to grants.⁴⁰ SB 1443 (86th, Campbell/Flynn) permissioned the Texas Military Preparedness Commission to consider mental health support and infrastructure development as part of their evaluations when examining grant applications.⁴¹

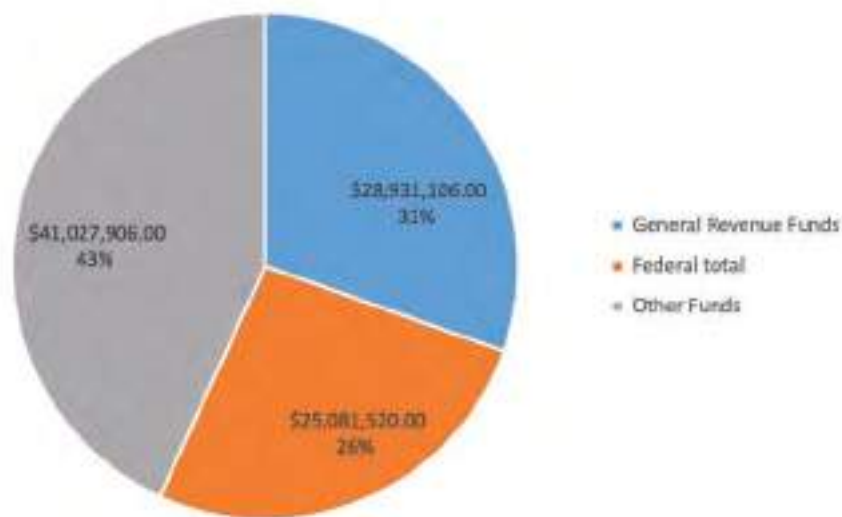
Of bills that failed to pass, HB 2307 (86th, Rosenthal) and HB 4513 (86th, Hunter) are most notable. HB 2307 would have required military cultural competency training for personnel by grant recipients providing mental health services to veterans in order to receive funding. HB 4513 would have required TVC to employ and train mental health professionals to assist the Texas Department of State Health Services to administer the mental health program for veterans.⁴²

Funding

TVC receives about 74 percent of its funds from the state (e.g., general revenue and other funds), and about 26 percent from federal dollars. The agency's budget increased over 3.6 percent from about \$91.730 million in FY 2018-19 to almost \$95.041 million in FY 2020-21.⁴³ Most of TVC's dollars come from funds other than general revenue and federal dollars, with a large percentage coming from the Fund for Veterans' Assistance. In terms of goals, the overwhelming majority of TVC funding goes towards helping veterans receive benefits and for funding direct services to veterans.⁴⁴ For FY 2022-23, TVC is requesting more than \$115.687 million, plus another \$2.429 million in Exceptional Items Requests.⁴⁵

*** Note: TVC is not part of the Health and Human Services enterprise.**

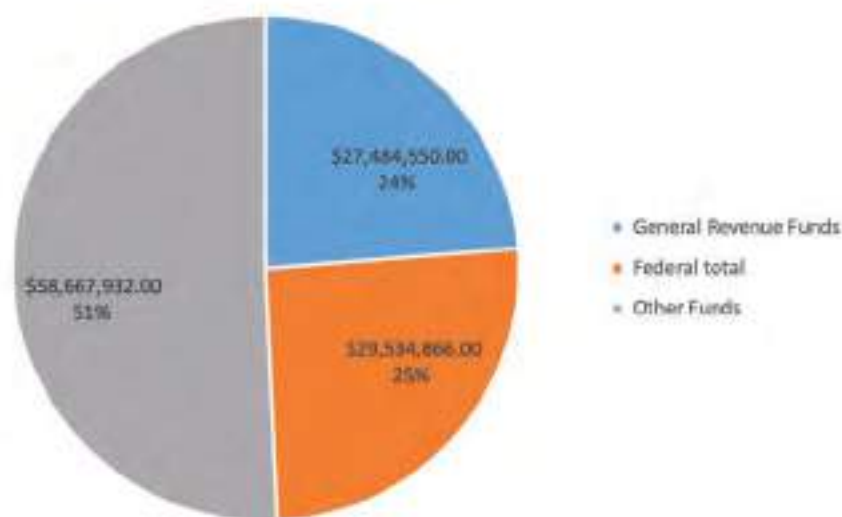
Figure 119. TVC Budget by Method of Finance FY 2020-21



Total TVC Budget for FY 2020-21: \$95,040,532.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1> *Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802

