A Guide to

Understanding Mental Health Systems and Services in Texas

3rd Edition – 2016

Hogg Foundation *for* Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

ACKNOWLEDGEMENT

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HOGG FOUNDATION FOR MENTAL HEALTH

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

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

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

LANGUAGE USAGE

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

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ABOUT THE GUIDE

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

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

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Introduction and Overview

Mental health, as defined by the World Health Organization (WHO), is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[1] Mental health and well-being are essential to an individual's ability to properly think, interact and have a quality life. Therefore, mental health inevitably has a direct impact on economic productivity, educational attainment, and public health and safety. Ultimately, the promotion of mental health should be prioritized for individuals, communities and societies throughout the world.

> ***Recovery*** *is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*
> ***—Substance Abuse and Mental Health Services Administration***

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

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

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

Public behavioral health services in Texas are dispersed among many programs and

agencies. Individuals needing treatment may receive care through a variety and combination of state agencies, including:

- Health and Human Services Commission
- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services (to be eliminated 9/1/17)
- Texas Department of Criminal Justice
- Texas Department of Juvenile Justice
- Texas Education Agency
- Texas Department of Housing and Community Affairs
- Texas Veterans Commission
- Texas Workforce Commission

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

In addition to state entities, behavioral health services are provided at the local level in jails, hospital emergency departments, schools, local mental health authorities, various nonprofit agencies, public health clinics and other settings, with people frequently moving between service systems. While the Harris County Jail is often referred to as the "largest mental health facility in Texas," this is not the case. The Harris County Jail is a correctional facility that offers minimal mental health services often limited to pharmacological treatment. This is not mental health and substance use care and does not aid an individual in working toward their recovery.

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

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

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

and individuals receiving mental health services, especially those with little experience or knowledge of this system of care, understanding the complexities of the patchwork of behavioral health care services can be particularly challenging.

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

The report is divided into the following four categories:

- **The Texas Environment:** A discussion of current issues and recent developments at the state level, including a description of new programs and organizational approaches to care, some of which are being implemented and others of which may require further legislative action during the 2015 session of the Texas Legislature.
- **National Context:** A basic overview of national activities and initiatives related to behavioral health care services, including a discussion of federal requirements that impact the types of benefits provided and the populations served under the Patient Protection and Affordable Care Act (ACA).
- **Public Behavioral Health Services in Texas:** An overview of the multiple Texas state agencies and programs that provide a wide range of behavioral health services for clients, including programs provided by Health and Human Services agencies and services administered by juvenile and criminal justice agencies, school districts and the Texas Education Agency, the Texas Department of Housing and Community Affairs, Texas Workforce Commission and the Texas Veterans Commission.
- **Appendices**

This third edition of the guide was somewhat more challenging to develop due to the major transformations taking place in the Health and Human Services System. We have attempted to include organizational structure and program alignment in place as of October 1, 2016, but are fully aware of the fact that changes will continue for the next several years.

Included in the Appendices of the report is a list of figures, a list of acronyms, additional resources, advisory committees, and a glossary of commonly used behavioral health terms. Some programs are subject to very specific, technical definitions in state or federal statutes that may vary from the more commonly used definitions included in this report. For that reason, readers may want to refer to additional resources noted throughout this document for more comprehensive information about a specific program.

The Hogg Foundation wants to emphasize that this report focuses primarily on state

programs for treating behavioral health care needs in Texas. Many communities and providers throughout the state are equally engaged in the development, implementation and oversight of locally operated (and often locally funded) programs and services that are more specifically designed to serve the needs of local residents. Due to the variations in programs and the lack of a central database that identifies these various resources, this report generally does not include programs created at the local level unless funded by the state. However, we recognize that there are many valuable and effective programs that provide critical services that supplement the programs described in this report.

The Hogg Foundation offers this guide to help policymakers in Texas understand the array of behavioral health services currently available, the multiple access portals and the numerous funding streams. We want to reiterate that this area of health care is extremely complex and constantly evolving. While the information in this report is the best available at the time, new innovations in health care, and new legislation and programs, are continually changing the landscape of behavioral health care services in Texas. We hope that this report serves as a useful introduction, reference and guidebook illustrating the critical need for a long-term, coordinated, sufficiently funded approach to providing effective behavioral health care services.

Endnote

1 World Health Organization. *Strengthening Mental Health Promotion*. Geneva, World Health Organization (Fact sheet no. 220), 2001.

Texas Environment

The Texas legislature, advocates, and other stakeholders continue to recognize the importance of improving mental health and substance use services and supports within the state. The past legislative session yielded both successes and lost opportunities for individuals with mental health and substance use conditions. Overall, the 2016-17 state budget appropriated $2.7 billion in General Revenue-Related Funds ($3.6 billion in All Funds) for behavioral health and substance use services.[1] The Department of State Health Services (DSHS) behavioral health budget increased by approximately $87 million over the prior biennium.[2] Further, mental health spending is not concentrated in one or two state agencies. In 2015, the Office of Mental Health Coordination recognized 54 cross-agency mental health initiatives spanning a total of 18 state agencies.[3] In this section, important areas of Texas behavioral health systems are highlighted.

Select Committee on Mental Health

On November 9, 2015, House Speaker Joe Straus announced the creation of a select committee on mental health to take a comprehensive look at Texas's current behavioral health system.[4] The committee was charged to review and make recommendations on issues including substance use, care for veterans, prevention of mental illnesses, and improving the delivery of mental health care. Speaker Straus appointed the following legislators to serve on the committee:

- Rep. Four Price (Chair)
- Rep. Joe Moody (Vice Chair)
- Rep. Greg Bonnen
- Rep. Garnet F. Coleman
- Rep. Sarah Davis
- Rep. Rick Galindo
- Rep. Sergio Muñoz, Jr.
- Rep. Andrew Murr
- Rep. Toni Rose
- Rep. Kenneth Sheets
- Rep. Senfronia Thompson
- Rep. Chris Turner
- Rep. James White

The first committee hearing was held in February 2016. Topics covered by the committee include: children's mental health, veterans' issues, insurance and parity, homelessness, substance use conditions, and the state hospital system. The committee continued to meet through September 2016 and will release a report with recommendations to the legislature before the start of the 85th legislative session in January 2017. More information on the committee, including archived recordings of the hearings, is available here: http://www.house.state.tx.us/committees/committee/?committee=382

Office of Mental Health Coordination

In recent years, mental health and substance use have become major topics of national dialogue. Recognizing the need to be more strategic in behavioral health service delivery and funding, the Texas Legislature took steps to increase and improve cross-agency planning, coordination, and collaboration. In 2013 the legislature created the Office of Mental Health Coordination, which it tasked with providing broad oversight for state mental health policy as well as managing cross-agency coordination of behavioral health programs and services.[5] The office is housed within HHSC with a vision "to ensure that Texas has a unified approach to the delivery of behavioral health services that allows Texans to have access to care at the right time and place."[6] Under the new organizational structure, this office reports to the deputy executive commissioner of the Medical and Social Services Division. The office has developed a website to provide consumers, families and providers up-to-date information on mental health and wellness. According to the site, it was "developed with the goal of providing information, resources, and direction to Texas residents who may have mental health related needs or who want to support someone who does". The website can be found at http://www.mentalhealthtx.org.

In 2015, the office documented 54 cross-agency mental health initiatives spanning a total of 18 state agencies.[7] The report on these cross agency behavioral health initiatives can be found at: https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/cabhi.pdf

Statewide Behavioral Health Coordinating Council

Also in 2015, as part of the state's ongoing efforts to coordinate services across agencies and departments (including those outside of the HHS enterprise), the legislature established the Behavioral Health Coordinating Council, which it tasked with establishing a statewide strategic plan for mental health programs and services. The HHSC assistant commissioner in the Office of Mental Health Coordination at HHSC served as chair of the council.[8] Eighteen agencies and departments worked together under the direction of the Office of Mental Health Coordination to develop the goals and strategies included in the plan. The plan can be found at http://www.hhsc.state.tx.us/reports/2016/050216-statewide-behavioral-health-strategic-plan.pdf.[9]

In addition to development of the behavioral health strategic plan, the Behavioral Health Coordinating Council was directed to develop a "coordinated statewide expenditure proposal" for mental health services for FY 2017. The legislative directive required approval of the proposal by the HHSC executive commissioner and the Legislative Budget Board. FY 2017 appropriations could not be expended until the budget was developed and the required approvals were obtained.

As a result of the legislative directive, the Behavioral Health Coordinating Council developed the *Coordinated Statewide Behavioral Health Expenditure Proposal, Fiscal Year 2017*. Figure 1 below summarizes the proposed budget. The full proposal can be found at https://hhs.texas.gov/sites/hhs/files//fy-2017-csbh-expenditure-proposal.pdf.

Figure 1. Coordinated Statewide Behavioral Health Expenditures Proposal for FY 2017

Agency	GAA, Article IX, Section 10.04, Expenditures - All Funds	Proposed FY 2017 Expenditures - General Revenue	Proposed FY 2017 Expenditures - All Funds
Office of the Governor (GOV)	$ 5,269,948	$ 950,000	$ 5,269,948
Texas Veterans Commission (TVC)	$ 2,000,000	$ -	$ 2,000,000
Article I Subtotal	**$ 7,269,948**	**$ 950,000**	**$ 7,269,948**
Department of Aging and Disability Services (DADS)	$ 12,316,944	$ 12,000,000	$ 12,316,944
Department of Family Protective Services (DFPS)	$ 27,668,231	$ 14,702,058	$ 27,668,231
Department of State Health Services (DSHS) [1]	$ 1,351,430,144	$ 993,696,956	$ 1,351,430,144
Health and Human Services Commission (HHSC) [2]	$ 40,093,912	$ 14,376,606	$ 38,224,548
Texas Civil Commitment Office (TCCO)	$ 154,611	$ 154,611	$ 154,611
Article II Subtotal	**$ 1,431,663,842**	**$ 1,034,930,231**	**$ 1,429,794,478**
University of Texas - Health Science Center at Houston (UTHSC - Houston)	$ 6,000,000	$ 6,000,000	$ 6,000,000
University of Texas - Health Science Center at Tyler (UTHSC - Tyler)	$ 4,000,000	$ 4,000,000	$ 4,000,000
Article III Subtotal	**$ 10,000,000**	**$ 10,000,000**	**$ 10,000,000**
Texas Department of Criminal Justice (TDCJ) [3]	$ 247,908,621	$ 250,386,515	$ 250,877,549
Texas Juvenile Justice Department (TJJD) [4]	$ 84,747,891	$ 85,458,830	$ 87,299,830
Texas Military Department (TMD)	$ 628,500	$ 628,500	$ 628,500
Article V Subtotal	**$ 333,285,012**	**$ 336,473,845**	**$ 338,805,879**
Texas State Board of Dental Examiners (BDE)	$ 124,250	$ 124,250	$ 124,250
Texas State Board of Pharmacy (BPH)	$ 238,585	$ 238,585	$ 238,585
Texas Board of Veterinary Medical Examiners (TBVME)	$ 30,000	$ 30,000	$ 30,000
Texas Optometry Board (TOB)	$ 36,000	$ 36,000	$ 36,000
Texas Board of Nursing (TBN)	$ 873,558	$ 873,558	$ 873,558
Texas Medical Board (TMB)	$ 533,969	$ 533,969	$ 533,969
Article VIII Subtotal	**$ 1,836,362**	**$ 1,836,362**	**$ 1,836,362**
Cross Article Total	**$ 1,784,055,164**	**$ 1,384,190,438**	**$ 1,787,706,667**

Summary by Service Type Category [5]	Proposed FY 2017 Expenditure
Education and Training	$ 4,000,000
Information Technology	$ 1,882,365
Infrastructure	$ 2,882,062
Intervention and Treatment Services	$ 1,657,002,029
Prevention	$ 98,976,583
Research	$ 6,000,000
Staff	$ 16,963,628
Cross Service Type Total	**$ 1,787,706,667**

Notes:
(1) DSHS funds include Medicaid as reflected in GAA, Art. IX, Sec. 10.04 rider; NorthSTAR funds will transfer to HHSC January 1, 2017. **(2)** HHSC variance from the GAA, Art. IX, Sec.10.04 includes revisions in CHIP projections based on the September 2015 operating budget forecast, as well as adjustments for the System of Care Grant, CCBHC Planning Grant, and the Texas Veteran + Family Alliance Pilot Program, which were unknown at the time the original rider amounts were developed. **(3)** TDCJ's FY 2017 expenditure proposal includes additional behavioral health funding in two strategies not included in the GAA, Art. IX, Sec.10.04 rider and an adjustment in one other strategy to specifically reflect only behavioral health-related initiatives. **(4)** TJJD's FY 2017 expenditure proposal includes additional behavioral health funding in two strategies not included in the GAA, Art. IX, Sec. 10.04 rider and an adjustment throughout several strategies to remove federal funding not specifically related to behavioral health. **(5)** The Education and Training and Research Service Type Categories are as defined by the BH Coordinating Council, the remaining categories are as defined by the LBB.

Source: Health and Human Services Commission, (July 2016). *Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2017*. Retrieved from https://hhs.texas.gov/sites/hhs/files//fy-2017-csbh-expenditure-proposal.pdf

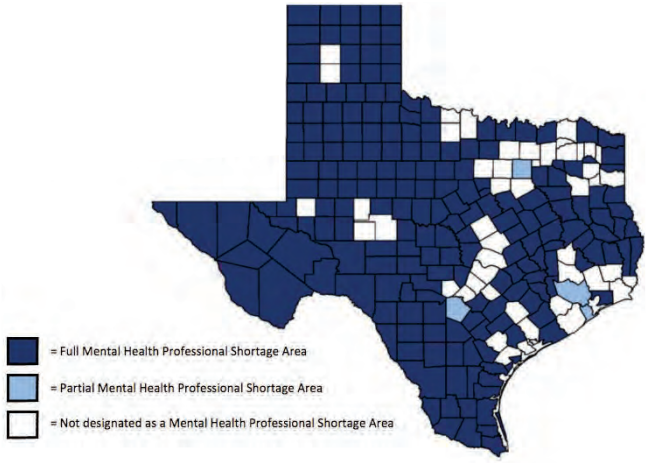
Mental Health Workforce in Texas

Mental health workforce challenges are not new to Texas or to the nation. Challenges include insufficient reimbursement rates, lack of residency slots and internship sites, an aging mental health workforce, and inadequate mental health training for primary care providers. A number of factors make it difficult to address these challenges including the diverse Texas population, the lack of cultural and linguistic competency among providers, the lack of license reciprocity, and the unwillingness of providers to accept patients with Medicaid.[10]

The federal government's measure of healthcare workforce shortages is known as Health Professional Shortage Areas (HPSA). The federal government uses a ratio of 1 psychiatrist for every 30,000 individuals in the general population as the threshold for designating a Mental Health HPSA, and this ratio is considered a valid measure of mental health workforce adequacy.[11] Texas' growing population, and widespread rural geography have created an environment where mental health professional shortage areas far outnumber areas of adequate access. The maldistribution of mental health providers across Texas demands unique strategies.

As of July 2015, 206 out of 254 (81.1%) Texas counties were designated as full or partial Mental Health HPSAs. Partial HPSA designations typically occur in large metropolitan areas, like Harris County and Travis County, where there is disproportionate access to mental health services in different parts of the city.[12] In 2011, twenty-five counties that were not previously designated as Mental Health HPSAs now hold the designation, and 181 other counties that were Mental Health HPSAs in 2010 still held that designation in 2015.[13] Further, 185 Texas counties did not have a single psychiatrist in 2015, which left over three million Texans in counties without access to a psychiatrist.[14] The rates are better for psychologists and social workers, but still far below what is needed. In 2015 there were 149 counties without a single licensed psychologist, while 40 counties did not have a licensed social worker.[15,16] Figure 2 below details the Mental Health HPSAs by county as of July 2015.

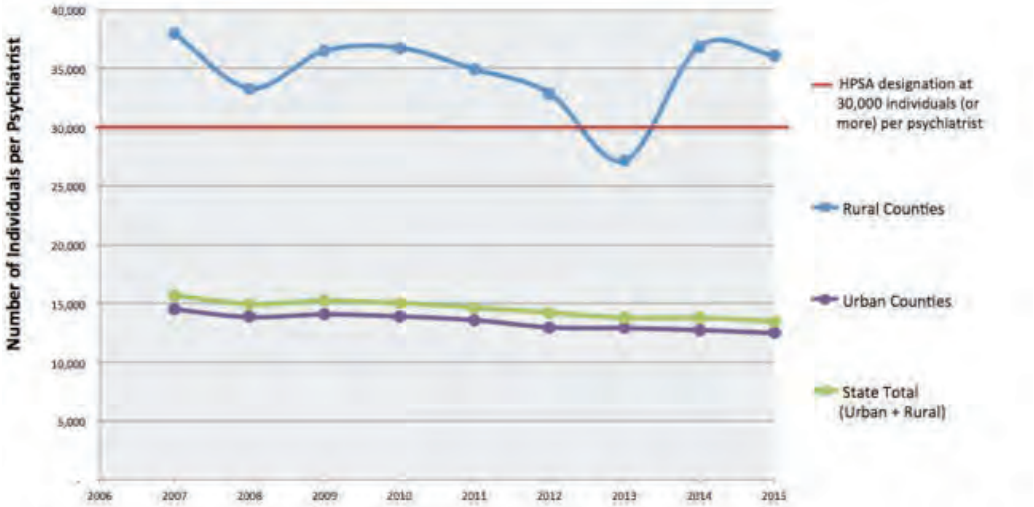
Figure 2. Federally Designated Mental Health Professional Shortage Areas as of July 2015



Source: U.S. Department of Health and Human Services, "Health Professional Shortage Area Data Download." Health Resources and Services Administration Data Warehouse. (2015). Data by Geography - Texas. Retrieved from https://datawarehouse.hrsa.gov/Tools/DataByGeographyResults.aspx?geoTyp=State&geoCd=48

Considering only psychiatrists, the graph below shows the drastic difference in the number of psychiatrists available in urban versus rural communities. This graph also highlights the reality that, due to the fact that urban areas have the vast majority of Texas' population, focusing only on statewide data can hide the true severity of the problem in rural counties. Figure 3 below details the distribution of psychiatrists across the state from 2006 to 2015.

Figure 3. Mental Health Professional Shortages: Distribution of Psychiatrists in Texas, 2006-2015



Source: Texas Department of State Health Services. "County Supply and Distribution Tables - Psychiatrists." (2015). Available: https://www.dshs.state.tx.us/chs/hprc/PSY-lnk.shtm; and Texas Department of State Health Services. "Definitions of County Designations." (2015). Available: https://www.dshs.state.tx.us/chs/hprc/counties.shtm

Texas has not adequately invested in developing a strong mental health workforce, and the consequences are increasingly evident. Critical shortages will likely continue unless Texas prioritizes the mental health workforce shortage and develops a comprehensive plan to address capacity problems.

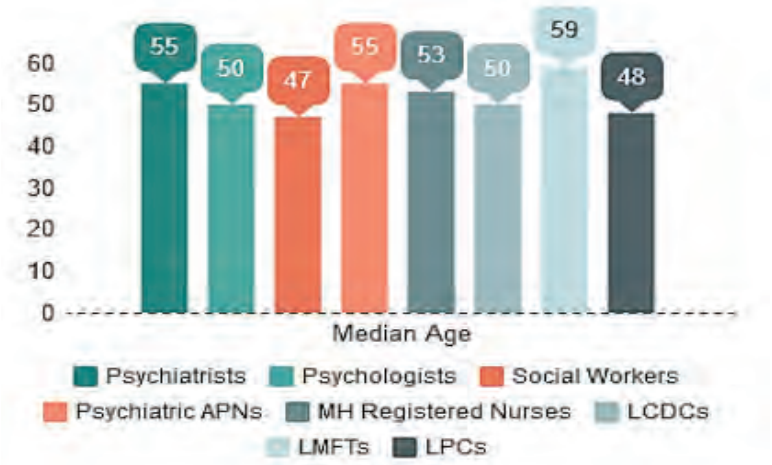
CONTRIBUTING FACTORS TO THE WORKFORCE CHALLENGES

Many variables converge to create mental health workforce challenges, including an aging mental health workforce, inadequate reimbursement rates, the unwillingness of mental health providers to accept patients with Medicaid, insufficient internship sites and residency slots, insufficient retention and recruitment practices, outdated education and training practices, linguistic and cultural barriers, and more. These issues will need to be addressed collectively in order to make a significant impact.

The percentage of mental health providers accepting Medicaid continues to decline, making it difficult for managed care organizations to build adequate networks of providers. In 2014, 76 percent of psychiatrists in Texas reported not accepting new clients who are recipients of Medicaid. [17] To increase the number of practicing mental health care providers willing to provide services to consumers with Medicaid, reimbursement rates should be evaluated and improved. While reimbursement rates are not the only incentive available to attract Medicaid providers, low rates are the most frequently identified barrier to expanding network participation.[18]

Additionally, the state is experiencing a massive shift in the mental health workforce as a large number of skilled mental health providers reach retirement age.[19] The median ages for mental health professionals range from Licensed Clinical Social Workers (45 years old) to Licensed Marriage and Family Therapists (59 years old).[20] At the same time, educational institutions are not producing enough graduates in mental health fields to meet the predicted demand.[21]

Figure 4. The Aging Mental Health Workforce in Texas



Source: *Statewide Health Coordinating Council. "2015-1016 Update to the State Health Plan". (2015). Retrieved from: https://www.dshs.state.tx.us/chs/shcc/SHPUpdate2015.pdf*

The composition of our psychiatric workforce does not mirror the Texas population. It is important that the state builds a diverse workforce to meet the needs of Texans by promoting more of a shared experiential base. Only 9.8 percent of psychiatrists in Texas are Hispanic/Latino and 5.7 percent are African American. However, Hispanic/Latinos make up 39.5 percent of the Texas population and African Americans make up 11.5 percent.[22] There is evidence that health care consumers who share a culture and race with a provider develop a stronger therapeutic alliance and have higher treatment retention rates.[23] One way to prioritize culturally relevant care is to assist mental health providers in developing a sensitivity to cultural differences in perceptions about illness, treatment, and recovery, as well as their ability to adapt care to the personal goals, cultural beliefs, and primary language of each consumer.[24]

Texas' mental health workforce challenges are very real. The solutions are not always easy to implement and they often require additional resources. However, the cost of ignoring the problem will be great. The growing Texas population coupled with the aging mental health workforce will continue to strain the behavioral health workforce.

Loan Repayment Program for Mental Health Professionals

The number of counties in Texas with an insufficient number of mental health providers remains a concern. In 2013, the Texas Legislature passed HB 1023 (83rd, Burkett/Nelson), requiring DSHS to conduct a study and develop a legislative report on the mental health workforce. The HB 1023 report, published in 2014, confirmed the critical workforce environment and offered recommendations. Additionally, both the Texas House and Senate were assigned interim charges targeting the mental health workforce.

Despite considerable discussion about the mental health workforce during the previous interim, little legislative action took place during the 84th legislative session. One notable action was SB 239 (Schwertner/Zerwas), which created a student loan repayment program to encourage mental health professionals to work in rural and underserved areas of Texas. SB 239's loan repayment program aims to address mental health professional shortage areas where there are gaps in services due to lack of providers.[25]

The funding for SB 239's loan repayment program is currently available through the 2016-17 biennium. The program serves eligible mental health professionals such as licensed clinical social workers, psychiatrists, psychologists, licensed professional counselors, psychiatric mental health advanced practice nurses who work in rural and underserved areas where there are significant workforce gaps.[26] The program, coordinated by the Texas Higher Education Coordinating Board (THECB), requires that these professionals assist only people enrolled in Medicaid or Children's Health Insurance Program (CHIP).[27]

THECB reported they had received 497 applications by the May 31, 2016 deadline.[28]

Peer Support Services/Peer Re-entry Pilot

According to the Centers for Medicare and Medicaid Services (CMS), "peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with recovery from mental illness and substance use disorders."[29] According to research sponsored by SAMHSA to assess evidence-based services, "peers are individuals with histories of successfully living with serious mental illness who, in turn support others with serious mental illness."[30] Certified peer specialists have both the lived experience and have achieved the education and examination requirements for certification. Peer support services generally fall into three categories:

1) A distinct set of activities or a curriculum that includes education and the development of coping and problem-solving strategies to facilitate self-management of a person's mental illness and reinforce daily living skills (for example, rehabilitative services);
2) Activities that are delivered as part of a [recovery] team that may include non-peers (for example, an assertive community treatment team); and
3) Traditional activities that are delivered in a way that is informed by a peer's personal recovery experience.[31]

Peer specialists assist individuals experiencing mental illness by helping them focus on recovery, wellness, self-direction, personal responsibility and independent living. While peer services are not intended to supplant other existing mental health/substance use services, the frequency of other services can be reduced when an individual is supported by a peer, often resulting in lower costs and better outcomes.[32] The behavioral health service array is not complete unless these services are included. Peer and recovery specialists play a critical role in supporting individuals experiencing mental health/substance use conditions who are working toward recovery.

Research shows that recovery-oriented peer support services produce positive outcomes. For example, peer support may increase feelings of personal empowerment and reduce negative clinical symptoms among behavioral health consumers.[33] Recent randomized controlled trials also demonstrate that peer service delivery can decrease hospitalizations and improve treatment engagement among participants.[34]

In Texas, certified peer providers serve individuals with behavioral health conditions in a variety of settings, including state hospitals, halfway houses, and all 39 local mental health authorities (LMHAs) located across the state. A peer provider may work as a **mental health peer specialist** or a **substance use recovery coach** to directly engage with others who are navigating the recovery process. In FY 2014, the top five services provided by peer providers in Texas included:

- One-on-one support
- Helping people advocate for themselves
- Goal setting
- Connecting people to community resources
- Facilitating support groups.[35]

To perform the services listed above, peers require more than lived experience within the behavioral health system. Mental health peer specialists and family partners must also complete a training and certification process during which they learn about the nature of serious mental illness and acquire rehabilitative practice skills.[36] In Texas, the nonprofit Via Hope operates a statewide peer specialist and family partners training program.[37] The trainings consist of interactive classroom courses, as well as a written certification exam. To maintain this certification, mental health peer specialists and family partners must earn 20 continuing education units (CEUs) every two years.[38] Additionally, peers and family partners may participate in endorsement trainings in which they develop specialized skills in areas such as trauma-informed care, intentional peer support, special education, and co-occurring disorders.[39] In FY 2016, Via Hope certified 115 individuals as peer specialists and 26 individuals as family partners. At the end of FY 2016, there were 560 individuals in

Texas with active peer specialist certifications and 121 individuals with active family partner certifications.[40]

DSHS and the Texas Certification Board of Addiction Professionals (TCBAP) provide similar training and certification opportunities for substance use recovery coaches. DSHS manages a 46-hour training curriculum for recovery coaches, which includes skills-based activities such as motivational interviewing and role clarity workshops.[41] If individuals wish to be certified through TCBAP, they must provide documentation that they have completed 46 hours of training across five specific domains (including advocacy, mentoring, education, recovery support, and ethics), as well as undergo 500 hours of supervision.[42] Between 2013 and 2016, over 1,450 individuals completed training as recovery coaches in Texas.[43] In FY 2016, DSHS used $4.4 million in block grants to fund 22 agencies that provide recovery coach services, including 14 substance use treatment providers, six community-based programs, and two stand-alone, peer-run centers.[44] Currently, there is no Medicaid reimbursement option for recovery coach services.

In 2015, the Texas Legislature approved a pilot program to reduce individuals involved in the criminal justice system from returning to jail or prison through the use of peer support. Research shows that reentry challenges are amplified for people with mental illness, who experience higher rates of disrupted treatments, homelessness, unemployment, and criminal activity upon release from incarceration.[45]

This peer pilot program aimed to address some of these issues with a $1 million budget rider. Rider 73 to the DSHS budget created a reentry peer support pilot to connect incarcerated persons with mental illness to peers with similar life experiences. Peers with dual mental health *and* criminal justice experience were recruited to help design and serve within the pilot program because they are particularly well-placed to assist formerly incarcerated persons through the recovery and reentry processes. Stakeholders in Texas developed the pilot after researching a similar program in Pennsylvania, where participants reported a three-year re-incarceration rate of 24%, compared to a 46% rate among other formerly incarcerated individuals in the state.[46]

DSHS selected three LMHAs to administer the pilot program: the Harris Center for Mental Health and IDD (which serves Harris County), MHMR Tarrant (which serves Tarrant County), and Tropical Texas Behavioral Health (which serves Cameron, Hidalgo, and Willacy counties). Hogg Foundation for Mental Health is funding an evaluation of the pilot program.

Also in 2015, during the 84th legislative session, Rep. Burkett filed HB 1541 hoping to expand access to peer provided services. The legislation passed the House, but did not get through the Senate. The legislation directed the Health and Human Services Commission to develop and adopt:

1) rules that establish training requirements for peer specialists so that they are able to provide services to persons with mental illness and services to persons with substance use conditions;
2) rules that establish certification and supervision requirements for peer specialists;

3) rules that define the scope of services that peer specialists may provide;
4) rules that distinguish peer services from other services that a person must hold a license to provide;
5) any other rules necessary to protect the health and safety of persons receiving peer services; and
6) rule to allow services provided under the medical assistance program (Medicaid) to include peer services provided by certified peer specialists to the extent permitted by federal law.

This legislation would have allowed more Medicaid recipients to use peer support services in a variety of settings.

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 benefits must provide those benefits at the same level ("parity") as surgical and medical benefits. To read more about the federal legislation requiring parity, please refer to the National Context section of this guide.

In 2011, the Texas Department of Insurance (TDI) adopted rules in response to MHPAEA. TDI's rules detail that mental health and substance use benefits must be offered at a comparable level to medical and surgical benefits. The rules do not address certain federal parity rules, including non-quantitative treatment limitations (NQTLs). While quantitative treatment limitations are numerical, like the number of visits per year or the number of days covered for inpatient treatment, NQTLs include "non-numerical limitations" like step-therapy or pre-authorization. A MHPAEA rule issued in 2013 requires parity in NQTLs, but TDI rules do not reflect this federal update. TDI's rules prohibit financial requirements and treatment limits from being more restrictive than the requirements or limits applied to medical and surgical benefits offered by the plan. TDI's rules also require out-of-network benefits for mental health and substance use conditions if the plan also covers out-of-network benefits for medical and surgical procedures.[47] Further, TDI's parity rules mandate coverage for necessary care and treatment of substance use conditions for employers of over 250 employees.

Parity is enforced by different agencies (both state and federal, including the federal Departments of Health and Human Services, Labor, and the Treasury) depending on the type of plan, which can make parity enforcement and oversight complex. TDI only has the regulatory control to enforce parity for "fully insured" individual and employer health insurance plans and HMOs. "Self-funded" employer plans are regulated by the Department of Labor. TDI has considered their parity enforcement as "responsive" rather than "proactive".

TDI's parity regulation is a dual approach. TDI reviews group health policy forms for compliance with Texas requirements (including coverage for serious mental illnesses (SMI) and quantitative parity).[48] TDI also reviews plans for network adequacy, which is meant to ensure that all covered services are accessible and available with an adequate number of providers.[49] Federal regulators review

individual and small group policies (which TDI does not regulate) for compliance with ACA's essential health benefits. Federal regulators also enforce parity consistent with rules that address quantitative and non-quantitative treatment limitations.[50]

Although Texas has its own parity rules and regulations, many consumers continue to struggle with their health plans to receive needed mental health and substance use services. National reports have indicated that the nation has serious barriers to true mental health parity. For example, a 2015 NAMI report found that people report being denied mental health care nearly twice as often as they report being denied general medical care.[51] Consumers face parity-related barriers including denials based on medical necessity, lack of access to an adequate provider base, and prescription cost and accessibility.[52] Parity is meant to ensure the equal treatment of mental health and substance use condition benefits to medical and surgical benefits, but consumers continue to report issues in accessing services. However, TDI reported that the agency only received seven total complaints related to parity in 2014 and ten complaints through June 2016.[53] This could be due to individuals reporting parity complaints to the Department of Labor or not labeling a complaint as a violation of parity. More work is needed to ensure that individuals with mental health and substance use conditions can access needed services at parity with medical and surgical benefits.

Lawsuit Against the Department of Family Protective Services on Behalf of Long-Term Foster Youth

In 2011, a class-action lawsuit was filed against the Department of Family Protective Services (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 — but over a dozen other advocacy organizations have since joined as plaintiffs in the case.[54] The lawsuit addressed how the Child Protective Services (CPS) division of DFPS treats children in the state's Permanent Managing Conservatorship (PMC) program, which serves children who have been unable to find a permanent placement within a year of their initial removal from their home.[55] The advocacy groups amended complaint stated that children in PMC's rights were violated, including their right not to be harmed while in state custody and their right to familial association.[56] The lawsuit against CPS increased public attention to the quality of care provided to the roughly 28,000 children who are under the care of the state at any given time.[57] In 2011, when the lawsuit was first brought against CPS, there were approximately:

- 12,000 children in Permanent Managing Conservatorship (PMC),
  - 6,400 children in PMC for three or more years,
  - 500 children in PMC for more than 10 years, and
  - More than 1/3 of children in PMC experiencing five or more placements.[58]

Since the lawsuit against DFPS began, the 84th Texas Legislature made some initial

reforms to DFPS' foster care system and increased CPS funding by $231 million.[59] However, a lack of available foster care homes that fit children's specific needs has continued to make it difficult to quickly find children in foster care a permanent placement — especially a placement that is close to the child's home community.[60] This shortage was further exacerbated by a series of increased caregiver eligibility requirements that were put into place at the beginning of 2015, making it more difficult for children to be placed in kinship placements (i.e. with extended family members). After these stricter safety-screening standards were put into place, CPS removals of children from their homes grew by 37 percent and short-term informal kinship placements fell by 56 percent during the same time. [61]

U.S. Federal District Judge Janis Graham Jack of Corpus Christi issued a ruling on the CPS case in December 2015. Judge Graham ruled against CPS, finding that the state had systematically violated the Fourteenth Amendment rights of children in the PMC foster care program to be free from an unreasonable risk of harm while in state custody.[62] In her decision, Judge Jack described the foster care system run by DFPS as one where:

> *"...Foster children often age out of care more damaged than when they entered... Years of abuse, neglect and shuttling between inappropriate placements across the state has created a population that cannot contribute to society, and proves a continued strain on the government through welfare, incarceration or otherwise. Although some foster children are able to overcome these obstacles, they should not have to."* [63]

The state appealed Judge Jack's ruling but as of October 2016 those appeals have been unsuccessful. The implementation of several of the ruling's reforms to improve the PMC program began in early 2016.[64] Most importantly, Judge Jack appointed two special masters in March 2016 to help guide and oversee changes to DFPS' foster care system — mediator and specialist attorney Francis McGovern and Kevin Ryan, former Commissioner of Children and Families for New Jersey.[65] At an estimated cost of $3 to $4 million per year, the co-transition special masters will create a plan for addressing capacity and workforce issues in CPS (e.g. defining "manageable" caseload sizes and addressing the amount of time children spend in PMC).[66] Judge Jack also addressed immediate concerns of child safety in foster care placements by prohibiting the placement of children in foster group homes without 24-hour awake supervision.[67] While that order is in place, the co-transition special masters will make a recommendation about whether group homes should continue to operate at all, depending on their determination as to whether group homes cause "an unreasonable risk of harm" to foster children.[68]

The main mission of the co-transition special masters is to help DFPS and CPS define a reasonable caseload size and improve caseworker turnover and overall conditions.[69,70] CPS caseworker turnover and high caseloads make it difficult for cases to be processed quickly and in some cases thoroughly, which leaves children in the foster care system longer and at greater risk of experiencing instability in their placements. [71, 72] Average CPS caseload sizes in Texas have fallen some in recent years — from 31 cases in 2014 to 28 in 2015 — but that still far exceeds the maximum number of cases (17) recommended in national best practices.[73,74] Caseworker turnover also remained high throughout 2015, with workers citing management concerns and overwhelming demands of the job in addition to low pay as reasons for leaving.[75]

In an effort to expand the caseworker applicant pool and reduce turnover, DFPS reduced hiring requirements for caseworker positions in June 2016. The new requirements allow individuals with relevant work experience and an associate's degrees (or two years of a bachelor's degree completed) to be eligible for employment as a CPS caseworker. Prior to this change only individuals with bachelor's degrees or higher were eligible for these positions.[76] Texas Speaker of the House Joe Strauss also declared that fixing the foster care system will be one of his top priorities for the 85th Legislature.

Behavioral Health Integration Advisory Committee (BHIAC)

People with mental health and substance use conditions may have poorer health outcomes than the average person.[77] This is mostly from untreated and preventable chronic physical conditions like hypertension, diabetes, obesity, and cardiovascular disease that can be aggravated by poor health habits such as lack of physical activity, poor nutrition, smoking, and substance abuse.[78] Fragmentation of mental and physical health care services is one of the primary barriers to realizing optimal health outcomes for individuals with mental illness. Integrated behavioral health care seeks to eliminate fragmentation through the systematic coordination of mental health and substance use services with general healthcare.[79] This care may address health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[80]

In recent years, Texas has taken steps to coordinate mental and behavioral health services across the various HHS agencies in order to improve service delivery for Texans with mental illness. The Behavioral Health Integration Advisory Committee (BHIAC) was created by SB 58 (Nelson/Zerwas) in the 83rd Legislative Session. The BHIAC was charged with addressing planning and development needs to integrate Medicaid mental health and substance use services, including targeted case management, mental health rehabilitative services and physical health services. Further, the committee was directed to seek input from consumers and providers within the behavioral health committee on the issues and provide formal recommendations to HHSC on how to best accomplish integrating behavioral health and physical health within Medicaid managed care.

BHIAC's presentations and reports are available at https://hhs.texas.gov/about-hhs/leadership/advisory-committees/behavioral-health-integration-advisory-committee.

Boarding Homes and Housing Choices

In 2009, the Texas Legislature directed the Health and Human Services Commission (HHSC) to establish model boarding home standards with HB 216 (81st, Menendez/Shapleigh). The legislation gave local governments the option to adopt the model standards, as well as to require boarding home permitting, fees, and inspections.

HHSC released its model standards in 2010.[81] The state does not require localities to adopt the model or permitting standards, but those who do must submit a report to HHSC with the number of homes in their jurisdiction.[82] DADS has had responsibility for compiling those reports and has published them biennially. Only a few local governments have adopted the HHSC standards for boarding homes in their jurisdiction. In 2014, DADS reported that only four municipalities had adopted the standards: Brenham, Dallas, El Paso, and San Antonio. Advocates have expressed concern that few municipalities are adopting the standards and that boarding homes in most cities continue to be unregulated and unsupervised. In November 2015, the House Committee on Human Services and House Committee on Urban Affairs received a joint interim charge to investigate the operation and regulation of boarding homes and identify communities that have adopted local standards.[83] The Mental Health America - Greater Dallas website on boarding home regulations is available: http://boardinghome.org/.

In 2013, the Legislature passed HB 1191 (83rd, Burkett/Zaffirini), which added housing resources specifically for people with mental health conditions to the online Texas Information and Referral Network (TIRN, also known as 2-1-1). Information about housing options for individuals with mental illness is currently available on the 2-1-1 website http://www.211texas.org/housing-choices-finding-a-place-to-live/.

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

Individuals with intellectual and other developmental disabilities (IDD) often experience mental health conditions as well as the harmful consequences of trauma. Analysis of recent data from the National Core Indicators suggests that approximately 34% of adults living with IDD also have a co-occurring mental health condition.[84] People with IDD experience abuse, neglect, exploitation, isolation, institutionalization, bullying, restraint, seclusion, violence, and other forms of trauma, yet rarely are IDD or special education systems and policies built on recovery and trauma-informed principles. Goals and objectives of these systems rarely address mental wellness. While we know that recovery from mental illness and trauma is possible, the developmental disabilities too often overshadow attention to possible mental health conditions or any consideration of the impact of past trauma.

Depression and anxiety seem to be two of the most frequently identified mental health conditions in people with IDD but are certainly not the only ones.[85] Research has also indicated an over-representation of schizophrenia in people with IDD compared to the general population. Post-traumatic stress disorder (PTSD) has also been identified as a significant cause of mental health concerns in people living with IDD.[86] Studies indicate that individuals with reduced developmental levels are more

at risk for experiencing PTSD and that their PTSD symptoms can be more severe.[87]

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

Texas is beginning to understand the current gap in our systems of supports and services for individuals with IDD living with co-occurring mental health conditions. HB 2789 (84th, Raymond/Zaffirini) required web-based trauma-informed care training for new employees hired at state supported living centers and intermediate care facilities for people with intellectual disabilities. As a result of the legislation, the Department of Aging and Disability Services and the Department of State Health Services developed a series of web-based training modules designed to help families and providers consider the mental health and wellness support needs of individuals with IDD as opposed to limiting their efforts to managing "challenging behaviors." Efforts have also been made in Texas to address the need for crisis intervention services for individuals with IDD experiencing a mental health crisis. This is a start, but does not address the inability of individuals with IDD to access quality mental health treatment and supports that could prevent a crisis.

As a result of Sunset legislation passed during the 84th Texas Legislative Session, the health and human services system is being re-structured and one of the changes combines IDD and mental health services in one division. Additionally, new HHS divisions will have units devoted to cross-division coordination. This offers opportunities to more comprehensively address the needs of the IDD population. At the same time, the state continues to expand the scope of health services included in the publicly-funded managed care system. The resulting integration of services will also offer opportunities for more holistic supports for individuals with IDD.

Recently the Hogg Foundation for Mental Health partnered with the National Child Traumatic Stress Network (NCTSN) to develop a training toolkit, *Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma.* The toolkit was developed over two years with the guidance of national mental health experts and IDD experts. The toolkit is designed to be a two-day train-the-trainer resource and is available free of charge at http://nctsn.org/products/children-intellectual-and-developmental-disabilities-who-have-experienced-trauma

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

Health and Human Services System Transformation

The Health and Human Services Commission and the HHS system are currently undergoing significant reorganization. Prior to the 84th session, the Texas Sunset Advisory Commission performed a comprehensive review of the system and recommended that the legislature consolidate agencies in order to improve efficiency and service delivery.[88] The 2014 Sunset Commission recommended further consolidation as a step toward achieving the state's 2003 vision for efficient, streamlined health and human services. According to the 2014 Sunset Commission, further system reorganization was also necessitated by recent developments in Texas healthcare, such as the transition to Medicaid managed care, the integration of behavioral health services into managed care, and the implementation of the federal Affordable Care Act (ACA).[89]

Informed by the commission's recommendations, the 84th Legislature directed the transfer of behavioral health and regulatory functions previously administered by DSHS and DFPS to HHSC, as well as a complete transfer of services and the ultimate elimination of DADS and DARS as separate entities.[90] The 84th Texas Legislature directed a reorganization of the entire HHS system, requiring that many programs and services transfer to HHSC from the other four HHS agencies. Implementation began in 2015 and will continue over the course of several years, although the majority of the structural reorganization is expected to be complete by September 1, 2017.

In addition to the transformation, HHSC is implementing many legislative directives passed during the 84th Legislative Session that address a number of policy and program areas such as the Medicaid substance use benefit, network adequacy in Medicaid managed care, and the discontinuation of the NorthSTAR managed care program. The commission also continues to implement directives from the 83rd Legislative Session, such as integrating behavioral health services with Medicaid managed care.

Finally, as part of the transformation plan for health and human services, SB 200 (84th, Nelson/Price) created the new Division of Transformation, Policy and Performance within HHSC. Among other duties, the Policy and Performance Office is responsible for:

- Evaluating current HHSC (and DSHS) performance measures,
- Developing "new and refined" measures, and
- Establishing targeted system-level measures that evaluate and communicate overall system performance.[91]

HHS TRANSFORMATION

During the 84th Legislative Session, the legislature adopted the Texas Sunset Commission's recommendation to reorganize the HHS enterprise (SB 200, 84th, Nelson/Price). The HHSC Sunset legislation requires the five HHS agencies to consolidate into three, discontinuing DARS and DADS and maintaining DSHS and DFPS as separate agencies until further legislative review in 2018.

HIGHLIGHTS

- **SB 200 (84th, Nelson/Price)** directed the state to transfer many of the programs and functions currently housed across the four other HHS agencies over to HHSC.
- **Phase one of the transformation** focused on reforming the enterprise's broader organizational structure, with major changes effective on September 1, 2016 and continuing through September 1, 2017.
- **Behavioral health programs at DSHS and DADS**, as well as select client services at DARS, were transferred to HHSC; DARS was discontinued as a separate agency on September 1, 2016.
- **DARS general vocational rehabilitation services,** vocational rehabilitation for individuals who are blind, Independent Living Services for older individuals who are blind, and Business Enterprises of Texas program was transferred to the Texas Workforce Commission on September 1, 2016.
- **Phase two** will focus on reforming program operations within the new HHS structure.
- **Regulatory functions at DSHS, DADS, and DFPS**, as well as operation of the state supported living centers (SSLCs) and the state hospitals, will transfer to HHSC by September 1, 2017.
- **DADS will be discontinued** on September 1, 2017.
- **DSHS and DFPS will continue to operate as separate agencies,** maintaining their public health and child protective services functions, until further legislative review in 2018.[92]

In July 2016, the commission published a revised version of *Health and Human Services System Transition Plan*, outlining its plan for carrying out the transformation directives in SB 200. The timeline for the anticipated changes is shown in Figure 5.

Figure 5. Proposed Health and Human Services Transformation Timeline

Date	Proposed Changes
By September 1, 2016 (Phase One)	DADS: All client services transfer to HHSC (social and medical) Regulatory, licensure and SSLC operations remain at agency DARS: Vocational Rehabilitation Programs transfer to Texas Workforce Commission (TWC) Remaining programs and functions transfer to HHSC Agency is discontinued DFPS: Prevention and Early Intervention programs transfer from HHSC to DFPS Protective services and regulatory functions remain at agency DSHS: All client services transfer to HHSC (social and medical) Public health and regulatory functions remain at agency

Date	Proposed Changes
By September 1, 2017 (Phase Two)	DADS: Regulatory, licensure and SSLC functions transfer to HHSC Agency is discontinued DFPS: Childcare placement licensure functions transfer to HHSC Protective services functions remain at agency DSHS: Regulatory and licensure functions transfer to HHSC Agency maintains public health functions HHSC: Begin organizational review of within-division and within-program operations
By September 1, 2018 (Continuing)	HHSC: Submit study and recommendations to the Transition Legislative Oversight Committee on whether to continue DSHS and DFPS as separate agencies

Source: Texas Health and Human Services Commission. (2016). *Health and Human Services system transition plan*. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/

The reorganization of the HHS enterprise is occurring in two phases:

- **Phase One:** Implemented on September 1, 2016, this phase focused on implementing broad structural changes to the HHS system. During this phase, HHSC facilitated the transfer of the majority of social and medical services into one HHSC division. The goal has been to transfer programs to HHSC in their entirety before attempting intra-program or intra-division organizational reform.
- **Phase Two:** During this phase, the agency plans to transfer remaining regulatory and facility operations to HHSC. The transfer of programs and functions to HHSC is expected to be complete by September 1, 2017. During this phase, the agency will begin to pursue reorganization within core functional divisions or specific programs, as necessary.[93]

The two-phase reorganization process is designed to minimize interruptions to client services during the transformation process.[94] While the majority of the structural changes are expected to be complete by September 1, 2017, the agency expects that reorganization within divisions and programs will occur over the course of several years.

By September 1, 2018, the agency must, additionally, submit a report to the Texas Legislative Oversight Committee providing recommendations as to whether DSHS and DFPS should continue to operate as separate agencies or be merged into HHSC. For more information, see the Health and Human Services Transition Plan at http://www.hhsc.state.tx.us/hhs-transformation/transition-plan.shtml

DISCONTINUATION OF NORTHSTAR

The HHSC Sunset legislation also requires the state to discontinue the NorthSTAR behavioral health demonstration project on December 31, 2016. Since 1999, the NorthSTAR program has provided behavioral health and substance use services to Medicaid-eligible clients in the Dallas area through a capitated payment system to

one managed behavioral health care organization.[95]

In 2014, the Sunset Commission found that NorthSTAR's behavioral health delivery system was outdated and inconsistent with Texas' systemwide efforts to integrate behavioral healthcare with other basic physical health services and Medicaid managed care.[96] In its analysis of Senate Bill 200 (84th, Nelson/Price), the Texas House Research Organization reported that dismantling NorthSTAR would:

- Produce cost-savings
- Facilitate behavioral health integration efforts
- Enhance access to federal funding[97]

SB 200 adopted the Sunset Commission's recommendations, removing reference to the NorthSTAR program from statute. Medicaid-eligible NorthSTAR clients will receive their behavioral health care services through the same managed care organization that provides their physical health care.[98] DSHS has established two Behavioral Health Authorities (BHAs) that will provide an alternative model for indigent care (mental health services for those not eligible for Medicaid).[99] LifePath Systems and the North Texas Behavioral Health Authority (NTBHA) have been selected as the two BHAs in the region.[100] These transitions become effective January, 1 2017.[101] See the HHSC section for more information about NorthSTAR.

HHS ADVISORY COMMITTEE REORGANIZATION

The HHSC Sunset legislation also directed important changes to the advisory committee structure in the HHS enterprise, eliminating 36 existing advisory committees from state statute while enabling the HHSC Executive Commissioner to establish new advisory committees in rule.[102] Advisory committees play an important role in the HHS enterprise, providing the agency with feedback from clients, families and other stakeholders on specific issues.

In 2015, a cross-agency workgroup evaluated the 133 existing HHS advisory committees. Following a public input process, the workgroup submitted recommendations to the HHS Executive Commissioner on which advisory committees to keep, consolidate or dismantle. A list of the recreated advisory committees can be found at https://hhs.texas.gov/about-hhs/leadership/advisory-committees.

The HHSC Sunset legislation expressly directed HHSC to establish an advisory committee that would address behavioral health issues, and the Behavioral Health Advisory Committee held its inaugural meeting in January 2016. Its role is to provide recommendations to the HHS Executive Commissioner on how to promote cross-agency coordination, ensure access to and integration of services, and promote behavioral health wellness and recovery.[103]

For a full listing of the Commissioner's final advisory committee recommendations, please see the *Health and Human Services Transition Plan* at https://hhs.texas.gov/transition-plan.

AUSTIN STATE HOSPITAL (ASH) - AUSTIN STATE SUPPORTED LIVING CENTER (AUSSLC) LOCATION FEASIBILITY STUDY

The legislature continues to discuss the future of the Austin State Hospital (ASH) and Austin State Supported Living Center (AuSSLC). Both facilities have been recognized to have outdated infrastructure that can create unsafe conditions for residents and staff. As of October 11, 2016, 345 people were on the forensic waiting list for a state hospital bed, including 270 individuals on the maximum security wait list.[104] State hospital bed availability has simply not kept pace with the growing population and need. Austin State Hospital (ASH) covers 30 counties, has 299 beds, and admits about 1600 people a year.[105] Senate Bill 200 required HHSC to conduct a study to determine the feasibility, costs, and benefits of transferring operation of ASH from its current facilities to a new facility at a new location. Rep. Workman requested the inclusion of Austin State Supported Living Center (AuSSLC) in the study, which will examine the following options:

- Consolidated ASH/AuSSLC facility at the existing ASH campus
- Consolidated ASH/AuSSLC facility at the existing AuSSLC campus
- Replacement ASH facility on other State-owned land
- Replacement ASH facility on the existing ASH campus
- Replacement ASH facility on a site not currently owned by the State
- Replacement ASH and AuSSLC facilities on a site not currently owned by the State.[106]

The final report was submitted to the Legislature in September 2016. It stated more research needs to be done before moving forward with a decision.

BEHAVIORAL HEALTH ADVISORY COMMITTEE

The Behavioral Health Advisory Committee (BHAC) was created as a result of the HHSC review of all advisory committees. According to the advisory committee webpage, the BHAC is charged with providing "input to the health and human services system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within the State of Texas." The recommendations of the committee are given to the executive commissioner for his consideration. The scope of the recommendations include:

- The promotion of cross-agency coordination, state/local and public/private partnerships in the funding and delivery of behavioral health services;
- The promotion of data-driven decision-making;
- The prevention of behavioral health issues and the promotion of behavioral health wellness and recovery;
- The integration of mental health and substance use disorder services in prevention, intervention, treatment, and recovery services and supports;
- The integration of behavioral health services and supports with physical health service delivery;
- Access to services and supports in urban, rural, and frontier areas of the state;
- Access to services and supports to special populations;
- Rules, policies, programs, initiatives, and grant proposals/awards for behavioral health services; and
- The five-year behavioral health strategic plan and coordinating expenditure plan.[107]

1115 Waiver: Texas Health Care Transformation and Quality Improvement Program

In December 2011, Texas was approved by the Centers for Medicare & Medicaid

Services (CMS) for a waiver of certain federal Medicaid regulations under section 1115 of the Social Security Act.[108] These waivers were designed to improve managed care delivery and access to services while maintaining supplemental payments to assist hospitals in covering the costs of uninsured patients during the initial implementation of the Affordable Care Act (ACA). Several parts of the 1115 waiver aim to improve primary healthcare services and coverage more generally (e.g. improving access to primary care physicians and chronic care management), but this section focuses specifically on the 1115 waiver's impact on improving behavioral health services.[109]

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

- Expand Medicaid managed care statewide
- Develop and maintain a coordinated care delivery system
- Improve health outcomes while containing costs
- Leverage federal Medicaid match dollars with local and state funding
- Transition health services to innovative, quality-based payment systems.[110]

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

- **The Uncompensated Care (UC) pool**, which replaces the Upper Payment Limit (UPL) program for reimbursing physicians and hospitals for Medicaid shortfalls and care provided to individuals who do not have third party coverage (i.e. health insurance).
- **The Delivery System Reform Incentive Payment (DSRIP) pool**, which provides incentive payments to fund infrastructure improvements and test innovative models of healthcare delivery for Medicaid recipients and low-income, uninsured individuals.[111]

The initial demonstration period for Texas' 1115 waiver was from September 2011 until September 2016. In September 2015, HHSC requested to extend the 1115 waiver for five years but that extension was denied by CMS.[112] Then in May 2016, CMS authorized HHSC's request for a 15-month extension of the 1115 waiver, which will continue the program through December 2017.[113]

THE UNCOMPENSATED CARE (UC) POOL

The UC Pool replaces Upper Payment Limit (UPL) funding for hospitals and physicians and allows them to receive payments for uncompensated care for low-income Medicaid eligible patients and others who are uninsured. While payments through the 1115 waiver UC pool initially helped Texas cover gaps in healthcare

coverage that resulted from the state's decision not to expand Medicaid under the Affordable Care Act, a policy passed by CMS in 2015 no longer allows for federal Medicaid funds to cover uncompensated care for individuals who would have been covered by statewide Medicaid expansion or a coverage waiver.[114]

As of June 2015, Texas has paid out an estimated $11 billion in payments from the UC pool — $6.3 billion for private hospitals, $4.1 billion for public hospitals, $294.3 million for physician groups and $263 million for ambulances and groups of dental providers.[115] With the 15-month extension of the 1115 waiver, roughly $2 billion of the funds received by hospitals from the UC pool will be from federal match dollars in 2016.[116]

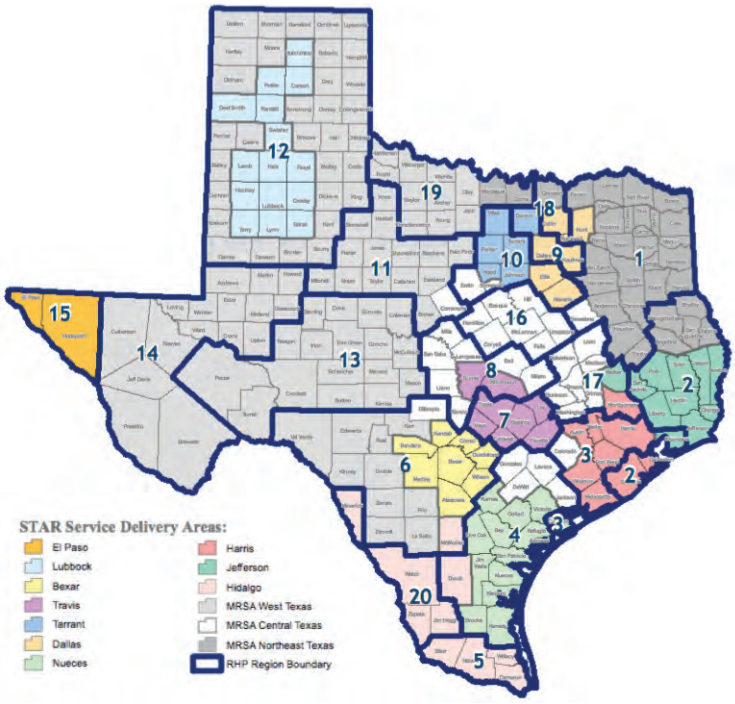
THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS (DSRIP) POOL

The goal of the DSRIP pool is to transform healthcare delivery systems, improve individual and population health, and lower overall healthcare costs through efficiencies and innovations.[117] The DSRIP pool incentivizes innovation by freeing providers from the constraints of traditional fee-for-service payments and reimbursing providers based on the quality of their services and their patient outcomes. In order to receive funding from the DSRIP pool, projects must meet their project-specific performance metrics.[118] Metrics should demonstrate improved patient outcomes, quality improvement, and the development of project infrastructures through the expansion of space, hours, and staff. Providers report on these performance metrics twice per year in order to earn DSRIP payments.[119]

The improvement of healthcare delivery systems through the DSRIP pool in Texas relies heavily on the 20 Regional Healthcare Partnerships (RHPs) across the state. RHPs are local collaborations that help to identify community needs and fund the state's portion of all waiver payments.[120] The goal of RHPs is to address specific regional concerns through individualized DSRIP projects while providing an overarching framework that allows for improved coordination and resource sharing across regions. The counties and other local entities providing the state share of funds determine how their funds are used in the RHP, consistent with waiver requirements.

Figure 6 below shows a map of the 20 RHPs in charge of Texas' DSRIP programs.

Figure 6. Map of Regional Healthcare Partnerships (RHPs) and Managed Care Service Delivery Areas (SRAs) in Texas: January 2016



Source: Texas Health and Human Services Commission. (January 6, 2016). *Texas: Regional Healthcare Partnerships (RHP) and Manages Care SDAs.* Retrieved from http://www.hhsc.state.tx.us/1115-docs/081816/TX_RHP_and_SDAs_Regions_010616_Update.pdf

In order to be meet the requirements of the 1115 waiver, RHPs must choose DSRIP projects that make improvements within at least one of the following four categories:

- **Category 1: Infrastructure Development.** "Lays the foundation for delivery system transformation through investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services."
- **Category 2: Program Innovation and Redesign.** "Includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention."
- **Category 3: Quality Improvements.** "Assess the effectiveness of Category 1 and 2 interventions for improving outcomes in the Texas healthcare delivery system. Each project [in] Categories 1 and 2 has one or more associated outcome measures from Category 3."
- **Category 4: Population-Focused Improvements**. "A series of reporting measures for a hospital to track the community-wide impact of delivery system reform investments. Required reporting includes data related to potentially preventable admissions, readmissions, and complications, patient-centered health care and emergency department utilization, with optional reporting of core healthcare quality measures for children and adults."[121]

As of May 2015, there were 1,458 active DSRIP programs in Texas operated by 298 distinct providers across the state's 20 RHPs.[122] Local mental health authorities (LMHAs) are the most common type of providers for DSRIP services, operating 340 different DSRIP projects, but hospitals, physician groups and local health departments also serve as providers for many DSRIP projects.[123,124] As of April 2016, DSRIP programs in Texas have received approximately $7.1 billion in total payments

as a result of meeting their pre-determined, program-specific success metrics.[125]

Behavioral health services have been targeted for significant expansion under the 1115 waiver. Texas prioritized behavioral health for its 1115 waiver by reserving 10 percent of DSRIP funds for community mental health centers (LMHAs) and including several behavioral health projects in the DSRIP menu.[126] DSRIP 1115 waiver projects related to behavioral health account for approximately one third (472) of all DSRIPs, with 46 of those projects focused specifically on providing children and adolescents with improved behavioral health services.[127] The 1115 waiver also creates the option for local communities to expand behavioral health services without conforming to the narrow eligibility requirements that exist for state-funded LMHA services.

DSRIP 1115 waiver projects related to behavioral health account for approximately one third (472) of all DSRIPs, with 46 of those projects focused specifically on providing children and adolescents with improved behavioral health services.[127]

Examples of current behavioral health DSRIP projects include:

- Improved and expanded crisis intervention (e.g. rapid response teams, psychiatric extended observation and stabilization units, and trainings for mental health deputies)
- Integration of behavioral health services with primary care (e.g. including behavioral health in obstetrics outpatient services to treat postpartum depression)
- Expansion of peer support services and early intervention programs
- Expanding community treatment options so that individuals experiencing a psychiatric crisis are not unnecessarily put into emergency rooms, state hospitals, prisons or jails
- Improved recovery programs that provide supportive services to increase compliance and success (e.g. transportation and meals to help individuals at a homeless shelter stay engaged and involved in their recovery)
- Expansion of providing behavioral health services through telemedicine/telehealth
- Implementation of the Family Preservation Program to provide continuity of care services for children at risk for out-of-home placements or who are returning to the community after a stay at an inpatient psychiatric hospital.[128,129]

FUNDING FOR TEXAS' 1115 WAIVER

For the first five years of the 1115 waiver, funds totaled $29 billion ($17.6 billion from the UC pool and $11.4 billion from the DSRIP pool).[130] The UC and DSRIP pools in the Texas 1115 waiver have an annual budget of roughly $6 billion, including $4 billion a year in federal matching funds and $2 billion from Intergovernmental Transfers (IGT) and other local sources, such as taxpayer money.[131,132]

As a result of DSHS Rider 59 in the 2016-2017 General Appropriations Act (and Rider 79 in the previous legislative session), community mental health centers (LMHAs) are now required to use GR funds appropriated by the state to draw down federal funds through the DSRIP pool whenever possible.[133] In FY 2014 and 2015, LMHAs leveraged roughly $219 million in GR appropriations and $55.5 million in local funds to draw down $385.1 million in federal funding for behavioral health services provided through the DSRIP pool.[134]

The 15-month extension of the 1115 waiver kept the same funding structure of the

initial five-year demonstration in place, with $3.1 billion available for each pool (i.e. DSRIP and UC) in the first 12 months of the extension. Both pools will receive a prorated amount for the final three months at the end of the extension.[135,136] However, CMS clearly stated in their approval of Texas' extension that the UC pool cannot be used to cover services that would have been covered had Texas expanded Medicaid under the ACA. CMS also stated that HHSC must work with the agency during the extension to develop a viable long-term plan.[137]

COST SAVINGS AND OUTCOMES OF DSRIP PROJECTS UNDER THE 1115 WAIVER

While there is some initial data available on the effectiveness and impact of DSRIP projects, more will be known about the efficacy and success of these projects as the initial demonstration period comes to a close in 2017. Examples of performance metrics for behavioral health projects include:

- Reductions in admissions and readmissions into the criminal justice system
- Reductions in emergency department visits
- Improved quality of life and overall functioning.[138]

While program-wide outcomes data is still forthcoming, there is some qualitative data available about the impact that DSRIP projects are having on the lives of individuals who are enrolled in services. One DSRIP project in Austin-Travis County that expands access to mobile psychiatric crisis units has successfully diverted roughly 90 percent of the individuals they have served from entering into the criminal justice system.[139] In another DSRIP project focused on integrating behavioral health services with primary care in RHP 1, one primary care physician expressed that the program has helped them to better recognize their clients' behavioral health needs — "[I'd] been treating this patient for years and never knew he was depressed. Because of our integration project, I learned he was suicidal and was able to get him treatment. DSRIP has changed how I practice medicine."[140]

One DSRIP project in Austin-Travis County that expands access to mobile psychiatric crisis units has successfully diverted roughly 90 percent of the individuals they have served from entering into the criminal justice system.[139]

Because reimbursements for DSRIP projects are tied to achieving specific patient-centered metrics, the financial success of these projects also signals improvements at the individual level. For example, behavioral health-related DSRIP projects earned roughly $1.7 billion in incentive payments as of January 2016 and are expected to earn an additional $1 billion in incentive payments by 2017.[141] These incentive payments come from meeting project-specific benchmarks, for instance successfully reducing the number of psychiatric hospital readmissions within 30 days of discharge or reductions in the use of emergency rooms for treating psychiatric needs. In the initial five-year demonstration of the 1115 waiver, Texas yielded an overall expected costs savings of $8.65 billion, coming from things such as reductions in pre-term births, diverting individuals from incarceration or unnecessary emergency room visits.[142]

In terms of expanding access to care, funds from the 1115 waiver provided behavioral health services for 50,350 new clients and enhanced services for 23,728 clients in year three of the waiver demonstration (October 2013 to September 2014).[143] In that

same time period, DSRIP projects altogether provided more than 2 million separate patient encounters that were not being provided before the 1115 waiver began.[144]

At the systems level, DSRIP projects have improved collaboration between different RHPs and DSRIP providers, allowing them to increase efficiency by sharing information on best practices and barriers to implementation. As a result of the 1115 waiver's DSRIP projects, there has been a 25 percent increase in the number of "collaborative inter-organization relationships" across the state's 20 RHPs.[145] The 400+ behavior health-related DSRIPs have increased collaboration and resource sharing between LMHAs, hospitals, and other community providers.[146] DSRIP projects have improved the mental health outcomes of thousands of Texans and laid the foundation for developing important community partnerships. However, as the 1115 extension approval letter from CMS explains, the 1115 waiver is not a permanent solution to Texas' shortcomings in providing behavioral health services and more long-term plans for coverage must be made.[147]

Telemedicine and Telehealth Services

Telemedicine and telehealth services generally refer to medical services or treatments that are provided to distant locations using advanced telecommunication technologies (e.g. interactive digital video conferencing programs like Skype) to remotely connect a patient with a doctor or other health professional.[148] According to Texas statutes, telemedicine services are provided by physicians or other health professionals acting under a physician's delegation while telehealth services can be delivered by a number of different licensed or certified health professionals acting within the scope of their license or certification (e.g. Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCWS), or Psychologists).[149,150]

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

- Psychiatric diagnostic evaluations
- Psychotherapy (with an individual and/or their family)
- Office visits
- Other outpatient visits including counseling, coordination of care with other physicians and decision-making
- Inpatient consultation, pharmacologic management and medication review[151]

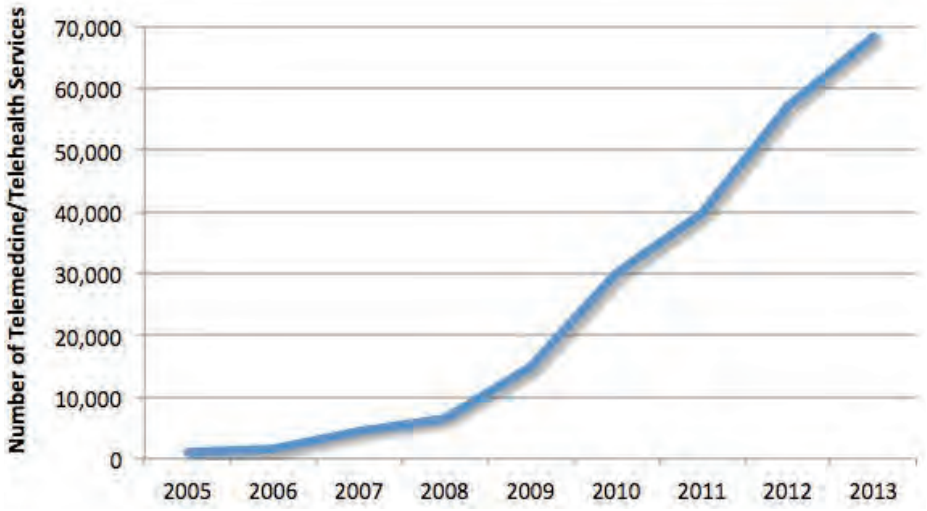
The legislative push for the approval of telemedicine medical services in Texas began in 1995.[152] Interest in telemedicine services waned in the early 2000s but in recent years, legislators have shown a renewed interest in funding and expanding telemedicine and telehealth options. The following telemedicine/telehealth bills were passed in 2015:

- **HB 1878 (84th, Laubenberg/Taylor)** — ensures reimbursement for physicians providing telemedicine services to children in primary or secondary school-based settings.[153]
- **SB 200 (84th, Nelson/Price)** — abolished the telemedicine and telehealth advisory committee and transferred all duties within DADS and DARS to HHSC (as part of the larger Health and Human Services Transformation).[154]

- **HB 2641 (84th, Zerwas/Schwertner)** — extends Medicaid reimbursement for home telemonitoring services (e.g. remote monitoring to determine compliance with psychotropic medications) until September 1, 2019. HB 2641 also adds patients with "mental illness or serious emotional disturbance" as eligible for telemonitoring services.[155]

Both Medicaid and Medicare now view telemedicine and telehealth services as cost-effective alternatives to traditional face-to-face appointments in a doctor's office.[156] As Figure 7 shows, telemedicine and telehealth services have become increasingly popular in Texas over the last eight to ten years.

Figure 7. The Growth of Telemedicine/Telehealth Services in Texas: 2005 - 2013



Source: Texas Health and Human Services Commission. (December 1, 2014). *Telemedicine, Telehealth and Home Telemonitoring Texas Medicaid Services.* Pages C1-C3. Retrieved from http://www.hhsc.state.tx.us/reports/2015/telemedicine-telehealth-home-monitoring.pdf

BENEFITS OF TELEMEDICINE AND TELEHEALTH SERVICES

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

- Quicker and easier access to a wider array of healthcare services and mental health specialists
- Improved and expanded televideo mental health trainings for providers in rural areas
- More equitable geographic distribution of healthcare workforce and specialist skills
- Cost savings for patients, private health insurers, and public health programs such as Medicaid through increased efficiencies, fewer redundancies, and earlier interventions during (or before) mental health crises.[157,158]

Telemedicine is increasingly being pursued as a solution to help alleviate access to care challenges experienced by certain marginalized groups. For instance, there is a national shortage of geriatric mental health care providers, and geriatric consumers traditionally have difficulties with transportation to and from medical appointments. Telemedicine can help geriatric consumers in rural areas better connect with the few geriatric specialists that exist. Telemedicine is also being used as a method to help solve some of the transportation and access to quality care issues experienced by individuals living in rural areas or for individuals who have mobility issues or visual impairments.[159] While

expanding access to telemedicine and telehealth services does not add any new mental health workers to the field, it can help to more equitably and efficiently redistribute the specialist skillsets that are currently available in the workforce.[160]

TELADOC LAWSUIT AGAINST TEXAS MEDICAL BOARD

The Texas Medical Board (TMB) recently adopted an "emergency" rule requiring physicians to meet with a patient face-to-face before providing any prescriptions or telemedicine/telehealth services.[161] The telemedicine company Teladoc has since filed an anti-trust lawsuit against the TMB, alleging that the new rules restrict Teladoc's ability to establish initial patient-client relationship via telephone and compete with other healthcare providers on the price and quality of their services.[162] On September 9, 2016, the Federal Trade Commission sent a letter to the U.S. 5th Circuit Court, criticizing the Texas Medical Board for allegedly "misinterpreting case law".[163] According to the Texas Tribune, the state has asked the appeals court to throw out Teladoc's lawsuit, and federal regulators urged the court not to on September 9, 2016.[164] The federal regulators stated that the Texas Medical Board "failed to show that any disinterested state official ever substantially reviewed the telemedicine rules to determine whether the rules promote a clearly articulated state policy to displace competition rather than the private interests of active market participants".[165]

Texas Dual Eligible Integrated Care Project

In an effort to address the concerns of the fragmented system that people who qualify for Medicaid and Medicare (also known as "dual eligibles") have to navigate, the Centers for Medicare & Medicaid Services (CMS) worked with states to test models focused on aligning the financing of the two systems and integrating primary, acute, behavioral health, and long-term services and supports for dual eligible individuals. Texas was one of thirteen states that offered this demonstration project to dual eligible individuals.[166]

On May 23, 2014, Texas and CMS entered a partnership to test a new model intended to better coordinate and provide a more person-centered care experience for dual eligible individuals, called "Texas Dual Eligibles Integrated Care Demonstration." Texas and CMS contracted with managed care organizations to work toward the goal of more enhanced, coordinated system for fully dual eligible individuals who reside in specific parts of the state. The demonstration project began on April 1, 2015 and served individuals from the following counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.[167] Individuals in six demonstration counties were passively enrolled into a Medicare-Medicaid plan, following a notification process. Individuals received a letter that explained the project and identified which plans the individual would be enrolled in if there was no action was taken (known as "passive enrollment"). Each plan within the demonstration project provides the individual the full array of both Medicaid and Medicare services, including the integration of both acute care and long term services and supports.[168] Figure 8 details the participating counties, with the number of individuals served and the health plans available in each county.

Figure 8. Demonstration Project: County, Number Served, and Health Plans

County	Number of Individuals Served	Health Plans
Bexar	26,452	Amerigroup, Molina, Superior
Dallas	27,941	Molina, Superior
El Paso	19,645	Amerigroup, Molina
Harris	47,160	Amerigroup, Molina, United
Hidalgo	27,090	Cigna-HealthSpring, Molina, Superior
Tarrant	16,986	Amerigroup

Source: Texas Health and Human Services Commission. (2016). *Texas Dual Eligible Integrated Care Project*. Retrieved from https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/texas-dual-eligible-integrated-care-project

HHSC identified the following objectives for the project:

- Make it easier for individuals served to get care.
- Promote independence in the community.
- Eliminate cost shifting between Medicare and Medicaid.
- Achieve cost savings for the state and federal government through improvements in care and coordination.[169]

Starting early 2017, the program will make a few changes related to passive enrollment and rapid re-enrollment. HHSC has announced that the program will restart monthly passive enrollment (rather than yearly enrollment) in early 2017. HHSC also announced that the program will begin rapid re-enrollment providing the option to rapidly re-enroll an individual back into their health plan if they regain Medicaid eligibility within sixty days from the effect date of disenrollment. This change allows an eligible individual who loses Medicaid, but regains eligibility quickly (no more than sixty days from the effective date of disenrollment) to be rapidly re-enrolled back into their original health plan. HHSC stated that this option would promote continuity of care for the individual and limit how many times the individual would be moved from one plan to the other.[170]

In September of 2015, HHSC sent a letter of intent to CMS asking to extend the demonstration for an additional two years. The original end date of the demonstration project was December 2018 but is now extended to 2020. The most up-to-date information on the Dual Eligible Integrated Care Project is available on the HHSC website at: https://hhs.texas.gov/services/health/medicaid-and-chip/provider-information/texas-dual-eligible-integrated-care-project

Children's Services: YES Waiver, Star-Kids, and Star-Health

Children in Texas receive a range of behavioral health services in various settings, from behavioral skills training in school classrooms and juvenile detention centers to psychiatric counseling in community-based clinics or in psychiatric hospitals. While the chapters throughout this guide will give in-depth descriptions of all the behavioral health programs and services within Texas' state agencies, this section

will discuss three specific child mental health initiatives that are being implemented across the state:

- Youth Empowerment Services (YES) Waiver
- STAR Health
- STAR Kids

YES WAIVER

Youth Empowerment Services (YES) is a Medicaid 1915(c) home and community-based waiver program for children ages 3 to 19 years old. The goal of the YES Waiver is to reduce Medicaid psychiatric hospital expenses, voluntary parental relinquishments to obtain care, and out-of-home placement for children with serious emotional disturbance by providing a full range of Medicaid services, non-traditional services and family supports. The YES waiver program offers an alternative to inpatient treatment by providing individualized and coordinated community-based care for youth with particularly complex or severe behavioral health needs, regardless of family incomes.[171] YES Waiver services are particularly effective for youth who do not respond well to traditional outpatient services and might have better success through innovative treatments, such as intensive in-home support or specialized therapies.[172]

HHSC contracts with local mental health authorities (LMHAs) and other community service providers to ensure all required YES waiver services are available (e.g. case management, respite service and non-medical transportation).[173] The YES Waiver program was approved for statewide expansion during the 84th legislative session (Rider 60) and as of September 2015, every LMHA in Texas is providing YES Waiver services to individuals across the state.[174,175] HHSC is currently in the process of applying a YES Waiver amendment (Amendment #9) that would make children who are in state conservatorship eligible to receive YES Waiver services.[176] Up-to-date information on the status of YES Waiver amendments can be found at https://www.dshs.texas.gov/mhsa/yes/

For more in-depth information on the YES Waiver, see the HHSC chapter in this guide.

STAR KIDS

STAR Kids is a new Medicaid managed care program designed specifically for children and young adults under the age of 21 who have disabilities.[177] STAR Kids provides a range of services for enrollees, including acute and community-based services as well as long-term services and supports (LTSS). An essential component of the STAR Kids program is that everyone receives a standard screening assessment during enrollment and has their individualized care plan monitored and updated based on their needs and ongoing response to treatment.[178] Eligibility for specific services within STAR Kids is dependent upon other services the individual receives:

- Individuals will receive basic health services and limited LTSS services through STAR Kids if they already receive Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiples Disabilities (DBMD), Home and Community-based Services (HCS), Texas Home Living (TxHml), or YES Waiver services.

- Individuals will receive basic health services and all of their LTSS services through STAR Kids if they are enrolled in the Medically Dependent Children Program (MDCP) or if they receive Social Security Income (SSI).[179,180]

Because it is a managed care program, STAR Kids members have the option to pick their health plan provider based on what services and providers are included in each health plan. The STAR Kids program began enrollment in Summer 2016 and started providing services to consumers on November 1, 2016.[181]

STAR HEALTH

The STAR Health program was created in 2008 to provide children in foster care with primary care and behavioral health services using a managed care delivery model.[182] STAR Health requires that each child in foster care has access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services, pharmaceuticals, and more.[183] STAR Health is designed to provide more comprehensive and coordinated services by improving the continuity of care through streamlined eligibility and accessibility.

Another benefit of the STAR Health program is the "Health Passport", which allows medical providers and certain family members to access medical and dental records for a child in foster care through one central location — https://www.fostercaretx.com/. Historically, the lack of a central medical records system for children in DFPS care created serious problems such as the over-prescription of medications or the sudden discontinuation of medications when a child's placement changed.[184] The Health Passport follows children wherever they go 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 and can access that information in one central, easy-to-find location. 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.[185]

Superior Health Plan contracted with the state to run STAR Health and has been operating the program since its inception.[186] In FY 2014, 30,732 children were enrolled in STAR Health (including those in kinship care, foster youth up to age 22, and former foster youth receiving transitional Medicaid services).[187]

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National Context

A national paradigm shift is underway to transform behavioral health delivery systems. Policy decisions made at the federal level have significant impact on programs and services in Texas. Initiatives at the federal level are impacted by key federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS). Both SAMHSA and CMS are increasingly focused on emphasizing recovery, wellness and self-directed care in behavioral health care. This broad change in treatment strategy offers a new approach to behavioral health that is designed to provide the right care at the right time and in the right setting.

The National Context section of this guide focuses on analyzing select bills and issues that are being discussed or implemented at the national level and have a direct impact on behavioral health systems and services in Texas.

SAMHSA

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

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

The Helping Families in Mental Health Crisis Act – H.R. 2646

Rep. Tim Murphy (R-Pa) and bill co-sponsor Rep. Eddie Bernice Johnson (D-Tx) introduced the Helping Families in Mental Health Crisis Act (H.R. 2646) to the House of Representatives in June 2016. (Note: The Helping Families in Mental Health Crisis Act is an updated version of H.R. 3717, a bill with the same name as

H.R. 2646 and introduced by Rep. Murphy in December 2013).[2] The legislation gained widespread bipartisan support in the House, culminating in 207 co-sponsors and a near unanimous passage of the bill (422-2) in July 2016. The future of the Helping Families in Mental Health Crisis Act is still uncertain and dependent on passage by the Senate, but the bill's strong bipartisan support in the House has given hope to Rep. Murphy (R-Pa) and the bill's other supporters.[3]

The full text of the bill is over 150 pages and can be found at the following link: https://www.congress.gov/bill/114th-congress/house-bill/2646/text

H.R. 2646, as passed by the House, includes (but is not limited to) the following components:

- Establishes a new position within SAMHSA (Assistant Secretary for Mental Health and Substance Use) to take over the duties of SAMHSA's Administrator
- Requires grant recipients to use evidence-based practices
- Mandates congressional oversight of all federal behavioral health grants
- Creates an interdepartmental branch in SAMHSA that focuses on mental health
- Increases alternatives for diverting individuals from institutionalized settings (e.g. diversion from jail, emergency rooms, psychiatric hospitals)
- Increases psychiatric inpatient bed capacity
- Expands crisis intervention training (CIT) for law enforcement personnel
- Reduces HIPAA restrictions on the sharing of protected health information during crises
- Opens Medicaid and Medicare incentive funds for peer supports and the meaningful use of electronic health records in behavioral health settings
- Expands telemedicine services for rural and underserved populations
- Promotes integrating mental health treatment with primary health care
- Clarifies mental health parity laws and strengthens enforcement of parity
- Increases funding for critical neuroscience research into the underlying causes of mental health and the efficacy of early intervention programs [4,5,6]

While H.R. 2646 has received widespread support from some behavioral health organizations and professional groups, many civil rights and patient advocacy groups — for example, the American Civil Liberties Union (ACLU) and the American Association for People with Disabilities (AAPD) — have expressed concerns over certain parts of the bill.[7] Some of those concerns include:

- New requirements that may increase the number of involuntary outpatient commitments through the expanded use of "Assertive Outpatient Treatment" (AOT) programs
- Reduced privacy protections for protected health information (PHI)
- The dramatic restructuring of SAMHSA and the creation of the new Assistant Secretary for Mental Health and Substance Use Disorders position.[8,9]

The Cassidy-Murphy Mental Health Reform Act of 2015 – S. 1945

On August 4, 2015, U.S. Senators Bill Cassidy (R-La) and Chris Murphy (D-Conn) introduced the Mental Health Reform Act of 2015. Since its introduction, the bill

has gained widespread support from national organizations, including the National Council for Behavioral Health, the National Alliance on Mental Illness (NAMI), the American Psychiatric Association, and the American Psychological Association.[10] As of October 1st, 2016, the Mental Health Reform Act of 2015 had been referred to the Committee on Health, Education, Labor and Pensions but had not had a hearing.[11]

The Mental Health Reform Act of 2015 introduced by Senators Cassidy and Murphy is similar to Sen. Tim Murphy's Helping Families in Mental Health Crisis Act that passed in the House of Representatives. However, the Cassidy-Murphy bill includes several important differences:

- Creates a new behavioral health grant program for early childhood intervention programs
- Creates the National Mental Health Policy Laboratory – an entity designed to fund innovation grants, bring new and effective models of care to scale, and fund demonstration grants.
- Reforms Medicaid and Medicare rules so that individuals can receive primary care and behavioral health services at the same location on the same day.
- Partially repeals the IMD Exclusion within Medicaid by allowing enrollees age 22-64 to receive inpatient psychiatric care so long as it "would not lead to a net increase in federal funding"[12]
- Does not extend the Excellence in Mental Health Act demonstration program or expand the Health IT Meaningful Use program to behavioral health providers, nor provide additional grants specifically for mental health awareness training.[13]

The Mental Health Reform Act of 2016 – S. 2680

In March 2016, Senator Lamar Alexander (R-Tn) introduced a new federal mental health reform bill into the Senate — the Mental Health Reform Act of 2016.[14] It is still too early to know the ultimate outcome of the proposed legislation, but in its current form, The Mental Health Reform Act of 2016 (S. 2680) is supported by NAMI and several other national organizations. The bill would make a number of improvements to behavioral health services at the national level, including but not limited to:

- Addressing rising suicide rates by authorizing the National Suicide Prevention Lifeline program and extending the Garret Lee Smith Memorial Act to provide suicide prevention,
- Increasing the mental health workforce by expanding grants for child psychiatry telehealth, creating a Minority Fellowship Program, and reauthorizing mental health training grants.
- Strengthening enforcement of mental health parity by increasing requirements for health plan audits and expanding federal guidance on complying with parity laws.
- Improving early intervention services by establishing more grants for early childhood mental health and requiring 5 percent of mental health block grants to fund early interventions.
- Expanding integration of mental health services into primary healthcare by supporting integrated care trainings for providers and creating new grants for integrated services.[15,16]

Updates on the Implementation of the Patient Protection and Affordable Care Act (ACA)

The Affordable Care Act (ACA) was passed in 2010 and dramatically reshaped the landscape of healthcare, health insurance, and behavioral health care in America. Among other provisions, the ACA requires that individuals maintain a minimum level of health insurance coverage or pay a penalty for noncompliance, known as the "individual mandate."[17] The ACA also requires that health plans sold in individual and small group markets (both inside and outside of the Health Insurance Marketplace) offer a comprehensive package of items and services known as essential health benefits. In order to satisfy the essential health benefits requirements, a health plan must include items and services that address the 10 essential health benefit categories. One of those 10 essential benefits is "mental health and substance use disorder services", which includes a range of behavioral health treatment such as counseling and psychotherapy. [18]

In addition to the individual mandate and essential health benefit requirements, the ACA also includes a number of provisions that significantly improve access to public and private behavioral health care services, including a requirement that health insurers provide coverage regardless of an individual's preexisting conditions, age, gender, disabilities, genetic information or health status. As of January 1, 2016, all of the ACA provisions applying to individual and group health insurance plans had been implemented (except for a specific excise tax on certain employee-sponsored health plans with high expenses).[19]

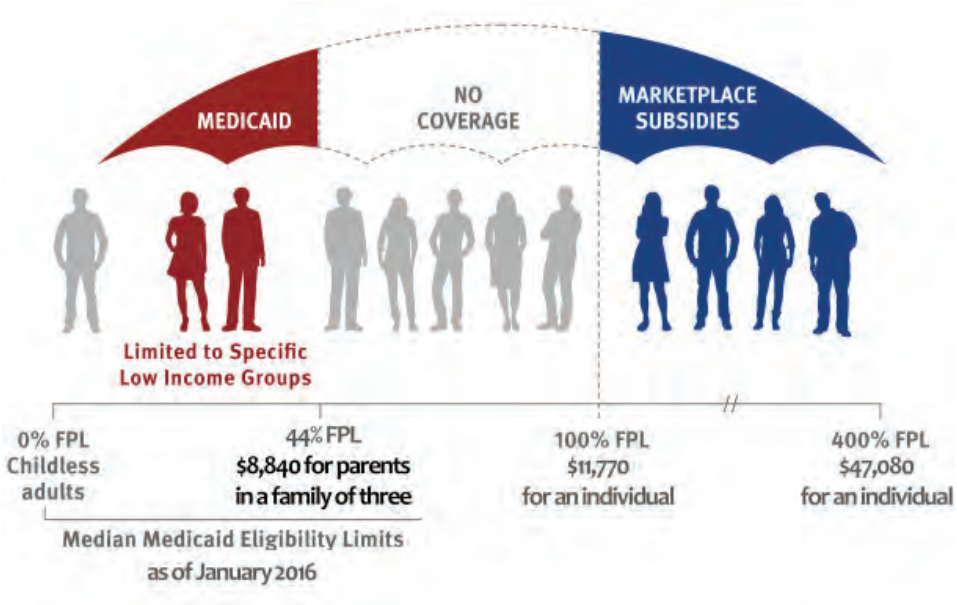
Medicaid Expansion Under the ACA

As part of the ACA's goal to expand health insurance coverage for all Americans, the ACA initially required states to expand Medicaid coverage to adults and children up to 138 percent of the federal poverty level (FPL). In Texas, this expansion primarily would have covered low-income adults generally not eligible for Medicaid unless they were receiving social security income (SSI) as a result of a disability. However, many states pushed back against the mandated Medicaid expansion and the Supreme Court's ruling in the case ended up preventing the federal government from withholding Medicaid payments to states for not expanding Medicaid coverage. As a result of the Supreme Court's ruling, states were able to choose whether to expand their Medicaid program. If a state chose to expand coverage, the federal government paid 100 percent of the cost for the first three years starting in 2014 and no less than 90 percent of the cost in future years.[20,21]

Because Congress wrote the ACA assuming that all U.S. citizens below 138 percent of FPL would be covered under the Medicaid expansion, the ACA does not provide tax credits for people below the poverty line (i.e., 100 percent of poverty).[22] Because these individuals have incomes below the threshold to qualify for subsidies on the

Health Insurance Marketplace but cannot afford private insurance and are not eligible for Medicaid (either because their income is too high or because they don't meet Medicaid's categorical eligibility requirements), they fall into a "coverage gap" and are likely to remain uninsured.[23] Figure 9 gives a visual depiction of the gap in coverage created in states that chose to not expand Medicaid under the ACA.

Figure 9. Coverage Gap for Adults in States Without the ACA's Medicaid Expansion



Source: Garfield, R. & Damico, A. (January 21, 2016). *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update*. Kaiser Family Foundation. Retrieved from http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

Following the release of the Supreme Court decision, Governor Rick Perry announced that Texas would not participate in the Medicaid expansion. This decision has effectively forfeited an estimated $6 billion in federal healthcare funds each year and created a gap in coverage for roughly 864,000 Texans.[24,25]

As of July 2016, 25 states (plus the District of Columbia) have expanded their traditional Medicaid program for adults while six other states have adopted an alternative coverage plan using federal waivers. The remaining 19 states (including Texas) have not expanded coverage and are currently using temporary solutions such as 1115 Medicaid waivers to provide services for individuals who fall in the coverage gap depicted in Figure 9.[26] Roughly 2.9 million individuals fall in this coverage gap nationwide, and more than a quarter of them (26 percent) live in Texas.[27]

There have been increased concerns about the long-term viability of the ACA as some insurers have started to cut the number of plans they offer through state health insurance exchanges. In 2016, Aetna reported a $300 million loss in 2016 on its ACA plans nationwide. Aetna decided to join United Healthcare and Scott & White by leaving the health insurance exchanges in Texas and other states.[28] Humana has also signaled it might withdraw from the ACA health insurance marketplaces soon, but other insurers with more experience serving low-income individuals through HMOs prior to the ACA (e.g. Centene and Molina) have done a better job of accurately

estimating client risks, service utilization, and health care costs in order to keep their ACA plans profitable.[29,30] Many insurers are choosing to rebound from underestimated costs and lower-than-expected revenues by increasing the prices of the health plans they offer on the exchange, with Blue Cross Blue Shield proposing rate hikes as high as 57-59 percent for some individual plans in Texas.[31]

The uninsured rate in Texas has fallen from roughly 25 percent before the ACA was implemented to 16.8 percent in 2015, but Texas remains the state with the highest percentage of uninsured individuals – almost double the national average of 9.1 percent.[33]

The number of Texans purchasing private health insurance plans through the Texas exchange rose from 1,205,174 individuals in 2015 to 1,306,208 in 2016.[32]

The uninsured rate in Texas has fallen from roughly 25 percent before the ACA was implemented to 16.8 percent in 2015, but Texas remains the state with the highest percentage of uninsured individuals — almost double the national average of 9.1 percent.[33]

RULE CHANGES TO CMS MANAGED CARE

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized 1,425 pages of revision and updates that strengthen Medicaid managed care rules.[34] The new rules will be slowly phased in beginning on July 1, 2017 and help clarify the federal government's increased expectations for state-run Medicaid managed care programs.[35] The new managed care rules from CMS aim to improve the quality of managed care services by improving accountability and incentivizing innovation and program integrity.[36] These new rules affect the approximately 72 million people enrolled in Medicaid managed care programs across the country — almost two thirds of all Medicaid enrollees.[37] The rule changes address a wide range of issues in the Medicaid managed care system. Some of the more important rule changes related to behavioral health services under managed care include:

- Establishing network adequacy standards that managed care programs must meet, particularly for specialty providers, so that enrollees have access to a full range of providers (including referral to out-of-network providers if other arrangements cannot be made)
- Updating the IMD exclusion rules so that states can receive capitated federal matching funds for individuals age 18-64 who need short-term inpatient treatment "in lieu of" state plan services
- Requiring managed care plans to comprehensively assess enrollees who need long-term services and supports (LTSS) and engage them in community-based, person-centered planning
- Enabling managed care enrollees to continue receiving services during appeals of denials
- Providing prospective and current enrollees with complete and easy-to-understand information detailing the providers and services available in different managed care plans
- Requiring states to have a written quality strategy that includes performance

measures, mechanisms for identifying enrollees with complex needs and a plan to reduce health disparities
- Increasing requirements for data reporting, transparency and accountability (e.g. requiring screenings of all new managed care network providers and makes federal matching funds conditional on the timely and complete reporting of enrollee encounter data)
- Establishing an 85 percent medical loss ratio (MLR) for reimbursement in order to create a sound rate-setting base that ensures reasonable and adequate payment for services. [38,39]

While it is still too early to know the full effect of implementing these new rule changes to Medicaid managed care, proponents of the changes are confident the new rules will help to modernize managed care programs and align standards more closely with the practices of private health insurance sector.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is considered one of the most impactful pieces of mental health legislation in recent decades. Enacted in 2008, MHPAEA was created to further expand the mental health parity requirements included in the 1996 Mental Health Parity Act. MHPAEA also added coverage requirements for substance use services. In addition to the restriction on annual or lifetime limits enacted under the 1996 law, MHPAEA requires insurers or health plans that offer mental health or substance use services to offer the benefits equally with other medical and surgical benefits covered under the plan, otherwise known as "parity". The law does not require plans to offer mental health or substance use disorder benefits.

MHPAEA did not require that behavioral health services be included in every group plan. However, the ACA required all marketplace plans to provide ten categories of Essential Health Benefits (EHB), which included mental health and substance use conditions beginning January 2014.[40] Through the intersection of MHPAEA and the ACA, most health plans offer mental health and substance use disorder benefits, creating a new group of individuals in the U.S. who could gain access to treatment if needed.

Federal MHPAEA laws apply to:
- Large employer-funded plans (with more than 51 insured employees)
- Small employer-funded plans (with 50 or fewer employees, unless "grandfathered")
- Individual market plans
- Medicaid managed-care programs
- Children's Health Insurance Program (CHIP)
- Medicaid Alternative benefit plans and benchmark equivalent plans.[41]

While MHPAEA does not directly apply to small group health plans, its requirements are applied indirectly in connection with the ACA's EHB requirements[42]. Medicare,

Medicaid, and CHIP are not group health plans or issuers of health insurance but are public health plans through which individuals obtain health coverage. Provisions of the Social Security Act that govern these plans require compliance with certain requirements of MHPAEA.[43]

MHPAEA is meant to ensure that individuals with a mental health or substance use condition are able to receive benefits equal to the medical and surgical benefits covered by their individual health plan. The Departments of Labor, Health and Human Services, and Treasury released the Final MHPAEA rules on November 13, 2013. The rules provided details about the implementation of the law, such as:

- Health plans must cover the treatment of mental health or substance use conditions at the same level as they cover other health care treatment. Again, MHPAEA does not require plans to cover mental health benefits.
- States may choose to mandate specific mental health benefits, and MHPAEA requires that such benefits must be in parity with medical and surgical benefits in the same policy. Some states may have mental health and substance use parity requirements that are stricter than federal requirements.
- The regulations distinguish between quantitative treatment limitations and non-quantitative treatment limitations. Quantitative treatment limitations are numerical, such as the number of visits a plan allows each year or the number of days covered for in-patient treatment. Non-quantitative treatment limitations (NQTLs) include but are not limited to step therapy and pre-authorization. Step therapy refers to the practice of using the most cost-effective medication and progressing to other more costly medications only if necessary.[44] Pre-authorization means that the health insurer or plan decides that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.[45]
- A group health plan or coverage cannot impose an NQTL with respect to mental health or substance use conditions unless the same processes are comparable to, and applied no less stringently than, those process used in applying the limitation with respect to medical and surgical benefits. The final regulation eliminated an exception that allowed for different NQTLs "to the extent that recognized clinically appropriate standards of care may permit a difference".
- The regulations provide that all plan standards that limit the scope or duration of benefits for services are subject to the non-quantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.[46]

To learn more about MHPAEA's implementation in Texas, please refer to the Texas Environment section of this Guide.

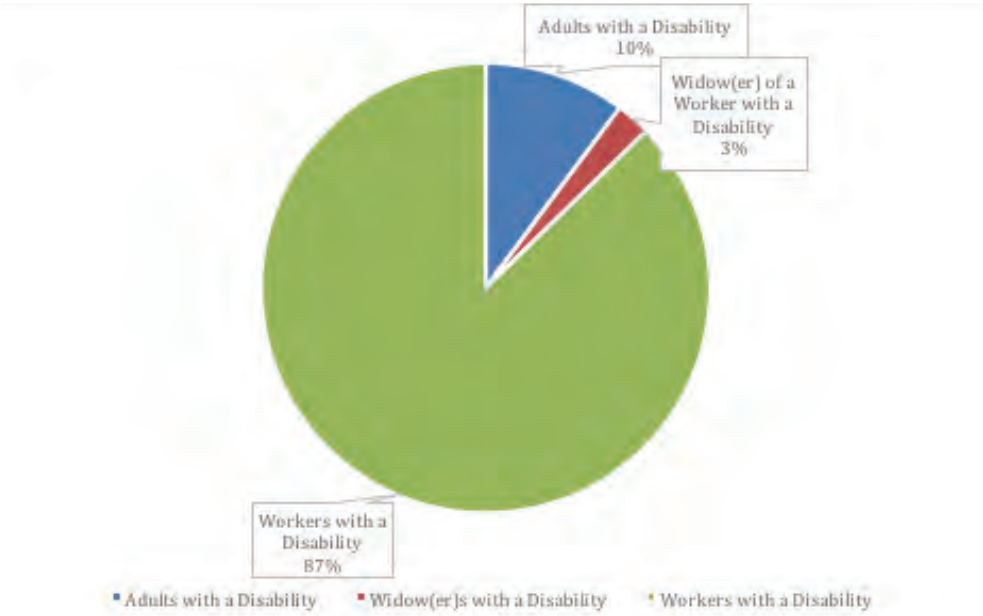
Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) have close ties to health insurance for people with disabilities. SSI is administered by the Social Security Administration (SSA) and falls under Title 16 of the Social

Security Act. SSI is for people with limited income who have a qualifying disability or are over 65. SSI is funded by general funds from the U.S. Treasury, not Social Security taxes. In most states, including Texas, individuals who receive SSI benefits are also immediately eligible for Medicaid under the same eligibility requirements. In 2014, the nation had 9,259,225 SSI beneficiaries and Texas had 665,989 beneficiaries.[47,48] The monthly maximum amount for SSI in 2016 are $733 for an eligible individual and $1,100 for an eligible individual with an eligible spouse.[49]

SSDI is also administered by SSA and falls under Title 2 of the Social Security Act. SSDI is for people who have a disability, have worked in a job covered by Social Security, and have earned enough credits in the Social Security program. In December 2014, there were 10,261,268 individuals receiving SSDI as workers with a disability, widow(er)s of a worker with a disability, or adults with disabilities. 87 percent of the total receiving SSDI were workers with a disability, 10 percent were adults with a disability, and 2 percent with widow(er)s with a disability.[50] Of individuals receiving SSDI benefits for a mental disorder at a national level in December 2014, 14.7 percent were men and 19.7 percent were women.[51] In 2014, there were 617,848 SSDI recipients in Texas accounting for 3.7 percent of the total state population.[52]

Figure 10. All SSDI Beneficiaries in December 2014



Source: Social Security – Office of Retirement and Disability Policy. (2016). *Annual Statistical Report on the Social Security Disability Insurance Program, 2014.* Retrieved from https://www.ssa.gov/policy/docs/statcomps/di_asr/2014/sect01.html

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

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

Figure 11. below details the major difference between the two programs.

