



Task Force established
by the Texas
Commission on Jail
Standards

DETENTION OF PERSONS WITH IDD

Comprehensive Study, as directed by HB 3116, for persons being housed in
Texas Jails with Intellectual and Developmental Disabilities



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Introduction and Background

A comprehensive study on best practice standards for the detention of persons with intellectual and developmental disabilities as mandated by HB3116

During the 86th Regular Session, State Representative James White, introduced House Bill 3116 which would require a comprehensive study on best practice standards for the detention of a person with an intellectual or developmental disability. As Chairman of the House Committee on Corrections, Chairman White was well versed in the responsibilities of safely detaining an individual and the additional challenges associated with inmates diagnosed with a mental health issue or intellectual or developmental disability. In a clear statement of the need for this effort, the Bill Analysis for HB 3116 notes, people with IDD are more likely than their similarly situated, non-disabled peers to be arrested, convicted, incarcerated, and serve longer sentences without equal opportunity for probation or parole. Meeting no opposition and passing both the Texas House and Senate unanimously, HB3116 was signed into law by Governor Abbott on June 10, 2019, with an effective date of September 1, 2019.

The Task Force created by HB 3116 was directed to review the following five areas:

1. current policies and procedures,
2. barriers to accommodation and justice,
3. best practice used in other states,
4. policies that would improve jail standards; and,
5. any other issue the task force considered appropriate.

After review of the five areas, the Task Force would then submit a report that included:

1. a description of the activities of the task force;
2. the findings and recommendations of the task force;
3. a plan for how the best practice standards identified by the task force can be implemented statewide;
4. any proposals for legislation; and
5. any other matter the task force considers appropriate.

Executive Summary

The charges in HB 3116 set forth the creation and designation of a Task Force to evaluate, research, and report the findings back to the Legislature by December 1st, 2020. With the timeline established, Texas Commission on Jail Standards Executive Director Brandon Wood and his staff, prepared recommendations of the Task Force members, as well as began identifying SME's (Subject Matter Experts) and Stakeholder groups to participate in this endeavor. The first formal meeting was held on January 16th in Austin, Texas. It should be noted, that following this meeting in response to Covid-19 precautions all subsequent meetings were conducted virtually.

The first priority of the Task Force was to ensure that all participants had a unified and clear understanding of not only the primary charges of HB 3116, but also of the definition and codified standards of IDD. Due to the fact that serious mental illness and IDD can be co-occurring, it was important that the differences between the two were understood as was their impact on the criminal justice system.

This report reflects the careful study of the intersection between intellectual and developmental disability services and the local criminal justice systems in the state of Texas. The recommendations contained herein warrant additional study and further action by the Texas Legislature. Additionally, the report is also intended to provide helpful information to County Jails across our great state to help them develop best practices on the procedures, treatment and proper support needed for persons arrested and detained who were determined to have Intellectual Disabilities.

It was established early on that data collection would be of paramount importance in determining how significant these individuals impact the local criminal justice system and county jails. The Task Force quickly discovered that this type of data was extremely limited or would have to be all manually extracted from individual locations, jurisdictions and agencies. Although this would impact historical data, there were however imminent systemic changes that were being implemented into the TLETS CCQ (Texas Law Enforcement Telecommunications System, Continuity of Care Query) that would allow the tracking of these data metrics. Since the activation on August 14, 2020, and at the time of the drafting of this report a 90-day sampling was obtained. This sample included results that exhibited a monthly average of 38 "exact" matches with another 1433 "probable" matches from a total of 37,838 CCQ checks completed at the time of booking.

Task Force leadership organized the report according to the workgroups formed during the Task Force deliberations to better facilitate and accomplish the multi-faceted goals of this effort. The charge of each Workgroup aligns with specific needs identified by Task Force members. A brief description of each workgroup has been detailed in a later section of this report.

The Task Force also focused on the role played by the LIDDA (Local Intellectual and Developmental Disability Authority) and LMHA (Local Mental Health Authority) relative to early identification/collection of information and service delivery. An equally important aspect of this was the understanding that there are age requirements for accessing state-funded IDD services, why those were established, as well as the nuanced differences of other disorders such as traumatic brain injury that can occur after the age restrictions included in the state criteria. This is delineated later in this report. In addition, the members explored existing resources and programs, identified state and national best practices, and finally formulated desired outcomes.

The challenges of Covid-19 severely limited the Task Force's ability to effectively analyze and explore each of the recommendations in more thorough depth and detail. This was exacerbated further given the sheer lack of available data to potentially support and justify targeted changes that could include Administrative Rule additions or modifications, and more importantly, legislative initiatives. The Task Force is committed to ensuring that, with sufficient time, proper and applicable research can be conducted, thorough budget and staffing assessments can be completed, and data criteria and reporting processes can be established.

Task Force leadership would like to express tremendous gratitude to everyone who has participated in this effort thus far. Their dedication, passion, and commitment should be recognized and commended, and truly demonstrates professionalism in the finest traditions in Texas. With this in mind, the Task Force Leadership would recommend that this group be reauthorized and allowed to fully complete this important mission, and, as stated earlier, be able to provide fully evaluated actionable recommendations better supported in quantified data metrics.

Task Force Members

The Texas Commission on Jail Standards was mandated to select the members of the Task Force that would carry out this important work. Communication with subject matter experts and the bill's author allowed the commission to identify the most appropriate individuals who were then nominated and confirmed by the Commission. These members represented a diverse array of stakeholders, including County Jail Administrators, advocates for people with IDD, Local Mental Health and Intellectual Disability Authorities, leadership from the Texas Commission on Jail Standards (TCJS) and Texas Sheriffs. The members selected and their qualifications are provided below:

Sheriff Kelly Rowe

Appointed as presiding officer and the representative from the Texas Commission on Jail Standards is Sheriff Kelly Rowe from Lubbock. In 1993 he began his career with the Midland County Sheriff's Office. Kelly Rowe began his tenure with the Lubbock County Sheriff's Office in 1999 as the Administrative Lieutenant of the Detention Division. Promoted to the rank of Captain in the Detention Branch and later transferred to Law Enforcement, Rowe formed the Transition Team, selected the initial staff and would ultimately be responsible to ensure that oversight and all tasks were completed to facilitate a smooth transition into the new facility For Lubbock County. Rowe was promoted to the position of Chief Administrator which had overall fiscal responsibility for all Sheriff's Office budgets and funds while also serving as a member of the Tactical Operations Unit and Commander of the Honor Guard. On September 16, 2009 he was appointed by the Lubbock County Commissioners to the position of Sheriff, the office he holds to this day.

Alex Cogan

Serving as the Public Policy and Advocacy for The Arc of Texas on Criminal Justice, Alex Cogan is the candidate for the position of statewide advocate for Individuals with Developmental Disabilities. She has worked in criminal justice reform clinically as a social work intern at the Travis County Correctional Complex and on the local and state level while at Grassroots Leadership, a community-led advocacy organization. During the 86th legislative session, she helped pass three pieces of criminal justice legislation that will ultimately provide greater access to justice for the I/DD population. In 2019, she trained more than 700 criminal justice professionals in Texas on interacting with and supporting individuals with I/DD, including law enforcement officers, legal professionals, and victim service providers. Alex supports criminal justice professionals to prevent the I/DD population from unnecessarily entering the criminal justice system and ensuring accommodations and services are provided if involvement is a necessary step. Founded in 1950 by a group of parents of children with intellectual and developmental disabilities, The Arc has been instrumental in the creation of virtually every program, service, right, and benefit that is now available to more than half a million Texans with intellectual and developmental disabilities. Today, The Arc continues to advocate for including people with intellectual and developmental disabilities in all aspects of society.

Janet Brunette

With more than 30 years working in the service delivery system of care that supports persons with an intellectual developmental disability, Ms. Janet Brunette currently serves as Director of Developmental Disability Services at Bluebonnet Trails Community Services. In this position, she works closely with the jail diversion coordinator and crisis response team to coordinate services for individuals detained in jail to expedite return to alternate living situations when appropriate. In addition, Brunette coordinates with IDD staff which are most appropriate to make first contact and focuses to work with community providers, police officers and crisis response teams to avoid incarceration when it is not determined to be appropriate.

Ramey Heddins

Ramey Heddins currently serves as Chief of Behavioral Health Services for MHMR Tarrant, where he oversees behavioral health services for both children and adults. Ramey has 34 years of experience in the behavioral field with 21 of those years supervising criminal justice programs. He is also a Certified Correctional Health Care Professional through the National Commission on Correctional Health Care. He works with the Tarrant County Sheriff's Department to coordinate behavioral health services in the Tarrant County Jail. This includes working closely with MHMR Tarrant Disability services to ensure the needs of persons with intellectual and developmental disabilities are addressed.

Amber McKeon-Mueller

The representative from a statewide organization that represents municipalities is Amber McKeon-Mueller, Assistant General Counsel for the Texas Municipal League. Created in 1913, The League provides services to Texas cities. They serve the needs and advocate the interests of cities and city officials and render services which individual cities have neither time, money nor strength to do alone.

Lieutenant Kevin Stuart

Founded in 1986, the Texas Jail Association with the main objective of providing a distinct and unified voice for corrections officers working in local jails. The association's membership is comprised of Jail Administrators, Corrections Officers, Sheriffs, Support Staff, and other interested parties of the corrections profession in Texas. Serving as the current president of the Association is Lieutenant Kevin Stuart who is the representative from a statewide organization that represents corrections professionals.

Sheriff Otto H. Hanak

Sheriff Otto H. Hanak was sworn in as Washington County's 27th Sheriff on January 1, 2013. His law enforcement career has covered more than 35 years with his last two duties being a Texas Ranger assigned to Washington County and as the District Attorney's Investigator, assigned to the 21st Judicial District of Texas. At the national level, Sheriff Hanak served on the Executive Security-Protective Detail for the George W. Bush Presidential Campaign. He also provided executive security for in-state and out-of-state dignitaries for more than 15 years. Sheriff Hanak's formal education was at Sam Houston State University, majoring in Criminal Justice. His professional education includes more than 4,300 training hours in various law enforcement training programs.

Major Ricky Armstrong

Major Ricky Armstrong currently serves as the Jail Administrator for McLennan County and has over 28 years' experience in the field of corrections. He is a charter member of the McLennan County Behavior Health Leadership Team and is a member of the McLennan County Reintegration Board. Major Armstrong has served on the Texas Jail Association as a Board of Directors for the last four years and is currently 2nd Vice President. A 2017 graduate of the National Jail Command Leadership Academy at Sam Houston State University in January 2019, Armstrong was appointed to the board of directors for the National Alliance on Mental Illness-Waco. Major Armstrong is the representative from a county jail.

Special Acknowledgements:

In addition to the designated Task Force members many others participated directly as Subject Matter Experts representing a broad spectrum of disciplined expertise and institutional system knowledge from affected stakeholder agencies and organizations. These individual's dedication to participate, provide highly relevant input, and contribute within the workgroups was invaluable to the success of this report and its charges. **Executive Director Brandon Wood** and his staff at the Texas Commission on Jail Standards continually provided crucial logistical, research, and knowledge, and of special note **Alicia Barker**, who's administrative support was key to maintaining all schedules, agendas, minutes, and submissions to effectively facilitate the team remotely.

Lee Johnson Deputy Director, Texas Council of Community Centers

Dr. Esmail Porsa Executive Vice President & Chief Strategy and Integration Officer at Parkland Hospital.
Vice Chairman- Texas Commission on Jail Standards

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Emily Eisenman Reentry Operations Manager, TDCJ-TCOOMMI

Isabel Casas Director of IDD Services, Texas Council of Community Centers

Valerie Murrieta Special Projects Coordinator IDD Program Operations, HHSC

Jonathan Lemuel Director of Jail Diversion, Bluebonnet Trails

Workgroup Organization

During the inaugural meeting, it was determined that the best approach to producing this report that covers this complex issue was to form work groups that were focused on specific subject areas. This would allow Task Forces members to best use the specific knowledge and experience of the members in individual workgroups to better facilitate offline and informal discussions and work. The progress and work products of these groups would be shared and reviewed at each formal meeting held until the drafting of the report had commenced. Listed below are the four workgroups that were created:

Data Collection

From the beginning, data collection was identified as a critical component, necessary to any effort to explore and better understand the significance and prevalence of IDD issues in the criminal justice system. In order to guide targeted approaches or solutions it is necessary to have data that can be analyzed which in turn can assist in identification of trends and key metrics. Although the Task Force ultimately encountered many limitations, the use of existing data sources, and the creation, distribution, and collation of surveys would provide the primary working information and background for this report.

Existing Resources and Programs

This workgroup was tasked with establishing a baseline snapshot to the extent possible as to what is currently occurring around the State of Texas. They were to examine if IDD was being readily identified upon entry to the criminal justice system by way of intake into the county jails, and what, if any, actions were being taken during that process to include management of the individual while incarcerated.

National Approaches

Although the Task Force recognized that there are tremendous innovations happening across the State of Texas, it was important to evaluate, compare and identify solid best practice solutions that have been established, tested, and are working around the country.

Desired Outcomes

The Task Force members and SME's would rely upon their professional knowledge and experiences, feedback from all the other workgroups, and situational comparative analysis to formulate recommendations for best practices. Subsequently this would reveal potential gaps and identify areas where legislative action may be necessary to resolve potential issues.

Definitions

A key component of this report, is helping jail staff and the general public gain a basic understanding of the definition of “IDD” and essential components of the service system for people with intellectual and developmental disabilities (IDD) as it applies to the state of Texas.

“Intellectual Disability” refers to a group of disorders characterized by:

1. a limited mental capacity (significant sub-average score on a standardized IQ test, 69 or below for state funded services);
2. Difficulty with adaptive behaviors such as daily hygiene tasks, managing money, schedules and routines, or social interactions; and,
3. People who have IDD have challenges with major life activities such as language, mobility, learning, self-help, independent living; and,
4. Both of which must be evident before the person’s 18th birthday (or 22 years of age for related conditions, such as autism).
5. It usually lasts throughout a person's lifetime.

NOTE: Persons who have previously been referred to as having a diagnosis of “Mental Retardation” are now referred to as having a diagnosis of “Intellectual Disability” (ID), as this has been identified as a more respectful and preferred term by community advocates and is also embraced by the medical community.

“Developmental Disabilities” refers to:

1. a condition (other than ID) that can affect a person’s cognitive ability, physical functioning, social functioning or any combination of these.
2. This term would only apply to conditions that were evident before the person’s 22nd birthday and are considered to be lifelong.

NOTE: A person could have both an Intellectual Disability and a Developmental Disability (i.e., ID and Cerebral Palsy).

LIDDA – The Local Intellectual and Developmental Disability Authority

Local intellectual and developmental disability authorities (LIDDAs) serve all 254 counties of Texas and are the point of entry for publicly funded intellectual and developmental disability (IDD) programs, whether the program is provided by a public or private entity. They:

- provide or contract to provide an array of services and supports for persons with IDD;
- are responsible for enrolling eligible individuals into the following Medicaid programs:
 - ICF/IID, which includes state supported living centers Intermediate Care Facility for Individuals with Intellectual Disabilities

- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)
- are responsible for Permanency Planning for people under 22 years of age who live in an ICF/IID, state supported living center or a residential setting of the HCS Program.

Select IDD Community Services and Supports

The service descriptions contained in this section of the report were provided by the Health and Human Services Commission (HHSC), Intellectual and Developmental Disabilities Services Section. A complete overview of IDD services and supports is available at:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/lidda/iddserviceseng.pdf>

The select programs described in this section are intended to provide high-level awareness of the IDD services and supports provided by the Texas Health and Human Services Commission. Be advised, some services and supports have interest lists because they do not have immediate openings available.

General Revenue (GR) Funded Services - Are provided by Local IDD Authorities and are primarily intended to help persons remain in their own or their family's home. With the exception of crisis services and determination of eligibility for IDD services and supports, to receive state-funded services, a person who lives in a Local IDD Authority service area must meet one of the following criteria:

1. Have a diagnosis of an intellectual disability, which is based on:
 - a. Measure of the person's IQ;
 - b. A determination of the person's adaptive behavior level; and
 - c. Evidence of the disability that originated before the person's 18th birthday.
2. Have a diagnosis of autism spectrum disorder
3. Be a nursing facility resident who is eligible for specialized services for intellectual disability or a related condition
4. Be eligible for early childhood intervention services.

Due to resource limitations, not all GR funded services are available in all areas of the state. GR funded services include:

1. Determination of eligibility for IDD services and supports: an assessment to determine if a person has an intellectual disability or is a member of the HHSC priority population for IDD.
2. Crisis Services: A crisis is a situation where a person's mental or physical health is at immediate and serious risk.
3. Crisis Intervention Specialist (CIS): CIS trains groups and providers to work with person's with IDD who are at risk of needing crisis services. CIS also helps people with IDD access crisis respite and

develop crisis prevention plans. CIS also works with Mobile Crisis Outreach Teams (MCOT) during a crisis event involving a person with IDD.

4. Crisis Respite: 24-hour supervision and support to a person with IDD in crisis. Depended on resources available in your community, crisis respite may be provided in the home or in a facility.
5. NOTE Additional GR Funded Services for people with IDD include: Screening, Eligibility Determination, Service Coordination, Community Support, Respite, Employment Assistance, Supported Employment, Nursing, Behavioral Supports, Specialized Therapies, Vocational Training, Day Habilitation, Independent Living Skills Training, Crisis Intervention Services, and Crisis Respite. For additional information about these services, please see the HHSC Explanation of Services and Supports for IDD services referenced above.

Medicaid Community First Choice (CFC) Services – are basic attendant and habilitation services for persons with disabilities and are available to Medicaid recipient with an institutional level of care. CFC services include: personal assistance services, CFC habilitation, CFC support management and CFC emergency response services.

Medicaid Intermediate Care Facilities (ICF) for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) program – 24 hour residential setting for people with IDD or a related condition. Two categories of ICF/IID are state supported living centers (SSLCs) and community-based ICF/IID. SSLCs provide campus-based services and support at 13 locations: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Harlingen, San Angelo and San Antonio. State law limits admission to SSLCs to persons with an intellectual disability. Community-based ICF/IID programs provide 24 hour residential services and supports for persons with an intellectual disability or a related condition.

Medicaid and Waiver Programs – Home and Community-based Services (HCS) program, Texas Home Living (TxHmL) program, Community Living Assistance and Support Services (CLASS) program, and Deaf Blind with Multiple Disabilities (DBMD) program.

For more information about any of the services described in this section of the report, please see the following:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/lidda/iddserviceseng.pdf>

<https://hogg.utexas.edu/what-we-do/policy-engagement/mental-health-guide>

Workgroup Findings: Data Collection

Data Collection

To understand the scope and breadth of the issue of inmates with IDD, collection of data would be paramount to guide the final recommendations of the Task Force. New functionality in the TLETS CCQ system to better identify people with IDD during the booking process was implemented on August 14, 2020 and the Task Force was only able to access preliminary data collected by the new system. This limitation in available data created a significant challenge. More time is necessary for this new functionality to be utilized in jails across the state so that useful data about the numbers of people with IDD in County Jails can be obtained to inform future study regarding the prevalence of IDD within local criminal justice systems across the state.

The background and implementation of this new functionality within the TLETS CCQ system is included in the full text in the attached [Appendix i – TLETS FY2020 Expansion].

Background

The 80th Texas Legislature, Regular Session, 2007, passed Senate Bill 839 which amended Health and Safety Code, §614.017, requiring the Department of State Health Services and Department of Public Safety (DPS) to develop a real-time identification and data-exchange system for special needs offenders. This amendment:

- Allows more expedient data exchange to support continuity of care for individuals with mental illness who are involved in the criminal justice system; and
- Facilitates local post-booking jail diversion activities.
- Identifies individuals served by Local Mental Health and Behavioral Health Authorities (LMHAs/LBHAs)
- Occurs when an individual is booked into county jails
- Jail staff use the DPS-operated Texas Law Enforcement Telecommunication System (TLETS) to conduct a Continuity of Care Query (CCQ).
- CCQ searches multiple criteria: individual's last name, first name, date of birth, sex, race, and social security number.
- TLETS interfaces with the Health and Human Services Commission's (HHSC) Clinical Management for Behavioral Health Services (CMBHS) system to see if the individual, within the last three years, received a service in any of the following:
 - A state mental health facility (i.e., state hospital);
 - An HHSC-funded, contracted, private psychiatric bed; or
 - A service provided by an LMHA or LBHA.

- There is the potential for an exact or probable match. If there is a match, CMBHS sends a CCQ return report to the authorized TLETS user at the jail.
- It is then the authorized TLETS user's responsibility to notify the LMHA or LBHA of the match. The LMHA or LBHA may then deploy to the county jail to meet with the individual and collaborate with the county jail and court to determine the need for in-jail or post-release services.

New IDD Functionality (Live August 2020)

- Code of Criminal Procedure (CCP), Article 16.22, includes requirements for sheriffs, municipal jailers, LMHAs, LIDDAs, or other qualified mental health or intellectual disability experts to identify, collect information and provide a written report to a magistrate regarding individual's suspected of having a mental illness or intellectual disability.
- In addition to these requirements under Article 16.22, the TLETS CCQ process provides a system to identify inmates with a history of receiving intellectual disability services.
- The enhanced system provides data tables and query to identify individuals with an IDD who have been served by a LIDDA in the last 3 years.
- Automated notification is sent to LMHAs/LBHAs and LIDDAs when exact or probable matches occur.

In partnership with the Texas Commission on Jail Standards, the Health and Human Services Commission (HHSC) coordinated multi-disciplinary training:

- Training for LMHAs/LBHAs and LIDDAs
 - ▶ Receiving daily notifications
 - ▶ Accessing match report
 - ▶ Collaboration with jails
 - ▶ Expected diversion and post-booking efforts
- Training for jail staff
 - ▶ Expansion project overview
 - ▶ Matching logic – exact and probable matches
 - ▶ Helpful hints when running the CCQ
 - ▶ Expectations when a match is received
 - ▶ LIDDA overview of services
 - ▶ Strategies for serving people with an IDD

Workgroup approach to manual Data Collection:

Members of the Texas Jail Association Board of Directors were asked to report any data they possessed on inmates with IDD. It was hoped that that this group of professionals would be more apt to report their data. They were requested to provide race/gender/age along with charges and length of stay or any information they had or could collection. Of the twelve counties represented by this group, seven responded with data.

This was followed by an email to all members of the Texas Jail Association requesting the same information. In an effort to assist this effort, the Texas Commission on Jail Standards distributed a letter (see attached) to counties that were participating in the stepping-up program. There were thirteen counties that respond, a majority of which did not collect any data.

While attempting to collecting this data, we were faced with the following obstacles

- Jails do not collect this data
- Jails do not have the staff to collect this data
- Jails do not differentiate between intellectual or developmental disability and mental health diagnosis.

Recommendations

The Data Collection workgroup makes the following two recommendations:

1. Further study of inmates with Intellectual or Developmental Disabilities in the criminal justice system is necessary.

2. Collect data. As the TLETS CCQ functionality continues to be used by jails across the state, additional data will become available. This information will inform future study of these issues and should continue to be analyzed. The Texas Commission on Jail Standards should study the feasibility of and consider potential job functions and responsibilities of new personnel at the agency to lead improved data collection efforts. The workgroup believes a full-time program specialist could continue the needed vital research and planning as follows:

- a. Assist counties with data gathering and reporting to the Commission
- b. Determine cost per day estimates and challenges
- c. Produce findings relative to Large, Medium, and Small jails
- d. Determine the extent of future actions

Workgroup Findings: Existing Resources

Existing Resources and Programs

In order for the Task Force to make recommendations, it was critical to identify existing practices and programs currently in place within Texas county jails that serve inmates with IDD. By understanding what is currently occurring and what is available, recommendations can more accurately be crafted into categories such as reinforcement of existing strategies, identifying gaps where new strategies might be required, or the potential finding that no action is required.

The Existing Resources and Programs workgroup communicated directly with county jails by email and followed up nonresponses with phone calls. In an attempt to not overlook any information that might be useful the format was kept simple. Counties were asked to list anything used by their facility to help manage and serve any inmates diagnosed or suspected of having IDD. A portion of the existing resources were gathered through that direct communication with counties while others were identified through the vast representation on the Task Force of subject matter experts from various fields. From the information collected, the workgroup was able to classify all items into several broad categories listed below.

1. In order to manage inmates with IDD, they first must be identified so that resources and programs can be properly directed.
 - a. Utilization of the expanded CCQ for IDD
 - b. Effective partnership with Local Mental Health Authority/Local IDD Authority
 - c. County Medical Staff/Doctor
2. Available Resources - Identify what resources are available in your facility and community.
 - a. LMHA/LIDDA
 - b. Local Chapters of the Arc of Texas
 - c. Community Faith Based Organizations
 - d. CRCG (Community Resource Coordination Group) <https://crcg.hhs.texas.gov/>
 - e. School District
 - f. Medical Staff
 - g. Programs or Activities
 - h. Specialized Jail Staff
3. Inmate Housing- inmates with IDD must be appropriately housed according to their risk and needs.
 - a. Housed in an area that reduces risk of victimization

- b. Housed in an area based on their specific challenges
- 4. Provide Available Programs and Activities – Once identified and housed appropriately, inmates with IDD should be provided programs and activities that may be available to your facility.
 - a. LMHA/LIDDA
 - c. Other activities based on the individual’s capabilities
 - d. Extra/Supplemental recreation

Two challenges encountered in the collection of this information are worth mentioning:

(1) Further study and identification of best practices is necessary for inmates who have co-occurring IDD and Mental Health diagnoses;

(2) the low response rate of counties surveyed indicates additional time to collect information could be beneficial for future efforts. Co-occurring diagnoses are challenging because jails struggle to identify inmates who may have an IDD condition. Instead of focused interventions for IDD, jails are often utilizing existing mental health resources. Appropriate strategies and resources, tailored to address IDD needs, would improve the effectiveness of jails interacting with these inmates and produce better outcomes. Since implementation of the new screening protocols in 2015, jails have improved their ability to identify inmates with mental illness. Unfortunately, the expanded capability of the TLETS/CCQ match process which will assist jails in identifying inmates with IDD did not go into effect until August 14, 2020. Additionally, this new capability only identifies individuals who have received services or supports at a LIDDA and within three years. Further, those who enter the criminal justice system are likely to have never received services or supports at LIDDAs, thus they will not be identified through the TLETS/CCQ match process. This capability is very promising though and should close one of the most important gaps. For the three-month period covering August 2020 to November 14, 2020, 114 exact matches (.10%) and 4,300 probable matches (3.7%) were generated out of the 113,515 queries submitted. As for the low response rate to the request for information, it is believed that this is indicative of jails not completely understanding the difference between IDD and mental health and the need for jails to improve how they identify inmates with IDD. This results in jails often utilizing existing mental health resources, instead of focused interventions for IDD. This in turn prevented the Task Force from being able to consider all strategies that are currently being used for this population which could be of value.

Recommendations

Based on the data collected and the discussions amongst task force members this workgroup makes the following recommendations.

1. Direct the Health and Human Services Commission (HHSC) to work in partnership with the Texas Commission on Jails Standards to further explore existing practices and identify gaps in IDD resources in Texas communities.
2. The Texas Commission on Jail Standards and the Health and Human Services Commission should partner to develop and compile strategies and resources for addressing the needs of people with IDD into a format that is easy to understand and that is easily accessible to all county jails. This

information should be available on each agencies website and should be promoted by Local Mental Health and Intellectual Disability Authorities as well as other stakeholders in various interactions with County Jails across the state.

3. The legislature should continue to make smart investments in community based services for people with IDD and continue making progress to create the services capacity necessary to fill gaps in community resources identified.

Workgroup Findings: National Approaches

National Approaches

The Task Force realized that while it was important to identify resources available within Texas, it was just as significant to understand national best practices for addressing inmates with IDD. A top down approach was utilized and the workgroup attempted to locate any material from two national organizations, the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). Unfortunately, cost was a barrier to obtaining any material regarding the standards promulgated by either of these two organizations. Additionally, ACA standards are targeted towards a prison population, which is a significantly different dynamic than county jails. The workgroup also reviewed the website of Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, for any relevant information as well as other national websites for pertinent articles. These efforts were also met with little return, further demonstrating the lack of dedicated programs for these inmates.

As for other states, the workgroup was unable to identify any dedicated programs for inmates with IDD. This, however, does not prove that programs to serve individuals with IDD are non-existent, rather they may not be advertised as such a program or may be included as part of larger programs. Regardless of their existence, there is no material available that was deemed beneficial to the workgroup in their efforts. This suggests further study could be useful.

In an effort to provide as robust best practices as possible, international approaches were reviewed. Throughout our research, we discovered a routine screening specifically tailored to identify individuals with IDD was administered by professionals upon entry. This confirms what limited research exists; the best first step to support this population in jails is to identify them more consistently upon entry using a form that is most likely to capture the presence of an IDD. With that in mind, the workgroup makes the following recommendations:

Recommendations

1. TCJS should convene a stakeholder group to modify the screening form.
 - a) This stakeholder group should explore the benefits and challenges with respect to adding the following questions to the Screening Form for Suicide and Medical/Mental/Developmental Impairments:
 - i. Have you ever had a concussion, hit your head, or passed out? How old were you?
 - ii. Are you afraid someone might hurt or kill you? Is this person someone you know? Is this person someone you live with?
 - iii. Did you go to special classes to help you learn in school? Did you learn at home? Did you finish high school? How old were you when you finished high school?
 - iv. Does it seem like the inmate is not paying attention? Is the inmate just answering questions with “yes” or “no”?
 - v. Do you have a guardian or someone else that helps take care of you?

- b. This stakeholder group should explore the benefits of reviewing and updating instructions for the Screening Form
 - c. This stakeholder groups should explore the benefits of providing updated automated/online training to every jailer on the use of the Screening Form
2. TCJS should through administrative action of the Board, create an advisory committee using the existing membership structure of the IDD Task Force and add Subject Matter Experts (SMEs) to:
 - a. Address IDD/BH issues
 - b. Review and perform trend analysis of data obtained to inform future decisions
3. A formalized advisory committee created in recommendation “2” should explore inquiring into the state education system IEP information. The IEP information may assist in quickly identifying individuals with a potential IDD and speed up the process to ensure proper services and accommodations are provided.
4. Resource page on TCJS website should include identified best practice resource guides referenced in this report and materials produced by Judicial Commission on Mental Health, the Court of Criminal Appeals, and other relevant stakeholders to assist County Jails and other law enforcement stakeholders in gaining a better understanding of IDD/BH issues.
5. Recommend that jails establish communication with the Community Resource Coordination Groups (CRCGs) for support in staffing complex IDD cases. It should be noted that CRCGs do not exist in all regions of Texas.
6. If resources are provided to the Texas Commission on Jail Standards, instruct the agency to implement data collection policies and procedures that require County Jails to submit certain data elements from the Screening Form for Suicide and Medical/Mental/Developmental Disabilities to TCJS.

Workgroup Findings: Desired Outcomes

Desired Outcomes

Through many discussions and review of data at length by members of this Task Force the desired outcome became apparent: Provide superlative care for those incarcerated who are diagnosed with IDD by ensuring that the organizations charged with their care have the resources and knowledge to do so. Recommendations for how to accomplish this were determined using evidence-based decision making principles. Any areas requiring more evidence are addressed in the recommendations as well.

The desired outcomes group reviewed data, strategies, best practices, and resources from the other workgroups in this Task Force. Any and all contributions were considered in order to form thoughtful and logical recommendations. There was no lack of caring, diverse, expert, service minded participants on this Task Force. The only challenges faced were those outlined in other workgroup reports such as lack of responsiveness to requests for information, the difficulties presented with identifying co-occurring IDD and BH diagnoses, and limited availability of data.

Recommendations

1. Collect accurate data, using systems already in place and mandated in county jails, of the number of individuals incarcerated who may have an IDD diagnosis.
2. Study the feasibility of providing local law enforcement access to relevant information, to include CCQ, for the purpose of diverting individuals into proper treatment instead of jail.
3. Instruct the Texas Commission on Jail Standards to create a TCOLE certified course on how to utilize the Intake Screening Form. The course should be available for both in person and virtual instruction.
4. Continue to support the TCOLE certified Master Mental Health Jailer Training Program presented by the Correctional Management Institute of Texas at Sam Houston State University.
5. Ensure that all TCOLE certified training identified as possessing a Mental Health or Behavioral Health component are updated regularly to reflect current best practices.

Appendix:



TEXAS
Health and Human
Services

Texas Law Enforcement Telecommunications System

FY20 – Expansion Project

Agenda



TEXAS
Health and Human
Services

- Background
- Current Process
- Project Scope
- Training Plan
- Local Intellectual and Developmental Disability Authorities (LIDDAs) Overview

Background

The 80th Texas Legislature, Regular Session, 2007, passed Senate Bill 839 which amended Health and Safety Code, §614.017, requiring the Department of State Health Services and Department of Public Safety (DPS) to develop a real-time identification and data-exchange system for special needs offenders. This amendment:

- Allows more expedient data exchange to support continuity of care for individuals with mental illness who are involved in the criminal justice system; and
- Facilitates local post-booking jail diversion activities.



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Current Process

- Identifies individuals served by Local Mental Health and Behavioral Health Authorities (LMHAs/LBHAs)
- Occurs when an individual is booked into county jails
- Jail staff use the DPS-operated Texas Law Enforcement Telecommunication System (TLETS) to conduct a Continuity of Care Query (CCQ).
- CCQ searches multiple criteria: individual's last name, first name, date of birth, sex, race, and social security number.



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Current Process

- TLETS interfaces with the Health and Human Services Commission's (HHSC) Clinical Management for Behavioral Health Services (CMBHS) system to see if the individual, within the last three years, received a service in any of the following:
 - ▶ A state mental health facility (i.e., state hospital);
 - ▶ An HHSC-funded, contracted, private psychiatric bed; or
 - ▶ A service provided by an LMHA or LBHA.



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Current Process

- There is the potential for an exact or probable match. If there is a match, CMBHS sends a CCQ return report to the authorized TLETS user at the jail.
- It is then the authorized TLETS user's responsibility to notify the LMHA or LBHA of the match. The LMHA or LBHA may then deploy to the county jail to meet with the individual and collaborate with the county jail and court to determine the need for in-jail or post-release services.



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Project Scope

- Code of Criminal Procedure (CCP), Article 16.22, includes requirements for sheriffs, municipal jailers, LMHAs, LIDDAs, and other qualified mental health or intellectual disability experts to identify, screen, or assess individual's suspected of having a mental illness or intellectual disability.
- In addition to the screening and assessment requirements under Article 16.22, the CCQ process is an opportunity to identify inmates with an intellectual disability.



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Project Scope

1. Enhance current data tables and query to identify individuals with an IDD who have been served by a LIDDA in the last 3 years.
2. Create automated notification to LMHAs/LBHAs and LIDDAs when matches occur.

Funding for the project is allocated in FY20. Project will be complete by 8/31/2020.



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Training Plan

- Training for LMHAs/LBHAs and LIDDAs
 - ▶ Receiving daily notifications
 - ▶ Accessing match report
 - ▶ Collaboration with jails
 - ▶ Expected diversion and post-booking efforts



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Training Plan

- Training for jail staff
 - ▶ Expansion project overview
 - ▶ Matching logic – exact and probable matches
 - ▶ Helpful hints when running the CCQ
 - ▶ Expectations when a match is received
 - ▶ LIDDA overview of services
 - ▶ Strategies for serving people with an IDD



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What is IDD?

An intellectual or developmental disability (IDD) includes many severe, chronic conditions that are due to mental and/or physical impairments.

- IDD can begin at any time, up to 18 years of age (or 22 years of age for related conditions, such as autism).
- It usually lasts throughout a person's lifetime.

People who have IDD have challenges with major life activities such as:

- Language
- Mobility
- Learning
- Self-help
- Independent living



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LIDDA Overview

- Local Intellectual and Developmental Disability Authorities (LIDDAs)
- Single point of access to certain publicly-funded IDD services and supports for residents within the LIDDA's local service area
- 39 LIDDAs across the state
- Most LIDDAs are the same entity as the local mental health authorities (LMHAs)



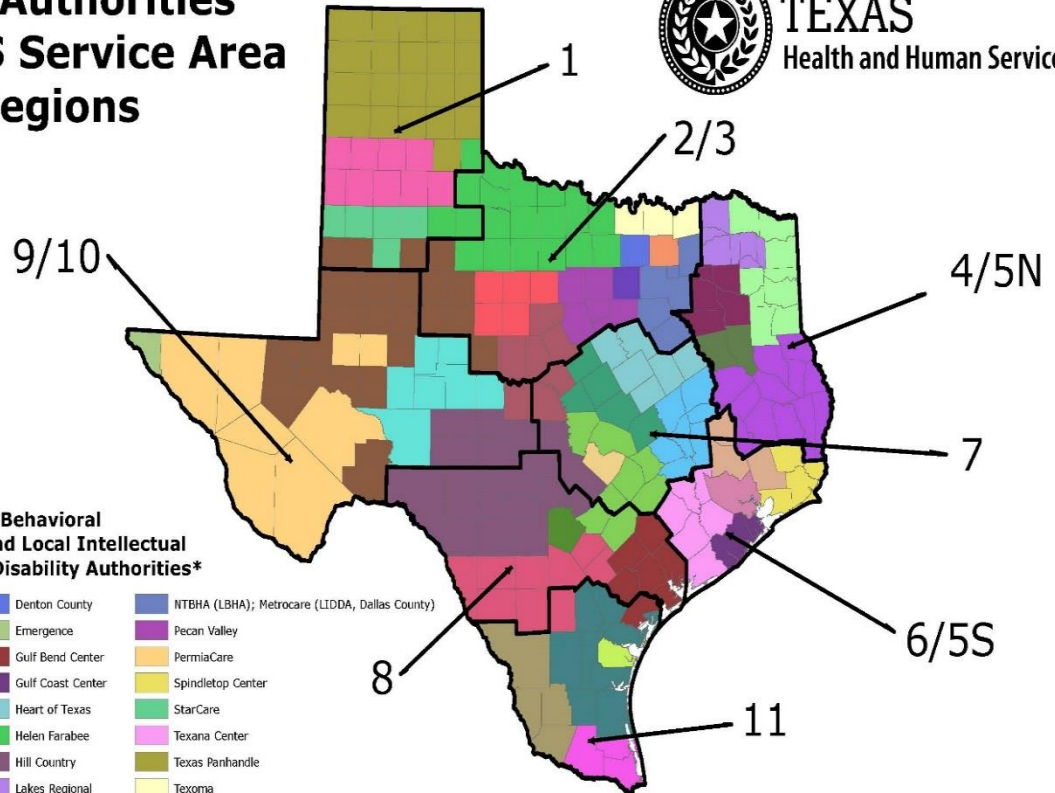
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LIDDA Service Areas

Local Authorities and HHS Service Area Regions



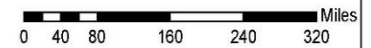
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Local Mental Health/Behavioral Health Authorities and Local Intellectual and Developmental Disability Authorities*

Health Service Region	Denton County	NTBHA (LBHA); Metrocare (LIDDA, Dallas County)
ACCESS	Emergence	Pecan Valley
Andrews Center	Gulf Bend Center	PermiaCare
Integral Care	Gulf Coast Center	Spindletop Center
Betty Hardwick	Heart of Texas	StarCare
Bluebonnet Trails	Helen Farabee	Texana Center
Border Region	Hill Country	Texas Panhandle
Burke Center	Lakes Regional	Texoma
Camino Real	LifePath Systems	Center for Health Care Services (LMHA); Alamo Area Council of Governments (LIDDA)
Center for Life Resources	MHMR Brazos Valley	Tri-County Services
Central Counties	MHMR Concho Valley	Tropical Texas
Central Plains	MHMR Harris County	West Texas Centers
Coastal Plains	MHMR Ilueces County	
Community Healthcare	MHMR Tarrant County	

(*authorities overlap except as indicated)



October 2018, v2

Source: Health and Human Services Commission, Behavioral Health Services



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What do LIDDAs do?

- Conduct diagnostic testing and evaluation for eligibility for publicly funded programs;
- Provide general revenue, state funded services to individuals with IDD;
- Place individuals on the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Interest List;
- Conduct service coordination for waiver programs;
- Conduct the preadmission screening and resident review (PASRR) evaluation for individuals in a nursing facility who are suspected of having an intellectual disability (ID) or developmental disability (DD);
- Conduct planning for the local service area;



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What do LIDDAs do?

- Conduct permanency planning for certain individuals under 22 years of age;
- Protect the rights of an individual; and
- Provide support through implementation of programs such as:
 - crisis intervention specialists (CIS),
 - crisis respite (CR),
 - enhanced community coordination (ECC); and,
 - transition support teams (TST).



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Service Coordination

LIDDAs provide service coordination for individuals in:

1. Nursing facilities (PASRR)
2. State Supported Living Centers or those transiting from either facility (ECC)
3. HCS and TxHML waivers
4. General revenue
5. Community First Choice (CFC) (Adults only)



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IDD Supports for Transitions

Crisis Intervention Specialists (CIS) are designed to enhance current Mobile Crisis Outreach Teams (MCOTs) to include:

- Real time response to crisis situations
- Working to train and educate MCOT workers on IDD supports and services

Crisis respite provides short-term respite for individuals with IDD

- Out-of-home crisis respite provides on-site therapeutic support and 24-hour supervision
- In-home crisis respite provides therapeutic support in a less restrictive setting for crises that can be resolved within a 72-hour period



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IDD Supports for Transitions Cont.

Eight Transition Support Team (TST) regions who provide support to other LIDDAs and community waiver providers in designated service areas

Opportunities include:

1. educational activities,
2. technical assistance, and;
3. case review for LIDDAs and community IDD waiver providers.



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LIDDA TLETS Requirements

1. Implementation

a. Training

b. LIDDA Handbook:

<https://hhs.texas.gov/laws-regulations/handbooks/lidda/local-intellectual-developmental-disability-authority-handbook>



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Thank you

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Explanation of Services and Supports

**Intellectual and Developmental
Disabilities**



TEXAS
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Health and Human Services Commission

June 2019

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Overview

This is a brief description of intellectual and developmental disability (IDD) services and supports provided by Texas Health and Human Services Commission (HHSC). Some services and supports have interest lists because they do not have immediate openings available. Persons who want particular services or supports should add their names to the appropriate interest list as soon as possible. Persons who are now receiving particular services or supports may add their names to the interest list for other services and supports.

For more information about services and supports, including a list of providers in your area, please contact your local IDD authority (LIDDA). You can find your LIDDA's contact information at <https://apps.hhs.texas.gov/contact/search.cfm>.

Services and supports provided through HHSC

Following are descriptions of services and supports organized by funding source (state or federal) and by program type. They range from community-based services and supports allowing persons to remain in their own or their family's homes, to residential services in which persons live in a structured setting with 24-hour supervision.

General Revenue (GR) funded services (state funded)

GR funded services are primarily intended to help persons remain in their own or their family's home. Not all GR funded services described in this section are available in all areas of the state. These services are provided by or through a LIDDA. Except for crisis services and a "determination of eligibility for IDD services and supports," to receive state-funded services, a person who lives in a LIDDA's service area must meet one of the following:

1. Have a diagnosis of an intellectual disability, which is based on:
 - measure of the person's IQ;
 - a determination of the person's adaptive behavior level (ABL); and
 - evidence of the disability that originated before the person's 18th birthday.

2. Have a diagnosis of autism spectrum disorder.
3. Be a nursing facility resident who is eligible for specialized services for intellectual disability or a related condition.
4. Be eligible for early childhood intervention services.

Determination of eligibility for IDD services and supports

A determination of eligibility is an assessment (or endorsement of an assessment) to determine if a person has an intellectual disability or is a member of the HHSC priority population for IDD. The assessment uses standardized tests to determine a person's IQ and ABL and is conducted by a qualified professional. An assessment (or endorsement) typically includes an interview with the person, the person's legally authorized representative (LAR), or, if the person doesn't have an LAR, others who are actively involved with the person. This service also may be requested as part of a formal petition for guardianship.

Crisis services

A crisis is a situation where a person's mental or physical health is at immediate and serious risk. During a crisis, a person can be a danger to himself, herself or others.

Crisis intervention specialist (CIS)

Crisis intervention specialists train groups and providers to work with persons with IDD who are at risk of needing crisis services. The CIS helps persons access crisis respite and develop crisis prevention plans. The CIS also works with the local Mobile Crisis Outreach Team (MCOT) during crisis events.

Crisis respite

Crisis respite provides 24-hour supervision and support to a person in crisis. A person with IDD may receive up to 14 days of crisis respite. Depending on your area, crisis respite may be provided:

- in the home; or
- in a facility.

Service coordination

Service coordination helps persons access medical, social, educational and other services and supports that will help them achieve an acceptable quality of life and community participation. Service coordination is provided by LIDDA staff who are referred to as service coordinators.

Community support

Community supports are individualized activities that are provided in the person's home and at community locations, such as libraries and stores. Supports may include:

- habilitation and support activities that foster improvement of, or facilitate, the person's ability to perform daily living activities;
- activities for the person's family that help preserve the family unit and prevent or limit out-of-home placement of the person;
- transportation for the person between home and his or her community employment site or day habilitation site; and
- transportation to facilitate the person's employment opportunities and participation in community activities.

Respite

Respite is either planned or emergency short-term relief provided by trained staff to the person's unpaid caregiver when the caregiver is temporarily unavailable. If enrolled in other services, the person continues to receive those services as needed during the respite period.

Employment assistance

Employment assistance helps persons locate paid jobs, and includes helping them:

- identify employment preferences, job skills, work requirements and work conditions; and
- identify prospective employers who offer appropriate employment.

Supported employment

Supported employment is provided to a person who has paid employment to help him or her sustain that employment. It includes individualized support services, supervision and training.

Nursing

Nursing is provided to persons who require treatment and monitoring of health care procedures that are:

- prescribed by a physician or medical practitioner; or
- required by standards of professional practice or state law to be performed by licensed nursing personnel.

Behavioral supports

Behavioral supports are specialized interventions to help persons increase adaptive behaviors and to replace or modify maladaptive behaviors that prevent or interfere with their inclusion in home and family life or community life. Supports include:

- assessing and analyzing assessment findings so that an appropriate behavior support plan can be designed;
- developing an individualized behavior support plan consistent with the outcomes identified in the person-directed plan;
- training and consulting with family members or other providers and, as appropriate, to the person; and
- monitoring and evaluating the success of the behavioral support plan and modifying it as necessary.

Specialized therapies

Specialized therapies are:

- assessment and treatment by licensed or certified professionals for social work services, counseling services, occupational therapy, physical therapy, speech and language therapy,

audiology services, dietary services and behavioral health services other than those provided by a local mental health authority; and

- training and consulting with family members or other providers.

Vocational training

Vocational training is a service provided to persons in industrial enclaves, work crews, sheltered workshops or affirmative industry settings to help them get a job.

Day habilitation

Day habilitation is assistance with getting, keeping or improving self-help, socialization and adaptive skills necessary to live successfully in the community and to participate in home and community life. Day habilitation is normally provided on a regular schedule in a group setting (not in the person's residence) and includes personal assistance for those who cannot manage their personal care needs during day habilitation, and assistance with medications and performing tasks delegated by a registered nurse.

Medicaid Community First Choice (CFC) Services

CFC services are basic attendant and habilitation services for persons with disabilities and are available to Medicaid recipients with an institutional level of care. CFC services are:

CFC personal assistance services

Services to help persons perform activities of daily living (such as eating, toileting, grooming, dressing and bathing), activities related to living independently in the community (such as meal planning and preparation, managing finances, shopping for food, clothing and other essential items), and health-related tasks based on the person-directed plan.

CFC habilitation

Acquisition, maintenance and enhancement of skills necessary for persons to accomplish activities of daily living, activities related to living independently in the community and health-related tasks.

CFC support management

Training on how to select, manage and dismiss attendants.

CFC emergency response services

Back-up systems and supports including electronic devices to ensure continuity of services and supports.

Medicaid ICF/IID Programs

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) program

An ICF/IID is a 24-hour residential setting for individuals with an intellectual disability or a related condition. An individualized plan of care is developed, based on the needs and choices of the person and the person's family. The unique needs of the person are the focus of the plan of care. Professional staff and other service providers work with the person and the person's family to develop a plan based on the person's skills, strengths and desires. Plans include comprehensive medical and therapy services and skill development programs. Staff helps with daily living activities so the person gains skills to increase independence. There is no waiting list or interest list for this program.

The two categories of ICF/IID are state supported living centers and community-based ICF/IID.

State supported living centers (SSLCs)

SSLCs serve persons with intellectual disabilities who have significant medical or behavioral health needs in a residential campus-based community. SSLCs provide 24-hour residential services, comprehensive behavioral treatment and health care, such as medical, psychiatry, nursing and dental services. Other services include skills training; occupational, physical and speech therapies; adaptive aids; day habilitation, vocational programs and employment services; participation in community activities; and services to maintain connections between residents and their families and natural support systems. SSLCs provide campus-based services and supports at 13 locations: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Harlingen, San Angelo and San Antonio. Each SSLC serves between 60 and 460 persons. Although the ICF/IID program criteria includes persons with only a related condition, state law limits admission to SSLCs to persons with an intellectual disability.

At least annually, LIDDAs must conduct the community living options information process (CLOIP) for individuals residing in an SSLC. CLOIP provides information and education about community living options to an individual who is residing in an SSLC or to the individual's LAR.

Community-based ICF/IID

A community-based ICF/IID is a residence that provides support services for persons with an intellectual disability or a related condition. If the person has a related condition, the condition must have begun before the person turned 22 and the person must also have:

- an IQ of 75 or below; or
- moderate to extreme deficits in adaptive behavior.

Community-based ICFs/IID provide 24-hour residential services, comprehensive and individualized health care, including physician, nursing and dental services, skills training, professional therapies, adaptive aids, vocational programs and habilitation services to persons to promote their independence. Persons are served in a six-bed home or in larger settings. There is no waiting list or interest list for a community-based ICF/IID. However, the owner/operator of each ICF/IID can determine additional admission criteria for its facility (for example, age or gender limitations) and can maintain its own interest list based on occupancy rate. A person can select a particular ICF/IID; however, the ICF/IID must have a vacancy and the provider must approve the admission.

Residential Options

Several programs offer 24-hour residential services, which are described in detail in the next few pages.

- SSLCs provide 24-hour care in residential campus-based communities.
- Residential services in a community ICF/IID are provided in small group homes and larger settings.
- The Home and Community-based Services (HCS) program can provide 24-hour residential services and supports in small group home settings or in a foster home setting.

You can search for a vacancy at an SSLC or an ICF/IID at <https://apps.hhs.texas.gov/icfsearch>.

Compare ICFs/IID in your area at <https://apps.hhs.texas.gov/ltcsearch/>.

Medicaid ICF/IID waiver programs

Medicaid home and community-based waiver programs provide services and supports to persons with an intellectual disability or a related condition who live in their own or their family's home or in another home-like setting. They are called waivers because certain ICF/IID requirements are waived.

In most situations, anyone who is eligible for the ICF/IID program is also eligible for one of the waiver programs. Funding in the waiver programs moves with the person to any part of the state. For example, if someone in a waiver program in Houston moves to El Paso, he or she can continue to participate in the waiver program there. A person also can change providers within the same city or area of the state.

Public or private entities may provide waiver program services and supports. All waiver providers are certified or licensed by HHSC.

The following two waiver programs serve persons with IDD for which a LIDDA helps the person to enroll.

Home and Community-based Services (HCS) program

The HCS program provides services to persons with IDD who live with their family, in their own home, in a host home/companion care setting, or in a residence with no more than four persons who also receive services. Services meet the person's needs so the person can maintain himself or herself in the community and have opportunities to participate as a citizen to the maximum extent possible. Services consist of adaptive aids, minor home modifications, professional therapies, behavioral support, dental treatment, nursing, residential assistance, respite, day habilitation and employment services. Service coordination is provided by the LIDDA. Residents of a host home/companion care setting or an HCS residence pay for their own room and board. There is a limit to the yearly cost of services provided through the HCS program.

Additional information about the HCS program can be found at

www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care.

You can search for a group home vacancy at <https://apps.hhs.texas.gov/ltcsearch/>. CFC services, described on Page 8, are available to persons enrolled in the HCS program.

If someone is offered an opportunity to enroll in the HCS program, the LIDDAs will provide information about enrollment requirements and timelines.

Texas Home Living (TxHmL) program

The TxHmL program provides essential services and supports so that persons with IDD can continue to live with their families or in their own homes. TxHmL services supplement but do not replace services and supports from other programs such as the Texas Health Steps program, or from natural supports such as family, neighbors or community organizations. Services consist of community support, nursing, adaptive aids, minor home modifications, specialized therapies, behavioral support, dental treatment, respite, day habilitation and employment services. Service coordination is provided by the LIDDAS. TxHmL program services are limited to a yearly cost of \$17,000 per person.

Additional information about the TxHmL program can be found at www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care. CFC services, described on Page 8, are available to persons enrolled in the TxHmL program.

If someone is offered an opportunity to enroll in the TxHmL program, the LIDDAs will provide information about enrollment requirements and timelines.

Community Living Assistance and Support Services (CLASS) program

The CLASS program provides services to persons with a related condition who need habilitation services. Persons with a related condition have a qualifying disability, other than a diagnosis of an intellectual disability, that originated before the age of 22 and that affects their ability to function in daily life. Services include adaptive aids and medical supplies, behavioral support, case management, nursing, respite care, specialized therapies, employment services and support family services.

Additional information about the CLASS program can be found at <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/community-living-assistance-support-services-class>. CFC services, described on Page 8 are available to those enrolled in the CLASS program. To apply for CLASS, call 877-438-5658.

Deaf Blind with Multiple Disabilities (DBMD) program

The DBMD program provides services to persons who are deaf and blind and also have an additional disability. The program helps persons communicate and interact with their environment. Services include adaptive aids and medical supplies, assisted living, audiology, behavioral support, case management, minor home modifications, dental, chore, intervener, therapies, orientation and mobility, day habilitation, nursing, respite, employment assistance and supported employment.

Additional information about the DBMD program can be found at <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/deaf-blind-multiple-disabilities-dbmd>. CFC services, described on Page 8 are available to those enrolled in the DBMD program. To apply for DBMD, call 877-438-5658.

Consumer Directed Services

Consumer Directed Services (CDS) is a service delivery option that allows recipients more control over how their services are delivered. The CDS option is available in waiver programs and certain CFC services described on Page 8. A person who chooses CDS is responsible for:

- Recruiting, hiring and training employees and backup employees (including family, friends or neighbors).
- Setting schedules and submitting timesheets for employees.
- Selecting a Financial Management Services Agency (FMSA) to:
 - train the person to hire and manage employees,
 - assist the person with creating a budget and setting wages and benefits for employees,
 - process timesheets and payroll,
 - process receipts and invoices, and
 - act as the person's agent to pay federal and state employment taxes.

Person-centered Planning

The LIDDA uses a person-centered planning process to develop an individualized plan of services and supports. This allows the person and family to direct the development of a plan that meets the person's outcomes. The process:

- identifies supports and services necessary to achieve the person's outcomes;

- identifies natural supports available to the person and negotiates needed service system supports;
- has the support of a planning team that consists of people chosen by the person and family; and
- accommodates the person’s style of interaction and preferences regarding time and setting.

Additional information about person-centered planning can be obtained from the LIDDA or at www.hhs.texas.gov/services/disability/person-centered-planning.

Selecting provider of services and supports

In most areas of the state, there is a choice of providers of services and supports.

When selecting a provider, you might ask some of the following questions. Not all questions may be pertinent to your situation but they may help you formulate your own questions.

1. What is your agency’s mission statement or philosophy? Why does your agency provide services and supports to persons with IDD?
2. How long has your agency been a provider? What areas of the state does your agency serve?
3. Do you own or lease your residential home(s)? If you lease, is it a short-term or long-term lease?
4. How many persons are receiving services and supports from your program? How many persons can the program serve?
5. Do you have references?
6. Does your staff have experience in serving persons with *[fill in the blank as appropriate, for example, intellectual disability, autism, mental illness]*?
7. How do you ensure that staff are trained and prepared?
8. Does your staff receive training in serving persons with *[fill in the blank as appropriate, for example, intellectual disability, autism, mental illness]*? Can you provide records for staff training specific to *[fill in the blank as appropriate, for example, intellectual disability, autism, mental illness]*?

9. How often does staff turnover, especially direct-care staff?
10. Do you require pre-employment screenings (for example, drugs, criminal background, abuse and neglect)?
11. What types of emergencies or crises are staff trained to handle?
12. What is your staff-to-participant ratio?
13. Do you have medical or dental staff on site or on call?
14. What type of licensure or credential is required for staff?
15. Describe ways in which you involve the person and family members in the development of the person's program plan. How are their preferences addressed if they differ from the goals of your agency?
16. What choices are provided with regard to day programming, vocational training, etc.?
17. Describe how staff helps a person learn daily living skills.
18. What types of personal-use items are purchased by your agency? What types are not?
19. Do you develop formal plans to manage behavior problems? If so, do those plans have to be approved by a special committee or an outside professional (for example, a psychiatrist)? If a special committee is used, does it include outside members, professionals, parents and persons with IDD?
20. What are your policies regarding visitors and privacy?
21. Do residents choose their daily routines?
22. What leisure and recreational activities are available?
23. How does your program accommodate a person who is non-ambulatory?
24. Do you have staff fluent in other languages or other types of communication (for example, sign language)? If not, is an interpreter available?
25. What type of transportation is available? Is it reliable and readily available?
26. Is staff available to support participation in community activities such as leisure activities, sports and religious services?

27. How and where are residents who are ill cared for?
28. Is medical staff willing to practice with a person who is uncomfortable with medical or dental procedures?
29. Will the person be able to live near *[fill in the blank as appropriate, for example, current school, day program, place of employment, family]*?
30. How does your agency build community awareness and prepare neighborhoods about persons with IDD who may move into their neighborhood? How are neighborhood disputes handled?
31. How does a person or family member lodge a complaint?
32. Have allegations about abuse or neglect been made about your program? Have any been confirmed?

Provider survey and certification information

Certification principles for program providers of HCS and TxHmL services can be found at www.sos.state.tx.us/tac/index.shtml. In the box on the right side of the screen, click on "View the current Texas Administrative Code." At the bottom of the screen, click on "Title 40 Social Services and Assistance." Click on "Part 1 Department of Aging and Disability Services." Click on "Chapter 9," then:

- For HCS provider certification principles, click on "Subchapter D," then click on §§9.172 through 9.179.
- For TxHmL provider certification principles, click on "Subchapter N," then click on §§9.578 through 9.580.

Every licensed or certified ICF/IID is required to post in its facility its most recent survey report and a notice that survey and related reports are available for public inspection.

Information about ICF/IID licensing, certification and enforcement can be found at www.hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/intermediate-care-facilities-individuals-intellectual-disability-or-related-conditions-icfiid/how-become-icfiid-provider.

Information about reporting abuse, neglect and exploitation in IDD programs can be found at www.hhs.texas.gov/about-hhs/your-rights/consumer-rights-services.

Other services and supports

Texas Workforce Commission (TWC)

TWC administers programs that help Texans with disabilities find jobs through vocational rehabilitation and ensure that Texans with disabilities live independently in their communities.

More information about TWC programs is available by calling 800-628-5115 or at www.twc.state.tx.us/jobseekers/vocational-rehabilitation-services.

Early Childhood Intervention (ECI) Services

HHSC administers a program which assists families in helping their children under age 3 with disabilities and delays in development to reach their full potential.

More information about the ECI program is available by calling 877-787-8999, selecting a language, then selecting Option 3; or at www.hhs.texas.gov/services/disability/early-childhood-intervention-services.

Preadmission Screening and Resident Review (PASRR)

PASRR is a federally mandated program that is applied to all individuals seeking admission to a Medicaid-certified nursing facility to identify:

- individuals who have a mental illness, an intellectual disability or a developmental disability (also known as related conditions),
- the appropriateness of placement in the nursing facility, and
- the eligibility for specialized services.

More information about PASRR can found at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/preadmission-screening-resident-review-pasrr>.

Additional information

After reviewing this information, you may have questions or concerns. You are encouraged to visit with your LIDDA representative in person. You may find it useful to speak with persons who are receiving services or their family members. Your LIDDA representative can help you do so. Additionally, there are organizations that provide advocacy and information to persons with IDD and their family members.

HHS Complaint and Incident Intake

800-458-9858

Cllcomplaints@hhsc.state.tx.us

HHS Office of the Ombudsman

877-787-8999

Texas Center for Disability Studies

The University of Texas at Austin

L4000 Commons Learning Center

10100 Burnet Road, Austin, Texas

78758-4445

800-282-7839

<http://tcds.edb.utexas.edu>

Disability Rights Texas

2222 West Braker Lane

Austin, Texas 78757-1024

512-454-4816

800-252-9108

www.disabilityrightstx.org

EveryChild, Inc.

8400 N. MoPac, Suite 201

Austin, Texas 78759

512-342-8844

877-742-8844 (toll free)

www.everychildtexas.org

The Arc of Texas (and Texas Advocates)

8001 Centre Park Drive, Suite 100

Austin, Texas 78754

800-252-9729

www.thearcoftexas.org

Texas Council for Developmental Disabilities

6201 E. Oltorf, Suite 600

Austin, Texas 78741-7509

800-262-0334

www.txddc.state.tx.us



Resource by County

7/18/2019

COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Anderson	Anderson-Cherokee Community Enrichment Services	903-723-6136
Andrews	West Texas Centers	888-831-6618
Angelina	Burke Center	800-621-1523
Aransas	Coastal Plains Community Center	361-528-4516
Archer	Helen Farabee Centers	800-669-4166
Armstrong	Texas Panhandle Centers	806-351-3212
Atascosa	Camino Real Community Services	800-491-5201
Austin	Texana Center	281-239-1363
Bailey	Central Plains Center	806-296-2726
Bandera	Hill Country MHDD Centers	830-387-5970
Bastrop	Bluebonnet Trails Community Services	844-309-6385
Baylor	Helen Farabee Centers	800-669-4166
Bee	Coastal Plains Community Center	361-528-4516
Bell	Central Counties Services	254-899-3061
Bexar	Alamo Area Council of Governments	210-832-5020
Blanco	Hill Country MHDD Centers	830-387-5970
Borden	West Texas Centers	888-831-6618
Bosque	Heart of Texas Region MHMR Center	254-757-3933
Bowie	Community Healthcore	800-446-8253
Brazoria	Gulf Coast Center	888-839-3229
Brazos	MHMR Authority of Brazos Valley	979-821-9433
Brewster	PermiaCare	432-580-2647
Briscoe	Central Plains Center	806-296-2726
Brooks	Coastal Plains Community Center	361-516-1067
Brown	Center for Life Resources	325-646-9574
Burleson	MHMR Authority of Brazos Valley	979-821-9433
Burnet	Bluebonnet Trails Community Services	844-309-6385
Caldwell	Bluebonnet Trails Community Services	844-309-6385
Calhoun	Gulf Bend Center	800-421-8825
Callahan	Betty Hardwick Center	325-690-5182
Cameron	Tropical Texas Behavioral Health	956-364-6600
Camp	Lakes Regional MHMR Center	903-243-9088 x2305
Carson	Texas Panhandle Centers	806-351-3212
Cass	Community Healthcore	800-446-8253
Castro	Central Plains Center	806-296-2726
Chambers	Spindletop Center	800-317-5809 x5481
Cherokee	Anderson-Cherokee Community Enrichment Services	903-723-6136
Childress	Helen Farabee Centers	800-669-4166
Clay	Helen Farabee Centers	800-669-4166
Cochran	StarCare Specialty Health System	800-687-7581
Coke	MHMR Services for the Concho Valley	325-658-7750
Coleman	Center for Life Resources	325-646-9574

Resource by County

7/18/2019

COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Collin	Lifepath Systems	972-727-9133
Collingsworth	Texas Panhandle Centers	806-351-3212
Colorado	Texana Center	281-239-1363
Comal	Hill Country MHDD Centers	830-387-5970
Comanche	Center for Life Resources	325-646-9574
Concho	MHMR Services for the Concho Valley	325-658-7750
Cooke	Texoma Community Center	866-233-4550
Coryell	Central Counties Services	254-899-3061
Cottle	Helen Farabee Centers	800-669-4166
Crane	West Texas Centers	888-831-6618
Crockett	MHMR Services for the Concho Valley	325-658-7750
Crosby	StarCare Specialty Health System	800-687-7581
Culberson	PermiaCare	432-580-2647
Dallam	Texas Panhandle Centers	806-351-3212
Dallas	Metrocare Services	214-333-7000
Dawson	West Texas Centers	888-831-6618
Deaf Smith	Texas Panhandle Centers	806-351-3212
Delta	Lakes Regional MHMR Center	903-243-9088 x2305
Denton	Denton County MHMR Center	940-565-5249
DeWitt	Gulf Bend Center	800-421-8825
Dickens	Helen Farabee Centers	800-669-4166
Dimmit	Camino Real Community Services	800-491-5201
Donley	Texas Panhandle Centers	806-351-3212
Duval	Coastal Plains Community Center	361-516-1067
Eastland	Center for Life Resources	325-646-9574
Ector	PermiaCare	432-580-2647
Edwards	Hill Country MHDD Centers	830-387-5970
El Paso	Emergence Health Network	915-599-6645
Ellis	Lakes Regional MHMR Center	903-243-9088 x2305
Erath	Pecan Valley Centers	866-948-7198
Falls	Heart of Texas Region MHMR Center	254-757-3933
Fannin	Texoma Community Center	866-233-4550
Fayette	Bluebonnet Trails Community Services	844-309-6385
Fisher	West Texas Centers	888-831-6618
Floyd	Central Plains Center	806-296-2726
Foard	Helen Farabee Centers	800-669-4166
Fort Bend	Texana Center	281-239-1363
Franklin	Lakes Regional MHMR Center	903-243-9088 x2305
Freestone	Heart of Texas Region MHMR Center	254-757-3933
Frio	Camino Real Community Services	800-491-5201
Gaines	West Texas Centers	888-831-6618
Galveston	Gulf Coast Center	888-839-3229

Resource by County

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COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Garza	West Texas Centers	888-831-6618
Gillespie	Hill Country MHDD Centers	830-387-5970
Glasscock	West Texas Centers	888-831-6618
Goliad	Gulf Bend Center	800-421-8825
Gonzales	Bluebonnet Trails Community Services	844-309-6385
Gray	Texas Panhandle Centers	806-351-3212
Grayson	Texoma Community Center	866-233-4550
Gregg	Community Healthcore	800-446-8253
Grimes	MHMR Authority of Brazos Valley	979-821-9433
Guadalupe	Bluebonnet Trails Community Services	844-309-6385
Hale	Central Plains Center	806-296-2726
Hall	Texas Panhandle Centers	806-351-3212
Hamilton	Central Counties Services	254-899-3061
Hansford	Texas Panhandle Centers	806-351-3212
Hardeman	Helen Farabee Centers	800-669-4166
Hardin	Spindletop Center	800-317-5809 x5481
Harris	The Harris Center for Mental Health and IDD	713-970-7070
Harrison	Community Healthcore	800-446-8253
Hartley	Texas Panhandle Centers	806-351-3212
Haskell	Helen Farabee Centers	800-669-4166
Hays	Hill Country MHDD Centers	830-387-5970
Hemphill	Texas Panhandle Centers	806-351-3212
Henderson	Andrews Center	800-374-6058
Hidalgo	Tropical Texas Behavioral Health	956-289-7000
Hill	Heart of Texas Region MHMR Center	254-757-3933
Hockley	StarCare Specialty Health System	800-687-7581
Hood	Pecan Valley Centers	866-948-7198
Hopkins	Lakes Regional MHMR Center	903-243-9088 x2305
Houston	Burke Center	800-621-1523
Howard	West Texas Centers	888-831-6618
Hudspeth	PermiaCare	432-580-2647
Hunt	Lakes Regional MHMR Center	903-243-9088 x2305
Hutchinson	Texas Panhandle Centers	806-351-3212
Irion	MHMR Services for the Concho Valley	325-658-7750
Jack	Helen Farabee Centers	800-669-4166
Jackson	Gulf Bend Center	800-421-8825
Jasper	Burke Center	800-621-1523
Jeff Davis	PermiaCare	432-580-2647
Jefferson	Spindletop Center	800-317-5809 x5481
Jim Hogg	Border Region Behavioral Health Center	361-527-5771
Jim Wells	Coastal Plains Community Center	361-516-1067
Johnson	Pecan Valley Centers	866-948-7198

Resource by County

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COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Jones	Betty Hardwick Center	325-690-5182
Karnes	Camino Real Community Services	800-491-5201
Kaufman	Lakes Regional MHMR Center	903-243-9088 x2305
Kendall	Hill Country MHDD Centers	830-387-5970
Kenedy	Coastal Plains Community Center	361-516-1067
Kent	West Texas Centers	888-831-6618
Kerr	Hill Country MHDD Centers	830-387-5970
Kimble	Hill Country MHDD Centers	830-387-5970
King	Helen Farabee Centers	800-669-4166
Kinney	Hill Country MHDD Centers	830-387-5970
Kleberg	Coastal Plains Community Center	361-516-1067
Knox	Helen Farabee Centers	800-669-4166
Lamar	Lakes Regional MHMR Center	903-243-9088 x2305
Lamb	Central Plains Center	806-296-2726
Lampasas	Central Counties Services	254-899-3061
LaSalle	Camino Real Community Services	800-491-5201
Lavaca	Gulf Bend Center	800-421-8825
Lee	Bluebonnet Trails Community Services	844-309-6385
Leon	MHMR Authority of Brazos Valley	979-821-9433
Liberty	Tri-County Services	936-334-3275 (City of Liberty) 281-432-3075 (City of Cleveland)
Limestone	Heart of Texas Region MHMR Center	254-757-3933
Lipscomb	Texas Panhandle Centers	806-351-3212
Live Oak	Coastal Plains Community Center	361-528-4516
Llano	Hill Country MHDD Centers	830-387-5970
Loving	West Texas Centers	888-831-6618
Lubbock	StarCare Specialty Health System	800-687-7581
Lynn	StarCare Specialty Health System	800-687-7581
Madison	MHMR Authority of Brazos Valley	979-821-9433
Marion	Community Healthcore	800-446-8253
Martin	West Texas Centers	888-831-6618
Mason	Hill Country MHDD Centers	830-387-5970
Matagorda	Texana Center	281-239-1363
Maverick	Camino Real Community Services	800-491-5201
McCulloch	Center for Life Resources	325-646-9574
McLennan	Heart of Texas Region MHMR Center	254-757-3933
McMullen	Camino Real Community Services	800-491-5201
Medina	Hill Country MHDD Centers	830-387-5970
Menard	Hill Country MHDD Centers	830-387-5970

Resource by County

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COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Midland	PermiaCare	432-571-3385
Milam	Central Counties Services	254-899-3061
Mills	Center for Life Resources	325-646-9574
Mitchell	West Texas Centers	888-831-6618
Montague	Helen Farabee Centers	800-669-4166
Montgomery	Tri-County Services	936-521-6200
Moore	Texas Panhandle Centers	806-351-3212
Morris	Lakes Regional MHMR Center	903-243-9088 x2305
Motley	Central Plains Center	806-296-2726
Nacogdoches	Burke Center	800-621-1523
Navarro	Lakes Regional MHMR Center	903-243-9088 x2305
Newton	Burke Center	800-621-1523
Nolan	West Texas Centers	888-831-6618
Nueces	Behavioral Health Center of Nueces County	361-884-9854
Ochiltree	Texas Panhandle Centers	806-351-3212
Oldham	Texas Panhandle Centers	806-351-3212
Orange	Spindletop Center	800-317-5809 x5481
Palo Pinto	Pecan Valley Centers	866-948-7198
Panola	Community Healthcore	800-446-8253
Parker	Pecan Valley Centers	866-948-7198
Parmer	Central Plains Center	806-296-2726
Pecos	PermiaCare	432-580-2647
Polk	Burke Center	800-621-1523
Potter	Texas Panhandle Centers	806-351-3212
Presidio	PermiaCare	432-580-2647
Rains	Andrews Center	800-374-6058
Randall	Texas Panhandle Centers	806-351-3212
Reagan	MHMR Services for the Concho Valley	325-658-7750
Real	Hill Country MHDD Centers	830-387-5970
Red River	Community Healthcore	800-446-8253
Reeves	West Texas Centers	888-831-6618
Refugio	Gulf Bend Center	800-421-8825
Roberts	Texas Panhandle Centers	806-351-3212
Robertson	MHMR Authority of Brazos Valley	979-821-9433
Rockwall	Lakes Regional MHMR Center	903-243-9088 x2305
Runnels	West Texas Centers	888-831-6618
Rusk	Community Healthcore	800-446-8253
Sabine	Burke Center	800-621-1523
San Augustine	Burke Center	800-621-1523
San Jacinto	Burke Center	800-621-1523
San Patricio	Coastal Plains Community Center	361-528-4516
San Saba	Center for Life Resources	325-646-9574

Resource by County

7/18/2019

COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Schleicher	Hill Country MHDD Centers	830-387-5970
Scurry	West Texas Centers	888-831-6618
Shackelford	Betty Hardwick Center	325-690-5182
Shelby	Burke Center	800-621-1523
Sherman	Texas Panhandle Centers	806-351-3212
Smith	Andrews Center	800-374-6058
Somervell	Pecan Valley Centers	866-948-7198
Starr	Border Region Behavioral Health Center	956-487-3748
Stephens	Betty Hardwick Center	325-690-5182
Sterling	MHMR Services for the Concho Valley	325-658-7750
Stonewall	Helen Farabee Centers	800-669-4166
Sutton	Hill Country MHDD Centers	830-387-5970
Swisher	Central Plains Center	806-296-2726
Tarrant	MHMR of Tarrant County	817-335-3022
Taylor	Betty Hardwick Center	325-690-5182
Terrell	West Texas Centers	888-831-6618
Terry	West Texas Centers	888-831-6618
Throckmorton	Helen Farabee Centers	800-669-4166
Titus	Lakes Regional MHMR Center	903-243-9088 x2305
Tom Green	MHMR Services for the Concho Valley	325-658-7750
Travis	Integral Care	512-472-4357
Trinity	Burke Center	800-621-1523
Tyler	Burke Center	800-621-1523
Upshur	Community Healthcore	800-446-8253
Upton	West Texas Centers	888-831-6618
Uvalde	Hill Country MHDD Centers	830-387-5970
Val Verde	Hill Country MHDD Centers	830-387-5970
Van Zandt	Andrews Center	800-374-6058
Victoria	Gulf Bend Center	800-421-8825
Walker	Tri-County Services	936-291-5875
Waller	Texana Center	281-239-1363
Ward	West Texas Centers	888-831-6618
Washington	MHMR Authority of Brazos Valley	979-821-9433
Webb	Border Region Behavioral Health Center	956-794-3060
Wharton	Texana Center	281-239-1363
Wheeler	Texas Panhandle Centers	806-351-3212
Wichita	Helen Farabee Centers	800-669-4166
Wilbarger	Helen Farabee Centers	800-669-4166
Willacy	Tropical Texas Behavioral Health	956-364-6600
Williamson	Bluebonnet Trails Community Services	844-309-6385
Wilson	Camino Real Community Services	800-491-5201
Winkler	West Texas Centers	888-831-6618

Resource by County

7/18/2019

COUNTY	LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY	PHONE NUMBER
Wise	Helen Farabee Centers	800-669-4166
Wood	Andrews Center	800-374-6058
Yoakum	West Texas Centers	888-831-6618
Young	Helen Farabee Centers	800-669-4166
Zapata	Border Region Behavioral Health Center	956-764-6504
Zavala	Camino Real Community Services	800-491-5201



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

4th Edition - 2018



Hogg Foundation
for Mental Health

HOGG FOUNDATION FOR MENTAL HEALTH

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

Over the years, the foundation has awarded millions of dollars in grants to continue the Hogg family's legacy of public service and dedication to improving mental health in Texas. Other donors have established smaller endowments at the foundation to support its mission.

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. To learn more, visit 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 discussion and differing perspectives about utilizing the terms “behavioral health” and “mental health.” In this document the term “behavioral health” is sometimes used when referring to both mental health and substance use. Our belief is that whether referring to mental health, substance use, or behavioral health, the goal is recovery and the focus is on the individual.

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Second Edition: November 2014

Third Edition: November 2016

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

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

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Overview and National Context

Overview

HOGG FOUNDATION FOR MENTAL HEALTH: OUR MISSION

TRANSFORM HOW COMMUNITIES PROMOTE MENTAL HEALTH IN EVERYDAY LIFE.

Mental health is not solely an individual responsibility, but is also a product of community conditions. The places where people live, learn, work, play, and pray can have a significant impact on improving mental health. Some mental health conditions are exacerbated by medical or clinical barriers, such as the lack of mental health professionals in the state. However, many poor outcomes stem from challenging environmental factors like housing stability, neighborhood infrastructure, and conditions at home, work and school.

Mental health should be a concept that is promoted beyond the walls of health clinics and integrated into everyday life. Community members, leaders, and professionals—from teachers and preachers, to police officers and judges—should understand the importance of mental health and the factors that influence it. Children should be supported by their families, teachers, peers, counselors, and administrators in ways that enhance social connection and resiliency.

PURPOSE OF THIS GUIDE

The primary purpose of this guide is to help inform mental health and substance use policy analysis, development, and decision-making. The maze of behavioral health services in Texas is complex, making it difficult to understand and consequently difficult to improve. The intended audience for this guide includes legislators, legislative staff, state agency staff, advocates with lived experience, family advocates, mental health providers, and other stakeholders interested in mental health and substance use policy.

Understanding the complex system of treatment, supports, and services is essential

to making well-informed decisions affecting access to public mental health services and the quality of services delivered. This 4th edition of *A Guide to Understanding Mental Health Systems and Services in Texas* is divided into the following sections:

- Overview and a National Context – offers the intended purpose of the guide and general information on mental health policy from the national perspective
- Texas Environment – provides an overview of the mental health and substance use issues currently being discussed by a broad spectrum of Texas stakeholders
- Public Mental Health Services – presents detailed information on public mental health and substance use services provided by the following Texas state agencies:
 - Texas Health and Human Services Commission
 - Texas Department of Family and Protective Services
 - Texas Education Agency
 - Texas Workforce Commission
 - Texas Department of Criminal Justice
 - Texas Juvenile Justice Department
 - Texas Department of Housing and Community Affairs
 - Texas Veterans Commission
- Appendices – includes additional information that helps to both maneuver this guide and supplement users’ research and learning efforts, including:
 - List of guide figures
 - Glossary of mental health terms
 - Additional resources

At the beginning of each section (see tabs) this guide will include a listing of the acronyms used in that section. We are hopeful that this will make for easier reading.

While this guide focuses primarily on state policies and programs for addressing mental health and substance use needs in Texas, the foundation recognizes the important role of communities. Many communities and local providers throughout the state are engaged in the development, implementation, and oversight of locally funded and operated programs and services that are specifically designed to meet the needs of those communities. We encourage communities to engage in local collaborative efforts aimed at addressing the mental health needs of Texans from a population health perspective. We encourage communities to place particular emphasis on identifying and supporting individuals who have been historically underrepresented in mental health policy discussions and those who experience significant health disparities.

Finally, The Hogg Foundation offers this guide to help policymakers and other stakeholders in Texas understand the array of mental health and substance use services currently available, the multiple access portals, and the numerous funding streams. While the information in this report is the best available at the time of its writing, the landscape is fluid and continually changing. We hope this guide serves as a useful introduction and a valuable resource that illustrates the critical need for a long-term, coordinated, sufficiently funded approach to providing effective mental health and substance use services in Texas.

The National Context

NATIONAL CONTEXT ACRONYMS

ACA – Affordable Care Act	RTC – Residential treatment center
CFCIP – Chafee Foster Care Independence Program	SAMHSA – Substance Abuse and Mental Health Services Administration
DFPS – Department of Family and Protective Services	SED – Serious emotional disturbance
FFPSA – Family First Protection Services Act	SMI – Serious mental illness
HHS – Health and Human Services Administration (US)	SSA – Social Security Administration
HHSC – Health and Human Services Commission	SSDI – Social Security Disability Income
IDU – Injectable drug use	SSI – Supplemental Security Income
LMHA – local mental health authority	SSP – Syringe Services Program
MHPAEA – Mental Health Parity and Addiction Equity Act	STR – State targeted response
	QRTP – Qualified residential treatment program

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

SAMHSA is the mental health and substance use agency within the U.S. Department of Health and Human Services. The 21st Century Cures Act created a new position at HHS – Assistant Secretary for Mental Health and Substance Use. Through grants, contracts, and technical assistance, SAMSHA is the country’s leading mental health and substance use agency supporting states’ efforts to improve mental health and substance use services. The agency’s primary objectives include mental health and substance research dissemination, dissemination of evidence-based programs, awarding grants with strong performance criteria, and strong collaboration with stakeholders and other federal agencies.¹ SAMHSA’s ten regional administrators conduct efforts throughout the country to support SAMHSA’s mission.

SAMHSA also offers services aimed at connecting people to the services they need. Some of these initiatives include:

- Behavioral Health Treatment Services Locator - <https://findtreatment.samhsa.gov/>
- National Helpline - <https://www.samhsa.gov/find-help/national-helpline>; 1-800-662-HELP (4357)
- National Suicide Prevention Lifeline - <https://suicidepreventionlifeline.org/>; 1-800-273-TALK (8255)
- Disaster Distress Helpline - <https://www.samhsa.gov/find-help/disaster-distress-helpline>; 1-800-985-5990
- Veteran’s Crisis Line - <https://www.veteranscrisisline.net/>; 1-800-273-TALK (8255); Text 838255
- Opioid Treatment Program Directory - <https://www.colleaga.org/tools/united-states-opioid-treatment-program-directory>

MENTAL HEALTH AND SUBSTANCE USE BLOCK GRANTS

SAMHSA awards mental health and substance use block grants to states to “establish, expand or enhance an organized, community-based system for providing mental health services for adults with serious mental illness (SMI), children with serious emotional disturbances (SED), and adults and adolescents with or at risk for substance use disorder (SUD).”² In previous years, separate applications for mental health and substance use block grant funds were submitted. The current practice, however, is for the applications to be combined. While these community mental health funds only account for approximately 5 percent of Texas’ expenditures for community mental health (offered through a network of local mental health authorities or LMHAs), approximately 87 percent of the state’s expenditures for substance use services are provided through the block grant. The amounts awarded to Texas for FY 2018-19 were \$43 million for community mental health services and \$145 million for substance use services.³ These funds are distributed throughout the 11 health and human services regions in Texas.

In recent years, Texas has attempted to coordinate the federal requirements for the block grant funds with the Texas Statewide Behavioral Health Strategic Plan to help develop more coordinated services at the local level. The FY 2018-19 block grant application can be accessed at <https://www.dshs.texas.gov/mhsa/blockgrant/>.

MEDICAID

Medicaid is a joint state and federal healthcare program designed for individuals with low household income, as well as the elderly and people with disabilities. Medicaid is the largest funder of mental health services in the public mental health system and also supports substance use funding, albeit not at the same level.⁴

Medicaid offers a broad array of mental health benefits including mental health evaluation, diagnosis, and treatment. Treatment options include individual therapy, group therapy, family therapy, detoxification, medication management, and more. In addition to Medicaid state plan services, mental health and substance use treatment and services can be offered through 1115 waiver projects, as well as 1915(c) waivers.

While Medicaid is a vital funding stream for mental health and substance use services, some federal proposals being considered may put these services at risk. Some of these potential risks include:

- Medicaid block granting – would give each state a set amount of funding for all Medicaid recipients. Currently each state is given a federal funding match per Medicaid enrollee. Medicaid block grants are often discussed as a way to reduce federal spending, but this funding change could result in a significant reduction of services available by not providing states a per enrollee funding allotment.
- Repeal of Medicaid expansion – while Medicaid expansion was not enacted in Texas, people with mental illness and substance use conditions have been the largest beneficiary of expansion benefits in other states.⁵ If Medicaid expansion were repealed, people with mental illness and substance conditions across the nation would lose access to health care.

- Sustainability of 1115 waiver funding – while Texas recently was granted a multi-year extension of its 1115 waiver funding, long-term sustainability is questionable with the gradual elimination of DSRIP funding; more than 400 of the original 1115 waiver projects in Texas were dedicated to mental health and/or substance use projects statewide.