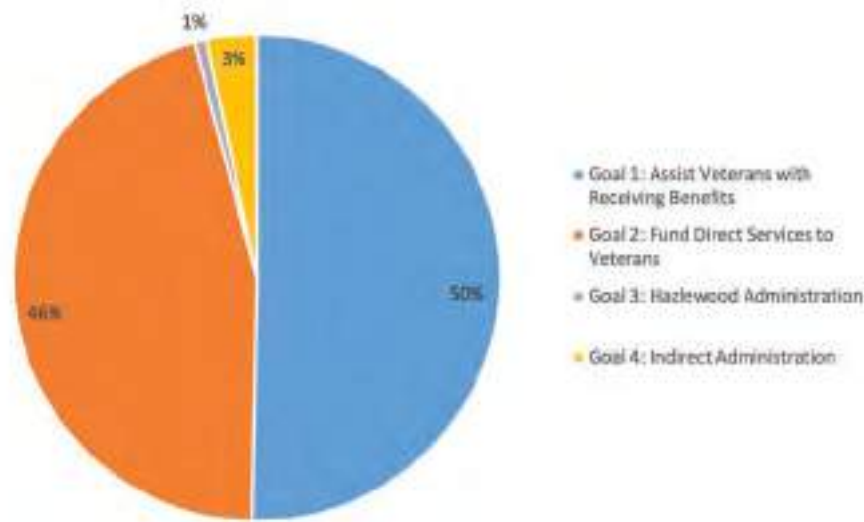
Figure 120. TVC Requested Budget By Method Of Finance FY 2022-23



Source: Legislative Budget Board (2020). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2022-2023*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020> *Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802

The total requested TVC budget for FY 2022-23 is \$115,687,348. If included in the budget, the Exceptional Items Requests would add an additional \$2,429,169.

Figure 121. TVC Funding by Strategy FY 2020-21



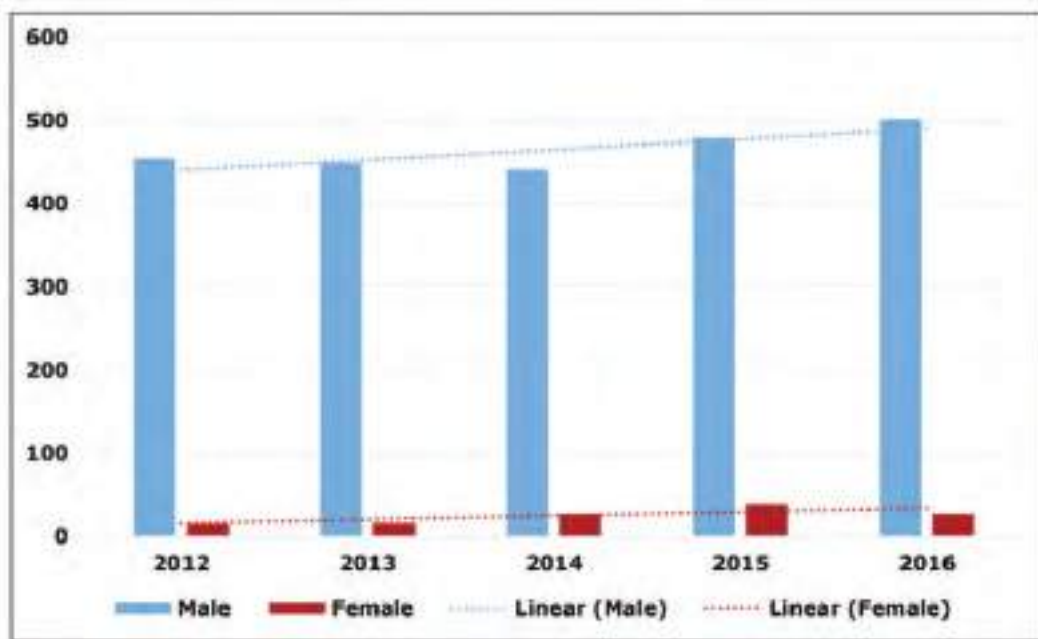
Total TVC Budget for FY 2020-21: \$95,040,532.00

Source: Zerwas & Nelson. (2019). H.B. No. 1 General Appropriations Act Eighty-Sixth Legislature. Retrieved from <https://capitol.texas.gov/BillLookup/History.aspx?LegSess=86R&Bill=HB1>