Figure 11. SSI and SSDI Differences

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

Source: The United States Social Security Administration. (2016). *Federal Benefit Rates, Total Annual Payments, and Total Recipients.* Retrieved from https://www.ssa.gov/policy/docs/statcomps/supplement/2015/supplement15.pdf

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Public Behavioral Health Services in Texas

Texas Health and Human Services System *At a Glance*

Texas Health and Human Services System

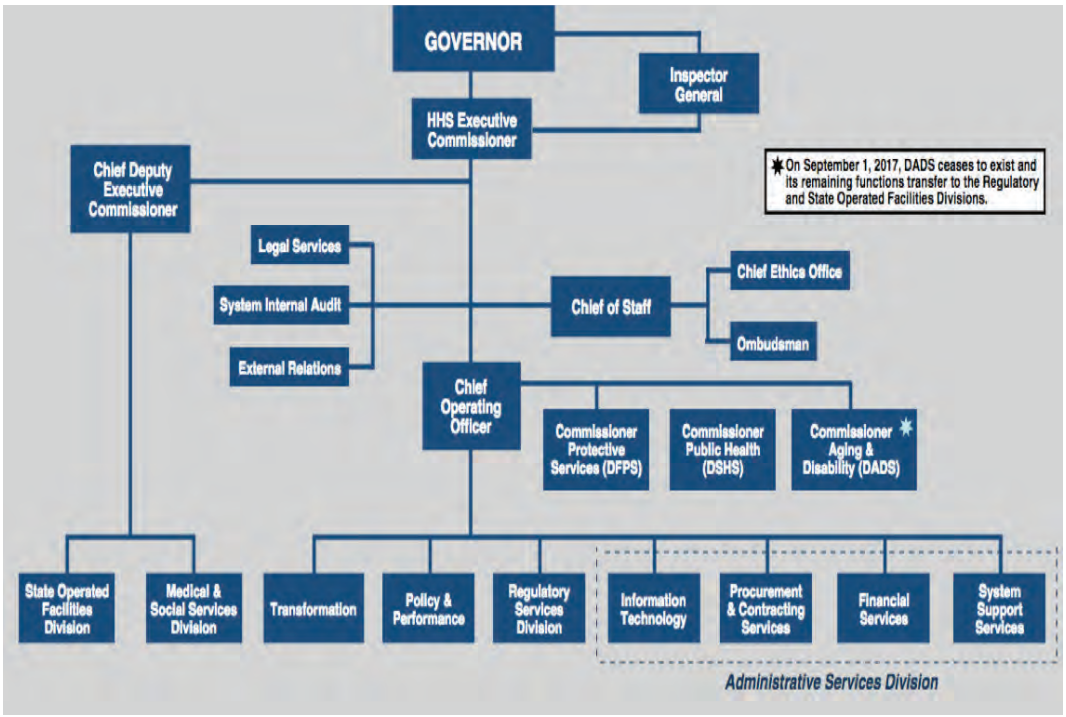
POLICY CONCERNS

- Maintaining continuity of client services during the human services (HHS) transformation
- Integrating behavioral health services into Medicaid managed care
- Providing access to services for low-income Texans with mental illness ineligible for Medicaid
- Ensuring adequacy of reimbursement rates for behavioral health and primary care services
- Maintaining funding for Medicaid 1115 Transformation Waiver projects and integrating successful projects into Medicaid managed care
- Enforcing mental health parity standards, as required by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008
- Monitoring and ensuring network adequacy in Medicaid managed care

FAST FACTS

- The FY 2016-17 HHSC appropriation was nearly $57 billion and comprised 27 percent of the state's entire budget.[1]
- One in seven Texans is enrolled in Medicaid.[2]
- Children without disabilities account for 67 percent of Medicaid enrollment but only 31 percent of program spending on direct healthcare services.[3]
- In 2014, Texas spent $12.5 billion on premium payments to Medicaid managed care organizations – or 39 percent of total Medicaid spending.[4]
- Texas has 72 Federally Qualified Health Centers (FQHCs) that serve over 1 million patients annually at nearly 450 sites statewide.[5]

ORGANIZATION CHART



Texas Health and Human Services System

Since the reform initiated by HB 2292 in 2003 as directed by the Texas Legislature, the Texas Health and Human Services Commission (HHSC) has been the umbrella agency overseeing Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), the Medical Transportation Program, the Disaster Assistance Program, and others, as well as the operation of four major departments:

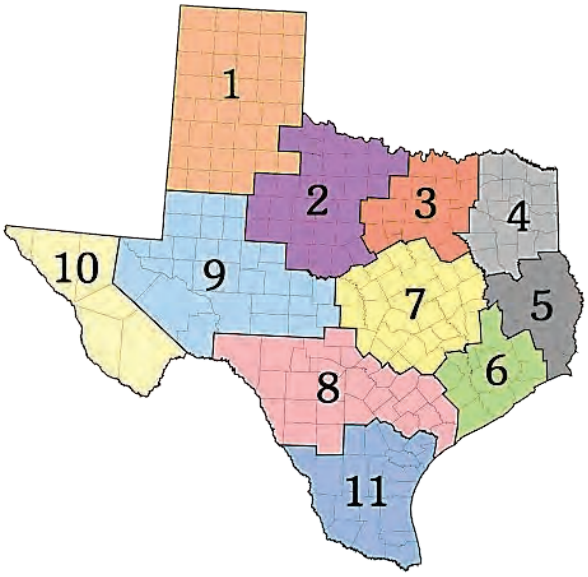
- Department of State Health Services (DSHS)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)

Together, HHSC and these departments comprised the Health and Human Services (HHS) "enterprise." For service delivery administration, the state is divided into 11 HHS regions, displayed in Figure 12. The HHS enterprise employs over 57,500 full-time employees.[6]

In 2015 the Texas Legislature passed a bill requiring a significant reorganization of the HHS system. Prior to the 84th session, the Texas Sunset Advisory Commission performed a comprehensive review of the system and recommended that the legislature consolidate agencies in order to improve efficiency and service delivery.[7] The 2014 Sunset Commission recommended further consolidation as a step toward achieving the state's 2003 vision for efficient, streamlined health and human services. According to the 2014 Sunset Commission, further system reorganization was also necessitated by recent developments in Texas healthcare, such as the transition to Medicaid managed care, the integration of behavioral health services into managed care, and the implementation of the federal Affordable Care Act (ACA).[8]

Informed by the commission's recommendations, the 84th Legislature directed the transfer of behavioral health and regulatory functions previously administered by DSHS and DFPS to HHSC, as well as a complete transfer of services and the ultimate elimination of DADS and DARS as separate entities.[9] This "HHS transformation" process began in 2015 and will take place over multiple years, altering the organizational structure of health and human services delivery in Texas. See the Changing Environment section for more information about the HHS transformation.

Figure 12. Health and Human Services Regions



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

Changing Environment

The Health and Human Services Commission and the HHS system are currently undergoing significant reorganization. As stated above, the 84th Texas Legislature directed a reorganization of the entire HHS system, requiring that many programs and services transfer to HHSC from the other four HHS agencies. Implementation began in 2015 and will continue over the course of several years, although the majority of the structural reorganization is expected to be complete by September 1, 2017.

In addition to the transformation, HHSC is implementing many legislative directives passed during the 84th Legislative Session that address a number of policy and program areas such as the Medicaid substance use benefit, network adequacy in Medicaid managed care, and the discontinuation of the NorthSTAR managed care program. The commission also continues to implement directives from the 83rd Legislative Session, such as integrating behavioral health services with Medicaid managed care.

Finally, as part of the transformation plan for health and human services, SB 200 (84th, Nelson/Price) created the new Division of Transformation, Policy and Performance within HHSC. Among other duties, the Policy and Performance Office is responsible for:

- Evaluating current HHSC (and DSHS) performance measures;
- Developing "new and refined" measures; and
- Establishing targeted system-level measures that evaluate and communicate overall system performance.[10]

HHS TRANSFORMATION: SB 200 (84TH, NELSON/PRICE)

During the 84th Legislative Session, the legislature adopted the Texas Sunset Commission's recommendation to reorganize the HHS enterprise (SB 200, 84th, Nelson/Price). The HHSC Sunset legislation requires the five HHS agencies to consolidate into three, discontinuing DARS and DADS and maintaining DSHS and DFPS as separate agencies until further legislative review in 2018.

HIGHLIGHTS

- **SB 200 (84th, Nelson/Price)** directs the state to transfer many of the programs and functions currently housed across the four other HHS agencies over to HHSC.
- **Phase one of the transformation,** focused on reforming the enterprise's broader organizational structure, concluded on September 1, 2016.
- **Behavioral health programs at DSHS and DADS**, as well as select client services at DARS, were transferred to HHSC; DARS was discontinued as a separate agency on September 1, 2016.
- **DARS general vocational rehabilitation services,** vocational rehabilitation for individuals who are blind, Independent Living Services for older individuals who are blind, and Business Enterprises of Texas program were all transferred to the Texas Workforce Commission on September 1, 2016.
- **Phase two** will focus on reforming program operations within the new HHS structure.
- **Regulatory functions at DSHS, DADS, and DFPS**, as well as operation of the state supported living centers (SSLCs) and the state hospitals, will transfer to HHSC by September 1, 2017.
- **DADS will be discontinued** on September 1, 2017.
- **DSHS and DFPS will continue to operate as separate agencies,** maintaining their public health and child protective services functions, until further legislative review in 2018.[11]

In July 2016, the commission published a revised version of *Health and Human Services System Transition Plan*, outlining its plan for carrying out the transformation directives in SB 200 (84th, Nelson/Price). The timeline for the anticipated changes is shown in Figure 13.

Figure 13. Proposed Health and Human Services Transformation Timeline

Date	Proposed Changes
By September 1, 2016 (Phase One)	DADS: All client services transfer to HHSC (social and medical) Regulatory, licensure, and SSLC operations remain at agency DARS: Vocational Rehabilitation Programs transfer to Texas Workforce Commission (TWC) Remaining programs and functions transfer to HHSC Agency is discontinued DFPS: Prevention and Early Intervention programs transfer from HHSC to DFPS Protective services and regulatory functions remain at agency DSHS: All client services transfer to HHSC (social and medical) Public health and regulatory functions remain at agency
By September 1, 2017 (Phase Two)	DADS: Regulatory, licensure, and SSLC functions transfer to HHSC Agency is discontinued DFPS: Childcare placement licensure functions transfer to HHSC Protective services functions remain at agency DSHS: Regulatory and licensure functions transfer to HHSC Agency maintains public health functions HHSC: Begin organizational review of within-division and within-program operations
By September 1, 2018 (Continuing)	HHSC: Submit study and recommendations to the Transition Legislative Oversight Committee on whether to continue DSHS and DFPS as separate agencies

Source: Texas Health and Human Services Commission. (2016). *Health and Human Services system transition plan*. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/

The reorganization of the HHS systems is occurring in two phases:

- **Phase One:** Completed on September 1, 2016, this phase focused on implementing broad structural changes to the HHS system. During this phase, HHSC facilitated the transfer of the majority of social and medical services into one HHSC division. The goal has been to transfer programs to HHSC in their entirety before attempting intra-program or intra-division organizational reform.
- **Phase Two:** During this phase, the agency plans to transfer remaining regulatory and facility operations to HHSC. The transfer of programs and functions to HHSC is expected to be complete by September 1, 2017. During this phase, the agency will begin to pursue reorganization within core functional divisions or specific programs, as necessary.[12]

The two-phase reorganization process is designed to minimize interruptions to client services during the transformation process.[13] While the majority of the structural changes are expected to be complete by September 1, 2017, the agency

expects that reorganization within divisions and programs will occur over the course of several years.

By September 1, 2018, the agency must, additionally, submit a report to the Texas Legislative Oversight Committee providing recommendations as to whether DSHS and DFPS should continue to operate as separate agencies or be merged into HHSC. For more information, see the Health and Human Services Transition Plan at http://www.hhsc.state.tx.us/hhs-transformation/transition-plan.shtml.

DISCONTINUATION OF NORTHSTAR: SB 200 (84TH, NELSON/PRICE)

The HHSC Sunset legislation also requires the state to discontinue the NorthSTAR behavioral health demonstration project on December 31, 2016. Since 1999, the NorthSTAR program has provided behavioral health and substance use services to Medicaid-eligible clients in the Dallas area through a capitated payment system to one managed behavioral health care organization.[14]

In 2014, the Sunset Commission found that NorthSTAR's behavioral health delivery system was outdated and inconsistent with Texas' system-wide efforts to integrate behavioral healthcare with other basic physical health services and Medicaid managed care.[15] In its analysis of Senate Bill 200 (84th, Nelson/Price), the Texas House Research Organization reported that dismantling NorthSTAR would:[16]

- Produce cost savings
- Facilitate behavioral health integration efforts
- Enhance access to federal funding

SB 200 adopted the Sunset Commission's recommendations, removing reference to the NorthSTAR program from statute. Medicaid-eligible NorthSTAR clients will receive their behavioral health care services through the same managed care organization that provides their physical health care.[17] DSHS has established two Behavioral Health Authorities (BHAs) that will provide an alternative model for indigent care (mental health services for those not eligible for Medicaid).[18] LifePath Systems and the North Texas Behavioral Health Authority (NTBHA) have been selected as the two BHAs in the region.[19] These transitions become effective January, 1 2017.[20] See the section on "Behavioral Health Services" section for more information about NorthSTAR.

HHS ADVISORY COMMITTEE REORGANIZATION: SB 200 (84TH, NELSON/PRICE) AND SB 277 (84TH, SCHWERTNER/SHEFFIELD)

The HHSC Sunset legislation also directs important changes to the advisory committee structure in the HHS enterprise, eliminating 36 existing advisory committees from state statute while enabling the HHSC Executive Commissioner to establish new advisory committees in rule.[21] Advisory committees play an important role in the HHS enterprise, providing the agency with feedback from clients, families, and other stakeholders on specific issues.

In 2015, a cross-agency workgroup evaluated the 133 existing HHS advisory

committees. Following a public input process, the workgroup submitted recommendations to the HHS Executive Commissioner on which advisory committees to keep, consolidate, or dismantle. A list of the recreated advisory committees can be found in the transformation plan at http://www.hhsc.state.tx.us/hhs-transformation/transition-plan.shtml.

The HHSC Sunset legislation expressly directed HHSC to establish an advisory committee that would address behavioral health issues, and the Behavioral Health Advisory Committee held its inaugural meeting in January 2016. Its role is to provide recommendations to the HHS Executive Commissioner on how to promote cross-agency coordination, ensure access to and integration of services, and promote behavioral health wellness and recovery.[22]

For a full listing of the Commissioner's final advisory committee recommendations, please see the *Health and Human Services Transition Plan* at http://www.hhsc.state.tx.us/hhs-transformation/docs/transition-plan.pdf.

NETWORK ADEQUACY IN MEDICAID MANAGED CARE: SB 760 (84TH, SCHWERTNER/PRICE) AND HHSC RIDER 81, HB 1, ARTICLE II (84TH, OTTO/NELSON)

As managed care becomes Texas' primary service delivery model for Medicaid, the legislature has expressed concern about the adequacy of provider networks available to clients enrolled in plans through Medicaid managed care organizations (MCOs). Historically, HHSC has contractually required MCO plans to maintain an adequate network of different provider types, but a number of stakeholders continue to identify network adequacy as an issue for Medicaid patients who experience difficulty finding in-network providers, including behavioral health providers.[23]

Network adequacy for Medicaid behavioral health providers remains a concern and is related to the national and state shortage of behavioral health providers.[24] (See *The Texas Mental Health Workforce: Continuing Challenges and Sensible Solutions,* http://hogg.utexas.edu/wp-content/uploads/2016/04/Workforce-Brief-20168-Low-Res.pdf.) Maintaining an adequate network of behavioral and mental health care providers among MCOs is increasingly important as these services are integrated into the bundle of services covered by Medicaid managed care (see discussion of behavioral health integration and Senate Bill 58 [83rd, Nelson/Zerwas]).

Among its multiple directives, SB 760 (84th, Schwertner/Price) requires HHSC to:

- Establish access standards for different provider types in an MCO network;
- Implement new remedies for MCOs that fail to comply with access standards;
- Submit reports to the legislature on MCO compliance with network adequacy standards;
- Ensure that MCOs submit plans for compliance with new access standards;
- Establish and implement an expedited credentialing process, heightened transparency standards, and an MCO compliance monitoring process; and
- Expand consumer support resources for clients enrolled in MCO plans.[25]

HHSC conducted a public input process and stakeholder forum in the fall of 2015 to gather feedback on SB 760's implementation.[26] In February 2016, the agency held a

managed care stakeholder meeting to discuss the agency's draft response to public input.[27] A follow-up forum was held in June 2016.

Relatedly, HHSC Rider 81, HB 1, Article II (84th, Otto/Nelson) directs HHSC to publish a report on network adequacy compliance and the number of disciplinary or corrective actions that the agency has taken against noncompliant MCOs.

EVALUATION OF SUBSTANCE USE TREATMENT BENEFIT IN MEDICAID: HHSC RIDER 44, HB 1, ARTICLE II (84TH, OTTO/NELSON)

In 2009, the legislature approved a Substance Use Disorder (SUD) benefit for adult Medicaid beneficiaries with the goal of reducing costs in the Medicaid program (SB 1, Article IX, 81st, Ogden/Pitts).[28] The legislation followed the release of Legislative Budget Board (LBB) findings that people with substance use disorders incur twice the medical costs as people without those disorders.[29]

The 2009 legislation required that HHSC discontinue the benefit if the agency finds that providing adult substance use services results in overall growth in Medicaid spending. In 2015, with HHSC Rider 44, HB 1, Article II (84th, Otto/Nelson), the legislature directed HHSC to evaluate the SUD benefit and its effect on overall Medicaid spending and client outcomes. HHSC released a progress report outlining its evaluation methodology in December 2015 and is required to submit either a final report or status update to the Office of the Governor by December 1, 2016.

INTEGRATION OF BEHAVIORAL HEALTH SERVICES WITH MEDICAID MANAGED CARE: SB 58 (83RD, NELSON/ZERWAS)

In an effort to optimize health outcomes for Medicaid beneficiaries with mental healthcare needs, in 2013 the legislature approved the integration of behavioral healthcare into the package of services reimbursable under Medicaid managed care.

Prior to the passage of Senate Bill 58 (83rd, Nelson/Zerwas), only local mental health authorities (LMHAs) were eligible to receive Medicaid reimbursement for mental health rehabilitation and targeted case management services. LMHAs provided these services under a fee-for-service payment arrangement with DSHS. Senate Bill 58 directed the agency to widen this provider network and incorporate these services into the package of services covered by Medicaid managed care organizations (MCOs). The bill established a Behavioral Health Integration Advisory Committee to provide recommendations and guidance through two distinct phases of implementation.

During Phase I of implementation, HHSC successfully oversaw the integration of LMHAs into the state's STAR and STAR+PLUS managed care networks. In September 2014, targeted case management and mental health rehabilitative services became fully reimbursable through the state's managed care providers. LMHAs statewide are now contracted with MCOs to provide behavioral healthcare services to Texans served in those networks.

While private providers are technically eligible to receive reimbursement for

behavioral health services, MCOs continue to contract primarily with LMHAs. This is largely because LMHAs have established capacity to deliver the integrated bundle of mental health services required of rehabilitative service providers. More participation from private providers is expected over time as they build the capacity to offer the integrated services necessary to receive reimbursement.

HHSC expects that achieving full integration will require years of ongoing effort and oversight. The advisory committee released its Phase II recommendations in July 2015, and the agency plans to focus on the following objectives during Phase II of implementation:

- Broadening the provider base to include private providers;
- Implementing systems changes recommended by the advisory committee;
- Conducting outreach and education to ensure that integration is happening at all levels;
- Defining the behavioral health medical policy benefits; and
- Developing and implementing two home health pilots.[30]

PROGRAMS TRANSFERRING FROM DARS TO HHSC AND TWC

The mission of the Texas agency formerly known as Department of Assistive and Rehabilitative Services (DARS) was "to ensure that Texans with disabilities and children with developmental delays enjoy the same opportunities as other Texans to live independent and productive lives."[31] DARS was intended to reduce the need for long-term support from other public programs and services. As of September 1, 2016, all DARS functions and responsibilities were transferred to either the Health and Human Services Commission (HHSC) or the Texas Workforce Commission (TWC) as a result of Sunset legislation. More information on Vocational Rehabilitation Services and other programs transferred to TWC can be found in the TWC section.

The Early Childhood Intervention (ECI) and Vocational Rehabilitation (VR) programs formerly administered under DARS are of special relevance to the promotion of mental health for Texans. The nurturing of a child's healthy emotional, behavioral, and social development can help to prevent the future development of mental health conditions.[32,33] Employment can help adults with mental or behavioral health conditions obtain independence, become integrated into society, and achieve social, emotional, and general well-being.[34]

The figure below illustrates where former DARS programs are now placed.

Figure 14. Former DARS Programs

Program Name	New Agency Placement	Transition Date
Vocational Rehabilitation for Individuals with Mental or Physical Disabilities	TWC	9/1/16
Independent Living Services for Older Individuals Who are Blind	TWC	9/1/16
Criss Cole Rehabilitation Center	TWC	9/1/16
Business Enterprises of Texas	TWC	9/1/16
Independent Living Services Program	HHSC	9/1/16
Blind Children's Vocational Discovery and Development Program	HHSC	9/1/16

Program Name	New Agency Placement	Transition Date
Blindness Education, Screening and Treatment Program (BEST)	HHSC	9/1/16
Children's Autism	HHSC	9/1/16
Comprehensive Rehabilitation Services	HHSC	9/1/16
Deaf and Hard of Hearing Services	HHSC	9/1/16
Early Childhood Intervention	HHSC	9/1/16
Disability Determination Services	HHSC	9/1/16

Source: Texas Health and Human Services Commission. (2016). *Health and Human Services System Transition Plan*. Page. 22. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/transition-plan.pdf

PROGRAMS TRANSFERRING FROM DADS TO HHSC

Prior to the implementation of the HHS transformation plan, the Texas Department of Aging and Disability Services (DADS) was responsible for providing long-term services and supports (LTSS) for Texans over the age of 60, people with physical disabilities, and people with intellectual and other developmental disabilities (IDD). LTSS (including both residential and community services) help individuals receive needed care and services to remain in their homes and communities of choice. DADS also had responsibility for regulating providers of LTSS and administering the state's guardianship program. As a result of the HHSC transformation, DADS as a separate agency will be abolished and the programs and services incorporated into the HHSC organizational structure. For more information, see DADS Transformation Recap below.

DADS was under the review of the Sunset Advisory Commission, along with the other Texas Health and Human Services agencies, before the 84th Legislative Session. Sunset staff carefully reviewed DADS' internal policies, procedures, and service delivery. The Commission ultimately recommended dissolving the agency and moving its functions into the Health and Human Services Commission (HHSC), in an effort to better serve older Texans and individuals with physical, intellectual, and other developmental disabilities (IDD).

The Sunset Commission also tackled the highly controversial issues surrounding the continued operation of the state support living centers (SSLCs). The Commission recommended closing six SSLCs: closing the Austin SSLC by September of 2017 and identifying five additional SSLCs to close by September of 2022.[35] Those recommendations, along with statutory recommendations on other programs within DADS, were solidified in the DADS Sunset bill, SB 204 (Hinojosa/Raymond). The bill passed the Senate with a few changes, but after lengthy discussion on the House floor, House members removed SB 204's recommendation to close the Austin SSLC and establish the SSLC Restructuring Commission. Members of the conference committee could not reach an agreement on the content of the DADS Sunset bill, consequently SB 204 died days before the end of the legislative session.[36]

The failure of SB 204 means that every SSLC will remain open until further legislative direction is received. However, many other DADS-related recommendations from the Sunset Commission were adopted in the final HHSC Sunset bill (SB 200), including changes to nursing home requirements and services for individuals with IDD.[37,38]

The HHSC Sunset bill (SB 200) transfers functions from DADS to HHSC. DADS' functions will transfer entirely to HHSC by September 1, 2017 and the agency will then be abolished. The majority of the agency's client services and program functions transferred to HHSC on September 1, 2016. The remaining regulatory functions and operation of the SSLCs will transfer by September 1, 2017, at which point the agency will be discontinued.

The Health and Human Services Transition Plan was released in March 2016 for review by the Transition Legislative Oversight Committee. The proposed plan outlines the future of DADS' programs and functions. The SSLCs will be placed in the new Facility Operations Division under HHSC, which will operate two types of state-owned facilities: state hospitals and SSLCs. For more information on the HHSC and DSHS Sunset changes, see the Texas Environment section of the guide.

The Sunset Advisory Commission's Staff Report of DADS, including the final results of the 84th legislative session is available at the following link: https://www.sunset.texas.gov/public/uploads/files/reports/DADS%20Staff%20Report%20with%20Final%20Results.pdf

The final HHSC Transformation Plan is available at https://hhs.texas.gov/about-hhs/hhs-transformation.

HHSC Funding

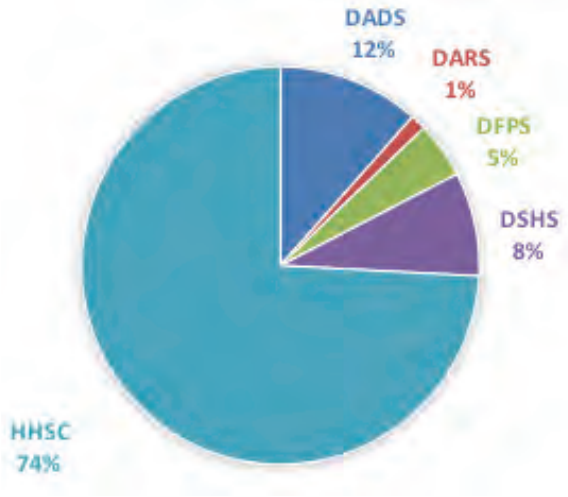
HHSC has proposed a FY 2018-19 consolidated budget that includes the funding needed to continue programs and services transitioned from the once separate agencies. DFPS and DSHS will continue to submit individual agency appropriations requests for the operations that are not currently being consolidated. The following paragraphs offer information on the FY 2016-17 budget approved by the 84th legislature as well as the FY 2018-19 budget proposed by HHSC for the new enterprise structure.

According to HB 1 (84th, Otto/Nelson) the 2016-17 HHSC budget of approximately $57 billion, constituted 27 percent of the entire Texas state budget and over 70 percent of the HHS system budget (see Figure 15). This represents a 17 percent increase from the 2014-15 HHSC budget of $49 billion.[39] It should be noted that these figures were prior to the restructuring of the HHS system. Spending on health and human services in Texas is primarily driven by anticipated caseload growth for programs such as Medicaid, CHIP, and foster care.[40] HHSC is requesting $30,906,433,838 General Revenue and $6,013,975,759 in exceptional item requests for FY 2018-19.[41] These amounts cannot be compared to prior years due to the changes in infrastructure and consequent legislative appropriations requests.

The FY 2016-17 HHS *system* (HHSC, DADS, DARS, DSHS, and DFPS) budget was over $77 billion in combined state and federal funding, representing approximately 37 percent of the entire state budget.[42] Figure 15 shows the percentage of HHS funding that was dedicated to each of the five agencies, and Figure 16 shows funding sources for the 2016-2017 HHS enterprise budget.

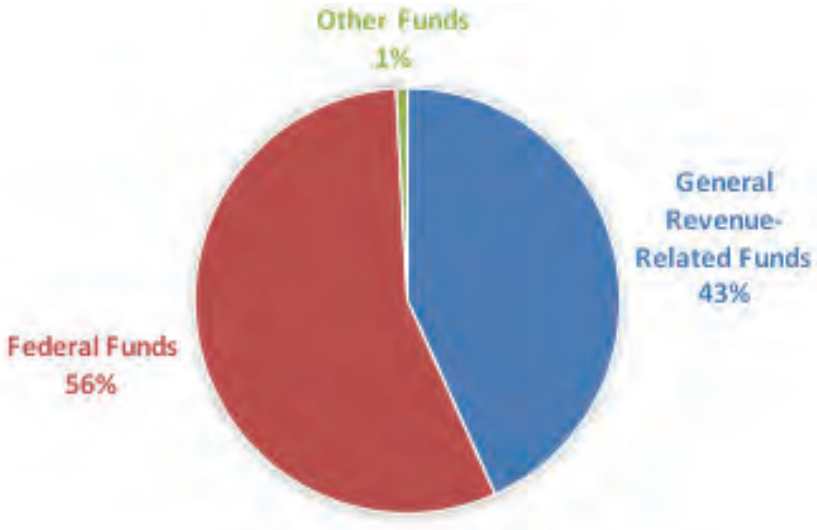
The majority of the HHSC budget (92 percent) is dedicated to Medicaid (see Figure 17), which is funded jointly by state General Revenue (GR) and federal matching funds. Federal funding comprises a large percentage (58 percent) of the HHSC budget, in part due to the joint federal-state funding arrangement for Medicaid. According to the July 2016 Coordinated Behavioral Health Expenditures Proposal approximately $1.8 billion is budgeted for mental health services across state agencies.[43,44] See the *Coordinated Statewide Behavioral Health Expenditures Proposal for FY 2017* in the Medical and Social Services Division section.

Figure 15. Health and Human Services Enterprise Budget by Agency (2016-2017)



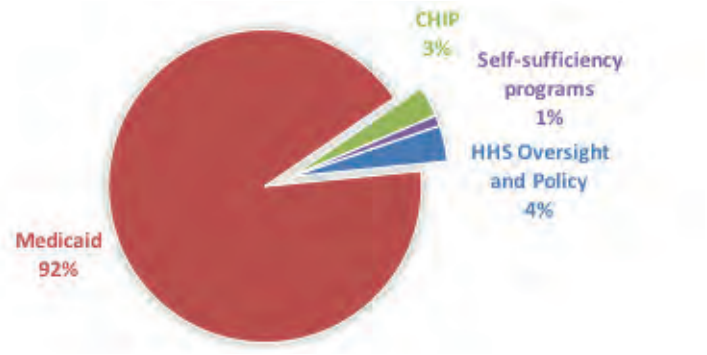
Note: Excludes system-wide employee benefits, debt service, and interagency contracts, which together comprise 1 percent of the HHS budget.
Source: Hogg Foundation analysis of General Appropriations Act, H.B. 1, Conference Committee Report, 2015 Leg., 84th Reg. Sess., art. II. (Tex. 2015). Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2016-2017.pdf

Figure 16. Health and Human Services Enterprise Budget by Method of Finance (2016-2017)



Source: Hogg Foundation analysis of General Appropriations Act, H.B. 1, Conference Committee Report, 2015 Leg., 84th Reg. Sess., art. II. (Tex. 2015). Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2016-2017.pdf

Figure 17. Health and Human Services Commission Budget by Item of Appropriation (2016-2017)



Note: Excludes allocations for program support, IT support, and the Office of the Inspector General, which together comprise less than 1 percent of the total HHSC budget.

Source: Hogg Foundation analysis of General Appropriations Act, H.B. 1, Conference Committee Report, 2015 Leg., 84th Reg. Sess., art. IX sec. 10.04. (Tex. 2015). Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2016-2017.pdf

As a result of the HHS system transformation, some programs and divisions were moved out of HHSC and many moved into HHSC. Therefore, the budget trends do not compare apples-to-apples, as the amounts requested for 2018 and 2019 do not align with the same programs and services of previous biennium.

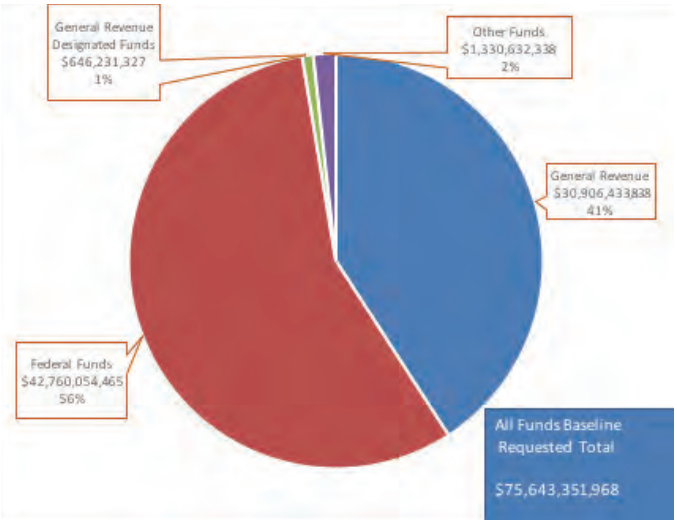
Figure 18. HHSC Funding Trends

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019
HHSC	$33,282,957,612	$34,274,853,313	$37,044,744,012	$37,266,380,145	$38,376,971,823

Source: Data Captured from HHSC Legislative Appropriations Request for FY 2018/19. September 12, 2016.

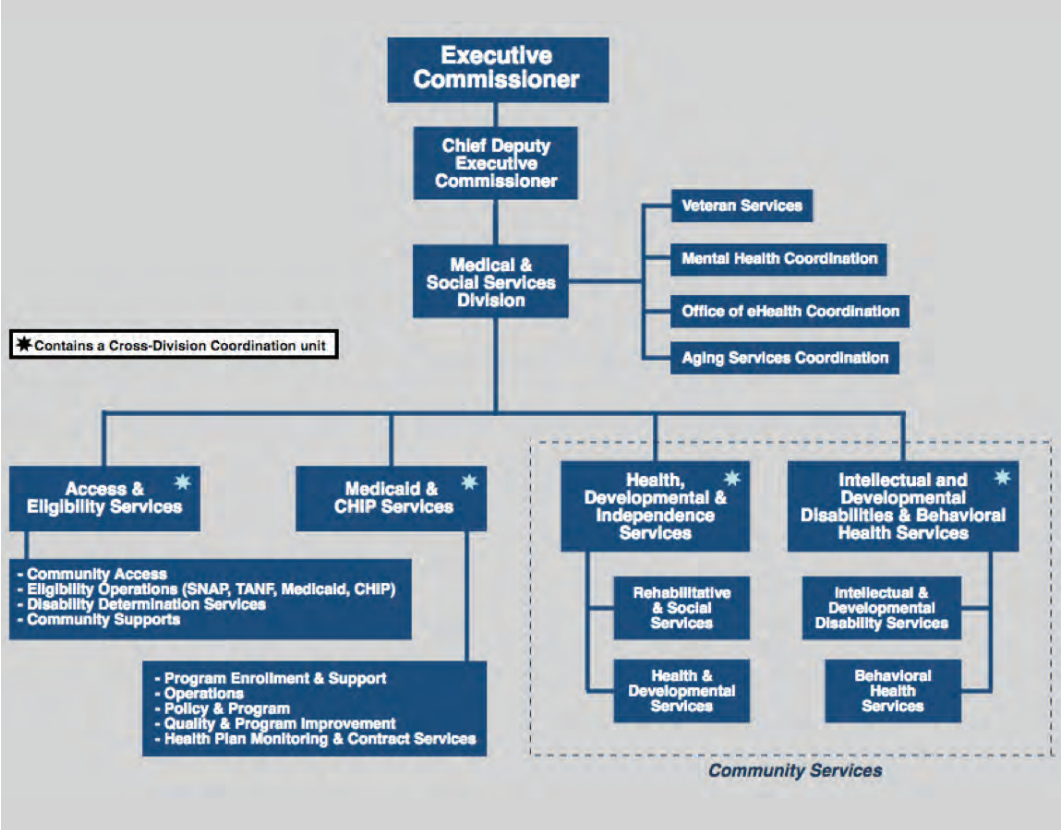
The figure below depicts the breakdown of the anticipated sources of funding for HHSC FY 2018-19.

Figure 19. 2018-19 Legislative Appropriations Request by Method of Financing, Baseline Budget



Source: Data captured from HHSC Legislative Appropriations Request for FY 2018-19. September 12, 2016.

Medical and Social Services Division



Under the new HHSC organizational structure, the chief deputy executive commissioner oversees the Medical and Social Services Division and the State Facilities Division. The Medical and Social Services Division will have responsibility for

- Medicaid and CHIP
- Community Services, which includes:
  - Health, Developmental & Independence Services; and
  - Intellectual and Development Disabilities & Behavioral Health Services
- Access and Eligibility Services

According to the HHS System Transition Plan, the Medical and Social Services Division will address historic fragmentation by placing client services including eligibility services, Medicaid activities, and community service programs in one division with a single line of authority.[45] Additionally, the Office of Mental Health Coordination now reports to the deputy executive commissioner of the Medical and Social Services Division.

Medical and Social Services Division *– Determines client eligibility serving as the entry point for services and providing information regarding access to services; oversees or provides client services, including aging services, community care, women's primary and preventative services, awareness and education services, behavioral health services, intellectual disability services, and rehabilitation services and supports; and develops policy, oversees provider and health plan contracts, and submits Medicaid State Plan amendments and waivers to the Center for Medicare and Medicaid Services. (HHS System Transition Plan, July 2016)*

Office of Mental Health Coordination

In recent years, mental health and substance use have become major topics of national dialogue. Recognizing the need to be more strategic in behavioral health service delivery, and funding, the Texas Legislature took steps to increase and improve cross agency planning, coordination, and collaboration. In 2013, the legislature created the Office of Mental Health Coordination, which it tasked with providing broad oversight for state mental health policy as well as managing cross-agency coordination of behavioral health programs and services.[46] The office was initially housed within HHSC with a vision "to ensure that Texas has a unified approach to the delivery of behavioral health services that allows Texans to have access to care at the right time and place."[47] Under the new organizational structure, this office reports to the deputy executive commissioner of the Medical and Social Services Division. The office has developed a website to provide consumers, families, and providers up-to-date information on mental health and wellness. According to the site, it was "developed with the goal of providing information, resources, and direction to Texas residents who may have mental health related needs or who want to support someone who does." The website can be found at http://www.mentalhealthtx.org.

In 2015, the office documented 54 cross-agency mental health initiatives spanning a total of 14 state agencies.[48] The report on these cross agency behavioral health initiatives can be found at https://hhs.texas.gov/sites/hhs/files//documents/about-hhs/cabhi.pdf.

Also in 2015, as part of the state's ongoing efforts to coordinate services across agencies and departments (including those outside of the HHS enterprise), the legislature established the Behavioral Health Coordinating Council, which it tasked with establishing a strategic statewide plan for mental health programs and services. The HHSC assistant commissioner who oversees the Office of Mental Health Coordination at HHSC serves as chair of the council.[49] Eighteen agencies and departments worked together under the direction of the Office of Mental Health Coordination to develop the goals and strategies included in the plan. The plan can be found at https://hhs.texas.gov/sites/hhs/files//050216-statewide-behavioral-health-strategic-plan.pdf.[50]

In addition to development of the behavioral health strategic plan, the Behavioral Health Coordinating Council was directed to develop a "coordinated statewide expenditure proposal" for mental health services for FY 2017. The legislative directive required approval of the proposal by the HHSC executive commissioner and the Legislative Budget Board. FY 2017 appropriations could not be expended until the budget was developed and the required approvals were obtained.

As a result of the legislative directive, the Behavioral Health Coordinating Council developed the Coordinated Statewide Behavioral Health Expenditure Proposal, Fiscal Year 2017. Figure 20 below, summarizes the proposed budget. The full proposal can be found at http://www.lbb.state.tx.us/Documents/Publications/Presentation/3190_Statewide_Behavioral_Health_Strategic_Plan.pdf.

Under the "transformed" HHS System, the Office of Mental Health Coordination reports to the deputy executive commissioner of the Medical and Social Services Division.

Figure 20. Coordinated Statewide Behavioral Health Expenditures Proposal for Fiscal Year 2017

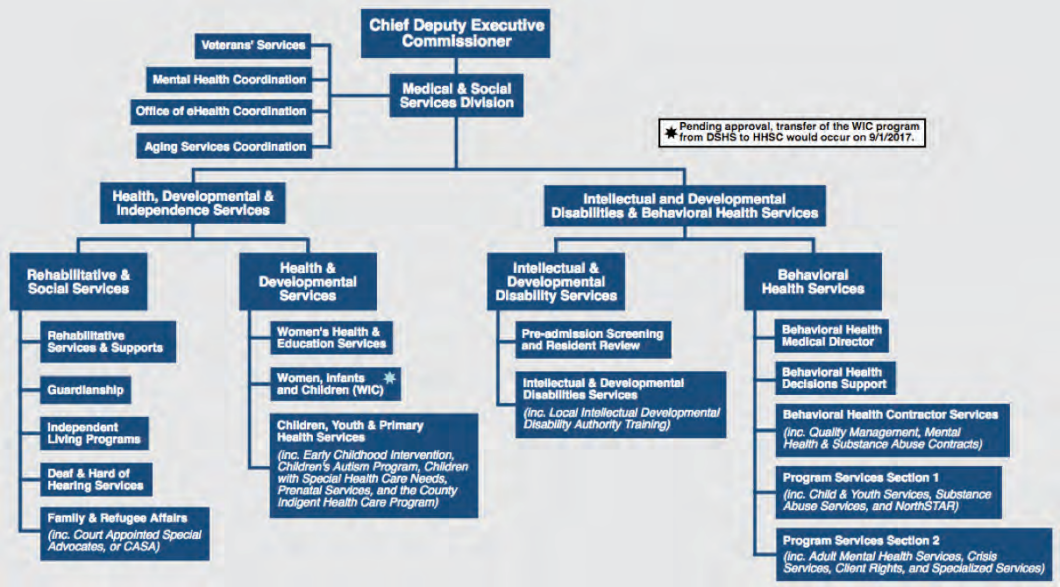
Agency	GAA, Article IX, Section 10.04, Expenditures - All Funds	Proposed FY 2017 Expenditures - General Revenue	Proposed FY 2017 Expenditures - All Funds
Office of the Governor (GOV)	$ 5,269,948	$ 950,000	$ 5,269,948
Texas Veterans Commission (TVC)	$ 2,000,000	$ -	$ 2,000,000
Article I Subtotal	**$ 7,269,948**	**$ 950,000**	**$ 7,269,948**
Department of Aging and Disability Services (DADS)	$ 12,316,944	$ 12,000,000	$ 12,316,944
Department of Family Protective Services (DFPS)	$ 27,668,231	$ 14,702,058	$ 27,668,231
Department of State Health Services (DSHS) [1]	$ 1,351,430,144	$ 993,696,956	$ 1,351,430,144
Health and Human Services Commission (HHSC) [2]	$ 40,093,912	$ 14,376,606	$ 38,224,548
Texas Civil Commitment Office (TCCO)	$ 154,611	$ 154,611	$ 154,611
Article II Subtotal	**$ 1,431,663,842**	**$ 1,034,930,231**	**$ 1,429,794,478**
University of Texas - Health Science Center at Houston (UTHSC - Houston)	$ 6,000,000	$ 6,000,000	$ 6,000,000
University of Texas - Health Science Center at Tyler (UTHSC - Tyler)	$ 4,000,000	$ 4,000,000	$ 4,000,000
Article III Subtotal	**$ 10,000,000**	**$ 10,000,000**	**$ 10,000,000**
Texas Department of Criminal Justice (TDCJ) [3]	$ 247,908,621	$ 250,386,515	$ 250,877,549
Texas Juvenile Justice Department (TJJD) [4]	$ 84,747,891	$ 85,458,830	$ 87,299,830
Texas Military Department (TMD)	$ 628,500	$ 628,500	$ 628,500
Article V Subtotal	**$ 333,285,012**	**$ 336,473,845**	**$ 338,805,879**
Texas State Board of Dental Examiners (BDE)	$ 124,250	$ 124,250	$ 124,250
Texas State Board of Pharmacy (BPH)	$ 238,585	$ 238,585	$ 238,585
Texas Board of Veterinary Medical Examiners (TBVME)	$ 30,000	$ 30,000	$ 30,000
Texas Optometry Board (TOB)	$ 36,000	$ 36,000	$ 36,000
Texas Board of Nursing (TBN)	$ 873,558	$ 873,558	$ 873,558
Texas Medical Board (TMB)	$ 533,969	$ 533,969	$ 533,969
Article VIII Subtotal	**$ 1,836,362**	**$ 1,836,362**	**$ 1,836,362**
Cross Article Total	**$ 1,784,055,164**	**$ 1,384,190,438**	**$ 1,787,706,667**

Summary by Service Type Category [5]	Proposed FY 2017 Expenditure
Education and Training	$ 4,000,000
Information Technology	$ 1,882,365
Infrastructure	$ 2,882,062
Intervention and Treatment Services	$ 1,657,002,029
Prevention	$ 98,976,583
Research	$ 6,000,000
Staff	$ 16,963,628
Cross Service Type Total	**$ 1,787,706,667**

Notes:
(1) DSHS funds include Medicaid as reflected in GAA, Art. IX, Sec. 10.04 rider; NorthSTAR funds will transfer to HHSC January 1, 2017. (2) HHSC variance from the GAA, Art. IX, Sec.10.04 includes revisions in CHIP projections based on the September 2015 operating budget forecast, as well as adjustments for the System of Care Grant, CCBHC Planning Grant, and the Texas Veteran + Family Alliance Pilot Program, which were unknown at the time the original rider amounts were developed. (3) TDCJ's FY 2017 expenditure proposal includes additional behavioral health funding in two strategies not included in the GAA, Art. IX, Sec.10.04 rider and an adjustment in one other strategy to specifically reflect only behavioral health-related initiatives. (4) TJJD's FY 2017 expenditure proposal includes additional behavioral health funding in two strategies not included in the GAA, Art. IX, Sec. 10.04 rider and an adjustment throughout several strategies to remove federal funding not specifically related to behavioral health. (5) The Education and Training and Research Service Type Categories are as defined by the BH Coordinating Council; the remaining categories are as defined by the LBB.

Source: Health and Human Services Commission, (July 2016). Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2017. Retrieved from http://www.hhsc.state.tx.us/news/presentations/2016/fy-2017-csbh-expenditure-proposal.pdf

Medicaid & CHIP Services



MEDICAID

Medicaid is a jointly funded federal and state health care program authorized in Title XIX of the Social Security Act. It was created as a way to provide health care benefits primarily to children in low-income families, pregnant women, and people with disabilities. The Texas Medicaid Program was first established in Texas in 1967. Roughly one in seven Texans (4.1 million out of 27.5 million) rely on Medicaid for acute and long-term services each month.[51] The Texas Medicaid program caseload is projected to exceed 4.6 million by 2017.[52]

The federal government defines the mandatory services that state Medicaid programs must provide and populations they must serve. States have the option to expand both the services offered and the populations eligible to receive those services through State Plan Amendments (SPAs) and Medicaid waivers. 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. Neither the federal government nor states can limit the number of eligible persons who enroll in the program.[53] Waiver programs, however, allow state to waive basic federal Medicaid requirements, such as 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: [54]

- **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. For more information on 1915(c) Waivers, see the Intellectual and Developmental Disability Services subsection of this guide

STATE MEDICAID AGENCY

HHSC has been the designated state Medicaid agency since 1993, administering the program and acting as a point of contact between Texas and the federal government on issues related to Medicaid. 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
- Establishing eligibility beyond the minimum federal eligibility groups[55]

Historically, Medicaid-funded behavioral health services have been provided through multiple HHS agencies. However, the HHS enterprise is currently undergoing reorganization (see Changing Environment). Figure 21 outlines the Medicaid-funded programs that each legacy agency has historically administered that will transition to HHSC.

Figure 21. Medicaid-Funded Programs Across HHS Agencies Included in or Transitioning to HHSC (2016)

State Agency	Medicaid-Funded Programs and Services
Health and Human Services Commission	*Oversees Texas Medicaid State Plan services.* Examples of duties include: Medicaid eligibility determination Managed care oversight 1115 Waiver oversight
Department of Aging and Disability Services	*Medicaid 1915(c) Waiver Programs* (transferred to HHSC Sept. 2016): Community Living Assistance and Support Services (CLASS) Medically Dependent Children Program (MDCP) Deaf-Blind with Multiple Disabilities (DBMD) Home and Community-Based Services (HCS) Texas Home Living (TxHmL) *Medicaid State Plan Entitlement Programs* (transferred to HHSC Sept. 2016): Primary Home Care (PHC) Day Activity and Health Services (DAHS) Community Attendant Services (CAS) Nursing Facilities Intermediate Care Facilities (for individuals with IDD) *Other Services* (transferred to HHSC Sept. 2016): Preadmission Screening and Resident Review (PASRR) Money Follows the Person Targeted case management for IDD Hospice Program of All-inclusive Care for the Elderly *Facilities and Regulatory Functions* (transferring to HHSC Sept. 2017): Long Term Care Licensing, Survey, and Certification State supported living centers State hospitals

State Agency	Medicaid-Funded Programs and Services
Department of State Health Services	*Medicaid 1915(c) Waiver Programs* (transferred to HHSC Sept. 2016): Youth Empowerment Services (YES) *Other Services* (transferred to HHSC Sept. 2016): Texas Health Steps (Early and Periodic Screening, Diagnosis and Testing) Case management for pregnant women and children Newborn screening, including hearing screening Family planning Home and Community-Based Services for Adult Mental Health (HCBS-AMH) Targeted case management and psychosocial rehabilitation services for persons with a mental health diagnosis
Department of Assistive and Rehabilitative Services	*Programs* (transferred to HHSC Sept. 2016): [a] Early Childhood Intervention Program (ECI) Targeted case management for the blind or visually impaired Children's Vocational Discovery and Development Program Note: Adult vocational rehabilitation transferred to the Texas Workforce Commission
Department of Family and Protective Services	*Medicaid Managed Care* (administered by HHSC and serving DFPS clients): STAR Health

[a] Non-Medicaid funded programs at DARS transferred to the Texas Workforce Commission in September 2016.

Sources: Texas Health and Human Services Commission. (2015). *Texas Medicaid and CHIP in perspective tenth edition*, 2-11. Retrieved from http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf; Texas Health and Human Services Commission. (2016). *Health and Human Services system transition plan*. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/transition-plan.pdf.

MEDICAID MANAGED CARE

Since the early 1990s, Texas has offered Medicaid coverage through two service models: fee-for-service and managed care. The traditional fee-for-service model, wherein providers receive payment based on the unit of service delivered, is now limited to very few Medicaid participants. Under the Medicaid managed care system, a single provider oversees the care of each client, and the state pays a monthly capitated rate to the provider for each enrollee. With support from the Medicaid 1115 Transformation Waiver, Texas has incrementally expanded its Medicaid managed care system to include more services and populations (see The Texas Environment for more information on the 1115 Waiver). Moreover, under the recent direction of Senate Bill 7 (83rd, Nelson/Raymond), managed care has become the primary platform for delivering Medicaid services in Texas.

In a managed care system, the Medicaid-eligible client selects a health plan (a managed care organization) and identifies a primary care physician from that plan's provider network. Clients have a choice between two or more health plans in each region. Members have the option to change plans down the line 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 expected to result in higher quality services.

STAR (State of Texas Access Reform) is the statewide managed care program that provides Medicaid acute care services to the majority of Medicaid beneficiaries. STAR+PLUS is the statewide managed care program that provides both acute and long term services and supports to people with disabilities and elderly participants.

Approximately 3.5 million Texas Medicaid clients (86 percent) were enrolled in managed care as of March 2016.[56] This is an increase from 2.8 million in 2013, prior

to the implementation of Senate Bill 7 (83rd, Nelson/Raymond), which expanded mandatory participation in the existing STAR+PLUS managed care program.

Senate Bill 7 generated major 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 intellectual or developmental disabilities (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.[57] The bill directed the design and implementation of a system of acute care and long-term services and supports for adults and children with IDD. Texans who receive services through the Medicaid 1915(c) Waiver programs now receive acute care services through STAR+PLUS, and Texans with SSI not enrolled in a 1915(c) IDD waiver program receive both acute and long-term care services through STAR+PLUS. In addition to expanding care in STAR+PLUS, Senate Bill 7 established a new managed care program for children with disabilities called STAR Kids, expected to launch in November 2016. HHSC and DADS are also working together to create a capitation pilot for the delivery of long-term services and supports for people with IDD receiving waiver services, as required by Senate Bill 7.

Figure 22 describes the five Texas Medicaid and CHIP managed care programs. These programs include STAR (State of Texas Access Reform), STAR+PLUS, STAR Health, CHIP, and STAR Kids.

Figure 22. Texas Medicaid and CHIP Managed Care Programs

Program	Description	Eligible Population	Mental Health Utilization Rate (2014)[a]
STAR (State of Texas Access Reform) Start date: 1991	Provides primary care, acute care, and pharmacy services to children, infants, and pregnant women in families with limited income. Includes behavioral/mental health rehabilitative and targeted case management services. Operates statewide.	*Mandatory:* · Income-eligible pregnant women, infants, and children · TANF recipients · Former foster care children (21-25) *Optional:* · Former foster care children (18-20)	Total: 15.4% Inpatient: 0.42% Intensive Outpatient: 0.10% Outpatient or ER: 13.73%
STAR+PLUS Start date: 1998	Provides acute care and long-term services and supports (LTSS) to individuals age 65 or over or those who have a disability. Integrates primary care, pharmacy services, and long-term care services. Service coordination is main feature. Operates statewide.	*Mandatory:* · Adults with SSI (> 21) · Income-eligible adults with a disability (> 21) · Individuals in nursing facilities covered by Medicaid · Long-term care only: · Medicare/Medicaid dual-eligible individuals *Acute care only:* · Individuals with IDD in an intermediate care facility or Medicaid 1915(c) waiver program[b]	Total: 31.34% Inpatient: 3.93% Intensive Outpatient: 0.72% Outpatient or ER: 30.96%

Program	Description	Eligible Population	Mental Health Utilization Rate (2014)[a]
STAR Health Start date: 2008	Provides all medically necessary services such as acute care, dental, vision, behavioral health, and pharmacy services to children currently or formerly under conservatorship of the Department of Family and Protective Services (DFPS). Provides case management and training to families, caregivers, clinicians, caseworkers, advocates, and members of the judiciary. Operates statewide.	*Mandatory:* · Children (≤ 17) under DFPS conservatorship, including foster and kinship care · Young adults (18-21) in voluntary foster care placements · Optional (choose STAR or STAR Health): · Young adults (18-20) receiving Medicaid under the Former Foster Care Children (FFCC) or Medicaid for Transitioning Foster Care Youth (MTFCY) titles. · Young adults (18-22) formerly under foster care, enrolled in higher education	Total: 82.04% Inpatient: 7.60% Intensive Outpatient: 1.38% Outpatient or ER: 82.05%
CHIP (Children's Health Insurance Program) 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 (≤17) in families with income under 200% of the Federal Poverty Level who are ineligible for Medicaid.	Total:[c] 5.30% Outpatient:[c] 0.70% Professional:[c] 5.0% Inpatient:[c] 0.20%
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. Will operate statewide.	*Mandatory:* · Children with SSI (≤ 20) · Children enrolled in Medically Dependent Children's Program (≤ 20) *Acute services only:* · Children and young adults in a Medicaid 1915(c) waiver program, including the YES program[b]	Not Available (new program)

[a] Mental health utilization numbers are for 2014 prior to the statewide expansion of STAR+PLUS and the implementation of the IDD and nursing home carve-ins, which became effective September 1, 2014. Total utilization refers to the summation of: (1) inpatient services; (2) intensive outpatient or partial hospitalization services; and (3) outpatient or emergency department services in the EQRO report.

[b] 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.

[c] CHIP mental health utilization data were provided by HHSC and reflect the number of clients with a claim divided by the unduplicated CHIP population. Utilization data for other programs were provided by the External Quality Review Organization (EQRO) report and are calculated using a separate methodology. The two sources are therefore not directly comparable.

Sources:

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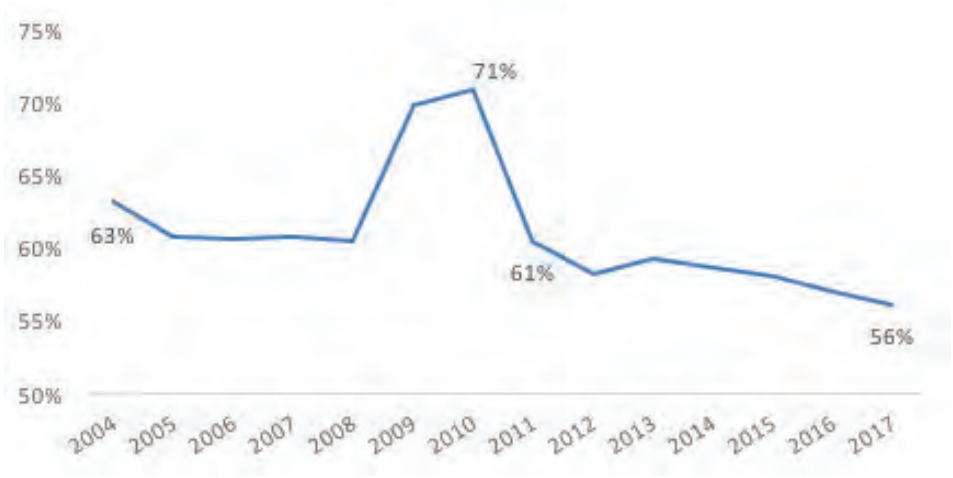
MEDICAID FUNDING

The Texas Medicaid program is jointly funded by the state and the federal government. Nationally, Medicaid is the largest source of public funding for mental health services nationwide, comprising a quarter of all public behavioral health expenditures.[58] The Substance Abuse and Mental Health Services Administration (SAMHSA) projects that by 2020 Medicaid will comprise 30 percent of all mental health expenditures nationally. In Texas, Medicaid represents 29 percent ($61 billion) of the state budget for 2016-2017.[59]

The federal share of the Medicaid program, known as the federal medical assistance percentage (FMAP), is determined on an annual basis and is dependent primarily on the average state per capita income compared to the U.S. average.[60] Texas' matching rates for 2016 and 2017 are 56.18 percent and 57.13 percent; that is, the state must pay 44 percent and 43 percent of all costs, respectively.[61]

Small changes in the FMAP can result in millions of dollars of funding fluctuations. Texas' rate of federal participation has been steadily declining over the last decade, as the state's average per capita income has increased relative to the national average. This decline was mitigated by three years of enhanced federal funds due to the American Reinvestment and Recovery Act, but those funds are no longer in place. To illustrate Texas' trend of declining federal Medicaid funding, in 2004 Texas' FMAP was 63.17 percent. Figure 23 below shows Texas' declining FMAP from 2004 to 2017.

Figure 23. Texas Federal Medical Assistance Percentage (2004-2017)



Source: The Henry J. Kaiser Family Foundation, State Health Facts. (2016). Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (Timeframe: FY 2004-2017) [CSV data download]. Retrieved from http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/.

Figure 24. Medicaid Funding Trends

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019
Medicaid	$24,263,552,164	$25,524,745,068	$30,633,479,619	$29,997,754,796	$31,096,040,565
Medicaid Contracts & Admin.	$794,556,896	$821,596,273	$833,899,485	$642,151,261	$642,126,323
Total	$25,058,109,060	$26,346,341,341	$31,467,379,104	$30,639,906,057	$31,738,166,888

Source: Data Captured from HHSC Legislative Appropriations Request for FY 2018/19. September 12, 2016.

MEDICAID ELIGIBILITY AND SERVICES

Medicaid was originally only available to recipients of cash assistance programs such as Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). However, during the late 1980s and early 1990s, the federal government expanded the program to meet the needs of a broader population, including pregnant women, older adults, and people with disabilities, delinking Medicaid eligibility from receipt of cash assistance.[62]

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. In Texas, to be eligible for Medicaid, an individual must meet income *and* categorical requirements. Categorical eligibility requires that beneficiaries be part of specific population group.

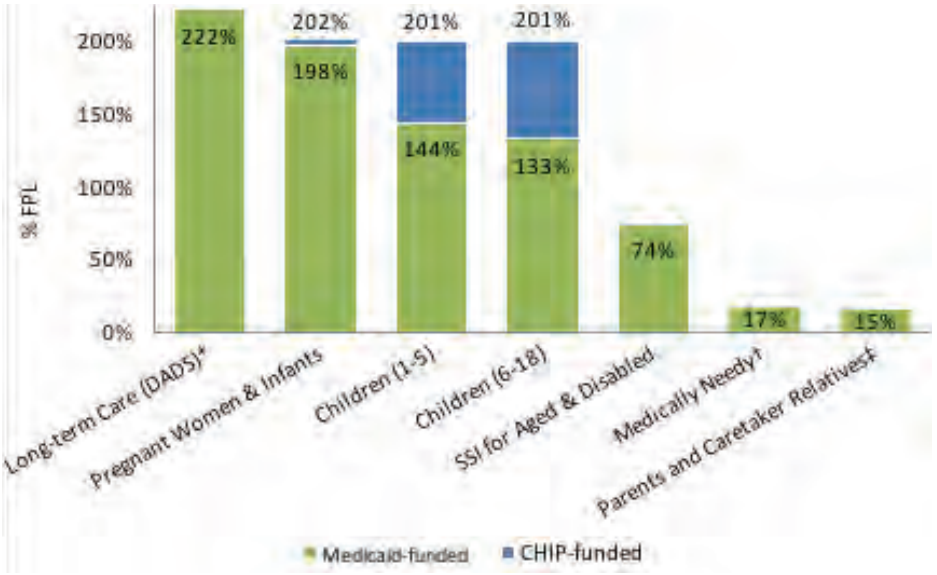
There are multiple Medicaid eligibility categories in Texas. Some of the primary categories include:

- Children age 18 and under
- Pregnant women and infants
- Families receiving Temporary Assistance for Needy Families (TANF)
- Parents and caretaker relatives
- Individuals receiving Supplemental Security Income (SSI)
- Adults over age 65 and people with disabilities
- Children and pregnant women who qualify as medically needy[63]

In 2014, under the Affordable Care Act, the federal government granted states the option to expand eligibility for Medicaid to all adults with incomes at or below 133 percent of the Federal Poverty Level (FPL), regardless of age, parental status, or disability status. Texas has elected not to participate in the expansion to date. The decision not to expand Medicaid eligibility means that Texas eligibility rules will continue to exclude many individuals with mental illness from coverage, including childless adults and some working low-income parents.

Currently in Texas, low-income parents are eligible to receive Medicaid only if their household income is below $251 a month (for a two-parent household); that is approximately 15 percent of FPL.[64] Childless adults who are below age 66 and do not have a disability are currently ineligible for Medicaid.[65] SAMHSA estimated that 6 percent of the population eligible for Medicaid expansion has a serious mental illness (SMI), 11 percent experience severe psychological distress, and 11 percent have a substance use disorder.[66] According to these data, approximately 130,000 uninsured Texas adults with serious mental illness and 255,000 with severe psychological distress could be served in an expanded Medicaid environment.[67] Figure 25 shows the income eligibility requirements for each Medicaid category while Figure 26 shows the accompanying Federal Poverty Levels for 2016.

Figure 25. Income Limits for Select Medicaid and CHIP Eligibility Categories



*Long-term Care Medicaid includes nursing facility and long-term care waivers administered by DADS.

†Category includes only pregnant women and children with medical bills exceeding the monthly Medicaid income limit

‡Eligibility is based on dollar amounts. In 2014, the allowed monthly income for a single-parent household was $230 and for a two-parent household $251.

Source: Texas Health and Human Services Commission. (2015). *Texas Medicaid and CHIP in perspective tenth edition*, 5-1 to 5-9. Retrieved from http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf.

Figure 26. Annual Household Income for Federal Poverty Level Guidelines (2016)

2016 Federal Poverty Level	Individual	Family of Four
15%	$1,782	$3,645
100%	$11,880	$24,300
133%	$15,800	$32,319
200%	$23,760	$48,600
400%	$47,520	$97,200

Source: US Department of Health and Human Services. (2016). U.S. federal guidelines used to determine financial eligibility for certain federal programs. Retrieved from https://aspe.hhs.gov/poverty-guidelines.

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 DSHS. DADS, in addition, 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 in the DSHS and DADS sections of this guide. Figure 27 contains a list of behavioral health services covered by Medicaid.

Figure 27. Approved Medicaid Behavioral Health Services

Service Category	Medicaid Services
Mental Health	Mental health assessment and diagnosis
	Therapy by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists
	Inpatient psychiatric care in a general acute care hospital
	Inpatient psychiatric hospitals for persons under 21 and those 65 and older
	Prescription medications
	Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance
	Ancillary services required to diagnose or treat behavioral health conditions
	Care and treatment of behavioral health conditions provided by a primary care physician
	Comprehensive community services for YES waiver participants
Substance Use	Outpatient adolescent chemical dependency counseling by state-licensed facilities
	Assessment to determine a client's need for services
	Individual and group outpatient substance use disorder treatment counseling
	Medication assisted therapy
	Outpatient and residential detoxification
	Residential treatment

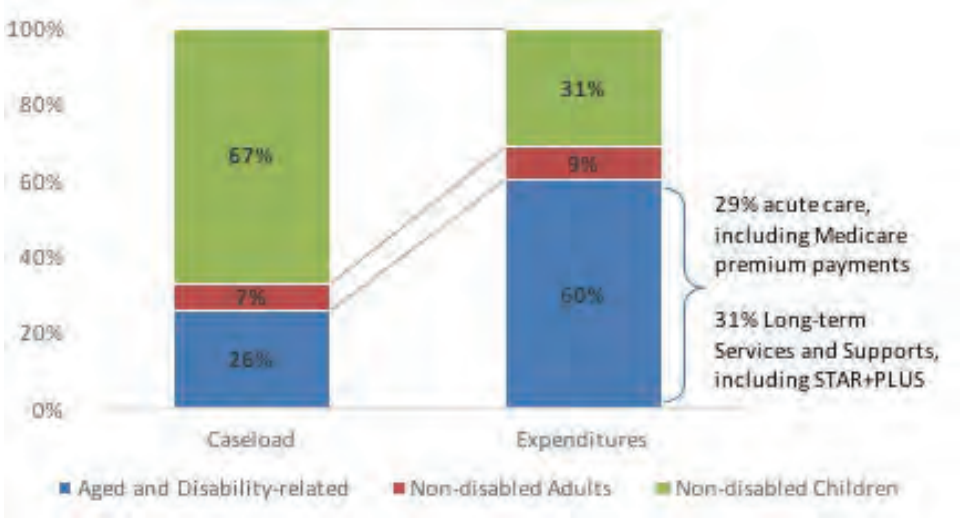
Source: Texas Health and Human Services Commission. (2015). *Texas Medicaid and CHIP in perspective tenth edition*, 6-20 and 6-23. Retrieved from http://www.hhsc.state.tx.us/medicaid/about/PB/PinkBook.pdf

DEMOGRAPHICS OF MEDICAID RECIPIENTS

Women and children account for the majority of the individuals receiving Medicaid benefits. In 2013, 55 percent of the Medicaid population was female and 77 percent was under the age of 21.[68] Children without disabilities comprise nearly 67 percent of all Medicaid recipients but represent only 31 percent of spending on direct health care services.[69] In contrast, individuals who are elderly or have a disability only account for 26 percent of the Medicaid population but represent over 60 percent of total estimated expenditures.[70] Figure 28 displays the population of Medicaid enrollees and program expenditures by age and disability status.

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/texas-medicaid-and-chip-pink-book.

Figure 28. Texas Medicaid Caseload and Expenditures by Age and Disability Status (2016)



Source: HHSC presentation to House Appropriations Subcommittee on Article II: Medicaid Long Term Services and Supports. April 6, 2016. Retrieved from http://www.hhsc.state.tx.us/news/presentations/2016/040616-hhsc-ltss.pdf.

CHILDREN'S HEALTH INSURANCE PROGRAM

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.[71] State participation in CHIP requires that the state develop, and that the Centers for Medicare and Medicaid Services (CMS) approve, a state CHIP Plan.[72] While CMS allows states to combine their Medicaid and CHIP programs under a single administrative umbrella, Texas administers these programs separately.

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, either through employment or purchasing on the individual market.[73] CHIP is available to children ages 0–18 who

are ineligible for Medicaid and who are living in households with an income of up to 201 percent of the FPL (annual income of approximately $48,600 for a family of four).[74] 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 that are based on a family's income. Families may pay up to a $50 enrollment fee for a 12-month period.[75] Texas has also opted to administer a CHIP perinatal program which covers perinatal services, including labor, delivery, and post-partum care for women and their unborn child with household incomes of up to 201 percent of the FPL.[76]

CHIP FUNDING

The figure below provides trends of past funding and projections for the coming biennium.

Figure 29. CHIP Funding Trends

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019
CHIP Services	$867,568,090	$868,632,909	$938,854,839	$988,775,530	$1,024,093,067
CHIP Contracts & Admin.	$10,998,892	$12,760,126	$12,714,677	$15,744,225	$15,744,225
Total	$878,566,982	$881,393,035	$951,569,516	$1,004,519,755	$1,039,837,292

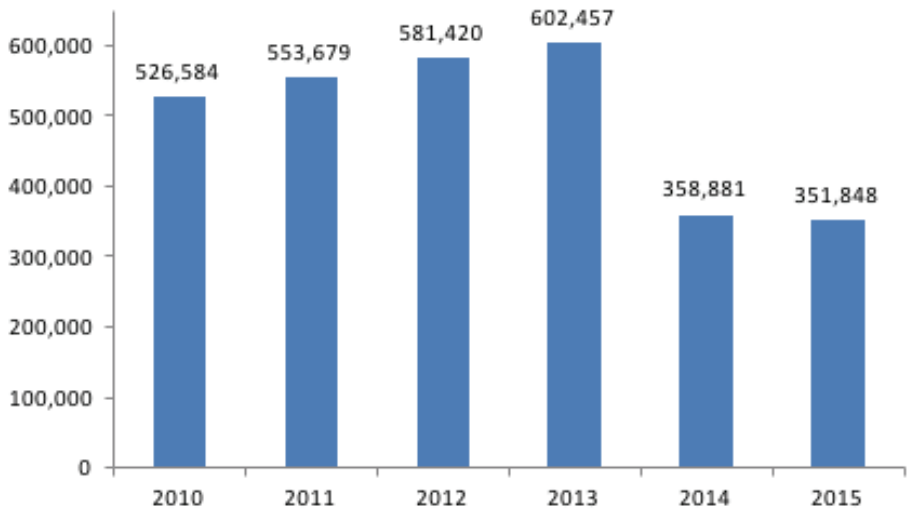
Source: Data captured from HHSC Legislative Appropriations Request for FY 2018-19. September 12, 2016.

ENROLLMENT

The majority of CHIP clients are over age 5, with 61 percent between the ages of 6 and 14, and 22 percent between the ages of 15 and 18.[77] Monthly CHIP enrollment levels increased steadily in the decade leading up to 2014, reaching more than 600,000 members per month in 2013 (see Figure 30). In 2014, however, the program experienced a decline in enrollment. In October 2015, just under 400,000 children were enrolled in CHIP.[78] This drop in enrollment is consistent with the expected effects of a 2014 ACA requirement directing states to expand Medicaid eligibility from 100 percent to 133 percent of the FPL for children up to age 19.[79] In 2014, therefore, Texas and 21 other states transferred all CHIP enrollees with household incomes between 100 percent and 133 percent of the FPL into Medicaid.[80]

CHIP has experienced sporadic spending growth in the last decade. However, the 2016-2017 budget appropriated approximately $1.8 billion to CHIP, an 11 percent reduction from the 2014 budget.[81] HHSC estimates that 70 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services, 15 percent on prescription drugs, and the remaining 15 percent on administration.[82]

Figure 30. Monthly CHIP Enrollment (2010-2015)



Note: Data are from October of each year. Source: Texas Health and Human Services Commission. (2015). *Statewide CHIP Enrollment, Renewals, Attempted Renewals, and Disenrollment by Month (XLS)* [data file]. Retrieved from http://www.hhsc.state.tx.us/research/CHIP/ChipDataTables.asp

Quality of Care Performance

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

Figure 31 presents Texas' performance statistics for select Medicaid and CHIP behavioral health quality of care measures. A check mark in the "benchmark" column indicates that Texas' 2014 performance on the measure exceeded the HEDIS 50th percentile nationally – in other words, showing where Texas is performing at or above average compared to the rest of the country. No check mark indicates an area where Texas lags behind most other states on a given performance indicator.

Figure 31. Selected Behavioral Health Quality of Care Measures for Medicaid and CHIP Programs (2012-2014)

Program	Measure	TX Performance Rate			Benchmark
		2012	2013	2014	≥ HEDIS 50th Percentile
STAR	Follow-up care for children prescribed ADHD medication at the initiation phase	39%	47%	50%	✓
	Follow-up care for children prescribed ADHD medication at the continuation phase	51%	62%	67%	✓
	Follow-up care after hospitalization for mental illness within 7 days	32%	32%	37%	
	Follow-up care after hospitalization for mental illness within 30 days	55%	54%	61%	
	Potentially Preventable Readmissions (per 1,000 member months)	0.21	0.23	N/Aa	N/A
STAR+PLUS	Antidepressant medication management at the acute phase	60%	44%	42%	
	Antidepressant medication management at the continuation phase	47%	31%	30%	
	Follow-up care after hospitalization for mental illness within 7 days	31%	30%	34%	
	Follow-up care after hospitalization for mental illness within 30 days	54%	51%	57%	
	Potentially Preventable Readmissions (per 1,000 member months)	5.52	5.41	N/Aa	N/A
STAR Health	Follow-up care for children prescribed ADHD medication at the initiation phase	52%	88%	89%	✓
	Follow-up care for children prescribed ADHD medication at the continuation phase	59%	93%	93%	✓
	Follow-up care after hospitalization for mental illness within 7 days	63%	59%	61%	✓
	Follow-up care after hospitalization for mental illness within 30 days	87%	86%	83%	✓
	Potentially Preventable Readmissions (per 1,000 member months)	1.68	1.43	N/Aa	N/A
CHIP	After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	34%	43%	43%	✓
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	45%	59%	57%	✓
	Follow-up care after hospitalization for mental illness within 7 days	32%	39%	42%	
	Follow-up care after hospitalization for mental illness within 30 days	58%	60%	64%	
	Potentially Preventable Readmissions (per 1,000 member months)	0.30	0.25	N/Aa	N/A

[a] 2014 data on potentially preventable readmissions for Medicaid managed care are not included in the new External Quality Review Organization report.

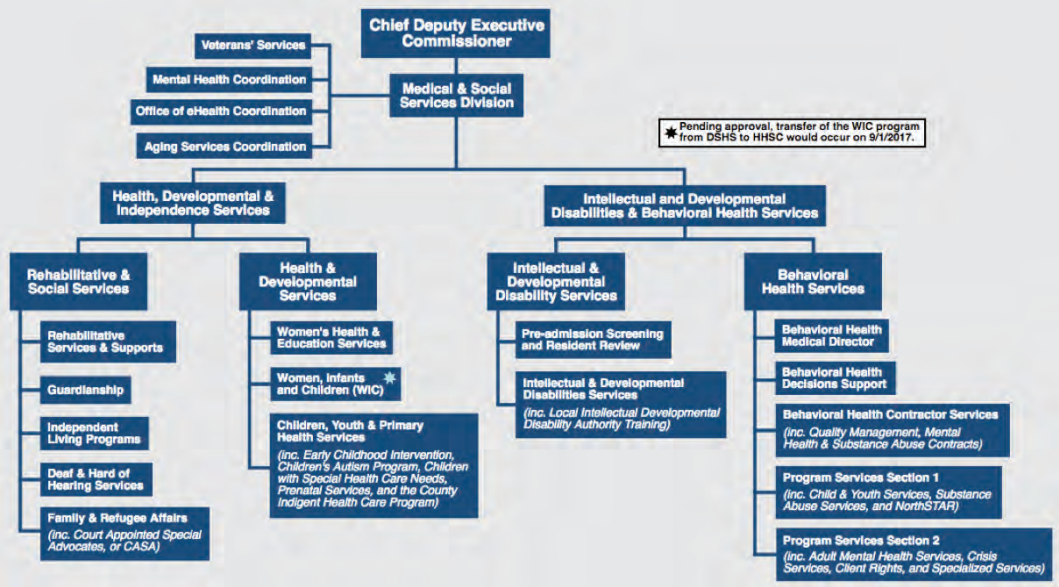
Sources:

Institute for Child Health Policy at the University of Florida. (2015). *Texas Medicaid managed care and Children's Health Insurance Program, external quality review organization summary of activity and trends in healthcare quality, Contract Year 2014*. Retrieved from https://hhs.texas.gov/sites/hhs/files//eqro-summary-healthcare-2014.pdf

Institute for Child Health Policy at the University of Florida. (2014). *Texas Medicaid managed care and Children's Health Insurance Program, external quality review organization summary of activity and trends in healthcare quality, Contract Year 2013*. Retrieved from http://www.hhsc.state.tx.us/reports/2014/EQRO-Healthcare-Summary-Report-2013.pdf

Texas Healthcare Learning Collaborative, Institute for Child Health Policy. (2016). Texas Medicaid quality of care reporting. Retrieved from https://thlcportal.com/index.php/public#

Community Services



Source: Texas Health and Human Services Commission. (August 2016). A Report to the Legislature: Health and Human Services System Transition Plan.

The **Community Services Section** of the Medical and Social Services Division is comprised of over 70 programs delivering a wide range of services. The programs in this section are organized into the following two major departments:

- **Intellectual and Developmental Disabilities and Behavioral Health Services**
- **Health, Developmental, and Independence Services**

The programs and services included in this division were previously spread throughout HHSC, DADS, DARS, and DSHS. All four of the units under these two departments offer some type of behavioral health services in addition to other services and supports for people with disabilities and mental health conditions. For the purposes of this guide, we will focus on the service and program areas that offer some level of behavioral health treatment, services, or supports.

Intellectual and Developmental Disabilities & Behavioral Health Services

The Intellectual and Developmental Disabilities & Behavioral Health Services Department combines responsibility for community services for individuals with intellectual/developmental disabilities and those living with mental health conditions under one associate commissioner authority. This Department is responsible for:

- Behavioral Health Services; and
- Intellectual & Developmental Disability Services

Information on these units is provided in this section.

Behavioral Health Services (formerly provided through the Department of State Health Services)

POLICY CONCERNS

- Ensuring access to quality community-based behavioral health services through integrated service delivery and managed care models that emphasize prevention and continuity of care.
- Addressing the critical shortage of mental health professionals, particularly in rural areas.
- Expanding peer specialist, recovery coach, and family partner support services.
- Successfully implementing the statewide expansion of YES waiver services to better support children with complex needs and keep them in their communities whenever possible.
- Repairing and replacing the physical infrastructure of the aging state hospital system.
- Improving client outcome performance measures to focus more on behavioral outcomes and patient-centered recovery, and less on easy-to-measure outputs (e.g., enrollment numbers).
- Reducing the time people spend incarcerated while waiting for competency restoration services.
- Ensuring that state hospital prescription drug formularies align with jail formularies so that individuals are able to retain progress and maintain continuity of care between both settings.

FAST FACTS

- The population growth in Texas between 2010 and 2015 (9.2 percent) was double the national average and the highest of all 50 states, increasing demand for DSHS services.[83,84]
- As of July 2015, 81 percent of counties in Texas (206 out of 254) were designated as full or partial Mental Health Professional Shortage Areas.[85]
- As of June 2016, Texas has 846 people trained as certified peer specialists and 526 individuals with active peer specialist certifications, enabling them to use their lived experiences with behavioral health issues to help recipients of DSHS-funded services.
- NorthSTAR — a managed care pilot program providing DSHS-funded behavioral health services for seven counties around Dallas — will be discontinued on January 1, 2017.
- There is an increasing number of individuals on waiting lists for forensic inpatient beds — 414 people as of February 2016, more than four times as many as there were in 2013.[86]
- In FY 2014, there were 240,088 adults with serious and persistent mental illness living below 200 percent of the Federal Poverty Level (FPL) in Texas. Of these, only 72 percent received DSHS-funded services through community mental health centers or NorthSTAR.[87]
- Similarly, only 38 percent of the 126,052 children with a serious emotional disturbance living below 200 percent of FPL received DSHS-funded mental health services in FY 2014.[88]

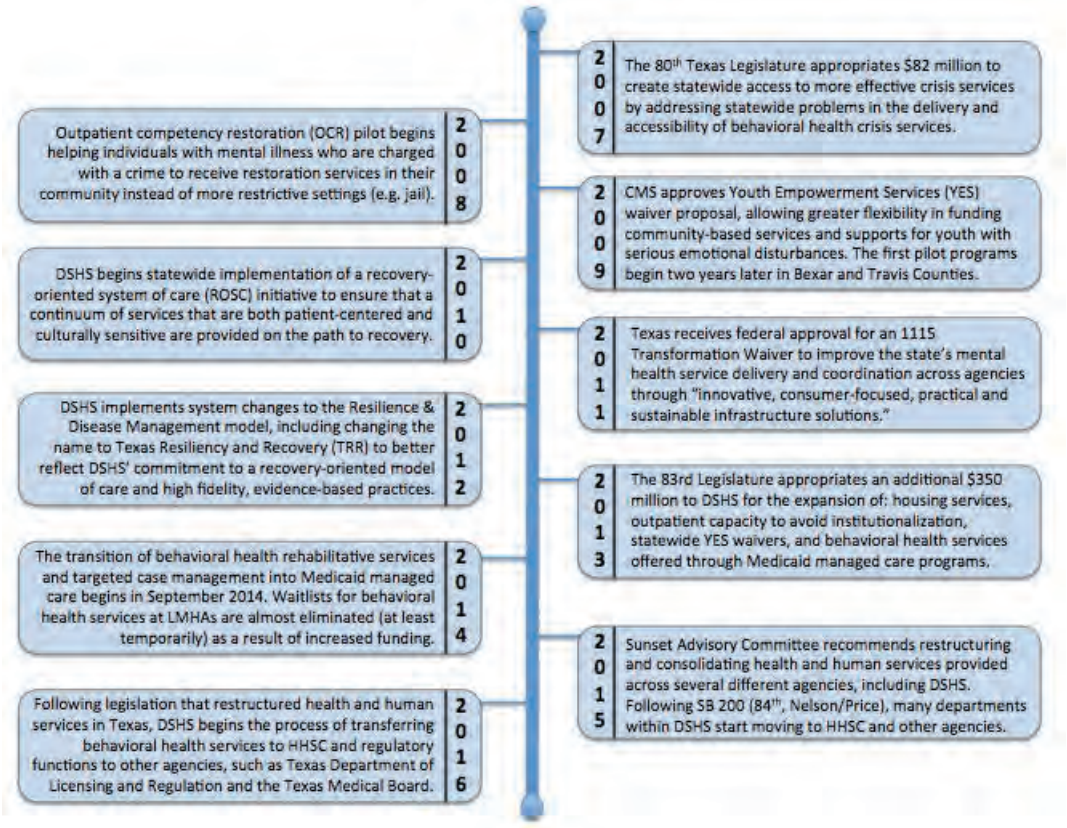
BACKGROUND

Public behavioral health services are mainly comprised of community mental health, substance use, and inpatient hospital services. These services are provided to residents through the 39 local mental health authority (LMHA) regions and 20 regional healthcare partnerships (RHPs) in all of Texas' 254 counties. The Medical and Social Services Division (MSSD) will have oversight responsibility for community behavioral health services while the State Facilities Division (SFD) will have oversight of inpatient services.

Despite limited funding over the past decade, staff at DSHS and HHSC has worked with legislators and made consistent efforts to implement innovations in behavioral health service delivery through major initiatives. Figure 32 shows a timeline of key events and reforms that reflect DSHS' general shift toward a more modern system that emphasizes mental health services that are:

- Person-centered;
- Rooted in recovery and resilience;
- Focused on alternatives to institutionalization; and
- Comprised of services on the full continuum of care.

Figure 32. Timeline of Selected Major Developments Within the Texas Public Mental Health System



The HHS system prioritizes access to treatment for serious mental health conditions

for individuals who are eligible for Medicaid, determined to be indigent, or who fall under the priority populations criteria. 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 conditions can receive the level of care and support that are clinically appropriate for their level of need. Prior to its transition to the consolidated HHS system, DSHS developed the website www.mentalhealthtx.org, which aims to improve access to information by acting as a central database where individuals can input their zip code and find available behavioral health services in their area.

SUNSET AND TRANSFORMATION HIGHLIGHTS

In an effort to improve the efficient coordination and quality of state health services, the 84th Legislature followed recommendations from the Sunset Commission and passed SB 200 (84th, Nelson/Price). This legislation reorganized and restructured how state agencies and state-funded programs deliver behavioral, physical, and public health services.[89] In regards to DSHS specifically, SB 200 redirected DSHS toward its mission of public health by refocusing it on issues such as infectious disease (e.g., immunizations), public health (e.g., food safety and emergency health response) and community public health services (e.g., maternal and child health programs).[90]

As of September 1, 2016, all of DSHS' community behavioral health programs were transferred to the new HHSC Medical and Social Services Division, with state hospitals scheduled to move to the new State Facilities Division within HHSC by September 1, 2017.[91] In addition to client services, DSHS has also historically managed more than a dozen programs that license and regulate health-related businesses, facilities, and occupations. By September 1, 2017, all of DSHS' regulatory and licensing programs will be transferred to the Texas Medical Board, the Texas Department of Licensing and Regulation (TDLR), or the newly created Regulatory Services Division within the new HHS system.[92] Following the September 1, 2017 deadline, DSHS will focus more narrowly on public health issues and be split into three distinct departments: Public Health Operations, Infectious Disease, and Community Health (see Figure 81: DSHS Organizational Structure After September 1, 2017).[93]

DSHS and the HHS system as a whole aim to maintain seamless operation of public health and behavioral health services during the system-wide transformation of health services. For more detailed information on the entire transformation plan, see the Texas Environment section.

CHANGING ENVIRONMENT

The 84th Legislative Session brought significant changes to the delivery and management of the state's behavioral healthcare system. Additionally, changes directed in the 83rd Legislative Session are continuing to be implemented and require ongoing monitoring.

DISCONTINUATION OF THE NORTHSTAR PROGRAM

The Texas Legislature created the NorthSTAR program in 1999 in an attempt to use a managed care model to integrate substance use and mental health services for Medicaid clients and individuals with very low income who are not eligible

for Medicaid. In FY 2015, NorthSTAR provided services for 71,913 individuals in a seven-county region in North Texas — Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall.[94] As a result of recommendations from the Sunset Advisory Commission and subsequent legislation passed by the 84th Legislature (SB 200, 84th, Nelson/Price), funding for NorthSTAR will be discontinued on January 1, 2017.[95] Rider 85 in HB 1 (84th, Otto/Nelson) assumes the discontinuation of NorthSTAR and reallocates funds to the successor agencies that will take responsibility for NorthSTAR's clients by 2017.[96]

There are plans in place to transfer NorthSTAR's responsibilities for providing mental health and substance use services to other local providers; North Texas Behavioral Health Authority (NTBHA) will become the behavioral health provider for individuals in Dallas, Ellis, Navarro, Kaufman, Hunt, and Rockwall counties while LifePath Systems will take over NorthSTAR's LMHA responsibilities in Collin County.[97] As of spring 2016, both NTBHA and LifePath Systems had met required benchmarks for the transition and were on schedule to take over NorthSTAR's responsibilities by January 2017. During this transition period, professionals from DSHS and HHSC have helped NTBHA and LifePath Systems to develop their IT infrastructure, diversify local funding streams, and strengthen their networks of behavioral health providers.[98]

FORENSIC DIRECTOR POSITION

In 2015, legislators passed SB 1507 (84th, Garcia/Naishtat) requiring DSHS to appoint a statewide forensic director in order to improve the coordination and oversight of forensic mental health services in Texas. The first state forensic director for mental health was appointed in February 2016. The director's responsibilities include:

- Coordinating and overseeing forensic services, including competency exams, competency restoration services, and mental health services provided in the community or at DSHS facilities;
- Facilitating the transition of forensic patients from inpatient settings to outpatient services or community-based programs;
- Managing forensic monitoring in the community;
- Coordinating forensic research and training; and
- Addressing issues concerning the delivery of forensic services, including the increased involvement of people with mental illness in the criminal justice system.

The bill requires the forensic director to work with a group of experts and stakeholders to develop recommendations for improved forensic service coordination. This workgroup, the Joint Committee on Access and Forensic Services, includes more than a dozen different organizations, including representatives from HHSC, DSHS, Texas Department of Criminal Justice (TDCJ), Texas Juvenile Justice Department (TJJD), Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), local mental health authorities (LMHAs), Sheriff's Association of Texas, Texas Hospital Association, Disability Rights Texas, and other agencies involved in the social, health, and legal aspects of forensic services.[99] The most up-to-date information on the progress of the Joint Committee on Access and Forensic Services workgroup can be found at: https://dshs.texas.gov/mhsa/SB1507/SB-1507.aspx.

SB 1507 also included two other provisions tangentially related to the new forensic director role:

- DSHS, the forensic director, and the Court of Criminal Appeals are required to develop a mental health-related training curriculum for judges and attorneys in Texas. The training must include information on alternatives to inpatient state hospitalization for forensic patients who are eligible for diversion and court ordered to receive mental health services.
- SB 1507 also requires DSHS to reconvene an advisory panel created by HB 3793 (83rd, Coleman/Hinojosa) to work with stakeholders to divide the state into distinct bed-allotment regions and adopt an allocation methodology for state-funded psychiatric beds and a bed utilization review protocol. The newly created Joint Committee on Access and Forensic Services took on this function.

ONGOING JAIL-BASED COMPETENCY RESTORATION PILOT PROGRAM

SB 1475 (83rd, Duncan/Zerwas) authorized DSHS to provide competency restoration services through 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 competency restoration services. SB 1475 also established a workgroup in 2013 to set rules for the pilot program that would be developed through a contract with a private contractor or local mental health authority (LMHA).[100] DSHS received only one proposal in response to its initial request for proposals to implement and operate the JBCR pilot, and the contract was awarded to Liberty Healthcare Corporation (LHC). LHC runs a jail-based competency restoration program in California similar to the one proposed in Texas. That program includes:

- Daily group meetings
- Twice daily 1:1 sessions with a staff member
- Weekly follow-up sessions with a psychiatrist
- Weekly case reviews
- Psychological assessments.[101]

The pilot program was projected to provide 20 beds for jail-based restoration services. The JBCR pilot program has faced significant barriers to implementation and did not begin on schedule (during the 2014-2015 biennium). Upon initial release of the pilot program's draft rules, advocates raised concerns that jails have not traditionally been therapeutic environments, and that the most effective competency restoration programs require staffing ratios and other resources only present in therapeutic environments. It was also determined during public discussion of the initial draft rules that the Texas JBCR pilot needed to focus on providing services and programming during regular business hours and required more consistency and overlap with JBCR models in other states.[102] In response to these concerns, DSHS issued revised draft rules for the jail-based competency restoration program in 2015.

During the 84th Legislature, Rider 70 in the DSHS section of Article II appropriated $1.74 million annually to fund the jail-based competency restoration pilot for FY 2016 and 2017.[103] DSHS stated that the goals of the JBCR pilot are:

- To reduce the number of individuals on the State Mental Health Program waiting list who are determined to be incompetent to stand trial (IST) due to behavioral health issues;
- To provide access to competency restoration services for individuals who do not qualify for outpatient competency restoration (OCR) services;
- To develop a cost-effective alternative to providing restoration services in state hospitals;
- To minimize the stress of incarceration for individuals enrolled in the JBCR pilot; and
- To collect data on the clinical and financial effectiveness of the JBCR pilot.[104]

DSHS distributed a new Request for Proposals in January 2016.[105] Among other changes, the updated 2015 rules increased staffing standards by requiring that "the day shift has services that are more substantial and the JCBR program providers will be responsible for collaborating with jail staff to ensure the safety and welfare of participants in the evening, night, and weekend hours."[106] JBCR proposals that met the new program requirements were due on March 4, 2016 but because DSHS did not award the contract to any of the proposals they received, the future of the JBCR pilot is uncertain.[107]

CONTINUED EXPANSION OF PEER SUPPORT SERVICES

Another initiative that has increased opportunities for recovery from behavioral health conditions is the use of certified peer support specialists and certified recovery coaches. Peer support programs allow individuals who have both lived experience and relevant training to aid in the recovery of others experiencing mental health conditions by focusing on recovery, wellness, self-direction, responsibility, and independent living. Peer support services have been deemed an evidence-based practice by the Centers for Medicare and Medicaid Services (CMS) and reimbursed by Medicaid since 2007, and the Substance Abuse and Mental Health Services Administration (SAMHSA) now lists several peer support interventions in their database of evidence-based programs.[108,109] Peer support specialists are a cost-efficient and effective intervention that can reduce the need for other more intensive and expensive services, resulting in lower costs and improved outcomes for both the individual and the healthcare system as a whole.

DSHS, Via Hope, and the Hogg Foundation developed the initial certification requirements for mental health peer specialists in Texas. As of June 2016, ViaHope has trained over 846 certified peer specialists (526 active certifications) and 183 family partners (127 active certifications).[110] ViaHope has also provided 889 specialized trainings (e.g., "Trauma Informed Peer Support" and "Co-occurring Disorders") for certified peer specialists and family partners.[111] In 2016, HHSC Associate Commissioner for Mental Health Services Sonja Gaines called peer services "one of the single most effective things we have done."[112]

During the 84th Legislative session, SB 578 (84th, Hinojosa/Rodriguez) improved access to peer services by requiring peer support specialists to be included in the county-specific resource packets that are now mandated to be given to individuals when they are discharged from TDCJ facilities.[113] Also passed in 2015, Rider 73 in the DSHS section of HB 1 appropriated $1 million for the 2016-17 biennium for DSHS to design and implement a peer support pilot program for individuals with mental

illness who are re-entering the community after incarceration. DSHS estimated that this reentry peer support program will serve 96 individuals in FY 2016 and 648 individuals in FY 2017.[114] For a more detailed description of the reentry peer support pilot, see the TDCJ section.

There is also an ongoing effort at the federal level to expand coverage of peer support services under Medicaid and Medicare. In Texas, HB 1541 (84th, Burkett/Perry) failed to pass; HB 1541 would have required HHSC to define in rule mental health peer support and recovery specialist services, certification requirements, and supervision requirements, and it would have expanded Medicaid reimbursement to include mental health peer and recovery specialist services.[115] For a more thorough discussion of the benefits of peer support services, see the Texas Environment section.

IMPLEMENTATION OF THE STATEWIDE EXPANSION OF THE YES WAIVER

Youth Empowerment Services (YES) is a Medicaid 1915(c) home and community-based waiver program for children ages 3 to 19 years old intended to reduce Medicaid psychiatric hospital expenses, voluntary parental relinquishments to obtain care, and out-of-home placement for children with serious emotional disturbance. 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.[116] As with other 1915(c) waivers, YES waivers do not take into account family income to determine eligibility.

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. These services are particularly effective for youth who do not respond well to traditional outpatient services and might have better success through innovative treatments, such as intensive in-home support or specialized therapies.[117] Services under the YES waiver are initially authorized for an 18-month period 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 states and the federal government.

HHSC contracts with local mental health authorities (LMHAs) to manage YES waiver services in each of their respective service regions. LMHAs then contract with community service providers to ensure all required YES waiver services are available. Services offered through the YES waiver program include: [118]

- 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 services

The YES waiver program was approved for statewide expansion during the 84th legislative session (Rider 60).[119] By September 2015, every LMHA in Texas had started

providing YES waiver services to individuals across the state, and funding for the program changed from general revenue to Medicaid dollars in April 2016.[120,121] Figure 33 shows that enrollment in YES waivers has increased steadily over the past six years:

Figure 33. Youth Empowerment Services (YES) Waiver Enrollment: 2011-2016

Year	Number of Children and Youth Enrolled in YES Waiver Services
2011	46
2012	63
2013	167
2014	294
2015	722
2016	1,237

Source: Lauren Lacefield Lewis & Gary Jessee. (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

The expansion of the YES waiver should allow even more youth with serious emotional disturbance (SED) to access intensive community behavioral health services and decrease the number of children who receive inpatient care and/or are relinquished to the Department of Family and Protective Services (DFPS) solely because of an inability to access needed mental health services.[122] In February 2016, DSHS began requiring that children at "imminent risk" of being relinquished to the state be prioritized for YES Waiver Services.[123] HHSC is also in the process of approving a YES Waiver amendment (Amendment #9) that would make children who are in state conservatorship eligible to receive YES Waiver services. Up-to-date information on the status of this amendment can be found at www.dshs.texas.gov/mhsa/yes/Proposed-Waiver-Amendments.aspx.[124]

In addition to the waiver statewide expansion, the 84th Legislature also appropriated $4.8 million to create an additional 20 beds (30 total, as funding for 10 beds was appropriated during the 83rd Legislative Session) at residential treatment centers (RTCs). These 30 beds are specially allocated for the prevention of parental relinquishment of children with serious emotional disturbance (SED) solely to obtain mental health services.[125] Between January 2014 and the beginning of 2016, 61 children were served by these specially-allocated RTC beds — 25 of those children successfully discharged back into their home from the RTC and 54 of them (89 percent) remained in their parent's custody after meeting program criteria. Thirteen children were able to avoid an RTC stay altogether as a result of receiving outpatient services through the YES Waiver or at their local LMHA.[126]

YES Waiver updates and information are available at www.dshs.state.tx.us/mhsa/yes/.

IMPROVEMENT OF CLIENT OUTCOME AND PERFORMANCE MEASURES

DSHS has been involved in an ongoing process to improve and update the outcomes

and measures used to evaluate client progress and the effectiveness of DSHS services. Rider 58 (83rd Legislature), required DSHS to improve the uniform measurement and collection of outcome data for medically indigent individuals and Medicaid enrollees. Also passed in 2013, SB 126 (83rd, Nelson/Davis) required DSHS to publicly report easily comparable performance measures for community behavioral health providers.[127] Following the 83rd legislative session, DSHS made a number of changes to how client outcomes and response to services are measured and reported, including the adoption of new uniform assessment tools for use across DSHS-funded mental health programs — the Child and Adolescent Needs Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA). The goal is for the CANS and ANSA to improve the accuracy and consistency of DSHS client outcome data. The Department of Family Protective Services has also begun using the CANS and ANSA assessments. See the DFPS section for more information.

Following the changes made by the 83rd Legislature, the Sunset Advisory Commission raised concerns that DSHS appeared to be collecting a large amount of client outcome measures (over 300) without focusing on how to use the data meaningfully to evaluate programs, compare effectiveness, and improve service delivery. The Sunset Commission's final report noted that of the 302 behavioral health performance measures DSHS collects for substance use and mental health services, 211 of them are measures created by DSHS itself (as opposed to being required by state or federal legislation).[128] The Commission also expressed concern that DSHS' data collection and reporting processes were cumbersome and may not "drive best practices or provide enough flexibility for clinicians who actually provide services."[129] The Commission recommended a complete overhaul of how DSHS tracks client outcomes and measures program performance. In response, the 84th Legislature passed two major riders that addressed the Sunset Advisory Commission's concerns about performance measures and client outcome data.

RIDER 58

Rider 58, "Mental Health Outcomes and Accountability" (HB 1, 84th, Otto/Nelson), requires DSHS to withhold 10 percent of general revenue (GR) funds from local mental health authorities (LMHAs) each quarter as a performance-based incentive to encourage providing high quality services.[130] Instead of penalizing specific LMHAs for failing to meet the outcome targets, Rider 58 is structured so that every LMHA begins each quarter at a 10 percent funding deficit and is required to reach certain client outcome targets in order to receive the final 10 percent of their full funding that was pre-emptively withheld. Initial outcome targets were set by DSHS in September 2013 (under Rider 78) and performance is assessed every six months.[131]

In order to better understand the types of measures currently used by DSHS, Figure 34 shows a sample of some of the measures that DSHS uses to gauge LMHA performance and make a determination whether to release the withheld funds.[132]

Figure 34. Examples of Performance Measures Used by DSHS as Performance-Based Incentives to Withhold Quarterly GR Funding (per Rider 58)

Population Measured	Area of Functioning Being Measured	Description of Performance Measure Used by DSHS
Adults	Employment	The percentage of adults in a Level of Care (LOC) service package who have paid employment (independent, competitive, supported, or self-employed).
Adults	Client Engagement and Monthly Provision of Services	The percentage of adults in an LOC service package who receive at least one service (face-to-face, telehealth, or telemedicine) per month.
Children	Improvement in Symptoms and Overall Functioning	The percentage of children in an LOC service package who show improvement in at least one area on DSHS' psychosocial assessment tool, the Child and Adolescent Strengths Assessment (CANS): Child Strengths, Behavioral and Emotional Needs, Life Domain Functioning, Child Risk Behaviors, Adjustment to Trauma, School Performance, Substance Use.
Children	Tenure in the Community	The percentage of children in a full LOC service package who avoid psychiatric hospitalization in a DSHS-funded inpatient bed after they begin LOC services.
Individuals in Crisis (Children or Adults)	Effective Crisis Response	The percentage of individuals who utilize crisis services and avoid admission to a DSHS operated or contracted psychiatric inpatient hospital bed for 30 days after the start of their initial mental health crisis episode.
Individuals in Crisis (Children or Adults)	Timely Access to Crisis Response Services	The percentage of calls to the LMHA's crisis hotline that are true mental health crises and result in that individual receiving face-to-face services within one day of his or her call. (Note: "True mental health crises" refers to an immediate need, as opposed to a routine request for services.)