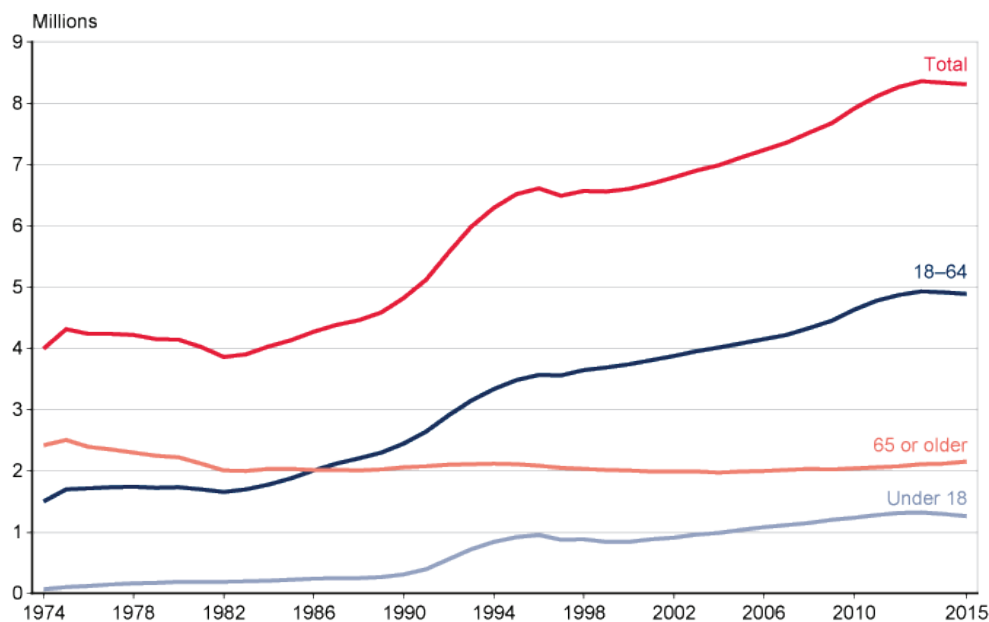
In addition to the mental health and substance use benefits offered by Medicaid, the program also offers primary medical benefits to eligible recipients. More information on Medicaid is in the HHSC section of the guide.

SOCIAL SECURITY INCOME AND SOCIAL SECURITY DISABILITY INCOME

Supplemental Security Income and Social Security Disability Insurance have close ties to health insurance for people with disabilities. SSI is administered by the Social Security Administration 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. In most states, including Texas, individuals who receive SSI benefits are also immediately eligible for Medicaid under the same eligibility requirements. Detailed information on SSI can be found in the Social Security Handbook, Chapter 21, at https://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-toc21.html.

Nationwide, the number of individuals receiving SSI benefits continues to rise. Figure 1 provides data on historical trends from 1974 through 2015.

Figure 1. Number of Recipients, 1974-2015



Source: Social Security Administration. (2018). *Facts and Figures About Social Security*. Retrieved from https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2016/fast_facts16.html.

To receive SSI, recipients must meet both income and asset limits. Table 1 depicts those criteria for 2018.

Table 1. Supplemental Security Income Program Rates and Limits

Supplemental Security Income Program Rates & Limits	2018
Monthly Federal Payment Standard (dollars)	
Individual	\$750
Couple	\$1,125
Cost-of-Living Adjustment (percent)	2.0%
Resource Limits (dollars)	
Individual	\$2,000
Couple	\$3,000
Monthly Income Exclusions (dollars)	
Earned Income ^a	\$65
Unearned Income	\$20
Substantial Gainful Activity (SGA) Level for the Non-blind Disabled (dollars)	\$1,180
^a The earned income exclusion consists of the first \$65 of monthly earnings, plus one-half of remaining earnings.	

Source: Social Security Administration. (2018). *OASDI and SSI Program Rates & Limits, 2018*. Retrieved from https://www.ssa.gov/policy/docs/quickfacts/prog_highlights/index.html.

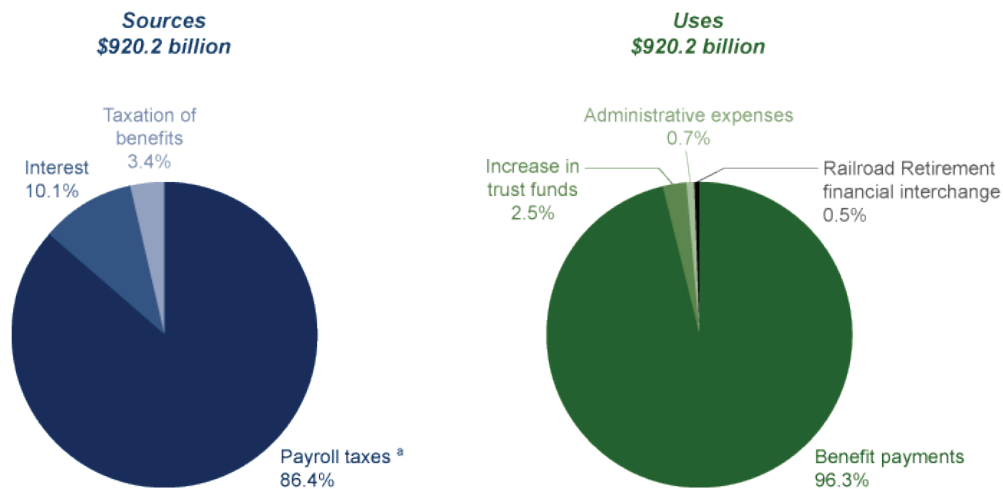
At the federal level, there is continued conversation regarding the sustainability of various social security programs. Figure 2 provides general information on how social security is financed.

Figure 2. How Social Security is Financed

How Social Security Is Financed

Social Security is largely a pay-as-you-go program. Most of the payroll taxes collected from today’s workers are used to pay benefits to today’s recipients. In 2015, the Old-Age and Survivors Insurance and Disability Insurance Trust Funds collected \$920.2 billion in revenues. Of that amount, 86.4% was from payroll tax contributions and reimbursements from the General Fund of the Treasury and 3.4% was from income taxes on Social Security benefits. Interest earned on the government bonds held by the trust funds provided the remaining 10.1% of income. Assets increased in 2015 because total income exceeded expenditures for benefit payments and administrative expenses.

Sources and uses of Social Security revenues in 2015



Source: 2016 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Table II.B1.

NOTE: Totals do not necessarily equal the sum of rounded components.

^aIncludes General Fund reimbursements, which accounted for less than 0.1% of Trust Fund income.

Social Security Disability Income 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.

At the beginning of 2018, Social Security paid an average monthly disability benefit of \$1,197 to all disabled workers. That is barely enough to keep a beneficiary above the 2017 poverty level (\$12,060 annually). For many beneficiaries, their monthly disability payment represents most of their income. SSDI payments allow people to meet basic needs and the needs of their families. Even these modest payments can make a huge difference in the lives of people who can no longer work.

Source: Social Security Administration. (2018) *The Faces and Facts of Disability*. Retrieved from <https://www.ssa.gov/disabilityfacts/facts.html>

Most people receiving SSDI benefits have not been able to work due to their disability for at least one year. SSDI beneficiaries are required 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.

In 2014, the social security disability benefit paid 715,796 Texans approximately

\$8.4 billion. Individuals received an annual average benefit of \$13,728, which is only slightly more than the federal poverty threshold of \$12,316.⁶

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.

Table 2 below details the major differences between the two programs.

Table 2. SSI and SSDI Differences

Program	Supplemental Social Income	Social Security Disability Insurance
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: <ul style="list-style-type: none"> • individuals over 65 • adults and children with a disability or blindness 	Benefits are payable to: <ul style="list-style-type: none"> • workers with a disability • their children • their surviving spouse • 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>

The United States Social Security Administration. (2015). *Disability Benefits*. Retrieved from <https://www.ssa.gov/pubs/EN-05-10029.pdf>

IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is federal law that prohibits certain health plans and health insurers from imposing stricter limitations on offered mental health and/or substance use benefits than on medical and/or surgical benefits. Although the law passed in 2008, changes to parity requirements were also included in the Patient Protection and Affordable Care Act (commonly referred to as the “ACA”), and the final federal parity regulations were not released until January 2014.

“The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Parity Law) promised equity in the insurance coverage of mental health and substance use disorder care, but years later mental health parity is still not a reality and too many Americans continue to be denied care when they need it the most. To fulfill the promise of the Parity law, we must hold health insurance plans accountable to comply with the letter and spirit of the law.”

The Kennedy Forum, retrieved from <https://www.thekennedyforum.org/vision/parity/>

While data on the implementation of parity regulations has been hard to collect, anecdotal information often indicates a disconnect between the federal government and state agencies with respect to responsibility for enforcement. The nationwide opioid crisis, however, has fueled the desire of many to ensure that appropriate treatment options are available to those who need the services.⁷

On April 23, 2018, the U.S. Department of Health and Human Services released its *Mental Health and Substance Use Disorder Parity Action Plan as required by the 21st Century Cures Act*. The action plan can be accessed at <https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/21st-century-cures-act-section-13002/index.html>. HHS has reiterated their commitment to parity for mental health and substance use services. As part of this commitment, HHS has created an online portal to help answer questions related to parity. The portal can be accessed at <https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html>.

For additional information on Texas-focused mental health and substance use parity initiatives, please see the Texas Environment section of this guide.

THE FAMILY FIRST PREVENTION SERVICES ACT

In February 2018 as part of the Bipartisan Budget Act of 2018 (H.R. 1892), Congress passed the Family First Prevention Services Act (FFPSA) restructuring the way the federal government pays for child welfare services.^{8,9} The legislation aims to help families in crisis safely stay together, reduce the foster care population by focusing on preventing entry into foster care, and increase the number of children successfully exiting foster care by reducing reliance on congregate care in favor of more family-like settings.¹⁰

The largest source of child welfare funding comes from Title IV-E of the Social Security Act, which provides states with funds to support foster care, adoption assistance, guardianship assistance, and the Chafee Foster Care Independence Program, a grant program that helps foster youth gain self-sufficiency. With the exception of CFCIP, children must meet income eligibility requirements for Texas to be reimbursed for IV-E funded programs. Beginning October 1, 2019, the FFPSA will change Title IV-E funding in two primary ways:

- More flexibility to invest in prevention programs
- Funding will no longer be available for certain congregate care placements

The FFPSA will provide states with additional funding to invest in prevention programs aimed to keep children at imminent risk of foster care placement out of the system, assist pregnant and parenting youth already in foster care, and better support kinship caregivers. Trauma-informed and evidence-based programs are required and the law allowed mental health and substance use prevention services to qualify for funds.

Additionally, the FFPSA precludes states from using IV-E funding to support children in foster care who spend more than two weeks in “child care institutions,” a broad term that encapsulates settings like group homes and residential treatment centers. Under the FFPSA, states can only use IV-E funding for services provided to children in the following congregate care settings beyond two weeks:

- facilities for pregnant and parenting youth
- supervised independent living for youth 18 and older
- specialized placements for youth who are victims of or at risk of becoming victims of sex trafficking
- family based residential treatment facilities for substance use disorder
- Qualified Residential Treatment Programs (QRTP)

A QRTP is a new standard for congregate care settings. The term refers to a program that has a trauma-informed treatment model designed to address the needs, including clinical, of children with serious emotional or behavioral disorders or disturbances.¹¹ Appropriately licensed clinical staff must be available to provide care 24 hours a day under this standard. Due to the complexity of the new QRTP standard, the federal government has allowed states the option of delaying implementation of the law until 2021.¹² States that choose to delay implementation cannot draw down any of the newly available prevention dollars until they are in full compliance with the law.

Further guidance from the federal government is due October 1, 2018. See the Department of Family and Protective Services section of this guide for details on how the FFPSA will impact Texas.

IMMIGRATION AND THE TRAUMA OF FAMILY SEPARATION

In May of 2018, the Trump Administration instituted a “zero tolerance” immigration policy, resulting in the separation of immigrant children from their families at the US border. Thus far, more than 2,500 immigrant and refugee children have been separated from their parents.¹³

Family separation is a traumatic event for parents, but especially for children. Separation from family is one of the most potent traumatic events a child can experience; the act of separation may increase children’s risk for developing a number of mental health diagnoses including depression, anxiety, and post-traumatic stress disorder.¹⁴ The emotional and physical trauma caused by family separation can affect children long after they are reunited with their parents. Research has found that children who experienced

trauma as a result of family separation still show signs of traumatic reactions, like the inability to trust others, well into adulthood.¹⁵ Additionally, many of these families were seeking legal asylum after fleeing from violence in their home countries. Cumulative exposure to trauma, including previous experiences with domestic or gang violence, increases the risk of developing traumatic reactions.¹⁶

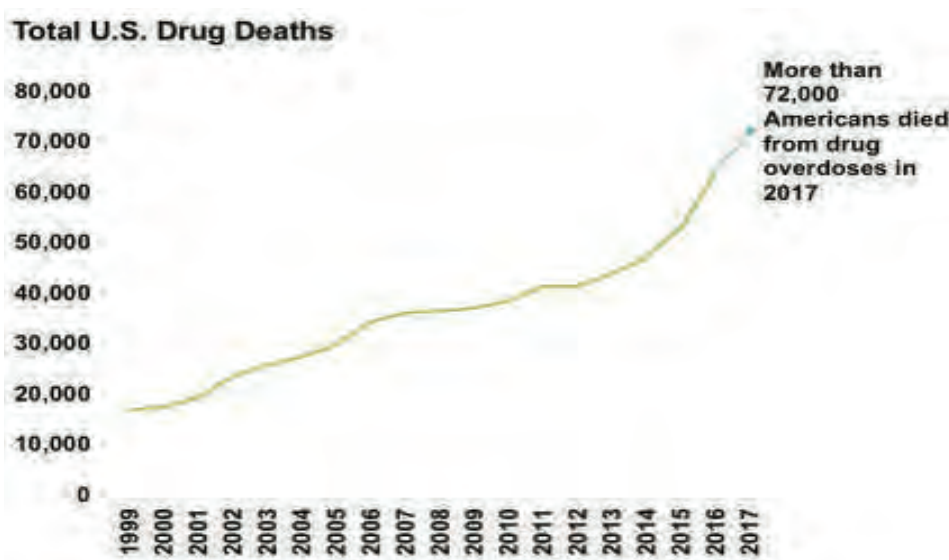
Fortunately, with the right supports, families can recover from trauma. Children and parents must be screened to identify their specific needs, followed by full assessments and the provision of appropriate, trauma-informed care.¹⁷

During the production of this guide, the many families remained separated and reunification efforts were still underway. As of August 10, 2018, 559 children had not been reunited with their parents.¹⁸

SUBSTANCE USE

Substance use conditions and drug overdoses across the United States continue to increase across the country and across demographics. The Center for Disease Control and Prevention released its in-depth analysis of drug overdoses in 2016, the most recent finalized data available. The analysis shows drug overdose deaths surpassed any previous collected data and resulted in more than 60,000 lost lives. Specifically, opioids have been synonymous with overdose conversations and accounted for over 40,000 of the reported deaths that year – five times higher than 1999. Estimates show that 116 people across the country die each day due to an opioid overdose.¹⁹ The full analysis can be found at <https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html>. Though not finalized, provisional data estimated that drug overdose deaths increased again in 2017, with more than 72,000 deaths. Figure 3 illustrates the total of number of deaths per year due to drug overdoses, inclusive of the preliminary data from 2017.

Figure 3. Number of overdose deaths in the United States - 1999-2017



Source: National Institute on Drug Abuse. (August 2018). *Overdose death rates*. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

The Comprehensive Addiction and Recovery Act (P.L. 114-198), signed into law in 2016, was the first major federal substance-use-focused legislation in over 40 years. The Act aimed to create a coordinated response through prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. While the legislation authorized over \$181 million each year in new funding, the law required that dollars be appropriated every year through the regular appropriations process.²⁰

Also in response to the overwhelming need for action on access to substance use treatment for opioids, the 21st Century Cures Act created Opioid State Targeted Response grants. In 2017, SAMHSA announced it would award over \$485 million per year for two years to all 50 states, the District of Columbia, four U.S. territories, and the free-associated states of Palau and Micronesia in Opioid STR grants. The focuses of the program include opioid services, increased access to treatment, reducing unmet treatment needs, and reduction of overdose deaths

Further, in 2018 HHS announced \$930 million to be awarded in additional opioid STR grants, aimed at “critical gaps in availability of treatment for opioid use disorders in geographic, demographic, and service level terms,” which increased capacity for opioid related topics covered in the original STR grants. At the time of print, the granting of these funds had yet to be published.²¹ For additional information on Texas’ Opioid STR grant funding, please see the Texas Environment section of this guide.

As the opioid epidemic has become more prevalent across the country, so has the number of individuals using substances intravenously, thus heightening the risk of communicable diseases.²² While opioids are not the only substance used intravenously, the recent attention has brought awareness to the public health implications and concerns. Injectable drug use has been shown to be the most common means of transmitting hepatitis C virus other common transmittal causes include transmission during birth from an HCV-infected mother and needlesticks in health care settings.²³ HIV has also become more common across IDU, now accounting for 1 in 10 new HIV diagnoses in the country.²⁴

One public health approach to combatting these issues are syringe services programs. SSPs are community-based programs that provide comprehensive harm reduction services such as sterile needles/syringes, testing, education, referrals, and counseling. SSPs have been shown to reduce needle stick injuries in first responders, reduce overdose deaths, while maintaining cost-effectiveness (\$1 invested is reported to save \$6 associated with treating HIV). Further, the individuals served by SSPs are five times more likely to enter substance use treatment, while exhibiting no increases in illicit drug use, including IDU.^{25,26,27} Prior to 2016, federal funding was unable to be used toward SSPs in any capacity. However the Consolidated Appropriations Act of 2016 modified the restrictions. Federal funds can now be used for services at SSPs, exclusionary of sterile needles, by state and local communities under certain circumstances. In 2018, there were 318 SSPs across 39 states, D.C., and Puerto Rico.²⁸ Texas and 10 other states do not currently have an SSP for reasons such as potential legal consequences of syringes/needles considered paraphernalia.

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Texas Environment Acronyms

ACA – Affordable Care Act	DARS – Department of Assistive and Rehabilitative Services
ACH – All Church Home	DEA – Drug Enforcement Agency
AMFI – Average median family income	DFPS – Department of Family and Protective Services
AMI – Area median income	DSHS – Department of State Health Services
CMHC – community mental health center	DSRIP – Delivery System Reform Incentive Payment Program
CMS – Centers for Medicaid and Medicare Services	
CSC – Coordinated specialty care	
DADS – Department of Aging and Disability Services	

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

Leadership Changes at the Texas Health and Human Services Commission

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

Health and Human Services System Transformation

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

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

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

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

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

Transforming Inpatient Psychiatric Services in Texas

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

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

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

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

- Aging infrastructure in need of extensive repairs
- Staff shortages resulting in available beds being taken offline
- Increased demand for inpatient services creating long waiting lists often resulting in long waits in jail for forensic patients awaiting competency restoration
- Reduced access to inpatient services for those entering the system through civil commitments
- Growing Texas population⁴

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

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

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

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

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

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

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

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

Community Mental Health

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

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

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

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

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

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

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

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

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

BEHAVIORAL HEALTH COLLABORATIVE MATCHING GRANT PROGRAMS

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

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

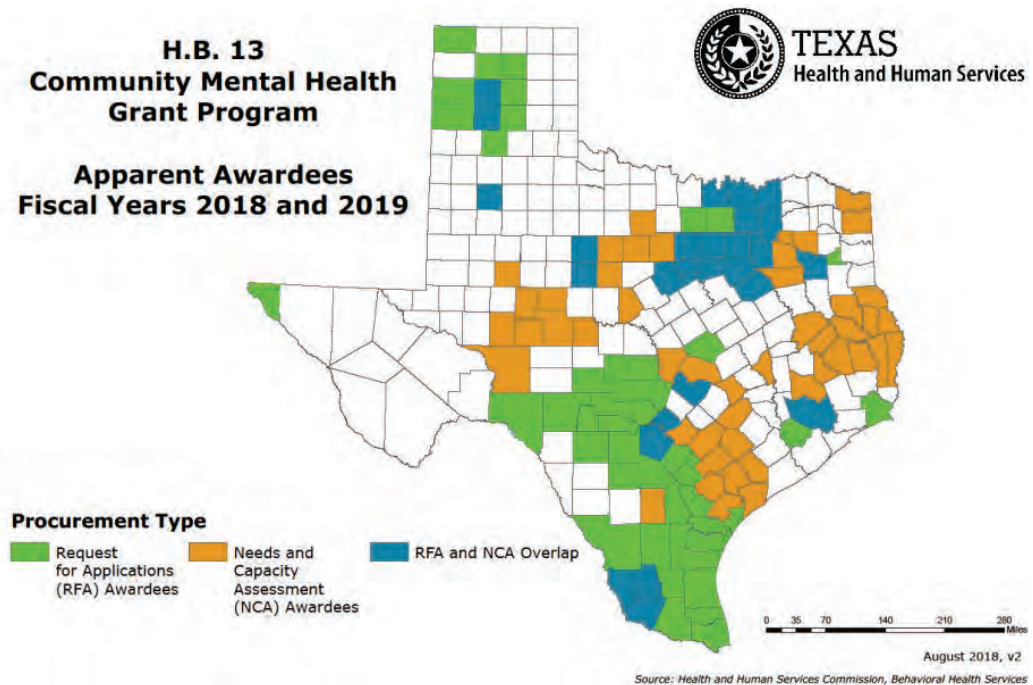
HHSC will award funding through either a Needs and Capacity Assessment or Requests for Application. NCAs are to be completed by LMHAs and LBHAs to determine awards, with half of the awards allocated to counties with populations under 250,000. RFAs are to be completed by non-profit and other governmental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

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

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

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

Figure 4. Map of HB 13 Grant Awards



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

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

Acceptable uses of the grant are:

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

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

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

Figure 5. Map of SB 292 Urban Grant Awards

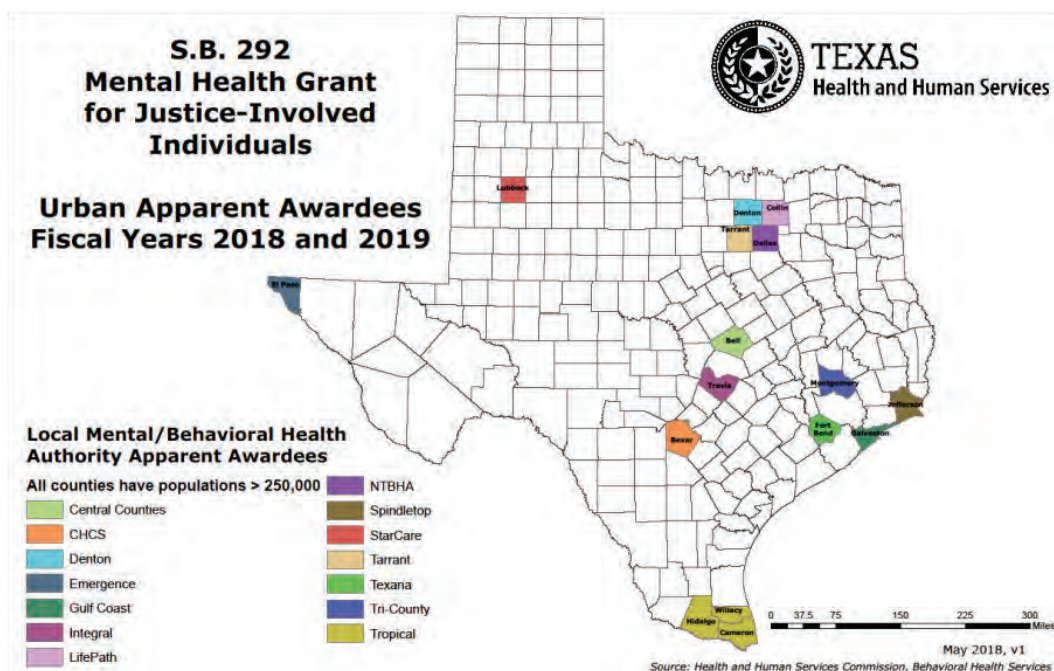
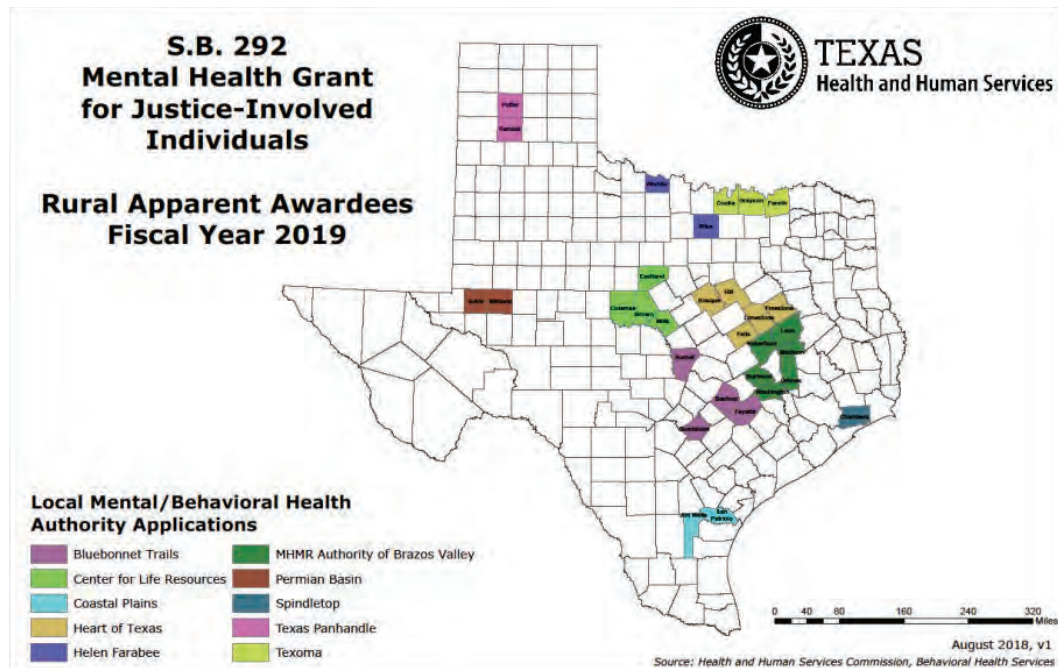


Figure 6. Map of SB 292 Rural Grant Awards



School Safety and Children's Mental Health

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

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

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

SCHOOL AND FIREARM SAFETY ACTION PLAN

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

INTERIM LEGISLATIVE HEARINGS

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

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

EXTREME RISK PROTECTIVE ORDERS

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

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

SCHOOL-BASED MENTAL HEALTH SERVICES

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

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

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

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

Peer Support Services

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

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

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

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

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

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

Mental Health and Substance Use Parity

Per federal regulations in the Mental Health Parity and Addiction Equity Act, all health plans that offer mental health or substance use benefits must provide those benefits at the same level (“parity”) as surgical and medical benefits. Originally passed in 2008, MHPAEA applied to only large employer plans but was expanded in 2010 through the Affordable Care Act to most private health plans, and eventually to Medicaid MCO plans and CHIP in 2016.³³

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

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

Parity is meant to ensure the equal treatment of mental health and substance use condition benefits to medical and surgical benefits, but consumers continue to report issues in accessing services. Although Texas had its own parity rules and regulations, many consumers continued to struggle to receive mental health and substance use services through their health plans. National reports indicate that the nation had serious barriers to true mental health parity. For example, a 2015 NAMI report found that people report being denied mental health care nearly twice as often as they report being denied general medical care.³⁴ Consumers face parity-related barriers including denials based on medical necessity, lack of access to an adequate provider base, and prescription cost and accessibility.³⁵ However, TDI reported that the agency only received seven total complaints related to parity in 2014 and ten complaints through June 2016.³⁶ This could be due to individuals reporting parity complaints to the Department of Labor or not labeling a complaint as a violation of parity.

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

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

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

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

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

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

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

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

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

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

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

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

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

Gap 9: Behavioral Health Services for Individuals with Intellectual Disabilities

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

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

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

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

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

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

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

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

1115 Waiver: Texas Health Care Transformation and Quality Improvement Program

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

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

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

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

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

RENEWAL

In December 2017, CMS approved a five-year renewal of the 1115 Waiver to continue the program through September 2022. The extension continues Medicaid managed care, the UC pool, and the DSRIP pool, though includes new standards and requirements for the funding pools. The renewal of the 1115 Waiver outlines a phase out plan for DSRIP funding and the new method of figuring and distributing UC payments. Following the renewal, CMS approved HHSC’s new Program and Funding Mechanics protocol that modifies the requirements for participation in DSRIP beginning October 1, 2017 through September 30, 2019.⁴⁷ The CMS approval letter of the 1115 Waiver renewal is available at <https://hhs.texas.gov/sites/>

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

THE UNCOMPENSATED CARE POOL

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

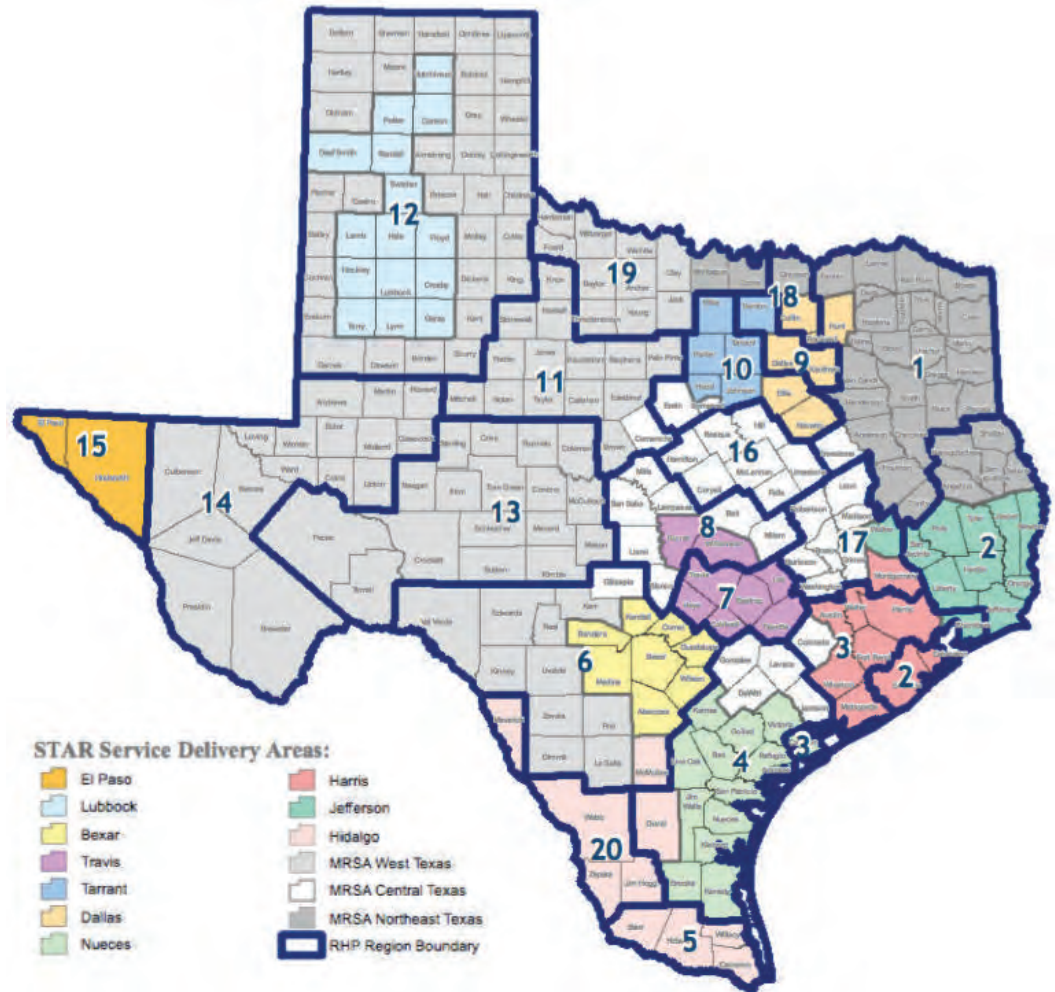
THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS POOL

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

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

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

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



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

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

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

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

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

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

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

Examples of current behavioral health DSRIP projects include:

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

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

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

OUTCOMES OF DSRIP PROJECTS UNDER THE 1115 WAIVER

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

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

DSRIP projects without continued DSRIP funding ⁶²

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

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

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

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

Telemedicine and Telehealth Services

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

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

- Psychiatric diagnostic evaluations
- Psychotherapy (with an individual and/or their family)
- Office visits
- Other outpatient visits including counseling, coordination of care with other physicians and decision-making
- Inpatient consultation, pharmacologic management and medication review⁷³

The legislative push for the approval of telemedicine medical services in Texas began in 1995.⁷⁴ Interest in telemedicine services waned in the early 2000s but in recent years, legislators have a renewed interest in funding and expanding telemedicine and telehealth options. The following telemedicine/telehealth bills were passed by the 84th Texas Legislature in 2015:

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

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

- Updated delivery modalities acceptable for reimbursement
- Updated patient and distant site guidelines, as specified by TMB
- Updated patient site presenter requirements, as specified by TMB
- Updated guidelines for valid prescriptions generated from a telemedicine visit, as specified by TMB, BON, TPAB, and TSBP
- Updated guidelines concerning the practitioner-patient relationship required for a telemedicine visit⁷⁸

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

- Eighty percent of emergency room visits are due to patients lacking access to a primary care physician; telemedicine eliminates nearly one in five emergency room visits.
- The average cost of an emergency room visit is \$2,168, while the average cost of a telemedicine visit is \$40.⁸⁰

BENEFITS OF TELEMEDICINE AND TELEHEALTH SERVICES

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

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

Telemedicine is increasingly being pursued as a solution to help alleviate access to care challenges experienced by certain marginalized groups, like geriatric consumers and individuals with mobility issues, in addition to consumers in rural areas.

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

Hurricane Harvey

EDUCATION

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

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

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

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

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

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

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

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

HOUSING

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

Just as there were major losses to single-family housing, many affordable multifamily housing units, often the only affordable housing options available to people experiencing serious mental illness, sustained severe damage. More than 1,930 units tied to Public Housing Assistance, including Section 8 and Housing Choice vouchers, were lost in the storm.⁹⁷ The total cost of these losses amounts to nearly \$25,600,000.⁹⁸ According to a FEMA-calculated needs assessment, approximately 46 percent of those in need of housing fall within the Low and Moderate Income category (under 80 percent of the Area Median Family Income).⁹⁹ Of those 46 percent, nearly half are people who make 30 percent or less AMFI and are considered to be extremely low income.¹⁰⁰

As of April 2018, two rounds of HUD funding were proposed for Harvey recovery. At the end of 2017, HUD allocated \$57.8 million in Community Development Block Grant – Disaster Recovery dollars to help address immediate housing needs.¹⁰¹ These funds were left over from CDBG-DR dollars issued to Texas for floods in 2015 and 2016. The GLO submitted an action plan to HUD for these dollars in March 2018.¹⁰² By rule, 80 percent of the money must be spent in Harris County, while the remaining 20 percent will be allocated across Aransas, Nueces, and Refugio counties for an affordable rental program.^{103,104} Additionally, 70 percent of the funds must benefit LMI households.¹⁰⁵ In Harris County, funds will be used to buy-out single family properties for LMI households and to provide federal match for the Partial Repair & Essential Power for Sheltering program. PREPS is a program specific to Harvey recovery that provides partial home repair to displaced families, allowing them to return home until full repairs can be completed. Outside of Harris County, dollars will be spent on rebuilding affordable workforce housing.

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

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

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

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

Substance Use in Texas

The substance use condition and drug overdose death epidemic continues to grow increasingly visible in national headlines. This epidemic has had devastating effects in Texas and across the country. From 1999-2016, drug overdoses have been responsible for over 630,000 deaths across the United States.¹⁰⁹ In 2016, there were a reported 2,831 overdose deaths in Texas alone, with opioid-related deaths reaching 1,375 and surpassing any previously collected data since 1999.¹¹⁰ Methamphetamine accounted for 715 deaths and according to half of the DEA offices in Texas, remains the major drug threat in Texas.¹¹¹

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

Another issue exacerbating the current substance use and overdose death crisis is access to treatment for people who are low-income and do not have health coverage. While substance use disorder benefits under Medicaid were expanded as a directive from the 81st legislature, not many people qualified for these services and only 5,967 individuals were treated for SUD under Medicaid in 2015.¹¹⁴ Other low-income individuals in need of SUD treatment can receive services through the Substance Abuse Prevention and Treatment block grant if the individual is unable to acquire private insurance, Medicaid,

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

TEXAS HOUSE SELECT COMMITTEE ON OPIOIDS AND SUBSTANCE ABUSE

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

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

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

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

TEXAS LAWSUIT AGAINST OPIOID MANUFACTURER

Nationally, sales of prescriptions for opioid medications have quadrupled since 1999, with a total of 15.9 million prescriptions written in Texas alone in 2015.¹¹⁹ Part of a

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

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

TEXAS TARGETED OPIOID RESPONSE

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

SUBSTANCE USE IN THE CRIMINAL JUSTICE SYSTEM

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

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

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

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

Mental Health Workforce

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

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

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

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

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

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

Veterans

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

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

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

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

During the 85th Interim, both committees in the House and Senate associated with Veteran Affairs were charged with the oversight of implementation of SB 27, while the House was also charged to monitor SB 578. HHSC is expected to have goals identified for the veteran suicide prevention plan by September 1, 2018, with short-term goals implemented by September 2021 and long-term goals by September 2027.¹³⁸ More information on veterans services is available in the Texas Veterans Commission section of the guide.

Housing for People Experiencing Mental Illness and Substance Use Disorder

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

units affordable to extremely low income households.¹⁴¹

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

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

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

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

First Episode Psychosis

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

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

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

Foster design/Community-Based Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Policy Concerns

- Providing access to services for low-income Texans with mental illness who are ineligible for Medicaid.
- Ensuring adequacy of reimbursement rates for behavioral health and primary care services.
- Sustained funding for Medicaid 1115 Transformation Waiver projects and integrating successful projects into Medicaid managed care.
- Continue efforts to enforce mental health and substance use parity for Medicaid and CHIP.
- Monitoring and ensuring behavioral health network adequacy in Medicaid managed care.
- Ensuring access to quality community-based mental health and substance use services through integrated service delivery and managed care models that emphasize recovery, prevention, and continuity of care.
- Addressing the critical mental health workforce shortage, particularly in rural areas.
- Expanding opportunities for peer specialist, recovery coach, and family partner support services; ensuring adequate reimbursement rates that validate the importance of these services.
- Ensuring the ongoing success and improvement of services for children and youth available through the YES Waiver.
- Continuation of efforts to improve and expand state inpatient psychiatric facilities and integrate a comprehensive continuum of supports and services.
- Improving client outcome performance measures to focus more on mental health outcomes and patient-centered recovery, and less on easy-to-measure outputs.
- Reducing the use of criminal justice agencies and programs to address the needs of individuals experiencing mental illness; reducing the time people spend incarcerated while waiting for competency restoration services.
- Expansion of access to comprehensive coordinated care as a response to FEP.
- Addressing the mental health needs of individuals with intellectual disabilities.
- Coordination of services between HHSC divisions and other state agencies offering mental health services (e.g., TEA, TDHCA, DFPS, TDCJ, TJJD, TWC)
- 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 waiver programs.
- Improved wait list time for inpatient and community-based services.

Fast Facts

- The 2018-2019 HHSC appropriation was over \$62 billion and comprised 29 percent of the state's entire budget.¹
- In May 2018, 4,351,298 individuals were enrolled in the Texas Medicaid program.²
- Children without disabilities account for 69 percent of Medicaid enrollment but only 32 percent of program spending on direct healthcare services.³

- Texas has 73 FQHCs serving over 1.3 million Texans at more than 300 sites statewide.⁴
- The population growth in Texas between 2010 and 2017 (12.6 percent) was more than double the national average (5.5 percent), increasing demand for HHSC-funded services.^{5,6}
- As of July 2018, 73 percent of counties in Texas (186 out of 254) were designated as Mental Health Professional Shortage Areas.⁷
- As of May 2018, Texas has 1141 people trained as certified mental health peer specialists and 624 individuals with active peer specialist certifications, enabling them to use their lived experiences with behavioral health issues to help recipients of HHSC-funded services.⁸
- Staffing issues are exacerbating waiting lists for forensic inpatient beds — more than 100 hospital beds were offline as of March 2018 because of staffing issues.⁹
- The coexistence of an IDD along with a mental illness is sometimes referred to as a dual diagnosis.¹⁰ The developmental disability often overshadows the mental health condition often leaving the individual undiagnosed or under-diagnosed.
- It is estimated that as many as 30 to 40 percent of persons with intellectual disabilities are diagnosed with a mental health condition.¹¹ 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.¹²
- Children with IDD are more likely to have experienced traumatic events including emotional, physical, and sexual abuse, as well as neglect and maltreatment when compared to their able-bodied peers.¹³ While many individuals with IDD have known histories of abuse (some research suggests nearly 30 percent), the rate may be higher because of underreporting or lack of recognition by family and other caregivers.¹⁴
- 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.¹⁵ 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.¹⁶
- As of June 2018, there were more than 263,000 individuals on interest lists for waiver program slots.¹⁷

HHSC Acronyms

ACA – Affordable Care Act

ACT – Assertive Community Treatment

ANSA – Adult Needs and Strengths Assessment

APS – Adult Protective Services

APS PI – Adult Protective Services Provider

Investigations

ASD – Autism spectrum disorders

BHAC – Behavioral Health Advisory Committee

CANS – Child and Adolescent Needs and Strength

Assessment

CBT – Cognitive behavioral therapy

CHIP – Children’s Health Insurance Program

CIHCP – County Indigent Health Care Program

CIL – Centers for Independent Living

CLOIP – Community living options information process

CMS – Centers for Medicaid and Medicare Services

COPSD – Co-occurring psychiatric and substance abuse

disorders services

CPS – Child Protective Services

CRS – Comprehensive Rehabilitation Services

CSC – Coordinated specialty care

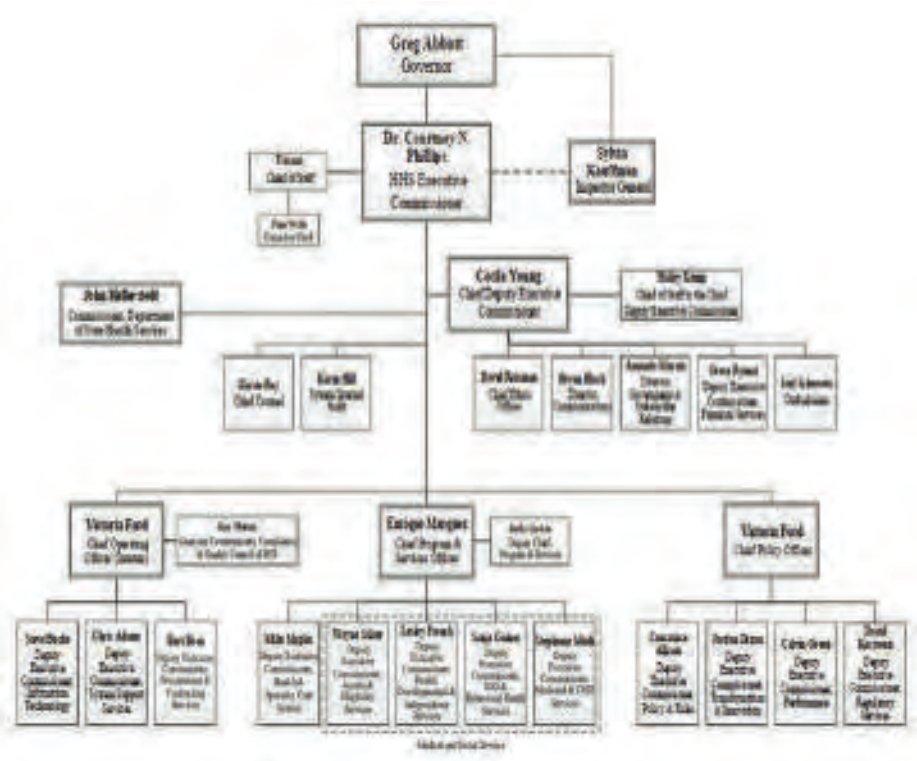
DADS – Department of Aging and Disability Services

DARS – Department of Assistive and Rehabilitative

Services

DDS – Disability Determination Services	OCR – Outpatient competency restoration
DFPS – Department of Family and Protective Services	ODPC – Office of Disability Prevention for Children
DSM-V – Diagnostic and Statistical Manual of Mental Disorders, 5 th edition	OSAR – Outreach, screening, assessment, and referral center
DSRIP – Delivery System Reform Incentive Payment	PASRR – Preadmission screening and resident review
ECI – Early Childhood Intervention	QTLs – Quantitative treatment limits
IDEA – Individuals with Disabilities Education Act	RHP – Regional healthcare partnership
FEP – First Episode Psychosis	ROSC – Recovery-oriented systems of care
FFCC – Former Foster Care Children	RSS – Recovery support services
FMAP – Federal medical assistance percentage	RTC – Residential treatment center
FPG – Federal poverty guidelines	SAMHSA – Substance Use and Mental Health Services Administration
FPL – Federal poverty level	SBIRT – Screening, brief intervention, and referral to treatment
FQHC – Federally Qualified Health Center	SCI – Spinal cord injury
GAO – Government Accounting Office	SED – Serious emotional disturbance
GR – General revenue	SH – State hospital
HCBS-AMH – Home and Community-based Services – Adult Mental Health	SMI – Serious mental illness
HCS – Home and community-based services	SNAP – Supplemental Nutrition Assistance Program
HCSSA – Home and community support services agency	SOC – Systems of care
HEDIS – Healthcare Effectiveness Data and Information Set	SPA – Medicaid state plan amendment
HHS – Health and Human Services	SPMI – Serious and persistent mental illness
HHSC – Health and Human Services Commission	SSA – Social Security Administration
HPSA – Health Professional Shortage Area	SSDI – Social Security Disability Income
HPSA-MH – Health Professional Shortage Area for Mental Health	SSI – Supplemental Security Income
ICF/IDD – Intermediate care facility-intellectual and developmental disabilities	SSLC – State-supported living center
ICM – Intensive case management	STAR – State of Texas Access Reform
ICR – Inpatient competency restoration	STAR Health – State of Texas Access Reform program for children in CPS system
IDD – Intellectual and other developmental disabilities	STAR Kids – State of Texas Access Reform program for children with disabilities eligible for SSI
IL – Independent living	STAR+Plus – State of Texas Access Reform program that includes long-term services and supports
IMD – Institutions for Mental Diseases	SUD – Substance use disorder
IST – Incompetent to stand trial	TANF – Temporary Assistance for Needy Families
JBCR – Jail-Based Competency Restoration	TAS – Transition assistance services
LAR – Legally authorized representative	TBI – Traumatic brain injury
LBB – Legislative Budget Board	TCCP – Texas Code of Criminal Procedures
LBHA – Local behavioral health authority	TDCJ – Texas Department of Criminal Justice
LIDDAs – Local intellectual/developmental disability authorities	TDHCA – Texas Department of Housing and Community Affairs
LMHAs – Local mental health authorities	TDI – Texas Department of Insurance
LOC – Level of care	TEA – Texas Education Agency
LOC-A – Level of care-authorized	TJJD – Texas Juvenile Justice Department
LOC-EO – Level of care-early onset	TMHP – Texas Medicaid Healthcare Partnership
LOC-R – Level of care-recommended	TRI – Texas Recovery Initiative
LOS – Length of stay	TRR – Texas Resiliency and Recovery
LTSS – Long-term services and supports	TVC – Texas Veterans Commission
MCO – managed care organization	TWC – Texas Workforce Commission
MCOT – Mobile crisis outreach teams	YES Waiver – Youth Empowerment Services Waiver
MDCP – Medically Dependent Children’s Program	
MSU – Maximum security unit	
MTFCY – Medicaid for Transitioning Foster Care Youth	
NQTLs – non-quantitative treatment limits	
NWI – National Wraparound Initiative	

Texas Health and Human Services System Organizational Chart



Source: Texas Health and Human Services Commission. (2018). Data request received October 8, 2018.

Overview

The Texas Health and Human Services Commission is the umbrella agency providing a multitude of services and programs to Texans. These programs and services include Medicaid, CHIP, long-term services and supports, SNAP food benefits, TANF cash benefits, mental health and substance use services, services for older Texans, and health services for women and people with disabilities. These services are delivered through a complex system of programs and benefits. HHSC also oversees certain regulatory functions such as nursing facility licensing and credentialing, licensing of child care providers and management of state supported living centers and state psychiatric facilities.

The Texas Department of State Health Services is also under the HHSC umbrella but operates as a separate department. DSHS focuses on public health functions such as vital statistics, compiling and disseminating health data, prevention of chronic and infectious diseases, laboratory testing, and licensing and regulating certain facilities and operations.

Changing Environment

The 2017 legislative session contained a wide variety of competing priorities for legislators to tackle. Mental health and substance use were priorities most legislators and stakeholders could agree on. The Select Committee on Mental Health released a report a few weeks before the legislative session began with a number of recommendations related to mental health services and funding. Some of the recommendations influenced legislation filed during the session. Bills passed during session lead to an overall funding increase for mental health and substance use services, including dedicated funds for community grant programs. A few notable bills related to HHSC that passed are detailed below.

HB 10 (85TH, PRICE/ZAFFIRINI) – IMPROVING MENTAL HEALTH PARITY

HB 10 required the Texas Department of Insurance to regulate and enforce both QTLs and NQTLs and other parity regulations for all health plans in Texas. It also directed:

- HHSC to create a Behavioral Health Access to Care Ombudsman position within the existing HHSC Office of the Ombudsman to:
 - Assist consumers in accessing needed services, file complaints or appeals with their health plan, and navigate the mental health or substance use system; and
 - Assist behavioral health care providers who are seeking information on behalf of consumers they serve, including parity complaints.
- HHSC to create a Parity Stakeholder Workgroup to create a parity compliance plan for the state, allowing the workgroup to be a subcommittee of the existing BHAC;
- HHSC and TDI to conduct data collection to compare denial rates of physical health services to mental health and substance use services;
- Reports containing this data should be available sometime late 2018.

The Parity Stakeholder Workgroup is a subcommittee of the Texas Behavioral Health Advisory Committee and met for the first time in November 2017. The ombudsman position was filled in Spring 2018 and is located in the Office of the Ombudsman at HHSC. The Behavioral Health Ombudsman webpage was established after the position was filled: <https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-behavioral-health-help>.

To further educate consumers and providers about the mental health and substance use parity, HHSC established a webpage for Mental Health and Substance Use Disorder Parity: <https://hhs.texas.gov/services/health/medicaid-chip/programs/mental-health-substance-use-disorder-parity>.

HB 13 (85TH, PRICE/SCHWERTNER) – BUILDING COMMUNITY COLLABORATIONS

HB 13 created a matching grant program within HHSC for community mental health programs providing services and treatment to individuals experiencing mental illness; both private nonprofit and governmental entities are eligible to apply. The legislation requires:

- Development of criteria for evaluating grant applications;
- That 50 percent of the funding appropriated for this grant program be reserved for programs in counties with a population of less than 250,000;
- An awardee match with non-state funds depending on the county population:
- Counties with a population of less than 250,000 are required to match 50 percent of the grant amount;
- Counties with a population greater than 250,000 are required to match 100 percent of the grant amount.

HB 1486 (85TH, PRICE/SCHWERTNER) - EXPANSION OF PEER SUPPORT SERVICES

HB 1486 (85th, Price/Schwertner) directed HHSC, with input from a formal workgroup, to develop rules defining peer support services, eligibility criteria to become a certified peer specialist, and certification and supervision requirements. The legislation also directed HHSC to include peer support services provided by certified peer specialists as a reimbursable service in the state Medicaid plan. Peer support services are inclusive of mental health services and substance use recovery services.

During 2018, HHSC and the workgroup developed the required rules, policies, and procedures with an expected implementation date of January 1, 2019.

More details on peer services can be found in the Texas Environment Section.

DIVERSION FUNDING TO PREVENT CHILD RELINQUISHMENT

Building on their 2015 investment of \$4.8 million, the 85th Legislature appropriated another \$1.4 million to add to the state's bed capacity at RTCs, increasing the total number of beds from 10 to 30.¹⁸ These 30+ beds are specially allocated for the prevention of parental relinquishment of children with SED solely to obtain mental health services.¹⁹ Between January 2014 and the beginning of 2016, 61 children were served by these specially-allocated RTC beds – 25 of those children were successfully discharged back into their homes 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 after receiving outpatient services through the YES Waiver or from their local mental health authority.²⁰

1115 MEDICAID TRANSFORMATION PROJECTS

The Texas Health Care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, was created for Texas to expand its use of Medicaid managed care while preserving hospital funding. The 1115 Transformation Waiver provides incentive payments for health care improvements and directs more funding to offset costs for hospitals that serve large numbers of uninsured patients.²¹

In December 2017, CMS approved an approximately \$25 billion five-year renewal of the Texas 1115 Transformation Waiver from October 2017 to September 2022. The funding is directed toward hospital's Uncompensated Care and DSRIP payments.

The uncompensated care pool payments are intended to help hospitals who serve a large number of uninsured patients who cannot pay for care. DSRIP Pool Payments are meant to test new models of providing health care, including mental health and substance use.²² Under CMS's new terms, DSRIP funding will temporarily continue and will eventually be phased down to zero by 2022.²³

Eligibility to receive Uncompensated Care or DSRIP payments requires participation in an RHP. RHPs support coordinated efficient delivery of quality health care and a plan for investments in system transformation that is driven by the needs of local hospitals, communities, and populations.²⁴

For a list of active DSRIP projects, see the HHSC list of approved and active projects at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/011316/Active-DSRIP-Projects-DY2-6_20170301.xlsx.

SB 1107 (85TH, SCHWERTNER/PRICE) – EXPANDING TELEMEDICINE AND TELEHEALTH SERVICES

Viewed as ways to help more Texans access health care in rural and underserved areas, telemedicine and telehealth were topics of interest for legislators in the 85th legislative session. SB 1107 (Schwertner/Price) created an accountability structure of a valid practitioner-patient relationship via telemedicine, including removes an existing rule that required a face-to-face visit for specific medical services. The bill also required the Texas Medical Board, the Texas Board of Nursing, the Texas Physician Assistant Board, and the Texas State Board of Pharmacy to jointly adopt rules that allow a valid practitioner-patient relationship to be established via telemedicine. SB 1107 required the aforementioned boards to jointly develop answers to frequently asked questions relating to prescriptions issued via telemedicine, and to publish the answers on their respective websites. Further, the bill stipulates that the standards of care for telemedicine or telehealth service be the same as would apply to the service or procedure in an in-person setting; prohibits any agency from adopting rules that would impose a higher standard of care for telemedicine or telehealth. Finally, SB 1107 excluded mental health services from the requirements of Chapter 111 related to practitioner-patient relationship for telemedicine medical services.

Changes from SB 1107 impacted private health plan coverage for telemedicine and telehealth in addition to Medicaid. HHSC accepted comments regarding SB 1107's changes to the telemedicine and telehealth benefit in spring of 2018. Implementation efforts were still underway during summer of 2018.

1915(i) HOME AND COMMUNITY BASED SERVICES WAIVER FOR ADULT MENTAL HEALTH

The Medicaid state plan allows for the 1915(i) Home and Community Based Services Waiver for Adult Mental Health. This waiver was intended to support adults with serious mental illness who are at risk of institutionalization by providing a number of services in addition to traditional mental health treatment to keep them living in the community. In order to qualify for the waiver services, an individual must meet financial eligibility guidelines along with mental health criteria. Services include, but are not limited to, TAS, HCBS Psychosocial Rehabilitation Services, Adaptive Aids, Employment Services, Transportation, Peer Support Services, Host Home and Companion Care, Supervised Living Services, Assisted Living Services,

Supported Home Living, Respite Care, Home Delivered Meals, and Minor Home Modifications.²⁵ Waiver services are typically provided through LMHAs and their contracted local partners.²⁶

ADULT PROTECTIVE SERVICES PROVIDER INVESTIGATIONS

As of September 1, 2017, the Adult Protective Services Provider Investigation program was transferred from DFPS to HHSC. APS PI investigates allegations of abuse, neglect, and exploitation of people served by certain providers in a facility setting (i.e., state hospitals, SSLCs, ICF/IDDs and certain contracted inpatient facilities). Investigations encompass:

- Allegations in state-operated or contracted programs that serve adults and children with mental illness and intellectual disabilities;
- Allegations involving Medicaid providers of home and community-based services and behavioral health services;
- Allegations of abuse, neglect, and exploitation involving Consumer Directed Services employees and certain HCSSA; and
- Allegations involving individuals residing in an HCS group home regardless of whether the individual is receiving services under the waiver program from the provider, as well as all children receiving services from an HCSSA.²⁷

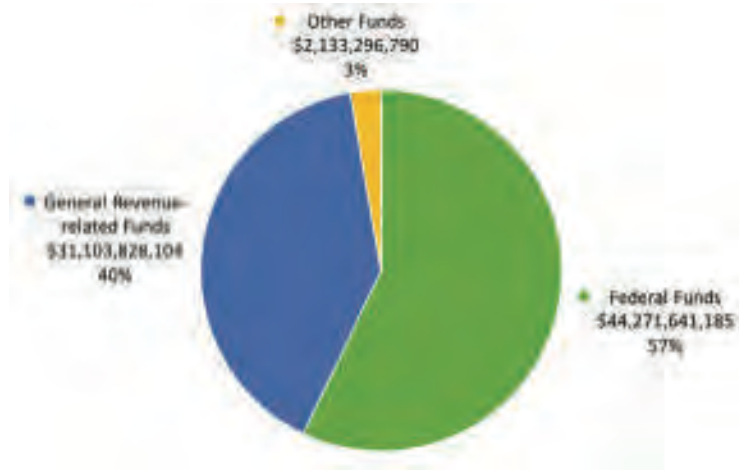
In FY 2017 APS PI completed 20,724 facility investigations responding to reports of abuse or neglect of adults.²⁸ The majority of facility abuse or neglect allegations were for individuals enrolled in Home and Community-Based Service Programs (37 percent), State-Supported Living Centers (24.1 percent), and Home and Community Based Services (18.6 percent).²⁹ Roughly 5 percent (1,050) of all allegations of abuse or neglect in adult facilities in 2017 (20,724) were confirmed after an investigation by APS PI.³⁰

The majority of reports of abuse and neglect in adult facilities come from three groups of people: the victims themselves (20.2 percent), institutional personnel (14 percent), and community agencies (13.7 percent).³¹ The Austin region had more allegations of abuse than any other region due to the region's high concentration of inpatient facilities, but Austin had a lower percentage of allegations confirmed as abuse or neglect (3.9 percent) when compared to the rates of the other 10 regions within the state (5.9 percent).³²

Funding

HHSC funding continues to be a major component of the State of Texas biennial budget comprising approximately 36 percent of the total budget for the FY 2018-19 biennium. Mental health funding has historically been underfunded, including reimbursement rates for providers. This impacts provider willingness to participate in the state Medicaid program which in turn directly impacts access to services. The Texas Legislature has increased mental health funding over the last several biennium, but many programs and services remain underfunded.

Figure 8. Health and Human Services Commission Budget by Method of Finance (FY 2018-19)



Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

Table 3 below shows the HHSC funding trends from 2017 through the 2021 funding requests.

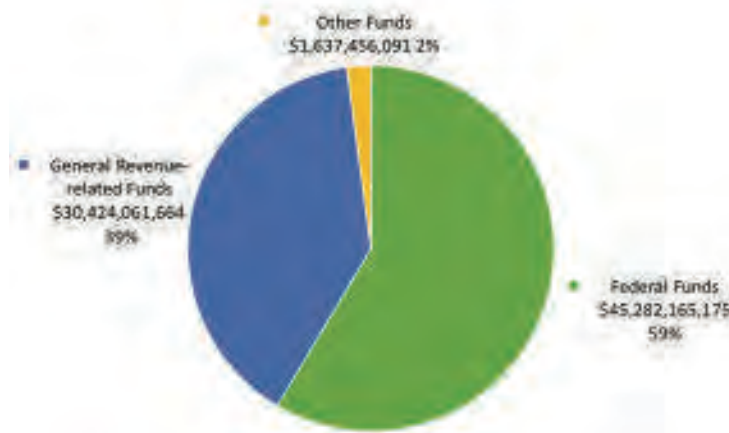
Table 3. HHSC Funding Trends

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
HHSC	\$35,954,627,574	\$38,151,559,499	\$39,357,206,580	\$38,291,959,320	\$39,051,723,610

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

Figure 9 below depicts the breakdown of the anticipated sources of funding for HHSC FY 2020/21.

Figure 9. 2020/21 Legislative Appropriations Request by Method of Financing, Baseline Budget



Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

Health and Human Services System Transformation (2003 to 2017)

Over the last 15 years, the Texas Health and Human Services System has undergone extensive reorganization in an attempt to streamline and improve services. The first round of reforms came in 2003 when the 78th Legislature passed HB 2292. Under that round of reforms, HHSC became the umbrella agency overseeing multiple programs including Medicaid, CHIP, SNAP, the Medical Transportation Program, and the Disaster Assistance Program. Additionally, HHSC was responsible for the operation of four major departments:

- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services

Together, HHSC and these departments comprised the Health and Human Services enterprise.

In 2015, the Texas Sunset Advisory Commission performed a comprehensive review of the HHS system and recommended that the legislature consolidate agencies to improve efficiency and service delivery.³³ The 2015 Sunset Commission Report recommended further consolidation as a step toward achieving the state's 2003 vision for efficient, streamlined health and human services. The sunset report also found that further system reorganization was needed because of 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.³⁴

Informed by the commission's recommendations in 2015, the 84th Legislature directed further consolidation of the HHS enterprise through SB 200. The initial phase of the transition transferred the following functions to HHSC:

- Client services other than vocational rehabilitation-related programs
 - Vocational rehabilitation-related programs transferred to the Texas Workforce Commission
- Client services previously administered through the Department of Disability and Aging Services
- Client services previously administered through the Department of State Health Services
- Administrative services that supported the above programs and client services.³⁵

Additionally, as part of the transition legislated by SB 200, behavioral health and regulatory functions previously administered by DSHS and DFPS were transferred to HHSC.³⁶ The Office of Mental Health Coordination was relocated to the Intellectual and Developmental Disability and Behavioral Health Services Department and reports to the associate commissioner of that department. Additionally, the Forensic Director position, previously in DSHS, was moved to the Behavioral Health Services Division. This position manages forensic services in both the inpatient and outpatient services programs and coordinates closely with both.

Due to the transfer of services to HHSC and TWC, the Department of Assistive and Rehabilitative Services was abolished effective September 2, 2016. Additionally, as of September 1, 2017, client services previously provided through DSHS and DADS were transferred to HHSC, including state hospital inpatient services, SSLCs, and some regulatory and administrative services. DADS was abolished effective September 1, 2017.

In the 2017 legislative session, HB 5 (85th, Frank/Schwertner) established the Department of Family and Protective Services as an independent agency effective September 1, 2017. Consequently, HHSC is now comprised of two agencies:

- Texas Health and Human Services Commission
- Texas Department of State Health Services

In 2018, the transition process continued and was monitored by the Joint Health and Human Services Transition Legislative Oversight Committee. Transformation planning and implementation continues within the HHS System and is led by the Transformation, Policy and Performance Office, which now reports to the Chief Policy Officer. The Chief Policy Officer reports directly to the executive commissioner and is responsible for innovation, performance management, policy development, and data analysis.³⁷

Additionally, the HHSC Executive Council was established as part of the transformation. The primary purpose of the council is to obtain public input and to advise the HHSC executive commissioner on policies relating to the health and human services system.³⁸ The Council meets approximately four times per year and is currently comprised of HHSC executive leadership, the commissioners of DFPS and DSHS, and three members of the public. Information on the HHSC Executive Council is available at <https://hhs.texas.gov/about-hhs/leadership/councils/health-human-services-commission-executive-council>.

HHSC Advisory Committees

As part of their 2015 assessment, the Sunset Commission reviewed all health and human services advisory committees. The committees were either continued, abolished, or consolidated with other committees. The continuing committees were reestablished in rule; a list is available on the HHSC website at <https://hhs.texas.gov/about-hhs/leadership/advisory-committees>. Several of the continuing committees have a direct impact on mental health and substance use policies, including but not limited to:

- Behavioral Health Advisory Committee
- Mental Health Condition and Substance Use Disorder Parity Workgroup (subcommittee of the Behavioral Health Advisory Committee)
- E-Health Advisory Committee
- Early Childhood Intervention Advisory Committee
- Medical Care Advisory Committee
- Policy Council for Children and Families Committee State Independent Living Council
- STAR Kids Managed Care Advisory Committee

- State Medicaid Managed Care Advisory Committee
- Statewide Advisory Coalition for Addressing Disproportionalities and Disparities
- Texas Autism Council
- Texas Council on Consumer Direction

HHS Regions

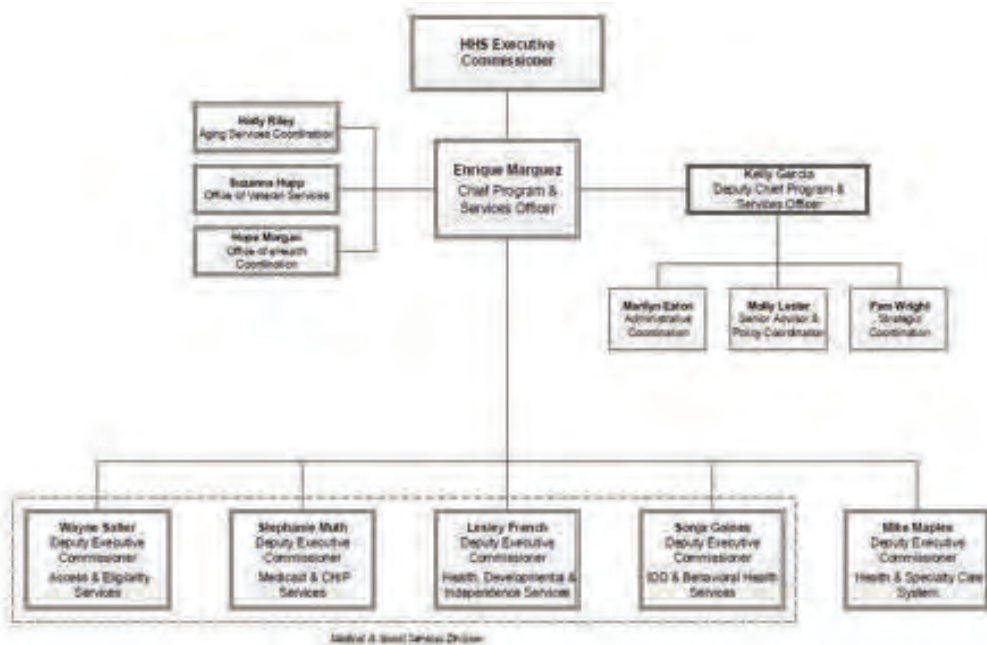
For service delivery administration, the state is divided into 11 HHS regions, displayed in Figure 10. The HHS system employs over 42,947 full-time employees.³⁹

Figure 10. Health and Human Services Regions



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

Medical and Social Services Division



Source: Health and Human Services Commission, Public Information Request, September 2018.

Under the new HHSC organizational structure, the chief deputy executive commissioner oversees the Medical and Social Services Division which now includes the Health and Specialty Care System Division previously known as the State Facilities Division. The Medical and Social Services Division is responsible for:

- Medicaid and CHIP Services
- IDD and Behavioral Health Services Division
- Health, Developmental & Independence Services Division
- Health and Specialty Care System (formerly known as the State Operated Facilities Division)
- Access and Eligibility Services, which includes:

OFFICE OF MENTAL HEALTH COORDINATION

In recent years, mental health and substance use (sometimes referred to as “behavioral health”) have become major topics of both state and 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 tasked with providing broad oversight for state mental health policy as well as managing cross-agency coordination of behavioral health programs, services, and expenditures.⁴⁰ The office reports directly to the deputy executive commissioner for IDD & Behavioral Health Services. The office developed a website to provide consumers, families, and providers with up-to-date information on mental health and substance use programs and services. More information is available at <http://www.mentalhealthtx.org>.

STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

In 2015, as part of the state's ongoing efforts to coordinate services across agencies and departments (including those outside of the HHS system), the legislature established the Behavioral Health Coordinating Council. The HHSC assistant commissioner, who oversees the Office of Mental Health Coordination at HHSC, serves as chair of the council.⁴¹ Twenty-three agencies and departments now work together under the direction of the Office of Mental Health Coordination. The agencies included in the Council are:

- Health & Human Services Commission
- Office of the Governor
- Texas Veterans Commission
- Department of Family and Protective Services
- Texas Civil Commitment Office
- University of Texas Health Science Center at Houston
- University of Texas Health Science Center at Tyler
- Texas Department of Criminal Justice
- Texas Juvenile Justice Department
- Texas Military Department
- Health Professions Council (includes six member agencies)
- Texas Education Agency
- Texas Tech University System
- Texas Commission on Jail Standards
- Texas Workforce Commission
- Texas Department of Housing and Community Affairs
- Texas Indigent Defense Commission
- Court of Criminal Appeals

The agencies represented on the Council worked together to develop a statewide strategic plan for mental health programs and services. The Statewide Behavioral Health Strategic Plan identified 15 primary gaps in behavioral health services in Texas, and is available at <https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf>.

Senator Jane Nelson, Chairwoman of the Senate Finance Committee during the 85th legislative session, has indicated that any legislative proposals directed toward behavioral health should address one or more of these identified gaps. The gaps include:

- Access to Appropriate Behavioral Health Services
- Behavioral Health Needs of Public School Students
- Coordination Across State Agencies
- Veteran and Military Service Members Supports
- Continuity of Care for Individuals Exiting County and Local Jails
- Access to Timely Treatment Services
- Implementation of Evidence-Based Practices
- Use of Peer Services
- Behavioral Health Services for Individuals with Intellectual Disabilities

- Consumer Transportation and Access to Treatment
- Prevention and Early Intervention Services
- Access to Housing
- Behavioral Health Workforce Shortage
- Services for Special Populations
- Shared and Usable Data⁴²

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.

The Behavioral Health Coordinating Council developed the Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2018. The table below summarizes the total behavioral health funding identified. The full proposal is available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/sb1-behavioral-health-expenditure-proposal-fy2018.pdf>

BEHAVIORAL HEALTH EXPENDITURES

The Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2018 is detailed across the state budget by article, as shown in Figure 11 below.

Figure 11. Coordinated Statewide Behavioral Health Expenditures Proposal for Fiscal Year 2018

Agency	GAA, Article IX, Sec. 10.04, FY 2018 Expenditures - All Funds	Proposed FY 2018 Expenditures - General Revenue	Proposed FY 2018 Expenditures - All Funds	Variance between GAA, Article IX, Sec. 10.04 and Proposed Expenditures - FY 2018 All Funds
Office of the Governor ¹	\$ 7,400,000	\$ (9,572,121)	\$ (2,172,121)	\$ (2,172,121)
Texas Wildlife Commission	\$ 7,400,000	\$ -	\$ 7,400,000	\$ -
Article II Subtotal	\$ 14,800,000	\$ (9,572,121)	\$ 5,227,879	\$ (9,572,121)
Department of Family and Protective Services	\$ 29,421,228	\$ 13,908,564	\$ 43,329,792	\$ 13,908,564
Health and Human Services Commission ²	\$ 1,217,219,200	\$ 1,099,281,181	\$ 1,198,502,361	\$ (118,716,839)
Texas Civil Commitment Office	\$ 254,811	\$ 254,811	\$ 254,811	\$ -
Article III Subtotal	\$ 1,484,777,182	\$ 1,112,840,796	\$ 1,499,463,811	\$ (285,933,371)
University of Texas - Health Science Center at Houston	\$ 8,000,000	\$ 8,000,000	\$ 8,000,000	\$ -
University of Texas - Health Science Center at Tyler	\$ 4,000,000	\$ 4,000,000	\$ 4,000,000	\$ -
Article III Subtotal	\$ 12,000,000	\$ 12,000,000	\$ 12,000,000	\$ -
Court of Criminal Appeals	\$ 318,500	\$ 318,500	\$ 318,500	\$ -
Article IV Subtotal	\$ 318,500	\$ 318,500	\$ 318,500	\$ -
Texas Commission on Jail Standards	\$ 385,185	\$ 385,185	\$ 385,185	\$ -
Texas Department of Criminal Justice	\$ 261,544,159	\$ 261,544,159	\$ 261,544,159	\$ -
Texas Juvenile Justice Department ³	\$ 80,245,891	\$ 81,985,268	\$ 82,796,116	\$ (1,548,773)
Texas Probation Department	\$ 966,700	\$ 966,700	\$ 966,700	\$ -
Article V Subtotal	\$ 348,457,875	\$ 347,685,262	\$ 348,112,529	\$ (345,346)
Texas State Board of Dental Examiners	\$ 111,828	\$ 111,828	\$ 111,828	\$ -
Texas State Board of Pharmacy	\$ 238,982	\$ 238,982	\$ 238,982	\$ -
Texas Board of Veterinary Medical Examiners	\$ 48,000	\$ 48,000	\$ 48,000	\$ -
Texas Optometry Board	\$ 36,000	\$ 36,000	\$ 36,000	\$ -
Texas Board of Nursing	\$ 1,005,498	\$ 1,005,498	\$ 1,005,498	\$ -
Texas Medical Board	\$ 541,921	\$ 541,921	\$ 541,921	\$ -
Article VIII Subtotal	\$ 1,998,448	\$ 1,998,448	\$ 1,998,448	\$ -
Cross Article Total	\$ 2,818,651,330	\$ 2,496,230,980	\$ 2,848,263,833	\$ 329,612,853

Source: Health and Human Services Commission (2017). *Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2018*. Retrieved from <https://hhs.texas.gov/reports/2017/11/coordinated-statewide-behavioral-health-expenditure-proposal>

Table 4 below details how behavioral health funding is spent by service type for all state agencies.

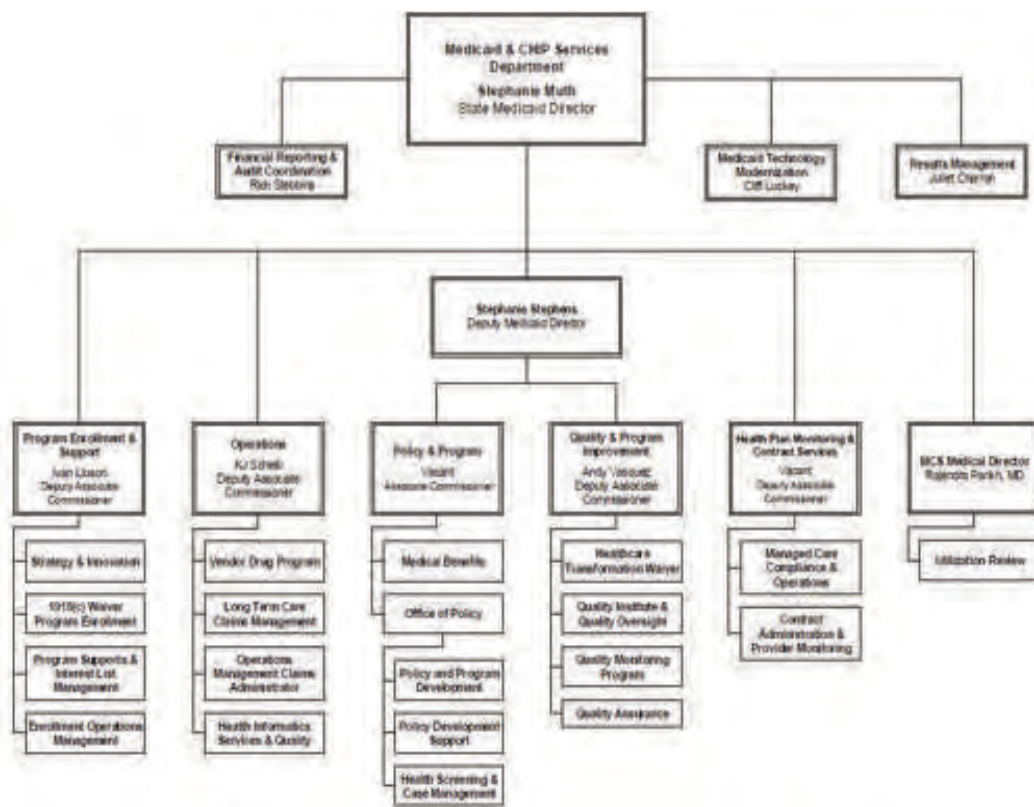
Table 4. Behavioral Health Expenditure Proposal Summary by Service Type Category

Summary by Service Type Category	Proposed FY 2018 Expenditures – All Funds
Education and Training	\$4,568,500
Information Technology	\$105,000
Infrastructure	\$186,979,386
Mental Health Services – Outpatient	\$612,450,393
Mental Health Services – Inpatient	\$526,120,295
Mental Health Services – Other	\$365,395,711
Research	\$8,000,000
Staff	\$58,053,164
Substance Use Disorder Services – Outpatient	\$19,458,473
Substance Use Disorder Services – Inpatient	\$1,150,439
Substance Use Disorder Services – Other	\$401,920,671

Source: Health and Human Services Commission (2017). *Coordinated Statewide Behavioral Health Expenditure Proposal for FY 2018*. Retrieved from <https://hhs.texas.gov/reports/2017/11/coordinated-statewide-behavioral-health-expenditure-proposal>

HHSC will receive the most behavioral health funding in FY 2018, as detailed in the chart below. HHSC is the state agency that administers Medicaid, CHIP, and other key mental health and substance use programs, with behavioral health funding anticipated to be over \$1.6 billion. TDCJ is the agency with the second highest behavioral health expenditures. See Figure 12 below for more information.

Medicaid & CHIP Services



Source: Health and Human Services Commission, Public Information Request, September 2018.

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. In February 2018, HHSC reported that 4,038,341 Texans were included in the state Medicaid caseload count.⁴⁵ By May 2018, that number increased to 4,351,298.⁴⁶

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 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 currently limit the number of eligible persons who enroll in the program.⁴⁷ Waiver programs, however, allow states 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:

- **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.⁴⁸

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 groups⁴⁹

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. According to a presentation to the House Human Services Committee on April 24, 2018, approximately 92 percent of Medicaid services in Texas are provided through managed care.⁵⁰

Under the Medicaid managed care system, a health plan provider oversees the care of each client, and the state pays a monthly capitated rate to the provider for each enrollee, known as the per member/per month rate. With support from the Medicaid 1115 Transformation Waiver, Texas has incrementally expanded its Medicaid managed care system to include more services and populations.

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

STAR 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. Additional managed care programs in Texas include: STAR Health (children in the CPS system), STAR Kids (children with disabilities who are SSI eligible), and CHIP (state healthcare program for children in lower income families who do not meet eligibility for Medicaid).⁵¹

Approximately 92 percent of Texas Medicaid clients were enrolled in managed care as of July 2017.⁵² This is an increase from 86 percent in 2016 after implementation of Senate Bill 7 (83rd, Nelson/Raymond), which expanded mandatory participation in the existing STAR+PLUS managed care program beginning in September 2013.

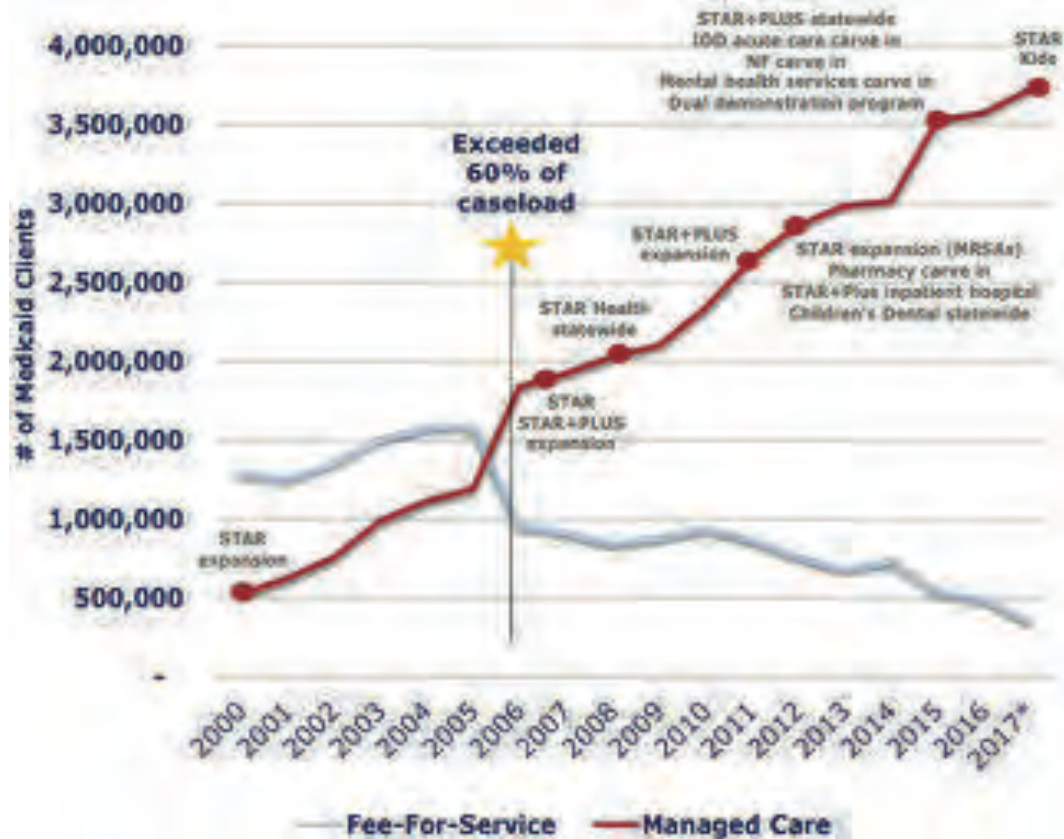
Senate Bill 7 directed the design and implementation of a comprehensive system

of acute care and long-term services and supports for adults and children. The bill generated immediate system delivery changes in Medicaid by expanding STAR+PLUS to serve all areas of the state, as well as transitioning nursing facility services and acute care services for individuals with IDD into STAR+PLUS. Long-term services and supports for individuals with IDD are currently scheduled to transition to Medicaid managed care over the next 2 to 5 years, depending on the program. However, recent legislative hearings have created concern over the health plan’s ability to add these services to existing programs.

Many of the changes instituted by SB 7 address coverage for individuals with IDD, who are three times more likely to experience a mental health condition than the general population.⁵³ 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, SB 7 established a new managed care program for children with disabilities called STAR Kids which launched in November 2016. Enrollment in STAR Kids for FY 2018 was 162,933.⁵⁴

Figure 13 graphically depicts the growth of Medicaid managed care in Texas from 2000 through 2017.

Figure 13. Growth of Managed Care Model: 2000 to 2017



Source: Marquez, E., Muth, S. (2018). *Presentation to the House Human Services Committee on Managed Care: Contract Oversight and Monitoring*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/leg-presentations/house-human-svcs-contract-oversight-june-20-2018.pdf>

Table 5 describes the five Texas Medicaid and CHIP managed care programs. These programs include STAR, STAR+PLUS, STAR Health, CHIP, and STAR Kids.