Veteran Suicides

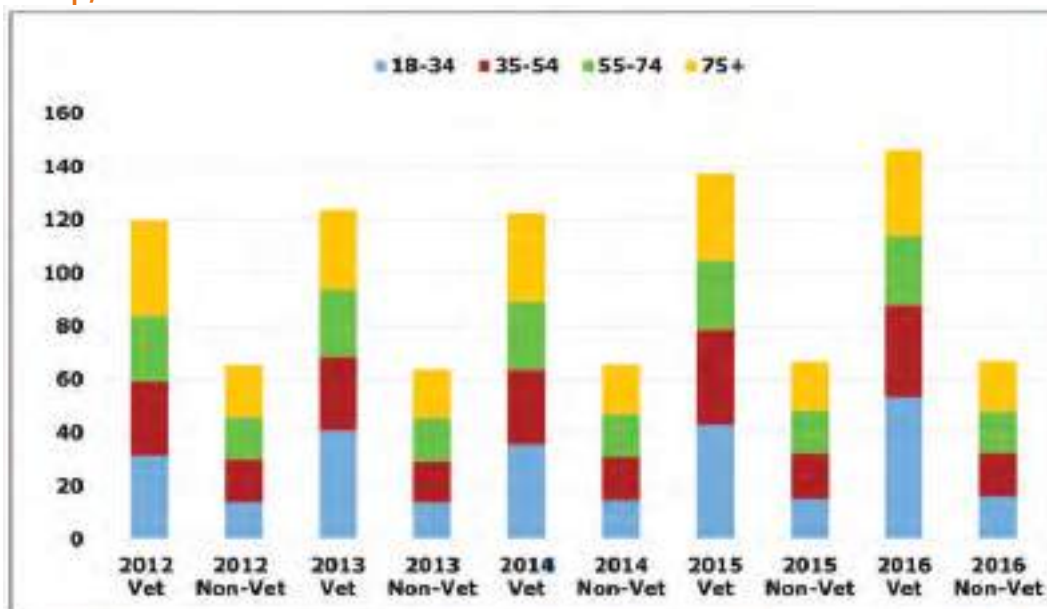
The veteran population continues to be at particular risk of suicide compared to the general population. Figure 122 reflects the upward trend of veteran suicides in Texas by gender, from 2012 to 2016. Male suicide rates were disproportionately higher than that of females, although both saw a slightly increased rate over the 4 years.⁴⁶ Of the 496 Texas veteran suicide deaths in 2017, over 95 percent were by males.⁴⁷ Figure 123 compares veteran and non-veteran suicide rates and breaks them down by age. The results show that veterans are significantly more likely to die by suicide, across all age categories.⁴⁸

Figure 122. Number and Trend of Veteran Suicides in Texas by Gender Calendar Years 2012-2016



Source: Texas Health and Human Services Commission. (2019, September). Report on Short-Term Action Plan to Prevent Veteran Suicides. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/short-term-veteran-suicide-plan-report-aug-2019.pdf>

Figure 123. Texas Suicide Death Rates Per 100,000, by Veteran Status and Age Group, Calendar Years 2012-2016



Source: Texas Health and Human Services Commission. (2019, September). Report on Short-Term Action Plan to Prevent Veteran Suicides. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/short-term-veteran-suicide-plan-report-aug-2019.pdf>

Access to firearms is the number one cause of veteran suicide death in Texas.⁴⁹ In 2017, the gun suicide death rate for Texas veterans was over 20 percent higher than the total Texas population's rate, and over 27 percent higher than the national average.⁵⁰ Ranked by type of lethal means used in Texas veteran suicides, firearms were at 78 percent, suffocation at 12.5 percent, poisoning at 6 percent, and other means at 3.4 percent.⁵¹ A 2007-2014 study from the *Annals of Internal Medicine* showed that although 8.5 percent of suicide attempts are fatal, firearms are the most lethal method of suicide with a mortality rate of 89.6 percent.⁵² Access to lethal means therefore plays a significant determinant in the fatality rates of suicide attempts.

As part of SB 578 (85th, Lucio/ Blanco), HHSC issued a report in September 2019 on the Short-Term Action Plan to Prevent Veteran Suicide. Implementation of goals must be achieved by September 2021, and will focus on:

1. Raising awareness among providers of the gaps in healthcare for service members, veterans, and families (SMVFs) which must be addressed to prevent suicide;
2. Promoting the use of evidence-based and best practices regarding suicide prevention efforts for the SMVF population; and
3. Normalizing safety seeking behavior.⁵³

Long-term recommendations for statutory, administrative, and budget-related policy initiatives and reforms will be completed by September 2021. Implementation of these goals must be achieved by September 2027.⁵⁴

VA Behavioral Health Services

Nationally, veterans' health care services are administered on a regional level by a system of 23 veterans integrated service networks (VISNs), 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 adjust to life post-combat. Texas is primarily supported by VISN 17: VA Heart of Texas Health Care Network.⁵⁵ In addition, VISN 16 serves areas of East Texas and VISN 19 serves parts of North Texas.⁵⁶ For more information on each VISN, see <https://www.va.gov/directory/guide/map.asp?dnum=1>.