Source: Department of State Health Services. (2016, February 18). *Presentation to the Select Committee on Mental Health*. Retrieved from: http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/5fc9614b-41a4-436e-9eba-67b14f00ad22.PDF

RIDER 82

The 84th Legislature also passed Rider 82 (HB 1, 84th, Otto/Nelson) "Behavioral Health Services Provider Contracts Review," that requires DSHS (in collaboration with HHSC) to "conduct a review to identify improvements to performance measurements, contract processing, and payment mechanisms for behavioral health services."[133] In addition to reviewing the outcome targets and methodology used under Rider 58 to withhold 10 percent of GR funds from LMHAs, Rider 82 requires DSHS to submit a report to the Texas Legislature by December 1, 2016 that includes the following:

- Identification of client outcomes and performance measures that are not required by state or federal statute and could be consolidated or eliminated altogether from DSHS provider contracts;
- Consideration of client outcome measures and contracting strategies that focus on recovery and whole health, similar to those used by managed care organizations (MCOs);
- Consideration of best practices in performance measurement, including incentive payments and sanctions that align with how HHSC purchases health care services; and
- A proposal for a publicly available web-based dashboard so that individuals can compare the performance of different behavioral health service providers that contract with DSHS.

Many newer, more holistic client outcome measures focus on features beyond traditional clinical diagnoses and include both symptom reduction and concepts of recovery, such as functioning and community integration. Historically, outcomes have focused narrowly on clinical recovery such as a decrease in symptoms or a reduction in acute need rather than measuring progress in terms of personal recovery. Recovery is a process of change through which individuals use self-directed approaches to improve their health and wellness and strive to reach their full potential.[134] There are a number of emerging recovery outcome measures that examine both individual experiences of recovery as well as the more traditional recovery-oriented measures based on service utilization and clinical improvement.[135,136] Because consumer-centered outcome measures are still a fairly new concept, there are some issues that remain to be solved in terms of their psychometric properties and consumer accessibility (i.e., length and reading level needed to understand measures).

BEHAVIOR HEALTH FUNDING

Mental health services are provided by many state agencies. The information provided in this section refers only to the funding appropriated to the behavioral health section of the Medical and Social Services Division (included in the HHS system but previously appropriated to DSHS). For a summary of all behavioral health funding by agency, please refer to the HHS System section *Office of Behavioral Health Coordination*.

Mental health services are funded by state general revenue (59 percent), federal funds (25 percent), and local funds (16 percent). In 2015, mental health program expenditures by state budget strategy were as depicted in Figure 35.

The figure below depicts historical trends and biennial requests from FY 2015-2019.

Figure 35. Mental Health Funding Trends

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019	Exceptional Items Request 2018	Exceptional Items Request 2019
Adult Mental Health Services	$291,239,098	$320,975,215	$338,641,135	$326,298,776	$326,298,776	$14,199,471	$14,699,471
Children's Mental Health Services	$84,603,781	$94,721,423	$79,700,014	$74,050,805	$74,050,802	$2,163,095	$2,163,095
Behavioral Health Waivers	0	0	$51,675,618	$51,675,618	$51,675,678	0	0
Mental Health State Hospitals	$439,414,324	$439,693,161	$441,537,717	$421,935,708	$422,071,390	$112,193,002	$108,194,641
Mental Health Community Hospitals	$80,962,106	$99,971,621	$109,971,620	$104,971,620	$104,971,621	$41,116,909	$41,079,969
Community Mental Health Crisis Services	$114,127,098	$127,248,806	$125,866,980	$126,306,873	$126,306,873	0	0
NorthStar	$128,080,169	$143,105,756	*	0	0	0	0
Substance Abuse Prev/ Intervention/ Treatment	$153,660,796	$205,627,295	$189,826,370	$187,024,788	$187,024,787	$11,734,183	$11,734,183
Total	$1,292,087,372	$1,431,343,277	$1,337,219,454	$1,292,264,188	$1,292,399,927	$181,406,660	$177,871,359

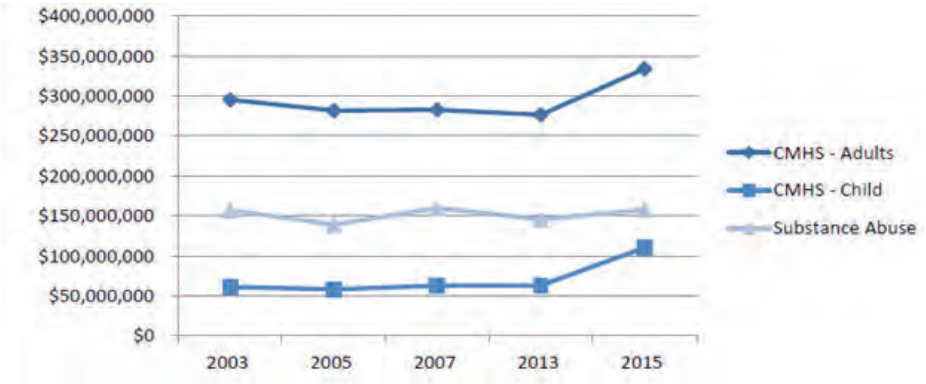
Source: Data captured from the HHSC Legislative Appropriations Request for FY 2018/19, September 12, 2016.

*HHSC and DSHS LARs did not include separate funding amounts for 2017. NorthStar will be eliminated as of January, 2017.

According to a 2013 Kaiser Foundation Report, the per capita mental health spending in Texas was $40.65 compared to the national average of $119.62.[137] Realizing that transformative actions were imperative to expand access to mental health services, nearly $332 million in new funding was appropriated for FY 2014 and 2015 than was allotted in the previous biennium. This increase put an end to a decade of flat funding for behavioral health. The FY 2014-15 DSHS budget contained an unprecedented $2.6 billion for the public mental health system, with $1.7 billion from the state general revenue.[138]

It should be noted that Medicaid 1115 Waivers have served a significant role in drawing down federal funds to help fund many different mental health programs within the HHS System. For detailed information regarding Medicaid 1115 Waivers, please refer to the Texas Environment Section.

Figure 36. Texas Public Behavioral Health Annual Spending: 2003-2015



Source: Ligon, K. (October 21, 2013). Sizing up the 2014-2013 Texas Budget: Mental Health. *Center for Public Policy Priorities.* Retrieved from http://forabettertexas.org/images/2013_10__PP_Budget_MentalHealth.pdf

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 fully keep pace with the increased cost of services and the ever-expanding Texas population, which has resulted in fewer services being available and a smaller percentage of persons receiving services.[139]

Much of the increased demand for behavioral health services in Texas is due to the state's rapidly expanding population, growing from a total population of 25,145,561 in 2010 to an estimated 27,469,114 in 2015 — a 9.2 percent increase, the highest of any state in the country.[140] The population growth rate in Texas between 2010 and 2015 (9.2 percent) was roughly double the national average growth rate (4.1 percent) and far outpaced other large states like California and Florida, accounting for roughly 19 percent of total population growth in the U.S. during that time and increasing demand for DSHS services.[141]

SERVICE PROVIDERS

Publicly funded mental health services in Texas are provided by the following four types of service providers:

- Medicaid Managed Care providers
- Local Mental Health Authorities (LMHAs)
- NorthSTAR (ending in January 2017)
- FQHCs and other community health centers

MEDICAID MANAGED CARE PROVIDERS

Texas is increasingly moving toward a managed care model of healthcare including for behavioral health services. In a Medicaid managed care system, individuals access services through a managed care organization (MCO) under contract with the state.[142] The state contracts with MCOs (sometimes referred to as "health plans") and pays a capitated rate (monthly base rate per member) for each client enrolled rather than paying a fee for each individual service provided.

MCOs are responsible for creating a network of public and private providers to ensure that adults and children receiving Medicaid are able to access needed services. MCOs are responsible for service authorization and directly contract with and reimburse service providers.

Managed care programs in Texas include:

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

See HHSC section for additional information on managed care services in Texas.

In 2013, SB 58 (83rd, Nelson/Zerwas) directed the integration of mental health and physical health services into Medicaid managed care. As of September 2014, the Medicaid managed care program is responsible for the network development and payment for mental health targeted case management and mental health rehabilitative services. Through these added services, targeted case managers are tasked with providing face-to-face crisis planning and mental health service coordination for Medicaid-eligible individuals with complex needs. Many of these integrated care programs started serving clients in September 2014 and are being continually guided by recommendations from the Behavioral Health Integration Advisory Committee. DSHS will not report data on the outcomes and costs of these programs until summer 2017.[143]

Rehabilitative services coordinated through targeted case management include:

- Crisis intervention services,
- Medication training and support services,
- Skills training, and
- Development services and day programs for acute care.[144]

SB 58 (83rd, Nelson/Zerwas) only allows providers to bill for targeted case management and rehabilitative services if they offer a full array of comprehensive services. The goal of these requirements is to provide continuity of care and seamless integration of services across a client's needs but as a result of these rigorous requirements, LMHAs continue to serve as the primary providers of rehabilitative and targeted case management for the majority of people in managed care. MCOs also contract with LMHAs to serve as Significant Traditional Providers (STPs) for Medicaid-eligible clients.

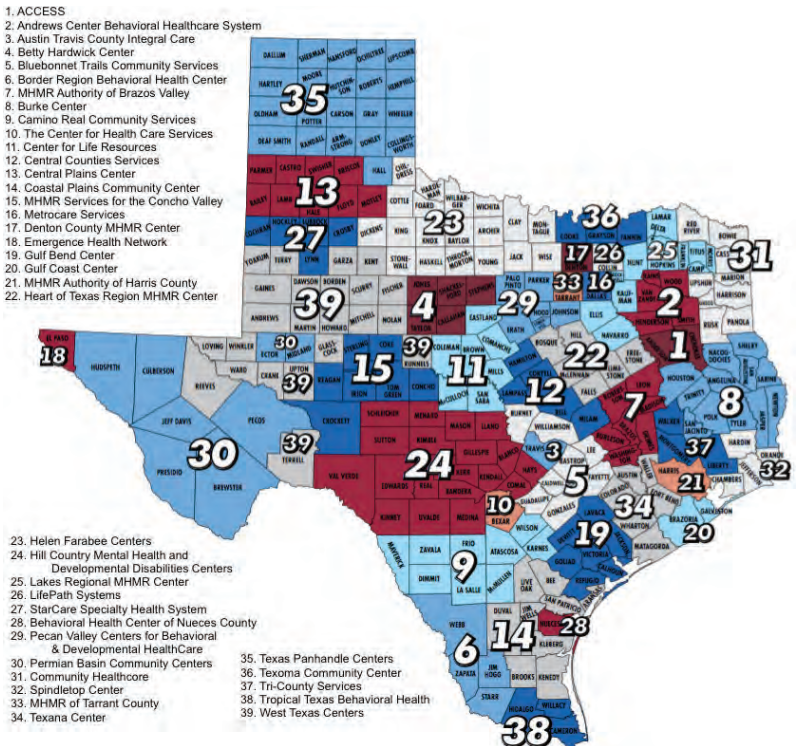
LOCAL MENTAL HEALTH AUTHORITIES

Public mental health services are primarily provided through designated LMHAs, also commonly known as community mental health centers. The HHS System contracts with 39 LMHAs 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; and
- Any individuals eligible for Medicaid who reside in that LMHA's designated geographic area, shown below in Figure 37.[145]

The Medical and Social Services Division oversees and regulates the quality of services provided to individuals through LMHAs and also regularly provides LMHA staff with training and technical assistance. Of the 39 LMHAs in Texas, 37 are designated as official LMHAs while two serve as contracted providers for the NorthSTAR service region.[146] NorthSTAR will be defunded and all its duties transferred to other providers on January 1, 2017.[147] Local Behavioral Health Authority (LBHA) is a newer term for LMHAs that better reflects the new requirements under SB 1507 (84th, Garcia/Naishtat) that in addition to providing mental health services, LMHAs must be responsible for providing substance use services and are the only entities that can act as Outreach, Screening, Assessment and Referral (OSAR) provider authorities.[148,149] As of September 1, 2015, 12 LMHAs are the OSAR provider authorities for all of the state's OSAR regions.[150] LMHAs are still authorized to subcontract with substance use providers to provide OSAR services, but the new requirements reflect a larger shift in DSHS toward more integrated and patient-centered behavioral health services that are easier to locate and access.[151]

Figure 37. Map of LMHAs and 39 Service Regions



Source: Texas Council of Community Centers. (2015). Community Centers of Texas Map. Retrieved from http://www.txcouncil.com/userfiles/file/TexasCouncil%20Map%20201301web.pdf

As an authority, LMHAs 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.[152,153]

Each LMHA is required to plan, develop, and coordinate local policy, resources, and services for mental health care. Additionally, LMHAs are required to develop external provider networks and serve as a provider of last resort when other subcontractors or providers are unavailable.[154] 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 mental health workforce shortages in rural counties and in the Texas-Mexico border regions. In such cases, LMHAs typically serve as primary service providers.

Individuals seeking behavioral health services can arrive at an LMHA with or without an appointment. Their first step into services is for a qualified mental health professional to provide them with a brief mental health screening to verify that they are seeking services that the LMHA is equipped to provide. If so, the client 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) and adults are given the Adult Needs and Strength Assessment (ANSA). An adult client's score on the ANSA is combined with a supplemental assessment specific to the client's diagnosis (for example, the Quick Inventory of Depressive Symptomology (QIDS) for individuals with a diagnosis of major depression), and a level of care (LOC) determination is calculated. For children, no supplemental assessments are used in conjunction with the CANS and the LOC is based solely on the child's diagnoses and the score obtained from the CANS. Individuals also may enter into LMHA services by first utilizing crisis services (via Mobile Crisis Outreach Teams [MCOT], mental health deputies, or a crisis hotline), in which case they are provided crisis services package. Once an individual is enrolled in LMHA services, providers regularly update the CANS and ANSA to verify that the LOC is still correct. The state also tracks changes in these scores over time to estimate how individuals and groups of individuals are responding to treatment. Clients seeking substance use services are referred to Outreach, Screening, Assessment and Referral (OSAR) providers.

LMHAs also work with schools and law enforcement to help integrate treatment plans and provide intervention as early as possible. During the 84th Legislature, HB 2186 (84th, Cook/Campbell) improved suicide prevention efforts by requiring suicide prevention trainings for school staff.[155] Additionally, SB 133 (84th, Schwertner/Coleman) strengthened efforts toward early intervention by allowing DSHS to provide mental health first aid training to school resource officers who are specially trained, school-based police officers, and school district employees.[156] The mental health first aid training teaches non-medical professionals how to respond to signs of potential mental health needs and crises. See the TEA section for more detailed information on mental health first aid training initiatives.

NORTHSTAR

The NorthSTAR managed care carve-out program was created in 1999 and will be discontinued as of January 1, 2017. For more information on NorthSTAR, see the Changing Environment section in the HHS System section.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) AND OTHER COMMUNITY PROVIDERS

In addition to state-funded LMHAs 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, including services such as mental health counseling or substance use treatment.[157] While the FQHC benefit was first added to Medicare in 1991, the passage of the Affordable Care Act (ACA) allocated $11 billion in new funding to build and expand health centers nationwide, and FQHCs have since become a central component of the push toward integrating behavioral health services with primary healthcare.[158,159] Being certified as an FQHC brings a number of benefits, including:

- Cost-based (enhanced) payment for Medicare and Medicaid patients;
- 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).[160]

In addition to the 73 FQHCs currently operating in Texas, there are also three FQHC-lookalikes — centers that offer similar services as FHQCs but do not receive all of the benefits as certified FQHCs.[161] 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.[162,163]

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.[164] 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 and other providers to offer behavioral health services in their clinics.[165,166] Because of the way FQHCs are funded there is less mandated reporting on client outcomes compared to LMHAs and Medicaid managed care providers, but FQHCs are increasingly becoming an integral part of the health safety net in many parts of Texas.

One example of an FQHC is Central Health in Austin, which operates local community health centers through its CommUnity Care clinics. CommUnity Care has partnered with the local mental health authority (LMHA) — Austin Travis County Integral Care — so that both organizations can draw on each other's resources and expertise to provide more comprehensive health care. Behavioral health professionals from ATCIC provide mental health assessments, counseling, and other psychiatric services in CommUnity Care community health centers while medical professionals from CommUnity Care provide primary care and wellness programs in ATCIC clinics.[167]

COMMUNITY MENTAL HEALTH SERVICES

TEXAS RESILIENCE AND RECOVERY FRAMEWORK

The state's vision for behavioral health services of "Hope, Resilience, 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.[168] The framework under which DSHS delivers public mental health services is known as Texas Resiliency and Recovery (TRR), an outgrowth of the shift in mental health service delivery that was launched in 2004 under the name Texas Resiliency and Disease Management (RDM).[169] In September 2012, the Texas mental health system's guiding framework changed to further reflect the state's commitment to person-centered, family-centered, and community-driven recovery-based approaches. The TRR model relies on evidence-based practices and principles of recovery and resilience to obtain the best possible outcomes and maximize the therapeutic impact of available resources.[170]

The TRR system is responsible for:

1) Establishing who is eligible for services through a uniform assessment (ANSA and CANS);
2) Establishing ways to manage service utilization;
3) Measuring clinical outcomes and impacts of services rendered; and
4) Determining service cost.[171]

Clinical needs are identified through a psychosocial assessment and a uniform clinical instrument. The Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths Assessment (CANS) are used to determine the appropriate level of care (LOC) and corresponding eligibility for services and specialty treatments. Within this model, the intensity of services is based on an individual's respective place on the continuum of active symptoms and corresponding mental health needs. The expectation built into the model is that as strengths are identified and resilience is built, the majority of individuals will transition to lower LOCs, and eventually to a place where they can transition into sustained recovery in the community. Figure 38 describes the adult target population and services provided at each TRR Level of Care (LOC). Figure 39 describes the same for children and adolescents.[172]

Figure 38. Texas Resiliency and Recovery (TRR) Levels of Care (LOC) for Adults

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-0: Crisis Services	The goal of crisis services is the resolution of an immediate mental health crisis and avoidance of more intensive and restrictive interventions (e.g., admission into a state psychiatric hospital) or relapse. Crisis services may be accessed in person at an LMHA or via a crisis hotline and do not require prior diagnosis or authorization for services using the ANSA. However, a crisis assessment and crisis ANSA must be completed within two business days of the encounter.	Brief interventions to address the immediate crisis and prevent the need for more intensive services: · Psychiatric diagnostic interview · Pharmacological management · Crisis intervention services (including coordination and transportation to an inpatient setting, or diversion from such settings to, for example, respite or extended observation units [EOU])
LOC-1M: Basic Services (Medication Management)	This service package is reserved for adults who meet the DSHS definition for priority populations and who have maintained a level of recovery and sustained success in treatment for at least 12 months. Individuals in an LOC-1M package have some need for occasional services, such as medication management, but they mostly maintain their recovery with coping skills and a network of natural supports. These individuals are generally ready to transition out of the public mental health system and will need help making the successful transition to appropriate community resources whenever they become available. The goal is to prevent deterioration until access to alternate psychiatric supports and pharmacological resources are available in the community.	Brief interventions that serve to help individuals maintain stability in their recovery from mental illness and ultimately transition to services in the community. Services include: · All crisis services · Routine case management
LOC-1S: Basic Services (Skills Training)	Services for adults who meet DSHS priority population criteria, present little risk of harm to self or others, have reasonable social supports, do not require intensive intervention, and can benefit from ongoing psychotherapy and support from a case manager. The goal of this level of care is to facilitate recovery by reducing and stabilizing symptoms, improve functioning through learning and practicing coping skills, and prevent deterioration of the condition by providing quick and easy access to formal mental health supports.	Non-intensive interventions that serve to help individuals reduce negative symptoms and work toward recovery and stability by learning new skills and coping mechanisms. Services include: · All LOC-1M services · Skills training and development (individual and group) · Medication training and support services (individual and group) · Supported employment · Supported housing · Cognitive processing therapy (CPT) · Flexible funds/community supports · Peer support services
LOC-2: Basic Services including Counseling	These services are for adults who have a diagnosis of major depressive disorder, a GAF score at or below 50, very little risk of harm, and some natural supports. These adults do not normally require intensive interventions and can benefit from psychotherapy. The goal of LOC-2 services is very similar to LOC-1S services, with the addition of improving functioning and preventing deterioration through cognitive behavioral therapy (CBT) services or psychotherapy.	Non-intensive interventions that serve to help individuals reduce negative symptoms and work toward recovery and stability by learning new skills and coping mechanisms. Services include: · All LOC-1S services · Cognitive behavioral therapy (CBT) (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	These services are for adults who meet DSHS priority population criteria and enter the system with moderate to severe levels of needs that require intensive rehabilitation and more frequent interventions. The goal is to support the adult in recovery through a team-based approach, integrating treatment plans and goals across providers and services. The services are meant to engage individuals and help to stabilize their symptoms, improve functioning, leverage strengths to foster independence, develop self-advocacy skills, increase natural supports, and sustain improvements made in more intensive LOCs and/or during past treatments.	A mix of intensive and routine interventions that serve to help individuals learn basic coping and life skills while reducing negative symptoms and working toward recovery and stability. A rehabilitative case manager must also provide supported housing and services for co-occurring psychiatric and substance disorder. Services include: · All LOC-1S services · Psychosocial rehabilitative services (individual and group) · Day programs for acute needs · Residential treatment
LOC-4: Assertive Community Treatment (ACT)	Individuals receiving LOC-4 services, also known as Assertive Community Treatment (ACT), have severe and persistent mental illness (such as schizophrenia or major depressive disorder) and have experienced multiple psychiatric hospital admissions at state hospitals or other community providers. A history of involvement with law enforcement is likely but not required for placement into this LOC. The goal of ACT is to provide a focused and fixed point of responsibility for a comprehensive array of services that merge the skills of clinical, medical, and rehabilitation staff together into one integrated whole. Provision of services takes place within a mobile delivery system so that the team can serve the person in recovery from their home or wherever else in the community is easiest for them.	This level of care requires more frequent interventions than the LOC-3 package but many of the same services, with more frequent intensive interventions and complex treatment planning to help maintain safety and reduce negative symptoms. ACT services work to help individuals achieve some sort of community-level functioning, with supports. A rehabilitative case manager must provide LOC-4 clients with supported housing and services for co-occurring psychiatric and substance disorder. Services include: · All LOC-3 services · Cognitive behavioral therapy (CBT)
LOC-5: Transitional Services	This level of care is for individuals who are transitioning out of a crisis package and still require supports and services, but do not qualify for DSHS-funded services. LOC-5 services are also utilized when someone discharges from an inpatient setting and needs help stabilizing and transitioning. The goal of LOC-5 services is to assist individuals in maintaining stability and preventing further crises by engaging them in patient-centered treatment planning and arranging for services provided by community-based professionals. Services can last for up to 90 days.	The LOC-5 package is highly individualized and can involve very intensive post-crisis safety planning or may involve less acute treatment planning for individuals with diagnoses best handled by private providers in the community. Services can include a mixture of any and all billable services for LOC-1M through LOC-4, but services must still be tied to specific goals laid out in a crisis treatment plan.

Source: Texas Department of State Health Services. (2015*). Adult Utilization Management Guidelines-FY 2014*. Retrieved from: https://www.dshs.state.tx.us/mhsa/trr/um/

Figure 39. Texas Resiliency and Recovery (TRR) Levels of Care (LOC) for Children and Adolescents

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-0: Crisis Services	The goal of crisis services is the resolution of an immediate mental health crisis and avoidance of more intensive and restrictive interventions (e.g., admission into a state psychiatric hospital) or relapse. Crisis services may be accessed in person at an LMHA or via a crisis hotline and do not require prior diagnosis or authorization for services using the CANS. However, a crisis assessment and crisis CANS must be completed within two business days of the encounter. As of June 2015, children who do not meet the usual criteria to be placed into a crisis package using the CANS assessment can be placed into an LOC-0 via an override process built into the CANS assessment.	Brief interventions to address the immediate crisis and prevent the need for more intensive services. This can include: · Psychiatric diagnostic interview · Pharmacological management · Crisis intervention services (including coordination and transportation to an inpatient setting, or diversion from such settings to, for example, respite or extended observation units [EOU])
LOC-1: Medication Management	This service package is for children and adolescents whose only current identified treatment need is medication management. The goal of LOC-1 is to maintain stability and utilize the child and their caregiver's natural supports and identified strengths to help transition to community-based providers when available.	Children in the LOC-1 package may have an occasional need for routine case management services to respond to a specific event or review lessons learned in past treatment, but their only routine and regular service is medication-related appointments. Other services may include: · LOC-0 services (crisis) · Medication training and support · Routine case management · Parent support group · Family partner supports · Family case management
LOC-2: Targeted Services	Children and adolescents must have identified needs that require either emotional or behavioral treatment. Children and adolescents in this package have very few needs, if any, in life domain functioning or maintaining basic safety. The goal of these services is to improve mood-related symptoms or address behavioral needs by building on strengths within the child, the caregiver, and the group as a whole. Services should be provided in the most convenient location for the child and caregiver, including offices, school, home, or other community locations. Services can be provided via 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 service specific to LOC-2 is either: · Counseling (individual, group, or family) or · Skills training (individual, group). The only exception occurs when counseling is the primary intervention and skills training is also provided to the child as a component of parent skills training.

Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-3: Complex Services	This service package is for children and adolescents who have identified both behavioral and emotional treatment needs that require more intensive intervention than lower packages. Children in this package may exhibit a moderate degree of risk behaviors and/or impairments in basic life functioning and skills that require multiple service interventions from multiple providers. The goal of LOC-3 services is to reduce or stabilize symptoms and risk behaviors, improve overall functioning, and build strengths and resiliency in the child and caregiver so that they can transition to lower levels of care. Services should be provided in the most convenient location for the child and caregiver, including offices, school, home, or other community locations. Services can be provided via telemedicine, if available.	While many of the services are the same, children and adolescents in LOC-3 receive interventions more frequently than LOC-2 clients because they have a higher level of need. Individuals in LOC-3 can receive: · All LOC-2 services · Respite services, both community-based and program-based Because of the increased need for interventions in this service package, LOC-3 providers may need to consider flexible office hours (i.e., night and weekend) to best support the complex needs of the child and their caregiver.
LOC-4: Intensive Family Services (Wraparound)	Children and adolescents in LOC-4 have the highest level of need, with both behavioral and emotional treatment needs and significant involvement with multiple child-serving systems. The child is typically at risk of placement outside of their home as a result of severe behavioral and emotional needs. These behaviors and mood symptoms often result in the child having a history of (or at risk of developing): Juvenile justice involvement; Expulsion from school; Displacement from home; Hospitalization; Residential treatment; Serious injury to self or others; and/or Death. The goal of LOC-4 services is to use a focused, integrated team approach to stabilize and control symptoms and risk behaviors, improve overall functioning, and build strengths and resiliency in the child and their caregiver(s). The provider team uses the National Wraparound Initiative's (NMI) model for wraparound services to provide the individual services (and their support network) with comprehensive services and 24/7 access to at least one provider on the wraparound team to help avoid out-of-home placement. Services should be provided in the most convenient location for the child and caregiver, including offices, school, home, or other community locations. Services can be provided via telemedicine, if available.	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: · All LOC-3 services · Stronger emphasis on family partner services and integrated care · Intensive case management, also known as "wraparound" The increased use of family partner services fosters caregiver resilience through building upon natural supports and strengths and linking to community resources through the wraparound planning process.

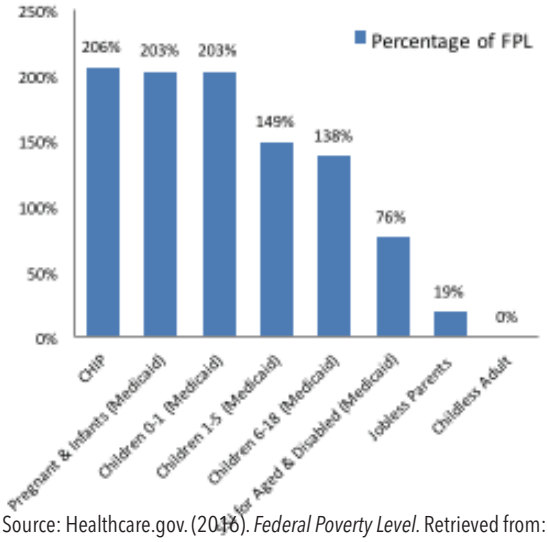
Level of Care (LOC)	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-YC: Young Child Services	This service package is for all children ages 3-5 with identified behavioral and/or emotional treatment needs. The young child may exhibit a moderate degree of deficits in basic life domains and functional impairments that require multiple service interventions. The goal of LOC-YC services is to focus on improving and leveraging the dyad relationship, which is the primary context for young children experiencing the world. Services are meant to reduce symptoms, prevent deterioration (or full development of an illness), improve overall functioning, and build strengths and resiliency in the child and caregiver. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services can be provided via telemedicine, if available.	Young children in the LOC-YC package are eligible to receive the following services: · All LOC-4 services While young children in the LOC-YC package are eligible for all LOC-4 services, they are expected to utilize a less comprehensive array of services on a less frequent basis than is required under the full wraparound approach. Providers may need to consider flexible office hours to support the needs of the young child and caregiver.
LOC-5: Transitional Services	Similar to LOC-5 services for adults, this level of care is for individuals who are transitioning out of a crisis package and still require supports and services, but they do not qualify for DSHS-funded services. LOC-5 services are also utilized when a child discharges from an inpatient setting and needs help stabilizing and transitioning to other community providers. The goal of LOC-5 services is to assist individuals in maintaining stability and preventing further crises from evolving by engaging them in patient-centered treatment planning and arranging for services provided by community-based professionals. Services can last for up to 90 days.	The LOC-5 package is highly individualized and can involve very intensive post-crisis safety planning or may involve less acute treatment planning for individuals with diagnoses best handled by private providers in the community. Services can include a mixture of any and all billable services for LOC-1 through LOC-4, but services must still be tied to specific goals laid out in a crisis treatment plan.

Source: Texas Department of State Health Services. (2015*). Child & Adolescent Utilization Management Guidelines-FY 2014.* Retrieved from: https://www.dshs.state.tx.us/mhsa/trr/um/

MEDICAID

Medicaid is a jointly funded federal and state program that serves low-income individuals who also meet other categorical eligibility requirements (e.g., presence of a disability). Medicaid covers acute health care needs as well as long-term services and supports for families, children, pregnant women, older adults, and people with disabilities.[173] Only U.S. citizens or legal permanent residents who live in Texas and have an income less than the federal poverty level (FPL) shown in Figure 40 may qualify for Texas Medicaid.[174]

Figure 40. Eligibility Levels For Subsidized Coverage in Texas in 2014 (Left) and Annual Income Levels Required to Obtain Coverage (Right)



FPL	Individual	Family of 4
15%	$1,782	$3,645
100%	$11,880	$24,300
133%	$15,800	$32,319
200%	$23,760	$48,600
400%	$47,520	$97,200

Source: Healthcare.gov. (2016). *Federal Poverty Level*. Retrieved from: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/; Center for Medicare & Medicaid Services (October 24, 2014). *State Medicaid and CHIP Income Eligibility Standards Effective July 1, 2014*. Retrieved from: http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf

As of July 2015, an estimated 1 million adults and 3.3 million children in Texas were enrolled in Medicaid. That translates to roughly 45 percent of all children living in Texas being enrolled in Medicaid.[175] Most Texans enrolled in Medicaid now receive health services through Medicaid managed care (discussed further in the Service Providers section in this chapter).

An optional Affordable Care Act (ACA) provision allows states to expand Medicaid coverage to wider populations, but Texas has no current plans to expand Medicaid coverage to adults below 100 percent of the FPL who do not have access to insurance through the Marketplace.[176] The federal match for ACA Medicaid expansion is much higher than typical Medicaid programs, starting at 100 percent and phasing down to 90 percent in 2020.[177] If Texas were to expand Medicaid eligibility to adults up to 138 percent of the FPL, the majority of medically indigent individuals requiring mental health and substance use services served by LMHAs would have access to health insurance.[178] For more information on the Texas Medicaid program, see HHS System section.

INDIVIDUALS CONSIDERED MEDICALLY INDIGENT

According to the Texas Health and Safety Code, a person is considered to be indigent 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.[179]

Individuals who are deemed to be medically indigent and meet the priority population criteria (described below) are eligible to receive services through

the state mental health system without the state receiving compensation or reimbursement for services.[180] Within the first 30 days of rendering mental health services, LMHA staff (typically benefits coordinators or office managers) conduct a financial assessment of an individual's ability to pay for services and calculates a maximum monthly fee or no fee, depending on the individual's gross income minus extraordinary expenses:[181]

- Individuals whose adjusted income is at or below 200 percent of the FPL are eligible for full funding of substance use services;
- Individuals whose adjusted income is at or below 150 percent of the FPL are eligible for full funding of all other mental health services; and
- All other contribution amounts are assessed on a sliding scale basis (based on family size and income).[182]

The County Indigent Health Care Program (CIHCP) also provides services to individuals who are deemed indigent. CIHCP provides health services through counties, hospital districts, and public hospitals throughout the state to eligible residents whose income does not exceed 21-50 percent (depending on the county) of the Federal Poverty Guidelines (FPG) and whose household resources do not exceed $3,000.[183] As of February 2015, indigent residents were being served by the following different CIHCPs:

- 143 of Texas' 254 counties administered a CIHCP for indigent residents;
- 142 hospital districts were served by CIHCPs; and
- 18 public hospitals provided CIHCP services (i.e., inpatient and outpatient hospital services).[184]

PRIORITY POPULATIONS

During the 83rd Legislative session, HB 3793 (83rd, Coleman/Hinojosa) amended the Health and Safety Code to expand treatment services provided by LMHAs beyond serving only adults with a "big three" diagnosis of schizophrenia, bipolar depression, and/or major depressive disorder.[185] Although providing treatment services to individuals with other diagnoses was not prohibited prior to 2013, previous law only mandated the provision of services to adults with those three major illnesses.[186] In an effort to reduce involvement in the criminal justice system and expand access to community mental health services for a wider variety of individuals, LMHAs with sufficient resources can now provide services for individuals with any of the diagnoses listed in Figure 41.[187,188]

Figure 41. LMHA 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; · 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: · 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 serious emotional disturbance (SED). *Children and adolescents with a single diagnosis of autism, pervasive developmental disorder, intellectual disability, or substance use do not meet the priority population criteria for mental health services, and are instead served through other programs developed for special populations (previously at DADS and or DARS; now at HHSC).

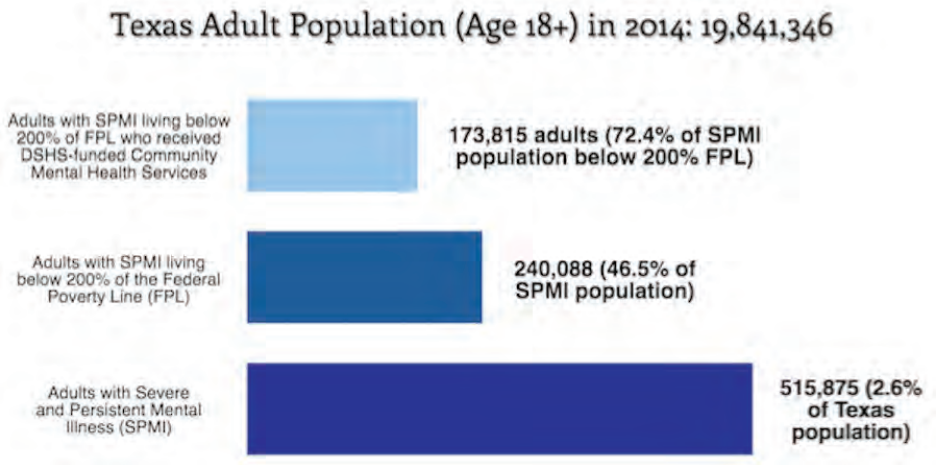
SYSTEM UTILIZATION (COMMUNITY MENTAL HEALTH SERVICES)

From FY 2010 through FY 2015, roughly 1.1 million adults and children received community mental health services in Texas through LMHAs (including NorthSTAR). The unduplicated number of persons who received publicly-funded mental health services increased by approximately 40 percent during this same five-year period, driven in part by a greater need for services by adults.[189,190] Much of the increased demand for behavioral health services in Texas is due to the state's rapidly expanding population, growing from a total population of 25,145,561 in 2010 to an estimated 27,469,114 in 2015 — a 9.2 percent increase, the highest of any state in the country.[191] The population growth rate in Texas between 2010 and 2015 (9.2 percent) was roughly double the national average growth rate (4.1 percent) and far outpaced other large states like California and Florida, accounting for roughly 19 percent of total population growth in the U.S. during that time and increasing demand for DSHS services.[192]

As illustrated in Figure 42 and Figure 43, there are many more adults and children in Texas who require mental health services than are currently being served in the public mental health system. In 2014, there were 240,088 adults in Texas who had a serious persistent mental illness (SPMI) such as schizophrenia or bipolar disorder and were living below 200 percent of the Federal Poverty Level (FPL); 66,273 of

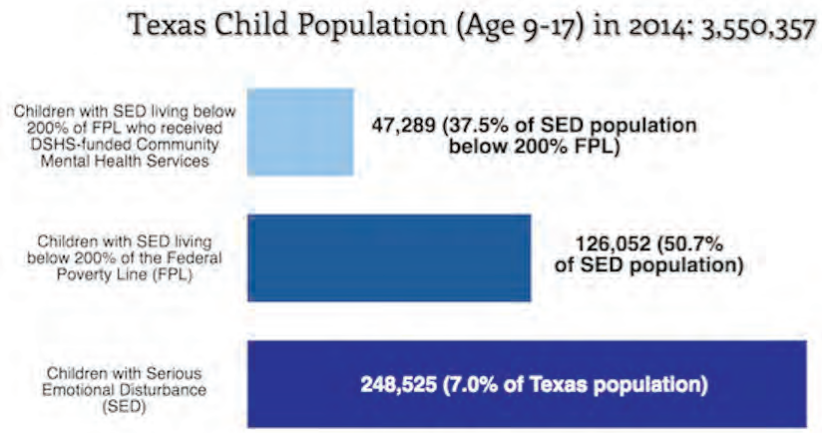
them— or 27.6 percent — did not receive services at DSHS-funded community mental health centers. Similarly, there were 126,052 children with serious emotional disturbances (SED) living below 200 percent of the FPL in 2014; 78,763 of them – or 62.5 percent) – did not receive services through DSHS-funded community mental health centers or NorthSTAR.[193]

Figure 42. Unmet Needs for Community Mental Health Services: Adults in FY 2014



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

Figure 43. Unmet Needs for Community Mental Health Services: Children and Adolescents in FY 2014



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

Adult Services: Utilization and Costs

Figure 44 shows the utilization and costs for adult community mental health services in Texas.

Figure 44. Utilization/Cost for Adult Community Mental Health Services

Utilization Measure	FY 2013	FY 2014	FY 2015
Average monthly number of adults receiving community mental health services	79,611	90,658	94,776
Average cost of community mental health services per adult served	$352	$422	$438

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

Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

Youth Service Utilization and Costs

Figure 45 shows the utilization and costs for child and adolescent community mental health services in Texas.

Figure 45. Utilization/Cost for Child and Adolescent Community Mental Health Services

Utilization Measure	FY 2013	FY 2014	FY 2015
Average monthly number receiving community mental health services	17,878	20,240	23,376
Average cost of community mental health services per child served	$383	$441	$441

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

Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

Quality of Care Measures

Figure 46 shows selected data on common child and adolescent outcome measures for FY 2013-2015.

Figure 46. Selected Measures for Children and Adolescents Receiving Community Mental Health Services

Quality of Care Measure	FY 2013	FY 2014	FY 2015	Performance Contract Target FY 2015
Percentage of children and adolescents in community mental health services receiving at least one hour of services per month	n/a	82.8%	79.0%	≥ 65%
Percentage of children and adolescents in community mental health services who experienced improved community tenure	n/a	100%	100%	≥ 98.1%
Percentage of children and adolescents in community mental health services meeting or exceeding the Reliable Change Index in one or more domains	n/a	65.8%	61.4%	25%

Note: Data for first two items are from each year's fourth quarter, data for the last item is from the third and fourth quarters combined.

Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

WAITLISTS FOR COMMUNITY-BASED MENTAL HEALTH SERVICES

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.[194] If an individual is approved for Medicaid while on the waitlist, the LMHA has 60 days to expedite the individual into services. Individuals on waitlists are contacted every 90 days by a mental health professional to assess basic mental health status and to determine if there has been any deterioration of their mental health. If immediate intervention is required, the individual waiting for routine services may be placed into crisis services.[195]

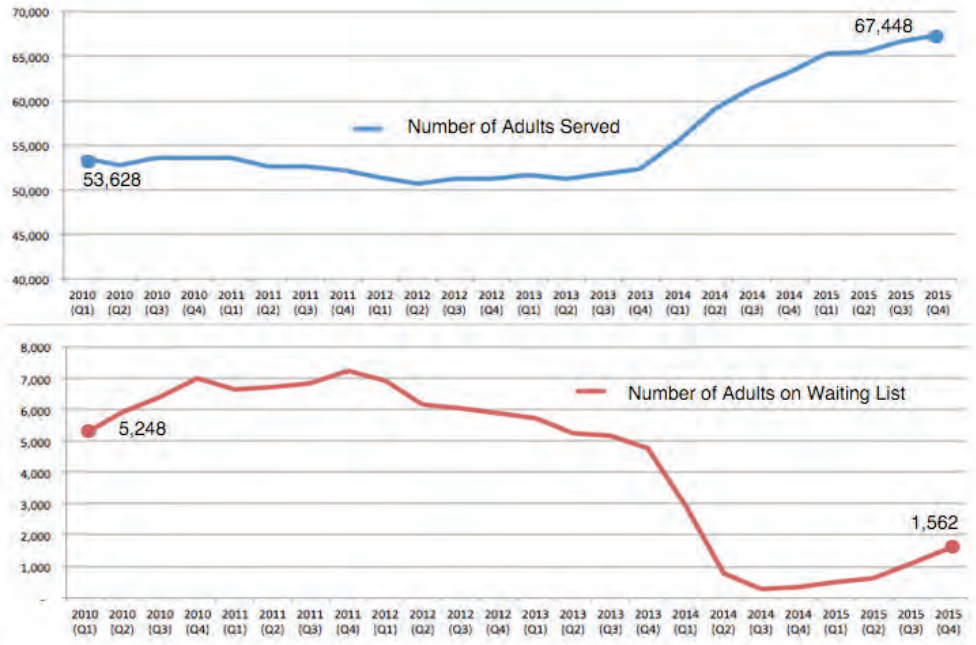
Recent legislative efforts have made significant progress toward addressing waitlist issues at LMHAs. Approximately $48.2 million of the supplemental mental health funding appropriated by the 83rd Legislature (Rider 92, DSHS section of Article II, SB 1) provided funding for adults and children requiring mental health services who were on LMHA waitlists as of May 2012.[196] An additional $43 million was appropriated to:

- Expand community health services;
- Address the needs of individuals who are underserved due to resource limitations; and
- Meet the treatment needs of a growing population that exhibits increasing demand for services.

The 84th Legislature continued to appropriate funding to help eliminate LMHA waitlists; Rider 71 directed $9 million toward reducing waitlists and an additional $46 million for LMHAs and NorthSTAR to increase the number of individuals receiving community-based services with a stated goal of preventing a waitlist in FY 2016-2017.[197]

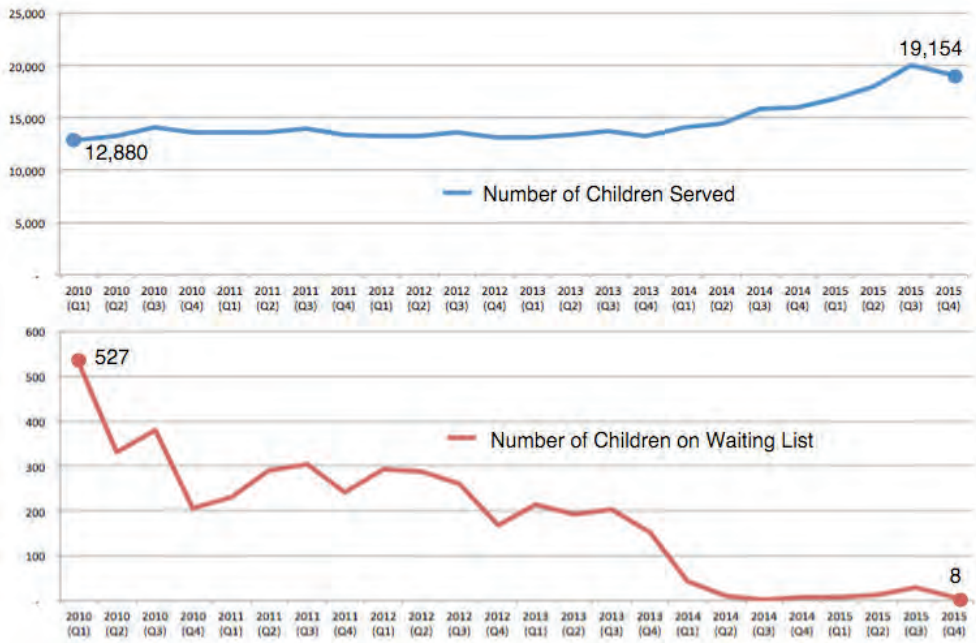
From FY 2009 to FY 2012, the number of adults on waitlists for community mental health services increased by an alarming 85 percent. In contrast, children on waitlists for community mental health services decreased by 24 percent during that same time period due to a special appropriation.[198] As a result of the bills passed during the 83rd legislative session mentioned above, the number of adults on waitlists dropped from over 7,000 in FY 2011 to just 285 adults by May 2014. That number rose back to 1,562 adults on waiting lists at the end of 2015. The child waitlists, on the other hand, dropped from a high of 527 youth waiting for LMHA services in 2010 to just eight by the end of 2015.[199]

Figure 47. Adult Waiting List and Adults Served Through Community Mental Health Centers: FY 2010 (Q1) – FY 2015 (Q4)



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

Figure 48. Child and Adolescents Waiting List and Children Served Through Community Mental Health Centers: FY 2010 (Q1) – FY 2015 (Q4)



Source: Data obtained from: 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

CRISIS SERVICES

The Texas Administrative Code defines a psychiatric crisis as a situation in which, due to a mental health condition, an individual:[200]

- 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.

During the 83rd legislative session, lawmakers appropriated funds to improve crisis services across the state by enhancing community-based psychiatric emergency services projects that serve as alternatives to divert individuals from hospitals, emergency rooms, and/or jails. While individuals with behavioral health issues only account for 9.5 percent of all initial hospital admissions, the clinical ineffectiveness of treating mental illness in an emergency room leads to individuals with behavioral health issues being disproportionately represented (28.2 percent) in hospital readmissions that occur within 15 days of discharge.[201]

In May 2013, LMHAs (and NorthSTAR) submitted needs assessments for psychiatric emergency service funding based on: demonstrated local need, cost effectiveness, collaboration with emergency rooms and the criminal justice system, clinical appropriateness, overall design, and demonstrated local project support.[202] As a result, 16 new crisis facilities were added and an additional three crisis sites were enhanced.[203]

The 84th Legislature maintained previous funding levels for crisis services and added an additional $13 million per year to enhance and expand the reach of psychiatric crisis services.[204] The number of persons using crisis intervention services increased as a result of increasing funding and resources, from roughly 5,039 in FY 2013 to 6,767 in FY 2015.[205]

Crisis services are available statewide to individuals whether or not they are enrolled in ongoing care. Figure 49 lists most of the crisis services available through state funded programs and providers:

Figure 49. Available DSHS Crisis Services

Service	Description
Crisis Hotline Services	Available 24 hours per day, seven days per week, all 39 LMHAs (and NorthSTAR) either operate their own crisis line or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS).
Mobile Crisis Outreach Teams (MCOT)	All 39 LMHAs operate an MCOT program in conjunction with their crisis hotlines and respond to crises in the field. In many service areas, MCOT works closely with the EMS department and law enforcement to divert individuals from the emergency room or jail to more therapeutic interventions.
Crisis Stabilization Units (CSU)	Provide immediate access to emergency psychiatric care and short-term residential treatment for the resolution of acute symptoms.
Extended Observation Units (EOU)	EOUs provide 23 to 48 hours of psychiatric observation in a controlled and locked environment, with a goal of short-term stabilization and diversion from more costly and intensive inpatient services if appropriate.
Crisis Residential Services	This service provides between 1-14 days of crisis-level services in a safe clinical, residential setting for individuals who present some immediate risk of harm to self or others. Services may be provided in state mental health hospitals or private hospitals.
Crisis Respite Services	Crisis respite provides a short period of relief, from the individual's normal environment and typical stressors. Services can last anywhere from eight hours to 30 days of 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 3 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.
Outpatient Competency Restoration Services (OCR)	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*. Retrieved from http://www.dshs.state.tx.us/mhsacsr/ 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

Crisis Services: Utilization and Costs

The utilization and costs for crisis mental health services are included in Figure 50 below.

Figure 50. Utilization/Cost for Crisis Behavioral Health Services

	FY 2013	FY 2014	FY 2015
Average monthly number of persons receiving mental health crisis services	5,039	5,209	6,767
Average monthly cost per person receiving mental health crisis services	$459	$669	$634

Note: Data are from each year's fourth quarter. Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

Inpatient Mental Health Hospital Services

IMPORTANT NOTE: INPATIENT MENTAL HEALTH HOSPITAL SERVICES

As a result of the HHS transformation directed by SB 200 (84th, Nelson/Price), DSHS, along with the entire HHS System has been undergoing massive reorganizations that are only partially complete as of the writing of this guide. Mental health and substance use *community* services transferred to HHSC on September 1, 2016. However, the state owned and operated psychiatric hospitals and the state supported living centers do not transfer until September 1, 2017. In order for this guide to provide information on mental health and substance use services as clearly and concisely as possible, information on state hospital services are included in this section and in the DSHS 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.[206]

Introduction to Inpatient Services and the Admissions Process

As discussed earlier, DSHS designates LMHAs as responsible for achieving continuity of care in meeting a person's need for mental health services. Within this continuum of care, the state 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 that requires the LMHA 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 decides on the least restrictive treatment setting available, with the very 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. Additionally, a hospital physician can make a referral to the local LMHA if the person has less acute needs and only requires coordinated alternative services.[207]

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.[208] Specific services include diagnostic interviews, structured therapeutic programming, collaboration with appropriate courts and law enforcement, suicide safety planning, and discharge planning.

There are two types of inpatient commitments in which individuals are provided comprehensive inpatient mental health services: civil and forensic. Within these two types of commitments, an administrative decision is made as to whether an individual needs a maximum security or non-maximum security placement.

CIVIL COMMITMENTS

Civil commitments to state hospitals occur when an individual is involuntarily detained by a peace officer because he or she has symptoms of mental illness that present a substantial and imminent risk of serious harm to themselves or others.[209] Voluntary civil commitments can also be initiated if the person needing help is actively seeking inpatient treatment.[210]

Once a mental health warrant has been granted and the individual has been transported to a mental health facility, the initial civil commitment is only valid for a 48-hour emergency detention, in which time a doctor must visit with the individual (within 24 hours) and make an assessment about whether an order of protective custody (OPC) should be issued and the emergency detention extended.[211,212] Within 72 hours of the initial detainment, a probable cause hearing must be held to determine whether the individual should stay at a mental health facility or in the community while he or she waits for their final mental health hearing.[213] During the final mental health hearing, the court takes testimony from medical experts, the patient, and individuals in the patient's life (e.g., family, friends, coworkers).[214] Following the final mental health hearing, emergency detentions can extend to 30-day orders of protective custody or 90-day court-ordered mental health service stays (which the court can then extend by three month increments if the treating physician has determined the individual is not stabilized and safe to return to the community).[215] In a small number of cases in which minimal improvement is seen in the first 60 days of inpatient treatment, an individual's treating physician may request an extended civil mental health commitment for up to 12 months, but individuals subject to extended commitments are entitled to have their case heard before a jury rather than a judge.[216]

FORENSIC COMMITMENTS

Individuals who are forensically committed to a state hospital in Texas go to either Rusk State Hospital or the Vernon Campus of North Texas State Hospital; this type of commitment happens for two reasons:

- Individuals have been admitted to a hospital by judicial order because they have

been determined Incompetent to Stand Trial (IST) 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 (NGRI) and were ordered to a state hospital for a period of time not exceeding the maximum sentence length of the crime they committed.[217]

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
- Charged with a violent felony offense involving an act, threat, or attempt of serious bodily injury.[218]

All cases involving serious bodily injury, imminent threat of harm, or use of a deadly weapon are sent to a maximum security unit (MSU) for an initial 30-day evaluation period.[219] 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.[220] Transitional programs for forensic commitments are available for individuals who transfer out of maximum security units after their treatment team and a judge determines that they are no longer manifestly dangerous to themselves or others.[221] In regards to the method of bed appropriation in inpatient settings, only transitional forensic programs and forensic maximum security beds are designated as forensic beds and reserved for those populations; all other psychiatric beds are available for either civil or forensic patients on a first come, first serve basis.

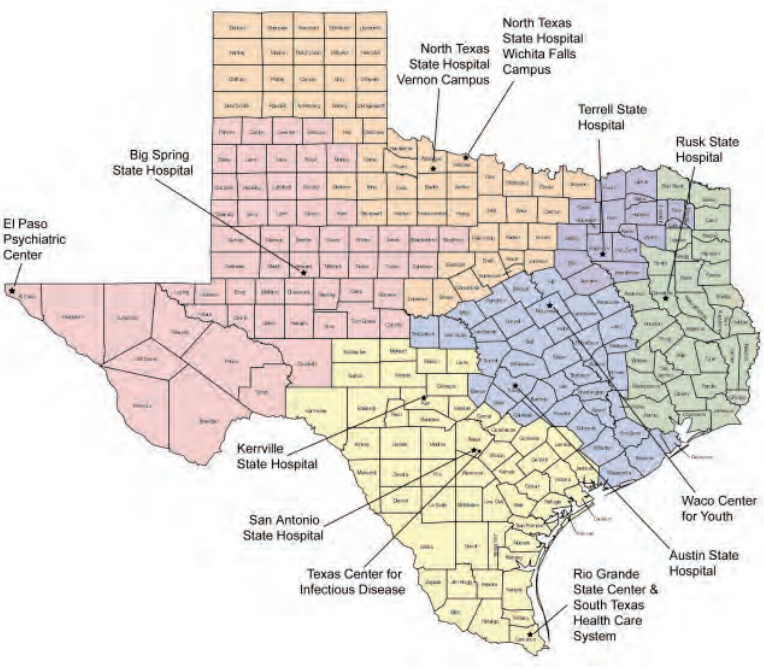
TYPES OF INPATIENT SETTINGS

State Hospitals

The State Hospital Services Division provides oversight of the nine state mental health hospitals and one psychiatric residential treatment facility for youth (the Waco Center for Youth) displayed in Figure 51. Each LMHA receives an allocation of state hospital resources to coordinate inpatient mental health services for residents of their specific state hospital service area. On average, Texas spends more per capita than comparable states on inpatient psychiatric services.[222]

On average, Texas spends more per capita than comparable states on inpatient psychiatric services.[222]

Figure 51. State Mental Health Hospitals and Waco Center for Youth: 2016



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

In FY 2015, the average daily census of all state hospitals in Texas was 2,238 individuals — 25 fewer individuals than in 2014.[223]

Figure 52 shows the total number of beds at each of the state-operated psychiatric hospital facilities in 2015; note that although this chart does not include community and private hospitals that contract with DSHS to provide inpatient treatment, those numbers can be found in Figure 56.

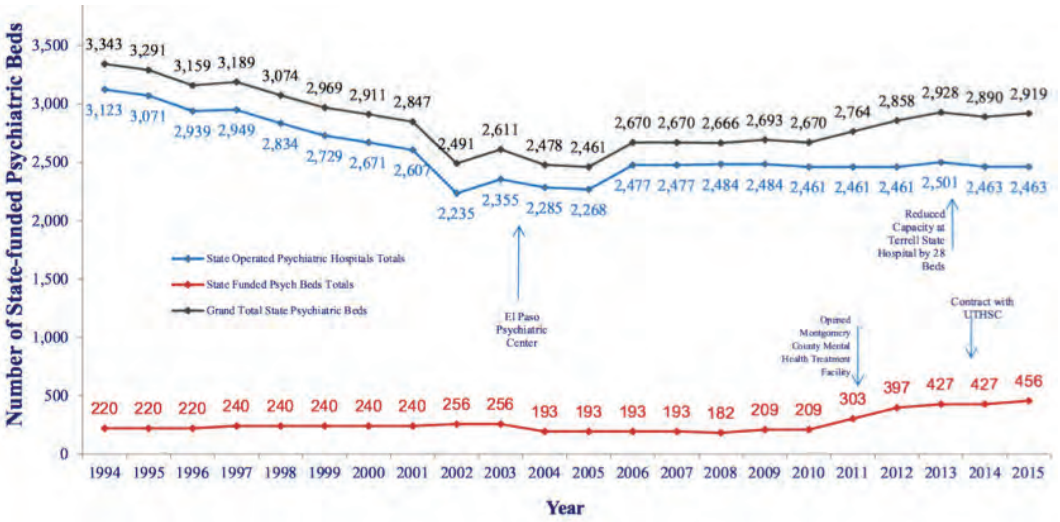
Figure 52. State-Operated Inpatient Psychiatric Beds In State Hospitals: 2016

State Mental Health Hospitals	Bed Type	Number of Beds
Austin State Hospital	Adults and children	299
Big Spring State Hospital	Adults only	200
El Paso Psychiatric Center	Adults and children	74
Kerrville State Hospital	Adults only	202
North Texas State Hospital	Adults and children	640
Rio Grande State Center	Adults only	55
Rusk State Hospital	Adults only	325
San Antonio State Hospital	Adults and children	302
Terrell State Hospital	Adults and children	288
Waco Center for Youth	Children only	78
Total, all bed types		2,463

Source: Texas Legislative Budget Board. (April, 2016). State Hospitals: Mental Health Facilities in Texas, Legislative Primer. Retrieved from http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3ea17faa-4c5b-4a15-9b2d-5af88e9cd4a9.PDF; confirmation that 2015 numbers apply to 2016 obtained via personal communication with Legislative Liaison for the Mental Health and Substance Abuse division of the Texas Department of State Health Services, on June 30, 2016.

Figure 53 below shows the total inpatient bed capacity in Texas, including both state-operated and state-funded psychiatric beds. In FY 2016, there were a total of 2,995 state psychiatric beds across all bed types available for children, adolescents, and adults in Texas. Of the 2,463 state-operated psychiatric beds in 2015, 204 were allotted to provide acute services for children and adolescents and 116 beds were designated for individuals who no longer need state hospital inpatient care but do not have community alternatives available.[224]

Figure 53. State-Funded Psychiatric Bed Capacity: FY 1994-2015



Source: Texas Department of State Health Services. (2016). *Presentation to Select Committee on Mental Health: The Behavioral Health System* [PowerPoint slides]. Slide 25. Retrieved from http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/5fc9614b-41a4-436e-9eba-67b14f00ad22.PDF

STAFFING AND FUNCTIONAL CAPACITY OF STATE HOSPITALS

In determining how many psychiatric inpatient beds there are in state hospitals, it is important to note that a hospital's functional capacity is typically lower than their total bed count. This happens 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.[225] In 2016 there were 2,463 inpatient beds in state-operated psychiatric hospitals, but the estimated available capacity of state-operated facilities was much lower (2,297 as of July 2016).[226] As of May 2016, the state-operated hospital system as a whole had a functional capacity that allowed them to provide services for:

- 256 individuals on maximum security forensic commitments;
- 955 individuals on non-maximum security forensic commitments;
- 915 individuals on non-maximum security civil commitments; and
- 26 individuals on maximum security civil commitments.[227]

While turnover in state hospitals has been an issue across all positions, state hospitals have had particular difficulty with staffing shortages in skilled nursing positions.[228] On top of the already-stressful work environment on 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. This 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 skill sets and required staffing ratios in place. The 84th Legislature appropriated $1.4 million for targeted increases in nursing salaries and appropriated to DSHS an additional $5.6 million to improve staff recruitment and retention through increased salaries and geographic-based incentive payments for nurses.[229]

FUNDING FOR INPATIENT CARE

In total, the 84th Legislature appropriated $872.6 million in all funds to operate the state hospital system for the 2016-17 biennium. In addition to maintaining current capacity and providing salary and benefits for 7,838 FTE positions per year, the funding also included:

- $24.4 million in GR funds to address inflation-related cost increases;
- $1.7 million to replace technology infrastructure; and
- $2.5 million to create a supported community transition program.[230]

Funding from federal sources accounted for 4.4 percent of the total appropriations for state hospitals in the 2016-17 biennium ($38.8 million) but because of the Institutions for Mental Diseases (IMD) Exclusion, this funding will be primarily used for youth under the age of 22 and adults over age 65.[231]

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019	Exceptional Items Request 2018	Exceptional Items Request 2019
Mental Health State Hospitals	$439,414,324	$439,693,161	$441,537,717	$421,935,708	$422,071,390	$112,193,002	$108,194,641
Mental Health Community Hospitals	$80,962,106	$99,971,621	$109,971,620	$104,971,620	$104,971,621	$41,116,909	$41,079,969
Total	$520,376,430	$539,664,782	$551,509,337	$526,907,328	$527,043,011	$153,309,911	$149,274,610

Source: Data captured from HHSC Legislative Appropriations Request for FY 2018/19, September 12, 2016

INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION

The 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."[232] Until

recently, the Act excluded funding inpatient services for individuals between 22 and 64 years of age in IMDs. The IMD exclusion policy has been in place since Medicaid was enacted in 1965 and was intended to promote the expansion of community services and ensure that the federal government did not have to assume financial responsibility for inpatient psychiatric care. Due to this federal restriction on funding for inpatient hospital services, state general revenue has traditionally been the primary funding source for state hospital services for adults between ages 22 and 64, and efforts to improve or expand public inpatient services were funded almost entirely by state funds without federal matching.[233]

The final managed care rules regarding the IMD exclusion were entered into the Federal Register on May 6, 2016.[234] The new rules permit "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 disorder inpatient care, or behavioral health crisis residential services.[235] Federal Financial Participation also only applies for 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). While some advocates have argued that the 15-day limit is too restrictive or that the new rules incentivize inpatient treatment over community-based interventions, CMS has expressed that this new rule will help a large number of cases because the average length of stay for all inpatient psychiatric hospitals is 8.2 days.[236] Before this rule change, stand-alone psychiatric facilities could not deny admission to individuals referred to them, but they also did not receive federal Medicaid match payments, creating the risk of lower quality care and premature discharge.[237] 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.

While it is still too early to directly analyze the impact of this new rule on individuals in Texas, a pilot study in the District of Columbia and 11 states, the Medicaid Emergency Psychiatric Demonstration (MEPD) pilot, provides some preliminary data on the possible impact of this new change to the IMD exclusion. While the final report on the MEPD pilot is not due until September 2016, initial results show that improving federal reimbursements for short-term admissions to IMDs results in:

- Shorter lengths of stay;
- Fewer transfers to other psychiatric facilities;
- Fewer readmissions to emergency rooms and general hospitals;
- Faster clinical response to patients experiencing a psychiatric crisis; and
- Lower overall costs of care.[238]

INPATIENT SERVICES AT STATE HOSPITALS: UTILIZATION AND COSTS

Over the past decade, the yearly average cost per patient served in state hospitals has almost doubled, from $11,912 in FY 2006 to $21,437 in FY 2015, an increase of $9,525 in the average cost per state hospital client (an 80 percent increase).[239] As Figure 54 shows, Kerrville State Hospital (which only provides transitional forensic services) had both the highest average length of stay (839 days) and the highest cost per individual served of all Texas state hospitals in 2015 ($34,749 per client per year).[240]

Figure 54 also shows that despite there being 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 fully utilize the number of beds they have. There has also not been any increase in the number of state-operated beds in recent years — only more contracted community hospital beds — and unmet hospital infrastructure repair and renovation needs have actually taken state contracted beds out of operation.[241]

Figure 54. Utilization and Costs for State-Operated Hospitals in FY 2015

State Hospital	Population Served	Average Daily Census (% of total capacity)	Average Length of Stay at Discharge	Average Cost per Client Served
Austin State Hospital	Mostly civil, some forensic	258 patients (86% of capacity)	49.3 days	$19,224
Big Spring State Hospital	Civil and forensic	180 patients (90% of capacity)	138.0 days	$27,292
El Paso Psychiatric Center	Mostly civil, some forensic	66 patients (89% of capacity)	27.5 days	$13,957
Kerrville State Hospital	Forensic only	196 patients (97% of capacity)	838.5 days	$34,749
North Texas State Hospital (Vernon & Wichita Falls)	Maximum security forensic (Vernon) and Civil and forensic (Wichita)	566 patients (88% of capacity)	116.3 days	$23,834
Rio Grande State Center	Mostly civil, some forensic	52 patients (95% of capacity)	25.5 days	$10,831
Rusk State Hospital	Civil and forensic	313 patients (96% of capacity)	137.3 days	$23,962
San Antonio State Hospital	Mostly civil, some forensic	268 patients (89% of capacity)	58.5 days	$19,479
Terrell State Hospital	Mostly civil, some forensic	246 patients (85% capacity)	41.8 days	$15,833
Waco Center for Youth	Civil only	72 patients (92% of capacity)	161.8 days	$25,616
TOTAL	2,236 patients (50.3% civil and 49.7% forensic)		73.5 days	$21,437

Data obtained from: Texas Legislative Budget Board. (April, 2016). State Hospitals: Mental Health Facilities in Texas, Legislative Primer. Retrieved from http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3ea17faa-4c5b-4a15-9b2d-5af88e9cd4a9.PDF

Whether due to an individual's especially severe 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. As Figure 55 shows, individuals who cycle in and out of state hospitals account for a significant portion of the roughly 2,236 patients who are in state hospitals on any given day.[242] Since inpatient hospitals serve as a safety net for many individuals who receive inadequate or no community-based treatments, the availability and quality of community-based services has a direct impact on inpatient hospital capacity.[243]

Figure 55. Number of Individuals Admitted to State Hospitals 3+ Times in 180 Days: September 2013 – May 2016

Source: Promoting Independence Advisory Committee. (July 21, 2016). Department Activity Report. Page 59. Retrieved from http://www.dads.state.tx.us/providers/pi/piac/7-21-16-reports.pdf

STATE-FUNDED COMMUNITY AND PRIVATE HOSPITALS

Community and private hospitals are neither owned nor operated by the state, but instead receive state funding in order to provide mental health inpatient services to individuals. The red line in Figure 53: State-Funded Psychiatric Bed Capacity: FY 1994-2015 shows the growth of community and private contracted hospitals over time while Figure 56 below shows the community hospitals that are currently contracted with DSHS, the state funds allocated for each facility, and the number of hospital beds available.

Figure 56. Purchased Community & Contracted Private Hospital Beds: Allocated Funds and Number of Beds in FY 2016

Contractor	Annual Funds	Number of Beds
Abilene Regional MHMR Center DBA Better Hardwick Center	$647,460	3
Anderson Cherokee Community Enrichment Services (Access)	$2,127,040	20
Austin-Travis County MHMR DBA Austin Travis County Integral Care	$1,798,500	10
Center for Health Care Services	$6,567,025	30
Coastal Plains Community MHMR Center	$981,000	5
Denton County MHMR Center	$1,247,832	6
Heart of Texas Region MHMR Center	$686,700	3
Lubbock Regional MHMR Center DBA Starcare Specialty Health	$4,126,274	30
MHMR Authority of Brazos Valley	$1,187,010	6
MHMR of Tarrant County	$6,123,860	28
Montgomery County	$15,417,450	94
Spindletop MHMR Services DBA Spindletop Center	$1,942,380	9
The Gulf Coast Center	$4,045,158	20
The Harris Center for Mental Health and IDD	$35,353,199	199
Tri-County Behavioral Healthcare	$1,104,125	5
Tropical Texas Behavioral Health	$2,208,250	10
University of Texas Health Center at Tyler	$9,210,000	44
West Texas Centers for MHMR	$1,978,350	10
TOTAL	$96,751,613	532

Source: Personal communication with Legislative Liaison for the Texas Department of State Health Services' Mental Health and Substance Abuse Division. (June 30, 2016).

The 84th Legislature allocated an additional $50 million to DSHS in order to secure 150 more contracted beds in community and private hospitals by the end of FY 2017.[244] DSHS has since contracted with 13 different LMHAs to provide an additional 94 inpatient beds by the end of FY 2016, at an estimated initial annual cost of $17.1 million.[245]

In addition to beds in community hospitals, locally supported beds also help meet psychiatric inpatient needs by providing approximately 1,936 psychiatric beds across the state. About half of these locally supported beds are funded by insurers (e.g., Medicaid and Medicare) while the other half are used to help indigent individuals who do not have insurance.[246] While efforts are underway to divert individuals experiencing mental health crises away from emergency rooms and into more therapeutic environments, regular hospitals also help meet the inpatient needs of individuals with mental illness. As of FY 2015, there were 2,808 licensed psychiatric beds in non-state-owned general and specialty hospitals in Texas and 4,408 licensed beds in freestanding psychiatric hospitals.[247] While there is no comprehensive information on the statewide utilization of inpatient beds in freestanding psychiatric hospitals, a survey by the Texas Hospital Association found that the majority of non-state-owned psychiatric beds are full.[248]

Due in part to the increasing need for forensic beds in recent years, DSHS considered privatizing some state-operated facilities to help alleviate the inpatient psychiatric bed capacity shortage. For example, DSHS entered into a contract in 2011 with Correct Care Recovery Services (CCRS), a privately owned provider of correctional and detention services, to run the first publicly funded and privately run psychiatric hospital in Texas — the Montgomery Country Mental Health Treatment Facility.[249] The Texas Legislature directed HHSC to attempt to privatize the Terrell State Hospital as well, even going so far as awarding the contract to CCRS in October 2015, but that plan was abandoned after the Texas State Auditor found HHSC undervalued the contract and failed to consult with the Texas Attorney General's office before awarding the contract. The state dropped a similar plan to privatize Rusk State Hospital in 2012 after concluding that it would not save money or improve care.[250]

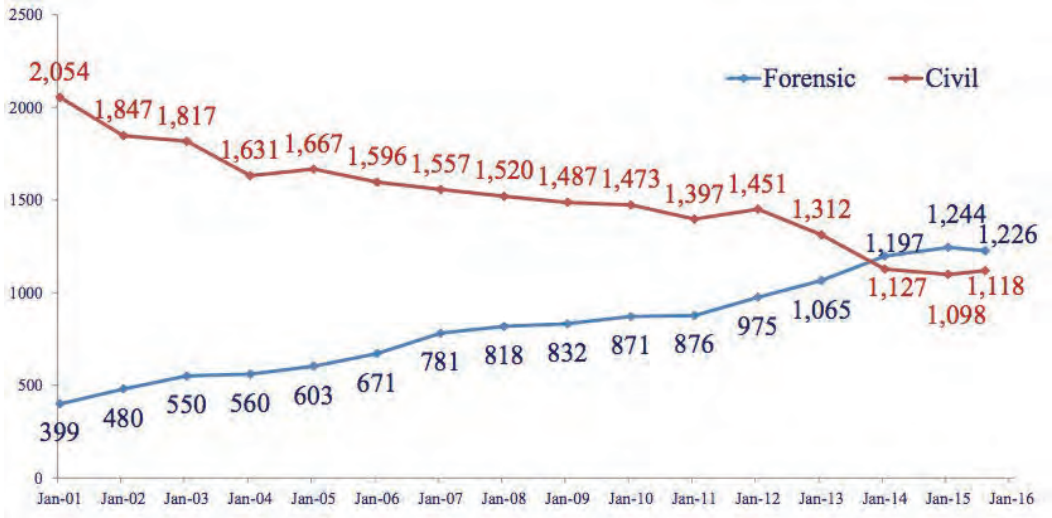
CONTINUING ISSUES

Addressing the Shortage of Publicly-Funded Inpatient Beds

The forensic population's use of state psychiatric hospital resources has grown significantly over the past decade, rising from 16 percent of all publicly funded inpatient beds in 2001 to more than half of all state beds (52 percent) in 2016.[251] The steady increase in Texas' population during this same period contributed to an overall decrease in the number of psychiatric beds available per capita in the state; while there were an estimated 18 inpatient psychiatric beds per 100,000 Texans in 1995, that number dropped to roughly 12 in 2003 and 10.5 in 2015.[252,253]

Figure 57 below shows how these co-occurring trends of more forensic commitments and fewer civic commitments have continued in recent years.

Figure 57. Snapshot of Daily Civil vs. Forensic Patient Population in State Hospitals: 2001-2016



Source: Texas Department of State Health Services. (February 18, 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

The increase in forensic commitments is one of the key drivers of the upsurge in hospital spending and waiting lists in recent years because forensic commitments are typically longer and more expensive than civil commitments. In FY 2015, the average length of stay at discharge for state mental health hospital forensic patients ruled NGRI was 421 days, compared to just 95 days for competency restoration involving a felony and 65 days for competency restoration involving a misdemeanor.[254] In contrast, the average length of stay at discharge was only 56 days for civil commitments and 41 days for voluntary commitments in FY 2015.[255] Long-term hospital stays are also on the rise, with the number of individuals residing in Texas state hospitals for over a year growing from less than 400 in 2001 to over 700 in 2014.[256] Because of the growing proportion of forensic commitments in recent years, the average length of stay for all state hospital patients (and the corresponding costs that come with a longer hospital stay) has continued to increase:

- 44.9 days in FY 2006;
- 58.3 days in FY 2012; and
- 74.4 days in FY 2015.[257]

The increase in forensic commitments has also resulted in waitlists for these services more than quadrupling since 2013; in all of FY 2015, an estimated 1,668 individuals sought forensic services and were put on waiting lists for competency restoration services.[258] While a 2012 Texas court ruling that required incompetent defendants to wait no longer than 21 days for competency restoration services was overturned on procedural grounds in 2014, DSHS stated that it intended to abide by the 21-day limit.[259] Unfortunately, the average length of time on forensic waitlists has continued to surpass the 21-day mark since 2014; in 2015, individuals needing a bed in a maximum-security forensic unit waited significantly longer (102 days) than individuals needing forensic services in non-maximum-security facilities (32 days).[260]

In order to address the needed expansion of inpatient capacity, the 84th Legislature passed Rider 86, which directed DSHS to evaluate the feasibility and potential benefits of allowing a university-related health institution to operate a state hospital. This model of operating inpatient facilities through a partnership between the state and a university has already seen success in Ohio, Georgia, and Kentucky.[261] Benefits from this type of model include: improved medical and psychiatric services, training opportunities for residents, increased integration of behavioral and primary health services, and improved recruitment through residency and internship programs.[262] The report from that study was released August 2016. An overview of the Rider 86 report is available at: http://www.dshs.texas.gov/ConsumerandExternalAffairs/legislative/2016Reports/RPCMemoUniversityPartnershipsMHSA08042016.pdf

Also passed in 2015, Rider 74 allocates $1.2 million annually to fund additional civil beds in a pilot program at the University of Texas Harris County Psychiatric Center for individuals needing treatment for less than 90 days.[263]

The 84th Legislature also passed SB 1507 (84th, Garcia/Naishtat), part of which deals with addressing capacity issues at state hospitals. Beyond improving coordination of forensic services and creating a new DSHS forensic director position, SB 1507 requires HHSC to work with LMHAs, stakeholders, and the new DSHS forensic director to develop a new regional methodology for the allocation of state-funded beds in state hospitals and other inpatient facilities that contract with DSHS.

The Joint Committee on Access and Forensic Services (established by SB 1507) submitted an initial proposal to HHSC for a bed day allocation methodology and a bed day utilization review protocol and which HHSC then adopted in the spring of 2016.[264,265] The joint committee will continue to meet quarterly to monitor and make recommendations regarding the implementation of the process.

Since the 84th Legislative session came to a close, problems with growing waitlists for forensic inpatient beds have continued; in January 2016, 424 individuals were in jails waiting for a forensic inpatient bed to become available — that is a record high for the previous 10 years and roughly four times as many individuals on forensic waiting lists as there were in August 2013.[266,267] As of February 19, 2016, the waiting list for forensic beds consisted of:

- 219 individuals waiting for non-maximum security beds
  - 117 individuals (53 percent) waiting more than 21 days
  - Average wait: 34 days
- 195 individuals waiting for maximum security beds
  - 161 individuals (83 percent) waiting more than 21 days
  - Average wait: 130 days (an 83 percent increase since April 2015)[268]

As of April 2016, an estimated 400 individuals were still on waiting lists for forensic beds in state-run mental health hospitals — over half of whom were waiting for maximum security beds.[269]

IMPROVEMENTS TO AGING STATE HOSPITAL INFRASTRUCTURE

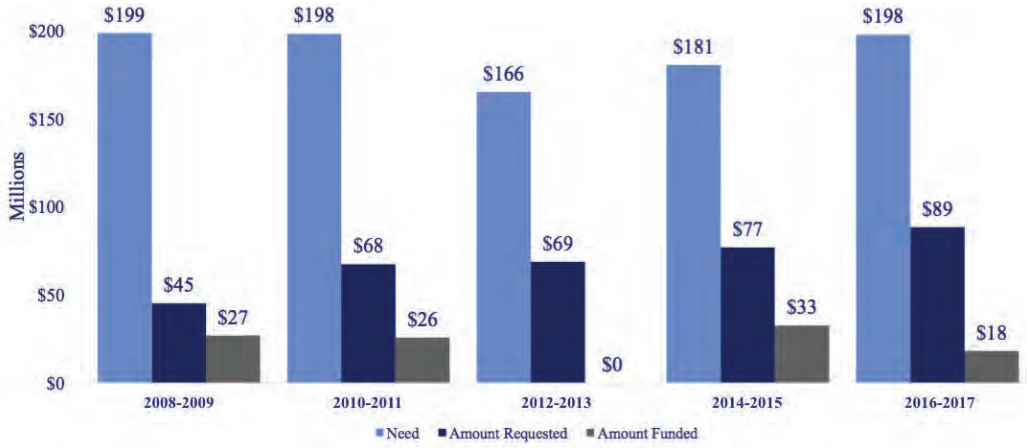
In 2013, the 83rd Legislature required DSHS (in conjunction with DADS) to develop and implement a 10-year plan on the future infrastructure of state hospitals and state supported living centers (Rider 83, SB1, Article II). This plan outlines operational needs, infrastructure needs, capacity issues, and recommendations on how to better serve individuals through community-based providers. The plan also includes best practices within inpatient settings and transitional services for individuals returning to the community.

As part of the 10-year plan, DSHS conducted an in-depth analysis of three facilities (Rusk State Hospital, North Texas State Hospital at Vernon, and San Antonio State Hospital) and found all three facilities to be in "poor to critical condition."[270] While all 10 of the state's hospitals are in need of extensive repairs or complete facility renovations, the preparation and replacement/renovation costs for just the three state hospitals mentioned above would cost more than all of the deferred state hospital maintenance funding appropriated by the previous five legislatures combined ($104 million): [271]

- Rusk State Hospital = $193 million
- North Texas State Hospital at Vernon = $50.1 million
- San Antonio State Hospital = $202.5 million[272]

Figure 58 below shows the vast gap between the amount of money needed to fully repair state hospital infrastructure and the amounts requested by DSHS and approved by the Legislature each biennium.

Figure 58. Deferred Maintenance Funding Requests for State Hospitals: FY 2008-2017



Source: Mike Maples & Lauren Lacefield Lewis. (June 16, 2016). *Inpatient Mental Health Planning: Presentation to the Senate Committee on Health and Human Services* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/ConsumerandExternalAffairs/legislative/2016Reports/SenateHHSinpatientMH.pdf

The 84th Legislature appropriated $18.3 million for critical state hospital repairs for the FY 2016-2017 biennium — roughly 20 percent of what the department asked for and less than 10 percent of what was needed to complete all crucial repairs and renovations.[273]

Also passed in 2015, Rider 86 allowed DSHS to use up to $12.4 million in surplus "Hospital Facilities and Services" funds for planning and developing renovations at Rusk State Hospital. Texas needs to add an estimated 570 publicly funded beds in psychiatric facilities in order to fully meet the current unmet need for inpatient services.[274] Looking at both privately and publicly funded inpatient beds, a 2014 evaluation by CannonDesign estimated that Texas needed 4,300 state-funded beds in 2014 to meet all inpatient mental health needs.[275] More recently (2016), the Joint Committee on Access and Forensic Services (JCAFS) estimated that Texas needs to add 1,800 hospital beds over the next eight years – 1,400 immediately and 50 more each year to keep up with population growth.[276] The JCAFS report also recommended that these beds be added through "a significant initial expansion of state-operated and state-funded inpatient capacity, to include additional maximum security beds, followed by a gradual increase in beds to meet both the current and future demand."[277]

In addition to exacerbating the current capacity issues at state hospitals, failure to renovate and repair the infrastructure of state hospitals may negatively impact their accreditation by The Joint Commission (TJC), which would make it nearly impossible for the state hospital system to meet the needs of individuals with acute mental health conditions in Texas.[278] Outside evaluators of the state hospital system indicate that five of the state hospitals (Austin, North Texas-Wichita Falls, Rusk, San Antonio, and Terrell) should be completely replaced and renovated while the

remaining five hospitals require significant repairs to continue meeting TJC hospital licensing standards in the future. These replacements and improvements would cost the state an estimated $2.9 billion over the next 10 years.[279,280]

OTHER ISSUES ASSOCIATED WITH INPATIENT SERVICES

Reducing the Use of Seclusions and Restraints

In an effort to promote behavioral management techniques that encourage well-being and decrease the risk of traumatization and injury, staff from RTCs across Texas have received training in how to reduce the use of seclusion and restraint. "Seclusion and restraint" refers to techniques used by administrators, clinical, and direct care staff to physically isolate (seclude) or hold with force (restrain) individuals believed to be at risk of harming themselves or others; this may include physical, mechanical, or chemical restraints.[281] Emotional and physical trauma is common among youth in RTC settings and seclusion and restraint techniques may exacerbate their trauma. Thus, instituting alternatives to seclusion and restraint techniques help reduce the likelihood that a resident youth will be re-traumatized.[282]

Texas has made improvements in the culture of care at the state hospitals, most notably reflected in reductions in both the numbers of incidents of restraint or seclusion, the numbers of individuals involved, and the length of time spent in restraint or seclusion per incident. In 2007, Texas was awarded a federal grant from SAMHSA to reduce or eliminate the use of restraints and seclusion in four of the state's psychiatric hospitals — this grant was called the State of Texas Alternative to Restraint and Seclusions grants (STARS grant).[283] One product resulting from a STARS grant was a toolkit designed to help reduce seclusion and restraint in any setting. *Creating a Culture of Care: A Toolkit for Creating a Trauma-Informed Environment* can be found at www.dshs.texas.gov/cultureofcare/toolkit.doc.

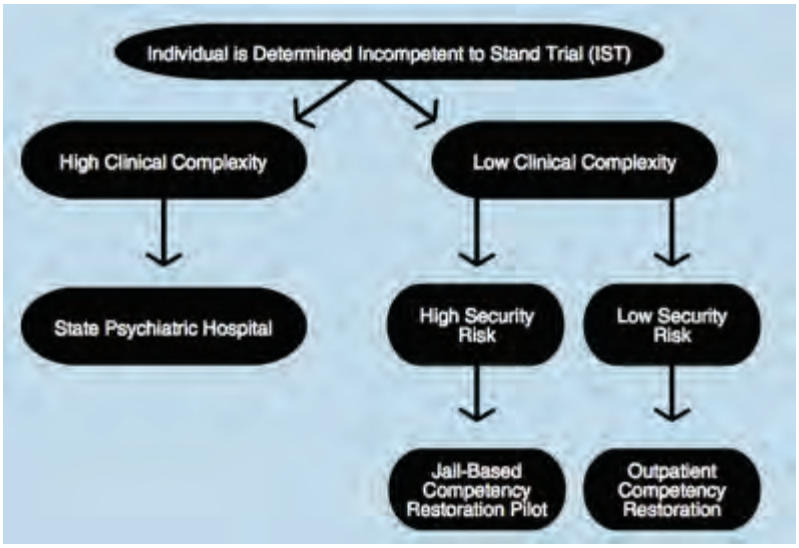
In 2015, the 84th Legislature passed SB 1129 (84th, Zaffirini/Raymond), which restricts the use of restraints by requiring that individuals must be able to sit upright during restraints that occur during apprehension, detention, or transportation, and mandating that restraints during transportation be documented and reported to the receiving facility.[284]

Increasing Access to Timely Competency Restoration Services

A person charged with a crime who is found incompetent to stand trial (IST) must be restored to competency before the legal process can continue. In order to be considered competent to stand trial, that person must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.[285,286] Individuals determined to be incompetent, typically due to mental illness or an intellectual disability, may be placed into inpatient competency restoration (ICR) programs, jail-based competency restoration (JBCS) programs, or outpatient competency restoration (OCR) programs.

Figure 59 displays a conceptual framework for placement into the three different competency restoration tracts. As shown in the diagram, 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.[287]

Figure 59. Placement Determination For Competency Restoration Programs



Delays in receiving timely restoration and mental health services may violate speedy trial provisions in the U.S. Constitution and can be extremely detrimental to long-term mental health outcomes for the individual. In 2006, DSHS attempted to address the growing shortage of inpatient psychiatric resources by implementing a policy requiring all individuals who are found IST and in need of restoration services be placed on the DSHS State Hospital Admissions Clearinghouse waitlist, capping the number of state hospital beds used for forensic commitments at 738. As a result, admission to one of the 738 designated state hospital forensic beds became more restricted because of its being contingent on limited availability. Because forensic commitments at state hospitals are on average much longer than civil commitments, bed capacity was reduced so much that an average of 250 patients were waiting in jail for six months or longer for competency restoration services.[288]

In 2012, a Travis County District Court judge ruled on a forensic restoration capacity lawsuit filed by Disability Rights Texas in 2007 that challenged the DSHS clearinghouse waitlist for people found IST.[289] The court found that a defendant deemed IST cannot be held in a jail for more than 21 days prior to admission into a competency restoration program.[290] However, in May 2014, the Third Court of Appeals in Austin overturned that ruling on procedural grounds, finding that plaintiffs in the case had failed to demonstrate that DSHS' list operates in an unconstitutional manner for *every* detainee. While the court found that the DSHS practice of maintaining the list was not unconstitutional, it indicated that detention beyond a certain period would be unconstitutional.[291] As of May 2016, Disability Rights Texas was still in litigation with DSHS over the constitutionality of the lengths of time experienced by individuals on the waitlist. Wait times for forensic services in April 2016 were still in some cases as long as nine months.[292]

Following the initial ruling in 2012, DSHS made several improvements and expansions to the state hospital system in an attempt to decrease wait times for beds, including:

- Adding eight maximum security beds, 32 intermediate security beds, and converting 20 civil beds to forensic beds at North Texas State Hospital (NTSH);

- Converting 25 civil beds to forensic beds and converting 40 beds to maximum security forensic beds at Rusk State Hospital (RSH); and
- Converting 35 civil beds to forensic beds at San Antonio State Hospital (SASH).[293]

However, as the Texas population and the corresponding demand for services has continued to increase in recent years, the average length of time on forensic waitlists has continued to surpass the 21-day mark; in 2015, individuals needing a bed in a maximum-security (102 days) or non-maximum-security forensic unit (32 days) waited significantly longer than the 21-day objective.[294]

Inpatient Competency Restoration

Individuals found IST (i.e., unable to competently understand court proceedings) may be committed to a state hospital forensic unit to receive treatment and hopefully restore their competency to stand trial. Before 2004, inpatient competency restoration was the only option for individuals found IST.[295] In FY 2015, individuals receiving inpatient competency restoration (ICR) services (872) accounted for roughly 39 percent of the average daily census of state-run psychiatric hospitals (2,235).[296] There has been a steady and significant increase in the percentage of forensic commitments for inpatient competency restoration services in recent years and because those commitments have a much longer average length of stay than civil or voluntary commitments, the average daily census for forensic patients has now surpassed that of civil patients.[297] The average cost of competency restoration in a Texas state hospital in FY 2013 was over $415 per bed per day, and a more recent national study of 47 states and the District of Columbia found an average per day cost of $603 ($300-$1,000) for ICR programs.[298,299]

Jail-Based Competency Restoration

The 83rd Legislature passed SB 1475 (83rd, Duncan/Zerwas) to create 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.[300] The pilot is projected to provide 20 beds for jail-based restoration services but has faced significant barriers to implementation — see Changing Environment section for more information on the JCBR pilot.

Outpatient Competency Restoration

Outpatient competency restoration (OCR) is a process of providing legal education training and other competency restoration services to non-dangerous individuals in a community-based, outpatient setting. The idea 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.[301] OCR programs typically provide mental health and substance use treatment, case management services, and legal education to people charged with misdemeanors and non-violent felony offenses.[302] 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, making treatment more difficult and generally more expensive.

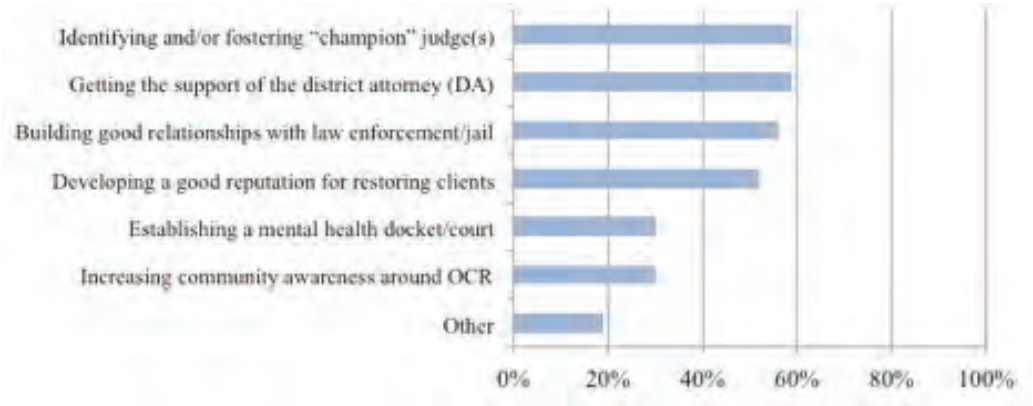
The Texas Code of Criminal Procedures (TCCP) began allowing individuals to be referred to OCR programs in 2003.[303] In 2007, Texas initiated four outpatient competency restoration (OCR) pilot programs in response to the growing number

of forensic commitments in state psychiatric hospitals. For the four pilot sites, the average cost to provide restoration services through OCR in FY 2012 was $11,894 per case, far less than the average cost of $50,520 for inpatient restoration in a state hospital.[304]

In 2011, Rider 78 (82nd Legislative Session) directed DSHS to allocate $4 million each year to support expanding the number of OCR pilot sites beyond the initial four.[305,306] Texas added another eight OCR programs between 2011 and 2013, now constituting the largest system of OCRs in the country and serving roughly 1,700 individuals as of 2016.[307,308] In the Hogg Foundation's 2014 evaluation of OCR programs in Texas, the typical participant was a 38- year-old (*SD* = 13) Black (46 percent) or White (32 percent) single (87 percent) male (72 percent) diagnosed with schizophrenia (63 percent) or bipolar disorder (21 percent) and whose criminal charge was not a felony (60 percent). In addition, 28 percent of participants were homeless.[309]

In addition to avoiding the high cost of hospitalization, OCR can reduce costs to jails and local communities by reducing the length of time individuals remain in jail and eliminating the cost of transporting an individual long distances to an available hospital bed. The Hogg Foundation's 2014 evaluation of OCR programs found that 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.[310] In addition, prior hospitalizations were shown to have a significant effect on a person's likelihood to be restored to competency in an OCR program; individuals in OCR programs who had zero (86.0 percent) or one (80.5 percent) prior psychiatric hospitalizations were more likely to be successfully restored to competency than individuals who had two (67.8 percent) or three or more (68.7 percent) prior hospitalizations.[311] Figure 60 below shows some of the most important components of successful OCR programs.

Figure 60. Most Important Factors Impacting Success of OCR Programs



Source: Hogg Foundation for Mental Health. (July 2015). *Texas Outpatient Competency Restoration Programs: Evaluation Report.* Page 16.

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."[312] 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).[313]

In Texas, OCR costs an average of $21,208 less per individual restored to competency compared to inpatient competency restoration.[314] Diverting individuals from inpatient competency restoration programs into OCR programs can also have the benefit of reducing forensic waitlists and free up state hospital beds for individuals with more severe needs and/or risk factors.[315]

Figure 61 compares the three different types of competency restoration programs based on cost, length of stay, and restoration success rate. As demonstrated in Figure 61, Texas's outpatient competency restoration programs provide treatment at lower costs and with higher success rates than the San Bernardino jail-based competency restoration program.

Figure 61. Comparison of Competency Restoration Programs**

Type of Program	Cost Per Day	Avg. Length of Stay	Avg. Total Cost per Individual Served	Success Rate
State Psychiatric Hospital[317] (FY 2012)	$421	120 days	$50,520	75% restored
Outpatient Competency Restoration[318] (FY 2013)	$229	128 days	$29,312	58% restored or improved with charges dropped*
Jail-Based Competency Restoration[319] (San Bernadino, CA program, FY 2012)	$278	63 days	$17,514	45% restored

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

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

SUBSTANCE USE SERVICES

According to the most up-to-date statistics from Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 20.2 million adults in America struggled with substance use disorders in 2014.[319] The addition of children between the ages of 12 and 18 increases that number by another 1.3 million for a total of 21.5 million Americans over age 12 with a substance use disorder — that is 8.1 percent of the total U.S population in 2014.[320]

Substance use can result in serious behavioral and emotional challenges — it has the potential to alter an individual's brain chemistry, and long-term usage can negatively impact behavior, judgment, mood, thought processes, and memory. Continued and persistent substance use can also lead to chemical dependency and drug addiction. Ultimately, substance use has a significant effect on the individual, family, and the community as a whole, and it can both create mental health conditions and exacerbate existing ones.

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 focused on how LMHAs can better integrate substance use services with the mental health services typically provided by LMHAs. As a result of SB 1507 (84th, Garcia/Naishtat), the Outreach, Screening, Referral and Assessment (OSAR) providers responsible for substance use screenings and referrals for substance use services are now co-located with LMHAs across all of Texas.[321]

The HHS System provides substance use services for eligible youth and adults and contracts with service providers to deliver treatment. The Medical and Social Services Division is responsible for creating and implementing policies regarding substance use services and defining optimal treatment outcomes. Within that division, the Substance Abuse Prevention, Intervention, and Treatment (SAPIT) Program's primary goal is to provide supports and services for substance use prevention, intervention, and treatment**.** Figure 62 describes the program's major activities relating to substance use. [322]

Figure 62. Major Programs within Substance Abuse Prevention, Intervention, and Treatment (SAPIT)

Program	Goals and Services Provided
Substance Abuse Prevention	Services include education, skills training for youth and families, community coalition-building, and 11 Prevention Resource Centers (PRCs) that serve as regional information clearinghouses to disseminate data and up-to-date resources.
Substance Abuse Intervention	Includes OSAR, which operates much like LMHAs by serving as the first point of contact for individuals seeking treatment for substance use. After an appointment with an OSAR counselor, referrals are made for inpatient treatment, outpatient treatment, or other appropriate services as needed. Besides OSAR services, the SAI program also offers: testing and case management for persons with HIV, specialized services for females such as pregnant/postpartum outreach, and special initiatives such as the rural border intervention program for persons at high risk of developing substance use issues.
Substance Abuse Treatment	Addresses the client's psychosocial and family systems to understand appropriate substance use or dependency treatment needs. Treatment services are evidence based, holistic, and emphasize coordination of care across the continuum of need. These services include both inpatient and outpatient programs funded by DSHS.
Recovery Support Services	In May of 2014, 22 different organizations began Recovery Support Service pilot programs across Texas, including 14 substance use treatment programs, six community-based programs, and two peer-run recovery organizations. The Recovery Support Services pilots have the goal of increasing focus on three areas: · Peer-support services; · Aligning treatment services with a recovery-oriented approach; and · Expanding community supports to help individuals successfully integrate into their communities.[323] While a full evaluation of the 22 pilot projects is still underway, over 10,000 individuals have received more than 35,000 hours of recovery support services as of February 2016, and initial reports show that these services help increase participants' ability to maintain housing, employment, and abstinence.[324]
Tobacco Prevention and Control	This division works to reduce tobacco-related health problems. The program focuses on preventing tobacco initiation, supporting cessation efforts, eliminating tobacco-related health disparities, reducing youth access to tobacco, and maintaining the infrastructure throughout the state to carry out these goals.

Figure 63. Available HHSC Substance Use Treatment Services

Type of Service	Target Population (Adult-Only, Youth-Only, or Both)
Screening	Both
Assessment	Both
Referral	Both
Residential intensive	Both
Residential intensive (specialized female)	Both
Residential intensive (women and children)	Both
Residential supportive	Both
Residential supportive (specialized female)	Both
Residential supportive (women and children)	Both
Residential detox	Adults Only
Residential detox (specialized female)	Adults Only
Ambulatory detox	Adults Only
Ambulatory detox (specialized female)	Adults Only
HIV residential	Adults Only
Outpatient services	Both
Individual	Both
Female	Both
Group	Both
Adolescent support	Youth Only
Family counseling	Youth Only
Family support	Youth Only
Psychiatrist consultation	Youth Only
Outpatient services (specialized female)	Adult
Individual	Adult
Group	Adult
Opioid substitution therapy	Adults only
Co-occurring psychiatric & substance use conditions	Both

Source: Texas Health and Human Services. (2016, October 12). Personal Communication: Available Substance Use Treatment Services.

ACCESS TO SUBSTANCE USE SERVICES

Only a small portion of individuals needing substance use treatment receive the appropriate services. In Texas in FY 2013, 18,088 (or 10.4 percent) of the 174,730 adults living below 200 percent of FPL with chemical dependence were served by state-funded substance use providers, including the NorthSTAR program.[325] Additionally, only 47,086 (or 38.4 percent) of the 122,580 children living below 200 percent of FPL with chemical dependence received services through DSHS or NorthSTAR; this means the majority of children living in poverty with substance use

treatment needs did not receive state-funded treatment services.* This discrepancy between need and utilization could result from shortages of substance use providers, low funding, waiting lists for services, stigma surrounding seeking services for drug use, worries about having drug use reported to law enforcement, and a general perception that mental health priorities take precedence over substance use priorities.[326]

** It should be noted that these figures for substance use service utilization don't include the number of individuals who are not living in poverty (i.e., below 200 percent of FPL) but may still have trouble accessing state-funded substance use services due to their falling in the Medicaid coverage gap and not having the financial resources to pay for services on a sliding scale.*

FUNDING FOR SUBSTANCE USE SERVICES

The level of public funding for substance use services is not sufficient to address need, creating significant barriers to treatment. The state is attempting to address these concerns by expanding the capacity of the substance use treatment delivery system beyond the level established by the Legislative Budget Board (LBB).

In 2013, legislators increased substance use funding by over $25 million, including nearly $11 million to increase provider reimbursement rates for substance use services in an attempt to attract new and competitive providers into the service system. The introduction of competitive service providers aimed to incentivize higher service quality, treatment, and recovery rates. During the 84th legislative session, DSHS received a $9.5 million increase for Substance Abuse Prevention, Intervention and Treatment services for the 2016-17 biennium.[327]

Figure 64. Funding Trends for Substance Use Services

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019	Exceptional Items Request 2018	Exceptional Items Request 2019
Substance Abuse Prev/Inter-vention/ Treatment	$153,660,796	$205,627,295	$189,826,370	$187,024,788	$187,024,787	$11,734,183	$11,734,183

Source: Data captured from HHSC and DSHS Legislative Appropriations Request for FY 2018/19, September 2016.