Table 5. Texas Medicaid and CHIP Managed Care Programs

Program	Description	Eligible Population
STAR 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.	<i>Mandatory:</i> <ul style="list-style-type: none"> Income-eligible pregnant women, infants, and children TANF recipients Former foster care children (21-25) <i>Optional (choose STAR or STAR Health):</i> <ul style="list-style-type: none"> Former foster care children (18-20)
STAR+PLUS Start date: 1998	Provides acute care and 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.	<i>Mandatory:</i> <ul style="list-style-type: none"> Adults with SSI (> 21) Income-eligible adults with a disability (> 21) Individuals in nursing facilities covered by Medicaid <i>Long-term care only:</i> <ul style="list-style-type: none"> Medicare/Medicaid dual-eligible individuals <i>Acute care only:</i> <ul style="list-style-type: none"> Individuals with IDD in an intermediate care facility or Medicaid 1915(c) waiver program
STAR Health Start date: 2008	Provides all medically necessary services such as acute care, dental, vision, behavioral health, and pharmacy services to children currently or formerly under conservatorship of DFPS. Provides case management and training to families, caregivers, clinicians, caseworkers, advocates, and members of the judiciary. Operates statewide.	<i>Mandatory:</i> <ul style="list-style-type: none"> Children (< 17) under DFPS conservatorship, including foster and kinship care Young adults (18-22) in extended foster care placements Young adults (18-21) in voluntary foster care placements <i>Optional (choose STAR or STAR Health):</i> <ul style="list-style-type: none"> Young adults (18-20) receiving Medicaid under the FFCC or MTF CY titles. Young adults (18-22) formerly under foster care, enrolled in higher education
CHIP Start date: 1999	Provides acute health care services to uninsured children living in low-income families who do not qualify for Medicaid. Operates statewide.	Uninsured children (<21) in families with income up to 201% of the Federal Poverty Level who are ineligible for Medicaid.
STAR Kids Start date: Nov. 2016	Provides acute and community-based services to children and young adults with disabilities. All children enrolled in the Medically Dependent Children's Program will transition to STAR Kids. Operates statewide.	<i>Mandatory:</i> <ul style="list-style-type: none"> Children and young adults with SSI (<19) Children and young adults who get services through MDCP Children and young adults who get services through a Medicaid buy-in program <i>Acute services only:</i> <ul style="list-style-type: none"> Children and young adults in a Medicaid 1915(c) waiver program, including the YES waiver program^a Children and young adults who live in a community-based intermediate care facility or nursing facility

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

Sources:

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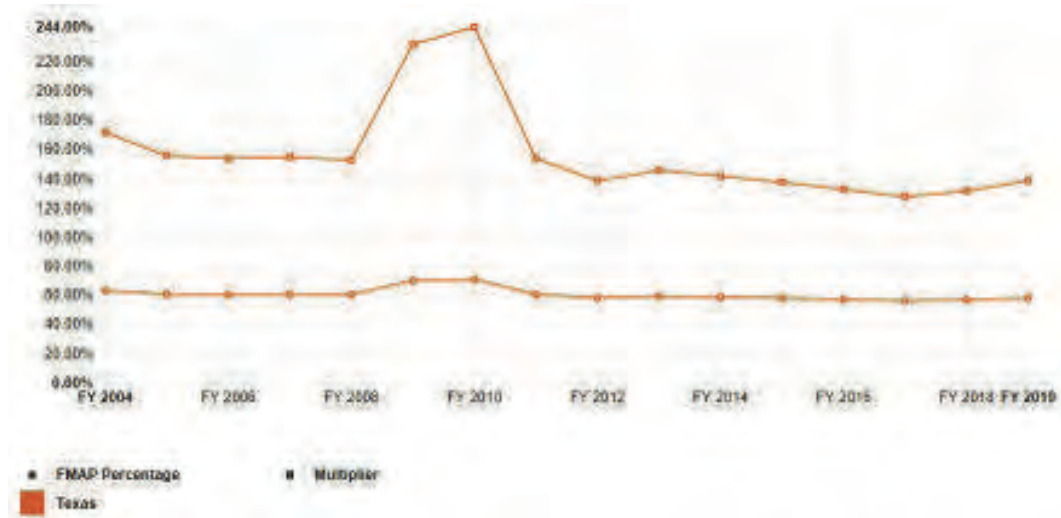
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MEDICAID FUNDING

The Texas Medicaid program is jointly funded by the state and the federal government. Medicaid is the largest source of public funding for mental health services nationwide, comprising a quarter of all public behavioral health expenditures.⁵⁵ SAMHSA projects that by 2020 Medicaid will comprise 30 percent of all mental health expenditures nationally.

The federal share of the Medicaid program, known as FMAP, is determined on an annual basis and is dependent primarily on the average state per capita income compared to the U.S. average.⁵⁶ Texas' matching rates for 2017 and 2018 are 56.18 percent and 56.88 percent; that is, the state must pay 43.82 percent and 43.12 percent of all costs, respectively.⁵⁷ The recently released FMAP percentage for Texas for 2019 will be 58.19 percent creating a state share of 41.81 percent.⁵⁸ In Texas, Medicaid represents 28 percent (\$61 billion) of the state budget for 2018-2019.⁵⁹

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, Texas' 2004 FMAP was 63.17 percent. Figure 14 below shows Texas' declining FMAP from 2004 to 2018.

Figure 14. Texas Federal Medical Assistance Percentage (2004-2019)

Source: Kaiser Family Foundation, State Health Facts. (2018). *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier (Timeframe: FY 2004-2019)*. Retrieved from <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>

Table 6. Medicaid Funding Trends

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
Medicaid	\$30,83,378,373	\$30,325,939,618	\$31,778,756,312	\$31,053,916,419	\$31,755,835,970
Medicaid Contracts & Admin.	\$552,086,759	\$554,997,661	\$565,129,710	\$566,991,046	\$606,086,974
Total	\$30,880,465,132	\$30,880,937,279	\$32,343,886,022	\$31,620,907,465	\$32,361,922,944

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

MEDICAID ELIGIBILITY AND SERVICES

Medicaid was originally only available to recipients of cash assistance programs such as TANF and SSI. However, during the late 1980s and early 1990s, the federal government decoupled Medicaid eligibility from the receipt of cash assistance and expanded the program to meet the needs of a broader population, including pregnant women, older adults, and people with disabilities.⁶⁰

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

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

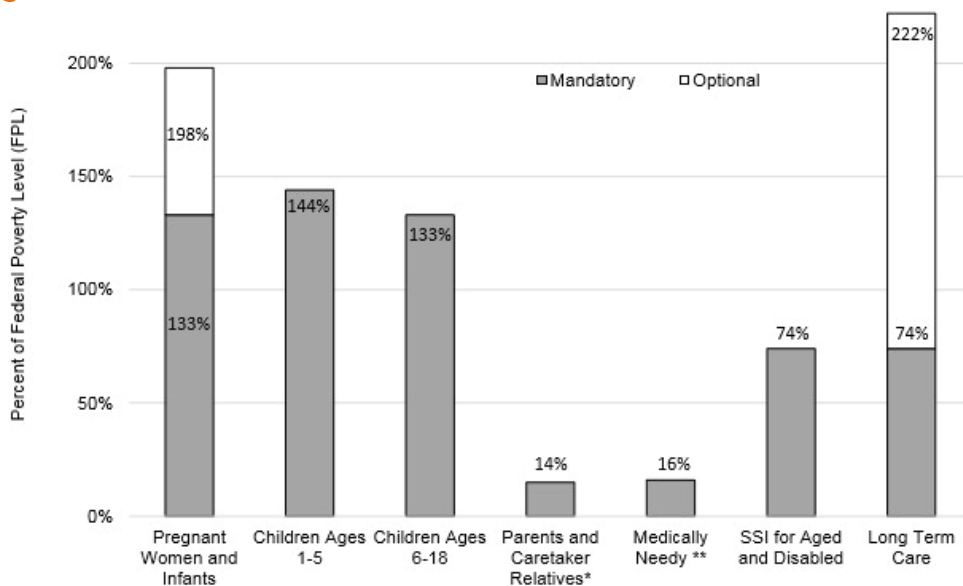
- Children age 18 and under

- Pregnant women and infants
- Families receiving Temporary Assistance for Needy Families
- Parents and caretaker relatives
- Individuals receiving Supplemental Security Income
- Adults over age 65 and people with disabilities
- Children and pregnant women who qualify as medically needy
- Former foster youth⁶¹
- Individual receiving Medicaid 1915(c) waiver services

In 2014, ACA granted states the option to expand eligibility for Medicaid to all adults with incomes at or below 133 percent of the FPL, regardless of age, parental status, or disability status. Texas has elected not to participate in the expansion to date, which 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. SAMHSA estimated that 6 percent of the population eligible for Medicaid expansion has an SMI, 11 percent experience severe psychological distress, and 11 percent have a substance use disorder.⁶² 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.⁶³

As of January 2018, Texas low-income parents are eligible to receive Medicaid only if their household income is 18 percent of FPL or below, about \$312 per month for a family of three.⁶⁴ Childless adults who are below age 66 and do not have a disability are currently ineligible for Medicaid.⁶⁵ Figure 15 shows the income eligibility requirements for each Medicaid category.

Figure 15. March 2016 Texas Medicaid Income Eligibility Levels for Selected Programs (as a Percent of the FPL)



Source: Texas Health and Human Services Commission. (2017). *Texas Medicaid and CHIP in perspective eleventh edition*. Page 4. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>

*For Parents and Caretaker Relatives, the maximum monthly income limit in SFY 2016 was \$230 for a family of three (one-parent household), which is the equivalent of approximately 14 percent of the FPL.

**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2016 was \$275 for a family of three, which is the equivalent of approximately 16 percent of the FPL.

Table 7 below shows the 2018 poverty guidelines for families or households of different sizes.

Table 7. 2018 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/Household	Poverty Guideline
1	\$12,140
2	\$16,460
3	\$20,780
4	\$25,100
5	\$29,420
6	\$33,740
7	\$38,060
8	\$42,380

Source: U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2018). *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs*. Retrieved from <https://aspe.hhs.gov/poverty-guidelines>.

Table 8 below shows the 2018 Federal Poverty Level Percentages for an individual and a family of four.

Table 8. Annual Household Income for Federal Poverty Level Guidelines (2018)

2018 Federal Poverty Level	Individual	Family of Four
15%	\$1,821	\$3,765
100%	\$12,140	\$25,100
133%	\$16,146	\$33,383
200%	\$24,280	\$50,200

Source: Hogg Foundation analysis of: U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2018). *U.S. Federal Poverty 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 LMHAs operating under HHSC. In addition, HHSC administers several Medicaid-funded waiver programs that offer behavioral health or long-term services and supports to specialized populations. These services and eligibility criteria are further described later in this section. Table XX contains a list of behavioral health services covered by Medicaid.

Following are approved Medicaid behavioral health services:⁶⁶

- Psychiatric diagnostic evaluation and psychotherapy performed by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists
- Psychological and neuropsychological testing performed by psychologists and physician
- Inpatient psychiatric care in a general acute care hospital
- Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older)
- Psychotropic medications and pharmacological management of medications
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance
- Care and treatment of behavioral health conditions provided by a primary care physician
- Comprehensive community services for YES waiver participants (see YES waiver section later in this section)

Note: *Peer Support services provided by Certified Peer Specialists are expected to become a Medicaid reimbursable service beginning in early 2019.*

Following are approved Medicaid Substance Use Services:⁶⁷

- 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
- Outpatient and residential detoxification
- Residential treatment
- Medication assisted therapy (e.g., methadone for opioid addiction)

Note: *Peer Support services provided by Certified Peer Recovery Specialists are expected to become a Medicaid reimbursable service beginning in early 2019.*

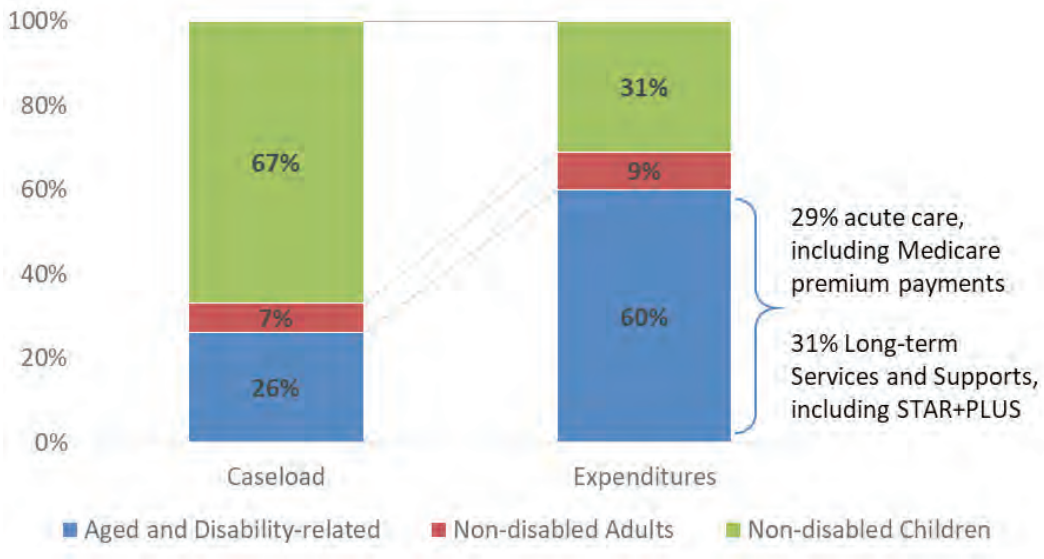
DEMOGRAPHICS OF MEDICAID RECIPIENTS

Women and children account for the majority of the individuals receiving Medicaid benefits. In 2015, 55 percent of the Medicaid population was female and 78 percent was under the age of 21.⁶⁸ Children without disabilities comprise 69 percent of all Medicaid recipients but represent only 32 percent of spending on direct health care services.⁶⁹ In contrast, individuals who are elderly, blind, or have a disability account for 24 percent of the Medicaid population but represent 59 percent of total estimated expenditures.⁷⁰

Figure 16 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/sites/default/files//documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>

Figure 16. Texas Medicaid Caseload and Expenditures by Age and Disability Status (2016)



Source: Health and Human Services Commission. (April 6, 2016). *HHSC presentation to House Appropriations Subcommittee on Article II: Medicaid Long Term Services and Supports*. [PowerPoint Slides].

TEXAS MEDICAID AND HEALTHCARE PARTNERSHIP

The Texas Medicaid and Healthcare Partnership 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.⁷¹ TMHP does not process claims for services provided by MCOs, but it does collect encounter data from MCOs to use for the evaluation of quality and utilization of managed care services.⁷²

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The federal government created CHIP in 1997 under Title XXI of the Social Security Act. As with Medicaid, CHIP is jointly funded by state and federal governments.⁷³ State participation in CHIP requires that the state develop and CMS approve a state CHIP Plan.⁷⁴ While CMS allows states to combine their Medicaid and CHIP programs under a single administrative umbrella, Texas administers these programs separately. In September 2017 federal funding for CHIP expired.⁷⁵ Short-term funding was included in the continuing budget resolutions of early 2018 that extended CHIP funding until 2027.⁷⁶ While the plan largely leaves CHIP untouched for 2018, changes were made that will impact the future of the program including:

- A decrease in the enhanced FMAP (as provided by ACA) from the current 23 percentage point enhancement to 11 in 2020 and down to traditional FMAP levels in 2021 and beyond;
- On October 1, 2019, states with CHIP eligibility levels above 300 percent FPL will have the option to lower eligibility to 300 percent FPL.⁷⁷ States with CHIP eligibility levels below 300 percent (including Texas, 201 percent FPL) must maintain current eligibility levels until September 30, 2027.

CHIP ELIGIBILITY

The federal government developed CHIP to provide a health insurance coverage option for children whose families had too much income or too many assets to qualify for Medicaid, but not enough to afford private insurance through their employer or purchasing on the individual market.⁷⁸ CHIP is available to children under age 19 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 \$48,240 for a family of four).⁷⁹ 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.⁸⁰ Texas has also opted to administer a CHIP perinatal program which covers perinatal services, including labor, delivery, and postpartum care for women and their unborn child with household incomes of up to 201 percent of the FPL.⁸¹

The table below provides household income limits for CHIP eligibility.

Table 9. Annual Household Income Limits for CHIP

Household Size	Maximum Income Level Per Year
1	\$48,240
2	\$64,960
3	\$81,680
4	\$98,400
5	\$115,120
6	\$131,840
7	\$148,560
8	\$165,280

Source: U.S. Department of Health and Human Services, 2018. *State Children's Health Insurance Program*. Retrieved from <https://www.benefits.gov/benefits/benefit-details/607>

CHIP FUNDING

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

Table 10. CHIP Funding Trends

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
CHIP Services	\$985,459,970	\$1,002,942,665	\$1,121,298,121	\$1,040,231,554	\$1,090,496,059
CHIP Contracts & Admin.	\$9,817,163	\$17,387,231	\$16,814,775	\$1,6814,775	\$1,6814,775
Total	\$995,277,133	\$1,020,329,896	\$1,138,112,896	\$1,057,046,329	\$1,107,310,834

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

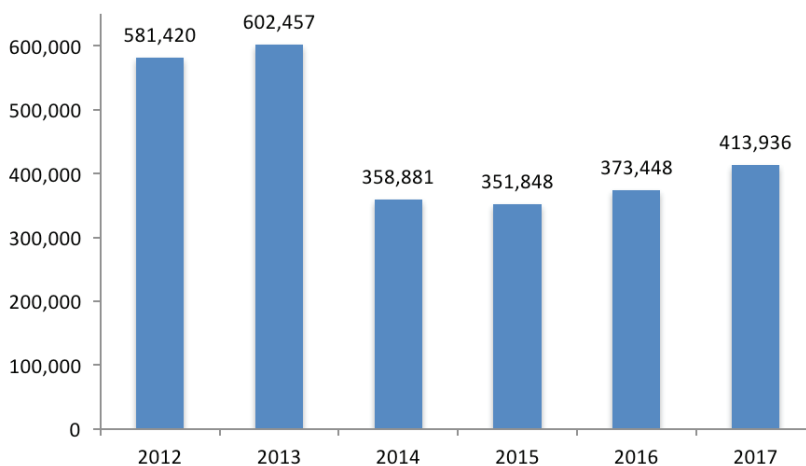
CHIP ENROLLMENT, UTILIZATION, AND COSTS

The majority of CHIP clients are over age five with 57 percent between the ages of 6 and 14, and 21 percent between the ages of 15 and 18.⁸²

CHIP has experienced sporadic spending growth in the last decade. The 2018-2019 budget appropriated over \$2 billion for CHIP.⁸³ 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.⁸⁴

Figure 17, below, shows the monthly CHIP enrollment numbers in Texas from 2012 to 2017.

Figure 17. Monthly CHIP Enrollment (2012-2017)



Note: Data are from October of each year.

Source: Texas Health and Human Services Commission. (n.d.). *CHIP Monthly Enrollment Detail (XLS)* [data file]. Retrieved from <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics>

HHSC QUALITY OF CARE PERFORMANCE AND THE HEALTHCARE QUALITY PLAN

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 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.

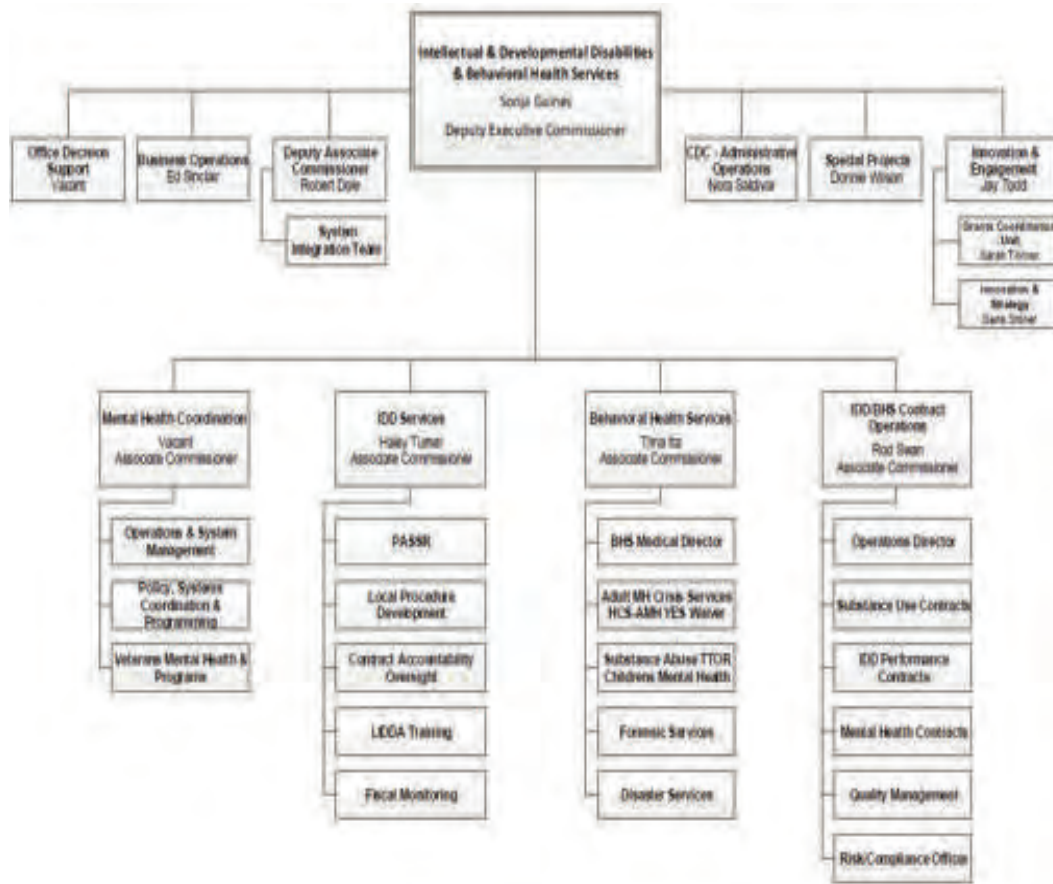
Improved performance, improved measurement of performance, and payment mechanisms based on performance appear to be a priority for both the legislature and HHSC. There are six strategic priorities incorporated in the HHSC Healthcare Quality Plan as required by SB 200 (84th, Nelson et al.) including:⁸⁵

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

HHSC has nine value-based care programs and initiatives including:⁸⁶

1. MCO/DMO Pay-for-Quality (P4Q)
2. MCO Alternative Payment Models (APM)
3. Hospital Quality Payment Program
4. DSRIP Program
5. Nursing Home Quality Incentive Payment Program (QIPP)
6. Value-Based Payment (VBP) Toolkit for Stakeholders
7. MCO Performance Indicator Dashboard
8. Texas Healthcare Learning Collaborative Portal
9. Advisory Committees and Workgroups

Intellectual and Developmental Disabilities & Behavioral Health Services Division



Source: Health and Human Services Commission, Public Information Request, September 2018.

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

BEHAVIORAL HEALTH SERVICES

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

INTRODUCTION - MENTAL HEALTH

HHSC 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 (major depression, bipolar disorder, and

schizophrenia). Resources, eligibility for services, and service delivery systems are the primary determinants of the accessibility and quality of services. Texas continues to seek ways to improve access so that individuals with mental health and substance use conditions can receive the level of care and support that are clinically appropriate for their level of need. HHSC maintains a central website, www.mentalhealthtx.org, to improve access to information. Individuals can enter their zip code and find available behavioral health services in their area.

MENTAL 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 *Statewide Behavioral Health Expenditure Report* above.

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.⁸⁷

Much of the increased demand for behavioral health services in Texas is due to the state's rapidly expanding population, which grew from 25,146,100 in 2010 to 28,304,596 in 2017.⁸⁸ The population growth rate in Texas was 12.6 percent between 2010 and 2017, more than double the national average of 5.5 percent.^{89,90}

Table 11. Health and Human Services Commission Mental Health Funding – SB 1, Article II, FY 2018/19 (Nelson/Zerwas)

HHSC Mental Health Strategies	Current Budget for FY 2016/2017 Biennium	SB 1 FY 2018/19	Difference
D.2.1 Mental Health – Adults	\$665,577,144	\$703,362,864	\$37,785,720
D.2.2 Mental Health - Children	\$204,650,668	\$166,373,576	(\$38,277,092)
D.2.3 Community Mental Health Crisis	\$253,570,022	\$325,430,552	\$71,860,530
NorthSTAR Behavioral Health*	\$174,064,540	\$0	(\$174,064,540)
D.2.4 Substance Abuse Prevention/Treatment	\$325,110,656	\$380,160,933	\$55,050,277
D.2.5 Behavioral Health Waivers	\$0	\$103,351,236	\$103,351,236
C.1.3 State Mental Health Hospitals	\$872,639,869	\$875,536,372	\$2,896,503
C.2.1 Community Mental Health Hospitals	\$209,943,241	\$243,830,476	\$33,887,235
F.1.2 Repair and Renovation: MH Facilities	\$ 24,046,914	**	**

Source: Hogg Foundation for Mental Health. (2017). *85th Legislative Summary*. Retrieved from http://hogg.utexas.edu/wp-content/uploads/2017/08/UPDATED-Legislative-Summary_2017.pdf

*NorthSTAR no longer exists and therefore no appropriation was made for the FY 2018/19 biennium.

**The current budget combines MH facilities Repair and Renovation funding with state supported living centers (SSLCs) and other facilities making comparison data unavailable. See Rider 2 below.

Funding for behavioral health services in Article II increased by \$92,489,869. This does not include additional funding appropriated for state hospital repair, renovation, or new construction (see Rider 2 below).

The following are budget riders enacted by the 85th Texas Legislature relating to mental health and substance use services.

Table 12. 85th Texas Legislature Mental Health and Substance Use Services Budget Riders

HHSC	
2	<p>Capital Budget – The amounts included in this rider may only be spend for the purposes indicated and cannot be used for other purposes.</p> <ul style="list-style-type: none"> • \$150,000,000 GR in each year of the biennium for new construction for state hospitals and other inpatient mental health facilities • \$78,302,186 in FY 2018 and \$79,702,186 in FY 2019 for facilities repair and renovations for state hospitals and state-supported living centers
29	<p>Medicaid Substance Abuse Treatment – HHSC shall evaluate the impact on overall Medicaid spending and client outcomes of substance use disorder treatment services provided to persons who are at least 21 years of age.</p>
30	<p>Monitor the Integration of Behavioral Health Services – HHSC shall monitor the integration of behavioral health services into the Medicaid managed care program.</p>
34	<p>Medicaid Funding Reduction and Cost Containment – HHSC shall develop and implement cost containment initiatives to achieve savings throughout the health and human services system. HHSC shall achieve savings of at least \$350,000,000 in GR funds and \$480,000,000 in federal funds for the 2018-19 biennium.</p>
40	<p>Contingency for Behavioral Health Funds – The Comptroller of Public Accounts shall not allow the expenditure of GR funds at HHSC as identified in Art. IX, Sec. 10.04, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures, if the LBB provides notification that the agency's planned expenditure of those funds in FY 2018 and FY 2019 does not satisfy the requirements of the Statewide Behavioral Health Strategic Plan and Coordinated Expenditures.</p>
41	<p>Client Services – It is the intent of the legislature that HHSC and the Department of Family and Protective Services enter into a memorandum of understanding for providing outpatient substance use treatment services by HHSC to clients referred by DFPS.</p>
42	<p>Offender Screening of Individuals with Mental Illness – HHSC and community centers shall identify offenders living with mental illness, collect and report prevalence data, and disclose information relating to a special needs offender as provided in Chapter 614, Health and Safety Code.</p>
43	<p>Local Service Area Planning – HHSC shall develop performance agreements with LMHAs that give regard to priorities identified by the community through a local needs assessment process and expressed in a local service plan.</p>
44	<p>Mental Health Outcomes and Accountability – HHSC shall place 10 percent of the GR quarterly allocation from each LMHA at risk. Funds placed at risk shall be subject to recoupment for failure to achieve outcome targets set by HHSC.</p>
45	<p>Mental Health Appropriations and the 1115 Medicaid Transformation Waiver – HHSC by contract shall require that GR funds be used to the extent possible to draw down additional federal funds through the 1115 transformation waiver or other federal matching opportunities.</p>
46	<p>Healthy Community Collaboratives – HHSC shall allocate an amount not to exceed \$25,000,000 in GR to fund grants to Healthy Community Collaboratives. Contingent upon enactment of legislation relating to certain requirements of counties and other governmental entities regarding behavioral health, \$10,000,000 in GR from the amount identified above may be allocated to fund Healthy Community Collaboratives in rural areas.</p>

HHSC	
47	Mental Health Peer Support Re-entry Pilot – HHSC shall allocate up to \$1,000,000 in GR to implement a mental health peer support re-entry program. In partnership with LMHAs and county sheriffs, HHSC shall establish a pilot program that uses certified peer support specialists to ensure inmates with a mental illness successfully transition from the county jail into clinically appropriate community-based care.
48	Quarterly Reporting of Waiting Lists for Mental Health Services – HHSC shall submit to the LBB and the Governor, no later than 60 days from the end of each fiscal quarter, the current waiting list and related expenditure data for: <ul style="list-style-type: none"> • Community mental health services for adults • Community mental health services for children • Forensic state hospital beds • Maximum security forensic state hospital beds
128	Mental Health for Veterans Grant Program – HHSC shall allocate \$20,000,000 in FY 2018 in GR to operate a grant program to provide mental health services for veterans.
147	Efficiencies at LMHAs and IDD Authorities – HHSC shall ensure that LMHAs and LIDDAs shall maximize the dollars available to provide services by minimizing overhead and administrative costs. Among strategies that should be considered are consolidations among local authorities and partnering among local authorities on administrative, purchasing, or service delivery functions.
171	Purchased Psychiatric Hospital Beds – Included in amounts appropriated is \$3,154,123 in GR in each fiscal year to increase the daily rates paid for purchased community and private psychiatric beds.
172	Medicaid Services Capacity for High-Needs Children in the Foster Care System – Included in the amounts appropriated is \$2,000,000 in GR in fiscal year 2018 for HHSC in collaboration with DFPS to establish a statewide grant program to increase access to targeted case management and rehabilitative services for high-needs children in the foster care system. HHSC may establish this one-time grant program no later than November 1, 2017. To receive grant funds, entities must provide local matching funds in an amount defined by HHSC based on the entity's geographical location. Funds may only be used to pay for costs related to developing, implementing, and training teams to provide targeted case management and rehab services to children in foster care. HHSC shall enter into an agreement with a nonprofit entity to serve as administrator of the initiative, at no cost to the state.
174	Mental Health Program for Veterans – HHSC shall allocate \$5,000,000 in GR in each fiscal year of the biennium for the purpose of administering the mental health program for veterans established pursuant to the Health and Safety Code Section 1001.221-.224.
175	Managed Care Organization Services for Individuals with Serious Mental Illness (SMI) – HHSC shall improve efforts to better serve individuals with SMI. HHSC shall develop performance metrics to better hold managed care companies accountable for care of enrollees with SMI. HHSC may, if cost effective, develop and procure a managed care program for an alternative model of managed care in at least one service delivery area of the state to serve individuals with SMI in Medicaid and CHIP managed care programs.
176	State Hospital Workforce – HHSC shall evaluate compensation levels, turnover and vacancy rates, and recruiting efforts at the ten state hospitals and develop recommendations to reduce turnover and vacancy rates.
179	State Hospital Planning – HHSC, for the purpose of repair and replacement of state hospitals, may partner with public or private entities to develop a master plan for the design of neuropsychiatric healthcare delivery systems in the area served by each facility. The master plan may also address the provision of a continuum of inpatient and outpatient brain health services on the site of the state hospital. Planning activities may include an evaluation of patient needs, a program map, proposals for the development of optimal care models, a proposal for the design of leading-edge facilities including engineering and architectural work required to initiate construction, and the implementation of preliminary pilot projects to guide new care design principles.

HHSC	
183	Increased Access to Community Mental Health Services – Included in amounts appropriated is \$27,215,094 in GR and \$3,889,356 in federal funds in each fiscal year in Community Mental Health Services – Adults and \$178,419 in GR and \$53,631 in federal funds in each fiscal year in Community Mental Health Services – Children, for the purpose of eliminating the waiting lists for community MH services, increasing capacity to avoid future waitlists, addressing population growth, and increasing equity in funding allocations to LMHAs.
186	Contingency for HB 10 (Mental Health Parity) – HHSC shall utilize funds to allocate no more than two full-time equivalent positions within the Office of the Ombudsman to implement the provisions of the legislation.
189	Reporting of Postpartum Depression Data – HHSa shall submit a report on the screening and treatment of postpartum depression.
191	Substance Abuse Funding for Guardians of Children – HHSC shall, to the extent authorized by state and federal law, seek federal funds for the provision of substance use services to individuals who suffer from substance use disorders and are the guardian of a child 18 or younger, and have been identified as needing services through the DFPS Family-Based Safety Services or Prevention programs.
193	Postpartum Depression Services – HHSC shall, to the extent authorized by state and federal law, seek federal funds for the screening and treatment of postpartum depression pursuant to the 21 st Century Cures Act.
195	Prioritization of Behavioral Health Treatment for Pregnant Women – HHSC shall seek to educate and inform the public and behavioral health service providers that pregnant women and women with dependent children are a priority population for services funded through the substance use prevention and treatment block grant.
196	Ensure Network Adequacy – HHSC shall seek to ensure that contracted managed care organizations maintain an adequate network of providers, especially with respect to community attendants.
197	State Hospital Contracting for Physician and Professional Services – Where feasible and cost effective, HHSC may contract with state universities to provide physician and professional services at the state hospitals.
199	Funding for Mental Health Programs – Included in the amounts appropriated for Community Mental Health Services for Adults is \$871,348 in GR in each fiscal year to continue funding for recovery-focused clubhouses at FY 2017 service levels. Also included in Community Mental Health Services for Children is \$3,850,744 in GR in each fiscal year for relinquishment prevention slots, including \$1,400,000 in GR to fund additional relinquishment slots above FY 2017 service levels.
206	Contingency for HB 12 – Contingent on enactment of HB 12, or similar legislation (relating to individuals with MH or IDD with involvement in the court system) is \$12,500,000 in GR in FY 2018 and \$25,000,000 in GR in FY 2019 to implement provisions of the legislation. HB 12 did not pass.
207	Contingency for HB 13 – Contingent on enactment of HB 13 relating to the creation of a matching grant program to support community mental health programs for individuals experience mental illness. Included is \$10,000,000 in GR in FY 2018 and \$20,000,000 in GR in FY 2019 to implement the provisions of the legislation. Community collaboratives that receive funding under the provisions of the bill shall report twice annually to the Statewide Behavioral Health Coordinating Council.
208	Quarterly Reporting of Mental Health Services in the Former NorthSTAR Service Area – HHSC shall report to the LBB on the use of funds appropriated to serve former NorthSTAR clients. The report shall include projections of the current and anticipated waiting list for mental health services in the area and a projection of any anticipated additional funding needed to avoid a future waiting list.
210	Integrated Care Study for Veterans with Post-Traumatic Stress Disorder – HHSC shall coordinate the University of Texas Health Science Center at Houston to conduct a study on the benefits of providing integrated care to veterans with post-traumatic stress disorder.
211	Contingency for HB 1486 – Relating to peer specialists, peer services, and the provision of those services under the medical assistance program – Included in amounts appropriated is \$360,366 in GR and \$474,234 in federal funds in FY 2018 and \$1,013,257 in GR and \$1,361,843 in federal funds in FY 2019 (in Disability-Related Strategy), and \$79,500 in GR in each fiscal year (in Medicaid Contracts and Administration Strategy) to implement the provisions of the legislation.

HHSC	
219	Evaluation of Medicaid Managed Care – HHSC shall contract with an independent organization to conduct a comprehensive evaluation of managed care in the Texas Medicaid program.
221	New Construction of State Hospitals – It is the intent of the Legislature to implement a three-phased approach to improve the state hospital system in the current and future biennia, beginning with initial planning and implementation of projects in the 2018-19 biennium. Included in amounts appropriated in Strategy Facility Capital Repairs and Renovations is \$300,000,000 in Economic Stabilization Funds for the planning of new construction projects at state hospitals and other state-funded inpatient mental health facilities and for implementation of new construction projects at state hospitals and other state-funded mental health facilities.

Source: General Appropriations Act, S.B. 1, Conference Committee Report, 2017 Leg., 85th Reg. Sess., art. II. (Tex. 2017). Retrieved from <https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00001F.pdf#navpanes=0>

*Rider numbers may differ across bill analyses due to changes made by the Legislative Budget Board after the bill was passed.

Table 13. SB 1, Article IX, Special Provisions (Nelson/Zerwas)

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

Sec. 10.04	<p>Statewide Behavioral Health Strategic Plan and Coordinated Expenditures</p> <ol style="list-style-type: none"> Informational Listing of Behavioral Health and Substance Abuse Services Appropriations across state agencies totaling \$2,015,951,330 for FY 2018 and \$2,022,947,500 for FY 2019. Statewide Behavioral Health Coordinating Council – Consists of a representative from each state agency that funds behavioral health programs or services related to the research, prevention, or detection of mental health conditions, as well as all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental health condition, including individuals living with alcohol or drug addiction. Statewide Behavioral Health Strategic Plan – The purpose of the statewide behavioral health coordinating council shall be to implement the five-year Statewide Behavioral Health Strategic Plan published May 1, 2016. Coordination of Behavioral Health Expenditures – The coordinating council shall submit to the executive commissioner of HHSC a coordinated statewide expenditure proposal for each agency, which shall include the appropriations amounts identified in subsection (a) of this special provision. The expenditure proposal must be submitted to the Legislative Budget Board (LBB). The Comptroller of Public Accounts shall not allow the expenditure of GR-related funds identified in subsection (a) to a particular agency if the LBB provides notification to the Comptroller that the agency's expenditure proposal has not satisfied the requirements of this provision.
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Table 14 below depicts historical trends and biennial requests from FY 2017-2021.

Table 14. Mental Health Funding Trends

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021	Exceptional Item Requests 2020	Exceptional Item Requests 2021
Adult Mental Health Services	\$328,381,109	\$353,747,613	\$353,588,788	\$351,639,018	\$351,639,018	\$33,661,572	\$33,491,289
Children Mental Health Services	\$91,212,165	\$84,188,775	\$82,184,801	\$81,852,484	\$81,852,484	\$6,965,037	\$6,958,012

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021	Exceptional Item Requests 2020	Exceptional Item Requests 2021
Behavioral Health Waivers	\$40,661,894	\$51,675,618	\$51,675,617	\$52,299,694	\$52,299,694	\$0	\$0
Mental Health State Hospitals	\$0	\$415,678,389	\$388,455,499	\$401,682,183	\$401,682,184	\$68,999,501	\$71,943,466
Community Mental Health Crisis Services	\$128,906,778	\$149,131,873	\$171,631,873	\$160,381,873	\$160,381,873	\$11,362,500	\$11,362,500
Substance Use Prevention/ Intervention/ Treatment	\$163,875,398	\$217,708,060	\$217,870,856	\$217,997,115	\$217,997,115	\$3,540,469	\$41,773,355
Total	\$753,037,344	\$1,272,130,328	\$1,265,407,434	\$1,265,852,367	\$1,265,852,368	\$124,529,079	\$165,528,622

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

SERVICE PROVIDERS

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

- Medicaid Managed Care providers;
- LMHAs; and
- FQHCs and other community health centers

Medicaid Managed Care Providers

Medicaid is the largest funder of behavioral health services in Texas. Texas continues to expand the managed care model of healthcare system wide, including behavioral health services. In a Medicaid managed care system, individuals access services through an MCO under contracts with the state. 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.

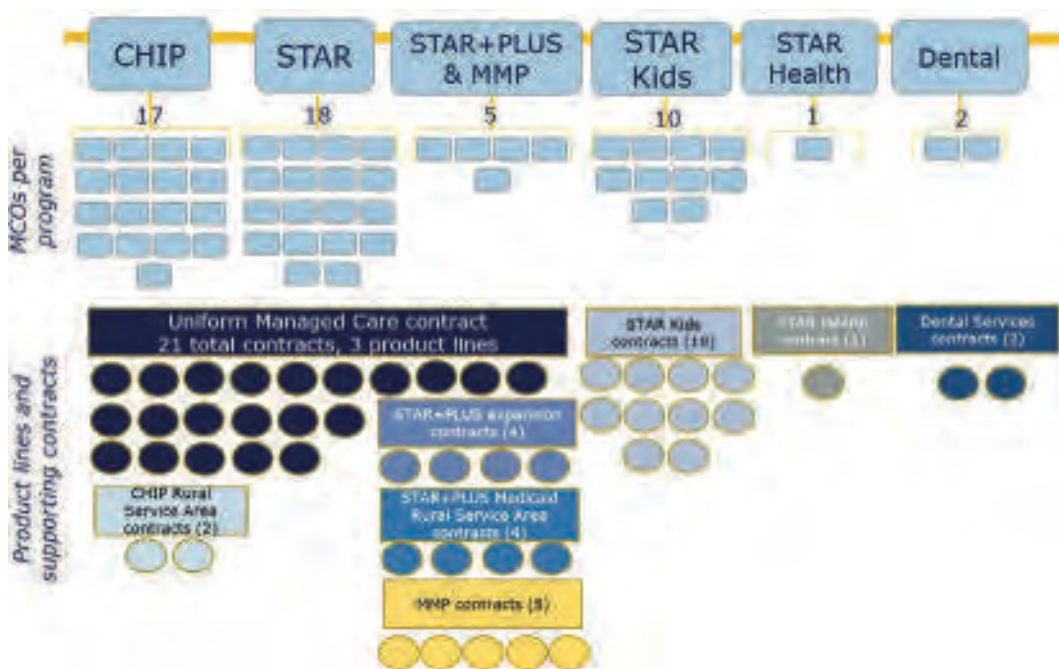
MCOs are responsible for creating a network of public and private providers to ensure that adults and children receiving Medicaid are able to access needed services. MCOs are responsible for service authorization and directly contract with and reimburse service providers.

Managed care programs in Texas include:

- STAR
- STAR +PLUS
- STAR HEALTH
- CHIP
- CHIP and Children’s Medicaid Dental
- STAR Kids

The figure below details the Medicaid Managed Care Program infrastructure.

Figure 18. Medicaid Managed Care Program Infrastructure as of February 2018



Source: Marquez, E., Muth, S. (2018). *Presentation to the House Human Services Committee on Managed Care: Contract Oversight and Monitoring*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018-leg-presentations/house-human-svcs-contract-oversight-june-20-2018.pdf>

Prior to 2013, public mental health services in Texas were made available through contracts between DSHS and the network of local mental health authorities. SB 58 (83rd, Nelson/Zerwas) directed the integration of physical health and behavioral health services into our managed care system. These public “safety net” services are now provided through HHSC contracts with managed care organizations and other comprehensive providers. Rider 30 of the appropriations bill (SB 1, 85th) requires legislative monitoring of the implementation of the integration mandates of SB 58 (83rd).

SB 58 (83rd, Nelson/Zerwas) allows providers to bill for targeted case management and rehabilitative services only 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 to address a client’s needs, but as a result of these rigorous requirements, local authorities continue to serve as the primary providers of rehabilitative services and targeted case management for the majority of people in managed care.

Rehabilitative services coordinated through targeted case management include:

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

Local Mental Health Authorities and Local Behavioral Health Authorities

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

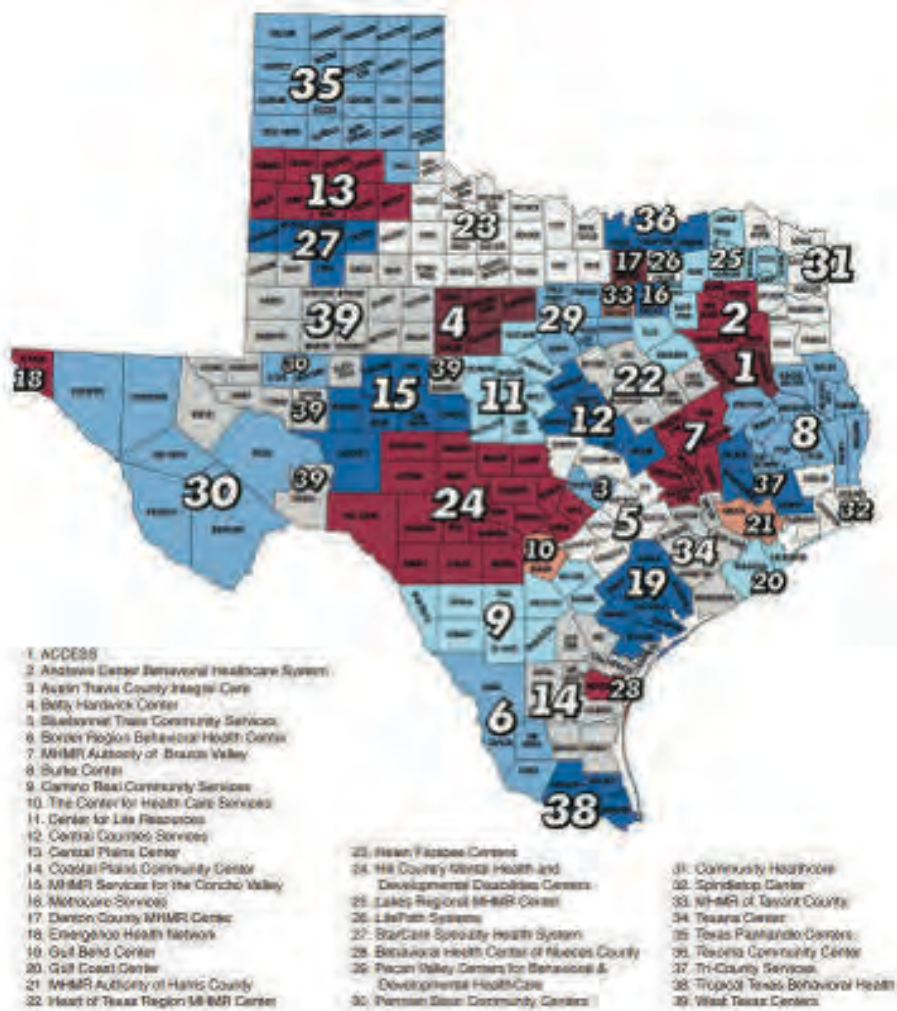
- Children, adolescents, and adults meeting medically indigent criteria;
- Individuals with a priority population diagnosis; and
- Any individuals eligible for Medicaid who reside in that LMHA's designated geographic area, shown below in Figure 19.⁹¹

The Medical and Social Services Division oversees and regulates the quality of services provided to individuals through LMHA/LBHA and regularly provides LMHA/LBHA staff with training and technical assistance.

SB 1507 (84th, Garcia/Naishtat) states 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 OSAR provider authorities.^{92,93} As of April 12, 2018, 11 LMHAs are the OSAR provider authorities for all of the state's OSAR regions.⁹⁴ LMHAs are still authorized to subcontract with substance use providers to provide OSAR services, but the new requirements reflect a larger shift in HHSC toward more integrated and patient-centered behavioral health services that are easier to locate and access.⁹⁵

Local Behavioral Health Authorities typically refers to local authorities that provide behavioral health services to include a broader range of substance use services than historically provided by LMHAs.

Figure 19. Map of LMHAs/LBHAs and 39 Service Regions



Source: Texas Council of Community Centers. (n.d.). *State Map of Service Areas*. Retrieved from <http://txcouncil.com/about-community-centers/state-map-of-service-areas/>

As an authority, LMHAs/LBHAs are responsible for:

- Allocating funds from the HHS Medical and Social Services Division to ensure mental health and substance use services are provided in the local service area for indigent populations;
- Balancing community input, cost effectiveness, and quality of care issues to ensure choice and the best use of public funds;
- Creating and maintaining a network of service providers;
- Recommending the most appropriate and available treatment alternatives for individuals requiring mental health services; and
- Demonstrating that the services provided comply with state health and regulatory standards, whether those services are provided directly by LMHA employees or through subcontractors and other private community providers involving state funds.^{96,97}

Each LMHA/LBHA is required to plan, develop, and coordinate local policy, resources, and services for mental health care. Additionally, LMHAs/LBHAs are required to develop external provider networks and serve as a provider of last resort when other

subcontractors or providers are unavailable.⁹⁸ 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/LBHA 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/LBHA 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 CANS assessment and adults are given the 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 Symptomatology for individuals with a diagnosis of major depression, and a level of care 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 may also enter into LMHA/LBHA services by first utilizing crisis services (via Mobile Crisis Outreach Teams, mental health deputies, or a crisis hotline). Once an individual is enrolled in LMHA/LBHA services, providers regularly update the CANS and ANSA to verify that the LOC is still appropriate. The state also tracks 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 OSAR providers. Sometimes OSARs are located within an LMHA/LBHA or may be a separate contracted facility.

Federally Qualified Health Centers

In addition to state-funded LMHAs/LBHAs and Medicaid managed care providers, individuals in Texas may also receive behavioral health services from 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.⁹⁹ While the FQHC benefit was first added to Medicare in 1991, the passage of 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.^{100,101}

Federally Qualified Health Centers 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 for people who are otherwise low-income and uninsured. There are 73 FQHCs in Texas with more than 300 service delivery sites statewide.¹⁰²

While FQHCs receive grant funding from the federal government, they also receive enhanced reimbursements for providing services to individuals receiving Medicaid and Medicare services.¹⁰³ 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 policy changes in 2010 made by ACA 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.

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 NHSC.¹⁰⁴

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.^{105,106}

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.¹⁰⁷ While the central mission of most community health centers is to provide effective and affordable primary healthcare, many community health centers have started to partner with LMHAs/LBHAs and other providers to offer behavioral health services in their clinics.^{108,109} Because of the way FQHCs are funded, there is less mandated reporting on client outcomes compared to LMHAs/LBHAs and Medicaid managed care providers, and FQHCs are increasingly becoming an integral part of the health safety net in many parts of Texas.

COMMUNITY MENTAL HEALTH SERVICES

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.¹¹⁰ 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.¹¹¹ 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/BMHAs with sufficient resources can now provide services for individuals with any of the diagnoses listed in Table 15.^{112,113}

Table 15. LMHA/LBHA Client Population

Populations	Eligibility Criteria
Adults	<p>Serious functional impairment and severe and persistent mental illness diagnosis of:</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • Have a serious functional impairment; • Are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; and/or • Are enrolled in a school system's special education program because of SED. <p>*Children and adolescents with a single diagnosis of autism, pervasive developmental disorder, intellectual disability, or substance use do not meet the priority population criteria for mental health services, and are instead served through other programs developed for special populations (previously at DADS and/or DARS; now at HHSC).</p>

Individuals Considered Medically Indigent

According to the Texas Health and Safety Code, a person is considered to be medically 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.¹¹⁴

Individuals who are deemed to be medically indigent and meet the priority population criteria (living with severe and persistent mental illnesses such as schizophrenia, major depression, or bipolar disorder) are eligible to receive services through the public mental health system without the state receiving compensation or reimbursement for services.¹¹⁵ Within the first 30 days of rendering mental health services, LMHA/LBHA staff (typically benefits coordinators or office managers) conduct a financial assessment of an individual's ability to pay for services and calculate a maximum monthly fee (or no fee) depending on the individual's gross income minus extraordinary expenses:¹¹⁶

The County Indigent Health Care Program was created by the Texas Legislature in 1985 and 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 and assets do not exceed criteria shown below.

Assets: A household is eligible if the total countable household resources do not exceed:

- \$3,000 when a person who is aged or disabled and who meets relationship requirements lives in the home, or
- \$2,000 for all other households.¹¹⁷

Income: A household is eligible if its monthly net income does not exceed 21 percent of the FPG. Counties may choose to increase the monthly income standard to a maximum of 50 percent FPG and still qualify to apply for state assistance funds.

Table 16. CIHCP Monthly Income Standards

# of Individuals in the CIHCP Household	21% FPG Minimum Income Standard	50% FPG Maximum Income Standard
1	\$213	\$506
2	\$289	\$686
3	\$364	\$866
4	\$440	\$1,046
5	\$515	\$1,226
6	\$591	\$1,406
7	\$667	\$1,586
8	\$742	\$1,766
9	\$818	\$1,946
10	\$893	\$2,126
11	\$969	\$2,306
12	\$1,045	\$2,486

Based on the 2018 Federal Poverty Guidelines; effective April 2018

Source: Texas Health and Human Services, Texas Department of State Health Services. (April 2, 2018). *County Indigent Health Care Program - Eligibility Criteria*. Retrieved from <http://www.dshs.texas.gov/cihcp/eligibility.shtm>

For more information on CIHCP, please see <http://dshs.texas.gov/cihcp/eligibility.shtm>. Additional information can be found in Title 25 of the Texas Administrative Code at [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=14&rl=104](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=14&rl=104)

YOUTH EMPOWERMENT SERVICES (YES) WAIVER

The YES Waiver is a Medicaid 1915(c) home and community-based waiver program for children ages 3 to 18 years old intended to reduce Medicaid psychiatric hospital expenses, voluntary parental relinquishments to obtain care, and out-of-home placement for children with SED. 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.¹¹⁸ As with other 1915(c) waivers, YES waivers do not take family income into account when determining 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. The program uses a wraparound approach that couples direct services with family supports to help the child stay connected with their community. 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 the state 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:¹¹⁹

- 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).¹²⁰ Table 17 shows the steady increase in YES waiver enrollments over the past seven years.

Table 17. Youth Empowerment Services Waiver Enrollment: 2011-2017

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

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>.

2017 data obtained from HHSC at April 16, 2018 stakeholder meeting.

The expansion of the YES waiver program should allow even more youth with SED to access intensive community behavioral health services and decrease the number of children who receive inpatient care and/or are relinquished to the DFPS solely because of an inability to access needed mental health services.¹²¹ However, as of April 2018 there were “inquiry lists” being kept by some waiver providers because of a lack of staff who were able to provide the necessary 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 In recent years, the YES waiver was amended to allow children who are in state conservatorship to be eligible to receive YES waiver services. Up-to-date information on the status of this amendment, as well as other YES waiver information, is available at www.dshs.texas.gov/mhsa/yes/.¹²⁴

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.¹²⁵ The framework under which DSHS delivers public mental health services is known as Texas Resiliency and Recovery, an outgrowth of the shift in mental health service delivery that was launched in 2004 under the name Texas Resiliency and Disease Management.¹²⁶ 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.¹²⁷

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.¹²⁸

Clinical needs are identified through a psychosocial assessment and a uniform clinical instrument. ANSA and CANS assessments are used to determine the appropriate LOC and corresponding eligibility for services and specialty treatments. Within this model, the intensity of services is based on an individual’s 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. Table 18 describes the adult target population and services provided at each TRR LOC. Table 19 describes the same for children and adolescents.¹²⁹

Table 18. Texas Resiliency and Recovery Levels of Care for Adults

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

Level of Care	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-2: Basic Services including Counseling	Services in this LOC are intended for individuals with symptoms of major depressive disorder with or without psychosis (GAF \leq 50 at intake) who present very little risk of harm, have supports, have a level of functioning that does not require more intensive levels of care, and can benefit from psychotherapy.	The overall focus of services in this LOC is to improve level of functioning and/or prevent deterioration of the individual's condition so that the individual is able to continue to work towards identified recovery goals. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings and include psychotherapy services in addition to those offered in LOC-1. Services include: <ul style="list-style-type: none"> • All LOC-1S services • Cognitive behavioral therapy (individual and group)
LOC-3: Intensive TRR Services with Team Approach	The general focus of services in this LOC is to support the individual served in his or her recovery through a team approach that: engages the individual served as a key partner; stabilizes symptoms that interfere with the person's functioning; improves functioning; develops skills in self-advocacy; increases natural supports in the community; and sustains improvements made in more intensive LOCs. Service focus is on leveraging identified strengths and amelioration of functional deficits through skill training activities focusing on symptom management; independent living; self-reliance; non-job-task specific employment interventions; impulse control; and effective interaction with peers, family, and community. Services are provided in outpatient office-based settings and community settings.	Services in this LOC are generally intended for individuals who enter the system of care with moderate to severe levels of need (or for those whose LOC-R has increased), who require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school). This may include maintaining the current level of functioning. A rehabilitative case manager who is a member of the therapeutic team must provide supported housing and COPSD services, if indicated. Supported employment services must be provided by a rehabilitative case manager or a supported employment specialist. It is highly recommended a dedicated employment specialist provide the supported employment services. Services include: <ul style="list-style-type: none"> • All LOC-1S services • Psychosocial rehabilitative services (individual and group) • Day programs for acute needs • Residential treatment
LOC-4: Assertive Community Treatment	The purpose of ACT is to provide a comprehensive program that serves as the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses. Persons receiving ACT services may have a diagnosis of schizophrenia or another serious mental illness such as bipolar disorder and have experienced multiple psychiatric hospital admissions either at the state or community level. Using an integrated services approach, the ACT team merges clinical and rehabilitation staff expertise (e.g., psychiatric, substance abuse, employment, and housing) within a mobile service delivery team that works in partnership with the person in recovery from his or her home. Accordingly, there will be minimal referral of individuals to other programs for treatment, rehabilitation, and support services. Limited use of group activities designed to reduce social isolation or address substance use/abuse issues is also acceptable as part of ACT.	Services include: <ul style="list-style-type: none"> • All LOC-3 services • Cognitive behavioral therapy

Level of Care	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-5: Transitional Services	The major focus for this LOC is to provide flexible services that assist individuals in maintaining stability, preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay varies by individual need. This LOC is available for up to 90 days. The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for a change in the LOC authorized. A Recovery/Treatment Plan is required. In the event that an additional LOC-5 post-initial 90 days is required, a new plan would be required for every 90 day LOC-5 authorization.	LOC-5 is designed to flexibly meet the needs of the individual prior to admission into ongoing services. All services are available in this LOC. Services should reflect the individual's needs and can include: <ul style="list-style-type: none"> • Routine case management • Psychiatric Diagnostic Interview examination • Pharmacological management • Medication training and support services (group and individual) • Skills training and development (group and individual) • Supported employment • Supported housing • Flexible funds • Flexible community supports • Engagement activity • Screening • Counseling (cognitive processing therapy) • Crisis intervention services • Crisis transportation • Safety monitoring • Day programs • Extended observation • Crisis residential treatment • Crisis stabilization • Respite services • Inpatient hospital services • Inpatient psychiatric services • Emergency room services (psychiatric) • Crisis follow-up & relapse prevention
LOC-6: Individual Refuses Services	ANSA indicates an LOC- R of 1M-4; however, the individual refuses services. These individuals will be authorized into LOC-A 6.	
LOC-8: Waiting for all Authorized Services	All providers who maintain a waitlist must adhere to the standards outlined in the performance contract. For information related to managing a waitlist, please refer to the performance contract.	
LOC-9: Not Eligible for Services	ANSA indicates an LOC- R of 9. A provider may request a review from each provider's Utilization Management Department if, based on the individual's clinical presentation and the provider's clinical judgment, it is determined that a different level of care may be clinically appropriate. The necessary clinical information will be reviewed in accordance with the provider's Utilization Management Policy and Procedures for those individuals with an LOC-R of 9. If it is determined the individual is clinically appropriate to receive services the individual may be authorized into a level of care.	
LOC-EO: Early Onset	The purpose of LOC-EO is to provide a specialized treatment approach for those experiencing their first episode of psychosis. Individuals in this level of care will have a diagnosis that includes psychotic features and will vary in terms of need and severity. The LOC-EO's goal is to identify and help individuals before their symptoms and/or diagnosis are the primary feature of his/her life. Due to the early intervention model, many individuals may be entering behavioral health services for the first time and require that a comprehensive array of services be available. The team-based approach is a vital aspect of the assistance an individual will receive when they participate in LOC-EO. Coordinated specialty care teams are trained in the CSC model and provide an individual with all clinical and support services so care is provided efficiently and with a focus on recovery.	Services include: <ul style="list-style-type: none"> • Psychiatric diagnostic interview examination • Routine case management • Psychosocial rehab (individual and group) • Peer support • Pharmacological management • Administration of an injection • Medication training and support (individual and group) • Family counseling • Individual psychotherapy • Group counseling • Supported housing • Supported employment • Engagement activity • Flexible funds • Adjunct services • Flexible community supports • Screening brief intervention and referral to treatment (SBIRT) • Crisis services

Source: Texas Health & Human Services Commission. (2017). *Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health, Effective April 2017*.

Table 19. Texas Resiliency and Recovery Levels of Care for Children and Adolescents

Level of Care	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-0: Crisis Services	The services in this LOC are brief interventions provided in the community that ameliorate the crisis situation. Services are intended to resolve the crisis, avoid more intensive and restrictive intervention, and prevent additional crisis events. Any service offered must meet medical necessity criteria.	<p>These services do not require prior authorization. However, utilization management staff must authorize the crisis service within two business days of presentation. If further crisis follow-up and relapse prevention services are needed beyond the authorization period, the youth may be authorized for LOC-5. Services include:</p> <ul style="list-style-type: none"> • Crisis intervention services • Adjunct services • Psychiatric diagnostic interview examination • Pharmacological management • Safety monitoring • Crisis transportation • Crisis flexible benefits • Respite services • Extended observation • Children's crisis residential • Family partner supports • Engagement activity • Inpatient hospital services • Inpatient psychiatric services • Emergency room psychiatric services • Crisis follow-up and relapse prevention
LOC-1: Medication Management	The services in this LOC are intended to meet the needs of youth whose only identified treatment need is medication management. Youth served in this LOC may have an occasional need for routine case management services, but do not have ongoing treatment needs outside of medication-related services. While services delivered in this LOC are primarily office-based, services may also be provided at school, in the community, or via telemedicine.	<p>The purpose of this LOC is to maintain stability and utilize the youth's and/or caregiver's natural supports and identified strengths to help them transition to community-based providers and resources, if available. Services include:</p> <ul style="list-style-type: none"> • Psychiatric diagnostic review • Pharmacological management • Adjunct services • Medication training and support (individual and group) • Routine case management • Parent support group • Family partner supports • Family case management • Crisis services • Transition age youth additional adjunct services
LOC-2: Targeted Services	The purpose of this LOC is to improve mood symptoms or address behavioral treatment needs while building strengths in the youth and caregiver. The services in this LOC are intended to meet the needs of youth with identified emotional or behavioral treatment needs. The youth must not have identified needs in both areas. In general, the youth will have low life domain functioning needs.	<p>The targeted service in this LOC is either counseling or individual skills training and targets a specific, identified treatment need. The only exception occurs when counseling is the primary intervention for the youth, but individual skills training is also provided as a component of parent skills training. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available.</p> <p>Individuals in LOC-2 can receive all of the LOC-1 services but generally receive interventions more frequently than LOC-1 clients. The targeted services specific to LOC-2 are:</p> <ul style="list-style-type: none"> • Counseling (individual, group, or family) • Skills training (individual or group) • Family training (individual or group) • Skills training and development (delivered to the caregiver or LAR)

Level of Care	Target Population and Service Goal	Description of Interventions and Billable Services
LOC-3: Complex Services	The services in this LOC are intended to meet the needs of youth with identified behavioral and emotional treatment needs. The youth may also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. This may indicate a need for interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or further exacerbation of symptoms and/or behaviors.	<p>The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and caregiver. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the youth and caregiver.</p> <p>Services include:</p> <ul style="list-style-type: none"> • All LOC-2 services • Respite services, both community-based and program-based
LOC-4: Intensive Family Services (Wraparound)	The services in this LOC are intended to meet the needs of youth with identified behavioral and/or emotional treatment needs who are involved with multiple child-serving systems, or who are at risk for removal from their home or community. The identified behavioral or emotional treatment needs may have resulted in—or are likely to result in—juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, or serious injury to self, others, or animals. Providers will need to consider flexible office hours to support the intensive needs of the youth and his/her caregiver. Caregiver resilience is fostered using the Wraparound planning process to identify and build upon existing natural supports and strengths, as well as through referrals and support in accessing other needed community-based services and resources.	<p>HHSC has identified the National Wraparound Initiative (http://nwi.pdx.edu/) model for the provision of wraparound planning in the delivery of intensive case management services. The wraparound team is meant to reduce the risk of out-of-home placement for the youth. Therefore, due to the high level of symptom severity of the youth, the wraparound team – specifically a member of the treatment team – shall be accessible to the youth and his/her caregiver 24 hours a day, 7 days a week. Wraparound child and family team meetings shall take place at least monthly to achieve wraparound fidelity and comply with ICM provisions in TAC §412.407. When a crisis has been identified by any member of the wraparound team, a team meeting shall occur within 72 hours or at the earliest time available to the youth and family team members following the crisis. All wraparound team meetings must include the youth and his/her caregiver. While some of the services are the same as LOC-3, children and adolescents in LOC-4 packages receive interventions more frequently because they have a higher level of need. Providers will likely need to maintain flexible office hours to support the complex needs of the child in services and their caregivers. Individuals in LOC-4 packages are eligible to receive:</p> <ul style="list-style-type: none"> • All LOC-3 services • Stronger emphasis on family partner services and integrated care • Intensive case management, also known as “wraparound”
LOC-YC: Young Child Services	The services in this LOC are intended to meet the needs of the young child (ages 3-5) with identified behavioral and/or emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions. All services are available in this level of care and the recovery plan should be developed based on the individual needs of the child. The provider may recommend any core service that will help address the developmental, behavioral, and emotional needs of the child. In this level of care, the participation of the caregiver in all services is strongly recommended and most services will require the participation of both the caregiver and the child in treatment.	<p>The purpose of this LOC is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver. The focus of services is placed on the dyad relationship as this relationship is the primary context for young children. These primary relationship(s) set the stage for future social-emotional behavior and future relationship behavior. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services may also be provided via telehealth/telemedicine, if available. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver.</p> <p>Young children in the LOC-YC package are eligible to receive the following services:</p> <ul style="list-style-type: none"> • All LOC-4 services

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

Source: Texas Health and Human Services. (2016). *Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services, Updated 2016*.

SYSTEM UTILIZATION (COMMUNITY MENTAL HEALTH SERVICES)

From FY 2013 through FY 2017, the average monthly number of adults receiving community mental health services increased from 79,611 to 117,792, a 32.4 percent increase over 5 years. The average number of children receiving community mental health services increased from 17, 878 to 30,064, a 41 percent increase over that 5 year period.¹³⁰ Figure 20 shows trends for the number served and the average cost per client from 2013 - 2017.

Figure 20. Utilization of Community Mental Health Services for Adults and Children, 2013-2017

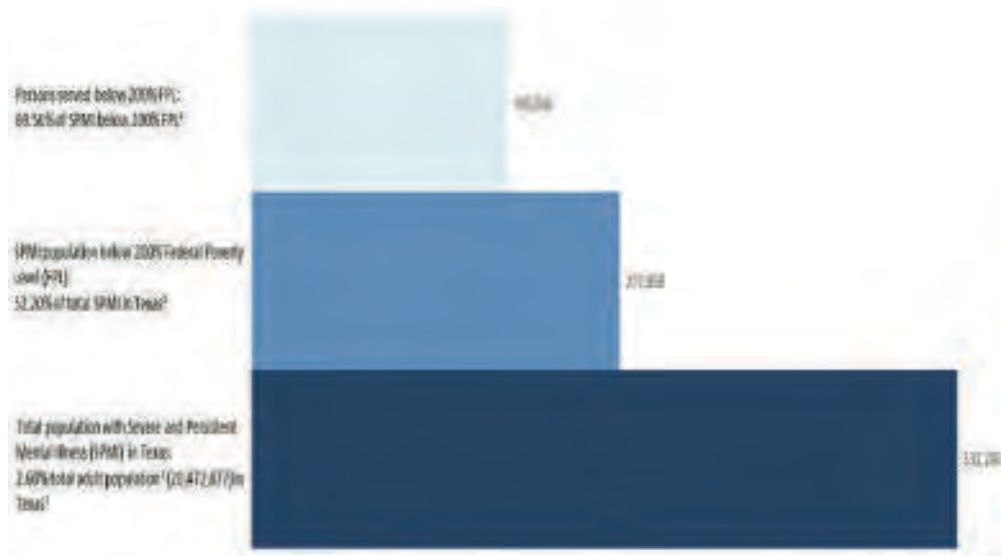
Utilization Measure	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Average monthly number of adults receiving community mental health services	79,611	90,658	94,776	98,502	117,792
Average cost of community mental health services per adult served	\$352	\$422	\$438	\$418	\$420
Average monthly number of children receiving community mental health services	17,878	20,240	23,376	23,887	30,064
Average cost of community mental health services per child served	\$383	\$441	\$441	\$407	\$404

Source: Health & Human Services Commission. Data request August 8, 2018. Data received from Michele Neal.

As illustrated in the figures below, 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 2017, there were 277,858 adults in Texas who had an SPMI such as schizophrenia or bipolar disorder and were living below 200 percent of the FPL; 193,266 of them—or 69.56 percent—received services at DSHS-funded community mental health centers. Similarly, there were 111,481 children with

SED living below 200 percent of the FPL in 2017; 61,279 of them—or 54.97 percent—received services through DSHS-funded community mental health centers.¹³¹

Figure 21. Unmet Need for Community Mental Health Services: Adults in FY 2017



Sources: Obtained from HHSC, August 8, 2018.

¹Population Projections, Texas State Data Center, 2017 statewide totals, migration rate 0.5 2010-2050

²CMHS, SAMHSA, HHS (1999) Estimation Methodology for Adults with Serious Mental Illness (SMI). Federal Register, v64

³Based on column – SMI: Serious Mental Illness Indicator, National Survey on Drug Use and Health, 2013

⁴Texas Department of State Health Services, Mental Health and Substance Abuse, Office of Decision Support, 10/4/2017

Figure 22. Unmet Needs for Community Mental Health Services: Children and Adolescents in FY 2017



Sources: Obtained from HHSC August 8, 2018.

¹Population Projections, Texas State Data Center, 2017 statewide totals, migration rate 0.5 2010-2050

²CMHS, SAMHSA, HHS (1998) Children with Serious Emotional Disturbance: Estimation methodology. Federal Register, v63 n137, pp 38661-38665

³Based on Column – CMBEYR_B: Youth Past Year Major Depressive Episode, National Survey on Drug Use and Health, 2013

⁴Texas Department of State Health Services, Mental Health and Substance Abuse, Office of Decision Support, 10/2/2016

Quality of Care Measures

Table 20 and Table 21 shows selected data on common adult and child/adolescent outcome measures for FY 2016-2017.

Table 20. Selected Measures for Adults Receiving Community Mental Health Services

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

Source: Health & Human Services Commission. Data request: Michelle Neal, August 8, 2018.

Table 21. Selected Measures for Children and Adolescents Receiving Community Mental Health Services

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

Source: Health & Human Services Commission. Data request: Michelle Neal, August 8, 2018.

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.¹³² As of May 2018, 309 adults were “waiting for all services,” and 793 underserved adults were waiting for additional services.¹³³

The number of children on the statewide waiting list in May 2018 was much lower than the adult list with only 9 children waiting for services and 170 underserved children waiting for additional services.¹³⁴

The factors identified by LMHAs as impacting waiting lists are shown in Table 22.

Table 22. Factors Impacting Community Mental Health Waiting Lists

Issue	Long or Short-term	Description
As Texas' population grows, so will the number of people likely to qualify for state-supported mental health services	Long-term	<ul style="list-style-type: none"> • Texas population to increase to over 40.5 million by 2050 • 811,000 adults likely to qualify for state-supported mental health services in 2050, compared to 533,907 in fiscal year 2016 • 320,000 youth likely to qualify for state-supported mental health services in 2050, compared to 253,466 in fiscal year 2016
Workforce shortages	Long-term	<ul style="list-style-type: none"> • Shortages cause challenges to recruiting and retaining psychiatrists, licensed clinicians, nurses, and qualified mental health professionals • Challenges are even greater in rural and underserved areas
Other workforce issues	Short-term	<ul style="list-style-type: none"> • Loss or retirement of a prescribing provider • Limited funding • Low reimbursement rates

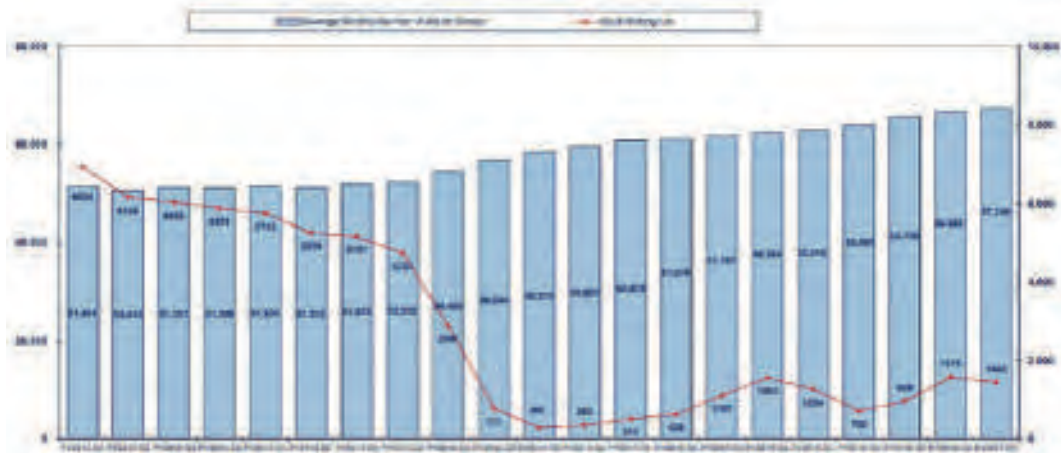
Source: Health and Human Services Commission. (July 2018). *Quarterly Reporting of Waiting Lists for Mental Health Services and of Mental Health Services for Former NorthSTAR Service Area.*

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

The 85th Legislature appropriated additional funding specifically to address the waiting lists for adult and children's services. These funds were 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.

Figure 23. Adult Waiting List and Adults Served Through Community Mental Health Centers: FY 2012 (Q1) - FY 2017 (Q1)



Source: Smith, C. & Lacefield Lewis, L., Texas Department of Health and Human Services. (March 9, 2017). *Presentation to the 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 24. Child and Adolescents Waiting List and Children Served Through Community Mental Health Centers: FY 2012 (Q1) - FY 2017 (Q1)



Source: Smith, C. & Lacefield Lewis, L., Texas Department of Health and Human Services. (March 9, 2017). *Presentation to the 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:

- 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.¹³⁵

During the 85th legislative session, lawmakers increased mental health crisis funding to a total of \$325,430,552 in the 2018/2019 biennium, an increase of \$71,860,530 from the 2016/2017 biennium.¹³⁶ Crisis services funding is used to enhance community-based psychiatric emergency services projects that serve as alternatives to divert individuals from hospitals, emergency rooms, and/or jails.

Crisis services are available statewide to individuals whether or not they are enrolled in ongoing mental health care. Table 23 lists most of the crisis services available through state-funded programs and providers:

Table 23. Available Mental Health Crisis Services

Service	Description
Crisis Hotline Services	Available 24 hours per day, seven days per week, all 39 LMHAs/BMHAs either operate their own crisis line or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS).
Mobile Crisis Outreach Teams	Mobile Crisis Outreach Teams provide face-to-face help to people who are at risk of harm to self or others. MCOTs provide counseling services to people at their home, school or other location. The services are available 24/7, 365 days a year.
Crisis Stabilization Units	Provide immediate access to emergency psychiatric care and short-term residential treatment for the resolution of acute symptoms.
Extended Observation Units	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 costlier 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 three to 10 days of psychiatric stabilization in a local hospital setting with a psychiatrist on staff working to stabilize an individual's symptoms and prepare them for maintaining continuity of care while transitioning to community-based services.
Outpatient Competency Restoration Services	Provides community competency restoration treatment to individuals with mental illness involved in the legal system, reduces unnecessary burdens on jails and state psychiatric hospitals, and provides psychiatric stabilization and participant training in courtroom skills and behavior.
Transitional Services (LOC-5)	Provides linkage between existing services, ongoing care, and temporary assistance to individuals post-crisis for up to 90 days. Individuals may be homeless, in need of substance use treatment or primary health care, involved in the criminal justice system, experiencing multiple psychiatric hospitalizations, and/or have a non-priority diagnosis.

Source: Texas Department of State Health Services. (2010). Crisis Services. Word document retrieved from <https://www.dshs.texas.gov/mhsacsr/Mental-Health-and-Substance-Abuse-Crisis-Services-Redesign.pdf> 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 outcomes for crisis mental health services are included in Figure 25 below.

Figure 25. Annual Utilization/Cost for Crisis Behavioral Health Services - Residential

Description	FY 2017	FY 2018	FY 2019
Persons Receiving Crisis Residential Services Per Year	24,400	24,832	25,000
Average GR Spent Per Person for Crisis Residential Services	\$2,756	\$2,345	\$2,800

Source: Legislative Budget Board, (September 2018). HHSC Legislative Appropriations Request for FY 20/21. 3A Strategy Request, p. 169.

Figure 26. Annual Utilization/Cost for Crisis Behavioral Health Services - Outpatient

Description	FY 2017	FY 2018	FY 2019
Persons Receiving Crisis Residential Services Per Year	84,606	89,403	90,000
Average GR Spent Per Person for Crisis Residential Services	\$553	\$504	\$600

Source: Legislative Budget Board, (September 2018). HHSC Legislative Appropriations Request for FY 20/21. 3A Strategy Request, p. 169.

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 percent of the total population).¹³⁷ This group is one of fastest growing populations in Texas and is expected to more than triple between 2010 and 2050, growing to 12 million.¹³⁸

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.¹³⁹ An estimated two million seniors in the United States have serious mental illness.¹⁴⁰ The suicide rate among older Texans (over age 55) is higher than the rate among younger groups.¹⁴¹

It is important to know that depression is not a normal part of aging.¹⁴² However, depression often co-occurs with other serious illnesses, such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.¹⁴³ Many health professionals mistakenly conclude that depression is a consequence of these problems, leaving the condition widely unrecognized and undertreated among older adults.¹⁴⁴

SUBSTANCE USE SERVICES

The national opioid crisis has brought substance use disorders to the center stage. For information on how it is being addressed in Texas, please see the Texas Environment section.

Prior to 2010, Medicaid reimbursement for substance use services was only available to individuals under the age of 21, and the substance use benefits were very limited. In 2009, the 81st Texas Legislature directed HHSC to develop Medicaid state plan substance use disorder benefits for adults. Implementation of these services began in 2010. Subsequently in 2015, the legislature directed HHSC to develop a methodology for evaluating the cost benefits of these services. The 85th Texas Legislature then directed HHSC to submit a report on the findings of the evaluation by December 1, 2017.¹⁴⁵ This report is available online at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/substance-abuse-disorder-treatment-nov-2017.pdf>.

The report submitted to the legislature in December 2017 showed that the average monthly Medicaid costs for individuals with a SUD diagnosis receiving SUD services (\$1,410) was lower than the average monthly cost for individuals with a SUD diagnosis (\$1,559) who did not receive treatment.¹⁴⁶

According to SAMHSA, in 2014, an estimated 22.5 million Americans aged 12 and older self-reported needing treatment for alcohol or illicit drug use.¹⁴⁷ SAMHSA also estimates that the impact of substance use costs the nation more than \$600 billion each year.¹⁴⁸ Whether an individual decides to use/abuse substances often depends on the risk factors they face and the protective factors available to them. Consequently, efforts to prevent substance use conditions often endeavor to increase protective factors and reduce the risk factors present in the individuals' environment and in their community.

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.¹⁴⁹

State agencies and organizations are increasingly using the term “behavioral health” in place of “mental health” to more accurately represent the co-occurrence of mental health and substance use conditions. In an effort to improve integrated care, there has also been increased focus on how LMHAs can better integrate substance use services with the mental health services typically provided by LMHAs/LBHAs. As a result of SB 1507 (84th, Garcia/Naishtat), the Outreach, Screening, Referral and Assessment providers responsible for substance use screenings and referrals for substance use services are now co-located within LMHAs/LBHAs across all of Texas.¹⁵⁰

The HHS System provides substance use services for eligible youth and adults and contracts with service providers to deliver treatment. The HHSC Mental Health and Substance Use Division is responsible for creating and implementing policies regarding substance use services and defining optimal treatment outcomes. Table 24 describes the program's major activities relating to substance use.^{151, 152}

Table 24. Major Programs Mental Health and Substance Use Division

Program	Goals and Services Provides
Substance Abuse Prevention	Goals include increasing protective factors/decreasing risk factors, strengthening family bonding and encouraging a drug-free lifestyle. Aimed at people abusing illegal and legal drugs, including alcohol and tobacco. Services include community coalition programs, youth prevention programs, services provided offered at 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, SAI services also offer: 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	Outreach, screening, assessment and referral services to help people get substance use services, case management and peer support. Treatment services are evidence based, holistic, and emphasize coordination of care across the continuum of need. These services include both inpatient and outpatient programs.
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: <ul style="list-style-type: none"> • Peer-support services; • Aligning treatment services with a recovery-oriented approach; and • Expanding community supports to help individuals successfully integrate into their communities.¹⁵³ <p>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.¹⁵⁴ Read more about the pilot projects and the evaluation in the Recovery Support Services (RSS) Pilot Evaluation subsection.</p>

Table 25. 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
<i>Individual</i>	Both
<i>Female</i>	Both

Type of Service	Target Population (Adult-Only, Youth-Only, or Both)
<i>Group</i>	Both
<i>Adolescent support</i>	Youth Only
<i>Family counseling</i>	Youth Only
<i>Family support</i>	Youth Only
<i>Psychiatrist consultation</i>	Youth Only
Outpatient services (specialized female)	Adult
<i>Individual</i>	Adult
<i>Group</i>	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.

CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

- 35.6 million adults had a mental health diagnosis and no substance use condition;
- 20.2 million adults in the U.S. had a substance use condition; 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.¹⁵⁵

Individuals living with mental health conditions are more likely than those without to have a co-occurring substance use condition.¹⁵⁶ Often, alcohol and/or substance use is used to relieve the struggles experienced as a result of a mental health condition. This is often referred to as “self-medicating.” Integrating physical and behavioral health care is the best way to ensure that any co-occurring conditions are addressed. Additionally, early detection, intervention, and treatment offer the best potential for positive outcomes.

The Texas program aimed at addressing co-occurring mental health and substance abuse conditions is the Co-Occurring Psychiatric and Substance Abuse Disorders Services, or COPSD. These programs emphasize the need to address both conditions as simultaneous, primary conditions.

ACCESS TO SUBSTANCE USE SERVICES

Only a small portion of individuals needing substance use treatment receive the appropriate services. In Texas in FY 2015, 39,387 (or 5.7 percent) of the 689,803 adults living below 200 percent of FPL with a substance use disorder were served by state-funded substance use providers.¹⁵⁷ Additionally, only 5,258 (or 5.7 percent) of the 92,071 children living below 200 percent of FPL with a substance use disorder received services through DSHS; 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.¹⁵⁸

** 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 HHSC-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.

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.¹⁵⁹ During the 85th legislative session, legislators increased funding for substance use services by approximately \$55 million.¹⁶⁰

Table 26. Funding Trends for Substance Use Services

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021	Exceptional Items Request 2020	Exceptional Items Request 2021
Substance Abuse Prev/ Intervention/ Treatment	\$163,875,398	\$217,708,060	\$217,870,856	\$217,997,115	\$217,997,115	\$3,540,469	\$41,773,355

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

PRIORITY POPULATIONS

Four populations receive priority for admission to substance use services before anyone else, in the following order of priority:

- 1) Pregnant females with SUD who inject drugs
- 2) Pregnant females with SUD
- 3) Males and females with SUD who inject drugs
- 4) Males and females with SUD who have been referred by DFPS¹⁶¹

Additionally, youth ages 13 to 17 who meet the DSM-V criteria for substance-related and addictive disorders who also meet financial eligibility guidelines can

receive youth treatment services.¹⁶² Adults ages 18 to 21 may be admitted to a youth treatment program if screening shows the person's needs, experiences and behavior are similar to those of youth clients.

SUBSTANCE USE SERVICES: UTILIZATION AND COSTS

The following two figures show the averaged utilization and costs of substance use services; Table 27 details information for adults and Table 28 is for children and adolescents.

Table 27. Utilization and Costs for Adult Substance Use Services

		2017	2018	2019
Intervention Programs	Average Monthly Number of Adults Served	6,715	7,491	7,400
	Average Monthly Cost Per Person	\$169	\$241	\$194
Treatment programs	Average Monthly Number of Adults Served	8,996	10,505	10,500
	Average Monthly Cost Per Person	\$1795	\$1,879	\$1,766

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

Table 28. Utilization and Costs for Child & Adolescent Substance Use Services

		2011	2012	2013
Prevention program	Average Monthly Number of Youth Served	134,918	161,037	155,000
	Average Monthly Cost Per Youth	\$18	\$22	\$17
Intervention programs	Average Monthly Number of Youth Served	486	596	600
	Monthly Cost Per Youth	\$232	\$247	\$261
Treatment programs	Average Monthly Number of Youth Served	1,200	1,173	1,200
	Monthly Cost Per Youth	Not Avail.	Not Avail.	Not avail.

Source: Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

SUBSTANCE USE SERVICES: QUALITY OF CARE MEASURES

HHSC monitors quality and performance in several areas based on the Texas Resilience and Recovery framework. More information on the TRR Framework is available under the Community Mental Health Services section. Table 29 shows

some of the measures tracked on a regular basis for adult substance use services and Table 30 shows the same for children and adolescent services.

Table 29. Selected Quality of Care Measures for Adult Substance Use Services (2014-2017)

Of Adults Entering a Substance Use Treatment Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Percentage completing a program per year	52%	49%	53%	47%	48%
Percentage completing a program who report abstinence at discharge	90%	91%	92	94%	92%
Percentage of those unemployed completing a program who have gainful employment at discharge	59%	58%	51%	58%	54%
Percentage completing a program not arrested	100%	100%	100%	100%	100%

Sources: Texas Health and Human Services Commission. Data request. Received 8/15/18.

*Data for these years not available.