TVC does not directly operate or provide behavioral health services to veterans; instead, it links veterans to these services through their claims representation and counseling programs described above. There is a wide array of VA settings that provide both inpatient and outpatient behavioral health services, including primary care clinics, general and specialty outpatient mental health clinics, residential care facilities, and community living centers. Services and programs include:

- Specialized PTSD services;
- Psychosocial rehabilitation and recovery services;
- Suicide prevention programs;
- Evidence-based psychotherapy programs; and
- Substance use services.

The VA also provides behavioral health services for family members and survivors of active duty military personnel and veterans. Additionally, 300 Vet Centers nationwide provide psychological counseling for war-related trauma and other services such as outreach, case management, and social services referrals.⁵⁷ Vet Centers served a total of 298,576 veterans, service members, and military families in FY 2018 and provided over 1.9 million no-cost visits for readjustment counseling.⁵⁸ The latest report on VA health care utilization by recent veterans reported a total 9.8 million veterans (49 percent) used at least one VA benefit or service in FY 2017.⁵⁹

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.

Veterans Mental Health Program and Other Supports

The Veterans Mental Health Program (VMHP) provides several services for veterans, including: Military Cultural Competency training for licensed mental health professionals, veteran mental health awareness training for community-based organizations and faith-based organizations, and programs for justice-involved veterans through engagement, training, and cooperation with justice system agencies.⁶⁰

The Military Veteran Peer Network is an affiliation of veterans and family members who actively identify and advocate for community resources for veterans and provide peer counseling services.⁶¹ Peer group leaders are trained in peer support and mental health awareness and establish peer group meetings in their communities. As of July 2020, the Military Veteran Peer Network website listed 37 available Peer Service Coordinators, which can be found here: https://www.milvetpeer.net/page/custompage_map.

“No one is better prepared to speak with a veteran about her experiences than another veteran, a peer.” – Military Veteran Peer Network

THE VETERANS CRISIS LINE

The Veterans Crisis Line (VCL) is a resource available during mental health crises, including suicide crises. VCL can be accessed by veterans, their families, and/or friends via telephone, text, or online chat to be connected with a trained VA responder. According to a January 2019 report, since its launch in 2007 the VCL had answered over 3.8 million calls and initiated the dispatch of emergency services to callers in imminent crisis over 112,000 times. The VCL anonymous online chat service, added in 2009, had engaged in more than 439,000 online chats. In November 2011, the VCL introduced a text messaging service to provide another way for veterans to connect through a personal cell phone or smart phone with

confidential, round-the-clock support. Since that time it had responded to more than 108,000 texts. Over 640,000 referrals had been sent to local VA Suicide Prevention Coordinators to ensure the continuity of care of veterans. On a daily basis in FY 2018, the VCL received an average of 1,766 calls, 203 chats, and 74 texts. They also dispatched emergency services for imminent danger an average of 80 times per day.⁶²

TEXVET

TexVet, a joint initiative by the Texas A&M Health Science Center and HHSC, is a network of health providers, community organizations, and volunteers who are committed to providing SMVFs with referrals and information to successfully access services. TexVet has initiated a “No Wrong Door” policy for the veteran community through its network and event-based activities, ensuring that veterans are properly connected to the services that they need by knowledgeable partners across the state.⁶³ For more information, visit: <http://texvet.org>.

SPECIALTY COURTS

Left untreated, mental health and substance use 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 traumatic brain injury, PTSD, depression, and substance use issues. Alternatively, a judge sitting in a specialty veteran’s court may have a better understanding of the mental health conditions and veteran-specific struggles that can increase risks for criminal behavior. The judge may also be more familiar with the range of community-based services and benefits available to veterans, and might include case managers and court clerks with military experience or familiarity working with veterans in the process. Thus, veteran’s courts may be more capable of diverting veterans from the criminal justice system and instead linking them and their families to benefits, services, and supports.