ELIGIBILITY FOR SUBSTANCE USE SERVICES

Following concerns in the 81st Legislative session about the high costs of treating substance use disorders, adults with substance use disorders who are on Medicaid began having access (on September 1, 2010) to inpatient and outpatient services (e.g., assessment, ambulatory detoxification, counseling, inpatient treatment, medication therapy, and specialized services for women) to treat substance use disorders free of cost.[328] As a part of the legislation authorizing coverage of these services, the Legislative Budget Board (LBB) was mandated to conduct a cost effectiveness analysis to see whether covering substance use treatment for adults increased overall Medicaid spending for those clients.[329] The LBB's

analysis of the cost effectiveness of paying for substance use treatment was incomplete due to data limitations, but the LBB's initial results indicate a 9.1 percent reduction in overall costs to Medicaid before substance use treatment ($900) and after treatment ($818). HHSC is planning to replicate the LBB cost analysis with more complete data and continuation of funding for substance use treatment under Medicaid will be dependent on the results of this second, more complete evaluation.[330,331]

Similar to the financial eligibility process for mental health services at LMHAs, individuals who are not eligible for Medicaid but are seeking state-funded substance use services must complete a financial assessment before beginning services with the substance use providers. Individuals whose adjusted income is at or below 200 percent of FPL are eligible for fully funded substance use services. If their adjusted income is greater than 200 percent, individuals will be assessed a fee on a sliding scale.

PRIORITY POPULATIONS

Three populations receive priority for admission to substance use services before anyone else, in the following order of priority:[332]

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

Additionally, youth age 13 to 17 who meet the DSM-V criteria for substance-related and addictive disorders are eligible for treatment services.[333] Adults ages 18 to 21 may be admitted to a youth treatment program depending on the individual's specific needs, experiences, developmental level, and behavior.[334]

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental illness and substance use disorders commonly occur in persons at the same time. Looking at national data from 2014:

- 35.6 million adults had a mental health diagnosis and no substance use disorder;
- 12.3 million adults had a substance use disorder and no mental health diagnosis; and
- 7.9 million adults had both a mental health and substance use diagnosis, of which:
  - 39.1 percent of individuals using substances had a mental health diagnosis; and
  - 18.2 percent of individuals with a mental health diagnosis also used substances.[335]

The high prevalence of these comorbidities demonstrates the need for interventions and policies that support dual diagnosis treatment — integrated treatment that addresses both conditions in concert. When examining the relationship of co-occurring psychiatric and substance use disorders, the following scenarios should be considered:[336]

- Drug use can lead to mental illness;
- Mental illness can lead to drug use; and
- Drug use and mental illness can be the result of other independent common risk factors.

The Texas HHS System supports the integration of substance use and mental health services for the simultaneous treatment of co-occurring disorders. The goal of co-occurring psychiatric and substance abuse disorder (COPSD) services is to provide coordinated services, wherein both conditions are treated in conjunction as the primary condition. The Medical and Social Services Division contracts with 488 outpatient substance use treatment facilities and 160 residential treatment facilities for this specialty service.[337] In FY 2015, 3,772 individuals were served through COPSD programs.[338]

SUBSTANCE USE SERVICES: UTILIZATION AND COSTS

The following two figures show the utilization and costs of substance use services; Figure 65 details information for adults and Figure 66 is for children and adolescents.

Figure 65. Utilization and Costs for Adult Substance Use Services

		2011	2012	2013	2014	2015
Prevention program	Number served per year	468,054	468,054	492,957	784,257	601,399
	Annual cost per adult	$16	$16	$15	$13	$19
Intervention programs	Number served per year	123,914	141,299	167,032	95,896	82,227
	Annual cost per adult	$89	$71	$60	$116	$182
Treatment programs	Number per year	31,627	31,206	31,303	32,816	32,250
	Annual cost per adult	$1,617	$1,582	$1,617	$1,764	$1,766
Total number of adults on a wait list for substance use treatment		8,193	9,034	10,516	10,119	10,624

Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

Figure 66. Utilization and Costs for Child & Adolescent Substance Use Services

		2011	2012	2013	2014	2015
Prevention program	Number served per year	1,843,263	1,920,024	1,939,809	1,875,143	1,716,359
	Annual cost per youth	$14	$14	$13	$13	$15
Intervention programs	Number served per year	26,519	58,903	68,977	16,519	7,025
	Annual cost per youth	$127	$55	$44	$98	$228
Treatment programs	Number per year	5,418	4,886	4,848	4,941	4,760
	Annual cost per youth	$3,713	$3,645	$3,246	$3,693	$3,630
Total number of children and adolescents on a wait list for substance use treatment		612	809	753	512	438

Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

SUBSTANCE USE SERVICES: QUALITY OF CARE MEASURES

HHSC monitors quality and performance in several areas based on the TRR framework. Figure 67 shows some of the measures tracked on a regular basis for adult substance use services and Figure 68 shows the same for children and adolescent services.

Figure 67. Selected Quality of Care Measures for Adult Substance Use Services

Of All Adults Entering a Substance Use Treatment Program:	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Percentage of adults completing a program per year	56%	53%	52%	49%	53%
Percentage of adults completing a program who report abstinence at discharge	89%	89%	90%	91%	92%
Percentage of unemployed adults completing a program who have gainful employment at discharge	52%	56%	59%	58%	51%
Percentage of adults completing a program not arrested	100%	100%	100%	100%	100%

Sources: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

Figure 68. Selected Quality of Care Measures for Youth Substance Use Services

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Percentage of youth completing substance use treatment programs per year	54%	52%	52%	44%	51%
Percentage of youth completing substance use treatment programs reporting abstinence at discharge	89%	89%	90%	89%	91%
Percentage of youth completing substance use treatment programs with positive school status at follow-up per year	83%	77%	75%	75%	78%
Percentage of youth completing substance use treatment programs not arrested	99%	99%	99%	99%	99%

Sources: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter* [PowerPoint slides]. Retrieved from http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

SYSTEMS OF CARE AND THE TEXAS RECOVERY INITIATIVE

The Texas Recovery Initiative (TRI) began in 2007 with the goal of ensuring that needed person-centered services and resources are available to support individuals in their recovery from a substance use disorder.[339] The purpose of the multi-phase TRI is "to gather information and recommendations for designing protocols that implement holistic, recovery-oriented models of care for use within the behavioral health community."[340] In order for a delivery system to be recovery-oriented, it must be person-centered, multi-disciplinary, and use coordinated treatment plans and a comprehensive array of services that allows individuals receiving services to take responsibility for their own recovery.

The Texas Recovery Initiative is supported by the Recovery Oriented System of Care (ROSC) framework, which coordinates "multiple systems, services, and supports that are person-centered, self-directed, and designed to readily adjust to meet the individual's needs and chosen pathway to recovery."[341] ROSC is an organizational framework for mental health and social services that is strength-based and collaborative. An SOC framework is sensitive to the youth and their family's cultural and linguistic preferences and 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.[342] Care for youth with intensive support needs is coordinated across agencies, private and public organizations, and families so that children can overcome the barriers that prevent them from accessing the services they need. The Texas System of Care (SOC) Consortium was established in 2013 to improve the delivery of mental health services for youth with high needs in Texas by expanding the SOC services throughout the state.[343]

TRI and the ROSC/SOC approach provide the philosophical and organizational framework that is essential for the collaborative, systematic planning and delivery of child and family mental health services. Established in practice and research for over 25 years, systems of care have been proven nationally to be a cost-effective approach resulting in better child and family outcomes and increased access to services and supports.[344] TRI and the ROSC framework underscore the significance of community

partnerships and collaborations between federal and local governments, nonprofit organizations, and faith-based entities. By providing continual support, ROSC services aim to enhance individuals' strengths and functioning by building resilience and recovery management skills. DSHS is currently assisting communities statewide to initiate the ROSC framework in local municipalities by:

- Conducting on-site informational trainings to organize communities and assisting them with the development of the initial phase of this systems change approach for achieving recovery;
- Providing telephone and email technical assistance regarding the ROSC concept;
- Participating in person and via teleconferencing in local ROSC community meetings;
- Adding a week-long educational track on recovery during the Texas Behavioral Health Institute; and
- Assisting with development and training of recovery coaches.[345]

There are currently 43 counties in Texas that have implemented federally-funded SOC frameworks to serve families in their community, 13 counties that have established Texas SOC community expansion sites, and three counties (McLennan, Denton, and Midland) that are "communities of interest" for future SOC frameworks.[346] As of spring 2015, over half of Texans are living in communities that have established or are in the process of actively establishing SOC frameworks.[347] Surveys in early 2016 indicate that communities across the state are becoming more familiar with the SOC philosophy and approach to services. Communities that have implemented the SOC framework report having improved coordination across agencies and better collaboration between providers and youth and their families.[348] Moving forward, surveys indicate a need for the SOC framework to focus more on giving communities more concrete steps to achieve the goals of SOC.[349]

A full list of ROSCs across Texas can be found at www.dshs.texas.gov/substance-abuse/ROSC/ and a list of upcoming TRI meetings in the state can be found at www.dshs.texas.gov/sa/texasrecoveryinitiative/

Intellectual and Developmental Disability Services Department

(formerly provided through the Department of Aging and Disability Services)

POLICY CONCERNS

- Addressing the mental health needs of individuals with disabilities
- Coordination of services between HHSC divisions during and after transition process
- Service delivery during the HHSC transformation process
- Access to crisis services including emergency respite
- System-wide implementation of trauma-informed care, positive behavior supports, and person-centered recovery-focused practices
- Improved psychiatric services in state supported living centers and community-based supports
- Significant wait time for community-based services
- Reduction of restraint in SSLCs

FAST FACTS

- The coexistence of an intellectual or developmental disability (IDD) along with a mental illness is sometimes referred to as a dual diagnosis.[350]
- It is estimated that as many as 30 to 40 percent of persons with intellectual disabilities are diagnosed with a mental health condition.[351] Further, reports indicate that individuals who have IDD are three to five times more likely to have a co-occurring mental health condition than the general population.[352]
- Children with IDD are more likely to have experienced traumatic events including emotional, physical, and sexual abuse, neglect, and maltreatment when compared to able-bodied peers.[353] While many individuals with IDD have known histories of abuse (some research suggesting nearly 30 percent), the rate may be higher in reality because of underreporting or lack of recognition by family and other caregivers.[354]
- 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.[355] 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.[356]

MENTAL HEALTH NEEDS OF INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Intellectual and developmental disabilities (IDDs) 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 past trauma.

Many systems of care for people with IDD continue to focus on controlling and managing behaviors, without considering whether underlying mental health, medical conditions, or past 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 addresses the symptoms but not the illness.[357] This significantly reduces opportunities for recovery.

PREVALENCE OF MENTAL HEALTH CONDITIONS FOR PEOPLE WITH DISABILITIES

The coexistence of an intellectual or developmental disability (IDD) along with a mental illness is one type of dual diagnosis.[358] Individuals with intellectual disabilities experience the full range of mental health conditions at rates higher than the general population.[359] It is estimated that as many as 30 to 40 percent of persons with intellectual disabilities are diagnosed with a mental health condition.[360] Further, reports indicate that individuals who have IDD are three to five times more likely to have a dual diagnosis (with a psychiatric disability) than the general population.[361] 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.[362] 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.[363]

Children with IDD are more likely to have experienced traumatic events including emotional, physical, and sexual abuse, neglect, and maltreatment when compared to able-bodied peers.[364] While many individuals with IDD have known histories of abuse (some research suggesting nearly 30 percent), the rate may be higher in reality because of underreporting or lack of recognition by family and other caregivers.[365]

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.[366]

Further, while DSHS has integrated recovery-focused interventions into its mental health system, the HHS enterprise has not yet incorporated the principles of recovery into its culture. 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.

Individuals with disabilities can experience all types of mental health conditions and require access to quality mental health services. People with disabilities, while at a higher risk of having mental health conditions than the general population, often experience significant disparities in their ability to access needed services. The mental health needs of people with intellectual disabilities are routinely overlooked in the research and they often don't receive quality mental health treatment.[367]

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. [368, 369]

Over the past decade, evidence has also shown a high prevalence of mental health conditions in people with autism spectrum disorder (ASD). Recent research indicates that 70 percent of children 10-14 years old living with autism had at least one co-occurring mental health condition, and 41 percent had two or more mental health diagnoses.[370]

MENTAL HEALTH NEEDS OF AGING TEXANS

Texas is home to a large number of aging individuals. According to the U.S. Census Bureau, in 2010 there were 3.8 million people in Texas age 60 or older (15 percentof the total population).[371] This group is one of fastest growing populations in Texas, and is expected to more than triple between 2010 and 2050. By 2050, this group is expected to grow to 12 million.[372]

Aging Texans require mental health and substance use services that meet their unique needs. People who are aging experience under-recognized and under-treated behavioral health conditions. Approximately 20 percent of the older population has some form of behavioral health condition, most commonly depression, a substance use disorder, or dementia-related behavioral or psychiatric symptoms.[373] An estimated two million seniors in the United States have serious mental illness.[374] The suicide rate among older Texans (over age 55) is higher than the rate among younger groups.[375]

It is important to know that depression is not a normal part of aging.[376] However, depression often co-occurs with other serious illnesses, such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.[377] Many health professionals mistakenly conclude that depression is a consequence of these problems, leaving the condition widely unrecognized and undertreated among older adults.[378]

CHANGING ENVIRONMENT

Prior to the implementation of the HHS transformation plan, the Texas Department of Aging and Disability Services (DADS) was responsible for providing long-term services and supports (LTSS) for Texans over the age of 60, people with physical disabilities and people with intellectual and other developmental disabilities (IDD). LTSS (including both residential and community services) help individuals receive needed care and services to remain in their homes and communities of choice. DADS also had responsibility for regulating providers of LTSS and administering the state's guardianship program. As a result of the HHSC transformation, DADS as a separate agency will be abolished and the programs and services incorporated into the HHSC organizational structure. For more information on the transition of DADS services see the DADS section of this guide.

HB 1 (84th, Otto/Nelson) - Additional Funding for Crisis Intervention Teams for People with IDD

The HB 1 (84th, Otto/Nelson) set aside funds in the state budget to help DADS expand crisis intervention teams to provide increased supports to people with IDD living in the community. Appropriations will provide an additional $18 million in state and federal funds over the 2016-17 biennium.[379] This total exceeds the recommendation by the Sunset Commission for $7.5 million for ten additional teams.[380]

SB 304 (84th, Schwertner/Raymond)- "Three Strikes Rule"

SB 304 requires that the HHSC executive commissioner revoke the license of a nursing home found to have three or more serious violations related to abuse, exploitation, or neglect within a two-year period. A serious violation occurs when a facility's non-compliance with one or more requirements causes, or is likely to cause, serious injury, harm, impairment, or death to a resident, necessitating immediate corrective action. If a license is revoked, DADS can: 1) request the appointment of a trustee to operate the institution; 2) assist with obtaining a new operator for the institution; or 3) assist with the relocation of residents to another institution. Among other provisions, the bill provides for the monitoring of certain facilities, including long-term care facilities, and expands the circumstances under which rapid response teams can visit those facilities.

HB 2789 (84th, Raymond/Zaffirini)- Trauma-Informed Care within SSLCs and ICFs

Texas policymakers have recognized the impact of trauma on development and behavior and have statutorily mandated trauma-informed care training in the child welfare and the juvenile justice systems, as well as within some LTSS programs and facilities as a result of HB 2789 (84th, Raymond/Zaffirini). HB 2789 required DADS to develop or adopt trauma-informed care training for employees who work with individuals with IDD in SSLCs and Intermediate Care Facilities (ICFs). The training may be provided through online training. Training requirements for new employees of SSLCs and ICFs went into effect on September 1, 2015.[381] As a result of HB 2789, DADS and DSHS collaborated to create an online training module titled "Trauma Informed Care for Individuals with IDD" as one module in a comprehensive online course, *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD)*. The training is available online at: https://tango.uthscsa.edu/mhwidd.

For information on DADS riders in the appropriated budget for FY 2016 and FY 2017, please see our Legislative Summary in Appendix X.

SB 7 (83rd, Nelson/Raymond) – Acute Care and Long-term Services and Supports

SB 7 required major changes in the delivery of both acute care and long-term services and supports (LTSS) to people with disabilities. See the HHSC section for more detailed information on the changes that have occurred and those that will be implemented in the coming year. Many of the changes in SB 7 involved expanding Medicaid managed care to provide services to people with disabilities. The SB 7

IDD System Redesign Advisory Committee is helping HHSC develop future service delivery systems that can better serve individuals with disabilities.

HB 3523 (84th, Raymond/Perry) IDD System Redesign Advisory Committee

HB 3523 reinforces the role of the IDD System Redesign Advisory Committee that was established through SB 7. HB 3523 delays the transition of Texas Home Living (TxHmL) by one year to September 1, 2018, and delays the transition of other IDD waivers and ICFs to managed care by one year, until September 1, 2021.[382] The bill also changes the start date of the IDD pilot to September 1, 2017 and removes requirements that the pilot last at least two years, as well as clarifies that managed care organizations can participate in the pilot.[383] HB 3523 clarifies that DADS can contract with IDD waiver service providers to deliver basic attendant and habilitation services (Community First Choice[CFC]) and specifies that DADS has regulatory and oversight authority over those providers in the delivery of CFC services.[384] Further, the bill requires additional analysis of provisions required by SB 7. The required analyses must inform future transition activities, including evaluation how these activities effect access to LTSS, quality of acute care and LTSS, outcomes, service coordination, employment options, housing, etc.[385]

SB 45 (83rd, Zaffirini/Naishtat) Employment Assistance and Supported Employment Services

In an effort to standardize the Medicaid waiver programs, SB 45 required the inclusion of employment assistance and supported employment services in all of the 1915(c) Medicaid home and community-based waivers and the STAR PLUS waiver in the 1115. Employment assistance is intended to help individuals with IDD find and secure a job according to the individual's preferences and individualized needs. Supported employment services is meant to assist not only with job placement, but also with daily job orientation and tasks to improve the longevity and successfulness of individuals with IDD in their employment, including employment adaptations and supervision.

SB 1226 (83rd, Zaffirini/Perez) – Employment First Task Force

SB 1226 created the Employment First Task Force to advise the state on its efforts to promote competitive employment for individuals with disabilities. The bill further established competitive employment as the desired outcome for people with disabilities. The bill further established competitive employment as the desired outcome for working-age people with disabilities who receive public benefits. Competitive employment is considered to be work in the labor market that is performed on a full-time or part-time basis in an integrated setting for which the individual is compensated at or above minimum wage, but not less than the customary and usual wage paid by an employer for the same or similar work performed by individuals who do not have a disability. The Employment First Task Force is comprised of self-advocates, employers, agency representatives (including TEA, HHSC, DARS, and DADS), providers of integrated and competitive employment services and other stakeholders who would like to increase opportunities for individuals with disabilities to find employment in competitive settings. As a result of the task force, HHSC (on behalf of all HHS agencies), TEA, and TWC all adopted an Employment First philosophy. Among its recommendations,

the task force wishes to bring the needs of individuals with more severe disabilities into the current discussion about inclusive employment services, as well as to end segregated employment and sub-minimum wage work for people with disabilities. The task force released a report in October 2014 with 72 recommendations. Find the most up-to-date information on task force activities and meetings at https://hhs.texas.gov/services/disability/employment/employment-first/employment-first-task-force.

FUNDING

Funding for LTSS program and services comes from both the federal and state governments. These figures include funding for an array of LTSS services and not limited to funding for mental health services.

Figure 69. LTSS Funding Trends and Requests

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019	Exceptional Items Request 2018	Exceptional Items Request 2019
Day Activity & Health Services	$7,886,545	$8,658,115	$8,822,412	$8,826,868	$9,458,542	$117,471	$121,402
Nursing Facility Payments	$1,357,454,134	$297,199,523	$299,250,636	$265,432,662	$315,486,226	$2,506,131	$1,221,484
Medicare Skilled Nursing Facility	,	$59,489,743	$50,387,328	$38,943,225	$57,069,377	0	0
Hospice	$256,600,233	$255,232,852	$272,048,636	$234,983,319	$271,202,479	0	0
Intermediate care Facilities – IDD	$269,727,154	$269,018,597	$269,298,561	$241,885,837	$263,216,275	$2,000,078	$2,002,733
Home and Community-based Services	$947,217,383	$1,079,856,374	$1,211,979,830	$1,200,481,108	$1,241,063,894	$190,545,882	$528,959,887
Community Living Assistance	$225,443,448	$238,826,476	$266,704,373	$246,048,017	$264,498,000	$75,006,330	$184,876,052
Deaf-Blind Multiple Disabilities	$9,393,172	$11,190,335	$12,777,600	$12,283,292	$13,166,800	$373,608	$674,818
Texas Home Living Waiver	$61,057,640	$117,145,547	$105,559,272	$90,722,978	$96,626,880	$12,197,155	$46,521,754

Strategy	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019	Excep-tional Items Request 2018	Exceptional Items Request 2019
All-Inclusive Care – Elderly (PACE)	$37,531,672	$41,507,058	$45,237,024	$44,277,843	$44,372,116	$6,733,111	$6,761,197
Medically Dependent Children's Program	$88,644,809	$92,299,005	$93,595,371	0	0	$8,069,057	$18,488,767
State Sup-ported Living Centers	$684,111,674	$702,396,976	$689,157,263	$668,105,568	$666,622,891	$34,755,899	$41,348,787
Total	$3,945,067,864	$3,172,820,601	$3,324,818,306	$3,051,990,717	$3,242,783,480	$332,304,722	$830,976,881

Source: Data captured from HHSC and DADS Legislative Appropriations Request for FY 2018/19, September 12, 2016.

Note: The funding reflected in this figure 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.

The reduction in nursing facility payments is due to the transition of these services into managed care as of 3/1/15.

PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES WHO HAVE CO-OCCURRING BEHAVIORAL HEALTH CONDITIONS

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

COMMUNITY LONG-TERM SERVICES AND SUPPORTS

In addition to Medicaid and Medicaid waiver services, HHSC is now responsible for the administration of community long-term services and supports. 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 be eligible for community-based services funded by HHSC if they also meet financial eligibility criteria. Some of the major community service programs are described below.

MEDICAID 1915(C) WAIVER SERVICES

HHSC now administers 1915(c) Medicaid Home and Community-based Services waiver programs (previously administered through DADS), 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 ranges from three to more than 10 years.

Figure 70 provides basic information about eligibility and services for three primary waivers for persons with intellectual and other developmental disabilities.

Figure 70. Community-Based Waiver Eligibility and Behavioral Health-Related Services for people with Disabilities

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
Home and Community-based Services (HCS)	Individuals of any age with an intellectual disability diagnosed before age 22. Must have an IQ score below 70 or a related condition and an IQ score below 75. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than $2,000. Parental income is not considered.	· Case management · Behavioral support, including social work and psychology · Day habilitation · Respite · Nursing services · Employment services · Supported employment · Residential assistance including: · supported home living · foster/companion care · supervised living (group home) · residential support
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.	· 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 below 70 or a related condition with an IQ below 75. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than $2,000. This is the only waiver that considers parental income when determining financial eligibility for children.	· Case management · Behavioral support · Day habilitation · Habilitation · Community support · Respite · Employment services · Supported employment · Specialized therapies

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
Deaf/Blind/Multiple Disabilities (DBMD)	Individuals with deaf-blindness and one or more other disabilities who meet eligibility for intermediate care facilities.	· 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 (DAHS)	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.	· Noon meal and snacks · Nursing and personal care · Physical rehabilitation · Social, educational and recreational activities · Transportation

Sources: Texas Department of Aging and Disability Services. (2015). *Reference Guide 2015.* Retrieved from http://www.dads.state.tx.us/news_info/budget/docs/fy15referenceguide.pdf

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

ROLE OF LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES (LIDDA) IN CONNECTING PEOPLE TO WAIVER SERVICES

There are 39 local intellectual and developmental disability authorities (LIDDAs) in Texas that cover all 254 counties and serve as the front door for long-term services and support programs for people with intellectual and developmental disabilities (IDD), including those who also have co-occurring mental health conditions. While the LIDDAs may co-locate with local mental health authorities across the state, the two entities have separate administrative authorities and are not the same. LIDDAs connect individuals with IDD to long-term services and supports, which includes state supported living centers (SSLCs), Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Medicaid waiver programs, safety net services, and Community First Choice (CFC).[386]

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 (TCM) services, maintaining Interest Lists for IDD Medicaid waivers, conducting Preadmission Screening and Resident Review (PASRR) evaluations for persons with IDD seeking admission to a nursing facility, providing continuity of care, and completing the Community Living Options Information Process (CLOIP) for persons residing in SSLCs. LIDDAs are also responsible for permanency planning for individuals less than 22 years of age who live in intermediate care facilities, state supported living centers, nursing facilities, and HCS group homes.

To identify the LIDDA serving a specific location, please refer to the LIDDA website https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-idd-authority-lidda.

Institutional Long-Term Services and Supports

Persons with disabilities residing in nursing facilities, privately operated intermediate care facilities, or in large state-operated supported living centers often experience co-occurring behavioral health conditions. Funding for these residential services is provided primarily through Medicaid. *The state supported living centers currently administered through DADS will transition to the State Operated Facilities Division of HHSC by September 1st, 2016. While that change has not yet occurred and the SSLCs will not be included in the Medical and Social Services Division, information is included in this section for comparison purposes.*

Skilled Nursing Facilities

Texas nursing facilities provide institutional care for older Texans and people with disabilities whose medical condition requires skilled licensed nursing services. In FY 2014, there were 1,224 licensed nursing facilities in Texas.[387] 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:[388]

- 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

In 2013, the Centers for Medicare and Medicaid Services directed Texas to make changes to the PASRR program. Three major changes included:

- Eliminating the role of nursing facilities in the PASRR Evaluation determination process by introducing local authorities (LA) as the party that will complete the PASSR 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.[389]

Community Intermediate Care Facilities

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 those

meeting eligibility criteria. Community-based ICFs can be licensed to provide services to people with intellectual disabilities or other developmental disabilities, referred to as related conditions. As of September 2016, there were 833 licensed ICFs in Texas.[390] These facilities provide residential services similar to the state supported living centers but are privately owned and operated. Community ICF facilities vary in size from six beds to over 160 beds; most community-based ICFs are small, with eight or fewer beds.

State Supported Living Centers (will transfer to HHSC by September 1st, 2017)

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

Approximately 3,145 individuals reside in these facilities.[391] 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 the SSLCs during the 84th legislative session due to the DADS Sunset Recommendations to close six SSLCs, including closing the Austin SSLC by September of 2017. As mentioned earlier, ultimately the legislature voted to keep the Austin SSLC and all other SSLCs operational. In Texas, only the Texas legislature can direct closure of a state supported living center.

Due to fixed costs and the deterioration of aging facilities, as the census in these facilities declines, the per person costs increase. According to the Sunset Commission final report, maintaining the large system of state-run facilities is costly, involving more than 13,900 employees and a budget of $661.9 million a year.[392] An HHSC report revealed that delivering services to a person in an SSLC costs $856.70 per day, totaling over $360,000 per year.[393] Further, maintaining the SSLCs' dilapidated infrastructure adds even more cost to the state.[394]

Figure 71. State Supported Living Center Enrollment Trends and Projections, Fiscal Years 2010-2019

FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016 (Projected)	FY 2017 (Projected)	FY 2018 (Projected)	FY 2019 (Projected)
4,207	3,993	3,756	3,547	3,362	3,186	3,075	2,931	2,787	2,643

Source: Texas Department of Aging and Disability Services (2016, May). *State Supported Living Centers Long-Range Plan May 2016.* Retrieved from https://www.dads.state.tx.us/services/SSLC/draft-sslc-planningreport-5-16.pdf

As part of a 2009 settlement agreement with the U.S. Department of Justice over conditions at SSLCs, DADS agreed to improve health, safety, and quality of care for consumers living in them. The agreement includes increased access to psychiatric care and psychological services, as well as improved policy and practices to reduce of the use of restraints. Independent monitors were assigned in mid-2014 to visit and

report on conditions at all 13 SSLCs.[395] Despite the 2009 agreement, the June 2015 monitoring report for the Austin SSLC continued to identify significant deficiencies.[396] The 2015 monitoring report also identified instances of "individuals receiving psychiatric services who were not making progress or maintaining stability."[397] Other monitoring reports in 2015 identified deficiencies at all of the SSLCs related to psychiatric and psychological services, including individual residents not progressing toward psychiatric goals and not maintaining psychiatric stability.[398]

Figure 72 presents information on the eligibility requirements and services provided by institutional providers of LTSS services.

Figure 72. Institutional Care Eligibility and Behavioral Health-Related Services

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
Nursing Facilities	· Have a medical condition that requires the skills of a licensed nurse on a regular basis. 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.	24-hour residential care and services that include: · PASRR (see above) · Behavioral health services · Medication management · Skilled nursing · Specialized therapies/services · Rehabilitative therapies
Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions	· Have a diagnosis of intellectual disability with a full-scale IQ score of below 70 and an adaptive behavior level with mild to extreme deficits, or · Have 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, or · Have 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, AND · Be 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.	24-hour residential care and services that include: · Physician services · Behavioral health services · Medication management · Nursing · Skills training · Occupational, physical and speech therapies · Services to maintain connections between residents and their families/natural support systems

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
State Supported Living Centers	· 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.[399]	24-hour residential care and services that include: · 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://www.dads.state.tx.us/news_info/budget/docs/fy15referenceguide.pdf

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

Figure 73 shows the trends over the past three years of the number of individuals in each Medicaid 1915(c) waiver program with a co-occurring mental health condition.

Figure 73. Percentage of People Enrolled in DADS Programs with a Behavioral Health Diagnosis

	FY2013				FY2014			FY 2015	
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

Intellectual and Developmental Disability Services Department

Intellectual and Developmental Disabilities & Behavioral Health Services

Medical and Social Services Division

HHSC

Health, Developmental, and Independence Services

This department include two units:

- Rehabilitative & Social Services
- Health & Developmental Services

REHABILITATIVE AND SOCIAL SERVICES UNIT

The Rehabilitative and Social Services Unit includes programs and services transferred from DARS to HHSC. The programs in this unit offering services to individuals living with mental illness include:

- Independent Living Programs
- Rehabilitative Services and Supports
- Guardianship

INDEPENDENT LIVING SERVICES PROGRAM

The Independent Living Services Program is intended to promote self-sufficiency for individuals with one or more significant disabilities.[400] Services within the Independent Living (IL) Program seek to provide the individual with "consumer control, peer support, self-help, self-determination, equal access and self-advocacy."[401] In FY 2015, 6,159 individuals received services under a plan or waiver from independent living centers. An additional 121,423 individuals without a plan or waiver received services from a Center for Independent Living.[402] In FY 2015, the average monthly cost per consumer was $437.[403]

Sunset legislation required both the blind and general independent living services programs to be combined into one Independent Living Program within HHSC.[404] However, the Independent Living Services for Older Individuals Who are Blind transferred to TWC on September 1, 2016, along with other programs for individuals who are blind including the Vocational Rehabilitation Services, Blind and Visually Impaired Services, and the Business Enterprises of Texas Program.[405] More information on these programs can be found in the TWC section of this guide.

The Independent Living Services Program partner with Centers for Independent Living (CILs) located around the state. These CILs are private, nonprofit, nonresidential centers that provide an array of independent living programs. CILs partner with HHSC (formerly with DARS), DADS and community-based organizations and are funded either privately or with state and federal funds. There are currently 27 CILs across Texas, 15 of which are funded by DARS. These 27 CILs serve 157 out of 254 Texas counties and are located in: Abilene, Amarillo, Angleton,

Austin, Beaumont, Belton, Bryan, Crockett, Corpus Christi, Dallas, Denton, El Paso, Fort Worth, Houston, Laredo, League City, Lubbock, McAllen, Odessa, Palestine, Plano, Round Rock, San Angelo, San Antonio, San Marcos, Sugarland, and Tyler.[406]

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 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.[407]

Services

Independent living services may include:

- Counseling and guidance
- Training and tutorial services
- Adult basic education
- Rehabilitation facility training
- Telecommunications, sensory and other technological aids for people who are hearing-impaired
- Vehicle modification
- Assistive devices such as artificial limbs, braces, wheelchairs, and hearing aids to stabilize or improve function
- Other services as needed, such as transportation, interpreter services, and maintenance, in order to achieve independent living objectives. [408]

SERVICES FOR INDIVIDUALS LIVING WITH BLINDNESS AND VISUAL IMPAIRMENTS

Figure 74 lists the programs and services formerly provided by DARS to achieve increased quality of life outcomes for Texans who are blind or have visual impairments. Figure 74 also provides an overview of the programs and services moving to HHSC.

Figure 74. Services for Individuals Who Are Blind and Visually Impaired Services

Program Name	Services	Number Served	Average Cost Per Individual
Blind Children's Vocational Discovery and Development Program	Assists children and youth up to 22 years old in developing the confidence and competence to become fully active members of their community.	4,053	$112[409]
Blindness Education, Screening and Treatment Program	Program goal is to prevent blindness. Also assists uninsured adults with paying for urgently needed eye-medical treatment.	3,353	$104[410]
Deaf and Hard of Hearing Services	Provides a variety of services including: communication access services, issuing equipment and service vouchers, issuing interpreter certificates, educating consumers and interpreters.	68,270[411]	n/a*

Source: Texas Department of Assistive and Rehabilitative Services. (2016). *Annual Report 2015.* Retrieved from http://www.dars.state.tx.us/reports/annual2015/annualreport2015.pdf

*The Deaf and Hard of Hearing Services Program provides a wide variety of services including communication devices and issuing interpreter certificates. There is not an accurate average cost per individual for this program due to the wide variety of services offered.

COMPREHENSIVE REHABILITATION SERVICES

The Comprehensive Rehabilitation Services (CRS) program serves people who have experienced traumatic brain injuries (TBIs) and/or traumatic spinal cord injuries (SCIs).[412] The program is intended to ensure that consumers who have TBIs and/or SCIs receive individualized services to improve their functioning within the home and community to promote independence.[413] In FY 2015, a total of 983 individuals were served, with 669 new applications received.[414] CRS also had 333 successful case closures, with 93 percent of individuals living at home or with family at time of closure. The average monthly cost per individuals is $3,840.[415]

Within CRS, consumers have the following conditions:

- 62% Traumatic Brain Injury (TBI)
- 32% Spinal Cord Injury (SCI)
- 6% both TBI and SCI[416]

CRS moved from DARS to HHSC on September 1, 2016.[417]

GUARDIANSHIP PROGRAM

The Guardianship Services program provides guardianship services to people referred by the Texas Department of Family and Protective Services, 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. In order for HHSC to provide guardianship services, lesser 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 an expectation that guardianship will meet the person's needs.[418]

The DADS self-evaluation submitted to the Sunset Commission in 2013 indicates that in 2012 there were, on average, 913 individuals receiving guardianship services from DADS at an average monthly cost of $432 per adult individual.[419] (Note: this is the most updated information available on DADS guardianship services available at print date)

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

- Incapacitated children upon reaching the age of 18 who have been in CPS conservatorship;
- Incapacitated adults age 65 or older, or between the ages of 18-65 with a disability, who were referred by Adult Protective Services (APS) following an investigation in which abuse, neglect, or exploitation was confirmed, and no other means of protecting the person is available and there is some indication the individual lacks capacity;and
- Incapacitated individuals referred directly to the program by a court with probate authority under certain criteria established in statute or rule.[420]

During the last legislative session, two bills passed that included supported decision-making agreements: HB 39 (84th, Smithee/Zaffirini) and SB 1881 (84th, Zaffirini/Peña). Supported decision-making is assistance in helping an adult with a disability understand the options, responsibilities, and consequences of their life decisions, without someone making those decisions on behalf of the adult with a disability.[421] Additionally, a number of related bills were adopted ensuring that attorneys and judges explore all alternatives to guardianship prior to appointing a guardian. The 84th legislative session provided no movement toward utilizing person-first language by changing the term "ward" to "person under guardianship," which many stakeholders prefer and consider more respectful.

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 when not addressed. Providing services to families and children at an early stage in development can reduce the cost of special needs services, enable families to provide support to their special needs children, and counter environmental risk factors.[422]

ECI is authorized by Part C of the Individuals with Disabilities Education Act (IDEA); 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.[423] State general revenue funds are required to draw down federal funding for ECI programs. The operating budget for ECI in the 2016-2017 biennium was $140,691,606.[424]

A Child's Journey through ECI:

Getting Started

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

Next Steps: ECI Services

4. Individualized Family Service Plan Meeting and Individualized Family Service Plan Development
5. ECI Service Delivery Begins
6. Review of Child's Progress

Future Steps: Leaving ECI

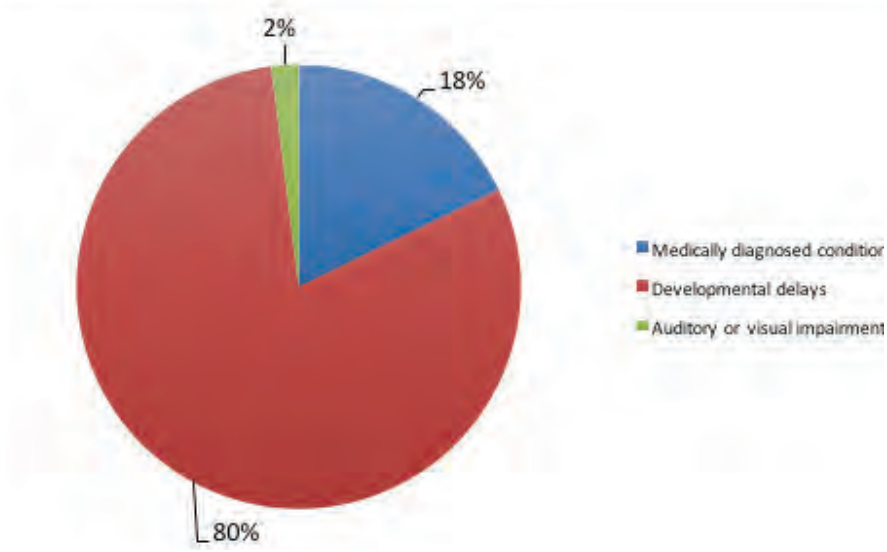
7. Children must transition out of ECI by their third birthday.[425]

Eligibility for Services

To determine eligibility for ECI services, a team of at least two professionals from different disciplines performs a comprehensive evaluation of a child's abilities. Generally, eligibility is determined by a child meeting at least one of following three criteria:[426]

- **Medically diagnosed condition:** Children with medical diagnoses that have a high probability of resulting in developmental delays. For a list of diagnoses that qualify for ECI see http://www.dars.state.tx.us/ecis/resources/diagnoses.asp.
- **Auditory or visual impairments:** Children with auditory or visual impairments as defined by the Texas Education Agency (TEA).[427]
- **Developmental delays:** Children with developmental delays of at least 25 percent that affect function in one or more areas of development.[428]

Figure 75. Reasons for Eligibility for X Programs/Services



Source: Texas Department of Assistive and Rehabilitative Services. (2016). *DARS Annual Report 2015.* Page. 38. Retrieved from http://www.dars.state.tx.us/reports/annual2015/annualreport2015.pdf

ECI evaluates a child for developmental delay using the Battelle Developmental Inventory, which includes an assessment of the child's social and emotional delays.[429] 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.[430]

Services, Utilization, and Costs

Eligible children can participate in ECI regardless of their income level and certain ECI services are free of charge, including evaluation and assessment, case management, development of an Individualized Family Service Plan (IFSP), and translation and interpreter services.[431] 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 receive all ECI services free of charge. In Texas,

65 percent of children receiving ECI services are recipients of Medicaid.[432] Other 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.[433]

Figure 76. Characteristics of Individuals utilizing ECI Services

	FY 2015
Total children referred	73,488
Total children who received comprehensive services	50,634
Average monthly cost per child	$440

* based on comprehensive services

Source: Texas Department of Assistive and Rehabilitative Services. (2016). *DARS Annual Report 2015*. Retrieved from http://www.dars.state.tx.us/reports/annual2015/annualreport2015.pdf

In FY 2015, the distribution of enrollment in the ECI program by age was fairly evenly split among the three key age groups, as follows: [434]

- 0 to 12 months: 37 percent
- 13 to 24 months: 34 percent
- 25 to 36 months: 30 percent

In FY 2015, the percentage of enrolled children using each of the major types of services was: [435]

- Developmental services: 82 percent
- Speech language therapy: 59 percent
- Occupational therapy: 30 percent
- Physical therapy: 26 percent
- Nutrition: 8 percent
- Psychological/social work: 4 percent
- Vision services: 2 percent
- Audiology: 2 percent

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

CHILDREN'S AUTISM PROGRAM

The Centers for Disease Control and Prevention (CDC) estimate that 1 in 68 children in the United States are born with or develop Autism Spectrum Disorder (ASD).[436] The DARS Autism Program started as a pilot project in FY 2008 and was intended to extend treatment services, including Applied Behavior Analysis (ABA) therapy, to children aged 3 through 8 on the autism spectrum in Houston and Dallas/Fort Worth.[437] Increases in funding from the Texas Legislature allowed the program to expand to Austin, Corpus Christi, El Paso, and San Antonio.[438] In FY 2015, 288 children

were served through the Children's Autism Program.[439] The 84th Legislature approved a total of $14 million to the Children's Autism Program for the FY 2016-17 biennium, up from $9 million in the FY 2014-15 biennium.[440] The increased funding allowed the program to expand to the following areas: Tyler, Round Rock, Brownwood, Bryan, Texarkana, Waco, San Angelo, Midland, Lubbock, Denton, and Edinburg.[441]

The 84th Legislature also required other changes to the program, including directing the phasing out of the Comprehensive ABA treatment services by August 31, 2017. The 84th Legislature required the expenditures for comprehensive ABA treatment services only be used for children enrolled in the program before August 31, 2015. All children enrolled on or after September 1, 2015 are limited to Focused ABA treatment services.[442] Focused ABA services are intended to target and improve a few specific outcomes including addressing certain behaviors and improving social and adaptive skills.[443] Comprehensive ABA services address a full range of life skills, including communication, sociability, and self-care.[444,445] The Children's Autism Program now serves children across the state ages 3 to 15 and includes parent participation, child attendance, and additional staff training requirements along with the treatment services.[446] In FY 2015, a total of 288 children were served through the Children's Autism Program.[447] The program aims to serve over 1004 children in FY 2016 – 59 in Comprehensive ABA services and 945 in Focused ABA services.[448]

Figure 77. Children Who Received Services in FY 2015

	Number of Children	Percent of Total
Comprehensive Applied Behavioral Analysis	204	71%
Focused Applied Behavioral Analysis	93	32%*

*Children may have received both Comprehensive and Focused ABA services during the year.

Source: Texas Department of Assistive and Rehabilitative Services. (2016). *Annual Report-2015*. Retrieved from http://www.dars.state.tx.us/reports/annual2015/annualreport2015.pdf

The Children's Autism Program moved from DARS to HHSC's Medical and Social Services Division on September 1, 2016.[449]

ADDITIONAL PROGRAMS FOR PEOPLE WITH DISABILITIES AND AGING TEXANS

NON-MEDICAID SERVICES

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

- Adult Foster Care
- Client Managed Personal Attendant Services
- Emergency Response Services
- Family Care
- Home Delivered Meals
- Special Services to Persons with Disabilities

- In-Home and Family Support Program
- Intellectual Disability Community Services

For more information on these programs and the services offered, please refer to the DADS FY2015 Annual Reference Guide.

ADDITIONAL FEDERALLY FUNDED PROGRAMS

Federal funds are currently available through the Promoting Independence initiative and the Money-Follows-the-Person Initiative. Additionally, while federal funds are not available for the Achieving a Better Life Experience (ABLE) initiative, federal and state authority has been granted to develop this program if states opt in. More information is provided below.

Promoting Independence Initiative

The Texas Promoting Independence Initiative began in January 2000 in direct response to the U.S. Supreme Court ruling in *Olmstead v. L.C.*, in which the court ruled that states must provide community-based services for persons with disabilities (including mental health conditions) under the following circumstances:[450]

- The person would otherwise be entitled to institutional services;
- The state's treatment professionals deem community-based placement to be appropriate;
- The affected person agrees to receive community-based services; and
- The placement can be reasonably accommodated given the resources available to the state and the needs of others who are receiving state-supported disability services.[451]

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

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

Money Follows the Person Program

Among the many HHSC initiatives affecting individuals with co-occurring conditions, Texas participates in a federally funded national demonstration program known as Money Follows the Person Demonstration (MFPD). Texas was among the first of 30 states chosen to participate in MFPD in 2007. As of June 2016, 43 states participate in this federal demonstration designed to help older adults or persons with disabilities move from institutional settings (including nursing facilities, ICFs, and SSLCs) back into their communities.[452]

MFPD provides federal grant funding as well as funding from Medicaid matching cost savings to assist states in moving individuals from institutions to the community. In FY16, the HHSC will receive over $16 million in federal funding to help individuals transition out of institutional settings. Funds are also used to provide behavioral health supports that help individuals remain living in the community andenhance opportunities for integrated employment, which leads to greater self-sufficiency, and increases the availability of affordable, accessible housing. The age span of individuals taking advantage of the Money Follows the Person program ranges from less than one year to more than 100 years old.

Since 2008, MFPD has helped over 10,000 individuals transition from institutional to community-based services. Another 34,598 individuals transitioned since 2003 under the Texas Promoting Independence initiative.[453]

Achieving a Better Life Experience (ABLE) Program

The Achieving a Better Life Experience (ABLE) program and the Texas ABLE Program Advisory Committee were created through SB 1664 (84th, Perry/Burkett). The federal ABLE act was signed into law in December 2014 making these programs optional for states. Each state must pass legislation to create its own statewide implementation of the ABLE program. The ABLE program was created to support the financial independence of certain individuals with disabilities by allowing them to set aside personal savings in secured accounts without affecting their eligibility for services they are qualified to receive such as SSI, SSDI, or Medicaid. Anyone, including the individual's family members and friends, can contribute to an ABLE account.[454]

The Texas ABLE program will be operated through the Comptroller's office. The Advisory Committee will provide assistance as needed to the Texas Prepaid Higher Education Tuition Board and Comptroller's office during the creation of the program. For the most updated information on the Texas ABLE program, visit texasable.org.

ADDITIONAL HHS SYSTEM PARTNERS AND PROGRAMS

HHSC and the Medicaid program have many partners and encompass a number of subprograms to help administer and provide services in Texas. The following sections highlight several subprograms and partnerships that help to administer or provide mental health services in Texas.

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) provide healthcare services to underserved communities, including Texans who are under- or uninsured. FQHCs receive federal grants through Section 330 of the Public Health Services Act and play an important role in providing comprehensive health care services to people with public health insurance such as Medicaid and CHIP, as well as to people who are otherwise low-income and uninsured. There are 72 FQHCs in Texas with nearly 450 service delivery sites statewide.[455] In 2014, FQHCs served nearly 1.2 million patients.[456]

While FQHCs receive grant funding from the federal government, they also receive enhanced reimbursements for providing services to individuals receiving Medicaid and Medicare services.[457] These reimbursements are designed to cover the additional

costs associated with providing comprehensive care to both uninsured and publicly funded patients. As a result of 2010 policy changes from the Affordable Care Act, many FQHCs are transforming their practices to health homes or comprehensive medical homes to improve the coordination and integration of care for clients with multiple chronic conditions, including mental health and substance use disorders. As of 2014, 54 percent of FQHCs nationally were recognized Patient-Centered Medical Homes (PCMHs).[458]

MEDICAID BUY-IN PROGRAMS

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

The Texas Medicaid buy-in program for adults is available to persons with a disability who are working and who do not live in a state institution or nursing home.[459] The Texas Medicaid buy-in for children is available to families who have a child with a disability who is age 18 or younger, a U.S. citizen or legal resident, and not married.[460] Most families are required to pay monthly premiums, co-pays, or deductibles. Cost-sharing is based on income, the number of people in the family, and access to employer-provided insurance or the Texas Health Insurance Premium Payment Program.[461]

TEXAS HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

The Texas Health Insurance Premium Payment program (HIPP) is a program that covers the expense of employer-sponsored healthcare premiums for **families** who also qualify for Medicaid.[462] HIPP may help people who otherwise would be uninsured obtain insurance.[463] Family members who would otherwise be ineligible for Medicaid may be eligible to receive employer-sponsored premium assistance from HIPP.

In order to qualify for the program, at least one member of the family must remain Medicaid eligible and HHSC must deem the employer-sponsored policy cost effective. Families eligible for both the STAR+PLUS Medicaid program and HIPP may remain enrolled in both plans. However, families eligible for STAR cannot remain enrolled in both STAR and HIPP. If a family on STAR applies and is found to be HIPP-eligible, then the family will automatically be transferred from STAR to HIPP. Families covered under both Medicaid and HIPP are not responsible for cost-sharing when receiving services from within the Medicaid network.[464] Families solely covered under HIPP are responsible for cost-sharing defined by terms in the employer-sponsored plan.

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.[465] TMHP does not process claims for services provided by managed care organizations (MCOs), but it does collect encounter data from MCOs to use for the evaluation of quality and utilization of managed care services.[466]

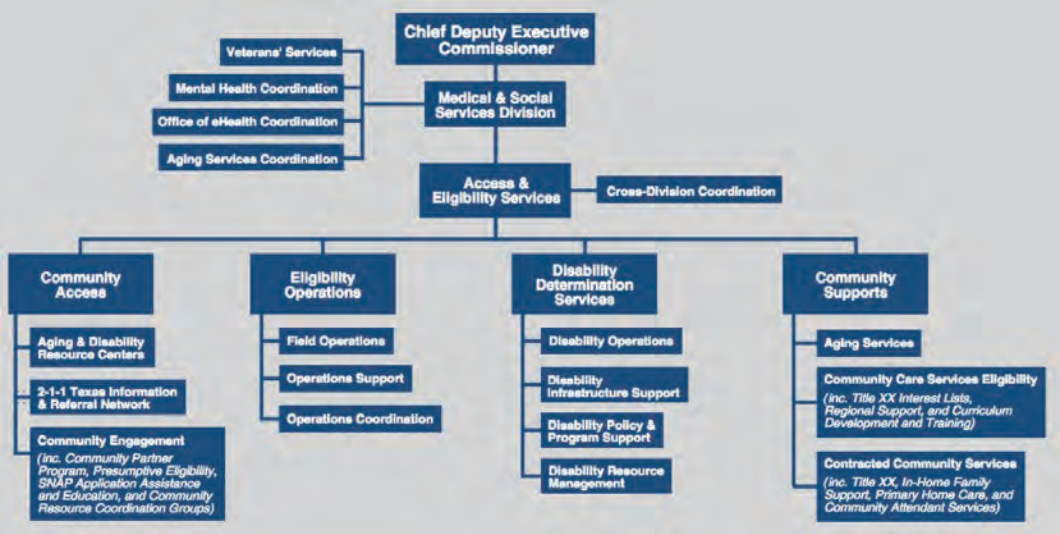
TEXAS WELLNESS INCENTIVES AND NAVIGATION PROJECT

In 2011, Texas won a "Medicaid Incentives for the Prevention of Chronic Disease" grant from the federal Centers for Medicare and Medicaid Services (CMS). The initiative is a national demonstration project evaluating the efficacy of providing incentives to Medicaid beneficiaries to adopt healthy behaviors. Texas received $2.7 million in the first year of the five-year grant period (and approximately $10 million over the lifetime of the project) to conduct a randomized, controlled trial on the efficacy of personal wellness incentives in improving health management and increasing utilization of preventive services among individuals with severe mental illness.[467] HHSC oversees the project, DSHS provides day-to-day project management, and the Institute for Child Health Policy at the University of Florida conducts the program evaluation and provides technical assistance. The study period concluded in December 2015 and the project is now in the analysis phase.[468] A final program evaluation report is due to CMS in late 2016.[469]

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.[470] The Veterans Services Division is an active participant in the Texas Coordinating Council for Veterans Services.[471] The HHS Enterprise offers Texas veterans services through several agencies including but not limited to the Department of State Health Services (DSHS), Texas Veterans Commission (TVC), and Texas Workforce Commission (TWC). More information on veterans can be found in the TVC section of this guide.

Access and Eligibility Services



DISABILITY DETERMINATION SERVICES (DDS)

The Disability Determination Services Division (DDS) makes disability determinations for individuals with severe disabilities. DDS works with individuals who apply for benefits through the federal Social Security Administration (SSA) to help pay for daily needs. Benefits available for both adults and children who meet eligibility include Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).[472]

Both SSI and SSDI are cash assistance programs administered by SSA. HHSC staff makes the initial disability determination for Texans applying for SSDI and/or SSI. Approximately 323,550 disability cases were determined in FY 2015.[473]

Some people with serious mental health conditions will qualify for either or both SSDI and SSI. Qualifying for both SSDI and SSI benefits at the same time is called "concurrent benefits." 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.[474]

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

SSDI is available for individuals who can no longer work due to a medical condition, including mental illness, that is expected to last at least one year or result in death.[475] 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/widower of worker

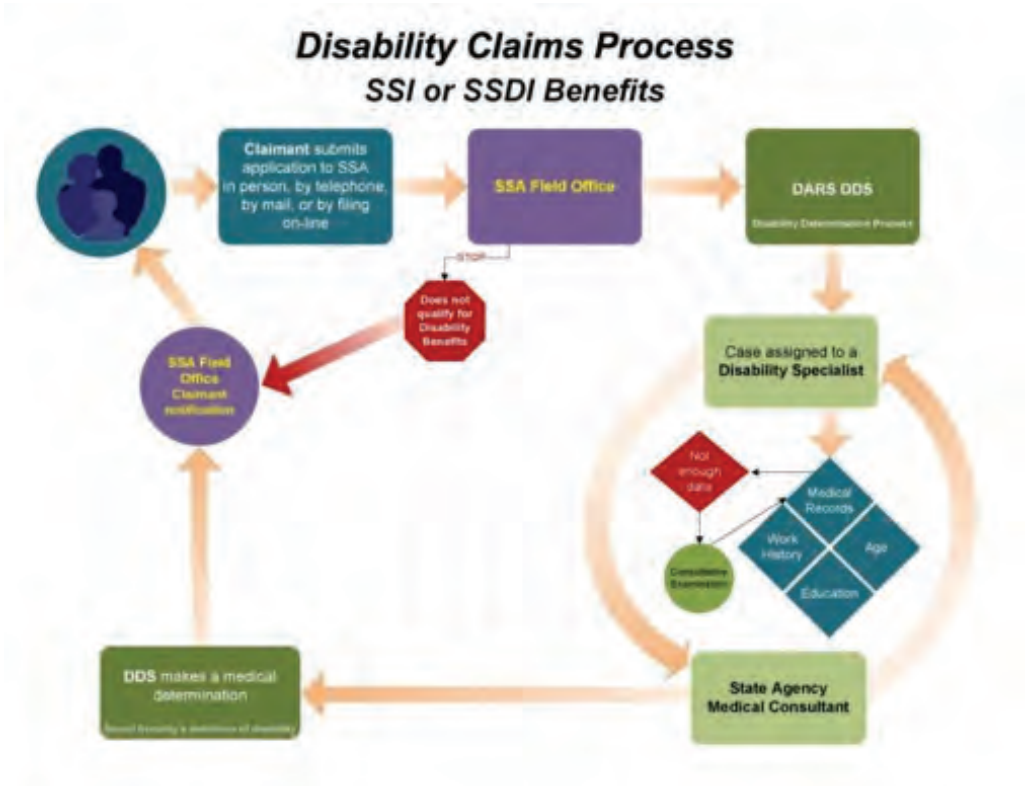
with a disability, and adult children (with a disability) of workers with sufficient work histories.[476] People become eligible for SSDI throughout their working lives by paying social security taxes.[477]Approval for SSDI payments results in eligibility for Medicare coverage after a two-year waiting period.[478] Approximately a third of individuals receiving SSDI assistance qualify on the basis of a mental health diagnosis.[479]

SUPPLEMENTAL SECURITY INCOME (SSI)

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.[480] Children who have a disability or are blind may also qualify for SSI. Unlike SSDI, SSI is not based on an individual's work history.[481] The monthly maximum amount for 2016 are $733 for an eligible individual and $1,100 for an eligible individual with an eligible spouse.[482] Once approved for SSI, participants are eligible for Medicaid.[483]

Figure 78 below details the disability claims process to receive SSI or SSDI benefits.

Figure 78. Disability Claims Process for SSI and SSDI Benefits



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

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

- **Reconsideration:** Another disability examiner and medical team reviews the case to determine if the decision was proper. Claimants may submit additional evidence to support their case.
- **Administrative Hearing:** Claimants may present witnesses and evidence at a formal, private hearing with an administrative law judge.
- **SSA Council Hearing:** Reviews decisions by judges at the administrative hearing level.
- **U.S. Federal District Court:** A hearing at the federal court level; very few cases reach this level.[484]

According to a report by the SSA that tracked SSDI outcomes from 2004–2013, the number of applicants who were granted awards upon initial review averaged 24 percent.[485] Of those who appealed their denial, 2 percent of applicants were subsequently granted benefits at the reconsideration state and 11 percent through a hearing.[486] A new report is scheduled to be released in November 2016.

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 disabling 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.[487]

According to a 2015 report by the SSA, mental health conditions constitute about a third of national SSDI diagnoses.[488] Disability determinations for SSDI on the basis of a mental health condition are categorized as:

- Organic mental disorders
- Schizophrenic, paranoid, and other psychotic disorders
- Affective disorders
- Intellectual disability
- Anxiety-related disorders
- Somatoform disorders
- Personality disorders
- Substance use disorders
- Autism Spectrum Disorder
- Other pervasive developmental disorders[489]

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.[490] 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).[491]

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

UTILIZATION

Figure 79 provides information on applications for benefits for Texas in 2015.

Figure 79. Utilization of Disability Determination Services in Texas

	2015
Total cases determined	323,550
Average initial case process time (in days)	73.4
Accuracy with regards to ultimate SSA decision	95.5%

Sources: Texas Department of Assistive and Rehabilitative Services. (2016). *DARS Annual Report 2015.* Retrieved from http://www.dars.state.tx.us/reports/annual2015/annualreport2015.pdf

DDS MOVED FROM DARS TO HHSC ON SEPTEMBER 1, 2016.[492]

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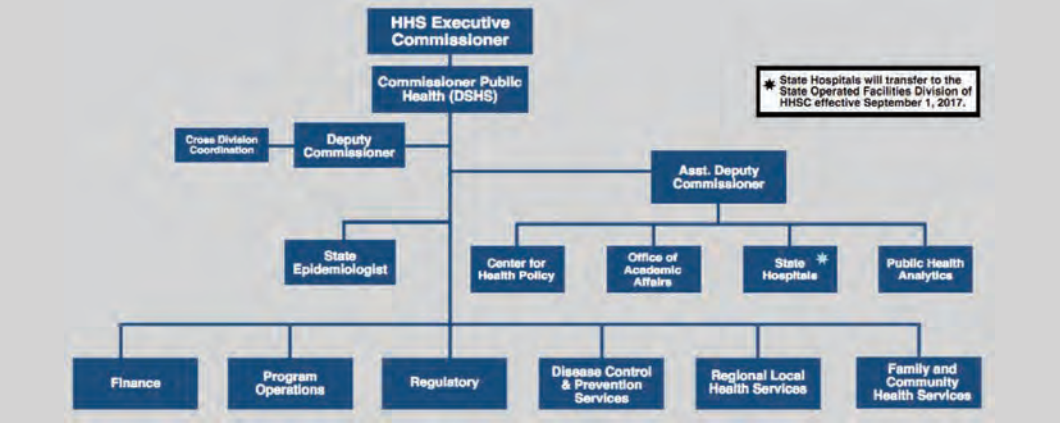
Texas Department of State Health Services *At a Glance*

Texas Department of State Health Services

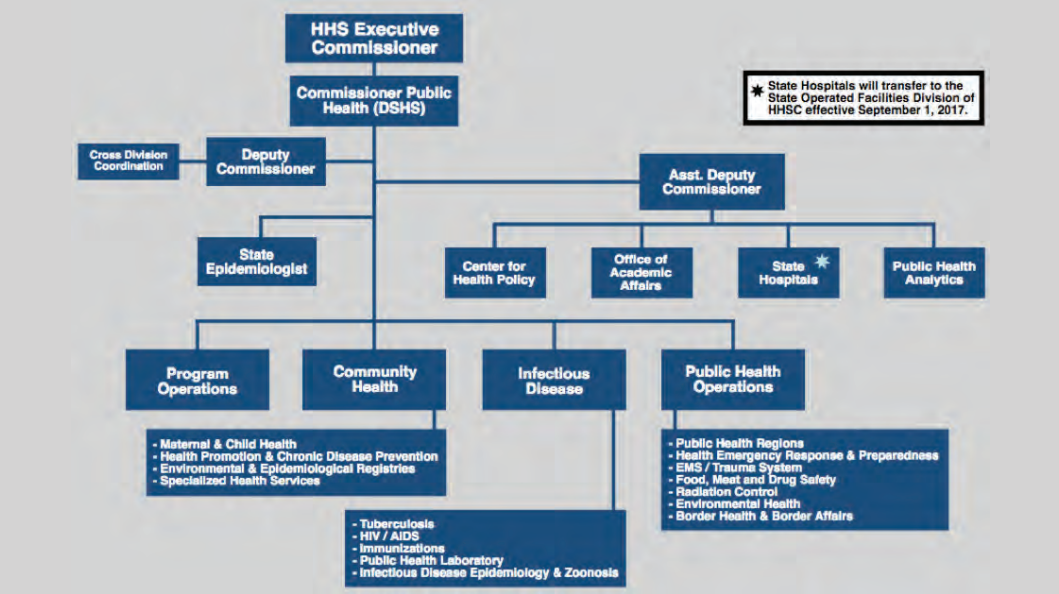
ORGANIZATIONAL CHARTS

Figure 80. Organizational Structure of DSHS as of September 1st, 2016



Source: Texas Health and Human Services Commission. (July 2016). *Health and Human Services System Transition Plan*. Page 21. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/Transformation-Plan-Update.pdf

Figure 81. DSHS organizational structure After September 1, 2017 (Post-Transformation)



Source: Texas Health and Human Services Commission. (July 2016). *Health and Human Services System Transition Plan*. Page 21. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/Transformation-Plan-Update.pdf

Texas Department of State Health Services

Since 2003, the Texas Department of State Health Services (DSHS) has been the state mental health and substance use authority for Texas. Within DSHS, the Mental Health and Substance Abuse Services Division (MHSA) has overseen the public behavioral health service delivery system. DSHS provided behavioral health services (i.e. mental health and substance use services) to individuals with a wide range of mental health service needs. It is estimated that roughly 1 million adults in Texas are living with serious mental illness (SMI) and 519,368 Texas children are living with serious emotional disturbance (SED).[1]

Important Note: Inpatient Mental Health Hospital Services

As a result of the HHS transformation directed by SB 200 (84th, Nelson/Price), DSHS, along with the entire HHS System has been undergoing massive reorganizations that are only partially complete as of the writing of this guide. Mental health and substance use *community* services transferred to HHSC on September 1st, 2016. However, the state owned and operated psychiatric hospitals and the state supported living centers do not transfer until September 1st, 2017. In order for this guide to provide information on mental health and substance use services as clearly and concisely as possible, information on state hospital services are included in this section and in the Behavioral Health Services tab under the HHS System section.

Inpatient Mental Health Hospital Services

Inpatient mental health services are provided by state, community, and private hospitals to children, adolescents, and adults experiencing a psychiatric crisis due to mental illness. Inpatient hospitalization may be necessary for a period of time so that individuals can be closely monitored to:

- Provide accurate diagnosis 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.[2]

INTRODUCTION TO INPATIENT SERVICES AND THE ADMISSIONS PROCESS

As discussed earlier, DSHS designates LMHAs as responsible for achieving continuity of care in meeting a person's need for mental health services. Within this continuum of care, the state 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 that requires the LMHA 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 decides on the least restrictive treatment setting available, with the very 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. Additionally, a hospital physician can make a referral to the local LMHA if the person has less acute needs and only requires coordinated alternative services.[3]

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.[4] Specific services include diagnostic interviews, structured therapeutic programming, collaboration with appropriate courts and law enforcement, suicide safety planning and discharge planning.

There are two types of inpatient commitments in which individuals are provided comprehensive inpatient mental health services: civil and forensic. Within these two types of commitments, an administrative decision is made as to whether an individual needs a maximum security or non-maximum security placement.

CIVIL COMMITMENTS

Civil commitments to state hospitals occur when an individual is involuntarily detained by a peace officer because he or she has symptoms of mental illness that present a substantial and imminent risk of serious harm to themselves or others.[5] Voluntary civil commitments can also be initiated if the person needing help is actively seeking inpatient treatment.[6]

Once a mental health warrant has been granted and the individual has been transported to a mental health facility, the initial civil commitment is only valid for a 48-hour emergency detention, in which time a doctor must visit with the individual (within 24 hours) and make an assessment about whether an order of protective custody (OPC) should be issued and the emergency detention extended.[7,8] Within 72 hours of the initial detainment, a probable cause hearing must be held to determine whether the individual should stay at a mental health facility or in the community while he or she wait for their final mental health hearing.[9] During the final mental health hearing, the court takes testimony from medical experts, the patient, and individuals in the patient's life (e.g. family, friends, coworkers).[10] Following the final mental health hearing, emergency detentions can extend to 30-day orders of protective custody or 90-day court-ordered mental health service stays (which

the court can then extend by three month increments if the treating physician has determined the individual is not stabilized and safe to return to the community).[11] In a small number of cases in which minimal improvement is seen in the first 60 days of inpatient treatment, an individual's treating physician may request an extended civil mental health commit commitment for up to 12 months, but individuals subject to extended commitments are entitled to have their case heard before a jury rather than a judge.[12]

FORENSIC COMMITMENTS

Individuals who are forensically committed to a state hospital in Texas go to either Rusk State Hospital or the Vernon Campus of North Texas State Hospital; this type of commitment happens for two reasons:

- Individuals have been admitted to a hospital by judicial order because they have been determined Incompetent to Stand Trial (IST) 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 (NGRI) and were ordered to a state hospital for a period of time not exceeding the maximum sentence length of the crime they committed.[13]

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
- Charged with a violent felony offense involving an act, threat, or attempt of serious bodily injury.[14]

All cases involving serious bodily injury, imminent threat of harm or use of a deadly weapon are sent to a maximum security unit (MSU) for an initial 30-day evaluation period.[15] 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.[16] Transitional programs for forensic commitments are available for individuals who transfer out of maximum security units after their treatment team and a judge determines that they are no longer manifestly dangerous to themselves or others.[17] In regards to the method of bed appropriation in inpatient settings, only transitional forensic programs and forensic maximum security beds are designated as forensic beds and reserved for those populations; all other psychiatric beds are available for either civil or forensic patients on a first come, first serve basis.

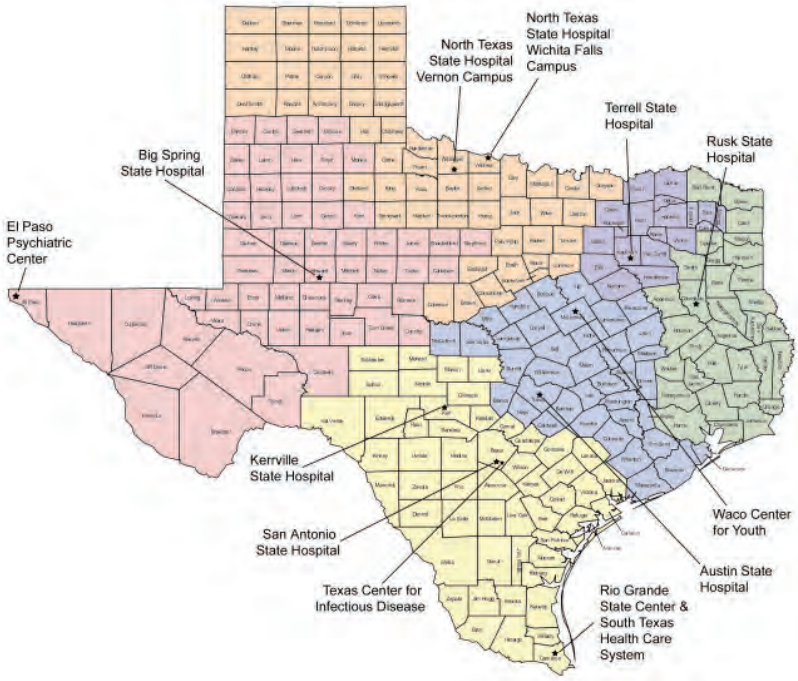
Types of Inpatient Settings

STATE HOSPITALS

The State Hospital Services Division provides oversight of the nine state mental health hospitals and one psychiatric residential treatment facility for youth (the

Waco Center for Youth) displayed in Figure 82 below. Each LMHA receives an allocation of state hospital resources to coordinate inpatient mental health services for residents of their specific state hospital service area. On average, Texas spends more per capita than comparable states on inpatient psychiatric services.[18]

Figure 82. State Mental Health Hospitals And Waco Center for Youth: 2016



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

In FY 2015, the average daily census of all state hospitals in Texas was 2,238 individuals — 25 fewer individuals than in 2014.[19]

Figure 83 below shows the total number of beds at each of the state-operated psychiatric hospital facilities in 2016; note that although this chart does not include community and private hospitals that contract with DSHS to provide inpatient treatment, those numbers can be found in Figure 56.

Figure 83 below shows the total inpatient bed capacity in Texas, including both state-operated and state-funded psychiatric beds. In FY 2016, there were a total of 2,995 state psychiatric beds across all bed types available for children, adolescents, and adults in Texas. Of the 2,463 state-operated psychiatric beds in 2015, 204 were allotted to provide acute services for children and adolescents and 116 beds were designated for individuals who no longer need state hospital inpatient care but do not have community alternatives available.[20]

Figure 83. State-Operated Inpatient Psychiatric Beds In State Hospitals: 2016

State Mental Health Hospitals	Bed Type	Number of Beds
Austin State Hospital	Adults and children	299
Big Spring State Hospital	Adults only	200
El Paso Psychiatric Center	Adults and children	74
Kerrville State Hospital	Adults only	202
North Texas State Hospital	Adults and children	640
Rio Grande State Center	Adults only	55
Rusk State Hospital	Adults only	325
San Antonio State Hospital	Adults and children	302
Terrell State Hospital	Adults and children	288
Waco Center for Youth	Children only	78
Total, all bed types		2,463

Source: Texas Legislative Budget Board. (April, 2016). State Hospitals: Mental Health Facilities in Texas, Legislative Primer. Retrieved from http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3ea17faa-4c5b-4a15-9b2d-5af88e9cd4a9.PDF ;Texas Department of State Health Services. (2016, June 30). Personal Communication: State Mental Health Hospitals.

QUALITY OF CARE MEASURES

Figure 84 shows selected data from on common adult outcome measures for FY 2013-2015.

Figure 84. Selected Measures for Adults Receiving Community Mental Health Services

Quality of Care Measure	FY 2013	FY 2014	FY 2015	Performance Contract Target FY 2015
Percentage of adults in community mental health services receiving at least one hour of mental health services per month	n/a	60.7%	74.5%	54.1%
Percentage of adults in community mental health services admitted three or more times in 180 days to a state or community psychiatric hospital	0.43%	0.09%	0.11%	≤ 0.3%
Percentage of adults in community mental health services who experienced improved employment	n/a	17.7%	19.1%	≥ 9.8%
Percentage of adults in community mental health services who experienced reliable improvement in at least one domain	n/a	47.9%	43.6%	≥ 20.0%

Note: Data for the first three items are from each year's fourth quarter, data for the last item is from the third and fourth quarters combined. Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter [PowerPoint slides]. Retrieved from* http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

CRISIS SERVICES: UTILIZATION AND COSTS

The utilization and costs for crisis mental health services are included in Figure 85 below.

Figure 85. Utilization/Cost for Crisis Behavioral Health Services

	FY 2013	FY 2014	FY 2015
Average monthly number of persons receiving mental health crisis services	5,039	5,209	6,767
Average monthly cost per person receiving mental health crisis services	$459	$669	$634

Note: Data are from each year's fourth quarter. Source: Texas Department of State Health Services. (2016). *Behavioral health data book, FY 2015, fourth quarter [PowerPoint slides]. Retrieved from* http://www.dshs.texas.gov/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8590002694

INPATIENT SERVICES AT STATE HOSPITALS: UTILIZATION AND COSTS

Over the past decade, the yearly average cost per patient served in state hospitals has almost doubled, from $11,912 in FY 2006 to $21,437 in FY 2015, an increase of $9,525 in the average cost per state hospital client (an 80 percent increase).[21] As shows, Kerrville State Hospital (which only provides transitional forensic services) had both the highest average length of stay (839 days) and the highest cost per individual served of all Texas state hospitals in 2015 ($34,749 per client per year).[22] also shows that despite there being 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 fully utilize the number of beds they have. There has also not been any increase in the number of state-operated beds in recent years — only more contracted community hospital beds — and unmet hospital infrastructure repair and renovation needs have actually taken state contracted beds out of operation.[23]

Figure 86. Utilization and Costs for State-Operated Hospitals in FY 2015

State Hospital	Population Served	Average Daily Census (% of total capacity)	Average Length of Stay at Discharge	Average Cost per Client Served
Austin State Hospital	Mostly civil, some forensic	258 patients (86% of capacity)	49.3 days	$19,224
Big Spring State Hospital	Civil and forensic	180 patients (90% of capacity)	138.0 days	$27,292
El Paso Psychiatric Center	Mostly civil, some forensic	66 patients (89% of capacity)	27.5 days	$13,957
Kerrville State Hospital	Forensic only	196 patients (97% of capacity)	838.5 days	$34,749

State Hospital	Population Served	Average Daily Census (% of total capacity)	Average Length of Stay at Discharge	Average Cost per Client Served
North Texas State Hospital (Vernon & Wichita Falls)	Maximum security forensic (Vernon) and Civil and forensic (Wichita)	566 patients (88% of capacity)	116.3 days	$23,834
Rio Grande State Center	Mostly civil, some forensic	52 patients (95% of capacity)	25.5 days	$10,831
Rusk State Hospital	Civil and forensic	313 patients (96% of capacity)	137.3 days	$23,962
San Antonio State Hospital	Mostly civil, some forensic	268 patients (89% of capacity)	58.5 days	$19,479
Terrell State Hospital	Mostly civil, some forensic	246 patients (85% capacity)	41.8 days	$15,833
Waco Center for Youth	Civil only	72 patients (92% of capacity)	161.8 days	$25,616
TOTAL	2,236 patients (50.3% civil and 49.7% forensic)		73.5 days	$21,437

Data obtained from: Texas Legislative Budget Board. (April, 2016). State Hospitals: Mental Health Facilities in Texas, Legislative Primer. Retrieved from http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3ea17faa-4c5b-4a15-9b2d-5af88e9cd4a9.PDF

Whether due to an individual's especially severe 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. As shows, individuals who cycle in and out of state hospitals account for a significant portion of the roughly 2,236 patients who are in state hospitals on any given day.[24] Since inpatient hospitals serve as a safety net for many individuals who receive inadequate or no community-based treatments, the availability and quality of community-based services has a direct impact on inpatient hospital capacity.[25]

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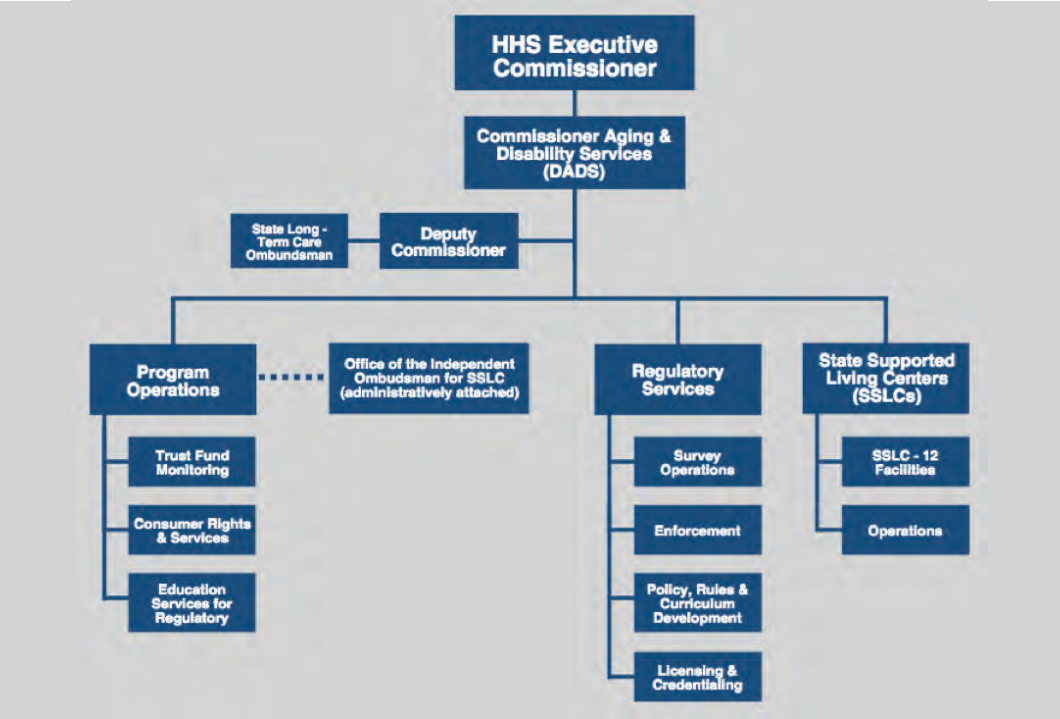
Department of Aging and Disability Services *At a Glance*

Department of Aging and Disability Services

All DADS programs and services transitioned to HHSC on September 1st, 2016 except for Program Operations, Regulatory Services and the state supported living centers (SSLCs) that are expected to transfer by September 1st, 2017. At that time, DADS will no longer exist as a separate agency.

DADS ORGANIZATION CHART (SEPTEMBER 1, 2016 – AUGUST 31, 2017)



Department of Aging and Disability Services

DADS Transformation Recap

DADS was under the review of the Sunset Advisory Commission, along with the other Texas Health and Human Services agencies, before the 84th Legislative Session. Sunset staff carefully reviewed DADS' internal policies, procedures, and service delivery. The Commission ultimately recommended dissolving the agency and moving its functions into the Health and Human Services Commission (HHSC), in an effort to better serve older Texans and individuals with physical, intellectual, and other developmental disabilities (IDD).

The Sunset Commission also tackled the highly controversial issues surrounding the continued operation of the state support living centers (SSLCs). The Commission recommended closing six SSLCs, closing the Austin SSLC by September 2017 and identifying five additional SSLCs to close by September 2022.[1] Those recommendations, along with statutory recommendations on other programs within DADS, were solidified in the DADS Sunset bill, SB 204 (Hinojosa/Raymond). The bill passed the Senate with a few changes, but after lengthy discussion on the House floor, House members removed the SB 204's recommendation to close the Austin SSLC and establish the SSLC Restructuring Commission. Members of the conference committee could not reach an agreement on the DADS Sunset Bill's content, and SB 204 died days before the end of the legislative session.[2]

The failure of SB 204 means that every SSLC will remain open until further legislative direction is received. However, many other DADS-related recommendations from the Sunset Commission were adopted in the final HHSC Sunset bill (SB 200), including changes to nursing home requirements and services for individuals with IDD.[3,4]

The HHSC Sunset bill (SB 200) transfers functions from DADS to HHSC. DADS' functions will transfer entirely to HHSC by September 1, 2017 and the agency will then be abolished. The majority of the agency's client services and program functions transferred to HHSC on September 1st, 2016. The remaining regulatory functions and operation of the SSLCs will transfer by September 1, 2017, at which point the agency will be discontinued.

The Health and Human Services Transition Plan was released in March 2016 for review by the Transition Legislative Oversight Committee. The proposed plan

outlines the future of DADS' programs and functions. The SSLCs will be placed in the new Facility Operations Division under HHSC, which will operate two types of state-owned facilities: state hospitals and SSLCs. For more information on the HHSC and DSHS Sunset changes, see the Texas Environment section of the guide.

The Sunset Advisory Commission's Staff Report of DADS, including the final results of the 84th legislative session is available at the following link: https://www.sunset.texas.gov/public/uploads/files/reports/DADS%20Staff%20Report%20with%20Final%20Results.pdf

The final HHSC Transformation Plan is available at https://hhs.texas.gov/sites/hhs/files/documents/about-hhs/transformation/final-transformation-plan.pdf.

State Supported Living Centers (will transfer to HHSC by September 1st, 2017)

Note: Additional information on services for individuals with intellectual and other disabilities in both community and residential settings can be found in the "Community Services" Medical and Social Services section under HHS System.

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

Approximately 3,145 individuals reside in these facilities.[5] 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 the SSLCs during the 84th legislative session due to the DADS Sunset Recommendations to close six SSLCs, including closing the Austin SSLC by September 2017. As mentioned earlier, ultimately the legislature voted to keep the Austin SSLC and all other SSLCs operational. In Texas, only the Texas legislature can direct closure of a state supported living center.

Due to fixed costs and the deterioration of aging facilities, as the number of residents in these facilities declines, the per person costs increase. According to the Sunset Commission final report, maintaining the large system of state-run facilities is costly, involving more than 13,900 employees and a budget of $661.9 million a year.[6] An HHSC report revealed that delivering services to a person in an SSLC costs $856.70 per day, totaling over $360,000 per year.[7] Further, maintaining the SSLCs' dilapidated infrastructure adds even more cost to the state.[8]

Figure 87. State Supported Living Center Enrollment Trend and Projections, Fiscal Years 2010-2019

FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016 (Projected)	FY 2017 (Projected)	FY 2018 (Projected)	FY 2019 (Projected)
4,207	3,993	3,756	3,547	3,362	3,186	3,075	2,931	2,787	2,643

Source: Texas Department of Aging and Disability Services (2016, May). *State Supported Living Centers Long-Range Plan May 2016.* Retrieved from https://www.dads.state.tx.us/services/SSLC/draft-sslc-planningreport-5-16.pdf

As part of a 2009 settlement agreement with the U.S. Department of Justice over conditions at SSLCs, DADS agreed to improve health, safety, and quality of care for consumers living in them. The agreement includes increased access to psychiatric care and psychological services, as well as improved policy and practices to reduce of the use of restraints. Independent monitors were assigned in mid-2014 to visit and report on conditions at all 13 SSLCs.[9] Despite the 2009 agreement, the June 2015 monitoring report for the Austin SSLC continued to identify significant deficiencies.[10] The 2015 monitoring report also identified instances of "individuals receiving psychiatric services who were not making progress or maintaining stability."[11] Other 2015 monitoring reports identified deficiencies related to psychiatric and psychological services at all of the SSLCs, including individual residents not progressing toward psychiatric goals and not maintaining psychiatric stability.[12]

Figure 88 presents information on the eligibility requirements and services supplied by SSLCs.

Figure 88. SSLC Eligibility and Behavioral Health-Related Services

Program	Eligibility	Behavioral Health Services Provided (in addition to Medicaid state plan services)
State Supported Living Centers	· 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.[13]	24-hour residential care and services that include: · 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

Data obtained from: Texas Department of Aging and Disability Services. (2015). *Reference Guide 2015*. Retrieved from http://www.dads.state.tx.us/news_info/budget/docs/fy15referenceguide.pdf

Average per person costs vary greatly between the long-term services programs.

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

Figure 89. describes the SSLC funding trends and requests for future funding.

Figure 89. SSLC Funding Trends and Requests

Program	Expended 2015	Estimated 2016	Budgeted 2017	Requested 2018	Requested 2019
SSLC	$684,111,674	$702,396,976	$689,157,263	$668,105,568	$666,622,891

Source: Data captured from HHSC Legislative Appropriations Request for FY 2018/19, September 12, 2016.

Figure 90 describes the state Medicaid costs per person, per month* living in an SSLC.

Figure 90. State Medicaid Costs Per Person, Per Month*

Program	FY2012	FY2013	FY2014	FY2015	FY2016
SSLC	$17,477	$19,680	$21,180	$23,103	$25,701

*30 days for one month

Source: Data captured from Health and Human Services Commission. (2015). *ICF Enhancement Rates.* Retrieved from http://www.hhsc.state.tx.us/Rad/long-term-svcs/downloads/2015-09-icf-rates.pdf

Figure 91 describes SSLC residents with a behavioral health diagnosis.

Figure 91. Percentage of SSLC Residents with a Behavioral Health Diagnosis

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Total SSLC Residents*	4,649	4,300	4,086	3,912	3,715	3,475
Number with a BH Diagnosis	2,654	2,472	2,336	2,196	1,745	1,455
Percentage	57.09%	57.49%	57.17%	56.13%	46.97%	41.87%

**We reported the data directly from DADS and HHSC. We are not aware of why the total SSLC resident numbers are different in this data set from the total number of residents in an earlier figure.*

Source: Texas Health and Human Services Commission. (2016, October 3). Personal Communication: Percentage of enrolled participants with a BH diagnosis.

Office of the Independent Ombudsman for SSLCs

Note: The State Long-term Care Ombudsman is not in the Office of the Independent Ombudsman for SSLCs.

Senate Bill 643 (81st, Nelson/Rose) passed in 2009 to create the Office of the Independent Ombudsman for SSLCs.[14] The Ombudsman office provides oversight and protection for individuals who reside in SSLCs. The office is independent of DADS and HHSC and reports directly to the state's elected officials in the executive and legislative branches.[15] Each SSLC has an independent ombudsman working onsite responsible for:

- Conducting independent reviews of complaints concerning agency policies or practices
- Ensuring policies and practices are consistent with the goals of the highest level of standard of care
- Ensuring people are treated fairly, respectfully, and with dignity
- Making referrals to other agencies, as appropriate
- Performing informal dispute resolution reviews for clients, their families, other stakeholders, and DADS[16]

Regulatory Services

According to the July 2016 HHS Transition Plan, the Regulatory Services Division will provide federal certification for health care facilities participating in the Long Term Services and Supports (LTSS) Medicaid and Medicare programs and state licensure for facilities providing licensed health care services. Regulatory Services will also provide licensure of home and community support services agencies that provide home health, personal assistance, and hospice services. Regulatory Services is intended to ensure that regulated facilities and agencies comply with federal and state rules appropriate to the services they provide, as well as make determinations regarding minimum standards and requirements for service, and identify deficient practice areas.[17]

The Regulatory Services division will house the following departments:

- Survey Operations
- Enforcement
- Policy, Rules, and Curriculum Development
- Licensing and Credentialing[18]

Endnotes

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Texas Department of Family and Protective Services *At a Glance*

Texas Department of Family and Protective Services

POLICY CONCERNS

- Maintaining quality, accessible services during the reorganization of the health and human services system.
- Tracking the usage and effectiveness of the Alternative Response System in the CPS investigative process.
- Increased focus on housing, employment and normalcy as crucial parts of recovery.
- Continued monitoring and prevention of child fatalities within the CPS system.
- Addressing disproportionality of minority and LGBTQIA youth in the CPS system.
- 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.
- 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 Project.

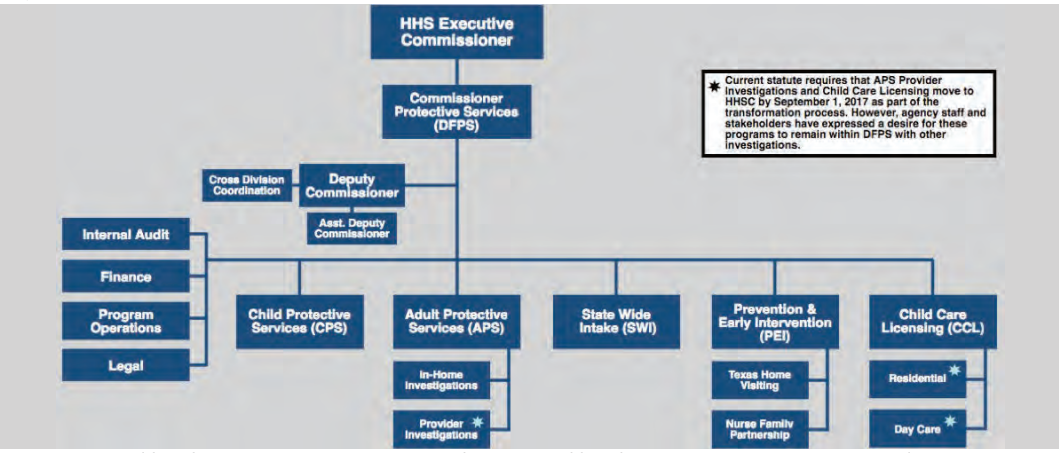
FAST FACTS

In FY 2015:

- The Statewide Intake (SWI) division of DSHS received an average of more than 2,000 contacts per day related to allegations of abuse, neglect or exploitation.[1]
- There were a total of 274,448 cases of alleged child abuse and neglect statewide.[2]
- 4,047 investigations of child abuse/neglect were transferred to the new Alternative Response (AR) system after being deemed low acuity and low safety risk reports.[3]
- 224,065 investigations of abuse/neglect were opened after CPS staff determined they met criteria for follow-up investigation.[4]
- Of the remaining 176,868 investigations completed, 40,506 were confirmed as child abuse and/or neglect and 17,151 children were removed from their homes.[5]
- 16,378 children were in the Texas foster care system as of August 31, 2015 (excluding the 11,517 children in non-foster substitute placements such as kinship care and DFPS adoptive homes).[6]
- DFPS confirmed 171 abuse/neglect related fatalities of children, five of whom died while they were enrolled in the state foster care system.[7]
- The prevalence of child abuse/neglect decreased slightly, from 9.2 confirmed cases per 1,000 children in 2014 to 9.1 confirmed cases per 1,000 children in 2015.[8,9]
- Adult Protective Services (APS) completed 78,180 in-home investigations, with 43,759 of those investigations being validated and 12,876 of those receiving follow-up services.[10]
- The majority of allegations of in-home elder abuse were reported by medical personnel (21.8 percent), relatives (16.4 percent), community agencies (13.7 percent), or the victim themselves (11.8 percent).[11]
- The Child Care Licensing (CCL) division of DFPS oversaw approximately 20,882 daycare operations (or homes) serving 1.09 million children (as of mid-year 2015).[12]

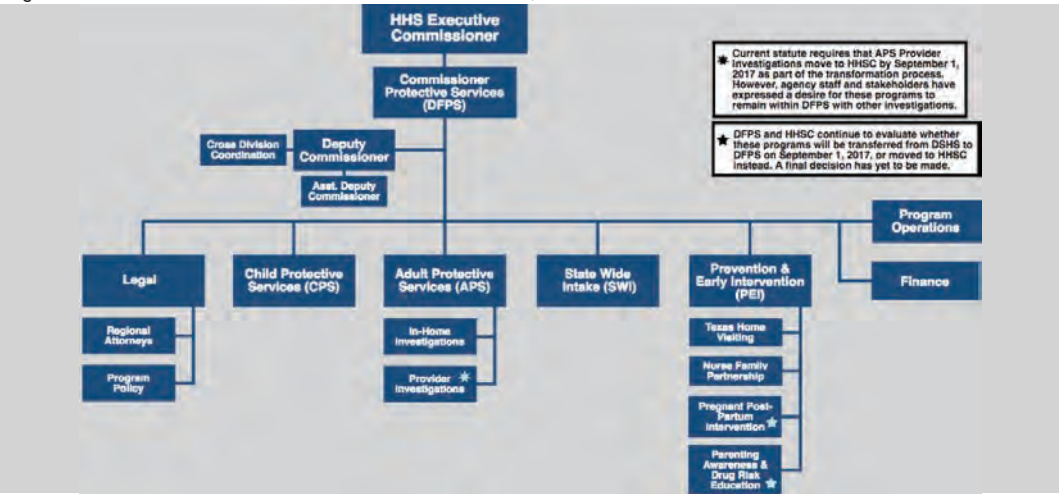
ORGANIZATIONAL CHARTS

Organizational Structure of DFPS (Pre-Transformation, 2016)



Source: Texas Health and Human Services Commission. (July 2016). *Health and Human Services System Transition Plan*. Page 19. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/Transformation-Plan-Update.pdf

Organizational Structure of DFPS (Post-Transformation, 2017)

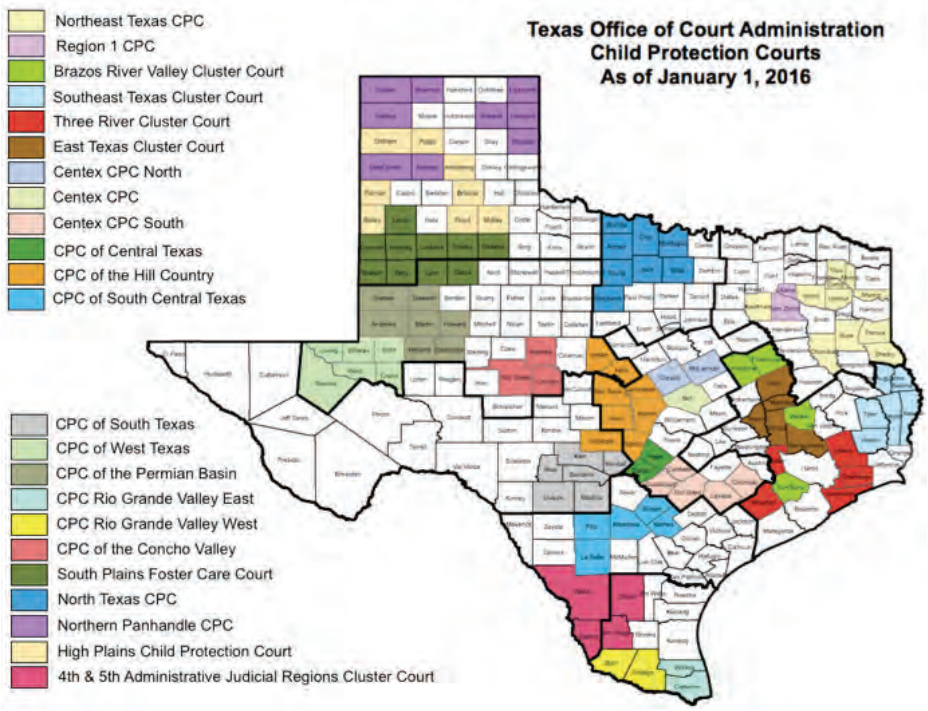


Source: Texas Health and Human Services Commission. (July 2016). *Health and Human Services System Transition Plan*. Page 19. Retrieved from http://www.hhsc.state.tx.us/hhs-transformation/docs/Transformation-Plan-Update.pdf

Texas Department of Family and Protective Services

The Department of Family and Protective Services (DFPS) is the state agency responsible for ensuring the safety of children, older adults, and adults with disabilities. DFPS provides services and supports to these vulnerable populations to reduce the likelihood of abuse, neglect, and exploitation. DFPS is headquartered in Austin and as of 2015 included 12,706 employees that work in 282 local offices in 11 geographic regions with regional headquarters.[13] DFPS is divided into the same 11 regions as the Health and Human Services System — see Figure 12 in the HHSC section for a map of those regions. As Figure 92 below shows, Texas is also divided into several regional networks of child protection courts.

Figure 92. Map of Child Protection Courts and Covered Regions



Data obtained from: Texas Office of Court Administration. (2016, January 1). *Child Protection Courts Map.* Retrieved from http://www.txcourts.gov/media/1135666/child-protection-courts.pdf

As Figure 93 shows, DFPS was comprised of five separate divisions before the reorganization of health and human services began.

Figure 93. 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. 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.
Prevention and Early Intervention (PEI)	Provides community outreach on mental health and other wellness services to help prevent child abuse, juvenile incarceration, and other risky behaviors before they happen. PEI runs its own prevention programs in addition to funding and supporting community providers of early prevention services.
Child Protective Services (CPS)	Investigates allegations of child abuse and neglect and responds accordingly. CPS strives to strengthen and stabilize families in order to safely retain 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.
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.
Child Care Licensing (CCL)	Regulates the childcare system to ensure safety and other statewide regulations are met. Educates parents and communities on childcare and childcare facilities. As a result of the ongoing HHSC Transformation process, the Child Care Licensing unit will be transferred from DFPS to HHSC in 2017.

Source: Texas Department of Family and Protective Services. (n.d.) *Learn about DFPS.* Retrieved from http://www.dfps.state.tx.us/About_DFPS/default.asp

Sunset and Transformation Highlights

In an effort to improve the efficient coordination and quality of state health services, the 84th Legislature followed recommendations from the Sunset Commission and passed SB 200 (84th, Nelson/Price), directing the reorganization and restructuring of the state agencies that provide health and human services in Texas, including behavioral health.[14] As a result of the Sunset Commission's evaluation process, DFPS was continued as a separate and distinct department with a new sunset date of September 1, 2023. [15]

SB 200 (84th, Nelson/Price) takes a phased approach to reorganizing the Texas health and human services system. In phase one of the transformation, some prevention and client support programs from agencies other than DFPS will be moved to DFPS' Prevention and Early Intervention (PEI) Division:

- The Texas Home Visiting program and the Nurse Family Partnership program, both previously managed by HHSC, were transferred to the PEI Division of DFPS on May 1, 2016. [16]

- The Sunset Commission recommended that The Pregnant Post-Partum Intervention and the Parenting Awareness and Drug Risk Education programs previously managed by DSHS be moved to DFPS by September 1, 2017, but the HHSS transformation plan recommends that these two programs move to HHSC instead. [17]

In phase two of the reorganization, all of the programs run by DFPS within the Child Care Licensing (CCL) division that regulate residential childcare and daycare facilities will be moved to new Regulatory Services Division within HHSC. Abuse and neglect investigations of community providers that are conducted by Adult Protective Services (APS) are also slated to move to HHSC's Regulatory Services Division in 2017, but stakeholders have expressed a desire to keep all investigations within DFPS.[19] The remaining four divisions within DFPS — State Wide Intake (SWI), Child Protective Services (CPS), Adult Protective Services (APS), and Prevention and Early Intervention (PEI) — will remain in DFPS and not be moved to HHSC.

DFPS will continue to operate as a separate agency during the transition and aims to maintain seamless delivery of all public health and behavioral health services during the reorganization process. SB 200 requires that HHSC further analyze the feasibility of moving all DFPS activities to the consolidated agency and requires that a report with recommendations for further reorganization of agencies to be submitted to the Transition Legislative Oversight Committee by September 1, 2018.[20] For more detailed information on the transformation plan, see the Texas Environment section of this guide.

Changing Environment

PARENTAL RELINQUISHMENT OF CUSTODY TO OBTAIN MENTAL HEALTH SERVICES

In some instances parents or guardians have no other options to get their child needed mental health services and voluntarily relinquish their child to state conservatorship solely for the purpose of accessing those mental health services through DFPS.[21] These children have serious mental health conditions and proper treatment is often expensive due to the need for temporary residential treatment or extensive outpatient supports. Some parents have insufficient insurance coverage while others lack insurance altogether, making it difficult to afford the mental health treatments that are necessary to guarantee safety in the household for themselves or other children. Parental relinquishment of custody to obtain critically needed mental health services has historically been considered as "Refusal to Assume Parental Responsibility" (RAPR) by DFPS, a form of neglect that results in the parents' or guardians' names being automatically added to the Texas Child Abuse/Neglect Central Registry. [22]

In 2013, the 83rd Texas Legislature began the initial work needed to address parental relinquishment of custody in Texas with the passage of Senate Bill 44 (83rd, Zaffirini/Burkett). In addition to ordering regular data collection and reporting

on parental relinquishment solely to obtain mental health services for a child, SB 44 required DSHS and DFPS to jointly study policy changes that could reduce the number of children being placed into state custody (i.e. managing conservatorship) for this reason.[23] Also in 2013, the 2014-2015 General Appropriations Act (S.B. 1, 83rd, Williams/Pitts) allocated $2.1 million to fund ten beds in private Residential Treatment Centers (RTCs) for children who are at risk of being relinquished into the state's custody solely to obtain needed mental health services.[24] This program — later expanded to a total of 30 beds— is known as the Residential Treatment Center (RTC) Diversion Bed Project.

Then in 2015, SB 1889 (84th, Zaffrini/Burkett) changed the definition of what constituted child neglect by a parent. SB 1889 requires DFPS to not include a parent or guardian's name in a Child Abuse/Neglect Central Registry if they relinquish custodial rights only because they attempted and were unable to obtain needed mental health services for a child with a serious emotional disturbance (SED). SB 1889 also directed DFPS to review previous case files to remove names of parents and guardians from the Child Abuse/Neglect Central Registry that meet this criterion.