Table 30. Selected Quality of Care Measures for Youth Substance Use Services

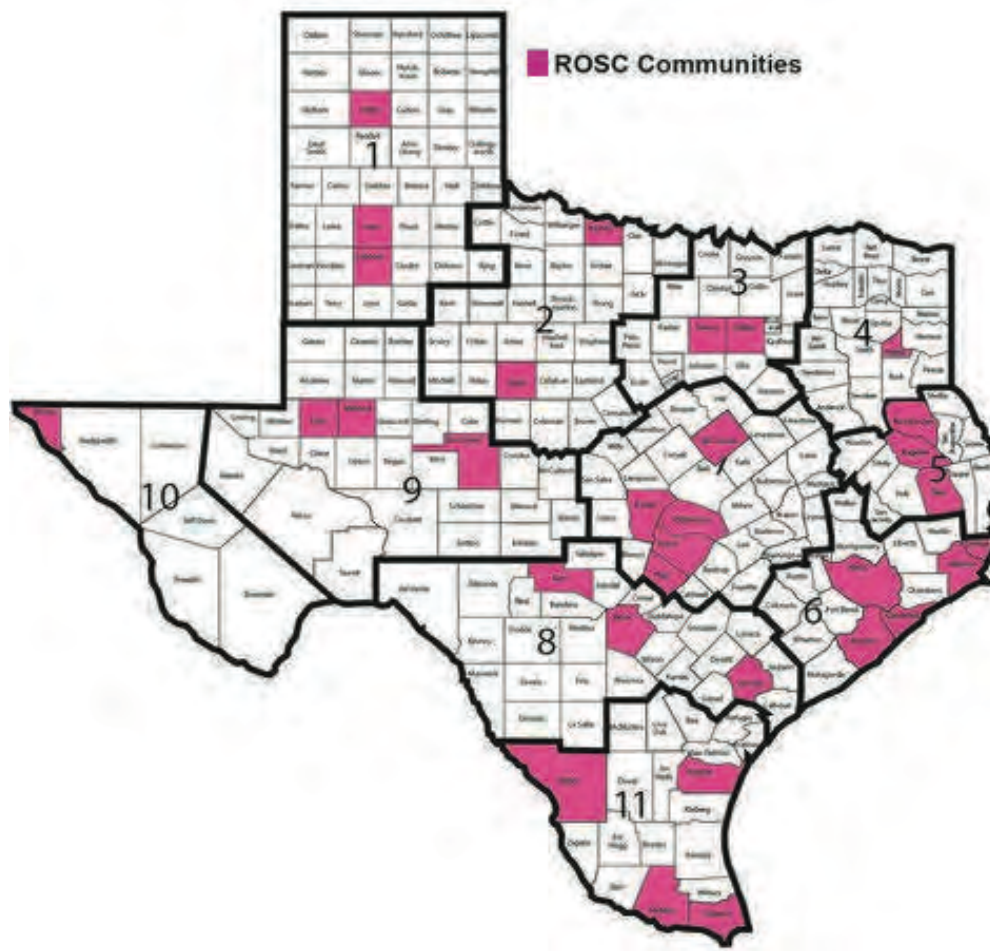
Of Youth Entering a Substance Use Treatment Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Percentage completing substance use treatment programs per year	52%	44%	51%	55%	50%
Percentage completing substance use treatment programs reporting abstinence at discharge	90%	89%	91%	91%	92%
Percentage completing substance use treatment programs with positive school status at follow-up per year	75%	75%	78%	77%	74%
Percentage completing substance use treatment programs not arrested	99%	99%	99%	99%	100%

Sources: Texas Health and Human Services Commission. Data request. Received 8/15/18.

RECOVERY-ORIENTED SYSTEMS OF CARE

The Texas Recovery-Oriented Systems of Care is a system of care that offers a framework for coordinating services and supports across systems for people with SUD. The services and supports are intended to be person-centered and self-directed to heighten the potential for individual recovery. ROSC communities are located in all 11 HHSC regions and are designed to build on individual, family, and community strengths, shown in the figure below.

Figure 27. Recovery Oriented Systems of Care Community Locations



Source: Ramirez, L. (2018). *Presentation to the House Select Committee on Opioids and Substance Abuse: Pregnant Women, Veterans and Homelessness*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/leg-presentations/house-select-special-populations-april-17-2018.pdf>

RECOVERY SUPPORT SERVICES (RSS) PROJECT

As described in the text box below, HHSC currently contracts with 22 sites for the Recovery Support Services (RSS) initiative. RSSs are intended to be community-based, nonclinical recovery services for SUDs. Only two of the current contracts are with recovery community organizations. The remaining contracts are providing recovery support in clinical settings. This reflects the limited infrastructure for recovery community organizations.

Recovery Support Services (RSS) Final Evaluation Report

In recent years, there has been a significant shift in the addiction field in the understanding of what it means to recover from a substance use disorder (SUD). Spurred by emerging research and the experiences of individuals in recovery, the field has moved away from an acute care model of brief treatment episodes focused on stabilization to a long-term, sustained recovery model that encompasses the whole health and well-being of individuals. This new approach requires a transformation in practice and policy at the local, state, and national levels. The state of Texas embarked on this transformation in 2010, with the Texas Health and Human Services Commission establishing a series of local community networks across the state to collaborate in identifying strengths and obstacles for individuals in recovery, and to improve the local environment to support recovery in a positive way. These local ROSCs were the framework for a long-term systems transformation. In 2014, HHSC took the further step of issuing a competitive bid to provide recovery support services to individuals with substance use disorders. The goals of the initiative included:

- Embedding long-term recovery support services into peer-based organizations, community-based organizations and substance use disorder treatment programs in local communities across Texas
- Expanding the recovery supports that are available to individuals in their natural community environments

Services included a wide array of non-clinical services and supports to help individuals initiate, support, and maintain recovery from alcohol and other drug use problems. One of the key elements included in the project was the recruitment and utilization of peer recovery coaches. Services also included peer-run groups; development and/or use of recovery homes and recovery schools; training around basic life skills such as financial management, parenting, employment and stress management; educational support; recovery check-ups; and assertive connections to mutual aid support groups. The resulting network of 22 RSS service providers funded by HHSC is collectively known as the Recovery Support Services Project. The program was operational on May 1, 2014. The University of Texas Addiction Research Institute coordinated with HHSC to develop the RSS data reporting system and to serve as the evaluator for the RSS project. The FY 2016 Final Evaluation Report assesses implementation of the HHSC Recovery Support Services Project using data collected May 1, 2014 through August 31, 2016. The report is available at <https://socialwork.utexas.edu/dl/ari/recovery-support-services-report-2016.pdf>.

Source: The University of Texas at Austin, Addiction Research Institute, School of Social Work. (2017). Recovery Support Services Project, Fiscal Year 2016 Final Evaluation Report.

RECOVERY HOUSING

The opioid epidemic has propelled substance use challenges into the national forefront. It is widely recognized that safe, substance-free housing is a vital resource needed by many who are experiencing substance use addiction. The following excerpt came from a recent GAO Report that included an evaluation of Texas. The report is available at <https://www.gao.gov/assets/700/690831.pdf>.

The Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services administers two federal health care grants for SUD prevention and treatment that states may use to establish recovery homes and for related activities. First, under its Substance Abuse Prevention and Treatment block grant, SAMHSA makes at least \$100,000 available annually to each state to provide loans to organizations seeking to establish recovery homes. Second, states have discretion to use SAMHSA funding available under a 2-year grant for 2017 and 2018 primarily for opioid use disorder treatment services, to establish recovery homes or for recovery housing-related activities. Of the five states GAO reviewed, only two, Texas and Ohio, have used any of their SAMHSA grant funds for these purposes. Four of the five states—Florida, Massachusetts, Ohio, and Texas—have also used state general revenue funds to establish additional recovery homes.

The Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services administers two federal health care grants for SUD prevention and treatment that states may use to establish recovery homes and for related activities. First, under its Substance Abuse Prevention and Treatment block grant, SAMHSA makes at least \$100,000 available annually to each state to provide loans to organizations seeking to establish recovery homes. Second, states have discretion to use SAMHSA funding available under a 2-year grant for 2017 and 2018 primarily for opioid use disorder treatment services, to establish recovery homes or for recovery housing-related activities. Of the five states GAO reviewed, only two, Texas and Ohio, have used any of their SAMHSA grant funds for these purposes. Four of the five states—Florida, Massachusetts, Ohio, and Texas—have also used state general revenue funds to establish additional recovery homes.

Source: Government Accounting Office (GAO). (March 2018). *Substance Use Disorder, Information on Recovery Housing Prevalence, Selected State's Oversight and Funding*.

OXFORD HOUSES

The Oxford House model of recovery residences has gained the support of Texas policymakers in recent years. The Oxford House program is a democratically operated, peer-run recovery model intended to be self-supporting after an initial start-up investment. Residents are expected to contribute to rent and expenses during their stay making the residences self-sustaining. In FY 2017, HHSC funded 200 Oxford Houses in Texas and planned for an additional 61 homes in FY 2018.¹⁶³ HHSC indicates that 62 percent of Oxford House residents have experienced homelessness.¹⁶⁴ HHSC also reported “improvements in employment, decreased rates of substance use and incarceration, and a cost savings of \$29,000 per person over a 2-year period.”¹⁶⁵

About Oxford House, Inc.

Oxford House™ is a concept and system of operations based on the experience of people with SUD recovery and who have learned that behavior change is essential to recovery from alcoholism and drug addiction. Oxford House provided these individuals the living environment that provided a comfortable environment to promote abstinent behavior in order to stay clean and sober without relapse. The program is replicated nationwide at a very low cost, and its headquarters are based in Maryland.

The Oxford House Manual© is the basic blueprint that provides the organization and structure that permit groups of recovering individuals to successfully live together in a supportive environment. All Oxford Houses are rented ordinary single-family houses in typical neighborhoods. There are Oxford Houses for men and for women but there are no co-ed houses. The range of residents per house is six to sixteen, with an average number of eight residents nationally.

Oxford Houses work because they: (1) have no time limit for how long a resident can live in an Oxford House; (2) follow a democratic system of operation; (3) utilize self-support to pay all the household expenses; and (4) adhere to the absolute requirement that any resident who returns to using alcohol or drugs must be immediately expelled. Oxford House provides the missing elements needed by most people with SUD to develop behavior to assure total abstinence. It provides the time, peer support, and structured living environment necessary for long-term behavior change to take hold.

Individuals living in an Oxford House learn or relearn values and responsible behavior and develop long-term behavior to assure comfortable sobriety for lifelong recovery. Some individuals live in Oxford Houses a few months, others for many years. By using participatory democracy and self-support, people with SUD and those with co-occurring mental illness achieve long-term recovery.

After 43 years of steady growth and successful recovery outcomes, Oxford House™ has been proven to work for many individuals with SUD. It is also a very cost-effective way to support long-term recovery from alcoholism, drug addiction, and co-occurring mental illness. At the end of 2017, there were 2,287 Oxford Houses with 18,025 beds throughout the country.

Oxford House is listed as a best practice on the National Registry of Evidence-based Programs and Practices and was singled out as an effective tool for long-term recovery in the U.S. Surgeon General's report “Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016.” (Silver Spring, Maryland January 30, 2018).

Source: Oxford House, Inc. (2017). Annual Report: Oxford House Self-run, Self-supported Recovery Housing. Retrieved from <http://oxfordhouse.org/userfiles/file/doc/ar2017.pdf>.

SYSTEMS OF CARE AND THE TEXAS RECOVERY INITIATIVE

The Texas Recovery Initiative 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.¹⁶⁶ 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.”¹⁶⁷ 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 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.”¹⁶⁸ 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.¹⁶⁹ 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 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.¹⁷⁰

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.¹⁷¹ 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.¹⁷²

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.¹⁷³ 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.¹⁷⁴ 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.¹⁷⁵ Moving forward, surveys indicate a need for the SOC framework to focus more on providing communities more concrete steps to achieve the goals of SOC.¹⁷⁶

A full list of ROSCs across Texas is available at <http://dshs.texas.gov/substance-abuse/ROSC/>.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES SERVICES

The Intellectual and Developmental Disabilities Services division oversees intellectual and developmental disability services provided by Local Intellectual and Developmental Disability Authorities.¹⁷⁷ Prior to the HHS system transformation required by the legislature in 2015, these services were located within the Department of Aging and Disability Services.

MENTAL HEALTH NEEDS OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Intellectual and developmental disabilities can often overshadow existing mental health or medical conditions. Professionals, caregivers, and family members who are accustomed to seeing an individual through the lens of 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.¹⁷⁸ This significantly reduces opportunities for recovery.

The coexistence of an intellectual or developmental disability (IDD) along with a mental illness is one type of dual diagnosis.¹⁷⁹ Individuals with intellectual disabilities experience the full range of mental health conditions at rates higher than the general population.¹⁸⁰ It is estimated that as many as 30 to 40 percent of persons with intellectual disabilities are diagnosed with a mental health condition.¹⁸¹ 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.¹⁸² 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.¹⁸³ 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.¹⁸⁴

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.¹⁸⁵ While many individuals with IDD have known histories of abuse (some research suggesting nearly 30 percent), the rate may be higher because of underreporting or lack of recognition by family and other caregivers.¹⁸⁶

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.¹⁸⁷

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

PREVALENCE OF MENTAL HEALTH CONDITIONS FOR PEOPLE WITH DISABILITIES

Individuals with disabilities can experience all types of mental health conditions and require access to quality mental health services. People with disabilities, while at a higher risk of having mental health conditions than the general population, often experience significant disparities in their ability to access needed services. Analysis of recent data from the National Core Indicators suggests that approximately 34 percent of adults living with IDD also have a co-occurring mental health condition.¹⁸⁸ People with IDD frequently experience trauma as the result of abuse, neglect, exploitation, isolation, institutionalization, bullying, restraint, seclusion, violence, and other forms of trauma, yet rarely are IDD, special education, or criminal/juvenile justice systems, programs, or policies for people with IDD developed on recovery and trauma-informed principles. Goals and objectives of these systems rarely address mental wellness.

The mental health needs of people with intellectual disabilities are routinely overlooked in the research and these individuals often do not receive quality mental health treatment.¹⁸⁹

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.^{190,191}

Over the past decade, evidence has also shown a high prevalence of mental health conditions in people with autism spectrum disorder. 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.¹⁹²

CHANGING THE PARADIGM

The conversation is changing from simply trying to “manage” behaviors to trying to recognize and address the mental health and trauma needs of individuals with

IDD. The Hogg Foundation for Mental Health partnered with the National Child Traumatic Stress Network to develop *The Road to Recovery: Supporting Children with IDD Who Have Experienced Trauma*. This is a two-day, train-the-trainer curriculum and toolkit that is available free of charge online. The Hogg Foundation funded a three-year grant to provide the training statewide. The toolkit is available on the NCTSN website at <https://learn.nctsn.org/enrol/index.php?id=370>. Registration and login are required, but the product is available to the public.

HHSC has begun to recognize the importance of addressing the mental health needs of individuals with IDD. A web-based series of trainings has been developed and is offered free of charge online. The series, *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHW-IDD)*, is available at <http://training.mhw-idd.uthscsa.edu/>. The course consists of the following six modules:

- Co-occurring Disorders: Intellectual and Developmental Disabilities and Mental Illness
- Trauma Informed Care for Individuals with IDD
- Functional Behavioral Assessment and Behavior Support
- Overview of Genetic Syndromes Associated with IDD
- Overview of other Medical Diagnoses Associated with IDD
- Putting it all Together: Supports and Strategies for Direct Service Workers

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

Long-term Services and Supports 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.

LONG-TERM SERVICES AND SUPPORTS FUNDING

Funding for LTSS programs and services comes from both the federal and state governments. These figures include funding for an array of LTSS services, both community-based and institutional care, and are not limited to funding for mental health services.

Table 31. LTSS Funding Trends and Requests

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
Day Activity & Health Services	\$9,083,658	\$8,130,528	\$8,872,746	\$9,123,267	\$9,393,590
Nursing Facility Payments	\$281,393,474	\$242,118,593	\$322,787,787	\$317,279,079	\$316,673,611
Medicare Skilled Nursing Facility	\$55,258,698	\$37,500,935	\$54,602,673	\$53,542,560	\$54,020,171
Hospice	\$248,441,636	\$229,147,835	\$269,311,743	\$276,958,763	\$280,652,492
Intermediate care Facilities - IDD	\$256,016,951	\$282,128,616	\$260,278,862	\$259,984,727	\$260,313,984

Strategy	Expended 2017	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021
Home and Community-based Services	\$1,102,175,534	\$1,070,740,677	\$1,137,810,107	\$1,140,285,551	\$1,140,161,616
Community Living Assistance	\$265,860,600	\$264,651,917	\$281,987,530	\$282,216,735	\$281,963,460
Deaf-Blind Multiple Disabilities	\$13,362,419	\$12,137,020	\$14,381,918	\$14,355,801	\$14,357,532
Texas Home Living Waiver	\$121,720,554	\$106,942,647	\$118,855,251	\$119,608,072	\$119,452,116
All-Inclusive Care – Elderly (PACE)	\$41,085,792	\$43,581,641	\$44,802,940	\$44,841,243	\$44,841,336
Medically Dependent Children's Program	\$41,343,421	0	0	0	0
State Supported Living Centers	0	\$694,036,425	\$688,787,866	\$694,036,429	\$694,036,429
Total	\$2,435,742,737	\$2,991,116,834	\$3,202,479,423	\$3,212,232,227	\$3,215,866,337

Source Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*.

Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx.

Note: The funding reflected in this table is included in the total Medicaid appropriation provided in the Medicaid section.

Note: Data on costs for behavioral health services in these programs is unavailable.

In addition to Medicaid and Medicaid waiver services, HHSC is now responsible for the administration of community LTSS. The majority of Texans with disabilities receive services in a community-based setting. Many of these programs provide needed services to people with disabilities and co-occurring behavioral health challenges. Older Texans meeting the medical criteria for nursing home services may also be eligible for community-based services funded by HHSC if they meet financial eligibility criteria. Some of the major community service programs are described below.

MEDICAID 1915(C) WAIVER SERVICES

HHSC 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.

Table 32 provides basic information about eligibility and services for the primary waivers for persons with intellectual and other developmental disabilities.

Table 32. Community-Based Waiver Eligibility and Behavioral Health-Related Services for people with Disabilities

Program	Eligibility	Services Provided (beyond Medicaid state plan services)
Home and Community-based Services	Individuals of any age with an intellectual disability diagnosed before age 22. Must have an ID diagnosis or a related condition and an IQ score of 75 or below. Must have functional limitations that qualify for intermediate care facility services. Must be able to get Medicaid services before enrolling. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than \$2,000. Parental income is not considered.	<ul style="list-style-type: none"> • Case management • Behavioral support, including social work and psychology • Day habilitation • Respite • Nursing services • Employment services • Supported employment • Residential assistance including: <ul style="list-style-type: none"> • supported home living • foster/companion care • supervised living (group home) • residential support
Community Living Assistance Supports and Services	Individuals of any age with a primary disability other than intellectual disability that originated before age 22 and affects the person's ability to function in daily life. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than \$2,000. Parental income is not considered.	<ul style="list-style-type: none"> • Case management • Psychological and behavioral support services • Habilitation • Respite • Nursing services • Employment services • Supported employment • Specialized therapies such as aquatic, music, recreational
Texas Home Living	Individuals with an IQ 69 or below or a related condition with an IQ below 75. Must have functional limitations that qualify for intermediate care facility services. Must meet financial eligibility requirements including income limit up to 300% of the SSI limit and countable resources of no more than \$2,000. This is the only waiver that considers parental income when determining financial eligibility for children.	<ul style="list-style-type: none"> • Case management • Behavioral support • Day habilitation • Habilitation • Community support • Respite • Employment services • Supported employment • Specialized therapies
Deaf/Blind/Multiple Disabilities	Individuals with deaf-blindness and one or more other disabilities who meet eligibility for intermediate care facilities.	<ul style="list-style-type: none"> • Case management • Behavioral support services • Day habilitation • Residential habilitation adaptive aids • Assisted living • Nursing services • Employment services • Supported employment • Chore services
Day Activity and Health Services	Individuals with a functional disability related to a medical diagnosis, a physician's order requiring care or supervision, and who need help with one or more personal care tasks. Must meet eligibility criteria for Medicaid (to get Title XIX services) or not exceed specified income and resource limits to get Title XX services.	<ul style="list-style-type: none"> • Noon meal and snacks • Nursing and personal care • Physical rehabilitation • Social, educational and recreational activities • Transportation

Sources: Texas Health and Human Services. (2017). *Texas Long-Term Service and Supports (LTSS) Waiver Programs*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/resources/ltss-waivers.pdf>

Navigate Life Texas. (n.d.). Waivers. Retrieved from <https://www.navigatelifetexas.org/en/insurance-financial-help/texas-medicaid->

waiver-programs-for-children-with-disabilities

Paying for Senior Care. (2018). *Day Activity and Health Services (DAHS) Program: Texas Medicaid Adult Day Care*. Retrieved from <https://www.payingforseniorcare.com/adult-day-care/tx-daahs-program.html>

As part of the 2018-19 biennial budget, the 85th Legislature passed Rider 55 allocating \$20,156,364 in GR and \$26,916,316 in federal funds to add an additional 735 HCS waiver slots:

- 325 Home and Community-based Services slots for persons moving out of large and medium intermediate care facilities for individuals with intellectual disabilities;
- 110 HCS slots for children aging out of foster care;
- 150 HCS slots for persons with IDD moving from nursing facilities; and
- 150 HCS slots for persons with IDD diverted from nursing facility admission.¹⁹³

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

There are 39 local intellectual and developmental disability authorities in Texas that cover all 254 counties and serve as the front door for long-term services and support programs for people with IDD, including those who also have co-occurring mental health conditions. While the LIDDAs may co-locate with LMHAs across the state, the two entities have separate administrative authorities. LIDDAs connect individuals with IDD to long-term services and supports, which include SSLCs, HCS and TxHmL Medicaid waiver programs, safety net services, and Community First Choice.¹⁹⁴

LIDDAs are responsible for program eligibility, waiver program enrollment, and determination of intellectual disability or a related condition as part of establishing the IDD priority population. Additional LIDDA responsibilities include developing service plans, providing targeted case management services, maintaining interest lists for IDD Medicaid waivers, conducting PASRR evaluations for persons with IDD seeking admission to a nursing facility, providing continuity of care, and completing 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.

continuity of care in meeting a person's need for mental health services. Within this continuum of care, the state hospitals' primary purpose is to stabilize people by providing inpatient mental health treatment. Each state hospital has a utilization management agreement with a partnering LMHA/LBHA that requires the LMHA/LBHA to screen all individuals seeking mental health services to determine if inpatient psychiatric services are required. If the screening and assessment determine that there is a need for inpatient psychiatric services, the LMHA/LBHA decides on the least restrictive treatment setting available, with the 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.

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.¹⁹⁶ Specific services include diagnostic interviews, structured therapeutic programming, collaboration with appropriate courts and law enforcement, suicide safety planning, and discharge planning.

Currently, the Health and Human Services Commission manages three different waiting lists¹⁹⁷

- Forensic – maximum security unit
- Forensic Clearinghouse – non-maximum security unit
- Civil – non-forensic adults, adolescents and children

There are two types of inpatient commitments in which individuals are provided comprehensive inpatient mental health services: civil and forensic.

CIVIL INPATIENT COMMITMENTS

Civil commitments to a state hospital can happen through a variety of pathways.¹⁹⁸ Voluntary admission is possible, although the majority of civil patients are involuntarily committed. Generally, LMHAs screen referrals (from individuals and others in the community such as family members and law enforcement officials) to determine the best and least restrictive placement for services.¹⁹⁹ If the LMHA does not screen the referral, the state hospital conducts an emergency psychiatric screening to determine whether admission is appropriate.

Voluntary admission is initiated by a request from a person at least 16 years old or a person responsible for a minor under age 18.²⁰⁰ The individual seeking admission must have symptoms of mental illness and would benefit from the services.²⁰¹ If a person voluntarily admitted to a facility later requests discharge and the responsible physician believes the person meets the criteria for involuntary admission, the facility may file an application for emergency detention or court-ordered services.²⁰²

Peace officers or the guardian of an adult can detain an individual involuntarily without a warrant and present them to the state hospital for screening.²⁰³ This process can also be initiated by other people who can file an application for a warrant with the county clerk or DA stating that the person is mentally ill, presents a substantial risk of serious harm to themselves or others that is imminent unless the person is immediately restrained.²⁰⁴ The application must have specific details

supporting these statements. If the judge or magistrate reviewing the application finds that emergency detention is needed, the court will issue a mental health warrant and a peace officer will attempt to detain the individual and transport them to a facility. The individual must be examined by a physician within 12 hours (to provide a medical certificate for the court to determine if it should issue an order of protective custody) and can be detained for no more than 48 hours without a hearing on an order of protective custody.²⁰⁵

An order of protective custody will be issued if the court determines that a physician stated that the individual is a person with mental illness and presents a substantial risk of serious harm and cannot be at liberty while waiting for a judicial hearing on court-ordered services.²⁰⁶ Within 72 hours of detention under an order of protective custody, the court will hold a probable cause hearing for a more thorough review of the evidence supporting the order.²⁰⁷ The hearing for court-ordered inpatient services must occur within 14 days of the original filing.²⁰⁸ The hearing allows for testimony from the individual involved, medical experts, and other people in the individual's life. Court-ordered inpatient services may occur under an order for temporary commitment (45 days or 90 days)²⁰⁹ or, after a jury trial at the individual's request, an order for extended commitment (12 months).²¹⁰

FORENSIC COMMITMENTS

Individuals needing forensic inpatient services are admitted to all the state hospitals. Individuals who require maximum security beds are admitted to either Rusk State Hospital or the Vernon Campus of North Texas State Hospital. Forensic commitments happens for two reasons:

- Individuals have been admitted to a hospital by judicial order because they have been determined incompetent to stand trial and are in need of competency restoration services so that they can better consult with legal counsel and understand the charges against them; or
- Individuals have been determined to be not guilty by reason of insanity and were ordered to a state hospital for a period of time not exceeding the maximum sentence length of the crime they committed.²¹¹

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.²¹²

All cases involving serious bodily injury, imminent threat of harm, or use of a deadly weapon are sent to a maximum security unit for an initial 30-day evaluation period.²¹³ 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.²¹⁴

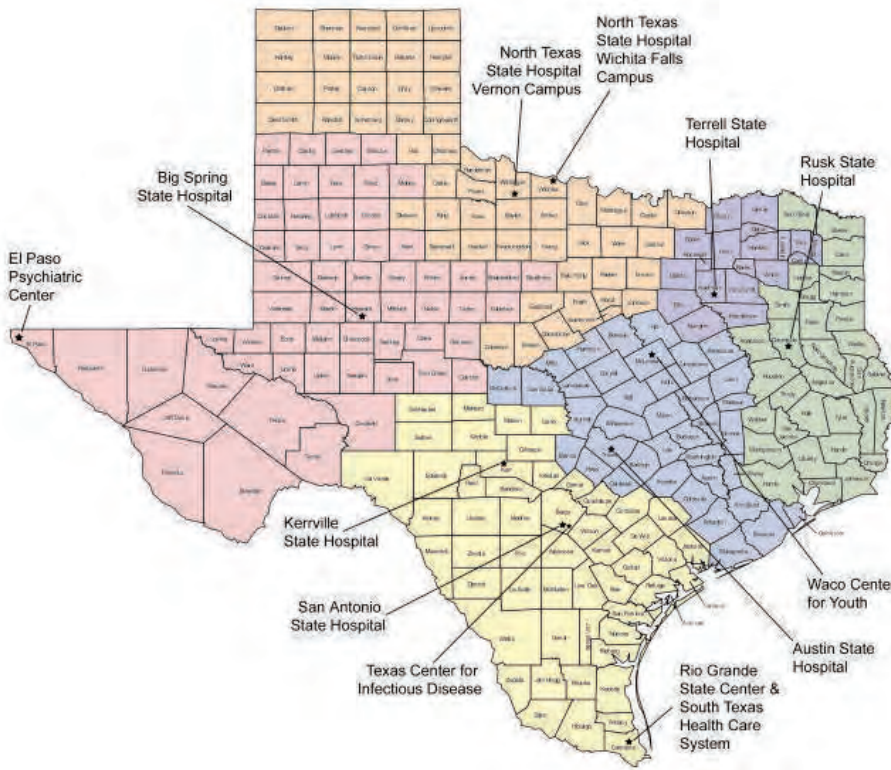
TYPES OF INPATIENT SETTINGS

State Hospitals

The State Hospital Services Department provides oversight of the ten state mental health hospitals and one psychiatric residential treatment facility for youth (the Waco Center for Youth) displayed in Figure 28. 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.²¹⁵

Hospitals in Austin, Big Spring, El Paso, Rusk, San Antonio, Terrell, Wichita Falls and the Rio Grande Center in Harlingen provide services to both civil and forensic patients. The Vernon Campus of the North Texas State Hospital offers inpatient psychiatric services to both adults and adolescents needing a maximum-security facility, and the Kerrville State Hospital provides adult forensic inpatient services. The state also operates the Waco Center for Youth as an adolescent residential treatment facility.²¹⁶

Figure 28. State Mental Health Hospitals and Waco Center for Youth



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

As of August 14, 2018 there were a total of 2,432 state hospital beds in Texas. Of those, only 2,264 were “online” or available for use due primarily to staffing shortages (continued evidence of the mental health workforce shortage).²¹⁷ Table 33 shows the total number of beds at each of the state-operated psychiatric hospital

facilities as of August 2018. These numbers do not include the community and private hospital beds in facilities that contract with HHSC.

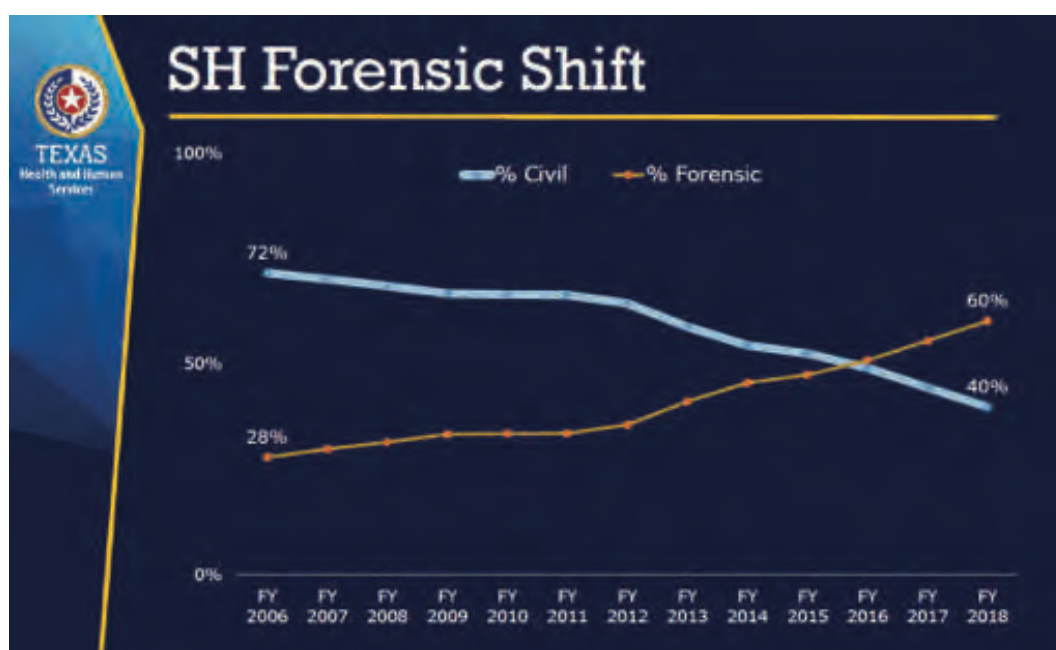
Table 33. State-Operated Inpatient Psychiatric Beds In State Hospitals: 2018

State Mental Health Hospitals	Bed Type	Number of Beds
Austin State Hospital	Adults and children	252
Big Spring State Hospital	Adults only	200
El Paso Psychiatric Center	Adults and children	74
Kerrville State Hospital	Adults only	218
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		2,432

Source: Health and Human Services Commission. Data request. Received August 14, 2018.

In the last decade, the state hospital population shifted from mostly civil patients to a majority forensic patient population. In FY 2006, civil patients were 62.3 percent of the state hospital population. As of August 2018, only approximately 40 percent of all state hospitals patients were there through civil commitments.²¹⁸ See Figure 29 below.

Figure 29. State Hospital Forensic Shift



Source: Maples, M. (2018). Health & Human Services presentation to the Judicial Commission on Mental Health.

The impacts of a growing forensic population lead to less available capacity for all patients, increased waiting lists, and a changing focus for hospital staff.²¹⁹ Waitlists for forensic beds increased steadily between FY 2006 and FY 2018. In August 2018, the waitlist for all forensic beds was 684, with 416 individuals on the waitlist for maximum security beds.²²⁰

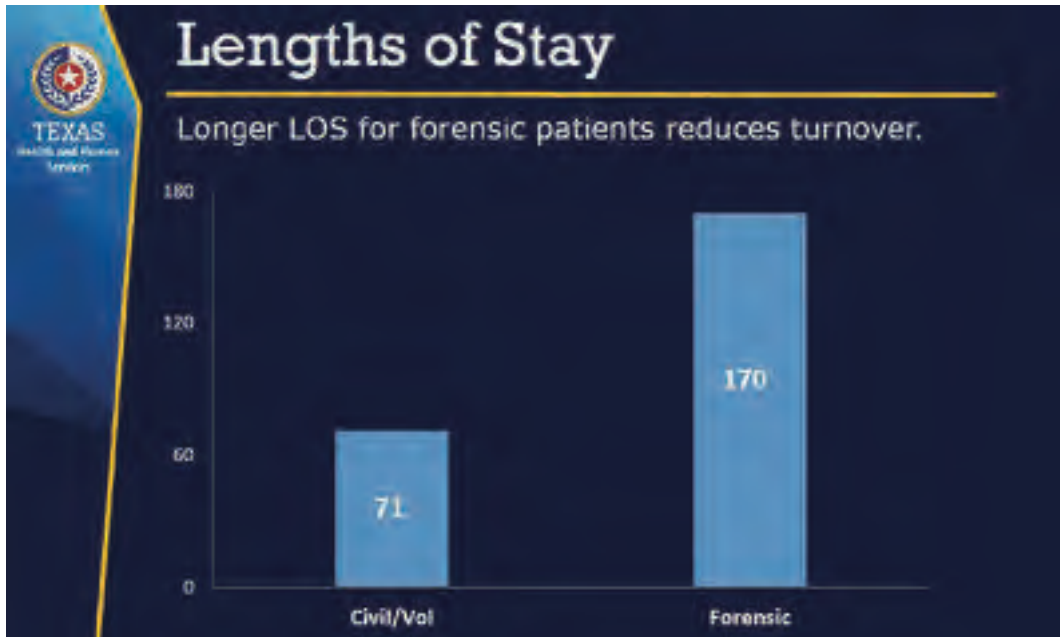
Figure 30. Forensic Waiting List Trends



Source: Maples, M. (2018). Health & Human Services presentation to the Judicial Commission on Mental Health.

Compounding the waiting list dilemma is that the shift to a majority of the state hospital beds serving forensic patients results in longer lengths of stay for forensic patients compared to civil patients. As patients stay in the hospital longer, there is less bed availability for new admissions. Figure 31 compares the forensic and civil patients lengths of stay.

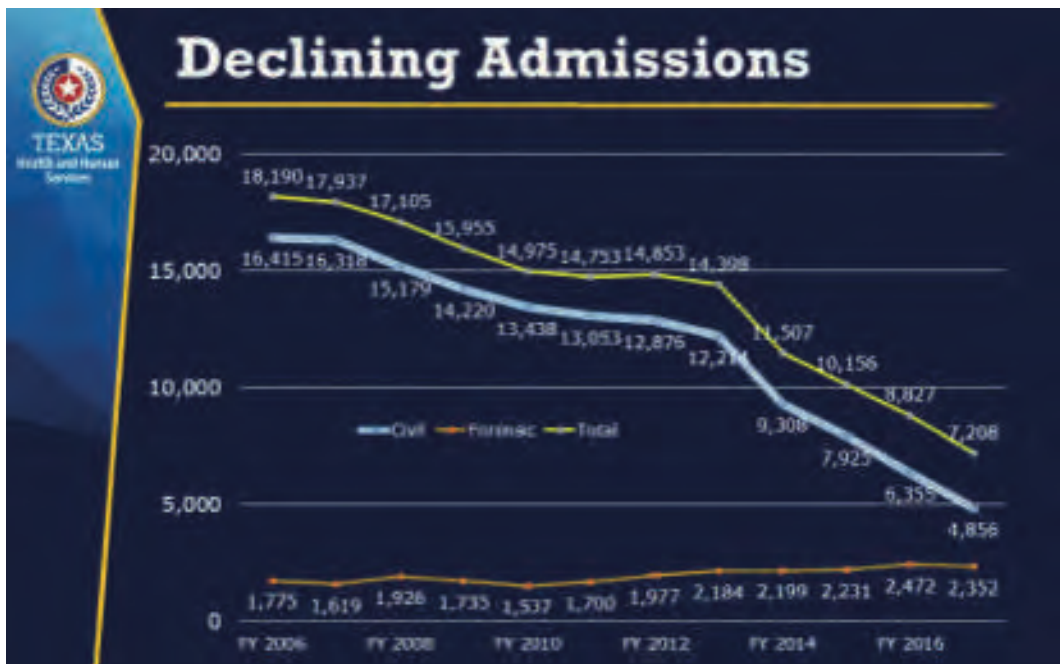
Figure 31. State Hospital Lengths of Stay, August 2018



Source: Maples, M. (2018). Health & Human Services presentation to the Judicial Commission on Mental Health.

The shift to a larger forensic population and the longer lengths of stay in state-operated facilities has resulted in significant reductions in admissions. See Figure 32 below:

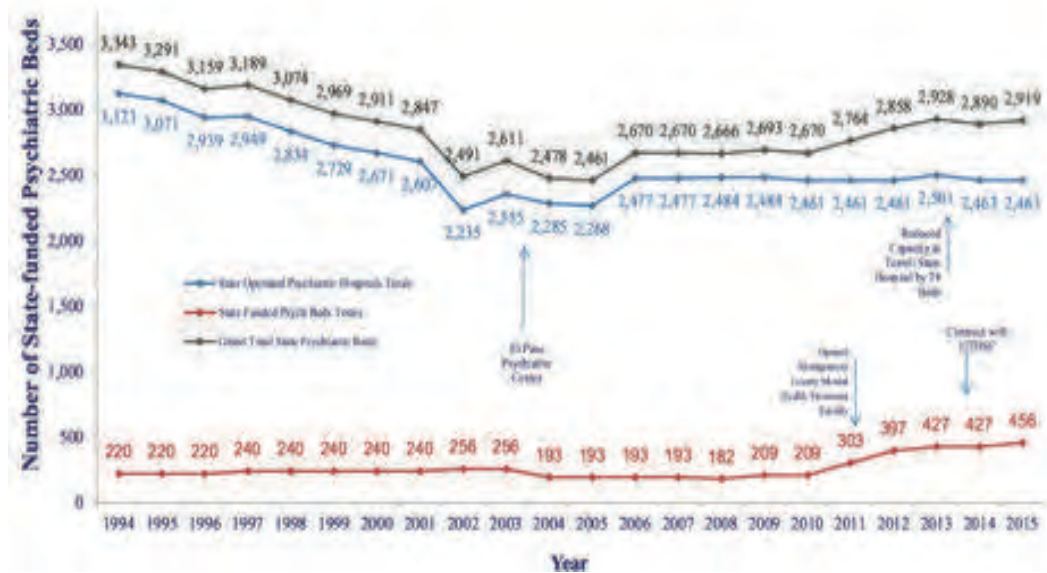
Figure 32. State Hospital Facilities Declining Admissions, August 2018



Source: Maples, M. (2018). Health & Human Services presentation to the Judicial Commission on Mental Health.

Figure 33 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.²²¹

Figure 33. State-Funded Psychiatric Bed Capacity: FY 1994-2018



Source: Texas Health and Human Services Commission. Data request. Received from C. Pomerleau August 22, 2018.

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.²²² In August 2018, there were 2,432 inpatient beds in state-operated psychiatric hospitals, but the estimated available capacity of state-operated facilities was much lower (2,264 as of July 2016).²²³ As of August 2018, the state-operated hospital system as a whole had a functional capacity as follows:²²⁴

- Average daily census - 2094
- Number of beds available for children/youth – 232
- Total number of maximum-security beds - 321

Staff turnover in state hospitals has been an issue across all positions; state hospitals have had particular difficulty with staffing shortages in skilled nursing positions.²²⁵ On top of the already-stressful work environment of state hospitals, salary caps for nurses working in state hospitals make it difficult for nurses to earn as much as they would in the private sector. 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 an additional \$5.6 million to improve staff recruitment and retention through increased salaries and geographic-based incentive payments for nurses.²²⁶

Funding for Inpatient Care

In total, the 85th Legislature appropriated approximately \$876 million in all funds to operate the state hospital system for the 2018-19 biennium. An additional \$244 million was appropriated for community hospital beds.²²⁷

Table 34. Inpatient Mental Health Funding Trends

Strategy	Estimated 2018	Budgeted 2019	Requested 2020	Requested 2021	Exceptional Items Request 2020	Exceptional Items Request 2021
Mental Health State Hospitals	\$415,678,389	\$388,455,499	\$401,682,183	\$401,682,184	\$68,999,501	\$71,943,466
Mental Health Community Hospitals	\$121,915,237	\$121,915,239	\$121,915,238	\$121,915,238	\$19,691,121	\$141,634,597
Total	\$537,593,626	\$510,370,738	\$523,597,421	\$523,597,422	\$88,690,622	\$213,578,063

Source: Source Legislative Budget Board. (2018). *Health and Human Services Commission Legislative Appropriations Request, FY 2020-21*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

Institutions for Mental Diseases Exclusion

The Institutions for Mental Diseases 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.”²²⁸ Until recently, the Social Security 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 the state without federal matching.²²⁹

The final managed care rules regarding the IMD exclusion were entered into the Federal Register on May 6, 2016.²³⁰ 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.²³¹ 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.²³² 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.²³³ 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.

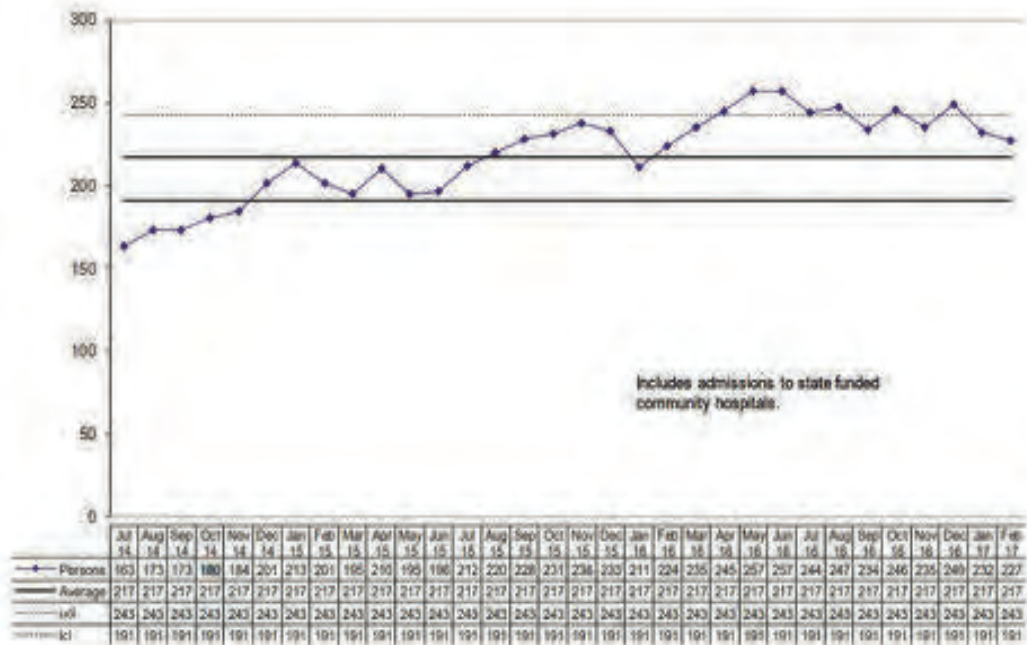
As of June 2018, 12 states have approved IMD SUD waivers, and 13 IMD SUD requests (including 12 new states, and one seeking to expand existing authority) are pending with CMS.²³⁴ Congress is considering amending the IMD payment exclusion, including one piece of legislation that would restrict IMD SUD services to those with opioid use disorder.²³⁵ As of August 2018, no federal legislation related to the IMD waiver had passed.

State Hospitals Utilization and Costs

Over the past decade, the yearly average cost per patient served in state hospitals has seen an 80 percent increase, from \$11,912 in FY 2006 to \$21,437 in FY 2017, an increase of \$9,525 in the average cost per state hospital client.²³⁶ Despite a shortage of inpatient psychiatric beds, the average daily censuses of all hospitals are below their total funded capacities. This is partly because hospitals must retain some open bed capacity in case of emergencies, but also because staffing shortages and high turnover have made it difficult for many hospitals to 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.²³⁷

Whether due to an individual's especially intensive mental health needs or their lack of access to community-based treatments and services, many individuals have trouble remaining in the community after discharging from a state hospital. As Figure 34 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.²³⁸ 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.²³⁹

Figure 34. Number of Individuals Admitted to State Hospitals 3+ Times in 180 Days: July 2014-February 2017



Source: Promoting Independence Advisory Committee. (2017). *PIAC First Quarter FY 2017 Report*. Page 28. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/piac-2nd-quarter-fy2017-feb2017.pdf>

Improvements to Aging State Hospital Infrastructure

In June 2016, Dr. David Lakey, the Chief Medical Officer for the UT Health System, identified the following key challenges present in the Texas mental health hospital system:²⁴⁰

- Lack of capacity
- Hospitals are poorly designed for modern healthcare
- Current condition of hospitals
- Cost of replacing hospitals
- Increasing medical complexity of patients
- Lack of integration between physical and mental health
- Lack of strong partnerships with academia
- Rural facilities are frequently the sole “industry” of the local community
- Recruiting staff
- Increasing outside medical care costs
- Role in disproportionate share hospital funding
- Current mental health hospital system is underfunded.

The 85th legislature appropriated funding for \$300 million to HHS for the construction or significant repair of the state hospitals. In August 2017, HHS submitted a comprehensive plan for transformation of the state hospital system, including a request to expend funds to the governor and the legislature. On December 18, 2017, the Legislative Budget Board and the governor approved the use of \$47.7 million for various projects. HHS started the projects in spring 2018. Phase I projects include: Rusk State Hospital, Kerrville State Hospital, Continuum of Care

Campus in Houston, Austin State Hospital, and the San Antonio State Hospital. More information is available in the Texas Environment section.

The Comprehensive Plan for State-Funded Inpatient Mental Health Services is available at: <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/comprehensive-inpatient-mental-health-plan-8-23-17.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. Table 35 below shows the community hospitals that are currently contracted with HHSC, the state funds allocated for each facility, and the number of hospital beds available.

Table 35. Purchased Community & Contracted Private Hospital Beds: Allocated Funds and Number of Beds in FY 2018

Fiscal Year 2018		
Contractor	Annual Funds	Number of Beds
Montgomery County	\$16,994,512.00	94
University of Texas Health Center at Tyler	\$9,216,250.00	44
Abilene Regional MHMR Center DBA Betty Hardwick Center	\$722,700.00	3
Anderson Cherokee Community Enrichment Services (ACCESS)	\$4,219,400.00	20
Austin-Travis County MHMR DBA Integral Care	\$2,007,500.00	10
Bluebonnet Trails Community MHMR Center	\$501,875.00	2
Burke Center	\$1,253,775.00	5
Camino Real Community Services	\$408,800.00	1.6
Center for Health Care Services – Bexar County MHMR Center	\$6,688,625.00	30
Center for Life Resources	\$190,895.00	1
Central Counties Center for MHMR Services	\$204,400.00	0.8
Coastal Plains Community MHMR Center	\$1,095,000.00	5
Collin County MHMR Center DBA Lifepath Systems	\$1,617,700.00	7
Denton County MHMR Center	\$2,462,290.00	10.6
El Paso MHMR DBA Emergence Health Network	\$121,454.00	0.5
Gulf Bend MHMR Center	\$481,800.00	2
Heart of Texas Region MHMR Center	\$766,500.00	3
Hill Country Community MHMR	\$1,208,150.00	5
Lakes Regional Mental Health and Mental Retardation Center DBA Lakes Regional Community Center	\$255,500.00	1
Lubbock Regional MHMR Center DBA Starcare Speciality Health	\$4,126,274.00	30
MHMR Authority of Brazos Valley	\$1,324,950.00	6
MHMR of Tarrant County	\$6,367,060.00	28
North Texas Behavioral Health Authority	\$6,373,407.00	23.6

Fiscal Year 2018		
Contractor	Annual Funds	Number of Beds
Pecan Valley MHMR Region	\$839,135.00	3.8
Spindletop MHMR Services DBA Spindletop Center	\$2,168,100.00	9
Texana Center	\$511,000.00	2
Texoma Community Center	\$511,000.00	2
The Gulf Coast Center	\$4,082,246.00	20
The Harris Center for Mental Health and IDD	\$30,800,496.00	177
The Harris Center for Mental Health and IDD	\$4,674,303.00	22
Tri-County Behavioral Healthcare	\$1,523,875.00	7
Tropical Texas Behavioral Health	\$3,312,375.00	15
West Texas Centers for MHMR	\$2,208,250.00	10
Totals	\$119,239,597.00	600.9

Source: Health & Human Services Commission. Data request. Received 9/13/18.

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. 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.²⁴¹

Institutional Long-Term Services and Supports

Persons with disabilities residing in skilled nursing facilities, privately operated intermediate care facilities, or large state-operated supported living centers often experience co-occurring behavioral health conditions. Funding for these residential services is provided primarily through Medicaid. SSLCs were previously administered through DADS but are now administered through the Health and Specialty Care System Division (formerly known as the State Operated Facilities Division) of HHSC.

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 2016, there were 1,220 licensed nursing facilities in Texas.²⁴² 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 Level 1 screening prior to admission to a nursing facility. PASRR screening is intended to identify the following:

- Individuals who have a mental illness, an intellectual disability, or other developmental disability (also known as related conditions);
- The appropriateness of placement in the nursing facility; and
- Eligibility for specialized services.²⁴³

In 2013, CMS directed Texas to make changes to the PASRR program. Three major changes include:

- Eliminating the role of nursing facilities in the PASRR evaluation determination process by introducing local authorities 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.²⁴⁴

Community Intermediate Care Facilities (ICF)

The federal government gives states the option to include intermediate care facility 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 2017, there were 805 licensed ICFs in Texas.²⁴⁵ These facilities provide residential services similar to the SSLCs 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 (SSLCs)

State supported living centers are large institutions that provide 24-hour residential services for people with intellectual and developmental disabilities. Individuals seeking placement in an SSLC must meet both financial and functional eligibility requirements. Behavioral health treatment is a required service that must be provided by the facilities, as some residents have both a mental health condition in addition to an IDD. The SSLCs are licensed and certified ICFs owned and operated by the state (community ICFs are privately owned). Approximately 60 percent of the SSLC operating funds come from the federal government, and 40 percent from state revenue and third-party revenue resources.²⁴⁶ 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.

As of FY 2017, 3,026 individuals reside in these facilities.²⁴⁷ Although the SSLC population has declined significantly over the past decade, any discussion related to closure or consolidation of facilities has been met with strong legislative opposition. There was significant debate around SSLCs during the 84th legislative session due

to the DADS Sunset Recommendations to close six centers, including closing the Austin SSLC by September of 2017. The legislature ultimately voted to keep the Austin SSLC and all other SSLCs operational. In Texas, only the legislature can direct closure of an SSLC. In the 85th legislative session, Senator Hinojosa introduced a bill, SB 602, which would have required a commission to review each SSLC.²⁴⁸ The legislation would have given the commission authority to recommend which SSLCs should be consolidated or closed. The bill did not pass during the 85th legislative session.²⁴⁹

Due to fixed costs and the deterioration of aging facilities, as the census in these facilities declines, the per person costs increase. According to a Sunset Commission final report in 2015, maintaining the large system of state-run facilities is costly, involving more than thousands of employees and a budget of \$661.9 million a year.²⁵⁰ An HHSC report revealed that delivering services to a person in an SSLC costs \$856.70 per day, totaling over \$360,000 per year.²⁵¹ According to a 2018 HHSC report, SSLCs in Texas employ 13,470 people or full-time equivalents.²⁵² Further, maintaining the SSLCs’ dilapidated infrastructure adds even more cost to the state.²⁵³ The 85th legislature appropriated approximately \$80 million to help address infrastructure improvements and maintenance needs for SSLCs.²⁵⁴

Table 36 below shows the SSLC enrollment trends from FY 2010 to the projected figures in FY 2020 and 2021.

Table 36. 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	FY 2017	FY 2018 (Projected)	FY 2019 (Projected)
4,207	3,993	3,756	3,547	3,362	3,186	3,103	3,019	2,983	2,947

Source: Texas Health and Human Services. (2018). *State Supported Living Center Long Range Planning Report*. Retrieved from <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/may2018-sslc-long-range-planning.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 residents. The agreement includes increased access to psychiatric care and psychological services, as well as improved policy and practices to reduce the use of restraints. Independent monitors were assigned in mid-2014 to visit and report on conditions at all 13 SSLCs.²⁵⁵ Despite the 2009 agreement, the October 2017 monitoring report for the Austin SSLC continued to identify deficiencies. Other monitoring reports in 2017 identified deficiencies at the SSLCs related to psychiatric and psychological services, including individual residents not progressing toward psychiatric goals and not maintaining psychiatric stability. Reports did indicate that when an individual was not making progress toward psychiatric goals, that revisions to treatment were made.²⁵⁶ Updated reports for all 13 SSLCs were released in 2018 as the centers continue to be evaluated by independent monitors every nine months.²⁵⁷

Table 37 presents information on the eligibility requirements and services provided by institutional providers of LTSS services.

Table 37. Institutional Care Eligibility and Behavioral Health-Related Services

Program	Eligibility	Behavioral Health Services Provided (beyond Medicaid state plan services)
Nursing Facilities	<ul style="list-style-type: none"> Have a medical condition that requires the skills of a licensed nurse on a regular basis. <p>Beginning May 1, 2015, people who are covered by Medicaid and living in a nursing facility receive their basic health services (acute care) and long-term services through STAR+PLUS. People who get Medicaid and Medicare (dual-eligible) receive their basic health services through Medicare and their long-term services through STAR+PLUS.</p>	<p>24-hour residential care and services that include:</p> <ul style="list-style-type: none"> PASRR (see above) Behavioral health services Medication management Skilled nursing Specialized therapies/services Rehabilitative therapies
Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions	<ul style="list-style-type: none"> Have a diagnosis of intellectual disability with a full-scale IQ score of below 70 and an adaptive behavior level with mild to extreme deficits, 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. 	<p>24-hour residential care and services that include:</p> <ul style="list-style-type: none"> 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
State Supported Living Centers	<ul style="list-style-type: none"> Meet ICF/ID eligibility requirements. Have severe or profound intellectual and developmental disabilities, or Have intellectual and developmental disabilities and be medically fragile, or Have intellectual and developmental disabilities and behavioral challenges, or Represent a substantial risk of physical injury to self or others. As an adult, be unable to provide for the most basic personal physical needs.²⁵⁸ 	<p>24-hour residential care and services that include:</p> <ul style="list-style-type: none"> Physician and nursing services Behavioral health services Skills training Occupational therapies Vocational programs and employment Services to maintain connections between residents and their families/natural support systems

Source: Texas Department of Aging and Disability Services. (2015). *Reference Guide 2015*.

Table 38 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.

Table 38. Percentage of People Enrolled in DADS Programs with a Behavioral Health Diagnosis

Program	FY2013			FY2014			FY2015		
	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.

Note: Updated data not available.

COMPETENCY RESTORATION SERVICES

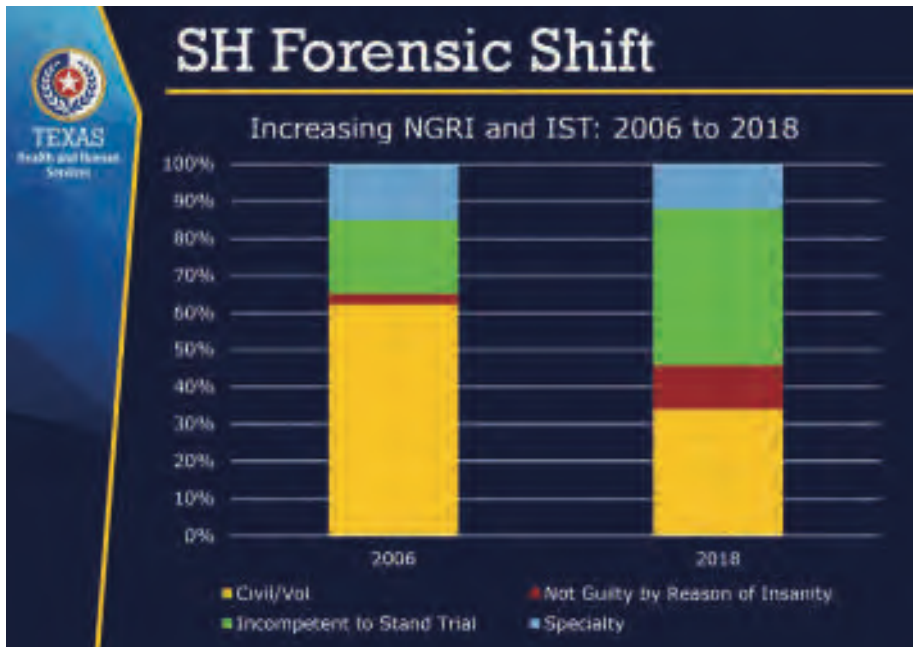
A person charged with a crime who is found incompetent to stand trial (i.e., unable to competently understand court proceedings) must be restored to competency before the legal process can continue. In order to be considered competent to stand trial, that person must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.^{259, 260} Individuals determined to be incompetent, typically due to mental illness or an intellectual disability, may be placed into inpatient competency restoration programs, jail-based competency restoration programs, or outpatient competency restoration programs. Placement into these specialty programs is determined by a mixture of factors, including an individual's clinical complexity, criminal history, and the safety risk they pose to the community and to other individuals placed in their program.²⁶¹

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.²⁶² 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.²⁶³ 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.²⁶⁴ 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 as long as nine months in some cases.²⁶⁵

Inpatient Competency Restoration

Individuals found IST 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.²⁶⁶ 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.²⁶⁷

Figure 35. State Hospital Forensic Shift



Source: Maples, M. (2018). Health & Human Services presentation to the Judicial Commission on Mental Health.

Jail-Based Competency Restoration

The 83rd Legislature passed SB 1475 (83rd, Duncan/Zerwas) to create a jail-based competency restoration pilot program for individuals who otherwise would be committed to a mental health facility or residential care facility for inpatient competency restoration services.²⁶⁸

In 2017, the HHSC JBCR pilot program report stated that the program experienced delays in implementation due to a “lack of strong interest in the procurement opportunity and a competitive pool; however, rules governing the provision of JBCR services were adopted in January 2016”.²⁶⁹ The 85th Legislature passed SB 1326 (Zaffirini/Price) to address a multitude of areas related to individuals with mental illness or IDD who are involved with the criminal justice system, including provisions to the JBCR program. More details on SB 1326 can be found in the Hogg Foundation Legislative Session summary: http://hogg.utexas.edu/wp-content/uploads/2017/08/UPDATED-Legislative-Summary_2017.pdf

Outpatient Competency Restoration

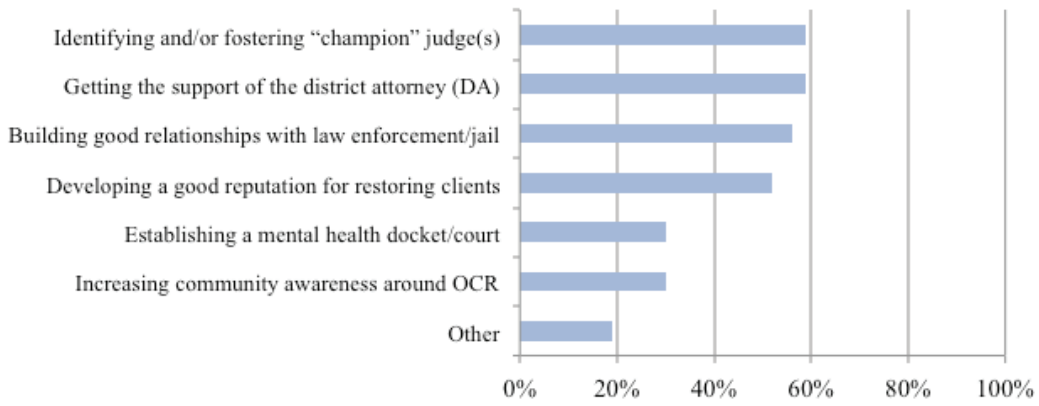
Outpatient competency restoration is a process of providing mental health services and legal education training and other competency restoration services to non-dangerous individuals in a community-based, outpatient setting. The idea of OCR is to give individuals the resources and services they need to maintain a level of psychiatric stability and be able to understand the legal process so that they can proceed through the court system.²⁷⁰ 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.²⁷¹ 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 began allowing referrals to OCR programs in 2003.²⁷² In 2007, Texas initiated four outpatient competency restoration pilot programs in response to the growing number of forensic commitments in state psychiatric hospitals. 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.²⁷³ Texas added another eight OCR programs between 2011 and 2013.²⁷⁴

Current Texas OCR sites include:²⁷⁵

- Austin (2008)
- San Antonio (2008)
- Fort Worth (2008)
- Dallas (2008)
- Tyler (2012)
- Longview (2012)
- El Paso (2012)
- Galveston (2012)
- Lubbock (2012)
- Corpus Christi (2012)
- Beaumont (2012)
- Waco (2013)

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.²⁷⁶ 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.²⁷⁷ Figure 36 below shows some of the most important components of successful OCR programs.

Figure 36. 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.”²⁷⁸ 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).²⁷⁹

Health, Developmental, and Independence Services



Source: Health and Human Services Commission, Public Information Request, September 2018.

This division's units include:

- Office of Disability Prevention for Children
- Rehabilitative & Social Services
- Health & Developmental Services

OFFICE OF DISABILITY PREVENTION FOR CHILDREN

This office is new to HHSC and was created after Governor Greg Abbott vetoed a bill that would have moved the Texas Office of Prevention of Developmental Disabilities to the University of Texas. Since the legislation was vetoed and TOPDD was eliminated, the Office of Disability Prevention for Children was created within HHSC.

ODPC focuses on the prevention of disabilities in children from birth through 12 years of age. ODPC has identified five priority areas, one of which is to address the mental health needs of children with IDD. These include:²⁸⁰

- Preventing disabilities caused by prenatal alcohol or substance exposure
- Preventing disabilities caused by maternal health issues during pregnancy
- Preventing acquired brain injury in children
- Early identification and diagnosis of disabilities to ensure early intervention and services
- Promoting mental health and wellness for individuals with an intellectual or developmental disability

One of the initial projects of this office was to facilitate trainings using *The Road to Recovery: Supporting Children with Intellectual Disabilities Who have Experienced Trauma* developed by the National Child Traumatic Stress Network and the Hogg Foundation for Mental Health.

Future tasks and objectives for this office are still being developed.

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 offer services to individuals living with mental illness including:

- Independent Living Services Programs
- Rehabilitative Services and Supports
- Guardianship

INDEPENDENT LIVING SERVICES PROGRAM

There are 30 independent living centers in Texas. A list of centers is available at <http://www.ilru.org/projects/cil-net/cil-center-and-association-directory-results/TX>. The Independent Living Services Program is intended to promote self-sufficiency for individuals with one or more significant disabilities.²⁸¹ Services within the Independent Living Program seek to provide the individual with “consumer control, peer support, self-help, self-determination, equal access and self-advocacy.”²⁸²

The Independent Living Services Program partners with Centers for Independent Living located around the state. These CILs are private, nonprofit, nonresidential centers that provide an array of independent living services. CILs partner with HHSC and community-based organizations and are funded either privately or with state and federal funds.

Eligibility

In order to be eligible for independent living services, an individual must be certified by a counselor to have a significant disability that results in a substantial impediment to the person’s ability to function independently in the family or community. There must also be a reasonable expectation that assistance will result in the person’s ability to function more independently.²⁸³

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.²⁸⁴

COMPREHENSIVE REHABILITATION SERVICES

The Comprehensive Rehabilitation Services program serves people who have experienced traumatic brain injuries and/or traumatic spinal cord injuries.²⁸⁵

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.²⁸⁶

The following are basic statistics available relating to the CRS program for FY 2017:

- Number of individuals serviced -- 877
- Number of new applications received – 488
- Number of successful case closures – 269
- Average monthly cost per individual -- \$4,232
- Traumatic Brain Injury – 444 individuals
- Spinal Cord Injury – 377 individuals
- Both TBI and SCI – 56²⁸⁷

GUARDIANSHIP PROGRAM

The Guardianship Services program provides guardianship services to people referred by DFPS, or by a court under limited circumstances as described in the Estate Code. The court appointment of guardianship over an individual is intended to provide protection for adults whom the courts deem incapacitated. Often guardianship is appropriate and works as intended, ensuring guardians effectively manage the affairs of older adults and people with disabilities fairly, honestly, and appropriately. Guardianship profoundly limits a person's decision-making rights and therefore must be considered carefully. Guardianship may include, but is not limited to, overseeing services, arranging for community or institutional placement, managing estates, and making medical decisions.

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

- Incapacitated children upon reaching the age of 18 who have been in CPS conservatorship;
- Incapacitated adults age 65 or older, or between the ages of 18-65 with a disability, who were referred by APS following an investigation in which abuse, neglect, 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.²⁸⁸

In order for HHSC to provide guardianship services, less restrictive alternatives must not be available; an appropriate and qualified alternate guardian must not be available and willing to serve; the individual under guardianship must have resources available to fund the services, including long-term care; and there must be an expectation that guardianship will meet the person's needs.²⁸⁹

During the 85th legislative session, multiple bills passed reforming the guardianship process in Texas. SB 36 (85th, Zaffirini/Thompson, Senfronia) strengthens regulations surrounding guardianship and requires the Judicial Branch Certification Commission to establish a database of all registered guardianship programs.²⁹⁰ The database is required to include information on whether these programs are in good standing and must be made available on JBCC’s webpage. Additionally, SB 1709 (85th, Zaffirini/Moody) requires a guardian to provide information regarding the person under guardianship’s health and residence to certain relatives.²⁹¹

SB 667 (85th, Zaffirini/Smithee) passed the legislature but was vetoed by Governor Greg Abbott on June 12, 2017. The bill would have created a guardianship compliance program to provide more resources for courts with jurisdiction over guardianship. The program would have created a guardianship compliance specialist position responsible for reviewing guardians and creating best practice guidelines. The 85th Legislature failed to pass a bill to require person-first language by changing the term “ward” to “person under guardianship,” which many stakeholders prefer and consider more respectful. SB 498 (85th, Zaffirini/Neave) attempted to update guardianship language but failed to pass.²⁹²

HEALTH AND DEVELOPMENTAL SERVICES

EARLY CHILDHOOD INTERVENTION (ECI) SERVICES

Early interventions have the potential to mitigate the impact of developmental delays that can lead to later physical, cognitive, and behavioral challenges. Providing 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.²⁹³

ECI is authorized by Part C of the Individuals with Disabilities Education Act; Part C is a federal grant program that assists states in operating a statewide early intervention program for infants and toddlers ages zero to three.²⁹⁴ State general revenue funds are required to draw down federal funding for ECI programs. The operating budget for ECI in 2018 was \$141,954,721.²⁹⁵

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.

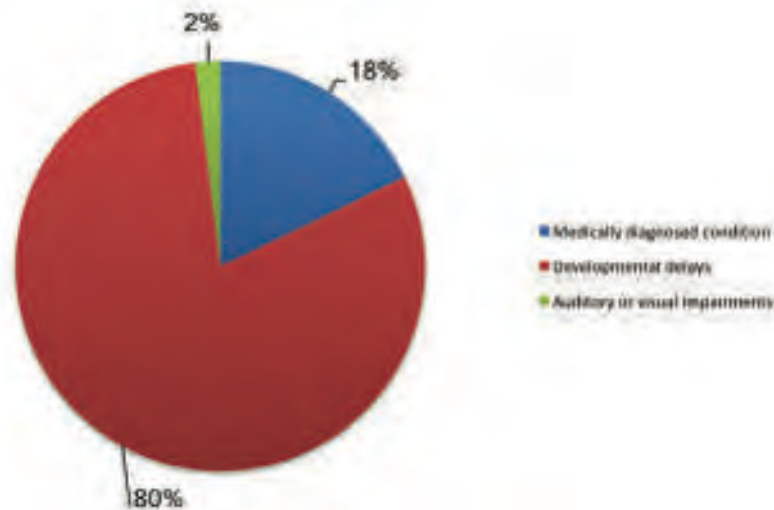
Source: Texas Health and Human Services. (n.d.). ECI Parent Handbook. Retrieved from http://www.mhmrct.org/Portals/0/PDF/ECI_Document_ParentHandbook_English.pdf

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:²⁹⁶

- **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 <https://hhs.texas.gov/services/disability/early-childhood-intervention-services>
- **Auditory or visual impairments:** Children with auditory or visual impairments as defined by the TEA.²⁹⁷
- **Developmental delays:** Children with developmental delays of at least 25 percent that affect function in one or more areas of development.²⁹⁸

Figure 37. Reasons for Eligibility for 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.²⁹⁹ 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.³⁰⁰

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, and

translation and interpreter services.³⁰¹ 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. 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.³⁰² In FY 2017, 55,412 children received comprehensive ECI services, up from 50,634 in FY 2015.³⁰³ Table 39 provides data on eligibility categories, the ages of children receiving the services, and the types of services provided.

Table 39. Early Childhood Intervention, FY 2017

<i>Reasons for eligibility (percentages)</i>	
Medically diagnosed	16.9%
Developmental delays	81.5%
Auditory or visual impairment	1.6%
<i>Number of children receiving services</i>	
Number of children receiving services	55,412
<i>Number of children in each age group receiving services</i>	
0-12 months	19,831
13-24 months	18,455
25-36 months	17,126
<i>Services used (percentages)</i>	
Developmental services	77.3%
Speech/language therapy	56.6%
Occupational therapy	26.7%
Physical therapy	21.8%
Nutrition	4.6%
Psychological/social work	0.1%
Vision services	1.5%
Audiology	1.9%

Note: Percentages were calculated based on the total number of plans for each service category/total number of children with plans. Please note that the total number of children with plans = 54,871, which is not the same as total number of children receiving services in 2017 (55,412), because children receiving service coordination only and enrolled children without an Individualized Family Service Plan are not counted in the total number of children with plans but are counted in the number of children receiving services.

Source: Health and Human Services Commission (2018). Open records request, Reference No. OR-20180816-16137. Received September 24, 2018.

AUTISM PROGRAM

The following description was captured from the HHSC website (retrieved from <https://hhs.texas.gov/services/disability/autism>):

Autism spectrum disorder (ASD) is the fastest growing serious, developmental disability, affecting an estimated 1 out of 68 children in the United States. With this number growing at a significant rate, there continues to be an unmet need for services. The Autism Program was developed in an effort to mitigate this need. The program champions excellence in the delivery of services for families of children with autism. Services are provided through grant contracts with local community agencies and organizations that provide applied behavioral analysis (ABA) and other positive behavior support strategies. The program helps improve the quality of life for children on the autism spectrum and their families.

The Autism Program started as a pilot project in fiscal year (FY) 2008 and was intended to extend treatment services, including Applied Behavior Analysis (ABA), to children ages 3 through 8 with a diagnosis on the autism spectrum. Initially, the pilot served two geographic areas of Texas: Houston and Dallas/Fort Worth. Subsequent increases in funding from the Texas Legislature allowed the program to expand services into Austin, Corpus Christi, El Paso, and San Antonio. In FY 2016, DARS will expand to other Health and Human Services regions.

On September 1, 2014, rules were adopted with two ABA services for children: comprehensive ABA services for children aged 3 through 5 years and focused ABA services for children aged 3 through 15 years. Other changes included parent participation, child attendance, and additional staff training requirements.

In 2015, the 84th Texas Legislature increased funding for the Autism Program. Legislation also required changes to the services provided in the program. The Comprehensive ABA treatment services will be phased out during the 2016-2017 biennium. Comprehensive ABA treatment services will only be available to children enrolled in the comprehensive program as of August 31, 2015. These children will receive comprehensive services until their eligibility expires. Comprehensive ABA treatment services will no longer exist after August 31, 2017. Focused ABA treatment services will continue to be available to all eligible children.

Table 40 provides limited data on the number of children served, the average cost perchild, and the number of program site in Texas.

Table 40. Autism Program, FY 2017

Autism Program	
Number of children served	1,008
Average cost per child ¹	\$524
Number of program sites and locations ²	21

Notes:

¹\$524 is the average monthly cost per child receiving focused autism services.

² Number of contractors.

Source: Health and Human Services Commission (2018). Open records request, Reference No. OR-20180816-16137. Received September 24, 2018.

Access and Eligibility Services



Source: Health and Human Services Commission, Public Information Request, September 2018.

Individuals living with mental illness and substance use conditions are often eligible for federal disability benefits. Accessing those benefits, however, can be challenging. While Supplemental Security Income and Social Security Disability Insurance are federally funded programs, disability determination for these services is conducted by the state through contracts with the federal government. Responsibility for disability determination is housed in the Access & Eligibility Services Division of HHSC.

In addition to conducting disability determination reviews for federal benefits, this division also partners with community organizations that assist low-income families apply for basic services such as obtaining food subsidies, temporary assistance to needy families, and Medicaid and CHIP services. With the assistance of Regional Community Relations specialists, communities work to improve access to the Medicaid and CHIP services often needed by individuals living with serious mental illness or children/youth with SED. A directory of these Regional Partnership Specialists can be found at <https://hhs.texas.gov/about-hhs/community-engagement/office-community-access-services>.

DISABILITY DETERMINATION SERVICES

The Disability Determination Services Division makes disability determinations for individuals with severe disabilities. DDS works with individuals who apply for benefits through the federal Social Security Administration to help pay for daily needs. Benefits available for both adults and children who meet eligibility include SSDI and SSI.³⁰⁴

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. Assistance applying for these cash assistance programs can be found at <https://www.ssa.gov/disability/determination.htm>.

Some people with serious mental health conditions will qualify for either 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.³⁰⁵

SOCIAL SECURITY DISABILITY INSURANCE

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.³⁰⁶ 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, widow/widower of workers with a disability, and adult children (with a disability) of workers with sufficient work histories.³⁰⁷ People become eligible for SSDI throughout their working lives by paying social security taxes.³⁰⁸ Approval for SSDI payments results in eligibility for Medicare coverage after a two-year waiting period.³⁰⁹ Approximately one-third of individuals receiving SSDI assistance qualify on the basis of a mental health diagnosis.³¹⁰

SUPPLEMENTAL SECURITY INCOME

Supplemental Security Income 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 65.³¹¹ 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.³¹² The monthly maximum amounts for 2018 are \$750 for an eligible individual and \$1,125 for an eligible individual with an eligible spouse.³¹³ Once approved for SSI, participants are eligible for Medicaid.³¹⁴ According to the Social Security Administration, in April 2018 over 8 million individuals were receiving SSI benefits in the U.S.³¹⁵

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.³¹⁶

According to a report by the SSA that tracked SSDI outcomes from 2006-2015, the number of applicants who were granted awards upon initial review averaged 23 percent.³¹⁷ Of those who appealed their denial, 2 percent of applicants were subsequently granted benefits at the reconsideration state and 9 percent through a hearing.³¹⁸

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.³¹⁹

According to a 2017 report by the SSA, mental health conditions constituted about one-third of the national SSDI diagnoses in 2016.³²⁰ 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 disorders³²¹

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.³²² 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).³²³

Additional information on eligibility criteria and how to apply is available on the Social Security website at <http://www.ssa.gov>.

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Texas Department of Family and Protective Services

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Policy Concerns

- Maintaining quality, accessible services during DFPS' transition to community-based care.
- 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 for foster youth, including those aging out of foster care.
- Continued monitoring and prevention of child fatalities within the CPS system.
- Addressing disproportionality of minority and LGBTQIA youth in the CPS system and providing adequate services to meet the needs of these children and youth.
- More individualized interventions and treatment plans for youth with dual diagnoses (i.e., mental health and substance use or intellectual/developmental

- disabilities).
- System-wide integration of trauma-informed practices into all levels of care.
- Improving support for youth transitioning from child to adult services (ages 17-24).
- Ongoing review of the barriers to implementation for the Foster Care Redesign/Community Based Care Project.
- Implementation of the Family First Prevention Services Act in Texas.

Fast Facts

In FY 2017:

- The Statewide Intake (SWI) division of DFPS received an average of more than 2,200 contacts per day related to allegations of abuse, neglect or exploitation.¹
- There were a total of 289,796 suspected victims of child abuse and neglect statewide.²
- 23,376 investigations of child abuse/neglect were transferred to the Alternative Response (AR) system after being deemed low acuity and low safety risk reports.³
- 232,911 investigations of abuse/neglect were opened after CPS staff determined they met the criteria for follow-up investigation.⁴
- Of the remaining 174,740 investigations completed, 39,570 were confirmed as child abuse and/or neglect and 19,782 children were removed from their homes.⁵
- 16,839 children were in the Texas foster care system as of August 31, 2018 (excluding the 13,213 children in non-foster substitute placements such as kinship care and DFPS adoptive homes).⁶
- DFPS confirmed 172 abuse/neglect-related fatalities of children, five of whom died while they were enrolled in the state foster care system.⁷
- Adult Protective Services (APS) completed 84,712 in-home investigations, with 63,982 of those investigations validated and 37,346 of those receiving follow-up services.^{8,9}
- The majority of allegations of in-home elder abuse were reported by medical personnel (22 percent), relatives (15 percent), community agencies (14 percent) and the victims themselves (11 percent).¹⁰
- The Child Care Licensing (CCL) division of DFPS oversaw approximately 20,882 daycare operations (or homes) serving 1,126,091 children in FY 2017.¹¹ In 2017, CCL moved from DFPS to the Health and Human Services Commission (HHSC).

DFPS Acronyms

ACA – Affordable Care Act

ACH – All church home

APS – Adult Protective Services

APS PI – Adult Protective Services provider investigations

AR – Alternative response system

CAC – Children’s Advocacy Center

CANS – Child and Adolescent Needs and Strengths assessment

CASA – Court appointed special advocate

CBCAP – Community-based child abuse prevention

CCL – Child Care Licensing

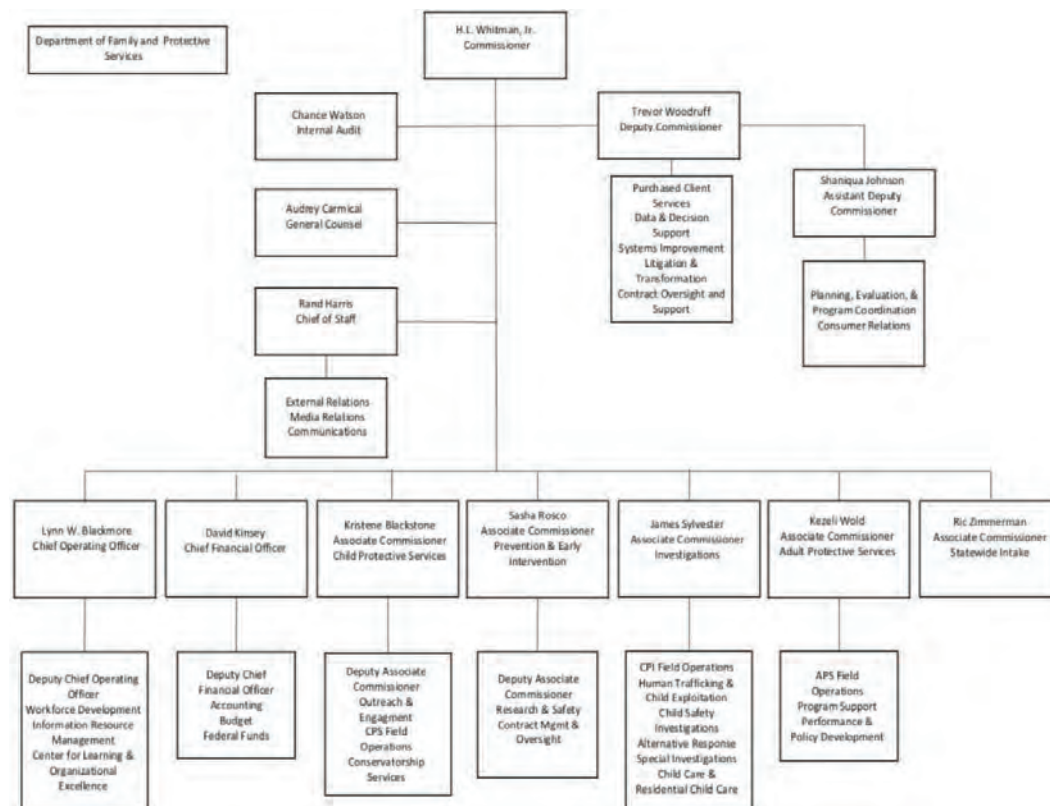
CPD – CPS professional development

CPS – Child Protective Services

- CYD – Community youth development
- DFPS – Department of Family and Protective Services
- FFCC – Former Foster Care Children
- FFPSA – Family First Prevention Services Act
- FGCM – Family group decision making
- GAO – Government Accounting Office
- GRO – general residential operations
- HHSC – Health and Human Services Commission
- HIP – Help through intervention and prevention
- HOPES – Health outcomes through prevention and early support
- IDD – Intellectual and other Developmental Disabilities
- LGBTQIA – Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
- LMHA – Local mental health authority
- MCO – Managed care organization
- MTFCY – Medicaid for transitioning foster care youth
- PAL – Preparation for adult living
- PEI – Prevention and early intervention
- PMC – Permanent managing conservatorship
- QRTP – Qualified residential treatment program
- RCCL – Residential child care licensing
- RTC – Residential treatment facility
- SNAP – Supplemental Nutrition Assistance Program
- SSCC – Single source continuum contractor
- STAR – Services to at risk youth
- SWI – Statewide intake
- SUD – Substance use disorder
- TANF – Temporary Assistance for Needy Families
- TEA – Texas Education Agency
- TFTS – Texas families together and safe

Organizational Charts

Figure 38. Organizational Structure of DFPS

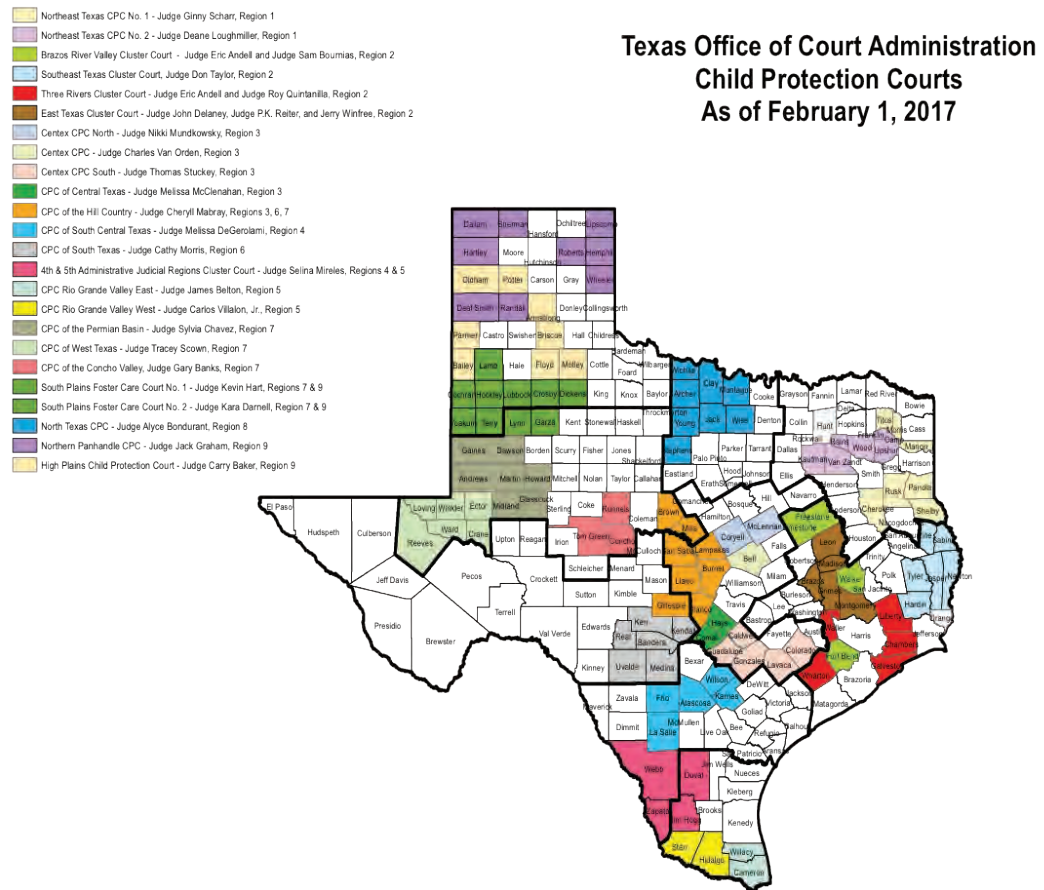


Source: Texas Legislative Budget Board. (August 30, 2018). *Texas Department of Family and Protective Services Legislative Appropriations Request for Fiscal Years 2020 and 2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=530&fy=2020>

Overview

The Department of Family and Protective Services (DFPS) is the state agency responsible for ensuring the safety of children, older adults, and adults with disabilities. DFPS is an independent agency that provides services and supports to these vulnerable populations to reduce the likelihood of abuse, neglect, and exploitation. Its headquarters are in Austin and as of 2017 included 13,000 employees that work in 268 local offices in 11 geographic regions.¹² DFPS is divided into the same 11 regions as the Health and Human Services System – see Figure X in the HHSC section for a map of those regions. As Figure 39 below shows, Texas is also divided into several regional networks of child protection courts.