The first veteran’s court in Texas, located in Harris County, began accepting cases in 2009. As of September 2019, there were veteran’s courts operating throughout the state in the following 50 counties:

- | | | | |
|------------|--------------|--------------|----------------------------|
| • Angelina | • El Paso | • Kaufman | • Tom Green |
| • Bell | • Fannin | • Kerr | • Travis |
| • Bexar | • Fort Bend | • Liberty | • Tribal |
| • Bowie | • Galveston | • Lubbock | • Uvalde |
| • Brazoria | • Grayson | • McLennan | • Val Verde |
| • Brazos | • Gregg | • Midland | • Victoria |
| • Burnet | • Guadalupe | • Montgomery | • Webb |
| • Caldwell | • Harris | • Nueces | • Williamson ⁶⁴ |
| • Cameron | • Hays | • Potter | |
| • Cass | • Hidalgo | • Rockwall | |
| • Collin | • Hill | • Rusk | |
| • Comal | • Hutchinson | • Smith | |
| • Dallas | • Jefferson | • Tarrant | |
| • Denton | • Jim Wells | • Titus | |

Women Veterans

Women are the fastest growing population of veterans and are projected to make up 15 percent of all living veterans by 2035. Women veterans are more likely than women non-veterans to die by suicide and more likely to do so with a firearm.⁶⁵ They are at a higher risk for exposure to sexual assault or harassment and are more likely than men to blame themselves for traumatic experiences. The VA has embarked on efforts to understand how to better serve woman veterans. In the general population, women are over twice as likely to develop PTSD as men.⁶⁶ A 2015 study found that the risk of PTSD for men and women veterans is not significantly different after experiencing combat.⁶⁷ However, women veterans are more likely to have lower incomes, lack private insurance, and have poorer health.⁶⁸

While women veterans are less likely than non-veterans to experience poverty, about 10 percent had incomes below the poverty level in 2015.⁶⁹ VA healthcare statistics concluding in March 2014 showed that 54.8 percent of women veterans who served after September 11, 2001 had accessed VA health services.⁷⁰ Because of their heightened risk for having experienced things like military sexual trauma, homelessness and financial stress, it is important that health care, including mental health and substance use services, support services, and transitional resources continue to be increasingly responsive to the needs of women veterans. Visit <https://www.tvc.texas.gov/women-veterans/> for more information on other initiatives serving women veterans.

Health and Human Services Commission Veterans Services

HHSC collaborates with TVC on several initiatives to improve outcomes for veterans. HHSC is a member of the Texas Coordinating Council for Veteran Services administered through TVC, and TVC participates on the HHSC Statewide Behavioral Health Coordinating Council.

HHSC administers the Texas Veterans + Family Alliance Grant Program authorized in 2015 through SB 55 (84th, Nelson/King) and the Mental Health Program for Veterans established by the 81st Texas Legislature. In 2018, HHSC awarded 20 grants through the program. Grantees secured a total of \$10 million to match \$10 million in state general revenue funding. The grants will serve almost 20,000 veterans and their families, helping them to receive expanded access to mental health treatments and services.⁷¹

HHSC also runs the Mental Health Program for Veterans, which allows peer-to-peer counseling services for veterans. In FY 2019, 133,144 peer services were delivered to SMVFs. Additionally, HHSC and TVC trained 5,552 peers, held 374 counseling sessions, and coordinated 33,669 services for justice-involved veterans and their families.⁷² The agency contracts with 39 LMHAs to provide these peer services.^{73,74,75}

A total of \$5 million was allocated in FY 2019 to operate the program, with \$1.04 million for TVC to provide trainings and coordinate services for justice-involved veterans.⁷⁶

The Texas Department of Family and Protective Service's Prevention and Early Intervention Division offers grants for their SMVF Program, which was established by HB 19 in the 84th Texas Legislature as an expansion of the Military Families and Veterans Pilot Prevention Program (MFVPP). This community-based initiative is meant to enhance coordination of community services to veterans with children. The program aims to improve child welfare and early education amongst other services. As of January 2020, Bell, Bexar, and El Paso counties all had community providers receiving MFVPP grants. The next solicitation will provide \$1.6 million each year for 5 years.⁷⁷

Another major veterans initiative of HHSC is the Texas Veterans App. This is a free smartphone application that offers access to the following:

- Crisis intervention services through the Veterans Crisis Line
- Services for women veterans
- Local veterans and veteran service organizations
- Texas Veterans Hotline
- Texas Veterans Portal⁷⁸

Texas Veterans Hazlewood Act

The Texas Veterans Hazlewood Act offers eligible Texas veterans, their spouses, and their dependent children tuition exemption for up to 150 hours of college credits. This includes most fees charged at public institutions of higher education in Texas, but does not cover living expenses, books, or supply costs. There have been repeated attempts to drastically alter the Hazlewood Act through legislative funding changes, but those efforts have not been successful. More information on the Hazlewood Act is available at <https://www.tvc.texas.gov/education/hazlewood-act/>.

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Mission

Transform how communities promote mental health in everyday life.

Vision

The people of Texas thrive in communities that support mental health and well-being.



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