As a result of SB 1889 (84th, Zaffirini/Burkett), DFPS has overturned previous findings of Refusal to Accept Parental Responsibility (RAPR) and removed the names of approximately 172 parents and guardians from the Child Abuse/Neglect Central Registry who met the criteria set forth in SB 1889.[25] The retrospective case review process found 888 unique cases dating from 2001 to 2010 that required review and notification letters were sent to the 73 overturned cases (i.e. 73 cases were previously ruled as child abuse/neglect but are now overturned as a result of SB 1889).[26] Cases between 2011-2012 are still being reviewed and data from DFPS on the revised outcomes of those cases is still forthcoming, but the 2013-2014 review of 662 cases found an additional 37 cases that met criteria for review, 11 of which were overturned and resulted in removing the names of the parent(s)/guardian(s) from the Child Abuse/Neglect Central Registry.[27]

In FY 2015, DFPS staff reviewed 954 cases that potentially met the criteria for being overturned by SB 1889:[28]

- 88 cases from FY 2015 were overturned (i.e. no longer "Reason to Believe" abuse happened).
- 11 of those cases were offered and granted joint managing conservatorship (JMC).
- 77 of those cases were granted temporary managing conservatorship (TMC) and only one of those cases was later ruled to be "Reason To Believe" (i.e. the initial removal was deemed appropriate).

SB 1889 also required DFPS to adopt the new definition of neglect into their operating procedures so that no new parents are deemed RAPR solely for relinquishing custody to obtain needed mental health services that they could not otherwise obtain. While SB 1889 (84th, Zaffirini/Burkett) established that certain parents and guardians are not reported to the child abuse registry for relinquishing parental rights to obtain needed mental health services, the number of children entering DFPS care solely to obtain mental health services has increased since 2015. In just the first half of FY 2016, 76 cases were overturned out of the 382 total case files that were reviewed — almost as many cases as were overturned in all of 2015.[29]

As part of the effort to help reduce the number of children entering into DFPS conservatorship solely to obtain mental health services, the 84th Legislature allocated $4.8 million to add 20 beds to the Residential Treatment Center (RTC) Diversion Bed Project that was started in 2013, making for a total of 30 beds.[30] Between September 2013 and May 2016, a total of 179 children have been referred to the RTC Diversion Bed Project:

- 150 children were diverted from being relinquished to DFPS conservatorship,
- 66 children received services at a residential treatment center, and
- 28 children were ultimately removed from their family home and taken into DFPS conservatorship.[31]

As of July 2016, a total of 22 children were on the waiting list for the 30 beds in the RTC Diversion Bed Project.[32]

Finally, SB 1889 also requires DFPS to offer families joint managing conservatorship of a child before DFPS files a suit requesting managing conservatorship of that child, so long as the child "suffers from a severe emotional disturbance" and is entering into conservatorship to obtain need mental health services.[33] SB 206 (84th, Schwertner/Burkett) also strengthened reporting requirements for voluntary relinquishments solely to obtain mental health services and required reporting of the number of subsequent joint and temporary managing conservatorships resulting from intervention via SB 1889.[34]

There is still no available data on the number of families who have been offered or who have accepted joint or temporary managing conservatorships with the state, but that data will be included in the SB 1889 implementation reports that DFPS will release in November of each even-numbered year.[35]

SENATE BILL 125: MANDATORY SCREENINGS FOR YOUTH ENTERING FOSTER CARE

The 84th Legislature passed a number of bills relating to trauma-informed care including SB 125 (84th, West/Naishtat), which requires children who are entering into DFPS conservatorship to receive a "developmentally appropriate comprehensive assessment" that includes a screening for trauma and mental health needs within 45 days of the child's entrance into DFPS care.[36] The uniform assessment adopted statewide for this purpose is the Child and Adolescent Needs and Strengths assessment, or CANS — the same tool routinely used by LMHAs to qualify children for mental health services. In addition to completing the CANS assessment, DFPS is also now required to conduct interviews with several individuals in the child's life who have knowledge about the child's ongoing mental health needs. SB 125 (84th, West/Naishtat) established more consistent and thorough screening procedures for children entering into DFPS care, and these new procedures are aimed at placing children with complex needs in placements that will better fit their individualized needs — hopefully resulting in fewer placement changes and more long-term stability and success for children.

LAWSUIT AGAINST DFPS/CPS

The foster care system operated by DFPS came under increased public scrutiny after a class-action lawsuit was filed against DFPS in 2011 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 have since joined as plaintiffs in the case.[37] The lawsuit specifically addressed 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 Permanent Managing Conservatorship (PMC),
  - 6,400 children in PMC for three or more years,
  - 500 children in PMC for more than 10 years, and
  - More than 1/3 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,"[40] where children "often age out of care more damaged than when they entered."[41] The state's appeals against Judge Jack's ruling have so far been unsuccessful, and several of the ruling's reforms to improve the PMC program started being 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 state.[42]
- Addressing concerns of child safety in foster care placements by disallowing placement of children in foster group homes without 24-hour awake supervision and addressing regulatory lapses in the state's "broken" residential licensing division.[43]

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 will create a plan for addressing the capacity issues, defining "manageable" caseload sizes, and resolving other problems with the PMC program identified in the lawsuit. CPS caseworker turnover and high caseloads make it difficult for cases to be processed quickly and in some cases thoroughly, which leaves children in the foster care system longer and at greater risk of experiencing instability in their placements. Average CPS caseload sizes in Texas have fallen some in recent years — from 31 cases in 2014 to 28 in 2015 — but that still far exceeds the maximum number of cases (17) recommended in national best practices.[46-47] Judge Jack estimated that the co-transition masters will cost roughly $3 to $4 million per year.[48] See the Texas Environment section for further information on the ongoing court case against DFPS.

In the intervening time since the lawsuit against DFPS began, capacity issues and a lack

of availability of homes within the foster care system have continued to be a problem. A series of policy changes at the beginning of 2015 made it more difficult for children to be placed in kinship placements (i.e. with extended family members). In 2015, child removals by CPS grew by 37 percent as a result of these stricter safety-screening standards, and short-term informal kinship placements fell by 56 percent during the same time.[49] As a result of this shortage of available foster placements, Texas foster children waiting for placements have been forced to stay in less-than-ideal locations; 16 children spent at least two nights sleeping in CPS offices in February 2016 alone.[50] Capacity shortages are also not just an issue of numbers, but of matching each child to the appropriate setting for their needs, background, and identity. As former head of DFPS John Specia described it to the Senate Health and Human Services Committee in April 2016, "we may have enough beds for every child in care, but once you overlay specific needs (including location, gender, age and behavior), our capacity does not align."[51] Increasing the number of available foster homes is part of the foster care redesign pilot project in Region 3b (west of Dallas); from November 2014 to August 2015, total foster placement capacity increased by 20 percent, from 1,950 beds to 2,330 beds.[52]

Texas Speaker of the House Joe Strauss has declared that fixing the foster care system is on the top of the legislative agenda for the 85th Legislative session in 2017.[53]

FOSTER CARE REDESIGN

Foster care and mental health delivery systems overlap because nearly all of 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.[54] The effects of trauma can last a lifetime. Individuals who experience significant childhood abuse and family discord in their youth have a higher incidence of physical and behavioral health problems as adults.[55] 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.[56] Children in foster care have undergone 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.[57] However, children's symptoms of trauma may sometimes be misinterpreted as deliberate problematic behavior or indicative of a condition unrelated to trauma.[58]

A disconnected and uncoordinated foster care system is likely to aggravate childhood trauma and any other mental health conditions if they are not properly addressed with timely and appropriate care. Lack of permanency and consistency in childcare placements can also create trauma and exacerbate mental health conditions for children in foster care.[59] A high number of placements is traumatizing for children who are navigating the foster care system, further elevating the need to embed trauma-informed care into CPS practices.

In an effort to reduce negative outcomes for children (such as victimization and fatality) in the foster care system, DFPS embarked on a Foster Care Redesign project in 2010 to improve outcomes for youth in the areas of safety, permanency, and well-being. The overarching goals of the Foster Care Redesign are to:

- Keep children and youth closer to home and connected to their communities and siblings.

- Improve the quality of care and positive outcomes for children and youth.
- Reduce the time to permanency for children in foster care.
- Reduce the number of times youth move between foster homes or other placements.[60, 61]

One of the biggest changes of the Foster Care Redesign 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 Residential Treatment Center). 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.[62]

The Foster Care Redesign also restructures service delivery so that care is coordinated from a Single Source Continuum Contractor (SSCC) rather than a compilation of DFPS contracts with over 300 private service providers. The goal of streamlining the delivery of care is to better coordinate services for families so that mental health 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.[63] Under the new system, an SSCC is required to provide a range of services for foster care youth in specific geographic catchment areas.[64]

The Stephens Group, a business and government consulting agency, released a report in November 2015 that assessed the "status, policies and practices that currently exist between Texas Child Protective Services (CPS) and Child Placing Agencies (CPA) in providing behavioral health case management services to children with the highest needs".[65] Approximately 12.5 percent of children who are in DFPS conservatorship have been identified as having high needs, meaning they have "special medical, behavioral or emotional indicators, or are in the IDD (intellectual and developmental disabilities) population".[66] The report from the Stephens Group highlighted several areas of the redesigned foster care system that still need to be addressed including:

- Lack of a clear and consistent definition of what constitutes "high-need" within the child welfare system makes it hard for families and children with particularly complex needs to receive the specialized and intensive services they require to succeed.
- Intricacies of the mental health system and caseworkers' inability to navigate and understand each part of the system leads to a lack of provider accountability and continuity of care as children move between service providers and systems.
- Gaps in training for both caseworkers and CPS foster care contractors make it difficult to provide high-needs children with "the right care, in the right setting, at the right time."[67]
- Escalation of needs and through under-utilization of mental health services provided through local mental health authorities (LMHAs), local IDD authorities, the Medicaid targeted case management benefit, and in-home supports.
- Lack of key performance measures make it difficult to hold CPAs or CPS caseworkers accountable for child outcomes while in DFPS care.[68]

The report from the Stephens Group raised concerns regarding the effectiveness of the Foster Care Redesign for children who have mental health diagnoses or IDD. The report indicated concern that recommendations for care may be too standardized and do not adequately meet the individualized needs and abilities of families and parents with complex mixtures of mental health, IDD, and/or substance use issues. There is also a provision in the Foster Care Redesign that allows children with dual diagnoses (i.e. mental health disorders and IDD diagnoses) to be placed in institutions far from their home community, which likely causes trauma and may not produce the best outcomes. The instability and trauma associated with repeatedly removing children from their community and familiar support networks can have detrimental effects on long-term well-being. As an example of this disproportionate impact, the average number of placements for children in DFPS care is 2.7 while youth identified as having high needs have 5.7 placements on average, more than twice as many.[69]

The initial results are mixed on the implementation of the Foster Care Redesign program. As Judge Jack pointed out in Spring 2016, the program currently only covers about 800 children and is operating in only two percent of Texas counties.[70] There is currently only one SSCC actively operating in Texas— All Church Home (ACH) Child Services, in the Fort Worth area. ACH's Our Community Our Kids program serves as the SSCC foster care provider for a seven-county region that includes Erath, Hood, Johnson, Palo, Parker, Pinto, Somervell, and Tarrant counties.[71] ACH expects to spend approximately $5 million of its own money over the course of the three-year contract, but representatives from the organization feel positive about the future of Foster Care Redesign as a whole.[72] Data on the effectiveness of ACH's program is forthcoming. 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 foster care redesign will return $3.44 in state revenue and $1.66 in local revenue.[73]

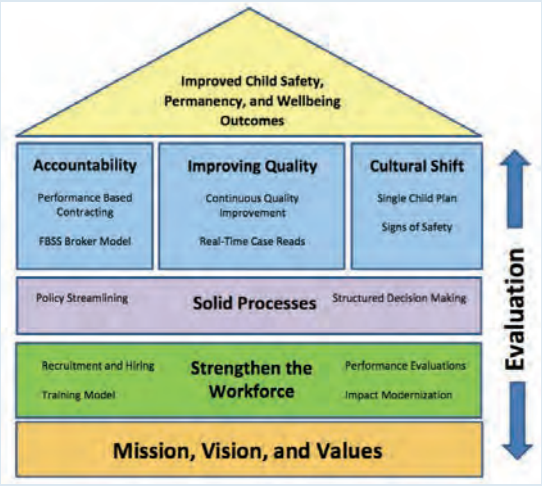
The most recent request for proposals (RFP) for Foster Care Redesign SSCC contracts was for DFPS Region 2 in Northwest Texas, and that RFP opened in Summer 2016.[74] Additionally, one of the exceptional items (#4) in DFPS' proposed 2018-19 budget is to "Strengthen and Expand High Quality Capacity and Systems in the Foster Care System", which includes the expansion of the Foster Care Redesign program to eight new catchment areas and roughly half of children in paid foster care, at an initial cost of $101.3 million.[75]

CPS "TRANSFORMATION" PLAN: REDUCE CASEWORKER TURNOVER AND CHILD FATALITIES

DFPS has been prioritizing "transformation" the past few years, a self-improvement process that is focused on making CPS a better place to work and a more effective system overall.[76] As part of this transformation, CPS designed and implemented a competency-based training program known as CPS Professional Development (CPD). As a result of CPD, newly hired CPS caseworkers receive improved classroom and hands-on experience in addition to being assigned a mentor upon hiring, which enables caseworkers to get direct feedback from another worker and spend more time "learning and practicing skills in the field".[77] Combined with the new CPD training program, the transformation process also aims to decrease child fatalities in DFPS care by using uniform, step-by-step procedures and flowcharts for caseworkers

who are assessing the immediate and long-term safety risks that children face. Figure 94 below shows the overarching philosophy and interdependent goals of the system-wide approach to transformation that DFPS is undertaking.

Figure 94. DFPS' Model of Agency-Wide Transformation



Source: Texas Department of Family and Protective Services. (April 2016). *Progress Report to the Sunset Advisory Commission: Child Protective Services Transformation.* Page 2. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2016/2016-05-05_CPS_Transformation_Progress_Report_Sunset.pdf

In addition to the transformation focusing on the interdependent goals of a system-wide approach depicted above, the new DFPS co-transition specialists appointed by Judge Jack in March 2016 will be in charge of choosing and setting regulations for what constitutes a safe and appropriate number of cases for a caseworker to be in charge of at once. High caseloads for CPS workers can lead to failures to conduct routine visits, identify safety risks, and intervene appropriately.[78,79,80] Having lower caseloads allows CPS caseworkers to be more effective and thorough in their work while providing needed attention and support to all vulnerable children.

The average caseload for CPS workers has improved in the last two years to about 31 or 32 active cases per worker in FY 2015. However, average caseloads remain significantly higher (almost double) than the 17 cases per caseworker recommended by the Child Welfare League of America.[81] High caseloads can lead to high turnover of staff, discontinuity on cases, and negative outcomes for children. The turnover rate for workers at CPS increased from 25.2 percent in 2014 to 25.7 percent in 2015, and the turnover rate for supervisors increased even more – from 6.3 percent in 2014 to 9.5 percent in 2015.[82] CPS worker turnover statewide was still at 23.0 percent in the second quarter of FY 2016, but statewide averages can have the unintended effect of hiding the fact that turnover rates in some counties have reached as high as 57 percent a year (Dallas County).[83,84] Exit surveys explain some of the most common reasons case workers report leaving:

- Job stress
- Safety concerns (e.g. working in unsafe neighborhoods late at night)
- High caseloads
- Poor supervision and pay.[85]

The new DFPS Commissioner Hank Williams has indicated that one of his priorities for the upcoming legislative session is to try to reduce CPS caseworker turnover by

increasing pay and adding new caseworker positions to help reduce caseload sizes.[86] For example, in DFPS' proposed budget for FY 2018-19, one of the exceptional items (#2) requests $202.2 million in new funding to add hundreds of new CPS workers (e.g. CPS Investigation Caseworkers, CPS Kinship Caseworkers, SWI Intake Specialists) to reduce caseload sizes and subsequently improve the ability of DFPS to fulfill their main mission – protecting vulnerable populations from being subjected to abuse and neglect.[87]

INCREASED FOCUS ON NORMALIZATION IN MENTAL HEALTH TREATMENTS AND INTERVENTIONS

The National Foster Care Youth & Alumni Council has defined normalcy as "the opportunity for children and youth in out-of-home placement to participate in and experience age and culturally appropriate activities, responsibilities and life events that promote normal growth and development."[88] DFPS encourages normalcy for children in care but foster families in particular receive mixed messages from caseworkers on what is and is not allowed. Many foster families fear regulatory or legal repercussions if a child is allowed to participate in an activity not specifically included in the child's service plan. The Promoting Independence Advisory Committee has been a crucial part of the system-wide push towards less restrictive and more patient-centered services.[89]

SB 830 (84th, Kolkhorst/Dutton) established an independent ombudsman office outside of DFPS (to be housed in HHSC) and required the new ombudsman to develop and implement statewide procedures to receive complaints from children and youth in DFPS conservatorship, provide any necessary assistance, and follow through with investigation.[90]

Another bill, SB 1407 (84th, Schwertner/Dukes), encouraged age-appropriate normalcy activities for children in foster care, defined a reasonable and prudent parent standard for such decisions, shifted several decision-making responsibilities from the caseworker to the caregiver, and put liability protections in place for caregivers. SB 1407 also required training on normalcy for caregivers, staff, and Residential Child Care Licensing staff. This training is part of CPS' larger focus on promoting normalcy by exposing children involved with CPS to activities and experiences that children outside of CPS care have the opportunity to experience in the normal course of life.

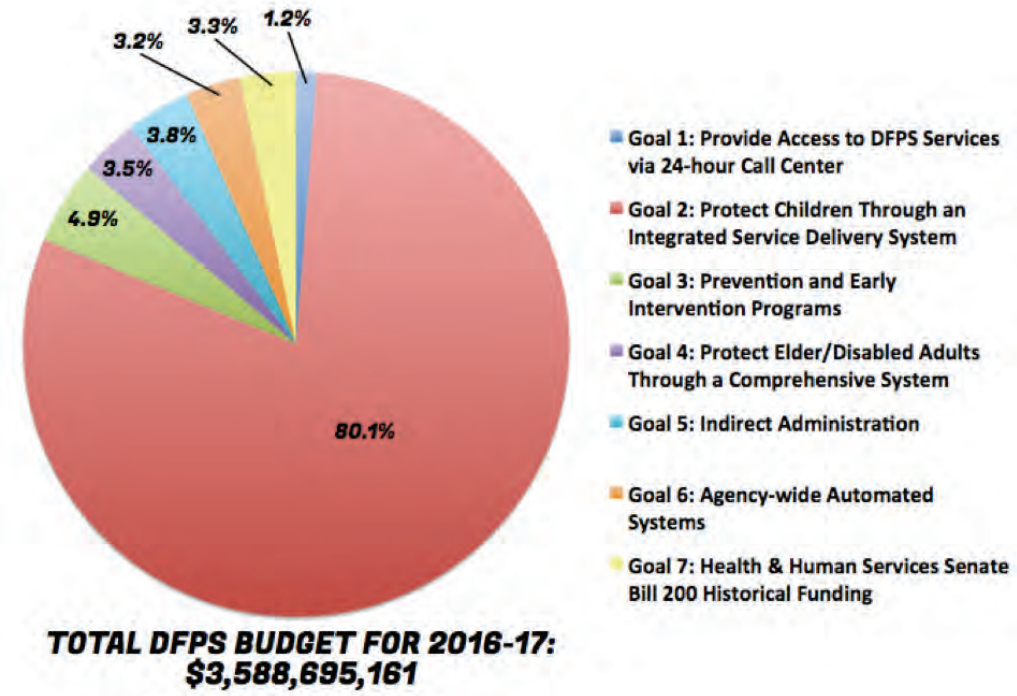
Funding

The Department of Family and Protective Services is jointly funded by both state and federal dollars. The budget for DFPS was roughly $1.375 billion in 2011 and $1.591 billion in 2015 — a 15.7 percent increase in that four-year period. In 2011, 57.4 percent of DFPS funding came from federal sources while the other 42.6 percent came from state sources (e.g. general revenue funds, GR-dedicated funds and other funding sources such as child support payments). By 2015, the federal share of funding for DFPS had dropped to 53.4 percent.[91,92]

As Figure 95 shows, the vast majority of the DFPS budget (80.1 percent) goes

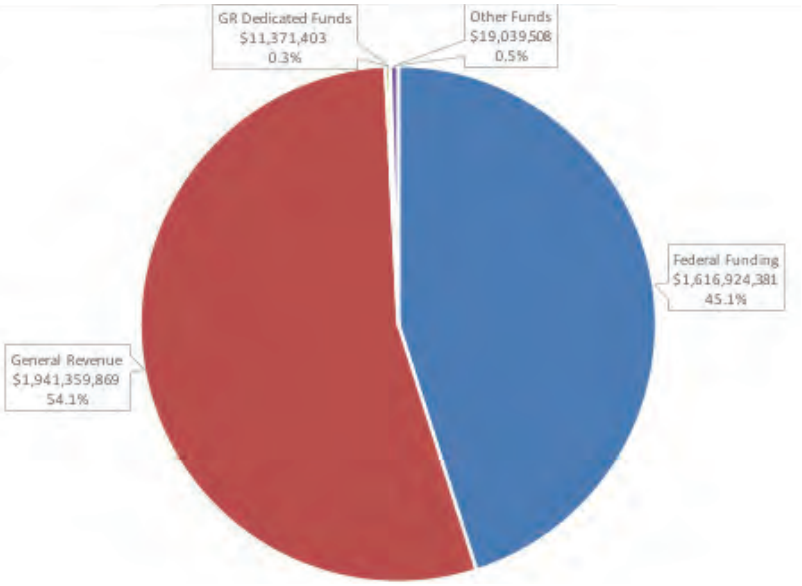
towards the department's CPS-related mission of protecting children by operating an integrated service delivery system.

Figure 95. DFPS Budget by Strategy for FY 2016-17



Source: Texas Department of Family and Protective Services. (September 6, 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019*. Pages 30-31. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Financial_and_Budget_Information/LAR/FY18-19/documents/18-19_LAR.pdf

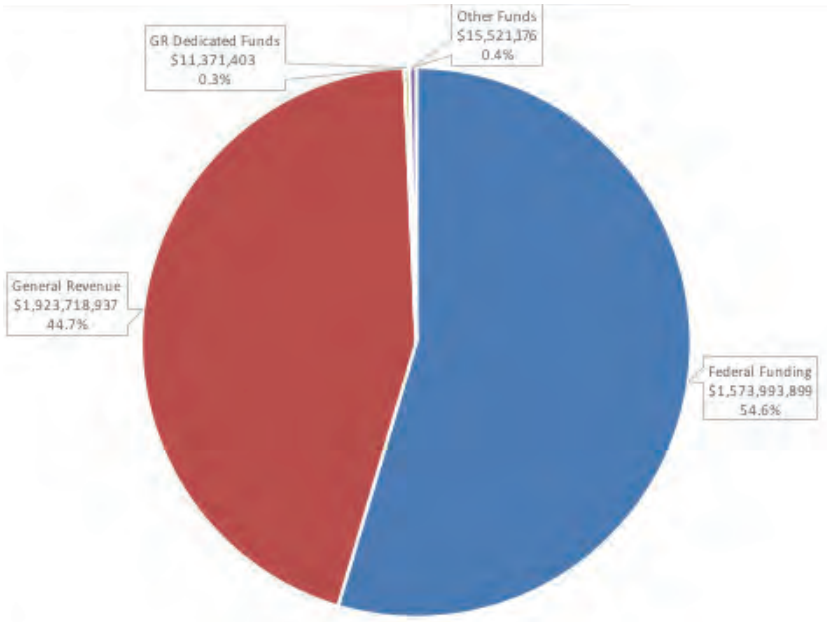
Figure 96. DFPS Budget by Method of Finance for FY 2016-17



The total budget for DFPS FY 2016-17 was $3,588,695,161.

Source: Texas Department of Family and Protective Services. (September 6, 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019*. Pages 30-31. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Financial_and_Budget_Information/LAR/FY18-19/documents/18-19_LAR.pdf

Figure 97. Total DFPS Requested Budget by Method of Finance for FY 2018-19



The total requested budget for DFPS FY 2018-19 is $3,524,605,414 not including Exceptional Item Funds. If included in the budget, those funds would add an additional $533,991,674 of funding.

Source: Texas Department of Family and Protective Services. (September 6, 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019.* Pages 30-31. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Financial_and_Budget_Information/LAR/FY18-19/documents/18-19_LAR.pdf

DFPS submitted a baseline budget request of $3.52 billion for the 2018-19 biennium (not including funds for exceptional items) — that is a net decrease of $64.09 million from the 2016-17 budget. Roughly $14.4 million in general revenue (GR) funds were cut from the DFPS legislative appropriations request for 2018-19 to comply with the legislature's requirement to reduce GR expenditures across all agencies by four percent. However, the majority of this decrease in the 2018-19 legislative appropriations request is a result of the HHS Transformation process, which is moving the Child Care Licensing & Regulation ($94.9 million) and APS Provider Investigations ($24.3 million) divisions from DFPS to HHSC.[93] Also as a result of the HHS Transformation, the Texas Home Visiting and Nurse Family Partnership programs will be moving from HHSC to DFPS, increasing the DFPS budget by roughly $10 million.[94]

The 2018-19 legislative appropriations request for DFPS also has an increase in GR funds to account for caseload growth in specific entitlement programs: Foster Care ($27.8 million) and Adoption Subsidy/Permanency Care Assistance Payments ($25.7 million).[95] As DFPS notes in their Legislative Appropriations Request for FY 2018-19, much of the need for increased state spending on services related to the foster care system is a result of both higher costs per foster care child and the nationwide trend of declining federal funding through the Title IV-E program:

> *"The decline in federal Title IV-E financial participation is the result of continuing erosion in the IV-E penetration rate – the percentage of children*

in foster care who are covered by IV-E. This erosion [...] is the direct result of linking IV-E eligibility to the Aid to Families with Dependent Children (AFDC) income and asset standards that were in place in 1996 [and] have not been increased or indexed for inflation in more than 15 years. Applying those same standards today means that a child has to come from a poorer household than in 1996." [96]

Statewide Intake (SWI)

The Statewide Intake (SWI) division of DFPS operates the Texas Abuse Hotline and is the central hub for all incoming reports of abuse, neglect, and exploitation. SWI receives the initial call and then routes the information to the appropriate department (i.e. CPS, APS, or Child Care Licensing, in addition to client service programs in DSHS and DADS). SWI handles reports of abuse for adults and children in all types of settings, including private homes, childcare facilities, nursing homes, and state facilities.[97]

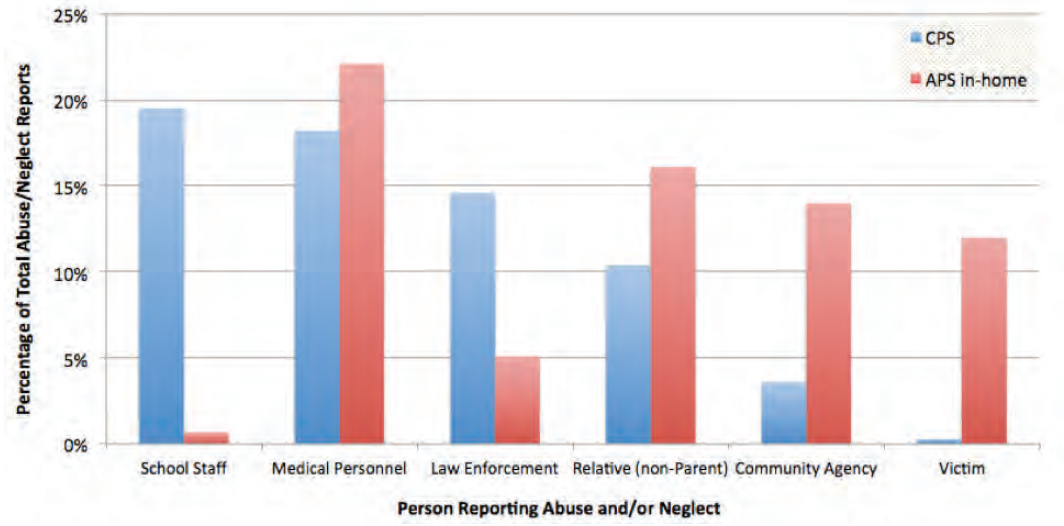
The average hold time for a phone call to the Statewide Intake department has increased by almost a minute in the last four years — from 7.3 minutes in 2011 to 8.2 minutes in 2015.[98,99]

In 2015, SWI employed approximately 418 FTE staff, 309 of which worked as intake specialists.[100] Those intake specialists handled 781,935 abuse- and neglect-related contacts during 2015 — that's an average of more than 2,000 reports of abuse or neglect per day.[101] Those 781,935 reports corresponded to the following departments within DFPS:

- 280,895 cases for CPS investigators (274,448 reports of alleged child abuse/neglect and 6,447 case related special requests),
- 110,290 cases for APS In-Home Investigators (110,277 reports of alleged adult abuse/neglect and 13 case related special requests),
- 12,952 cases for APS Facility Investigators,
- 3,700 cases for Day Care Licensing (DCL) Investigators within the CCL division, and
- 4,516 cases for Residential Child Care Licensing (RCCL) within the CCL division.[102]

While 77.6 percent of the reports of abuse/neglect received by SWI in 2015 came via phone, a significant number of reports came through the Internet (18.5 percent) and mail/fax (3.2 percent).[103] Figure 98 below shows some of the most common types of reporters of abuse and neglect for children and in-home investigations of adult victims.

Figure 98. Source of Abuse/Neglect Reports Received by State-wide Intake in 2015: CPS and APS In-Home Programs



Source: Texas Department of Family Protective Services. (2016). *2015 Annual Report and Data Book*. Page 6. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/

The SWI division of DFPS also operates the Texas Youth Hotline (1-800-98-YOUTH or www.TexasYouth.org), an easily accessible resource that provides "counseling, resources, and referrals to youth and their parents in an effort to prevent abuse, neglect, truancy, delinquency, and running away from home."[104] The Texas Youth Hotline provides both crisis intervention and information regarding community resources.

Child Protective Services (CPS)

Child Protective Services (CPS) is responsible for responding to and investigating allegations of child abuse and neglect, providing at-home services for families and youth in need, removing children from unsafe environments, managing the foster care system, as well as assisting youth to successfully transition out of the CPS system and into safe environments. Thus, CPS interacts with children at three stages: investigating abuse allegations, placing youth in emergency custody or inpatient treatment, and transitioning youth back into normalcy and a healthy environment.

In FY 2015, a total of 290,471 children statewide were alleged victims of abuse or neglect in 274,448 cases (some cases involve more than one child) of alleged child abuse and neglect — a more than 23 percent increase from the number of CPS reports of child abuse/neglect in 2011.[105,106] Of those 274,448 allegations in 2015:

- 46,336 allegations were screened out for not meeting criteria for abuse/neglect [107]
- 4,047 low acuity and low-risk cases were transferred to the new Alternative Response system (1.5 percent of all allegations) [108]
- 224,065 investigations were opened and 176,868 investigations were completed.[109]
- 40,506 of completed investigations were confirmed abuse or neglect cases (confirmed is defined as "based on [a] preponderance of evidence, staff concluded that abuse or neglect occurred").[110]

- In the 40,506 confirmed cases of child abuse or neglect, there were 66,721 unduplicated confirmed child victims (i.e. some cases have more than one victim).[111]
- Following different degrees of CPS intervention, 17,151 children were removed from their homes in FY 2015 in order to keep them safe from an abusive and/or neglectful caregiver or environment.[112]
- DFPS confirmed 171 abuse/neglect related fatalities of children, five of whom died while they were enrolled in the state foster care system.[113]

CHILD ABUSE/NEGLECT AND CPS INVESTIGATIONS

CPS investigates abuse and neglect allegations to make a determination as to whether there is a threat to the safety of the children in their home environment. During child abuse and neglect investigations, a CPS worker 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 CPS 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. This 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.

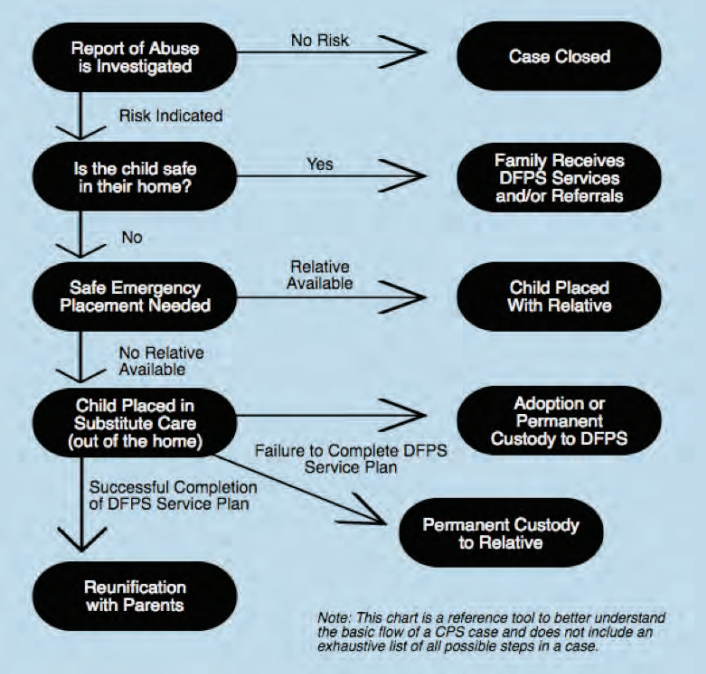
A child is placed in foster care after other parent engagement services and outpatient treatment options have been exhausted. As of August 31, 2015, there were 16,378 children in the Texas foster care system (excluding the 11,517 children in non-foster substitute placements such as kinship care and DFPS adoptive homes).[114,115] A total of more than 47,000 children were in DFPS custody at some point during FY 2015, and 31,200 of them lived in some type of a foster care placement.[116] Hispanic (39.2 percent) and Caucasian children (32.0 percent) make up the majority of children in foster care, with African-American children (22.4 percent) as the third most prevalent racial group.[117] However, when you take into account the racial demographics of Texas children as a whole, African-American children (11.4% of Texas child population) 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.[118]

More than 40 percent of children in DFPS conservatorship are in kinship placements.[119] When it is unsafe for a child to remain in his or her home and there are no appropriate family or friends 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
- Facilities overseen by another state agency.[120]

Figure 99 illustrates the CPS investigation process upon receipt of an allegation:

Figure 99. How CPS Investigates Allegations of Child Abuse



Source: Texas Department of Family and Protective Services. (2016). *Annual Report and Data Book 2015*. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2015/pdf/Databook2015.pdf

ALTERNATIVE RESPONSE SYSTEM

The CPS Alternative Response (AR) system aims to ameliorate the stress of a CPS investigation and provide services to more families in need by adapting the typical investigation process when workers identify a lower-risk allegation. In doing so, CPS provides a non-adversarial means of dealing with less serious cases of abuse and neglect in a more client-centered and less intrusive manner. In considering diverting a case to AR, staff considers 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.[121]

The AR used by Texas' CPS is characterized by the following features:

- The CPS worker conducts "assessments", not investigations.
- A completed assessment does not declare a formal finding of abuse or neglect.
- The report does not designate an alleged perpetrator (i.e. the name of the perpetrator is not added to the Child Abuse/Neglect Central Registry).
- The CPS worker connects families with appropriate service providers.
- The AR process as a whole encourages collaboration with families and a focus on treatment and rehabilitation.[122]

National research has found that differential response systems lead to more

positive outcomes related to child safety, better family engagement, increased community involvement, and improved worker satisfaction.[123] Despite higher initial investments, this approach is more cost-effective in the long run because it reduces the need for long-term services and more costly intensive interventions.[124] 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.

Texas DFPS began AR pilot programs in FY 2015 in three regions — Amarillo, Dallas and Laredo. A few cases have been transferred to Tyler and Midland, where DFPS plans to have AR fully functioning by May 2016. If the current success of AR continues and there are no unforeseen barriers to implementation, DFPS expects AR to be used in all regions statewide by the end of 2017.[125]

A total of 4,047 allegations of child abuse or neglect were transferred to the new AR System in FY 2015, only 1.5 percent of the 274,448 total reports of abuse or neglect for the year.[126] CPS caseworkers have received training on how to implement the AR protocols and only 230 of the 4,047 cases that were initially referred to AR in FY 2015 were later transferred to full abuse/neglect investigations.[127]

ACCESSING MENTAL HEALTH SERVICES

SUPERIOR HEALTH SYSTEM (STAR HEALTH)

In 2008, the STAR Health program was created to provide children in foster care with primary care and behavioral health services using a managed care delivery model. Superior Health Plan contracted with the state to run the STAR Health program and has been operating the program since its inception.[128] 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.

In FY 2014, 30,732 children were enrolled in STAR Health (including those in kinship care, foster youth up to age 22, and former foster youth receiving transitional Medicaid services).[129] STAR Health requires that each foster care child has access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services, and more.[130] Behavioral health services offered by Superior include:

- Psychiatric services
- Psychological testing (including screening, assessment, and diagnosis)
- Rehabilitation skills training
- Detoxification services
- Depression Disease Management Program[131]

Historically, the lack of a central medical records system for children in DFPS care created serious problems such as the over-prescription 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.[132] The Health Passport follows children wherever they go 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 and can access 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.[133]

FORMER FOSTER CARE CHILDREN PROGRAM (FFCC) AND MEDICAID FOR TRANSITIONING FOSTER CARE YOUTH (MTFCY)

Many foster children who age out of the foster care system lose health insurance coverage. 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.[134] 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 wellbeing.[135]

As a component of the Affordable Care Act (ACA), the Former Foster Care Children Program (FFCC) provides extended health insurance coverage to former foster care children under the age of 26.[136] 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. Effective January 2014, former foster care children receiving healthcare services through one of the insurance plans that existed at that time — Medicaid for Transitioning Foster Care Youth (MTFCY) or Former Foster Care in Higher Education Program (FFCHE) — were transitioned to FFCC.[137] Those who do not qualify for FFCC will still be covered under MTFCY as long as they meet MTFCY income requirements.

There are two groups of young adults previously in CPS conservatorship that are ineligible for access to post-care health services: individuals originally from Texas who have aged out of the foster care system in another state and individuals who have aged out of the Texas foster care system and have since moved to another state.[138] 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.

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 HHSC section for more information on STAR and STAR Health services and eligibility.[139]

See Figure 100 for an overview of existing health insurance programs for former foster care children.

Figure 100. Health Insurance Programs for Former Foster Care Children

Plan Name	Eligibility	Income or Other Requirements
Former Foster Care Children Program (FFCC)	· Anyone who has aged out of foster care or the Unaccompanied Refugee Minor Resettlement Program in the state of Texas at age 18 or older. · Ages 18 to 26. · Started receiving Medicaid when he or she aged out of foster care. · Meet all other Medicaid eligibility criteria such as U.S citizenship, alien status, and residence.	No asset, income, or educational requirements.
Medicaid for Transitioning Foster Care Youth (MTFCY)	· Ineligible for FFCC (typically because they did not have Medicaid on their 18th birthday) · Covers ages 18 to 21 · U.S. citizen or qualified non-citizen. · Aged out of Texas conservatorship at age 18 or older. · Inadequate health coverage.	Income limit of $3,955 per month (with an added $1,384 for each additional person in a family)

Source: Texas Department of Family Protective Services. (n.d.) *Medical Benefits.* Retrieved from https://www.dfps.state.tx.us/Child_Protection/Youth_and_Young_Adults/Transitional_Living/medical_benefits.asp; and Texas Law Help. (n.d.) *Free Health Insurance Medicaid for Aged Out Foster Youth Ages 18-25 Former Foster Care Children's (FFCC) Program and Medicaid for Transitioning Foster Care Youth (MTFCY): September 2015 version.* Pages 4 and 5. Retrieved from http://texaslawhelp.org/files/685E99A9-A3EB-6584-CA74-137E0474AE2C/attachments/2AC8E4AE-0BE2-452E-90B0-6668C21C7A2D/foster-youth-health-insurance-finalsept2015.pdf

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.[140] If this option is not available or appropriate, the child may be placed in a foster home with foster parents, a foster family group home, or a general residential operations (GRO) facility. A GRO is a congregate care facility that provides residential services for 13 or more children up to the age of 18 years. GROs are licensed by DFPS and include long-term residential facilities that provide basic childcare, emergency shelters in which children are typically placed for less than 30 days, and more long-term residential treatment centers (RTC). An RTC provides care and treatment services exclusively for children with complex emotional and psychological needs.[141]

As of August 2015, there were a total of 235 licensed GROs regulated by DFPS — 74 of those GROs are classified as RTCs and another 124 of them provide treatment services for children with emotional disorders.[142,143] RTCs had capacity to provide services to a total of 3,483 children in August 2015, while GROs had capacity to serve a total of 9,026 youth.[144] DFPS provides an online search tool that lists all of these child-care facilities in the state — that search tool can be found at www.dfps.state.tx.us/Child_Care/Search_Texas_Child_Care/ppFacilitySearchResidential.asp.

CONTINUING ISSUES

CHILD FATALITIES IN THE CPS SYSTEM

Child fatalities continue to occur in the Texas child welfare system, but the rate of these deaths has decreased in recent years. DFPS reports that a total of 171 children in Texas died as a result of child abuse or neglect in FY 2015 — a 36 percent decrease from FY 2011, when there were 231 such deaths. The majority of these deaths were neglect-related (59 percent) as opposed to abuse-related (41 percent).[145]

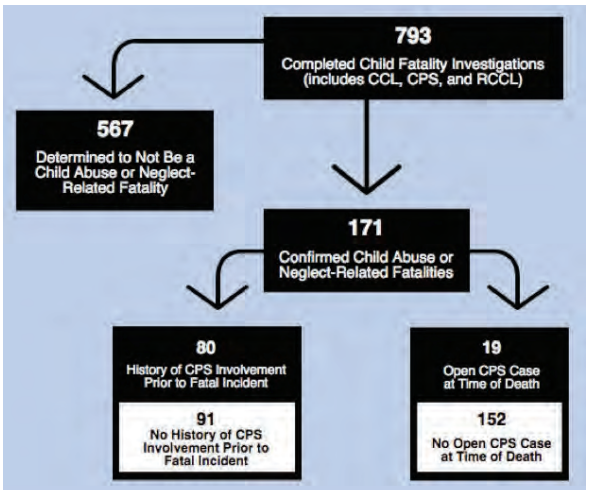
The rate of child abuse and neglect-related deaths per 100,000 Texas children is also dropping, down from 3.5 in 2011 to 2.3 in 2015.[146] Overall abuse and neglect-related child fatalities in Texas have fallen in recent years.[147] Confirmed deaths from physical abuse or intentional trauma dropped by 26 percent between 2011 and 2015, and confirmed deaths from neglect (e.g. drowning or death from unsafe sleeping conditions) decreased by 22.5 percent during that same time period.[148]

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 out from the following pieces of information:

- While the majority of the 171 child deaths in FY 2015 continued to involve Anglo (51) and Hispanic (67) children, African-American youth are more disproportionately represented in child abuse and neglect-related death statistics, with a 4.2 per capita fatality rate.[149]
- A history of child maltreatment and domestic abuse increases child fatality risks; 47 percent of families who had a confirmed child abuse or neglect-related fatality in 2015 had a history of prior involvement with CPS.[150]
- More than 11 percent of abuse- and neglect-related fatalities involved families and/or perpetrators with an open and active CPS case at the time of death.[151]
- Between 39 percent (FY 2015) and 48 percent (FY 2014) of abuse and neglect-related child fatalities include a parent or guardian actively using substances and/or actively under the influence of substances that impacted their ability to protect and care for the child.[152]
- Children under the age of three accounted for roughly 80 percent of all confirmed child abuse and neglect-related deaths between 2011 and 2015.[153]
- Mothers (36 percent) and fathers (27 percent) represented the majority of primary perpetrators in child abuse or neglect-related deaths in FY 2015, but boyfriends (18 percent) and baby sitters/day cares (7 percent) accounted for roughly a quarter of perpetrators in these cases.[154]

Figure 101 provides details on the child fatalities in Texas in FY 2015:

Figure 101. Child Fatalities in Texas: FY 2015



Source: Texas Department of Family and Protective Services. (2016, April). *Child Abuse and Neglect Fatalities Annual Report: FY 2014 and FY 2015 Analysis*. Page 50. Retrieved from https://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Office_of_Child_Safety/documents/Child_Fatality_Annual_Report_2014_2015.pdf

There are many possible reasons for this dramatic decline in child abuse and neglect-related deaths in Texas:

- DFPS formed the Office of Child Safety in 2014, tasked with independently analyzing child abuse and neglect fatalities and the risk factors and systemic issues that perpetuate these fatalities,
- Increased community-level interventions and initiatives to combat child deaths, such as the Blue Ribbon Task Force and state and local Child Fatality Review (CFR) Teams,
- More consistent system-wide guidelines (beginning in 2012) for CPS workers who handle child fatality cases involving co-sleeping, drowning, firearm accidents, suicide, and vehicle safety.
- More accessibility and availability of preventive, community-based behavioral health services,
- Improved training and availability of treatment resources for the medical community, including the Medical Child Abuse Resources and Education System (MEDCARES), and
- A bigger focus on public health approaches to reducing three of the most prevalent causes of neglect-related child fatalities: unsafe sleeping arrangements, unsafe vehicles, and injury resulting from domestic violence.[155]

Following internal rule changes within DFPS to address abuse and neglect related deaths of children in foster care, HB 781 (84th, Burkett/Zaffirini) addressed the issue by requiring foster care providers and child placing agencies to include more rigorous minimum caregiver training requirements before contracts and placements are approved.[156] New regulations were put into place that enforce stricter monitoring of foster care homes; some of these new rules include:

- Additional interviews with neighbors, clergy, school employees, community

members, and family members living outside the home,
- Assessment of personal relationships and parenting of foster parents, and
- Review of household finances and past law enforcement calls to the home.[157]

In addition to these stricter screening requirements and the new child fatality trainings and risk assessment tools that are part of the CPS transformation process (see Changing Environment Section), child placing agencies (CPAs) are also now required to closely monitor changes in all foster homes (such as job losses, marriages, divorces, frequent visitors, and family additions). The goal of this change is to provide more oversight and protection of foster care children and prevent not only child fatalities, but also unnecessary trauma and/or neglect.[158] Another bill passed in 2015 that should improve safety for children in foster care going forward is SB 830 (84th, Kolkhorst/Dutton), which created an independent ombudsman for youth in foster care to help streamline and standardize investigations into reports of abuse and neglect.[159]

DISPROPORTIONALITY AND DIVERSITY OF CHILDREN AND YOUTH IN CPS

Racial and Ethnic Diversity in CPS

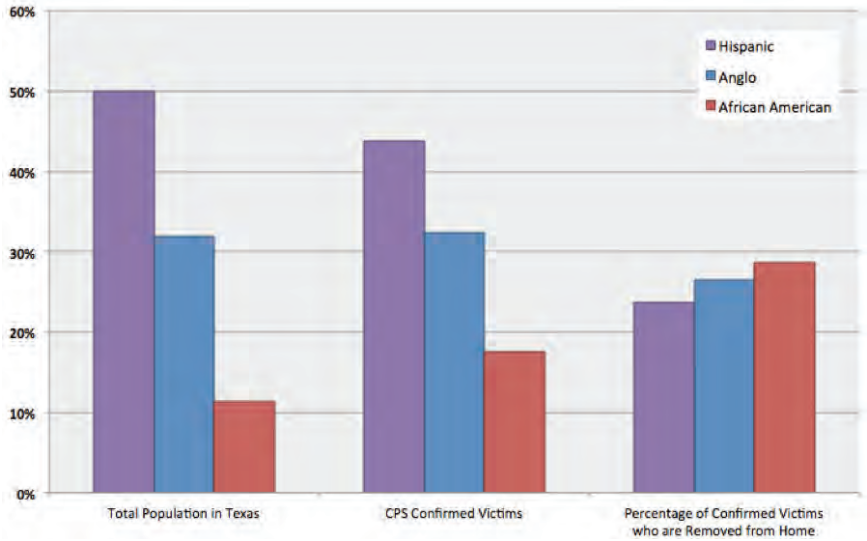
The disproportionate representation of African American children and youth in the statewide CPS system continues.[160] While not overrepresented at the statewide level, Hispanic children in Texas are another group disproportionately represented at certain points in the child welfare system. This overrepresentation of African American and Hispanic youth receiving child welfare services has been present in all 50 states and is not unique to Texas.[161]

A number of theories have been offered as explanations for the disproportional 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 stable housing and employment,
- Racial biases among CPS workers and individuals who report abuse and neglect, and/or
- Lack of cultural competence among CPS investigators and caseworkers.[162,163]

Figure 102 shows the ethnic and racial profile of children in Texas compared with children invoved in the CPS system at various levels:

Figure 102. Disproportionality in CPS: Racial and Ethnic Differences in FY 2015



Source: Texas Department of Family and Protective Services. (2016). *2015 DFPS Data Book*. Page 42. Retrieved from http://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2013/Combined13.pdf

According to 2015 data, African-American children also wait much longer to be adopted (median of 12.3 months) compared to Hispanic children (9.6 months) and Anglo children (9.6 months). And while Asian children account for a very small proportion of the confirmed victims of abuse (.6 percent) and the number of children removed from a home because of safety concerns (.4 percent), Asian children in Texas typically wait longer than any other group to be adopted (13 months).[164] In FY 2015, there were a total of 6,888 children waiting to be adopted in Texas.[165]

While DFPS' main goal is to address disproportionality 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. For example, CPS started to provide some caseworkers with Poverty Simulation trainings in 2013. The goal of the simulations is to increase understanding and awareness about the realities and struggles that families in poverty face.[166] CPS has also created disproportionality specialist positions and worked to increase staff diversity and collaboration with the Disproportionality Advisory Committee to reduce disparities. New DFPS caseworkers (both CPS and APS) are also now required to take a racial diversity training called, "Knowing Who You Are: Racial and Ethnic Identity Training." To date, more than 5,000 workers have taken the training and DFPS reports that feedback from caseworkers has been very positive.[167]

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 aren't eligible to receive support services like Temporary

Assistance for Needy Families (TANF) or Supplemental Nutrition Assistance Program (SNAP) benefits. CPS provides only limited financial help to encourage kinship placements.[168] Once kinship placements take place, 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.[169]

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual Youth (LGBTQIA)

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 over-represented in the child welfare system. The stigma associated with LGBTQIA identity makes this population more vulnerable to both trauma and mental health conditions such as depression, substance use, and heightened risk of suicide.[170] That 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 LGBTQIA youth are overrepresented in foster care, accounting for between 5 and 15 percent of all youth in foster care.[171]

Research studies show that LGBTQIA youth have an increased risk of experiencing several different negative situations and outcomes compared to their hetero-normative peers:

- LGBTQIA 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, depression, and substance use.[172] One study found that over 30 percent of LGBTQIA youth reported suffering physical violence at the hands of a family member after coming out.[173]
- Higher rates of harassment, exclusion and unfair treatment due to negative social attitudes. [174]
- Difficulty finding a foster family that understands, accepts, and is responsive to their full range of needs and identity. One study found that up to 78 percent of LGBTQIA youth in foster care were either removed or ran away from their foster placements as a result of encountering hostility toward their sexual orientation or gender identity.[175]
- Disparities for LGBTQIA foster care youth continue into adulthood, as studies show that LGBTQIA former foster care youth are less financially stable as adults than their heterosexual peers.[176]

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 hetero-normative peers. Increasing family and caregiver support services 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.

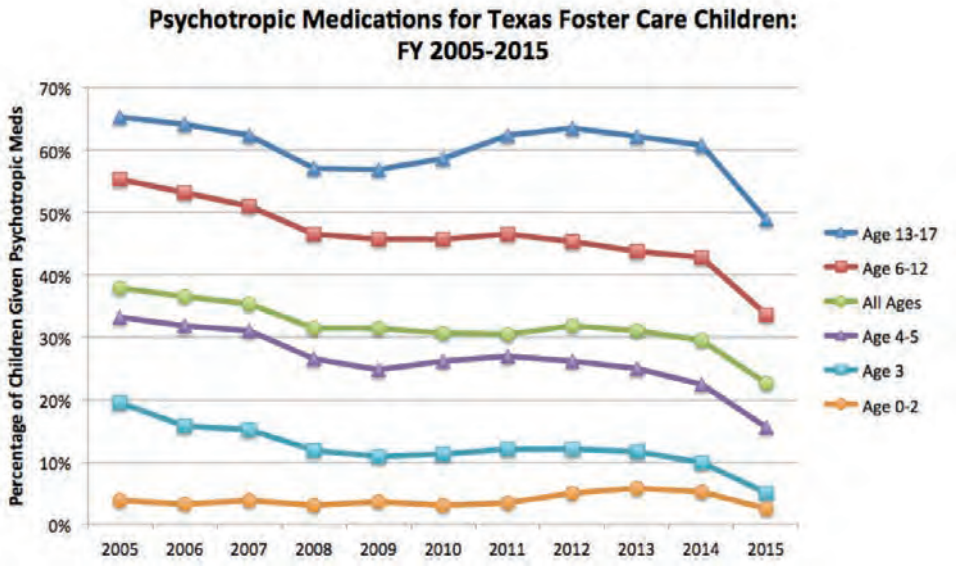
PSYCHOTROPIC MEDICATIONS IN FOSTER CARE

Foster children historically have been disproportionately treated for their behavioral health needs with psychotropic medications, drugs that affect an individual's mind, emotions, and behavior.[177] Psychotropic medication prescriptions for foster youth in Texas reached a peak in 2004, when close to 42 percent of all children in foster care were prescribed at least one psychotropic medication.[178] A 2011 report by the U.S. Government Accountability Office (GAO) showed that in Texas, children in foster care were prescribed psychotropic drugs at rates 2.7 to 4.5 times higher than children not in foster care.[179]

Even when effective in treating mental health conditions, psychotropic medications also carry significant and potentially long-lasting side effects, including trembling, decreased/increased appetite, weight gain, headaches, nausea, and increased risk of suicidal thoughts.[180] Usage of psychotropic medications may also result in long-term effects such as stunted physical development.[181] One research study showed that nationally, 10 percent of foster kids received antipsychotic medications, a powerful subset of psychotropic medications that can carry significant side effects in children.[182,183]

Over the past decade, Texas has undertaken a series of different steps to better regulate and monitor the prescription of psychotropic medications for foster care children. Following the alarming rates of prescriptions in foster care in 2004 and subsequent increased media focus on the issue, HHSC, DSHS and DFPS released Psychotropic Medication Utilization Parameters in 2005 that established standards and requirements for the prescription of psychotropic medication.[184] The goal of the parameters was to encourage clinically appropriate and informed usage of psychotropic medications.

Figure 103. Reduction of Psychotropic Medication Use in The Texas Foster Care



Source: Texas Health and Human Services Commission. (2016). "Update on the Use of Psychotropic Medications for Children in Texas Foster Care: Fiscal Years 2002-2015". Retrieved from https://www.hhsc.state.tx.us/hhsc_projects/upmtfc/2015-Update-on-Psychotropic-Medications-Use-in-TexasFosterChildrenACCESS.pdf

As shown above in Figure 103, psychotropic medication prescriptions for foster

care youth have declined significantly in recent years, particularly in 2014 and 2015. This reduction is the result of over a decade of efforts by legislators and advocates to address the issue of overprescribing psychotropic medications for children in foster care. A few recent successes include:

- The passage of HB 915 (83rd, Kolkhorst/Nelson), which improved accountability and regulation of psychotropic prescriptions, required additional training for adults authorized to consent to medical care for foster children, required a doctor's office visit every 90 days for children on psychotropic medication, created a medical consenter informational brochure and youth transition plan for children taking prescription medications, and required notification to biological parents of their child being prescribed psychotropic medications.
- HB 915 (83rd, Kolkhorst/Nelson), which created provisions to strengthen informed consent in prescribing psychotropic medications to children in state custody. Guardians ad litem and attorneys ad litem are now required to discuss with youth clients the medical and mental health care they are receiving and ask for their input. They are also now required to explicitly inform youth ages 16 and older that they may petition the court to be their own medical consenter. By involving individuals who can consent to medical care on behalf of the child, the child, and the judiciary system, everyone involved in a child's care can be kept abreast of the child's medical history.[185]
- The creation of the Health Passport discussed previously, which allows DFPS staff, medical professionals, foster parents and caregivers to track and easily access each child's medication history and medical information in one central online location.
- The establishment of one managed care organization (MCO) providing all pharmacy and acute care utilization for children in foster care, allowing for improved information sharing and streamlined decision making regarding past and current treatments.[186]

As a result of these and other changes, the percentage of children in Texas foster care being prescribed any psychotropic medication has dropped from 37.9% in 2005 to 22.6% in 2015 (see Figure 103 above). Looking more closely at children taking multiple medications, Texas has reduced the number of children in foster care prescribed two or more psychotropic drugs by 71 percent since 2004 and reduced by 73 percent the number of children taking five or more psychiatric medications.[187]

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, and the overwhelming majority of children who enter the foster care system experience trauma as a result of neglect or abuse.[188] Many children in foster care also experience trauma as a result of multiple removals and placements in different foster homes and shelters, and nearly half of youth in the child welfare system have clinically significant emotional or behavioral problems.[189] Rates of behavioral problems, developmental delays, and need for psychiatric intervention for foster care youth range from 60 to 80 percent.[190, 191] Professionals who interact and work with these children must therefore be cognizant of their trauma-related needs and increased potential for mental health care.

Trauma-informed care recognizes the effects of trauma on the individual, and

provides care that is evidence-based and tailored to an individual's needs and unique experiences. It therefore provides a non-pharmacological approach to healing that decreases reliance on psychotropic medications and increases placement stability.[192] Trauma-informed care is not a discrete intervention, but rather is 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 workers 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 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 three bills that expanded education and training on trauma and trauma-informed care. While these bills did not directly modify DFPS operations, they had a definite impact on children receiving services through DFPS:

- SB 1356 (83rd, Van de Putte/McClendon) required trauma-informed training for probation officers, juvenile supervision officers, and court-supervised community-based personnel.[193]
- SB 7 (83rd, Nelson/Raymond) ensured that professionals working on behavioral health intervention teams have training in trauma-informed practices.[194]
- SB 152 (83rd, Nelson/Kolkhorst) required direct care staff at state hospitals to have training in trauma-informed care.[195]

Then in 2015, the 84th Legislature significantly expanded and improved trauma-informed care within DFPS. SB 125 (84th, West/Naishtat) mandated that children entering into DFPS care receive a comprehensive assessment that includes a screening for trauma within 45 days of their entry into services.[196] 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.[197]

Prevention and Early Intervention (PEI)

The Prevention and Early Intervention (PEI) division of DFPS partners with community providers and families to prevent abuse, neglect, truancy, runaway, 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. 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 altogether.[198] Programs and outreach efforts coordinated through this division address negative outcomes and try to provide services for youth before they are in crisis.

In FY 2015, 75,449 people were served by PEI programs — an almost 4.5 percent increase over the number of individuals receiving PEI services in FY 2014.[199] Figure 104 lists the various programs and services provided through the PEI division of DFPS.

Figure 104. Prevention and Early Intervention (PEI) Programs and Services in Texas

Program	Program Description and Service	Regional Availability
Community-Based Child Abuse Prevention (CBCAP)	Uses federal grant dollars to develop and support existing 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.	Funds distributed to many communities across Texas.
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.	Amarillo (79107), Austin (78744), Brownsville (78520), Corpus Christi (78415), Dallas (75216), Dallas (78217), El Paso (79924), Fort Worth (76106 & 76164), Galveston (77550), Houston (77081), Pasadena (77506), Lubbock (79415), McAllen (78501), San Antonio (78207), Waco (76707)
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 are targeted to specific counties and include a home-visiting component.	Cameron County, Ector County, El Paso County, Gregg County, Hidalgo County, Potter County, Travis County, Webb County
Preparation for Adult Living Program (PAL)	Intended to prepare older youth in substitute (foster) care for their exit from DFPS custody and CPS. PAL classes provide youth with the social and financial skills needed to lead a successful life. Services include: vocational skills training, housing, transportation, health, financial management, GED classes, counseling, and mentoring. PAL also providers Supervised Independent Living (SIL) programs and transitional living allowances for eligible individuals.	All counties in Texas

Program	Program Description and Service	Regional Availability
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.	All counties in Texas
Services to At Risk Youth (STAR)	Contracts with community providers to offer short-term services to youth who experience conflict at home, have been truant or delinquent, or have run away. Service available through STAR include: family crisis intervention counseling, short-term emergency residential care, and individual and family counseling.	All counties in Texas
Statewide Youth Services Network	Supports statewide networks of community-based programs that provide evidence-based services aimed at preventing juvenile delinquency.	All counties in Texas
Texas Families: Together and Safe (TFTS)	Funds community-based programs designed to alleviate stress and promote family cohesion. Programs focus on teaching parental techniques that increase the ability of families to successfully nurture their children and work towards family self-sufficiency.	Bexar County, Cameron County, Hidalgo County, Kerr Country, and Nueces County

Sources: Texas Department of Family and Protective Services. (2016). *DFPS Annual Report 2015.* Pages 20-23. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Annual_Reports_and_Data_Books/2015/pdf/DFPS_FY15_Annual_Report.pdf; and Texas Department of Family and Protective Services. (n.d.). *Prevention and Early Intervention (PEI) Programs.* Retrieved from https://www.dfps.state.tx.us/prevention_and_early_intervention/about_prevention_and_early_intervention/programs.asp

Adult Protective Services (APS)

The Adult Protective Services (APS) division of DFPS investigates allegations of abuse, neglect, and exploitation for specific groups of people. APS provides services for individuals age 65 or older and adults age 18-64 who are:

- Living at home with a mental, physical and/or intellectual/developmental disability,
- Living in state hospitals, contracted inpatient facilities, state-supported living centers (SSLCs) and Intermediate Care Facilities for Intellectual Disabilities and related conditions (ICF/IDD),
- Receiving community-based services from DSHS or DADS (e.g. LMHAs and IDD providers) or
- Receiving services contracted through an HHS agency or MCO.[200,201]

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 population of Texans aged 65 and older reached 3,225,614 in 2015, about 11.6 percent of Texas' total population, and that number is expected to increase to 18 percent in the next 20 years.[202,203] Since 2000, individuals age 65 and older have been the fastest growing age group in Texas.[204] This growth will likely lead to an increased demand for mental health services in the future as more individuals in the "baby boomer" generation become eligible for Medicare and other social services that are tailored to older Americans. Because Medicare does not have financial requirements for eligibility like Medicaid and all individuals over age 65 are eligible, many individuals who do not receive publicly-funded health services as adults begin receiving them at age 65 when they enter Medicare.[205] The rising costs of prescription drugs will also continue to increase the overall cost of the Medicare program as baby boomers become eligible for Medicare coverage.[206]

The incidence of adult abuse, neglect and exploitation per 1,000 Texans aged 65 or older has fallen in recent years, from 12.4 percent in 2011 and 10.4 percent in 2013 to 8.9 percent in 2015.[207,208,209] There were 110,277 reports made of in-home abuse/neglect of adults in FY 2015, with the majority of reports initiated by medical personnel (21.8 percent), relatives (16.4 percent), community agencies (13.7 percent) and the victim themselves (11.8 percent).[210] Adult children were the most common perpetrators of APS investigations into in-home maltreatment (38 percent).[211] The following breakdown shows the outcomes of the 110,277 reports of in-home abuse or neglect made to APS in 2015:

- 78,180 completed in-home investigations
- 43,759 separate instances of validated in-home allegations
- 29,442 of the validated in-home allegations received services (67.3 percent)[212]

As mentioned earlier, APS conducts abuse and neglect investigations in facilities in additions to client's private homes. In regards to investigations of abuse or neglect in residential facilities (i.e. state hospitals, SSLCs, ICF/IDDs and certain contracted inpatient facilities), APS completed 11,935 facility investigations into reports of abuse or neglect of adults in FY 2015.[213] The majority of facility abuse/neglect allegations were for individuals enrolled in Home and Community-Based Service Programs (32.3 percent), State-Supported Living Centers (31.1 percent), and State Hospitals (21.3 percent).[214] Roughly 10 percent (1,192) of all allegations of abuse or neglect in adult facilities in 2015 (11,935) were confirmed after an investigation by APS.[215]

In contrast to in-home investigations, the majority of reports of abuse and neglect in adult facilities come from just two groups of people: institutional personnel (27.1 percent) and the victims themselves (23.4 percent).[216] The Austin region had more allegations of abuse than any other region due to the high concentration of inpatient facilities in the Austin region, but Austin also had a higher percentage of allegations confirmed as abuse or neglect (12 percent) when compared to the rate in the state's other 10 regions (9.5 percent).[217]

One possible reason for the higher percentage of validated in-home allegations than validated facilities allegations is that most in-home cases involve self-neglect and are thus more readily validated than allegations involving a perpetrator. When

allegations are confirmed, APS provides emergency service interventions but does not have the capability or resources to provide ongoing supports or services after an affirmative finding of abuse/neglect.[218] Whereas CPS can provide services regardless of whether there have been affirmative findings of abuse or not, APS is not statutorily authorized to provide services to adults who have unsubstantiated or unconfirmed allegations of abuse/neglect.[219] Individuals who are incapable of consenting to services are referred to the HHSC to receive guardianship services. APS investigators and staff will alert law enforcement immediately if the suspected abuse may constitute criminal conduct.

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.[220] APS also distributes literature about health risks for the elderly, including dangers related to excessive summer heat.

Child Care Licensing (CCL)

The Texas Child Care Licensing (CCL) division regulates childcare operations, approves permits for new residential childcare facilities, and monitors ongoing compliance with state licensing standards, rules and laws. CCL also works to educate the public on the minimum standards required for childcare facilities to operate and helps to investigate instances of abuse and neglect at childcare facilities that CCL monitors for compliance. Figure 105 describes the five types of childcare operations regulated, monitored and/or overseen by the CCL division of DFPS:

Figure 105. Childcare Operations Overseen and Regulated by CCL

Facility Type	Description
Residential Childcare (including Child Placing Agencies and Residential Treatment Centers)	Facilities that provide childcare services to 13 or more children for 24 hours a day in a location other than the child's own home. Facilities often provide medical and mental health services. Inspected annually for compliance.
Licensed Child Care Centers or Day Cares	Centers that serve seven or more children from ages 0 to 13 who attend the child-care center for only part of the 24-hour day. Inspected annually for compliance.
Licensed Childcare Homes (also known as Group Day Care Homes or At-home Day Cares)	Individuals provide childcare in the caregiver's residence for children from birth through 13 years. Including the children related to the caregiver running the day care, the total number of children must not exceed 12 at any time. Inspected annually for compliance.
Registered Child Care Homes	Similar to Licensed Childcare Homes but inspected less frequently (every 1-2 years), held to slightly less stringent standards, and only six children under the age of 14 are allowed to be present in the home at any given time.
Listed Family Homes	Includes individuals who receive compensation for providing in-home childcare for 1-3 unrelated children. These homes are not inspected unless there is a reported allegation of abuse, neglect, or misconduct.

Source: Texas Department of Family and Protective Services. (2015). *Types of Childcare.* Retrieved from https://www.dfps.state.tx.us/child_care/other_child_care_information/childcare_types.asp

The CCL division's regulation of childcare services and facilities in Texas ultimately reduces the risk of injury, abuse, neglect, negative social and emotional outcomes, and the transmission of communicable diseases. Licensing childcare facilities and monitoring compliance with regulations is the first line of defense in ensuring that Texans are getting the behavioral health services and treatment that will help them through the recovery process.

In FY 2015, there were 20,882 daycare centers and homes in Texas, almost 1,000 fewer centers than were operating in Texas in 2013.[221] These 20,882 childcare centers served a total of 1,099,918 children in FY 2015, with the vast majority of those children (91.7 percent) served by childcare programs in licensed childcare centers, before- and after-school programs, and school age programs.[222] The remaining 8.3 percent of children (90,761) who received childcare through CCL-monitored child care facilities in FY 2015 received those services in registered or license child care homes, listed family homes, temporary shelters, and small employer-based child care providers.[223]

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Texas Workforce Commission *At a Glance*

Texas Workforce Commission

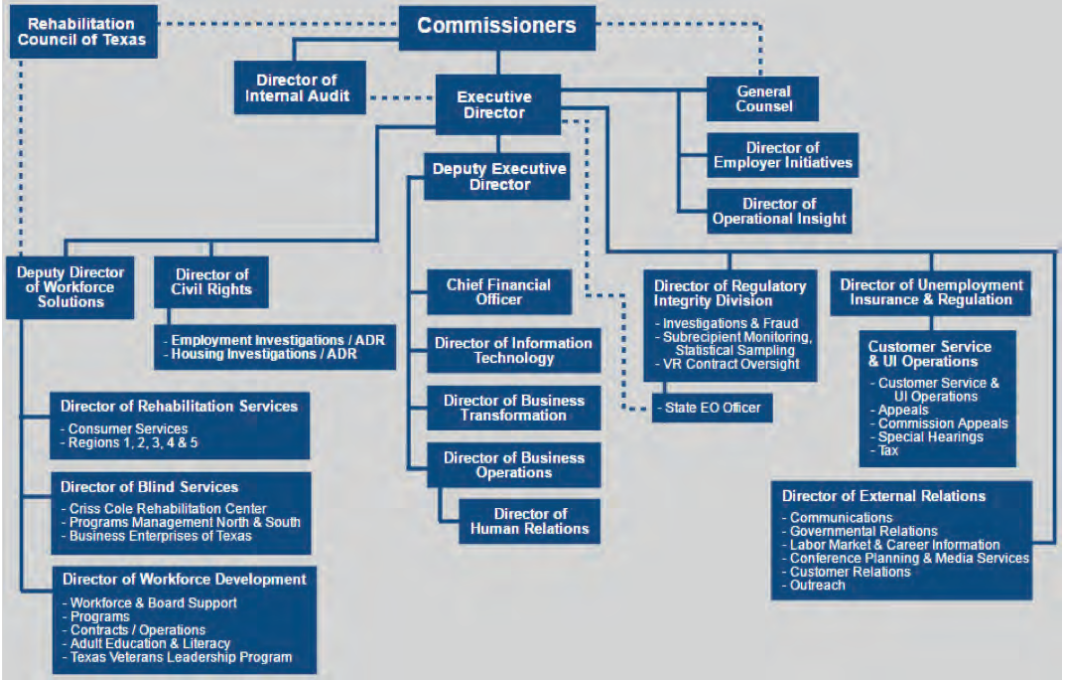
POLICY CONCERNS

- Ensuring sustainable employment outcomes for people with serious and persistent mental illness
- Maintaining continuity of services during the transfer of services from DARS to TWC
- Establishing accountability for outcome-based vocational rehabilitation services for individuals living with serious and persistent mental illness

FAST FACTS

- The national unemployment rate was 4.7% in May 2016, down 0.3% from the previous month, according to the Bureau of Labor Statistics.[1] The unemployment rate in Texas was 4.4% in April 2016, up 0.1% from the previous month.[2] The unemployment rate is the ratio of the population that is unemployed and seeking employment to the current labor force.[3]
- 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% in 2012.[4] The same year, the unemployment rate for individuals receiving services through the public mental health system in Texas was 85.6%.[5]
- For individuals with IDD, the national labor force participation rate is 30.5%.[6] The labor force participation rate is the percentage of the population that is either employed or actively seeking work.[7]
- In March 2016, there were 4.3 million people with disabilities (ages 16 to 64) employed in the United States. This group represented 3% of the nation's total workforce.[8]

ORGANIZATION CHART



Source: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019 – Texas Workforce Commission.* Pg. 15. Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=320&fy=2018

Texas Workforce Commission

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.

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.[9] 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.[10]

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 is 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."[11]

In FY2015, TWC served nearly 770,000 Texans through programs every year, in addition to over 86,000 employers.[12] Figure 106 describes three major types of beneficiaries who utilize TWC services.

Figure 106. TWC Beneficiary and Coordinated Action

Beneficiary	TWC Action
Texans Seeking Unemployment Benefits	Provides temporary income to workers who have lost their jobs through no fault of their own.
Employers	Offers recruiting, training and retaining, outplacement services, and valuable information on employment law and labor market trends and statistics.
Job Seekers	Offers career development information, job search resources, training programs, and, as appropriate, unemployment benefits.

The national unemployment rate was 4.7% in May 2016, down 0.3% from the previous month, according to the Bureau of Labor Statistics.[13] The unemployment rate in Texas was 4.6% in July 2016, up 0.1% from the previous month.[14]

Individuals with disabilities, including serious mental illness, often experience barriers associated with joining and participating fully in the labor force.[15] 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.[16] 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 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% in 2012.[17] The same year, the unemployment rate for individuals receiving services through the public mental health system in Texas was 85.6%.[18] Yet for persons living with serious mental illness, employment can play a primary role in recovery and well-being.[19]

A 2016 report by the Texas Workforce Investment Council stated that based on 2014 data, there were over 3.4 million individuals with disabilities living in Texas, the second largest number per state in the nation.[20] In 2015, the average monthly labor force participation rate for individuals with intellectual and developmental disabilities (IDD) across the country was 30.5%.[21]

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. Integration of these individuals can contribute to the economic growth of Texas when provided with the appropriate opportunities and supports.[22]

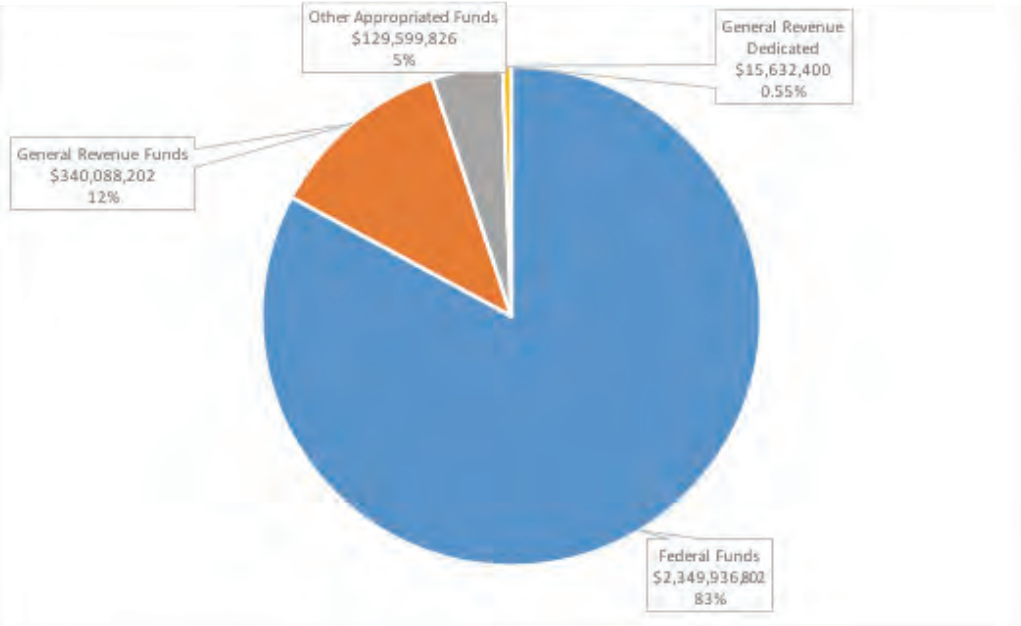
Funding

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 (WIA), Temporary Assistance for Needy Families (TANF) Choices, Employment Services, Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T), child care, 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 (FUTA) to the states to pay for administrative and operational costs.[23]

Note that the DARS to TWC transfer of programs moves approximately $309 million in FY 2017 to TWC (82% of which are federal funds).[24]

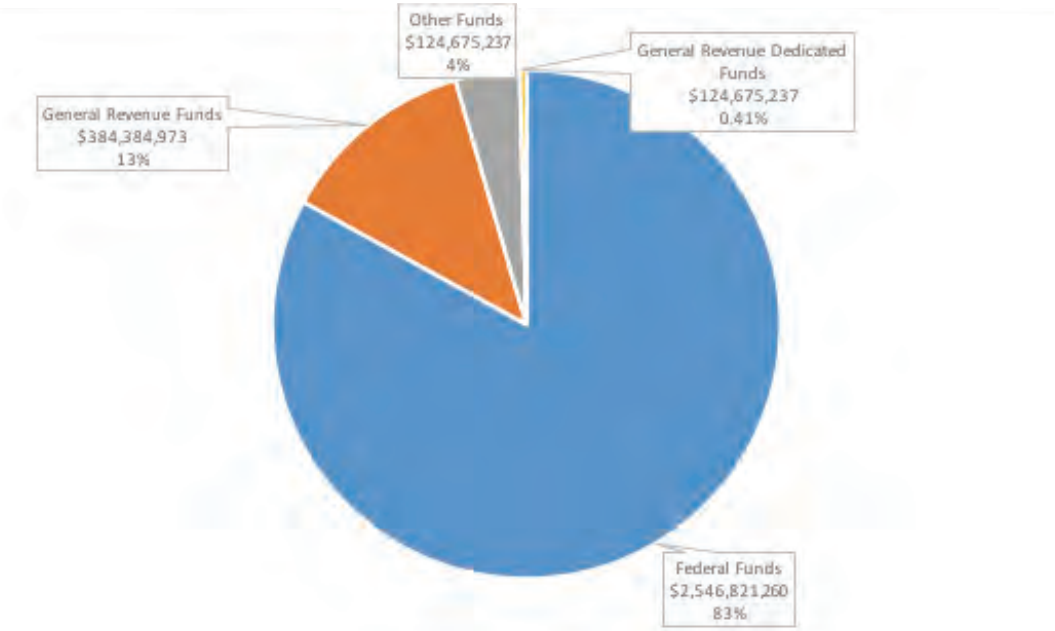
Figure 107. TWC Budget by Method of Finance FY 2016-17



The total TWC budget for FY 2016-17 was $2,835,257,230.

Source: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019 – Texas Workforce Commission.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=320&fy=2018

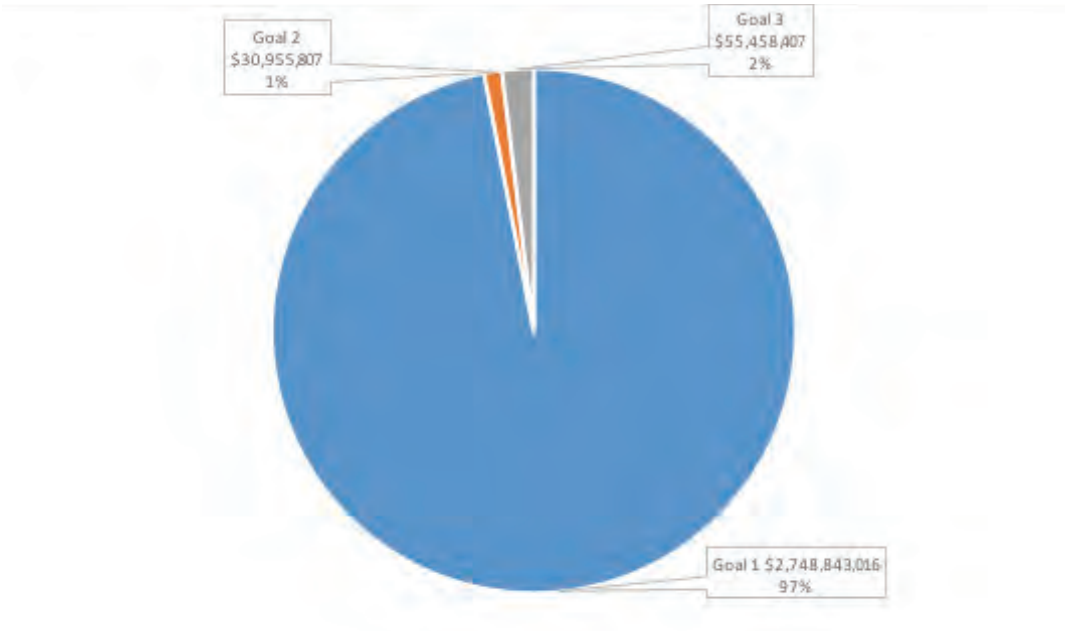
Figure 108. TWC Requested Funding by Method of Finance FY 2018-19



The total requested TWC budget for FY 2018-19 is $3,068,520,433. If the Exceptional Item Funds were included, the additional funds would add $16 million to the budget.

Source: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019 – Texas Workforce Commission.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=320&fy=2018

Figure 109. TWC Funding by Strategy FY 2016-17



Goal	Description
Goal 1	Support a workforce system to achieve and sustain economic prosperity
Goal 2	Program accountability and enforcement
Goal 3	Indirect administration

Source: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019 – Texas Workforce Commission.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=320&fy=2018

Changing Environment

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 (DARS) to TWC as part of the HHSC Transformation process. As a result, starting September 1, 2016, TWC began to work directly with individuals with disabilities, including serious mental illness, hearing impairment, substance use disorders, traumatic brain injury, and other physical, developmental, or mental disabilities.[25]

Sunset Highlights

On September 1, 2016, DARS dissolved as a state agency and several of its programs were transferred to TWC. Those programs include:

- The Vocational Rehabilitation program for individuals with visual impairments
- The Criss Cole Rehabilitation Center
- The Vocational Rehabilitation Program for individuals with disabilities
- The Business Enterprises of Texas Program
- The Independent Living Services Program for Older Individuals Who Are Blind

SB 208 (84th, Campbell/Burkett), the TWC "Sunset Bill," placed all of the state's programs that are funded through the federal Workforce Innovation and Opportunity Act (WIOA) together under one agency, TWC. Programs within DARS that met that criterion will now be housed in TWC, while all other DARS programs will be transferred to HHSC.

SB 208 also required the DARS commissioner and TWC executive director to join the Health and Human Services Transition Legislative Oversight Committee (created by SB 200, 84th, Nelson/Price) as ex-officio members. Additionally, SB 208 required the executive commissioner of HHSC, the commissioner of DARS, and TWC's executive director to develop a plan to be submitted to both the Oversight Committee and the governor detailing the transfer of all services and programs to ensure a careful and deliberate transition. The transition plan focused on ensuring the continuity and accountability of the programs being transferred from DARS to TWC and HHSC. SB 208 also required HHSC, DARS, and TWC leaders to include their DARS transition plan within the larger HHS transition plan that was submitted to the Oversight Committee, the governor, and the LBB on March 1, 2016, with a revised version delivered in August 2016. Required by SB 200, the larger HHS transition plan outlines how the state will implement the health and human services consolidation in coming years. More information on SB 200 can be found in the HHSC section of this Guide.

SB 208 identified nine requirements for the transfer of Vocational Rehabilitation (VR) services, including that measures be taken to ensure that unnecessary disruptions of transferred services and programs did not occur and that there be a strategy for exchanging data with other state agencies that refer consumers for VR services.[26] The transfer of the programs from DARS to TWC involved 1,860.9 full-time equivalent employees; a budget of $309 million (82% of which are federal funds), including state and federal funds; and more than 96,000 consumers.[27]

Figure 110. Key Transition Dates

Date	Action
March 1, 2016	HHSC's executive commissioner was required to submit a transition plan (including the plan for the transfer of vocational rehabilitation (VR) and other programs to TWC) to the Oversight Committee, the governor, and the Legislative Budget Board (LBB).
March 3, 2016	Texas was required to submit the WIOA State Plan to the Secretary of the U.S. Department of Labor.
September 1, 2016	Vocational Rehabilitation Program and other programs transferred from DARS to TWC.
October 1, 2017	TWC is required to integrate the two separate VR programs for individuals with visual impairments and individuals with other disabilities into a single program.
August 31, 2018	TWC must integrate its VR staff into the Local Workforce Development Boards and Workforce Solutions Offices.

Source: Texas Workforce Commission. (2015). *Plan for the Transfer of Vocational Rehabilitation Services and Other Services and Programs.* Retrieved from http://www.twc.state.tx.us/files/news/dars-transition-plan-twc.pdf

Programs Transferred from DARS per Sunset Legislation

VOCATIONAL REHABILITATION FOR PERSONS WITH DISABILITIES (VR)

For people with mental illness, work can play a primary role toward their recovery and wellbeing.[28] Benefits of a job for an individual living with mental illness can include a daily routine, financial security, health benefits, social interaction, and a sense of purpose.[29] Individuals with IDD also benefit from employment. Studies of self-reported data show that earnings, productivity, and the quality of social relationships are the main reasons why individuals with IDD maintain employment.[30]

While challenges such as difficulty with particular schedules, medication side effects, and stigma can make it harder for an individual with a disability or serious mental illness to get and keep a job, there are options for support such as flexible work schedules, part-time work, or supported employment.[31,32] There are programs to help individuals with work readiness and employment success. 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 school to work.[33]

In order to receive VR services, an individual must:

- Be present in the state of Texas;
- Have a physical and/or mental condition that affects the individual's ability to work;
- Need vocational rehabilitation services in order to help the individual get and/or keep a job; and
- Be able to get and keep a job after receiving services.

If a person already receives Supplemental Security Income (SSI) or Social Security

Disability Insurance (SSDI), the individual is presumed eligible for vocational rehabilitation services.[34] Eligibility for VR services does not depend on an individual's income.[35]

People who are eligible to receive VR services work with a VR counselor to determine what services are appropriate and needed for each case. VR services are consumer-focused, meaning that those who receive services have a voice in an Individualized Plan for Employment (IPE), which consumers create with their VR counselors. An IPE helps outline 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 the disability, needs, and employment goals. Work-related services may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services.[36] Consumers who obtain these vocational rehabilitation services follow six steps in the service delivery process:

1. Apply for services
2. Undergo an assessment to determine service eligibility
3. Develop an Individualized Plan for Employment (IPE) with VR counselors
4. Receive training and related services, as needed
5. Receive employment assistance services
6. Receive post-employment services, as needed

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.[37]

More information on the VR program can be found online at http://www.twc.state.tx.us/jobseekers/vocational-rehabilitation-adults.

VOCATIONAL REHABILITATION PROGRAM FOR INDIVIDUALS WITH VISUAL IMPAIRMENTS

The Vocational Rehabilitation Program for Individuals with Visual Impairments provides services to eligible individuals who: 1) have a visual impairment that is a barrier to employment, 2) can benefit from VR services to better their employment outcomes, and 3) require VR services to prepare for, get, and retain gainful employment.[38] VR services available to eligible individuals with visual impairments include:

- Assessments
- Rehabilitation teaching
- Counseling, guidance, and referral
- Specialized services for deafblind individuals

The DARS to TWC transition plan states that after September 1, 2016, TWC and HHSC will continue to coordinate the delivery of services to children with blindness or visual impairments. While HHSC now operates the Blind Children's Program, TWC will closely coordinate with HHSC to ensure that the needs of consumers with blindness or visual impairments are addressed.[39] The transition plan states that there will be specific ongoing efforts to coordinate services for these consumers

during the transition of aging out of the Blind Children's Program in HHSC to VR services in TWC.[40]

INTEGRATING THE VOCATIONAL REHABILITATION PROGRAMS

On September 1, 2016, all VR services transitioned from DARS to TWC. The requested VR programs budget for the FY2018-19 biennium was over $590 million.[41] The VR staff at that time continued providing the same services during the transition. As part of the integration process, TWC used the expertise of the VR staff to develop plans to organize services based on each consumer's individualized needs and to support specialization of VR counselors serving different client populations.

TWC was further required to integrate the VR Program for Persons with Physical and Mental Disabilities with the VR Program for Individuals with Visual Impairments into a single VR program no later than October 1, 2017.[42]

TWC must facilitate this integration through the following minimum actions:

1) Reorganize service delivery to achieve an integrated VR program that meets each consumer's individual needs;
2) Develop a plan to support specialization of VR counselors serving different client populations;
3) Redesign performance measures;
4) Consolidate policies; and
5) Recommend adoption of any necessary rules.

TWC was required to develop a transition plan for the integration of the VR programs no later than September 1, 2016. Before the VR programs transferred to TWC, the VR programs serving the general population and the visually impaired population had different regional boundaries, different regional management structures, different policies for providing consumer services, and different standards for vendors who provide services.[43] During the transition process, DARS and TWC will review program policies and provider standards to identify necessary revisions and associated timelines. The agency must also determine how to realign the regional boundaries of the two programs. This review in FY 2016 was intended to position TWC to make needed policy and standards changes by October 1, 2017, a date mandated by the Texas Legislature. All accepted changes will go into effect on October 1, 2017.[44]

SB 208 required TWC to integrate VR staff into the network of Local Workforce Development Boards and Workforce Solutions Offices by August 31, 2018. TWC will work with each of the 28 Boards to ensure integration is successful.[45]

THE CRISS COLE REHABILITATION CENTER

The Criss Cole Rehabilitation Center (CCRC) is a comprehensive VR training facility that was formerly operated by the DARS Division for Blind Services (DBS). CCRC is an adult residential training facility in Austin named in honor of Judge Criss Cole, who lost his sight while serving as a Marine during World War II. During his time as a member of the Texas House of Representatives and the Texas Senate, Judge Cole

was a strong advocate for providing access to services for people with disabilities.[46]

Today, CCRC works with consumers who are blind to help them achieve employment and independent living goals.[47] Residents at CCRC receive training in core skills such as orientation and mobility, Braille, daily living, career development, and assistive technology.[48] CCRC's ultimate goal is to empower consumers to fully participate in their employment, community, and society.[49]

THE BUSINESS ENTERPRISES OF TEXAS PROGRAM

The Business Enterprises of Texas (BET) program is a federally-sponsored, state-administered program that provides food management opportunities to Texans who are blind.[50] BET collaborates with the Vocational Rehabilitation Program for Individuals with Visual Impairments to identify individuals who may be ideal participants in this program and who are interested in food service and vending management training and employment.[51] People who are selected to join the BET program become licensed BET managers and earn their personal income from profits produced by their businesses which are located on state and federal properties. In 2015, businesses managed by BET managers produced more than $65 million in annual sales.[52] The same year, BET employed over 1,400 Texans in its food service and vending facilities.[53]

On September 1, 2016, the BET program transitioned from DARS to TWC. The program continues to operate as it was structured before the transition. TWC is currently undergoing a review of the BET program rules and program structure in the FY2016-17 biennium to identify any opportunities for improved operational efficiency. The BET Trust Fund, which provides benefits to managers in the program, will continue to operate as it currently does.[54]

INDEPENDENT LIVING SERVICES PROGRAM FOR OLDER INDIVIDUALS WHO ARE BLIND

The Independent Living Services Program for Older Individuals Who Are Blind provides services to help eligible individuals avoid institutionalization and live independently in their own homes and communities. Although TWC will continue to receive grant funding and be responsible for program oversight, the agency will enter into an interagency contract with the HHSC who will administer these services. TWC will work closely with HHSC and its administration of additional independent living programs.[55]

Overview of Texas Workforce Commission (TWC) Programs

SKILLS DEVELOPMENT

TWC's Skills Development program provides grants, also called Skills Development Funds, to community and technical colleges in order to provide customized job training programs for businesses who want to train new workers or upgrade the skills of their existing workforce.[56] Successful outcomes of the program are achieved through collaborations between TWC, local businesses, public community and technical colleges, workforce development boards, and economic development partners. In FY 2014, TWC:

- Awarded 63 Skills Development Fund Grants totaling $36 million;
- Served 103 Texas businesses;
- Supported the creation of 5,779 new jobs; and
- Upgraded the skills of 10,003 workers in existing jobs.[57]

Examples of past grant projects include:

- CoServ Inc. partnered with TWC and North Central Texas College for a $161,845 grant that trained 143 employees within the electrical industry.
- Osteogenics Biomedical partnered with TWC and South Plains College for a $60,757 grant that trained 18 small business employees to become compliant with health care regulations.
- Texas Hydraulics partnered with TWC and Temple College for a $399,254 grant that trained 400 welders, mechanists, and engineers to increase the number of certified workers.[58]

The Skills Development program is funded entirely by appropriations from the Texas Legislature.[59]

VETERANS SPECIFIC SERVICES

TWC provides services to veterans living in Texas, as well as more indirect support through specific rules, policies, guidance, and initiatives. Veterans are given priority within the TWC service delivery system, meaning that while many services are the same as those provided to non-military civilians, veterans receive priority service at all Workforce Solutions offices.[60] Many of the TWC Workforce Solutions offices across the state have veterans representatives, who specialize in assisting veterans with employment-related needs. In FY 2015, TWC and Workforce Solutions offices provided over 112,000 veterans with services such as job search assistance, training, and other transition assistance.[61]

Examples of TWC's veteran-specific services include the Texas Veterans Leadership Program and the College Credit for Heroes.[62] The Texas Veterans Leadership Program is a resource and referral network connecting veterans of Iraq and

Afghanistan to a veterans resource and referral specialist in each of the 28 workforce development areas. College Credit for Heroes is a program that allows veterans to receive classroom credit for their military experience through certain colleges.[63]

OTHER TWC PROGRAMS

Figure 111. TWC Programs & Services with Program Overview

Programs & Services	Program Overview
Adult Education and Literacy	Provides English language, math, reading, and writing instruction to help students succeed in the workplace.
Appeals	Provides unemployment insurance claimants and employers with the opportunity to challenge an adverse determination concerning the entitlement to benefits or the chargeback of benefits to an employer's account.
Apprenticeship	Grants funds to local public educational institutions to support the cost of job-related classroom instruction in registered apprenticeship training programs.
Career Schools & Colleges	Licenses and regulates private career schools and colleges; provides information and technical assistance to schools, students, and the public.
Child Care Services	Subsidizes child care services for eligible low-income families, which promotes long-term self-sufficiency by enabling parents to work, attend school, or participate in job training.
Choices	Provides the foundation for customers to transition from public assistance to work and self-sufficiency through employment-related services.
Civil Rights	Investigates complaints of employment and housing discrimination; provides training to prevent employment and housing discrimination; reviews applicable state agency policies for compliance.
Employment Service	Provides comprehensive recruiting, job search, and related services to businesses and job seekers in order to connect employers seeking workers and individuals seeking employment.
Foreign Labor Certification	Assists employers with testing the labor market in the recruitment of domestic workers before they are granted approval to bring non-immigrant foreign workers to the U.S.
Labor Law	Resolves claims of unpaid wages; ensures that a child is not employed in an occupation or manner that is detrimental to the child's safety, health, or well-being.
Labor Market & Career Information	Provides employment statistics and customized information regarding occupational staffing or hiring patterns, working conditions, salary, local employment history, and trends.
Noncustodial Parent Choices	Assists noncustodial parents in overcoming substantial barriers to employment and career advancement while becoming economically self-sufficient and making consistent child support payments.
Rapid Reemployment Services	Identifies unemployment benefits claimants who are likely to exhaust all unemployment benefits, and connects them with reemployment services to help them quickly return to work.
Self Sufficiency	Provides grants to community colleges, technical colleges, and community-based organizations in order to implement customized job training programs for customers eligible for Temporary Assistance for Needy Families (TANF) in cooperation with employers.

Programs & Services	Program Overview
Senior Community Service Employment Program	Assists eligible individuals ages 55 and older in gaining competitive job skills through temporary subsidized employment and training, and in securing unsubsidized employment.
Skills for Small Business	Finances tuition and fees for community and technical college courses for current and newly hired employees of small businesses (less than 100 employees).
Skills for Veterans	Addresses the training needs of post-9/11 veterans returning home and entering the Texas workforce by providing grants to community and technical colleges in order to provide customized job training programs for businesses that want to hire and train veterans.
Supplemental Nutrition Assistance Program Employment & Training	Promotes long-term self-sufficiency and independence by preparing Supplemental Nutrition Assistance Program (SNAP) recipients for employment through work-related education and training activities.
Trade Adjustment Assistance (TAA)	Provides training, re-employment services, temporary financial assistance, and other services to individuals who have lost their jobs due to foreign import of goods and services or of job shifts.
Unemployment Benefits	Provides temporary, partial income replacement to eligible individuals who have lost jobs through no fault of their own.
Unemployment Tax	Collects wage information and unemployment taxes from employers subject to the Texas Unemployment Compensation Act.
Workforce Investment Act	Provides market-driven employment, training, adult education, and vocational programs for adults, dislocated workers, and youth.
WorkInTexas.com	Provides recruitment assistance to Texas employers and job search assistance to anyone seeking work in Texas.
Work Opportunity Tax Credit	Provides a federal tax credit for private, for-profit businesses that hire qualified employees from a target population who may be somewhat disadvantaged in their efforts to find employment.

Source: Texas Workforce Commission. (n.d.) *Programs and Services.* Retrieved from http://www.twc.state.tx.us/programs

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Texas Department of Criminal Justice and Local Criminal Justice Agencies *At a Glance*

Texas Department of Criminal Justice and Local Criminal Justice Agencies

POLICY CONCERNS

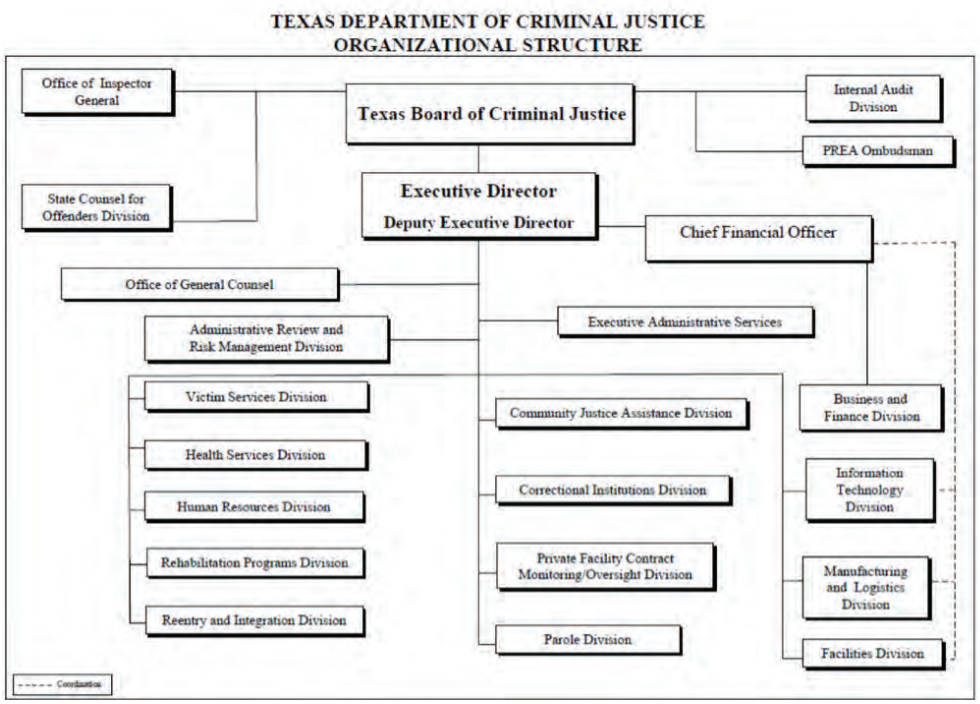
- Diverting people with mental illness who commit low-level offenses away from correctional facilities and into treatment settings
- Expanding training for jailers and correctional staff on mental health issues and de-escalation techniques
- Improving mental health screening, safety, and suicide prevention procedures in correctional settings
- Decreasing the use of prolonged solitary confinement, repeated restraints, and other aversive interventions on persons incarcerated with mental illness
- Increasing external oversight within prisons, jails, and other incarceration settings to ensure that persons with mental illness experience constitutional and humane conditions of confinement

- Improving access to jail diversion opportunities and a full range of psychiatric medications, especially within rural jail facilities
- Increasing access to intensive support services as individuals with mental illness transition from jail or prison into the community, including jail in-reach programs, forensic assertive community treatment (FACT) teams, and reentry peer support

FAST FACTS

- Studies estimate that over half of all adults who are incarcerated in U.S. prisons and jails have at least one mental health condition.[1]
- On May 31, 2016, there were 146,746 people incarcerated in Texas prisons, which accounted for 98% of TDCJ's operating capacity.[2]
- In FY 2014, the average cost for an adult in a Texas prison was $54.89 per day.[3] In contrast, adults on parole cost $4.04 per day, and adults under community supervision (formerly called adult probation) cost $3.20 per day.[4]
- The average daily cost per person who requires medical care in Texas prisons is between $96 and $104,[5] while the average daily cost per person in a psychiatric correctional facility is $145.[6]
- On June 1, 2016, Texas county jails collectively operated at 70.5% capacity with a total jail population of 65,793.[7]
- In FY 2015, about one million people cycled through local jails in Texas.[8]
- In 2015, 50% of grievances submitted by incarcerated people to the Texas Commission on Jail Standards (TCJS) involved complaints regarding medical services, including mental health services.[9]

ORGANIZATIONAL CHART



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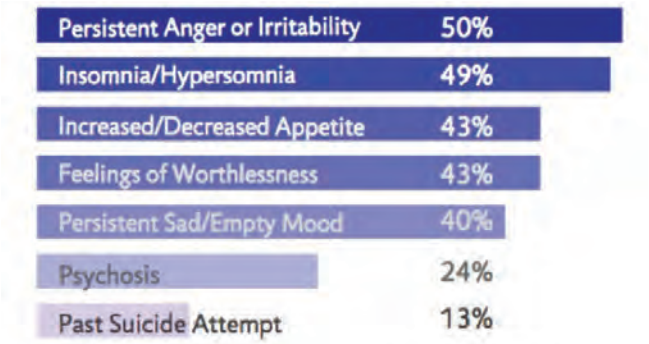
Texas Department of Criminal Justice and Local Criminal Justice Agencies

A significant number of individuals involved in the Texas criminal justice system live with one or more mental health conditions, and many have co-occurring substance use disorders. The strong connection between mental health and the criminal justice system has not always existed. In the 1970s, only 5% of incarcerated persons in the U.S. had a serious mental illness, such as schizophrenia or bipolar disorder.[10] Almost 50 years later, studies estimate that 15% to 24% of incarcerated persons have a serious mental illness.[11] In 2015, about 30% of people in local Texas jails had at least one serious mental illness.[12] 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 problem.[13] Figure 112 demonstrates that a large proportion of individuals in jails across the country self-report at least one mental health symptom.