Figure 39. Map of Child Protection Courts and Covered Regions



Data obtained from: Texas Office of Court Administration. (2017, February 1). *Child Protection Courts Map*. Retrieved from <http://www.txcourts.gov/media/1376968/child-protection-courts-map.pdf>

As Table 41 shows, DFPS was comprised of five separate divisions before the reorganization of the Health and Human Services enterprise.

Table 41. 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, neglect, delinquency and truancy of Texas children. PEI runs its own prevention programs in addition to funding and supporting community providers of early prevention services.
Child Protective Services (CPS)	Investigates allegations of child abuse and neglect and responds accordingly. CPS strives to strengthen and stabilize families to keep children in their own home. CPS also oversees and manages the foster care system for children who are removed from unsafe home environments and placed into foster care homes or state custody.
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 was 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

Changing Environment

The mental health needs of children involved with the child welfare system are far-reaching. Of the 32,000 children in foster care, half are living with a mental illness.¹³ Child Protective Services (CPS) has been plagued for years with serious issues including child fatalities, overburdened caseworkers, and a 2015 Supreme Court ruling that stated the system had “systematically violated the constitutional rights of children in foster care.”¹⁴ Due to critical issues within the child welfare system, transforming CPS was a legislative priority in the last several legislative sessions.

FUNDING FOR CPS CASEWORKER SALARIES AND KINSHIP CAREGIVERS

In order to help with caseworker turnover and retention, DFPS was granted \$150 million in emergency funding in December 2016 to increase caseworker salaries and

hire more caseworkers.¹⁵ During the 85th legislative session, lawmakers approved an additional \$500 million for CPS over the next two years to continue funding the additional caseworkers and maintain raises.¹⁶ The Texas Legislature also increased available funding for kinship caregivers with HB 4 (85th, Burkett/Schwertner).¹⁷

HB 5: DFPS AS A STAND-ALONE AGENCY

In addition to funding for caseworker salaries and kinship caregivers, several major bills were filed related to the DFPS structure in efforts to improve the child welfare system. HB 5 (85th, Frank/Schwertner), authorized DFPS to operate as an independent agency separate from the HHS system and required DFPS to report directly to the Governor of Texas. The bill was passed to allow DFPS “independence to be able to act quickly to make the changes and improvements needed to better protect children and adults from abuse, neglect, and exploitation.”¹⁸

SB 11: COMMUNITY-BASED CARE

Another major reform bill passed during the 2017 legislative session was SB 11 (85th, Schwertner/Thompson, Senfronia), which directs DFPS to expand the “Community-Based Care” model (formerly known as foster care redesign). Community-based care allows the state to contract with nonprofit organizations to serve children in foster care, adoptive care, and kinship care. Based on geographic service area, a single source continuum contractor (SSCC) will be responsible for case management and services that move children from foster care or kinship care into a permanent home. The goal is to gradually shift CPS’ role to quality oversight of foster care and services for children and families provided by nonprofit organizations, rather than providing the services directly through the state agency.¹⁹ Importantly, DFPS will remain responsible for all investigative functions. Some advocates have expressed concern with nonprofit groups taking on the work of CPS, particularly around finding appropriate homes for children with serious mental health conditions. However, supporters believe that a community-based care system based on geographic region will allow children to stay closer to home and prevent some of the highly-publicized tragedies occurring under the current system.²⁰ More information on community-based care can be found later under the “Foster Care Redesign/Community-Based Care” subsection.

OTHER DFPS-RELATED LEGISLATION

Other DFPS-related bills passed during the 85th legislative session include HB 7 (85th, Wu/Uresti, Carlos), which addresses issues related to CPS legal proceedings. The bill reinforced an emphasis on children being placed with relatives (known as “kinship care”), required a Foster Care Bill of Rights, expanded the rights and responsibilities of guardians and attorneys ad litem, and restricted in-patient psychiatric hospitalization requests by guardians or conservators of individuals younger than 18. The bill also required DFPS to periodically review the need for continued inpatient treatment and created a community-based dropout recovery program to give youth access to alternative education opportunities.

HB 1542 (85th, Price/Birdwell) amended the definition of “least restrictive

environment” for children in foster care to mean the placement that is most family-like in comparison to all other available placements. The bill allows placements for foster homes or general residential operations operating as a “cottage home” to be considered as the “least restrictive environment” for children over the age of six who cannot find a placement with a relative or other designated caregiver. For children below the age of six, a cottage home placement is only considered if DFPS determines it is in the best interest of the child. HB 1542 also defines additional considerations for selecting a placement, including the geographic proximity to a child’s home, the most able to meet the identified needs of the child, and if the placement satisfies any expressed interests of the child relating to the placement.

HB 2335 (85th, Miller/Rodriguez, Justin) would have required evidence-based trauma training for attorneys ad litem, court-appointed special advocate (CASA) volunteers or employees, and CPS employees who have contact with children who have experienced trauma. The bill did not pass.

LAWSUIT AGAINST DFPS/CPS

The DFPS foster care system 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 joined as plaintiffs in the case.²¹ The lawsuit focused on how CPS treats children in the state’s Permanent Managing Conservatorship (PMC) program, specifically children who have been unable to find a permanent placement within a year of their initial removal from their home.²² In 2011, when the lawsuit was first brought against CPS, there were approximately:

- 12,000 children in PMC, of which there were
 - 6,400 children in PMC for three or more years,
 - 500 children in PMC for more than 10 years, and
 - More than 1/3 of children in PMC experiencing five or more placements.²³

In December 2015, U.S. Federal District Judge Janis Graham Jack of Corpus Christi issued a ruling on the case, finding that the state had systematically violated the constitutional rights of children in PMC foster care. Judge Jack described the foster care system run by DFPS as one “where rape, abuse, psychotropic medication and instability are the norm,” where children “often age out of care more damaged than when they entered.”^{24, 25} Several of the ruling’s reforms to improve the PMC program were implemented in the beginning of 2016. These changes include:

- Addressing caseworker turnover and caseload size issues by directing DFPS to hire enough caseworkers to “ensure that caseloads are manageable” across the state.²⁶
- Addressing concerns of child safety in foster care placements by prohibiting placement of children in foster group homes without 24-hour awake supervision and addressing regulatory lapses in the state’s “broken” residential licensing division.²⁷

Judge Jack appointed two special masters in March 2016 to help guide and oversee the changes to DFPS’ foster care system.²⁸ 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, 2016.²⁹ The co-transition masters created a plan to address the capacity issues, defining “manageable” caseload sizes, and resolving other problems with the PMC program identified in the lawsuit. Their plan guided Judge Jack’s final ruling, released on January 19, 2018, which is discussed below.

Legislative Response to the Court’s Initial Order

In January 2017, prior to the 85th legislative session, the court issued its initial order with recommended steps to protect children in the PMC program.³⁰ Texas Speaker of the House Joe Strauss declared that fixing the foster care system was on the top of the legislative agenda for the 85th Legislative session and the Legislature acted by making several changes consistent with the court’s order.³¹ For example, to address the caseworker turnover and workload challenge, the Legislature sustained the emergency funding for CPS (\$142.4 million approved in December 2016) and included a requirement in SB 11 (85th, Schwertner/Thompson, Senfronia) for DFPS to create a caseload management system. Consistent with the court’s order to improve outcomes for youth who age out of care, the Legislature required DFPS to overhaul the Preparation for Adult Living (PAL) classes and now require attorneys and guardians to obtain birth certificates and other identifying documents for foster youth age 16 or older. The Legislature strengthened oversight of foster care facilities by requiring foster care group homes to meet General Residential Operations (GRO) standards in HB 7 (85th, Wu/Uresti, Carlos) and improved kinship care support in order to increase placements in family-like settings in HB 4 (85th, Burkett/Schwertner) and HB 7 (85th, Wu/Uresti, Carlos).³² Perhaps the most significant change is the Legislature’s embrace of community-based care throughout Texas in order to keep children closer to home and connected with their communities and families. While the 85th Legislature did not address all of the issues raised by the court’s initial ruling, it took significant steps to address the concerns raised by the court.

Judge Jack’s Final Court Order

On January 19, 2018, Judge Jack issued a final order in accordance with the recommended plan of implementation by the two special masters assigned to the case. The final order requires DFPS to implement nearly 100 changes to the CPS system. According to Texas CASA, some of the most important are a reduction in caseloads for conservatorship caseworkers, creation of a new comprehensive data system, expansion of placement capacity to meet regional needs, and payment of attorneys ad litem by DFPS while children are in PMC.³³ After the final ruling was issued, the 5th U.S. Circuit Court of Appeals upheld Attorney General Ken Paxton’s request for a temporary stay on Judge Jack’s order.³⁴

FOSTER CARE REDESIGN/COMMUNITY-BASED CARE

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.³⁵ 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.³⁶ 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.³⁷ Children in foster care often experience abuse and neglect and as a result experience different degrees of traumatization. Mental health conditions are one of the consequences that typically result from traumatic experiences.³⁸ However, children's symptoms of trauma may sometimes be misinterpreted as deliberate problematic behavior or indicative of a condition unrelated to trauma.³⁹

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.⁴⁰ 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, such as victimization and fatality, for children in the foster care system, DFPS embarked on a Foster Care Redesign project, now known as Community-Based Care, in 2010 to improve outcomes for youth in the areas of safety, permanency, and well-being. The guiding principles of Community-Based Care are:

- Above all, children and youth are safe from abuse and neglect.
- Children and youth are placed in their home communities.
- Children and youth are appropriately served in the least restrictive environment.
- Children and youth have stability in their placements.
- Connections to family and others important to the child are maintained.
- Children and youth are placed with their siblings.
- Services respect the child's culture.
- Children and youth are provided opportunities, experiences, and activities similar to those enjoyed by their peers who are not in foster care.
- Youth are fully prepared for successful adulthood.
- Youth have opportunities to participate in decisions that affect their lives.
- Children and youth are reunified with their biological parents when possible.
- Children and youth are placed with relative or kinship caregivers if reunification is not possible.⁴¹

One of the biggest changes resulting from Community-Based Care has been the switch from service-based funding to performance-based funding. Under the previous system, payment was linked to a child's service level (basic, moderate, specialized, or intensive) and placement type (Child Placement Agency, Emergency Shelter, General Residential Operation, or 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.⁴²

Community-Based Care 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.⁴³ Under the new system, an SSCC is required to provide a range of services for foster care youth in specific geographic catchment areas.⁴⁴

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 CPS and Child Placing Agencies (CPA) in providing behavioral health case management services to children with the highest needs.”⁴⁵ 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.”⁴⁶ 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;”⁴⁷
- Escalation of needs and 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; and
- Lack of key performance measures make it difficult to hold CPA or CPS caseworkers accountable for child outcomes while in DFPS care.⁴⁸

The report from the Stephens Group raised concerns regarding the effectiveness of Community-Based Care for children who have mental health diagnoses or IDD. The report indicated that recommendations for care might be too standardized to adequately meet the individualized needs and abilities of children and families with complex mixtures of mental health, IDD, and/or substance use issues. There is also a provision in Community-Based Care 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, in 2015 the average number of placements for children in DFPS care was 2.7 while youth identified as having high needs had more than twice as many, with an average of 5.7 placements.⁴⁹

In 2017, the Texas Legislature passed SB 11 (85th, Schwertner/Thompson, Senfronia) to expand the Community-Based Care model to include both foster care and relative or kinship care and services, and give the SSCC sole responsibility for case management.⁵⁰

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

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

In August 2018 DFPS announced the next two Community-Based Care areas for FY 2019: Region 1 (Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, and Yoakum counties) and Region 8b (Atascosa, Bandera, Calhoun, Comal, De Witt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala counties).⁵¹

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

- In Stage I, the SSCC will develop a network of services and provide foster care placement services. The focus in Stage I is improving the overall well-being of children in foster care and to keep them closer to home and connected to their communities and families.
- In Stage II, the SSCC will provide case management, kinship and reunification services. The focus of Stage II is expanding the continuum of services to include services for families and to increase permanency outcomes for children.⁵²

The first SSCC was awarded to All Church Home (ACH) Child Services in Region 3b in 2013. 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 Pinto, Parker, Somervell, and Tarrant counties.⁵³ The initial results of the implementation of the Community-Based Care program in Region 3b are positive, as DFPS found an improvement in outcomes for children in Community-Based Care in that region, compared to children in the legacy system outside the region.⁵⁴ As of December 2, 2017, ACH had 1,281 children enrolled, representing 98 percent of all foster children in Region 3b and approximately 7 percent of the overall children and young adults in paid foster care in Texas.⁵⁵ With the opening of a new 20-bed residential treatment center (RTC), and a hospital-based clinic specifically geared toward the medical needs of foster care youth, capacity for therapeutic foster care for high-needs children increased. As a result, 72 percent of children entering foster care in Region 3b live within 50 miles of their family home, compared to 62 percent statewide.⁵⁶ Due to recruitment efforts, as of August 2017 foster care capacity within Region 3b had grown by 20 percent since 2016, with a dramatic increase in rural areas such as Palo Pinto County, which saw a 150 percent increase.⁵⁷

Using data from the Region 3b service area (including Fort Worth and Dallas County)

one study from the Perryman Group estimates that every dollar invested in the state’s Community-Based Care program will return \$3.44 in state revenue and \$1.66 in local revenue.⁵⁸

CPS “TRANSFORMATION” PLAN: REDUCE CASEWORKER TURNOVER AND CHILD FATALITIES

In 2014 CPS adopted a “transformation” plan, a self-improvement process focused on making CPS a better place to work and a more effective system overall.⁵⁹ Transformation efforts were meant to address historical struggles at the agency including high turnover, high caseloads, investigations taking too long and poor caseworker supervision.⁶⁰ 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”.⁶¹ A University of Texas evaluation found caseworkers who completed the new training were 18 percent less likely to leave within their first year compared to caseworkers who had the old training. In 2017, 340 fewer CPS caseworkers left the agency, saving about \$18 million a year.⁶² 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. The number of abuse or neglect-related child fatalities in Texas decreased from 222 in FY 2016 to 172 in FY 2017.⁶³

In addition to the transformation’s focus on the interdependent goals of the system-wide approach depicted above, the new DFPS co-transition specialists appointed by Judge Jack in March 2016 set regulations for what constitutes a safe and appropriate number of cases for a caseworker to be in charge of simultaneously. As a result of improvements in caseworker retention and increased funding, CPS investigation caseloads in FY 2017 declined 32.5 percent, conservatorship caseloads declined 12.1 percent, and family-based safety services caseloads declined 29.6 percent compared to FY 2016.⁶⁴

DFPS Commissioner Hank Whitman has indicated that one of his priorities is to reduce CPS caseworker turnover by increasing pay and adding new caseworker positions to help 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.⁶⁵ In December 2016, the state Legislature approved an emergency funding bill of \$142.4 million for CPS. The bill was intended to reduce turnover and help the agency work off backlogs of unseen children. With the additional funding, CPS was able to hire 829 new employees and offer \$12,000 raises to about 6,000 special investigators and caseworkers.⁶⁶ In the first four months of 2017 after the pay raise, an average of just 72 caseworkers a month have left the agency. This is compared to the last four months of 2016, which saw 131 caseworkers quit per month.⁶⁷ In the 85th regular legislative session, lawmakers approved an additional \$500 million for CPS over the 2018/2019 biennium to continue funding the additional caseworkers and maintain raises.⁶⁸

In the months following the emergency funding for CPS in 2016, investigators’ average

daily caseload dropped to 14.5. This was an 18 percent decline from the previous year. Meanwhile, family-based caseloads remained at 15 and conservatorship caseloads declined to 28. Overall, CPS turnover fell from 25.4 percent in FY 2016 to 18.4 percent by August 2017.⁶⁹

INCREASED FOCUS ON NORMALIZATION FOR CHILDREN IN CARE

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.”⁷⁰ DFPS encourages normalcy for children in care but advocates state that foster families often 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.

In 2015, SB 830 (84th, Kolkhorst/Dutton) established an independent ombudsman office outside of DFPS (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.⁷¹

Another bill passed during the 2015 legislative session was SB 1407 (84th, Schwertner/Dukes), which 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.

FAMILY FIRST PREVENTION SERVICES ACT

In February 2018 Congress passed the Family First Prevention Services Act (FFPSA), which restructured the way the federal government pays for child welfare services.⁷² The legislation aims to help families in crisis safely stay together and reduce the foster care population by focusing on prevention of entry into foster care, and increasing the number of children successfully exiting foster care by reducing reliance on congregate care in favor of more family-like settings.⁷³

The largest federal source of child welfare funding comes from Title IV-E of the Social Security Act, which provides states with funds to support foster care, adoption assistance, guardianship assistance and the Chafee Foster Care Independence Program, a grant program that helps foster youth gain self-sufficiency. With the exception of Chafee, children must meet income eligibility requirements for Texas to be reimbursed for IV-E funded programs. Beginning October 1, 2019 the FFPSA will change Title IV-E funding in two primary ways:

- More flexibility to invest in prevention programs

- Funding will no longer be available for certain congregate care placements

The FFPSA will provide states with additional funding to invest in prevention programs aimed to keep children at imminent risk of foster care placement out of the system, assist pregnant and parenting youth already in foster care, and better support kinship caregivers. Trauma-informed and evidence-based programs are required and the law allows mental health and substance use prevention services to qualify for funds.

Additionally, the FFPSA precludes states from using Title IV-E funding to support children in foster care who spend more than two weeks in “child care institutions,” a broad term that encapsulates settings like group homes and residential treatment centers. Under the FFPSA, states can only use Title IV-E funding for services provided to children in the following congregate care settings beyond two weeks:

- Facilities for pregnant and parenting youth
- Supervised independent living for youth 18 and older
- Specialized placements for youth who are victims of or at risk of becoming victims of sex trafficking
- Family-based residential treatment facilities for substance use disorder
- Qualified residential treatment programs (QRTP)

A (QRTP) is a new standard for congregate care settings. The term refers to a program that has a trauma-informed treatment model designed to address the needs, including clinical, of children with serious emotional or behavioral disorders or disturbances.⁷⁴ Appropriately licensed clinical staff must be available to provide care 24 hours a day under this standard.

Under FFPSA, many of Texas’ congregate care placements would become ineligible for funding. However, the federal government has allowed states the option of delaying implementation of the law until 2021 in order to ramp up services and prepare.⁷⁵ States that choose to delay implementation cannot draw down any of the newly available prevention dollars until they are in full compliance with the law.

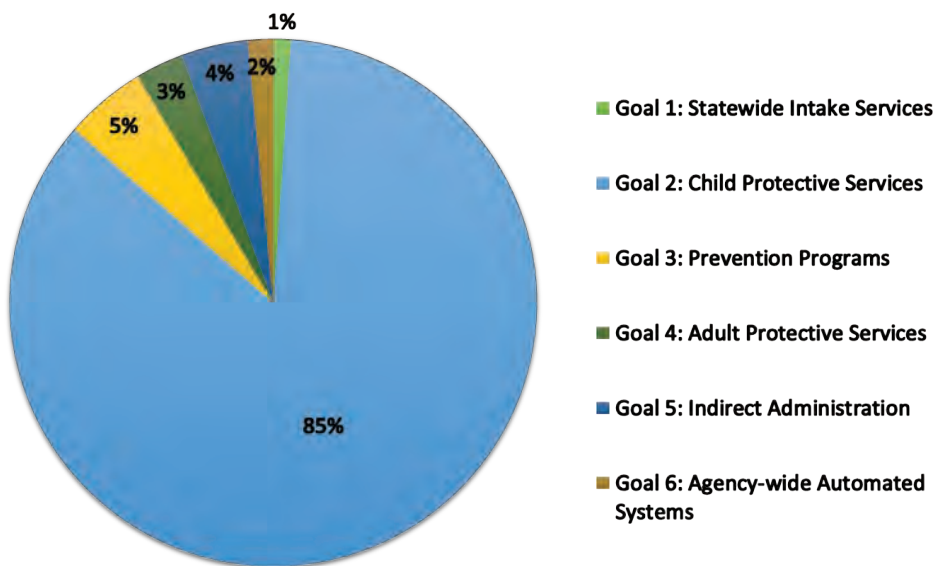
Further guidance from the federal government is due October 1, 2018. See the National Context section for additional discussion of the FFPSA.

FUNDING

The Department of Family and Protective Services is jointly funded by both state and federal dollars. The budget for DFPS was roughly \$3.487 billion for FY 2016-17 and \$4.185 billion for FY 2018-19 — a 16.68 percent increase in two years.^{76,77} In FY 2016-17, 45 percent of DFPS funding came from federal sources while the other 55 percent came from state sources (e.g., general revenue funds, GR-dedicated funds and other funding sources such as child support payments). In FY 2018-2019, the federal share of funding for DFPS had dropped to 41.98 percent.^{78,79}

As Figure 40 shows, the vast majority of the DFPS budget (85 percent) goes towards the department’s CPS-related mission of protecting children by operating an integrated service delivery system.

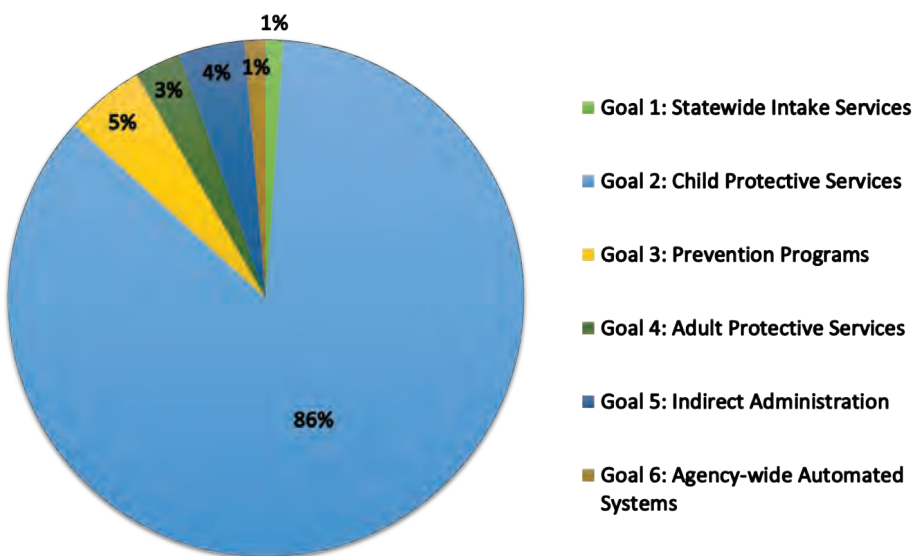
Figure 40. DFPS Budget by Strategy for FY 2018-19



**Total DFPS Budget for 2018-19:
\$4,185,222,633**

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Family and Protective Services*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=530&fy=2020>

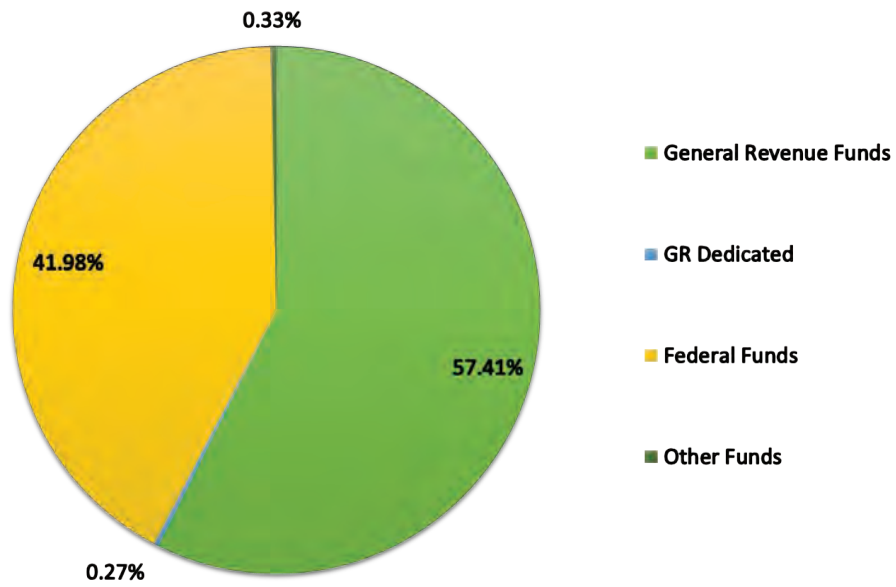
Figure 41. DFPS Budget by Strategy for FY 2020-21



**Total DFPS Budget for 2020-21:
\$4,239,036,314**

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Family and Protective Services*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=530&fy=2020>

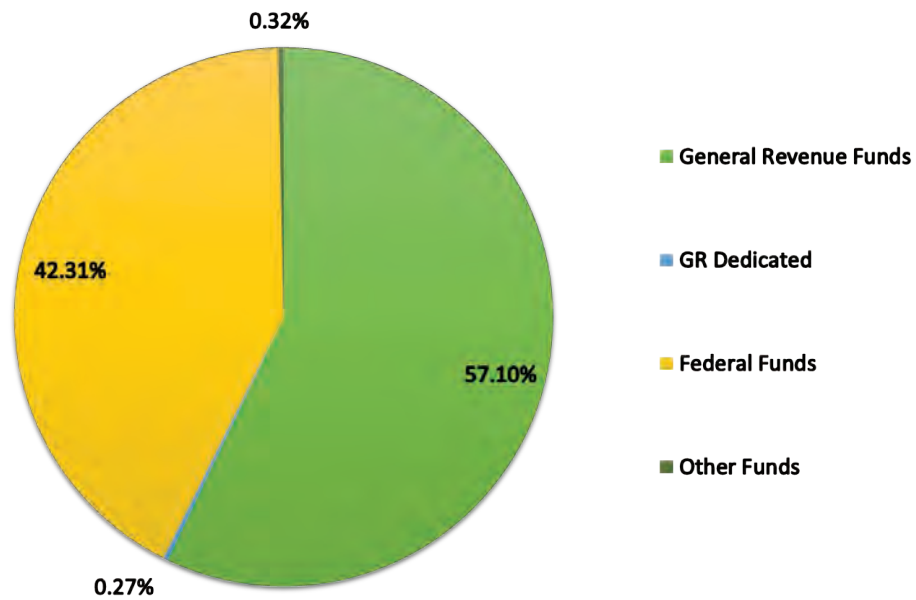
Figure 42. DFPS Budget by Method of Finance for FY 2018-19



**Total DFPS Budget for 2018-19:
\$4,185,222,633**

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Family and Protective Services*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=530&fy=2020>

Figure 43. Total DFPS Requested Budget by Method of Finance for FY 2020-21



**Total DFPS Budget for 2020-21:
\$4,239,036,314**

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Family and Protective Services*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=530&fy=2020>

DFPS submitted a baseline budget request of \$4.2 billion for the 2020-21 biennium (not including funds for exceptional items) – which is a net increase of \$53.8 million from the 2018-19 budget.⁸⁰

CHILD PROTECTIVE SERVICES DIVISION (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 2017, a total of 289,796 children statewide were suspected victims of abuse or neglect in 295,485 cases – a 4.7 percent increase from the number of confirmed victims of child abuse/neglect in 2016.⁸¹ Of these 295,485 cases:

- 56,885 cases were screened out for not meeting criteria for abuse/neglect.⁸²
- 23,376 low acuity and low-risk cases were transferred to the Alternative Response system (8 percent of all allegations). In 2016, only 17,970 allegations were referred to the Alternative Response System.⁸³
- The remaining 215,224 cases resulted in investigations - 174,740 investigations were completed.⁸⁴
- 39,570 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”).⁸⁵
 - Following different degrees of CPS intervention, 19,782 children were removed from their homes in FY 2017 in order to keep them safe from an abusive and/or neglectful caregiver or environment.⁸⁶
 - DFPS confirmed 172 abuse/neglect-related fatalities of children, five of whom died while they were enrolled in the state foster care system.⁸⁷

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

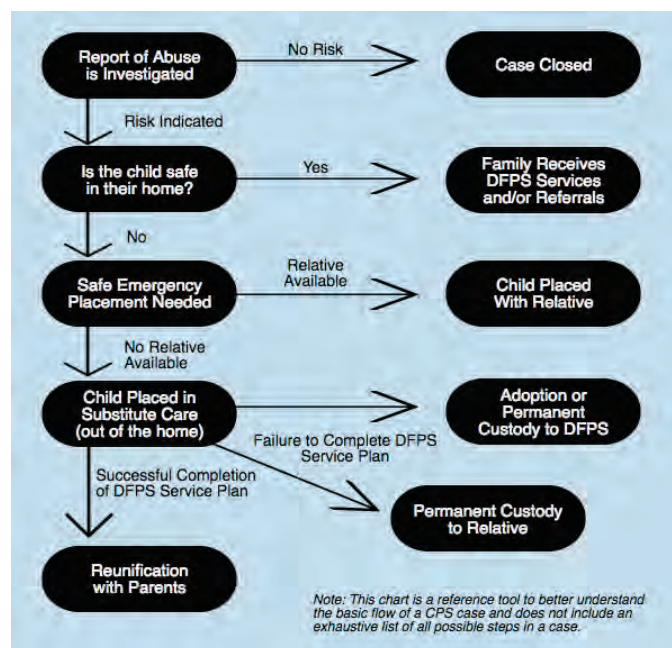
treatment options have been exhausted. As of December 31, 2017, there were 16,399 children in the Texas foster care system (excluding the 13,213 children in non-foster substitute placements such as kinship care and DFPS adoptive homes).^{88, 89} More than 48,889 children were in DFPS custody at some point during FY 2017, and 32,584 of them lived in some type of a foster care placement.⁹⁰ Hispanic (41 percent) and Caucasian children (31 percent) make up the majority of children in foster care, with African-American children (21 percent) as the third most prevalent racial group.⁹¹ However, when you take into account the racial demographics of Texas children as a whole, African-American children (11.4 percent 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.⁹²

As of August 31, 2017, 39 percent of children in DFPS conservatorship were in kinship placements.⁹³ 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; and
- Facilities overseen by another state agency.⁹⁴

Figure 44 illustrates the CPS investigation process upon receipt of an allegation.

Figure 44. 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/Annual_Report/2015/pdf/DFPS_2015_Annual_Report_and_Databook.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. When considering if AR is appropriate for a case, staff reviews the type and severity of the allegation, any history of previous reports, and the willingness of the family to participate and be involved with support services. AR, also known at the national level as “differential response,” places an emphasis on reinforcing family strengths, fostering parental involvement, and the development of support systems.⁹⁵

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; and
- As a whole, the AR process encourages collaboration with families and a focus on treatment and rehabilitation.⁹⁶

National research has found that differential response systems have demonstrated generally positive outcomes related to child safety, parent satisfaction, service delivery and improved worker satisfaction.⁹⁷ Despite higher initial investments, this approach is more cost-effective in the long run because costs for case management and services are lower.⁹⁸ AR engages parents, prompts them to identify their strengths, and connects them to providers to help address behaviors that may be harming a child’s cognitive, social, emotional, or physical development.

In FY 2016, Texas DFPS was using AR programs in the Amarillo, Austin, Dallas, Laredo, and Midland areas.⁹⁹ Currently, CPS has implemented Alternative Response in the Lubbock, Arlington, Tyler, Beaumont, Austin, Midland, El Paso and Edinburg regions.¹⁰⁰ CPS plans to use the approach statewide by 2019, with implementation in other regions done on a region-by-region basis.

A total of 23,376 allegations of child abuse or neglect were transferred to the new AR system in FY 2017, less than 8 percent of 298,732 total reports of abuse or neglect for the year.^{101, 102} CPS caseworkers have received training on how to implement the AR protocols and only 1,532 of the 23,376 cases that were initially referred to AR in FY 2017 were later transferred to full abuse/neglect investigations.¹⁰³

ACCESSING MENTAL HEALTH SERVICES

Star Health (Superior Health System)

In 2008, the STAR Health program was created to provide children in foster care with primary care and behavioral health services using a managed care delivery model. Superior Health Plan contracted with the state to run the STAR Health program and has been operating the program since its inception.¹⁰⁴ 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 2017, the STAR Health average monthly enrollment was 32,091.¹⁰⁵ The state provides immediate STAR Health eligibility for children in DFPS conservatorship and for former foster care children up to age 21. Youth aged 18 to 22 who sign extended foster care agreements are also eligible.¹⁰⁶ In FY 2017, 53 percent of children in STAR Health had a diagnosis of a mental health condition or a substance use condition. Texas spent \$174 million on those children and youth, which accounted for 68 percent of STAR Health total expenditures in FY 2017.¹⁰⁷

STAR Health requires that each foster care child has access to primary care physicians, behavioral health clinicians, specialists, dentists, vision services, and more.¹⁰⁸ Behavioral health services offered by Superior include:

- Education, planning, and coordination of behavioral health services;
- Outpatient mental health and substance abuse services;
- Psychiatric partial and inpatient hospital services (for members 21 and under);
- Non-hospital and inpatient residential detoxification, rehabilitation and half-way house (for members 21 and under);
- Crisis services 24 hours a day, 7 days a week;
- Residential care (for members 21 and under);
- Medications for mental health and substance abuse care;
- Lab services;
- Referrals to other community resources; and
- Transitional health care services.^{109,110}

Historically, the lack of a central medical records system for children in DFPS care created serious problems, including 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.¹¹¹ The Health Passport follows children to each placement so that every caregiver, DFPS staff member, and medical professional working with a child has a full understanding of his or her past and current treatments. The Health Passport allows access to that information in one central, easy-to-find location. Each child's Health Passport is available online through a password-protected website and can be accessed by DFPS staff and medical consenters. While the Health Passport is not a full and complete medical record, it provides claims data on pharmacy, dental, vision, physical, and behavioral health services provided to each child. Information on a child's drug allergies can also be directly uploaded to the Health Passport website and the system can alert medical professionals and caregivers if there is a potentially unsafe drug interaction or allergy.¹¹²

Former Foster Care Children's Program (FFCC) and Medicaid For Transitioning Foster Care Youth (MTFCY)

Numerous 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.¹¹³ Thus, retaining health insurance for former foster care children for a longer period of time may lead to better outcomes by ensuring that they have more consistent and reliable access to the mental health care services and supports needed for recovery and long-term well-being.¹¹⁴

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 who were on Medicaid while in foster care.¹¹⁵ 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 transitioned to FFCC or, for those ineligible for FFCC because they were not enrolled in Medicaid while in care, Medicaid for Transitioning Foster Care Youth (MTFCY).¹¹⁶

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.¹¹⁷

There are some groups of young adults who will not qualify for either program, including young adults who aged out of the Texas foster care system and moved to another state, and young adults who were not in foster care when they turned 18.¹¹⁸ ¹¹⁹ Young adults who do not qualify for FFCC may purchase health insurance through the Health Insurance Exchange if they have sufficient resources and/or federal marketplace subsidies, or they may still qualify for Medicaid. See Table 42 for an overview of existing health insurance programs for former foster care children.

Table 42. Health Insurance Programs for Former Foster Care Children

Plan Name	Eligibility	Income or Other Requirements
Former Foster Care Children Program (FFCC)	Be age 18 through 25; Have been in Texas foster care on his or her 18th birthday or older; Be receiving Medicaid when he or she aged out of Texas foster care; and Be a US citizen or have a qualified alien status, such as a green card.	No asset, income, or educational requirements.
Medicaid for Transitioning Foster Care Youth (MTFCY)	Be age 18 through 20; Have been in Texas foster care on his or her 18th birthday or older; Not have other health coverage; Meet program rules for income; and Be a US citizen or have a qualified alien status, such as a green card.	Income limit of \$4,179 per month (with an added \$1,487 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

Texas Health and Human Services. (2015). *TWH, M-1500, Income*. Retrieved from <https://hhs.texas.gov/laws-regulations/handbooks/texas-works-handbook/part-m-medicaid-transitioning-foster-care-youth-mtfcy/section-1500-income>

Institutional Residential Services

While the state recognizes that it is preferred that children grow up in family, home-based environments, some children in the custody of the state are placed in congregate care facilities. Prior to placing a child in foster care, the court is required to consider temporary placement with a relative if possible (kinship placement).¹²⁰ If kinship placement is not available or appropriate, the child may be placed in a foster home with foster parents, a foster family group home, or a general residential operations (GRO) facility. A GRO is a congregate care facility that provides residential services for 13 or more children up to the age of 18 years. 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 long-term residential treatment centers (RTC). An RTC provides care and treatment services exclusively for children with complex emotional and psychological needs.¹²¹

As of August 2017, there were a total of 168 licensed GROs regulated by DFPS — 77 of which are classified as RTCs and another 136 of them provide treatment services for children with emotional disorders.^{122,123} RTCs had capacity to provide services to a total of 3,567 children in August 2017, while GROs had capacity to serve a total of 11,284 youth.¹²⁴ DFPS provides an online search tool that lists all of these childcare 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 172 children in Texas died as a result of child abuse or neglect in FY 2017 — a 22.5 percent decrease from FY 2016 when there were 222 such deaths. The rate of child abuse and neglect-related deaths per 100,000 Texas children dropped from 3.5 in 2011 to 2.3 in 2015.¹²⁵ In 2016, the number of child abuse and neglect-related deaths per 100,000 children rose to 3.0 before dropping back to 2.3 in 2017.¹²⁶

It is important to look at trends in past child deaths in order to understand the risk factors that can be used by DFPS to prevent child abuse and neglect-related fatalities in the future. Some of the most salient risk factors for child abuse or neglect-related fatalities can be drawn from the following pieces of information:

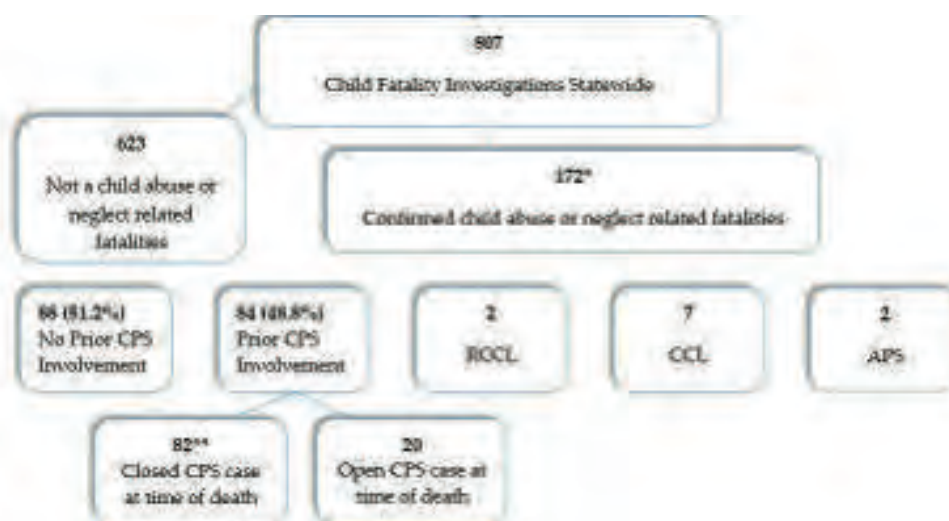
- While the majority of the 172 child deaths in FY 2017 continued to involve Anglo (57) and Hispanic (55) children, African-American youth are disproportionately represented in child abuse and neglect-related death statistics, with a 5.48 per capita fatality rate.¹²⁷
- A history of child maltreatment and domestic abuse increases child fatality risks;

50.5 percent of families who had a confirmed child abuse or neglect-related fatality in 2017 had a history of prior involvement with CPS.¹²⁸

- 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.¹²⁹
- In FY 2017 52 percent of abuse and neglect-related child fatalities included 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.¹³⁰
- Children under the age of three accounted for roughly 73 percent of all confirmed child abuse and neglect-related deaths between in FY 2017.¹³¹
- Mothers (34 percent), fathers (21 percent) or both parents together (12 percent) were the most common perpetrators in child abuse or neglect-related deaths in FY 2017. Boyfriends are the most common non-familial relation to be involved in child abuse or neglect-related deaths (8 percent).¹³²

Figure 45 provides details on the child fatalities in Texas in FY 2017:

Figure 45. Child Fatalities in Texas: FY 2017



* Note: one child fatality occurred during an open FBSS case that also had a new investigation opened. **prior history can involve the victim or the perpetrator or both in any previous CPS stage of service. Includes duplication.

RCCL: Residential Child Care Licensing

CCL: Child Care Licensing

APS: Adult Protective Services

Source: Texas Department of Family and Protective Services. (2018, March 1). *Fiscal Year 2017: Child Maltreatment Fatalities and Near Fatalities Annual Report*. Page 34. Retrieved from http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/PEI/documents/2018/2018-03-01-Child_Fatality_Annual_Report-FY2017.pdf

Disproportionality and Diversity of Children and Youth in CPS

Racial and Ethnic Diversity

There is disproportionate representation of African American and Native American children and youth in the Texas CPS system, as well as child welfare systems across the country.¹³³ These groups tend to be overrepresented because a higher percentage

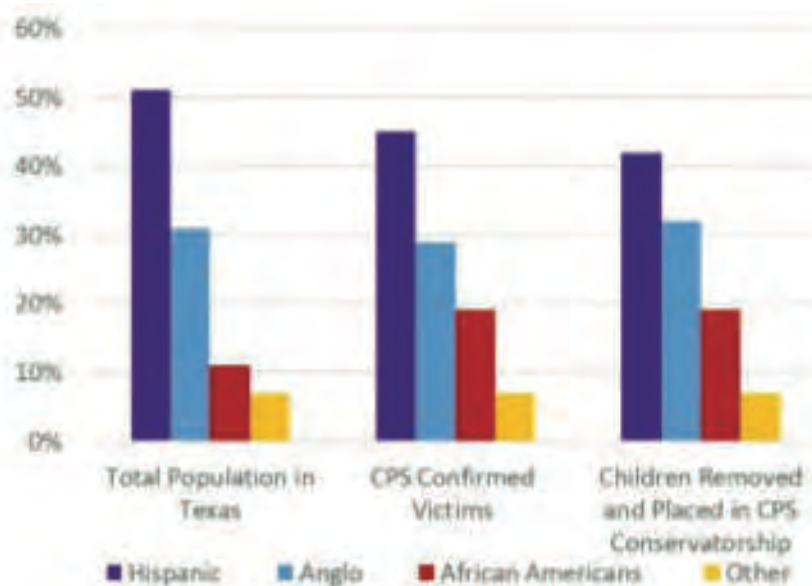
are removed from their homes due to abuse or neglect, they do not return home to their families and they grow up in foster care without being adopted or finding another permanent placement.¹³⁴

A number of theories have been offered as to why there is disproportionate representation of certain racial and ethnic groups in the child welfare system, including:

- Increased parent and family risks;
- Increased rates of poverty and exposure to neighborhood risks and harms;
- Societal disparities that make it difficult for parents to obtain 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.^{135,136 137}

Figure 46 shows the ethnic and racial profiles of children in Texas compared with children involved in the CPS system at various levels:

Figure 46. Disproportionality in CPS: Racial and Ethnic Differences in FY 2017



Sources: Texas Department of Family and Protective Services. (n.d.). *CPS Populations at Risk*. Interactive Table. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Populations_at_Risk.asp

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According to 2017 data, African-American children were less likely to be adopted than Hispanic children or Anglo children. While African-American children made up 23 percent of children waiting to be adopted as of August 31, 2017, they made up only

17 percent of children adopted in 2017. The percent of Hispanic children waiting to be adopted roughly matched the percent adopted (43 percent) and the percent of Anglo children waiting to be adopted (27 percent) was less than the percent adopted (32 percent). As of August 31, 2017, there were a total of 7,236 children waiting to be adopted in Texas.¹³⁸

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, in 2013 CPS collaborated with the DFPS Center for Learning and Organizational Excellence to develop Poverty Simulation trainings for caseworkers and external stakeholders. The goal of the simulations is to increase understanding and awareness about the realities and struggles facing families in poverty.¹³⁹ 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.¹⁴⁰

Another key component to addressing racial and ethnic disproportionality is CPS' increasing support for kinship care — placing the child with a relative or someone close to the family so that children maintain connections to their community, family, support network and culture. Unfortunately, individuals who take on this kinship responsibility are not eligible to receive 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.¹⁴¹ 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.¹⁴² In order to encourage kinship care, the Texas Legislature passed HB 4 (85th, Burkett/Schwertner) to increase the monetary assistance available to kinship caregivers.

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 overrepresented 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.¹⁴³ 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.¹⁴⁴

Research shows that LGBTQIA youth have an increased risk of experiencing several different negative situations and outcomes compared to their heteronormative peers, such as:

- 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 (8.4 times more likely), depression (5.9 times higher), and substance use (3.4 times more likely).¹⁴⁵
- Higher rates of harassment, exclusion and unfair treatment due to negative social attitudes.¹⁴⁶
- LGBTQIA youth report a more negative experience with the child welfare system, and are more likely to be moved, hospitalized for emotional reasons and are more likely to live in group settings.¹⁴⁷
- 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.¹⁴⁸

There are currently no policies in Texas specifically addressing the needs of LGBTQIA youth in the state's foster care system and there is no required data reporting on the number of LGBTQIA youth awaiting adoption in comparison to their heteronormative peers. Increasing family and caregiver support services 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.

In the 85th session, Texas passed HB 3859 (Frank/Perry), which protects child welfare providers from retaliation if they assert their “sincerely-held religious beliefs.” Among other things, the bill allows child welfare organizations to preclude certain people from participating in programs, and refuse to enter into contracts with providers that do not share their religious beliefs.¹⁴⁹

Psychotropic Medications in Foster Care

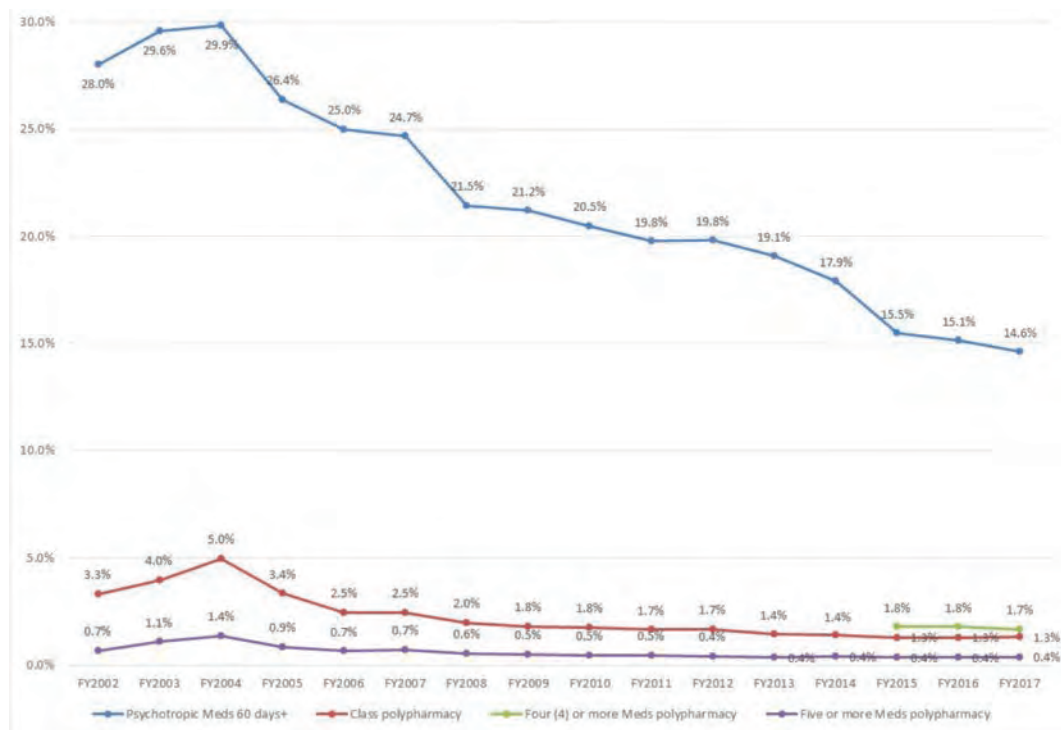
Foster children have historically been disproportionately treated for their behavioral health needs with psychotropic medications, which are drugs that affect an individual's mind, emotions, and behavior.¹⁵⁰ Psychotropic medication prescriptions for foster youth in Texas reached a peak in 2004, when close to 42 percent of all children in foster care were prescribed at least one psychotropic medication.¹⁵¹ 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.¹⁵²

Even when effective in treating mental health conditions, psychotropic medications also carry significant and potentially long-lasting side effects, including tremors, decreased/increased appetite, weight gain, headaches, nausea, and increased risk of suicidal thoughts.¹⁵³ Usage of psychotropic medications may also result in long-term effects such as stunted physical development.¹⁵⁴ One research study showed that nationally, 10 percent of foster children received antipsychotic medications, a

powerful subset of psychotropic medications that can carry significant side effects in children.^{155,156}

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.¹⁵⁷ The goal of the parameters was to encourage clinically appropriate and informed usage of psychotropic medications.

Figure 47. Percentage of Children in Texas Foster Care Receiving Psychotropic Medications by Category



Source: Texas Health and Human Services Commission. (2017). "Update on the Use of Psychotropic Medications for Children in Texas Foster Care: Fiscal Years 2002-2017". Retrieved from https://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2017-10_Update_on-Psychotropic_Medications_in_Texas_Foster_Children.pdf

As shown above in Figure 47, psychotropic medication prescriptions for foster care youth have declined significantly in recent years, particularly from 2014 to 2017. This reduction is the result of over a decade of efforts by legislators and advocates addressing the issue of overprescribing psychotropic medications for children in foster care. A few 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 consent 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) also 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 consentor. 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 is kept abreast of the child's medical history.¹⁵⁸
- The creation of the Health Passport, which allows DFPS staff, medical professionals, foster parents, and caregivers to easily access and track each child's medication history and medical information in one centralized 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.¹⁵⁹

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 percent in 2005 to 22.3 percent in 2017.¹⁶⁰ 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.¹⁶¹

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.¹⁶² 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.^{163,164} Rates of behavioral problems, developmental delays, and need for psychiatric intervention for foster care youth reach up to 80 percent.^{165,166} Professionals who interact and work with these children must therefore be cognizant of their trauma-related needs and how they impact their mental health.

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.¹⁶⁷ Trauma-informed care is not a discrete intervention, but rather a treatment framework that strengthens service delivery at all levels of care. In a trauma-informed system, every component of the service system is evaluated and reframed with an understanding of the role that trauma and violence play in the lives of people seeking behavioral health services.

Awareness of an individual's trauma-inducing experiences can help 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 with a better set of skills for understanding how to approach traumatized children and provide them the services and supports needed.

The push for trauma-informed care in Texas gained traction in 2013 with 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.¹⁶⁸
- SB 7 (83rd, Nelson/Raymond) ensured that professionals working on behavioral health intervention teams have training in trauma-informed practices.¹⁶⁹
- SB 152 (83rd, Nelson/Kolkhorst) required direct care staff at state hospitals to have training in trauma-informed care.¹⁷⁰

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. The assessment is called the Child and Adolescent Needs and Strengths (CANS).¹⁷¹ CANS assessments are required for every child over age five entering care and every 90 days for children in treatment settings.¹⁷² The CANS assessment is a tool used by substitute caregivers, case managers clinicians, care coordinators, and conservatorship workers to gather information needed to make decisions about the best course of action to take to address a child's needs.¹⁷³

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.¹⁷⁴

In 2017, the 85th Legislature further addressed several issues related to trauma and trauma-informed care. SB 11 (85th, Schwertner/Thompson, Senfronia) requires an SSCC to verify that any child who is provided therapeutic foster care services is screened for trauma at least once every 90 days. SB 179 (Menéndez/Minjarez), known as "David's Law," focused on bullying and cyberbullying in public schools and requires TEA to coordinate with HHSC to establish a website to provide resources for school employees when working with students experiencing a mental health

condition. The website is required to include grief and trauma-informed practices and building skills related to managing emotions. Though it did not pass, HB 3887 (Coleman) would have required trauma-informed training for school personnel.¹⁷⁵ HB 2335 (85th, Miller/No Senate Sponsor) would have required evidence-based trauma training for attorneys ad litem, CASA volunteers or employees, and CPS employees who have contact with children who have experienced trauma. The bill failed to pass during the 85th legislative session.¹⁷⁶

PREVENTION AND EARLY INTERVENTION DIVISION (PEI)

The Prevention and Early Intervention (PEI) division of DFPS partners with community providers and families to prevent abuse, neglect, truancy, runaway youth, and involvement with law enforcement. Community-based early intervention strategies and programs can address mental health conditions by providing timely access to services and reducing disparities for low-income and minority populations who may not have access to private providers or specialists. 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.¹⁷⁷ 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 2017, more than 64,000 youth and families were served by PEI programs — an 8 percent increase over the number of youth and families receiving PEI services in FY 2016 (59,192).¹⁷⁸ Table 43 lists the various programs and services provided through the PEI division of DFPS.

Table 43. 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 current service providers to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services. Services provided through CBCAP contracts include: respite, parental education, fatherhood services, parent leadership, home visitation, and public awareness campaigns.	Funds distributed in Cameron, Concho, Denton, El Paso, Fort Bend, Harris, Runnels, Tarrant, Taylor, and Tom Green counties
Community Youth Development (CYD)	Contracts with community organizations in zip codes that have a high incidence of juvenile crime to implement juvenile delinquency prevention programs. Services offered vary across communities but may include mentoring, youth employment programs, career preparation, recreational activities, and youth leadership development.	22 zip code service areas in Bexar, Cameron, Dallas, Denton, El Paso, Galveston, Harris, Hidalgo, Lubbock, McLennan, Nueces, Potter, Tarrant, and Travis counties
Health Outcomes through Prevention and Early Support (HOPES)	HOPES aims to prevent child abuse and neglect for children age 0 to 5 by encouraging the development of protective factors that will reduce the likelihood of child abuse and neglect. Services target specific counties and include a home-visiting component.	Funds distributed to 21 contractors in 59 counties

Program	Program Description and Service	Regional Availability
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 provides Supervised Independent Living (SIL) programs and transitional living allowances for eligible individuals.	All counties in Texas
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.	24 primary, 76 surrounding counties
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. Services 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.	Sites in 21 counties across Texas

Sources: Texas Department of Family and Protective Services. (2018). DFPS Annual Report 2017. Pages 21-24. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Annual_Report/2017/DFPS_2017_Annual_Report.pdf; and Texas Department of Family and Protective Services. (n.d.). Prevention and Early Intervention (PEI) Programs Available in Your County. Retrieved from https://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Programs_Available_In_Your_County/default.asp; Texas Institute for Child & Family Wellbeing. (n.d.). Project HOPES Evaluation. Retrieved from <https://txicfw.socialwork.utexas.edu/research/project/project-hopes-evaluation/>; Texas Department of Family and Protective Services. (2017). 2017 Annual Report & Data Book. Retrieved from (https://www.dfps.state.tx.us/Prevention_and_Early_Intervention/documents/Rider_38_Outcomes_Combined_Report.pdf)

ADULT PROTECTIVE SERVICES DIVISION (APS)

The Adult Protective Services (APS) division of DFPS investigates allegations of abuse, neglect, and exploitation for individuals age 65 or older and adults with a mental, physical and/or intellectual/developmental disability.¹⁷⁹ Investigations by APS involve both in-home investigations and facility investigations. Reported allegations can include self-neglect, abuse of parents by their adult children, physical and emotional abuse by caregivers, financial exploitation (e.g., taking social security checks or misusing a joint bank account), sexual assault, and any other forms of abuse, neglect or exploitation. These investigative and support services help to protect the mental health and wellness of persons with disabilities and aging Texans.

The primary APS program is the In-Home Investigations and Services Program.

The In-Home program investigates allegations of abuse, neglect, and financial exploitation of adults age 65 and older and adults age 18-64 who have a substantial physical or mental disability and live in their own homes or other community settings.¹⁸⁰ This program also investigates allegations of financial exploitation of adults living in nursing homes, assisted living facilities, or adult foster care homes who may be financially exploited by someone from outside the facility.

The state also conducts investigations into allegations of adult abuse within facilities called the Adult Protective Services Provider Investigations (APS PI) program. APS PI investigates allegations of abuse, neglect, and exploitation of people served by certain providers in a facility setting. As of September 1, 2017 the APS PI program transferred to the Regulatory Division in HHSC. For more information on this program, please refer to the HHSC section of this guide.

The incidence of validated adult abuse, neglect and exploitation per 1,000 Texans aged 65 or older fell between 2014 to 2015, from 1.7 victims in 2014 to 1.3 victims in 2015. However, the incidence of validated abuse rose to 1.6 per 1,000 Texans in 2016 and was 1.5 in 2017.¹⁸¹

There were 116,051 reports made of in-home abuse/neglect of adults in FY 2017, with the majority of reports initiated by medical personnel (22 percent), relatives (15 percent), community agencies (14 percent) and the victim themselves (11 percent).¹⁸² The following breakdown shows the outcomes of the 116,051 reports of in-home abuse or neglect made to APS in 2017:

- 84,712 completed in-home investigations
- 63,982 instances of validated in-home allegations¹⁸³
- 37,346 of the validated in-home allegations received services (58.4 percent)¹⁸⁴

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.¹⁸⁵ APS also distributes literature about health risks for the elderly, including dangers related to excessive summer heat

Endnotes

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Policy Concerns

- Funding needs post-Harvey, including mental health services for dealing with trauma related to the storm and its aftermath.
- Implementation of TEA Special Education Strategic Plan to correct the 8.5 percent limit on special education.

- Need for more recovery-oriented educational supports, such as schoolwide positive behavioral interventions and support and classroom-based social and emotional learning
- 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, and juvenile justice alternative education programs.
- 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.
- Lack of trauma-informed care training.

Fast Facts

- According to TEA’s Texas Academic Performance Report, 8.8 percent of school-aged children were enrolled in special education services in 2016-17, compared to the national average of almost 13 percent.¹
- The rate of special education enrollment in Texas rose slightly to 8.8 percent for the 2016-17 school year, with 477,281 of the total student population (5,359,127) enrolled in special education services.^{2,3}
- Roughly 33 percent of students eligible for special education services in 2016-17 had a primary diagnosis of a learning disability, 12.4 percent had a primary diagnosis of Autism, and 5.7 percent had a primary diagnosis of emotional disturbance.⁴
- In the 2016-17 school year, 8.8 percent of students in Texas schools were enrolled in special education services, but those students represented 18.4 percent of expulsions to Juvenile Justice Alternative Education programs, 16.6 percent of expulsions to Disciplinary Alternative Education programs and 12.5 percent of expulsions without placement.⁵
- Students receiving special education services were also overrepresented in receiving out-of-school suspensions (19.7 percent) and in-school suspensions (15.5 percent) in 2016-17.⁶
- The majority of expulsions to DAEPs and JJAEPs continued to be discretionary in 2016-17 (i.e., expulsions that were not mandated by state law but instead involve local codes of conduct).⁷
- The majority of students in Texas identify as Hispanic (52 percent) and many students in Texas — nearly one million — are still learning English.⁸

TEA Acronyms

AISD – Austin Independent School District

ARD – Admission, review and dismissal

ASCA – American School Counselor Association

CCIT – Children’s crisis intervention training

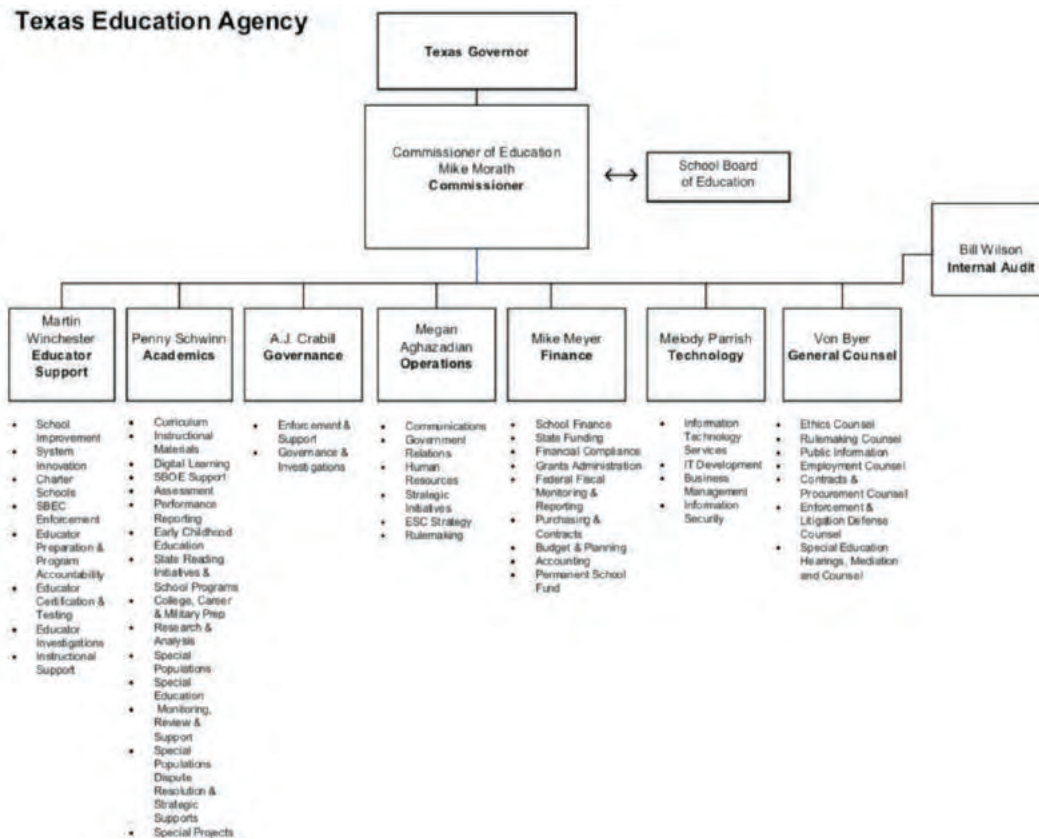
CEU – Continuing education unit

CIS – Communities in schools

- CIT – Crisis intervention teams
- DAEP – Disciplinary alternative education program
- DFPS – Department of Family and Protective Services
- DSHS – Department of State Health Services
- ESC – Education service center
- HHSC – Health and Human Services Commission
- IDD – Intellectual and other developmental disabilities
- IDEA – Individuals with Disabilities Education Act
- IEP – Individual education plan
- ISD – Independent school district
- ISS – In-school suspension
- JJAEP – Juvenile justice alternative education program
- LEA – Local education agency
- LSSP – Licensed specialist in school psychology
- MFA – Mental health first aid
- NCEC – Non-categorical early childhood
- NCTSN – National Child Traumatic Stress Network
- OSEP – Office of Special Education Programs
- OSS – Out-of-school suspension
- PBIS – Positive behavior interventions and services
- PPCD – Preschool program for children with disabilities
- PTSD – Post-traumatic stress disorder
- RSC – Regional service centers
- SEL – Social and emotional learning
- SHAC – School health advisory committee
- SHARS – School Health and Related Services Program
- SSA – Shared service agreement
- SRO – School resource officer
- TBSI – Texas Behavior Support Initiative
- TIC – Trauma-informed care

Organizational Chart

Figure 48. Organizational Structure of TEA



Source: Legislative Budget Board. (August 2018). *Texas Education Agency, Fiscal Year 2020-2021 Legislative Appropriations Request*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2020>

Overview

The Texas Education Agency provides oversight and administrative functions for all primary and secondary public schools for the 1,203 school districts and 675 open-enrollment charter school campuses in the state of Texas.⁹ According to TEA, 5,359,127 students were enrolled in Texas public schools in the 2016-17 school year, including charter schools and early education providers.¹⁰ Over a ten-year period, total enrollment in Texas schools increased by roughly 16.6 percent, or 764,185 students.¹¹

Undiagnosed or poorly managed mental health conditions can negatively impact a child's academic performance, classroom behavior, and school attendance.^{12,13} The most recently available data from the National Survey of Children's Health (2016) reveals that of the 716,584 children in Texas with mental health needs, 59.7 percent (428,123) reported having trouble getting the mental health treatment or counseling needed.¹⁴

In Texas, mental health supports and services may be provided in school settings by a number of trained professionals, including school counselors, nurses, school psychologists, and social workers. Despite the professional title, school counselors have many duties that are only tangentially related to mental health; however, 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."¹⁵ Although the American School Counselor Association recommends a ratio of 250 students per school counselor, the ratio in Texas is almost double that number: there were 442 students per counselor for the 2016-17 school year.¹⁶ 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, with 3,318 LSSPs working in Texas public schools in 2017.¹⁷

Changing Environment

SCHOOL SAFETY

The horrific mass school shootings experienced in Texas and around the country have elevated school safety to the forefront. This issue was amplified for Texas on May 18, 2018 when a Sante Fe High School student used a firearm to kill ten people and injure 13 others. Across the nation, educators, lawmakers, parents, students and others concerned with the safety of students and teachers are weighing options for making schools safer. On May 30, 2018 Governor Abbott and other state and local policymakers unveiled a School and Firearm Safety Action Plan containing 40 recommendations. The action plan can be found at https://gov.texas.gov/uploads/files/press/School_Safety_Action_Plan_05302018.pdf.

While some options are easily agreed upon, many are controversial and not easy to implement. In Texas, several interim legislative committee hearings were held to

study the issue and take input. Some of the recommendations included in the plan and the legislative hearings include:

- Increasing law enforcement presence at schools
- Increasing the numbers of school marshalls (armed teachers) on school campuses
- Installing metal detectors in schools
- Providing more emergency response training
- Increasing access to mental health evaluations and services
- Increasing mental health first aid training
- Consideration of “red flag” laws to identify potentially dangerous individuals
- Consideration of strengthening the Safe Firearm Storage Law
- Improving judicial access to critical information

FEDERAL INVESTIGATION ON TEXAS’ SPECIAL EDUCATION SERVICES

In recent years, Texas has identified a very low percentage of school-age children as having special education needs, largely because of an 8.5 percent target implemented by TEA in 2004. An estimated 8.7 percent of school-aged children in Texas were identified as having special education needs in the 2015-16 school year.¹⁸ The percentage of children in Texas schools identified as eligible for special education services was far lower than in other states with the national average being about 13 percent.¹⁹ The low number of children receiving special education services in Texas prompted a *Houston Chronicle* series and a U.S. Department of Education investigation which concluded with directives for TEA to reform special education in Texas.

In 2016-17, according to TEA’s Texas Academic Performance Report, 8.8 percent of school-aged children were enrolled in special education services.²⁰ According to TEA’s Special Education Report for 2017-18, 498,320 students were identified as having special education needs in 2016-17. Of those:

- 29,029 students (5.74%) were classified as having emotional disturbance
- 53,037 students (10.64%) were classified as having an intellectual disability
- 64,783 students (13%) were classified as having autism
- 70,360 students (14.12%) were classified as other health impaired
- 157,752 students (31.65%) were classified as having a learning disability.²¹

In 2016, a *Houston Chronicle* report by Brian Rosenthal alleged that TEA had systematically denied special education services to children across Texas by implementing an 8.5 percent target for children with disabilities served in school districts.²² The report by the *Houston Chronicle* was launched in response to a dramatic decrease in the percentage of students in special education in Texas between 2004 and 2014 – a decrease from 11.7 percent to 8.5 percent. Texas had the lowest percentage of children in special education in the country, while the national average remained at or near 13 percent of children.²³ The *Chronicle* disclosed that the benchmark was implemented in 2004, while TEA was facing a \$1.1 billion state budget cut, and that it has effectively led to a denial of “vital supports to children with autism, attention deficit hyperactivity disorder, dyslexia, epilepsy, mental illnesses, speech impediments, traumatic brain injuries, even blindness and deafness.”²⁴

The *Houston Chronicle* report prompted a federal investigation by the U.S. Department of Education. In 2017, the Office of Special Education Programs within the U.S. Department of Education released a monitoring report that found three specific areas where TEA failed to comply with the federal Individuals with Disabilities Education Act:

1. TEA failed to ensure that all children with disabilities residing in the state who are in need of special education and related services were identified, located and evaluated, regardless of the severity of their disability, as required by IDEA.
2. TEA failed to ensure that a free appropriate public education was made available to all children with disabilities residing in the State in Texas’s mandated age ranges (ages 3 through 21), as required by IDEA.
3. TEA failed to fulfill its general supervisory and monitoring responsibilities as required by IDEA to ensure that independent school districts throughout the state properly implemented the IDEA’s child find and FAPE requirements.²⁵

Beginning in November of 2016, TEA began to address concerns expressed by OSEP. Actions included:

1. Issuing a letter to every independent school district in the state reiterating their child find responsibilities under the IDEA
2. Coordinating a series of listening sessions throughout the state which were attended by both OSEP and TEA staff
3. Governor Abbott, with the Texas Legislature, implemented a new law that prohibits the use of school performance indicators that solely measure total number or percentage of enrolled children receiving special education and related services under the IDEA.²⁶

Following the full 15-month investigation, the U.S. Department of Education released their full report in January 2018. The investigation concluded that Texas failed to ensure students with disabilities were properly evaluated and that the state failed to provide an adequate public education for students with disabilities.²⁷ According to *The Texas Tribune*, the report found that TEA was “more likely to monitor and intervene in school districts with higher rates of students in special education, creating a statewide system that incentivized denying services to eligible students” and that “school district officials said they expected they would receive less monitoring if they served 8.5 percent of students or fewer.”²⁸ Further, school administrators delayed federally required evaluation of students suspected of having disabilities, often by providing intensive academic support.²⁹ The report outlined corrective action for TEA to take including documentation of special education evaluation practices, developing a plan to evaluate previously denied students and directing educators on how to identify students with disabilities.³⁰

On April 24, 2018 TEA announced the posting of its final strategic action plan for special education. The plan can be found at <https://tea.texas.gov/TexasSPED/>.

TRANSITION PLANNING FOR YOUTH WITH DISABILITIES

The 85th Legislature passed HB 748 (85th, Zaffirini/Allen, Alma) to update transition planning to reflect new state alternatives to guardianship for youth with disabilities.

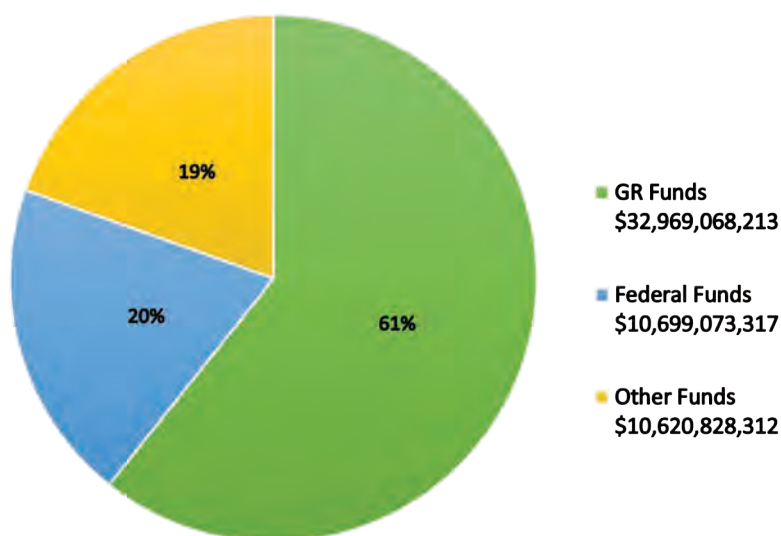
The bill updates the factors the admission, review, and dismissal committee must consider regarding whether a student has sufficient exposure to supplementary services to help the student develop decision-making skills. The bill requires TEA to update the Texas Transition and Employment Guide with information about long-term services, community supports, and alternatives to guardianship. Additionally, the bill requires TEA to develop and post a list of services and public benefits available to an adult student.³¹

CROSS-AGENCY COORDINATION OF SERVICES

In 2017, HB 2904 (85th, White/Watson) included TEA in the current law which requires agencies to have a memorandum of understanding to coordinate services for people in need of services from multiple agencies. Included as a new subcategory is services designed to prevent delinquency, truancy, and dropouts.³² The legislation requires that services for individuals needing multiagency coordination must be provided in the least restrictive appropriate setting.

Funding

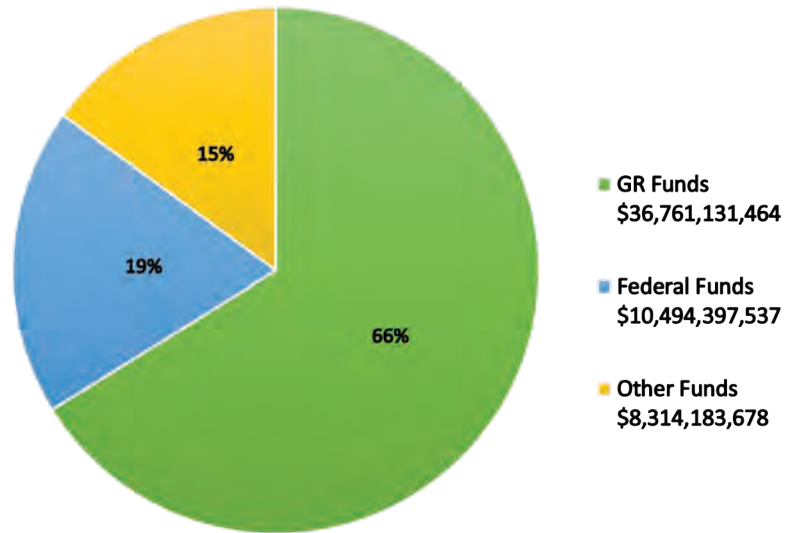
Figure 49. TEA Legislative Appropriations Request by Method of Finance FY 2020-21



Source: Legislative Budget Board (2018). *Texas Education Agency, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2020>

The total requested TEA budget for FY 2020-21 is \$54,288,969,842. If included in the budget, the Exceptional Items Requests would add an additional \$115,012,054.

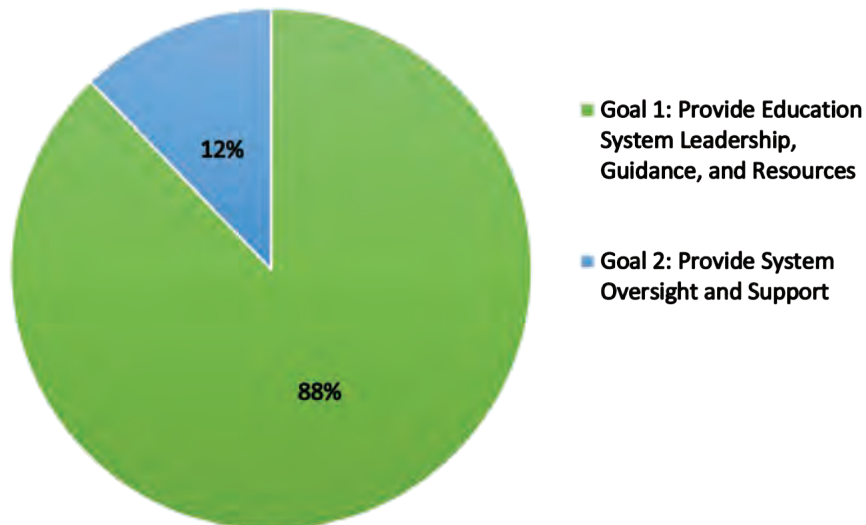
Figure 50. TEA Budget by Method of Finance FY 2018-19



The total TEA budget for FY 2018-19 was \$55,569,712,679.

Source: Legislative Budget Board (2018). *Texas Education Agency, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2020>

Figure 51. TEA Legislative Appropriations Request by Strategy FY 2020-21



Source: Legislative Budget Board (2018). *Texas Education Agency, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=703&fy=2020>

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.³³

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.³⁴ 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.³⁵ 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 24.³⁶

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.³⁷ According to a separate Center for Disease Control report, the percentage of children with diagnosed mental, behavioral, and developmental disorder is consistently higher in rural areas.³⁸ In Texas, the suicide rate is roughly 15 percent higher in rural counties (less than 20,000 residents) than in metropolitan ones.³⁹ 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.⁴⁰

The different methods of delivering mental health services in schools are described in Table 44.^{41, 42}

Table 44. 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).
<i>Formal Connections with Community Mental Health Services</i>	Formal agreements and contracts made with community mental health agencies (e.g. LMHAs) to provide services in school or at the community agency.

School-Based Mental Health Service Delivery	Description
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.
<i>Classroom-Based Curricula</i>	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.
<i>Comprehensive, Multi-Faceted and Integrated Approaches</i>	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 emotional issues or mental health conditions. When academic performance is impacted due to a student's disability, the Individuals with Disabilities Education Act requires schools to provide special education and related services based on an individualized educational plan, which may include mental health treatment and supports.⁴³

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 meeting that typically includes the student, the student's parents and/or caregivers, any mental health professionals involved in the child's care, and school personnel including at least one of the child's regular and special education instructors.⁴⁴ The ARD meeting is an essential part of creating, updating, amending and improving the individualized education plan 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.⁴⁵

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
- Individual support in the regular classroom setting, specialized classes, and other

services for students with developmental delays, physical conditions, serious emotional disturbances, intellectual and other developmental disabilities, and other disabilities.

In recent years, Texas has failed to identify significant numbers of student eligible for special education services. A series of articles in the *Houston Chronicle* was the impetus for a federal investigation of special education practices in Texas. See a summary of the allegations and repercussions in the Changing Environment Section above.

SPECIAL EDUCATION FOR EARLY CHILDHOOD – DEVELOPMENTAL DELAYS

Because children’s brains are growing and their behaviors are constantly changing, it can be difficult to diagnose a young child with a psychological condition. There are also children without a mental health diagnosis who may still benefit from early intervention services. To bridge the gap for young children who do not have a specific diagnosis and may not receive services before entering school in kindergarten, the Individuals with Disabilities Education Act allows for children between the ages of three and nine to qualify for special education services under a broader diagnostic category called “developmental delay,” as long as the diagnosis is made using proper instruments and procedures.⁴⁶ 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 ^{47, 48}

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 developmental delay category “Non-Categorical Early Childhood”. 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.⁴⁹ Children who fall under the NCEC category are provided services through a program called Preschool Program for Children with Disabilities. 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
- Autism⁵⁰

EMERGING ADULTS

In recent years, Texas made efforts to bridge the gap in services and supports for students with special needs transitioning out of high school. To assist students who receive special education services with a successful transition from school to appropriate post-school activities, such as postsecondary and vocational education or integrated employment and independent living, schools must begin individual transition planning with students and their families by age 14. Schools are required to identify needed courses and related services for postsecondary education and to develop adult living objectives through each student's IEP. The availability, comprehensiveness, and quality of transition services available in Texas vary widely across the state. Individual school districts, TEA, HHSC, and other state agencies make transition information available through a central website: www.transitionintexas.org.

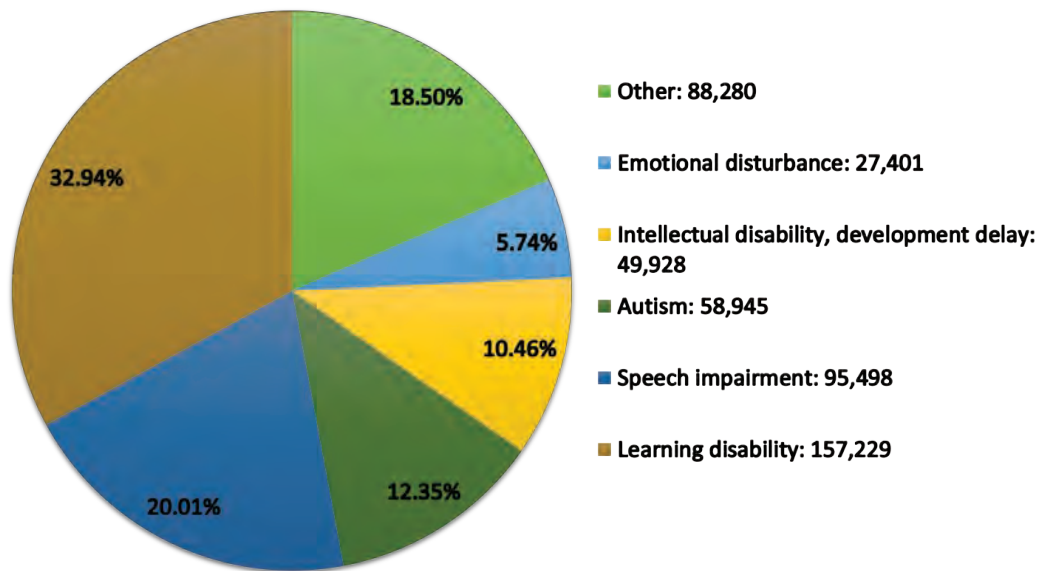
In recent legislative sessions, legislators made efforts to strengthen the transition planning process conducted in Texas schools. To strengthen supports for youth transitioning into adulthood, the 84th Legislature passed SB 1117 (84th, Zaffirini/Naishtat), which required information on housing and independent living to be provided in the transition/discharge plans given to youth over the age of 16 who are under DFPS conservatorship.⁵¹ Also, SB 1259 (84th, Rodríguez/Allen) improved the Admission, Review and Dismissal process where families and school staff develop an individual education plan by requiring the ARD meeting to include a teacher who is involved with implementing a portion of the child's IEP.⁵² SB 1259 also required notes reflecting the discussions and any actions taken during the ARD meetings.⁵³

The 85th Legislature passed HB 748 (85th, Zaffirini/Allen) to update transition planning to reflect new state alternatives to guardianship. The bill updates the factors the admission, review, and dismissal committee must consider regarding whether a student has sufficient exposure to supplementary services to help the student develop decision-making skills. The bill requires TEA to update the Texas Transition and Employment Guide with information about long-term services, community supports, and alternatives to guardianship. Additionally, the bill requires TEA to develop and post a list of services and public benefits available to an adult student.⁵⁴

ELIGIBILITY FOR SPECIAL EDUCATION SERVICES

Special education services encompass a wide range of interventions; children can become eligible for these services by receiving a diagnosis for a specified condition that impacts their learning. Figure 52 shows the various mental health diagnoses, behavioral conditions, and developmental disabilities that qualified 477,281 students in Texas for special education services in the 2016-17 school year:

Figure 52. Reasons for Special Education Eligibility in Texas Schools: 2016-2017



**Total Students Receiving Special Education Services in Texas:
477,281**

Note: "Other" includes Other Health Impairment, Auditory Impairment, Non-Categorical early childhood, Orthopedic impairment, Visual impairment, Deaf/blind and Traumatic Brain Injury.

Data obtained from: Texas Education Agency. (March 2018). 2016-2017 Special Education Reports: All Texas Public Schools Including Charter Schools, Students Receiving Special Education Services by Primary Disability, PEIMS Data 2016-17. Retrieved from <https://rptsvr1.tea.texas.gov/adhocrpt/adser.html>

During the 2016-17 school year, over 27,000 Texas students were identified as having serious emotional disturbance — roughly 5.7 percent of all students identified as eligible for special education services.⁵⁵ Nationwide, students identified as having serious emotional disturbance have the highest drop-out rate (55.9 percent) among students receiving special education or general education.⁵⁶ However, there are students who receive special education based on other primary disabilities (e.g., intellectual disabilities and autism) who also have mental health needs, such as depression, anxiety, post-traumatic stress disorder, attention deficit disorder, and more.

Eligibility for IDEA school-based mental health services for serious emotional disturbance is based on the student exhibiting one or more of the following characteristics to a marked degree over an extended period of time, in ways that adversely affect the student's educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health impairments
- An inability to relate appropriately to peers and teachers
- Inappropriate types of behaviors or feelings under normal circumstances
- A general mood of unhappiness and depression
- A tendency to develop physical symptoms, pains, or fears from personal or social problems⁵⁷

When determining whether special education services will be provided, school personnel seek evidence that the student’s behavior and need for services is not the result of a temporary reaction to adverse yet normal situations at home, in school, or in community situations.

FUNDING FOR SPECIAL EDUCATION SERVICES

During the 2014-15 school year, roughly 6.6 million public school students received special education services across the U.S —13 percent of all students nationwide.⁵⁸ During the same year, only 8.6 percent of the student population in Texas received special education services — the lowest percentage in the country.⁵⁹ Additionally, the percentage of students identified with emotional disturbance in the special education population has decreased nationally and in Texas in recent years.⁶⁰

Between 2004 and 2014 the population of Texas students receiving special education services decreased from 11.7 percent to 8.5 percent.⁶¹ The decrease in the proportion of students enrolled in special education services in Texas led to the *Houston Chronicle* series revealing an 8.5 percent benchmark implemented by the state in 2004. A federal investigation by the U.S. Department of Education found that Texas was violating federal law and has released a detailed report with actions for Texas to return to compliance. Fulfilling the federal requirements will require an increase in funding for disability services for students, a process that Texas and TEA are currently working through. For more information on this, see the Changing Environment section above.

Funding for the “Students with Disabilities” strategy within TEA is expected to remain relatively consistent in the upcoming years, with \$2,108,308,102 budgeted for the 2016-17 biennium, \$2,227,210,464 for the 2018-19 biennium, and a requested \$2,232,210,464 (plus an additional \$50,000,000 exceptional item request) for the 2020-21 biennium.⁶² In FY 2018-19 federal funding accounted for 93.1 percent of the total funding for the “Students with Disabilities” strategy within TEA.⁶³ 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 the Academic Innovation & Mentoring program, the Best Buddies program, and the Educator Excellence Humanities Texas program.⁶⁴

On April 23, 2018, TEA released the Special Education Strategic Plan. The majority of the strategic plan is funded through federal Individuals with Disabilities Education Act funding and state discretionary funds (more details on IDEA are in the following subsection). According to the strategic plan, the discretionary funds required for the strategic plan may be paid in part through available discretionary funds in the amount of \$45 million. The remaining activities may be pulled from annual state discretionary federal funds, at an anticipated allocation of approximately \$15 billion.

The strategic plan states: “...the agency does not have the authority to appropriate funds. However, regardless of this (or any other) strategic plan – but as a function of federal and state law – the activities associated in this plan are costs that have always been the responsibility of districts (identification, evaluation, and services for students). This plan addresses the state’s role of monitoring that this work is

being done, and providing support and technical assistance to districts. There are no requirements for districts in this plan above and beyond what has been, and remains, a requirement of federal and state law. However, it is also important to acknowledge that LEAs who had not identified all students eligible for special education will incur costs - and receive the prescribed weighted funding - associated with the following:

- Testing more students who are identified as potentially having a disability
- Compensatory services, as applicable (may vary based on individual need)
- Providing services to which the student is entitled⁶⁵

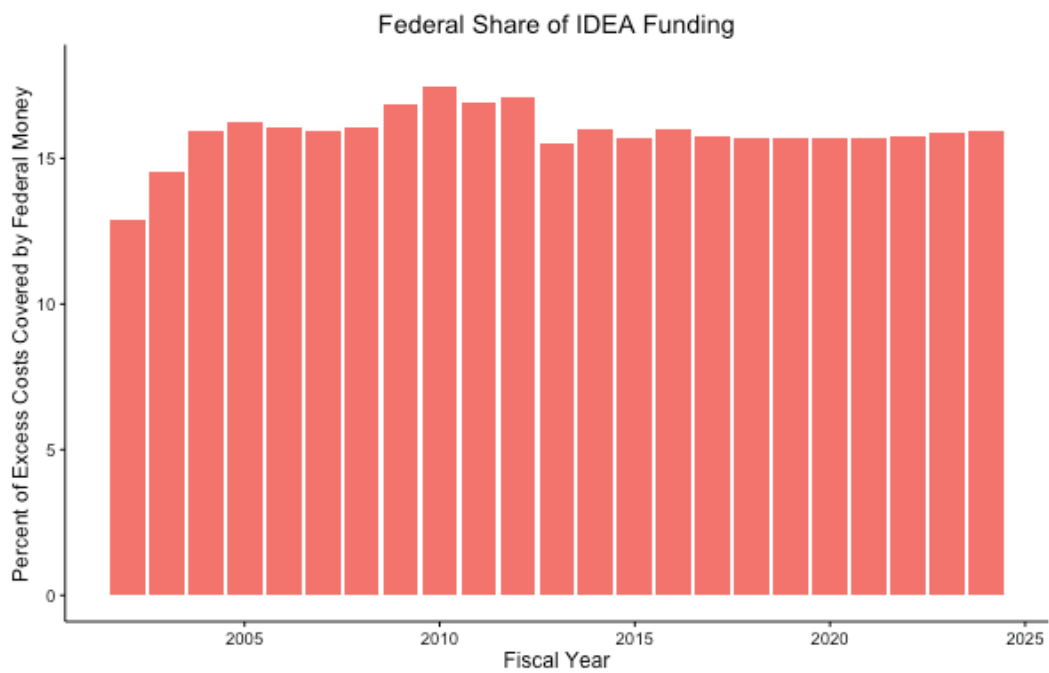
More details can be found in the strategic report: <https://tea.texas.gov/WorkArea/DownloadAsset.aspx?id=51539621194>

INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Under the Individuals with Disabilities Education Act, children and adolescents between the ages of 3 and 21 who have disabilities are entitled to receive a free and appropriate public education.⁶⁶ 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.⁶⁷ To support schools with increased costs, the federal government committed to contributing up to 40 percent of this anticipated additional cost.⁶⁸ Despite this commitment, the federal government has given less than half of its committed financial support since IDEA's first year of funding in 1981.⁶⁹

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.⁷⁰ Local funding must make up the difference in funding for this increased need in order to meet IDEA's requirements for providing special education services in schools.⁷¹ As Figure 53 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.⁷² 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 2014.⁷³ The federal FY 2018 budget provides \$13.13 billion in funding for IDEA, up from \$12.8 billion in FY 2017.^{74 75}

Excluding funding for preschools through IDEA, TEA received \$2,030,489,139 in federal IDEA Part B funding for the 2018-19 biennium, and that number is expected to increase by 2 percent (to \$2,035,489,139) for the 2020-21 biennium.⁷⁶

Figure 53. 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/>

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 program. Services provided by SHARS are made available through the coordination of TEA and HHSC.⁷⁷ SHARS is a Medicaid financing program that allows local school districts and shared services arrangements to obtain Medicaid reimbursement for certain health-related services provided to students in special education.⁷⁸ 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.⁷⁹

Services covered by SHARS include:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy
- Personal care services
- Physical therapy
- Physician services
- Psychological services, including assessments
- Speech therapy
- Transportation in a school setting⁸⁰

In order to receive SHARS services, students must meet all of the following requirements:

- Be 20 years of age and younger
- Have a disability or chronic medical condition
- Be eligible for Medicaid
- Be enrolled in a public school’s special education program
- Meet eligibility requirements for special education described in IDEA
- Have an individualized education program that identifies the needed services.⁸¹

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 IEP.⁸² 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

Created in 1965, 20 regional educational service centers in Texas provide support and technical assistance to all school districts throughout the state in a variety of areas, including special education and behavioral support. A map of service center regions is shown in Figure 54.

Figure 54. 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 specialize in specific topic areas and services and then provide resources, support, programmatic assistance and general expertise to

school districts or schools statewide.⁸³ For example, the Region IV Education Service Center in Houston specializes in Positive Behavioral Interventions and Supports with the goal of enhancing the education experience for all students by addressing the needs of students with behavior challenges.⁸⁴ Additionally, the Region XIII Education Service Center in Austin has a Behavior Team that includes general and special education specialists who focus on providing campuses with workshops, consultations, and technical assistance for behavioral supports.⁸⁵

A total of \$23,750,000 million was allocated for ESCs in the 2018-19 biennium and has been requested for the 2020-21 biennium, a 5 percent funding reduction by TEA for ESCs from the 2017-18 biennium.⁸⁶ The ESC infrastructure as a whole supports schools in complying with IDEA and, according to a 2014 report, saves public and charter schools an estimated \$623.5 million per year.⁸⁷ 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).⁸⁸

A total of 949,916 individuals were trained through ESCs in 2017, up from 903,257 trained in 2015. For 2020-21 TEA expects to continue training an estimated 885,000 individuals per year through the state's 20 ESCs.^{89,90}

COORDINATED SCHOOL HEALTH MODEL

Counseling and mental health services are a core element of TEA's Coordinated School Health Model.⁹¹ 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.”⁹² 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.⁹³ 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 education⁹⁴

COMMUNITIES IN SCHOOLS AND DROPOUT PREVENTION

Communities in Schools is a national dropout prevention program funded through state and local support. CIS provides individualized case management, counseling, and other mental health-related services.⁹⁵ In the 2015-16 school year, CIS provided case management services for 93,529 students through 28 local CIS programs operating in 146 school districts across Texas.⁹⁶ Of the students receiving CIS case management services in grades 7-12, 99 percent stayed in school during the 2015-16 school year, and 95 percent of CIS participants were promoted to the next grade or graduated.⁹⁷

State funding cuts to the CIS program in 2013 significantly impacted service delivery, but the roughly \$5 million that was cut from the CIS budget has largely been restored in the years since, increasing annual state appropriations for CIS to an estimated \$15,521,815 in 2016 and 2017.⁹⁸ This partially restored funding allowed CIS to serve more students in 2016 (93,529) than in 2013 (63,527).^{99,100} In the 85th legislative session, the Legislature appropriated \$15,521,817 in General Revenue and \$3,898,450 in TANF funds for 2018, and \$15,521,815 in General Revenue and \$3,898,450 in TANF funds for 2019.¹⁰¹

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 or juvenile justice alternative education programs.^{102,103} 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 example in the 2016-17 school year, 575,031 students in Texas were removed from the classroom at least once, totaling 1,652,775 separate incidents that resulted in the removal of a student from the classroom.¹⁰⁴

IN-SCHOOL SUSPENSIONS AND OUT-OF-SCHOOL SUSPENSIONS

A disruptive student can be removed from the regular classroom and assigned one or more days to a separate in-school suspension classroom to complete their class assignments, or they may be required to remain off campus for a specified period of time.¹⁰⁵ 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.¹⁰⁶ In addition to removing children from their regular classroom and from normal interactions with their peers, ISS and OSS can also lead to significant cost increases for schools and families.¹⁰⁷ 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.¹⁰⁸

In the 2016-17 school year, students receiving special education services accounted for 8.8 percent of the total student population but represented 15.5 percent of in-school suspensions and 19.75 percent of out-of-school suspensions.¹⁰⁹

EXPULSIONS TO DISCIPLINARY ALTERNATIVE EDUCATION PROGRAMS

Every school district in Texas is required to provide a Disciplinary Alternative Education Program. 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.¹¹⁰ According to statute, the central academic mission of DAEPs “is to enable students to perform at grade level.”¹¹¹ Any DAEP that serves a student with an IEP must provide the services outlined in that plan.¹¹² 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.”¹¹³

Certain infractions require mandatory removal to a DAEP according to the Texas Education Code:

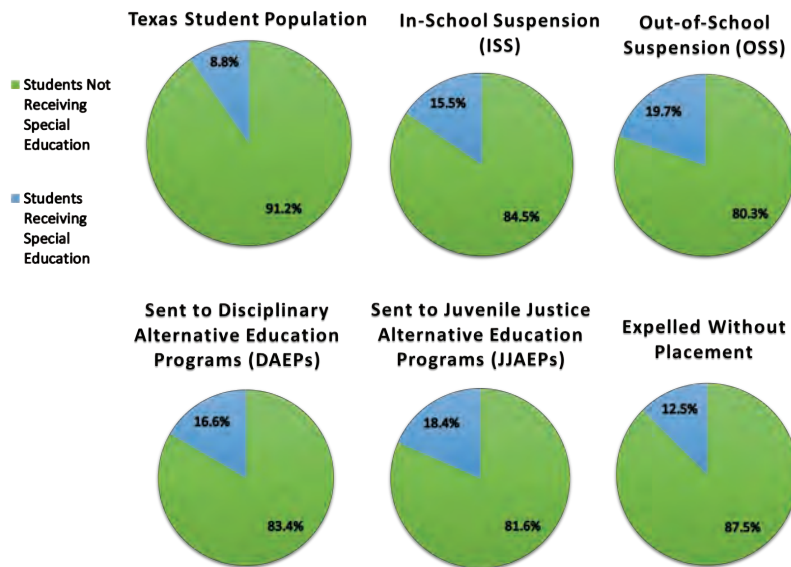
- Committing a felony or engaging in conduct punishable as a felony
- Assaulting another student or school employee
- Selling, giving, possessing, or being under the influence of a dangerous drug or alcohol
- Committing an offense that involves volatile chemicals, public lewdness, or retaliation against a school employee
- Making a terroristic threat or a false alarm/report¹¹⁴

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.”¹¹⁵ In the 2016-17 school year, 54.8 percent of all removals to DAEPs (47,952) were discretionary.¹¹⁶

Similar to other methods of exclusionary discipline, students receiving special education services are overrepresented in removals from the classroom to DAEPs. In the 2016-17 school year, 8.8 percent of all students in Texas public schools were identified as eligible for special education services, but those students represented 16.6 percent of referrals to DAEP.¹¹⁷

Unfortunately, exclusionary discipline has a disproportionate impact on students receiving special education services. Figure 55 is a breakdown of the overrepresentation of all exclusionary discipline removals for the 2016-2017 school year:

Figure 55. Overrepresentation of Youth in Special Education in Exclusionary Discipline



Data obtained from: Texas Education Agency. (2017). *Counts of Students and Discipline Actions by Discipline Action Groups: PEIMS 2016-2017 Data*. Retrieved from https://rptsrv1.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.¹¹⁸ 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.¹¹⁹ In the 2016-17 school year, discretionary removals accounted for:

- 52.5 percent of expulsions to JJAEPs
- 66.3 percent of DAEP removals, and
- 62.3 percent of expulsions without placement (i.e., “to the streets”).¹²⁰

Exclusionary discipline practices also disproportionately target African American students.¹²¹ While only representing 12.6 percent of Texas’ total student population in the 2016-17 school year, African American youth accounted for:

- 34.2 percent of out-of-school suspensions,
- 25.9 percent of in-school suspensions, and
- 21.2 percent of expulsions.^{122 123}

In the 2013-14 school year, elementary school students were suspended 88,000 times. Further, over 2,500 suspensions were given to pre-kindergarten students and over 36,000 of those suspensions were students in grades K-2.¹²⁴ In 2017, the 85th Legislature passed HB 674 (85th, Johnson/Garcia) to prohibit discretionary out-

of-school suspensions for students below third grade.¹²⁵ The bill also allows public schools to implement a positive behavior program with age-appropriate alternatives to out-of-school suspensions.¹²⁶

EXPULSIONS TO JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS & 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 or expelled without placement into a program (i.e., "expelled to the streets"), and a small number of expelled students are sent to DAEPs. JJAEPs were created in 1995 to provide ongoing educational services for students who have been expelled. Every county in Texas with a population of more than 125,000 residents at the time of the 2000 census must have a JJAEP.¹²⁷ Counties that meet the 125,000 population requirement after the year 2000 are able to, but do not have to, open a JJAEP.

JJAEPs are operated by juvenile boards with oversight provided by TJJD so when a student is expelled to a JJAEP, that referral is considered involvement in the juvenile justice system.¹²⁸ Legislative intent in creating JJAEPs was "to provide continuing educational opportunities for students expelled from school for the most serious offenses."¹²⁹ The primary goals of JJAEPs are to "reduce delinquency, increase offender accountability and rehabilitate offenders through a comprehensive, coordinated community-based juvenile probation system."¹³⁰ 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.¹³¹ 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. A major factor in the drop in JJAEP entries after the 2010-11 school year was the removal of "persistent misbehavior" as an expulsion reason from the Texas Education Code, Chapter 37.¹³²

During the 2016-17 school year, JJAEPs had the potential to serve 31 counties in Texas, of which 26 were mandatory while 5 discretionary counties declined to open JJAEPs.¹³³ ¹³⁴ Texas school districts placed students into JJAEPs on 2,939 separate actions in 2016-17, and 433 of those actions (or 15 percent) were for students in special education.¹³⁵

During the 2016-17 school year, the mandatory JJAEP counties in 2016-17 included: Bell, Denton, Jefferson, Taylor, Bexar, El Paso, Johnson, Travis, Brazoria, Fort Bend, Lubbock, Webb, Brazos, Galveston, McLennan, Wichita, Cameron, Harris, Montgomery, Williamson, Collin, Hays, Nueces, Dallas, Hidalgo, and Tarrant.¹³⁶

A report from TJJD cited 433 entries into JJAEPs for students in special education in 2016-17:

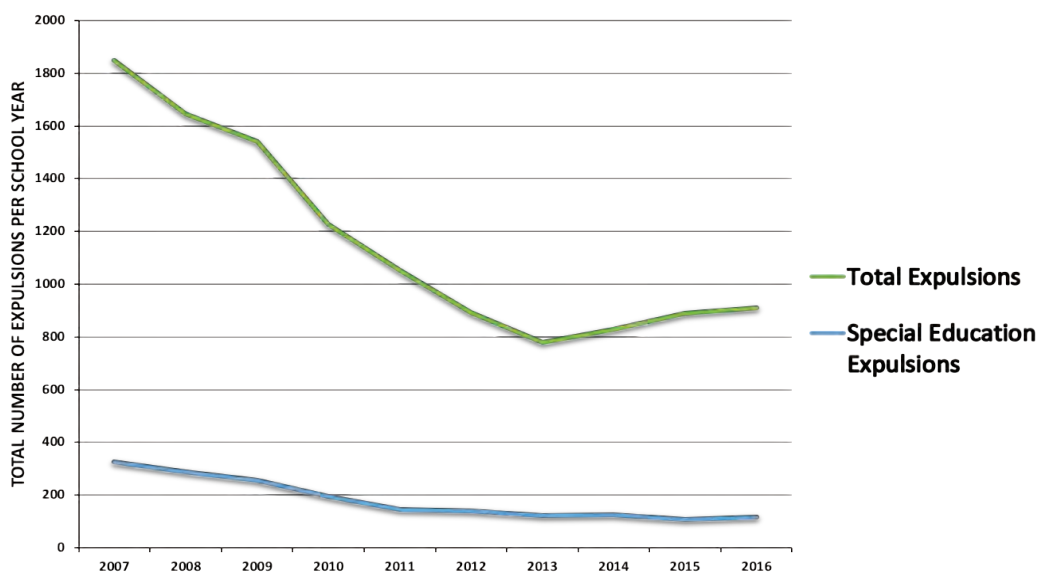
- 199 students had a primary diagnosis of a learning disability (46%)
- 106 students had a primary diagnosis of serious emotional disturbance (24%), and
- 128 had a primary diagnosis of Other (30%), which includes attention deficit disorder, speech problems, physical disabilities, traumatic brain injuries, or intellectual disabilities.¹³⁷

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.¹³⁸ In 2016-17, 41 percent of expulsions to JJAEPs were discretionary while 46 percent were mandatory and 13 percent were non-expelled.¹³⁹

The vast majority (77 percent) of mandatory referrals to JJAEPs in 2016-17 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.¹⁴⁰ Discretionary expulsions for “serious misbehavior” and misdemeanor drug charges represent 65 percent of all discretionary expulsions in 2016-17, down 11 percent from 2014-2015.¹⁴¹ 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.¹⁴² However, TJJJD publishes data that provides some understanding of how long students spend in JJAEPs at the macro level. In 2016-17, the average length of stay for all students who finished JJAEP was 74 days (82 days for mandatory expulsions and 67 days for discretionary) — a slight reduction compared to previous years.¹⁴³

In the 2016-17 school year, students receiving special education made up only 8.8 percent of the student population in Texas but accounted for over 18 percent of expulsions to JJAEPs.¹⁴⁴ Figure 56 details the difference between number of expulsions for students in special education services and total student expulsions.

Figure 56. Expulsions in Texas Public Schools: 2007-2016



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. (2017). Counts of Students and Discipline Actions by Discipline Action Groups: PEIMS 2016-2017 Data. Retrieved from https://rptsrv1.tea.texas.gov/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.^{145,146} 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.¹⁴⁷ For example, students who have been sent to ISS, OSS, or a DAEP are more likely to be expelled and sent to a JJAEP than those who are not referred to one of these exclusionary discipline settings.¹⁴⁸ Furthermore, students sent to a DAEP or a JJAEP are more likely to drop out of school and enter the adult criminal justice system.¹⁴⁹ 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.”¹⁵⁰ 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. 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.¹⁵¹

School Ticketing and Class C Misdemeanors

For many years under Texas law, school resource officers could legally 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 involved students in 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.^{152,153}

A report by Texas Appleseed and Texans Care for Children published in 2016 found that school-based tickets, complaints and arrests dropped significantly after 2013 when legislation was passed to prohibit SROs from issuing tickets.^{154,155} However, totals plateaued through 2015.¹⁵⁶

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 significant 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.

In 2017, the 85th Legislature passed HB 2904 (85th, White/Watson) to expand the joint memorandum of understanding between agencies to better coordinate services. The agencies included in the joint memorandum include HHSC, DFPS, DSHS, and TEA. The bill requires the memorandum of understanding to clarify the statutory responsibilities of each agency related to delinquency, truancy, and school dropouts.¹⁵⁷

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. TEA does not collect data on the use of corporal punishment so it is difficult to track its use. 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.¹⁵⁸ In the 2011-12 school year alone, roughly 28,569 children in Texas received corporal punishment (i.e., spanking or paddling).¹⁵⁹ Nationwide and in Texas, students with disabilities and African American students are disproportionately the targets of corporal punishment.¹⁶⁰ 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.^{161,162} Beginning in 2012, parents in Texas are now given the option to sign a waiver that excludes their child from receiving corporal punishment (opting out), but allowance of corporal punishment remains the default option in many districts.^{163,164}

Use of force (e.g., physical restraints and Tasers) by SROs has also surfaced as a concern of child advocates. While under nine percent of Texas students were classified as special education students (i.e., served by IDEA) in the 2011-12 school year, those students served by IDEA represented 79 percent of students who were physically restrained.¹⁶⁵ 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.¹⁶⁶ 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.¹⁶⁷ 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.¹⁶⁸ 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.¹⁶⁹ 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.¹⁷⁰ There was an unsuccessful legislative attempt to ban Tasers and pepper spray in schools statewide during the 83rd Legislative Session and there are currently no statewide standards regarding the use of Tasers by SROs.¹⁷¹ 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.¹⁷²

There are districts implementing less aversive ways to address disciplinary matters. One example is crisis intervention teams 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.¹⁷³ Building community partnerships to support youth's ability to access services and supports is the foundation of a successful CIT program.¹⁷⁴ As an example, Bexar County created the Children's Crisis Intervention Training for use in schools in the Greater San Antonio area. The 40-hour training is approved by the Texas Commission on Law Enforcement Officer Standards and provides CEUs for SROs who have not previously received any CIT training.¹⁷⁵ Bexar County's CCIT includes education on:

- Officer tactics and safety in school campus environments
- Active listening and de-escalation techniques
- Mental illness, learning and developmental disabilities, and substance abuse in children and youth
- Psychotropic medications
- Family perspective and community resources
- Legal issues relating to school environment and minors and emergency detention
- Role-play scenarios that allow officers to gain practical experience in active listening and de-escalation techniques specific to students experiencing a crisis¹⁷⁶

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:

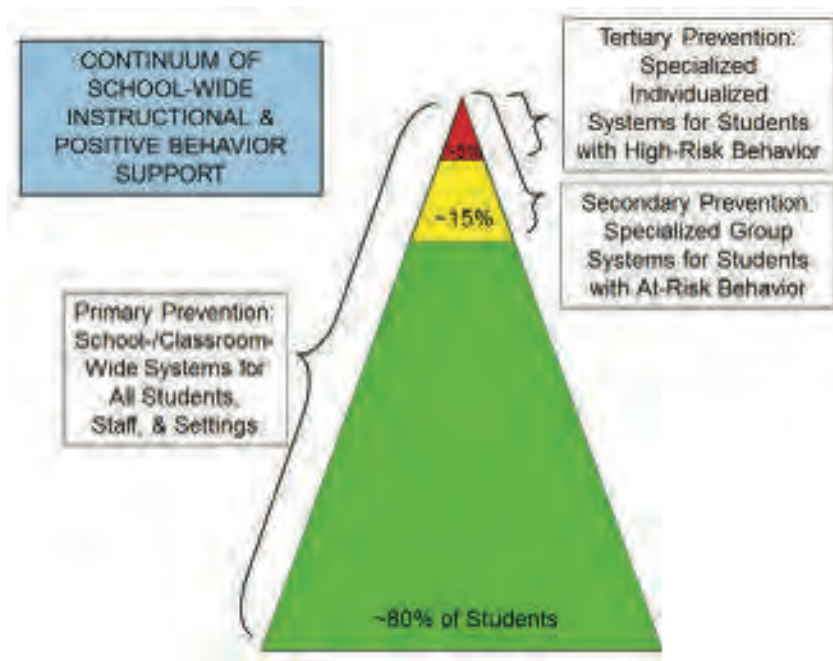
- positive behavioral interventions and supports
- social and emotional learning
- trauma-informed care
- restorative justice (also known as restorative discipline)

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.¹⁷⁷

Positive Behavioral Interventions and Supports

A well-known example of a positive and proactive approach to school-based services is positive behavioral interventions and supports.¹⁷⁸ Figure 57 illustrates the basic framework of PBIS.

Figure 57. 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.¹⁷⁹

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.¹⁸⁰

School-wide Positive Behavior Interventions and Supports

TEA does not track information on school districts or campuses implementing school-wide PBIS. However, the agency has designated the Region 4 ESC in Houston as the state lead for the Texas Behavior Support Initiative, including a network of representatives from each of the 20 ESCs in Texas available to assist school district efforts to implement PBIS. As of 2014-15, more than 500 campuses reported to Region 4 that they were using school-wide PBIS.⁴⁵ This number is likely to be a significant undercount of the campuses using PBIS since not all schools use ESC resources to implement this popular proactive disciplinary approach.

Source: *Student Mental Health After the Storm, Hurricane Harvey Raises the Stakes for Supporting Healthy Minds in Texas Schools*. November 2017, Texans Care for Children

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.¹⁸¹ Technical assistance to implement PBIS is available through the network of regional educational service centers and the Texas Behavior Support Initiative.¹⁸² 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.¹⁸³

The 85th Texas Legislature passed three bills related to PBIS. These included:

1. HB 4056 – requiring the inclusion of PBIS on the state's best practice list.
2. SB 179 - requires that if a district does develop any practices or procedures related PBIS, it must include them in their student handbook and district improvement plans.

3. HB 674 – allows schools to develop positive behavior programs for students in grade levels below grade three as a disciplinary alternative.

Social and Emotional Learning

Social and emotional learning is not a specific program, but a framework to help change the school’s approach to working with students.¹⁸⁴

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.¹⁸⁵

Schools can choose from a variety of proven, effective SEL programs, but it is not necessary to hire additional staff to implement SEL – the primary costs of an SEL program are related to staff training and student surveys.¹⁸⁶ SEL programs can be implemented from preschool through high school and can improve student functioning in a number of areas.

Austin Independent School District in Central Texas has committed to incorporate SEL in its schools – one of the first districts in the country to make this commitment.¹⁸⁷ AISD began implementing SEL in 2013, with 73 of AISD’s 129 schools implementing SEL in the first school year, reaching over half of the students enrolled.¹⁸⁸ By the 2015-16 school year, all 86,000 students in AISD’s 129 different campuses were involved in the SEL program.¹⁸⁹ Dallas ISD and El Paso ISD began the SEL initiative in 2016, and Round Rock ISD and Houston ISD have recently started the SEL implementation process.¹⁹⁰

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^{191,192}

Trauma-Informed Care

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.¹⁹³ 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.¹⁹⁴ 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. In the 85th Legislative Session, SB 179 (85th, Menendez/Minjarez), known as David's Law, authorized continuing education requirements for classroom teachers and principals to include instruction on grief and trauma-informed care. The bill also required TEA and HHSC to create a website to provide public school employees with resources including grief and trauma-informed practices. Additionally, HB 4056 (85th, Rose/Lucio) expanded the list of best practice-based programs to include trauma-informed practices.¹⁹⁵

Mental health treatment practices (including trauma-informed care) and school-based behavioral practices have yet to catch up with the reality that people with IDD live with serious mental health conditions including PTSD. The opportunities for experiencing traumatic events is greater for individuals with IDD than in the general population, yet the behaviors associated with any resulting mental health challenges, including PTSD can manifest differently than in the general population and often go unrecognized.¹⁹⁶ It is important that we continue to improve the accuracy of assessment tools and the effectiveness of a variety of therapies and treatments for individuals with IDD, keeping recovery in the forefront.

Too many IDD systems of care (including schools) continue to focus on controlling and managing challenging behaviors without adequate consideration of the potential for underlying mental health conditions or the impact of trauma as the cause of the behaviors. The focus of school interventions and treatment has historically been to develop behavior management plans to promote compliance or the use of medications to control the behaviors. In both cases the treatment is targeting the behavior and not the actual mental health condition, making recovery unlikely and doing little to reduce or remove barriers to learning.

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

1. Setting the stage
2. Development, IDD, and Trauma
3. Traumatic Stress Responses in Children with IDD
4. Child and Family Well-being and Resilience
5. IDD Trauma-informed Services and Treatment
6. Provider Self-Care

The toolkit includes a facilitator’s guide, videos, participant manual, case vignettes, board game/activities, slide kit, and supplemental materials. This training would be beneficial to anyone working with or supporting children with IDD. To access the toolkit requires creating an account on the website, however, the toolkit is free to anyone with an account.

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.¹⁹⁷ 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.¹⁹⁸ 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.¹⁹⁹ 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.²⁰⁰ 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. Restorative justice trainings have been implemented in ten of the state’s 20 RSCs. In the fall of 2016, 1,400 administrators and 400 coordinators received training on restorative discipline practices. TEA plans to provide training for the remaining ten regional service centers.^{201 202}

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.²⁰³ Examples of these side effects include anxiety, low grades, and social rejection.²⁰⁴

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.²⁰⁵ 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.²⁰⁶ Schoolwide efforts like PBIS and SEL also have the potential to reduce bullying by creating an environment of open communication and respect across the school campus.

In the 85th Legislative Session, SB 179 (85th, Menendez/Minjarez), known as David's Law, was passed in an effort to address cyberbullying in public schools. The bill defines bullying and cyberbullying, requires school boards to establish procedures for reporting on bullying, and enables districts to develop policies to help prevent and mediate bullying.

The bill increases the criminal penalty for bullying. Students can now be expelled or placed in DAEP if they engage in bullying that incites violence, encourages suicide, or releases or threatens “intimate visual material” of another student. School administrators are now allowed to report cyberbullying to law enforcement officials.²⁰⁷

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Texas Department of Criminal Justice and Local Criminal Justice Agencies

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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 health conditions experience constitutional and humane conditions of confinement
- Improving access to 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 teams, and reentry peer support
- Expanding access to specialty courts to divert people with mental health concerns and substance use issues away from jail settings

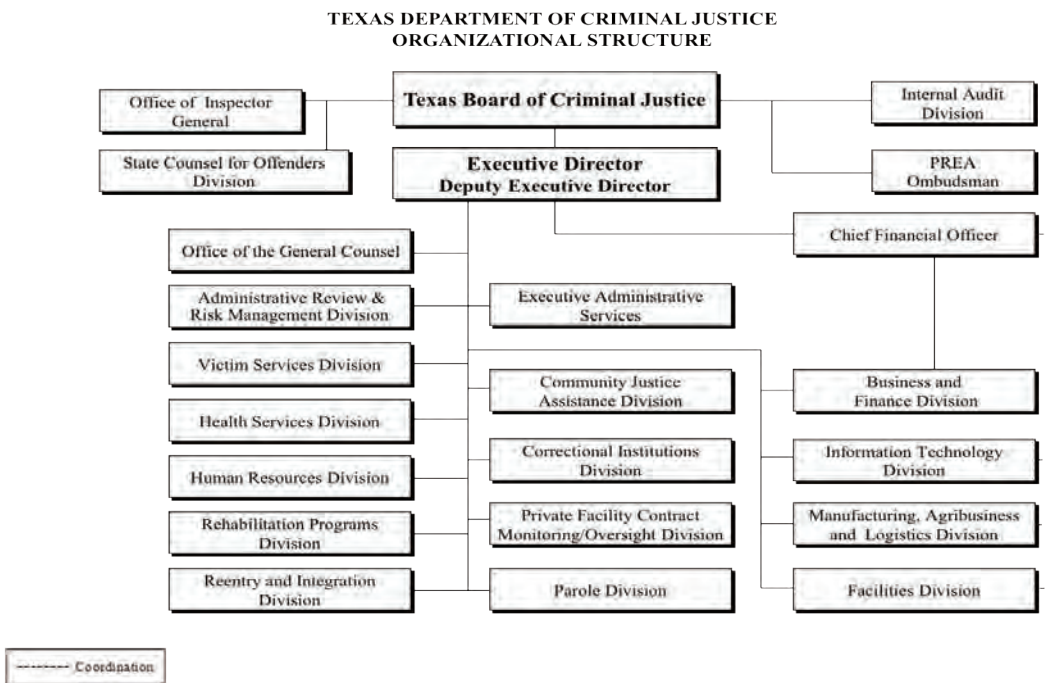
Fast Facts

- In a parallel to conversations about respectful language in mental health, growing numbers of people criticize terms like “inmate,” “prisoner,” “felon,” or “ex-con” that don’t make explicit the person behind the status. Terms like “justice-involved individual” or “person in prison” are increasingly common.¹
- Studies estimate that over half of all adults who are incarcerated in U.S. prisons and jails have at least one mental health condition.²
- Texas has the 7th highest imprisonment rate in the U.S. and African Americans in Texas are four times more likely than whites to be incarcerated.³
- On August 31, 2018, there were 145,078 individuals incarcerated in Texas prisons, which accounted for over 99 percent of TDCJ’s operating capacity.⁴
- In FY 2016, the average cost of incarcerating an individual in a state facility was \$61.63 per day. In contrast, individuals on parole cost was \$4.39 per day, and individuals on community supervision cost was \$3.42 per day.⁵
- The average daily cost for correctional health care is \$12.93;⁶ the average daily cost in a psychiatric correctional facility is \$160 per person.⁷
- On September 1, 2018, Texas county jails operated at 72.4 percent of their collective capacity with a total jail population of 68,493; about 87 percent had not been convicted of a crime and were awaiting trial.⁸
- In 2018, researchers estimated that people go to jail over 10.6 million times in the U.S. every year, though only about 615,000 people are jailed on any given day.⁹ If those proportions hold true for Texas, over one million people pass through Texas jails each year.
- In 2017, 42 percent of grievances submitted to the Texas Commission on Jail Standards by people in county jails involved complaints regarding medical services, including mental health services.¹⁰

TDCJ Acronyms

- ACLU – American Civil Liberties Union
- BAMBI – Baby and Mother Bonding Initiative
- CCQ – Continuity of care query
- CIT – Crisis intervention team
- CJD – Criminal Justice Division
- CMBHS – Clinical management for behavioral health services
- CTI – Critical time intervention
- CMHCC – Correctional Managed Health Care Committee
- CMI - Chronically Mentally Ill Program
- DDP – Developmental Disabilities Program
- DWI – Driving while intoxicated
- FACT – Forensic assertive community treatment
- HHSC – Health and Human Services Commission
- IDD – Intellectual and other developmental disabilities
- IPTC – In-Prison Therapeutic Community
- LBB – Legislative Budget Board
- LMHA – Local mental health authority
- MCOT – Mobile crisis outreach teams
- MHJDP – Mental health jail diversion pilot
- MHPD – Mental health public defender
- OCR – Outpatient competency restoration
- OMHM&L – Office of Mental Health Monitoring and Liaison
- PAMIO – Program for Aggressive Mentally-Ill Offender
- PREA – Prison Rape Elimination Act
- PRSAP – Pre-Release Substance Abuse Program
- PRTC – Pre-Release Therapeutic Community
- SAFPF – Substance Abuse Felony Punishment Facility
- SAMHSA – Substance Abuse and Mental Health Services Administration
- TCJS – Texas Commission on Jail Standards
- TCOLE – Texas Commission on Law Enforcement
- TCOOMMI – Texas Correctional Office on Offenders with Medical or Mental Impairments
- TDCJ – Texas Department of Criminal Justice
- TDHCA – Texas Department of Housing and Community Affairs
- TTUHSC – Texas Tech University Health Science Center

Organizational Chart

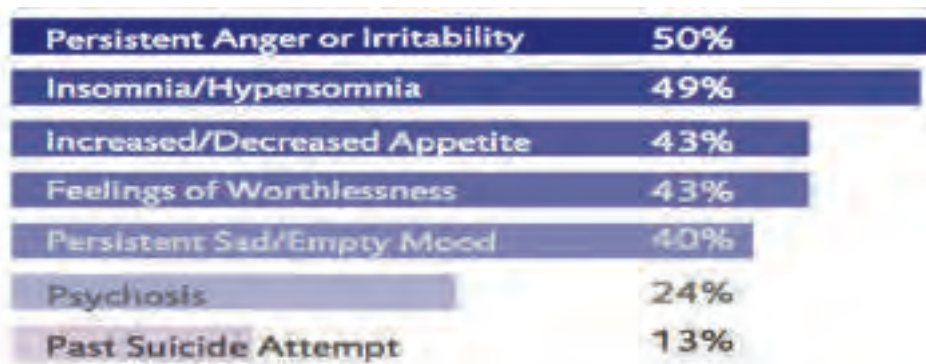


Source: Texas Department of Criminal Justice. (n.d.). *Organizational Charts: Texas Department of Criminal Justice*. Retrieved from http://tdcj.state.tx.us/org_chart/pdfs/org_chart_tdcj.pdf.

Overview - Criminal Justice and Behavioral Health

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 percent of incarcerated persons in the U.S. had a serious mental illness, such as schizophrenia or bipolar disorder.¹¹ Decades later, recent studies estimate that 14 percent of people in prisons and 26 percent of people in jails experienced serious psychological distress in the preceding 30 days (in contrast to 5 percent of the general population).¹² In 2015, about 30 percent of people in local Texas jails had at least one serious mental illness.¹³ The percentage of justice-involved individuals with less severe mental health issues, such as mild depression, is even greater; researchers estimate that over half of people incarcerated in U.S. prisons and jails have at least one mental health condition.¹⁴ Figure 58 demonstrates that a large proportion of individuals in jails across the country self-report at least one mental health symptom.

Figure 58. Percentage of Mental Health Symptoms Self-Reported by People in Jail



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>

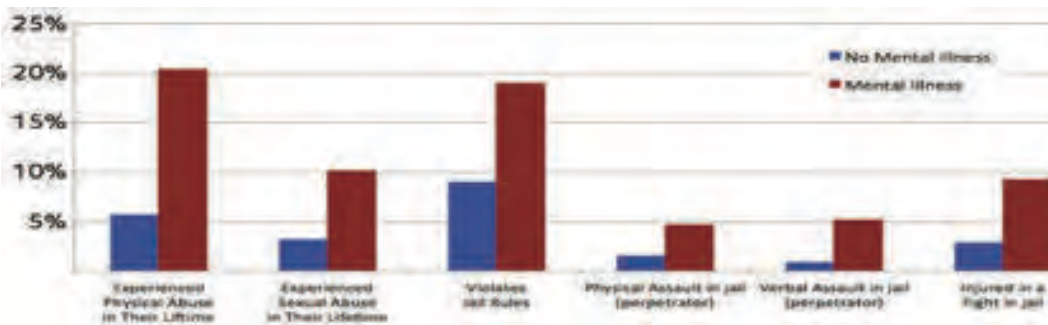
Despite the overrepresentation of people with mental illness in U.S. prisons and jails, research suggests that only 7 percent of these individuals enter the criminal justice system because of behavior linked directly to their mental illness.¹⁵ Instead, their alleged criminal behaviors are often tied to behavioral factors (such as hostility, disinhibition, or emotional reactivity)¹⁶ or to social factors (such as poverty and homelessness).¹⁷

The extent to which serious mental illness is connected to dangerous behavior is often misrepresented as research shows that this link is weak. In fact, people with mental illness only commit an estimated 4 percent of violent acts in the U.S.¹⁸ 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.¹⁹ The vast majority of people with a diagnosable serious mental illness never engage in any violent activities.²⁰ Statistical evidence shows that, in the absence of a substance use disorder, most mental illnesses are unrelated to acts of violence.²¹ 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.²²

Prior to their imprisonment, justice-involved persons with mental health conditions are more likely to have used drugs, experienced homelessness, or survived abuse,²³ and once incarcerated, 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 traumatic experiences like physical abuse, solitary confinement, and sexual victimization.²⁴ All of these experiences can exacerbate preexisting mental health diagnoses.²⁵ Figure 59 demonstrates some of the challenges that people with mental illness disproportionately face prior to and during their time in local jails. 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 59. Experiences of Individuals With and Without Mental Illness Prior to and During Their Jail Time



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), 102. Data derived from Bureau of Justice Statistics. (2006). *Mental Health Problems of Prison and Jail Inmates*. 4, 10. Retrieved from <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>

DISPROPORTIONALITY IN THE TEXAS CRIMINAL JUSTICE SYSTEM

In recent years, national attention has focused on remarkably high rates of incarceration in the U.S. – six to ten times greater than other industrialized nations.²⁶ Strikingly, the trends in incarceration rates are independent of changes in crime rates.²⁷ Much of the increase in incarceration – and much of the racial disparities in those incarcerated – are linked to behavioral health issues, particularly substance use.

The burden of imprisonment falls disproportionately on African Americans. A noted legal expert observed that the U.S. locks up a larger percentage of its black citizens than South Africa did during apartheid.²⁸ African Americans are sentenced to state prisons at a rate 5.1 times larger than whites.

These racial disparities are not rooted in racial differences in criminality. Much of the volume and complexion of incarceration in the U.S. is linked to the “War on Drugs” and sentences related to drug possession and sales.²⁹ Yet where research does identify differences in behavior is white youth are more likely to engage in drug-related crime.³⁰

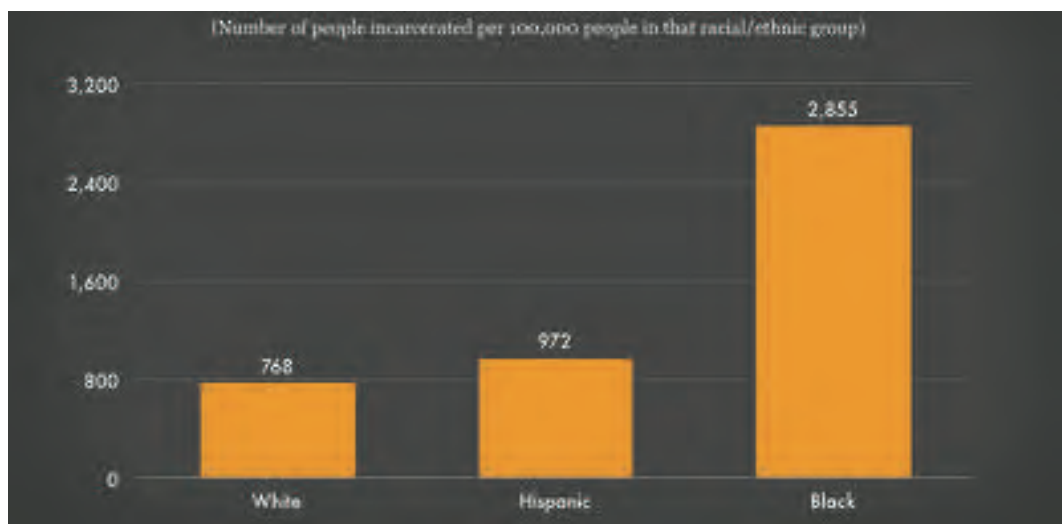
Research has identified three root causes for these racial disparities:³¹

- Policies and practices, e.g., federal drug sentencing laws mandating a minimum sentence of 5 years for distribution of 5 grams of crack or 500 grams of powder cocaine³²
- Implicit bias and stereotypes in decision making, e.g., disparities in court referrals to treatment versus prison³³
- Structural disadvantages in communities of color, such as higher rates of poverty, housing insecurity, and exposure to trauma (what some call the social determinants of legal engagement).³⁴

As with many issues, there is less available information about racial and ethnic disparities in county jail populations. There are significant disparities between white and black jail populations, but those disparities seem to be narrowing.³⁵

In Texas, the key racial disparities are between white and black incarceration rates. Based on U.S. Census data, African Americans comprised 12 percent of the population in 2010, but comprised 32 percent of the people incarcerated in Texas jails and prisons.³⁶ Figure 60 depicts incarceration rates by race and ethnicity.

Figure 60. Texas Incarceration Rates by Race/Ethnicity, 2010



Source: Prison Policy Initiative. (n.d.). *Racial and Ethnic Disparities in Prisons and Jails in Texas*. Retrieved from <https://www.prisonpolicy.org/profiles/TX.html>.

More recent data from 2014 focused specifically on prisons shows that after adjusting for proportions in the general population, African Americans Texans face a 4:1 imprisonment ratio compared to white Texans and Hispanic Texans have a 1.2:1 imprisonment ratio compared to white Texans.³⁷

In Harris County (Houston), stakeholders received a MacArthur Foundation Safety and Justice Challenge grant to reduce the high jail population and racial disparities in that population. Strategies under the grant include implementing a pretrial risk assessment tool to increase personal bonds granted, implementing a newly designed docket system to address the large volume of drug possession cases, and hiring a Racial Disparity and Fairness Administrator to promote training, community engagement, and data-driven decision-making.³⁸

SPECIAL CONCERNS FOR WOMEN

The United States incarcerates women at the highest rate in the world and Texas exceeds the U.S. rate by 34 percent.³⁹ The number of women in Texas prisons ballooned over 900 percent from 1980-2016 and continues to grow.⁴⁰ Women in correctional settings have distinct and possibly greater mental health needs than other people both inside and outside of correctional facilities. Women in jail and prison are:

- Ten times more likely to be dependent on drugs than women without experience in the justice system;⁴¹
- Seven times more likely to experience sexual abuse prior to their imprisonment than incarcerated males;⁴² and
- Four times more likely to experience physical abuse prior to their imprisonment than incarcerated males.⁴³

A recent survey of over 430 women in TDCJ custody reported that 55 percent of women had a mental health diagnosis, but only 27 percent were on a mental health caseload.⁴⁴ Furthermore, 70 percent of the women were identified as having a substance use disorder, but only 21 percent reported receiving substance use treatment inside TDCJ.⁴⁵

Research shows that women with histories of trauma and abuse require more specialized treatment than traditional, male-oriented models of care typically offer.⁴⁶ Few women have access to such programming. In 2010, TDCJ started the Baby and Mother Bonding Initiative 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.⁴⁷ In its first five years of operation, the program produced an 8 percent recidivism rate.⁴⁸ TDCJ estimates that about 250 babies are born to incarcerated women in Texas each year,⁴⁹ but the program can only serve 20 women at a time.⁵⁰ Typically, new mothers visit with their newborn for less than two weeks, potentially increasing the possibility of postpartum depression.⁵¹

Less information is available about pregnant women in the county jail system. TCJS collects data on the number of pregnant women booked into Texas county jails each

month; in September 2018, the total was 414.⁵² But data collection and reporting are inconsistent at the county level, limiting an understanding of women’s health experiences in county jail.⁵³

Changing Environment

For over a decade, Texas has been on the forefront of criminal justice reform across the U.S. In 2007, the 80th Texas Legislature altered the trajectory of criminal justice policy by prioritizing diversion from incarceration over the construction of new prisons. In the 85th session, legislators passed a budget that required TDCJ to close four prisons by September 1, 2017, contributing to a total of eight facility closures. In addition to mandating the four closings, lawmakers passed significant legislation to improve jail processes and created matching grants to increase diversion and reduce recidivism. Despite the prison closures, Texas still has the 7th highest imprisonment rate in the U.S., with African-Americans in Texas four times more likely than whites to be incarcerated.⁵⁴

MAJOR LEGISLATION FROM THE 85TH TEXAS LEGISLATURE

The major legislation and budget riders related to mental health and adult criminal justice passed in 2017 are explained below. Legislation is described in the order by which an individual with mental health conditions may encounter the state and local criminal justice system. Information in this section is not a comprehensive account of the mental health and criminal justice-related legislation passed during the 85th legislative session.

SB 292: Mental Health Grant Program for Justice-Involved Individuals

Legislators created three significant behavioral health-related matching grant programs to fund community programs or collaboratives.⁵⁵ One of these, contained in SB 292 (Huffman/Price), focused specifically on justice-involved individuals and aimed to reduce recidivism, arrests, incarceration, and forensic bed wait times for people with mental health conditions. HHSC Rider 206 allocated \$12.5 million in FY 2018 and \$25 million in FY 2019 for this grant program. Local collaboratives must match any state grant dollars, 100 percent for counties with a population of 250,000 or more or 50 percent for smaller counties with a population less than 250,000.⁵⁶ In January 2018, HHSC announced awards to 14 organizations across the state for the first phase of these grants.⁵⁷

SB 1849: Jail Diversion and Safety [the Sandra Bland Act]

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 the Waller County jail where Bland could not afford to post bail. Three days later, Bland was found dead in her cell by apparent suicide.⁵⁸ The controversy highlighted the risks that

aggressive arrest procedures and money bail practices pose, particularly 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, various interim processes focused on jail safety, law enforcement and correctional officer safety, and the disproportionate incarceration of people with mental illness. These efforts culminated in SB 1849 (Coleman/Whitmire), known as the Sandra Bland Act. The bill's broad scope focuses on safety and other needs of individuals suspected of having a mental health condition who are interacting with the criminal justice system. Key components include:⁵⁹

- Quicker notification of the magistrate (within 12 hours rather than 72 hours) when a detained person is suspected of having a mental illness or IDD;
- Diversion for non-violent misdemeanors when the root of the behavior appears to be a mental health crisis or substance use;
- Funding to create or expand Healthy Community Collaboratives providing services to address homelessness, substance use, or mental health; HHSC Rider 46 allocated \$25 million for these matching grants and set aside \$10 million for rural counties;
- Presumption of release on personal bond for individuals after an expert assessment indicates the person is competent but has mental illness or IDD needing treatment;
- Jail safety provisions including 24-hour access to a mental health professional through telehealth and automatic sensors or cameras to ensure checks of individuals who are at risk of harming themselves;
- Rapid medical review of all prescriptions when individuals come into custody and rules that ensure continuity of prescription medication;
- Monthly reporting of serious incidents including suicide and attempted suicide;
- Independent investigation of all deaths in custody; and
- Development of a Texas Commission on Law Enforcement-approved exam for county jail administrators other than a sheriff, an 8-hour mental health training for jailors, and a new law enforcement officer requirement for training on de-escalation techniques to use with members of the public (not just people with mental health conditions).

SB 1326: Procedures for Individuals with Mental Illness or Intellectual and other Developmental Disabilities (IDD)

Too often people with mental illness or IDD confront procedural barriers or delays that extend their time engaged with the criminal justice system. SB 1326 (Zaffirini/Price) aimed to address some of these procedural problems. Like the Sandra Bland Act, the legislation reduced the time to notify magistrates when a sheriff arrested a person suspected of having a mental illness or IDD. SB 1326 created a mechanism for magistrates to release certain individuals on bond while requiring them to submit to treatment as a condition of bond, authorized counties to create jail-based competency restoration programs, and clarified procedures related to jail and outpatient competency restoration programs. To inform policy related to specialty courts, it requires the Office of Court Administration to collect outcomes data and produce a report by December 1, 2018.

HB 337: Suspension of Medicaid Benefits While in Jail

Even brief periods in jail can cause significant life challenges, jeopardizing employment, housing, and benefits. HB 337 (Collier/Menendez) created a mechanism to allow a person’s Medicaid benefits to be suspended rather than terminated during time in jail. The legislation allows the Medicaid benefits to be reinstated within 48 hours of a person’s release.

SB 613: Competence to Participate in Sex Offender Treatment

Like many states, Texas civilly commits individuals identified as “sexually violent predators” after they have completed their full criminal sentences. These individuals are subject to treatment and supervision until their “behavioral abnormality has changed to the extent that the person is no longer likely to engage in a predatory act of sexual violence.”⁶⁰ Many of these people are unable to participate in treatment because of the severity of their mental illness.⁶¹ Under this bill, HHSC must provide inpatient mental health services to make participation in sex offender treatment possible.

RELEVANT BUDGET RIDERS

Legislators also addressed criminal justice and mental health-related issues through riders to the budget (HB 1, Nelson/Zerwas). These budget riders do not provide new funding; they are legislative directives instructing agencies how to spend certain appropriated funds. Relevant riders are listed below.

HHSC (Article II):

- **Rider 42** requires HHSC and community centers to identify offenders with mental illness, collect and report prevalence data, and disclose information to TCOOMMI as needed for continuity of care.
- **Rider 47** allocates up to \$1 million to fund a reentry peer support program that uses certified peer support specialists to help people with mental health conditions released from county jails transition into community-based care.
- **Rider 48** requires HHSC to report waiting lists and expenditure data for community mental health services for adults, community mental health services for children, forensic state hospital beds, and maximum-security forensic state hospital beds quarterly to the LBB and the Governor.

Court of Criminal Appeals (Article IV):

- **Rider 3** allocates \$262,000 for the biennium to provide judicial training on indigent defendants and mental health.
- **Rider 6** clarifies that appropriated funds may be used to educate judges, prosecutors, and defense attorneys on alternatives to inpatient forensic commitments, including outpatient competency restoration and jail-based competency restoration.
- **Rider 7** dedicates \$375,000 for the biennium for judicial education on mental health issues and pre-trial diversion.

Department of Criminal Justice (Article V):

- **Rider 39** allocates \$1 million for the biennium for a 90-day post-release supply of medication for defendants leaving state hospitals after being restored to competency.
- **Rider 63** allocates \$743,000 for the biennium for a 30-day supply of medication for people leaving TDCJ facilities, with emphasis placed on mental health issues and medical issues impacted by a lapse in medication.

Overview - 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. On August 1, 2018, about 87 percent of people held in Texas county jails had not been convicted of a crime and were awaiting trial.⁶² While county sheriffs manage local jails, the Texas Commission on Jail Standards acts as the external regulatory agency for all 241 county jails, including 13 privately-operated county jails.⁶³ By setting jail standards and inspecting county jail facilities, TCJS is tasked with assisting 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; municipal jails in Texas are not regulated by any external agencies.⁶⁴

In contrast, state-operated facilities, such as state jails and prisons, hold individuals who have been convicted of an offense. TDCJ operates these facilities and oversees contracts with private correctional agencies. Unlike county jails and juvenile facilities, Texas prisons and state jails are not monitored by an external state agency; in recent years, advocacy groups have argued the need for effective, independent oversight.⁶⁵ Table 45 contains a glossary of terms typically used in the criminal justice system.

Table 45. 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	A facility operated by a county or city or private contractor and designed to house individuals awaiting trial or serving short-term sentences for misdemeanor convictions.
State jails	A facility operated by TDCJ or private contractor and designed to house individuals convicted of felonies with punishments ranging from 180 days to two years.

Term	Definition
State prisons	A facility operated by TDCJ or private contractor and 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.). *Questions?* Retrieved from <https://cscd.harriscountytexas.gov/Pages/FAQs.aspx>

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

THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE

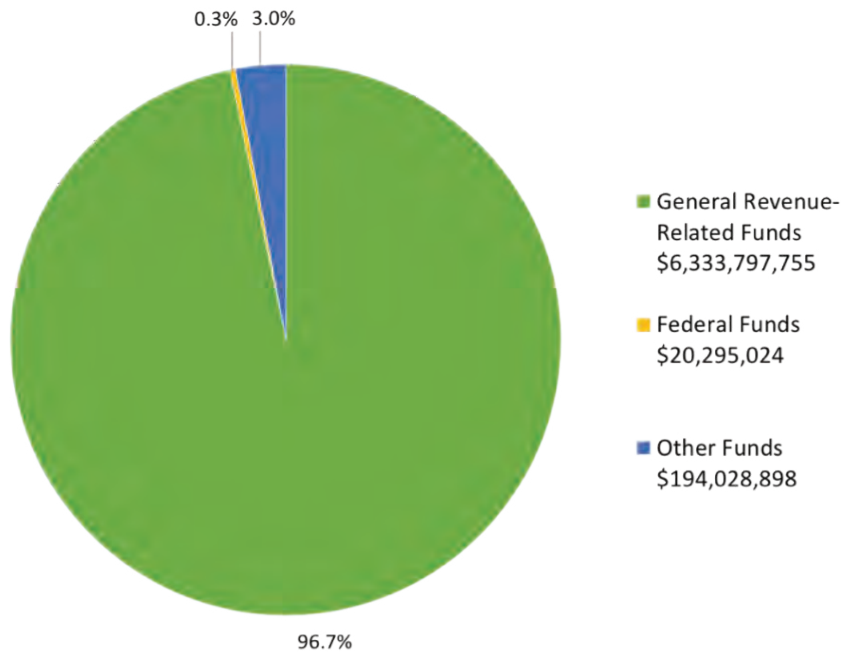
TDCJ's mission is to “provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime.”⁶⁶ The Department manages people who are convicted of criminal offenses and confined in state prisons, state jails, and private correctional facilities or in the community on parole.⁶⁷ TDCJ is responsible for providing health services, including mental health and substance use services, to people who are convicted and sentenced to state jails, state prisons, and private correctional facilities that contract with TDCJ. The Correctional Managed Health Care Committee must develop statewide policies regarding correctional health care services and coordinate the delivery of those services to persons in the TDCJ system. The committee is made up of nine voting members, including a TDCJ representative, medical doctors, and mental health professionals, as well as one non-voting member who is appointed by the Texas Medicaid director.⁶⁸

COST AND FUNDING SUMMARY

On August 31, 2018, there were 145,078 individuals incarcerated in Texas prisons, which accounted for over 99 percent of TDCJ's operating capacity.⁶⁹ The average cost of incarcerating an individual in a state facility was \$61.63 per day in 2016.⁷⁰ In contrast, individuals on parole cost was \$4.39 per day, and individuals on community supervision cost \$3.42 per day.⁷¹

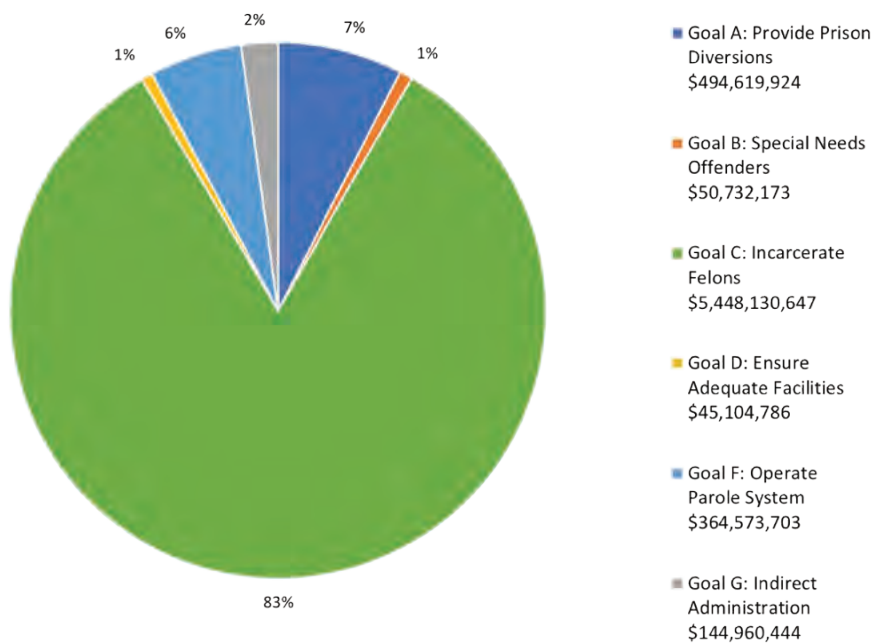
The TDCJ budget for FY 2018-19 was \$6,548,121,677, with over 96 percent of the funding coming from general revenue-related funds.⁷²

Figure 61. TDCJ FY 2018-19 Budget by Method



Source: Legislative Budget Board. (2018). *Texas Department of Criminal Justice Fiscal Years 2020-2021, Legislative Appropriations Request*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=696&fy=2020>

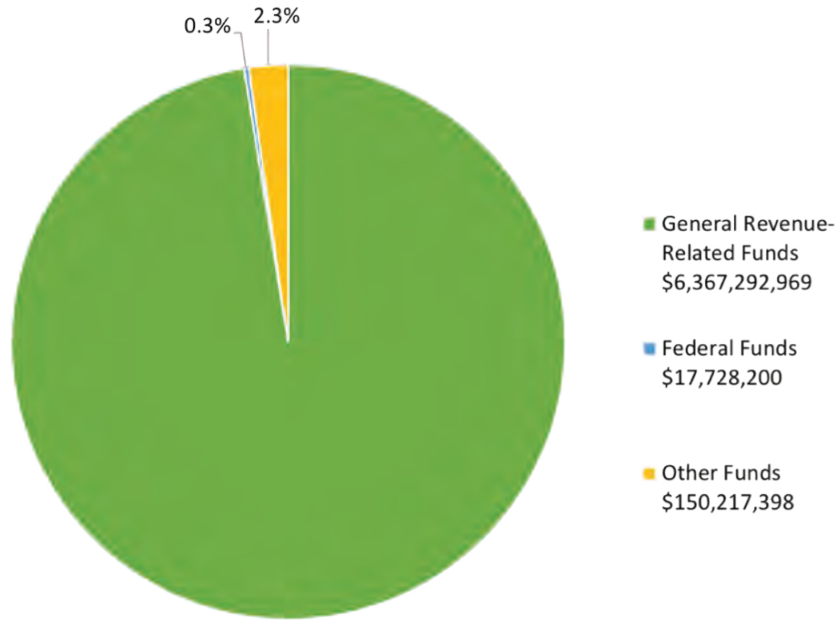
Figure 62. TDCJ FY 2018-19 Budget by Agency Goal



Source: Legislative Budget Board. (2018). *Texas Department of Criminal Justice Fiscal Years 2020-2021, Legislative Appropriations Request*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=696&fy=2020>

The total requested TDCJ budget for FY 2020-21 is \$6,535,238,567. If included in the budget, the Exceptional Items Requests would add an additional \$725,700,000.

Figure 63. TDCJ FY 2020-21 Requested Budget by Agency Method



Source: Legislative Budget Board. (2018). *Texas Department of Criminal Justice Fiscal Years 2020-2021, Legislative Appropriations Request*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=696&fy=2020>

TDCJ FACILITIES AND HOUSING ISSUES

TDCJ has a number of facilities located throughout the state, with headquarters in both Austin and Huntsville. Table 46 below depicts TDCJ's population distribution by type of facility.

Table 46. Facility Types and Populations in August 2018

Type of Facility	Number of Units	Population
Prison	50	92,220
Pre-Release	4	3,637
Psychiatric / Developmental Disabilities	4	2,667
Geriatric	1	509
Medical	2	644
Private Multi-Use	1	497
Private Prisons	7	4,029
Private State Jail	3	4,251
Transfer	12	14,568
State Jail	14	17,642
Substance Abuse Felony Punishment	4	n.a.

Sources: Texas Department of Criminal Justice. (n.d.). Unit Directory. Retrieved from http://www.tdcj.texas.gov/unit_directory/index.html. Texas Tribune. (2018, August). Prison Units. Retrieved from <https://www.texastribune.org/library/data/texas-prisons/units/>.

While all states have prisons, Texas has an unusual “state jail” category. The state jail felony system was created in 1993 by legislators seeking to address prison overcrowding by creating an alternative for people convicted of low-level, non-violent offenses.⁷³ State jails were intended to provide a brief term of confinement as a part of community corrections, with rehabilitation a key motivation of the system. TDCJ was mandated to create work, rehabilitation, education, and recreational programming on a 90-day cycle, which was the intended maximum normal term for those committed to state jail.⁷⁴ Yet the framework was dependent on courts’ commitment to keep people convicted of state jail felonies on the docket for the entirety of their sentence, so that judges could continue to supervise defendants upon release back to the community. Judges widely rejected this model and preferred to sentence defendants to determinate sentences in state jails with no post-release supervision. Moreover, the legislature never funded programming inside state jail, ensuring that people released from state jail would return to the community having accessed little rehabilitative programming. Therefore, people released from state jails have worse recidivism rates than those released from prison.⁷⁵ In FY 2016, only 87 of the 19,985 people leaving state jail were under community supervision (0.4%), and 3-year rearrest, reconviction, and readjudication rates were between 35–53 percent higher for people leaving state jails compared to prison.^{76,77}

While “state jail” is a placement category, there are no separate facilities for state jails. In 2003, TDCJ’s State Jail Division merged into the Correctional Institutions Division. The facilities are considered “transfer facilities.” People convicted of state jail felonies are in a separate dormitory, but the transfer facilities also house people convicted of more serious felonies who are in “transfer” status for up to two years waiting for a bed in a state prison unit.⁷⁸

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

SOLITARY CONFINEMENT

Incarceration in any jail or prison can have a serious impact on an individual’s mental health. People confined in isolation are at even greater risk for lifelong impacts on their mental health and well-being. 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 die by suicide.⁷⁹ In a 2015 study, the ACLU of Texas and the Texas Civil Rights Project reported that TDCJ holds 4.4 percent of its incarcerated population in solitary confinement – a proportion that is four times greater than the national average.⁸⁰ People with mental health conditions are overrepresented in the population of people in solitary confinement. In 2014, about 30 percent of TDCJ’s isolated population was identified as having some form of mental illness treatable by outpatient care.⁸¹

Historically TDCJ utilized two types of solitary confinement for varying lengths of time. First, correctional officers used short-term disciplinary segregation for punitive purposes. This option was eliminated in September of 2017; the ban required a change in placement for 76 people.⁸² Second, TDCJ used administrative segregation to house people for an indefinite period of time when they are considered dangerous to

themselves or others, holding individuals in a small, isolated cell for about 22 hours per day.⁸³ Administrative segregation is still common within TDCJ. In September 2017, roughly 4,000 people were in administrative segregation.⁸⁴ On average, TDCJ inmates remain in isolation for almost four years, but in 2015, ten individuals in TDCJ custody reached 30 consecutive years in administrative segregation.^{85,86} 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.⁸⁷

Despite these adverse mental health outcomes, until recently individuals were frequently 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 administrative segregation, which causes TDCJ to release them directly from the most restrictive prison environment (i.e., isolation) to the streets without any supervision or support. Research shows that flat release is linked to higher recidivism rates, which places both formerly incarcerated individuals and their fellow community members at risk.⁸⁸ By the end of 2016, TDCJ no longer released people directly from administrative segregation.⁸⁹ Instead the agency now requires individuals housed in administrative segregation to complete a pre-release program, most commonly the 120-day Corrective Intervention Pre-Release Program. This program is grounded in motivational interviewing, cognitive change programming, and reentry planning.⁹⁰

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 2013 survey by the Bureau of Justice Statistics ranked the U.S. prisons with the highest sexual assault complaints reported by people confined in prisons; 25 percent of those prisons were located in Texas (an improvement over the 2008 survey in which Texas was home to 50 percent of those prisons).^{91,92} People with mental illness are at much higher risk of sexual assault. The 2013 survey showed that 6.3 percent of people in prison identified with “serious psychological distress” reported sexual victimization by another person under confinement, in contrast to reported victimization by 0.6% of people without a mental health condition.⁹³

The Prison Rape Elimination Act, a federal law passed in 2003, intended 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.”⁹⁴

The Texas PREA Ombudsman is responsible for ensuring that TDCJ follows federal regulations created to eliminate sexual assaults in prison facilities. In 2016, the PREA Ombudsman Office reviewed 615 allegations of inmate-on-inmate sexual abuse reported by TDCJ.⁹⁵ Over 43 percent of the incidents met the elements of the Texas Penal Code for Sexual Assault or Aggravated Sexual Assault; the rest were categorized as Abusive Sexual Contact.⁹⁶ The PREA Ombudsman Office also received 952 allegations of staff-on-inmate sexual abuse and harassment.⁹⁷ Of the 669 allegations determined to be sexual abuse, 13 percent of these incidents were identified by the

Office of the Inspector General as Sexual Assault or Aggravated Sexual Assault under the Texas Penal Code.⁹⁸

Jails are also required to comply with PREA requirements, with oversight provided by the Texas Commission on Jail Standards as part of its general oversight duties.⁹⁹

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 responsible for meeting the physical and behavioral health needs of people confined in prisons. Table 47 provides a brief description of each office or agency.

Table 47. Health-Related Divisions within TDCJ

Entity	Description
Health Services Division	The division must ensure that people in TDCJ custody have access to health care services; employees also monitor the quality of those services. The division investigates grievances from people in TDCJ custody or their family members, conducts service audits, and collaborates with health care contractors and the CMHCC. ¹⁰⁰
Office of Mental Health Services Liaison and Utilization Review	Within the Health Services Division, the OMHL&UR assists in screening people with mental illness for participation in programs supporting integration into the general prison population. ¹⁰¹
Office of Mental Health Monitoring and Liaison	Within the Health Services Division, the OMHM&L monitors TDCJ's mental health services and provides expert guidance to other TDCJ offices on mental health-related issues. ¹⁰²
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. ¹⁰³
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. ¹⁰⁴
Texas Correctional Office on Offenders with Medical or Mental Impairments	Comprised of representatives from multiple state agencies and nonprofit organizations, TCOOMMI provides a formal structure for criminal justice, health and human services, and other affected agencies to coordinate on legislative, policy, and programmatic issues affecting incarcerated individuals with special needs. ¹⁰⁵ Among other duties, TCOOMMI case managers work as liaisons between correctional staff and service providers at LMHAs to improve continuity of care, provide case management services, and facilitate adherence to treatment plans.
Correctional Managed Health Care Committee	CMHCC is the oversight and coordination authority charged with developing a managed health care plan (called the Offender Health Services Plan) for all people confined by TDCJ. The committee manages a partnership arrangement between TDCJ's Health Services Division, the University of Texas Medical Branch at Galveston, and Texas Tech University Health Sciences Center. TTUHSC is responsible for providing medical services (including mental health care) in the western part of the state where TDCJ incarcerates 22% of its population; UTMB is responsible for the same services in the eastern half of Texas where TDCJ incarcerates 78% of its population. ¹⁰⁶ 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 people in their custody with adequate health care services and that denial of such services constitutes cruel and unusual punishment.¹⁰⁷ 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 percent of men and 75 percent of women in prisons across the U.S. experience a mental health problem that requires behavioral or mental health services each year.¹⁰⁸

To meet an individual’s behavioral health needs, TDCJ operates a managed health care plan rather than a fee-for-service plan. Managed care plans receive a set amount of funding per beneficiary, whereas fee-for-service plans are paid for each service that is utilized. Managed care plans are intended to ensure that beneficiaries have better health outcomes and quality of care while remaining fiscally conscious. “Unit and Psychiatric Care” expenses constitute the majority of health care costs.¹⁰⁹ The Correctional Managed Health Care Committee has noted the growth in need for correctional mental health services and the possibility of considering another inpatient psychiatric facility.¹¹⁰ The average daily cost for correctional health care is \$12.93,¹¹¹ while the average daily cost in a psychiatric correctional facility is \$160 per person.¹¹²

Access to Services

The Offender Health Services Plan developed by the Correctional Managed Health Care Committee 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 Table 48 below.¹¹³

Table 48. 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 life threatening, but without which the patient could not be maintained without significant risk of serious deterioration, or where there is a significant reduction in the possibility of repair later without treatment.	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 health conditions during the intake process or upon referrals from security staff who receive mental health-related training.¹¹⁴

Individuals initiating a visit to a correctional health care provider must pay an Annual Health Care Services Fee of \$100.¹¹⁵ People who are indigent will receive health care but will be charged the fee if funds become available at a later date.¹¹⁶

Mental Health Services

Qualified mental health providers may recommend the following mental health diagnostic and treatment services for people in TDCJ custody with behavioral health needs¹¹⁷:

- Emergency mental health crisis services (available 24 hours a day, seven days per week);
- Professional medical services such as medication management and monitoring;
- Continuity of care services;
- Psychosocial services including talk therapy;
- Crisis management/suicide prevention;
- Inpatient services provided by a correctional health care approved facility, including diagnostic evaluation, acute care, transitional care, and extended care; and
- Outpatient services;
- Specialized programs (see Table 49 for a description of these programs)

Table 49. Specialized Programs for Individuals with Mental Illness or a Developmental Disability

Level of Service	Description
Program for the Aggressive Mentally-Ill Offender ¹¹⁸	This voluntary treatment program within TDCJ for men with mental health needs and a history of aggressive behavior is designed to prepare them for less restrictive housing. At the time of admission, the person must be in administrative segregation, G4 or G5 custody status,* or at risk of increasing custody classification, and must have at least 18 months of his sentence left in order to complete the program.
Developmental Disabilities Program ¹¹⁹	Incarcerated individuals suspected of having an intellectual disability or borderline intellectual functioning diagnosis and individuals whose adaptive functioning is judged significantly impaired may be referred to a DDP facility for further evaluation and services.
Chronic Mentally Ill Program ¹²⁰	The CMI program enrolls participants in one of two separate treatment tracks. The <i>inpatient treatment track</i> (CMI-TP) serves people with mental illness in administrative segregation or those with a G5 security status who require close monitoring and medication management. The <i>outpatient sheltered housing track</i> (CMI-SH) engages individuals who refuse treatment and who do not meet criteria for inpatient psychiatric commitment.

Source: Correctional Managed Health Care Committee. (September 2015). *Correctional Managed Health Care Policy Manual*. Retrieved from http://tdcj.state.tx.us/divisions/cmhc/docs/cmhc_policy_manual/A-08.03.pdf.

*Note: TDCJ classifies individuals housed in state prisons into six custody levels.¹²¹ 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.

Substance Use Treatment Services

Within TDCJ, 70 percent of women and 58 percent of men have been identified as having a substance use disorder.¹²² TDCJ also manages a number of programs within its Rehabilitation Programs Division to serve people with substance use conditions. Table 50 below describes these programs.

Table 50. Substance Use Service Descriptions

Program	Description
Substance Abuse Felony Punishment Facility and In-Prison Therapeutic Community	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 and Pre-Release Therapeutic Community	PRSAP and PRTC are intensive six-month programs intended for individuals who are incarcerated with serious substance use conditions, chemical dependency, or "criminal ideology issues." The Board of Pardons and Parole votes to place inmates in these programs prior to their release into the community. The PRTC involves collaboration between the Rehabilitative Programs Division, the Windham School District, and the Parole Division.
State Jail Substance Abuse Program	Eligible people in state jail are placed in either a 60- to 90-day program or a 90- to 120-day program based on an Addiction Severity Instrument assessment and their criminal history. Participants are provided rehabilitation, counseling, and related services designed to meet their unique needs.
Driving While Intoxicated In-Prison Program	The six-month program uses an aftercare component and a variety of education and treatment activities to reduce the risk of recidivism among people incarcerated for a DWI offense. Participants engage in evidence-based practices that focus on substance use disorders, victim awareness, and cognitive therapies. ¹²³

Source: Texas Department of Criminal Justice. (n.d.). *Rehabilitation Programs Division*. Retrieved from http://www.tdcj.texas.gov/divisions/rpd/substance_abuse.html.

Post-Incarceration Community-Based Services

Recidivism is a key concern for all people returning to the community after a period of incarceration. In the three years after leaving TDCJ custody, re-arrest rates range from 46 percent (prison) to 63 percent (state jail) and reincarcerations rates are 21 percent (prison) and 32 percent (state jail).¹²⁴ TDCJ operates a number of programs aimed at supporting more successful re-entry into the community and reducing recidivism rates.

As part of TDCJ's Reentry and Integration Division, TCOOMMI provides a variety of institutional and community-based services to facilitate the reentry of people with special needs from incarceration into the community. Individuals with special needs include older adults and persons with physical disabilities, terminal illness, mental illness, and/or intellectual disabilities.¹²⁵ TCOOMMI partners with LMHAs to provide three types of reentry services for people with mental illness: continuity of care, case management, and medically recommended intensive supervision.¹²⁶ Continuity of care programs are designed to include pre-release screenings of clients who are incarcerated and provide referrals for aftercare psychiatric treatment services, which are typically delivered by LMHAs. In recent years, TCOOMMI has expanded eligibility to include all people with serious and persistent mental illness. In FY 2016, TCOOMMI provided continuity of care services to 35,305 individuals.¹²⁷ Upon their release from incarceration, TCOOMMI refers clients to LMHAs for services, such as case management, psychological and psychiatric services, medication and monitoring, and benefit eligibility services (including federal entitlement application processing). For example, in FY 2017, TCOOMMI worked with LMHAs to provide 26,367 justice-involved individuals with community-based behavioral health services.¹²⁸

Case management services can be instrumental in reducing recidivism. Linking formerly incarcerated individuals to community services and supports 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.¹²⁹ In 2015, the three-year recidivism rate was 12.4 percent 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 percent.¹³⁰ In FY 2017, TCOOMMI provided case management services to 7,507 individuals.¹³¹

Medically Recommended Intensive Supervision is an early parole and release program serving people in TDCJ facilities who have 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 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 FY 2016, 86 people in prison and 9 people in state jail were approved for MRIS release.¹³²

Specialized Programs for People on Parole

TCOOMMI provides services to only a portion of individuals with mental health conditions leaving TDCJ custody. TDCJ's Parole Division operates specialized programs designed for some individuals with mental health and substance use issues who are released from incarceration. Table 51 below provides an overview of the most relevant programs:

Table 51. Specialized Programs within TDCJ's Parole Division

Name	Description	Monthly Average Number of Individuals in Supervision Program in FY 2017
District Reentry Centers	Focuses on newly-released, high-risk, and high-need individuals using a comprehensive approach to promote personal responsibility and address anger management, cognitive restructuring, substance use, and victim empathy.	1,062 individuals
Special Needs Offender Program	Supervises individuals with intellectual disabilities, mental health conditions, terminal illnesses, or physical disabilities.	99 individuals with intellectual development disorders 6,169 individuals with mental health conditions 878 individuals with terminal illnesses or physical disabilities 177 individuals on medically recommended intensive supervision
Therapeutic Community Program	Offers continuity of care services for individuals within TDCJ facilities with substance use issues. Consists of a three-phase program for individuals who participated in an in-prison therapeutic community or a SAFPF.	7,130 individuals
Substance Abuse Counseling Program	Provides relapse prevention services to individuals with substance use treatment needs.	21,088 individuals received Level I prevention services in FY 2017 [no monthly average given] 1,289 individuals received Level II outpatient treatment services
Drug Testing Program	Provides instant-read drug testing.	174,857 drug tests conducted monthly

Source: Texas Department of Criminal Justice. (n.d.). *Annual Review 2017*. Page 30. Retrieved from http://www.tdcj.state.tx.us/documents/Annual_Review_2017.pdf.

LOCAL CRIMINAL JUSTICE SYSTEMS

Local criminal justice systems consist of law enforcement agencies, prosecutors, jails, courts, and probation departments 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.

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, LMHAs provide community-based interventions that can prevent criminal justice involvement. TCOOMMI within TDCJ also collaborates with some of the 39 LMHAs to provide multi-service alternatives to incarceration for justice-involved individuals with special needs. For more information, see the “Texas Correctional Office on Offenders with Medical or Mental Impairments

(TCOOMMI)” section of this chapter.

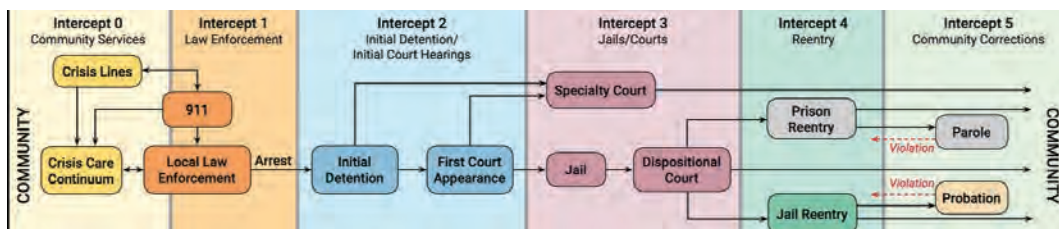
Finally, TDCJ awards grant funding to county stakeholders in order to pursue the first goal outlined in its 2017-21 strategic plan: “to provide diversions to traditional incarceration.”¹³³ The aim of these prevention and diversion programs is to use cost-effective, safe, and clinically appropriate strategies that curb the over-incarceration of people with mental illness (among others) charged with low-level crimes.

SEQUENTIAL INTERCEPT MODEL

The Substance Abuse and Mental Health Services Administration promotes the sequential intercept model as a way to organize prison and jail diversion strategies.¹³⁴ The sequential intercept model, developed in conjunction with the GAINS Center, emphasized five “intercept points” at which individuals may be diverted from the justice system. More recently, after feedback from communities including some in Texas, the GAINS Center added an Intercept 0.¹³⁵ The intercept points illustrated in Figure 64 include:

- **Intercept 0:** Community services;
- **Intercept 1:** Law enforcement and emergency services;
- **Intercept 2:** Initial detention and court hearings;
- **Intercept 3:** Jails and courts;
- **Intercept 4:** Reentry into the community; and
- **Intercept 5:** Community corrections and support services.

Figure 64. The Sequential Intercept Model



Source: Policy Research Associates. (2017, August). *The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders*. Retrieved from <https://www.prainc.com/wp-content/uploads/2017/08/SIM-Brochure-Redesign0824.pdf>.

Table 52 below describes specific diversion strategies that can be implemented at each step of the sequential intercept model.

Table 52. Examples of Diversion Strategies at Sequential Intercept Points

Intercept	Examples of Diversion Strategies
Intercept 0: Community services	Mobile crisis outreach teams staffed by mental health professionals who can provide on-site assistance to people with mental illness before or as they interact with police officers and paramedics. Crisis peer respite centers to provide intensive support for people experiencing challenges that create a risk of mental health crisis but no safety risk.
Intercept 1: Law enforcement and emergency services	Specialty mental health deputies and crisis intervention teams staffed by local police officers who can identify and divert individuals experiencing mental crises. Individualized analysis and response to frequent callers of 911 with mental health challenges.
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 programs for individuals who do not pose a threat to public safety.
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 health conditions, and successful recovery.
Intercept 5: Community corrections and support services	Forensic assertive community treatment teams that work with probation departments to prevent supervision revocation. Modifications of community supervision requirements to better match the needs of people with mental illness.

Source: Frost, L. (2016, January 22). Mental Health Diversion from Jail. *University of Houston Law Center Police, Jails, and Vulnerable People Symposium*. [Updated by the author on September 22, 2018 to include Intercept 0.] 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 health conditions who commit minor offenses are linked to community-based, recovery-oriented services, supports, and treatment as soon as possible. Jail diversion efforts can then improve mental health outcomes, save money, and increase public safety.¹³⁶

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.¹³⁷ 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.¹³⁸

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.¹³⁹ The program employs both pre- and post-booking diversion methods.¹⁴⁰ First, Bexar County uses a 24/7 crisis center to provide county residents with immediate intervention when they are experiencing a mental health crisis. Then, MCOTs and CITs work to divert individuals with mental health conditions away from jail settings before they are arrested and booked in a local jail. After booking, the diversion program identifies people with mental illness already in the system and recommends appropriate alternatives to jail, such as court-supervised community treatments or mental health bonds. The county created two centers: The Restoration Center for integrated substance use and mental health services and The Crisis Care Center for 24-hour psychiatric emergency care.¹⁴¹ 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.¹⁴²

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 2015, the county was decommissioning a privately-operated detention center in order to better use 1,000 empty beds at the Bexar County Jail.¹⁴³ The program diverts about 26,000 people a year, saving an estimated \$10 million annually in jail and emergency department costs.¹⁴⁴ 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.¹⁴⁵

Harris County Mental Health Jail Diversion Program

In recent years, Harris County, home to the fourth largest jail in the nation,¹⁴⁶ has adopted a significant jail diversion program. In 2013, state legislators passed SB 1185 (83rd, Huffman/Schwertner) to create the Harris County Mental Health Jail Diversion Pilot program. The ongoing goal of the program is to promote and sustain recovery for justice-involved individuals with mental health conditions by expanding services in the areas of housing, education, supportive employment, and peer advocacy.¹⁴⁷ Between 2014 and 2019, the state appropriated \$5 million each year, matched by \$5 million from the county, to support the pilot.¹⁴⁸

In the first few years, the Harris County MHJDP program used two local providers to safely divert people with mental illness away from the criminal justice system. First, the Harris Center for Mental Health and IDD (formerly MHMR of Houston) used a jail-based team, a community- and clinic-based team, and critical time intervention case management services; together, these strategies identified people in jail with mental illness, initiated pre-release treatments, and linked participants to established

community support networks. Second, Healthcare for the Homeless-Houston and SEARCH Homeless Services enrolled eligible participants in a Permanent Supportive Housing program. For more on PSH, see the TDHCA chapter of this guide. More recently, the Harris Center has served as the lead agency and the newly-opened Judge Ed Emmett Mental Health Diversion Center provides a 29-bed resource for pre-jail diversion of people accused of low-level non-violent offenses.¹⁴⁹ People can spend a few hours or days at the Harris Center to get treatment and connected to a range of community-based services. At each stage of the diversion program, people with mental health concerns receive access to evidence-based services, including cognitive behavioral therapy, substance use interventions, peer support, permanent supportive housing, and intensive case management.¹⁵⁰

In fiscal years 2015 and 2016, of the 4,155 people who were referred to the Harris County MHJDP program, the program screened and assessed 1,385 people who were found ineligible, and enrolled 554 people.¹⁵¹ After one year of enrollment in the program, participants showed positive outcomes: jail bookings dropped 0.8 per person, charges dropped decreased by 0.83 per person, felonies decreased by 0.14 and misdemeanors by 0.68 per person, and jail days decreased by 18.9 per person.¹⁵² Harris County estimates that savings based on the decrease in jail days alone totaled \$571,564 in FY 2016.¹⁵³ These preliminary results supported the creation of the SB 292 matching grant program to enable other Texas communities to develop jail diversion programs. For more information on the SB 292 matching grant program, see the “Major Legislation from the 85th Texas Legislature” section of this chapter.