Figure 112. Percentage of Mental Health Symptoms Self-Reported by Jail Inmates



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*. 2. Retrieved from http://www.bjs.gov/content/pub/pdf/mhppji.pdf

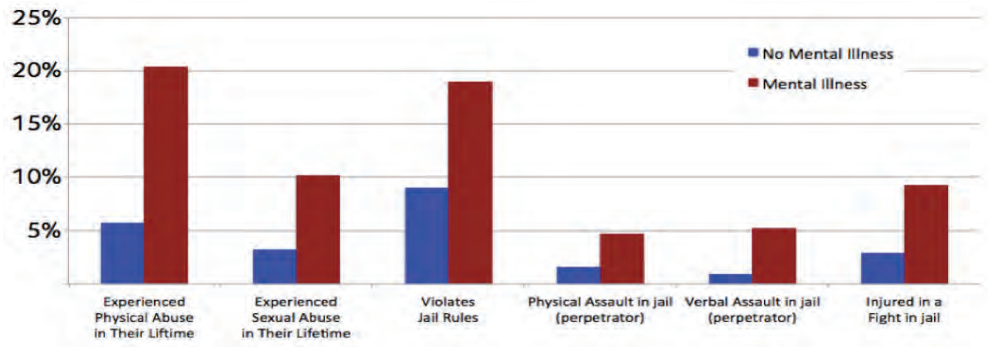
Despite the overrepresentation of people with mental illness in U.S. prisons and jails, research suggests that only 7% of these individuals enter the criminal justice system because of behavior linked directly to their mental illness.[14] Instead, their alleged criminal behaviors are often tied to behavioral factors (such as hostility, disinhibition, or emotional reactivity)[15] or to social factors (such as poverty and homelessness).[16]

The extent to which serious mental illness is connected to dangerous behavior is 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% of violence in the U.S.[17] Contrary to the fear created by highly publicized shootings and the discussions of mental illness that often follow, persons with serious mental illness commit a small proportion of homicides in which a gun is used.[18] The vast majority of people with a diagnosable serious mental illness never engage in any violent activities.[19] Statistical evidence shows that, in the absence of a substance use disorder, most mental illnesses are unrelated to acts of violence.[20] Unfortunately, the science of risk assessment has not advanced sufficiently to allow researchers to identify which individuals will commit violent acts. Psychiatrists can rule out who is *not* going to be violent better than they can identify who will be violent.[21]

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.[22] Once incarcerated, they also tend to face challenges that can worsen their mental health conditions. People with mental illness are more likely than other incarcerated populations to experience physical abuse, solitary confinement, and sexual victimization.[23] All of these experiences can exacerbate preexisting diagnoses.[24] Figure 113 demonstrates some of the challenges that people with mental illness disproportionally 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 and county budgets.

Figure 113. Experiences of Individuals With and Without Mental Illness Prior to and During Their Incarceration



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Changing Environment

Across the nation, Texas serves as a model for criminal justice reform. 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

2015, legislators continued that trend. Lawmakers passed legislation to enhance the detection of mental illness, increase diversion opportunities, and improve the reentry process. For their work, Senator Whitmire (D-Houston), Senator Ellis (D-Houston), and Representative McClendon (D-San Antonio) received the *Dallas Morning News'* Texans of the Year title.[25] Together, these legislators worked with other senators and representatives across the political aisle to pass reforms that are projected to cut costs, decrease incarceration rates, and better serve persons with mental illness.

The major legislation and budget riders related to mental illness and adult criminal justice passed in 2015 are explained below. Legislation is described in the order by which an individual with mental illness may experience the Texas criminal justice system. Information in this section is not a comprehensive account of the mental health and criminal justice-related legislation passed during the 84th legislative session.

It should be noted that the Texas Legislature's 2015 reforms will be implemented under new TDCJ leadership. In April 2016, Brad Livingston, TDCJ's executive director who served the agency for 12 years, announced his retirement.[26] In June, the Texas Board of Criminal Justice selected TDCJ's deputy executive director, Bryan Collier, to serve as the agency's new executive director. Collier has worked for TDCJ in various line staff and management positions for over 30 years.[27]

MAJOR LEGISLATION FROM THE 84TH TEXAS LEGISLATURE

HB 1338: Training for Peace Officers and First Responders on Brain Trauma
In 2015, Texas legislators passed HB 1338 (84th, Naishtat/Menendez) to improve the detection of brain injury and mental illness at the first stage of the criminal justice process – encounters with law enforcement officers. HB 1338 requires the Texas Commission on Law Enforcement to partner with the HHSC Office of Acquired Brain Injury and the Texas Traumatic Brain Injury Advisory Council to design training for peace officers and first responders regarding persons affected by brain trauma. The training must incorporate information on the direct effects of acquired brain injury and traumatic brain injury, which can include major depression, bipolar affective disorder, and anxiety disorders.[28] The training curriculum is meant to improve encounters between first responders and individuals with brain injuries, particularly veterans. HB 1338 presents an opportunity to detect mental illness and divert individuals from involvement in the criminal justice system before they are arrested and booked into a local jail.

SB 1507: Statewide Coordination and Oversight of Forensic Mental Health Services

Between 2001 and 2016, the number of forensic commitments to Texas state hospitals more than tripled.[29] Forensic commitments involve individuals with mental illness who have been arrested for a crime and subsequently admitted to a state hospital because they are deemed incompetent to stand trial or not guilty by reason of insanity. In 2015, legislators passed SB 1507 (84th, Garcia/Naishtat) to expand upon past efforts to address the growing forensic population. The bill required DSHS to appoint a statewide forensic director in order to improve the coordination and oversight of forensic mental health services. The bill also specified

that the forensic director must work with a group of experts and stakeholders to develop recommendations for improved forensic service coordination. The workgroup includes representatives from HHSC, the Texas Department of Criminal Justice (TDCJ), the Texas Juvenile Justice Department (TJJD), local mental health authorities (LMHAs), and other agencies involved in the social, health, and legal aspects of forensic services

For more on SB 1507 and forensic services in general, see the HHSC and DSHS sections of this guide.

HB 1083: Mental Health Assessments for Individuals in Administrative Segregation

Individuals with mental illness who serve time in Texas prisons and jails are disproportionately housed in solitary confinement (known in Texas as administrative segregation or "ad seg"). Psychological research shows that placement in ad seg can both cause and exacerbate mental health issues, such as anxiety, depression, paranoia, and self-harm.[30] In 2016, about 32% of people confined in ad seg were also on TDCJ's mental health caseload.[31] Legislators passed HB 1083 (84th, Marquez/Whitmire) to improve health outcomes for individuals with mental illness who are confined in ad seg units. The bill requires a medical or mental health professional to perform a mental health assessment for incarcerated individuals before they are confined in ad seg. If the assessment determines that ad seg is inappropriate for the person's mental or physical health condition, TDCJ must assign the individual to a different housing unit.

For example, in 2014, TDCJ began a mental health diversion pilot program at the Hughes Unit for individuals who require separation from the general population but for whom ad seg is clinically inappropriate. Equipped with 420 beds, the six-month program allows participants to engage in group therapy and meet with on-site mental health professionals before "graduating" and integrating back into the general prison population.[32] During the summer of 2016, TDCJ will expand the program to include 420 additional beds at the Michael Unit.[33] The goal is to divert all 1,500 individuals in solitary confinement who are also on TDCJ's mental health caseload away from ad seg units and into more therapeutic environments.

SB 578: Providing Incarcerated Individuals with Reentry and Reintegration Information

About 95% of incarcerated individuals are released back into their communities, but this transition can be challenging for many.[34] Formerly incarcerated people face stigma and institutional barriers upon release, which increases the likelihood that they will cycle back through the criminal justice system. To ease the reentry process, Texas lawmakers passed SB 578 (84th, Hinojosa/Allen). The bill requires TDCJ to collaborate with nonprofits, faith-based organizations, and other criminal justice-focused groups in the development of reentry resource packets for people who are about to be released from incarceration. The packets must include county-specific information about emergency assistance programs, workforce offices, housing options, counseling services, and other relevant resources that can improve the reentry process and decrease recidivism. TDCJ is required to make the reentry packets available to individuals 180 days before their release.

RELEVANT RIDERS

Legislators also addressed criminal justice and mental health-related issues through riders to the Department of State Health Services (DSHS) budget (HB 1, Art. II). Relevant riders are listed below.

- **Rider 35** required DSHS and community mental health centers to identify individuals with mental illness in the justice system and report prevalence data on this target population.
- **Rider 61** appropriated approximately $32 million in general revenue funds to expand Medicaid state plan services in order to divert individuals away from jails and emergency rooms and into community-based treatment programs.
- **Rider 66** required DSHS to allocate $5 million in both FY 2016 and FY 2017 to the Harris County Jail Diversion Pilot Program. The 83rd Texas Legislature created the program in 2013 through SB 1185 (83rd, Huffman/Schwertner). For more information on the program, Harris County Jail Diversion Pilot Program later in this chapter of the guide.
- **Rider 70** appropriated about $1.7 million per year in general revenue funds for FY 2016 and FY 2017 to implement a jail-based competency restoration pilot program for individuals who would otherwise be transferred from a jail to a mental health facility. The 83rd Legislature created the pilot program in 2013 through SB 1475 (83rd, Duncan/Zerwas). For more information on the program, see the DSHS chapter of this guide.
- **Rider 73** appropriated $1 million in general revenue funds for FY 2016 and FY 2017 to implement a peer support reentry pilot program. For more information on the program, see Reentry Peer Support section in this chapter of the guide.

SANDRA BLAND AND JAIL SAFETY CONCERNS

After the 84th legislative session concluded, the Texas criminal justice system was brought into the national media spotlight. In July 2015, 28-year-old Sandra Bland was pulled over after failing to use her turn signal when changing lanes. Her confrontation with a state trooper led to her arrest and booking at a Waller County jail where Bland could not afford to post bail. Three days later, Bland was found dead in her cell by apparent suicide.[35] The controversy highlighted the risks that aggressive arrest procedures and money bail practices pose for people with mental illness. Bland's death also demonstrated the need for improved mental health screening procedures and increased adherence to jail safety standards within incarceration settings.

In response to Bland's death, the House Committee on County Affairs and the Senate Criminal Justice Committee convened interim hearings to discuss the state's jail standards.[36,37] The Texas Senate received an interim charge to evaluate jail safety guidelines and review law enforcement and correctional officer training as it relates to individuals with mental illness.[38] Finally, House Speaker Joe Straus appointed representatives to the House Select Committee on Mental Health; Speaker Straus formed the committee to examine the Texas behavioral health system, including the disproportionate incarceration of persons with mental illness in Texas jails and prisons.[39]

Overview of the Texas Criminal Justice System

Individuals involved in the criminal justice system may be placed in a variety of settings. Local jails operated by counties or municipalities hold defendants who are awaiting trial and people who have been convicted of low-level crimes. In January 2016, about 63% of people held in Texas county jails had not been convicted of a crime and were awaiting trial.[40] While county sheriffs manage local jails, the Texas Commission on Jail Standards (TCJS) acts as the external regulatory agency for all county jails and seven privately-operated municipal jails. By setting jail standards and inspecting county jail facilities, TCJS assists local governments in providing safe and constitutional conditions of confinement for individuals who are detained across Texas. However, TCJS does not provide oversight within city-operated municipal jails.[41] Instead, the municipal jails located in Texas are not regulated by any external agencies, though individuals, including those with mental illness, may be confined here for extended periods of time.[42]

In contrast, state-operated facilities, such as state jails and prisons, hold individuals who are convicted of more serious offenses. TDCJ operates these facilities and oversees contracts with private correctional agencies. Unlike county jails, an external oversight body does not monitor Texas prisons and state jails. In previous legislative sessions, however, advocates have introduced legislation to create such a body.

Figure 114 contains a glossary of terms typically used in the criminal justice system.

Figure 114. Common Criminal Justice Definitions

Term	Definition
Community Supervision (previously known as adult probation)	An alternative to a prison sentence whereby an individual is released to the community and ordered to a continuum of programs and sanctions for a specified period of time. The individual must also meet with his or her community supervision officer on a regular basis.
Parole	A discretionary release of a person from prison by the Board of Pardons and Paroles to serve the remainder of a sentence under supervision in the community.
Local county or municipal jails	Designed to house individuals awaiting trial or serving short-term sentences for misdemeanor convictions.
State jails	Designed to house individuals convicted of felonies with punishments ranging from 180 days to two years.
Prisons	Designed to house individuals convicted of third-degree felonies or higher with punishments ranging from two years to death.
Restitution	Monies that a court orders an individual to pay to a victim's family. Payments are usually given in monthly installments.

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

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

People receiving public behavioral health services make up a sizeable portion of the total population of justice-involved persons in Texas. In 2016, the HHSC estimated that 37% of individuals in Texas prisons had contact with the public mental health system prior to their incarceration.[43] These incarcerated persons tend to experience greater functional impairments from mental illness, more housing instability, and less family and community support than other incarcerated groups.[44]

During the 80th legislative session, Texas policymakers adopted a new way to identify justice-involved individuals with behavioral health needs. Legislators passed SB 839 (80th, Duncan/Madden), which required DSHS and DPS to replace a 72-hour manual data exchange process with a real-time identification system for incarcerated persons with special needs.[45] When individuals are booked at a county jail, correctional officers must now check each person's information against the DSHS Clinical Management for Behavioral Health Services (CMBHS) database. The process, known as a Continuity of Care Query (CCQ), instantly tells jail employees if a particular person has been hospitalized in a state psychiatric facility or if the person has experienced an encounter, authorization, or assessment by a local mental health authority (LMHA) within the past three years.[46] If a match is detected, the jail then contacts the relevant LMHA in order to link the individual to available community resources.

Between September 2014 and August 2015, 234 counties in Texas initiated 991,073 CCQ match requests for adults.[47] About 7% (73,844) of the queries were exact matches with information maintained in the DSHS mental health database, and about 37% (369,013) were probable matches.[48] Both exact and probable matches alert the local jails and LMHAs to exchange pertinent information.

The Texas Department of Criminal Justice

TDCJ's mission is to "provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime."[49] In addition to confining convicted individuals, TDCJ manages community-based jail diversion programs and oversees individuals on community supervision and parole.[50] TDCJ is responsible for providing health services, including behavioral health services, to people who are convicted and sentenced to state jails, state prisons, and private correctional facilities that contract with TDCJ. The Correctional Managed Health Care Committee (CMHCC) develops statewide policies regarding correctional health care services and coordinates the delivery of those services to persons in the TDCJ system. This committee is made up of nine voting members, including a TDCJ representative, medical doctors, and mental health professionals, and one non-voting member who is appointed by the Texas Medicaid director.[51]

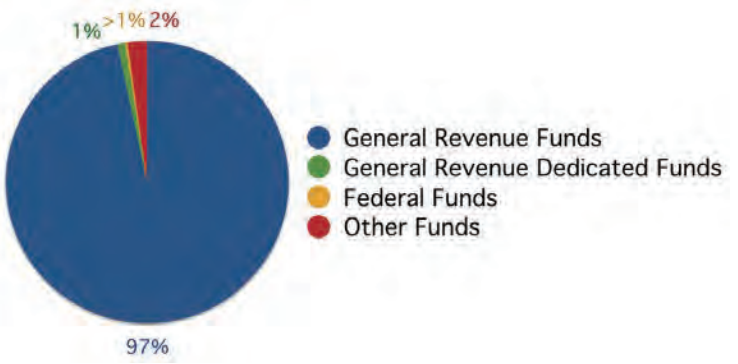
COST AND FUNDING SUMMARY

On May 31, 2016, there were 146,746 individuals incarcerated in Texas prisons.[52] The average cost of incarcerating an individual in a state facility was $54.89 per day in

2014.[53] In contrast, individuals on parole cost was $4.04 per day, and individuals on community supervision cost $3.20 per day.[54]

The TDCJ operating budget for FY 2016 was $3,406,167,380.[55] Figure 115 breaks down TDCJ's budget by funding source, and Figure 116 breaks down the budget by agency goal.

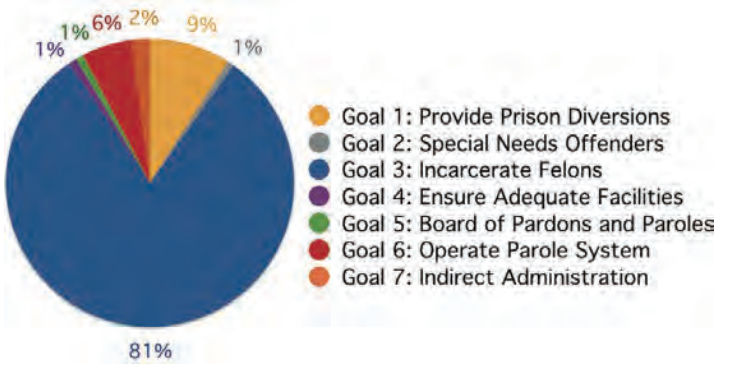
Figure 115. TDCJ FY 2016 Operating Budget by Funding Source



Source: Texas Department of Criminal Justice. (2015, December 1). *Operating Budget for Fiscal Year 2016 Submitted to the Governor's Office of Budget, Planning and Policy and the Legislative Budget Board*. 6. Retrieved from http://tdcj.state.tx.us/documents/finance/Agency_Operating_Budget_FY2016_Governor.pdf

Note: The "Other Funds" category includes interagency contracts, appropriated receipts, and general obligation bond proceeds.

Figure 116. TDCJ FY 2016 Operating Budget by Agency Goal



Source: Texas Department of Criminal Justice. (2015, December 1). *Operating Budget for Fiscal Year 2016 Submitted to the Governor's Office of Budget, Planning and Policy and the Legislative Budget Board*. 1-2. Retrieved from http://tdcj.state.tx.us/documents/finance/Agency_Operating_Budget_FY2016_Governor.pdf

The 84th Texas Legislature appropriated about $247.9 million in both FY 2016 and FY 2017 for the provision of behavioral health and substance use services within TDCJ.[56] In 2015, legislators also created the Statewide Behavioral Health Coordinating Council comprised of 18 state agencies, including TDCJ, to develop a five-year strategic plan and expenditure proposal (See HHSC section). The plan and proposal will help agency leaders determine how behavioral health funds can be spent most efficiently and effectively across the state.

TDCJ FACILITIES AND HOUSING ISSUES

TDCJ has a number of facilities located throughout the state and has headquarters in both Austin and Huntsville. Figure 117 below depicts TDCJ's population distribution and capacity by type of facility.

Figure 117. Facility Types, Capacities, and Populations in FY 2015

Type of Facility	Number of Units	Capacity	Population
Prison	50	96,825	92,475
Pre-Release	4	4,210	4,009
Psychiatric / DDP	4	3,051	2,831
Geriatric	1	566	532
Medical	2	314	621
Private Prisons	7	4,118	4,073
Multi-Use	1	836	816
Transfer	14	17,106	15,871
Pre-Parole Transfer	2	700	690
State Jail	15	20,056	17,633
Private State Jail	4	5,129	4,979
Substance Abuse	5	2,791	2,680
Number of Facilities	***109***		
Totals		155,702	147,210

Source: Texas Department of Criminal Justice. (2016, April). Data request: TDCJ facility statistics.

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

ADMINISTRATIVE SEGREGATION

Incarceration in TDCJ facilities can have a serious impact on an individual's mental health. People confined in isolation are at even greater risk for mental health deterioration. These individuals 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 commit suicide.[57] In a 2015 study, the ACLU of Texas and the Texas Civil Rights Project reported that TDCJ holds 4.4% of its incarcerated population in solitary confinement – a proportion that is four times greater than the national average.[58] People with mental health conditions are overrepresented in the population of segregated inmates. In 2014, about 30% of TDCJ's isolated population was identified as having some form of mental illness treatable by outpatient care.[59]

TDCJ utilizes two types of solitary confinement for varying lengths of time. First, correctional officers use short-term disciplinary segregation for punitive purposes. Second, TDJC uses administrative segregation to house inmates for an indefinite period of time when they are considered dangerous to themselves or

others. Both types of segregation involve holding individuals in a small, isolated cell for about 22 hours per day.[60] On average, TDCJ inmates remain in isolation for almost four years,[61] but in 2015, ten TDCJ inmates reached 30 consecutive years in administrative segregation.[62] Individuals confined in isolation for even short spans of time can experience negative mental health outcomes, including major depression, cognitive disturbances, psychosis, and suicidal ideation.[63]

Despite these adverse mental health outcomes, individuals can be released directly from administrative segregation into the community. Termed "flat release," this practice occurs when incarcerated individuals finish their prison sentences while they are housed in ad seg, causing TDCJ to release them directly from the most restrictive prison environment (i.e., isolation) to the streets without supervision or support. Research shows that flat release is linked to higher recidivism rates, which places both formerly incarcerated individuals and their fellow community members at risk.[64]

In recent years, TDCJ leaders and state legislators have taken steps to decrease the use of flat release in Texas. In 2012, TDCJ created the Ad Seg Pre-Release Program (ASPP) which uses cognitive behavioral interventions and group recreation to improve each participant's reentry process; a total of 476 individuals completed the transitional program in FY 2014.[65] TDCJ then created the Administrative Segregation Therapeutic Diversion Program (ASTDP) in 2014 to better connect segregated inmates with mental health services and improve their future behavioral and recidivism outcomes.[66] By the end of 2016, 840 beds at the Hughes and Michael Units will be available for ASTDP participants.[67] In addition to these reform initiatives, the Senate Committee on Criminal Justice and House Committee on Corrections also received interim charges during the 2016 interim session to review reentry opportunities for individuals housed in administrative segregation.[68,69]

SEXUAL ASSAULT AND PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATIONS

Traumatic experiences, such as sexual assault, can also impact the mental health of people incarcerated in the general prison population. A 2008 study by the Bureau of Justice Statistics ranked the ten U.S. prisons with the highest inmate-reported sexual assault complaints; five of those prisons were located in Texas.[70] The Prison Rape Elimination Act (PREA), a federal law passed in 2003, seeks to address this problem by instituting a zero-tolerance policy for prison rape in correctional settings. Though former Governor Rick Perry refused to comply with PREA standards, his successor, Governor Greg Abbott, stated in 2015 that Texas would comply with the federal standards "wherever feasible."[71]

The Texas PREA Ombudsman is responsible for ensuring that TDCJ is in compliance with federal regulations created to eliminate sexual assaults in prison facilities. In 2014, the PREA Ombudsman Office reviewed 727 administrative investigations of inmate-on-inmate sexual abuse allegations in Texas.[72] About 40% of the incidents met the elements of the Texas Penal Code for Sexual Assault or Aggravated Sexual Assault.[73] The PREA Ombudsman Office also received 766 allegations of staff-on-inmate sexual abuse and harassment.[74] About 13% of these incidents met the elements of the Texas Penal Code for Sexual Assault or Aggravated Sexual Assault.[75]

BEHAVIORAL HEALTH SERVICES AND PROGRAMS IN THE STATE CRIMINAL JUSTICE SYSTEM

TDCJ is comprised of many subdivisions that manage and operate the agency, supervise incarcerated individuals, and provide services to crime victims. Within TDCJ, there are several offices and agencies that hold the responsibility for meeting the physical and behavioral health needs of inmates. Figure 118 provides a brief description of each office or agency.

Figure 118. Behavioral and Mental Health-Related Divisions within TDCJ

Entity	Description
Health Services Division	The division must ensure that incarcerated persons have access to health care services; employees also monitor the quality of those services. The division investigates grievances, conducts service audits, and collaborates with health care contractors and the Correctional Managed Health Care Committee (CMHCC).[76]
Office of Mental Health Monitoring and Liaison (OMHM&L)	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.[77]
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.[78]
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.[79]
Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI)	Comprised of representatives from 21 agencies and organizations, TCOOMMI provides a formal structure for criminal justice, health and human services, and other affected agencies to coordinate on legislative, policy, and programmatic issues affecting incarcerated individuals with special needs.[80] 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)	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 (UTMB), and Texas Tech University Health Sciences Center (TTUHSC). TTUHSC is responsible for providing medical services (including mental health care) in the western part of the state where TDCJ incarcerates 22% of its population; UTMB is responsible for the same services in the eastern half of Texas where TDCJ incarcerates 78% of its population.[81] TDCJ may contract with any entity to implement the managed health care plan.

In Estelle v. Gamble (1976), the U.S. Supreme Court determined that prison officials are constitutionally required to provide incarcerated individuals with appropriate health care services and that denial of such services constitutes cruel and unusual punishment.[82] As the number of people with mental illness in state prisons rises, however, maintaining a constitutional level of care becomes challenging. Research over the past decade estimates that 50% of men and 75% of women in prisons across the U.S. experience a mental health problem that requires behavioral or mental health services each year.[83]

To meet an individual's behavioral health needs, TDCJ operates a managed health care plan rather than a fee-for-service plan. The average daily cost for people who requires medical care in Texas prisons is between $96 and $104 per person.[84] The average daily cost in a psychiatric correctional facility is $145 per person.[85]

ACCESS TO SERVICES

The Offender Health Services Plan developed by the Correctional Managed Health Care Committee (CMHCC) describes the levels of health care services made available to incarcerated individuals within TDCJ. The plan specifies two classifications of health services for medical, dental, and mental health needs. The classifications are listed in Figure 119 below.[86]

Figure 119. Level of Health Service

Level of Service	Description	Availability
Level I Medically Mandatory	Care that is essential to life and health and without which rapid deterioration is expected. The recommended treatment intervention is expected to make a significant difference or be very cost effective.	Provided to all incarcerated individuals.
Level II Medically Necessary	Care that is not immediately essential to life, 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.	Provided to all, but evolving standards and practice guidelines control the extent of service.

Source: Correctional Managed Health Care Committee. (2015, September). *Offender Health Services Plan*. 4. Retrieved from http://tdcj.state.tx.us/divisions/cmhc/docs/Offender_Health_Services_Plan.pdf

Additionally, 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. At intake, incarcerated persons are provided information on how to obtain health care services within their assigned facility. Facilities may identify people with mental illness during the intake process or upon referrals from security staff who receive mental health-related training.[87]

BEHAVIORAL HEALTH SERVICES

Qualified mental health providers may recommend the following mental health diagnostic and treatment services for incarcerated individuals with behavioral health needs:

- Emergency mental health services (available 24 hours a day, seven days per week);
- Professional services, such as medication management and monitoring;
- Continuity of care services;
- Psychosocial services;
- Crisis management/suicide prevention;
- Inpatient services provided by a correctional health care approved facility, including diagnostic evaluations, acute care, transitional care, and extended care; and
- Professional services, such as medication monitoring and management.[88]

TDCJ also administers specialized programs for certain incarcerated individuals with a mental illness or developmental disability. Figure 120 describes these programs:

Figure 120. Specialized Programs for Individuals with Mental Illness or a Developmental Disability

Level of Service	Description
Program for the Aggressive Mentally-Ill Offender (PAMIO)	This voluntary treatment program utilizes cognitive behavioral techniques to evaluate and treat individuals in administrative segregation, those with a G4 or G5 security status,* and others who have a history of mental illness and aggressive behavior. Enrolled individuals must have at least two years of their sentence left in order to complete the program.
Developmental Disabilities Program (DDP)	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 Developmental Disabilities Program (DDP) facility for further evaluation and services.
Chronic Mentally Ill Program (CMI)	The CMI program enrolls participants in one of two separate treatment tracks. The *inpatient treatment track* serves people with mental illness in administrative segregation or those with a G4 or G5 security status who require close monitoring and medication management. The *outpatient sheltered housing track* engages individuals living in a single-cell housing unit who are psychiatrically stable in therapeutic programming.

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

*Note: TDCJ classifies individuals housed in state prisons into six custody levels.[89] 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 live in cells rather than dorms, and they may not work outside the security fence without armed supervision. Individuals with a G5 security status have histories of assaultive or aggressive behavior; they live in cells and may not work outside the security fence without armed supervision.

TDCJ also manages a number of programs within its Rehabilitation Programs Division to serve people with substance use conditions. Figure 121 below describes these programs.

Figure 121. Substance Use Service Descriptions

Program	Description
Substance Abuse Felony Punishment Facility (SAFPF) and In-Prison Therapeutic Community (IPTC)	Both SAFPF 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 SAFPF 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 state jail inmates are placed in either a 60- to 90-day program or a 90- to 120-day program based on an Addiction Severity Instrument (ASI) 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.[90]

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

POST-INCARCERATION COMMUNITY-BASED SERVICES

As part of TDCJ's Reentry and Integration Division, the Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI) provides a variety of institutional and community-based services to facilitate the reentry of incarcerated people with special needs into the community. Individuals with special needs include older adults and persons with physical disabilities, terminal illness, mental illness, and/or intellectual disabilities.[91] TCOOMMI partners with local mental health authorities (LMHAs) to provide three tiers of reentry assistance for people with mental illness.[92] Figure 122 describes each type of reentry support.

Figure 122. Reentry Assistance Services Provided by TCOOMMI and LMHAs

Reentry Assistance	Description
Continuity of care services	These services are available for 90 days after a person's release from incarceration. Eligible individuals include those with bipolar disorder, major depressive disorder, schizophrenia, post-traumatic stress disorder, psychosis, or any other disorder that is severe or persistent in nature. LMHA staff meet face-to-face with participants at least three times to link individuals to community supports and medication assistance.
Adult intensive case management	Individuals may receive intensive case management for up to two years after their release from incarceration. Eligible participants include those with bipolar disorder, major depressive disorder, schizophrenia, post-traumatic stress disorder, psychosis, or any other disorder that is severe or persistent in nature. On a case-by-case basis, an extension of services may be granted. Services include at least 3.5 hours per month of contact with LMHA staff, medication management, skills training, assistance with benefits applications, and group services.
Adult transitional case management	Transitional case management services are available on an as-needed basis for individuals on supervision who require step-down services from adult intensive case management. This caseload also serves individuals who do not qualify for an intensive service package and who have moderate or low criminogenic risk.

Source: Texas Criminal Justice Department. (2016, April). Personal communication: Reentry services.

Continuity of care programs are designed to include pre-release screenings of incarcerated clients and provide referrals for aftercare psychiatric treatment services, which are typically delivered by LMHAs. Upon release from incarceration, people with mental illness are referred to LMHAs for services, such as case management, psychological and psychiatric services, medication and monitoring, and benefit eligibility services (including federal entitlement application processing).

TCOOMMI's transitional supports can be instrumental in reducing recidivism. Linking formerly incarcerated individuals to community services can help to address the root causes underlying a person's previous criminal behavior in order to prevent reentry into the criminal justice system. In 2013, TCOOMMI implemented the Risk Needs Responsivity model to reduce recidivism among high-risk individuals utilizing TCOOMMI case management services.[93] In 2015, the three-year recidivism rate was 12.4% for clients with high criminogenic risk and high clinical needs who were served for at least one year in TCOOMMI case management programs, while TDCJ's general recidivism rate was 21.4%.[94]

The majority of TCOOMMI's services were traditionally reserved for individuals with one of three specific mental health diagnoses – bipolar disorder, major

depressive disorder, or schizophrenia. However, even among this narrow target population, only 25% of eligible individuals under parole or community supervision received TCOOMMI case management services in 2013.[95] The remaining 75% of individuals with one of these diagnoses did not receive case management services due to a combination of their failure to meeting TCOOMMI's criminogenic risk criteria and the agency's lack of sufficient resources.[96] During the 84th legislative session, lawmakers passed HB 1908 (84th, Naishtat/Garcia) to revise TCOOMMI's eligibility requirements. Now, individuals with mental illness who have diagnoses other than bipolar disorder, major depressive disorder, or schizophrenia may participate in TCOOMMI's continuity of care and case management programs. The 84th Legislature increased TCOOMMI's general revenue funding by $6 million for the 2016-2017 biennium to accommodate the change.[97]

MEDICALLY RECOMMENDED INTENSIVE SUPERVISION

Medically Recommended Intensive Supervision (MRIS) is an early parole and release program that serves incarcerated people with special needs, including older adults and persons with mental and developmental disabilities, terminal illnesses, illnesses requiring long-term care, or physical disabilities. The purpose of the program is to release incarcerated 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, TCOOMMI specialists will expedite the release planning process and facilitate reentry case management. In 2015, 1,690 people incarcerated in state correctional institutions were referred for MRIS release, 210 were presented to the Board of Pardons and Paroles (BPP), and 82 were approved for release.[98] That same year, 48 people incarcerated in state jails were also referred for MRIS release, 3 were presented to the presiding judge, and 3 were approved for release.[99]

Discrepancies between the number of incarcerated persons who are *referred* for MRIS and the number of people who are ultimately *approved* for early release exist as a result of the MRIS referral process. Diverse sources, including unit medical staff, legislators, attorneys, TCOOMMI personnel, families of incarcerated persons, and incarcerated persons themselves, may initiate an MRIS referral.[100] After a referral is made, a person's eligibility must be determined based upon his/her current offense and medical condition. TDCJ representatives described that the vast majority of those who are referred for early release do not meet the program's strict eligibility criteria and thus cannot have their cases presented to the BPP for a vote.[101] For example, individuals who commit a sex offense must be in a persistent vegetative state or suffer from an organic brain syndrome that causes significant to total mobility impairment in order to qualify, while persons convicted of aggravated offenses must be terminally ill or require long-term care to qualify.[102]

RELEASE ON PAROLE SPECIAL PROGRAMS

TDCJ's Parole Division operates a series of specialized programs for individuals with mental health and behavioral health issues who are released from incarceration. Figure 123 below provides an overview of these programs:

Figure 123. Specialized Programs within TDCJ's Parole Division

Name	Description	Monthly Average Number of Individuals in Supervision Program in FY 2014
District Reentry Centers	Targets 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.	1,115 individuals
Serious and Violent Offender Reentry Initiative	Provides individuals in administrative segregation with reentry services beginning during their incarceration and extending through their supervision in the community.	A total of 58 SVORI program participants were released to the Parole Division in FY 2014.
Special Needs Offender Program	Supervises individuals with intellectual disabilities, mental health conditions, terminal illnesses, or physical disabilities.	· 147 individuals with intellectual development disorders · 5,941 individuals with mental health conditions · 831 individuals with terminal illnesses or physical disabilities · 129 individuals on medically recommended supervision
Sex Offender Program	Provides supervision, contracted specialized treatment, and relapse prevention services for individuals who have a current or prior sex offense conviction, who have admitted to committing sexually deviant behavior, or who are required to participate by the Texas Board of Pardons and Paroles.	5,443 individuals
Therapeutic Community Program	Offers continuity of care services for incarcerated individuals with substance use issues. Consists of a three-phase program for individuals who participated in an in-prison therapeutic community or a substance abuse felony punishment facility (SAFPF).	6,507 individuals
Substance Abuse Counseling Program (SACP)	Provides relapse prevention services to individuals with substance use treatment needs.	A total of 22,269 individuals received Level I prevention services in FY 2014. Approximately 804 individuals per month received Level II outpatient treatment services from contracted vendors and Parole Division counselors. Two intermediate sanction facilities provided residential treatment to 1,481 people, cognitive intervention services to 1,572 people, substance use services to 2,488 people, and relapse treatment to 815 people.
Drug Testing Program	Provides instant-read drug testing.	160,806 drug tests conducted monthly

Source: Texas Department of Criminal Justice. (2015). *Annual Review 2014.* 28-29. Retrieved from http://tdcj.state.tx.us/documents/Annual_Review_2014.pdf

SPECIAL CONCERNS FOR INCARCERATED FEMALES

If Texas were its own country, its rate of female incarceration would be the sixth highest in the world.[103] Incarcerated women have distinct and possibly greater mental health needs than other people both inside and outside of correctional facilities. Incarcerated women are:

- **Ten** times more likely to be dependent on drugs than women without experience in the justice system;[104]
- **Seven** times more likely to experience sexual abuse prior to their imprisonment than incarcerated males;,[105] and
- **Four** times more likely to experience physical abuse prior to their imprisonment than incarcerated males.[106]

Research shows that women with histories of trauma and abuse require more specialized treatment than traditional, male-oriented models of care typically offer.[107] TDCJ has a number of programs designed to accommodate for the special needs of its female population. For example, in 2010, TDCJ started the Baby and Mother Bonding Initiative (BAMBI) to address the physical, emotional, and health needs of women experiencing pregnancy or giving birth while incarcerated. Housed at the Santa Maria Hostel Unit, BAMBI seeks to combat recidivism by teaching new mothers the basics of parenting. Eligible participants typically include women scheduled for release within 12 months following their due date. Women who have been convicted of arson, a violent offense, a sex offense, or an offense against a child that caused harm or bodily injury cannot participate in BAMBI.[108] In its first five years of operation, the program produced an 8% recidivism rate, and as of May 2016, 197 women have been enrolled in the program.[109,110] TDCJ estimates that about 250 babies are born to incarcerated women in Texas each year, but the program can only serve 20 women at a time.[111,112]

Local Criminal Justice Systems

Local criminal justice systems consist of law enforcement agencies, prosecutors, jails, courts, and probation departments that are responsible for promoting public safety by enforcing federal, state, and local laws in a specified region. Local systems are responsible for criminal cases from the point of arrest through the trial and sentencing stages. Local jails hold four groups 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 June 1, 2016, Texas county jails operated at 70.5% of their collective capacity with a total jail population of 65,793.[113] This population figure, however, masks the total number of people who cycle through jails each year. A daily population statistic (like the one provided above) 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, during one year more clearly captures the high volume of people who experience confinement in a jail over time. In 2016, researchers estimated that people go to jail over 11 million times in the U.S. every year, though only about 646,000 people are jailed on any given day.[114] In FY 2015, about one million people cycled through Texas jails.[115]

Jail administrators face challenges in delivering services to their large detainee populations. In 2015, 50% of grievances submitted by incarcerated people to the Texas Commission on Jail Standards (TCJS) involved complaints regarding medical services, including mental health services.[116] Leaders from the Texas Jail Project, a nonprofit that aims to improve jail conditions, reported that about 80% of the complaints they receive from inmates and their families typically involve a lack of adequate medical care.[117]

Many people detained in local jails live with co-occurring mental health and substance use issues. Their untreated needs can lead to behavior that results in their entrance (or re-entrance) into the criminal justice system. 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 tend 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.

Despite the high proportion of people with mental health needs in jails, correctional officials often lack the training required to provide individuals with the mental health treatment and support that they need. County jail systems, especially in rural areas, may lack the necessary resources to implement best training and treatment practices in order to meet the needs of detainees with mental health conditions. For example, TCJS standards dictating the provision of medications to individuals upon their release from county jails do not exist.[118] As a result, people with mental illness in affluent counties may receive over a week's worth of medications upon their release, while those in less affluent counties may not receive any medications at all. Untreated mental health needs and a lack of post-incarceration treatment planning can lead to an individual's cycling in and out of jail, which diminishes mental health outcomes and creates added policing and incarceration costs for local communities.[119]

TEXAS COMMISSION ON JAIL STANDARDS

The Texas Commission on Jail Standards (TCJS) is an external regulatory agency for all county jails and seven privately-operated municipal jails.[120] TCJS establishes minimum standards for the management and operation of Texas jails. TCJS's key responsibilities include:

- Performing on-site inspections of jails to verify compliance with minimum standards;
- Providing technical assistance and training regarding jail management;
- Reviewing proposed jail construction and renovation plans;
- Auditing and reporting on jail populations;
- Providing management consultation; and
- Performing other activities relating to policy development and enforcement.[121]

Out of the 254 counties in Texas, all but 19 operate at least one jail; therefore, TCJS must travel to 235 counties in addition to seven privately-operated facilities.[122] Each county is visited for a compliance inspection at least once each fiscal year.[123] TCJS does not perform oversight in municipal jails located in Texas.

TCJS standards include requirements for the custody, care, and treatment of jail

detainees. Upon admission to jail, each individual receives a "health tag" that notes a special medical or mental health need in the individual's medical record. Those needs are then brought to the attention of health personnel and/or the admissions supervisor on duty.[124] 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 and maintain a separate health record for each incarcerated 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 should also contain current medical and mental health treatment information and behavioral observations, including the incarcerated individual's state of consciousness, risk of suicide, and mental health status.[125]

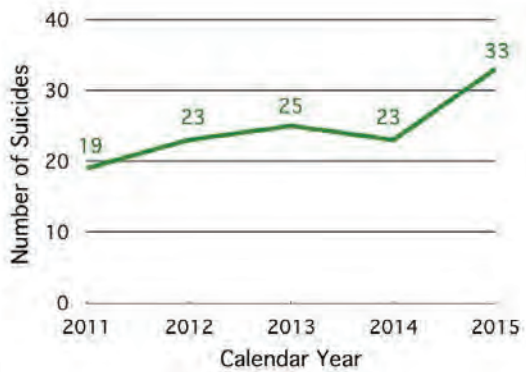
Correctional administrators may use inmate health records when individuals are transferred to or re-incarcerated within different facilities across the state. TCJS does not formally require jail administrators to share incarcerated persons' health records with other entities, but many do obtain these records with a signed release.[126] However, TCJS does require jail administrators to send a Texas Uniform Health Status Update form when incarcerated persons are transferred from one jail to any other correctional facility.[127] 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."[128] This information may include details about an incarcerated person's treatment needs; social, criminal, and vocational history; supervision status; and medical and mental health history.

SUICIDE IN LOCAL JAILS

National data show that suicide occurs roughly three times more frequently in jails than in prisons.[129] People with mental illness who are awaiting trial (and thus have not been convicted of a crime) are at even greater risk. National data show that pretrial individuals complete suicide at a rate seven times higher than their convicted peers do.[130]

In Texas, the number of jail suicides increased by about 43% between CY 2014 and CY 2015. Figure 124 demonstrates the number of suicides that occurred within county jails between 2011 and 2015.

Figure 124. Number of Completed Suicides in Texas County Jails Between CY 2011 and CY 2015



Source: Texas Commission on Jail Standards. (2016, May 18). Data request: Suicides in county jails.

To decrease the incidence of suicide in jail settings, the Texas Administrative Code requires county sheriffs and jail operators to develop and implement a mental disabilities/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.[131]

Jail administrators in Texas also use an approved screening tool to identify detainees who are at risk for suicide. Upon admission to the jail, each individual must be evaluated immediately with a TCJS-approved mental disabilities/suicide prevention screening instrument.[132] The previous instrument asked newly incarcerated 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.[133] The new 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. For example, the new screening form contains the question: "Are you feeling hopeless or have nothing to look forward to?" If the detained person answers "yes," jailers must immediately notify a supervisor, magistrate, and mental health professional.[134] The form also uses a grading system to provide further guidance on when jailers should contact a mental health professional if they suspect suicidal risk but the screening instrument fails to initiate an immediate referral.[135]

In October 2015, the new form was tested in several counties across the state. Jail administrators in tested facilities reported increases in the number of individuals placed on suicide watch after the new procedure was put in place.[136] On December 1, 2015, all Texas counties were required to implement the updated mental health screening form. In December 2016, TCJS will conduct an analysis to assess the new form's impact on jail suicide rates.[137]

INCARCERATION PREVENTION AND DIVERSION PROGRAMS

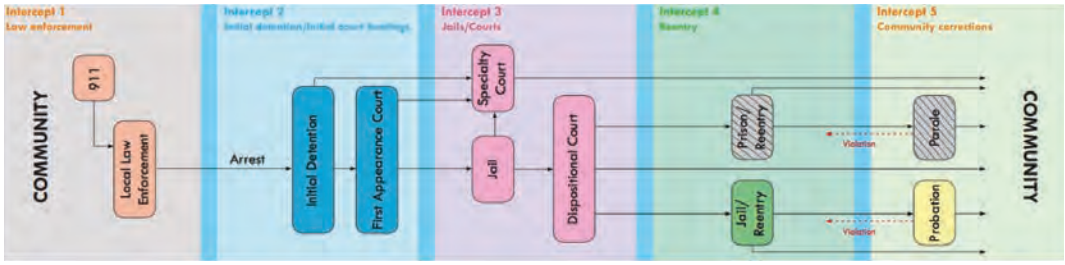
Increased demand for mental health services within state prisons and county jails has pushed stakeholders to develop opportunities for diversion from incarceration. For example, local mental health authorities (LMHAs) provide community-based interventions to prevent criminal justice involvement. TCOOMMI also collaborates with all 39 LMHAs to provide multi-service alternatives to incarceration for justice-involved individuals with special needs (See page X in this chapter of the guide for

more information on TCOOMMI.) Finally, TDCJ awards grant funding to county stakeholders in order to pursue the top goal outlined in its 2017-2021 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 charged with low-level crimes.

The Substance Abuse and Mental Health Services Administration (SAMHSA) promotes the sequential intercept model as a way to organize prison and jail diversion strategies.[139] The sequential intercept model, developed in conjunction with the GAINS Center, emphasizes five "intercept points" at which individuals may be diverted from the justice system. The intercept points illustrated in Figure 125 include:

- **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 125. The Sequential Intercept Model



Source: H. Steadman. (2014, July). "When Political Will Is Not Enough: Jails, Communities, and Persons with Mental Health Disorders." *John D. and Catherine T. MacArthur Criminal Justice Reform Initiative*. 4. Retrieved from http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/05/when-political-will-not-enough.pdf

Figure 126 below describes specific diversion strategies that can be implemented at each step of the sequential intercept model.

Figure 126. Examples of Diversion Strategies at Sequential Intercept Point

Intercept	Examples of Diversion Strategies
Intercept 1: Law enforcement and emergency services	· Specialty mental health deputies and crisis intervention teams (CITs) staffed by local police officers who can identify and divert individuals experiencing mental crises. · Mobile crisis outreach teams (MCOTs) staffed by mental health professionals who can provide on-site assistance to people with mental illness as they interact with police officers and paramedics.
Intercept 2: Initial detention and court hearings	· Deferred prosecution programs that allow people charged with low-level crimes to have their criminal cases dismissed and arrests expunged. · Jail diversion instant messaging programs that enable law enforcement and jail staff to access a person's medical and behavioral health history more efficiently.
Intercept 3: Jails and courts	· Mental health courts that prioritize therapeutic dispositions over traditional sentences. · Outpatient competency restoration (OCR) programs for individuals who do not pose a threat to public safety.

Intercept	Examples of Diversion Strategies
Intercept 4: Reentry into the community	· Jail in-reach programs that connect incarcerated individuals with community support and treatment providers prior to release. · Peer support services that pair justice-involved individuals with peers who have lived experience with incarceration, mental illness, and successful recovery.
Intercept 5: Community corrections and support services	· Forensic assertive community treatment (FACT) 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.

Source: Frost, L. (2016, January 22). Mental Health Diversion from Jail. University of Houston Law Center Police, Jails, and Vulnerable People Symposium. See Dr. Frost's presentation at https://www.youtube.com/watch?v=LRgNJh2aZuY&index=2&list=PLu2WuYWXjUtcxvWsUGuF3KXhTuUJZ2c1t

COMMUNITY EXAMPLES OF JAIL DIVERSION STRATEGIES

At each step of the criminal justice process, the sequential intercept model encourages collaboration between LMHAs, law enforcement agencies, and the court system. Collaboration among key stakeholders helps to ensure that people with mental illness who commit minor offenses are linked to community-based, recovery-oriented treatment as soon as possible. Jail diversion efforts can then improve mental health outcomes, save money, and increase public safety.[140]

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. 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 sequential intercept model. Other rural and urban areas, however, 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 actually receive diversion services.[141]

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.[142] The program employs both pre- and post-booking diversion methods.[143] 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, Mobile Crisis Outreach Teams (MCOTs) and Crisis Intervention Teams (CITs) work to divert individuals with mental illness 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. Finally, Bexar County offers programs, such as Haven for Hope, that provide continuity of care and housing services for people in need of assistance who are released from incarceration into the community.[144]

Since its implementation, Bexar County's jail diversion strategies, combined with falling crime rates, significantly reduced the county jail population. In 2003, the jail population exceeded the jail's capacity by nearly 1,000 people, but by February 2016, over 1,000 beds were empty at the Bexar County Jail.[145] Since 2003, program administrators estimate that about 20,000 people have been diverted from jail to treatment, which saves the county approximately $10 million per year.[146] Mental health-related training also helped to decrease the use of physical force by Bexar County law enforcement officers against people with mental illness. In 2009, officers used physical force about 50 times per year when taking a person with mental illness into custody; between 2009 and 2015, officers used similar force only three times total.[147]

Harris County Jail Diversion Pilot Program

In recent years, Harris County, home to the third largest jail in the nation, has adopted diversion strategies similar to Bexar County's program. In 2013, state legislators passed SB 1185 (83rd, Huffman/Schwertner) to create a mental health jail diversion pilot in Harris County. The ongoing goal of the program is to promote and sustain recovery for justice-involved individuals with mental illness by expanding services in the areas of housing, education, supportive employment, and peer advocacy.[148] Between 2014 and 2017, the state and county both appropriated $5 million each year to support the pilot.[149]

The Harris County pilot program uses 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) uses a jail-based team, a community- and clinic-based team, and critical time intervention (CTI) services; together, these strategies identify incarcerated people with mental illness, initiate pre-release treatments, and link participants to established community support networks. Second, Healthcare for the Homeless-Houston and SEARCH Homeless Services enroll eligible participants in a Permanent Supportive Housing (PSH) program (for more on PSH, see the TDHCA chapter of this guide). At each stage of the program, people with mental illness receive evidence-based services, including cognitive behavioral therapy, substance use interventions, peer support, and intensive case management.[150]

Between August 2014 and April 2016, the pilot program served 1,107 people, which includes persons who were screened, assessed, and enrolled.[151] The cost per participant was $5,401.53.[152] DSHS is required to submit a formal program evaluation to legislators by December 1, 2016.

SPECIALTY COURTS

Counties can also use specialty courts to divert people with serious mental illness and substance use conditions 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. The most common types of specialty courts relevant to criminal law, mental health, and substance use are drug courts, mental health courts, family drug courts, DWI courts, and veterans' courts.

In July 2016, there were 191 specialty courts operating in Texas.[153] In FY 2016, the Criminal Justice Division (CJD) of the Office of the Governor allocated $11.6

million in general revenue-dedicated funds for discretionary grants to 89 specialty courts across Texas.[154] In FY 2015, CJD-funded courts served approximately 3,570 participants, 61% of whom completed their program successfully.[155]

In 2013, the Criminal Justice Division of the Office of the Governor produced an overview of Texas specialty courts, which stated that these courts have reduced the number of people with mental illness who are incarcerated in the state.[156] However, the Hogg Foundation's attempts to gather data on the total number of individuals 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. As of July 2016, centralized data on the number of individuals served in all specialty courts (not only those funded through CJD grants) and their overall outcomes did not exist.[157] Further, although research shows that the courts produce positive outcomes, recent data also highlight racial and ethnic disparities in access to some specialty courts, particularly drug courts[158] and mental health courts.[159]

Drug Courts

Drug courts provide supervision that is more comprehensive and intensive than other forms of community supervision.[160] The drug court model assumes that supervised treatment in combination with judicial monitoring can more effectively reduce drug use and crime than either treatment or judicial sanctions can achieve separately.[161] Data show that this model works; researchers have found that drug court participation can decrease three-year recidivism rates by up to 50%.[162] 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.[163] In February 2016, there were approximately 80 drug courts (not including DWI courts) in counties throughout Texas.[164]

Mental Health Courts

Mental health courts were developed across the country as an alternative to the standard adjudication process for people with mental illness 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. The two types of courts differ, however, because drug courts are more likely than mental health courts to use a formalized set of treatment steps and to employ punitive sanctions for treatment noncompliance.[165]

In 2012, Harris County implemented a felony mental health court using a grant from the Bureau of Justice Assistance. Components of the court program include:

- Comprehensive criminogenic risk assessments to determine the likelihood of future criminal behavior;
- Clinical psychosocial evaluations to determine each participant's strengths and needs;
- Frequent appearances before the felony mental health court judge;
- Regular visits with specially trained community supervision officers;
- Intensive treatment by mental health professionals;
- Substance use treatment for participants with co-occurring mental health and substance use conditions; and
- Random alcohol and drug testing.[166]

The court team is comprised of a diverse group of professionals, including: two district court judges, a project director, three full-time licensed mental health clinicians, two dedicated part-time assistant district attorneys, two dedicated part-time assistant public defenders, three dedicated full-time community supervision officers, a clerk, and a bailiff.[167] The court's typical caseload is about 55 to 60 cases. Once participants are accepted into the program, they must work with the court team for a minimum of 18 months.[168] The court team then holds two graduation ceremonies each year in which past, current, and potential graduates may participate.

In order to promote graduation from the program, staff members connect clients to community-based services that reflect the participant's unique needs and strengths. If the client fails to meet the program's requirements, staff members first attempt to identify barriers to success, but if that is unsuccessful, staff can use graduated sanctions to address the client's behavior. The court's clinical team also works with participants to develop an individualized reentry plan that focuses on five main areas of interest: mental health treatment, medication management, housing needs, substance use treatment, and access to income and benefits.[169]

Because of court team's services are so intensive and time-consuming, Harris County's mental health court can only serve a small fraction of defendants with mental illness. As of March 1, 2016, the court had served 130 participants, 75.4% of whom had co-occurring mental health and substance use conditions.[170] By February 2016, 39 participants had successfully graduated from the program and another six participants were on track to graduate by the spring of 2016.[171]

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

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 with mental illness. Not all counties, however, have such an office in place. Thus, some areas without designated countywide public defenders have established a Mental Health Public Defender (MHPD) Office that specializes in addressing the legal needs of people with mental illness who are charged with crimes.

In 2007, Travis County, which does not have a public defender office, received a four-year grant to begin the nation's first stand-alone MHPD Office. Administrators set four major goals for the office:

- Minimize the number of days that people with mental illness spend in jail;.
- Increase the number of case dismissals among defendants with mental illness;
- Reduce recidivism by providing intensive case management services;and
- Enhance legal representation by providing attorneys with the specialized knowledge they need to defend persons with mental illness.[172]

A 2011 cost benefit analysis of the Travis County MHPD found that 41.2% of misdemeanor clients remained out of custody and/or had not returned to jail for up to five years after receiving MHPD Office services.[173] Figure 127 shows the percent

by which the MHPD Office also decreased jail bookings and jail bed days consumed among different types of clients. In the spring of 2016, the Travis County MHPD Office also began conducting a second cost benefit analysis.[174]

Figure 127. Travis County MHPD Office Outcomes between FY 2011 and FY 2011

Client Type	Number Served	Decrease in Jail Bookings	Decrease in Jail Bed Days Consumed
Legal client	735	38%	13%
Case management client	562	57%	20%

Source: Travis County Attorney's Office. (2011). Mental Health Public Defender Office Cost Benefit Analysis, Part 1: Analysis of Performance of the Texas Task Force on Indigent Defense Grant. 2-3. Retrieved from https://www.traviscountytx.gov/images/criminal_justice/Doc/cost_ben_MHPD_110922.pdf

As of March 2016, there were four MHPD Offices in Texas located in Bexar, El Paso, Fort Bend, and Travis counties.[175] These counties all have a MHPD representing defendants charged with misdemeanors. The Travis and Fort Bend MHPD Offices also provide referrals to a variety of social services for defendants charged with felonies.

REENTRY PEER SUPPORT

Successful reintegration into the community can be a challenge for formerly incarcerated people with a criminal record. Peer support 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.[176] 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 (for more information in peer support services, see the Texas Environment chapter of this guide).

In 2015, legislators approved Rider 73 to the DSHS budget, which created a peer support reentry pilot program in Texas. In April 2016, DSHS began funding pilot programs in three locations: Harris County, Tarrant County, and Tropical Texas (which serves Cameron, Hidalgo, and Willacy counties).[177] County sheriffs and LMHAs in each location will use certified peer support specialists to help individuals with mental illness successfully transition out of local jails and into their communities. The non-profit Via Hope created a reentry endorsement training (i.e., a specialization) to prepare peer specialists for their work with justice-involved individuals living with mental illness. Via Hope then developed the curriculum for the pilot's peer support specialists and began training peer specialists in advanced reentry skills and service provision at the end of March 2016. As of July 2016, 26 individuals completed the reentry peer training program,[178] and all three pilot locations had hired a reentry peer specialist to implement the program.[179] The Hogg Foundation for Mental Health will oversee the program's evaluation and release formal results in December 2016 and September 2017.[180]

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The Texas Juvenile Justice Department and Local Juvenile Justice Agencies *At a Glance*

The Texas Juvenile Justice Department and Local Juvenile Justice Agencies

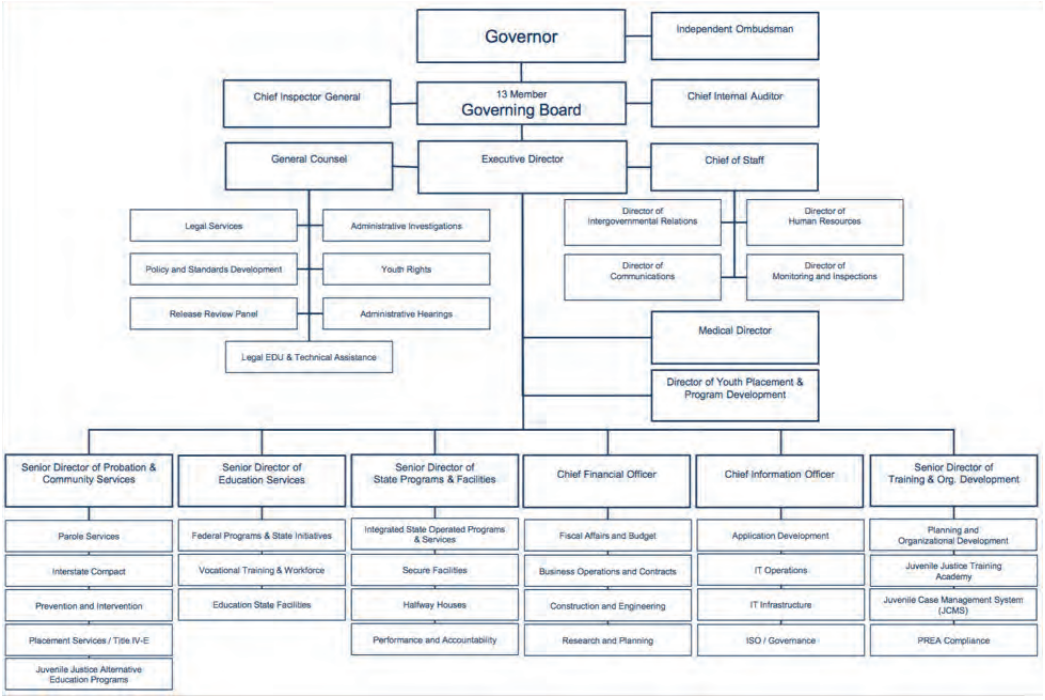
POLICY CONCERNS

- Successfully implementing of the Office of the Independent Ombudsman's expanded oversight role in county-level juvenile facilities
- Assessing outcomes for state secure facilities and community interventions
- Diverting youth with behavioral health needs away from secure confinement facilities and into their home communities
- Decreasing the use of restraints and prolonged isolation of youth in secure confinement facilities
- Assessing the impact of detaining youth in adult correctional facilities
- Adjusting the upper and lower age limits of juvenile court jurisdiction based on the science of adolescent development
- Addressing the school-to-prison pipeline for youth of color and youth with special education needs

FAST FACTS

- About 70% of youth in the juvenile justice system have a diagnosable mental health condition, compared to 20% of youth in the general population.[1]
- The majority of youth who are involved in the justice system commit misdemeanor offenses.[2]
- On May 31, 2016, there were 1,086 youth committed to five state secure facilities, 126 youth in halfway houses, and 114 youth in contract care facilities in Texas.[3]
- In 2015, the Legislative Budget Board (LBB) estimated that youth in residential facilities cost $437.11 per day, youth on parole cost $31.93 per day, and youth on probation cost $5.40 per day.[4]
- Texas has 49 pre-adjudication facilities operated at the county level. Nineteen of these facilities offer programs for youth with mental health conditions, and 15 provide programs for youth with substance use conditions.[5]
- Texas has 36 post-adjudication facilities operated at the county level. Twenty-seven of these facilities offer programs for youth with mental health conditions, and 31 provide programs for youth with substance use conditions.[6]
- In FY 2015, counties funded 73% of juvenile probation services, while the state and federal government provided 27% of total funding.[7]

ORGANIZATIONAL CHART



Source: Texas Juvenile Justice Department. (2015, September). *Organizational Chart*. Retrieved from http://www.tjjd.texas.gov/docs/TJJDOrgChart.pdf

The Texas Juvenile Justice Department and Local Juvenile Justice Agencies

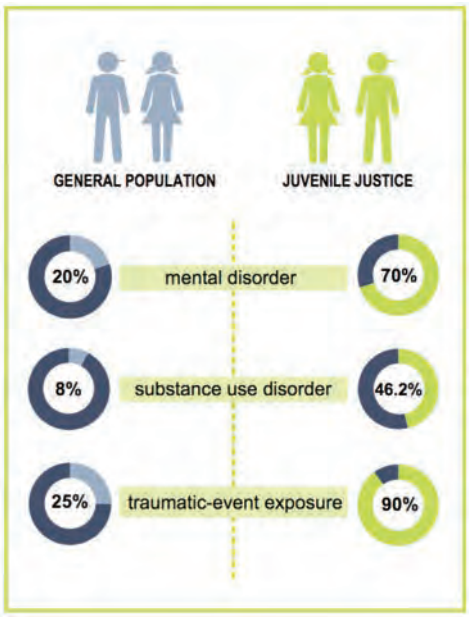
The Texas juvenile justice system is comprised of the Texas Juvenile Justice Department (TJJD) and local juvenile probation departments throughout the state. These agencies work together to provide services designed to rehabilitate youth who commit crimes between the ages of 10 and 17. (For more definitions used in the juvenile justice system, the Texas Juvenile Justice System section later in this chapter.)

In 2011, the 82nd Texas Legislature abolished the Texas Juvenile Probation Commission (TJPC) and the Texas Youth Commission (TYC), the two state agencies that previously managed the state's juvenile justice system. In their place, SB 653 (82nd, Whitmire/Madden) created TJJD. The new agency was charged with "increasing the proportion of youth in local custody, rather than committed to state lockups."[8] TJJD'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. To this end, TJJD provides oversight and funding to local juvenile probation departments across Texas and continues to fulfill some of TYC's former responsibilities, including the operation of five secure state facilities for youth.[9]

JUVENILE JUSTICE AND MENTAL HEALTH

Youth in the juvenile justice system are more likely than children in the general public to have mental health and substance use conditions. Researchers estimate that about 70% of justice-involved youth have a mental illness, while 60% of justice-involved youth have a co-occurring mental illness *and* substance use disorder.[10] Figure 128 shows a side-by-side comparison of mental health needs for youth in the general population and youth in the juvenile justice population.

Figure 128. Prevalence of Mental Health Conditions, Substance Use Disorders, and Traumatic-Event Exposure Among U.S. Youth



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While 70% of justice-involved youth around the country have a diagnosable mental health disorder, about 30% have disorders severe enough to require immediate and significant treatment.[11] In FY 2015, almost 33% of Texas youth referred to juvenile probation had mental health needs.[12] The vast majority of children in juvenile justice settings also have a history of trauma. Close to 75% of these youth have not only been exposed to violence, crime, and abuse; they have also *experienced* traumatic victimization themselves.[13] These experiences can contribute to the development of post-traumatic stress disorder (PTSD), which is disproportionately found among youth in the justice system.[14]

Recent meta-analyses also demonstrate that between 30% and 60% of justice-involved youth have experienced a traumatic brain injury (TBI).[15] After sustaining a brain injury, juveniles are more likely than their uninjured peers to engage in delinquency.[16] In 2011, TJJD and HHSC collaborated on a federal grant to identify youth with brain injuries in the juvenile justice system. Between FY 2011 and FY 2014, 4,316 individuals under 23 years old were screened for TBI using the Brain Injury Screening Questionnaire (BISQ).[17] About 67% of the Texas youth met the criteria for a mild or moderate-severe brain injuries, and more than half of those youth sustained their first injury before committing their first offense.[18] These juveniles reported higher distress levels on mental health assessments than individuals without a brain injury; they were also more likely than other juveniles to be diagnosed with a psychiatric disorder.[19] TJJD ended most of its TBI screenings in 2014 when the pilot ended because the agency no longer had access to the proprietary BISQ tool.[20]

Alongside improved screening techniques, juvenile justice leaders have taken other steps to address the trauma backgrounds of many adjudicated youth in

Texas. Between 2011 and 2014, the Texas Network of Youth Services (TNOYS, in collaboration with the Hogg Foundation) started an initiative to decrease the use of seclusions and restraints among juveniles who are committed to residential treatment centers (RTCs). Research demonstrates that seclusion and restraint practices can re-traumatize youth who have already experienced physical or psychological harms in the past.[21] TNOYS's Creating a Culture Change initiative aimed to assist youth service providers in developing other methods to alter negative behavior among Texas juveniles, including those within the justice system. For example, in Bexar County Juvenile Probation Department facilities, staff members were given trainings and technical assistance to prioritize their use of trauma-informed care practices (such as active listening and verbal de-escalation) and minimize their use of seclusions and restraints as a "last resort" option.[22] In a 2015 evaluation, analysts demonstrated that the initiative decreased the use of restraints by 25% in participating facilities and enhanced the knowledge and practice of trauma-informed care among youth service providers.[23]

Changing Environment

Beginning in 2007, the Texas Legislature made deliberate efforts to decrease youth incarceration rates across the state. In 2013, Senator Whitmire (D-Houston), chair of the Senate Criminal Justice Committee, asked the Council of State Governments (CSG) Justice Center to analyze the impact of those reform efforts.[24] In 2015, the CSG released 14 key findings, including:

- Legislative reforms helped to decrease commitments to and populations within state-level secure juvenile detention facilities.[25]
- 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.[26]
- While reforms have benefited state- and county-level juvenile justice systems, Texas can do more to decrease recidivism rates among justice-involved youth. In particular, 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.[27]

In 2015, Texas lawmakers aimed to further past reform initiatives. The major pieces of legislation related to mental health and juvenile justice passed during the 84th legislative session are explained below. Legislation is described in the order in which youth may confront the Texas juvenile justice system.

The information provided below is not a comprehensive account of the mental health and criminal justice-related legislation passed during the 84th legislative session.

MAJOR LEGISLATION FROM THE 84TH LEGISLATURE

SB 2398: Truancy Reform

In 2015, the Texas Legislature passed HB 2398 (84th, White/Whitmire) to prevent more Texas youth from entering the school-to-prison pipeline. The pipeline refers to punitive school policies that lead students (particularly youth of color)

toward justice involvement.[28] Before legislators passed HB 2398, Texas students who repeatedly skipped school could be prosecuted in criminal court. Now, school districts must hire truancy prevention facilitators who work directly with the students to determine the underlying causes of truancy, such as mental illness.[29] School officials must also adopt minimum prevention standards developed by the Texas Education Agency (TEA). If students continue to skip school, they cannot be criminally prosecuted. Instead, they may go to civil court, where a judge can order the student to attend counseling or other activities. HB 2398 stipulates that students cannot be fined or jailed for skipping school, but they can be transferred to the juvenile justice system if they defy court orders.

HB 2684: Training Programs for School-Based Police Officers

The 84th Texas Legislature also passed HB 2684 (84th, Giddings/Whitmire) to further combat the school-to-prison pipeline. In recent years, school police officers in Texas have increasingly used punitive strategies, such as physical force and arrest, against students.[30] These strategies tend to push students away from school and toward the criminal justice system. HB 2684 aims to improve school safety and decrease youth arrests by matching police officers' tactics with the school environment. The bill requires all school districts with 30,000 students or more to adopt "youth-focused" training programs for school-based police officers.[31] The Texas Commission on Law Enforcement (TCOLE) must create and distribute training materials for school district police departments, law enforcement officers, and any other entities that train school-based police officers. The training materials must include information on:

- Child and adolescent development and psychology;
- The behavioral health needs of children, particularly those with disabilities or special needs;
- Mental health crisis intervention;
- Positive behavioral interventions, conflict resolution, and restorative justice techniques; and
- Cultural competency.

Over 40 school districts were required to adopt a training policy by February 1, 2016, and officers were required to complete their training by June 1, 2016. See the following summary created by Texas Appleseed for a list of school districts affected by HB 2684 reforms: https://www.texasappleseed.org/sites/default/files/HB%202684%20Explanation%20FINAL.pdf.

SB 1630: Keeping Justice-Involved Youth Closer to Home

After their adjudication (i.e., the juvenile equivalent of a conviction), youth may receive a wide range of sentences, including community supervision or state-level detention. In 2015, Council of State Governments (CSG) Justice Center and the Public Policy Research Institute released an analysis demonstrating the state and local impact of Texas juvenile justice reforms.[32] The research showed that juveniles are more likely to succeed when they complete their dispositions closer to their home communities.[33] The 84th Texas Legislature translated these findings into a reform effort that targeted both county- and state-level juvenile justice systems. Legislators passed SB 1630 (84th, Whitmire/Turner), which emphasized the use of community-based placements and programming over commitments to state-operated secure facilities. As a result, legislators expect to improve rehabilitative

outcomes, decrease recidivism, and cut costs. SB 1630 included three main components: a regionalization plan, increased disposition options for youth, and expanded powers for the Office of the Independent Ombudsman (IO).

First, SB 1630 required TJJD to establish a task force with local juvenile justice stakeholders in order to develop a regionalization plan that keeps adjudicated youth closer to home. Task force members were charged with designing a plan that would: 1) identify the capacity of county-level post-adjudication facilities that can be used to divert youth away from state-level facilities and 2) determine the resources that the seven regions will need to complete these diversions successfully. In September 2015, the task force began meeting regularly to define the target population for diversion, determine how state funding for the reforms would be allocated, and finalize the regional and statewide plans.[34] TJJD must also create a new division to assist in the plan's implementation. The division is required to:

- Approve plan protocols;
- Provide training on best practices for all local probation departments affected by the plan;
- Assist TJJD and local departments in the creation of evidence-based programs, particularly for youth with behavioral health issues;
- Monitor the effectiveness of those programs; and
- Issue reports on community programs and placements.

In FY 2016 and FY 2017, the regions must collectively divert 180 youth from state secure facilities. The task force identified several categories of youth who are particularly appropriate for diversion, including:

- Youth with a serious mental illness;
- Youth with an IDD;
- Youth between the ages of 10 and 12;
- Youth adjudicated for non-violent offenses; and
- Youth with a low or moderate re-offense risk.[35]

SB 1630 also expanded disposition options for youth. The law requires juveniles to undergo validated risk and needs assessments in order to identify individuals with behavioral health conditions. Once identified, those juveniles also become eligible for placement in county-level facilities closer to their homes. Further, TJJD must develop specialized programs to rehabilitate youth with behavioral health needs who cannot be served in their communities due to insufficient resources. SB 1630 requires TJJD to measure recidivism rates and juvenile well-being in order to determine if programs are addressing the underlying factors that influence delinquency.

Finally, SB 1630 increased the IO's responsibilities to include the oversight of county-level post-adjudication facilities. For more information about the IO, see the Office of the Independent Ombudsman section later in this chapter of the guide.

SB 1149: Youth with Mental Illness and/or IDD in County-Level Justice Settings
In 2015, the Texas Legislature passed SB 1149 (84th, Watson/Workman),

which complements the reforms passed in SB 1630. While SB 1630 addresses a regionalization plan for all justice-involved youth, SB 1149 includes specific provisions about the treatment of youth with mental illness and intellectual development disabilities (IDD) in county-level justice settings. First, the bill requires juvenile boards and probation departments to accept youth with mental illness and/or IDD into their custody. Then, the bill differentiates between the treatment that those juveniles should receive when they have an indeterminate or determinate sentence.

Indeterminate-sentenced youth: Juveniles with an indeterminate sentence (i.e., a sentence that may not extend beyond the youth's 19th birthday) must be discharged if: 1) they have completed their minimum length of stay determined by their committing offense, and 2) the juvenile board or probation department determines that the juveniles cannot progress in their current treatment program because of their mental illness and/or IDD. Before discharge, the juvenile board or probation department must allow a psychiatrist to examine each juvenile with mental health needs and refer the youth to appropriate treatment services. Similarly, the board or department must refer youth with IDD to appropriate community services. These juveniles may also receive reentry services from Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI).

Determinate-sentenced youth: The bill allows juvenile boards and probation departments to petition juvenile courts for the initiation of mental health commitment proceedings for youth with determinate sentences (i.e., a blended sentence that allows for a youth's transfer to the adult system upon his or her 19th birthday). If a youth's commitment to a mental health facility expires prior to the end of his or her determinate sentence, a juvenile judge may either: 1) transfer the youth to a county-level juvenile probation department, 2) transfer the youth to the Texas Department of Criminal Justice (TDCJ), or 3) release the youth under supervision in the community.

HB 839: CHIP and Medicaid Eligibility for Newly-Released Youth

The Texas Legislature also passed HB 839 (84th, Naishtat/Rodriguez) to improve continuity of care services for justice-involved youth with physical and mental health needs. Before legislators passed the bill, HHSC terminated medical benefits for juveniles who were sent to detention facilities and required them to reapply for benefits upon their release. As a result, youth experienced a gap in their health care coverage and rehabilitative progress. Legislators passed HB 839 to eliminate this coverage gap. The bill requires HHSC to merely suspend (rather than terminate) a juvenile's eligibility for the child health plan program (CHIP) or Medicaid services and to reinstate each youth's eligibility within 48 hours of his or her release from detention. The legislation also required HHSC to develop means by which juvenile facility employees may determine whether adjudicated youth are or were receiving CHIP or Medicaid benefits.

Raising the Age of Criminal Responsibility

One highly debated juvenile justice reform did not pass in 2015. The Texas House of Representatives attempted to raise the age of criminal responsibility in Texas from 17 to 18 years old, but the Senate opposed the change. Currently, Texas and six other states set the age of criminal responsibility below 18. As a result, 17-year-old

Texans are automatically treated as adults if they commit a crime. Then, they may be placed in adult prisons, where teenagers face inadequate treatment and educational opportunities and heightened risks of sexual victimization.[36]

Texas' age of criminal responsibility also contradicts federal age standards established by the Prison Rape Elimination Act (PREA) of 2003. According to PREA's Youthful Inmate Standard, any individuals under 18 who are incarcerated in adult correctional settings must be separated by "sight and sound" from adult prisoners.[37] This PREA standard creates logistical and financial challenges for correctional administrators, especially those managing small jails who do not have sufficient resources to separate youth by any means other than solitary confinement – a housing option that creates long-lasting mental health problems, such as anxiety, depression, hallucinations, and uncontrollable rage.[38] If prison and jail officials fail to comply with PREA's Youthful Inmate Standards, the federal government may withhold funding from the state of Texas.

By raising the age of criminal responsibility, 17-year-old Texans who commit crimes would be handled in the juvenile justice system by default; only those who commit the most serious offenses would be certified as adults and transferred to the adult system. The policy change could ease the mental health and management challenges created by PREA's Youthful Inmate Standard. The Senate requested further study of the issue before the Texas Legislature takes action to raise the age of criminal responsibility.

THE CLOSING OF THREE TJJD FACILITIES

The Corsicana Residential Treatment Center

During the 2013 legislative session, the Legislature directed TJJD to reduce the number of state-operated detention facilities from six to five following a decline in the juvenile justice population. In June 2013, TJJD recommended closing the Corsicana Residential Treatment Center, a secure facility located south of Dallas in Navarro County that was designated solely for youth with significant mental health needs. Some of the services offered at the Corsicana facility included psychotherapy, behavioral interventions, substance use treatment, mental health assessments, and medication management.[39] Between 2009 and 2012, Corsicana reported twice as many violent rule violations as any other TJJD facility.[40] In 2012, the facility housed only 10% of TJJD's juveniles but experienced 32% of all violent incidents reported by TJJD.[41]

In the years before the facility's closure, TJJD reviewed Corsicana youth to determine whether their needs could be met in a less restrictive setting. In December 2013, all 65 youth were transferred to a the McLennan Residential Treatment Center in Mart, Texas.[42] The McLennan County facility now serves as the primary mental health treatment center for youth committed to state confinement.

Though Corsicana closed as a normal operations facility in 2013, three staff members remained at the facility to complete administrative tasks. As of March 2016, the Legislative Budget Board (LBB) had not formally approved the closing of the Corsicana facility. In February 2016, however, TJJD employees from other secure facilities were sent to strip the Corsicana facility of its equipment.[43]

The Turman and Beto Halfway Houses

In 2013, the TJJD Board of Directors also voted to close down two underused halfway houses: the Turman House in Austin and the Beto House in McAllen.[44] A halfway house is a residential center where juveniles may live following their release from a secure institution.[45] Youth placed in these centers continue to receive support and monitoring as they begin their reentry process.

Between 2009 and 2013, TJJD decreased its use of commitments to secure and non-secure residential facilities by 44%.[46] Following this population decline, TJJD board members decided to condense halfway house services from 10 to 8 facilities. Before closing in 2013, the Turman House served an average daily population of 16.98 youth, while the Beto House served an average daily population of 15.58 youth.[47] After closing, youth who typically would have received treatment at the Turman House were sent to the Ayres House in San Antonio; youth who would have received treatment at the Beto House were sent to the Edna Tamayo House in Harlingen.[48]

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY PILOT

In 2011, TJJD partnered with the University of Texas at Austin Center for Social Work Research to adopt an evidence-based treatment for trauma designed specifically for juvenile correctional settings. TJJD piloted the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) program at Ron Jackson State Juvenile Correctional Complex, McLennan County State Juvenile Correctional Facility, and Giddings State School.[49] TF-CBT is an evidence-based treatment designed to reduce negative emotional and behavioral responses following traumatic events.[50] By March 2016, a treatment developer trained 40 clinical staff at TJJD facilities in TF-CBT,[51] and 57 youth were enrolled in the pilot program.[52]

As of May 2016, the UT Center for Social Work Research had not yet released an evaluation of the TF-CBT pilot program. Therefore, the Center cannot yet state the measured impact that the program has had on service delivery and outcomes. However, since the pilot's inception, TJJD mental health providers have reported that the program increased the consistency and sophistication with which therapy was provided to youth with histories of trauma.[53] In 2013, TJJD's Director of Treatment formally required all psychiatry staff to provide evidence-based therapy to committed youth.[54] By 2016, all youth with a mental health need, including those with trauma-related diagnoses, were receiving therapy services by psychiatry staff.[55]

The Texas Juvenile Justice System

The Texas Juvenile Justice Department's (TJJD) mission is to "transform young lives and create safer communities" throughout Texas.[56] To accomplish this mission, TJJD provides educational and behavioral health services to justice-involved youth committed to the agency's five secure state facilities and eight halfway houses.[57] 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:[58]

- 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.

While the adult system is a criminal system that emphasizes punishment, the juvenile system is a civil system that emphasizes rehabilitation.[59] As a result, the legal terms and concepts used in juvenile justice procedures differ from those used in the adult criminal justice setting. Figure 129 and Figure 130 offer a point of reference for parallel terms used in the adult and juvenile justice systems, as well as common definitions for terms used in the juvenile system.

Figure 129. Terms and Concepts

Juvenile Justice Term/Concept	Analogous Adult Criminal Justice Term/Concept
Delinquent conduct	Criminal conduct
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

Figure 130. Common Juvenile Justice Definitions

Term	Definition
Juvenile	A person between 10 and 17 years old at the time he or she committed an act defined as "delinquent conduct" or "conduct indicating a need for supervision."
Delinquent Conduct	Generally conduct that, if committed by an adult, could result in imprisonment or confinement.
Conduct Indicating a Need for Supervision (CINS)	Generally conduct that, if committed by an adult, could result in only a fine, or conduct that is not a violation of the law if committed by an adult, such as truancy or running away from home.
Adjudication	A court finding that a youth has committed delinquent or CINS conduct. It is equivalent to a "conviction" in adult court.
Deferred adjudication	A youth is placed under supervision, and his or her adjudication is deferred to a later date. If the juvenile meets the terms of his or her supervision, the case may be 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 and distinct due process hearings.

Term	Definition
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 of time, not to exceed his or her 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. This is set 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 his or her 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.). *Definitions for Common TJJD Terms & Acronyms.* Retrieved from http://www.tjjd.texas.gov/about/glossary.aspx

Source: Texas Juvenile Justice Department. (n.d.). *Determining How Long Youth Stay in TJJD*. Retrieved from http://www.tjjd.texas.gov/about/how_class.aspx

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

COST AND FUNDING SUMMARY

On May 31, 2016 there were 1,086 youth committed to TJJD's state secure facilities, 126 youth in halfway houses, and 114 youth in contract care facilities.[60] In 2015, the LBB estimated that youth in these residential facilities cost $437.11 per day.[61] In contrast, youth on parole cost $31.93 per day, and youth on probation cost $5.40 per day.[62] Figure 131 shows the difference in cost between the adult and juvenile justice systems in Texas.

Figure 131. Differences in Cost Per Day Between the Adult and Juvenile Justice Systems

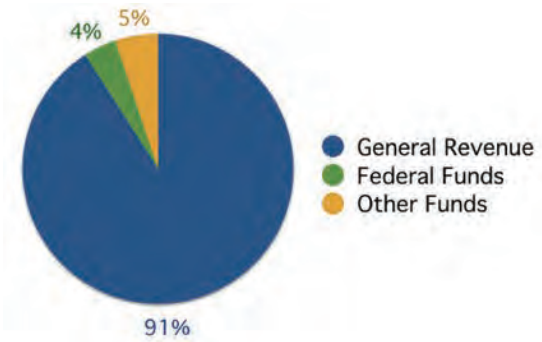
Placement	Adult System Cost	Juvenile System Cost
Adult prison or juvenile detention facility	$54.89	$437.11
Parole supervision	$4.04	$31.93
Community or probation supervision	$1.63	$5.40

Source: Legislative Budget Board. (2015, April 1). *Fiscal Note, 84th Legislative Regular Session in Re: HB 1205 by Dutton*. 2. http://www.capitol.state.tx.us/tlodocs/84R/fiscalnotes/pdf/HB01205I.pdf#navpanes=0

TJJD FUNDING

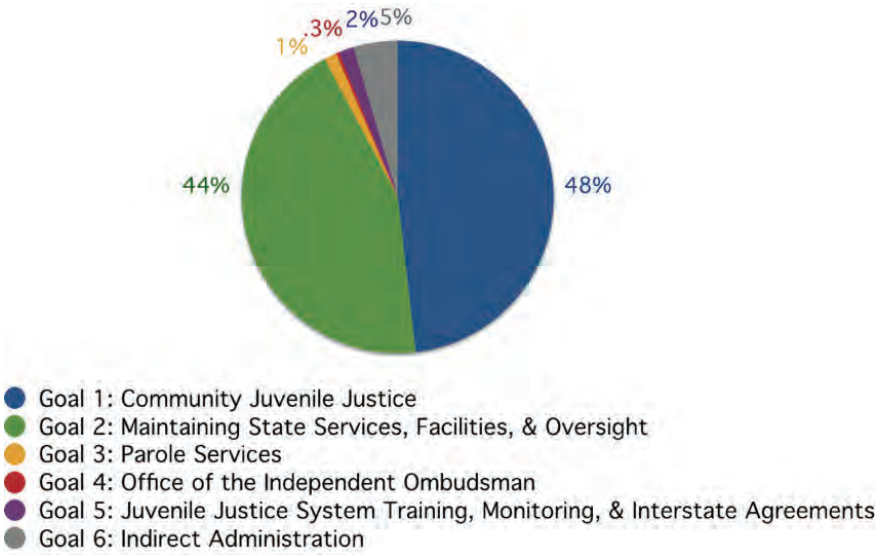
TJJD's operating budget in FY 2016 was $324,782,192. Figure 132 breaks down TJJD's budget by funding source, and Figure 133 breaks down the budget by agency goal. In FY 2016, mental health care services were incorporated within TJJD's Goal 2 (Maintaining State Services, Facilities, and Oversight) shown in green within Figure 133.[63]

Figure 132. TJJD FY 2016 Operating Budget by Funding Source



Source: Texas Juvenile Justice Department. (2015, December 1). *Operating Budget Fiscal Year 2016 Submitted to the Governor's Office of Budget, Planning and Policy and the Legislative Budget Board*. 8. Retrieved from https://www.tjjd.texas.gov/about/operating_budget.pdf. Note: The category "Other Funds" includes the following: interagency contracts, such as criminal justice grants and transfers from the Foundation School Fund No. 193; appropriated receipts; and general obligation bond proceeds.

Figure 133. TJJD FY 2016 Operating Budget by Agency Goal



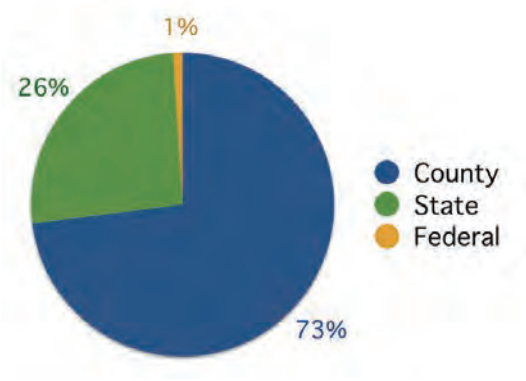
Source: Texas Juvenile Justice Department. (2015, December 1). *Operating Budget Fiscal Year 2016 Submitted to the Governor's Office of Budget, Planning and Policy and the Legislative Budget Board*. 4. Retrieved from https://www.tjjd.texas.gov/about/operating_budget.pdf.

The 84th Texas Legislature appropriated about $84.2 million in FY 2016 and $84.7 million in FY 2017 for the provision of behavioral health and substance use services within TJJD.[64] Legislators also created the Statewide Behavioral Health Coordinating Council comprised of 18 state agencies, including TJJD, to develop a five-year strategic plan and expenditure. The plan and proposal will help agency leaders determine how behavioral health funds can be spent most efficiently and effectively across the state. For more information on the strategic plan and the expenditure proposal for 2017 can be found in the HHSC section of this guide.

LOCAL JUVENILE PROBATION DEPARTMENT FUNDING

TJJD distributes a portion of its state funding to local juvenile probation departments in order to underwrite various probation activities, including special services for juveniles with behavioral health needs. County probation departments may also use federal funding to support their activities. For example, federal Title IV-E funding is a key resource for youth who are involved in both foster care and the justice system.[65] Counties, however, provide the majority of funding for community-based probation services. Using a mix of local, state, and federal funds, county probation departments offer a wide array of mental health and substance use services, including counseling, intensive in-home family services, and substance use prevention and intervention.[66] Figure 134 shows the funding breakdown for local juvenile probation departments in FY 2015.

Figure 134. Funding Breakdown for Local Juvenile Probation Departments in FY 2015



Source: Texas Juvenile Justice Department. (2015, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs.* 7. Retrieved from http://www.tjjd.texas.gov/publications/reports/AnnualReportFundingandRiders2015.pdf

HOW JUVENILES MOVE THROUGH TJJD

Texas youth who move through TJJD's system typically encounter six major steps, including:

1. An arrest by local law enforcement;
2. Sentencing by a county juvenile court judge;
3. 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;
4. Appraisal by the TJJD Release Review Panel (for youth committed to a secure state-level facility);
5. Completion of parole supervision; and
6. Discharge from TJJD.

The following section will describe each of these steps in greater detail.

JUVENILE ARRESTS

The vast majority of juveniles who come into contact with the justice system commit low-level offenses. In 2014, Texas law enforcement officers made 57,447 juvenile arrests.[67] Larceny-theft, running away from home, drug abuse violations, and violations of curfew and loitering laws (all of which are nonviolent offenses) accounted for nearly 50% of those arrests.[68] Figure 135 shows the top five most common crimes for which Texas youth were arrested in 2014. In contrast, juveniles were arrested for 1,567 aggravated assaults, 759 robberies, and 30 murders in 2014.

Figure 135. Top Five Arrest Categories for Texas Juveniles in 2014

Offense Type	Classification	Total Arrests by Offense in 2014
Larceny-theft (excluding motor vehicle)	Depends on value of property taken	10,807
Non-aggravated assault	Misdemeanor	9,020
Runaway	Misdemeanor	7,472
Marijuana possession	Depends on amount in possession	5,466
Curfew and loitering law violation	Misdemeanor	2,866

Source: Texas Department of Public Safety. (2015). 2014 Crime in Texas Report: Texas Arrest Data. 73. http://dps.texas.gov/crimereports/14/citCh9.pdf

Youth with mental illness are three times more likely than their peers to be arrested before finishing grade school.[69] Once they have made contact with the police, these individuals are more likely than others to face charges for minor offenses, such as those listed in Figure 135.[70] Some youth also 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.[71]

JUVENILE COURTS, SENTENCES, AND PLACEMENTS

Following an arrest, juveniles are taken to a county juvenile probation department, where they go through the intake and assessment process. At this stage, most youth are released to a parent or guardian as they await more information about their disposition.[72] Others may be diverted away from the justice system and into community-based programs, or 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.[73]

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 his or her community on a deferred prosecution or probation sentence, or the judge may sentence the youth to detention in a county or state facility. Placements within a detention facility are reserved for high-risk youth whom judges determine are in need of 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.[74] Between 2007 and 2015, TJJD relied more heavily on community-based interventions for youth, causing the average daily population within residential facilities to decrease by about 76%.[75]

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.[76] 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.[77]

Figure 136 shows the number of referrals and dispositions for youth involved in the juvenile justice system in FY 2015. For more information about secure placements and the behavioral health treatments available to youth within these placements, see the "Behavioral Health Services in the Juvenile Justice System" section of this chapter.

Figure 136. Referrals and Dispositions of TJJD Youth in 2015

Referrals and Dispositions	FY 2015
Formal Referrals to Juvenile Probation Departments	62,535
Juveniles Referred	44,060
Total Dispositions	63,965
TJJD Commitment Dispositions	825
Adult Certification Dispositions	115

Source: Texas Juvenile Justice Department. (2015, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs.* 13. Retrieved from http://www.tjjd.texas.gov/publications/reports/AnnualReportFundingandRiders2015.pdf

Note: The "formal referrals" data include 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.

RELEASE REVIEW PANEL AND PAROLE

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.[78] The panel may choose to release the youth into the community on parole or extend his or her stay within a TJJD facility. In FY 2015, the Release Review Panel extended juveniles' stays within secure facilities 66% of the time.[79] Within those extension decisions, about 19% of the juveniles had moderate mental health needs and about 40% had high substance use treatment needs.[80]

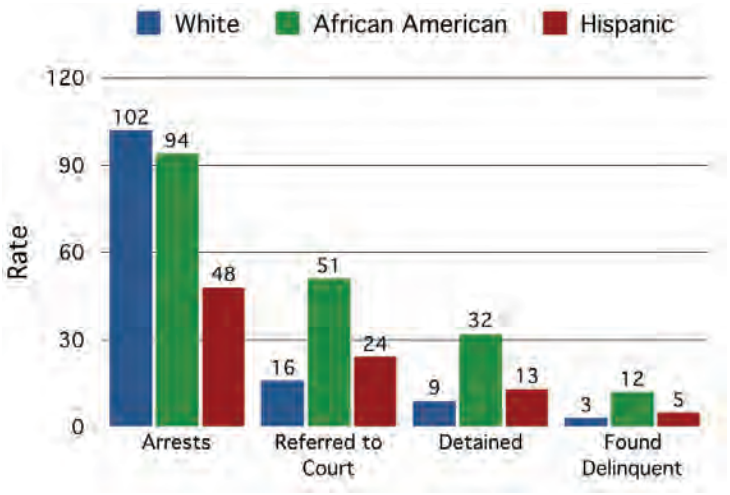
DISCHARGE FROM TJJD

When juveniles successfully complete their dispositions, TJDD may discharge them from custody. Juveniles are typically discharged because 1) they finish their treatment program, 2) they turn 19 and are no longer under TJJD's jurisdiction, or 3) they receive a determinate sentence and are transferred to the adult justice system in order to complete their sentence. Just like adults, justice-involved youth with mental illness often face challenges upon reentry, including stigma and discontinuity of care.

DISPROPORTIONALITY IN THE TEXAS JUVENILE JUSTICE SYSTEM

Black and Hispanic youth tend to fare worse than their white peers at most stages of the justice process.[81] For example, across the country, 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.[82] Figure 137 shows the rates at which white, African American, and Hispanic youth in Texas experienced various stages of the juvenile justice system in FY 2013. Though white juveniles had higher rates of arrest, youth of color were more likely to be referred to court, detained, and found delinquent.

Figure 137. Texas Rates of Juvenile Justice Involvement by Race and Ethnicity in FY 2013



Source: The W. Haywood Burns Institute for Juvenile Justice Fairness & Equity. (2013). *Unbalanced Juvenile Justice*. Retrieved from http://data.burnsinstitute.org/decision-points/44/texas#comparison=2&placement=1&races=2,3,4,5,6&offenses=5,2,8,1,9,11,10&odc=0&dmp=1&dmp-comparison=2&dmp-decisions=2,3,5,7&dmp-county=-1&dmp-races=1,2,3,4,7,5,6&dmp-year=2013.
Note: Comparisons of arrest to population are rates per 1,000 youth. All other categories are rates per 100 youth at the prior decision point (e.g., 16 white youth referred to court per 100 white youth arrested).

Youth of color are also more likely to be caught in the school-to-prison pipeline. 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.[83] In Texas specifically, researchers found that, after controlling for 83 different variables, African American youth are 31% 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).[84] Such disparities in school discipline place youth of color at greater risk for becoming involved in the juvenile justice system in the future.[85]

In 2015, the Council of State Governments (CSG) Justice Center analyzed the racial and ethnic impacts of Texas juvenile justice reforms that have taken place since 2007. Researchers found that the reforms impacted youth of all races equally; the policies did not exacerbate or improve disproportionate minority involvement in the Texas juvenile justice system.[86]

In 2011, SB 501 (82nd, West/Dukes) created the Interagency Council on Addressing Disproportionality (the IC) to complete two tasks: 1) examine best practices for addressing disproportionality in the human health and services agencies, including juvenile justice settings, and 2) develop recommendations on the best means of eliminating disproportionality in the long-run. In 2012, the agency developed a report for the Texas Legislature summarizing their progress on these tasks. The full report can be found here: http://www.hhsc.state.tx.us/hhsc_projects/cedd/11-29-2012-Report-to-the-83rd-Legislaturel.pdf

The report highlighted the "Texas model" as a means to address disproportionality. The model includes the following components:

- Data-driven strategies;
- Leadership development;
- A culturally competent workforce;
- Community engagement;
- Cross-systems collaborations; and
- Training defined by anti-racist principles, as well as an understanding of the history of institutional racism and its impact on poor communities and communities of color[87]

In 2013, the IC expired, and the Legislature replaced it with the Statewide Advisory Coalition for Addressing Disproportionality and Disparities.[88] The coalition operates within HHSC's Center for Elimination of Disproportionality and Disparities (CEDD) and holds responsibilities similar to those of the IC. In 2016, the coalition's main priorities included children's mental health, infant mortality, and workforce issues for individuals with disabilities.[89] In December 2016, CEDD will release a report for the Texas Legislature outlining the coalition's formal recommendations, including means to strengthen data collection on disparity issues. CEDD, however, does not hold the power to enforce its recommendations. Only DFPS is legislatively mandated to address disproportionality within its service delivery, while other agencies, including TJJD, may choose whether to implement the coalition's suggestions.[90]

THE OFFICE OF THE INDEPENDENT OMBUDSMAN

In 2007, the 80th Texas Legislature created the Office of the Independent Ombudsman (IO) as a separate state agency responsible for investigating, evaluating, and securing the rights of youth committed to TJJD.[91] The independent ombudsman investigates a variety of complaints, including medical and mental health concerns, abuse allegations, and suicidal ideation and attempts. Three of the IO's major duties include:

- Providing information to legislators and the public regarding facility grievance procedures;
- Regularly visiting and inspecting secure TJJD facilities; and
- Tracking Abuse, Neglect, and Exploitation (ANE) incidents in all county facilities.[92]

During the 84th legislative session, lawmakers passed SB 1630 (84th, Whitmire/Turner) to implement broad reforms to the juvenile justice system, including an expansion of the IO's oversight duties. Prior to 2015, the IO was responsible for inspecting state-level secure TJJD facilities, halfway houses, state contract care facilities, and parole offices. Following SB 1630, the IO must also inspect county-level post-adjudication facilities and contract facilities where county post-adjudicated youth are placed.[93] Figure 138 below summarizes the IO's activities during FY 2015, and the first half of FY 2016. The IO receives the majority of complaints directly from youth while inspectors visit state secure facilities and county post-adjudication facilities.[94]

Figure 138. Account of Site Visits, Youth Contact, and Cases Closed by the IO

Activity	FY 2015	First Half of FY 2016
Site Visits	207	85
Number of youth interviewed	1,305	1,329
Number of youth interviews conducted	3,004	1,974
Closed cases	106	41

Source: Independent Ombudsman for the Texas Juvenile Justice Department. (2016). Second Quarter Report FY 16: December 1, 2015 to February 29, 2016. 1. Retrieved from http://www.tjjd.texas.gov/ombudsman/reports/IO_Second_Quarter_2016.pdf

Behavioral Health Services in the Juvenile Justice System

The Texas Juvenile Justice Department, local juvenile probation departments, and the Texas Correctional Office for Offenders with Medical and 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.

Between 2009 and 2015, a growing proportion of justice-involved youth required and received behavioral health services in Texas. In 2015, 99% of the newly-admitted youth to TJJD required at least one area of specialized treatment.[95] Half of the new youth also required mental health treatment by a licensed or specially trained provider.[96] Between 2009 and 2015, TJJD increased its use of specialized treatment by 32% to meet juveniles' behavioral health needs.[97] During that same time period, advances in early detection and treatment for youth with mental health conditions reduced re-arrest rates, off-site hospitalizations, and self-harm among TJJD youth.[98] However, while the percentage of youth in need of both mental health *and* substance use treatments has increased since 2012, the percentage of youth successfully completing both types of programs fell from 61% in 2012 to 42% in 2014.[99]

The following section describes the behavioral health services available to justice-involved youth. Services are divided into the following four categories:

1. Behavioral health services in state secure facilities
2. Behavioral health services in county-level secure facilities
3. Behavioral health services for youth on parole
4. Community-based behavioral health services offered by juvenile probation departments

BEHAVIORAL HEALTH SERVICES IN STATE SECURE FACILITIES

Texas operates five state secure facilities for youth adjudicated for felony offenses.[100] On May 31, 2016, there were 1,086 youth housed at the state's five secure facilities.[101] Figure 139 below shows the name and location of the state secure facilities. In FY 2015, about one-quarter of newly-committed youth were adjudicated for high-severity crimes, such as capital offenses.[102]

Figure 139. TJJD Secure Facilities

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

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

INTAKE, ORIENTATION, AND PLACEMENT

All juveniles who are committed to a TJJD facility must first go to the Ron Jackson State Juvenile Correctional Complex to receive orientation and assessment services.[103] These services last approximately 28 to 35 days during which time youth receive psychiatric and health evaluations, as well as an introduction to TJJD's treatment programs.[104]

After orientation, youth are dispersed to various state secure facilities depending upon the juvenile's specific treatment needs. Approximately 15% of youth are placed in a halfway house following orientation, while many other juveniles in state custody fulfill their dispositions within secure detention facilities.[105] All girls who are committed to a detention facility must remain at the Ron Jackson complex because it is the only secure facility that serves females. Programming and services at Ron Jackson are similar to those offered at the McLennan County Residential Treatment Center, but they are modified to reflect the unique needs of female youth.[106] In November 2013, the Ron Jackson 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. Though girls and boys are housed in the same facility, they attend different rehabilitative programs and live in separate units.[107] In FY 2015, the Ron Jackson facility served 188 girls and 887 boys (including boys who solely received orientation services at the facility).[108]

In October 2014, the Ron Jackson complex also created a male intake unit for boys under 15 years old. Between October 2014 and March 2016, the intake unit served 35 boys.[109] Children under 15 who have been committed to a state secure facility are kept at the Ron Jackson facility until they are about 14 years old.[110] At this 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 be kept 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 five 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.[111] 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.[112] 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. Youth who are identified as having a serious mental health need are taken to TJJD's primary mental health treatment facility, the McLennan Residential Treatment Center (MRTC) in Mart, Texas. Youth with the most severe forms of mental illness, such as schizophrenia, may be served within MRTC's Crisis Stabilization Unit (CSU). Equipped with eight beds, the CSU provides hospital-level psychiatric care within a secure TJJD facility.[113] 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.[114]

Youth who are identified as having a high need for specialized 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. Figure 140 highlights the specialized treatment programs that exist across the state.

Figure 140. Specialized Treatment Programs in Texas

Program	Location[115]	Participants	Treatment Services and Outcomes
Alcohol or Other Drug Use Treatment Programs (AODTP)	Services available at all the institutional facilities and several halfway houses. Residential programs are offered at all five state secure facilities.	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. · In 2014, 99% of juveniles in need of AODTP were enrolled, and 92% of those in need completed treatment.[116]
Aggression Replacement Therapy (ART) Program	Services available at all five state secure facilities.	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 (CSVOTP)	Services available at Giddings State School, Ron Jackson Correctional Complex, and McLennan County Correctional Facility.	Youths who are committed for murder, capital murder, and offenses involving the use of a weapon or deadly force.	· CSVOTP helps young people understand feelings associated with their violent behavior and identify alternative ways to respond when faced with risky situations. · Participants are required to reenact their crimes and play the role of both the perpetrator and victim. · Participation in the program reduces the likelihood of being re-incarcerated for any offense by 55%.[117] · In 2014, 98% of juveniles in need of CSVOTP received treatment, and 91% of those in need completed treatment.[118]
Violent Offender Program *Note: This program began serving youth in July 2015.*	Services available at Giddings State School, Ron Jackson Correctional Complex, and McLennan County Correctional Facility.	Youths who have committed a violent crime but whose offenses are not serious enough to qualify for CSVOTP	· The program is similar to CSVOTP, though participants have committed less serious crimes, such as aggravated robbery. · Youth engage in two months of orientation and six months of programs. · Counselors do not utilize the same role play activities used in CSVOTP. Instead, they focus on self-regulation, anger management, and value-changing activities.[119]
Girls' Circle	Services available at Ron Jackson State Juvenile Correctional Complex.	Female youth	· Girls' Circle uses a support group structure to promote resilience, engage female youth in gender-specific discussions, and increase self-esteem.
Mental Health Treatment Program (MHTP) *Note: Less intensive mental health programs for youth with moderate needs are available at all campuses.*	Services available at McLennan Residential Treatment Center and Ron Jackson State Juvenile Correctional Complex.	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. · In 2014, 85% of juveniles in need of MHTP were enrolled, and 55% of those in need completed treatment.[120]

Program	Location[115]	Participants	Treatment Services and Outcomes
Sexual Behavior Treatment Program	Services available at McLennan Residential Treatment Center, McLennan County Correctional Facility, Giddings State School, and Gainesville State School.	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. · In 2014, 98% of juveniles in need of the program were enrolled, and 85% of those in need completed treatment.[121]
Strategies for Anger Management	Services available at all five state secure facilities and all halfway houses.	Youth with a low need for violent offender treatment.	· The 12-session program uses cognitive behavioral therapy to help youth identify their triggers for anger. · Participants are taught to develop more effective substitutes for responding to those triggers.

Source: Texas Juvenile Justice Department. (2015, December). *The Annual Review of Treatment Effectiveness*. Retrieved from https://www.tjjd.texas.gov/Docs/TreatmentEffectivenessReview_2015.pdf

BEHAVIORAL HEALTH SERVICES IN COUNTY-LEVEL SECURE FACILITIES

At the county level, juveniles may be placed in two different types of facilities that offer various behavioral health services: pre- and post-adjudication facilities. Texas has 49 pre-adjudication facilities operated by counties to detain youth who are deemed unsafe for release back into the community while awaiting adjudication. These juveniles are detained before a judge provides a "true" or "not true" finding for each youth's offense.[122] Approximately 500 Texas juveniles spent 100 days or more in pre-adjudication facilities at the county level in FY 2015.[123] About 36% (180 youth) of these individuals were formally referred for a non-felony offense.[124]

Texas also has 36 post-adjudication secure facilities operated at the county level. These facilities detain adjudicated youth who have committed offenses that are not severe enough to warrant placement in a state secure facility.[125]

Because local juvenile justice systems rely heavily on county and local funding sources, the availability of treatment and support services varies across the state. Figure 141 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: http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx.

Figure 141. Number (and Percentage) of Post-Adjudication Facilities with Specific Services in Texas

Type of Service	Pre-Adjudication Facilities	Post-Adjudication Facilities
Mental Health	19 (39%)	27 (75%)
Substance Use	15 (31%)	31 (86%)
Sex Offense	7 (14%)	20 (56%)
Female-Specific	8 (16%)	17 (47%)

Source: Texas Juvenile Justice Department. (n.d.). Registered Juvenile Facilities in Texas (CY2015). Retrieved from http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx

Following SB 1630 (84th, Whitmire/Turner), at least 180 juveniles will be diverted away from state secure facilities and into county juvenile justice systems.[126] However, as shown in Figure 140, counties differ in their capacity to provide services for justice-involved youth. In 2015, county-level stakeholders reported that the lack of professional mental health providers within their regions was a potential barrier to the successful implementation of SB 1630.[127] In November 2015, the TJJD Regionalization Task Force began developing funding protocols to ensure that county-level juvenile justice departments would have the necessary financial support to provide services to diverted youth. These protocols state that TJJD may allocate the $11.3 million available for SB 1630 reforms in two ways.[128] First, regions can receive start-up funds each year between FY 2016 and FY 2019 that can be used to benefit juveniles targeted for diversion, as well as other justice-involved youth.[129] Second, regions may apply for additional funding that must be directed specifically to the programming and placement needs of youth targeted for diversion from state-run facilities.[130]

BEHAVIORAL HEALTH SERVICES FOR YOUTH ON PAROLE

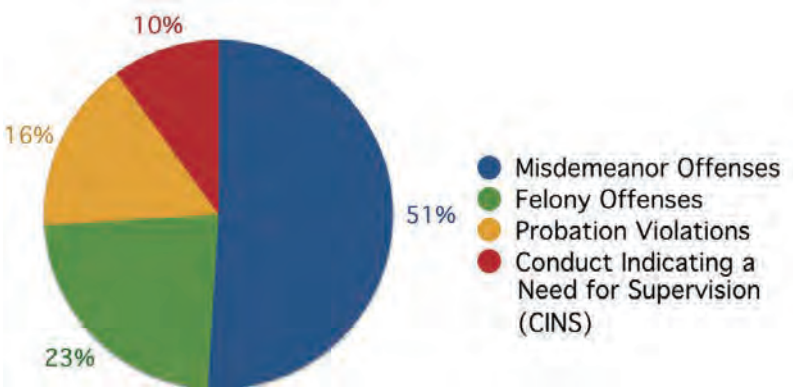
In Texas, parole officers must receive extensive training on working with youth with mental and behavioral health issues.[131] Further, TCOOMMI provides continuity of care services to youth with a mental health diagnosis who are released on parole following their placement in a state or county secure facility. (TCOOMMI also provides services to youth on probation; those services will be described in the next subsection.) In May 2016, the average daily population on parole in Texas was 420 youth.[132] The state may also place paroled youth with a mental illness in therapeutic foster homes, group living arrangements, or residential treatment facilities. Services targeted for youth released on parole who have a serious mental illness and who require post-release treatment include:

- Individualized assessments;
- Service coordination;
- Medication monitoring;
- Advocacy services in the community;
- Transitional services to other treatment programs; and
- Benefits eligibility and application assistance.[133]

COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES OFFERED BY JUVENILE PROBATION DEPARTMENTS

In FY 2015, juvenile probation departments received 62,535 formal referrals throughout the state.[134] The majority (51%) of referrals were for youth who committed misdemeanors.[135] Figure 142 shows the type of offenses that precipitated referrals to juvenile probation departments.

Figure 142. Offense Type for Juveniles Referred to Juvenile Probation Departments



Source: Texas Juvenile Justice Department. (2015, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders, and Special Diversion Programs*. 12. Retrieved from http://www.tjjd.texas.gov/publications/reports/AnnualReportFundingandRiders2015.pdf

By law, local juvenile probation departments must screen all Texas 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).[136] 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.[137] In 2015, TJJD reported that 35% of juveniles who were referred to juvenile probation had an identified mental health need.[138] Approximately 20% of formally referred juveniles screened in FY 2015 were recommended for a subsequent mental health assessment.[139] For a detailed flowchart of the screening and referral process, see http://www.tjjd.texas.gov/publications/forms/2010/TJPCFS0410.pdf.

Texas counties vary in their capacity to identify and address youth with mental health needs. Though there is a high prevalence of mental health need among justice-involved youth, few juveniles access mental health services prior to entering the justice system. Instead, many juveniles experience mental health treatment for the first time after they have been arrested, adjudicated, or diverted to mandated community treatment programs.[140]

County juvenile probation departments may partner with TCOOMMI, local mental health authorities (LMHAs), 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. Communities initially created these groups in 1987 after the Texas Legislature directed state agencies to improve community-based services for juveniles with cross-agency needs.[141]

Youth with mental health needs may receive services from juvenile probation departments, TCOOMMI, LMHAs, and CRCGs for a variety of reasons. Some children may be diverted from the probation system to receive mandated behavioral health services in their home communities. Judges could also offer youth deferred adjudication and order treatment as a condition of dismissing each juvenile's

charges. Finally, 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. Approximately 39% of juveniles on deferred prosecution or probation supervision were identified as having a mental health need in FY 2015, a decrease from 44% in FY 2013.[142]

Figure 143 indicates the number of youth discharged from detention and supervision in FY 2015 who were linked to community services, such as behavioral health treatment, care management, and support services, through TCOOMMI or CRCGs. Discharge does not always coincide with a youth's release into the community; instead, discharge refers to the ending of all TJJD custody, supervision, and/or services. Youth on parole, for example, have been released into the community but not discharged from TJJD because they must remain under correctional control until they complete their parole disposition.

Figure 143. Youth Discharged and Linked to Community Services, including Behavioral Health Treatment, Care Management, and Support Services in FY 2015

Type of Discharge	Number Served
Referred to TCOOMMI or CRCG services	382
Received mental health aftercare services in the community	146 (includes youth released on TJJD parole, as well as youth released to a non-secure residential facility (hallway house)
TJJD youth on parole receiving mental health aftercare services in the community	98

Source: Texas Juvenile Justice Department. (2016, July). Data Request: Services for discharged youth.

In FY 2015, 33,926 unique youth were served in community-based programs.[143] About 39% of those youth (or approximately 13,200 individuals) had an identified mental health need; these youth participated in 32,504 community-based programs throughout FY 2015.[144] Figure 144 indicates the number of programs in which youth with mental health needs participated during FY 2015, including mental health and mental health court programs, counseling services, substance abuse prevention and intervention programs, and substance abuse treatment and drug court programs.

Figure 144. Number of Community-Based Programs in Which Youth with Behavioral Health Needs Participated

Type of Service	Number of Programs
Mental health programs and mental health court programs	2,571
Behavioral health services for a mental health problem (including one-time mental health assessment and evaluation services)	5,210
Counseling services programs	2,006
Substance abuse prevention and intervention programs	1,059
Substance abuse treatment and drug court programs	1,370

Source: The Texas Juvenile Justice Department. (2016, June). Data Request: Community-based behavioral health programs

Definitional Note: "Behavioral health services" are typically one-time events designed to meet a juvenile's immediate need, such as a medical appointment, an assessment, or psychological testing. "Programs," such as the counseling and substance use treatment programs listed in Figure 144, are planned activities or interventions with specific goals and curricula. These programs may include counseling, anger management, and the Special Needs Diversionary Program.

STATE-FUNDED PROGRAMS AVAILABLE TO LOCAL JUVENILE PROBATION DEPARTMENTS WITH BEHAVIORAL HEALTH SERVICE COMPONENTS

TJJD 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.

Prevention and Intervention Programs

In 2011, the 82nd Texas Legislature funded prevention and intervention programs to stop "at-risk behaviors that can lead to delinquency, truancy, school dropout, or referral to the juvenile justice system."[145] In 2012, TJJD approved the initial investment of $1.4 million for 24 prevention and early intervention programs.[146] The programs are designed to serve youth ages 6 to 17 who are not currently receiving supervision services but who are at high risk for referral to the justice system.[147]

In FY 2015, almost $3.1 million was appropriated for prevention and early intervention services, and 23 departments were awarded funding.[148] The departments focused on three types of interventions:[149]

- Partnerships with out-of-school service providers who can provide educational assistance, skills building, character development, and mentoring services after school and during the summer;
- Programs for parents and guardians of at-risk youth to help caregivers better manage their child's behaviors; and
- Collaborations with local elementary, middle, and high schools to prevent truancy by ensuring that at-risk students remain actively engaged in their educational environments.

In FY 2015, 3,355 youth received prevention and intervention services.[150] The average age of the participants was 11 years old, and about three-quarters of the youth served were either Hispanic or African American.[151] In 2015, 91% of youth exiting prevention and intervention programs finished their program's requirements successfully.[152] Service providers predict that participation in such programs can reduce each youth's chances of becoming involved in the juvenile and adult justice systems in the future. Figure 145 shows the number of youth who began, finished, or successfully completed participation in prevention and intervention programs in FY 2015.

Figure 145. Youth Beginning and Exiting Prevention and Intervention Programs in FY 2015

Participation Status	Number of Youth
Youth Beginning a Program	2,221
Youth Exiting a Program	2,185
Youth Completing a Program	1,999
Percent of Youth Exiting a Program Who Successfully Completed that Program	91%

Source: Texas Juvenile Justice Department. (2015, December). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs.* 19. Retrieved from http://www.tjjd.texas.gov/publications/reports/AnnualReportFundingandRiders2015.pdf

The 2015-2016 General Appropriations Act required TJJD to partner with the Texas Department of Family and Protective Services (DFPS), the Texas Education Agency (TEA), and the Texas Military Department in the provision of juvenile delinquency prevention and intervention programs.[153] The agencies created a workgroup to minimize redundancy and optimize services for at-risk Texas youth. In particular, the Legislature requested that the agencies determine how they will manage the consolidation of prevention and intervention services following the HHSC Transformation. (For more information on the HHSC Transformation, see the HHSC chapter of this guide). By September 2016, the workgroup must submit a five-year strategic plan to the Texas Legislature. By October of each fiscal year, the agencies must also submit utilization and effectiveness data to the LBB.[154]

Community-Based Programs and Services

Community-based programs within juvenile probation departments continue to grow each fiscal year.[155] To manage information about these programs, TJJD created its online Program and Services Registry in 2010. The registry catalogues all active community-based programs offered by various juvenile probation departments across the state. Both juvenile probation departments and contracted agencies must provide information regarding the service components of active programs, including their duration, funding, and eligibility requirements. To access the registry, visit https://www.tjjd.texas.gov/programregistryexternal/members/searchprograms.aspx.

In May 2016, local juvenile probation departments offered 2,245 active community-based programs to at-risk youth, justice-involved youth, and their families.[156] These programs involved a wide array of services, including counseling services, gang intervention programs, parenting classes, and employment training. In FY 2015, 29% of youth participants were enrolled in a treatment-based program, 48% were enrolled in a skills-building program, and 23% were enrolled in a surveillance-based program.[157] Almost half (47%) of all youth on deferred prosecution or under probation supervision participated in at least one community-based program in 2015, and 27% participated in three or more programs.[158]

Community-based programs are not dispersed evenly across the state's 166 juvenile probation departments. The availability of community-based programs depends upon local county resources and the unique needs of youth in a particular

community.[159] In 2013, the ten urban juvenile probation departments had the most programs, with an average of 42 per department.[160] Medium and large probation departments offered an average of 11 and 18 programs, respectively.[161] Small departments offered an average of five programs per department, but they often did not offer targeted programs, such as mental health courts or runaway programs, that are typically available in larger counties. Instead, smaller departments provided counseling and educational programs designed to serve the needs of a wide array of juveniles, not only those with more specific behavioral health needs.[162]

The duration of community-based programs also varies widely. Some programs last one afternoon while others can last the entirety of a juvenile's supervision. Figure 146 lists the average duration of service for community-based programs with behavioral health components.

Figure 146. Average Expected Length of Stay in Various Community Programs

Program Type	Days in Program
Counseling	109
Cognitive Behavioral Therapy	70
Mental Health Court	170
Mental Health Programming	161
Substance Abuse Treatment	109

Source: Texas Juvenile Justice Department. (2013, June). Community-Based Program Evaluation Series: Overview of Community-Based Juvenile Probation Programs. 4. Retrieved from http://www.tjjd.texas.gov/statistics/CommunityBasedJuvenileProbationPrograms.pdf

Community Corrections Diversion Program (Grant C)

In 2009, the 81st Legislature created the Commitment Diversion Program (Grant C) through Rider 21 in the general appropriations bill. Through this program, the state provides funds to local juvenile probation departments in order to develop community-based rehabilitative services and divert youth away from TJJD facilities.[163] The funds support a range of 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.[164] All probation departments are eligible for the grant program, but 11 departments declined to participate in 2015.[165]

In FY 2015, 6,528 juveniles received a program, placement, or service funded at least in part by the Community Corrections Diversion Program.[166] The majority (72%) of juveniles served by Grant C funds were under probation supervision, though youth on deferred prosecution are also eligible for services. In total, 3,533 juveniles exited the supervision disposition associated with a Grant C program, and of those, 78% completed their supervision successfully.[167]

Mental Health Services Grant (Grant N)

In 2014, TJJD began allocating funds for the Mental Health Services Grant (Grant N) in order to expand the availability of mental health screenings, assessments, and evaluations for juveniles within local probation departments.[168] Juvenile probation

departments cannot use Grant N funds to cover administrative expenses or to supplant local funding.[169] Instead, the Mental Health Services Grant must be used to fund:

- Mental health screenings, assessments, and evaluations to identify youth with mental illness;
- Residential mental health services;
- Salaries for mental health professionals and contracted service providers;
- Medications associated with treating a diagnosed mental illness; and/or
- Community mental health programs and services.[170]

TJJD allocated $12.8 million in both FY 2016 and FY 2017 to fund mental health services provided by local juvenile probation departments.[171] Funding was provided in two tiers.[172] Tier I funding may be used to establish new mental health services on a per-referral basis. Higher rates of funding are provided to smaller probation departments that operate pre- or post-adjudication facilities. Probation departments that manage one or more facilities with 80 beds or fewer may receive Tier I funding for one full-time mental health professional; departments that manage facilities with more than 80 beds may receive Tier I funds for two full-time mental health professionals.[173] Departments without a pre- or post-adjudication facility can also receive Tier I funding to secure mental health services.[174] Tier II funding may be used to fund and/or expand existing services for youth with mental health conditions.[175]

Diversion Programs for Youth with Behavioral Health Conditions

In its 2017-2021 strategic plan, TJJD stated that its top goal moving forward is to minimize juveniles' immersion in the justice system.[176] Diverting youth with mental health conditions from incarceration and further involvement in the juvenile justice system has significant health and economic benefits. Texas operates a number of diversion initiatives around the state to help youth "stay as shallow as possible" in the justice system.[177] This section will describe several of those programs in the order in which juveniles experience the justice system.

THE FRONT-END DIVERSION INITIATIVE

In 2008, the MacArthur Foundation targeted front-end juvenile justice diversion through its Models for Change grant initiative. Texas was among the original eight states that received grant funding. In partnership with local probation departments, TJJD developed the Front-End Diversion Initiative (FEDI) to divert youth away from the justice system *before* they are formally adjudicated.[178] FEDI links youth with mental health needs to specialized juvenile probation officers (SJPO) who receive comprehensive training on mental illness, family engagement, de-escalation, and problem-solving techniques.[179] For about 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 this 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.[180]

In 2008, FEDI was launched in four Texas counties: Austin, Dallas, Lubbock, and San Antonio.[181] The program was later expanded to include Houston. In 2014, the National Institute of Justice designated FEDI as a "Promising Program"[182] for its successes with pre-adjudicated youth, and in 2016, FEDI program researchers in Texas were recruited to replicate FEDI in Maryland. Some of FEDI's successes include:

- Within 90 days of supervision, FEDI participants are 11 times less likely to be adjudicated than their peers receiving traditional supervision services.[183]
- Four FEDI sites (Austin, Dallas, Lubbock, and San Antonio) report a 0% percent turnover rate among SJPOs, while most juvenile probation departments report a 35% turnover rate over four years.[184]
- FEDI officers engage in over 10 times more collateral contacts in the community than traditional probation officers do, leading participants to use more community services than other justice-involved youth.[185] Figure 147 shows the difference in the use of community services among youth enrolled in the FEDI program and youth receiving traditional supervision services.

Figure 147. Percentage of Youth in the FEDI Program and Under Traditional Supervision Who Accessed Community Services

Service Type	Youth in the FEDI Program	Youth Under Traditional Supervision
Individual Therapy	82%	9.4%
Family Counseling	35.4%	4.7%
Other Community Resources	69.2%	20.3%

Source: National Center for Mental Health and Juvenile Justice. (2015, April). *Diverting Youth at Probation Intake: The Front-End Diversion Initiative*. 6. Retrieved from http://cfc.ncmhjj.com/wp-content/uploads/2015/04/FEDI-508.pdf

SPECIALTY JUVENILE COURTS

Specialty courts aim to address the underlying causes of juvenile justice involvement. The courts serve individuals who could benefit from supervised treatment but for whom commitment to a secure facility may be clinically inappropriate. Specialty courts often operate as one piece of a larger continuum of diversion services for youth with behavioral health conditions. The most frequently used specialty courts for juveniles are mental health courts and drug courts. Both types of courts utilize individual treatment plans, case management, and judicial supervision to link youth to treatment services in the community.

In April 2016, Texas operated specialized mental health courts for youth in Bexar, Dallas, Harris, El Paso, and Travis counties.[186] A 2011 evaluation of specialty courts found that mental health courts in Texas 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.[187] In 2015, researchers also demonstrated that individuals who participate in juvenile mental health courts experience improved psychiatric outcomes and significantly fewer re-arrests and re-convictions than their peers with similar criminal histories.[188]

Although the courts produce positive outcomes, recent data also show racial and

gender disparities in access to this diversion strategy.[189] Further, the authors' 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. As of July 2016, centralized data on the number of youth served in specialty courts and their overall outcomes did not exist.[190]

Collaborative Opportunities for Positive Experiences (COPE) is a Travis County juvenile court project initially funded through the Bureau of Justice Assistance. COPE was the first program in Texas to divert youth with mental illness or brain injuries away from the justice system *before* prosecution and adjudication.[191] Each multi-disciplinary COPE team consists of a court judge, a legal representative for the youth, the assistant district attorney, three probation officers, a casework manager, and mental health professionals with expertise in child mental health.[192] To participate in COPE, juveniles must be eligible for deferred adjudication and their families must commit to involvement in the program. Enrolled youth must cooperate under intensive probation supervision, engage in therapeutic mental health treatment, and successfully meet individualized program requirements in order to have their charges dismissed.[193] Every three to six weeks, juveniles also attend family meetings during which the COPE team can monitor each juvenile's progress and address problems using a strengths-based perspective. Enrollment typically lasts about six to 12 months before juveniles are released from the program and their charges are dismissed.[194]

Juvenile drug courts use a similar model of diversion. Juveniles who have been charged with drug-related crimes receive a combination of judicial supervision and treatment management in order to prevent future involvement with the justice system. In 2015, there were over 400 juvenile drug courts nationwide.[195] In April 2016, 24 of those courts were located in Texas.[196]

THE SPECIAL NEEDS DIVERSIONARY PROGRAM

In 2001, the 77th Texas Legislature appropriated specialized funding to Texas Juvenile Probation Commission (since changed to TJJD) and TCOOMMI in order to provide mental health treatment and intensive supervision to Texas youth who committed crimes.[197] The agencies used this funding to establish the Special Needs Diversionary Program (SNDP), which seeks to rehabilitate and prevent future justice involvement among youth with diagnosed mental health conditions (excluding substance use conditions, intellectual disabilities, autism, and pervasive development disorder).[198] Once enrolled in SNDP, juveniles and their families have 24/7 access to at least one SNDP core team member for crisis resolution services.[199]

In 2015, 20 local juvenile probation departments utilized SNDP services. Specialized probation officers partnered 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.[200]

In FY 2015, the Texas Legislature appropriated about $2 million to SNDP, and the program served 1,309 juveniles.[201] Of those served in FY 2015, 37% of youth had at least three previous juvenile probation referrals, 52% had a felony offense in their history, and nine percent were previously spent time in a residential placement facility.[202] Traditionally, three of the most common diagnoses among SNDP participants are attention deficit hyperactivity disorder, oppositional defiant disorder, and bipolar disorder.[203,204]

Referrals to secure state facilities and re-offense rates are used as measures of program effectiveness. Of the youth starting SNDP in FY 2014, 58% committed a new Class B misdemeanor offense or an offense of greater severity within one year.[205] Further, about 2% of youth who began SNDP in 2014 were committed to a TJJD facility within one year.[206] Figure 148 shows the number of juveniles who entered, exited, and successfully completed SNDP in FY 2014 and FY 2015.

Figure 148. Juveniles Entering, Exiting, and Successfully Completing the SNDP in FY 2015

Program Status	Number of Youth
Juveniles Beginning SNDP	853
Juveniles Ending SNDP	864
Juveniles Completing SNDP Successfully	552
Percent Completing Program Successfully	64%

Source: Texas Juvenile Justice Department. (2015, December). Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs. 18. Retrieved from http://www.tjjd.texas.gov/publications/reports/AnnualReportFundingandRiders2015.pdf

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Texas Education Agency and Local School Districts *At a Glance*

Texas Education Agency and Local School Districts

POLICY CONCERNS

- Need for more recovery-oriented educational supports, such as schoolwide positive behavioral interventions and support (SWPBIS) and classroom-based social and emotional learning (SEL)
- Disproportionate amount of disciplinary measures for students receiving special education services and racial/ethnic minorities (in-school and out-of-school suspension, district alternative education programs (DAEPs), and juvenile justice alternative education programs (JJAEPs).
- Disproportionate use of corporal punishment on students with disabilities or special needs.
- Potential impact of budget reductions that could limit access to school counseling services.
- Lack of transparency and comprehensive training of school district law enforcement (school resource officers), including a need for Children's Crisis Intervention Training (CCIT).
- Lack of trauma-informed care training.

FAST FACTS

- A 2011-2012 report found that, compared to the national average of 12.9 percent of students identified as eligible for special education services, Texas only had 8.7 percent of students receiving special education services – the lowest percentage in the country.[1,2]
- The rate of special education enrollment in Texas remained steady at 8.7 percent for the 2015-2016 school year, with 463,185 of the total student population (5,299,728) enrolled in special education services.[3,4]
- Roughly 34.4 percent of students eligible for special education services in 2015-2016 had a primary diagnosis of a learning disability, 11.7 percent had a primary diagnosis of Autism, and 5.8 percent had a primary diagnosis of emotional disturbance. [5]
- In the 2014-2015 school year, 9.5 percent of students in Texas schools received special education services, but those students represented 18.3 percent of expulsions to Juvenile Justice Alternative Education Programs (JJAEPs), 17.1 percent of expulsions to Disciplinary Alternative Education Programs (DAEPs) and 14.9 percent of expulsions without placement. [6]
- Students receiving special education services were also overrepresented in receiving out-of-school suspensions (19.3 percent) and in-school suspensions (15.4 percent) in 2014-2015. [7]
- The majority of expulsions to DAEPs and JJAEPs continued to be discretionary in 2014-2015 (i.e. expulsions that were not mandated by state law but instead involve local codes of conduct). [8]
- The majority of students in Texas are Hispanic (52.0 percent) and many students in Texas – nearly one million – are still learning English. [9]

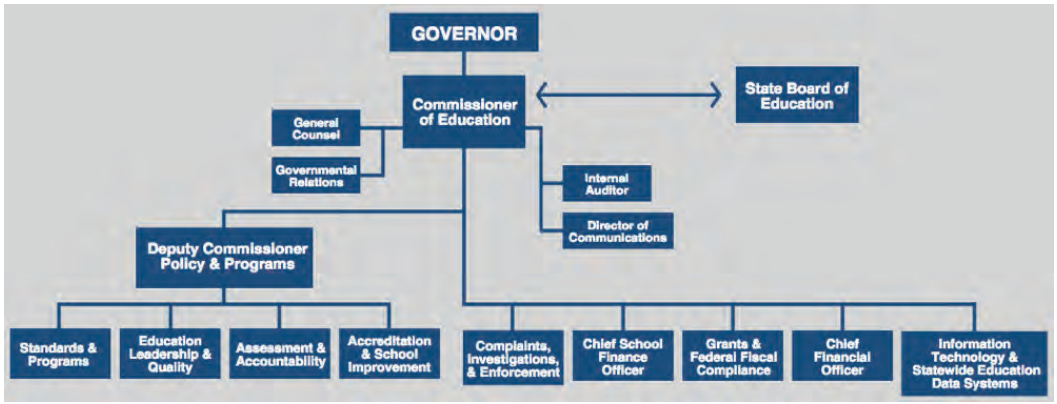
Texas Education Agency and Local School Districts

Overview of Texas Education Agency and Local School Districts

The Texas Education Agency (TEA) provides oversight and administrative functions for all primary and secondary public schools for the 1,247 school districts and 616 open-enrollment charter school campuses in the state of Texas.[10,11] According to TEA, 5,299,728 students were enrolled in Texas public schools in the 2015-2016 school year, including charter schools and early education providers.[12] Over an eleven-year period, total enrollment in Texas schools increased by roughly 20.4 percent, or 899,084 students.[13,14]

Undiagnosed or poorly managed mental health conditions can negatively impact a child's academic performance, classroom behavior, and school attendance.[15,16] The most recently available data from the National Survey of Children's Health (2011-2012) reveals that roughly 500,000 children in Texas have mental health needs but almost half (40.5 percent) of those children do not receive the behavioral and psychological services they need.[17]

Figure 149. Organizational Structure of TEA (Unaffected by Transformation)



Source: Texas Education Agency. (January 2016). TEA Hierarchy Chart. Retrieved from https://mansfield.tea.state.tx.us/TEA.AskTED.TSD/TSDfiles/tsd2016/not_tagged/tea_hierarchy_chart_org_chart.pdf

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 their title, school counselors have many duties that are only tangentially related to mental health; according to Texas law, "the primary responsibility of a school counselor is to counsel students to fully develop each student's academic, career, personal, and social abilities."[18] Although the American School Counselor Association (ASCA) recommends a ratio of 250 students per school counselor, the ratio in Texas is almost double that amount: there were 438 students per counselor for the 2014-2015 school year.[19,20] It should be noted, however, that these ratios do not take into account non-counselor mental health workers who play a crucial role in treating mental health issues in schools, such as 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 (LSSPs), but only 1,582 LSSPs worked in Texas public schools in 2015.[21]

Changing Environment

MENTAL HEALTH FIRST AID (MHFA) TRAINING IN TEXAS SCHOOLS

Mental Health First Aid (MHFA) is an evidence-based program that teaches individuals (such as teachers and other school employees and support staff) how to:

- Recognize signs, symptoms, and risk factors of mental health and substance use issues
- Identify professional and self-help resources to treat mental and behavioral health issues
- Create a 5-step action plan to assess a situation and offer immediate assistance
- Increase individuals' overall confidence and comfort in helping people who are experiencing distress related to a mental health condition or substance use. [22]

Several bills passed during the 83rd Legislative Session that support early intervention programs like MHFA. SB 460 (83rd, Deuell/Coleman) required all certified public school teachers, counselors, principals, and other appropriate personnel to be trained in the early detection and identification of students who are at risk for suicide or experiencing other mental or behavioral health needs.[23] Another bill, HB 3793 (83rd, Coleman/Hinojosa), created two grant programs making mental health first aid training available to interested individuals and educators throughout Texas. TEA authorized continuing education units for educators who complete the MHFA training.[24] As of June 2014, 1,829 educators had been trained in MHFA.[25]

In 2015, the 84th Legislature provided further support for MHFA training and the early identification of mental health needs by passing two bills: SB 133 (84th, Schwertner/Coleman) and SB 674 (84th, Campbell/Coleman). SB 133 sought to improve campus-wide identification of mental health issues by expanding the types of public school employees authorized to receive mental health first aid training that

is paid for by the Department of State Health Services (DSHS). Previously, educators were the only group targeted to be trained in MHFA. SB 113 allowed DSHS to create supplemental grants to local mental health authorities (LMHAs) with any unused money appropriated for MHFA trainings.[26]

Thousands of Texas school employees have received MHFA trainings as a result of bills passed in the 83rd and 84th Legislatures. In 2015 alone, 6,527 educators and 4,792 non-educator school staff were trained in MHFA.[27] By 2016, over half a million individuals had been trained in MHFA across the U.S. and Texas is has the third highest number of individuals trained in MHFA (33,468, compared to California's 52,637 and Pennsylvania's 44,704).[28]

SB 674 strengthened training requirements for public school employees by requiring them to be trained in the detection of mental or emotional disorders as well as complete a best-practice-based program that provides instruction on how to respond to the wide range of suicidal risk factors and behavioral health issues faced by students.[29] This new training has a mandated emphasis on teaching school staff how to use de-escalation techniques and positive behavioral interventions to better support the psychological and emotional needs of students in the regular school environment.[30] As of April 2016, TEA and the State Board for Educator Certification (SBEC) were on track to have these new training requirements fully implemented in September 2016.[31]

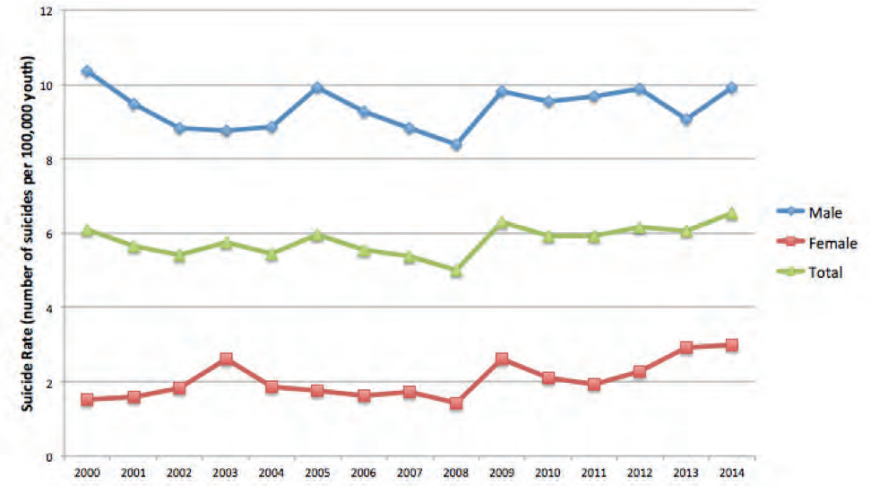
Training teachers to recognize and offer support for students' mental health needs, especially before a crisis, results in better mental health outcomes for students. Although MHFA has not been re-evaluated using SAMHSA's updated criteria from 2015, MHFA is listed as an effective "legacy program" in the National Registry of Evidence-based Programs and Practices (NREPP).[32] Studies show that MHFA trainings provide participants with a number of beneficial outcomes, including:

- Decreased negative attitudes about mental health conditions
- Increased confidence and comfort helping a young person in distress
- Increased knowledge of mental health and behavioral health conditions
- Clarified when to assess for suicide risk and how to listen non-judgmentally
- Increased supportive behavior towards individuals experiencing mental health issues
- Reductions in stigma associated with behavioral health conditions.[33]

SUICIDE PREVENTION AND PROGRAMS THAT PROMOTE HEALTHY BEHAVIOR

In 2014, suicide was one of the four leading causes of death among individuals age 10-24, accounting for roughly 12 percent of all deaths in that age group.[34] Suicide rates in the U.S have steadily increased over the last 10 years, with females age 10-14 experiencing one of the highest increases of any group.[35] And while females are more likely to experience suicidal thoughts than males, Figure 150 shows that males are roughly four times as likely to die by suicide between the ages of 6 and 24. Furthermore, the data in Figure 150 shows that 2014 had the highest suicide rate for Texas youth age 6-24 in over a decade.

Figure 150. Youth Suicide Rates in Texas (Ages 6-24): 2000-2014



Data compiled from: Center for Disease Control. (2016). *WISQARS Fatal Injury Reports, 1999-2014, for National, Regional, and State (Restricted): 2000 - 2014, Texas Suicide Injury Deaths and Rates per 100,000, All Races, Both Sexes, Ages 6 to 24, ICD-10 Codes: X60-X84, Y87.0, *U03.* Retrieved from http://webappa.cdc.gov/cgi-bin/broker.exe

On the national level, an estimated 42,773 people of all ages died by suicide in the U.S. in 2014— that is roughly one suicide every 12 minutes.[36] Looking specifically at nationwide trends in suicidality in high school students in 2015:

- 17.7 percent considered attempting suicide some time during the previous year
- 14.6 percent made a suicide plan some time during the previous year
- 8.6 percent of students attempted suicide at least once within the previous year
- 2.8 percent of students made a suicide attempt that resulted in overdose, injury, or poisoning.[37]

In Texas alone, 3,254 individuals died by suicide in 2014.[38] In the same year, the suicide rate in Texas (12.1 per 100,000 people) was slightly lower than that national suicide rate (13.4 per 100,000 people).[39] The most recently available data (2013) shows that suicide in Texas is the second leading cause of death among male adolescents and adults ages 15-34 (17.1 percent all deaths in that group), and is the third leading cause of death among young adult females ages 25-35 (8.6 percent of all deaths in that group).[40] Although there are many different causes and risk factors for suicide, as many as 90 percent of those who die by suicide have been diagnosed with a mental illness or substance use disorder.[41] While white males have the highest suicide rates of any specific population, it is important to recognize that suicide occurs in all ethnicities, ages, races, socioeconomic classes and genders.[42]

SB 460 (83rd, Deuell/Coleman) improved suicide prevention training for Texas educators in 2013, and those efforts continued into the 84th Legislative Session; passed in 2015, HB 2186 (84th, Cook/Campbell) required that there be an evidence-based suicide prevention training included in the annual orientation for all new school employees.[43] SB 674 (84th, Campbell/Coleman) also strengthened suicide prevention training requirements by requiring public school educators to receive training in mental health, youth suicide, and substance use issues.[44] In regards to suicide prevention on college campuses and universities, SB 1624 (84th, Rodriguez/Márquez) required information about available mental health and suicide

prevention services to be provided to all undergraduate, graduate and professional students in general academic teaching institutions.[45] Similarly, HB 197 (84th, Price/Nelson) required certain public institutions of higher education to create a web page that compiles available mental health services, including the number of the local mental health authority.

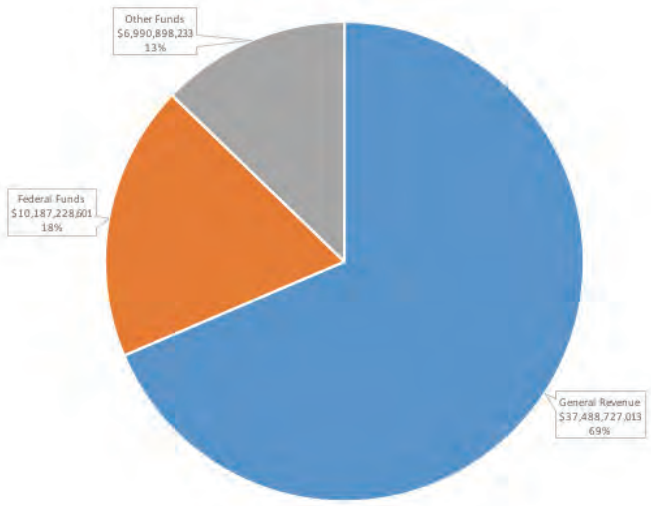
Finally, HB 2684 (84th, Giddings/Whitmire) improved suicide prevention efforts by requiring the school staff most likely to intervene in mental health crises — school resource officers (SROs) and school district police officers — to complete at least 16 hours of youth-focused education and training on behavioral health.[46] While any school district can request this new training for its officers, HB 2684 only mandated this training for school districts with a student enrollment over 30,000.[47] The new training was put into place in February 2016 and must include information on:

- Child and adolescent development and psychology
- Positive behavioral interventions and supports (PBIS)
- Conflict resolution and de-escalation techniques
- How to reduce the use of restraints
- Effective mental health crisis intervention
- The overarching behavioral health needs of children with disabilities or special needs. [48]

While all of these bills together provide a better safety net for students that may be experiencing a psychiatric crisis or suicidal thoughts, suicide prevention continues to be an ongoing effort at both the state and local levels.

Funding

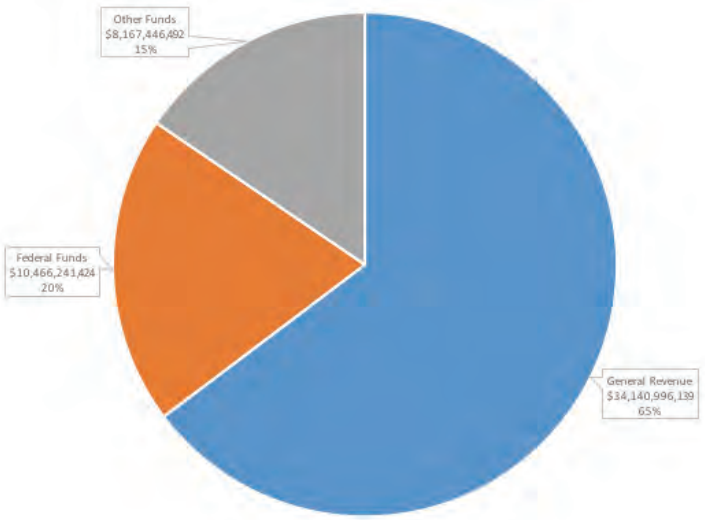
Figure 151. TEA Budget by Method of Finance FY 2016-17



The total TEA budget for FY 2016-17 was $54,666,853,847.

Source: Texas Education Agency. (August 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019.* Page 39. Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2018

Figure 152. TEA Budget by Method of Finance FY 2018-19



The total requested TEA budget for FY 2018-19 is $52,774,684,055. If included in the budget, the Exceptional Item Requests would add an additional $199,442,002.

Source: Texas Education Agency. (August 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019.* Page 39. Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2018

Figure 153. TEA Budget by Strategy FY 2016-17

Goal	Description
Goal 1	Provide education system leadership, guidance, and resources
Goal 2	Provide system oversight and support

Source: Texas Education Agency. (August 2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019.* Pg. 39. Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2018

Efforts to Reduce and Decriminalize Truancy

Prior to 2015, Texas law allowed school resources officers (SROs) to issue tickets to students for low-level misbehavior such as disrupting class or missing school. These tickets were citations in lieu of arrest and required the student and a parent to appear in a municipal or justice of the peace court. One type of ticket SROs gave Texas students is Failure to Attend School (FTAS), or truancy. According to the Texas Education Code, a youth commits FTAS if they miss 10 or more days in a six-month period or three or more days in a four-week period.[49] Before the 84th Legislative session, FTAS was often treated as a Class C Misdemeanor and processed in an adult criminal court forum where students were not entitled to many of the protections available in a juvenile court. One study by Texas Appleseed found that 34 percent (roughly 76,000 cases) of Class C Misdemeanor tickets for students in 2011 were for FTAS.[50]

However, the criminalization of truancy through the use of formal courts and fines is not an effective method to reduce the prevalence of FTAS because it fails to address the underlying root causes for the absences.[51] Students punished through the criminalization of truancy were often further alienated from school while going through the formal court system and some students ended up with a criminal conviction on their record, which has the possibility of negatively impacting future schooling, educational funding, and/or employment. The burden of fines is particular tough on families already under financial strain.[52]

The 83rd Legislature passed two bills to improve the approaches and strategies used to reduce FTAS:

- HB 1479 (83rd, Villarreal/Van de Putte) established the requirement for a committee in counties of a certain size to recommend uniform truancy policies,[53] and
- SB 1419 (83rd, West/Lewis) provided funding for juvenile case managers through court costs, expanded the services they provide, and established a truancy prevention and diversion fund.[54]

HB 1479 and SB 1419 attempted to improve policies related to truancy prevention, but schools were still authorized to issue Class C Misdemeanors for FTAS following the 83rd Legislative session.

In 2015, the 84th Legislature passed SB 107 (84th, Whitemire/Thompson) and HB

2398 (84th, J. White/Whitemire).[55] SB 107 established a requirement for all public schools to have a campus behavior coordinator who is responsible for maintaining student discipline, in addition to notifying parents and guardians when a student has been involved in certain types of disciplinary measures.[56] HB 2398 repealed FTAS as a criminal offense and removed school absences from the list of conduct that warrants community supervision.[57] Courts now have the discretion to dismiss truancy cases "if the court finds that a dismissal would be in the interest of justice because: (1) there is a low likelihood of recidivism by the defendant; or (2) sufficient justification exists for the failure to attend school".[58] HB 2398 also developed a set range of fines that can be used in cases in which a parent contributed to the child's absences from school.[59]

Delivery of Mental Health Services in Schools

Schools have a long history of providing mental health services to students and because children spend such a large part of their day in academic settings, schools often serve as the first point of intervention when a child needs psychiatric testing or behavioral health services.[60] On the national level, the President's New Freedom Commission on Mental Health recognized the critical role that schools can play in the continuum of mental health services.[61] Schools can provide convenient access to services for children and families in an environment that is less stigmatizing than a traditional mental health setting.

Early intervention with mental health issues 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.[62] Children who enter kindergarten with effective social skills have an easier time developing relationships with peers and generally do better in school.[63] 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.[64] Without early intervention, child and adolescent disorders frequently continue into adulthood. As much as 50 percent of all lifetime cases of mental illness are apparent by age 14, and 75 percent are apparent by age 24.[65]

School-based mental health services encompass a wide variety of different programs and approaches. A study from Texas A&M University-Kingsville 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.[66] The study also referenced prior research that said depression, substance use and suicide rates among children are higher in rural areas and that school counselors play a critical role in providing mental health services to students.[67] In Texas, the suicide rate is roughly 15 percent higher in rural counties (less than 20,000 residents) than in metropolitan ones.[68] 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.[69]

The different methods of delivering mental health services in schools are described in Figure 154.[70, 71]

Figure 154. 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, behavioral health 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.

Special Education Services in Texas

Schools are accountable for the academic performance of all students, including those with serious behavioral 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), which may include mental health treatment and supports.[72]

Special education and related services can include a wide range of supports depending on each student's specific and individualized needs. The types of special education services and supports provided are determined through an annual Admission, Review and Dismissal (ARD) meeting with the student, the student's parents and/or caregivers, any mental health professionals involved in the child's care, school personnel, and at least one of the child's regular and special education instructors.[73] The ARD meeting is an essential part of creating, updating, amending and improving the individualized education plan (IEP) on an ongoing basis. The IEP is the organizing framework and plan used to specify the behavioral supports and interventions that must be provided by the school district to help the student experience stability and success in the classroom.[74]

Some examples of school-based and educational services related to behavioral health include:

- Assessments or medical services to diagnose or evaluate a student's disability
- Parental and family counseling
- Case management
- Skills training
- Specialized classes and services for students with developmental delays, physical conditions, Intellectual and Developmental Disability (IDD) diagnoses, and other types of disabilities

An estimated 8.7 percent of school-aged children in Texas were identified as having special education needs in the 2015-2016 school year.[75] The percentage of children in Texas schools identified as eligible for special education services is far lower than in other states.[76] Of the 463,185 students identified as having special education needs in 2015-2016:

- 5.8 percent were classified as having emotional disturbance
- 10.0 percent were classified as having an intellectual disability
- 11.7 percent were classified as having autism
- 34.4 percent were classified as having a learning disability.[77]

SPECIAL EDUCATION FOR EARLY CHILDHOOD AND YOUTH TRANSITIONING TO ADULTHOOD

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, the Individuals with Disabilities Education Act (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," so long as the diagnosis is made using proper instruments and procedures.[78] 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 [79]

However, states have the authority to decide what to call the "developmental delay" category, how to define it, and what ages to include as eligible. Texas calls this development delay category "Non-Categorical Early Childhood" (NCEC) and children between the ages of three and five who have "general delays in their physical, cognitive, communication, social, emotional or adaptive development(s)" are included in the developmental delay category and eligible to receive special education services.[80] 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 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
- Autism [81]

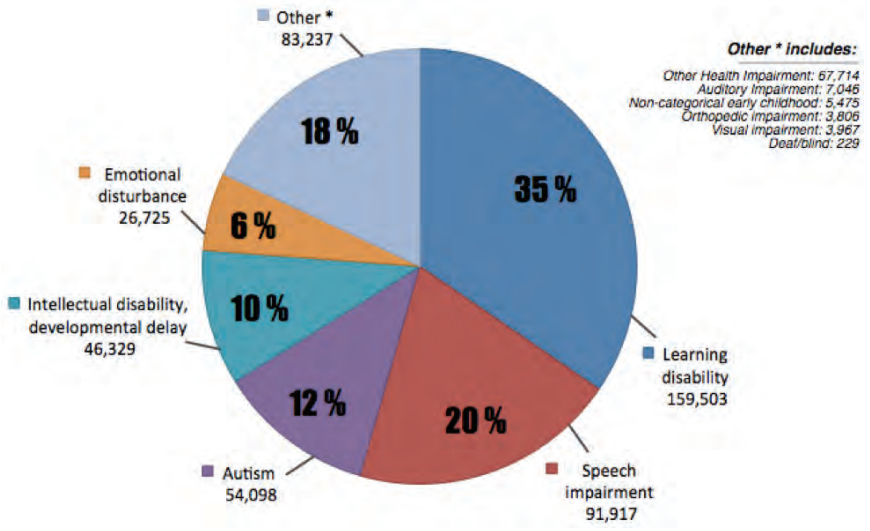
Texas has also worked to bridge the gap in services and supports for students with special needs transitioning out of high school. To assist students who receive special education services with a successful transition from school to appropriate post-school activities, such as postsecondary and vocational 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.

The 83rd Legislature passed HB 617 (83rd, Rodriguez/Zaffirini), which required school districts to assign at least one employee to provide transition and employment services to students receiving special education services.[82] HB 617 also requires school districts to work with DSHS, TEA, and other state agencies to make transition information available through a central website: www.transitionintexas.org. To further strengthen supports for youth transitioning into adulthood, the 84th Legislature also passed SB 1117 (84th, Zaffirini/Naishtat), which required information on housing and independent living to be provided in the transition/discharge plans given to youth over the age of 16 who are under DFPS conservatorship.[83] Finally, SB 1259 (84th, Rodríguez/Allen) improved the Admission, Review and Dismissal (ARD) process wherein families and school staff develop an Individual Education Plan (IEPs) by requiring the ARD meeting to include a teacher who is involved with implementing a portion of the child's IEP.[84] SB 1259 also required there to be notes taken about actions taken and discussions during ARD meetings.[85]

ELIGIBILITY FOR SPECIAL EDUCATION SERVICES

Special education services encompass a wide range of interventions and children can become eligible for these services by receiving a diagnosis for a specified condition that impacts the child's learning and the child has a need for special education services. Figure 155 shows the various mental health diagnoses, behavioral conditions, and developmental disabilities that made 463,185 students in Texas eligible for special education services in the 2015-2016 school year:

Figure 155. Reasons for Special Education Eligibility in Texas Schools: 2015-2016



Data obtained from: Texas Education Agency. (July 2016). *2015-2016 Special Education Reports: All Texas Public Schools Including Charter Schools, Students Receiving Special Education Services by Primary Disability, PEIMS Data 2015-16.* Retrieved from https://rptsvr1.tea.texas.gov/adhocrpt/adser.html

In the 2015-2016 school year, over 26,000 Texas students were identified as having serious emotional disturbance — roughly 5.8 percent of all students identified as eligible for special education services.[86,87] Nationwide, students identified as having serious emotional disturbance have the highest rate of school failure, with half of this population dropping out of high school.[88] 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 anxiety, post traumatic stress disorder, attention deficit disorder, and more.

Eligibility for 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 problems [89]

In determining whether special education services will be provided, school personnel also seek evidence that the student's behavior and need for services is not the result of a temporary reaction to adverse yet normal situations at home, in school, or in community situations.

FUNDING FOR SPECIAL EDUCATION SERVICES

In the 2013-2014 school year, roughly 6.5 million public school students received special education services across the U.S — about 13 percent of all students nationwide.[90] During the same year, only 8.6 percent of the student population in Texas received special education services — the lowest percentage in the country.[91] Additionally, the percentage of students identified with emotional disturbance in the special education population has decreased nationally and in Texas in recent years.[92]

From the 2003-2004 to the 2012-2013 school year, the population of Texas students receiving special education services decreased by 3.1 percent while there was only a 0.3 percent decrease nationally.[93] The proportion of students enrolled in special education services in Texas has dropped over the last ten years, but the reason for the percentage decrease is unclear and further research on this topic is needed to better understand discrepancies between Texas and national special educational enrollment levels.

Funding for the "Students with Disabilities" strategy (1.2.3) within TEA is expected to remain relatively consistent in the upcoming years, with $2,108,308,102 budgetted for the 2016-17 biennium and $2,153,551,378 requested for the 2018-19 biennium.[94] Federal funding accounted for 94.6 percent (2016-17) and 94.8 percent (2018-19) of the total funding for the "Students with Disabilities" strategy within TEA.[95] In order to comply with the Texas Legislature's goal of reducing government agency budgets by four percent, TEA has proposed a number of funding cuts, including completely defunding of the Academic Innovation & Mentoring program, the Best Buddies program, and the Educator Excellence Humanities Texas program.[96]

SPECIAL EDUCATION FUNDING: INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

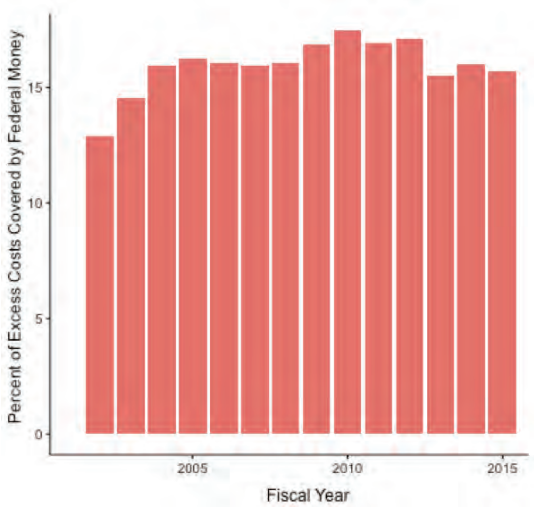
Under the Individuals with Disabilities Education Act (IDEA), children and adolescents between the ages of 3 and 21 who have disabilities are entitled to receive a free and appropriate public education.[97] The Individuals with Disabilities Education Act (IDEA) first passed in 1975 (as the Education for All Handicapped Children Act, PL 94-142) and has been reauthorized multiple times. When IDEA was created, the expected cost of educating students with special needs was projected to be twice as much as the national average of educating students who do not require special education services.[98] To support schools with increased costs, the federal government committed to contributing up to 40 percent of this anticipated additional cost.[99] 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.[100]

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.[101] Local funding must make up the difference in funding for this increased need in order to meet IDEA's requirements for funding special education services in schools.[102] As Figure 156 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.[103] This trend of under-funding special education at the federal level resulted in IDEA falling more than $10 billion short of being fully funded in FY 2014.[104]

Excluding funding for preschools through IDEA, TEA received $1,952,599,033 in federal IDEA Part B funding for the 2016-17 biennium, and that number is expected to increased by 2.3 percent (to $1,996,823,246) for the 2018-19 biennium.[105]

Figure 156. Federal Share of Special Education Funding Through IDEA: 2002-2024



Source: Dancy, K. (March 23, 2016). *Fully Funding IDEA: A Democratic Dream or Just an Empty Promise?*. New America Foundation. Retrieved from https://www.newamerica.org/education-policy/edcentral/fully-funding-idea/

SPECIAL EDUCATION FUNDING: 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 the Health and Human Services Commission (HHSC).[106] SHARS is a Medicaid financing program that allows local school districts and shared services arrangements (SSAs) to obtain Medicaid reimbursement for certain health-related services provided to students in special education.[107] The state match requirement for SHARS Medicaid funding is met by using state and local special education allocations that already exist. School districts and SSAs must enroll as Medicaid providers and employ or contract with qualified professionals to provide these services.[108]

The SHARS program includes:

- Assessment
- Audiology
- Counseling
- School health services
- Medical services
- Occupational therapy
- Physical therapy

- Psychological services
- Speech therapy
- Special transportation
- Personal care services.[109]

In order to receive SHARS services, students must be eligible for Medicaid, qualify to receive special education services under IDEA, and have an IEP.[110]

Mental Health Support Systems for Schools

Mental health services are required by law to be provided for students who receive special education services if those services are part of their Individual Education Plan (IEP).[111] Although schools are not required to provide mental health services unless specifically stated in an IEP, there are still students in the general population who receive mental health services. Mental health supports and services vary between individual schools and districts, but there are certain mental health services available across the state. This next section describes the mental health services and related programs available statewide.

EDUCATION SERVICE CENTERS (ECSs)

Created in 1965, 20 regional educational service centers (ESCs) in Texas provide support and technical assistance to all school districts throughout the state in a variety of areas, including special education and behavioral support. A map of service center regions is shown in Figure 157.

Figure 157. Map of Education Service Center Regions

Source: Texas Education Agency. (2016). *Education Service Centers Map.* Retrieved from http://tea.texas.gov/regional_services/esc/.

Regional education service centers also specialize in specific topic areas and services and then provide resources, support, programmatic assistance and general expertise to school districts or schools statewide.[112] For example, the Region IV Education

Service Center in Houston specializes in Positive Behavioral Interventions and Supports (PBIS) with the goal of enhancing the education experience for all students by addressing the needs of students with behavior challenges.[113] Additionally, the Region XIII Education Service Center in Austin has a Behavior Team that provides general and special education specialists who focus on providing campuses with workshops, consultations, and technical assistance for behavioral supports.[114]

A total of $25 million was allocated for ESCs in the 2016-17 biennium, and TEA reduced funding for ESCs by two percent for the 2018-19 biennium.[115] The ESC infrastructure as a whole supports schools in complying with IDEA and saves public and charter schools an estimated $623.5 million per year.[116] Annual savings are mainly a result of school districts having 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).[117]

A total of 903,257 individuals were trained through ESCs in 2015, up from 853,573 trained in 2013. For 2017-2019, TEA expects to continue training an estimated 885,000 individuals per year through the state's 20 ESCs.[118,119]

COORDINATED SCHOOL HEALTH MODEL

Counseling and mental health services are a core element of TEA's Coordinated School Health Model.[120] DSHS defines coordinated school health as "an integrated, systematic set of planned, sequential, school-affiliated strategies, activities and services designed to advance student academic performance and promote their optimal physical, emotional, social and educational development."[121] Texas school districts are required to provide a coordinated school health program by law. The Coordinated School Health Model focuses on eight core components of student health, modeled after the Centers for Disease Control and Prevention's 8-Component Model, and is directed by a mandatory, multidisciplinary team, known as the School Health Advisory Council (SHAC).[122] SHAC members are appointed by the school district to serve and make recommendations for the district's Coordinated School Health program.

The 8-Component Model for Coordinated School Health includes the following components:

- School health services
- Counseling, psychological and social services
- Family and community involvement
- Nutrition services
- Physical education
- Healthy school environment
- School-site health promotion for staff
- Comprehensive school health education [123]

COMMUNITIES IN SCHOOLS (CIS) 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.[124] In the 2014-2015 school year, CIS provided case management services for 87,990 students through 27 local CIS programs operating in 145 school districts across Texas.[125] All but two percent of the students receiving CIS case management services in grades 7-12 stayed in school during the 2014-2015 school year, and 94 percent of CIS participants were promoted to the next grade or graduated.

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 was mostly restored in the years since, increasing annual state appropriations for CIS to an estimated $15,521,815 in 2016 and 2017.[126] This partially restored funding allowed CIS to serve more students in 2015 (87,990) than in 2013 (63,527), but state funding for CIS is still roughly $600,000 less than appropriations before the 2012-2013 funding cuts, which limits the amount of students who can benefit from CIS services.[127,128] CIS is also at risk of losing more funding in the 85th legislative session; in an effort to comply with the Legislature's stated goal of reducing spending in government agencies by four percent, the legislative appropriations request for TEA reduces CIS funding by 14.7 percent (or $4,541,545) for the 2018-19 biennium.[129]

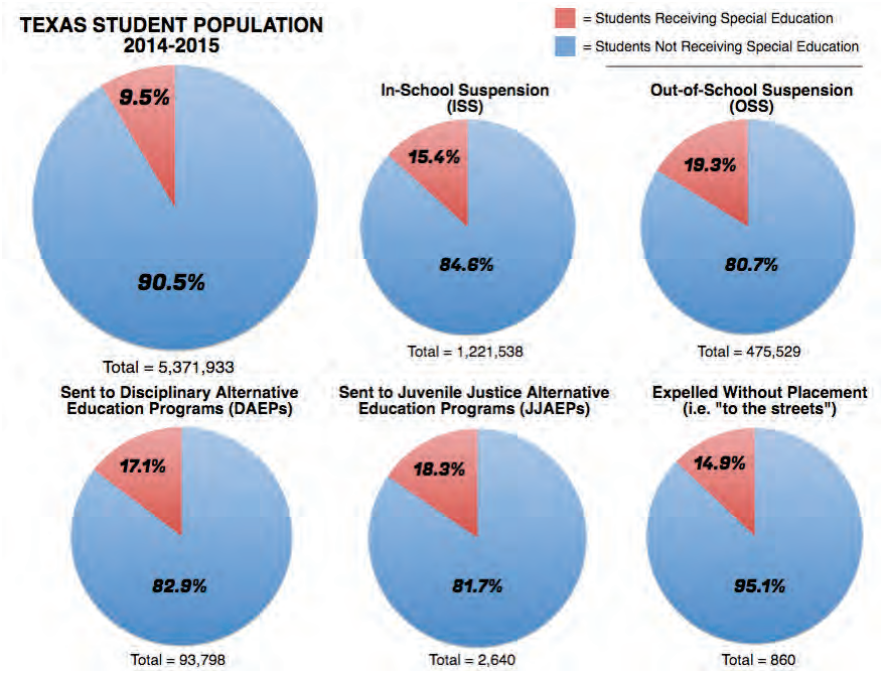
To learn more about CIS services in Texas and see a list of all CIS providers in the state, visit http://tea.texas.gov/interiorpage.aspx?id=4639.

Exclusionary Discipline in Schools

Exclusionary discipline in schools refers to practices that remove students from the classroom. Removal from the classroom excludes students from common, daily experiences that are conducive to normal childhood and student development. Under state law, schools have the option to remove or expel students to disciplinary alternative education programs (DAEPs) or juvenile justice alternative education programs (JJAEPs).[130,131] Schools can even remove or expel special education students after following protective procedures required under federal law. Many children are sent to these programs more than once in a given school year; for instance in the 2014-2015 school year, 616,987 students in Texas were removed from the classroom at least once, adding up to a total of 1,840,642 separate incidents that resulted in the removal of a student from the classroom.[132]

Unfortunately, exclusionary discipline has a disproportionate impact on students receiving special education services. The following is a breakdown of the overrepresentation of all exclusionary discipline removals for the 2014-2015 school year:

Figure 158. Overrepresentation of Youth in Special Education in Exclusionary Discipline



Note: Total student population and special education population data in this chart is increased because discipline reports are tabulated using the 3rd submission of PEIMS data while annual enrollment is tabulated using 1st submission data from the fall. Data obtained from: Texas Education Agency. (2016). *Counts of Students and Discipline Actions by Discipline Action Groupings: PEIMS 2014-2015 Data.* Retrieved from https://rptsvr1.tea.texas.gov/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html

Removals from the classroom to these disciplinary programs can be mandatory or discretionary. Mandated referrals, determined by state code, occur when a student performs a specific act that automatically requires the removal from the classroom. Discretionary referrals, determined by school district policy, vary widely from district to district. Discretionary referrals are made by teachers or administrators based on policies in their local student code of conduct.[133] These policies can be vague, allowing for wide interpretation when determining what and how behaviors should be disciplined. A significant portion of disciplinary referrals are not mandated by law, but instead authorized at the discretion of school districts.[134] In the 2014-2015 school year, discretionary removals accounted for:

- 51.9 percent of expulsions to JJAEPs
- 58.8 percent of DAEP removals
- 60.8 percent of expulsions without placement (i.e. "to the streets") [135]

Discretionary removals also disproportionately impact children receiving special education services; in 2015, students in special education were more likely to be sent to In-School Suspension (34.5 percent of ISS actions) or Out-of-School Suspension (16.3 percent) for discretionary reasons compared to their peers (22.8 percent and 8.5 percent, respectively).[136]

Breaking Schools' Rules, a pivotal 2011 study conducted by the Council of State

Governments Justice Center and the Public Policy Research Institute at Texas A&M University, found that three out of four Texas students who qualified for special education had been suspended or expelled at least once. Students diagnosed with emotional disturbance were even more likely to be suspended or expelled.[137] More recent research conducted in 2014 found that students who had been removed from the classroom (i.e. suspended) were up to 10 times more likely to feel negatively about school, be held back a grade, fail academically, drop out of school entirely, or be incarcerated.[138] There has been some increased attention in recent years on the over-representation of students receiving special education services among the population of students removed from classrooms for disciplinary reasons.

Exclusionary discipline practices also disproportionately target African American students.[139] While only representing 12.7 percent of Texas' total student population in the 2014-2015 school year, African American youth accounted for:

- 34.8 percent of out-of-school suspensions (OSS),
- 25.4 percent of in-school suspensions (ISS), and
- 15.9 percent of expulsions.[140]

IN-SCHOOL SUSPENSIONS (ISS) AND OUT-OF-SCHOOL SUSPENSIONS (OSS)

A disruptive student can be removed from the regular classroom and assigned one or more days to a separate ISS classroom to complete their class assignments, or they may be required to remain off campus for a specified period of time (OSS).[141] 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.[142] In addition to removing children from their regular classroom and from normal interactions with their peers in a classroom, ISS and OSS can also lead to significant cost increases for schools and families.[143] 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.[144]

In the 2014-2015 school year, students receiving special education services accounted for 9.5 percent of the total student population but represented 15.4 percent of in-school suspensions (ISS) and 19.3 percent of out-of-school suspensions (OSS).[145]

EXPULSIONS TO DISCIPLINARY ALTERNATIVE EDUCATION PROGRAMS (DAEPS)

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.[146] According to statute, the central academic mission of DAEPs "is to enable students to perform at grade level."[147] Any DAEP that serves a student with an Individualized Education Plan (IEP) must provide the services outlined in the IEP.[148] 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."[149]

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. [150]

Texas schools also have wide discretion to send students to a DAEP for other offenses listed in their student code of conduct. Depending on the school district, these offenses can range from "fighting and gang activity to disrupting class, using profanity, playing a prank such as throwing a tennis ball in the hallway and narrowly missing another student, misusing a school parking decal, inadvertently bringing a prescription or over-the-counter drug to school, or doodling in class when the drawing contains a weapon."[151] In the 2014-2015 school year, 58.8 percent of all removals to DAEPs (or 55,192) were discretionary.[152]

Questions have been raised about the quality of education services provided in DAEPs. The Legislative Budget Board has expressed the following concerns about DAEPs:

- Failure to staff the DAEP with certified teachers
- Failure to provide a learning environment equivalent to mainstream campuses
- Inadequate training for DAEP instructors and staff
- Lack of instructional alignment between DAEP and mainstream campuses
- Insufficient communication between a student's home campus and DAEP
- Absence of transitional programming upon a student's return from a DAEP. [153]

Similar to other methods of exclusionary discipline, students receiving special education services are overrepresented in removals from the classroom to DAEPs. In the 2014-2015 school year, 9.5 percent of all students in Texas public schools were identified as eligible for special education services, but those students represented 17.1 percent of referrals to DAEP.[154]

EXPULSIONS TO JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS (JJAEPS) & EXPULSIONS WITHOUT PLACEMENT (ALSO KNOWN AS "EXPULSIONS TO THE STREETS")

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. Juvenile Justice Alternative Education Programs

(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 must have a JJAEP.[155] JJAEPs are operated by juvenile boards with oversight provided by the Texas Juvenile Justice Department (TJJD) so when a student is expelled to a JJAEP, that referral is considered involvement in the juvenile justice system by itself.[156] Legislative intent in creating JJAEPs was "to provide continuing educational opportunities for students expelled from school for the most serious offenses."[157] The primary goals of JJAEPs are to "reduce delinquency, increase offender accountability and rehabilitate offenders through a comprehensive, coordinated community-based juvenile probation system."[158] 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.[159] 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. Overall, referrals to JJAEPS following expulsion have declined by 33 percent between the 2010-2011 and 2014-2015 school years.[160]

In the 2014-2015 school year, JJAEPs served 282 school districts across 26 counties in Texas.[161] Texas school districts placed students into JJAEPs on 2,640 separate occasions in 2014-2015, and 483 of those placements (or 18.3 percent) were for students in special education.[162] While students receiving special education are still disproportionately represented in JJAEP referrals, that overrepresentation has fallen from 20 percent in the 2010-2011 school year.[163]

Looking specifically at a report from the Texas Juvenile Justice Department (TJJD) that cited 438 entries into JJAEPs for students in special education in 2014-2015:

- 199 students had a primary diagnosis of a Learning Disability (45 percent)
- 104 students with a primary diagnosis of Serious Emotional Disturbance (24 percent)
- 135 had a primary diagnosis of Other (31 percent), which includes Attention Deficit Disorder, speech problems, physical disabilities, traumatic brain injuries, or intellectual disabilities.[164]

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 serious criminal behavior. Discretionary expulsions vary widely from serious criminal offenses that occur within 300 feet from the school, to assault on a school employee or serious misbehavior in a DAEP.[165] In 2014-2015, 51.9 percent of expulsions to JJAEPs were discretionary while 48.1 percent were mandatory.[166]

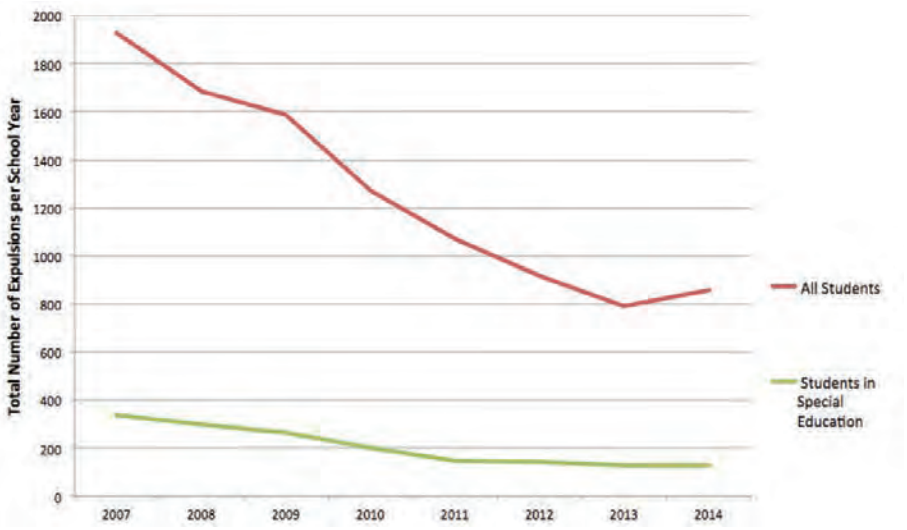
The vast majority (80 percent) of mandatory referrals to JAEPs in 2014-2015 were for felony drug offenses or weapons offenses while reasons for discretionary referrals were more varied, suggesting wide variation in discretionary disciplinary policies between schools.[167] Discretionary expulsions for "serious or persistent misbehavior" and misdemeanor drug charges represent the vast majority (76

percent) of all discretionary expulsions in 2014-2015.[168] 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.[169] However, TJJD publishes data that provides some understanding of how long students spend in JJAEPs at the macro level. In 2014-2015, the average length of stay for all students who finished JJAEP was 77 days (84 days for mandatory expulsions and 72 days for discretionary) — a slight reduction compared to previous years.[170]

In the 2014-2015 school year, students receiving special education made up only 9.5 percent of the student population in Texas but accounted for 18.3 percent of expulsions to JJAEPs and 14.9 percent of expulsions without placement.[171] Similar to the overrepresentation of African Americans in in-school and out-of-school suspension rates, a 2014 study found that African American students nationally are approximately three times more likely then white students to be expelled.[172]

While total expulsions (both to a JJAEP or to the street) increased approximately 38 percent between 2002 and 2007, there was a 26 percent decrease in expulsions between 2007 and 2009 and expulsions have continued to decrease since 2009.[173] Figure 159 shows the trend of expulsions between the 2007-2008 and 2014-2015 school years.

Figure 159. Expulsions in Texas Public Schools: 2007-2015



Note: *Years correspond with the beginning of the school year (i.e. 2007 stands for the 2007-2008 school year.* Data obtained from: Texas Education Agency. (2007-2015). *Discipline data products: 2007-2015 counts of students and discipline actions by discipline action groupings (PEIMS Data).* Retrieved from http://ritter.tea.state.tx.us/adhocrpt/Disciplinary_Data_Products/DAG_Summaries/Download_State_DAG_Summaries.html

Many experts agree that there is a school-to-prison pipeline for many of the students who are removed from the classroom using exclusionary discipline practices.[174,175] 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.[176] 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 actions.[177] Furthermore, students sent to a DAEP or a JJAEP are more likely to drop out of school and enter the adult criminal justice system.[178] However, data from TJJD suggests that there may be some short-term positive effects from attending a JJAEP; in the short-term, a student's successful completion of a JJAEP program appears to reduce the rate of school absences, improve academic achievement, and lower the number of disciplinary referrals.[179] 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."[180] 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.

SCHOOL TICKETING AND CLASS C MISDEMEANORS

For many years under Texas law, school resource officers (SROs) could issue tickets to students for low-level misbehavior such as disrupting class or skipping school. These tickets were citations in lieu of arrest for Class C misdemeanors and required the student and a parent to appear in a municipal or county court, possibly facing up to $500 in fines. The proceedings were public criminal proceedings and students did not have a right to an attorney because Class C misdemeanors are not punishable by jail time. These tickets inserted students into the criminal justice system and unfairly targeted students in special education. Many families could not afford the fines and failure to pay can result in a warrant for arrest upon the student's 17th birthday.[181,182]

During the 83rd Legislative Session, two bills were passed that addressed the increasing number of students receiving Class C misdemeanors for minor misbehavior. SB 393 (83rd, West/Lewis) and SB 1114 (83rd, Whitmore/Herrero) worked in conjunction to prohibit school resource officers (SROs) from issuing tickets for Class C misdemeanors (excluding traffic violations) by only allowing SROs to issue complaints for Class C misdemeanors.[183,184] In contrast to a ticket, a complaint may or may not lead to a criminal charge once it has been submitted to the court for evaluation, depending on the context of the behavior and the amount of supporting documentation and evidence provided. SB 393 and SB 1114 also required that schools explore alternatives to issuing tickets. For example, schools may use graduated sanctions or refer students to first-time offender programs if they engage in a Class C misdemeanor, or encourage prosecutors to consider non-court sanctions such as tutoring or counseling for an offense.[185,186]

In 2015, the 84th Legislature built on the previous session's significant progress in addressing the overuse of ticketing and disciplinary sanctions in public schools. The most impactful change dealt with repealing truancy as a ticketable offense and promoting strengths-based disciplinary intervention programs that can prevent problems before law enforcement gets involved.

CORPORAL PUNISHMENT AND THE USE OF FORCE IN SCHOOLS

In Texas, each school district is allowed to determine whether corporal punishment is permitted on their campus. According to the most recently available data, Texas is one of the states with the highest number of students receiving corporal punishment, with approximately 40 percent of Texas school districts permitting students to be struck when they misbehave.[187] In the 2011-2012 school year alone, roughly 28,569 children in Texas received corporal punishment (i.e. spanking or paddling).[188] Nationwide and in Texas, students with disabilities and African American students are disproportionately the targets of corporal punishment.[189] Corporal punishment can cause serious injury, psychological harm, trauma, and academic disengagement; it also is not an evidence-based practice and has been banned by the majority of states (31) in the U.S and many school districts, including Houston ISD.[190,191] Internationally, over 100 countries have banned all corporal punishment in schools and the U.N. has condemned corporal punishment as a violation of human rights.[192] Beginning in 2012, parents in Texas are now given the option to sign a waiver that excludes their child from receiving corporal punishment, but allowance of corporal punishment remains the default option in many districts.[193,194]

Use of force (e.g. physical restraints and Tasers) by SROs has also surfaced as a concern of child advocates. While under 9 percent of Texas students were classified as special education (i.e. served by IDEA) in the 2011-2012 school year, those students served by IDEA represented 79 percent of students who were physically restrained.[195] While the Texas Police Chiefs Association states that many police departments working in schools have a specific policy on use of force in schools, those policies are not shared with the public.[196] 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.[197] However, HB 2684 (84th, 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.[198] TEA also requires each school to have a team of school staff trained in restraints appropriate for youth and certain school staff positions are required to be a part of this team. The participation of SROs is not mandated in current law.

A particular concern is the use of Tasers and pepper spray by SROs in Texas public schools. These weapons are completely (Tasers) or mostly (pepper spray) prohibited from being used in juvenile justice facilities, and advocates argue that the same should be true for public schools.[199] Some school districts in Texas, such as the Houston ISD, have already banned the use of Tasers and limited the use of pepper spray by SROS at the local level.[200] There was an unsuccessful legislative attempt to ban Tasers and pepper sprays in schools statewide during the 83rd Legislative Session and there are currently no statewide standards regarding the use of Tasers by SROs.[201] There has been a renewed push against the use of these weapons in schools after one high school student in Central Texas intervened to stop a fight and fell into a coma after he was Tasered by an SRO and hit his head on the ground.[202]

There are districts implementing less aversive ways to address discipline matters.

One example is crisis intervention teams (CIT) for children and youth that are designed to divert individuals with mental health needs to appropriate behavioral health services and supports instead of referring them to the juvenile justice system.[203] Building community partnerships to support youth's ability to access services and supports is the foundation of a successful CIT program.[204] As an example, Bexar County created the Children's Crisis Intervention Training (CCIT) 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 Continuing Education Units (CEUs) for SROs who have not previously received any CIT training.[205] The CCIT includes education on:

- Officer tactics and safety in school campus environments
- Active listening and de-escalation techniques
- Mental illness, learning and developmental disoabilities, 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 crisis. [206]

Holistic Approaches to Discipline and Student Mental Health

Exclusionary discipline practices have developmental, behavioral, and academic costs, as well as a high financial cost. The alternative models of intervention discussed in this section can support the social and emotional development of students and improve student behavior while remaining more cost-effective than the resource-intensive exclusionary discipline practices (i.e. suspension and expulsion) that are currently used in Texas public schools. This section will focus on four specific interventions:

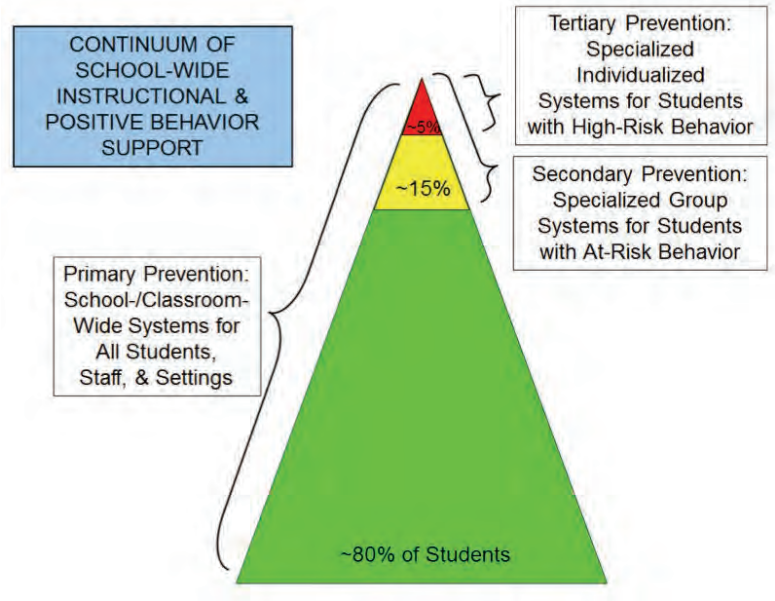
- positive behavioral interventions and supports (PBIS)
- social and emotional learning (SEL)
- trauma-informed care (TIC)
- restorative justice (also known as restorative discipline)

Public schools in Texas are increasingly moving to 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 developmental needs of all students. These initiatives generally include campus-wide prevention activities, targeted early intervention for students with risk factors, and individualized services for students with complex needs. Texas is among a number of states promoting positive approaches to preventing mental and emotional problems in children.[207]

POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS (PBIS)

A well-known example of a positive and proactive approach to school-based services is Positive Behavioral Interventions and Supports (PBIS).[208] Figure 160 illustrates the basic framework of PBIS.

Figure 160. 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

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.[209] 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 issues. 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. [210]

The Texas Education Agency recommends that school districts utilize PBIS to address student behavior, but Texas public schools are not currently required to use PBIS or other related approaches.[211] Technical assistance to implement PBIS is available through the network of regional educational service centers and the Texas Behavior Support Initiative (TBSI).[212] TBSI was designed to build capacity in Texas schools for the provision of positive behavioral interventions by assisting schools in developing and implementing a wide range of behavior strategies and prevention-based interventions.[213]

In 2009, more than 800 schools were actively participating in the PBIS trainings facilitated by TBSI.[214] Schools that have implemented PBIS have achieved a wide range favorable outcomes, including fewer disciplinary referrals, improved academic performance, and overall less use of physical restraints.[215] When PBIS initiatives include an anti-bullying component, schools have seen a 55-69 percent drop in misbehavior.[216] PBIS also serves as a key organizing framework for other interventions, such as the Social and Emotional Learning (SEL) approach described below. The cost to implement a school-wide PBIS program varies greatly between campuses but can be as low as roughly $10,000 per year, including compensation for staff, training, and the infrastructure and data resources needed to implement a PBIS program.[217,218] However, there are many different variables that affect the cost of implementing PBIS, including the size of the school and its proximity to large urban centers.

SOCIAL AND EMOTIONAL LEARNING (SEL)

Social and Emotional Learning (SEL) is not a specific program, but a framework to help change the school's approach to working with students.[219] 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 staff training and student surveys.[220] SEL programs can be implemented from preschool through high school and have the ability to improve student functioning in a number of areas.

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
- Make decisions that are safe, ethical, and responsible. [221]

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.[222] AISD began implementing SEL in the 2013, with 73 of AISD's 129 schools implementing SEL in the first school year, reaching over half of the students enrolled.[223] By the 2015-2016 school year, all 86,000 students in AISD's 129 different campuses were involved in the SEL program.[224]

While there is currently no outcomes data available for SEL programs in Austin or elsewhere in Texas, national research on the effectiveness of SEL has found:

- Improved academic performance (11 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
- A reduction in reports of depression, anxiety and stress.[225,226]

TRAUMA-INFORMED CARE (TIC)

While training in trauma-informed care is not required for educators or public school employees in Texas, many children in Texas public schools have experienced trauma in some form. 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.[227] Creating a trauma-informed environment (in this case a school) 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.[228] 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.

Trauma-informed care is an overarching concept that can be implemented through the training of teachers and school personnel who interact with children. For more information on trauma-informed care, refer to the Texas Environment section.

RESTORATIVE JUSTICE FRAMEWORK

Restorative justice is a prevention-oriented framework that views bad behavior as more than an infraction of the school's rule by reframing the behavior as harming people, relationships, and the school community. A restorative justice framework can be applied to the entire school setting by focusing on the impact of harmful student behavior on others, and how that student and their school community can recover from the incident in a healthy way.[229] Restorative justice can be implemented by using restorative circles in the classroom, wherein students can 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.[230] 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.[231] This particular school in San Antonio 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.[232] 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. Statewide implementation of restorative justice in schools is still in its early stages, but restorative justice trainings are now being offered through 10 of the state's 20 regional educational service centers (ESCs).[233]

EFFORTS TO REDUCE BULLYING

Texas legislators and a wide range of advocacy organizations now acknowledge 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.[234] Examples of these side effects include anxiety, low grades, and social rejection.[235]

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.[236] 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.[237] 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.

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Texas Department of Housing and Community Affairs *At a Glance*

Texas Department of Housing and Community Affairs

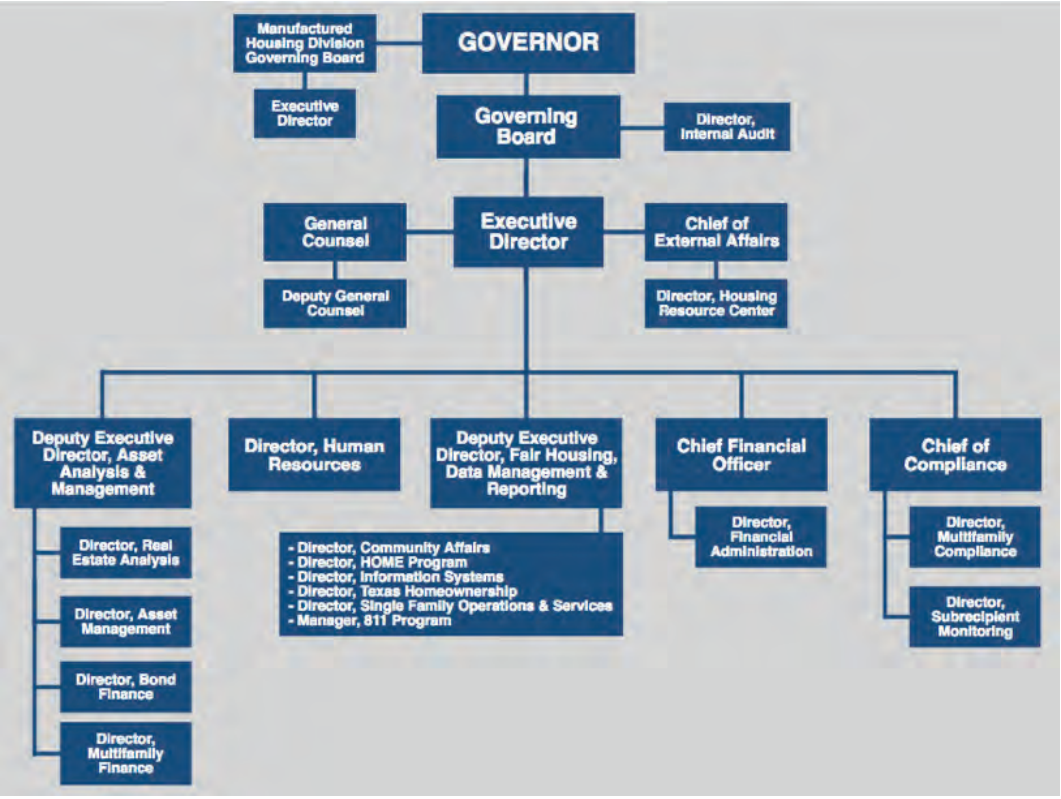
POLICY CONCERNS

- Lack of affordable housing options for people with disabilities, including individuals living with mental illness
- Implementation and distribution of funds from the National Housing Trust Fund
- Development of permanent supportive housing
- Availability of housing support for veterans
- Reducing the Section 8 rental assistance wait list
- Housing discrimination against Texans with mental illness and source of payment discrimination against Section 8 voucher-holders
- Location of Low Income Housing Tax Credit (LIHTC) developments for persons with disabilities
- Reducing housing barriers for individuals with criminal justice history and mental health needs

FAST FACTS

- In 2015, TDHCA served a total of 562,097 households and individuals through its combined programs, including 155,192 through its homeless services (up from 39,213 in 2014).[1]
- The most recent Point-in-Time (PIT) count of homelessness in Texas found that nearly 19 percent of individuals who are homeless (over 4,400) have a severe mental illness, and nearly half of those individuals are unsheltered.[2]
- According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness across the country have a serious mental illness; around two-thirds have a primary substance use condition or other chronic health condition.[3]
- 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.[4] In 2014, recipients of SSI in Texas received only $721 a month from SSI, which constituted 93 percent of the average fair market rent for a one-bedroom housing unit.[5]
- The 2016-2017 TDHCA budget contains $421 million in federal funding, constituting 87 percent of TDHCA's total funding for the biennium.[6]

ORGANIZATIONAL CHART



Data obtained from: Texas Department of Housing and Community Affairs. (2016). TDHCA organizational chart. Retrieved from https://www.tdhca.state.tx.us/hrdocs/org-chart.pdf

Texas Department of Housing and Community Affairs

Individuals with serious and persistent mental illness can experience significant barriers to permanent housing. According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness; around two-thirds have a primary substance use condition or other chronic health condition.[7] Serious mental illness and substance use conditions may create difficulties in accessing and maintaining stable, affordable, and appropriate housing.[8]

The Texas Department of Housing and Community Affairs (TDHCA) operates several major affordable housing programs. The agency disperses federal funds for housing and community services and is responsible for allocating housing tax credits under the federal Low Income Housing Tax Credit (LIHTC) 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 multi-family housing as well as federally-funded rental assistance programs. States and cities can act as PHAs and there are over 200 PHAs in the state of Texas, including TDHCA.[9]

In addition to supporting the housing needs of low-income Texans, TDHCA has programs and policies that specifically serve people with disabilities and those experiencing homelessness. A significant number of people with disabilities face extreme housing needs.[10] In 2015, HUD reported that nearly 40 percent of low-income households with a nonelderly 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.[11]

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 enhance coordination between housing and health service agencies in order to provide more service-enriched housing options.[12] 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."[13]

The executive director of TDHCA chairs the coordination council, which since its inception has made efforts to provide new housing and health-related resources and add additional staff who are conversant in both housing and health services.[14] 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 2014-2015 plan is available at http://www.tdhca.state.tx.us/hhscc/docs/14-15-BiennialPlan.pdf.

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 opportunity for low-income Texans broadly. The broader housing programs benefit Texans with disabilities and mental illness, however, by expanding the overall stock of affordable housing and services in the state. Low-income individuals living with 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. Figure 161 lists the housing assistance and services that TDHCA offers in each area of need.

Under its "rental assistance" category in Figure 161, TDHCA provides three different forms of assistance:

- **Tenant-based rental assistance:** Texas provides vouchers to help offset the cost of market-rate rental housing for low-income renters. 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 through the voucher. Tenants select rental units themselves in the private market, though landlords must agree to accept the rental voucher from TDHCA. This form of assistance includes the federally funded HUD Section 8 housing voucher program that serves specific areas of the state and the disability specific, Project Access vouchers. These programs are called tenant-based assistance because the subsidy is linked to and stays with the tenant. In addition, TDHCA utilizes federal HOME funding to provide time limited rental assistance.
- **Project-based rental assistance:** The new HUD Section 811 program provides a rental subsidy to the housing provider directly to keep a unit affordable to low-income tenants with disabilities linked to long-term services. The voucher stays with the housing provider, rather than the tenant.

- **Development assistance**: Lastly, the state provides subsidies to developers to construct or rehabilitate affordable multi-family rental housing. This form of assistance includes the Low Income Housing Tax Credit Program (LIHTC), HOME Multifamily and TACP funding

TDHCA's non-rental programs focus on single-family homeownership, rehabilitation or construction, as well as services for low-income or homeless individuals and families.

Figure 161. TDHCA Housing Support Continuum Activities

Continuum Activity	Program	Household Income Eligibility[a]
Poverty and Homelessness Prevention	*Community Services Block Grant (CSBG):* Local services and poverty programs	<125% FPL
	Comprehensive Energy Assistance (CEA): Energy education and utility assistance	<150% FPL
	Emergency Solutions Grants Program (ESG): Assistance for persons who are homeless or at risk of homelessness	<30% AMFI (or homeless)
	Homeless Housing and Services Program: For cities over 285,500 to assist individuals and families who are homeless	<30% ELI (or homeless)
Rental Assistance	*Section 811 Project Rental Assistance:* Project-based rental assistance for very low-income persons with disabilities, linked with long-term services	<30% AMI
	Section 8 Housing Choice Voucher Program: Tenant-based rental assistance vouchers for individuals in rural areas, or statewide for individuals with disabilities through Project Access	<50% AMI
	Tenant-based Rental Assistance (HOME-funded): Local grants to provide tenant-based rental vouchers	<80% AMI
	Low Income Housing Tax Credit Program (LIHTC): Tax credits for construction or rehabilitation of affordable rental housing	<60% AMI
	Multifamily Bond Program: Loans to develop or preserve affordable housing	<60% AMI
	HOME Multifamily and TCAP RF Rental Housing Development: Loans or grants to develop or preserve affordable housing, for qualified developers	<80% AMI

Continuum Activity	Program	Household Income Eligibility[a]
Homebuyer Education, Assistance and Single Family Development	*Colonia Self-help Center (SHC):* Funding for housing rehabilitation and construction, homebuyer assistance, and housing education in colonias	<80% AMI
	Texas Statewide Homebuyer Education: Training for nonprofits to provide homebuyer education	No income limit
	Homebuyer Assistance (HOME-funded): Down payment and closing cost assistance for single family buyers, can include rehabilitation or accessibility modifications	<80% AMI
	Contract for Deed Conversion (funded through HOME and Housing Trust Fund): Assisting colonia residents to convert contract-for-deed to warranty deed	<60% AMI
	My First Texas Home: Low-interest loans and down payment costs for first-time homebuyers	<115% AMI (non-targeted) <140% AMI (targeted)
	Mortgage Credit Certificate (MCC): Tax credit for homebuyers based on mortgage interest	115% AMI
	Single Family Development (HOME-funded): Loans to qualified developer for single-family construction, rehabilitation, or acquisition	<80% AMI
	Texas Bootstrap Loan Program: 0% interest loans to owner-builders, through nonprofits, to rehabilitate or construct their home through self-help construction	<60% AMI
Rehabilitation and Weatherization	*Amy Young Barrier Removal (funded through Housing Trust Fund):* Grants to fund accessibility modifications to homes for people with disabilities	<80% AMI
	Homeowner Rehabilitation Assistance (HOME-funded): Grants to fund home repair and replacement assistance	<80% AMI
	Weatherization Assistance: Grants to fund minor home repairs to increase efficiency	150%-200% FPL
Disaster Assistance	*Community Services Block Grant:* Emergency shelter, food and clothing	125% FPL
	Disaster Relief (HOME-funded): Home repair, rehabilitation, construction, homebuyer assistance, and tenant-based rental assistance for households affected by a disaster	<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. (2016). *2016 State of Texas low income housing plan and annual report,* 169. Retrieved from https://www.tdhca.state.tx.us/housing-center/docs/16-SLIHP.pdf

Changing Environment

NATIONAL HOUSING TRUST FUND

The federal government created the National Housing Trust Fund (NHTF) in 2008 under the Housing and Economic Recovery Act. The intent was to provide additional funding for states to develop affordable rental housing for extremely low-income individuals and families. The NHTF is funded by a percentage of new business generated by Fannie Mae and Freddie Mac, thereby providing a dedicated stream of revenue to the fund not subject to the annual federal appropriations process.[15] Implementation of the fund was initially halted after the federal government's decision to take conservatorship of Fannie and Freddie during the 2008 housing crisis. In 2014, HUD announced that it would lift its suspension of the fund's implementation and grant funds to states beginning in 2016. In 2016, HUD granted $174 million in formula grants to states, based on the state's Area Median Income and poverty levels. Texas received $4.8 million from the fund.[16]

TDHCA is responsible for administering and distributing the Texas funds. The intent of the fund is to support extremely low-income persons and to address individuals with worst-case housing needs. Data suggest that worst-case housing needs are high among low-income households with members who have a disability, and some advocates have highlighted the fund as an opportunity to create more permanently affordable units for individuals with disabilities. HUD will require NHTF units to remain affordable for a period of 30 years.[17]

In April, 2016 TDHCA held a roundtable meeting to obtain feedback from stakeholders on its draft NHTF Allocation Plan.[18] TDHCA released the draft for public comment in July 2016 and a public hearing was held on August 4, 2016.[19] Advocates expect TDHCA to tie funding to the state's Housing Tax Credit (HTC) program (known federally as the Low Income Housing Tax Credit Program, or LIHTC). For more information, see the materials provided by the National Low Income Housing Coalition at http://nlihc.org/issues/nhtf.

LIMITING SOURCE OF INCOME PROTECTIONS (SB 267, 84TH, PERRY/HUBERTY)

In 2015, the legislature passed SB 267 (84th, Perry/Huberty), which prevents municipalities from adopting source of income protections for most renters. Source of income protections prohibit landlords from discriminating against renters who receive federal housing assistance, such as Section 8 rental assistance vouchers. Public Housing Authorities (PHAs) provide rental assistance vouchers, also referred to as "Section 8" or "Housing Choice" vouchers, to low-income renters to help them afford market-rate rental housing. Individuals pay up to 30 percent of their income in rent and the PHA provides a voucher subsidizing the difference between the tenant's income and the price of rental housing. In Texas, TDHCA dedicates a part of its Section 8 voucher funds to individuals with mental illness through a program called Project Access.

Vouchers can act as a source of housing support for individuals with disability or mental illness, whose ability to work may be limited and whose income may consist solely of SSI (placing them at only 18 percent of the federal poverty level). However, data show that voucher-holders often experience difficulty locating housing. In 2012, an Austin Tenants' Council audit showed that only six percent of housing units in the Austin Metropolitan Statistical Area accepted vouchers as a source of payment.[20] In response to these data, in 2014 the City of Austin approved source of income protection rules, barring landlords from discriminating against recipients of federal housing assistance. Opponents of the city's rules expressed concern about the imposition of additional paperwork and administrative costs on landlords.[21] Accepting housing vouchers typically requires the landlord to participate in inspections and meet other administrative requirements.[22] In 2015, in response to these and other concerns, the Texas Legislature passed SB 267, overriding Austin's source of income protection and preventing cities from passing laws that prohibit landlords from refusing to rent to individuals whose income includes federal housing assistance. SB 267 does not prevent cities from passing source of income protection for veterans. Some housing and disability advocates have expressed concern that voucher-holders will continue to face discrimination in the private housing market and that this may disproportionately affect individuals with disabilities.

INCLUSIVE COMMUNITIES AND THE LOW INCOME HOUSING TAX CREDIT PROGRAM

Since 2012, in response to a lawsuit filed against the state by the Inclusive Communities Project in Dallas, TDHCA has made changes to the rules that it uses to allocate federal Low Income Housing Tax Credits (LIHTCs) for multifamily rental housing (also known as the Housing Tax Credit program, or HTC, in Texas). The 2008 lawsuit alleged that Texas' annual Qualified Allocation Plan (QAP) for housing credits systematically concentrated LIHTC units in high-poverty communities of color, violating fair housing standards.[23] In 2012, as a result of a federal court summary judgment, Texas committed to altering its QAP in order to reduce racial and economic segregation in the program.[24] Texas, since then, has taken steps to locate LIHTC housing in high-opportunity areas, emphasizing school quality and high-income census tracts.