SPECIALTY COURTS

Counties can also use specialty courts to divert people with mental health concerns and substance use issues away from jail settings. These courts apply problem-solving techniques to provide community-based alternatives to incarceration. Each type of specialty court requires the collaboration of judges, prosecutors, defense attorneys, law enforcement officers, and mental health professionals. Specialty courts tend to focus on an identified issue (mental illness, substance use), an identified group (veterans, law enforcement officials), or a specific offense (DWI, prostitution).

As of May 2017, there were 200 specialty courts operating in Texas.¹⁵⁴ In FY 2016, the Criminal Justice Division of the Office of the Governor allocated \$11.6 million in general revenue-dedicated funds for discretionary grants to 89 specialty courts across Texas.¹⁵⁵ In FY 2015, CJD-funded courts served approximately 3,570 participants, 61 percent of whom completed their program successfully.¹⁵⁶

As of 2018, there was no statewide data collected on specialty courts.¹⁵⁷ Texas is one of only two states that charge the executive branch with specialty court certification and oversight rather than placing that function in the judicial branch.¹⁵⁸ 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.¹⁵⁹ 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. National studies tend

to show that the courts produce positive outcomes, although recent data also highlight racial and ethnic disparities in access to some specialty courts, particularly drug courts¹⁶⁰ and mental health courts.¹⁶¹

Drug Courts

Drug courts provide supervision that is more comprehensive and intensive than other forms of community supervision.¹⁶² 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.¹⁶³ Data show that this model works; researchers have found that drug court participation can decrease three-year recidivism rates by up to 50 percent.¹⁶⁴ 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.¹⁶⁵ As of May 2017, there were approximately 128 drug courts (including DWI, veteran's treatment, co-occurring disorder, and hybrid DWI/drug courts) in counties throughout Texas.¹⁶⁶

Mental Health Courts

Mental health courts were developed across the country as an alternative to the standard adjudication process for people with mental health conditions who have committed low-level offenses. Like drug courts, mental health courts use non-adversarial, judicially-supervised treatment plans to reduce recidivism that is fueled by untreated mental illness and substance use conditions. The two types of courts differ however; 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.¹⁶⁷ As of May 2017, Texas had roughly 18 mental health courts.¹⁶⁸

In 2012, Harris County implemented a felony mental health court that included the following components:¹⁶⁹

- Comprehensive evaluation 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;
- Random alcohol and drug testing; and
- Minimum 18-month participation.

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.¹⁷⁰

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 health concerns; the court's typical caseload is about 55-60 cases.¹⁷¹ As of March 1, 2016, the court had served 130 participants, 75.4 percent of whom had co-occurring mental health and substance use conditions.¹⁷² By February 2016, 39 participants had successfully graduated from the program and another six participants were on track to graduate by the spring of 2016.¹⁷³

MENTAL HEALTH PUBLIC DEFENDER OFFICES

Criminal cases involving people with mental health conditions often present unique legal issues that require specialized knowledge and skills. Jurisdictions that have a public defender office can train attorneys on mental health-related issues in order to better serve clients, however not all counties have such an office in place. Thus, some areas without designated countywide public defenders have established a Mental Health Public Defender office that specializes in addressing the legal needs of people with mental illness who are charged with crimes. As of 2016, there were at least ten MHPD offices (or private defenders organized like MHPDs) in Texas.¹⁷⁴

Travis County created a stand-alone MHPD office in 2007. Administrators set four major goals for the office:¹⁷⁵

- 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.

A 2011 cost-benefit analysis of the Travis County MHPD found that 41.2 percent of misdemeanor clients remained out of custody and/or had not returned to jail for up to five years after receiving MHPD Office services.¹⁷⁶ The MHPD also decreased jail bookings by 38 percent for legal clients, 57 percent for case management clients, and decreased jail bed days consumed by 13 percent (legal clients) and 20 percent (case management clients).¹⁷⁷ A more recent study looking at results over six years of operation found that MHPD clients spent 44 percent fewer days between arrest and court disposition, as opposed to individuals who were assigned counsel.¹⁷⁸ The MHPD clients were 28 percent more likely to have their cases dismissed and, if convicted, were sentenced to 23 percent fewer days.¹⁷⁹ The same study looked at recidivism rates in the year following disposition over the course of five years of MHPD office operation; 39 percent of MHPD clients were rearrested within a year, in contrast to 50 percent of individuals assigned an attorney.¹⁸⁰

REENTRY PEER SUPPORT

Successful reintegration into the community can be a challenge for formerly incarcerated people. Peer education and peer support have been used for decades to support people in prisons without a specific focus on people with mental health conditions.¹⁸¹ Peer support for people with mental health conditions has become an established service in other contexts (e.g., reentry from state hospitalization), and interest is growing for the use of peer support in incarceration settings. Reentry peer

support programs allow people with lived mental health and criminal justice experience to mentor others in the justice system who are beginning the recovery and reentry process.¹⁸² 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 on 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 2016, DSHS funded pilot programs in three locations: Harris County, Tarrant County, and Tropical Texas (which serves Cameron, Hidalgo, and Willacy counties); in the fourth quarter of FY 2016, the pilots had served 48 people.¹⁸³ County sheriffs and LMHAs in each location used certified peer support specialists to help individuals with mental health conditions successfully transition out of local jails and into their communities. The nonprofit Via Hope created a community reentry endorsement training (i.e., a specialization) to prepare peer specialists for their work with justice-involved individuals living with mental health conditions. Through June 2016, 135 individuals had completed the community reentry peer training program.¹⁸⁴

The Hogg Foundation for Mental Health funded the program’s evaluation and will release formal results in December 2018. Data from qualitative interviews of peer reentry specialists and participants suggests that peers worked with participants to address multiple client needs, including procuring substance use and mental health treatment, housing, employment, transportation, and documentation (e.g., social security cards). A number of structural barriers, such as limited access to housing and long wait lists for clinical care, prevented peers from addressing some client needs.¹⁸⁵

COUNTY JAILS

County 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 September 1, 2018, Texas county jails operated at 72.4 percent of their collective capacity with a total jail population of 68,493.¹⁸⁶ 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 2018, researchers estimated that people go to jail over 10.6 million times in the U.S. every year, though only about 615,000 people are jailed on any given day.¹⁸⁷ If those proportions hold true for Texas, over one million people pass through Texas jails each year.

TEXAS COMMISSION ON JAIL STANDARDS

The Texas Commission on Jail Standards is an external regulatory agency for

all county jails and privately-operated municipal jails. TCJS's mission is to support localities in providing safe, secure and suitable local jail facilities.¹⁸⁸ A key statutorily-mandated role to fulfill this mission is to adopt minimum standards for the management and operation of these jails.¹⁸⁹ TCJS's most recent strategic plan identifies four goals:

- Ensuring efficient and effective operations of county jails;
- Ensuring a high level of consultation, training, and technical assistance to local governments with the objective of increasing and maintaining compliance with adopted standards;
- Ensuring cost-effective construction of county jails; and
- Implementing the Prisoner Safety Fund for capital improvements to county jails such as automated electronic sensors or cameras¹⁹⁰

Out of the 254 counties in Texas, all but 13 operate at least one jail; therefore, the seven TCJS Inspection and Enforcement staff members must travel to 241 counties.¹⁹¹ Each county is visited for an unannounced compliance inspection at least once each fiscal year.¹⁹² As of December 31, 2017, 22 county jails (9.2 percent) were out of compliance with minimum standards for violations in the categories of life safety, management, and construction.¹⁹³ Common violations include failure to correctly conduct mental health screenings, failure to perform a Continuity of Care Query to identify a history of public mental health services, and failure to provide medical care to individuals experiencing mental health symptoms.¹⁹⁴

No agency has oversight authority for municipal jails operated by local governments. The Legislative Budget Board noted that little statewide data exists about the operation of the 349 city jails and lockups in Texas, especially regarding people with mental health conditions.¹⁹⁵ An LBB survey indicated that less than a third of city jails and lockups use the TCJS intake screening form required of county jails and only 74 percent do any kind of mental health screening.¹⁹⁶

MENTAL HEALTH SERVICES IN COUNTY JAILS

Many people detained in local jails live with co-occurring mental health and substance use issues. Further, people receiving public behavioral health services make up a sizeable portion of the total population of justice-involved persons in Texas. National data indicates that over half of justice-involved individuals have a mental health condition.¹⁹⁷ Texas data shows that almost 30 percent of people booked into a county jail have already received public mental health services in Texas.¹⁹⁸ Untreated mental health needs can lead to behavior that results in the 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 are more likely to provide treatment and successfully link individuals to community-based social services in order to prevent recidivism. Texans detained in other facilities, particularly those in rural areas with fewer resources, may experience deterioration of their mental health status due to a lack of adequate therapeutic services.

When individuals are booked at a county jail, correctional officers use a real-time identification system for incarcerated persons with special needs. They are required

to perform a Continuity of Care Query, checking each person's information against the DSHS Clinical Management for Behavioral Health Services database. The CCQ instantly tells jail employees if a person has been hospitalized in a state psychiatric facility or if the person has experienced an encounter, authorization, or assessment by the public mental health system through an LMHA within the past three years.¹⁹⁹ If a match is detected, the jail could contact the relevant LMHA in order to link the individual to available community resources, but typically only does so if the person is in crisis.²⁰⁰ The counties with jails operated by private providers do not perform CCQs.²⁰¹

Between September 1, 2017 and June 22, 2018, the 235 counties in Texas that participate in the system initiated 872,350 CCQ match requests for adults.²⁰² Under 5 percent (40,949) of the queries were exact matches with information maintained in the DSHS mental health database, and about 24 percent (207,974) were probable matches.²⁰³ Both exact and probable matches alert the local jails and LMHAs to exchange pertinent information. As this process does not identify individuals not receiving services or those who have received mental health services in the private sector or other states, it undercounts the number of people with mental health conditions.

MENTAL HEALTH TRAINING FOR JAILORS

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 do not address the provision of medications to individuals upon their release from county jails.²⁰⁴ 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. Jail behavioral health medication formularies vary significantly based on local decision-making, creating missed opportunities and higher costs.²⁰⁵ Untreated mental health needs and a lack of post-incarceration treatment planning can lead to an individual cycling in and out of jail. The cycle of incarceration and re-incarceration diminishes the individual's mental health outcomes and creates added policing and incarceration costs for local communities.²⁰⁶

Jail administrators face challenges in delivering services to their large detainee populations. In 2017, 42 percent of grievances submitted to the Texas Commission on Jail Standards by people in county jails involved complaints regarding medical services, including mental health services.²⁰⁷ Leaders from the Texas Jail Project, a nonprofit that aims to improve jail conditions, reported that over 80 percent of the complaints they receive from inmates and their families typically involve a lack of adequate mental health care.²⁰⁸ And – echoing several national surveys -- county jails continue to report to the TCJS that managing inmates who have mental health issues is their primary challenge.^{209,210,211}

HEALTH RECORDS IN COUNTY JAILS

TCJS standards include requirements for the custody, care, and treatment of people in county jail. The standards require that when a person is admitted to jail, any

“health tag” identifying the person as having a special medical or mental health need must be noted in the individual’s medical record and brought to the attention of health personnel and/or the supervisor on duty.²¹² Each facility must also create and implement a written health services plan for the jail population’s medical, mental health, dental, and pregnant inmate services. In addition, the facility must maintain a separate health record for each person. These health records must include a health screening and a mental health evaluation administered by medical personnel or by a trained booking officer upon a person’s entry into the jail. At a minimum, each record must also contain current medical and mental health treatment information and behavioral observations, including the individual’s state of consciousness, mental health status, and risk of suicide.²¹³

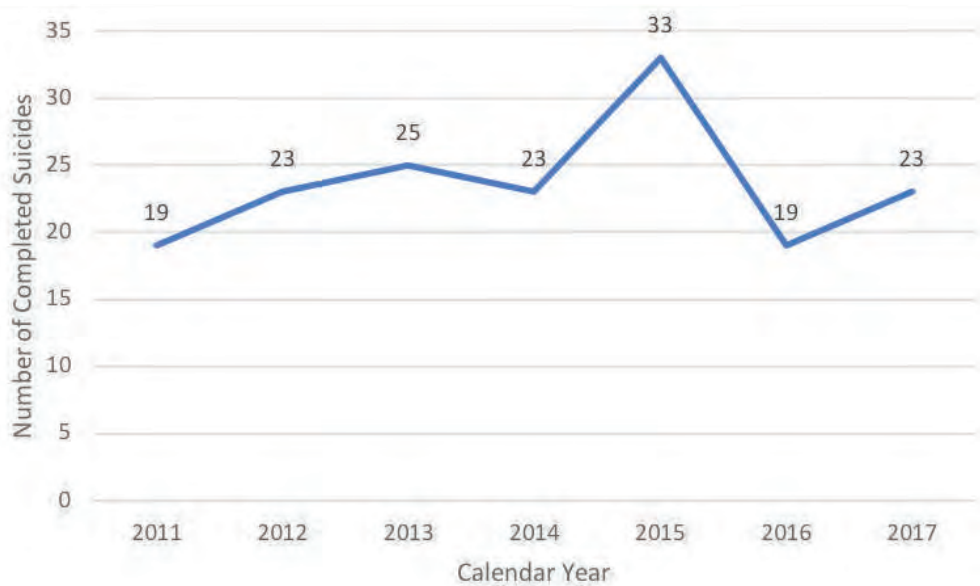
Jail administrators may use health records when individuals are transferred to or re-incarcerated within different facilities across the state. State and federal laws govern sharing people’s health records with other entities. TCJS requires jail administrators to send a Texas Uniform Health Status Update form when people are transferred from a jail to any other correctional facility.²¹⁴ 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.”²¹⁵ This information may include details about an individual’s treatment needs; social, criminal, and vocational history; supervision status; and medical and mental health history.

SUICIDE IN COUNTY JAILS

National data show that suicide occurs roughly three times more frequently in jails than in prisons.²¹⁶ Entering jail can be a traumatic experience, as even a short stay prior to trial can jeopardize a person’s job, housing, social support, and sense of normalcy.²¹⁷ Jail staff typically have less information about the people who enter their facilities than do prison staff. People with mental health conditions who are awaiting trial (and thus have not been convicted of a crime) are at even greater risk. National data show that pretrial individuals die by suicide at a rate seven times higher than their convicted peers do.²¹⁸ An older national study indicates that jails under 100 beds report a suicide rate up to five times higher than larger jails.²¹⁹

For many years, suicide has been the leading cause of death in local jails across the U.S.²²⁰ In Texas, the number of jail suicides increased by about 43 percent between 2014 and 2015, the most recent data available. In 2016, 2017, and 2018, TCJS continued to find county jails out of compliance due to failure to conduct required observation checks.^{221,222,223} Figure 65 demonstrates the number of suicides that occurred within county jails between 2011 and 2017.

Figure 65. Number of Completed Suicides in Texas County Jails Between CY 2011 and CY 2017



Source: Texas Commission on Jail Standards. (2016, May 18 and 2018, October 3). 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.²²⁴

Jail administrators in Texas also use an approved screening tool to identify people who are at risk for suicide. Upon admission to the jail, each individual must be evaluated immediately with a TCJS-approved screening form for suicide and medical/mental/developmental impairments.²²⁵ The previous form asked newly jailed people to self-report their medical problems and mental health histories, but jail employees still had discretion when determining whether to refer the person to treatment services.²²⁶ The form that was created in 2015 removes subjectivity from the process. Jail employees must now follow explicit instructions when detained individuals provide certain responses to predetermined questions. For example, the 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 “supervisor, magistrate, and mental health [providers].”²²⁷ Early results show that 66 percent of county jails reported an increase in positive screens for mental health conditions after implementing the revised TCJS screening form.²²⁸

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Policy Concerns

- Diverting youth with behavioral health needs away from secure confinement facilities and into their home communities

- Addressing youth needs as close to home as possible
- Assessing the impact of detaining youth in adult correctional facilities and adjusting the upper and lower age limits of juvenile court jurisdiction based on the science of adolescent development
- Addressing the school-to-prison pipeline and the disproportionality for youth of color and youth with special education needs
- Ensuring strong oversight by the Office of the Independent Ombudsman at a time of significant systems change for the Texas Juvenile Justice Department
- Assessing and sharing outcomes for state secure facilities and community interventions

Fast Facts

- About 70 percent of youth in the juvenile justice system have a diagnosable mental health condition, compared to 20 percent of youth in the general population.¹
- Very few of the youth who are involved in the justice system are arrested for serious offenses like aggravated assault, robbery, rape or murder (under 3,000 out of almost 50,000 arrests in 2016).²
- On July 31, 2018, there were 865 youth committed to five state secure facilities, 124 youth in halfway houses, and 114 youth in contract care facilities in Texas.³
- In FY 2016, the Legislative Budget Board estimated that youth in residential facilities cost \$441.92 per day, youth on parole cost \$39.12 per day, and youth on probation cost \$14.39 per day.⁴
- Texas has 48 pre-adjudication facilities operated at the county level. Twenty of these facilities offer programs for youth with mental health conditions, and 20 provide programs for youth with substance use conditions.⁵
- Texas has 35 post-adjudication facilities operated at the county level. Thirty of these facilities offer programs for youth with mental health conditions, and 32 provide programs for youth with substance use conditions.⁶
- In FY 2017, counties funded 73 percent of juvenile probation services, while the state funded 26 percent and the federal government provided only 1 percent of total funding.⁷

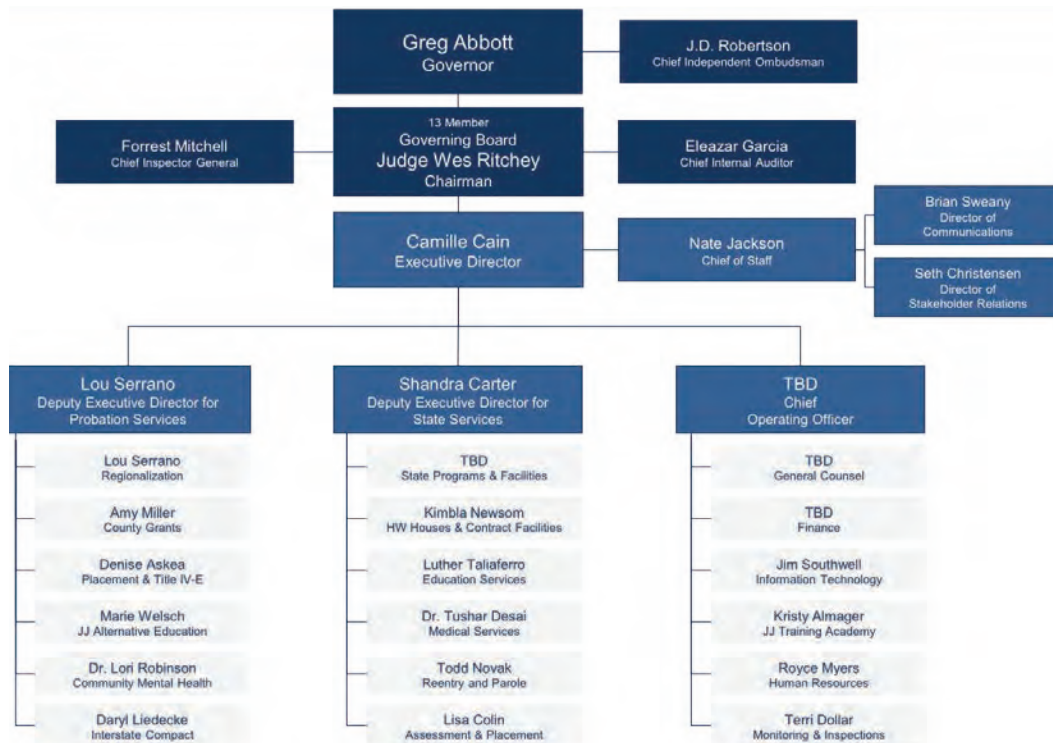
TJJD Acronyms

ACEs – Adverse Childhood Experiences	DFPS – Department of Family and Protective Services
ART – Aggression replacement therapy	FEDI – Front-End Diversion Initiative
BISQ – Brain injury screening questionnaire	IO – Independent Ombudsman
CEED – Center for Elimination of Disproportionality and Disparities	LBB – Legislative Budget Board
CINS – Conduct indicating need for supervision	LCSG – Council of State Governments
COG – Capital Offender Group	MRTC – McLennan Residential Treatment Center
CRCG – Community resource coordination groups	OMHSE – Office of Minority Health Statistics and Engagement
CSU – Crisis stabilization unit	PAWS – Pairing Achievement with Service
CSVOTP – Capital and Serious Violent Offender Treatment Program	PTSD – Post-traumatic stress disorder

SJPOs – Specialized juvenile probation officers
 SNDP – Special Needs Diversionary Program
 TBI – Traumatic brain injury
 TCOOMMI – Texas Correctional Office for Offenders
 with Medical and

Mental Impairments
 TEA – Texas Education Agency
 TJJD – Texas Juvenile Justice Department
 VOP – Violent Offender Program

Organizational Chart



Source: Texas Juvenile Justice Department. (August 2018). Organizational Chart. Retrieved from <http://www.tjjd.texas.gov/docs/TJJDorgChart.pdf>

Overview

The Texas juvenile justice system is comprised of the Texas Juvenile Justice Department and local juvenile probation departments throughout the state. These agencies work together to provide services designed to rehabilitate youth who commit delinquent conduct between their 10th and 17th birthdays.

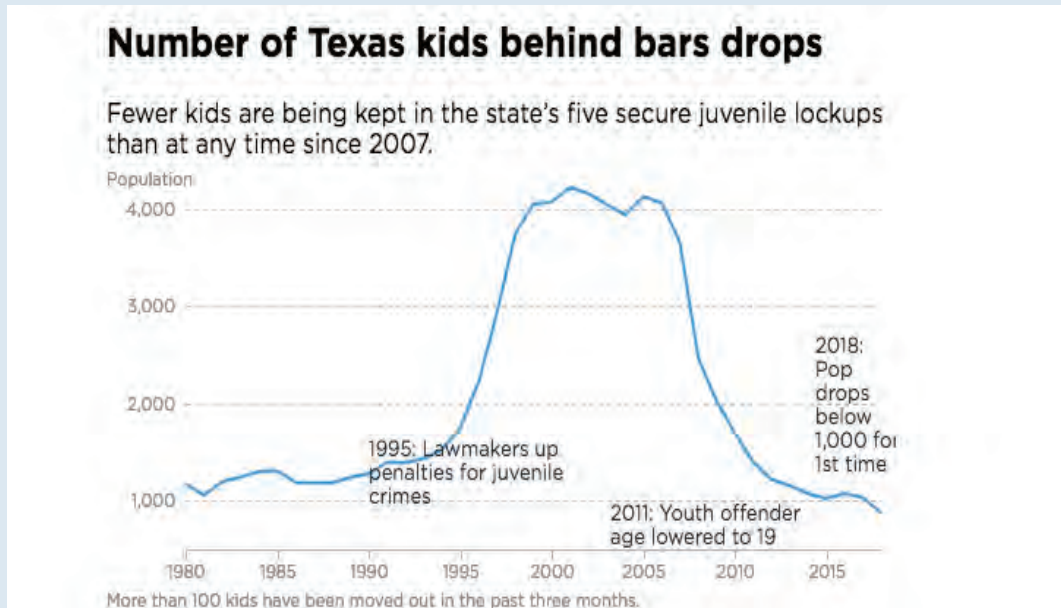
TJJD was created in 2011 and charged with “increasing the proportion of youth in local custody, rather than committed to state lockups.”⁸ The department’s ultimate goal is to prevent a juvenile’s entrance into the adult criminal justice system by providing treatment plans tailored to each child’s unique strengths and needs. To this end, TJJD provides oversight and funding to local juvenile probation departments across Texas and operates five state secure facilities for youth.⁹

TJJD

Changing Environment

In 2007, the Texas Legislature made deliberate efforts to decrease youth incarceration rates across the state after the number of youth in Texas state secure juvenile facilities averaged 4,000 throughout the previous decade. In 2018, the youth population in secure juvenile facilities across Texas fell below 900. This was the first time fewer than 1,000 youth were in these facilities since the 1980s.¹⁰ Figure 66 illustrates Texas' state secure juvenile facility population between 1980 and 2017.

Figure 66. TJJJ Secure Facility Population



Source: McGaughy, L. (April 6, 2018). The number of Texas kids behind bars is suddenly at its lowest point in decades. *Dallas Morning News*. Retrieved from <https://www.dallasnews.com/news/crime/2018/04/06/number-texas-kids-behind-bars-suddenly-lowest-point-decades>

At the request of Senator Whitmire, chair of the Senate Criminal Justice Committee, the Council of State Governments Justice Center analyzed the impact of those reform efforts.¹¹ In 2015, the CSG released key findings, including: (1) Youth confined in state-run facilities are two times more likely to be re-incarcerated within five years of release than youth sentenced to county-level probation¹² and (2) While reforms have benefited state- and county-level juvenile justice systems, Texas can do more to decrease recidivism rates among justice-involved youth. In particular, CSG researchers recommended that TJJJ and county probation departments concentrate their interventions on youth with the highest risk to reoffend and minimize involvement with low-risk youth.¹³

After the end of the 85th legislative session in late 2017, confirmed incidents of staff abusing youth at one of the remaining five TJJJ facilities became public.¹⁴ As a result, Governor Abbott replaced the TJJJ executive director, board chair, and the Independent Ombudsman. In June 2018, the new TJJJ executive director Camille

Cain submitted a letter to Gov. Abbott with proposed short-term solutions and long-term goals.¹⁵ The short-term focus for the agency was stabilizing operations by improving supervision ratios (both by reducing the youth population and increasing the number of employees), improving safety, and adjusting training. Later that month, TJJD approved a strategic plan for 2019-23 detailing the future direction of the agency.¹⁶ More detailed information on the strategic plan can be found later in this section.

MAJOR LEGISLATION FROM THE 85TH LEGISLATURE

During the 85th legislative session, few bills passed relating to juvenile justice and the most significant pieces of legislation related to mental health and juvenile justice are explained below. Legislation is described roughly in the order in which it would affect youth moving through the Texas juvenile justice system.

The information provided below is not a comprehensive account of the mental health and justice-related legislation.

HB 1204 (85th, White/West) - Diversion to Services for 10- and 11-Year-Olds; Prosecution of Juveniles for Fine-Only Misdemeanors

For the youngest children subject to juvenile court jurisdiction, HB 1204 (85th, White/West) created a mechanism for the person doing the preliminary investigation of the alleged offense to refer a child under 12 to a community resource coordination group and delay referring the case to a prosecutor based on the child's successful participation in services. Experts believe that detention of these youngest children should occur only as a last resort. An amendment to this bill also required the Texas Office of Court Administration to complete a study of varying definitions of "juvenile," "child," and "minor" in Texas code and to determine whether it is just and efficient to prosecute youth charged with fine-only misdemeanors in the adult criminal justice system.

HB 1521 (85th White/Whitmire) and HB 932 (85th, Johnson/West) - Information Regarding Dual-System Youth

For youth involved with both the juvenile justice and child welfare systems (sometimes known as "crossover" or "dual-system" youth), the legislature took steps to improve information sharing to streamline duplicative or conflicting services. HB 1521 (85th, White/Whitmire) required the Texas Department of Family and Protective Services to share information with TJJD within 14 days of TJJD's request if that information is "necessary to improve or maintain community safety" or to assist with continuity of care or provision of services. HB 932 (85th, Johnson/West) required TJJD, DFPS, and local juvenile probation departments to collect and share data and report on how many youth in the juvenile justice system have ever been in foster care.

SB 1548 (85th, Menéndez/Minjarez) - Voluntary Post-Discharge Services

To reduce the high risk of recidivism after a youth leaves the supervision of the juvenile justice system, SB 1548 (85th, Menéndez/Minjarez) gave counties the option

of offering voluntary support services – including mental health and substance use services – to youth discharged from probation, regardless of the age of the youth.

SB 1304 (85th, Perry/White) - Juvenile Records and Privacy

Incorporating work of a state task force on juvenile records, SB 1304 (85th, Perry/White) streamlined the process for creating and handling juvenile records, including photographs and fingerprints and further limited who can have access. In some cases, the bill required automatic sealing or permanent destruction of juvenile records.

HB 122 (85th, Dutton) - Raising the Age of Criminal Responsibility

Currently, Texas is one of six states with the legal age of criminal responsibility below 18.¹⁷ As a result, 17-year-old Texans are automatically considered to be adults if they commit a crime. Then, if convicted and sentenced to incarceration, they are placed in adult prisons, where teenagers often face inadequate treatment and educational opportunities, as well as heightened risks of sexual victimization.¹⁸

Texas' age of criminal responsibility contradicts federal age standards established by the Prison Rape Elimination Act 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.¹⁹ 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.²⁰ 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. Recent data shows that the majority of 17-year-olds in the Texas criminal justice system are arrested for low-level misdemeanors.²¹ The policy change could ease the mental health and management challenges created by PREA's Youthful Inmate Standard.

However, legislative efforts to change the age of criminality did not pass in the 85th legislative session. HB 122 (85th, Dutton) would have raised the age of criminal responsibility from 17 to 18 years old. While the bill was passed by the House of Representatives, the Senate never held a hearing on the bill or the Senate counterpart before the end of the legislative session. The Senate requested further study of the issue before the Texas Legislature takes action to raise the age of criminal responsibility.

TJJD Cost and Funding

COST PER DAY FOR ADULT AND JUVENILE SYSTEMS

On July 31, 2018 there were 865 youth committed to TJJD’s state secure facilities, 124 youth in halfway houses, and 114 youth in contract care facilities.²² In FY 2016, the LBB calculated that youth in these residential facilities cost \$441.92 per day.²³ In contrast, youth on parole cost \$39.12 per day, and youth on probation cost \$14.69 per day.²⁴ Figure 67 shows the difference in cost between the adult and juvenile justice systems in Texas.

Figure 67. Differences in Cost Per Day Between the Adult and Juvenile Justice Systems

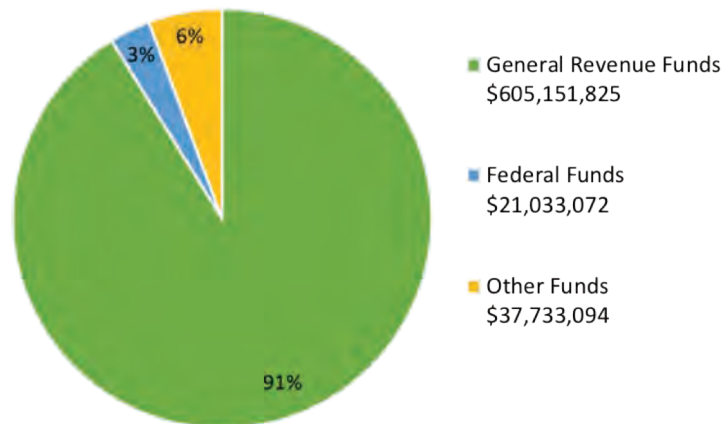
Placement	Adult System Cost	Juvenile System Cost
Adult prison or juvenile detention facility	\$61.63	\$441.92
Parole supervision	\$4.39	\$39.12
Community or probation supervision	\$3.42	\$14.39

Source: Legislative Budget Board. (February 8 2017). *Overview of Criminal and Juvenile Justice Correctional Population Projections, Recidivism Rates, and Costs Per Day*. Page 19. Retrieved from http://www.lbb.state.tx.us/Documents/SFC_Summary_Recs/85R/SFC_OverviewFeb2017.pdf

TJJD FUNDING

TJJD’s budget in FY 2018-19 was \$663,917,991.²⁵ Figure 68 breaks down TJJD’s budget by funding source, and Figure 69 breaks down the budget by agency goal.

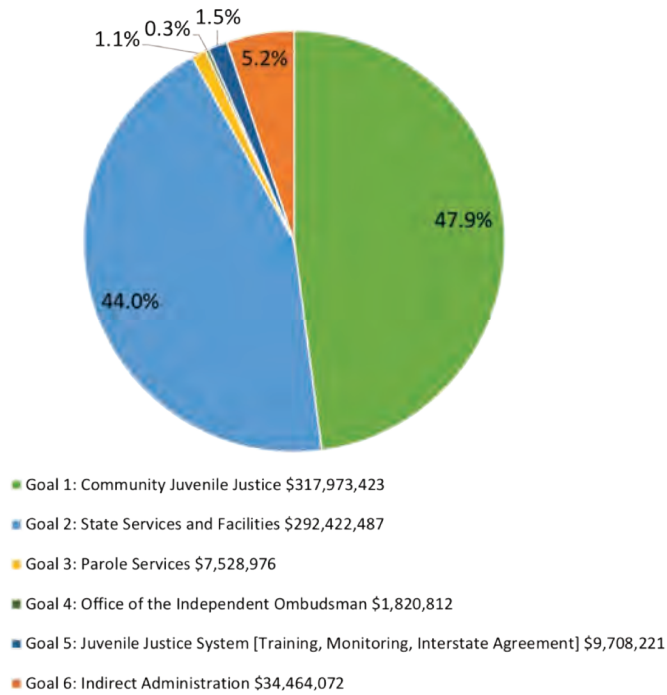
Figure 68. TJJD Budget by Funding Source FY 2018-19



Source: Legislative Budget Board. (2017). *85th Texas Legislature, Senate Bill 1, General Appropriations Act for the 2018-19 Biennium*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.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 the economic stabilization fund.

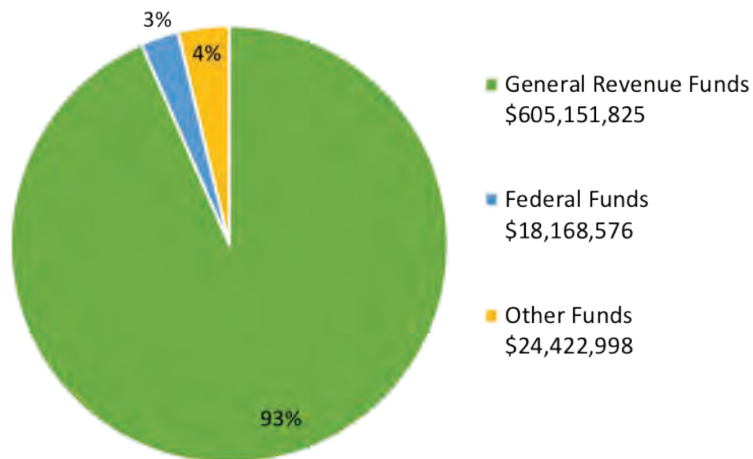
Figure 69. TJJJ FY 2018-19 Operating Budget by Agency Goal



Source: Legislative Budget Board. (2017). *85th Texas Legislature, Senate Bill 1, General Appropriations Act for the 2018-19 Biennium*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.pdf

Figure 70 illustrates the legislative appropriations request by funding source for FY 2020-21. The total requested TJJJ base budget for FY 2020-21 is \$647,743,399. If included in the budget, the Exceptional Items Request would add an additional \$53,833,175.

Figure 70. Funding Breakdown for Legislative Appropriations Request FY 2020-21

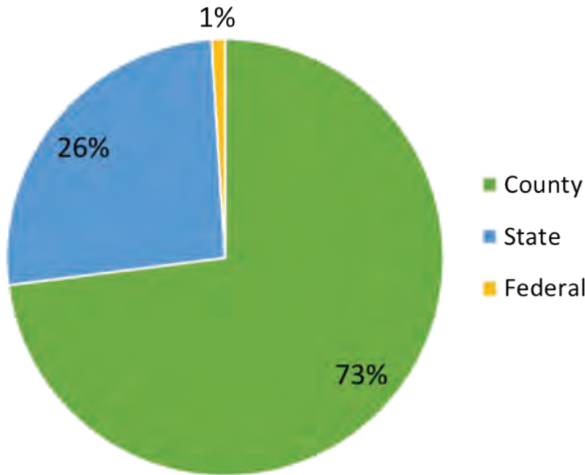


Source: Legislative Budget Board (2018). *Texas Juvenile Justice Department, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from http://www.lbb.state.tx.us/Agency_Docs.aspx

LOCAL JUVENILE PROBATION DEPARTMENT FUNDING

TJJD allocates more of its budget to community juvenile justice than to state services and facilities.²⁶ The state agency distributes 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.²⁷ 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, anger management, cognitive behavioral programming, animal/equine therapy, and substance use prevention and intervention.²⁸ Figure 71 shows the funding breakdown for local juvenile probation departments in FY 2017.

Figure 71. Funding Breakdown for Local Juvenile Probation Departments in FY 2017



Source: Texas Juvenile Justice Department. (December 2017). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Page 7. Retrieved from http://www.tjjd.texas.gov/publications/reports/17_AnnualReport_for_Governor-LegBudgetBoard.pdf

Texas Juvenile Justice System

TEXAS JUVENILE JUSTICE DEPARTMENT

The Texas Juvenile Justice Department’s mission is to “transform young lives and create safer communities” throughout Texas.²⁹ To accomplish this mission, TJJD provides educational and behavioral health services to justice-involved youth committed to the agency’s five state secure facilities and eight halfway houses.³⁰ 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:

TJJD

- 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.³¹

While the adult system is a criminal system that emphasizes punishment, the juvenile system was designed to be a civil system that emphasizes rehabilitation.³² As a result, the legal terms and concepts used in juvenile justice procedures differ from those used in the adult criminal justice setting. Table 53 and Table 54 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.

Table 53. Terms and Concepts

Juvenile Justice Term/Concept	Analogous Adult Criminal Justice Term/Concept
Delinquent conduct	Criminal conduct
Take into custody	Arrest
Petition	Indictment
Detention hearing	Arraignment
Pre-adjudication facility	Local jail where individuals are detained before trial
Adjudication hearing	Trial
Finding of "true/not true" at adjudication hearing	Finding of "guilt/innocence" at trial
Disposition	Sentence

Table 54. 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 (CINS)."
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 TJJJ 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>

TJJD STRATEGIC PLAN

In June 2018, TJJD approved a new strategic plan for fiscal years 2019-23.³³ The plan included four goals:

1. Improve current operations at secure facilities
2. Develop and implement a fully trauma-informed system
3. Improve cross functional collaboration and local control
4. Deliver the Texas Model across the state

The Texas Model, as articulated in a plan issued shortly before the strategic plan, includes both principles for designing the juvenile justice system and principles for programmatic interventions:

System Principles:

- A focus on need and risk levels of youth
- A graduated set of options to meet youth and system needs, which may change over time
- A greater focus on a single juvenile justice system as a partnership between county juvenile probation departments and TJJD
- A commitment to the shortest appropriate length of stay
- Youth stay closer to their communities in every possible case
- Youth stay as shallow in the system as possible
- Provide for scalability to meet changing or emerging needs³⁴

Intervention Principles:

- A foundation in trauma-informed care
- A treatment-rich environment and direct-care staff who reinforce treatment goals
- An approach grounded in evidence-based practices
- Transparent plans between agency and youth to understand requirements and the consequences of their actions—both positive and negative—with strong accountability

HOW JUVENILES MOVE THROUGH THE JUVENILE JUSTICE SYSTEM

Texas youth who move through the entire juvenile justice system typically encounter six major steps, including:

- Step One: An arrest by local law enforcement or referral to juvenile probation;
- Step Two: Disposition by a county juvenile court judge;
- Step Three: Fulfillment of a disposition (i.e., sentence) in a state-level facility (e.g., a detention center or halfway house), county-level facility, and/or in the community, depending upon the juvenile's committing offense and judicial discretion;
- Step Four: Appraisal by the TJJD Release Review Panel (for youth committed to a secure state-level facility);
- Step Five: Completion of parole supervision; and
- Step Six: Discharge from TJJD.

Diversion from the juvenile justice system and to community-based services is possible before any of these steps. Diversion is increasingly a focus for all youth, particularly for youth with significant trauma histories and behavioral health needs. For more information on diversion, see the “Local Criminal Justice Systems” section in the Texas Department of Criminal Justice (TDCJ) chapter of this guide.

The following section will describe each of the six steps in greater detail.

STEP ONE: JUVENILE ARRESTS AND REFERRALS

Each year over 100,000 juveniles are arrested or referred to juvenile probation.³⁵ The vast majority of juveniles who come into contact with the justice system commit low-level offenses. In 2016, Texas law enforcement officers made 49,959 juvenile arrests.³⁶ Larceny-theft, motor vehicle theft, running away from home, alcohol and drug violations, and violations of curfew and loitering laws (all of which are nonviolent offenses) accounted for nearly 50 percent of those arrests.³⁷ Table 55 shows the top five most common crimes for which Texas youth were arrested in 2016. In contrast, juveniles were arrested for 1,602 aggravated assaults, 933 robberies, and 28 murders in 2016.

Table 55. Top Five Arrest Categories for Texas Juveniles in 2016

Offense Type	Classification	Total Arrests by Offense in 2016
Non-aggravated assault	Misdemeanor	10,070
Larceny-theft (excluding motor vehicle)	Depends on value of property taken	7,848
Runaway	Misdemeanor	5,034
Marijuana possession	Depends on amount in possession	4,481
Curfew and loitering law violation	Misdemeanor	2,109

Source: Texas Department of Public Safety. (2017). *2016 Crime in Texas Report: Texas Arrest Data*. Page 74. Retrieved from <http://www.dps.texas.gov/crimereports/16/citCh9.pdf>

In addition, during the academic year 2015-16, 59,054 non-traffic Class C misdemeanor cases were filed against juveniles in adult criminal court.³⁸ Youth with disabilities, including mental health conditions, and African-American youth, are over-represented in arrests and court filings.³⁹

Youth with mental illness are three times more likely than their peers to be arrested before graduating high school.⁴⁰ 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 Table 55.⁴¹ 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.⁴²

STEP TWO: JUVENILE COURTS, DISPOSITIONS, 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.⁴³ Other youth may be diverted away from the justice system and into community-based programs. Alternatively, their cases may be dismissed entirely. Youth who are not diverted or released to a caretaker must appear before a juvenile court judge within 48 hours of intake.⁴⁴

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.

Specialty courts serve a small number of youth by aiming to address the underlying causes of juvenile justice involvement. Specialty courts often operate as one piece of a larger continuum of diversion services for youth with behavioral health conditions. The most common specialty courts for juveniles are drug courts and mental health courts. Both types of courts utilize individual treatment plans, case management, and judicial supervision to link youth to treatment services in the community rather than place them in a secure facility.

Juvenile Drug and Mental Health Courts

In 2018, there were 320 juvenile drug courts nationwide and 19 were located in Texas.⁴⁵ In the same year, Texas operated specialized mental health courts for youth in five counties: Bexar, Dallas, Harris, El Paso, and Travis.⁴⁶ 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.⁴⁷ 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.⁴⁸ Although the courts produce positive outcomes, recent data also show racial and gender disparities in access to this diversion strategy.⁴⁹ 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.

STEP THREE: FULFILLMENT OF A DISPOSITION

If a youth is adjudicated for delinquent conduct, the youth may be placed on probation or sent to detention in a county or state facility. Placements within a detention facility are reserved for high-risk youth whom judges determine need intensive intervention. Since 2007, only juveniles who commit felonies are eligible

for placement in state secure facilities, while youth who commit misdemeanors must be kept in county-level facilities or in their home communities.⁵⁰ Youth who are adjudicated for certain serious offenses may receive a determinate sentence and possible transfer to adult prison depending on the youth’s behavior and progress while placed in a TJJD facility.⁵¹

Between 2007 and 2018, TJJD relied more heavily on community-based interventions for youth, causing the average daily population within residential facilities to decrease by over 80 percent.⁵² Texas data shows racial disparities in commitment rates;⁵³ between 2003 and 2013, those rates increased 4 percent for African American youth, decreased 15 percent for Hispanic youth, and decreased 40 percent for American Indian youth.⁵⁴

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.⁵⁵ 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.⁵⁶ In 2017, Harris County certified 23 youth (and declined to certify 7 youth), a 39 percent decrease from 2016.⁵⁷

Figure 72 shows the number of referrals and dispositions for youth involved in the juvenile justice system in FY 2017. For more information about secure placements and the behavioral health treatments available to youth within these placements, see the “Behavioral Health Services in State Secure Facilities” section of this chapter.

Figure 72. Referrals and Dispositions of TJJD Youth in 2017

Referrals and Dispositions	FY 2017
Formal Referrals to Juvenile Probation Departments	53,860
Juveniles Referred	38,677
Total Dispositions	55,110
TJJD Commitment Dispositions	819
Adult Certification Dispositions	138

Source: Texas Juvenile Justice Department. (December 2017). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Page 13. Retrieved from http://www.tjtd.texas.gov/publications/reports/17_AnnualReport_for_Governor-LegBudgetBoard.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.

STEP FOUR: APPRAISAL BY TJJD REVIEW PANEL

After juveniles with indeterminate sentences complete their minimum length of stay within a TJJD facility, officials on TJJD's Release Review Panel assess each youth's progress. The three-member panel examines the youth's behavior, educational accomplishments, and response to behavioral health treatments to determine if the youth can be served safely in the community.⁵⁸

STEP FIVE: COMPLETION OF PAROLE SUPERVISION OR EXTENDED STAY IN TJJD FACILITY

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 2018, the Release Review Panel extended juveniles' stays within secure facilities 63.4% of the time. Within those extension decisions, about 13.2% of the juveniles had moderate mental health needs and about 26.8% had high substance use treatment needs.⁵⁹

Most youth paroled from a TJJD facility are supervised by a TJJD parole officer. These 32 statewide parole officers are located at offices in key population centers across Texas. In addition to in person visitation, they also engage with some youth & families in more remote areas pre- and post- release through virtual visits using videoconferencing. A small proportion (roughly 9%) of youth are supervised through contracts with probation staff in rural juvenile probation departments; these probation officers will typically have a caseload of 2-3 youth paroled from TJJD as well as a traditional probation caseload and some counties have enough youth to support officers solely dedicated to TJJD youth on parole.

TJJD parole officers are in the preliminary stages of being trained in Effective Practices in Community Supervision (EPICS), an evidence-based approach designed to shift supervisory interactions from a confrontational nature to a relationship-building approach grounded in fairness, trust, and an authoritative (not authoritarian) style.⁶⁰ Using EPICS, each meeting between a parole officer and a youth includes four steps: check-in, review, intervention, and homework. Typical interventions are evidence-based and may be designed to develop motivational skills, problem-solving skills, or cognitive behavioral skills. TJJD reports that EPICS' foundation of positive relationships is complimentary to TJJD's implementation of Trust-Based Relational Intervention.⁶¹

STEP SIX: DISCHARGE FROM TJJD

When juveniles successfully complete their dispositions, TJDD may discharge them from custody. Juveniles are typically discharged because 1) they finished their treatment program, 2) they turned 19 and are no longer under TJJD's jurisdiction, or 3) they received a determinate sentence and are transferred to the adult justice system in order to complete their sentence. Just like adults, justice-involved youth with mental illness often face challenges upon reentry, including stigma and discontinuity of care.

THE OFFICE OF THE INDEPENDENT OMBUDSMAN

In 2007, following highly publicized allegations of abuse within a state secure facility,

the 80th Texas Legislature created the Office of the Independent Ombudsman as a separate state agency responsible for investigating, evaluating, and securing the rights of youth committed to TJJD.⁶² The independent ombudsman is responsible for investigating a variety of complaints including medical and mental health concerns, abuse allegations, and suicidal ideation and attempts.

During the 84th legislative session, lawmakers expanded the IO’s oversight duties as part of a broader reform to the juvenile justice system. The IO’s responsibility for inspecting state-level secure TJJD facilities, halfway houses, state contract care facilities, and parole offices was expanded to include county-level post-adjudication facilities and contract facilities where county post-adjudicated youth are placed.⁶³ The IO receives the majority of complaints directly from youth while inspectors visit state secure facilities and county post-adjudication facilities.⁶⁴ Table 56 below summarizes the IO’s activities during FY 2018 compared to earlier periods.

Table 56. Account of Site Visits, Youth Contact, and Cases Closed by the IO

Activity	FY 17, Q3	FY 18, Q3	FY 16	FY 17	FY 18 1 st 3 Quarters
Site Visits (TJJD/Contract)	61	60	196	232	172
Site Visits (County Post Adjudicated/ Contract)	104	70	300	474	276
Number of youth interviewed	1150	1147	3,194	3,137	2,678
Number of youth interviews conducted	1614	1368	5,451	6,742	4,348
Closed cases	24	9	119	145	96

Source: Independent Ombudsman for the Texas Juvenile Justice Department. (2017). *Fourth Quarter Report FY 17: June 1, 2016 to August 31, 2017*. Page 2. Retrieved from https://www.tjjd.texas.gov/ombudsman/reports/IO_4Q_17.pdf

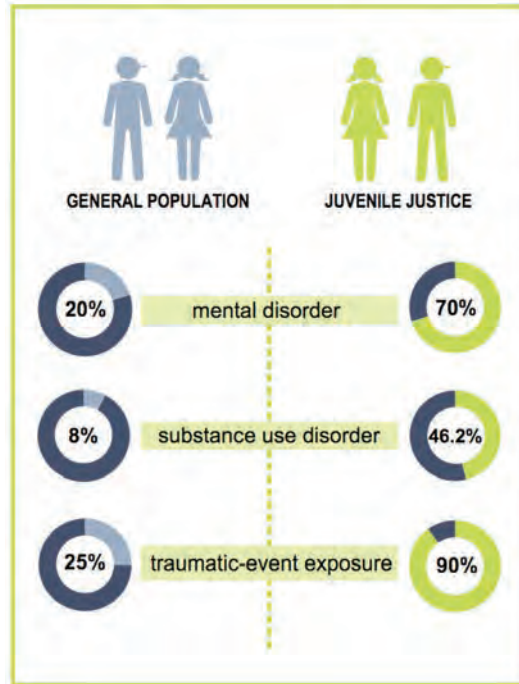
Independent Ombudsman for the Texas Juvenile Justice Department. (2018). *Third Quarter Report FY 18: March 1, 2018 to May 31, 2018*. 3. Retrieved from https://www.tjjd.texas.gov/ombudsman/reports/IO_3Q_18.pdf

JUVENILE JUSTICE AND MENTAL HEALTH

For all but the most violent behavior, youth are processed in a separate justice system rooted in different premises about adolescent behavior versus adult behavior. In recent decades, significant advances in developmental and brain science have been cited as support for changes in juvenile justice policy. Research documents differences in adolescents’ decision-making capacity, risk taking, self-regulation, ability to delay gratification, and vulnerability to external pressure.⁶⁵ While these studies are not probative in any specific case, the research is used in many localities to support emergent juvenile justice policies.

Youth in the juvenile justice system are more likely to have mental health and substance use conditions than children in the general public. Researchers estimate that about 70 percent of justice-involved youth have a mental illness, while 60 percent of justice-involved youth have a co-occurring mental illness and substance use disorder.⁶⁶ Figure 73 shows a side-by-side comparison of mental health needs for youth in the general population and youth in the juvenile justice population.

Figure 73. Prevalence of Mental Health Conditions, Substance Use Disorders, and Traumatic-Event Exposure Among U.S. Youth



Source: National Center for Mental Health and Juvenile Justice & the Technical Assistance Collaborative. (2015). *Strengthening Our Future: Key Elements to Developing a Trauma-Informed Juvenile Justice Diversion Program for Youth with Behavioral Health Conditions*. Retrieved from <http://www.ncmhjj.com/wp-content/uploads/2016/01/traumadoc012216-reduced-003.pdf>

While 70 percent of justice-involved youth around the country have a diagnosable mental health disorder, about 30 percent have conditions severe enough to require immediate and significant treatment.⁶⁷ In FY 2017, 99 percent of Texas youth committed to TJJD had a need for specialized mental health treatment, with 40 percent (and 75 percent of the females) having at least a moderate level of need.⁶⁸ The prevalence of substance use disorders is also high among youth in the juvenile justice system. A large multi-state study found a substance use disorder diagnosis in 17 percent of youth at the point of intake, 39 percent at detention, and 47 percent at commitment to a secure facility post adjudication.⁶⁹ In Texas, 78 percent of youth committed to TJJD in FY 2017 had a high or moderate need for substance use treatment.⁷⁰

The vast majority of children in juvenile justice settings also have a history of trauma. Close to 75 percent of these youth have not only been exposed to violence, crime, and abuse; they have also experienced traumatic victimization themselves.⁷¹ In a large Florida study, researchers found that juvenile offenders were 13 times less likely to report no Adverse Childhood Experiences than the original ACE study population and four times more likely to report four or more ACEs.⁷² These experiences can contribute to the development of PTSD, which is disproportionately found among youth in the justice system.⁷³

Recent meta-analyses also demonstrate that between 30 percent and 60 percent of justice-involved youth have experienced a traumatic brain injury.⁷⁴ After sustaining a brain injury, juveniles are more likely than their uninjured peers to

engage in delinquency.⁷⁵ 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.⁷⁶ About 67 percent 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.⁷⁷ 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.⁷⁸ 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.⁷⁹

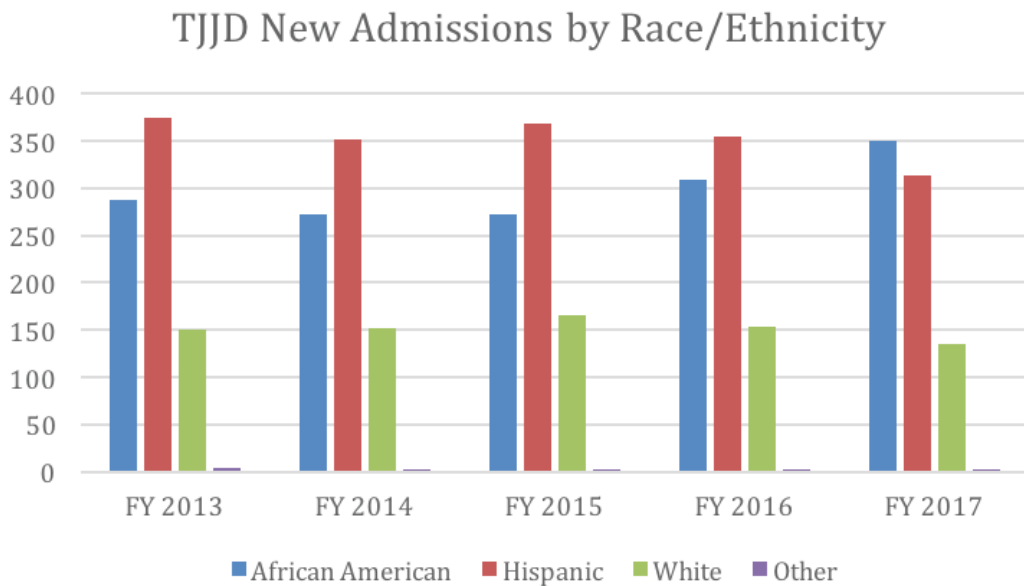
DISPROPORTIONALITY IN THE TEXAS JUVENILE JUSTICE SYSTEM

Black and Hispanic youth tend to fare worse than their white peers at most stages of the justice process.⁸⁰ 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.⁸¹

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.⁸² In Texas specifically, researchers found that, after controlling for 83 different variables, African American youth are 31 percent more likely than their white and Hispanic peers to receive a disciplinary action for a discretionary violation (e.g., a behavioral violation for which school administrators have the discretion to remove a student from the classroom environment, though they are not required to do so).⁸³ Such disparities in school discipline place youth of color at greater risk for becoming involved in the juvenile justice system in the future.⁸⁴

In 2015, the Council of State Governments 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.⁸⁵ Figure 74 shows that since 2015, the proportion of African American youth newly admitted to TJJD has increased dramatically.⁸⁶

Figure 74. TJJD New Admissions by Race/Ethnicity



Source: Data from Texas Juvenile Justice Department.(n.d.) *Texas Juvenile Justice Department Youth Characteristics*. Retrieved from <http://www.tjjd.texas.gov/statistics/youth-characteristics1317.pdf>.

Prior to the 85th legislative session, disproportionate minority contact in Texas juvenile justice settings was a concern of HHSC’s Center for Elimination of Disproportionality and Disparities. The CEDD, however, did 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 any suggestions.⁸⁷ SB 1 (85th, Nelson/Zerwas), Rider 216, reconstituted the CEDD as the Office of Minority Health Statistics and Engagement with a revised mandate to research, evaluate, develop, and recommend policies that address minority health (including in juvenile justice) to ensure equitable policies and practices statewide. The OMHSE subsequently was closed effective September 1, 2018.

Community-Based Behavioral Health Services for Justice-Involved Youth

TJJD, local juvenile probation departments, and the Texas Correctional Office for Offenders with Medical and Mental Impairments provide services for youth with mental health and substance use conditions in a variety of juvenile justice settings, including state secure facilities, secure residential treatment centers, and county secure facilities. The agencies also provide services for youth who are under probation or parole supervision in the community.

A growing proportion of justice-involved youth require and receive behavioral health services in Texas. In 2017, 99 percent of the newly-admitted youth to TJJD required at least one area of specialized treatment and 87 percent had multiple

areas of need.⁸⁸ For youth admitted since FY 2009 and released by FY 2016, 61.5 percent of youth with high or moderate mental health needs successfully completed treatment.⁸⁹ Over the last decade, as Texas shut eight state secure juvenile facilities, TJJD has changed from an agency focused on operating state juvenile correctional facilities to an agency devoting the majority of its budget to local juvenile probation departments providing community supervision and services.⁹⁰ In its 2017-21 strategic plan, TJJD stated that its top goal moving forward is to minimize juveniles' immersion in the justice system.⁹¹ Diverting youth with mental health conditions from incarceration and further involvement in the juvenile justice system has significant health and economic benefits. The most recent plan (for 2019-23) has a goal of spreading the Texas Model statewide, a model premised on keeping youth as shallow as possible in the system and close to their communities.⁹²

County-level services received additional support through funding for SB 1630 (84th, Whitmire/Turner), which mandated regionalization to ensure more youth would stay within their home regions. A regionalization task force determined that medium and low risk youth had been committed to TJJD because of high needs for specialized treatment.⁹³ The task force's Regionalization Plan noted a particular need to divert from TJJD commitment:

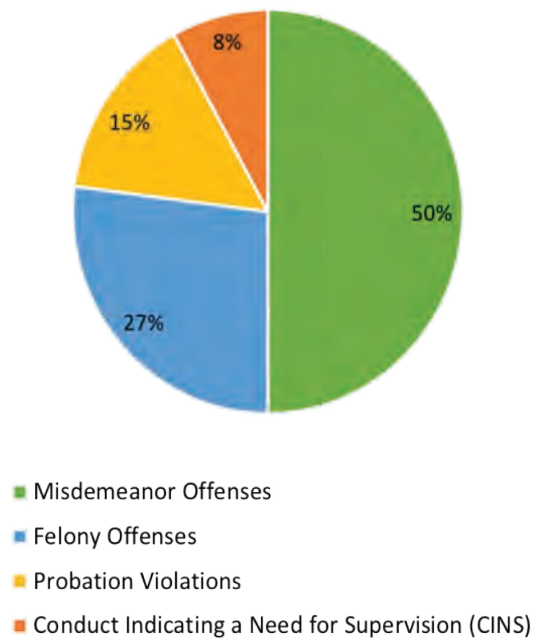
- younger offenders (those between the ages of 10-12);
- youth with a serious mental illness;
- youth with a developmental or intellectual disability;
- youth with non-violent offenses; and
- youth with low to moderate risk levels for re-offense.

The plan anticipates that as counties build out services for these youth, more youth with high and moderately high risk needs can also be diverted.

NEED FOR BEHAVIORAL HEALTH SERVICES THROUGH JUVENILE PROBATION DEPARTMENTS

In FY 2017, juvenile probation departments received 53,860 formal referrals throughout the state, a 14 percent drop from FY 2015.⁹⁴ Just over a quarter of referrals were for felony offenses. Figure 75 shows the type of offenses that precipitated referrals to juvenile probation departments.

Figure 75. Offense Type for Juveniles Referred to Juvenile Probation Departments



Source: Texas Juvenile Justice Department. (December 2017). *Annual Report to the Governor and Legislative Budget Board: Community Juvenile Justice Appropriations, Riders and Special Diversion Programs*. Page 14. Retrieved from https://www.tjjd.texas.gov/publications/reports/17_AnnualReport_for_Governor-LegBudgetBoard.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).⁹⁵ 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.⁹⁶ In FY 2017, 38,677 youth were referred to juvenile probation departments. Of youth under supervision by probation departments, 68 percent received at least one behavioral health service.⁹⁷

Texas counties vary in their capacity to identify and address youth with mental health needs. Though there is a high prevalence of mental health needs among justice-involved youth, few juveniles access mental health services prior to entering the justice system. Instead, many juveniles experience mental health treatment for the first time after they have been arrested, adjudicated, or diverted to mandated community treatment programs.⁹⁸

PARTNERSHIP WITH TEXAS CORRECTIONAL OFFICE FOR OFFENDERS WITH MEDICAL AND MENTAL IMPAIRMENTS (TCOOMMI)

County juvenile probation departments may partner with TCOOMMI, LMHAs, or Community Resource Coordination Groups 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.⁹⁹

Youth with mental health needs may receive services for a variety of reasons. Some children may be diverted from the probation system to receive mandated behavioral health services. Judges could also offer youth deferred adjudication and order treatment as a condition of dismissing each juvenile's charges. Youth who are adjudicated and placed on probation may be required to participate in either residential or community-based programs, such as counseling or substance use treatment; youth returning to the community after placement in a secure community or state facility may receive treatment as a condition of parole.

TCOOMMI coordinates continuity of care for some youth with a mental health diagnosis released on parole following their placement in a state or county secure facility. In July 2018, the average daily population on juvenile parole in Texas was 369 youth.¹⁰⁰ Depending on needs, the state may place paroled youth with a mental illness outside of their homes in community-based therapeutic foster homes, group living arrangements, or residential treatment facilities. Some youth receive intensive and collaborative wrap-around services that may include collaborative case planning, skills training and education, psychiatric services and medication monitoring, individual and/or group therapy, early intervention, vocational services, benefits eligibility services, and parental support and education.¹⁰¹ TCOOMMI also participates in the Texas System of Care and the statewide Community Resource Coordination Group Committee to address systems issues. As of September 21, 2018, TJJJ reported 21 youth receiving TCOOMMI services.¹⁰² Figure 76 outlines TCOOMMI eligibility criteria.

Figure 76. Eligibility for referral to TCOOMMI

(c) **Eligibility Criteria.**

For a youth to be eligible for referral to TCOOMMI, the following must apply:

Age at Time of Release or Discharge	Eligibility Criteria
17 or younger	<ul style="list-style-type: none"> • Current or prior diagnosis of conduct disorder and one or more of the following diagnoses: intellectual disability, autism spectrum disorder, pervasive developmental disorder, attention deficit hyperactivity disorder, mood disorder, depression, anxiety, bipolar disorder, intermittent explosive disorder, psychotic disorder, schizophrenia spectrum, schizoaffective disorder, adjustment disorders, and other similar diagnoses; or • Current prescription for psychotropic medication; or • Currently receiving care from a mental health professional or psychiatric provider or in the past six months had been under the care of a mental health professional or psychiatric provider; or • Currently assigned to the McLennan Residential Treatment Center or Ron Jackson Mental Health Treatment Program; or • Other clinical justifications (e.g., history of admission to psychiatric hospital or diagnosed with possible traumatic brain injury); or • Current complex and severe medical condition(s).
18	<ul style="list-style-type: none"> • Current or prior diagnosis of major depression, bipolar disorder, schizophrenia, schizoaffective disorder, post-traumatic stress disorder, psychotic disorder, anxiety disorder, delusional disorder, or another mental health disorder that is severe or persistent in nature; or • Current prescription for psychotropic medication; or • Current complex and severe medical condition(s); or • Other clinical justifications (e.g., recent admission to psychiatric hospital).

Source: Texas Juvenile Justice Department. (2018, September 21). Personal communication: Youth TCOOMMI eligibility criteria

COMMUNITY-BASED PROGRAMS AND SERVICES

To manage information about community-based programs, TJJD created its online Program and Services Registry in 2010.¹⁰³ The registry catalogues all active community-based programs offered by various juvenile probation departments across the state. Both juvenile probation departments and contracted agencies provide information regarding the service components of active programs, including their duration, funding, and eligibility requirements.¹⁰⁴

In FY 2017, local juvenile probation departments offered 1,517 community-based programs to at-risk youth, justice-involved youth, and their families.¹⁰⁵ These programs involved a wide array of services including counseling services, gang intervention programs, parenting classes, and employment training. In FY 2017, 34 percent of youth participants were enrolled in a treatment-based program, 41 percent were enrolled in a skill-building/activity-based program, and 25 percent were enrolled in a surveillance-based program.¹⁰⁶ Over half (54 percent) of all youth on deferred prosecution or under probation supervision participated in at least one community-based program in 2015, and 26 percent participated in three or more programs.¹⁰⁷

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.¹⁰⁸ In 2013, the ten urban juvenile probation departments had the most programs, with an average of 42 per department.¹⁰⁹ Medium and large probation departments offered an average of 11 and 18 programs, respectively.¹¹⁰ 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.¹¹¹

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. Table 57 lists the average duration of service for community-based programs with behavioral health components as determined by a 2013 evaluation.

Table 57. 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. (June 2013). *Community-Based Program Evaluation Series: Overview of Community-Based Juvenile Probation Programs*. Page 4. Retrieved from <http://www.tjjd.texas.gov/statistics/CommunityBasedJuvenileProbationPrograms.pdf>

SPECIAL PROGRAMS AVAILABLE TO LOCAL JUVENILE PROBATION DEPARTMENTS

TJJJD partially funds programs in local juvenile probation departments through diverse initiatives and grants. The programs aim to keep youth out of state-operated secure facilities and instead serve them in their local communities. The following section describes a variety of programs with behavioral health components that are available to local juvenile probation departments.

THE FRONT-END DIVERSION INITIATIVE

In 2008, using MacArthur Foundation funding, TJJJD developed the Front-End Diversion Initiative in partnership with local probation departments to divert youth away from the justice system *before* they are formally adjudicated.¹¹² FEDI links youth with mental health needs to specialized juvenile probation officers who have comprehensive training on mental illness, family engagement, de-escalation, and problem-solving techniques.¹¹³ 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.¹¹⁴

Five Texas counties implemented FEDI programs: Austin, Dallas, Lubbock, San Antonio, and Houston.¹¹⁵ In 2014, the National Institute of Justice designated FEDI as a “Promising Program” for its successes with pre-adjudicated youth.¹¹⁶ Some of FEDI’s successes include:-

- Within 90 days of supervision, FEDI participants were 11 times less likely to be adjudicated than their peers who received traditional supervision services.¹¹⁷
- Four FEDI sites (Austin, Dallas, Lubbock, and San Antonio) reported a 0 percent turnover rate among SJPOs, while most juvenile probation departments reported a 35 percent turnover rate over four years.¹¹⁸
- FEDI officers engaged in over 10 times more collateral contacts in the community than traditional probation officers did, leading participants to use more community services than other justice-involved youth.¹¹⁹ Table 58 shows the difference in the use of community services among youth enrolled in the FEDI program and youth receiving traditional supervision services.

Table 58. 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. (April 2015). *Diverting Youth at Probation Intake: The Front-End Diversion Initiative*. Page 5-6. Retrieved from <https://www.ncmhjj.com/wp-content/uploads/2016/02/FEDI-ARIAL-508-final.pdf>

THE SPECIAL NEEDS DIVERSIONARY PROGRAM

Through the Special Needs Diversionary Program, TJJD and TCOOMMI seek to rehabilitate and prevent future justice involvement among post-adjudication youth with diagnosed mental health conditions (excluding substance use conditions, intellectual disabilities, autism, and pervasive development disorder).¹²⁰ Specialized probation officers partner with mental health professionals from LMHAs to provide diverse services, including mental health services such as individual and family therapy; probation services such as life skills training, anger management, and mentoring; and parental support and education services. The program requires in-home contact with the youth and family, small caseloads, and 24/7 access for crisis resolution services.¹²¹

In FY 2017, the Texas Legislature appropriated about \$2 million to SNDP, serving 1,255 juveniles through 21 local juvenile probation departments.¹²² Of those served in FY 2017, 33 percent of youth had at least three previous juvenile probation referrals, 54 percent had a felony offense in their history, and 9 percent had a previous residential placement coordinated by the probation department.¹²³ Although the program tracks completion rates (66 percent in FY 2017), referrals to state secure facilities and re-offense rates can be good measures of program effectiveness. Of the youth starting SNDP in FY 2014, 58 percent committed a new Class B misdemeanor offense or an offense of greater severity within one year.¹²⁴ This compares to a re-offense rate of 42 percent calculated in FY 2009.¹²⁵ About 2 percent of youth who began SNDP in FY 2014 were committed to a TJJD facility within one year.¹²⁶

PREVENTION AND EARLY INTERVENTION PROGRAMS

In 2011, the 82nd Texas Legislature funded prevention and intervention services to stop “at-risk behaviors that can lead to delinquency, truancy, school dropout, or referral to the juvenile justice system.”¹²⁷ The services were required to focus on youth ages 6 to 17 who are not currently receiving supervision services, but who are at high risk for referral to the justice system.¹²⁸ In FY 2017, over \$3.1 million was appropriated for prevention and early intervention services, and 35 counties were awarded funding.¹²⁹ The juvenile probation departments focused on providing youth with educational assistance, skills building, character development, mentoring services after school and during the summer, and skills, services, and supports to parents and guardians of at-risk youth.¹³⁰

In FY 2017, 3,717 youth received prevention and intervention services.¹³¹ The average age of the participants was 11 years old, which aligned with the goal of reaching youth prior to contact with the juvenile justice system. Of the participants, 39 percent were Hispanic and 16 percent were African American.¹³² The percentage of youth in the prevention and early intervention program closely reflected the 46 percent Hispanic new admissions to TJJD state secure facilities over a 7-year period, but less than half of the 34 percent average African American admissions.¹³³

The 84th legislature required TJJD to partner with DFPS, TEA, and the Texas Military Department in the provision of juvenile delinquency prevention and intervention programs.¹³⁴ The workgroup noted as a key consideration that “active, untreated behavioral health concerns in students remain an on-going challenge

in dropout and delinquency prevention and intervention.”¹³⁵ By October of each fiscal year, the agencies must submit utilization and effectiveness data to the LBB.¹³⁶ Figure 77 shows available outcomes data for the first five years of the programming.

Figure 77. Outcomes, Outputs and Efficiencies for FY 2012-2016

TJJJ PREVENTION AND EARLY INTERVENTION PROGRAMS					
FY:	2012	2013	2014	2015	2016
Number of youth who started in program during the fiscal year	1,296	2,054	2,141	2,844	3,083
Number of youth who ended the program during the fiscal year	119	1,960	2,562	2,800	3,328
Percentage of youth completing prevention program successfully	96.6%	91.4%	92.7%	90.6%	90.6%
Percentage of eligible youth not referred to juvenile probation during program participation	97.2%	95.9%	94.8%	95.5%	96.7%
Number of youth for whom consents were received (not unduplicated)	34	893	1,108	1,295	Available Oct. 2018
Percentage of youth with the same or fewer school absences	58.8%	59.8%	61.6%	61.3%	Available Oct. 2018
Number of youth with discipline referrals (not unduplicated)	8	624	717	792	Available Oct. 2018
Percentage of youth with the same or decreased number of discipline referrals at school	62.5	80.0%	81.6	80.1%	Available Oct. 2018

Source: Texas Juvenile Justice Department, Texas Department of Family and Protective Services, Texas Education Agency & Texas Military Department. (October 2017). *Agency Coordination for Youth Prevention & Intervention Services*. Page 8. Retrieved from https://www.tjjd.texas.gov/services/prevention/docs/2017_inter-agency.pdf

COMMITMENT DIVERSION PROGRAM (GRANT C)

In 2009, the 81st Legislature created the Commitment Diversion Program (Grant C). 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 TJJJ facilities.¹³⁷ 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.¹³⁸

In FY 2017, 4,132 juveniles received a program, placement, or service funded at least in part by Community Diversion funds.¹³⁹ The majority (83 percent) of juveniles served by Grant C funds were under probation supervision, though youth on deferred prosecution are also eligible for services. In total, 2,199 juveniles exited the supervision disposition associated with a Grant C program, and of those, 75 percent completed their supervision successfully.¹⁴⁰

REGIONAL DIVERSION ALTERNATIVES PROGRAM (GRANT R)

The 84th legislature required TJJJ to develop a plan to reduce commitments to state secure facilities by diverting youth of low to moderate risk of re-offending.¹⁴¹ Youth with a serious mental illness were highlighted as particularly appropriate

for diversion. Regional Diversion Alternative Program grants serve to reimburse juvenile probation departments on a case-by-case basis for services to divert eligible youth from TJJD secure placements.¹⁴² Departments can also apply for Grant R funds to increase availability of evidence-based, intensive community-based, residential, reentry, and aftercare programs that improve the department’s capacity to treat youth locally.¹⁴³

Behavioral Health Services in County-Level Secure Facilities

At the county level, juveniles may be placed in two types of secure facilities, both of which offer various behavioral health services: pre-adjudication detention and post-adjudication correctional facilities. As of March 2018, select Texas counties operated 48 secure juvenile pre-adjudication detention facilities for the purpose of detaining juveniles who are deemed unsafe or inappropriate for release back into the community while awaiting their adjudication and/or disposition hearings.¹⁴⁴ These juveniles can be detained until a juvenile judge provides a “true” or “not true” finding for each youth’s offense. Approximately 540 Texas juveniles spent 100 days or more in pre-adjudication facilities at the county level in FY 2016.¹⁴⁵ About 33% (175 youth) of these individuals were formally referred for a non-felony offense.¹⁴⁶

Texas also has 35 post-adjudication secure facilities operated at the county level.¹⁴⁷ These facilities detain adjudicated youth who have committed offenses that are not severe enough to warrant placement in a state secure facility. They also may detain adjudicated youth who are waiting for placement in a treatment program for substance use or mental health challenges.¹⁴⁸

Because local juvenile justice systems rely heavily on county and local funding sources, the availability of treatment and support services varies across the state. Table 59 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>.

Table 59. Number and Percentage of Texas Pre- and Post-Adjudication Facilities with Specific Services

Type of Service	Pre-Adjudication Facilities	Post-Adjudication Facilities
Mental Health	20 (42%)	30 (86%)
Substance Use	20 (42%)	32 (91%)
Sex Offense	9 (19%)	22 (63%)
Female-Specific	8 (17%)	18 (51%)

Source: Texas Juvenile Justice Department. (n.d.). *Registered Juvenile Facilities in Texas (CY2018)*. Retrieved from <http://www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx>

Behavioral Health Services in State Secure Facilities

Texas operates five state secure facilities for youth adjudicated for felony offenses.¹⁴⁹ On July 31, 2018, there were 865 youth housed at the state's five secure facilities.¹⁵⁰ Table 60 below shows the name and location of the state secure facilities. In FY 2017, 29 percent of newly-committed youth were adjudicated for high-severity crimes, such as capital offenses.¹⁵¹

Table 60. 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.tjtd.texas.gov/programs/facilities_list.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.¹⁵² The services last approximately 28 to 35 days, which includes psychiatric and health evaluations and an introduction to TJJD's treatment programs.¹⁵³

After orientation, youth are relocated to various state secure facilities depending upon the juvenile's specific treatment needs. Approximately 15 percent of youth are placed in a halfway house following orientation, while many other juveniles in state custody fulfill their dispositions within secure detention facilities.¹⁵⁴ All girls who are committed to a detention facility must remain at the Ron Jackson complex because it is the only secure facility for females. Programming and services at Ron Jackson are designed to be similar to those offered at the McLennan County Residential Treatment Center, but are modified to reflect the unique needs of female youth.¹⁵⁵ 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.¹⁵⁶ In calendar year 2016, the Ron Jackson facility served 870 youth through the Orientation and Assessment Unit and on February 6, 2017 had a population of 181.¹⁵⁷

In October 2014, the Ron Jackson complex created a male intake unit for boys under 15 years old. Between October 2014 and March 2016, the intake unit served 35

boys.¹⁵⁸ Children under 15 who have been committed to a state secure facility remain at the Ron Jackson facility until they are about 14 years old.¹⁵⁹ At that time, TJJD and juvenile court stakeholders may choose between three courses of action depending upon the individual child's treatment needs:

1. The child may remain at Ron Jackson to finish his or her assigned sentence;
2. The child may be sent to another secure facility that can meet his or her treatment needs; or
3. The child may be transferred to a halfway house or to the community if TJJD staff members determine that release is both safe and clinically appropriate.

REHABILITATION AND SPECIALIZED TREATMENT PROGRAMS

All 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.¹⁶⁰ 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.¹⁶¹ The program aims to reduce criminogenic risk factors, increase protective factors, and decrease recidivism among justice-involved youth.

Psychiatric and psychological services are also available within all secure facilities. Male youth who are identified as having severe mental health needs are taken to TJJD's primary mental health treatment facility, the McLennan Residential Treatment Center in Mart, Texas, while similarly situated females stay at the Ron Jackson facility. Youth with the most mental health needs who also pose a danger to themselves or others are served within MRTC's Crisis Stabilization Unit. Equipped with eight beds, the CSU provides crisis intervention psychiatric care.¹⁶² 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.¹⁶³

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. Table 61 highlights the specialized treatment programs that exist at the five state secure facilities.

Table 61. Specialized Treatment Programs in Texas

Program	Participants	Treatment Services and Outcomes
Alcohol or Other Drug Use Treatment Programs	Youth with substance use issues or chemical dependencies.	Program components include evidence-based treatment curricula, substance use education, social skills training, counseling, and relapse prevention. Criminal behavior is addressed by linking the use of drugs to the youth's life story and offense. For youth admitted since FY2009 and released by FY2016, 91.5% of those with high or moderate need completed treatment. ¹⁶⁴
Aggression Replacement Therapy Program	Youth with a moderate need for treatment to address aggressive behavior.	The ART program offers treatment in 30 group sessions over ten weeks. Case managers use cognitive behavioral concepts and moral reasoning strategies to help participants develop pro-social values that help them function more safely in their relationships.
Capital and Serious Violent Offender Treatment Program	Capital Offender Group: Youths who are committed for murder, capital murder, and offenses involving the use of a weapon or deadly force. Violent Offender Program: Youths who have committed a violent crime but whose offenses are not serious enough to qualify for COG.	CSVOTP helps young people understand feelings associated with their violent behavior and identify alternative ways to respond when faced with risky situations. COG participants are required to reenact their crimes and play the role of both the perpetrator and victim. VOP participants do not engage in the same role play activities; instead, they focus on self-regulation, anger management, and value-changing activities. ¹⁶⁵ For youth admitted since FY2009 and released by FY2016, 94% of those with high or moderate need completed treatment and only 12.2% were rearrested for a violent offense with the first year following release [almost all of this data is exclusively the COG, as VOP began in July 2015]. ¹⁶⁶
Girls' Circle	Female youth	Girls' Circle uses a support group structure to promote resilience, engage female youth in gender-specific discussions, and increase self-esteem.