LIHTC is an important source of funding for affordable rental housing, and in the past the QAP has contained specific provisions to incentivize permanent supportive housing (PSH) developments that serve individuals with special needs.[25] LIHTC housing is an important source of affordable rental housing for individuals with disabilities because LIHTC developments are required to accept Section 8 housing vouchers.[26] Without vouchers, however, LIHTC units are often unaffordable for individuals with disabilities whose primary source of income is SSI.[27] The agency rewrites its QAP annually, and disability advocates closely follow the amount of points and incentives provided for supportive housing developments. In 2015, the state added additional points for developments that participate in the Section 811 Project-based Rental Assistance program, which serves individuals with severe mental illness in Texas.[28]

Texas has added some points and incentives for PSH developments to the QAP in past years, making these developments more competitive for tax credit awards. At the same time, some advocates have expressed concern that the QAP opportunity index, which the agency adopted following the 2012 summary judgment in the *Inclusive Communities* case, rewards more developments located in suburban neighborhoods. Individuals with disabilities, and those who live in supportive housing units, can benefit from access to transit, services, and other amenities that often exist in urban areas. Suburban areas, however, typically have higher median incomes and better schools, which gives them an advantage in the QAP scoring system. The opportunity index was designed to advance fair housing objectives and address the agency's obligation to disperse its LIHTC units, and stakeholders continue to monitor how evolving standards may affect Texans with disabilities.

Lastly, stakeholders have expressed concern that supportive housing projects incur heightened levels of "Not in My Backyard" or "NIMBY" opposition from local residents. There is concern among some stakeholders that provisions in the QAP requiring letters of support from state representatives for a LIHTC development may disadvantage supportive housing developments. Siting of LIHTC housing, as directed through the QAP, continues to generate annual discussion among fair housing advocates, developers, and disability advocates.

APPLICATION FOR HOMEBUYER ASSISTANCE FUNDS (HB 1428, 84TH, RAYMOND/ZAFFIRINI)

In 2015, the legislature passed HB 1428 (84th, Raymond/Zaffirini). TDHCA's HOME-funded homebuyer assistance program contains a set-aside for individuals with disabilities, and this legislation allows an individual applying for funds under the disability set-aside to apply *prior* to entering into a contract to purchase a home.[29] Prior to this legislation, individuals were required to have a contract to purchase a home before applying for homebuyer assistance. This created challenges, given that individuals did not know whether they would receive financial assistance when attempting to purchase the home. This change allows individuals to apply for homebuyer assistance prior to making the home purchase commitment, thereby allowing them to engage in more effective financial planning and enter into a home purchase contract with greater financial stability. Individuals who receive assistance will have at least 90 days to find a suitable home to purchase under the program.

LANDLORD LIABILITY FOR INDIVIDUALS WITH A CRIMINAL JUSTICE RECORD (HB 1510, 84TH, THOMPSON/GARCIA)

HB 1510 relieves landlords from legal liability associated with renting to an individual with a criminal justice record. Given the prevalence of mental illness among individuals in the criminal justice system, disability advocates have expressed concern that housing and employment discrimination against individuals with a criminal justice history will disproportionately affect individuals with mental health conditions. Mental health advocates have expressed optimism that HB 1510 will help mitigate discrimination against individuals with a lived experience of both mental illness and criminal justice involvement by relieving landlords of legal liability for renting to individuals with a criminal record.

Funding

Most 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 specifications and restrictions related to their use and are subject to fair housing law. The following is a brief description of TDHCA's funding for the 2016-2017 biennium.

The 2016-2017 TDHCA budget contains $421 million in federal funding, constituting 87 percent of TDHCA's total funding for the biennium.[30] TDHCA receives federal funding through several departments, including the US Department of Health and Human Services (HHS), Department of Housing and Urban Development (HUD), Department of Energy (DOE), and the Centers for Medicare and Medicaid Services (CMS).[31] HUD and HHS provide the largest financial support to TDHCA.[32] TDHCA uses federal funds in a variety of ways, including but not limited to: direct rental and housing development assistance, disbursing funds to other agencies, disaster-related assistance, direct financial assistance to address energy needs, and mortgage bonds.

TDHCA also receives general revenue from the state. For 2016-2017, the legislature appropriated $26.5 million to TDHCA, comprising approximately 5 percent of total agency funding.[33] General revenue primarily funds the state Housing Trust Fund (HTF), which the legislature created in 1993 and is TDHCA's only state-funded affordable housing program.[34] The state HTF may be used to assist low- and very-low income individuals and families, provide technical assistance and capacity-building assistance to nonprofit organizations that develop affordable housing, and to serve as security for repayment of low-income housing revenue bonds.[35] In practice, the HTF currently funds the following programs:

- Amy Young Barrier Removal Program
- Contract-for-Deed Conversion Program for colonia residents
- Texas Bootstrap Home Loan Program

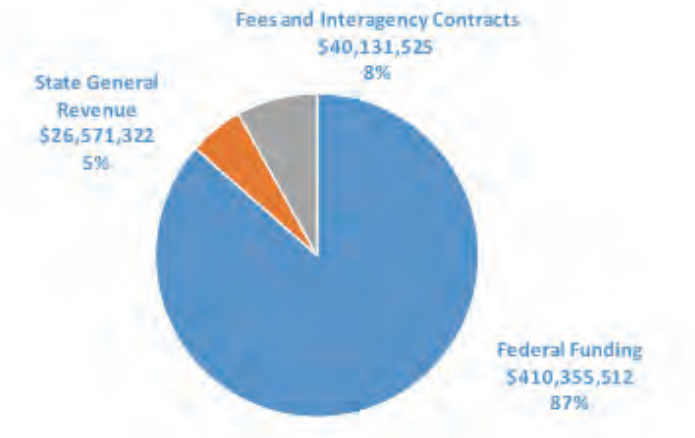
The HTF acts as an important revenue source to fund some affordable housing programs in Texas, but falls short of addressing the overall housing need in Texas.

TDHCA also collects fees from several of its housing programs and its regulation of the manufactured housing industry. For 2016-2017, this source of funding constitutes $39 million, or approximately 8 percent, of the agency's total funding.[36] These fees help finance the administration of the Housing Tax Credit program and other indirect administrative costs. [37]

Interagency contracts provide another source of funding for TDHCA's affordable housing programs. Two agencies hold contracts with TDHCA: The Texas Department of Agriculture (TDA) and the Department of Aging and Disability Services (DADS).[38] The interagency contract with TDA supports the Colonia Service Centers. A colonia is "a residential area along the Texas-Mexico border that may lack some of the most basic living necessities, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing."[39] The contract with DADS funds additional housing opportunities for persons with disabilities. Funding from

interagency contracts accounts for less than 1 percent of TDHCA's revenue.[40] Figure 162 shows TDHCA funding by Method of Finance.

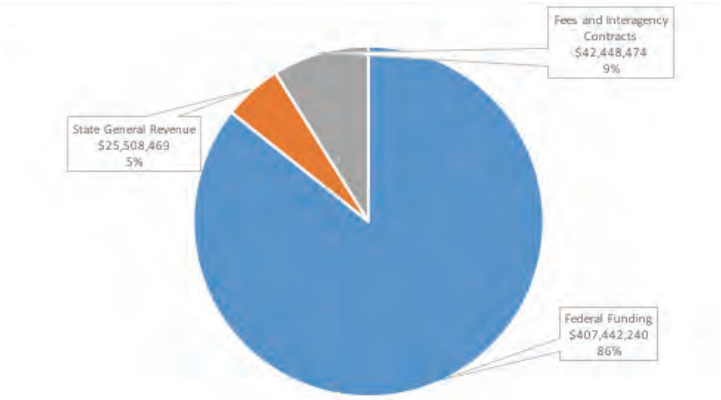
Figure 162. TDHCA Funding by Method of Finance for FY 2016-17



Total funding for TDHCA for FY 2016-17 was $477,058,359.

Data obtained from: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019, Texas Department of Housing and Community Affairs.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2018

Figure 163. TDHCA Funding by Method of Finance for FY 2018-19



Total funding requested for TDHCA for FY 2018-19 was $475,399,183. The TDHCA Legislative Appropriations Request did not include any Exceptional Item Requests.

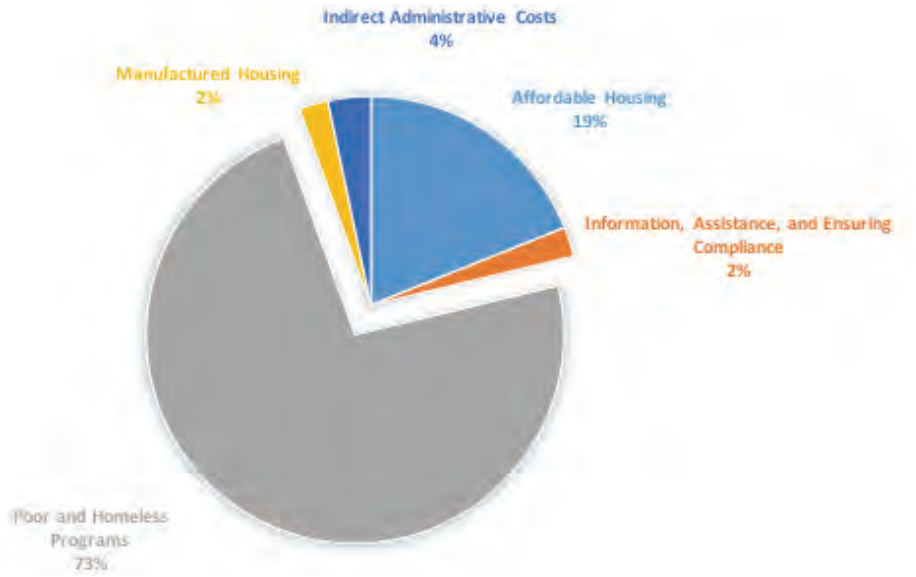
Data obtained from: Legislative Budget Board. (2016). *Legislative Appropriations Request for Fiscal Years 2018 and 2019, Texas Department of Housing and Community Affairs.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2018

In terms of its total expenditures, TDHCA is a unique agency. One of TDHCA'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 does not appear in the biennial state budget because it is funded by indirect (often private or federal) sources for which the agency acts as an allocator or administrator.[41]

In terms of direct allocations outlined in the state budget, 73 percent of TDHCA's 2016-2017 budget goes toward its homeless and poverty services. Only 19 percent goes toward affordable housing programs, including rental assistance and subsidies to multi-family housing developers. 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.[42] Direct biennial funding to TDHCA comprises only a small portion of Texas' total budget. For 2016-2017, the agency's budget is $487 million, or less than 1 percent of Texas' $209 billion budget. Figure 164 below illustrates the agency's budget by programmatic earmark, as described in the biennial 2016-2017 budget.

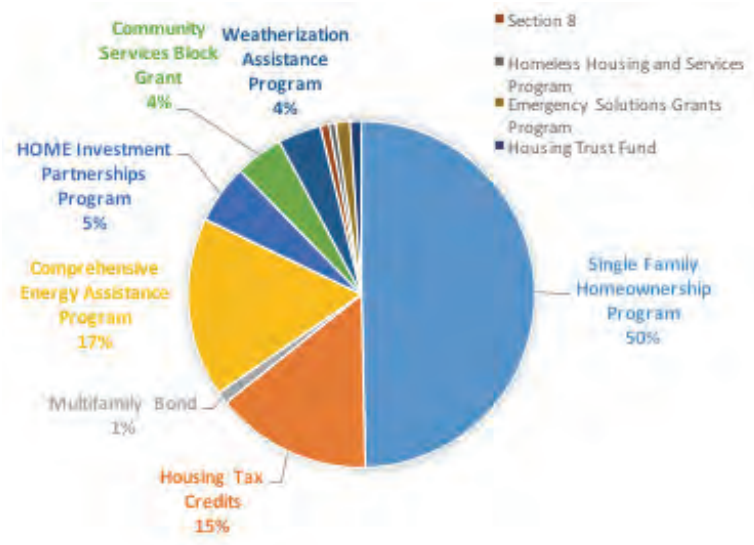
Figure 164, however, does not reflect the amount of indirect funding that the agency *distributes* through either the federal LIHTC program or its privately financed single-family homeownership program. The agency reports that, in FY 2015, it expended a total of over $628 million in both direct and indirect funding.[43] This includes almost $92 million for the federal LIHTC program, financed through federal tax credits, for the new construction or rehabilitation of affordable rental housing.[44] It also includes over $311 million 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.[45] Figure 165 below illustrates the total direct and indirect funding expended by the agency in FY 2015, according to its most recent annual report.

Figure 164. TDHCA Funding by Program for FY 2016-17



Data obtained from: Bill, H.B. 1, Conference Committee Report, 2015 Leg., 84th Reg. Sess., art. VII. (Tex. 2015).

Figure 165. TDHCA Expenditures, from Direct and Indirect Funding Sources (2015)



Data obtained from: Texas Department of Housing and Community Affairs. (2016). *2016 State of Texas low income housing plan and annual report,* 169 Retrieved from https://www.tdhca.state.tx.us/housing-center/docs/16-SLIHP.pdf

Affordable Housing

Safe, stable and affordable housing is an essential component of support systems that facilitate recovery from mental illness.[46] However, many Texans face a housing cost burden.[47] A housing cost burden exists when a household pays more than 30 percent of its total income before taxes and deductions toward housing.[48] In Texas, 31 percent of all households face a housing cost burden.[49] Data from 2008-2012 show that, of renter households with incomes below 30 percent of Area Median Family Income (AMFI), 66 percent face a housing costs burden.[50] This is compared to only 4 percent of households with incomes over 100% AMFI.[51] Overall, 2008-2012 data show that 2.2 million Texas renter and homeowner households with incomes below 100% AMFI face a housing cost burden.[52]

Barriers to affordable housing can disproportionately affect many Texans living with behavioral health conditions. Supplemental Security Income (SSI) is a federal program that provides a monthly income to people with little income and few resources who are blind, disabled, or elderly.[53] Many SSI recipients are unable to work due to severe mental illness or disability.[54] Research reveals a housing affordability gap for Supplemental Security Income (SSI) recipients. In 2014, recipients of SSI in Texas received only $721 a month from SSI, which constituted 93 percent of the average fair market rent for a one-bedroom housing unit.[55] Without affordable housing options, people with serious mental illness are priced out of the housing market. A 2012 Travis County study found that 69 percent of people with four or more psychiatric hospitalizations within a certain period were homeless.[56]

In order to direct resources to the people who are most in need and 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 (ACS) 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 nonmetropolitan counties.

Texas' 2016 AMFI is $62,800.[57] Low-income households are those whose income does not exceed 80% of AMFI. HUD breaks "low-income" down further, as described below. For a Texas household of four in 2015, HUD establishes the following income categories:

- Low-income (≤ 80% AMFI): ≤ $50,250
- Very low-income (≤ 50% AMFI): ≤ $31,400
- Extremely low-income (≤ 30 percent AMFI): ≤ $18,850[58]

The negative stigma associated with mental illness also prevents many Texans from participating in community life and accessing affordable housing. People with a mental health condition who also have a criminal record can have a difficult time finding housing.

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 disabilities[59]

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 seeks to facilitate 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.[60]

A significant number of people who are homeless also have a mental health condition. The most recent Point-in-Time (PIT) count of homelessness in Texas found that nearly 19 percent of homeless individuals (over 4,400) have a severe mental illness, and nearly half of homeless individuals with severe mental illness are unsheltered.[61] Homeless individuals with mental illness are at higher risk of chronic homelessness and remaining homeless for longer periods of time than homeless people without a mental illness.[62] Affordable housing programs that focus on homelessness prevention are therefore likely to serve a number of people who have a mental health condition. In 2015, TDHCA served a total of 562,097 households and individuals through its combined programs.[63]

Permanent Supportive Housing

Permanent supportive housing (PSH) is permanent, affordable housing linked to a range of support services that enable vulnerable tenants, especially people who experience chronic homelessness, to live independently and participate in community life. PSH is a cost-effective, evidence-based practice that is a key component in promoting recovery for people with behavioral health conditions.

According to SAMHSA, the core elements of permanent supportive housing are:

- A high degree of choice offered to tenants
- Functional separation of housing management and services staff
- Affordability
- Integration with the surrounding community
- Full rights of tenancy under federal and state law
- Immediacy of access to housing
- Available services and supports[64]

No permanent supportive housing project is assumed to be able to offer all of these core elements, but the extent to which they are able to do so tends to predict whether the project will be successful.[65] For more information on permanent supportive housing see resources from SAMHSA at http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

Housing First

Housing First is an approach to ending chronic homelessness that seeks to connect individuals with housing immediately and does not require sobriety, mental health treatment or supportive service participation as a precondition for housing. The philosophy undergirding Housing First is that once housing stability is achieved, clients will be better positioned to effectively address serious mental illness or co-occurring substance use. A 2007 HUD study on Housing First for individuals with mental illness experiencing chronic homelessness found that direct access to housing provided by Housing First programs enhanced housing stability for this population.[66] The United States Interagency Council on Homelessness suggests using Permanent Supportive Housing in combination with a Housing First approach to address chronic homelessness.[67]

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 for People with Disabilities or Mental Health Conditions

Several of Texas' 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. 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. A number of 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 http://portal.hud.gov/hudportal/documents/huddoc?id=HUDPrograms2016.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 (i.e. 50 percent or below AMFI) to participate in the program.[68] In FY 2016, the statewide AMFI was $62,800.[69] In addition, 75 percent of households participating in the voucher program must be Extremely Low Income (i.e. 30 percent or below AMFI).[70] In addition to meeting these income requirements, several other factors are taken into account to determine eligibility, including size and composition of the household, citizenship status, assets, medical expenses, and childcare expenses.[71]

Once 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.[72]

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 2015, TDHCA spent a total of $279,657 to serve 68 households through Project Access.[73] 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 one's ability to live independently. Applicants must also meet the requirements of the criteria in either 1 or 2 below:

1) Be an at risk applicant. That is, be a current recipient of Tenant-based Rental Assistance (TBRA) from TDHCA's HOME Investments Partnership Program and within six months of expiration of assistance, and either
   a) a previous resident of a nursing facility, intermediate care facility, state psychiatric hospital, or board and care facility as defined by the U.S. Department of Housing and Urban Development, or
   b) a current resident of a nursing facility, intermediate care facility, state psychiatric hospital or board and care facility at the time of voucher issuance as defined by HUD
2) Be eligible for the DSHS pilot program for residents of Texas state psychiatric hospitals at the time of placement on the voucher waiting list[74]

TDHCA works in collaboration with the Department of Aging and Disability Services (DADS) and Department of State Health Services (DSHS) to implement Project Access. Assistance through Project Access vouchers is not time limited. However, there is a high demand for Project Access vouchers and there is a waitlist for the program.[75] TDHCA is working with DADS and DSHS on a process that allows people on the Project Access waitlist to relocate from an institution using the HOME-funded TBRA program.[76] The goal is for a person to be admitted to the Project Access program by the time the HOME-funded TBRA assistance expires. While this is not a permanent fix, it allows for people to transition into community settings sooner than they would be able to otherwise.

LOW INCOME HOUSING TAX CREDIT PROGRAM

The Housing Tax Credit (HTC) program, also known as the Low Income Housing Tax Credit (LIHTC) program, is federally funded multi-family 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 United States and in recent years has produced 100,000 units of rental housing nationally per year.[77]

TDHCA provides federal tax credits to investors in multifamily housing who set aside a specific number of units of the development for affordable housing. The tax credits require the units to be leased to qualifying low-income residents at below-market rate. These affordable units must, minimally, 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. In 2015, TDHCA allocated $92 million in housing tax credits to construct or rehabilitate approximately 11,500 rental units in Texas.[78]

The program is important for renters with disabilities or mental health conditions, many of whom have limited income and would qualify for LIHTC units. Moreover, LIHTC developments are required to accept Section 8 housing vouchers. Additionally, Texas codifies its requirements for the competitive tax credit award

process annually in its Qualified Allocation Plan (QAP). The 2016 QAP contains provisions that provide scoring incentives for Permanent Supportive Housing, including the following:

- 30 percent Basis Boost, used to calculate the amount of tax credits for which the property is eligible, for entirely supportive housing developments
- Contain at least a 5 percent special needs unit set-aside (but no more than 18 percent)
- Points for offering supportive services
- Points for if a supportive housing development contains a 20 percent extremely low-income set-aside, for tenants with incomes below 30% AMFI
- Incentives for developments participating in the Houston Permanent Supportive Housing program[79]

HOME INVESTMENTS PARTNERSHIPS PROGRAM

The Texas HOME Investments 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 (PHAs), local nonprofits, and private housing actors.[80] HOME finances both single and multifamily programs, some of which are described below. The 2016-2017 budget allocates approximately $60 million to provide affordable housing through the HOME program.[81] By state law, 95 percent of Texas HOME funds must serve jurisdictions, mostly rural, that do not receive HOME funds directly from HUD.[82] However, there is a 5 percent set-aside for activities that serve persons with disabilities, regardless of the areas of the state in which they live.[83]

PERSONS WITH DISABILITIES (PWD) SET-ASIDE

Five percent of HOME funds are set aside for persons with disabilities, and these funds can be used for Homebuyer Assistance (HBA), Tenant-based Rental Assistance (TBRA), or Homeowner Rehabilitation Assistance (HRA). See below for more details about these programs. Local governments, PHAs, and nonprofit entities can apply for set-aside funds with TDHCA.[84]

HOMEBUYER ASSISTANCE PROGRAM

Nonprofits, PHAs, and units of local government are eligible to participate in the Homebuyer Assistance (HBA) program, funded by HOME. Organizations can use HBA funding to provide down-payment and closing cost assistance to single family homebuyers.[85] 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

The HOME-funded Tenant-Based Rental Assistance (TBRA) program assists tenants with the cost of moving and provides 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, pending funding.[86] TBRA is a short-term assistance program that also has the possibility to be a bridge program for individuals on the waitlist for the Section 8 Housing Project Access program.

SECTION 811 SUPPORTIVE HOUSING FOR PEOPLE WITH DISABILITIES

Section 811 is one of HUD's supportive housing programs for people with disabilities and is authorized by the Cranston-Gonzales National Affordable Housing Act of 1990, reformed in 2010.[87] Prior to the changes to the program in 2010, the HUD Section 811 provided interest-free development funds and operating subsidies to nonprofit developers of affordable housing for people with disabilities. HUD continues to offer interest-free capital advances to nonprofits. With revisions to the program in recent years, however, HUD now provides rental assistance to be used in developments funded through other subsidy programs, such as the Low Income Housing Tax Credit and HOME programs.

SECTION 811 PROJECT RENTAL ASSISTANCE

In February 2013, Texas became one of 13 states awarded funds for the Section 811 program.[88] Subsequently in 2014, HUD awarded a second round of funds to TDHCA as well. Combined, the awards total received $24 million to provide project-based rental assistance for extremely low income persons with disabilities.[89] People with serious mental illness and people with disabilities exiting institutions are target populations for this program, as well as youth exiting foster care.[90] TDHCA and the Texas Health and Human Services Commission (HHSC) have entered an inter-agency agreement, per a requirement of the grant application. This agreement addresses the characteristics of the population that will be targeted for this program, how this population will be reached and referred to the program, and the commitments of services from the health and human service agencies.[91] The number of units created will depend on the prevailing rents at the time the units are placed in services, household incomes and other factors. TDHCA anticipates that the program will help create between 300 and 400 new integrated, supportive housing units per $12 million award in eight areas throughout the state. 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 (AYBR) Program provides funding for persons with disabilities to improve accessibility and remove dangerous conditions in their homes. The program provides one-time grants of up to $20,000 for accessibility home modifications to people with a disability whose household incomes are below 80% of AMFI.[92] 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. About $2.2 million was spent to serve 116 households in FY 2015.[93] TDHCA disburses funds to nonprofit organizations and local governments that process applications, verify eligibility, and oversee construction.[94]

POVERTY AND HOMELESS PREVENTION PROGRAMS

TDHCA has several programs that specifically serve people who are experiencing homelessness.

EMERGENCY SOLUTIONS GRANTS PROGRAM

The Emergency Solutions Grants (ESG) program is funded by HUD and administered by TDHCA. TDHCA distributes ESG funds to private nonprofit organizations, cities, and counties to assist homeless persons and persons at risk of homelessness to regain stability in permanent housing. In FY 2015, TDHCA dispersed $8.4 million to 53,140 people through the ESG program.[95] ESG funds are intended to provide assistance by improving the quality and number of emergency shelters, rapidly re-housing homeless individuals and families, and preventing families and individuals from becoming homeless. The program targets individuals who are homeless or at risk of homelessness.[96]

HOMELESS HOUSING AND SERVICES PROGRAM

The Homeless Housing and Services Program (HHSP) was established by Rider 18 in Article VII of the General Appropriations Bill of the 81st Legislative Session (SB 1, 81st, Ogden/Pitts), and codified in 2011.[97] TDHCA administers this program in the eight largest cities in Texas – Arlington, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston and San Antonio. The program serves individuals and families experiencing homelessness. Services include case management, housing placement and supports designed to help people retain housing. HHSP received an initial appropriation of $20 million during the 81st legislative session, and the legislature allocated $10 million to the program for the 2016-2017 biennium.[98] In FY 2015, TDHCA dispersed $5 million to HHSP to serve 12,277 individuals.[99]

COMMUNITY SERVICES BLOCK GRANT PROGRAM

TDHCA administers the Community Services Block Grant (CSBG) Program through funding from HUD. Nonprofit organizations and local units of governments are eligible to receive these funds to provide essential services and poverty programs with the aim to promote stability and self-sufficiency among low income individuals. In 2015, TDHCA spent $28 million in CSBG funding to serve over 324,000 individuals in the program.[100]

RELATED SERVICES AND PROGRAMS - OTHER STATE AGENCIES

MODEL BOARDING HOME STANDARDS AND HOUSING REFERRAL NETWORK

Boarding homes serve an important role in the continuum of care for people with mental health conditions and other disabilities, and some homes provide safe and affordable living quarters for their residents. A boarding home is a business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the

owner. Securing affordable and safe housing continues to be a major challenge for many people with serious mental health conditions. Efforts have been made to better support people with mental health conditions in terms of affordable and safe housing in the past few years.

In 2009, the Texas Legislature directed the Health and Human Services Commission (HHSC) to establish model boarding home standards with HB 216 (81st, Menendez/Shapleigh). Relatedly, in 2013, the legislature passed HB 1191 (83rd, Burkett/Zaffirini), which added housing resources for people with mental illness to the online Texas Information and Referral Network (TIRN, also known as 2-1-1). See the Texas Environment and HHSC Sections of this guide for more information about HB 216 and HB 1191.

HOME AND COMMUNITY BASED SERVICES - ADULT MENTAL HEALTH

The Department of State Health Services (DSHS) administers the Home and Community Based-Adult Mental Health services (HCB-AMH). This program is funded through a Medicaid 1915(i) State Plan Amendment, and seeks to provide home-based services and supports to individuals with long-term tenure in state mental health facilities, providing a transition from these facilities into the community.[101] The program serves adults with serious mental illness who are not otherwise served in a Medicaid waiver program, and provides services such as companion care, supportive home living, peer support, residential services, transportation services, and other continuity of care services.[102] This program is important for individuals with serious mental illness because it provides a number of supports that allow them to live in housing within the community, rather than an institutional setting. For more information, see the Department of State Health Services and the Texas Environment sections.

SUPPORTIVE HOUSING RENT AND UTILITY ASSISTANCE PROGRAM

In 2013, during the 83rd Legislative Session, the Legislature awarded an exceptional item to DSHS to provide short-term rental and utility assistance to individuals with mental illness through the Local Mental Health Authorities (LMHAs). In FY 2016, the program received $5.4 million.[103] The program was originally established to act as a stop-gap measure while individuals waited to receive Section 8 rental vouchers.[104] The program today provides longer-term assistance of up to 18 months and a limit of approximately $10,300 per recipient, and shorter-term assistance (up to three months) of approximately $2,600 in assistance for rent and utilities.[105]

HOUSING AND SERVICES PARTNERSHIP ACADEMY

In 2013, TDHCA and DADS worked together to create and implement a Housing and Services Partnership (HSP) Academy. The academy provided local communities with the tools and education necessary to create safe, affordable, accessible housing for people with disabilities in their communities. TDHCA held meetings in partnership with the Corporation for Supportive Housing in January, April, July, and October of 2016.[106] More information on upcoming partnership academies can be found on the TDHCA website http://www.tdhca.state.tx.us/hhscc/.

HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES CLEARINGHOUSE WEBSITE

In September 2013, DADS and TDHCA finalized and made available a clearinghouse for housing and services resources on the 2-1-1 Texas.org website. The online clearinghouse provides an interactive resource for people with disabilities, as well as local service providers, to find community-based affordable housing and health services. The clearinghouse website can be found at https://211texas.hhsc.state.tx.us/211/clearinghouse/main.do

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.[107] 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. In ensuring compliance with this obligation, HUD requires federal funding recipients to submit an analysis of challenges to fair housing choice in their communities every three to five years.

In its 2013 Analysis of Impediments to fair housing, Texas identified three impediments specific to people with disabilities, including people with mental health conditions. These three impediments are: lack of accessible housing and visitability standards, inadequate information about programs to assist persons with disability, and barriers to mobility and free housing choice for protected classes.[108] In a survey conducted for the report, seventy-four percent of stakeholders reporting high geographic concentrations of low-income housing said that concentrated housing disproportionately affects people with disabilities.[109] Moreover, in large metropolitan areas, 16 percent of people with disabilities report that they have felt discriminated against when trying to find housing.[110]In response to these impediments, TDHCA adopted the goal of improving housing options for people with disabilities. The report identifies the following state action items to achieve this goal:

- Work with stakeholders who are knowledgeable about the housing needs of persons with disabilities to identify specific needs in communities
- Provide findings from above process to local governments
- Promote local approaches to meeting these needs
- Include information about group home requirements in educational and outreach efforts
- Educate stakeholders, local government officials, planners, and Councils of Governments (COGs) about the benefits of universal design and visitable housing[111]

In addition to these recommendations, the report outlines action steps for local governments:

- Conduct an assessment of the need for affordable, accessible housing serving persons with disabilities
- Review zoning and land use ordinances for language that treats small group homes as commercial and industrial use
- Build universal design concepts into planning goals and articulate them to local developers[112]

For more information on these recommendations, see the full report at http://www.tdhca.state.tx.us/housing-center/fair-housing/docs/DRAFT-FairHousingChoice-AI-Phase2.pdf

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Texas Veterans Commission *At a Glance*

Texas Veterans Commission

POLICY CONCERNS

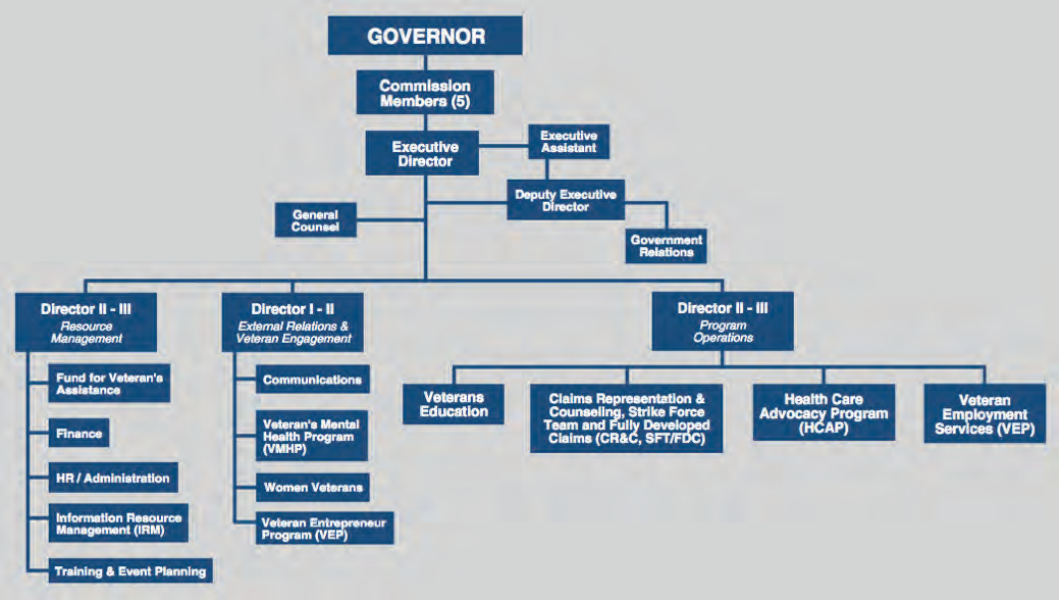
- Continued expansion of veteran peer specialist services
- Tracking the needs of, outreach to, and services available to women veterans in the state
- Coordination of federal and state services
- High risk of post-traumatic stress disorder (PTSD) and suicide among veterans
- High rates of homelessness among veterans
- Lack of supports for veterans returning to civilian life after deployment

FAST FACTS

- Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.[1]
- Women are the fastest growing group within the veteran population and are projected to make up 16 percent of all living veterans by 2043.[2] There are over 177,000 women veterans in Texas.[3]
- Fifty-five 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), while in the military.[4]
- A 2016 report by the Department of Veterans Affairs found that the prevalence of veterans with mental health or substance use conditions receiving services through the Veterans Health Administration (VHA) had increased from 27 percent in 2001 to more than 40 percent in 2014.[5]

- Veterans exhibit significantly higher suicide risk compared with the U.S. general population.[6] The Department of Veterans Affairs 2016 Suicide Data Report concluded that 20 veterans die from suicide each day.[7] Three out of five veterans who died by suicide were diagnosed as having a mental health condition.[8]
- Reports show that veterans are overrepresented in the U.S. homeless population, constituting 12.3 percent of all adults experiencing homelessness in the country but only 9.7 percent of the total US population.[9]

ORGANIZATIONAL CHART



Data obtained from: Texas Veterans Commission. (2016). Texas Veterans Commission Organizational Chart. Retrieved from http://www.tvc.texas.gov/Documents/Organizational_Chart-FY_2016-4thQ.pdf

Texas Veterans Commission

Introduction

Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.[10] Veterans face a myriad of challenges as they transition from active duty to civilian life. Among these challenges is an increased risk for behavioral health conditions. Approximately 11-20 percent of veterans of the Iraq and Afghanistan wars (Operations Iraqi Freedom and Enduring Freedom) are diagnosed with post-traumatic stress disorder (PTSD).[11] In comparison, only 7-8 percent of American adults in the general population will experience PTSD at some point during their lifetime.[12] In addition to combat trauma, sexual assault while in military duty (referred to as military sexual trauma) can also result in symptoms of PTSD.[13]

Among those women who use Veterans Affairs (VA) 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.[14] Additionally, 55 out of 100 women and 38 of 100 men report having been sexually harassed, which includes behavior such as offensive comments about a person's body or sexual activity, displays of pornographic material, and unwanted sexual advances while in the military.[15] Thus, veterans are at increased risk for developing mental health conditions and substance use problems stemming from their military service.

Veterans with mental health and substance use conditions face a number of increased risk factors including: chronic homelessness, a greater risk of suicide, a wide range of serious medical problems, premature mortality, and incarceration.[16,17]

Unfortunately, only about half of all veterans with a diagnosed behavioral health condition have accessed appropriate services, and even fewer have received adequate care.[18]

The Texas Veterans Commission (TVC) serves veterans and their dependents in all matters pertaining to veterans' disability benefits and rights. It is the designated agency of the state of Texas to represent the state and its veterans before the U.S. Department of Veterans Affairs (VA). The agency represents veterans in filing VA disability claims and during VA appeals processes, and it assists dependents with survivor benefits. Additionally, the TVC focuses on the following program areas:

- Veterans' employment services
- Veterans' education services
- Claims representation and counseling
- Funding assistance

Both the claims representation and counseling and funding assistance programs impact veterans' ability to access behavioral health services. [19]

The U.S. Department of Defense Military Health System is responsible for providing health care to active duty and retired U.S. military personnel and their families. For more information, visit www.health.mil.

Changing Environment

In 2015, the 84th legislature appropriated funding to help to address the mental health needs of veterans in Texas through several pieces of legislation. ***It is important to note that the following bills are related to veterans' behavioral health but not coordinated directly through the Texas Veterans Commission (TVC).***

SB 55 – THE TEXAS VETERANS + FAMILY ALLIANCE PROGRAM

Senate Bill 55 (84th, Nelson/S. King) directed HHSC to establish a new grant program to support community mental health programs that provide mental health services and treatment for both veterans and their families. HHSC must work with an outside stakeholder to administer the pilot program. The Meadows Mental Health Policy Institute (MMHPI) is the administrator of the one-year pilot program. The program is currently in the pilot phase and was funded through $1 million in state funds and $1 million raised through private and local funds. The request for proposals (RFP) was released in December 2015.

Twenty million dollars was appropriated by the 84th legislature to continue and expand this grant program for the current biennium, which started in September of 2016.[20] The grant funding period will continue through August 31, 2017.

The pilot program awardees are:

- Center for BrainHealth
- Emergence Health Network
- Texas Panhandle Centers
- United Way of Denton County
- Tropical Texas Behavioral Health[21]

The most recent updates on the Texas Veterans + Family Alliance program can be found at http://www.texasstateofmind.org/tvfa/.

HB 3404 – STUDY ON VETERANS WITH POST-TRAUMATIC STRESS DISORDER (PTSD)

HB 3404 (84th, Thompson/Lucio) required Health and Human Services Commission to conduct a study on the benefits of providing integrated care to veterans with post-traumatic stress disorder (PTSD). The study will be coordinated with a university and medical school with expertise in behavioral health or PTSD. The study will evaluate the benefits of 1) using a standardized comprehensive trauma and PTSD

assessment to identify and target evidence-based treatment services to provide integrated care for veterans; and 2) involving family members in the treatment of veterans diagnosed with PTSD. Finally, HB 3404 requires a report describing the results of this new effort to be released by December 1, 2016.[22]

The 84th legislature did not appropriate funding in the biennial budget for the study required in HB 3404. As of print date, HHSC is exploring options for partnering with institutions of higher education.[23]

SB 1304- MENTAL HEALTH INTERVENTION PROGRAMS FOR FEMALE VETERANS

SB 1304 (84th, Menéndez/ Minjarez) required DSHS to develop a mental health initiative as part of the mental health intervention program for female veterans. Women veterans face unique mental health concerns, from military sexual trauma to consolidating dual roles as soldiers and family caregivers.[24]

SB 1305- MENTAL HEALTH INTERVENTION PROGRAMS FOR VETERANS LIVING IN RURAL AREAS

SB 1305 (84th, Menéndez/ Minjarez) also required DSHS to develop a mental health initiative for veterans living in rural areas of the state. Of the 1.67 million veterans in Texas, 30 percent (approximately 503,000) live in rural areas with limited or no access to mental health services. Veterans in these areas have been historically underserved in this capacity.[25] These disparities are compounded by the continued shortage of mental health professionals in rural areas (see the Texas Environment section for further discussion of the mental health workforce shortage in rural areas).

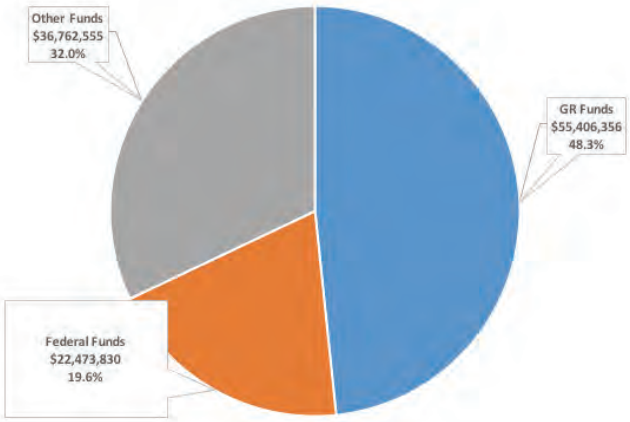
SB 169- INTEREST AND WAIT LISTS OF HHS PROGRAMS FOR ACTIVE DUTY SERVICE MEMBERS

SB 169 (84th, Uresti/King, S.) required health and human services agencies to ensure active duty members, or their spouses or dependents, do not lose their place on interest lists or other waiting lists for any assistance programs provided by certain agencies. This provision impacts veterans, their spouses, or dependents who are temporarily residing out of state as a result of military service. SB 169 states that this protection ends one year after the military member leaves active duty, is killed in action, or dies while in the service. If a military member is out of state when his or her name reaches the top of the interest list, agencies will maintain the individual's position on the interest list. Several agencies already allow this protection for veterans, their spouses, and dependents. This legislation provides consistency across program policies and agencies. SB 169 applies to programs at DADS, DARS, DSHS, and HHSC. Implementation varies by agency and program. [26]

Funding

The Texas Veterans Commission (TVC) receives both state and federal funding, as well as other funds. Note: TVC is not part of the Health and Human Services enterprise.

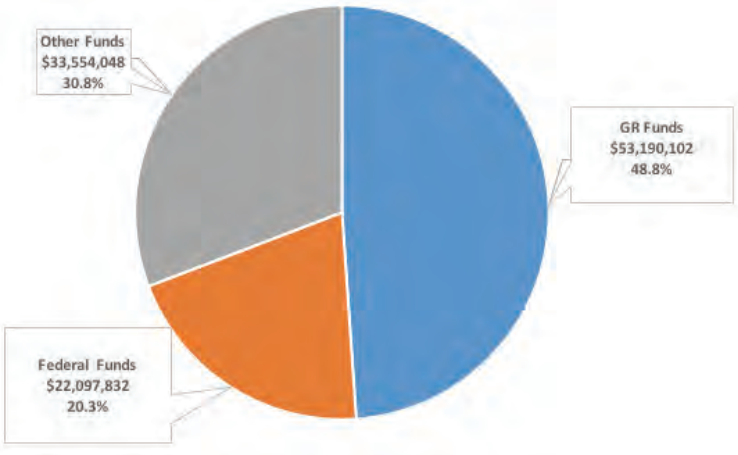
Figure 166. TVC Funding by Method of Finance for FY 2016-17



Source: Legislative Budget Board. (2016). *Veterans Commission, Legislative Appropriations Request Fiscal Years 2018-2019.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2018

*Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802, Governor's Emer/Def Grant

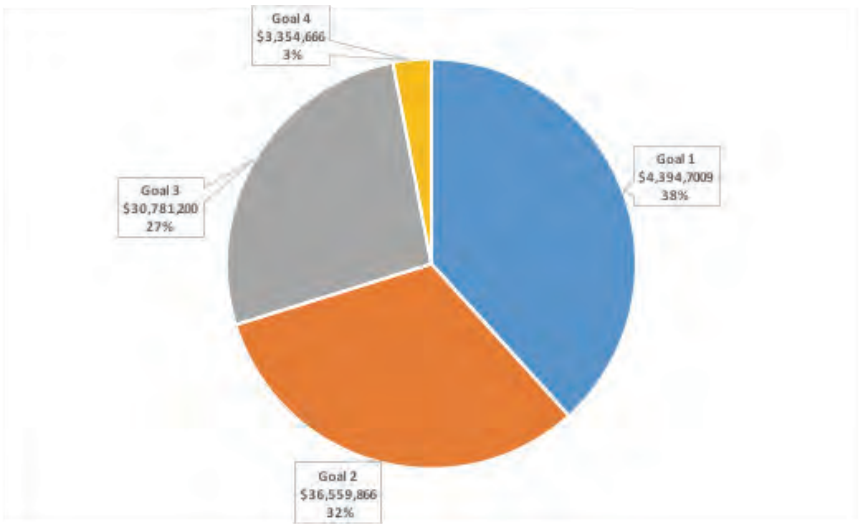
Figure 167. TVC Funding by Method of Finance for FY 2018-19



Source: Legislative Budget Board. (2016). *Veterans Commission, Legislative Appropriations Request Fiscal Years 2018-2019.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2018

*Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802, Governor's Emer/Def Grant

Figure 168. TVC Funding by Strategy for FY 2016-17



Goal	Description
Goal 1.	Ensure veterans, their dependents and survivors receive all due benefits
Goal 2.	Ensure veterans receive general assistance, mental health, and housing services
Goal 3.	Provide Administration and Reimbursements for Hazlewood Exemption Program
Goal 4.	Indirect Administration

Source: Legislative Budget Board. (2016). *Veterans Commission, Legislative Appropriations Request Fiscal Years 2018-2019.* Retrieved from http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2018

Claims Representation and Counseling Program

TVC's claims representation and counseling program helps veterans and their family members apply for disability benefits and enroll in VA health care programs. TVC employs over 75 counselors accredited by the VA to provide direct representation in claims and appeals as well as general assistance with the process of securing benefits at many veterans integrated service network (VISN) facilities. Claims counselors act as liaisons between the veteran and VA medical facilities and assist veterans with applications for VA compensation benefits.[27]

The following sections describe VA benefits eligibility and available VA behavioral health services that can be accessed by an individual independently or with the assistance of TVC counselors. TVC counselors work with veterans throughout the state.

Eligibility for VA Benefits

Eligibility for most VA benefits, including health services, occurs upon discharge from active military service, except when under dishonorable conditions.[28] Veterans are assigned to one of eight priority groups upon enrollment. The higher priority

groups include veterans with service-connected disability ratings, including former prisoners of war, Purple Heart Medal recipients, Medal of Honor recipients, veterans discharged with a disability incurred or aggravated in the line of duty, and veterans awarded special eligibility due to a disability incurred during treatment or vocational rehabilitation.[29] For a complete listing of all eight priority groups, see http://www.va.gov/healthbenefits/resources/priority_groups.asp.

There are two types of compensation available: 1) Service-Connected and 2) Non-Service Connected. Service-Connected compensation is a monetary benefit paid to veterans who suffered an injury or illness incurred or aggravated during military service, regardless of their combat experience.[30] A Non-Service Connected pension is a monetary benefit paid monthly to veterans with low or no income who are aged 65 and older, or have permanent disability. [31] Additional eligibility requirements for a Non-Service Connected pension include: having served 90 days or 24 months (depending on dates of service) of active duty with one day during a period of wartime (combat experience not required) and a family income lower than a specified limit (depending on spouse/dependents).[32]

VA Behavioral Health Services

Nationally, veterans' health care services are administered on a regional level by a system of 23 veterans integrated service networks (VISN), each containing a hierarchy of medical centers, on-site outpatient clinics, community-based outpatient clinics and vet centers, which provide counseling, outreach, and referral services to help veterans adjust to life post-combat. Texas has one VISN, VISN 17: VA Heart of Texas Health Care Network, which is located in Arlington, along with multiple clinics and vet centers throughout the state.[33] For more information, see http://www2.va.gov/directory/guide/state.asp?State=TX&dnum=ALL.

The TVC does not directly operate or provide behavioral health services to veterans; instead it links veterans to these services through the 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.[34] Additionally, 300 Vet Centers nationwide provide psychological counseling for war-related trauma and other services such as outreach, case management, and social services referrals.[35] Vet Centers served a total of 219,509 veterans, service members, and military families in FY 2015 and provided 1,663,011 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services. [36] There were a total

8.97 million veterans enrolled in the VA Health Care system in FY 2015.[37]

For a comprehensive description of federal benefits and services available to veterans, family members and survivors, visit http://www.va.gov/opa/publications/benefits_book.asp.

TVC Employment Services

Unemployment among veterans can have negative mental health and economic consequences, which creates additional obstacles for veterans in securing stable housing.[38] Gainful employment is therefore key to ensuring that veterans live independently and self-sufficiently.[39] The TVC offers employment services to assist qualified veterans in finding and obtaining meaningful and long-term employment. Veteran employment representatives provide job coaching, job training, and resume assistance. They can also provide access to education programs, and conduct outreach to businesses and employers to promote the hiring of veterans.[40] Other employment-related services for veterans include intensive services, vocational services, referrals to training, and other supportive services.[41]

Fund for Veterans' Assistance (FVA)

The Fund for Veterans' Assistance (FVA) is operated by the TVC and is funded through a combination of state funds and private donations. The FVA awards four categories of grants to eligible organizations that provide direct services to veterans and their families. The four categories include:

- General Assistance Grants,
- Housing for Heroes Grants,
- Veterans Mental Health Grants, and
- Veterans Treatment Court Grants.[42]

FVA General Assistance grants reimburse charitable organizations, local government agencies, and veterans service organizations (VSO) for providing direct support services to veterans and their families, including housing assistance, counseling for PTSD and traumatic brain injury, transportation to medical appointments, and information and referrals to other services.[43] Housing for Texas Heroes grants support nonprofit or local government organizations that provide temporary and permanent housing assistance for veterans and their families.[44] Veterans Mental Health Grants fund projects that provide direct mental health services to veterans and their families through a range of services such as peer counseling, PTSD treatment, traumatic brain injury (TBI) services, group therapy, equine therapy, and co-occurring disorder counseling, among others.[45] Veterans Treatment Court Grants assist Texas veterans in obtaining services through Veterans Treatment Court programs.[46]

The FVA is funded through four primary sources: the sale of $2 scratch-off lottery tickets, online or check donations, vehicular registration donations, and the State Employee

Charitable Contribution Campaign.[47] The FVA funded 11 organizations involved in veterans mental health across the state for a total of over $1 million for 2016.[48]

For a list or organizations and grant awards beginning January 1, 2016, visit http://www.tvc.texas.gov/Grants-Awarded.aspx

Veterans Mental Health Program (VMHP) and Other Supports

Veterans exhibit significantly higher suicide risk compared with the U.S. general population.[49] The Department of Veterans Affairs 2016 Suicide Data Report (the most recent study of its kind) concludes that 20 veterans die from suicide each day.[50] The Veterans Crisis Line is a resource available during mental health crises, including suicide crises, and can be accessed by veterans, their families, and/or friends. Callers can reach the hotline via telephone, text, or online chat where they will be connected with a trained VA responder. Since its launch in 2007, the Veterans Crisis Line has answered over 2 million calls and initiated the dispatch of emergency services to callers in crisis over 56,000 times. The Veterans Crisis Line anonymous online chat service, added in 2009, has engaged in more than 267,000 online chats. In November 2011, the Veterans Crisis Line introduced a text-messaging service to provide another way for veterans to connect through their personal cell phone or smart phone with confidential, round-the-clock support, and since then has responded to more than 48,000 texts.[51]

TexVet, an initiative by the Texas A&M Health Science Center, is a network of health providers, community organizations, and volunteers who are committed to providing veterans, military members, and their families with referrals and information to successfully access services. TexVet has initiated a "No Wrong Door" policy for the veteran community through its network and event-based activities, which ensures that veterans are properly connected to the services that they need by knowledgeable partners across the state.[52] For more information, visit: http://texvet.org.

MILITARY VETERAN PEER NETWORK

One of the Veterans Mental Health Program (VMHP) resources available on the TexVet network is the Military Veteran Peer Network. This organization is an affiliation of veterans and family members who actively identify and advocate for community resources for veterans and provide peer counseling services. Peer Group Leaders are trained in peer support and mental health awareness and establish peer group meetings in their communities. Because members of the group set their own rules, no two peer groups are the same. The Military Veteran Peer Network has 37 chapters across the state and is supported by grants from the Department of State Health Services (DSHS).[53]

"No one is better prepared to speak with a Veteran about her experiences than another Veteran, a peer." – Military Peer Veteran Network

OTHER VMHP SERVICES

The Veterans Mental Health Program also provides additional services including: Military Cultural Competency training for licensed mental health professionals, Veterans Mental Health Awareness training for community-based organizations and faith-based organizations, and Coordination of Justice Involved programming through engagement, training, and cooperation with justice system agencies.

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 PTSD, TBI, depression, and substance use issues. Alternatively, a judge sitting in a specialty veterans 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 often include case managers and court clerks with military experience or familiarity working with veterans. Thus, veterans 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 veterans court in Texas, located in Harris County, began accepting cases in 2009. Results from seven veterans courts (Bexar, Dallas, El Paso, Harris, Hidalgo, Tarrant, and Travis counties) in FY 2013 included: 651 total veterans were assessed for eligibility to participate in the program, 451 veterans enrolled in the program, 226 of the 451 veterans were new enrollees, and 124 veterans successfully completed the program.[54]

As of May 2016, there are twenty-three veterans courts operating throughout the state in the following counties:

- Bell
- Bexar
- Cameron
- Collin
- Comal
- Dallas
- Denton
- El Paso
- Fort Bend
- Galveston
- Guadalupe
- Harris
- Hays
- Hidalgo
- Midland
- Montgomery
- Nueces
- Tarrant
- Travis
- Rockwall
- Smith
- Webb
- Williamson[55]

TEXAS VETERANS PORTAL (TVP)

The Texas Veterans Portal (TVP), managed by the TVC, is a collaborative effort of several state agencies and commissions to provide assistance, services, and benefits for Texas veterans, their families, and service providers. The site provides online access to a comprehensive range of information about veteran's benefits, education, employment, and health services. Additionally, TVP is a single access point to download pertinent forms, locate community resources, and review frequently asked questions. Currently the TVP collaborates with:

- TVC
- Texas Workforce Commission
- Texas Veterans Land Board (Texas General Land Office)
- 2-1-1 (Texas Health & Human Services Commission)
- TexVet (Texas A&M Health Science Center)
- Office of the Governor
- Texas Department of Information Resources
- Staff from Texas State Representative Chris Turner and U.S. Representative John Carter's offices
- Texas Army National Guard (Camp Mabry).[56]

The Texas Veterans Portal is available at www.texas.gov/veterans#sthash.96yEX5Qf.dpuf.

WOMEN VETERANS

Women are the fastest growing group within the veteran population and are projected to make up 16 percent of all living veterans by 2043.[57] Recognizing the growing number of female veterans, the VA has embarked on efforts to understand how to better serve woman veterans. In the general population, women are more likely to develop PTSD than men.[58] It is unclear whether the incidence of PTSD is higher among military women than military men.[59] However, woman veterans are more likely to have lower incomes, lack private insurance, and have poorer health.[60] Female veterans earn almost $10,000 less per year than male veterans and are up to four times more likely to be homeless than nonveteran women.[61,62] Because of their heightened risk for having experienced military sexual trauma, PTSD, homelessness and financial stress, it is important that health care, including mental health and substance use services, support services, and transitional resources are responsive to the needs of woman veterans.

The TVC created the Texas Women's Initiative in an effort to better serve women veterans, by helping them obtain their benefits, increasing services for women veterans throughout the state, and coordinating services and supports with local community organizations. The 84th legislature passed SB 1304 (84th, Menéndez/ Minjarez), requiring DSHS to create an initiative focused on the mental health needs of women veterans.

Visit http://www.tvc.texas.gov/Women-Veterans.aspx for more information on other initiatives to serve women veterans.

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Appendices

List of Figures

List of Acronyms

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

DHHS - U.S. Department of Health and Human Services
DRS - Division for Rehabilitation Services
DM-ID - Diagnostic Manual – Intellectual Disability
DSM-V - Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition
DSRIP - Delivery System Reform Incentive Pool
EAP - Employee Assistance Plan
EBP - Evidence-Based Practice
ECT - Electroconvulsive Therapy
ECI - Early Childhood Intervention [program]
EPSDT - Early and Periodic Screening, Diagnosis and Treatment
ESG - Emergency Solutions Grants
FDA - Food and Drug Administration
FFCC - Former Foster Care Children [program]
FFCHE - Former Foster Care in Higher Education [program]
FMAP - Federal Medical Assistance Percentage
FPG - Federal Poverty Guideline
FPL – Federal Poverty Level
FQHC - Federally Qualified Health Center
FTAS - Failure to Attend School
FVA - Fund for Veterans' Assistance
GAD - Generalized Anxiety Disorder
GAF – Global Assessment of Functioning
GAO- U.S. General Accounting Office
GRO – General Residential Operations [facility]
HBA - Texas Homebuyer Assistance
HCBS - Home and Community-Based Services
HCBS-AMH - Home and Community-Based Services—Adult Mental Health [program]
HEDIS - Healthcare Effectiveness Data and Information Set
HHS- Health and Human Services
HHSC - Health and Human Services Commission
HHSP - Homeless Housing and Services Program
HIPP - Health Insurance Premium Payment [program]
HMO - Health Maintenance Program
HTC - Home Tax Credit [program]
HTF - Housing Trust Fund
HUD - U.S. Department of Housing and Urban Development
ICCD - International Center for Clubhouse Development
ICF - Intermediate Care Facility
IDD - intellectual and developmental disabilities
IDEA - Individuals with Disabilities Education Act
IEP – Individualized Education Plan
IFSP - Individualized Family Service Plan
IMD - Institution for Mental Disease
ISD - Independent School District
ISS - In-School Suspension
IST – Incompetent to Stand Trial
JJAEP - Juvenile Justice Alternative Education Program
JDTR - Jail Diversion and Trauma Recovery
LBB – Legislative Budget Board
LGTBQ – Lesbian, Gay, Transgender, Bisexual, Queer

LIHTC - Low Income Housing Tax Credit [program]
LMHA - Local Mental Health Authority
LOC – Level of Care
LSSP - Licensed Specialist in School Psychology
LTSS - Long-Term Services and Supports
MAYSI - Massachusetts Youth Screening Instrument
MCO- Managed Care Organization
MCOT - Mobile Crisis Outreach Team
MDCP - Medically Dependent Children Program
MDD - Major Depressive Disorder
MH – Mental Health
MHFA - Mental Health First Aid
MHPAEA - Mental Health Parity and Addiction Equity Act
MOU - Memorandum of Understanding
MRSA- Medicaid Rural Service Area
MTFCY - Medicaid for Transitioning Foster Care Youth
NAMI - National Alliance on Mental Illness
NCEC - Non-Categorical Early Childhood
NCTSN - National Child Traumatic Stress Network
NCTIC - National Center for Trauma Informed Care
NGRI - Not Guilty By Reason of Insanity
NNTY - National Network for Youth Transition
OCD - Obsessive-compulsive Disorder
OCR – Outpatient Competency Restoration
OIO - Office of the Independent Ombudsman
OSS - Out-of-School Suspension
PASRR – Pre-Admission Screening and Resident Review
PCP - Primary Care Physician
PE - PASRR Evaluation
PEI – Prevention and Early Intervention
PHA - Public Housing Agency
PHC - Primary Home Care
PPCD – Pre-school Program for Children with Disabilities
PPO – Preferred provider organization
PRA - Project Rental Assistance [demonstration program]
PRC - Prevention Resource Center
PSH - Permanent Supportive Housing
PTSD - Post-Traumatic Stress Disorder
RDM - Resiliency and Disease Management
RHP - Regional Healthcare Partnership
ROSC – Recovery- Oriented System of Care
RTC - Residential Treatment Center
SAMHSA - Substance Abuse and Mental Health Services Administration
SAPIT - Substance Abuse Prevention, Intervention, and Treatment
SED – Severe Emotional Disturbance
SEL - Social and Emotional Learning
SHAC - School Health Advisory Council
SHARS - School Health and Related Services
SMVF - Service Members, Veterans, and Family Members
SNAP - Supplemental Nutrition Assistance Program

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

Additional Resources

AGENCY WEBSITES

Texas Health and Human Services Commission (HHSC): https://hhs.texas.gov/

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

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

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

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

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

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

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

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

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

CERTIFIED PEER SPECIALISTS AND CERTIFIED RECOVERY COACHES

Carter Center, Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services http://www.pillarsofpeersupport.org/final%20%20PillarsofPeerSupportService%20Report.pdf

Centers for Medicaid and Medicare Services, Letter to state Medicaid directors regarding peer support services: www.magellanhealth.com/training2/peersupport/magellanmodule1/graphics/cms.pdf

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

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

Institute for Recovery and Community Integration: http://www.mhrecovery.org/home

Mental Health of America: http://www.mentalhealthamerica.net/peer-services

NAADAC (The Association for Addiction Professionals), Understanding the Role of Peer Recovery Coaches in the Additional Profession: www.naadac.org/understandingtheroleofpeerrecoverycoachesintheadditionprofession

National Academy for State Health Policy, Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness: http://nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf

National Coalition for Mental Health Recovery, Peer Support: Why It Works http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf

NCBI, Motivations of Persons with Psychiatric Disabilities to Work in Mental Health Peer Services: A Qualitative Study Using Self-Determination Theory: https://www.ncbi.nlm.nih.gov/pubmed/23576121

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

SoberHood: www.soberhood.org

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

CHILD WELFARE/CHILDREN'S MENTAL HEALTH

Bazelon Center for Mental Health Law: http://www.bazelon.org/Where-We-Stand/Success-for-All-Children.aspx

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

Child Welfare Information Gateway: https://www.childwelfare.gov/topics/system-wide/bhw/

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

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

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

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

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

Texas Network of Youth Services: http://tnoys.org/

CIVIL RIGHTS

American Civil Liberties Union of Texas: https://www.aclutx.org/

Disability Rights Texas: https://www.disabilityrightstx.org/

Judge David L. Bazelon Center for Mental Health Law: http://www.bazelon.org

CONSUMER AND FAMILY ORGANIZATIONS

Texas Catalyst for Empowerment: http://www.mytce.org/

Via Hope – Texas: http://www.viahope.org/

Prosumers of San Antonio: http://www.prosumersinternational.org/

Mental Health America: http://www.mentalhealthamerica.net/

Mental Health America – Texas: http://www.mhatexas.org/

National Alliance on Mental Illness: http://www.nami.org/

National Alliance on Mental Illness – Texas: http://www.namitexas.org/

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

CRIMINAL/JUVENILE JUSTICE AND MENTAL HEALTH

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

National Center for Mental Health and Juvenile Justice: http://www.ncmhjj.com

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation: http://gainscenter.samhsa.gov/

Texas Appleseed: https://www.texasappleseed.org/

Texas Criminal Justice Coalition: http://www.texascjc.org/

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

CULTURAL AND LINGUISTIC COMPETENCY

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

Hogg Foundation for Mental Health. Enhancing the delivery of health care: *Eliminating health disparities through a culturally and linguistically centered integrated health care approach*: http://muse.jhu.edu/article/545273

NAMI Multicultural Action Center: http://www2.nami.org/namiland09/MACmaterialslist.pdf

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

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

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

EARLY CHILDHOOD AND MENTAL HEALTH

TexProtects: http://www.texprotects.org/

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

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

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

GENERAL INFORMATION ON MENTAL HEALTH AND SUBSTANCE USE

Meadows Mental Health Policy Institute of Texas: http://www.texasstateofmind.org

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

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

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

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

Substance Use and Mental Health Services Administration, Center for Mental Health Services Uniform Reporting System & Client Level Data: http://www.nri-inc.org/#!urs-client-level-data/cz0l and https://www.healthypeople.gov/2020/data-source/uniform-reporting-system

HOUSING

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

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

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

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

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

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

INTEGRATED PHYSICAL AND MENTAL HEALTH CARE

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

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

Hogg Foundation for Mental Health: http://hogg.utexas.edu/what-we-do/integrated-health-care-2

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

National Council on Community Behavioral Health's Center for Integrated Solutions: http://www.thenationalcouncil.org/consulting-best-practices/center-for-integrated-health-solution/

INTELLECTUAL DISABILITY WITH CO-OCCURRING MENTAL HEALTH CONDITIONS

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

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

NCTSN and the Hogg Foundation for Mental Health, The Road to Recovery: Supporting Children with Intellectual Disabilities Who have Experienced Trauma toolkit (must create a free account to access the toolkit): http://learn.nctsn.org/enrol/index.php?id=370

Karyn Harvey, Positive Identity Development: An Alternative Treatment Approach for Individuals with Mild and Moderate Intellectual Disabilities (book) http://www.karynharvey.com/

Karyn Harvey, Trauma-informed Behavioral Interventions: What Works and What Doesn't (book) http://www.karynharvey.com/

Texas Advocates, a coalition of self-advocates throughout the state working to support one another: http://arctx.convio.net/site/PageServer?pagename=TXA_homepage

Mental Health Care for Adults with Intellectual and Developmental Disabilities toolkit: http://vkc.mc.vanderbilt.edu/etoolkit/mental-and-behavioral-health/

MENTAL HEALTH IN SCHOOLS

Center for Health and Health Care in Schools: http://www.healthinschools.org/

Communities in Schools (CIS) of Texas: http://www.cisoftexas.org/

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

Texas Education Agency: http://www.tea.state.tx.us/

Texas Education Service Centers (ESCs): http://www.tea.state.tx.us/regional_services/esc/

UCLA School Mental Health Project: http://smhp.psych.ucla.edu/

University of Maryland Technical Assistance Center on School Mental Health: http://csmh.umaryland.edu/

MENTAL HEALTH WORKFORCE DEVELOPMENT

SAMSHA, An Action Plan for Behavioral Health Workforce Development prepared by The Annapolis Coalition: http://annapoliscoalition.org/?portfolio=action-plan-on-the-behavioral-health-workforce

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

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

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

PROMOTORES(AS)

Migrant Health Promotion Training and Support for Promotores/Promotoras: http://www.migranthealth.org/index.php?option=com_content&view=article&id=67&Itemid=65

Promotoras in Mental Health: A Literary Review: https://www.ncbi.nlm.nih.gov/pubmed/22367256

USA Center for Rural Public Health Preparedness: http://www.usacenter.org/

RECOVERY AND WELLNESS

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

National Council on Alcoholism and Drug Dependence, Inc.: https://www.ncadd.org/

Recovery Innovations: http://riinternational.com/

SAMHSA- Recovery and Recovery Support: http://www.samhsa.gov/recovery

Texas Department of State Health Services, Recovery-oriented systems of care (ROSC): https://www.dshs.state.tx.us/substance-abuse/ROSC/

Via Hope Recovery Institute: http://www.viahope.org/programs/recovery-institute

Recovery Support Center, Houston: http://wellnessandrecovery.org/recovery-coaching.html

Association of Recovery Community Organizations: http://www.facesandvoicesofrecovery.org/who/arco

Recovery Community Organization toolkit: http://www.facesandvoicesofrecovery.org/sites/default/files/resources/7.13.15%20FINAL%20Recovery%20Community%20Organization%20Toolkit.pdf

SUICIDE PREVENTION

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

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

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

Texas Suicide Prevention: http://www.texassuicideprevention.org/

Texas Suicide Prevention Resource Center: http://www.sprc.org/states/texas

Texas Department of State Health Services, Texas Suicide Prevention: http://www.dshs.state.tx.us/mhsa/suicide/Suicide-Prevention.aspx

TELEMEDICINE AND TELEHEALTH

American Telemedicine Association: http://www.americantelemed.org/

University of Colorado Denver Telemental Health Guide: http://www.tmhguide.org/

VETERANS SERVICES

Make the Connection: Share experiences and supports for veterans: http://makethe-connection.net/

Military Veteran Peer Network: http://www.milvetpeer.net/

Texas Veterans Commission: http://www.tvc.texas.gov/

TexVet: www.texvet.org

US. Department of Veterans Affairs: http://www.va.gov/

Glossary: Common Behavioral Health Terms

1115 Waiver: A waiver under section 1115 of Social Security Act that allows CMS and states more flexibility in designing programs to ensure delivery of Medicaid services.

Acute: Refers to a disease or condition that develops rapidly and is intense and of short duration.

Adjudication: Is a finding that a youth has engaged in delinquent conduct or "conduct in need of supervision." It is similar to a "conviction" in adult court.

Affect: Feeling or emotion, especially as manifested by facial expression or body language.

Affordable housing: Housing units that are affordable for people who have an income below the median family income of a specific area. Affordable is often considered to be 30% or less of a person's monthly income.

Alternative therapy: Mental health care that is used instead of or in addition to conventional mental health services.

Anxiety: A sense of fear, nervousness, and apprehension about something.

Anxiety disorders: A group of chronic disorders ranging from feelings of uneasiness to immobilizing bouts of terror. Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder.

Behavioral health care: Continuum of services for individuals at risk of, or currently living with, one or more mental health conditions, substance use disorders or other behavioral health disorders.

Behavioral therapy: Therapy focusing on changing unwanted behaviors through rewards, reinforcements and desensitization. Desensitization, or exposure therapy, is a process of confronting something that arouses anxiety, discomfort or fear and overcoming the unwanted responses.

Biomedical treatment: Treatment involving medication. The kind of medication a psychiatrist prescribes varies with the disorder and the individual being treated; also referred to as psychopharmachology.

Bipolar disorder: A mood disorder in which a person alternates between episodes of major depression and mania.

Boarding home: A business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the owner.

Capitated: Relating to, participating in, or being a health-care system in which a medical provider is given a set fee per patient (as by an HMO) regardless of treatment required.

Caregiver: A person who has special training to help people with mental health conditions. Caregivers can be, but are not required to be, mental health professionals. Caregivers may include social workers, teachers, psychologists, psychiatrists, family members and mentors.

Case manager: An individual who organizes and coordinates services and supports for persons with mental health needs and their families. [Also service coordinator, advocate and facilitator.]

Centers for Medicare and Medicaid Services (CMS): The U.S. federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Certified Family Partner (CFP): Individuals with experience parenting a child with mental, emotional or behavioral health disorders and have had personal involvement with the public mental health system and have received approved training and passed a certification exam. A family partner provides information and support to other parents in similar circumstances.

Certified Peer Recovery Coach - Peer Recovery Support Specialists are individuals who are in recovery from substance use or co-occurring mental health disorders. Their life experiences and recovery allow them to provide recovery support in such way that others can benefit from their experiences. Certified peer recovery coaches have received approved training and have passed a certification exam.

Certified Peer Specialist (CPS): Individuals whose personal experience and struggles with mental illness or substance use enables them to provide assistance and recovery support to other people with similar diagnoses. Certified peer specialists have received approved training and have passed a certification exam.

Children's Health Insurance Program (CHIP): CHIP was created in 1997 under Title XXI of the Social Security Act. As with Medicaid, CHIP is jointly funded by the state and federal governments and is available for children aged 0–19 with income up to 200 percent of the federal poverty level so that low-income children can have access to health care, including inpatient and outpatient mental health and substance use services.

Chronic: Refers to a disease or condition that persists over a long period of time.

Cognitive therapy: Aims to identify and modify distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or self-destructive.

Cognitive behavioral therapy (CBT): A combination of cognitive and behavioral therapies that help people identify and modify maladaptive thought patterns, beliefs, and behaviors. Counseling is intended to be brief, time-limited and focused.

Conduct in need of supervision (CINS): Generally conduct committed by a minor that, if committed by an adult, could result in only a fine, or conduct that is not a violation if committed by an adult, such as truancy or running away from home.

Consumer: A person who is obtaining, or has obtained, conventional or alternative treatment or support for a mental health condition.

Consumer-operated service providers: Independent organizations operated and governed by individuals in recovery that deliver services through subcontracts with Local Mental Health Authorities (LMHAs), such as peer support, outreach, education and advocacy. A fundamental component of COSPs is peer support.

Crisis: A situation in which, due to a mental health condition, an individual presents an immediate danger to self or others or is at risk of serious deterioration of mental or physical health, or a situation in which an individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.

Crisis intervention services: Interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of an individual to a more restrictive environment. This service may be delivered to anyone experiencing a mental health crisis. This service does not require prior authorization.

Cyclothymia: A mood disorder characterized by periods of mild depression followed by periods of normal or slightly elevated mood.

DSM-V (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition): A book published by the American Psychiatric Association that gives general descriptions and characteristic symptoms of different mental illnesses. Physicians and other mental health professionals use the DSM-V to confirm diagnoses for mental illnesses.

DM-ID (Diagnostic Manual – Intellectual Disability): A textbook of diagnoses of mental disorders in persons with intellectual disabilities. This manual was developed cooperatively by the National Association of the Dually-Diagnosed and the American Psychiatric Association.

Day treatment: Treatment including special education, counseling, parent training, vocational training, skill building, crisis intervention and recreational therapy for at least 4 hours a day.

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured company) begins to pay its contract share. Often insurance plans are based on yearly deductible amounts.

Delusion: An idiosyncratic belief or impression that is maintained despite being contradicted by what is generally accepted as reality.

Developmental disability: a severe, chronic disability of an individual that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is manifested before the individual attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (e) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

Disease: An impairment of health or functioning often characterized by physical findings and specific symptoms that are common among a number of individuals who ultimately receive a diagnosis of the disease in question.

Disorder: An interruption of the normal structure or function of the body or mind that is manifested by a characteristic set of physical findings or specific symptoms.

Disproportionality: Overrepresentation of a particular group of people in a particular group or system.

Dose: A quantity to be administered at one time, such as a specified amount of medication.

Dually diagnosed: This term refers to an individual who has co-occurring conditions. The term is often used when an individual has both a substance use disorder and a mental health condition, or an individual living with one or more developmental or intellectual disabilities and a substance use disorder or mental health condition.

Dysthymic disorder: A mood disorder characterized by feelings of sadness, loss of interest or pleasure in usual activities, and some or all of the following: altered appetite, disturbed sleep patterns, lack of energy, decreased ability to concentrate and feelings of hopelessness. Symptoms are less severe than those of major depressive disorder.

Exclusionary discipline: Disciplinary practices in schools that remove students from the classroom.

Electroconvulsive therapy (ECT): A highly controversial technique using electrical stimulation of the brain to treat some forms of major depression, acute mania and some forms of schizophrenia.

Employee assistance plan (EAP): Resources provided by employers either as part of, or separate from, employer-sponsored health plans. EAPs typically provide preventive care measures, various health care screenings and wellness activities.

Euthymia: Mood in the "normal" range, without manic or depressive symptoms.

Evidence-based practices (EBP): Integration of best research evidence, clinical experience, and patient values.

Food and Drug Administration (FDA): A federal agency whose responsibilities include protecting the public health by assuring the safety, efficacy, and security of prescription and over-the-counter drugs.

Forensic commitment: Patients on a forensic commitment fall into one of the following two categories: 1) the patient has been admitted to a hospital by judicial order because they have been determined not to have the capacity to stand trial, or 2) the patient has been determined to be not guilty by reason of insanity (NGRI).

Generalized anxiety disorder (GAD): An anxiety disorder characterized by consistent feelings of anxiety for a period of at least six months and accompanied by symptoms such as fatigue, restlessness, irritability and sleep disturbance.

Generic: Drugs that do not have a brand name but are typically required to be equivalent to a brand-name counterpart, with the same active ingredients, strength and dosage form and have the same medical effect. Some drugs are protected by patents and supplied by only one company. When the patent expires, other manufacturers can produce its generic version.

Genetic: Inherited; passed from parents to offspring through genes.

Group-model health maintenance organization (HMO): A health care model involving contracts with physicians organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

Group therapy: Therapy involving groups of usually 4 to 12 people who have similar experiences and who meet regularly with a mental health professional. The mental health professional uses the emotional interactions of the group's members to help them get relief from distress and possibly modify their behavior.

HMO (health maintenance organization): A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.

Halfway house: A residential center or home where drug users, sex offenders, persons with mental illness, or individuals convicted of a felony are placed immediately after their release from a primary institution such as a prison, hospital or rehabilitation facility. The purpose of a halfway house is to allow the persons to begin the process of reintegration with society, while still providing monitoring and support; this is generally believed to reduce the risk of recidivism or relapse when compared to a release directly into society.

Hallucination: The perception of something, such as a sound or visual image, that is not actually present.

Health and Human Services (HHS) Enterprise: refers to state agencies under the Health and Human Services Commission (HHSC), including the Texas Department of State Health Services (DSHS), Texas Department of Family Protective Services (DFPS), Texas Department of Aging and Disability Services (DADS) and Texas Department of Assistive and Rehabilitative Services (DARS).

Health Insurance Marketplace: The Health Insurance Marketplace, also called the health exchange, was developed as a result of the Affordable Care Act and is accessible online. It allows a person to shop and enroll for a health plan. The Health Insurance Marketplace also lets you compare prices, coverage levels, and other details for health insurance plans.

Health Homes: Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. Health Home providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Home and Community Based Services (HCBS): provides opportunities for Medicaid beneficiaries to receive services in their own home or community with the goal of preventing institutionalization.

Homeless (USC 42 §11302(a)): An individual who lacks a fixed, regular, and adequate nighttime residence.

Housing cost burden: A housing cost burden exists when a household pays more than 30 percent of its total income before taxes and deductions toward housing.

Housing first: An approach that offers permanent, affordable housing as quickly as possible for individuals and families experiencing homelessness, and then provides the supportive services and connections to the community-based supports people needed to keep their housing and avoid returning to homelessness.

Inpatient care: The term refers to medical treatment that is provided in a hospital or other facility and requires at least one overnight stay.

Intermediate Care Facilities (ICF-IDD): Intermediate care facility/ developmentally disabled is a facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to developmentally disabled clients whose primary need is for developmental services and who may have a recurring but intermittent need for skilled nursing services.

Individualized Education Plan (IEP): A plan developed that specifies the behavioral supports and interventions to be provided by the school district for the students who receive special education services.

Integrated health care: The systematic coordination of primary and behavioral health services addressing the needs of the whole person.

Juvenile defendant: A person who is at least 10 years old but not yet 17 at the time he or she committed an act defined as "delinquent conduct" or "conduct in need of supervision."

Local Mental Health Authorities (LMHAs): Also known as community mental health centers, LMHAs provide services to a specific geographic area of the state, called the local service area. LMHAs are required by the state to plan, develop policy, coordinate, allocate and develop resources for mental health services in the local service area.

Long-Term Services and Supports (LTSS): May be provided in institutional settings or through community-based services. This may include assistance with activities of daily living, such as getting dressed, taking medication, preparing meals, habilitation, attendant care, specialized therapies, respite, managing money and more.

Major Depressive Disorder (MDD): A mood disorder characterized by intense feelings of sadness and hopelessness that persist beyond a few weeks.

Mania: Feelings of intense mental and physical hyperactivity, elevated mood and agitation.

Manic-depression: See bipolar disorder.

Managed care: An organized system for delivering comprehensive health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment. Generally, managed care controls health care costs and discourages unnecessary hospitalization and overuse of specialists. The health plan operates under contract to a payer.

Managed care organizations (MCOs): An organization that combines the functions of health insurance, delivery of care and administration. Services are available primarily through a network of providers contracting with the MCO.

Medicaid: A federal-state funded health insurance assistance program for low-income children and families and people with disabilities.

Medicare: A federal insurance program serving individuals with disabilities and persons over the age of 65. Most costs are paid via trust funds that beneficiaries pay into over the courses of their lives; small deductibles and co-payments are required.

Medication training and support services: Includes education on diagnosis, medications, monitoring and management of symptoms, and side effects.

Medically indigent: an individual who: (1) possesses no property; (2) has no person legally responsible for the patient's support; and (3) is unable to reimburse the state for the costs of the patient's support, maintenance and treatment.

Medication therapy: Prescription, administration, and assessment of drug effectiveness and monitoring of potential side effects of psychotropic medications.

Mental health: A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health prevention: A proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

Mental health professionals: A mental health professional is a health care practitioner who offers services for the purpose of improving an individual's mental health or to treat mental health conditions. This broad category includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, mental health counselors, professional counselors, peer professionals, pharmacists and many other professionals.

Mental health condition: A health condition that disrupts a person's thinking, feelings, mood, ability to relate to others or daily functioning and causes the person distress.

Mental Health First Aid (MHFA): An in-person training to learn about mental illnesses and addictions, including risk factors and warning signs. The training also offers strategies on how to support individuals experiencing a mental health crisis.

Mood disorders: Disorders in which the essential feature is a disturbance of mood manifested as one or more episodes of mania, hypomania, depression, or some combination of bipolar I and bipolar II disorders, cyclothymic disorder, major depressive disorder and dysthymic disorder.

Mood stabilizer: Lithium and/or an anticonvulsant for treatment of bipolar disorder, often combined with an antidepressant.

Neurotransmitters: Chemicals that transmit information from one neuron to another by crossing the space between two adjacent neurons.

NorthSTAR: a publicly funded managed care approach to the delivery of behavioral health services to the eligible residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties. This service delivery model is referred to as a "carve-out," as behavioral health services are provided through a behavioral health managed care organization and is not integrated with primary care services.

Obsessive-compulsive disorder (OCD): An anxiety disorder characterized by recurrent thoughts, feelings, ideas or sensations (obsessions) or repetitive, ritualized behaviors (compulsions).

Outcome measure: A measure that identifies the results or impact that services, interventions and supports have on the individuals or communities.

Outpatient care: Health care that does not require an overnight stay in a hospital or health care facility.

Panic disorder: An anxiety disorder in which people have feelings of terror, rapid heartbeat and rapid breathing that strike suddenly and repeatedly without reasonable cause.

Patient Protection and Affordable Care Act (ACA): A United States federal statute established in March 23, 2010 that is characterized as the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Permanent supportive housing: An evidence-based practice that combines stable and affordable living arrangements with access to flexible health and human services designed to promote recovery for people with behavioral health conditions.

Pharmacological management services: Includes supervision of administration of medication, monitoring of effects and side effects of medication, and assessment of symptoms. Includes one psychiatric evaluation per year.

Phobia: An intense or irrational fear of something. Examples of phobias include fear of closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs and injuries involving blood.

Post-Traumatic Stress Disorder (PTSD): A mental health condition that is triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.

Primary care physician (PCP): The PCP is responsible for monitoring an individual's overall medical care and referring the individual to more specialized physicians for additional care. Typically PCPs are included in the following specialties: group practice, family practice, internal medicine, obstetrics/gynecology and pediatrics.

Promising practice: A prevention or treatment intervention that shows positive outcomes but does not have the same level of rigorous scientific evaluation as evidenced-based practice.

Psychiatric/psychotherapeutic/psychotropic medications: Medications capable of affecting the mind, emotions and behavior that are used to treat or manage a psychiatric symptom or challenging behavior.

Psychiatrist: A medical doctor who specializes in the diagnosis, treatment and prevention of mental illness.

Psychologist: A health care professional who diagnoses and treats mental, nervous, emotional and behavioral conditions.

Psychosis: A severe mental health condition in which thought and emotions are so impaired that a person loses contact with external reality.

Psychotherapy: A treatment method for mental health concerns in which a mental health professional and a consumer discuss needs and feelings to find solutions. Psychotherapy can help individuals change their thought or behavior patterns and understand how past experiences affect current behaviors.

Public Housing Agency (PHA): A governmental entity that is responsible for the operation of subsidized housing and rental assistance programs.

Rapid cycling: Experiencing changes in mood from mania to major depression, or mixed states, within hours, days or months.

Receptor: A molecule that recognizes specific chemicals, including neurotransmitters and hormones, and transmits the message into the cell on which the receptor resides.

Recidivism: The tendency to relapse into a previous type of behavior.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Rehabilitative case management: A form of service that provides a variable level of integrated support to people including assistance in accessing medical, social, psychological, educational and other appropriate support services. Where routine case management is similar to basic service coordination and has higher caseloads, rehabilitative case management is similar to the Medicaid service of targeted case management.

Relapse: The reoccurrence of symptoms of a disease; a deterioration in health after a temporary improvement.

Rental assistance: Rental assistance funds help tenants with low incomes afford rent at or near market rate for specified housing units. Typically, rental assistance funds allow eligible tenants to pay approximately 30 percent of their income toward rent. A subsidy pays the difference between that amount and the market rent for the specific unit.

Residential treatment: Behavioral health services provided at a residential health care facility.

Routine case management: A form of service that includes basic facilitation of access to resources and services and coordination of services with the individual, as well as administration of instruments to assess treatment progress.

Seclusion and Restraint: Techniques used by administrators and staff to isolate (seclude) or restrict (restrain) movement of individuals. Restraints may be physical, mechanical, or chemical.

Serotonin: A neurotransmitter that most likely contributes to the regulation of sleep, appetite and mood. People experiencing depression or anxiety often have a serotonin deficiency.

Signs: Indications of illness that are observed by the examiner rather than reported by the individual.

Skilled Nursing Facility: Licensed healthcare facility that serves chronically ill, usually elderly patients, and provides long-term nursing care, rehabilitation, and other services.

Social Security Disability Insurance (SSDI): A federal supplemental income for individuals or their family members who have a disability, have worked in a job covered by Social Security, and have paid enough money into the Social Security program. SSDI is funded by Social Security taxes.

Social Security Income (SSI): A federal supplemental income funded by general tax revenue, not Social Security taxes. SSI is for people with limited income and who have a qualifying disability or are over 65.

Serious Emotional Disturbance (SED): A group of psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

State hospital: A hospital run by the state for the care and treatment of patients affected with acute or chronic mental illness; also called a mental health hospital or a state psychiatric facility.

State Supported Living Center (SSLC): Large institutions that provide 24-hour residential services to people with intellectual and developmental disabilities; formerly called state schools.

Stigma: A negative stereotype about a group of people.

Supported employment: A service that provides individualized assistance in choosing and obtaining employment at integrated work sites in the community of the consumer's choice. It includes supports provided by identified staff that will assist individuals in keeping employment and finding another job as necessary. This may include the services of a job coach to support the individual at the job site.

Symptom: An indication of a disease or other disorder experienced by the patient

Syndrome: A collection of physical signs and symptoms that, when occurring together, are characteristic of a specific condition.

System of Care: An organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated community-based services for youth with a serious emotional disturbance and their families

Substance use disorder: A medical condition that includes the abuse or dependence on alcohol or drugs.

Sunset review: The Sunset Advisory Council's periodic evaluation of state agencies in order to determine whether an agency's functions are still needed and whether it operates efficiently and effectively.

Telemedicine/Telehealth: The use of technology to deliver health care services.

Trauma: Occurs from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

Trauma-informed approach: Treatment interventions that specifically addresses the consequences of trauma on an individual and are designed to facilitate healing. A trauma-informed approach has the following principles: safety, trustworthiness, peer support, collaboration and mutuality, empowerment, voice, and choice. Trauma-informed support should also consider cultural, historical, and gender issues.

Traumatic Brain Injury (TBI): Caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain.

Third-party payer: A public or private organization that is responsible for the health care expenses of another entity.

Veteran: Somebody formerly in the armed forces.

Vocational rehabilitation services: Services that include job finding, development, assessment and enhancement of work-related skills, as well as provision of job experience to individuals.

Sources:

Institute of Medicine

National Institute of Mental Health

U.S. Dept. of Health and Human Services

Substance Abuse Mental Health Services Administration (SAMHSA)

Texas Resilience and Recovery

Various medical dictionaries

Advisory Committees

TEXAS HEALTH AND HUMAN SERVICES COMMISSION (HHSC)

Advisory Committee on Qualifications for Health Care Translators and Interpreters:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/advisory-committee-qualifications-health-care-translators-and-interpreters

- Advises on various items related to qualifications for health care interpreters and translators.

Aging and Disability Resource Center Advisory Committee (ADRCAC):
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/adrc-advisory-committee

- Assists in developing and implementing an ADRC program in Texas to include program and policy development, designing and operating ADRCs, and obtaining stakeholder input.

Aging Texas Well Advisory Committee:
https://hhs.texas.gov/about-hhs/community-engagement/age-well-live-well/aging-texas-well

- Advises the department and makes recommendations to state leadership on implementation of the Aging Texas Well Initiative.

Behavioral Health Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/behavioral-health-advisory-committee

- Provides customer/consumer and stakeholder input by making recommendations regarding the allocation and adequacy of behavioral health services and programs within the state of Texas.

Behavioral Health Integration Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/behavioral-health-integration-advisory-committee

- Charged with addressing initial planning and development needed to integrate Medicaid behavioral health services into managed care by September 1, 2014. Phase II recommendations will address systemic changes needed to create a truly integrated system.

Board for Evaluation of Interpreters (BEI):
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/board-evaluation-interpreters-bei

- Ensures that prospective interpreters are proficient in their ability to meaningfully and accurately comprehend, produce, and transform ASL to and from English.

Children's Policy Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/childrens-policy-council

- Helps in developing, implementing, and administering family support policies and related long-term care and health programs for children. Develops recommendations for the legislature and executive commissioner.

Consumer Direction Workgroup:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/texas-council-consumer-direction

- Advises HHSC on the development, implementation, expansion, and delivery of services through consumer direction, in all programs offering long-term services and supports that enhance a consumer's ability to have freedom and exercise control and authority over the consumer's choices, regardless of age or disability.

Council on Children and Families:
https://hhs.texas.gov/about-hhs/council-children-and-families

- Established during the 2009 legislative session to help improve the coordination of state services for children.

Drug Utilization Review Board:
http://www.txvendordrug.com/advisory/index.shtml

- Develops and submits recommendations for the preferred drug list, suggests clinical prior authorizations on outpatient prescription drugs, recommends education interventions for Medicaid providers, and reviews drug usage across Medicaid programs.

Early Childhood Intervention Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/eci-advisory-committee

- Advises the DARS Division for Early Childhood Intervention Services on development and implementation of policies that constitute the statewide ECI system.

Employment First Task Force:
https://hhs.texas.gov/services/disability/employment/employment-first/employment-first-task-force

- Promotes competitive employment for people with disabilities and sets the expectation that individuals with disabilities are able to meet the same employment standards, responsibilities, and expectations as other working adults.

Executive Waiver Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/1115-waiver-rules-and-workgroups

- Provides with feedback on the hospital finance component of the 1115 Waiver.

Foster Care Redesign Public Private Partnership:
https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/Foster_Care_Redesign/public-private.asp

- Charged by DFPS in 2010 to serve as the guiding body for the development of recommendations for a redesigned foster care system. Includes members of the judiciary, foster care providers, advocates, provider associations, foster care alumni, a DFPS Advisory Council member, and DFPS executive staff.

Governor's Emergency Medical Services (EMS) and Trauma Advisory Council:
https://www.dshs.texas.gov/emstraumasystems/governor.shtm

- Promotes, develops and maintains a comprehensive EMS/Trauma System that will meet the needs of all patients and that will raise the standards for community health care by implementing innovative techniques and systems for the delivery of emergency care for the entire population.

Health Information Exchange System:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/electronic-health-information-exchange-system-advisory-committee

- Advises about the development and implementation of an electronic health information exchange system to improve the quality, safety and efficiency of health care services provided through Medicaid and the Children's Health Insurance Program (CHIP).

Hospital Payment Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/hospital-payment-advisory-committee

- Advises HHSC to ensure reasonable, adequate, and equitable payments to hospital providers and to address the essential role of rural hospitals.

Intellectual and Developmental Disability System Redesign Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/intellectual-and-developmental-disability-system-redesign-advisory-committee

- Advises HHSC and DADS on the implementation of the acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities.

Interagency Obesity Council:
https://www.dshs.texas.gov/CWWObesityInteragencyCouncil/

- Monitors and evaluates obesity prevention efforts in the state of Texas for children and adults.

Maternity Mortality and Morbidity Task Force:
https://www.dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm

- Studies maternal mortality and morbidity by studying and reviewing cases of pregnancy-related deaths and trends in severe maternal morbidity, determining the feasibility of the task force studying cases of severe maternal morbidity, and recommending ways to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

Medicaid and CHIP Regional Advisory Committees:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/medicaid-and-chip-regional-advisory-committees

- Accepts public input on Medicaid and CHIP and provides recommendations on the program to HHSC.

Medicaid/CHIP Quality-Based Payment Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/medicaidchip-quality-based-payment-advisory-committee

- Advises HHSC on Medicaid and CHIP reimbursement systems, standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability of managed care organizations, health care providers and facilities.

Medical Advisory Board:
https://dshs.texas.gov/medical-advisory-board/

- Helps reduce traffic deaths, disability and injury by evaluating medical histories, providing medical opinions and making recommendations to the Texas Department of Public Safety regarding the medical limitations of referred driver licensees and candidates and concealed handgun licensees and candidates.

Medical Care Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/medical-care-advisory-committee

- Federally mandated to review and make recommendations to state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs.

Newborn Screening Advisory Committee:
https://www.dshs.texas.gov/newborn/NBSAdvComm.aspx

- Advises on strategic planning, policy, rules and services related to newborn screening and additional newborn screening tests.

Nursing Facility Administrators Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/nursing-facility-administrator-advisory-committee

- Provides recommendations for licensure sanctions and rule changes for the Nursing Facility Administrator Licensing Program.

Palliative Care Interdisciplinary Advisory Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/palliative-care-interdisciplinary-advisory-council

- Consults with and advises on matters related to the establishment, maintenance, operation and outcome evaluation of the statewide palliative care consumer and professional information and education program.

Perinatal Advisory Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/perinatal-advisory-council

- Develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation and a process for the assignment of levels of care to a hospital, makes recommendations for dividing the state into neonatal and maternal care regions, examines utilization trends in neonatal and maternal care, and recommends ways to improve neonatal and maternal outcomes.

Physician Payment Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/physician-payment-advisory-committee

- Functions as a subcommittee of the Medical Care Advisory Committee to advise the committee and HHSC about technical issues regarding physician payment policies.

Preparedness Coordinating Council:
(No website available at print date)

- Advises DSHS on activities regarding preparedness, training, planning, communications, and emergency response to public health and medical emergencies.

Promotor(a) or Community Health Worker Training and Certification Advisory Committee:
(No website available at print date)

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

Promoting Independence Advisory Committee (PIAC): http://www.dads.state.tx.us/providers/pi/piac/

- Advises in the development of a comprehensive, effectively working plan to ensure appropriate care settings for persons with disabilities. Created in response to the U.S. Supreme Court's *Olmstead* Decision.

Public Health Funding and Policy Committee
http://dshs.texas.gov/phfpcommittee/default.aspx

- Defines core public health services a local health entity should provide in a county or municipality; evaluates public health in the state and identifies initiatives for areas that need improvement; identifies funding sources available to local health entities; and establishes public health policy priorities.

SB 1220 Medicaid and CHIP Border Rates and Expenditures Advisory Committee: https://hhs.texas.gov/about-hhs/leadership/advisory-committees/s-b-1220-medicaid-and-chip-border-rates-and-expenditures-advisory-committee

- Advises HHSC regarding eliminating the disparities between the Texas-Mexico border region and other areas of the state in capitation rates, fee-for-service per capita expenditures and total professional services expenditures for Medicaid and CHIP enrollees under age 19.

STAR Kids Managed Care Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/star-kids-managed-care-advisory-committee

- Advises on the development and implementation of the STAR Kids Medicaid managed care program.

State Child Fatality Review Committee:
https://www.dshs.texas.gov/mch/child_fatality_review.shtm

- Looks to reduce preventable child deaths by understanding the causes and incidences of child deaths, identifying procedures to reduce the number of preventable deaths, and promoting public awareness.

State Independent Living Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/state-independent-living-council

- Leads, promotes, and advances the independent living philosophy and advocates for the rights of people with disabilities.

State Medicaid Managed Care Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/state-medicaid-managed-care-advisory-committee

- Provides recommendations and ongoing input on the statewide implementation and operation of Medicaid managed care.

State Preventive Health Advisory Committee:
(No website available at print date)

- Works with HHS to develop and implement the state plan for the Preventive Health and Health Services Block Grant.

Statewide Advisory Coalition for Addressing Disproportionality and Disparities
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/state-advisory-coalition-addressing-disproportionality-and-disparities

- Address disproportionality and disparities in Texas by addressing racial disproportionality and disparities.

Statewide Health Coordinating Council
http://www.dshs.texas.gov/chs/shcc/

- Ensures health care services and facilities are available to all Texans through health planning activities.

Stroke Committee (Subcommittee of the Governor's EMS and Trauma Advisory Council):
(No website available at print date)

- Assists Governor's EMS & Trauma Advisory Council in the development of a statewide stroke emergency transport plan and stroke facility criteria.

Task Force for Children with Special Needs:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/task-force-children-special-needs

- Charged with developing a comprehensive five-year strategic plan to address the needs of children with chronic illnesses, intellectual or other developmental disabilities or serious mental illness.

Task Force on Domestic Violence:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/task-force-domestic-violence

- Created during 2013 Texas legislative session to examine the effect of domestic violence on the health of mothers and children and ways to improve health services for domestic violence victims.

Telemedicine/Telehealth Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/telemedicine-and-telehealth-advisory-committee

- State-mandated advisory committee assists HHSC to evaluate reimburseable services and delivery processes, as well as monitor type of programs receiving these services.

Texas Brain Injury Advisory Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/texas-brain-injury-advisory-council

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

Texas Center for Nursing Workforce Studies Advisory Committee:
http://www.dshs.texas.gov/chs/cnws/default.shtm

- Serves as a resource for data and research on the nursing workforce in Texas.

Texas Council on Alzheimer's Disease and Related Disorders:
https://www.dshs.texas.gov/alzheimers/meetings.shtm

Texas Council on Autism and Pervasive Developmental Disorders:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/texas-council-autism-and-pervasive-developmental-disorders

- Advises and makes recommendations to state agencies and the state Legislature to ensure that the needs of persons of all ages with autism and other pervasive developmental disorders and their families are addressed and that all available resources are coordinated to meet those needs.

Texas Council on Cardiovascular Disease and Stroke:
https://www.dshs.texas.gov/heart/Texas-Council-on-Cardiovascular-Disease-and-Stroke.aspx

- Conducts health education, public awareness and community outreach; improves access to treatment; coordinates activities among state agencies; develops a database of recommendations for treatment and care.

Texas Council on Consumer Direction:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/texas-council-consumer-direction

- Advises on the development, implementation, expansion, and delivery of services through consumer direction, in all programs offering long-term services and supports that enhance a consumer's ability to have freedom and exercise control and authority over the consumer's choices, regardless of age or disability.

Texas Diabetes Council:
http://www.dshs.texas.gov/diabetes/

- Addresses issues affecting people with diabetes in Texas and advises the Texas Legislature on legislation that is needed to develop and maintain a statewide system of quality education services for all people with diabetes and health care professionals who offer diabetes treatment and education.

Texas HIV Medication Advisory Council:
https://www.dshs.texas.gov/hivstd/meds/advise.shtm

Texas Nonprofit Council:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/texas-nonprofit-council

- Helps direct the work of the Interagency Coordinating Group and provides guidance on faith-based and community-based initiatives.

Texas Radiation Advisory Board:
https://www.dshs.texas.gov/trab/

- Reviews and evaluates state radiation policies, programs, and proposed rules. The board also makes recommendations and provides technical advice that may be required on matters relating to development, use, and regulation of sources of radiation.

Texas Respite Advisory Committee:
https://www.dads.state.tx.us/taketimetexas/about.html#committee

- Helps develop strategies to reduce barriers to access respite services, improves the quality of respite services, and provides training, education and support to family caregivers.

Texas School Health Advisory Committee:
https://www.dshs.texas.gov/schoolhealth/shadvise.shtm

- Provides active leadership in the identification and dissemination of school health best practices and resources for school policy makers.

Texas System of Care Consortium:
http://www.txsystemofcare.org/

- Helps Texas achieve well-being for children and youth.

Tobacco Settlement Permanent Trust Account Administration Advisory Committee:
http://www.dshs.texas.gov/tobaccosettlement/advcom.shtm

- Reviews the results of audit, disputes and rules regarding the state's tobacco settlement.

Toxic Substances Coordinating Committee:
http://www.tscc.state.tx.us/

- Protects and promotes the health and environment of Texas through the prevention and control of adverse health and environmental effects related to toxic substances and harmful agents.

Women's Health Advisory Committee:
https://hhs.texas.gov/about-hhs/leadership/advisory-committees/womens-health-advisory-committee

- Advises on women's health programs.

Youth Camp Advisory Committee:
http://www.dshs.texas.gov/youthcamp/advisory-committee.aspx

- Provides advice on the development of standards, procedures, and rules to implement the Youth Camp Act.

Note: All advisory committee information printed above was retrieved from the HHSC Advisory Committee page before or on October 13, 2016.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Advisory Committee on Promoting Adoption of Minority Children:
(No website available at print date)

- Advises DFPS on policies and practices that affect the licensing and recruitment of families for minority children awaiting adoption. Charged with studying, developing, and evaluating programs and projects relating to community awareness and education, family support, counseling, parenting skills and education, and reform of the child welfare system.

Foster Care Redesign Public Private Partnership
https://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/Foster_Care_Redesign/public-private.asp

- Charged by DFPS in 2010 to serve as the guiding body for the development of recommendations for a redesigned foster care system. Includes members of the judiciary, foster care providers, advocates, provider associations, foster care alumni, a DFPS Advisory Council member, and DFPS executive staff.

Committee on Advancing Residential Practices:
(No website available at print date)

- Residential Child Care Contractors, stakeholder associations, and DFPS representatives meet to improve communication and provide a venue for focusing on enhancements to the system that support increased safety, permanency, and well-being for children.

Statewide Parent Collaboration Group:
https://www.dfps.state.tx.us/Child_Protection/Family_Support/pcb.asp

- Allows input from biological parents in the design, implementation, and evaluation of the Child Protective Services program.

Youth Leadership Council:
(No website available at print date)

- Seeks youth input on new policies and programs being developed by DFPS, allows foster youth to discuss issues of concern and generate potential solutions to improve foster care, and imparts advocacy skills.

Note: All advisory committee information printed above was retrieved from the DFPS website before or on October 17, 2016.

Mission

The Hogg Foundation for Mental Health advances mental wellness for the people of Texas as an impactful grantmaker and catalyst for change.

Hogg Foundation
for Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

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