Program	Participants	Treatment Services and Outcomes
Mental Health Treatment Program	Youth with mental health conditions.	<p>The goal for the program is to treat the underlying mental health problem and allow youth to regain control over their behavior.</p> <p>The final goal is to reintegrate the young person with his or her family and community in a program that addresses his or her mental health and correctional therapy needs. Services in addition to others in this chart include trauma groups, Trauma-Focused Cognitive Behavioral Therapy, Seeking Safety curriculum, and psychosexual groups.</p> <p>More intensive services are centralized at the McLennan Residential Treatment Center (boys) and Ron Jackson (girls); services for youth with moderate or low need are available at all facilities.</p> <p>For youth admitted since FY2009 and released by FY2016, 61.5% of those with high or moderate need completed treatment and only 10.1% were rearrested for a violent offense with the first year following release.¹⁶⁷</p>
Pairing Achievement with Service	Youth who apply and participate in psychological screening.	<p>Youth train dogs in their care, including some dogs who are trained as service dogs for people with special needs.</p> <p>The dogs come from local animal shelters and earn a Canine Good Citizen Certificate.¹⁶⁸</p>
Sexual Behavior Treatment Program	Youth who are committed to TJJD for sex offenses.	<p>The program uses cognitive behavioral strategies and a relapse prevention component.</p> <p>Juveniles receive additional individual and group counseling, education, and trauma resolution therapies that focus on each youth's deviant sexuality and arousal patterns.</p> <p>For youth admitted since FY2009 and released by FY2016, 87% of those with high or moderate need completed treatment and only 4.6% were rearrested for a violent offense with the first year following release.¹⁶⁹</p>

Source: Texas Juvenile Justice Department. (December 2017). *The Annual Review of Treatment Effectiveness*. Retrieved from <http://www.tjtd.texas.gov/publications/reports/TER2017.pdf>

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Texas Department of Housing and Community Affairs

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Policy Concerns

- Lack of affordable housing options for people with disabilities, including individuals living with mental illness and substance use disorder
- Implementation and distribution of funds from Hurricane Harvey disaster relief
- 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 substance use disorder
- Location of Low Income Housing Tax Credit developments for persons with disabilities
- Reducing housing barriers for individuals with criminal justice history and mental health needs

Fast Facts

- In 2017, TDHCA served a total of 684,864 households and individuals through its combined programs, including 36,555 through its homeless services (up from 33,297 in 2016).¹
- The most recent point-in-time count of homelessness in Texas found that nearly 22 percent of individuals who are homeless have a severe mental illness (over 5,100), and half of those individuals are unsheltered.²
- The PIT count found that almost 19 percent of individuals who are homeless have a chronic substance use condition (over 4,000), and are more likely to be unsheltered than individuals with a mental illness.³
- Recent data indicates that 39 percent of all households in Texas are rent-burdened, paying more than 30 percent of their gross income toward housing.⁴ Data from 2010-2014 show that 67 percent of households making less than 30 percent AMFI in Texas are rent-burdened.⁵
- Research reveals a housing affordability gap for SSI recipients, many of whom are unable to work due to severe mental illness or disability.⁶ In 2018, recipients of SSI can receive a maximum of \$750 a month, which constitutes 109 percent of the average fair market rent for a one-bedroom housing unit.⁷
- As of 2016, Texas has a deficit of 613,185 available rental units affordable to extremely low income households (0-30% AMFI).⁸

TDHCA Acronyms

ACS – American Community Survey

AMFI – Average median family income

AMI – Area median income

AYBR – Amy Young Barrier Removal Program

CDBG-DR – Community Development Block Grant –

Disaster Relief

CEAP – Comprehensive Energy Assistance Program

CSBG – Community Service Block Grant

DADS – Department of Aging and Disability Services

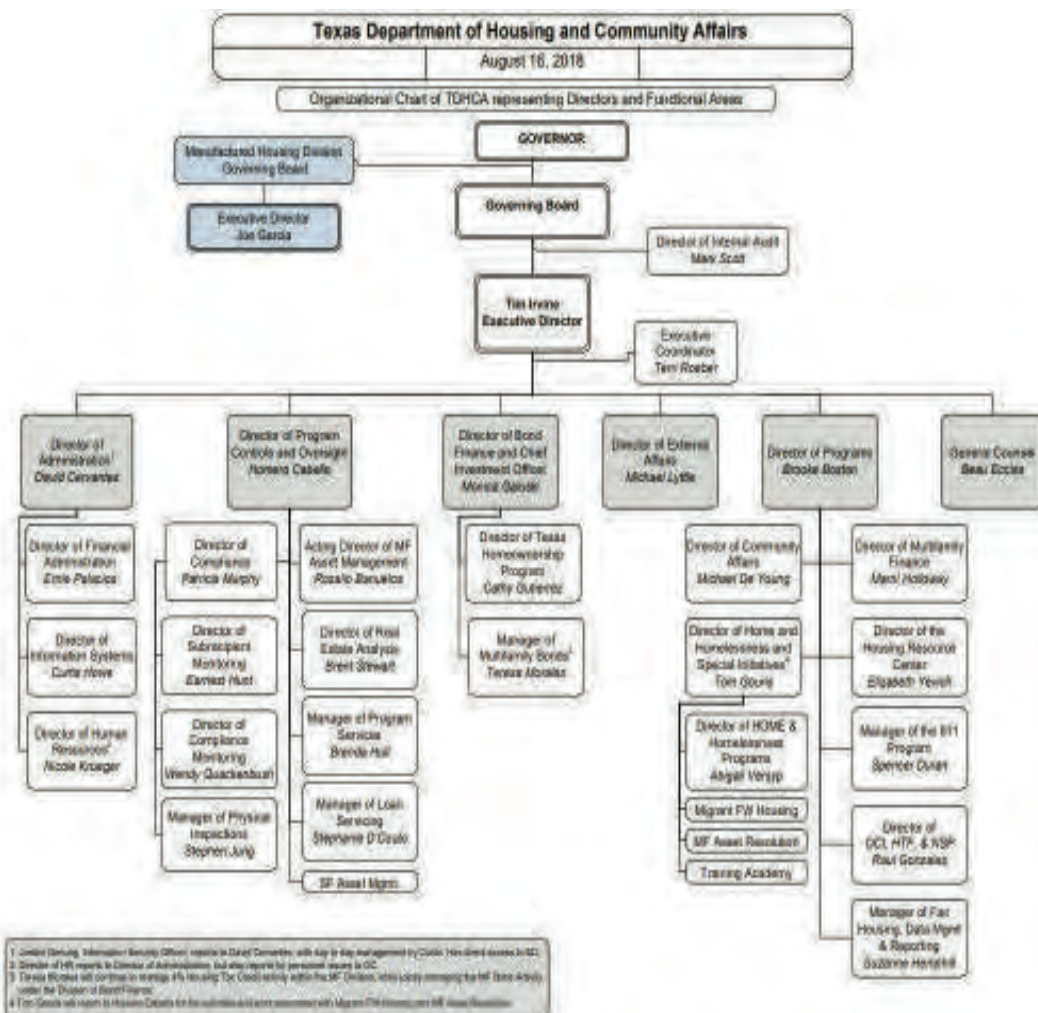
DOE – Department of Energy

ESG – Emergency Solutions Grants

FEMA – Federal Emergency Management Agency

- GLO – General Land Office
- HBA – Home buyer assistance
- HHS – Health & Human Services
- HHSC – Health and Human Services Commission
- HHSP – Homeless Housing and Services Program
- HRA – Home rehabilitation assistance
- HTF – Housing Trust Fund
- HUD – Housing and Urban Development
- LIHTC – Low income housing tax credit
- LMHA – Local mental health authority
- LMI – Low and moderate income
- PHA – Public housing authority
- PREPS – Partial Repair and Essential Power for Sheltering Program
- PSH – Permanent supportive housing
- TCAP – Tax Credit Assistance Program
- PIT – Point-in-time
- PRA – Project rental assistance
- QAP – Qualified Allocation Plan
- SAMHSA – Substance Use and Mental Health Services Administration
- SHC – Self-help center
- SSI – Supplemental Security Income
- TBRA – Tenant-based rental assistance
- TDA – Texas Department of Agriculture
- TDHCA – Texas Department of Housing and Community Affairs

Organizational Chart



TDHCA

Data obtained from: Texas Department of Housing and Community Affairs. (2018). TDHCA organizational chart. Retrieved from <https://www.tdhca.state.tx.us/hrdocs/org-chart.pdf>

Overview

Individuals with serious and persistent mental illness can experience significant barriers to permanent housing. The most recent PIT count of homelessness in Texas found that nearly 22 percent of homeless individuals (over 5,100) have a severe mental illness, and almost 19 percent of homeless individuals have a chronic substance use condition.⁹ 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.¹⁰ Serious mental illness and substance use conditions may create difficulties in accessing and maintaining stable, affordable, and appropriate housing, and affordable housing programs that focus on homelessness prevention are critical to helping this population become successfully housed.¹¹

The Texas Department of Housing and Community Affairs operates several major affordable housing programs. The agency distributes federal funds for housing and community services and is responsible for allocating housing tax credits under the federal Low Income Housing Tax Credit program. TDHCA ensures compliance with federal and state laws governing various housing programs and provides essential services and affordable housing opportunities to low-income Texans. TDHCA is also a Public Housing Agency, responsible for operating publicly-owned multifamily 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.¹² In 2017, TDHCA served a total of 684,864 households and individuals through its combined programs.¹³

In addition to supporting the housing needs of low-income Texans, TDHCA has programs and policies that specifically serve people with disabilities, including people with mental illness and substance use conditions, and those experiencing homelessness. A significant number of people with disabilities face extreme housing needs.¹⁴ In 2015, HUD reported that nearly 40 percent of low-income households with a non-elderly person with a disability experienced “worst case housing needs” – defined as paying more than half of income in rent or living in severely inadequate conditions without receiving government assistance.¹⁵

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.¹⁶ 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.”¹⁷

The executive director of TDHCA chairs the Council that, 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.¹⁸ 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 2016-2017 plan is available at <http://www.tdhca.state.tx.us/hhscc/docs/16-17-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 opportunities for low-income Texans broadly. However, the broader housing programs benefit Texans with disabilities and mental illness by expanding the overall stock of affordable housing and services in the state. Low-income individuals living with a disability or mental illness who experience a housing burden may be able to access rental assistance, housing rehabilitation funds, or energy assistance, for example. In addition, programs such as Section 811 and Project Access are tailored to individuals with disabilities.

Under its “rental assistance” category in Figure 78, TDHCA provides three different forms of assistance:

- **Tenant-based rental assistance:** Texas uses federal HOME funding to provide rental assistance to help offset the cost of market-rate rental housing for low-income renters. Tenants are required to pay up to 30 percent of their income toward rent for a market-rate housing unit, and the state makes up the remainder. Tenants select rental units themselves in the private market, though landlords must agree to accept the rental assistance from TDHCA. These programs are called tenant-based assistance because the subsidy is linked to and stays with the tenant. This type of assistance is time-limited to 24 months, but can be extended if funding is available.
- **Project-based rental assistance:** Project-based rental assistance is housing assistance that is attached to a property rather than a tenant. The HUD Section 811 program provides a rental subsidy to the housing provider directly to keep a unit affordable to extremely low-income tenants with disabilities linked to long-term services. This type of assistance is not time-limited.
- **Development assistance:** Lastly, the state provides subsidies to developers to construct or rehabilitate affordable multifamily rental housing. This form of assistance includes LIHTC, HOME Multifamily Loan and Bond programs, and TCAP.

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 78 lists the housing assistance and services that TDHCA offers in each area of need.

Figure 78. TDHCA Housing Support Continuum Activities

Continuum Activity	Program	Household Income Eligibility ^a
Poverty and Homelessness Prevention	<i>Community Service Block Grant (CSBG)</i> : Local services and poverty programs	<125% FPL
	<i>Comprehensive Energy Assistance Program (CEAP)</i> : Energy education and utility assistance	<150% FPL
	<i>Emergency Solutions Grants Program (ESG)</i> : Rapid assistance for persons who are homeless or at risk of homelessness	<30% AMFI (or homeless/at risk of homeless)
	<i>Homeless Housing and Services Program (HHSP)</i> : For large urban areas to assist individuals and families who are homeless	<30% AMFI (or homeless/at risk of homeless) or <50% for recertification
Rental Assistance and Multifamily Development	<i>Section 811 Project Rental Assistance</i> : Project-based rental assistance for very low-income persons with disabilities, linked with long-term services	The higher of <30% AMI or <FPL
	<i>Section 8 Housing Choice Voucher Program</i> : Tenant-based rental assistance vouchers for individuals in specific areas, or statewide for individuals with disabilities through Project Access	<50% AMI
	<i>Tenant-based Rental Assistance (TBRA, HOME-funded)</i> : Local grants to provide tenant-based rental vouchers	<80% AMI
	<i>Low Income Housing Tax Credit Program (LIHTC)</i> : Tax credits for construction or rehabilitation of affordable rental housing	<60% AMI
Homebuyer Education, Assistance and Single-Family Development	<i>Colonia Self-help Center (SHC)</i> : Funding for housing rehabilitation and construction, homebuyer assistance, and housing education in colonias	<80% AMI
	<i>Texas Statewide Homebuyer Education</i> : Training for nonprofits to provide homebuyer education	No income limit
	<i>Homebuyer Assistance (HBA, HOME-funded)</i> : Down payment and closing cost assistance for single family buyers, can include rehabilitation or accessibility modifications	<80% AMI
	<i>Contract for Deed (funded through HOME and Housing Trust Fund)</i> : Assisting colonia residents to convert contract-for-deed to traditional mortgage	<60% AMI
	<i>My First Texas Home</i> : Low-interest loans and down payment costs for first-time homebuyers	<115% AMI (non-targeted) <140% AMI (targeted)
	<i>Mortgage Credit Certificate (TX MCC)</i> : Tax credit for homebuyers based on mortgage interest	<115% AMI (non-targeted) <140% AMI (targeted)
	<i>Single Family Development (HOME-funded)</i> : Loans to qualified non-profit developer for single-family construction, rehabilitation, or acquisition	<80% AMI
	<i>Texas Bootstrap Loan Program</i> : 0% interest loans to owner-builders, through nonprofits, to rehabilitate or construct their home through self-help construction	<60% AMI
	<i>Neighborhood Stabilization Program</i> : Funds to purchase and redevelop foreclosed or abandoned homes	<120% AMI

Continuum Activity	Program	Household Income Eligibility ^a
Rehabilitation, Barrier Removal and Weatherization	<i>Amy Young Barrier Removal (funded through Housing Trust Fund)</i> : Grants to fund accessibility modifications to homes of people with disabilities	<80% AMI
	<i>Homeowner Rehabilitation Assistance (HRA, HOME-funded)</i> : Grants to fund home repair and replacement assistance	<80% AMI
	<i>Weatherization Assistance</i> : Grants to fund minor home repairs to increase efficiency	<150% (Low Income Housing Energy Assistance Program [LIHEAP]) <200% FPL (Dept. of Energy Weatherization Assistance Program [DOE WAP])
Disaster Assistance Relief	<i>Community Services Block Grant</i> : Emergency shelter, food and clothing	<125% FPL
	<i>Disaster Relief (HOME-funded)</i> : Home repair, rehabilitation, construction, homebuyer assistance, and tenant-based rental assistance for households affected by a disaster	<80% AMI

^aFPL = 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. (2018). 2018 State of Texas low income housing plan and annual report, 106. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/18-SLIHP.pdf>

Changing Environment

HURRICANE HARVEY

On August 25, 2017 Hurricane Harvey made landfall near Port Aransas, Texas as a Category 4 hurricane. The storm lasted for four days, dropped as much as 60 inches of rain in some areas of the state and is estimated to have caused \$120 billion of damage.¹⁹ The size and severity of the storm resulted in devastating flooding that destroyed the homes of thousands of Texans, many in areas that had never flooded before. The Texas General Land Office estimates that more than 1 million homes were impacted by the storm, and as of February 2018 the FEMA Individuals and Households program had received over 896,000 applications for housing and related assistance.²⁰

Just as there were major losses to the single-family housing stock, many affordable multifamily housing units, often the only affordable housing options available to people experiencing mental illness, sustained severe damage. More than 1,930 units tied to Public Housing Assistance, including Section 8 and Housing Choice vouchers, were lost in the storm.²¹ The total cost of these losses amounted to nearly \$25,600,000.²² According to a FEMA-calculated needs assessment, approximately 46 percent of those in need of housing fall within the Low and Moderate Income category (under 80 percent AMFI).²³ Of those 46 percent, nearly half are people who make 30 percent or less AMFI, considered to be extremely low income.²⁴

As of April 2018, two rounds of HUD funding have been proposed for Harvey

recovery. At the end of 2017, HUD allocated \$57.8 million in Community Development Block Grant – Disaster Recovery dollars to help address immediate housing needs.²⁵ These funds were leftover from the CDBG-DR dollars issued to Texas for the 2015 and 2016 floods. The GLO submitted an action plan to HUD for these dollars in March 2018.²⁶ By rule, 80 percent of the money must be spent in Harris County.²⁷ The remaining 20 percent will be allocated across Aransas, Nueces and Refugio counties for an affordable rental program.²⁸ Additionally, 70 percent of the funds must benefit LMI households.²⁹ In Harris County, funds will be used to buy-out single family properties for LMI households and to provide federal match for the Partial Repair & Essential Power for Sheltering program, a program specific to Harvey recovery that provides partial home repair to displaced families to allow them to return home until full repairs can be completed. Outside of Harris County, dollars will be spent on rebuilding affordable workforce housing.

The second round of funding for approximately \$5 billion was proposed in February 2018 and approved in August 2018. These funds are part of the 2017 national disaster aid package included in the Continuing Appropriations Act, 2018 and Supplemental Appropriations for Disaster Relief Requirements Act, 2017.³⁰ The plan for these dollars is broader-reaching than the first, but 70 percent of funds must be used for LMI projects and all proposed projects must primarily consider unmet housing needs.³¹ The GLO action plan includes two programs to address LMI housing needs: the Homeless Prevention Program providing utility assistance, short-term mortgage assistance and Tenant-Based Rental Assistance vouchers; and the Affordable Rental Program providing funds for rehabilitation, reconstruction, and new construction of affordable multifamily housing projects.³²

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.³³ As part of that law, recipients of HUD funds are under an obligation to “affirmatively further” nondiscrimination policies. This requirement obligates recipients of HUD funding not just to prohibit discrimination but to take proactive steps to fight housing segregation and promote inclusive and integrated communities. HUD requires agencies that receive any Community Planning and Developments funds to undertake fair housing planning: in Texas, that plan is the Analysis of Impediments to Fair Housing report.³⁴ The last report was completed in 2013 and planning is currently underway for the next one due out in 2019.

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 2018-2019 biennium.

The 2018-2019 TDHCA budget contains \$526 million in federal funding, constituting 88 percent of TDHCA's total funding for the biennium.³⁵ TDHCA receives federal funding through several departments, including the US Department of Health and Human Services, Department of Housing and Urban Development, and the Department of Energy.³⁶ HUD and HHS provide the largest financial support to TDHCA.³⁷ 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 2018-2019, the legislature appropriated \$24 million to TDHCA, comprising approximately five percent of total agency funding.³⁸ General revenue primarily funds the state Housing Trust Fund, which the legislature created in 1993 and is TDHCA's only state-funded affordable housing program.³⁹ 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.⁴⁰ In practice, the HTF currently funds the following programs:

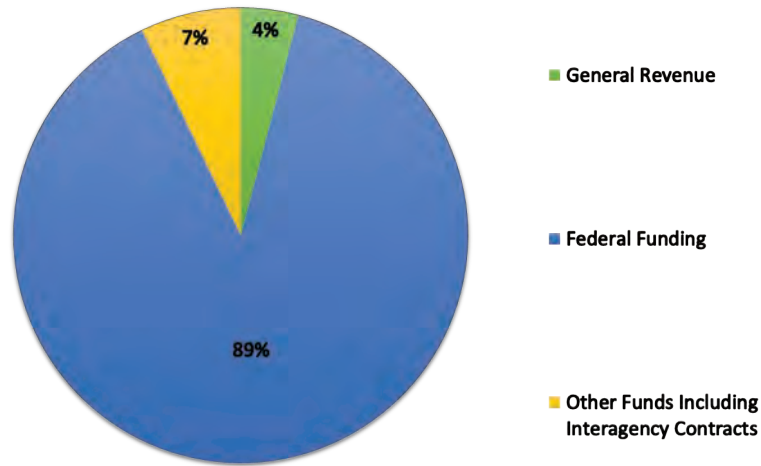
- Amy Young Barrier Removal Program
- Texas Bootstrap Home Loan Program

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 to help finance the administration of the Housing Tax Credit program and other indirect administrative costs.⁴¹ For 2018-2019, this source of funding constitutes \$41.6 million, or approximately nine percent, of the agency's total funding.⁴²

Interagency contracts provide another source of funding for TDHCA's affordable housing programs. The Texas Department of Agriculture is in contract with TDHCA to support Colonia Self-Help Centers.⁴³ TDA sets aside and transfers 2.5% of Community Development Block Grant funds to TDHCA to support these centers.⁴⁴ A colonia "is a geographic area located within 150 miles of the Texas-Mexico border that has a majority population composed of individuals and families of low and very low income," often lacking basic services like potable water and sewage systems.⁴⁵ Figure 79 shows TDHCA funding by Method of Finance.

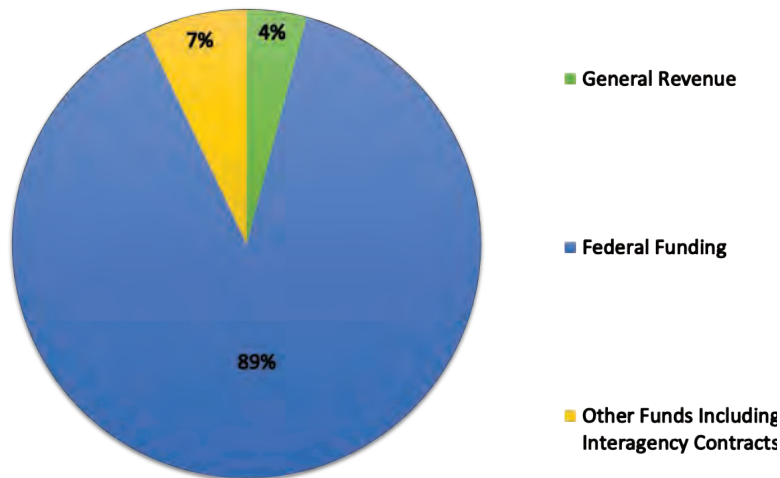
Figure 79. TDHCA Funding by Method of Finance for FY 2018-19



Total funding for TDHCA for FY 2018-19 is \$ 593,471,097.

Data obtained from: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Housing and Community Affairs*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2020>

Figure 80. TDHCA Funding by Method of Finance for FY 2020-21



Total funding requested for TDHCA for FY 2020-21 is \$587,692,913 . The TDHCA Legislative Appropriations Request did not include any Exceptional Item Requests.

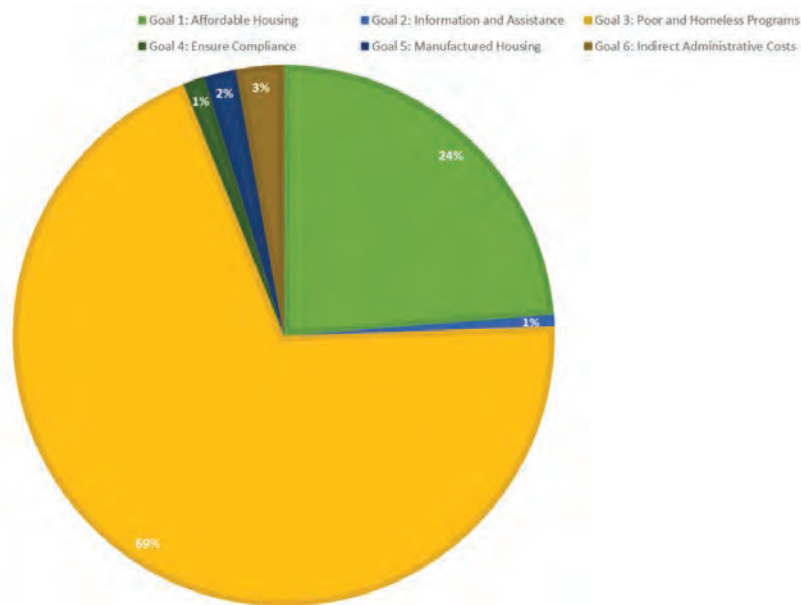
Data obtained from: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Housing and Community Affairs*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2020>

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.⁴⁶

In terms of direct allocations outlined in the state budget, 70 percent of TDHCA's 2018-2019 budget goes toward homeless and poverty services.⁴⁷ Only 21 percent goes toward affordable housing programs, including rental assistance and subsidies to multifamily housing developers.⁴⁸ 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.⁴⁹ Direct biennial funding to TDHCA comprises only a small portion of Texas' total budget. For 2018-2019, the agency's budget is \$474 million, or about .2 percent of Texas' \$217 billion budget.⁵⁰ Figure 81 below illustrates the agency's budget by programmatic earmark, as described in the biennial 2018-2019 budget.

Figure 81, 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 2017, it expended a total of over \$1.6 billion in both direct and indirect funding.⁵¹ This includes almost \$74 million for the federal LIHTC program, financed through federal tax credits, for the new construction or rehabilitation of affordable rental housing.⁵² It also includes over \$870 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.⁵³ Figure 82 below illustrates the total direct and indirect funding expended by the agency in FY 2017, according to its most recent annual report.

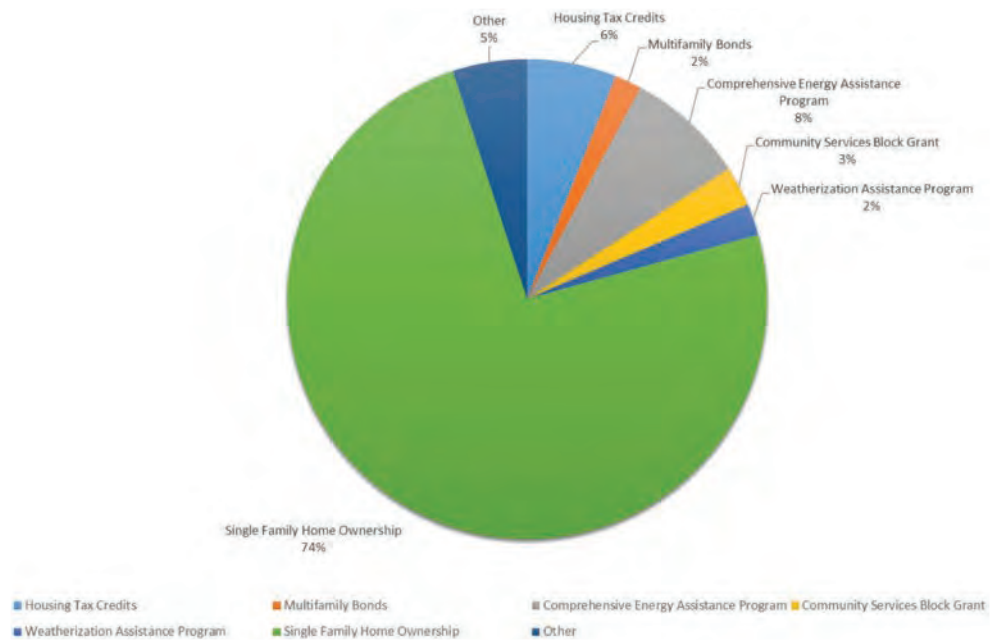
Figure 81. TDHCA Funding by Goal for FY 2018-19



Total TDHCA Budget for FY 2018-2019 is 593,471,097

Data obtained from: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021, Texas Department of Housing and Community Affairs*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=332&fy=2020>

Figure 82. TDHCA Expenditures, from Direct and Indirect Funding Sources (2017)



FY 2017 TDHCA Expenditures by direct and indirect funding sources Total: \$1,177,699,946

*Note - "Other" category includes: HOME Investment Partnerships Program, Section 8, Emergency Solutions Grants (ESG) Program, Homeless Housing and Services Program (HHSP), Housing Trust Fund (HTF), Multifamily Direct Loan, and Section 811 PRA. Data obtained from: Texas Department of Housing and Community Affairs. (2018). 2018 State of Texas low income housing plan and annual report, Page 47. Retrieved from <http://www.tdhca.state.tx.us/housing-center/docs/18-SLIHP.pdf>

Affordable Housing

Without a safe, stable and affordable place to live, it is nearly impossible to achieve a high level of overall health and wellness.⁵⁴ However, many Texans face a housing cost burden.⁵⁵ A housing cost burden exists when a household pays more than 30 percent of its gross income toward housing.⁵⁶ In Texas, 39 percent of all renter households and 20 percent of all homeowners face a housing cost burden, regardless of income.⁵⁷ Data from 2010-2014 show that, of Texas renter households with incomes below 30 percent of Area Median Family Income, 67 percent face a housing cost burden.⁵⁸ This is compared to only 4 percent of renter households with incomes over 100 percent AMFI.⁵⁹ Overall, 2010-2014 data show that 2.4 million Texas renter and homeowner households with incomes below 100 percent AMFI face a housing cost burden.⁶⁰

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 to determine AMFI in communities throughout the country. The AMFI calculation uses data that are unique and specific to a metropolitan area, sub-areas of a metropolitan area, and non-metropolitan counties.

Texas' 2017 AMFI is \$68,800.⁶¹ Low-income households are those whose income does not exceed 80 percent of AMFI. HUD breaks “low-income” down further, as described below. For a Texas household of four in 2018, HUD establishes the following income categories:

- Low-income (≤ 80% AMFI): ≤ \$55,050
- Very low-income (≤ 50% AMFI): ≤ \$34,400
- Extremely low-income (≤ 30% AMFI): ≤ \$20,650⁶²

Barriers to affordable housing can disproportionately affect many Texans living with behavioral health conditions. If a person's ability to work is hindered by their mental illness or substance use condition, it is likely that their income will not be sufficient to afford quality housing. Supplemental Security Income is a federal program that provides a monthly income to people with little income and few resources who are blind, disabled, or elderly.⁶³ Many SSI recipients are unable to work due to severe mental illness or disability.⁶⁴ Research reveals a housing affordability gap for SSI recipients. In 2018, recipients of SSI in Texas receive a maximum of \$750 a month, which constitutes 109 percent of the average fair market rent for a one-bedroom housing unit.⁶⁵ Without affordable housing options, people with serious mental illness are left without community living options and are at risk of having to live in institutional settings like nursing homes or psychiatric facilities.⁶⁶

Another ongoing barrier to affordable housing is the negative stigma associated with mental illness that can also prevent many Texans from participating in community life and accessing housing. People with a mental health condition who also have a criminal record can be barred from a number of housing options and have an extremely 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 disabilities⁶⁷

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.⁶⁸

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing is long-term, 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 supports⁶⁹

No PSH project is assumed to be able to offer all of these core elements, but the extent to which they are able to do so tends to predict whether the project will be successful.⁷⁰ For more information on PSH, 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 of Housing First is that once housing stability is achieved, people will be better positioned to effectively address serious mental illness or co-occurring substance use. The US Department of Veterans Affairs adopted a Housing First model in 2015, and an assessment of their year one pilot showed an increase in housing retention rates and a decrease in healthcare utilization for Housing First tenants compared to those in housing with treatment requirements.⁷¹ The United States Interagency Council on Homelessness suggests using PSH in combination with a Housing First approach to address chronic homelessness.⁷²

For more information on the Housing First model, see the US Interagency Council on Homelessness checklist: https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf.

Housing Programs Serving People with Disabilities or Mental Health Conditions

Several of Texas' 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, including mental illness.

A variety of TDHCA programs have policies that specifically reserve funding or space for persons with disabilities or mental health conditions – these reserved funds are known as “set-aside” funds.

The programs described below do not represent a comprehensive listing of all the affordable housing resources in Texas. 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.⁷³ In FY 2017, the statewide AMFI was \$68,800.⁷⁴ In addition, 75 percent of households participating in the voucher program must be Extremely Low Income (30 percent or below AMFI).⁷⁵ Along with meeting these income requirements, several other factors are taken into account to determine eligibility, including size and composition of the household, citizenship status, and childcare expenses.⁷⁶

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.⁷⁷

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 2018, up to 140 of the 900 total Housing Choice Vouchers available can be used by people with disabilities in the Project Access program.⁷⁸ To be eligible for a Project Access voucher, an individual must have a permanent disability as defined in Section 223 of the Social Security Code, or be determined to have a physical, mental, or emotional disability that is expected to be of long-continued and indefinite duration and impedes the individual’s ability to live independently. Applicants must also meet one the following requirements:

- be an At-Risk Applicant and a previous resident of a nursing facility, intermediate care facility, Texas state psychiatric hospital, or board and care facility as defined by the U.S. Department of Housing and Urban Development; or
- be a current resident of a nursing facility, intermediate care facility, Texas state psychiatric hospital or board and care facility at the time of voucher issuance as defined by the U.S. Department of Housing and Urban Development; or
- be eligible for a pilot program with the Health and Human Services Commission

for residents of Texas state psychiatric hospitals.⁷⁹

At-Risk Applicants meet the following criteria:

- current recipient of Tenant-Based Rental Assistance from the Department's HOME Investments Partnership Program; and
- within six months prior to expiration of assistance.

TDHCA works in collaboration with the Health and Human Services Commission to implement Project Access. Assistance through Project Access vouchers is not time limited; however, there is a waiting list for Project Access vouchers.⁸⁰ TDHCA established a process that allows people on the Project Access waitlist to relocate from an institution using the HOME-funded Tenant-based Rental Assistance program (see below).⁸¹ The goal is for a person to be admitted to the Project Access program by the time TBRA assistance expires.⁸² While this is not a permanent fix, it allows for people to transition into community settings sooner than they would be able to otherwise.

LOW INCOME HOUSING TAX CREDIT PROGRAM

The Low Income Housing Tax Credit program is a federally funded multifamily rental development program. TDHCA administers the program, which is funded by the US Treasury Department through the federal tax code. LIHTC is the largest affordable housing program in the history of the United States and produces around 75,000 affordable housing units nationally per year.⁸³

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 2018, TDHCA allocated \$74 million in housing tax credits to construct or rehabilitate approximately 9,900 rental units in Texas.⁸⁴

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. Texas codifies its requirements for the competitive tax credit award process annually in its Qualified Allocation Plan. The 2018 QAP contains provisions that provide scoring incentives for developments that can benefit people with disabilities:

- 30 percent Basis Boost, used to calculate the number of tax credits for which the property is eligible, for developments dedicated to providing only supportive housing, or developments setting aside an extra 10 percent of their units for families at or below 30 percent AMFI.
- Contain at least a five percent special needs unit set-aside (but no more than 18 percent)
- Points for supportive housing developments offering support services
- Points for supportive housing developments containing a 20 percent extremely

low-income set-aside for tenants with incomes below 30% AMFI⁸⁵

HOME INVESTMENT PARTNERSHIPS PROGRAM

The Texas HOME Investment Partnerships Program is a federally-funded set of programs that seek to expand the supply of decent, safe, affordable housing and enhance partnerships between state and local governments, public housing authorities, local nonprofits, and private housing actors.⁸⁶ HOME finances both single and multifamily programs, some of which are described below. The 2018-2019 budget allocates approximately \$70 million to provide affordable housing through the HOME program.⁸⁷ By state law, 95 percent of Texas HOME funds must serve jurisdictions, mostly rural, that do not receive HOME funds directly from HUD.⁸⁸ However, there is a five percent set-aside for activities that serve persons with disabilities, regardless of where they live.⁸⁹

PERSONS WITH DISABILITIES SET-ASIDE

Five percent of HOME funds are set aside for persons with disabilities which can be used for Homebuyer Assistance, Tenant-based Rental Assistance, or Homeowner Rehabilitation Assistance. See below for more details about these programs. Local governments, PHAs, and nonprofit entities can apply for set-aside funds with TDHCA.⁹⁰

HOMEBUYER ASSISTANCE PROGRAM

Nonprofits, PHAs, and units of local government are eligible to participate in the Homebuyer Assistance program to provide down payment and closing cost assistance to single family homebuyers.⁹¹ The program may also help to fund rehabilitation or accessibility modifications to single family homes. In addition to providing financial tools, these programs offer educational opportunities to learn how to manage homeownership.

TENANT-BASED RENTAL ASSISTANCE PROGRAM

The HOME-funded Tenant-Based Rental Assistance program provides utility deposits and rental subsidies to tenants seeking affordable housing in their community. These HOME rental subsidies last up to 24 months and are contingent on participation in a self-sufficiency program. Individuals may receive assistance for up to five years, pending funding.⁹² TBRA is a short-term assistance program that also has the possibility to be a bridge program for individuals on the waitlist for the Project Access program.

HOMEOWNER REHABILITATION ASSISTANCE PROGRAM

The Homeowner Rehabilitation Assistance program funds units of local governments, PHAs, and nonprofits to provide a variety of services for homeowners including same-site rehabilitation or reconstruction of owner-occupied housing, new construction or replacement of owner-occupied Manufactured Housing Units, and new construction or replacement of owner-occupied MHUs that have become inhabitable.⁹³

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 1990.⁹⁴ The program bolsters housing for people with disabilities in two ways: interest-free development funds and operating subsidies for nonprofit developers of affordable housing for people with disabilities, and rental assistance to be used in developments funded through other subsidy programs, such as the Low Income Housing Tax Credit and HOME programs.

SECTION 811 PROJECT RENTAL ASSISTANCE

The Section 811 Project Rental Assistance program is used to provide rental assistance paired with voluntary support services to eight major metropolitan areas across Texas.⁹⁵ Eligible properties apply to commit units to the program.⁹⁶ People with serious mental illness and people with disabilities exiting institutions are target populations for this program, as well as youth exiting foster care.⁹⁷ TDHCA, HHSC, and DFPS have entered an inter-agency agreement to effectively address the needs of the population that will be targeted for this program, how this population will be reached and referred to the program, and the commitments of services from the health and human service agencies.⁹⁸ Since the Section 811 PRA program began in 2012, two rounds of funding have been awarded; Texas received awards in both the FY 2012 and FY 2013 cycles. Combined, Texas received about \$24 million to serve an estimated 658 units.⁹⁹ In the 2019 Multifamily program funding cycle, TDHCA anticipates adding a further 400 units to the program, bringing the total commitment to about 1,200 units.¹⁰⁰ Additionally, around 40 percent of families served through this program were previously homeless.¹⁰¹ For more information on this program, please visit the TDHCA website <https://www.tdhca.state.tx.us/section-811-pra/>.

AMY YOUNG BARRIER REMOVAL PROGRAM

The Amy Young Barrier Removal Program provides funding for persons with disabilities to improve accessibility and remove dangerous conditions from their homes. The program provides one-time grants of up to \$20,000 for accessibility home modifications to people with a disability whose household incomes are below 80 percent of AMFI.¹⁰² Accessibility modifications may include the installation of ramps, handrails, or door widening, for example. Program beneficiaries may be homeowners or renters. Funds for the AYBR Program come from the state's Housing Trust Fund. In 2018 TDHCA announced that \$1.5 million will be available in 2019 for the program.¹⁰³ TDHCA disburses funds to nonprofit organizations and local governments that process applications, verify eligibility, and oversee construction.¹⁰⁴

POVERTY AND HOMELESS PREVENTION PROGRAMS

TDHCA has several programs that specifically serve people who are experiencing homelessness.

HOMELESS HOUSING AND SERVICES PROGRAM

The Homeless and Housing Services Program was established during the 81st Texas Legislature through an appropriations rider and codified during the 82nd Texas Legislature.¹⁰⁵ This state-funded program provides funding to the either largest cities in Texas to support a variety of activities to address and prevent homelessness including:

- construction, development, or procurement of housing for homeless persons;
- rehabilitation of structures targeted to serving homeless persons or persons at-risk of homelessness;
- provision of direct services and case management to homeless persons or persons at-risk of homelessness; or
- other homelessness-related activity as approved by the Department.¹⁰⁶

Case management was the highest-funded activity during FYs 2015 and 2016 and can include behavioral health services like counseling and drug and substance rehabilitation.¹⁰⁷ From FY 2010 through FY 2016, HHSP served 45,672 people, making up 35,553 households.¹⁰⁸

EMERGENCY SOLUTIONS GRANTS PROGRAM

The Emergency Solutions Grants program is a competitive grant that awards funds to private nonprofit organizations, cities, and counties to provide the services necessary to help persons that are at-risk of homelessness or homeless quickly regain stability in permanent housing.¹⁰⁹ The ESG program is funded by the U.S. Department of Housing and Urban Development and provides two-year awards. Program funds can be used to support multiple activities related to preventing and mitigating homelessness including:

- Engaging homeless individuals and families living on the street;
- Improving the number and quality of emergency shelters for homeless individuals and families;
- Helping operate these shelters;
- Providing essential services to shelter residents;
- Rapidly rehousing homeless individuals and families; and
- Preventing families and individuals from becoming homeless.

In 2017 28,706 people were served by ESG using a little over \$9 million.¹¹⁰

Related Services and Programs - Other State Agencies

MODEL BOARDING HOME STANDARDS

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. 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. Legislative efforts have been made to improve boarding homes to make them a better option for more Texans experiencing mental illness including a bill in 2009 (HB 216, 81st Menendez/Shapleigh) directing HHSC to establish model boarding home standards.¹¹¹

SUPPORTIVE HOUSING RENTAL 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 LMHAs. The program was originally established to act as a stopgap measure while individuals waited to receive other vouchers.¹¹² The program today provides short-term assistance for up to three months to help people maintain their current housing, and longer-term assistance of up to 12 months with extensions given on a case-by-case basis.¹¹³ The program has received level funding from the legislature since its inception at a biennial amount of \$11.6 million in the base budget.¹¹⁴ Since the program began, participants have reported positive outcomes: in 2017, participants reported a reduction in homelessness and an increase in their choice of permanent supportive housing by the end of their service.¹¹⁵ The program now operates at 20 LMHAs across the state and is administered by HHSC.¹¹⁶ An estimated 8,000 people will be served by this program in 2018.¹¹⁷

HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES THROUGH 2-1-1

In September 2013, DADS and TDHCA finalized and made available a clearinghouse for housing and services resources on the 2-1-1 Texas website. Searchable by geographic area, this online clearinghouse provides an interactive resource for finding community-based affordable housing including subsidized and supportive options. There is also a section dedicated to services for people experiencing mental illness, including counseling and support groups. The clearinghouse website is now overseen by HHSC and is available at <https://www.211texas.org/guided-search/>

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Policy Concerns

- Ensuring sustainable employment outcomes for people with serious and persistent mental illness
- Establishing accountability for outcome-based vocational rehabilitation services for individuals living with serious and persistent mental illness
- Lack of available information and data regarding employment outcomes for people experiencing mental illness.

Fast Facts

- The national unemployment rate was 3.9% in August 2018, down from 4.4% in August 2017 according to the Bureau of Labor Statistics.¹ The unemployment rate in Texas was 3.9% in August 2018, down 0.1% from August 2017.² 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

- In 2016, about 39% of Texans with disabilities living in the community were employed compared to 76% of people without a disability.⁶ In the same year, the national unemployment rate for people with a disability was 10.5%, nearly twice that of people without a disability.⁷

TWC Acronyms

FUTA – Federal unemployment tax

HHSC – Health and Human Services Commission

IDD – Intellectual and other developmental disabilities

NAMI – National Alliance on Mental Illness

SNAP E&T – Supplemental Nutrition Assistance

Program Employment and Training

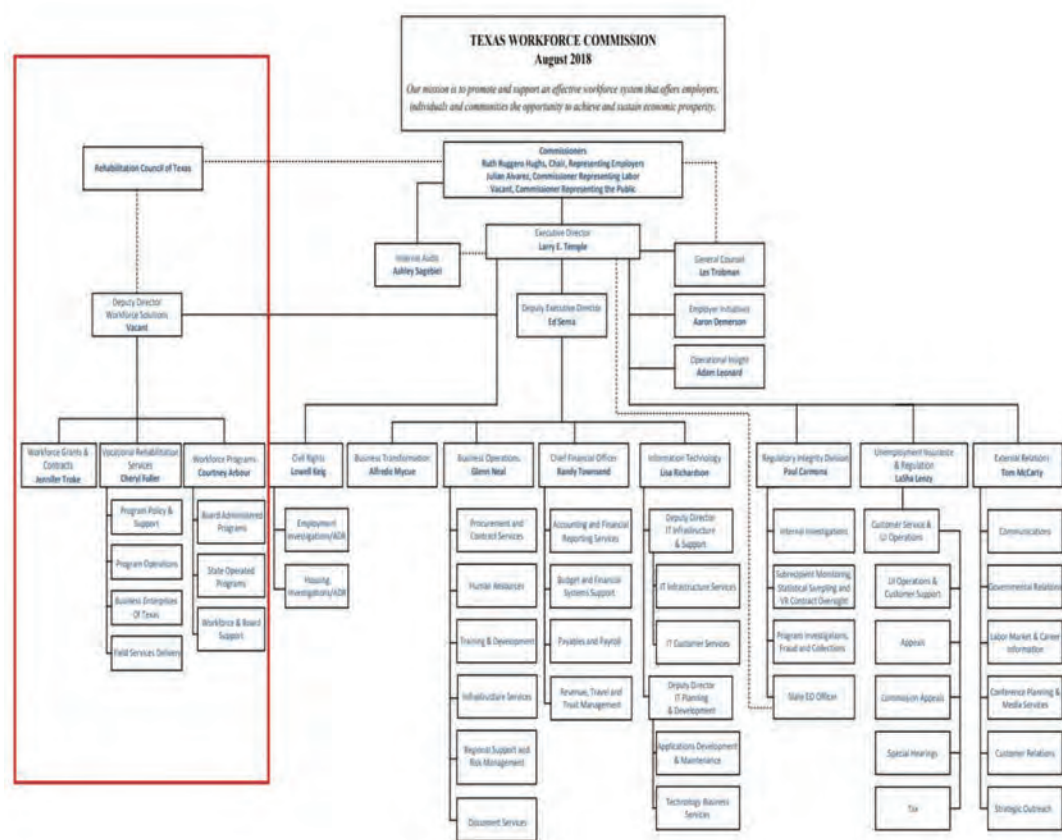
TANF – Temporary Assistance for Needy Families

TWC – Texas Workforce Commission

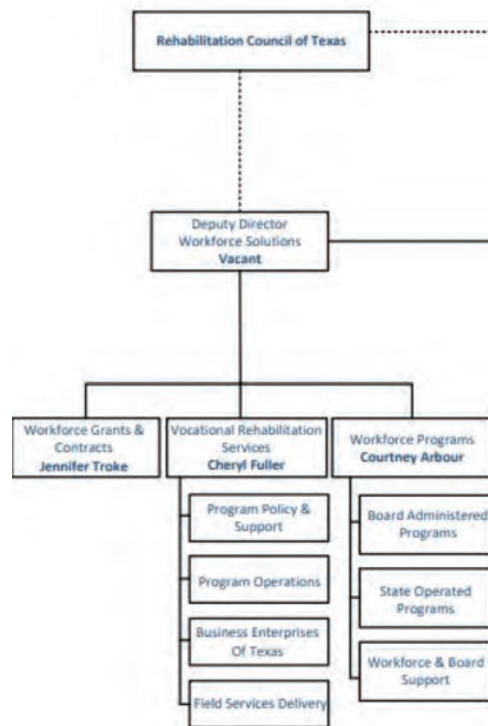
VR – Vocational rehabilitation

WIA – Workforce Investment Act

Organization Chart



Sub-Organization Chart – Programs for People with Disabilities



Source: Texas Workforce Commission (2018). *Organizational Chart*. Retrieved from <http://www.twc.state.tx.us/files/agency/agency-organizational-chart-twc.pdf>

Overview

The Texas Workforce Commission 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.⁸ 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.⁹

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.”¹⁰

In FY 2017, TWC served nearly 680,000 Texans through its programs, in addition to over 85,400 employers.¹¹ Table 62 describes three major types of beneficiaries who utilize TWC services.

Table 62. 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.

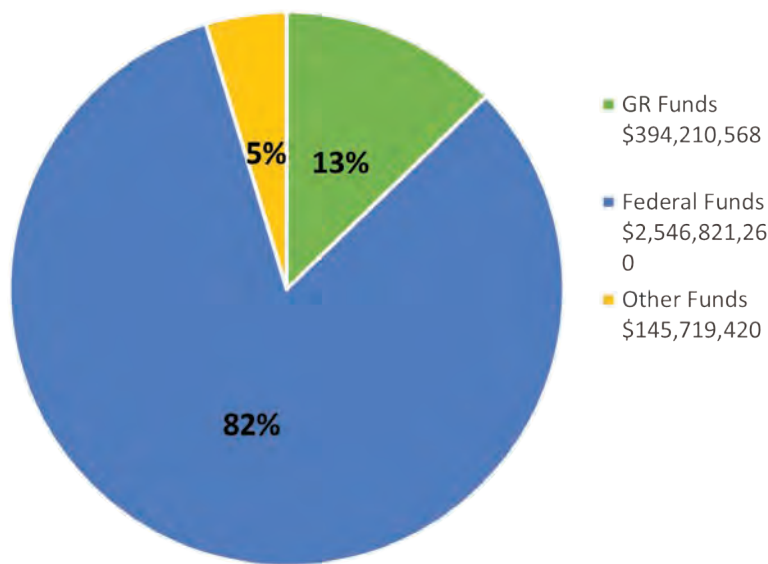
Individuals with disabilities, including serious mental illness, often experience barriers associated with joining and participating fully in the labor force.¹² People with disabilities are more likely to work part time and, on average, earn less than individuals without disabilities at every level of educational attainment.¹³ Because of the unique challenges individuals with disabilities face in the job market, national and state-level unemployment rates do not always reflect the prevalence of unemployment for people with serious mental illness or IDD. NAMI reported that the national unemployment rate for individuals receiving public mental health services was approximately 80 percent in 2012.¹⁴ The same year, the unemployment rate for individuals receiving services through the public mental health system in Texas was 85.6 percent.¹⁵ Yet for persons living with serious mental illness, employment can play a primary role in recovery and well-being.¹⁶ In 2014, The Bazelon Center for Mental Health Law reported that at least two thirds of people with a serious mental illness want to work, and many have been previously employed.¹⁷

In 2016, 11.8 percent of Texas’ population, or about 3.2 million people, had a disability, the second largest number per state in the nation.¹⁸ Individuals with disabilities, including serious mental illness, can enhance workforce diversity and offer employers unique skill sets and perspectives when integrated into the labor force. Employing people with disabilities is advantageous to businesses as it results in lower turnover, increased productivity, and access to a wider pool of skilled workers.¹⁹

Funding

TWC's funding is comprised of both federal and state dollars, with the majority of funding coming from federal sources. TWC provides grants through allocation formulas to Workforce Development Boards that plan and administer the Workforce Investment Act, Temporary Assistance for Needy Families Choices, Employment Services, Supplemental Nutrition Assistance Program Employment and Training, childcare, and other workforce and support services. Employer-paid state unemployment taxes and reimbursements pay for state unemployment benefits. The U.S. Department of Labor allocates funds from the Federal Unemployment Tax to the states to pay for administrative and operational costs.²⁰

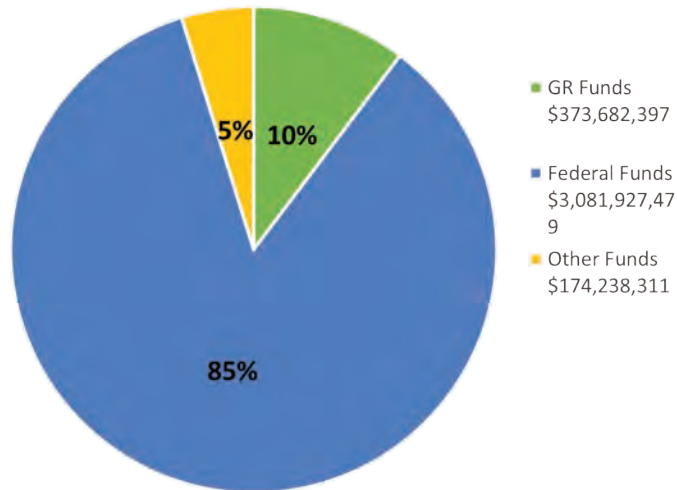
Figure 83. TWC Budget by Method of Finance FY 2018-19



The total TWC budget for FY 2018-19 was \$3,086,751,248.

Source: Legislative Budget Board. (November 2017). *General Appropriations Act for the 2018-19 Biennium: Text of Conference Committee Report on Senate Bill No. 1*. Retrieved from http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.pdf

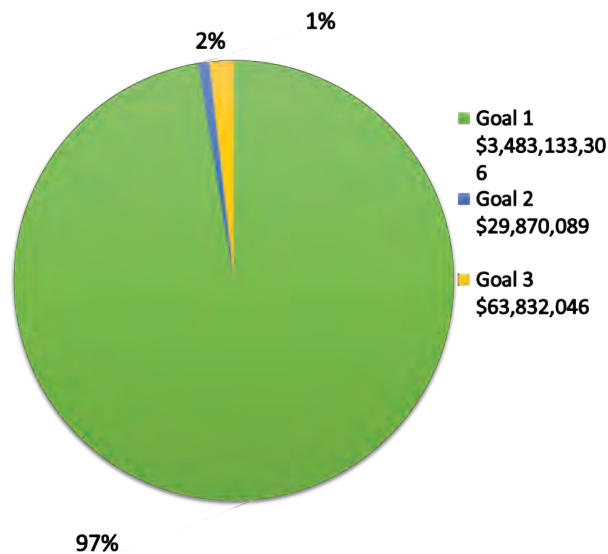
Figure 84. TWC Requested Funding by Method of Finance FY 2020-21



The total requested TWC budget for FY 2020-21 is \$3,726,772,657. If the Exceptional Item Funds were included, the additional funds would add \$67 million to the budget.

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021 – Texas Workforce Commission*. Retrieved from

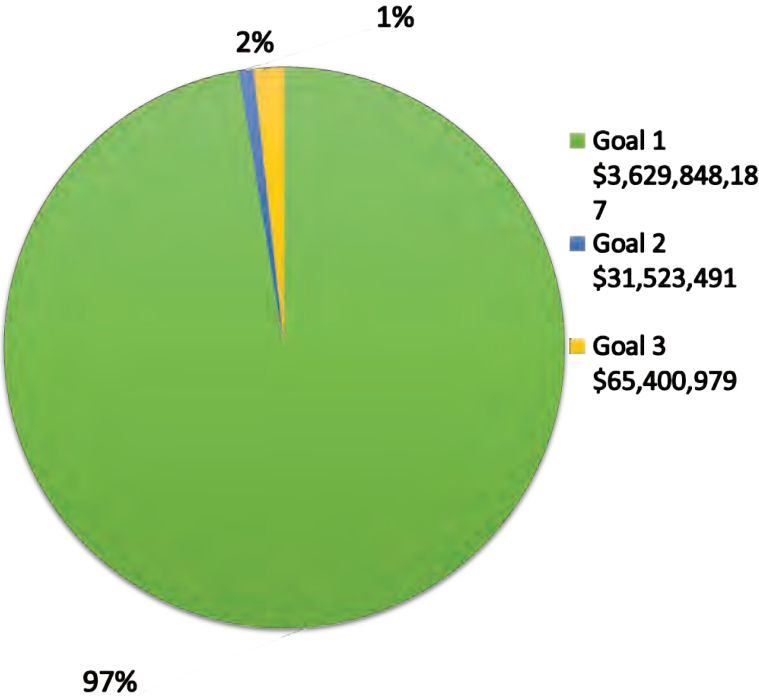
Figure 85. TWC Funding by Strategy FY 2018-19



Goal	Description
Goal 1	Support a workforce system to achieve/sustain economic prosperity
Goal 2	Program accountability/enforcement
Goal 3	Indirect administration

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021 – Texas Workforce Commission*.

Figure 86. TWC Funding by Strategy FY 2020-21



Goal	Description
Goal 1	Support a workforce system to achieve/sustain economic prosperity
Goal 2	Program accountability/enforcement
Goal 3	Indirect administration

Source: Legislative Budget Board. (2018). *Legislative Appropriations Request for Fiscal Years 2020 and 2021 – Texas Workforce Commission*.

Changing Environment

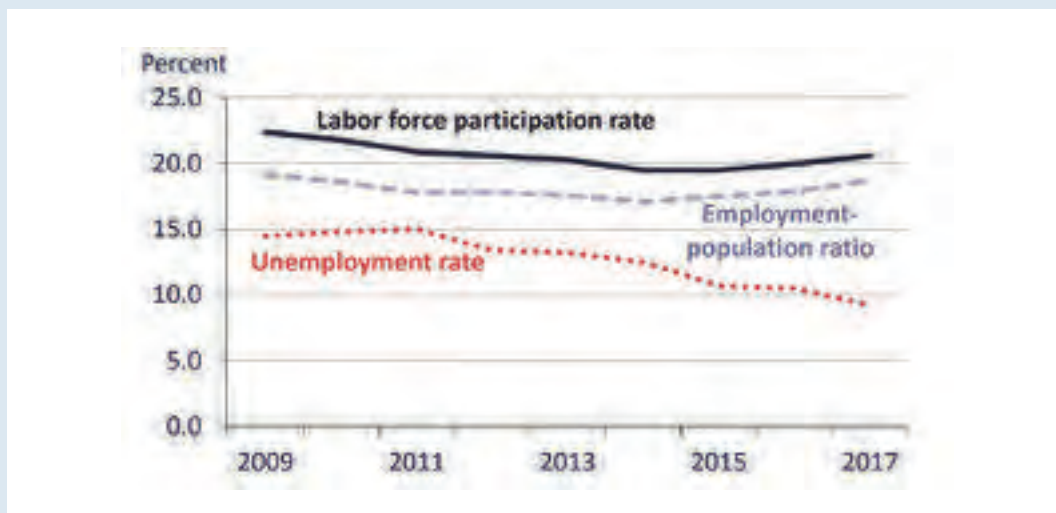
TRANSFER OF SERVICES FROM DARS TO TWC

Prior to September 2016, TWC did not provide any direct behavioral health treatments or supports to Texans with a mental health condition. However, in 2016, the state transitioned employment-related programs from DARS to TWC as part of the HHSC transformation process. As a result, TWC began to work directly with individuals with disabilities primarily through the Vocational Rehabilitation program. The VR program provides services for people with disabilities to help them prepare for, obtain, retain or advance in employments.²¹

EMPLOYMENT TRENDS IMPROVING THOUGH OVERALL OUTCOMES ARE POOR

Employment rates of people with disabilities have been improving. Nationally, labor force participation rates (the number of people available for work as a percentage of the total population) and employment rates for people with disabilities have been increasing while unemployment rates for people with disabilities have been decreasing.²² However, employment outcomes for people with disabilities continue to be far worse than for people without disabilities. In 2016, about 39 percent of Texans with disabilities living in the community were employed compared to 76 percent of people without a disability.²³ In the same year, the national unemployment rate for people with a disability was 10.5 percent, nearly twice that of people without a disability.²⁴

Figure 87. Selected National Labor Force Indicators, Persons with a Disability, 2009-2017



Source: Division of Labor Force Statistics. (June 25, 2018). *Persons with a Disability, 2017*. Presentation to Office of Disability Employment Policy (ODEP). Retrieved from https://www.dol.gov/odep/pdf/DOL_ODEP_Briefing_without_notes_06_2018.pdf

Programs for People Experiencing Mental Illness

VOCATIONAL REHABILITATION FOR PERSONS WITH PHYSICAL AND MENTAL DISABILITIES

For people experiencing mental illness, work can play a primary role in their lifelong recovery and wellbeing.²⁵ Employment promotes social acceptance, community integration, and gives people a sense of purpose, self-esteem, and self-worth.²⁶ People with mental illness face unique challenges to employment including stigma, discrimination, and fear of losing benefits. However, there are employment programs to help minimize these challenges, assist individuals with work readiness, and help them achieve long-term success in the workplace.²⁷

The Vocational Rehabilitation program is a state-federal partnership designed to help individuals with disabilities (physical and developmental disabilities as well as serious mental health conditions) prepare for, find, and keep jobs. The VR program is also intended to help individuals with disabilities transition from high school to a work environment.²⁸

An individual may be eligible for VR services if they:

- Have a disability which results in substantial barriers to employment
- Require services to prepare for, obtain, retain, or advance in employment
- Are able to obtain, retain or advance in employment as a result of services²⁹

People receiving social security disability benefits also qualify for VR services.³⁰ People who are eligible to receive VR services work with a VR counselor to determine what services are appropriate and needed. VR services are consumer-focused, meaning that those who receive services have a voice in their services. Consumers work with their VR counselors to create an individualized plan for employment, which outlines what employment goals an individual has and how VR services can assist in achieving those goals. VR services are based on an individual's needs and vary greatly depending on disability, needs, and employment goals. Work-related services may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services.³¹

Consumers can obtain these vocational rehabilitation services by applying with their local Texas Workforce Solutions – Vocational Rehabilitation Services Office; eligibility decisions are typically made within 60 days. If deemed eligible, the person will work with their assigned counselor to develop an IPE within 90 days that will include the services necessary for the person to reach their employment goals.

VR service providers partner with businesses to develop new employment opportunities. Program staff also work with public school districts to target students with disabilities who need services to help them transition from secondary education to post-secondary school or work.³²

More information on the VR program can be found online at <http://www.twc.state.tx.us/jobseekers/vocational-rehabilitation-adults>.

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Texas Veterans Commission

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Policy Concerns

- Continued expansion of veteran peer specialist services for mental health and substance use
- Long waiting lists for mental health services
- Coordination of federal and state services
- High risk of PTSD and suicide among veterans
- High rates of homelessness among veterans
- Lack of supports for veterans returning to civilian life after deployment
- Access to mental health services and supports in rural areas of the state

Fast Facts

- Texas is home to over 1.6 million veterans of the armed forces, more than any other state except California.¹ Texas is projected to have the most veterans of any state by 2020.²
- The Veterans Health Administration is America's largest integrated health care system, providing care at 1,240 health care facilities, including 170 medical centers and 1,061 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled veterans each year.³
- Women are the fastest growing group within the veteran population and are projected to make up 18.4 percent of all living veterans by 2045.⁴ There are nearly 169,000 women veterans in Texas.⁵
- While serving in the military, 55 out of every 100 women and 38 out of every 100 men report having been sexually harassed (including offensive comments about a person's body or sexual activity, displays of pornographic material, and unwanted sexual advances).⁶
- 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 VHA had increased from 27 percent in 2001 to more than 40 percent in 2014.⁷
- Veterans exhibit significantly higher suicide risk compared with the U.S. general population.⁸ *The Department of Veterans Affairs 2016 Suicide Data Report* concluded that 20 veterans die from suicide each day.⁹ Three out of five veterans who died by suicide were diagnosed as having a mental health condition.¹⁰
- 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.¹¹

TVC Acronyms

HHSC – Health and Human Services Commission

PTSD – Post-traumatic stress disorder

TBI – Traumatic brain injury

TVC – Texas Veterans Commission

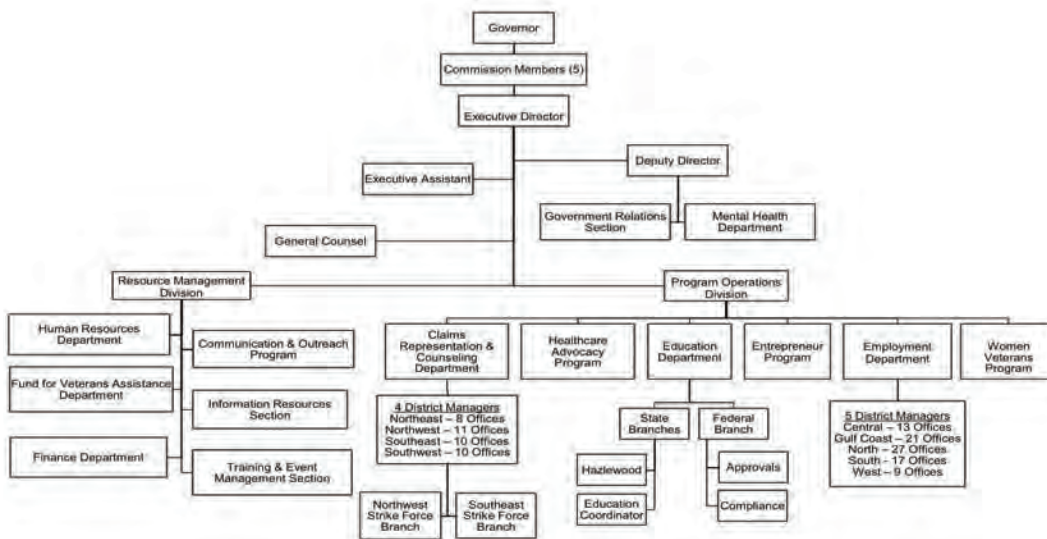
VA – Veterans Affairs

VHA – Veterans Health Administration

VISN – Veterans integrated service networks

VMHP – Veterans Mental Health Program

Organizational Chart



Retrieved from Legislative Budget Board (2018). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2020-2021*.

Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020>

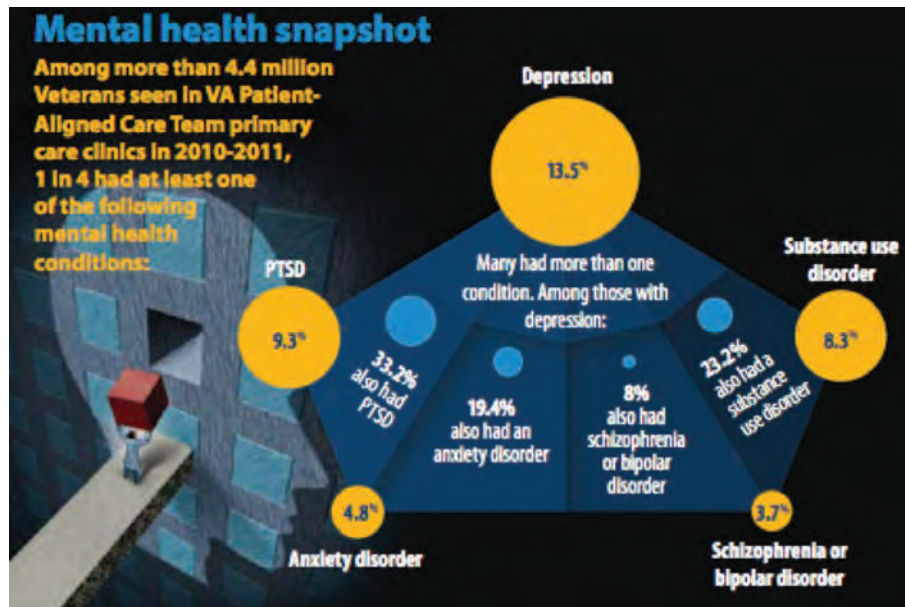
Overview

Texas is home to nearly 1.6 million veterans of the armed forces and represent 8 percent of the adult population, higher than the national average of 6.6 percent.¹² 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 to 20 percent of veterans of the Iraq and Afghanistan wars (Operations Iraqi Freedom and Enduring Freedom) are diagnosed with PTSD.¹³ In comparison, only 7 to 8 percent of American adults in the general population will experience PTSD at some point during their lifetime.¹⁴ In addition to combat trauma, sexual assault while in military duty (referred to as military sexual trauma) can also result in symptoms of PTSD.¹⁵

Among those women who use the VA to access health care, 23 out of 100 report having been sexually assaulted (unwanted physical sexual touching that involves some form of coercion) while in the military.¹⁶ Additionally, 55 out of 100 women and 38 out of 100 men report having been sexually harassed, which includes behavior such as offensive comments about a person's body or sexual activity, displays of pornographic material, and unwanted sexual advances while in the military.¹⁷ Thus, veterans are at increased risk for developing mental health conditions and substance use problems stemming from their military service.

Veterans have the option to receive mental health care from the VA. The figure below shows the prevalence of mental health conditions among veterans who received care in VA Patient-Aligned Care Team primary care clinics. PTSD, substance use conditions, and anxiety were the most commonly reported conditions for those veterans.¹⁸

Figure 88. A Mental Health Snapshot



Source: U.S. Department of Veterans Affairs. (2018). *Veterans Benefits Administration – Posters and Infographics*. Retrieved from <https://benefits.va.gov/BENEFITS/infographics.asp>

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.^{19,20} Only about half of all returning veterans who need services seek them out, and unfortunately just over one half of those veterans who seek services receive adequate care.²¹

The Texas Veterans Commission serves veterans and their dependents in all matters pertaining to veterans' disability benefits and rights. The TVC is Texas' designated agency to represent the state and its veterans before the U.S. Department of Veterans Affairs. The Commission submitted the TVC Strategic Plan for Fiscal Years 2019-2023 to the governor in June 2018. The plan is available at https://www.tvc.texas.gov/wp-content/uploads/2018/06/TVC_Strategic_Plan_2019-2023_Final.pdf.

The TVC 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.

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

Veterans' mental health is a focus for many legislators in Texas. A variety of legislation was filed in efforts to help more veterans access mental health treatment in hopes of reducing the suicide rate. In 2017, the 85th Legislature passed SB 578 (Lucio/Gutierrez) which directed HHSC to create a comprehensive action plan to “increase access to, and availability of, professional veteran health services to prevent suicide among the [veteran] population.”²² In addition to HHSC, other federal and state agencies must be involved in the coordination of the action plan, including the Texas Coordinating Council for Veterans Services, the U.S. Department of Veteran's Affairs, veteran advocacy groups, medical providers, and others. The action plan must include specific short-term recommendations in addition to long-term statutory, administrative, and budget-related recommendations to address veteran suicides.²³

An additional focus of the legislature included the treatment of PTSD and traumatic brain injury. Legislators passed HB 271 (Miller/Buckingham), which directed HHSC to “use existing resources to establish a pilot program to provide eligible veterans suffering from PTSD or traumatic brain injury with diagnostic services, hyperbaric oxygen treatment, and support services subject to available funding.” This legislation also created the Veteran's Recovery Fund, a dedicated account in the general revenue fund.²⁴

Another comprehensive veterans mental health bill passed in the 85th legislative session was SB 27 (Campbell/Blanco). The bill aimed to improve access to mental health services by:

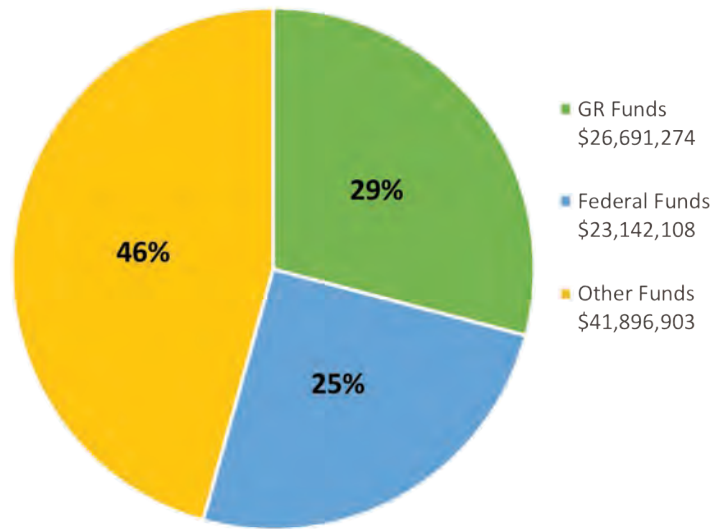
- Allowing the establishment of the National Center for Warrior Resiliency at the University of Texas Health Science Center at San Antonio;
- Requiring the development and implementation of peer service coordinator certification training;
- Improving access to mental health professionals, training, and technical assistance for peer service coordinators.²⁵

Funding

The Texas Veterans Commission receives both state and federal funding, as well as other funds.

*** Note: TVC is not part of the Health and Human Services enterprise.**

Figure 89. TVC Budget by Method of Finance FY 2018-19

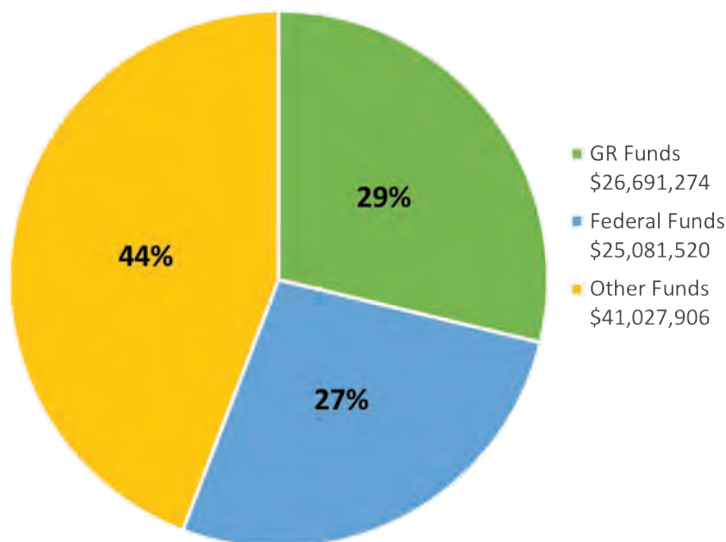


The total TVC budget for FY 2018-2019 was \$91,730,285.

Source: Legislative Budget Board (2018). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020>

*Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802, Governor's Emer/Def Grant

Figure 90. TVC Requested Budget by Method of Finance FY 2020-21

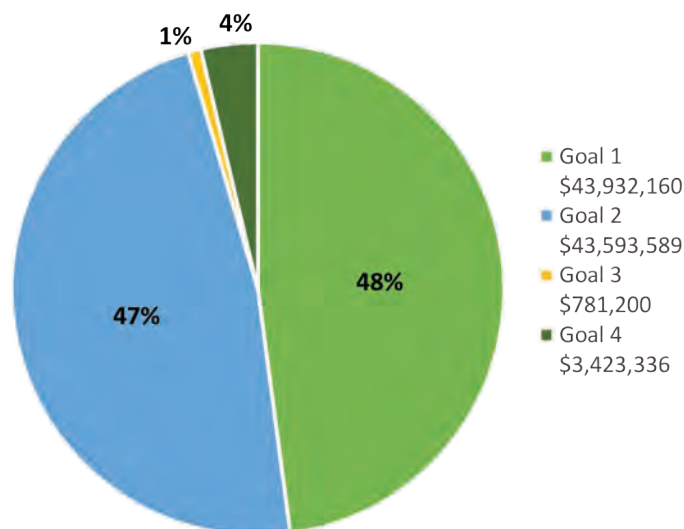


The total requested TVC budget for FY 2020-21 is \$92,800,700. If included in the budget, the Exceptional Items Requests would add an additional \$4,143,122.

Source: Legislative Budget Board (2018). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020>

*Other funds include: Fund for Veterans Assistance, Appropriated Receipts, Interagency Contracts, License Plate Trust Fund No. 0802, Governor's Emer/Def Grant

Figure 91. TVC Budget by Strategy FY 2018-19



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 (2018). *Texas Veteran Commission, Legislative Appropriations Request Fiscal Years 2020-2021*. Retrieved from <http://docs.lbb.state.tx.us/display.aspx?DocType=LAR&agy=403&fy=2020>

VA Behavioral Health Services

Nationally, veterans’ health care services are administered on a regional level by a system of 23 veterans integrated service networks, each containing a hierarchy of medical centers, on-site outpatient clinics, community-based outpatient clinics and vet centers, which provide counseling, outreach, and referral services to help veterans adjust to life post-combat. Texas is served by two VISNs: VISN 16: South Central VA Health Network, which provides services to areas of East Texas including Houston and Beaumont; and VISN 17: VA Heart of Texas Health Care Network, which provides services to the rest of the state.^{26, 27} For more information, see <https://www.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 their claims representation and counseling programs described above. There is a wide array of VA settings that provide both inpatient and outpatient behavioral health services, including primary care clinics, general and specialty outpatient mental health clinics, residential care facilities, and community living centers. Services and programs include:

- Specialized PTSD services,

- Psychosocial rehabilitation and recovery services,
- Suicide prevention programs,
- Evidence-based psychotherapy programs, and
- Substance use services.

The VA also provides behavioral health services for family members and survivors of active duty military personnel and veterans. Additionally, 300 Vet Centers nationwide provide psychological counseling for war-related trauma and other services such as outreach, case management, and social services referrals.²⁸ Vet Centers served a total of 287,095 veterans, service members, and military families in FY 2017 and provided 1,960,900 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services.²⁹ The latest report on VA health care utilization by recent veterans reported a total 9.7 million veterans used at least one VA benefit or service in FY 2016.³⁰

Across Texas, there are 67 VA Healthcare facilities and 21 Vet Centers. However, 41 VA Healthcare facilities and 19 Vet centers do not have TVC personnel available to professionally advocate in support of veterans and their families. Additionally, there are currently 50 counties that do not have Veteran County Service Officers, and of those 50 counties, 46 counties also lack TVC representation.³¹

For a comprehensive description of federal benefits and services available to veterans, family members and survivors, visit http://www.va.gov/opa/publications/benefits_book.asp.

Veterans Mental Health Program and Other Supports

Veterans exhibit significantly higher suicide risk compared with the U.S. general population.³² The Department of Veterans Affairs 2016 Suicide Data Report (the most recent study of its kind) concluded that 20 veterans die from suicide each day.³³ 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 are connected with a trained VA responder. Since its launch in 2007, the Veterans Crisis Line has answered over 2.8 million calls and initiated the dispatch of emergency services to callers in crisis over 74,000 times. The Veterans Crisis Line anonymous online chat service, added in 2009, has engaged in more than 332,000 online chats. In November 2011, the Veterans Crisis Line introduced a text messaging service to provide another way for veterans to connect through a personal cell phone or smart phone with confidential, round-the-clock support, and since that time has responded to more than 67,000 texts.³⁴

TexVet, a joint initiative by the Texas A&M Health Science Center and HHSC, is a network of health providers, community organizations, and volunteers who are committed to providing 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, ensuring that veterans are properly connected to the services that they need by knowledgeable partners across the state.³⁵ For more information, visit: <http://texvet.org>.

MILITARY VETERAN PEER NETWORK

One of the Veterans Mental Health Program 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 39 chapters across the state and is supported by grants from HHSC.³⁶

In FY 2016, 133,056 peer services were delivered to service members, veterans, and their families, representing a 34 percent increase from the previous year. Additionally, HHSC and TVC trained 6,074 peers, a 49 percent increase from FY 2015.³⁷

“No one is better prepared to speak with a veteran about her experiences than another veteran, a peer.” – Military Veteran Peer 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 traumatic brain injury, PTSD, depression, and substance use issues. Alternatively, a judge sitting in a specialty veteran’s court may have a better understanding of the mental health conditions and veteran-specific struggles that can increase risks for criminal behavior. The judge may also be more familiar with the range of community-based services and benefits available to veterans, and might include case managers and court clerks with military experience or familiarity working with veterans in the process. Thus, veteran’s courts may be more capable of diverting veterans from the criminal justice system and instead linking them and their families to benefits, services, and supports.

The first veteran’s court in Texas, located in Harris County, began accepting cases in 2009. As of May 2016, there are twenty-nine veteran’s courts operating throughout the state in the following counties:

- Bell
- Bexar
- Brazoria
- Cameron
- Collin
- Comal
- Dallas
- Denton
- El Paso
- Fannin
- Fort Bend
- Galveston
- Grayson
- Guadalupe
- Harris
- Hays
- Hidalgo
- Kaufman
- Midland
- Montgomery
- Nueces
- Rockwall
- Smith
- Tarrant
- Travis
- Webb
- Williamson^{38,39}

Women Veterans

Women are the fastest growing group in the veteran's population and are projected to make up 16 percent of all living veterans by 2043.⁴⁰ 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 twice as likely to develop PTSD as men.⁴¹ The risk of PTSD for men and women veterans is the same.⁴² However, women veterans are more likely to have lower incomes, lack private insurance, and have poorer health.⁴³ Women veterans earn almost \$10,000 less per year than male veterans and are up to four times more likely to be homeless than non-veteran women.^{44,45} Because of their heightened risk for having experienced things like military sexual trauma, homelessness and financial stress, it is important that health care, including mental health and substance use services, support services, and transitional resources are responsive to the needs of women veterans.

Visit <https://www.tvc.texas.gov/women-veterans/> for more information on other initiatives serving women veterans.

Health and Human Services Commission Veterans Services

HHSC collaborates with the TVC on several initiatives to improve outcomes for veterans. HHSC is a member of the Texas Coordinating Council for Veteran Services administered through TVC and TVC participates on the HHSC Statewide Behavioral Health Coordinating Council.

HHSC administers the Texas Veterans + Family Alliance Grant Program authorized by the 84th Legislature through SB 55 (Nelson/King) and the Mental Health Program for Veterans established by the 81st Texas Legislature. The 2017 legislature allocated \$20 million in FY 2018 to operate the Texas Veterans + Family Alliance Program, required by Rider 128.⁴⁶

HHSC also runs the Mental Health Program for Veterans, which allows for peer-to-peer counseling services for veterans offering more than 133,000 peer services in 2017.⁴⁷ Rider 174 directed HHSC to allocate \$5 million for both FY 2018 and 2019 to operate the program.⁴⁸ These services were made available to active service members, veterans, and family members.

Another major veterans initiative of HHSC is the Texas Veterans App. This is a free smartphone application that offers access to the following:

- Crisis intervention services through the Veterans Crisis Line
- Services for women veterans
- Local veterans and veteran service organizations
- Texas veterans hotline
- Texas Veterans Portal⁴⁹

Texas Veterans Hazlewood Act

The Texas Veterans Hazlewood Act offers eligible Texas veterans, their spouses, and their dependent children tuition exemption for up to 150 hours of college credits. This includes most fees charged at public institutions of higher education in Texas. More information on the Hazlewood Act is available at <https://www.tvc.texas.gov/education/hazlewood-act/>.

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Appendix 2. 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 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

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>

Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation: https://scholar.google.com/scholar?q=Peer-based+addiction+recovery+support+History,+Theory,+Practice,+and+Scientific+evaluation&hl=en&as_sdt=0&as_vis=1&oi=scholar

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/>

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

CHILD WELFARE/CHILDREN'S MENTAL HEALTH

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

National Child Traumatic Stress Network: <http://www.nctsnct.net.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>

TexProtects Champions for Safe Children: <https://www.texprotects.org/>

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

Prosumers of San Antonio: <http://www.prosumersinternational.org/>

Mental Health America: <http://www.mentalhealthamerica.net/>

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/>

World Federation for Mental Health: <https://wfmh.global/>

World Health Organization: <http://www.who.int/>

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 Jail Project: <https://texasjailproject.org/>

Texas Public Policy Foundation: <https://www.texaspolicy.com/centers/detail/effective-justice>

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>

U.S. Department of Health & Human Services: Office of Minority Health: <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>

EARLY CHILDHOOD AND MENTAL HEALTH

First3Years (previously Texas Association for Infant Mental Health): <https://first-3yearstx.org/>

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

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

FAITH-BASED MENTAL HEALTH

American Psychiatric Association Foundation, Mental Health – A Guide for Faith Leaders: https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental_Health_Guide_Tool_Kit_2018.pdf

Hogg Foundation for Mental Health: <http://hogg.utexas.edu/what-we-do/faith-based-outreach-education>

Mental Health.gov: <https://www.mentalhealth.gov/talk/faith-community-leaders>

NCBI Resources (National Center for Biotechnology Information/National Institute of Health): <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4000587/>

Substance Abuse and Mental Health Services Administration: <https://www.samhsa.gov/faith-based-initiatives>

GENERAL INFORMATION ON MENTAL HEALTH AND SUBSTANCE USE

Center for Public Policy Priorities: <http://forabettertexas.org/>

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/cz01> and <https://www.healthypeople.gov/2020/data-source/uniform-reporting-system>

HOUSING

Coalition for Supportive Housing: <https://www.csh.org/about-csh/in-the-field/tx/>

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/>

Hogg Foundation for Mental Health | A Guide to Understanding Mental Health Systems and Services in Texas

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: <https://integrationacademy.ahrq.gov/about/what-integrated-behavioral-health>

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/>

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Karyn Harvey, Positive Identity Development: An Alternative Treatment Approach for Individuals with Mild and Moderate Intellectual Disabilities (book) <http://www.karynharvey.com/>

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Texas Advocates, a coalition of self-advocates throughout the state working to support one another: http://arctx.convio.net/site/PageServer?pagename=TXA_homepage

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Mental Health Care for Adults with Intellectual and Developmental Disabilities toolkit: <http://vkc.mc.vanderbilt.edu/etoolkit/mental-and-behavioral-health/>

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Communities in Schools (CIS) of Texas: <http://www.cisoftexas.org/>

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Appendix 3. Glossary: Common Behavioral Health Terms

1115 Waiver: A waiver under section 1115 of Social Security Act that allows CMS and states more flexibility in designing programs to ensure delivery of Medicaid services.

Acute: Refers to a disease or condition that develops rapidly and is intense and of short duration.

Adjudication: Is a finding that a youth has engaged in delinquent conduct or “conduct in need of supervision.” It is similar to a “conviction” in adult court.

Affect: Feeling or emotion, especially as manifested by facial expression or body language.

Affordable housing: Housing units that are affordable for people who have an income below the median family income of a specific area. Affordable is often considered to be 30% or less of a person’s monthly income.

Alternative therapy: Mental health care that is used instead of or in addition to conventional mental health services.

Anxiety: A sense of fear, nervousness, and apprehension about something.

Anxiety disorders: A group of chronic disorders ranging from feelings of uneasiness to immobilizing bouts of terror. Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder.

Behavioral health care: Continuum of services for individuals at risk of, or currently living with, one or more mental health conditions, substance use disorders or other behavioral health disorders.

Behavioral therapy: Therapy focusing on changing unwanted behaviors through rewards, reinforcements and desensitization. Desensitization, or exposure therapy, is a process of confronting something that arouses anxiety, discomfort or fear and overcoming the unwanted responses.

Biomedical treatment: Treatment involving medication. The kind of medication a psychiatrist prescribes varies with the disorder and the individual being treated; also referred to as psychopharmacology.

Bipolar disorder: A mood disorder in which a person alternates between episodes of major depression and mania.

Boarding home: A business that provides basic care, such as meals and transportation, to at least three residents who have a disability and/or are elderly, where the residents are unrelated to the owner.

Capitated: Relating to, participating in, or being a health-care system in which a medical provider is given a set fee per patient (as by an HMO) regardless of treatment required.

Caregiver: A person who has special training to help people with mental health conditions. Caregivers can be, but are not required to be, mental health professionals. Caregivers may include social workers, teachers, psychologists, psychiatrists, family members and mentors.

Case manager: An individual who organizes and coordinates services and supports for persons with mental health needs and their families. [Also service coordinator, advocate and facilitator.]

Centers for Medicare and Medicaid Services (CMS): The U.S. federal agency that administers Medicare, Medicaid, and the State Children’s Health Insurance Program.

Certified Family Partner (CFP): Individuals with experience parenting a child with mental, emotional or behavioral health disorders and have had personal involvement with the public mental health system and have received approved training and passed a certification exam. A family partner provides information and support to other parents in similar circumstances.

Certified Peer 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, employ-

er-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:

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U.S. Dept. of Health and Human Services

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Mission

Transform how communities promote mental health in everyday life.

Vision

The people of Texas thrive in communities that support mental health and well-being.



Hogg Foundation for Mental Health

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February 14, 2020

Sheriff Eddy Lange
Sheriff, Bell County
P.O. Box 749
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Sheriff Lange,

As you may be aware, HB 3116 86(R) created a task force to review best practice standards for the detention of persons with intellectual and developmental disabilities (IDD). At our first meeting, the IDD Task Force discussed the need to better understand:

- local process for identifying the possible presence of an inmate with IDD;
- the average length of stay for these inmates; and
- the cost of housing an inmate suspected of having IDD.

It is our understanding; your county has participated in the "Stepping Up Program" and may have the capability of identifying inmates with mental health issues and Intellectual or Developmental Disabilities.

In order to ensure the data we collect is consistent from all the participating counties, we are requesting you provide the following for Calendar Year 2016, 2017, 2018 and if available 2019:

- Average length of stay for an inmate determined to have IDD at your facility.
- Average cost per day to house an inmate with IDD at your facility.
- Average length of stay for an inmate with a mental health diagnosis.
- Average cost per day to house an inmate with a mental health diagnosis.

For the purposes of this effort, an inmate with IDD is one that has received that designation through a formal diagnosis. This could include the Local Intellectual and Developmental Disability Authority (LIDDA), independent psychologist (who doesn't necessarily need to be with the LIDDA), neurologist or any doctor (i.e. someone who diagnoses cerebral palsy) with supporting documents that indicate the disability. If an inmate has been diagnosed with both a mental health issue and IDD, please include them in the IDD data. If you have any additional questions, please contact Alicia Barker at (512)463-3236 or alicia.barker@tcjs.state.tx.us

We request this information be submitted no later than March 1, 2020.

Thank you,


Brandon S. Wood
Executive Director

Judge Bill Stoudt, Longview, Chair
Dr. Esmail Porsa, M.D., Parker, Vice-Chair
Melinda E. Taylor, Austin

Sheriff Dennis D. Wilson, Groesbeck
Sheriff Kelly Rowe, Lubbock
Patricia M. Anthony, Garland

Commissioner Ben Perry, Waco
Duane Lock, Southlake
Monica McBride, Alpine

"The Commission on Jail Standards welcomes all suggestions and will promptly respond to all complaints directed against the agency or any facilities under its purview".

To empower local government to provide safe, secure and suitable local jail facilities through proper rules and procedures while promoting innovative programs and ideas